8. Quality Report (Account) 2022/23

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Part 1

Statement on quality from the Chief Executive

I am pleased to introduce our Quality Report which outlines the progress we have made in advancing the quality of services for our patients. This document summarises our commitment to continually improve and put patients at the forefront of everything we do. Of course, we still have a way to go to deliver our vision of providing outstanding care every time, and the challenges we have faced whilst trying to recover from the impact of the Covid-19 pandemic are also detailed in this report together with some key achievements across the year.

It continues to be inspiring to see how much our teams at St George's have been able to achieve during periods of high operational pressure, while supporting the safety of our patients. Many staff have gone above and beyond to give patients the best experience of care and I am very grateful for their hard work and dedication.

As we now learn to live with Covid-19 we continue to respond to the effects of the pandemic and have worked hard on our recovery plans to deliver improved performance against the national access measures to ensure patients get the planned and emergency care they need.

The impact of Covid on our waiting lists has been significant and part of our recovery efforts, as in 2021-22, has involved collaborative working with our hospital Group colleagues in Epsom and St Helier, system colleagues in Croydon and Kingston hospitals, and partners in the region. The Surgical Treatment Centre at Queen Mary's Hospital which we opened in June 2022 providing four new operating theatres has continued to be pivotal in supporting our recovery efforts.

At the end of March 2023 98.2% of patients received their diagnostic test within 6 weeks, which was an improvement of 3.1% when compared with February 2023 (95.1%). The decrease is driven by reductions in Endoscopy. Performance is meeting the elective recovery target of 95%.

At the end of 2020/21, there were 2,644 patients waiting more than 52 weeks for routine surgery at St George's as a direct result of the pandemic. At the end of February 2023 this number had reduced to 481 and is below the plan of 800. While this is a significant improvement, our focus is to reduce this number to an absolute minimum.

allow other spaces – such as St George's – to focus on specialist and complex cases. Theatre utilisation increased to 82% and the average case per list continues to rise - we are currently at 1.65 compared to 1.4 which is our pre-Covid level. We continue to make positive progress on elective activity and continue to focus on tackling our cancer performances too.

This year we have also seen unprecedented demand for urgent and emergency care

93 with a significantly increased number of people visiting our emergency department from June 2022 onwards and into the winter months. This increased demand and severe operational pressures has meant that for some of our patients we were not able to ensure they were seen, treated, and either admitted or discharged within four hours.

Many staff have gone above and beyond to give patients the best experience of care and I am very grateful for their hard work and dedication.

Colleagues across the south west London healthcare system meet weekly to discuss elective care recovery activity and seek to distribute activity where it can be managed most efficiently. Our system network is crucial in managing pressures and ensuring elective activity remains on track despite the disruptions. As outlined above, we have set up surgical hubs with protected theatre space, which has been vital in supporting our vision of working through high volume, low complexity cases across south west London to aid recovery and

Although the Trust does compare well with others with reference to the four hour performance target, due to the increased pressures we have had patients waiting in our ED for admission to an inpatient bed for longer that twelve hours. We continue to work hard to improve flow throughout the hospital.

We also continue to review nosocomial infections at a local and system level and have revised infection prevention and control procedures as and when necessary. I am pleased to say

that the steps we have taken to keep patients, staff and visitors safe has resulted in a reduction in nosocomial infections when compared to last year.

The Kirkup Report was published in October 2022 and set out the findings of the investigation of maternity services at East Kent Hospitals University NHS Foundation Trust and the outcomes for 202 mothers and families who received maternity care at the Trust between 2009-2020. It describes how those responsible for the provision of maternity services failed to ensure the safety of women and babies, leading to repeated suboptimal care and poor outcomes. This made for difficult reading. We conducted a gap analysis, which we discussed at Trust Board, on the broad areas for action and associated recommendations and developed an improvement plan.

We champion an open culture at St George's where everyone feels psychologically safe to raise concerns. We have been working on this for over two years as part of our culture improvement work, supported by the Board.

We are pleased to report on our compliance against the eight 'immediate and essential actions' as part of the assurance process for the Ockenden review, which was published in March 2023. St George's is one of only six NHS Trusts in London demonstrating 100% compliance, validated by external review – despite the staffing challenges we faced over the year. As well as this, we have achieved Baby Friendly Gold Status, launched a maternity helpline for pregnant women, and introduced a new Maternity Support Worker Development Programme to upskill our staff.

However, in light of both reports we have commissioned an external review of the culture of Maternity and Midwifery Services at St George's and at Epsom and St Helier Hospitals with the report expected in August 2023.

This year we were unable to declare full compliance with the CNST (Clinical Negligence Scheme for Trusts) for maternity services. Trusts are required to self-assess and make a declaration of compliance against ten safety actions. We took our self-assessment to Trust Board in January 2023 and confirmed our compliance in six out of ten safety actions. We also reviewed a comprehensive improvement plan to address the areas where it was required. Although disappointing, this reflected our challenges in staffing and the impact on safety actions.

Following the Ockenden Review the Care Quality Commission (CQC) initiated a national inspection programme of maternity and midwifery services. Our services were inspected on 28 March 2023. The national inspection programme focussed on the Safe and Well-led key lines of enquiry. Following this inspection, the CQC issued the Trust with a section 29A Warning Notice in relation to:

- Effective and timely triage services
- Environment and equipment maintenance
- Staffing levels
- Oversight and governance

We immediately commenced a targeted improvement plan to address the issues and will formally respond to the CQC by 28 June 2023 to provide assurance – together with supporting evidence - on the completion of the improvement actions taken.

The full inspection report is expected by the end of June 2023.

Disappointingly, the Trust has breached the NHSE number of Clostridium Difficile infections for 2022/23 and recorded 60 cases against the national threshold set for the Trust of 43 cases. An action plan is in place and since quarter two of 2022/23 we have seen the monthly prevalence start to reduce. The improvement actions include increased surveillance and audits on areas where positive cases are identified to ensure we identify all IPC issues where we can do better.

We are seeing more people with respiratory conditions and viruses requiring hospital care including children, and these illnesses are also impacting our staff. We are continuing to promote our roll-out of the flu vaccine to support greater protection levels and reduce the risk of requiring hospital care for these conditions over the winter months. We also saw a rise in cases of Strep A, but overall, there are still fewer cases than this time two years ago. We saw a real decline in these type of infections in the pandemic as people were not mixing. This is why there are more reported cases in children under four, who have not previously been exposed to infection during the pandemic. We also worked closely with our clinical partners in the community to support families in managing Strep A infections and we worked closely across south west London to manage the new Monkeypox virus successfully treating patients in most cases on a virtual basis in their own homes.

We sustained our significant research portfolio and recruited 9,600 patients to more than 50 clinical research studies. We are among the top NHS Trusts in the country for the number of urgent public health Covid studies, and we led a major Vaccine Task Force funded clinical trial on Covid vaccines in pregnancy – due to collaborative working with St George's, University of London.

Our performance metrics continue to evidence the shift in culture to one of an organisation constantly looking to improve. Consistent achievement of SHMI (Summary hospital level mortality indicator) at lower than expected, and VTE (venous thromboembolism) assessments have increased to 97%. We also delivered a clinical audit programme where the Trust performed above the national average on a number of important quality and safety indicators.

As well as improvements in care, we have also made progress with upgrading the environments that patients are treated in – for example the modernisation of our emergency department and upgrading our cardiac catheter labs. We have also completely refurbished one of our surgical wards in St James Wing to deliver a dedicated 22 bed Major Trauma Ward. We have doubled the number of single occupancy rooms within the accommodation, introduced motorised patient hoists and improved the overall facility for patients and staff. Our new MRI Annex delivers a dedicated MRI facility accommodating three scanners, multiple reporting rooms and dedicated training and seminar space. Our new ITU building will provide 20 additional ITU beds in a purpose-built unit. Patients as well as our staff have benefitted from these new environments.

The formation of the St George's, Epsom and St Helier University Hospitals Health Group last year continues to build on our long-standing relationship with Epsom and St Helier University Hospitals NHS Trust. As a group, we will continue to run efficient and high-quality services for the benefit of our local people and communities.

The partnership continues to bring benefits to patient care. For example this year we have action plans in place to drive improvement across the Group for pressure ulcer prevention, falls prevention and reduction of Covid-19 nosocomial deaths. In addition, our plans for the implementation of the new Patient Safety Incident Response Framework have been driven at a Group level for implementation at our sites in order to reduce any unwarranted variation in our processes. Going forward, this will enable reduction in avoidable harm to be effectively measured both at Trust-level and across the Group.

To the best of my knowledge the information contained in this document is an accurate and true account of the quality of the health services we provide. I would like once again to thank our staff for continuing to deliver compassionate and outstanding care for our patients during another challenging year.

Jacqueline Totterdell
Group Chief Executive
30 June 2023

Part 2

2.0 Priorities for improvement and statements of assurance from the board

2.1 Our quality priorities for 2023/24

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.

In September 2022 the Trust Board agreed a refresh of our corporate objectives, setting out our priorities for rest of the year (September 2022 to March 2023). This did not change our vision or our five-year strategy.

Our new corporate objectives drive everything we do and help us focus our efforts on what matters most. They are not designed to be an exhaustive list of everything we are doing, but to help us prioritise and guide decision-making, at a Trust, managerial and staff level.

For each of our three objectives of Care, Culture and Collaboration, a series of priorities underpin them, and these are set out below.

Care	Culture	Collaboration
Patients and staff feel cared for when accessing and providing high quality timely care at St George's	Transform our culture to create an inclusive, compassionate and enabling place to work where staff feel respected and understand their role in delivering high quality clinical care for our patients and service users	We will engender an ethos of collaborative working across our teams within St George's, Epsom and St Helier and with our ystem partners to achieve the best outcomes for patients, building on the spirit of collaboration developed internally and externally through the Covid-19 response.
1. Improve patient safety by reducing avoidable harm in relation to: ➢ Learning from all local SWL nosocomial Covid cases ➢ Treatment Escalation Plans agreed within 24 hours of admission ➢ Improving the practice of consent 2. Improve the clinical effectiveness and efficiency of all patient pathways 3. Embed a quality, safety and learning culture through monthly patient safety, mortality and morbidity meetings for every specialty	4. Deliver on our Health and Wellbeing promise to all staff by investing in physical and mental health staff services and flexible working 5. Develop an environment where staff feel psychologically safe to speak up and use their voices to improve our services to patients 6. Taking action on our culture to ensure we are more inclusive and diverse, where discrimination, violence and bullying is not tolerated – improving the experience of BAME staff in particular 7. Develop and implement an inclusive talent management approach to ensure that we improve our opportunities for our staff	8. Continue to work in partnership and collaboration with the SWL Integrated Care System (ICS) and Acute Provider Collaborative (APC) 9. Delivering a transformational step change in use of resources (to achieve the Cost Improvement Programme) at SGUH, across the Group and across South West London ICS, for the benefit of patients and the welfare of our staff 10. Explore and deliver opportunities for collaboration across the Group 11. Make best use of our resources at St George's and across South West London ICS, for the benefit of patients and the welfare of our staff

A new five-year strategy for St George's, Epsom St Helier (gesh) Group (2023-2028)

St George's and Epsom and St Helier hospital have been working together for some time and in 2021, became a Hospital Group. As a result, over the course of 2022/23, a new 5-year strategy for St George's, Epsom St Helier (gesh) Group has been developed, launched May 2023, which sets our ambitions for 2028 across the following domains:

- **Collaboration and Partnership**
- **Affordable healthcare, fit for the future**
- **Right care, right place, right time**
- **Empowered, engaged staff**

Our ambition for 2028 is that our corporate objectives provide a framework against which staff across the Group can pursue continuous improvement. This could apply at every level of the organisation, from a site team to service triumvirate to an individual ward.

Our corporate objectives, set out below (for example, improving productivity and collaborating across teams, departments, Group, and system to improve flow), sit alongside strategic initiatives which are large, complex, multi-year programmes of work that require significant executive leadership and board oversight (for example, the Outpatient Transformation Programme and the Group Collaboration Programme).

Corporate objectives

Collaboration and Partnership	Affordable healthcare, fit for the future	Right care, right place, right time	Empowered engaged staff
Work across teams, the Group & the wider system to improve flow & elective waits	**Return to pre- COVID productivity levels**	**Make improvements in safety / the fundamentals of care**	**Retain and develop our staff**
Measured by: • Average non-elective LOS back to 19/20 level • Reduction in 12 hour waits vs 22/23 • Delivery of elective recovery trajectories • Narrowing performance gap between ESTH and SGUH	Measured by: • 85% theatre utilisation • Reduction in DNA & 1st/FU ratio Elective LOS back to 19/20 level	Measured by: • Reduction in falls with harm vs 22/23 • 95% VTE • 0 pressure ulcers grade 3 & 4 HSMR <100, SHMI <1	Measured by: • Turnover rate ≤ 12% • 90% appraisal rate Improvement in staff survey feedback on quality of appraisals

Our new gesh Group Strategy (2023-2028), will help both organisations to shape a common sense of direction and identify a clear set of ambitions for our patients and public for the years ahead. Corporate objectives for 2024/25 will reflect the new strategy priorities.

