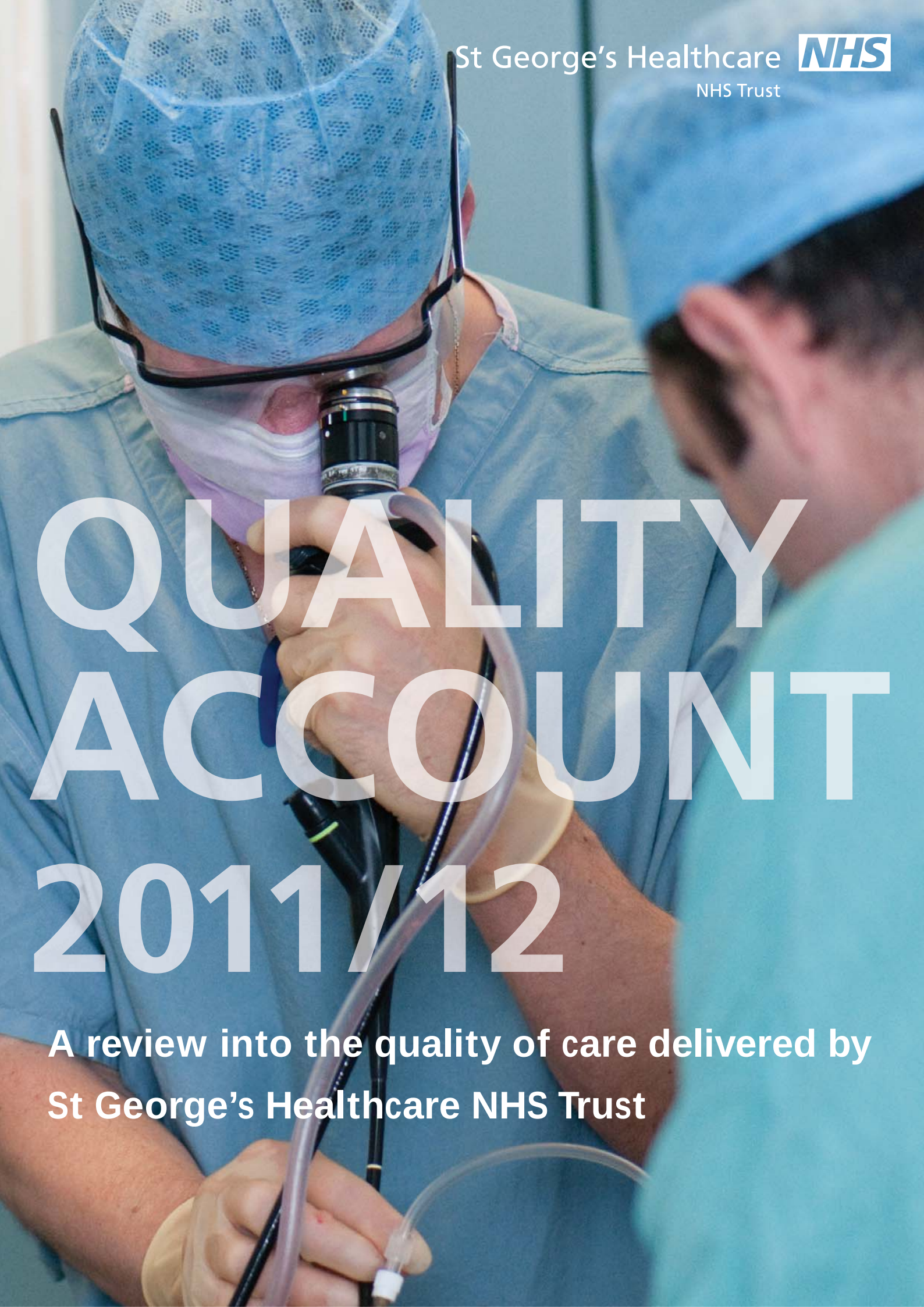

St George's Healthcare NHS
NHS Trust

QUALITY ACCOUNT 2011/12

A review into the quality of care delivered by St George's Healthcare NHS Trust

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Statement on quality

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

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

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

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

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

This is illustrated in the latest summary hospital-level mortality indicator (SHMI) data. The SHMI measures the likelihood of individual patients dying given their underlying condition, age and deprivation group – compared against the actual number of deaths that occurred. The SHMI and other mortality measures consistently show that we have significantly lower than expected mortality. Maintaining this exceptional performance is a huge achievement and a testament to the safety measures we have in place, as well as the clinical skill and dedication of our staff.

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

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

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

Patient participation in our clinical research studies this year increased by over 200 per cent compared with the same period last year. St George's is an important focal point for clinical research and this increasing level of participation and engagement is a powerful demonstration of our commitment to improving the quality of our patient care and to making a significant contribution to wider health improvement.

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

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

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

Miles Scott
Chief executive

Our aims during 2011/12

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

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

Mandatory reporting

Aim	**Outcome** – achieved / partially achieved / ongoing
Introduce a more rigorous approach to performance management against our CQUINs alongside processes to help staff monitor these on a monthly basis	**Achieved.** A more rigorous approach to performance management resulted in us meeting 90 per cent of our CQUINs which is a significant improvement on the previous year. You can read more about our CQUINs from page 23.
Do more to engage our staff in the development of the 2011/12 quality account	**Achieved.** The 2010/11 Quality Account included an electronic feedback mechanism for both staff and patients. All staff at the trust were given the opportunity to feedback their thoughts on our plans for the 2011/12 Quality Account through an online survey. This was promoted through the trust's intranet and via the trust's weekly all staff email and we received 69 responses.
Launch a new policy to fully establish our expectations of staff, clearly illustrating standards of behaviour and how adopting the trust's values will have a positive impact on patient care, quality and clinical outcomes	**Achieved.** A new policy was launched in June 2011 to fully establish our expectations of staff, clearly illustrating standards of behaviour and how embracing the trust's values makes a positive impact on patient care, quality and clinical outcomes. The expected behaviour of staff is explained clearly to all new employees as part of their induction process.

Improving patient outcomes

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

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

	over 95 per cent patients waiting within four hours and this will be completed by June 2012. The service has experienced a significant increase in attendances, especially over this winter period with an average of 360 attendances per day. Staff are working with colleagues from primary and community services in order to review all aspects of demand and ensuring that patients are seen appropriately, the new Accident and Emergency Department model will commence on June 11th 2012.
Successfully implement the 'productives' initiative (a programme designed to release more staff time to care for patients) in A&E, outpatient departments and 18 community services teams.	**Achieved.** The *productives* series is still very much on our agenda and we have successfully implemented productive theatres, productive wards and productive community. We intended to roll the project out in A&E; however, a project for the productive A&E was not launched nationally, so this was not possible.
Implement new performance indicators for equality and human rights to help embed equality into mainstream activity and deliver on the requirements of the Equality Act 2010	**Achieved.** An equality delivery strategy to improve the collection and analysis of information from key protected groups within reports at a corporate level was approved by the trust board in March 2011 to enable us to deliver against the requirements of the Equality Act 2010.
Strengthen our business planning and performance arrangements in order to be able to demonstrate quality of care at service level	**Achieved.** We will continue to build on this work by introducing a new performance management framework for the trust during 2012.
Establish a 'virtual outpatient directorate', including GP and patient representatives, which will oversee performance in all outpatient services	**Achieved.** The virtual outpatient directorate has been established and is tackling the following improvements: - Establishing a follow up call centre to deal with calls from follow up patients.) - Ensuring that the booking of ward discharge appointments is done in a timely manner at/prior to discharge - Sourcing medical notes more quickly - Plans to better meet demands for increasing capacity within the service - Established systems to ensure patients leave clinic with a suitable follow-up appointment

Patient safety

Aim	**Outcome.** – achieved / partially achieved / ongoing
Keep patients safe from venous thromboembolism (VTE) by conducting risk	**Achieved.** In 2011/12 we met both national and commissioner targets for VTE risk assessment. We also

assessments for at least 95 per cent of patients and giving appropriate thromboprophylaxis for at least 95 per cent of the patients who need it	met both national and commissioner led targets for giving appropriate thromboprophylaxis (medicines to prevent blood clots).
Agree a clear framework of safety priorities through the patient at risk group to increase organisational learning	**Achieved.** We have focused on using the themes from incidents and serious incidents to prioritise projects that can improve systems and keep patients safe. We have developed an intranet based Safety Dashboard which outlines our safety priorities with resources to enable us to achieve our aims. It also facilitates a more robust way of measuring whether these initiatives lead to improved outcomes. We have also developed a video project to capture patient experiences when something goes wrong. These videos are being used to highlight the importance of patient safety and are being incorporated into a number of training courses.
Use medication safety monitoring visits to develop a systematic way of staff monitoring and training that will increase awareness of medication incidents and identify areas for improvement	**Achieved.** We also conducted a comprehensive medicines safety audit on which both trust- wide and divisional plans are being developed. We have also established five medicines safety workshops to increase knowledge and awareness among nursing staff. Identified safety issues are recorded in an action log and communicated to senior nursing and pharmacy staff.
Carry out appropriate audits to ensure that the Situation, background, assessment, response (SBAR) tool whenever patient information is shared, to ensure that this is carried out clearly and effectively	**Achieved.** To promote effective communication the SBAR (situation, background, assessment, recommendation) tool is included on the revised Early Warning Score (EWS) documentation, and evidence of its use is included in the audit. This was documented in 50 per cent of cases in the latest audit, which is an improvement from 37 per cent observed when it was a separate document.
Introduce printed wristbands across all relevant clinical areas of the trust that will contain the patient's NHS number to close the outstanding NPSA alert from November 2010	**Achieved.** Most patients coming into hospital to have a procedure, whether they are staying overnight or are a day case, will need to wear an identity wristband. During 2011, we completed the roll out of printed wristbands to replace handwritten ones. The printed wristbands include a barcode with the patient's details. These are printed automatically in some areas such as when a patient comes to the A&E department or when registering a newborn baby. This process helps improve patient safety. The compliance of printed wristbands was audited at 95 per

