St George's University Hospitals NHS
NHS Foundation Trust

Quality Account
2017/18

Excellence in specialist and community healthcare

Chief executive's statement on quality

As Chief Executive I see, every day, the positive impact we have on patients and the communities we serve. This is down to the 9,000 staff who work across our hospitals and community services.

This quality report sets out the approach we are taking to continuously improve the quality and safety of care we provide our patients at St George's. Our ultimate goal is to provide Outstanding Care, Every Time, and this vision is helping to drive forward the improvements we want to make.

During my first year at St George's, it has been very rewarding to see how much goodwill there is locally for St George's to succeed. This includes our patients, their families, and the many partner organisations that we work with.

This inspires me to help move the Trust out of our current Care Quality Commission rating, to become a Trust recognised for the excellent care we provide and the staff we develop.

In September, we refreshed our Quality Improvement Plan which reflected a renewed focus, and a longer term ambition, to become an outstanding Trust. This new plan covers everything we do; from improvements in end of life care, dementia care, outpatient services, to learning from the findings of the NHS Friends and Family Test. We also set ourselves stretching targets to ensure we put patient safety at the heart of St George's so ensuring our services are organised to meet people's needs, and to prevent delays to treatment.

We did not achieve all of our national performance targets, but we have achieved a number of the targets that we set ourselves as we work towards consistently achieving national targets. We continued to make considerable progress in improving the care which we provide to our patients and we will build on this progress during 2018-19. Our priority is to provide high quality, safe care for all patients, and to learn from our mistakes if we fall short of these standards.

We also set out to consistently improve our performance against the national performance standards. This is an ongoing process and performance in some areas, such as against the four emergency care standard, is still not where it needs to be.

This year's quality account shows, however, that we have made progress in the past year through the delivery of our Quality Improvement Plan, which is credit to staff, particularly given the financial challenge we have also set the organisation.

We are pleased that the CQC recognised the progress we have made during their focused inspection in July 2017. Following their visit, the warning notice received after our last full inspection in November 2016 was lifted by the CQC. The CQC carried out an unannounced inspection of our hospital and community services in March 2018, and we await their report.

We Trust that this quality report illustrates the progress we have made to deliver safe and compassionate care to our patients. To the best of our knowledge, the information in this document is accurate and accountable.

I would like to thank our dedicated staff who work tirelessly every day to provide Outstanding Care, Every Time for our patients.

Jacqueline Totterdell
Chief Executive
24 May 2018

Our quality priorities for 2018/19

Our vision is to provide outstanding care, every time. This ambition is reflected in our strategic objectives. In October 2017 we published our Quality Improvement Plan (QIP) which describes the change projects we will deliver through 2018-19 to move us closer to our goal of providing outstanding care, every time.

The programmes that make up the QIP will help us to improve the provision of healthcare to our patients and to mitigate any risks to quality that arise from our challenging financial plans. We view quality, safety and efficiency as intrinsically linked and our commitment to this underpins the Quality Improvement Plan.

The breadth of our quality ambition is described in the QIP and the priorities selected for the Quality Report are specific objectives within an improvement programme.

Each priority comes under one of three quality themes:

- Patient safety: having the right systems and staff in place to minimize the risk of harm to our patients and, if things do go wrong, to be open and learn from our mistakes.
- Clinical effectiveness: providing the highest quality care, with world class outcomes whilst also being efficient and cost effective.
- Patient experience: meeting our patients' emotional as well as physical needs

Our quality priorities and why we chose them

Improving patient safety

Reduce the impact of serious infections (CQUIN)

This priority builds on our 2017/18 priority to improve response to the early warning score and identification of the deteriorating patient. It continues to be a priority to meet the national CQUIN goals to reduce the impact of serious infections. The aim is to ensure the timely identification and treatment of sepsis and a reduction of clinically inappropriate antibiotic prescription and use. We will screen all patients for whom sepsis screening is appropriate and rapidly initiate intravenous antibiotics for patients with suspected severe sepsis, red flag sepsis or septic shock. Sepsis is a common and potentially life-threatening condition that can cause inflammation, swelling and blood clotting. This can lead to a significant decrease in blood pressure, which may reduce blood supply to vital organs such as the brain, heart and kidneys. Sepsis is recognised as a significant cause of poor outcomes and death and is almost unique among acute conditions in that it affects all age groups.

What success will look like: We will meet the 2018-19 national CQUIN goals for the identification and treatment of sepsis.

Reduce patient falls resulting in significant harm

We continue to work to reduce the risk of falls and to reduce the harm caused by falls, recognising that our population is frailer and the risk of falls is increasing and is likely to continue to increase. We now have a falls co-ordinator in post and have put systems in place to verify our falls data to support learning. We will assure ourselves that all no harm falls are being reported to ensure that we learn from these no harm events.

What success will look like: We will reduce the number of falls that result in any significant harm by 30% against the number of falls with significant harm in 2017-18. Significant harm will include all fractures and head injury.

Reduce acquired grade 3 pressure ulcers

In 2017/18 we achieved our priority for this fundamental of care and no patient acquired an

avoidable grade 4 pressure ulcer in our care. In 2017/18 we have seen an increase in the number of acquired grade 3 pressure ulcers, the majority have been found to be unavoidable. We want to assure ourselves that all possible steps are being taken to prevent patients acquiring grade 3 pressure ulcers in our care and we want to reduce the total number of grade 3 pressure ulcers acquired in our hospitals.

What success will look like: We will reduce the total number of grade 3 pressure ulcers acquired in our hospitals by 20% against the number for 2017-18.

Improving patient experience

Provide a responsive, high quality complaints service

We want to provide a complaints service based on the principles in 'My expectations for raising concerns and complaints' (Parliamentary Health Service Ombudsman and others) so that complainants are able to say: 'I felt confident to speak up and making my complaint was simple.

I felt listened to and understood. I felt that my complaint made a difference.'

What success will look like: We will reduce the number of complaints where local resolution is not achieved by the first response to 4% from 8%. We will achieve our targets for responding to complaints.

Build a patient partnership structure to enable patients to be involved in improvement work from the earliest stage

We want to put working in partnership with our patients and the public at the centre of all that we do. We want to encourage the active participation of patients in their individual care and treatment and also give them a voice and enable their participation in the planning and development of services.

What success will look like: We will have a patient partnership forum and be able to demonstrate that patients have been involved in service development, improvement or change projects.

Improve immediate feedback from patients through the FFT by increasing response rates for both inpatient and outpatient services

We want to hear from our patients about their experience so we can ensure that actions we take are directed at areas they are concerned about. At present we have a very low response rate in our outpatient services. We will identify ways of getting feedback that engage a significant number of our patients and improve response rates in outpatient and inpatient services.

What success will look like: We will achieve a response rate of 20% by the end of 2018-19 to our outpatient FFT.

Improving effectiveness and outcomes

Improve services for people with mental health needs who present to the Emergency Department. (CQUIN)

People with mental ill health are 3 times more likely to present to the Emergency Department than the general population. More than 1 million presentations are currently recorded as being directly related to mental ill health. People with known mental ill health are 5 times more likely to be admitted to acute hospitals and 80% of these emergency admissions are recorded as being primarily for physical health reasons. This highlights the need for acute hospitals to be equipped to detect and treat urgent mental health needs that are cited as the primary reason for presentation as well as improving identification of underlying mental health conditions where the primary presenting reason may be a physical health one.

