Quality Report (Account) 2019/20

Part 1

Statement on quality from the Chief Executive

I am pleased to write this introduction to the Quality Report, particularly as I believe we have made real progress over the last twelve months.

Since joining the organisation as Chief Executive in May 2017, I've talked about the need for St George's to become an organisation that is constantly looking to improve, day in, day out, and the last year gives us real hope that this is now becoming part of the cultural norm.

In December 2019, we were commended by the Care Quality Commission for delivering 'significant improvements' to the services we provide. Our services for children and young people were rated outstanding overall, and three of our core services improved to Good for being safe.

Crucially, the CQC also recommended the Trust be removed from the special measures regime for quality of services, and this was officially confirmed by NHS Improvement in March 2020.

Of course, we still have a long way to go to deliver our vision of providing outstanding care, every time, but exiting special measures was a big step forward for the organisation, and staff morale.

In March 2020, NHS Improvement published the findings of an external, independent review of cardiac surgery at St George's Hospital. The report concluded that there were failings in the care provided to 102 patients between 2013 and 2018. We fully accepted the panel's findings, and apologised unreservedly to the patients' families that the care we provided fell way short of the high standards they deserved.

The heart surgery service at St George's is now safe, and the current service is very different to the one we took urgent steps to improve in 2017. These improvements were confirmed by the Care Quality Commission in their December 2019 inspection report.

We have completed the recommendations put forward by the panel in their review. There is still more work to do, but heart surgery patients should now be confident they will receive safe and effective care at St George's.

Quality and safety continues to be central to how we plan and deliver care for patients. During 2019/20, the Trust Board approved a new quality and safety strategy for the next five years (2019-24), and our teams continue to participate in a wide range of national and local clinical audits; which helps ensure we remain in step with care trends across key specialties.

Reducing harm to our patients means creating a culture where staff feel supported to raise concerns about any aspect of patient care. Over the past year, we have taken proactive steps to make it easier for staff to do this by creating a network of Freedom to Speak Up Champions, and raising awareness about how to report incidents from the moment staff join the Trust at their induction.

Over the past twelve months, we have also worked on giving staff access to the information and tools they need to deliver joined up care. This includes the extension of iClip – our electronic patient record – to Queen Mary's Hospital in Roehampton, making it much easier for staff across our different hospital sites to access and update information about our patients.

In many areas, we are setting the standard for others to follow. For example, as part of our commitment to research, we doubled the number of patients taking part in clinical research during 2019/20; and the partnership we have with St George's, University of London is a key part of this success.

This year, we also established a Medical Examiners' Office on the St George's Hospital site. The team, led by Dr Nigel Kennea, one of our consultants, provides independent scrutiny of deaths, guidance in death certification and helps to support bereaved families; the important role they play has been particularly evident since the start of the Covid-19 pandemic.

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

Finally, I would like to thank our dedicated staff who work tirelessly every day to provide safe and compassionate care to the communities we serve.

Jacqueline Totterdell
Chief Executive

25 June 2020

Part 2

2.0 Priorities for improvement and statements of assurance from the board

2.1 Our quality priorities for 2020/21

Context

Our vision is to provide outstanding care, every time for our patients, staff and the communities that we serve as described in the Trust's clinical strategy 2019/2024.

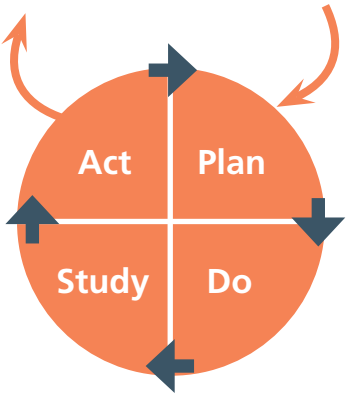
Throughout 2019/20 a series of underpinning strategies were developed to support the delivery of the Trust clinical strategy; one of which is our quality and safety strategy 2019/2024.

To support the delivery of our quality and safety strategy we have further developed our approach to quality improvement to help teams solve problems at their own level and to embed a culture of quality, safety and learning. Our experience is that we will best achieve this by continuing to use a simple yet effective improvement model to bring about positive change: Plan, Do, Study, Act (PDSA).

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?



Staff undertaking service improvement initiatives will continue to be able to draw upon support from our Quality Improvement Academy with particular emphasis on culture, leadership support, accountability, reliability and sustainability.

In 2019/20 we also refocused our quality improvement plan (QIP) by reviewing the progress we had made against the previous year's QIP and external assessments: care Quality Commission (CQC) inspections; national surveys; and local and national audit. We were also keen to move away from a plethora of action plans and have one plan so the refocused QIP was integrated with the Trust's Annual Plan 2019/20 and aligned to the Trust's Corporate Objectives 2019/20.

Our quality priorities 2020/21 and why we chose them

The quality priorities for 2020/21 were informed by:

- themes highlighted from our ward and departmental accreditation scheme
- progress against our QIP 2019/20
- local and national audit
- national priorities for sepsis, safe staffing, falls, and infection prevention and control
- actions from the 2018 CQC inspection which we implemented during 2018/19.

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

As part of the development of our quality and safety strategy 2019/24 we also met and listened to the views of our patients and staff.

Our priorities for 2020/21 are aligned with year one of our quality and safety strategy and set out our programme of work for the year to come so that we continue to make improvements to safety and the quality of care for our patients and their families.

Each quality priority comes under one of three quality themes:

Priority 1 – Improve 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

Priority 2 – Improve patient experience: meeting our patients' emotional as well as physical needs

Priority 3 – Improve effectiveness and outcomes: providing the highest quality care, with world class outcomes whilst also being efficient and cost effective

Patients are safer when there

Priority 1 – Improve patient safety

is a safety culture that is fully embedded in everyday business. We believe that all our staff have responsibility to take all necessary steps to avoid harm to our patients, to learn from best practice, deliver the best possible outcomes and reduce unwarranted variation.

In 2020/21 the patient safety priorities we will focus on are interlinked with the full implementation of our new critical care outreach service which we established at the end of 2019/20. The critical care outreach service will have a significant impact on supporting our staff to manage deteriorating patients promptly and effectively.

WHAT	HOW	WHAT WILL SUCCESS LOOK LIKE
Timely escalation and response to deteriorating patients	Ensure all non-elective adult inpatients have a treatment escalation plan (TEP) in place within 24 hours of admission	Reduction in avoidable harm and death associated with missed opportunities when compared with 2019/20 Improved response to the National Early Warning Score (NEWS2) when compared with 2019/20 All adult inpatients will have a TEP Reduction in the number of cardiac arrests compared with 2019/20
Patients who lack mental capacity will have proper protection and care	Demonstrate through audit of healthcare records that patients who lack mental capacity are identified promptly, and have proper protection and care	Achieve compliance with our training targets for Mental Capacity Act (MCA) training and target specific areas based on analysis of notes audit
Consent for treatment	All patients will be supported to give consent for treatment	All adult inpatients will have a TEP Audit of consent demonstrates an improved position when compared with 2019/20
Learn from deaths	Embed medical examiner service and learning from deaths processes	Maintain Summary Hospital Level Mortality Indicator (SHIMI) within confidence intervals

Priority 2 – Improve patient experience

We want to provide the fundamentals of care that matter to our patients: communication; privacy; dignity; safety; nutrition and hydration; comfort; and warmth, in order to meet both their emotional and physical needs. We will listen to our patients and their carers and use patient feedback to focus on continuous improvement

WHAT	HOW	WHAT WILL SUCCESS LOOK LIKE
Timely escalation and response to deteriorating patients	Ensure all non-elective adult inpatients have a treatment escalation plan (TEP) in place within 24 hours of admission	Reduction in avoidable harm and death associated with missed opportunities when compared with 2019/20 Improved response to the National Early Warning Score (NEWS2) when compared with 2019/20 All adult inpatients will have a TEP Reduction in the number of cardiac arrests compared with 2019/20
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Consent for treatment	All patients will be supported to give consent for treatment	All adult inpatients will have a TEP Audit of consent demonstrates an improved position when compared with 2019/20
Learn from deaths	Embed medical examiner service and learning from deaths processes	Maintain Summary Hospital Level Mortality Indicator (SHIMI) within confidence intervals

WHAT	HOW	WHAT WILL SUCCESS LOOK LIKE
Learn from complaints to provide patients with an excellent experience	Undertake thematic analysis of our complaints to identify recurrent themes and share the findings	Reduction in the number of complaints when compared with the 2019/20 baseline
Provide an equitable experience for patients from vulnerable groups	Undertake self-assessment against the National Learning Disability Standards	Improvement in our self-assessment when compared to baseline
Improve patient flow particularly with reference to improved discharge processes	Continue with our clinically led long length of stay meeting with local authority input to support patients with complex discharge needs. Progress further the implementation of Red to Green in iClip to highlight the issues that delay discharge Continue to survey our patients on discharge and respond to what they tell us to ensure our patients are equipped with the information they need to manage their health and know how to access appropriate support Continue to improve our process for discharge summaries and enable our patients to leave our care with a follow up appointment or investigation date if required	Reduction in the number of patients awaiting external assessment, repatriation or external care when compared with the 2019/20 baseline See an upward trend in our patients reporting involvement in their discharge arrangements when compared with 2019/20 Improvement in the number of discharge summaries received in general practice within 48 hours of discharge when compared with 2019/20 Improvement in the patients who were discharged from an inpatient setting with a follow up appointment or investigation date when compared with 2019/20

Priority 3 – Improve effectiveness and outcomes

We want to support continuous learning and improvement. We want to demonstrate measurable improvement in patient outcomes and reduce unwarranted variation as evidenced in the results of national audits and quality standards reviews.

WHAT	HOW	WHAT WILL SUCCESS LOOK LIKE
Develop and implement an integrated training and education framework	With SWL and St George's Mental Health Trust we develop an integrated education and training framework for our staff to support the care and treatment of mental health patients in an acute setting	We will have an integrated education and training framework
Embed a culture of quality, safety and learning	Implement the recommendations from the external reviews of our clinical governance processes to ensure they support the delivery of safe, high quality care	Improvements in related questions in the NHS Staff Survey
Patients will not wait too long for treatment	Deliver care in line with activity plans	Achievement of targets for: • Referral to Treatment (RTT) within 18 weeks • Diagnostics within six weeks • Four hour operating standard • Cancer standards

2.1.4 How progress to achieve these priorities will be reported

The progress against 'what will success look like' outlined against our quality priorities above will be reported and monitored by monthly progress reports to the Patient Safety Quality Group and quarterly progress reports to the Quality and Safety Committee, a sub-committee of the Trust Board.

2.1.5 Progress against priorities for 2019/20 [See part 3]

Queen Mary's Hospital in Roehampton

2.2 Statements of assurance from the Board of Directors

This section contains the statutory statements concerning the quality of services provided by St George's University Hospitals NHS Foundation Trust. These are common to all quality reports and can be used to compare our Trust with other organisations.

