

Quality Account 2013/14 St George's Healthcare NHS Trust



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Statement on quality by Miles Scott, Chief Executive

There is no simple way to define quality, especially for such a large organisation with such a large spectrum of services with more than one million patient contacts every year.

However, what is clear is that the people who matter and the organisations that scrutinise us think we are a strong organisation and that the quality of our services is beyond doubt. More than 95 per cent of our patients have told the Department of Health that they would recommend St George's as a place to receive treatment and be cared for through the Friends and Family Test.

In the latest edition of the National Staff Survey our staff are again ranked as being amongst the most highly motivated in the country and in the highest band for staff who feel proud of their trust and would recommend that their friends and family receive care there.

The Care Quality Commission have declared that St George's is meeting every one of the essential domains of care following their latest unannounced inspection in February. The CQC found the overall standard of care we provide at all of our sites to be 'good' and awarded the trust an overall 'good' rating, with some aspects of care rated as 'outstanding', confirming St George's place as one of the country's leading teaching hospitals.

This level of recognition from the CQC provides assurance that we offer high standards of clinical services to our local community and beyond and that we remain true to our values to provide excellence across clinical care, education and research, which ultimately means better care for all our patients.

I am delighted that some of our critical and intensive care and maternity services were recognised as being outstanding. It is great, not just for us but for women thinking about where to have their babies, to be able to read this comment in the CQC report: "The maternity service provided safe, effective, responsive, well-led services to women. The care delivered was considered to be outstanding."

The CQC reported numerous examples of commendable practice, including excellent multidisciplinary working across community and acute teams, systems developed by the trust to promote the safety of children, young people and families, and the well-led, integrated working and calm environment within A&E, our theatres and rehabilitation services.

Our Quality Account 2014 is littered with examples of high performance and commendable practice. We are one of the few trusts in the country to have reported significantly lower than expected mortality rates every year since publication started, with our ratios dropping even further during 2013/14. The number of patients acquiring c.difficile this year compared to last year has more than halved. 36 per cent fewer senior health

patients suffered a fall in hospital or at home. Last year we also further increased the number of clinical audits we took part in.

We achieve these high levels because the culture at St George's is to always look at how we can improve. There is a deep rooted desire running throughout the organisation to always find ways to make things better for our patients. Sometimes those improvements are huge developments that are easily noticeable for everybody, like our new helipad that will help the most seriously injured and ill people from across the south east of England receive the expert life-saving care they need sooner. But sometimes they are the less obvious but equally important changes, like improving our discharge planning processes so that patients are less likely to have to return to hospital for further treatment after going home.

I was very proud to be able to show off some of the improvements we have made to a returning friend of St George's last November when Sir Bruce Keogh, Medical Director of NHS England and former St George's cardiologist, visited St George's Hospital. Sir Bruce, one of the most respected voices in the country on healthcare, spoke to an audience of hundreds of clinicians and senior managers about the challenges and opportunities facing the NHS and fielded questions from our staff. Sir Bruce said that the NHS has a fantastic opportunity to improve services if it ignores mediocrity and makes an opportunity out of the difficult challenges facing it. It is an inspiring message that we have taken to heart at St George's.

Since the last Quality Account, as well as the new helipad we have also opened new facilities for patients undergoing surgery, enhanced our already state-of-the-art medical and dental simulation training facilities and added to our leading cardiac intensive care unit and cath-labs. We have also opened the new haematology and oncology outpatients department at St George's providing a massively improved environment for our cancer patients and their friends, families and carers.

I am delighted to be able to report that last year we entered into a partnership with King's Health Partners as joint leaders of the new South London Collaboration for Applied Health Research and Care (CLAHRC). The CLAHRC pools the clinical and research expertise of both the NHS and universities in south London, and will make sure that patients benefit from innovative new treatments and techniques that could revolutionise future healthcare.

Continued investment in research and our services at St George's and Queen Mary's Hospitals and in the community is key to our plans for the future of the trust.

This year promises to be one of the most important in the history of St George's, as we go through the assessment phase of our application to become a Foundation Trust. Our application has been years in the making and is extraordinarily strong. We are one of the most financially stable NHS organisations in London, with our strong financial management over the last few years giving us the ability to invest in facilities and staff, which lead to improved patient safety, experience and outcomes.

As a Foundation Trust we will be formally accountable to our members, who now number more than 20,000. If you are not yet a member, I strongly encourage you to sign up so you can influence our future by contacting our Membership Office on 020 8725 6132 or at members@stgeorges.nhs.uk









Yours sincerely






























































A handwritten signature in black ink, appearing to read 'Miles Scott', written in a cursive style.















































































Miles Scott
Chief Executive

Dashboard - our priorities from last year

Key

	Achieved our aims and/or targets		Relates to Care Quality Commission 'safe' essential domain
	Part achieved our aims and/or targets		Relates to Care Quality Commission 'effective' essential domain
	Did not achieve our aims and/or targets		Relates to Care Quality Commission 'caring' essential domain
123	Page where more information can be found		Relates to Care Quality Commission 'responsive' essential domain
			Relates to Care Quality Commission 'well-led' essential domain

Priority	Status	Page	CQC essential domains
London Quality Standards		15	    
Participation in clinical audits		25	   
Increase number of patients taking part in research projects		26	
Use of CQUIN payment framework		30	    
Maintain information governance toolkit band		31	
Data quality		33	
Clinical coding error rate	N/A	36	
Statement from the Care Quality Commission		37	    
Patient safety incident reporting		42	    
Never events		43	    
Improving clinical communication systems		44	   
Implement the national safety thermometer		44	   
Reducing medication errors		44	   
Reducing patient falls		49	  

Priority	Status	Page	CQC essential domains
Reducing rate of C.diff infections		51	   
Reducing rate of MRSA infections		51	   
Assessing risk of VTE in admitted patients		54	  
Root cause analysis of VTE cases		54	   
Implement the early warning score indicator at HMP Wandsworth		57	   
Reduce grade three and four pressure ulcers		58	   
Increase the return rate for Friends and Family Test		62	 
Increase the number of patients who would recommend us to friends and family		62	  
Respond to 85 per cent complaints within 25 days		70	   
Increase number of community learning disability referrals seen within four weeks of referral		75	  
Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers		78	    
Staff who would recommend the trust to friends or family		79	    
Maintain lower than expected mortality rates		84	    
Improve participation rates for patient reported outcome measures		87	 
Implement clinical outcome measures in community services		87	 
Increase sexual health support in Wandsworth secondary schools		90	  
Reduce hospital readmissions		92	   

Our priorities for improvement in 2014/15

Our main priorities for 2014/15 are to make sure we act on the recommendations the CQC made following their inspection of the trust in February 2014 (read more on page 34):

- Ensure consistent understanding of the Mental Capacity Act across the trust
- Ensure medical records are always available in outpatient departments.

For 2014/15 we have also refreshed our Quality Improvement Strategy priorities to take account of some national issues and the broader recommendations highlighted in the CQC report:

- Conduct twice yearly nursing and midwifery reviews as recommended in the National Quality Board report 'how to ensure the right people, with right skills, are in the right place at the right time'.
- To ensure that we implement the recommendations of the Clwyd/Hart review of the complaints system in hospitals to further strengthen our response to patient complaints, learn from their feedback and use as a means to implement improvements.
- To ensure that we meet the 'Duty of Candour' requirements to ensure we continue to endorse and develop a culture of openness and transparency.
- To ensure we focus on improving the experience of patients visiting our outpatient departments.
- To continue to focus on reducing avoidable harm by further reducing avoidable grade 3 and 4 pressure ulcers, implementing the Sepsis Care Bundle to improve care of patients with severe sepsis, and improving our discharge processes.
- To maintain our commitment to improving end of life care.
- To establish the dementia and delirium team to meet the national CQUIN requirements, embed the 'butterfly' scheme and improve the care of this vulnerable group of patients.

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

We will be reporting on our performance against our Quality Improvement Strategy at our public board meetings throughout 2014/15. Our performance will also be reported on our website www.stgeorges.nhs.uk

Our 10 year strategy

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

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

Our 10 year strategy sets out a compelling vision for the future, built around delivering healthcare of exceptional quality underpinned by leading edge research and teaching. The success of this strategy will be determined by the strength of our partnerships with our colleagues in the healthcare, social services and the voluntary and charity sectors.

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

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

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

Our goals:

- **Redesign care pathways to keep more people out of hospital**
We will play a key role in keeping people healthy and well at home by working with our partners in primary and social care and the charity and voluntary sector. This ranges from keeping people healthy for as long as possible to enabling those with a health condition to live as independently as possible.
- **Redesign and reconfigure our local hospital services to provide higher quality care**
We need to improve the way in which we provide our local hospital services from planned surgery through to discharge planning. We will work with other NHS trusts in south west London to ensure the highest quality, sustainable configuration of clinical services.
- **Consolidate and expand our key specialist services**
We will work to ensure that south west London patients continue to have access to a comprehensive range of specialist services available locally at St George's.

- **Provide excellent and innovative education to improve patient safety, experience and outcomes**
We will build on our strong history as a teaching institute and our partnerships with St George's, University of London and Kingston University to provide excellent education.
- **Drive research and innovation through our clinical services**
We will strengthen our approach to research programmes, making research a part of the trust's core business.
- **Improve productivity, the environment and systems to enable excellent care**
There are some changes that we need to make to our systems and processes, such as investment in our IT system, to ensure we are able to continue to provide the highest quality care. We will also look to make major improvements to our buildings and facilities.
- **Develop a highly skilled and motivated workforce championing our values**
Services cannot be delivered without our staff and we will continue to invest in our staff to ensure that they have the right skills, and are engaged and motivated to provide consistently excellent services.

To help us realise our mission, values and goals we have developed seven supporting detailed strategies for strategically important areas of the trust's work:

- Clinical strategy
- Education strategy
- Research strategy
- Quality improvement strategy
- Workforce strategy
- Communications strategy
- Estates strategy

You can read our 10 year strategy and the seven supporting strategies above on our website at www.stgeorges.nhs.uk/about/our-strategy

Developing the Quality Account

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

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

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

- Review of services
- Participation in clinical audits
- Research
- Use of CQUIN payment framework
- Statements from the Care Quality Commission
- Data Quality
- Information governance toolkit attainment levels
- Clinical coding error rate
- Mortality rates
- Patient reported outcome measures
- Emergency readmissions
- Staff who would recommend the trust to friends and family
- Cancer referrals
- Friends and family test (*new for 2013/14*)
- Responsiveness to patients needs
- Patient safety incidents
- Infection control
- VTE rates

Trusts are also encouraged to identify at least three voluntary indicators to include in their Quality Accounts. Because St George's is one of the largest trusts in the country, providing the full range of hospital and community services, for the last three years we have reported on a much larger number of voluntary indicators in a bid to better reflect the services we provide and the patients we care for. This year we have taken the same approach.

We have worked with local stakeholders to identify which indicators to include in this year's Quality Account to make sure that the areas that matter most to the people who use and provide our services are covered. These stakeholders included our patient reference group, our staff, local Clinical Commissioning Groups (CCGs), Wandsworth Healthwatch and Wandsworth Council.

The voluntary indicators we have chosen to include in this Quality Account fit into the three essential domains of our Quality Improvement Strategy - improving patient safety, improving patient experience and improving patient outcomes.

Improving patient safety voluntary indicators:

- Medication errors (*new for 2013/14*)
- Patient falls (*new for 2013/14*)
- Patient safety thermometer (*new for 2013/14*)
- Offender healthcare

Improving patient experience voluntary indicators:

- Community learning disability referrals (*new for 2013/14*)
- Complaints (*new for 2013/14*)

Improving patient outcomes voluntary indicators:

- Sexual health in secondary schools (*new for 2013/14*)
- Clinical outcome measures in community services (*new for 2013/14*)

As well as grouping the voluntary indicators together under the same three essential domains of our Quality Improvement Strategy, we have also stated which of the CQC's five domains apply to each indicator. The five CQC domains are:

- Are services **safe**?
- Are services **effective**?
- Are services **caring**?
- Are services **responsive**?
- Are services **well led**?

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

This Quality Account has been reviewed by:

- St George's Quality and Risk Committee
- St George's Audit Committee
- St George's Executive Management Team
- St George's Board
- St George's Patient Reference Group
- Wandsworth Healthwatch
- Merton Healthwatch
- South London Commissioning Support Unit
- Wandsworth CCG
- Merton CCG
- Wandsworth Council Adult Care and Health Overview and Scrutiny Committee
- Merton Council Healthier Communities and Older People Overview and Scrutiny Panel

Sharing a draft version of the report with our stakeholders has given them the opportunity to provide a feedback on our performance in a formal statement. These statements are published on page 97.

To put our performance into context we have compared our performance for all of the indicators in this report against our own performance over the last two years, and where possible and relevant, against the national average performance as published on the Health & Social Care Information Centre www.hscic.gov.uk

London Quality Standards



Background

In 2011 a NHS London review of London hospital-based acute medicine and emergency surgery departments found hugely variable and inadequate involvement of consultants in the assessment and subsequent management of acutely ill patients - particularly overnight and at the weekend when there were on average half the number of consultants on duty as during weekday office hours.

This review demonstrated that patients admitted to hospital as an emergency at the weekend in London had a significantly increased risk of dying compared to those admitted on a weekday. Data showed that a minimum of 500 lives in London could be saved every year if the mortality rate for patients admitted at the weekend was the same as for those admitted on a weekday. Reduced service provision, including fewer consultants working at weekends, was associated with this higher mortality rate.

London's heart attack centres, major trauma centres and hyper acute stroke units already operated a consultant-delivered service seven days a week and no observed difference was found in mortality rates for admissions during the week and those at the weekend. This demonstrated that where systems are in place to respond seven days a week, there is a direct effect on mortality rates. St George's Hospital is one of the London hospitals that has a heart attack centre, major trauma centre and hyper acute stroke unit.

The London Quality Standards

Clinical expert and patient panels developed 70 evidence-based London quality standards for acute and emergency services to address the variations found in service arrangements and patient outcomes.

These standards represent the minimum quality of care patients admitted as an emergency should expect to receive in every hospital in London that accepts patients on an emergency basis. Compliance with these standards would ensure that the assessment and subsequent care of patients admitted to these services on an emergency basis would be consultant-delivered, seven days a week and consistent across all providers of these services. The London quality standards are in line with the national clinical standards which were published in December 2013.

St George's Hospital volunteered to be the pilot site for the Quality and Safety Programme Audit in 2012, which helped to inform how London hospitals would be assessed and audited for their performance against the London Quality Standards.

How did we do?

St George's Hospital and all other acute hospitals in London submitted a self assessment against the full suite of London Quality Standards to NHS England in November 2013. We did not submit an assessment for Queen Mary's Hospital because it is a community hospital and does not provide emergency services.

In total St George's Hospital is fully compliant with 50 of the 70 London Quality Standards, with plans in place to make sure that nine other standards are met next year. This is a significant improvement from last year, when we were fully compliant with 38 standards. The most significant improvement has been made against the adult emergency surgery standards.

St George's Hospital 2013 self assessment against London Quality Standards:

London Quality Standards (number of standards assessed)	Red		Amber		Green	
	2013	2012	2013	2012	2013	2012
Adult emergency medicine (22 standards)	4	6	4	3	15	15
Adult emergency surgery standards (27 standards)	7	18	3	1	17	10
Critical care (4 standards)	0	0	0	0	2	2
Emergency departments (4 standards)	0	0	0	0	4	4
Fractured neck of femur pathway (4 standards)	0	0	1	0	5	3
Maternity services (4 standards)	0	2	1	0	3	1
Paediatric services (4 standards)	0	1	0	0	4	3

Note - Not all standards assessed in 2013 were the same as those assessed in 2012, hence difference in number of standards above

The full list of standards and our assessment of compliance against each standard is in [Appendix D](#).

The full reports for St George's Hospital and every other acute hospital in London are available on the My Health London website at <http://www.myhealth.london.nhs.uk/your-health/londons-health-services/hospital-quality-and-safety-audit-reports>

Learning from other organisations

At St George's we are committed to learning from other organisations to see how we can apply best practice from high performing services elsewhere for the benefit of our patients.

As well as learning from best practice, we also have a duty to learn from organisations where mistakes have been made and serious failings uncovered. It is vital that we understand what went wrong at these organisations so we can make sure we are doing all we can to minimise the risk of the same things happening at St George's.

We have strong governance and audit processes that help us to react quickly and decisively to emerging reports, guidance, inquiries and recommendations.

As well as reviewing the integrity of our financial accounts, our Audit Committee, which is made up of Executive and Non-Executive Directors, has the other main role:

- To review and independently scrutinise the trust's systems of clinical governance, internal control and risk management. This ensures through proper process and challenge that integrated governance principles are embedded and practised across all St George's activities and that they support the achievement of the trust's objectives.

The Audit Committee ensures the work of own internal auditors, clinical auditors (read more on page 25) and our external auditors is aligned. The Audit Committee reviews the work and findings of the external auditors and considers the implications and the trust's responses, and makes sure that the responsibility and accountability for developing and implementing any necessary actions sits at Board and senior clinician level.

Below and over the coming pages is a brief summary of how we have reacted to some high profile inquiries and reports. As part of our commitment to transparency and to increase patient confidence in our services, we publish our reaction to these high profile inquiries and reports on our website and discuss them in our public Board meetings, which are open to all members of the public. These papers and details of our Board meetings are available at www.stgeorges.nhs.uk/about/board

Mid Staffordshire NHS Foundation Trust Public Inquiry

A full public inquiry into the role of the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire Foundation NHS Trust. The inquiry was chaired by Robert Francis QC, whose report made 290 recommendations to the Secretary of State for Health.

Our response

We held a board strategy session and published two board papers outlining our seven commitments and providing an update on progress against these commitments.

We committed to:

1. Ensure that Quality is maintained as the boards top priority.
2. To strengthen clinical leadership, including medical and nursing.
3. To embed and live the trust values.
4. To ensure that there is a clear approach to the identification of a single lead consultant in multidisciplinary care.
5. To ensure the constant improvement in the quality of care.
6. To devolve the boards commitments to quality at every level throughout the organisation.
7. To meet the trust's responsibilities under the Duty of Candour.

The Keogh Mortality Review

The Keogh Mortality Review was a review into the quality of care and treatment in 14 trusts with high mortality rates. The Keogh Report was the precursor to the Chief Inspector of Hospital's new CQC inspection regime. The report identified six barriers to delivering high quality care and highlighted eight ambitions for improvement.

Our response

A reflective commentary was compiled identifying work already underway within the organisation relevant to each ambition with reflections of further actions to consider. This report was presented for discussion at Executive Management Team, Patient Safety Committee and the September Board meeting.

Berwick review into patient safety - A promise to learn, a commitment to act: improving the safety of patients in England

This report highlights the main problems affecting patient safety in the NHS and makes nine recommendations to address them.

Our response

A reflective piece similar to the response to the Keogh Report was compiled and triangulated, and presented to the Patient Safety Committee.

The Clwyd-Hart Report - Putting patients back in the picture

Putting patients back in the picture called for a major revolution in how complaints are currently dealt with. It called on NHS boards to lead this change with the support of the whole system. The report made four recommendations and included pledges by representatives of 12 leading bodies that will influence the NHS to take action in response to the review's findings. NHS Employers and the NHS Confederation have both made pledges.

Our response

Presentation and discussion at the December 2013 Quality and Risk Committee seminar. A gap analysis was undertaken and areas for improvement identified, with trust policy and procedures revised.

The Cavendish Review of healthcare assistants and support workers in NHS and social care

This independent review by Camilla Cavendish makes a number of recommendations on how the training and support of both healthcare assistants who work in hospitals, and social care support workers who are employed in care homes and people's own homes, can be improved to ensure they provide care to the highest standard.

The review proposes that all healthcare assistants and social care support workers should undergo the same basic training, based on the best practice that already exists in the system, and must get a standard 'certificate of fundamental care' before they can care for people unsupervised.

Our response

We conducted a review of healthcare assistant recruitment, selection, induction and development and presented the findings and recommendations to the Workforce and Education Committee in September 2013 and to the Nursing Board in October 2013.

Review of services

St George's is the largest healthcare provider in south west London, and one of the largest in the country. St George's serves a population of 1.3 million people across south west London. A large number of services, like cardiothoracic medicine and surgery, neurosciences and renal transplantation, also cover significant populations from Surrey and Sussex, totalling around 3.5 million people.

Most of the services are provided at St George's Hospital in Tooting, but we also provide most of the services based at Queen Mary's Hospital in Roehampton, health centres across Wandsworth, Wandsworth Prison and from GP surgeries, schools, nurseries and in patients' own homes.

We also provide care for patients from a larger catchment area in south east England for specialist services like complex pelvic trauma. Other services treat patients from all over the country like family HIV care and bone marrow transplantation for non-cancer diseases.

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

During 2013/14 we provided and/or sub-contracted 54 NHS services. We have reviewed all the data available on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2013/14 represents 100 per cent of the total income generated from the provision of NHS services by St George's Healthcare NHS Trust for 2013/14.

The services we provide can be categorised as:

- **National specialist centre**
We provide specialist care to patients from across the country for complex pelvic trauma, family HIV care, lymphoedema and penile cancer.
- **Tertiary care**
We provide tertiary care like cancer services, neurosciences and renal services for the six boroughs of south west London and the counties of Surrey, Sussex and Hampshire.

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

- **Local acute services**

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

- **Community services**

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

Our clinical divisions

Our services are split into four clinical divisions, which all have their own clinically led divisional management boards. Each board has a Divisional Chair who is an experienced clinician, providing expert clinical leadership to the staff of each service so that the needs of the patients who use them are best met. Every division has a Divisional Director of Nursing and Governance who is responsible for nursing, patient experience and making sure that there are strong governance structures within their division for improving the quality of their services and safeguarding high standards of care. Each division also has a Divisional Director of Operations who is responsible for managing the operational, business and logistical aspects of providing healthcare services. The divisional boards are made up of the clinical directors and heads of nursing who are responsible for the specialist services within their division.

Last year we strengthened our professional leadership and oversight of therapy services by establishing the new role of Chief Therapist. Therapy services include physiotherapy, occupational therapy, dietetics, speech and language therapy, radiography, podiatry, prosthetics, orthotics and art and play specialists.

Surgery, theatre, neurosciences and cancer division

Surgery and trauma clinical directorate

- Trauma and orthopaedics
- Ear, nose and throat
- Maxillofacial
- Plastic surgery
- Urology
- General surgery
- Dentistry
- Audiology

Theatres and anaesthetics clinical directorate

- Theatres and decontamination
- Anaesthetics and acute pain

Neurosciences clinical directorate

- Neurosurgery and neuroradiology
- Neurology
- Neurorehabilitation
- Pain clinic

Cancer clinical directorate

- Cancer

Medicine and cardiovascular division

Emergency and acute medicine

- Emergency department
- Acute medicine

Specialist medicine

- Lymphoedema
- Clinical infection unit
- Rheumatology
- Diabetes and endocrinology
- Chest medicine
- Endoscopy and gastroenterology
- Dermatology

Renal, haematology and oncology clinical directorate

- Renal transplantation
- Renal
- Medical oncology
- Clinical haematology
- Palliative care

Cardiovascular clinical directorate

- Cardiology
- Cardiac surgery
- Vascular surgery
- Blood pressure unit

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

Children's clinical directorate

- Paediatric surgery
- Newborn services and neonatal intensive care unit
- Paediatric intensive care unit
- Paediatric medicine

Women's clinical directorate

- Gynaecology
- Obstetrics

Therapeutics clinical division

- Adult critical care
- Therapies
- Pharmacy

Diagnostics clinical division

- Clinical genetics
- Breast screening
- Pathology
- Radiology
- Laboratory haematology

Outpatients clinical directorate

- Outpatients

Community services

Children and family clinical directorate

- School and special school nursing
- Children's continuing care
- Health visiting
- Child safeguarding team
- Children's therapies and immunisation
- Homeless, refugees and asylum seeker team

Older people and neurorehabilitation clinical directorate

- Community nursing and community wards
- Intermediate care
- Specialist nursing
- Older people and neuro therapies
- Day hospitals
- Senior health inpatient wards and elderly rehabilitation
- Community learning disabilities

Adult and diagnostic clinical directorate

- Outpatient services
- Minor Injuries Unit
- Diagnostics
- Integrated sexual health
- Specialist rehabilitation
- Adult therapies - physiotherapy, dietetics and podiatry

Offender healthcare

- Primary care
- Substance misuse
- Inpatient care
- Primary care mental health

Where our services are based

We provide healthcare services at:

Hospitals

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

Therapy centres

- St John's Therapy Centre

Health centres

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

Prisons

- HMP Wandsworth

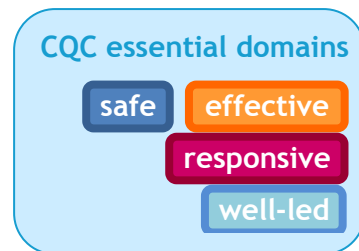
Community

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

Find out more about our services and the clinicians and healthcare professionals that provide them on the services section of our website www.stgeorges.nhs.uk/services

Participation in clinical audits

During 2013/14, 36 national clinical audits and two national confidential enquiries covered NHS services that St George's Healthcare NHS Trust provides.