	cent and the outstanding NPSA alert from November 2010 was closed in August 2011. In 2012, Theatres implemented new patient tracking software into the Day Surgery Unit which now makes use of a barcode scanner to scan the printed wristbands. This makes sure that the right patient goes into the operating theatre as the details are matched against the patient's electronic record.
Develop more collaborative work across both acute and community services to reduce the number of older people suffering fragility fractures	**Achieved.** The trust's inpatient falls rate was 3.4 per 1000 bed days for all age groups in 2010-2011. While there was a small increase in the falls rate in the 1st quarter 2011-2012, the average inpatient falls rate for all age groups over the 2nd and 3rd quarters has remained steady at 3.35 per 1000 bed days. These figures remain below the rate of 5.6 per 1000 bed days for acute hospitals (NPSA 2010). The Trust has continued to work on developing falls and bone health pathways across the acute and community interface in Wandsworth in collaboration with public health, patient representatives, voluntary organisations and community colleagues. This has included the development of a falls and bone health strategy in Wandsworth with implementation planned for 2012-2013.
Monitor the number of serious incidents (SIs) in 2011/12 and introduce measures to address underlying SI themes to prevent reoccurrence	**Achieved.** We undertake a comprehensive thematic analysis of our SIs every six months on which we base our patient safety initiatives. We have also developed a series of DVDs of patients and their families telling stories which helps staff understand the real-life impact of SIs. See page 49 for more information.
Continue to raise profile and implementation of the Early Warning Score (EWS) and improve our scores for timely, appropriate and full responses when patients are deteriorating and Introduce a new colour coded chart to make completing the EWS tool more efficient for ward staff	**Both achieved.** A revised EWS chart was developed and piloted on a number of wards during the year. Following the pilot the final version of the form was agreed and is being rolled out across the trust. As part of the implementation a programme of regular audit has been introduced. The results of the latest audit show that a full set of observations was recorded in 89% of cases, compared with 71% in the pilot period and against the local target of 80%. The tool appears to support more accurate scoring of observations, with this achieved in 69% of cases on the new form, against less than 60% when the old form was in use. However, this needs to be improved and the project team members are acting as mentors to

	provide ward-based training.

Patient experience

Aim	**Outcome** – achieved / partially achieved / ongoing
Introduce a dedicated midwife to improve support for women in our maternity unit to feed their babies in the early days	**Achieved.** We have introduced a dedicated midwife to improve support for women in our maternity unit to breast feed their babies in the early days
Continue to develop weekly mealtime audits throughout 2011/12 to ensure that patients are receiving appropriate nutrition and hydration on our wards	**Achieved.** In place and monitored via our nutritional operational group. The CQC inspection of privacy and nutrition in older people judged that we were compliant against both standards. Read page 24 for more information.
Develop a single integrated system for reporting complaints and PALS contacts across both acute and community services	**Achieved.** Complaints and PALS contacts are reported through the Patient Issues Committee.
Publish nutrition and hydration information online and in the inpatient booklet to provide patients with the information they need about hospital meals before they arrive for their care	**Achieved.** Information has been added to the website to better inform patients of the catering services available before they arrive for their care and a reference has been added to the inpatient booklet. *Your guide to meals in hospital* can be found here: http://www.stgeorges.nhs.uk/patientleaflets.asp
Introduce a more efficient nutritional assessment tool to record the nutritional needs of patients on admission	**Partially achieved.** Our assessment tool has been revised and piloted. Further revisions are required before a trust-wide implementation of the new tool.
Reduce the time it takes to take all patients home after their appointments via patient transport – 90 per cent collected within 60 minutes	**Partially achieved.** We have met the target for collecting 90% of renal patients within 60 minutes. Although we continued to improve, we did not meet this target for all patient groups. Work continues to reduce these waiting times. Lost journeys have been reduced to 5.1% in March 2012 and have been consistently under 6% since October 2011.

Vision and values

The trust has six strategic aims, which are:

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

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

Our vision: By 2015 we will be a thriving foundation trust at the heart of an integrated healthcare system – one that delivers improved patient care in the community, hospital and specialist settings, supported by a unique and nationally recognised programme of research, education and employee engagement.

To achieve our vision we will keep patients at the heart of everything that we do – our values aim to inspire our staff to achieve this. 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

By delivering our strategic aims within this framework of values and behaviours we aim to ensure that there is a wide choice of high quality care provided closer to patients' homes, and that we reduce the number of patients admitted to hospital.

Effective management of patient pathways within the trust will ensure that patients do not spend longer than they have to in hospital and that the right support is in place in their community once they are discharged from our care.

Our tertiary services, such as trauma, stroke and cardiac, will flourish and provide a basis for both our research and education programmes. By fully developing our staff foundation trust membership scheme and our organisational development plan, all staff can contribute to our success.

Developing the quality account 2011/12

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

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

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

In summary, the indicators are:

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

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

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

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

- Wandsworth Local Involvement Network
- Merton Local Involvement Network
- Sutton Local Involvement Network

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

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

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

This report was written to adhere to the Quality Accounts toolkit 2011/12 and we have worked alongside the Audit Commission, as required, to ensure that this report has been produced with rigour and honesty.

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

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

Priorities for improvement 2012/13

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

Priority	Aim	Monitoring
Quality strategy	Revise existing Quality strategy and launch new strategy during 2012/13	- Quarterly quality and Risk Committee - Trust board approval
Summary hospital standardised mortality indicator (HSMI)	Maintain our performance and consistently achieve a mortality ratio which is lower than expected	- Monthly mortality monitoring meeting - Clinical Effectiveness and Audit Committee
Patient reported outcome measures (PROMS)	Improve our participation rates to match the national average	- Bi-monthly Patient Issues Committee
28 day emergency re-admission rate	Successfully reduce the number of emergency readmissions each year and demonstrate this through a reduction in the threshold penalty (financial penalty levied on each emergency readmission) agreed with our commissioners.	- Quarterly Performance Management Reviews
Responsiveness to inpatients' personal needs	Improve our score for responsiveness to inpatient needs while at least remaining in the expected score range for our organisation. Establish a mechanism to record whether patients would recommend the trust to family and friends	- Bi-monthly Patient Issues Committee
Staff who would recommend the provider to friends and family	To score within the top 20 per cent of trusts for staff that would recommend the trust as a place to work or receive treatment by 2015.	- Quarterly HR and Workforce committee
Percentage of	Continue to meet national and	- Quarterly performance