St George's University Hospitals NHS Foundation Trust is the largest healthcare provider in south west London, and one of the largest healthcare providers in the country. The Trust serves a population of 1.3 million people across south west London. A number of services, such as cardiothoracic medicine and surgery, neurosciences and renal transplantation, also cover significant populations from Surrey and Sussex, providing care for about 3.5 million people in total.

Most of our services are provided at our main site, St George's Hospital in Tooting, but we also provide services from Queen Mary's Hospital in Roehampton and from health centres in Wandsworth. We also provided healthcare services for residents of HMP Wandsworth until August 2019 when the service was transferred to another provider.

We also provide care for patients from a larger catchment area in south east England for specialist services such as complex pelvic trauma. A number of our services treat patients from across England this includes family human immunodeficiency virus (HIV) services and bone marrow transplantation for non-cancer diseases.

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

2.2.1 During 2019/20 the Trust provided and/or subcontracted 64 relevant health services. A detailed list is available in the Statement of Purpose on our website www.stgeorges.nhs.uk/about

2.2.1.1 The Trust has reviewed all the data available to us on the quality of care in 64 of these relevant health services through our performance management framework and our assurance processes.

2.2.1.2 The income generated by the relevant health services reviewed in 2019/20 represents 100% of the total income generated from the provision of relevant health services by St George's University Hospitals NHS Foundation Trust for 2019/20.

2.2.2 Participation in clinical audit and National Confidential Enquiries

During 2019/20, 67 national clinical audits and four national confidential enquiries covered relevant health services that St George's University Hospitals NHS Foundation Trust provides.

2.2.2.1 During that period St George's University Hospitals NHS Foundation Trust participated in 99% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

2.2.2.2 The national clinical audits and national confidential enquiries that St George's University Hospitals NHS Foundation Trust was eligible to participate in during 2019/20 are as follows:

NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES (TITLE)		RELEVANT	PARTICIPATING
Assessing Cognitive Impairment in Older People / Care in Emergency Departments		✓	✓
British Association of Urological Surgeons (BAUS) Data & Audit Programme	Cystectomy	✓	✓
	Female Stress Urinary Incontinence	X	X
	Nephrectomy	✓	✓
	Percutaneous Nephrolithotomy	✓	✓
	Radical Prostatectomy	✓	✓
Care of Children in Emergency Departments		✓	✓
Case Mix Programme (CMP)	Neurology Intensive Care Unit	✓	✓
	General Adult Intensive Care	✓	✓
	Cardiothoracic Intensive Care Unit	✓	✓
Child Health Clinical Outcome Review Programme: National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Long Term Ventilation	✓	✓
Elective Surgery – National Patient Reported Outcome Measures (PROMs) Programme		✓	X
Endocrine and Thyroid National Audit		✓	✓
Falls and Fragility Fractures Audit programme (FFFAP)	Fracture Liaison Service Database (FLS-DB)	✓	✓
	National Audit of Inpatient Falls (NAIF)	✓	✓
	National Hip Fracture Database (NHFD)	✓	✓
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit		✓	✓
Major Trauma Audit (TARN)		✓	✓
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection		✓	✓
Maternal, Newborn and Infant Clinical Outcome Review Programme	Confidential Enquiry into Maternal Deaths	✓	✓
	Perinatal Mortality Surveillance	✓	✓
	Perinatal Mortality and Morbidity Confidential Enquiries	✓	✓
Medical and Surgical Clinical Outcome Review Programme	Acute Bowel Obstruction	✓	✓
	Out of Hospital Cardiac Arrests (OHCA)	✓	✓
	Dysphagia in Parkinson's Disease	✓	✓
Mental Health - Care in Emergency Departments		✓	✓

NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES (TITLE)		RELEVANT	PARTICIPATING
Mental Health Care Pathway - CYP Urgent & Emergency Mental Health Care and Intensive Community Support		X	X
Mental Health Clinical Outcome Review Programme		X	X
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Chronic Obstructive Pulmonary Disease (COPD)	✓	✓
(NACAP)	Adult Asthma	✓	✓
	Paediatric Asthma	✓	✓
	Pulmonary Rehabilitation	✓	✓
National Audit of Breast Cancer in Older People (NABCOP)		✓	✓
National Audit of Cardiac Rehabilitation (NACR)		✓	✓
National Audit of Care at the End of Life (NACEL)		✓	✓
National Audit of Dementia (Care in general hospitals)		✓	✓
National Audit of Pulmonary Hypertension (NAPH)		X	X
National Audit of Seizure Management in Hospitals (NASH3)		✓	✓
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)		✓	✓
National Bariatric Surgery Registry (NBSR)		✓	✓
National Cardiac Arrest Audit (NCAA)		✓	✓
National Cardiac Audit Programme (NCAP)	Adult Cardiac Surgery	✓	✓
	Adult Percutaneous Coronary Interventions	✓	✓
	Cardiac Rhythm Management (Arrhythmia Audit)	✓	✓
	Congenital Heart Disease in Children and Adults	X	X
	Heart Failure Audit	✓	✓
	Myocardial Ischaemia National Audit Programme (MINAP)	✓	✓
National Clinical Audit of Anxiety and Depression		X	X
National Clinical Audit of Psychosis		X	X
National Diabetes Audit (NDA)	Adults: Core Audit	✓	✓
	Adults: Inpatient Audit (NaDIA)	✓	✓
	Adults: Foot Care Audit	✓	✓
	Adults: National Pregnancy in Diabetes (NPID)	✓	✓
National Early Inflammatory Arthritis Audit (NEIAA)		✓	✓
National Emergency Laparotomy Audit (NELA)		✓	✓
National Gastro-intestinal Cancer Programme		✓	✓
National Joint Registry (NJR)		✓	✓
National Lung Cancer Audit (NLCA)		✓	✓
National Maternity and Perinatal Audit (NMPA)		✓	✓
National Neonatal Audit Programme – Neonatal Intensive and Special Care (NNAP)		✓	✓
National Ophthalmology Audit (NOD)		X	X
National Paediatric Diabetes Audit (NPDA)		✓	✓
National Prostate Cancer Audit		✓	✓

NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES (TITLE)		RELEVANT	PARTICIPATING
National Smoking Cessation Audit		✓	✓
National Vascular Registry		✓	✓
Neurosurgical National Audit Programme		✓	✓
Paediatric Intensive Care Audit Network (PICANet)		✓	✓
Perioperative Quality Improvement Programme (PQIP)		✓	✓
Prescribing Observatory for Mental Health (POMH-UK)		X	X
Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis)	Antibiotic Consumption	✓	✓
Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis)	Antimicrobial Stewardship	✓	✓
Sentinel Stroke National Audit programme (SSNAP)		✓	✓
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme		✓	✓
Society for Acute Medicine's Benchmarking Audit (SAMBA)		✓	✓
Surgical Site Infection Surveillance Service		✓	✓
UK Cystic Fibrosis Registry		X	X
UK Parkinson's Audit		✓	✓

2.2.2.3 The national clinical audits and national confidential enquiries that St George's University Hospitals NHS Foundation Trust participated in during 2019/20 are as follows:

NATIONAL CLINICAL AUDIT AND NATIONAL CONFIDENTIAL ENQUIRIES (TITLE)	
Assessing Cognitive Impairment in Older People / Care in Emergency Departments	
British Association of Urological Surgeons (BAUS) Data & Audit Programme	Cystectomy
	Nephrectomy
	Percutaneous Nephrolithotomy
	Radical Prostatectomy
Care of Children in Emergency Departments	
Case Mix Programme (CMP)	Neurology Intensive Care Unit
	General Adult Intensive Care
	Cardiothoracic Intensive Care Unit
Child Health Clinical Outcome Review Programme: National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Long Term Ventilation
Elective Surgery – National Patient Reported Outcome Measures (PROMs) Programme	
Endocrine and Thyroid National Audit	
Falls and Fragility Fractures Audit programme (FFFAP)	Fracture Liaison Service Database (FLS-DB)
	National Audit of Inpatient Falls (NAIF)
	National Hip Fracture Database (NHFD)
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	
Major Trauma Audit (TARN)	
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	
Maternal, Newborn and Infant Clinical Outcome Review Programme	Confidential Enquiry into Maternal Deaths
	Perinatal Mortality Surveillance
	Perinatal Mortality and Morbidity Confidential Enquiries
Medical and Surgical Clinical Outcome Review Programme	Acute Bowel Obstruction
	Out of Hospital Cardiac Arrests (OHCA)
	Dysphagia in Parkinson's Disease
Mental Health – Care in Emergency Departments	

NATIONAL CLINICAL AUDIT AND NATIONAL CONFIDENTIAL ENQUIRIES (TITLE)	
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)	COPD
	Adult Asthma
	Paediatric Asthma
	Pulmonary Rehabilitation
National Audit of Breast Cancer in Older People (NABCOP)	
National Audit of Cardiac Rehabilitation (NACR)	
National Audit of Care at the End of Life (NACEL)	
National Audit of Dementia (Care in general hospitals)	
National Audit of Seizure Management in Hospitals (NASH3)	
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	
National Bariatric Surgery Registry (NBSR)	
National Cardiac Arrest Audit (NCAA)	
National Cardiac Audit Programme (NCAP)	Adult Cardiac Surgery
	Adult Percutaneous Coronary Interventions
	Cardiac Rhythm Management (Arrhythmia Audit)
	Heart Failure Audit
	Myocardial Ischaemia National Audit Programme (MINAP)
National Diabetes Audit (NDA)	Adults: Core Audit
	Adults: Inpatient Audit (NaDIA)
	Adults: Foot Care Audit
	Adults: National Pregnancy in Diabetes (NPID)
National Early Inflammatory Arthritis Audit (NEIAA)	
National Emergency Laparotomy Audit (NELA)	
National Gastro-intestinal Cancer Programme	
National Joint Registry (NJR)	
National Lung Cancer Audit (NLCA)	
National Maternity and Perinatal Audit (NMPA)	
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	
National Paediatric Diabetes Audit (NPDA)	
National Prostate Cancer Audit	
National Smoking Cessation Audit	
National Vascular Registry	
Neurosurgical National Audit Programme	
Paediatric Intensive Care Audit Network (PICANet)	
Perioperative Quality Improvement Programme (PQIP)	
Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis)	Antibiotic Consumption
	Antimicrobial Stewardship
Sentinel Stroke National Audit programme (SSNAP)	
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	
Society for Acute Medicine's Benchmarking Audit (SAMBA)	
Surgical Site Infection Surveillance Service	
UK Parkinson's Audit	

2.2.2.4 The national clinical audits and national confidential enquiries that St George's University Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2019/20, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

