Quality Report

Quality Report

Statement on quality from the Chief Executive

Twelve months ago, I talked in my introduction to the Quality Report about our Quality Improvement Plan and the efforts across the Trust to improve both the quality and safety of the patient care we provide.

One year on, I am pleased at the progress we have made in a number of areas – and this is down to the efforts of staff across the organisation, in a wide variety of roles.

We want to see a cultural shift in how we look at improving quality and safety, and I believe we have made positive steps in this direction. Of course, there have also been challenges, some significant, which are rightly detailed in this report.

In March 2019, we took a big step forward as an organization when we recommenced reporting our 18 week referral to treatment figures, following a two year hiatus due to data quality concerns.

This means we are now reporting our referral to treatment data again, but – more importantly – it sends a clear message to our patients and the communities we serve that we can now monitor and track people on our waiting lists accurately.

Many of our patients would rightly assume this is something we have always been able to do, but sadly this has not been the case. However, we now have confidence that our waiting lists are robust and accurate, meaning patients are not at risk of suffering harm because of being inaccurately tracked on our systems.

During the past year, we also improved our Care Quality Commission (CQC) inspection rating from Inadequate to Requires Improvement. The Trust was rated Inadequate in November 2016, so moving to Requires Improvement is a significant milestone, but it is far from the end of our improvement journey if we want to provide outstanding care, every time for our patients.

I have said previously that there is a real will within the organisation to make our services safer and better for patients. This is fantastic, but it is clear that staff have not always had access to the tools and techniques they need to make this happen in a sustainable way. This is why I am pleased the work of our Quality Improvement Academy is making progress to embed a quality improvement culture within the Trust.

This will take time – we are a large organisation, and not everyone is open to change - but our work with the Institute for Healthcare Improvement (IHI) has been extremely valuable, and given us the impetus we need to drive this forward.

To the best of my knowledge the information contained in this document is accurate and reflects our view of the quality of the health services we provide.

Finally, I would like to thank the 9,000 staff who work so hard to deliver outstanding care, every time for our patients – they are a credit to the organisation.

Jacqueline Totterdell
Chief Executive
23 May 2019

Our quality priorities for 2019-20

As described in the Trust's strategy, published in April 2019, our vision is to provide outstanding care, every time for our patients, staff and the communities that we serve.

To achieve this, our aim is to embed quality improvement throughout the organisation. Two key tenants to make this ambition a reality are our Quality Improvement Plan (QIP) and our Quality Improvement Academy.

Towards the end of this year we refocused the QIP by reviewing the progress we have made against the Quality Improvement Plan 2018-2019 and external assessments (CQC inspections, national surveys and local and national audit) to ensure that we are both describing the change projects that will ensure we achieve our vision of outstanding care, every time – and that we are focusing on the areas we need to deliver upon to improve our rating of 'Requires Improvement' from the CQC.

To ensure that the QIP is not working in isolation the refocused QIP for 2019/20 has been integrated with the Trust Annual Plan 2019-2020 and aligned to the Trust's Corporate Objectives and Trust Strategy.

To deliver sustainable change we have established the Quality Improvement Academy (QIA) this is a key enabler for driving and implementing sustainable change. It is through the QIA that the Trust is building quality improvement capacity and capability throughout the organisation to create the right conditions for sustainable success.

Supporting programmes such as Getting It Right First Time (GIRFT) and High Performing Teams are led by the Quality Improvement Academy. GIRFT uses national data to identify variations and outcomes and is used by a service to reduce unwanted variations in practice.

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Our quality priorities and why we chose them

The quality objectives for 2019-2020 were informed by reviewing themes highlighted from our ward and departmental accreditation scheme (as described on page 19 of this report) and progress against the Quality Improvement Plan 2018-2019.

We also reviewed information from external assessments and local and national audit and the national priorities for sepsis, safe staffing, falls, and infection control and actions remaining open from the CQC action plan 2018-2019. These include as part of the Trust's on-going improvement plans to improve our 4 hour performance in ED and time of arrival to receiving treatment in ED.

The key priorities for quality improvement have also been identified through analysis of serious incidents, incidents and feedback from national and local surveys and Healthwatch 'Enter and View' visits.

Each quality 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.
- Patient experience: meeting our patients' emotional as well as physical needs.
- Clinical effectiveness: providing the highest quality care, with world class outcomes whilst also being efficient and cost effective.

Improving patient safety

The patient safety priorities we will focus on in 2019/20 are inter- linked and with the establishment of a critical care outreach service will have a significant impact on supporting our staff to manage deteriorating patients promptly and effectively.

Treatment escalation plans

What success will look like: We will ensure that all non-elective inpatients have a treatment escalation plan (TEP) in place within 24 hours of admission as described earlier in this report.

Identification, protection and care of patients who lack mental capacity to make certain decisions

What success will look like: We will demonstrate through audit of healthcare records that patients who lack mental capacity are identified promptly, and have proper protection and care. We will achieve compliance with our training targets for MCA training.

Recognising the deteriorating patient

We will ensure that inpatients that deteriorate are recognised and treated promptly; consistently identifying the deteriorating patient so that we can intervene promptly and improve outcomes for patients.

What success will look like: We will identify deteriorating patients early and so reduce the number of cardiac arrests compared with the 2018/19 baseline. We will improve the outcomes in our audits on appropriate response to the National Early Warning Score (NEWS2).

Improving patient experience

Provide a responsive, high quality complaints service.

This priority is being brought forward from 2018/19, our ambition is to provide a complaints service based on the principles in 'My expectations for raising concerns and complaints' (Parliamentary Health Service Ombudsman and others 2014) 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.' In 2018/19 we made some of the changes to deliver against this priority and will deliver the improvement we want to see in 2019/20.

What success will look like: We will achieve our targets for responding to complaints by the end of September 2019.

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

This priority is being brought forward from 2018/19. 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. During 2018/19 the Patient Experience and Partnership Group (PPEG) has been established; patient partners have been recruited and the first year of the Patient Experience and Partnership Strategy is being delivered.

What success will look like: We will deliver year one of the strategy and develop the strategy for the next three years. The PPEG strategy is published to the Trust's website www.stgeorges.nhs.uk/patients-and-visitors/patient-involvement/ppeg.

Improve immediate feedback from patients through the Friends and Family Test (FFT) by increasing response rates for both inpatient and outpatient services

This priority is being brought forward from 2018/19. 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. We have not achieved the improvement in the response rate in outpatients to 20%. We also need to improve response rates to the FFT in other services. A number of changes have been made in the final quarter of 2018/19; these include the FFT being made available on the Trust website and the launch of FFT by text message. We are taking this priority forward into 2019/20 to ensure that action taken achieves the improvement we want to see and to ensure that learning is extended to other areas where response rates need to improve.

What success will look like: We will achieve a response rate of at least 20% by the end of 2019-20 for both inpatient and outpatient services and the emergency department.

The Friends and Family Test (FFT) is a feedback tool that asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience.

The national clinical audits and national confidential enquiries that we are eligible to participate in during 2018/19 are listed below in Table 1.

Table 1

Title		Relevant	Participating
Adult Cardiac Surgery		✓	✓
Adult Community Acquired Pneumonia		✓	✓
BAUS Urology Audit - Cystectomy		✓	✓
BAUS Urology Audit – Female Stress Urinary Incontinence (SUI)		X	N/A
BAUS Urology Audit - Nephrectomy		✓	✓
BAUS Urology Audit - Percutaneous Nephrolithotomy (PCNL)		✓	✓
BAUS Urology Audit – Radical Prostatectomy		✓	✓
Cardiac Rhythm Management (CRM)		✓	✓
Case Mix Programme (CMP) (ICNARC)	Neurology Intensive Care Unit	✓	✓
	General Adult Intensive Care	✓	✓
	Cardiothroracic Intensive Care Unit	✓	✓
Child Health Clinical Outcome Review Programme	Cancer in Children, Teens, and Young Adults	✓	✓
	Long Term Ventilation	✓	✓
Elective Surgery (National PROMs Programme)		✓	✓
Falls and Fragility Fractures Audit Programme (FFFAP)*	Fracture Liaison Service Database	✓	✓
	Inpatient Falls	✓	✓
	National Hip Fracture Database	✓	✓
Feverish Children (care in emergency departments)		✓	✓
Inflammatory Bowel Disease programme / IBD Registry		✓	✓
Learning Disability Mortality Review Programme (LeDeR)		✓	✓
Major Trauma Audit		✓	✓
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection		✓	✓
Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal Mortality Surveillance	✓	✓
	Perinatal Mortality and Morbidity confidential enquiries	✓	✓
	Maternal Mortality surveillance and mortality confidential enquiries	✓	✓
	Maternal morbidity confidential enquiries	✓	✓
Medical and Surgical Clinical Outcome Review Programme	Perioperative Diabetes	✓	✓
	Acute Bowel Obstruction	✓	✓
	Pulmonary Embolism	✓	✓
Mental Health Clinical Outcome Review Programme		X	N/A
Myocardial Ischaemia National Audit Project (MINAP)		✓	✓
National Asthma and COPD Audit Programme	Pulmonary Rehabilitation	✓	✓
	COPD - Secondary Care Audit	✓	X
	Adult Asthma - Secondary Care Audit	✓	✓
National Audit of Anxiety and Depression		X	N/A
National Audit of Breast Cancer in Older People		✓	✓
National Audit of Cardiac Rehabilitation		✓	✓
National Audit of Care at the End of Life (NACEL)		✓	✓
National Audit of Dementia		✓	✓
National Audit of Intermediate Care		✓	N/A