During that period we participated in 97.2 per cent of national clinical audits and 100 per cent of national confidential enquiries of the national clinical audits and national confidential enquiries which we were eligible to participate in.

The national clinical audits and national confidential enquiries that we were eligible to participate in during 2013/14 are listed in [Appendix A](#) 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 23 national clinical audits were reviewed by St George's Healthcare NHS Trust Board in 2013/14. A summary of the actions agreed in response to these audits is given in [Appendix B](#).

The reports of 13 local clinical audits were reviewed by St George's in 2013/14. A summary of the actions agreed is given in [Appendix C](#).

Research

CQC essential domains

safe

effective

well-led

Why is it important?

As a major teaching trust, many of our staff are actively involved in undertaking clinical research studies with the aim of improving patient outcomes and experience and enhancing their own personal knowledge.

Research at St George's is overseen the trust's Associate Medical Director for Research, and we have a number of joint appointments with St George's, University of London and the Joint Faculty of Health and Social Care Sciences with Kingston University. We have a joint department that is responsible for research governance and performance called the Joint Research & Enterprise Office (JREO).

The key reason for our participation in clinical research is to develop new and improved clinical treatments for our patients and to realise better ways to manage health conditions, thereby ultimately improving the health of our local community.

St George's, in its partnership with St George's University of London Medical School, aims to bring new ideas and solutions into clinical practice for the benefit of patients.

Our strong relationship with the pharmaceutical industry enables our patients to have access to the newest treatments within clinical trials.

One of the goals of the trust's 10 year strategy is to drive research and innovation through our clinical services, achieved by strengthening our approach to research programmes. Specifically, we are working to:

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

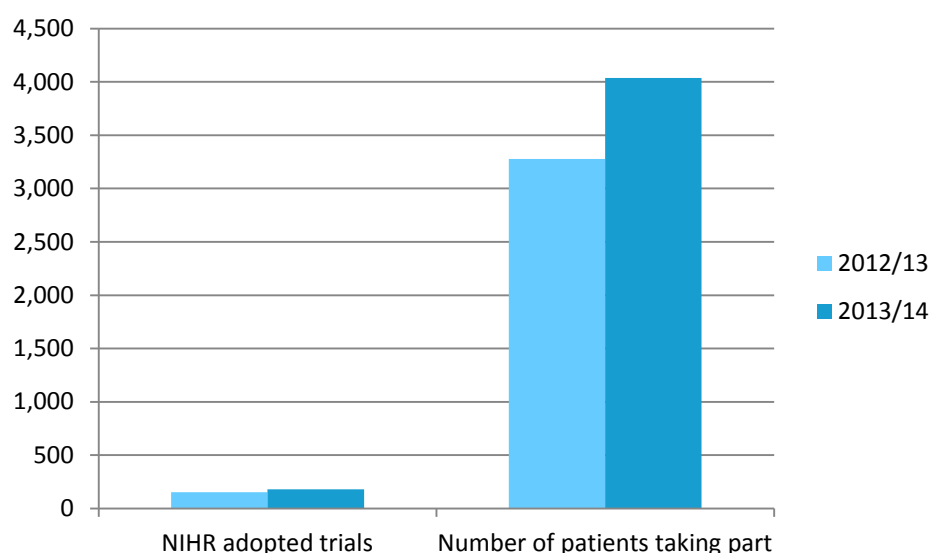
By sticking to these principles towards research in the longer term, this will allow us to provide higher quality clinical care and to recruit, retain and further motivate the best staff.

How did we do?

We measure our performance in research against the NIHR national performance metrics. Below is a summary of our performance against the NIHR Clinical Research Network High Level Objectives.

Participation

One of the key ways of offering new treatments is through participation in clinical trials that are approved by the National Institute for Health Research (NIHR). The NIHR supports NHS and academic institutions to deliver quality research that is patient-focused and relevant to the NHS. In the period October 2012 to September 2013 (the period specified by the NIHR for patient accrual into research studies), we had 178 NIHR adopted trials open and recruiting, with 4,037 patients taking part. This was an increase from last year's figures, when we had 151 studies involving 3,278 patients.



Approvals

In 2013, the JREO approved 164 new studies at St George's. These range from clinical trials of medicinal products (new drugs) and medical device studies, through to service and patient satisfaction studies. Around 30 per cent of these are adopted on the NIHR portfolio. Studies that are not adopted onto the NIHR portfolio include 'Proof of Concept' studies, in which our researchers and clinicians are gathering evidence that may develop into larger adopted trials, student studies and trials sponsored by commercial companies.

Of these studies, 80 per cent were approved within 30 days of submission to the JREO.

Trials starting recruitment

In our most complex trials, we endeavour to get the study approved and the first patients recruited within 70 days of submission to the JREO. This is a new national metric and we have seen a steady improvement across the year, from 12.8 per cent from January to March 2013, to 40.3 per cent between October and December 2013. We intend to continue improving this measure through 2014.

Ensuring Quality

All trials require one institution or company to have the legal responsibility to ensure that the trial is run safely and gathers good quality information in order to answer the research question e.g. *does a new drug lead to better outcomes compared to the standard treatment?*

When we are the responsible institution (sponsor) all our trials are closely monitored by a team from the JREO. This is a legal requirement that sponsors must “monitor” **all** of these trials, in all locations where that trial is being undertaken. Therefore 100% of our sponsored trials are monitored by St George’s.

When we host studies that are sponsored by other organisations or companies, as well as having the legally required monitoring visits (described above), we also undertake our own system of review (audit), in order to ensure best practice by our researchers. In October-December 2013, we reviewed 10 studies to ensure that our staff are meeting all of the regulatory and compliance requirements, and patient safety is maintained.

Increase the number of clinicians active in research

In 2013/14, we made it easier for our clinicians to develop their research ideas into research protocols. We have made additional funds available to pay for staff to cover the posts of clinicians who are working on research programmes. This means that our clinicians can now submit a research proposal to the JREO confident that if successful, their patients will not be adversely affected for the short period of time (generally six months) needed to develop new ideas and treatments for patients at St George’s. To be successful, these proposals will be externally reviewed, and funded by research-grant awarding bodies.

Our aims

Increase participation

We intend to maintain and improve upon our patient participation rates in NIHR adopted trials by doing more to make patients and staff aware of the research opportunities at St George’s.

To do this we took part in the International Clinical Trials Day on 20th May 2014 and will continue to take part every year. We are also increasing staff and patient awareness by holding disease-specific events for specific trials with services and patient groups and by improving and increasing the amount of patient information in clinical areas.

Approvals

In 2014/15, we intend to continue to be green-rated for our approval times i.e. at least 80 per cent of our trials are approved within 30 days.

We have already noticed an increase in the number of proposed studies, and we intend to meet the challenge of approving more studies in a shorter time.

Trials starting recruitment

We intend to continue increasing the number of trials that get up and running quickly so that the trials can be successful.

Ensuring Quality

We will ensure that 100% of our sponsored research trials are monitored

We will continue to audit 10% of all hosted active research studies at St George's each year to provide assurance of the safety and quality of studies undertaken here - even as they will also be monitored by their sponsor.

Increase the number of clinicians active in research

We will continue to provide our clinicians with the opportunity to take time to develop their ideas to write successful grant applications. We will allow clinicians time to recruit patients to trials in their daily roles and support them with research staff.

Use of CQUIN payment framework

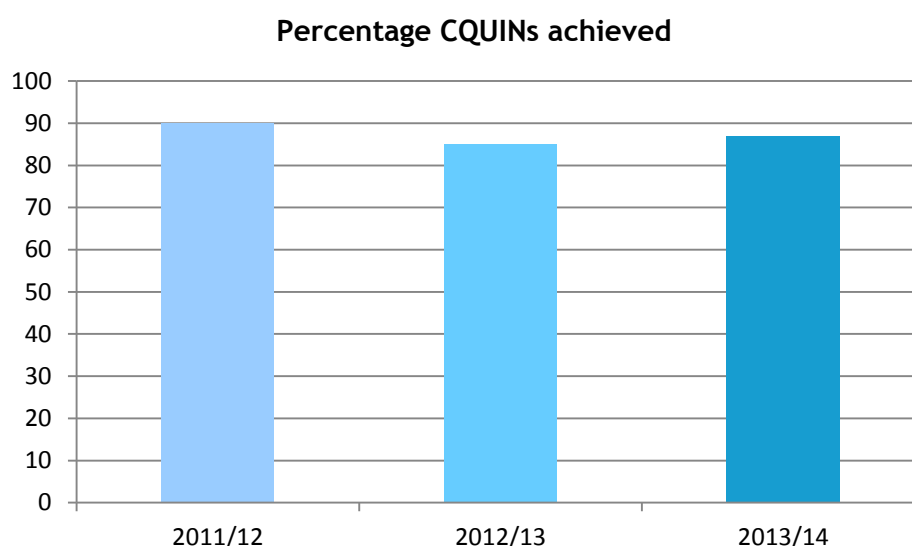


A proportion of our income in 2013/14 was conditional on meeting quality improvement and innovation goals. These are objectives agreed between the trust and its commissioners and clinical commissioning groups, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

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

We achieved 87 per cent overall performance against the 40 CQUINs we agreed with our commissioners in 2013/14. Last year we achieved 85 per cent of our CQUINs.

The total trust wide value for CQUINs was £12,668,550 of which we achieved £10,989,516.



Our 2013/14 CQUIN objectives for acute, specialised and community services are outlined in [Appendix E](#). The tables explain what our key objectives were, and whether or not we met them.

Our proposed 2014/15 acute, specialised and community service CQUINs are also included in [Appendix F](#). At the time of publication the trust is in discussions with commissioners and the list is subject to amendment.

Information governance

CQC essential domains

well-led

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 on-going, rolling information governance programme, dealing with all aspects of confidentiality, integrity and the security of information. Annual information governance training is mandatory for all staff, which ensures that everyone is aware of their responsibility for managing information in the correct way. An internal audit conducted in 2013/14 gave the trust “reasonable” assurance that the trust is managing information appropriately and that staff are aware of their responsibilities.

Our patient administration system increased both the security and accuracy of information at the trust. All staff accessing the system use a secure and strictly authenticated smartcard which defines what they are permitted to access in the system. Last year we upgraded the radiology and pathology modules of the system, this year we are running projects to enhance the clinical documentation, ePrescribing and medicine administration. Secure access to and storage of trust information is being enhanced through the virtual desktop and single sign on programmes.

How did we do?

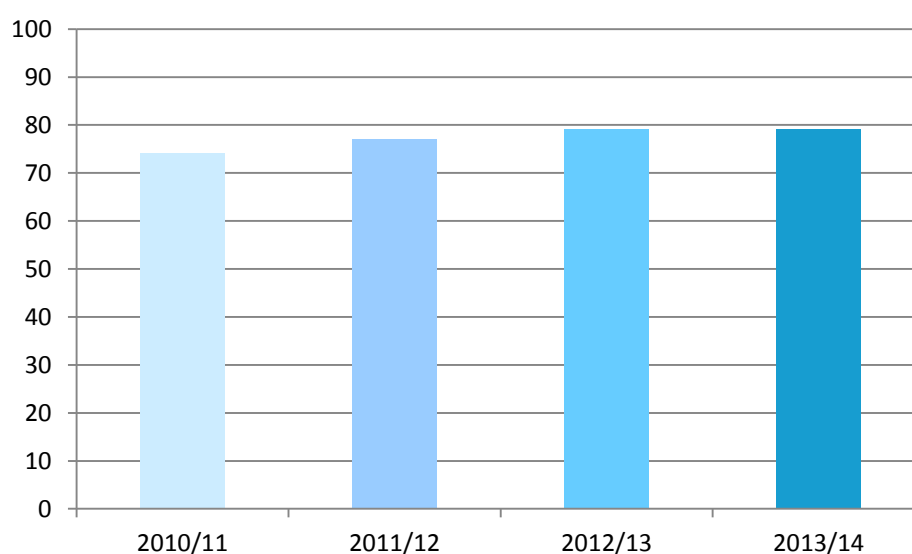
Each year we submit scores and provide evidence to the Department of Health (DH) by using the NHS Information Governance Toolkit. The toolkit is an online system which allows NHS organisations and partners to assess themselves against DH information governance policies and standards. It also allows members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

St George’s Healthcare’s information governance assessment report overall score for 2013/14 was 79 per cent and was graded green, or ‘satisfactory’ according to the criteria set nationally. This is the highest grading possible, and can only be awarded by achieving Attainment Level 2 on every requirement in the NHS Information Governance Toolkit.

This is the same score we achieved last year, meaning we are successfully maintaining the high standards we have achieved in information management over the last four years. In 2011/12 we scored 77 per cent, and in 2010/11 we scored 74 per cent, which were both green grades.

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, and other organisations, at www.igt.connectingforhealth.nhs.uk. St George's is listed as an acute trust and our organisation code is **RJ7**.



Year	Information governance assessment score (per cent)	Grade
2013/14	79	Green
2012/13	79	Green
2011/12	77	Green
2010/11	74	Green

Data quality

CQC essential domains

well-led

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.

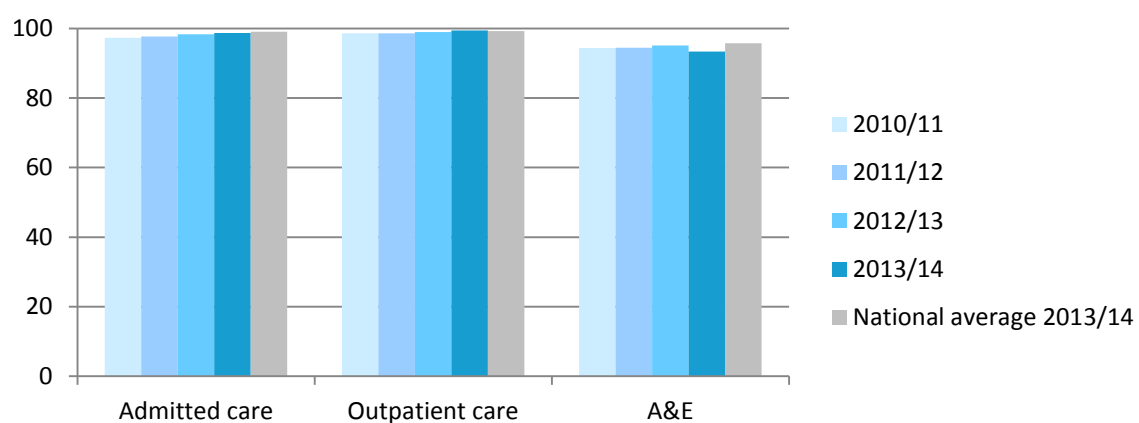
Most data is gathered as part of the everyday activity of frontline and support staff who work throughout the trust in a huge variety of settings. It's important that we accurately capture and record the care we provide and the information in this report aims to demonstrate how well we are doing this.

St George's Healthcare submitted records during 2013/14 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

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

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

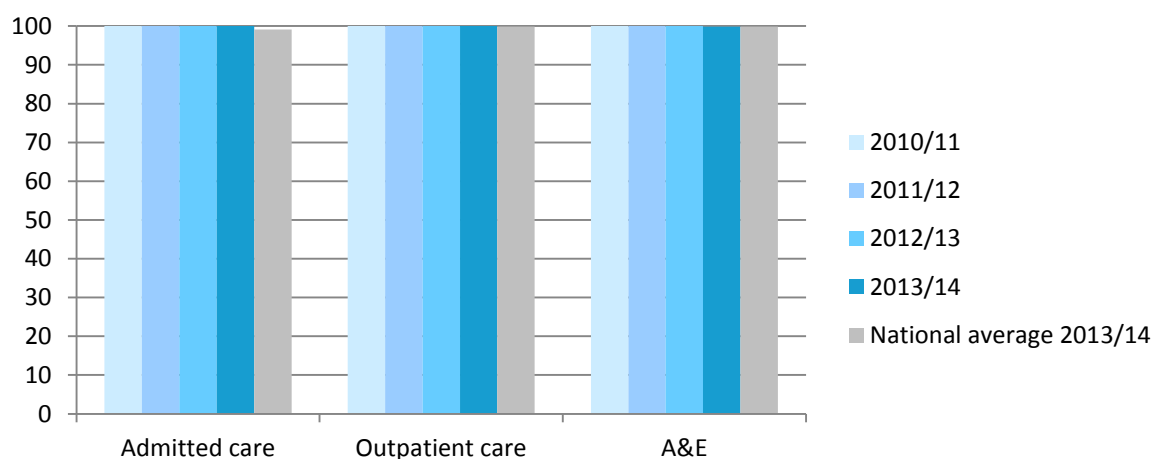
Records with valid NHS number	Admitted care (per cent)	Outpatient care (per cent)	A&E (per cent)
2013/14	98.7	99.4	93.4
2012/13	98.3	99.0	95.1
2011/12	97.7	98.6	94.5
2010/11	97.3	98.6	94.4
National average 2013/14	99.1	99.3	95.8



Our NHS Number completeness has improved, but is still fractionally behind the national average for Admitted care and A&E. We have a data quality improvement strategy which we have developed with our commissioners that details planned improvements in the way our Patient Administration System (PAS), Cerner, accesses the national Patient Demographic Service (PDS) that should see these numbers improve next year.

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

Records with valid general medical practice	Admitted care (per cent)	Outpatient care (per cent)	A&E (per cent)
2013/14	100	100	99.9
2012/13	100	100	100
2011/12	100	100	100
2010/11	100	100	100
National average 2013/14	99.1	99.9	99.9



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.

Clinical coding error rate

CQC essential domains

well-led

Why is this important?

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.

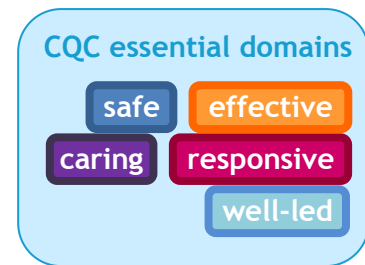
Healthcare providers are paid based on the HRG coding system. This is known as Payment by Results (PbR). The aim of PbR is to provide a transparent, rules-based system for paying hospitals for the work they do. It is very important that we code patient care accurately, so that we are paid appropriately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

How did we do?

We were not subject to the PbR clinical coding audit by the Audit Commission in 2013/14.

We were last subjected to the PbR clinical coding audit in 2012/13, when we were in the best performing 25 per cent of trusts in the country.

Statement from the Care Quality Commission



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

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

St George's Healthcare NHS Trust is registered with the CQC and is licensed to provide services from each of its locations. The trust has no conditions placed on it and the CQC has not taken any enforcement action against the trust in 2013/14.

In May 2013, Professor Mike Richards was appointed as Chief Inspector of Hospitals and under his leadership, a new style CQC inspection and a new framework of standards has been developed which focus upon five domains:

- Are services **safe**?
Are people protected from abuse and avoidable harm?
- Are services **effective**?
Does people's care and treatment achieve good outcomes and promote a good quality of life, and is it evidence based where possible?
- Are services **caring**?
Do staff involve and treat people with compassion, kindness, dignity and respect?
- Are services **responsive**?
Are services organised so that they meet people's needs?
- Are services **well led**?
Does the leadership, management and governance of the organisation assure the delivery of high-quality patient-centred care, support learning and innovation and promote an open and fair culture?

The CQC rating system has four categories - **outstanding**, **good**, **requires improvement** or **inadequate**. NHS trusts are given an overall rating and a range of services within the trust are also given one of these four ratings.

How did we do?

In February 2014 the trust was subject to a full inspection using the new CQC inspection methodology against the five domains. The CQC inspected the treatment and care provided at St George's Hospital, Queen Mary's Hospital, St John's Therapy Centre and selected community services provided from other health centres in Wandsworth.

The CQC found the overall standard of care to be **good** across all sites and has awarded the trust an overall **good** rating, with some aspects of care rated as **outstanding**. St George's and Queen Mary's Hospitals both received **good** overall ratings.

The CQC rated 62 specific standards. Out of these, **four were rated outstanding**, **50 were rated good** and **eight were in the requires improvement category**. None of our services were judged inadequate. The full breakdown of how our hospitals performed against each of the five CQC essential domains is available over the coming pages.

CQC statement on St George's Hospital

Service	CQC essential domain - safe	CQC essential domain - effective	CQC essential domain - caring	CQC essential domain - responsive	CQC essential domain - well led	Overall
A&E	Good	Not assessed	Good	Good	Good	Good
Medical care	Requires Improvement	Good	Good	Good	Good	Good
Surgery	Requires Improvement	Good	Good	Good	Good	Good
ITU/CCU	Outstanding	Good	Good	Good	Outstanding	Outstanding
Maternity	Good	Good	Outstanding	Good	Good	Good
Children & Young People	Good	Good	Good	Good	Good	Good
End of Life Care	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Outpatients	Requires Improvement	Not assessed	Good	Good	Good	Good
Overall	Requires Improvement	Good	Good	Good	Good	Good

CQC statement on Queen Mary's Hospital

Service	CQC essential domain - safe	CQC essential domain - effective	CQC essential domain - caring	CQC essential domain - responsive	CQC essential domain - well led	Overall
A&E (Minor Injuries Unit)	Requires Improvement	Not able to rate	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Outpatients	Good	Not able to rate	Good	Requires Improvement	Good	Good
Community Inpatient Services	Not rated at this time	Not rated at this time	Not rated at this time	Not rated at this time	Not rated at this time	Not rated at this time
Overall	Requires Improvement	Good	Good	Good	Good	Good

The audit of our community services at Queen Mary's Hospital, St John's Therapy Centre and other health centres was a pilot to help the CQC develop the methodology for auditing community services in the future. The CQC is not yet rating community services so no rating was given for the community inpatient service at Queen Mary's or for the services based at St John's and our other health centres.

The CQC reported its findings back to us at a Quality Summit that included representatives from:

- St George's Healthcare NHS Trust
- The CQC
- The Trust Development Agency (TDA)
- NHS England
- Wandsworth Council
- Healthwatch Wandsworth
- Wandsworth CCG
- Merton CCG

In its report on the trust, the CQC highlighted numerous examples of commendable practice, including:

- Outstanding maternity care underpinned by information provided to women and partners and robust midwifery staffing levels with excellent access to specialist midwives
- Exceptional end of life care demonstrated within the maternity department

- Outstanding leadership of intensive care and high dependency units with open and effective team working and a priority given to dissemination of information, research and training
- Excellent multidisciplinary working within and across community and acute teams
- The functioning of the hyper acute stroke unit, short term reablement and rehabilitation service
- The well led, integrated working and calm environment within A&E
- Multi-professional team working in neuro theatres
- Systems developed by the trust to promote the safety of children, young people and families
- An evident culture of positive learning from medicine administration errors
- Development and use of DVDs to engage staff with ongoing practice improvements

As well as highlighting some aspects of care which required improvement the CQC also asked that we take action to ensure staff awareness and implementation of the Mental Capacity Act at Queen Mary's Hospital. The CQC noted that most staff had attended or completed training on safeguarding adults and that there was appropriate specialist input through the trust's safeguarding lead and two specialist learning disability nurses. However, varying levels of understanding of the Mental Capacity Act were identified.

Since the inspection in February 2014, work has begun to address this issue. We are reviewing our approach to training around the Mental Capacity Act and Deprivation of Liberty Standards, and are working on an action plan that will be approved by the Board and then shared with the CQC.

The CQC also asked that we take action to improve the availability of medical records in outpatient clinics where there was an over reliance on temporary records. In April 2014 we held a notes tracking week to identify flaws within the systems we use to get medical records across the trust, and have started to implement changes to make the improvements needed. We are recruiting new permanent staff to reduce our reliance on temporary agency staff to manage medical records, and have introduced audits across all of our divisions to ensure compliance.

We have also introduced a number of other initiatives to improve patient experience in our outpatient services. You can read more about these initiatives on page 67.

We welcome the level of scrutiny from the CQC as part of our commitment to continuous improvement, and we have ensured our Quality Improvement Strategy encompasses the lessons learned from this external scrutiny.

