

St George's Healthcare NHS Trust

2011/12 annual report



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Foreword from Christopher Smallwood, chairman

I am delighted to welcome you to the St George's Healthcare NHS Trust annual report 2011/12, my first as chairman.

I am pleased to have joined the trust at such a crucial and exciting time in its history, and would like to pay tribute to Naaz Coker for her leadership over the last eight years. During her time as chair the trust became established as a major trauma centre and hyper-acute stroke unit, significantly improved its quality and safety of care, successfully integrated with community services Wandsworth and worked to improve its financial position.

Since becoming chairman in November 2011 I have enjoyed working with the board and staff as the trust continues to develop its services to meet the needs of the modern NHS. The trust has a significant role to play in ensuring that the public in southwest London continue to have access to first class healthcare services in hospital and community settings.

During the coming financial year we plan to submit our application to become a Foundation Trust (FT), which is crucial to the long-term future of the organisation. FT status is a sign of quality in terms of clinical care, management and performance and will give us the freedom to redesign services that meet local needs. Importantly it will make us more accountable to our patients, staff and community. We currently have over 5,000 patient and public trust members and we will work to grow this number as part of our FT plans.

Key to our FT application is our financial and operational performance, both of which have been excellent this year.

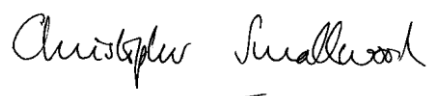
During 2011/12 we returned a £5.7 million surplus, which will be invested in improving our frontline services. The benefits of this prudent financial management can be seen in the redeveloped A&E, where the new Acute Medicine Unit, Clinical Decisions Unit, Children's Emergency Department and Paediatric Assessment Unit are making a real difference for patients. The opening of the new Rose Centre for breast screening and the state-of-the-art simulation centre are further signs of how we are investing in the future.

Importantly we have managed to maintain high standards of patient care while meeting our financial targets. During the last year St George's Healthcare was named by Department of Health as having some of the lowest mortality rates in the country. In addition a Myocardial Ischaemia National Audit Project showed the trust as having the best response rate for treating heart attack patients in London.

Over the last year St George's Healthcare has also reported its best ever MRSA bacterium (blood stream) rates, with only one patient acquiring the infection in the last twelve months. Our national inpatient survey results have shown a remarkable improvement in terms of patient experience over the last two years.

The challenge for the trust is to continue to build on this good work during a time of significant change in the NHS. It's a

challenge I look forward to meeting with the support of the board and, most importantly, with the staff across the organisation whose dedication and hard work is what makes St George's such a great institution.

A handwritten signature in black ink that reads "Christopher Smallwood". The signature is written in a cursive style with a horizontal line underneath the name.

Christopher Smallwood
Chairman

Introduction from Miles Scott, chief executive

Since joining St George's Healthcare as chief executive in November 2011 I have been hugely impressed by the quality, professionalism and hard work of staff across the organisation.

Without doubt the biggest challenge for the 2012/13 financial year will be to deliver our budgets. Across the trust our productivity improvement requirement is 6%, and we also need to plan for similar levels in future years. Our improvement programme will play a significant role in addressing this.

However, we can take heart and inspiration from our financial performance last year, when we not only made the significant savings demanded of us but also paid off the final instalment of our historic debt.

Our strong financial performance saw St George's Healthcare named as being one of only two NHS trusts in the capital that is financially viable in the long-term in NHS London's Sustainable and Financially Effective (SaFE) report. This demonstrates that the careful financial management of the previous five years has provided a platform to achieve our goal of becoming a Foundation Trust in 2014.

Meeting our financial targets means that we have been able to continue to invest in services that are improving care for patients and saving lives.

We are already a major trauma centre, hyper-acute stroke unit and a centre of excellence for cancer and cardiac care. This year we will further increase our

operating theatre capacity, develop our acute children's services both in the hospital and community, and start the installation of a helipad on top of St James Wing at St George's Hospital to support the major trauma centre.

Key to our credibility as a major healthcare provider is our ability to maintain the highest standards of patient care while meeting our financial targets. Last year we demonstrated that in tackling our financial challenges we have excelled in a number of areas which you can read about in this report.

I am particularly proud that the 2011 Care Quality Commission patient surveys have shown that we are putting our patients first. We can hit every financial and performance target in the book, but that would never compensate for our patients and their families and carers not feeling as though we are doing everything we can to make their experience with us as good as possible.

Importantly in these challenging times the 2011 NHS staff survey showed that our staff believe that the trust is committed to supporting a healthy work life balance. The survey also showed a good awareness across the organisation of the trust values of excellent, kind, responsible and respectful which go to the heart of everything that we do.

The next twelve months promise to be very exciting for St George's Healthcare. As well as submitting our Foundation Trust application, we are taking a leading role in establishing a LETB (Local Education and Training Board) for south

London that will take over responsibility for professional education and training from NHS London and the London Deanery. Together with St George's, University of London we will develop a new research strategy this year. In doing so we will also formalise relations with one of London's Academic Health Science Networks. Over the coming year we will also have a large role to play in the *Better Services, Better Value* review of how healthcare is provided across southwest London.

I am very grateful to all of our staff for the welcome extended to me and more importantly for everything they have done for our patients over the last year. I would also like to pay tribute to the work of my predecessor David Astley who stepped-down in May 2011 after four successful years at the trust. My experience so far gives me great optimism for what can be achieved at St George's Healthcare and I look forward to helping the trust to achieve its full potential.

A handwritten signature in black ink, appearing to read 'Miles Scott'.

Miles Scott
Chief Executive

About St George's Healthcare NHS Trust

With nearly 8,000 dedicated staff caring for patients around the clock, we are the largest healthcare provider in southwest London.

Our main site, St George's Hospital in Tooting – one of the country's principal teaching hospitals – is shared with St George's, University of London, which trains medical students and carries out advanced medical research. St George's Hospital also hosts the St George's, University of London and Kingston University Faculty of Health and Social Care Sciences, which is responsible for training a wide range of healthcare professionals from across the region.

As well as acute hospital services, we provide a wide variety of specialist care and a full range of community services to patients of all ages following integration with Community Services Wandsworth in 2010.

St George's Healthcare serves a population of 1.3 million across southwest London. A large number of services, such as cardiothoracic medicine and surgery, neurosciences and renal transplantation, also cover significant populations from Surrey and Sussex, totalling around 3.5 million people.

The trust also provides care for patients from a larger catchment area in southeast England, for specialties such as complex pelvic trauma. Other services treat patients from all over the country, such as family HIV care and bone marrow transplantation for non-cancer diseases. The trust also provides a nationwide state-of-the-art endoscopy training centre.

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 the quality of services for patients. These include the South London Cardiac and Stoke 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.

We provide healthcare services at:

Hospitals

- St George's Hospital, Tooting
- Queen Mary's Hospital, Roehampton

Therapy centres

- St John's Therapy Centre

Health centres

- Balham Health Centre
- Bridge Lane Health Centre
- Brocklebank Health Centre
- Doddington Health Centre
- Eileen Lecky Clinic
- Joan Bicknell Centre
- Stormont Health Clinic
- Tooting Health Clinic
- Tudor Lodge Health Centre
- Westmoor Community Clinic

Prisons

- HMP Wandsworth

We also provide services in GP surgeries, schools, nurseries, community centres and in patients own homes

A brief history

1733	The original St George's Hospital opens at Lanesborough House, now the Lanesborough Hotel, on Hyde Park Corner
1868	St George's Hospital Medical School established at the hospital
1869	The Atkinson Morley Hospital opens in Wimbledon
1948	The National Health Service is established
1954	The Grove Fever Hospital and Fountain Hospital in Tooting become part of the St George's Group
1973	Building of the new St George's Hospital in Tooting begins on the Grove Fever Hospital site
1976	St George's Hospital Medical School moves to the new Tooting site and hospital services begin to transfer from Hyde Park Corner
1980	St George's at Hyde Park Corner formally closes in June, with Her Majesty the Queen officially opening the Tooting site in November
1984	Jenner Wing opens
1988	St James Wing opens following the closure of the St James Hospital in Balham
1993	St George's Group becomes St George's Healthcare NHS Trust
2003	Atkinson Morley Hospital in Wimbledon closes, with services moving into the new Atkinson Morley Wing at St George's Hospital
2009	St George's Healthcare named as large trust of the year by Dr Foster, and the Grosvenor Wing refurbishment is completed
2010	<p>St George's Healthcare becomes one of four major trauma centres and one of eight hyper-acute stroke units for London</p> <p>The trust merges with Community Services Wandsworth, becoming responsible for services based at Queen Mary's Hospital in Roehampton, and health centres, GP practices, schools and nurseries in Wandsworth, and healthcare for offenders at HMP Wandsworth.</p>
2012	The Wolfson Neurorehabilitation Centre in Wimbledon closes, with services moving to St George's Hospital and Queen Mary's Hospital

2011/12 review

Pioneering stem cell treatment cures sickle cell patient Remmy Kamya



Pioneering stem cell transplant treatment used for sickle cell patients successfully cured 23-year-old Remmy Kamya of this crippling disease. The treatment, which is a UK first, was led by Dr Mickey Koh, director of stem cell transplants and consultant haematologist at St George's Hospital.

The management of sickle cell disease has traditionally focused on treating symptoms. The only cure up until now being a stem cell transplant, using high levels of chemotherapy to kill off the unhealthy blood cells and to ensure that the donor's tissue is not rejected. These transplants are often restricted to children as the levels of chemotherapy may be too toxic for an adult.

The new procedure is novel because it does not use any chemotherapy in the transplant regimen. Instead, it relies on low dose radiotherapy and antibody which modulates the immune system. This makes the treatment tolerable to the patient while minimising graft rejection

and other potential serious complications from the transplant.

Mickey Koh says: "This exciting development opens up the possibility for more patients affected by this disease to be potentially cured by a transplant. This novel chemotherapy free regimen was well tolerated and successful in terms of graft acceptance and the absence of serious post transplant complications."

Twelve months on from his transplant, Remmy leads a normal life and is due to finish university this summer. He said: "I am less tired and have not suffered a sickle cell crisis since!"

Remmy is the first patient in the UK to receive this breakthrough treatment. Sickle cell anaemia is an inherited, lifelong disease and is the most common of the hereditary blood disorders.

You can read more about Remmy's pioneering treatment and sickle cell anaemia at <http://www.stgeorges.nhs.uk/mediagazette.asp>

Major trauma saving lives



Getting the right patient to the right hospital as quickly as possible has now become a reality for trauma patients across London. St George's Hospital is home to one of four major trauma centres serving the capital.

In 2010 Robert Williamson lay in a road after a serious motorbike accident in Streatham Hill with a shattered pelvis, crushed bowel and dislocated hips. Just 12 months later Robert was back on his feet.

Robert was lucky in that he was brought straight to St George's Hospital's major trauma unit to receive life-saving care.

X-rays of Robert's pelvis immediately after the accident showed it was completely shattered and he had to undergo 20 operations over a period of months.

Robert said: "Initially the doctors told me that if I was able to walk again I would definitely have a severe limp. Fortunately that isn't the case now, but it was very bleak at the time – I had a lot of extreme pain. If I didn't have access to the major

trauma centre I might not be walking at this point. I'm sure most people want to be like me and on the way back to full health after something like this and I put this down to the trauma team."

Martin Bircher, consultant orthopaedic and trauma surgeon, operated on Robert and found the type of open pelvic fracture, where there may be contact with the skin or internal organs, to be one of the most dangerous. He said: "When I started treating these sorts of injuries in the late 1980s, the mortality was approaching 50 per cent. Through the tremendous team work of everybody from roadside to major trauma unit and beyond, Robert's life was saved and his long-term disability reduced"

St George's Hospital is the major trauma centre for the South West London and Surrey Trauma Network and has all the specialist staff and state-of-the-art facilities to care for patients suffering life-threatening injuries, such as stabbings, gunshot wounds and serious road traffic accidents.

You can read more about Robert's treatment at the major trauma centre at <http://www.stgeorges.nhs.uk/mediagazette.asp>

Mum receives daughter's kidney in tissue incompatible kidney transplant



In July 2011 the transplant team at St George's Hospital performed its first tissue incompatible (also known as HLA incompatible) kidney transplant on Debra Gouldbourne, who was born with a condition that caused her kidneys to fail.

Debra's daughter Jade was tested as a match for Debra but the results showed that her body would attempt to reject the organ. Despite this setback, innovative medicine and the support of a multi-disciplinary healthcare team meant the transplant could still go ahead.

Normally when a donor receives a tissue incompatible organ, the body's immune system will attack the kidney with antibodies and cause it to fail. In Debra's case a complex series of treatments successfully bypassed her body's natural response, allowing her to accept the organ.

A month before her operation Debra was given an infusion which removed some of the white cells – cells responsible for producing antibodies and triggering an

immune response – from her blood. She also went through a treatment known as double filtration plasma exchange, which reduced the unwanted antibodies already present in her bloodstream to very low levels.

The low levels of antibodies in Debra's bloodstream allowed the kidney to be accepted and, over four months after the transplant, Debra has fully recovered and there has been no sign of rejection.

Though Debra will continue taking immunosuppressive medicines, she is back to everyday life with normal kidney function.

Debra said: "Accepting a kidney from my daughter has been a very emotional experience for both of us. We spoke to each other over a long period of time and built up to the surgery together, so we shared a huge emotional journey as well as the physical recovery."

Jade said: "The idea of donating a kidney was scary but the clinical team at St George's were really reassuring and gave me great confidence. They really did everything they could to make both of us comfortable and keep us informed so that we understood what was happening. I can't thank them enough for what they've done for us."

Both Debra and Jade are Jehovah's Witnesses so were unable to accept blood transfusions, which made the surgery more complicated.

Consultant renal transplant surgeon Mohamed Morsy (recipient surgeon) said:

“A key challenge to the theatre team was making sure that we absolutely minimised blood loss during the operation. Though we put into place special measures in line with Debra’s faith to control blood loss, she bled very little which was the perfect result for us.”

Nicos Kessarlis (donor surgeon) consultant renal transplant surgeon and lead in antibody incompatible transplantation said:

“The preparation for surgery is what made this whole procedure possible and that is down to the talented multidisciplinary team of doctors, nurses, clinical scientists and surgeons we have at St George’s Hospital.

“Debra was perfectly prepared for the procedure when she reached the operating table. Suppressing her immune system so that she could successfully accept Jade’s kidney was very challenging and is a huge achievement for the team.”

It is believed that this is the first time in the world that the procedure has been conducted between two Jehovah’s Witnesses.

You can read more about Debra and Jade at <http://www.stgeorges.nhs.uk/mediagazette.asp>

Innovative robotic surgery for bladder cancer patients



The trust is using cutting-edge technology to improve outcomes for bladder cancer patients.

A radical robotic cystectomy is a minimally invasive alternative technique to the open surgery that is usually used when performing this procedure. A cystectomy is the removal of all or part of the bladder and is part of the standard treatment for bladder cancer.

Robotic surgery was introduced about five years ago as a minimally invasive alternative technique and remains a fairly novel treatment, with only a handful of hospitals in the UK currently performing this surgery.

63-year-old Margaret Box from West Wimbledon is one of the first people at St George’s to undergo a radical robotic cystectomy. She is enjoying her busy lifestyle again after undergoing the treatment nearly a year ago.

Margaret was in hospital for 12 days and after five days felt comfortable enough to stop taking painkillers. She has not

needed any since. Margaret has high praise for the level of care she received from staff at St George's. She said: "Staff were very kind. Everyone I came into contact with during my treatment was very friendly and accommodating."

Matthew Perry, urology consultant, said: "Robotic surgery for bladder cancer offers the advantages of less trauma to the patient while maintaining excellent cancer control rates. This means patients get better faster, have less complications, shorter hospital stays and a faster return to work."

St George's Healthcare's urology department is a regional centre for prostate, bladder and renal cancer and treats patients from across southwest London and Surrey.

You can read more about Margaret and how we are using robotic surgery at <http://www.stgeorges.nhs.uk/mediagazette.asp>

New technology is pushing the boundaries and saving lives



Heart patients treated at St George's Hospital are benefiting from cutting-edge

technology that is helping clinicians to save the lives of those who have suffered a cardiac arrest.

The LUCAS 2 is an automated chest compression device that takes over the 'cardiac massage' part of cardiopulmonary resuscitation (CPR) when a patient goes into cardiac arrest. This allows clinicians to perform emergency treatment quicker which increases the patients' chance of survival. St George's is one of only three pioneering heart attack centres in London currently using the LUCAS 2.

Patient Cliff Daubney, from Surrey, was one of the first patients at the hospital that the device was used on. He said: "The care I have received from the team here at St George's has been phenomenal. The nurses are wonderful and have made me very comfortable during my stay here. This machine is an amazing piece of equipment, and will help save the lives of many patients."

Breege Skeffington, senior sister, coronary care unit said: "Mr Daubney came to the hospital suffering from a prolonged cardiac arrest. The LUCAS 2 machine gave him regular chest compressions during CPR, and ensured blood was still pumping around his body. This method of treatment was more successful than the alternatives would have been, and helped to bring his condition back under control."

You can read more about Cliff and the LUCAS 2 system at <http://www.stgeorges.nhs.uk/mediagazette.asp>

New information and support centre for cancer patients



The Macmillan information and support centre for patients, carers and families affected by cancer opened its doors at St George's Hospital in July 2011.

The centre provides vital information and support for anyone affected by cancer, whether they are worried they may have the disease, during treatment, or whilst adjusting to life afterwards. The relaxed and informal space includes a main room offering information booklets and leaflets and a quiet room.

There is a large screen and keyboard for people to access helpful websites, and two specialist members of staff on hand to answer any questions. Patients, carers and their families are able to drop in at any time without an appointment.

Read more about the Macmillan information and support centre at <http://www.stgeorges.nhs.uk/mediagazette.asp>

Leading the way in shortening patient stays



An innovative change in the way cancer services are provided means patients can now leave St George's Hospital sooner after surgery.

The trust is one of 13 pilot sites in England working in collaboration with NHS Improvement to take forward the day case or overnight stay discharge model for women receiving breast surgery.

This change means that many people are able to have surgery and return home the same or next day. In the past patients might have been in hospital for up to six days.

Patients are only discharged if it is safe for them to go home. Once they get home they are not left to their own devices – they are supported by a Macmillan breast care nurse and district nurses in their own home.

Discharging patients earlier reduces inpatient stays and improves patient recovery. It also helps patients avoid deep vein thrombosis and hospital

83%

of breast cancer patients discharged the same or next day

acquired infections such as MRSA which are often associated with increased length of stay.”

83% of breast cancer patients discharged the same or next day – none of the patients discharged within 23 hours readmitted to hospital within 30 days

You can read more about how we are shortening patient stays at <http://www.stgeorges.nhs.uk/mediagazette.asp>

information and support, making sure that the neo-natal unit has consistent, high quality family centred care. Caring for a premature baby’s entire family is widely recognised as a crucial part of their overall clinical care, making a positive contribution to the long-term health and wellbeing of the child.

You can read more about our family centred care coordinator at <http://www.stgeorges.nhs.uk/mediagazette.asp>

First family centred care coordinator for neo-natal unit



First Touch, the trust’s neo-natal unit charity, and Bliss, the special care baby charity, joined forces in 2011 to create the UK’s first family centred care (FCC) coordinator post at St George’s Hospital. This innovative position provides care for families of premature and sick babies from across south west London at what is an extremely difficult and challenging time.

The coordinator is based on the neo-natal unit and works with families to provide

Community service transforming care for patients



A year after integrating with Community Services Wandsworth (CSW) patients from across the borough are seeing the benefits. Integration has been a positive experience and change. CSW and St George’s Healthcare staff have a much clearer understanding of each other’s priorities and this is helping them to work better together and deliver improved patient care.

In senior health services (previously known as geriatrics), streamlined care pathways and changes such as the development of common processes for

falls prevention have had a significant impact.

New models of care have also seen patients and staff benefit from increased access to consultant geriatrician expertise. The community ward has also improved the care given to patients with long-term conditions and reduced admissions for those at high risk who are now able to receive treatment in their own homes.

The 'settling home' and telehealth initiatives are also giving patients access to primary care therapy equipment and urgent care services at home, helping them to manage their conditions better.

In respiratory services, patients are receiving earlier assessment and follow-up on discharge, which has seen both length-of-stay and readmission rates for the services drop by 33 per cent.

You can find out more about how integration with Community Services Wandsworth is transforming care for patients at <http://www.stgeorges.nhs.uk/mediagazette.asp>

Enhancing care for sickle cell patients



We are continuing to transform our sickle cell services, working closely with NHS Wandsworth, community nurses and GPs to deliver a multi-disciplinary service with more care delivered closer to patients' homes. This will mean that only those patients with the most complex healthcare needs will come into hospital.

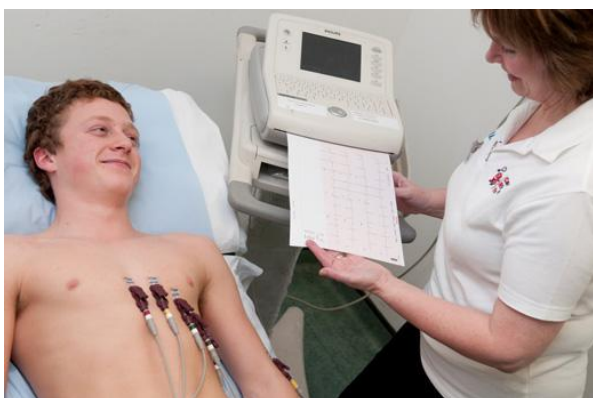
Two specialist appointments were made in 2011 to ensure improved care for local sickle cell patients.

Elizabeth Rhodes joined the trust as sickle cell haematology consultant ensuring that patients living with this condition receive stabilised and consistent care. Penelope Cream joined as clinical health psychologist, a role that is crucial in supporting patients in the management of their condition as well as dealing with the chronic and acute pain.

Sickle cell anaemia is an inherited, life-long disease that affects people from African and African-Caribbean communities, and is the most common of the hereditary blood disorders.

You can read more about how we are enhancing care for sickle cell patients at <http://www.stgeorges.nhs.uk/mediagazette.asp>

Cardiac arrest survival rates among the best in London



The survival rates of patients brought to St George's Hospital having suffered a cardiac arrest is in the top two in London. The London Ambulance Service found that between August 2010 and July 2011 the survival rate of patients brought to St George's was 15.4 per cent, placing the hospital in the top two out of more than 30 London hospitals for the second year running.

These statistics demonstrate that the service we provide is among the best anywhere.

The teamwork between several departments, including A&E, cardiology, resuscitation services and intensive care, combined with the latest technologies ensures that patients receive specialist attention as quickly as possible, which ultimately saves lives.

St George's Hospital has one of the biggest cardiology units in the country. It provides emergency care, diagnosis, medical treatment and outpatient services for all heart disorders. This includes heart attacks, heart failure, heart valve disease, heart muscle disease, congenital heart defects, high blood pressure and arrhythmia (irregular heart beat). The hospital is the heart attack centre for southwest London, providing a 24-hour emergency angioplasty service, enabling life-saving treatment to be given to heart attack patients.

You can read more about our cardiology services at <http://www.stgeorges.nhs.uk/mediagazette.asp>

New resus unit opens



In September 2011 the Mayor of Wandsworth, Cllr Mrs Jane Cooper, officially opened a new £1.4m resuscitation unit in accident and emergency (A&E) at St George's Hospital.

The unit provides eight resuscitation bays each with a large bed space to allow emergency care staff to manage the most

complex of cases. The unit also houses a dedicated overhead x-ray system built into the ceiling of the department.

You can read more about the new resus unit at St George's Hospital at <http://www.stgeorges.nhs.uk/mediagazette.asp>

Enhanced service for home births



In April 2011, the trust's maternity service launched the Rainbow Team for women choosing to have their babies at home.

The team, based at Brocklebank Health Centre on Garratt Lane, operates across Wandsworth and Merton.

This service is open to all women who are expected to have a noncomplex pregnancy, including first time mothers. Women can refer themselves online or direct to the midwives so don't need a GP referral.

All the care is delivered by the midwives' in patients' homes or at local clinics, and women booked to give birth at St George's Hospital can transfer to the

Rainbow Team at any point in their pregnancy.

The key to the service is providing women with choice. Some mums-to-be hate the idea of hospitals and with the Rainbow Team they receive all their care in the comfort of their own home. They are also able to choose a variety of different ways to give birth including water and hypno births."

Call the Rainbow Team on 020 8812 5456

You can read more about the Rainbow Team at <http://www.stgeorges.nhs.uk/mediagazette.asp>

Mortality rates among the lowest in England



In November 2011 Dr Foster, the independent healthcare intelligence group, announced that St George's Healthcare has one of the lowest mortality (death) rates in the country.

The Dr Foster Hospital Guide 2011 named us among trusts with a 'better than expected' outcome for Hospital Standardised Mortality Ratio (HSMR).

Publication of the new NHS-wide summary hospital-level mortality indicator (SHMI) also shows the trust to have 'lower than expected' mortality. The SHMI measures the ratio of observed deaths to expected deaths and the trust is one of 14 identified as having the lowest mortality rates in England.

St George's was one of the first healthcare organisations anywhere in the world to monitor mortality to ensure that we could understand the death rate for every individual area of practice. Our rates are published on our website and this approach ensures that we have the clearest possible picture to help us maintain low mortality rates.

You can read more about our mortality rates at <http://www.stgeorges.nhs.uk/mediagazette.asp>

Vascular surgery death rates among the best in Europe



An audit by the Vascular Society of Great Britain and Ireland has shown St George's Hospital has one of the lowest mortality rates in the country for abdominal aortic aneurysm (AAA) surgery.

The audit, the first of its kind, found that across a two-year period, the mortality rate for patients undergoing an operation to treat AAA was just 0.8 per cent, far lower than the average mortality rate of 1.9 per cent in hospitals that perform the procedure regularly.

AAA is a swelling in the aorta, the body's biggest artery, which can rupture. While it is much rarer in women, the condition affects thousands of men every year in England and Wales.

The audit also showed that the national average percentage of fatalities from AAA surgery had fallen significantly, from 7.5 to 2.4 per cent.

You can read more about vascular surgery and abdominal aortic aneurysm at <http://www.stgeorges.nhs.uk/mediagazette.asp>

New community wards improve care for vulnerable patients



Working with other local health and social care providers in Wandsworth, the trust launched four community wards during last winter which succeeded in reducing emergency attendances and hospital

admissions for Wandsworth's most vulnerable patients.

The Wandsworth community wards provide a highly responsive range of health and social care services to elderly patients and patients with chronic long-term conditions, such as diabetes, asthma and sickle-cell, in their own homes. This continuity of care means that community services are able to respond in a timely way to treat acutely unwell patients, preventing their illnesses becoming more serious and requiring hospital care.

The Wandsworth community wards have been praised by Professor David Oliver, Department of Health National Clinical Director for Older People, as "a model of good practice and an example that other trusts across the country should aspire to follow."

The Wandsworth community wards bring together a range of health and social care services that as well as caring for patients in their own homes, supports the earlier discharge of those patients who are admitted to hospital. These services include:

- *St George's Healthcare NHS Trust services*
 - *GPs, community matrons, ward clerks, specialist nurses, district nurses, palliative care, community physiotherapy, occupational therapy, intermediate care, community pharmacy*
- *Wandsworth Council services*

- *social services, mental health services, including drug and alcohol team*
- *London Ambulance Service*

You can read more about our community wards at <http://www.stgeorges.nhs.uk/mediagazette.asp>

Improving neurorehabilitation services



During November and December 2011 we formally consulted with patients, staff and stakeholders on proposals designed by trust clinicians to relocate services based at the Wolfson to new homes in St George's and Queen Mary's Hospital.

The plans were designed by consultants, nurses and therapists following a detailed clinical review into how the services are currently provided. Clinicians concluded that that moving the services to Queen Mary's, a modern hospital designed for rehabilitation services, would provide the best clinical outcomes as well as being the most cost effective option.

During the consultation the trust received feedback from patients, patient representative and local voluntary groups,

charities and health partners, and received 167 formal responses with a lot of support for the proposals.

The move was given agreed by the board at a public meeting in January 2012.

You can read more about our improving neurorehabilitation services in southwest London public consultation at <http://www.stgeorges.nhs.uk/contactconsultationwolfson.asp>

Working with St Helier



The trust was invited to bid to merge with St Helier in July 2011 by the special transaction board set up to oversee the demerger of Epsom and St Helier University Hospitals NHS Trust. Before submitting a formal bid in November 2011 the trust met with a wide range of local stakeholders, including staff, patient and public representative groups, health partners, local council members and MPs, to help develop a bid that reflected the needs of the local community.

After careful consideration the trust board decided in January 2012 that it would be unable to proceed further with a merger.

The level of financial challenge facing hospitals in southwest London, combined with the inability to pre-empt the outcome of a public consultation around the *Better Services Better Value* (BSBV) review, meant that the time was not right for us to progress with the transaction.

The two organisations continue working together to build on the existing links that are in place for clinical services, with over 60 consultants working across the two trusts and 17 services benefitting from working closely in existing clinical networks.

We are particularly keen to develop these clinical and academic networks, and explore opportunities to establish new networks across services to the benefit of patients from southwest London.

You can read more about St Helier Hospital at <http://www.stgeorges.nhs.uk/aboutsthelier.asp>

New breast cancer unit opened



January 2012 saw the opening of The Rose Centre, a £4 million state-of-the-art breast diagnostic unit at St George's Hospital. St George's Hospital is a

regional cancer centre and its clinical results for breast screening are among the best in London. The Rose Centre provides modern, high quality services for the diagnosis and treatment of breast cancer and other breast diseases. The unit is also home to the South West London Breast Screening Service and St George's National Breast Screening Training Centre.

The Rose Centre is named after breast cancer research pioneer Rose Kushner. The name was chosen after a public vote which attracted more than 400 votes, with more than half choosing the "Rose Centre".

You can read more about the Rose Centre at <http://www.stgeorges.nhs.uk/mediagazette.asp>

State-of-the-art clinical training facility opens at St George's



December saw the opening of a new £350,000 state-of-the-art training facility at the St George's campus.

The Advanced Patient Simulator Centre, a joint project between St George's Healthcare NHS Trust and St George's,

University of London, provides specialist training for healthcare professionals and students. The centre allows them to test their skills in practical scenarios based on real-life situations including surgical and medical emergencies by working with computer-controlled patient manikins that realistically mimic a wide range of health problems.

Since opening the unit has attracted doctors from across Europe looking to learn new clinical skills, to improve their team work and to develop their techniques in a safe environment.

