St George's University Hospitals NHS
NHS Foundation Trust

Quality Account
2015/16

Excellence in specialist and community healthcare

Contents

Chief executive's statement on quality

At St George's, we are committed to providing high quality care and to continuous improvement of our services.

Our task is to make that commitment a reality, a key part of which is to sometimes admit that we do not always get it right.

What do we mean by quality?

There can be no single measure of quality, and a great deal of information is required to build an overall picture across the range of services we provide, to many patients.

It is this complexity that drives the Care Quality Commission's inspection process, which looks at five domains, namely;

- are we safe?
- are we effective?
- are we caring?
- are we responsive?
- are we well led?

We publish this report as we look forward to our next comprehensive CQC inspection in June 2016. The inspection will provide us with a detailed, up to date picture of our services, and whether they are meeting the needs of the people and communities we serve.

A continual journey of improvement

In this report, we have set out to provide three things; a summary of what we do, how well we do it and how we compare to both our own previous performance, and other trusts.

We have also set out some of our plans for improvement whilst also acknowledging that there will undoubtedly be more.

Don Berwick, the world's leading expert on patient safety, articulates clearly the type of approach we want to foster at St George's, namely:

'While "Zero Harm" is a bold and worthy aspiration, the correct goal is "continual reduction". All in the NHS should understand that safety is a continually emerging property, and that the battle for safety is never "won"; rather, it is always in progress'.

With this in mind, the improvements we want to make will be driven not only by building on our successes, but also by acknowledging areas where we are not doing well. Our staff survey results are a real concern and, like all hospitals, even one 'never event' is too many. We absolutely must do better in this regard.

I commit myself, and the staff of St George's, to that continual improvement journey. We will always try to do better. We will always remember that behind every statistic is a real person. Crucially, we will also say sorry when we get it wrong.

Of course, there is much to be proud of in this report. For example, 94.4% of patients reported as having harm free care; 90% of patients said that they would recommend St George's as a place to receive treatment; our mortality rates also continue to be amongst the lowest in the country. We have also seen a 24% reduction in Clostridium difficile infection rates, which is very encouraging.

Since last year's report, we have also opened new facilities for patients. This includes the commissioning of a heart failure unit, an extension of neurosurgical beds to support spinal surgery, and a new neurorehabilitation unit at our Queen Mary's Roehampton site. In addition, we have worked with commissioning colleagues to implement a new community adult health service model to provide care in patients' own homes.

We need to further embed a culture at St George's that is constantly looking at ways in which we can improve. This is evident in many areas of the trust, but needs to be universal. Embedding this culture is particularly challenging due to the financial and performance issues the trust faces.

The executive team know that we need to ensure staff can continue to focus on quality, despite the current and challenged situation we find ourselves in.

Over the coming months, this will be our focus, as will emphasising 'value' and the' importance of getting it right first time' in the day to day delivery of our services.

Simon Mackenzie
Acting chief executive
2nd June

Priorities for improvement in 2016/2017

We have agreed commitments against each domain. These priorities have been determined through a review of activity during 2015/16.

The priorities indicated below are reflected in the quality improvement strategy annual plan for 2016/17 and each element has agreed outcomes with a nominated person accountable for delivery against the priorities.

Improving patient safety

- Ensuring that we are getting patients in the right place first time to improve the safety of care and reduction in length of stay through the trust's flow programme, review of specific clinical pathways, management of cancer pathways and the outpatient programme.
- Agreeing and embedding high quality standardised processes seven days a week through building on existing processes within the trust for the management of deteriorating patients eg use of the National Early Warning Scoring system, management of sepsis and management of results. In addition, the delivery of a reduction in never events outside of the main theatre environment.
- Ensuring we promote an open and transparent culture where we listen, and act on staff concerns by treating staff fairly when they are involved in incidents. This will be done through the re-establishment of a regular staff forum for feedback and follow up, engaging front line staff more closely in the identification of issues from incidents and the planning of actions, encouraging a 'fresh pair of eyes' approach to identify systems that could be improved and ensuring that managers at all levels have systems to listen to staff concerns.

Improving patient experience

- Investing capital resource to reduce clinical risks through the delivery of an environmental programme that addresses both small and large scale projects during 2016/17 including the provision of dementia friendly environments.
- Delivery of end of life care programme to improve the standard of care provision across the trust and in community services.
- An ability to evidence the changes and improvements made as a result of patient feedback with a sustainable change in service delivery standards.

Improving patient outcomes

- Building on our existing mortality programme to encompass avoidable mortality monitoring.
- Providing transparency on outcomes through publication and triangulation of a range of data points.
- Improving the impact of national clinical audits through increasing the quality and completeness of data, and ensuring that each division has a prioritised programme of local and national clinical audit activity.
- Evidence implementation of best practice through improving our NICE compliance profile and conducting audits of key guidance.

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

We will be reporting on our performance against our quality improvement strategy at our public board meetings throughout 2016/17.

In last year's Quality Account we identified a number of priorities for improvement during 2015/16 to ensure that we continue to raise quality throughout the trust.

Improvement priority for 2015/16	Progress as of April 2016
Create reliable processes to reduce avoidable harm. Examples of outcome measures: audit of practice against the World Health Organisation (WHO) safer surgery checklist, ward level data eg heat map/safety thermometer to support management action at the front line.	■ We continue to conduct quarterly audits of the WHO safer surgery checklist in both theatre and non-theatre areas. This data is available at team level to support management action at the point of care. This programme will be extended to other areas that carry out invasive procedures to comply with national requirements which will be in place from September 2016. ■ Monthly participation in the 'classic' safety thermometer has continued across the trust and monthly reporting of the level of harm-free care by ward/clinical teams along with details of any old or new harm are communicated to clinical teams. This year the children and young person's safety thermometer has also been launched and local reporting of harms at team level is now becoming embedded. ■ Heat map data goes to the board monthly and is shared through the divisions. ■ A quality observatory has been rolled out to medicine and surgery divisions collecting data on key clinical performance.
Establish strong multidisciplinary teams who communicate clearly across boundaries through development forums for clinical governance leads.	■ Regular meetings set up with the associate medical director and information sent out to support learning.
Give timely and relevant feedback to teams to enable staff to be knowledgeable about patient safety.	■ Upgrade to Datix system to support more robust feedback. ■ CARE folders on wards now include learning section with local and trust-wide lessons from incidents and serious incidents.

Promote an open and transparent culture where we listen and act on staff concerns through the safety forum initiative, and on-going development/ monitoring in relation to the Duty of Candour.	■ Duty of Candour guidance available on all wards through CARE folders. ■ Rolling out enhanced training around Duty of Candour.
Encourage the involvement of patients in patient safety initiatives through the roll out of the patient safety booklet/ films.	■ Booklet was distributed across the trust and the film placed on patientline screens. Training for staff to support patients' understanding and use of booklet.
Listen to and involve people who use our services through further improvement work in relation to the complaints function and monitoring of key metrics.	■ Patient representatives involved in quality inspections to capture patient feedback. ■ Friends and Family Test feedback displayed in clinical areas, comments reflected on and action plans developed.
Use feedback as a vehicle for continuous improvement adopting best practice where possible through triangulation.	■ Complaints pertinent to specific groups shared at meetings eg end of life care and nutrition to ensure areas for development are addressed.
Ensure our patients are cared for in a clean, safe and comfortable environment through the use of the clinical audit programme and ensuring that findings are acted upon.	■ As part of the quality inspection programme, infection control and estates staff joined the inspection team to provide feedback and ensure continuous improvements are made.
Ensure that our most vulnerable patients and service users are listened to and protected from harm through introduction of the dementia and delirium team and monitoring the clinical care for individual patients.	■ Passports are in use for patients with dementia and learning disabilities to ensure optimum communication.

Evaluate clinical audit results and act on findings to ensure audit contributes to improvements for patients.	■ Key national and local audits are reported on a monthly basis to the board as part of the quality update, helping to drive forward improvements. ■ Summaries of the audit programme are produced each quarter so that divisions may identify key areas for action and escalation.
Support staff to improve outcomes, promoting shared learning and prioritisation of improvement projects.	■ Staff are supported to improve outcomes through the offer of regular training sessions on using clinical audit for quality improvement and also on effective data analysis and presentation. Each division has a dedicated resource to support them in the delivery of priority topics. Our key shared learning event is the annual clinical audit half day which this year was attended by more than 200 staff.
Evidence that we are clinically effective and implementing evidence-based best practice.	■ We have just launched a project to review our approach to NICE implementation, which will help us to improve processes and provide a more complete picture of implementation. This information will help us to better identify and then manage any risks associated with non-compliance. This year we introduced new baseline assessment forms which require the evaluation of risk where full implementation has not been achieved. ■ Reports from confidential enquiries are prepared for the board as part of the quality update, in addition to national audits.

Fully participate in national clinical audits and use results to improve local practice.	■ The reporting structures mentioned above help us to use results to improve local practice, but it is recognised that this could be strengthened and better evidenced. This will remain a key focus of the clinical audit team through the next year. ■ All national clinical audits are included on the annual audit programme, but it is acknowledged that there are challenges particularly in regards to data quality. These must be taken forward through local action planning. Although we participate in a number of elements of the national diabetes audit, there remain strands where we do not participate. This is being taken forward at a divisional level, with corporate support as appropriate, but remains outstanding at year end.
Aspire to achieve best practice across all clinical areas so that patients have the best possible outcome.	■ Through the monitoring of national and local audits and the reporting structures detailed we endeavour to share and celebrate best practice. ■ We continue to build on our strong governance of mortality to ensure that a large subset of deaths are reviewed centrally and are driving the proportionate review of all deaths. Our overall mortality as measured by the hospital standardised mortality ratio (HSMR) remains significantly better than expected, and as measured by the summary hospital-level mortality indicator (SHMI) our mortality is as expected or better than expected, depending on the 12 month period considered.

Developing the quality account

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

The Department of Health (DH) and Monitor 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 both Monitor's reporting requirements and those set by DH. Monitor requires us to produce an annual quality report which includes all of the reporting requirements of the quality account plus some additional requirements 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 Monitor's quality reporting requirements we have consolidated all the quality information into one document – the quality report, but for reporting purposes to DH we will call the quality report the 'quality account'.

Monitor 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 ten this year in a bid to better reflect the services we provide and the patients we care for.

We have worked with local stakeholders to identify which indicators to include in this year's quality account to make sure that the areas that matter most to the people who use and provide our services are covered. These stakeholders included our 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 we will be reporting on in next year's quality account (2016/17). These have also been shared with stakeholders.

The voluntary indicators chosen for 2016/17 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 2015/16 to support embedding the 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	Voluntary indicators chosen for next year's report (2016/17)
Patient safety	**Patient safety**
Medication errors Patient falls Patient safety thermometer Offender healthcare	Medication errors Patient deterioration Staff learning through incident feedback Learning from never events outside of theatres
Patient experience	**Patient experience**
End of life care Complaints Community learning disability referrals	End of life care Complaints Dementia and delirium
Patient outcomes	**Patient outcomes**
Clinical records Sexual health in secondary schools Clinical outcome measures in community services	Clinical records Mortality

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

Testing

It is a requirement that our auditors test certain indicators to provide assurances that there is a robust audit trail.

Two indicators are mandatory. These are:

1) percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period

2) percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.

One local indicator needs to be selected by the trust's council of governors. For 2015/16 they have chosen the patient safety thermometer.

London Quality Standards

Why is this important?

Many patients are admitted to hospital as emergencies and the treatment they receive in the first hours and days in hospital are very important. The London Quality Standards (LQS) were developed in 2011 after a review found variable, and often inadequate, involvement of consultants in the assessment and management of acutely ill patients in London. It was estimated that improved care would save 500 lives each year across the city. The standards specify the optimal way to manage patients in the crucial early period after admission. There are different standards appropriate for different groups of patients.

As part of the south west London five year strategic plan St George's agreed to progress towards meeting the full range of the LQS by the end of 2016/17. In November 2014 we participated in a peer review audit with the other acute providers in south west London. This covered the full range of LQS except for maternity.

http://www.swlccgs.nhs.uk/2015/03/south-west-london-urgent-emergency-care-peer-review-visit-report/

We have continued to update this as part of our collaborative work with the other acute providers in south west London. The reporting format is slightly altered so that a standard may be reported as partially met.

How are we doing?

Our most recent report was in December 2015. In total St George's met 142 of the 176 standards in full, a further nine in part and did not meet 23. There has been improvement in most areas over the year although challenges remain, particularly around adult acute medicine, and paediatric surgery. Whilst the care required is delivered, it is not always as quickly as we would like it to be or consistently through every hour of every day. These difficulties mostly relate to competing demands on staff. It has been difficult to recruit additional acute physicians despite efforts this year.

	RED: not fully met	AMBER: partially met	GREEN: met
Adult acute medicine (22 standards)	4	2	16
Adult emergency general surgery (26 standards)	2	2	22
Emergency department (14 standards)	1	2	11
Critical care (26 standards)	1	0	25
Fractured neck of femur pathway (13 standards)	2	1	10
Paediatric acute medicine (21 standards)	6	0	15
Paediatric surgery (23 standards)	6	0	17
Urgent care centre (31 standards)	1	1	27

What are our aims?

Our aim is to continue to work towards meeting the standards by 2016/17. This is a key aim of the Acute Provider Collaborative with the other acute trusts in south west London (Croydon, Epsom and St Helier, Kingston).

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. Other services treat patients from all over the country like 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 2015/16 we provided and/or sub-contracted 54 NHS services. We have reviewed all the data available on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2015/16 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 2015/16.

The services we provide can be categorised as:

- **National specialist centre**
  We provide specialist care to patients from across the country for complex pelvic trauma, family HIV care, lymphoedema and penile cancer.
- **Tertiary care**
  We provide tertiary care like cancer services, neurosciences and renal services for the six boroughs of south west London and the counties of Surrey, Sussex and Hampshire. We also provide specialist children's cancer services in partnership with The Royal Marsden NHS Foundation Trust.
- **Local acute services**
  We provide a range of local acute services like A&E, maternity and general surgery to the people of Wandsworth, Merton, and Lambeth.
- **Community services**
  We provide a full range of community services to the people of Wandsworth, making sure people can manage their health better by accessing the services they need closer to where they live and work and in their own homes.

Our clinical divisions

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

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

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 www.stgeorges.nhs.uk/services.

Staff Friends and Family Test (FFT)

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

Why is this important?

One of the trust's strategic aims is to be an exemplary employer. To achieve this we must commit time, resources and effort into supporting our staff and making St George's both a great place to receive healthcare and a great place to work. Our staff are central 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 with our own workforce. In quarters one, two and four we give staff the opportunity to complete the survey, which comprises two 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 aims

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

We aim to further improve our scores in the Friends and Family Test for staff in 2016.

National NHS staff survey

Our 2016/17 workforce strategy action plan sets out a programme of work that will support the trust to respond to the issues raised in the national NHS staff survey. These include:

Confidence to raise concerns

The 2015 staff survey results showed that the trust had a below average score for staff agreeing they would feel secure about raising concerns about unsafe clinical practice. The trust will be implementing the national 'Freedom to Speak Up' review. We encourage staff to raise concerns and will ensure that they receive support in doing so and feedback on the outcome of the complaint.