Corporate objectives

Throughout 2022/23 and whilst the above strategies were developed the Trust continued to implement the quality priorities against the seven priority areas as set out below in our Quality and Safety Strategy 2019/24:

1. We will minimise avoidable harm across our organisation, utilising the developments in technology and embedding further, robust quality assurance and learning processes

2. We will improve outcomes for patients through timely diagnosis, exceptional care and treatment and by working with our partners to ensure we contribute to developing the whole pathways of care for our patients

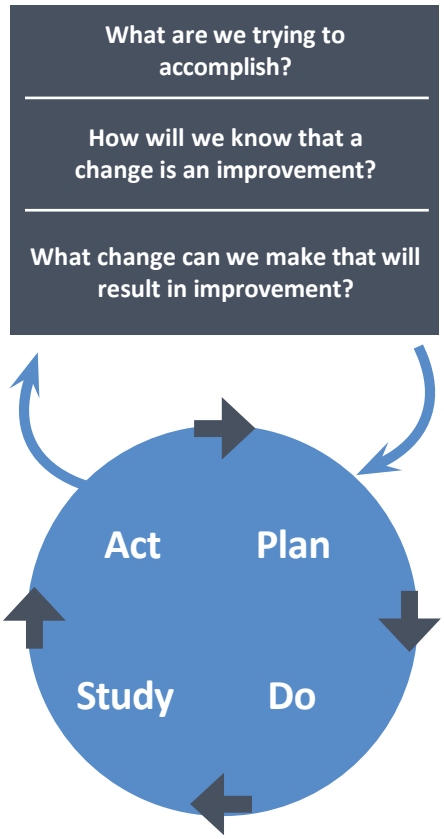
3. We will provide patients with an excellent experience through their journey with us, monitoring and acting on feedback to ensure continual improvements in the areas that matter the most to our patients

4. We will improve staff experience, enabling staff to feel valued, supported, and equipped to deliver high quality safe care and improve their work via quality improvement methodology

5. We will provide patients with an equitable experience by proactively reaching out with system partners to our communities and our vulnerable groups

6. We will embed a culture in which quality, safety and learning is embraced across the organisation, and is supported by robust systems of safety governance

7. We will be at the forefront of providing and developing pioneering and leading edge treatments for today and for the future



Our Approach to Quality Improvement

To support the delivery of our Quality and Safety Strategy we maintained our approach to quality improvement to help teams solve problems at their own level and to embed a culture of quality, safety and learning.

Together with the focus on the quality priorities the Trust's quality improvement (QI) programme amalgamates human factors concepts and tools with QI methodology (The Model for improvement), pushing QI beyond is traditional boundaries to offer a more diverse spectrum of methods to explore everyday work and help develop collaborative solutions. We have been incorporating human factor principles to optimise system and human performance, and enhance staff wellbeing across many strands of work, including simulation-based education and patient safety investigation.

We continue to use a simple yet effective approach to improvement to bring about positive change: Plan, Do, Study, Act (PDSA).

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

In 2022/23 we developed the implementation plan for that year to support the delivery of our five-year Quality and Safety Strategy. Although, the objectives of the implementation plan were not fully met due to the ongoing impact of the pandemic, progress was made across all areas. The progress we made was reported to our Quality Committee in Common, which is a sub-committee of the Trust Board and is outlined in part 3.

Our quality priorities for 2023/24, what they were informed by and why we chose them

- Our progress against the Quality Priorities for 2022/23 which was impacted by the ongoing effects of the Covid-19 pandemic
- Themes highlighted from our ward and departmental accreditation programme
- The findings of the 2019 CQC inspection and the resulting improvement action plan which we implemented during 2020-21
- Analysis of our complaints and PALs enquiries
- Analysis of our serious incidents and moderate and low harm incidents
- Previous feedback from Healthwatch 'Enter and View' visits
- Local and national audit
- National priorities for sepsis, safe staffing, falls, pressure ulcer prevention, and infection prevention and control

We have not held specific listening events in the last year. However in the previous 2 years and due to the Covid-19 pandemic we have rolled forward the quality priorities to provide a longer period of time to generate real improvement. This year we have taken a different approach to identifying our quality priorities for 2023/24 and held a half-day workshop where we discussed and re-set our quality priorities outlined below with key stakeholders. Our key stakeholders comprised colleagues from Epsom and St Helier Hospitals and the Integrated Care System and we identified our quality priorities under three quality themes:

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

Linking our quality priorities to our new 5-year strategy for St George's, Epsom St Helier (gesh) Group (202302028)

Our new 5-year strategy for St George's, Epsom St Helier (gesh) Group (2023-2028) as outlined on page 8 above, has identified the following domains:

- Collaboration and Partnership
- Affordable healthcare, fit for the future
- Right care, right place, right time
- Empowered, engaged staff

With reference to our new strategy our quality priorities for 2023/24 will help us to deliver against the domain of Right care, right place, right time.

Our quality priorities for 2023/24, what they were informed by and why we chose them

- Our progress against the Quality Priorities for 2022/23 which was impacted by the ongoing effects of the Covid-19 pandemic
- Themes highlighted from our ward and departmental accreditation programme
- The findings of the 2019 CQC inspection and the resulting improvement action plan which we implemented during 2020-21
- Analysis of our complaints and PALs enquiries
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- Local and national audit
- National priorities for sepsis, safe staffing, falls, pressure ulcer prevention, and infection prevention and control

Priority 1 – Improve patient safety

Patients are safer when there 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 2023/24 we want to focus on fundamentals of care and getting the basics right every time in terms of screening, risk assessments and review, we want to learn from all patient safety incidents to reduce avoidable harm and improve patient experience, and we want to respond appropriately to our patients needs if their condition deteriorates whilst under our care.

In order to address these patient safety priorities, we will continue to work collaboratively across the St George's and Epsom and St Helier University Hospitals Health Group. For the purposes of the quality account the measures for success will reflect St George's University Hospitals NHS Foundation Trust performance only.

Priority 1 – Improve patient safety **Domain from 5-year strategy: Right care, right place, right time**							
Reduce waiting times		Improve patient safety	√	Improve patients outcome and experience with us	√	Tackle health inequalities	
What		**How**		**What will success look like**			
Delivering the fundamentals of care		We will get the basics right every time and consistently complete risk assessments in line with expected standards of performance		With reference to pressure ulcer prevention there will be: • no category 4 pressure ulcers • a 5% reduction in category 3 pressure ulcers With reference to VTE there will be: • a 5% reduction in the number of hospital acquired thrombosis when compared with the previous year With reference to falls we will see: • a 5% reduction in the number of falls with harm per 1000 bed days when compared with the previous year With reference to delirium, we will see: • a 10% improvement in the number of delirium risk assessments completed for our patients with a diagnosis of dementia when compared to baseline			
Learning from patient safety incidents		In line with the national patient safety strategy we will develop the Trust's learning response plan and implement the new patient safety incident response framework		Patient Safety Incident Reporting Framework in place including: • Governance structure • Patient Safety Incident Response Plan • A Group Policy for Patient Safety Incident reporting			
Responding to the deteriorating patient: patients will have Treatment Escalation Plans (TEP)		Ensure non- elective adult inpatients have a TEP in place within 24 hours of admission		60% of all adult inpatients will have a TEP in place by March 2024 Reduction in the number of cardiac arrests compared with 2022/23			

Priority 2 - Improve patient experience

We want to improve our communication with our patients. We will listen to our patients and their carers and use patient feedback to focus on continuous improvement.

In 2023/24 we want to enhance our understanding of the population we serve with improved data collection and IT systems that talk to each other, improved use of our patient portal and improved triangulation of patient feedback to ensure we fully understand and use the feedback we receive.

In order to address these patient experience priorities, we will work continue to work collaboratively across the St George's and Epsom and St Helier University Hospitals Health Group. For the purposes of the quality account the measures for success will reflect St George's University Hospitals NHS Foundation Trust performance only.

Priority 2 - Improve patient experience							
Domain from 5-year strategy: Right care, right place, right time							
Reduce waiting times		Improve patient safety		Improve patients outcome and experience with us	√	Tackle health inequalities	√
What		**How**		**What will success look like**			
Ensuring enhanced data collection		We will improve how we capture patient ethnicity data		95% of patients our will have their ethnicity recorded (excluding those patients who choose not to confirm their ethnicity) by March 2024 Ethnicity profiles of our patients will be increasingly included in quality and safety reports from ward and directorate level up to and including Group Board and we will analyse the quality impact to determine areas where there may be inequalities to improve patient care to identified groups			
Using MyCare, our patient portal		Determine the patient demographic using MyCare and identify areas for improvement and increased use		Include details on the demographic using MyCare in our patient experience reports Increase the use of MyCare by 10% by March 2024			
Understanding what our patients tell us about their experience		In collaboration with our Integrated Care System colleagues, we will consistently review and triangulate all sources of patient feedback to improve our understanding of what good looks like for our patients and their families		We will utilise our QI approach and hold 3 Group wide learning events We will develop, implement and monitor a Group improvement plan with SMART improvement actions (specific, measurable, achievable, realistic and time bound) to reflect the learning from the above events and update this as required throughout the year			

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.

In 2023/24 we want to focus on the quality, safety and learning culture and working with the Integrated Care System to improve the discharge pathway for our patients and the pathway for CAMHS (Children and Adolescent Mental Health Services) following an in-patient admission.

In order to improve effectiveness and outcomes for patients, we will continue to work collaboratively across the St George's and Epsom and St Helier University Hospitals Health Group. For the purposes of the quality account the measures for success will reflect St George's University Hospitals NHS Foundation Trust performance only.

Priority 3 - Improve effectiveness and outcomes							
Domain from 5-year strategy: Right care, right place, right time							
Reduce waiting times	√	Improve patient safety	√	Improve patients outcome and experience with us	√	Tackle health inequalities	√
What		**How**		**What will success look like**			
Ensuring a quality, safety and learning culture Working in collaboration with our Integrated Care System colleagues to improve patient flow particularly with reference to improved discharge processes		We will integrate our Quality Improvement resources across the Group to maximise service improvement activity		We will see collaborative QI projects in place across the Group underpinned by the Group Quality and Safety Strategy (in development)			
Working in collaboration with our Integrated Care System colleagues to improve patient flow particularly with reference to improved discharge processes		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		See an upward trend in our patients reporting involvement in their discharge arrangements compared with 2022/23 Improvements in the number of discharge summaries received in general practice within 48 hours of discharge when compared with 2022/23			
Working in collaboration with our Integrated Care System colleagues to improve the pathway for CAMHS (Children and Adolescent Mental Health Services) following an inpatient admission		Continue to escalate discharge delays for CAMHs patients awaiting a specialist inpatient admission for MDT and system discussion		We will see a reduction in the average number of days our CAMHS patients wait in our paediatric wards for specialist inpatient admission to CAMH inpatient services			

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 progress reports to the Patient Safety Quality Group and the Quality Committee in Common, a sub-committee of the Group Board.

2.1.5 Progress against priorities for 2022/23 [See part 3]

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 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 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.

As outlined in the Chief Executive's introduction, the NHS has remained pressured - with St George's no exception.

Our urgent and emergency care pathway has been very busy and flow is increasingly difficult through the hospital, to the wards and home.

We have had added pressures culminating from industrial action across the healthcare sector, often coinciding with bank holiday weekends. To mitigate these, our senior team developed detailed operational plans, and our communications team worked with our system partners to promote alternatives to ED to the public. We know that tens of thousands of people saw our messages and we hoped it helped to ensure some people were redirected to the right care for their needs.

St Georges, Epsom and St Helier Group

This year we have seen a number of exciting developments across the Group.

- We continue to make strides towards collaboration with Epsom and St Helier for the benefit of staff and patients. We are having good conversations on cancer 109 collaboration and how we work with our partners in the system. We continue to look at where we have variations in care, where we can learn from each other, integrate services across the group, and are asking our staff to talk to their partners at Epsom and St Helier.
- We continue to make progress with Cerner (sometimes referred to as iClip) development and implementation to provide a shared electronic patient records system to deliver streamlined patient care. Due to complete in 2024, the shared system means that our clinical teams will in future be able to access patient hospital information and records, irrespective of where care is provided across the Group. It also enables more effective working with health and care partners including neighbouring hospitals, with the potential for benefits to be scaled across the South West London Integrated Care System (ICS).
- We have seen increased joint working in Infection Prevention and Control (IPC) with the infection prevention and control teams from both sites working together on a weekly basis led by the Group Chief Nurse and Director of Infection Prevention and Control to discuss any IPC issues and agree required actions.
- We continued to respond to Covid-19 guidance throughout the year and we enter this year with reduced levels of lateral flow testing for our patients and staff, no requirement for the wearing of face masks in most clinical environments (unless the patient or staff member chooses to do so) and fully restored patient visiting practices.

St George's

Despite the ongoing demand for our services and capacity issues this year we have seen a number of exciting developments at St George's.

