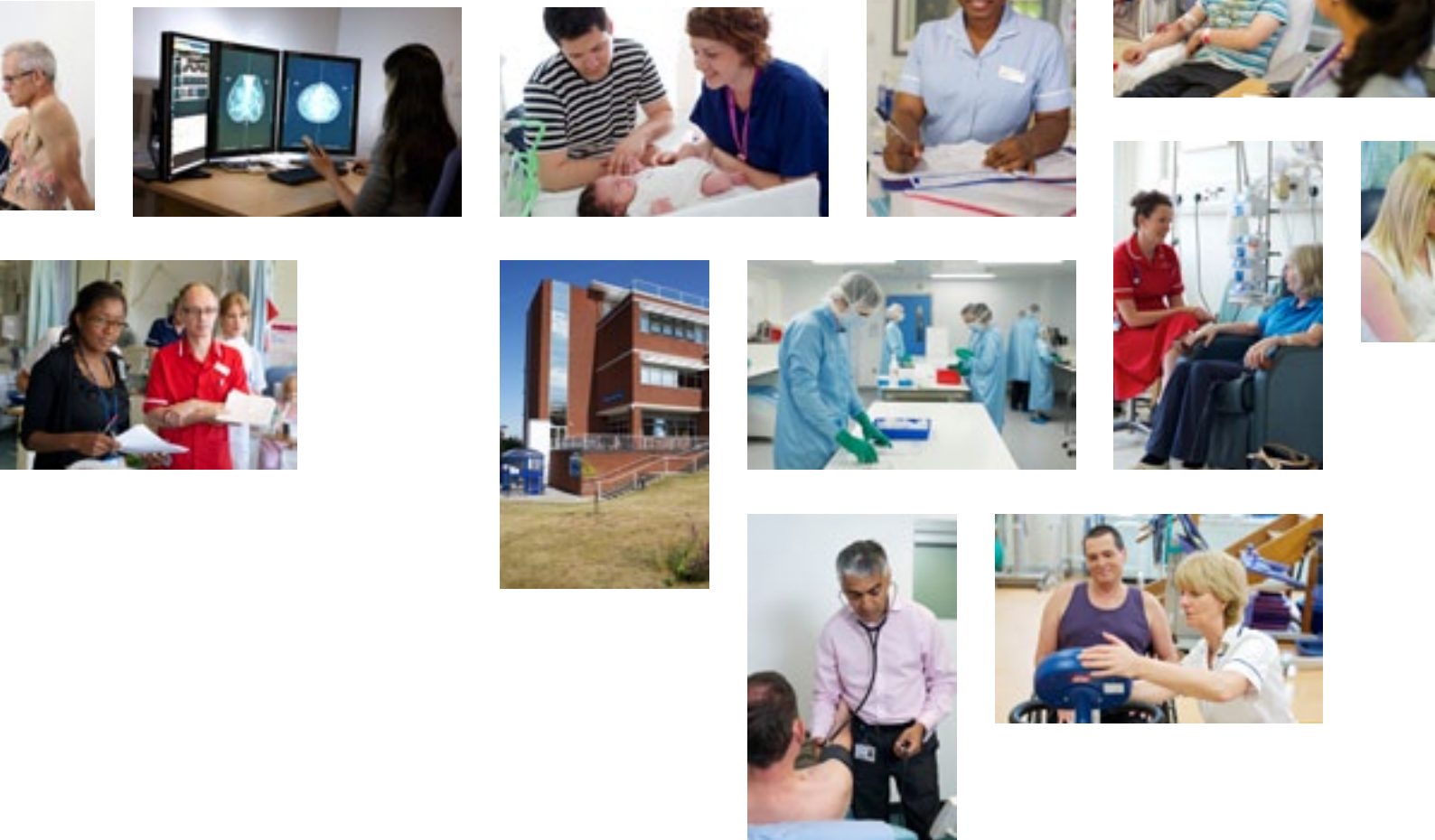


# St George's Healthcare NHS Trust

## 2012/13 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 2012/13.

Since joining St George's as chairman in 2011 I have visited wards and departments throughout the trust, and have always left each area with a sense of pride that staff give their absolute best in embodying our values and ensuring that patients receive the best care possible.

The past year has seen many successes, and I know this is in huge part down to the commitment and strong work ethic that staff have shown across all units and departments.

During the year we continued our proud tradition of providing excellent patient care. The Dr Foster Hospital Guide has once again identified St George's as one of only a handful of trusts to have statistically significant low mortality rates. This is a key marker of quality and safety which has helped to cement our status as one of the country's leading healthcare institutions. It is also a testament to the dedication of our skilled clinical teams, and the trust's commitment to research and innovation.

Across the trust, teams and services have celebrated success this year. From our cardiology and cancer teams through to services in the community, many teams have been recognised on a regional, and some on a national level.

Furthermore, the strength and expertise of our clinicians has been evident in the roles to which some of our staff have been appointed. Two of our cancer clinicians have been appointed pathway chairs in the London Cancer Alliance. One of our consultant anaesthetists has become the president of the Royal College of Anaesthetists, whilst an allied health professional has become part of a national clinical expert database, which will provide expert guidance to national healthcare policies.



During 2012/13 we returned a £6.28 million surplus, which is a significant achievement in the prevailing economic climate. The trust's prudence in financial terms over the last few years has allowed us to invest and provide improvements to our frontline services.

During the year we have seen official openings of our pre-operative care centre (POCC) and paediatric intensive care unit (PICU), and are also seeing the benefits of our emergency department and acute

medicine unit (AMU) which were fully refurbished and modernised last year. These are significant services for the significant populations of south west London and south east England, and we must continue to strive for the best for our patients and for our staff, ensuring the services we offer are of the highest and safest quality.

The year ahead will bring change, not only for St George's but for the NHS as a whole. We are now working in a much-changed environment. The trust will now work with local clinical commissioning groups (CCGs), Commissioning Support Units (CSUs) and the wider NHS England to help us provide a real difference to those we serve.

The trust will also have the extra target of becoming a Foundation Trust (FT) in the next year. I strongly believe that becoming an FT is crucial to the long-term future of the organisation, and will result in real benefits for patients, staff and our community. The strides forward we have made this year will hold us in good stead for the challenges that lie ahead. I have every confidence that St George's Healthcare can rise to that challenge.

A handwritten signature in blue ink that reads "C Smallwood". The signature is written in a cursive, slightly slanted style.

**Christopher Smallwood**  
chairman

## Introduction from Miles Scott chief executive

St George's is on the brink of a future that will strengthen our position as one of the country's leading NHS organisations. Over the last year we have continued to deliver safe, outstanding services for our patients. This has given us the perfect platform to begin implementing our recently agreed ten year strategy which will place quality healthcare at the heart of our work.



The strategy sets out our goals for the next decade, and outlines our vision for delivering outstanding healthcare of exceptional quality, underpinned by leading edge research and teaching, always ensuring we uphold the highest standards.

This coming year we expect to become a Foundation Trust (FT). This will bring new opportunities for us to really connect with patients, staff and local people, and will enable us to develop our services and facilities as set out in our strategy. The discipline and external scrutiny in preparation for becoming an FT means that local people can have even greater confidence in St George's as an organisation.

One of our major projects over the next year which fits into our strategy is the St George's Hospital helipad, a crucial addition that will allow patients with major trauma injuries from as far as the south of England faster access to life-saving care. Longer-term, we will continue developing plans for a children's and women's hospital at St George's, providing an environment that matches the clinical excellence of our staff.

Reconfiguring our services can also improve quality of care. Clinical services and patients can benefit from change, and local healthcare reviews such as Better Services, Better Value will undoubtedly have an impact. We are committed to working with local trusts to ensure the most sustainable configuration of hospital and specialist services in the region. Previous reviews of stroke,

major trauma and neurorehabilitation services have successfully improved patient care. We will ensure this achieves the same ends, and that the level of care continues to be nothing short of excellent.

Some of our objectives are 'behind the scenes' changes, and may not be instantly obvious. We must invest in the facilities, systems and processes our staff use for patients to have a better experience. We will look to make significant investment

in our IT systems in order to provide the consistent service our staff and patients deserve.

Our staff initiatives have also been a success, and I was pleased to launch the Listening into Action programme, putting staff at the centre of change. Initiatives like these are essential in telling us where improvement is required from staff on the front line. Our workforce are best placed to point out where we can improve.

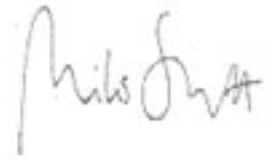
As well as 'fine tuning' the work environment, we want to develop a highly skilled and motivated workforce. Our strategy continues to invest in staff, making certain they are well placed to provide excellent care which embodies our values.

We will also consolidate our work with other education providers across south London, including our relationship with St George's, University of London (SGUL) to provide superb education and ensure the skilled doctors of tomorrow are trained here today.

Research will become a core part of our business. We will take the lead in improving patient safety, experience and outcomes through research. We are an active member of the South London Health and Innovation Cluster, as well as the South West London Academic Health Science Network (AHSN). We will promote innovation and best practice, improving health outcomes and strengthening St George's reputation as a research leader.

Finally, it is important that whilst looking forward to the future, we must not become complacent now. The patient experience must match the excellence of our clinical outcomes. We can best respect the experiences of patients who have been failed by the NHS, including at St George's, by rooting out poor care where we find it and by always putting patients first.

I believe our strategy encompasses all that St George's can become in the next ten years. We have the tools to build on our position as a leading healthcare provider whilst continuing to uphold the highest standards. By planning well for the years ahead, I know we will be at the forefront of healthcare now and in the future.

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

**Miles Scott**  
**chief executive**

## Introduction from Alison Robertson chief nurse and director of operations

St George's has many positives to take from the last year, as well as areas to further develop and make progress.

Patient experience is one area where we have continued to improve. For example, the CQC's inpatient survey rated us 'about the same' as most other trusts in the country. However, specifically there were six areas where the trust improved significantly when compared to our results last year, relating to cleanliness, food choices and the level of involvement patients felt they had in their care. We have made good progress in three years with this survey, but we must use the opportunity to focus on how we can continue to improve.

Being responsive to feedback from our patients is fundamental in helping us identify where we need to do better. This has been recognised in a report naming us as one of just six trusts to respond effectively to online feedback through websites such as NHS Choices and Patient Opinion. Indeed, this year the trust has seen a 20 per cent reduction in formal complaints received. We value all comments from our patients, whether positive or critical, as it allows us to identify trends and patterns where we can take appropriate action to improve.

There have been areas where our performance should have been better. Last year more patients acquired an MRSA bloodstream infection than we find acceptable. Similarly, although our figures for Clostridium difficile (C.diff) infections saw a 28 per cent reduction in comparison with last year,



they have been at a level which is not satisfactory either for staff or our patients. It is essential to keep patients at St George's safe, and we will strengthen our focus on infection control to raise our performance and provide the best care possible.

We need to be proactive in identifying areas where we can become safer, better and smarter in our work practices; these are the main principles of our trust-wide service

improvement programme, which we have established over the last year.

Through the programme we can ensure we deliver high quality patient-centred services by equipping staff with the confidence to identify changes in their areas and give them the support they need to put those changes into action. Improving the efficiency of our services has a positive impact on the experiences of our patients.

Our corporate strategy commits us to deliver beyond our goals over the next ten years by having operational systems that are efficient and effective. By transforming our systems and environment to develop knowledge and experience, we can establish a culture of improvement throughout the organisation which we can sustain and encourage in the long term.

A handwritten signature in black ink, appearing to read 'Alison Robertson'.

**Alison Robertson**  
chief nurse and director of operations



## Introduction from Ros Given-Wilson medical director

This has undoubtedly been an extremely busy year for St George's; for example, over 147,000 patients were seen in our emergency department. Despite this rise, staff have maintained a safe environment for patients with excellent outcomes. Our consistently low mortality rates in the Dr Foster report demonstrates that we are safe, and patients can take great comfort in this.



Our successes are proven through our performance in independent reports. We monitor patient outcomes in the organisation against a number of local and national audits and reports, and have demonstrated major achievements, such as in the work of our heart attack and stroke teams. Over the next year I hope we can continue to consolidate and build on our performances across all departments.

We are absolutely committed to promoting and supporting the personal and professional development of our staff, students and trainees. We provide a range of multiprofessional training – in the last financial year nearly 25,000 hours of training was provided for members of staff, aimed at ensuring our workforce was both caring and competent.

We also regularly fund external training courses for our staff to attend short courses, conferences and degrees, and in 2012/13 over 3,200 applications were made. When taken with our extensive range of internal programmes such as skills training equality and diversity, medicines management and managerial leadership, we have a truly comprehensive set of tools available for staff to use for development and career progression.

Looking ahead, I am also excited that we will be placing an emphasis on research in the coming years. Our newly-developed strategy makes provision for committing to research, which is vital if we are to maintain our high-performing position. We look forward to the prospect of nurturing a closer relationship with our research partners, which will lead to better healthcare for all.

A handwritten signature in blue ink that reads "Ros Given-Wilson".

**Ros Given-Wilson**  
medical director

## About us

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

We also provide care for patients from a larger catchment area in south east 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 Stroke Network and the South West London and Surrey Trauma Network, for which St George's Hospital is the designated heart attack centre, hyper-acute stroke unit and major trauma centre.

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.

For more information on our services, see [page 86](#) in the quality account section of this report.

## Becoming a Foundation Trust

For St George's, becoming a Foundation Trust (FT) is an essential and significant milestone for the organisation, which we aim to achieve in 2014. FTs are different from existing NHS Trusts as they are more financially flexible, are free from central government control and have different governance arrangements.

We launched our public consultation on proposals for becoming a Foundation Trust on Monday 1st February 2013, running until Friday 26th April 2013.

We contacted more than 10,000 people by post, email, online and face-to-face on trust premises, as well as at 35 internal and external meetings.

More than 500 individuals and 23 organisations responded formally, either in writing or by completing our consultation questionnaire. The questionnaire contained seven questions on the specifics of our proposals, all of which received the support of more than two-thirds of respondents.

As a result of the responses we received, we made two substantial changes to our proposals:

- *We will reallocate the number of Governors from each constituency roughly in proportion with trust income from each area.*
  - *This measure will increase the number of Wandsworth-based Governors from four to six and reduce the number elected from the regional or 'rest of England' constituency from six to four, keeping the total number of public Governors at 15.*
  - *Merton and Lambeth will elect the same number as originally proposed, four and one respectively.*
- *We will also increase the number of staff governors from four to five, adding a new constituency representing those working in community services.*

In preparing for our application for FT status, we have also been building on our public membership numbers. Recruitment staff have been talking to patients, visitors and other members of the public about the opportunity to become a member of the trust.

We have set ourselves a target to reach a total membership of 11,000 members during 2013, which we believe will give us a good representation of the communities served by the trust. Developing this membership will increase the trust's accountability to patients, staff and the public, which will result in real benefits for all of our stakeholders.

This year, we will begin work to establish a Council of Governors in preparation for our expected authorisation as an FT in 2014.

## A brief history

<b>1733</b>	The original St George's Hospital opens at Lanesborough House, now the Lanesborough Hotel, on Hyde Park Corner
<b>1868</b>	St George's Hospital Medical School established at the hospital
<b>1869</b>	The Atkinson Morley Hospital opens in Wimbledon
<b>1948</b>	The National Health Service is established
<b>1954</b>	The Grove Fever Hospital and Fountain Hospital in Tooting become part of the St George's Group
<b>1973</b>	Building of the new St George's Hospital in Tooting begins on the Grove Fever Hospital site
<b>1976</b>	St George's Hospital Medical School moves to the new Tooting site and hospital services begin to transfer from Hyde Park Corner
<b>1980</b>	St George's at Hyde Park Corner formally closes in June, with Her Majesty the Queen officially opening the Tooting site in November
<b>1984</b>	Jenner Wing opens
<b>1988</b>	St James Wing opens following closure of the St James Hospital in Balham
<b>1993</b>	St George's Group becomes St George's Healthcare NHS Trust
<b>2003</b>	Atkinson Morley Hospital in Wimbledon closes, with services moving into the new Atkinson Morley Wing at St George's Hospital
<b>2009</b>	St George's Healthcare named as large trust of the year by Dr Foster, and the Grosvenor Wing refurbishment is completed
<b>2010</b>	St George's Healthcare becomes one of four major trauma centres and one of eight hyper-acute stroke units for London 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.
<b>2012</b>	The Wolfson Neurorehabilitation Centre in Wimbledon closes, with services moving to St George's Hospital and Queen Mary's Hospital
<b>2013</b>	Redeveloped emergency department opens at St George's Hospital, and work starts on new helipad above St James Wing

## 2012/13 in review

# Children's and Women's, Diagnostics, Therapies and Critical Care division

### Introduction from Val Thomas, divisional chair

The last year has been exciting and very positive for the division. We have made significant progress in raising the profile of our services and also improving the quality of care we provide to our diverse range of patients.

Our success has been evident through independent reports about our services such as in maternity, demonstrating a real marker of quality and safety for newborns and their mothers. There are challenges ahead for the next year including re-organisation of pathology services across South West London, a process in which we are playing a leading role.

Critical care provision is also being expanded in response to increased numbers of seriously ill patients being treated at St George's to ensure appropriate levels of access.

Looking further ahead, the trust is prioritising the redevelopment of children's and women's services with a major investment for inpatient and outpatient accommodation. This will allow us to deliver an environment which complements the high quality clinical services and reflects the expectations of patients and their families.

We are giving our patients confidence that the service they should expect from us is nothing short of excellent, and I look forward to another exciting year ahead.

Highlights of the year from the children's and women's, diagnostics, therapies and critical care division include:

### Royal visit for paediatric intensive care unit



The paediatric intensive care unit (PICU) at St George's Hospital was officially opened by HRH Princess Alexandra in September.

The refurbishment was generously funded by the Giauque family, who live locally, and includes a dedicated parents' area which enables families to rest while their children are on the unit. The Princess met families, staff and former patients during her tour of the unit.

### Maternity services receive high praise from mother

Emily Holyfield has nothing but praise for St George's maternity unit after having her baby, Giorgio, at the hospital in July 2012.

Emily and her partner live in West Sussex with their six year old daughter Eva. When she fell pregnant, she was referred to St George's fetal medicine unit at 16 weeks after having a high risk blood test result, to rule out any chromosome disorders.

Giorgio was diagnosed with a Congenital Diaphragmatic Hernia, where a malformation allows the organs to push into the lung area preventing the lung from developing properly. This can be life-threatening, and has a 50% survival rate for babies diagnosed with this condition in the womb.

Emily said:

“The team who treated me were exceptional. I was treated with the utmost sensitivity, but also given clear information regarding the condition and the options that were available to me. The staff were so professional and sensitive in their handling of this news.”

Emily and her partner met with key staff so they could ask questions about the next stages if they were to continue with the pregnancy and come to a decision based on their expertise. Emily said: “After a lot of research, conversations with my family and a huge amount of consideration we decided to continue with the pregnancy.

After Giorgio was born, he spent three days on the neonatal unit before undergoing surgery for his condition. The surgery went well and Giorgio spent a week recovering on the neonatal unit and a week on the special care baby unit.

Emily said:

“All the staff on the neonatal unit and the special care baby unit were outstanding.”

She started breastfeeding Giorgio after 17 days, who had until then been fed by a nasogastric tube. Giorgio was discharged after 17 days and is still under the care of the trust’s neonatal team.

## ITV Daybreak pay Christmas visit to neonatal unit

ITV breakfast show Daybreak made St George’s neonatal unit the centre of the nation’s attention at Christmas with a live feature about families and staff who were spending the festive season on the unit.

The neonatal unit cares for nearly 600 newborn babies each year, with up to 39 babies on the unit at any one time. It provides care for newborn babies from across south east England requiring specialist treatment, including premature and low-birth weight babies and those needing surgery.

Host Gethin Jones said:

“It was an absolute privilege to meet the amazing staff, families, and of course the incredibly brave children on the neonatal unit at St George’s Hospital.

“The work they do here is so important – life-changing in fact. I’m really pleased we were able to give the unit the recognition it deserves by reporting on it.”



## A successful year for maternity services

Significant improvements to both patient safety and the quality of service over the last 12 months have helped to make sure that mothers and babies get the attention they need before and during labour and after they have given birth.

Some achievements of the past year for maternity services include the following:

- *Our maternity unit has maintained the lowest caesarean section rate in London. Women are also less likely to have a caesarean at St George’s Hospital than any other hospital in London.*
- *We have one of the lowest emergency caesarean section rates for failed vaginal births in London, demonstrating excellent clinical management of the second stage of labour.*
- *Our rate of emergency caesarean sections for failed instrumental deliveries is amongst the lowest in the UK.*

- *We have one of the lowest hypoxic ischaemic encephalopathy (HIE) rates in the UK. HIE is a condition that occurs when the baby's brain is starved of oxygen.*
- *The unit has achieved green ratings (the highest performance level) for the following clinical outcomes indicators:*
  - *third degree perineal tears*
  - *readmissions after caesarean sections*
  - *unexpected admissions to the neonatal unit*
  - *unexpected admissions to intensive care*
  - *full-term and pre-term stillbirths*
  - *early neonatal deaths*
  - *meconium aspiration syndrome (when a baby breathes a mixture of meconium and amniotic fluid into the lungs during delivery).*



## Minimising patient harm through effective risk management

Our maternity unit has become only the second in London to achieve level three status in the NHS Litigation Authority (NHSLA) Clinical Negligence Scheme for Trusts (CNST). This demonstrates that we are practicing effective risk management to minimise harm to patients. This is a fantastic achievement and recognition of the excellent standards of care on the unit.

To achieve level 3 status, our maternity unit was assessed by the NHSLA against five standards applying to antenatal, intrapartum and postnatal

services, including care of the newborn, midwifery led care, obstetrics, anaesthetics and ultrasonography. These standards are:

- *Organisation*
- *Clinical care*
- *High risk conditions*
- *Communication*
- *Postnatal and newborn care*

Each standard covers an area of risk and has ten specific underpinning criteria, each with detailed breakdown, against which Trusts are assessed. We achieved 43 of the 50 criteria against a performance benchmark of 40. Our aim now is to maintain the excellent standards we have set in these 43 criteria and to develop our performance against the other seven criteria.

## Rainbow Team passes first year with flying colours

A tea party was held at St George's in April to celebrate the first anniversary of the trust's Rainbow Team.

The team offers an enhanced service to women with non-complex pregnancies. Expectant mothers are given the choice to have their appointments at home or at the hospital, and also the option to have a home birth at any point during their pregnancy.

### Introduction from Eric Chemla, divisional chair

This year has seen many achievements for the division. We have consolidated our lymphoedema service which has allowed us to organise changes in our wards to accommodate bariatric (weight loss) patients.

We have also been able to recruit more staff in our division; we have more nurses and physiotherapists in our lymphoedema service, and have recruited new clinical staff in our adult oncology, emergency and vascular services. We have also welcomed two cardiac surgeons, allowing us to increase our capacity to treat patients in theatre and the number of patients we are able to see.

One of our main targets for the next year is to work on providing extra capacity for our services affected by seasonal variations. We are also working on major estates and capital projects, including a new hybrid theatre for complex vascular and complex vascular access surgery which will bring cutting-edge technology for the most delicate cases.

Here are some of the highlights of the year for the medicine and cardiothoracic division:

### Acute Medicine Unit officially opened

Ann Radmore, chief executive of NHS South West London, officially opened St George's Hospital's Acute Medicine Unit in December.

The consultant-led unit provides patients with immediate access to the specialist emergency care they need and has been successful in reducing patients' length-of-stay in hospital by more than 30 per cent.

Jane Evans, lead consultant for acute medicine, said:

“We aim to provide a high-quality service to patients with acute medical problems and work hard to ensure that they are managed in the correct setting.

“Our team adopt a truly multi-disciplinary approach to all our patients which ensures they receive a holistic assessment and reduces waiting times for treatment and therapies.”



### HIV tests in emergency department aim to save lives

Patients at St George's Hospital's emergency department (ED) were offered HIV tests in spring 2012.

In the UK around 91,500 people are known to be living with HIV and the number of people diagnosed with HIV acquired in the UK has doubled in the last 10 years. However, it is also thought that around 25% of people infected with HIV are unaware of their condition.

The pilot targeted patients aged 18 to 65 and aimed to save lives by reducing the number of cases of undiagnosed HIV. Testing was offered to patients who were having routine blood tests as part of their visit to the ED.

Dr Melissa Hempling, consultant in emergency medicine, said:

“We carried out a pilot study in 2011 that showed routine HIV tests can detect undiagnosed cases. This and other initiatives showed an increase in the diagnosis of HIV outside a sexual health setting, and we hope to build on this.”



## Heart Attack Centre catheter lab has London's best survival rates

A report published by London Ambulance Service (LAS) found that the catheter lab at St George's Hospital had achieved the best survival rates in London.

St George's Hospital is one of seven designated Heart Attack Centres in the capital, and is home to a state-of-the-art catheter lab which is used to perform lifesaving angioplasty for patients suffering cardiac arrest and other serious heart conditions. 72.4 per cent of patients suffering from cardiac arrest who were brought directly to the catheter lab at St George's Hospital survived, according to the Cardiac Arrest Annual Report 2011/12. The overall survival rate for patients taken to any Heart Attack Centre in London was 63.3 per cent.

Angioplasty is a procedure where a catheter is inserted into an artery where a blockage is causing the heart attack. A small balloon is inflated to open the artery and a tiny tube called a stent is then inserted to keep the artery open. Angioplasty is recognised as the best possible treatment for a heart attack.

Pitt Lim, consultant cardiologist and clinical lead for cardiac intervention, said:

“This report clearly demonstrates that patients suffering a heart attack have a much higher chance of survival when they are taken directly to a Heart Attack Centre with a modern catheter lab. We provide one of the most effective cardiac intervention services in the country and a 24/7 enhanced heart attack service which saves many lives each year.”

## Innovative BreckerWire enhancing patient safety

A St George's consultant cardiologist has designed an innovative device with the aim of reducing the risk of complications during cardiac interventions.

Known as the BreckerWire, the device is a new design of intracardiac guidewire developed by Dr Stephen Brecker, a cardiologist here at St George's since 1996.

Intracardiac guidewires are used in a number of cardiac procedures, including a minimally invasive procedure to replace the aortic valve. This is known as a transcatheter aortic valve implantation (TAVI).

The BreckerWire is a preshaped, flexible wire which enables the safer delivery of valves to the heart. Previously, a standard stiff guidewire was used in the TAVI procedure which carried a risk of complications, such as perforation of the ventricle.

In 2008, Dr Brecker aimed to redesign the traditional guidewire to allow more controlled use during high risk cardiac procedures. The idea was developed in conjunction with NHS Innovations London, and was also highly commended in the NHS Innovations London annual awards in 2009.

A clinical trial of the BreckerWire took place in 2010, and it is now used routinely in TAVI procedures at St George's.

Dr Brecker said:

“To me, it seemed an obvious and simple idea which no-one else had done. Taking the idea from my head to the bedside was the difficult step, but having done this I am keen to assist others within the trust to do the same.”

## Modernised emergency department officially opened

Dame Ruth Carnall, chief executive of NHS London, officially opened St George's Hospital's modernised emergency department in January.



The department underwent a full scale refurbishment which has improved a number of areas including:

- *The children's emergency department, which has been expanded to include a new space for a combined walk-in and minor paediatric injuries service*
- *A new paediatric majors area, where children with more serious injuries are treated*
- *A new Paediatric Assessment Unit, which is a short stay area for children who need short stay observation or are awaiting investigations, but do not need to be admitted*
- *An expanded Clinical Decisions Unit creating more capacity. It has also been kitted out with improved facilities to provide a better patient experience*
- *Additional space for the Urgent Care Centre (UCC), which replaced the Tooting Walk-in Centre in July 2012. The UCC provides treatment for minor illnesses and injuries like strains, bites, burns, infected wounds or chest infections*
- *A new reception, waiting room and triage area*

Dame Ruth Carnall said:

“I am so pleased to be able to officially open the unit. As one of the busiest A&E departments in the country and a major trauma centre for London, the hospital cares for patients who are in need of urgent and specialist care.”

“Staff are clearly enthusiastic about the care they provide and have worked hard to develop a smooth pathway of treatment for patients.”

## Renal team a group of 'outstanding individuals'

44-year-old Blaine Wilson was living a healthy life in Australia enjoying golf, swimming and taekwondo when he was struck down suddenly with kidney failure in March 2004.

“The doctors didn't know what caused it. The medication wasn't really working, and I had made a decision a few months before to move back to the UK, so once I was given the all clear to fly by my doctor, I came back.”

Blaine was referred to St George's in May 2005 where he underwent more biopsies to determine what was wrong. Doctors discovered he had FSGS (focal segmental glomerulosclerosis) which is a rare kidney condition.

“My body responded to the treatment a little but I still had to have a strong injection every now and again to help my body get rid of all the fluid. I would put on 10 to 15kgs at a time which was all fluid!”

“Dr Stephen Nelson was instrumental in driving my programme of treatment forward and really helped me carry on with my life in spite of my illness. The team were so fantastic and did everything they could to keep me on my feet which was essential for my demanding work schedule. Hazel Pinto, clinic co-ordinator, was wonderful – if I needed an urgent appointment I could call her up and get one quickly – this was so invaluable when I was in pain.”

In November 2008 Blaine's kidneys needed more support and so he went onto peritoneal dialysis (PD). The advantage of PD is that the treatment affords patients more independence than haemodialysis and can very easily be set up as a home treatment.

Blaine then went onto haemodialysis in 2009, as PD was no longer providing adequate dialysis. Unlike PD, which uses the patient's peritoneum to clean the blood inside the body, haemodialysis

takes place outside the body in a filter known as a dialyser (artificial kidney). Blood is taken from the body, pumped into the dialysis machine, cleaned and then pumped back into the body via a circuit. This is done as continuous process three times a week for about four hours each time.

Blaine received his new kidney in 2010 from his sister. But a day after the operation tests showed that the same condition – FSGS – that had damaged his own kidneys was affecting the kidney transplant he received.

Dr Joyce Popoola, renal and transplant consultant, said:

“FSGS is a challenging condition for kidney patients who undergo transplants as the condition is well known to recur in the transplant kidney. In some cases the newly transplanted organ is ‘lost’ within days, which is devastating for both the patient and donor.”

“A lot of research is being undertaken worldwide to understand the cause and best management of this condition. At St George’s we have been working with the team on Ruth Myles to provide plasma exchanges with a view to suppress the condition.”

Blaine said:

“I finally got the all clear in December 2011 from Dr Popoola. Nearly two years on from my transplant I feel 100 per cent and while I still come to the hospital for regular check ups, I’m not on any dialysis and no longer require plasma exchanges.

“I cannot thank the team enough for being so amazing – from all the nurses on the ward, and in the clinics, to my consultants. They are an outstanding bunch of individuals.”



### Introduction from Drew Fleming, divisional chair

The success of the division this year has been down to the hard work of our staff, who always provide an excellent level of care to our patients. Since our major trauma centre was launched in 2010 it has continually passed all assessments for quality since its opening, despite consistent increased activity.

Over the next year we look forward to completing our project to build a helipad on top of St George's Hospital. Having such a major addition to our services will allow patients to get the life-saving care they need quicker than ever before.

Our other priorities for the year include improving the patient experience by acting on the feedback we receive. We will also look to drive efficiency through improving our processes without compromising patient safety and also provide an environment for staff that encourages innovation and research.

Highlights from the last year in the surgery, theatres, neurosciences and cancer division include:

### Breast cancer service wins national improvement award

Our breast cancer service team won an NHS Improvement award in May for reducing the amount of time that patients spend in hospital following surgery.

The team introduced a new 23-hour discharge model for breast cancer patients. As a result there has been a remarkable improvement in the length-of-stay figures for breast patients, with 83 per cent discharged in two days or less. Patients previously stayed up to five days in hospital.

Mr Dibyesh Banerjee, consultant oncoplastic breast surgeon said:

“Most of our patients now stay in hospital for just a single night, with some being

safely discharged on the same day as their surgery. When we introduced the model we had initially aimed for a target of 70 per cent of discharges within two days.

“However, we have achieved a far better result by streamlining care pathways and introducing a nurse-led discharge service. This means that patients can now be discharged efficiently and safely seven days a week.”

### South London's first hospital helipad coming to St George's



In September, we announced the development of a helipad at St George's Hospital. It will be only the second hospital helipad in London and the first south of the river. The development will be partly funded through a grant of £1million from the County Air Ambulance Trust HELP (Helicopter Emergency Landing Pad) Appeal.

The facility will be built on the rooftop of St James Wing, with direct lift access to the hospital's state-of-the-art emergency department. It will support air ambulances bringing the most seriously injured casualties for emergency treatment at the hospital, which provides the Major Trauma Centre for the South West London and Surrey Trauma Network.

Heather Jarman, clinical director for major trauma at St George's, said:

“We are at a pivotal time in the development of trauma care systems. With the emergence of Major Trauma Centres and rapid transfers, helicopters are fast becoming essential to the success of these systems.

“At the moment, air-lifted patients from South West London and Surrey often travel past St George's Hospital, which naturally delays their care at a time when every second counts.”

## Pre-operative care centre improving patient safety and experience



The new pre-operative care centre (POCC) at St George's Hospital was officially opened in March by Cllr Ravi Govindia, leader of Wandsworth Council.

The POCC is designed to enhance quality of care and improve the experience for patients coming to hospital for surgery. Patients are checked here to make sure they are in strong enough health before their operation, which reduces the risk of cancelled surgery. Staff also ensure that appropriate arrangements are made for the patient's admission to hospital, their eventual discharge home and for ongoing care afterwards.

Previously delivered from a range of locations across St George's Hospital, pre-operative care services are now based in one specialist environment, offering a “one stop shop” where patients can have

their assessment as well as investigations, including ECGs (electrocardiograms), breathing tests and blood tests, all in one place. This reduces the overall time patients have to spend in hospital as they can now avoid visiting separate departments for each test.

Jo Bratchell, lead nurse for pre-operative assessment, said:

“We are so pleased that Cllr Govindia was able to officially open the unit for us. Pre-operative care is an essential part of the planned care pathway, enhancing the quality of care for patients in a number of ways.

“96.5 per cent of the 1450 patients who have attended an appointment since the centre opened in July 2012 have rated their experience as excellent or good, and this is a testament to the enthusiasm and passion of our fantastic staff.”

## Annual national cancer targets passed

St George's passed all national cancer treatment and diagnosis targets for 2012/13, improving the prospects for thousands of cancer patients.

Figures published by the Department of Health showed 95 per cent of patients with suspected cancer were seen at St George's or 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.

Cancer targets are set nationally and ensure that patients who are either suspected of having cancer or who have been diagnosed receive treatment as quickly as possible. If found to have cancer, patients must receive their first treatment and any subsequent treatment within specific timelines.

Mr Nicholas Hyde, clinical director for cancer services, said: “The trust has at times during 2012/13 seen over a thousand two-week referrals in one month. This demonstrates how important the cancer service is to the local and regional population of St George's.

Over the last year our figures show that we have met all the national targets including the number of patients receiving their first definitive treatment for cancer within two months (62 days) of a GP's urgent referral for specialist cancer.

“Over the next year we will ensure that we maintain this excellent record and continuously strive to improve the cancer care patients receive.”

## Cutting edge robotic surgery improving cancer care



We are one of only a handful of hospitals in the UK to use robotic, minimally invasive surgery to improve outcomes for bladder cancer patients.

Part of the standard treatment for bladder cancer patients is a cystectomy, the removal of all or part of the bladder. A radical robotic cystectomy is a minimally invasive procedure that offers an alternative to the traditional open surgery technique.

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

## Butterfly Scheme for dementia launched

Over 200 trust staff attended an event in May to mark the launch of the Butterfly Scheme, a new initiative aimed at helping raise awareness of dementia in hospitals.

The scheme works by affixing a blue butterfly sticker to the notes and name boards of patients with dementia. This allows staff to identify those patients that require extra support. Staff who have learnt more about the scheme also wear a blue butterfly badge to identify themselves to colleagues, patients and their families.

Jen Tulloch, clinical nurse specialist for dementia said:

“The Butterfly Scheme enables staff to offer the most appropriate care to patients with dementia. Everyone who meets a patient has an effect on their safety, and educating staff will allow them to offer considerate and suitable support to patients with memory impairment.

“The Scheme is recommended by staff at hospitals that have used it for some time, which indicates that staff find it an extremely useful tool in patient care.”

## Cancer clinicians appointed LCA pathway group chairs

Two St George's clinicians have been appointed pathway group chairs for the London Cancer Alliance (LCA).

Mr Nicholas Hyde, lead cancer clinician, who already sits on the LCA Clinical Board, has been appointed LCA pathway group chair for head and neck cancer, and Professor Barry Powell, head of melanoma services, has been appointed the LCA pathway group chair for skin cancer.

The LCA was established in 2011 as the integrated cancer system across south and west London. LCA Pathway Groups ensure that patients across south and west London have access to the same high quality diagnostics and care, as well as taking on responsibility for co-ordinating the research, education and development of cancer services.

### Introduction from Paul Alford, divisional chair

Community services have continued their integration with St George's over the last year, improving the choices available to local people by providing more care in their own homes, reducing unnecessary admissions to hospital and helping patients leave hospital as soon as it is safe for them to do so.

In a lot of cases this year, community services have stood out as one of the many excellent services provided by the trust; whether acting as a national case study for other services or launching schemes to help patients with dementia, the division has embraced the trust's values and applied them to all areas of their work. This must be commended and encouraged amongst all staff.

I would also like to recognise the efforts of the team based at HMP Wandsworth, who have made some significant improvements over the past year with the services they offer to prisoners. This progress is set to continue with some exciting new projects in the year ahead.

I hope the ongoing success of the division will continue over the coming twelve months, enabling community staff to provide the high level of care we want for our patients.

Highlights from the last year in the community services division include:

### Productive community services a 'national beacon'

The NHS Institute of Innovation and Improvement were so impressed with the trust's wheelchair services results in releasing time to care as part of the productive community services programme, they asked them to be a national case study to highlight the benefits of the programme to other community services across the country.



Jane Attrill, head of rehabilitation services, said:

“The productive community services programme has helped us to increase the amount of time we get to spend with each patient and increase in the number of patients our therapists are able to see each day.

“We provide a wheelchair service to 15,000 service users from across south west London and Surrey and the programme is helping us to make sure that whether dealing with a therapist, rehabilitation engineer or team administrator, our service users are getting a consistent quality of service.”