What will success look like: We will meet the 2018-19 national CQUIN goals for services to patients with mental health needs in the ED.

Improve the effectiveness of our discharge process ensuring that patients are equipped

with the information they need to manage their health and that they know how to access appropriate support.

We know from the national patient survey that we can improve the way we discharge patients so that they feel fully involved in their own care and treatment and are equipped with the information they need.

What will success look like: We will see an improvement in the response to these questions on our local patient survey and in the national patient survey in 2019.

Statements of assurance from the Board of Directors

This section contains the statutory statements concerning the quality of services provided by St Georges NHS Foundation Trust. These are common to all quality reports and accounts and can be used to compare us with other organisations.

A review of our 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 number of services, such as cardiothoracic medicine and surgery, neurosciences and renal transplantation, also cover significant populations from Surrey and Sussex, providing care for about 3.5 million people in total.

Most of our services are provided at St George's Hospital in Tooting, but we also provide services from Queen Mary's Hospital in Roehampton and health centres in Wandsworth and Merton. We also provide healthcare services for residents of HMP Wandsworth.

We provide care for patients from a larger catchment area in south east England for specialist services such as complex pelvic trauma. A number of our services treat patients from across England these include 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 2017/18 we provided 54 NHS services. A detailed list is available in the Statement of Purpose on our website www.stgeorges.nhs.uk.

We have reviewed data available on the quality of care in all of these services through our performance management framework and our assurance processes.

The income generated by the NHS services reviewed in 2017/18 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 2017/18.

Participation in clinical audit and National Confidential Enquiries

During 2017/18, 56 national clinical audits and two national confidential enquiries covered relevant health services provided by St George's University Hospitals NHS Foundation Trust.

During that period, St George's University Hospitals NHS Trust participated in 98% 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 University Hospitals NHS Foundation Trust was eligible to participate in during 2017/18 are shown here, 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**
BAUS Urology Audits: Cystectomy		✓	✓	**Ongoing**
BAUS Urology Audits: Nephrectomy		✓	✓	**Ongoing**
BAUS Urology Audits: Percutaneous Nephrolithotomy		✓	✓	**Ongoing**
BAUS Urology Audits: Radical prostatectomy		✓	✓	**Ongoing**
BAUS Urology Audits: Urethroplasty		✓	✓	**Ongoing**
BAUS Urology Audits: Female stress urinary incontinence		✗	**N/A**	**N/A**
Bowel cancer (NBOCAP)		✓	✓	**Ongoing**
Cardiac Rhythm Management (CRM)		✓	✓	**Ongoing**
Case Mix Programme (ICNARC)		✓	✓	**Ongoing**
Child Health Clinical Outcome Review Programme	Children with Chronic Neurodisability	✓	✓	**100%**
	Young People's Mental Health	✓	✓	**87.5%**
	Cancer in Children, Teens and Young Adults	✓	✓	**87.5%**

Title		Relevant	Participating	Submission rate (%) / Comment
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)		✗	N/A	N/A
Case Mix Programme (ICNARC)		✓	✓	Ongoing
Diabetes (Paediatric) (NPDA)		✓	✓	Ongoing
Elective Surgery (National PROMS Programme)		✓	✓	Ongoing
Endocrine and Thyroid National Audit		✓	✓	Ongoing
Falls and Fragility Fractures Audit Programme	Fracture Liaison Service Database	✓	✓	Ongoing
	Inpatient Falls	✓	✓	90%
	National Hip Fracture Database	✓	✓	Ongoing
Fractured Neck of Femur (RCEM)		✓	✓	100%
Head and Neck Cancer Audit		✓	✓	Ongoing
Inflammatory Bowel Disease (IBD) programme		✓	✓	10%
Learning Disability Mortality Review Programme (LeDeR Programme)		✓	✓	100%
Major Trauma Audit		✓	✓	Ongoing
Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal Mortality Surveillance	✓	✓	Ongoing
	Perinatal Mortality and Morbidity confidential enquiries	✓	✓	Ongoing
	Maternal Mortality surveillance and mortality confidential enquiries	✓	✓	Ongoing
	Maternal morbidity confidential enquiries	✓	✓	Ongoing
Medical and Surgical Clinical Outcome Review Programme	Acute Heart Failure	✓	✓	Ongoing
	Peri-operative diabetes	✓	✓	100%
Mental Health Clinical Outcome Review Programme		✗	N/A	N/A
National Audit of Anxiety and Depression		✗	N/A	N/A
National Audit of Breast Cancer in Older Patient (NABCOP)		✓	✓	Ongoing

Title		Relevant	Participating	Submission rate (%) / Comment
National Audit of Dementia		✓	✓	**100%**
National Audit of Intermediate Care		✓	✓	**36 forms returned – unable to give percentage as the denominator is not defined**
National Audit of Psychosis		✗	**N/A**	**N/A**
National Audit of Rheumatoid and Early Inflammatory Arthritis		✗	**N/A**	**This audit was not operational in 2017/18. We have signed up to participate in 2018/19 when the project relaunches.**
National Audit of Seizures and Epilepsies in Children and Young People		✗	**N/A**	**This audit was not operational in 2017/18. We have signed up to participate in 2018/19 when the project relaunches.**
National Bariatric Surgery Registry (NBSR)		✓	✓	**Ongoing**
National Cardiac Arrest Audit (NCAA)		✓	✓	**Ongoing**
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	Pulmonary rehabilitation	✓	✓	**100%**
	Secondary care	✓	✓	**Ongoing**
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)		✓	✓	**100%**
National Comparative Audit of Blood Transfusion	Audit of Red Cell & Platelet Transfusion in Adult Haematology Patients	✓	✓	**100%**
	2017 National Comparative Audit of Transfusion Associated Circulatory Overload	✓	✗	**We were unable to participate in this audit due to resource. This audit is not mandated.**
National Diabetes Audit – Adult	Core Diabetes Audit	✓	✓	**Ongoing***
	Foot Care	✓	✓	**Ongoing**
	Inpatient Audit (NaDia)	✓	✓	**100%**
	Pregnancy in Diabetes	✓	✓	**Ongoing**
National Emergency Laparotomy Audit (NELA)		✓	✓	**Ongoing**
National End of Life Care Audit		✗	**N/A**	**This audit was not operational in 2017/18. We have signed up to participate in 2018/19 when the project relaunches.**
National Heart Failure Audit		✓	✓	**Ongoing**

Title	Relevant	Participating	Submission rate (%) / Comment
National Joint Registry (NJR)	✓	✓	**Ongoing**
National Lung Cancer Audit (NLCA)	✓	✓	**Ongoing**
National Maternity and Perinatal Audit	✓	✓	**100%**
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	✓	✓	**Ongoing**
National Ophthalmology Audit	✗	**N/A**	**Not applicable**
National Vascular Registry	✓	✓	**Ongoing**
Neurosurgical National Audit Programme	✓	✓	**Ongoing**
Oesophago-gastric Cancer (NAOGC)	✓	✓	**Ongoing**
Paediatric Intensive Care (PICANet)	✓	✓	**Ongoing**
Pain in children (RCEM)	✓	✓	**26%**
Prescribing Observatory for Mental Health (POMH-UK)	✗	**N/A**	**Not applicable**
Procedural Sedation in Adults (care in emergency departments)	✓	✓	**59%**
Prostate cancer	✓	✓	**Ongoing**
Sentinel Stroke National Audit Programme (SSNAP)	✓	✓	**Ongoing**
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	✓	✓	**Ongoing**
UK Parkinson's Audit	✓	✓	**100%**

Data notes:

Each audit within a programme has been counted separately. Where 'Ongoing' is stated this indicates that the data collection deadline for complete 2017/18 data has not been reached at time of reporting and therefore data submission for the 2017/18 audit period is ongoing and cannot be reported.