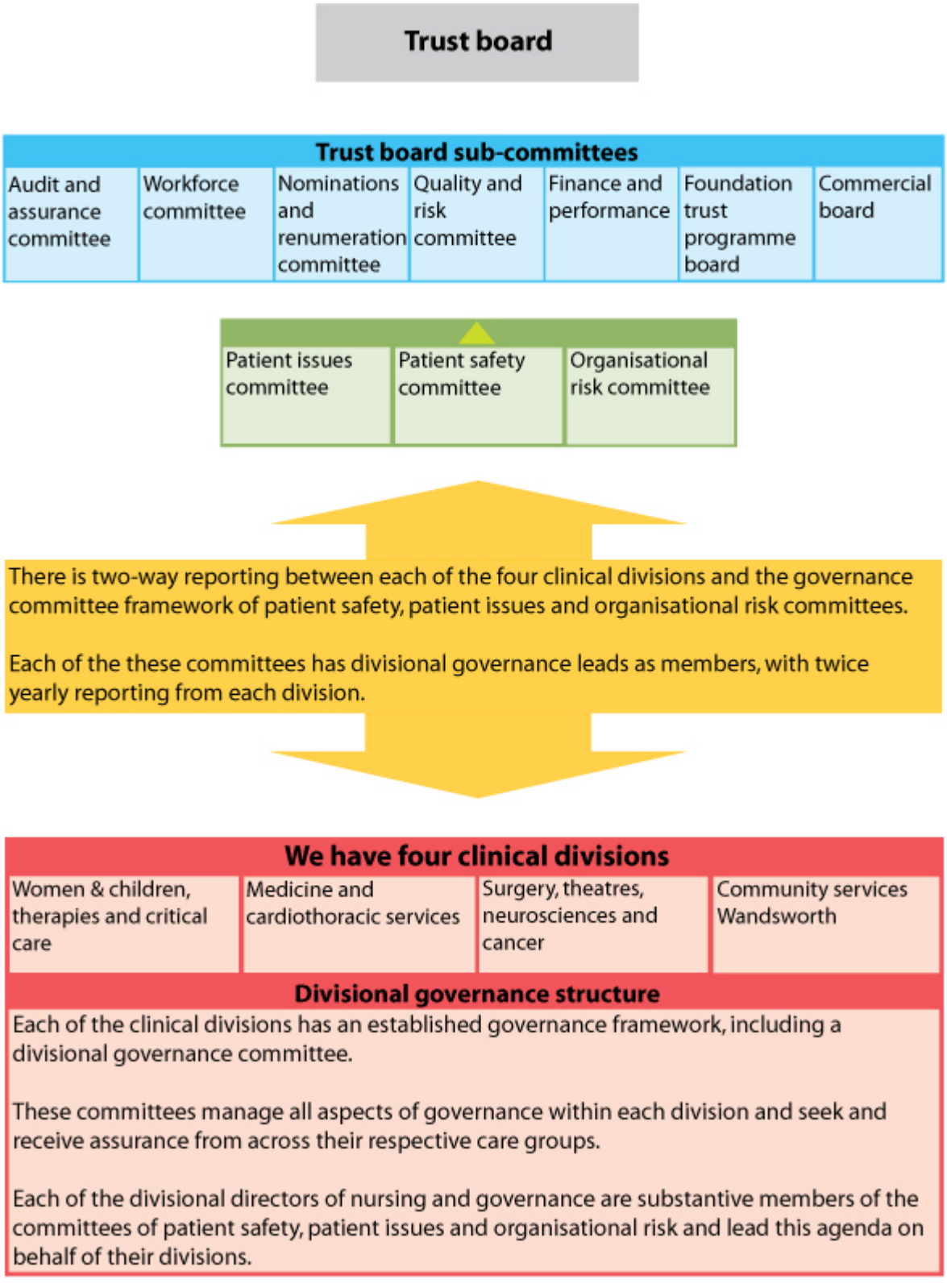
admitted patients risk assessed for VTE	commissioner led targets for VTE risk assessment and appropriate thromboprophylaxis	management reviews
Rate of *Clostridium difficile* and MRSA bacteraemia	Identify no more than 52 *C.diff* infections at St George's Hospital No more than two patients diagnosed with MRSA blood stream infection	- Fortnightly Healthcare Associated Infection Taskforce - Quarterly Infection Control Committee - Quarterly performance review
Rate of patient safety incidents and percentage resulting in severe harm or death	Continue to embed the lessons learned from reported PSIs and related investigations. Introduce measures to address underlying SI themes to prevent reoccurrence and continue to encourage an open and effective safety culture	- Monthly Patient Safety Committee
Patient discharge from ITU onto a ward	Undertake a process review of ITU pathways and capacity and identify actions to reduce the number of patients waiting longer than six hours for an appropriate specialty bed	- Quarterly Performance Management Reviews - Patient Issues Committee
18 week referral to treatment	Ensure that we accurately report our performance against and successfully treat 90 per cent of patients within the 18 week referral to treatment target	18 week programme Board -Quarterly Performance Management Reviews
Nutrition and hydration	Introduce a more efficient nutritional assessment tool to record the nutritional needs of patients on admission	- Quarterly Nutrition Steering Group - Nursing Board - Patient Issues Committee
Patient transport	Reduce the time it takes to take patients home after their appointments via patient transport – 90 per cent collected within 60 minutes	- Access Group - Patient Issues Committee
Research	Develop a research strategy and have appointed an	

	associate medical director to lead the delivery of this strategy on behalf of the trust	
Mixed sex accommodation	Reduce the number of mixed sex accommodation breaches by improving discharge from adult intensive care units into the appropriate specialty wards	- Patient Issues Committee
Community services	Ensure that 90 per cent of patients admitted to Queen Mary's, Roehampton, inpatient wards are asked the dementia screening question Ensure that 90 per cent of patients admitted to Queen Mary's, Roehampton, inpatient wards who are found to be at risk of dementia following screening, have a dementia risk assessment within 72 hours of admission 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	

How we will measure, monitor and achieve these priorities?

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

Governance Framework



- INTRODUCTION

- MANDATORY REPORTS

This section of the Quality Account contains all the items that we are **required** to report against annually.

- VOLUNTARY REPORTS
- CONTACTS AND APPENDICES

Review of services

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

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

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

Participation in clinical audit

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

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

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

The national clinical audits and national confidential enquiries that St George's Healthcare NHS Trust was eligible to participate in during 2011/12, and for which the data collection was completed during 2011/12, are listed in Appendix C (page 79) alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

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

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

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

Research

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

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

Together with our academic partner, St George's, University of London (SGUL), the trust hosts the South East Stroke Research Network (SRN) and operates a joint clinical research facility, both of which help to increase the numbers of patients joining clinical trials.

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

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

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

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

The CQUIN payment framework

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

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

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

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

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

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

Statements from the Care Quality Commission

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

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

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

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

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

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

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

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

Action	
Involve people who use services	- Added a question on privacy and dignity to real time patient surveys on the wards - Introduced face to face privacy and dignity interviews with patients
Training for staff	- Introduced more information during healthcare assistant development days - Introduced a presentation during nurse induction days
Raise awareness of nutritional assessments and follow-up actions	A series of training sessions across the trust, including: - Nutrition scoring – calculation, reassessments and

	recording of information - Follow through actions for patients at risk including referral to dietician & completing food and fluid charts.
	Review content of nutrition session at nurse and health care assistant induction for all new starters. Particular focus on scoring/assessment and recording of food and fluid charts
	Include 'follow through actions' in nutrition observation audit. Observe for: - Nutrition score correct - Documented evidence of referral to dietician if patient at risk
Thickened drinks need to be of the correct consistency to reduce risks to patients' wellbeing.	A series of training sessions across the trust to ensure staff awareness heightened in the process of mixing and delivery of thickened drinks.
	Include capture of patient satisfaction with the consistency of thickened drinks in nutrition observation audit.

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

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

Compliance

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

Survey of women's experiences of maternity services

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

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

Action	Outcomes
Zero tolerance to poor staff behaviour	- Improve staff morale(staff survey)

and attitude	- Women reporting fewer incidents of not being treated kindly and with understanding
Improve communication with, and information for women	- Audit of notes shows they are completed comprehensively - Positive feedback from women attending classes (survey form) - Women report that necessary information is given.
Improve support with breasts feeding in early days	- Women report adequate support with feeding
Hourly rounding on postnatal ward	- Women report feeling cared for and supported

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

Action	Progress
Zero tolerance to poor staff behaviour and attitude	There has been a significant drop in the number of complaints relating to staff attitude. - 2011 – 6 - 2010 – 11
Improve communication with, and information for women	- Daily group discharges now taking place - Intentional rounding (hourly rounds asking specific questions) started - Patient experience tracker results regularly reviewed and actions taken are leading to improved scores
Improve support with breast feeding in early days	- Increased reporting level of support seen in patient experience tracker results
Hourly rounding on postnatal ward	- Rolled out intentional rounding in Jan 2012

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

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

Data quality

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

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

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

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

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

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

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

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

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

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

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

Our scores, particularly for recording the NHS number in admitted care, were expected to be better than those recorded. We believe that a technical fault within the flow of information to our data warehouse may be the root

cause of this slight under-performance. We are investigating our dataflow process and will correct any flaw in our reporting in order to ensure a more accurate demonstration of our data quality in 2012/13.

Information governance

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

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

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

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

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

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

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

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

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

Clinical coding

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

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

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

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

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

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

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

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

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

Clinical coding accuracy is measured by counting the percentage of procedures and diagnoses recorded inaccurately. The average error rate on this basis was 3.9 per cent which is better than the latest national average of 11 per cent.

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

- INTRODUCTION
- MANDATORY REPORTS

- VOLUNTARY REPORTS

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

- CONTACTS AND APPENDICES

Summary hospital level mortality indicator (SHMI)

Why is this important?

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

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

Our outcomes

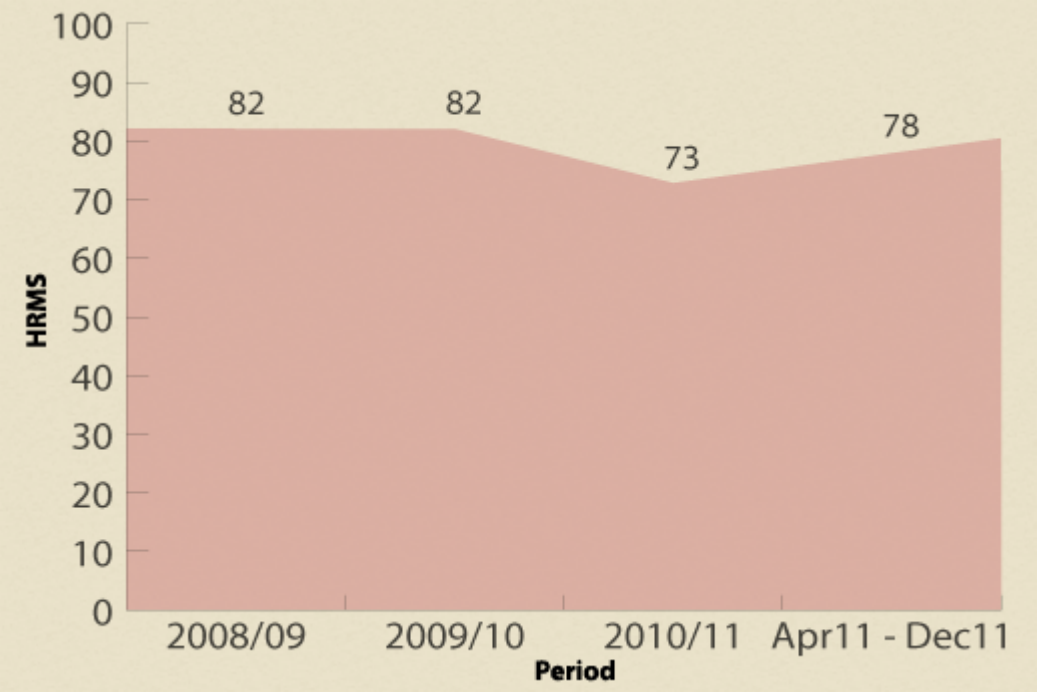
For both April 2010 to March 2011 and October 2010 to September 2011 our mortality rate has been lower than would be expected, and we are one of only 14 trusts in the country with this performance.

