Council of Governors Meeting

Date and Time: Wednesday 17 May 2017, 10:30 – 12:30
Venue: Boardroom H2.6, 2nd Floor, Hunter Wing

Time	Item	Subject	Action	Format
10:30	**1**	**Welcome and Apologies** *Chairman, Gillian Norton*	-	-
	2	**Declarations of Interest** *All led by Chairman, Gillian Norton*	-	Verbal
	3	**Minutes of Meeting held on 15 March 2017** *Chairman, Gillian Norton*	Approve	Paper
10:40	**4**	**CEO's Report and Overview** *Jacqueline Totterdell, CEO* (including an opportunity for questions from Governors)	Inform	Presentation
11:10	**5**	**Chairman's Report and Overview** *Chairman, Gillian Norton*	Inform	Paper
11:30	**6**	**Strengthening the Board – Recruitment of New Non-Executive Director** *Chairman, Gillian Norton*	Approve	Paper
11:40	**7**	**Self-Certification with the NHS Provider Licence** *Trust Secretary & Head of Corporate Governance, Fiona Barr*	Approve	Paper
11:45	**8**	**Draft Annual Cycle for the Council of Governors** *Trust Secretary & Head of Corporate Governance, Fiona Barr*	Discuss	Paper
11:50	**9**	**Quality Account 2016-17:** **a. Report from the Governor Sub-Group Meeting on the Governor Selected Quality Account Indicator** *Staff Governor, Will Hall* **b. Draft Quality Account 2016-17** *Chief Nurse, Avey Bhatia and Interim Head of Governance, Paul Linehan* **c. Independent Auditor's Report on the Quality Report Assurance** *External Auditor,*	Inform Inform Receive	Oral Paper Paper
12:25	**10**	**Any Other Business** *All led by Chairman, Gillian Norton*	-	Oral
12:30		**Close**		

Date and Time of Next Meeting of Full Council of Governors: 11 October 2017 at 11:00
Council of Governors Workshop: July 2017 (date to be agreed)

Council of Governors: Purpose, Membership, Quoracy and Meetings

Council of Governors Purpose:	The general duty of the Council of Governors and of each Governor individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

Membership and Those in Attendance		
Members	**Designation**	**Abbreviation**
Gillian Norton	Chairman	Chairman
Gail Adams	Public Governor, South West Lambeth	GA
Sue Baker	Public Governor, Merton	SB
Mia Bayles	Public Governor, Rest of England	MB
Patrick Bower	Appointed Governor, Wandsworth CCG	PB
Nigel Brindley	Public Governor, Wandsworth	NB
Val Collington	Appointed Governor, Kingston University	VC
Anneke de Boer	Public Governor, Merton	AB
Jenni Doman	Staff Governor, non-clinical	JD
David Flood	Staff Governor, Nursing & Midwifery	DF
Frances Gibson	Appointed Governor, St George's University	FG
Stuart Goodden	Public Governor, Wandsworth	SG
Mike Grahn	Appointed Governor, Healthwatch Wandsworth	MG
Will Hall	Staff Governor, Allied Health Professionals	WH
Hilary Harland	Public Governor, Merton	HH
Tim Hodgson	Appointed Governor, Merton CCG	TH
Kathryn Harrison	Public Governor, Rest of England	KH
Robin Isaacs	Public Governor, Rest of England	RI
Philip Jones	Appointed Governor, Merton Council	PJ
David Kirk	Public Governor, Wandsworth	DK
Yvonne Langley	Public Governor, Wandsworth	YL
Dagan Lonsdale	Staff Governor, Doctors and Dental	DL
Sarah McDermott	Appointed Governor, Wandsworth Council	SM
Derek McKee	Public Governor, Wandsworth	DM
Noyola McNicolls-Washington	Staff Governor, Community Services	NM
Simon Price	Public Governor, Wandsworth	SP
Stephen Sambrook	Public Governor, Rest of England	SS
Khaled Simmons	Public Governor, Merton	KS
Secretariat		
Fiona Barr	Corporate Secretary and Head of Corporate Governance	Trust Secretary
Richard Coxon	Membership & Engagement Manager	MEM

Council of Governors	The quorum for any meeting of the Committee shall be at least one third of the Governors present.

Extraordinary Council of Governors Meeting
15 March 2017
Hyde Park Room, 1st Floor, Lanesborough Wing

Name	Title	Abbreviation
PRESENT		
Sir David Henshaw	Non-Executive Director/Chair	Chair
Mia Bayles	Public Governor, Rest of England	MB
Nigel Brindley	Public Governor, Wandsworth	NB
Jenni Doman	Staff Governor, Non-Clinical	JD
Mike Grahn	Appointed Governor, Healthwatch Wandsworth	MG
Will Hall	Staff Governor, Allied Health Professionals	WH
Hilary Harland	Public Governor, Merton	HH
Kathryn Harrison	Public Governor, Rest of England	KH
Robin Isaacs	Public Governor, Rest of England	RI
Philip Jones	Appointed Governor, Merton Council	PJ
David Kirk	Public Governor, Wandsworth	DK
Dagan Lonsdale	Staff Governor, Clinical and Dental	DL
Sarah McDermott	Appointed Governor, Wandsworth Council	SM
Derek McKee	Public Governor, Wandsworth	DMK
Stephen Sambrook	Public Governor, Wandsworth	SS
Khaled Simmons	Public Governor, Merton	KS
APOLOGIES		
Gail Adams	Public Governor, South West Lambeth	GA
Sue Baker	Public Governor, Merton	SB
Anneke de Boer	Public Governor, Merton	AdB
Patrick Bower	Appointed Governor, Wandsworth CCG	PB
Val Collington	Appointed Governor, Kingston University	VC
David Flood	Staff Governor, Nursing & Midwifery	DF
Frances Gibson	Appointed Governor, St George's University	FG
Stuart Goodden	Public Governor, Wandsworth	SG
Tim Hodgson	Appointed Governor, Merton CCG	TH
Yvonne Langley	Public Governor, Wandsworth	YL
Noyola McNicolls-Washington	Staff Governor, Community Services	NM
Gillian Norton	Non-Executive Director/Chair Designate	NED
Simon Price	Public Governor, Wandsworth	SP
SECRETARIAT		
Fiona Barr	Interim Corporate Secretary & Head of Corporate Governance	Co Sec
Richard Coxon	Membership & Engagement Manager	MEM

OPENING ADMINISTRATION	
Welcome and Apologies	
1.2	Apologies were received from Gail Adams, Sue Baker, Anneke de Boer, Patrick Bower, Val Collington, David Flood, Frances Gibson, Stuart Goodden, Tim Hodgson, Yvonne Langley, Noyola McNicolls-Washington, Gillian Norton and Simon Price.
Declarations of Interest	
1.2	There were no declarations of interests.
Minutes of Meeting held on 16.02.17 and Matters Arising	
1.3	The minutes were accepted as a true and accurate record of the meeting held on 16.02.17 except KH asked that it be made clear that she had chaired the meeting.

BOARD DIRECTOR ROLES	
2.1	**Approval of the Chief Executive Officer (CEO) Appointment** The Chair introduced the paper circulated at the meeting recommending the appointment of the new CEO. Although he had not been part of the recruitment process he had met the shortlisted candidates and was pleased by the strong candidates who had applied for the challenging role.
2.2	The Governors had been involved in the recruitment process by taking part in the stakeholder focus group, KH had been on the shortlisting panel and SB had been the Governor representative on the interview panel.
2.3	KS, asked for a verbal reasoning of why Jacqueline Totterdell had been chosen over the other candidates. The Chair responded that GN and SB who had been on the interview panel were not present to give a response but the panel had been unanimous in their decision. He would ask Mark Gammage, HR Advisor to the Board, to circulate the reasoning behind the selection decision to the Governors. **Action: MG to circulate reasoning on selection decision**
2.4	The Governors were asked to vote to confirm that they approved the decision to appoint Jacqueline Totterdell as CEO. **The majority of Governors voted yes.**
2.5	**Approval to extend term for Associate Non-Executive Director** The Noms & Rems Committee had previously agreed to extend Thomas Saltiel's term of office as Associate NED until the 30.06.17. This would give enough time to advertise for a new NED and Associate NED led by GN as new Chair. The committee recommended to the council to extend Thomas Saltiel's term until the 30.06.17. **The Governors confirmed their approval.**
2.6	**Approval of Deputy Chair Appointment** The Chair Designate had held discussions with the NEDs and Lead Governor and have agreed that Ann Beasley will fill the role of Deputy Chair from 01.04.17 and the Governors were asked for their approval. **The Governors confirmed their approval.**
2.7	**Senior Independent Director Appointment** Following the same discussions, the Chair Designate had agreed with Sir Norman Williams that he would be the Senior Independent Director from the 01.04.17 and the Governors were being consulted on his appointment. **The Governors confirmed their approval.**
Closing Administration	
3 Items for future meetings:	
3.1	• Draft Quality Report • Gender Pay Reporting • CoG Away Day • Annual Cycle of Business • HR Capacity & Demand Model • CoG Effectiveness Review • NED Appraisals 2016-17 • Election of Lead Governor

4 Any Other Business	
4.1	N/A
5 Date and Time of Next Meeting:	
5.1	17 May 2017 in H2.6, 2nd Floor, Hunter Wing

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Council of Governors		
Date:	17 May 2017	**Agenda No**	**6**
Report Title:	Recruitment of a Non-Executive Director		
Lead:	Gillian Norton, Chairman		
Report Author:	Richard Coxon, Membership & Engagement Manager		
Presented for:	Approval		
Executive Summary:	The purpose of this paper is propose the recruitment of a Non-Executive Director. This is due to vacancy created by Gillian Norton being appointed as Chair from the 01.04.17.		
Recommendation:	It is recommended that the Council of Governors endorses the process and timetable to recruit a new NED to fill the vacant position on the Board and that a meeting of the Council of Governors N&RC is convened to agree the detail of the process, agree the job description and the Appointment Panel. The governors are invited to put forward to the Membership Manager any suggestions for essential and desirable criteria to be added to the job description.		
Supports			
Trust Strategic Objective:	All objectives		
CQC Theme:	Addresses all five key themes: Safe, Effective, Caring, Responsive and Well-led		
Single Oversight Framework Theme:	Well-led		
Implications			
Risk:	N/A		
Legal/Regulatory:	The Trust requires an appropriate number of non-executive directors to meet the regulatory standards of a fully functioning Board and to comply with its constitution.		
Resources:	There are no resource implications.		
Previously Considered by:	N/A	**Date**	
Equality Impact Assessment:	N/A		
Appendices:	Appendix 1: NED Role Description Appendix 2: NED Recruitment Timetable		

Recruitment of a Non-Executive Director
Council of Governors, 15 March 2017

1.0 PURPOSE

1.1 The purpose of this paper is to seek approval for the appointment a recruitment consultant to find suitable Non-Executive Director candidates to replace Gillian Norton.

2.0 BACKGROUND

2.1 The St George's Constitution sets outs that the composition of the Board of Directors should comprise a Non-Executive Chairman and six other Non-Executive Directors (NEDs).

2.2 The Trust Board currently has five NEDs following Gillian Norton's appointed as Chairman of the Trust from 01.04.17. Our current five NEDs all have a wealth of experience and knowledge:

- Ann Beasley – Civil Service/Finance
- Stephen Collier – Private Healthcare
- Jenny Higham – Principal of St George's University, Consultant Obstetrician & Gynaecologist
- Sir Norman Williams – Retired Surgeon, Special Adviser to the Secretary of State
- Sarah Wilton – Senior Accountant, Magistrate

3.0 APPOINTMENT PROCESS FOR A NEW NON-EXECUTIVE DIRECTOR

3.1 Whilst there is a template job description for the role of NED (see Appendix 1), the Governors Nomination & Remuneration Committee (N&RC) will review this with the Chairman and identify any other skills/experience required on the Trust Board. They may also look at other factors to ensure that the Board reflects the diversity of the local population that the hospital serves.

3.2 It is proposed that we use an external recruitment agency to help us find suitable candidates as we lack the experience and capacity to do this in house. We have recently used an external agency, Gatenby Sanderson Executive Recruitment, to good effect to assist us in finding high calibre applications for the Chairman, Chief Executive Officer, Chief Finance Officer and three Non-Executive Director roles. There will need to be an appropriate procurement process for this though it has been built into the timetable.

3.3 The N&RC will lead on the recruitment process on behalf of the Council of Governors and agree an Appointments Panel which will consist of the Chairman, at least two elected Governors and one appointed Governor. Also, given the successful recruitment of the Chairman, it is proposed that the best practice and format from this process is re-used.

3.4 The governors are invited to consider any particular essential or desirable criteria that should be included in the NED job description and are encouraged to put these forward to the Membership Manager on behalf of the Chairman. These will be considered by the N&RC which will finalise the job description.

3.5 Suggest essential or desirable experience includes people who have experience of:

- Large and complex organisations;

- Major transition and re-engineering of services;
- Strategic leadership;
- Specific skills in key areas such as;
    - marketing;
    - legal;
    - risk management;
    - governance;
    - commercial;
    - commissioning;
- Financial or acumen.

3.6 The timetable for recruiting a new NED is presented at Appendix 2.

4.0 RECOMMENDATION

4.1 It is recommended that the Council of Governors endorses the process and timetable to recruit a new NED to fill the vacant position on the Board and that a meeting of the Council of Governors N&RC is convened to agree the detail of the process, agree the job description and the Appointment Panel. The governors are invited to put forward to the Membership Manager any suggestions for essential and desirable criteria to be added to the job description.

Appendix 1

Draft Non-Executive Director Job Description

The Non-Executive Director will work alongside the Chair, other Non-Executive Directors and Executive Directors of the existing Trust Board to advise on the development of strategy and oversee the performance of the Trust. Non-executive directors form part of a unitary Board with the Executive Directors, but are responsible for determining appropriate levels of remuneration of executive directors and have a prime role in appointing and, where necessary, removing executive directors. Governors hold the Non-Executive Director individually and collectively to account.

The successful appointee will share responsibility with the other Directors for the success of the organisation using the available resources to deliver healthcare and improving the health of local people. They will bring independent and objective judgement to bear on issues of strategy, performance and resources.

As a Non-Executive Director your role will be to use your skills and your personal experience as a member of your community to contribute to the work of the Board.

Responsibilities to include the following:

- Contribute to the development of strategic plans to enable the organisation to fulfil its leadership responsibilities for healthcare of the local community.
- Ensure that the Board sets challenging objectives for improving its performance across the range of its functions.
- Monitor the performance of the executive team in meeting the agreed goals and improvement targets.
- Ensure that financial controls and systems of risk management are robust and that the Board is kept fully informed through timely and relevant information. (You may be asked to sit on the Audit Committee or other sub-committees of the Board.)
- Accept accountability for the delivery of the organisation's objectives and ensure that the board acts in the best interests of its local community.
- Take part in the appointment of the Chief Executive and other senior staff when necessary (and to sit on the Nominations and Remuneration Committee, to decide on their remuneration).
- Ensure that the organisation values diversity in its workforce and demonstrates equality of opportunity in its treatment of staff and patients and in all aspects of its business.
- Take a personal responsibility to ensure that they do not discriminate, harass or bully or contribute to the discrimination, harassment or bullying of any colleague(s) or visitors or condone discrimination, harassment or bullying by others.

To complement the skills of the existing Board, the Trust would like to hear from candidates who can demonstrate the following skills/expertise:

Candidates will be assessed initially against the essential 'expertise' identified above. Where candidates are able to demonstrate that they have the essential expertise, we will use the desirable expertise to differentiate between candidates of equal merit when assessed against the essential expertise. Candidates should note that they are not expected to have experience in all of the areas identified.

In addition to the expertise detailed above, all candidates interviewed will need to show that they have the competencies required to be effective in a board level role.
They are:

Patient and community focus	A high level of commitment to patients, carers and the community, especially to disadvantaged groups.
Strategic direction	The ability to think and plan ahead, balancing needs and constraints.
Holding to account	The ability to accept accountability and probe and challenge constructively.
Effective influencing and communication	Be able to influence and persuade others.
Team working	Be committed to working as a team member.
Self-belief and drive	The motivation to improve NHS performance and confidence to take on challenges.
Intellectual flexibility	The ability to think clearly and creatively.

Induction and Training

The Trust will organise appropriate induction and training for the successful candidate. Healthcare experience is not essential.

Time Commitment

The successful candidate will need to devote sufficient time to ensure satisfactory discharge of his/her duties. This may mean up to six days per month.

This will comprise a mixture of set commitments (such as a monthly Board meeting and Committee meetings) and more flexible arrangements for ad hoc events and reading and preparation. A degree of flexibility will be required and some time commitment may be during the evening.

Remuneration

- This post attracts a remuneration of £12,000 per annum.
- Remuneration is taxable and subject to National Insurance Contributions. It is not pensionable.
- You will be eligible to claim allowances for travel and subsistence costs necessarily incurred on Trust business.

Appointment and Term of Office

- The appointment will be for an initial period of up to three years and will be subject to annual performance reviews.
- The appointment is subject to a Fit and Proper Persons test.

- While you will act as a consultant/advisor to the Board you will not be an employee of the Trust so the role is not subject to the provisions of employment law. To ensure that public service values are maintained at the heart of the National Health Service, all Directors are required, on appointment, to subscribe to the Codes of Conduct and Accountability enshrined in the Trust Board Policies and Procedures.
- You must demonstrate high standards of corporate and personal conduct. Details of what is required of you and the Trust Board you serve are set out in the Codes of Conduct and Accountability enshrined in the Trust Board Policies and Procedures.
- You should note particularly the requirement to declare any conflict of interest that arises in the course of Board business and the need to declare any relevant business interests, positions of authority or other connections with commercial, public or voluntary bodies.

Criteria for Disqualification

Not everybody is eligible to be appointed to an NHS body. All appointments are governed by legislation which details the circumstances in which individuals may be disqualified. They do vary, but you may not serve as a Non-Executive if, at the same time, you are a:

- **Chair or Non-Executive of another NHS body including** all Clinical Commissioning Groups and NHS Trusts. There are exceptions relating to those serving on some Special Health Authorities.
- **Member of staff employed by the NHS** including honorary or unpaid medical or dental posts. There are one or two exceptions in prescribed circumstances.
- **Practising healthcare professional** including practising GPs, General Dental Practitioners and their employees and people who have been removed from or suspended from a list of Part II practitioners, in some circumstances.
- **Serving MP** including MEPs and candidates for election as MP or MEP.

Other circumstances

- People who have received a prison sentence or suspended sentence of 3 months or more in the last 5 years;
- People who are currently the subject of a bankruptcy restriction order or interim order;
- Anyone who has been dismissed (except by redundancy) by any NHS body;
- In certain circumstances, those who have had an earlier term of appointment terminated;
- Anyone who is under a disqualification order under the Company Directors Disqualification Act 1986;
- Anyone who has been removed from trusteeship of a charity.

Monitoring/Diversity information

St George's University Hospitals NHS Foundation Trust welcomes applications from all sections of the communities the Trust serves. The Trust recognises that everyone is different, valuing the unique contribution that individual experience, knowledge and skills can make in delivering service goals and that is visible and apparent at all levels of the organisation including the Trust Board. All appointments are based on merit and the principles of openness and transparency of process.

Appendix 2

NED Recruitment Timetable

Week 1	N&RC meet and agree JD and recruitment process
Week 2	Invite bids from selected companies using procurement guidelines
Week 3	Evaluate bids and agree which company provides best value and most experience for the role being recruited. Prepare appropriate financial authority (purchase order form) and appointment letter.
Week 4	Candidate search begins and job advert normally placed in national press (Sunday Times) with closing date (3/4 weeks hence) and interview date (4-5 weeks after closing date).
Week 5	*Recruitment Consultants will submit weekly reports of applications received and candidates they have approached.*
Week 6	*Recruitment Consultants will submit weekly reports of applications received and candidates they have approached.*
Week 7	*Recruitment Consultants will submit weekly reports of applications received and candidates they have approached.*
Week 8	Closing date – Recruitment Consultants provide list of applications categorised A, B and C, depending on strength of application.
Week 9	If a large number of applications received the N&RC will meet to long list candidates or shortlist if a small number.
Week 10	Preliminary interviews by consultants.
Week 11	*Arrange and agree focus groups and timetable for interview day.*
Week 12	*Arrange and agree focus groups and timetable for interview day.*
Week 13	Focus Groups and Panel Interviews, N&RC to agreed decision immediately and CoG to formally approve appointment as soon as possible afterward.

Author: **Richard Coxon, Membership & Engagement Manager**
Date: **03.05.17**

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Council of Governors		
Date:	17 May 2017	**Agenda No**	**7**
Report Title:	Annual Self Assessment of Compliance with Foundation Trust Licence		
Lead:	Fiona Barr, Trust Secretary and Head of Corporate Governance		
Report Author:	Michael Wuestefeld-Gray, Corporate Governance Advisor		
Presented for:	Approval		
Executive Summary:	Each year all Foundation Trusts must make a submission of their self-assessment of compliance with their licence conditions. The submission covers three licence conditions: • Appropriate risk management processes and systems are in place (condition G6) • There are sufficient resources to deliver services over the coming 12 months (condition CoS7) • The Trust has appropriate governance structures and systems in place (condition FT4) • The Trust has provided adequate and appropriate training to its governors.		
Recommendation:	Governors are asked to review the proposed response to each area where self-certification is required and indicate whether they accept the proposed response; and if they have any comments of suggestions that the Board should consider prior to final approval.		
Supports			
Trust Strategic Objective:	All objectives		
CQC Theme:	Addresses all five key themes: Safe, Effective, Caring, Responsive and Well-led		
Single Oversight Framework Theme:	Well-led		
Implications			
Risk:	N/A		
Legal/Regulatory:	An assessment of compliance with licence conditions is required annually.		
Resources:	There are no resource implications.		
Previously Considered by:	N/A	**Date**	
Equality Impact Assessment:	N/A		
Appendix:	None		

Introduction

NHS Improvement requires the Trust to self-certify on 3 licence conditions and one further activity, the training of governors. NHS Improvement will ensure compliance by auditing selected trusts' responses.

This is a slightly different approach than in previous years, and is not in line with the approach taken with some other regulatory submissions such as NHS Digital's annual Information Governance Toolkit Submission.

What is required?

The Trust must self-certify that it:

- Has appropriate risk management processes and systems in place (condition G6)
- Has sufficient resources to deliver services over the coming 12 months (condition CoS7)
- Has appropriate governance structures and systems in place (condition FT4)
- Has provided adequate and appropriate training to its governors.

The submission is made online. For each condition or activity the Trust must either:

- Confirm it has complied with the specific requirement; or
- Confirm it has not complied with the specific requirements, and explain why.

Where the Trust has complied there is no option to include free text.

The submission must be signed off by the Board and take due account of the opinion of the Council of Governors. Submissions must also be published.

Recommendation

Governors are asked to review the proposed response to each area where self-certification is required and indicate whether they accept the proposed response; and if they have any comments of suggestions that the Board should consider prior to final approval.

Next Steps

A final form of words will be drafted for approval by the Board at its meeting on 31 May 2017, which is the meeting to sign off the Annual Report and Accounts.

The deadline for submission of all self-certifications except for FT4 is 31 May 2017. For FT4 it is 30 June 2017, but there is no reason not to provide all responses at the same time.

Key Questions and Suggested Responses:

G6: Has the Trust taken appropriate steps to establish, review and maintain systems to identify and effectively manage risks?

Suggested response: Confirmed. This is because has taken appropriate steps, in that the risk register and Board Assurance Framework have undergone recent reviews and I understand are to be subject to an external review as part of wider support to Trust governance. The risk management lead has appropriate expertise and there is an established Risk Management Committee with robust input and challenge from non-executive directors.

CoS7: As the date of submission does the Trust apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate as an NHS provider? And does it foresee applying them over the 17/18 financial year

Suggested response: Confirmed. This statement is forward looking and there is no standard model against which governance systems can be assessed. Guidance is that for 'confirmed' there should be effective Board and committee structures, reporting lines, and performance and risk management systems, which the Governance Team has worked and is working hard to develop.

FT4: Does the Trust have a reasonable expectation that it will have the required resources available, taking into account any liabilities and expected income/savings, that it needs to deliver services for the next 12 months?

Suggested Response: Not Confirmed. The Trust is under both quality and financial special measures due to regulatory determinations that it is in breach of its licence under conditions FT4(5), (6) and (7). The Trust is working with NHS Improvement to deliver on the improvement undertakings, including a financial recovery plan, it has entered into as part of exiting special measures.

Training of Governors: has the Trust taken steps to ensure governors are equipped with the skills and knowledge they require?

Suggested response: Confirmed. There is dedicated time built in to the council of govs annual plan to formally review the training needs of governors. On appointment governor training needs are assessed and training provided if required through an induction process. Arrangements are made for governors to attend training and networking events. There was a joint Council-Board held in July 2016 and a Governor/NEDs away day in November 2016. Structured time is being built into the Governor programme in 2017-18 to ensure that the Governors and NEDs can meet on a regular basis.