Improving patient safety

Our commitment to patients

This section of the Quality Account looks at patient safety quality indicators. In our Quality Improvement Strategy we outlined our commitment to patients:

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

You can read more about our commitment to improving patient safety in our Quality Improvement Strategy on our website at www.stgeorges.nhs.uk/about/our-strategy/strategies

Our patient safety indicators

The patient safety indicators in this section are:

- Patient safety incidents
- Medication errors
- Patient falls
- Patient safety thermometer
- Offender healthcare
- Infection control
- VTE rates

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



Why is this important?

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

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

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

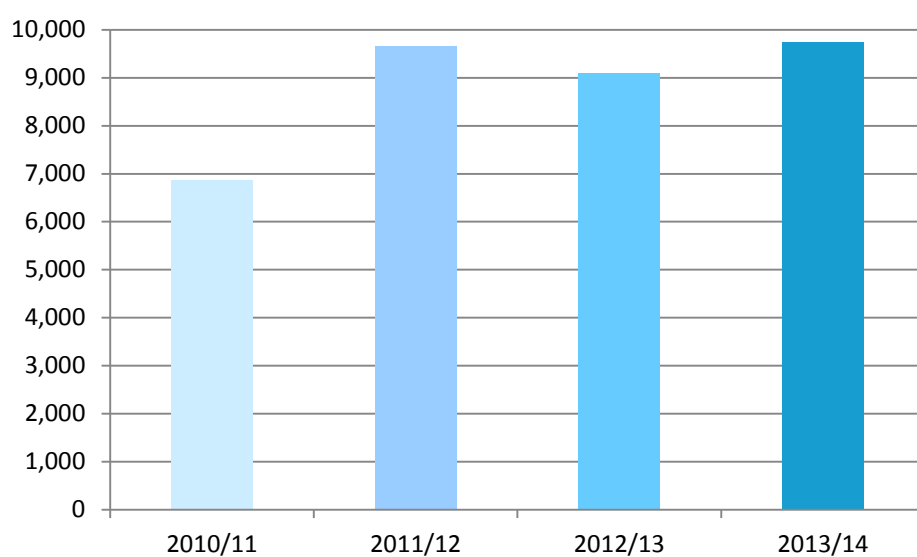
Patient safety incidents

There were 9,739 patient safety incidents in 2013/4 compared to 9,084 the previous year. This shows that we continue to actively report as many incidents as we can, demonstrating that at St George's we are committed to developing good systems that enable us to learn from things that go wrong and prevent them from happening again.

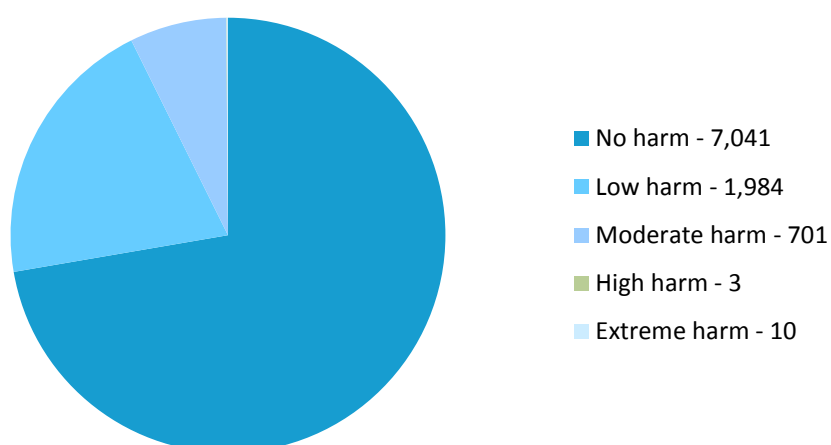
Of the 9,739 patient safety incidents there were 12 high and extreme severity incidents during the year. This is 0.12 per cent of all reported incidents.

Year	Number of patient safety incidents
2013/14	9,739
2012/13	9,084
2011/12	9,663
2010/11*	6,854

* St George's merges with Community Services Wandsworth during 2010/11



Types of patient safety incident



Over the last year we have introduced some important changes to help us reduce any risk to our patients. We have:

- Carried out awareness raising weeks for handover and documentation
- Identified leads in all care groups for dissemination of quality information
- Carried out regular staff open forum so that staff are aware of safety messages
- Introduced new initiatives within nursing to ensure safe staffing levels
- Set up new processes to support Duty of Candour and have an updated policy and regular training
- Trialled a patient safety booklet for patients

Never events

A never event is an event or incident that is unacceptable and preventable within the NHS. During 2012/13 there were five never events at the trust.

Although no patients were harmed during any of these events, these five incidents are hugely regrettable. All of these incidents have been thoroughly investigated, with the underlying cause being individual human error rather than system failings. Each incident took place in a surgical environment, where we have been using the World Health Organisation Surgical Safety Checklist since its development in 2008.

Where appropriate disciplinary action has been taken against responsible staff and additional training put in place. Detailed action plans have been implemented across the trust and these incidents used in training and patient safety forums to reduce the risk of similar incidents happening again.

Year	Never events
2013/14	5
2012/13	0
2011/12	4
2010/11	0

Because of the low number of never events we cannot publish any details about these incidents as this would breach information governance rules by risking the confidentiality of the patients involved.

Telling patient stories

Behind the statistics recorded above are individuals who may be affected by incidents. As part of the patient safety programme we have sought to tell some of their stories in a DVD

format. Telling a story often conveys the importance of patient safety issues in a much more graphic way. The library of stories has increased over the year and covers a wide range of issues that are important to patients and staff alike. One tells the story of a drug error and another about a post operative patient where the expected discharged arrangements did not work as anticipated. They are used at the patient safety forum and in a range of training and other events. They also stimulate a number of actions that can help to make us safer.

CQC commendation

This initiative was highly commended by the CQC in their February inspection and praised as a best practice example of bringing patient issues to life at Board level. The CQC have now invited us to share our approach with other NHS trusts.

HSJ Awards 2013

We were very proud to be finalists in the patient safety category of the prestigious Health Service Journal Awards 2013. Speaking about our approach to telling patient stories and to making sure that staff know they will be supported to improve patient safety, the judges said that we had a *"moving approach to enabling people to speak out about safety."*

Improving our clinical communication systems

Since we started thematic analysis of serious incidents, communication and handover have been consistent themes. To improve these aspects of care, we have introduced a number of initiatives to help address these problem areas.

Handover of care

In 2013 we introduced a new handover policy following a detailed assessment of how medical and nursing handovers were conducted across the trust that highlighted some key areas that needed improving. The new policy for the way patients are transferred is now much more robust and we are piloting a new telephone handover system between our Acute Medical Unit and acute medical wards that covers all essential systems.

We have also reviewed weekend and night-time consultant cover to make sure that there is continued senior clinician cover and input at all times.

Daily ward rounds

During 2013/14 we have implemented new processes aimed at making sure that all patients in acute services are reviewed every day by a senior clinician. This is in addition to the daily assessments conducted by registrars and junior doctors, and complements the intentional nurse-led ward rounds that have been in place at the trust for some time. In some wards these intentional rounds are conducted hourly and in some wards every four hours, depending on the clinical needs of patients on the ward at the time.

We have also introduced new boards above every patient bed in St George's and Queen Mary's Hospitals that display the names of the consultant and nurses responsible for and managing that patient's care, as recommended in the Francis Report.

SBAR communication

We have adopted the SBAR (Situation, Background, Assessment and Response) structured approach to quickly identify the escalation of deteriorating patients. This approach was developed by the military and has been adapted to be used worldwide in healthcare systems. All patient observation charts used across the trust now have the SBAR format on the reverse side and the approach is regularly monitored and audited.

Clinical fellowship post

In 2013/14 we successfully bid for a fellowship post from the Fellowship in Clinical Leadership Programme (also known as the Darzi Fellowships). We are now in the process of recruiting to a fellowship post to focus on to further developing systems for safe discharge and improving clinical communication systems. Fellowships are typically awarded to clinicians in the early stages of their career, with the post holders mentored a medical or clinical director at the trust.

National safety thermometer

Making sure that patients do not suffer avoidable harm is a key focus for the trust. This year we have extended our use of the national safety thermometer to community therapy services after introducing it to inpatient services in 2012.

The safety thermometer is a quick and simple point-of-care tool for surveying patient harms and analysing results so that you can measure and monitor local improvement and harm free care.

Developed by the NHS for the NHS, the safety thermometer collects data on high risk areas including falls, pressure ulcers, urinary catheter related infections and blood clots. The safety thermometer allows us to merge patient safety data across all the teams and wards in the trust, with the built-in analysis charting functions allowing us see the results straight away so we always have a clear picture of what is happening in any service at any time. This means we can take immediate remedial action where necessary to reduce avoidable harm to patients.

Our target for 2013/14 was to capture six months of data for all of the high risk areas listed above across all inpatient areas at St George's and Queen Mary's Hospitals, which we have achieved.

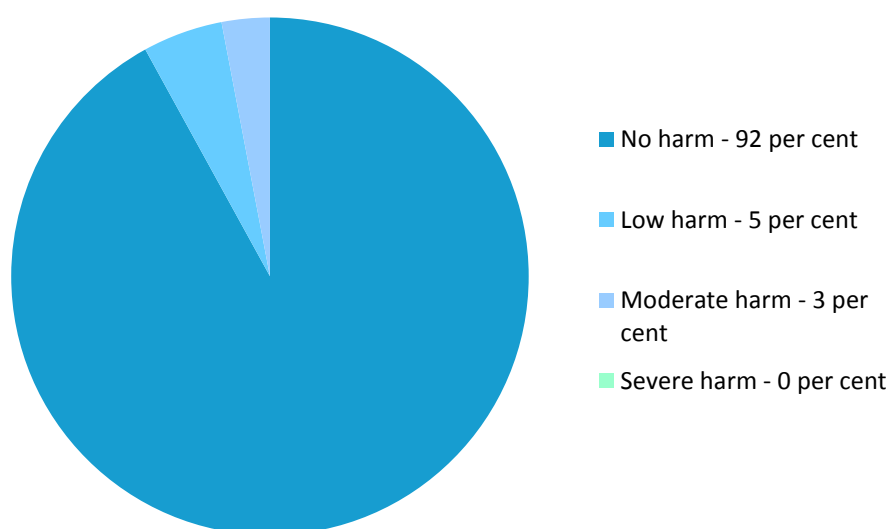
All data recorded on the safety thermometer is submitted to the Health & Social Care Information Centre with monthly national reports developed and published at www.hscic.gov.uk/thermometer

New patient safety thermometers for medication safety and maternity services are being piloted in a number of trusts across the country at time of publication. We will implement these new safety thermometers at St George's in 2014/15 if NHS England approves them after analysing their use at the pilot sites.

Reducing medication errors

Over the years we have worked hard to develop and maintain our strong reporting culture, a key indication of an effective safety culture. Following their audit of the trust in February 2014, the CQC reported that there is an evident culture of positive learning from medicine administration errors at St George's.

This year the National Reporting and Learning System have reported that St George's medication error reporting is higher than the national benchmark for reporting medication incidents. Last year we reported 1,138, reflecting a good safety culture at the trust. Of these incidents, 92 per cent resulted in no harm, 5 per cent in low harm and 3 per cent in moderate harm. There were no medication errors that resulted in severe harm to patients. The most common types of error are omissions and delays to administer medication and administering the wrong dose of medication.



We have an intensive medication safety teaching programme for clinical staff and our pharmacy team manage a comprehensive audit programme, including auditing prescribing accuracy, medicines reconciliation, antibiotic point prevalence, medicine handling and medication safety. The pharmacy medication safety team also co-ordinate medication safety monitoring visits to clinical areas to monitor medication safety issues.

Staff training and awareness

We have a range of initiatives designed to maintain and improve awareness of patient safety issues. These include a monthly patient safety forum which outlines lessons learned from serious incidents and related issues. This forum is well attended by staff from all services every month.

We have also introduced a student nurse safety forum with two main aims - firstly to develop safety awareness in the nurses of tomorrow, and secondly to take feedback from them on the unsafe practices they may observe on our wards. Feedback is compiled into a newsletter that is distributed to senior sisters, charge nurses and matrons. Plans are in place to run a similar forum for medical students.

We continue to publish a regular patient safety newsletter, and have strengthened our pharmacy alerts system for drug safety issues.

We have a full range of patient safety training programmes for medical, nursing and therapy staff that includes state-of-the-art multidisciplinary simulation training, which allows teams to practice difficult situations on life-like computer controlled manequins. For example, our maternity service use our simulation centre to practice managing rare and potentially life-threatening post partum haemorrhages.

Our aims

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

To help us further develop our patient safety learning culture over the next year, we are focussing on two key areas: creating reliable feedback systems to staff who report incidents and working on communication systems across boundaries to ensure a smooth patient journey.

We will also focus on the number of serious incidents that relate to missed cancer diagnosis. We will include reports on these types of incidents in our monthly Clinical Quality and Risk Meetings with commissioners, and will report an overall picture in next year's Quality Account.

During 2014/15 we will trial a new St George's patient safety app in our children's services. We hope to be able to roll out the app across the trust following this trial. The bespoke app has been developed specifically to St George's needs and will give staff access to patient safety guidance, tools and feedback systems on their mobile phones. Development of the app has been funded by Health Education South London.

Reducing patient falls

CQC essential domains

safe

effective

caring

Why is this important?

People aged over 75 suffering falls is one of the main causes of emergency admissions to hospitals. Incidents of falls within healthcare environments equally contributes to the length of stay of complex patients, as well as presenting a risk to both patients and the organisation.

Unfortunately we will never be able to completely eliminate the risk of our patients falling. We know that even in the community one in three people over the age of 65 will fall rising to one in two for over 80 year olds. The hospital falling population has some of the similar characteristics as the community dwelling population, and in addition there are the additional risks around acute illness and sudden change in environment which presents further challenges for those impaired by cognition/vision etc. Following the acute phase of management the patient undertakes a rehabilitation phase. An inherent part of patient rehabilitation is risk taking, which must balance the management of risk with the need to facilitate progress and enable goal attainment. We try to make sure that a full falls and bone health risk assessment is completed and that the falls care bundle is completed for ward patients, providing a quality patient experience within a safe environment.

Last year we had a target of reducing the number of falls by five per cent.

How did we do?

We have reduced the number of falls by 41 per cent. Last year we had 233 patient falls in hospital and in the community, compared to 392 in 2012/13. Our target was that we would have no more than 372 patient falls.

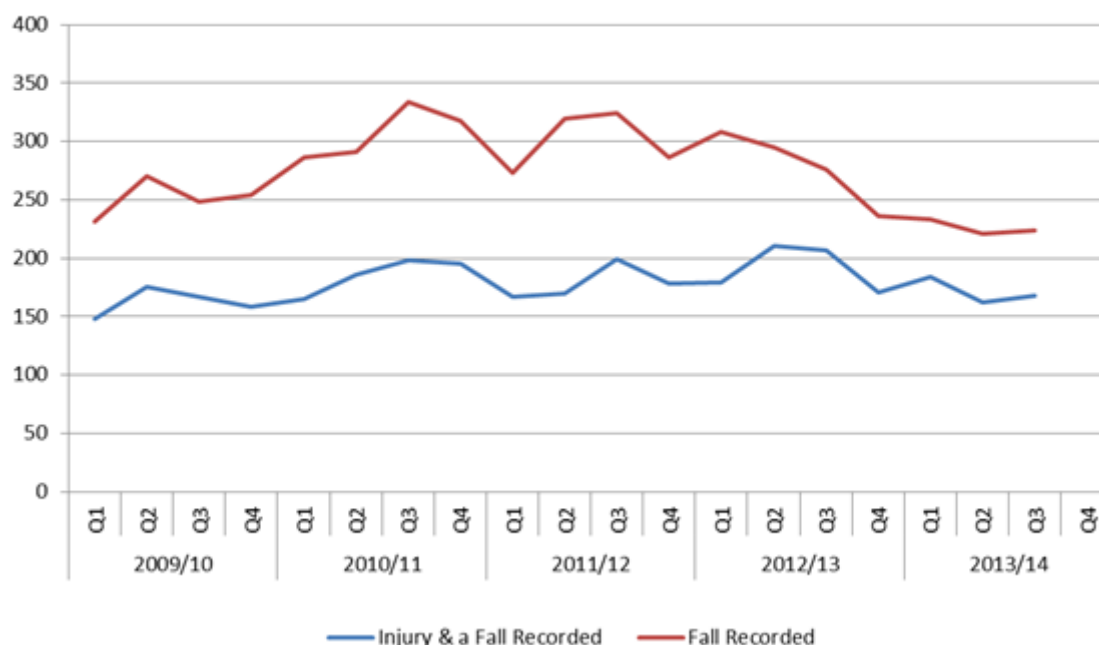
At St George's we have an Integrated Falls and Bone Health Service (IFS&BH). A major part of this team's work has been around ensuring that a falls risk profile is completed irrespective of what service the patient accesses as the prevention of falls has to be seen as a core role for all staff - the framework has been modified to fit with the existing services. It is a standard part of the service provision by the following teams:

- IFS&BH
- Intermediate care team
- Primary care therapy team
- Community Neuro team
- Brysson Whyte Rehabilitation Unit
- Day Hospital at St John's Therapy Centre
- Community nursing, community matrons and specialist nursing

This joined up approach across community services and the expansion of the IFS&BH to ensure that there is greater capacity to provide specialist intervention for the populations

at risk of fall and fractures has ensured that the number of Wandsworth patients being admitted to hospital with falls has steadily decreased.

Chart Showing number of Emergency Admissions for Fallers and Fallers with an Injury Recorded



In addition those patients who do sustain falls/fractures despite our efforts in the community, if they have been assessed and managed by the IFS&BH their improved pre-morbid health and mobility status should reduce their length of stay in hospital. Following the new NICE guidelines in 2013 -the falls risk profile used in the Community Services Division will replace STRATIFY as a risk assessment tool in 2014/15 across the wards throughout all clinical divisions at St Georges.

In 2012 we launched the Bone Boost programme to provide a care pathway for people with osteoporosis or osteopenia to reduce the incidence of fragility fracture in Wandsworth. Watch a video about the Bone Boost service and the impact it has had on the patients who have been referred to it at www.stgeorges.nhs.uk/services/senior-health/bone-boost

Our aims

We aim to maintain the current rate of reported falls during 2014/15. We will continue to review the success of our significant reduction in falls last year and identify lessons learned through structured evaluation and benchmark ourselves against other organisations when possible.

Infection control

CQC essential domains

safe

effective

caring

well-led

Why is this important?

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

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

What is C.diff?

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

C. diff is a bacterium that is present naturally in the gut of around 3 per cent of adults and 66 per cent of children.

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

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

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

What is MRSA?

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

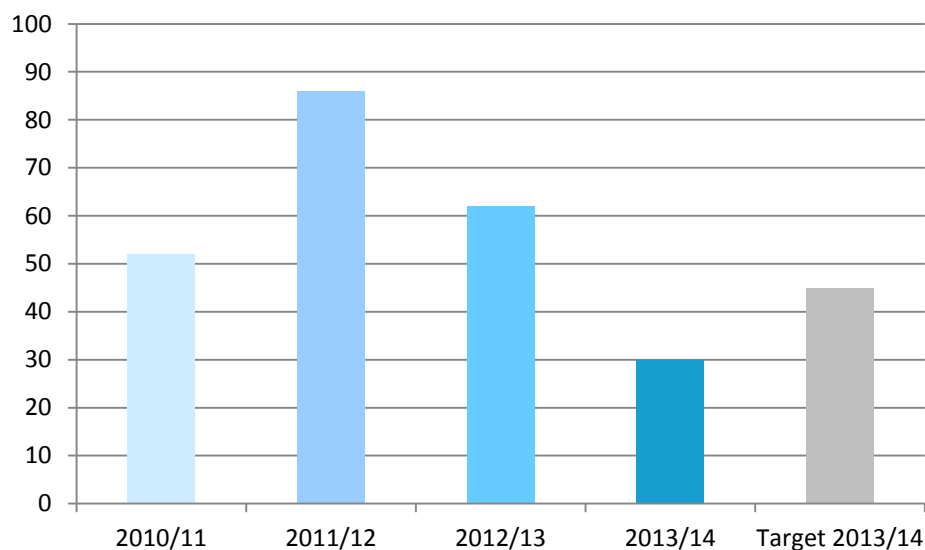
Most people with MRSA carry it without any harm to themselves or their family. However it can sometimes cause serious infections, especially if it gets into a wound. This is why we try to stop MRSA spreading around the hospital.

Our *C.diff* outcomes

30 patients acquired *C.diff* whilst under our care during 2013/14. This is a 52 per cent reduction in the number of cases compared to the previous year, and means that we achieved our nationally agreed target to acquire no more than 45 cases.

Our 2014/15 target is to acquire no more than 40 cases of *C.diff*.

Year	Number of patients acquired <i>C.diff</i>
2013/14	30
2012/13	62
2011/12	86
2010/11	52
Target 2013/14	45

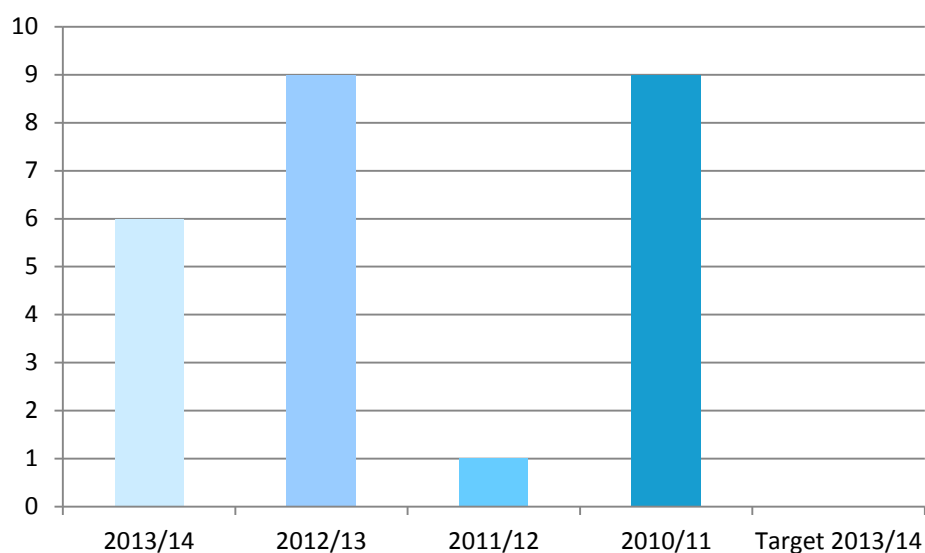


Our MRSA outcomes

Six patients acquired MRSA bloodstream infections whilst under our care during 2013/14. This means we breached our nationally agreed target which was to acquire no infections during the year. In 2012/13 we acquired nine infections.

We have investigated each individual case to identify any potential patterns in the nature of infection and whether any of the infections were avoidable. Two of the cases were avoidable, with intravenous (IV) line care identified as the root cause for these cases. We have redoubled our focus on line care at the trust in order to improve our performance.

Year	Number of patients acquired MRSA
2013/14	6
2012/13	9
2011/12	1
2010/11	9
Target 2013/14	0



Our aims

During 2014/15 we aim to have no more than 40 cases of *C.diff* and no cases of MRSA.

Assessing risk of VTE in admitted patients

CQC essential domains

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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.

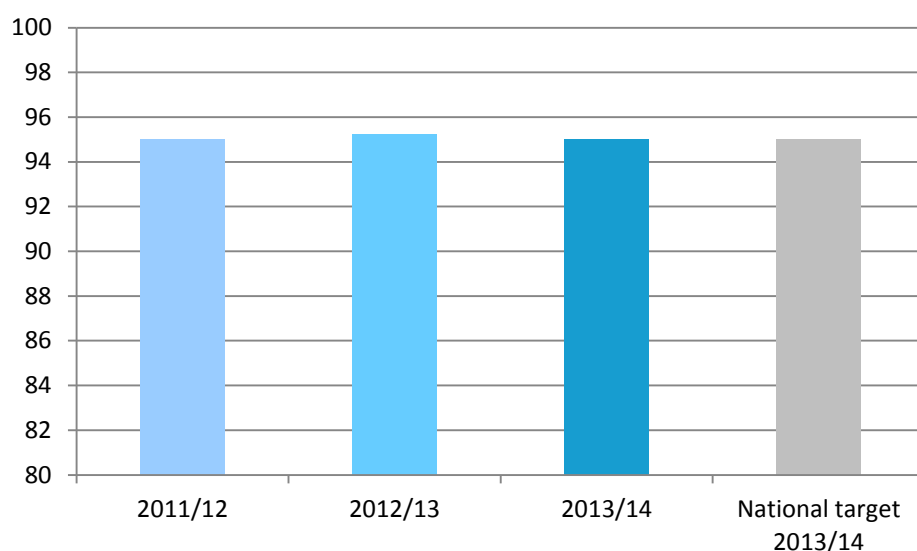
How did we do?