Caroline Stanfield, wheelchair service team leader, said:

“Everything's much more organised, we know where things are, we can get to things much quicker. We've also been sending out a questionnaire to patients every few months, and most people are saying very positive things about the service.

## Bone boost helping patients improve way of living

Our bone boost service, part of the integrated falls and bone health service, is the first of its kind in the country and was set up specifically to deal with the problems of bone health in Wandsworth.

Based at St John's Therapy Centre, the bone boost service is run by Dr Katie Moss, consultant rheumatologist and osteoporosis specialist, and Bernadette Kennedy, lead for falls and bone health.

Katie says:

“We know that within Wandsworth there is a very high incidence of hip fractures. If we can pick them up and treat them then we are likely to be able to prevent them having a hip fracture when they are older. This is important as we know that hip fractures and vertebral fractures are associated with very high morbidity and mortality.”

“We're very happy to speak to GPs about their patients with osteoporosis and I would encourage GPs who have any queries to contact us.”

Bernadette said:

“The earlier we intervene in a patient's journey the more effective we can be. By helping patients to make changes to their way of living we can bring in the evidence based practice that we know will improve their bone health.”

The service delivers regular physiotherapy sessions and exercises tailored to each individual patient in local health centres, community centres and in a patient's own homes.

## Work of senior health staff recognised by London Mayor



Staff from the senior health team at St George's Hospital met Mayor of London Boris Johnson at an event in February acknowledging the outstanding work of members of the community.

The team were invited to the reception at London's City Hall after the Mayor's office received a letter praising staff in senior health for their excellent care of a patient at St George's.

Stephen Wood, principal physiotherapist in senior health, said:

“The evening was a huge success and gave the staff full recognition for their dedication to patient dignity and care. Boris kindly spoke to us and was very keen to hear about our senior health initiatives and aspirations for the trust.

“All senior health staff have a valuable role in the care of our older patients, and we were honoured to represent them at this event.”



## Vulnerable patients keep warm and active through Winter Warmer initiative

The trust launched an innovative new campaign in February to keep elderly and vulnerable patients in the community warm and well in their own homes during the cold weather.

The Winter Warmers initiative worked with the Leonard Cheshire Disability charity and Age UK to reach as many vulnerable patients as possible. Specialist instructors visited specialist day centres and day hospitals in Wandsworth to teach a home exercise programme designed to keep people active, healthy and warm at home.



The initiative issued the Winter Warmers package, which includes a room thermometer, gloves, blankets and heat packs to make sure patients are well equipped to stay warm.

Digital radios were also be given out to help reduce feelings of loneliness and enable access to DAB radio stations such as The Wireless, which played show tunes and reminded people of their exercises and how to stay warm.

Bernadette Kennedy, head of integrated falls and bone health, said:

“All the clinical evidence shows that keeping warm and active at home during cold periods significantly reduces the risk of being admitted to hospital, and is very good for your emotional wellbeing.

“Starting an initiative like this means we can get to more of our more vulnerable patients and ensure they have all they need to keep the effects of the cold at bay.”

## Research

We recognise that research is key to improving quality of care and the patient experience, which is why the trust remains committed to research and innovation.

We have committed to building on our strong history as a teaching institute and our partnerships with St George's, University of London (SGUL) and Kingston University. This will allow us to deliver excellence in education and allow us to work more collaboratively on upcoming projects.

Some of the highlights of our research studies over the year are outlined below:

- *The stroke unit at St George's has recruited the most patients to clinical trials in stroke research in the UK. This has allowed the group to identify some of the key genetic factors involved in the risk of stroke.*
- *A clinical trial for a novel treatment for a rare metabolic disorder has attracted substantial industrial and Medical Research Council (MRC) investment.*
- *We have worked together with colleagues at St George's, University of London and Quantum DX on new handheld device technology, which can deliver the DNA sequence of infections from a single drop of blood in just 15 minutes. The device is currently being developed to determine strains of malaria, allowing the correct drug to be used in treatment. However, it is hoped that the device could also be used in the treatment of hospital-acquired infection and acute septicaemia.*

### Having a major research focus

As a major teaching trust, many of our staff are actively involved in undertaking clinical research studies to enhance their knowledge and improve our clinical services. There are numerous joint appointments with St George's, University of London (SGUL) and the Joint Faculty of Health and Social Care Sciences with Kingston University. A new ten-year strategy for St George's Healthcare was agreed in December 2012 after a year of development with our staff and partners. As well as refining our mission, vision and values for the next ten years, seven strategic goals were set for the next decade across a number of areas, including in research.

The trust has a goal to drive research and innovation through our clinical services, achieved by strengthening our approach to research programmes. Specifically, we will:

- *Develop a culture that places research at the core*
- *Maximise the benefits of our partnership with St George's, University of London*
- *Partner with an Academic Health Science Centre (AHSC) at the heart of a vibrant South London Academic Health Science Network (AHSN)*
- *Increase the success of research funding from grant-giving bodies*
- *Become a preferred partner with industry for pharmaceutical research and medical innovation*
- *Develop a robust infrastructure to support research*

By sticking to these principles towards research in the longer term, this will allow us as a healthcare organisation to provide higher quality clinical care and recruit, motivate and retain the best staff.

# Living our values

The St George's Board agreed a new 10 year strategy for the trust after development with our staff and partners.

The strategy has been developed to ensure that we deliver:

- *Better health outcomes for all*
- *Improved patient access and experience*
- *Empowered, engaged and well supported staff*
- *Inclusive leadership at all levels*

The success of this strategy will be determined by the strength of our partnerships with our colleagues in the healthcare, social services, voluntary and charity sectors.

## Our mission

To provide excellent clinical care, education and research to improve the health of the populations we serve.

## Our vision

To become an excellent integrated care provider and a comprehensive specialist centre for south west London, Surrey and beyond with thriving programmes of education and research.

## Our values

We are committed to keeping patients at the heart of everything that we do – our values are designed to inspire our staff to achieve this.

The trust's set of values were developed following detailed discussions with the board, directors, patients and members of our workforce at a variety of levels, and were launched in April 2010.

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*

## Managing complaints

The trust cared for over one million patients in 2012/13. We accept that among this number of patients the experience for some will not meet their expectations.

The trust adheres to the Parliamentary and Health Services Ombudsman's Principles for Remedy, which provides guidance on the way in which public bodies respond to complaints and concerns raised by patients and members of the public.

We are absolutely prepared to change and improve in response to feedback from patients, visitors and other stakeholders. The lessons learned and trends identified from information collected via our complaints process play a key role in improving the quality of care we provide.

The trust has a dedicated complaints team which works to investigate and provide responses to complaints which are made. All complaints are acknowledged within three working days, and the team aim to provide a response to a complaint within 25 working days, or where a longer period of time to investigate is necessary, an agreed time-scale with the complainant.

In addition, our Patient Advice and Liaison Service (PALS) help to address any problems or concerns that patients may have regarding the trust's services. The services listen to the views and comments of patients and can provide them with access to interpreters, signers and other services they may need to improve their experience.

PALS staff also provide customer care training to staff and often assist staff when they are in need of support.

The contacts received by PALS are put into two categories:

- **Category A (general contacts)** refers to any enquiry or request that does not raise areas of concern within the trust. For example, a patient requesting information about a service or a member of staff seeking advice about how to contact an outside organisation. Also included in this category are patients and relatives who expressed thanks.
- **Category B (concerns)** refers to when a patient or relative has raised a concern about the trust but does not wish to follow the formal complaints procedure.

## Taking action in response to complaints

The trust takes complaints very seriously, and takes action where improvement is needed to make sure the same situation does not happen again. Below are some examples of complaints made, and the actions taken in response.

Complaint	Actions taken
Patient was dissatisfied with nursing care on recovery unit and ward	Ward staff supported by a course administered by the training and development team, aimed at setting goals around the patient's experience and expectations.
Patient raised concerns about treatment, delays and staff communication	Staff spoken to by the manager, reminded of trust values and attended customer care training.  Additional staff recruited to assist with smooth running of clinic.  Manager sent a memo to remind all staff of the need to introduce themselves and wear name badges at all times.
Patient experienced difficulty with outpatient appointments:  Received letter 24 hours before their appointment  Experienced rude staff on the phone Told there was a two-hour wait with no explanation	Processes have been reviewed and the team now telephone patients if appointment cancellation is a short notice.  Outpatient service manager reminded all staff of the importance of keeping patients informed of delays.  Correspondence to patients was amended to incorporate a sentence advising patients there may be delays.
Patient found staff member to be rude and unhelpful	Staff members were spoken to and it was explained their behaviour was unacceptable. Staff members were monitored.

## Continued improvement for inpatient care

The 2012 Care Quality Commission (CQC) survey of adult inpatients showed that St George's had maintained and built on its improvements to inpatient care.

The national inpatient survey is an important indicator of how all NHS trusts in the country are performing, and the 2012 survey looked at the experiences of patients who were admitted to hospital for at least one night.

The 2012 survey rates us 'about the same' as most other trusts in the country for all 70 questions. Specifically there were six areas we had improved significantly from the previous year:

- *More patients felt their room or ward was clean*
- *More patients were encouraged to give their views on the quality of care they received*
- *More patients felt they received clear answers from the questions they asked nursing staff*
- *A choice of food was given to more patients*
- *More patients thought staff were clear in the advice they gave and did not contradict each other*
- *Fewer patients reported nurses talked in front of them as if they were not there*

## Celebrating our staff and recognising our nurses



In **December**, comedian Arthur Smith brought sparkle and laughter to the St George's annual staff awards.

Hosted by Christopher Smallwood, chairman, and Miles Scott, chief executive, the dinner honoured staff who have given 25 years' service to St George's, as well as the trust's 2012 special achievement award winners. Volunteers who had given 10 years' service to St George's were also recognised.

The dinner was attended by more than 100 award winners, guests and senior members of staff.

In **May**, we marked International Nurses' Day by holding our annual nursing awards. Staff are nominated by their colleagues for outstanding contributions to nursing and patient care at the trust.

The award categories include:

- *Nurse of the year*
- *Midwife of the year*
- *Healthcare assistant of the year*
- *Mentor of the year*

A special nursing education award of up to £1,000 is also granted to a member of staff or team at the trust who wish to develop an area of practice or create a new initiative for the benefit of patients.

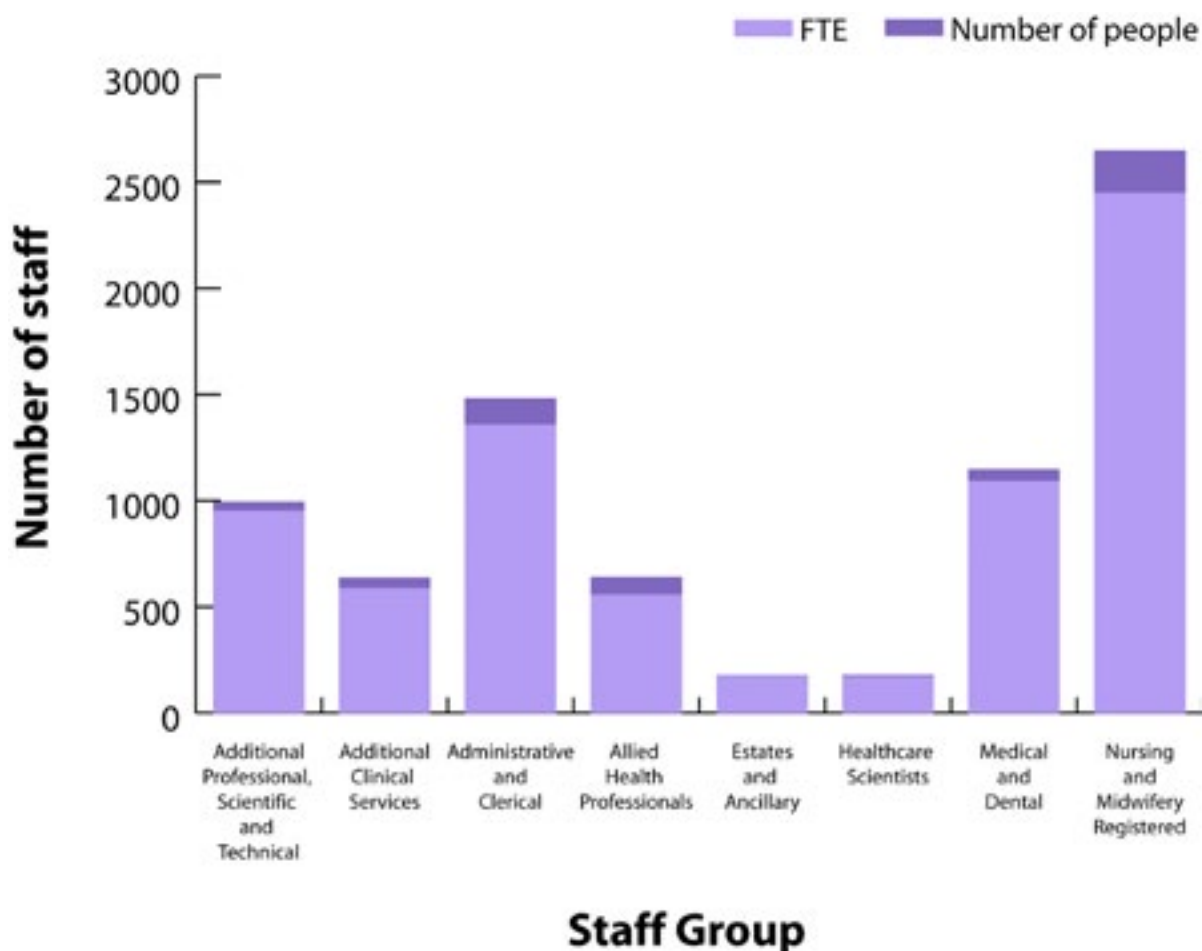
## Working at St George's

St George's is one of the biggest employers in south west London, with nearly 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 where 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? (as of 31st March 2013)

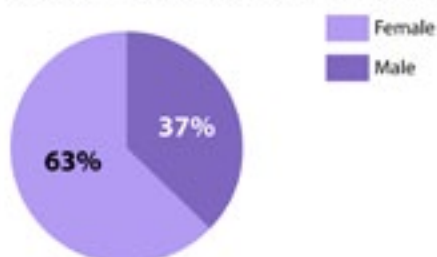
Staff Group	Full time equivalent (FTE)	Number of people
Additional Professional, Scientific and Technical	951	993
Additional Clinical Services	585	637
Administrative and Clerical	1356	1482
Allied Health Professionals	556	640
Estates and Ancillary	173	177
Healthcare Scientists	168	178
Medical and Dental	1091	1147
Nursing and Midwifery Registered	2448	2648
<b>Grand Total</b>	<b>7327</b>	<b>7902</b>



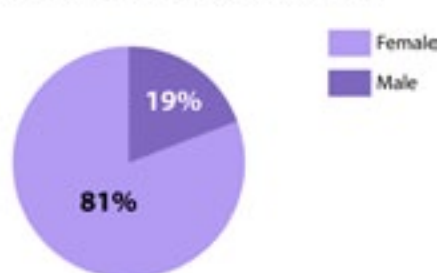
## St George's Healthcare staff by gender (as of 31st March 2013)

Staff Group	Male	Female
Add Prof Scientific and Technical	371	622
Additional Clinical Services	123	514
Administrative and Clerical	333	1149
Allied Health Professionals	92	548
Estates and Ancillary	155	22
Healthcare Scientists	77	101
Medical and Dental	574	573
Nursing and Midwifery Registered	252	2396
<b>Grand Total</b>	<b>1977</b>	<b>5925</b>

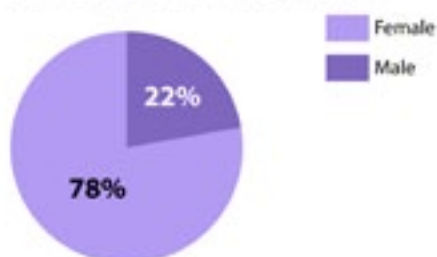
**Add Prof Scientific and Technical**



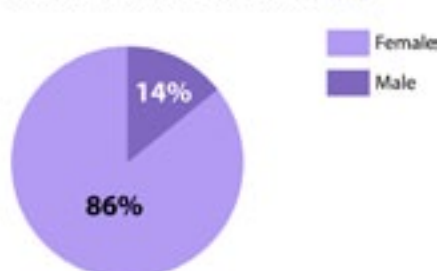
**Additional Clinical Services**



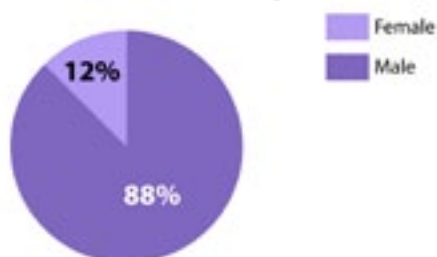
**Administrative and Clerical**



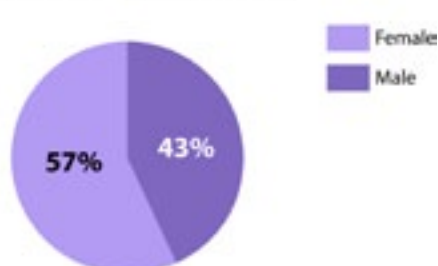
**Allied Health Professionals**



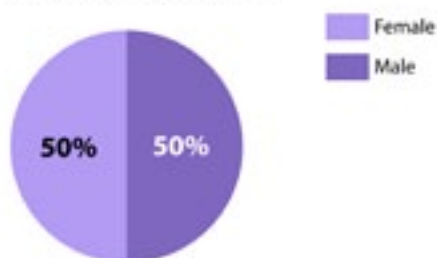
**Estates and Ancillary**



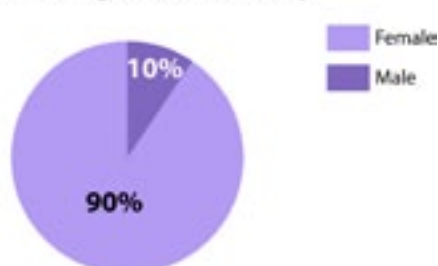
**Healthcare Scientists**



**Medical and Dental**



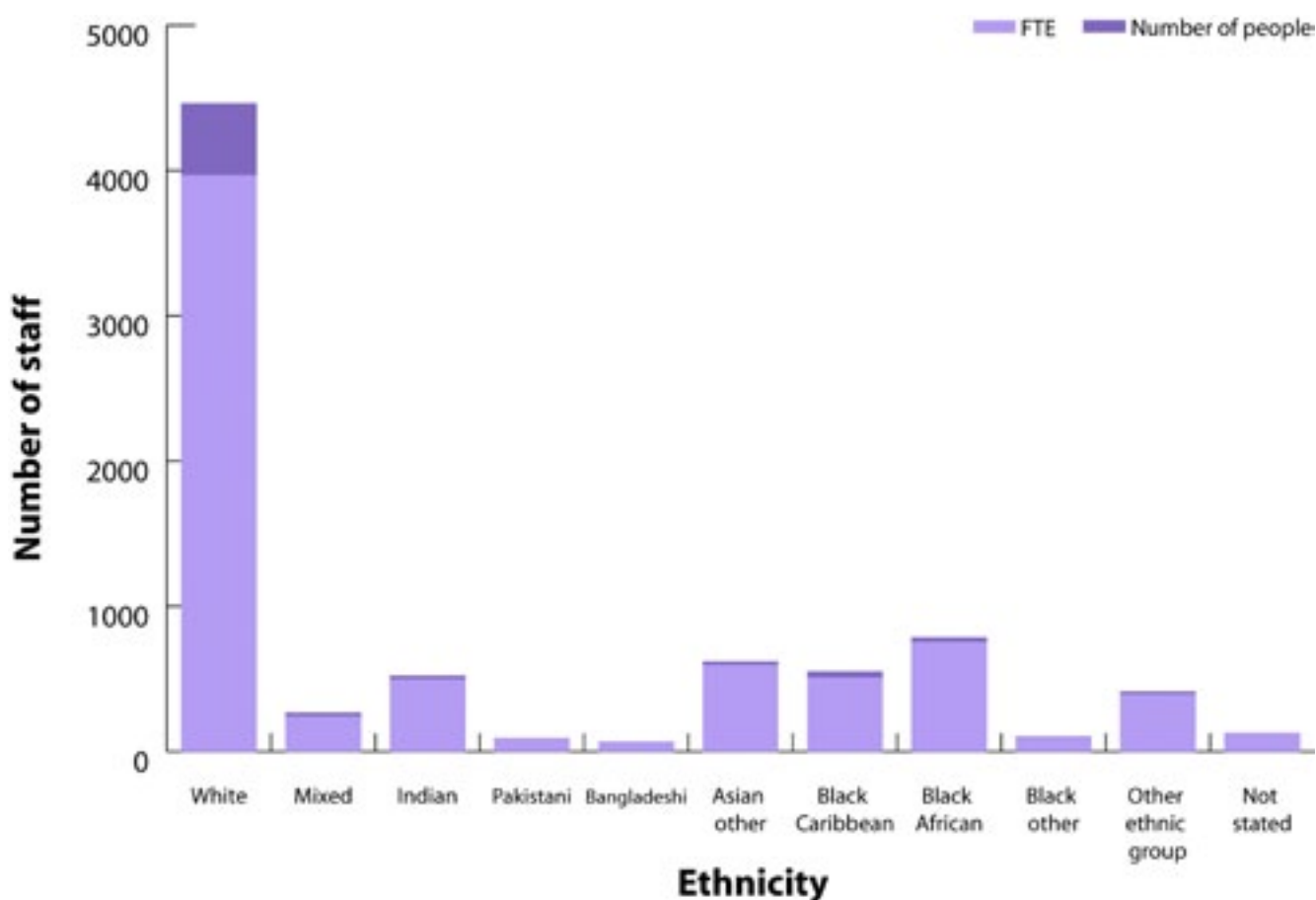
**Nursing and Midwifery**





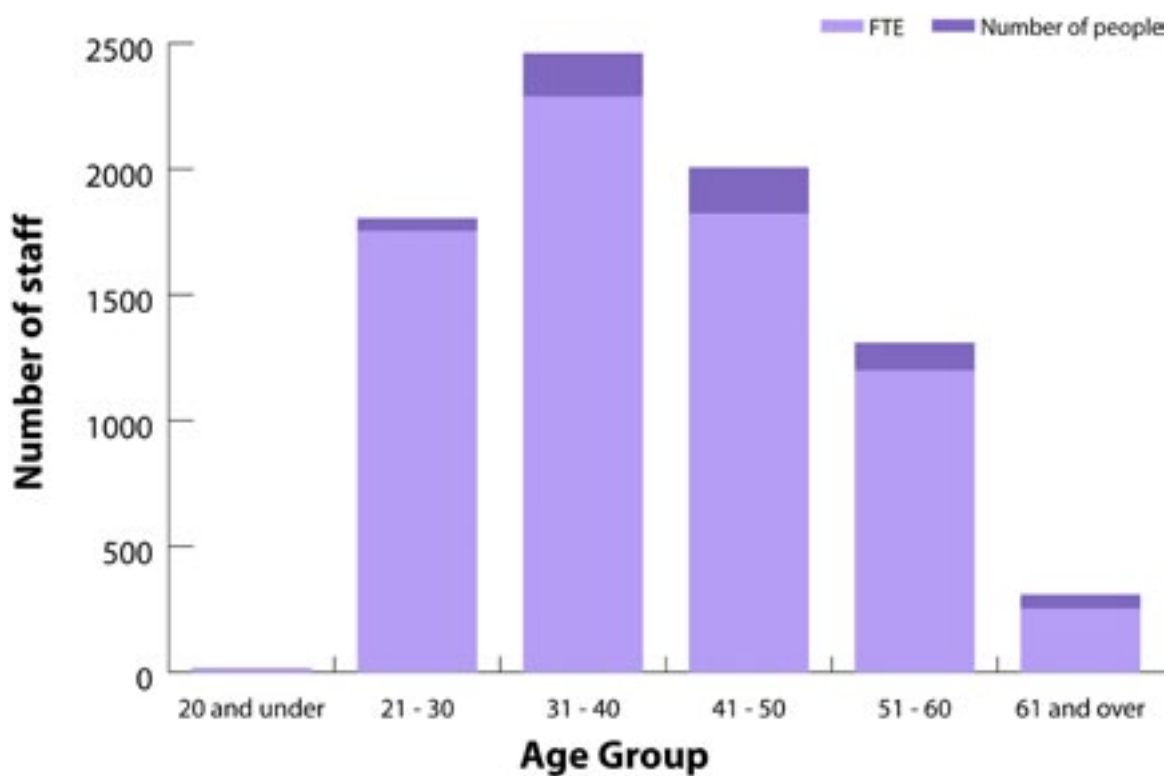
## St George's Healthcare staff by ethnicity (as of 31st March 2013)

Ethnic group	Full time equivalent (FTE)	Number of people
White	3967	4462
Mixed	243	267
Indian	496	521
Pakistani	84	89
Bangladeshi	62	65
Asian other	596	620
Black Caribbean	509	551
Black African	753	795
Black other	96	101
Other ethnic group	394	412
Not stated	127	19
<b>Grand total</b>	<b>7327</b>	<b>7902</b>



## St George's Healthcare staff by age (as of 31st March 2013)

Age band	Full Time Equivalent (FTE)	Number of people
20 and under	14	16
21 – 30	1752	1803
31 – 40	2287	2460
41 – 50	1822	2006
51 – 60	1198	1309
61 and over	252	308
<b>Grand Total</b>	<b>7327</b>	<b>7900</b>



## Promoting equal opportunities

The trust is an equal opportunities employer, and abides by the Equality Act 2010 which consolidated, strengthened and clarified existing anti-discrimination legislation.

The trust abides by the Public Sector Equality Duty (PSED) and its three principles:

- *To eliminate unlawful discrimination, harassment, victimisation and any other conducted prohibited by the Act*
- *To advance equality of opportunity between people who share protected characteristics and those who do not*
- *To foster good relations between people who share protected characteristics and those who do not*

The term 'protected characteristics' is used to embody the grounds upon which discrimination is unlawful. Under section 4 of the Equality Act, the protected characteristics are:

- *Age*
- *Disability*
- *Gender reassignment*
- *Marriage and civil partnership*
- *Pregnancy and maternity*
- *Race and ethnicity*
- *Religion or belief*
- *Gender*
- *Sexual orientation*

The trust demonstrates its adherence to the three PSED principles outlined in the Equality Act 2010 by:

- *Removing and minimising disadvantages suffered by people due to their protected characteristics*
- *Meeting the needs of people with protected characteristics*
- *Tackling prejudice and promoting understanding between people with protected characteristics and others*

## Keeping staff engaged

St George's has a number of channels through which we communicate regularly and effectively with staff. Staff can access information through the intranet, as well as keeping engaged through the following methods:

- **eG**  
*Staff receive a weekly email news bulletin which informs them of important messages from senior managers, provides news on trust events and meetings, services and training available.*
- **Staff open forums**  
*Regular forums are held where the chief executive or members of the executive team update staff on trust developments. All staff are welcome to attend, and can raise concerns or ask questions directly to senior staff.*
- **Patient safety forums**  
*A series of forums are also held with staff on the issue of patient safety. These are presented by senior members of staff, often using an example of a serious incident at St George's. Staff are also given the opportunity to ask questions as to how we can make patients safer at the trust.*

- **All staff emails**

*It is occasionally necessary for individual messages to be sent to all trust staff via email. This is usually reserved for important messages that require the attention of many or all staff in the trust.*

- **The Gazette**

*The Gazette is a bimonthly magazine produced by the communications team, which contains various pieces of trust news and teams, as well as positive patient experiences*

*As well as being distributed to all members of staff, copies of The Gazette to public trust members, GPs in south west London and our stakeholders.*

## **Listening into Action**

We recognise that as well as listening to our patients, it is also important that we involve staff when trying to identify where improvements could and should be made.

During the 2013/14 financial year, we will take part in the Listening into Action programme, in which staff from across the trust at all levels will be involved in a common goal; to put clinicians and staff at the centre of change for the benefits of our patients, staff and the trust as a whole.

Listening into Action complements other important projects taking place at the trust, including the Improvement Programme. In fact, the change methodologies, systems and experience staff develop and gain through this programme will in many cases be used to help achieve changes which are identified by Listening into Action.

Staff will be encouraged to attend Big Conversations, where workers from all departments, levels and roles will come together and talk openly about what matters to them, and what changes should be prioritised to

We hope to use the feedback from these sessions to inform our future actions and to support and enable our teams to do the very best for our patients and their families, in a way which makes us proud of our work.

## **NHS staff survey**

In autumn 2012 the Care Quality Commission (CQC) sent NHS staff survey questionnaires to St George's staff, with 38 per cent taking the time to respond. This was a decrease of 6% from the 2011 staff survey.

The staff survey is important as it not only lets us know where we are performing well, but also tells us if there are areas where our staff need more support to carry out their duties effectively.

The survey results named St George's staff as being among the most highly motivated and engaged staff in the country.

The survey results show that compared to most of the 142 other acute trusts in the country, staff at St George's:

- *have more ability to contribute towards improvements at work;*
- *have higher levels of motivation at work;*
- *are more likely to recommend St George's as a place to work or receive treatment.*

More staff at St George's believe that they are making a difference to patients than at almost every other trust in the country, and more staff are satisfied with the quality of work and patient care they are able to deliver.

Our staff are also more likely to report errors, near misses or incidents than at most other trusts.

Despite our strong performance in the NHS staff survey, we have identified areas where it feels improvements could be made to further improve the working lives of staff. Our staff report high levels of harassment and tend to work longer hours than staff at other trusts.

The trust is working closely with staff and unions to address these issues and bring them into line with the highest performing trusts.

We will continue to work closely with our staff, the unions and our partners to identify what needs to be done to make the improvements we need while maintaining our very strong performance in areas where staff have said we are doing well. We hope for this to be reflected in next year's staff survey results.

## **Preparing for emergencies**

Section 2.45 of the NHS Operating Framework 2012/13 states that emergency preparedness continues to be a core function of the NHS. It also requires all NHS organisations to have emergency preparedness plans in place and to give high priority to testing those plans.

The trust has an organisational risk committee which meets regularly to discuss updates regarding major incident planning and business continuity during internal incidents. On-call training is also provided to on-call directors and managers on an ongoing basis to adequately prepare them for emergency situations.

In May the trust took part in a live exercise to test the trust's HAZMAT (CBRN) plan. This was in conjunction with a police and local authority partners to test the support they would provide to St George's in the event of a major incident.

This training was put into action in September when the trust was declared for its first major incident since 1988 with a major road traffic accident on the A3 in Surrey.

In addition to these duties, the trust also had a number of measures in place to prepare for the impact of the London 2012 Olympic and Paralympic Games.

An Olympics Operational Group was established and was comprised of key stakeholders across the organisation, meeting regularly with the key aim of fulfilling the NHS's commitment to provide business as usual.

Major incident and emergency planning continued as usual in the run up to the Games. An internal communications campaign for staff was run to ensure staff were adequately prepared for the impact of the Games. Our external website also had a dedicated 'Olympics' page which provided advice to patients who were due to visit the trust's sites during Games-time.

## **Education and development**

During 2012/13 our education and development department supported the commissioning, co-ordination and delivery of an extensive portfolio of individual, team and organisation development activities.

## The education and development department's year in numbers

- 1,565 staff, students and trainees attended induction and orientation programmes
- 1,805 staff members completed their statutory and mandatory training at face-to-face training sessions – this resulted in 43,130 subjects completed in 24,910 hours of learning time
- 3,228 staff members completed their statutory and mandatory training online – this resulted in 37,307 subjects undertaken through eLearning in 3,228 hours of learning time
- 3,218 applications to attend study days, courses, qualifications and conferences from non-medical staff were funded. These applications were from non-medical staff, both clinical and non-clinical
- 607 doctors attended training on external courses funded via the London Deanery and in-house development programmes
- 1,202 members of staff attended management development courses, leadership and team development programmes
- 2,014 staff members attended in-house training programmes such as equality and diversity, mentorship updates, preceptorship, train the trainer and various medicines administration courses
- 2,581 healthcare professionals attended clinical skills and simulation courses based at the trust, as well as 'in situ' training within community settings
- 343 young people were given work experience placements in the trust, including five students from Project SEARCH, a work experience programme for local students with a learning disability

## Focus on healthcare assistants (HCAs)

- 98 HCAs joined the trust this year and took part in relevant induction programmes
- 13 HCAs are studying the new Foundation Degree in Healthcare Practice which is delivered by Kingston University
- 19 HCAs received funding to attend courses to develop technical and interpersonal skills
- 75 took part in team building sessions
- 50 attended the HCA forum which provides an opportunity to learn from peers and trust experts
- 60 HCAs took part in ward-based development work
- 300 attended briefing sessions on the new HCA competencies developed by the trust and launched in August 2012

## This year's education and development achievements

- In March the education and development department was awarded a 'Citation for exceptional work in the support of less than full training 2011/12' by the South Thames Foundation School, demonstrating the trust's dedication to its work with foundation level junior doctors
- Towards the end of 2012 the department also had a successful visit from the General Medical Council and the London Deanery; at both visits the trust was commended for its commitment to education in general and postgraduate medical and dental education in particular. The trust's planning process for consultants, to ensure that those with educational responsibilities have allocated time to fulfil these roles, was also raised as good practice, as were the close links between the trust and St George's, University of London.
- The trust was appointed Lead Provider of Postgraduate Medical Education for four specialities:
  - Gastroenterology for south London
  - Trauma and orthopaedics for south west London
  - Clinical radiology for south west London
  - Geriatric medicine for south west London
- In November 2012 the trust was successful in bidding for funding to build an innovative dental simulation facility for training dentists and dental practitioners, which is due to come online during 2013.

## Spotlight on the portering team



The portering team work hard behind the scenes; carrying out a number of duties that keep the trust ticking over. Without them, the trust would come to a standstill.

The team cover a range of departments and areas such as radiology, the transport lounge, cardiac investigations and neurology. They do everything from equipment and furniture deliveries to moving waste, ensuring post is delivered, and making sure that medicines get to wards and departments on time.

The porters also have a fundamental role in the emergency department, transferring patients to various wards and radiology, collecting samples and making sure that it is stocked with oxygen and other equipment. The team also cover cardiac arrests and are an important part of the fire team.

During the day there are on average 50 porters covering St George's Hospital and overnight the hospital is covered by about five or six porters. There is also a dedicated portering team at St John's Therapy Centre.

The 80 strong team are led by Richard Shannon, portering manager, who agrees that his team are invaluable. He said: "I am very proud of the porters and the work they do. They are a very important frontline service and without them the hospital would stop. They cover key roles in major departments and always give 110 per cent to everything they do."

"St George's has become a busier trust over the last two years and the team have felt the impact. We have seen an increase in patients across the board. The porters are working harder than ever to deliver a great service; I think their efforts should be applauded. Having been a porter myself in the past I can see how the role has changed and how diverse the role has become lately, meeting the needs of a very busy trust."

## Spotlight on the pain management programme team

It is estimated that one in seven adults in the UK have a chronic pain problem. Many of these people are able to find way to live with and manage their condition. However, for some it can interfere with their daily lives – including work, family, relationships and general mood. This is where the pain management programme (PMP) can offer help.

Chronic pain is a term used to describe pain which has lasted longer than three months, and continues after treatment for the condition causing the pain itself. It can be quite a complex problem, as some people can experience chronic pain even when there is no clear identifiable cause.

The PMP team at St George's is part of the larger chronic pain service, and complements the work of the pain clinic at St George's Hospital. The team take around 300 referrals per year from GPs and the pain clinic. Patients are usually referred when they reach the point that it is recognised further treatment for pain would be inappropriate.

Through the PMP, patients learn a number of techniques to improve their ability to:

- *Manage pain*
- *Reduce their anxieties about pain*
- *Increase their levels of physical activity*
- *Achieve their goals and return to daily activities*

At St George's, the PMP has run for six years, and is one of the longest established programmes in London. It initially started as a back pain rehabilitation class, before evolving into the programme used today.

The PMP team is made up of a number of staff from different areas, including:

- *Consultant clinical psychologist*
- *Physiotherapy clinical specialist*
- *Occupational therapist*
- *Nurse*
- *Specialist therapy technician*
- *Administrative co-ordinator*



All members of the team work together to provide unique skills and general specialist knowledge to provide one cohesive care programme to the patient.

Claire Copland, consultant clinical psychologist and member of the PMP team, said:

“Although it is not a cure for pain, the programme aims to improve patients’ quality of life, despite the pain they have.”

“The number of referrals for the programme has increased over the six years it has been running, and during that time we have seen more and more patients, some with increasingly complex needs.”

“PMPs have developed since the 1980s as an evidence-based alternative to treatment for pain. This was as part of an increasing awareness that medication cannot always solve chronic pain, allowing alternative methods to be considered.

“The programme is more than patients having separate sessions from different departments. There is a thread that runs through the programme which encourages patients to learn new techniques to manage their pain when they need to do so.”

## Spotlight on the Acute Medicine Unit (AMU)

The Acute Medicine Unit (AMU) provides patients with immediate access to the specialist emergency care they need. The service has undergone several changes in recent years; the most recent being a re-build that completed in January 2012 to create a purpose-built unit.

Jane Evans, lead consultant for acute medicine, said: “The aim of the AMU is to ensure that patients have access to the right person in the right environment from the start. We aim to provide a high-quality service to patients with acute medical problems and work hard to ensure that they are managed in the correct setting and in doing so minimise unnecessary admissions to hospital.”

The service is led and delivered by a team of consultants who work closely with the nursing, therapies and pharmacy teams on the unit.



Patients are assessed on their arrival to the unit and are given a treatment plan (known as a STAT – senior triage, assessment and treatment – plan) which outlines their care. Consultants visit patients twice daily and the ward rounds are undertaken by a multi-disciplinary team of staff including a senior nurse, senior pharmacist, therapies representative and the medical team.



This ensures that patients receive a holistic assessment when they are seen which reduces waiting times for diagnostics (i.e. scans and blood tests), treatment and therapies. This multi-disciplinary approach ultimately reduces length-of-stay in hospital and has shown an improvement in patient safety and satisfaction across the NHS. Since January the unit has seen the average length-of-stay reduce by more than 30 per cent.

Jane says that the key to providing an efficient service is through effective teamwork. She said: "the success of our unit is down to the excellent team who work here. We adopt a truly multi-professional approach to all our patients."

The unit also runs both undergraduate and post-graduate education programmes for all healthcare professionals. It is a favoured unit on which to work and train with many students requesting secondments to the AMU. The unit was also one of the first areas to introduce simulation-based training for a multi-disciplinary team in the management of medical emergencies.