Governors with a DBS check and who have been trained have also been involved in mock CQC inspections. The Trust aims to offer training to enhance governors' role and encourage them to attend Governwell Governor networking events and courses. The governors were also had an NHS Finance workshop at their Away Day in November 2016 given by the Director of Finance and were invited to a presentation on RTT given to the Board members in April 2017 by the Programme Director Elective Care (data quality) Recovery. Governors are also encouraged to 'chair' the monthly Health Talks for members.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Council of Governors		
Date:	17 May 2017	**Agenda No**	**8**
Report Title:	Draft Annual Cycle for Council of Governor Business		
Lead:	Gillian Norton, Chairman		
Report Author:	Fiona Barr, Trust Secretary and Head of Corporate Governance		
Presented for:	Approval		
Executive Summary:	The purpose of this paper is propose an Annual Cycle of business to guide the work of the Council of Governors. The Annual Cycle has been developed with reference to the Monitor Code of Governance and drawing on best practice from working with other Councils of Governors.		
Recommendation:	The Council of Governors is invited to consider the draft Annual Cycle of Business and propose any additions or changes.		
Supports			
Trust Strategic Objective:	All objectives		
CQC Theme:	Addresses all five key themes: Safe, Effective, Caring, Responsive and Well-led		
Single Oversight Framework Theme:	Well-led		
Implications			
Risk:	N/A		
Legal/Regulatory:	Having an Annual Cycle is in line the principles of good governance and provides focus and direction for the work of the Council of Governors.		
Resources:	There are no resource implications.		
Previously Considered by:	N/A	**Date**	
Equality Impact Assessment:	N/A		
Appendix:	Appendix 1: Draft Annual Cycle for the Council of Governors		

St George's University Hospitals NHS
NHS Foundation Trust

Annual Cycle for the Council of Governors

Item	When
Declaration of Interests	Every Meeting
Minutes	Every Meeting
Matters Arising	Every Meeting
Report from the Chairman	Every Meeting
Report from the CEO	Every Meeting
Report from Governors attending Board Committees	Every Meeting
Quality Account and External Auditor's Report	May
Self-Assessment against Foundation Trust Licence	May
Outcome of Chair and NED Appraisals	May
Annual Review against Code of Governance	May
Quality Account Update	July, September/October, December, February
Annual Review of Membership Strategy and Membership & Engagement Programme	July
Annual Review of Governor Skills and Training Needs	July
Receive the Trust's Annual Report & Account and Quality Account (usually at the Annual Members' Meeting)	September/October
Annual Refresh of Membership Strategy	September/October
Annual Review of Role of Lead Governor	September/October
Plans for Next Year's Elections	September/October
Chair and NED Appraisal Process	December
Governor Input into Annual Plan	December
Welcome to New Governors	February
Annual Declaration against Fit & Proper Person's Test	February
Annual Declaration of Interests	February
Annual Review of Effectiveness of Council of Governors	February

As required:

- External Auditors
- Appointment of Non-Executive Director (likely to be September 2017)
- Approval of the appointment of the CEO
- Approval of amendments to the Constitution
- Making Decisions on Significant Transactions
- Making Decisions on non-NHS Income
- Feedback from:
    - Patient Safety Walkarounds
    - Committees attended
    - Governor groups
    - Membership activity

Each year there will also be:

- Annual Members Meeting
- At least one workshop with the NEDs or full Board

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Quality Account 2016/17 – Update to Council of Governors**		
Date:	Wednesday 17 May	**Agenda No.**	**9**
Report Title:			
Lead Director/ Manager:	Paul Linehan – Head of Quality Governance		
Report Author:	Sharna Reeves – Communications Consultant (Quality Account)		
Freedom of Information Act (FOIA) Status:	Unrestricted Restricted		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	This paper provides a summary update on activity relating to the trust Quality Account for 2016/17.		
Recommendation:	To review the Quality Account for 2016/17 (draft v10) for information.		
Supports			
Trust Strategic Objective:	Supports trust objectives for proving high quality and safe care for patients.		
CQC Theme:	Patient safety, patient experience, effectiveness, caring and leadership.		
Single Oversight Framework Theme:	Single Oversight Framework (SOF) requirement.		
Implications			
Risk:	No applicable.		
Legal/Regulatory:	Mandatory requirement for production of the Quality Account 2016/17.		
Resources:	Project Manager in place.		
Previously Considered by:		**Date:**	
Equality Impact Assessment:			
Appendices:			

Quality Account 2016/17 – Summary paper
Council of Governors – 17 May 2017

1.0 PURPOSE

1.1 To update the Council of Governors on progress relating to the trust Quality Account for 2016/17.

2.0 CONTEXT

2.1 The Quality Account 2016/17 will form part of the trust Annual Report and Accounts.

2.2 The Quality Account and Annual Report and Accounts for 2016/17 will be formally submitted to NHS Improvement on Wednesday 31 May and uploaded onto the NHS Improvement portal on 30 June.

2.3 Statements from Stakeholders to the trust (forming part of the Quality Account) are expected on Monday 15 May 2017. Wandsworth CCG has indicated that they will submit their feedback and statement on Wednesday 17 May, after the draft Quality Account has been submitted to their governance committee meeting on Tuesday 16 May.

3.0 ANALYSIS

3.1 All content for the Quality Account has been submitted to Sharna Reeves (Communications Consultant – Quality Account) by trust authors.

3.2 The Quality Account has been reviewed by our external auditors, Grant Thornton. Suggestions for minor amendments have been made (in line with NHS Improvement guidelines). No major issues or areas of concern have been raised.

3.3 We are fully confident that the Quality Account for 2016/17 will be complete for formal submission to NHS Improvement on 31 May. The Quality Account currently stands at draft version ten.

4.0 IMPLICATIONS

Risks

4.1 No current risks identified.

Legal Regulatory

4.2 NHSI Statutory Reporting Framework.

Resources

4.3 Additional resource in place from 27 March 2017 for three months, to support drafting and submission of the trust Quality Account 2016/17 to NHS Improvement on 31 May.

5.0 NEXT STEPS

5.1 The 2016/17 Quality Account will be presented to EMT for final draft approval on Monday 22 May.

5.2 The 2016/17 Quality Account will be submitted to the trust Quality Committee for final draft approval on Tuesday 23 May.

5.3 The 2016/17 Quality Account will be submitted to the trust Communications Team for final proofing week commencing 22 May.

5.4 The 2016/17 Quality Account will be submitted to the trust board for final draft review and approval on Wednesday 31 May.

5.5 The final 2016/17 Quality Account will be submitted to NHS Improvement as part of the trust Annual Report and Accounts on Wednesday 31 May.

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6.0 RECOMMENDATION

6.1 That the Council of Governors notes the current status of the trust Quality Account for 2016/17.

Author: Sharna Reeves (Communications Consultant – Quality Account)

St George's University Hospitals NHS
NHS Foundation Trust

St George's University Hospitals NHS Trust

Quality Accounts 2016/17

DRAFT v10 10 May 2017

What we are responsible for/certificate

Grant Thornton

DRAFT - Chief executive's statement on quality

Providing high quality care to our patients is our number one priority, and we need to ensure we put quality – and the safety of our patients – at the forefront of everything we do.

The Care Quality Commission's inspection report for St George's, published in November following their visit in June 2016, raised concerns about the quality of care the trust provides in certain areas, and we were placed in special measures for quality as a result.

We are developing a Quality Improvement Plan to help us address the issues identified by the CQC. But our plan needs to be about much more than this – we need all 9,000 of our staff, wherever they work, to want to make St George's better for patients, and the communities we serve.

This means engaging staff in the quality improvement process – which involves listening to their concerns, and taking time to truly understand where they feel improvements need to be made. This is a key priority for us over the coming months, and crucial to us achieving the step-change in quality we all believe the organisation needs.

Last year, the trust set out a range of quality ambitions under the headings of *Patient Safety, Patient Experience* and *Patient Outcomes*.

As you will read in the report that follows, we have made significant progress in some areas; for example, our Standard Hospital Mortality Rate (SHMR) is 81%, an improvement from 85% in 2015. We are also prioritising our care for patients with dementia and delirium, and in the past year have established a new and improved delirium pathway.

In all areas, there is still a huge amount to do; we still need to deliver much needed improvements to the way in which we handle and manage complaints. Whilst every complaint is one too many, we need to maximise our learning from them, so as to help us prevent a recurrence in the future.

Quality priorities for 2017/18

For the coming year, we have set new ambitions, whilst also making sure we build on the work already started.

These priorities have been agreed with our stakeholders and governors, who play a crucial role in helping to shape our quality ambitions for the organisation.

Our priorities include:

- Improved Early Warning Score documentation
- Staff survey response increase
- Improved response rate for complaints against the 25 day target
- Reduction of day theatre cancellations by 40%
- A comprehensive clinical review process for in-hospital deaths

Given our financial and performance challenges, it is my job, and that of the senior team, to ensure we retain our focus on quality, as that is what our patients rightly expect us to do.

Jacqueline Totterdell
Chief Executive
XXX 2017

Duty of Candour

Paul Linehan to finalise copy.

‘Duty of Candour’ formally came into force on 27 November 2014 for NHS Trusts, Foundation Trusts, and Special Health Authorities in England

The trust has a legal duty to be open and transparent when there has been negligence relating to a patients care. This process helps patients to receive accurate, truthful information from hospitals and other healthcare providers and also sets out specific requirements that the trust must follow when there are issues with patient care and treatment.

This includes informing the appropriate individuals about an incident, providing reasonable support, providing truthful information and apologising if there is proven negligence on behalf of the trust.

Openness and transparency

The trust has an obligation to be open and transparent: In terms of duty of candour:

- Open’ means enabling concerns and complaints to be raised freely without fear and questions asked to be answered
- ‘Transparent’ means allowing information about performance and outcomes to be shared with staff, patients, the public and regulators.

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 fundamental 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.

The CQC inspection framework focuses on 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.

CQC Inspection in 2016

The trust was rated as **good** overall in a 2014 CQC comprehensive inspection. A further comprehensive inspection in June 2016 rated the trust as **inadequate**. This most recent inadequate rating reflects a marked deterioration in the safety and quality of some of the trust services as well as to its overall governance and leadership.

Whilst the CQC have rated the trust as inadequate overall, they noted good care in several areas and some outstanding practice in maternity. The trust was rated as **good** overall under the CQC 'Caring' domain.

It is important to note that at the time of the inspection, the trust had introduced a range of supportive and recovery mechanisms as a means of stabilising the organisation. An interim chair and chief executive had been appointed to offer the organisation direction and to develop a robust and deliverable recovery plan. A number of interim appointments had been made to ensure there was focused leadership in place to implement the organisation's recovery plan.

The executive team was clear about the challenges that they and the trust faced and acknowledged the need for significant improvement across the organisation. Key substantive appointments were made to the non-executive board, which included the appointment of individuals with significant experience and expertise in regards to improving patient safety.

Other contributing factors for the deterioration in the trust's overall CQC rating include; *neglect of maintenance of its buildings, failure to ensure the requirements of the fit and proper persons regulation*

had been implemented and a leadership culture which was weighted towards trying to achieve financial stability, which inadvertently impacted on the quality of services being provided.

Members of the executive and non-executive recognised that an attitude of 'learnt helplessness' existed across the organisation. Both the Chairman and Chief Executive recognised the need to improve staff engagement, to develop a long term sustainable vision and strategy for the organisation and to reintroduce accountability and strong leadership across all divisions within the trust.

Section 29A Warning Notice

Following their June inspection, the CQC issued a letter of intent to the trust proposing to take urgent enforcement action under Section 31 of the Health and Social Care Act, 2008 due to the state of disrepair of some buildings at St George's Hospital. In response to this action by the CQC, the trust took appropriate improvement measures which resulted in the CQC warning notice being withdrawn.

However, the CQC issued a Section 29A Warning Notice to the trust in August 2016 for breaches in regulations that required significant improvement regarding *premises and equipment, mental capacity assessments and best interest decisions, good governance* and the *fit and proper persons requirement.*

Under the 29A Warning Notice, the CQC determined that within the trust:

1. There were unsafe and unfit premises where healthcare is provided and accommodates staff
2. There was a lack of formal mental capacity assessments and best interest decision making and that some patients had decisions made for them that they were capable making themselves
3. The design and operation of the governance arrangements were not effective in identifying and mitigating significant risks to patients
4. Risks to the delivery of high quality care were not being systematically identified, analysed and mitigated
5. Staff were not being held to account for the management of specific risks
6. There were a lack of processes in place to provide systematic assurance that high quality care is being delivered; priorities for assurance had not been agreed and were not kept under review. Effective action had not been taken when risks were not mitigated
7. The data used in reporting, performance management and delivering high quality care was not robust and valid
8. There were not suitable arrangements in place for ensuring that directors are fit and proper

The trust implemented an immediate action plan in response to the Section 29A warning and wrote to the CQC in November 2016, confirming that actions relating to the issues identified had either been completed or were being addressed.

Actions that the trust has taken in response to the Section 29A Warning Notice is outlined in the progress report table below. An assurance rating is also provided against each action:

RED	Not assured
AMBER	Assured of progress to date but requires on-going monitoring and surveillance to ensure full compliance. An amber rating does not imply that the trust has taken sufficient action but rather that full delivery of the work plan requires more time due to scale of the issue or complexity involved in delivery. In this case the CQC will review the work plan, risk management approach, mitigation in place to ensure patient safety, timescales and achieving key milestones for delivery
GREEN	Fully assured

CQC Section 29A Warning Notice - Trust Progress Report, April 2017

Patient safety issue and compliance matter	Status	Comments / concerns	Assurance rating
1. Maintenance and refurbishment of Operating Theatres	On-going	There are a total of 16 theatres that require full or partial refurbishment. Theatres 5&6 have been completed and 2 further theatres are due to commence in June 2017. It takes approx. 5 months to fully refurbish 2 theatres. The timescale for full refurbishment is 3-4 years. Significant maintenance and surveillance is in place to maintain patient safety and respond quickly to any risks that emerge. This has been RAG rated amber as significant work and investment is required over a number of years to deliver the theatre refurbishment plan.	
2. Lack of capital investment in Lanesborough, St James's and Paul Calvert Theatres	On-going	Addressed via above action (No 1).	
3. Theatre air handling units in St James Wing failing	Complete	As per the action (No 1), above. Significant new plant, routine planned maintenance and surveillance is in place to maintain patient safety and respond quickly to any risks that emerge.	
4. Thermoregulation on Lanesborough Theatre 1	On-going	Addressed via above action (No 1), new plant, routine maintenance and automated surveillance is in place to maintain patient safety and respond quickly to any risks that emerge.	
5. Repair of Maternity Staff Room Roof in Lanesborough Wing	Complete	None. The cause of the original leak has been replaced and the drainage repaired. There have been no repeats of the original fault.	
6. Continued occupation of Wandle Unit after fire concerns identified	Complete	None. The original Wandle Annex has been demolished and replaced with a brand new modular building.	
7. Conclude renal unit patient moves from Buckland Ward, Knightsbridge Wing	Complete	None.	
8. Assure fixed wire installation compliance across the SGUH site	On-going	The fixed wire test is on-going and progressing well but is not fully complete at the time of this report. There is documented evidence of the testing schedule and that CQC accept the plan as evidence of addressing this area of compliance.	
9. Water Safety Management – Legionella Contamination	On-going	The CQC wanted to review evidence of twice weekly flushing records to demonstrate the mitigation of risks to patients. These have been 100% compliant since September 2016. There have been two external expert assessments of our water safety programme (one from the HSE and one from an ex-HSE Inspector) and the reviews have made a number of recommendations which are being actioned and monitored via the Water Safety Committee (WSC).	

Patient safety issue and compliance matter	Status	Comments / concerns	Assurance rating
		A programme of work is in place which involves the trust undertaking regular tests on water samples using a risk based approach, treating appropriately if levels are high and then re-testing, use of tap filters as indicated, the on-going removal of 'dead legs' in the pipework and a replacement programme of sinks and taps. There remains further work to address particular issues in relation to supply between Grosvenor Wing and the Medical School and availability of accurate schematic drawings. Overall the risk to patients is adequately mitigated but relentless focus is required to keep this under control. This issue is kept under review by the Patient Safety Quality Board and Infection Prevention and Control Committee to which the WSC reports.	
10. Water Safety Management - Pseudomonas	On-going	This is particularly relevant to areas of augmented care for example renal dialysis and Intensive Care Units as it requires low use water outlets to be flushed every 24 hours. Ideally all low use outlets would be removed however bays or bed areas can be closed or simply not be occupied for a period of time so outlet usage can fluctuate from normal to low use. It is essential that we can demonstrate that these low use outlets are recognised and are being flushed in line with requirements. We have two consecutive months' data demonstrating 100% compliance and by end of April we will have three months. Work is underway to all agree a combined approach which is more efficient and sustainable for both Legionella and Pseudomonas.	
11. MCA Policy requires updating	Complete	None.	
12. Awareness amongst staff of care interventions that might constitute restraint – bed rails and use of mittens to prevent removal of NG tubes	On-going	No patient (whether they have capacity or not) have decisions made for them without informed consent or formal mental capacity assessment and best interest decisions being taken and clearly documented). A significant amount of work has been done to train and educate staff on understanding the Mental Capacity Act and its' application in practice. Training is available both face to face and via e learning. Risk assessments have been introduced for bed rails and the use of mittens and are being completed. Further work is required to ensure consistency across the 3 of the 4 wards identified as concerns by the CQC. Gwynne Holford (1 of the 4 wards) has taken an exemplar mufti professional approach in	

Patient safety issue and compliance matter	Status	Comments / concerns	Assurance rating
		fully addressing this issue which has been led by the medical staff and supported by nursing and allied health professionals. This area will continue to be regularly tested in practice as well as comprehensive twice yearly audits on mental capacity assessments and deprivation of liberty safeguards.	
13. Recording of MCA and Best Interest Decisions	On-going	As above in action 12, significant progress has been made but consistency is still an issue. Comprehensive twice yearly audits will be undertaken as well as regular spot checks and assessment during internal compliance inspections.	
14. Fragmentation of Hospital and Community End of Life Care Teams	On-going	The objective for end of life care (EoLC) is that every patient has a dignified death. There is one recommended change to ensure that the trust meets this standard. The EoLC strategy was approved at Trust board in December 2016 together with a comprehensive implementation plan. The plan includes indicators and outcomes through to 2020. The plan includes milestones for delivery at corporate and divisional/ directorate level and these are broken into deliverable, time specific measurable pieces of work. Delivery is monitored at the Community Services divisional performance reviews and the EoLC steering committee. To ensure seamless coordinated care there are now monthly meetings between acute and community staff. Access to training resources and services are equitable across community and acute. The Trust is also fully engaged with the NHSI EoLC collaborative	
15. Risk Management process insufficient	On-going	Risk management systems and processes have been strengthened. There remains concern about the trusts overall clinical and corporate governance. An external review has been commissioned which is due to commence as soon as possible.	
16. Timeliness of reporting & investigating Sis, particularly in Surgery Division	Complete	This is monitored at the weekly serious incident panel.	
17. RTT Waiting List Management	On-going	A significant programme of work is underway but remains non-compliant and requires continued dedicated resource and focus to improve our processes, train our staff and manage the clinical risk for our patients.	
18. Monitoring serial numbers for FP10 prescription pads, particularly in OPD	Complete	None.	
19. Radiographers administering contrast media	Complete	None.	

Patient safety issue and compliance matter	Status	Comments / concerns	Assurance rating
without authorised PGD in place			
20. Inadequate compliance with Fit & Proper Person Checks amongst board Members	On-going	System and processes to improve this are in place however due to the significant current transition of board members this area that requires regular assessment to ensure all aspects for all directors are complete.	
21. Workforce Race Equality Standards (WRES) 2015 published without presentation to the Board	Complete	None.	

Overall CQC inspection rating

The CQC rated 60 specific standards across the trust during their inspection in June 2016. Out of these:

- 1 was rated as outstanding
- 27 were rated as good
- 23 were rated as requires improvement
- 8 were rated as inadequate

The full breakdown of how our hospitals performed against each of the five CQC essential domains is set out in the following tables.

CQC ratings for St George's Hospital - Tooting

Service	CQC essential domain – safe	CQC essential domain – effective	CQC essential domain – caring	CQC essential domain – responsive	CQC essential domain – well led	Overall
Urgent and emergency services	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Medical Care	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Surgery	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Critical Care	Requires Improvement	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Outstanding	Good	Good	Good	Good
Services for children & Young People	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
End of Life	Requires	Requires	Good	Good	Requires	Requires

care	Improvement	Improvement			Improvement	Improvement
Outpatients and diagnostic imaging	Requires Improvement	Not rated	Good	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

CQC ratings for Community Services

Service	CQC essential domain – safe	CQC essential domain – effective	CQC essential domain – caring	CQC essential domain – responsive	CQC essential domain – well led	Overall
Community health services for adults	Good	Good	Good	Good	Requires Improvement	Good
Community health services for children, young people and families	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Community health inpatient services	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate
Community End of Life Care services	Requires Improvement	Inadequate	Good	Requires Improvement	Inadequate	Inadequate
Overall Community	Requires Improvement	Requires Improvement	Good	Requires Improvement	Inadequate	Requires Improvement

CQC ratings for St George's University Hospitals NHS Foundation Trust

Service	CQC essential domain – safe	CQC essential domain – effective	CQC essential domain – caring	CQC essential domain – responsive	CQC essential domain – well led	Overall
Overall	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate

The CQC reported its findings back to us at a quality summit that included representatives from:

- St George's University Hospitals NHS
- Foundation Trust
- The CQC
- NHS Improvement
- NHS England
- Wandsworth Council
- Healthwatch Wandsworth

- Wandsworth CCG
- Merton CCG

In its report on the trust, the CQC highlighted several areas of outstanding practice:

- Outcomes for renal patients in relation to survival rates and transplantation were excellent and were amongst the best in the country
- The outcomes achieved by the specialist medical and surgical services provided by the hospital
- The effectiveness of maternity care delivered by the hospital
- The responsiveness of the neonatal unit to parents whilst their baby was on the unit and the support provided by the outreach nurse
- The involvement of children of varying ages on the interview panel as part of the recruitment process for ED paediatric nurses

The CQC reported that the trust must take actions to improve:

- Develop a long term strategy and vision
- Move towards having a stable, substantive leadership team
- Ensure all premises and facilities are safe, well maintained and fit for purpose
- Ensure all care is delivered in accordance with the Mental Capacity Act, 2005, when appropriate
- Review and implement robust governance processes, so that patients receive safe and effective care. Ensure RTT data is robust and accurate so that patients are given appointments and treatment based on their needs and within national targets
- Ensure serial numbers of prescriptions (FP10s) for prescribers are always monitored for use
- Ensure radiographers only administer medication (contrast media) where appropriately authorised
- Patient Group Directions (PGDs) are in place
- Ensure the fit and proper persons' requirement regulations for directors are always complied with
- Ensure the paediatric ward environment, staffing and training requirements are suitable for treating and caring for children and young people with mental health conditions
- Ensure medicines are stored in an appropriate manner, by keeping cupboards locked when not in use
- Ensure the process for decontamination of nasoendoscopes is compliant with guidance

The CQC also reported that the trust should:

- Maintain patient privacy, dignity and confidentiality at all times
- Review the fluid storage within the ED major incident cupboard to ensure that training equipment is not stored with 'live' equipment
- Ensure that staff consistently follow guidance related to the prevention of healthcare associated infections with specific regard to hand hygiene
- Ensure medical equipment across the trust stored on is cleaned and that there are systems in place for monitoring the cleanliness of equipment returned to the ward
- Ensure all staff caring for children receive level 3 safeguarding training
- Ensure the process for investigating serious incidents is timely and undertaken by people trained in investigation so they understand the root causes of an
- incident and identify measurable action
- Minimise the cancellation of operations and when this cannot be avoided, they are rescheduled within 28 days
- Reduce the moves of patients to wards that are not appropriate
- Ensure that staff use the early warning scoring system effectively, including the timely escalation of deteriorating patients to relevant personnel
- Ensure divisional and trust priorities are shared by personnel of all grades and professions who work together to promote the quality and safety of patient care

- Address the low morale among theatre staff and consultant surgeons
- Replace damaged chairs and furniture within patient areas so that they can be thoroughly cleaned
- Ensure that all patients within the ED 'streaming' area are assessed within a private area
- Ensure staff can observe the patients whilst they are waiting in their outpatient departments
- Ensure patient electronic records are not easily visible or their paper records are not easily accessible by the public
- Improve the percentage of telephone calls answered by staff in the outpatient department are within the service level agreement targets
- Communicate effectively with patients when outpatient clinics overrun
- Ensure there are sufficient cystoscopes (to examine the inside of the bladder) to supply day surgery, main theatres and endoscopy
- Ensure all relevant staff are appropriately inducted to the trust and within clinical environments to which they are allocated to work

Trust Quality Improvement Plan 2017/18

Following the inspection by the CQC the trust prepared a detailed Quality Improvement Plan (QIP). This plan takes account of pre-existing compliance matters, the Section 29A warning notice from the CQC and all the 'must do' and 'should do' recommendations from the CQC reports which formed the basis for their judgement and rating for the trust in June 2016.

The trust's long term aim is to achieve a 'good' or 'outstanding' rating from the CQC by 2019.

The three phases of the QIP:

Phase 1 is primarily concerned with addressing the defects found during inspection. Phase 1 is expected to conclude on or before 30 September 2017, and essentially addresses the immediate compliance concerns highlighted by CQC. The focus for Phase 1 of the QIP is mandated in accordance with NHS Improvement's (NHSI's) enforcement undertakings. Successful implementation of Phase 1 will lead to the withdrawal, by the CQC, of the Section 29A Warning Notice and, following satisfactory conclusion of NHSI's enforcement undertakings, lead to a recommendation for the trust to exit special measures for quality.

Phase 2 is primarily concerned with embedding good governance and compliance across trust acute and community services and is designed to allow the progression from an 'inadequate' rating to a 'requires improvement rating by quarter 4 of 2018/19. It is acknowledged that elements of Phase 2 may require further evolution and refinement following completion of an independent well-led governance review required as part of NHSI's enforcement undertakings.

Phase 3 is primarily concerned with building capability, confidence and competence, allowing the progression from a 'requires improvement' rating to the restoration of an overall trust rating of at least 'good' by the end of 2019.

The CQC will undertake an unannounced inspection visit focusing on the trust's *'must do'* actions arising from the Section 29A warning notices. The CQC will also undertake a full inspection at the trust as part of their continued announced inspection regime, planned for September 2017.

Priorities for improvement in 2017/18 [draft to be finalised]

We have agreed commitments against each domain. These priorities have been determined through a review of activity during 2016/17 and via feedback from our stakeholders.

The priorities indicated below are reflected in the trust Quality Improvement Plan for 2017/18 and each element has agreed outcomes with a nominated person accountable for delivery against the priorities.

Improving patient safety

- Improved Early Warning Score documentation
- Rollout of local Safer Surgery – Local Safety Standards for Invasive Procedures (LOCSSIPS)
- Reduced patient falls resulting in fractures
- No avoidable Grade 4 pressure ulcers in patients
- Prevention of healthcare acquired venous thromboembolism

Improving patient experience

- Documented discussion on End of Life care pathways
- 'Always Events' for patients with learning disabilities
- Staff survey response increase
- Improved response rate for complaints against the 25 day target
- Reduction of day theatre cancellations by 40%

Improving patient outcomes

- Improve trust SHMI and HSMR mortality rates
- A comprehensive clinical review process for in-hospital deaths

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 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 2017/18.

In last year's Quality Account we identified a number of priorities for improvement during 2016/17 to ensure that we continue to raise quality throughout the trust. Progress on these priorities as of April 2017 is outlined below.

Improvement priority for 2016/17	Progress as of April 2017
Patient safety **Medication errors**	• The trust continues to have a very low profile of patient harm associated with medication errors. The number of medication errors reported continues to be high, however in-depth analysis of these incidents has identified that they relate to minor process errors that are picked up by the controls stipulated within the trust medicines policy.

Patient deterioration	• In May 2016 the trust established a DAG for the purpose of focusing timely and appropriate care to deteriorating patients. Identification of deteriorating patients through use of the National Early Warning Score (nEWS) has increased over the year and the trust continues to focus upon ensuring that patients whose condition is declining receive the appropriate level of care.
Staff learning through incident feedback	• The trust has introduced a number of learning initiatives and has continued to work towards enhancing some of the existing mechanisms throughout 2016/17. These include: - Risk Management input into training programmes. - Increased frequency of root cause analysis (RCA) training. - Increased involvement from medical staff in following up incidents. - Monthly Governance Newsletter which is circulated to all matrons, governance leads, care group leads and other senior staff. - Introduction of quarterly analysis report – Complaints, Litigation, Incidents, PALS, Inquests (CLIPI) report and Learning from SIs.
Learning from never events outside of theatres	• Overall the number of reported adverse incidents has increased, based on a comparison with data from 2015/16. The number of SIs declared has decreased, compared with 2015/16. • The trust has revised the correct site policy to include outside theatre areas in line with the NatSSIP policy. This is now called “Safer Standards for Invasive Procedures” and covers all invasive procedures in and outside theatres. • Learning from Never Events is included in the monthly Governance Newsletter which is circulated to all matrons, governance leads, care group leads and other senior staff.
<u>Patient experience</u> **End of life care**	• Development of service improvements through information obtained from a comprehensive audit program. A quality improvement program for EOLC services is being implemented in response to issues identified by the CQC. The CQC report emphasised an issue relating to lack of an integrated service. This is an area that is being specifically targeted in terms of improvement. • A trust wide strategy for end of life care

	was developed and put into place in November 2016. • A structured EOLC governance framework has been established, confirming the medical, nursing and management leadership. • A detailed implementation plan is in place to support the delivery of the strategy.
Complaints	• Complaints – awaiting narrative
Dementia and delirium	• A clinical lead for delirium was appointed within the trust in November 2016. • A new and improved delirium pathway has been established. • Just under 7000 Trust staff have completed dementia awareness training, with an overall response rate of 84%.
Patient outcomes	
Clinical records	• Trust performance against national record-keeping standards are good (>85%) for records being bound, organized and ensuring clinical entries are legible, dated and signed. • The trust has an Information Governance Toolkit rating of 68%. This is satisfactory, but marginally lower than achieved in 2015/16. • A trust timeline for full implementation of iClip is to be finalised. The trust will potentially invest in infrastructure over the next 12 months. Once complete, the trust will commence an iCLIP deployment project – forecast for 2018/19.
Mortality	• For the two major indicators of mortality, the trust continues to show better than expected performance. • Standard Hospital Mortality Rate (SHMR) is 81%, an improvement from 85% in 2015/16 • Summary Hospital Level Mortality Indicator (SHMI) is 0.86, an improvement on 0.91 in 2015/16 • The trust has fully engaged in the national agenda through participation in the Royal College of Physicians *National Mortality Case Record Review* pilot. • Trust-wide and local processes have been strengthened to ensure deaths are reviewed in a timely fashion. • On-line screening and review tools have been built, embracing clinical judgement review to enable data collection and capture learning. • These improvements mean that the trust is in a strong position to implement the national framework *'Learning from Deaths'* during 2017/18.