Our scores, by quarter, are listed here:

	Staff response	Would recommend for treatment	Would recommend as a place to work
Q1	695	79%	50%
Q2	274	75%	46%
Q4	508	75%	50%
Full year	1502	76%	49%

Tackling poor behaviour and bullying

Trust performance has remained fairly steady with 33% of staff saying that they have experienced harassment, bullying or abuse from staff in the past 12 months. The strategy to tackle bullying includes coaching and training for managers dealing with difficult staffing issues, and reviewing our policy to ensure it meets best practice standards.

Discrimination

The trust position has remained the same with regard to members of staff reporting discrimination. Of greatest concern is that 31% of black and minority members of staff report discrimination as compared to 13% of white members of staff. It is of further concern that 35% of black and minority members of staff report experiencing harassment, bullying or abuse from members of staff in the last 12 months as compared to 32% of white members of staff. Our 'St George's as One' inclusion programme was set up in 2015 to help address these issues.

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

Listening into Action

We recognise that as well as listening to our patients, it's also important that we listen to our staff and involve them when we try to identify where improvements could and should be made. That's why we are fully on board with the national Listening into Action staff engagement programme.

Listening into Action launched at St George's in March 2013. It's our way of working with and engaging staff at St George's. It's about achieving a fundamental shift in the way we work and lead, putting clinicians and staff at the centre of change for the benefit of our patients, our staff and the trust as a whole.

Essentially, Listening into Action is about:

- engaging all the right people around delivering better outcomes for our patients, our staff and our trust
- aligning ideas, effort and expertise behind the patient experience, safety and quality of care
- overcoming widespread challenges around staff engagement and morale
- developing confidence and capability of our leaders to 'lead through engagement'
- collaborating across the usual boundaries, and
- engendering a sense of collective ownership and pride.

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

We use the feedback from staff 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.

Research

Why is it important?

At St George's we are committed to innovating and improving the healthcare we offer and a key way we do this is by participating in research. Our clinical staff keep abreast of the latest treatment developments and through clinical trials, patients are offered new drugs and devices and better clinical care evolves. The key reason for our participation in clinical research is to develop new and improved clinical treatments for our patients and to realise better ways to manage illness, thereby ultimately improving the health of our local community.

St George's is a collaborating site with Genomics England for the '100,000 Genomes Project' and the genetics service has begun to recruit patients from our services to contribute data and samples to the project. St George's runs the South West Thames Regional Genetic Services which provides a specialist service to people living in south west London, Surrey and West Sussex, in 18 hospitals across the region. Initially the focus will be on rare disease, cancer and infectious disease, but our clinicians are working with the project to identify other key disease areas.

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. There has been significant investment in new academic clinical appointments in the previous year. We look forward to growth in research activity in neurosciences, cardiology and maternal and fetal health in 2016. In the key research areas of St George's Medical School, University of London, there have important studies across both organisations.

In infection and immunity:

- New diagnostic techniques for TB.
- Pain relief in rheumatoid arthritis.
- Follow-up on babies who had meningitis.
- Looking at the ways different patients respond to antibiotics.
- Developing MRI scan techniques in cancer.
- New physiotherapy techniques for patients with lung disease.

In cardiovascular and cell sciences:

- Studies looking at cardiac problems in otherwise healthy individuals.
- Identifying new genetic influences in cardiac problems.
- New treatments for vascular dementia.
- Developing a renal inpatient nutrition screening tool.
- New ECG techniques in inherited heart conditions.

Our strong relationship with the pharmaceutical industry continues – we recruited the largest number of patients on to commercial trials in South London CRN (clinical research network). This enables our clinical staff to keep abreast of the latest developments and our patients to have access to the newest treatments within clinical trials.

Our outcomes

I. Participation:

One of the key ways of offering new treatments is through participation in clinical trials that are approved by the National Institute for Health Research (NIHR), which supports NHS and

academic institutions to deliver quality research that is patient-focused and relevant to the NHS. These studies are adopted onto the NIHR portfolio.

In the calendar year 2015, there were 198 NIHR adopted trials open and recruiting in St George's, with 7561 patients taking part. This was a decrease from 2014 where 9,021 patients took part in research. However, there were several unusual trials in both years – and having around 5,000 patients would be reasonable for 2016.

We don't have data for the number of patients receiving relevant health services provided or sub-contracted by St George's in 2015/16 that were recruited during the period to participate in research approved by a research ethics committee. This information is not collected as we don't store the number of patients of studies outside the ones already reported on. We also don't have the number of studies that we are recruiting to, only the studies that are active.

II. Approvals:

In 2015, the research office approved 168 new studies to be performed at St George's, a slight decrease (19 in total) from 2014. These range from clinical trials of medicinal products (new drugs) and medical devices, through to service and patient satisfaction studies. Just less than 70% are adopted on the NIHR portfolio, up from 30% in 2013, and 60% in 2014. Non-adopted studies include 'proof of concept' studies, in which our researchers and clinicians are gathering evidence that may develop into larger adopted trials, student studies and trials sponsored by commercial companies.

The approval time for studies has been a focus at St Georges in 2014. However, there are national changes in the approval system that has taken effect from 1st April 2016, meaning that approval for studies will be undertaken by the Health Research Authority, not St George's staff. Our staff will only check that we have the ability to undertake the study. Therefore, as yet, we are unclear about the extent of the impact this will have on the number of studies approved at St Georges. Our aim for 2016 is to maintain the number of studies approved and active.

III. Trials starting recruitment:

In our most complex trials, we endeavour to get the study approved and the first patients recruited within 70 days of submission to the research office. We have seen a steady increase in this from 40.3% in December 2013 to 80.0% in December 2014, to 93.2% in December 2015.

We intend to maintain this level in 2016.

IV. Ensuring compliance with 'Good Clinical Practice ' guidelines for research

All trials require one institution or company to have the legal responsibility to ensure that the trial is run safely and gathers good quality information in order to answer the research question e.g. does a new drug lead to better outcomes compared to the standard treatment? When we are the responsible institution (sponsor) all our trials are closely monitored by a team from the research office. When we host studies that are sponsored by other organisations or companies, we also undertake our own system of review (audit), in order to ensure best practice and optimal safety for our patients. In 2014, we aimed to audit 10% of all active trials (21 trials), and we actually reviewed 21 studies to ensure that our staff are meeting all of the regulatory and compliance requirements, and patient safety is maintained.

Our aims in 2016

I. Increase participation

We intend to maintain and improve upon our patient participation rates in NIHR adopted trials at 2013 levels, understanding that 2014 and 2015 were unusual years. We hope to recruit 5,000 patients or more in 2016.

We intend to ensure that patients are made aware of the research opportunities at the trust. In order to do this we will participate in the International Clinical Trials Day on Friday 20th May 2016.

II. Approvals

In 2016, there are significant changes to the national approvals process that could affect the number of studies approved at St Georges. We intend to ensure that we maintain the number of studies approved at St Georges, at 168 with at least 70% being NIHR adopted.

III. Trials starting recruitment

We intend to continue increasing the number of trials that get up and running quickly so that the trials can be successful. We hope to achieve 90% of relevant trials recruiting their first patient within 70 days.

IV. Ensuring quality

We will continue to review 10% of all active research studies each year to provide assurance of the safety and quality of studies undertaken here.

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

Participation in clinical audits

During 2015/16, 45 national clinical audits and eight national confidential enquiries covered NHS services that St George's University Hospitals NHS Foundation Trust provides.

During that period St George's participated in 88.9% 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 2015/16 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 16 national clinical audits were reviewed by trust board in 2015/16. A summary of the actions agreed in response to these audits is given in Appendix B.

The reports of 14 local clinical audits were reviewed by St George's in 2015/16. A summary of the actions agreed is given in Appendix C.

Use of CQUIN payment framework

St George's University Hospitals NHS Foundation Trust's income in 2015/16 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and innovation payment framework because of the trust's contract type.

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.

St George's University Hospitals NHS Foundation Trust is registered with the CQC and is licensed to provide services from each of its locations. The trust has no conditions placed on it and the CQC has not taken any enforcement action against the trust in 2015/16. St George's has not participated in any special reviews or investigations by the CQC during the reporting period.

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.

How did we do?

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

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

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

CQC statement on St George's Hospital

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

CQC statement on Queen Mary's Hospital

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

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

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

- St George's University Hospitals NHS Foundation Trust
- The CQC
- The Trust Development Authority (TDA)
- NHS England
- Wandsworth Council
- Healthwatch Wandsworth
- Wandsworth CCG
- Merton CCG.

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

- outstanding maternity care underpinned by information provided to women and partners and robust midwifery staffing levels with excellent access to specialist midwives
- exceptional end of life care demonstrated within the maternity department
- outstanding leadership of intensive care and high dependency units with open and effective team working and a priority given to dissemination of information, research and training
- excellent multidisciplinary working within and across community and acute teams
- the functioning of the hyper acute stroke unit, short term reablement and rehabilitation service
- the well led, integrated working and calm environment within A&E
- multi-professional team working in neuro theatres
- systems developed by the trust to promote the safety of children, young people and families
- an evident culture of positive learning from medicine administration errors
- development and use of DVDs to engage staff with ongoing practice improvements.

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

During 2015/16 the trust has continued to take action to address the two issues identified by the CQC. A formal action plan was developed and approved by the trust board before being shared with the CQC. The plan set out how the trust would ensure improvements in the availability of medical records in outpatient clinics, it also set out the measures we would take to ensure that trust staff at Queen Mary's Hospital (QMH) have a good level of understanding of the Mental Capacity Act in order to deliver safe, responsive and effective care.

There has been an improvement project in the corporate outpatient department and better availability of medical records was just one of the improvements made. This is monitored on an ongoing basis.

The trust designed and delivered a tailored training programme to all staff at QMH around the implementation of the Mental Capacity Act and all staff have now attended and have evaluated the training and a case note audit showed practice had improved.

Progress on the action plan was been presented to the trust's commissioners and the CQC on a quarterly basis and both commissioners and the CQC indicated that they assured good progress has been made to improve quality of care where needed. As such the action plan was closed in July 2015, however all actions in the plan continue to be monitored by the trust.

The CQC has announced that they will return to the trust on 21st June 2016 to carry out a full inspection as part of their continued announced inspection regime. The trust has started to prepare for the inspection, the results of which will become available in late 2016.

Data quality

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

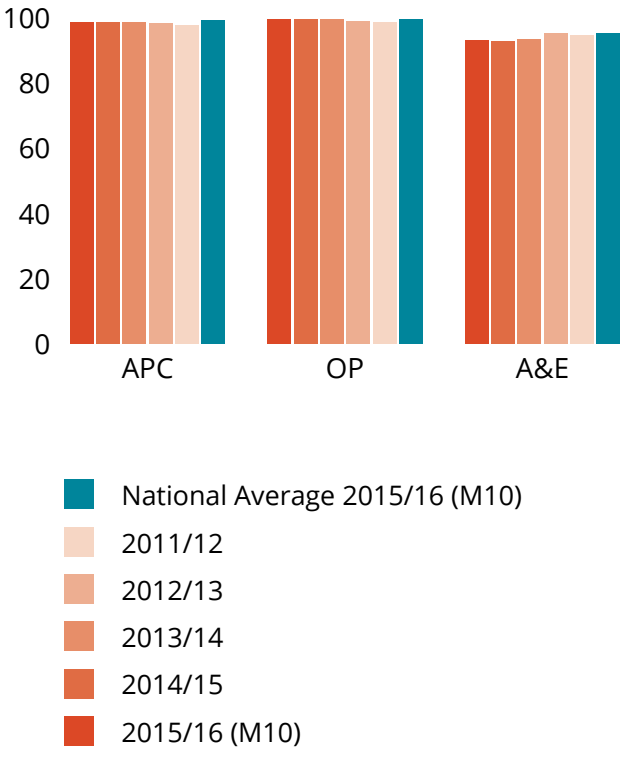
Most data is gathered as part of the everyday activity of frontline and support staff who work throughout the trust in a huge variety of settings. It is important that we accurately capture and record the care we provide and the information in this report aims to demonstrate how well we are doing this. We have been working closely with our IT suppliers this year to increase the robustness of our data capture and processing.

St George's submitted records during 2016 for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

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

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

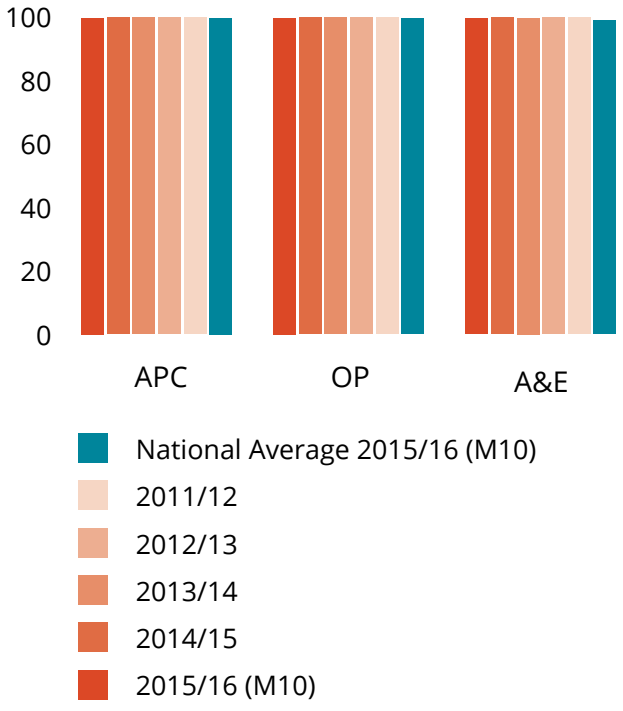
Valid NHS no	APC	OP	A&E
2015/16 (M10)	98.7	99.5	93
2014/15	98.6	99.4	92.7
2013/14	98.7	99.4	93.4
2012/13	98.3	99	95.1
2011/12	97.7	98.6	94.5
National average 2015/16 (M10)	99.2	99.4	95.3



Our NHS number completeness remains good, but is behind the national average for admitted care and A&E. St George's will be taking the following actions to improve data quality. We have a data quality improvement strategy which we have developed with our commissioners that details planned improvements in the way our patient administration system (PAS) Cerner, accesses the national Patient Demographic Service (PDS) that should see these numbers improve next year.

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

Valid GP	APC	OP	A&E
2015/16 (M10)	99.9	99.9	99.8
2014/15	100	100	100
2013/14	100	100	99.9
2012/13	100	100	100
2011/12	100	100	100
National average 2015/16 (M10)	99.9	99.8	99.1



Note: The data quality figures shown above are correct as at month 10 (April 2015 to January 2016 data). This is the most recent data available.

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

Information governance

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

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

- held securely and confidentially
- obtained fairly and efficiently
- recorded accurately and reliably
- used effectively and ethically
- shared appropriately and lawfully.

We have an ongoing information governance programme, dealing with all aspects of confidentiality, integrity and the security of information. Annual information governance training is mandatory for all staff, which ensures that everyone is aware of their responsibility for managing information in the correct way. An internal audit conducted in 2015/16 gave the trust 'reasonable' assurance that the trust is managing information appropriately and that staff are aware of their responsibilities.

Our patient administration system increased both the security and accuracy of information at the trust. All staff accessing the system use a secure and strictly authenticated smartcard which defines what they are permitted to access in the system. Virtual desktops are now in use across two thirds of the trust, increasing the security and availability of our systems. The trust has introduced a new electronic system for managing referrals improving both the accuracy and allocation of appointments. The trust is rolling out electronic document scanning across a number of areas moving away from a dependence on paper records.