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

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

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

Hospital standardised mortality ratio



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

Our aims

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

Patient reported outcome measures

Why is this important?

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

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

- Hip replacements
- Knee replacements
- Hernia
- Varicose veins

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

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

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

Our outcomes

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

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

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

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

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

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

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

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

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

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

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

Our aims

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

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

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

28-day emergency re-admission rate

Why is this important?

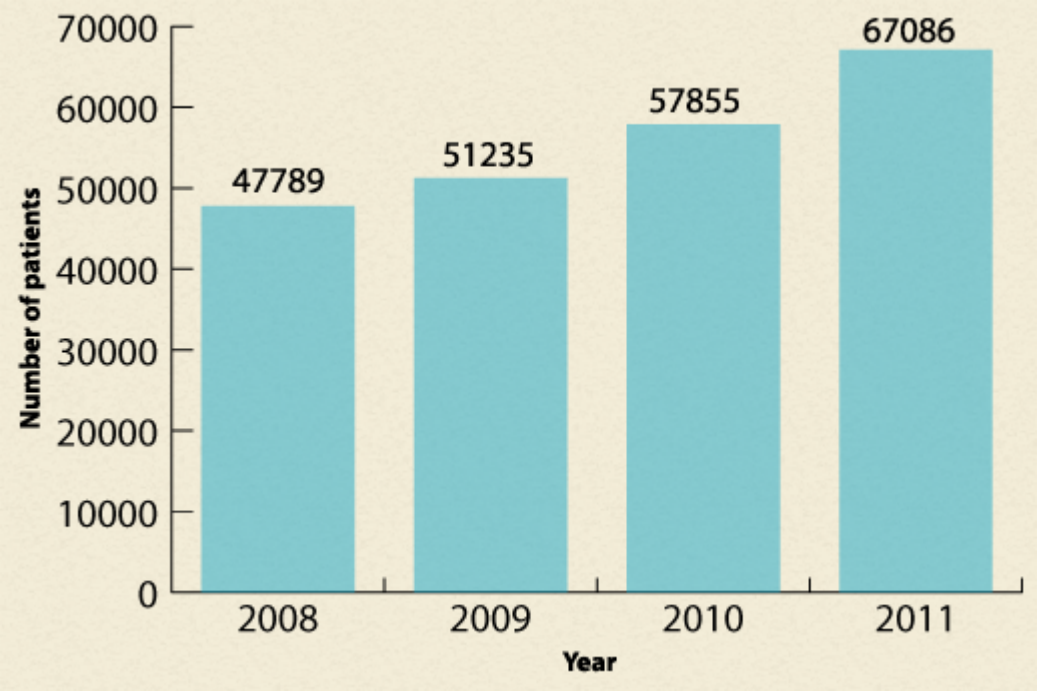
Monitoring emergency readmission rates can help the trust to prevent or reduce unplanned readmissions to hospital. An emergency readmission is recorded when a patient has an unplanned re-admission to hospital within 28 days of a previous discharge. Reducing emergency readmissions has always been a priority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

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

Our outcomes

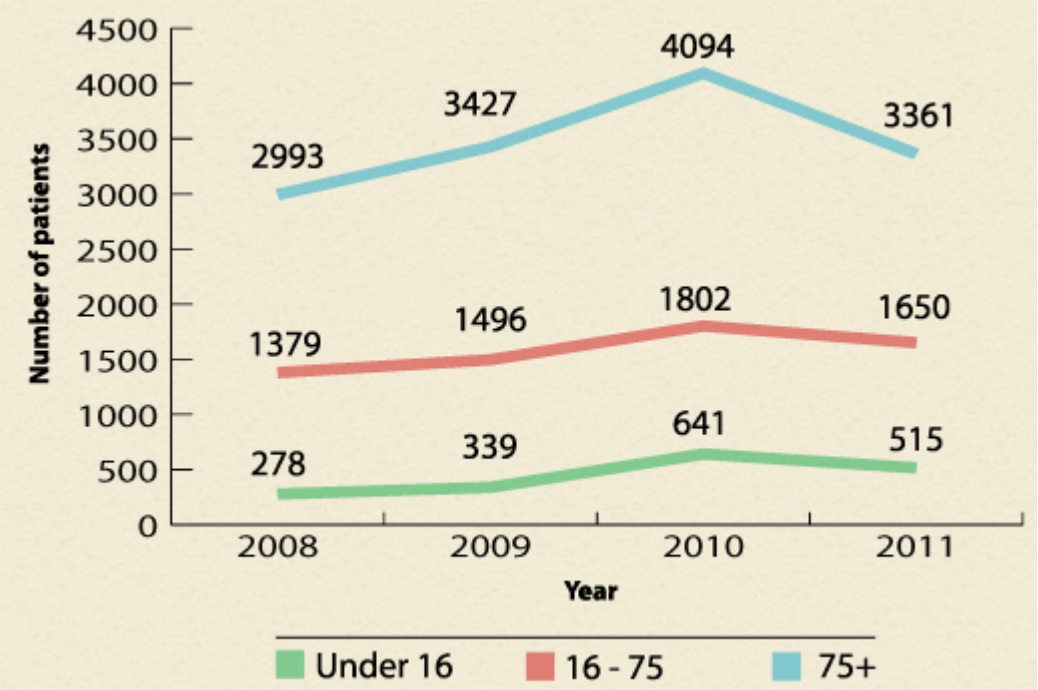
From 2008 – 2011 there has been a steady increase in patient admissions year-on-year with around 67,086 admissions in total at St George's in 2011.

Total number of admissions



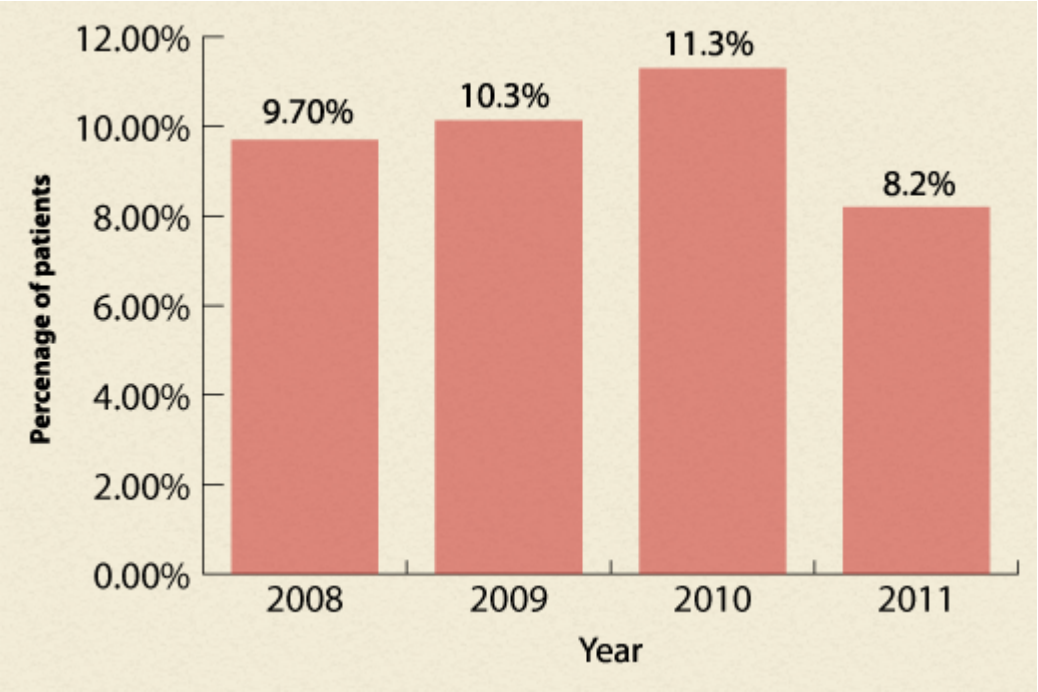
Emergency readmissions for all age groups rose in line with the general increase in admissions between 2008 and 2010. However, in 2011, the total number of emergency readmissions declined across all age groups, despite admissions continuing to rise significantly.

28 day readmission by age



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

28 day readmission rates



Our aims

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

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

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

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

Responsiveness to inpatients' personal needs

Why is this important?

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

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

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

Our outcomes

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

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

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

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

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

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

Our aims

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

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

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

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

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

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

Special patient experience report: Mixed sex accommodation

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

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

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

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

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

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

Staff who would recommend the provider to friends and family

Why is this important?

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

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

Our outcomes

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

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

Our aims

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

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

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

Percentage of admitted patients risk assessed for VTE

Why is this important?