***** *Data for the Diabetes Core Audit was submitted to NHS Digital; however, our data is not presented in the associated national report due to an error in the submission file which was not communicated to us for resolution. We continue to collect data for this audit.*

The reports of national clinical audits were reviewed by St George's University Hospitals in 2017/18 and we intend to take the following actions to improve the quality of healthcare provided.

National audit of dementia

This report has seven themes - governance, assessment, nutrition provision, discharge, information and communication, and the overall carer rating of care.

The Trust did better than the national average in staff and carer communications. However, overall scores were below the national average for governance, nutrition, discharge planning and assessment.

The Trust has taken or is taking the following actions to improve: The dementia carer passport has been introduced to facilitate extended visiting hours, including to enable families to help patients at mealtimes; ensuring food options for patients with dementia are in line with best practice; identification of dementia champions at directorate level; targeted audits of pain and pressure ulcer risk documentation in patients with dementia; dementia advisor available in the hospital two days a week to provide support and advice to dementia carers; creation of a dementia hub to provide an enhanced and dedicated space where people with dementia and their carers can receive support and advice; electronic flag to identify those with a dementia diagnosis to ensure they receive the support they need.

Local clinical audits

The reports of over 125 local clinical audits were reviewed in 2017/18 by care groups and directorates and in the following table are examples of some of the actions St George's University Hospitals intends to take to improve the quality of healthcare provided.

Local clinical audit	Action to improve quality / Comment
Surgical Antibiotic Prescribing Audit	■ Promote the Microguide application which provides easy access to local guidelines. ■ Share the audit outcomes to raise awareness of the gap between practice and gold standard and highlight the role of the guidelines. ■ Incorporate antibiotic guidance into induction for new doctors. ■ Re-audit to test the effectiveness of the action taken.
Sepsis in obstetric HDU	■ This audit of compliance with the Sepsis 6 care bundle was carried out after a week-long educational initiative to improve management and recognition of sepsis in obstetrics. Following this week which included drop in workshops, in situ simulation work and daily teaching session compliance with the bundle was reaudited. ■ Compliance improved significantly achieving 85% compliance with administration of antibiotics within 1 hour and 100% of patients received intravenous fluids, a similar improvement in compliance was seen across all components of the Sepsis 6 care bundle. ■ The effectiveness of the week of intensive educational activities was demonstrated.
Post-operative pain management in paediatrics	■ A cohort of children having a surgical procedure that required an overnight stay were looked at to audit the effectiveness of post-operative pain management. ■ The majority of patients had good pain control and satisfaction amongst the children and parents was generally high. The audit recommendations are to continue to improve the consistency of analgesic prescriptions for all post-operative children and to maintain a focus on documenting pain scores.

Local clinical audit	Action to improve quality / Comment
nEWS Audit January 2018	■ In 2017-18 the Trust has increased its compliance target with the National Early Warning Score to 100% to stretch performance as we have been consistently achieving over 80% for each criteria. The outcome of the Jan 2018 audit continues to show improvement in compliance with an overall Trust score of 93%. ■ To continue to improve all wards that scored below 100% will provide an action plan, this will include education and competency assessment of all staff and participation in monthly ward level.
Annual Consent Audit 2017/18	■ The audit has been shared with clinical colleagues and presented at the Quality and Safety Board Committee. Improving our consent process is a project in the Quality and Safety programme and is led by a senior clinician. ■ The project links with the Outpatients work stream and seeks to improve practice by moving consent to the outpatient clinic as our waiting times improve.

Our participation in clinical research

At St George's we are committed to innovating and improving the healthcare we offer. A key way to achieve this is by participating in clinical research. Our clinical staff are fully engaged with the latest treatment developments and through clinical trials patients can be offered access to new treatment interventions, leading to better clinical outcomes for patients. St George's, in its partnership with St George's University of London, aims to bring new ideas and solutions into clinical practice. Clinical teams are collaborating with scientists to investigate the causes of a range of diseases, to develop better ways of diagnosis and tailored treatments.

In the 2014 Research Excellence Framework, 70% of the research submissions from St George's were judged to be of international standard in terms of originality, significance and rigour. The strongest aspects of clinical medical research were cardiovascular research and cell biology/functional genetics. The strong partnership between St George's and its partner University underpins this excellence.

A key way to offer new treatments is through participation in clinical trials that are approved by the National Institute for Health Research (NIHR), which supports NHS and academic institutions to deliver quality research that is patient-focused and relevant to the NHS. In 2016/17 St George's recruited 5,040 patients onto the NIHR portfolio adopted studies. Provisional recruitment for 2017/18 shows a significant improvement to 6,300 patients.

Approvals

At St George's in 2017 we had 575 active research studies registered on our database. 318 of these studies were adopted onto the NIHR portfolio. 249 research applications were received in the Joint Research and Enterprise Office (JREO) in 2017 and St George's opened 173 new research studies.

Our Commissioning for Quality and Innovation (CQUIN) performance

A proportion of St George's University Hospitals NHS Foundation Trust's income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between St George's University Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

In 2017/18 over £15 million of our income is conditional on achieving quality improvement and innovation goals. In 2016/17 the income achieved for achieving quality improvement and innovation goals was £12 million.

Further details of the agreed CQUIN goals for 2017/18 and our goals for 2018/19 are available via the St George's website. www.stgeorges.nhs.uk.

Our registration with the Care Quality Commission

St George's University Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is "registered without conditions or restrictions".

Our services were assessed by the CQC in June 2016; the outcome of this inspection was an overall rating for the Trust of 'inadequate'. There were services that were rated as 'good' and in the caring domain we were pleased to receive a rating of 'good', our maternity services were rated 'outstanding' in the 'effectiveness' domain. The table below shows some of the detail behind our overall rating.

Overall rating	Inadequate

Safe	Inadequate		
Effective		Requires improvement	
Caring			Good
Responsive		Requires improvement	
Well led	Inadequate		

The Care Quality Commission took enforcement action against St George's following the June 2018 inspection issuing a Warning Notice under Section 29A of the Health Act 2008. This Warning Notice remained in place until September 2017, at this time the CQC was assured following an inspection in May 2017 that the necessary action and improvements had been made.

St George's University Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Previous reports of inspections for St George's University Hospitals are available on the CQC website www.cqc.org.uk.

Our data quality

St George's University Hospitals NHS Foundation Trust submitted records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data: *****

Which included the patient's valid NHS number was:

- 98% for admitted patient care
- 99.2% for outpatient care; and
- 93.4% for accident and emergency care

Which included the patient's valid General Medical Practice Code was:

- 99% for admitted patient care
- 99.9% for outpatient care; and
- 99.6% for accident and emergency care

***** Source – SUS Data quality reports

Information governance toolkit

The Information Governance Toolkit sets out the standards for management of information in the NHS, organisations carry out a self-assessment against the standards each year. In 2017/18 the St George's Information Governance Assessment Report overall score was 66% and was graded green and satisfactory. In late 2017/18 we identified gaps in our self-assessment that may have an impact on our overall percentage score. These gaps were reported to the May 2018 Audit Committee and are being addressed in readiness for the Data Security and Protection Toolkit submission in October 2018.