NATIONAL CLINICAL AUDIT AND NATIONAL CONFIDENTIAL ENQUIRIES (TITLE)		SUBMISSION RATE (%)
Assessing Cognitive Impairment in Older People / Care in Emergency Departments		100%
British Association of Urological Surgeons (BAUS) Data & Audit Programme	Cystectomy	100%
	Nephrectomy	100%
	Percutaneous Nephrolithotomy	On-going
	Radical Prostatectomy	74%
Care of Children in Emergency Departments		100%
Case Mix Programme (CMP)	Neurology Intensive Care Unit	100%
	General Adult Intensive Care	100%
	Cardiothoracic Intensive Care Unit	100%
Child Health Clinical Outcome Review Programme: National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Long Term Ventilation	100%
Elective Surgery - National PROMs Programme		0%
Endocrine and Thyroid National Audit		On-going
Falls and Fragility Fractures Audit programme (FFFAP)	Fracture Liaison Service Database (FLS-DB)	On-going
	National Audit of Inpatient Falls (NAIF)	100%
	National Hip Fracture Database (NHFD)	100%
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit		On-going
Major Trauma Audit (TARN)		100%
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection		100%
Maternal, Newborn and Infant Clinical Outcome Review Programme	Confidential Enquiry into Maternal Deaths	Submitted on case by case basis
	Perinatal Mortality Surveillance	100%
	Perinatal Mortality and Morbidity Confidential Enquiries	100%
Medical and Surgical Clinical Outcome Review Programme	Acute Bowel Obstruction	66.7%
	Out of Hospital Cardiac Arrests (OHCA)	100%
	Dysphagia in Parkinson's Disease	100%
Mental Health - Care in Emergency Departments		100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)	Chronic Obstructive Pulmonary Disease (COPD)	On-going
	Adult Asthma	On-going
	Paediatric Asthma	100%
	Pulmonary Rehabilitation	On-going
National Audit of Breast Cancer in Older People (NABCOP)		100%
National Audit of Cardiac Rehabilitation (NACR)		On-going
National Audit of Care at the End of Life (NACEL)		95%
National Audit of Dementia (Care in general hospitals)		100%
National Audit of Seizure Management in Hospitals (NASH3)		100%

NATIONAL CLINICAL AUDIT AND NATIONAL CONFIDENTIAL ENQUIRIES (TITLE)		SUBMISSION RATE (%)
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)		100%
National Bariatric Surgery Registry (NBSR)		On-going
National Cardiac Arrest Audit (NCAA)		100%
National Cardiac Audit Programme (NCAP)	Adult Cardiac Surgery	On-going
	Adult Percutaneous Coronary Interventions	On-going
	Cardiac Rhythm Management (Arrhythmia Audit)	On-going
	Heart Failure Audit	On-going
	Myocardial Ischaemia National Audit Programme (MINAP)	On-going
National Diabetes Audit (NDA)	Adults: Core Audit	On-going
	Adults: Inpatient Audit (NaDIA)	100%
	Adults: Foot Care Audit	On-going
	Adults: National Pregnancy in Diabetes (NPID)	On-going
National Early Inflammatory Arthritis Audit (NEIAA)		On-going
National Emergency Laparotomy Audit (NELA)		97.9%
National Gastro-intestinal Cancer Programme		100%
National Joint Registry (NJR)		100%
National Lung Cancer Audit (NLCA)		100%
National Maternity and Perinatal Audit (NMPA)		N/A
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)		On-going
National Paediatric Diabetes Audit (NPDA)		On-going
National Prostate Cancer Audit		100%
National Smoking Cessation Audit		100%
National Vascular Registry		On-going
Neurosurgical National Audit Programme		On-going
Paediatric Intensive Care Audit Network (PICANet)		On-going
Perioperative Quality Improvement Programme (PQIP)		On-going
Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis)	Antibiotic Consumption	100%
	Antimicrobial Stewardship	100%
Sentinel Stroke National Audit programme (SSNAP)		On-going
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme		100%
Society for Acute Medicine's Benchmarking Audit (SAMBA)		100%
Surgical Site Infection Surveillance Service		On-going
UK Parkinson's Audit		100%

2.2.2.5 National clinical audits – action taken

The reports of 32 national clinical audits were reviewed by St George's University Hospitals NHS Foundation Trust in 2019/20 and the Trust intends to take the following actions to improve the quality of healthcare provided.

NATIONAL CLINICAL AUDIT	ACTION: BASED ON INFORMATION AVAILABLE AT THE TIME OF PUBLICATION
British Association of Urological Surgeons (BAUS) Urology Audit: Percutaneous Nephrolithotomy	The Trust is performing in line with national averages on all aspects of this audit. As the department is performing well on this audit, the clinical lead plans to continue working towards a high level of compliance, meeting the targets set by BAUS.
British Association of Urological Surgeons (BAUS) Urology Audit: Radical Prostatectomy	The report showed favourable performance against the national average with regards to average length of stay (both are measured at 3 days per patient). The Trust also provides treatment for a larger number of high risk patients than average. For example, the percentage of patients with Gleason 3+3 (low grade cancer) that are treated is 11.75%, against the national average of 13.49%. However, the Trust fell short of submission targets, with only 74% of the expected cases submitted for this audit. As the department is performing well on this audit the service is working on improving data quality levels and continuing working towards a high level of compliance, meeting the targets set by BAUS.
British Association of Urological Surgeons (BAUS) Urology Audit: Cystectomy	The Trust submitted 106% of the expected cases for this audit, showing good reporting from the department. The Trust is at 0% for both of 30-day and 90-day mortality rates, below the national average of 1.14% and 1.95% respectively. This is despite performing surgery on more high risk patients (≥75yo, with a BMI outside of healthy parameters, and with kidney function below normal) than national. As the department is performing well on this audit, the project lead plans to continue working towards a high level of compliance, meeting the targets set by BAUS.
British Association of Urological Surgeons (BAUS) Urology Audit: Nephrectomy	The Trust submitted 125% of the expected cases for this audit, showing good data quality. 2.02% of cases at the Trust involved a complication; lower than the national average of 2.51%. The measured mortality rate is 0% on this procedure, below the national average of 0.36%. As the department is performing well on this audit, the clinical lead plans to continue working towards a high level of compliance, meeting the targets set by BAUS.
Fracture Liaison Service Database (FLS-DB)	Results from the last audit report show the Trusts submission rate is low for the year. This has led to the Trust currently in the below average for 9 key metrics. The service has responded by entering data regularly onto the FLS database rather than storing it locally for bulk upload. This has already led to an increased number of submissions and the audit lead is hopeful the next report will reflect this.
Intensive Care National Audit and Research Centre (ICNARC): Case Mix Programme (CMP)	The audit lead stated that the Trust performed as expected for the three 3 streams of cardiothoracic intensive care, general adult critical care and neuroscience critical care. The action plan for this year is to work to improve mortality and morbidity meetings for all three streams.
Major Trauma Audit (TARN)	This project looks at survival rates of patients undergoing treatment for injuries. The Trust had a 98% case ascertainment rate between January 2018 and July 2019; this is significantly higher than the expected rate of 80%. The report shows number of survivors broken down by their survival chance pre-operatively. The Trust was found to have over performed on patients with a lower chance of survival (between 0%-45%), with 44 expected survivors against 56 actual survivors. Due to this good performance, the department plans to keep working towards the same standards they have set, while monitoring to make sure compliance stays high.
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Adult Asthma	The service reports that there have been issues with spirometry recording carried out in primary care. Due to vacancies within the respiratory CNS team, the Trust was unable to participate in the previous audit round, but this team is now back to full establishment and data collection recommenced at the start of 2019/20. Work is underway to improve the rate of patients receiving: • Specialist input to their care within 24 hours of admission • A discharge bundle before discharge

NATIONAL CLINICAL AUDIT	ACTION: BASED ON INFORMATION AVAILABLE AT THE TIME OF PUBLICATION
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): COPD	The service has steadily improved submission rates throughout the year in response to The Royal College of Physicians stating that the audit may move to being linked to best practice tariff. The audit lead has been working with the Trust IT team in order to arrange for all relevant patient data to be automatically extracted, which will allow the service to collect a sample every month, reduce the workload for clinical staff and further improve submission rates.
National Audit of Breast Cancer in Older People (NABCOP)	The latest audit report indicated a 100% submission rate for the Trust. Performance is generally in line with the national average except for Triple Diagnostic (clinical assessment, imaging and tissue biopsy). An action plan is in place to improve this performance moving forward.
National Audit of Percutaneous Coronary Interventions (PCI)	The audit report indicates that radial rate is stable and continues to be in line with the national average. The service plans to review NSTEMI data after making changes to data collection which will involve bringing this work under the remit of a clinical audit lead for Cardiology and tasking them with data submission, review and feedback to clinical teams.
National Cardiac Audit Programme (NCAP): National Heart Failure Audit	The Trust performed well for patients that are discharged from hospital on either angiotensin receptor blockers or beta blockers. Areas for improvement have been identified to look at the number of patients seen by a specialist, where the Trust was lower than national average for this measure and the number of patients referred to cardiac rehabilitation with confirmed heart failure.
National Cardiac Rhythm Management	The service reports that data collection is now collated for submission via PaceNet, an electronic record system. Results being uploaded once a month which has seen a large improvement in data quality and turnaround time which it is hoped will be reflected in the next audit round. Moving forward, this work will be brought under the remit of a clinical audit lead for Cardiology, who will be responsible for overseeing data submission, review and feedback to clinical teams.
National Diabetes Audit (NDA) - Adults: Pregnancy in Diabetes	The latest report indicates that the Trust were above the national average for managing HbA1c levels in the first and third trimesters. However, the Trust was below average for the number of women taking folic acid prior to pregnancy; the number of pregnancies where the first contact with the antenatal diabetes team was at less than 10 weeks gestation; and the percentage of babies born at or after 37 weeks who were admitted to a neonatal unit. The audit lead has recognised these issues and an action plan is under development.
National Diabetes Core Audit (NDA)	The service measures well against its peers in the latest report. However, it has been identified that the service are not capturing all eligible cases. Due to the low submission numbers the service lead and the clinical audit team are working with the Trust IT team in order to develop a system to automatically capture the 8 main criteria for the audit. This system will provide data that can be collated with the intent of monitoring improvements in patient results.
National Diabetes Footcare Audit (NDFA)	The Trust performs well against the national average for outcomes in the latest report results, and was in the minority of Trusts that all 6 care structures provided. The service is prioritising the following areas in the coming year: • Providing training sessions for ward staff and community teams on diabetic foot examination • Developing dedicated referral pathway into diabetic foot care and referral forms on primary care systems in the community for direct e-referral and assessment within 1 working day of referral. A pathway for A&E referrals and ward referrals to the service also exists • Integrated foot protection pathway covering community and acute settings from Tier 1 to Tier 4 • Integrated step-down pathway for patients returning to community foot protection. Promoting shared care with community podiatry and district nursing teams.
National Early Inflammatory Arthritis Audit (NEIAA)	The audit report highlighted the low numbers of submission from the Trust. The service have recognised this as due to a lack of patient pathway for eligible patients, and are in the process of modifying the pathway so all patients are seen and treated within the 6 week specified period. A new GP pro forma is being developed to assist GPs in identifying appropriate patients.