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 in terms of performance, but also means that we can learn from other trusts who offer similar services.

The Department of Health (DH) and NHS Improvement produce guidance on what should be reported in the quality account for NHS trusts and NHS foundation trusts (from 1st April 2016 Monitor and the Trust Development Authority merged and were renamed NHS Improvement).

We must comply with NHS Improvement's reporting requirements and additionally those set by The Department of Health. NHS Improvement requires us to produce an annual quality report which includes all of the reporting requirements of the quality account, plus some additional requirements that they have set.

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

- Mortality rates
- Patient reported outcome measures (PROMS)
- Emergency readmissions
- Responsiveness to patients' needs
- Friends and Family Test for staff
- Venous thromboembolism rates (VTE).
- C.difficile rates
- Patient safety incidents.

To meet both DH and NHS Improvement's quality reporting requirements, we have consolidated all trust quality information into one document – known as the 'quality report'. However, for reporting purposes to DH we will call the quality report the 'quality account'.

Voluntary indicators [to be finalised]

NHS Improvement requires the trust to report on nine voluntary indicators that reflect how we are improving patient safety, patient outcomes and patient experience. We have reported on nine this year, to reflect the services we provide and the patients we care for.

We have worked closely 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. The trust local stakeholders include our council of governors, our local Clinical Commissioning Group (CCG), Wandsworth Healthwatch, Merton Healthwatch, Lambeth Healthwatch and Wandsworth Council.

The table below shows the voluntary indicators reported on in this document, and the indicators that we will be reporting on in next year's quality account (2017/18). These have also been shared with stakeholders for review and input.

The voluntary indicators chosen for 2017/18 reflect some specific issues where the trust wishes to undertake a bespoke programme of work, or where there is a need to continue to build on work previously undertaken in 2016/17 to support and embed learning in practice, which is an important element of any programme.

The indicators we have chosen to include fit into the three essential domains of our quality improvement strategy – *improving patient safety, improving patient experience* and *improving patient outcomes.*

Voluntary indicators in this report for 2015/16	Voluntary Indicators chosen for next year's report (2017/18)
Patient safety • Medication errors • Patient deterioration • Staff learning through incident feedback • Learning from never events outside of theatres	**Patient safety** • *Improved levels of Early Warning Score (EWS) documentation (identifying patients who are deteriorating) • *Rollout of local Safer Surgery – Local Safety Standards for Invasive Procedures (LOCSSIPS) • *Reduction of patient falls resulting in fractures (25% reduction) • *No avoidable Grade 4 pressure ulcers • *Prevention of healthcare acquired venous thromboembolism
Patient experience • End of life care • Complaints • Dementia and delirium I	**Patient experience** • Ensure fully documented discussion with patients and relatives on end of life care pathway • *Develop and implement 'Always Events' for patients with learning Disabilities in a relevant clinical setting • Staff survey response increase participation from 40.4% to 50% and engagement score from 3.7 to national average (future stretch targets to attain a score of 4.) • Aim to achieve an 85% response rate for complaints against the 25 day target. • Reduce on the day theatre cancellations by 40% from 2016/17 levels.
Patient outcomes • Clinical records • Mortality	**Patient outcomes** • Improve trust SHMI and HSMR mortality rates - ensure risk-adjusted mortality remains better than national expected values (SHMI and HSMR), maintaining our 'better than expected' position. • *Ensure a comprehensive clinical review process for all in-hospital deaths, implementing the Learning from Deaths recommendations

	(including the openness and publication of mortality data and learning).
	*As identified in Trust Quality Priorities

Mandatory audit testing

It is a requirement that our external auditors Grant Thornton test certain indicators to provide assurance that there is a robust audit trail within the trust.

Two indicators are mandatory as set out by NHS Improvement. These are:

1) A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge
2) All cancers: 62-day wait for first treatment from:
- Urgent GP referral for suspected cancer
- NHS Cancer Screening Service referral.

One local indicator needs to be selected by the trust's council of governors. For 2016/17 they have chosen 'Complaints' as their quality indicator for external audit – namely the percentage of complaints responded to within 25 days.

Grant Thornton has been unable to test the NHS Improvement mandatory indicator relating to 'Referral to Treatment' (RTT). Following publication of the findings of the MBI Health Group review in June 2016, the trust board took the decision to suspend national reporting against the RTT (18 week) standard. Further information relating to this decision is outlined in the *'Statement of Directors' Responsibilities for the Quality Report'* section of this document.

Stakeholders

The draft quality account has been shared with stakeholders 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
- Wandsworth Healthwatch
- Merton Healthwatch
- Lambeth Healthwatch
- Wandsworth CCG
- Wandsworth Council Adult Care and Health Overview and Scrutiny Committee.

Sharing a draft version of the report with our stakeholders has given them the opportunity to provide feedback on our performance in a formal statement. These statements are published in Annex 1.

To put our performance into context, we have compared it for all of the indicators in this report against how we performed 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

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 many services from 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. Some of our services also treat patients from all over the country, including for family HIV care, bone marrow transplantation for non-cancer diseases and penile cancer.

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 2016/17 we provided and/or subcontracted 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 2016/17 represents 100 per cent of the total income generated from the provision of NHS services by St George's University Hospitals NHS Foundation Trust for 2016/17.

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 such as 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 such as 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 also within 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.

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
- Resuscitation

Neurosciences clinical directorate

- Neurosurgery and neuroradiology
- Neurology
- Neurophysiology
- Neurorehabilitation
- Pain clinic

Cancer clinical directorate

- Cancer

Medicine and cardiovascular division

Emergency and acute medicine

- Emergency department
- Acute medicine and senior health

Specialist medicine

- Lymphoedema
- Infection department
- 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
- Thoracic surgery

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

Children's directorate

- Paediatric surgery
- New born services and NICU
- PICU
- Paediatric medicine

Women's directorate

- Gynaecology
- Obstetrics

Therapeutics

- Adult critical care
- Therapies
- Pharmacy

Diagnostics

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

Outpatients

- Outpatients

Community services

Community adult and children's directorate

Community adult health services

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

Children and family services

- 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

Adult and diagnostic services

- Outpatient services
- Minor injuries unit
- Diagnostics
- Specialist rehabilitation
- Adult therapies – physiotherapy, dietetics and
- podiatry
- Integrated sexual health

Offender healthcare

- Primary care
- Substance misuse
- Inpatient care

Where our services are based

Hospitals

We provide healthcare services at:

- St George's Hospital
- Queen Mary's Hospital

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
- Nelson Health 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 who provide them on the services section of our website at: www.stgeorges.nhs.uk/services.

Seven Day Services

Why is this important?

Many patients are admitted to hospitals as emergencies and the treatment they receive in the first hours and days in hospital is crucial. It is also important that patients receive a high level of care no matter what day of the week, or time of the day they need it. A key element of the NHS urgent and emergency care review is that patients requiring services for acute stroke, heart attacks, major trauma, emergency vascular and paediatric intensive care receive consistent, high quality care throughout the seven day week.

The *NHS Operational Planning and Contracting Guidance for 2017-19* (published in September 2016) clearly outlines the ambition that by November 2017, the five network specialist services outlined above meet the four priority standards for seven-day hospital services.

We have been working hard to meet these ambitions by developing our teams and measuring how we are doing against the standards in the five key areas.

What standards are we trying to meet?

First consultant review

All emergency admissions must be seen and receive a thorough clinical assessment by a suitable consultant as soon as possible, but at the latest within 14 hours from the time of admission to hospital.

Timely access to diagnostics

Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week:

- Within 1 hour for critical patients
- Within 12 hours for urgent patients
- Within 24 hours for non-urgent patients

Access to consultant directed interventions

Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols. These interventions would typically be:

- Interventional radiology
- Interventional endoscopy
- Emergency general surgery
- Emergency renal replacement therapy
- Urgent radiotherapy
- Stroke thrombolysis
- Percutaneous Coronary Intervention
- Cardiac pacing (either temporary via internal wire or permanent)
- Critical care

On-going review

All patients with high dependency needs should be seen and reviewed by a consultant twice daily (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every twenty-four hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

How are we doing?

Our most recent self – audit report (submitted to NHS Improvement) was in September 2016. Whilst we perform reasonably well in most areas there is room for improvement. Nationally we sit just below the average for first consultant review and have been working hard with our teams to make sure that trust consultants have the time needed in their job plans to be able to see patients in a timely manner.

We will continue to collect data on our performance over the coming year to ensure that we continue to make progress towards our targets.

	Weekday	Weekend
First Consultant review	61%	61%
Timely Access To Diagnostics		
Within 1 hour	92%	66%
Within 12 hours	92%	71%
Access To Consultant Directed Interventions		
Interventional radiology	90%	86%
Interventional endoscopy	95%	90%
Emergency general surgery	100%	100%
Emergency renal replacement therapy	100%	100%
Urgent radiotherapy	73%	39%
Stroke thrombolysis	100%	100%
Percutaneous Coronary Intervention	100%	100%
Cardiac pacing (either temporary via internal wire or permanent)	100%	100%
Critical care	100%	100%
On-going review		
Twice Daily	97%	86%
Once Daily	99%	94%

Data from trust self-audit report, September 2016

Our aims

Our aim is to work towards fully meeting the standards outlined in the *NHS Operational Planning and Contracting Guidance* by November 2017, for our five urgent networked services. This is a key aim for the trust and the NHS as a whole, to help deliver care to patients seven days a week.

Mandatory surveillance of healthcare-associated infections

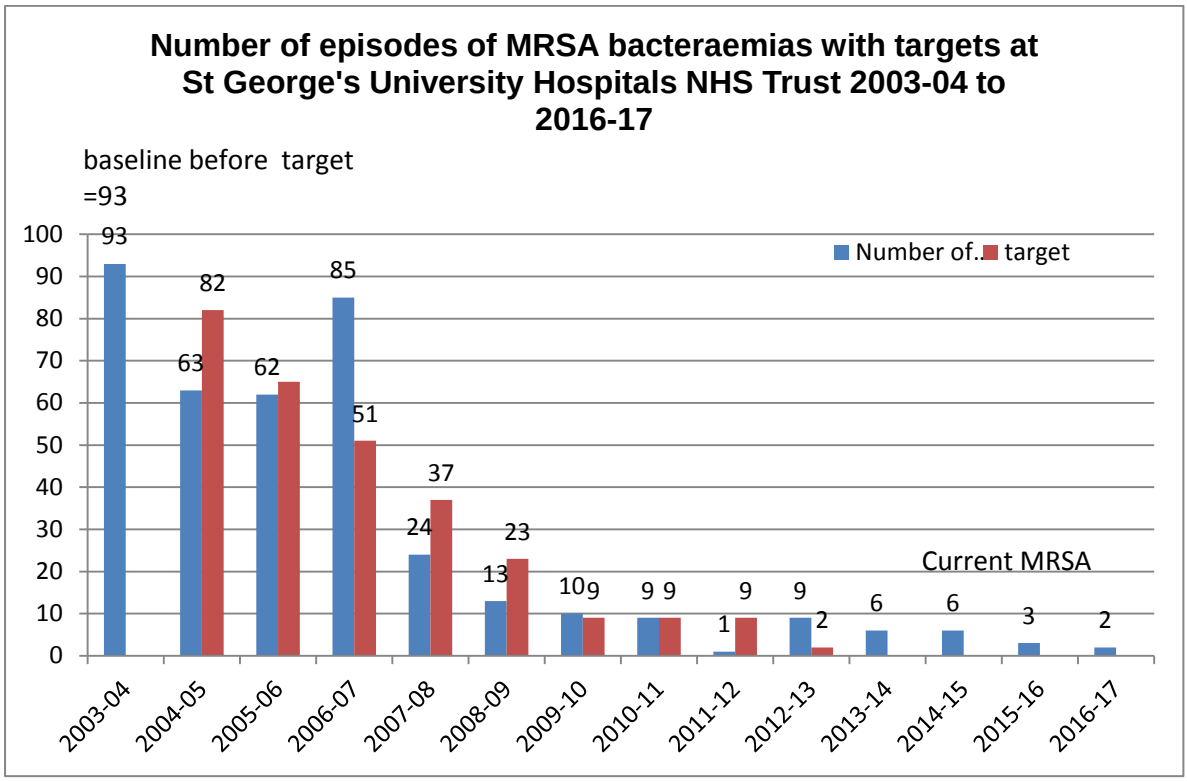
Meticillin-resistant *Staphylococcus aurues* (MRSA) bacteraemia

Since 1 April 2001, all NHS Trusts have been required to report the number of episodes of bacteraemia (bloodstream infection) with MRSA.

Bacteraemias are categorised into community-acquired episodes (positive within 48 hours of admission or hospital-acquired episodes). All MRSA bacteraemias are initially apportioned to the organisation based on the timing of the positive blood culture. The MRSA bacteraemia then undergoes a post infection review (PIR) process, the results of which are submitted to Public Health England. The bacteraemia is then assigned to the organisation deemed to be responsible. Disagreements are dealt with by an appeals process. Previously, trusts were given specific targets (thresholds) but since 2013-14 the target has been 0.

In line with the government thresholds, St George's has reduced the number of MRSA hospital assigned bacteraemias significantly since 2002-03, as outlined in the table below. In recent years the number of assigned episodes is as follows:

- 2011/12 - one episode
- 2012/13 - nine episodes
- 2013/14 - six episodes
- 2014/15 - six episodes
- 2015/16 - three episodes
- 2016/17 – two episodes



Our outcomes

When compared to other Teaching Hospital Trusts in London, St George's has low rates of MRSA bacteraemia. These rates are expressed as number of episodes per 100,000 bed days. The rate for 2016-17 was 0.65, which was the lowest for any teaching hospital in London and the 6th lowest for any of the 29 teaching hospital trusts in England. The worst performing trust had rates 4 times higher than St George's.

Meticillin-susceptible *Staphlococcus aureus* (MSSA) bacteraemia

From 1 January 2011, NHS trusts have been required to report all episodes of meticillin susceptible *Staphylococcus aureus* (MSSA) bacteraemia, using similar criteria as employed for MRSA surveillance. There were 78 episodes in 2016/17 of which 31 were apportioned to the trust. This compares to 91 episodes in 2015/16 with 39 of these apportioned to the Trust. In 2014-15 the numbers of episodes were 82 and 29 respectively.

There are no national thresholds for MSSA bacteraemia at present. The 2016-17 rate of trust-apportioned episodes for St George's is 10.1 per 100,000 bed days and represents the median rate for compared to other similar trusts in London.

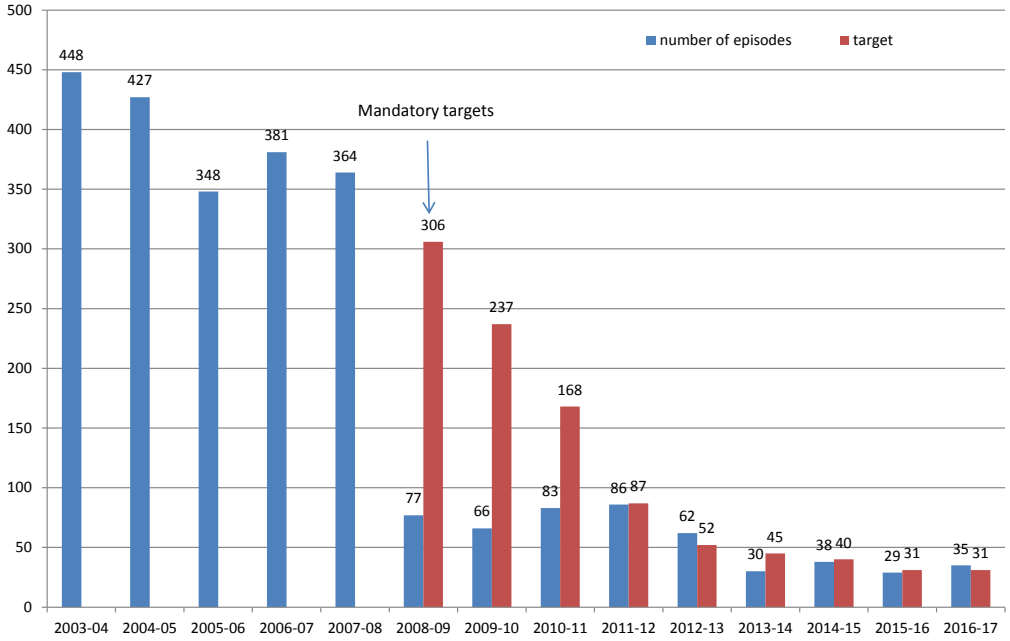
***Clostridium difficile* infection**

Clostridium difficile infection is a major cause of antibiotic-associated diarrhoea, and became widespread in UK hospitals in the late 1990s. In response to this, the Government announced in October 2007 a plan to reduce the number of *C difficile* infections nationally by 30% by the end of the calendar year 2010-11.

The baseline that this reduction was applied to was the number of 'attributable' episodes in the financial year 2007-8. The 30% reduction was for the total number of episodes nationally. Some trusts already had low levels before the start of the programme in 2008-09; thus the reductions were applied differentially. St George's has significantly improved its *C. difficile* rate since then.

Figure 2 indicates the reduction in numbers of episodes since 2002-03. Each year the trust has a target (threshold) for trust-apportioned episodes. The targets are individualised for each trust with a very wide range. The target for St George's in 2016-17 was 31 episodes equating to a rate of 10.2 per 100,000 bed days. Other London Teaching hospital trusts have targets up to 4 times higher.

Figure 2. Numbers of hospital-acquired infections with *Clostridium difficile* at St George's 2003-04 to 2016-17 with targets



For the first time in three years, the trust had more episodes of trust-apportioned *C. difficile* episodes in 2016/17 than the target, i.e. 36 versus a target of 31. This equates to a rate of 11.77 episodes per 100,000 bed days. However the rate for St George's was still lower than the majority of other London Teaching hospitals and was the 7th lowest of all 29 teaching hospital trusts in England. The best and worst performing trusts had rates of 8.84 and 33.6 respectively.

Glycopeptide resistant enterococcal bacteraemia

This reporting scheme started on 1 October 2003 and data has been published annually for all hospitals between the months of October to September. St George's figures are illustrated in the table below with figures up to end of September 2016. There are no national thresholds.

St George's has always had very low levels (more than 75% lower than some trusts) and this trend has continued in the last financial year.

Annual numbers of GRE bacteraemias at St George's Hospital:

Year	Number of patients
October 2009 - September 2010	3
October 2010 - September 2011	4
October 2011 - September 2012	13
October 2012 - September 2013	11
October 2013 - September 2014	12
October 2014 - September 2015	11
October 2015 - September 2016	8

Sepsis

Overall trust progress in 2016/17

Prior to April 2016 there was no robust system for screening for sepsis in the St George's emergency department or on the wards. During 2016/17, a robust system for screening and early intervention with antibiotics was set up in the emergency department and on four adult wards. Doctors and nurses have also been trained to screen for sepsis and initiate antibiotics early. This training has been supported by the GAPS Simulation centre in the form of the Sepsis 6 course and the Critical Care Liaison project team. A Sepsis Awareness week was also successfully held across the trust in March 2017.

Our aims

Our aim is to ensure that every patient with sepsis is identified early and has treatment initiated within one hour.

Sepsis in adults in the emergency department

The Sepsis CQUIN commenced in the trust in April 2016. Prior to this, there was no robust mechanism to screen for sepsis and no data was collected on screening. Training on screening took place in May and June 2016, with data collection commencing in July.

Figure 1 below shows the marked improvement in the percentage of patients meeting the criteria for screening, who were actually screened for sepsis on arrival.

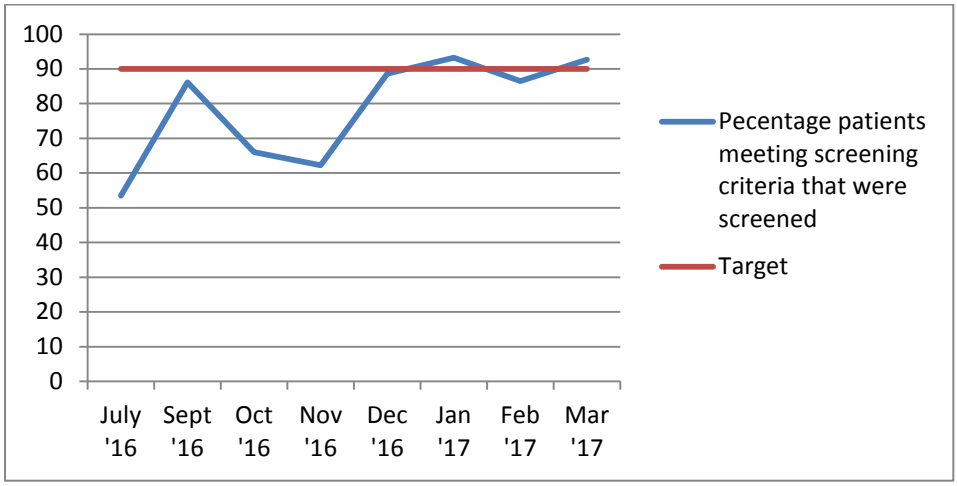


Figure 1: Adult ED patients meeting the screening criteria who were screened on arrival

Antibiotics

An audit of time-to-antibiotics commenced in October 2013. The percentage of adults in the emergency department receiving antibiotics within one hour improved from 25% to 50% by April 2016. With the implementation of the Sepsis CQUIN, the percentage of patients receiving antibiotics within one hour has continued to improve. By the end of March 2017 this figure stood at 86%, as indicated in Figure 2 below.

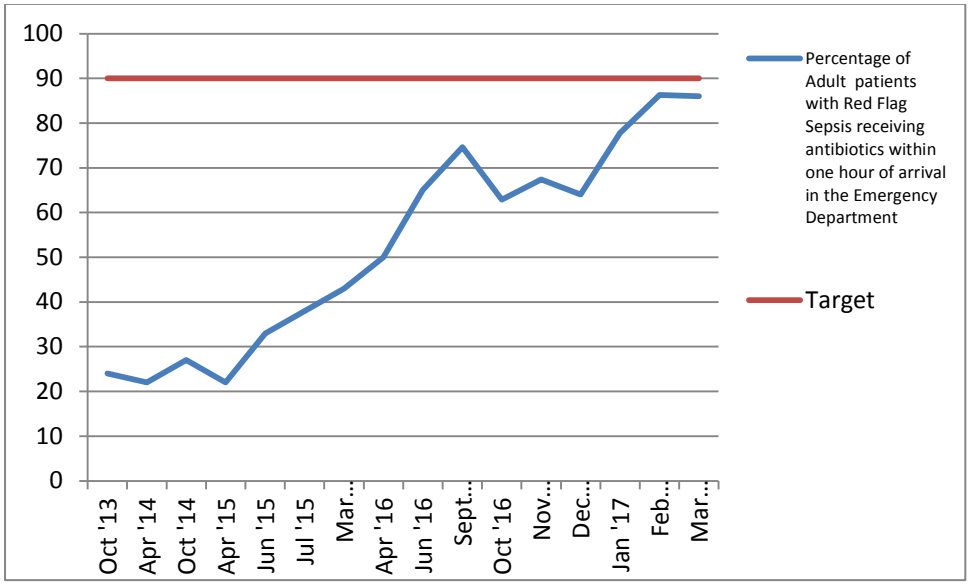


Figure 2: Adult emergency department patients who met Red flag sepsis criteria at triage who received antibiotics within an hour

Sepsis in children in the emergency department

Prior to the implementation of the sepsis CQUIN within the trust in April 2016, there was no formal system for screening for sepsis nor was there a guideline on sepsis management in children in the emergency department.

No data is available for Q1 of 2016. In Q2, 3 and 4 there were 4, 67 and 105 children respectively, recognised as potentially having sepsis. The number of patients screened improved from 1 in Q2 to 14 and 25 in Q3 and 4, respectively. There were initially issues regarding the logistics and usage of the screening tool. This was resolved by incorporating the screening tool and the Sepsis 6 treatment bundle in the new paediatric emergency department notes.

Approximately 25% of children with sepsis receive antibiotics within one hour of arrival. This is expected to improve with the implementation of the new improved paediatric emergency department notes incorporating the screening tool and the treatment bundle.

Sepsis on the adult wards

Prior to the commencement of the sepsis CQUIN in April 2016, there was no system for screening for sepsis on St George's hospital wards. In Q3 and 4 the trust invested in three Band 7 Critical Care Liaison Project nurses on 4 wards to screen patients for sepsis and commence treatment. Screening on the wards improved from **0 to 100%** with 1,022 patients being screened for sepsis in Q4. The percentage of patients receiving antibiotics within one hour also improved from 0% to 62.5%.

Sepsis on the paediatric wards

The paediatric wards will be engaged in the Sepsis CQUIN in 2017-18.

Research

Why is it important?

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

St George's, in its partnership with St George's University of London, aims to bring new ideas and solutions into clinical practice. Clinical teams are collaborating with scientists to investigate the causes of a range of diseases, to develop better ways of diagnosis and tailored treatments. We look forward to growth in research activity in trauma, neurosciences, cardiology and maternal and foetal health in 2017.

The past year has seen the first phase one study in St George's Clinical Research Facility, testing a therapeutic vaccine in chronic hepatitis B infection. The Clinical Research Facility's infrastructure has improved, with a new laboratory opening which will support clinical trials.

Key to our research is the partnership that the trust has with St George's University of London. Some major areas of research undertaken in the past year include:

- New diagnostic techniques for tuberculosis
- Understanding the pain pathways in osteoarthritis
- Development of antibiotic dosing guidelines for paediatrics
- Developing MRI scan techniques in cancer
- New physiotherapy techniques for patients with lung disease.
- Evaluation of rapid clinical diagnosis for STIs
- Studies looking at cardiac problems in otherwise healthy individuals
- Identifying new genetic influences in cardiac problems
- Development of non-invasive techniques to predict and prevent pre-term birth
- New treatments for vascular dementia
- Developing a renal inpatient nutrition screening tool
- Improving outcomes of spinal injury trauma patients
- New ECG techniques in inherited heart conditions
- A national study of maternity patient awareness in surgery
- The effects of e-cigarettes on health and well being
- Outcome of very old people in intensive therapy units

Our outcomes

Sir Norman: Stress what are our particular strengths both nationally and internationally as recognised by the last REF and how these areas are being strengthened.

