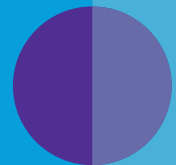
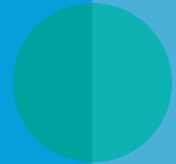


Quality
Accounts
2011-12



contents

	page
1 Statement on quality from the Chief Executive	1
2 Our quality priorities for 2012-13	6
3 Progress against 2011-12 priorities	21
4 Annex – Feedback on our 2011/12 Quality Accounts	39
Statement of Directors' responsibilities	
Independent Auditors Assurance Report to the Council of Governors	
Summary of CQUIN initiatives	

1

Statement on quality from the Chief Executive

This quality report aims to assure our commissioners, patients and the local population that we continue to provide the highest quality of care.

We have three quality priorities which form the basis of everything that we do: to make sure that our patients are kept safe; to provide the highest quality care; and to find ways to improve the experience for our patients. I hope that this quality report demonstrates this commitment.

Underpinning our ambition is our quality strategy. This sets out our determination to put our patients first; we aim to keep patients safe and ensure that their experience with us is positive.

Last year, we again sought to involve our stakeholders in developing our Quality Accounts, particularly our quality priorities. We have held events to seek the views of patients, staff, commissioners and representatives from our local councils, and also held discussions at meetings of our Council of Governors and Board of Directors.

We have made significant progress in some areas, but there is more to do. We have a major investment programme that will see a new outpatient centre open at St Thomas' and improved care for our emergency patients. At Guy's, we are progressing plans for a major new cancer centre.

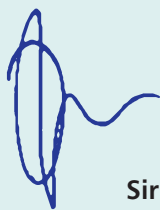
Quality involves getting the fundamentals right, as well as meeting national targets. Overall, we performed well in most areas, but we found it difficult to meet the demanding targets set for the number of MRSA blood infections last year end and the 62-day cancer wait for patients referred to us from other hospitals. We are working hard to make further improvements in these and other areas, and to make sure that we provide patients with an excellent standard of care.

There are plenty of positives: we are reducing waiting times; we have a low patient mortality rate for hospitals seeing a complex case mix that includes many patients who are seriously ill; and we also had good results in the national patient surveys.

We have successfully integrated community services in Lambeth and Southwark, which is helping us to improve the experience of our patients and to ensure that care is provided in the right place, at the right time.

We have also made changes to improve the experience of outpatients at our hospitals, including areas such as booking appointments and reducing waiting times in clinics. Without invaluable input from our Council of Governors, this would have been much harder to achieve, so I would like to thank them for their continuing support.