The new centre will train around 2,500 people each year, including doctors, nurses, other healthcare workers and students, from St George's as well as other London hospitals and universities. The project was funded by St George's Hospital Charity, which also donated £150,000 for a new patient simulation manikin, one of the most advanced types available.

You can read more about our new state-of-the-art clinical training facility at <http://www.stgeorges.nhs.uk/mediagazette.asp>

Living our values



The trust has six strategic aims, which are:

- To provide outstanding quality of care
- To become an exemplary employer
- To strengthen education research and innovation that will benefit our patients
- To build a leading integrated healthcare system via integration with community services
- To deliver robust operational and financial performance
- To continuously improve our facilities and environment

Our mission

To improve the health of our patients and our local community by achieving excellence in clinical care, research, education and employment.

Our vision

Our vision is to improve the health of our patients and the local community by achieving excellence in clinical care, research and education.

By 2015 we will be a thriving Foundation Trust at the heart of an integrated

healthcare system that delivers improved patient care in the community, hospital and specialist settings, supported by a unique and nationally recognised programme of research, education and employee engagement.

To achieve our vision we need to keep patients at the heart of everything that we do – our values are designed to inspire our staff to achieve this. Following detailed discussions with the board, directors, patients and members of our workforce at a variety of levels, we developed a new set of values.

We launched the new values in April 2010 and have been working hard to establish them throughout the organisation over the last 12 months. These values set out the standards of behaviour we expect from all our staff:

Excellent

- Look after our patients as we would like to be looked after ourselves
- Set ourselves high standards and be open to new ideas
- Be professional in our approach and in our appearance
- Promote and share best practice

Kind

- Anticipate and respond to patients' and carers' concerns and worries
- Support each other under pressure and consider the impact of our actions on others
- Help people find their way if they look unsure or lost

- Smile, listen and be friendly

Responsible

- Have patient safety as our prime consideration
- Be responsible for ensuring good patient experience
- Use resources wisely
- Challenge poor behaviour in others
- Learn from experience including our mistakes
- Say sorry when things go wrong

Respectful

- Keep patients, families and carers involved and informed.
- Protect patients' dignity and confidentiality
- Wear our name badges, introduce ourselves and address people in a professional manner
- Respect colleagues' roles in patient care and experience
- Value and understand the diversity of those around us

Living our values award winners

Excellent



- Trauma and orthopaedics therapy team



- Barbara Peters, senior mortuary technologist

Kind



- Wandsworth community neuro team



- Susie George, advanced physio practitioner

Responsible



- Annett Blochberger, neurology pharmacist
- Alexis Powell and Alex Stamp, outpatients central booking service

Respectful



- Samantha Ives, palliative care service delivery manager



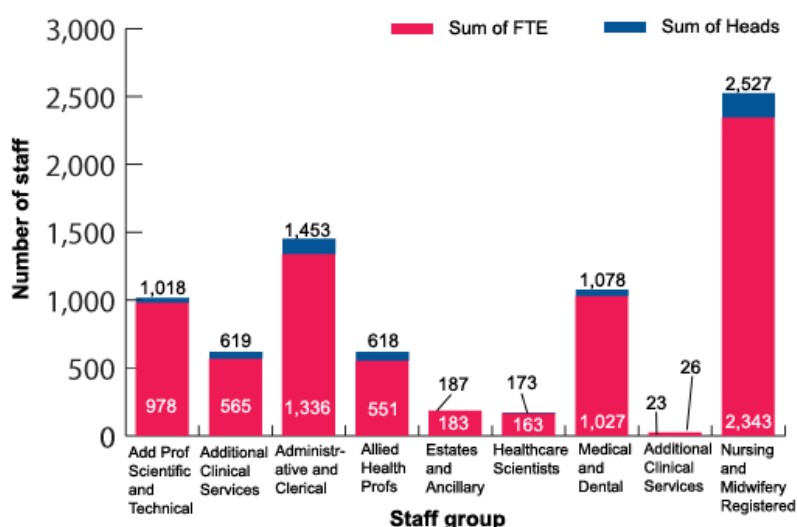
- Sewing room team

Working at St George's Healthcare

St George's Healthcare is one of the biggest employers in southwest London, with almost 8,000 staff working across a variety of specialist professions all with the common goal of providing world class services to improve the health of our patients.

None of our achievements this year would have been possible without the hard work and dedication of our staff. We are committed to providing a working environment in which every member of staff feels valued and supported so that they are able to perform to the best of their ability.

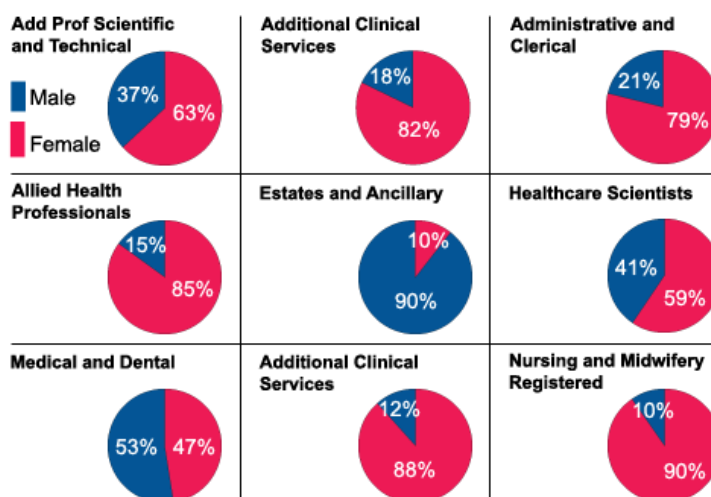
How many people work for St George's Healthcare?



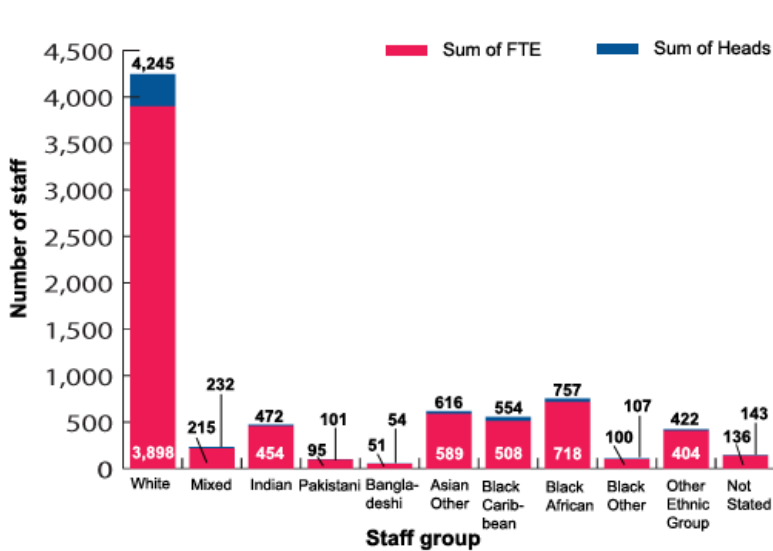
Staff Group	Full time equivalent (FTE)	Number of people
Add Prof Scientific and Technical	978	1,018
Additional Clinical Services	565	619
Administrative and Clerical	1,336	1,453
Allied Health Professionals	551	618
Estates and Ancillary	183	187
Healthcare Scientists	163	173
Medical and Dental	1,027	1,078
Additional Clinical Services	23	26
Nursing and Midwifery Registered	2,343	2,527
Grand Total	7,173	7,699

St George's Healthcare staff by gender

Staff Group	Female	Male	Total
Add Prof Scientific and Technical	644	374	1,018
Additional Clinical Services	510	109	619
Administrative and Clerical	1,148	305	1,453
Allied Health Professionals	527	91	618
Estates and Ancillary	20	167	187
Healthcare Scientists	103	70	173
Medical and Dental	513	565	1,078
Additional Clinical Services	23	3	26
Nursing and Midwifery Registered	2,284	243	2,527
Grand total	5,772	1,927	7,699

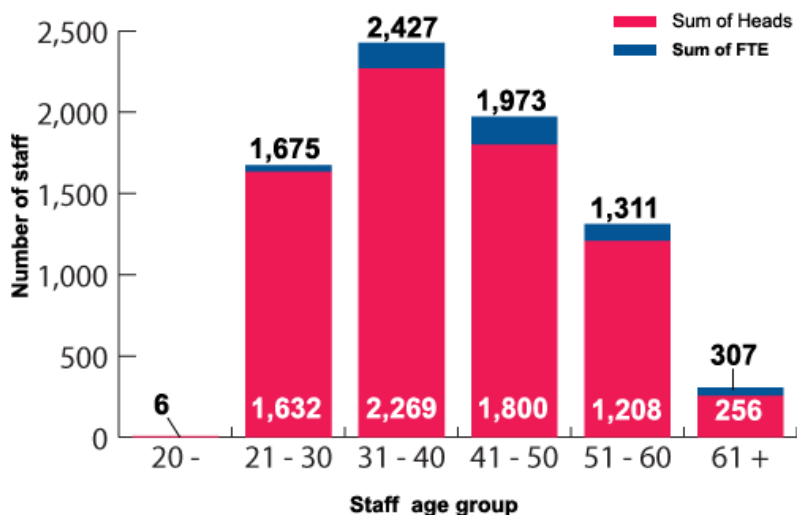


St George's Healthcare staff by ethnicity



Ethnic group	Full time equivalent (FTE)	Number of people
White	3,898	4,245
Mixed	215	232
Indian	454	472
Pakistani	95	101
Bangladeshi	51	54
Asian other	589	616
Black Caribbean	508	554
Black African	718	753
Black other	100	107
Other ethnic group	404	422
Not stated	136	143
Grand Total	7,173	7,699

St George's Healthcare staff by age



Age Band	Full time equivalent (FTE)	Number of people
20 & Under	6	6
21 - 30	1,632	1,675
31 - 40	2,269	2,427
41 - 50	1,800	1,973
51 - 60	1,208	1,311
61 & Over	256	307
Grand Total	7,173	7,699

NHS staff survey

Last autumn the Care Quality Commission sent NHS staff survey questionnaires to 3,418 members of staff, with 44 per cent of staff taking the time to respond. This was an increase of 4% from the 2010 staff survey.

The results are significant as they help the trust board understand employees' views on what it is like to work at St George's and also indicate where we can make improvements.

The 2011 staff survey results showed that St George's Healthcare staff believe the trust is committed to supporting a healthy work life balance. The survey also revealed that staff are satisfied with the quality of their work, the patient care that they are able to deliver and believe that their roles make a difference to patients

The 2011 survey results showed have seen positive results in the following areas:

- Staff are satisfied with the quality of their work, the patient care that they are able to deliver and believe that their roles make a difference to patients
- Staff believe the trust is committed to supporting a healthy work life balance
- Compared to the national average, fewer staff at the trust have experienced abuse or harassment from patients, relatives, or members of the public
- 86 per cent of staff have received an appraisal in the last 12 months

and the percentage of those having a well structured appraisal, with a personal development plan, is above the national average

There are, however, a number of areas where improvements can be achieved:

- Supporting staff who experience bullying or harassment
- Ensuring that staff feel valued by their colleagues
- Making sure that colleagues have better access to hand washing materials at all times
- 86 per cent of staff know what the trust values are, but some work is also needed to embed those values.

We have worked hard with our staff and union representatives to develop action plans for the areas we need to improve that are being implemented across the trust, and are hopeful that this work will be reflected in next year's staff survey results.

Education and Development

We are committed to the personal and professional development of all our staff, supporting our students and trainees and enabling the development of young people in our local community.

Last year our education and development department supported the commissioning, co-ordination and delivery of a very wide portfolio of

individual, team and organisation development activity.

The education and development department's year in numbers

- 1,400 staff students and trainees attended induction and orientation programmes
- 5,872 applications for and engagement in core mandatory and statutory training programmes, both face-to-face training and e-learning
- 1,336 staff accessed management, leadership and team development opportunities, including consultant master-classes, black and minority ethnic leadership programme, leadership for managers, appraisal skills training and team development sessions
- 3,461 non-medical staff benefited from funding opportunities provided by NHS London to attend short courses, conferences and degrees
- 393 doctors in training also had opportunities to attend external courses funded via the London Deanery and in-house development programmes
- 940 applications for in-house training programmes like equality and diversity, mentorship updates, medicines management and IV drug administration
- 2,862 staff attended clinical skills and simulation courses
- 411 people from our local community were given work experience placements

Spotlight on the security team



The St George's Hospital security team work around the clock, seven days a week to ensure that the site is kept safe.

The team is made up of 22 permanent staff, three of whom are special constables. They are responsible for all security matters and in addition to regularly patrolling the site they manage the car park and traffic flow around the grounds, attend fire alarms and respond to calls from staff who are experiencing abusive behaviour. The team investigates any crimes that are reported on site, liaising closely with the police. They are also responsible for access to every ward.

Neil Dowden, deputy security manager, has been at the trust for 13 years. He said:

"I am also the chair of the board for the local Safer Neighbourhood Team who we work closely with as the hospital is one of the 'beats' of this team. That is why you see police officers around the hospital on a regular basis. We also work with the Wandsworth Borough Commander – it's all part of working together."

The job is a varied one, which the team enjoy. Neil said;

“The best part of the job is that no two days are ever the same. We deal with a variety of stuff. You can’t complain of being bored because you never know what you’re going to come in to”

A big challenge for the team is trying to meet the needs of everyone on site – patients, public and staff. Neil said:

“We work on a site that has more than 7,000 colleagues and the perimeter road is more than a mile in length, so it is a massive site to be controlled on a daily basis.”

You can read more about Neil and the security team at

<http://www.stgeorges.nhs.uk/mediagazette.asp>

Spotlight on Neal Deans



As director of estates and facilities, I am responsible for managing the trust’s property portfolio and much of its support facilities including maintenance, cleaning,

catering and transport. I also oversee capital projects, which includes new builds or refurbishments.

Over the last year the key priorities for the estates and facilities directorate were continuing to maintain and further improve the fabric of the estate and the responsiveness of all of our services. Our key projects this year have included the development of the Rose Centre, a modern stand-alone facility for the South West London Breast Screening Service.

We have also built a new extension to the current resuscitation department bay in A&E to meet the extra demands on this department following our major trauma centre status. We have also redeveloped the acute medicine unit (AMU) to create an expanded 43 bed ward with improved spacing between beds and an increase in en-suite facilities to meet infection control and single sex accommodation requirements. This in conjunction with the Richmond annex will provide a total of 58 AMU beds.

This year we also successfully managed to decommission the Wolfson Neurorehabilitation Centre as part of our plans to improve neurorehabilitation services in south west London, and are planning a new facility at Queen Mary’s Hospital, Roehampton.

We have also invested heavily in order to improve the cleaning and catering services which are instrumental to the smooth functioning of the hospital.

The redevelopment of the Grove staff accommodation is another big scheme

which, with the help of Thames Valley Housing, has transformed the Grove into 557 modern flats and 78 shared ownership properties with affordable rents for all St George's Healthcare staff.

I joined the trust in 2005. It's my local hospital and two of my sons were born here. It's a great place to work and it's wonderful to be part of a hospital that provides such excellent clinical and specialist care.

You can read more about Neal at
<http://www.stgeorges.nhs.uk/mediagazette.asp>

Spotlight on the mortuary team



The mortuary's work covers a wide variety of areas including consented post mortems, routine coroner's post mortem to establish causes of death, forensic post mortems and high risk post mortems as well as being a regional perinatal centre (still births and miscarriages) serving south London and southeast England.

Barbara Peters, senior technologist, leads on the perinatal post mortems, and works closely with the maternity services and bereavement nurses. She said: "The job

is nothing like the portrayal you see on the TV, or on the other hand, the stereotypical stigma people associate with mortuaries – we are just very normal people."

The unit does not only cater for the deceased, it also needs to consider those left behind, and a modern viewing suite provides an area where parents and family members can pay their respects to their loved-ones.

Barbara said: "The service is a credit to St George's Healthcare; professional colleagues from other hospitals visit us for ideas for their own viewing suites."

Although the viewing suite is non-denomination, it includes a compass on the floor showing north, south, east and west, so families can use this as a point of reference if their religion dictates it, and artefacts for each of the main religions are available, so the room can be set out as the family would wish.

Robin Dobinson, mortuary manager, said: "Families should come and go without having to see anyone else, so each viewing is as private as possible. We aim to run an excellent department that offers a respectful and professional service."

But apart from the busy day-to-day life they lead, emergency situations do arise and team members can be called to major international emergencies to offer expert advice on identifying bodies.

Robin has been involved with major incidents such as the 7/7 bombings and the Clapham Rail Disaster. He was

invited to Buckingham Palace for recognition of work and services during the 7/7 bombings for the three weeks identification process.

You can read more about the mortuary team at <http://www.stgeorges.nhs.uk/mediagazette.asp>

Spotlight on the community palliative care team

Our 19 community nursing teams (based in four community wards across Wandsworth) deliver care across the borough and are responsible for delivering the appropriate palliative care to the patients on their caseload.

Gillian Best, clinical team leader for community nursing, said: “End of life care is a significant part of our work and always involves the multi-disciplinary team (MDT). This is usually made up of the GP, community nursing team, night service community nursing team, clinical nurse specialists from the acute sector and from the hospices, as well as therapists and social services.

“We provide all the hands-on care for this group of patients, right up to and including their last day of life if they have chosen to be cared for at home. We receive specialist advice and support from the clinical nurse specialists in the hospices who are part of the MDT, but are not actively hands-on.”

“The care we provide for this group of patients is probably the most privileged

and rewarding aspect of being a community nurse.”

You can read more about the community palliative care team at <http://www.stgeorges.nhs.uk/mediagazette.asp>

Spotlight on Stuart Reeves



“I started working at Queen Mary’s as a student nurse back in 1983 before qualifying as a staff nurse in 1986 and working on R Ward under Sister Sibthorp. I went on to work for Johnson and Johnson Orthopaedics and Kings College Hospital for a few years, but as soon as the opportunity to come back in 1995 arose, there was no stopping me.

“Now I am responsible for most of the services based at Queen Mary’s Hospital, Roehampton including radiology, rehabilitation and urgent care, and for some specialist services provided in the community like dentistry. I am also responsible for all the Queen Mary’s service level agreements and business management.

“I have always been really keen to learn and develop so that I can do the best job

possible for my patients. Whilst I have always been happy to take on extra responsibility, I certainly never set out to become the man that people look to for answers. Over the years I have developed a skill set that fits this job and have not been afraid to tackle the challenges head on.

“I don’t get to treat patients any more, but my job now means that I can influence and improve services for more patients than I could have ever seen as a nurse. Last year the services I am responsible for treated 175,000 patients, so I still get to go home and feel proud at the end of the day.

“The demand for services that have traditionally been delivered in bigger hospitals like St George’s and Kingston to be provided closer to patients’ homes means we will see more of these services come to Queen Mary’s to serve people from Roehampton, Putney and Richmond.

“We already have a state of the art day case unit and rapid access diagnostic unit, and since integrating last year we have started to treat patients with more complex needs .

“We are also working with local GPs to provide primary care services from the Minor Injuries Unit and to look at other areas we can develop further.”

You can read more about Stuart at <http://www.stgeorges.nhs.uk/mediagazette.asp>

Spotlight on the sewing room



The sewing room is not the first department that comes to mind when you think about the support services that a healthcare organisation needs. Yet they provide an essential service; providing uniforms for staff and helping out with alterations and repairs.

The sewing room, run by Fatima Zerroud and Souad Areiqat, is the first port of call for staff who need a uniform. The team provide around 600 uniforms a month; measuring staff for size, ordering the uniforms and then making any alterations necessary to ensure that it fits perfectly.

The team are also responsible for altering or repairing up to 120 garments a week and repair curtains and other such items requested by the wards and departments.

The sewing room is not just for staff but also for patients, as they carry out adjustments and repairs to clothing to help both groups. They have made bespoke clothing for burns victims which will not irritate their healing skin, and repaired items such as small support pillows for babies on the neonatal unit.

The team is led by Catherine Leak, assistant facilities manager and Andrea Wright assistant general manager. Catherine said: “The overriding impression given by the ladies of the sewing room is that they care - for the staff they assist, for the smooth running of the sewing room and for the standards of the uniforms they distribute and repair. We are lucky to have such a good humoured and dedicated team.

“They are an outstanding team who are dedicated and committed in all areas of their work ensuring staff leave the department with their uniforms and a smile!”

You can read more about the sewing room team at
<http://www.stgeorges.nhs.uk/mediagazette.asp>

Spotlight on Hazel Glead



“I am charged with ensuring that the organisation can fulfil its legal responsibilities as set out in the Civil Contingencies Act 2004. This includes putting in place a Major Incident Plan that is fully compliant with the requirements of

the NHS Emergency Planning Guidance 2005 and all associated guidance.

“In practice, this means that we have to be able to treat and care for patients that are brought to us following a major incident such as a train crash or a bombing, or during an internal incident such as flooding or a power failure it means we would need to keep our services running appropriately and safely during this time. When incidents do occur, I help ensure that the incident is managed properly and identifies the lessons and actions that will improve our response the next time.

“As the emergency planning and liaison officer, I am a team of one or a team of 8,000 whichever way you want to look at it. I prefer the latter, as I could not be successful in my role without the time, help and support of everyone else around the trust.

“I work with colleagues across the trust to help ensure that the plans we write are practical and feasible, that people understand their roles and have access to training and an opportunity to practise their roles before their skills are tested out in a real incident.

“I also work with colleagues in partner organisations including the ambulance, fire and police services, local council and other NHS organisations. We map out and test our plans together and this helps us understand how each other’s organisations work and improves the working relationships.

“I know it’s a cliché, but there really is no typical day! Some days I am supporting colleagues on various projects, for example the lift refurbishment projects, and others are spent developing and delivering training or being trained. I attend many meetings as part of the internal and external governance of emergency planning and am also often found at my desk developing or updating plans. A few days are inevitably spent on helping support real incidents and events like the London riots or public sector industrial action day last year.

“The forthcoming London 2012 Olympic Games is the largest sporting event in the world and is going to be on our doorstep for the summer and is definitely the key issue for people to think about! We know that the as part of the Olympic bid, London promised that the NHS would deliver business as usual. We are working hard to raise awareness with our patients and staff to ensure that they are all aware of the potential impacts, particularly in relation to travel times to and from our healthcare sites.”

You can read more about Hazel at
<http://www.stgeorges.nhs.uk/mediagazette.asp>

Spotlight on Yvonne Connolly



“Modern healthcare is increasingly complex and occasionally things can go wrong even with the best practices and procedures in place. At St George’s Healthcare we are committed to having good systems that enable us to learn from things that do go wrong and prevent them happening again.

“Over the last year we have implemented a number of projects that focus on patient safety and are helping us to improve our systems

“We have launched a safety dashboard to support priority projects across the trust giving staff access to a range of resources via the intranet. Other projects that we have run that have raised standards across the trust have focussed on prevention of patient deterioration, medication safety, patient identification and falls and pressure ulcer prevention.

“During Patient Safety Week in November 2011 we carried out a number of high profile events including an afternoon conference which focussed on human factors and patient experience. It also allowed for the launch of some new patient safety initiatives.

“During the year we have also developed videos that tell patient stories about their experiences whilst under our care. These videos are a key component of our awareness raising campaign for 2012/13.”

You can read more about Yvonne at
<http://www.stgeorges.nhs.uk/mediagazette.asp>

Our Board

The St George's Healthcare Board's primary role is to set the trust's strategic direction and objectives, ensure delivery of these within planned resources, and oversee the trust's performance. The Board is made up of a chairman, six non-executive directors and seven executive directors (three voting and four non-voting).

The chairman and the non-executive directors come from a range of professional backgrounds with a wide range of skills and experience that reflect the needs of the trust. Although members of the Board, non-executive directors are not part of the St George's Healthcare executive management team, and are effectively independent experts in their field employed to challenge the trust and provide expert leadership and guidance. The Board has in place a scheme of delegation and a schedule of powers and decisions reserved to the Board to ensure that decisions are taken at the appropriate level.

The chairman and non-executive directors' responsibilities include:

- Contributing to the development of strategic plans to enable the trust to fulfil its leadership responsibilities for healthcare of the local community.
- Ensuring that the Board sets challenging objectives for improving its performance across the range of its functions.
- Monitoring the performance of the executive team in meeting the

agreed goals and improvement targets.

- Ensuring that financial controls and systems of risk management are robust and that the Board is kept fully informed through timely and relevant information.
- Accountability to the Strategic Health Authority for the delivery of the trust's objectives and ensuring that the board acts in the best interests of its local community.
- Taking part in the appointment of executive and other senior staff.
- Ensuring that the organisation values diversity in its workforce and demonstrates equality of opportunity in its treatment of staff and patients and in all aspects of its business.

Non-executive directors, including the chairman, are appointed by the trust's nominations and remunerations committee working with NHS London and The Appointments Commission. All Board appointments are made using fair and transparent selection processes with specialist human resources input. When appointing to the Board due consideration is given to the range of skills and experience required for the running of the trust.

Each year every member of the Board has their performance assessed by the chairman through a formal appraisal process. During this appraisal the Board member's strengths and aspirations and learning and development needs are reviewed.

Non-executive director posts have a fixed term of four years. This term can be extended by another four years subject to satisfactory annual performance appraisals. At the end of their second term a non-executive director can be re-appointed for a maximum of another two years if it is deemed to be in the best interests of the trust. Executive directors do not have fixed term contracts.

During 2012/13 our divisional management teams are taking more responsibility for their own affairs to ensure we can continue with the momentum built up over the last few years. Key changes will see the resources of the divisions reporting through the divisional directors of operations to the divisional chair. The divisional chairs will in turn report directly to the chief executive.

Non-executive directors

Christopher Smallwood

Chairman (from November 2011)



No declared interests

Membership of committees (Board sub-committees):

- Finance & Performance Committee (Chair)
- Nominations and Remunerations Committee (Chair)
- Foundation Trust Programme Board (Chair)

Naaz Coker

Chair (until October 2011)



Declared interests

- Member, London South sub-committee, ACCEA (Advisory Committee on Clinical Excellence Awards)
- Patron - The Jewish Museum
- Vice President - Medact
- Trustee - Royal Society of Arts
- Patron - St George's Kidney Patients' Association
- Council Member - St George's University of London
- Non Executive Director: Ethical Property Company
- Trustee of C3 Collaborating for Health
- The Clore Social Leadership Programme

Emma Gilthorpe

Deputy chair (until July 2012)



Declared interests

- Director of Regulation, British Airports Authority

Membership of committees (Board sub-committees):

- Quality and Risk Committee (Chair)
- Audit Committee
- Commercial Board
- Nominations and Remuneration Committee

Graham Hibbert

Non-executive director



Declared interests

- Member Royal Surrey County Hospital NHS Foundation Trust

Membership of committees (Board sub-committees):

- Workforce Committee (Chair)
- Finance & Performance Committee
- Audit Committee
- Nominations and Remuneration Committee

Paul Murphy

Non-executive director



Declared interests

- Chief Executive, Jordans and Ryvita

Membership of committees (Board sub-committees):

- Quality and Risk Committee
- Commercial Board (Chair)
- Nominations and Remuneration Committee

Mike Rappolt

Non-executive director



Declared interests

- Chairman - Wimbledon Civic Theatre Trust
- Various Shareholdings (all under 1% of company)

Membership of committees (Board sub-committees):

- Audit Committee (Chair)
- Nominations and Remuneration Committee
- Finance & Performance Committee

Professor Peter Kopelman

Non-executive director



Declared interests

- Principal, St George's University of London
- Board Member, Medical Education, England
- Governance Board Member, Centre for Workforce Intelligence
- Member, DH Strategic Education Funding Advisory Group

Membership of committees (Board sub-committees):

- Workforce Committee

Professor Sean Hilton

Non-executive director (until July 2011)



Declared interests

- Chair - Anglo-European Chiropractic College

Sarah Wilton

Associate non-executive director



Declared interests

- NED of Capita Managing Agency and of Hampden Members' Agency.
- Director/trustee and Vice Chair of Paul's Cancer Support Centre
- Director/trustee of South Thames Crossroads - Caring for Carers

Membership of committees (Board sub-committees):

- Audit Committee
- Nominations and Remuneration Committee
- Foundation Trust Programme Board

Moira Nangle

Associate non-executive director (until November 2011)



Declared interests

- Trustee - CRI (Crime Reduction Initiatives)
- Trustee - Womankind Worldwide

Read full biographies for each of our non-executive directors on our website at <http://www.stgeorges.nhs.uk/aboutbiog.asp>

Executive directors

Miles Scott

Chief executive



Declared interests

- AUKUH representative on the GMC Undergraduate Board

Membership of committees (Board sub-committees)

- Foundation Trust Programme Board
- Nominations and Remunerations Committee
- Finance & Performance Committee

David Astley

Chief executive (until May 2011)



Declared interests

- Employer Representative, ACCEA (Advisory Committee on Clinical Excellence Awards)

Peter Coles

Interim chief executive (from May to October 2011)



Declared interests

- Director, Peter Coles Consulting Ltd
- Wife, Sara Coles, Director of Performance, NHS London

Richard Eley

Director of finance (until April 2012)



Declared interests

- Chairman - Chartered Accountants in Business for Thames Valley

Membership of committees (Board sub-committees):

- Finance & Performance Committee
- Audit Committee (attendee)

Dr Ros Given-Wilson

Medical director



No declared interests

Membership of committees (Board sub-committees):

- Quality & Risk Committee
- Workforce Committee
- Finance & Performance Committee

Mike Bailey

Medical director (until June 2011)



No declared interests

Professor Alison Robertson

Chief nurse and director of operations



Declared interests

- Chair of the Association of Leaders in Nursing (until September 2011)
- Vice chair of the Association of UK University Hospitals Nurse Directors Forum

Membership of committees (Board sub-committees):

- Quality & Risk Committee
- Audit Committee
- Workforce Committee

Patrick Mitchell

Chief operating officer (until March 2012)



No declared interests

Executive directors – non voting

Neal Deans

Director of estates and facilities



No declared interests

Membership of committees (Board sub-committees):

- Quality & Risk Committee
- Finance & Performance Committee

Peter Jenkinson

Trust secretary

No declared interests



Membership of committees (Board sub-committees):

- Quality & Risk Committee
- Finance & Performance Committee
- Audit Committee (attendee)

Dr Trudi Kemp

Director of strategic development

No declared interests



Membership of committees (Board sub-committees):

- Foundation Trust Programme Board

Jean-Pierre Moser

Director of communications

Declared interests

- Committee Member – Chartered Institute of Public Relations (CIPR) Health & Medical Group (unpaid)

Membership of committees (Board sub-committees):

- Workforce Committee



Wendy Gay

Director of human resources and organisational development (from

January 2012 – joint post with St George's, University of London)



Declared interests

- Director of human resources and organisational development, St George's, University of London
- Mentor, Kids Company, Development of Quays University Technical College

Membership of committees (Board sub-committees):

- Quality & Risk Committee
- Workforce Committee
- Finance & Performance Committee

Annette Gately

Interim director of human resources (until April 2011)

Declared interests

- Substantive post – director of human resources at Croydon Health Services NHS Trust

Jacqueline McCullough

Interim director of human resources (April 2011 to December 2011)

No declared interests

Read full biographies for each of our executive directors on our website at <http://www.stgeorges.nhs.uk/aboutbiog.asp>

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 that 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.