Participation

A key way to offer new treatments is through participation in clinical trials that are approved by the National Institute for Health Research (NIHR), which supports NHS and academic institutions to deliver quality research that is patient-focused and relevant to the NHS. In 2016 St George's recruited 4452 patients onto the NIHR portfolio adopted studies.

Approvals

At St George's in 2016 we had 575 active research studies registered on our database. 318 of these studies were adopted onto the NIHR portfolio. 249 research applications were received in the Joint Research and Enterprise Office (JREO) in 2016 and St George's opened 173 new research studies.

Trials open to recruitment

There is a national target to recruit the first patient to a trial within 70 days of receipt of the study application pack. In the last quarter, 39% of patients met this target.

Ensuring compliance with 'Good Clinical Practice' (GCP) guidelines for research

The International Council for Harmonisation Good Clinical Practice (ICH GCP) has its origin in the Declaration of Helsinki and is a set of guidelines that contains 13 principles, which form a framework to ensure that the safety, rights and wellbeing of trial participants are protected. All trials require a sponsor to take on the legal responsibility to ensure that the trial is conducted safely and gathers good quality information. All of our clinical trials sponsored by St George's are closely monitored by a team from the JREO. When we 'host' studies that are sponsored by other organisations, we undertake our own system of review (audit), in order to ensure best practice and optimal safety for our patients. Every 3 months the JREO randomly selects a number of active studies and clinical trials to audit, to check the study has been conducted in accordance with the standards as described in the ICH GCP guidelines.

Our aims in 2017

1. Increase participation

We intend to maintain and improve upon our patient participation rates in NIHR adopted trials. We will do this through better supporting clinical research in a variety of ways.

We are targeting our CRN budget allocation to the clinical research delivery workforce – those research nurses and coordinators who are the mainstay of clinical trials. We are pro-actively working with the CRN and investigators to identity those trials which St George's can support. The JREO – under new leadership – has implemented a new and improved structure and is streamlining processes to provide optimal support to investigators.

Each year on International Clinical Trials Day, the JREO together with the Clinical Research Facility raise awareness about research by hosting facility tours and inviting potential participants interested in volunteering to studies to add their names to our 'volunteer database'. We are planning the 2017 event for 19 May.

2. Approvals

In 2016, a new governance approval process was introduced by the government in England, hosted by the Health Research Authority (HRA). This new process caused significant delays in activating studies across England and here at St George's. The process is now embedded at St George's and this – along with improved structures and processes - will allow us to increase approvals.

3. Trials open to recruitment

We intend to significantly improve on the number of trials which meet the 70 day target for recruiting the first patient, through improved structures and processes.

4. Ensuring quality

We will aim to audit 10% of all active research studies each year to provide assurance of the safety and quality of studies conducted at St George's. We will continue to support our clinicians to develop their research questions into successful grant applications.

Staff Friends and Family Test (FFT)

Staff who would recommend the trust as a place to receive treatment and as a place to work to friends or family

Why is this important?

One of the trust's strategic aims is to be an exemplary employer. To achieve this we must commit time, resources and effort into supporting our staff and making St George's both a place of excellence to receive healthcare and a positive place to work. All of 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?

Every year we conduct the Friends and Family Test within our own workforce. In quarters one, two and four of the financial year we give all trust staff the opportunity to complete the survey, which comprises of two important questions:

- How likely are you to recommend this organisation to friends or family if they needed care or treatment?

- How likely are you to recommend this organisation to friends or family as a place to work?

Quarter three is given over to the annual national NHS staff survey.

Our scores for 2016-17 by quarter are listed as follows:

	Staff response	Percentage who would recommend for treatment	Percentage who would recommend as a place to work
Q1 April – June	655	79%	50%
Q2 July – Sept	534	74%	36%
Q4 Jan - March	403	77%	47%
Full year	1,592	76%	44%

Listening into Action

We recognise that as well as listening to our patients, it is also important that we listen to our staff and involve them as much as possible in identifying where improvements could and should be made across the trust.

As a result, we are fully engaged with the national *Listening into Action* staff engagement programme. Listening into Action (LiA) launched at St George's in March 2013 and demonstrates the trust's commitment to working with and engaging all staff at St George's. Listening into Action is focused on achieving a positive shift in the way that the trust operates and demonstrates leadership, placing our clinicians and staff at the heart of change for the benefit of our patients, staff and the trust as a whole.

Essentially, Listening into Action is about:

- Engaging the best placed individuals to help deliver better outcomes for our patients, our staff and our trust

- Aligning ideas, effort and expertise across the trust to deliver better patient experience, safety and quality of care
- Overcoming widespread challenges that may affect our staff
- Positive and consistent engagement and morale
- Developing confidence and capability in our leaders to help them effectively 'lead through engagement'
- Collaborating across the usual boundaries, and;
- Encouraging a sense of collective ownership and pride across the trust

Listening into Action complements existing projects and pieces of work that are taking place across the trust. The change methodologies, systems and experiences that staff develop and gain through Listening into Action is in many cases used to help affect and achieve wider change relating to these projects.

Staff from all departments, levels and roles across the trust have and continue to work together and talk about what matters to them and what changes should be prioritised. We use staff feedback to inform our future actions and to support and enable our teams to do the very best for our patients and their families in a way that makes us proud of our work.

Listening Into Action is Staff Engagement (LIAiSE)

At the trust *Big Conversations* in April and May 2013, the idea of providing a dedicated service for staff, based on our Patient Advice and Liaison Service (PALS), was first discussed. The idea was raised by staff at more than one *Big Conversation* and generated much interest. As a result, the Listening into Action Sponsor Group devised a staff advisory service known as LIAiSE – *Listening into Action is Staff Engagement*. The service is provided by a LIAiSE Adviser who provides a listening and signposting service to trust staff, identifying where support is available. This service is provided on a one to one, individual, self-referral basis and additionally to teams who request intervention. The LIAiSE Adviser is also the first *Freedom to Speak up* guardian for the trust.

Values Awards

Our trust values are designed to inspire our staff and ensure that we keep patients at the heart of everything we do. Both staff and patients can nominate members of staff for one of the trust's Values Awards – Excellent, Kind, Responsible and Respectful. The Listening into Action Sponsor Group oversees nominations and each month members of staff that are nominated are presented with their award. Each year, all nominees are put forward for the annual trust Values Awards, which celebrate both an individual and team for each values category.

National NHS Staff Survey 2016

For the 2016 NHS staff survey St George's had an overall response rate of 40%, an improvement from the 2015 score of 31%, which is below the average response for combined acute and community trusts (42.3%). The range of questions remains consistent from year to year, making it possible to benchmark against previous years as well as against other trusts. The survey was communicated to all staff via our internal trust communications channels including our weekly e-newsletter, bi-monthly newsletter and staff forums.

In summary, the trust performed slightly better than in 2015 but our scores were still lower than the national average for combined acute and community trusts. Our top 4 ranking and bottom 4 ranking scores are summarised in the table below.

Table 1: Top and bottom four ranking scores for 2016/17

	2015/16		2016/17		
	St George's	National Average	St Georges	National Average	Improvement/ deterioration
Response rate	31%	43%	40.4%	42.3%	Improvement
Top 4 ranking scores					
KF13. Quality of non-mandatory training, learning or development	4.05	4.04	4.10	4.07	Improvement
KF12. Quality of Appraisals	3.04	3.03	3.19	3.11	Improvement
KF18. % of staff feeling under pressure to attend work when not well	57%	58%	53%	55%	Improvement
KF29. % of Staff reporting errors, near misses or incidents witnessed in the last month	88%	90%	91%	91%	Improvement
Bottom 4 ranking scores					
KF19. Organisation and management interest in action on health and wellbeing	3.33	3.59	3.41	3.61	Improvement
KF14. Staff Satisfaction with resourcing and support	3.11	3.72	3.15	3.28	Improvement
KF26. % of staff experiencing harassment, bullying or abuse from staff in the last 12 months	27%	24%	32%	23%	Deterioration
KF10. Support from immediate line managers	3.58	3.72	3.63	3.74	Improvement

For 2017 the trust has agreed to focus on three key areas:

- Addressing bullying and harassment
- Improving staff engagement
- Improving equality and diversity

Confidence to raise concerns

This year the trust has improved on the 2015 score for staff feeling secure about raising concerns about unsafe clinical practice but this is still lower than the national average for combined acute and community trusts. The trust continues to implement the national *'Freedom to Speak Up'* review. Staff are encouraged to raise concerns and we ensure that they receive support and feedback on the outcome of the complaint. The trust has also introduced a number of initiatives to improve communication, working practices and team feedback, such as:

- ’Back to the floor fridays’ - senior managers go in to the wards and departments every friday to engage with staff and discuss concerns
- Road shows - managers travel to various sites across the trust and provide updates on a variety of trust issues e.g. service improvement, trust finance position, etc
- ‘Schwartz rounds’ – allowing staff to discuss the highs and lows of work in a confidential, expertly facilitated environment

Tackling poor behaviour and bullying

In the 2016 staff survey, 32% of staff at the trust reported harassment, bullying or abuse from other staff and the national average for combined community and acute trusts was 23%. The score in 2015 was 33%, thus performance in this area has not dramatically increased or decreased.

Tackling poor behaviour, bullying and harassment is one of the key areas that the trust has agreed to focus on this year. The trust acknowledges that a fundamental change is required, and amongst a variety of initiatives implemented to tackle bullying (such as reviewing the trust *Dignity at Work – A policy against Bullying and Harassment*, running unconscious bias training sessions and the Bullying and Harassment support helpline), the trust has made a decision to engage a Bullying & Harassment specialist. The specialist will provide training sessions across the organisation and at the same time address related issues from minor communication issues between colleagues to perceptions of unfair treatment by management. This decision follows a successful case study of the NHS London Ambulance Service Trust.

Discrimination

The staff survey key questions that are required for the Workforce Race Equality Scheme (WRES) showed that when asked if staff believed that the organisation provides equal opportunities for career progression or promotion, 83% of white staff and 63% of black, minority and ethnic (BME) staff agreed. There was no difference in the score for white staff from last year but the score for BME staff had increased from 59% to 63%. This marked difference between white and BME staff is greater than that for comparator trusts where the score is 88% and 75% respectively. The Staff Network Action Group will work to address issues in relation to BME staff and ensure that staff have equal access to opportunities.

Health and Wellbeing

As part of trust plans to address the health and wellbeing of staff, we are implementing a wellbeing strategy in order to reduce sickness absence and enhance a sense of personal responsibility and engagement amongst staff. In March 2017 we appointed a permanent Staff Wellbeing lead who has developed a wellbeing strategy that includes a wide-range of wellbeing initiatives designed to promote good health. The health and wellbeing lead worked closely with colleagues in the Occupational Health Department, the Chief Executive and the Medical Director to improve the uptake of the flu vaccine achieving 72% vaccination rate for patient-facing staff. We have also employed a physiotherapist to work in our occupational health service to support staff back to work following muscular skeletal absences, and assist them in maintaining good health. Regular Pilates, yoga and other fitness sessions have proved to be a success with staff and these initiatives will continue.

Participation in clinical audits

During 2016/17, 50 national clinical audits and 7 national confidential enquiries covered the NHS services that St George's University Hospitals NHS Foundation Trust provides.

During that period, St George's participated in 96% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that St George's was eligible to participate in during 2016/17 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 12 national clinical audits were reviewed by trust board in 2016/17. A summary of the actions agreed in response to these audits is given in Appendix B.

The reports of 8 local clinical audits were reviewed by St George's in 2016/17. A summary of the actions agreed is given in Appendix C.

Use of CQUIN payment framework

As at April 2016, St George's has agreed Q3 performance with commissioners. The trust currently envisage an 81% overall performance against the suite of CQUINs agreed with commissioners. Estimated income will be £12 million. Details of the trust's CQUIN schemes for 2016/17 are provided in Appendix D.

Data quality

Why is it important?

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

Staff at the trust who record patient information have a responsibility to the NHS and to our patients to ensure that all data held electronically or on paper is accurate, complete and captured in a timely manner. Accurate data also ensures improved reporting, up to date statistics, correct invoicing and improved decision making.

Our outcomes

Most data is gathered as part of the everyday activity of frontline and support staff throughout the trust, working in a variety of settings. It is vital that we collectively and accurately capture and record the care that we provide. The information provided below demonstrates how well we do this. Throughout 2017 the trust has been working closely with our IT suppliers to increase the robustness of both our data capture and processing.

Statistics to show % of Patient Demographic Data captured from SUS (Secondary Users Services)

Note: The data quality figures shown below are correct for 2016/17 to month 11.

			2013/14	2014/15	2015/16	2016/17
	Data Set	National Benchmark	SGH % Valid	SGH % Valid	SGH % Valid	SGH % Valid
	Trust Score	0	90.4	90.8	94.0	94.0
APC	NHS Number	99.2%	98.7%	98.7%	98.0%	97.9%
	Postcode	99.8%	100.0%	99.9%	99.7%	99.5%
	Reg GP Practice	99.9%	100.0%	100.0%	99.8%	99.8%
OP	NHS Number	99.4%	99.4%	99.5%	98.5%	99.1%
	Postcode	99.8%	100.0%	100.0%	99.9%	99.6%
	Reg GP Practice	99.8%	100.0%	100.0%	99.9%	99.9%
A&E	NHS Number	96.4%	93.9%	92.7%	92.3%	93.3%
	Postcode	99.3%	99.8%	99.9%	99.7%	99.9%
	Reg GP Practice	98.8%	99.9%	100.0%	99.4%	99.5%

Overall the trust figure for NHS numbers remains high, but still marginally short of the National Benchmark set out by NHS England. A high percentage of unrecorded NHS numbers are due to the amount of overseas patients treated by the trust.

Data Quality Team

A Data Quality Team was established within the trust in September 2016 to focus on data cleansing, improving recorded data and reinforcing the importance of data quality to all services across the Trust.

The team work directly with front end users to ensure that they are aware of the importance of capturing good data within our trust systems. The data quality team also work closely with the training team and systems team to ensure that the Patient Administration System (PAS) is robust and that staff are provided with the opportunity to be trained and ask questions.

Data quality dashboards are also in the process of being created to monitor how services across the trust are performing, highlighting to the data quality team staff and services that require additional support and training.

Information governance

Information is a vital asset, both in terms of the clinical management of individual patients and the efficient organisation of services and resources. St George's aims to safeguard patient confidentiality and maintain data security whilst empowering staff within the trust to perform their role using key information governance principles.

What is Information Governance and why is it important?

Information Governance is the way in which the NHS handles all of its information, and in particular, the personal and sensitive information relating to patients and employees. It provides a framework to ensure that personal information is dealt with legally, securely, efficiently and effectively, in order to deliver the best possible care. It also offers NHS employees a clear structure to deal consistently with the many different rules about how information is handled.

Information Governance Toolkit

The Information Governance Toolkit is a Department of Health Policy delivery vehicle that NHS Digital is commissioned to develop and maintain. It draws together the legal rules and central guidance set out by DH policy and presents them in in a single standard as a set of information governance requirements. The organisations in scope of this are required to carry out self-assessments of their compliance against information governance requirements.

There are different sets of information governance requirements for different organisational types. However all organisations, including St George's, have to assess themselves against requirements for:

- Management structures and responsibilities (e.g. assigning responsibility for carrying out the information governance assessment, providing staff training, etc.)
- Confidentiality and data protection assurance
- Information security assurance
- Clinical information assurance
- Secondary use assurance
- Corporate information assurance

All Health and Social Care service providers, commissioners and suppliers must have regard to the Information Governance Toolkit Standard approved by the Standardisation Committee for Care Information (SCCI).

All organisations that have access to NHS patient data must provide assurances that they are practising good information governance and use the Information Governance Toolkit to evidence this. Where services are commissioned for NHS patients, the commissioner is required to obtain this assurance from the provider organisation and this requirement should be set out in the commissioner-provider contract.

For 2016/2017 the trust achieved a compliant evidence based Information Governance Toolkit score of 68%.

The information governance scores for St George's can be found at www.igt.hscic.gov.uk. St George's is listed as an acute trust and our organisation code is RJ7.

Improving patient safety

Reducing medication errors

Over the years the trust has worked hard to develop and maintain its strong reporting culture. Following their audit of the trust in June 2016, the Care Quality Commission (CQC) reported that staff understood how to recognise and report medicines related safety issues. This is reflected in the higher than average reporting rate of medication incidents at the trust.

How did we do?

In 2016, the National Reporting and Learning System reported that St George's medication error reporting was higher than the national benchmark for reporting medication incidents. 13.7% of all incidents reported by St George's involved medication, in comparison to 10.8% for all acute teaching organisations for the period of April – September 2016.[1]

In quarters 1-3 of 2016/17, St George's reported 1420 medication incidents, reflecting a good safety culture at the trust. Of these incidents 94.4 % resulted in no harm, 4.5% in low harm and 1.1% in moderate harm. No medication incidents resulted in severe harm. The most common types of error were omissions and delays to administer medication and administering the wrong dose of medication.

Degree of harm:

No harm – 94.4%
Low harm – 4.5%
Moderate harm – 1.1%
Severe harm – 0%

Trend of reporting medication incidents continued to increase over 2016/17, without an increase in the degree of harm. 94.4% of incidents were no harm in quarters 1-3 of 2016/17, compared to 93.0% for the previous year.

Monitoring

Medicine errors and safety incidents are reported via Datix and these are reviewed by the trust Pharmacy and the Medicines Optimisation Committee on a quarterly basis. The feedback and learning to staff is communicated through a variety of channels such as newsletters, trust-wide memos, quarterly meetings with senior nursing staff for each division, divisional governance meetings and face to face meetings with relevant staff.

The trust pharmacy department has 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, medication handling and medication safety. The pharmacy medication safety team also co-ordinate medication safety monitoring visits to clinical areas to monitor medication safety issues.

During 2016/17, medication safety visits have been conducted in community services, ward and non-ward areas including radiology and endoscopy.

References:

1. National Reporting and Learning System (March 2017) Organisation Patient Safety Incident Reports: 01 April 2016 – 30 September 2016; St Georges University Hospitals NHS Trust.

Patient deterioration

Summary

St George's outreach functions are covered by various individuals and departments, however the trust does not have a dedicated nursing outreach team. Internal National Early Warning Score (nEWS) and global trigger tool audits have identified some failures in care. Several Serious Incident (SI) reports have suggested patients may have suffered harm or death due to failures in the recognition or escalation of acute physiological deterioration.

Additionally, there have been a growing number of potentially avoidable out of hours' referrals to GICU. In 2016 'deteriorating adult' was added to the Trust Risk Register and was exposed to a 'deep dive' in a trust risk meeting in April 2017.

In May 2016, the Deteriorating Adult Group (DAG) was convened to in response to the above concerns. This group has wide representation from across the hospital and has highlighted variable or unreliable practice in some areas of the hospital with regard to:

- Recognition of physiological deterioration
- Local escalation to senior nursing and medical staff
- Lack of routine junior and senior medical input on some wards
- Gaps in consultants review of deteriorating patients
- Poor use treatment escalation plans (TEP) and DNA-CPR orders

Vision

The trust will provide high quality safe care for every adult inpatient, with the aim of recognising and escalating timely deteriorating patients. The trust will provide appropriate treatments according to individualised treatment escalation plans.

Aims

Our aims are to:

- Reduce avoidable cardiac arrest
- Improve individualised in-patient care
- Improve end of life care

Achievements

Deteriorating Adults Group (DAG)

The Deteriorating Adults Group meets every two weeks with divisional and departmental representatives to review progress with recognition and management of the deteriorating adult patient and engage clinicians from across the organisation.

Policy

The policy for the Minimum Standard for Adult In-Patient Observation has been updated to improve the processes of recognition, escalation, management and governance and in particular strengthen the escalation criteria (see below). The policy is available on the trust policy hub (http://stg1wordpress01/wordpress/?s=Adult+In-Patient+Observation+) and has been widely disseminated and communicated through trust divisional structures.

National Early Warning Score (nEWS) audit

Historically we have audited compliance with nEWS bi-annually. Our last audit in January 2017 demonstrated improvement in all four key standards from the previous year's audits. A full report is provided in Appendix E.

Standard	Jan 2017	July 2016	Jan 2016
Recording a complete set of observations	89%	87%	86%
Scoring nEWS correctly	83%	74%	66%
Appropriate response	80%	68%	50%
Spacing	84%	59%	57%

We have developed a method using RATE for all wards to audit themselves monthly, in addition to continuing the bi-annual assurance audits. This data will be available on the new trust scorecard. Trust governance structures have been engaged in the delivery and action ownership of these audits. Ward managers have also been designated to be the ward nursing leads for nEWS and the deteriorating patient.

Education and Training

We have mapped the education and training available in the trust to enable recognition and management of the deteriorating adult patient. All permanent and temporary nursing, medical and HCA staff will be expected to complete the National Early Warning Score (nEWS) online training upon arrival in the trust. The training will also be expected to be completed within one year for all current staff.

In addition, permanent staff will be expected to complete within one year a Medical Emergencies: Evaluation, Response and Keeping Attention on Team Communication and Patient Safety (MEERKATS) programme. Both of these will be MAST, be reassessed triennially and recorded on TOTORA.

HCA and nursing staff will also complete nEWS competencies - HCA's annually and nursing staff tri-annually. Newly graduated nurses will also receive a programme called Harm Free Care (HFC) the content of which is currently under review. Only after successful completion of this mandatory education will nursing staff be considered for academic programmes related to acutely unwell adults.

To enable ward based education, effective competency assessment and appropriate nursing faculty for MEERKAT's, HFC and Sepsis simulation, the Practice Educators across the trust have been requested to spend a one day a week working on deteriorating adult education.

To assist them, corporate tools for teaching nEWS and Sepsis have been developed and a new competency assessment for HCA's has been published.

Critical care liaison pilot (CCLP)

This six-month pilot funded via the Sepsis CQUIN came to an end on 31 March 2017. The team of three individuals leading the pilot have been integral to delivering much of the work described in this report.

They have worked closely with four wards, identifying and introducing measures to address poor ward handover and knowledge of patients scoring a nEWS ≥ 5; poor utilisation of ward whiteboards; poor knowledge of nEWS amongst the HCA group, poor use of treatment escalation plans and DNA-CPR.

How representative these issues are of the wider hospital remains speculative, but similar concerns have been raised through other channels. The CCLP has delivered the ward portion of the 16/17 Sepsis CQUIN and provided ad hoc support to the ICU SpR and Med Reg with the care of patients recognised to be deteriorating. The additional, highly skilled resource provided under the pilot has received excellent feedback.

A further year of funding has now been agreed, although only one post is currently funded. The remaining two posts will be taken from the ICU budgets and commence in May 2017. This team will continue with this quality initiative, working with the wards in succession to assess their current practice and introduce new processes to improve the care of deteriorating patients including:

- Daily handover sheets that must contain the latest nEWS score and highlight the trend
- Patients with a nEWS score ≥ 5 must be discussed on board rounds and an action plan documented in their notes. The responsible consultant should be made aware of these patients
- Ward whiteboards should be utilised to provide real time reporting of patient nEWS and to provide a median and range of the ward nEWS scores to identify both individual patients and overall ward acuity
- All in-patients with acute or chronic life limiting conditions should have a TEP +/- DNA-CPR in place within 48 hours of admission
- Regular use in conjunction with the Practice Educators of mobile simulation pertinent to the ward area

Serious incident (SI) reporting

SI reporting is now a regular item on the Deteriorating Adults Group agenda. New SI's and closed SI's are discussed to ensure trust wide dissemination of this knowledge. A thematic analysis of the last years SI's is in progress.

Work in progress

We are working closely with the trust IT service to ensure that the whiteboards are functioning to enable real time nEWS scores to be available on each ward and to develop the functionality to enable mean/median nEWS scores per ward, as a proxy marker of acuity.

We are also working with ward staff to ensure they use the iCVSM (observation machine) correctly, to ensure data is sent to iCLIP or the whiteboard. Currently the majority of nEWS recording is paper based. The current iCLIP system has limited functionality, has only partially been rolled out and cannot provide reliable audit data. Consideration should be given to deploying an electronic nEWS system, capable of recording, prompting, reporting, recognition and escalation.

Individualised and End of Life Care

Currently, treatment escalation plans (TEP) and DNA-CPR are poorly utilised. The CCLP will continue to work with palliative care to develop a TEP and roll out to the wards. Baseline audits were completed on three wards by the pilot team. General Intensive Care Unit is also working with ward to consultants to offer ICU consultant input into complex ward patients regarding the development of treatment escalation plans.

Education

A metric is being developed to understand the baseline education required to ensure adequate levels of skill in the wards to recognise and manage the deteriorating adult. This will include Basic Life Support (BLS) and Immediate Life Support (ILS) compliance, as well as MEERKAT's, nEWS competencies, and nEWS e-learning. We aim to introduce HCA's to MEERKATS programmes.

Situation Background Assessment Recommendation (SBAR)

We are developing an SBAR sticker for use when escalating a patient's condition and a corporate teaching tool. These will be trialled on the critical care liaison pilot wards.

SAFER bundle

Implementation of the SAFER bundle has commenced within the trust. The purpose of SAFER is to ensure the optimal flow of patients in and out of the ward, ensuring senior medical review for each hospital inpatient.

Outreach team

The hospital has a variable response to deteriorating adults. Currently this service is provided by an on call General Medical SpR, the GICU SpR, speciality SpRs such as Cardiology, the “6111” and “7647” Anaesthetic SpRs, the resuscitation service and the Hospital at Night team. Currently, with the exception of Hospital at Night, there is no central co-ordination of people or processes.

In order to reduce the current variability of care, the Trust is developing a standardised hospital wide response model for the care of deteriorating adults. The model will consider the need for a critical care outreach team, and/or developing a hospitalist model of care as outlined by the Royal College of Physicians Future Hospitals Project.

Hospital at Night

The Hospital at Night Advance Nurse Practitioner s should be considered the night time component of ‘outreach’ and should be the first point of call for all deteriorating patients, unless the patient fulfils the criteria for an “arrest” call. They should work more closely with the on call acute medical and critical care teams to ensure there is a clear understanding of patients who are rapidly deteriorating or with a nEWS≥5 in the wards. The CCLP are planning to provide clinical support to cover a gap at weekends and will be working with the current Hospital at Night staff to ensure that the initiatives developed though the CCLP pilot are also utilised at night.