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

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

116,256 patients were admitted at St George's and Queen Mary's Hospitals during 2013/14. 110,446 of these patients were documented on their discharge summary as being given VTE risk assessments, which is 95 per cent. The national target for VTE risk assessments is 95 per cent. In 2012/13 we documented risk assessments for 95.24 per cent of 113,081 patients.

Year	VTE risk assessments (per cent)
2013/14	95.00
2012/13	95.24
2011/12	95.00
National target 2013/14	95.00



Root cause analysis of VTE cases at St George's and Queen Mary's Hospitals

This year there has been a national CQUIN requiring that root cause analysis be carried out in cases identified as hospital acquired thrombosis (HAT). We have identified 123 cases of which 106 had their index admission at St George's. In those who had previously been admitted to another hospital, we have notified those hospitals of the case. Of the 106 cases at St George's, all have been notified to the admitting consultant and to the care group and divisional leads.

Root cause analysis has been completed in 102 (96 per cent) of these cases. This exceeds the national target of 75 per cent. Results show that risk assessment was carried out in 94.5% and appropriate prophylaxis given in 56%. Reasons for inadequate prophylaxis included failing to record the reasons for prophylaxis doses not being given, not escalating the dose for patients who weighed more than 100kg, and failure to reassess patients who were at high risk of bleeding on admission. These findings have been presented at the specialties' governance and care group meetings and actions to improve practice have been implemented

In 2014/15 year the VTE prevention programme will be included as a key performance indicator for the trust and a new audit programme is being developed to collect the necessary data.

Our aims

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

To help us further improve the number of patients risk assessed and the number of patients given appropriate thromboprophylaxis we will continue our programme of

training, education and feedback across the trust. Basic VTE training has been added to the trust's mandatory training programme that all staff have to complete every year.

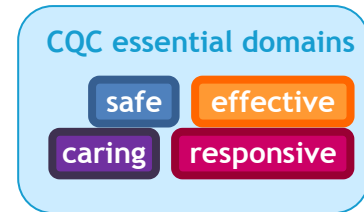
To ensure that all new staff are aware of the importance of VTE risk assessments, we have made VTE awareness part of the staff induction programme that all staff have to complete before starting work with us, and have developed specialist VTE training programmes for junior doctors. Our clinical divisions now have named VTE leads, and we have recruited junior doctor and physician associate VTE champions, new roles to further raise awareness of the importance of VTE prevention amongst medical staff.

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

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

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

Implementing the early warning score indicator at HMP Wandsworth



Why is this important?

We provide all healthcare and substance misuse services to the 1,665 offenders at HMP Wandsworth, the largest prison in the UK. The Jones Unit is a six bedded inpatient facility in the prison. The unit is a step down from a hospital ward and is used for offenders whose condition needs closer monitoring than can be provided on an outpatient basis whilst they stay in their cell. Prisoners requiring isolation are also located on the Jones unit. The unit reduces the need for unwell offenders to be transferred to St George's Hospital, freeing up beds in the hospital for other patients.

The early warning score indicator is a simple tool in a patient's observation notes used by medical and nursing staff to determine the severity of illness. A number of observations are regularly recorded on the chart which allows any deterioration to be quickly identified. The observations recorded are:

- Heart rate
- Respiratory rate
- Blood pressure
- Level of consciousness
- Oxygen saturations
- Temperature

The early warning score indicator has been used at St George's and Queen Mary's Hospital for a number of years and our aim for 2013/14 was to introduce the early warning score indicator to offender healthcare services.

How did we do?

The early warning score indicator has been successfully implemented at HMP Wandsworth with all patient observation charts on The Jones Unit including the indicator. All offender healthcare service staff have been trained on use of the early warning score indicator meaning that any deterioration is identified quickly.

Our aims

A clinical audit of the implementation and use of the early warning score indicator on The Jones Unit will be conducted in June 2014.

Reducing pressure ulcers

CQC essential domains

safe

effective

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Why is this important?

Pressure ulcers, also known as bed sores or pressure sores, are a type of injury that breaks down the skin and the underlying tissue. They are caused when an area of skin is placed under a large amount of pressure.

Patients who are unable to get out of bed are at high risk of developing pressure ulcers on their shoulders, elbows, back of the head, ears, knees, ankles, heels, toes and spine. Wheelchair users are at risk of developing pressure ulcers on their buttocks and the back of their arms, legs and hip bones.

Pressure ulcers are graded on a scale of one to four.

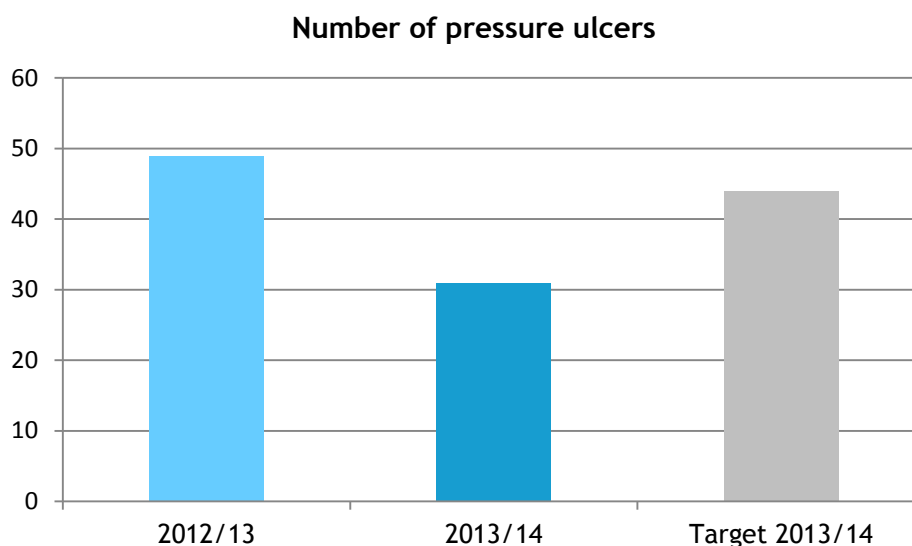
- Grade one ulcers are superficial. The skin is discoloured but intact and may itch or hurt.
- Grade two ulcers look like an open wound or blister with some of the deeper layer of skin potentially damaged.
- Grade three ulcers look like a deep cavity-like wound, with skin loss and damage to the underlying tissue.
- Grade four ulcers are the most severe with the skin and underlying tissue severely damaged and the underlying muscles and bone also potentially damaged. People with a grade four ulcer are at high risk of developing life-threatening infections.

The benefits to patients not developing pressure ulcers are obvious, but the financial rewards for avoiding pressure ulcers and stopping existing pressure ulcers getting worse is also significant. Treating a grade one ulcer costs the NHS just over £1,000, whilst treating a grade four ulcer costs more than £24,000.

Our target for 2013/2014 was to demonstrate a 10 per cent reduction in avoidable grade three and four pressure ulcers acquired by patients under our care. In 2012/13 there were 49 avoidable pressure ulcers acquired at St George's and Queen Mary's Hospitals, meaning our target for 2013/14 was to acquire no more than 44 pressure ulcers.

How did we do?

31 patients acquired pressure ulcers that were avoidable in 2013/14. A further 10 cases are under review at the time of publication. This means that we achieved our target of no more than 44 patients acquiring avoidable pressure ulcers in 2013/14.



During the year we appointed two new Tissue Viability Nurses. These nurses are highly visible within the organisation and review each serious incident as they are reported.

Our Tissue Viability Nurses promote a promote zero tolerance of avoidable pressure ulcers and work with our clinical divisions to reinforce a firm understanding of pressure ulcers and to advise on interventions promptly. They also provide training and education sessions, sharing best practice across the trust and run staff awareness campaigns.

We have also introduced initiatives like the use of the “Heel Pro” boot and application of preventative dressings to reduce pressure ulcers acquired under our care.

We have a pressure ulcer task group which meet every two weeks to review progress, share innovations across the organisation and plan further initiatives. All serious incidents are reviewed at the pressure ulcer strategy group chaired by the Deputy Chief Nurse.

We have also worked hard to improve the speed of our Medical Physics Team's mattress delivery service. At the beginning of 2013/14 the number of special mattresses for high risk patients delivered within two hours was less than 15 per cent, but by the end of the year that figure had risen to more than 70 per cent, with 95 per cent delivered within four hours. This has had a significant impact on the reduction of pressure ulcers, and has been achieved by purchasing new equipment, adding a new post to the service and developing new systems of work.

Our aims

In 2014/15 we aim to further reduce the number of grade three and four pressure ulcers acquired under our care.

The pressure ulcer task group will continue to drive the prevention of avoidable pressure ulcers by:

- Close monitoring of performance to reduce avoidable pressure ulcers
- Review of all grade two pressure ulcers to eliminate inaccurate reporting, using the review process by the Tissue Viability Nurses as an opportunity for local training in the clinical area
- Design and development of an e learning package on pressure ulcers for health care assistants and qualified staff
- Audits will continue to be undertaken 6 monthly to monitor compliance with documentation and track improvements or areas for development
- Tissue Viability Nurses will work a shift clinically in allocated areas each week alongside clinical staff to educate, advise and offer support
- Close working will continue with external colleagues, via the Pressure Ulcer Forum organised by the Wandsworth Clinical Commissioning Group (CCG)
- Close working will continue with Medical Physics team to ensure mattress provision is maintained at an optimum level and continues to improve. Progress will be reviewed regarding the managed contract for beds and mattresses
- A programme of structured education which will be delivered across the organisation at induction, on team days, via simulation and as requested
- The pressure ulcer prevention policy will be reviewed to reflect the positive changes and achievements made throughout 2013/14

Improving patient experience

Our commitment to patients

This section of the Quality Account looks at patient experience quality indicators. In our Quality Improvement Strategy we outlined our commitment to patients:

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

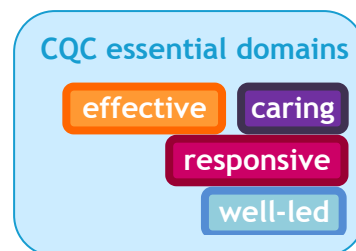
You can read more about our commitment to improving patient safety in our Quality Improvement Strategy on our website at www.stgeorges.nhs.uk/about/our-strategy/strategies

Our patient experience indicators

The patient experience indicators in this section are:

- Responding to patient feedback
- Responding to complaints
- Cancer referrals
- Community learning disability referrals
- Mixed sex accommodation
- Staff who would recommend the trust to friends and family
- Complaints

Responding to patient feedback



Why is this important?

Patient experience is a key measure of the quality of care. At St George's we continually strive to be more responsive to the needs of our service users, including needs for privacy, information and involvement in decisions. Every year we take part in the national inpatient survey published by the Care Quality Commission (CQC), as well as others less frequently for A&E, Maternity and Outpatients. The national inpatient survey is an important indicator of how all NHS trusts in the country are performing, looking at the experiences of more than 70,000 patients each year who were admitted to hospital for at least one night. In 2013 a new measure was introduced, the Friends and Family Test (FFT) and this has replaced the National Inpatient Survey as a CQUIN.

Friends and Family Test

The Friends and Family Test (FFT) is a national CQUIN and is the single question asked of patients on discharge about how likely they are to recommend our hospital wards, accident and emergency department and maternity services to a friend or relative based on their treatment. There are six options; extremely likely, likely, neither likely nor unlikely, unlikely, extremely unlikely or don't know.

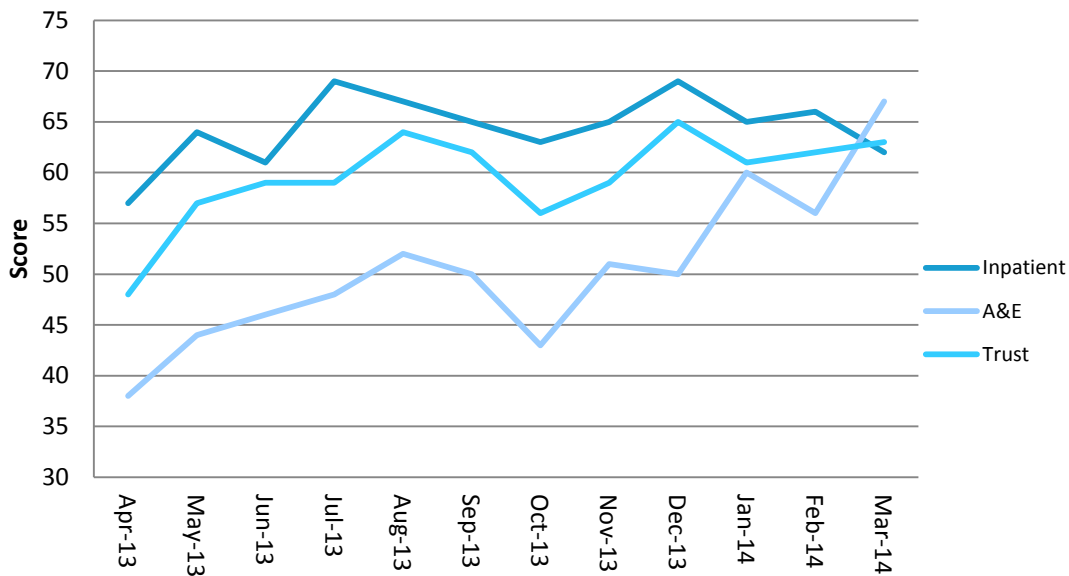
The scoring is based on the Net Promoter Score and has a minimum (-100) and maximum (+100) value. Answers are scored either positively, negatively or are neutral. The only answer that scores positively is "extremely likely" with "neither nor" being neutral and all others scoring negatively except don't know which does not score.

FFT has now been in place for almost a year and was rolled out to A&E and inpatient adult areas for April 2013 and to Maternity in October 2013.

Maternity is different from A&E and adult wards as there are four occasions or "touch points" when women are asked to rate the service (antenatal, birth, postnatal ward and postnatal community) whereas A&E and inpatient adult areas is only once on discharge.

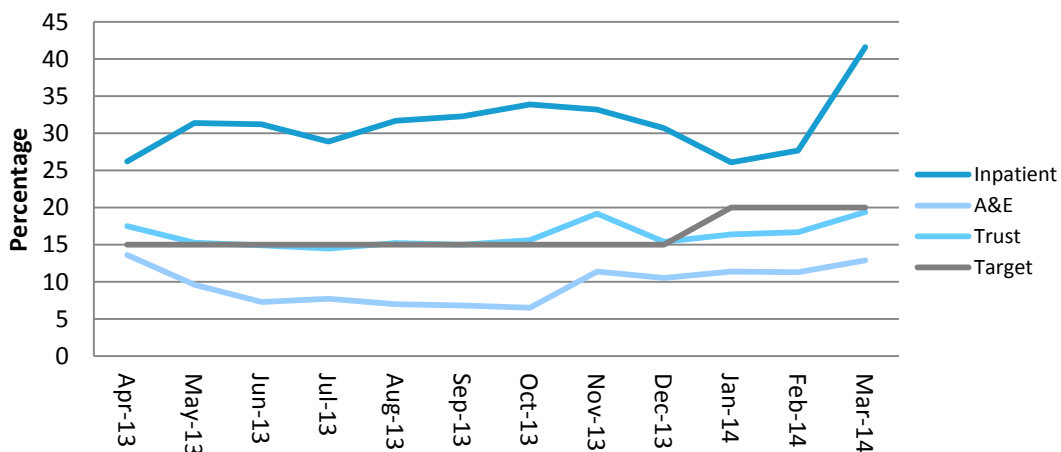
The actual FFT score has remained stable and has been good overall in the mid +60's. As a percentage it would mean that on average approximately 95% of patients overall are likely or extremely likely to recommend us. The score has increased in A&E significantly as the year progressed. The roll out will continue to Outpatients, Day Surgery and Community in October 2014.

FFT Score



For 2013/14 there was a minimum requirement for the number of surveys completed. This was 15 per cent for the first three quarters of the year but increased to 20 per cent for quarter four. The scores will be separated out for the 2014/15 CQUIN. The trust met the 15 per cent target but narrowly missed the 20 per cent target in quarter four. This was because of a low response rate in A&E.

Response Rates



In addition we also have a number of other survey questions that we ask patients (anonymously) about their experience based on the national annual inpatient survey. Our bespoke RaTE system allows for almost real-time feedback to enable staff to share good



A word cloud from one of our patient surveys

National Inpatient Survey

The National Inpatient Survey is conducted every year by the CQC to find out how patients aged 16 or over who spent at least one night in hospital felt about their experience. The 2013 survey was split into 10 sections for the first time, with trusts given a score between 0 and 10 for each section. As well as the score for each section, trusts were ranked as either being 'better' than most other trusts in the country, 'about the same' as most other trusts in the country, or 'worse' than most other trusts in the country.

We were ranked as being 'about the same' as most other trusts in the country in all 10 sections.

Survey section	Score	Band
The Emergency/A&E Department	8.6	
Waiting list and planned admissions	8.9	
Waiting to get to a bed on a ward	7.6	
The hospital and ward	8.0	
Doctors	8.5	
Nurses	8.2	
Care and treatment	7.6	
Operations and procedures	8.0	
Leaving hospital	7.1	
Overall views and experiences	5.2	

The CQC no longer gives trusts an overall score, as was the case in previous surveys. In 2012 St George's was ranked as 'about the same as other trusts'. However, the 2013 survey is the first time that we have achieved this rank in every section, continuing the significant improvements we have made to the experience of patients who have to stay in hospital.

We now have plan in place to further improve inpatients' experience, including improving the choice and availability of food and drink on our wards, improving our discharge processes and the information given to patients when they leave hospital, and asking patients for their feedback whilst they are on the ward.

National Cancer Survey

In September 2013 NHS England and Macmillan Cancer Support published the results of National Cancer Patient Experience Programme 2012/13 national survey, a survey of cancer patients at all 155 acute trusts that provide cancer services in the country.

Overall the ratings for cancer patients in England, including at St George's, were high. That said, we don't want any of our patients to have a poor experience and St George's was one of nine London trusts to be named in the bottom 10 in the country for patient experience. Our low ranking relative to others shows that we have clear room for improvement that we are determined to make up.

We are working hard with Macmillan and our own cancer patients group to make real improvements. These include:

- refurbishing the outpatient clinics and inpatient wards services are delivered from
- reviewing all written information given to patients for all cancer types
- reviewing all written information given to patients about support available, including financial support and support for carers
- promoting the Macmillan Information and Support Centre and increasing the number of places on wards and clinics cancer information leaflets are available
- setting up a dedicated 'cancer patient helpline' telephone service
- implement new training programmes to improve nurses' communication skills
- establishing a patient volunteer programme to help improve busy outpatient clinics
- establish patient workshops to help highlight communication issues and how they can be improved

While these initiatives have mostly been under way for over a year, we would not have expected them to be reflected in the latest survey which was based on patients whose experience of St George's was during autumn 2012. As Macmillan say this is a marathon not a sprint. We are determined to improve and have made patient experience our top priority for improvement at St George's.

We are working closely with other trusts who refer patients to us to make sure the referral process is seamless for our patients, and also with GPs to ensure that they have all the

information they need to provide the best possible care for their patients who are receiving treatment at or have been discharged from St George's.

The clinical outcomes for our patients are excellent and amongst the best in the country, but at St George's we set ourselves demanding standards, and one patient not being completely satisfied about every aspect of their care is one patient too many for us. It is one of our key aspirations and goals to be amongst the highest performing trusts in the country for patient experience.

We are confident that the hard work of our staff who deliver the services with our patient user groups and partners like Macmillan will see patient experience improve further so that we can confidently say that we are meeting all of our patients' needs all of the time.

Maternity survey

A national mandatory survey of women's views was carried in spring 2013 of all women who gave birth during February 2013. We have previously surveyed women who gave birth under our care in 2010 and 2012, which allows us to look at trends and focus attention on areas for improvement. In the 2012 survey we demonstrated significant improvement in 14 questions, 11 of which related to postnatal care in hospital.

In the 2013 survey we showed improvement in every area compared to the 2012 survey, with significant improvements in three areas:

- 59 per cent of women say that they received support and encouragement which is an increase from 42 per cent in 2012. The national average was 60 per cent.
- 59 per cent of women say that they received enough information about their own recovery after birth, compared to 42 per cent in 2012. The national average was 61 per cent
- 51 per cent of women were given enough information about emotional changes that may be experienced after giving birth, compared to 40 per cent in 2012. The national average was 42 per cent.

We also had two results that were significantly better than the national average:

- 91 per cent of our patients said that they were given the choice of where to give birth. The national average was 84 per cent.
- 98 per cent of women discussed postnatal checkups of their health with midwives at home. The national average was 92 per cent.

To make sure that we continue the progress we have made in our maternity unit since the first survey in 2010 we will continue with projects already started, such as named midwife and a DVD that will be given to all mothers on discharge from hospital that gives information and advice about their own health as well as their baby's.

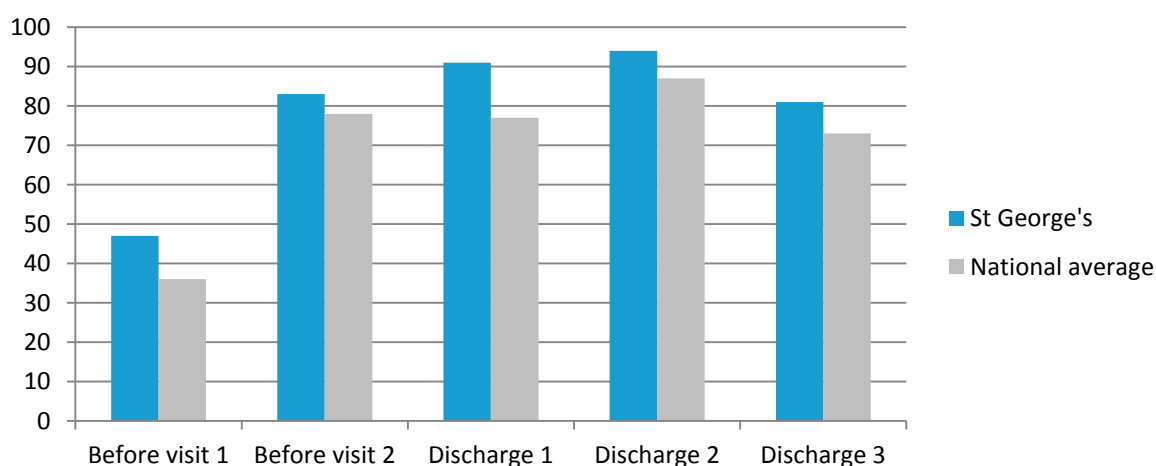
We will also implement a Listening to Learn training programme using patient stories to improve care and communication in obstetrics and midwifery, with innovative workshops focussing specifically on patient experience and staff attitude.

Day case survey 2013

In 2013 we were one of 16 trusts in the country to take part in a voluntary CQC survey of day case (day surgery) patients. This was the second time the survey was conducted, and the second time we took part.

364 of our patients completed the 74 question survey. 96 per cent of patients said that they would recommend St George's to friends and family, and our results were significantly better than other trusts in a number of areas:

Day case survey question	St George's (per cent)	National average (per cent)
Before visit: given choice of dates for surgery	47	36
Before visit: given information about condition or treatment	83	78
Discharge: given written/printed information about what they should or should not do after leaving hospital	91	77
Discharge: told who to contact if worried	94	87
Discharge: receiving copies of letters sent between hospital doctors and GP	81	73



There were also significant improvements in a number of areas compared to the 2012 survey, including doctors answering questions before surgery clearly, nurses not talking in front of patients and the cleanliness of hospital toilets. There were also significant improvements in a number of questions about being discharged after surgery.

The survey also highlighted areas where there is room for improvement. We have developed an action plan for these areas focussing on three main themes:

- Making sure patients feel they have opportunities to talk to a nurse or doctor
- Providing optimal pain control after surgery
- Reducing delays in discharging patients

Our aims

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

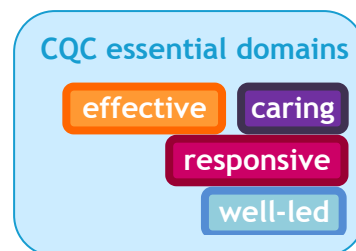
We will also ensure that nutrition and hydration are kept high on the agenda ensuring that patients have choice and help with meals and drinks when they need it. There is more work to do on hydration and also in making sure that patients are not kept nil by mouth unnecessarily and for any longer than is clinically necessary.