## Our Board

Our 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 eight executive directors (four 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 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 (NHS England from 1st April 2013) 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 (until March 2013), The Appointments Commission (until October 2012) and the NHS Trust Development Authority (from October 2012). 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.

### Declarations of interest

NHS employees are required to be impartial and honest in the conduct of their business and remain above suspicion. It is also the responsibility of all staff to ensure that they are not placed in a position which risks or appears to risk conflict between their private interest and NHS duties.

The primary responsibility applies to all NHS staff, including the executive team and non-executive directors. Members of the board are asked to declare any interests they have before the start of each bimonthly board meeting. The following interests are required to be declared by all members of staff, including members of the board:

## Business interests

The trust needs to be aware of all cases where an employee, or his or her close relative or associate has a controlling (e.g. partner or director) and/or significant financial interest (more than 1%) in a business (including a private company, public sector organisations, other NHS employer and/or voluntary organisation) or in any other activity or pursuit, which may compete for an NHS contract to supply either goods or services to the trust.

## Outside employment

Trust employees are advised not to engage in outside employment which may conflict with their NHS work, or be detrimental to it. All outside employment must be notified to the trust.

## Outside interests

Trust employees are expected to ensure that their private interests and public duties do not conflict. Staff are advised to consider whether action taken as a result of membership of organisations, comes into conflict with their duties as trust employees.

## Register of interests

All staff who are either responsible for and/or involved in the requisitioning and/or purchasing of goods and services, should declare any interests they are aware of.

## Council of Governors

As we move towards becoming a Foundation Trust, a Council of Governors will be elected from the trust's membership during the next year. The Council is the body which will represent the views of the membership and advise the Board of Directors.

The Council will have a number of roles. It will:

- *Engage with the Board on their performance and other matters related to the trust*
- *Advise the Board on strategic plans and service developments*
- *Appoint the chair and non-executive directors*
- *Appoint the trust's external auditors*

The Council of Governors will consist of three component parts:

- *Public Governors, elected from the public membership*
- *Staff Governors, from the trust's workforce*
- *Stakeholder Governors, who will be appointed by some of the trust's key stakeholders, including local authorities, commissioners and academic partners*

## Non-executive directors

### Christopher Smallwood

#### Chairman

##### **No declared interests**

##### **Membership of committees**

- › Finance and Performance Committee (Chair)
- › Nominations and Remunerations Committee (Chair)
- › Workforce and Education Committee
- › Foundation Trust Programme Board (Chair)

### Emma Gilthorpe

#### Non-executive director and deputy chair (until July 2012)

##### **Declared interests**

- › Director of Regulation, British Airports Authority
- › Non-executive director, London First

##### **Membership of committees**

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

### Professor Peter Kopelman

#### Non-executive director

##### **Declared interests**

- › Board member, Medical Education England
- › Governance Board member, Centre for Workforce Intelligence
- › Member, Department of Health Strategic Education Funding Advisory Group
- › Board of Trustees, University of London
- › Membership of committees
- › Workforce and Education Committee

### Dr Graham Hibbert

#### Non-executive director (until September 2012)

##### **No declared interests**

##### **Membership of committees**

- › Workforce Committee (Chair)
- › Finance and Performance Committee
- › Audit Committee
- › Nominations and Remunerations Committee

### Paul Murphy

#### Non-executive director (to July 2013)

##### **Declared interests**

- › Chief Executive, Jordans Ryvita
- › Trustee, Prince's Countryside Fund

##### **Membership of committees**

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

### Mike Rappolt

#### Non-executive director

##### **Declared interests**

- › Chairman, Wimbledon Civic Theatre Trust
- › Various shareholdings (all under 1% of company)

##### **Membership of committees**

- › Audit Committee (Chair)
- › Nominations and Remunerations Committee
- › Finance and Performance Committee

### Sarah Wilton

#### Non-executive director designate

##### **Declared interests**

- › Non-executive director, Capita Managing Agency and Hampden Members' Agency
- › Director/trustee and Vice Chair, Paul's Cancer Support Centre
- › Magistrate, South West London Magistrates' Court

##### **Membership of committees**

- › Audit Committee
- › Nominations and Remunerations Committee
- › Finance and Performance Committee
- › Quality and Risk Committee
- › Foundation Trust Programme Board

## Dr Judith Hulf

### Non-executive director (from January 2013)

#### **Declared interests**

- › Responsible Officer and Senior Medical Advisor, General Medical Council

#### **Membership of committees**

- › Quality and Risk Committee
- › Audit Committee

## Stella Pantelides

### Non-executive director (from January 2013)

#### **Declared interests**

- › Consulting, General Dental Council and various private sector companies
- › Commissioner, Judicial Appointments Commission and Civil Service Commission
- › Non-executive director of Service Personnel Board, Ministry of Defence
- › Member, School Teachers' Review Board (STRB)

#### **Membership of committees**

- › Workforce and Education Committee
- › Finance and Performance Committee

## Executive directors

## Miles Scott

### Chief executive

#### **No declared interests**

#### **Membership of committees**

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

## Dr Ros Given-Wilson

### Medical director

#### **No declared interests**

#### **Membership of committees**

- › Quality and Risk Committee
- › Workforce and Education Committee
- › Finance and Performance Committee
- › Foundation Trust Programme Board

## Professor Alison Robertson

### Chief nurse and director of operations

#### **Declared interests**

- › Deputy chair, Association of UK University Hospitals Nurse Directors Forum

#### **Membership of committees**

- › Finance and Performance Committee
- › Quality and Risk Committee
- › Audit Committee (attendee)
- › Foundation Trust Programme Board

## Richard Eley

### Director of finance (until April 2012)

#### **Declared interests**

- › Chairman – Chartered Accountants in Business for Thames Valley

#### **Membership of committees**

- › Finance and Performance Committee

## Dominic Sharp

### Interim director of finance (May 2012)

#### **No declared interests**

#### **Membership of committees**

- › Finance and Performance Committee

## Dr Trudi Kemp

### Director of strategic development

#### **No declared interests**

#### **Membership of committees**

- › Foundation Trust Programme Board

## Bill Boa

**Interim director of finance and performance (from June to August 2012)**

**No declared interests**

**Membership of committees**

- › Finance and Performance Committee
- › Commercial Board
- › Audit Committee
- › Foundation Trust Programme Board

## Steve Bolam

**Director of finance, performance and informatics (from September 2012)**

**No declared interests**

**Membership of committees**

- › Finance and Performance Committee
- › Commercial Board
- › Audit Committee (attendee)
- › Foundation Trust Programme Board

## Executive directors – non-voting

### Neal Deans

**Director of estates and facilities (Joint post with St George's, University of London from September 2012)**

**Declared interests**

- › Member of executive team, St George's, University of London

**Membership of committees**

- › Quality and Risk Committee
- › Finance and Performance Committee
- › Foundation Trust Programme Board

## Peter Jenkinson

**Trust secretary (until June 2012)**

**Director of corporate affairs (from July 2012)**

- › No declared interests

**Membership of committees**

- › Quality and Risk Committee
- › Finance and Performance Committee
- › Audit Committee (attendee)
- › Workforce and Education Committee
- › Foundation Trust Programme Board

## Jean-Pierre Moser

**Director of communications (until September 2012)**

**Declared interests**

- › Committee member, Chartered Institute of Public Relations (CIPR) Health and Medical Group (unpaid)

**Membership of committees**

- › Workforce and Education Committee
- › Foundation Trust Programme Board

## Wendy Brewer

**Joint director, human resources**

**Declared interests**

- › Director, St George's, University of London
- › Mentor, Kids Company
- › Member, Steering Committee of South Bank University Technical College

**Membership of committees**

- › Workforce and Education Committee
- › Finance and Performance Committee
- › Foundation Trust Programme board

Full biographies for each of our executive directors are available on our website at:

[www.stgeorges.nhs.uk/aboutbiog.asp](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 attendance

Name	May 2012	Jul 2012	Sep 2012	Nov 2012	Jan 2013	Mar 2013
Christopher Smallwood	✓	✓	✓	✓	✓	✓
Paul Murphy	✓	✓	✓	✓	✓	✓
Mike Rappolt	✓	✓	✗	✓	✗	✓
Emma Gilthorpe	✓	✓				
Graham Hibbert	✓	✓	✗			
Sarah Wilton	✗	✓	✓	✓	✓	✗
Judith Hulf					✓	✗
Stella Pantelides					✓	✓
Peter Kopelman	✓	✓	✓	✓	✓	✗
Miles Scott	✓	✓	✓	✓	✓	✓
Ros Given-Wilson	✓	✓	✓	✗	✓	✗
Alison Robertson	✓	✓	✓	✓	✓	✓
Bill Boa		✓				
Steve Bolam			✓	✓	✓	✓
Neal Deans	✓	✓	✗	✗	✓	✓
Peter Jenkinson	✓	✓	✓	✓	✓	✓
Trudi Kemp	✓	✓	✓	✓	✓	✗
Wendy Brewer	✓	✓	✓	✓	✓	✓
Jean-Pierre Moser	✓	✗				

### Finance and Performance Committee attendance

Name	Apr 2012	May 2012	Jun 2012	Jul 2012	Aug 2012	Sep 2012	Oct 2012	Nov 2012	Dec 2012	Jan 2013	Feb 2013	Mar 2013
Christopher Smallwood	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓
Steve Bolam						✓	✓	✓	✓	✓	✓	✓
Neal Deans	✓	✓	✓	✓	✓	✗	✓	✗	✓	✓	✓	✓
Wendy Brewer	✗	✓	✓	✓	✗	✓	✓	✗	✗	✓	✗	✓
Graham Hibbert	✓	✓	✓	✓	✓	✗						
Peter Jenkinson	✓	✓	✓	✓	✗	✓	✓	✓	✓	✗	✓	✓
Mike Rappolt	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	✗	✓
Alison Robertson	✓	✓	✓	✓	✓	✗	✓	✓	✓	✗	✗	✓
Miles Scott	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓
Ros Given-Wilson	✓	✗	✓	✓	✓	✓	✓	✗	✓	✗	✗	✗
Sarah Wilton	✗	✗	✓	✓	✓	✓	✓	✓	✓	✓	✗	✗
Bill Boa			✓	✓	✓							
Stella Pantelides										✓	✓	✗
Richard Eley	✓											

## Quality and Risk Committee attendance

Name	May 2012	Jul 2012	Sep 2012	Nov 2012	Jan 2013	Mar 2013
Emma Gilthorpe	✓	✓				
Sarah Wilton			✓	✗	✓	✓
Alison Robertson	✓	✓	✓	✓	✓	✓
Peter Jenkinson	✓	✓	✓	✓	✓	✗
Neal Deans	✓	✓	✓	✗	✓	✓
Jacqueline McCullough	✓	✓	✓	✓	✓	✓
Ros Given-Wilson	✓	✓	✗	✓	✗	✓
Paul Murphy	✓	✗	✓	✓	✗	✓
Judith Hulf					✓	✓

## Workforce and Education Committee attendance

Name	May 2012	Jul 2012	Sep 2012	Nov 2012	Mar 2013
Christopher Smallwood	✓	✓	✗	✗	✗
Wendy Brewer	✓	✓	✓	✓	✓
Ros Given-Wilson	✗	✗	✓	✓	✓
Graham Hibbert	✓	✓	✓		
Peter Jenkinson	✓	✓	✓	✓	✓
Peter Kopelman	✓	✓	✗		✓
Stella Pantelides					✓

## Foundation Trust Programme Board attendance

Name	Apr 2012	May 2012	Jun 2012	Jul 2012	Aug 2012	Sep 2012	Oct 2012	Nov 2012	Dec 2012	Jan 2013	Feb 2013	Mar 2013
Christopher Smallwood	✓	✓	✓	✗	✓	✓	✓	✓	✗	✓	✓	✗
Miles Scott	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓	✗	✗
Steve Bolam						✓	✓	✓	✓	✗	✗	✓
Peter Jenkinson	✓	✓	✗	✓	✗	✓	✓	✓	✓	✓	✓	✗
Neal Deans	✓	✗	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓
Alison Robertson	✓	✓	✓	✗	✓	✓	✓	✗	✓	✓	✗	✓
Wendy Brewer	✗	✓	✓	✗	✗	✓	✗	✓	✗	✗	✓	✓
Ros Given-Wilson	✓	✓	✗	✓	✗	✗	✓	✗	✗	✓	✗	✗
Jean-Pierre Moser	✗	✗	✗	✗	✗							
Trudi Kemp	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓
Bill Boa			✓	✓	✓							
Sarah Wilton	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓



## Commercial Board attendance

Name	May 2012	Nov 2012	Dec 2012	Feb 2013
Paul Murphy	✓	✓	✓	✗
Christopher Smallwood	✓	✗	✗	✗
Miles Scott	✓	✓	✓	✓
Neal Deans	✓	✗	✗	✓
Emma Gilthorpe	✓			
Trudi Kemp	✗	✗	✓	✓
Steve Bolam		✓	✓	✓
Peter Jenkinson	n/a	n/a	n/a	✓

## Nominations and Remunerations Committee attendance

Name	Apr 2012	Oct 2012
Christopher Smallwood	✓	✓
Paul Murphy	✓	✓
Emma Gilthorpe	✓	
Graham Hibbert	✓	
Mike Rappolt	✓	✓
Sarah Wilton	✓	✓
Peter Kopelman	✓	✓
Judith Hulf		
Stella Pantelides		

## Audit Committee

The audit committee is a committee of the board of directors. The committee has four main roles:

- *To review and independently scrutinise the trust's systems of clinical governance, internal control and risk management. This ensures through proper process and challenge that integrated governance principles are embedded and practised across all St George's activities and that they support the achievement of the trust's objectives.*
- *To review key internal and external financial, clinical, fraud and corruption and other policies, reports and assurances functions, in order to provide independent assurance on them to the St George's Board.*
- *To review the integrity of financial statements prepared on the trust's behalf*
- *To undertake all other statutory duties of an NHS Audit Committee*

Grant Thornton were appointed as our external auditors in November 2012 following a competitive tender process. Before this, our external audit service was provided by the Audit Commission. The audit committee reviews the work and findings of the external auditor and considers the implications and management's responses to their work.

Fees for the year are shown below:

Expenditure	2012/13	2011/12
External audit fees	£188,000	£262,000
Other external auditor's remuneration	£0	£297,000
<b>Total</b>	<b>£188,000</b>	<b>£559,000</b>

## Audit Committee attendance

Name	Jun 2012	Sep 2012	Nov 2012	Feb 2013	Mar 2013
Mike Rappolt (Chair)	✓	✓	✓	✓	✓
Graham Hibbert	✓	✗			
Sarah Wilton	✗	✓	✓	✗	✗
Emma Gilthorpe	✗				
Judith Hulf				✓	✓
Peter Jenkinson	✗	✓	✓	✓	✓
Bill Boa	✗				
Steve Bolam		✓	✓	✓	✓
Alison Robertson	✓	✗	✓	✗	✓
Paul Murphy	n/a	n/a	✓	n/a	n/a

## Our community

As the largest healthcare provider in south west London, St George's has an important role to play in the local economy, and by becoming a responsible corporate citizen we will demonstrate our commitment to the community.

We take corporate citizenship very seriously and has developed a framework which ensures we work positively with our partners in the local community and surrounding areas. This includes with other hospitals, GPs as well as educational establishments such as St George's, University of London and Kingston University.

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

### Working together with Wandsworth Council

St George's, NHS Wandsworth, local GPs and pharmacists and Wandsworth Council have been working together over the last 18 months on the Planning All Care Together (PACT) programme.

PACT puts service users, patients and carers at the heart of service delivery and uses the strengths of NHS and council services as well as the voluntary sector to design and deliver innovative approaches to care, which better meets the needs of people with long term conditions in Wandsworth.

The programme is aimed at patients with a number of chronic health conditions. Rather than assessing and treating each patient's individual condition separately, patients are reviewed and a more holistic plan of care is developed, working with primary care professionals and local pharmacies.

A key part of the process is supporting patients to become experts in managing their own care through improving access to education and self management programs.

New technologies also have an important role to play. Assistive technologies like telehealth and telecare are already supporting people to stay at home for as long as possible and helping patients to increase and maintain their independence.

### Working together with local students



This year, St George's and Hammersmith and Fulham Action on Disability (HAFAD) teamed up to give students with learning disabilities of Cricket Green School in Mitcham the chance to gain valuable work experience.

The trust and the school have been running the Project SEARCH scheme in collaboration with HAFAD and Merton Council since November 2012. The Project SEARCH scheme helps people with moderate or severe learning difficulties experience employment, providing a series of work placements at a host organisation.

Students have been working across different departments at St George's Hospital, Tooting, including estates and facilities, cardiothoracic outpatients and hospital records. This has allowed them to learn and master competitive work skills.

Training programmes like Project SEARCH are a unique collaboration between an education provider, a service organisation and a business that provides real work experience for students to build their confidence and ensure they gain competitive and marketable skills.

## Opening our doors to the community

In October, we opened our doors to members of the public for the 2012 St George's Community Open Day.

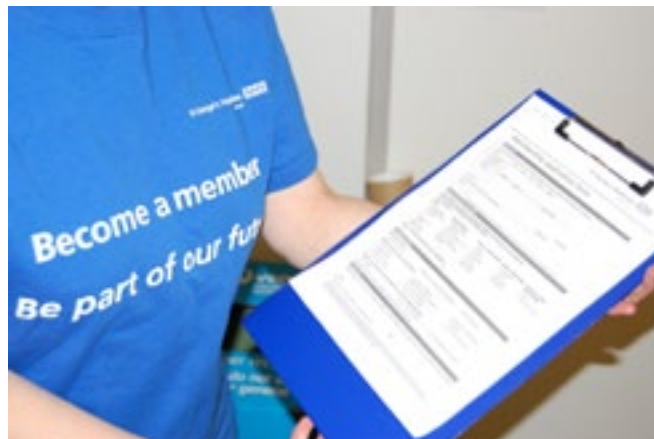
Members of the community of all ages were invited to take a behind-the-scenes glimpse at the workings of a busy NHS hospital and university. The day showcased around 40 of the hospital's departments and visitors enjoyed guided tours of one of the hospital's operating theatres, CT scanner and the simulation unit, while many took a step back in time to learn more about the history of St George's.

University researchers were on hand to speak about their pioneering projects into new medicines and treatment, while student ambassadors provided practical demonstrations of bandaging skills, blood pressure monitoring and prosthetic-finger making.

Miles Scott, chief executive, said: "My thanks to everyone who came along and I hope that everyone enjoyed themselves. I look forward to future events celebrating both the trust and university."



## Engaging with our membership



Our public members are becoming increasingly better engaged as we head towards Foundation Trust status, and we have been able to become efficient with keeping all informed.

Upon joining, members are asked if they would prefer to receive their communications by email, which has considerable benefits for the trust in terms of cost and paper consumption. Nearly half of our members now receive communications by email, including the trust's magazine, the gazette.

Our successful series of members' health lectures have continued. Events in 2011/12 included lectures on diabetes, heart attacks and the brain. Lectures are free and always open to both public and staff members to attend.

This year, members were able to hear more about the work of our alcohol liaison team, who assess patients' alcohol consumption and offer support where necessary.

A set of heritage tours of both St George's Hospital and St George's, University of London (SGUL) were very popular with our members last year and more sessions were put on to meet demand.

This year we will begin the process of bringing together our Council of Governors ready for our authorisation as an FT. This will involve a number of information sessions for prospective governors, as well as the nominations and election process.

## Working with Local Involvement Networks (LINks) and Healthwatch

Local Involvement Networks (LINks) are independent bodies made up of selected patient representatives from across the community. They act as watchdogs and hold local health and 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. LINK meetings also provide an opportunity to investigate issues that individual patients may have with the health-care they receive.

From April 2013, LINks will be replaced by local Healthwatch groups, which will continue to work to represent the views of people who use health and care services. Regional Healthwatch groups will also report directly to Healthwatch England, who can raise matters of concern to the Care Quality Commission (CQC). We look forward to working with local Healthwatch groups in the coming year to provide better healthcare for our patients.

For more information about local Healthwatch groups visit:

- *Healthwatch Wandsworth*
- *Healthwatch Merton*
- *Healthwatch Sutton*
- *Healthwatch Lambeth*
- *Healthwatch Croydon*
- *Healthwatch Richmond*
- *Healthwatch England*

## Sustainability report

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 recovered or recycled 486.6 tonnes of waste in 2012/13. This is an increase of over 100 tonnes compared to 2011/12 and equal to 17 per cent of the total waste we produce.

Our total energy consumption for the year was 121,366 MWh. Our energy costs also increased by six per cent during the year.

Renewable energy represented 10 per cent of our total energy use, and we also generated 38 per cent of our electricity on site. All electricity imported from the National Grid is generated from renewable sources.

Our measured greenhouse gas emissions have increased by 3,509 tonnes this year.

Our water consumption has increased by 27,922 cubic metres in the recent financial year. In 2012/13 we spent £287,984 on water.

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 gross expenditure on the CRC Energy Efficiency Scheme was £283,344.

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. 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 with the goods and services we procure.

Our director of estates and facilities is the Board-level lead for sustainability. This ensures that sustainability issues have visibility and ownership at the highest level of the organisation.

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.

The trust 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.

## Charities at St George's

The trust is supported by a number of charities, both national and local. Through their fundraising, vital funds are raised for projects, equipment and services which can make a real difference to patient care and experiences. Below are the profiles of charities who work with St George's.

### Giving to George's – St George's Hospital Charity

The trust and St George's Hospital Charity share a very important relationship. Through working together, the lives and experiences of patients at the trust can be improved.

The work of the Charity includes fundraising and grant-giving. It supports the work of the trust by:

- *Enhancing the physical environment of the hospital for patients, staff and visitors through refurbishment and building projects*
- *Funding clinical research*
- *Helping to fund state-of-the-art equipment*
- *Supporting St George's staff through training and development*

By raising money the Charity can fund projects which touch the lives of the thousands of people care for by the trust each year.

You can find out more about St George's Hospital Charity by visiting the Giving to George's website [www.givingtogeorges.org.uk](http://www.givingtogeorges.org.uk) – here you can also find a short film which tells you more about the work of the charity.

Highlights of the charity's year included:

- *Take That singer Mark Owen opening a new children's garden at St George's in April. The educational garden has been designed for inpatients and outpatients, and provides an area for rest, relaxation and learning. The garden was made possible thanks to donations from the Christian Blandford Fund, the Max Temple Thompson fund and the Paediatric Unit Fund.*
- *John McFall, Paralympian and former patient, returned to Queen Mary's Hospital in July to celebrate a series of Movement and Music classes led by Rambert Dance Company for amputee patients*
- *HRH Princess Alexandra officially opened the paediatric intensive care unit (PICU) in September, the refurbishment of which was generously funded by the Giauque family*
- *Television presenter, singer and actress Toyah Willcox officially opened a new children's art exhibition at St George's Hospital in October*
- *A massive £16,300 total was raised from Christmas collections at the Royal Albert Hall, which was shared with Paul's Cancer Support Centre in Clapham*
- *Dame Ruth Carnall, NHS London's chief executive, officially opened the fully refurbished and modernised emergency department at St George's Hospital*

### First Touch

First Touch is the neonatal charity for St George's Hospital, funding vital medical equipment, specialist nurse training and a welfare scheme for families on the neonatal unit (NNU).

The charity have recruited 'ambassadors' in Tooting, Balham, Wandsworth, Wimbledon, Raynes Park and Colliers Wood to raise the profile of the charity, and will be looking to recruit more in the coming months.

First Touch also gained national attention in May when two of its patrons, actress Martine McCutcheon and her fiancé Jack McManus, won £30,000 for the charity as part of their appearance on ITV game show All Star Family Fortunes.

During the year 2012/13 First Touch funding initiatives have included:

- £21,000 for a Family-Centred Coordinator post
- £75,000 for three ventilators
- £15,000 for a breast milk pasteuriser
- £400 for Christmas stockings for babies on the neonatal unit

For more information about First Touch, visit [www.first-touch.org.uk](http://www.first-touch.org.uk). You can also find the charity on Facebook or follow on Twitter @FirstTouchNNU

## Full Circle Fund

The Full Circle Fund is dedicated to enhancing the quality of life of patients through pioneering supportive therapies. Based in haematology, oncology and paediatric wards, the Fund's services benefit adults, babies and children with life-threatening conditions.

A range of therapies offered by the Fund aim to achieve improved quality of life, a reduction of anxiety, improvements in sleeping, feelings of wellbeing and control and a reduction in the perception of pain.

The Fund works in three key areas:

- **Therapy** – *quality of life support and training programmes for patients*
- **Research** – *scientific research and evaluation for better understanding of supportive therapies and survivorship*
- **Education** – *informing and educating healthcare professionals and the general public about the role and benefits of supportive therapy*

You can find out more about the Full Circle Fund by visiting their website [www.fullcirclefund.org.uk](http://www.fullcirclefund.org.uk). You can also visit their Facebook page.

## Friends of St George's Hospital

The Friends have been part of St George's Hospital for more than 60 years, first at Hyde Park Corner and now in Tooting.

The aims of the Friends have remained unchanged; to help and support patients and staff. There have of course been huge changes over the years; originally the Friends provided items for patients that were regarded as 'icing on the cake'.

However, medicine is always evolving and incredible life-saving technology is very expensive. Any trust department can apply for funding and our Trustees will carefully consider all requests, as we strive to meet the wishes of the trust and the ever evolving needs of clinicians.

The Friends of St George's can be contacted on 020 8725 2125 or by emailing [friends@stgeorges.nhs.uk](mailto:friends@stgeorges.nhs.uk)



## Ronald McDonald House, St George's Hospital

Ronald McDonald House Charities keeps families together so children in hospital can get the love and comfort they need. The charity provides 'home away from home' accommodation for families with children in hospital; somewhere free to stay for as long as they need to.

The mission of Ronald McDonald House Charities is to ensure there are sufficient funds and expertise to develop and sustain free accommodation at specialist children's hospital in the UK.

The House at St George's Hospital is one of 14 across the UK. Many families travel miles from home so that their child can receive expert medical care and many have to remain in hospital for months at a time. Without our local Ronald McDonald House, parents would have to sleep on a chair by their child's bed, or pay vast sums of money for hotel accommodation.

The Ronald McDonald House has eight en suite bedrooms, a kitchen, children's playroom, lounge, laundry facilities and a garden. They look after 200 families each year whilst their children are being cared for at St George's Hospital.

As an independent charity, the charity relies on the support and generosity of families, volunteers and donors. It is because of fundraising efforts that they are able to look after families with children in hospital.

There have been a number of fundraisers in aid of Ronald McDonald House Charities this year, including:

- *70 members of staff from local McDonald's restaurants played in a five-a-side football tournament and raised £1450 for the Tooting House in September*
- *In December, the Tooting House held its annual raffle where families, supporters and staff gathered to draw the winners. Major donor Kalpesh Patel donated a cheque for £20,000 for the House.*
- *The Prime Minister's wife, Samantha Cameron, hosted a reception at Downing Street in February in recognition of the work of Ronald McDonald House Charities across the UK. St George's Healthcare chief executive Miles Scott attended, along with other selected healthcare professionals, MPs and supporters.*

For more information on Ronald McDonald House Charities, visit their website at [www.rmhc.org.uk](http://www.rmhc.org.uk). You can also find the charity on Facebook or follow their Twitter account @RMHCUK.

# 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 including internal control that supports the achievement of the organisation's policies, aims and objectives. I am also responsible for the propriety and regularity of accounting for the public funds entrusted to this organisation 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.

This statement covers the financial year April 2012 to March 2013 and up to the date of signature (6th June 2013).

## 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 [page 64](#) of this report.

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.*

Senior leadership in corporate governance is provided by the director of corporate affairs 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.

## Care Quality Commission inspections in 2012/13

In January 2013 the Care Quality Commission undertook a routine but unannounced inspection of the St George's Hospital site (Tooting). The CQC's findings against the essential standards for quality and safety are summarised below:

CQC Outcome	Description	Finding	Impact
1	Respecting and involving people who use services	Action needed	Moderate
4	Care and welfare of people who use services	Action needed	Moderate
5	Meeting nutritional needs	Action needed	Minor
7	Safeguarding people who use services from abuse	Standard met	n/a
8	Cleanliness and infection control	Action needed	Moderate
13	Staffing	Action needed	Minor
14	Supporting workers	Standard met	n/a
21	Records	Action needed	Minor

The trust takes the non-achievement of these six essential standards of quality and safety extremely seriously and has developed a robust action plan to ensure future compliance. This has been shared with the CQC. The action plan has been designed to both address the individual issues of non-compliance and to achieve wider organisational learning, in order to ensure the consistent delivery of high standards of care. The implementation of these actions will be governed by the trust's quality and risk committee.

There were no other CQC inspections of the trust during the year.

## 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 shown on [page 65](#) 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 Adult Care and Health 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 the chart on [page 65](#)).

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. An online governance solution has been implemented that provides real time data to the Board and management teams with information and assurances needed to plan, manage and report on objectives, risks, action plans and regulatory obligations.

The executive management team and the quality and 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 is provided through the trust's current Level 2 accreditation with the National Health Service Litigation Authority (NHSLA) risk management standards. This is a comprehensive assessment of how well the policy framework that governs risk management in a NHS organisation is embedded. In February 2013 the trust also achieved level 3 accreditation (the highest level) in the Clinical Negligence Scheme for Trusts maternity clinical risk management standards.

## **New risks identified in 2012/13**

The following risks were identified and added to the Board assurance framework during 2012/13, and the associated controls overseen by the executive management team and the quality and risk committee:

- 1.** *Due to increasing pressures on internal capacity the trust may be unable to meet demands from future activity. This may have a negative effect on a number of crucial areas in the trust including 18 weeks targets, single sex accommodation, ICU and A&E*
- 2.** *Failure to provide adequate supporting evidence for all the CQC essential standards of quality and safety*
- 3.** *Volume risks*
  - a)** *Tertiary competition. Activity and associated income/contribution will be lost due to competition from other specialist service providers resulting in reductions in tertiary market share*
  - b)** *Decommissioning of services. Activity and associated income / contribution will be lost from services decommissioned due to risks to the safe delivery of care, changing national guidance and centralisation plans*
  - c)** *Any Qualified Provider competition. Activity and associated income/contribution will be lost due to competition from any Quality Providers and Service Line tenders*
- 4.** *Tariff risks*
  - a)** *The tariffs applicable to trust clinical services are adversely changed as a result of national tariff changes, local tariff changes, specialist commissioning, changes, transfer of tariff responsibilities to Monitor*
  - b)** *Emergency Threshold Tariff. The trust's income and service contribution is reduced due to application of 30% tariff to emergency activity exceeding the contract thresholds*
  - c)** *CQUIN premium. Trust income is not maximised due to failure to deliver required performance against CQUIN quality standards*
  - d)** *Performance, penalties and payment challenges. Trust income is reduced by contractual penalties due to poor performance against quality standards and KPIs, payment challenges*
- 5.** *Cost reduction slippage. The trust does not deliver its cost reduction programme objectives:*
  - a)** *to meet the level of savings in the 2012/13 plan*
  - b)** *to achieve the 2012/13 savings recurrently*
  - c)** *to detail savings plans for the next two years*

6. *Cost pressures. The trust faces higher than expected costs due to unforeseen service pressures and/or higher than expected inflation*
7. *Minimise service costs. The trust faces higher than expected costs due to higher marginal costs, i.e. higher than expected investment required to deliver service increases*
8. *Tariff risk. Multi professional education and training (MPET) income will be lost due to the review of education funding arrangements*
9. *Increased uncertainty in south west London because of failure of Epsom / Ashford & St Peter's Hospitals merger and consequent delay to Better Services, Better Value programme*
10. *Research does not form key part of SGH future activity – potential associated loss of funding/ability to recruit and retain staff*
11. *Risk to patient safety of inappropriate anti-microbial prescribing due to conflicting and out of date guidance*
12. *Ability of trust to demonstrate compliance with Regulatory Reform (Fire Safety) Order 2005.*

The table on [page 67](#) details those risks that were closed or removed from the Board Assurance Framework in 2012/13.

## Data security breaches

The trust had no data security breaches that were eligible to be reported to the Information Commissioner's Office during 2012/13.

## Performance against national priorities set out in the NHS Operating Framework 2012/13

During 2012/13 the trust has demonstrated strong performance against the key performance indicators. Key achievements this year include:

- *Achievement of A&E 4 hour waiting time target*
- *Achievement of all cancer waiting time targets*
- *Achievement of the 18 week waiting time target for admitted and non-admitted patients.*

The trust did not achieve its agreed minimum thresholds for MRSA and C.Difficile infections. A comprehensive infection control action plan and refreshed policies are in place to strengthen infection control measures throughout the trust.

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.

## 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 me with significant assurance that the internal controls are operating effectively within the fundamental financial systems, as a whole. In other internal audits carried out, a range of assurances from significant assurance to limited assurance have been given. The limited assurance reports were Choose and Book, Rheumatology Homecare Drugs and arrangements

for the management of bribery risks. The head of internal audit has stated that in all cases, management has taken a positive approach and developed action plans to address the issues raised and considers that the trust will build upon the improvements already achieved during the year.

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 full range of internal audits undertaken in the year and the associated level of assurance are included in the table on [page 66](#).

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 2012/13, included on [page 72](#) of this report, and the governance system described above has been used to validate its content and the data on which it is based.

I consider that non-compliance with the six CQC essential standards for quality and safety to be significant issues, and all appropriate corrective action will be 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.

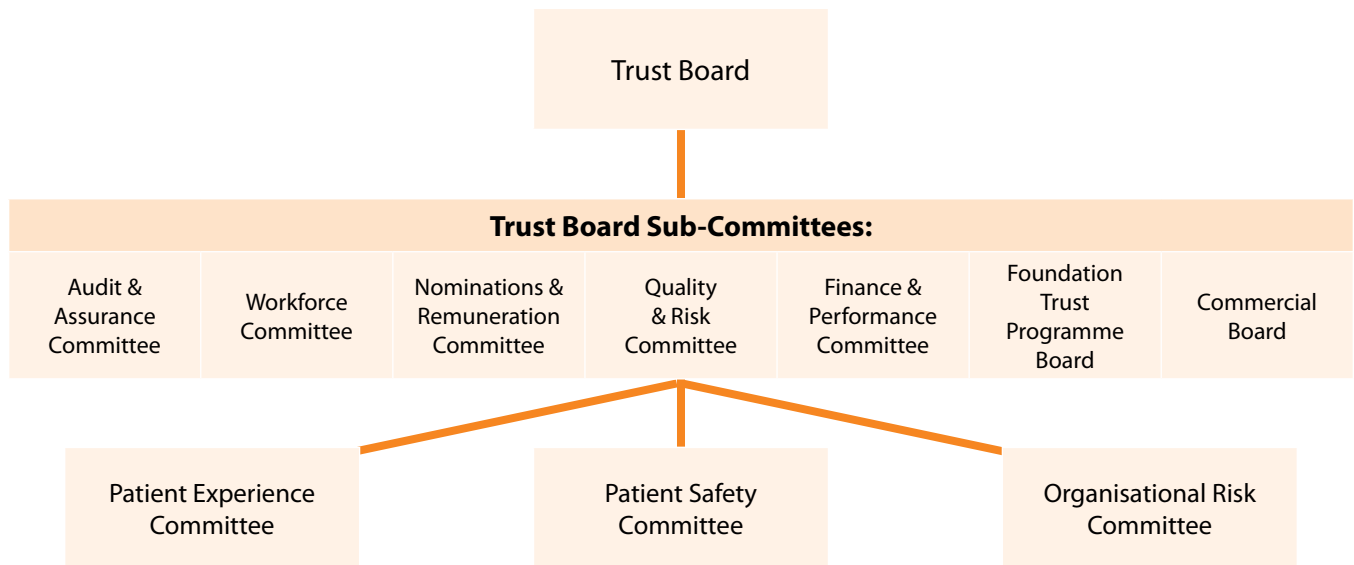


**Alison Robertson**  
**Acting chief executive**

St George's Healthcare NHS Trust

6th June 2013

## Governance framework



There is two-way reporting between each of the four clinical divisions and the governance committee framework of Patient Safety, Patient Experience and Organisational Risk committees.

Each of these committees has divisional governance leads as members, with twice yearly reporting from each division.

**St George's Healthcare NHS Trust has four Clinical Divisions:**

Women & Children, Therapies And Critical Care	Medicine And Cardiothoracic Services	Surgery, Theatres, Neurosciences And Cancer	Community Services
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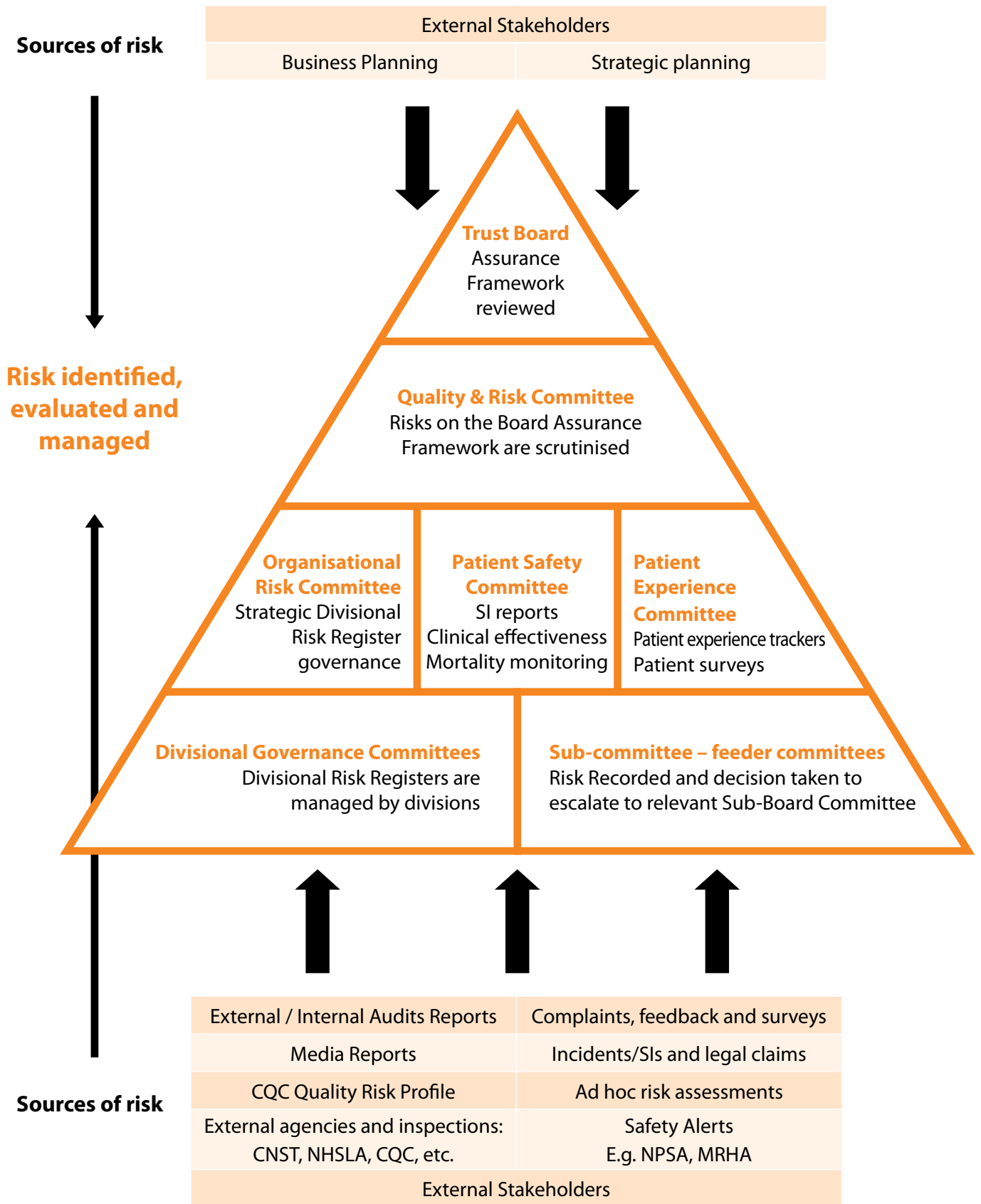
**Divisional Governance Structure**

Each of the clinical divisions has an established governance framework, at the top of which each division has a divisional management board and divisional governance committee.