Metrics

A series of process and outcome metrics is under development, currently these include:

Process

- Accuracy in four measures of nEWS
- % Compliance with escalation for all patients scoring nEWS ≥5
- Number of patients with consultant led plan of care within 24 hours of admission
- Number of patients with TEP/DNAR-CPR within 48 hours of admission

Outcome

- Mortality after cardiac arrest or peri-arrest
- Number of cardiac arrests

Future Strategy

Our future and long term strategy within the trust is to:

- Increase awareness and local ownership of risk in every ward
- Embed inpatient care and deteriorating adult care into the governance of every care group
- Improve nEWS monitoring and escalating compliance
- Monitor mortality and incidents and feedback locally
- Create safety work climate by supporting wards with training and change
- Reallocate resources where possible ± recruitment
- Achieve 100% SAFER compliance in the wards
- Set individual escalation and end of life plans for every patient admitted to the hospital

Areas for improvement

- Overwhelming workload – we need to focus on what can be done
- Local ownership of risk and process not currently embedded in care, directorate or divisional routine governance
- Clinical care reducing the time that clinical staff have to engage with quality initiatives
- Despite the provision and availability of simulation programmes to assist in the recognition and escalation of deteriorating ward patients (MEERKAT's), ward nursing staff are not being released to attend
- Financial constraints

Staff learning through incident feedback

Why is this important?

The trust operates a single electronic incident reporting system for all adverse incidents and near misses. Reporting an incident is one of the most important ways that staff can help the trust learn from things that go wrong. The trust also has a responsibility to ensure that feedback should be provided to staff who report incidents.

How did we do?

The incident reporting system provides the following mechanisms to enable prompt feedback to staff regarding incidents:

- Confirmation email sent to staff when incidents are reported
- Email communication function, to allow shared communication regarding incidents
- Automated feedback via email when an incident is closed on the system, providing staff with details of how an incident has been followed up – this function has recently been put into place

The trust has also introduced a number of other learning initiatives and has continued to work towards enhancing some existing mechanisms throughout 2016/17:

- Risk Management input into training programmes, including the new manager's induction and preceptorship nursing, regarding incidents and serious incidents (SIs)
- Increased frequency of root cause analysis (RCA) training from bi-monthly to monthly to enable more staff to understand the importance of learning from incidents and enhanced involvement in the SI investigation process
- Use of a 'safety huddle' initiative to share learning amongst ward staff in some medical wards
- Increased involvement from medical staff in following up incidents
- Implementation of a job description for governance leads signed off by Medical Board
- A monthly governance newsletter circulated to all matrons, governance leads, care group leads and other senior staff
- Reporting of incident/SI data to Board and Board sub-committees, as well as at divisional level
- Raising awareness of how to gain feedback using CARE folders in wards/departments
- Introduction of quarterly analysis report – Complaints, Litigation, Incidents, PALS, Inquests (CLIPI) report and learning from SIs.

Overall the number of reported adverse incidents has increased across the trust, based on comparison with data from 2015/16. Higher and, or increased levels of incident reporting is considered as a positive indicator for effective risk management culture and systems in the NHS.

The number of SIs declared has decreased, compared with 2015/16. Observed in parallel, a decline in the number of Serious Incident (SIs) reported in 2016/17, together with an increase in the total reported incidents is a good indication that the organisation is improving from learning gained from adverse incidents.

Our aims

- Creating a culture of shared learning - encouraging openness and candour so that staff feel able and confident to raise concerns
- Promoting a positive change culture in order to become a learning environment
- Zero Never Events
- Introduce specific training programme for SI chairs and panels
- Increased involvement of simulation to support education and learning
- Improve incident reporting feedback on incidents at time of closure

Learning from never events outside of theatres

Why is this important?

It is equally as important to learn from never events that occur outside of theatres, because they can be as damaging and harmful as never events that occur during surgery (e.g. radiation incidents, risk of sepsis with retained swabs in obstetrics, wrong biopsies with missed cancer diagnosis).

How did we do?

The trust has revised its site policy to display outside theatre areas, in line with the current NatSSIP policy. The policy is now named 'Safer Standards for Invasive Procedures' and covers all invasive procedures inside and outside of theatres.

Quarterly audits on Local Safety Standards for Invasive Procedures (LocSSIPs) have been established and the data is monitored by the Patient Safety and Quality Board.

The trust is extending the auditable database on LocSSIPs monthly.

There have been zero Never Events outside of theatres at the trust since December 2015.
Sir Norman - compared with how many in the same period during the previous year?

Learning from Never Events is included in the monthly trust Governance Newsletter and circulated to all matrons, governance leads, care group leads and other senior staff.

Our aims

- Zero Never Events
- Extending the LocSSIPs database
- Regular audit with eventual aim of rotational peer audit long term

End of life care

Why is this important?

End of life care is provided to patients by all of our clinical staff with approximately 1750 deaths per annum for patients under our care in our acute and community services.

'Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020' states that:

"End of life care is care that affects us all, at all ages, the living, the dying and the bereaved. It is not a response to a particular illness or condition. It is not the parochial concern of a particular group or section of society. When it comes to death the statistics are stark. 100% of us will die…palliative and end of life care must be a priority.

The quality and accessibility of this care will affect all of us and it must be made consistently better for all of us. The needs of people of all ages who are living with dying, death and bereavement, their families, carers and communities must be addressed, taking into account their priorities, preferences and wishes.

As people, professionals and local leaders within the health and social care system and our communities, we must commit to these ambitions and to the framework that will enable their delivery."

End of life care affects every part of the trust, from the neo-natal unit to the mortuary. This type of care is about helping people live as well as possible until death, with dignity and according to their wishes. There has always been good and positive direct patient care at St George's, but improved governance and operational oversight has meant that we can now evidence where things are working well, and areas where we can do better.

How did we do?

We have participated in a number of key audits in recent years and have understood what we need to do in order to continually develop our services to deliver good quality accessible end of life care.

The Care Quality Commission (CQC) rated end of life care at the trust as 'requires improvement' in 2014. We developed an action plan and work was undertaken across the trust to improve our services.

The CQC inspected the trust again in June 2016. In November 2016 we were rated as:

- 'Inadequate' for End of Life care overall
- 'Good' for Caring
- 'Requires Improvement' for Safe and Responsive and;
- 'Inadequate' for 'Well Led' and 'Effective' domains

The CQC highlighted that patients were treated with dignity, kindness and compassion and that there was consistently positive feedback from patients and their relatives about the service.

However, the CQC highlighted that there was no integrated strategy for end of life care within the trust and no leadership and governance framework to support executive oversight of the community end of life care services. The CQC also highlighted that there was no evidence of joint working and that there was limited evidence of our ability to demonstrate our performance and/or effectiveness of our care. Additionally, there was no assurance provided to the CQC that our staff had access to appropriate training.

From November 2016 we developed a trust wide end of life care strategy: *'Patients, Families and Carers First: End of Life Care Strategy 2016 – 2020'.*

We nominated a non-executive board member for end of life care and re-established the end of life care Steering Group with divisional and departmental representation and including external stakeholders. We also developed a structured governance framework and confirmed the medical, nursing and management leadership for end of life care.

We now have a detailed implementation plan in place to support the delivery of the strategy which is divided into time specific milestones for end of life care service development and delivery across the divisions and the trust as a whole.

From January 2017 the trust has committed to:

- Reviewing and analysing end of life care related complaints and incidents
- Reviewing staff education and training levels
- Reviewing agreed key performance metrics e.g. the numbers of patients who died in their preferred place of death
- Providing and end of life care related audit and;
- Making recommendations for improvement in practice

Our aims

The trust end of life care strategy is shaped by *'Getting end of life care right'- South West London Sustainability and Transformation Plans* and is informed by the outcome of the CQC inspection in 2016.

It reflects the six ambitions for end of life care, regardless of age, diagnosis or locality and will be delivered seamlessly by our hospital and community services embracing a multi-disciplinary and multi-agency approach to care. Implementation and delivery will take different forms across different specialities and services and will be reflective of the specific needs of discrete populations, such as children or older people.

Our vision is: *End of life care matters to everybody and that people under our care are able to die with choice and dignity.*

The trust has detailed the following 6 ambitions which are common to all:

1. Each person is seen as an individual
2. Each person gets fair access to care
3. Maximising comfort and wellbeing
4. Care is co-ordinated
5. All staff are prepared to care
6. Each community is prepared to help

We will know we are doing well by successfully delivering the following principle objectives in line with our 6 ambitions:

- Promoting the use of Advance Care Planning to enable people to state their end of life care wishes and ensure they are adhered to. To date each division has developed a local process to identify patients who might be entering the last year of life
- Ensuring high quality end of life care. To date we have developed a trust wide care plan for last days and hours of life aligned to the five priorities of care for the dying person
- Changing the perception of 'death is failure' to 'a good death is a successful care outcome'. To date we have created a staff and patient communication and engagement strategy and we are participating this year again in the Dying Matters national campaign

- Developing transparent processes for access to rapid response 24/7 end of life care. To date each division has implemented guidance for identification of patients in the last hours and days of life
- Ensuring health and social care professionals have access to appropriate and high quality training and education. To date we have successfully secured Health Education England funding to develop and education framework across the trust and primary care. We are benchmarking our training content with another London trust and monitoring the levels of our training activity
- Improving the co-ordination of end of life care between varied providers. To date we have agreed that *Co-ordinate My Care* is the electronic End of Life care record for patients in our care. Our community staff participate in the gold standard framework MDT meetings with GPs and colleagues. Our specialist palliative care team have access to *Co-ordinate My Care* to update and create *Co-ordinate My Care* records. Our community and acute colleagues meet on a monthly basis to discuss individual patient care and End of Life care service development

Complaints

Why is this important?

Last year St George's University Hospitals Trust 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 that 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 (PALS), who will work with them and the relevant service to resolve any issues. Complaints and compliments can also be formally submitted to our Complaints Department. We aim to investigate and provide a full response to all formal complaints within 25 working days of the complaint being received, or within a longer timeframe if agreed with the complainant.

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 in which we engage with our patients and visitors.

Our outcomes

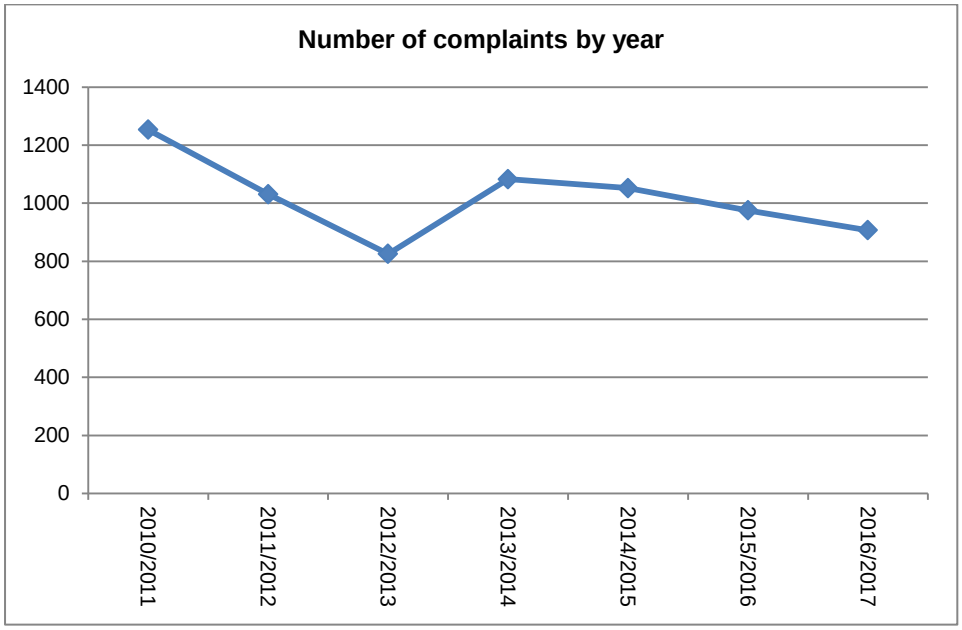
In 2016/2017 we received 907 (THIS NUMBER MAY CHANGE BEFORE FINAL COPY IF ANY COMPLAINTS ARE DE-ESCALATED) formal complaints, a reduction of 7% compared to 975 complaints in 2015/16. In addition we dealt with 533 informal issues and queries via the Complaints Department and we received 701 compliments. The Patient Advice and Liaison Service received 7777 contacts of which 3948 were categorised as concerns.

It is difficult to benchmark our complaints statistics against other NHS trusts, as there is currently no uniform method for trusts to record complaints. This results in inconsistency across the NHS.

We view all types of patient feedback as positive and we are constantly exploring how we can encourage patients, carers and families to provide the trust with their views and feedback.

Number of complaints

Year	Number of complaints
2016/2017	907
2015/2016	975
2014/2015	1052
2013/2014	1083
2012/2013	825
2011/2012	1031
2010/2011	1253



Complaints response rate

We fully responded to NOT YET KNOWN 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 NOT YET KNOWN 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.

The chart below tracks peformance throughout the year. It can be seen that across the year any improvements in peformance against the 85% target were not sustained.

For complaints received in February 2016 performance dipped below 60% for the first time since April 2014.

Action plans have been put in place in consistently poorly performing divisions with the aim of improving and delivering performance against internal standards – these are however not achieving the desired results. As at May 2016, a new action plan is being developed and this will be presented and monitored at the Quality and Risk Committee in the coming year. TO BE UPDATED WHEN PERFORMANCE FIGURES ARE KNOWN.

INSERT CHART HERE TRACKING PERFORMANCE THROUGHOUT THE YEAR

Dementia and delirium

Why is this important?

People living with dementia and/or experiencing delirium are some of our most vulnerable service users. Our focus during 2016/17 has been to bring practice within the trust in line with the National Institute of Clinical Excellence (NICE) delirium quality standard. This requires us to assess all 'at risk' patients for the presence of delirium, treat delirium appropriately and actively prevent delirium developing in hospital.

To achieve this, we have developed a new delirium pathway which is being implemented across the hospital. In addition, as part of the *Personalised Care Quality Improvement Plan*, we have developed several targets for improving dementia and delirium care in the trust. We are also committed to listening to carers of people living with dementia through administering and acting on the results of our Dementia Carers Questionnaire. Additionally, we value input from voluntary sector partners, ensuring that the Alzheimer's Society and Wandsworth Carers' Centre are fully represented at the Trust's Dementia Strategy Group.

How did we do?

In recognition of the importance of delirium, the trust appointed a clinical lead for delirium to work alongside the dementia clinical lead in November 2016.

The nurse-led dementia and delirium team has been supporting the introduction of the new delirium pathway, as well as providing formal and informal training to staff and advising on the care of patients with dementia and/or delirium. Routine referrals of inpatients to the team have increased from an average of 5.4 per week in 2016 (total referrals = 280) to an average of 9.2 per week in 2017 (total referrals to date = 120).

The increase in 2017 does not take into account additional referrals made when the delirium team attended a ward as part of the delirium roll-out strategy (range: 10-20 additional referrals/week).
By 31 March 2017, the new delirium protocol had been introduced on 17 wards, including all general medical, acute surgical and senior health wards. Analysis of routine referrals reveals that 90% come from wards where the new delirium pathway has been introduced, compared to 10% that come from wards awaiting roll-out.

Just under 7000 trust staff have completed dementia awareness training, an overall response rate of 84%.

In May 2016, 32 wards were assessed using the PLACE (Patient-Led Assessments of the Care Environment), which includes measures of dementia-friendliness. Since then 238 dementia clocks, which help patients to maintain orientation in time, have been distributed to 33 wards. We have also introduced a pictorial food menu to make it easier for patients with communication difficulties to select their preferred drinks and meals.

Responses to the trust Dementia Carers Questionnaire in 2016/17 show that:

- 86% of carers would recommend the ward where the patient was looked after to friends or family, with similar numbers reporting that they received good communication from staff and felt sufficiently involved in the patient's care plan
- 95% of carers reported that the person living with dementia was treated with dignity and respect
- Two-thirds of carers said that they would like the opportunity to stay overnight with the patient, but only one in five had been able to do this

Our aims

During 2017/18 we will:

- Introduce scorecards to allow individual wards and directorates to rate the quality of their dementia care
- Audit compliance with the new delirium pathway
- Audit use of the *Butterfly Scheme* (our identification and care response scheme for people living with dementia) across the hospital
- Ensure that, where appropriate, ward staff offer dementia carers the opportunity to stay overnight with the person they care for
- Launch a new volunteering role providing activities (such as use of "memory boxes") for inpatients with dementia
- Receive our data from the 2016 National Audit of Dementia, and adjust our dementia and delirium strategy accordingly

Clinical records

Why is this important?

Health records serve many purposes in the modern healthcare environment, but fundamentally they are the foundation of high quality, safe patient care. Clinical practice in the UK increasingly relies upon the electronic storage and communication of patient records and electronic communication of records. Electronic records make handwriting misunderstandings redundant and facilitate improved communication across the healthcare systems.The trust is currently in transition with the deployment of iClip (Cerner Millennium) that will eventually mean a fully digital record of the patient's care. In the meantime, the trust conducts regular audits of existing paper-based health records to monitor the quality of record-keeping against published national standards set by the Royal College of Physicians in 2008.

How did we do?

At present 24 out of 35 Care Groups within the trust continue to rely on paper-based health records for the care of inpatients. Of the Care Groups participating in these audits, performance against record-keeping standards are good (>85%) for records being bound, organized and ensuring clinical entries are legible, dated and signed.

However, across the trust poor performance (63%) has been noted for the consultant's name or their team not being recorded in patient health records. Additionally, not making use of the patient labels on the history (continuation) sheet has been noted in approximately 50% of records.

Our aims

Until such time as iClip is fully deployed across the entire trust, we will continue to monitor and feed back to Care Groups about their existing performance against established standards in record-keeping, to ensure that clinical staff remain aware of the importance of good record-keeping in maintaining patient safety.

The terms of a timeline for full deployment and implementation of iClip are to be finalised. The trust will potentially invest in infrastructure over the next 12 months or so, i.e. cabling, servers, etc. Once this has been done, the trust will commence an iCLIP deployment project – forecast for 2018/19.

Mortality

Why is this important?

St George's is committed to understanding mortality data and learning from any care issues in patients who die. The trust has a well-established Mortality Monitoring Committee, chaired by the Associate Medical Director for Mortality. The membership is multi-professional, with representatives from all divisions and external Public Health. Key corporate functions are also represented to ensure development of consistent approaches to clinical coding and information management.

As defined by the terms of reference the primary purposes of the committee are:

- To monitor and report mortality metrics and consider for investigation areas where we appear to be an outlier
- To review all deaths that occur following elective admission
- To benchmark mortality at a procedure and diagnosis level and to provide oversight of investigations where outcomes appear to be statistically significantly different to the national average or appropriate peer group
- To lead and promote effective governance of mortality within divisions through sharing best practice and implementing trust-wide protocols
- To promote and support care groups to identify learning and actions from the proportionate review of all their in-hospital deaths
- To engage with the evolving national strategy for measurement and learning from mortality. The committee has fully engaged in the national strategy, and the pilot of the Royal College of Physicians National Mortality Case Record Review Programme

Our outcomes

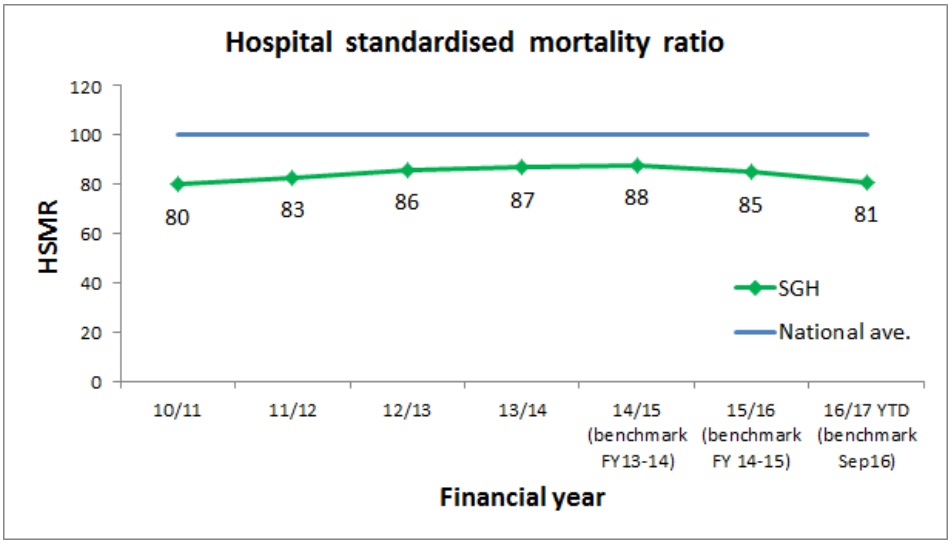
The summary hospital-level mortality indicator (SHMI) is intended to be a single consistent measure of mortality rates. It shows whether the number of deaths linked to an organisation is more or less than would be expected, when considered in light of average national mortality figures, given the characteristics of the patients treated there. It also shows whether that difference is statistically significant.

Our SHMI is currently lower than expected. The table below summarises the quarterly publications for this period. As well as considering our overall position we evaluate this data by diagnosis group and investigate areas where mortality may be higher than expected.

Publication date	Reporting period	Ratio	Banding
23 June 2016	**January 2015 – December 2015**	**0.91**	**As expected**
22 September 2016	**April 2015 – March 2016**	**0.90**	**Lower than expected**
15 December 2016	**July 2015 – June 2016**	**0.88**	**Lower than expected**
23 March 2017	**October 2015 – September 2016**	**0.86**	**Lower than expected**

Source: NHS Digital

At St George's we continue to use the hospital Standardised Mortality Ratio (HSMR) in addition to the SHMI to monitor risk-adjusted mortality. The chart below shows our performance over the last six years. With the HSMR, if our mortality matched the expected rate our score would be 100. The HSMR indicates that St George's mortality is consistently significantly better than expected.



Source: Dr Foster Intelligence

Palliative care coding

As it includes all deaths, the SHMI makes no adjustment for palliative care. The Health and Social Care Information Centre publishes contextual indicators to support interpretation of the SHMI, one of which is 'the percentage of deaths with palliative care coding'. This presents crude percentage rates of deaths that are coded with palliative care either in diagnosis or treatment fields.

The data displayed below shows the percentage of deaths with palliative care coding for the trust compared to the national average.

Publication date	Reporting period	St George's	National
23 June 2016	January 2015 – December 2015	33.4%	27.6%
22 September 2016	April 2015 – March 2016	39.1%	28.5%
15 December 2016	July 2015 – June 2016	42.8%	29.2%
23 March 2017	October 2015 – September 2016	48.9%	29.7%

Source: NHS Digital

Our aims

Learning from Deaths

Following the recent findings of the Care Quality Commission report *'Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England'*, the National Quality Board (NQB) published the first edition of *'National Guidance on Learning from Deaths for Trusts'* in March 2017.

The purpose of the guidance is to help standardise and improve the way acute, mental health and community trusts identify, report, review, investigate and learn from deaths, and engage with bereaved families and carers in this process.

St George's has a mature mortality review system and will engage in meeting the requirements of this framework in full. An implementation plan was discussed by the Board in April 2017 and a non-executive director has been appointed to provide oversight of progress.

The framework demands that from April 2017, the Trust collects and publishes on a quarterly basis specified information on deaths, which will include the number of in-patient deaths and those deaths subjected to case record review. Of those reviewed we must report an estimate of how many deaths were judged to be more likely than not to have been due to problems in care. There is a particular focus on vulnerable groups, for example patients with learning disabilities or mental health issues. This data and learning will be published in future Quality Accounts.

30 Day Re-admissions

Why is this important?

Re-admission can be planned or unplanned. High levels of unexpected unplanned re-admissions have often been considered as a measure of the quality of hospital care. At the individual level, re-admission can represent a failure or breakdown in plans of care for a particular patient, or the occurrence of an unexpected adverse outcome. However, as might be expected, health care is almost always more complicated and the trust has to deliver cost-effective treatment and at the same time ensure that discharge planning provides not only the healthcare professional but the patient with the support and information they need to reduce and prevent re-admissions.

How did we do?

Reducing emergency admission has been hugely challenging for the trust considering the regulatory financial constraints; however we are aware that the benefits of reducing emergency re-admission are immense to our patients and have made this one of our key priorities.

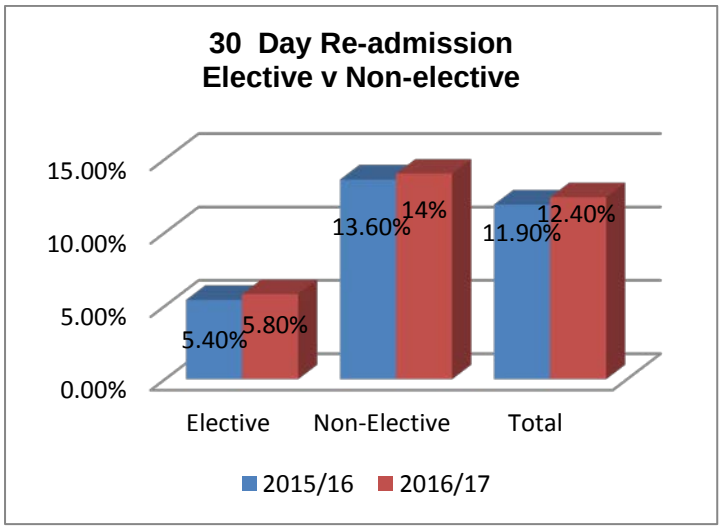
In 2016/17, 12.4% of our patients were re-admitted to hospital within 30 days of discharge. In real terms 6903 of our patients were re-admitted from a previous unplanned or planned admission. This a slight increase in our performance on the previous year of 11.8%, when 6030 patients were re-admitted.

Planned and unplanned re-admissions (data to February 2017)

The trust had 83,988 planned admissions in 2016/17 compared to 86,714 in 2015/16 and saw a slight increase in planned re-admissions rates from 5.3% to 5.8%.

In 2016/17 our trust performance for unplanned re-admissions was 14%, an increase of 0.90% on re-admissions for the same period the year previous. The higher admission rates occurred in patients with diagnosis such as cancers, hematologic conditions, lung disease and mental health disorders. Although our re-admission rates are higher than similar trusts whose rates average around 9%, our performance is still above expected levels compared to trusts with a similar number of discharges.

St George's Hospital is a major trauma centre within London, a hyper-acute stroke unit, a heart attack centre and treats seriously ill patients with complex cases from across the county including South West London, Surrey and as far afield as East Anglia. This means that the risk of patients needing to be re-admitted after leaving hospital is higher for St George's than other acute trusts in the areas.



Our aims

In 2017/18 the trust is committed to reducing re-admission for all patients irrespective of whether that care is planned or unplanned. We will work to ensure that all patients are discharged when it is safe to do so and that there is a coordinated approach with our partners and local authorities to ensure the right support is in place for them.