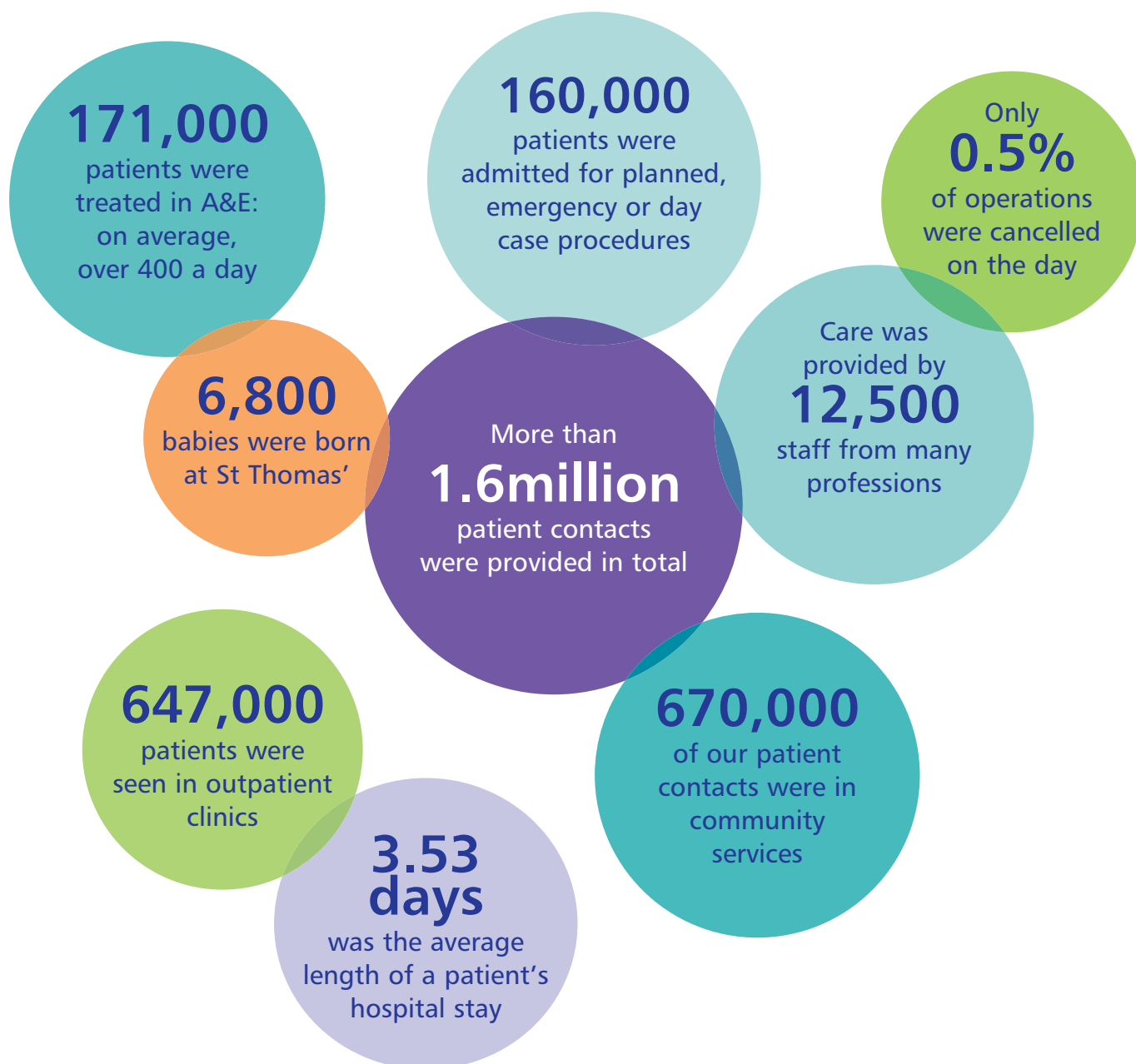
Finally, it remains to say that, to the best of my knowledge, the information in this quality report is accurate.



Sir Ron Kerr, Chief Executive

A snapshot of our activity and performance

Last year



Successes in 2011-12

- We launched our new quality strategy that focuses on patient safety and improving the patient experience.
- We have consistently achieved one of the lowest mortality rates in the NHS in England.
- Last year was the first time we had 100 days without a falls-related fracture, with an almost 40 per cent reduction in falls fractures in our hospitals.
- We saw our lowest level of cardiac arrests on the wards since 2009, which was when formal records began.
- We had no grade 4 pressure ulcers, cases of MRSA blood infections or cases of *C.difficile* in our community inpatient units. We also had no attributable grade 4 pressure ulcers in our hospitals for the first time.
- We had one of the highest rates of assessment and one of the lowest rates of readmission to hospital for blood clots (venous thromboembolisms) among our London peers.
- We were the best performing London teaching hospital in the national outpatient survey and second best London teaching hospital in the national inpatient survey.
- We saw an increase of 40 per cent in the number of community patients who were cared for on the Liverpool Care Pathway – the ‘gold standard’ for supporting patients at the end of their lives.

Where we need to improve

- Although we are one of the best performing hospitals in London for infection prevention, we want to do even better. We were set a very demanding MRSA target last year and are disappointed that we failed to achieve this.
- Despite improvement during the year, some of our patients waited longer for planned procedures than we would have liked. Also, while our performance against the national cancer targets has improved, we did not achieve this target and find it difficult to do so where patients are referred to us late in their pathway from other hospitals.
- Though our performance in the national inpatient survey was one of best in London, we believe that there is more that we need to do to improve the experience of care for our patients.

Using our Quality priorities to drive continuous

2009/10

2010/11

Patient safety

Review and improve the recognition of acutely ill patients.
Improve the quality of fluid balance recording
Review and improve the use of nasogastric tubes in adults.

Assess our patients for venous thromboembolism
Review unexpected deaths using the 'Global Trigger Tool'
Reduce harm from medicine errors, falls and MRSA infection rates

Clinical effectiveness

Review our unplanned readmissions
Reduce our caesarean section rates
Reduce smoking in pregnancy
Improve 12 week access in maternity

Improve the discharge of older people
Establish a Trust-wide clinical outcomes group
Develop new ward-level safety information
Roll out 'releasing time to care' across our wards
Implement the year one Healthcare for London dementia goals.