The trust has controls in place to mitigate the risk of bribery including a register of gifts and hospitality and a Standards of Business Conduct policy which requires all budget holders to complete declarations of interest on an annual basis. The trust also has standing financial instructions (SFIs) that outline individuals' authority and duties in any procurement process.

Board attendance

Trust Board

Name	May 2011	Jul 2011	Sep 2011	Nov 2011	Jan 2012	Mar 2012
Naaz Coker	✓	✓	X	-	-	-
Mike Bailey	✓	-	-	-	-	-
Peter Coles	-	✓	✓	-	-	-
Neal Deans	✓	✓	✓	✓	✓	✓
Richard Eley	✓	✓	✓	✓	✓	✓
Wendy Brewer	-	-	-	-	-	✓
Emma Gilthorpe	✓	✓	✓	X	✓	X
Ros Given-Wilson	✓	✓	✓	✓	✓	✓
Graham Hibbert	✓	✓	✓	✓	✓	✓
Sean Hilton	✓	✓	-	-	-	-
Peter Jenkinson	✓	✓	✓	✓	✓	✓
Trudi Kemp	✓	✓	✓	✓	✓	X
Peter Kopleman	-	-	-	X	✓	X
Jacquiline McCullough	✓	X	✓	✓	✓	-
Patrick Mitchell	✓	✓	X	✓	X	X
Jean-Pierre Moser	✓	✓	✓	✓	✓	✓
Paul Murphy	✓	X	✓	✓	✓	X
Moira Nangle	X	X	✓	-	-	-
Michael Rappolt	✓	✓	✓	✓	✓	✓
Alison Robertson	✓	✓	✓	✓	✓	✓
Miles Scott	-	-	-	✓	✓	✓
Christopher Smallwood	-	-	-	✓	✓	✓
Sarah Wilton	✓	X	✓	✓	✓	✓

Audit committee

Name	Jun 2011	Sep 2011	Nov 2011	Jan 2012	Mar 2012
Emma Gilthorpe	✓	✓	✓	✓	✓
Graham Hibbert	✓	✓	✓	✓	✓
Paul Murphy	✓	✓	✓	X	✓
Michael Rappolt	✓	✓	✓	✓	✓
Sarah Wilton	-	-	-	-	✓

Nominations and remunerations committee

Name	Apr 2011	Jan 2012
Emma Gilthorpe	✓	✓
Graham Hibbert	✓	✓
Sean Hilton	X	-
Peter Kopleman	-	✓
Paul Murphy	✓	✓
Moira Nangle	X	-
Michael Rappolt	✓	✓
Christopher Smallwood	-	✓
Sarah Wilton	-	✓

Finance and performance committee

Name	Apr 2011	May 2011	Jun 2011	Jul 2011	Aug 2011	Sep 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012
Peter Coles	-	-	✓	X	✓	✓	✓	-	-	-	-	-
Neal Deans	X	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	✓
Richard Eley	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Wendy Brewer	-	-	-	-	-	-	-	-	-	-	✓	X
Emma Gilthorpe	X	X	X	X	X	X	X	X	X	X	-	-
Ros Given-Wilson	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	✓
Graham Hibbert	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓
Sean Hilton	✓	✓	X	✓	-	-	-	-	-	-	-	-
Peter Jenkinson	-	-	-	-	✓	X	✓	X	✓	✓	✓	✓
Trudi Kemp	-	-	-	✓	-	-	-	-	-	-	-	-
Jacquiline McCullough	✓	✓	✓	X	✓	✓	✓	✓	X	✓	-	✓
Patrick Mitchell	✓	✓	✓	✓	✓	X	✓	X	✓	✓	✓	✓
Moirá Nangle	✓	X	✓	✓	✓	X	X	-	-	-	-	-
Michael Rappolt	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Miles Scott	-	-	-	-	-	-	-	✓	X	✓	✓	✓
Christopher Smallwood	-	-	-	-	-	-	-	✓	✓	X	✓	✓
Sarah Wilton	X	X	✓	X	X	✓	X	X	✓	✓	-	-

Quality and risk committee (previously RAC)

Name	May 2011	Jul 2011	Sep 2011	Nov 2011	Jan 2012	Mar 2012
Neal Deans	✓	✓	✓	X	✓	X
Emma Gilthorpe	✓	X	✓	✓	✓	✓
Ros Given-Wilson	X	✓	✓	✓	✓	X
Peter Jenkinson	✓	✓	✓	✓	✓	✓
Jacquiline McCullough	✓	✓	✓	✓	✓	✓
Patrick Mitchell	X	✓	✓	✓	✓	X
Paul Murphy	✓	X	✓	✓	✓	✓
Moira Nangle	X	✓	✓	-	-	-
Alison Robertson	X	✓	✓	✓	✓	X

Workforce committee

Name	Feb 2011	Apr 2011	Jul 2011	Nov 2011
Naaz Coker	✓	✓	X	X
Neal Deans	-	X	X	-
Ros Given-Wilson	✓	✓	X	-
Sean Hilton	-	X	X	-
Peter Jenkinson	✓	X	✓	✓
Jacquiline McCullough	✓	✓	✓	✓
Patrick Mitchell	X	✓	✓	-
Jean-Pierre Moser	✓	✓	✓	-
Moira Nangle	✓	✓	✓	✓

Our community

Member events in 2011/12



Over 700 members attended our series of members' health lectures during the year presented by expert staff, on subjects including keeping the brain healthy, facts and myths surrounding vaccines and diabetes. Our lectures on breast health have been particularly very well received, and hosting them in the new Rose Centre allowed members to see the work our breast screening staff at first hand.

In January members were able to meet the new trust chairman and chief executive of the trust.

Tours of the hospital and the university, allowed us to show members the rich heritage of St George's

With the London 2012 Olympic Games on the horizon we took the opportunity to show our members the science behind sports cardiology, as well as looking at emergency planning for the games at the trust.

Member engagement in 2011/12



As we work towards achieving Foundation Trust status, it is important that we engage with our public members, through both events and other means. This will allow us to ensure that the decisions we make reflect the needs and interests of the membership.

The Membership Advisory Group (MAG), comprised of a representative group of public members, meets every two months to discuss issues relevant to membership engagement.

One example of the MAG's work involves the trust's staff and stakeholder magazine, *the gazette*. In March 2012 the magazine was re-launched and sent to all of the trust's public members. MAG members offer comments on the content and style of the magazine. They also put forward ideas and opinions for the content of future issues.

Community open day celebrates a Tooting success story



In June 2011 St George's Hospital and University were invaded by bizarre balloon monsters, octo-armed jugglers, pint-sized spidermen, and beautiful butterflies. But the university and hospital are still standing, and looking to build on the success of the first ever St George's community open day.

The hospital and university which share a campus in Tooting opened their doors to more than 2,000 visitors on Saturday 18th June. The day was a chance to gain an insight into the work of both institutions, the science of the human body, and the cutting-edge research conducted at St George's.

Staff were very active on the day manning stands to talk about key areas of activity including A&E, infection control, stroke, trauma and cancer services, student courses, research and community engagement work.

In addition more than 200 people took part in the tours of the robotic operating theatre and sterile services department, CT scanning unit and Ronald McDonald

House. The public were also able to go on a history tour of St George's.

The day included entertainment for all ages with a face painter, juggling lessons, balloon modeller and pop-up street performances. A fire engine, police car and ambulance were also on site for visitors to explore.

Corporate citizenship



As the largest healthcare organisation in southwest London, the trust has an important role to play in the local economy, and by becoming a good corporate citizen we will demonstrate our commitment to the community.

Organisations that are good corporate citizens recognise the wider impacts of their activities and seek to maximise these by working in partnership with others. In the case of St George's Healthcare good corporate citizenship not only reflects the trust's core values but also supports our Foundation Trust aspirations.

We have worked with our local partners to come up with three key areas to focus on:

Sustainable development

The NHS aims to reduce its carbon footprint by 10 per cent between 2009 and 2015. Reducing the amount of energy used in our organisation contributes to this goal. There is also a financial benefit which comes from reducing our energy bill. We have not yet quantified our plans to reduce carbon emissions and improve our environmental sustainability.

We recover or recycle 375.75 tonnes of waste, which is 13.86 per cent of the total waste we produce.

Our total energy consumption has risen during the year, from 169,870 to 174,496 MWh. Our relative energy consumption has also risen during the year, from 1.27 to 1.31 MWh/square metre.

Renewable energy represents zero per cent of our total energy use, though we have this year made arrangements to purchase electricity generated from renewable sources.

Our measured greenhouse gas emissions have increased by 2,006 tonnes this year. We do not currently collect data on our annual Scope 3 emissions.

Our water consumption has reduced by 436,234 cubic meters in the recent financial year. In 2011/12 we spent £273,000 on water.

During 2011/12 our gross expenditure on the CRC Energy Efficiency Scheme was £283,428. The CRC Energy Efficiency Scheme is a mandatory scheme aimed at improving energy efficiency and cutting emissions in large public and private sector organisations.

During 2011/12 our total expenditure on business travel was £354,703.

Our organisation has an up-to-date Sustainable Development Management Plan. This is a good way to ensure that an NHS organisation fulfils its commitment to conducting all aspects of its activities with due consideration to sustainability, whilst providing high quality patient care. The NHS Carbon Reduction Strategy asks for the boards of all NHS organisations to approve such a plan.

We consider the potential need to adapt the organisation's buildings and estates as a result of climate change, but not the potential need to adapt the organisation's activities. Adaptation to climate change will pose a challenge to both service delivery and infrastructure in the future. It is therefore appropriate that we consider it when planning how we will best serve patients in the future.

Sustainability issues are not included in our analysis of risks facing our organisation. NHS organisations have a statutory duty to assess the risks posed by climate change. Risk assessment, including the quantification and prioritisation of risk, is an important part of managing complex organisations.

In addition to our focus on carbon, we are also committed to reducing wider environmental and social impacts associated with the procurement of goods and services. This will be set out within our policies on sustainable procurement. We have started work on calculating the carbon emissions associated goods and services we procure.

Our director of estates and facilities is the Board Level Lead for Sustainability. The Board Level lead for Sustainability ensures that sustainability issues have visibility and ownership at the highest level of the organisation.

Sustainability issues, such as carbon reduction, are not currently included in the job descriptions of all staff; however, our staff energy awareness campaign is ongoing. A sustainable NHS can only be delivered through the efforts of all staff. Staff awareness campaigns have been shown to deliver cost savings and associated reductions in carbon emissions.

Our organisation has a Sustainable Transport Plan. The NHS places a substantial burden on the transport infrastructure, whether through patient, clinician or other business activity. This generates an impact on air quality and greenhouse gas emissions. It is therefore important that we consider what steps are appropriate to reduce or change travel patterns.

Key achievements from 2011/12:

- Introduction of low-voltage lighting, sold energy back to the national

grid and reviewed heating in low-use areas across the trust

- Our IT department has begun a 'green computing' project which includes initiatives such as automatic shutdown on PCs and rationalisation of printers across the trust
- Strengthened our links with local organisations and community groups to share best practice in areas such as waste disposal, transport, recycling and energy

Over the next few years we aim to:

- Reduce building energy such as heating, hot water and electricity consumption.
- Encourage more staff to walk, cycle or use public transport to travel to the hospital
- Reduce waste – paperless workstreams
- Spend more of our procurement budget locally

Improving public health and reducing health inequalities

Key achievements so far:

- The joint trust/university Community open day 2011 was attended by over 2000 people and included stands from services around the trust
- Hosted member events highlighting a range of public health issues including nutrition, heart attacks and how to avoid them, keeping your brain healthy, vaccines and diabetes

The trust is working to prevent ill health by providing advice to patients, public and staff within key areas:

- Smoking cessation
- Improving diet and nutrition to reduce obesity
- Increasing exercise
- Alcohol related problems
- Breast feeding and childhood immunisation
- Engaging with staff, patients and the community to improve services
- Contributing to local borough health inequality strategies
- Aiming to be a major lead education provider with regards to job related training

Promoting staff wellbeing

- Provide an environment for healthy and well-motivated staff

hold local health and social care services to account.

We meet with Wandsworth, Merton and Sutton LINKs regularly, giving the diverse communities who use our services most a stronger voice in how their health services are delivered. LINKs meetings also provide an opportunity to investigate issues that individual patients may have with the healthcare they receive.

For more information about your LINKs in your area and to find out how you can join visit

- Wandsworth LINK
- Merton LINK
- Sutton LINK
- Croydon LINK
- Richmond LINK
- Lambeth LINK

Local Involvement Networks (LINKs)



Local Involvement Networks (LINKs) are independent bodies made up of elected patient representatives from across the community who act as watchdogs and

Giving to George's

The relationship between the trust and St George's Hospital Charity is an important one – it is a valuable partnership that brings real benefits to patients and staff in areas where the St George's Healthcare is not able to make grants or cannot stretch its budget. The work of the Charity includes fundraising and grant-giving.

The Charity's work in the business and local community continues, with links to schools, local businesses, the Tooting town centre partnership and local community associations. This work places St George's Hospital Charity at the heart of its community.

The major focus over the next few years will continue to be upon increasing our fundraising capability. This is essential if we are to continue to be able to make grants that will improve the lives of patients throughout the hospital.

Of course none of our work would be possible without the help and support of the many people who fundraise on our behalf and make voluntary donations to the Charity. It is not possible to mention everyone who has supported us over the year but each gift, large or small, has been gratefully received and has contributed to the excellent work carried out at St George's.

Our short film tells you more about us – please take a moment to watch it.

You can find out more about us by visiting the Giving to George's website
www.givingtogeorges.org.uk

Find us on Facebook and follow us on Twitter @GivingtoGeorges

Annual governance statement

Scope of responsibility

The Trust Board is accountable for governance in St. George's Healthcare NHS Trust. As Accountable Officer and Chief Executive of this Board, I have responsibility for maintaining a sound system of governance that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets, for which I am personally responsible as set out in the Accountable Officer Memorandum.

Accountability for Risk Management is set out in the Trust's Risk Management Policy. The Executive Team is collectively responsible for maintaining the systems of internal control and directors are accountable to me for ensuring effective governance arrangements in their individual areas of responsibilities. These areas of responsibility are detailed in the Trust's Scheme of Delegation.

Governance Framework

The Trust has an integrated governance approach to ensure decision-making is informed by a full range of corporate, financial, clinical and information governance, and ensures compliance with the five main principles of the Corporate Governance Code: Leadership, Effectiveness, Accountability, Remuneration and Relations with Stakeholders. This governance framework spans from "Board to Ward" and is outlined in Appendix 1.

There is an established and robust governance framework, supported and maintained by a framework of committees. The Trust Board (the 'Board') has overall responsibility for the effectiveness of the governance framework and as such requires that each of its sub-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 sub-committees. I achieve this in a number of ways.

- Monitoring of attendance
- Maintaining an overview of the quality of the presented information, including agenda items and supporting evidence
- Requesting the attendance of representatives from across the trust as and when required
- Ensuring that there is an annual declaration of interests by the members
- Ensuring that each of the Board Sub-Committees reviews its own performance and reports this to the Board.

In addition to the regular annual review of effectiveness of each committee, a

systems review of the board sub-committees was completed in March 2012 with changes made to the structure to further improve the effectiveness of the board's committee framework.

Senior leadership in corporate governance is provided by the Trust Secretary through the Trust's Compliance Unit. Governance is embedded across the corporate directorates and clinical divisions, led by Directors or Divisional Chairs, thus ensuring clear responsibility and accountability across the trust. Each Division has an established and active governance structure which reports into a Divisional Management Board and Divisional Governance Committee; these in turn report directly into the trust-wide governance framework. This system provides central direction and oversight whilst supporting local ownership and management of objectives and risks.

The governance framework is designed to manage governance and performance in an integrated way. During 2011/2012, the Trust's performance management framework was redeveloped to allow divisions greater autonomy within a clear framework of regulation and accountability. This performance management framework includes compliance with the Care Quality Commission's (CQC) Essential Standards of Quality and Safety.

During the course of 2011/2012, the trust was subject to three separate assessments by the CQC. The first of these was as part of the national assessment of dignity and nutrition in the care of the elderly and the second was an

unannounced but scheduled regular review of the St. George's Hospital site's compliance with all of the core outcomes of the Essential Standards of Quality and Safety. In March 2012, the CQC visited the Trust as part of a national review of the completion of the Department of Health forms (HSA1 Form) for termination of pregnancy (TOP). The trust was found to be fully compliant in all of these assessments.

Risk Management

The Trust is committed to providing high quality care, in an environment which is safe for patients, visitors and staff and which is underpinned by the public service values of accountability, probity and openness. Robust risk management and internal control are an essential part of good governance and is integral to the delivery of this commitment. The governance committee structure in Appendix 1 provides an effective and robust system of risk management across the trust.

The key aim of the Trust's risk management approach is to ensure that all risks to the Trust's achievement of strategic objectives (whether clinical, non-clinical, information, research or financial) are identified, analysed, evaluated, treated, monitored and managed appropriately.

The system of risk management is described in the trust's Risk Management Policy which is accessible to all staff via

the Trust Intranet. It is based on an iterative process of:

- identifying and prioritising the risks to the achievement of the organisation's policies, aims and objectives
- evaluating the likelihood of those risks being realised and the impact should they be realised
- managing the risks efficiently, effectively and economically.

This is achieved through a sound organisational framework, underpinned by a robust policy framework, which promotes early identification of risk, the co-ordination of risk management activity, the provision of a safe environment for staff and patients, and the effective use of financial resources. It ensures that staff are aware of their roles and responsibilities and outlines the structures and processes through which risk is assessed, controlled and managed.

Risks are identified through feedback from many sources such as proactive risk assessments, adverse incident reporting and trends, clinical benchmarking and audit data, complaints, legal claims, patient and public feedback, stakeholder/partnership feedback and internal/external assurance assessments.

Key stakeholders are involved in the management of risks via patient and public involvement groups and activities, patient and staff surveys, public Board meetings, the Local Involvement Network and the local Overview and Scrutiny Committees.

Risks are evaluated using a recognised risk assessment tool which assesses the impact and likelihood of the risk occurring using a 5 x 5 matrix scoring system. This risk score feeds into the decision-making process about whether a risk is considered acceptable. Higher level unaccepted risks require control measures/contingency plans to reduce them to an acceptable level. Each risk has an identified owner who is responsible for reassessing and monitoring the effectiveness of the controls in place to manage and mitigate the risk; this is recorded and reported back regularly to the appropriate committees.

Risk management is embedded within the organisation through the Corporate, Divisional, Directorate and Care Group structures and the reporting and feedback mechanisms are in place (as shown in Appendix 2).

The Compliance Unit, which includes the corporate risk and assurance department, supports staff in disseminating good practice across the organisation. Involvement in risk management activities is also included within the Trust's objective setting and individual performance review of staff and the organisation's business planning process. The corporate risk and assurance department works closely with the Head of Patient Safety to ensure a joined-up approach to improving patient safety.

The Trust's Board Assurance Framework, which is aligned to the Trust's strategic corporate objectives, is a high-level document based on structured and on-

going assessment of the principal risks to the Trust achieving its corporate objectives. It describes the controls and assurance mechanisms in place to manage the identified risks.

The Executive Management Team and the Quality & Risk Committee (QRC) regularly review the Board Assurance Framework, with the most significant risks being reported to each public Trust Board meeting. Divisional and Directorate Risk Registers are reviewed regularly by the Organisational Risk Committee with high-level risks being reported to the QRC.

In addition, the Trust uses its Assurance Map to record the outcome of any external accreditation visit or statutory inspection, and assurance that actions are being taken to address any issues identified through these inspections is provided to the Board.

Risk management training is a mandatory requirement for Trust staff at induction. Further education is available for Trust staff, relevant to their authority and duties; this includes modules within the Clinical Leadership Programme and Senior Staff Induction programme. Expert guidance and facilitation from the Corporate Risk and Assurance Department supports this function.

Significant external assurance as to the robustness of this system was provided in September 2011 with the successful assessment at Level 2 of the National Health Service Litigation Authority (NHSLA). NHSLA Level 2 is a comprehensive assessment of how well

the policy framework that governs risk management in a NHS organisation is embedded. The Trust became one of the first newly merged (following the merger with Community Services Wandsworth in October 2010) organisations to achieve NHSLA Level 2 in the country.

New risks identified in 2011/2012

The following risks were identified and added to the Board Assurance Framework during 2011/12, and the associated controls overseen by the Executive Management Team and the Quality & Risk Committee:

- The Trust financial targets are not achieved and the Trust does not achieve FRR of 3 for 2011/12.
- Failure to achieve the level of year on year financial savings necessary to offset against the anticipated future reduction in Government funding to the Trust
- Inability to create effective longer term business plans in light of the reduction in funding for NHS
- The Trust loses SIFT and Madel funding in 2011/12
- Failure to achieve individual CQUIN Target
- Failure to remove money from the appropriate budgets when a CRP has been delivered
- Patient care and financial income could be affected if iClip system unavailable
- Potential merger with St. Helier Hospital: Transaction Preparation Phase (now closed)

- Gaps in Board composition and capability (now closed)
- Patient safety will be negatively affected as a result of delays or disruptions to patient transfers, including urgent transfers, as a result of lift outages.
- Failure to maintain Paediatric oncology service.

- Achievement of A&E Type 1 performance target.
- Achievement of all cancer waiting time targets.
- Achievement of the 18 week waiting time target for admitted and non admitted patients.
- Venous Thromboembolism targets were achieved.

Data Security Breaches

The Trust had two such breaches that were reported to the Information Commissioner’s Office during 2011/2012. They were:

Date reported	ICO Reference	DATIX Reference	Description
26/05/2011	COM0393565	DW 12540	Patient letters sent to wrong address
01/11/2011	ENF0423048	DW16793	Hardcopy left on public transport

Performance against national priorities set out in the NHS Operating Framework 2011/12

During 2011/12 the Trust has demonstrated strong performance against the key performance indicators. Key achievements this year include:

- Only one incidence of MRSA bacteraemia
- 86 incidents of Clostridium Difficile infection against a shadow threshold agreed with commissioners of 87 incidents.

The Trust did not achieve the target on Eliminating Mixed Sex Accommodation. The majority of the breaches of this target were patients delayed whilst waiting for an appropriate speciality bed to transfer to when leaving Intensive Care. As this is in the best interests of the patient and decisions are based on safe and appropriate care, our Commissioners agreed these breaches as being clinically appropriate and as a result did not impose any financial penalties for these occurrences. Other breaches occurred during an outbreak of norovirus and were in the interest of infection control and patient safety. This enabled the cohorting of patients who had or had not been in contact with others positive for the virus and was also discussed and agreed with our commissioners. Had this decision had not been taken the outbreak would have lasted for a longer period. All patients / families were spoken to and an apology together with reasons for the actions taken was given.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways:

The Head of Internal Audit has provided me with an overall opinion of reasonable assurance that the internal controls are working effectively. This was based on an assessment of the Assurance Framework and on the controls reviewed as part of the internal audit work. However, only limited assurance could be provided on the controls in certain areas including eRostering, Benefits Realisation from the Integration of Wandsworth Community Services, income and management of implantable cardiac devices and A & E Target management, although a follow up review of this latter area enabled reasonable assurance to be provided. The Head of Internal Audit has noted the determination of senior management to instigate improvements in controls and governance arrangements generally and action plans have been drawn up taking account of his recommendations.

Reviews of the Board Assurance Framework and CQC registration were carried out with the conclusion that they were generally sound. A wide range of audits were undertaken, several of which provided significant assurance that the controls and systems were operating effectively.

In addition to the Head of Internal Audit opinion, the Audit Committee Chairman provides a written report following each committee meeting to the next meeting of the Trust Board, which includes significant conclusions arising from the Committee's work, concerns and recommendations. A summary of the key issues highlighted this year are included in Appendix 3.

Executive Directors and managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance.

The Board Assurance Framework provides me with evidence that the effectiveness of the controls used to manage the risks to the organisation achieving its principal objectives have been regularly reviewed.

The Trust's committee structures ensure sound monitoring and review mechanisms to ensure the systems of internal control are working effectively.

My review is also informed by a variety of other sources of information. These include:

- the views and comments of stakeholders
- patient and staff surveys
- internal and external audit reports
- clinical benchmarking and audit reports
- mortality monitoring
- reports from external assessments such as the CQC Quality Risk Profile
- Deanery and Royal College assessments
- accreditation inspections of clinical services
- NHSLA Risk Management Standards assessment
- Patient Environmental Action Team self assessments.

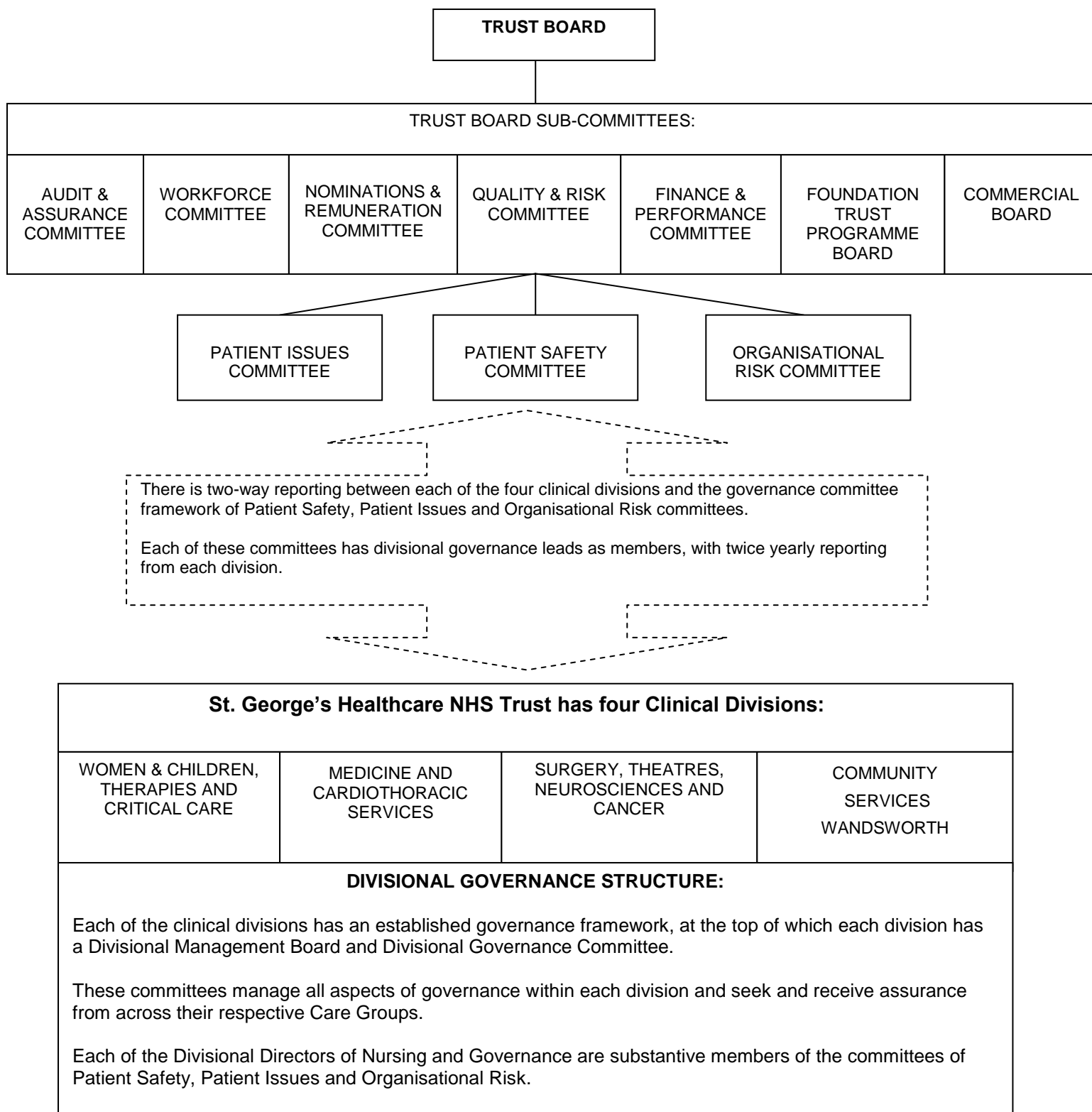
The Trust has produced an Annual Quality Account for 2011/12 and the governance system described above has been used to validate its content and the data on which it is based.