How did we do?

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

St George's University Hospitals NHS Foundation Trust information governance assessment report overall score for 2015/2016 was 73% per cent and was graded green, or 'satisfactory' according to the criteria set nationally. This is the highest grading possible, and can only be awarded by achieving an attainment Level 2 on every requirement in the NHS Information Governance Toolkit.

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

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

Year	Information governance assessment score (per cent)	Grade
2015/16	73	Green
2014/15	77	Green
2013/14	79	Green
2012/13	79	Green
2011/12	77	Green

Clinical coding error rate

St George's University Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2015/16 by the Audit Commission.

Improving patient safety

Reducing patient falls in the community and whilst under the care of the hospital

Why is this important?

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

Unfortunately, we will never be able to completely eliminate the risk of our patients falling. We know that even in the community one in three people over the age of 65 will fall, rising to one in two for over 80 year olds. However we also know that falling is not an inevitable part of ageing and that reversible risk factors can be addressed to reduce the risk of falling and fracturing.

The inpatient hospital population has some similar characteristics to the community dwelling population, and in addition there are the additional risks around acute illness and sudden change in environment which present further challenges for those impaired by cognition/vision etc. Following the acute phase of management the patient begins their rehabilitation. An inherent part of patient rehabilitation is risk taking, which must balance the management of risk with the need to facilitate progress and enable goal attainment. We try to make sure that a multifactorial falls and bone health risk assessment is completed and that a care plan to reduce the individual's risk factors is implemented, providing a quality patient experience within a safe environment.

How did we do?

For hospital inpatient services we have:

- implemented an electronic multifactorial falls risk assessment in line with the NICE falls guidelines
- developed an interim paper-based multifactorial falls risk assessment for clinical areas that are not yet electronic
- developed and implemented a bed rails risk assessment tool which must be completed for all adult inpatients on admission to hospital
- conducted an audit of bed rail risk assessment across the trust and have implemented an action plan to improve compliance
- developed patient information leaflets on falls prevention and the use of bed rails
- been running monthly patient simulation study days to promote best clinical practice for falls and other harms.

We have participated in the national inpatient falls audit. The results showed that we are below the national average for falls resulting in moderate/severe harm or death per 1000 bed days (0.03 versus 0.19) and slightly below the national average for number of falls per 1000 bed days (6.12 versus 6.63).

However, the audit showed that in seven key indicators of good falls prevention, we achieved amber status for four areas (assessment of delirium, assessment of continence, call bell in reach, walking aid in reach) and red status for three areas (postural blood pressure measurement, visual assessment and medication review). An action plan to improve practice has been developed and we will be participating again in the autumn.

There has been no significant reduction in the number of inpatient falls across the trust this year.

Community based services:

We have an integrated falls and bone health service (IFS&BH). This is predominantly a prevention-focused service that dovetails with other reactive community services and is fully integrated with the hospital-based sister services such as osteoporosis/orthopaedics/older people services.

Following assessment, optimisation of the patient is a clear target for the team. This requires multiple communications, influencing other health and non-health professionals and implementing a tailored treatment plan in order to address the reversible risk factors for falls and fractures. Assessments are carried out in patients' homes, health venue clinics and at satellite clinics in non-health venues such as sheltered accommodation sites. Part of the service provision is the running of 25 community based exercise groups a week – six of these with transport to ensure a fair and accessible service to all. Another arm of the service is the bone boost provision – an early prevention model targeting the population at risk of fracture This short film explains more about the service: www.youtube.com/watch?v=-dsQ1uIa9hM

Building on the success of joint working with the acute-based services, further development work has continued this year:

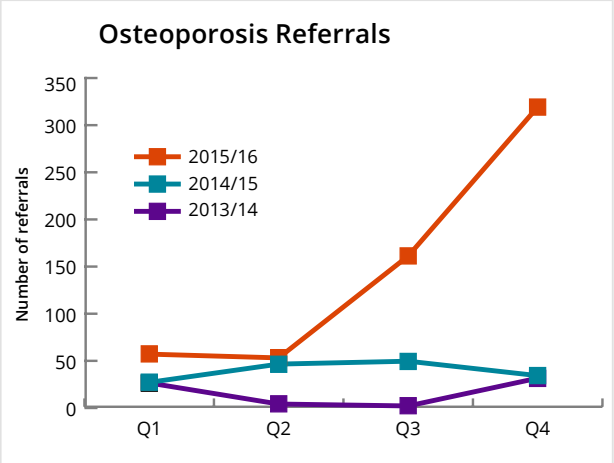
- Development of the Denosumab PGD – an innovative work stream about skilling up the IFS&BH pharmacist and physiotherapists to provide this important injection for the prevention of fractures in community settings for more frail patients.

- Evolution of a niched falls prevention exercise group for our diabetes patients –recognising their more complex needs and a different approach.

- Development of a rapid referral service for vertebral fracture patients – a smooth pathway for immediate access to appropriate vertebral bracing support has been implemented with the orthotics department.

- Monthly integrated falls and fracture meetings between the rheumatology, renal, orthopaedic consultants and head of IFS&BH to ensure service developments and pathway improvements for fragility fracture patients especially with hip fractures.

- Monthly meetings with the dexa scan technician, fracture liaison nurse and the IFS&BH clinical lead to ensure effective and efficient pathway design – accessing patients early with community intervention following a diagnosis of osteopenia/osteoporosis. This early intervention prevention service will help to reduce the burden of fragility fractures further down the line. The graph below shows the significant increase in referrals through closer working together.



This year has also seen the implementation of ARCH – Active Residents in Care Homes – our joint research feasibility trial with St George's and Kingston University. This is an exciting project which will yield some important findings about the prevention of falls and fractures for this population. The clinical team for this £300k research trial funded by the CSP (Chartered Society of Physiotherapists) are all from the IFS&BH team. The trial will continue into 2016/17.

Presentations and posters:

Two clinical audit posters were presented at the trust's clinical governance day.

In addition to our integrated working within our own organisation we have also led on an integrated work stream at Kingston hospital – the falls prevention navigator role which was presented at the CSP conference in Liverpool this year. www.physiotherapyuk.org.uk/programme

Bernadette Kennedy, head of integrated falls and bone health, also presented at the recent Department of Health Global Progress on Safety Summit in Westminster regarding whole systems approaches to falls and fracture prevention: mhforum.org.uk/conferences/progress-on-safety-learning-together-event/

Our aims

- To reduce the admissions for falls and fragility fractures in Wandsworth through our community provision.
- To reduce the current rate of reported falls during an inpatient episode.
- We will continue to identify the trends and themes and implement targeted action plans through structured evaluation and benchmark ourselves against other organisations when possible.
- We aim to maintain our position as a leading falls and fracture prevention service in the country, continuing to work with our patient populations to deliver innovative services that meet individual and population needs.

Patient safety thermometer

Making sure that patients do not suffer avoidable harm is a key focus for the trust. The 'classic' safety thermometer is a quick and simple point-of-care tool for surveying patient harms and analysing results so that you can measure and monitor local improvement and harm-free care.

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

We have regular and reliable data for all of the high risk areas listed above, across all inpatient and community services. All data recorded on the safety thermometer is submitted to the Health & Social Care Information Centre with monthly national reports developed and published at www.hscic.gov.uk/thermometer . Teams can then be given feedback on the proportion of their patients who are harm-free which gives them a powerful tool for improvement.

In 2015/16 we collected data on 15,478 patients, of which 94.4 per cent were free of the harms being measured in this way. This compares with a national benchmark of 94.2%.

Next year for the 'classic' safety thermometer we will try collecting the data in a slightly different way which will help us to identify where harms have developed. This will make the data more useful to us in identifying areas where care might be improved.

A safety thermometer specific to children and young people has been developed by the national team and we have been piloting this at St George's since June. The harms that are measured include deterioration, extravasation, pain and skin integrity. The process of audit and action planning are becoming embedded. Each month a report is provided to all children's wards and they are asked to report back actions against harms.

During the year there has been a lot of work undertaken to reduce medication errors, and piloting the medication safety thermometer was part of this work.

Reducing medication errors

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

This year the National Reporting and Learning System has reported that St George's medication error reporting is higher than the national benchmark for reporting medication incidents. 14.1% of all incidents reported involved medication for St George's in comparison to 10.3% for all acute teaching organisations. In Q1-3 of 2015/16 the trust reported 1202 medication incidents, reflecting a good safety culture. Of these incidents, 93.0% resulted in no harm, 5.6% in low harm and 1.2% in moderate harm. One medication incident (0.08%) 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 – 93.0%
Low harm – 5.6%
Moderate harm – 1.2%
Severe harm – 0.08%

The trend of reporting medication incidents continued to increase over 2015/16, without an increase in the degree of harm. 94.9% of incidents were no harm in Q3 201/16 compared to 92.1% for Q3 of the previous year.

The 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-ordinates medication safety monitoring visits to clinical areas to monitor medication safety issues.

During 2015/16 medication safety visits have been conducted in community services, ward and non-ward areas including radiology and endoscopy.

Implementing the early warning score indicator at HMP Wandsworth

Why is this important?

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

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

- **heart rate**
- **respiratory rate**
- **blood pressure**
- **level of consciousness**
- **oxygen saturations**
- **temperature.**

The early warning score (EWS) indicator has been used at St George's and Queen Mary's Hospital for a number of years and our aim for 2013/14 was to introduce the early warning score indicator to offender healthcare services and subsequently to devise an electronic template so that the EWS is integral to the clinical information system and to patients' medical records.

How did we do?

In 2013/14 the early waning score indicator was successfully implemented at HMP Wandsworth with all patient observation charts on the Jones unit including the indicator. All offender healthcare service staff were trained in the use of the early warning score indicator meaning that any deterioration was identified quickly.

An electronic template was also devised and put into use in quarter four of 2015/16, and the first audit illustrated that the EWS tool was used for patients on 118 occasions. This was significant as not only has it shown an improvement in numbers recorded, but the quality of the assessments were also improved by the electronic nature of the template as it automatically calculates scores so as to remove the opportunity for error.

Our aims

Further work is required in 2016/17 to maintain a consistent approach in the use and recording of EWS, and to subsequently expand its use to cover emergency response and substance misuse observations.

Mortality

Why is this important?

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

Our outcomes

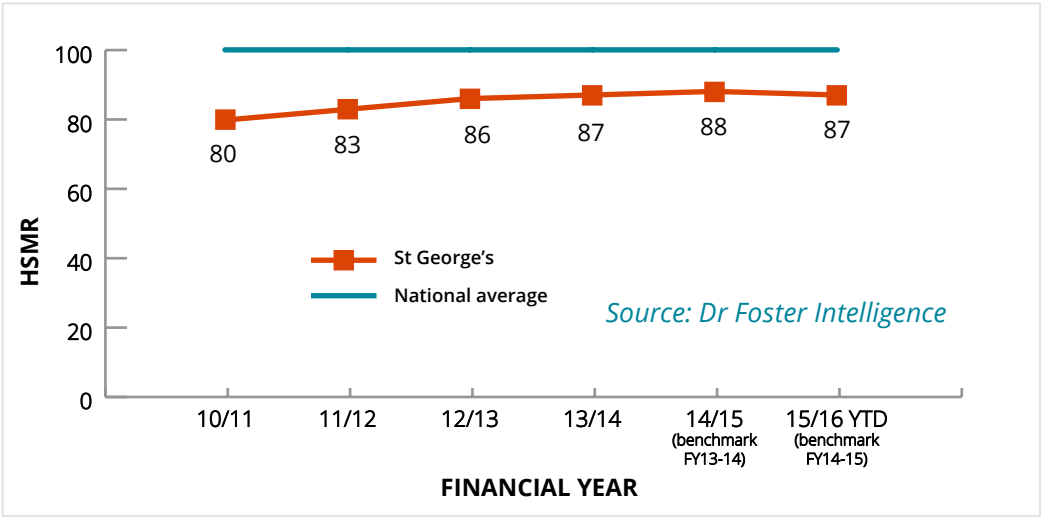
Our SHMI continues to be either lower than expected, or in line with what would be expected. The table below summarises the quarterly publications for this period. As well as considering our overall position we look at this data by diagnosis group and investigate areas where mortality may be higher than expected.

Publication date	Reporting period	Ratio	Banding
April 2015	October 2013 – September 2014	0.86	Lower than expected
July 2015	January 2014 – December 2015	0.89	Lower than expected
October 2015	April 2014 – March 2015	0.92	As expected
January 2016	July 2014 – June 2015	0.90	Lower than expected
March 2016	October 2014 – September 2015	0.91	As expected

Source: Health and Social Care Information Centre

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

Hospital Standardised Mortality Ratio



St George's considers that this data is as described for the following reasons. These data are reviewed by the trust's mortality monitoring committee which meets on a monthly basis. The group, which is chaired by the associate medical director for governance and has members from across the trust, also considers mortality data at diagnosis and procedure level and reviews all deaths in hospital following an elective admission. By examining this range of data we are able to scrutinise our outcomes and the care we provide to patients. Where there are lessons to be learnt these are identified and acted upon and where best practice is observed this is acknowledged and shared.

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.

Our aims

The trust intends to take the following actions to improve this indicator and the quality of its services. Our aim for the coming year is to further strengthen our governance of mortality and we hope to achieve a mortality ratio which is lower than expected. We will continue to expand our scrutiny of deaths and to identify opportunities for learning. We are committed to implementing the anticipated national mortality case record review programme.

Publication date	Reporting period	St George's	National
April 2015	October 2013 – September 2014	29.0%	25.3%
July 2015	January 2014 – December 2014	28.8%	25.7%
October 2015	April 2014 – March 2015	29.3%	25.7%
January 2016	July 2014 – June 2015	29.4%	26.0%
March 2016	October 2014 – September 2015	29.6%	26.6%

Source: Health and Social Care Information Centre

Assessing risk of VTE in admitted patients

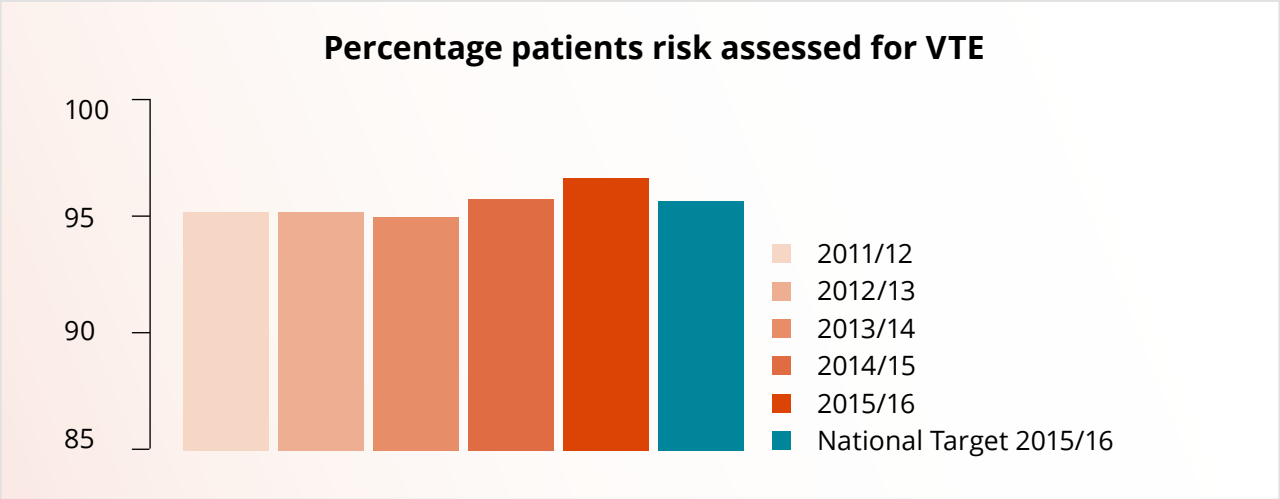
Why is this important?