Title		Relevant	Participating
National Audit of Percutaneous Coronary Interventions (PCI)		✓	✓
National Audit of Pulmonary Hypertension		X	N/A
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)		✓	✓
National Bariatric Surgery Registry (NBSR)		✓	✓
National Bowel Cancer Audit (NBOCA)		✓	✓
National Cardiac Arrest Audit (NCAA)		✓	✓
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)		✓	✓
National Clinical Audit of Psychosis		X	N/A
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)		✓	✓
National Comparative Audit of Blood Transfusion programme*	Use of Fresh Frozen Plasma and Cryoprecipitate in neonates and children	✓	✓
	Management of massive Haemorrhage	✓	✓
National Congenital Heart Disease (CHD)		X	N/A
National Diabetes Audit – Adults*	Core Audit	✓	✓
	Foot Care Audit	✓	✓
	Inpatient Audit (NaDia)	✓	✓
	Pregnancy in Diabetes	✓	✓
National Emergency Laparotomy Audit (NELA)		✓	✓
National Heart Failure Audit		✓	✓
National Joint Registry (NJR)		✓	✓
National Lung Cancer Audit (NLCA)		✓	✓
National Maternity and Perinatal Audit (NMPA)		✓	✓
National Mortality Case Record Review Programme		✓	✓
National Neonatal Audit Programme (NNAP)		✓	✓
National Oesophago-gastric Cancer (NAOGC)		✓	✓
National Ophthalmology Audit		X	N/A
National Paediatric Diabetes Audit (NPDA)		✓	✓
National Prostate Cancer Audit		✓	✓
National Vascular Registry		✓	✓
Neurosurgical National Audit Programme		✓	✓
Non-Invasive Ventilation – Adults		✓	✓
Paediatric Intensive Care (PICANet)		✓	✓
Prescribing Observatory for Mental Health (POMH-UK)		x	N/A
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)*	Antibiotic Consumption	✓	✓
	Antimicrobial Stewardship	✓	✓
Sentinel Stroke National Audit programme (SSNAP) Royal College of Physicians		✓	✓
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance		✓	✓
Seven Day Hospital Services		✓	✓
Surgical Site Infection Surveillance Service		✓	✓
UK Cystic Fibrosis Registry		X	N/A
Vital Signs in Adults (care in emergency departments)		✓	✓
VTE risk in lower limb immobilisation (care in emergency departments)		✓	✓

The national clinical audits and national confidential enquiries for which data collection was completed during 2018/19 are listed in Table 2 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. For the remaining projects that the Trust participated in (Table 1) the 2018/19 data collection completes during 2019/20 and therefore submission rates are not available at the time of this report.

Table 2

Title		Submission rate (%)
Case Mix Programme (CMP) (ICNARC)	Neurology Intensive Care Unit	100%
	General Adult Intensive Care	100%
	Cardiothroracic Intensive Care Unit	100%
Child Health Clinical Outcome Review Programme	Cancer in Children, Teens, and Young Adults	100%
Falls and Fragility Fractures Audit Programme (FFFAP)*	Inpatient Falls	100%
	National Hip Fracture Database	98%
Feverish Children (care in emergency departments)		100%
Learning Disability Mortality Review Programme (LeDeR)		100%
Major Trauma Audit		94%
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection		100%
Maternal, New-born and Infant Clinical Outcome Review Programme	Perinatal Mortality Surveillance	100%
	Perinatal Mortality and Morbidity confidential enquiries	100%
	Maternal Mortality surveillance and mortality confidential enquiries	100%
Medical and Surgical Clinical Outcome Review Programme	Perioperative Diabetes	100%
	Pulmonary Embolism	100%
National Audit of Breast Cancer in Older People		100%
National Audit of Care at the End of Life (NACEL)		41%
National Audit of Dementia		100%
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)		100%
National Comparative Audit of Blood Transfusion programme*	Use of Fresh Frozen Plasma and Cryoprecipitate in neonates and children	100%
	Management of massive Haemorrhage	100%
National Joint Registry (NJR)		94.2%
National Lung Cancer Audit (NLCA)		100%
National Maternity and Perinatal Audit (NMPA)		100%
National Mortality Case Record Review Programme		87%
National Neonatal Audit Programme (NNAP)		100%
National Oesophago-gastric Cancer (NAOGC)		100%
National Prostate Cancer Audit		100%
Neurosurgical National Audit Programme		100%
Paediatric Intensive Care (PICANet)		100%
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)*	Antibiotic Consumption	100%
	Antimicrobial Stewardship	100%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance		100%
Seven Day Hospital Services		100%
Surgical Site Infection Surveillance Service		100%
Vital Signs in Adults (care in emergency departments)		100%
VTE risk in lower limb immobilisation (care in emergency departments)		100%

National clinical audits – action taken

The reports of 35 national clinical audits were reviewed by St George's University Hospitals NHS Foundation Trust in 2018/19 and we are taking the following actions to improve the quality of healthcare provided.

Chronic Obstructive Pulmonary Disease (COPD): National Report Pulmonary Rehabilitation 2018
We will continue to improve GP and primary care engagement to increase referral numbers for eligible patients
We will work towards the Pulmonary Rehabilitation Services Accreditation Scheme (PRSAS)
National pulmonary rehabilitation audit data collection will be monthly from March 2019
Local audit projects to continue
COPD: Time to Integrate Care - Organisational Audit Report 2018
The service is working to reduce admissions and re-admissions
More COPD patients to be cared for in respiratory wards
Improved access to integrated, cross sector respiratory services
Improved access to respiratory care at weekends
An action plan was put in place to address these aims, the service reports piloting project to promote collaboration across primary and secondary care settings
COPD: Working Together – National Clinical Audit Report 2018
The national report listed a number of recommendations:
Ensure spirometry results are available for all admissions with acute exacerbation of COPD
Ensure all current smokers are identified and offered smoking cessation pharmacotherapy
MBRRACE-UK Perinatal Mortality Surveillance Report – Jan to Dec 2016
Having reviewed the recommendations in the report the service confirmed that it is:
Renewing efforts to focus on reducing stillbirths
Using the National Perinatal Mortality Review Tool to review all appropriate stillbirths and neonatal deaths
Ensuring data captured is of the highest quality, especially with complex and high-risk cases
Working to ensure all parents of babies who die are provided with unbiased counselling for post-mortem
Carrying out placental histology for all stillbirths and if possible all anticipated neonatal deaths
National Audit of Breast Cancer in Older People (NABCOP)
The report published in June 2018, the performance of the service at St George's was in line with national averages
The report has been used to identify opportunities to improve further
National Prostate Cancer Audit
Clinical Nurse Specialists are now in post and are can be contacted easily by patients helping to reduce anxiety that may be experienced after surgery
Patient reported urinary functional outcomes are in line with the national performance
UK Parkinson's Clinical Audit – Transforming Care 2017
Improved provision of information at diagnosis by having information packs for newly-diagnosed patients available in outpatient clinic and ensure all neurologists are aware of them
Development of a prompt sheet for patient completion prior to appointment in waiting area, to aid with patient decision making, these provide space for patients to identify three key areas to address in clinic
Improving documentation and assessment/management of fracture risk, through preparation of new pathway and protocol to assess bone health and fracture risk
National Adult Bronchiectasis Audit 2017
The service is working to maintain and improve standards relevant to the management of bronchiectasis, these include:
85% of patients to have an up to date chest x-ray or CT scan
71% of trust patients were found in the audit to have been taught chest clearance techniques. The service exploring the possibility of a joint bronchiectasis and physiotherapy clinic to improve this performance