I consider that the two data security breaches detailed in this statement to be significant issues, and all appropriate corrective action has been taken in response. Through review of the assurance framework, the Board has not

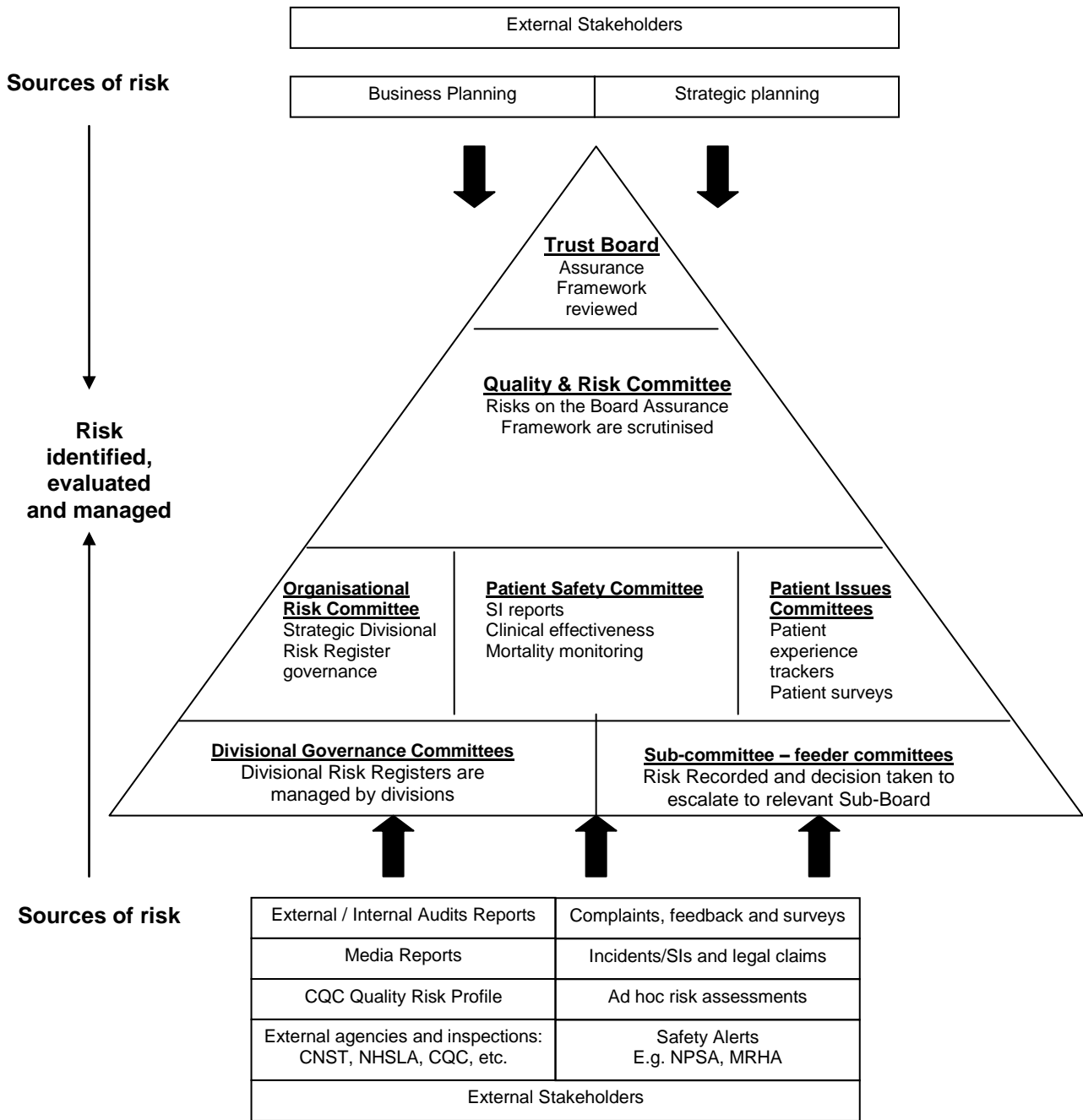
identified any further significant issues that fall within the scope of the requirements of this Governance Statement.

Alison Robertson
Acting Chief Executive
7th June 2012

Appendix 1 – Governance framework



Appendix 2 – risk management



Appendix 3 – Audit Committee reports to the Board

e-Rostering

The Committee received a report from Internal Audit on the implementation of the Trust's e-Rostering system. This report provided only limited assurance that the implementation project had been effectively managed, rosters were being set that were consistent with Trust protocols and funded establishment and that the planned benefits were being achieved. The report did also highlight areas of good practice.

Efficient Purchasing and Control

An Internal Audit report provided reasonable assurance that the control environment in this area was operating effectively. Management had been aware of some of the deficiencies and a proposed restructuring of the department was underway and other corrective actions in progress.

Private Patients and Overseas Visitors

This Internal Audit report provided overall reasonable assurance and that controls had noticeably strengthened. However some weaknesses were still evident, particularly around the ability to identify all overseas visitors and secure payment for any non emergency treatment provided. There were also a number of issues around updating prices and securing appropriate deposits amongst other matters all of which management of the Trust are addressing.

A&E Target Management

The Committee received a report from Internal Audit in November which provided limited assurance that the Trust was able to accurately demonstrate compliance with several A&E clinical targets. As a result the Committee commissioned a further review, undertaken in February, 2012 to

determine whether expected improvements had been achieved. The Committee was pleased to be advised that the assurance level had improved to reasonable.

Data Quality/Payments by Results

A report was received from the Audit Commission which noted improvements in the accuracy of clinical coding and other data items that affect the price commissioners pay the Trust for activity under Payments by Results. The Committee was very pleased to note these improvements.

PFI Contract Management

An Internal Audit report on the management of the Trust's Private Finance Initiative contract provided reasonable assurance that the contract was being properly managed and monitored.

CQUIN

The Committee received a report from Internal Audit which provided reasonable overall assurance, although noted that the Trust was likely not to achieve all of the CQUIN targets and was, consequently, likely not to receive all of the income available. The report noted that responsibility for and performance monitoring of Trust-wide CQUINs had improved since last year and that the financial exposure had reduced considerably from the year before.

People Development and Workforce Strategy

The Committee received a report from Internal Audit which provided reasonable assurance overall although could only provide limited assurance around the achievement of various targets set by the Trust. The Committee was concerned about the apparent lack of formal and effective performance management of staff and requested that the Executive

provide assurance on the measures being taken to address this. (See below – Organisational Performance Management)

Cardiac Stores

An Internal Audit report, commissioned jointly by the Finance Director and Chief Operating Officer, on Cardiac Stores provided limited assurance that controls were operating effectively. The review was initiated as a result of large fluctuations in monthly expenditure being noted. A number of recommendations have been made and accepted by management to improve the control and management in this area. The recommendations will be examined to see if they are relevant to other areas.

Procurement

The Committee was pleased to note that changes within the department had been effected and processes and procedures had been documented and that improvements were beginning to be identified.

Clinical Coding

The Committee received a report from Internal Audit which provided overall reasonable assurance although there were a large number of recommendations for improvement. The Committee were pleased to note that improvements had been noted in a later report, from the External Auditors, on Payments by Results (see above).

Mandatory and Statutory Training

The Committee received a report from Internal Audit which provided reasonable assurance that that core Mandatory and Statutory training was being provided and recorded. However, role specific training was not being captured in a systematic or adequate manner although the Audit Committee received assurances from the Executive that in fact it was being

undertaken and that there were no safety issues. In order to provide an appropriate audit trail the executive were urged to rectify this situation as soon as possible finding a way to ensure systematic recording.

Partnership with St George's, University of London

The Committee was pleased to note that good progress has been made in formalising the relationships in place with St George's University of London which had for a long time been informal and unstructured.

However the Committee remained concerned over the level and age of debtor and creditor balances between the two organisations and the number of agreements which are yet to be finalised. The Committee urged the organisations to finalise outstanding matters as quickly as possible and since this report there has been a significant improvement in the debtor positions between the two organisations.

Outpatients

An Internal Audit review of Outpatients services was undertaken to follow up and expand upon the External Audit review carried out in 2010/11. The report could only provide limited assurance on the adequacy and effectiveness of controls in place to manage outpatients' appointments. The Committee recognised that improvements continue to be made and the matter is still work in progress. As the Committee were assured that no patient safety issues were involved as a result of weaknesses identified the Committee will receive a further report in 2012/13.

Access Policy

The Committee received a report from Internal Audit which provided reasonable assurance that there was sound governance and reporting structure to performance manage key elements of the Trust's Access policy.

The report highlighted that although targets were likely to be met during 2012/13 there were significant challenges to maintaining this in the future without backlogs increasing. The report noted further work was required by the trust to ensure and demonstrate equality of access.

Organisational Performance Management

The Committee received, from the Chief Executive and Director of HR, in March 2012, an overview of the steps the Trust is taking to improve people management processes. The Committee was satisfied that the substantial progress would be made in addressing the current weaknesses with implementation of these steps.

Benchmarking

The Audit Committee places great emphasis on the effective use of benchmarking to improve quality of care and efficiency. The Committee received a report from Internal Audit on back office benchmarking which highlighted a lack of a systematic and consistent approach to benchmarking.

Financial Systems

The Committee was pleased to note that there continued to be a general improvement in controls over financial systems during 2011/12.

IT Business Continuity

The Committee received an update from the Director of IT indicating that progress was being in developing an inventory of critical systems and whether business

continuity plans exist for such systems. The Committee urged the Executive to act rapidly when the full inventory is reported in order to ensure adequate and tested continuity plans exist for all critical systems of the Trust.

Tender Waivers

The Committee received at each meeting a schedule of purchases which had been subject to waivers allowing single tender action. Having expressed concerns about the number and level of waivers last year the Committee was pleased to note and reduction in 2011/12. The Committee asked that annual comparisons to be prepared in order to monitor and compare levels on a yearly basis.

Annual Accounts

The Audit Committee reviewed the 2010/11 annual financial statements, the Annual Report and the Statement on Internal Control and was able to recommend, subject to minor amendments, adoption by and signing on behalf of the Board.

Action Tracking

The Committee continues to closely monitor the action tracking reports which detail the progress being made in implementing agreed recommendations. These reports are produced by the Trust Secretary to provide assurance that prompt remedial action was taken by relevant management in response to actions agreed following internal audit and external audit reports. The Committee is pleased to report that throughout the year actioning of outstanding items by the Trust continues to be achieved in a timely manner.

General Trends

Two general themes have been drawn to management's attention:

Performance management of Trust

staff

There appears a constant theme that the Trust is failing to adequately, appropriately and therefore effectively performance manage its staff. Appraisal rates are low and appear in some instances to be carried out as a tick box exercise which misses an opportunity to change culture and improve performance.

Use of standard project management methodology

For a number of years the Committee has received reports which have drawn attention to the lack of use of an appropriate project management methodology. This continued in reports received in the first half of 2011/12. After recommending on a number of occasions that the Executive develop a standard project management methodology the Committee was pleased to receive a plan which set out how implementation of a Trust-wide standard methodology would commence 1 April 2012.

Our performance

Infection control

This year the trust has reported its best ever infection control rates, with a 95 per cent reduction in MRSA over the last five years, with only one MRSA bacteraemia (blood stream) infection in the last twelve months.

86 C.diff infections were detected last year. Since 2010 the trust has been taking part in a Department of Health trial to investigate optimising and standardising C.diff testing methods. The new test is 60 per cent more sensitive than the traditional test and means that we are able to treat our patients more quickly and effectively. Because the trial test is more sensitive, we exceeded our annual target of no more than 52 C.diff detections, however, a shadow threshold target of no more than 87 cases was agreed with commissioners, which took into account the affect of improved diagnostics, and we successfully met this target. The new test also means that comparison with previous year's performance is difficult, although the trust has recorded an 80 per cent reduction in Clostridium difficile (C.diff) infections.

Mortality

We were named by the Dr Foster report for the Department of Health as having some of the lowest mortality rates in the country. The trust was one of only 14 in the country to have statistically significant lower than expected mortality rates.

Referral to treatment

This year the trust met the referral to treatment in 18 weeks standards for both admitted and non-admitted patients for the first time. This is great news for our patients and demonstrates that even for more complex referrals the trust can provide timely access to clinics, diagnostics and treatment. Meeting the target represents a major improvement from where the trust was only a few years ago. To ensure that the trust can continue to meet these standards in the long-term, a plan has been developed with our clinical commissioners that will see us record performance figures of less than 90 per cent for admitted patients in the first half of the year.

Accident and emergency

We achieved the four hour emergency access standard with 95.06 per cent of patients being admitted, transferred or discharged within four hours. Last year saw attendances at A&E increase to 333 a day, with an additional 114 people per day accessing the Tooting Walk-in Centre and 50 a day using the Queen Mary's Hospital Minor Injuries Unit.

Last year saw the introduction of the new national A&E clinical quality indicators, which have been introduced to improve the quality of emergency care across the country. The new indicators are:

- Ambulatory Emergency Care Achieved – target 10 per cent,

performance 3 per cent for deep vein thrombosis, 1.7 per cent cellulitis

- Unplanned re-attendance rate
Achieved – target 5 per cent, performance 4.9 per cent
- Total time in the A&E department
Achieved – target 240 minutes, performance 225 minutes
- Left without being seen rate
Achieved – target 5 per cent, performance 2.7 per cent
- Service experience
Patient experience focus group established and patient experience trackers based in A&E department
- Time to initial assessment
Not achieved – target 15 minutes, performance 20 minutes
- Time to treatment
Not achieved – target 60 minutes, performance 63 minutes
- Consultant sign off
Good performance in external audit by College of Emergency Medicine

2012/13 will see the opening of the Acute Medicine Unit, Paediatric Assessment Unit and Urgent Care Centre at St George's Hospital, which will all significantly improve patient safety and experience, and improve the pathways through the department.

The A&E department is focusing on patient flows from attendance to admission to reduce waiting times for patients for initial assessment and

treatment. This work has shown an initial improvement against these clinical indicators and we are optimistic that trend will continue throughout this year.

Cancer

The trust has passed all national cancer treatment and diagnosis targets for 2011/12, improving the prospects for thousands of cancer patients.

Over 95 per cent of patients with suspected cancer were seen at St George's and Queen Mary's Hospitals within 14 days of seeing their GP. Nearly 98 per cent of cancer patients received their first treatment within one month of being diagnosed. The trust can sometimes see over a thousand two-week referrals in one month.

Cancer targets are set nationally by the Department of Health and ensure that patients, who are either suspected of having cancer or who have been diagnosed, receive treatment as quickly as possible. Our performance against these targets was:

- Two week wait
95.4 per cent of patients seen in 14 days by specialist when referred by GP or dentist with suspected cancer – target 93 per cent
- 31 day first treatment
97.9 per cent of patients receiving their first definitive treatment within one month of diagnosis – target 96

per cent

- 31 day subsequent treatment (drugs)
100 per cent patients receiving their second or subsequent treatment within one month of decision to treat – target 98 per cent
- 31 day subsequent treatment (surgery)
97.9 per cent patients receiving their second or subsequent treatment within one month of decision to treat – target 94%
- 62 day standard treatment
88.3% of patients receiving their first treatment within two months of GP or dentist referral with suspected cancer – target 85%
- 62 day screening standard
94.8 per cent of patients receiving their first treatment within two months of referral from national screening service – target 90 per cent
- 62 day consultant upgrade
97.4 per cent of patients receiving their first treatment within two months of consultant upgrade suspected cancer – target 90 per cent

- Breast symptom two week wait
95.5 per cent of patients seen in 14 days by a specialist when referred with breast symptoms not suspected cancer – target 93 per cent

You can read about the trust's performance and participation in clinical audits in more detail in the Quality Account section of the report. You can read the trust's full 2011/12 performance report on the website at <http://www.stgeorges.nhs.uk/performanceindex.asp>

Quality Account

Statement on quality

The quality of care we provide is one of our greatest responsibilities and is at the heart of all that we do.

A complex mixture of safety, clinical effectiveness and patient experience, quality is something our staff are dedicated to improving. The key questions that we ask ourselves are:

- Are our patients being treated well when they are with us?
- Are our patients free from avoidable harm?
- How can we measure this and be absolutely sure?

Our patients should be confident in the care that we provide, both in terms of specialist and local hospital services, as well as community based care – in patients' homes and health centres across Wandsworth in South West London.

We have made significant progress in reducing mortality rates so that they are lower than expected and have ranked among the trusts with the lowest rates in the country for several years. We are dedicated to keeping it that way.

This is illustrated in the latest summary hospital-level mortality indicator (SHMI) data. The SHMI measures the likelihood of individual patients dying given their underlying condition, age and deprivation group – compared against the actual number of deaths that occurred. The SHMI and other mortality measures consistently show that we have significantly lower than

expected mortality. Maintaining this exceptional performance is a huge achievement and a testament to the safety measures we have in place, as well as the clinical skill and dedication of our staff.

Likewise our outstanding performance in relation to infection control continued this year, with only one MRSA bacteraemia (blood stream infection) recorded for the whole of 2011/12. We have very robust systems in place to ensure our patients are safe from infection, and everyone is encouraged to maintain high standards of hygiene when visiting our wards and patient areas. This year we also trialled more sensitive *Clostridium difficile* testing methods which have increased the accuracy of our testing regimes and dramatically improved safety for patients.

In the 2011 national inpatient survey our scores have improved and we are now achieving results expected of a major healthcare provider that compare favourably with similar organisations. The national inpatient survey is an important indicator of how all NHS trusts in the country are performing, looking at the experiences of more than 70,000 patients each year who were admitted to hospital for at least one night.

The 2011 survey now ranks St George's Healthcare as 'about the same' as most other trusts in the country for every question. We are proud of the improvements we have made and sustained and recognise this as a solid foundation to get even better.

Patient participation in our clinical research studies this year increased by over 200 per



of cancer patients received their first treatment within one month of being diagnosed

cent compared with the same period last year. St George's is an important focal point for clinical research and this increasing level of participation and engagement is a powerful demonstration of our commitment to improving the quality of our patient care and to making a significant contribution to wider health improvement.

Our ongoing drive to improve quality has also been endorsed by the Care Quality Commission, the independent regulator of health and social care in England, who visited St George's Hospital in May 2011 and assessed the site as compliant against their performance standards. Meeting these standards is an important indicator of the quality of our services.

Staff throughout the trust are committed to maintaining the high standards we have set as well as making improvements where these can be achieved. This Quality Account aims to demonstrate the measures we are taking to improve the quality of patient care and services we provide.

To the best of my belief, the information in our Quality Account is an honest and accurate reflection of quality standards at St George's Healthcare NHS Trust. I hope it inspires confidence in our services and shows how important quality improvement and patient safety are to us.

Miles Scott
Chief executive

Our aims during 2011/12

In our 2010/11 quality account we identified a number of priorities for improvement during 2011/12 to ensure that we continued to raise quality throughout the trust.

We set out to achieve all of our aims and the following tables show how we performed:

Mandatory reporting

Aim	Outcome – achieved / partially achieved / ongoing
Introduce a more rigorous approach to performance management against our CQUINs alongside processes to help staff monitor these on a monthly basis	Achieved. A more rigorous approach to performance management resulted in us meeting 90 per cent of our CQUINs which is a significant improvement on the previous year. You can read more about our CQUINs from page 121
Do more to engage our staff in the development of the 2011/12 quality account	Achieved. The 2010/11 Quality Account included an electronic feedback mechanism for both staff and patients. All staff at the trust were given the opportunity to feedback their thoughts on our plans for the 2011/12 Quality Account through an online survey. This was promoted through the trust's intranet and via the trust's weekly all staff email and we received 69 responses.
Launch a new policy to fully establish our expectations of staff, clearly illustrating standards of behaviour and how adopting the trust's values will have a positive impact on patient care, quality and clinical outcomes	Achieved. A new policy was launched in June 2011 to fully establish our expectations of staff, clearly illustrating standards of behaviour and how embracing the trust's values makes a positive impact on patient care, quality and clinical outcomes. The expected behaviour of staff is explained clearly to all new employees as part of their induction process.

Improving patient outcomes

Aim	Outcome – achieved / partially achieved / ongoing
Ensure that we accurately report our performance against and successfully treat 90 per cent of patients within the 18 week referral to treatment target	Partially achieved. Despite the difficulties in meeting the 18 week target for admitted patients in 2011/12, in December the trust achieved the 18 week standard. Since then this has been maintained with performance in February and March above the 90 per cent target. Non-admitted waits is in line with planned performance and has all year consistently been above 95 per cent. More work needs to be done during 2012/13 to ensure that performance is sustained.
Approve a clinical audit strategy and annual programme to improve the organisation of clinical audit at the trust	Achieved. The Board approved the audit strategy in May 2011, and subsequently an annual programme was agreed in September 2011. We are progressing well with compiling the programme for 2012/13 and this is to be

	<p>presented to the Patient Safety Committee in May 2012. We have continued to make improvements in line with the strategy, for example we have introduced new technology which will support improved data collection and dissemination of findings. There is a plan in place to help us sustain improvements in 2012/13.</p>
<p>Meet or achieve lower than the expected rate for readmissions by improving communication between acute and community services and increasing assessment of mental health needs</p>	<p>Partially achieved. We established a multidisciplinary group, including community healthcare staff, to review readmissions on a monthly basis. The group identified whether readmission was due to a failure in the discharge planning process, a failure in the care delivery once at home or a new illness. Key learning points were then identified and shared with staff involved in the discharge process or in the provision of care in the home (health and social care). In 2011/12 the total number of emergency readmissions declined across all age groups, despite admissions continuing to rise significantly. In 2011 our percentage of emergency readmissions was 8.2 per cent which is a significantly lower than the previous year. Our performance remains however above the national average rate for emergency readmission, which is currently five per cent.</p>
<p>Establish tracking and reporting mechanisms for the A&E reporting measures introduced on 1st April 2011, putting actions in place to remedy any shortfalls</p>	<p>Achieved. In 2011/12 we successfully treated 95.06 per cent of patients in the Accident and Emergency department (A&E) within four hours, meeting the national target of 95 per cent.</p> <p>A&E performance is now measured against eight national clinical quality indicators designed to improve the quality of care in A&Es across the country.</p> <p>Our performance against these indicators is published monthly on the St George's website http://www.stgeorges.nhs.uk/performanceindex.asp</p> <p>Staff are working towards improving performance against three indicators; reducing the average wait for initial assessment by a nurse from arrival, from 18 minutes to target of 15 minutes, and time to treatment decision by a member of the clinical team from 65 minutes to 60 minutes. Reviewing available capacity and patient flow is also taking place in order to achieve a monthly average of over 95 per cent patients waiting within four hours and this will be completed by June 2012.</p> <p>The service has experienced a significant increase in attendances, especially over this winter period with an average of 360 attendances per day. Staff are working with colleagues from primary and community services in order</p>

	to review all aspects of demand and ensuring that patients are seen appropriately, the new Accident and Emergency Department model will commence on June 11 th 2012.
Successfully implement the 'productives' initiative (a programme designed to release more staff time to care for patients) in A&E, outpatient departments and 18 community services teams.	Achieved. The <i>productives</i> series is still very much on our agenda and we have successfully implemented productive theatres, productive wards and productive community. We intended to roll the project out in A&E; however, a project for the productive A&E was not launched nationally, so this was not possible.
Implement new performance indicators for equality and human rights to help embed equality into mainstream activity and deliver on the requirements of the Equality Act 2010	Achieved. An equality delivery strategy to improve the collection and analysis of information from key protected groups within reports at a corporate level was approved by the trust board in March 2011 to enable us to deliver against the requirements of the Equality Act 2010.
Strengthen our business planning and performance arrangements in order to be able to demonstrate quality of care at service level	Achieved. We will continue to build on this work by introducing a new performance management framework for the trust during 2012.
Establish a 'virtual outpatient directorate', including GP and patient representatives, which will oversee performance in all outpatient services	Achieved. The virtual outpatient directorate has been established and is tackling the following improvements: <ul style="list-style-type: none"> - Establishing a follow up call centre to deal with calls from follow up patients.) - Ensuring that the booking of ward discharge appointments is done in a timely manner at/prior to discharge - Sourcing medical notes more quickly - Plans to better meet demands for increasing capacity within the service - Established systems to ensure patients leave clinic with a suitable follow-up appointment

Patient safety

Aim	Outcome. – achieved / partially achieved / ongoing
Keep patients safe from venous thromboembolism (VTE) by conducting risk assessments for at least 95 per cent of patients and giving appropriate thromboprophylaxis for at least 95 per cent of the patients who need it	Achieved. In 2011/12 we met both national and commissioner targets for VTE risk assessment. We also met both national and commissioner led targets for giving appropriate thromboprophylaxis (medicines to prevent blood clots).
Agree a clear framework of safety priorities through the patient at risk group to increase organisational learning	Achieved. We have focused on using the themes from incidents and serious incidents to prioritise projects that can improve systems and keep patients safe. We have developed an intranet based Safety Dashboard which outlines our safety priorities with resources to enable us to

	<p>achieve our aims. It also facilitates a more robust way of measuring whether these initiatives lead to improved outcomes.</p> <p>We have also developed a video project to capture patient experiences when something goes wrong. These videos are being used to highlight the importance of patient safety and are being incorporated into a number of training courses.</p>
<p>Use medication safety monitoring visits to develop a systematic way of staff monitoring and training that will increase awareness of medication incidents and identify areas for improvement</p>	<p>Achieved. We also conducted a comprehensive medicines safety audit on which both trust- wide and divisional plans are being developed. We have also established five medicines safety workshops to increase knowledge and awareness among nursing staff.</p> <p>Identified safety issues are recorded in an action log and communicated to senior nursing and pharmacy staff.</p>
<p>Carry out appropriate audits to ensure that the Situation, background, assessment, response (SBAR) tool whenever patient information is shared, to ensure that this is carried out clearly and effectively</p>	<p>Achieved. To promote effective communication the SBAR (situation, background, assessment, recommendation) tool is included on the revised Early Warning Score (EWS) documentation, and evidence of its use is included in the audit. This was documented in 50 per cent of cases in the latest audit, which is an improvement from 37 per cent observed when it was a separate document.</p>
<p>Introduce printed wristbands across all relevant clinical areas of the trust that will contain the patient's NHS number to close the outstanding NPSA alert from November 2010</p>	<p>Achieved. Most patients coming into hospital to have a procedure, whether they are staying overnight or are a day case, will need to wear an identity wristband. During 2011, we completed the roll out of printed wristbands to replace handwritten ones. The printed wristbands include a barcode with the patient's details. These are printed automatically in some areas such as when a patient comes to the A&E department or when registering a newborn baby. This process helps improve patient safety. The compliance of printed wristbands was audited at 95 per cent and the outstanding NPSA alert from November 2010 was closed in August 2011.</p> <p>In 2012, Theatres implemented new patient tracking software into the Day Surgery Unit which now makes use of a barcode scanner to scan the printed wristbands. This makes sure that the right patient goes into the operating theatre as the details are matched against the patient's electronic record.</p>
<p>Develop more collaborative work across both acute and community services to reduce the number of older people suffering fragility fractures</p>	<p>Achieved. The trust's inpatient falls rate was 3.4 per 1000 bed days for all age groups in 2010-2011. While there was a small increase in the falls rate in the 1st quarter 2011-2012, the average inpatient falls rate for all age groups</p>

	<p>over the 2nd and 3rd quarters has remained steady at 3.35 per 1000 bed days. These figures remain below the rate of 5.6 per 1000 bed days for acute hospitals (NPSA 2010). The Trust has continued to work on developing falls and bone health pathways across the acute and community interface in Wandsworth in collaboration with public health, patient representatives, voluntary organisations and community colleagues. This has included the development of a falls and bone health strategy in Wandsworth with implementation planned for 2012-2013.</p>
<p>Monitor the number of serious incidents (SIs) in 2011/12 and introduce measures to address underlying SI themes to prevent reoccurrence</p>	<p>Achieved. We undertake a comprehensive thematic analysis of our SIs every six months on which we base our patient safety initiatives. We have also developed a series of DVDs of patients and their families telling stories which helps staff understand the real-life impact of SIs. See page 49 for more information.</p>
<p>Continue to raise profile and implementation of the Early Warning Score (EWS) and improve our scores for timely, appropriate and full responses when patients are deteriorating <i>and</i> Introduce a new colour coded chart to make completing the EWS tool more efficient for ward staff</p>	<p>Both achieved. A revised EWS chart was developed and piloted on a number of wards during the year. Following the pilot the final version of the form was agreed and is being rolled out across the trust.</p> <p>As part of the implementation a programme of regular audit has been introduced. The results of the latest audit show that a full set of observations was recorded in 89% of cases, compared with 71% in the pilot period and against the local target of 80%. The tool appears to support more accurate scoring of observations, with this achieved in 69% of cases on the new form, against less than 60% when the old form was in use. However, this needs to be improved and the project team members are acting as mentors to provide ward-based training.</p>

Patient experience

Aim	Outcome – achieved / partially achieved / ongoing
<p>Introduce a dedicated midwife to improve support for women in our maternity unit to feed their babies in the early days</p>	<p>Achieved. We have introduced a dedicated midwife to improve support for women in our maternity unit to breast feed their babies in the early days</p>
<p>Continue to develop weekly mealtime audits throughout 2011/12 to ensure that patients are receiving appropriate nutrition and hydration on our wards</p>	<p>Achieved. In place and monitored via our nutritional operational group. The CQC inspection of privacy and nutrition in older people judged that we were compliant against both standards. Read page 24 for more information.</p>
<p>Develop a single integrated system for reporting complaints and PALS contacts across both acute and community services</p>	<p>Achieved. Complaints and PALS contacts are reported through the Patient Issues Committee.</p>

<p>Publish nutrition and hydration information online and in the inpatient booklet to provide patients with the information they need about hospital meals before they arrive for their care</p>	<p>Achieved. Information has been added to the website to better inform patients of the catering services available before they arrive for their care and a reference has been added to the inpatient booklet. <i>Your guide to meals in hospital</i> can be found here: http://www.stgeorges.nhs.uk/patientleaflets.asp</p>
<p>Introduce a more efficient nutritional assessment tool to record the nutritional needs of patients on admission</p>	<p>Partially achieved. Our assessment tool has been revised and piloted. Further revisions are required before a trust-wide implementation of the new tool.</p>
<p>Reduce the time it takes to take all patients home after their appointments via patient transport – 90 per cent collected within 60 minutes</p>	<p>Partially achieved. We have met the target for collecting 90% of renal patients within 60 minutes. Although we continued to improve, we did not meet this target for all patient groups. Work continues to reduce these waiting times.</p> <p>Lost journeys have been reduced to 5.1% in March 2012 and have been consistently under 6% since October 2011.</p>

Developing the quality account 2011/12

Quality is a key component of our activity as a provider of health services and the improvement of quality is a specific strategic aim for the trust, expressed in our annual objectives. We have a quality strategy which was approved in 2010 and is currently under review.

We monitor and performance manage the organisation against a number of measures and active engagement from our patients through various committees, including Patient Issues Committee, Patient Access Committee and Patient Safety Committee, helps to ensure our approach to healthcare is open and honest.

In developing the content of this Quality Account we have taken into account guidance issued by the National Quality Board, which has steered the policy underpinning Quality Accounts since their introduction, as to how Quality Accounts could be strengthened through the introduction of mandatory reporting against a small, core set of quality indicators from 2012/13.

In summary, the indicators are:

- Summary hospital-level mortality indicator (SHMI)
- Patient reported outcome scores (PROMS)
- Emergency readmissions to hospital within 28 days of discharge
- Responsiveness to inpatients' personal needs (national inpatient survey)
- Percentage of staff who would recommend the provider to friends or family needing care (staff survey)
- Percentage of admitted patients risk assessed for VTE
- Rate of Clostridium Difficile
- Rate of patient safety incidents and percentage resulting in severe harm or death

The indicators align closely with the NHS Outcomes Framework, which sets out the outcomes and corresponding indicators that will be used to hold the NHS Commissioning Board to account for the outcomes it delivers through commissioning health services from 2012/13. All the indicators are based on data that trusts routinely report on nationally.