Venous thromboembolism (VTE) occurs when a deep vein thrombosis (blood clot in a deep vein, most commonly in the legs) and pulmonary embolism (where such a clot travels in the blood and lodges in the lungs) causes substantial long term health problems or death. VTE is associated with long periods of immobility and can be prevented with appropriate preventative measures at the earliest possible time according to the needs of each patient.

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

How did we do?

Every trust in the country is required to report the number of documented VTE risk assessments being conducted on admission as a proportion of the total number of hospital admissions. In addition they are also required to report the proportion of cases where there is a documented risk assessment that appropriate thromboprophylaxis has been prescribed.
In 2015/16 there were 190,362 risk assessed admissions at St George's and Queen Mary's Hospitals and of these 96.7% were given VTE risk assessments, thus exceeding the national target for VTE risk assessments of 95% and our 2014/15 performance of 95.89%.



Infection control

Why is this important?

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

Our infection control team, made up of doctors and nurses, works around the clock, monitoring infections and providing ward staff with advice on how to prevent, treat and contain the spread of infections to our patients.

Infections can spread in many different ways. For that reason we use an array of measures to stop the spread of infection to our patients. The success of these measures can be assessed in different ways. In particular we carry out surveillance for several 'alert organisms'. One such organism is Clostridium difficile.

What is Clostridium difficile?

Clostridium difficile (C. difficile) is a bacterium that can cause mild to severe diarrhoea and inflammation of the bowel. C. difficile infection can be prevented by a range of measures, including good hand hygiene, careful use of antibiotics and thorough environmental cleaning. By monitoring the prevalence of infections acquired in hospital we can obtain information on how good we are at adhering to high standards of environmental cleanliness, hand hygiene, and isolation of infectious patients. We can also introduce better measures to reduce the risk of infection for all of our patients.

C. difficile is present naturally in the gut of around 3% of adults and 66% of children. However, some antibiotics that are used to treat other health conditions can interfere with the balance of 'good' bacteria in the gut. When this happens, C. difficile bacteria can multiply and cause symptoms such as diarrhoea and fever.

As C .difficile infections are often caused by antibiotics, most cases usually happen in a healthcare environment, such as a hospital or care home. Both appropriate and inappropriate antibiotic use can cause C. difficile infection and there is always a balance of risk in treating patients with antibiotics. A strong antimicrobial stewardship program is important to ensure appropriate antibiotic usage only. Transmission can occur from patient to patient however with good modern infection control practices this is no longer common, Older people are most at risk from infection, with the majority of cases (80%) occurring in people over 65.

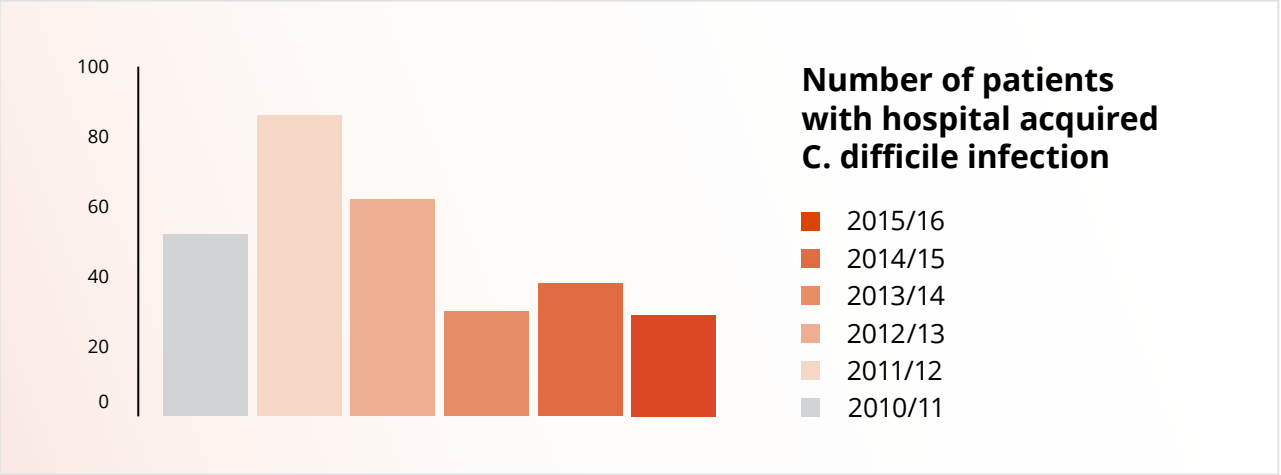
Even with stringent adherence to control measures, it is not possible to prevent all infections with C. difficile.

Most people with a C. difficile infection make a full recovery. However, in rare case the infection can be protracted and occasionally fatal.

Our C. difficile outcomes

In 2015/16, our aim was to have fewer than 31 hospital-acquired infections with Clostridium difficile. During the year 2015/16 29 patients acquired C. difficile whilst under our care. This represents a decrease of 24% compared to last year.

Year	Number of patients with hospital-acquired Clostridium difficile infection
2010/11	52
2011/12	86
2012/13	62
2013/14	30
2014/15	38
2015/16	29



Our aim

Nationally the number of infections in 2015/16 has increased. Given the national increase, the mandatory target for St George's remains at 31 but our target is to reduce the number of infections further in 2016/17.

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

Why is this important?

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

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

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

Patient safety incidents

There were 11,216 reported patient safety incidents in 2015/16 compared to 10,187 the previous year. This shows that we continue to actively report as many incidents as we can, demonstrating that at St George's we are committed to developing good systems that enable us to learn from things that go wrong and prevent them from happening again.

Of the 11,216 patient safety incidents there were 38 high and extreme severity incidents during the year. This is 0.3 per cent of all reported patient safety incidents.

Year	Number of patient safety incidents
2015/16	**11,216**
2014/15	**10,187**
2013/14	**9,739**
2012/13	**9,084**
2011/12	**9,663**

The number of never events declared over this period was eight.

Division	Service	Never event
Surgery	Dentistry	Retained foreign object (dental roll)
Surgery	ENT	Wrong site surgery
Surgery	Trauma and orthopaedics	Retained foreign object
Therapeutics	Critical Care	Misplaced NG tube
Therapeutics	Critical Care	Maladministration of insulin
Women's	Obstetrics	Retained foreign object (swab)
Community services	Dermatology	Wrong site surgery
Renal, haematology and oncology	Renal Medicine	Retained foreign object

Community learning disability referrals

Why is this important?

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

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

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

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

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

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

- review of documentation such as past assessments, IQ tests, reports, statements of educational needs
- initial screening test (the Initial Service Assessment Checklist – Adults or the Learning Disability Screening Questionnaire).
- IQ test (eg Wechsler Adult Intelligence Scale) and Social Functioning Assessment (eg Vineland or Adaptive Behaviour Assessment System).

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

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

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

How did we do?

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

Ensuring eligibility is assessed and completed within 28 days is challenging due to the requirement to obtain the necessary evidence of a learning disability which can be complex.

During 2015 the CLDHT reviewed their eligibility pathway and introduced a weekly clinic to assist supporting the eligibility process with the aim to ensuring commencement on the eligibility pathway within 28 days of receipt of the referral.

The table below shows that to date during 2015/16 the target of commencing eligibility within 28 days of receipt of referral is 100% with more than 70% of assessments completed within this time frame.

Community Learning Disability Health Team - quarterly account targets

Month/ year	Total number of referrals received for month	Total number of new/eligibility query referrals for month	% of new / eligibility assessments initiated within month	Total number of eligibility assessments completed within month	% of eligibility assessments completed within month
Q1 (April-June)					
Apr-15	30	4	100%	2	50%
May-15	40	4	100%	4	100%
Jun-15	64	9	100%	6	67%
Total	**134**	**17**	**100%**	**12**	**70.58%**
Q2 (July-September)					
Jul-15	55	5	100%	4	80%
Aug-15	67	5	100%	4	80%
Sep-15	59	8	100%	5	63%
Total	**181**	**18**	**100%**	**13**	**72%**
Q3 (October-December)					
Oct-15	28	2	100%	2	100%
Nov-15	31	3	100%	2	66%
Dec-15	47	6	100%	4	66%
Total	**106**	**11**	**100%**	**4**	**72%**
Q4 (January-March)					
Jan-16	18	2	100%	2	100%
Feb-16	27	0	100%	0	0%
Mar-16	45	6	100%	4	66%
Total	**90**	**8**	**100%**	**6**	**75%**

Our overall performance for 2015/2016 ended at 72%

Quarter	Total number of referrals received for quarter	Total number of new/ eligibility query referrals for quarter	% of new / eligibility assessments initiated within quarter	Total number of eligibility assessments completed within quarter	% of eligibility assessments completed within quarter
Q1	134	17	100%	12	70.58%
Q2	181	18	100%	13	72%
Q3	106	11	100%	8	72%
Q4	**90**	**8**	**100%**	**6**	**75%**
Overall % for the year	511	54	100%	39	72%

Complaints

Why is this important?

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

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

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

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

Our outcomes

In 2015/2016 we received 975 formal complaints, a reduction of 7% compared to 1,052 complaints in 2014/15.

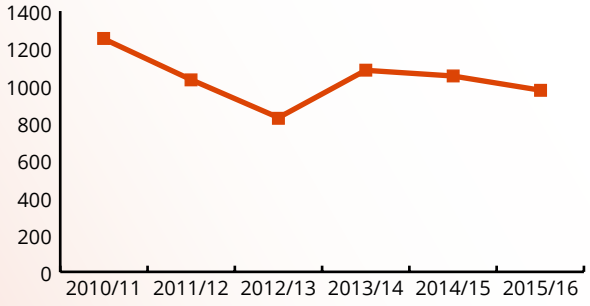
It is very difficult to benchmark complaints against other trusts as there is no uniform way for trusts to record complaints, meaning there is a lot of inconsistency across the NHS.

We view all types of patient feedback as positive and we are constantly looking at how we can encourage patients, carers and families to give their views.

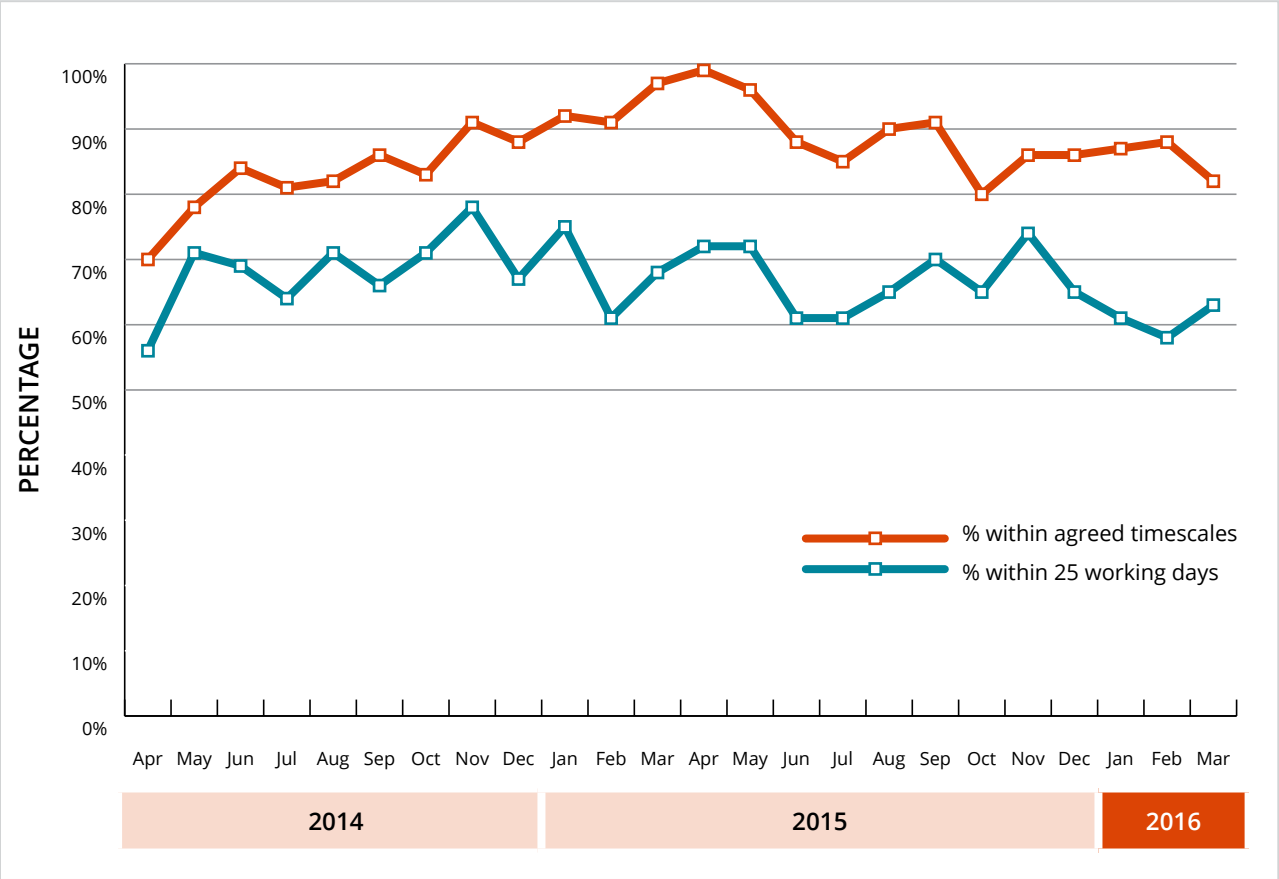
Number of complaints

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

Number of complaints by year



Complaints performance by month



Complaints response rate

We fully responded to 67% of complaints within 25 working days. Our target is that 85% of complaints are fully responded to within 25 working days.

We fully responded to 89% of complaints within 25 working days or an agreed timescale. Our target is that 100% 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 performance 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 in place in consistently poorly performing divisions with the aim of improving and delivering performance against internal standards but these are 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.

Responding to patients' needs

Why is this important?

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

In 2013 a new measure was introduced - the Friends and Family Test (FFT).

Friends and Family Test

The Friends and Family Test is a single question asked of patients on discharge about how likely they are to recommend our services to a friend or relative based on their treatment. There are six options; extremely likely, likely, neither likely nor unlikely, unlikely, extremely unlikely or don't know.

The scoring is based on the percentage of people that said they were "Extremely likely" or "Likely" to recommend our service if a friend or family member needed similar care or treatment.

The FFT has now been in place for three years, having been rolled out to A&E and inpatient adult areas for April 2013, maternity in October 2013 followed by outpatient and community services in September 2014.