National Paediatric Bronchiectasis Audit 2017
The service is developing closer working with Speech & Language Therapy for increased support
National Audit of Dementia (NAD): Spotlight Audit 2017-2018
The emergency department have introduced 4AT (delirium screen) for all patients over the age of 65 and have a specific delirium pathway
We have introduced an automatic electronic delirium assessment for all inpatients over the age of 16. Training on applying the assessment is being provided for doctors. This electronic system will allow for easier auditing, so issues will be identified promptly
Piloting new nursing screening for development of delirium on selected medical wards to improve early recognition of delirium
National Neonatal Audit Programme 2018
The service has focussed on neonatal hypothermia in the delivery suite and has purchased new monitoring equipment, re-arranged the team and is using heated mattresses to warm babies in the delivery suite
The service will be focusing on the rate of separation of mums and term and late preterm babies in the coming year
National Paediatric Diabetes Audit (NPDA) Report 2018
St George's was declared an alarm level outlier for the metric 'case-mix adjusted mean HbA1C' by NPDA, this is an indicator of diabetic control
The service has put an action plan in place to improve:
In August 2017, the service set up a weekly pre-clinic meeting held the day before the clinic where key issues of the patients attending the appointments the following day are highlighted
Patients due annual review have blood forms pre-printed and ready to be given at their appointments
Non-compliers with annual review checks are also identified and special attention given to complete their investigations
National Emergency Laparotomy Audit (NELA)
The following improvement actions have been taken:
Risk assessment is now part of trainee doctor induction programme and is highlighted on emergency theatre booking forms
Theatre delays are discussed at care group level and an emergency theatre protocol prioritising patients according to risk is being developed
National Joint Registry (NJR) Annual Report 2018
St George's does not perform routine joint replacements; these are conducted by South West London Elective Orthopaedic Centre
St George's is not an outlier on any of the NJR measured criteria and compliance on reporting, consent rate, and linking (records with a valid NHS number) all exceeded the benchmark of 95%
National Oesophago-Gastric Cancer Audit (NOGCA) 2018
The service is working on the following key areas in the coming year:
Exploring the possibility of developing a direct access clinic for GPs to refer for Oesophago-Gastroduodenoscopy (OGD)
A new clinic for investigations allows patients to have OGD earlier; this is being coupled with GP education sessions
Royal College of Emergency Medicine (RCEM): Procedural Sedation in Adults Clinical Audit 2017/18
The service has increased training and education in the emergency department on procedural sedation and the use of the procedural sedation proforma to ensure the RCEM standards are met
The service is carrying out local audit to monitor the impact of the training
Royal College of Emergency Medicine (RCEM) : Fractured Neck of Femur Clinical Audit 2017/18
To improve recording and acting on pain scores in the emergency department an education programme for staff has been put in place and new guidelines are being developed
Royal College of Emergency Medicine (RCEM): Pain in Children Clinical Audit 2017/18
To improve documentation of the management of pain in children new documentation and electronic records are being introduced. Education in the emergency department is in place to raise awareness

The National Audit of Cardiac Rehabilitation (NCAR) 2018
The service is participating in London wide cardiac rehabilitation review with a view to improving uptake of female patients
Fracture Liaison Service Database (FLS-DB)
A new referral system is in place to make it easier for nurses and technicians to refer patients to the integrated falls service
The Fracture Liaison Service nurses now telephone all patients after 3 months to check compliance, the national report had highlighted a decline in monitoring in 2017
National Heart Failure Audit 2016/17 Summary Report
The service is exploring options for increasing the proportion of Heart Failure patients who receive specialist input – there is ongoing work with the CCG to improve access to cardiac rehabilitation
Myocardial Ischaemia National Audit Report 2017
The service is exploring reasons why there is a difference in the call to balloon times for patients admitted directly to the Heart Attack Centre at St George's, and those transferred in. Areas to explore are possible delays in decision making (at either end), delays in the process of transferring patients from the referring hospital, or delays in door-to-balloon times
National Audit of Percutaneous Coronary Interventions (PCI)
The service is investigating issues with data completion rates for non-ST-elevation myocardial infarction (NSTEMI) patients, specifically where they had been admitted from. Over the coming year, the audit team will be providing administrative support to improve data collection and so the information available to identify areas where the service could be improved
National Vascular Registry audit 2018
70% of patients at St George's were discussed at MDT meetings compared to the national average of 83%. This is being investigated further and improvement in this area is being prioritised by the service
The national report also recommends that local services review their current pathways for vascular procedures. The times from diagnosis to treatment at St Georges are amongst national leading times for carotid endarterectomy and AAA patients
British Association of Urological Surgeons (BAUS): Cystectomy
No recommendations from the report which showed that data quality was high and a 0% 90day mortality rate which is below the national average of 2.21%
British Association of Urological Surgeons (BAUS): Nephrectomy
Report released in Aug 2018. While it made no recommendations on the basis of the results, data quality was reported to be high, with median length of stay in line with the national average, and mortality lower than average
British Association of Urological Surgeons (BAUS): Radical Prostatectomy
Report released in September 2018. No recommendations were made on the basis of the results, but the audit showed that generally we operate on higher risk patients at St George's than the national average
British Association of Urological Surgeons (BAUS): Percutaneous Nephrolithotomy (PCNL)
Report released in May 2018. It made no recommendations on the basis of the results. St George's was generally in line with national average on the key measures
National Bowel Cancer Audit (NBOCA) 2018
Based on the report, the service confirmed that the trust is working on the below actions:
Cancer data management team to continue with use of Infoflex (an information management software tool) which has been shown to maintain high data quality
National Hip Fracture Database (NHFD) Annual Report 2018
The audit lead for the project reports that the service is responding to the national report with the following actions:
Audit and look to putting together a business case to provide 7 day physiotherapy cover, which will improve rates of first day mobilisation. Review bed capacity modelling for patients admitted to orthopaedic wards to improve number of patients on ward within four hours of admission

Surveillance of Surgical Site Infections (SSI) in NHS hospitals in England, 2017-2018
Report published in December 2018. St George's SSI rate is higher than the national average on all measures, although never by more than 0.2%
Falls and Fragility Fractures Audit Programme (FFFAP): Inpatient Falls
The service is working to link up the National Audit Inpatient Falls and the National Hip Fracture Database to ensure that any gaps in care identified when patients suffer from inpatient falls and fractured neck of femur injuries are identified
National Mortality Case Record Review Programme
See Learning from Deaths
Intensive Care National Audit and Research Centre (ICNARC) (Case mix)
This audit has three streams focussed on improving the quality of care in Intensive Care Units, Neurology, General Adult and Cardiothoracic in Intensive Care. The Trust has submitted 100% of the data for these streams; collection is underway for Q4 and closes in May 2019. The annual report is due to be published later this year
Serious Hazards of Infection (SHOT)
Issues regarding the wrong blood put into tubes have been highlighted and in response a Trust wide campaign to raise awareness was conducted. The service is proposing a full end to end transfusion tracking system and the business case is being developed

*Based on information available at the time of publication

Local clinical audits

The reports of 10 local clinical audits were reviewed by St George's University Hospitals NHS Foundation Trust in 2018/19 and we intend to take the following actions to improve the quality of healthcare provided.

Controlled Drugs Audit
This audit relates to security, storage and record keeping of controlled drugs (CD)
A new standard operating procedure (SOP) has been published to support staff when reviewing incidents involving CD discrepancies
All liquid CDs must now be fitted with an ENFit® compatible bottle adapter, to minimise discrepancies due to repeated small volumes lost when measuring out doses
Venous Thromboembolism (VTE) Audit
This audit looks at four areas; whether a VTE Risk Assessment was completed and filled in correctly upon patient admission; whether VTE risk assessments were done every 24 hours; whether appropriate prophylaxis was provided
Improvement actions:
The Thrombosis Group to continue to provide education and training to promote awareness of weight based dosing
The Trust has rolled out its electronic patient management system (iClip) throughout all wards; once established this will improve data collection
Local Safety Standards for Invasive Procedures (LocSSIPs) Audit
This audit project looks at reviewing the Trusts use of LocSSIPs for all invasive procedures, and looks at how these are applied in both the theatre setting and outside of a theatre setting
Improvement actions:
The audit tool is being reviewed to ensure it is suitable for the wide range of procedures being audited
Early Warning Score (EWS)
This audit measures the response for patients identified as being at risk of clinical deterioration. This links to our quality priority 'recognising and responding to the deteriorating patient'
Improvement actions:
Better performing wards providing mentorship to other wards
Quality improvement projects being undertaken with some teams, in order to analyse reasons why observations are poorly recorded or reported