NATIONAL CLINICAL AUDIT	ACTION: BASED ON INFORMATION AVAILABLE AT THE TIME OF PUBLICATION
National Gastrointestinal Cancer Programme: National Bowel Cancer Audit (NBoCA)	The Trust submitted 143 cases for this audit period, which was RAG rated green by NBoCA. The report highlighted that 42% of patients having major resections were classed as urgent or emergency cases. The national average is 15%. The audit lead believes this is largely due to incorrect coding by support staff. The service is working on raising awareness and implementing training around this topic to address this. Also only 7% of the Trust's patients were reported as being seen by a CNS, against a national average of 87% - this is an error in reporting, as the pathway exists that that a CNS attend every appointment. Historic data available shows that Trust compliance on this measure has never been below 95% and has always been above national average. A plan is in place to correct data entry.
National Gastrointestinal Cancer Programme: National Oesophago-Gastric Cancer Audit (NOGCA)	The Trust submitted 131 records during the audit period, within the expected parameters based on HES. 20.7% of patients with oesophago-gastric cancer at the Trust were diagnosed after an emergency admission. This figure is 13% nationally. The audit lead believes that this rate is not truly accurate, as those reviewed in the acute ambulatory area will have been coded as an emergency, when in fact they were a GP referral. Awareness and education has been implemented to rectify this issue. The national target on referral to start of treatment is 62 days. The Trust reports patients have their treatment started after, on average, 69 days for curative treatment, and 78 days for non-curative treatment. Actions to address this include setting up a new telephone triage clinic, faster reporting times of CTs and a new nurse appointment for identified patients.
National Joint Registry (NJR)	The Trust submitted 100% of eligible cases with data quality also being either as expected or above the national standard. On both hip and knee replacements, the Trust performed 'as expected' on the three KPIs – 90 Day Mortality, Revision Rate Operations Aug 14-Aug 19 and Revision Rate: Operations Aug 14-Aug 19. As the service performed well, the project lead plans to continue working to the same standards, and hopes to keep the same high quality of results for the next audit round.
National Lung Cancer Audit (NLCA)	The Trust had a 100% submission rate. However, data completeness was below the national average. The audit lead has attributed this to Infoflex, the data collection tool, being incompatible with the Trust's IT infrastructure. System upgrades are due to be implemented this year and it is hoped to see an improvement in the next audit round.
National Maternity and Perinatal Audit (NMPA)	The service is performing well against the national average for key metrics in this project, including the number of babies given breast milk and the proportion of late preterm babies admitted to NNU. Actions for the coming year include embedding a new bariatric pathway for women with high BMI with a specific obstetric consultant and midwifery team, and monitoring the induction of labour rates for changes due to reduced fetal movements' guidance and 36-40 week scans.
National Paediatric Diabetes Audit (NPDA)	The audit lead confirmed that the service are working towards the following: • Increasing insulin pump usage by offering access to more modern insulin pumps and continuous glucose monitoring systems. A business case has been submitted to obtain funding for this equipment • Routinely offering families a separate appointment primarily for structured diabetes education and psychological support. • To improve the completion of all 7 cre processes, we have investigated the issues and have discovered shortfalls in receiving and reporting of the samples. An action plan is in place to address this.
Paediatric Intensive Care Audit Network (PICANet)	The latest audit report indicates that the rate of unplanned extubation was higher in 2018 compared to 2017 and was reflected nationally. The Trust performed well against the relative rate of emergency readmissions within 48 hours of discharge. The audit lead recognised these findings and an action plan is in place.
Perioperative Quality Improvement Programme (PQIP)	The Trust is performing above national average with regards to patients eating and drinking within 24 hours. The department reports to be continuing to strive towards a high level of compliance.

NATIONAL CLINICAL AUDIT	ACTION: BASED ON INFORMATION AVAILABLE AT THE TIME OF PUBLICATION
Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis): Antibiotic Consumption	The Trust increased its compliance against lowering UTIs during the year, but has identified further education and quality improvement work to be done within the elderly care department, whilst a new UTI pathway is introduced to the emergency department. Compliance improved for colorectal surgery over the year, meeting target in Q3. The project lead is working with the clinical coding department to improve timely identification of patients. The results for Q4 were unavailable and will be reviewed and responded to in due course.
Royal College of Emergency Medicine (RCEM): Feverish child audit 2019	The Trust was fully compliant in the audit submitting 120 cases. The Trust were below the national average for assessing risk of sepsis, assessing source of infections as per NICE guidance, timely reviews by seniors and an appropriate 'safety net' for discharged children. The results were fed back to staff during the departmental audit meeting and it was accepted that there is room for improvement. An action plan has been developed to address the main issue of documentation issue which will be rectified by using electronic record systems over the next 12 months with co-ordination from the clinical audit team.
Royal College of Emergency Medicine (RCEM): VTE risk in Lower Limb immobilisation 2019	The Trust was fully compliant in submitting 123 cases. The national report summarised the results into 3 key standards and we were above the national average for all of these measures showing a positive outcome. Results were fed back to staff during the service audit meeting by the project lead. A re-audit is planned for this year.
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	The project lead has identified that wrong blood in tube remains an on-going issue, along with avoidable transfusion reaction. There have been a low number of transfusion associated circulatory overload cases, which is a risk common in vulnerable patients. The following actions have been outlined for the coming year: • Continue to raise awareness and educate regarding common issues around the transfusion practice, including fluid balance and danger of transfusion associated circulatory overload cases • Currently auditing all sampling practice across the Trust, and putting together a business case for blood transfusion management software • Investigations into each case of transfusion reactions and share learning.
Surgical Site Infection Surveillance Services	The Trust was below the national average for the percentage of SSI cases for inpatients. Actions for the service in the coming year include: • Revising and adapting the RCA tool to expand the situations where it can be used • Reviewing the type of sutures used • Feeding back the findings of reports to wider range of stakeholders.
The National Audit of Cardiac Rehabilitation (NCAR) 2019	The Trust met all 7 of the key metrics of the audit. The service reports to be concentrating their efforts on the following areas in the coming year: • Continuing to maintain full certification of the standards required • Examining heart failure referrals into the Trust, as local figures suggest that there are potentially more patients who could be referred into the service, which could then pose a risk to capacity • Investigating the ratio of male to female referrals across all conditions/treatment groups, as the figures from the past 3 years suggest an imbalance. The service will update the departmental website with patient testimonials from a diverse set of patients to encourage attendance to the service.
UK Parkinson's Audit	The Trust performed well against 8 of the 9 key metrics and reported 100% submission rate. The report showed that the Trust performed below national average for patients feeling they were given suitable levels of information at diagnosis or when prescribed new medication. These finds have seen the following actions: • The service has implemented a 'newly diagnosed' session which provides patients with substantially more information than before • Working with clinicians to improve patient led decision making when new medications are prescribed.

2.2.2.6 Local clinical audits – actions taken

The reports of eight local clinical audits were reviewed by St George's University Hospitals NHS Foundation Trust in 2019/20 and the Trust intends to take the following actions to improve the quality of healthcare provided.

LOCAL CLINICAL AUDIT	ACTION: BASED ON INFORMATION AVAILABLE AT THE TIME OF PUBLICATION
Controlled Drugs Check & Stock Audit	This audit is conducted quarterly and ensures that controlled drugs are correctly stored and secured and that an adequate record is kept which complies with controlled drug guidance. Performance over the year has been largely positive, including a new standard related to Enfit bottle adaptors. Following the introduction of Enfit bottle adaptors the proportion of incorrect balance incidents involving liquid discrepancies has decreased Actions noted for the year ahead include: • Ward pharmacists have identified the need for enhancing the ward training package, to include how to order, how to enter into registers and calculate the amount of medication required • Implement brief training sessions on controlled drugs directly to ward nurses.
Early Warning Score Audit	This audit measures the graded response strategy used by the Trust for patients identified as being at risk of clinical deterioration as per NICE guidelines. The lead for this project reported an action plan for the next audit round: • Investigate the deterioration of the previous baseline for 'appropriate response' of 75% to a plateau of 60%. • Ensure ID card sized aide memoirs for escalation are available for staff.
Emergency Department Mental Health Documentation Audit	This audit was implemented in response to Care Quality Commission recommendations. The audit is conducted quarterly and has been in place since 2018, the last audit round indicated a need for improvement in nursing documentation. The following actions are planned for the upcoming year: • Teaching sessions – both at staff induction and on-going sessions. • Undertake review of any related research • Increase the sample size audit with assistance from medical students • Modify the audit tool to reflect new paper-light process in the department.
IV to Oral Switch Compliance Audit	This project aims to ascertain the number of patients who are prescribed IV antibiotics and those that are eligible to switch to oral antibiotics. Data is sampled from across different specialities. The average percentage of patients on IV antibiotics was measured higher than previous years due to assessing a select number of wards with the highest usage across the different specialities. All cases that were eligible for IV to oral switch were carried out within 24 hours, which is an improvement over previous audit rounds.
Local Safety Standards for Invasive Procedures (LocSSIPs): Theatre Areas	This audit project looks at reviewing the Trusts use of LocSSIPs for all invasive procedures. In Q4 19/20, 14 of the 17 reporting specialties were 100% compliant on all aspects of the LocSSIPs audit. Action plan for the coming year is to review all LocSSIPs tools to make sure that they are fit for purpose, as well as ensuring that all eligible procedures are audited.
Mechanical Thrombophylaxis Audit	An audit on medical thrombophlaxis was conducted to understand compliance behaviour at the Trust, following introduction of electronic prescribing, and to assess performance against guidance. The project lead confirmed the following actions in light of the findings: • Nurses, midwifes and healthcare assistants to be continuously trained on measuring, fitting and monitoring of anti-embolism stockings • Ensure information leaflets are available on all wards on VTE prevention • VTE champions to highlight importance of VTE prevention • Increase the focus on prescribing and nursing documentation by providing regular training sessions to doctors and nursing staff.

LOCAL CLINICAL AUDIT	ACTION: BASED ON INFORMATION AVAILABLE AT THE TIME OF PUBLICATION
Nasogastric Tube Audit	This audit was introduced as a response to investigate the care and maintenance of nasogastric tubes. The results showed that there is shortfall in the information recorded with respect to the insertion of and positioning of tubes prior to administering food, drink or medication. In response improvement actions were as follows: • Update the Trust policy to reflect changes to intensive care department guidance • Modify aspirate restrictions on wards, which contributes to more x-rays and delays in feeds or medication • Work at organisational level to send clear guidance to improve and standardise documentation on electronic record system • Electronic record system champions to offer training across all wards • Re-audit in 2020.
Safety Thermometer	The Trust has continued to submit data for this project, which focuses on the four most commonly occurring harms in healthcare: pressure ulcers, falls, UTI (in patients with a catheter) and VTEs. The average harm free care over the previous 13 months is 96%, which is both higher than the national average and the national standard of 95%.