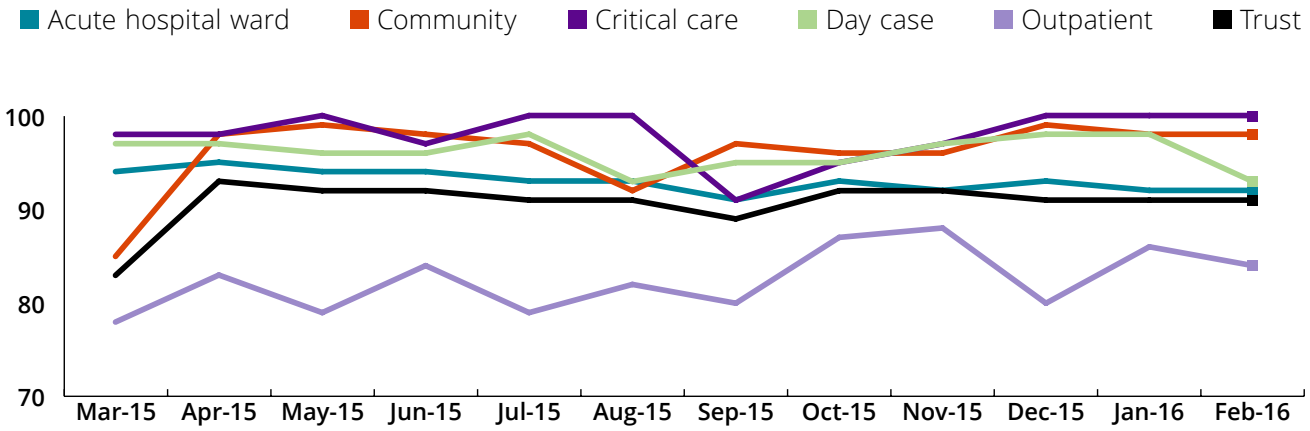
The maternity survey is different from A&E and adult wards as there are four occasions or 'touch points' when women are asked to rate the service (antenatal, birth, postnatal ward and postnatal community) whereas A&E and inpatient adult areas is only once on discharge.

In addition, we also have a number of other survey questions that we ask patients (anonymously) about their experience based on the national annual inpatient survey. A bespoke system allows for almost real-time feedback to enable staff to share good practice and implement any actions that may be required. We will continue to undertake national surveys but hope this process allows for more rapid feedback and action. The data below is a summary for the year outlining the additional questions with the percentage relating to positive answers.

Percentage of patients that were "Extremely likely" or "Likely" to recommend the service

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Acute hospital ward	94	95	94	94	93	93	91	93	92	93	92	92
Community	85	98	99	98	97	92	97	96	96	99	98	98
Critical care	98	98	100	97	100	100	91	95	97	100	100	100
Day case	97	97	96	96	98	93	95	95	97	98	98	93
Outpatient	78	83	79	84	79	82	80	87	88	80	86	84
Trust	83	93	92	92	91	91	89	92	92	91	91	91

Percentage of patients that were "Extremely likely" or "Likely" to recommend the service



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

National inpatient survey

The Care Quality Commission has confirmed that the results of the 2015 inpatient survey are under embargo until 8th June, and that this embargo applies to the any document that will be shared outside of the trust before this date, including Quality Accounts.

End of life care

Why is this important?

Providing high quality end of life care services to all patients who are felt to be in the last year of life, continues to be a priority for St George's. This core service currently comprises specialist palliative care input available seven days a week including a rapid discharge service; general palliative care provision from all clinical specialities; a spiritual care team led by chaplaincy; and bereavement and mortuary services. The end of life care programme board was established to take a strategic view of improving this core service in line with the five priorities set out in One Chance to Get It Right (2014), and to recognise that end of life care is everyone's responsibility. The membership of this board has recently been reviewed and an action plan developed to clarify strategic priorities. In order to deliver on this strategic view, a new end of life care operational group was developed to drive through improvements and changes at an operational level.

In recognition of the wider need across the trust for improving end of life care services to all patients in the last year of their life, we're in the process of developing a St George's end of life care strategy. The development of this strategy will include engaging key stakeholders within the trust and ensuring representation at divisional and board level.

What will we do?

Current quality improvements are focused on improving the care of dying adult patients within St George's Hospital and this includes:

- the development of a nursing daily evaluation for patients in the last hours and days of life – education and awareness sessions have accompanied the plan's dissemination
- three cohorts of staff have attended QELCA (Quality End of Life Care for All) training and are sharing their learning with colleagues at St George's, we hope to send an additional three cohorts later this year
- funding has been obtained to run a 'Dying matters' week 9-13th May 2016, to raise awareness of end of life issues with hospital staff, this will coincide with the National 'Dying Matters' events. Mortuary services have had recent approval to fund a £410k project to increase mortuary capacity.

These key issues have been shared with our executive management team and positive contributions by the executive team have been noted, including the appointment of a non-executive with responsibility for end of life care.

The National Care of the Dying Audit 2015/2016 results have been released and St George's is above average on most areas nationally. However we must strive to continue to improve in this area.

Our aims

One of the areas within the audit where the trust needs to improve is in relation to patients' perception about the quality of communication between staff and patients particularly when patients were admitted to the trust.

It is hoped that the introduction of Sage and Thyme (training staff how to listen and respond to patients who are distressed or concerned) will improve general communication skills across the trust and positively impact the National Patient Experience survey.

Sage and Thyme foundation level communication courses are available at St George's. Unfortunately this year we lost 50% of our trained facilitators due to staff leaving the trust. This has meant a reduction in the number of courses being offered and a number of courses being cancelled at short notice. Last year we were able to offer three courses and trained 41 staff across a number of disciplines. We plan to run more courses this year and will hopefully obtain funding to train more facilitators who are outside the palliative care team.

Improving patient outcomes

Sexual health in secondary schools

Why is this important?

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

Schools are responsible for providing sex and relationships education. St George's provides school nursing services in Wandsworth.

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

How did we do?

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

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

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

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

Reporting period	Number of young people seen for sexual health advice	Number referred onto sexual health clinics
Q1	18	12
Q2	24	12
Q3	30	17
Q4	39	18

No secondary schools have agreed to the administration of emergency contraception at present.

Our aims

We have three main aims for young people in Wandsworth:

- To have quick and easy access to sexual health information in a confidential and appropriate way giving them the option to make informed choices about their sexual health.
- To be protected from harm.
- To have easy access to emergency contraception where a holistic assessment will be carried out by a school nurse. This then gives the opportunity to make sure the young person is safe and address any other health concerns.

Clinical outcome measures in community services

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

During 2015/16 we have continued to develop our data collection processes to enable us to effectively analyse our community services and see both where we are performing well and where we can make improvements. We have continued to participate in a national programme on community indicator development.

In addition, during 2015/16 we have worked with Wandsworth CCG to jointly develop an outcomes framework for Community Adult Health Services (CAHS). This focus was driven by the recent service redesign to ensure that it provided outcome results.

We set up processes to identify and share 40 patient care plans on a quarterly basis with the CCG as follows:

- 20 joint care plans CAHS/primary care.
- 10 ongoing case management care plans.
- 10 under review/surveillance care plans.

The provision of the 40 anonymised care plans per quarter was to enable CCG-led audits to ensure that appropriate plans are in place and are being followed to allow best outcomes for patients.

This was a developmental piece of work with Wandsworth CCG and we also participated in the evaluation process with the CCG. As a result of the Wandsworth CCG-led audit 'My Wandsworth Shared Care Plan' has been developed by them to support joint care provision for patients on an enhanced care pathway in 2016. The audit process also showed the number of patients with an identified key worker and the extent to which the patient had identified care/treatment goals.

Patient reported outcome measures (PROMS)

Why is this important?

Patient reported outcome measures (PROMs) assess the quality of care from the patient's perspective. Covering four procedures, they calculate health gains after surgical treatment using short, self-completed, pre and post-operative questionnaires.

Our outcomes

The trust considers that this data is as described for the following reasons. The table below shows the percentage of patients who reported an increase in their health following surgery, using three scoring methods, which are explained briefly below. The range is between 0 and 100 and higher scores are better. This makes no adjustment for the type of patients treated.

For all four procedures EQ-5DTM and EQ-VAS indices measure a general view of health, and for three there is also a measure specific to the condition treated.

- EQ-5DTM is a combination of five key criteria concerning general health.
- EQ VAS assessed the current state of the patient's general health marked on a visual analogue scale.
- Condition specific measures include a series of questions specific to the patient's condition.

		Apr11 – Mar12 (final)		Apr12 – Mar13 (final)		Apr13 – Mar14 (final)		Apr14 – Mar15 (provisional)	
		SGH	Eng.	SGH	Eng.	SGH	Eng.	SGH	Eng.
Hip replacement (primary)	EQ-5DTM	87.8	87.3	100	89.7	86.4	87.9	87.5	88.3
	EQ-VAS	57.9	63.6	72.2	65.5	65.2	64.2	75.0	65.3
	Specific	93.2	95.7	95.0	97.1	80.8	96.0	100	96.5
Knee replacement (primary)	EQ-5DTM	63.0	78.4	68.8	80.6	60.0	80.3	66.7	80.6
	EQ-VAS	30.0	53.8	53.3	54.9	50.0	54.6	55.6	55.4
	Specific	76.5	91.6	86.7	93.2	80.0	93.0	90.0	92.3
Groin hernia	EQ-5DTM	48.0	49.9	36.4	50.2	37.8	49.7	30.0	49.9
	EQ-VAS	40.2	38.9	32.7	37.7	25.0	37.3	34.1	38.0
Varicose vein	EQ-5DTM	58.2	53.2	48.6	52.7	48.3	51.8	32.4	51.9
	EQ-VAS	50.0	42.0	26.7	40.9	30.4	39.9	36.8	39.2
	Specific	81.5	83.1	79.4	83.3	71.4	82.9	74.3	82.3

Source: Health and Social Care Information Centre
Data notes: Total questionnaire count for survey and procedure type is less than 30.

The latest publication provides provisional data for April 2015 to September 2015. This does not allow us to make comparison to the national picture as the number of completed pre and post-operative questionnaires is too low and is therefore not reflected in the table above.

Adjusted health gain

Adjusted average health gains have been calculated using statistical models which account for the fact that each provider organisation treats patients with a different casemix. This allows for fair comparisons between providers and England as a whole.

Data reported in the table below shows that for the majority of measures there are insufficient records for this analysis to be reported for St George's patients. This is true for all measures for the partial year 2015/16 and the period is therefore excluded from the table.

Provisional data for 2015/16 shows that for varicose vein surgery we are an outlier for two of the three measures, meaning that our patient reported outcomes are worse than the national average. For groin hernia there is only one measure available, and this shows our patient reported outcomes to be worse than the national average. The number of records is too low for analysis of hip and knee replacement outcomes. It should be noted that at St George's we perform only a small number of complex cases of knee and hip replacements, with the majority of routine cases being referred to the South West London Elective Orthopaedic Centre for treatment.

		Apr11 – Mar12 (final)	Apr12 – Mar13 (final)	Apr13 – Mar14 (final)	Apr14 – Mar15 (provisional)
Hip replacement (primary)	**EQ-5D**	*	*	*	*
	EQ-VAS	*	*	*	*
	Specific	Not outlier	*	*	*
Hip replacement (revision)	**EQ-5D**	-	*	*	*
	EQ-VAS	-	*	*	*
	Specific	-	*	*	*
Knee Replacement (primary)	**EQ-5D**	*	*	*	*
	EQ-VAS	*	*	*	*
	Specific	*	*	*	*
Knee Replacement (revision)	**EQ-5D**	-	*	*	*
	EQ-VAS	-	*	*	*
	Specific	-	*	*	*
Groin hernia	**EQ-5D**	Not outlier	Not outlier	*	*
	EQ-VAS	Not outlier	Negative 95% outlier	Negative 95% outlier	Negative 95% outlier
Varicose vein	**EQ-5D**	Not outlier	Not outlier	Not outlier	Not outlier
	EQ-VAS	Not outlier	Negative 95% outlier	Negative 95% outlier	Negative 95% outlier
	Specific	Not outlier	Negative 99.8% outlier	Negative 95% outlier	Negative 95% outlier

Data notes: ***** *insufficient records*
- *split between primary and revision procedures was not made in 2011/12*
Source: Health and Social Care and Information Centre

Participation

St George's is responsible for providing patients with the opportunity to complete pre-operative questionnaires. Post-operative questionnaires are sent by contractors working for the Department of Health directly to patients that have completed the initial survey. Our aim is to provide the choice of completing the questionnaire to all appropriate patients, however it is voluntary and not all patients will choose to take part.

	Apr11 – Mar12 (final)		Apr12 – Mar13 (final)		Apr13-Mar14		Apr14-Mar15		Apr15 – Sep15 (provisional)	
	SGH	Eng.	SGH	Eng.	SGH	Eng.	SGH	Eng.	SGH	Eng.
All procedures	64.5%	74.6%	66.8%	75.5%	77.4%	76.2%	47.1%	75.4%	52.4%	73.1%
Hip replacement	88.2%	82.3%	87.0%	83.2%	137.1%	85.9%	79.4%	85.6%	73.9%	84.1%
Knee replacement	101.7%	89.3%	127.9%	90.4%	137.5%	93.7%	131.6%	94.8%	125.0%	93.4%
Groin hernia	**52.4%**	**60.6%**	**72.1%**	**61.7%**	**69.8%**	**59.9%**	**54.9%**	**58.3%**	**58.6%**	**56.4%**
Varicose vein	68.9%	48.9%	34.3%	44.3%	71.7%	40.5%	30.2%	39.3%	34.4%	31.6%

Source: Health and Social Care Information Centre

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

Our participation rate for the most recent period available (April 2015 to September 2015) is 52.4 per cent, which is below the national average of 73.1 per cent; however, for three of the four procedures our participation rate is above the national average.

The trust has taken the following actions to improve this indicator and so the quality of its services. Local monitoring and regular reporting is in place and whenever a decline in submissions is observed this is addressed with local teams to ensure patients are provided the opportunity to participate. This work will be overseen by the Patient Experience Committee during 2016/17.

Clinical records - driving quality improvement through the use of iCLIP data

Why is this important?

By March 2016, NHS England says that the Care Quality Commission (CQC) will measure digital maturity within healthcare settings as part of their inspection regime. In addition, by 2020, being 'paperless' will be a pre-requisite for holding an operating licence to provide publically funded healthcare.

These significant measures will mean that successfully deploying electronic clinical documentation is an even bigger priority for health care professionals and health care providers. By implementing an electronic clinical documentation system the trust will enable transformational programmes that focus on modernisation, increased patient safety and greater productivity.

National initiatives:

- Five Year Forward View – systems that 'talk to each other' to enable different parts of the health service to work together and harness the shared benefits that come from interoperable systems.
- Patients being able to access their online records and write in them.
- NHS Paperless by 2018.
- Lord Carter report.

Local drivers:

- Risk management, patient and staff safety.
- Real time reporting.
- Transparency and accountability.
- Aligned with CQUINs (Commissioning for Quality and Innovation) and KPIs (key performance indicators).

How did we do it?

We have deployed electronic clinical documentation and electronic prescribing and medicines management (ePMA) to 44% of the hospital. This has been supported by clinician engagement in designing and implementing the system. A comprehensive training programme was devised to support the rollout.

Interactive whiteboards

Integrated whiteboards support length of stay management and provide the ability to view the current status of all beds and additional information to support the bed managers in controlling the flow of supply and demand. They also provide a plethora of both demographic and clinical data to inform the clinician and enhance the decision making process, a medications timeline showing past, present and future medications and an events timeline giving access to clinical results: they span across all inpatient locations in the hospital.