Patient-Led Assessments of the Care Environment (PLACE)
PLACE assessments are an annual appraisal of the non-clinical aspects of healthcare settings; they are carried out by teams made up of staff and members of the public. The main actions that were highlighted are:
Following reports of potential gaps in accessibility for patients, funding has been provided by the St George's charity to audit the Trust on the disability access. This audit will be completed by the not for profit organization, AccessAble
Reviewing standards of cleaning, after an increased number of failures against cleaning in particular areas
Introduction of 24 hour access to catering services for visitors and carers
Looking at the possibility of providing a lockable storage solution for all patients
Mental Capacity Act (MCA)
The annual report for MCA and Deprivation of Liberty Safeguards (DoLS) was reviewed in July 2018, improvement actions include:
Staff across disciplines being invited to participate in the audits to provide education and information to team members who can then lead in supporting others to deliver best practice in relation to the MCA
Monthly Deep Dive Audits in different clinical areas
Joint work with the Corporate Nursing Quality Team underway to analyse and interpret questions from the monthly observatory audit that relate to the use of restrictions and restraint
Further staff knowledge audits are planned on a rolling basis through the year
Human Tissue Act (HTA)
This report was covered both the Human Application License Audit for Stem Cell Donor Consent & Work Up, along with the Human Application License Audit in Theatres
Knowledge based audits that are being conducted locally and reviewed throughout the year
Cervical Screening
This annual report was reviewed in November 2018, and reported the following actions:
Regular meetings are taking place with the sector Cervical Screening Provider Lead (CSPL's)
The colposcopy unit is appointing a clinical nurse specialist to support the anticipated increase in colposcopy envisaged with the introduction of HPV Primary Screening
Working to improve the service provided for women attending their Cervical Screening, and onward referral to Colposcopy if required
Local Cervical Screening updates and training for sample takers is being provided by SWL Pathology
Falls Prevention
This work builds on the National Inpatient Falls Audit, and is overseen by a dedicated Falls Prevention Coordinator, based on this local project a number of actions have been highlighted:
Falls champions for each ward are in place, they review incidents to highlight patterns, trends and themes and share results with other wards
Falls working group with multi-disciplinary team involvement has been established to review audit results and agree a quality improvement plan
Joint partnership working with Tissue Viability Nurses, to share and develop similar approaches and learning as part of the wider patient safety perspective
Safeguarding
The annual safeguarding report agreed that a service development plan would be produced and implemented:
Reviewing the Trust's Safeguarding Children's training and capacity
Closer integration of Domestic Violence into both Children and Adults safeguarding work at the Trust
Reviewing internal governance, including a review of the Safeguarding Children Committee
Working closely with Clinical Commissioning Group colleagues and other partners to improve outcomes

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 2018 Research Excellence Framework, 100% of the research outputs submitted by St Georges and the University of London 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 2018/19 St George's recruited 13,082 patients onto the NIHR portfolio adopted studies.

Our Commissioning for Quality and Innovation (CQUIN) performance

A proportion of St George's University Hospitals NHS Foundation Trust's income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between St George's 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 2018/19 £15.5 million of our income is conditional on achieving quality improvement and innovation goals. In 2017/18 the income achieved for achieving quality improvement and innovation goals was £13.5 million.

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".

A group of core services were inspected by the CQC in March 2018; the report was published in July 2018 and our rating improved from Inadequate to Requires Improvement. There were services that were rated as 'good' and in the caring domain we were pleased to receive a rating of 'good', in some areas services were assessed as outstanding. For detailed CQC reports relating to St George's, visit the CQC's website at www.cqc.org.uk.

During 2018/19, the Trust took proactive steps to deliver improvements within our cardiac surgery service. At the start of the year, we commissioned Professor Mike Bewick, former deputy medical director of NHS England, to carry out an independent review of cardiac surgery at the Trust following concerns we had about team-working, and mortality rates that were higher than expected when compared with the national average.

We accepted Professor Bewick's recommendations in full, and have introduced a series of improvements within the service as a result – including moving to a consultant of the week model (which is considered best practice). We also appointed two new consultants, and all new cardiac surgery cases are now reviewed by a multi-disciplinary team on a daily basis.

In December 2018, we appointed Mr Steve Livesey, an experienced cardiac surgeon previously based in Southampton, to provide clinical leadership within the service. In addition, we arranged for the most complex cardiac surgery operations to be temporarily transferred to other cardiac surgery centres – and trainees to be removed from the service in the medium-term – to enable us to deliver the required improvements.

The Trust continues to provide a safe cardiac surgery service, and this was confirmed by the Care Quality Commission (CQC) following an inspection of the service in August 2018. They also confirmed that further improvements are needed, and our plan to deliver the required changes within the service are being overseen by an independent scrutiny panel set up by NHS Improvement in September 2018.

A separate panel of independent experts is also reviewing all patient deaths following cardiac surgery that occurred between April 2013 and September 2018. The panel is examining the safety and quality of care that patients received during this period.

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 carried out of services provided by 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 2018/19 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:

- 98.9% for admitted patient care
- 99.6% for outpatient care; and
- 94.5% for accident and emergency care

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

- 100% for admitted patient care
- 100% for outpatient care; and
- 99.9% for accident and emergency care

*Source – SUS Data quality reports as at 10/04/19

Data Security and Protection toolkit

The Information Governance Toolkit closed at the end of 2017/18 and has been replaced by the Data Security and Protection Toolkit which sets out the standards for management of information in the NHS. The Trust is compliant with all the mandatory requirements of the NHS DSPT.

Payment by Results

St George's University Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2018/19.

Improving data quality

In January 2016, St George's University Hospitals NHS Foundation Trust became concerned about the quality and robustness of data being reported; particularly the management of referral to treatment (RTT) waiting lists. The Trust has taken, and will be taking, the following actions to improve data quality.

An external review of RTT data and patient tracking systems identified serious issues relating to Trust operational processes and technology. These issues created significant risks to the quality of care and patient safety as well as flaws with reporting 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 the Trust suspended national reporting of RTT data in June 2016 and made a decision not to recommence reporting until confidence could be assured on the accuracy and quality of data available.

In September 2017 the appointed Chief Operating Officer took over the management of the dedicated waiting list improvement programme, the Elective Care Recovery Programme. Following the formation of the programme a systemic and detailed audit of the waiting lists for patients at the St George's site was undertaken. This resulted in an increase in the number of patients reported to be waiting over 18 weeks on an open pathway (yet to have received treatment). There was also an increase in the number of patients who had reportedly waited over 52 weeks. To ensure that no patients came to harm as a result of waiting longer on the waiting list a Clinical Harm Review panel was established to review any patients identified by the validation exercise that may have suffered some harm.

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

Clinical teams have since 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.

In March 2018 the Trust introduced a new Patient Tracking List (PTL) for patients waiting for elective care at Queen Mary's Hospital. Plans are being created to migrate Queen Mary's Hospital data onto the same Patient Administration System (PAS) as used at St George's. This will ensure consistency of pathway management and create seamless management of patients across both hospital sites. Migration is currently planned for autumn 2019 subject to Trust Board approval.

In December 2018 the Trust underwent an external assessment of its data quality and operational processes. This assessment was jointly commissioned by the Trust and Merton and Wandsworth CCG. The

aim of the assessment was to provide assurance of the accuracy of Trust data and operational readiness to return to national reporting on RTT performance. There were three conditions outlined in the report which needed to be met, these were resolved and as a result the recommendation from the external assessment was for the Trust to return to national reporting from February 2019 using January 2019 performance data.

The full external report on our data quality was taken through our governance framework. In January 2019 the Trust Board had sufficient assurance on data quality to make the decision to return to national reporting of our referral to treatment times.

A separate assessment will be carried out before data from Queen Mary's Hospital is moved to the patient administration system used at St George's Hospital. This will ensure that data quality on the St George's Hospital system will not be adversely affected.

Learning from deaths

During 2018/19 1,550 of St George's University Hospitals NHS Foundation Trust's patients died. This comprised the following number of deaths which occurred in each quarter of this reporting period:

Table 1

Number of deaths 2018/19	Q1	Q2	Q3	Q4
	366	342	395	447

By 31 March 2019 1346 case record reviews have been carried out in relation to 87% 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:

Table 2

Case record review or investigation	Q1	Q2	Q3	Q4
	300	284	343	419

Ten representing 0.7% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter this consisted of:

Table 3

Problems in healthcare	Q1	Q2	Q3	Q4
Number	2	3	3	2
% of all deaths	0.67%	1.06%	0.87%	0.48%

These numbers have been estimated using our locally developed online screening tool and structured review, which is based on the Royal College of Physicians (RCP) tool. We have a dedicated independent team supporting the bereavement office, and we ensure that we review 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. 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 and the duty of candour is carried out. 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.