Payment by results

St George's University Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2017/18.

Improving data quality

In January 2016, we became concerned about the quality and robustness of our data reporting; particularly the management of our waiting lists (referral to treatment times).

An external review of our referral to treatment times (RTT) data and patient tracking systems identified serious issues relating to our operational processes and technology. These issues created significant risks to the quality of care and patient safety as well as flaws with our reporting processes at St George's Hospital. A subsequent review carried out in April 2017 identified similar problems at Queen Mary's Hospital in Roehampton.

As a result of our concerns we suspended national reporting of our RTT data in June 2016 and made a decision not to recommence reporting until we have full confidence that the information we are providing is reliable.

St George's University Hospitals NHS Foundation Trust has taken, and will be taking, the following actions to improve data quality:

In September 2017 the newly appointed Chief Operating Officer took over the management of the dedicated waiting list improvement programme, the Elective Care Recovery Programme. Since the formation of the programme we have undertaken a systemic and detailed audit of the waiting lists for patients at the St George's site. This resulted in an increase in the number of patients reported to be waiting over 18 weeks from referral to treatment. We also identified a number of patients who had been waiting over 52 weeks. As part of the validation exercise our Medical Director undertook a clinical review led by doctors from across the Trust to ensure patients were not coming to clinical harm as a result of their waits.

In April 2017 we launched a 'Better Data, Safer Patients' campaign across the Trust to emphasise the importance of accurate clinical coding and to ensure that this is managed correctly and consistently. One of the early successes included reducing the number of patients with 'no due date' in our records for endoscopy procedures from 3,200 to zero.

Our clinical teams have focused on treating those patients who have waited the longest; they have also improved administrative processes, and increased capacity through additional evening and weekend clinics and operating lists. We have also provided mandatory training to 3,500 staff to improve awareness of the significance of waiting list management and other vital data to ensure patient safety.

In early 2018 we introduced a new Patient Tracking List (PTL) for patients waiting for elective care at St George's. The new single system will improve the speed at which we treat patients, effectively manage waiting times and ensure that we are capturing information accurately and consistently.

In March 2018 we introduced a new Patient Tracking List (PTL) for patients waiting for elective care at Queen Mary's Hospital. We are also currently carrying out a scoping exercise to identify the infrastructure required to support the rollout of the iClip (Cerner) System at Queen Mary's Hospital – to ensure both of our main hospital sites are using the same system and so improve data quality.

We now have 48,000 patients on our waiting lists, with a plan to reduce it to fewer than 40,000 by the end of April 2019. This is a significant step forward as we continue to reduce the waiting list times for our patients.

The Trust has identified significant opportunities to improve existing clinical coding processes. There are being addressed through a change programme. The data quality team focuses on data cleansing, improving recorded data and reinforcing the importance of data quality to all services across the Trust. The team works closely with front line users to ensure that they are aware of the importance of capturing good data within our systems. The data quality team also works closely with IT trainers to ensure that the patient administration system (PAS) is robust and that staff are provided with appropriate levels of training. Data quality dashboards are in place to monitor how services are managing data.

Learning form deaths

During 2017/18 1,760 of St George's patients died. This comprised the following number of deaths which occurred in each quarter of this reporting period:

Number of deaths 2017/18	Q1	Q2	Q3	Q4
	374	385	449	552

By 31 March 2018 1244 case record reviews and 233 investigations have been carried out in relation to 89% of the deaths in table 1. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

Case record review or investigation	Q1	Q2	Q3	Q4
	328	287	393	469

By 31 March 2018 1244 case record reviews and 233 investigations have been carried out in relation to 89% of the deaths in table 1. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

Problems in healthcare	Q1	Q2	Q3	Q4
Number	52	40	60	81
% of all deaths	13.9%	10.4%	13.4%	14.7%

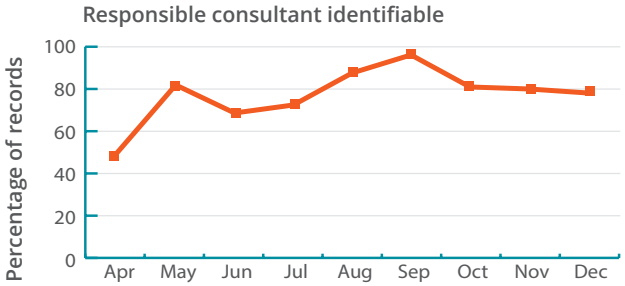
These numbers have been estimated using our locally developed online screening tool and structured review based on the Royal College of Physicians (RCP) tool. We have a dedicated independent team supporting the bereavement office, and reviewing deaths in a timely way. All patients where a care issue may have contributed to death are escalated to the risk team on the same day and included in our serious incident decision meeting (SIDM) discussions. A judgement regarding avoidability of death is made for all reviews.

Some problems in healthcare may occur with excellent care, others may occur and not affect the outcome, or the problem may not have affected the clinical course of events in any way. The majority, 96.3% of deaths, were assessed as being 'definitely not avoidable', and no deaths were thought to be 'definitely avoidable'. Any death where review suggests it may have been avoidable is escalated to the risk team to consider possible investigation and rapid response through our serious incident process. Any significant problem of care, whether or not it affected outcome, is brought to the attention of the clinical team for discussion and learning at the local morbidity and mortality meeting

What we have learnt and action taken

Responsible consultant

When the process of independent review began the identification of responsible consultant in the healthcare record was flagged as an issue. This was escalated to divisional teams for action and to care group leads for areas identified as needing particular improvement. Ongoing monitoring shows improvement in this area.



DNACPR discussions

Although a large number of patients had good and early discussions about resuscitation, reviews continue to identify patients where such discussions should have occurred, or could have occurred earlier. Clinical teams have been asked to consider their practice and discuss this at their morbidity and mortality meetings.

Monthly data allows us to look in more detail at practice across the Trust and to track performance. This theme is one of the focuses of the End of Life (EOL) steering group and has highlighted the essential role of our palliative care team. A high proportion of patients dying in our Trust (52.4%, July 16 - June17) are coded as having specialist palliative care input; this is much better than the national average (31.1%).

Issues that have been highlighted to care groups include the appropriateness of inter-hospital transfer and the need for consultant-level discussion; ward frequency of consultant review; multi-disciplinary team (MDT) discussion and decision making between teams; ceilings of care and appropriateness of DNACPR decisions.

Cases have been referred to our deteriorating adults group for investigation as they have occurred following a cardiac arrest outside of an intensive care area, for the majority of these cases there was no clear end of life plan and is linked to the work around DNACPR discussions.

Guardian of safe working

We have appointed a Guardian of Safe Working to ensure our doctors are always working a safe number of hours. The Guardian acts as the champion of safe working hours and receives reports and monitor's compliance against our doctor's terms and conditions, where necessary the Guardian escalates issues to the relevant executive director for decision and action to reduce any risk to our patients' safety. Gaps in the rota for medical staff are monitored and managed at service level. Information on unfilled shifts is not available at Trust level, but is monitored by individual services. The Trust plans to implement a central roster system during 2018/19.