- St George's documentary 'Baby Surgeons: Delivering Miracles' was nominated for a BAFTA. The documentary was filmed inside our fetal medicine, neonatal and maternity units at St George's, and followed the extraordinary work of our staff as they treat women experiencing rare and complex pregnancies.
- We opened a new training suite for parents and carers of ill children offering training in life-saving interventions. Parents are supported by a new specialist nurse, in the WellChild Better at Home training suite, which was funded by WellChild, the national charity for seriously ill children. Previously, training for parents and carers would often take place at a child's hospital bedside prior to discharge. Bedside training can be limited and does not always prepare families for emergency situations which might arise at home. This training suite is a wonderful addition that is already helping parents and carers learn the skills they need to care for children after they leave hospital.
- 18,000 patients registered on MyCare - our new, secure online portal launched in March 2022 that allows patients to access their hospital record, view upcoming appointments, and receive test results and messages from clinicians. It is very important to us that our patients are better informed about their care, especially as evidence shows that people being more actively involved in their own care can improve outcomes and experience for patients
- We received accreditation from the Improving Quality in Liver Services (IQILS) programme run by the Royal College of Physicians. The aim of the programme is to improve the quality of medical liver services throughout the UK.
- A new Urgent Treatment Centre (UTC) was opened in a purpose-designed area, close to our Emergency Department, and will significantly support our capacity for treating urgent cases.
- Our cardiac catheter labs three, four and five are now operational. This will boost our capacity for diagnostics and support efficient and speedy patient care.
- We held our first ever Childhood Cancer Awareness event in September 2022. The event brought together former young cancer patients and their families, to raise awareness and celebrate their cancer journeys, and our staff who have treated them. It was especially heart-warming for our former and current patients to reunite with the staff who treated them, and for parents to connect and share experiences with other families to empathise and support each other.

Staff awards

Our staff and teams have been successful in a range of award programmes. Just a few of the successes include:

- Our Group Chief Nurse and Director of infection Prevention and Control was awarded her MBE at Windsor Castle by the then HRH Prince Charles. As a fantastic role model and visible leader who listens to staff and flies the flag for the thousands of nurses, midwives and health care support workers across our hospital Group.
- Our Group Chief Executive Jacqueline Totterdell was named as one HSJ's top 50 hospital CEOs. The 15 strong panel looked at a range of criteria including performance during the pandemic, overall performance and the Trust's contribution to the wider health and social care system.
- Professor Indranil Chakravorty – consultant in acute and respiratory medicine at St George's – was awarded an MBE for his contributions to healthcare as part of the Queen's platinum jubilee honours. Passionate about diversity and inclusion in healthcare, he has made an enormous contribution to medical education, and research into tackling health inequalities.
- Lt Col Jey Jeyanathan, one of our consultants in Anaesthetics and Intensive Care, received an OBE in King Charles' first New Year's honours in recognition of his hugely commendable service, and more recently his major role in developing transfer services for critically ill patients to manage bed shortages across the south est.
- Dr Sree Kondapally, Locum Consultant Cardiologist, was awarded the top prize for his service improvement project in cardiology. Dr Kondapally received the award at this year's centenary conference of the British Cardiovascular Society (BCS), under the society's flagship Emerging Leadership Programme (ELP). Dr Kondapally's project was on the implementation of iClip triage for cardiology outpatient referrals and was judged the top service improvement project for this year.
- Juliann Welch staff nurse on Gordon Smith ward received the RCN London Black History Month Rising Star Award. She was recognised as a Rising Star by the Royal College of Nursing, for her work supporting international colleagues.
- Estelle Le Galliot a Health and Wellbeing Co-ordinator in the Macmillan team received the BBC Radio London Make A Difference Key Worker Award. She was recognised for her work during lockdown when she went above and beyond for our cancer patients by helping shielding patients by setting up a YouTube channel and Chemotherapy Comfort Kits.

- A team of staff covering Medical Physics, Radiology and Trauma and Orthopaedics British Institute of Radiology received the Make it Better Award at the British Institute of Radiology (BIR) Annual Congress. The team was nominated for the creation of a new pathway which has improved the service for patients, which came about as a result of surgeon colleagues and our CT team in Radiology discussing how they could improve the imaging carried out on their post-surgical patients.
- Our Functional Neurologic Disorder team won Best designed virtual service award at the Healthcare Excellence Through Technology (HETT) Innovation awards ceremony. The service was set up to provide a digital first approach to treating functional neurological disorders. The outcomes have been excellent, reducing waiting times by 90% and is delivered at 10% of the cost of usual treatment.
- The St George's Musculoskeletal (MSK) Physiotherapy team was shortlisted for a Health Service Journal (HSJ) NHS Partnership of the Year Award for their involvement in the GetUBetter project. GetUBetter is a digital tool which helps musculoskeletal patients self-manage their symptoms - giving them more independence and freeing up time for clinicians.
- Seamus McMahon, was shortlisted for the National MyPorter Awards for Porter of the Year. These awards are organised by NHS England and are a great way to bring some national recognition to NHS facilities teams for the wonderful work they do.

For our commissioned services

2.2.1 During 2022/23 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 2022/23 represents 100% of the total income generated from the provision of relevant health services by St George's University Hospitals NHS Foundation Trust for 2022/23.

2.2.2 Participation in clinical audit and National Confidential Enquiries

During 2021/22, 60 national clinical audits and 4 national confidential enquiry 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 were relevant to St George's University Hospitals NHS Foundation Trust and those Trust was eligible to participate in during 2022/23 (n=60) are as listed in Table 1 below

2.2.3 The national clinical audits and national confidential enquiries for which data collection was completed during 2022/23 are listed alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry. For the remaining projects that the Trust participated in (Table 1) the 2022/23 data collection completes during 2023/24 and therefore submission rates are not available at the time of this report.

TITLE		RELEVANT	PARTICIPATING	% of cases submitted
Breast and Cosmetic Implant Registry	Breast and Cosmetic Implant Registry	✓	✓	Ongoing
Case Mix Programme	Neurology Intensive Care Unit	✓	✓	100%
	General Adult Intensive Care	✓	✓	Ongoing
	Cardiothoracic Intensive Care Unit	✓	✓	Ongoing
Child Health Clinical Outcome Review Programme	Transition from Child to Adult Health Services	✓	✓	100%
	Testicular Torsion Study	✓	✓	100%
Cleft Registry and Audit Network Database		X	X	
Elective Surgery (National PROMs Programme)		✓	X	0%
Emergency Medicine QIPs	Pain in Children (care in Emergency Departments)	✓	✓	100%
	Assessing for cognitive impairment in older people	✓	✓	100%
	Mental health self-harm	✓	✓	100%
Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People	Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People [2]	✓	✓	100%
Falls and Fragility Fracture Audit Programme	Fracture Liaison Service Database	✓	✓	100%
	National Audit of Inpatient Falls	✓	✓	100%
	National Hip Fracture Database	✓	✓	100%
Gastro-intestinal Cancer Audit Programme	National Bowel Cancer Audit	✓	✓	100%
	National Oesophago-gastric Cancer	✓	✓	100%
Inflammatory Bowel Disease Audit		✓	✓	100%
LeDeR - learning from lives and deaths of people with a learning disability and autistic people (previously known as Learning Disability Mortality Review Programme)		✓	✓	Ongoing

TITLE		RELEVANT	PARTICIPATING	% of cases submitted
Maternal and Newborn Infant Clinical Outcome Review Programme	Maternal and Newborn Infant Clinical Outcome Review Programme	✓	✓	100%
Medical and Surgical Clinical Outcome Review Programme	Crohn's Disease Study	✓	✓	100%
	Epilepsy Study	✓	✓	100%
Mental Health Clinical Outcome Review Programme	Mental Health Clinical Outcome Review Programme	X	x	N/A
Muscle Invasive Bladder Cancer Audit	Muscle Invasive Bladder Cancer Audit	✓	X	0%
National Adult Diabetes Audit	National Diabetes Core Audit	✓	✓	100%
	National Diabetes Foot care Audit	✓	✓	100%
	National Diabetes Inpatient Safety Audit	✓	✓	100%
	National Pregnancy in Diabetes Audit	✓	✓	100%
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme	Adult Asthma Secondary Care	✓	✓	100%
	Chronic Obstructive Pulmonary Disease Secondary Care	✓	✓	Ongoing
	Paediatric Asthma Secondary Care	✓	✓	100%
	Pulmonary Rehabilitation - Organisational and Clinical Audit	✓	✓	100%
National Audit of Breast Cancer in Older Patients	National Audit of Breast Cancer in Older Patients	✓	✓	100%
National Audit of Cardiac Rehabilitation	National Audit of Cardiac Rehabilitation	✓	✓	100%
National Audit of Cardiovascular Disease Prevention (Primary Care)	National Audit of Cardiovascular Disease Prevention (Primary Care)	X		N/A
National Audit of Care at the End of Life	National Audit of Care at the End of Life	✓	✓	100%
National Audit of Dementia	National Audit of Dementia	✓	✓	100%
National Audit of Pulmonary Hypertension	National Audit of Pulmonary Hypertension	X		N/A
National Bariatric Surgery Registry	National Bariatric Surgery Registry	✓	✓	Ongoing
National Cardiac Arrest Audit	National Cardiac Arrest Audit	✓	✓	Ongoing
National Cardiac Audit Programme	a. National Congenital Heart Disease	X	X	N/A
	Myocardial Ischaemia National Audit Project	✓	✓	100%
	National Adult Cardiac Surgery Audit	✓	✓	100%
	National Audit of Cardiac Rhythm Management	✓	✓	100%
	National Audit of Percutaneous Coronary Interventions	✓	✓	100%
	National Heart Failure Audit	✓	✓	100%
National Child Mortality Database	National Child Mortality Database	✓	✓	100%
National Clinical Audit of Psychosis	National Clinical Audit of Psychosis	X	X	N/A
National Early Inflammatory Arthritis Audit	National Early Inflammatory Arthritis Audit	✓	✓	Ongoing
National Emergency Laparotomy Audit	National Emergency Laparotomy Audit	✓	✓	Ongoing
National Joint Registry	National Joint Registry	✓	✓	Ongoing
National Lung Cancer Audit	National Lung Cancer Audit	✓	✓	Ongoing
National Maternity and Perinatal Audit	National Maternity and Perinatal Audit	✓	✓	100%
National Neonatal Audit Programme	National Neonatal Audit Programme	✓	✓	100%
National Ophthalmology Audit Database	National Ophthalmology Audit Database	X	X	N/A
National Paediatric Diabetes Audit	National Paediatric Diabetes Audit	✓	✓	Ongoing
National Perinatal Mortality Review Tool	National Perinatal Mortality Review Tool	✓	✓	100%
National Prostate Cancer Audit	National Prostate Cancer Audit	✓	✓	Ongoing
National Vascular Registry	National Vascular Registry	✓	✓	100%
Neurosurgical National Audit Programme	Neurosurgical National Audit Programme	✓	✓	Ongoing

TITLE		RELEVANT	PARTICIPATING	% of cases submitted
Paediatric Intensive Care Audit	Paediatric Intensive Care Audit	✓	✓	100%
Perioperative Quality Improvement Programme	Perioperative Quality Improvement Programme	✓	✓	100%
Prescribing Observatory for Mental Health	The use of melatonin	X	X	N/A
Renal Audits	National Acute Kidney Injury Audit	✓	✓	100%
	UK Renal Registry Chronic Kidney Disease Audit	✓	✓	100%
Respiratory Audits	Adult Respiratory Support Audit	✓	✓	100%
	Smoking Cessation Audit- Maternity and Mental Health Services	✓	✓	100%
Sentinel Stroke National Audit Programme	Sentinel Stroke National Audit Programme	✓	✓	82.6%
Serious Hazards of Transfusion UK National Haemovigilance Scheme	Serious Hazards of Transfusion UK National Haemovigilance Scheme	✓	✓	100%
Society for Acute Medicine Benchmarking Audit	Society for Acute Medicine Benchmarking Audit	✓	✓	100%
Trauma Audit and Research Network	Trauma Audit and Research Network	✓	✓	Ongoing
UK Cystic Fibrosis Registry	UK Cystic Fibrosis Registry	X	X	N/A
UK Parkinson's Audit	UK Parkinson's Audit	✓	✓	Ongoing

2.2.2.5 National clinical audits - action taken

The reports of 36 national clinical audits were reviewed by St George's University Hospitals NHS Foundation Trust in 2022/23 and the Trust intends to take the following actions based on the information available at the time of publication.

National Clinical Audit	**Action:** Based on information available at the time of publication
Breast and Cosmetic Implant Registry	The clinical audit lead reports that whilst participation has historically been low, that the service has planned to increase engagement with this project. Action planning for the coming year: - Enlisting consultants and theatre staff to complete data collection in a timely manner - Use of both paper and electronic data collection methods to ensure data completeness
National Confidential Enquiry into Patient Outcome and Death: Epilepsy Care for Adults	This report was released in late 2022 in response to data collected in 2021/22. The recommendations were disseminated to relevant specialities and operational managers by the project lead. Action planning includes clinical audit projects to assess the organisations performance against the key findings.
National Confidential Enquiry into Patient Outcome and Death: Physical Healthcare in Mental Healthcare	This report was released in late 2022 in response to data collected in 2021/22. The recommendations were disseminated to relevant specialities and operational managers by the project lead. Action planning includes strengthening clinical pathways between St George's and our partner organisations.
Pain in children	The audit report breaks down performance into 3 key metrics. St George's performed inline or above the national average for both fundamental standards but fell below the recommended standard for patients with moderate or severe pain having documented evidence of re-evaluation and action within 60 minutes of receiving the first dose of analgesic. Action planning in response included: - Electronic documentation improvement, including automatic prompting to clinicians. - Simplifying triage pain documentation. - Implementing discharge leaflets and QR for patients.