Benefits

Enhanced patient safety is the overarching benefit which includes:

- improved access to real-time patient information
- ensuring nursing tasks are completed in a timely manner
- improved patient flow and increased capacity
- reduced length of stay
- improved access to real time clinical information eg early warning scores.

Integrated vital signs monitors

The monitoring devices integrate with the trust-wide acute Electronic Patient Record (EPR) - Cerner Millennium. Vital signs are matched into the patient's clinical record and auto-calculations based on established algorithms (national early warning score - NEWS) are available to provide decision support. Reference text in the electronic record directs the nurse to the NEWS document that codifies the NEWS result and described situation, background, assessment and recommendation (SBAR) communication tool actions.

Benefits

Enhanced patient safety is the overarching benefit which includes:

- keeping the nurse at the bedside whilst 'releasing time to care'
- displays early warning score at the bedside with visual prompt for required escalation
- eliminates the need to transcribe results – saving time and transcription errors
- results are immediately available to clinicians across the trust via the patient's record and on the interactive whiteboard
- eliminates need to access limited number of computers, or move workstations on wheels (WOWs) around with the monitor
- improves the recording of complete sets of observations and correctly scoring the NEWS.

Clinical Exchange Platform (CEP)

Work is progressing to expand the sharing of data between acute, community and primary care through our CEP. So far there is a link established with Wandsworth GPs which gives clinicians in St George's a real time view of data from the GPs. The GPs can also access St George's information from within their EMIS system. Data shared includes certain laboratory results, medications, allergies and discharge summaries.

Benefits

Our local GPs tell us access to patients' hospital records enables them to provide better care for their patients. Including:

- access to hospital records from anywhere (so long as the GPs have the means to access their own clinical system)
- peace of mind that the built-in security and audit trail features allow access to registered patient records only and facilitate monitoring of unauthorised use
- real-time access to a range of information about their patients including appointments, discharge summaries, medications, allergies, diagnostics and problems.

Endorsing results

Endorsement (signing off) of diagnostic test results has always been possible in iCLIP however in 2013/14 the trust had 15 serious incidents where diagnostic tests were not reviewed or followed up in a timely or appropriate manner. Although changes to the way the iCLIP system operates have been introduced to limit endorsement to high risk tests there are still issues with results endorsement. Problems with business processes and incorrect consultant attribution have contributed to this and are being investigated by the data quality board and the associate medical director for transformation.

Benefits

- All radiology and cellular pathology results in a clinician's inbox to be endorsed ensuring the appropriate clinical interventions are actioned in a timely manner.

Offender health

E-drug administration and e-prescribing have been implemented at Wandsworth Prison to enable transmission of drug information between prisons replacing a complex paper process.

Electronic Documentation Management (EDM)

Electronic Document Management (EDM) allows paper health records to be stored electronically so that they are available to be viewed at any location where care is being delivered. This will improve patient experience and quality of care by ensuring relevant information is always available whilst significantly reducing the trust's reliance on paper medical records.

New referrals to the trust are now stored immediately in the EDM system instead of a paper folder for urology, chest medicine and rheumatology. Completion of the deployment will enable us to move closer towards our goal of being a paper-light organisation.

Our aim

In 2016/17 we aim to complete the inpatient deployment of electronic clinical documentation and ePMA to inpatient bed areas.

The clinical systems programme board will continue to drive the deployment by monitoring:

- the deployment plan
- pre and post-deployment support including the use of champion users and training
- risk associated with the transition from paper to electronic processes
- issue logs to identify any themes or trends that might impact patient care and safety
- future developments ie care pathways
- data captured and data quality.

Reducing hospital readmissions

Why is this important?

An emergency readmission is recorded when a patient has an unplanned re-admission to hospital within 30 days of a previous discharge. Reducing the number of emergency and elective readmissions would ease the pressure on our emergency department, which is one of the busiest in the country. This would in turn create extra capacity in the hospital for elective patients and mean that less elective procedures are cancelled because of surges in emergency activity

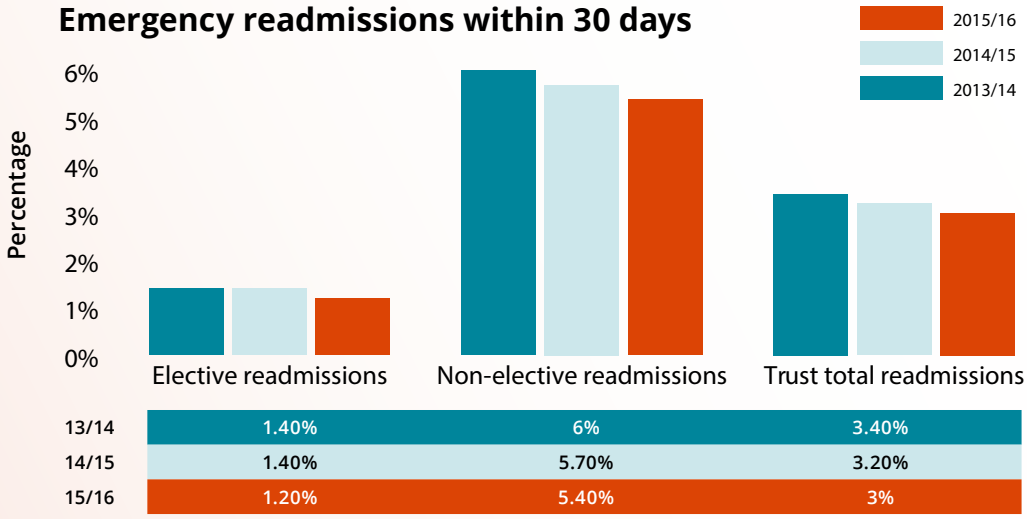
Hospitalisation is costly and re-admissions contribute to that cost however to aim for a readmissions rate of zero is unrealistic and may even indicate poor quality care, as many readmissions are medically appropriate due to an unavoidable change in condition, a medical error, adverse event that occurred during the initial hospitalisation, lack of understanding of discharge instructions, or communication following discharge. These types of avoidable readmissions are those that the trust aims to prevent or reduce.

The quality account refers to emergency readmissions within 30 days rather than Health and Social Care Information Centre compendium indicators' 28 days. This is because trusts report on their emergency readmissions within 30 days at frequent intervals as part of their quality reporting and as per NHS Improvement accountability frameworks.

How did we do?

Reducing emergency readmission remains one of the trusts key priorities and a continued area of focus between St George's, our partners in primary care and local councils. It is a substantial and hugely challenging task given the financial and regulatory constraints, but the potential benefits are enormous to patients.

In 2015/16, 3% of patients were readmitted to hospital within 30 days. In real terms this means that 4459 patients were re-admitted to hospital within 30 days of being discharged from their previous emergency or elective admission. This is an improved position on the previous year when 3.2% of patients were readmitted within 30 days of discharge. **Data to Feb 16*



Elective and emergency readmissions

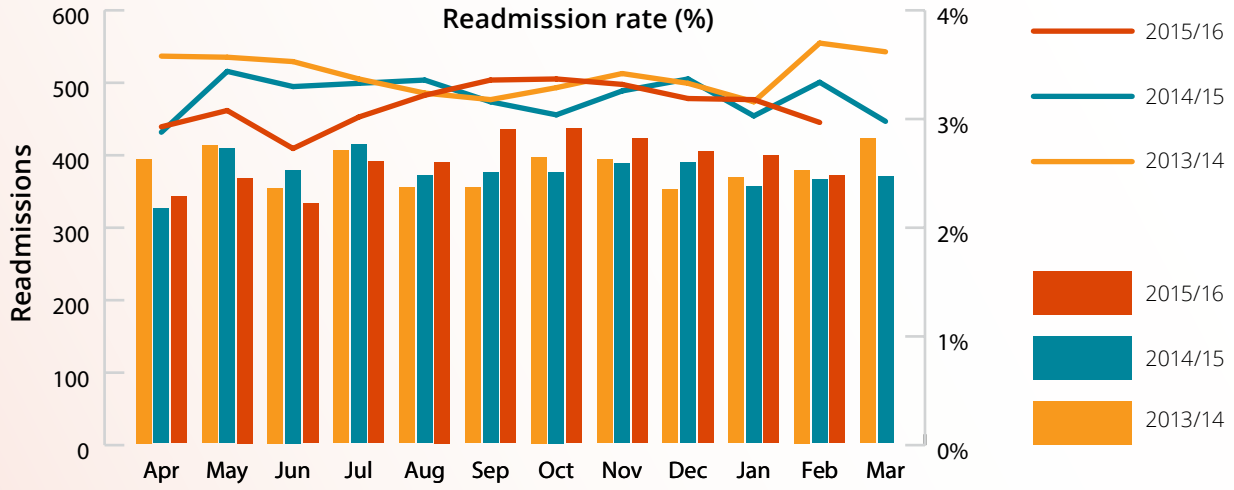
In 2015/16, the trust had 86714 elective admissions compared to 80665 in 2014/15. Despite the increase in admissions the trust saw a reduction in the readmission rate from 1.4% in 2014/15 to 1.2% in 2015/16. For patients admitted for elective care, an important part of this process has been the pre-operative assessment, which has helped to reduce the risk of complications during and following admission.

The number of emergency patients coming to St George's increased in 2014 from 59901 in 2014/15 to 62740 in 2015/16 with the emergency readmission rate reducing from 5.7% in 2014/15 to 5.4% in 2015/16.

St George's considers that this data is as described for the following reasons. St George's Hospital is a regional major trauma centre, hyper-acute stroke unit and heart attack centre and treat seriously ill patients and complex cases from across south west London and Surrey, with some emergency patients coming from as far afield as East Anglia. This means that the risk of patients needing to be readmitted after leaving hospital is higher for St George's than or other acute trusts in that area.

A reduction in readmission rates overall reflects the hard work St George's has been doing around trying to ensure that our patients are not discharged before they should. It also highlights our collaborative work with GPs and community services to provide a highly responsive approach to the management of patients with chronic long term conditions in their own homes.

Emergency readmissions within 30 days following an elective admission



Our aim

The trust intends to take the following actions to improve this indicator and so the quality of its services.

In 2016/17 the trust is committed to continuing the reduction in readmissions for all patients, whether they have received emergency or elective (planned) treatment, by making sure that all discharges are properly planned and that patients are not discharged until it is safe to do so. A vital part of this is working collaboratively with community and social services to ensure that services are in place to support patients in their own home when they are ready to leave hospital. For patients admitted for elective care, an important part of this process is the pre-operative assessment, which reduces the risk of complications during and following their stay in hospital.

Performance table

	Indicator	Target	2014/15	2015/16	2016/17
ACCESS	Referral to Treatment Incomplete	92%	91.33%	90.25%	Specialty level compliance.92% achieved by all specialities
	A&E All Types Monthly Performance	95%	92.14%	90.44%	Improve performance in line with trajectory to achieve 95% target
	62 Day Standard	85%	84.70%	82.50%	Improve performance in line with trajectory to achieve target
	62 Day Screening Standard	90%	91.50%	90.40%	
	31 Day Subsequent Drug Standard	98%	100%	100%	Maintain and continue to improve target
	31 Day Subsequent Surgery Standard	94%	98.50%	96.50%	Maintain and continue to improve target
	31 Day Standard	96%	97.80%	97.00%	Maintain and continue to improve target
	Two Week Wait Standard	93%	95.93%	87.80%	Improve performance in line with trajectory to achieve target
	Breast Symptom Two Week Wait Standard	93%	96.66%	93.40%	
OUTCOMES	Clostridium(C.) Difficile - meeting the C.difficile objective (de minimis of 12 applies)	31	38	28	No more than 31 cases of Cdiff during 2016/17
	Incidents of MRSA	0	6	3	Zero MRSA incidents
	Mixed Sex Accomodation	0	16	11	Compliance to achieve the target of zero
	Never Event	0	5	8	No never events in 2016/17
	Mortality	Lower than expected	Lower than expected		Maintain lower than expected mortality rates
	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?	Compliant	Yes	Yes	Maintain and continue to improve performance
	Does the Trust provide available and comprehensive information to patients with learning disabilities about the following criteria: - treatment options; complaints procedures; and appointments?	Compliant	Yes	Yes	
	Does the Trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities?	Compliant	Yes	Yes	
	Does the Trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff?	Compliant	Yes	Yes	
	Does the Trust have protocols in place to encourage representation of people with learning disabilities and their family carers?	Compliant	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?	Compliant	Yes	Yes	
	Referral to treatment- Q4 2015/16	50%	55	56.3	Maintain and continue to improve performance
	Referral Information- Q4 2015/16	50%	88	88.2	
	Treatment Activity- Q4 2015/16	50%	70	70.83	
	Trust Overall Quality Governance Score- Concern Trigger and Under Review			**4**	**Improve our Quality Governance score**

Note: RTT and A&E performance reported is avg YTD for April to March 2015/16 - Cancer performance reported is YTD for April to March 2015/16

Monitor governance thresholds:	
	GREEN: as service perfromance score of >=4.0 or 3 consecutive quarters' breaches of single metric
	Governance concern Trigger and Under Review: a service performance of >=4.0 or 3 consecutive quarters' breaches of single metric monitr undertaking a formal review, with no regulatory action.
	RED: a service performance of >=4.0 or 3 consecutive quarters' breaches of single metric and with regulatory action to be taken.

Note: RTT and A&E performance reported is avg YTD for April to March 2015/16 - Cancer performance reported is YTD for April to March 2015/16

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

Healthwatch Wandsworth and Healthwatch Lambeth

Introduction

The following comments are submitted on behalf of Healthwatch Lambeth and Healthwatch Wandsworth.

Presentation of report

Two suggestions here. First, to make the report easier to read, could we suggest that a standard format be adopted for each quality indicator, on the lines of:

- why it is important
- the 2015/16 aim/indicator and target
- what we did
- did we meet the target?
- what next?

Some parts of the report are currently formatted in this way, but not others. Second, would it be possible to structure the report so that there is a logical flow to the various sections? The quality indicators (the ten voluntary ones) currently appear in different places, in between statutory reporting, and not always in the same order, so that it was difficult to keep track of them all.

General comments on content

In general, the report confirms our perception that the trust was able to maintain its quality of care over the year 2015/16 despite the considerable pressures it has faced. However, this was possible only because of the continued efforts of staff working beyond what was expected of them. Staffing levels have been relatively protected in the trust, and it is unlikely that they will improve in future. Therefore, the only way in which standards can continue to be maintained, or even improved, is through changes in the ways in which people do their work. This represents a considerable challenge for the coming year and any failure to manage this process well will have serious consequences for patients.

Our impression too is that the trust is also now experiencing the consequences of historic and chronic under-investment in the maintenance and renewal of buildings, equipment and IT infrastructure. This has had a more visible impact on the working experience of the staff to date than on the patient experience, but also affects patients in areas such as the outpatients booking system, and it cannot continue without accumulating negative consequences.

The indications that the trust is keen to involve patients in the re-design of services and facilities are to be welcomed.

Specific comments

Improving patient safety

In order to achieve greater patient safety it is vital that the trust achieves an open and transparent culture of learning and improvement in which staff are encouraged to discuss errors and 'near misses' in a 'no-blame' culture. This does not sit

well with the wording of 'zero tolerance', though we understand and share the underlying ambition this represents. Messages to staff must be clear in promoting a culture in which unsafe practices carried out through ignorance or thoughtlessness can be challenged without blame or unduly negative consequences for staff.