There were no (0) case record reviews and no (0) investigations completed after 30 April 2018 which related to deaths which took place before the start of the reporting period. All case record reviews and investigations for deaths in 2017/18 are included in the report for the 2017/18 reporting period.
What we have learnt and action taken

Management of deterioration and establishing ceilings of care

Although a large number of patients have good and early discussions about resuscitation, reviews continue to identify patients where such discussions should have occurred, but did not, or could have occurred earlier. Issues that have been highlighted to care groups include the appropriateness of transfer between hospitals and the need for consultant level discussion; frequency of consultant review; multi-disciplinary team (MDT) discussion and decision making between teams; ceilings of care and appropriateness of do not attempt cardiopulmonary resuscitation (DNACPR) decisions.

Cases have been referred to the deteriorating adults group for investigation when 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. This indicates that we need to improve our discussions with patients and families about establishing ceilings of care. In 2018/19 we launched the Treatment Escalation Plan; this documents these discussions and the agreed plan of care for an individual patient.

Medical Examiner

From April 2019, a national system of medical examiners will be introduced to provide much-needed support for bereaved families and to improve patient safety. The expectation of the National Medical Examiner (ME) is that from April 2019 NHS Trusts will be designing and implementing local systems and that by the end of March 2020 all deaths in secondary care will be subject to scrutiny by a local ME.

In January 2019 the Trust approved a business case to introduce an ME office and the implementation plan is progressing under the guidance of the Chief Medical Officer and Chief Nurse. The ME office will build on established good practice in bereavement and independent mortality review and we are confident that the Trust will meet the National Medical Examiner's requirements by the end of 2019/20.

Guardian of safe working

We have a Guardian of Safe Working who ensures 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 doctors 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.

During 2018/19 a business case has been developed and approved to extend our health roster system to medical staff. The project team has been established and roll out began at the end of Q4 2018/19. Twenty services will go live before August 2019.

Standards for Seven day Services

The Trust is compliant with standards 5, 6 and 8 for seven day services and has improved compliance with standard 2 (all emergency admissions must be seen by a consultant within 14 hours of admission) from 70% to 82% in the past two years. To be fully compliant with standard 2 would require a significant increase in staffing resources in certain specialities and therefore opportunities for pathway redesign and alternative ways of delivering a consultant review within 14 hours are being explored.

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. 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)	Apr 15 - Mar 16	Jul 15 - Jun 16	Oct 15 - Sept 16	Jan 16 - Dec 16	Apr 16 - Mar 17	July 16 - June 17	Oct 16 - Sep 17	Oct 17 - Sep 18
SHMI	89.5	88.2	86.5	84.4	83.6	83.8	82.5	83.9
Banding	Lower than 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	39.1%	42.8%	48.9%	51.3%	51.1%	52.4%	50.9%	50.6%

Source: NHS Digital

St George's considers that this data is as described 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.

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.

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 two clinical procedures, which are hip replacement or knee replacement (the varicose vein and groin hernia PROMs programmes were discontinued in October 2017). 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.

Percentage of patients reporting an increase in health following surgery		2013-14		2014-15		2015-16		2016-17		2017-18	
		SGH	National average	SGH	National average	SGH	National average	SGH	National average	SGH	National average
Hip replacement	EQ-5DTM	86	87.9	90	88.2	100	88.4	77	89.1	71	90
	EQ-VAS	65	64.2	80	65.1	58	65.6	75	67.2	43	68.3
	Specific	81	96	100	96.4	94	96.5	71	96.7	75	97.2
Knee replacement	EQ-5DTM	60	80.3	60	80.5	69	80.7	100	81.1	0	82.6
	EQ-VAS	50	54.6	50	55.3	33	56.4	40	57.5	33	59.7
	Specific	80	93	82	93.2	85	93.6	100	93.8	33	94.6

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. 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 and we consider it likely that this explains our variance from the national average score. For example where we have scored 0 in 2017/18 we know that this concerns two patients, one patient felt there had been no change and the other patient declined to participate.

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 2018-19.

Readmissions	2016-17			2017-18			2018-19		
	Under 16	16 and over	Total	Under 16	16 and over	Total	Under 16	16 and over	Total
Discharges	14102	46946	61048	14201	47572	61773	13975	48206	62181
28 day readmissions	659	4236	4895	651	4428	5079	751	4006	4757
28 day readmissions rate	4.67%	9.02%	8.02%	4.58%	9.31%	8.22%	5.37%	8.31%	7.65%

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	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
St George's University Hospitals	66.6	68.8	68.6	67.9	66	65
National average	68.1	68.7	68.9	69.6	68.1	68.6
Highest (best)	84.4	84.2	86.1	86.2	85.2	85
Lowest	57.4	54.4	59.1	58.9	60	60.5

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 NHS National 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 of the Trust as a place to receive care, we achieved an average score.

Staff recommendation	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
St George's University Hospitals	67%	73%	71%	70%	73%	69%
Average for Acute	66%	68%	70%	68%	69%	70%
Highest Acute Trust	94%	93%	93%	95%	86%	87%
Lowest Acute Trust	40%	36%	46%	48%	47%	41%

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

Friends and Family Test	2016-17		2017-18		2018-19*	
St George's University Hospitals	A&E	Inpatient	A&E	Inpatient	A&E	Inpatient
Response rate	23.10%	30.76%	20.19%	25.50%	26.20%	26.40%
% would recommended	83.80%	95.81%	84.26%	96.24%	87.00%	97.00%
% would not recommend	10.51%	1.29%	10.39%	1.08%	8.50%	1.00%
* 2018-19 data to Feb 19						

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	2018-19
St George's University Hospitals					
Trust apportioned cases	38	29	36	16	31
Trust bed-days	254,213	273,493	287,962	296,981	282,339
Rate per 100,000 bed days	14.9	10.6	12.5	5.4	11.0
National average*	33.7	33.7	30.2	31.2	
Worst performing trust*	121	139	116	113	
Best performing trust*	0	0	0	0	
*trust apportioned cases					

St George's University Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services.

We are taking urgent action to address significant challenges with our estate which impact on infection control. This includes water safety, and the risk of legionella bacteria growing in our water supply. We are taking action to maintain water safety, including regular testing and monitoring of the water supply. We have installed special filters to taps in a number of areas. During 2019/20, we will be investing a further £3.5m, which will enable us to create additional water supplies to the site.

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-Sept 17	Oct 16-Mar 17	Apr 17-Sep 18
St George's University Hospitals						
Total reported incidents	5,188	5,353	5,453	5,964	5,928	5,548
Rate per 1000 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-Sept 17	Oct 16-Mar 17	Apr 17-Sep 18
St George's University Hospitals						
Incidents causing Severe Harm or death	16	23	20	15	13	14
% incidents causing Severe Harm or death	0.31%	0.43%	0.37%	0.25%	0.22%	0.25%
National average (acute non-specialist)	0.50%	0.43%	0.79	0.38%	0.37%	0.35%
Highest reporting rate	5.10%	1.96%	1.33%	1.38%	1.09%	1.23%
Lowest reporting rate	0.05%	0.09%	0%	0.02%	0.03%	0.02%

St George's University Hospitals NHS Foundation Trust 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 2018/19. 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, a monthly governance newsletter and a quarterly analysis report and thematic learning.

Venous thromboembolism

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.

VTE Assessments	2014-15	2015-16	2016-17	2017-18	2018-19
St George's University Hospitals	95.89%	96.77%	96.64%	95.90%	95.50%
National Average	96.10%	95.76%	95.61%	95.80%	
Best performing Trust*	100%	100%	100%	100%	
Worst performing Trust*	79%	78.1%	63%	72%	

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 2018-19

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?**
We will reduce the impact of serious infections	Achievement of the 2018-19 CQUIN goals for the identification and treatment of sepsis	**We achieved this** We will continue to monitor our performance with the management of serious infections through the patient safety priorities for 2019/20 concerning identification of the deteriorating patient and the consistent use of treatment escalation plans.
We will reduce patient falls resulting in significant harm	Achieve a 30% reduction in falls that cause significant harm against the number of these falls in 2017/18	**We achieved this** Significant progress has been made in the training and education of staff. Falls champions are in place on wards and the falls prevention coordinator provides intensive support to wards based on their risk of falls. In 2019/20 performance in preventing falls will be monitored through our governance framework as part of ensuring we achieve high quality standards for getting the basics right.
We will reduce acquired category 3 pressure ulcers	Achieve a 20% reduction in the total number of category 3 pressure ulcers against the number for 2017/18.	**We have not achieved this reduction** The process for reporting of pressure ulcers has been strengthened during 2018/19 improving our assurance that all category 2 and above pressure ulcers are reported and investigated, identifying root causes and improving practice. In 2019/20 the prevention of pressure ulcers will be monitored through our governance framework as part of ensuring we achieve high quality standards for getting the basics right.
Patient experience		
Our quality priorities and why we chose them	**What success will look like**	**How did we do?**
We will provide a responsive, high quality complaints service	We will achieve a reduction in the number of complaints where local resolution is not achieved with the first response to 4 or fewer in a month. We will achieve compliance with the response target for each complaint.	**We did not achieve this** At the time of report this measure has been achieved in only one month to date with a year to date average of 7.5%. **We did not achieve this** Action being taken to improve responsiveness includes the restructure of the central complaints team which is underway. The post of Head of Patient Experience and Partnership is in the recruitment process. This priority is taken forward into 2019/20