Ensuring that patients have the right care, at the right time delivered by the right staff is crucial. In the year ahead we will be implementing the recommendations from the recent National Quality Board (NQB) report and will be introducing monthly workforce reports to the board and undertake reviews of nursing and midwifery establishments every six months. Clinical areas will display planned versus actual staff on duty and quality indicators will accompany the workforce information that goes to the board.

In 2014 we are looking to change the way our senior sisters and charge nurses work by giving all of them more supervisory time to monitor standards and quality. We will continue to focus on strong, visible leadership and will continue with our development programme for ward leaders as well as rolling out an equivalent for junior sisters and charge nurses.

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

Complaints



Why is this important?

Last year we had more than one million appointments and inpatient stays at our hospitals and in the community. With this number of patients and appointments, we know that there will unfortunately be times when we do not meet the expectations of our patients.

We encourage our patients and their friends, family and carers to let us know when this happens so we can make the changes that are needed to improve.

As well as dealing directly with our staff, patients and their friends, family and carers can also discuss any concerns they have with our Patient Advice and Liaison Service who will work with them and the service to resolve any issues. Complaints and compliments can also be formally submitted to our complaints and improvements department. We aim to investigate and provide a full response to all formal complaints within 25 working days of the complaint being received.

The lessons learned and trends identified from information collected from our complaints process play a key role in improving the quality of our services and the way we engage with our patients and visitors.

Our outcomes

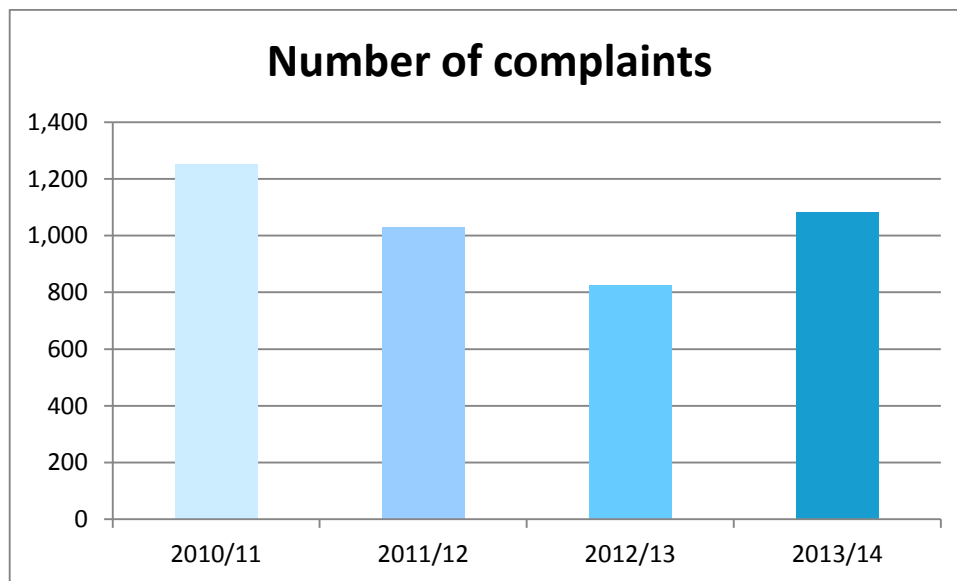
In 2013/14 we received 1,083 formal complaints, a 31 per cent increase compared to 825 complaints in 2012/13. This number of complaints is similar to the number recorded in 2011/12.

It is very difficult to benchmark complaints against other trusts as there is no uniform way for trusts to record complaints, meaning there is a lot of inconsistency across the NHS.

The reasons for the significant increase in complaints are not clear as complaints have increased across a number of areas and subjects with no obvious specific themes. During 2013/14 we significantly increased the profile of the complaints process and the Complaints and Improvements Department across the trust which may have contributed towards the increase as patients are more aware about their options and how to raise concerns and complaints. The introduction of the Friends and Family Test has also raised the profile of the department and increased awareness of the complaints process, as has the publication of national reports on the handling of complaints by NHS hospitals in England. We view all types of patient feedback as positive and we are constantly looking at how we can encourage patients, carers and families to give their views.

Following their inspection of the trust in February 2014, the CQC commended our approach to learning from any mistakes that we may make and being honest if we get things wrong, stating that there was strong evidence that we are using complaints to make improvements to our services.

Year	Number of complaints
2013/14	1,083
2012/13	825
2011/12	1,031
2010/11	1,253

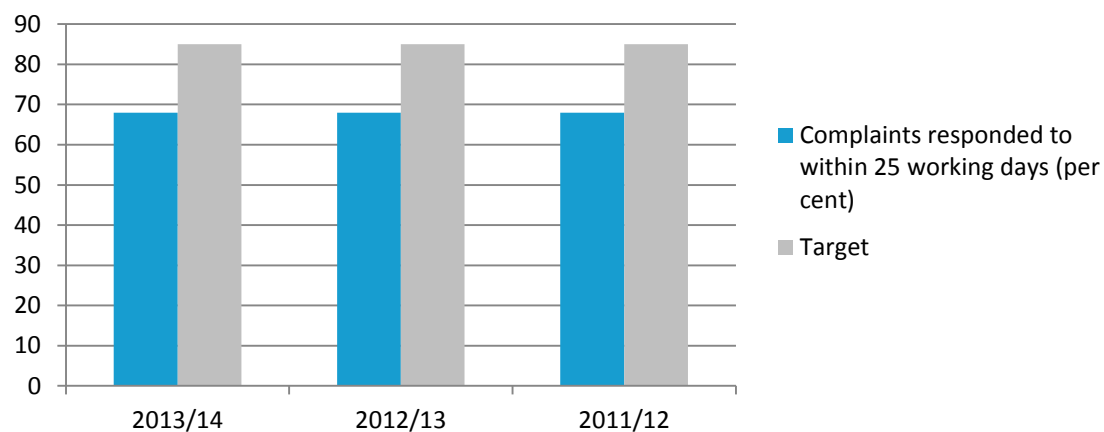


Complaints response rate

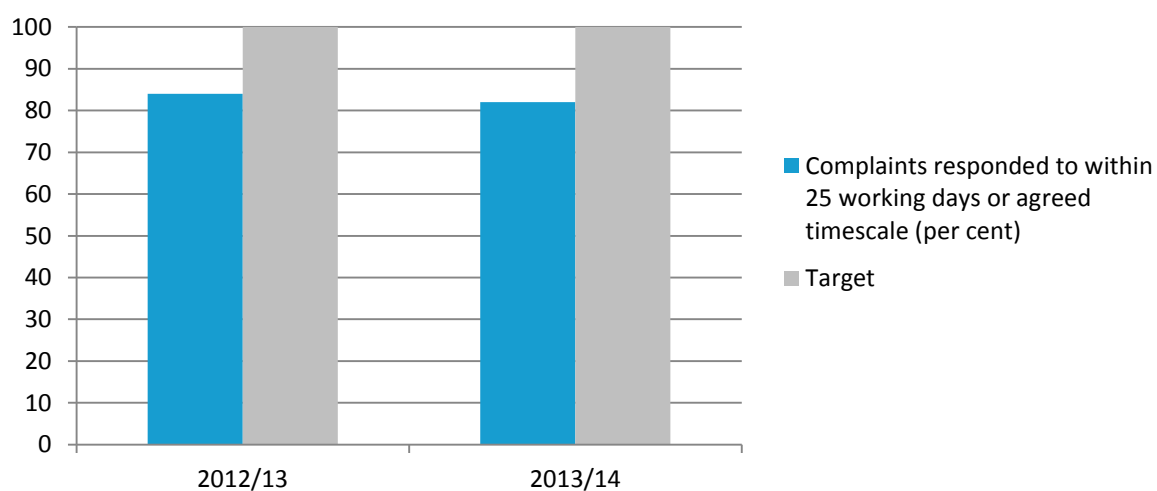
We fully responded to 68 per cent of complaints within 25 working days. Our target is that 85 per cent of complaints are fully responded to within 25 working days.

We fully responded to 82 per cent of complaints within 25 working days or an agreed timescale. Our target is that 100 per cent of complaints are fully responded to within 25 working days or an agreed timescale.

Year	Complaints responded to within 25 working days (per cent)	Target
2013/14	68	85
2012/13	68	85
2011/12	68	85



Year	Complaints responded to within 25 working days or agreed timescale (per cent)	Target
2013/14	82	100
2012/13	84	100



In 2012/13 we responded to 68 per cent of complaints within 25 working days, and 84 per cent within 25 working days or an agreed timescale.

We are very concerned about our response rate and consider it to be an unacceptable level. Those patients who do not receive a timely and helpful response to a complaint they have raised would be right to feel that they have not been afforded the respect they deserve. Making sure we respond to complaints more quickly is a key priority for us in 2014/15.

Patient advice and Liaison Service (PALS)

Our Patient Advice and Liaison Service (PALS) received 6,943 contacts in 2013/14, of which 2,674 were concerns rather than information requests. In 2012/13 PALS received 6,753 contacts, of which 2,198 were concerns.

Our PALS is a patient friendly, easy to access advice, help and information service for patients and their family, friends and carers. The PALS team listen to any concerns people have and help to find ways of resolving them. The team also take note of every contact and feedback to our clinical services so that we can make improvements for our patients.

You can find out more about PALS on our website at www.stgeorges.nhs.uk/patients-and-visitors

Our aims

We are clear that we must improve our response rate to complaints, making sure that we significantly increase the number of complaints responded to within 25 days.

As well as making sure we acknowledge and respond fully to all complaints in a timely fashion, we will also work to make sure we continue to adhere to use complaints to make improvements and that all recommendations set out in the Clwyd Hart report - *Putting patients back in the picture* (see page 17).

Outpatient services

One of the most complained about service areas is our outpatient service, with communication and attitude consistent themes. We have implemented a number of initiatives in our outpatients service as a result of the feedback from patients. These include procuring a new reminder system which synchronises with our patient administration system so that text message appointment reminders have more information and the option to be connected to a member of staff at the press of a button. We are also working with our administration team managers and senior outpatient nursing teams to clearly outline their leadership responsibilities when clinics are not running smoothly.

As well as the initiatives we have already implemented, during 2014/15 we are launching a major two year improvement project in outpatient services involving all four of our clinical divisions. A number of engagement events with patients, administrative staff and

clinicians have highlighted five key areas to be taken forward to to improve outpatient service efficiency, enhance clinical engagement with the corporate outpatient team and, most importantly, improve the experience of the many thousands of people who use our services. The categories are:

- **Improving patient experience**
This will include a review of complaints, mandatory annual customer care training to all staff, regular contact with patient representative groups and the introduction of a variety of mechanisms to seek and receive feedback from service users.
- **Technology**
To expand the technology and capabilities that will support efficiencies, like the use of e-tracking to track patient notes and improve the flow of information, appointment reminder services, self-check-in booths.
- **Environment**
The outpatient team and patient representatives surveyed the current estate and facilities in the outpatient departments and made a series of recommendations for where and how improvements can be made. These will now be costed, prioritised and scheduled into the improvement plan.
- **Business rules**
Designed to ensure optimum communication and engagement between the corporate outpatient and clinical teams. A number of metrics will be measured and published monthly to inform services and the outpatient team how well they are doing.
- **Engagement with clinicians**
A formal review of strategies for communication and engagement will be undertaken with clinicians to foster positive working relationships.

How to make a complaint

If you would like to make a complaint or compliment about any aspect of our service you can email complaints.compliments@stgeorges.nhs.uk or write to use at:

Complaints and Improvements Department
St George's Hospital
Blackshaw Road
London, SW17 0QT

Contacting PALS

You can visit the PALS office between 9am and 5pm, no appointment is needed. You can find PALS on the ground floor of Grosvenor Wing at St George's Hospital.

Alternatively, you can contact PALS by phone on **020 8725 2453**. If you call outside of normal office hours a member of the PALS team will return your call the next working day. You can also email PALS at pals@stgeorges.nhs.uk

Community learning disability referrals

CQC essential domains

caring

responsive

well-led

Why is this important?

The Wandsworth Community Learning Disability Health Team (CDLHT) is a multi-professional team providing community based health care for adults with learning disabilities. The service facilitates access to generic NHS services. Where people with learning disabilities are unable to access mainstream services they should be in receipt of specialist learning disability community services to address their complex needs.

The service is provided in the setting most appropriate to the service users' needs. This can be in their own home, place of work or education, out in the community, in an NHS facility, or at the CLDHT team base.

Our CLDHT provides a person-centred, multi-disciplinary community service to people who need a specialist learning disability service so there may be just one or several CLDHT professionals involved with a service user at any one time. Most service users have a network around them which can include family members and a range of health and social care providers. Working collaboratively with colleagues in the CLDHT and the service user's network is essential for the delivery of a quality service that meets their needs.

It is important that people referred to the service are assessed for eligibility within a four week period so we can make sure that people with learning disabilities are in receipt of appropriate care to support their complex health needs as soon as possible.

Confirming eligibility for the receipt of CHLDT services is a time intensive process that can be delayed by things like accessing healthcare records. Once a referral is received the service user will follow the eligibility pathway, and as soon as it is established the individual has a learning disability they will be accepted by the CLDHT for the provision of specialist health services.

If the referral is for somebody who is already known to the CLDHT (for example, a re-referral) they will be accepted straight away. If the person is unknown to the CLDHT there is a three-stage process to determine eligibility. The referral can be accepted at any point where there is sufficient evidence of a learning disability:

- Review of documentation such as past assessments, IQ tests, reports, Statements of Educational Needs
- Initial screening test (the Initial Service Assessment Checklist - Adults or the Learning Disability Screening Questionnaire)
- IQ test (e.g. Wechsler Adult Intelligence Scale) and Social Functioning Assessment (e.g. Vineland or Adaptive Behaviour Assessment System)

To receive the CLDHT service clients must have a learning disability which is:

- Impaired intelligence (a significantly reduced ability to understand new or complex information and learn new skills with an IQ of less than 70)
- Impaired social functioning (a reduced ability to cope independently)
- Both of which started before adulthood with a lasting effect on development

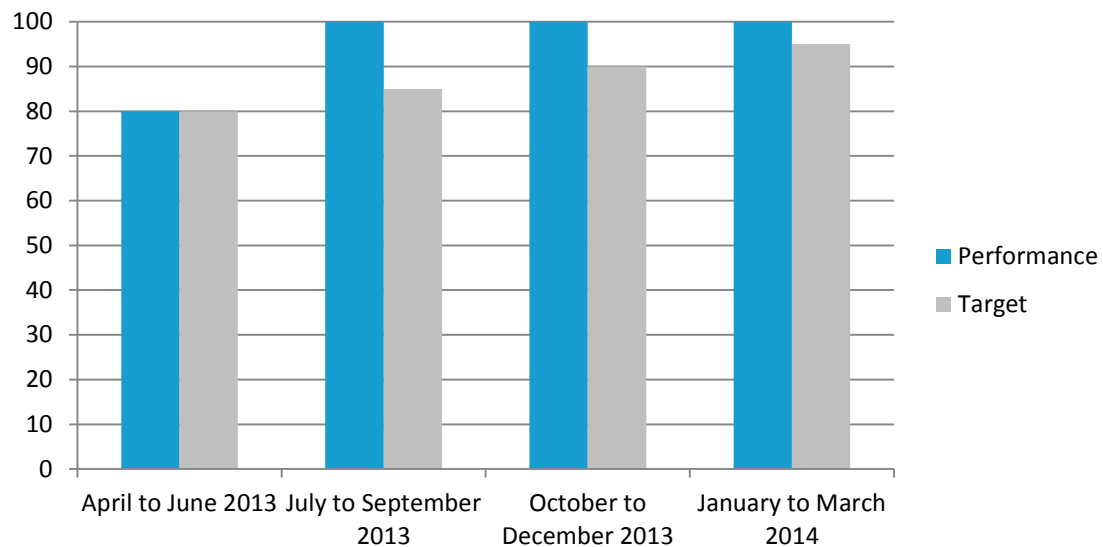
If at any point in the eligibility process, it becomes clear the person does not have a learning disability, they will be signposted to the most appropriate service. If the individual is assessed as having a learning disability but it is felt they are not in need of specialist services for their specific problem, they will be signposted to the most appropriate mainstream service.

How did we do?

2013/14 was the first year we have formally reported on the rate of patients going through the eligibility pathway within 28 days of referral. Because of this we had a target that increased every quarter, with our target starting at making sure 80 per cent of service users referred between April and June 2013 were assessed within 28 days, increasing to 95 per cent for those referred between January and March 2014.

For the first quarter of the year we achieved our target by making sure that 80 per cent of referred service users were assessed. 100 per cent of patients referred between July 2013 and March 2014 were assessed within 28 days.

	April to June 2013	July to September 2013	October to December 2013	January to March 2014
Target	80 per cent	85 per cent	90 per cent	95 per cent
Performance	80 per cent	100 per cent	100 per cent	100 per cent



Our aims

We plan to maintain our level performance making sure that all patients go through the eligibility pathway within 28 days of referral.

Minimising mixed sex accommodation

Mixed sex accommodation has been virtually eliminated at St George's and Queen Mary's Hospitals.

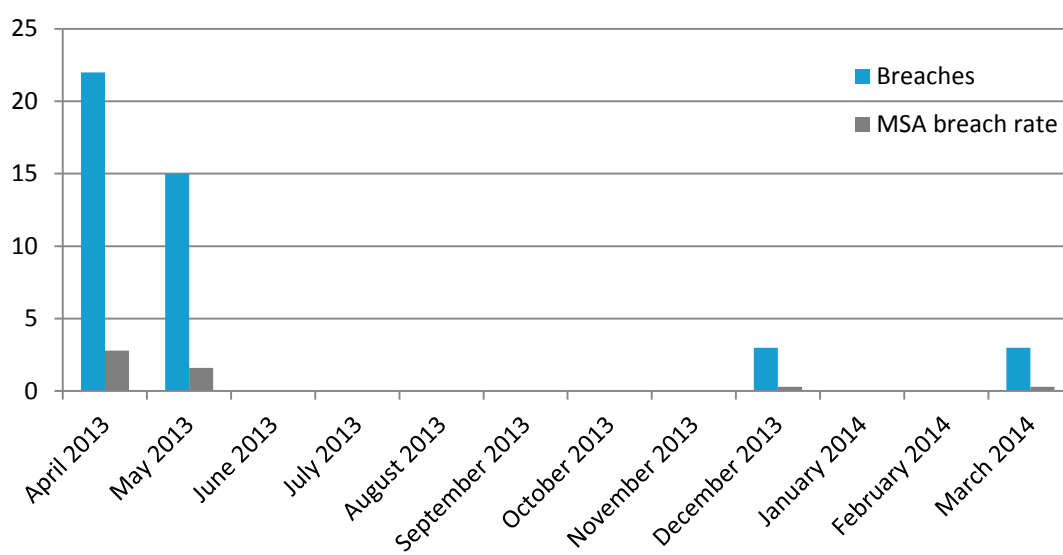
We are compliant with government's requirement to minimise mixed sex accommodation, except when it is in the patient's best clinical interests or reflects their personal choice. At St George's we have the necessary facilities and resources to make sure that patients who are admitted to our hospitals will only share the room where they sleep with members of the same sex, and that same sex toilets and bathrooms are close to their bed.

Sharing with members of the opposite sex only happens when clinically necessary such as when patients need specialist intensive care equipment, or when it is a patient's choice, as is sometimes the case in renal units.

During 2013/14 we had 43 mixed sex accommodation breaches at St George's and Queen Mary's Hospitals. This means our MSA breach rate for the year was 0.4 patients per 1,000 patients. In 2012/13 we had 274 breaches and a MSA breach rate of 2.6 per 1,000 patients.

Of the 43 breaches last year, 37 happened in April and May 2013. Since then new procedures have been put in place that have seen a dramatic reduction in the number of breaches.

Month	Number of breaches	MSA breach rate*
April 2013	22	2.8
May 2013	15	1.6
June 2013	0	0
July 2013	0	0
August 2013	0	0
September 2013	0	0
October 2013	0	0
November 2013	0	0
December 2013	3	0.3
January 2014	0	0
February 2014	0	0
March 2014	3	0.3



When there is a mixed sex accommodation breach we conduct an investigation and report the findings to the Board and to our commissioners.

Read more about our plans to minimise mixed sex accommodation at www.stgeorges.nhs.uk/about/living-our-values

Cancer referrals



Why is this important?

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

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

Our outcomes

83 per cent of cancer patients had their first treatment within 62 days of being referred to St George's by their GP. This means that we missed the national target of 85 per cent.

Like other organisations we have found achieving this target very challenging. During 2013/14, we achieved this target in six of the twelve months, narrowly missing the target in the other six months.

Of the patients who do not receive treatment within 62 days of referral, around a quarter of these are because it is not clinically appropriate to start treatment within this time frame. This is usually due to complications with other pre-existing conditions that need to be treated first that could be compromised by chemotherapy, radiotherapy or surgery.

Our aims

There are many factors which have a direct bearing on performance against this standard. We are committed to making sure that the changes we implement to improve our performance are long-term solutions rather than quick fixes.

During 2014/15 we are changing the way patients treated at Queen Mary's Hospital are recorded so that patients treated by Kingston Hospital staff are recorded as being Kingston Hospital NHS Trust patients rather than St George's patients, which has historically been the case.

In April 2014 we recruited new urology and radiology consultants and introduced a new urology pathway that will reduce the time between scanning and follow up from eight weeks to 10 days for most patients. Over the last couple of years urology patients have been the largest patient group to breach the 62 day target.

We are also developing our cancer informatics system to allow a direct feed from the Queen Mary's Hospital patient administration system so all staff can see live information. The updated system will also include a new patient tracking module for all tumour types,

access to treatment plans and end of treatment summaries, and will allow data collection for submission to national audits.

We are working with the London Cancer Alliance to analyse and improve our pathways for cancer patients and the clinical systems and will be regularly monitoring ourselves against the London Cancer Alliance best practice checklist. We have also started conducting peer reviews with other large trusts from across the country to share best practice and to identify pathways and systems we could adopt at St George's.

We are also working with GPs and other healthcare referrers and with the St George's cancer service user group ICE (Improving the Cancer Experience) to identify changes we can make in our cancer services to improve patient experience.

Other cancer targets

We have achieved the seven other national cancer treatment and diagnosis targets for 2013/14, improving the prospects for thousands of cancer patients by providing quick screening, diagnosis and treatment for cancer patients. During 2012/13 we met every national cancer target.

- Two week wait - 97.6 per cent patients seen in 14 days by specialist when referred by GP or dentist with suspected cancer (target 93 per cent)
- Breast symptom two week wait - 98 per cent patients seen in 14 days by a specialist when referred with breast symptoms not suspected cancer (target 93 per cent)
- 31 day first treatment - 97.6 per cent patients receiving their first definitive treatment within one month of diagnosis (target 96 per cent)
- 31 day subsequent treatment (drugs) - 100 per cent patients receiving their second or subsequent treatment within one month of decision to treat (target 98 per cent)
- 31 day subsequent treatment (surgery) - 99.1 per cent patients receiving their second or subsequent treatment within one month of decision to treat (target 94 per cent)
- 62 day screening standard - 94.6 per cent of patients receiving their first treatment within two months of referral from national screening service (target 90 per cent)
- 62 day consultant upgrade to treatment - 87.5 per cent (target 85 per cent)

Staff who would recommend the trust as a place to receive treatment to friends or 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 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.

How did we do?

In the National NHS Staff Survey staff are asked to state whether *If a friend or relative needed treatment I would be happy with the standard of care provided by my organisation.*

69 per cent of our staff said that agreed with this statement. This is slightly higher than the national average of 65 per cent. Nine per cent of our staff said they did not agree, compared to the national average 11 per cent. 22 per cent of our staff said that they neither agreed nor disagreed.

In the 2012 National NHS Staff Survey, 70 per cent of our staff agreed with this statement, and 10 per cent said disagreed.