These committees manage all aspects of governance within each division and seek and receive assurance from across their respective care groups.

Each of the divisional directors of nursing and governance are substantive members of the committees of Patient Safety, Patient Experience and Organisational Risk.





## Internal audit reports issued in 2012/13

Topic	Assurance Level
<b>Patient Safety and Service Quality</b>	
Outpatients	Reasonable
Waste Management	Reasonable
Decontamination	Reasonable
<b>Governance</b>	
Assurance Framework and Risk Register	Reasonable
CQC Registration Authority	Reasonable
Bribery Act	Limited
<b>Fundamental Financial Systems</b>	
Financial Ledger	Significant
Financial Reporting and Budgetary Control	Significant
Accounts Payable	Reasonable
Efficient Purchasing and Control	Reasonable
Cash Flow and Investment, Borrowing and EFL, and cashiering	Significant
Capital Asset Register/ Capital Charges	Significant
Stores – cyclical coverage	Significant
<b>Income</b>	
Income and Debtors System	Significant
NHS Service Agreements	Significant
Rheumatology Homecare Service	Limited
<b>Human Resources and Payroll</b>	
ESR Payroll System Management	Reasonable
Consultant Job Plans and Appraisals	Reasonable
Bank Office Management	Reasonable
<b>Estates and Facilities</b>	
Health and Safety	Reasonable
Security	Reasonable
<b>IT/Information</b>	
Information Governance & Security/ Data Accreditation (IG Toolkit)	Reasonable
Clinical Coding	N/A – follow up review
Pathology System	Reasonable
Choose and Book	Limited
<b>Contingency</b>	
Working Capital Review	Reasonable
Working Capital – Further Review	Reasonable

## Risks closed/removed from the Board assurance framework in 2012/13

Ref	Risk Description	Reason
A531-01	Failure to maintain Paediatric oncology service	The oncology service is established with controls in place
A529-09	Failure to meet the NHS carbon reduction target	This target is on track to be met
A611	Patient safety will be negatively affected as a result of delays or disruption to patient transfers, including urgent transfers as a result of lift outages	Risk reduced to 8 and entered onto the divisional risk register
A536	Patient care compromised as result of duplicate records	Risk reduced to 8 and entered onto the divisional risk register
A525	Failure to rectify issues regarding inaccurate and incomplete data as a result of the implementation of iClip	Risk reduced to 12 and entered onto the divisional risk register
A538	Inability to investigate access or amendments to electronic patient records not retained in transaction log	Risk reduced to 8 and entered onto divisional risk register
A601	IT related disaster recovery plans and procedures not as detailed as required leading to slow recovery	Risk reduced to 6 and entered onto the divisional risk register
A526	Medical gas turned off resulting in no supply to the patient	All controls in place. Remove this risk from BAF.
A603	Risk of patients contracting Multi Drug Resistant Pseudomonas infection. 2 SI declarations in the past (most recently 2010). RCA undertaken on every patient; source of infection not located.	No new cases of pseudomonas and this risk has been at the residual risk rating of 10 for 4 months. All known controls in place
A507	Inability to create effective longer term business plans in light of the reduction in funding for NHS	Closed
A530	Failure to sufficiently address the safety issues on paediatric wards	Closed
A515	Poor results in national survey of inpatients and failure to improve thereon adversely impact patient choice and the Trust's reputation	2011 survey ranks St George's Healthcare as 'about the same' as most other trusts in the country for every question. Two areas the trust has made significant improvements in are 'doctors talking in front of patients as if they weren't there', and 'patients receiving copies of letters sent between hospital doctors and GPs once they have been discharged'.

## Our performance

There is much for St George's to be proud of in the last 12 months. A key component of the trust's mission is to provide excellent clinical care and improve the health of the populations it serves. To ensure that the services we commission meet the needs of our patients, the trust monitors its performance against the required national performance standards and its own corporate objectives on an ongoing basis.

During 2012/13 some targets have been challenging and the trust has worked hard to meet them. This will continue in 2013/14, with particular focus being placed on infection control, referral to treatment, cancer and A&E waiting times.

We have also started to prepare for and consider the key indicators associated with becoming a Foundation Trust by monitoring ourselves against the standards set out within the Monitor Compliance Framework and the Department of Health NHS Performance Framework, which sets the benchmarks required for Foundation Trusts.

The table below shows the trust's performance against these key national targets. This is followed by a more detailed explanation of these figures and targets.

Target	Threshold	2012/13	2011/12
Referral to treatment – admitted waits	90%	91.4%	81.7%
Referral to treatment – non-admitted waits	95%	96.8%	95.72%
Total time in A&E	95%	96%	96.2%
Cancer – Two week waits	93%	95%	95.6%
Cancer – breast symptoms	93%	93.4%	95.5%
All cancer – 31 day waits from diagnosis to first treatment	96%	97.8%	97.8%
All cancer – 31 day waits from diagnosis to first treatment (drugs)	98%	100%	100%
All cancer – 31 day waits from diagnosis to first treatment (surgery)	94%	98.9%	98%
All cancer – 62 day waits for first treatment	85%	88%	88.9%
All cancer – 62 day waits for first treatment (screening referral)	90%	94.7%	95.13%
Data completeness community services	Compliance	Compliant	Compliant
Clostridium difficile infections	52	62	86
MRSA infections	2	9	1
CQC registration	Compliance	Compliant	Compliant
Mixed sex accommodation breaches	-	274	361

## Infection control

### Clostridium difficile (C.diff) infections

Infections 2012/13	Infections 2011/12
62	86

This year the trust reported 62 C.diff infections against a full year threshold of 52 cases. This position is significantly reduced from the previous year when the trust reported 86 cases for the same period, representing a reduction of 28 per cent.

Whilst this is a positive reduction in the number of cases, there are still improvements to be made. Our target for 2013/14 is to report no more than 45 cases, but our ambition is to reduce this number to zero avoidable cases.

### MRSA bacteraemia (bloodstream) infections

Infections 2012/13	Infections 2011/12
9	1

The trust detected nine MRSA cases against a threshold of two infections for the year. The majority of these cases occurred in a two-month period. This figure is against a background of only two hospital-acquired bloodstream infections in the preceding 18 months.

For 2013/14 we aim to meet our target of zero avoidable cases of MRSA by implementing our comprehensive infection control action plan and using refreshed policies to strengthen our infection control measures across the trust.

Read more about infection control on [page 115](#).

### Mortality rates

St George's Healthcare was 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 only one of 16 in the country to have statistically significant lower than expected mortality rates.

Read more about the trust's mortality rates on [page 99](#).

### Referral to treatment

Improving access to services by reducing patient waiting times has been a key objective for St George's Healthcare in 2012/13.

This year, 96.8 per cent of our non-admitted patients received their treatment within 18 weeks of referral, against a national standard of 95 per cent.

For admitted patients this figure was 91.4 per cent, against the national standard of 90 per cent.

### Accident and emergency

In 2012/13, the trust achieved the four-hour emergency access standard. Over 95 per cent of patients attending the emergency department were admitted, transferred or discharged within four hours of their arrival.

This target is affected by the effectiveness of the entire healthcare system, including GPs and social services. It is therefore important that we continue to work with its partners to ensure the four-hour standard is maintained over the next year.

The trust also measures its progress through the national A&E quality indicators, which aim to improve the quality of emergency care nationwide. The indicators are outlined below:

Target	National target	St George's Healthcare	Target met?
<b>Ambulatory emergency care</b> The percentage of A&E attendances for cellulitis and deep vein thrombosis (DVT) that end in admission	Less than 10%	DVT – 5.4% Cellulitis – 2.0%	✓
<b>Unplanned re-attendance rate</b> Unplanned re-attendance at A&E within seven days of original attendance	Less than 5%	5.0%	✓
<b>Total time in the A&amp;E department (admitted)</b> Total time spent in the A&E department for patients admitted to hospital	Less than 240 minutes	227 minutes	✓
<b>Total time in the A&amp;E department (non-admitted)</b> Total time spent in the A&E department for patients treated and discharged	Less than 240 minutes	149 minutes	✓
<b>Patients who left without being seen</b> Percentage of people who leave the A&E department without being seen	Less than 5%	3.2%	✓
<b>Time to initial assessment</b> The time from arrival at A&E to the start of full assessment, including a pain score and early warning score, for all patients presenting by ambulance	Less than 15 minutes	0 minutes	✓
<b>Time to treatment</b> Time in minutes that patients wait to be seen by a member of the clinical team who is able to diagnose and make an initial plan of treatment	No longer than 60 minutes from initial registration	38 minutes	✓
<b>Consultant sign-off</b> Percentage of patients who are reviewed by an emergency medicine consultant before being discharged	n/a	76% of patients had consultant sign-off (national figure – 71%)	n/a

## Service experience – the Friends and Family Test

From April 2013, the Department of Health's Friends and Family Test question will require patients are asked how likely they are to recommend our emergency department to friends or family if they need similar care or treatment. This will be rolled out across the trust during the next year.

Our teams are making the adequate preparations for this new requirement, and will work to implement this change during the next year.

The past year has seen the opening of the acute medicine unit, paediatric assessment unit and urgent care centre at St George's Hospital, which have contributed to promoting patient safety and experience whilst also improving pathways within the department and the wider hospital.

The trust will continue to work with its partners to ensure these standards continue to be met in 2013/14.

You can find out more about how the trust is meeting the needs of our inpatients on [page 107](#).

## Cancer

During the year the trust has met all national cancer treatment and diagnosis targets.

Cancer targets are set nationally by the Department of Health and ensure that patients who are suspected of having cancer or have been diagnosed receive treatment as quickly as possible.

Our performance against these targets are as follows:

Target	National target	Our figure for 2012/13
Patients seen within two weeks of urgent GP referral for suspected cancer	93%	95%
Patients with breast symptoms seen within two weeks of urgent GP referral for suspected cancer	93%	93.4%
Patients starting cancer treatment within 62 days of GP referral	85%	88%
Patients received their first treatment within 62 days of referral from national screening service	90%	94.7%
Patients received their first treatment within 31 days of cancer diagnosis	96%	97.8%
Patients received their subsequent chemotherapy treatment for cancer within 31 days of decision to treat	98%	100%
Patients received their subsequent surgical treatment for cancer within 31 days of a decision to treat	94%	98.9%

You can read about the trust's performance and participation in clinical audits in more detail in the quality account, which follows this section.

You can also read the trust's full 2012/13 performance report on our website at <http://www.stgeorges.nhs.uk/performanceindex.asp>.

# Quality account

## Statement by the chief executive on quality

This Quality Account for 2012/13 highlights the good work we have done and our achievements over the last year. It also points out areas where there remains room for improvement. This will guide our efforts to make the changes necessary to improve those services and to continue to deliver the best possible care to the communities and individuals whose care and treatment is entrusted to us.

## A lot to be proud of

The Quality Account 2012/13 demonstrates that St George's Healthcare NHS Trust has a huge amount to be proud of and that our commitment to placing our patients at the heart of everything we do is driving up quality across the trust. Our services have been judged by Dr Foster to be amongst the safest in the country with our mortality rates again amongst the lowest in England.

We have again met all of our annual cancer targets, ensuring that our patients receive timely expert treatment whatever service they require.

It is clear that the foundations for the future are very strong, but we must ensure that we do not allow complacency to creep in. It takes a lot of hard work to become a highly performing trust, and it needs a lot more hard work to maintain those standards.

## Room for improvement

As well as showcasing some of our strengths, importantly this report also highlights areas we are clear we need improve. For example, we are extremely disappointed not to have achieved our infection control targets this year, despite seeing rates drop from last year and a 95 per cent decrease in MRSA and C.difficile infections over the last five years. We are determined to continue reducing the number of infections in our hospitals and to achieve the high standards we set ourselves again this year.

Our patients have told us that we have made improvements to both inpatient and outpatient services in the CQC national patient surveys. However, we still have a lot of work to do before we can say that our patient experience levels match our excellent technical and clinical outcomes. We have seen important improvements in areas like maternity and outpatient services, but making sure that we have consistently high patient experience levels across all of our services is a key priority within our Quality Improvement Strategy.

In January 2013 we were subjected to a routine inspection by the CQC. During their inspection, the CQC found that six of the eight core standards inspected were not always being delivered in practice. This is clearly unacceptable. We have addressed the issues identified by the CQC and will demonstrate improved compliance when they return this summer.

## Being open and honest will help us improve

Open organisations are safer organisations, and being open and transparent about where things are not working well and why will help the people who use our services and our partners see that we are working hard to address the issues.

Having an open and honest culture, reviewing performance as part of the education process and learning how to improve our services are all very much part of what we do.

We investigate when things go wrong within an open culture where staff are empowered to report honestly in an effort to find out what went wrong and learn from it rather than solely seeking to apportion blame. We regularly hold staff open forums and patient safety forums which are an important part of reporting and learning from our mistakes. Sharing the lessons learned is the only way we can improve performance across the organisation.

Sadly, things do not always go well in hospitals and when they don't the consequences can be devastating. In July 2012 a coroner's inquest into the death of Kane Gorny at St George's Hospital in 2009



identified a series of failings in our duty of care. We can never bring Kane back, and we can never apologise enough for his death. What we can do is make sure that we learn from this tragic case. Whilst mistakes do unfortunately happen in hospitals, this is a mistake that should never have occurred. When things do not go right, we are committed to being open about our mistakes and doing all we can to learn from them.

## A bright future for St George's

These are exciting times for St George's. We are on course to achieve Foundation Trust status by next summer, which will give us greater control of our finances and more freedom to design and deliver services that meet the needs of our patients.

This spring saw the launch of the South London Academic and Health Science Network (AHSN), a new partnership that will drive lasting improvements in patient care across south London by sharing innovations across the health system and capitalising on each member's knowledge, experience and strengths in teaching and research. As well as St George's, South London AHSN members include King's Health Partners, The Royal Marsden, London Ambulance Service NHS Trust and The Royal Hospital for Neurodisability as well as a number of local authorities, hospices, community providers, GP practices and academic institutions. The launch of the AHSN positions St George's at the forefront of research and innovation and will help us to further improve the quality of our services as well as addressing the important public health issues that face people living and working in south London.

We know that giving our staff the best possible facilities and resources to treat our patients is a key factor in improving the quality of our services. Our commitment to providing the best possible environment can be demonstrated by the new neurorehabilitation facilities we are building at Queen Mary's Hospital and our plans to redevelop Lanesborough Wing at St George's Hospital into a state-of-the-art specialist children and women's hospital.

## Putting patients at the heart of everything we do

Quality is not a dashboard of statistical measurements. It is also the perception of our patients and their families and carers, and how they feel about their experience whilst under our care.

Our quality indicators are not just numbers on a spreadsheet. Not only is each number an individual patient, the overall picture is a very important tool for helping us to see where things are working and where they are not, and learning from that. We work with other organisations to learn from them as well as internally sharing information and best practice between our varied services so that we can learn from each other.

We have taken note of the Francis report into the failings which occurred in Mid Staffordshire. The most important guidance we have taken from the report is that putting patients at the centre of everything we do will ensure that the quality of our services remains consistently high.

Staff take great pride in the services they deliver and are in the NHS because they care and want to help people. As an organisation we must continue to strive to make sure our staff have the best facilities and environment to deliver the highest quality services possible, and that they are supported at every level.

We aim for a whole systems approach. High quality can only be achieved if everybody is pulling in the same direction, from the porters and health-care assistants to the most senior consultants and non-executive directors. Of course, this approach will not work if we fail to understand our place in a much wider health and social care system. Our excellent relationships with our partners in our clinical networks, social services and the charity and voluntary sectors are vital to our success.

With this in mind we have agreed a Quality Improvement Strategy which will give all of us at the trust the roadmap we need to achieve our quality priorities during 2013/14.

Schemes such as our Improvement Programme are helping us to work better, safer and smarter – using tools such as lean principles to help us work efficiently and in the most effective way for good patient outcomes. We're putting the foundations in

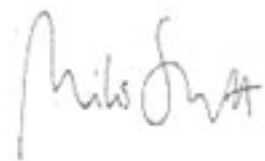
place to create a stronger, more intelligent organisation in the future, which will help us realise all of our ambitions, including step changes in quality and safety.

## A new landscape for the NHS

The changes to NHS structure and the advent of Clinical Commissioning Groups (CCGs) mean that we will be able to work even closer with our GP colleagues to develop services that put patients at their heart whilst consistently delivering the best possible outcomes.

CCGs are now responsible for commissioning and designing local health services focused on delivering better outcomes and responding to the needs and wishes of patients. There are six CCGs in South West London: Croydon, Kingston, Wandsworth, Sutton, Merton and Richmond.

Public Health England has been established to protect and improve the nation's health and wellbeing, and to reduce inequalities, with responsibility for public health in each London Borough with the respective Local Authorities. The involvement of Local Authorities is exciting for the NHS. We already enjoy a very close relationship with our Local Authorities but this gives us further opportunity to avoid duplication and maximise the potential of our resources to help improve the health and well being of the people we serve.



**Miles Scott**

Chief executive

## Phrases and terms used in this report

In this Quality Account there are a number of phrases and abbreviations used that are not commonly used outside of the NHS. We have tried to make sure that these are explained throughout the report in the relevant place. For example, we have explained that VTE stands for venous thromboembolism, a blood clot, on the VTE indicator section on [page 112](#). Below is a summary of some of the phrases and abbreviations that are more commonly used throughout this report.

### St George's

This refers to St George's Healthcare NHS Trust, incorporating St George's Hospital in Tooting and services at Queen Mary's Hospital in Roehampton, St John's Therapy Centre, HMP Wandsworth, health centres across Wandsworth and services provided in GP practices, schools, nurseries and in people's own homes.

### Patients

Throughout this report we use the term patients as a reference to anybody who uses any of the services we provide. In some services patients are more commonly referred to by other terms like service users or clients. We decided to use the term patients in this report following feedback from last year's report and discussions with stakeholders whilst planning this year's report.

### CCG

Clinical commissioning groups, the new GP-led organisations who took on responsibility for commissioning services from primary care trusts in April 2013.

### CQC

Care Quality Commission, the organisation responsible for checking all healthcare providers in England to make sure that they are meeting national standards.

### Specialist services

We provide specialist care to patients from across the country for complex pelvic trauma, family HIV care, lymphoedema and penile cancer.

### Tertiary care/services

We provide tertiary care like cancer, neurosciences, cardiac and renal services for the six boroughs of south west London and the counties of Surrey, Sussex and Hampshire.

### Secondary care/services or local acute services

We provide a range of local acute services like A&E, maternity and general surgery to the people of Wandsworth, Merton, and Lambeth.

### Community services

We provide a full range of community services, including sexual health, community nursing and services for people with learning disabilities.

### Targets

Performance targets for specific areas of clinical practice, and are designed to ensure healthcare providers maintain a strong focus on achieving and maintaining high standards, and highlighting areas where improvement is needed. Some targets are set nationally by the Department of Health, whilst others are agreed locally between St George's and the CCGs who commission our services.

### Commissioners

Commissioners are the people who buy and monitor the performance of services from healthcare providers on behalf of the people they represent. For example, services for people who live in Wandsworth are commissioned by Wandsworth CCG. Some more specialist services like family HIV care are commissioned by regional or national specialist commissioning organisations.

### CQUIN

Commissioning for Quality and Innovation (CQUIN) payment framework. The key aim of CQUINs 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 healthcare providers everywhere.

### **Dr Foster**

Dr Foster is a joint venture between The Department of Health and Dr Foster Holdings LLP. It aims to help bridge the gap between data and knowledge. Their stated objective is to promote the development of an information culture in the NHS by providing appropriate information and analysis to clinicians and managers in order to help them deliver the best quality healthcare. Dr Foster also promotes greater access to data across all public services and more intelligent use of data to understand variations in outcomes and availability of services.

### **Healthwatch**

Healthwatch organisations replaced Local Involvement Networks (LINKs) on 1st April 2013. There is a Healthwatch organisation for each borough in London. Healthwatch is the new independent consumer champion created to gather and represent the views of the public. Healthwatch will play a role at both national and local level and will make sure that the views of the public and people who use services are taken into account.

## Developing the Quality Account

All NHS trusts report the same information which allows us to benchmark our performance against other trusts. This is important for not only letting us know how we are doing, but means that trusts with similar services can learn from each other.

The Department of Health and Monitor produce guidance on what should be reported in the Quality Account for NHS trusts and NHS Foundation Trusts (FTs). As an aspiring FT, we have decided to follow the Monitor guidance, which covers all aspects of the Department of Health guidance plus additional criteria.

Every NHS trust in the country has to report against the eight mandatory indicators listed below:

- *Review of services*
- *Participation in clinical audits*
- *Research*
- *Use of CQUIN payment framework*
- *Statements from the Care Quality Commission*
- *Data Quality*
- *Information governance toolkit attainment levels*
- *Clinical coding error rate*

Trusts are also encouraged to identify at least three voluntary indicators to include in their Quality Accounts. We worked with local stakeholders to identify which indicators we would report on this year to make sure that the report was truly reflective of an integrated acute and community healthcare provider and that the areas that matter most to the people who use and provide our services are covered. These stakeholders included our patient reference group, our staff, local Clinical Commissioning Groups, Acute Commissioning Unit, South London Commissioning Support Unit, LINks/Healthwatch groups and Wandsworth Council.

We decided that because of the size of St George's and the range of services we provide, choosing only three additional indicators to report on would not be enough. The voluntary indicators we have chosen to report are the same as last year to promote consistency and to demonstrate progress over time, and three new indicators:

- *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*
- *Percentage of staff who would recommend St George's to friends or family needing care (new indicator for 2012/13)*
- *Percentage of admitted patients risk assessed for VTE*
- *Rate of c.difficile*
- *Rate of MRSA*
- *Rate of patient safety incidents and percentage resulting in severe harm or death*
- *Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers*

- *Health visiting service provision (new indicator for 2012/13)*
- *Offender healthcare medicine management (new indicator for 2012/13)*

The draft report has been shared with stakeholders throughout its development, both for assurance and to increase understanding of the value of the report and how we record the data for each indicator.

This report has been reviewed by:

- *St George's quality and risk committee*
- *St George's audit committee*
- *St George's finance and performance committee*
- *St George's executive management team*
- *St George's Board*
- *St George's Healthcare Patient Reference Group*
- *Wandsworth Healthwatch*
- *Merton Healthwatch*
- *Wandsworth Clinical Commissioning Group*
- *South London Commissioning Support Unit*
- *Wandsworth Council Adult Care and Health Overview and Scrutiny Committee*
- *Merton Healthier Communities and Older People Overview and Scrutiny Panel*

Sharing a draft version of the report with our stakeholders has given them the opportunity to provide a feedback on our performance in a formal statement. These statements are published from [page 128](#) onwards.

To put our performance into context we have compared our performance for all of the indicators in this report against our own performance over the last two years, and where possible and relevant, against the national average performance.

## Our 10 year strategy

At the end of 2012 St George's Healthcare launched a new 10 year strategy for the trust following nearly a year of development with our staff and partners. We have developed this strategy to ensure that we deliver:

- *Better health outcomes for all*
- *Empowered, engaged and well-supported staff*
- *Improved patient access and experience*
- *Inclusive leadership at all levels*

The 10 year strategy sets out a compelling vision for the future, built around delivering healthcare of exceptional quality underpinned by leading edge research and teaching.

The success of this strategy will be determined by the strength of our partnerships with our colleagues in the healthcare, social services and the voluntary and charity sectors.

In our strategy we have revised our mission (our purpose) and vision (what we want to be), and outlined our high-level plans for what we need to do to ensure that this vision is realised.

**Our mission** is to provide excellent clinical care, education and research to improve the health of the populations we serve.

**Our vision** is to become an excellent integrated care provider and a comprehensive specialist centre for south west London, Surrey and beyond with thriving programmes of education and research.

### Our goals:

- **Redesign care pathways to keep more people out of hospital**  
*We will play a key role in keeping people healthy and well at home by working with our partners in primary and social care and the charity and voluntary sector. This ranges from keeping people healthy for as long as possible to enabling those with a health condition to live as independently as possible.*
- **Redesign and reconfigure our local hospital services to provide higher quality care**  
*We need to improve the way in which we provide our local hospital services from planned surgery through to discharge planning. We will work with other NHS trusts in south west London to ensure the highest quality, sustainable configuration of clinical services.*
- **Consolidate and expand our key specialist services**  
*We will work to ensure that south west London continues to have access to a comprehensive range of specialist services available locally at St George's Hospital.*
- **Provide excellent and innovative education to improve patient safety, experience and outcomes**  
*We will build on our strong history as a teaching institute and our partnerships with St George's, University of London and Kingston University to provide excellent education.*
- **Drive research and innovation through our clinical services**  
*We will strengthen our approach to research programmes, making research a part of the trust's core business.*
- **Improve productivity, the environment and systems to enable excellent care**  
*There are some changes that we need to make to our systems and processes, such as an investment in our IT system, to ensure we are able to continue to provide the highest quality care. We will also look to make major improvements to our buildings and facilities.*
- **Develop a highly skilled and motivated workforce championing our values**  
*Services cannot be delivered without our staff and we will continue to invest in our staff to ensure that they have the right skills, and are engaged and motivated to provide consistently excellent services.*

Each year we will publish an annual plan which will set out the key annual objectives for the year ahead that we need to achieve to deliver our vision. The annual plan will be published on our website [www.stgeorges.nhs.uk](http://www.stgeorges.nhs.uk)

## Outcomes on our priorities for improvement in 2012/13

In our 2011/12 Quality Account we outlined a number of priorities for improvement during 2012/13 to ensure that we continued to raise quality throughout St George's.

The following table shows how we performed against all of these aims.

Aim	Outcome – achieved / partially achieved / not achieved
<p><b>Summary hospital level mortality indicator</b></p> <p>Maintain our performance and consistently achieve a mortality ratio which is lower than expected.</p>	<p><b>ACHIEVED</b></p> <p>In January 2013 St George's Healthcare was identified by the Health and Social Care Information Centre (HSCIC) as one of 11 trusts that have had a lower than expected mortality rate for the two years analysed to date (July 2010 to June 2011 and July 2011 to June 2012). We were also identified as one of 10 trusts that have had lower than expected mortality for each of the five quarterly publications<sup>1</sup>. In addition to our maintained summary hospital level mortality indicator performance, St George's Healthcare has again been named as one of only 16 trusts in the country to have a statistically significant lower than expected hospital standardised mortality rates (HSMR) in the 2012 Dr Foster Hospital Guide, published for the Department of Health. You can read more about our mortality rates on <a href="#">page 99</a></p>
<p><b>Patient reported outcome measures (PROMS)</b></p> <p>Improve our participation rates to match the national average.</p>	<p><b>NOT ACHIEVED</b></p> <p>Data published on 14th February 2013 which covers the period April 2012 – September 2012 suggests that this has not been met for the first six months of the year. Our participation rate stands at 51.2 per cent overall, which is lower than the national rate of 72.6 per cent</p> <p>Read more about PROMS on <a href="#">page 101</a></p>
<p><b>Quality strategy</b></p> <p>Revise existing quality strategy and launch new strategy during 2012/13</p>	<p><b>ACHIEVED</b></p> <p>In November 2012 the Trust Board approved the 2012-2017 Quality Improvement Strategy and an implementation plan was agreed in March 2013 for the period 2013 to 2017</p>
<p><b>28 day emergency re-admission rate</b></p> <p>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.</p>	<p><b>NOT ACHIEVED</b></p> <p>In 2012/13 11.8 per cent of patients were readmitted to the trust within 28 days compared to 10.4 per cent in 2011/12. Therefore we failed to reduce emergency readmissions this year.</p> <p>Read more about emergency readmissions on <a href="#">page 104</a></p>



Aim	Outcome – achieved / partially achieved / not achieved
<p><b>Responsiveness to inpatients' personal needs</b></p> <p>Improve our score for responsiveness to inpatient needs while at least remaining in the expected score range for our organisation.</p>	<p><b>ACHIEVED</b></p> <p>We achieved an overall score of 66.6 compared to 66.1 the previous year. Our 2012 score shows that overall the inpatient experience at St George's is 'about the same as other trusts', and as expected of us by the Care Quality Commission</p> <p>Read more about responsiveness to inpatients needs on <a href="#">page 107</a></p>
<p><b>Staff who would recommend the provider to friends and family</b></p> <p>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.</p>	<p><b>ACHIEVED</b></p> <p>St George's Healthcare is now ranked amongst the top 20 per cent of trusts nationally on this measure, two years ahead of our target. Our task now is to maintain and possibly improve on our performance in this area.</p>
<p><b>Percentage of admitted patients risk assessed for VTE</b></p> <p>Continue to meet national and commissioner led targets for VTE risk assessment and appropriate thromboprophylaxis.</p>	<p><b>PARTIALLY ACHIEVED</b></p> <p>The percentage of patients given appropriate thromboprophylaxis was 99 per cent against a target of 98 per cent. The percentage of patients given a VTE risk assessment was 95.2 per cent against the national target of 95 per cent. However, we have also agreed a local target of 98 per cent with our commissioners, which meant that we narrowly missed this target.</p> <p>Read more about VTE on <a href="#">page 112</a></p>
<p><b>Rate of Clostridium difficile and MRSA bacteraemia</b></p> <p>Identify no more than 52 C.diff infections at St George's Hospital. No more than two patients diagnosed with MRSA blood stream infection.</p>	<p><b>NOT ACHIEVED</b></p> <p>In 2012/13 there were 62 cases of C.diff, a 28 per cent decrease on the previous year but still above the nationally agreed target of 52. Our MRSA outcomes showed nine blood stream infections, again in breach of our national target. We are extremely disappointed to have missed the national target and have made improving our performance in these areas a top priority.</p> <p>Read more about infection control on <a href="#">page 115</a></p>
<p><b>Rate of patient safety incidents and percentage resulting in severe harm or death</b></p> <p>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</p>	<p><b>ACHIEVED</b></p> <p>There were 9,084 patient safety incidents recorded in 2012/13 compared to 9,663 the previous year. This shows that we continue to actively report as many incidents as we can, demonstrating our commitment to developing good system that enable us to learn from things that go wrong to reduce the risk of them happening again.</p> <p>Read more about patient safety on <a href="#">page 117</a></p>

Aim	Outcome – achieved / partially achieved / not achieved
<p><b>Mixed sex accommodation and patient discharge from ITU</b></p> <p>Reduce the number of mixed sex accommodation breaches by improving discharge from adult intensive care units into the appropriate specialty wards</p>	<p><b>ACHIEVED</b></p> <p>During 2012/13 we recorded 274 mixed sex accommodation breaches. This is 87 less breaches than we recorded in 2011/12. For 2013/14 the Department of Health changed its guidance from aiming to eliminate mixed sex accommodation to aiming to minimise mixed sex accommodation. The breaches we have recorded at St George’s are from areas where it has been decided by our commissioners that it is in the best clinical interests of the patient to be in a mixed sex area, for example, in A&amp;E and transfers from intensive care units.</p>
<p><b>18 week referral to treatment</b></p> <p>Ensure that we accurately report our performance against and successfully treat 90 per cent of patients within the 18 week referral to treatment (RTT) target</p>	<p><b>PARTIALLY ACHIEVED</b></p> <p>Meeting the 18 week RTT target has traditionally been difficult for St George’s due to demand from commissioners and patient choice, commissioners and referrers, and a period of difficulty in accurately recording the data following the implementation of a new IT system in 2010. The issues with data recording have now been addressed, though demand for St George’s services is now higher than ever. During 2012/13 we agreed a RTT delivery plan with our commissioners to help us address the historic issues that have undermined our efforts to consistently achieve this target in the past. As part of the plan we have developed a new RTT governance structure which has improved monitoring of performance and allowed us to address issues in certain services as they arise. Following the implementation of this plan in October 2012 we have consistently met the 90 per cent target for admitted patients in accordance with this plan, though our overall performance for the year is 88.13 per cent. We treated 97.5 per cent of non-admitted patients within 18 weeks, against a target of 95 per cent.</p>
<p><b>Nutrition and hydration</b></p> <p>Introduce a more efficient nutritional assessment tool to record the nutritional needs of patients on admission.</p>	<p><b>ACHIEVED</b></p> <p>The Nutrition Operational Group has designed a new nutritional assessment document to include a care plan. This is in use across the trust and has been well received by staff.</p>

Aim	Outcome – achieved / partially achieved / not achieved
<p><b>Patient transport</b></p> <p>Reduce the time it takes to take patients home after their appointments via patient transport – 90 per cent collected within 60 minutes and 95% within 90 minutes.</p>	<p><b>NOT ACHIEVED</b></p> <p>Waiting times – 80 per cent of patients journeys went home via patient transport within 60 minutes, and 88 per cent of all patients went home within 90 minutes of transport being booked during 2012/13. Extra vehicles and staff were added to the service in January 2013 to reduce the waiting time and this has led to an improved response time with 95 per cent of patients going home within 90 minutes in March 2013. We have improvement projects in place including a review and redesign of the booking of transport to increase the notice time provided to the transport team, and a redesign of the renal transport service to improve response times and reduce the time patients wait for transport. Lost Journeys – Lost journeys have reduced from a yearly average of 5.1 per cent in 2011/12 to 4.1 per cent in 2012/13. As a result of an improvement project which commenced in February 2013 the lost journey percentage has dropped to 2.39% in March 2013.</p>
<p><b>Research</b></p> <p>Appoint an associate medical director with responsibility for development of a research strategy.</p>	<p><b>ACHIEVED</b></p> <p>We have appointed an associate medical director and highlighted research and innovation as a key element of our strategy in our 10 year plan.</p> <p>Read more about research on <a href="#">page 86</a></p>
<p><b>Community services – dementia screening</b></p> <p>Ensure that 90 per cent of patients admitted to Queen Mary’s, Roehampton, inpatient wards are asked the dementia screening question.</p>	<p><b>ACHIEVED</b></p> <p>This indicator applies to individuals over 75 years of age. In Q4, 149 inpatients admitted were over 75 years. Of these, 144 were asked the dementia screening question (97%)</p>
<p><b>Community services – dementia risk assessment</b></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 screening, have a dementia risk assessment within 72 hours of admission.</p>	<p><b>ACHIEVED</b></p> <p>16 of the patients asked the dementia screening question were found to be at risk of dementia. All of these patients (100%) were risk assessed formally.</p>
<p><b>Community services – dementia specialist diagnosis</b></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>	<p><b>ACHIEVED</b></p> <p>All 16 patients risk assessed formally for dementia were referred for a specialist diagnosis (100%).</p>

## Our priorities for improvement in 2013/14

We have agreed a new Quality Improvement Strategy which centres on the three essential domains of safety, experience and outcomes. We agreed six commitments against each domain which illustrate how we will achieve improvements in quality at St George's:

- **Improving patient safety**

- › *We will promote a culture of zero tolerance through challenging unsafe practice*
- › *We will establish strong multidisciplinary teams who communicate clearly across boundaries*
- › *We will encourage involvement of patients in patient safety initiatives*
- › *We will give timely and relevant feedback to teams to enable staff to be knowledgeable about patient safety*
- › *We will promote an open and transparent culture where we listen and act on staff concerns*
- › *We will create reliable processes to reduce avoidable harm*

- **Improving patient experience**

- › *We will listen to and involve people who use our services*
- › *We will use feedback as a vehicle for continuous improvement, adopting best practice where possible*
- › *We will ensure that our patients are cared for in a clean, safe and comfortable environment*
- › *We will ensure that our most vulnerable patients and service users are listened to and protected from harm*
- › *We will protect patients' dignity by ensuring that we comply with the national requirements to eliminate mixed sex accommodation*
- › *We will focus on the fundamentals of care that matter to patients (privacy, dignity, nutrition, hydration etc)*

- **Improving patient outcomes**

- › *We will evaluate clinical audit results and act on findings to ensure audit contributes to improvements for patients*
- › *We will support staff to improve outcomes by provision of training and expert support*
- › *We will evidence that we are clinically effective and implementing evidence based best practice*
- › *We will communicate outcomes, promoting shared learning and prioritisation of improvement projects*
- › *We will fully participate in national clinical audits and use results to improve local practice*
- › *We will achieve best practice in all clinical areas so that patients have the best possible outcome*

Our four clinical divisions have each taken these commitments and translated them into Quality Improvement Plans specific to their patients and services. The implementation of these plans will be overseen by our Quality and Risk Committee, which is responsible for monitoring quality at the trust.