Infection Control	Three key metrics were identified from the data collection. St Georges performed inline with one of these metrics, whilst performing below for potentially infectious patients being placed in a non-clinical area following triage, and the need for vulnerable patients to be isolated in a side-room as soon as possible. In response an action plan was drawn up by the clinical audit lead: - Implementing a new patient flow system throughout 22/23 based on the successful North Bristol NHS Trust model. Enabling a significant reduction in delays for ambulance offloads and patients reaching their inpatient beds - Mandatory screening questions added to electronic patient record system.
Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People [2]	The clinical audit lead monitors and updates on performance regularly within the Trust. The overall ascertainment completeness for the organisation is 99.6%, compared to 85% nationally. The Trust performed well in a the majority of the 12 of the key performance metrics. With areas for improvement when reviewing performance for patients' diagnostic status, most notably having a higher percentage of children diagnosed as 'uncertain episodes'. The clinical audit project lead is continuing to drive high standards across the service, including implementing epilepsy training delivered to the general paediatricians.
Fracture Liaison Service Database	The service reports continued live data entry onto the audit portal. The latest report was released in January 2023 and show that the Trust submitted 385 cases in 2021 and achieved green status for 3 of the 10 key performance metrics and red for 6 and 1 was amber. The clinical audit lead has acknowledged the report and its findings. They believe that acute resource constraints have led to reduced coverage in the organisation and are reflected in the audit findings. Action planning for the coming year includes business planning for additional support, and automated prompts for referrals on the electronic healthcare systems.
National Audit of Inpatient Falls	The Trust is currently 100% compliant in the study, with continuous data collection. The latest findings from the October 2022 report were summarised by the clinical audit lead however, the results were only based on 3 cases. The Trust reported 33% for having checked signs of injury before movement from the floor, nationally this was reported at 74%, medical assessment completed within 30 minutes of a fall was recorded for 100% of cases (72% nationally), and 0% using a safe manual handling method to move patient from the floor (33% nationally). The Trust falls meeting have acknowledged and discussed these findings, and plan on ensuring that manual handling training is addressed at ward level across the organisation.
National Hip Fracture Database	The Trust performed within expected limits of 5 out of 6 performance metrics in the latest audit report. But were below the national average for crude overall hospital length of stay (21 days compared to 15 days nationally). The clinical lead has presented these findings and is working to improve this metric in the upcoming year.
National Oesophago-gastric Cancer	Annual report released in January 2023 for data from April 2019 to March 2021. The findings indicate that the Trust was within the expected threshold for case ascertainment, and that the percentage of urgent GP referrals who waited longer than 62 days from referral to first treatment was below the national average (58.3% compared to 62.1%). The Trust achieved 37.7% for patients with clinical stage 0-3 disease who have a treatment plan compared to 58.5% nationally. The clinical lead is investigating this further and is working to assemble an action plan for the coming year.
Inflammatory Bowel Disease Audit	The clinical audit lead reports that quarterly uploads of data are continuing but cautions that limited data completeness has been achieved data due to resource constraints in the service. These constraints are affecting medical, nursing, pharmacy, and corporate support staff. This has been raised through with corporate management with action planning for the coming year will be focussed on relieving these pressures in order for better support for quality improvement and audit initiatives.
Maternal and Newborn Infant Clinical Outcome Review Programme	The latest report was published in November 2022 and examined lessons learned in order to inform maternity care. The key findings based on national data show an increase in maternal deaths during or up to six weeks after the end of pregnancy. There remain disparities in maternal mortality rates amongst women from black, Asian and white ethnic backgrounds, along with women from deprived areas continuing to see an increase in mortality over their peers in affluent areas. The report has been shared with the service and actions for the following year will be based on the recommendations.

National Diabetes Foot Care Audit	The latest audit report was released in May 2022 and reviewed performance from 2021. The results showed the Trust was compliant with all the integrated specialist survey structures listed within the national report which also relate to specific NICE guidelines. A SMART action plan was completed by the clinical lead, with all key recommendations acknowledged and responded to: - Providing training to HCP locally and across the regional network - Maintaining regular contact with our community colleagues - continuing to provide rotational opportunities, advice and support - Maintaining daily specialist clinics and weekly MDTs in line with NICE, local and GIRFT guidance for patients with diabetes - Continuing to promote awareness and education surrounding foot ulcers
National Diabetes Inpatient Safety Audit	Audit methodology changed in last year, with data collection and reporting now a continuous process. Results indicate that the Trust have the correct structures and systems in place of care for people with diabetes. The clinical lead reports that action planning for the year ahead is to address the Getting it Right First Time (GIRFT) review findings.
National Pregnancy in Diabetes Audit	The clinical audit lead reports that data collection is continuing apace, and that all recommendations have been reviewed and planned for in the coming year. Key actions: - Implementing a real time continuous glucose monitoring system, so that this is available to all children and young people with diabetes who wish to use one - Supporting this implementation with an education programme to ensure optimal use.
Adult Asthma Secondary Care	The latest benchmarking data was released in January 2023 and broke down results into 5 key performance indicators. The Trust were above the national average for all 5 of the key metrics reported - however this is based on a limited data set. The clinical lead acknowledged the findings and is looking forward to continuing the positive performance in the coming year. The lead also reports full data collection is now taking place despite workforce pressures.
Chronic Obstructive Pulmonary Disease Secondary Care	The latest benchmarking data was released in January 2023 and broke down results into 6 key performance indicators. The Trust generally performed in line with equivalent organisations, however fell below the national average (60% compared to 44% locally) for patients having a respiratory review within 24 hours of admission to hospital. Action planning for the year is centred on an electronic referral system within the Trust, to flag up patient admissions.
Pulmonary Rehabilitation - Organisational and Clinical Audit	The clinical audit lead reports that 2021 data indicated good performance for the Trust with patients starting pulmonary rehab within 90 days of referral, and average wait times from referral is 34 days. Data from July 2022 showed the Trust compliant with 5 of 6 key performance indicators, with further work needed to ensure patients are offered six-minute walk tests (6MWT) to measure exercise capacity, use a 30-metre course to adhere to technical standards. SMART action planning included: - Assessing and providing PR options patients within 1 month of receipt of referral to ensure they have 2 months to start PR programme - Ensure use of 6MWT standardised outcome measure at every face to face initial assessment - Every patient is assessed using an outcome measure in mobility/strength (6MWT/60second STS), anxiety/depression (PHQ-4)and health status (CAT) - Each site face-to-face and virtual service to have a standard operating procedure (SOP) written - Complete discharge assessments with the non-completers despite the fact they have chosen not to continue with PR course
National Audit of Breast Cancer in Older Patients	The latest report was released in May 2022, with 18 key metrics for performance improvement. The Trust performed above expectation with 5 of these, 10 in line with expectations, 2 metrics did not provide data, and 1 metric was below expectation. This was proportion of patients (non-screen detected) receiving a triple diagnostic assessment in a single visit. Action planning for the following year was recommended to comprise: - Ensuring older patients have sufficient information about their care and treatment and are engaged in a shared decision- making process - Ensuring adoption of fitness assessments for patients attending the first diagnostic clinic - Examination of reoperation rates after breast conservation surgery to identify areas where reoperation rates can be reduced, whilst supporting safe breast conservation. - Review chemotherapy associated morbidity in their units, to reduce unplanned chemotherapy-related admission rates. - Ensure an identified clinician can take responsibility for reviewing data returns and feeding back to staff within their breast units. - Investigate consistency between (1) discussion of patients with recurrence at MDTs, (2) recording of recurrence (3) low percentages of recurrence found in national datasets, by reviewing data capture, and ensuring these data are uploaded to cancer registration. - Ensure information on the initiation of endocrine therapy treatment, and use of bisphosphonates for disease modification, in secondary care is recorded within routine data submissions.

National Audit of Cardiac Rehabilitation	The latest report showed that the Trust achieved above expectation performance in the 7 key performance metrics and are performing well in this audit. Action planning has centred around preparing for the possible increased workload of the national data opt process, however this has now been resolved due to the NACR receiving an exemption. The clinical lead is now focussing on continuing to keep standards high within the service.
National Audit of Care at the End of Life	Data submission for 2022/23 completed in October 2022 The latest national report was published in June 2022. St George's achieved a positive outcome when compared to the national average for most of the key measures and were inline or above for 11 of the 13 key metrics. The Audit Lead responded to all key recommendations and a SMART action plan has been completed: - End of life nursing care plan is currently being updated on the electronic record system. - Creating a mandatory EOLC training video for staff. - Trust wide training, analysing and highlighting what training each staff member should have. - Specific training days to be implemented including simulation training days, human rights training days, EOLC champions and individual wards, and medical students and post-grad individuals.
National Audit of Dementia	The clinical audit lead reports that data collection ongoing for Round 5 of the clinical audit. Actions throughout this year and into next year focus on a pilot project between the clinicians and estates team to investigate whether the introduction of coloured crockery increases intake of food and drink in patients with dementia. There is some evidence that this can increase oral intake by 20%. Patients, their carers and staff feedback will also be collected.
Myocardial Ischaemia National Audit Project	The latest report was published in 2022 and examines data from 2020/21, at the height of the COVID-19 pandemic. The clinical lead has received and acknowledged the findings. Action planning for the year ahead will centre on delays in primary percutaneous coronary intervention, place of care provided, and referrals for cardiac rehabilitation.
National Adult Cardiac Surgery Audit	The cardiac surgery audit report showed that the number of procedures completed in the Trust was far lower in 20/21, including emergency procedures. The total captured in the audit was 346, compared to 670 in 2019/20 and over 1000 in 2017/18. This fall in participation is mirrored nationally with 19333 cases audited across the UK in 2020/21 compared to 29112 in 2019/20. This figure is likely to be caused by the pandemic where national clinical audits were made non-mandatory for a large part of the financial year. The risk adjusted in-hospital survival rate remains just above 97% which is slightly below the national average but within the control limits. The clinical audit project lead is continuing to drive high standards across the service, with performance being closely monitored and reported on.
National Audit of Cardiac Rhythm Management	The most recent report published in June 2022. Previous reporting highlighted the Trust having a higher-than-expected re-intervention rate for complex devices, this trend continues in the current report. The clinical lead reports this was due to a system error duplicating entries not an issue with the care provided. Action planning for the coming year will focus on improvements on two key areas based on the most recent set of results: - ECG Indication in-particular shows over 40% of patients were not meeting the NICE related standard (TA314). - Improving completeness on GMC numbers, and new consultants and SPRs must be added correctly to the system.
National Heart Failure Audit	The most recent findings were published in June 2022 and the latest figures showed the Trust were above the national average for 10 of the 15 key metrics listed in the national report. The clinical audit lead is continuing to work on two key areas for improvement: - To increase the number of patients being referred to cardiac rehab. The national report showed that this figure had increased nearly 5% since the previous set of results. - To drive improvements to heart care in cardiology wards as this figure has decreased over the last two audit rounds
National Early Inflammatory Arthritis Audit	The service have recruited a new consultant to lead on a Early Inflammatory Arthritis service. Action planning for the year ahead centres around consolidating the new patient pathway and more consistent recruitment of patients for inclusion in the clinical audit.
National Emergency Laparotomy Audit	The clinical audit lead provided a validated action plan for the latest findings of the audit: - The service to establish a team of junior doctors allocated to upload data with consultant support from surgery, anaesthetics, and radiology - QI project being launched to ensure initial data upload is done prospectively at the time of surgery alongside the WHO checklist - Fostering good communication across MDT in emergency, surgical, perioperative, acute, and critical care to increase fruitful collaboration - Organising training days for discussion of interesting cases which highlight the merit of good communications amongst all specialties.