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

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

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

Our outcomes

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

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

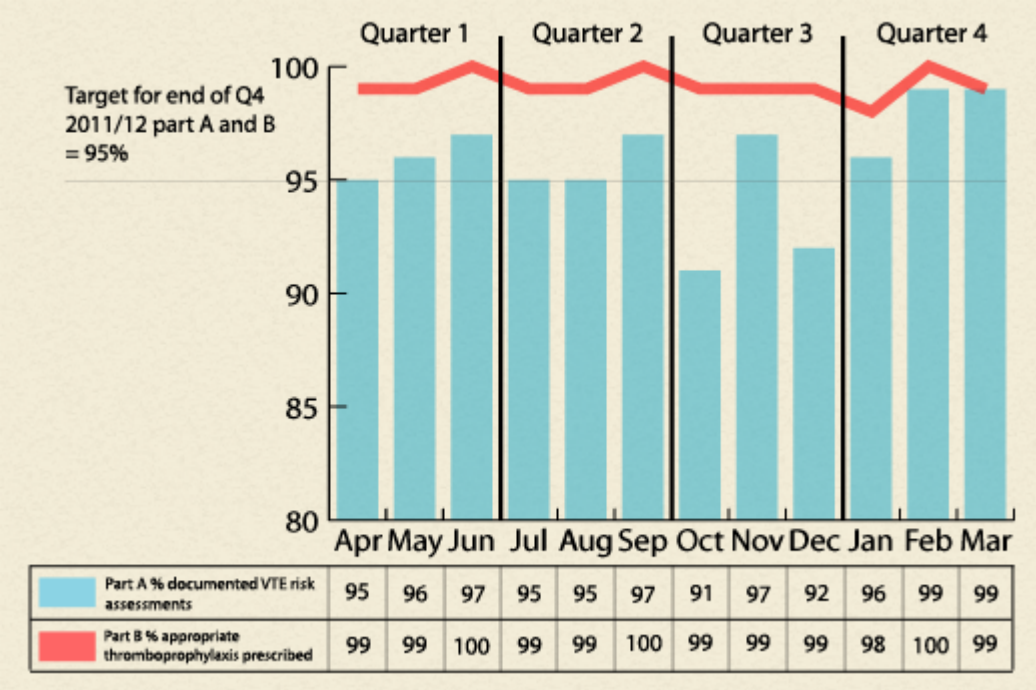
- Part a) the trust has documented evidence for VTE risk assessment being conducted within the trust, achieving 95 per cent by the end of 2011/12.
- Part b) In those cases where there is documented risk assessment, appropriate thromboprophylaxis (preventative treatment) is being prescribed in more than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

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

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

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

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Part A % documented VTE risk assessments	95	96	97	95	95	97	91	97	92	96	99	99
Part B % appropriate thromboprophylaxis prescribed	99	99	100	99	99	100	99	99	99	98	100	99

Our aims

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

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

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

Clostridium difficile rates

Why is this important?

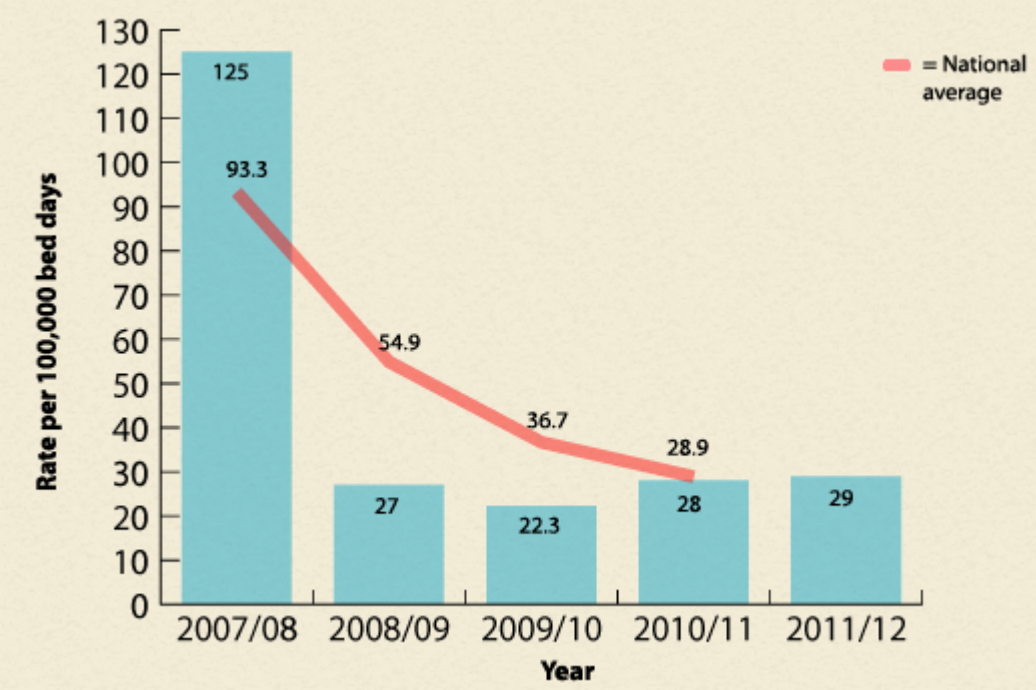
Clostridium difficile (*C.diff*) is a bacteria that can cause mild to severe diarrhoea and inflammation of the bowel. *C.diff* infection can be prevented by a range of measures, including good hand hygiene, careful use of antibiotics and thorough environmental cleaning. By monitoring the prevalence of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

Our outcomes

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

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

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



*National average figure for 2011/12 not yet available

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

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

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

Our aims

We intend to introduce additional measures to reduce the rate of *C.diff* infection, including detailed surveillance with feedback to individual consultant teams, detection of carriers of the *C.diff* organism and the appointment of infection control champions from amongst our consultant staff who will act as role models to reinforce and disseminate best practice.

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

Rate of patient safety incidents

Why is this important?

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

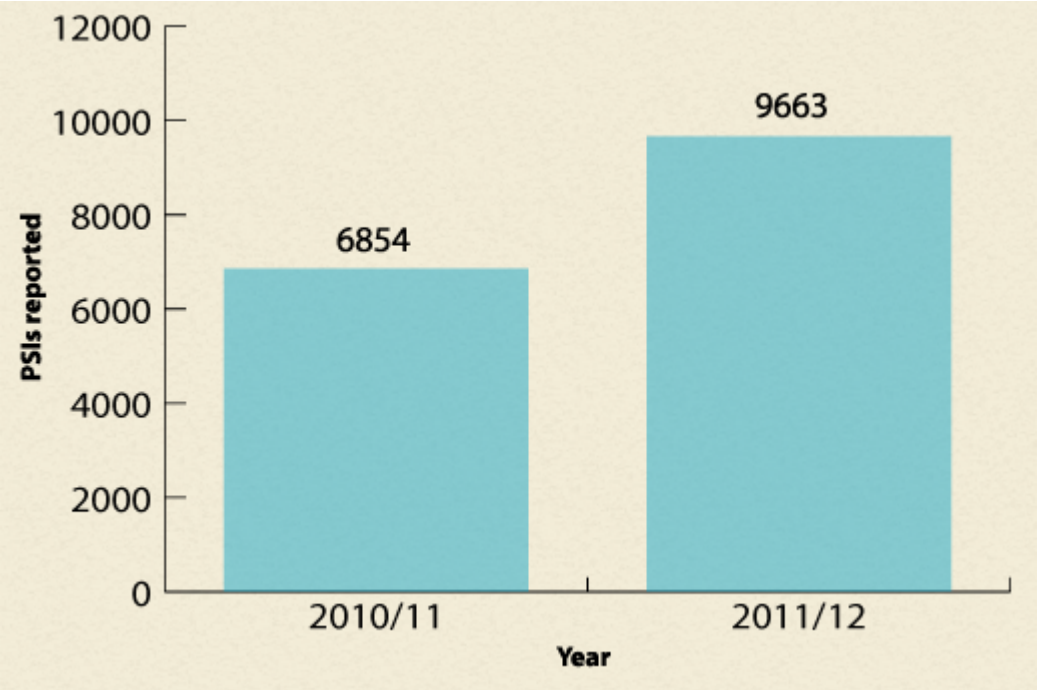
An open reporting and learning culture is important to enable the NHS to identify trends in incidents and implement preventative action. The rate of reported patient safety incidents – i.e. unintended or unexpected incidents which could have led, or did lead, to harm for one or more patients receiving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

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

Our outcomes

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

Patient safety incidents (PSI) 2011/12



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

Our aims

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

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

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

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

- INTRODUCTION

- MANDATORY REPORTS
- VOLUNTARY REPORTS

- CONTACTS AND APPENDICES

Acknowledgements

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

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

Contacts

Support from us

The PALS team at St George's Healthcare offers support, information and assistance to patients, relatives and visitors. The PALS office at St George's Hospital is open 09.00hrs – 17.00hrs weekdays.

T: 020 8725 2453

E: pals@stgeorges.nhs.uk

Working with us

If you are interested in a career at St George's Healthcare, visit the trust's website www.stgeorges.nhs.uk, or get in touch with our recruitment services team.

T: 020 8725 0600

E: HRRecruitment@stgeorges.nhs.uk

Feedback to us

Please feed back to the communications team and help us improve the information included in the report next year.

T: 020 8725 5151

E: communications@stgeorges.nhs.uk

Give to us

Would you like to give to St George's Healthcare? You can do so in many ways so please talk to St George's Hospital Charity about how you can help.

T: 020 8725 4916

E: giving@stgeorges.nhs.uk

Follow us

We post all of our latest news online. You can follow us on Twitter and Facebook, watch our videos on Youtube or visit our website www.stgeorges.nhs.uk.