The aim is to make comparison across organisations easier for readers and, in a letter from the Department of Health, trusts were invited to become early adopters of these indicators in 2011/12, in anticipation that reporting against them in Quality Accounts will become mandatory from 2012/13.

We invited the following stakeholders to contribute their views on the content of our Quality Account, taking into consideration the National Quality Board guidance and experience from previous reports:

- Wandsworth Local Involvement Network
- Merton Local Involvement Network
- Sutton Local Involvement Network
- St George's Patients Forum

- St George's Healthcare Patient Reference Group
- NHS South West London (our commissioners)
- St George's Healthcare staff

Stakeholders were invited to an event which helped shape the content for this 2011/12 report. Our staff were also broadly surveyed to find out their views on our priorities. We have taken feedback on board from these and other groups to ensure that the topics included this year reflect the interests of our patients, staff and stakeholders.

In setting our priorities for this document and committing to the eight quality indicators agreed by our stakeholders and recommended by the National Quality Board, we have omitted several items studied in detail in the 2010/11 account. These items are acknowledged in Appendix A, which gives a brief summary of our progress to date on these important performance indicators and through which committees they are monitored (from page 63). We have also included a number of additional aims for 2012/13, some of which roll over from 2011/12.

This report was written to adhere to the Quality Accounts toolkit 2011/12 and we have worked alongside the Audit Commission, as required, to ensure that

this report has been produced with rigour and honesty.

We have aimed to make the best use of relevant statistics, where available, to illustrate how we are improving quality over time and to benchmark the trust against national performance data.

We hope that the information in this Quality Account will give a clear illustration of quality standards at St George's Healthcare NHS Trust and help readers to more meaningfully compare our performance against similar healthcare providers.

Priorities for improvement 2012/13

The trust has determined the following priorities for improvement during 2012/13.

Priority	Aim	Monitoring
Quality strategy	Revise existing Quality strategy and launch new strategy during 2012/13	- Quarterly quality and Risk Committee - Trust board approval
Summary hospital standardised mortality indicator (HSMI)	Maintain our performance and consistently achieve a mortality ratio which is lower than expected	- Monthly mortality monitoring meeting - Clinical Effectiveness and Audit Committee
Patient reported outcome measures (PROMS)	Improve our participation rates to match the national average	- Bi-monthly Patient Issues Committee
28 day emergency re-admission rate	Successfully reduce the number of emergency readmissions each year and demonstrate this through a reduction in the threshold penalty (financial penalty levied on each emergency readmission) agreed with our commissioners.	- Quarterly Performance Management Reviews
Responsiveness to inpatients' personal needs	Improve our score for responsiveness to inpatient needs while at least remaining in the expected score range for our organisation. Establish a mechanism to record whether patients would recommend the trust to family and friends	- Bi-monthly Patient Issues Committee
Staff who would recommend the provider to friends and family	To score within the top 20 per cent of trusts for staff that would recommend the trust as a place to work or receive treatment by 2015.	- Quarterly HR and Workforce committee
Percentage of admitted patients risk assessed for VTE	Continue to meet national and commissioner led targets for VTE risk assessment and appropriate thromboprophylaxis	- Quarterly performance management reviews
Rate of <i>Clostridium difficile</i> and MRSA bacteraemia	Identify no more than 52 <i>C.diff</i> infections at St George's Hospital No more than two patients	- Fortnightly Healthcare Associated Infection Taskforce - Quarterly Infection Control Committee

	diagnosed with MRSA blood stream infection	- Quarterly performance review
Rate of patient safety incidents and percentage resulting in severe harm or death	Continue to embed the lessons learned from reported PSIs and related investigations. Introduce measures to address underlying SI themes to prevent reoccurrence and continue to encourage an open and effective safety culture	- Monthly Patient Safety Committee
Patient discharge from ITU onto a ward	Undertake a process review of ITU pathways and capacity and identify actions to reduce the number of patients waiting longer than six hours for an appropriate specialty bed	- Quarterly Performance Management Reviews - Patient Issues Committee
18 week referral to treatment	Ensure that we accurately report our performance against and successfully treat 90 per cent of patients within the 18 week referral to treatment target	18 week programme Board -Quarterly Performance Management Reviews
Nutrition and hydration	Introduce a more efficient nutritional assessment tool to record the nutritional needs of patients on admission	- Quarterly Nutrition Steering Group - Nursing Board - Patient Issues Committee
Patient transport	Reduce the time it takes to take patients home after their appointments via patient transport – 90 per cent collected within 60 minutes	- Access Group - Patient Issues Committee
Research	Develop a research strategy and have appointed an associate medical director to lead the delivery of this strategy on behalf of the trust	
Mixed sex accommodation	Reduce the number of mixed sex accommodation breaches by improving discharge from adult intensive care units into the appropriate specialty wards	- Patient Issues Committee
Community services	Ensure that 90 per cent of patients admitted to Queen Mary's, Roehampton, inpatient wards are asked the dementia screening question Ensure that 90 per cent of patients admitted to Queen Mary's, Roehampton, inpatient wards who are found to be at	

	<p>risk of dementia following screening, have a dementia risk assessment within 72 hours of admission</p> <p>Ensure that 90 per cent of patients admitted to Queen Mary's, Roehampton, inpatient wards who are found to be at risk of dementia following the dementia risk assessment are referred for specialist diagnosis</p>	
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How we will measure, monitor and achieve these priorities?

The board assurance framework provides assurance to the board for delivery of all key objectives including our quality improvement priorities. Each objective has a senior lead that is accountable for the delivery of that objective. Our management and governance framework provides a mechanism for reporting progress against the priorities, for implementing change and assurance on risk.

Quality Account mandatory reports

Review of services

During 2011/12 St George's Healthcare provided and/or sub-contracted 52 NHS services. The trust has reviewed all the data available to them on the quality of care in all 52 of these NHS services. The income generated by the NHS services reviewed in 2011/12 represents 100 per cent of the total income generated from the provision of NHS services by St George's Healthcare for 2011/12.

Services provided by St George's Healthcare in 2011/12, categorised within our four divisions:

Children, women, therapies and diagnostics	Community services Wandsworth	Medicine, cardiothoracic and vascular	Surgery, cancer and neurosciences
Breast screening	Adult and diagnostic	Accident and emergency	Audiology
Cardiac ICU	Children and family	Blood pressure unit	Dental
Clinical genetics	Older and	Cardiac surgery	Ear, nose and throat
Community paediatrics	neurorehabilitation	Cardiology	General surgery
Gynaecology	People with learning	Chest medicine	Maxillofacial
Intensive care unit	disabilities	Clinical infection unit	Neurology
Neuro intensive care	Offender healthcare	Clinical haematology	Neurorehabilitation
Newborn services	Senior health	Dermatology	Neurosurgery
Obstetrics		Diabetes / endocrinology	Pain clinic
Paediatric ITU		Gastro and endoscopy	Plastic surgery
Paediatric medicine		General medicine	Trauma and
Paediatric oncology		Genitourinary medicine	orthopaedics
Paediatric surgery		Lymphoedema	Urology
Pathology direct access		Medical oncology	
Radiology		Renal surgery	
Therapies		Renal medicine	
		Rheumatology	
		Vascular surgery	

Participation in clinical audit

National clinical audit is designed to improve patient outcomes across a wide range of conditions. Its purpose is to engage all healthcare professionals in a systematic evaluation of their practice against standards, to support and encourage improvement and deliver better outcomes for patients. National confidential enquiries also assist in maintaining and improving standards of care by reviewing the management of patients through confidential surveys and research, and then publishing results and recommendations aimed at driving improvements.

During 2011/12, 45 national clinical audits and four national confidential enquiries covered NHS services that St George's Healthcare NHS Trust provides.

During that period St George's Healthcare NHS Trust participated in 91.1 per cent of national clinical audits and 100 per cent of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in. The previous year we took part in 74 per cent of these.

The national clinical audits and national confidential enquiries that St George's Healthcare NHS Trust was eligible to participate in during 2011/12, and for which the data collection was completed during 2011/12, are listed in Appendix C (page 79) 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.

The reports of 25 national clinical audits were reviewed by St George's in 2011/12. The actions we intend to take to improve the quality of healthcare are included in Appendix D (page 83).

The reports of 11 local clinical audits were reviewed by St George's in 2011/12. The actions we intend to take to improve the quality of healthcare are listed in Appendix E (page 85).

More detailed information about the actions we have taken from clinical audit will be available in our clinical effectiveness and audit annual report from August 2011.

Research

Research is a key driver for improving quality of care and the patient experience and we continue to improve our commitment to research at St George's.

During the period October 2010 to September 2011 (the period specified by the National Institute for Health Research for patient accrual into research studies), we conducted over 500 clinical studies and 8,203 NHS patients took part in research at the trust*. Participation in research trials has therefore doubled compared with the same period the previous year (3,786).

Together with our academic partner, St George's, University of London (SGUL), the trust hosts the South East Stroke

Research Network (SRN) and operates a joint clinical research facility, both of which help to increase the numbers of patients joining clinical trials.

Community sites and excellent links to primary care, combined with specialist and regional acute services and academic partnerships, offers St George's an opportunity to move forward with a strategic, collaborative approach to research in southwest London.

This increasing level of participation and engagement in clinical research demonstrates our commitment to improving the quality of our patient care and to making a significant contribution to wider health improvement.

We are currently developing a research strategy and have appointed an associate medical director to lead the delivery of this strategy on behalf of the trust.

* Patients receiving NHS services provided or sub-contracted by St George's Healthcare between October 2010 and September 2011 that were recruited during that period to participate in research approved by a research ethics committee (National Institute for Health Research portfolio studies only).

The CQUIN payment framework

A proportion of income for St George's Healthcare in 2011/12 was conditional on meeting quality improvement and innovation goals. These are objectives agreed between the trust and its commissioners, primary care trusts, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

The key aim of CQUIN is to support a shift towards a vision where quality is the organising principle. The framework therefore helps ensure that quality is always part of discussions between commissioners and hospitals everywhere.

We achieved 90 per cent overall performance against CQUINs in 2011/12 – a significant improvement on 2010/11.

The total trust-wide value for CQUINs was circa £6,962,032.

Our CQUIN objectives for 2011/12 acute, specialised and community services are outlined in Appendix B (page 64). The tables explain what our key objectives were and whether or not we met them.

Our proposed 2012/13 acute, specialised and community service CQUINs are also included in Appendix B. At the time of print the trust is in discussions with commissioners and the list is subject to amendment.

Statements from the Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and social care in England. It regulates care provided by the NHS, local authorities, private companies and voluntary organisations that provide regulated activities under the Health and Social Care Act 2008.

The CQC registers, and therefore licenses, all NHS trusts. It monitors trusts to make sure they continue to meet very high standards of quality and safety. If services drop below the CQC's essential standards it can impose fines, issue public warnings, or launch investigations. In extreme cases it has the power to close services down.

St George's Healthcare NHS Trust is required to register with the CQC and its current registration status is licensed to provide services. The trust has no conditions placed on it, which means that we continue to meet the requirements of quality and safety for each of the CQC's 28 essential standards for quality and safety.

The CQC has not taken any enforcement action against the trust in 2011/12.

We participated in the following special reviews or investigations by the CQC during 2011/12:

Dignity and nutrition inspection

In April 2011, the CQC carried out an unannounced visit of St George's Hospital, Tooting, as part of a themed national inspection programme of 100 acute NHS hospitals to assess how well older people are treated during their hospital stay. They visited two wards and spoke with patients, staff and senior members of trust staff involved in monitoring and delivering care and nutrition for older people at the hospital.

Although fully compliant, the CQC recommended some minor actions to ensure that we sustain performance against two of the standards:

- Respecting and involving people who use services
- Meeting nutritional needs

Action	
Involve people who use services	<ul style="list-style-type: none">- Added a question on privacy and dignity to real time patient surveys on the wards- Introduced face to face privacy and dignity interviews with patients

Training for staff	<ul style="list-style-type: none"> - Introduced more information during healthcare assistant development days - Introduced a presentation during nurse induction days
Raise awareness of nutritional assessments and follow-up actions	<p>A series of training sessions across the trust, including:</p> <ul style="list-style-type: none"> - Nutrition scoring – calculation, reassessments and recording of information - Follow through actions for patients at risk including referral to dietician & completing food and fluid charts. <p>Review content of nutrition session at nurse and health care assistant induction for all new starters. Particular focus on scoring/assessment and recording of food and fluid charts</p> <p>Include ‘follow through actions’ in nutrition observation audit. Observe for:</p> <ul style="list-style-type: none"> - Nutrition score correct - Documented evidence of referral to dietician if patient at risk
Thickened drinks need to be of the correct consistency to reduce risks to patients’ wellbeing.	<p>A series of training sessions across the trust to ensure staff awareness heightened in the process of mixing and delivery of thickened drinks.</p> <p>Include capture of patient satisfaction with the consistency of thickened drinks in nutrition observation audit.</p>

Actions were completed and we submitted all of the appropriate information to the CQC within the timeframe required.

Termination of pregnancy

This was an unannounced national visit to review the process of consenting women undergoing termination of pregnancy. This review took place in March 2012 and we were found to be meeting the essential standards of quality and safety.

Compliance

In May 2011 St George’s Hospital was subject to a routine inspection of compliance and was found to be fully compliant with all of the 28 essential standards of quality and safety.

Survey of women’s experiences of maternity services

In last year’s Quality Account, we mentioned that the results of a survey of women using maternity services were pending and that we would report back on these in the 2011/12 report. The study found the trust’s scores were in the average range for four out of five categories, which you can read more about online in last year’s report.

We intend the following actions to address the requirements reported by the CQC:

Action	Outcomes
Zero tolerance to poor staff behaviour and attitude	<ul style="list-style-type: none"> - Improve staff morale(staff survey) - Women reporting fewer incidents of not being treated kindly and with understanding
Improve communication with, and information for women	<ul style="list-style-type: none"> - Audit of notes shows they are completed comprehensively - Positive feedback from women attending classes (survey form) - Women report that necessary information is given.
Improve support with breasts feeding in early days	<ul style="list-style-type: none"> - Women report adequate support with feeding
Hourly rounding on postnatal ward	<ul style="list-style-type: none"> - Women report feeling cared for and supported

St George's Healthcare NHS Trust has made the following progress by 31st March 2012 in taking action to address the requirements reported by the CQC:

Action	Progress
Zero tolerance to poor staff behaviour and attitude	<p>There has been a significant drop in the number of complaints relating to staff attitude.</p> <ul style="list-style-type: none"> - 2011 – 6 - 2010 – 11
Improve communication with, and information for women	<ul style="list-style-type: none"> - Daily group discharges now taking place - Intentional rounding (hourly rounds asking specific questions) started - Patient experience tracker results regularly reviewed and actions taken are leading to improved scores
Improve support with breast feeding in early days	<ul style="list-style-type: none"> - Increased reporting level of support seen in patient experience tracker results
Hourly rounding on postnatal ward	<ul style="list-style-type: none"> - Rolled out intentional rounding in Jan 2012

These actions are monitored by the trust's maternity taskforce, chaired by the chief nurse and director of operations.

During 2011/12 we also took part in the mandatory annual CQC outpatient survey, the results of which you can read on the CQC website www.cqc.org.uk and the voluntary paediatric survey, the results of which are not currently available.

Data quality

The collection of data is vital to the decision making process of any organisation, particularly NHS trusts like St George's. It forms the basis for meaningful planning and helps to alert us to any unexpected trends that could affect the quality of our services.

Most data is gathered as part of the every day activity of frontline and support staff who work throughout the trust in a huge variety of settings. It's important that we accurately capture and record the care we provide and the information in this report aims to demonstrate how well we are doing this.

St George's Healthcare submitted records during 2011/12 to the secondary uses service for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

HES is the national statistical data warehouse of the care provided by English NHS hospitals and for NHS hospital patients treated elsewhere. The body provides a data source for a wide range of healthcare analyses of the NHS, government and many other organisations and individuals.

The percentage of records in the published data which included the patient's valid NHS number was:

2011/12	Admitted care	Outpatient care	A&E
St George's Healthcare	97.70%	98.60%	94.50%
National Average	98.30%	98.40%	91.40%

The percentage of records in the published data which included the patient's valid general medical practice was:

2011/12	Admitted care	Outpatient care	A&E
St George's Healthcare	100%	100%	100%
National Average	99.8%	99.6%	99.6%

We continue to achieve exemplary scores in registered GP practice recording, where we perform better than the national average across admitted, outpatient and A&E services, each scoring 100 per cent.

Minor improvements have been made in NHS number recording during 2011/12, where we have improved recording in admitted care by 0.4 per cent and A&E care by 0.1 per cent compared to 2010/11.

We continue to perform better than the national average in NHS number recording for both outpatient care and A&E care; however, we aim to continue improving in 2012/13.

Our scores, particularly for recording the NHS number in admitted care, were expected to be better than those recorded. We believe that a technical fault within the flow of information to our data warehouse may be the root cause of this slight under-performance. We are investigating our dataflow process and will correct any flaw in our reporting in order to ensure a more accurate demonstration of our data quality in 2012/13.

Information governance

Information governance is the term used to describe the standards and processes for ensuring that organisations comply with the laws, regulations and best practices in handling and dealing with information. Information governance ensures necessary safeguards for, and appropriate use of, patient, staff and business information.

The key objective of information governance is to maintain high standards of information handling by ensuring that information used by the organisation is:

- Held securely and confidentially
- Obtained fairly and efficiently
- Recorded accurately and reliably
- Used effectively and ethically
- Shared appropriately and lawfully

We have an ongoing, rolling information governance programme, dealing with all aspects of confidentiality, integrity and the security of information. Annual information governance training is mandatory for all staff, which ensures that everyone is aware of their responsibility for managing information in the correct way.

The replacement of our patient administration system with a new, modern system in 2010 increased both the security and accuracy of information at the trust. All staff accessing the new system use a secure and strictly authenticated smartcard which defines what they are permitted to access in the system.

Each year we submit scores and provide evidence to the Department of Health (DH) by using the NHS Information Governance Toolkit. The toolkit is an online system which allows NHS organisations and partners to assess themselves against DH information governance policies and standards. It also allows members of the public to view each organisation's score and compare them.

St George's Healthcare's information governance assessment report overall score for 2011/12 (including community services) was 77 per cent and was graded green, or 'satisfactory' according to the criteria set nationally.

The information quality and records management attainment levels assessed within the Information Governance Toolkit provide an overall measure of the quality of data systems, standards and processes within an organisation.

You can explore the information governance scores for St George's Healthcare, and other organisations, at www.igt.connectingforhealth.nhs.uk. St George's Healthcare is listed as an **acute trust** and our organisation code is **RJ7**.

Clinical coding

Clinical coding is the translation of medical terminology written down by a healthcare professional. It describes the patient's complaint, problem, diagnosis, treatment or reason for seeking medical attention, using a coded format which is nationally and internationally recognised.

The system uses healthcare resource group (HRG) codes, which identify procedures or diagnoses that have been judged to consume a similar level of resource. For example, there are a number of different knee-related procedures that all require similar levels of resource, so they may all be assigned to one HRG code.

Therefore, for every consultant episode (a period of care under one consultant) and hospital spell (a period of care from admission to discharge), each patient is assigned an HRG code.

HRG codes consist of five characters: two letters followed by two numbers and a final letter. The first two letters correspond to body areas or body systems, identifying the area of clinical care that the HRG falls within. The final letter identifies the level of complexity associated with the HRG.

Healthcare providers are paid based on the HRG coding system. This is known as payment by results (PbR). The aim of PbR is to provide a transparent, rules-based system for paying hospitals for the work they do. It is very important that we code patient care accurately, so that we are paid appropriately for the complexity of the care we provide.

St George's Healthcare was subject to the PbR clinical coding audit during 2011/12 by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding), were as follows:

Specialty	Number of finished consultant episodes	% of episodes changing HRG
Locally determined specialty - Neurosurgery	100	8.5
Random selection	100	6.3
TOTAL	200	7.4

In 2011/12 the Audit Commission selected the 200 samples from the Secondary Uses Service (SUS), which is provided by the NHS Information Centre. Neurosurgery was selected by the South West London Acute Commissioning Unit and the other was one random selection from 100 episodes in SUS.

On performance of just the clinical coding alone the HRG error rate (the percentage of episodes changing HRGs on audit) was 7.5 per cent, which is better than the latest national average of 9.1 per cent. Of the coding errors, 61.4 per cent were due to error by clinical coding staff. The remaining errors were not the fault of staff but of issues such as poor source documentation or system errors.

Clinical coding accuracy is measured by counting the percentage of procedures and diagnoses recorded inaccurately. The average error rate on this basis was 3.9 per

cent which is better than the latest national average of 11 per cent.

All 200 episodes audited were found to be “safe to audit”, which means that the notes and documentation used were found to be complete and contained all the requisite information. The Audit Commission commended the trust on this.

Quality Account voluntary reports

This section of the Quality Account contains all the items that we have **agreed** to report against, through consultation with our patients, staff and other stakeholders.

Summary hospital level mortality indicator (SHMI)

Why is this important?

The summary hospital-level mortality indicator was introduced across England in October 2011 as a single, consistent measure of mortality rates. It shows whether the number of deaths linked to a particular organisation is more or less than would be expected, when considered in light of average national mortality figures, given the characteristics of the patients treated there. It also shows whether that difference is statistically significant.

If the number of patient deaths linked to St George's matched exactly what would be expected the trust's mortality score would be 1. A score below 1 indicates lower than expected mortality.

Our outcomes

For both April 2010 to March 2011 and October 2010 to September 2011 our mortality rate has been lower than would be expected, and we are one of only 14 trusts in the country with this performance.

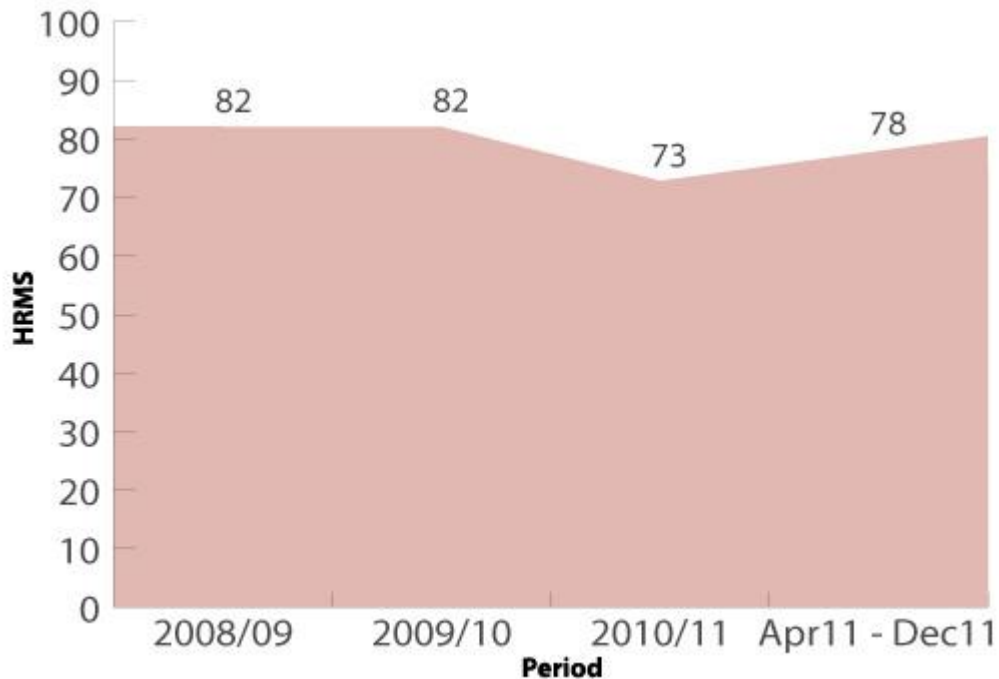
	Apr '10 – Mar '11	Oct '10 – Sep '11
SHMI value	0.78	0.77
SHMI banding	lower than expected	lower than expected
Percentage of patients admitted to a hospital within the trust whose treatment included palliative care	0.8 (national average 0.9)	1.0 (national average 0.9)
Percentage of patients admitted to a hospital within the trust whose deaths were included in the SHMI and whose treatment included palliative care	19.5 (national average 16.0)	20.6 (national average 16.4)

The SHMI makes no adjustments for end-of-life (palliative) care. Therefore, to add some context to the interpretation of the measure, palliative care contextual indicators have been published since January 2012. These indicators show the percentage of all admitted patients who are coded as receiving end-of-life care and the percentage of all patient mortalities coded as end-of-life care.

At St George's we continue to use the hospital standardised mortality ratio (HSMR) in addition to the SHMI to monitor mortality. The chart below shows our performance over the last few years. With the HSMR, if our mortality matched the expected rate our score would be 100. A score below 100 indicates lower than expected mortality. The HSMR indicates

that St George's mortality rate has been consistently better than expected over the last four years.

Hospital standardised mortality ratio



These low mortality rates should give confidence to our patients as a strong indicator of clinical safety at the trust.

Our aims

Our aim for the coming year is to maintain our strong performance and consistently achieve a mortality ratio which is lower than expected. We will achieve this by continuing to expand our scrutiny of mortality at local specialty level and taking action if we find areas where improvements are required.

Patient reported outcome measures

Why is this important?

Patient reported outcome measures (PROMs) attempt to measure quality from the patient perspective. Currently covering four clinical procedures, PROMs calculate the health gain experienced by patients using surveys both before and after surgery.

All providers of NHS-funded care are currently required to collect PROMs for the following four clinical areas.

- Hip replacements
- Knee replacements
- Hernia
- Varicose veins

PROMs are short, self-completed questionnaires, which measure a patient's health status or health related quality of life at a single point in time. Patients are given the same survey both before and after their surgery. The difference between these survey responses is used to determine the outcome of the operation as perceived by the patient.

The health status information captured from patients in this way provides an indication of the quality of care delivered to NHS patients.

In addition to the mandatory programme, we have been participating in a pilot project to extend PROMS to patients undergoing Percutaneous Coronary Intervention (PCI) and Coronary Artery Bypass Graft (CABG) since November 2011.

Our outcomes

The table below shows the percentage of patients that reported an increase in their health following surgery, using three scoring methods. The range is between 0 and 100 and in this case a higher score is better. For each measure the corresponding national data is given in brackets. Index 1 and Index 2 both use generic questions to assess a patient's self-reported health status. Hip, knee and vein surgery patients are also invited to answer a questionnaire specific to their condition.

		Apr '09 – Mar '10	Apr '10 – Mar '11	Apr '11 – Sep '11
Hip replacement surgery	Index 1	93.3 (87.8)	73.3 (86.8)	90.9 (87.7)
	Index 2	78.6 (61.4)	64.3 (61.3)	60.0 (63.4)
	Condition specific	93.8 (95.7)	94.1 (95.8)	100 (93.4)
Knee replacement surgery	Index 1	100.0 (77.6)	82.4 (77.9)	*
	Index 2	75.0 (50.2)	60.0 (50.7)	*
	Condition specific	95.5 (91.4)	94.1 (91.5)	66.7 (92.0)

Groin hernia surgery	Index 1	40.0	(49.3)	44.6	(50.5)	50.0	(50.9)
	Index 2	37.5	(38.2)	35.7	(39.1)	45.6	(39.2)
	Condition specific	<i>Not applicable</i>					
Varicose veins surgery	Index 1	50.7	(52.4)	47.7	(51.5)	64.0	(53.3)
	Index 2	43.3	(40.4)	35.0	(39.8)	65.2	(42.2)
	Condition specific	82.9	(83.4)	77.8	(82.5)	89.2	(83.9)

*The number of questionnaires is too small to allow meaningful analysis.

The following table shows the number of patients that successfully completed both parts of the questionnaire for each procedure. The numbers appear low because of those patients that completed the questionnaire, not all will receive post-op questionnaires from the DH, and then only around 50 per cent of those are returned for our population.

Number improving		Measure		
		EQ-5D Index	EQ-VAS	Condition Specific
Procedure	Groin Hernia	31	26	N/A
	Hip Replacement	10	6	12
	Knee Replacement	*	*	6
	Varicose Vein	16	15	19

*The number of questionnaires is too small to allow meaningful analysis.

Adjusted health gain is also calculated, which allows comparison between organisations against the national adjusted health gain. The adjusted measure takes into account the fact that organisations treat patients with different case mixes. Only complete scores are used, therefore the number of questionnaires used for the calculation is often fewer than the total of linked questionnaires.

For 2011/12 we only have sufficient numbers for groin hernia to allow comparison and in those cases the adjusted average health gain is not significantly different to the England average at either 95 per cent or 99.8 per cent confidence control limits.

Using both local and national data we routinely monitor our participation rates and health gain. For all procedures other than hernia surgery our performance is largely in line with, or better than, national performance. For groin hernia fewer of our patients report improved health following surgery.

We monitor submission rates for all procedures on a monthly basis and taking action where necessary to improve the processes for administration of questionnaires has resulted in an improvement in our overall participation rate for the year. During the year a senior clinical lead was appointed (head of nursing), whose role is central to achieving and sustaining increased participation.

Our aims

Ensuring that each of our patients is given the opportunity to participate will ensure we have richer information, which we will then be able to use more effectively to assess the quality of care we provide.

We aim to improve our participation rates to match the national average. We have started work on this already with improved leadership of the programme, ongoing training and education for staff to support administration of the questionnaires and regular monitoring of participation rates. This has resulted in improvement from 43.6 per cent for April 2010 to March 2011, to 60.6 per cent for April – September 2011. We will build on this work and ensure that providing patients with the opportunity to complete the questionnaires is included in our pre-assessment centre that will be opened in the coming year.

It is hoped that team-level analysis, which is to be introduced nationally, will make these results more useful. Our progress against PROMs is monitored and reported twice a year to the trust's Patient Issues Committee.

28-day emergency re-admission rate

Why is this important?