National Core Set of Quality Indicators

In 2012 a statutory core set of quality indicators came into effect. Eight indicators apply to acute hospital Trusts. All Trusts are required to report their performance against these indicators in the same format with the aim of making it possible for the reader to compare performance across similar organisations.

For each indicator our performance is reported together with the national average and the performance of the best and worst performing Trusts.

Mortality

The summary hospital level mortality indicator (SHMI) is a mortality measure that takes account of a number of factors, including a patient's condition. It includes patients who have died while having treatment in hospital or within 30 days of being discharged from hospital. The SHMI score is measured against the NHS average which is 100, a score below 100 denotes a lower than average mortality rate. The SHMI is not a measure of quality of care but a higher than expected number of deaths should be viewed as a 'smoke alarm' which requires further investigation. Similarly, an 'as expected' or 'lower than expected' SHMI should not immediately be interpreted as indicating satisfactory or good performance. It is recognised that the SHMI cannot be used to directly compare mortality outcomes between Trusts and for this 'reason 'best' and 'worst' Trusts are not shown for this indicator.

Summarised hospital level mortality indicator (SHMI)	Jan 15 - Dec 15	Apr 15 - Mar 16	Jul 15 - Jun 16	Oct 15 - Sep 16	Jan 16 - Dec 16	Apr 16 - Mar 17	Jul 16 - June 17	Oct 16 - Sep 17
SHMI	90.6	89.5	88.2	86.5	84.4	83.6	83.8	82.5
Banding	As expected	Lower than expected	Lower than expected	Lower than expected	Lower than expected	Lower than expected	Lower than expected	Lower than expected
% Deaths with palliative care coding	33.4%	39.1%	42.8%	48.9%	51.3%	51.1%	52.4%	50.9%

Source: NHS Digital

St George's University Hospitals consider that this data is as shown for the following reasons. Our data is scrutinised by the Mortality Monitoring Committee and validated through the examination of additional data including daily mortality monitoring drawn directly from our own systems, and monthly analysis of information from Dr Foster. When validated internally we submit data on a monthly basis to NHS Digital. The SHMI is then calculated by NHS Digital with results reported quarterly for a rolling year. Our coding team work closely with our palliative care team to continually improve the accuracy of coding to fully capture the involvement of palliative care services, this is reflected in the increase in the percentage of deaths with a palliative care coding.

We have taken the following actions to improve our SHMI and so the quality of our services:

We have fully implemented the Learning from Deaths Framework and have been recognised as an exemplar Trust. We will continue to strengthen our mortality monitoring process and review of all deaths to ensure we identify every opportunity to learn, and in sharing learning to improve the care our patients receive. We also monitor our outcomes using information from national audits and mortality alerts from external agencies. For example the National Institute for Cardiovascular Outcomes Research (NICOR) has written to the Trust about the results of the recent National Cardiac Surgery Audit and while the Trust is not a published outlier, we are currently investigating survival rates that are below the national average.

Patient reported outcome measures

Patient reported outcome measures (PROMs) measure quality from the patient perspective and seek to calculate the health gain experienced by patients following one of four clinical procedures. We are reporting on patients who have had a hip replacement or a knee replacement.

We believe our data is as shown for the following reasons:

Patients who have had these procedures are asked to complete a short questionnaire which measures a patient's health status or health related quality of life at a moment in time. The questionnaire is completed before, and then some months after surgery, and the difference between the two sets of responses is used to determine the outcome of the procedure as perceived by the patient. 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.

The complexity of the cases carried out at St George's may be reflected in a slightly lower perception of improvement after surgery than the national average.

Percentage of patients reporting an increase in health following surgery		2012-13		2013-14		2014-15		2015-16		2016-17 (provisional)	
		SGH	National average	SGH	National average	SGH	National average	SGH	National average	SGH	National average
Hip replacement	EQ-5D™	100	89.7	86.4	87.9	90	88.2	100	88.4	75	88.8
	EQ-VAS	72.2	65.5	65.2	64.2	80	65.1	58.3	65.6	72.2	67.2
	Specific	95	97.1	80.8	96	100	96.4	94.4	96.5	76.5	96.4
Knee replacement	EQ-5D™	68.8	80.6	60	80.3	60	80.5	69.2	80.7	57.1	80.9
	EQ-VAS	53.3	54.9	50	54.6	50	55.3	33.3	56.4	25	57.5
	Specific	86.7	93.2	80	93	81.8	93.2	84.6	93.6	87.5	93.5

For both procedures the EQ-5DTM and EQ-VAS scores give the patients view of their general health improvement, the specific score comes from questions about improvement related to the hip or the knee replacement, higher scores are better.

Readmission within 28 days of discharge

The most recent information available from NHS Digital is for 2014-15. Using our own data we are able to access full year information for 2017-18.

	2015-16			2016-17			2017-18		
Readmissions	Under 16	16+	Total	Under 16	16+	Total	Under 16	16+	Total
Discharges	9961	31918	41879	14102	46946	61048	14201	47572	61773
28 day readmissions	618	3511	4129	659	4236	4895	651	4428	5079
28 day readmissions rate	6.2%	11%	9.86%	4.67%	9.02%	8.02%	4.58%	9.31%	8.22%

We consider our data is as shown for the following reasons: Monitoring emergency re-admission rates help the Trust to prevent or reduce unplanned re- admission into the hospital. An emergency re-admission occurs when a patient has an unplanned re-admission to hospital with 30 days of a previous discharge.

St George's University Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by committing to reducing re-admission for all patients irrespective of whether that care is planned or unplanned. We will work to improve our current overall re-admission rate by ensuring that all patients are discharged when it is safe to do so and that there is a coordinated approach with our partners and local authorities to ensure that the right support is in place for them.

Patient experience

Our score for the five questions in the national inpatient survey relating to responsiveness and personal care are consistent with the national average as shown below. The data compared to average, highest and lowest performers and our own previous performance is shown below:

Patient experience	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
St George's University Hospitals	66.1	66.6	68.8	68.6	67.9	66
National Average	67.4	68.1	68.7	68.9	69.6	68.1
Highest (best)	85	84.4	84.2	86.1	86.2	85.2
Lowest	56.5	57.4	54.4	59.1	58.9	60

We consider that the data is as shown as it is validated through the Trust's informatics and reporting processes. St George's University Hospitals NHS Foundation Trust intends to take the following actions to maintain and improve this percentage, and so the quality of its services, by continuous and on-going engagement with patients, family, friends and carers.

Staff recommendation to friends and family

We consider that this data is as described for the following reasons: we outsource the collection of data for the Staff Survey; it is collected and submitted annually to the Staff Survey Co-ordination Centre. The data shows that we are in a band with the majority of Trusts for staff recommendation achieving an average score.

Patient experience	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
St George's University Hospitals	70%	67%	73%	71%	70%	73%
Average for acute	60%	66%	68%	70%	68%	69%
Highest acute Trust	86%	94%	93%	93%	95%	86%
Lowest acute Trust	35%	40%	36%	46%	48%	47%

St George's University Hospitals NHS Foundation Trust intends to improve this percentage, and so the quality of its services, by focusing on staff engagement and quality improvement, listening to staff and addressing their concerns.