Statements on this quality account

Statement of directors' responsibilities in respect of the Quality Account

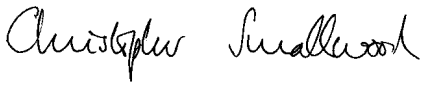
The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service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

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

- The Quality Accounts presents a balanced picture of the trust's performance over the period covered;
- The performance information reported in the Quality Account is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- The Quality Account has been prepared in accordance with Department of Health guidance.

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

By order of the Board



Tuesday 12th June 2012 Chair

Tuesday 12th June 2012 Chief executive

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

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

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

The Trust's performance on measures relating to patient experience is not quite so strong. Too many people who are waiting for treatment have been waiting for over 18 weeks since referral, and the number of people reported as having been waiting for over 52 weeks, although much reduced, remains unacceptable. Whilst the Trust's scores on the national inpatient survey are assessed by the Care Quality Commission as 'about the same as other trusts', it is unfortunate that the improvements in patient satisfaction recorded in the 2010 survey have not been maintained. Likewise, given the Trust's great clinical strength, it is disappointing that Trust staf are not significantly more likely than the national average to recommend the Trust to family and friends as a place to work or receive treatment. It is suggested that, in its priorities for 2012/13, the Trust should focus on improving these aspects of its services.

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

Feedback: South West London Commissioning Unit

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

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

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

	2011/12	**2012/13**
18 Week Waiting Times 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 9 months of the year but was achieved in the final quarter.	To achieve recovery plan agreed with commissioners and reduce the numbers of patients waiting longer than 18 weeks.
Emergency Access (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.	96.24% of patients were treated, admitted or discharged within 4hrs As part of the Trust's development as a Major Trauma Centre the resuscitation unit has been refurbished and expanded.	Maintain above 95%
Cancer Waiting Times Targets 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

CQUIN Achievement	A significant improvement on 2010/11 SGH 90% QMR 85% CSW 94%	To maintain a good performance against CQUIN targets at SGH, QMR and CSW
Eliminating Mixed Sex Accommodation	The Trust maintained good performance with regards to mixed sex accommodation in 2011/12 A remaining problem area is delayed discharge from critical care beds. The majority of which are caused by waits for a bed on the appropriate ward.	Trust to take the necessary action to further improve performance so that the number of patients in mixed sex accommodation is further reduced in 2012/13.
Healthcare Acquired Infections no more than 2 cases of MRSA (bacteraemia) during 2011/12 no more than 52 cases of Clostridium Difficile during 2011/12.	SGH had 1 case of MRSA in 2011/12 SGH exceeded the national target for C Difficile as a more sensitive testing methodology was introduced. Commissioners agreed a local target for C-Difficile and this was met.	To maintain a good performance
Maternity Services	In order to reduce pressure on the service a catchment area was introduced for births at SGH. Since its introduction the ratio of midwives to deliveries has improved.	To achieve Maternity CQUIN milestones in 2012/13
Never Events	There were 4 never events in 2011/12	No Never Events in 2012/13
Serious Incidents (SI) Timely reporting and learning	The Trust met the national target for completing root cause analysis within the time frame.	To maintain a good performance in root cause analysis of SIs.

from errors	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.	
CQC / External Audit Results		
National Survey of Adult Inpatients	The results of the 2011 National Inpatient Survey showed SGH were about the same as all other hospitals in the response to all 77 questions. QMR undertook their own inpatient survey in 2011/12. The results indicated an improvement against two questions: 1. Were you as involved as you wanted to be in decisions about your care and treatment? 2. Were you told who to contact if you were worried about your condition after you left hospital? The improvement represents a 1.8 increase on the 2010/11 score of 64.3 QMR's final score in 2011/12 was 66.1	Further improvement in experience of inpatients.

National Outpatient Department Survey	SGH were: Among the best performing 20% of Trusts for 2 questions. In the intermediate 60% of hospitals for 17 questions. Within the worst performing 20% of Trusts in 20 areas.	Action plan in place to improve patient experience in outpatients

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

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

Respective responsibilities of Directors and auditors

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

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

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

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

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

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

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

Assurance work performed

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

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

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

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

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

Conclusion

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

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

28 June 2012

Feedback: Wandsworth Local Involvement Network (LInK)

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

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

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

Looking forwards, we appreciate that there will be a number of changes in the nature and method of delivery of services provided by the trust as a result of wider reorganisations together with a development of the Trust's own strategy as it moves towards Foundation Trust status. We appreciate the level of patient and public involvement that has been achieved in these processes to date and would wish for this to be continued and extended. Amongst the concerns expressed by patients are that these changes will erode the level of service provided to local people. We would wish to work closely with the Trust to ensure that this does not happen.

Appendix A: Omissions from 2010/11

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

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

Item	2011/12 performance	Monitoring
Using audit to achieve service improvement	Clinical audit is used to compare our performance to best practice and allows us to see where our standards of care are as they should be, or require improvement. The acute oncology service is a new service for cancer patients – specifically those undergoing chemotherapy – created following a national audit that identified a need for speedy expert treatment for this cohort of patients. Two local audits have also helped to develop it. Both audits identified areas of good practice and some areas where improvements can be made. We are already putting these improvements in place and plan to re-audit later in 2012 when the new service is fully established. A trust wide audit on medical and surgical wards found that evidence of documented pain assessment was generally poor but that in general, patients reported that pain was well controlled. The audit results were discussed in a governance meeting and as a result a number of actions have been put in place including ongoing discussion of pain as part of the MDT process and the investigation and evaluation of tools that can help assess pain in patients with communication difficulties.	- Clinical effectiveness and audit committee - Patient Safety Committee
Clinical administrative system - Cerner Millennium	The transition to 'business as usual' for the clinical information system, Cerner Millennium was completed in 2011. More system checks have been put into place and processes have been revised to improve the accuracy and timeliness of data entry into the system.	- ICT Committee

	Staff have been trained in these revised procedures. In conjunction with the on going work on our referral to treatment times these processes continue to be monitored. The next phase of development of Cerner Millennium to make more clinical information available via the system including electronic prescribing and diagnostic results reporting has now commenced.	
Outpatient services	During 2011/12 we improved response rates in the call centre from only 50% of calls being answered to 95% of calls being answered within one minute and 75%+ of calls being answered within 30 seconds. We have also improved our productivity in sourcing medical notes by 90% following the establishment of a central search team in 2011. We also established new systems to ensure patients leave clinic with a follow up appointment thus ensuring patient safety We secured funds from our Strategic Health Authority NHS London to hold bespoke customer training courses for front-line staff which has contributed to a decrease in complaints.	- Divisional Management Board of the Children's, Womens, Diagnostics, Therapeutics and Critical Care Division - Virtual Outpatient Directorate
Medication safety monitoring	Since February 2011 a total of 98 visits have been conducted. All wards and clinical areas across the trust are visited. The visits are themed however other types of medication safety issues, such as security of medications, are reviewed. Since November 2011 the visits have focused on insulin. These have helped us to improve the accuracy of fridge temperature monitoring. Identified safety issues are recorded in an action log and communicated to senior nursing and pharmacy staff.	- Patient Safety Committee
Never events	A never event is an event or incident that is unacceptable and preventable within the NHS. During this year there have been four "never" events reported by this trust to NHS London. Three related to retained vaginal swabs in obstetrics and gynaecology. The final event related to the misidentification of a patient resulting in them receiving the wrong medication. The trust greatly regrets these events and accepts that	- Patient Safety Committee

	they all could have been prevented by good systems that are clear and fully implemented by staff. All of the above events have been fully investigated and action plans developed to ensure that they could not happen again. Lessons have been widely disseminated to staff and systems and processes have been changed with the aim of increasing reliability. The trust cannot be complacent about such events and will continue to monitor the systems that have been implemented.	
Managing complaints	In 2010/11 we received 1031 formal complaints which represents a decrease of 17 per cent when compared to the previous year. In 2011/12 we received reports on two complaints which had been investigated by the Parliamentary and Health Services Ombudsman and complied with all recommendations contained therein. You can read more about how we manage complaints at St George's in our 2011/12 Annual Report which will publish by September 2012.	- Patient Issues Committee
Volunteers	There are currently more than 250 volunteers working in a variety of areas providing invaluable assistance to staff and improving the patient experience without pay. Roles include way-finding assistance on corridors and information desks, basic clerical assistance in departments, meeting and greeting patients in clinics and assisting patients at mealtimes. For further information visit http://www.stgeorges.nhs.uk/careersVol.asp.	- Patient Issues Committee
Healthcare environment	During 2011/12 there were a number of developments in the facilities provided by the trust. A state of the art breast screening and diagnostic unit opened at St George's Hospital. Known as the Rose Centre, the unit is home to the South West London Breast Screening Service and St George's National Breast Screening Training Centre. A new Macmillan information and support centre for patients, carers and families affected by cancer opened its doors at St George's Hospital in July 2011. The centre, located at St George's Hospital on the Grosvenor Wing ground floor, provides vital information	- N/A

	and support for anyone affected by cancer, whether they are worried they may have the disease, during treatment or whilst adjusting to life afterwards. The relaxed and informal space includes a main room offering information booklets and leaflets and a quiet room. A year after integrating with Community Services Wandsworth (CSW) patients from across the borough are seeing the benefits. In senior health services, streamlined care pathways and changes such as the development of common processes for falls prevention have had a significant impact. New models of care have seen patients and staff benefit from increased access to consultant geriatrician expertise. The community ward has also improved long-term condition management and reduced admissions for high risk patients who can now receive treatment from a multi-disciplinary and agency team in their own homes. In September a new resuscitation unit was opened at St George's Hospital. The unit, the most modern in London, provides eight resuscitation bays each with a large bed space to allow emergency care staff to manage the most complex of cases. The unit also houses a dedicated overhead x-ray system built into the ceiling of the department.	
Dementia care	The trust is committed to the highest possible standard of care for patients with dementia. All patients aged 65 or over are asked to complete the Abbreviated Mental Test Score (AMTS), a brief memory test, on admission to hospital via A&E or the Acute Medical Unit, or as part of preparation for elective surgery. An audit on the elderly care ward in July 2011 found that 92% of patients had received a memory test, complying with our target of 50% in 2011/12. Since Autumn 2010 we have had a dedicated liaison mental health nurse for older adults. The dementia strategy group has developed a "confused person's pathway" which will provide staff with guidance on best practice and an appropriate care pathway for people with dementia and delirium in hospital. The strategy group has decided to embed this	- Dementia strategy group - Patient Issues Committee

	within in an over-arching dementia policy for the Trust with the aim of introducing both the pathway and the policy during 2012. We are currently developing the role of “dementia champions” in response to the 2011 National Audit of Dementia. We plan to offer an extended training course for these staff, ideally the eight half-day modular course offered by Wandsworth social services. The first five champions should start this course in April 2012. We are developing additional audit tools to monitor the quality of care for people with dementia e.g. tablet-based patient experience surveys, and including dementia-related parameters in regular ward quality audits.	