Patient experience

Improve involvement of patients in their care
Review and improve our same-sex accommodation
Improve our patient's dignity and communication

Improve our patient experience in the five key areas highlighted by the Department of Health:

- 1 Patients being involved in their care
- 2 Patients being given enough privacy and dignity
- 3 Patients having someone to talk to about their worries and fears.
- 4 Patients being told about medicine side effects
- 5 Patients having enough information on discharge

improvement

2011/12

The increase in priorities reflects our integration with community services.

Reduce the number of pressure ulcers.
Achieve our *C.difficile* reduction targets
Reduce the number of patients who suffer a harmful fall in hospital
Reduce the number of patients who suffer a harmful fall in the community
Focus on high-risk medicine safety
Asses at least 90% of our patients for venous thromboembolism
Improve our childhood immunisation rates

2012/13

Improve staff knowledge and understanding of patient safety
Reduce harm from falls, pressure ulcers and infection
Increase new birth visits in the community

Review and improve our nutrition and hydration practices
Improve communication between district nurses and GPs.
Roll out the 'productive series' to our operating theatres and community services
Develop a ward accreditation scheme
Increase new birth visits by our health visitors
Establish a group to reduce readmissions

Improve the efficiency of outpatient services
Enhance support for our ward sisters
Improve childhood immunisation rates
Improve communication between GPs and district nurses

Improve our end of life care
Renew our focus on dementia care
Improve women's satisfaction with maternity care
Improve our community patient information leaflets
Improve our performance against the five national patients experience questions (see 2010/11)

Improve staff communication with patients
Improve the care of vulnerable patients
Increase patient satisfaction as measured by responses to the national patient surveys

2 Our quality priorities for 2012-13

We want to demonstrate our commitment to quality and to show where we intend to focus our efforts next year. We have come up with 10 quality priorities that we will focus on from 1 April 2012 to 31 March 2013.

We have selected areas that combine hospital and community priorities. Each priority comes under one of our three quality themes:

Patient safety – having the right systems and staff in place to minimise the risk of harm to our patients and, if things do go wrong, to be open and learn from our mistakes.

Clinical effectiveness – providing the highest quality care, with world class outcomes, while also being efficient and cost effective.

Patient experience – meeting our patients' emotional as well as physical needs. This includes patients being treated with dignity and respect, in a comfortable, clean and safe environment; being given the right information about care and discharge; and being treated without avoidable delays.

The areas we have chosen this year are those that our stakeholders told us were where we needed to improve. Where appropriate, we have aligned our priorities with our 2012-13 Commissioning for Quality and Innovation (CQUIN) targets, a range of local and national quality priorities chosen by our commissioners and by the Department of Health. For more information, see page 47.

Progress against these priorities will be regularly reported to the Trust's Board of Directors.

Our quality strategy

The Trust's quality strategy was launched in November 2011 with the aim of making sure that our patients are kept safe and that their experience with us is a positive one.

The quality strategy sets out our plans in relation to seven major areas of avoidable patient harm. It focuses on:

1 – Safety leadership first

2 – Safer medicines management

3 – Preventing healthcare associated infection

4 – Minimising harm from slips, trips and falls

5 – Detecting and preventing venous thromboembolism

6 – Prevention of pressure damage

7 – Recognising and responding to the acutely unwell patient

These areas were chosen as they not only span across the organisation, but are locally and nationally regarded as high risks in healthcare. By bringing these seven areas together and focusing on improving outcomes, we aim to achieve our goal as being the UK leader in reducing avoidable patient harm.

At our quality strategy launch, we distributed 200 Quality Account questionnaires to our doctors, nurses and therapists – and more than 100 were returned. This formed our Quality Accounts 'long list' of priorities.

Our 'long list' of quality priorities was considered by our governors, Local Involvement Networks (LINKs), commissioners, local GPs, local authority health overview and scrutiny committees and colleagues from King's College Hospital at two stakeholder events. We asked them to review, add to and rank the priorities, and we chose to prioritise at least one of the top three priorities chosen by our stakeholders in each theme.

The Chief Nurse and the Medical Director informed the Board and Trust Management Executive of our priorities in March 2012, and they were agreed in April 2012.