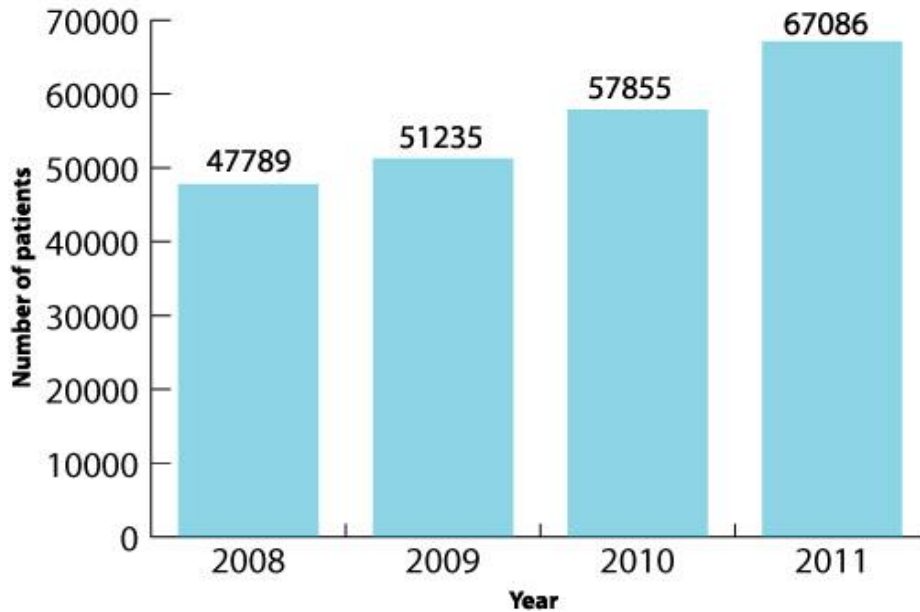
Monitoring emergency readmission rates can help the trust to prevent or reduce unplanned readmissions to hospital. An emergency readmission is recorded when a patient has an unplanned re-admission to hospital within 28 days of a previous discharge. Reducing emergency readmissions has always been a priority for the trust.

This Quality Account refers to emergency readmissions within 28 days rather than the NHS Outcomes Framework indicator's 30 days because trusts report on their emergency readmissions within 28 days at frequent intervals as part of their Hospital Episode Statistics.

Our outcomes

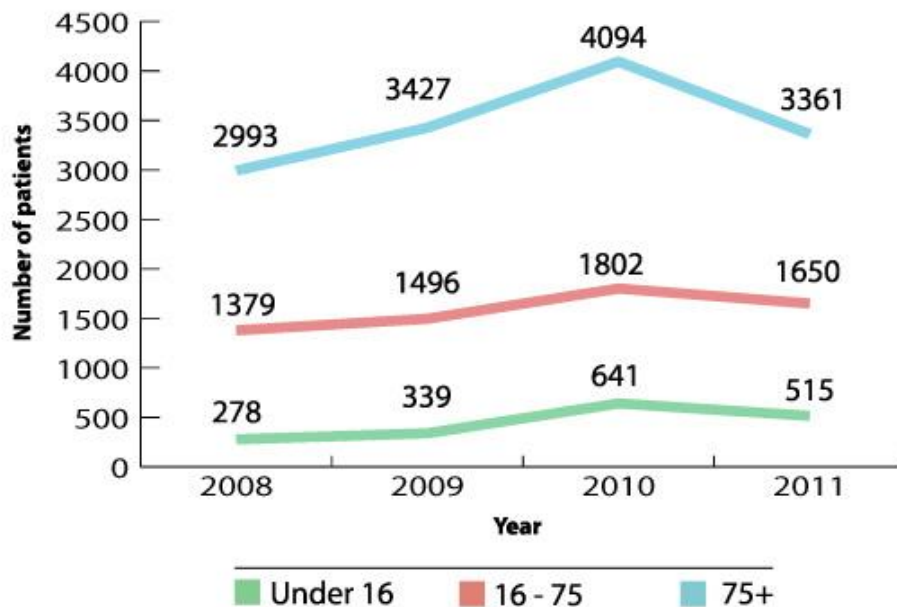
From 2008 – 2011 there has been a steady increase in patient admissions year-on-year with around 67,086 admissions in total at St George's in 2011.

Total number of admissions



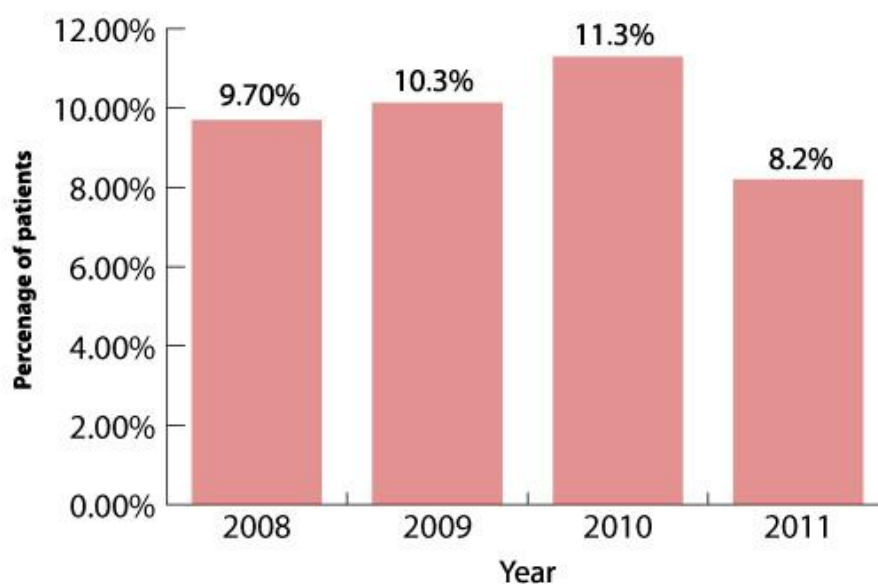
Emergency readmissions for all age groups rose in line with the general increase in admissions between 2008 and 2010. However, in 2011, the total number of emergency readmissions declined across all age groups, despite admissions continuing to rise significantly.

28 day readmission by age



In 2011 our percentage of emergency readmissions was 8.2 per cent which is a significantly lower than the previous year. Our performance remains however above the national average rate for emergency readmission, which is currently five per cent.

28 day readmission rates



Our aims

We are fully committed to reducing emergency re-admission rates and we are working with commissioners to determine where improvements can be made, including how we can manage more patients with long-term conditions in a clinic or home setting.

From April 2012 we will be subject to a penalty, set in consultation with our commissioners, which will be levied on all emergency readmissions considered avoidable (either by us or any other healthcare agency). This penalty is likely to result in our commissioners withholding a proportion of the money we would usually expect to be paid for the care we provide to the re-admitted patient. This money will be used by commissioners to invest in areas of the healthcare network to develop rehabilitation and re-ablement services and help prevent readmissions in the future. This 'threshold' penalty will be determined following an audit in June 2012.

The threshold penalty for 2013/14 will be set based on the number of emergency readmissions we receive during 2012/13. Therefore, if we successfully reduce the number of emergency readmissions each year then our threshold penalty is also likely to reduce in future.

We aim to provide a better service to patients by establishing a number of specific acute medicine clinics where patients with chronic conditions can be seen more frequently. This will improve the follow up care patients experience and help prevent readmissions. We will provide a detailed report of our progress in next year's Quality Account.

Responsiveness to inpatients' personal needs

Why is this important?

Patient experience is a key measure of the quality of care. At St George's we continually strive to be more responsive to the needs of our service users, including needs for privacy, information and involvement in decisions.

To help demonstrate the standard of patient experience at the trust we are given a score out of 100 by the Care Quality Commission. This is an average score for answers to the following five questions in the Care Quality Commission's national inpatient survey:

- A)** Were you involved as much as you wanted to be in decisions about your care and treatment?
- B)** Did you find someone on the hospital staff to talk to about your worries and fears?
- C)** Were you given enough privacy when discussing your condition or treatment?
- D)** Did a member of staff tell you about medication side effects to watch for when you went home?
- E)** Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

Our outcomes

Our score for 2011 was 66.1 which is lower than the national average score of 67.4 and higher than the average score for London, which was 65.0.

Year	Overall	A	B	C	D	E
2009	62.2	66.5	53.2	78.7	38.6	73.9
2010	68.4	70.3	63.6	82.7	49.5	75.7
2011	66.1	70.3	56.4	82.3	46.4	75.2

	2009	2010	2011
St George's	62.2	68.4	66.1
SHA	64.4	64.7	65.0
National	66.7	67.3	67.4

Our 2011 score shows that the inpatient experience at St George's is 'about the same as other trusts', which means that patient experience was no better or worse than expected by the CQC. This is also reflected in our results throughout the 2011 national inpatient survey, where we are rated 'about the same as other trusts' across all questions in the survey.

The national inpatient survey is an important indicator of how all NHS trusts in the country are performing, looking at the experiences of more than 70,000 patients each year who were admitted to hospital for at least one night.

We are now achieving results expected of a major healthcare provider that compare favourably with similar organisations. In taking time to reflect on our performance we are considering how we can implement improvements to develop our services further.

Our aims

We have been working hard to improve food and nutrition, making sure that there is sufficient choice and that patients get the help they require at mealtimes and this will remain a focus for the year ahead.

Privacy, dignity and compassionate care remain some of our top priorities. We have revised our matrons' weekly quality rounds as well as our monthly nursing "scorecard".

We aim to improve patient discharge, including the information we hand out about medication, danger signals to look out for and how discharged patients can access support when they need it.

Ensuring that patients and their families know how to raise any concerns is very important and we plan to make this clearer and make our staff more accessible to deal with concerns.

We are continuing to invest in the general estate/buildings and are aware that further refurbishment is required in some areas to ensure that patients' experience is as good as it can be given that some parts of the organisation are considerably older than others.

Through focusing on the above, in 2012/13 we aim to improve our score for responsiveness to inpatient needs and at least remain in the expected score range for our organisation.

Special patient experience report: Mixed sex accommodation

In April 2012 the trust confirmed that it is compliant with the Government's requirement to eliminate mixed sex accommodation, except when it is in the patient's overall best interest, or reflects their personal choice.

Although the trust is compliant and remains committed to the same sex agenda and ensuring privacy and dignity (core values) there have been a number of breaches in 2011/12. The majority of these have been patients in one of our three adult intensive care units, delayed whilst waiting on an appropriate speciality bed to transfer to.

As this is in the best interests of the patient and decisions are based on safe and appropriate care, our commissioners have agreed these breaches as clinically appropriate and have not therefore imposed any financial penalties on the trust.

We continue to improve our compliance against mixed sex standards and have taken the following actions to improve our performance:

- Redesigned our clinical decision unit and refurbished our day surgery unit at St George's Hospital to create separate facilities for men and women
- Added new toilets to the endoscopy unit at St George's Hospital and refurbished the endoscopy unit at Queen Mary's, Roehampton, to improve same sex facilities
- Re-vamped toilet and bathroom signage throughout the trust to make these facilities clearer for patients
- We conduct regular patient surveys

In 2012 /13 we aim to reduce the number of mixed sex accommodation breaches by improving discharge from adult intensive care units into the appropriate specialty wards.

Staff who would recommend the provider to friends and family

Why is this important?

One of the trust's strategic aims is to be an exemplary employer and to be successful in the future we must commit time, resources and effort into supporting our staff and making St George's Healthcare both a great place to receive healthcare and a great place to work.

Our staff are core to our success and are well-placed to judge the quality of care we provide to our patients.

Our outcomes

As part of the 2011 NHS staff survey our staff were asked whether they would recommend the trust as a place to work or receive treatment. In response, 93 per cent of our staff said they would recommend St George's as a place to work or receive treatment which is better than the national average for acute trusts, which is 91 per cent.

On a scale of 1-5, with 5 being the most positive, this question was rated at 3.57 by our staff compared to 3.50 nationally for acute trusts.

Our aims

We are committed to ensuring that staff have access to the appropriate training they need to carry out their role and one of our objectives for the coming year is to enhance the skills of our managers so that they can support staff in a changing environment.

We want to make sure that our staff know that what they do makes a difference to patients and in the staff survey consistently over 90 per cent of our staff agree that their role makes a difference to patients.

Our long term aim is to score within the top 20 per cent of trusts for staff that would recommend the trust as a place to work or receive treatment by 2015.

Percentage of admitted patients risk assessed for VTE

Why is this important?

Venous thromboembolism (VTE) is a condition where a blood clot forms in a vein, which can cause substantial long term health problems.

Risk assessments for VTE ensure that we intervene with preventative measures at the earliest possible time according to the needs of each patient. It also helps us to identify any instances of deep vein thrombosis or pulmonary embolus occurring within 90 days of admission so that we can investigate and learn how to avoid these in the future.

The focus on this condition has helped to improve practice and ensure that our patients are treated safely.

Our outcomes

All trusts across the country report the proportion of documented VTE risk assessments being conducted as a percentage of all admitted patients. The national target expects that at least 90 per cent of all admitted patients should receive a VTE risk assessment.

Our commissioners also stipulated the following two requirements for St George's to meet its CQUINs target:

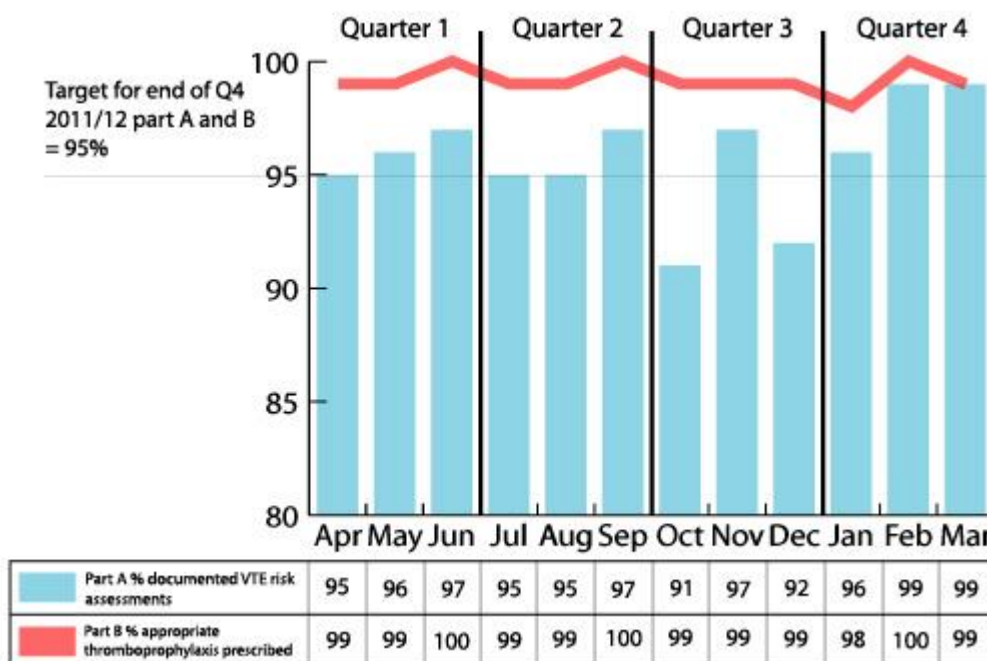
- Part a) the trust has documented evidence for VTE risk assessment being conducted within the trust, achieving 95 per cent by the end of 2011/12.
- Part b) In those cases where there is documented risk assessment, appropriate thromboprophylaxis (preventative treatment) is being prescribed in more than 95 per cent of cases

The total number of risk assessments undertaken in March was 8,891 against a total number of hospital admissions of 8,979. Therefore, the percentage of documented VTE assessments conducted for the month of March 2012 was 99 per cent. This demonstrates that we have met both national and commissioner targets for VTE risk assessment.

Nationally, of the 3.3m adult patients admitted to NHS funded acute care between July and September 2011 (the latest available data), 88 per cent of these received a VTE risk assessment on admission, which shows that we are also performing better than the national average.

The number of patients found with documented and completed VTE charts was 340 and the number of patients given appropriate thromboprophylaxis, based on the completed form, was 336. The percentage of appropriate thromboprophylaxis at St George’s was therefore 99 per cent. This demonstrates that we have met both national and commissioner targets for giving appropriate thromboprophylaxis.

Monthly % compliance for VTE CQUINs part A and B 2011/12



Our aims

Tackling the risk of VTE remains a top clinical priority for us. We will ensure that there is a programme of regular audit within the trust and feedback to individual consultants and divisions. We will also raise awareness of the National Thrombosis week 2012, to increase patient knowledge of VTE, its risks and how we address it at St George’s.

An independent audit of our VTE documentation was carried out in May 2012 by the Audit Commission which found some challenges in the recording of VTE risk assessment in the patient notes. The information in this report has been compiled using data held in patient discharge summaries, as agreed with our commissioners, however we will ensure in future that VTE documentation is recorded more accurately as part of the patient’s medical notes, as well as in the discharge summaries.

In 2012/13 we aim to continue to meet national and commissioner led targets for VTE risk assessment and appropriate thromboprophylaxis.

***Clostridium difficile* rates**

Why is this important?

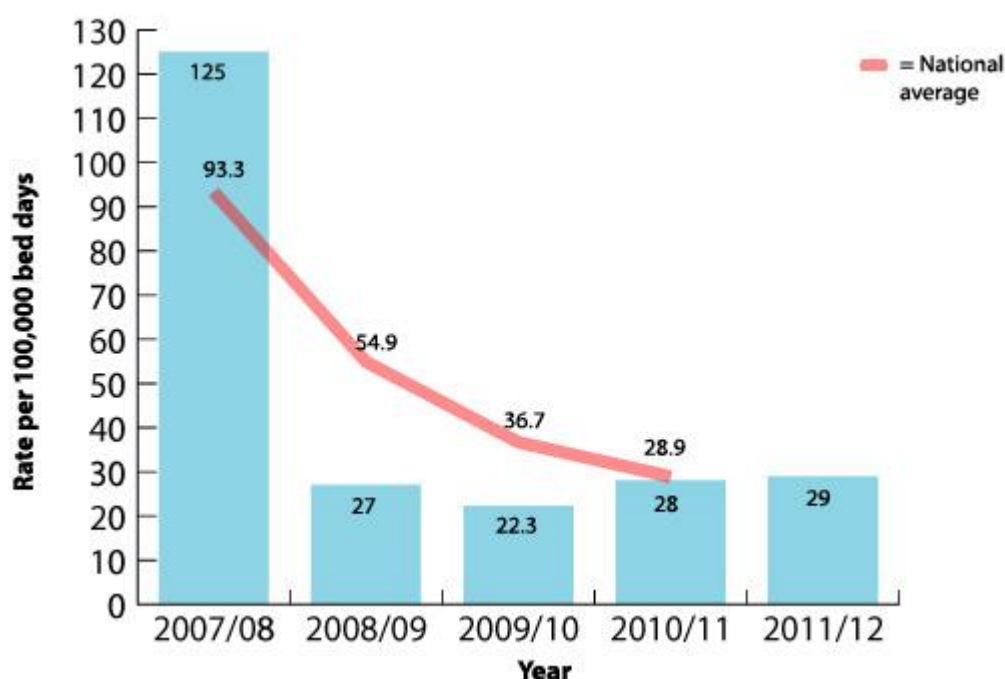
Clostridium difficile (*C.diff*) is a bacteria that can cause mild to severe diarrhoea and inflammation of the bowel. *C.diff* infection can be prevented by a range of measures, including good hand hygiene, careful use of antibiotics and thorough environmental cleaning. By monitoring the prevalence of infections acquired in hospital, we can introduce better measures to reduce the risk of infection for all of our patients.

Our outcomes

The rate of acquired *C.diff* infections per 100,000 bed days among patients aged two years and over was 29.0, which is slightly above the latest available national average rate, which is 28.9 (Sept 2011). The national average rate for 2011/12 will be available in September 2012.

Since 2008/09 our rate of *C.diff* infection has remained below the national average. Markedly improved performance was achieved between 2007/08 and 2008/09, largely through more careful use of antibiotics.

Rate of *Clostridium Difficile* infection at St George's Hospital



*National average figure for 2011/12 not yet available

Since 2010, comparison of figures both between hospitals and within the hospital compared to past years has become complex due to the introduction of improved diagnostics. We have been participating in a research trial sponsored by the Department of Health, using improved *C.diff* diagnostic tests, which resulted in the detection of cases that wouldn't have been found under previous testing regimes. 86 *C.diff* infections were detected at St George's Hospital in 2011/12 which exceeded our annual target of no more than 52. However, a shadow threshold target of no more than 87 cases was agreed with commissioners, which took into account the affect of improved diagnostics, and we successfully met this target.

We detected four more cases in 2011/12 compared to 2010/11; however, adjusting for the impact of improved diagnostics, which are now known to detect around 40 per cent more cases, the real trend demonstrates a continuing reduction in cases.

One patient was diagnosed with a hospital acquired MRSA bacteraemia (blood stream infection) during 2011/12. We have very robust systems in place to ensure our patients are safe from infection, and everyone is encouraged to maintain high standards of hygiene when visiting our wards and patient areas.

Our aims

We intend to introduce additional measures to reduce the rate of *C.diff* infection, including detailed surveillance with feedback to individual consultant teams, detection of carriers of

the *C.diff* organism and the appointment of infection control champions from amongst our consultant staff who will act as role models to reinforce and disseminate best practice.

Our target for 2012/13 will be to acquire no more than 52 *C.diff* infections at St George's Hospital.

Rate of patient safety incidents

Why is this important?

Modern healthcare is increasingly complex and occasionally things go wrong, even with the best practices and procedures in place.

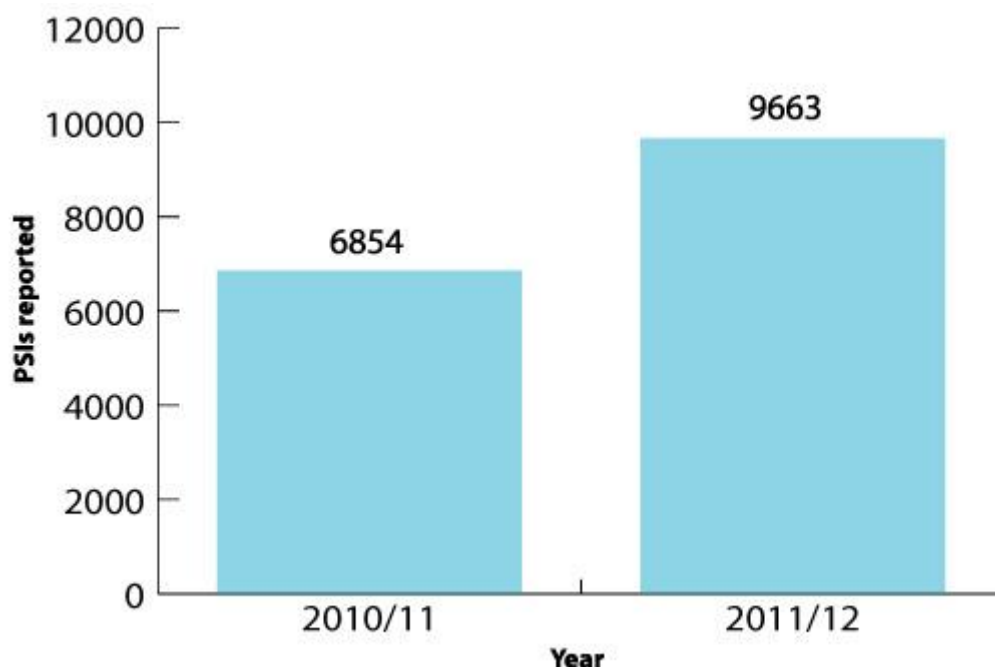
An open reporting and learning culture is important to enable the NHS to identify trends in incidents and implement preventative action. The rate of reported patient safety incidents – i.e. unintended or unexpected incidents which could have led, or did lead, to harm for one or more patients receiving NHS-funded healthcare – is expected to increase as a reflection of a positive patient safety culture.

This view is supported by the National Patient Safety Agency (NPSA) who state “organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are.”

Our outcomes

There has been a 41 per cent increase in the number of reported Patient Safety Incidents (PSIs) in 2011/12, compared to 2010/11, which demonstrates that at St George's we are committed to developing good systems that enable us to learn from things that go wrong and prevent them from happening again.

Patient safety incidents (PSI) 2011/12



Out of the total number of PSIs for 2011/12, there were four incidents that resulted in severe harm or death. This represents less than 0.5% of all reported PSIs.

Our aims

We undertake a comprehensive thematic analysis of our SIs every six months on which we base our patient safety initiatives, such as the Early Warning Score, which helps our staff to act promptly to avoid any preventable harm when a patient is found to be deteriorating, and the *Situation Background Assessment Recommendation* tool, a structured tool to ensure effective communication occurs when care is handed over from one healthcare professional to another. We have also developed DVDs of patients and their families telling stories, which helps staff understand the real-life impact of SIs and are being incorporated into a number of training courses.

We have developed an intranet based Safety Dashboard which outlines our safety priorities with resources to enable staff to achieve these aims. It also facilitates a more robust way of measuring whether these initiatives lead to improved outcomes.

Five medicines safety workshops were established in 2011 to increase knowledge and awareness among nursing staff and we also finished rolling out printed wristbands to replace ones handwritten by staff.

In 2012/13 we aim to continue to embed the lessons learned from reported PSIs and related investigations. We will introduce measures to address underlying SI themes to prevent reoccurrence and continue to encourage an open and effective safety culture.

Quality Account feedback and statements

Statements on this quality account

Statement of directors' responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

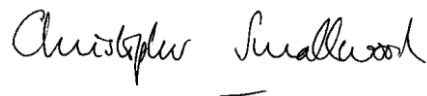
In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- The Quality Accounts presents a balanced picture of the trust's performance over the period covered;
- The performance information reported in the Quality Account is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, 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 Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and

- The Quality Account has been prepared in accordance with Department of Health guidance.

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

By order of the Board



Christopher Smallwood
Chairman
Tuesday 12th June 2012



Miles Scott
Chief executive
Tuesday 12th June 2012

Acknowledgements

We would like to thank those who generously provided the feedback and key contributions that shaped the contents of this report:

- Our staff
- Our patients
- Wandsworth Local Involvement Network
- Sutton Local Involvement Network
- St George's Patients Forum
- St George's Patient Reference Group
- NHS South West London

Feedback: The Wandsworth Adult Care and Health Overview and Scrutiny Committee

The Wandsworth Adult Care and Health Overview and Scrutiny Committee welcomes the opportunity to comment on the St George's Healthcare NHS Trust Quality Account. It is strongly supportive of the Trust's decision to be an early adopted [sic] of the new core data set for quality accounts. Use of this core data set makes it much easier to compare the Trust's performance with that of other providers and to understand its strengths and weaknesses.

The most significant strength demonstrated is the Trust's good performance on the Summary Hospital-level Mortality Indicator, which is confirmed by its equally good performance on the Hospital Standardised Mortality Ratio. Performance against other indicators, such as VTE assessment and prophylaxis, prevention of hospital acquired infections, and patient safety reporting, demonstrate that the Trust's good clinical outcomes are based on a strong clinical and patient safety focus.

The Trust's performance on measures relating to patient experience is not quite so strong. Too many people who are waiting for treatment have been waiting for over 18 weeks since referral, and the number of people reported as having been waiting for over 52 weeks, although much reduced, remains unacceptable. Whilst the Trust's scores on the national inpatient survey are assessed by the

Care Quality Commission as 'about the same as other trusts', it is unfortunate that the improvements in patient satisfaction recorded in the 2010 survey have not been maintained. Likewise, given the Trust's great clinical strength, it is disappointing that Trust staff are not significantly more likely than the national average to recommend the Trust to family and friends as a place to work or receive treatment. It is suggested that, in its priorities for 2012/13, the Trust should focus on improving these aspects of its services.

An area of patient experience to which the Committee attaches particular importance is the care of patients who have dementia. The Trust has an undoubted commitment to improving care for this group and has been able to evidence some progress. However, care of patients with dementia is an increasing challenge for all providers of acute care and it is clear that the trust has some way to go before its proposed approach is fully in place. It is therefore suggested that the Trust should continue to report on progress in this area in future quality accounts.

Feedback: South West London Commissioning Unit

The commissioners have reviewed the Trust's Quality Accounts report for 2011 and the following is a summary of performance against national standards (listed below).

The Trust has worked hard to improve the quality of care it provides to our patients. The improvement in the 2011/12 CQUIN performance and the good performance on Healthcare Acquired Infections serves to demonstrate this.

However, as in 2010/11, there have been continuing problems with patients waiting in excess of 18 weeks for admitted care. An 18 week recovery plan has been agreed with commissioners for 2012/13 and we look forward to an improvement during 2012/13 in this and other areas that have not met the agreed standards.

	2011/12	2012/13
<p>18 Week Waiting Times</p> <p>patients to wait no longer than 18 weeks from referral to treatment.</p>	<p>The target was met throughout the year for non-admitted patients</p> <p>For admitted patients the target was not met for the first 9 months of the year but was achieved in the final quarter.</p>	<p>To achieve recovery plan agreed with commissioners and reduce the numbers of patients waiting longer than 18 weeks.</p>
<p>Emergency Access (A&E 4 hour target)</p> <p>95% of all patients attending accident and emergency should be treated, admitted or discharged within a maximum of 4 hours.</p>	<p>96.24% of patients were treated, admitted or discharged within 4hrs</p> <p>As part of the Trust's development as a Major Trauma Centre the resuscitation unit has been refurbished and expanded.</p>	<p>Maintain above 95%</p>
<p>Cancer Waiting Times Targets</p> <p>2 week rule (the maximum wait for an urgent referral).</p> <p>1 month to treatment from confirmed diagnosis.</p> <p>2 months to treatment (wait from urgent referral).</p>	<p>All targets met</p>	<p>Maintain good performance on all targets</p>
<p>CQUIN Achievement</p>	<p>A significant improvement on 2010/11</p> <p>SGH 90%</p> <p>QMR 85%</p> <p>CSW 94%</p>	<p>To maintain a good performance against CQUIN targets at SGH, QMR and CSW</p>

Eliminating Mixed Sex Accommodation	<p>The Trust maintained good performance with regards to mixed sex accommodation in 2011/12</p> <p>A remaining problem area is delayed discharge from critical care beds. The majority of which are caused by waits for a bed on the appropriate ward.</p>	Trust to take the necessary action to further improve performance so that the number of patients in mixed sex accommodation is further reduced in 2012/13.
<p>Healthcare Acquired Infections</p> <p>no more than 2 cases of MRSA (bacteraemia) during 2011/12</p> <p>no more than 52 cases of Clostridium Difficile during 2011/12.</p>	<p>SGH had 1 case of MRSA in 2011/12</p> <p>SGH exceeded the national target for C Difficile as a more sensitive testing methodology was introduced. Commissioners agreed a local target for C-Difficile and this was met.</p>	To maintain a good performance
Maternity Services	In order to reduce pressure on the service a catchment area was introduced for births at SGH. Since its introduction the ratio of midwives to deliveries has improved.	To achieve Maternity CQUIN milestones in 2012/13
Never Events	There were 4 never events in 2011/12	No Never Events in 2012/13
<p>Serious Incidents (SI)</p> <p>Timely reporting and learning from errors</p>	<p>The Trust met the national target for completing root cause analysis within the time frame.</p> <p>The Trust has strengthened SI review processes. These include a regular thematic analysis of SIs, to reduce, as far as possible, the potential for the same error to recur.</p>	To maintain a good performance in root cause analysis of SIs.
CQC / External Audit Results		

<p>National Survey of Adult Inpatients</p>	<p>The results of the 2011 National Inpatient Survey showed SGH were about the same as all other hospitals in the response to all 77 questions.</p> <p>QMR undertook their own inpatient survey in 2011/12. The results indicated an improvement against two questions:</p> <ol style="list-style-type: none"> 1. Were you as involved as you wanted to be in decisions about your care and treatment? 2. Were you told who to contact if you were worried about your condition after you left hospital? <p>The improvement represents a 1.8 increase on the 2010/11 score of 64.3</p> <p>QMR's final score in 2011/12 was 66.1</p>	<p>Further improvement in experience of inpatients.</p>
<p>National Outpatient Department Survey</p>	<p>SGH were: Among the best performing 20% of Trusts for 2 questions.</p> <p>In the intermediate 60% of hospitals for 17 questions.</p> <p>Within the worst performing 20% of Trusts in 20 areas.</p>	<p>Action plan in place to improve patient experience in outpatients</p>

Feedback: Wandsworth Local Involvement Network (LiNK)

Wandsworth Link welcomes the work done by St George's over the past year to maintain and improve the quality of care offered to Wandsworth residents. We note that patient records and information systems have been improved and that efforts have been made to increase staff availability for direct patient care and contact.