We will be reporting on our performance against our Quality Improvement Strategy at our public board meetings throughout 2013/14. Our performance will also be reported on our website

[www.stgeorges.nhs.uk](http://www.stgeorges.nhs.uk)

## **Our priorities for 2013/14 are as follows:**

### ● **Improving patient safety**

- › *Reduce incidence of hospital related venous thromboembolism (VTE)*
- › *Reduce incidence of Healthcare associated infection within agreed targets, MRSA (0) and C diff (52)*
- › *Reduce incidence of newly acquired category 2,3 and 4 pressure ulcers*
- › *Reduce the number of medication errors causing serious harm*
- › *Reduce the number of falls in the community by 5%*
- › *Roll out the early warning score indicator system in the Jones Unit at HMP Wandsworth*

### ● **Improving patient experience**

- › *Minimise mixed sex accommodation breaches.*
- › *Increase the number of patients (who are able and willing) who return real time feedback including FFT by 10% across the trust*
- › *Achieve and maintain the initial 15% return rate for the Friends and Family test in 2013/14 and aim to increase in line with agreed national trajectories until 2017*
- › *Increase the proportion of patients who would recommend us to a family member or friend (FFT)*
- › *Respond to 80% of all complaints within 25 working days or less (100% with an agreed extension)*
- › *95% of community learning disability patients to be seen within four weeks of referral*

### ● **Improving patient outcomes**

- › *We will continue to achieve lower than expected mortality rates (less than 100 using the Summary Hospital Mortality Indicator)*
- › *Reduce readmissions following a non-elective admission*
- › *Reduce readmissions following an elective admission*
- › *50% of secondary schools in Wandsworth to have sexual health support on the school grounds*
- › *Implement clinical outcome measures reporting in community services*

## Review of services

During 2012/13 St George's Healthcare NHS Trust provided and/or sub-contracted 52 NHS services.

St George's Healthcare has reviewed all the data available to them on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2012/13 represents 100 per cent of the total income generated from the provision of NHS services by St George's Healthcare NHS Trust for 2012/13.

The services we provide can be categorised as:

- **National specialist centre**

*We provide specialist care to patients from across the country for complex pelvic trauma, family HIV care, lymphoedema and penile cancer.*

- **Tertiary care**

*We provide tertiary care like cancer, neurosciences and renal services for the six boroughs of south west London and the counties of Surrey, Sussex and Hampshire.*

*We also provide specialist children's cancer services in partnership with The Royal Marsden NHS Foundation Trust*

- **Local acute services**

*We provide a range of local acute services like A&E, maternity and general surgery to the people of Wandsworth, Merton, and Lambeth.*

- **Community services**

*We provide a full range of community services to the people of Wandsworth, making sure people can manage their health better by accessing the services they need closer to where they live and work and in their own homes.*

Services provided by St George's Healthcare in 2012/13, categorised within our four clinical divisions:

### **Surgery, theatres, neurosciences and cancer.**

- Audiology
- Dental
- Ear, nose and throat
- General surgery
- Maxillofacial
- Neurology
- Neurorehabilitation
- Neurosurgery
- Pain clinic
- Plastic surgery
- Trauma and orthopaedics
- Urology

## Medicine and cardiovascular

- Accident and emergency
- Blood pressure unit
- Cardiac surgery
- Cardiology
- Chest medicine
- Clinical infection unit
- Clinical haematology
- Dermatology
- Diabetes / endocrinology
- Gastro and endoscopy
- General medicine
- Genitourinary medicine
- Lymphoedema
- Medical oncology
- Renal surgery
- Renal medicine
- Rheumatology
- Vascular surgery

## Children's and women's, diagnostics, therapeutics and critical care

- Breast screening
- Cardiac ICU
- Clinical genetics
- Community paediatrics
- Gynaecology
- Intensive care unit
- Neuro-intensive care
- Newborn services
- Obstetrics
- Paediatric ITU
- Paediatric medicine
- Paediatric oncology
- Paediatric surgery
- Pathology direct access
- Radiology
- Therapies

## Community services

- Adult and diagnostic services
- Children and family services
- Older people and neurorehabilitation services
- Services for people with learning disabilities
- Offender healthcare services
- Senior health services
- Sexual health and reproductive services
- Queen Mary's Hospital, Roehampton
- St John's Therapy Centre
- 11 health centres across Wandsworth
- Four community wards providing services in patients' own homes

## Participation in clinical audits

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 2012/13, 42 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 92.9 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 national clinical audits and national confidential enquiries that St George's Healthcare NHS Trust was eligible to participate in during 2012/13 are listed in Appendix C 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 28 national clinical audits were reviewed by the Board of St George's Healthcare NHS Trust in 2012/13. A summary of the actions agreed in response to these audits is given in the table on [page 151](#).

The reports of 11 local clinical audits were reviewed by St George's in 2012/13. A summary of the actions agreed is given in the table on [page 152](#).



## Research

St George's is committed to research as a key driver for improving the quality of care and the patient experience. We have chosen to highlight research and innovation as a key element of our strategy in our 10 year plan.

During 2012/13 we appointed Dr Daniel Forton to the new role of associate medical director for research, and published a new research strategy which firmly places research at the heart of the trust's work.

In March 2013 we agreed a strategic alliance with the King's Health Partners Academic Health Science Centre (AHSC). We will also have a leading role in the South London Academic Health Science Network (AHSN) and are positioned to contribute to developments in medical research and innovation within the changing landscape in south London.

Together with our academic partner St George's, University of London, the trust hosts the South East Stroke Research Network. We operate a joint research office and clinical research facility, both of which serve to increase the number of patients involved in clinical research. The trust has a broad range of tertiary specialist and regional acute services and, combined with excellent links to primary care, community sites and established academic partnerships, we have an opportunity to move forward with a strategic, collaborative approach to research in south west London.

During the period October 2011 to September 2012 (the period specified by the National Institute for Health and Research for patient accrual into research studies), we conducted over 151 studies and 3,278 NHS patients took part in research at the trust<sup>(1)</sup>.

This 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.

### Working to improve therapies for MNGIE patients

The St George's pharmacy department and the St George's, University of London erythrocyte research team, led by Dr Bridget Bax, are working on a Medical Research Council funded project which aims to accelerate the development of an investigational therapy for mitochondrial neurogastrointestinal encephalomyopathy (MNGIE).

MNGIE causes energy dependent tissues such as skeletal muscle and nervous system to be adversely affected, causing abnormal functioning of the gut, nerve damage and severe muscle weakness. The condition is relentlessly progressive with patients usually dying from a combination of nutritional failure and muscular disability at an average age of 38.

The only current potential cure is bone marrow transplantation, but this carries a 50 per cent mortality risk.

The investigational therapy for MNGIE is based on introducing an enzyme directly into patients' red blood cells.

Several patients with urgent medical needs have already been effectively treated. Administration has been effective in reducing or eliminating the concentrations of the toxic substances that accumulate in tissues of patients with MNGIE. Clinical improvements have also been reported, with a reduction in the number of nausea and vomiting attacks and a reduction in weight loss.

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1. Patients receiving NHS services provided or sub-contracted by St George's Healthcare between October 2011 and September 2012 that were recruited during that period to participate in research approved by a research ethics committee (National Institute for Health Research portfolio studies only).

## Use of CQUIN payment framework

A proportion of income for St George's Healthcare NHS Trust in 2012/13 was conditional on meeting quality improvement and innovation goals. These are objectives agreed between the trust and its commissioners, primary care trusts and clinical commissioning groups, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

The key aim of CQUINs 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 healthcare providers everywhere.

We achieved 84.5 per cent overall performance against the 79 CQUINs we agreed with our commissioners in 2012/13. This is a slight reduction from 2011/12, when we achieved 90 per cent.

The total trust wide value for CQUINs was £11m of which we achieved £9.3 million.

Our 2012/13 CQUIN objectives for acute, specialised and community services are outlined on [page 140](#). The tables explain what our key objectives were, and whether or not we met them.

Our proposed 2013/14 acute, specialised and community service CQUINs are also included on [page 145](#). At the time of publication 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 require action to be taken, 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 registered with the CQC and is licensed to provide services from each of its locations. The trust has no conditions placed on it and the CQC has not taken any enforcement action against the trust in 2012/13.

In January 2013 St George's Hospital (Tooting) was subject to a routine inspection of compliance against eight of the 28 essential standards. While the CQC found much to commend in their report, they also highlighted a number of instances where the inspectors observed that the care provided or the environment for patients fell short of expectations. The trust therefore failed six out of the eight standards inspected.

Of these six areas of non-compliance, three were considered to have a minor impact on patients and services and three were considered to have a moderate impact. Although there were no observations which had a major impact on patients or required the CQC to impose an enforcement notice, and the report contains many positive comments from patients and their families, the trust recognises that this reflects a lack of consistency in the standard of patient care being provided.

Outcome	Topic	Compliance	Impact on patients (as judged by CQC)
1	Respecting & involving people who use services	<b>Not met</b>	Moderate
4	Care & welfare of people who use services	<b>Not met</b>	Moderate
5	Meeting nutritional needs	<b>Not met</b>	Minor
7	Safeguarding people who use services from abuse	<b>Standard met</b>	n/a
8	Cleanliness and infection control	<b>Not met</b>	Moderate
13	Staffing	<b>Not met</b>	Minor
14	Supporting workers	<b>Standard met</b>	n/a
21	Records	<b>Not met</b>	Minor

We welcome this level of scrutiny from the CQC as part of our commitment to continuous improvement, and we take the issues identified by the inspectors very seriously. We recognise that we must improve the patient experience so that it matches the excellence of our clinical outcomes and that is a key focus of our quality improvement strategy.

In our quality improvement strategy we recognise that we have some excellent outcomes, but that the patient experience is too inconsistent. We are building a strong foundation to improve our patient and service users experience and can demonstrate that a relentless focus on this can deliver results, such as in our maternity services. However, it is too inconsistent and we want to continue to demonstrate continual improvement in this domain of quality. Caring for patients is our core business and we need to make sure that our members of staff strongly focus on every aspect of the experience of the care and services they provide.

Since the inspection in January 2013 we have been working hard to address the issues identified by the CQC and to ensure that the quality of care that our patients receive is consistently high in all areas. A comprehensive action plan was submitted to the CQC outlining the measures already taken and those underway following their visit, with most of the minor deficiencies having been rectified as soon as they were highlighted during the inspection and on receipt of the final report from the CQC. We expect to have completed implementation of this action plan by the end of June 2013.

## The Francis Report

The St George's Board welcomes the report by Robert Francis QC into the failings of Stafford Hospital.

The Board is rightly proud of the job that our staff do every day of the year, but we also know that we can do better. We can best respect the experience of patients failed by the NHS in Stafford or elsewhere, including at St George's, by taking this opportunity to root out poor care wherever it can be found.

As an organisation committed to continually improving what we do, the St George's Board is reflecting on the report in detail and using it as an opportunity to reflect more widely on patient safety and experience at the trust.

The trust has established a steering group made up Board members and colleagues from a range of disciplines, clinical and non-clinical, to review the 290 recommendations in detail, and has drafted a formal response to the recommendations. Most of the key recommendations outlined in the report that apply to provider organisations are already part of our daily practice though we are working hard on identifying and implementing those recommendations that we do not adhere to.

The Board has written to every member of staff via email, and has asked everybody to reflect on the report and on their own services to ask "could any aspect of the failings at Stafford Hospital happen here?" They have been reminded that where the answer is yes, whether significant or apparently incidental, they all have a duty to do something about it. None of us should "walk on by" and tolerate poor quality care.

Since the publication of the Francis Report, the trust has discussed the report with staff at the monthly patient safety forum and with staff and the public at the public meetings that are a key part of our consultation on becoming a Foundation Trust. The report has also been formally discussed at the Clinical Management Board, staff open forum and at the public Board meeting. At these meetings we will have taken the opportunity to conduct some more reflective work around the findings, what they mean to the trust and the assurances we can give around our governance processes.

We are working closely with the Clinical Quality Review Group, the forum our local CCGs use to monitor our quality and performance, and have revised the schedule of topics we discuss at these meetings to ensure that they are aligned to the findings of the Francis Report.

We have also written to our partners in the local authorities, Local Involvement Networks and Clinical Commissioning Groups and the MPs that represent our patients to assure them of the steps we are taking following the Francis Report and of the safety and quality of our services.

## 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.

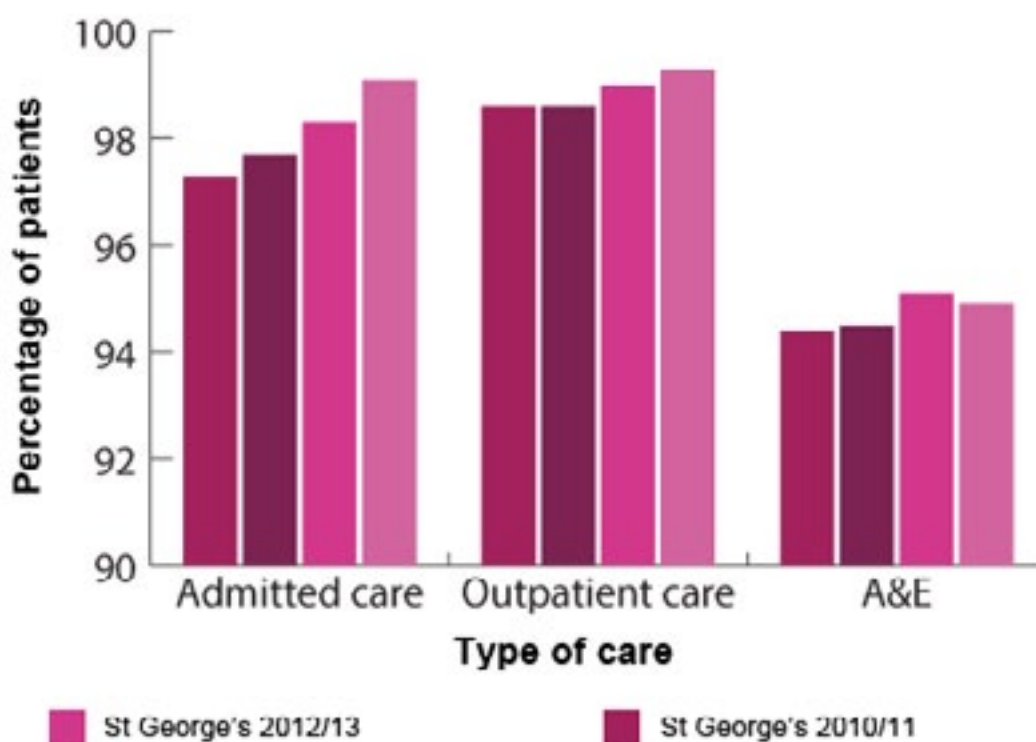
St George's Healthcare submitted records during 2012/13 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

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:

Records with valid NHS number	Admitted care (%)	Outpatient care (%)	A&E (%)
St George's 2012/13	98.3	99.0	95.1
St George's 2011/12	97.7	98.6	94.5
St George's 2010/11	97.3	98.6	94.4
National average 2012/13	99.1	99.3	94.9

### Records with valid NHS Number (%)

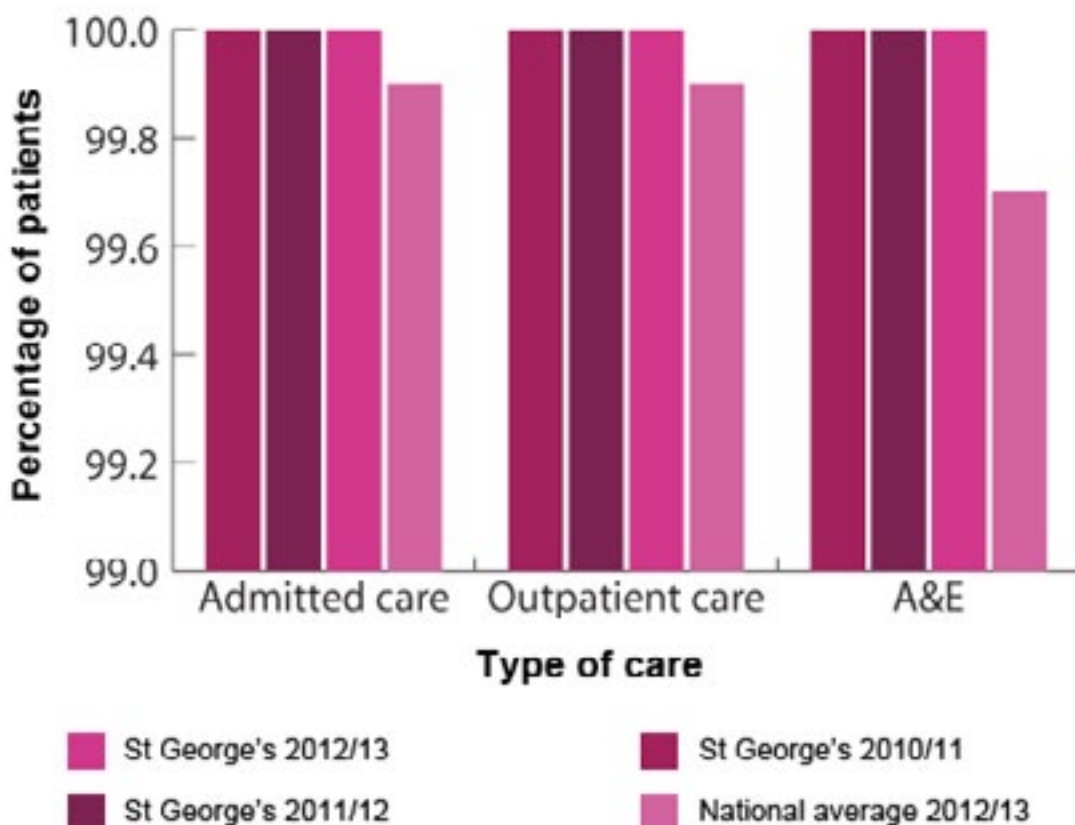


Our NHS Number completeness has improved, but is still fractionally behind the national average for Admitted care and Outpatient care. Planned improvements in the way our Patient Administration System (PAS), Cerner, accesses the national Patient Demographic Service (PDS) should see these numbers improve further in 2013/14.

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

Records with valid general medical practice	Admitted care (%)	Outpatient care (%)	A&E (%)
St George's 2012/13	100	100	100
St George's 2011/12	100	100	100
St George's 2010/11	100	100	100
National average 2012/13	99.9	99.9	99.7

### Records with valid general medical practice (%)



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.

## Information governance toolkit attainment levels

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. An internal audit conducted in 2012/13 gave the trust reasonable assurance that the trust is managing information appropriately and that staff are aware of their responsibilities.

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 system use a secure and strictly authenticated smartcard which defines what they are permitted to access in the system. In 2012 the Trust has further upgraded the system to improve the efficiency and enhance the security of “order communications” – the requesting and reporting of pathology and radiology results.

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 2012/13 was 79 per cent and was graded green, or ‘satisfactory’ according to the criteria set nationally.

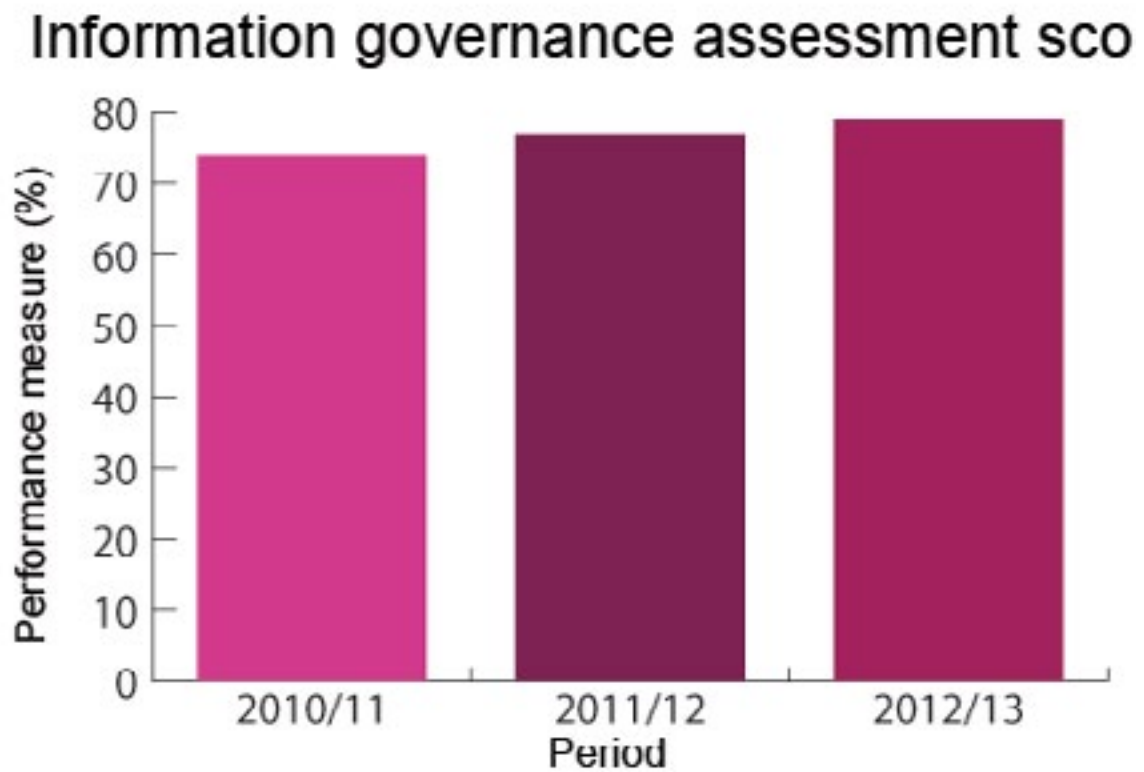
This demonstrates further improvement in our information governance management. In 2011/12 we scored 77 per cent, and in 2010/11 we scored 74 per cent.

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](http://www.igt.connectingforhealth.nhs.uk). St George’s Healthcare is listed as an acute trust and our organisation code is RJ7.

## How our performance has improved

Information governance assessment score	Performance measure (%)
St George's 2012/13	79
St George's 2011/12	77
St George's 2010/11	74





## Clinical coding error rate

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 2012/13 by the Audit Commission. The error rates reported in the latest published audit for 2012/13 for diagnoses and treatment coding (clinical coding), were as follows:

Audit Commission indicator (all services)	Error rate (%)
Primary diagnoses incorrect	10.0
Secondary diagnoses incorrect	4.5
Primary procedures incorrect	7.3
Secondary procedures incorrect	5.1

For the PbR clinical coding audit the Audit Commission audited our cardiology service for the period of July to September 2013.

Speciality	Admitted patient spells	% of episodes changing HRG
Cardiology	150	4.0

In the sample audited, we had 4.0 per cent of spells with an error that affected the price. This means that 4.0 per cent of spells had either a clinical coding error affecting the HRG or a data entry error (or both). Both types of error result in the PCT being charged the incorrect price for that spell. If all the errors are added together there is a gross financial error of £17,738. The commissioner was overcharged by £9,806 for the errors in the audit sample.

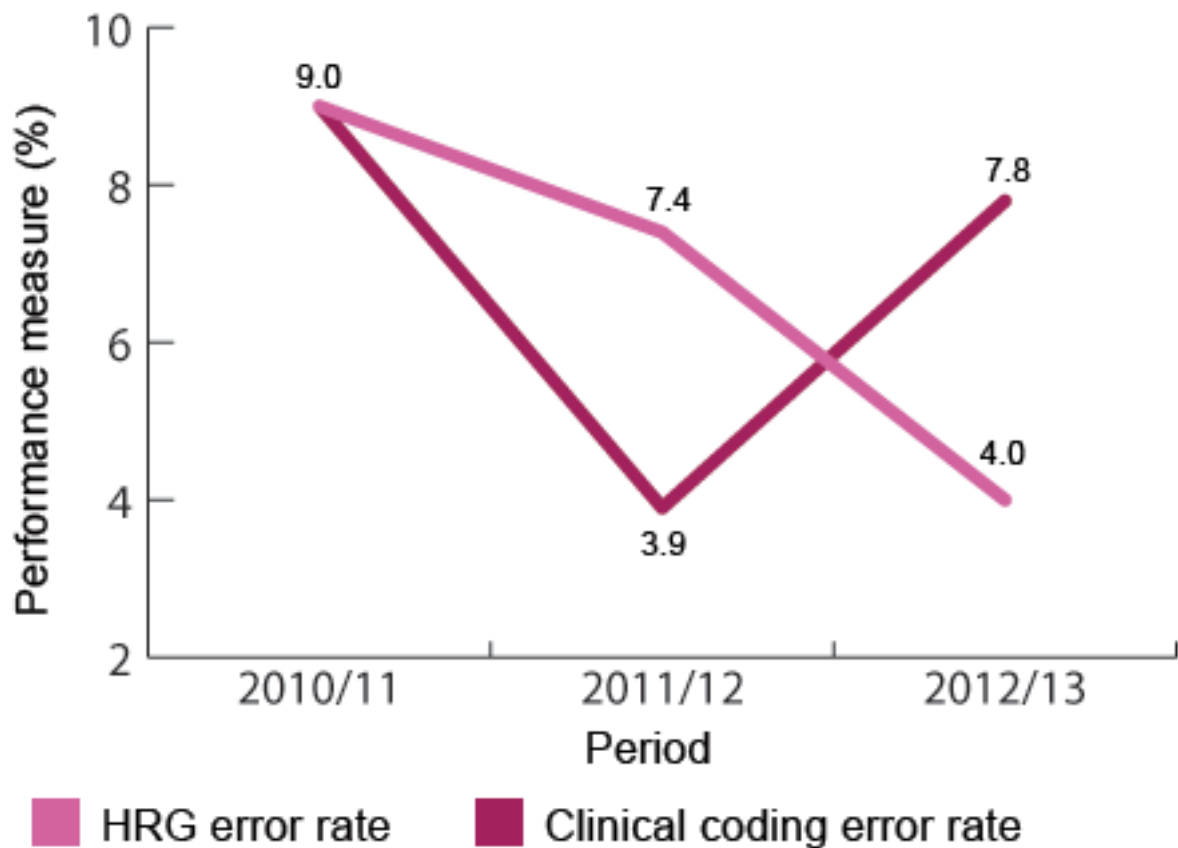
The performance of St George's, measured against the number of spells with an incorrect payment, places the trust in the best performing 25 per cent of trusts in the country compared to last year's national performance.

## How do we compare to previous years?

HRG error rate	Performance measure (%)
St George's 2012/13	4.0
St George's 2011/12	7.4
St George's 2010/11	9.0

Clinical coding error	Performance measure (%)
St George's 2012/13	7.8
St George's 2011/12	3.9
St George's 2010/11	9.0

### HRG & Clinical coding error rates



# Summary hospital-level mortality indicator (SHMI)

## Why is this important?

The summary hospital-level mortality indicator (SHMI) is intended to be a single consistent measure of mortality rates. It shows whether the number of deaths linked to an 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 the difference is statistically significant.

## Our outcomes

We have continued to consistently record some of the lowest SHMI rates in the country, demonstrating that St George's provides some of the safest and most effective services in England.

In April 2013 St George's was identified by the Health and Social Care Information Centre (HSCIC) as one of 11 trusts that have had a lower than expected mortality rate for the two years analysed to date, October 2010 to September 2012<sup>(1)</sup>.

The table below summarises our SHMI as published quarterly.

SHMI publication	Reporting Period	Ratio	Banding
January 2012	July 2010 – June 2011	0.76	Lower than expected
April 2012	October 2010 – September 2011	0.77	Lower than expected
July 2012	January 2011 – December 2011	0.79	Lower than expected
October 2012	April 2011 – March 2012	0.79	Lower than expected
January 2013	July 2011 – June 2012	0.80	Lower than expected
April 2013	October 2011 – September 2012	0.82	Lower than expected

Source: The Health and Social Care Information Centre website

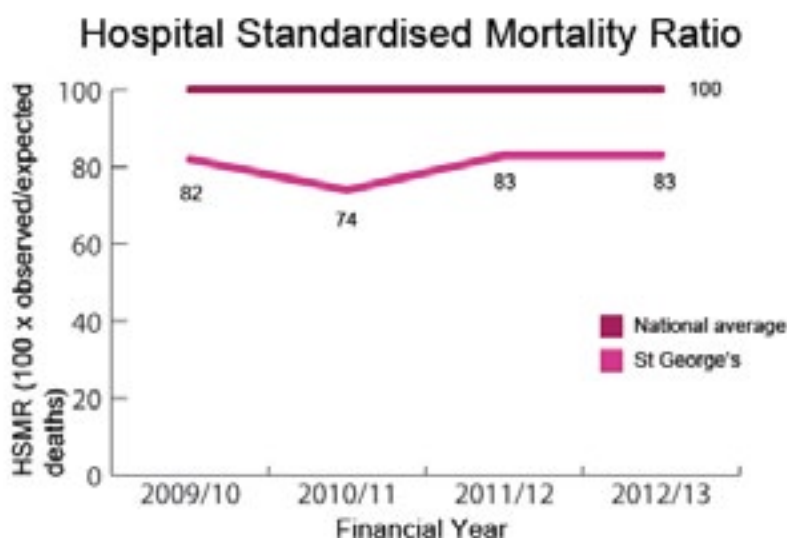
The Dr Foster Hospital Guide 2012 again named St George's Healthcare as being one of only 16 trusts in the country to have statistically significant lower than expected SHMI and Hospital Standardised Mortality Ratio (HSMR)<sup>(2)</sup>.

The SHMI makes no adjustment for end of life (palliative) care, therefore to add some context to the interpretation of the measure, palliative care data is published alongside the SHMI data. These indicators show the percentage of patient admissions that have palliative care coding and the percentage of deaths with palliative care coding. The latest data for St George's is shown in the table below, alongside the national average.

Indicator	St George's Oct 2011 to Sep 2012	National Oct 2011 to Sep 2012
Percentage of patient admissions with palliative care coded at either diagnosis or specialty level	0.9	1.0

1. For more detailed data visit the Health and Social Care Information Centre website <https://catalogue.ic.nhs.uk/publications/hospital/outcomes/shmi-deat-hosp-eng-oct-11-sep-12-exp-stat/shmi-deat-hosp-eng-oct-11-sep-12-exp-stat-supp-rep.pdf>
2. For more detailed data visit the Dr Foster Intelligence website [http://drfosterintelligence.co.uk/wp-content/uploads/2013/02/Hospital\\_Guide\\_2012.pdf](http://drfosterintelligence.co.uk/wp-content/uploads/2013/02/Hospital_Guide_2012.pdf)

Indicator	St George's Oct 2011 to Sep 2012	National Oct 2011 to Sep 2012
Percentage of patient deaths with palliative care coded at either diagnosis or specialty level	20.3	18.9



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. The HSMR indicates that St George's mortality has been consistently significantly better than expected over the last four years.

St George's Healthcare was one of the first healthcare organisations anywhere 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.

The trust's Mortality Monitoring Group, which is chaired by an Associate Medical Director and has members from across a number of services and professions, meets on a monthly basis. This group considers both the SHMI and the HSMR alongside mortality at diagnosis and procedure level. In addition the group review all deaths that have occurred in the trust following an elective admission. By looking at this range of data we are able to scrutinise our outcomes and the care we provide to patients. Where lessons need to be learned these are identified and acted upon and where best practice is observed this is recognised and acknowledged.

As St George's Hospital is a major trauma centre, hyper acute stroke unit and heart attack centre, and a centre of excellence for cancer, maternity, cardiothoracic, neurosciences and renal services, our staff are used to treating the most seriously ill and vulnerable people from across south west London and Surrey every day.

The fact that even for the most complex emergency services our mortality rates are significantly lower than expected is a testament to both the professionalism and dedication of our skilled clinical teams and to trust's commitment to research and innovation to improve quality and safety.

## 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 (PROMS)

## Why is this important?

Patient reported outcome measures (PROMs) assess the quality of care delivered to NHS patients from the patient's perspective. Currently covering four clinical procedures, PROMs calculate the health gains after surgical treatment using short, self completed pre – and post-operative questionnaires.

## 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 higher scores are better. For all four procedures EQ-5D and EQ-VAS indices measure a general view of health, and for three there is also a measure specific to the condition being treated.

		Apr 09 – Mar 10 (final)		Apr 10 – Mar 11 (final)		Apr 11 – Mar 12 (provisional)		Apr 12 – Dec 12 (provisional)	
		SGH	England	SGH	England	SGH	England	SGH	England
Hip replacement surgery	EQ-5D index	93.3	(87.2)	73.3	(86.7)	89.5	(87.3)	*	(89.8)
	EQ-VAS index	78.6	(61.4)	64.3	(61.4)	57.1	(63.6)	*	(65.2)
	Condition specific	93.8	(95.7)	94.4	(95.8)	95.1	(95.8)	*	(96.3)
Knee replacement surgery	EQ-5D index	100.0	(77.6)	77.8	(77.9)	62.5	(78.4)	No data	(79.4)
	EQ-VAS index	75.0	(50.2)	62.5	(50.8)	29.6	(53.7)	*	(55.0)
	Condition specific	95.5	(91.4)	95.0	(91.4)	74.2	(91.6)	*	(92.4)
Groin hernia surgery	EQ-5D index	40.0	(49.3)	45.3	(50.5)	47.5	(49.8)	23.1	(50.4)
	EQ-VAS index	37.5	(38.2)	35.2	(39.1)	40.5	(38.8)	41.0	(39.0)
	Condition specific	Not applicable							
Varicose veins surgery	EQ-5D index	50.7	(52.4)	47.7	(51.6)	59.3	(53.2)	60.0	(52.0)
	EQ-VAS index	43.3	(40.4)	35.0	(39.8)	49.1	(42.0)	17.6	(41.1)
	Condition specific	82.9	(83.4)	77.8	(82.5)	83.0	(83.1)	80.0	(82.9)

Source: HESonline \*Suppressed due to small numbers

For one measure St George's shows 'No data' meaning that there have been no pairs of pre-operative and post-operative questionnaires completed.

It should be noted that at St George's we perform a small number of complex cases of knee and hip replacements, with the majority of routine cases being referred to South West London Elective Orthopaedic Centre for treatment. The questionnaire issue rate is also less than 20 per cent for these procedures. These two factors mean that the data is too small to be reported.

## Participation

St George's is responsible for providing patients with the opportunity to complete pre-operative questionnaires. Our aim is to provide the choice of completing the questionnaire to all appropriate patients, however it is entirely voluntary and not all patients will choose to take part. Our participation rate for the period considered here (April 2012 to December 2012) is 64.9 per cent which is similar to the national average of 67.1 per cent.

Post-operative questionnaires are sent by organisations working for the Department of Health directly to patients that have completed the initial survey. For this period patients completed 296 pre-operative questionnaires and 171 post-operative questionnaires were then issued on behalf of the Department of Health (57.8 per cent issue rate). At the time of publication 76 of these have been returned (44.4 per cent response rate).

	April 09 – March 10 (final)		April 10 – March 11 (final)		April 11 – March 12 (provisional)		April 12 – December 12 (provisional)	
	SGH	England	SGH	England	SGH	England	SGH	England
<b>All four procedures</b>	51.9	66.1	43.8	69.9	64.5	74.6	64.9	67.1
<b>Groin Hernia</b>	59.7	55.0	51.8	55.7	52.4	60.6	71.1	55.0
<b>Hip Replacement</b>	51.4	76.3	32.1	78.8	88.2	82.3	79.6	74.0
<b>Knee Replacement</b>	60.4	78.4	39.4	83.8	101.7	89.3	123.7	80.1
<b>Varicose Vein</b>	41.7	43.4	39.4	47.7	68.9	48.9	34.9	39.4

Source: HESonline

Note: Participation rates of over 100% are possible for a number of reasons; an operation is cancelled following completion of the pre-operative questionnaire; surgery is carried out by a different provider; coding issues.

Last year we stated our intention to increase participation rates and to meet the national average. Although the data currently available is only for part of the year and is provisional it does appear that we have failed to meet our target.

In July 2012 a new pre-operative care centre was opened at St George's Hospital. This specialist environment provides opportunity for patients who are due to undergo a procedure to have the majority of assessments, investigations and consultations in one place. The pre-operative PROMs questionnaire is now offered as part of this process and it is hoped that this will have a positive impact on our participation rates in the future.

We have recently conducted detailed analysis of participation rates by procedure and treatment location and have identified gaps in the process for offering questionnaires, particularly around groin hernia and varicose vein. Processes have been strengthened in these areas and we will monitor the impact of this on a monthly basis, reporting to individual members of staff involved in the process.

We will continue to report twice a year to the Patient Experience Committee in order that any issues can be addressed and increased participation can be facilitated.

## **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 during 2013/14. Providing patients with the opportunity to complete the questionnaires should be easier now since our new pre-operative assessment centre opened in 2012.

# Emergency readmissions to hospital within 28 days of discharge

## 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.

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.

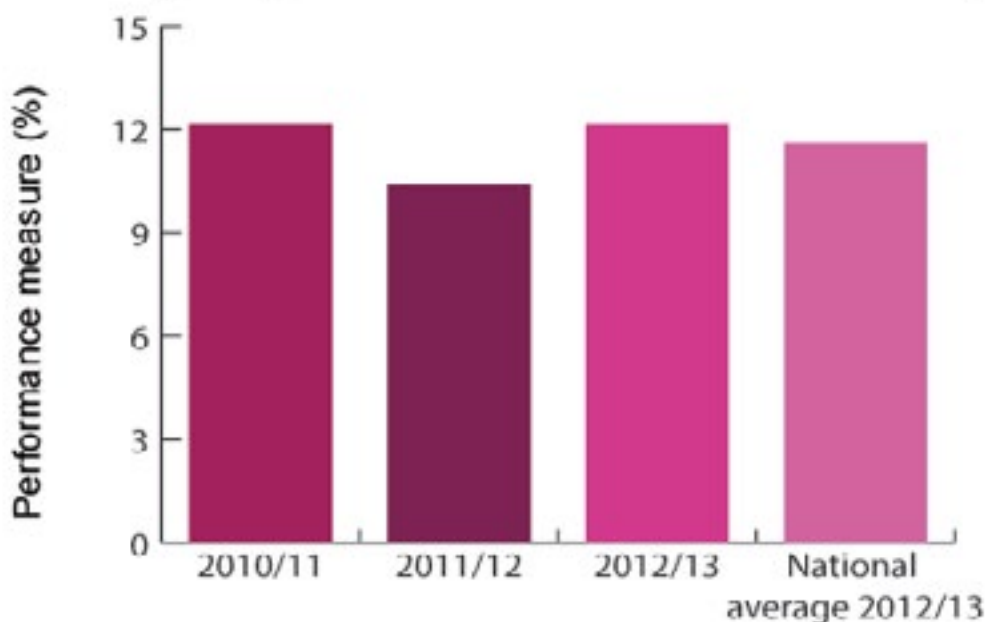
## Our outcomes

Reducing emergency readmissions has always been a priority for the trust. In 2012/13, 11.8 per cent of patients were re-admitted to the trust within 28 days. In real terms this means that in the year, 5,661 patients were readmitted to hospital within 28 days of being discharged. Although this shows an increase, this followed a 19 per cent reduction in readmissions between 2011 and 2012.