Performance table

Theme	Indicator	Target	2014/15	2015/16	2016/17	Rag Rating 2016/17	2017/18
ACCESS	A&E 4 hours waiting time	95%	92.14%	90.4%	91.56%	🔴	Improve and maintain performance in line with trajectory to achieve compliance
	18 Weeks RTT compliance: Incomplete	92%	91.33%	90.3%	83.60%	🔴	Improve and maintain performance in line with trajectory to achieve compliance
	Cancer 14 Day GP Referral	93%	86%	87.8%	89.90%	🔴	Improve and maintain performance
	Cancer 14 Day Breast Symptomatic	93%	95%	93.2%	92.90%	🔴	Improve and maintain performance
	31 Day First Treatment	96%	97%	96.6%	97.20%	🟢	Maintain compliance and ensure performance remains within target
	31 Day First Subsequent Treatment Surgery	94%	96%	96.0%	96.90%	🟢	Maintain compliance and ensure performance remains within target
	31 Day First Subsequent Treatment Drug	98%	98%	100.0%	99.70%	🟢	Maintain compliance and ensure performance remains within target
	62 Day Referral	85%	80%	85.2%	84.90%	🔴	Improve and maintain performance
	62 Day Screening	90%	93%	90.4%	93.20%	🟢	Maintain compliance and ensure performance remains within target
	62 Day Consultant Upgrade	85%	88%	92.7%	92.27%	🟢	Maintain compliance and ensure performance remains within target

Theme	Indicator	Target	2014/15	2015/16	2016/17	Rag Rating 2016/17	
OUTCOMES	Clostridium Difficile	31	38	28	36	🔴	To be compliant and ensure performance within target
	MRSA bacteraemia cases	0	6	9	2	🔴	Zero MRSA incidents. Position as at Feb 17
	Mixed Sex Accommodation	0	16	11	0	🟢	To be compliant and ensure performance within target
	Total number of Never Events	0	5	8	3	🔴	No Never Events in 2017/18
	Mortality	100	Lower than expected levels achieved			🟢	Sustain low mortality rates

Certfication of Compliance Learning Disabilities						
Does the Trust have mechanism in place to identify and flag patients with learning disabilities and protocols that ensure the pathways of care are resonably adjusted to meet the health needs of these patients?	**Yes/No**	**Yes**	**Yes**	**Yes**	🟢	Continue to maintain high levels of performance
Does the Trust provide available and comprehensive information to patients with learning disabilities about the following criteria: - treatment options; complaints procedures; and appointments?	**Yes/No**	**Yes**	**Yes**	**Yes**	🟢	
Does the Trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities?	**Yes/No**	**Yes**	**Yes**	**Yes**	🟢	
Does the Trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff?	**Yes/No**	**Yes**	**Yes**	**Yes**	🟢	
Does the Trust have protocols in place to encourage representation of people with learning disabilities and their family carers?	**Yes/No**	**Yes**	**Yes**	**Yes**	🟢	
Does the Trust have protocols in place to regulary audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?	**Yes/No**	**Yes**	**Yes**	**Yes**	🟢	

Note: RTT performance reported is avg YTD for April to March 2016/17 - Cancer performance reported is YTD for April to March 2016/17

Annex 1: Statements from commissioners, Healthwatch and Overview and Scrutiny Committee

Healthwatch Wandsworth and Healthwatch Lambeth

Wandsworth to submit statement on Weds 17 May after CCG committee meeting on Tues 16 May.

Wandsworth Adult Care and Health Overview Scrutiny Committee

[Insert]

Statement from Wandsworth CCG, Public Health and Surrey Downs

[Insert]

Statement from the governors of St George's University Hospitals NHS Foundation Trust

Kathryn Harrison – Lead Governor

Annex 2: Statement of directors' responsibilities for the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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

- The content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016/17 and supporting guidance

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

    - board minutes and papers for the period 1st April 2015 to 2nd June 2016 and papers relating to quality reported to the board over the period 1st April 2015 to 2nd June 2016
    - feedback from commissioners dated 24/05/2016 - feedback from governors dated 24/05/2016 - feedback from local Healthwatch organisations dated 17/05/2016 – feedback from Wandsworth Overview and Scrutiny Committee dated 16/05/2016 - feedback from Wandsworth CCG dated 24/05/16
    - the trust's complaints report published under Services and NHS Complaints Regulations 2009, dated 2014/15
    - the latest national patient survey dated 2015 (please note the results are under embargo and cannot be published in this report). The latest national staff survey dated 2015
    - the head of internal audit's annual opinion over the trust's control environment dated 26/05/2016
    - CQC Intelligent Monitoring Report May 2015

- The quality report presents a balanced picture of the trust's performance over the period covered

- The performance information reported in the Quality Report is reliable and accurate

- There are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice

- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

- The quality report has been prepared in accordance with NHS Improvement's annual reporting guidelines (which incorporate the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

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

Non-reporting disclosure – Referral to Treatment (RTT)

Following a series of performance and data issues, the trust commissioned a comprehensive review of the systems and processes in place to manage patients along the elective care pathway. The outcome of the review, conducted by MBI Health Group and endorsed by the NHS Improvement Intensive Support Team, identified multiple operational process and technology issues that highlighted significant risks to the quality of care and safety of patients at every stage of their pathway - whether on RTT pathways or not.

The scale and complexity of the challenge is significant and the review recognised that the trust had neither the required expertise, nor resources to manage the required corrective action. Following publication of the findings of the MBI Health Group review in June 2016, the trust Board took the decision to suspend national reporting against the RTT (18 week) standard.

In response to the findings and to implement the recommendations of the review the trust has established the Elective Care Recovery programme to lead the corrective action necessary to return the trust to reporting.

Led by the appointment of a Programme Director, the plan comprises six work streams which are necessary to improve the trust IT systems, data quality and operational processes of tracking and which includes the requirement to validate a significant number of pathways on the trusts systems. The validation process is complex and it is envisaged will take more than a year to be completed.

It is not expected that the trust will return to national reporting in 2017/18.

As the trust is currently not reporting performance against RTT, the trust directors have a plan in place to remedy this as outlined above. The scale of the issues identified means that it is not possible at this time to say when the trust will return to full national reporting against the RTT standard.

Jacqueline Totterdell	XXX
Acting chief executive	Chairman
XXX	XXX

Appendices

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

The national clinical audits and national confidential enquires that St George's University Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2016/17, are listed below 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.

Title		Relevant	Participating	Submission rate (%) / Comment
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)		✓	✓	On-going
Adult Asthma		✓	x	This is not included on the mandatory NCAPOP list. We were unable to participate due to a lack of resource.
Adult Cardiac Surgery		✓	✓	On-going
Asthma (paediatric and adult) care in emergency departments		✓	✓	100%
Bowel cancer (NBOCAP)		✓	✓	On-going
Cardiac Rhythm Management (CRM)		✓	✓	On-going
Case Mix Programme (ICNARC)		✓	✓	On-going
Child Health Clinical Outcome Review Programme	Children with Chronic Neurodisability	✓	✓	100%
	Young People's Mental Health	✓	✓	On-going
	Cancer in Children, Teens and Young Adults	✓	✓	On-going
Chronic Kidney Disease in primary care		x	N/A	Not applicable
Congenital Heart Disease (CHD)		✓	✓	On-going
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)		✓	✓	On-going
Diabetes (Paediatric) (NPDA)		✓	✓	On-going
Elective Surgery (National PROMS Programme)		✓	✓	On-going
Endocrine and Thyroid National Audit		✓	✓	100%
Falls and Fragility Fractures Audit Programme	Fracture Liaison Service Database	✓	✓	100%
	Inpatient Falls	✓	✓	Data collection for this audit did not take place nationally in 2016/17. We participated in 2015/16 and have registered to participate in 2017/18.
	National Hip Fracture Database	✓	✓	98.8%
Head and Neck Cancer Audit		✓	✓	On-going
Inflammatory Bowel Disease (IBD) programme		✓	✓	On-going
Learning Disability Mortality Review		✓	x	This programme was in pilot

Programme (LeDeR Programme)				phase in 2016/17 and we volunteered, but were not selected as a pilot site. Our LD CNS has completed training and we have registered to begin participation from 1st May 2017 as required nationally
Major Trauma Audit		✓	✓	On-going
Maternal, New born and Infant Clinical Outcome Review Programme		✓	✓	100%
Medical and Surgical Clinical Outcome Review Programme	Acute Non-invasive Ventilation (NIV)	✓	✓	100%
	Mental Health in General Hospitals	✓	✓	100%
	Acute Pancreatitis	✓	✓	100%
Mental Health Clinical Outcome Review Programme		x	N/A	Not applicable
National Audit of Dementia		✓	✓	100%
National Audit of Pulmonary Hypertension		x	N/A	Not applicable
National Cardiac Arrest Audit (NCAA)		✓	✓	On-going
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme		✓	✓	On-going
National Comparative Audit of Blood Transfusion	Audit of Red Cell & Platelet Transfusion in Adult Haematology Patients	✓	✓	100%
	Re-audit of Patient Blood Management in Scheduled Surgery	✓	✓	On-going
	Audit of Patient Blood Management in Scheduled Surgery	✓	✓	100%
	Audit of the use of blood in Lower GI bleeding	✓	✓	100%
National Diabetes Audit – Adult	Core Diabetes Audit	✓	✓	On-going
	Foot Care	✓	✓	On-going
	Inpatient Audit (NaDia)	✓	✓	100%
	Pregnancy in Diabetes	✓	✓	100%
	Transition	✓	✓	100%
National Emergency Laparotomy Audit (NELA)		✓	✓	On-going

National Heart Failure Audit	✓	✓	On-going
National Joint Registry (NJR)	✓	✓	On-going
National Lung Cancer Audit (NLCA)	✓	✓	On-going
National Neurosurgery Audit Programme	✓	✓	On-going
National Ophthalmology Audit	x	N/A	Not applicable
National Prostate Cancer Audit	✓	✓	On-going
National Vascular Registry	✓	✓	On-going
Neonatal Intensive and Special Care (NNAP)	✓	✓	On-going
Nephrectomy Audit (BAUS)	✓	✓	On-going
Oesophago-gastric Cancer (NAOGC)	✓	✓	81-90%
Paediatric Intensive Care (PICANet)	✓	✓	100%
Paediatric Pneumonia	✓	✓	100%
Percutaneous Nephrolithotomy (PCNL)	✓	✓	100%
Prescribing Observatory for Mental Health (POMH-UK)	x	N/A	Not applicable
Radical Prostatectomy Audit (BAUS)	✓	✓	100%
Renal Replacement Therapy (Renal Registry)	✓	✓	On-going
Rheumatoid and Early Inflammatory Arthritis	✓	✓	Data collection for this audit did not take place nationally in 2016/17. We participated in all previous years.
Sentinel Stroke National Audit Programme (SSNAP)	✓	✓	On-going
Severe Sepsis and Septic Shock – care in emergency departments	✓	✓	100%
Specialist rehabilitation for patients with complex needs	✓	✓	100%
Stress Urinary Incontinence Audit	x	N/A	Not applicable
UK Cystic Fibrosis Registry	x	N/A	Not applicable

Data notes:

Each audit within a programme has been counted separately. Where ‘on-going’ is stated this implies that the data collection deadline for complete 2016/17 data has not been reached at time of reporting and therefore data submission for the 2016/17 audit period is on-going and cannot be reported.

Appendix B: National clinical audit actions undertaken

The reports of 12 national clinical audits were reviewed by the provider in 2016/17 and St George's University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

National clinical audit	Action*
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis	Details of the report were discussed within the care group. A major concern was the amount of resources required to complete the audit which was complex and used a data collection system that was very unreliable. Locally we have started education to GPs to address the need to mention persistent synovitis in referrals. We offer a DMARD service, and are planning earlier DMARD training for patients, although this is dependent on resources. Issues concerning the audit have been fed back to the BSR and a local audit of practise is underway, as it is felt that the published results of the national project do not present an accurate picture of the service we provide.
Adult Community Acquired Pneumonia (CAP) December 2014 – January 2015	The main recommendations of the audit (with 3 year targets) are: • to increase the proportion of patients who have a chest radiograph within 4 hours of admission to 90% • to increase the proportion of patients who receive their first dose of antibiotic therapy within 4 hours to 85% • to improve the proportion of adults with moderate and high severity CAP administered combination β-lactam and macrolide therapy to 85% • to improve the proportion of coded CAP cases of pneumonia who have a CXR confirmed pneumonia to 85% (i.e. to improve accuracy of diagnosis) These improvements will be facilitated by better use of the CAP care bundle and this has already been adopted within SGH. There will be no national audit in 15/16 or 16/17 but it is anticipated that progress will be monitored in a local audit.
Neonatal National Audit Programme (NNAP): 2015 Annual Report on 2014 data	The report authors note that nationally completeness of data has improved over recent years, and the same appears to be true here with very few data items missing. This improvement is supported by the clinical lead who reviews the regular national data quality reports. Consideration is also being given to whether further resource is necessary to improve data recording, quality and completeness. Many tertiary units have a data manager to manage this audit and that option will be explored.
National Diabetes Inpatient Audit 2015	Results were discussed within the diabetes care group and a monthly meeting introduced to address areas of concern. The full national report and recommendations will further guide actions and response. Commitment to participate in re-audit in 2016.
National Prostate Cancer Audit Second Year Annual Report 2015	Data management system (Infoflex) to be amended to include additional data fields to meet audit requirements. These data fields are to be completed at the MDT both pre and post treatment. One of the MDT co-ordinators is to complete the metrics as patients are discussed in the meeting. This should open the door to better BAUS (national urology audit) submissions also. Infoflex to be our hub for these data collections and submissions to prevent double-filling. The current computers and laptops in the Pathology Seminar room to be upgraded to ensure the hardware is up to speed with our

	requirements and response in real time.
The End of Life Care (EOLC) Audit – Dying in Hospital 2015	The results of the audit together with the requirements of the new NICE guidelines have been discussed by the palliative care team and the End of Life Care Programme Board. Actions have been planned to address any shortfalls in both care quality indicators and organisational quality indicators. These are detailed below. **Care Quality Indicators:** • We are currently above average national average in 4 out of 5 of the clinical indicators, which is very encouraging. Guidance issued at St. George's advises all expected deaths should be referred to the palliative care team, so that we could write an 'individualised EOLC plan'. We will continue to refer all expected deaths to palliative care team and will audit compliance. • To improve our Holistic Assessment of the patient's needs regarding an individual plan of care we have introduced a guidance document to support nursing staff in writing the patients EOLC plan (Daily Nursing End of Life Care Evaluation Guidance). We are in the process of developing an electronic EOL nursing care plan to support nurses in delivering and evidencing the care they give and developing a medical template for EOL that will support clinicians to ensure the care they give is according to NICE guidance and document this in a structured format, once the whole of the Trust has moved to electronic notes. It is hoped that both electronic documents can be 'rolled out' together combined with an education programme provided by the palliative care team. This will depend on the IT strategy and scheduling for the CERNER roll out. • We will audit the use of daily nursing EOLC evaluation guidance in Q3. **Organisational Indicators:** • A board member now fulfils the role of lay member on the Trust Board with a responsibility for EOLC. • As part of the EOLC strategy we are developing an educational strategy, which we anticipate will be completed in Q3. • We are also developing an educational programme for the Trust which will include releasing one CNS per month from clinical responsibilities to devote time to Education and Training. This will include hands on support for staff caring for dying patients. We plan to implement this by Q3. • A survey of bereaved relatives and carers is underway. Initial results will be available in Q3.
National Audit of Percutaneous Coronary Interventions (PCI), January 2014 – December 2014	**Door to balloon time:** local audit is underway to pinpoint exactly where delays are occurring. This will provide us with a better understanding of where improvements are required. **Access:** Practice is changing and recent data shows an improving picture. In February 2016 43% of cases used radial access, this increased to 56% in March 2016 and we will continue to monitor. Within St Georges any death following PCI is the subject of a review. Consultant level outcomes which are derived from this national audit and reported publically show that none of the St George's operators have outcomes as measured by the major adverse cardiac and cerebrovascular event (MACCE) rate, which are outside of confidence limits.
Sentinel Stroke National Audit Programme (SSNAP)	Increased consultant presence in ED has reduced the waiting time for patients. The TIA (Transient Ischaemic Attack) clinic has increased its activity by 15% in the last year to help reduce the demand on inpatient beds. Continued work with radiology means most patients get a CT scan in the ED within their first hour in hospital. This year, the Trust

	expects to launch the first 24/7 thrombectomy service in the country. It took part in trials to evidence that this treatment works and have recently appointed two interventional neuroradiologists who make up a team of five specialists doing the procedure. Thrombectomy removes clots from the arteries of blocked vessels and reduces disability in severe stroke. This service will be offered to patients from SW London and our neuroscience network of partner hospitals in Surrey.
Royal College of Emergency Medicine (RCEM): VTE risk in lower limb immobilisation in plaster cast	Following the Care Group presentation of RCEM results, action plans were drawn up, implemented. Re-audit of VTE documentation was conducted after each implemented change. Step 1 – education of staff (24/11/15) Step 2 – reminder sheet added to each CDU folder (17/02/16) Step 3 – Reminder column added to CDU handover sheet (08/03/16) Step 4 – addition of check box for VTE risk assessment on CDU admission sheet (Due 30/07/16). Audit was conducted at each step and demonstrated that improvements followed each implemented change.
Royal College of Emergency Medicine (RCEM): Procedural Sedation audit	Results show that there is a lot of good practice, but as with the national picture there are improvements to be made and ED have presented results locally and commenced their action plan. • Re-develop procedural sedation proforma. • Create written patient information leaflet. • Create and deliver teaching plan for doctors and nurses – to be given in formal teaching and/or after induction. • Develop schedule for teaching and assessment of procedural sedation competencies for doctors. • Incorporate code for 'sedation' in discharge communications – liaise with clinical informatics/IT.
National Paediatric Diabetes Audit 2014-15	The service continues to explore ways to improve patient education and lifestyle choices to improve personal management. Education of children will be undertaken jointly between the nurse specialist and dietician. There is a newly appointed dietician in post and a new pump review clinic has been established. Missing data on coeliac disease was due to coding issues. This matter is now rectified. Albuminuria rates are low, on-going action reminding patients to present their urine samples. The service prompts patients on need for eye screening and foot management, but do not provide the services.
Royal College of Emergency Medicine (RCEM) Paediatric Vital Signs	**1. Dissemination of results and staff education:** Disseminate results to nursing and medical leads, highlighting issues and lead actions. Triage vital signs training and nursing education Reinstate POPS (Paediatric Observation Priority Scores). **2. IT systems, mandatory fields and alerts:** Temp, RR, HR, Oxygen sats, GCS/AVPU & Cap refill mandatory fields on paper light system. iClip Alert on the system for another full set of observations POPS score on iClip as a mandatory field. **3. Monitoring & re-audit:** Regular monitoring of nursing documentation Those with abnormal vital signs to have a further complete set of observations. Re-audit September 2016.

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

Notes:

At the beginning of quarter 3 the approach to reporting to the trust board was amended, which has resulted in fewer national audits being reported to the board. This gap has been recognised and a new process is to be introduced in 2017/18 to ensure that all national audits are reported to the Patient Safety and Quality Board in the first instance. This will ensure that due attention is given to all national audit results over the coming year and that any relevant reports can be escalated for trust board attention.

Appendix C: Local clinical audit actions undertaken

The reports of eight local clinical audits were reviewed by the provider in 2016/17 and St George's University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Local clinical audit	Action*
Pre-Operative Fasting Audit – 2016	• Information to Patient Pathway Co-ordinators (PPCs) and Surgical Admission Lounge (SAL) staff around fasting so they can share this with patients more easily. • Change patient information leaflets to emphasize negative impact of prolonged fasting. • More prominent information displayed in SAL about availability of water etc. • Longer term project to improve emergency theatre communication with wards to reduce fasting times. • Re-audit upon completion of action points.
Use of nEWS Re-Audit - January 2016	Individual ward results have been disseminated through the divisional structures. Managers on wards with less than 80% compliance in any of the three main target measures must ensure that staff are adequately educated by their nEWS lead and perform monthly re-audits until compliance has reached 80% consistently. These wards are also to provide an action plan for improvement through nursing board. A PowerPoint presentation is already available to wards for training days and utilised in MEERKAT's training and the Harm Free Care study day. Wards scoring poorly for appropriate response should ensure that staff attend this training. As there continues to be an issue with spacing, particularly at night time, more attention needs to be paid to adhering to documented regularity. Wards that are using the Welch Allyn device are encouraged to seek appropriate training.
Venous Access Device Care Annual Audit Report 2016	Immediate feedback was provided at the point of audit if deemed necessary in the area of VAD management. Overall, there was significant improvement in all areas apart from 'dressing dated' which remained unchanged. On-going actions involve the Venous Access Team continuing to work with the clinical areas to improve documentation of the dressing and highlight suboptimal electronic and paper documentation.
WHO Surgical Checklist Audit 4th Quarter 2015/16 (Peer review audit round)	• Theatres Care Group Lead to present report at local governance meetings to enable discussion and to agree any actions for improvement in compliance. • Summary report to be presented at Theatres Care Group meeting in April 2016 and Division Governance Board. • Matrons and Team leaders to disseminate results and agreed actions at local team meetings. • On-going programme of quarterly audit in all theatre areas.
Bereavement Survey, June 2016	Positive and negative comments have been studied to identify opportunities for learning and improvement. This has provided valuable insight and so it has been agreed that the survey will continue to run, with quarterly analysis to track progress. Furthermore, the survey has been amended so that any relative/carer that would like a response to their comments or concerns can provide their contact details. Any such instances will be reported to the End of Life Programme Board so that an

	appropriate investigation and response can be provided to the bereaved. This will support a positive experience and will also help us to act on any issues in a timely way.
Health Records audit Q1 2016-17	• Patient labels: Continuing to increase the use of patient labels from the current level of 61% is likely to improve the results for patient identifiers on history sheets, in particular the inclusion of the NHS number. • Improve use of dividers in ring folders. • Designation Stamps: Identification of the consultant in charge of the patient's care remains a priority area for action. Using name stamps would improve the recording of name and designation in entries.
Accounting for Swabs, Needles and Instruments - Obstetric Theatres	• The team will continue with re-audit to maintain standards for the 3 of 4 phases that had achieved 100%. • To remind staff on using the accepted method for skin preparation and to re-audit to monitor improvement. • Plan to roll out this audit project to other theatre areas in 3rd quarter of 2016/17.
Annual Consent Audit 2015/16	The audit has been shared with clinical colleagues via the Medical Director, and he is supporting the audit team to identify a clinical lead/group to take this project forward. The audit team would propose to carry out smaller, more regular audits focussed on specific aspects of policy where improvement actions have been agreed.

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

Appendix D: Details of trust CQUIN schemes for 2016/17

Notes: this information is a forecast from Quarter 3 of 2016/17. Quarter 4 performance is currently being reviewed and approved by our commissioners.

CQUIN Goals and Indicators	Achievement	Comments
National CQUIN schemes		
NHS Staff and Wellbeing • Introduction of staff health & wellbeing initiative (Option 1b) • Healthy food for NHSE staff, visitors and patients • Improving the uptake of flu vaccinations for front line staff within Providers	Partially met	72% against a target of 75% or above for uptake of flu vaccinations.
Timely identification and treatment of Sepsis • Timely identification and treatment for Sepsis in emergency departments • Timely identification and treatment for Sepsis in acute inpatient settings	Fully met	
Antimicrobial Resistance and Antimicrobial Stewardship • Reduction in antibiotic consumption per 1000 admissions • Empiric review of antibiotic prescriptions	Fully met	
Local CQUIN schemes		
Maternity • Maintain 1:27 midwife ratio and 24/7 supernumerary midwife 98% of the time • 144 hours per week consultant cover	Partially met	Consultant cover not achieved in Q1, Q2 and Q3.
Global Trigger Tool • To continue the Institute for Health Improvement Global Trigger Tool with specialty involvement to increase dissemination of learning.	Fully met	
Paediatric Asthma • Meet the London Asthma standards for Acute Asthma inpatient admissions. • Ensure appropriate follow up for children attending ED/PAU at St George's • Develop Outpatient Service for children at High Risk from Asthma • Closer integration of primary and secondary care asthma services • Set up school programme.	Fully met	
Children's Services Improvement Programme (CSIP) for children who are high users of Emergency department and Paediatric Assessment Unit Achieve system-wide improvement through the adoption of a person and family centred model of integrated healthcare.	Fully met	
Planned Care Service redesign for Gynaecology, Trauma & Orthopaedics, Elderly care and Urology.	Partially met	Delivery of CQUIN requirements met for Gynaecology, Trauma & Orthopaedics and Elderly care only.
Paediatric Outpatient Parenteral Antibiotic Treatment (POPAT) Establish a paediatric outpatient antibiotic treatment	Partially met	Extension not met due to late commencement of Consultant nurse to post in Quarter 3.

service across all paediatric wards, neonatal unit and emergency department. POPAT will be in line with the national and hospital strategy for the reduction of antimicrobial resistance and hospital acquired infections.		
Ambulatory Emergency Care (AEC) • To ensure that patients with ambulatory care sensitive and similar conditions that do not normally require admission are managed to support early discharge in order to free beds • To ensure patients are streamed on presentation directly to AEC following timely assessment in emergency department • To support a standardised model for AEC across SW London so that patients receive the same treatment regardless of location, and ensuring that there is a consistent 7 day a week service in operation	Fully met	
Enhanced cancer consultant nurse provision • Improved access to consultant nurse/key worker support for patients on suspected cancer pathways for lung, gynaecology, urology, head and neck and upper/ lower gastro-intestine • Improved pathway co-ordination and support to patients, particularly on the identified pathways Co-ordination of investigations (particularly when commissioned cross-site) to reduce time from first seen to diagnosis • Redefining the Cancer consultant nurse role to be more patient facing, and less administratively focused • Enhancing the Cancer consultant nurse role, aiding retention and recruitment	Not met	Unable to recruit to post therefore CQUIN not delivered.
Consultant Advice Service (Kinesis) • Incentivise Trust to increase the number of consultants offering a Kinesis advice/consultation service • In key specialties, build a significant sub specialty service Undertake an analysis of the number and type of referrals; the response time; the capacity requirement by individual consultants for types of referrals; the number of Outpatient appointments avoided – as the basis for development of a more sophisticated tariff for 2017-19. Reduction in system costs, cost effective for providers and deliver savings for commissioners. • Gather evidence on the conversion rate for Kinesis referral and outpatient attendance; by specialty • Consider and report on the most cost effective way of managing the interface with diagnostic testing • Develop a Kinesis performance dashboard Gather evidence on the most effective induction for acute consultant staff, education/marketing to primary care and joint workshop sessions that generate the optimal usage of Kinesis to drive improved patient	Fully met	

pathways • Align the introduction of Kinesis at the Trust across all SW London commissioners • Be an exemplar for Kinesis across London		
Community CQUIN schemes		
Community Adult Health Services • Plan the process as to how the CAHS MDT will be operationalized, and evidence would be collected by working with the new PACT ECP Provider. • CAHS and ECP staff to work together to set-up MDT meetings including required attendance, and develop a checklist to help staff operate weekly MDTs effectively. • Key worker to be made known and entered on care plan. • All care plans to be updated in the MDT and evidence of a plan set for each patient discussed at weekly MDT.	Fully met	
Special Schools Matrix Tool Refining the dataset to incorporate all pupils at all Special Schools, updating the information as each child is reviewed.	Partially met	Some schools have yet to be mapped to the matrix tool
Special Schools Clinical Skills Educator • Deliver the necessary range of training/skills so that an increased numbers of Children who qualify for complex care are able to have packages delivered via carers. • Work with the Community Nursing Team to increase the number of children who can have services delivered via carers. • Deliver the training/skills in a cost effective manner to a range of stakeholders including families, care providers, Trust staff and other identified parties. • To ensure that the training/skills give parents confidence in the quality of care that will be provided.	Partially met	No provision of evidence of training plan or provision of details of the number of parents trained.
Learning Disability • Seek to identify people with learning disability, autism and behaviour that challenges who could benefit from receiving a Personal Health Budget by applying specific criteria. • The intention is to improve the experience of service users encourage the development of joint care plans within and across services with service user at the core of the plans.	Partially met	Requirement to provide further evidence to ascertain how many patients have been mapped across both the Trust and the Mental Health Trust.
NHS England CQUIN schemes		
Hepatitis C Virus (HCV) Improving Treatment Pathways through Operational Delivery Networks (ODNs) Joint scheme with Kings College Hospital NHS Foundation Trust. • Governance and Partnership working • Stewardship and NICE compliance	Partially met	NHSE does not consider that the Trust has fully met the requirements of this CQUIN; however in conjunction with Kings this is being disputed by the Trust.