2.2.3 Our participation in clinical research

Research is core to the purpose of St George's. Through research, we play our part in developing the treatments of tomorrow, give our patients access to new treatments and improve our clinical care. We lead and undertake research across our clinical specialities, supported by our diverse research nursing teams and Clinical Research Facility.

St George's recently launched its 2019/24 research strategy, with plans built on our strong research base and invest more in our staff to support their research ambitions, invest in our IT research infrastructure and gain core National Institute for Health Research (NIHR) funding for our Clinical Research Facility.

Crucial to our research is our partnership with St George's, University of London. We have set up four Clinical Academic Groups in specific areas where both institutions have expertise and critical mass, in which clinicians, clinical academics and scientists can collaborate to improve research activity. As part of our new research strategy, we are establishing the St George's Institute of Clinical Research, a joint NHS-University structure to increase collaboration and further our research.

A key way to develop and offer new treatments is through participation in clinical research studies that are approved by the NIHR, which supports NHS and academic institutions to deliver quality research that is patient-focused and relevant to the NHS. In 2019/20 St George's recruited 10,710 patients onto the NIHR portfolio adopted studies, which is double the number of three years ago.

The number of patients receiving relevant health services provided or subcontracted by St George's University Hospitals NHS Foundation Trust in 2019/20 that were recruited during that

The team behind our record increase in clinical trials

reporting period to participate in research approved by a research ethics committee was 10,928.

2.2.4 Our Commissioning for Quality and Innovation (CQUIN) performance

A proportion of St George's University Hospitals NHS Foundation Trust's income in 2019/20 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.

Further details of the agreed goals for 2019/20 and for the following 12-month period are available electronically at NHS England » 2019/20 CQUIN

In 2019/20 £8.3 million of our income is conditional on achieving quality improvement and innovation goals. In 2019/20 the percentage value for CQUIN dropped from 2.5% to 1.25% (1.55% for NHS England) of total contract income (excluding drugs and devices); hence the reduction.

2.2.5 Our registration with the Care Quality Commission (CQC)

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".

In 2019 we were named Innovative Trust of the Year by the Health Innovation Network (HIN)

The CQC has not taken any enforcement action against St George's University Hospitals NHS Foundation Trust during 2019/20.

A group of core services were inspected by the CQC in July 2019; the report was published in December 2019 and our rating was confirmed as 'Requires Improvement'. We were pleased to see significant improvement in our ratings across the key lines of enquiry for core services when compared with the 'Requires Improvement' position of the previous year.

Services for children and young people were rated as 'Outstanding' overall and there were services that were rated as 'good' overall. In the caring domain we were also pleased to receive a rating of 'Outstanding' for services for children and young people and 'Good' for all other services. The table overleaf shows the ratings for our core services and our overall rating.

The CQC made a recommendation to NHS England and Improvement (NHSE/I) for the Trust to be removed from Quality Special Measures. In February 2020 NHSE/I confirmed that the Trust was removed from Quality Special Measures, a significant step forward and one that recognises the improvements in quality and safety for our patients, their families and our staff.

Ratings for St George's Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires Improvement →← Dec 2019	Good ↑ Dec 2019	Good →← Dec 2019	Requires Improvement →← Dec 2019	Good ↑ Dec 2019	Requires Improvement →← Dec 2019
Medical care (including older people's care)	Requires Improvement →← Dec 2019	Requires Improvement →← Dec 2019	Good →← Dec 2019	Requires Improvement ↓ Dec 2019	Requires Improvement ↓ Dec 2019	Requires Improvement →← Dec 2019
Surgery	Good ↑ Dec 2019	Good ↑ Dec 2019	Good →← Dec 2019	Requires Improvement →← Dec 2019	Good →← Dec 2019	Good ↑ Dec 2019
Critical care	Requires Improvement Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Maternity	Good Nov 2016	Outstanding Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Services for children and young people	Good ↑ Dec 2019	Good →← Dec 2019	Outstanding ↑ Dec 2019	Outstanding ↑ Dec 2019	Good ↑ Dec 2019	Outstanding ↑↑ Dec 2019
End of life care	Requires Improvement Nov 2016	Requires Improvement Nov 2016	Good Nov 2016	Good Nov 2016	Requires Improvement Nov 2016	Requires Improvement Nov 2016
Outpatients	Good ↑ Dec 2019	Not rated	Good →← Dec 2019	Requires Improvement →← Dec 2019	Requires Improvement ↑ Dec 2019	Requires Improvement →← Dec 2019
Overall*	Requires Improvement →← Dec 2019	Requires Improvement →← Dec 2019	Good →← Dec 2019	Requires Improvement →← Dec 2019	Requires Improvement →← Dec 2019	Requires Improvement →← Dec 2019

*Overall ratings for the Trust are identified by the CQC by combining the ratings for the services. The CQC decisions on overall ratings take into account the relative size of services. The CQC uses their professional judgement to reach fair and balanced ratings.

Throughout 2019/20 the Trust continued to take proactive steps to deliver improvements within our cardiac surgery service and continues to provide a safe cardiac surgery service, confirmed by the Care Quality Commission (CQC) following an inspection of the service in August 2018. The CQC carried out a further inspection of our cardiac surgery service in July and September 2019 and the report, published on 18 December 2019, recognised the improvements made to the service and that the CQC were assured that there was credible and effective leadership in the cardiac surgery service. The CQC also noted the further improvements in governance, particularly in relation to mortality and morbidity meetings.

A separate panel of independent experts reviewed all patient deaths that occurred following cardiac surgery between April 2013 and December 2018. The panel examined the safety and quality of care that patients received during this period. The report was published in March 2020.

External oversight of the service is being maintained by NHSE/I and a package of support measures is in place to ensure there is continued progress and improvement.

2.2.7 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 NHS Foundation Trust are available on the CQC website www.cqc.org.uk

2.2.8 Our data quality

St George's University Hospitals NHS Foundation Trust submitted records during 2019/20 for inclusion in the Hospital Episode Statistics which are included in the latest published data.

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

- 98.86% for admitted care
- 99.60% for outpatient care
- 94.98% for accident and emergency care

The percentage of records in the published data which included the patient's valid General Medical Practice code was:

- 99.96% for admitted care
- 99.92% for outpatient care
- 99.95% for accident and emergency care

2.2.9 Our Information Governance Assessment Report

The Trust planned to be compliant with all the mandatory requirements of the NHS Data Security and Protection Toolkit (DSPT) by 31 March 2020. Due to Covid-19 outbreak, NHS Digital allowed all NHS organisations to postpone the toolkit submission until 30 September 2020. They also extended Mandatory Information Governance Training Requirement and National Data Opt-OUT Compliance until 30 September 2020. The Trust's Information Governance Manager together with the Informatics Services continues to work on the toolkit submission under the leadership of the Chief Information Officer while tackling emergent challenges due to the impact of Covid-19. The Trust will submit the toolkit with all the mandatory requirements by "Satisfactory Standard Met Status" by 30 September 2020.

2.2.10 Payment by Results

St George's University Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2019/20.

2.2.11 Learning from deaths

During 2019/20 1,660 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:

- 406 in the first quarter
- 370 in the second quarter
- 426 in the third quarter
- 458 in the fourth quarter

By 31 March 2020, 1063 case record reviews have been carried out in relation to 64% of the deaths included.

In 1063 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record or an investigation was carried out was:

- 384 in the first quarter
- 349 in the second quarter
- 312 in the third quarter
- 18 in the fourth quarter

Five (representing 0.3%) 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:

- Three representing 0.74% of the number of deaths which occurred in the first quarter
- Zero representing 0% of the number of deaths which occurred in the second quarter
- Two representing 0.47% of the number of deaths which occurred in the third quarter
- Zero representing 0% of the number of deaths which occurred in the fourth quarter

These numbers have been estimated using the locally developed online screening tool and structured review, which is based on the Royal College of Physicians (RCP) tool. Any death that is judged to be more than likely avoidable (more than 50:50) is included in this figure.

What we have learnt and action taken

Summary

Through timely review of a significant proportion of the deaths that occur within the Trust it is inevitable that opportunities for learning and reflection will be found. For any death where the central Mortality Review Team feel there is significant concern, the case is escalated immediately to the Risk Team to consider if a serious incident, or other, investigation is required. Any significant problem of care, whether or not it affected outcome, is highlighted to the clinical team for discussion and local learning.

During the course of the year a number of issues have been highlighted for local reflection and learning, including instances where excellent practice has been observed. These issues include documentation and communication, management of end of life care, early consideration of treatment escalation plans, responsiveness of medical teams and frequency of senior review. A selection of brief examples of issues raised and actions taken during the year are given below:

- There were a small number of cases where potential issues of care related to a lack of senior review at weekends. These were raised directly with the Chief Medical Officer for his consideration and were used to inform existing work-streams

looking at the configuration of care out of hours.

- Potential learning in relation to the discussion and documentation of decisions not to attempt resuscitation have been identified in a small number of cases. Reflections from clinical teams and discussion at local Morbidity and Mortality meetings identified the need to improve the transfer of information between teams and to ensure that documentation of decisions is not deferred.
- Improvements in communication related to patients transferred from Queen Mary's Hospital to St George's Hospital were realised through the deployment of our electronic patient system (iClip) to Queen Mary's, significantly improving information sharing and reducing the risk of communication difficulties in the future.
- Liaison with specialist teams continues to bring benefits. Mortality reviews for all patients that had venous thrombus embolisms in the Trust are now considered by the Hospital Thrombosis Group, in particular to consider whether they might influence any current clinical guidelines and practice. The Palliative Care Team have been consulted for their assessment of care in a number of cases and this has resulted in the team being invited to specialty meetings to provide training.

Action taken in 2019/20 and plans for 2020/21

For the first three quarters of the year our independent team of trained mortality reviewers ensured the timely review of over 90% of deaths in line with the Learning from Deaths framework. All patients where a care issue may have contributed to death were escalated to the risk team and included in our serious incident decision meeting (SIDM) discussions. Any death where review suggested it may have been potentially avoidable was escalated to the risk team to consider detailed investigation and rapid response through our serious incident process. Any significant problem of care, whether or not it affected outcome, was brought to the attention of the clinical team for discussion and learning at the local morbidity and mortality meeting.

In the final quarter of the year we introduced the Medical Examiner service. The Medical Examiner scrutinises non-coronial deaths and alerts the Trust's team of trained mortality reviewers to any death that requires completion of a structured judgement review, in line with Learning from Deaths. To support robust clinical governance processes the Medical Examiner will alert clinical teams to any deaths where potential learning has been identified.