National Joint Registry	The Trust performed in line with the expected rate with regard to 90-day mortality rates on knee & hip procedures, with data quality at 100% on all measures, higher than the expected standard. The clinical audit lead is working towards the following actions in the coming year: - Due to the increasing medical complexity of the patients referred to the Trust and as the revision network matures we are developing our multidisciplinary team to include anaesthetic and care of the elderly support. - We are developing a one stop clinic for emergent regional referrals for periprosthetic joint infection and impending periprosthetic fractures performing surgical, diagnostic and high risk anaesthetic review. - Despite increases in surgical and medical complexity, the service is aiming to ensure patient morbidity and mortality is reduced.
National Neonatal Audit Programme	The latest report was released in November 2022 and reports on based on NNAP data relating to babies discharged from neonatal care in England and Wales between January and December 2021. St Georges performed well with most metrics in the audit. The clinical audit lead has acknowledged the report and is working towards compiling an action plan for the coming year.
National Perinatal Mortality Review Tool	The latest report indicated that the Trust performed above the national average in the following metrics: stabilised and risk- adjusted extended perinatal mortality rate, and stabilised and risk-adjusted extended perinatal mortality rate, excluding congenital anomalies. Both figures were still within the control limits. The report has been shared with the service and actions for the following year will be based on the recommendations.
National Prostate Cancer Audit	The latest report released in January 2023. There are limited but positive results available for the Trust. The organisation compares favourably to the national average in both available measures – 'Number of men who had an emergency readmission within 90 day of radical prostate cancer surgery' (1.8% of STG patients against 12.4% nationally), and 'Number of men who experienced at least one GU complication' (3.2% locally, compared to 7.2% nationwide). This report has been shared with the clinical leads who look forward to continuing the high quality work in the coming year, and closely monitoring results with supplementary local level audits.
National Vascular Registry	The latest audit report was released in November 2022 with benchmarking comparing site level and national performance for 5 key metrics. For 3 metrics the Trust continued to perform well compared to the national average. Of note is the median time from symptom to surgery for patients receiving a Carotid Endarterectomy (8 days compared to 13 days nationally) highlighting a quick response time. The clinical lead has responded to these findings and is working towards addressing them in in the coming year.
UK Renal Registry Chronic Kidney Disease Audit	The latest report was published in September 2022 and was shared with the service. The results of the patient reported experience measures (PREM) survey shows that the Trust is performing below national average for each of the three metrics. The clinical audit lead is compiling an action plan to respond to these patient concerns.
National Smoking Cessation Audit	This report released in July 2022 and covered data collection from 2021. The clinical lead acknowledged the report and the findings of the report, in response they provided a SMART action plan: - Working with Trust Estates to enshrine a vape friendly policy and to provide designated vaping areas. - Ensuring that a standardised clerking proforma has space for documenting smoking status of newly admitted patients. - Working with pharmacy colleagues to ensure that Bupropion pharmacotherapy is added to the formulary.
Sentinel Stroke National Audit Programme	The audit results indicate that the Trust is performing above or in line with national averages on all key indicators. The clinical lead has conducted horizon scanning and raised the issue of increased workforce pressures, impacting on the revised audit methodology into the next year. This has been raised through the divisional structures, and planning is being prepared to alleviate these pressures.

2.2.2.6 Local clinical audits – actions taken

The reports of more than 70 local clinical audits were reviewed by the Trust in 2022- 23 and at quality half day meetings and the appropriate divisional management team meetings. Table four details the actions in relation to a sample of local audits that the Trust intends to take to improve the quality of healthcare provided based on the information available at the time of publication.

Local Clinical Audit	**Action:** Based on information available at the time of Publication
Controlled Drugs Check & Stock Audit	This audit is carried out quarterly and ensures that controlled drugs are correctly stored and secured and that an adequate record is kept which complies with controlled drug guidance. The project lead confirmed that performance in this quarterly project, which ensures storage and security of controlled drugs, has been largely positive despite wider disruptions due to workforce and resource constraints. The focus of actions for the coming year will be expanding the training outreach to ensure learning points are embedded across the all areas of the Trust.
Audit of Local Safety Standards for Invasive Procedures (LocSSIPs) - Theatre areas	This audit project runs quarterly and examines the use of LocSSIPs for all invasive procedures across the in theatres areas across the organisation. The clinical audit lead provided actions for coming year based on the findings: - Establishing a LocSSIPs dashboard to more easily access timely information - Refining the data collection tool to accurately reflect all specialities - Piloting new variants of the audit tool with staff to ensure full data capture.
Audit of Patient Group Directions (PGD)	An annual audit and review of every PGD in practice must be undertaken as per Trust policy. The Patient Directions Authorisation Group (PAG) are responsible for providing assurances and compliance. The 2022/23 audit took place in July 2022 and 113 PGDs were audited across the Trust over a 2-week period. 95% compliance was achieved in all but one of the 12 measurable standards. Action is taken through issuing of red, amber, or green letters which respond to compliance levels with standards in each of the specialities audited. Specific focus areas for the coming year is ensuring PGD and associated documents are stored correctly in designated folders in speciality areas.
Consent Audit	The Trust Consent Audit aims to measure the effectiveness of the consent process throughout the organisation. And focuses on both a quantitative measure of data completeness of consent forms, and a qualitative assessment of the consent process as recorded in the patient records. The audit has been piloted this year, and actions for the coming year are expanding this to be a quarterly audit with results reported to corporate patient safety and quality meetings.
Falls Prevention Audit	The Trust wide Falls Prevention Audit has been re-launched and piloted across several specialities in the Trust this year, and seeks to expand on the data collected in the Falls and Fragility Fracture Audit Programme (FFFAP). Actions for the coming year include roll out to all clinical areas, and to provide more timely and actionable data.
Protected Mealtimes Audit & Nutritional Screening Audit	This audit is carried out quarterly across the Trust and is made up of two elements, firstly the audit examines the principals of avoiding non-clinically urgent mealtime interruptions for inpatients, along with if appropriate assistance was provided - the nursing team carry out this part of the audit. The nutritional screening component examines if appropriate measurements are taken of patients, and if nutritional assessments were carried out – dieticians carry out this element of the audit. Action for the coming year centre around targeted training in poorer performing areas, ensuring that patient feedback is gathered, and focussed work on all wards participating in the audit project in a timely manner.
Treatment Escalation Plan Audit	This audit examines the National Early Warning Score (NEWS) process, which provides a graded response strategy for patients identified as being at risk of clinical deterioration. All adult wards are included in this project. Action plans for the year ahead focus on understanding the barriers and enablers to complete a treatment escalation plan (TEP) within 24 hours of patient admission.
VTE - Risk assessment compliance	This audit is run by the Hospital Thrombosis Group (HTG) to assess Trust-wide performance based on standards set by NICE, GIRFT and VTE Exemplar Status revalidation criteria. The audit shares examples of both excellent practice, and areas for improvement. Action planning for specific areas in the coming year focus on: - Clinical teams focussing on completing the initial VTE risk assessment within the 14-hour target and to carry out reassessments in a timely manner. - Clinicians to ensure they are up to date with Trust policy and know where to access this information. - To ensure accurate documentation on the Trust's locally adapted risk assessment tool on electronic records system to provide an auditable trail of the decision-making process. - Use the VTE prevention plan on electronic records system to ensure correct weight-based dosing is prescribed

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 for 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 2019/24 Research Strategy sets out plans to build on our strong research base, including investing more in our staff to support their research ambitions and developing our IT research infrastructure. Another key part of our research strategy is to gain core National Institute for Health Research (NIHR) funding, which we have achieved through a successful application for NIHR Clinical Research Facility designation which commenced in September 2022.

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. In 2020, we established the St George's Translational and Clinical Research Institute (TACRI), a joint NHS-University structure to increase collaboration and further our research, and during 2023 we will extend this across GESH

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 2022 we also appointed our first Research Director for Nursing, Midwifery and Allied Health Professions (NMAHPs) to develop and implement an innovative and forward-thinking strategy to support a research culture in these professions. The role has led to an increase in the development of clinical academic opportunities and pathways for NMAHPs, including Trust research internships and fellowships which provide salary and training costs for aspiring researchers. There has also been a growth in the number of NMAHPs leading research studies at St George's and a network for those undertaking doctoral and post-doctoral study.

The number of patients receiving relevant health services provided or subcontracted by St George's University Hospitals NHS Foundation Trust in 2022/23 that were recruited during that reporting period to participate in research approved by a research ethics committee was 9, 690 compared with 7,955 in the previous year.

2.2.4 Our Commissioning for Quality and Innovation (CQUIN) performance

The NHS Contracting Framework was suspended during the Covid pandemic. NHS England re-introduced the requirement for Commissioners and Providers to hold an NHS Contract from 2022-23. The contract requirements suspended during Covid have been re-introduced, including Commissioning for Quality and Innovation (CQUIN) schemes.

CQUIN schemes are developed nationally by NHS England and each Trust is required to report data on each scheme that applies to it. In addition, local Commissioners may choose 5 CQUIN schemes (per contract) to performance manage. CQUIN funding is 1.25% of the total contract value and Commissioners may withhold a proportion of this funding on underperformance of the schemes. The Trust's contract with South West London Integrated Care Board (SWLICB) states that Providers will not be financially penalised for CQUIN underperformance.

Following negotiations with Commissioners, the following 6 CQUINs (5 Acute and one Community) were included in the Trust's NHS Contract. The performance in each quarter is outlined in the table below.

The Trust manages the CQUINs through the CQUIN Programme Board, chaired by the site Chief Nurse with project management and administrative support provided by the Finance Department.

CQUIN Programme 2022/23

Research is core to the purpose of St George's. Through research, we play our part in developing the treatments for 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.

No	CQUIN GOAL DESCRIPTION	Baseline %	Trajectory %	Q1 value	Q2 Value	Q3 value	Q4 value	Comments
CCG1	Achieving 90% uptake of flu vaccinations by frontline staff with patient contact	72%	Q1: n/a Q2: n/a Q3: 70% Q4: 80%	n/a	n/a	n/a	47.8%	Challenges nationally due to 'vaccination fatigue' and concurrent COVID vaccination programme negatively impacting uptake versus previous financial years where Trust had achieved upwards of 85% performance. As this scheme is mandatory nationally, it is carried forward into 23/24
CCG2	Achieving 60% of all antibiotic prescriptions for UTI in patients aged 16+ years that meet NICE guidance for diagnosis and treatment	Joint agreement between CNO, CMO and ICB Director of Quality that this CQUIN was not achievable due significant resource requirement for reporting of data. Scheme had been amended from previous years scheme to include a much wider cohort of patients across the organisation. Agreement that one-off touch point audit to be undertaken over specified time-period to provide assurance on Quality aspect.						
CCG3	Achieving 60% of all unplanned critical care unit admissions from non- critical care wards of patients aged 18+, having a NEWS2 score, time of escalation (T0) and time of clinical response (T1) Recorded	60%	Q1: 40% Q2: 50% Q3: 55% Q4: 60%	68%	70%	97%	72%	Performance met in all 4 quarters. Small cohort of patients for audit results in some quarter- to-quarter fluctuations.

CCG4	Achieving 65% of referrals for suspected prostate, colorectal, lung and oesophago-gastric cancer meeting timed pathway milestones as set out in the rapid cancer diagnostic and assessment pathways	12.65%	Q1: 12.65% Q2: 32% Q3: 45% Q4: 55%	17.9%	14.9%	24.2%	34.2%	Remedial action plan has been in place throughout the year to improve performance. System issues around electronic triaging process being worked through with IT and Business Intelligence colleagues which has allowed steady improved performance to develop automation for each Tumour Group. Nationwide issues with performance against this indicator especially due to issues surrounding diagnostic capacity.
CCG8	Ensuring that 70% of surgical inpatients are supported to drink, eat and mobilise within 24 hours of surgery ending	55%	Q1: 55% Q2: 60% Q3: 65% Q4: 70%	55%	73%	52%	Not available at time of writing	Action plan in place to address issues around documentation in notes in areas affecting CQUIN performance.
CCG13	Achieving 70% of community hospital inpatients having a nutritional screening that meets NICE Quality Standard QS24 (Quality statements 1 and 2), with evidence of actions against identified risks	52%	Q1: 52% Q2: 55% Q3: 60% Q4: 65%	52%	62%	58%	Not available at time of writing	Performance in line with trajectory.

Ratings for St George's Hospital						
Division	Sale	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.

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".

The CQC has not taken any enforcement action against St George's University Hospitals NHS Foundation Trust during 2022/23.

However, on 28 March 2023 following the inspection of Maternity and Midwifery Services as part of the national inspection programme focusing on the key lines of enquiry Safe and Well-led, the CQC issued the Trust with a section 29A Warning Notice. The Trust immediately commenced a targeted improvement plan to address issues identified in:

- Effective and timely triage services
- Environment and equipment maintenance
- Staffing levels
- Oversight and governance

The Trust will formally respond to the CQC by 28 June 2023 to provide assurance together with supporting evidence on the completion of the improvement actions taken.

The last formal CQC inspection of CQC selected core services was in July 2019; the report was published in December 2019 and our rating was confirmed as 'Requires Improvement'.

At that time 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 in the 2018 CQC inspection. 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 published ratings for our core services and our overall rating.

In December 2019 the CQC also made a recommendation to NHS England and Improvement (NHSE/I) for the Trust to be removed from Quality Special Measures. In March 2020 NHSE/I confirmed the removal of the Trust 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. In April 2021 the Trust was also removed from Financial Special Measures.

During the last year the Trust has continued to meet with the CQC on a three monthly basis to discuss service and Trust wide issues of quality and safety.

Throughout 2022/23 the quality and safety standards were maintained within the cardiac surgery service which is supported by the data from the National Institute for Cardiovascular Research (NICOR). The Trust Board continues to review mortality for patients undergoing Cardiac Surgery on a regular basis.

It has been recognised across the NHS that the Covid-19 pandemic has impacted on the quality of services. In October 2022 a St George's, Epsom and St Helier (GESH) Quality Recovery Plan was approved at Board level. The plan outlines a programme of supported self-assessment, action planning, implementation and re-assessment focusing on a return to quality, team engagement/ collaboration and sharing of success. The plan has helped services to identify areas for improvement against the CQC key lines of enquiry of Safe, Caring, Responsive, Effective and Well-led. Targeted improvement plans have been developed and are in place supported by an effective governance framework to ensure the oversight and monitoring of delivery.