Patient recommendations to friends and family

Patient experience	2015-16		2016-17		2017-18	
St George's University Hospitals	A&E	Inpatient	A&E	Inpatient	A&E	Inpatient
Response rate	24.3%	27.74%	23.1%	30.76%	20.19%	25.5%
% would recommend	84.29%	93.57%	83.8%	95.81%	84.26%	96.24%
% would not recommend	11%	1.62%	10.51%	1.29%	10.39%	1.08%

** 2017-18 data to Feb 18*

Infection control

We continue to implement a range of measures to tackle infection and improve the safety and quality of our services. These include a strong focus on antibiotic stewardship and improved environmental hygiene, supported by continuous staff engagement and education.

We consider that the data is as described for the following reasons, the Trust has a process in place for collating data on C.difficile cases, the data is collated internally and submitted to Public Health England.

Cdifficile	2014-15	2015-16	2016-17	2017-18
Trust apportioned cases	38	29	36	14
Trust bed-days	254213	273493	287962	296981
Rate per 100,000 bed days	14.9	10.6	12.5	4.7
National average	33.7	33.7	30.2	
Worst performing Trust	121	139	116	
Best performing Trust	0	0	0	

St George's University Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by implementation of the following processes; improved recognition of patients at risk of infection by alerting the infection prevention and control team when patients with past history are admitted, improving diagnostic screening of patients at risk and planning that all wards are decanted and deep cleaned on a regular basis.

Patient safety incidents

St George's University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: this data is validated through the Trust's informatics and reporting processes.

Patient safety incidents	Oct 14 - Mar 15	Apr 15 - Sep 15	Oct 15 - Mar 16	Apr 16 - Sep 16	Oct 16 -Mar 17	Apr 17 - Sep 17
Trust reported incidents	5188	5353	5453	5964	5928	5548
Rate per 100,000 bed days	34.1	33.2	32.8	36.5	37.6	34.2
National average (acute non-specialist)	37.1	39.3	39.6	40.8	41.1	42.8
Highest reporting rate	82.2	74.7	75.9	71.8	69	111.7
Lowest reporting rate	3.6	18.1	14.8	21.1	23.1	23.5

Patient safety incidents	Oct 14 - Mar 15	Apr 15 - Sep 15	Oct 15 - Mar 16	Apr 16 - Sep 16	Oct 16 -Mar 17	Apr 17 - Sep 17
Incidents causing Serious Harm or death	16	23	20	15	13	14
% Incidents causing Serious Harm or death	0.31%	0.43%	0.37%	0.25%	0.22%	0.25%
% National average (acute non-specialist)	0.5%	0.43%	0.79%	0.38%	0.37%	0.35%
% Highest reporting rate	5.1%	1.96%	1.33%	1.38%	1.09%	
% Lowest reporting rate	0.05%	0.09%	0%	0.02%	0.03%	

St George's has taken the following actions to improve this number and rate, and so the quality of its services, by introducing a number of learning initiatives and continuing to work towards enhancing existing mechanisms throughout 2017/87. These include: risk management input into training programmes; increased frequency of root cause analysis (RCA) training; increased involvement from medical staff in following up incidents; human factors training with multidisciplinary teams with the support of the simulation centre; a monthly governance newsletter and the introduction of quarterly analysis report and thematic learning.

Venous thromboembolism

St George's considers that this data is as described for the following reasons: this data is validated through the Trust's informatics and reporting processes.

VTE Assessments	2014-15	2015-16	2016-17	2017-18
St George's University Hospitals	95.89%	96.77%	96.64%	95.90%
National Average	96.10%	95.76%	95.61%	Not available
Best performing trust*	100%	100%	100%	Not available
Worst performing trust*	79%	78.1%	63%	Not available

***** *position as at Q4*

St George's University Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by maintaining our high risk assessment rate (this is currently higher than the national average).

Progress against priorities for 2017-18

The progress we have made in delivering our quality priorities for last year is set out in the following tables. All the data used to assess our success in achieving our objectives has been derived from the Trust performance management systems and, where applicable, the indicators are consistent with national definitions.

Patient Safety		
Our quality priorities and why we chose them	**What success will look like**	**How did we do?**
Improve levels of Early Warning Score (EWS) documentation identifying patients who are deteriorating	Accurate documentation in a minimum of 95% of patients	**We achieved this.** This indicator is also being used to monitor delivery of the deteriorating patient workstream of the QIP. We are tracking, 'full set of observations recorded' and 'observations correctly scored'; both continue to show improvement in compliance with our stretch targets. We have been exceeding the NICE standard for some years and have now set ourselves a stretch target of 100% compliance and we are showing steady progress towards this. In January2018 the compliance with 'full set of observations recorded' was 98.4% and with 'observations correctly scored' was 99.4%.

Roll out of Local Safety Standards for Invasive Procedures to all applicable services and locations	Registers of procedures in place in all applicable services	**We partially achieved this.** Registers of procedure that have a Local Safety Standard are in place for the majority of services and are held in the divisions.
Reduce falls resulting in harm	Achieve a 25% reduction in patient falls resulting in a fracture	**We have partially achieved this.** The falls coordinator has carried out a detailed review of falls for a defined period to verify the data. Verification of incident reports is going to be managed at department level in the future to ensure the information is consistent.
Zero grade 4 pressure ulcers		**We achieved this.** We have had zero avoidable grade 4 pressure ulcers
No avoidable inpatient cardiac arrests (exclude Emergency Department)		**We partially achieved this.** Audit tool developed and a process to assess avoidable cardiac arrest baseline data commenced. This work is being carried out in the deteriorating patient workstream of the QIP

Patient experience		
Our quality priorities and why we chose them	**What success will look like**	**How did we do?**
Documented discussion and agreed plans for end of life care		**We achieved this.** End of Life Care is a workstream in the Safe and Effective Care Programme of the QIP. Implementation of a care plan aligned to the '5 Priorities of Care for the Dying Person' is an action within the End of Life Care Strategy. The care plan has been piloted for use across the Trust.
Increase participation in the staff survey		**We achieved this.** Staff engagement is an enabling programme of the QIP. The staff survey for 2017 saw increased participation with 45% of staff completing the survey.
Reduction in on the day cancellations of surgery by 25%		**We partially achieved this.** Theatres Improvement is a workstream in the Flow and Clinical Transformation Programme of the QIP. Work to reduce the number of same day cancellations includes the development of standard operating procedures (SOPs) to help create suitable theatre lists in advance of surgery. These have been developed by the multi-disciplinary teams involved and will mean that patients, staff and equipment are better prepared and in the right place at the right time. As the SOPs become embedded and are used consistently we will continue to monitor the number of on the day cancellations.

Clinical effectiveness		
Our quality priorities and why we chose them	**What success will look like**	**How did we do?**
Improve Summary Hospital Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR)		**We achieved this.** The latest HSMR data for the Trust shows mortality remains significantly better than expected for our patient group and the SHMI is lower than expected when benchmarked against national comparators. Both indicators also show an improvement trend.
Implement a comprehensive clinical review process for in hospital deaths		**We achieved this.** We published our policy relating to responding to deaths of patients in our care in September 2017. Since April 2017 members of the Mortality Monitoring Committee have carried out independent reviews of deaths using a structured judgement review tool.

Our performance against the NHS Improvement Single Oversight Framework

NHS Improvement uses a number of national measures to assess access to services and outcomes, and to make and assessment of governance at NHS foundation Trusts. Performance against these indicators acts as a trigger to detect potential governance issues and we are required to report on most of them every three months.