The implementation of the treatment escalation plan (TEP) process was one of three clinical priorities for the Trust this year. Our mortality reviews suggest that an increasing proportion of patients are benefitting from having a TEP in place and continuing to embed this will help to address a number of issues that have been identified through our Learning from Deaths process. Common themes for improvement include documentation, particularly of discussions between teams and with families and carers; management of end of life care; and the involvement of senior team members at key points in the patients' care. The TEP process and associated documentation supports improved practice across these elements of care.

In addition to promoting reflection and learning by highlighting to governance and clinical teams where care or treatment could potentially have been better, the mortality review team has also sought to achieve this aim through acknowledging excellent practice.

This year an extensive review of mortality governance has been completed and the action plan arising from this has been endorsed by the Board. The aim of this work is to strengthen existing processes to ensure that we maximise the opportunities for learning identified by mortality reviews, and to support the design and delivery of appropriate action plans.

During 2019/20 the Trust has established a Medical Examiner Office to further support the bereaved. Medical Examiners began scrutinising deaths in January 2020 and have been expanding the coverage of the service during the final quarter of the year with the intention of performing full scrutiny of all non-coronial in-hospital deaths by April 2020, in line with the expectations of the National Medical Examiner. In 2020/21 the focus will be on refinement of the Medical Examiner service and planning the extension of scrutiny to deaths that occur outside of hospital.

There were no (0) case record reviews and no (0) investigations completed after 30 April 2019 which related to deaths which took place before the start of the reporting period.

Five representing 0.3% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient.

This number has been estimated using the locally developed online screening tool and structured review, which is based on the Royal College of Physicians (RCP) tool.

Five representing 0.3% of patient deaths during 2019/20 are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.2.12 Standards for Seven day Services

The Trust is compliant with standards five, six and eight for seven day services and has improved compliance with standard two (all emergency admissions must be seen by a consultant within 14 hours of admission). Throughout 2019/20 a series of improvement actions were taken by the Trust however the Trust was unable to deliver full compliance by April 2020.

Due to the impact of Covid-19 the Board assurance statement has been deferred until September 2020 and will be reflected in the Quality Account 2020/21.

2.2.13 How our staff can speak up

Staff are encouraged and supported to speak up and have various ways of doing so. Staff are encouraged in the first instance to raise issues with their line manager, often concerns can be resolved at this level. However, it is recognised that some staff may not feel comfortable in taking this route, especially if the concern being raised pertains to their line manager.

Staff can raise concerns with:

- Any manager/ leader within their department
- Freedom to Speak up Guardian/ Champion
- Their Human Resource Adviser/ Manager
- Executive and Non – Executive leads for Freedom to Speak Up
- Chief Corporate Affairs Officer
- Chairman

Staff can raise concerns in different ways such as:

- Face to Face (verbally)
- In writing (letter/ email)
- Telephone contact

Staff are also advised of external reporting routes if they are unhappy with using any of the internal reporting routes or if they indicate that after raising a concern they do not feel the concern was investigated in line with Trust procedures, for example Care Quality Commission, and recognised professional or union body.

Staff who speak up are advised to report incidents where they feel due to speaking up they have come to a detriment. If it is found that this is the case, the Trust will take appropriate action to mitigate the risk to the staff member concerned and if necessary appropriate action taken under the Trusts disciplinary procedure. Staff are also regularly referred for additional support after raising concerns to our staff support team and or Occupational Health by agreement with the staff member.

Once an outcome is received the feedback is given to the person raising the concern either in writing or verbally dependent upon the issue raised, how it was resolved i.e. formally or informally and the preference of the person raising the concern. Clearly, anonymous concerns cannot be fed back however the outcome is logged by the Trust.

2.2.14 Guardian of Safe Working

We have a Guardian of Safe Working Hours who ensures our doctors are always working a safe number of hours and comply with the Terms and Conditions for Doctors and Dentists in Training (NHS England, update 2019). The Guardian acts as the champion of safe working hours and receives reports and monitors compliance. 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. A health roster system is now available to all medical staff.

In 2019/20 throughout the year the rota gap ran at an average of 10%. A total of 348 exceptions (rota gaps) were reported which is a significant reduction from 2018/19 (369 exception reports). Ten were highlighted as an immediate safety concern, compared with fifteen immediate safety concerns raised in 2018/19. Each safety concern was addressed immediately and no patients came to harm. Improvement plans were developed which saw targeted recruitment to support rota cover, a full work schedule review in one case, communication on how to escalate clinical concerns (also included in junior doctor induction), IT training and provision of laptops to support different ways of working and specific support for trainees in difficulty.

Gaps in rotas remain a nationwide problem and despite active recruitment, posts can stand unfilled for substantial periods of

time. The Trust workforce strategy 2019-24 focusses on recruitment and retention of all staff which will benefit doctors in training.

2.3 Reporting against Core Indicators 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.

2.3.1 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 1, a score below 1 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.

SUMMARY HOSPITAL LEVEL MORTALITY INDICATOR (SHMI)	Apr 18 – Mar 19	May 18 – Apr 19	Jun 18 – May 19	Jul 18 – Jun 19	Aug 18 – Jul 19	Sep 18 – Aug 19	Oct 18 – Sep 19	Nov 18 – Oct 19	Dec 18 – Nov 19	Jan 19 – Dec 19
SHMI	0.82	0.82	0.81	0.83	0.83	0.83	0.85	0.85	0.85	0.86
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	Lower than expected	Lower than expected
% Deaths with palliative care coding	51	51	50	49	49	50	49	49	48	47

Source: NHS Digital

2.3.1.1 The Trust 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.

2.3.1.2 The Trust has taken and plans to take the following actions to improve this indicator and so the quality of our services:

- We have fully implemented the Learning from Deaths Framework and commenced implementation of the Medical Examiner System. We undertook a review of our mortality monitoring process. We plan to continue to strengthen this and review all deaths to ensure we identify and share every opportunity to learn and improve the care our patients receive.

2.3.2 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.

Percentage of patients reporting an increase in health following surgery		2013-14		2014-15		2015-16		2016-17		2017-18		2018-19*	
		SGH	National average	SGH	National average	SGH	National average	SGH	National average	SGH	National average	SGH	National average
Hip replacement	EQ-5D™	86	82.7	90	88.2	100	88.4	77	89.1	71	90	66.7	90.2
	EQ-VAS	65	64.2	80	65.1	58	65.6	75	67.2	43	68.3	66.7	69.6
	Specific	81	96	100	96.4	94	96.5	71	96.7	75	97.2	100	97.2
Knee replacement	EQ-5D™	60	80.3	60	80.5	69	80.7	100	81.1	0	82.6	No data	82.7
	EQ-VAS	50	54.6	50	55.3	33	56.4	40	57.5	33	59.7	No data	59
	Specific	80	93	82	93.2	85	93.6	100	93.8	33	94.6	No data	94.7

Source: NHS Digital9https://digital.nhs.uk/data-and-information/publications/statistical/patient-reported-outcome-measures-proms/hip-and-knee-replacement-procedures---april-2018-to-march-2019

* The 2019/20 data has not been published at the time of submitting this report. This data will be included in the Quality Report 2020/21.

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, we had three patients with total hip replacements and no patients for total knee replacement in 2019/20 (although this data has not been published at the time of writing this report).

2.3.2.1 The Trust considers that this data is as described 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 a minimum of three 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.

2.3.2.2 The Trust has taken and plans to take the following actions to improve this indicator and so the quality of our services:

- Continue to offer patients the opportunity to participate in PROMs and contact the patient at the three month intervals to prompt a further response.

2.3.3 Readmission within 28 days of discharge

Emergency readmission occurs when a patient has an unplanned re-admission to hospital within 28 days of previous discharge.

READMISSIONS	2016-17			2017-18			2018-19			2019-20		
	0-15	16 and over	Total	0-15	16 and over	Total	0-15	16 and over	Total	0-15	16 and over	Total
Discharges	14102	46946	61048	14201	47572	61773	13975	48206	62181	13022	47103	60125
28 day readmissions	659	4236	4895	651	4428	5079	751	4006	4757	932	4218	5150
28 day readmissions rate	4.67%	9.02%	8.02%	4.58%	9.31%	8.22%	5.37%	8.31%	7.65%	7.16%	8.95%	8.57%

2.3.3.1 The Trust considers that this data is as described for the following reasons:

- This data is validated through the Trust's informatics and reporting processes.

2.3.3.2 The Trust has taken and plans to take the following actions to improve this indicator and so the quality of our services:

- By committing to reducing re-admission for all patients irrespective of whether that care is planned or unplanned, 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.

2.3.4 Patient experience

In the national inpatient survey five questions are asked focussing on the responsiveness and personal care of patients. Our scores are consistent with the national average shown below. The data below shows the average, highest and lowest performers and our previous performance.

PATIENT EXPERIENCE	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19*
St George's University Hospitals	66.6	68.8	68.6	67.9	66	65	67.2
National average	68.1	68.7	68.9	69.6	68.1	68.6	67.2
Highest (best)	84.4	84.2	86.1	86.2	85.2	85	85
Lowest	57.4	54.4	59.1	58.9	60	60.5	58.9

https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework/current/domain-4-ensuring-that-people-have-a-positive-experience-of-care-nof/4-2-responsiveness-to-inpatients-personal-needs

* The 2019/20 data has not been published at the time of submitting this report. This data will be included in the Quality Report 2020/21.

2.3.4.1 The Trust considers that this data is as described for the following reasons:

- This data is validated through the Trust's informatics and reporting processes.

2.3.4.2 The Trust has taken and plans to take the following actions to improve this indicator and so the quality of our services:

- Continue to maintain and improve performance, by continually engaging with patients, family, friends and carers
- Respond to the findings of our ward and department accreditation programme
- Take improvement action in line with our Quality and Safety Strategy 2019/24.

2.3.5 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 for 2019/20 shows that we achieved above average scores for staff who would be happy with the standard of care that would be provided to a friend or a relative who needed treatment by this organisation.

STAFF RECOMMENDATION	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
St George's University Hospitals	67%	73%	71%	70%	73%	69%	72%
Average for Acute	66%	68%	70%	68%	69%	70%	71%
Highest Acute Trust	94%	93%	93%	95%	86%	87%	87%
Lowest Acute Trust	40%	36%	46%	48%	47%	41%	40%

http://www.nhsstaffsurveyresults.com/wp-content/uploads/2020/02/NHS_staff_survey_2019_RJ7_full.pdf

2.3.5.1 The Trust considers that this data is as described for the following reasons:

- This data is validated through the Trust's informatics and reporting processes.