Nationally Standardised Dose Banding Adult Intravenous Systemic Anticancer Therapy (SACT) A national incentive to standardise the doses of SACT in all units across England in order to increase safety, to increase efficiency and to support the parity of care across all NHS providers of SACT in England.	Fully met	
Clinical Utilisation Review • installation and implementation of software; • reduction in inappropriate hospital utilisation; • reporting of results	Not met	The Trust decided not to implement this CQUIN as there was concern that an embedded system with clinical utilisation data capture was already being used. The Trust, along with others tried to get their own in-house system recognised as being accredited for the CQUIN but not one of them was successful as the CUR software has an embedded decision support tool which other systems do not.
Activation System for Patients with Long Term Conditions (LTCs) Development of a system to measure skills, knowledge and confidence needed to self-manage long term conditions, and with that information to support adherence to medication and treatment and to improve patient outcomes and experience.	Not met	The Trust decided not to implement this CQUIN as it was considered that there are already systems in place which this scheme would overlap with and therefore the Trust would not be able to realise the benefits the CQUIN required it to deliver.
Optimal Device Maintenance/improvement in the optimisation of device usage during a year of transition to a centralised national procurement and supply chain arrangement through: • the enhancement and maintenance of local systems to assure compliance with national policies and specifications; • the development of local policies to optimise cost effective device usage and ensuring quality outcomes for patients.	Fully met	
Adult Critical Care timely discharge • to reduce delayed discharges from ACC to ward level care by improving bed management in ward based care, thus removing delays and improving flow. • to support the removal of delays of more than 4 hours, whilst continuing to encourage more emphatically removal of delays of more than 24 hours.	Fully met	
HIV Drugs Identify a number of switches of drug regimen making best use of newer forms of antiretroviral drug regimes	Fully met	NHS England acknowledged the role of the Trust in the delivery of QIPP schemes and set aside a percentage of the CQUIN value to incentivise the Trust to deliver this.
Telemedicine To improve patient experience by reducing the number of times a patient is required to attend a face to face outpatient appointment; but instead has their follow-up care and advice conducted through a non-face to face method.	Not met	NHS England acknowledged the role of the Trust in the delivery of QIPP schemes and set aside a percentage of the CQUIN value to incentivise the Trust to deliver this. The Trust was unable to identify specialties where the number of telephone follow ups could be increased for outpatients which are mostly or wholly commissioned by NHSE.

		Specifically, Neurology was identified as a possibility but it was found that there was no potential for telephone follow up appointments in this area.
Neo-natal Length of Stay This scheme is designed to improve community nursing support enabling timely discharge for babies <36 weeks gestation.	Fully met	NHS England acknowledged the role of the Trust in the delivery of QIPP schemes and set aside a percentage of the CQUIN value to incentivise the Trust to deliver this.
Other CQUIN schemes to deliver QIPP savings	Partially met	NHS England acknowledged the role of the Trust in the delivery of QIPP schemes and set aside a percentage of the CQUIN value to incentivise the Trust to deliver this. The Trust was able to demonstrate that savings had been on a number of QIPP schemes but commissioners did not consider these to be of a sufficient value to achieve the requirements of the CQUIN.
Offender Healthcare NHS Staff and Wellbeing • Introduction of staff health & wellbeing initiative (Option 1b) • Healthy food for NHSE staff, visitors and patients • Improving the uptake of flu vaccinations for front line staff	Partially met	Target of 75% of staff receiving flu vaccinations not achieved.
Dental • Recording of data for oral surgery and orthodontics • Participate in referral management and triage • Participate in Managed Clinical Networks	Fully met	

Appendix E: National Early Warning Score (nEWS) trust audit, January 2017

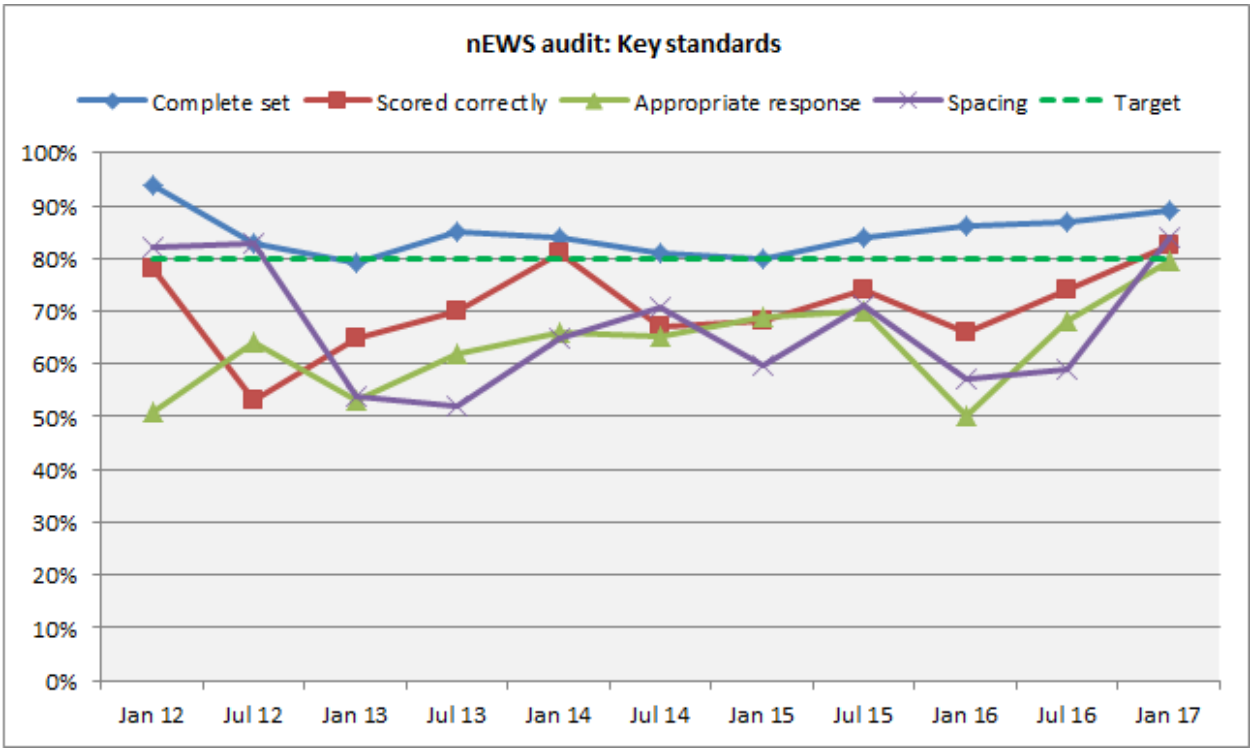
Deborah Dawson – to check whether all data is relevant to the Quality Account.

Summary of results

Main measures of compliance with the National Early Warning Score (nEWS) are summarised in the table below.

Standard	Target	Achieved
Recording a complete set of observations	80%	89%
Scoring nEWS correctly	80%	83%
Appropriate response	80%	80%
Spacing	80%	84%

The following graph shows the comparison with audits conducted since January 2012 when the new version of the nEWS came in to use. There is improvement in all key standards, with the target met across all standards for the first time.



Introduction

NICE states that a graded response strategy for patients identified as being at risk of clinical deterioration should be agreed and delivered locally. To comply with this guideline, St George's has been using EWS chart since 2000 and adopted the national EWS in January 2012.

The chart incorporates a section for reporting concerns using SBAR (Situation, Background, Assessment, and Recommendation). SBAR is a structured mechanism for communicating clinical information, or framing conversations, in order to elicit prompt and appropriate action from another health professional. The EWS and SBAR tools should help to improve patient care, reduce risk and reduce patient safety incidents, including SIs.

The audit was commissioned by Deborah Dawson, Consultant Nurse Critical Care and Paula O'Shea GICU Liaison Nurse and covered all adult wards in the Trust. At this round of audit the wards using Cerner documentation were also included.

Standards

The current target for each of the criteria audited is 80% compliance. Achieving this standard for complete set of observations and accurate EWS scoring provides evidence of compliance with NICE clinical guideline 50 (July 2007).

Methodology

Thirty four adult wards were included in the audit. For each ward, a number of charts where patients had been on that ward for over 24hrs (where possible) were audited to assess compliance with seven measures. Wards using the CERNER system to record their nEWS (Champneys, Belgrave, Ben Weir and Caroline) were included in this round. Data was extracted from (PIEDW – Power Insight Enterprise Data Warehouse) by an Information Analyst and reviewed by the clinical team.

In the majority of wards 10 patients were audited, but on smaller units this figure was lower. The audit data was collected by a team of senior nurses from critical care, week commencing 9 January 2017.

The full audit criteria were:

1. The chart has a **name**, number [**MRN**]
2. **Regularity** of observations is recorded (where appropriate in line with EWS triggers)
3. Observations are evenly **spaced** throughout the 24 hour period
4. A **full** or **complete set** of observations are recorded on each occasion
5. EWS is **scored correctly** on each occasion
6. Where EWS has triggered, an appropriate **response** is recorded
7. Each set of observations is **signed**

The main measures for the audit were: whether observations are evenly spaced (question 3), whether a complete set of observations was recorded (question 4), whether nEWS was scored correctly (question 5) and, where nEWS has triggered a score, an appropriate response has been documented (question 6). The compliance target was 80% for each of these factors.

Data was directly available from the chart itself with exception of question 6. This required reviewing both nursing and medical notes to check if a response had been recorded. As the patient's nEWS rises it should set off triggers and, various escalation procedures should be implemented. The triggers are divided into low, medium and high risk categories. For audit purposes, we have looked for a cumulative score ≥4 or individual parameter score 3, as these represent patients moving from a low to medium risk category.

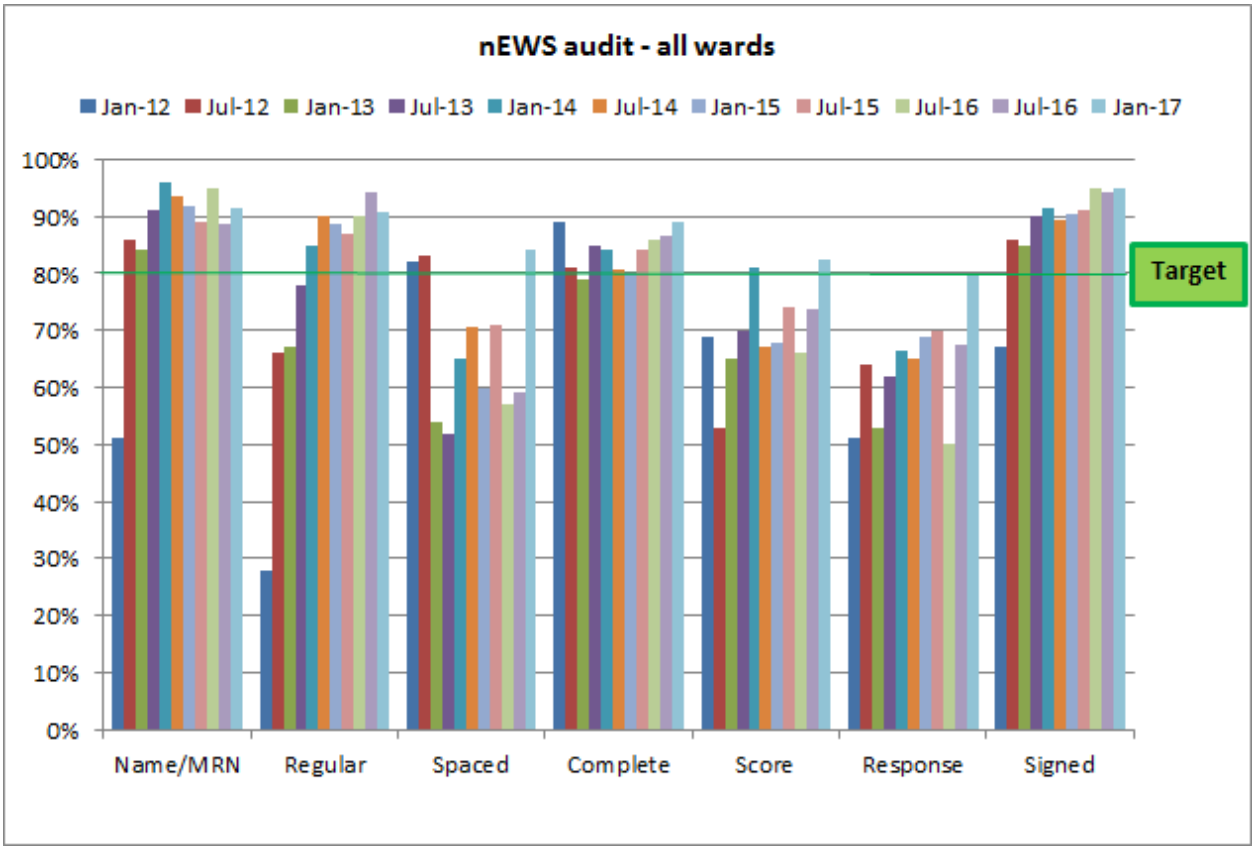
An audit tool was housed on RaTE and data was collected on a combination of paper forms and directly via a tablet. The data was then downloaded and analysed by the clinical audit department.

Results

All adult wards on SGH and QMH were audited. The results for 34 wards, (327 cases), are presented. In this round of audit results for Champneys are compared to Buckland, following the relocation of renal inpatient beds. James Hope was not audited as patients that require an overnight stay are accommodated on the Charles Pumphrey unit, and therefore comparison is between the two areas. The new Nye Bevan unit was audited in place of the Surgical Assessment Unit.

Results for January 2017 compared to previous audits

The following chart summarises the results for all measures and all adult wards. Full achievement of the 80% compliance target is noted for the first time, along with improvement in six out of seven measures. However, the chart also demonstrates variation in compliance between different criteria. There are some elements where best practice appears to be well established, such as recording of patient identifiers and signing of scores; however there are other elements where sustained improvement is sought.



The table below shows results for January 2017 compared to previous audits. RAG ratings have been added, where ≥80% is green, 60-79% is amber and <60% is red.

Audit Period	Name/ MRN	Regular	Spaced	Complete	Score	Response		Signed
January 2017	91%	91%	84%	89%	83%	70/88	80%	95%
July 2016	89%	94%	59%	87%	74%	52/77	68%	94%
January 2016	95%	90%	57%	86%	66%	25/50	50%	95%
July 2015	89%	87%	71%	84%	74%	37/53	70%	91%
January 2015	92%	89%	60%	80%	68%	31/45	69%	90%
July 2014	93%	90%	71%	81%	67%	28/43	65%	89%
January 2014	96%	85%	65%	84%	81%	69/104	66%	92%
July 2013	91%	78%	52%	85%	70%	62/100	62%	90%
January 2013	84%	67%	54%	79%	65%		53%	85%
July 2012	86%	66%	83%	81%	53%		64%	86%

Results for January 2017 by ward

The table below shows percentage compliance for each standard, by ward. RAG ratings have been added, where ≥80% is green, 60-79% is amber and <60% is red. Please see Appendix 1 for ward results over time.

Ward	Name/ MRN	Regular	Spaced	Full set	Score correct	Appropriate Response [1]		Signed	Comments
Allingham (10)	70	100	80	100	100	75	6/8	100	Details missing include hospital number, name, DOB
Amyand (10)	100	90	50	90	70	100	1/1	90	Irregularity mainly at night; in 2 cases frequency should have been changed
Belgrave (10)	100	20	20	90	90	n/a	-	100	Irregularity at night, with no explanation of rationale
Ben Weir (6)	100	17	17	67	67	100	1/1	100	Irregularity at night, with no explanation of rationale
Brodie (10)	100	100	100	80	80	n/a	-	90	
C Hawkins (10)	100	100	90	100	70	100	3/3	80	
Caroline (9)	100	22	22	100	100	0	0/1	100	Irregularity mainly at night, with no explanation of rationale
Cavell (10)	100	100	100	100	100	100	8/8	100	
Champneys (10)	100	90	80	100	100	n/a	-	100	
Charles Pumphrey (7)	100	100	100	71	71	n/a	-	100	
Cheselden (10)	80	90	50	60	50	50	2/4	90	Irregularity at night, with an explanation only given in one case
Dalby (10)	50	100	100	90	80	n/a	-	90	Hospital number missing in 5 cases, and DOB in 1 case.
Florence N (10)	100	90	90	90	70	100	4/4	90	
Gordon Smith (10)	90	100	90	90	80	100	1/1	90	
Gray (10)	90	100	100	100	100	100	2/2	100	
Gunning (10)	100	100	100	80	70	75	3/4	90	
G Holford (10)	100	90	90	100	100	n/a	-	100	
Heberden (9)	100	100	56	78	89	50	3/6	89	Irregularity at night, with no explanation of rationale
Holdsworth (9)	89	100	100	78	67	50	1/2	89	
Keate (9)	89	100	100	89	67	n/a	-	100	
Kent (10)	70	90	50	90	80	14	1/7	100	Details missing include hospital number, name, DOB. Irregularity at day and night.
Marnham (10)	90	100	100	90	90	89	8/9	100	
M Seacole A (10)	70	100	100	90	90	100	1/1	100	Hospital number missing in 3 cases
M Seacole B (10)	70	100	100	100	100	n/a	-	100	Hospital number missing in 3 cases
McEntee (8)	100	100	88	100	88	100	2/2	100	
McKissock (15)	100	100	100	87	80	100	1/1	93	
Nye Bevan (7)	100	100	100	100	100	100	2/2	100	
Richmond (10)	90	80	100	100	100	100	8/8	100	
Rodney Smith (10)	100	100	100	90	70	n/a	-	100	
Ruth Myles (10)	100	100	70	100	100	67	2/3	90	Irregularity at night, with no explanation of rationale
T Young (10)	90	90	100	80	70	n/a	-	100	
T Howell (8)	100	100	88	100	100	100	4/4	88	
Vernon (10)	90	90	100	80	50	100	2/2	90	
William Drummond (10)	90	90	100	80	50	100	4/4	90	
Jan 2017 (327)	91	91	84	89	83	80	70/88	95	

Notes: (1) "n/a" means that no nEWS was triggered, therefore no response was required or assessed as to whether appropriate.

Overall there has been improvement in six of seven measures; however, variance between wards is observed. Previously zero compliance with one measure was noted on 5 occasions; this has decreased to 1. Furthermore, 12 wards met the compliance standard of 80% across all measures. Cavell and Nye Bevan achieved full compliance with all standards. Several wards (Cavell, Gray, Mary Seacole B, Nye Bevan and Richmond) achieved 100% in the four main measures; Nye Bevan and Cavell in all seven.

There were improvements in recording of patient identifiers on the nEWS chart, with compliance reaching 91%. 19 wards achieved full compliance. In the 9% of cases (n=28) where name/MRN was missing from the chart the most frequently reported omissions were MRN (26), DOB (7) and name (6). In 9 cases two or more demographic details were missing from the chart.

Scores for regularity of observations decreased slightly, from 94% in July 2016 to 91% at this round. However, spacing of observations improved significantly, from 59% to 84%. At the last round of audit only one ward scored 100% and 13 scored less than 60%; on this occasion 18 wards were fully compliant and 7 scored below 60%. It remains the case that in only a small number of instances was staff able to provide a rationale where there was a discrepancy between the prescribed and observed frequency of observations. As reported previously in a number of cases vital signs were omitted for periods of up to 9 hours, and mostly this occurred overnight.

There was further improvement in recording of a full set of observations on each occasion to 89%. Where a full set of observations has not been recorded it impacts both on the calculation and accuracy of the score. Correspondingly correct scoring also increased, from 74% to 83%. In the 11% of cases (n=36), where a full set of observations had not been recorded the missing details included:

Observation	Temp	HR	BP	Resp	SpO2	Flow rate	Neuro
No. patients missed	11	2	3	11	7	11	10
Frequency missed	1 to 10 times	1	1	1 to 2 times	1 to 2 times	1 to 3 times	1 to 3 times

The appropriateness of the response also improved and the target of 80% was met for the first time since the programme of audit commenced. There remains variation across the wards, but the proportion scoring 100% has increased from 47% to 63% the proportion rated as red decreased from 41% to 21%.

Compliance with the 80% target for the signing of scores was achieved on all wards, with over half reaching 100%.

Divisional results for key measures

Division	Name/ MRN	Regular	Spaced	Complete	Score	Response		Signed
MC (n=167)	92%	85%	73%	90%	84%	41/51	80%	95%
STNC (n=140)	94%	96%	95%	86%	79%	28/36	78%	95%
CSD (n=20)	70%	100%	100%	95%	95%	1/1	100%	100%
ALL (327)	91%	91%	84%	89%	83%	70/88	80%	95%

Actions:

- A target of 80% was set to provide an achievable goal when ten national EWS system was introduced to St George's. The clinical goal should however be 100% in all measures. Some wards have achieved this in most or all measures. Future audits will be measured against this target.
- This report will be discussed by the project team and reported to the Nursing Board, Patient Safety and Quality Board and the Quality Improvement Board for discussion of organisation level results and discussion of required actions.
- The report will also be sent to the divisional leadership teams for distribution and action through the divisional structures
- Ward managers on wards with less than 80% compliance in any of the three main target measures are responsible for ensuring that staff are adequately educated by their nEWS lead. It is suggested that these wards provide an action plan for improvement through nursing board, this should include education and competency assessment of all HCA and RN staff and more regular re-audit. This is the joint responsibility of matrons, ward managers and practice educators in these areas.
- A programme of monthly audit will be launched staring February 2017; this is already being completed by many wards. The programme of 6-monthly audits by an independent clinical team will continue, supplemented by monthly audits conducted by the wards for 5 month periods.
- It was hoped that with the introduction of the Welch Allyn Vital links device, 100% compliance with accurate scoring could be achieved. Wards who are using this device are encouraged seek appropriate training for staff who are using this device**.**
- The Policy for the Minimum Standard for Adult In-Patient Observation has just been updated and is available on the Policy Hub. An awareness campaign will highlight these updates to all staff.

Appendix 1: Ward level results over time for 3 key measures

RAG ratings have been added, where ≥80% is green, 60-79% is amber and <60% is red. Champneys results prior to 2017 contain results for Buckland, due to the relocation of renal inpatient beds at the end of 2016. In this round James Hope was not audited, as patients that require an overnight stay are now accommodated on the Charles Pumphrey unit, and therefore comparison is between the two areas. The new Nye Bevan unit was audited in place of the Surgical Assessment Unit.

1: Complete Set (% compliance)	Jan 2012	Jul 2012	Jan 2013	Jul 2013	Jan 2014	Jul 2014	Jan 2015	Jul 2015	Jul 2016	Jan 2017
Allingham	90	90	80	100	100	50	70	80	100	100
Amyand	90	90	80	60	100	70	70	100	90	90
Belgrave	80	60	70	90	90	60				100
Ben Weir	100	60	60	90	100	90				67
Brodie									80	80
Caesar Hawkins	100		80	70	80	70	80	80	100	100
Caroline	60	80	60	80	50	70				100
Cavell (formerly Gray)	80	60	50	67	90	50	80	80	60	100
Champneys (formerly Buckland)	80	80	100	50	100	100				100
Charles Pumphrey (prior 2017 James Hope)			80	100		40				71
Cheselden	90	60	100	100	90	90	100	90	90	60
Dalby		90	70	80	90	70	50	70	70	90
Florence Nightingale	90	90	90	100	90	90	90	100	90	90
Gordon Smith								90	90	90
Gray (formerly Cavell)	90	90	80	80	90	60	100	80	100	100
Gunning	80	60	100	80	100	100	100	90	90	80
Gwynne Holford		69	60	100	70	90	90	100	80	100
Heberden	90	70	90	100	100	80	60	90	100	78
Holdsworth	100	90	90	100	90	90	100	70	80	78
Keate	80	90	80	90	100	88	100	90	100	89
Kent		100	40	80	90	80	90	90	70	90
Marnham	80	80	90	100	80	50	50	100	80	90
Mary Seacole A			80	100	20	80	80	100	100	90
Mary Seacole B									100	100
McEntee	80	100	80	90	100	100	80	90	90	100
McKissock			40	60	40	90	70	60	60	87
Nye Bevan (prior 2017 SAU)									100	100
Richmond	100	90	60	100	50	70	60	50	90	100
Rodney Smith	100	100	90	90	100	90	100	80	80	90
Ruth Myles	100	80	75		100	100	67	80	100	100
Thomas Young	100	100	80	100	100	100	80	100	60	80
Trevor Howell	100	90	90	90	80	80	50	70	90	100
Vernon	90	100	100	80	70	100	100	100	90	80
William Drummond			80	57	80	80	90	89	88	60

ALL	**89**	**83**	**79**	**85**	**84**	**80**	**80**	**84**	**87**	**89**

2: Correct score (% compliance)	Jan 2012	Jul 2012	Jan 2013	Jul 2013	Jan 2014	Jul 2014	Jan 2015	Jul 2015	Jul 2016	Jan 2017
Allingham	100	80	70	70	100	50	60	90	90	100
Amyand	80	100	60	50	80	60	60	90	80	70
Belgrave	70	30	70	70	90	60				90
Ben Weir	60	10	60	70	90	80				67
Brodie									70	80
Caesar Hawkins	30		50	30	70	70	60	70	80	70
Caroline	70	30	60	30	50	40				100
Cavell (formerly Gray)	50	40	17	67	80	25	70	80	50	100
Champneys (formerly Buckland)	30	60	90	30	100	80				100
Charles Pumphrey (prior 2017 James Hope)			80	100		40				70
Cheselden	30	60	70	90	80	60	80	80	70	50
Dalby		40	50	80	60	70	50	80	60	80
Florence Nightingale	100	60	70	80	90	60	80	90	80	70
Gordon Smith								80	60	80
Gray (formerly Cavell)	90	90	60	50	90	60	80	80	50	100
Gunning	70	40	70	60	100	90	80	70	90	70
Gwynne Holford		58	70	100	100	90	80	90	70	100
Heberden	80	100	80	90	90	40	50	90	80	89
Holdsworth	70	50	90	90	80	90	90	70	70	67
Keate	20	50	40	90	90	88	100	90	100	67
Kent		50	30	60	90	70	60	70	60	80
Marnham	90	10	70	70	70	30	30	90	40	90
Mary Seacole A			100	90	60	80	60	70	100	90
Mary Seacole B									100	100
McEntee	80	100	80	90	100	70	60	50	80	88
McKissock			30	40	30	70	60	30	50	80
Nye Bevan (prior 2017 SAU)									100	100
Richmond	70	50	50	70	50	60	60	40	80	100
Rodney Smith	60	40	90	90	100	90	80	80	80	70
Ruth Myles	80	30	88		100	86	56	50	90	100
Thomas Young	100	70	80	100	100	100	80	100	60	70
Trevor Howell	90	40	60	70	80	40	40	50	90	100
Vernon	60	70	90	60	70	80	90	90	70	50
William Drummond			40	14	80	80	90	89	50	70
ALL	69	53	63	70	81	67	68	74	74	83

3: Appropriate response[1] (% compliance)	Jan 2012	Jul 2012	Jan 2013	Jul 2013	Jan 2014	Jul 2014	Jan 2015	Jul 2015	Jul 2016	Jan 2017
Allingham	40	100	0	75	100	67	100	100	100	75
Amyand	67	90	25	0	57	100	n/a	100	33	100
Belgrave	50	0	75	33	0	100				n/a
Ben Weir	25	100	80	50	60	n/a				100
Brodie									83	n/a
Caesar Hawkins	50		100	n/a	25	0	100	N/A	100	100
Caroline	57	100	67	17	67	100				0
Cavell (formerly Gray)	20	n/a	0	33	33	n/a	n/a	50	20	100
Champneys (formerly Buckland)	0	100	33	67	50	50				n/a
Charles Pumphrey (prior 2017 James Hope)			100	n/a		n/a				n/a
Cheselden	25	n/a	50	100	100	67	n/a	100	50	50
Dalby		n/a	0	n/a	33	0	100	50	n/a	n/a
Florence Nightingale	100	50	n/a	75	n/a	100	n/a	100	n/a	100
Gordon Smith								67	100	100
Gray (formerly Cavell)	80	n/a	100	20	100	67	n/a	N/A	40	100
Gunning	25	100	33	71	100	0	100	100	n/a	75
Gwynne Holford		0	20	80	90	n/a	n/a	90	n/a	n/a
Heberden	50	100	50	100	n/a	50	50	0	50	50
Holdsworth	40	100	75	100	33	50	n/a	n/a	0	50
Keate	0	n/a	100	n/a	75	n/a	0	n/a	33	n/a
Kent		100	50	n/a	50	0	100	n/a	71	14
Marnham	100	80	50	50	33	63	50	n/a	33	89
Mary Seacole A			70	90	50	100	n/a	20	n/a	100
Mary Seacole B									100	n/a
McEntee	33	83	n/a	50	n/a	n/a	100	75	0	100
McKissock			n/a	n/a	n/a	0	n/a	n/a	100	100
Nye Bevan (prior 2017 SAU)									n/a	100
Richmond	100	100	86	50	67	100	70	83	100	100
Rodney Smith	25	n/a	0	n/a	25	n/a	50	n/a	75	n/a
Ruth Myles	50	80	n/a		n/a	n/a	n/a	n/a	100	67
Thomas Young	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a	100	n/a
Trevor Howell	83	50	43	50	100	100	50	100	0	100
Vernon	67	0	100	33	100	100	n/a	n/a	100	100
William Drummond			25	100	100	100	100	50	100	100
ALL	51	77	55	62	66	65	69	70	68	80

1: N/A means that an EWS was not triggered, therefore no response was required nor assessed as to whether appropriate

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

We have been engaged by the Council of Governors of St George's University Hospitals NHS Foundation Trust to perform an independent limited assurance engagement in respect of St George's University Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2017 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2016/17' and additional supporting guidance in the 'Detailed requirements for quality reports for foundation trusts 2016/17' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge;
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers. We refer to these national priority indicators collectively as the 'Indicators'.