Our performance against these indicators can be seen in the table below.

Key performance indicators

Referral to treatment times	Non-reporting	Target	Annual performance
ED access	95% of patient wait less than 4 hours	95%	87.56%
Cancer access	% cancer patients treated within 62 days of urgent GP referral	85%	82.6%
	% patients treated within 62 days from screening referral	90%	90.33%
Diagnostic waits	Maximum 6 week wait for diagnostic procedures	1%	0.2%

Statements

Statement of Directors' responsibilities in respect of the Quality Report

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

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

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

- The content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18 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 April 2017 to 24 May 2018
  - papers relating to quality reported to the board over the period April 2017 to 24 May 2018
  - feedback from commissioners dated 22 May 2018
  - feedback from local Healthwatch organisations dated 18 May 2018
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 1 September 2017
  - the latest national patient survey dated 5 March 2018 (please note the results are under embargo and cannot be published in this report
  - the latest national staff survey dated 3 March 2018
  - the Care Quality Commission inspection reports dated 1 November 2016 and 3 August 2017; and
  - the Head of Internal Audit's annual opinion of the Trust's control environment dated 21 May 2017.
- 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.
- As the Trust is currently not reporting performance against the RTT indicator due to data quality issues, the Trust directors have a plan in place to remedy this as outlined in further detail below. The scale of the issues identified means that it is not possible for Trust directors to say at this time when the Trust

will return to full national reporting against the RTT standard. An Elective Care Recovery programme has been established to lead on the action necessary to return the Trust to reporting.

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

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

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

By order of the board

Gillian Norton
Chair
24 May 2018

Jacqueline Totterdell
Chief Executive
24 May 2018

2017/18 limited assurance report on the content of the Quality Reports and mandated performance indicators

Independent auditor's report to the Council of Governors of St George's University Hospitals NHS Foundation Trust on the Quality Report

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

We have been engaged by the Council of Governors of St George's University Hospitals NHS Foundation Trust to perform an independent limited assurance engagement in respect of St George's University Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation Trust annual reporting manual 2017/18' and additional supporting guidance in the 'Detailed requirements for quality reports 2017/18' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge; and
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers
- We refer to these national priority indicators collectively as the 'Indicators'
- Respective responsibilities of the directors and Practitioner
- The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS foundation Trust annual reporting manual 2017/18' and supporting guidance issued by NHS Improvement.
- Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:
- The Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation Trust annual reporting manual 2017/18' and supporting guidance
- The Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2017/18'
- 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 2017/18' and supporting guidance and the six dimensions of data quality set out in the "Detailed requirements for external assurance for quality reports 2017/18'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation Trust annual reporting manual 2017/18' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period 1 April 2017 to 24 May 2018
- Papers relating to quality reported to the Board over the period 1 April 2017 to 24 May 2018
- Feedback from commissioners dated 22 May 2018
- Feedback from local Healthwatch organisations dated 18 May 2018
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, dated 1 September 2017
- The national patient survey dated 5 March 2018
- The national staff survey dated 3 March 2018
- The Care Quality Commission inspection reports dated 1 November 2016 and 3 August 2017
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 21 May 2017.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information. The firm applies International Standard on Quality Control 1 (Revised) and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

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

This report, including the conclusion, has been prepared solely for the Council of Governors of St George's University Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting St George's University Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body, and St George's University Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- making enquiries of management
- limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation
- comparing the content requirements of the 'NHS foundation Trust annual reporting manual 2017/18' and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable, measurement techniques that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS foundation Trust annual reporting manual 2017/18' and supporting guidance.

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

Our audit work on the financial statements of St George's University Hospitals NHS Foundation Trust is carried out in accordance with our statutory obligations. This engagement will not be treated as having any effect on our separate duties and responsibilities as St George's University Hospitals NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to St George's University Hospitals NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006.

Our audit work is undertaken so that we might state to St George's University Hospitals NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of St George's University Hospitals NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than St George's University Hospitals NHS Foundation Trust and St George's University Hospitals NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation Trust annual reporting manual 2017/18' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2017/18'; and
- the indicators in the Quality Report identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation Trust annual reporting manual 2017/18' and supporting guidance.

Grant Thornton UK LLP
Chartered Accountants
London

Statement from Wandsworth Clinical Commissioning Group (on behalf of local CCGs)

Wandsworth CCG has worked in close partnership with St George's University Hospitals NHS Foundation Trust during 2017/18. We have worked together to address the quality issues that were identified by the Care Quality Commission in 2016/17. We were pleased to note that the warning notice issued in 2016 under Section 29A of the Health Act 2008, was lifted following the CQC inspection in May 2017.

There have been robust arrangements in place to agree the priorities, monitor the action plan and review the quality of its services. The Clinical Quality Review Group meets monthly and brings together GPs, senior clinicians and managers from both St George's University Hospitals NHS Foundation Trust, Wandsworth CCG, associate commissioners, NHS England and NHS Improvement. We have received assurance that the necessary action and improvement in relation to the CQC warning notice had been made. We have also received assurance throughout the year from the trust in relation to other key quality issues, both where quality and safety has improved and where it occasionally fell below expectations, with remedial plans put in place and learning shared wherever possible.

The development of the Trust Quality Improvement Plan, with the ambition to provide outstanding care, every time, has helped to consolidate the quality areas of concern identified at the CQC inspection. The Plan also identifies quality priorities from the Trust strategic objectives, in a single dashboard that has been regularly monitored by the Clinical Quality Review Group. Wandsworth CCG recognises that the Quality Improvement Plan is an ambitious programme, and that there are areas where further work is required in order to improve the quality of service provision.

On review of the Quality Account for 2017/18, the CCG commends the Trust on the good progress made in delivering the quality priorities set for 2017/18, and acknowledges the hard work that has been put into delivering the specified areas.

The CCG welcomes the continued focus on patient safety, clinical effectiveness and patient experience and is pleased to note that most of the outstanding areas of work relating to quality have been incorporated within the priorities for 2018/19.

We would have liked to have seen a greater emphasis on the Referral to Treatment Target issues that the Trust has faced, with more emphasis on the role of the Clinical Harm Group in monitoring the impact of these issues on patient safety. The Trust has been open about these issues and has worked closely with the CCG. As a result the harm to patients of the long patient waits has been kept to a minimum, and managed appropriately where harm has been identified. A significant amount of work has been undertaken during 2017/18 to address this issue so this could have been highlighted within the data quality section of the report.

This remains an area of concern as there is still some work to be done to ensure that a fully functioning and effective patient tracking system is in place at both the Trust and Queen Mary sites. The CCG would therefore like to see this prioritised in 2018/19, and aligned with the Outpatient Transformation Programme which has been set up to address a number of the outpatient related issues identified.

Staff engagement is an essential part of providing high quality services for patients. This has not been covered in the report although the Trust

has undertaken some work on staff engagement as part of the Quality Improvement Plan. The CCG would support a greater focus on workforce, particularly staff engagement, as part of the priorities for 2018/19.

Overall comments

The new leadership team within the Trust is now embedded and has worked closely with Wandsworth CCG to address a number of the quality concerns at the Trust in 2017/18.