Improving patient experience

The renewed emphasis on listening to patients is welcomed, but it must be recognised that staff need to be given sufficient time in which to listen and to respond appropriately. It must be explicitly acknowledged that this policy will additional require investment in patient-facing staff and this investment needs to be quantified and committed.

We felt also that the wording of this section read somewhat passively: a suggested redraft is annexed.

Tackling poor behaviour and bullying; discrimination

We were disappointed to see no improvement in the numbers of staff reporting that they were experiencing harassment, bullying or abuse since last year. We also noted the disturbing number of staff reporting discrimination, together with a perceived inequality reported by staff from BME backgrounds. That said, the development of a number of strategies and initiatives to tackle this suggests that the trust is taking this issue seriously and we look forward to hearing about your progress.

Reducing patient falls

Despite implementing several interventions to reduce the number of inpatient falls, no improvements have been achieved in 2015/16. Although the trust has an action plan in place to address this, it would be useful to provide a short summary of the learning from the past year to better understand the reasons behind this. Given the importance of this issue and the failure to meet the expected aim, we would suggest that achievements against this indicator are reported again next year.

HMP Wandsworth

We would have liked to see a broader coverage of healthcare services in Wandsworth prison in the report. Healthwatch Wandsworth is planning to engage directly with both prison staff and prisoners in the coming year.

Community learning disability referrals

We commend the trust for its work to provide assessments for people with learning disabilities in the community.

Complaints

This section records details of the timescale in which complaints are responded to. Whilst this needs to be kept to as short a period as reasonable, a much more important measure would be what proportion of complaints were considered as resolved to the satisfaction of the complainant and evidence of learning from complaints such as changes in procedures etc.

Friends and Family Test

This test provides an opportunity to capture more general feedback from patients. We understand that at least in some parts of the trust, patients are given the opportunity to make comments when doing this test. Evidence of the nature of these comments and actions taken beyond the image of the 'word cloud' would be useful (or at least an example of a word cloud from a more challenged area would be informative).

It would also be interesting to know why the trust believes outpatient satisfaction as measured through the test is far lower than in the other services, and what plans are in place to address this.

End of life care

We appreciate that the work on 'end of life' care is in its early stages and will need more time for outcomes to be fully realised. More broadly, a true test of whether these plans and activities have resulted in improvements for the experience of patients can only genuinely be made through sharing feedback from your targeted patients. We would very much welcome more efforts to amplify patient voice here, possibly through the development of patient experience indicators specific to these areas, to be reported in future reports.

In 2014/15 Healthwatch Lambeth noted that we would like to see more emphasis on the views of family and carers and this remains the case.

Clinical outcome measures in community services

We would have welcomed a more substantive report on this. It is not clear what progress was made during the year.

Conclusion

We appreciate the opportunity to comment on this draft, and wish to reiterate our gratitude to the staff of the trust for their dedicated service to the people of Lambeth and Wandsworth.

Dr Clive Norris CB,
Chair, Healthwatch Wandsworth
17/05/16

Healthwatch Merton

Healthwatch Merton is pleased to see that St George's University Hospitals NHS Foundation Trust has performed well across most of its performance indicators and reflects the quality of delivery. We are also happy that the trust has continued tackling the issue of hospital readmissions over the past year and has once again seen a reduction in readmission rates reflecting the hard work done in this area.

It's great to see that St George's has one of the lowest rates of patients acquiring C. difficile whilst under its care in London and has seen a 24% decrease in the last year.

It's also very good to see there has been a significant increase in the number of referrals of people with osteoporosis to early intervention service within the community falls prevention team that is helping reduce fragility fractures.

Notes of caution are the same as we raised in the previous quality account. It is very concerning that a year on one third of staff (identical to a year ago) have once again reported experiencing bullying, harassment and abuse from other staff. Last year we acknowledged the trust had a strategy to tackle this and it would appear this strategy is not quite delivering what it needs to and would ask that St George's fully reviews it and develops a new strategy that has different approaches to hopefully see the number of staff experiencing this reduced in the coming year which would surely benefit all.

On the subject of staff, it is disheartening to read that only 50% would recommend the trust as a place to work and given one of the trust's strategic aims is to be an exemplary employer, we would hope to see an increase in this percentage in the next quality account.

Dave Curtis
Manager, Healthwatch Merton
20/05/2016

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

The council of governors is pleased to have the opportunity to comment on the Quality Report.

Firstly, we would like to recognise that it has been a difficult year for St George's and that this report is set against a background of financial instability, which the governors are still seeking clarity and an understanding of, and many changes at board level. In all, this has made it more difficult than it should have been to exercise our statutory duty of holding the non-executive directors to account in terms of quality as well as other aspects of board management. We hope that the coming year will bring some stability, enabling governors to contribute in a more meaningful way.

Governors have welcomed taking part in the internal quality inspections throughout the year and are encouraged that across the trust patients have responded very positively to questions about their care and those who provide it. We have also welcomed the opportunity to observe committee meetings and provide written feedback where appropriate. Members for Medicine talks, the Annual Members Meeting and the recently introduced "Meet the Governors" sessions have all given us the opportunity to hear about quality from a diverse section of the public in a variety of ways. We are pleased that we have been invited to share our views as part of the forthcoming CQC inspection.

We recognise that there is much to do but see the steps that are being taken as positive and shall be considering what we can do as a council to support the new phase that the trust is entering.

Kathryn Harrison
Lead governor
25/05/16

Wandsworth Adult Care and Health Overview Scrutiny Committee

Our statement in the trust's 2014/15 quality account acknowledged the high clinical standard of the trust's services, reflected in the low mortality rates amongst those undergoing treatment at St George's Hospital. It also noted that patient experience of the trust's services, which had consistently been much less satisfactory, was showing signs of improvement, although there were concerns about the trust's performance on measures of access to treatment.

Over the past year, the committee's main concern in relation to St George's has been over the dramatic deterioration in the trust's financial position, and whether this might affect the quality of the services offered. We have yet to be presented with a convincing explanation of the approach the trust will take in prioritising its activities in order to achieve the full savings required without adverse effect on services. We are pleased to note that that the evidence presented in this quality account demonstrates a continuing focus on clinical excellence. However, whilst the mortality rate remains relatively low there appears to have been some deterioration and it is important that reasons for this are explored and addressed.

It is a serious concern that the most recent NHS staff survey shows a sharp deterioration in the morale of staff at St George's. The most recent survey of users of maternity services, published in December 2015, also shows deterioration, reversing some of the gains made in previous years. Whilst we recognise that there are also positive developments on patient experience, with performance on the Friends and Family Test having been maintained and an improvement in the handling of complaints, it is essential that this aspect of the trust's work is a focus of attention in the trust's action to deal with its deficit.

It is also clear that the challenges around access to services remain current, with the continuing failure to meet targets for waiting times from referral to treatment and within accident and emergency, and for adherence to the 62-day standard for cancer. We note that the trust has agreed detailed plans and trajectories for improvement against these targets over the coming year, and we will be monitoring progress against these commitments.

We endorse the commendation of the work of the falls service, which is jointly commissioned by the council with Wandsworth CCG, and forms an important element of our Better Care Fund plan and we note that the council and CCG will be working with St George's over the coming year to review how best to reduce the incidence of falls and fractures in the community.

Finally, we recognise that this is a challenging time for the trust, with a change in leadership and an imminent Care Quality Commission inspection. We are aware that the trust is experiencing difficulties with recruitment and retention of staff, especially in its community services division, and are concerned that the trust should re-establish the strong and stable leadership that is necessary to resolve this. It is important that the pressures the trust faces do not lead to a loss of focus on quality and, especially, the continuing need to improve patient experience of services.

Richard Wiles
Health policy team leader, Wandsworth OSC
16/05/2016

Statement from Wandsworth CCG, Public Health and Surrey Downs

We have consulted with other commissioners in preparing this statement, including from Public Health and Surrey Downs CCG.

The CCG welcomes the trust's commitment to improving quality and specifically to the high level priorities for improvement set out for 2016/17.

We note the continued relatively low mortality rates and the relatively strong performance on harm-free care as measured by the NHS safety thermometer.

The report doesn't address some of the quality challenges the trust has faced in 2015/16, such as the removal of medical training posts from Interventional Radiology and Vascular Surgery (and the subsequent Quality Risk Summit) or the ongoing workforce challenges in community services.

There is no acknowledgement of the quality impact of poor performance against core NHS Constitution standards, in terms of timely patient access to services (ED, cancer, RTT, diagnostics).

The trust has faced and continues to face significant financial challenges, and we will continue to work with the trust to mitigate any impact of addressing these on the quality of services for our patients, including through reviewing the impact of cost improvement programmes.

The priorities for improvement 2016/17 appear aspirational rather than SMART objectives for delivery – we would welcome more detail being presented to the Clinical Quality Review Group.

Sean Morgan
Director of corporate affairs, performance and quality, Wandsworth CCG
25/05/2016

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.

Monitor 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 2015/16 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 regulation 18 of the Local Authority Social 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 Monitor's annual reporting guidelines (which incorporates 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.

Simon Mackenzie
Acting chief executive
2nd June

Sir David Henshaw
Chairman
2nd June

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 2015/16, 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)		✓	✓	Ongoing
Adult Cardiac Surgery		✓	✓	Ongoing
Bowel Cancer (NBOCAP)		✓	✓	Ongoing
Cardiac Rhythm Management (CRM)		✓	✓	Ongoing
Case Mix Programme (CMP)		✓	✓	Ongoing
Congenital Heart Disease (CHD) – Adult		✓	✓	Ongoing
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)		✓	✓	Ongoing
Diabetes (Paediatric) (NPDA)		✓	✓	100%
Elective Surgery (National PROMs Programme)		✓	✓	Ongoing
Emergency Use of Oxygen		✓	✓	100%
Falls and Fragility Fractures Audit programme	Fracture Liaison Service Database	✓	✓	100%
	Inpatient Falls	✓	✓	100%
	National Hip Fracture Database	✓	✓	100%
Inflammatory Bowel Disease (IBD) programme		✓	✓	>75%
Major Trauma Audit		✓	✓	Ongoing
Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal Mortality Surveillance	✓	✓	100%
	Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths)	✓	✓	100%
	Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity) early pregnancy deaths and pre-eclampsia, plus psychiatric morbidity)	✓	✓	100%
	Maternal mortality surveillance	✓	✓	100%
Medical and Surgical Clinical Outcome Review Programme	Acute Pancreatitis	✓	✓	100%
	Physical and mental health care of mental health patients in acute hospitals	✓	✓	Ongoing
	Sepsis	✓	✓	100%
	Gastrointestinal Haemorrhage	✓	✓	100%
National Audit of Intermediate Care		✓	x	Difficulty in participation as the Intermediate Service was changing. We will not be participating in 2016 as not relevant to the current structure.

National Cardiac Arrest Audit (NCAA)		✓	✓	Ongoing
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme - Pulmonary rehabilitation		✓	✓	77%
National Comparative Audit of Blood Transfusion programme	Use of blood in Haematology	✓	✓	100%
	Audit of Patient Blood Management in Scheduled Surgery	✓	✓	100%
National Diabetes Audit - Adults	National Footcare Audit	✓	X	0%
	National Pregnancy in Diabetes Audit	✓	✓	100% of consented women were audited. The consultant lead is seeking to improve the rate of consent.
	National Core	✓	✓	**n = 117** Data was submitted for all patients with an insulin pump, but not for the complete cohort of diabetic patients. A working group has been established to develop an IT solution to allow full participation. Progress with implementation is monitored by the Quality and Risk Committee.
National Emergency Laparotomy Audit (NELA)		✓	✓	**<50%** During the year improved processes have been established to identify relevant patients for the audit
National Heart Failure Audit		✓	✓	Ongoing
National Joint Registry (NJR)	Knee replacement	✓	✓	Ongoing
	Hip replacement	✓	✓	Ongoing
National Lung Cancer Audit (NLCA)		✓	✓	Ongoing
National Prostate Cancer Audit		✓	✓	Ongoing
National Vascular Registry		✓	✓	Ongoing
Neonatal Intensive and Special Care (NNAP)		✓	✓	Ongoing
Oesophago-gastric Cancer (NAOGC)		✓	✓	Ongoing
Paediatric Asthma		✓	✓	100%
Paediatric Intensive Care (PICANet)		✓	✓	Ongoing
Procedural Sedation in Adults (care in emergency departments)		✓	✓	**30%** This audit round the RCEM sample size increased from the usual 50 cases to 100 cases. 30% of data were submitted due to demands on the service.
Renal Replacement Therapy (Renal Registry)		✓	✓	Ongoing
Rheumatoid and Early Inflammatory Arthritis	Clinician/Patient Follow-up	✓	✓	n = 13
	Clinician/Patient Baseline	✓	✓	n = 22
Sentinel Stroke National Audit programme (SSNAP)		✓	✓	Ongoing
UK Parkinson's Audit	Occupational Therapy	✓	X	We did not participate in these elements of the audit due to reconfiguration of the therapies service and a lack of resources
	Speech and Language Therapy	✓	X	
	Physiotherapy	✓	X	
	Patient Management, elderly care and neurology	✓	✓	100% neurology cases
Vital signs in children (care in emergency departments)		✓	✓	**51%** This audit round the RCEM sample size increased from the usual 50 cases to 100 cases.
VTE risk in lower limb immobilisation (care in emergency departments)		✓	✓	**51%** This audit round the RCEM sample size increased from the usual 50 cases to 100 cases

Appendix B:

National clinical audit actions undertaken enquiries

The reports of 16 national clinical audits were reviewed by the provider in 2015/16 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 Audit of Intermediate Care 2014	The intermediate care service is currently being reconfigured as part of the community adult health service redesign. This may affect the classification of some service lines so they may not meet the inclusion criteria as an Intermediate care services in future years.
National Prostate Cancer Audit Report 2014	Results presented by Cancer Network, with St George's included in the South West London network. Data completeness - our network has shown significant improvement, scoring 77% for 2012 compared to 44% in 2006-2008. The national score is 71% in 2012 and 53% in 2006-2008. The trust carried out a self-assessment of current performance against national recommendations and met all those relevant to services provided. High-dose brachytherapy is not available in this trust, however if this is needed, patients are either referred to Royal Marsden or University College Hospital.
National Paediatric Diabetes Audit 2013/14	**1)** Resources: Increased diabetes nurse specialists to 2.5WTE; increased dietician time to 1WTE and also secured 0.6WTE psychology support. Service manager in post to support improved processes of care over appointments and education activities, issuing clinic reminders and HbA1c quality control. Introduced a consultant led formal transition service for 15-19 year olds. **2)** Education: Sessions at home and school, including special sessions for ethnic minorities. **3)** Technology: Changes including pump use, with meter and pump downloads in clinic. Capillary HbA1c testing in clinic with quality control.