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 at www.cqc.org.uk

2.2.8 Our data quality

St George's University Hospitals NHS Foundation Trust submitted records during 2022/23 for inclusion in the Hospital Episode Statistics which are included in the latest published data.

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

99.6% for admitted patient care (against 99.7% national average)

99.8% for outpatient care (against 99.8% national average)

98.4% for accident and emergency care (against a 98.8% national average)

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

99.1% for admitted patient care (against 99.7% national average)

99.1% for outpatient care (against 99.6% national average)

99.5% for accident and emergency care (against a 99.2% national average)

2.2.9 Our Information Governance Assessment Report

The Trust was compliant with all the mandatory requirements of the NHS Data Security and Protection Toolkit (DSPT) for 2022/23 and planned compliance for 2023/24 by 31 March 2023. The Trust aims to submit the Toolkit with all the mandatory requirements by "Satisfactory Standard Met Status" by 30 June 2023. The Data Security and Protection Toolkit managed by NHS Digital is available at https://www.dsptoolkit.nhs.uk/ together with facilities to view organisation compliance status.

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 2022/23.

2.2.11 Learning from deaths

During 2021/22 1,487 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:

- 298 in the first quarter
- 358 in the second quarter
- 433 in the third quarter
- 398 in the fourth quarter

By 31 March 2021, 145 case record reviews have been carried out in relation to 9.8% of the deaths included. The number of deaths in each quarter for which a case record or an investigation was carried out was:

- 36 in the first quarter
- 26 in the second quarter
- 40 in the third quarter
- 43 in the fourth quarter 4 representing 0.27% 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:

- 1 representing 0.34% of the number of deaths which occurred in the first quarter
- 0 representing 0% of the number of deaths which occurred in the second quarter
- 3 representing 0.69% of the number of deaths which occurred in the third quarter
- 0 representing 0% of the number of deaths which occurred in the fourth quarter These numbers have been estimated using the structured judgement review, which was based on the Royal College of Physicians (RCP) tool. Any death that was judged to be more than likely avoidable (more than 50:50) was included in this figure.

What we have learned and action taken

During the year a number of investigations were conducted. As part of these investigations, issues were highlighted for local reflection and learning, including instances where excellent practice was observed, for example:

- The Trust has continued to demonstrate full compliance with the Clinical Negligence Scheme for Trusts (CNST) Safety Action One, as evidenced by the quarterly Perinatal Mortality Review Tool reports. In addition to summarising compliance with the safety standards each report also detailed potential areas for learning and improvement. Over the year these included enhancements to bereavement care through recruitment to a specialist bereavement midwife role and review of the bereavement pathway to ensure compliance with national standards. Improvements to the documentation and support provided to parents following loss, and provision of staff education and training has further strengthened this service
- A review of mortality following major trauma has progressed significantly, leading to changes designed to improve clinical documentation, governance, and clinical pathways. Enhancements to our electronic patient record have been designed to enable improved documentation of immediate major trauma care to support efficient delivery of best practice care and accurate data collection. Clinical pathways that have been amended following the mortality review include those for patients admitted medically and those who have experienced pelvic trauma. The Trust is continuing to seek opportunities for improvement which will be further informed through a strengthened prospective mortality review process.

Summary of action taken in 2022/23 and plans for 2023/24

This year we have made significant progress against the action plan arising from the external governance review of mortality conducted in 2019. The aim of this work is to maximise the learning identified through review and investigation of mortality and to support implementation of improvements as a result. This year we have introduced a team of six Mortality and Morbidity Coordinators to support clinical teams and to facilitate enhanced governance across the Trust.

Each clinical team has an allocated coordinator who is facilitating Mortality and Morbidity meetings. The team are working with governance leads to develop and implement consistent approaches to mortality governance. This includes defining a core, but adaptable, range of data that will be examined for each death reviewed, alongside guidelines and protocols for the operation of the meeting and sharing of findings. Pilots are underway which will inform the agreed approach to be implemented in the coming year. The coordinators are beginning to support shared learning through facilitating liaison between teams where discussion identifies that consideration of the case is required within another service. A strengthened link with the learning from deaths review process has also been established.

This year our clinical lead for Learning from Deaths recruited two additional consultants to the Mortality Review Team. This team of four consultants working on a sessional basis support independent mortality reviews using the structured judgement review developed by the Royal College of Physicians. Through this increased team we have been able to support a larger number of timely reviews of deaths that meet the criteria defined within our Learning from Deaths policy. These include:

- Deaths where the Medical Examiner has identified a potential concern
- Deaths where bereaved families, or staff, had raised a significant concern
- Deaths of inpatients with learning disabilities
- Deaths of inpatients with a clinical diagnosis of autism
- Deaths of inpatients with severe mental illness
- Deaths in a speciality where the Mortality Monitoring Group agreed that enhanced oversight was required or that learning would inform the Trust's quality improvement work
- Deaths where the patient was not expected to die including all deaths following elective admission

For any death where the Mortality Review Team felt there was significant concern, the case was escalated immediately to the Patient Safety Team to consider if a serious incident, or other, investigation was required. Significant problems of care, whether or not it affected the outcome, were highlighted to the clinical team for discussion and local learning in their Mortality and Morbidity meetings. In addition to promoting reflection and learning by highlighting to governance and clinical teams where care or treatment could potentially have been better, the Learning from Deaths Lead also highlighted excellent practice.

During the year the Medical Examiner (ME) service continued to scrutinise all non- coronial deaths in addition to those referred to the coroner. The service continued to support accurate and consistent certification of death and to support the bereaved. Where the ME identified potential governance issues that need to be further explored these have been referred either to the Lead for Learning from Deaths, to the Patient Safety Team, or to the clinical team involved with the patient's care.

This year the service has prepared for the expansion of the service to encompass the scrutiny of all deaths that occur within Merton and Wandsworth. Through collaboration with colleagues in primary care the service have agreed a pilot in several practices prior to the introduction of the statutory system. Three Medical Examiner Officers have been appointed to the team and recruitment of two Medical Examiners from non-acute services is underway. These enhancements to the team are essential to the successful expansion of the ME service.

There were no (0) case record reviews and no (0) investigations completed after 30 April 2021 which related to deaths which took place before the start of the reporting period.

T0 representing 0% 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 structured judgement review, which is based on the Royal College of Physicians (RCP) tool.

2.2.12 Standards for Seven Day Services

Reporting for standards for 7-day services has changed to reflect the framework published in February 2022 and is now undertaken biannually.

The updated framework no longer refers to compliance for standards 2 and 5 and now advises that for each acute specialty consultant job plans should be reviewed to ensure that there is sufficient timetabled consultant time to meet the anticipated demand from emergency admissions. The framework also advises that the precise level of consultant presence required to deliver these standards is for the provider to assess locally rather than being specified centrally, as each organisation has its own requirements.

The Trust has increased weekend consultant presence across 7 specialties to improve performance against standards 2 and 5 and a divisional review process has confirmed adequate mitigations for safety and hospital flow are in place. With reference to standard 8 and 7-day equitable access to MRI scanning, the service is currently limited to a number of conditions.

In addition, hospital SITREP data shows a similar length of stay for admissions over 7 days, with no significant weekend disparity. The percentage of discharges occurring at the weekend continues to be lower than weekday activity, and this pattern for discharge activity is similar to regional and national benchmark data. Any individual clinical areas showing variance are subject to deep dives and oversight by the hospital flow programme.

2.2.13 How our staff can speak up

Staff are encouraged and supported to speak up about any concerns they have about any aspect of their work and have various ways of doing so. The Trust has in place a clear policy that sets out how staff can raise concerns which reflects relevant national guidance from NHS England and the National Guardian's Office for Freedom to Speak Up.

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
- Any other Executive and non- executive
- Chairman

Staff can raise concerns in different ways such as:

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

Staff are also advised how they can raise concerns externally if they are unhappy with using any of the internal routes for raising concerns or if they indicate that after raising a concern they do not feel the concern was investigated in line with the Trust policy. These external routes include the Care Quality Commission, and recognised professional or union body. Staff with concerns about potential fraud are encouraged to raise concerns with NHS Counter Fraud.

Staff who speak up are advised to report incidents where they feel due to speaking up they have come to a detriment from speaking up. 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. Anonymous concerns cannot be fed back however the outcome is logged by the Trust.

Themes and trends in the concerns raised by staff that come to the FTSU Service are reported to the Trust Board and to the Board's People Committee.

2.2.14 Guardian of safe working

The year 2022/2023 has not been dominated by the covid 19 pandemic in the same ways as previous years, but the impact of the pandemic is still felt. There has been no redeployment of juniors over this period and departments and specialties have resumed normal routine and acute work. There are additional pressures from back logs created during the pandemic and the ongoing care of patients suffering from covid 19 infection. The workload and intensity of work for junior doctors has remained very high throughout the year and across many specialities. January-December 2021 saw a total of 382 exception reports and January- December 2022 has seen a total of 500 reports. Although the increase in reports is in some ways disappointing- reflecting the additional work that juniors across the trust are putting in- it is clear that juniors are being encouraged, and feel able, to exception report.

As in previous years, approximately three quarters of all reports are from acute and general medicine. It is reassuring that medical consultants remain supportive of the juniors, encourage reporting and signing off exception reports for payment or TOIL in a timely manner. A long term work force strategy for medicine is being reviewed at senior level. There has been a pilot of physician assistants (PAs) working in acute medicine to help support junior doctors on the ward. This pilot will be reviewed during 2023.

Locally employed doctors (LED) have been able to exception report through the same system as trainees since beginning 2022. It was positive to see the first exception reports from this group received in January 2023. We plan to continue to work to increase reporting in this underrepresented group. The GOSW is also working with LED lead to look at study leave policies for LED across the trust in an attempt to standardise policy and support LED.

After a period of poor attendance over the covid 19 pandemic, interest and attendance at the Junior Doctors Forum (JDF) is improving. In October 2022, three new co-chairs for the JDF were appointed. The first JDF meeting in December 2022 was well attended, with over 25 junior doctors from across the trust present.

The redecoration and refurbishing works of junior doctor's mess commenced in February 2023 using well-being funds and will be completed before the summer.

We have started the new year with junior doctor industrial action. This is an unsettling time for juniors and the support of the consultants and wider team will be hugely important over the coming months.

Finally, the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 require the Trust's Guardian of Safe Working to provide quarterly reports on rota gaps to the Trust Board. We define rota gaps as the number of vacancies (which need to be filled to ensure that service provision requirements are met) which arise as a result of any shortfalls in the number of doctors in training recruited when compared with the number allocated by Health Education England. The gaps are derived from the HEE portal April trainee reports.

The rota gaps by Division for 2022-23 are summarised below.

Division	WTE
Medicine	13
Surgery	13.6
Children and women	9
Total gaps in the rota	**35.6**

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 (where available).

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)	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	Jan 20- Dec 20	Dec 20- Nov 21	Jan 21- Dec 21	Jan22- Dec22
SHMI	**0.81**	**0.83**	**0.83**	**0.83**	**0.85**	**0.85**	**0.85**	**0.86**	**0.84**	**0.90**	**0.91**	**0.94**
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**	**As expected**	**As expected**	**As expected**
% Deaths with palliative care coding	**50**	**49**	**49**	**50**	**49**	**49**	**48**	**47**	**49**	**54**	**54**	**58**

Source: NHS Digital- https://app.powerbi.com/view?r=eyJrIjoiMjAyMmRjMzItYWZlZC00MWU4LWFjYTQtNzRkODYyNmFmOTYxIiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9

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 embedded the implementation of the Medical Examiner System. We undertook a review of our mortality monitoring process. We have recruited an additional 6.0 wte posts to strengthen the administrative support to the monitoring process and additional Medical Examiner Officers to support the reviews. We review all deaths to ensure we identify and share every opportunity to learn and improve the care our patients receive.involvement of palliative care services.

2.3.2 Patient reported outcome measures

For Trusts providing relevant acute services 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 paients reporing an increase in health following surgery		2020-21*	2021-22*	2022-23*
		SGH	SGH	SGH
Hip replacement	EQ-5D™	No data	No data	Not published at time of writing and will be included in the 2023-24 report
	EQ-VAS	No data	No data	
	Specific	No data	No data	
Knee replacement	EQ-5D™	No data	No data	
	EQ-VAS	No data	No data	
	Specific	No data	No data	

Source: NHS Digital 9https://digital.nhs.uk/data-and-information/publications/statistical/patient-reported-outcome- measures-proms/hip-and-knee-replacement-procedures---april-2019-to-march-2020

*No data submitted

For both hip and knee replacement 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 (SWELEOC).

This year given the level of activity at St George's we have explored the option of submitting data alongside Epsom and St Helier University Hospitals NHS Trust for SWELEOC cases but we made limited progress.

We also looked at St George's becoming accredited in order to submit data directly to the audit rather than submitting via an external data collector, however this process has been suspended by NHS Digital.

This year we will make the case for the Trust to withdraw from participation in this audit.