The CCG acknowledges the improvements made in 2017/18, and commends the Trust on the production of a clear quality report that sets out the key priorities for 2018/19. It is in agreement with the priorities as specified in the report and would like to see the following areas also reflected:

- Improvements in data quality to address Referral To Treatment/patient tracking issues
- Workforce/staff engagement

We will continue to work closely with the Trust and look forward to supporting it to deliver the priorities reflected in the quality report in the year to come

Dr Nicola Jones MBE
MBChB DRCOG MRCGP MBA
Chair, Wandsworth Clinical Commissioning Group
22 May 2018

Statement from Healthwatch Wandsworth

Healthwatch Wandsworth are once again grateful for the opportunity to comment on the draft Quality Account. This year's draft version is a significant improvement on last year's, being readable and clearly presented within the prescribed format. It also reflects the Trust's journey towards fresh confidence in what it does well, where progress has been made and openness to aspects still needing improvement.

We are pleased to have been kept up-to-date at regular Quality Committee meetings that oversee and scrutinise quality monitoring and improvement. Moreover, several of our volunteer team have taken part in and supported Patient Led Assessments of the Care Environment and Mock Quality Inspections. Over the year there has been a concerted effort to move the Trust forward from the Care Quality Commission's 'inadequate' rating in 2016, including the removal of a warning notice. There is coherence in the Quality Account about continuing improvements needed, such as patient falls and avoidable ulcers, and in all cases where progress has been partial in 2017-18, remedial work will continue.

Looking ahead in to the next year we welcome the 2018-9 Quality Priorities that include a focus on engagement with patients and fresh work to do more to involve patients in work from earlier stages, including planning and development of services. We have been asking local people about their experiences at the hospital and there have been many positive comments, but there are still a few less positive comments, particularly around communication which is also reflected in the Trusts own data. Working more closely with patients, we hope will begin to reveal how improvements can be made in this area and it will allow patients to help the Trust in its quality improvement intentions. Aims to improve complaints processes and feedback received via the National Impatient Survey and the Friends and Family Test will help support this.

We have been consulted on ambitious plans for a new Patient Partnership and Engagement Group (PPEG) to involve patients in service development, improvement and change. This will require clear and effective governance which will need careful crafting. We are interested to see how details of

the structure, objectives, strategy and impact assessment develop. The PPEG might be invited to have some input into the ongoing work to improve the quality of complaints' responses given that the main themes of communication with the patient, carers and between clinical teams have persisted.

Another major piece of work to sustain patient involvement is the Outpatients Transformation programme, which could prove invaluable to the Trust. Although it is not detailed in the draft of the report, if successful it will go some way to improving patient experiences shared with us around appointments and communication. Apart from the overall effectiveness of access arrangements one particular focus could be on the work to embed patient consent earlier in treatment. Patient representatives could also make a contribution, for example on how best different service users receive information.

With regard to the focus on liaison psychiatry in the Emergency Department we understand this has been undertaken as a national initiative to help identify frequent attenders with mental health needs as well as physical needs to provide for dual diagnosis, treatment and referral. This is to be welcomed as timely and we note that progress will be measured by meeting the national CQUIN targets. A broader measure though could look at further integration of community care for mental health needs when urgent and crisis care might be needed and how the Trusts work together with other partners, including Public Health. Patient information sharing between the services still seems to provide some barriers to joined up care and local protocols would be beneficial if national ones have not been devised. We are also very interested to know how carers will be involved. The focus on dementia care and the steps outlined for implementation following the National Dementia Audit should provide all round improvement benefiting patients, families and staff. We conducted an Enter and View visit to a number of senior health wards in 2017 which revealed how communication and interactions with patients and carers was an important part of care in these wards. We hope to see how carers are increasingly involved as important participants in a patient's care across the hospital.

Following the involvement and communication theme it is encouraging to see a priority given to improving the effectiveness of the discharge process, 'ensuring that patients are equipped with the information they need to manage their health and that they know how to access appropriate support'. This is possibly a complex piece of work given the many considerations needed during discharge, perhaps even extending to areas like patient transport. Getting discharges right will bring significant benefits, not least enabling patients to better manage their situation to help prevent future issues as well as ensuring improvements in recovery and outcomes.

Finally, we have seen determined and exemplary work undertaken for Learning from Deaths and End of Life Care work which should provide a firm foundation for continuing service improvement. It is to be hoped that next year the Trust will be able to focus on developments and progress for more long term and sustainable quality improvements after having developed their close management of quality in the past year. We are pleased to see that there is some progress in bringing patients in as partners in the process. We also hope that the hospital will be able to increasingly work with other local stakeholders on improvements, for example, looking at how services can work better together and simplifying pathways and access. This could be beneficial for many of the quality priorities, such as improving effective discharges.

Clive Norris
Chair Healthwatch Wandsworth
18 May 2018

St George's University Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2018

This representation letter is provided in connection with the limited assurance engagement in respect of St George's University Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2018 for the purpose of reporting on the Quality Report and certain performance indicators contained therein (the "Quality Report") in accordance with the 'Detailed requirements for external assurance for quality reports 2017/18' published by NHS Improvement.

We have fulfilled our responsibilities, as set out in the terms of the limited assurance engagement letter dated 16 May 2018, for the content and preparation of the Quality Report in accordance with the requirements of the Health Act 2009 (the "Act") and the requirements set out in the National Health Service (Quality Accounts) Regulations 2010 (the "Regulations") and subsequent amendments and the requirements set out in the 'NHS foundation trust annual reporting manual 2017/18' (the "NHS FT ARM") and supporting guidance, and the 'Detailed requirements for external assurance for quality reports for 2017/18'.

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

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

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

iii We have provided you with:

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

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

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

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

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

vi The disclosures within the Quality Report fairly reflect our understanding of the Trust's performance over the period covered and have been prepared in accordance with the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance, and the 'Detailed requirements for external assurance for quality reports 2017/18' issued by NHS Improvement.

Yours faithfully

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

Gillian Norton
Chairman
St George's University Hospitals
NHS Foundation Trust
24 May 2018

Jacqueline Totterdell
Cheif Executive
St George's University Hospitals
NHS Foundation Trust
24 May 2018

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

We have been engaged by the Council of Governors of St George's University Hospitals NHS Foundation Trust to perform an independent limited assurance engagement in respect of St George's University Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and additional supporting guidance in the 'Detailed requirements for quality reports 2017/18' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge; and
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

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

Respective responsibilities of the directors and Practitioner

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance issued by NHS Improvement.

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

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2017/18'; 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 2017/18' and supporting guidance and the six dimensions of data quality set out in the "Detailed requirements for external assurance for quality reports 2017/18'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period 1 April 2017 to 24 May 2018;
- papers relating to quality reported to the Board over the period 1 April 2017 to 24 May 2018;
- feedback from commissioners dated 22 May 2018;
- feedback from local Healthwatch organisations dated 18 May 2018;
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, dated 1 September 2017;
- the national patient survey dated 5 March 2018;
- the national staff survey dated 3 March 2018;
- the Care Quality Commission inspection reports dated 1 November 2016 and 3 August 2017 2017; and
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 21 May 2017.

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

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of St George's University Hospitals NHS Foundation Trust as a body, to assist the Councilof Governors in reporting St George's University Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body, and St George's University Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- making enquiries of management
- limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation
- comparing the content requirements of the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement.

The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable, measurement techniques that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance.

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

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

Conclusion

Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2017/18'; and
- the indicators in the Quality Report identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance.

Grant Thornton UK LLP
Chartered Accountants
London
24 May 2018