Our quality priorities for 2012-13

Patient safety		
Our quality priorities and why we chose them	What success will look like	How our stakeholders ranked this
<p>Improving staff knowledge of patient safety Our staff are crucial in delivering safe, high-quality care. We want to ensure that they receive appropriate training to keep our patients safe.</p>	<ul style="list-style-type: none"> – In line with our CQUIN targets, we will introduce the national NHS safety thermometer tool¹ in our high risk wards and departments by the end of March 2013. – We will recruit 130 students to assist ward staff in collecting and analysing data for weekly safety reports. 	This was ranked number 1
<p>Reducing severe harm events In line with our quality strategy, we will further reduce the most common and severe harm events in our hospitals and community settings by setting ourselves further targets for falls and pressure ulcers.</p>	<ul style="list-style-type: none"> – We will further reduce fall-related fractures in hospital by 10 per cent. – We will have zero attributable grade 4 pressure ulcers across our hospital and community sites. – In our hospitals, we will reduce hospital acquired grade 2 pressure ulcers by 10 per cent and hospital acquired grade 3 pressure ulcers by 50 per cent. – We will achieve our hospital MRSA and <i>C.difficile</i> targets. 	This was ranked number 2
<p>Increase new birth visits Picking up issues early, and assisting mothers with newborn babies, are important in good community healthcare. There is scope to improve in this area.</p>	<ul style="list-style-type: none"> – We will increase the percentage of newborn babies who receive a visit within 14 days to at least 95 per cent by the end of March 2013. 	Approved by stakeholders to be carried over from 2011-12 to 2012-13
Clinical effectiveness		
Our quality priorities and why we chose them	What success will look like	How our stakeholders ranked this
<p>Improve the efficiency of outpatient services Patients tell us that their experience is generally good, but we know that we can do more to improve the experience, especially when it comes to waiting times.</p>	<ul style="list-style-type: none"> – We will reduce how long our patients have to wait for their first appointment. – We will reduce clinic waiting times. – We will reduce the number of patients who 'did not attend' or cancel their appointment. 	This was ranked number 2
<p>Supporting our ward sisters/charge nurses Our ward sisters/charge nurses are the key coordinators of care at our hospitals. We want to equip and empower them to lead efficient and safe services for our patients.</p>	<ul style="list-style-type: none"> – We will support staff and strengthen the voice, role and accountability of the ward sister across our hospitals and in the community. – We will establish a ward leaders expert group to drive quality improvements. – We will further strengthen the links between ward leaders and senior ward doctors (specialist registrars). 	This was ranked number 5
<p>Improving childhood immunisation rates We can increase the number of children we immunise locally. Poor vaccination rates can lead to an increase in preventable illnesses, which can have a devastating effect on families.</p>	<ul style="list-style-type: none"> – In line with our CQUIN targets we will increase the proportion of MMR2 and pre-school booster immunisations. 	Approved by stakeholders to be carried over from 2011-12 to 2012-13
<p>Improve communication between GPs and community nurses. Since community services were integrated into the Trust, we have improved communications between GPs and community nurses, but further improvements can be made.</p>	<ul style="list-style-type: none"> – Our community teams will confirm receipt of GP referrals. – Community teams will also communicate with a patient's GP after an initial assessment and when a patient is discharged from their care. 	Approved by stakeholders to be carried over from 2011-12 to 2012-13

Patient experience

Our quality priorities and why we chose them	What success will look like	How our stakeholders ranked this
<p>Improving staff communication with patients. Communicating with patients is extremely important. We will launch a major staff communications campaign aimed at improving our patients' experiences.</p>	<ul style="list-style-type: none"> – We will introduce a new ward welcome pack for every inpatient. – We will launch an initiative giving patients and their carers direct access to senior staff 24 hours a day, seven days a week. – We will launch a staff training campaign to improve the experience of elderly or vulnerable patients. – We will roll out ward comfort rounds² for all inpatients by the end of March 2013. 	<p>This was ranked number 1</p>
<p>Improving the care of vulnerable patients This will focus on patients with dementia and delirium.</p>	<ul style="list-style-type: none"> – We will achieve our dementia CQUIN objectives, including better assessment and early intervention of patients with dementia or delirium. – We will launch a training initiative so that all staff are equipped to deal with vulnerable patients, including those with dementia. 	<p>This was ranked number 2</p>
<p>Increasing patient satisfaction, as measured by responses to the national patient surveys. We also have our own local systems to get near-time (close to immediate) feedback from patients.</p>	<ul style="list-style-type: none"> – As agreed with our commissioners and reflected in our CQUIN targets, we will improve our hospital and community performance in the national patient experience surveys. – We will roll out our near-time patient feedback to key community services. 	<p>This wasn't included in the ranking exercise, but forms part of our CQUIN targets</p>

Healthcare for the homeless

One of our clinical nurse specialists, Kendra Schneller, won Nursing Standard magazine's community nurse of the year award for establishing a health clinic at a 120-bed hostel for the homeless, managed by the St Mungo's charity.