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	2019-20			2020-21			2021-22			2022-23		
	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	13022	47103	60125	8,522	34,886	43,408	9,945	35, 549	45, 494	9,365	32,041	41,406
28-day readmissions	932	4218	5150	524	3,638	4,162	672	3,233	3,905	576	2,781	3,357
28-day readmissions rate	7.16%	8.95%	8.57%	6.15%	10.43%	9.59%	6.76%	9.09%	8.58%	6.15%	8.68%	8.11%

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

Last year and in previous Quality Accounts the national inpatient survey asked five questions focussing on the responsiveness and personal care of patients. From the table below it can be seen that our scores were generally in line with the national average shown below. The data below also shows the average, highest and lowest performers and our previous performance.

Further to the merger of NHS Digital and NHS England the data in this format set out in the following table is no longer available via the https link below.

Patient Experience	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
St George's University Hospitals	**65**	**67.2**	**67.1**	65	Not available	
National average	68.6	67.2	64.2	67.1	Not available	
Highest (best)	85	85	84.2	84.4	Not available	
Lowest	60.5	58.9	59.5	54.4	Not available	

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

We have reviewed a related section in the national CQC inpatient survey (2021/22). This section is made up of several questions relating to personal care, food, and assistance with eating.

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

This data is validated through the external CQC national inpatient survey methodology

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

Paient Experience	2021-22	2022-23*
St George's University Hospitals	**7.3**	
National average		
Highest (best)		
Lowest		

St George's University Hospitals NHS Foundation Trust.pptx (live.com)

* The 2022/23 data has not been published at the time of submitting this report. This data will be included in the Quality Report 2023/24

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 2022/23 shows a 3.6 % reduction in staff who would recommend St George's to their friends and families.

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

Staff recommendaion	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
St George's University Hospitals	73%	69%	72%	76%	71.2%	67.6%
Average for Acute	69%	70%	71%	74%	66.9%	61.9%
Highest Acute Trust	86%	87%	87%	92%	89.5%	86.4%
Lowest Acute Trust	47%	41%	40%	49%	43.6%	39.2%

http://www.nhsstaffsurveyresults.com/wpcontent/uploads/2021/02/NHS_staff_survey_2020_RJ7_full.pdfhttps://public.tableau.com/app/profile/piescc/viz/ST20localdashboards/Aboutthesurvey

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 inpatient services in 2022/23 with 98.42% of our Inpatients saying they would recommend our services to their friends and family.

Unfortunately, due to the significant demand for A&E services and the associated waiting times 74.42% of those visiting our A&E department said they would recommend our services to their friends and family.

Friends and Family Test	2018-19		2019-20		2020-21- Dec21		2021-22- Mar 22		2022-23	
St George's University Hospitals	A&E	Inpatient	A&E	Inpatient	A&E	Inpatient	A&E	Inpatient	A&E	Inpatient
Response rate	26.20%	26.40%	15.27%	34.38%	18.97%	28.74%	12.82%	32.71%	12.43%	29.17%
% would recommend	87.00%	97.00%	82.41%	96.5%	89.83%	97.5%	77.86%	97.70%	74.42%	98.42%
% would not recommend	8.50%	1.00%	12.36%	1.14%	6.52%	0.75%	12.82%	0.60%	17.24%	0.41%
National comparison positive response rate	12.3%	24.6%	12.1%	24.4%	N/A*	N/A*				
National comparison as at March 2020 % would recommend	86%	96%	85%	96%	N/A*	N/A*				
National comparison as at March 2020 % would not recommend	8%	2%	9%	2%	N/A*	N/A*				

..\Performance Visibility Team\Performance Board & Quality Monthly Reports\Archive

Friends-and-Family-Test-inpatient-data-January-2022.xlsm (live.com)

* FFT data collection was suspended in March 2020 and was re-started in December 2020 due to Covid-19. No national data has been published since national collection restarted.

2.3.6.1 TThe 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:

- 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. Our scores were an improvement on the previous year. The data is no longer benchmarked at a national level therefore data for the average, highest and lowest performers is no longer published.

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

VTE Assessments	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
St George's University Hospitals	95.90%	96.0%	93.9%	96.18%	96.8%	97%
Naional Average	95.80%	95.6%	95.5%	95.33%	N/A	N/A
Best performing Trust*	100%	100%	100%	100%	N/A	N/A
Worst performing Trust*	72%	74.4%	71.7%	77.16%	N/A	N/A

https://improvement.nhs.uk/resources/venous-thromboembolism-vte-risk-assessment-q2-202021/

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

- Continue to working to achieve higher VTE risk assessment rates
- Optimisation of iClip and anticoagulation prescribing

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. The Trust has breached the NHSE number of Clostridium Difficile infections for 2022/23, an action plan is in place and on-going with monthly prevalence reduced since quarter 2, 2022/23.

Clostridium Difficile	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
St George's University Hospitals *Data is from April 21 to Mar 22						
Trust apporioned cases *Change in reporing: denotes those Cases confirmed due to lapses in care	16	31	8	34	33	60
Trust bed-days	296,981	282,339	285,321	225,244	278,832	290,474
Rate per 100,000 bed days	5.4	11.0	2.8	15.09	11.8	20.3
Naional average	31.2	33	3	21.52	25.81	27.51
Worst performing trust	113	177	15	98.61	91.6	98.8
Best performing trust	0	0	0	0	0	0

NHSI HCAI Dashboard: Trust Overview - Tableau Server (england.nhs.uk)

Bed Occupancy: Acute Bed Occupancy - Tableau Server

C. difficile infection: monthly data by prior trust exposure - GOV.UK (www.gov.uk)

Data showing National, Worst and Best performing Trust included all CDIff data. Does not separate Hospital and Community Onset.

NOTE: In 2020-21 Hospital capacity was organised in new ways as a result of the pandemic to treat Covid-19 and non-Covid-19 patients separately and safely in meeting the enhanced Infection Prevention Control measures. This results in beds and staff being deployed differently from in previous years in both emergency and elective settings within the hospital. As a result, caution should be exercised in comparing overall occupancy rates between this year and previous years. In general, hospitals will experience capacity pressures at lower overall occupancy rates than would previously have been the case.

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

We are committed to improving safety by avoiding or reducing Clostridium Difficile which results in shorter length of stay and improved patient experience. The Trust has breached the NHSE number of Clostridium Difficile infections for 2022/23, an action plan is in place and on-going with monthly prevalence reduced since quarter 2, 2022/23.

Patient Safety Incidents	Apr 17-Sep 18	Oct 18-Mar 19	Apr 19-Sep 19	Oct 19-Mar 20	Apr 20-Mar 21	Apr 21-Mar 22	Apr 22-Mar 23
St George's University Hospitals							
Total reported incidents	5548	5934	6268	6697	12352	13092	13880
Rate per 1000 bed days	34.2	39.5	45.3	45.4	51.2	51.7	55.0
***Naional average (acute non-specialist)**	42.8	46.1					
***Highest reporing rate**	111.7	95.9					
***Lowest reporing rate**	23.5	16.9					

Paient Safety Incidents	Apr 17-Sep 18	Oct 18-Mar 19	Apr 19-Sep 19	Oct 19 – Mar 20	Apr 20-Mar 21	Apr 21-Mar 22	Apr 22-Mar 23
St George's University Hospitals							
Incidents causing severe harm or death	14	23	10	9	21	46	Not available at time Of writing
Rate per 1000 bed days	0.25%	0.38%	0.16%	0.13%	0.17%	0.35%	
***Naional average (acute non-specialist)**	0.35%	0.36%					
***Highest reporing rate**	1.23%	0.49					
***Lowest reporing rate**	0.02%	0.01%					

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

*As of April 2019 NHS Digital no longer publishes data on the national averages for patient safety incidents

The data submitted to the National Reporting and Learning System (NRLS) was previously published every six months. This has now changed to use annual timeframes, rather than six-monthly, and from 2020/21 the data is published on an annual basis.

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 It should be noted that 3 of the incidents in 2022-23 were never events. 2 were related to retained foreign object (retained guidewire and vaginal swab) and 1 was related to a misplaced nasogastric tube. Serious incident investigations were undertaken and improvement actions were identified and implemented.

2.3.9.3 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 2023/24. 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 bi-monthly patient safety newsletter and a quarterly analysis report and thematic learning
- Commenced the implementation of the new Patient safety Incident reporting Framework (PSIRF) in line with the new National Patient Safety Strategy.

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.

		Target	Annual performance 2019-20	Annual performance 2020-21	Annual performance 2021-22	Annual performance 2022-23
Referral to treatment times	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	92%	84.20%	69.30%	72.30%	67.9%
	Number of 52 week breaches	0	32	2,644	846	517
ED access	95% of patient wait less than 4 hours	>=95%	83.20%	92.80%	81.60%	76.60%
Cancer access	% cancer patients treated within 62 days of urgent GP referral	>=85%	85.20%	77.10%	72.60%	66.0%
	% patients treated within 62 days from screening referral	>=90%	88.80%	80.80%	75.90%	71.0%
Diagnostic waits	Maximum 6 week wait for diagnostic procedures	99%	95.70%	89.80%	98.20%	98.20%

3.2 Our performance against our Quality priorities in 2022-23

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, 2020/21. 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.

1.0 Patient Safety			
Our quality priorities	**What will success look like?**	**How did we do in 2022/23?**	**How our performance compared with 2021/22**
Prevent Nosocomial Covid-19 infection for inpatients	Reduction in the level of Nosocomial Covid-19 infection when compared with the previous year	**We did not achieve this** Between April 2022 and March 2023 the Trust had reported 426 cases of HOHA (hospital onset, hospital acquired) nosocomial hospital onset healthcare associated >14 days after admission Between April 2022 and March 2023 the Trust had reported 247 cases of HOPA (hospital onset, probable acquired) nosocomial hospital onset healthcare associated 8-14 days after admission	In 2021/22 we reported 227 cases of HOHA nosocomial hospital onset healthcare associated >14 days after admission In 2021/22 we reported 137 cases of HOPA nosocomial hospital onset healthcare associated 8- 14 days after admission
Emergency patients will have a Treatment Escalation Plan (TEP)	All adult inpatients will have a Treatment Escalation Plan (TEP) Reduction in avoidable harm and death associated with missed opportunities when compared with the previous year Improved response to the National Early Warning Score (NEWS2) when compared with the previous year Reduction in the number of cardiac arrests compared with the previous year	**We did not achieve this** All wards have a TEP Dashboard and daily tableau reports are generated for ward managers Compliance across all wards ranges between 36 - 51% against a trajectory of 40% and is monitored monthly by the Divisional teams Compliance on Senior Health wards was 90-95% In March 2023 45% of adults had a TEP in place confirmed by a snapshot audit The number of cardiac arrests in March 2023 was 1.92/1000 inpatient admissions NEWS2 audits showed an appropriate response performance of 92% in March 2023. The methodology for this audit is self-audit by a member of the ward team. Going forward enhanced assurance can be provided by the Bi-annual NEWS2 survey undertaken by the Critical Care Outreach Team supported by the audit team.	In 2021/22 we established an improvement project and built an electronic TEP in the test domain of iClip In March 2022 37.4% of adults had a TEP in place within 24 hours of admission. The number of cardiac arrests in 2021/22 was 7.7/1000 inpatient admissions NEWS2 audits showed an appropriate response performance of 90.8% in March 2022 which was an improvement in appropriate response performance from 89% in

We will ensure the 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 Level 1 and 2 Mental Capacity Act (MCA) Training	**We did not achieve this** Internal audit (TIAA) report published in August 2022 – all but two recommended improvement actions arising have been completed. Consent Policy on two pages circulated to all care groups – inclusive of MCA flowchart. New consent audit live December to January and quarterly thereafter. Mental Capacity Act and Deprivation of Liberties (MCA/DoLs) Training – Level 1 training performance was 90.70% in March 2023 Level 2 training performance was 61% in March 2023 **Important note:** In 2022/23 the Trust was still awaiting the release of the guidance for the implementation of the new framework for MCA/DoLS – the Liberty Protection Safeguards (LPS). The revision of the Level 2 training module was paused whilst the new framework was awaited which impacted on training performance. It has now been confirmed that LPS will not be implemented.	Since 2019 Mental Capacity Act and Deprivation of Liberties (MCA/DoLs) Training – Level 1 training performance had achieved the target Level 2 training performance was 69.7% in March 2022
All patients will be supported to give consent for treatment	All non- elective adult inpatients will have a treatment escalation plan (TEP) in place within 24 hours of admission	**We did not achieve this** In March 2023 45% of adults had a TEP in place confirmed by a snapshot audit At the time of writing this report consent audit data has not been published	In March 2022 35% of adults had a TEP in place within 24 hours of admission, performance in March 2021 was 33.8% No consent audit data was available in 2021/22
Embed medical examiner service and learning from deaths processes	Maintain Summary Hospital Level Mortality Indicator (SHMI) within confidence intervals	**We achieved this** Mortality as measured by the summary hospital-level mortality indicator (SHMI) remained as or lower than expected	Mortality as measured by the summary hospital-level (SHMI) was lower than expected
2.0 Patient experience			
Our quality priorities	**What will success look like?**	**How did we do in 2022/23?**	**How our performance compared with 2021/22**
We will undertake thematic analysis of our complaints to identify recurrent themes and share their findings	Reduction in the number of complaints when compared with the 2019/20 baseline (complaint numbers impacted in 2020/21 and 2021/22 due to the pandemic)	**We partially achieved this** We undertook thematic analysis on a quarterly basis which identified recurrent themes: care and treatment; communication; and staff attitude The total number of complaints in 2022/23 was 650	The number of complaints received in previous years was as follows: • 2021/22: 1,044* • 2020/21: 708* • 2019/20: 956 • 2018/19: 1101 *Impacted by Covid-19