Patient experience		
Our quality priorities and why we chose them	**What success will look like**	**How did we do?**
We will improve immediate feedback from patients through the FFT by increasing response rates for both inpatient and outpatient services.	We will achieve a response rate of 20% to our outpatient family and friends test.	**We did not achieve this** Improvements that are expected to enable us to achieve this target have been put in place in Q4; these include the FFT being made available on our public website and in recent weeks the launch of FFT by text message. This priority is taken forward into 2019/20 to ensure that the action taken achieves this target and that the learning is extended to other areas where response rates to the FFT need to improve.
Clinical effectiveness		
Our quality priorities and why we chose them	**What success will look like**	**How did we do?**
We will improve services for people with mental health needs who present to the Emergency Department.	We will achieve the 2018-19 national CQUIN goals for services to patients with mental health needs in the emergency department.	**We achieved this** We have met our CQUIN goal and achieved our objective for 2018/19. This has been achieved in part through a project together with SW London MH NHS Trust to improve physical and mental health care for those in crisis.
We will improve the effectiveness of our discharge process.	We will achieve an improvement against questions concerning discharge in the 2019 National Patient Survey.	**We will not know if we have achieved this at the time of this report.** Work with Healthwatch tells us that discharge continues to be an area where our patients and our local community want to see us improve. This priority is being carried forward into 2019/20.

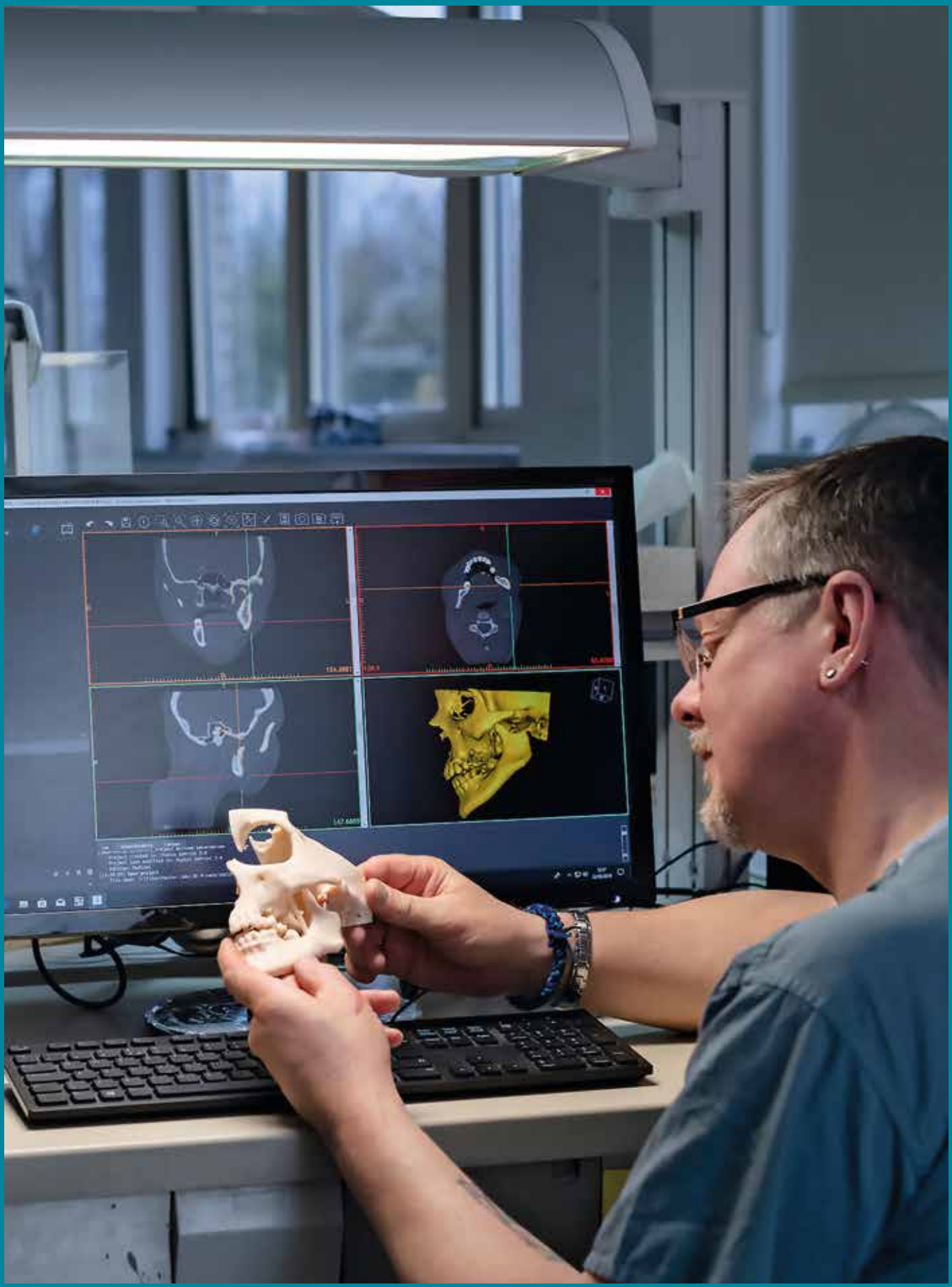
Our performance against the NHS Improvement Single Oversight Framework

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

		Target	Annual performance
Referral to treatment times	**Non reporting from April 18 – December 18**		**Not available**
ED access	**95% of patient wait less than 4 hours**	**>=95%**	**88.4%**
Cancer access	**% cancer patients treated within 62 days of urgent GP referral**	**>=85%**	**86.9%**
% patients treated within 62 days from screening referral	**>=90%**	**86%**	
Diagnostic waits	**Maximum 6 week wait for diagnostic procedures**	**99%**	**99%**



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 2018/19 and supporting guidance – Detailed requirements for quality reports 2018/19.

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 2018 to 23 May 2019
- papers relating to quality reported to the board over the period April 2018 to 23 May 2019
- feedback from commissioners dated 16 May 2019
- feedback from local Healthwatch organisations dated 14 May 2019
- feedback from Wandsworth overview and scrutiny committee dated 14 May 2019
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 1 September 2018
- the latest national patient survey (embargoed until July 2019)
- the latest national staff survey dated March 2019
- the Care Quality Commission inspection reports dated 19 July 2018 and 18 December 2018; and
- the Head of Internal Audit's annual opinion of the Trust's control environment dated April 2019
- The Quality Report presents a balanced picture of the Trust's performance over the period covered 2018/19.

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

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

The data underpinning the measures of performance reported in the Quality 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
Chairman
23 May 2019

Jacqueline Totterdell
Chief Executive
23 May 2019

Statement from Wandsworth Clinical Commissioning Group

Wandsworth Clinical Commissioning Group (CCG) is responsible for the commissioning of health services from St George's University Hospitals NHS Foundation Trust (SGUH) on behalf of the population of Wandsworth and surrounding boroughs.

Wandsworth CCG has worked in close partnership with SGUH during 2018/19 to ensure that we receive a high level of assurance in relation to these commissioned services, obtained mainly through the monthly Clinical Quality Review Group (CQRG) meetings. The CQRG meetings bring together stakeholders, including GPs, senior clinicians and managers from both SGUH and Wandsworth CCG, Commissioners from local CCGs, NHS England and NHS Improvement. Assurance is also gained through undertaking quality assurance visits in SGUH, which we have undertaken jointly with NHS Improvement colleagues.

SGUH has been proactive in addressing quality issues identified through the CCG's well-established GP Quality Alert system (Make a Difference). This is a system which allows General Practitioners and other healthcare professionals to raise quality issues relating to a provider to the CCG. The provider is then required to address the issues and respond to the alert. SGUH have successfully addressed a number of quality issues identified through this system, and the CCG is pleased to note that some of these issues, including improving the effectiveness of the discharge process, have been included in the priorities for 2019/20. It is important that SGUH investigates and responds to the alerts thoroughly and that responses should involve senior members of the relevant clinical team to ensure that a quality improvement approach is facilitated and learning leads to embedded changes.