Appendix B: CQUINs

Acute CQUINs 2011/12

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

		and antenatal.
	Ensure 90% of patients at risk of alcohol misuse have been referred to a specialist service.	**Met**
Outpatient Experience	Ensure a reduction in first and follow up cancellations as well as ensuring that patients whose appointments have been cancelled at more than 6 weeks notice are rebooked within 6 weeks of original appointment.	**Partially met for cancellation of new appointments. Fully met for cancellation of follow ups and for re-booking.**
	Ensure there is no voicemail on booking systems and that calls are answered within 30 seconds for new appointments and within 60 seconds for follow ups.	**Met**
	Ensure most services are covered by choose and book.	**Met**
	Ensure outpatient appointments are booked before patients are discharged.	**Not Met** – this process has now been revised as an action for our outpatient taskforce
Urinary catheter management	Continue the improvement of catheter management by standardising the equipment review ensuring Trustwide compliance with the urinary catheter protocol	**Met**
Pressure Ulcer	Improve the management of pressure ulcers by developing and ensuring the use of a standardised assessment tool and improving communication with primary care.	**Met**
Medicines Management	Ensure increased prescribing of low cost medicines where appropriate, increase the safety of prescribing of non steroidal anti-inflammatory drugs and conduct an audit on agreed medicines to assess outcomes of treatments.	**Met**

Specialised CQUINs 2011/12

CQUIN	Detail	Performance
Reduce avoidable death, disability and chronic ill	Ensure 90 per cent of adult inpatients have had a VTE Risk assessment	**Met**

thromboembolism (VTE)	risk following VTE risk assessment have been provided with appropriate prophylaxis.	
Adult bone marrow transplant	Review and develop action plans if necessary for patients who die within 100 days of an autologous transplant for myeloma. Update the BMT registry and reduce the number of patients who experience 2nd and 3rd episodes of stem cell mobilisation.	**Met**
Haemophilia	Review reasons for clotting factor usage for severe haemophilia in adults and ensure at least 80% of children have had trough level measurement within the previous 6 months.	**Met**
Neonatal intensive care unit (NICU)	Ensure a satisfactory (same as or below average level for network) length of stay for babies admitted to a neonatal unit and ensure babies born at less than 30 week gestation have access to multi disciplinary team monitoring for 2 years.	**Met**
HIV	Ensure patients are involved in decisions about their care and supported to self manage.	**Met**
	Support patients to register with a GP and ensure communication with their GPs.	
Paediatric intensive care unit (PICU)	Ensure an acceptable level of unplanned readmissions (max. ratio of 3% unplanned / all admissions)	**Met**

Quality Account CQUIN summary – CSW contract CQUINs

CQUIN detail	Performance
50% of patients on community nursing (including community matrons), intermediate care and specialist nursing caseload to have multi-disciplinary team meeting	**Met**
50% of non-cancer end of life care patients to die in their preferred place of death	**Met**
70% of community nursing (including community matrons), intermediate care and specialist nursing to have pressure ulcer risk assessment in place	**Met**
80% of community nursing (including community matrons), intermediate care and specialist nursing staff at band 6 and above to receive education and competency around pressure care	**Met**
90% of pressure relieving mattresses required for patients on the	**Met**

community nursing (including community matrons), intermediate care and specialist nursing caseloads provided within clinically agreed timeframe	
20% reduction in short stay admissions of Wandsworth patients at SGH	**Met**
90% of patients on the community nursing (including community matrons), intermediate care and specialist nursing with a falls risk profile in place (if at risk of falling)	**Partially met**. Targets set throughout the year. Q1 target of 10% not achieved but all subsequent targets met (including Q4 target of 90%).
85% of babies born have breastfeeding status recorded at the new birth visit	**Met**
85% of babies born have breastfeeding health promotion provided recorded at the new birth visit	**Met**
90% of eligible children receiving School Leaver Booster immunisation	**Partially met**. Achieved 81.9% during financial year; considerable improvement on 55% baseline from 2010/11.
Parental non-response to HPV vaccination offer reduced to 5%	**Met**
All schools where uptake of HPV vaccination is below 90% receive additional immunisation sessions	**Met**
70% of adult sickle cell patients on the community Haemoglobinopathies team caseload have care plan in place	**Met**
85% of year 6 children defined as overweight or obese via the National Child Measurement Programme invited to attend physical activity sessions	**Met**
10 CSW staff trained in self-management techniques and facilitation under the Co-Creating Health Programme; 2 staff trained as trainers	**Met**
Increasing patient engagement and self-management following on from Co-Creating Health Programme	**Partially met.** We achieved all the work for this CQUIN. However one deadline in quarter three was missed. This resulted in partial achievement.
Referral pathways for 5 long term conditions mapped out and publicised to all CSW staff	**Met**
95% respiratory specialist nurses trained in smoking cessation support	**Met**
85% of smokers on the respiratory specialist nursing caseload referred to smoking cessation	**Met**
85% of appointment requests acknowledge within 72 hours and 70% of offenders reporting improvements in the process	**Partially met**. Appointment request target met but only 67% of offenders feeling that the process had improved.

80% of offenders completing 4/6 sessions on smoking cessation programmes and 70% of offenders completing full programmes	**Partially met**. 4/6 session attendance target met but only 62% of offenders attended full programmes
90% of QMH inpatients being assessed for VTE on admission	**Met**
Improvement of 5 points on the national inpatient survey questions for QMH beds	**Partially met**. Achieved 1.8 point improvement from 2010/11 baseline
Reasons for catheterization documented in 95% of all catherised QMH inpatients	**Met**
Catheter protocol followed for 95% of QMH inpatients	**Met**
95% of QMH inpatients to have pressure ulcer risk assessment in place	**Met**
95% of QMH inpatient staff at band 6 and above to receive education and competency around pressure care	**Met**
95% of pressure relieving mattresses required for QMH inpatients	**Met**
Reduction in hospital cancellation of first appointments and follow-up appointments at QMH to 7.5% and 14.6% respectively	**Partially met**. Cancellation of first appointment target met; cancellation of follow-up target not met – reduced to 16.9% only.
Reduction in hospital cancellation of Choose & Book appointments at QMH to 12.1%	**Met**
98% of QMH outpatient specialties and 70% of clinics within these specialties available to book via Choose & Book	**Met**
Review and refresh of current, and development of new, Rapid Diagnostic Pathways at QMH. Additional 1,000 RDP activities delivered at QMH.	**Partially met**. All review, refresh and development work met. However only 722 additional activities delivered.

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

For 12/13 the total CQUIN value for the acute and community contracts is estimated as £11m.

Proposed Acute CQUINs 2012/13

CQUIN	Detail
Reduce avoidable death, disability	Ensure 96 per cent of adult inpatients have had a VTE Risk assessment

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

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

Proposed Specialised CQUINs 2012/13

CQUIN	Detail
Reduce avoidable death, disability	Ensure 96 per cent of adult inpatients have had a VTE Risk assessment

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

Community services Wandsworth CQUINs 2012/13

Indicator	
Community contract	60% of patients on community nursing (including community matrons), intermediate care and specialist nursing caseload to have multi-disciplinary team meeting
	70% of non-cancer end of life care patients to die in their preferred place of death
	80% of community nursing (including community matrons), intermediate care and specialist nursing to have pressure ulcer risk assessment in place