Last year we had specific concerns regarding the discharge process and we appreciate that measures implemented by the Trust have led to improvements in this. However, reports from patients suggest that the resilience of the systems could be further improved, since the absence of a single staff member can still result in significant delays.

We note that the current report focuses on a set of standard metrics that will allow easier comparison between Trusts. However, very few of these directly reflect the quality of the patient experience and would therefore support a greater opportunity for patient feedback to be gathered and reported.

Looking forwards, we appreciate that there will be a number of changes in the nature and method of delivery of services provided by the trust as a result of wider reorganisations together with a development of the Trust's own strategy as it moves towards Foundation Trust status. We appreciate the level of patient and public involvement that has been

achieved in these processes to date and would wish for this to be continued and extended. Amongst the concerns expressed by patients are that these changes will erode the level of service provided to local people. We would wish to work closely with the Trust to ensure that this does not happen.

Independent auditor's limited assurance report to the director's of St George's Healthcare NHS Trust on the annual Quality Account

I am required by the Audit Commission to perform an independent assurance engagement in respect of St George's Healthcare NHS Trust's Quality Account for the year ended 31 March 2012 ("the Quality Account") as part of my work under section 5(1)(e) of the Audit Commission Act 1998 (the Act). NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010 and the National Health Service (Quality Account) Amendment Regulations 2011 ("the Regulations"). I am required to consider whether the Quality Account includes the matters to be reported on as set out in the Regulations.

Respective responsibilities of Directors and auditors

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, 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 Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

My responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to my attention that causes me to believe that the Quality Account is not consistent with the requirements set out in the Regulations.

I read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for my report if I become aware of any inconsistencies.

This report is made solely to the Board of Directors of St George's Healthcare NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010.

Assurance work performed

I conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the NHS Quality Accounts Auditor Guidance 2011/12 issued by the Audit Commission on 16 April 2012. My limited assurance procedures included:

- making enquiries of management;
- comparing the content of the Quality Account to the requirements of the Regulations.

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

The scope of my assurance work did not include consideration of the accuracy of the reported indicators, the content of the quality account or the underlying data from which it is derived.

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. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

Conclusion

Based on the results of my procedures, nothing has come to my attention that causes me to believe that the Quality Account for the year ended 31 March 2012 is not consistent with the requirements set out in the Regulations.

Andy Mack
District Auditor
Audit Commission
1st Floor, Millbank Tower
Millbank
London
SW1P 4HQ

28 June 2012

Quality Account appendices

Appendix A: omissions from 2010/11

There are a number of quality indicators that we reported on in detail in the 2010/11 Quality Account which we have chosen to omit from this report. All are important quality measures and give a valuable picture of quality and patient experience at St George's. However, this year, we decided, in consultation with our staff and patients, to focus on a smaller number of quality measures that apply universally to all trusts across the country. We believe this will help readers to more meaningfully compare our performance against similar trusts and make better choices about where to receive their healthcare.

This appendix provides a brief summary of performance during 2011/12 for each omitted item from the 2010/11 report.

Item	2011/12 performance	Monitoring
Using audit to achieve service improvement	<p>Clinical audit is used to compare our performance to best practice and allows us to see where our standards of care are as they should be, or require improvement.</p> <p>The acute oncology service is a new service for cancer patients – specifically those undergoing chemotherapy – created following a national audit that identified a need for speedy expert treatment for this cohort of patients. Two local audits have also helped to develop it. Both audits identified areas of good practice and some areas where improvements can be made. We are already putting these improvements in place and plan to re-audit later in 2012 when the new service is fully established.</p> <p>A trust wide audit on medical and surgical wards found that evidence of documented pain assessment was generally poor but that in general, patients reported that pain was well controlled. The audit results were discussed in a governance meeting and as a result a number of actions have been put in place including ongoing discussion of pain as part of the MDT process and the investigation and evaluation of tools that can help assess pain in patients with communication difficulties.</p>	<ul style="list-style-type: none"> - Clinical effectiveness and audit committee - Patient Safety Committee
Clinical administrative system - Cerner Millennium	<p>The transition to 'business as usual' for the clinical information system, Cerner Millennium was completed in 2011. More system checks have been put into place and processes have been revised to improve the accuracy and timeliness of data entry into the system. Staff have been trained in these revised procedures. In conjunction with the on going work on our referral to treatment times these processes continue to be monitored.</p>	<ul style="list-style-type: none"> - ICT Committee

	The next phase of development of Cerner Millennium to make more clinical information available via the system including electronic prescribing and diagnostic results reporting has now commenced.	
Outpatient services	<p>During 2011/12 we improved response rates in the call centre from only 50% of calls being answered to 95% of calls being answered within one minute and 75%+ of calls being answered within 30 seconds.</p> <p>We have also improved our productivity in sourcing medical notes by 90% following the establishment of a central search team in 2011.</p> <p>We also established new systems to ensure patients leave clinic with a follow up appointment thus ensuring patient safety</p> <p>We secured funds from our Strategic Health Authority NHS London to hold bespoke customer training courses for front-line staff which has contributed to a decrease in complaints.</p>	<p>- Divisional Management Board of the Children's, Womens, Diagnostics, Therapeutics and Critical Care Division</p> <p>- Virtual Outpatient Directorate</p>
Medication safety monitoring	<p>Since February 2011 a total of 98 visits have been conducted. All wards and clinical areas across the trust are visited. The visits are themed however other types of medication safety issues, such as security of medications, are reviewed. Since November 2011 the visits have focused on insulin. These have helped us to improve the accuracy of fridge temperature monitoring. Identified safety issues are recorded in an action log and communicated to senior nursing and pharmacy staff.</p>	- Patient Safety Committee
Never events	<p>A never event is an event or incident that is unacceptable and preventable within the NHS.</p> <p>During this year there have been four "never" events reported by this trust to NHS London. Three related to retained vaginal swabs in obstetrics and gynaecology. The final event related to the misidentification of a patient resulting in them receiving the wrong medication.</p> <p>The trust greatly regrets these events and accepts that they all could have been prevented by good systems that are clear and fully implemented by staff.</p> <p>All of the above events have been fully investigated and action plans developed to ensure that they could not happen again. Lessons have been widely disseminated to staff and systems and processes have been changed with the aim of increasing reliability. The trust cannot be complacent about such events and will continue to monitor the systems that have been implemented.</p>	- Patient Safety Committee
Managing complaints	<p>In 2010/11 we received 1031 formal complaints which represents a decrease of 17 per cent when compared to the previous year.</p> <p>In 2011/12 we received reports on two complaints which had been investigated by the Parliamentary and Health</p>	- Patient Issues Committee

	<p>Services Ombudsman and complied with all recommendations contained therein.</p> <p>You can read more about how we manage complaints at St George's in our 2011/12 Annual Report which will publish by September 2012.</p>	
Volunteers	<p>There are currently more than 250 volunteers working in a variety of areas providing invaluable assistance to staff and improving the patient experience without pay.</p> <p>Roles include way-finding assistance on corridors and information desks, basic clerical assistance in departments, meeting and greeting patients in clinics and assisting patients at mealtimes. For further information visit http://www.stgeorges.nhs.uk/careersVol.asp</p>	- Patient Issues Committee
Healthcare environment	<p>During 2011/12 there were a number of developments in the facilities provided by the trust. A state of the art breast screening and diagnostic unit opened at St George's Hospital. Known as the Rose Centre, the unit is home to the South West London Breast Screening Service and St George's National Breast Screening Training Centre.</p> <p>A new Macmillan information and support centre for patients, carers and families affected by cancer opened its doors at St George's Hospital in July 2011. The centre, located at St George's Hospital on the Grosvenor Wing ground floor, provides vital information and support for anyone affected by cancer, whether they are worried they may have the disease, during treatment or whilst adjusting to life afterwards. The relaxed and informal space includes a main room offering information booklets and leaflets and a quiet room.</p> <p>A year after integrating with Community Services Wandsworth (CSW) patients from across the borough are seeing the benefits. In senior health services, streamlined care pathways and changes such as the development of common processes for falls prevention have had a significant impact. New models of care have seen patients and staff benefit from increased access to consultant geriatrician expertise. The community ward has also improved long-term condition management and reduced admissions for high risk patients who can now receive treatment from a multi-disciplinary and agency team in their own homes.</p> <p>In September a new resuscitation unit was opened at St George's Hospital. The unit, the most modern in London, provides eight resuscitation bays each with a large bed space to allow emergency care staff to manage the most complex of cases. The unit also houses a dedicated overhead x-ray system built into the</p>	- N/A

	ceiling of the department.	
Dementia care	<p>The trust is committed to the highest possible standard of care for patients with dementia.</p> <p>All patients aged 65 or over are asked to complete the Abbreviated Mental Test Score (AMTS), a brief memory test, on admission to hospital via A&E or the Acute Medical Unit, or as part of preparation for elective surgery. An audit on the elderly care ward in July 2011 found that 92% of patients had received a memory test, complying with our target of 50% in 2011/12.</p> <p>Since Autumn 2010 we have had a dedicated liaison mental health nurse for older adults.</p> <p>The dementia strategy group has developed a "confused person's pathway" which will provide staff with guidance on best practice and an appropriate care pathway for people with dementia and delirium in hospital. The strategy group has decided to embed this within in an over-arching dementia policy for the Trust with the aim of introducing both the pathway and the policy during 2012.</p> <p>We are currently developing the role of "dementia champions" in response to the 2011 National Audit of Dementia. We plan to offer an extended training course for these staff, ideally the eight half-day modular course offered by Wandsworth social services. The first five champions should start this course in April 2012.</p> <p>We are developing additional audit tools to monitor the quality of care for people with dementia e.g. tablet-based patient experience surveys, and including dementia-related parameters in regular ward quality audits.</p>	<ul style="list-style-type: none"> - Dementia strategy group - Patient Issues Committee

Appendix B: CQUINs

Acute CQUINs 2011/12

CQUIN	Detail	Performance
Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)	Ensure 95 per cent of adult inpatients have had a VTE Risk assessment	Met
	Ensure 95 per cent of patients found to be at risk following VTE risk assessment have been provided with appropriate prophylaxis.	Met
Patient experience survey	Undertake an annual survey of inpatients asking about dignity, quality of care and treatment and score better than five similar hospitals as well as improvement against previous years.	Not Met - We maintained the improvements made in the 2010 survey and performed significantly better on two questions, however, we didn't meet the milestones agreed with commissioners.
Acute Oncology Service	Ensure 95% of cancer patients admitted via A&E due to complications of chemotherapy are reviewed by a member of the acute oncology team within 24 hours of admission.	Met
Midwives	Ensure a min of 85% (hours) coverage of supernumerary midwife is on the Delivery Suite evenings, nights and weekends.	Met
Cardiac Arrest	Achieve a 15% reduction in cardiac arrests outside critical care by ensuring the appropriate use of the agreed warning tool (EWS).	Met
End of Life care	Establish a hospital based register for patients at the end of their lives and offer discussions regarding their preferred priorities of care. Communicate the information with primary care for patients who have consented.	Met
Alcohol Misuse	Ensure 65% of A&E, 85% of gastro and 65% of antenatal patients have been screened for alcohol misuse.	Partially met for A&E. Fully met for gastroenterology and antenatal.
	Ensure 90% of patients at risk of alcohol misuse have been referred to a specialist service.	Met
Outpatient Experience	Ensure a reduction in first and follow up cancellations as well as ensuring that patients whose appointments have been cancelled at more than 6 weeks notice are rebooked	Partially met for cancellation of new appointments. Fully met for

	within 6 weeks of original appointment.	cancellation of follow ups and for re-booking.
	Ensure there is no voicemail on booking systems and that calls are answered within 30 seconds for new appointments and within 60 seconds for follow ups.	Met
	Ensure most services are covered by choose and book.	Met
	Ensure outpatient appointments are booked before patients are discharged.	Not Met – this process has now been revised as an action for our outpatient taskforce
Urinary catheter management	Continue the improvement of catheter management by standardising the equipment review ensuring trust wide compliance with the urinary catheter protocol	Met
Pressure Ulcer	Improve the management of pressure ulcers by developing and ensuring the use of a standardised assessment tool and improving communication with primary care.	Met
Medicines Management	Ensure increased prescribing of low cost medicines where appropriate, increase the safety of prescribing of non steroidal anti-inflammatory drugs and conduct an audit on agreed medicines to assess outcomes of treatments.	Met

Specialised CQUINs 2011/12

CQUIN	Detail	Performance
Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)	Ensure 90 per cent of adult inpatients have had a VTE Risk assessment	Met
	Ensure 95 per cent of patients found to be at risk following VTE risk assessment have been provided with appropriate prophylaxis.	Met
Adult bone marrow transplant	Review and develop action plans if necessary for patients who die within 100 days of an autologous transplant for myeloma. Update the BMT registry and reduce the number of patients who experience 2 nd and 3 rd episodes of stem cell mobilisation.	Met
Haemophilia	Review reasons for clotting factor usage for severe haemophilia in adults and ensure at least 80% of children have had trough level measurement within the previous 6 months.	Met
Neonatal intensive care unit (NICU)	Ensure a satisfactory (same as or below average level for network) length of stay for babies admitted to a neonatal unit and ensure babies born at less than 30 week gestation	Met

	have access to multi disciplinary team monitoring for 2 years.	
HIV	Ensure patients are involved in decisions about their care and supported to self manage.	Met
	Support patients to register with a GP and ensure communication with their GPs.	
Paediatric intensive care unit (PICU)	Ensure an acceptable level of unplanned readmissions (max. ratio of 3% unplanned / all admissions)	Met

Quality Account CQUIN summary – CSW contract CQUINs

CQUIN detail	Performance
50% of patients on community nursing (including community matrons), intermediate care and specialist nursing caseload to have multi-disciplinary team meeting	Met
50% of non-cancer end of life care patients to die in their preferred place of death	Met
70% of community nursing (including community matrons), intermediate care and specialist nursing to have pressure ulcer risk assessment in place	Met
80% of community nursing (including community matrons), intermediate care and specialist nursing staff at band 6 and above to receive education and competency around pressure care	Met
90% of pressure relieving mattresses required for patients on the community nursing (including community matrons), intermediate care and specialist nursing caseloads provided within clinically agreed timeframe	Met
20% reduction in short stay admissions of Wandsworth patients at SGH	Met
90% of patients on the community nursing (including community matrons), intermediate care and specialist nursing with a falls risk profile in place (if at risk of falling)	Partially met. Targets set throughout the year. Q1 target of 10% not achieved but all subsequent targets met (including Q4 target of 90%).
85% of babies born have breastfeeding status recorded at the new birth visit	Met
85% of babies born have breastfeeding health promotion provided recorded at the new birth visit	Met
90% of eligible children receiving School Leaver Booster immunisation	Partially met. Achieved 81.9% during financial year; considerable improvement on 55% baseline from 2010/11.
Parental non-response to HPV vaccination offer reduced to 5%	Met
All schools where uptake of HPV vaccination is below 90% receive additional immunisation sessions	Met
70% of adult sickle cell patients on the community Haemoglobinopathies team caseload have care plan in place	Met
85% of year 6 children defined as overweight or obese via the National Child Measurement Programme invited to attend physical activity	Met

sessions	
10 CSW staff trained in self-management techniques and facilitation under the Co-Creating Health Programme; 2 staff trained as trainers	Met
Increasing patient engagement and self-management following on from Co-Creating Health Programme	Partially met. We achieved all the work for this CQUIN. However one deadline in quarter three was missed. This resulted in partial achievement.
Referral pathways for 5 long term conditions mapped out and publicised to all CSW staff	Met
95% respiratory specialist nurses trained in smoking cessation support	Met
85% of smokers on the respiratory specialist nursing caseload referred to smoking cessation	Met
85% of appointment requests acknowledge within 72 hours and 70% of offenders reporting improvements in the process	Partially met. Appointment request target met but only 67% of offenders feeling that the process had improved.
80% of offenders completing 4/6 sessions on smoking cessation programmes and 70% of offenders completing full programmes	Partially met. 4/6 session attendance target met but only 62% of offenders attended full programmes
90% of QMH inpatients being assessed for VTE on admission	Met
Improvement of 5 points on the national inpatient survey questions for QMH beds	Partially met. Achieved 1.8 point improvement from 2010/11 baseline
Reasons for catheterization documented in 95% of all catheterised QMH inpatients	Met
Catheter protocol followed for 95% of QMH inpatients	Met
95% of QMH inpatients to have pressure ulcer risk assessment in place	Met
95% of QMH inpatient staff at band 6 and above to receive education and competency around pressure care	Met
95% of pressure relieving mattresses required for QMH inpatients	Met
Reduction in hospital cancellation of first appointments and follow-up appointments at QMH to 7.5% and 14.6% respectively	Partially met. Cancellation of first appointment target met; cancellation of follow-up target not met – reduced to 16.9% only.
Reduction in hospital cancellation of Choose & Book appointments at QMH to 12.1%	Met
98% of QMH outpatient specialties and 70% of clinics within these specialties available to book via Choose & Book	Met
Review and refresh of current, and development of new, Rapid Diagnostic Pathways at QMH. Additional 1,000 RDP activities delivered at QMH.	Partially met. All review, refresh and development work met. However only 722 additional activities delivered.

Our proposed acute and specialised CQUINs for 2012/13 are included in the following table. At the time of print the trust is in discussions with commissioners and the list is still subject to amendment.

For 2012/13 the total CQUIN value for the acute and community contracts is estimated as £11m.

Proposed Acute CQUINs 2012/13

CQUIN	Detail
Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)	Ensure 96 per cent of adult inpatients have had a VTE Risk assessment
	Ensure 98 per cent of patients found to be at risk following VTE risk assessment have been provided with appropriate prophylaxis.
Patient experience survey	Undertake an annual survey of inpatients asking about dignity, quality of care and treatment and score better than five similar hospitals as well as improvement against previous years.
Dementia Screening	Ensure an agreed % of all patients aged 75 or over have been screened following admission to hospital.
	Ensure an agreed % of patients found to be at risk have had a risk assessment.
	Ensure an agreed % of patients at risk have been referred for specialist diagnosis.
NHS Safety Thermometer	Put processes in place to ensure improved data collection in relation to pressure ulcers, falls, urinary tract infection in those with a catheter and VTE.
End of Life care	Increase the use of the register through and sustain and improve levels of identification of patients in the last year of life
Alcohol Misuse	Continue to screen patients in A&E and gastro for alcohol misuse and ensure an agreed % of patients at risk of alcohol misuse have been referred to a specialist service.
	Agree processes to identify, assess and refer repeat alcohol related attenders.
Outpatient Experience	Ensure a reduction in first and follow up cancellations as well as ensuring that patients whose appointments have been cancelled at more than 6 weeks notice are rebooked within 4 weeks of original appointment.
	Increase the coverage of areas which are

	booked by the Central Booking Service.
	Ensure patient transport is also cancelled when an appointment is cancelled.
	Ensure outpatient appointments are booked before patients are discharged.
Pressure Ulcer	Improve the management of pressure ulcers in some specialist areas by providing awareness and training and improve communication with primary care through discharge forms.
Medicines Management	Produce a price comparison report between drugs purchased by the Trust and prices available through the London Procurement Programme.
	Improve reporting and compliance for all available Patient Access Scheme and for excluded drugs.
Early Warning Scoring (EWS)	Improve compliance in the use of the EWS tool.
Maternity	Achieve a midwifery workforce ratio of 1:28
	Ensure there is a supernumerary midwife cover on the delivery suite.
	Reach and maintain an agreed coverage of obstetric consultant cover on the delivery suite each week.
Falls	Achieve an improvement in falls risk assessment and management in high risk areas.
Oncology Service	Ensure an agreed % of new cancer patients with stage of tumours at time of diagnosis is accurately recorded.
	Ensure an agreed % patients admitted through A&E with previously undiagnosed cancer are reviewed by a member of the oncology team within 24 hours of referral.
Paediatrics	Transfer of the management of Paediatric Non-Accident Injury.
	Increase paediatric consultant cover from 9am till 9pm, 7 days a week.
Medication Safety	Ensure improved medication safety.
Patient Notes	Improve the quality (inc. content) of patient notes.

Proposed Specialised CQUINs 2012/13

CQUIN	Detail
Reduce avoidable death, disability and chronic ill health from Venous-	Ensure 96 per cent of adult inpatients have had a VTE Risk assessment
	Ensure 98 per cent of patients found to be at risk following VTE risk assessment have been provided with appropriate prophylaxis.

thromboembolism (VTE)	
Patient experience survey	Undertake an annual survey of inpatients asking about dignity, quality of care and treatment and score better than five similar hospitals.
Quality Dashboard	Improve the quality of collecting and reporting data in agreed areas.
Adult bone marrow transplant	Report on outcomes for 100 days, 1 year and 2 years post transplant.
Neonatal intensive care unit (NICU)	Ensure a reduction in the length of stay for babies admitted to a neonatal unit.
HIV	Ensure people living with HIV are registered with a GP.
	Ensure a letter has been sent to the patients' GP for an agreed % of patients who have consented the service to send a letter
	Increase the number of patients receiving their antivirals by home delivery.
	Assess the implementation and impact of the HIV QIPP plan.
Paediatric intensive care unit (PICU)	Treating and caring for people in a safe environment.

Community services Wandsworth CQUINs 2012/13

Indicator	
Community contract	60% of patients on community nursing (including community matrons), intermediate care and specialist nursing caseload to have multi-disciplinary team meeting
	70% of non-cancer end of life care patients to die in their preferred place of death
	80% of community nursing (including community matrons), intermediate care and specialist nursing to have pressure ulcer risk assessment in place
	80% of community nursing (including community matrons), intermediate care and specialist nursing staff at band 5 and below to receive education and competency around pressure care
	95% of patients will a falls risk profile in place to have 95% of all core information completed and 80% of additional information completed
	Develop and deliver falls and bone health education for local GPs to support the falls and bone health pathway

	development
	Implement processes and collect pilot data in preparation for the NHS Safety Thermometer ready for 2013/14
	Implement revised referral forms for Single Point of Contact services (detailing a minimum dataset and additional service specific elements)
	90% of referrals from SPoC defined as 'urgent' where contact is made by telephone within 1 hour and where the patient is seen within 4 hours.
	20% reduction in short stay admissions of Wandsworth patients at SGH
	95% of children in Wandsworth noted as unregistered with a GP referred to HV team contacted (exclusions apply as above) and a % reduction in number of GP unregistered children on Wandsworth Child Health Register overall
	90% of new adult sickle cell patients on haemoglobinopathies team caseload are referred to appropriate self-management programmes if requested; 75% of adult sickle cell patients who have been on the haemoglobinopathies team caseload for 12 month have a formal care plan review carried out and documented.
	75% of adult sickle cell patients discharged from SGH are contacted or visited by the Haemoglobinopathies Team Clinical Nurse Specialist (CNS) within 48 hours of discharge summary being received
	85% of children assessed as obese or overweight (BMI \geq 91st percentile) contacted by telephone and 50% (42.5% of those classified as overweight or obese) of these are referred to weight management and activity programmes
	95% of young people seen by school health service for sexual health issues are given information about sexual health support/ services available and signposted to a young person appropriate sexual health service
	80% of pregnant Wandsworth teenagers booked in at SGH offered ante-natal support. Plan to develop and provide post-natal structured support developed.
	85% of mothers identified as smokers at the new birth visit are provided with smoke free homes information and referred to smoking cessation programmes
	Implement a system to make improvements to the scores around the annual breastfeeding audit and carry out the audit in 2013.
	Review use of clinical outcome measures in CSW and implement outcome measure use in all services.
HMP Wandsworth contract	Ensure agreed annual health check and health improvement opportunities are met for 50% of offenders within Q4 and that a plan for review of all of offenders and for delivering care to all is in place for 2013/14.
	Redesign the Primary Care Mental Health Service at HMPW. Ensure that 80% of these received were offered assessment

	and treatment within agreed minimum standards.
	70% of offenders who have polypharmacy verified following Reception have a review 6 weeks post receipt of verification; 70% of offenders in receipt of polypharmacy for the past 12 months have an annual review in the past 12 months
	80% of offenders risk assessed as suitable to hold their medications as 'in possession' do actually hold their medication 'in possession'. Review processes and protocols and risk issues to assure of safety.
	60% of requests for urgent, non-urgent and routine appointments offered an appointment within target waiting times
Queen Mary's, Roehampton (QMH)	90% of QMH inpatients having a SGH VTE risk assessment on admission; 90% of QMH inpatients with a VTE risk assessment in place indicating that prophylaxis is required, receive prophylaxis as per guidelines
	Improvement of 1-3 points on the national inpatient survey questions for QMH beds
	90% of patients admitted to QMH inpatient wards are asked the dementia screening question
	90% of patients admitted to QMH inpatient wards who are found to be at risk of dementia following screening, have a dementia risk assessment within 72 hours of admission
	90% of patients admitted to QMH inpatient wards who are found to be at risk of dementia following the dementia risk assessment are referred for specialist diagnosis
	Implement processes and collect pilot data in preparation for the NHS Safety Thermometer ready for 2013/14
	Develop and deliver revised and new Rapid Diagnostic Pathways at QMH in conjunction and collaboration with commissioners
	Attend GP engagement events held by NHS Wandsworth and NHS Richmond in relation to QMH and develop and deliver marketing strategy to increase referrals and activity from GPs that do not usually use QMH
	Pilot increased capacity in pain and neurology clinics at QMH
	Carry out an in-depth review of outpatient demand, capacity, activity, waiting, backlog and current utilisation of the QMH estate. Use this demand to forecast what the future demand and activity could be and what capacity may be required to meet this. Assess the impact on the utilisation of space at QMH.
	Ensure that 90% of all QMH inpatients requiring a full falls risk assessment have this in place and that 80% of these assessments contain complete and accurate data.
	90% of inpatients to have EWS completed and accurately scored and 70% of completed EWS tools have appropriate responses to triggers in place
	Maintain pressure risk assessment completion for 95% of

	QMH inpatients and ensure 95% of QMH inpatients assessed as at high risk of developing a pressure ulcer have a repositioning chart completed
	90% of QMH inpatient band 5 nurses and HCSWs have attended training and achieved competency in pressure ulcer management
	85% of wheelchair service and special seating service patients have documented pressure considerations on the referral form and where appropriate action has been taken

Appendix C: National clinical audit and national confidential enquiries

Eligible audit/ enquiry	Participation	Submission rate (%) / comments
National neonatal audit programme	Yes	100
Paediatric pneumonia (British Thoracic Society)	Yes	100
Paediatric asthma (British Thoracic Society)	Yes	70
Pain management (College of Emergency Medicine)	Yes	100
National childhood epilepsy audit (Epilepsy 12)	Yes	100
Paediatric intensive care audit network (PICANet)	Yes	100
RCPH National paediatric diabetes audit	Yes	100
Emergency use of oxygen (British Thoracic Society)	Yes	100
Adult community acquired pneumonia (British Thoracic Society)	Yes	Data collection period beyond 2011/12
Non-invasive ventilation (NIV) – adults (British Thoracic Society)	Yes	100
Pleural procedures (British Thoracic Society)	Yes	100
National cardiac arrest audit	No	There was a delay in requesting the joining pack while we upgraded web browser software and sourced funding to allow the trust to take part. The dataset required for the NCAA continues to be collected locally, and is presented to the trust's resuscitation committee and patient safety committee. We have registered to participate in this audit and will begin collecting and submitting data in 2012/13.
Severe sepsis and septic shock	Yes	100
Adult critical care centre case mix programme (ICNARC)	Yes	100
Potential donor audit (NHS Blood and Transplant)	Yes	100
National audit of seizure management	Yes	100
National adult diabetes audit	No	We do not use the database which would enable our participation in this audit. Senior trust staff are working to ensure that the issues which have delayed our implementation of this database are resolved.