National Congenital Heart Disease Audit Report 2011/14	Data submitted to the audit is subjected to rigorous validation comprising site visits by a clinical auditor and clinician. A data quality indicator is calculated, with NICOR's expectation that units will achieve 90 per cent. St George's consistently achieves this standard, with our most recent score being 90.75. Analysis of all hospitals shows an upward trend in survival in the most recent 18 months. St 30 day survival is 100 per cent.
Sentinel Stroke National Audit Programme (SSNAP)	■ Changes have been made to the way bed managers are alerted to ED admissions. ■ Work is in progress developing the stroke nurse role in ED. ■ More information is being added to iClip to minimise the need for paper notes. ■ A 7.15am morning MRI slot had been launched to reduce admissions for MRI. ■ Discussions with local hospitals around improving repatriations are on-going.
British Thoracic Society (BTS) Pleural Procedures Audit 2014	Three national improvement objectives were outlined in the report. ■ Written consent should be taken for greater than 95% chest drains inserted (excluding those placed in an acute emergency) ■ Greater than 95% of chest drains should be placed in a dedicated clean area (procedure room), away from the patient bedside. ■ Patients with chest drains should be nursed on wards with staff specifically trained in chest drain care, in more than 95% of cases. We have a new pleural consultant, a role which will help facilitate any changes needed in order to meet these objectives and to fully contribute to future audits. It is also hoped that this new post will enable management of some of these patients in an out-patient setting.

College of Emergency Medicine - Mental Health in the Emergency Department	■ ED revising mental health risk assessment ■ Reinforcing good clinical documentation is an on-going piece of work in ED, and shall now include emphasis on reporting mental health. Meeting with trainees to discuss documentation. ■ Meeting held between ED and psych liaison team. Liaison team have data showing mean time from referral to being seen was 25 minutes. To improve accuracy of data liaison team have been asked to inform ED co-ordinator when they attend to see a patient ■ Facilities requests have been submitted to make the necessary changes to the assessment room. Requests supported by GM.
College of Emergency Medicine - Assessing for Cognitive Impairment in Older People	■ ED clinical notes to be amended as they currently state that all patients >65 require assessment ■ Information to the GP will require an iCLIP modification so that this information is transferred ■ Further investigation of how information can be given to carers is required and how best practice units are achieving this ■ Nursing input is required to ensure EWS scores are calculated and reported for all patients
National Hip Fracture Database (NHFD) Report 2015	■ Senior health are working with the therapy team to increase one day mobilisation, through dementia and pain assessment training. ■ A new theatre template has been introduced to increase efficiency. As it is the main reason for failure to meet the best practice tariff it is a priority area for improvement. ■ There are now two orthogeriatricians in post and we are achieving 90- 100% medical assessment rates. ■ Quarterly clinical governance presentations, using timely NHFD data to monitor performance and discuss areas of shortfall.

National Audit of Inpatient Falls 2015	■ Falls that result in moderate or severe harm are investigated at a divisional level ■ Replacing stratify tool with a multi-factorial risk assessment tool to be used for all patients at risk of falling. ■ Introduction of new tool to be supported by concurrent training and audited once embedded. ■ Conducting a bed rail audit.
MBRRACE-UK - Perinatal Mortality Surveillance Report Recommendations	Self-assessment conducted against national recommendations, found compliance with all but one relevant item relating to the offer of post-mortems. An audit will be conducted to explore reasons why post-mortem may not be offered and to design actions accordingly.
PICANet (Paediatric Intensive Care Audit Network) – November 2015 Annual report	Recommendations were made for commissioners and providers. Locally, actions are in place to improve our position in relation to staffing. The unit continue to recruit band 5 and 6 staff. External recruitment of Band 6 staff has proven challenging, therefore the unit are trying to grow their own staff by training and developing them.
National COPD Audit Programme: Resources and organisation of Pulmonary Rehabilitation services in England and Wales 2015	Overall we provide a robust service compliant with all the quality standards set out by the BTS. However, the overall number of referrals both nationally and locally is low compared to the number of patients who are likely to benefit from PR and the figure for the uptake of assessments by patients referred is just 69% (this is both the national figure and that for SGH) although the reason for this is not clear. Given the proven benefits of a PR service the report recommends that the pathway is reviewed and enhanced. The local results suggest that we also look at ways to encourage patients to complete their PR. To commissioners it is recommended that steps are taken to ensure providers have a clear, long-term funding framework that will allow programmes to recruit and retain staff with an appropriate skill and seniority mix, this is already in place for SGH and we are currently recruiting permanent staff members.

National Vascular Registry 2015 Annual Report	For indicators where it is possible to compare performance at St George's with overall results we are performing better than the national average. At St George's we are largely compliant and no specific areas have been highlighted for action by the vascular care group.
National Pregnancy in Diabetes Audit 2014	■ Contacted the national project team and HQIP (Healthcare Quality Improvement Partnership) to request local unit reports (with or without benchmarking) to inform local action planning. ■ Improved processes for consenting women to increase the number of cases submitted by St George's. The numbers of women consenting to participate has substantially improved on the first year.
National Head and Neck Cancer Audit 2014	Eight measures were identified and the trust scores were above the national and London Cancer Alliance (LCA) scores for seven. One measure which relates to patient seen by CNS prior to first treatment by MDT scored 50.8% which is lower than the national score (62.9%) and London Cancer Alliance score (61.3%). Discussion is currently on going as to the reasons for this and how to improve. ■ MDT to encourage all clinicians to refer patients to the CNS team as early in the pathway post diagnosis as possible. ■ CNS access to and contemporaneous entry onto Infoflex must be a priority. ■ If patients get diagnosis and treatment plan the same day and go to RMH (Royal Marsden) for first definitive treatment the SGH CNS's do not get to see the patients in clinic as they see the RMH doctors. In this instance the presence of the RMH CNS in the H&N clinic at St George's to register the patients as seen here prior to transfer for RT/CRT.

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

Appendix C:

Local clinical audit actions undertaken

The reports of fourteen local clinical audits were reviewed by the provider in 2015/16 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*
Pressure Ulcer Prevention (PUP) Audit	In total, 334 patients were audited across the trust. Assessment documentation was checked for 329 patients and 73.6% of these had an up to date assessment form, this represents a small decrease from the previous audit. All patients audited were on a pressure relieving mattress, 87% had a repositioning chart, and this was fully completed in an average of 71% of cases, which is an increase from previous audits. Communication sheets (giving ongoing information) were in progress for 35.25% of patients but only 19 (6%) had been given a patient information leaflet. Overall the audit showed that there are pockets of excellent care but also areas where improvements are required. Results were considered alongside details of PU incidents and PU training. Planned actions to facilitate improvements include targeted reviews of the wards where there appears to be most room for improvement and a recheck of some wards where there may be some lesser issues.
Venous Access Device Re-Audit 2014/15	VAD device training is currently being reviewed and practice educators plan to be attend team study days to provide this training. A section about VAD management training is to be included in the Infection control MAST training by end of May 2015.
IV Administration Audit 2014	Recommendations include using existing educational and management forums to increase knowledge of the policy and design of an e-learning tool to promote on going learning and updates of knowledge.

Protected mealtimes, nutrition and hydration audit, March – May 2015	Local action plans developed in accordance with ward results. Wards are required to enforce protected mealtimes and challenge colleagues accordingly. Ward sisters and matrons to review practice to ensure that there is a robust approach to nutritional screening and support, including the use of red trays.
Trust-wide Consent Re-Audit 2014/15	■ Legibility needs to be addressed and adoption of name stamps is recommended. ■ Divisions have received divisional analysis to facilitate local discussion and action planning. ■ The legal services manager will include a summary of the key areas for action as part of a presentation on consent to the STNC division. ■ Associate medical director for governance to recruit a new lead to help drive recommendations and implement action plans.
WHO Surgical Checklist Audit 4th Quarter 2014/15	■ Report circulated to clinical governance leads and findings presented at theatre care group meeting for discussion. ■ Support to be given to three specialties with the lowest results to understand the issues they face and help improve compliance. ■ Clinical lead to visit best performing areas to congratulate them and gain insight into their successful processes, which can then be shared. ■ Focus on improvements to time-out checks, with target of 100% compliance at next audit round. ■ Matrons and team leaders to discuss findings with their local teams. ■ Surgeons and anaesthetists to collect data for quarter 1 2015/16.

Healthcare Records Audit Report Q1 2015/16	■ Local action will be required to improve standards and to this end care group results are available alongside the trust level report ■ A number of measures have been recommended at trust level, particularly around the improved access to patient labels, use of clinician name stamps, patient identification stickers and dividers in ward ring folders. Where the audit revealed that there is no access to a working label printer this has been reported to divisions for local resolution.
End of Life Discharge Home Service Report	The end of life discharge service demonstrated an increased demand in the year 2014/15, and achieved a high number of patients discharged to their PPC/PPD. The palliative care team are working more closely with the ward discharge coordinators and there are proposed changes to the hospital discharge team to help fast track patients. The team are trialling a system of one CNS focusing just on fast tracks for a week at a time to provide better continuity.
Tissue Handling Audit (HTA) 2015	■ Patients encouraged to fully complete the consent form, indicating consent or refusal to all the use of tissue in diagnosis and audit, teaching and research. ■ Recommended staff are formally trained and competency assessed by implementing a training schedule to cover all activities, including information regarding legal requirements. ■ Theatre matrons to schedule regular teaching sessions and presentations. ■ All new staff should be supervised to promote adherence to the protocols and SOPs, ensuring clinical competence. ■ All the SOPs and quarantine procedures for autologous tissues are to be reviewed by the theatre team.
Safe and Secure Handling of Medicines Annual Audit	■ Local actions were taken at the time of completing the audit and further actions are informed by considering detailed local results and feedback. ■ At an organisational level a number of actions are agreed to improve the audit process, thereby providing a full picture of performance and identifying best and poor practice.

Controlled Drugs Check & Stock Audit Quarter 2 2015/16	Pharmacists carried out local education and training of ward staff as issues were identified during the audit process. Furthermore, divisional reports including targeted action plans will be presented at the DGB meetings. In some areas ward pharmacists have identified the need for CD training, to include how to order CDs, entering CDs into registers and calculating the amount of medication required. A training package is being piloted on General Medicine wards in Quarter 3 to address these issues.
Healthcare Records Audit Report Q3 2015/16	The clinical audit department hope to create a report in PIEDW (iCLIP) by which to audit the quality of electronic documentation in those areas that use iClip. This is dependent on training and the format of the electronic record. Standard of documentation as reported by this audit and other data to be considered when formulating the Quality Improvement Strategy for 2016/17.
WHO Surgical Checklist Audit 3rd Quarter 2015/16	■ Peer review audit will be undertaken in the next audit round (4th quarter). ■ This information will be included in the new theatre efficiency project led by Martin Wilson (Director for Transformation) ■ To continue circulating the results to Theatres Care Group and Governance leads.
Controlled Drugs Check & Stock Audit, Quarter 3 2015/16	■ Pharmacists carried out local education and training of ward staff as issues were identified during the audit process. Corrective action was also taken at the time of the audit and this has been reported to divisions for ongoing support. ■ Where pharmacists have identified the need for CD training, to include how to order CDs, entering CDs into registers and managing stock held, mini training sessions are being held to address these issues.

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

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

We have been engaged by the Council of Governors of St George's University Hospital NHS Foundation Trust to perform an independent limited assurance engagement in respect of St George's University Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2016 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in Annex 2 to Chapter 7 of the 'NHS Foundation Trust Annual Reporting Manual 2015/16' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2016 subject to the limited assurance engagement consist of those national priority indicators as mandated by Monitor:

- RTT – percentage of incomplete pathways over 18 weeks **(page 60)**
- A&E – percentage of unplanned A&E attendances that were admitted, discharged or transferred within 4 hours from attendance **(page 60)**

We refer to these national priority indicators collectively as the 'Indicators'.

Respective responsibilities of the Council of Governors and Practitioner

The Council of Governors are responsible for the content and the preparation of the Quality Report covering the relevant indicators and in accordance with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual 2015/16' issued by Monitor and 'Detailed guidance for external assurance on quality reports 2015/16.

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
- the Quality Report is not consistent in all material respects with the sources specified in Monitor's 'Detailed guidance for external assurance on quality reports 2015/16; 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 2015/16' and supporting guidance and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports 2015/16'.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual 2015/16, 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 2015 to 2 June 2016
- Papers relating to quality reported to the

Board over the period 1 April 2015 to 2 June 2016

- Feedback from Commissioners dated 24 May 2016
- Feedback from Governors dated 24 May 2016
- Feedback from local Healthwatch organisations dated 17 May 2016
- Feedback from Overview and Scrutiny Committee dated 16 May 2016
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2014/15
- The national patient survey dated 2015;
- The national staff survey dated 2015;
- Care Quality Commission Intelligent Monitoring Report dated May 2015;
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 26 May 2016; and
- Any other information obtained during our limited assurance engagement.

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 have complied with the independence and other ethical requirements of the Code of Ethics for Professional Accountants issued by the International Ethics Standards Board for Accountants, which is founded on the fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour. 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 Hospital NHS Foundation Trust as a body, to assist the Council of Governors in reporting St George's University Hospital 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 2016, 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 Hospital 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
- analytical procedures
- limited testing, on a selective basis, of the data used to calculate the indicators back to supporting documentation
- comparing the content requirements of the

'NHS Foundation Trust Annual Reporting Manual 2015/16' to the categories reported in the Quality Report; and

- reading the documents.

The procedures performed in a limited assurance engagement vary in nature and timing from, and are less in extent than for, a reasonable assurance engagement and consequently, the level of assurance obtained in a limited assurance engagement is substantially lower than the assurance that would have been obtained had a reasonable assurance engagement been performed.

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 thereof, 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 2015/16'.

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 Hospital NHS Foundation Trust.

Our audit work on the financial statements of St George's University Hospital 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 Hospital NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to St George's University Hospital 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 Hospital 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 Hospital 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 Hospital NHS Foundation Trust and St George's University Hospital 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.

Basis for qualified conclusion

The Trust was unable to provide patient-level populations to support the reported indicator figures in the Quality Report for both of the mandated indicators. We were unable to obtain assurance over the completeness of the datasets provided for audit.

The indicator reporting the 'percentage of incomplete pathways within 18 weeks for patients on incomplete pathways' did not meet all six dimensions of data quality for the following reasons:

- the trust was unable to provide comprehensive listings of pathways at patient level which were consistent with the numerator and denominator of the indicator as reported in the Quality Report; and

- we identified 4 cases in our testing of 25 cases where it was not possible to agree the duration of the pathway to supporting information provided by the Trust.

Because of the extent of the data accuracy errors, we have not been able to obtain sufficient assurance against the six dimensions of data quality for this indicator.

The indicator reporting the 'percentage of unplanned A&E attendances that were admitted, discharged or transferred within 4 hours from attendance' did not meet all six dimensions of data quality for the following reasons:

- the Trust was unable to provide comprehensive listings of A&E attendances at patient level which were consistent with the numerator and denominator of the indicator as reported in the Quality Report; and
- we identified 5 cases in our testing of 25 cases where it was not possible to agree the time of admission, discharge or transfer reflected in the indicator to the supporting records.

Because of the extent of the data accuracy errors, we have not been able to obtain sufficient assurance against the six dimensions of data quality for this indicator.

Qualified conclusion

Based on the results of our procedures, with the exception of the matters reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- the Quality Report is not prepared in all material respects in line with the Criteria;
- the Quality Account is not consistent in all material respects with the sources specified in Monitor's 'Detailed guidance for external assurance on quality reports 2015/16'; 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 2015/16' and supporting guidance and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports 2015/16'.

Grant Thornton UK LLP
Chartered Accountants
London
3rd June 2016