2.3.5.2 The Trust has taken and plans to take the following actions to improve this indicator and so the quality of our services:

- Focus on staff engagement and quality improvement, listening to staff and addressing their concerns.

2.3.6 Patient recommendations to friends and family

Our patients are very positive about our services and in 2019/20, 96.5% of our Inpatients and 82.4% of those visiting our A&E department said they would recommend our services to their friends and family.

FRIENDS AND FAMILY TEST	2016-17		2017-18		2018-19		2019-20	
St George's University Hospitals	A&E	Inpatient	A&E	Inpatient	A&E	Inpatient	A&E	Inpatient
Response rate	23.10%	30.76%	20.19%	25.50%	26.20%	26.40%	15.27%	34.38%
% would recommended	83.80%	95.81%	84.26%	96.24%	87.00%	97.00%	82.41%	96.5%
% would not recommend	10.51%	1.29%	10.39%	1.08%	8.50%	1.00%	12.36%	1.14%
National comparison as at March 2020 response rate	12.9%	26.1%	12.8%	23.2%	12.3%	24.6%	12.1%	24.4%
National comparison as at March 2020 % would recommend	87%	96%	84%	96%	86%	96%	85%	96%
National comparison as at March 2020 % would not recommend	7%	1%	9%	2%	8%	2%	9%	2%

..\Performance Visibility Team\Performance Board & Quality Monthly Reports\Archive\FFT 2017.xlsx

2.3.6.1 The Trust considers that this data is as described for the following reasons:

- This data is validated through the Trust's informatics and reporting processes.

2.3.6.2 The Trust has taken and plans to take the following actions to improve this indicator and so the quality of our services:

- Continue to improve the quality of its services, by listening to patients and addressing their concerns.

2.3.7 Venous thromboembolism

Venous thromboembolism (VTE) occurs when a deep vein thrombosis (blood clot in a deep vein, most commonly in the legs) and pulmonary embolism (where such a clot travels in the blood and lodges in the lungs) causes substantial long term health problems or death. Risk assessments for VTE ensures that we intervene with preventative measures at the earliest possible time

2.3.7.1 The Trust considers that this data is as described for the following reasons:

- This data is validated through the Trust's informatics and reporting processes.

2.3.7.2 The Trust plans to take the following actions to improve this indicator and so the quality of our services:

- Continue to working to achieve higher VTE risk assessment rates
- Optimisation of iClip.

VTE ASSESSMENTS	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
St George's University Hospitals	95.89%	96.77%	96.64%	95.90%	96.0%	93.9%
National Average	96.10%	95.76%	95.61%	95.80%	95.6%	95.5%
Best performing Trust*	100%	100%	100%	100%	100%	100%
Worst performing Trust*	79%	78.1%	63%	72%	74.4%	71.7%

https://improvement.nhs.uk/resources/venous-thromboembolism-vte-risk-assessment-q2-201920/

2.3.8 Infection control

We are committed to improving safety by avoiding or reducing Clostridium Difficile which results in shorter length of stay and improved patient experience.

CLOSTRIDIUM DIFFICILE	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
St George's University Hospitals						
Trust apportioned cases *Change in reporting: denotes those Cases confirmed due to lapses in care	38	29	36	16	31	*8
Trust bed-days as at 20/2/20	254,213	273,493	287,962	296,981	282,339	285,321
Rate per 100,000 bed days	14.9	10.6	12.5	5.4	11.0	2.8
National average	33.7	33.7	30.2	31.2	33	3
Worst performing trust	121	139	116	113	177	15
Best performing trust	0	0	0	0	0	0

http://stg1tableau01/#/site/L/views/BedOccupancy_1/OccupiedBedDaysbyAdmissionMethod?:iid=4

2.3.8.1 The Trust considers that this data is as described for the following reasons:

- We have a process in place for collating data on Clostridium Difficile cases. The data is collated internally and submitted to Public Health England. The CCG reviews the root cause analysis undertaken and provides validation as to whether Clostridium Difficile acquisition was due to a lapse in our care.

2.3.8.2 The Trust plans to take the following actions to improve this indicator and so the quality of our services:

- 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 improved environmental hygiene and antibiotic stewardship supported by continuous staff engagement and education.

2.3.9 Patient safety incidents

PATIENT SAFETY INCIDENTS	OCT 14 - MAR 15	Apr 15 - Sep 15	Oct 15 - Mar 16	Apr 16 - Sep 16	Oct 16- Mar 17	Apr 17- Sep 18	Oct 18- Mar 19	Apr 19- Sep 19	Oct 19 – Mar 20
St George's University Hospitals									
Total reported incidents	5,188	5,353	5,453	5,964	5,928	5,548	5934	6268	Not published
Rate per 1000 bed days	34.1	33.2	32.8	36.5	37.6	34.2	39.5	45.3	Not published
*National average (acute non-specialist)	37.1	39.3	39.6	40.8	41.1	42.8	46.1	Not	Not published
*Highest reporting rate	82.2	74.7	75.9	71.8	69	111.7	95.9	Not published	Not published
*Lowest reporting rate	3.6	18.1	14.8	21.1	23.1	23.5	16.9	Not published	Not published

PATIENT SAFETY INCIDENTS	OCT 14 - MAR 15	Apr 15 - Sep 15	Oct 15 - Mar 16	Apr 16 - Sep 16	Oct 16- Mar 17	Apr 17- Sep 18	Oct 18- Mar 19	Apr 19- Sep 19	Oct 19 – Mar 20
St George's University Hospitals									
Incidents causing Severe Harm or death	16	23	20	15	13	14	23	10	Not published
% incidents causing Severe Harm or death	0.31%	0.43%	0.37%	0.25%	0.22%	0.25%	0.15%	0.12%	Not published
*National average (acute non-specialist)	0.50%	0.43%	0.79	0.38%	0.37%	0.35%	0.36%	Not published	Not published
*Highest reporting rate	5.10%	1.96%	1.33%	1.38%	1.09%	1.23%	0.49	Not published	Not published
*Lowest reporting rate	0.05%	0.09%	0%	0.02%	0.03%	0.02%	0.01%	Not published	Not published

https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework/current/domain-5-treating-and-caring-for-people-in-a-safe-environment-and-protecting-them-from-avoidable-harm-nof/5-6-patient-safety-incidents-reported-formerly-indicators-5a-5b-and-5-4

2.3.9.1 The Trust considers that this data is as described for the following reasons:

- This data is validated through the Trust's informatics and reporting processes.

2.3.9.2 The Trust has taken the following actions to improve this indicator and so the quality of our services:

- Continue to work towards enhancing existing mechanisms throughout 2020/21. 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.

Part 3

3.1 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 can be seen in the table below.

Key performance indicators

		TARGET	ANNUAL PERFORMANCE 2018-19	ANNUAL PERFORMANCE 2019-20
Referral to treatment times	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on a complete pathway		N/A (Not reporting)	84.2%
ED access	95% of patient wait less than 4 hours	>=95%	88.4%	83.2%
Cancer access	% cancer patients treated within 62 days of urgent GP referral	>=85%	86.9%	85.2%
	% patients treated within 62 days from screening referral	>=90%	86%	88.8%
Diagnostic waits	Maximum 6 week wait for diagnostic procedures	99%	99%	95.7%

3.2 Our performance against our Quality priorities in 2019-20

The progress we have made in delivering our quality priorities for last year is set out in the table below and where able, compared with performance for the previous year, 2018/19.

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. In addition, all qualitative measures of success have been assured through the relevant Trust governance frameworks.

PATIENT SAFETY			
OUR QUALITY PRIORITIES	WHAT WILL SUCCESS LOOK LIKE?	HOW DID WE DO IN 2019/20?	HOW OUR PERFORMANCE COMPARED WITH 2018/19
Emergency adult patients will have treatment escalation plans (TEP)	We will ensure that all non-elective adult inpatients have a treatment escalation plan (TEP) in place within 24 hours of admission	We partially achieved this We implemented TEP in paper format whilst we built an electronic TEP in the test domain of iClip. We rolled out the electronic TEP Trustwide in March 2020 in response to Covid-19. We will take this quality priority forward in to 2020/21 and develop an electronic mechanism to monitor the number of TEPs in place for adults within 24 hours of admission	In 2018/19 we established an improvement project and started developed the TEP (paper)
Identification, protection and care of patients who lack mental capacity to make certain decisions	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 Mental Capacity Act (MCA) training	We partially achieved this Revisions to iClip have been made in the test domain to standardise recording and enable efficient audit processes. The electronic forms will be implemented in 2020/21. Mental Capacity Act and Deprivation of Liberties (MCA/DoLs) Training – Level 1 training performance has achieved the target of 90% or above Level 2 training performance is 76.4% against a target of 85%	In 2018/19 we established an improvement project and developed level 1 and 2 training modules

PATIENT SAFETY			
OUR QUALITY PRIORITIES	**WHAT WILL SUCCESS LOOK LIKE?**	**HOW DID WE DO IN 2019/20?**	**HOW OUR PERFORMANCE COMPARED WITH 2018/19**
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	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)	We partially achieved this We have successfully launched the Critical care Outreach team who operate on the wards in response to calls and also pro-actively seek out patients with high NEWS2 scores NEWS2 audits showed 94.1% in March 2020 The number of cardiac arrests in 2019/20 showed a reduction of 12% when compared with 2018/19. (From 177 in 2018/19 to 151 in 2019/20)	The number of cardiac arrests in 2018-19 showed a slight increase reduction of 2.3% when compared with 2017/18. (From 173 in 2017/18 to 177 in 2018/19). NEWS2 audits showed 89.6 % in March 2019
We will provide a responsive, high quality complaints service	We will achieve our targets for responding to complaints by the end of September 2019	We achieved this From August 2019 to March 2020 we achieved the complaints response performance targets across all 3 complaint response categories	The performance targets were not met in 2018/19: • 68% against 85% target for 25 day responses • 55% against 90% target for 40 day responses • 62% against 100% target for 60 day responses
We will build a patient partnership structure to enable patients to be involved in improvement work from the earliest stage	We will deliver year one of the strategy and develop the strategy for the next three years	We achieved this We delivered the objectives as set out in the one year Patient Partnership and Experience Strategy 2019/20. The strategy for Patient Partnership and Experience is included as a priority focus area within the Quality and Safety Strategy 2019/24	In 2018/19 twelve patient partners were recruited to the Patient Experience and Partnership Group. A service level patient user group was established in dermatology, urology and at Queen Mary's Hospital
We will improve immediate feedback from patients through the Friends and Family Test (FFT) by increasing response rates for both inpatient and outpatient services	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	We did not achieve this Our response rate for inpatient, outpatient and the emergency department was 34.5%, 5.6% and 15.3% respectively Changes in FFT guidance will be implemented in April 2020. The guidance encourages patients to provide feedback throughout their care episode. In preparation for this and in line with guidance, the wording of the questions and changes to the Trust systems have been developed for launch when appropriate to do so in 2020 (responding to the impact of Covid-19)	In 2018/19 the improvements that were expected to enable the Trust to achieve this target were put in place in Q4; these include FFT being made available on our public website and by launching text messaging