National audit of heavy menstrual bleeding	Yes	55
National pain database audit: chronic pain services	No	Although we participated in Phase 1 of the project in 2010/11 we were unable to submit data this year due to reorganisation and relocation of the pain clinic. During this time local audit has continued and a meeting is planned for early 2012/13 to establish how we will participate in the future.
Ulcerative colitis and Crohn's disease – UK inflammatory bowel disease audit	Yes	100
National Parkinson's disease audit	Yes	100
Adult asthma (British Thoracic Society)	Yes	100
Bronchiectasis (British Thoracic Society)	Yes	100
National joint registry- hip, knee and ankle replacements	Yes	100
National PROMs programme – elective surgery	Yes	60.6 (Apr 11 - Sep 11)
Coronary angioplasty - NICOR Adult cardiac interventions audit	Yes	100
Peripheral vascular surgery - VSGBI vascular surgery database	Yes	100
Carotid intervention audit	Yes	100
Adult cardiac surgery audit - CABG and valvular surgery	Yes	100
Myocardial ischaemia national audit project	Yes	100
Heart failure audit	No	No cases have been submitted for 2011/12, as the application made a year ago for a central cardiac audit database licence to enable local data entry and higher participation has not yet been granted. This has been escalated to clinical and managerial leads. Once granted we are preparing to enter data retrospectively.
Stroke improvement national audit programme	Yes	100
Cardiac rhythm management audit	Yes	100
Renal replacement therapy (Renal registry)	Yes	100
Renal transplantation (NHS Blood & Transplant UK Transplant registry)	Yes	100
National lung cancer audit	Yes	66
National bowel cancer audit programme	Yes	14.2

Head & neck cancer (DAHNO)	Yes	97
National oesophago-gastric cancer audit	Yes	>70
National hip fracture database	Yes	85.6
Trauma audit & research network	Yes	100
National comparative audit of blood transfusion - Bedside transfusion audit	Yes	100
National comparative audit of blood transfusion - Medical use of blood	Yes	100
National health promotion in hospitals audit	Yes	100
National care of the dying audit – hospitals 3 rd round	Yes	96.7
Bariatric surgery national confidential enquiry into patient outcome and death	Yes	100
Cardiac arrest procedures confidential enquiry into patient outcome and death	Yes	75
Peri-operative care confidential enquiry into patient outcome and death	Yes	100
Surgery in children confidential enquiry into patient outcome and death	Yes	100

Appendix D: National clinical audit - actions taken

National clinical audit	*Action
National audit of angioplasty procedures	Reporting and recording of timings and identification and investigation of delays is ongoing, with a monthly meeting to discuss current performance, where all breaches are reviewed.
National audit of falls & bone health	Local audit conducted. Results presented to divisions by chair of Falls Prevention Committee and support given with action planning. Task & finish group revised risk assessment tool, currently being piloted.
National kidney care audit – Patient transport	The trust has the highest number of dialysis patients using patient transport. All renal patients are being checked for eligibility.
National neonatal audit programme	Action has been taken to resolve issues with the data submission system, which adversely affected some of our results. Local data analysis conducted to ensure accurate picture of performance. Work undertaken to determine whether lower administration of steroids is due to missed opportunities to prescribe or because a higher proportion of mothers present precipitously.
London Ambulance Service Cardiac Arrest annual report	Best practice has been extended by the introduction of the Heart Attack team, and it is planned that in the coming year pathways will be established to enable non ST elevation MI patients to be taken directly to the catheter lab.
Stroke improvement national audit programme	Quarterly benchmarking reports are prepared, enabling the service to monitor performance. To fully engage with the revised national stroke programme which will combine this audit with the sentinel stroke audit.
Myocardial ischaemia national audit project	Each month the service review their achievements against key measures relating to time to treatment, ensuring we remain vigilant to performance throughout the year. Each breach is discussed at the monthly meeting.
National lung cancer audit	A new data collection and consultant led validation process has been introduced to ensure that results accurately reflect practice, thereby enabling us to use the data to drive and demonstrate improvement.
National audit of epileptic seizures	A new pathway for diagnostic tests is being developed, which will include improving information on driving, anti-epilepsy drug levels and alcohol consumption. Emergency department to be granted access to neurosciences folder on the trust network to improve sharing of information.
Heart failure audit	The trust applied for a licence for the central cardiac audit database to facilitate timely and increased submissions. This request remains outstanding and has been escalated to managerial and clinical leads for action. Service committed to entering data retrospectively if the licence is granted.
British Thoracic	Respiratory consultant nurse has disseminated results widely,

Society Emergency Oxygen audit	including presentations at nursing board and divisional meetings. In addition to this increased awareness, more training is planned.
National audit of Inflammatory Bowel Disease (IBD)	Recruiting an IBD clinical nurse specialist to support reduction in admissions and length of stay. Areas for improvement to be discussed by the multidisciplinary team: i) appropriateness of emergency laparoscopic surgery; ii) need for dedicated dietetic input; iii) importance of CdT assay. Paediatric findings presented at national conference by trust consultant.
National bowel cancer audit	Poor submission rate is being addressed as part of an action plan to improve the quality and completeness of data submission for the various audits and information requirements relevant to cancer services.
National audit of dementia care	Recommendations being taken forward by the trust's dementia strategy group, which has been incorporated as a sub-committee of the Patient Issues Committee. Local audit of abbreviated mental test score demonstrated overall achievement of agreed standard, but identified areas for improvement.

*Based on information available at time of publication

Appendix E: Local clinical audit – actions taken

Local clinical audit	*Action
Annual falls prevention re-audit	Increased awareness among staff has led to improved reporting of incidents. Task & finish group revised the falls risk tool and care plan to improve its utility and feasibility on wards. Investigating external product suppliers to prevent in-hospital falls.
Eliminating mixed sex accommodation	Comprehensive review of bathroom and toilet signage and installation of new signs to ensure clarity of information for patients. Continued monitoring and root cause analysis of breaches.
Trust-wide audit of record keeping	Introduced quarterly programme of audit, using an electronic data collection and reporting tool. Involvement of trainees in audit to promote learning and implementation of best practice.
Early warning score (EWS) and SBAR tool audit	Pilot of new tool and subsequent roll out trust wide, resulting in improved recording of observations. SBAR (situation, background, assessment, recommendation) communication tool incorporated into EWS documentation and bi-annual audit in conjunction with the same.
Patient Identification audit	Automated printing of ID bracelets rolled out trust wide. Escalated to Risk, Assurance and Compliance committee. Guidance provided to all staff on procedure to follow in event of IT problems. Actions taken in areas of poor compliance and snapshot audits undertaken to provide assurance of improvement.
WHO theatre checklist audit	Re-launch of checklist and programme of regular audit introduced. Action plans developed in areas where compliance is below standard. Definition of roles and responsibilities to identify staff members tasked with leading the checks. Snag books introduced to document actions and reviews following debriefs. Improvements made to audit methodology to ensure reliability of data.

*Based on information available at time of publication

Financial report

St George's Healthcare NHS Trust made a revenue surplus of £5.7 million in 2011/12. The trust has now generated revenue surpluses in five consecutive years and these surpluses have enabled the repayment of all the working capital loans totalling £34 million the trust borrowed from the Department of Health in 2007.

The trust generated an under-spend on its Capital Resource Limit (CRL) of approximately £7.4 million in 2011/12 as a result of the timing of the completion of two major property disposals in March 2012. This capital under-spend is carried forward to 2012/13 to fund capital investment.

The trust undershot its External Financing Limit (EFL) by approximately £7.4 million and therefore stayed within the overall cash limit set by the Department of Health. The undershoot was caused primarily by the disposal of properties just before the year end.

2012/13

The surplus of £5.7m earned in 2011/12 includes significant one-off income that is not available in 2012/13. Therefore the trust needs to continue to improve productivity in 2012/13 whilst at the same time enhancing the quality of its clinical services so that it meets its performance and financial targets.

Statement of comprehensive income

For the year ended 31st March 2012

	2011/12 £000	2010/11 £000 (restated)
Revenue		
Employee benefits	(389,717)	(386,082)
Other costs	(219,260)	(212,793)
Revenue from patient care activities	543,339	529,091
Other operating revenue	77,072	81,856
Operating surplus/(deficit)	11,434	12,072
Investment revenue	87	151
Other gains and (losses)	4,843	5,171
Finance costs	(3,785)	(4,327)
Surplus/(deficit) for the financial year	12,579	13,067
Public dividend capital dividends payable	(6,851)	(7,178)
Retained surplus/(deficit) for the year	5,728	5,889
Other comprehensive income		
Impairments and reversals	0	0
Net gain/(loss) on revaluation of property, plant & equipment	0	0
Net gain/(loss) on revaluation of intangibles	0	0
Net gain/(loss) on revaluation of financial assets	0	0
Net gain/(loss) on other reserves	0	0
Net gain/(loss) on available for sale financial assets	0	0
Net actuarial gain/(loss) on pension schemes	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0
Total comprehensive income for the year	5,728	5,889
Financial performance for the year		
Retained surplus/(deficit) for the year	5,728	
Prior period adjustment to correct errors	0	
IFRIC 12 adjustment	1,433	
Impairments	0	
Adjustments iro donated asset/gov't grant reserve elimination	(1,060)	
Adjusted retained surplus/(deficit)	6,101	

Statement of financial position

For the year ended 31st March 2012

	31 st March 2012	31 st March 2011 (restated)
	£000	£000
Non-current assets:		
Property, plant and equipment	282,179	288,602
Intangible assets	2,521	2,960
Investment property	0	0
Other financial assets	0	0
Trade and other receivables	38	77
Total non-current assets	284,738	291,639
Current assets:		
Inventories	6,293	5,886
Trade and other receivables	48,648	50,396
Other financial assets	0	0
Other current assets	1	2
Cash and cash equivalents	29,916	20,524
Total current assets	84,858	76,808
Non-current assets held for sale	426	0
Total current assets	85,284	76,808
Total assets	370,022	368,447
Current liabilities		
Trade and other payables	(72,696)	(70,106)
Other liabilities	0	0
Provisions	(1,011)	(682)
Borrowings	(3,470)	(2,656)
Other financial liabilities	0	0
Working capital loan from Department of Health	0	(7,990)
Capital loan from Department of Health	0	0
Total current liabilities	(77,177)	(81,434)
Non-current assets plus/less net current assets/liabilities	292,845	287,013
Non-current liabilities		
Trade and other payables	0	0
Other liabilities	0	0
Provisions	(1,278)	(1,330)
Borrowings	(53,926)	(53,770)
Other financial liabilities	0	0
Working capital loan from Department of Health	0	0
Capital loan from Department of Health	0	0
Total non-current liabilities	(55,204)	(55,100)
Total assets employed:	237,641	231,913
FINANCED BY:		
TAXPAYERS' EQUITY		
Public Dividend Capital	131,475	131,475
Retained earnings	16,360	(3,225)
Revaluation reserve	88,656	102,513
Other reserves	1,150	1,150
Total taxpayers' equity:	237,641	231,913

Statement of changes in taxpayers' equityFor the year ended 31st March 2012

	Public dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
	£000	£000	£000	£000	£000
Balance at 1st April 2011	131,475	(3,225)	102,513	1,150	231,913
Opening balance adjustments		0	0	0	0
Adjustments for Transforming Community Services transactions		0	0	0	0
Restated balance at 1st April 2011	131,475	(3,225)	102,513	1,150	231,913
Changes in taxpayers' equity for 2011/12					
Retained surplus/(deficit) for the year		5,728			5,728
Net gain / (loss) on revaluation of property, plant, equipment			0		0
Net gain / (loss) on revaluation of intangible assets			0		0
Net gain / (loss) on revaluation of financial assets			0		0
Net gain / (loss) on revaluation of assets held for sale			0		0
Impairments and reversals			0		0
Movements in other reserves				0	0
Transfers between reserves		13,857	(13,857)	0	0
Release of reserves to SOCI			0		0
Transfers to/(from) other bodies within the resource account boundary	0	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets			0		0
Reserves eliminated on dissolution	0	0	0	0	0
Originating capital for trust established in year	0				0
New PDC received	0				0
PDC repaid in year	0				0
PDC written off	0				0
Transferred to NHS Foundation Trust	0	0	0	0	0
Other movements in PDC in year	0				0
Net actuarial gain/(Loss) on pension	0			0	0
Net recognised revenue/(expense) for the year	0	19,585	(13,857)	0	5,728
Balance at 31st March 2012	131,475	16,360	88,656	1,150	237,641

There were no transfers from the revaluation reserve to retained earnings in respect of impairments.

The trust's other reserves relates to taxpayer's equity recognised retrospective for land that was excluded on the trust's inception.

	Public dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
	£000	£000	£000	£000	£000
Changes in taxpayers' equity for 2010/11					
Balance at 1st April 2010	131,475	(15,836)	109,225	1,150	226,014
Retained surplus/(deficit) for the year		5,889			5,889
Net gain / (loss) on revaluation of property, plant, equipment			0		0
Net gain / (loss) on revaluation of intangible assets			0		0
Net gain / (loss) on revaluation of financial assets			0		0
Net gain / (loss) on revaluation of assets held for sale					0
Impairments and reversals			0		0
Movements in other reserves				0	0
Transfers between reserves		6,722	(6,712)	0	10
Reclassification adjustment on disposal of available for sale financial assets			0		0
Reserves eliminated on dissolution		0	0	0	0
Originating capital for trust established in year	0				0
New PDC received	0				0
PDC repaid in year	0				0
PDC written off	0				0
Transferred to NHS Foundation Trust	0	0	0	0	0
Other movements in PDC in year	0				0
Net actuarial gain/(loss) on pension		0		0	0
Net recognised revenue/(expense) for the year	0	12,611	(6,712)	0	5,899
Balance at 31st March 2011	131,475	(3,225)	102,513	1,150	231,913

Statement of cash flowsFor the year ended 31st March 2012

	2011/12 £000	2010/11 £000
Cash Flows from operating activities		
Operating surplus/deficit	11,434	12,072
Depreciation and amortisation	18,698	18,363
Interest paid	(3,780)	(4,732)
Dividend paid	(7,128)	(7,178)
(Increase)/decrease in inventories	(407)	(374)
(Increase)/decrease in trade and other receivables	1,025	(10,855)
(Increase)/decrease in other current assets	0	0
Increase/(decrease) in trade and other payables	5,299	9,287
(Increase)/decrease in other current liabilities	0	0
Provisions utilised	(178)	(154)
Increase/(decrease) in provisions	413	141
Net cash inflow/(outflow) from operating activities	25,376	16,570
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest received	86	151
(Payments) for property, plant and equipment	(23,256)	(14,716)
(Payments) for intangible assets	(424)	(1,906)
Proceeds of disposal of assets held for sale (PPE)	15,750	13,302
Proceeds of disposal of assets held for sale (Intangible)	0	0
Proceeds from disposal of investment with DH	0	0
Proceeds from disposal of other financial assets	0	0
Proceeds from the disposal of financial assets (LIFT)	0	0
Rental revenue	0	0
Net cash inflow/(outflow) from investing activities	(7,844)	(3,169)
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	17,532	13,401
CASH FLOWS FROM FINANCING ACTIVITIES		
Public dividend capital received	0	0
Public dividend capital repaid	0	0
Loans received from DH - new capital investment loans	0	0
Loans received from DH - new working capital loans	0	0
Other loans received	1,551	0
Loans repaid to DH - capital investment loans repayment of principal	0	0
Loans repaid to DH - working capital loans repayment of principal	(7,990)	(7,994)
Other loans repaid	(194)	0
Cash transferred to NHS Foundation Trusts	0	0
Capital element of payments in respect of finance leases and on-SoFP PFI	(2,269)	(1,668)
Capital grants and other capital receipts	762	641
Net cash inflow/(outflow) from financing activities	(8,140)	(9,021)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	9,392	4,380
Cash and cash equivalents (and bank overdraft) at beginning of the period	20,524	16,144
Effect of exchange rate changes in the balance of cash held in foreign currencies	0	0
Cash and cash equivalents (and bank overdraft) at year end	29,916	20,524

Notes to the accounts

For the year ended 31st March 2012

Revenue from patient care activities	2011/12	2010/11
	£000	£000
Strategic Health Authorities	1,073	119
NHS trusts	1,731	1,120
Primary Care Trusts - tariff	468,982	466,010
Primary Care Trusts - non-tariff	10,201	7,934
Primary Care Trusts - market forces factor	46,332	44,606
Foundation Trusts	1,876	2,122
Local Authorities	444	0
Department of Health	3	311
NHS other	323	0
Non-NHS:		
Private patients	4,259	3,216
Overseas patients (non-reciprocal)	1,497	1,008
Injury costs recovery	3,813	2,536
Other	2,805	109
Total patient care revenue	543,339	529,091

Other operating revenue

Recoveries in respect of employee benefits	6,740	5,831
Patient transport services	98	1
Education, training and research	51,946	53,232
Charitable and other contributions to expenditure	236	726
Receipt of donations for capital acquisitions	2,595	1,186
Receipt of government grants for capital acquisitions	51	1,146
Non-patient care services to other bodies	11,864	12,841
Income generation	2,308	2,859
Rental revenue from finance leases	0	0
Rental revenue from operating leases	110	264
Other revenue	1,124	3,770
Sub-total	77,072	81,856
Total operating revenue	620,411	610,947

Revenue	2011-12	2010-11
	£000	£000
From rendering of services	618,915	609,458
From sale of goods	1,496	1,489

Operating expenses (excluding employee benefits)	2011/12	2010/11
	£000	£000
		(restated)
Services from other NHS trusts	6,566	5,771
Services from PCTs	288	1,736
Services from other NHS bodies	136	9,608
Services from Foundation Trusts	1,052	635
Purchase of healthcare from non NHS bodies	3,729	3,097
Trust chair and non executive directors	70	67
Supplies and services - clinical	111,035	103,764
Supplies and services - general	14,596	10,688
Consultancy services	2,788	2,177
Establishment	5,254	4,603
Transport	5,348	4,136
Premises	35,491	27,888
Impairments and reversals of receivables	1,475	(227)
Inventories write down	3	5
Depreciation	17,835	17,549
Amortisation	863	814
Impairments and reversals of property, plant and equipment	0	0
Impairments and reversals of intangible assets	0	0
Impairments and reversals of financial assets [by class]	0	0
Impairments and reversals of non current assets held for sale	0	0
Impairments and reversals of investment properties	0	0
Audit fees	262	272
Other auditor's remuneration (including internal audit and VAT advisors)	297	345
Clinical negligence	8,147	7,034
Research and development (excluding staff costs)	281	363
Education and training	1,510	1,295
Other	2,234	11,173
	219,260	212,793
Employee benefits		
Employee benefits excluding Board members	388,825	385,259
Board members	892	823
Sub-total - employee benefits	389,717	386,082
Total operating expenses	608,977	598,875

Staff Sickness absence and ill health retirements	2011/12	2010/11
	Number	Number
Total days lost	59,039	50,155
Total staff years	7,260	6,145
Average working days lost	8	8
Number of persons retired early on ill health grounds	10	4

Better Payments Practice Code compliance	2011/12	2011/12	2010/11	2010/11
	Number	£000	Number	£000
Non-NHS payables				
Total non-NHS trade invoices paid in the year	113,794	207,469	130,047	216,122
Total non-NHS trade invoices paid within target	58,004	123,030	83,395	140,638
Percentage of NHS trade invoices paid within target	50.97%	59.30%	64.13%	65.07%
NHS payables				
Total NHS trade invoices paid in the year	4,736	51,867	4,382	59,573
Total NHS trade invoices paid within target	1,447	20,299	1,490	35,949
Percentage of NHS trade invoices paid within target	30.55%	39.14%	34.00%	60.34%

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

The above figure shows the number of invoices paid by the due date, unadjusted for delays in receipt of a valid invoices or resolved.

In 2011/12 the trust implemented a new invoice manager system for its direct supplier invoices. As a result of this implementation the trust has improved its payment processes and an action plan has been developed to increase the proportion of invoices paid within 30 days in 2012/13.

Salary and pension entitlements of senior managers

A) Remuneration

Name and title	2011/12				2010/11		
	Salary (bands of £5,000) £000	Other Remuneration (bands of £5,000) £000	Performance related bonuses (bands of £5,000) £000	Benefits in Kind Rounded to the nearest £100	Salary (bands of £5,000) £000	Other Remuneration (bands of £5,000) £000	Benefits in Kind Rounded to the nearest £100
Executive directors							
Mr David Astley , chief executive (to May 2011)	15-20			0	180-185		0
Mr Peter Coles , interim chief executive (from June to December 2011)	85-90			0			
Mr Miles Scott , chief executive (from November 2011)	85-90			5,400			
Mr Richard Eley , director of finance (to April 2012)	140-145			0	140-145		0
Mrs Alison Robertson , chief nurse and director of operations	120-125			0	120-125		0
Mr Michael Bailey , medical director (to June 2011)	5-10	15-20		0	20-25	60-65	0
Dr Rosalind Given-Wilson , medical director	20-25	115-120	45-50	0	20-25	140-145	0
Mrs Sally Storey , interim director of human resources (to December 2010)					60-65		0
Mrs Annette Gately , interim director of human resources (to April 2011)	5-10			0	15-20		0
Ms Jacqueline McCullough , interim director of human resources (April 2011 to January 2012)	80-85			0			
Ms Wendy Gay , Director of human resources and organisational development (from February 2012)	5-10			0			
Mr Alan Thorne , director of transformation (to November 2010)					65-70		0
Dr Trudi Kemp , director of strategic development	95-100		5-10	0	105-110		0
Mr Neal Deans , director of estates and facilities	100-105			0	100-105		0
Mr Jean-Pierre Moser , director of communications (to September 2012)	90-95			0	90-95		0
Mr Patrick Mitchell , chief operating officer (to March 2012)	130-135			0	130-135		0
Mr Peter Jenkinson , trust secretary/director of corporate affairs	90-95			0	90-95		0

Name and title	2011/12				2010/11		
	Salary (bands of £5,000) £000	Other Remuneration (bands of £5,000) £000	Performance related bonuses (bands of £5,000) £000	Benefits in Kind Rounded to the nearest £100	Salary (bands of £5,000) £000	Other Remuneration (bands of £5,000) £000	Benefits in Kind Rounded to the nearest £100
Non-executive directors							
Ms Naaz Coker , chair (to October 2011)	10-15			0	20-25		0
Mr Christopher Smallwood , chairman (from November 2011)	5-10			0			
Ms Emma Gilthorpe , deputy chair (to July 2012)	5-10			0	5-10		0
Dr Graham Hibbert , non-executive director	5-10			0	5-10		0
Mr Paul Murphy , non-executive director	5-10			0	5-10		0
Professor Sean Hilton , non-executive director (to July 2011)	1-5			0	5-10		0
Mr Michael Rappolt , non-executive director	5-10			0	5-10		0
Moirá Nangle , associate non-executive director (to October 2011)	1-5			0	5-10		0
Ms Sarah Wilton , associate non-executive director	5-10			0	0-5		0
Dr Peter Kopelman , non-executive director	5-10						

Signed:
Chief executive

Date:

Signed:

Date:

Director of finance

Notes **1.** The performance-related bonuses are both Clinical Excellence Awards paid to medical consultants. They are separated for 2011/12 but not for 2010/11. **2.** Wendy Gay is the joint director of human resources and organisational development for the trust and St George's, University of London. Our figure excludes the amount that we recharge to them. **3.** In 2011/12 a contractual payment for loss of office was made to senior manager of £91,946.52.

B) Pension benefits

Name and title	Real increase in pension and related lump sum at age 60	Lump sum at aged 60 related to real increase in pension	Total accrued pension and related lump sum at 31st March 2012	Cash Equivalent Transfer Value at 31st March 2012	Cash Equivalent Transfer Value at 31st March 2011	Real Increase in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension
	(bands of £2,500) £000	(bands of £2,500) £000	(bands of £5,000) £000	£000	£000	£000	To nearest £100
Mr David Astley , chief executive (to May 2011)	-5 to -2.5	2.5-5	340-345	1,930	1,837	22	0
Mr Peter Coles , interim chief executive (from June to December 2011)	0 to 2.5	0-2.5	0-5	0	0	0	0
Mr Miles Scott , chief executive (from November 2011)	7.5 to 10	12.5-15	230-235	917	720	72	0
Mr Richard Eley , director of finance (to April 2012)	0 to 2.5	17.5-20	185-190	968	865	76	0
Mrs Alison Robertson , chief nurse and director of operations	2.5 to 5	5-7.5	185-190	768	640	108	0
Mr Michael Bailey , medical director (to June 2011)	-2.5 to 0	0-2.5	265-270	0	0	0	0
Dr Rosalind Given-Wilson , medical director	30 to 32.5	27.5-30	315-320	1,667	1,390	234	0
Mrs Annette Gately , interim director of human resources (to April 2011)	0 to 2.5	5-7.5	50-55	320	252	60	0

Pension benefits continued

Name and title	Real increase in pension and related lump sum at age 60	Lump sum at aged 60 related to real increase in pension	Total accrued pension and related lump sum at 31st March 2012	Cash Equivalent Transfer Value at 31st March 2012	Cash Equivalent Transfer Value at 31st March 2011	Real Increase in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension
	(bands of £2,500) £000	(bands of £2,500) £000	(bands of £5,000) £000	£000	£000	£000	To nearest £100
Ms Jacqueline McCullough , interim director of human resources (April 2011 to Jan 2012)	-5 to -2.5	-2.5-0	85-90	367	329	23	0
Ms Wendy Gay , director of human resources and organisational development (from February 2012)	0 to 2.5	5-7.5	105-110	490	409	11	0
Dr Trudi Kemp , director of strategic development	-10 to -7.5	2.5-5	115-120	499	425	61	0
Mr Neal Deans , director of estates and facilities	0 to 2.5	2.5-5	125-130	651	592	41	0
Mr Jean-Pierre Moser , director of communications (to Sep 2012)	2.5 to 5	2.5-5	30-35	121	89	29	0
Mr Patrick Mitchell , chief operating officer (to March 2012)	0 to 2.5	2.5-5	170-175	740	625	96	0
Mr Peter Jenkinson , trust secretary/director of corporate affairs	2.5 to 5	2.5-5	50-55	191	142	45	0

As Non-Executive members do not receive pensionable remuneration, there are 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 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.

The Chancellor has changed the measure of inflation used to calculate public sector pensions. The CETV for this year has been calculated on the new basis, but last year's figure remains on the old basis. The CETV is lower than it would have been if the previous basis had been maintained.



Miles Scott
Chief executive



Bill Boa
Interim director of finance

Remuneration Relationship

Reporting bodies are 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 banded remuneration of the highest paid director in the organisation in the financial year 2011/12 was £235,231 (2010/11: £202,820). This was 7.58 times (2010/11: 6.54 times) the median remuneration of the workforce, which was £31,015.

In 2011/12, six employees (2010/11: eight) received remuneration in excess of the highest paid director. Remuneration ranged from £236,424 to £448,704 (2010/11: £217,078 to £294,243).

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

Independent auditor's report

I have examined the summary financial statement for the year ended 31 March 2012 which comprises Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers' Equity, Statement of Cash Flows, Remuneration Report, Revenue from patient care activities note, Other operating revenue note, Operating expenses note, Staff sickness absence and ill health retirements note, Better Payments Practice Code note and Remuneration Report.

This report is made solely to the Board of Directors of St George's Healthcare NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010.

Respective responsibilities of directors and auditor

The directors are responsible for preparing the Annual Report.

My responsibility is to report to you my opinion on the consistency of the summary financial statement within the Annual Report with the statutory financial statements.

I also read the other information contained in the Annual Report and consider the implications for my report if I become aware of any misstatements or material

inconsistencies with the summary financial statement.

I conducted my work in accordance with Bulletin 2008/03 "The auditor's statement on the summary financial statement in the United Kingdom" issued by the Auditing Practices Board. My report on the statutory financial statements describes the basis of my opinion on those financial statements.

Opinion

In my opinion the summary financial statement is consistent with the statutory financial statements of St George's Healthcare NHS Trust for the year ended 31 March 2012. I have not considered the effects of any events between the date on which I signed my report on the statutory financial statements (8 June 2012) and the date of this statement.

Andy Mack
District Auditor
Audit Commission
1st Floor, Millbank Tower
Millbank
London
SW1P 4HQ

28 August 2012

Contact us

Support from us

Our PALS team offers support, information and assistance to patients, relatives and visitors. The PALS office at St George's Hospital is open 9am to 5pm, Monday to Friday.

020 8725 2453

pals@stgeorges.nhs.uk

Work for us

If you are interested in working for St George's Healthcare visit our website www.stgeorges.nhs.uk or get in touch with our recruitment services team.

020 8725 0600

hrrecruitment@stgeorges.nhs.uk

Become a member

We need our patients, local community and members of staff to become members of the trust to help us to ensure we meet the needs of our patients and local communities.

By becoming a member you will be in a position to help make decisions that will impact on the development of the trust's services. Members will also be entitled to elect and stand for election to the council of governors, and help to shape the long-term future of the trust.

If you would like to sign up or find out more about being a member contact the membership team.

020 8266 6133

members@stgeorges.nhs.uk

Giving to George's

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

020 8725 4916

giving@stgeorges.nhs.uk

www.givingtogeorges.org.uk

Volunteer

Our volunteers perform roles as varied as manning information desks, general housekeeping, administrative work and helping patients find their way around. If you would like to volunteer at any St George's Healthcare sites contact the voluntary services team.

020 8725 1452

susan.taleghany@stgeorges.nhs.uk

Request a summary or printed report

Contact the communications team if you would like a copy of the summary annual report, or a print out of the full annual report.

020 8725 5151

communications@stgeorges.nhs.uk

Let us know what you think

Please let us know what you think about this annual report so you can help us improve the information included in next year's report. You can complete the survey online or get in touch with the communications team.

020 8725 5151

communications@stgeorges.nhs.uk

Annual report survey

Please take a few moments to let us know what you think about the annual report to you can help us improve next year's report. You can send your response or write to the communications team at communications@stgeorges.nhs.uk or **Room 1.037 Grosvenor Wing, St George's Hospital, SW17 0QT**

How would you rate the annual report on a scale of 1 to 5 (1 being poor, 5 being excellent)?

1 – poor	2	3	4	5 – excellent

How would you rate each section of the annual report on a scale of 1 to 5?

	1 – poor	2	3	4	5 - excellent
Foreword and introduction					
About St George's Healthcare					
A brief history					
2011/12 review					
Living our values					
Working at St George's Healthcare					
Our Board					
Our community					
Giving to George's					
Annual governance statement					
Our performance					
Quality account					
Financial report					

How would you rate the summary annual report on a scale of 1 to 5?

1 – poor	2	3	4	5 – excellent
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What would you like to read more about in future annual reports?

.....
.....
.....

Do you have any other comments on the annual report and/or summary annual report?

.....
.....
.....

Please let us know which of these groups you fit into (you can select more than one option)

- | | |
|---|---|
| <input type="radio"/> St George’s Healthcare staff | <input type="radio"/> Local authority staff or councillor |
| <input type="radio"/> GP | <input type="radio"/> LINK member |
| <input type="radio"/> Other NHS staff | <input type="radio"/> Member of the public |
| <input type="radio"/> St George’s Healthcare member | <input type="radio"/> Other (please specify) |

.....

How did you find out about the annual report? You can select more than one option

- | | |
|--|-------------------------------------|
| <input type="radio"/> Email | <input type="radio"/> The Gazette |
| <input type="radio"/> Facebook | <input type="radio"/> Twitter |
| <input type="radio"/> St George’s Healthcare website | <input type="radio"/> Other website |
| <input type="radio"/> Newspaper | <input type="radio"/> Poster |
| <input type="radio"/> Somebody told me | <input type="radio"/> Other |

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