Provide an equitable experience for patients from vulnerable groups	Improvement in our self-assessment against the National Learning Disability Standards having had the opportunity to make service improvements	**We partially achieved this** The action plan to address improvements identified in the 2021 national standards self-assessment did not progress as expected due to significant staffing shortages in the team. South West London ICB and Acute Hospitals worked together to create a pathway for referral to STOMP (stopping over medication of people with a learning disability, autism or both). This will cover each Acute Trust and will support patients to have psychotropic medication reviewed as part of ongoing care. A part time Healthcare Assistant post has been created to provide additional psychosocial engagement for inpatients, and support outpatients to navigate appointments. The Learning Disability (LD) team have approval from Charity Funds to purchase tablet computers to enhance patient experience whilst an inpatient. Radiology Administrative staff trained in LD, recognising a hospital passport LD PPEG was relaunched face to face. The self-assessment was completed against national standards for Learning Disability patients and at the time of writing we are awaiting the results.	In March 2021 we received the results of the NHS benchmark assessment that was completed against national standards for Learning Disability patients. There were 107 national benchmark Learning Disability Standards, of which 79 benchmark standards applied to SGH. 48/79 (61%) were in line with the national standard 20/79 (25%) were above the national standard 11/79 (14%) were below the national standard
Improve patient flow particularly with reference to improved discharge processes	Continue to survey our patients on discharge and respond to what they tell us to ensure our patients are quipped 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 patientsmto leave our care with a follow upnappointment or investigation date if required	**We achieved this** The multi-agency Discharge Forum has continued Recruitment to full Transfer of Care (TOC) service undertaken with 7 day service running 08:00-18:00 Planning and mapping of involvement of voluntary services in expediting discharges and admission avoidance. New flow model implemented – 1 of 5 Trusts involved in national trial	Discharge hub implemented and aligned to the site team to enable increased oversight of expected discharges Implemented South West London system approach of agreed discharge to assess process Created a monitoring process: the multi-agency Discharge Forum

3.0 Effectiveness and outcomes			
Our quality priorities	**What will success look like?**	**How did we do in 2022/23?**	**How our performance compared with 2021/22**
With SWL and St George's Mental Health Trust we will develop an integrated education and training framework for our staff to support the care and treatment of mental health patients in an acute setting	An integrated training and education framework will be in place with SWL and St George's Mental Health Trust	**We did achieve this** Parity of Esteem (PoE) lead was recruited and commenced in post in December 2022. Mental Health Training Matrix in place The educational programme delivery with has been negotiated with SWLSTG and has commenced. The terms of reference have been reviewed to restart the inter-Trust operational meeting.	The integrated training and education framework was not developed due to the new post of Head of Nursing commencing in post December 2020
Embed a culture of quality, safety and learning	Implement the national patient safety training syllabus across the Trust Launch the new patient Safety training Incident Reporting Framework Establish Patient Safety Partners Share learning via the bi-monthly Patient Safety Bulletin	Carry forward to 2022/23 We were unable to deliver on this Quality Priority in 2022-23 as the new national Patient Safety Incident Response Framework was not launched until August 2022.	N/A
Deliver care in line with our revised activity plans to ensure our patients do not wait too long for treatment	Achievement of targets for: • Referral to Treatment (RTT) within 18 weeks • Diagnostics within six weeks • Four-hour operating standard • Cancer standards	**We did not achieve this** As reported in section 3.1 of this report **RTT:** The Trust eliminated all 78 week waits by March, except for four patients that will be treated in April, due to patient choice. At the end of February 481 patients were waiting for treatment for more than 52 weeks, this is below the plan of 800. **Diagnostics:** We did not meet our diagnostics within 6-weeks standards **Cancer:** We did not meet our cancer access standards **Four-hour target:** We did not deliver against the four-hour operating standard. We delivered 73.5% against the target of 95%	As reported in section 3.1, 2021-22 report **RTT:** We delivered against the revised trajectories for 78 week waits other than for General Surgery and Cardiology. As required, we maintained the end of September 2021 position for the 52-week trajectory **Diagnostics:** We did not meet our diagnostics within 6- weeks standards **Cancer:** We did not meet our cancer access standards **Four-hour target:** We did not deliver against the four-hour operating standard

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

A1.1 Statement from South West London Integrated Care Board

Thank you for sharing the Trust's 2022/2023 Quality Account with South West London Integrated Care Board (SWL ICB). Having reviewed the Quality Account, we are pleased to see the progress made by the Trust in maintaining high quality care standards. It is evident that there is a significant amount of positive work the Trust has undertaken to improve outcomes for both patients and staff.

The ICB congratulates the Trust on achieving the priorities set for 2022/2023 and identifying areas where work will continue into 2023/2024. We are encouraged to see that you have a medical examiner service embedded and learning from deaths processes in place, this will complement the work you are undertaking implementing the Patient Safety Incident Response Framework (PSIRF).

We applaud the improvements to patient flow, for embracing a multi-agency discharge forum and using the new flow model as one of five Trusts involved in the national trials. We are assured that you are recruiting to the Transfer of Care (TOC) service, which provides a 7-day service running 08:00- 18:00, including innovative ways to involve voluntary services in expediting discharges and admission avoidance.

We congratulate you on training your radiology administrative staff in recognising Learning Disability (LD) patients and developing the hospital passport, and also for relaunching LD PPEG face-to-face.

We are committed to ongoing work with you in creating a pathway for referral to STOMP (stopping over medication of people with a learning disability, autism or both) as we ensure all Trusts will support patients to have psychotropic medication reviewed as part of ongoing care. This is in alignment with the Integrated Care System's priorities to tackle health inequalities for people living with a learning disability.

We commend the work you are undertaking for staff around the integrated education and training framework with SWL St Georges' Mental Health Trust to support the care and treatment of mental health patients in an acute setting.

In the spirit of collaboration and integration, we compliment that your 2023/24 priorities and the new 5 year strategy have been jointly developed as a Group with alignment to Epsom and St Helier, with an aim to work closer with SWL ICS and the Acute Provider Collaborative. For 2023/2024, we acknowledge the Trust has identified the following quality priorities:

- **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.

We commend the alignment of your quality priorities to the 5-year strategy for GESH Group and note other quality priorities include:

Well Led

- Deliver on our Health and Wellbeing promise to all staff by investing in physical and mental health staff services and flexible working.
- Develop and implement an inclusive talent management approach to ensure that we improve our opportunities for our staff.

Reduce Health Inequalities

- Taking action on our culture to ensure we are more inclusive and diverse, where discrimination, violence and bullying is not tolerated – improving the experience of BAME staff in particular.

Develop Sustainable Quality-led Services

- Develop an environment where staff feel psychologically safe to speak up and use their voices to improve our services to patients.

Quality Management System

- Continue to work in partnership and collaboration with the SWL Integrated Care System (ICS) and Acute Provider Collaborative (APC).
- Delivering a transformational step change in use of resources (to achieve the Cost Improvement Programme) at SGUH, across the Group and across South West London ICS, for the benefit of patients and the welfare of our staff.

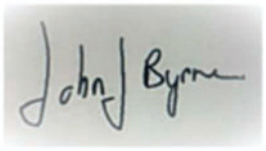
- Explore and deliver opportunities for collaboration across the Group.
- Make best use of our resources at St George's and across South West London ICS, for the benefit of patients and the welfare of our staff.

We are pleased to see all priorities align to the ICB's Joint Forward Plan and System Quality Strategy, and we are committed to working with the Trust and Group as a core a member of the Integrated Care System to improve outcomes and deliver our shared quality priorities.

We recommend that the Trust considers the following actions within its agreed priorities:

- Working in collaboration with system and local partners to tackle systemic health inequalities; a particular focus on quality in SWL is ensuring that all Trusts have effective and adequate pathways adhering to the NICE guidance to improve compliance of the 30-minute to analgesia target in Emergency Departments for sickle cell patients.
- Proactively work to improve and sustain quality of care in maternity services following the Care Quality Commission warning notice to the Trust.

We look forward to continued work with the Trust under our partnership arrangements and strengthening our collaborative approach to system quality improvement.



John Byrne
Chief Medical Officer

A1.2 Statement from Healthwatch Wandsworth

Healthwatch Wandsworth (HWW) welcomes the opportunity to comment on the Quality Account 2021-22 for St George's University Hospital Foundation Trust. Please note that our comments are based on a draft copy of the Account which may not contain all the information that will appear in the final version.

The openness and honesty of the report, and the considerable detail is very welcome. There are examples of some good performance on tackling the back log of treatment and appointments, especially in those wating over 52 weeks. This year there have been a lot of factors adding to pressure and demand on hospital staff and resources, across services and particularly affecting the Emergency Department. In light of this, the achievements that have been made in these challenging circumstances are commendable. We hope that the next year that further progress can be made against some of the targets and indicators that were more difficult to achieve this year.

Hospital discharge is a particular area of interest for us and for local people. We heard from carers about the improvements that can be made to care when they are more informed and involved in the process and are very pleased that the carers toolkit will be used because it was informed by what people told us. Ambitions set out in the account for the next year aim to ensure people have the information to manage their health and know how to access support and that discharge summaries will be improved as well as making sure people have a planned follow-up appointment or investigation. We hope to see next year that these measures have had an impact on the indicators demonstrating re-admissions and in responses from patients to surveys about their experience.

We've also seen better collaboration with the Patient Involvement team over the past year and welcome the renewed focus on embedding this across all services. There is an encouraging statement in the account that there will be collaboration with Integrated Care System colleagues to review and triangulate all sources of patient feedback to improve our understanding of what good looks like for patients and their families. This will bring a welcome focus on ensuring that people are heard and an increased impact of the time they spend sharing their experiences. People often tell us they are asked to comment several times on aspects of their care, so avoiding duplicating collection of insight from people will be appreciated and will help build trust that there is a benefit to sharing their views.

The detail about insight from national inpatient surveys was very limited in the draft report we viewed, which means that we cannot make any meaningful comments. We hope there will be more reported on patient experience next year.

Another topic we often hear about that has an impact on experiences is communication, particularly around appointments. MyCare patient portal offers a solution that could help many people with information and with arranging and confirming appointments. Improving these things will ensure people can manage their own care and that they can access and navigate the system, as well as potentially breaking down some barriers in communication. We hope that the portal continues to develop to support people more, and that this is done by working with patients to understand how it works for them, what is working well or where there could be barriers to using it for others. We have particularly heard that communications and letters are an issue for people with sight loss and hope that there is further consideration of whether this portal or another means can improve the experience.

Other areas of welcome focus outlined in the report include:

- the focus on implementing the National Patient Safety Framework and the development of Patient Safety Partners which we hope will be achieved in a timely way.
- focus on inequalities starting with better data collection by ethnic and other protected characteristics to examine outcomes by different patient groups.
- meeting the emotional wellbeing of patients and their families.
- learning across the group and bench marking with similar institutions so best practice is implemented.

Areas for further development that we think will be important include:

- issues related to maternity services in particular the latest CQC inspection – we look forward to the action plan and improved outcomes.
- focus on improving efforts to reduce falls and pressure ulcers. These are areas which may have a direct impact on patients' length of stay, rehabilitation and plans for discharge.

- support for staff to feel safe raising concerns and to have an increased culture of openness.
- embedding the patient experience and feedback and making this real and meaningful within the new GESH strategy.
- that new measures to learn from deaths improve the Summary Hospital Level Mortality Indicator score.
- improvements to reverse the upward trend in the numbers reported in section 2.3.9 around patient safety incidents.Areas for further development that we think will be important include:

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

- Voluntary provision of comments – none received.

A1.4 Our response to our stakeholders

The Trust is grateful for the considered responses from all our stakeholders and their input in developing our Quality Account. These have been helpful and will be considered with the relevant stakeholders in 2023-24.

A1.5 Limited assurance report on the content of the Quality Reports and mandated performance indicators

[Not required and limited to a read through against the Annual Report and Accounts]

A1.6 Independent auditor's report to the Council of Governors of St George's University Hospitals NHS Foundation Trust on the Quality Report

[Not required]

Annex 2:

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

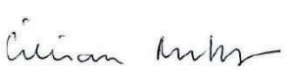
The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

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 2021/22 and supporting guidance Detailed requirements for quality reports 2021/22
- the content of the quality report is not inconsistent with internal and external sources of information including:
  - i. board minutes and papers for the period April 2022 to June 2023
  - ii. papers relating to quality reported to the board over the period April 2022 to June 2023
  - iii. feedback from the Integrated Care Board
  - iv. feedback from Governors
  - v. feedback from local Healthwatch organisations (voluntary)
  - vi. the Trust's complaints report 2021-22 published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
  - vii. the latest national patient survey for Adult Inpatients; Urgent and Emergency Care; Children and Young People; and Maternity Services
  - viii. the latest national staff survey
  - ix. the Head of Internal Audit's annual opinion of the Trust's control environment dated [Not required]
  - x. 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
30 June 2023

Jacqueline Totterdell
Chief Executive
30 June 2023