The CCG also acknowledges the significant progress made by the Trust in delivering on the CQC action plan that has been in place since the CQC inspection report was published in July 2018. The CQRG has monitored the actions closely and reported progress to the CQC throughout 2018/19. We have received assurance on the actions delivered. We will continue to monitor the outstanding actions which have now been incorporated within the Trust Quality Improvement plan.

The CCG welcomes the opportunity to provide a statement for SGUH's Quality Account for 2018/19.

We confirm that we have reviewed the information contained within the draft Quality Account and acknowledge the work that has been put into delivering most of the quality priorities for 2018/19.

The CCG agrees with the Trust's assessment of the delivery of the 2018/19 priorities. We are disappointed to note that the target for time taken to respond to complaints, was not met for 2018/19. However, we are pleased to note that this has been rolled over to 2019/20, and hope that the work already undertaken in this area will support the Trust in achieving compliance in 2019/20.

The CCG welcomes the continued focus on patient safety, clinical effectiveness and patient experience. We have taken particular account of the identified quality priorities for 2019/20, including the rationale for identifying those. We are pleased to note that these priorities are in line with those agreed at the CQRG and acknowledge that other areas of work have also been identified for action at CQRG and although these do not appear in the quality report, they are nevertheless, of significance and require attention. We are pleased to note the Trust aspiration to set up a critical care outreach team to support the management of the deteriorating patient. We would urge SGUH to consider broadening the priority in relation to the deteriorating patient to include recognising and reporting/escalation of the deteriorating patient. This will ensure that the appropriate response is provided in a timely manner in order to avoid complications, as this has been a theme that has been identified from the CCG review of serious incidents from the Trust.

In addition, we would like to have seen an emphasis on quality improvement systems and processes across the organisation. There must be learning from the external review of deaths within the Cardiac Surgery Service, which can be applied across other departments and disciplines and work on this should get underway in 2019/20

The CCG would also support a greater focus on staff health and wellbeing, including staff engagement, as part of the priorities for 2019/20. This will build on the work already started by the Trust, to improve staff engagement based on the publication of the NHS 2018 staff survey results.

Overall comments

Overall, the Quality Report provides an encouraging account of quality within the Trust and reflects the work that the senior team has invested in improving quality over the year.

The CCG acknowledges the improvements made in 2018/19 and commends the Trust on the production of a quality report that sets out the key priorities for 2019/20. We are in agreement with the priorities, as specified in the report and would like to see the following areas also reflected:

- Recognising and responding to the deteriorating patient
- Staff health and wellbeing and staff engagement
- Finally, commissioners would welcome the opportunity to review the Trust Quality Account earlier in the development stages in future years, in order to allow time to consult more widely with commissioning colleagues and neighbouring CCGs.

We will continue to work closely with the Trust and look forward to supporting it to deliver the priorities identified in the quality report for 2019/20.

Dr Nicola Jones MBE
MBChB DRCOG MRCGP MBA
Chair, Wandsworth Clinical Commissioning Group
14/05/2018

Statement from Healthwatch Wandsworth

Thank you for the opportunity to view and provide comments on this year's quality account. We have appreciated the opportunity to have been kept informed and involved in the monitoring of quality improvement throughout the year at the monthly Quality and Safety Committee. This year we have also been able to attend and take part in the newly formed Patient Partnership Engagement Group and continue to take part in other areas of governance with a Healthwatch appointed Governor.

In December 2018 we took the opportunity to ask attendees at our regular public meeting what they thought the priorities for quality at St. George's Hospital should be. Elizabeth Palmer, Director of Quality Governance, presented an introduction and asked the attendees for feedback. The following themes were suggested:

- Administration and communication improvements are needed because these services are affecting improvements in other issues.
- Patient advice and information should be clear, timely and include information to help people manage their condition and prevent further health problems. Discharge was mentioned as especially important.
- The hospital could improve how it works with other parts of the system as well as with patients and carers.
- To continue work to reduce sepsis, falls, and pressure ulcers.

We have been able to discuss these comments further with Elizabeth Palmer and staff focused on improvements across the hospital. Our comments on the specific detail in this year's quality account follows below.

Mental Capacity Act

One of the key aims for the next year is to identify and record proper protection and care for patients with mental health needs. We would suggest consideration as to whether audit alone would be sufficient as a tool to ensure compliance or whether something similar to a peer review process, involving staff might help give them more confidence in decision making and embedding practices. It could also be considered whether patients or a representative could be involved in this process.

It is important that family and carers fully understand the process and decisions made about mental capacity as well as what it means for them. We think it is important that there is assurance that patient information and communication is as helpful to the process and future management of health and wellbeing as possible.

Improving patient experience

The aim stated is to provide a responsive, high quality complaints service, and the Quality Account outlines performance targets for responding to complaints. It is an important topic and it is disappointing to see slow progress against target. We welcome the steps that the Trust are taking to make progress by September, but information about the steps being taken could be made clearer to tell people how you will achieve improvements. We also think it would be useful to review the complaints process and communication from the patient's perspective in the process. Last year we spoke to people about how they would like to be communicated with during a complaints process (this was not a discussion about St. George's Hospital in particular). The full report is available on our website, but in summary people has told us that they would like clear information about raising a complaint and about what might happen, as well as reassurance that they will be listened to and that their feedback will be useful to prevent problems happening again.

Many people also wanted to know that they can share feedback without making a complaint or that they could de-escalate a complaint at any stage. The National Inpatient survey and the National Patient Cancer survey performance showed that patients at St. George's Hospital reported having insufficient opportunity to discuss their worries and concerns with staff. If this situation were improved, we suggest that it might reduce the number of concerns that escalate into formal complaints.

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

The aim stated is to deliver year one of the strategy and develop the strategy for the next three years. We think it is important part of this strategic process to undertake an evaluation with staff and patients about how the Patient Partnership Engagement Group (PPEG) has progressed, including demonstrating how patients have been involved and the outcomes. An important measure of success would be the impact that those on the PPEG felt they had on influencing patient involvement throughout the hospital. We would welcome the opportunity to contribute to the evaluation and the development of the new strategy. We would also like to see mention of how patient involvement can help improve quality in the areas identified in the Quality Account.

Improve 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.

We are pleased to see that our feedback on behalf of the local people who have spoken to us has been taken into account. We would question whether testing success through patient surveys should be the only indicator of success. It might not capture the knock-on effects if discharge hadn't gone as well as it could have, for example if someone is re-admitted or doesn't get a follow-up appointment. Perhaps outpatient or GP surveys might be useful.

Finally, we had a few comments about areas of quality improvement we could not see mention of in the Quality Account:

- Working with partners to make quality improvements and also assurance and measuring of improvements. We think, for example, there could be some really useful information available from partners about patient experience and areas for improvement.
- Outpatients has not been specifically mentioned as a priority, yet this is something we receive a lot of feedback from patients about. The focus on improving outpatients' efficiency and experience should still be prioritised for improvement.
- Improving support to carers is an important part of improving the quality of patient experience and ongoing care. Previously, a target about carer passports was included in quality governance. It would be useful to continue to focus on carers and support for them. Local carers have, for example, told us that they need more information the health condition of the person they care for and how to manage it. The hospital may be the first point at which a person becomes a carer and is an ideal opportunity to make sure they have the support they need as early as possible.

As a last comment we wanted to congratulate the hospital in achieving the sizable and complex task to re-organise and return to reporting referral to treatment waiting times.

Healthwatch Wandsworth
14 May 2019

Statement from Wandsworth Adult Care and Health Overview Scrutiny Committee

Whilst this statement is submitted on behalf of the Wandsworth Adult Care and Health Overview and Scrutiny Committee, the tight timescale for its submission means that any outstanding year end information that was not included in the original report sent on 24th April, has not been covered here. Also due to the timings allowed for its submission means that it has not been possible to agree it at a Committee meeting and the below comments have been prepared in consultation with its leading members.

We are encouraged by participation in 98% of eligible clinical audits and 100% of eligible National Confidential Enquiries and would be interested in how this compared to previous years.

From the performance against 2018/19 priorities, it was noted that the reduction in category 3 pressure ulcers priority was not achieved. We would like the Trust to confirm with figures whether this was reduced at all and by what percentage.

Following the CQC inspection in March 2018, overall the Trust moved from inadequate to requires improvement and it was noted that all core services of the Trust scored 'good' for the 'caring' domain. It was noted that maternity services were rated good in all areas and outstanding for effectiveness. The result of this inspection increases our confidence that Wandsworth residents using the Trust are receiving quality care in maternity services and that staff attitudes and behaviours are found to be supportive. We would like to agree how we can work together to build on these strengths to maximise the potential for early intervention in line with the ambitions set out in our early help strategy THRIVE Wandsworth and the local Health and Care Plan in line with the wider Prevention Framework.