Staff recommendation of the trust as a place to work or receive treatment

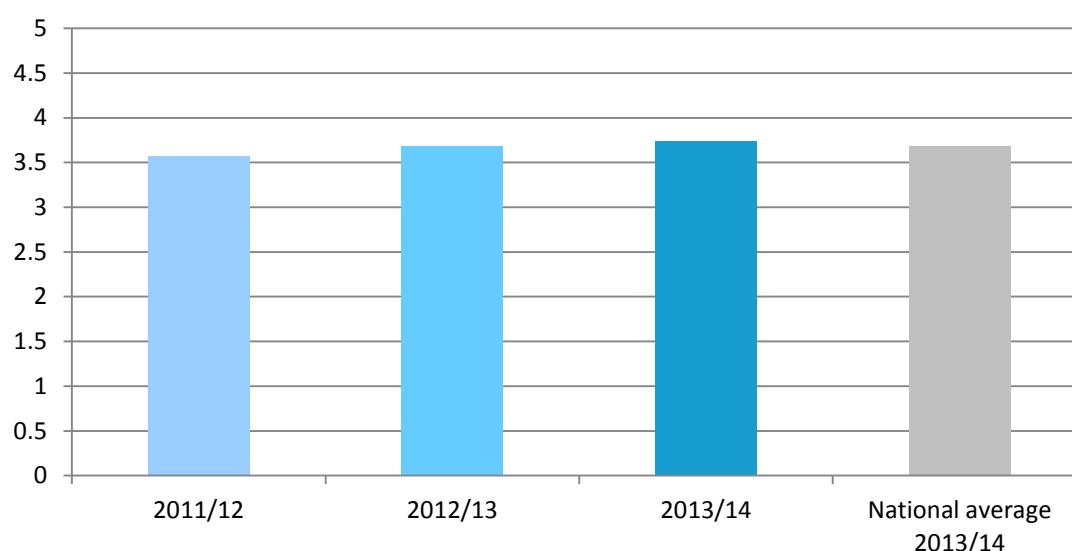
As well as giving an individual score for each question, a score is calculated for a number of key indicators based on the answers to the questions grouped under each indicator.

One of these key indicators is *staff recommendation of the trust as a place to work or receive care.*

On a scale of 1-5, with 5 being the most positive, St George's scored 3.74 compared to 3.68 nationally for acute trusts. Last year our score was 3.68, and the national acute trust average was 3.57.

This means that we have maintained our status as one of the top 20 per cent of trusts in the country for staff who would recommend the trust as a place to work or receive treatment. We first achieved this milestone last year, having originally aiming to break into the top 20 per cent in 2015 when we set ourselves this goal in 2012.

Year	Staff who would recommend St George's as a place to work or receive treatment (1 being poor, 5 being excellent)
2013/14	3.74
2012/13	3.68
2011/12	3.57
National average 2013/14	3.68



Our aims

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

We aim to further improve our score in the *staff recommendation of the trust as a place to work or receive care* indicator and maintain our status as one of the top 20 per cent of trusts in the country.

We are developing and implementing an action plan to address bullying and harassment at the trust and to make sure that all staff feel empowered to report any concerns and that they are supported by their team and by the trust as a whole.

To address perceptions of discrimination we are working in partnership with trade unions to review employee relations equality data and to establish how any inconsistencies can be addressed. We are also reviewing how we can roll out the successful Midwifery Futures Programme to other areas of the trust.

The National NHS Staff Survey placed us amongst the lowest 20 per cent in the country for staff suffering from work related stress. To improve this we are introducing self help health sessions for staff and will implement a new well-being strategy in 2014/15 aimed at reducing sickness absence and enhancing a sense of personal responsibility and engagement amongst staff.

Our workforce strategy explains how we aim to maximise the well-being of our staff and their levels of contribution and engagement. You can read the workforce strategy at www.stgeorges.nhs.uk/about/our-strategy/strategies

Listening into Action

As well as listening to our patients, it is also vital that we listen to our staff, especially when trying to identify where improvements can be made.

During 2013/14 we launched the Listening into Action programme in which staff from across the trust are all involved with one clear goal - to put clinicians and support staff at the centre of change for the benefits of our patients, staff and the trust as a whole.

Listening into Action complements other initiatives at the trust like The Improvement Programme.

During the year we held a number of Big Conversations, where staff from all departments, levels and roles came together to talk openly about what matters to them, and what changes should be prioritised. Find out more about Listening into Action at www.stgeorges.nhs.uk/work-with-us

Improving patient outcomes

Our commitment to patients

This section of the Quality Account looks at patient outcomes quality indicators. In our Quality Improvement Strategy we outlined our commitment to patients:

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

You can read more about our commitment to improving patient safety in our Quality Improvement Strategy on our website at www.stgeorges.nhs.uk/about/our-strategy/strategies

Our patient outcomes indicators

This section of the Quality Account is about the work we are doing to improve patient outcomes. The indicators in this section are:

- Mortality rates
- Patient reported outcome measures
- Sexual health in secondary schools
- Emergency readmissions
- Clinical outcome measures in community services

Mortality rates

Why is this important?

The summary hospital-level mortality indicator (SHMI) is intended to be a single consistent measure of mortality rates for acute and non-specialist NHS trusts. The SHMI gives the ratio between the actual number of patients who die compared to the expected number given the characteristics of the patients treated.



SHMI covers the deaths of all admitted patients who either die in hospital or within 30 days of being discharged, and shows whether the number of deaths at an organisation is more or less than would be expected compared to average national mortality figures. It also shows whether that difference is statistically significant.

At St George's we also continue to use the hospital standardised mortality ratio (HSMR) in addition to the SHMI to monitor mortality.

Our SHMI and HSMR data is reviewed by the trust's Mortality Monitoring Committee, which meets every month. The committee, which is chaired by the Associate Medical Director for Governance and has members from across the trust, also considers mortality data at diagnosis and procedure level and reviews all deaths in hospital following an elective admission. By examining this range of data we are able to scrutinise our outcomes and the care we provide to patients. Where there are lessons to be learnt these are identified and implemented across the trust, and where best practice is observed this is acknowledged and shared.

How did we do?

This year our mortality rates for both SHMI and HSMR are again amongst the best in the country.

The Dr Foster Hospital Guide 2013² identified St George's as being one of only 19 trusts in the country to have statistically significant lower than expected mortality as measured by the SHMI and the HSMR for 2012/13.

St George's has been named in this elite group of trusts every year since mortality data started to be published, demonstrating that St George's is one of the safest trusts in the country and that the most complex and seriously ill patients are more likely to survive at St George's than at most other trusts in the country.

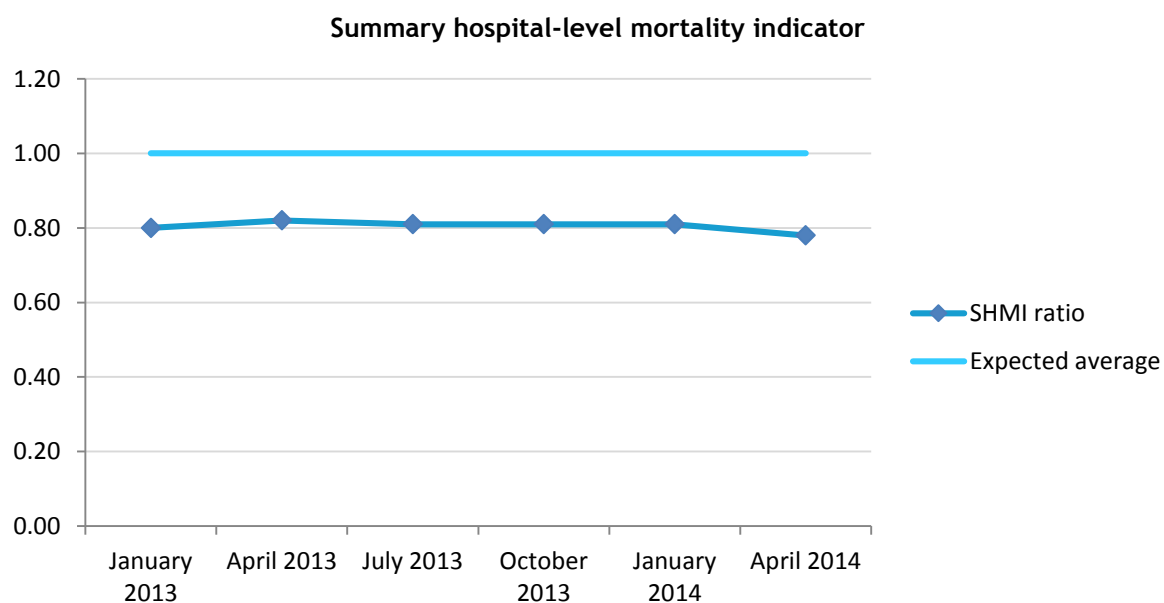
Summary hospital-level mortality indicator

Our SHMI continues to be amongst the lowest in country, with our mortality categorised as lower than expected since SHMI was introduced in 2011. For the latest SHMI data published in January 2014, covering the period July 2012 to June 2013, we had a SHMI ratio of 0.81 (expected average 1.00).

The table below summarises the quarterly publications for this period.

Publication date	Reporting period	Ratio	Banding
April 2014	October 2012 to September 2013	0.78	Lower than expected
January 2014	July 2012 to June 2013	0.81	Lower than expected
October 2013	April 2012 to March 2013	0.81	Lower than expected
July 2013	January 2012 to December 2012	0.81	Lower than expected
April 2013	October 2011 to September 2012	0.82	Lower than expected
January 2013	July 2011 to June 2012	0.80	Lower than expected

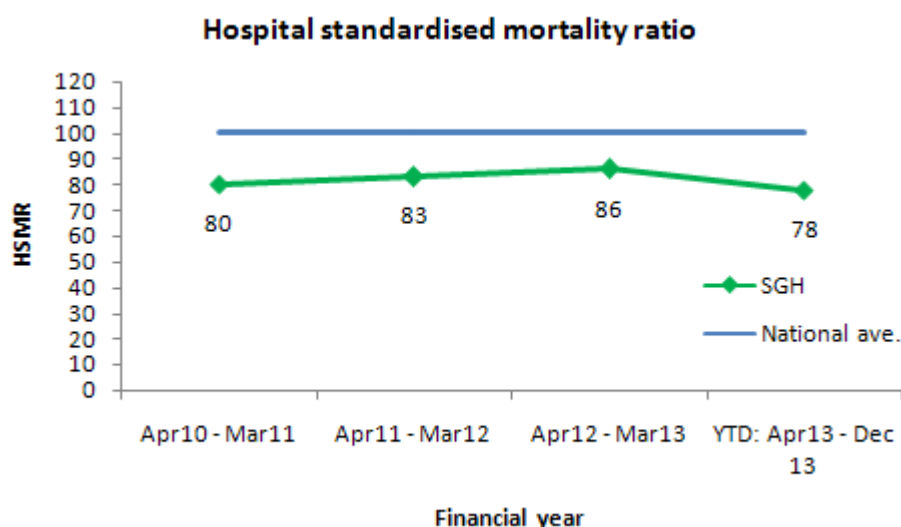
Source: Health and Social Care Information Centre¹



Hospital standardised mortality ratio

With the HSMR, if our mortality matched the expected rate our score would be 100. The most recent HSMR data publication gives us a HSMR score of 78. This is lower than last year's HSMR score of 86 and means that our mortality rates continue to be significantly better than expected.

The chart below shows our performance over the last few years.



Source: Dr Foster Intelligence

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 and expanding our scrutiny of deaths and taking action as necessary. We will strive to develop our governance further by participating in a national study examining avoidable mortality.

¹ For more detailed data visit <http://www.hscic.gov.uk/catalogue/PUB13455>

²For additional information visit <http://myhospitalguide.drfoosterintelligence.co.uk>

Patient reported outcome measures (PROMS)

CQC essential domains

effective

responsive

Why is this important?

A patient-reported outcome measure is a series of questions that patients are asked in order to gauge their views on their own health. In the examples of groin hernia, knee replacement, hip replacement and varicose vein surgery patients are asked to score their health before and after surgery. We are then able to understand whether patients see a 'health gain' following surgery.

The data provided gives the average difference between the first score (pre-surgery) and second score (post-surgery) that patients give themselves. However, it is important to note that the sample size for all patient reported outcome scores is very small which may impact upon the meaningfulness of the data.

How did we do?

Unfortunately, at the time of reporting we do not have sufficient numbers of completed post-operative questionnaires to be able to report health gain for the 2013/14 year to date (April 2013 to September 2013).

Post-operative questionnaires are sent by contractors working for the Department of Health directly to patients that have completed the initial survey. As detailed below our participation is above the national average, however the issue rate for post-operative questionnaires currently stands at just 5.8 per cent. This has been escalated to the contractor who has confirmed the delay in issuing questionnaires and consequent unavailability of data was caused by a change in their processes. We have been assured that all due post-operative questionnaires have now been sent to patients, and it is hoped that some data regarding health gain for 2013/14 will be available in the next quarterly Health and Social Care Information Centre publication.

This information will be published on the Health and Social Care Information Centre www.hscic.gov.uk

Participation

We are responsible for providing patients with the opportunity to complete pre-operative questionnaires. Our aim is to provide the choice of completing the questionnaire to all appropriate patients, however it is voluntary and not all patients choose to take part.

Our participation rate for 2013/14 is 87 per cent, a significant improvement from 66.8 per cent in 2012/13. In 2011/12 our response rate was 64.5 per cent, and in 2010/11 our response rate was 51.9 per cent.

Our participation rate and is above the national average of 72.7 per cent, meaning that we have achieved the target we set ourselves last year.

Our participation rate for the most recent period considered here (April 2013 to September 2013) is 87.0 per cent, which is above the national average of 72.7 per cent.

	April 2013 to September 2013 (provisional)		April 2012 to March 2013		April 2011 to March 2012		April 2010 to March 2011	
	SGH	England	SGH	England	SGH	England	SGH	England
All procedures	87.0	72.7	66.8	74.9	64.5	74.6	51.9	66.1
Hip replacement	108.0	79.2	87.0	82.6	88.2	82.3	51.4	76.3
Knee replacement	215.4	90.5	127.9	87.0	101.7	89.3	60.4	78.4
Groin hernia	89.1	57.6	72.1	61.3	52.4	60.6	59.7	55.0
Varicose vein	59.8	39.9	34.3	44.0	68.9	48.9	41.7	43.4

Source: Health and Social Care Information Centre

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

Our aims

During 2014/15 we aim to maintain participation rates that are in line with the national average. We also plan to extend our scrutiny of PROMs data to support us in identifying areas for improvement. This activity will be reported to and guided by the Patient Experience Committee.

Implementing clinical outcome measures in community services

Within community services it can be very hard to report on clinical outcomes as interventions can extend over a long period of time and care can focus on many different issues. Some services focus not on illness but promoting health and wellbeing. All of these factors can make it hard to measure clinical outcomes in community services and to know when best to do this. The NHS continues to work with professional bodies like the Royal

College of Nursing and Chartered Society of Physiotherapy to develop the best way to measure clinical outcomes.

Like other providers of community services, during 2013/14 we have been refining our measurements and our data collection processes so that we can be confident that the data we collect allows us to effectively analyse our community services objectively and see both where we are performing well and where we can make improvements.

Over the last year we have delivered comprehensive staff training on the use of clinical outcome measures covering both the collection and analysis of data. Various collection mechanisms and methods have been developed to ensure the extra work has minimal impact on front line clinical time. Additionally, systems are in place to allow the trust to process this information using business intelligence systems to support complex operational decision making that will optimise patient care. We are continuing to work on how to measure outcomes in areas that are traditionally health promoting.

During 2013/14 we have developed and rolled out condition specific and generic outcome measures for the following community services:

- Heart failure specialist nursing
- Respiratory specialist nursing
- Intermediate care and telehealth
- Diabetes specialist nursing
- Tissue viability nursing
- Community nursing
- Community neurorehabilitation
- Integrated falls service
- Primary care therapies
- Physiotherapy
- Dietetics
- Podiatry
- Children's therapies - complex needs
- Children's therapies - community
- Children's therapies - special schools
- Community paediatric audiology
- Community learning disabilities health team

Sexual health in secondary schools

CQC essential domains

effective

caring

responsive

Why is this important?

Supporting young people to grow up with a good knowledge about their sexual health and how to both protect themselves and keep safe is really important. Historically Wandsworth has had a high teenage pregnancy rate which has halved in the last 10 years due to improved services and education.

Schools are responsible for providing sex and relationships education and Wandsworth Council has supported this to be provided by trained and confident teaching and teaching support staff, with school nurses also contributing to the education programme. St George's provides school nursing services in Wandsworth.

To improve access to sexual health advice, support and signposting our school nursing service provides a drop in service in secondary schools in Wandsworth. Our target is for 50% of secondary schools in Wandsworth to have sexual health support on the school grounds.

How did we do?

All 11 secondary schools in Wandsworth have a linked school nurse who spends up to three days a week in the school supporting pupils.

All 11 secondary schools have a weekly drop in session when pupils can see a school nurse confidentially (there is always the need however to inform pupils that if a safeguarding concern is raised this will need to be shared).

All of our school nurses have received training in sexual health and the administration of emergency contraception, with a patient group direction (PGD) and competency framework for the administration of emergency contraception developed and implemented.

Sexual health information is freely available in all secondary schools. Information is also given to pupils about The Point sexual health clinics in Wandsworth, with pupils actively encouraged to attend if they are likely to be sexually active.

Our Aims

We have three main aims for young people in Wandsworth:

- to have quick and easy access to sexual health information in a confidential and appropriate way giving them the option to make informed choices about their sexual health.
- to be protected from harm.

- to have easy access to emergency contraception where a holistic assessment will be carried out by a school nurse. This then gives the opportunity to make sure the young person is safe and address any other health concerns.

Reducing hospital readmissions

CQC essential domains



Why is this important?

Monitoring emergency readmission rates can help us to prevent or reduce unplanned readmissions to hospital. An emergency readmission is recorded when a patient has an unplanned re-admission to hospital within 30 days of a previous discharge.

This Quality Account refers to emergency readmissions within 30 days rather than HSCIC compendium indicator's 28 days because trusts report on their emergency readmissions within 30 days at frequent intervals as part of their quality reporting and as per Monitor Compliance and NHS Trust Development Agency accountability frameworks.

Reducing hospital readmissions is a substantial and hugely challenging task given the financial, systemic and regulatory constraints, but the potential benefits are enormous to patients. We are committed to reducing readmissions for all patients, whether they have received emergency or elective (planned) treatment, by making sure that all discharges are properly planned and that patients are not discharged until it is safe to do so, and that the appropriate community and social services are in place to support them in their own home when they are ready to leave hospital. For patients admitted for elective care, an important part of this process is the pre-operative assessment, which reduces the risk of complications during and following their stay in hospital.

Reducing the number of emergency and elective readmissions would ease the pressure on our Emergency Department, which is one of the busiest in the country. This would in turn create extra capacity in the hospital for elective patients and mean that less elective procedures are cancelled because of surges in emergency activity. Reducing elective readmissions would also mean that waiting times for elective procedures could be reduced.

The risk is heightened in the winter when pressure on our services increases significantly. We have strong plans that help us to manage the surge in attendance and admissions in the winter, including opening a winter ward that is closed during warmer months when there is less emergency activity.

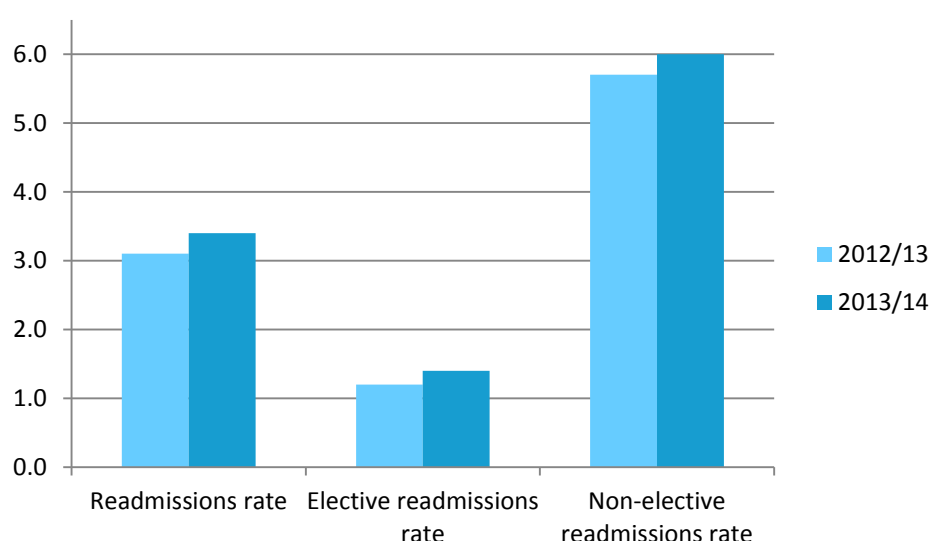
We also have a complex modelling system that helps us to predict how busy our emergency department will be at any given time by analysing activity levels over previous weeks and years. This helps us to make sure that we have the appropriate staffing levels in our emergency department. This of course means that waiting times are shorter, but more importantly that our patients receive the care and attention their condition needs.

How did we do?

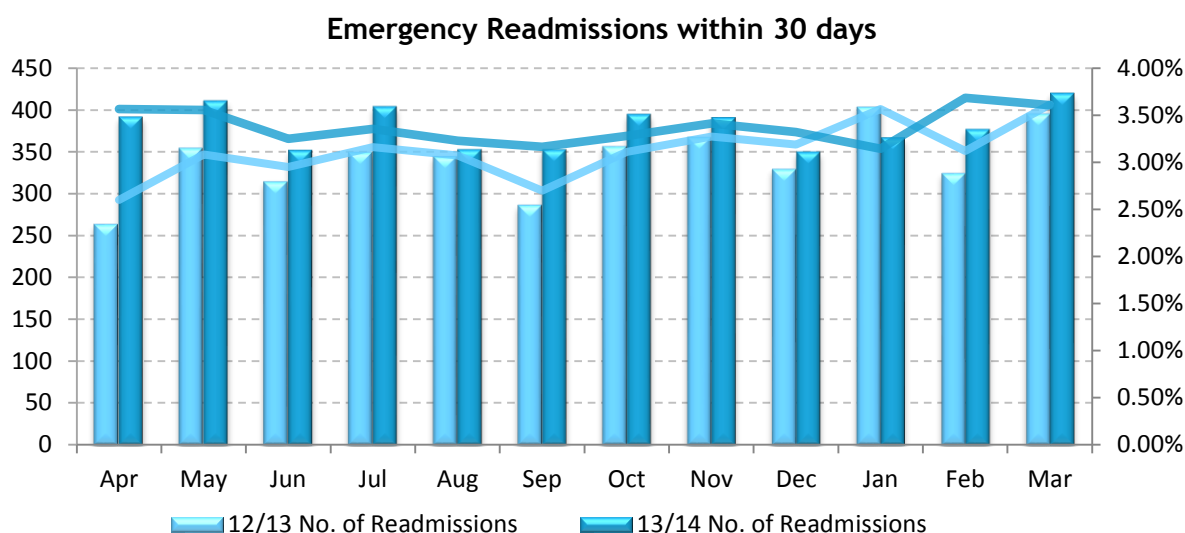
Reducing emergency readmissions has always been one of our priorities. In 2013/14, 3.4 per cent of patients were readmitted to hospital within 30 days. In real terms this means

that 4,565 patients were readmitted to hospital within 30 days of being discharged from their previous emergency or elective admission. 3.1 per cent of patients were readmitted to within 30 days of discharge in 2012/13.

Emergency readmissions within 30 days	2012/13	2013/14
Readmissions rate	3.1	3.4
Elective readmissions rate	1.2	1.4
Non-elective readmissions rate	5.7	6.0



Our increased readmission rates highlight the complexity of the challenges we face. As St George's Hospital is the regional major trauma centre, hyper-acute stroke unit and heart attack centre, we treat the most seriously ill patients and most complex cases from across south west London and Surrey, with some emergency patients coming from as far away as Hampshire. This means that the risk of patients needing to be readmitted after leaving hospital is higher for St George's than other acute trusts in that area. The number of emergency patients coming to St George's from further afield will increase following the opening of the helipad at St George's Hospital in April 2014.



Our four community virtual wards in Wandsworth are helping us to treat patients with chronic long term conditions who are more likely to need acute services more effectively in the community, reducing the number of patients who need to be readmitted following discharge.

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

We also have more than 50 telehealth units which allow our virtual community ward staff to monitor patients with heart failure or respiratory illness whilst they recuperate in their own homes. The telehealth units allow our community nurses to react quickly to any changes in a patient's condition, reducing the risk of more serious complications and the patient deteriorating to the point when they would need emergency care.

Our aims

Reducing hospital readmissions is a substantial task given the financial, regulatory, and systemic constraints, however while challenging, the gains can be enormous. Reducing emergency readmission remains one of our key priorities and a continued area of focus for between St George's and our partners in primary care and local councils.

We have started a detailed clinical audit of emergency readmissions to evaluate the proportion of readmissions that were clinically avoidable and additionally to identify the key reasons driving this. The findings of the audit will help us to set specific actions in order to objectively improve performance.