CLINICAL EFFECTIVENESS AND OUTCOMES			
OUR QUALITY PRIORITIES	**WHAT WILL SUCCESS LOOK LIKE?**	**HOW DID WE DO IN 2019/20?**	**HOW OUR PERFORMANCE COMPARED WITH 2018/19**
We will improve services for people with mental health needs who are in an acute healthcare setting	We will demonstrate through audit of healthcare records that patients' mental health needs have been met when they are receiving care from our acute services	We achieved this We have met our CQUIN goal and achieved our objective for 2019/20	In 2018/19 we met our CQUIN goal and achieved this objective through the delivery of a joint project with SW London Mental Health NHS Trust to improve physical and mental health care for those in crisis
We will improve the effectiveness of our discharge process by ensuring that patients are equipped with the information they need to manage their health and that they know how to access appropriate support	We will see an improvement in the response to these questions on our local patient surveys and in the national patient survey 2019	We partially achieved this 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 2020/21	We did not see an improvement in the response to these questions on our local patient surveys and in the national patient survey
We will review and improve our clinical governance	We will carry out a review of our clinical governance processes throughout the trust to ensure they support the delivery of safe, high quality care	We achieved this We carried out two external reviews: Review 1 Mortality Meetings and MDT review meetings; Review 2 Clinical Governance Resilience and Capacity. Improvement plans have been developed and will be implemented throughout 2020/21 together with a third external review that will look at the quality and safety reporting and monitoring within the divisions up to the sub-committees of the Board	Not applicable

Annex 1: Statements from commissioners, local Healthwatch organisations and Overview and Scrutiny Committees

A1.1 Statement from Wandsworth Clinical Commissioning Group (Now SWL CCG)

Wandsworth Clinical Commissioning Group (CCG) was the host commissioner for St George's University Hospitals NHS Foundation Trust (SGUH) during 2019/20 and was responsible for the commissioning of high-quality health services from the Trust on behalf of the population of Wandsworth and surrounding boroughs. On 1 April 2020, Wandsworth CCG became part of the new South West London (SWL) CCG. The reference made in this statement to 'The CCG' therefore refers to the previous Wandsworth CCG.

The SGUH leadership team has engaged fully with Wandsworth CCG during 2019/20 and has provided a good level 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/ Improvement. Assurance is also gained through undertaking

quality assurance visits in SGUH, and intelligence gained from other sources including the patient feedback directly to the CCG.

SGUH has been proactive in addressing quality issues identified through the CCG's well-established Quality Alert system (Make a Difference). This system 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 addressing the long wait for treatment and improving patient flow in relation to discharges, have been included in the priorities for 2020/21.

The CCG has worked closely with the Trust throughout 2019/20 on their implementation of the CQC action plan, which has been monitored monthly at the CQRG. The CCG commends the Trust on the significant progress made by the Trust in delivering on the CQC action plan. This was reflected in the outcome of the CQC inspection in 2019, reported in December 2019, which recommended that the Trust should be removed from quality special measures. We will continue to monitor the CQC action plan from the inspection throughout 2020/21.

The CCG welcomes the opportunity to provide a statement for SGUH's Quality Account for 2019/20. We confirm that we have reviewed the information contained within the draft Quality Account and agree with the Trust's assessment of the delivery of the 2019/20 priorities. We are pleased to note the significant progress made in delivering our quality priorities for last year, particularly the launch of the critical care outreach team as well as the achievement of the complaints response performance targets. We are pleased to note that the focus for the next year will be to undertake thematic analysis of complaints to identify themes and share findings. In addition, the CCG would like to see the Trust focus on the triangulation of these findings with themes from other sources, like incidents and serious incidents to achieve integrated learning.

The CCG was disappointed to note that only little progress was made in improving effectiveness of discharge processes in 2019/20. Work with Healthwatch and quality alerts received by the CCG during the year suggest that discharge continues to be an area where our patients and our local community want to see improvements. We are encouraged to note that this priority is being carried forward into 2020/21.

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 2020/21 and are pleased to note that these priorities are in line with those agreed at the CQRG. We are also pleased with the continued priorities on managing the deteriorating patient and outpatient follow up appointments.

We would urge SGUH to also consider a focus on improving outcomes for non-cohorted heart failure patients, and the implementation of the maternity continuity of care targets for 2020/21.

In addition, we would like to have seen an overview of some of the quality challenges in 2019/20 in relation to the cardiac surgery services and emphasis of some of the quality improvement work that has already taken place in the services. We were pleased to note that the actions from the two clinical and mortality governance reviews will continue to be implemented in 2020/21. It is important for the Trust to continue to focus on improvements to the clinical and quality governance systems and processes across the organisation.

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 is committed to working collaboratively to support the Trust in delivering the priorities identified in the quality report for 2019/20.

Dr Nicola Jones MBE
MBChB DRCOG MRCGP MBA
Chair, Wandsworth Clinical Commissioning Group (Now SWL CCG)

05 June 2020

A1.2 Statement from Healthwatch Wandsworth

Thank you for the opportunity to view and provide comments on this year's Quality Account. We have continued to have been kept informed and involved in the monitoring of quality improvement throughout the year at the monthly Quality and Safety Committee, the Clinical Quality Review Group and the Patient Partnership Engagement Group. We also take part in other areas of governance through our Healthwatch appointed Governor.

Although at times, it can be challenging for our small team of staff and volunteers to keep pace with the fast pace of arrangements for meetings and the preparation involved, we are grateful for the welcome our input and presence receives and for the opportunity to comment on the annual quality account.

We witness a great deal of time and energy spent on quality improvement plans, processes and assurance. Staff at all levels can be congratulated for the achievements made to move the Trust forward from CQC Quality Special Measures and a number of ratings of 'Outstanding'. As the quality account alludes to, there are still areas of challenge and need for further improvement. We hope that it will not be long before the Trust is able to progress from 'Requires Improvement' as they develop an organisation wide culture of continuous improvement.

Discharge

We were pleased that discharge was a focus for quality improvement during the year based on our feedback. In 2019-20 we conducted Enter and View activity at the hospital's discharge lounge. Many patients were positive about their experience, but we were able to highlight areas the Trust can focus on for further development and we are pleased to see discharge as a quality improvement priority for the next year.

In 2019, Healthwatch Wandsworth conducted a 'Enter and View' in our departure lounge (pictured).

Consent

Consent has appeared as an area for improvement, particularly in relation to cardiac surgery. We think this is a crucial part of managing quality because it is essential to the patient experience and as assurance that the patient has made an informed choice about their own care.

Cardiac surgery

We welcome the independent review of cardiac deaths, and the Trust's commitment to implement all the recommendations. We look forward to monitoring the action plan. Within the Quality Account we think it could be more meaningful to include some more detail about this, specifically the finding that out of 202 deaths between 2013 and 2018 examined by the independent panel, 'there were failings in the care provided to 102 patients at St George's during this period, and that for 67 patients these care failings either definitely, more likely or probably contributed to their deaths.'

Patient experience data

The Trust has improved its response times in the complaints process over the year, which had previously appeared a significant challenge. Over the next year we shall see if we begin to hear more positive experiences of the process. We hope that use of insight from complaints continues to develop and provide learning and improvement opportunities,

and that patients are involved in any further development of the complaints and feedback mechanisms as well as their individual cases.

Response rates for the 'Family and Friends Test' have room to be improved. Could the Trust explore other ways of obtaining direct feedback that can inform quality improvement monitoring systems?

We would welcome more of a sense about the feedback from patients on the quality priorities as mentioned in the introduction, and how patients' feedback influences quality improvement.

Experience for patients who lack mental capacity

This is an essential area for the Trust to focus on. We suggest that patient and carer experiences could offer an informative and insightful contribution to develop something that works for them, as well as enhancing staff understanding of care needs. There are many community-based support organisations where experience could be gathered.

Provide an equitable experience for patients from vulnerable groups

The focus this year is on patients with learning disabilities which is very important. We would like to see some mention of other protected characteristic groups.

Waits for treatment

We support the priority targets for waiting for treatment and commend progress made in improving processes to monitor and improve waiting times. However, it would be useful to see how the achievability of targets have been tempered by the impact of Covid-19.

We recognise that the Covid-19 pandemic only struck towards the end of the reporting year. Nevertheless, its impact on patients and communities has been so great that we feel it merits greater attention in this Account. We would welcome explicit assurance that, as services continue to change in response to the pandemic, quality will remain at the forefront of the new plans, and that, while recognising the need at times for pace, patients will remain engaged and consulted throughout.

Finally, St George's Hospital is a valued and central service within our Wandsworth Community. The Covid-19 pandemic has demonstrated how the service and staff are needed and appreciated by our community. Stronger frameworks for collaborative working are now being established within Wandsworth and a wider region, such as that of the new South West London CCG and ICS, and closer links with Epsom and St Helier through a shared chairperson. Covid-19 has already encouraged closer alignment with community, primary and social services on key areas such as discharge management. It would be fitting for the Account to refer explicitly to these strategic opportunities to raise quality and standards of care through improved collaboration.

Stephen Hickey
Chair, Healthwatch Wandsworth

09 June 2020

A1.3 Statement from Wandsworth Adult Care and Health Overview Scrutiny Committee

[Not provided due to Covid-19 pandemic]

A1.4 2018/19 limited assurance report on the content of the Quality Reports and mandated performance indicators

[Not provided due to Covid-19 pandemic]

A1.5 Independent auditor's report to the Council of Governors of St George's University Hospitals NHS Foundation Trust on the Quality Report

[Not provided due to Covid-19 pandemic]

Annex 2: A2.1 Statement of Directors' responsibilities for the Quality Report

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

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

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2019/20 and supporting guidance Detailed requirements for quality reports 2019/20
- 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 2019 to 25 June 2020
  - papers relating to quality reported to the board over the period April 2019 to June 2020
  - feedback from commissioners dated 5 June 2020
  - feedback from governors dated 5 June 2020 [Governors invited to comment]
  - feedback from local Healthwatch organisations dated 9 June 2020
  - feedback from overview and scrutiny committee dated [Not provided due to Covid-19 pandemic]
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 6 December 2019
  - the latest national patient survey Inpatient, June 2019; Urgent and Emergency Care, October 2019; Children and Young People, November 2019; and Maternity, January 2020
  - the latest national staff survey dated March 2020
  - the Head of Internal Audit's annual opinion of the Trust's control environment dated [Not provided due to Covid-19 pandemic]
  - the CQC inspection reports dated 18 December 2019
- the Quality Report presents a balanced picture of the Trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality 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
25 June 2020

Jacqueline Totterdell
Chief Executive
25 June 2020