As a major acute trust we treat the most seriously ill patients and most complex cases from across south west London and Surrey. This means that the risk of patients needing to be readmitted after leaving hospital is higher for St George's than for other trusts in the area.

This risk is heightened in the winter when pressure on our services increases significantly. We have strong plans in place that help us manage the surge in attendances and admissions during the challenging winter months, including opening a winter ward that is vacant during quieter periods. Our new acute medicine ward and the four community wards in Wandsworth are also helping us to manage patients with chronic long term conditions who are more likely to need acute services better in the community, reducing the number of patients who need to be readmitted following discharge.

## Emergency readmissions within 28 days





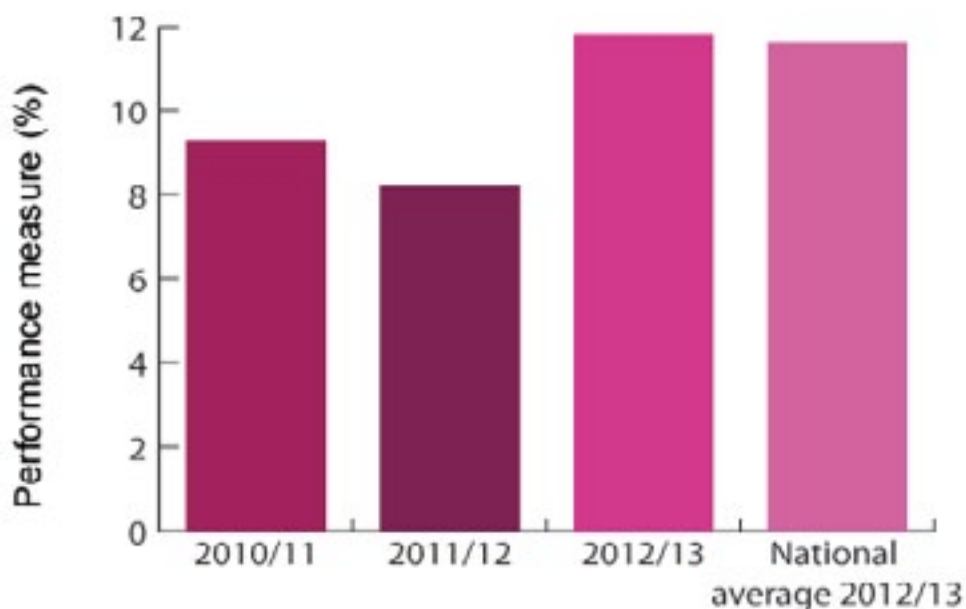
Emergency readmissions with 28 days	Performance measure (%)
St George's 2012/13	11.8
St George's 2011/12	10.4
St George's 2010/11	12.2
National average 2012/13	11.6

This compares closely with the England average of 11.63 per cent (Department of Health report published in January 2013).

Readmissions tend to vary depending on the age of the patient. In 2012/13 re-admission rates in the Trust for patients aged 0-14 was 11.7 per cent compared to 11.8 per cent for those aged 15 and over. This was an increase on 2011/12 when readmissions rate was 8.2 per cent for the 0-14 yr age group and 10.7 per cent for those aged over 15 years old.

Emergency readmissions with 28 days patients aged under 15	Performance measure (%)
St George's 2012/13	11.8
St George's 2011/12	8.2
St George's 2010/11	9.3
National average 2012/13	11.6

Emergency readmissions within 28 days - patients aged under 15



## Our aims

Reducing hospital readmissions is a substantial task given the financial, regulatory, and systemic constraints, however while challenging, the gains can be enormous. In 2013/14, the trust remains committed to reducing readmission, by ensuring that all discharges are properly planned, appropriate community services are in place, and patients are not discharged until it is safe to do so.

## Community virtual wards and telehealth technology helping patients avoid emergencies

The provision of telehealth units in the home facilitate the remote monitoring of a patient with heart failure or respiratory illness and early response and treatment to a change in the patient's condition. We have 55 units that are allocated to patients as appropriate.

Our community virtual wards provide a highly responsive multidisciplinary approach to the management of patients with chronic long-term conditions who are registered with a Wandsworth GP in their own homes. By providing care to patients in their own homes, the community wards help to avoid emergency attendances and hospital admissions for some patients by addressing complications before they escalate into serious issues.

The wards also augment existing health, social and GP services to support the earlier discharge of patients back home wherever possible.

The community virtual wards bring together the following staff groups who treat patients in their own homes:

- *GPs*
- *Community matrons*
- *Specialist nurses*
- *District nurses*
- *Palliative care*
- *Community physiotherapy*
- *Occupational therapy*
- *Community pharmacy*
- *Intermediate care team*
- *Mental health, including drug and alcohol team*
- *Social services*
- *London Ambulance Service*

At St George's we have 55 telehealth units which allow us to remotely monitor patients with heart failure or respiratory illness whilst they recuperate in their own homes. The telehealth units allow our community nurses to react quickly to any changes in a patient's condition, reducing the risk of the more serious complications and the patient deteriorating so that they need emergency care.

Previously, patients using telehealth units would had to have been kept in hospital for observation.

# 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. Every year we take part in the national inpatient survey published by the Care Quality Commission (CQC), as well as others less frequently for A&E, Maternity and Outpatients. 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.

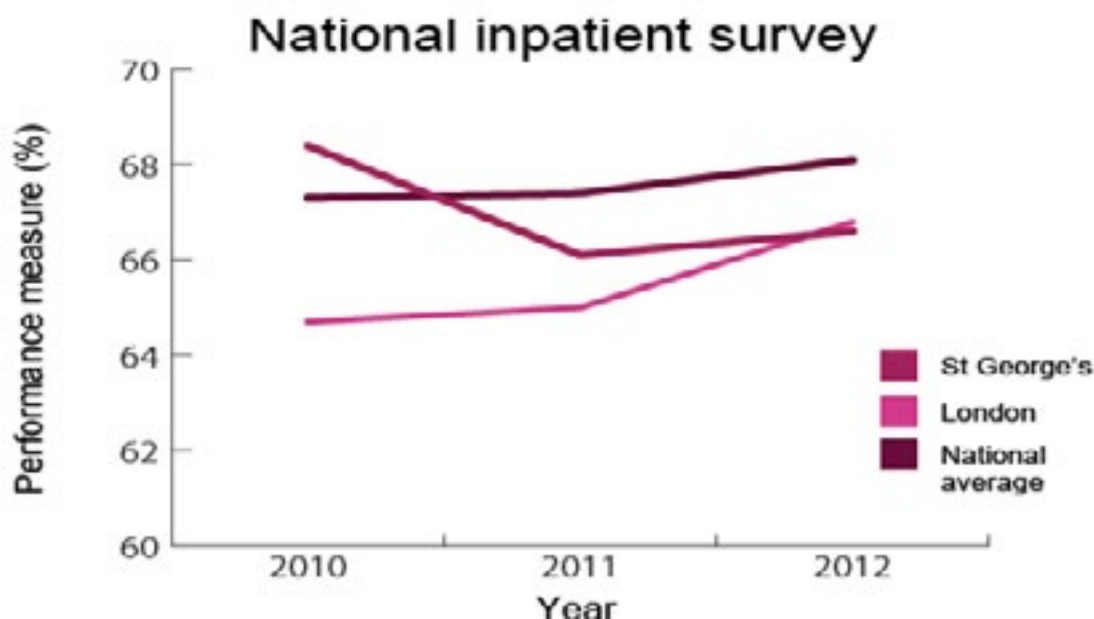
## Our outcomes

To help demonstrate the standard of patient experience at the trust we are given a score out of 100 by the CQC. There are five specific questions in the survey which were used for the national CQUIN which are:

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

## Our outcomes

	Performance measure 2010 (%)	Performance measure 2011 (%)	Performance measure 2012 (%)
St George's	68.4	66.1	66.6
London	64.7	65.0	66.8
National average	67.3	67.4	68.1



The score above is a composite score of the five questions. Our 2012 score shows that overall the inpatient experience at St George's is 'about the same as other trusts', and as expected of us by the CQC. This is also reflected in our results throughout the survey, where we are rated in the middle range for trusts across almost all sections in the survey. What this does not reflect is that a historical comparison of our scores shows significant improvement from our 2011 survey in six areas as below:

- *Hospital: room or ward not very clean or not at all clean*
- *Hospital: not offered a choice of food*
- *Nurses: did not always get clear answers to questions*
- *Nurses: talked in front of patients as if they were not there*
- *Care: staff contradict each other*
- *Overall: not asked to give views on quality of care*

Since April 2013, there is now another way for patients to feedback called the "Friends and Family Test" (FFT). The trust has now implemented this initiative in the majority of adult, inpatient areas and A&E. On discharge patients are asked how likely they are to recommend us to a friend or family member and why they have given us their rating. In 2013/14 we are required to survey a minimum of 15% of patients discharged and publish the overall score. The score is calculated as a proportion of those who are extremely likely to recommend us versus those who are extremely unlikely, unlikely or neither/nor. The lowest possible score is - 100 and the highest is +100.

In addition we also have a number of other survey questions that we ask patients (anonymously) about their experience based on the national annual inpatient survey. Our bespoke system allows for almost real-time feedback to enable staff to share good practice and implement any actions that may be required. We will continue to undertake national surveys but hope this process allows for more rapid feedback and action.

Staff use word clouds to display comments from patients in their clinical areas. Our word clouds give greater prominence to the words that appear most often in our survey results.



A word cloud from one of our patient surveys

## Our aims

Following the Mid Staffordshire inquiry, we will undertake another review of our complaints processes in line with any national recommendations expected summer 2013. We will aim to respond fully in a timely way, whilst learning from any mistakes that we may make and being honest if we get things wrong.

Areas of focus in the year ahead include building on all of the work undertaken in relation to privacy and dignity. We will continue to undertake visits to clinical areas with our patient representatives ensuring our values of kindness and respect are lived by all staff.

We will also ensure that nutrition and hydration are kept high on the agenda ensuring that patients have choice and help with meals and drinks when they need it.

All patients should be seen regularly by nursing staff via our intentional rounding scheme which has now been rolled out across the trust. Keeping patients informed and involved in their care is a priority.

Patient safety and ensuring that patients do not suffer avoidable harm is also a key focus and we have implemented the national Safety Thermometer which looks each month at high risk areas including VTE, falls, pressure ulcers, infections and blood clots. This information is submitted nationally and available to view on a public website.

Ensuring that patients have the right care, at the right time delivered by the right staff is crucial. In the year ahead we are looking to change the way our senior sisters and charge nurses work by giving them more time to monitor standards and work more in a supervisory capacity. We are focussing on strong, visible leadership so have introduced a development programme and have changed the uniforms of our senior ward staff so that they can be quickly and easily identified following feedback that some patients didn't know who was in charge on their ward.

We hope that these and a number of other initiatives will ensure that our patients experience the highest standards of care in every area, every time.

## Percentage of staff who would recommend the provider to friends or family needing care

### 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

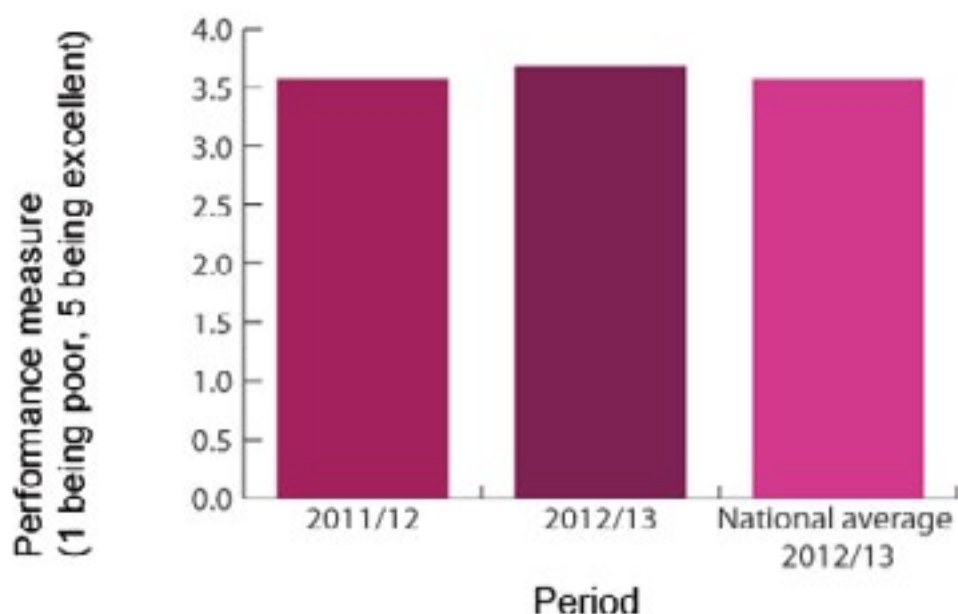
As part of the 2012 NHS staff survey our staff were asked whether they would recommend the trust as a place to work or receive treatment. In response, 90 per cent of our staff said they would recommend St George's as a place to work or receive treatment.

On a scale of 1-5, with 5 being the most positive, this question was rated at 3.68 by our staff compared to 3.57 nationally for acute trusts.

St George's Healthcare is now ranked amongst the top 20 per cent of trusts nationally for staff who would recommend the trust as a place to work or receive treatment. Last year we stated that this was an achievement we were aiming to achieve by 2015.

Staff who would recommend St George's	Performance measure (1 being poor, 5 being excellent)
St George's 2012/13	3.68
St George's 2011/12	3.57
National average 2012/13	3.57

### Staff who would recommend St George's Hospital



## Our aims

The workforce is vital to the delivery of the highest quality clinical services, education and research, and will need to evolve to meet future needs. The trust needs to value its staff and ensure they champion the trust's values. Patients have commented that happy staff result in happy patients.

The trust has developed a workforce strategy that sets out our response to an analysis of the strengths, weaknesses, opportunities and threats in the workforce including information from the staff survey.

Key actions to develop a highly skilled and engaged workforce are:

- *To undertake the Listening into Action staff engagement programme.*
- *To agree and implement a well being strategy.*
- *To establish a Midwifery Futures programme.*
- *To strengthen leadership and line management including the quality of appraisal.*
- *To improve patient safety, experience and outcomes through the provision of excellent and innovative education.*
- *Strengthen the sense of belonging to the trust of all acute and community staff.*

# 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

VTE documentation of risk assessments is considered one of the highest clinical priorities nationally and is has been a national CQUIN for all NHS trusts for 2011/12 and 2012/13.

All trusts across the country need to report the number of documented VTE risk assessments being conducted on admission as a proportion of the total number of hospital admissions.

We also have to report the proportion of those cases where there is a documented risk assessment that appropriate thromboprophylaxis has been prescribed.

113,081 patients were admitted at St George's and Queen Mary's Hospitals during 2012/13\*. 107,699 of these patients were documented on their discharge summary as being given VTE risk assessments, which is 95.24 per cent. The national target for VTE risk assessments is 95 per cent. We have also agreed a local target of 98 per cent with our commissioners, which demonstrates the importance of this target and our commitment to ensuring our patients' safety.

The number of patients given appropriate thromboprophylaxis was 4,078 out of 4,080, which is 99.9 per cent against a target of 98 per cent.

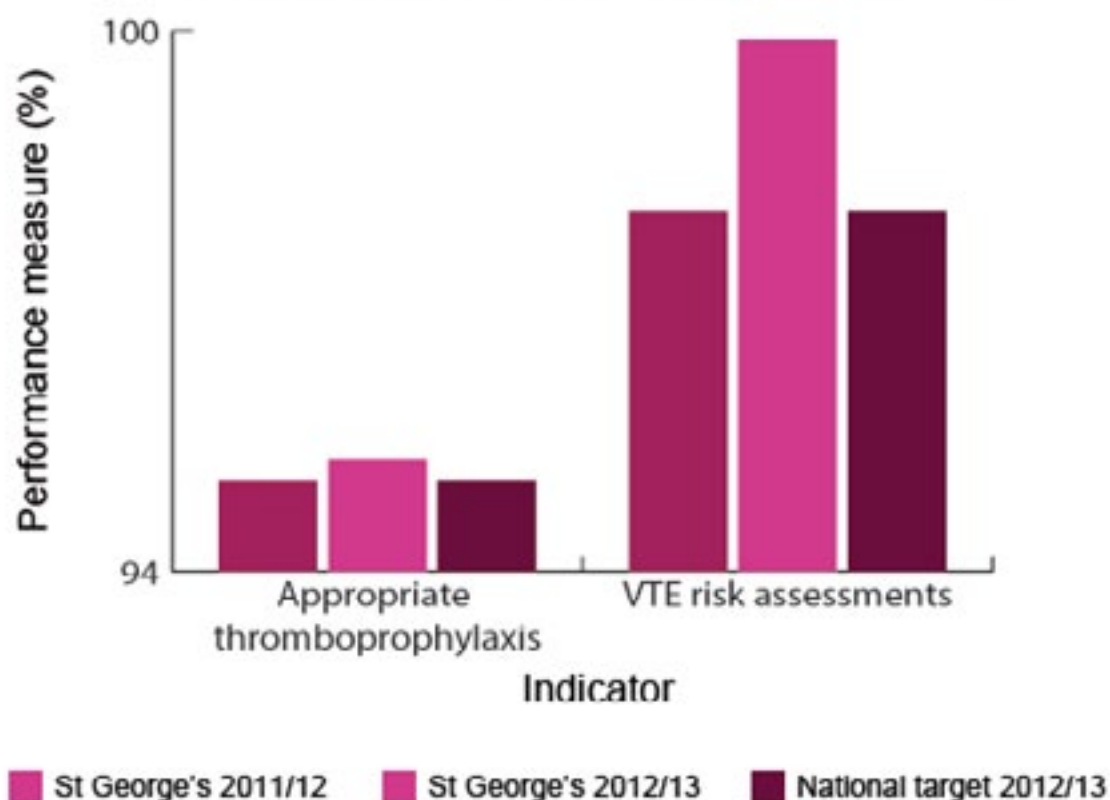
VTE risk assessments	Performance measure (%)
St George's 2012/13	95.24
St George's 2011/12	95
National target 2012/13	95

Appropriate thromboprophylaxis	Performance measure (%)
St George's 2012/13	99.9
St George's 2011/12	98
National target	98

\*data from Queen Mary's Hospital was included from June 2012



## Venous thromboembolism (VTE)



### How we record our data and report our performance

We report on the number of patients who are documented on their discharge summary as having had a VTE risk assessment as this information is recorded electronically, whereas the documentation for the VTE risk assessments conducted when a patient is admitted are paper based. Because we treat over 113,000 inpatients each year, our commissioners agreed that this has been the best way to report the data over the last few years.

Our own internal audits have found that there is a difference between the number of assessments we report on the discharge summaries and the number of paper assessment forms completed on admission.

We have been auditing the level of VTE assessments by checking 10 patients' records from every ward every month, which means we are auditing more than 4,000 records per year. Our audits show that whilst more than 90 per cent of patients' VTE assessment forms have been filed, only around 60 per cent of the forms are completed fully, i.e. every field is answered and the relevant fields are signed by a doctor. The number of assessment forms both filed and fully completed has risen over the last 18 months though it is of course a concern for the trust that there is a difference between the paperwork and the electronic data.

We are working to make recording VTE risk assessments simpler for our doctors. To achieve this we are developing a new VTE risk assessment form on our patient administration system and a new simple step-by-step guide on using this new form. As well as making the documentation process simpler and easier to audit, this will also allow us to report on assessments on admittance rather than discharge.

## Our aims

VTE prevention and treatment is a top clinical priority for St George's. We are amongst the highest performing trusts in the country for VTE prevention, but we are working hard to make further improvements.

Next year we will be carrying out root cause analysis on all VTE cases at St George's and Queen Mary's Hospitals within 90 days of the patient being admitted to hospital. This includes day surgery, fracture clinic, regular day attendees and obstetrics patients as well as all inpatients. This root cause analysis will help us to understand why some patients develop VTE, and whether there are any changes we could make to our clinical practice that would reduce the risk of patients developing VTE.

To help us further improve the number of patients risk assessed and the number of patients given appropriate thromboprophylaxis we will continue our programme of training, education and feedback across the trust.

To ensure that all new staff are aware of the importance of VTE risk assessments, we have made VTE awareness part of the staff induction programme that all staff have to complete before starting work with us, and have developed specialist VTE training programmes for junior doctors.

We have also invested extra resources into extra consultant time to be dedicated to VTE risk assessments and teaching, and have a specialist VTE nurse supporting assessments, teaching, auditing and awareness across the trust.

Our performance against both of these indicators will be continue to reported on a monthly basis at divisional governance meetings, with divisional VTE leads helping to maintain awareness of the importance of VTE assessments across all of our wards.

To further increase the profile of VTE prevention we have implemented the national Safety Thermometer which looks each month at high risk areas including VTE, falls, pressure ulcers, infections and blood clots, and have introduced a harm free care study day for nursing and midwifery staff which has VTE prevention as one of the modules.

# Infection Control: Rates of C.difficile and MRSA

## Why is this important?

The prevention and control of healthcare acquired infections at St George's is a top priority. Our aim is to make our facilities as clean and safe for patients as possible. Alongside the cleanliness of our wards, we also continue to focus on our programme of comprehensive training for staff, stringent hand hygiene and careful use of antibiotics.

The trust uses an array of measures to stop the spread of infection to patients. Our Infection Control Team, made up of doctors and nurses, works around the clock, monitoring infections and providing ward staff with advice on how to prevent, treat and contain the spread of bugs to patients. The trust also routinely screens all appropriate elective patients for MRSA, in line with our MRSA screening policy

## What is C.diff?

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.

Clostridium difficile (C. diff) is a bacterium that is present naturally in the gut of around 3% of adults and 66% of children.

C. diff does not cause any problems in healthy people. However, some antibiotics that are used to treat other health conditions can interfere with the balance of 'good' bacteria in the gut. When this happens, C. diff bacteria can multiply and cause symptoms such as diarrhoea and fever.

As C. diff infections are usually caused by antibiotics, most cases usually happen in a healthcare environment, such as a hospital or care home. Older people are most at risk from infection, with the majority of cases (80%) occurring in people over 65.

Most people with a C. diff infection make a full recovery. However, in rare cases, the infection can be fatal.

## What is MRSA?

MRSA stands for Methicillin Resistant Staphylococcus aureus. This means that Methicillin (an antibiotic) does not work on this type of bacteria. Therefore infections with MRSA can be harder to treat with antibiotics. However, the majority of patients who develop an MRSA infection are successfully treated with antibiotics.

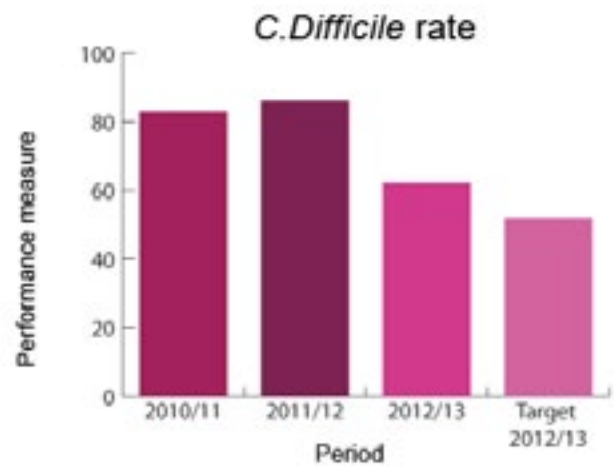
Most people with MRSA carry it without any harm to themselves or their family. However it can sometimes cause serious infections, especially if it gets into a wound. This is why we try to stop MRSA spreading around the hospital.

## Our C.diff outcomes

During 2012/13 we acquired 62 cases of C.diff which is a 28% reduction in the number of cases compared to the previous year. We did, however, breach our nationally agreed target for C.diff during 2012/13, which was to acquire no more than 52 cases.

Our 2013/14 target is to acquire no more than 45 cases of C.diff.

C.difficile rate	Performance measure
St George's 2012/13	62
St George's 2011/12	86
St George's 2010/11	83
Target 2012/13	52

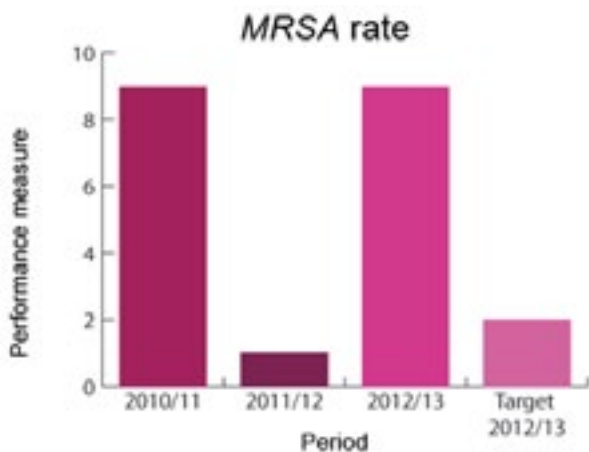


## Our MRSA outcomes

We acquired nine MRSA bloodstream infections during 2012/13 and subsequently breached our nationally agreed target which was to acquire no more than two infections during the year. This is also an increase compared to the previous year during which time we acquired only one infection.

We are disappointed in this rise, and have investigated each individual case to identify any potential patterns in the nature of infection. Intravenous line care has been identified as one of the contributory factors in this rise, so we have redoubled our focus on line care at the trust in order to improve our performance.

We have conducted a 'table top' peer review with colleagues from another London trust to help review our current practice and have also reintroduced C.diff ward rounds to ensure a real-time review of patients' care and management, including cleaning standards.



MRSA rate	Performance measure
St George's 2012/13	9
St George's 2011/12	1
St George's 2010/11	9
Target 2012/13	2

## Our aims

We aim to record no more than 45 cases of C.diff during 2013/14 and zero cases of MRSA.

# Rate of patient safety incidents and percentage resulting in severe harm or death

## 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.

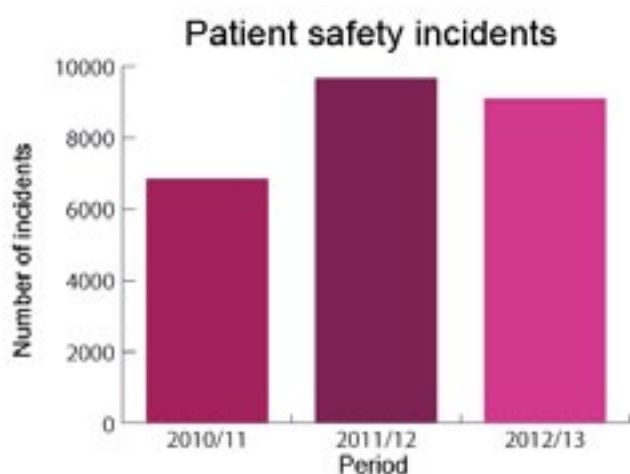
This view is supported by the National Patient Safety Agency (NPSA) who state “organisations that report more incidents usually have a better and more effective safety culture. You can’t learn and improve if you don’t know what the problems are.”

## Our outcomes

There were 9,084 patient safety incidents in 2012/13 compared to 9,663 the previous year. This shows that we continue to actively report as many incidents as we can, demonstrating 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.

There were two high and two extreme severity incidents during the year. This is less than 0.05 per cent of all reported incidents. Serious Incident investigations are ongoing for three of these incidents, so the severity grading may change upon completion of the investigation.

Patient safety incidents	Number
St George’s 2012/13	9,084*
St George’s 2011/12	9,663
St George’s 2010/11	6,854

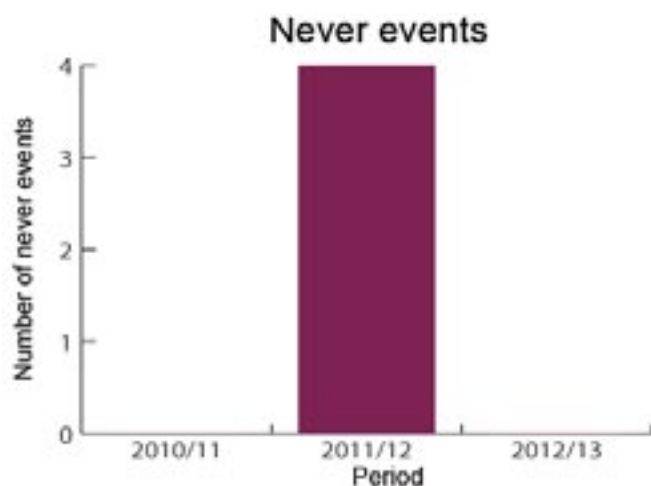


Over the last year we have introduced some important changes to help us reduce any risk to our patients, including making improvements to patient information and encouraging patients to share their worries and concerns with a senior sister or matron on the ward so that they can be resolved quickly. We have also introduced a SBAR (situation, background, assessment and recommendation) tool across the trust to help staff fully evaluate each patient and to gather all the necessary information to ensure accurate and timely communication between clinical teams.

## Never events

A never event is an event or incident that is unacceptable and preventable within the NHS. During 2012/13 there were no never events at St George's.

Never events	Number
St George's 2012/13	0
St George's 2011/12	4
St George's 2010/11	0



## Our aims

Maintaining the safety of our patients will always be an absolute priority for the trust, and one of our biggest challenges. When things do go wrong, it is vital that we learn from them and adapt our approach to make sure we do not repeat our mistakes.

To help us further develop our open reporting and learning culture over the next year, we are focussing on two key areas, creating reliable systems and culture and engagement:

### ● Creating reliable systems

- › Create divisional priority plans for safety and integrate with other quality initiatives.
- › Develop ward level data to mirror St George's safety data integrating with other relevant performance reports.
- › Ensure that ward establishments are adequate to provide safe effective care in clinical areas

### ● Culture and engagement

- › Identify leads in all care groups for dissemination of quality information.
- › Identify systems that prevent staff working as effectively as they need and prioritise for action.
- › Foster a culture of staff engagement to ensure that managers listen and act on staff concerns.
- › Host regular patient safety staff open forum so that staff are aware of safety messages.
- › Identify systems to measure culture and use data to identify further safety work.
- › Implement the contractual Duty of Candour.
- › Provide information for patients on how to keep themselves safe in hospital.

## Learning from Serious Incidents – Kane Gorny

Unfortunately things don't always go well in hospitals and the consequences can be devastating. July 2012 saw a coroner's inquest into the death of Kane Gorny at St George's Hospital in 2009. Kane had very complex medical needs and had been successfully treated at St George's for a number of years following a brain tumour, but when he was admitted for an operation on his hip we failed to care for him as we should have, and sadly he died as a result.

Kane suffered a medically induced dehydration brought on by him not being given the hormone medication he needed to control his highly abnormal fluid levels. This was made worse by a number of missed opportunities and failings to provide the care that Kane needed before he died. Kane's death was truly shocking and has deeply upset our staff.

The coroner was severe in their criticism of the way Kane was treated, ruling that the cause of Kane's death was dehydration by neglect. However, the coroner was also clear that Kane's death had prompted the appropriate response from the trust, with a significant number of changes made across the organisation to reduce the risk of anything like this happening again.

Following Kane's death in 2009, our staff have worked hard to make the changes needed to improve care for other patients as they are identified, reducing the risk of any issues escalating and becoming more serious. We have made changes to senior leadership on our wards and following feedback from staff and patients have implemented a visible leadership programme with senior sisters on our wards now wearing bright red uniforms, making it easier for everybody to identify who is in charge and who to escalate problems to.

Our staff have also identified and implemented a number of patient safety measures, including an early warning score system on our patient's notes. Our new electronic patient records system reduces the risk of our clinicians not having access to vital and life-saving information, which is sadly what happened when Kane was admitted.

We have introduced a number of additional safety measures in our surgical trauma and orthopaedic wards. We have also opened a new Pre-Operative Care Centre to improve assessment of patient's needs before surgery.

We have also introduced monthly patient safety forums which look at Serious Incidents where there are lessons to be learned, and encourage staff to think about how systems could be improved to further support patient safety and experience in their own areas. These monthly forums are attended by staff from across the organisation.

We can never bring Kane back, and we can never apologise enough for his death. What we can do is make sure that he is never forgotten, and honour him by making sure that we learn from this tragic case. Whilst mistakes do unfortunately happen in hospitals, this is a mistake that should never have occurred. When things do not go right, we are committed to being open about our mistakes and doing all we can to learn from them.

# Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

## Why is this important?

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.

An earlier diagnosis often means a better outcome for the patient – because treating cancer as early as possible is one of the best ways to stop it in its tracks, so the aim is always to get people in for treatment as quickly as possible if there is a suspected cancer.

## Our outcomes

The trust has passed all national cancer treatment and diagnosis targets for 2012/13, 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.

88 per cent of cancer patients had their first treatment within 62 days of being referred to St George's Healthcare by their GP. In 2012/13 the trust treated 88 per cent of cancer patients within two months of referral. The national target for this indicator is 85 per cent.

95 per cent of all cancer patients had their first appointment with a specialist cancer consultant within two weeks of their referral.

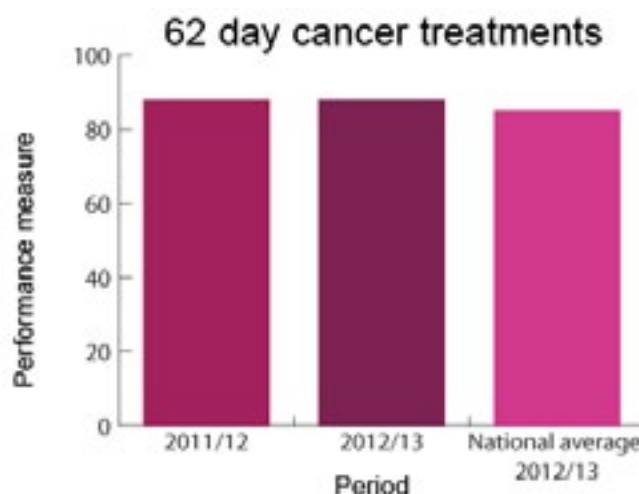
During 2012/13 the trust met every national cancer target, providing quick screening, diagnosis and treatment for cancer patients. This is the second year in a row the trust has met all targets.

As well as meeting our targets for treating cancer patients within 62 days, we have consistently met all our cancer targets over the last few years. These include:

- *Two week wait – patients seen in 14 days by specialist when referred by GP or dentist with suspected cancer*
- *Breast symptom two week wait – patients seen in 14 days by a specialist when referred with breast symptoms not suspected cancer*
- *31 day first treatment – patients receiving their first definitive treatment within one month of diagnosis*
- *31 day subsequent treatment (drugs) – patients receiving their second or subsequent treatment within one month of decision to treat*
- *31 day subsequent treatment (surgery) – patients receiving their second or subsequent treatment within one month of decision to treat*
- *62 day standard treatment – 88.3 per cent of patients receiving their first treatment within two months of GP or dentist referral with suspected cancer*
- *62 day screening standard – patients receiving their first treatment within two months of referral from national screening service*



62 day cancer treatments	Performance measure
St George's 2012/13	88%
St George's 2011/12	88%
National target 2012/13	85%



## Our aims

The primary aim of the cancer service is to maintain continuation of compliance with all national cancer targets in 2013/14. The service will maintain this through the regular monitoring and interrogation of breaches and following up with care group leads to generate action plans where required. Also, whilst the trust is currently performing above the requirements, there are a couple of areas for improvement in order to build upon the successes of the previous two years.

The cancer services department is working closely to monitor and improve process with regards to the administration of both the 14 day GP referral and 14 day breast symptomatic referral standards. Both targets are directly linked to the successful operations of the two week rule office and, although performance is still above target for the year, cancer services are aware that performance can be built upon moving into the new financial year. An action plan has been formulated and the cancer management team will be supporting the operations of the two week rule office to ensure efficiency and quality is maintained and improved further.

Cancer services have also highlighted the need to work closely with referring trusts in south west London to ensure patients are tracked and are seamlessly transferred between providers to avoid unnecessary administrative delays. St George's engagement with the London Cancer Alliance, as well as ongoing discussions with local providers, will continue to form the basis of solid foundations to further enhance inter-trust operations. Collaboration between our main referring providers will improve and strengthen the trusts position against all three of the 62 day targets.

## London Cancer Alliance

Two St George's Healthcare NHS Trust clinicians have been appointed pathway group chairs for the London Cancer Alliance (LCA).

Mr Nicholas Hyde, lead cancer clinician at St George's, who already sits on the LCA Clinical Board, has been appointed LCA pathway group chair for head and neck cancer, and Professor Barry Powell, head of melanoma services at St George's, has been appointed the LCA pathway group chair for skin cancer.

The LCA was established in 2011 as the integrated cancer system across south and west London. The LCA works in partnership with 17 NHS organisations to provide comprehensive, integrated cancer patient pathways and services, driving improvements in patient outcomes and experience for the populations served.

LCA Pathway Groups ensure that patients across south and west London have access to the same high quality diagnostics and care, as well as taking on responsibility for co-ordinating the research, education and development of cancer services.

Mr Hyde said: "I am delighted to be part of what promises to be a very exciting project in the development of London's cancer services. I hope the group I will chair is able to increase awareness of the signs and symptoms of head and neck cancer to help reduce the stage at which this disease presents.

"There are undoubtedly some significant hurdles to overcome and my hope is that I might bring leadership and direction to this work."

Professor Powell said: "St George's has always been at the forefront of skin cancer services, not only nationally but internationally. It is right that the trust is recognised for this by taking a lead role for the development of skin cancer services for a large area of London."

Ros Given-Wilson, medical director, said: "These appointments underline St George's reputation as an accredited centre of excellence for cancer services. Having two of our clinicians appointed to these roles is a testament to the trust's development of its cancer services over the last 10 years and to the dedication of Nicholas, Barry and their teams. We are very proud to support Barry and Nicholas in their roles at the LCA."

# Health visiting service update of service provision

## Why is this important?

During 2012/13 the St George's Healthcare health visiting team was named by the Department of Health as an early implementer site for the Health Visitor Implementation Plan, which has been established to expand and strengthen health visiting services nationally.

As an early implementer site the health visiting service has had additional support from the Department of Health to develop a universal antenatal health visiting pathway, to further assist in delivery of the full Healthy Child Programme in Wandsworth and to lead the way on developing new programmes for health visiting training and return to practice roles, which sees qualified nurses return to health visiting after working in other areas.

As an Early implementer site we have managed to create and produce a New Health Visiting information leaflet for families and other professionals to understand the service offer available. This was done by using the current practice development group. This leaflet will be sent to all families in the antenatal period as an introduction to the service. We have forged good links to the midwifery service within St Georges to aim a more streamline referral pathway to our service.