During 2014/15 we will continue our efforts to reduce readmissions by making sure that all discharges are properly planned, appropriate community services are in place, and patients are not discharged until it is safe to do so.

Statements on the Quality Account 2013/14

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, the National Health Service (Quality Accounts) Amendment Regulations 2011 and the National Health Service (Quality Accounts) Amendment Regulations 2012.

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

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

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

By order of the Board



Christopher Smallwood
Chairman



Miles Scott
Chief Executive

Wandsworth Council Adult Care and Health Overview and Scrutiny Committee

The Trust's continuing excellent performance on mortality rates demonstrates the benefits to the Wandsworth population of the clinical expertise concentrated in St George's. The generally positive findings from the Care Quality Commission inspection conducted in February 2014 are a welcome reflection of the Trust's efforts to address the deficiencies identified in the inspection undertaken in 2013, and the high proportion of targets achieved from the 2013/14 quality priorities is also commendable. The proposed priorities for 2014/15 represent a sensible response to the issues identified in the inspection and wider developments. It is to be hoped that these proposed priorities will be operationalised as specific and measurable targets. The Committee would welcome consultation on this.

To key challenge to the Trust is to extend the excellence achieved in its clinical outcomes to patient experience of the services offered. Whilst there has been a substantial improvement in the results of the Friends and Family Test in the course of the year, the Trust's results on the national inpatient survey are only average and the results of the survey of the experience of cancer patients were poor. It is very disappointing that, over the course of the last three years, there has been no improvement in the Trust's performance in responding to complaints, and it is suggested that this should be a major focus for the coming year. The Committee is also concerned at the high proportion of questions in the NHS Staff Survey 2013 in which the Trust ranked in the bottom 20 per cent, and hopes to see a substantial improvement over the coming year.

A specific concern arising from this year's Quality Account is the occurrence of five never events in the course of the year. Whilst each of these may be the result of individual human error, it is important that there are thorough investigations to determine whether there are common factors underlying this cluster of events.

Healthwatch Wandsworth

Healthwatch Wandsworth welcomes and applauds St George's good performance on some critical issues for patients as noted in the Quality Account, including:

1. Continuing to maintain lower than expected mortality rates
2. Reducing the rate of C.diff infections
3. Reducing grade three and four pressure ulcers
4. Meeting targets for reducing patient falls

These all indicate a positive culture of clinical care. The picture of the hospital provided by the report broadly matches that of Healthwatch Wandsworth obtained from patient and visitor comments and participation in unannounced inspection visits. We were pleased to be able to provide input into the structure and coverage of the Account and note that the summary provides a good comparison with the outcomes of the previous year's Account and highlights links to detail and the relevant Care Quality Commission domains. We also commend the continued inclusion of additional indicators including those perceived as important by external stakeholder groups. We note that these include areas of challenge as well as success.

Of concern to us are indicators of less successful clinical outcomes:

1. The failure to reduce hospital readmissions
2. Missing targets for the waiting time from urgent GP referral to first treatment of cancers
3. Missing the targets for reducing the rate of MRSA infections

We support the focus on patient safety and hope that, in addition to initiatives at ward and clinical level, further work will need to be introduced to improve the infrastructure in areas such as notes availability and staff training. Similarly, we would wish to see improvements in outpatient clinic settings backed up with improvements in booking and information systems.

On the results from methods for capturing patient experience, we welcome the increase in the number of patients who would recommend St George's to friends and family. We accept that an increase in the number of complaints may, in part, reflect improvements in eliciting feedback but are concerned at the failure to meet targets for responding to complaints. We perceive a lack of coordination and transparency in the presentation of a multiplicity of ways that are used to ask for patient feedback (such as Quality Inspections, internal audits, internal and external surveys). We recognise that some of these are conducted by bodies external to the Trust, but feel that more can be done to present a unified interface between St George's and its users. We ask that better use is made of information held on patients' views and that this is put into the public domain in an accessible format on a regular basis.

In conclusion, we would like to see concerted effort made to improve patient experience in three key areas:

1. Hospital readmissions
2. Cancer waits
3. Preventing and responding to complaints

Wandsworth, Merton, Lambeth, Sutton, Kingston and Richmond Clinical Commissioning Groups

Wandsworth and Merton CCG commissioners have reviewed the Trust's Quality Account for 2013/14 and the following is a summary of performance against national standards, with expectations for the year ahead (listed in the tables below).

The Trust has continued to perform well and have worked hard to improve the quality of care it provides to our patients. In particular, we are very encouraged by the positive CQC inspection which found that the overall standard of care provided was 'good', with some services identified as 'outstanding'. St George's continues to have lower than expected mortality rates, and has made commendable improvements in rates of c-difficile infections, mixed sex accommodation and maternity services.

It is disappointing, however, that three Never Events were reported throughout the year, and that the Trust failed to achieve the 62 day wait cancer treatment target and A&E 4-hour wait time target. We have learnt from what were the root causes of this performance last year and are now working very closely with the Trust and the wider health economy through the coming year. There is a particular focus on achieving all targets that the Trust have been set to build a sustainable and resilient system to reduce pressures on urgent care.

The Trust has been open and honest in its reporting of Serious Incidents to commissioners during 2013/14 and has taken positive steps to learn for incidents and implement planned actions. We look forward to seeing an increased emphasis on reducing emergency readmissions through the better management of patients with long-term conditions, and on improving systems for acting on test results. Commissioners are committed to working collaboratively to assist the Trust in achieving their goals, particularly plans to redesign care pathways to keep more people out of hospital. We will also be working to help prevent admissions from occurring by identifying those with increased needs and providing greater capacity to undertake appropriate interventions in the community. Transforming community services for older people and out of hospital care is a priority for the CCGs in 2014/15.

The CCGs welcome the specific priorities for 2013/14 which the Trust has highlighted in the quality report; all are appropriate areas to target for continued improvement and link with clinical commissioning priorities.

Table one - St George's performance against key national indicators

Indicator	2013/14 performance	2014/15 targets
Mortality indicators	<p>ACHIEVED</p> <p>St George's was identified by the Health and Social Care Information Centre (HSCIC) as one of 15 trusts that have had a lower than expected mortality rate (January to December 2012). The Trust has also maintained this for the preceding two years.</p>	Maintain lower than expected mortality rate.
<p>Cancer Waiting Times</p> <ul style="list-style-type: none"> • 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) 	<p>PARTIALLY ACHIEVED</p> <p>2 week rule (the maximum wait for an urgent referral) and 1 month to treatment from confirmed diagnosis targets met in 2013/14.</p> <p>2 months to treatment (wait from urgent referral) target not met in 2013/14 at 84.1%, against a target of 85%.</p>	Improve performance against 2 months to treatment (wait from urgent referral) cancer target, above 85%.
CQUIN achievement	<p>PARTIALLY ACHIEVED</p> <p>In 2013/14, the Trust experienced a fall in trust-wide performance against CCG contracted CQUINs to 78.6% compared to 80% in 2012/13.</p> <p>2013/14 YTD achievement (percentage):</p> <ul style="list-style-type: none"> • Q2 - 90.1% • Q3 - 83.2% • Q4 - 78.6% <p>Significant underachieving areas in 2013/14 included Venous Thromboembolism (VTE) and Smoking Cessation:</p> <ul style="list-style-type: none"> • VTE: The Trust undertook an audit and found performance was better than data submitted to UNIFY. The Trust must improve and maintain data reporting quality for 2014/15. • Smoking Cessation: Failure to achieve due to recruitment issues which 	To improve trust-wide performance against CQUIN targets.

Indicator	2013/14 performance	2014/15 targets
	have been resolved for 2014/15.	
Minimising mixed sex accommodation	<p>ACHIEVED</p> <p>The Trust maintained good performance with regards to mixed sex accommodation in 2013/14.</p> <p>A remaining problem area is the delayed discharge of patients from critical care beds. The majority of which are caused by waits for a bed on the appropriate ward.</p>	Commissioners acknowledge that the Trust has achieved significant reduction during 2013/14 but improvement in breaches due to capacity contracts need to be a key focus.
<p>Healthcare Acquired Infections</p> <ul style="list-style-type: none"> No more than 45 cases of Clostridium Difficile during 2013/14. 	<p>ACHIEVED</p> <p>SGH accumulated 30 c.diff in 2013/14 - a significant improvement on the previous year (62 cases in 2012/13).</p> <p>Commissioners agreed a local target of 40 c.diff cases for 2014/15.</p>	No more than 40 cases of c.diff during 2014/15.
<p>Healthcare Acquired Infections</p> <ul style="list-style-type: none"> No more than 0 cases of MRSA (bacteraemia) during 2013/14 	<p>NOT ACHIEVED</p> <p>SGH exceeded the zero tolerance target by 6 cases of MRSA in 2013/14, however this represents an improvement on the previous year (9 cases in 2012/13).</p>	No cases of MRSA in 2014/15.
Maternity Services	<p>ACHIEVED</p> <p>Similar to 2012/13, the maternity CQUIN was fully met with the ratio of midwives to deliveries having been maintained at 1:27 throughout the year.</p>	To achieve the maternity CQUIN milestones for 2014/15.
Never Events	<p>NOT ACHIEVED</p> <p>There were five never events in 2013/14.</p>	No never events in 2014/15
<p>Serious Incidents</p> <ul style="list-style-type: none"> Timely reporting and learning from errors 	<p>ACHIEVED</p> <p>The Trust continues to perform very well against SI reporting timescales. The incident reporting rate is increasing which we consider reflects an open and transparent culture.</p>	To continue good performance in reporting timeframes, and to take a more thematic approach to SI evaluations and action plans.

Indicator	2013/14 performance	2014/15 targets
	<p>The CCG and the Trust have developed an effective working relationship enabling us to have a joint approach to management and oversight of incidents.</p>	
<p>Care Quality Commission Inspection report</p>	<p>ACHIEVED</p> <p>The Trust achieved an overall rating of 'Good' in the new-style February CQC inspection, though improvement is required in the following acute areas:</p> <ul style="list-style-type: none"> • Safe: Medical Care, Surgery, End of Life Care and Outpatients. • Well-led: End of Life Care <p>Improvement is also required in the following community (QMH) areas:</p> <ul style="list-style-type: none"> • Safe: A&E Minor Injuries Unit) • Responsive: Outpatients <p>The Trust is developing an action plan focused on improving the availability of medical records in outpatients and Training compliance for the Mental Health Capacity Act at Queen Mary's Hospital (QMH).</p>	<p>Further improvement in experience of inpatients.</p> <p>Address issues raised and ensure consistency of high quality care across Trust.</p>
<p>National Inpatient Department Survey</p>	<p>ACHIEVED</p> <p>St George's 2013 result show the overall inpatient experience at St George's is "about the same as other trusts" and as expected by the CQC.</p> <p>The Trust's scores show a consistent performance against 2012 with improvements in some sub-categories.</p>	<p>Continue to improve and extend the feedback system the "Friends and Family Test"</p>

The table below outlines St George's performance against key national performance indicators which are not reported in the 2013/14 Quality Account that the south west London CCGs would like to see included in the 2014/15 Quality Account.

Indicator	2013/14 performance	2014/15 targets
<p>18 Week Waiting Times</p> <ul style="list-style-type: none"> Patients to wait no longer than 18 weeks from referral to treatment. 	<p>PARTIALLY ACHIEVED</p> <p>The target was met throughout the year for both admitted and non-admitted patients at a trust-wide level. However the Trust has not met the 18 weeks specialty specific contractual targets.</p>	<p>To maintain overall compliance throughout the year with 18 week waiting times target for admitted and non- admitted patients. To improve specialty level compliance in line with aggregate achievement.</p>
<p>Emergency Access (A&E 4 hour target)</p> <ul style="list-style-type: none"> 95% of all patients attending accident and emergency should be treated, admitted or discharged within a maximum of 4 hours. 	<p>NOT ACHIEVED</p> <p>The target was not met in 2013/14 due to failure to meet 95% in Q3 and Q4.</p> <p>94.6% of patients were treated, admitted or discharged within 4hrs in 2013/14, compared to 95.97% in 2012/13.</p>	<p>Improve performance above 95%.</p>

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

We are required by the Audit Commission to perform an independent limited assurance engagement in respect of St George's Healthcare NHS Trust's Quality Account for the year ended 31 March 2014 ("the Quality Account") and certain performance indicators contained therein as part of our work under section 5(1)(e) of the Audit Commission Act 1998 ("the Act"). NHS Trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in the National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2014 subject to limited assurance consist of the following indicators:

- percentage of patient incidents resulting in severe harm or death (page 43)
- percentage of patients risk assessed for venous thromboembolism (VTE) (page 55)

We refer to these two indicators as "the indicators".

Respective responsibilities of the Directors and auditors

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

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

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

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

- the Quality Account is not prepared in all material respects in line with the criteria set out in the regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2013/14 issued by the Audit Commission on 17 February ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2013 to June 2014;
- papers relating to the Quality Account reported to the Board over the period April 2013 to June 2014;
- feedback from the Commissioners dated 23/06/2014;
- feedback from Local Healthwatch dated 17/06/2014;
- feedback from Wandsworth Council dated 19/06/2014;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009 dated September 2013 and progress reports to the Board, dated September 2013 and January 2014;
- the latest national patient survey dated 2013;
- the latest national staff survey dated 2013;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 04/06/2014;
- the annual governance statement dated 04/06/2014; and
- Care Quality Commission Intelligent Monitoring Report dated March 2014.

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

This report, including the conclusion, is made solely to the Board of Directors of St George's Healthcare NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 44 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2014. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and St George's Healthcare NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- analytical procedures;
- limited testing, on a selective basis, of the data used to calculate the indicators back to the supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance process is much 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 reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision

thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by St George's Healthcare NHS Trust.

Basis for qualified conclusion

The indicator reporting the percentage of patients risk-assessed for venous thromboembolism (VTE) did not meet all six dimensions of data quality, for the following reasons:

Accuracy; Relevance; Timeliness; Reliability; Validity and Completeness - the Trust could not provide data sets for the denominator (the total number of admissions) or the numerator (the number of patients risk assessed for VTE as reported to NHS England). As a result we could not test this indicator.

Accuracy - the Trust uses "live" systems to calculate this indicator and has not maintained a record of data used from these systems as at the date the Trust calculated the indicator reported in the Quality Account. The Trust cannot reconcile the live data records to the published information the Trust reported to NHS England during the year.

Reliability - the Trust uses two different systems to collate the information for the numerator and denominator and does not reconcile the figures between the two systems. We are therefore unable to confirm that all cases included in the numerator are also included in the denominator.

Qualified conclusion

Based on the results of our procedures, with the exception of the matters reported in the basis for qualified conclusion paragraphs above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and

- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the guidance.

Grant Thornton UK LLP

Grant Thornton House
Melton Street
Euston Square
London
NW1 2EP

27 June 2014

Appendix A - Participation in national clinical audits and national confidential enquiries

Audit/confidential enquiry	Relevant	Participating	Submission rate (per cent) / Comment
Acute			
National confidential enquiry into patient outcome and death	✓	✓	Tracheostomy study: 100 per cent
			Lower limb amputation study: 71 per cent
			Gastrointestinal haemorrhage study: 60 per cent to date, but anticipate 100 per cent return by submission deadline 17/06/14
National audit of seizures in hospital	✓	✓	100 per cent
ICNARC - Adult critical care case mix programme	✓	✓	100 per cent
Emergency use of oxygen (BTS)	✓	✓	100 per cent
National emergency laparotomy audit	✓	✓	100 per cent
National joint registry	✓	✓	100 per cent
Paracetamol overdose (care provided in Emergency Departments)	✓	✓	100 per cent
Severe sepsis & shock	✓	✓	100 per cent
TARN - Trauma audit and research network	✓	✓	76 per cent
Blood and transplant			
National comparative audit of blood transfusion	✓	✓	Audit of the use of Anti-D: 100 per cent
			Audit of the management of patients in Neuro Critical Care Units: 100 per cent
			Audit of patient information and consent: In progress; anticipate 100 per cent

Audit/confidential enquiry	Relevant	Participating	Submission rate (per cent) / Comment
Cancer			
NBOCAP - Bowel cancer	✓	✓	Data entry open until October 2014
DAHNO - Head and neck oncology	✓	✓	Data entry open until November 2014
NLCA - Lung cancer	✓	✓	Data entry open until June 2014
NAOGC - Oesophago-gastric cancer	✓	✓	Data entry open until October 2014
Heart			
MINAP - Myocardial ischaemia national audit project	✓	✓	All 2013/14 data has to be completed by 31/05/2014. Process in place to submit 100 per cent of patients.
Adult cardiac surgery	✓	✓	Approximately 80-90 per cent
Cardiac rhythm management	✓	✓	Devices: 100 per cent
			EP: currently <10%, however the service are working to improve on this rate and are reviewing their processes in order to achieve full submissions
Congenital heart disease	✓	✓	100 per cent
Coronary angioplasty	✓	✓	87.5 per cent to date with process in place to submit 100 per cent by submission deadline
Heart failure	✓	✓	Data complete and submitted to date = 38 per cent. Expect to submit 80 per cent by submission deadline
NCAA - National cardiac arrest audit	✓	✓	100 per cent
National vascular registry	✓	✓	Carotid interventions audit (CIA): data submitted to date = 80 per cent. Expect to submit 90-100 per cent by submission deadline
			Abdominal aortic aneurysm (AAA): data submitted to date = 80 per cent. Expect to submit 90-100 per cent by submission deadline

Audit/confidential enquiry	Relevant	Participating	Submission rate (per cent) / Comment
			Peripheral arterial disease (PAD): Expect to submit 90-100 per cent by submission deadline
Long term conditions			
Diabetes (Adult)	✓	x	Continuous audit: 0 To allow participation the service require new software. A business case is currently being prepared and we are working to begin participation in 2014/15
			National diabetes inpatient audit: 100 per cent
Diabetes (Paediatric)	✓	✓	100 per cent
Inflammatory Bowel disease (IBD)	✓	✓	Adult: 100 per cent
			Paediatric: Ulcerative colitis 50 per cent; biologics 85.7 per cent, with data submissions ongoing
National Chronic Obstructive Pulmonary Disease Audit Programme	✓	✓	Ongoing, aiming for 100 per cent
Paediatric bronchiectasis	✓	✓	75 per cent
Renal replacement therapy (Renal Registry)	✓	✓	Data submitted on 100% of patients and work ongoing to improve completion of dataset
Rheumatoid and early inflammatory arthritis	✓	x	We intend to participate in this audit which commenced in February 2014 but as yet no data has been submitted. We are currently designing a process to facilitate participation in 2014/15
Older people			
Falls and Fragility Fractures Audit Programme (FFFAP): National hip fracture database (NHFD)	✓	✓	100 per cent
Sentinel stroke national audit programme	✓	✓	>80 per cent

Audit/confidential enquiry	Relevant	Participating	Submission rate (per cent) / Comment
Other			
Elective surgery - National patient recorded outcomes measurements (PROMS) programme	✓	✓	87 per cent (April to September 2013)
Women's and children's health			
Epilepsy 12: Childhood epilepsy	✓	✓	100 per cent
Maternal, infant and newborn programme (MBRRACE-UK)	✓	✓	Currently 55 per cent of still births and 100 per cent of neonatal deaths have been submitted. Maternity services are taking action to improve submissions.
Moderate or severe asthma in children (care provided in emergency departments)	✓	✓	100 per cent
Neonatal intensive and special care (NNAP)	✓	✓	100 per cent
Paediatric asthma (BTS)	✓	✓	100 per cent
Paediatric intensive care (PICAnet)	✓	✓	100 per cent

Appendix B - National clinical audit actions taken

National clinical audit	Action*
Epilepsy12: National audit of childhood epilepsies	The results show that we perform well compared with other Trusts however the service has taken action to address areas that may be improved. The audit showed the service needed to improve documentation of contraception and pregnancy for girls aged 12 years and over. Action was taken to amend the existing clinic pro-forma to provide an aide memoire to full assessment and documentation criteria, and the service also added ECG investigations criteria to the patient pro forma that is used in clinic. The consultant clinical lead and department manager have taken action to commit time on a monthly basis in order to identify the annual audit sample and data collection is proceeding well.
National Head and Neck Cancer audit	The 8 th annual report presented a largely positive picture of local performance (results are available by network, rather than individual hospital). Although the network's performance is higher than average for nutritional and speech and language assessment, there are plans in place to recruit additional specialist staff to the trust. Close liaison with other trusts in the network around this issue is also expected to lead to improvement.
National bowel cancer audit report	Case ascertainment and data completeness for St George's patients has increased since last year, yet remains lower than the national average. This is being taken forward by the service, and the clinical nurse specialist, multi-disciplinary team co-ordinators and clinicians are working together to achieve this.
National audit of dementia	We have also introduced new training programmes and care protocols such as the Butterfly scheme and the use of the personal information documents such as "This is Me" and the Wandsworth dementia passport.
National hip fracture database (NHFD)	Care is audited against six key standards, and for half of these St George's performed better than the national average. A new orthogeriatrician consultant has been appointed and it is anticipated that this will have a positive impact on patient care and our compliance with a number of standards. In addition, ongoing trust-wide work, including recruitment of specialist Tissue Viability Nurses is designed to support improvements in pressure ulcer prevention for this patient group.

National Paediatric Diabetes Audit (NPDA)	The paediatric diabetes service has taken action on data quality issues through acquisition of the Twinkle database and clinical leadership to ensure data is accurate and complete. The service are confident that the next NPDA report will present a fair representation of the care provided by St George's.
National heart failure audit	Our results show that for the majority of key measures of clinical practice we compare favourably to the national average, particularly in regard to referral to heart failure (HF) liaison services. There is currently a service improvement project underway to design an integrated care pathway for heart failure patients; these results along with the recommendations contained within the national report will further inform that work.
PICANet (Paediatric intensive care audit network)	The trust's mortality rates remain below the median when compared to the national data set. Just over thirty percent of admissions are planned and readmissions within 24 hours continue to be below the median. The report shows medical and nurse levels for 2012 to be below Paediatric Intensive Care Society (PIC) standards, although audit of staffing levels measured against patient dependencies at specific times were within PIC safe staffing levels. Business cases are in progress to meet Paediatric Intensive Care Society staffing compliance.

**Based on information available at the time of publication*

Appendix C - Local clinical audit actions taken

Local clinical audit	Action*
VTE risk assessment	The assessment form has been amended, providing more visible prompts to record key information. A number of other trust-wide actions have been agreed including education and communication campaigns. Local results have been provided to support action planning at a service level.
Nil-by-mouth re-audit	<p>The principal actions include review of the current patient information leaflet to clarify pre-operative fasting instructions. A poster on fasting guidelines will also be designed and displayed in the surgical admissions lounge (SAL). This will be reinforced by strengthening verbal pre-operative patient information. Installation of a water fountain on SAL is planned.</p> <p>Information for staff will also be improved, with the nil-by-mouth (NBM) pathway displayed in SAL and all theatres, and the display of starvation instructions on SAL.</p>
WHO checklist audits	A programme of peer review audit has been introduced to ensure performance is maintained and is consistent across all theatre areas. In non-theatre areas actions include conducting random checks throughout the day to see if staff have completed the checklist fully and correctly. A programme of education is also underway to familiarise staff with the correct way to carry out the check and complete the form.
Use of the early warning score (EWS) chart	An updated trigger system, in line with the national EWS and improved chart design is currently being rolled out, particularly to help with recording at night. Implementation will be supported by a new training tool used in MEERKATS training and the Harm free care study days. Further improvements will be supported, particularly in relation to accurate scoring, through roll out of electronic recording of observations as part of the clinical documentation phase of the Cerner patient administration system programme.