However we are concerned that the remainder of all core services apart from maternity, 'require improvement' in one or more domains and that the least well performing domain is 'safety' and about the implications of this on Wandsworth residents. We would like to see an expansion of the proposed actions to address the 'inadequate' rating for the 'well led' domain for Outpatient Services, and a detailed action plan for how safety will be improved across all services. As a priority we would like an action plan to respond to all issues relating to Children's Safeguarding to include the actions identified in the quality account as below:

- Reviewing the Trust's Safeguarding Children's training and capacity
- Closer integration of Domestic Violence into both Children and Adults safeguarding work at the Trust
- Reviewing internal governance, including a review of the Safeguarding Children Committee, to ensure that the Committee's work is as effective as possible.
- Approaching CCG colleagues to ensure that working relationships and reporting structures are as productive and strategic as they can be
- Focus partnership working activity, within the available capacity of the team, which has a clear focus on improving outcomes

The Team participate in a variety of London wide discussions with Safeguarding Children's colleagues in provider Trusts and seeking to capture best practice regionally will be a theme of the year ahead and for progress to be reported to the Children's Safeguarding Board.

Domestic violence is highlighted in the quality account and this is a very significant issue for families, along with neglect and abuse this is a primary reason for social care involvement. We ask that specific actions are included to ensure close working at both a strategic and operational level between services in relation to these areas.

There are some key areas of improvement that are not specifically identified and in this context we would like to see more explicit references to meeting the needs of vulnerable adolescents particularly in speedy delivery of the improvements necessary in SANDPIT to ensure that statutory duties in respect of Looked After Children (timely and robust Initial Health Assessments and Health Reviews etc) are full discharged and a clear commitment to responding to the CCG's performance management in relation to children coming into care.

We would like specific commitments from the Trust to support our preventative agenda in relation to knife crime, gangs, CSE, missing and the use of drugs and alcohol.

We would like more explicit actions in relation to delivering the requirements in relation to children and young people with SEND (special education needs and/or disabilities) and the contribution that

the Trust will make to improving outcomes for these children. We are very concerned about and wish to seek clarity on, the intended withdrawal of Paediatric delivery in the Community. We believe this will disrupt St George's relationship with Special Schools in Wandsworth which has been built up over many years and impact negatively on children and families.

We are interested in the developments that took place in 2018/19 around cardiac surgery, following the issues previously reported, in particular to the new clinical leadership appointment, additional consultant surgeons and move to multidisciplinary case reviews to improve the outcomes for cardiac patients. We look forward to seeing how these actions are implemented and the outcomes from them. We would welcome information on how patients and their carers and relatives have been involved in these developments.

The inclusion of 24-hour access to catering services for visitors and carers and the audit of accessibility for people with disabilities, following the Patient-Led Assessments of the Care Environment (PLACE), is welcomed. We would like the Trust to confirm that the catering will comply with the NHS Hospital Food Standards recommended by the Department of Health and Social Care.

We welcome the new developments following national audit of dementia 2017-18 for the Trust to become more dementia-friendly, with delirium screening offered for all patients over 65 and a delirium pathway. We are interested to know what other actions are being taken around the dementia-friendly environment such as cubicles in relevant out-patients departments, A&E and waiting areas and staff training provision, including non-clinical staff e.g. receptionists, customer services in all retail outlets and cleaners. We would also like to see full detailed plans for managing in-patients who have dementia. Further information on how dementia patients, their carers and relatives have or will be involved in these developments would be welcomed.

We are encouraged by planned developments for the fracture clinic, with improved staffing levels, re-establishing longitudinal follow-up of patients to check compliance and more timely data uploads. Information on how fracture patients, their carers and relatives have been or will be involved in these developments is welcomed.

We are encouraged by the improvements in data quality following investigations in 2016 and this provides assurance of the services being delivered to Wandsworth residents.

We are also encouraged by the improved compliance with Standards for Seven Day Services, in particular for Standard 2 (all emergency admissions must be seen by a consultant within 14 hours of admission) from 70% to 82%. We would like the Trust to confirm how the risks of not being fully compliant with Standard 2 will be met in more detail, including staffing increases.

We have noted that Patient Experience scores have remained more or less consistent since 2011/12, which has ranged from 66% in 2018/19 to 68.8% in 2013/14 and would like the Trust to confirm what actions are being taken to maintain and improve this percentage for 2019/20.

We would be interested to see more detail about the results and actions of the Staff Survey, including response rate and the views relating to areas in need of improvement, as well as reflections on current improvements, to better understand staff opinions. We are keen to know if the Trust has a Workforce Strategy, which includes the health of staff, as a major London employer and if this strategy involves signing-up to the Healthy Workplace Charter. We recommend the Trust gets involved in the work around the local Health and Care Plan which proposes actions to improve workplace health in line with the wider Prevention Framework.

Smoking cessation is a highly evidenced-based intervention, giving an estimated 10 years of life back to a person after quitting. We understand that the Trust was certified smoke-free in 2018/19, following support from public health and note that there is no mention of this development in the report and would like the Trust to consider including this achievement to reflect their work in this area.

It is noted that there is no mention of mandatory reporting of female genital mutilation (FGM), given the diverse local population of Wandsworth, particularly in the immediate surroundings of the Trust following the audit undertaken in 2016. We ask the Trust to confirm the numbers of patients identified through mandatory reporting is included in this quality account. In addition, we ask how and how often FGM is communicated to staff and the public, how many staff and from which departments have engaged in training. We would also like the Trust to confirm whether palliative care services are involved in identifying women who have undergone FGM and reversing the procedure.

We welcome the new priority identified in the quality account around improving care for people with mental health needs who are in an acute

setting. We would suggest this is of particular note for South West London and St George's Mental Health NHS Trust, who provide the Psychiatric Liaison Service for St George's. However, officers from Adult Social Care receive regular referrals to assess people in acute care under the Mental Health Act 1983. The key concern encountered by our Approved Mental Health Act Professionals when carrying out assessments at St George's Hospital, is a lack of appropriate rooms in which to conduct the assessment interviews. We note that Kingston Hospital recently opened a Mental Health Assessment Unit (managed by the acute Trust) that is separate from the A&E department, which would be useful to have at St George's.

It is also noted that there is no mention of people with learning disabilities in this report and we would like the Trust to confirm how the needs of patients of all ages with learning disabilities are being met.

There are also areas that impact on service quality that are not included in the quality account report which would benefit patients. We would welcome an update on what progress is being made to improve and integrate IT systems to facilitate joined up record keeping, and enable patients to book and change appointments online. Another area we highlight as a concern is in respect of the current estates, and would welcome an update on what is the current estates strategy to bring redundant buildings back into use or disposed of, and to upgrade substandard buildings.

We have been receiving update briefings from the Trust on the progress made in respect of its quality improvement plan at our meetings over the past couple of years, as well as updates on any other significant areas of interest, and we would like to thank the Trust for attending the meetings and answering our questions.

Finally, we would like to take this opportunity to thank the Trust for the opportunity to comment on this quality account.

Wandsworth Adult Care and Health Overview and Scrutiny Committee
14 May 2019

2018/19 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 2019 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and additional supporting guidance in the 'Detailed requirements for quality reports 2018/19' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2019 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 2018/19' 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 2018/19' 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 2018/19'; 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 2018/19' and supporting guidance and the six dimensions of data quality set out in the "Detailed requirements for external assurance for quality reports 2018/19'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2018/19' 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 2018 to 23 May 2019
- papers relating to quality reported to the Board over the period 1 April 2018 to 23 May 2019
- feedback from commissioners dated 16 May 2019
- feedback from local Healthwatch organisations dated 14 May 2019
- feedback from the Overview and Scrutiny Committee dated 14 May 2019
- 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 2018
- the national patient survey embargoed until July;
- the national staff survey dated March 2019
- the Head of Internal Audit's annual opinion over the Trust's control environment dated April 2019
- the Care Quality Commission's inspection report dated 19 July 2018 and 18 December 2018.

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

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 2019, 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 2018/19' and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable, measurement techniques 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 2018/19' and supporting guidance.

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

Our audit work on the financial statements of St George's University Hospitals NHS Foundation Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as St George's University Hospitals NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to St George's University Hospitals NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to St George's University Hospitals NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose.

Our audits of St George's University Hospitals NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than St George's University Hospitals NHS Foundation Trust and St George's University Hospitals NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the 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 2019:

- 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 2018/19' 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 2018/19'; and
- the indicators in the 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 2018/19' and supporting guidance.

Grant Thornton UK LLP
Chartered Accountants
London

23 May 2019