Respective responsibilities of the directors and Practitioner

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance issued by NHS Improvement.

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

- The Quality Report is not prepared in all material respects in line with the Criteria set out in the NHS foundation trust annual reporting manual 2016/17 and supporting guidance;
- The Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports for foundation trusts 2016/17'; and
- The indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance and the six dimensions of data quality set out in the 'Detailed requirements for external assurance for quality reports for foundation trusts 2016/17.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period 1 April 2016 to **[date of signing of the limited assurance report]**;
- papers relating to quality reported to the Board over the period 1 April 2016 to [**date of signing of the limited assurance report**];
- feedback from Commissioners dated [**XX/XX/20XX**];
- feedback from Governors dated [**XX/XX/20XX**];
- feedback from local Healthwatch organisations dated [**XX/XX/20XX**];
- feedback from Overview and Scrutiny Committee dated [**XX/XX/20XX**];

- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 01/09/2016;
- the national patient survey dated 08/06/2016;
- the local patient survey dated [**XX/XX/20XX**];
- the national staff survey dated [**XX/XX/20XX**];
- the local staff survey dated [**XX/XX/20XX**];
- the Care Quality Commission inspection report dated 01/11/2016;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 25/05/2017.

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

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of St George's University Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting St George's University Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2017, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators.

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

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- Limited testing, on a selective basis, of the data used to calculate the indicators tested back to supporting documentation;
- Comparing the content requirements of the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance to the categories reported in the Quality Report; and
- Reading the documents.

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance.

The scope of our limited assurance work has not included governance over quality or non-mandated indicators which have been determined locally by St George's University Hospitals NHS Foundation Trust.

Our audit work on the financial statements of St George's University Hospitals NHS Foundation Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as St George's University Hospitals NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to St George's University Hospitals NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to St George's University Hospitals NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of St George's University Hospitals NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than St George's University Hospitals NHS Foundation Trust and St George's University Hospitals NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the work described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- The Quality Report is not prepared in all material respects in line with the Criteria set out in the NHS foundation trust annual reporting manual 2016/17 and supporting guidance;
- The Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports for foundation trusts 2016/17'; and
- The indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance.

[**TO BE SIGNED**]

Grant Thornton UK LLP
Chartered Accountants
London

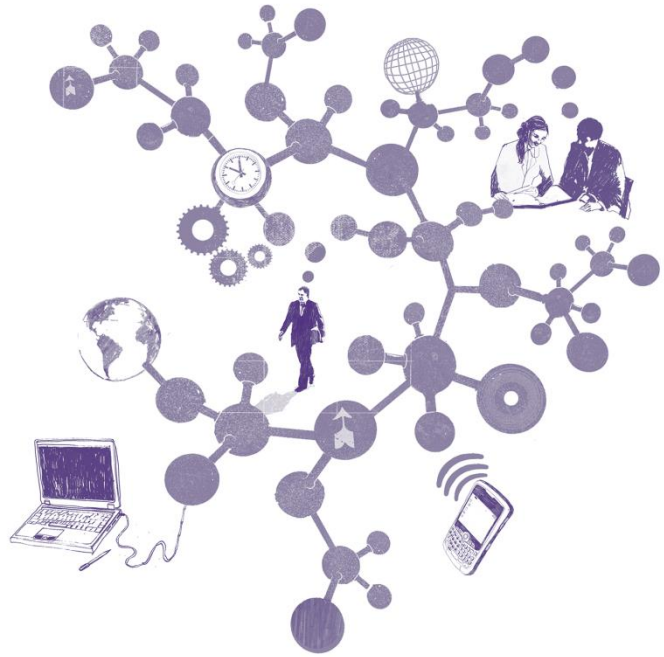
[**UNDATED**]

Report to the Governors on the Quality Report 2016/17

St George's University Hospitals NHS Foundation Trust

Year ended 31 March 2017

17 May 2017



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Executive summary

The Quality Report

The Quality Report is Report is a mandatory part of a foundation trust's Annual Report. Its aim is to encourage and improve the foundation trust's public accountability for the quality of the care it provides. It allows leaders, clinicians, governors and staff to show their commitment to continuous, evidence-based quality improvement, and to explain progress to the public.

Purpose of this report

This report to governors summarises the results of our independent assurance engagement on your Quality Report. It is issued in conjunction with our signed limited assurance report, which is published within the Quality Report section of the Trust's Annual Report for the year ended 31 March 2017.

In addition, this report provides the findings of our work on the indicator you selected for us to perform additional substantive testing on to support your governance responsibilities.

In performing this work, we followed NHS Improvement's 'Detailed requirements for external assurance for quality reports for foundation trusts 2016/17' ('Guidance').

The output from our work is a limited assurance opinion on whether anything has come to our attention which leads us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports for foundation trusts 2016/17' Guidance;
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance.

Conclusion

Our work on your Quality Report is largely complete although we are finalising our procedures in respect of:

- performance of testing in respect of the performance indicator 'maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers';
- performance of testing on the data for March 2017 for the local indicator not subject to the limited assurance report, 'percentage of complaints responded to within 25 days' because data for this indicator for the last month of 2016/17 is note to be finalised until the week commencing 15 May 2017;
- checking the final version of the Quality Report reflecting changes discussed with management;
- reviewing feedback from Commissioners, Governors, local Healthwatch organisations and the relevant Overview and Scrutiny Committee to ensure that it is reflected in the final version of the Quality Report; and
- obtaining a letter of representation from management.

Subject to this, we are proposing to issue an unqualified conclusion on your Quality Report.

The text of our proposed limited assurance report can be found at Appendix B.

Executive summary

Key messages

- We have noted marked improvements compared to the previous year in the Trust's arrangements for preparation of the Quality Report for 2016/17 and for supporting our work to provide external assurance in respect of the Quality Report. The Trust's senior management have taken greater responsibility for supporting the audit process, with Paul Linehan (Head of Quality Governance) acting as lead contact for the audit.
- Despite the improvements from previous years in supporting the Quality Report assurance process, our testing of mandated performance indicators is not yet complete and in future periods we would recommend that the timetable for auditor testing of performance indicators be brought forward to allow the testing to be completed at an earlier stage.
- We confirmed that the Quality Report had been prepared in all material respects in line with the requirements of the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance.
- We confirmed that the Quality Report was not materially inconsistent with the sources specified in NHS Improvement's Guidance.
- We note that the Trust has not reported performance against the indicator 'percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period' which would otherwise be mandatory for being subjected to external assurance. This is due to a decision taken by the Trust Board in July 2016 to cease reporting of performance for this indicator as a result of significant data quality issues identified. We agree that the Trust has a valid reason for not reporting performance against this indicator and have seen evidence of the actions that the Trust is taking to improve data quality in this area to an adequate level.
- Our testing of two indicators included in the Quality Report is in progress and we are not able to conclude are work in this area. Our work in respect of the Trust's performance indicator 'percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge' is close to completion and so far we found no evidence that these this indicator indicators had not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance. Our work in respect of he Trust's performance indicator 'maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers' is on-going and we are not able to draw any conclusions at this stage.
- Our testing of the indicator selected by governors found no evidence that this indicator was not reasonably stated in all material respects in accordance with relevant guidelines on calculation. In line with NHS Improvement's Guidance, we do not express any assurance in respect of this indicator.

We have made a recommendation for improvement in relation to the recording of referrals to the Emergency Pregnancy Unit within A&E admissions data which we have discussed and agreed with management. This can be found at Appendix A.

Acknowledgements

We would like to thank the Trust staff for their co-operation in assisting us with completing this engagement.

Compliance with regulations

We checked that the Quality Report had been prepared in line with the requirements set out in NHS Improvement's *"NHS foundation trust annual reporting manual 2016/17*" and supporting guidance.

Requirement	Work performed	Conclusion
Compliance with regulations	We reviewed the content of the Quality Report against the requirements of the 'NHS foundation trust annual reporting manual 2016/17' and the supporting guidance 'Detailed requirements for quality reports for foundation trusts 2016/17'.	Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017, the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS foundation trust annual reporting manual 2016/17 and supporting guidance.

Consistency of information

We checked that the Quality Report is consistent in all material respects with the sources specified in NHS Improvement's *'Detailed requirements for external assurance for quality reports for foundation trusts 2016/17'*.

Requirement	Work performed	Conclusion
Consistency with other sources of information	We reviewed the content of the Quality Report for consistency with specified documentation, set out in the auditor's guidance provided by NHS Improvement. This includes the board minutes and papers for the year, feedback received on the Quality Report, survey results from staff and patients and the Head of Internal Audit opinion.	Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017, the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's *'Detailed requirements for external assurance for quality reports for foundation trusts 2016/17'*.
Other checks	We also checked the Quality Report to ensure that the Trust's process for identifying and engaging stakeholders in the preparation of the Quality Report has resulted in appropriate consultation with patients, governors, commissioners, regulators and any other key stakeholders.	Overall, we concluded that the process resulted in appropriate consultation.

Data quality of reported performance indicators

We undertook substantive testing on certain indicators in the Quality Report.

Selecting performance indicators for review

The Trust is required to obtain assurance from its auditors over three indicators.

For trusts providing acute, specialist or community services NHS Improvement requires that we select two indicators in a prescribed order of preference from the list of four mandated indicators that are relevant to this Trust.

These two indicators are subject to a limited assurance opinion in line with the requirements set by NHS Improvement. We have to report on whether there is evidence to suggest that they have not been reasonably stated in all material respects in accordance with the '*NHS foundation trust annual reporting manual 2016/17*' and supporting guidance.

In line with the auditor guidance, we have reviewed the following indicators:

- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge: indicator mandated by NHS Improvement for auditor testing
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers: selected from the subset of mandated indicators because this is the next highest priority indicator for testing specified in the NHS Improvement guidance for trusts not reporting performance against the indicator 'percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period' (see below).

NHS Improvement has identified the indicator 'percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period', more commonly known as "referral to treatment" (RTT), as a mandatory indicator for external assurance for trusts providing acute, specialist or community services. However, performance against this indicator has not been reported within the Quality Report for St George's University Hospitals NHS Foundation Trust, due to a decision by the Trust Board in July 2016 to cease reporting performance against this indicator as a result of significant data quality issues identified. As such, we have not performed testing of this indicator and have instead tested the indicator 'maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers' as is set out above.

We concur that the decision by the Trust not to report performance against the RTT indicator is reasonable and note that the data quality issues identified in this area are consistent with the findings that we have previously reported to the Council of Governors. Based on findings from our testing of the RTT indicator for the year ended 31 March 2016, in our report to the Council of Governors on the Quality Report for 2015/16 we highlighted that the Trust was unable to demonstrate completeness of the dataset supporting this indicator and we identified errors in waiting time calculations for 4 out of a sample of 25 patients on incomplete pathways.

Data quality of reported performance indicators (continued)

In 2016/17, NHS foundation trusts also need to obtain assurance through substantive sample testing over one additional local indicator included in the Quality Report, selected by the governors of the Trust. Although the Trust's external auditors are required to undertake the work, this indicator does not form part of the limited assurance report.

In line with the auditor guidance, we have reviewed the following local indicator:

- Percentage of complaints responded to within 25 days – this indicator was selected for testing because complaints identified by the Council of Governors as a key priority for 2016/17.

Data quality of reported performance indicators (continued)
Basis for not reporting the 'percentage of incomplete pathways within 18 weeks for patients on incomplete pathways' indicator

Data issues identified in relation to the 'percentage of incomplete pathways within 18 weeks for patients on incomplete pathways' indicator

The St George's University Hospitals NHS Foundation Trust is required by NHS Improvement to report performance for the 'percentage of incomplete pathways within 18 weeks for patients on incomplete pathways' indicator, more commonly known as the 'referral to treatment' (RTT) indicator. This is one of the key performance indicators that NHS foundation trusts are assessed against as part of NHS Improvement's 'Single Operating Framework' performance monitoring arrangements.

The Trust has not reported performance for this indicator within the Quality Report. This is because in July 2016 the Trust Board took the decision to cease reporting performance against RTT due to significant data quality issues identified following a commissioned external review that identified significant deficiencies in the Trust's processes for reporting and tracking RTT data. This includes a number of manual workarounds established in areas of the Trust to bypass proper use of the RTT functionality within the Patient Administration System (PAS).

The RTT indicator is a mandatory indicator for external auditor assurance for acute foundation trusts. As no RTT performance has been reported within the Trust's Quality Report that we could test, NHS Improvement's guidance required that we provide assurance in respect of the indicator 'Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers' instead.

NHS Improvement require that where a foundation trust has not reported a mandated indicator within its Quality Report due to a planned failure by the trust to report an indicator that the Trust should make an assertion within the 'statement of directors' responsibilities' of the reason for the non-reporting of the indicator. We have reviewed the disclosures in respect of this matter provided within the Quality Report and verified them to be reasonable and appropriate.

The Trust has established an Elective Care Recovery programme to lead the corrective action necessary to return the trust to reporting. We are satisfied that the Trust has put in place and adequate plan to respond to the issues identified in respect of RTT reporting, though we note that the data quality issues identified are significant in scale and that the Trust is not expected to return to RTT reporting in 2017/18.

Data quality of reported performance indicators (continued)
Indicators subject to limited assurance report

Indicator & Definition	Indicator outcome	Work performed	Conclusion
Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge The A&E indicator shows the percentage of patients admitted to A&E who were admitted, transferred or discharged within 4 hours. The national target for this indicator for NHS foundation trusts is 95%. The indicator is calculated as: Numerator - Total number of patients who have a total time in A&E over 4 hours from arrival to admission, transfer or discharge Denominator – Total number of unplanned A&E attendances	***91.56%***	We documented and walked through the process used by the Trust to collect data for the indicator. We checked that the indicator presented in the Quality Report reconciled to the underlying data. We then tested a sample of 25 admissions to the Emergency Department at St George's Hospital in order to ascertain the accuracy, completeness, timeliness, validity, relevance and reliability of the data, and whether the calculation of the indicator was in accordance with the definition. We plan to perform further testing in relation to admissions into the Trust's Minor Injuries Unit (which make up approximately 11% of the Trust's emergency admissions covered by this indicator).	Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017, the indicator has not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance. We have noted immaterial misstatement of the indicator in relation to the recording of referrals to the Emergency Pregnancy Unit (EPU) from the Emergency Department: - We note that on regular occasions the Emergency Department team do not report EPU admissions correctly and instead report daily admissions of a notional figure of 25 admissions, rather than reporting the actual figure based upon actual admissions as per the Trust's iCLIP system for recording A&E admissions. This is a long-standing practice and occurs typically after bank holidays, weekends and other busy teams, when staff claim that they don't have sufficient time to submit the correct number of admissions. - EPU admissions make up approximately 4% of the Trust's A&E admissions. We are satisfied from our review that this issue has not given rise to material misstatement of the indicator. We have made a recommendations to the Trust in relation to this matter, which is set out in Appendix A. We will reach a full conclusion in respect of this indicator on completion of our outstanding testing of data in respect of admissions to the Minor Injuries Unit.

Data quality of reported performance indicators (continued)
Indicators subject to limited assurance report

Indicator & Definition	Indicator outcome	Work performed	Conclusion
Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers The 62 cancer days referral indicator shows the percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer. The national target for this indicator for NHS foundation trusts is 85%. The indicator is calculated as: Numerator - Number of patients receiving first definitive treatment for cancer within 62 days following an urgent GP referral for suspected cancer within a given period for all cancers Denominator – Total number of patients receiving first definitive treatment for cancer following an urgent GP referral for suspected cancer within a given period for all cancers	***84.90%***	At the time of issue of our report, we are yet to complete our work in respect of this indicator. This work has been delayed due to issues around staff availability and is now scheduled to be performed on Thursday 18 May 2017. We plan to document and walk through the process used by the Trust to collect data for the indicator. We will also check that the indicator presented in the Quality Report reconciles to the underlying data. We then plan to test a sample of 25 items in order to ascertain the accuracy, completeness, timeliness, validity, relevance and reliability of the data, and whether the calculation of the indicator was in accordance with the definition.	Our work in respect of this indicator is in progress and we will reach a conclusion once our testing has been completed.

Data quality of reported performance indicators (continued)
Local indicator not subject to limited assurance report

Indicator & Definition	Indicator outcome	Work performed	Conclusion
Percentage of complaints responded to within 25 days St George's University Hospitals NHS Foundation Trust has a locally-set target to respond to 85% of complaints within 25 days. If a complaint is not responded to within 25 working days an extension must be agreed with the complainant. The indicator is calculated as: Numerator – number of formal complaints received during the year ended 31 March 2017 that were responded to within 25 days Denominator – number of formal complaints received during the year ended 31 March 2017 In line with the requirements of NHS Improvement's *Guidance*, this indicator is not subject to a limited assurance opinion. We do not provide the Governors with any formal assurance in relation to whether this indicator is fairly stated.	***TBC – the data for March 2017 is yet to be finalised***	We documented and walked through the process used by the Trust to collect data for the indicator. We checked that the indicator presented in the Quality Report reconciled to the underlying data. We then tested a sample of 23 items for the period 1 April 2016 to February 2017 in order to ascertain the accuracy, completeness, timeliness, validity, relevance and reliability of the data, and whether the calculation of the indicator was in accordance with the definition. We plan to test a further sample of 2 items for the period 1 March 2017 to 31 March 2017	Based on the results of our procedures so far we did not identify any material issues in relation to the calculation of this indicator or the six dimensions of data quality. We will reach a full conclusion in respect of this indicator on completion of our outstanding testing of data for the period 1 March 2017 to 31 March 2017.

Fees

Fees for the audit of the Quality Report

Service	Fees £
For the audit of the Quality Report 2016/17	£10,000
Additional fee for delays in testing the 62 cancer days indicator	TBC

Our fee assumptions include:

- our fees are exclusive of VAT

Appendices

Appendix A - Action plan

	Assessment	Issue and risk	Recommendations
1.	Deficiency	• One regular occasions the Emergency Department team do not report correctly the number of A&E admissions referred immediately to the Emergency Pregnancy Unit (EPU) and instead report daily admissions of a notional figure of 25 admissions, rather than reporting the actual figure based upon actual admissions as per the Trust's iCLIP system for recording A&E admissions. This is a long-standing practice and occurs typically after bank holidays, weekends and other busy teams, when staff claim that they don't have sufficient time to submit the correct number of admissions. • This practice gives rise to inaccuracies in data reported on A&E admissions.	• The Emergency Department team should ensure that for A&E admissions referred to EPU, the number of admissions is reported based upon the actual amount and not based upon a notional amount of 25.

Assessment
- Significant deficiency – issue leading to qualification of limited assurance report or risk of significant misstatement
- Deficiency – issue for improvement in processes or risk of inconsequential misstatement

Appendix B – Form of limited assurance report

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

We have been engaged by the Council of Governors of St George's University Hospitals NHS Foundation Trust to perform an independent limited assurance engagement in respect of St George's University Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2017 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2016/17' and additional supporting guidance in the 'Detailed requirements for quality reports for foundation trusts 2016/17' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge;
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers We refer to these national priority indicators collectively as the 'Indicators'.

Respective responsibilities of the directors and Practitioner

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance issued by NHS Improvement.

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

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the NHS foundation trust annual reporting manual 2016/17 and supporting guidance;

Appendix B – Form of limited assurance report (continued)

- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports for foundation trusts 2016/17'; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance and the six dimensions of data quality set out in the 'Detailed requirements for external assurance for quality reports for foundation trusts 2016/17.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period 1 April 2016 to [date of signing of the limited assurance report];
- papers relating to quality reported to the Board over the period 1 April 2016 [date of signing of the limited assurance report];
- feedback from Commissioners dated [**XX/XX/2017**];
- feedback from Governors dated [**XX/XX/2017**];
- feedback from local Healthwatch organisations dated [**XX/XX/2017**];
- feedback from Overview and Scrutiny Committee dated [**XX/XX/2017**];
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 01/09/2016;
- the national patient survey dated 08/06/2016;
- the local patient survey dated 31/03/2017;
- the national staff survey dated 17/03/2017;
- the local staff survey dated 31/03/2017;
- the Care Quality Commission inspection report dated 01/11/2016;

Appendix B – Form of limited assurance report (continued)

- the Head of Internal Audit's annual opinion over the Trust's control environment dated 25/05/2017.

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

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of St George's University Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting St George's University Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2017, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body, and St George's University Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;

Appendix B – Form of limited assurance report (continued)

- making enquiries of management;
- limited testing, on a selective basis, of the data used to calculate the indicators tested back to supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance.

The scope of our limited assurance work has not included governance over quality or non-mandated indicators which have been determined locally by St George's University Hospitals NHS Foundation Trust.

Our audit work on the financial statements of St George's University Hospitals NHS Foundation Trust is carried out in accordance with our statutory

Appendix B – Form of limited assurance report (continued)

obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as St George's University Hospitals NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to St George's University Hospitals NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to St George's University Hospitals NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of St George's University Hospitals NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than St George's University Hospitals NHS Foundation Trust and St George's University Hospitals NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the work described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the NHS foundation trust annual reporting manual 2016/17 and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports for foundation trusts 2016/17'; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance

[**TO BE SIGNED**]

Grant Thornton UK LLP

Chartered Accountants

London

[**UNDATED**]

Appendix C – Form of management representation letter

Our Ref SGH01
Your Ref

Grant Thornton UK LLP

Grant Thornton House

Melton Street

Euston Square

London

NW1 2EP

[date of signing of the Quality Report]

Dear Sirs

St George's University Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2017

This representation letter is provided in connection with the limited assurance engagement in respect of [Name of NHS Foundation Trust]'s Quality Report for the year ended 31 March 2017 for the purpose of reporting on the Quality Report and certain performance indicators contained therein (the "Quality Report") in accordance with the 'Detailed requirements for external assurance for quality reports for foundation trusts 2016/17' published by NHS Improvement.

We have fulfilled our responsibilities, as set out in the terms of the limited assurance engagement letter/contract addendum dated [**DATE**], for the content and preparation of the Quality Report in accordance with the requirements of the Health Act 2009 (the "Act") and the requirements set out in the National Health Service (Quality Accounts) Regulations 2010 (the "Regulations") and subsequent amendments and the requirements set out in the 'NHS foundation trust annual reporting manual 2016/17' (the "NHS FT ARM") and supporting guidance, and the 'Detailed requirements for external assurance for quality reports for foundation trusts 2016/17'.

We confirm to the best of our knowledge and belief having made such enquiries (including, where appropriate, of other members of management and staff with relevant knowledge and experience or inspection of supporting documentation) sufficient to satisfy ourselves that we can properly make each of the following representations to you:

i. We have complied with the relevant requirements as set out in the Statement of Directors' Responsibilities in preparing the Quality Report.

ii. We acknowledge our responsibility for the design, implementation, maintenance and monitoring of internal controls over the collection and reporting of the measures of performance included in the Quality Report.

iii. We have provided you with:

Appendix C – Form of management representation letter (continued)

a) access to all of the Trust's Quality Report performance records and all other records and related information, including the minutes of all directors' and governors' meetings and ensured that there is no relevant performance information of which you are unaware;

b) additional information that you have requested from us for the purpose of this limited assurance engagement; and

c) unrestricted access to persons within the Trust from whom you determined it necessary to obtain evidence.

iv. We have communicated to you all deficiencies in internal controls relevant to the Quality Report contained therein that are not clearly trivial and inconsequential of which we are aware.

v. We have disclosed to you all our knowledge of any actual, suspected or alleged intentional non-compliance with the Act, the Regulations or the NHS FT ARM, or misstatement of information contained within the Quality Report and confirm that the indicators contained within the Quality Report are free from such misstatement.

vi. We have not adjusted for the misstatements identified from your work that you have brought to our attention, attached to this letter, as we consider that they are immaterial, individually and in aggregate to the Quality Report and certain performance indicators contained therein.

vii. The disclosures within the Quality Report fairly reflect our understanding of the Trust's performance over the period covered and have been prepared in accordance with the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance, and the 'Detailed requirements for external assurance for quality reports for foundation trusts 2016/17' issued by NHS Improvement.

Yours faithfully

Signed on behalf of the Council of Governors and Board of Directors by:

Signature …….

Name……

Position……..

St George's University Hospitals NHS Foundation Trust

Date…….

grant-thornton.co.uk