Wandsworth is one of the London's largest boroughs with close to 300,000 residents, and is also one of the youngest and most ethnically and culturally diverse. The St George's Healthcare health visiting team provides vital healthcare services to the families of the 25,000 children under the age of five living in Wandsworth. Our health visiting service plays a vital role in helping children get the best and healthiest start in the vital early stages of life which will assist them to reach their full potential in both childhood and later life.

Health visitors play a vital role in identifying the health needs of young children and in supporting parents to provide the care their children need. Each GP practice in the borough of Wandsworth has a linked St George's Healthcare health visitor, and every Children's centre in Wandsworth has a St George's Healthcare health visitor as a board member and a team which provide sessions within children centres based on local needs.

Our health visiting team works very closely with colleagues from Wandsworth Council, schools, Early years settings, voluntary sector organisation, GP practices and other health professionals, and play a vital role in identifying potential safeguarding issues.

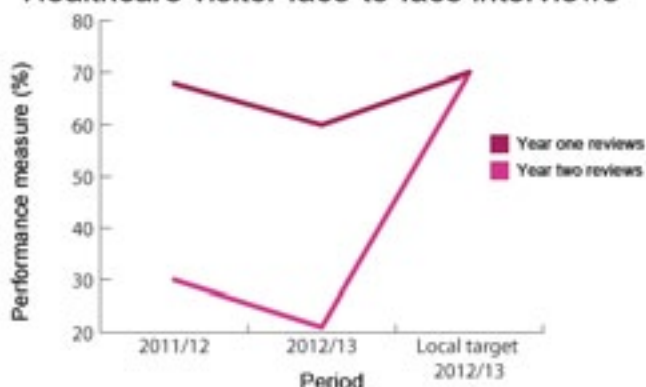
## Our outcomes

Our health visitors aim to conduct face-to-face family health assessments with each child in Wandsworth annually for the first three years after they are born. These assessments are voluntary and parents don't have to take part in them if they don't want to. Our target was to see 70% of families at year one reviews and 70% at year two reviews.

During 2012/13 we invited 100% of families to attend and successfully completed and recorded 68% of face-to-face year one reviews and 30% of year two reviews.

This represents an increase compared to 2011/12, when 60% of year one reviews were completed and 21% of year two reviews were completed.

### Healthcare visitor face-to-face interviews



We have increased the rate of assessments through increasing awareness of the team and the benefits of the assessments across the borough, and by improving the way data is recorded and the quality of the data. We are working with the local authority to improve our year two performance.

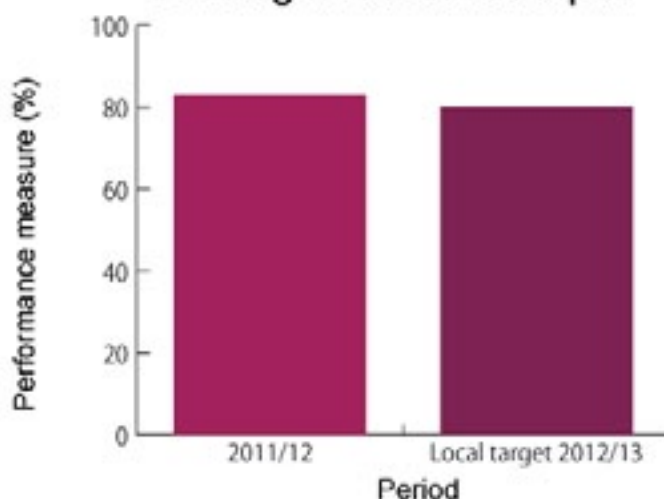
In addition, the health visiting service has also supported 35 out of a possible 42 pregnant Wandsworth teenagers with ante-natal input. This is 83% against a CQUIN target of 80%.

Healthcare visitor face-to-face interviews	Year one reviews	Year two reviews
St George's 2012/13	68%	30%
St George's 2011/12	60%	21%
Local target 2012/13	70%	70%

### Our aims

- Increase the current antenatal offer to more women, including women booked outside of St George's Hospital
- Increase the 2-2.5 year review activity – aim for 75% uptake
- Continue to improve links with children's centres and local GP's
- Use client feedback from surveys to enhance the service offer.
- Better support for women to prolong breast-feeding and work towards baby friendly accreditation
- Continue to work towards the national health visiting agenda to promote health visiting and increase the core service offer.
- Continue to support student health visitors in line with the national agenda.
- Work with Local Early Year's partners to increase the referrals from health visitors to Children's Centre with the introduction of an information sharing card – to commence in March/ April 2013.
- Increase patient facing time for health visiting to 40%
- Explore the possibility of providing Family Nurse Partnership within Wandsworth 2013/14 to support teenage parents. (In line with the national Framework)

### Teenager antenatal input



Teenager antenatal input	Performance
St George's 2012/13	83%
Local target 2012/13	80%

# Offender healthcare medicine management

## Why is this important?

St George's provides primary care and substance misuse healthcare services at HMP Wandsworth. HMP Wandsworth is a category B male prison and is the largest prison in the UK with a certified normal accommodation of 1,665 offenders.

Offenders are less likely to have accessed health services before getting to prison and are more likely to suffer from long term chronic conditions than non-offenders. There is also a higher rate of mental health conditions and addictions amongst offenders when compared to the general population.

Poor medicine management has historically been identified as a recurring theme in serious incidents reported at the prison. We are committed to improving the health of offenders and to reducing the risk of serious harm or illness through conducting medication risk assessments and developing better systems for helping offenders manage their medication.

## Our outcomes – polypharmacy clinic

A new polypharmacy clinic was introduced at HMP Wandsworth in August 2012 as a pilot scheme. The clinic reviews offenders who are in receipt of a complex medication regime of five medications or more. Our aim for 2012/13 was to hold a polypharmacy appointment with 70 per cent of offenders who met the criteria for this.

124 prisoners met the criteria for requiring a poly-pharmacy review during 2012/13. All were offered an appointment and 99 out of 124, or 80 per cent, attended a polypharmacy clinic appointment, meaning that we achieved our target.

## Our outcomes – in-possession medication risk assessments

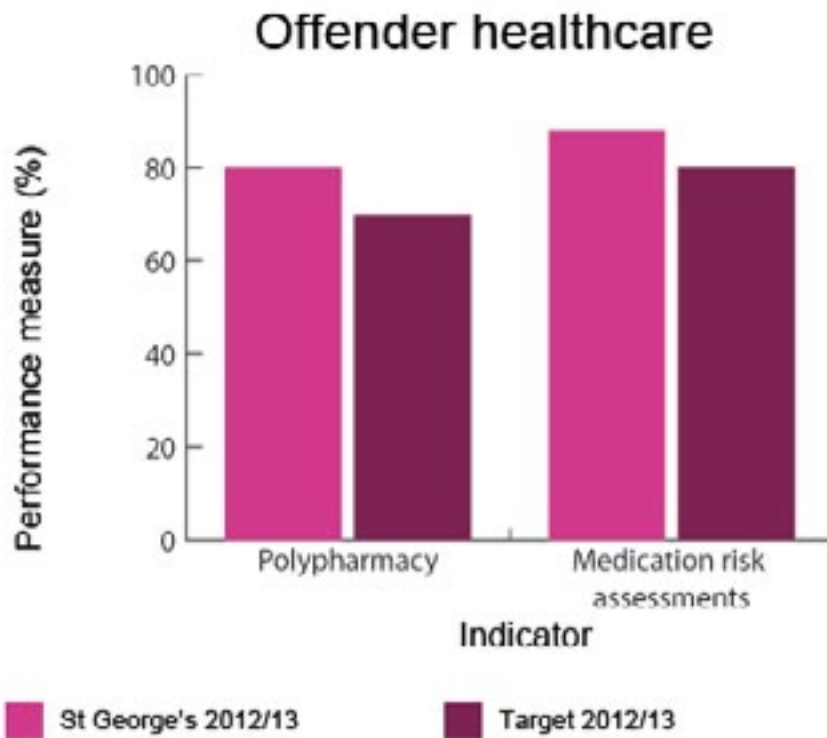
Medication for offenders is provided in two main ways

- *In-possession medications, where a prisoner is given a supply of medication to self administer in their cell.*
- *Non-in possession medications, the offender goes to a medication hatch and receives their medication under supervision.*

Where it is appropriate offenders undergo a risk assessment to hold their medications 'in-possession. Holding medications in-possession is a positive step in assisting offenders to take responsibility for their health. From January to March 2013 295 prisoners were assessed for in-possession medications and 88 per cent of these received their medications in-possession. This means that we also met another CQUIN target which was to have over 80 per cent of offenders risk assessed for in-possession medication.

Offender healthcare	Polypharmacy appointments
St George's 2012/13	80%
Target 2012/13	70%

Offender healthcare	In-possession medication risk assessments
St George's 2012/13	88%
Target 2012/13	80%



### Aims for 2013/14

Following the successful pilot of the polypharmacy clinic, we have made the decision to keep the clinic running indefinitely, and will continue to offer appointments to all offenders who meet the criteria.

We will also continue to promote the use of in-possession medications where appropriate after reviewing risk assessments of relevant offenders.

During 2013/14 we will also complete phase two of the SystemOne electronic prescribing and administering work programme, and will finalise the establishment of processes up for the identification and monitoring of prescribing patterns. Both of these will help us to further improve medication management in HMP Wandsworth.

## Statements on the Quality Account 2012/13

### 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



**Miles Scott**  
Chief executive

## Feedback: Healthwatch Wandsworth

Healthwatch Wandsworth is interested in St George's performance in the three key areas of effectiveness, safety and patient experience. The report shows that much has been achieved over the past year and equally there are many areas that have been identified for scrutiny and improvement.

Our comments on the Quality Account are grouped under these headings:

- **Effectiveness**

*The continued good performance on mortality is very much welcomed. What is not clear is whether St George's understands why it is performing so well so that this can be sustained going forward, giving patients further reassurance that adverse events will be avoided as far as possible.*

*The increase in emergency readmissions within 28 days over the past year is worrying. It is accepted that the reasons are complex and that the solutions needed require multi agency co-operation. We believe this needs close and regular scrutiny.*

*The reduction in positive comments received from patients comparing their health before and after treatment is another area of concern. We would wish to see the coverage of the data and the response rate improved so as to provide a more robust measure of this important indicator.*

- **Safety**

*We note that rates for MRSA and C Diff infection are reducing, which is to be applauded – but not fast enough according to St George's own targets.*

*We note that CQC did not think that their standard for cleanliness and infection control was being met. We are pleased that this is being taken seriously – if an Inspector on one day spots a lot of good things but also spots something worrying, the chances are that it is not a one off.*



## **Patient Experience**

We found the evidence about patient experience disappointingly thin and partial. Effective measures are restricted to the annual CQC patient survey and the methodically limited Friends and Family Test. Other measures are relevant, particularly the welcome reduction in mixed sex accommodation. But it is disappointing that transport waits are lengthening.

We are concerned that the CQC annual patient survey shows St George's may be flat-lining at an average level of performance. We are also concerned at CQC's critical judgement on patient experience issues at its most recent inspection – we feel that this reflects a level of inconsistency in staff implementation of good practice which should be urgently addressed.

However, we appreciate that the cost improvements required in 2012/13 were particularly large and they may have somehow affect St. George's performances in this area.

## **Learning from experience**

We note and welcome the Trust's commitment to openness and to learning from mistakes and believe that the Trust has robust mechanisms to achieve this. However, we could find little in the Quality Account to demonstrate this in action.

We look forward to working with St George's to improve their presentation of performance to the wider public during 2013/14.

## **Feedback: Wandsworth Council Adult Care and Health Overview and Scrutiny Committee**

The Trust is rightly proud that it consistently achieves a lower than expected mortality rate for the treatments it provides. This is a good indicator of the high clinical quality it achieves. There is much other evidence of the Trust's commitment to clinical excellence. In the past year, the Committee's own review of clinical negligence claims and clinical risk management confirmed that St George's performs better than any other acute trust in South West London and is on a par with other London teaching hospitals.

On the other hand, the Quality Account perhaps understates the importance which must be attached to the Care Quality Commission inspection of January 2013. It is fairly noted that the Care Quality Commission reported that the majority of patients spoken to commented positively on their experience of the Hospital. However, the number of standards which the Trust was found not to be meeting gives rise to the Overview and Scrutiny Committee's concern that the Trust's culture of excellence in clinical care does not extend to other aspects of patient experience. It is suggested that the Trust's key improvement priority should be to address this. All aspects of the patient experience must be considered, and there must be systems in place to monitor patient experience at all stages of the patient journey. It is essential that this focus is fully and visibly supported by the Trust's management and clinical leadership. This will be a focus for the Committee's scrutiny for the coming year.

The Overview and Scrutiny Committee welcomes the recognition that community services should be priorities. It will continue to ensure the Trust and Council work effectively together on these services and will include them in future scrutiny.

## **Feedback: South London Commissioning Support Unit on behalf of Clinical Commissioning Groups that commission services from St George's**

CCG commissioners have reviewed the Trust's Quality Account for 2012/13 and the following is a summary of performance against national standards, with expectations for the year ahead (listed below).

The Trust has continued to perform well and worked hard to improve the quality of care it provides to our patients. St George's sustained cancer performance along with improvements in both the outpatient and inpatient survey, never events and 18 week waiting times is commended.

It is disappointing however that performance has decreased in MRSA bacteraemia and C.Difficile infections. Commissioners have had sight of the Trust's Infection Control Action Plan for 2013/14 and welcome the continued focus on stringent measures to ensure zero-tolerance for HCAs for 2013/14. The Trust has been open and honest in its reporting of Serious Incidents to commissioners during 2012/13. Commissioners hope that continued joint review of incidents and implementation of organisational learning from subsequent reviews brings a reduction in both serious incidents and healthcare acquired infections (HCAs) in 2013/14.

We are encouraged to see the Trust is reviewing its performance following the recommendations of the Francis report and we await their full response later on in the year. We look forward to seeing an increased focus on patient experience and consistency of quality of care across the whole Trust, recently highlighted as an area for improvement in the Care Quality Commission inspection in January 2013.

Commissioners are committed to working collaboratively to assist the Trust in achieving their goals, particularly plans to redesign care pathways to keep more people out of hospital. We will also be working to help prevent admissions from occurring by identifying those with increased needs and providing greater capacity to undertake appropriate interventions in the community. Transforming community service and out of hospital care is a priority for the CCG's in 2013/14. The CCG's are also reviewing the models of care and the urgent care pathways and are committed to continuing to work closely with the Trust to ensure the right clinical balance of services. The CCG's welcome the specific priorities for 2013/14 which the Trust has highlighted in the quality report, all are appropriate areas to target for continued improvement and link with the Clinical Commissioning priorities.

Indicator	2012/13	2013/14
<b>Mortality indicators</b>	St George's Healthcare was identified by the Health and Social Care Information Centre (HSCIC) as one of 11 trusts that have had a lower than expected mortality rate for the two years analysed to date (July 2010 to June 2011 and July 2011 to June 2012).	Maintain lower than expected mortality rate
<b>18 Week Waiting Times</b>  Patients to wait no longer than 18 weeks from referral to treatment.	The target was met throughout the year for non-admitted patients  For admitted patients the target was not met for the first 6 months of the year but was achieved in the final six months.	To maintain compliance throughout the year with 18 week waiting times target for admitted and non-admitted patients.
<b>Emergency Access</b>  (A&E 4 hour target)  95% of all patients attending accident and emergency should be treated, admitted or discharged within a maximum of 4 hours.	95.97% of patients were treated, admitted or discharged within 4hrs	Maintain above 95%
<b>Cancer Waiting Times Targets</b>  2 week rule (the maximum wait for an urgent referral).  1 month to treatment from confirmed diagnosis.  2 months to treatment (wait from urgent referral).	All targets met	Maintain good performance on all targets
<b>CQUIN Achievement</b>	A fall in performance for St George's overall, however an improvement on 2011/12 for the Queen Mary's site  SGH 75%  QMR 90%  CSW 90%	To improve performance against CQUIN targets at SGH, QMR and CSW
<b>Eliminating Mixed Sex Accommodation</b>	The Trust maintained good performance with regards to mixed sex accommodation in 2012/13  A remaining problem area is the delayed discharge of patients from critical care beds. The majority of which are caused by waits for a bed on the appropriate ward.	Commissioners acknowledge that the Trust has achieved significant reduction during 2012/13 but more still needs to be done and this is still a priority focus area for 2013/14.

Indicator	2012/13	2013/14
<b>Healthcare Acquired Infections</b>  No more than 52 cases of Clostridium Difficile during 2012/13.	SGH exceeded the national target for C Difficile (61 cases ) however this represents a marked improvement on the previous year (86 cases in 2011/12)  Commissioners agreed a local target for C-Difficile which was met.	Trust to continue improvement in 2013/14  No more than 45 cases of Clostridium Difficile during 13/14.  Commissioners did not agree a local target for 2013/14.
<b>Healthcare Acquired Infections</b>  No more than 2 cases of MRSA (bacteraemia) during 2012/13	SGH had 9 cases of MRSA in 2012/13	No cases of MRSA in 13/14.
<b>Maternity Services</b>	The Maternity CQUIN was fully met including ratio of midwives to deliveries has been maintained at 1:27 throughout the year.	To achieve the Maternity CQUIN milestones in 2013/14
<b>Never Events</b>	There were no never events in 2012/13	No Never Events in 2013/14
<b>Serious Incidents (SI)</b>  Timely reporting and learning from errors	The Trust met the national target for completing root cause analysis within the time frame.  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.	To maintain a good performance in root cause analysis of SIs.
<b>CQC / External Audit Results</b>		
<b>Care Quality Commission Inspection report. QC in</b>	The results of a CQC inspection visit in January 2013 to measure compliance against eight of the 28 essential standards. The results were very disappointing with only two out of eight standards met.  Out of the six areas of non-compliance, three were considered to have a minor impact on patients and three were considered to have a moderate impact. No areas were considered to have a major impact.	Further improvement in experience of inpatients.  Address issues raised and ensure consistency of high quality care across Trust.
<b>National inpatient Department Survey</b>	St George's 2012 result show the overall inpatient experience at St George's is 'about the same as other trusts' and as expected by the CQC.  The Trust's scores show significant improvement in six areas in comparison with their 2011 survey.	Improve 2013 score in line with the national average (68.1%)  Implement and embed new patient feedback system the 'Friends and Family Test'

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

We are required by the Audit Commission to perform an independent limited assurance engagement in respect of St George's Healthcare NHS Trust's Quality Account for the year ended 31 March 2013 ("the Quality Account") and certain performance indicators contained therein as part of our 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, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

## Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the following indicators:

- *Percentage of patient safety incidents that resulted in severe harm or death (on pages 138-142); and*
- *Percentage of patients readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period (on pages 119-122).*

We refer to these two indicators collectively as "the indicators".

## 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 Regulations).

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.*
- *Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:*
- *the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;*

- *the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2012/13 issued by the Audit Commission on 25 March 2013 (“the Guidance”); and*
- *the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.*
- *We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.*
- *We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:*
  - *Board minutes for the period April 2012 to June 2013;*
  - *papers relating to the Quality Account reported to the Board over the period April 2012 to June 2013;*
  - *feedback from the Commissioners dated 21/06/2013;*
  - *feedback from Local Healthwatch dated 21/06/2013;*
  - *the Trust’s complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated 03/10/2012;*
  - *feedback from Wandsworth Council Adult Care and Health Overview and Scrutiny Committee dated 25/06/2013;*
  - *the latest national patient survey dated 16/04/2013;*
  - *the latest national staff survey dated 28/02/2013;*
  - *the Head of Internal Audit’s annual opinion over the trust’s control environment dated 24/05/2013;*
  - *the annual governance statement dated 06/06/2013;*
  - *Care Quality Commission quality and risk profiles dated 31/03/2013;*
  - *the results of the Payment by Results coding review dated 02/06/2013; and*
  - *We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively “the documents”). Our responsibilities do not extend to any other information.*

This report, including the conclusion, 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. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and St George’s Healthcare NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

## **Assurance work performed**

We conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the Guidance. Our limited assurance procedures included:

- *evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;*
- *making enquiries of management;*
- *testing key management controls;*

- *analytical procedures;*
- *limited testing, on a selective basis, of the data used to calculate the indicators back to supporting documentation;*
- *comparing the content of the Quality Account to the requirements of the Regulations; and*
- *reading the documents.*
- *A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.*

## Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by St George's Healthcare NHS Trust.

## Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

- *the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;*
- *the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and*
- *the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.*

### Andy Mack

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26th June 2013



## CQUINS for 2012/13

### Quality Account CQUIN summary – St George’s Hospital contract CQUINs 2012/13 as at May 2013

CQUIN	Annual forecast achievement	Comments
VTE assessment	<b>Partially met</b>	The percentage of documented VTE assessments conducted for the financial year is 95.2%. The Trust has not achieved VTE CQUIN Part A target of 98%. VTE continues to be a top clinical priority within the trust and performance will be reported on a monthly basis at Divisional Governance meetings.
VTE prophylaxis	<b>Fully met</b>	98 per cent of patients found to be at risk following VTE risk assessment have been provided with appropriate prophylaxis.
Patient experience	<b>Not met</b>	Although four out of five questions have improved as has the score compared to last year, as the overall composite score and the combined score for the 2 specific questions have not met the target, the CQUIN has not been achieved. This is very disappointing and does not demonstrate the standards maintained and improvements achieved overall.
Dementia	<b>Not met</b>	The 90% target has not been reached, plans are in place to change the recording system with the aim of achieving this target this year.
Safety Thermometer	<b>Fully met</b>	Processes put 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	<b>Fully met</b>	Use of the end of life care register increased and levels of identification of patients in the last year of life improved and sustained
Outpatients – cancelled appointments	<b>Partially met</b>	0.6% against target of 0.5%
Outpatients – increase Central Booking System	<b>Fully met</b>	Areas which are booked through the Central Booking System increased
Outpatients – booking outpatient appointment before inpatient discharge	<b>Not met</b>	Performance increased from 19% in Q1 to 64% in Q4 so this was a great improvement but we did not meet the Q4 target of 75%. A Service Improvement Project will be in place to improve performance on this measure in 2013/14
Outpatients – cancelling patient transport	<b>Fully met</b>	Successfully ensured that patient transport is cancelled when an appointment is cancelled.
Alcohol screening and referrals	<b>Partially met</b>	Screening in A&E has stabilised around 50% when referrals are taken into account, but random sample shows several factors that need to be improved for 2013-14. Screening rates need to increase as quarterly target rises, and A&E implementation of Alcohol Screening questions on iClip and by patient self-completion survey ought to have a positive impact.

CQUIN	Annual forecast achievement	Comments
Pressure ulcer management and reduction	<b>Fully met</b>	Improved 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	<b>Fully met</b>	Produced a price comparison report between drugs purchased by the trust and prices available through the London Procurement Programme.  Improved reporting and compliance for all available Patient Access Scheme and for excluded drugs.
Early Warning Scores	<b>Partially met</b>	A new action plan has recently been agreed with the DDNG and, it is hoped, will demonstrate beneficial effects by the next audit (July 2013).
Maternity – midwifery 1:28 ratio	<b>Fully met</b>	Implemented a midwifery workforce ratio of 1:27
Maternity – supernumerary midwife cover	<b>Fully met</b>	Ensured supernumerary midwife cover on delivery suite at all times.
Maternity – consultant cover	<b>Fully met</b>	Maintained agreed coverage of obstetric consultant cover on the delivery suite each week.
Falls – risk assessment	<b>Fully met</b>	Achieve an improvement in falls risk assessment and management in high risk areas.
Falls – education	<b>Fully met</b>	Implemented education programme aimed at increasing awareness of falls, reducing the number of falls and improving care for patients who have suffered falls.
Falls – reducing falls	<b>Partially met</b>	The target was 3.3% falls per 1000 bed days against the 3.9% falls per 1000 bed days which were reported in Q4.
Oncology – cancer staging	<b>Fully met</b>	New cancer patients with stage of tumors at time of diagnosis is accurately recorded
Oncology – acute oncology service	<b>Fully met</b>	Patients admitted through A&E with previously undiagnosed cancer are reviewed by a member of the oncology team within 24 hours of referral.
Paediatrics – non-accidental injury	<b>Fully met</b>	Management of paediatric non-accidental injury transferred.
Paediatrics – paediatric consultant cover	<b>Fully met</b>	Paediatric consultant cover increased to 9am till 9pm, seven days a week.
Medication safety	<b>Not met</b>	Documentation of reasons for omissions has improved, however it is still a cause for concern. In cases where the medication chart had no documented reason for omission, nursing notes were checked, and only in one case was the reason for omission documented. The documentation for omissions of medicines is required to be on the medication charts as that is the document that doctors and pharmacists refer to when assessing why medicines have been omitted.

CQUIN	Annual forecast achievement	Comments
Patient notes	<b>Not met</b>	The trust narrowly missed the target for filing notes in chronological order (90% against a target of 95%) but seriously missed the target for having the responsible consultant identified in the notes (65% against a target of 95%). Plans are in place to improve this performance this year.
Neonatal Intensive Care Unit	<b>Fully met</b>	Achieved reduction in the length of stay for babies admitted to a neonatal unit.
Paediatric Intensive care Unit	<b>Fully met</b>	Ensured that paediatric patients are treated and cared for in a safe environment.
Adult bone marrow transplant	<b>Fully met</b>	Successfully reported on outcomes for 100 days, 1 year and 2 years post transplant.
HIV	<b>Fully met</b>	<p>Ensured people living with HIV are registered with a GP.</p> <p>Ensured a letter has been sent to the patients' GP for an agreed percentage of patients who have consented the service to send a letter.</p> <p>Increase the number of patients receiving their antivirals by home delivery.</p> <p>Assess the implementation and impact of the HIV QIPP.</p>

## Community services contract CQUINs 2012/13 year end achievement

Inl Indicator	Annual achievement	Comments
<b>1a</b> 80% of community nursing (including community matrons), intermediate care and specialist nursing patients risk assessed using standard pressure ulcer assessment tool	<b>Fully met</b>	Final audit results in Q4 indicate that of 110 records audited, 103 had a pressure ulcer assessment tool in place – 94.5%
<b>1b</b> 80% of community nursing (including community matrons), intermediate care and specialist nursing staff at band 5 and below received education and competency around pressure care	<b>Fully met</b>	All 136 identified staff have been trained; met at 100%.
<b>2a</b> 95% of patients with a falls risk profile in place have 95% of all core information completed and 80% of additional information completed	<b>Partially met</b>	Q1 and Q2 targets were met but Q3 and Q4 targets were not met. Work is ongoing with clinical teams around completing falls risk profiles.
<b>2b</b> Falls and bone health education delivered to local GPs to support the falls and bone health pathway development	<b>Fully met</b>	All delivered and used to inform service developments around falls and bone health for 2013/14
<b>3</b> Implement processes and collect pilot data in preparation for the NHS Safety Thermometer ready for 2013/14	<b>Fully met</b>	Community nursing and intermediate care completed data collection and all processes have been trialed ready for 2013/14
<b>4a</b> 60% of patients on community nursing (including community matrons), intermediate care and specialist nursing caseload have a multi-disciplinary team meeting	<b>Partially met</b>	Q1 and Q2 targets were met. In Q3 the target was not met but focused improvement work meant that in Q4 61% of patients had an MDT meeting.
<b>4b</b> Reduce short stay admissions to 1,300 maximum	<b>Fully met</b>	During 2012/13 only 643 short stay admissions were recorded for Wandsworth patients.
<b>4c</b> 70% of non-cancer end of life care patients died in their preferred place of death	<b>Fully met</b>	Final audit results in Q4 indicate that 77% of patients died in their preferred place.
<b>5a</b> Developed and implemented triage processes for Single Point of Contact	<b>Fully met</b>	Single Point of Contact operating and processes are in place. Amendment to processes will continue through close operational working relationships.
<b>5b</b> 90% of 'urgent' referrals from SPoC contacted by telephone within 1 hour and visited within 4 hours.	<b>Fully met</b>	In the final Q4 audit 18 patients were identified as urgent and all were contacted by telephone within one hour and visited within 4 hours.

InI Indicator	Annual achievement	Comments
<b>6a</b> 95% of children in Wandsworth noted as unregistered with a GP referred to HV team contacted and a reduced % of GP unregistered children on Wandsworth Child Health Register overall	<b>Fully met</b>	The original number of 1,715 records flagging as unregistered have all be resolved and a clear process is in place to minimize new records flagging as unregistered.
<b>6b</b> 90% of new adult sickle cell patients on haemoglobinopathies team caseload 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.	<b>Partially met</b>	All appropriate adult sickle cell patients were supported around self-management activities; however not all those requiring a 12 month care plan review had these. This is an area that will continue to be focused on in 2013/14.
<b>6c</b> 75% of adult sickle cell patients discharged from SGH contacted or visited by the Haemoglobinopathies Team Clinical Nurse Specialist (CNS) within 48 hours of discharge summary being received	<b>Fully met</b>	During 2012/13 70 patients were discharged from SGH and of these 61 were followed up within 48 hours – 87%
<b>6d</b> 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 referred to weight management and activity programmes	<b>Fully met</b>	Completed in Q3
<b>6e</b> 95% of young people seen by school health service for sexual health issues given information about sexual health support/ services available and sign-posted to a young person appropriate sexual health service	<b>Fully met</b>	All students who contacted the school health service were signposted and provided with information.
<b>6f</b> 80% of pregnant Wandsworth teenagers booked in at SGH offered ante-natal support. Plan to develop and provide post-natal structured support developed.	<b>Fully met</b>	35 young women out of a possible 42 received ante-natal input in the final audit – 83%
<b>6g</b> 85% of mothers identified as smokers at the new birth visit are provided with smoke free homes information and referred to smoking cessation programmes	<b>Fully met</b>	All mothers in audit sample identified as smokers have been referred to smoking cessation programmes.
<b>6h</b> Implement a system to make improvements to the scores around the annual breastfeeding audit and carry out the audit in 2013.	<b>Fully met</b>	Breastfeeding survey completed and action plan in place.

InI Indicator	Annual achievement	Comments
7	Review use of clinical outcome measures in CSW and implement outcome measure use in all services.	<b>Fully met</b> Project work has been carried out and clinical outcome measures are being used and reviewed in community services. The project will continue into 13/14.
<b>HMP Wandsworth contract CQUINs</b>		
1	Annual health check and health improvement opportunities are met for 50% of offenders with COPD, diabetes or primary hypertension and a plan for review of all of offenders and for delivering care to all is in place for 2013/14.	<b>Fully met</b> At the end of 2012/13, 70% of COPD patients had had a review, 62% of primary hypertension patients had been reviewed and 91% of diabetes patients had had a review. These clinics are programmed to continue in 2013/14 and further long term condition clinics around epilepsy and asthma are planned.
2	Redesigned Primary Care Mental Health Service at HMPW. 80% of offenders audited received were offered assessment and treatment within agreed minimum standards.	<b>Fully met</b> The Primary Care Mental Health Service now operates an appointment system and waiting times are within expected parameters. Of the audit sample 19/ 20 (95%) received input within the agreed minimum standards.
3a	70% of offenders who had polypharmacy verified following Reception had a review 6 weeks post receipt of verification; 70% of offenders in receipt of polypharmacy for the past 12 months had an annual review in the past 12 months	<b>Fully met</b> In Q4, 13 offenders met the criteria for polypharmacy verification following Reception into HMPW. All verifications were received within 1 week of request. Also in Q4, 124 offenders required a 12 month poly-pharmacy review and all 124 were offered an appointment for this. 99 attended – 80%.
3b	80% of offenders risk assessed as suitable to hold their medications as 'in possession' hold their medication 'in possession'. Processes, protocols and risk issues reviewed to assure of safety.	<b>Fully met</b> During Q4 295 offenders were risk assessed to hold their medication 'in possession'. Of these 261 then held their medication 'in possession' – 88%
4	60% of requests for urgent, non-urgent and routine appointments offered an appointment within target waiting times	<b>Fully met</b> In Q4, appointment requests were offered
<b>Queen Mary's Hospital contract CQUINs</b>		
1	97% of QMH inpatients having a SGH VTE risk assessment on admission; 95% of QMH inpatients with a VTE risk assessment in place indicating that prophylaxis is required, receive prophylaxis as per guidelines	<b>Fully met</b> In Q4, 193/194 inpatients at QMH had a VTE assessment on admission (99.5%); 182 of these patients required prophylaxis and all of these received this as per guidelines (100%)

InI Indicator	Annual achievement	Comments
2 Improvement of 1-3 points on the national inpatient survey questions for QMH beds	<b>Not met</b>	The results indicate that this is not met due to a combination of sample size, scoring system and responses. All responses are being reviewed and an improvement plan is being put in place.
3a 90% of patients admitted to QMH inpatient wards asked the dementia screening question	<b>Fully met</b>	This indicator applies to individuals over 75 years of age. In Q4, 149 inpatients admitted were over 75 years. Of these, 144 were asked the dementia screening question (97%)
3b 90% of patients admitted to QMH inpatient wards who were found to be at risk of dementia following screening, were risk assessed for dementia within 72 hours of admission	<b>Fully met</b>	16 of the patients asked the dementia screening question were found to be at risk of dementia. All of these patients (100%) were risk assessed formally.
3c 90% of patients admitted to QMH inpatient wards who were found to be at risk of dementia following the dementia risk assessment were referred for specialist diagnosis	<b>Fully met</b>	All 16 patients risk assessed formally for dementia were referred for a specialist diagnosis (100%).
4 Implement processes and collect pilot data in preparation for the NHS Safety Thermometer ready for 2013/14	<b>Fully met</b>	Both inpatient wards completed data collection and all processes have been trialled ready for 2013/14
5a Develop and deliver revised and new Rapid Diagnostic Pathways at QMH in conjunction and collaboration with commissioners	<b>Partially met</b>	RDPs are in place. However evaluation of one RDP has not been able to be completed due to timescales. This is why the indicator is marked as partially achieved.
5b Implement COPD revised and integrated patient pathway	<b>Fully met</b>	On track
5c Improve GP engagement with QMH, implemented marketing strategy and redeveloped website	<b>Fully met</b>	NB: The achievement of this CQUIN was moved to May 2013 at the request of commissioners and was fully achieved.
5d Piloted increased capacity in pain and gynaecology clinics at QMH	<b>Fully met</b>	Increased capacity is being provided; waiting times are reducing but not to 2 weeks as initially intended.
5e Review capacity and utilization at QMH	<b>Fully met</b>	Completed in Q2
6 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.	<b>Fully met</b>	52 patients were audited in Q4 all (100%) has a falls risk assessment in place. Of these 52, 51 (98%) contained full and accurate data.
7 90% of inpatients have the Early Warning Score (EWS) completed and accurately scored and 70% of completed EWS tools have appropriate responses to triggers in place	<b>Fully met</b>	30 patients were audited in Q4 and all (100%) had a completed and accurately scored EWS and appropriate responses to triggers in place.

InI Indicator	Annual achievement	Comments	
<b>8a</b>	95% of QMH inpatients have pressure ulcer risk assessment in place and 95% of QMH inpatients assessed as at high risk of developing a pressure ulcer have a repositioning chart completed	<b>Fully met</b>	Of the 194 inpatients admitted in Q4, 192 had a pressure ulcer risk assessment in place (99%). 48 of these were assessed as high risk and all (100%) had a repositioning chart completed.
<b>8b</b>	90% of QMH inpatient band 5 nurses and HCSWs have attended training and achieved competency in pressure ulcer management	<b>Fully met</b>	All 53 staff identified as requiring training received this (100%)
<b>8c</b>	85% of wheelchair service and special seating service patients have documented pressure considerations on the referral form and where appropriate action has been taken	<b>Fully met</b>	50 patient notes were audited in Q4. Of these pressure was noted as a concern clinically in 21 cases. In 19 of these cases (90%) appropriate pressure considerations were documented and action taken.
London Specialised Commissioning Group – HIV CQUINs			
<b>1</b>	70% of HIV patients attending SGH are registered with a GP and have disclosed their HIV status to their GP	<b>Met</b>	89% patients were registered with a GP and have disclosed their status to their GP as at the end of Q4 2012/13.
<b>2</b>	95% of HIV patients who are registered with a GP and have disclosed their status to their GP, receive are written to by the service	<b>Met</b>	99.6% of patients registered with a GP and who have disclosed their status to their GP were written to by the service.
<b>3</b>	70% of HIV patients receiving anti-retrovirals receive these via Home Delivery	<b>Met</b>	74.3% of patients are receiving anti-retrovirals via Home Delivery
<b>4</b>	QIPP plan and service improvement plan aspects are delivered	<b>Met</b>	QIPP and service improvement plans around pharmacy, patient experience and outcomes have all been delivered.



## CQUINS for 2013/14

Our proposed CQUINs for 2013/14 are outlined in the tables below. At the time of publication the trust is in discussions with commissioners and the list is subject to change.

For 2013/14 the total CQUIN value is estimated as £13 million.