	80% of community nursing (including community matrons), intermediate care and specialist nursing staff at band 5 and below to receive education and competency around pressure care
	95% of patients will a falls risk profile in place to have 95% of all core information completed and 80% of additional information completed
	Develop and deliver falls and bone health education for local GPs to support the falls and bone health pathway development
	Implement processes and collect pilot data in preparation for the NHS Safety Thermometer ready for 2013/14
	Implement revised referral forms for Single Point of Contact services (detailing a minimum dataset and additional service specific elements)
	90% of referrals from SPoC defined as 'urgent' where contact is made by telephone within 1 hour and where the patient is seen within 4 hours.
	20% reduction in short stay admissions of Wandsworth patients at SGH
	95% of children in Wandsworth noted as unregistered with a GP referred to HV team contacted (exclusions apply as above) and a % reduction in number of GP unregistered children on Wandsworth Child Health Register overall
	90% of new adult sickle cell patients on haemoglobinopathies team caseload are referred to appropriate self-management programmes if requested; 75% of adult sickle cell patients who have been on the haemoglobinopathies team caseload for 12 month have a formal care plan review carried out and documented.
	75% of adult sickle cell patients discharged from SGH are contacted or visited by the Haemoglobinopathies Team Clinical Nurse Specialist (CNS) within 48 hours of discharge summary being received
	85% of children assessed as obese or overweight (BMI ≥91st percentile) contacted by telephone and 50% (42.5% of those classified as overweight or obese) of these are referred to weight management and activity programmes
	95% of young people seen by school health service for sexual health issues are given information about sexual health support/ services available and signposted to a young

	person appropriate sexual heatlh service
	80% of pregnant Wandsworth teenagers booked in at SGH offered ante-natal support. Plan to develop and provide post-natal structured support developed.
	85% of mothers identified as smokers at the new birth visit are provided with smoke free homes information and referred to smoking cessation programmes
	Implement a system to make improvements to the scores around the annual breastfeeding audit and carry out the audit in 2013.
	Review use of clinical outcome measures in CSW and implement outcome measure use in all services.
HMPW contract	Ensure agreed annual health check and health improvement opportunities are met for 50% of offenders within Q4 and that a plan for review of all of offenders and for delivering care to all is in place for 2013/14.
	Redesign the Primary Care Mental Health Service at HMPW. Ensure that 80% of these received were offered assessment and treatment within agreed minimum standards.
	70% of offenders who have polypharmacy verified following Reception have a review 6 weeks post receipt of verification; 70% of offenders in receipt of polypharmacy for the past 12 months have an annual review in the past 12 months
	80% of offenders risk assessed as suitable to hold their medications as 'in posession' do actually hold their medication 'in possession'. Review processes and protocols and risk issues to assure of safety.
	60% of requests for urgent, non-urgent and routine appointments offered an appointment within target waiting times
Queen Mary's, Roehampton (QMH)	90% of QMH inpatients having a SGH VTE risk assessment on admission; 90% of QMH inpatients with a VTE risk assessment in place indicating that prophylaxis is required, receive prophylaxis as per guidelines
	Improvement of 1-3 points on the national inpatient survey questions for QMH beds
	90% of patients admitted to QMH inpatient wards are asked the dementia screening question
	90% of patients admitted to QMH inpatient wards who are found to be at risk of dementia following screening, have a dementia risk assessment within 72 hours of admission

	90% of patients admitted to QMH inpatient wards who are found to be at risk of dementia following the dementia risk assessment are referred for specialist diagnosis
	Implement processes and collect pilot data in preparation for the NHS Safety Thermometer ready for 2013/14
	Develop and deliver revised and new Rapid Diagnostic Pathways at QMH in conjunction and collaboration with commissioners
	Attend GP engagement events held by NHS Wandsworth and NHS Richmond in relation to QMH and develop and deliver marketing strategy to increase referrals and activity from GPs that do not usually use QMH
	Pilot increased capacity in pain and neurology clinics at QMH
	Carry out an in-depth review of outpatient demand, capacity, activity, waiting, backlog and current utilisation of the QMH estate. Use this demand to forecast what the future demand and activity could be and what capacity may be required to meet this. Assess the impact on the utilisation of space at QMH.
	Ensure that 90% of all QMH inpatients requiring a full falls risk assessment have this in place and that 80% of these assessments contain complete and accurate data.
	90% of inpatients to have EWS completed and accurately scored and 70% of completed EWS tools have appropriate responses to triggers in place
	Maintain pressure risk assessment completion for 95% of QMH inpatients and ensure 95% of QMH inpatients assessed as at high risk of developing a pressure ulcer have a repositioning chart completed
	90% of QMH inpatient band 5 nurses and HCSWs have attended training and achieved competency in pressure ulcer management
	85% of wheelchair service and special seating service patients have documented pressure considerations on the referral form and where appropriate action has been taken

Appendix C: National clinical audit and national confidential enquiries

Eligible audit/ enquiry	Participation	Submission rate (%) / comments
National neonatal audit programme	Yes	100
Paediatric pneumonia (British Thoracic Society)	Yes	100
Paediatric asthma (British Thoracic Society)	Yes	70
Pain management (College of Emergency Medicine)	Yes	100
National childhood epilepsy audit (Epilepsy 12)	Yes	100
Paediatric intensive care audit network (PICANet)	Yes	100
RCPH National paediatric diabetes audit	Yes	100
Emergency use of oxygen (British Thoracic Society)	Yes	100
Adult community acquired pneumonia (British Thoracic Society)	Yes	Data collection period beyond 2011/12
Non-invasive ventilation (NIV) – adults (British Thoracic Society)	Yes	100
Pleural procedures (British Thoracic Society)	Yes	100
National cardiac arrest audit	No	There was a delay in requesting the joining pack while we upgraded web browser software and sourced funding to allow the trust to take part. The dataset required for the NCAA continues to be collected locally, and is presented to the trust's resuscitation committee and patient safety committee. We have registered to participate in this audit and will begin collecting and submitting data in 2012/13.
Severe sepsis and septic shock	Yes	100
Adult critical care centre case mix programme (ICNARC)	Yes	100
Potential donor audit (NHS Blood	Yes	100

and Transplant)		
National audit of seizure management	Yes	100
National adult diabetes audit	No	We do not use the database which would enable our participation in this audit. Senior trust staff are working to ensure that the issues which have delayed our implementation of this database are resolved.
National audit of heavy menstrual bleeding	Yes	55
National pain database audit: chronic pain services	No	Although we participated in Phase 1 of the project in 2010/11 we were unable to submit data this year due to reorganisation and relocation of the pain clinic. During this time local audit has continued and a meeting is planned for early 2012/13 to establish how we will participate in the future.
Ulcerative colitis and Crohn's disease – UK inflammatory bowel disease audit	Yes	100
National Parkinson's disease audit	Yes	100
Adult asthma (British Thoracic Society)	Yes	100
Bronchiectasis (British Thoracic Society)	Yes	100
National joint registry- hip, knee and ankle replacements	Yes	100
National PROMs programme – elective surgery	Yes	60.6 (Apr 11 - Sep 11)
Coronary angioplasty - NICOR Adult cardiac interventions audit	Yes	100
Peripheral vascular surgery - VSGBI vascular surgery database	Yes	100
Carotid intervention audit	Yes	100
Adult cardiac surgery audit - CABG and valvular surgery	Yes	100
Myocardial ischaemia national audit project	Yes	100
Heart failure audit	No	No cases have been submitted for

		2011/12, as the application made a year ago for a central cardiac audit database licence to enable local data entry and higher participation has not yet been granted. This has been escalated to clinical and managerial leads. Once granted we are preparing to enter data retrospectively.
Stroke improvement national audit programme	Yes	100
Cardiac rhythm management audit	Yes	100
Renal replacement therapy (Renal registry)	Yes	100
Renal transplantation (NHS Blood & Transplant UK Transplant registry)	Yes	100
National lung cancer audit	Yes	66
National bowel cancer audit programme	Yes	14.2
Head & neck cancer (DAHNO)	Yes	97
National oesophago-gastric cancer audit	Yes	>70
National hip fracture database	Yes	85.6
Trauma audit & research network	Yes	100
National comparative audit of blood transfusion - Bedside transfusion audit	Yes	100
National comparative audit of blood transfusion - Medical use of blood	Yes	100
National health promotion in hospitals audit	Yes	100
National care of the dying audit – hospitals 3rd round	Yes	96.7
Bariatric surgery national confidential enquiry into patient outcome and death	Yes	100
Cardiac arrest procedures confidential enquiry into patient outcome and death	Yes	75
Peri-operative care confidential enquiry into patient outcome and death	Yes	100

Surgery in children confidential enquiry into patient outcome and death	Yes	100

Appendix D: National clinical audit - actions taken

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

	Emergency department to be granted access to neurosciences folder on the trust network to improve sharing of information.
Heart failure audit	The trust applied for a licence for the central cardiac audit database to facilitate timely and increased submissions. This request remains outstanding and has been escalated to managerial and clinical leads for action. Service committed to entering data retrospectively if the licence is granted.
British Thoracic Society Emergency Oxygen audit	Respiratory consultant nurse has disseminated results widely, including presentations at nursing board and divisional meetings. In addition to this increased awareness, more training is planned.
National audit of Inflammatory Bowel Disease (IBD)	Recruiting an IBD clinical nurse specialist to support reduction in admissions and length of stay. Areas for improvement to be discussed by the multidisciplinary team: i) appropriateness of emergency laparoscopic surgery; ii) need for dedicated dietetic input; iii) importance of CdT assay. Paediatric findings presented at national conference by trust consultant.
National bowel cancer audit	Poor submission rate is being addressed as part of an action plan to improve the quality and completeness of data submission for the various audits and information requirements relevant to cancer services.
National audit of dementia care	Recommendations being taken forward by the trust's dementia strategy group, which has been incorporated as a sub-committee of the Patient Issues Committee. Local audit of abbreviated mental test score demonstrated overall achievement of agreed standard, but identified areas for improvement.

*Based on information available at time of publication

Appendix E: Local clinical audit – actions taken

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

*Based on information available at time of publication

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The quality account 2011/12 is available online on our website http://www.stgeorges.nhs.uk/quality/index.asp or scan the QR using your mobile phone*.

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