<p>Venous access device (VAD) care audit</p>	<p>A comprehensive action plan has been drawn up. Poorly performing areas have been provided with their results and asked to submit action plans addressing local issues to the Venous access service and Infection control team. Ward staff will be supported through increased education provided by both of these teams.</p> <p>At a trust level policy has been developed to provide clear guidance on care standards and the removal of devices that are no longer needed. Development of a combined VAD surveillance form and reintroduction of the CVC line care ward round will further support improvement.</p>
<p>Pressure ulcer prevention (PUP) audit</p>	<p>Staff training in PUP is on-going and audit results have been used to target areas where improvement is most needed and to highlight some general points that were noted in the audit process. In particular staff have been reminded that the use of a pressure relieving mattress of any sort never replaces the need to turn patients and even if a patient is “self-positioning” documentation is needed to provide assurance that the patient is changing position regularly.</p>
<p>Healthcare records audit</p>	<p>Focus of Patient Safety Week 2013, culminating in Mock Coroner’s Inquest to highlight importance of good record keeping.</p> <p>Service managers are now involved in ensuring clinical teams complete the audit.</p> <p>The history sheet has been redesigned to include prompts for essential information and a number of other measures have been recommended at trust level, particularly around the use of clinician name stamps and patient identification stickers.</p> <p>Local action will be required to improve standards and to this end care group results and divisional reports are produced alongside the trust level report. The clinical lead for this project regularly attends Divisional Governance Boards to present and discuss local results and to engage colleagues in monitoring and quality improvement.</p>

**Based on information available at the time of publication*

Appendix D - Assessment of compliance against London Quality Standards

London Quality Standards		Clinical Assessment 2012/13		Clinical Assessment 2013/14		Planned year of achievement
		Medicine	Surgery	Medicine	Surgery	
Acute medicine and emergency general surgery						
1	All emergency admissions to be seen and assessed by a relevant consultant within 12 hours of the decision to admit or within 14 hours of the time of arrival at the hospital	Not Met (Plan in place)	Not Met	Not Met (Plan in place)	Met	2014
2*	A clear multi-disciplinary assessment to be undertaken within 12 hours and a treatment or management plan to be in place within 24 hours (for complex needs see 23 and 24)	Met	Not Met	Met	Not Met (Plan in place)	2015
3*	a) All patients admitted acutely to be continually assessed using a standardised early warning system	Met	Met	Met	Met	n/a
	b) Consultant involvement is required for patients who reach trigger criteria. Consultant involvement for patients considered 'high risk' to be within one hour	Not Met	Not Met	Met	Met	n/a
4	When on-take, a consultant and their team are to be completely freed from any other clinical duties or elective commitments	Not Met (Plan in place)	Met	Met	Met	n/a

London Quality Standards		Clinical Assessment 2012/13		Clinical Assessment 2013/14		Planned year of achievement
		Medicine	Surgery	Medicine	Surgery	
5	In order to meet the demands for consultant delivered care, senior decision making and leadership on the acute medical/ surgical unit to cover extended day working, seven days a week	Not Met (Plan in place)	Not Met	Not Met (Plan in place)	Met	2014
6	All patients on acute medical and surgical units seen and reviewed by a consultant during twice daily ward rounds, including all acutely ill patients directly transferred, or others who deteriorate	Not Met	Not Met	Not Met (Plan in place)	Not Met (Plan in place)	2014
7	All hospitals admitting medical and surgical emergencies to have access to all key diagnostic services in a timely manner 24 hours a day, seven days a week to support clinical decision making: - Critical - imaging and reporting within 1 hour - Urgent - imaging and reporting within 12 hours - All non-urgent - within 24 hours	Met	Met	Met	Met	n/a
8	All hospitals admitting medical and surgical emergencies to have access to interventional radiology 24 hours a day, seven days a week: - Critical patients - 1 hour - Non-critical patients - 12 hours	Met	Met	Met	Met	n/a

London Quality Standards		Clinical Assessment 2012/13		Clinical Assessment 2013/14		Planned year of achievement
		Medicine	Surgery	Medicine	Surgery	
9	Rotas to be constructed to maximise continuity of care for all patients in an acute medical and surgical environment. A single consultant retain responsibility for a single patient on the acute medical/ surgical unit. Subsequent transfer or discharge must be based on clinical needs.	Not Met	Not Met	Not Met (Plan in place)	Not Met (Plan in place)	2014
10	A unitary document to be in place, issued at the point of entry, which is used by all healthcare professionals and all specialties throughout the emergency pathway.	Met	Not Met	Met	Not Met	n/a
11	Patients admitted for unscheduled care to be nursed and managed in an acute medical or surgical unit, or critical care environment	Met	Not Met	Met	Not Met (Plan in place)	2015
12	All admitted patients to have discharge planning and an estimated discharge date as part of their management plan as soon as possible and no later than 24 hours post-admission. A policy to be in place to access social services seven days per week. Patients to be discharged to their names GP.	Not Met	Not Met	Not Met	Not Met	n/a
13	All hospitals admitting emergency general surgery patients to have access to a fully staffed emergency theatre immediately available and a consultant on site within 30 minutes at any time of the day or night	n/a	Met	n/a	Met	n/a

London Quality Standards		Clinical Assessment 2012/13		Clinical Assessment 2013/14		Planned year of achievement
		Medicine	Surgery	Medicine	Surgery	
14	All patients admitted as emergencies are discussed with the responsible consultant if immediate surgery is being considered. For each surgical patient, a consultant take an active decision in delegating responsibility for an emergency surgical procedure to appropriately trained junior or speciality surgeons. This decision is recorded in the notes and available for audit.	n/a	Not Met	n/a	Met	n/a
15	All patients considered as 'high risk' to have their operation carried out under the direct supervision of a consultant surgeon and consultant anaesthetist; early referral for anaesthetic assessment is made to optimise peri-operative care. High risk is defined as where the risk of mortality is greater than 10%.	n/a	Not Met	n/a	Met	n/a
16	All patients undergoing emergency surgery to be discussed with consultant anaesthetist. Where the severity assessment score is ASA3 and above, anaesthesia is to be provided by a consultant anaesthetist	n/a	Not Met	n/a	Met	n/a

London Quality Standards		Clinical Assessment 2012/13		Clinical Assessment 2013/14		Planned year of achievement
		Medicine	Surgery	Medicine	Surgery	
17	a) The majority of emergency general surgery to be done on planned emergency lists on the day that the surgery was originally planned. The date, time and decision maker should be clearly documented in the patient's notes and any delays to emergency surgery and the reasons why recorded.	n/a	Met	n/a	Not Met (Plan in place)	2015
	b) Any operations that are carried out at night to meet NCEPOD classifications and be under direct supervision of a consultant surgeon	n/a	Met	n/a	Not Met (Plan in place)	2014
18	All referrals to intensive care made from consultant to consultant	Met	Not Met	Not Met (Plan in place)	Not Met (Plan in place)	n/a
19	A structured process to be in place for the medical handover of patients twice a day. These arrangements to also be in place for the handover of patients at each change of responsible consultant/medical team. Changes in treatment plans are to be communicated to nursing and therapy staff as soon as possible if they are not involved in the handover discussions.	Met	Met	Met	Met	n/a
20*	Consultant-led communication and information to be provided to patients.	Met	Not Met (Plan in place)	Met	Met	n/a
21	Patient experience data is captured, recorded and routinely analysed and acted on. Is a permanent item on board agenda and findings are disseminated.	Met	Not Met	Met	Met	n/a

London Quality Standards		Clinical Assessment 2012/13		Clinical Assessment 2013/14		Planned year of achievement
		Medicine	Surgery	Medicine	Surgery	
22	All acute medical and surgical units to have provision for ambulatory emergency care.	Met	Not Met	Not Met (Plan in place)	Not Met (Plan in place)	2015
23	Prompt screening of all complex needs inpatients to take place by a multi-professional team which has access to pharmacy and therapy services, including physiotherapy and occupational therapy, seven days a week with an overnight rota for respiratory physiotherapy.	Not Met	Not Met	n/a	n/a	n/a
24	Single call access for mental health referrals available 24 hours a day, seven days a week with a maximum response time of 30 minutes.	Not Met	Not Met	Not Met	Not Met	n/a
25	Hospitals admitting emergency patients to have access to comprehensive 24 hour endoscopy services that has a formal consultant rota 24 hours a day, 7 days a week	Met	Met	Met	Met	n/a
26	a) All hospitals dealing with complex acute medicine to have onsite access to levels 2 and 3 critical care (i.e. intensive care units with full ventilatory support)	Met	Met	Met	Met	n/a
	b) All acute medical units have access to a monitored and nursed facility.	Met	n/a	Met	n/a	n/a
27	Training to be delivered in a supportive environment with appropriate, graded consultant supervision.	Met	Not Met	Met	Met	n/a

London Quality Standards		Clinical Assessment 2012/13		Clinical Assessment 2013/14		Planned year of achievement
		Medicine	Surgery	Medicine	Surgery	
Critical Care						
1	Medical staff trained in critical care must be available on site 24 hours a day, with access to an appropriately trained consultant at all times.	Met		Met		n/a
2*	Nurse: patient ratio. 1:1 nursing ratios for level 3 patients and 1:2 ratios for level 2 patients	Met		Met		n/a
3	Non-critical transfers out of and into a unit	0		n/a		n/a
4	Proportion of discharges during out of hours (i.e. between 22.01 and 06.59)	7.0%		6.0%		n/a
Emergency Departments						
1	A trained and experienced doctor (ST4 and above) in emergency medicine to be present in the emergency department 24 hours a day, seven days a week	Met		Met		n/a
2*	24/7 access to plain x-rays and CT	Met		Met		n/a
3*	A clinical decision unit/observation area in the emergency department	Met		Met		n/a
4*	Timely support from inpatient teams and efficient procedures for admission to hospital	Met		Met		n/a
Fractured neck of femur pathway						
1	Hip fracture patients should be operated on within 24/ 36/ 48 hours of admission	Patients admitted Sun-Thurs	Patients admitted Fri and Sat	Patients admitted Sun-Thurs	Patients admitted Fri and Sat	n/a
	Within 24 hours	No previous information	No previous information	Met	Met	

London Quality Standards		Clinical Assessment 2012/13		Clinical Assessment 2013/14		Planned year of achievement
		Medicine	Surgery	Medicine	Surgery	
	Within 36 hours	No previous information	No previous information	Met	Met	
	Within 48 hours	No previous information	No previous information	Met	Met	
2	All patients presenting with a fragility fracture should be managed on an orthopaedic ward with routine access to acute orthogeriatric medical support from the time of admission	Met		Met		n/a
3	Is all hip fracture surgery undertaken on planned trauma lists	Met		Met		n/a
4	Offer patients mobilisation at least once a day (seven days a week) and ensure regular physiotherapy and input from occupational therapists	Met		Not Met (Plan in place)		2014
Maternity services						
1	Service has staffing levels for obstetric presence on the labour ward in line with Safer Childbirth recommendations	Not Met		Not Met (Plan in place)		2016
2*	Obstetric unit provides a ratio of one midwife to 28 births (Current midwife ratio for birth ratio for London is 1:30)	Not Met		Met		n/a
		1:30		1:27		
3	Women are provided with 1:1 care during active labour			Met		n/a
4*	Clinical labour ward co- ordinators are supernumerary to midwives providing 1:1 care	Met		Met		n/a

London Quality Standards		Clinical Assessment 2012/13		Clinical Assessment 2013/14		Planned year of achievement
		Medicine	Surgery	Medicine	Surgery	
Paediatric emergency services						
1	All paediatric emergency admissions to be seen by a consultant paediatrician (or equivalent staff, specialty and associate specialist grade doctor who is trained and assessed as competent in acute paediatric care) within the first 24 hours.	Met		Met		n/a
2	All emergency admissions to be seen and assessed by the responsible consultant within 12 hours of admission or within 14 hours of the time of arrival at the hospital.	Not Met		Met		n/a
	Where children with surgical problems are admitted to a non-specialist surgical unit, they should be jointly managed and reviewed by both surgical and paediatric senior teams within 12 hours of admission.	n/a		Not Met (Plan in place)		n/a
3	One paediatric trained nurse to be present in the emergency department at all times.	Met		Met		n/a
4*	Access to a paediatrician with child protection experience and skills (of at least Level 3 safeguarding competencies) to provide immediate advice and subsequent assessment, if necessary, for children and young people under 18 years of age where there are child protection concerns.	Met		Met		n/a

The full reports for St George's Hospital are available on the My Health London website at <http://www.myhealth.london.nhs.uk/your-health/londons-health-services/hospital-quality-and-safety-audit-reports>

Appendix E - CQUINs for 2013/14

CQUIN goals and indicators	Achievement	Comments
National targets		
Friends & Family Test <ul style="list-style-type: none"> Phased expansion Increased response Improved performance on the Staff Friends and Family Test 	Partially met	<p>Increased response across the Trust but failed to achieve the target for the whole year in A&E.</p> <p>Read more about the Friends and Family Test on page 63.</p>
NHS Safety Thermometer <ul style="list-style-type: none"> Data collection Improvement 	Fully met	Read more on the NHS Safety Thermometer on page 47.
Dementia <ul style="list-style-type: none"> Find, assess, investigate and refer Clinical leadership Supporting carers of people with dementia 	Partially met	Unlikely to meet the Assessment (FAIR) for the year.
Venous thromboembolism (VTE) <ul style="list-style-type: none"> VTE assessment Root cause analysis 	Partially met	<p>The trust met the target in Q1 but failed to reach the stretch target in Q2, Q3 and Q4 through the UNIFY submission (CQUIN request method of reporting). However, through internal audit the trust did meet the target and the commissioners recognised this in the year-end settlement of 95% achievement for national CQUINs.</p> <p>Read more about VTE on page 55.</p>
Local Targets		
End of Life <ul style="list-style-type: none"> Establish an ongoing education and training programme around key areas of end of life care Extension of use of CMC or equivalent and audit use of LCP 	Fully met	
Alcohol misuse <ul style="list-style-type: none"> Targeted screening for alcohol misuse among inpatients Signposting or referral on to hospital based alcohol liaison nurses Identification, assessment and on referral of repeat attenders Improved rates of treatment 	Partially met	<p>Three areas partially met, Screening, Referral seen and GP communication. These targets were marginally missed and the service is working on an improved data collection and working with the ward on screening and referrals to the ALT. This is not a CQUIN for 2014/15</p>

CQUIN goals and indicators	Achievement	Comments
<p>completed within a care planned framework or referred on for completion</p> <ul style="list-style-type: none"> Improved communication with GPs with patients with alcohol misuse diagnosis 		
<p>Smoking cessation</p> <ul style="list-style-type: none"> Improve the physical health of users and work place staff by providing smoking cessation support Recruitment of clinical nurse specialist 	Partially met	The OP referrals target was not met in Q3 and Q4. This was due to delays in recruitment which were outside the trusts control. The service is fully staffed now and it projecting meeting the targets in 2014/15
<p>Maternity services</p> <ul style="list-style-type: none"> Increase midwifery workforce ratio Supernumerary midwife cover on Delivery Suite 	Fully met	Read more about maternity services on page 68.
<p>COPD integration</p> <ul style="list-style-type: none"> Development of tiered model Admissions In reach admissions avoidance 	Fully met	
<p>Oncology</p> <ul style="list-style-type: none"> Streamlining the pathway for patients with suspected cancers 	Partially met	<p>The trust failed to meet the targets in Q1, Q3 and Q4 for inpatients seeing a consultant with one working day. This scheme relates to very low number of patients and therefore if the target is not met for a few clients then the target of 95% is not achieved.</p> <p>Read more about cancer services on page 81.</p>
<p>Paediatric services</p> <ul style="list-style-type: none"> Transfer of the management of paediatric non-accident injury (NAI) Paediatric consultant cover from 9am to 9pm, seven days a week 	Fully met	
<p>Medicines management</p> <ul style="list-style-type: none"> Appropriate use of antibiotics to minimise C.Difficile infection Medicines reconciliation Homecare quality and efficiency Appropriate insulin prescribing and NICE guidance adherence 	Fully met	Read more about medicines management on page 48.
GP communication	Partially met	The target was not met in Q3 only for electronic communication with GPs. The

CQUIN goals and indicators	Achievement	Comments
<ul style="list-style-type: none"> Electronic A&E, outpatient and discharge letters Quality A&E, outpatient and discharge letters 		position was recovered in Q4.
Dermatology <ul style="list-style-type: none"> Redesign Queen Mary's Hospital dermatology service 	Fully met	
Heart failure service <ul style="list-style-type: none"> Develop integrated heart failure service 	Fully met	
Fracture liaison service <ul style="list-style-type: none"> Develop integrated fracture liaison service 	Fully met	
Diabetes service redesign <ul style="list-style-type: none"> Development and implementation of a tiered diabetes model Patient education programme 	Fully met	
Reducing patient falls <ul style="list-style-type: none"> Reduce the number of falls in the community and on senior health and rehabilitation wards 	Fully met	Read more about reducing patient falls on page 50.
Community minimum data set <ul style="list-style-type: none"> Progression to meeting the non-mandatory minimum data set for community services 	Fully met	
Community wards <ul style="list-style-type: none"> Multidisciplinary team working core MDT Multidisciplinary team working wider MDT 	Partially met	<p>The Trust failed the Q3 target only for attendance at the wider MDT. The position was recovered in Q4.</p> <p>Read more about our community wards on page 97.</p>
Children's phlebotomy service <ul style="list-style-type: none"> Paediatric phlebotomy development 	Fully met	
Bone marrow transplantation <ul style="list-style-type: none"> Percentage of UK donors rather than European or US The number of confirmatory typing (CT)/extended typing (ET) tests per patient The number of searches undertaken per transplant 	Fully met	

CQUIN goals and indicators	Achievement	Comments
<ul style="list-style-type: none"> The turnaround times (TAT) from the date of the search request to the delivery of the donor report 		
HIV <ul style="list-style-type: none"> Improve registration and communication with GPs 	Fully met	
Specialised cancer <ul style="list-style-type: none"> Access to and impact of clinical nurse specialist support on patient experience 	Fully met	Read more about cancer services on page 81.
Renal dialysis <ul style="list-style-type: none"> Reduce the incidence of preventable acute kidney injury (AKI) Increase use of renal patient view (RPV) by all dialysis patients 	Fully met	
Renal transplantation <ul style="list-style-type: none"> Cold ischaemic time 	Fully met	
Haemophilia <ul style="list-style-type: none"> Joint scores in sever and moderate haemophilia A & B (patients aged 4 years and over) Haemtrack monitoring 	Fully met	
Major trauma <ul style="list-style-type: none"> Improve outcomes of major trauma orthopaedic injuries 	Partially met	The Trust failed the Q1 and Q4 targets. The number of patients this refers to is very low so to fail a couple means the target of 80% cannot be achieved. The services continues to monitor and improve.
Neonatal Intensive Care Unit <ul style="list-style-type: none"> Improve access to breast milk in preterm infants Timely administration of total parenteral nutrition in preterm infants 	Fully met	
Fetal medicine <ul style="list-style-type: none"> Rapidity of obtaining a tertiary level fetal medicine opinion 	Fully met	
Dashboards <ul style="list-style-type: none"> Complete dashboards for HIV, medical genetics, major trauma, paediatric intensive care, 	Fully met	

CQUIN goals and indicators	Achievement	Comments
neonatal critical care, haemophilia, renal and bone marrow transplantation		
Long-term conditions <ul style="list-style-type: none"> Improve the management of patients with long-term conditions and the provision of health promotion activities 	Fully met	Read more about how we are working to reduce hospital readmissions for people with long-term conditions on page 97.
Hepatitis B <ul style="list-style-type: none"> Improve public health in relation to Hepatitis B 	Not met	Target not met because of data recording and prison office staffing issues. Action plan being developed to improve performance.
Hepatitis C <ul style="list-style-type: none"> Improve public health in relation to Hepatitis C 	Fully met	
People with learning disabilities <ul style="list-style-type: none"> Improve the identification of people with learning disabilities Improve the information provided to people with learning disabilities in Wandsworth Prison 	Fully met	Read more about referrals for people with learning disabilities on page 76.
Abdominal aortic artery (AAA) screening <ul style="list-style-type: none"> Improve AAA screening rates and the information available to patients 	Fully met	
Bowel screening <ul style="list-style-type: none"> Improve bowel screening rates and the information available to patients 	Fully met	
Breast screening <ul style="list-style-type: none"> Improve breast screening rates and the information available to patients 	Fully met	
DESP (retinal screening) <ul style="list-style-type: none"> Improve retinal screening rates and the information available to patients 	Fully met	
Early years <ul style="list-style-type: none"> Improve access to health visiting and early years services 	Fully met	

The overall achievement of the trust was 87 per cent which exceeded the provisional achievement level set internal at the beginning of the year of 85 per cent. However, during the year-end settlement negotiations with the CCGs the commissioners recognised that some of the schemes would have been fully met with different and potentially more robust report mechanisms the trusts' achievement would have been higher, therefore the achievement level agreed with CCGs was 95 per cent for all schemes. The year-end settlement affected the national schemes for both CCGs and NHSE commissioners. The trust achievement for NHSE CQUIN schemes was 96 per cent.

Appendix F - CQUINs for 2014/15

CCG CQUIN Schemes 2014/15	
Goal Name	Description of Goal
Friends and Family Test	To improve the experience of patients in line with Domain 4 of the NHS Outcomes Framework.
NHS Safety Thermometer	To measure and reduce harm. The power of the NHS Safety Thermometer lies in allowing frontline teams to measure how safe their services are and to deliver improvement locally.
Dementia	To incentivise the identification of patients with dementia and delirium, alone and in combination alongside their other medical conditions, to prompt appropriate referral and follow up after they leave hospital and to ensure that hospitals deliver high quality care to people with dementia and support their carers.
Smoking Cessation	Smokers are supported by being given advice and sign posted to relevant SSS if interested in quitting.
PAU Consultant Cover	To ensure the Paediatric Assessment Unit has consultant cover for 5 days a week, between 9am and 9pm
GP Communication	Continue to improve on the quality and speed of communication of discharge letters to GPs. Expand the services involved and work on developments to improve communication to patients.
Care of the Elderly	To improve patient care on discharge and help signpost patients to the correct care without the need for readmission.
Maternity	To support the trust in maintaining a good quality maternity service the CQUIN will help fund the 1:27 ratio, having a supernumerary midwife 24/7 and increasing consultant hours to provide 24/7 cover.
Heart Failure	The aim of this indicator is to improve quality of care, and reduce mortality and morbidity
COPD	To improve the COPD pathway.

TB	Improve contacts with positive TB patients, improve communication with GPs, ensure positive plural TB patients have a home visit in two weeks and complex TB patient are better cared for.
Medicines Management	Implementation of the 'New Oral Anticoagulants (NOACs) guidance. Improved reporting of medication-related safety incidents.
End of Life Care	Improve training and awareness of how to deal with EOLC.

Community CQUINs	
Goal Name	Description of Goal
Friends & Family Test	To improve the experience of patients in line with Domain 4 of the NHS Outcomes Framework.
Shadow Tariff	Development of Shadow Tariff Card for Community Services, CAHS , Learning Disabilities and Children
Learning Disabilities	Review of the service to support future redesign
Children's Services	Review of the service to support future redesign
Information Sharing	Developing MDTs and a platform for primary care to access community data.
COTE - MDT Team	Developing MDTs to ensure staff are sharing information and providing advice and support from people with different skills.

NHSE CQUIN Schemes for 2014/15	
Goal Name	Description of Goal
Friends and Family Test	To improve the experience of patients in line with Domain 4 of the NHS Outcomes Framework.
NHS Safety Thermometer	To measure and reduce harm. The power of the NHS Safety Thermometer lies in allowing frontline teams to measure how safe their services are and to deliver improvement locally.

Dementia	To incentivise the identification of patients with dementia and delirium, alone and in combination alongside their other medical conditions, to prompt appropriate referral and follow up after they leave hospital and to ensure that hospitals deliver high quality care to people with dementia and support their carers.
Dashboards	Ensure providers embed and routinely use the required clinical dashboards developed during 2013/14 for specialised services.
Perinatal Pathology	To implement a nationally predictable reporting time of 42 calendar days for 70% of perinatal autopsies and also adhere to the current specification a total of 90% of all perinatal autopsies issued within 56 days
Cardiac Surgery	Patients referred as semi urgent to have coronary artery bypass grafting as an inpatient (with or without transfer) within 7 days of angiogram. 20% reduction in patients not being treated within 7 days following baseline received.
Specialised Orthopaedics	Complex cases of orthopaedic surgery (mainly revisions) are discussed in a network MDT and in line with agreed network protocols, to improve outcomes and reduce infections and revisions.
Tertiary Level Fetal Medicine Opinion within 3 days	90% of newly suspected/diagnosed lethal or major fetal abnormalities or other life threatening fetal disorders referred to the fetal medicine centre seen within 3 working days.
Retinopathy in Prematurity	Increase in screening to a target of 95% of babies with a birth weight of <1501g or a gestation of <32+0 weeks who undergo 1st Retinopathy of Prematurity (ROP) screening whilst still an in-patient and screening 'on time'
Out of London Transfers (PICU)	To monitor and minimise the number and percentage of patients transferred out of network/normal catchment per quarter in 2014/15 compared to total admissions.
HIV Switch to Generics Reporting	HIV: Switch from branded ARV products to generic ARV products as available.
Breast Screening	Increase in update
Bowel Screening	Increase in update
Early Years	CHIS to CHIS interface and smoking cessation
Offender Healthcare	Improved access to services, screening and treatment for TB Hep Primary Care and mental Health