### National indicators

CQUIN	Detail
Friends and Family Test	● Friends and Family Test – Phased expansion
	● Friends and Family Test – Increased Response
	● Friends and Family Test – improved performance on the Staff Friends and Family Test
NHS Safety Thermometer	● NHS Safety Thermometer – Data collection
	● NHS Safety Thermometer – Improvement
Dementia	● Dementia – Find, Assess, Investigate and Refer
	● Dementia – Clinical Leadership
	● Dementias – Supporting Carers of People with Dementia
VTE	● VTE Assessment
	● VTE Root Cause Analysis (RCA)

### Local indicators

CQUIN	Detail
End of Life	● To establish an on-going education and training programme around key areas of end of life care.
	● Extension of use of CMC or equivalent and audit of use of LCP
Alcohol Misuse	● Targeted Screening for alcohol misuse among in-patients
	● Signposting or Referral on to hospital based alcohol liaison nurses.
	● Identification, assessment and on referral of repeat attenders
	● Improved rates of treatment completed within a care planned framework or referred on for completion
	● Improved communications with GP's with patient with alcohol misuse diagnosis

<b>CQUIN</b>	<b>Detail</b>
<b>Smoking Cessation</b>	● <i>Improve the physical health of users &amp; work place staff of St George's Hospital by providing smoking cessation support.</i>
	● <i>Recruitment of CNS</i>
<b>Maternity</b>	● <i>Increase Midwifery Workforce Ratio</i>
	● <i>Supernumerary Midwife Cover on Delivery Suite</i>
	● <i>Consultant Cover</i>
<b>COPD Integration</b>	● <i>Development of the tiered model</i>
	● <i>Admissions</i>
	● <i>In reach admissions avoidance</i>
<b>Oncology</b>	● <i>Streamlining the pathway for patient with suspected cancers</i>
<b>Paediatric Services</b>	● <i>Transfer of the management of Paediatric Non-Accident Injury (NAI)</i>
	● <i>Paediatric Consultant Cover from 9am till 9pm, 7 days a week</i>
<b>Queen Mary's Hospital Service Redesign</b>	● <i>Dermatology service redesign</i>
<b>Medicines Management</b>	● <i>Appropriate use of Antibiotics t minimise C Difficile infection</i>
	● <i>Medicines Reconciliation</i>
	● <i>Homecare Quality and Efficiency</i>
	● <i>Appropriate insulin prescribing and Nice Guidance adherence</i>
<b>GP Communication</b>	● <i>Electronic A&amp;E, Outpatient and Discharge Letters</i>
	● <i>Quality A&amp;E, Outpatient and Discharge Letters</i>
<b>Community Data Quality</b>	● <i>Progression to meeting the non-mandatory MDS for Community Services</i>
<b>Community Ward</b>	● <i>Multidisciplinary Team Working Core MDT</i>
	● <i>Multidisciplinary Team Working Wider MDT</i>
<b>Diabetes Integration</b>	● <i>Development and implementation of a tiered diabetes model</i>
	● <i>Patient Education Programme</i>
<b>Fracture Liaison Service</b>	● <i>Fracture Liaison Service</i>
<b>Community Paediatrics</b>	● <i>Paediatric phlebotomy development</i>

## Specialised indicators

CQUIN	Detail
HIV	
Bone Marrow Transplant	<ul style="list-style-type: none"> <li>● The percentage use of UK donors rather than European or US</li> </ul>
	<ul style="list-style-type: none"> <li>● The number of Confirmatory Typing(CT)/Extended Typing (ET) tests per patient</li> </ul>
	<ul style="list-style-type: none"> <li>● The number of searches undertaken per transplant</li> </ul>
	<ul style="list-style-type: none"> <li>● The Turnaround Times (TAT) from the date of the search request to the delivery of the donor report</li> </ul>
Specialised Cancer	<ul style="list-style-type: none"> <li>● Access to and impact of clinical nurse specialist (CNS) support on patient experience</li> </ul>
Renal Dialysis	<ul style="list-style-type: none"> <li>● Reducing the incidence of preventable acute kidney injury (AKI)</li> </ul>
	<ul style="list-style-type: none"> <li>● Increase use of renal patient view (RPV) by all dialysis patients</li> </ul>
Renal Transplantation	<ul style="list-style-type: none"> <li>● Cold ischaemic Time</li> </ul>
Haemophilia	<ul style="list-style-type: none"> <li>● Joint scores in severe and moderate haemophilia A &amp; B (patients aged 4 years and over)</li> </ul>
	<ul style="list-style-type: none"> <li>● Haemtrack monitoring</li> </ul>
Major Trauma	<ul style="list-style-type: none"> <li>● Improving outcomes of major trauma orthopaedic injuries</li> </ul>
NICU	<ul style="list-style-type: none"> <li>● Improved access to breast milk in preterm infants</li> </ul>
	<ul style="list-style-type: none"> <li>● Timely administration of total parenteral nutrition in preterm infants</li> </ul>
Fetal Medicine	<ul style="list-style-type: none"> <li>● Rapidity of obtaining a tertiary level fetal medicine opinion</li> </ul>

## HMP Wandsworth

CQUIN	Detail
HMP Wandsworth	<ul style="list-style-type: none"> <li>● Annual health check and health improvement opportunities are met for 80% of offenders with epilepsy and asthma and a plan for review of all offenders and for delivering care to all is in place for 2013/14.</li> </ul>
	<ul style="list-style-type: none"> <li>● Achieve 80% uptake of Hepatitis B immunisation (excluding formal refusals)</li> </ul>
	<ul style="list-style-type: none"> <li>● Achieve 60% screening for Hepatitis C (excluding formal refusals)</li> </ul>
	<ul style="list-style-type: none"> <li>● Ensure 90% of second day screening attendees are screened for learning disability and that following this 90% of those identified as having learning disability (excluding refusals) receive a health check and learning disability appropriate information</li> </ul>

## Participation in national clinical audits and national confidential enquiries

Audit/enquiry	Relevant	Participation	Submission rate (%) / Comment
<b>Acute</b>			
National confidential enquiry into patient outcome and death	✓	✓	Alcohol related liver disease: 100
			Subarachnoid haemorrhage: 50
			Bariatric surgery: 100
			Cardiac arrest procedures: 62.5
Adult community acquired pneumonia (BTS)	✓	✓	Data collection open until 31st May 2013 – data to be published early 2014
ICNARC - Adult critical care case mix programme	✓	✓	100
Emergency use of oxygen (BTS)	✓	✓	90
National joint registry	✓	✓	100
Adult non-invasive ventilation (BTS)	✓	✓	Data collection open until 31st May 2013 – data to be published early 2014
Renal colic	✓	✓	100
TARN - Trauma audit and research network	✓	✓	96
<b>Blood and transplant</b>			
National comparative audit of blood transfusion: Audit of Blood Sampling and Labelling	✓	✓	100
Potential donor audit	✓	✓	100
<b>Cancer</b>			
NBOCAP - Bowel cancer	✓	✓	Data collection open until 1st October 2013
DAHNO - Head and neck oncology	✓	✓	Data collection open until November 2013
NLCA - Lung cancer	✓	✓	Data collection for cases up to Dec12 open until 30th June 2013
NAOGC - Oesophago-gastric cancer	✓	✓	Data collection open until 1st October 2013
<b>Heart</b>			
MINAP - Myocardial ischaemia national audit project	✓	✓	Processes are in place to submit 100% by deadline of 31/05/13
Adult cardiac surgery	✓	✓	100

Audit/enquiry	Relevant	Participation	Submission rate (%) / Comment
Cardiac arrhythmia	✓	✓	Devices: 100 Electrophysiology: Service has not been able to submit all cases due to computer interface problems. New web portal access will support improved participation in 2013/14.
Congenital heart disease	✓	✓	100
Coronary angioplasty	✓	✓	100
Heart failure	✓	✓	Processes are in place to submit 100% by deadline of 31/05/13
NCAA – National cardiac arrest audit	✓	✓	100
National vascular registry	✓	✓	VSGBI vascular service database -100 AAA – 100
<b>Long term conditions</b>			
Adult asthma (BTS)	✓	✗	We intended to participate in the audit however problems with the project website have prevented us from doing so. We will use the data collected locally to compare our performance to the national data and identify actions accordingly.
Bronchiectasis (BTS)	✓	✗	We participated in 4 of the 5 adult audits run by the British Thoracic Society (BTS) but did not have resources available to participate in this audit
Diabetes (Adult)	✓	✓	Continuous audit: 0 To allow participation the service require new software and this is currently being explored Inpatient audit: 100
Diabetes (Paediatric)	✓	✓	100
Inflammatory Bowel disease (IBD) Includes paediatric audit, in addition to adult	✓	✓	Adult: data collection period January to December 13 Paeds: data collection period January to December 13
National review of asthma deaths (NRAD)	✓	✓	100

Audit/enquiry	Relevant	Participation	Submission rate (%) / Comment
Pain database	✓	✗	This project has been carried out in 3 phases. We participated in Phase 1, but were unable to take part in Phase 2 due to service reconfiguration. This has excluded us from participating in Phase 3, however we continue to collect a comparable dataset locally.
Renal replacement therapy (Renal Registry)	✓	✓	100
Renal transplantation	✓	✓	100
<b>Older people</b>			
Carotid interventions audit	✓	✓	100
Fractured neck of femur	✓	✓	100
Hip fracture database	✓	✓	100
National audit of dementia	✓	✓	100
Parkinson's disease	✓	✓	Therapy: 77 Neuroscience: 0
Sentinel stroke national audit programme	✓	✓	Acute organisational audit: 100 Stroke improvement national audit project (SINAP): 98-101
<b>Women and children's health</b>			
Child health programme	✓	✓	100
Epilepsy 12: Childhood epilepsy	✓	✓	100
Maternal, infant and newborn programme (MBRRACE-UK)	✓	✓	Recording cases but submission not yet possible as the reporting system is not operational
Neonatal intensive and special care	✓	✓	100
Paediatric asthma (BTS)	✓	✓	93
Paediatric fever (College of emergency medicine)	✓	✓	100
Paediatric intensive care (PICAnet)	✓	✓	100
Paediatric pneumonia (BTS)	✓	✓	Tbc
<b>Other</b>			
Elective surgery – National PROMS programme	✓	✓	64.9 (April 12 – December 12)

## National audit actions taken

National clinical audit	Action*
National bowel cancer audit	An action plan has been developed to improve our low participation. The service are trying to engage all relevant clinicians in the audit. Support for data entry and submission has been identified and a process outlined so that cases are entered onto the system following the multidisciplinary meeting. Data will be validated by the lead clinician.
BTS non-invasive ventilation audit	Education sessions are provided to all incoming doctors.
UK national audit of percutaneous coronary interventional procedures	The only unit level data available shows our data to be of high quality. National results and recommendations have been considered by service leads for local action where relevant.
National audit of seizure management	We participated in a regional meeting to discuss actions and had already implemented those around provision of information to patients. Improved sharing of information to assist in the management of patients across the trust has also been established.
Paediatric intensive care audit (PICAnet)	The report has been discussed in detail with lead nurses and clinicians. A review of nursing establishment is planned to ensure needs of the unit are met.
National hip fracture database	There are plans to recruit an additional Orthogeriatrician.
National health promotion in hospitals audit	Improvement in the smoking cessation service and monitoring of referrals to track progress.
National paediatric diabetes audit	Considering how to improve IT systems which will allow for improved and more efficient participation
Severe sepsis and septic shock	Updating guidelines to clarify the need for high flow oxygen in septic patients and to measure urine output. Guidelines made available on the intranet. Steps taken to promote recognition and management of sepsis, such as displaying posters and installing screensaver messages
BTS emergency use of oxygen	A programme of training and awareness raising in place for doctors and nurses, particularly of the need to treat oxygen as a drug. Oxygen alert cards have been introduced.
National heart failure	Results are being used to develop a case for an acute heart failure unit which would substantially improve the percentage of patients cared for in a cardiology setting; a key marker of quality.

\*Based on information available at the time of publication

## Local clinical audit actions taken

National clinical audit	Action*
Use of the early warning score (EWS) chart	<p>Project team engage with wards and act as mentors to provide ward-based training.</p> <p>Regular programme of education incorporated in new 'Harm Free Care' training.</p>
Safe and secure storage of medicines audit and re-audit	<p>Monthly 'Improving medication safety' sessions.</p> <p>Quarterly audits to monitor performance and track progress.</p> <p>Medication safety visits in areas where compliance can be improved.</p> <p>Improvements to drug fridges in order to improve security.</p>
Primary prevention of osteoporotic fragility fractures in post-menopausal women	<p>Links established between the trust and Wandsworth Health's new osteoporosis practitioner. Improved communication with GPs.</p>
Cardiac rehabilitation re-audit	<p>Continue to provide information and education during the programme as results indicate that addressing cardiac beliefs can reduce patient anxiety and depression.</p>
Protected mealtimes re-audit	<p>Ensure protected mealtime poster is displayed on all wards. Improve identification of patients requiring assistance on ward nutrition boards. Local action plans to be developed.</p>
WHO surgical checklist audit	<p>Focused on safer surgery in Patient Safety week in September 2012.</p> <p>Targeted support and teaching in poorly performing areas.</p> <p>Made briefing and debriefing mandatory parts of the process.</p> <p>Quarterly audit programme demonstrating significant progress.</p>
Healthcare records audit	<p>Quarterly audit mandatory for all care groups.</p> <p>Re-design of continuation sheets to support improved documentation.</p> <p>Renewed focus on documentation on doctor induction.</p> <p>Trust-wide publicity campaign</p>

\*Based on information available at the time of publication



## Financial report

St George's made a revenue surplus of £6.286 million in 2012/13. This compares with a surplus of £6.101m in 2011/12. The trust has now generated revenue surpluses in six consecutive years and no longer has any historic NHS debt to repay. The total savings challenge the trust faced in 2012/13 was £37.17m. Delivery was at £36.97m, a small undershoot of £194k.

The trust's liquidity position improved during the year and is rated at 4 using the definition of Monitor, the regulator for Foundation Trusts, which the trust applies to measure its liquidity. The year end cash balance of £24.1m is equivalent to approx 13.5 days of operating expenses – ahead of the 10 days operating expenses minimum set by the trust and regarded as best practice. The trust's treasury management policy permits the investment of temporary cash surpluses with the National Loans Fund to earn interest income which is then re-invested in services.

The capital structure of the trust remained broadly the same as last year with movements in borrowings relating to scheduled repayments of existing loans and leases and replacement of leases that expired during the year. Medium term financial plans assume a significant increase in borrowings to fund higher levels of capital investment in upgraded facilities and equipment. This capital investment will be subject to robust business case approval processes including where applicable approval by the National Trust Development Agency to ensure they are affordable.

The pension scheme operated by the trust is the NHS Pension Scheme managed by the NHS Pensions Agency. Employer and employee contributions to the scheme are collected and paid over to the NHSPA on a monthly basis. Therefore the cost of membership of the scheme is included in operating expenses. Pensions information for senior managers is disclosed in accordance with the requirements of the Greenbury report in the enclosed remuneration report. Further information on the accounting and valuation policy of the NHS Pension Scheme is given in note 1.5 in the Accounts.

The trust generated an underspend on its Capital Resource Limit (CRL) of approximately £9.0 million in 2012/13 as a result mainly of slippage on the Helipad project, the procurement of new Monitoring equipment throughout the Trust over the next few years and the Neuro-rehabilitation relocation. The trust undershot its External Financing Limit (EFL) by approximately £7.5 million and therefore stayed within the overall cash limit set by the Department of Health. The undershoot was caused primarily by the slippage on the capital programme.

The trust faces a similar level of financial challenge in 2013/14, needing to identify savings of £37.1m. The delivery of savings of this magnitude is highly challenging and consequently carries significant risk for the trust. Therefore to support the delivery of the savings programme the trust has invested significantly in a service improvement programme with the support of NHS London. This has been an area of real focus for the trust in 2012/13 and the methods and approach are beginning to bring real benefits which will help us meet our productivity challenge in 2013/14 and beyond whilst improving the quality of care we offer and the patient experience we deliver.

The trust's long term financial value is dependent primarily on its ability to deliver high quality clinical activities efficiently and to earn surpluses sufficient to finance the levels of capital investment necessary to sustain its facilities and equipment infrastructure to a reasonable standard. The principal risks to long term value therefore are the changes in patient flows and configuration of services that may take place locally and nationally. The trust must ensure its clinical strategy anticipates these changes so that its financial viability is assured.

## Requesting a copy of the full accounts

The financial statements in this report may not contain sufficient information for a full understanding of the trust's financial position and performance.

Copies of the full accounts are available on request by contacting the trust's communications team using the following methods:

Write to us:

### **Communications team**

Room 37

First floor

Grosvenor Wing

St George's Healthcare NHS Trust

Blackshaw Road

London

SW17 0QT

Tel: **020 8725 5151**

Email: **[communications@stgeorges.nhs.uk](mailto:communications@stgeorges.nhs.uk)**

# Statement of Comprehensive Income

## For the year ended 31 March 2013

	2012-13 £000	2011-12 £000
<b>Revenue</b>		
Employee benefits	(393,566)	(389,717)
Other costs	(234,960)	(219,260)
Revenue from patient care activities	562,414	543,339
Other Operating revenue	79,354	77,072
<b>Operating surplus/(deficit)</b>	<b>13,242</b>	<b>11,434</b>
<b>Investment revenue</b>	<b>99</b>	<b>87</b>
Other gains and (losses)	156	4,843
Finance costs	(3,196)	(3,785)
<b>Surplus/(deficit) for the financial year</b>	<b>10,301</b>	<b>12,579</b>
Public dividend capital dividends payable	(7,167)	(6,851)
<b>Retained surplus/(deficit) for the year</b>	<b>3,134</b>	<b>5,728</b>
<b>Other Comprehensive Income</b>		
Impairments and reversals	(3,313)	0
Net gain/(loss) on revaluation of property, plant & equipment	9,661	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
<b>Total comprehensive income for the year</b>	<b>9,482</b>	<b>5,728</b>
<b>Financial performance for the year</b>		
Retained surplus/(deficit) for the year	3,134	5,728
IFRIC 12 adjustment	1,349	1,433
Impairments	1,028	0
Adjustments iro donated asset/gov't grant reserve elimination	775	(1,060)
<b>Adjusted retained surplus/(deficit)</b>	<b>6,286</b>	<b>6,101</b>

# Statement of Financial Position

## For the year ended 31 March 2013

	31 March 2013	31 March 2012
	£000s	£000s
<b>Non-current assets:</b>		
Property, plant and equipment	282,716	282,179
Intangible assets	6,282	2,521
Investment property	0	0
Other financial assets	0	0
Trade and other receivables	38	38
<b>Total non-current assets</b>	<b>289,036</b>	<b>284,738</b>
<b>Current assets:</b>		
Inventories	7,191	6,293
Trade and other receivables	45,969	48,648
Other financial assets	0	0
Other current assets	27	1
Cash and cash equivalents	24,127	29,916
<b>Total current assets</b>	<b>77,314</b>	<b>84,858</b>
Non-current assets held for sale	0	426
<b>Total current assets</b>	<b>77,314</b>	<b>85,284</b>
<b>Total assets</b>	<b>366,350</b>	<b>370,022</b>
<b>Current liabilities</b>		
Trade and other payables	(62,837)	(72,696)
Other liabilities	0	0
Provisions	(741)	(1,011)
Borrowings	(3,047)	(3,470)
Other financial liabilities	0	0
Working capital loan from Department	0	0
Capital loan from Department	0	0
<b>Total current liabilities</b>	<b>(66,625)</b>	<b>(77,177)</b>
<b>Non-current assets plus/less net current assets/liabilities</b>	<b>299,725</b>	<b>292,845</b>
	£000s	£000s
<b>Non-current liabilities</b>		
Trade and other payables	0	0

	<b>31 March 2013</b>	31 March 2012
Other Liabilities	<b>0</b>	0
Provisions	<b>(1,285)</b>	(1,278)
Borrowings	<b>(51,290)</b>	(53,926)
Other financial liabilities	<b>0</b>	0
Working capital loan from Department	<b>0</b>	0
Capital loan from Department	<b>0</b>	0
<b>Total non-current liabilities</b>	<b>(52,575)</b>	(55,204)
<b>Total Assets Employed:</b>	<b>247,150</b>	237,641

#### **FINANCED BY:**

#### **TAXPAYERS' EQUITY**

Public Dividend Capital	<b>131,475</b>	131,475
Retained earnings	<b>21,750</b>	16,360
Revaluation reserve	<b>92,775</b>	88,656
Other reserves	<b>1,150</b>	1,150
<b>Total Taxpayers' Equity:</b>	<b>247,150</b>	237,641

## Statement of changes in taxpayers' equity

### For the year ended 31 March 2013

	Public Dividend capital £000s	Retained earnings £000s	Revaluation reserve £000s	Other reserves £000s	Total reserves £000s
<b>Balance at 1 April 2012</b>	<b>131,475</b>	<b>16,360</b>	<b>88,656</b>	<b>1,150</b>	<b>237,641</b>
<b>Changes in taxpayers' equity for the year ended 31 March 2013</b>					
Retained surplus/ (deficit) for the year	0	3,134	0	0	<b>3,134</b>
Net gain on revaluation of property, plant, equipment	0	0	9,661	0	<b>9,661</b>
Impairments and reversals	0	0	(3,313)	0	<b>(3,313)</b>
Transfers between reserves	0	2,256	(2,229)	0	<b>27</b>
<b>Net recognised revenue/(expense) for the year</b>	<b>0</b>	<b>5,390</b>	<b>4,119</b>	<b>0</b>	<b>9,509</b>
<b>Balance at 31 March 2013</b>	<b>131,475</b>	<b>21,750</b>	<b>92,775</b>	<b>1,150</b>	<b>247,150</b>

The Trust's Other Reserves relates to Taxpayer's Equity recognised retrospective for land that was excluded on the Trust's inception.

<b>Balance at 1 April 2011</b>	<b>131,475</b>	<b>(3,225)</b>	<b>102,513</b>	<b>1,150</b>	<b>231,913</b>
<b>Changes in taxpayers' equity for the year ended 31 March 2012</b>					
Retained surplus/(deficit) for the year	0	5,728	0	0	5,728
Transfers between reserves	0	13,857	(13,857)	0	0
<b>Net recognised revenue/(expense) for the year</b>	<b>0</b>	<b>19,585</b>	<b>(13,857)</b>	<b>0</b>	<b>5,728</b>
<b>Balance at 31 March 2012</b>	<b>131,475</b>	<b>16,360</b>	<b>88,656</b>	<b>1,150</b>	<b>237,641</b>

# Statement of cash flows

## For the year ended 31 March 2013

	2012-13 £000s	2011-12 £000s
<b>Cash Flows from Operating Activities</b>		
Operating Surplus/Deficit	13,242	11,434
Depreciation and Amortisation	18,787	18,698
Impairments and Reversals	1,028	0
Interest Paid	(3,158)	(3,780)
Dividend Paid	(6,797)	(7,128)
Increase in Inventories	(898)	(407)
Decrease in Trade and Other Receivables	2,679	1,025
Movement in Other Current Assets	0	0
Decrease in Trade and Other Payables	(12,997)	5,299
Provisions Utilised	(670)	(178)
Increase in Provisions	367	413
<b>Net Cash Inflow/(Outflow) from Operating Activities</b>	<b>11,583</b>	<b>25,376</b>
<b>Cash Flows From Investing Activities</b>		
Interest Received	99	86
Payments for Property, Plant and Equipment	(12,196)	(23,256)
Payments for Intangible Assets	(2,730)	(424)
Proceeds of disposal of assets held for sale (PPE)	610	15,750
<b>Net Cash Inflow/(Outflow) from Investing Activities</b>	<b>(14,217)</b>	<b>(7,844)</b>
<b>Net Cash Inflow/(Outflow) Before Financing</b>	<b>(2,634)</b>	<b>17,532</b>
<b>Cash Flows From Financing Activities</b>		
Other Loans Received	0	1,551
Loans repaid to DH – Revenue Support Loans	0	(7,990)
Other Loans Repaid	(388)	(194)
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	(2,775)	(2,269)
Capital grants and other capital receipts	8	762
<b>Net Cash Inflow/(Outflow) from Financing Activities</b>	<b>(3,155)</b>	<b>(8,140)</b>
<b>Net Increase/(Decrease) In Cash and Cash Equivalents</b>	<b>(5,789)</b>	<b>9,392</b>
<b>Cash and Cash Equivalents ( and Bank Overdraft) at Beginning of the Period</b>	<b>29,916</b>	<b>20,524</b>
<b>Cash and Cash Equivalents (and Bank Overdraft) at year end</b>	<b>24,127</b>	<b>29,916</b>

# Notes to the accounts

## For the year ended 31 March 2013

	2012-13 £000s	2011-12 £000s
<b>Revenue from Patient Care Activities</b>		
Strategic Health Authorities	533	1,073
NHS Trusts	506	1,731
Primary Care Trusts – tariff	493,239	468,982
Primary Care Trusts – non-tariff	9,112	10,201
Primary Care Trusts – market forces factor	47,940	46,332
NHS Foundation Trusts	1,967	1,876
Local Authorities	706	444
Department of Health	638	3
NHS other	0	323
Non-NHS:		
Private patients	3,681	4,259
Overseas patients (non-reciprocal)	880	1,497
Injury costs recovery	3,060	3,813
Other	152	2,805
<b>Total Revenue from Patient Care Activities</b>	<b>562,414</b>	<b>543,339</b>
Injury Cost Recovery income is subject to a provision for impairment of receivables of approx. 9.8% to reflect expected rates of collection.		
<b>Other Operating Revenue</b>		
Recoveries in respect of employee benefits	5,779	6,740
Patient transport services	0	98
Education, training and research	53,670	51,946
Charitable and other contributions to revenue expenditure – NHS	179	0
Charitable and other contributions to revenue expenditure – non – NHS	145	236
Receipt of donations for capital acquisitions – NHS Charity	244	2,595
Receipt of Government grants for capital acquisitions	452	51
Non-patient care services to other bodies	16,758	11,864
Income generation	1,829	2,308
Rental revenue from finance leases	0	0
Rental revenue from operating leases	137	110
Other revenue	161	1,124
<b>Total Other Operating Revenue</b>	<b>79,354</b>	<b>77,072</b>
<b>Total Operating Revenue</b>	<b>641,768</b>	<b>620,411</b>



	2012-13	2011-12
	£000	£000
<b>Revenue</b>		
From rendering of services	640,246	618,915
From sale of goods	1,522	1,496
<b>Total Revenue</b>	<b>641,768</b>	620,411

	2012-13	2011-12
	£000s	£000s
<b>Operating Expenses (excluding employee benefits)</b>		
Services from other NHS trusts	6,875	6,566
Services from PCTs	936	288
Services from other NHS bodies	145	136
Services from foundation trusts	359	1,052
Purchase of healthcare from non NHS bodies	5,555	3,729
Trust Chair and Non-executive Directors	83	70
Supplies and services – clinical	117,648	111,035
Supplies and services – general	15,021	14,596
Consultancy services	3,039	2,788
Establishment	6,309	5,254
Transport	5,719	5,348
Premises	39,653	35,491
Impairments and Reversals of Receivables	660	1,475
Inventories write down	0	3
Depreciation	17,910	17,835
Amortisation	877	863
Impairments and reversals of property, plant and equipment	1,028	0
Audit fees	188	262
Other auditor's remuneration	0	297
Clinical negligence	9,088	8,147
Research and development (excluding staff costs)	430	281
Education and Training	1,160	1,510
Other	2,277	2,234
<b>Total Operating Expenses (excluding employee benefits)</b>	<b>234,960</b>	219,260

<b>Employee benefits</b>		
Employee benefits excluding Board members	392,622	388,825
Board members	944	892
<b>Total Employee Benefits</b>	<b>393,566</b>	389,717

<b>Total Operating Expenses</b>	<b>628,526</b>	608,977
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	<b>2012-13</b>	<b>2011-12</b>
<b>Staff Sickness absence and ill health retirements</b>	<b>Number</b>	<b>Number</b>
Total Days Lost	56,622	59,039
Total Staff Years	7,203	7,260
Average working Days Lost	7.9	8.1
Number of persons retired early on ill health grounds	8	10

	<b>2012-13</b>	<b>2012-13</b>	2011-12	2011-12
<b>Better Practice Payments Code compliance</b>	<b>Number</b>	<b>£000s</b>	Number	£000s
<b>Non-NHS Payables</b>				
Total Non-NHS Trade Invoices Paid in the Year	<b>118,770</b>	<b>221,836</b>	113,794	207,469
Total Non-NHS Trade Invoices Paid Within Target	<b>96,247</b>	<b>174,026</b>	58,004	123,030
<b>Percentage of NHS Trade Invoices Paid Within Target</b>	<b>81.04%</b>	<b>78.45%</b>	50.97%	59.30%

<b>NHS Payables</b>				
Total NHS Trade Invoices Paid in the Year	<b>5,072</b>	<b>63,078</b>	4,736	51,867
Total NHS Trade Invoices Paid Within Target	<b>3,592</b>	<b>41,427</b>	1,447	20,299
<b>Percentage of NHS Trade Invoices Paid Within Target</b>	<b>70.82%</b>	<b>65.68%</b>	30.55%	39.14%

## Prompt Payments Code

The trust is not a signatory to the Prompt Payments Code. However its payment of suppliers is monitored by the Department of Health using the Better Payment Practice Code (BPPC), established by the Confederation of British Industry.

The BPPC objective is to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is the later. The trust improved its performance in 2012/13 against the BPPC.

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

## Responsibility in charging for information

The trust complies with HM Treasury guidance on setting charges for information, which states that public bodies including NHS Trusts should provide information available either for free or at low cost.

Information about the trust is freely available on our website [www.stgeorges.nhs.uk](http://www.stgeorges.nhs.uk), and is used as a primary tool to communicate with patients and the public.

Requests for more extensive information do carry a charge (such as for medical records), which covers the cost of copying and staff time. These costs are kept as low as possible.

In the majority of Freedom of Information (FOI) requests the trust will absorb the cost of copying materials requested by the public. However, requests can be refused on cost grounds if the cost of obtaining information exceeds a cost of £450.

## Salary and pension entitlements of senior managers

A) Remuneration	2012-13				2011-12			
	Salary (bands of £5000)	Other Remuneration (bands of £5000)	Performance related bonuses (bands of £5000)	Benefits in Kind Rounded to the nearest £100	Salary (bands of £5000)	Other Remuneration (bands of £5000)	Performance related bonuses (bands of £5000)	Benefits in Kind Rounded to the nearest £100
Executive Directors	£000	£000	£000		£000	£000	£000	
<b>Mr David Astley</b> Chief Executive (to May 11)	0			0	15-20			0
<b>Mr Peter Coles</b> Interim Chief Executive (from Jun 11 to Dec 11)	0				85-90			
<b>Mr Miles Scott</b> Chief Executive (from Nov 11)	210-215			12,300	85-90			£5,400
<b>Mr Richard Eley</b> Director of Finance (to April 12)	46-50			0	140-145			0
<b>Mr Dominic Sharp</b> Acting Finance Director (May 12)	5-10			0	0			0
<b>Mr William Boa</b> Acting Director of Finance and Performance (Jun-Aug 12)	85-90			0	0			0
<b>Mr Steven Bolam</b> Director of Finance, Performance and Informatics (from Sep 12)	90-95			0	0			0
<b>Mrs Alison Robertson</b> Chief Nurse and Director of Operations	135-140			0	120-125			0
<b>Mr Michael Bailey</b> Medical Director (to Jun 11)	0	0		0	5-10	15-20		0

A) Remuneration	2012-13				2011-12			
	Salary (bands of £5000)	Other Remuneration (bands of £5000)	Performance related bonuses (bands of £5000)	Benefits in Kind Rounded to the nearest £100	Salary (bands of £5000)	Other Remuneration (bands of £5000)	Performance related bonuses (bands of £5000)	Benefits in Kind Rounded to the nearest £100
Executive Directors	£000	£000	£000		£000	£000	£000	
<b>Dr Rosalind Given-Wilson</b> Medical Director	20-25	115-120	45-50	0	20-25	115-120	45-50	0
<b>Mrs Annette Gately</b> Interim Director of Human Resources (to Apr 11)	0			0	5-10			0
<b>Ms Jacqueline McCullough</b> Interim Director of Human Resources (to Jan 11)	0			0	80-85			0
<b>Ms Wendy Brewer</b> Director of Human Resources (joint post with SGUL from Feb 12)	65-70			0	5-10			0
<b>Dr Trudi Kemp</b> Director of Strategic Development	90-95		5-10	0	95-100		5-10	0
<b>Mr Neal Deans</b> Director of Estates & Facilities (joint post with SGUL from Sep 12)	90-95			0	100-105			0
<b>Mr Jean-Pierre Moser</b> Director of Communications (to Sep 12)	40-45			0	90-95			0
<b>Mr Patrick Mitchell</b> Chief Operating Officer (seconded from Mar 12)	0			0	130-135			0
<b>Mr Peter Jenkinson</b> Director of Corporate Affairs	110-115			0	90-95			0

A) Remuneration	02012-13				2011-12			
	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Performance related bonuses (bands of £5000) £000	Benefits in Kind Rounded to the nearest £100	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Performance related bonuses (bands of £5000) £000	Benefits in Kind Rounded to the nearest £100
<b>Non-Executive Directors</b>								
<b>Ms Naaz Coker</b> Trust Chair (to Oct 11)	0			0	10-15		0	
<b>Mr Christopher Smallwood</b> Trust Chair (from Nov 11)	20-25			0	5-10		0	
<b>Ms Emma Gilthorpe</b> Deputy Chair (to Jul 12)	0-5			0	5-10		0	
<b>Dr Graham Hibbert</b> Non-Executive Director (to Sep 12)	0-5			0	5-10		0	
<b>Dr Judith Hulf</b> Non-Executive Director (from Jan 13)	0-5			0	0		0	
<b>Mr Paul Murphy</b> Non-Executive Director (to July 2013)	5-10			0	5-10		0	
<b>Professor Sean Hilton</b> Non-Executive Director (to Jul 11)				0	1-5		0	
<b>Mr Michael Rappolt</b> Non-Executive Director	5-10			0	5-10		0	
<b>Moira Nangle</b> Associate Non Executive Director (to Oct 11)				0	1-5		0	
<b>Ms Sarah Wilton</b> Associate Non- Executive Director	5-10			0	5-10		0	
<b>Dr Peter Kopelman</b> Non-Executive Director	5-10			0	5-10		0	
<b>Mrs Stella Pantelides</b> Non-Executive Director (from Jan 13)	0-5			0	0		0	

The above table is subject to final audit approval.

Signed:  .....  
**Miles Scott Chief Executive**

Signed:  .....  
**Steve Bolam Director of Finance**

**B) Pension Benefits**

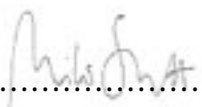
	Real increase in pension and related lump sum at age 60	Lump sum at aged 60 related to real increase in pension	Total accrued pension and related lump sum at age 60 at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2012	Real Increase in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension
	(bands of £2500) £000	(bands of £2500) £000	(bands of £5000) £000	£000	£000	£000	To nearest £100
<b>Mr Miles Scott</b> <b>Chief Executive</b>	2.5 - 5	12.5 - 15	260 - 265	1,051	957	94	0
<b>Mr Richard Eley</b> <b>Director of Finance</b> (to April 12)	0 - 2.5	2.5 - 5	200 - 205	N/A	968	N/A	0
<b>Mr Dominic Sharp</b> <b>Acting Finance Director</b> (May 12)	0 - 2.5	5 - 7.5	70 - 75	283	241	42	0
<b>Mr Steven Bolam</b> <b>Finance Director</b> (from Sep 12)	2.5 - 5	10 - 12.5	130 - 135	482	412	70	0
<b>Mrs Alison Robertson</b> <b>Chief Nurse and Director of Operations</b>	5 - 7.5	20 - 22.5	215 - 220	911	768	143	0
<b>Dr Rosalind Given-Wilson</b> <b>Medical Director</b>	2.5 - 5	7.5 - 10	325 - 330	1,781	1,667	115	0
<b>Ms Wendy Brewer</b> <b>Director of Human Resources</b> (from Feb 12, joint post with SGUL)	5 - 7.5	20 - 22.5	130 - 135	634	490	144	0
<b>Dr Trudi Kemp</b> <b>Director of Strategic Development</b>	2.5 - 5	12.5 - 15	125 - 130	562	499	96	0
<b>Mr Neal Deans</b> <b>Director of Estates &amp; Facilities</b> (joint post with SGUL from Sep 12)	2.5 - 5	12.5 - 15	140 - 145	770	651	119	0
<b>Mr Jean-Pierre Moser</b> <b>Director of Communications</b> (to Sep 12)	0 - 2.5	2.5 - 5	35 - 40	143	121	22	0
<b>Mr Peter Jenkinson</b> <b>Director of Corporate Affairs</b>	2.5 - 5	10 - 12.5	65 - 70	257	191	66	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 above table is subject to final audit approval.

Signed:  .....  
**Miles Scott Chief Executive**

Signed:  .....  
**Steve Bolam 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 2012/13 was £213,279 (2011/12: £235,231). This was 7.04 times (2011/12: 7.58 times) the median remuneration of the workforce, which was £30,304. The apparent reduction is due to a revised calculation of the net salary.

In 2012/13, 1 employee (2011/12: 6) received remuneration in excess of the highest paid director. This employee's remuneration was £239,661 (2011/12: £236,424 to £448,704).

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

We have examined the summary financial statement for the year ended 31 March 2013 which comprises the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers' Equity, Statement of Cash Flows and notes on revenue from patient care activities, other operating revenue, revenue, operating expenses, employee benefits, staff sickness absence and ill health retirements, and Better Practice Payments Code compliance.

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. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust's directors and the Trust as a body, for our audit work, for this report, or for opinions we have formed.

### Respective responsibilities of directors and auditor

The directors are responsible for preparing the Annual Report.

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

We also read the other information contained in the Annual Report and consider the implications for our report if we become aware of any misstatements or material inconsistencies with the summary financial statement.

We conducted our 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. Our report on the statutory financial statements describes the basis of our opinion on those financial statements.

### Opinion

In our opinion the summary financial statement is consistent with the statutory financial statements of the Trust for the year ended 31 March 2013. We have not considered the effects of any events between the date on which we signed our report on the statutory financial statements (7 June 2013) and the date of this statement.

Grant Thornton UK LLP

Grant Thornton House

Melton Street

Euston Square

LONDON

NW1 2EP

30 August 2013

## Contact us

### Let us know what you think

Please feed back to the communications team and help us improve the information included in the report next year.

Telephone: **020 8725 5151**

Email: [communications@stgeorges.nhs.uk](mailto:communications@stgeorges.nhs.uk)

### 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.

Telephone: **020 8725 2453**

Email: [pals@stgeorges.nhs.uk](mailto: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](http://www.stgeorges.nhs.uk) or get in touch with our recruitment services team.

Telephone: **020 8725 0600**

Email: [hrrecruitment@stgeorges.nhs.uk](mailto: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. If you would like to sign up or find out more about being a member contact the membership team.

Telephone: **020 8266 6132**

Email: [members@stgeorges.nhs.uk](mailto:members@stgeorges.nhs.uk)

### Follow us

We post all of our latest news online. You can visit our website [www.stgeorges.nhs.uk](http://www.stgeorges.nhs.uk) or follow us:



StGeorgesTrust



@StGeorgesTrust



StGeorgesTrust

### 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.

Telephone: **020 8725 4916**

Email: [giving@stgeorges.nhs.uk](mailto:giving@stgeorges.nhs.uk)

Web [www.givingtogeorges.org.uk](http://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.

Telephone: **020 8725 1452**

Email: [zoe.holmes@stgeorges.nhs.uk](mailto:zoe.holmes@stgeorges.nhs.uk)

### Request a printed report

Contact the communications team if you would like a printed copy of the annual report or quality account.

Telephone: **020 8725 5151**

Email: [communications@stgeorges.nhs.uk](mailto:communications@stgeorges.nhs.uk)