The clinic, part of our intermediate care service in Lambeth, provides NHS care to a group of people with poor health who rarely use mainstream services.

The service made such a difference to the hostel residents' health that their attendance at A&E was halved.

The project was supported by Guy's and St Thomas' Charity.

(1) The NHS safety thermometer is a national inpatient and community 'safety census' carried out each month. It looks at harm events related to falls, pressure ulcers, infection and blood clots. It observes and calculates a 'snapshot' rate of harm-free care for each department assessed.

(2) Comfort rounds: a member of the ward team reviews each patient on a regular basis to ensure that they are comfortable and that their essential nursing needs are met, checking, for example, that items each patient needs are always within easy reach.

2.1 Statements of assurance from the Board of Directors

This section contains the statutory statements concerning the quality of services provided by Guy's and St Thomas' NHS Foundation Trust. These are common to all trust Quality Accounts and can be used to compare us with other organisations.

2.2 A review of our services

During the reporting period 2011-12, as well as providing care to patients at Guy's and St Thomas' Hospitals, we also provide, NHS clinical services in other locations:

- five satellite dialysis units (Camberwell, Forest Hill, New Cross Gate, and Tunbridge Wells kidney treatment centres and Queen Mary's Hospital in Sidcup)
- four chemotherapy day units (Dartford, Sidcup, Bromley and King's College Hospital)
- plastic surgery at Princess Royal University Hospital Bromley
- a urology service at University Hospital Lewisham
- our community directorates provide care to patients across Lambeth and Southwark, including in three inpatients units: the Pulross Centre, Minnie Kidd House and Lambeth Community Centre.

We have reviewed and continue to review all the data available on the quality of care in these NHS services. The total income for these activities last year was £15.7 million, which represents 1.4 per cent of our total income. The income generated by these NHS services received in the last year represents 100 per cent of the total income generated from the provision of community services by the Trust.

2.3 Participation in clinical audits and National Confidential Enquiries

A clinical audit aims to improve patient care by reviewing services and making changes where necessary. National Confidential Enquiries investigate an area of healthcare and recommend ways to improve it.

We are committed to participating in relevant National Confidential Enquiries to help assess the quality of healthcare nationally and to make improvements in safety and effectiveness.

Last year, we took part in 47 out of 51 possible national audits. We also participated in four National Confidential Enquiries. By doing so, we participated in 88 per cent of national clinical audits and 100 per cent of National Confidential Enquiries in which we were entitled to participate.

The national clinical audits that we participated in, and for which we collected data, are listed in the table opposite. The information provided also includes 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.

Last year, the Trust participated in four National Confidential Enquiries into Patient Outcome and Death (NCEPOD) studies. These included studies into bariatric surgery; cardiac arrest procedures; perioperative care; and children's surgery. We were 100 per cent compliant with the audit terms for each. The Trust also participated in the enquiry into maternal and child health (CEMACH), and again we were 100 per cent compliant. We continue to learn and share the lessons from the detailed reports generated from these national studies.

National clinical audits 2011-12

Audit title	Participation	% cases submitted
Peri and neonatal		
Perinatal mortality (MBRRACE-UK)	MBRRACE-UK has been discontinued. All our neonatal deaths are reported to NPEU via the badger (SEND) database, hence 100% participation.	
Neonatal intensive and special care (NNAP)	Yes	100%
Children		
Paediatric pneumonia (British Thoracic Society)	Yes	100%
Paediatric asthma (British Thoracic Society)	No	Plan to participate 2012-13
Pain management (College of Emergency Medicine)	Yes	100%
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	Yes	100%
Paediatric intensive care (PICANet)	Yes	100%
Paediatric cardiac surgery (NICOR Congenital Heart Disease Audit)	Yes	100%
Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	100%
Acute care		
Emergency use of oxygen (British Thoracic Society)	Yes	100%
Adult community acquired pneumonia (British Thoracic Society)	Yes	Data collection ongoing
Non invasive ventilation – adults (British Thoracic Society)	Yes	100%
Pleural procedures (British Thoracic Society)	Yes	6 to 8 patients
Cardiac arrest (National Cardiac Arrest Audit)	Yes	100%
Severe sepsis and septic shock (College of Emergency Medicine)	Yes	100%
Adult critical care (ICNARC CMPD)	Yes	100%
Potential donor audit (NHS Blood and Transplant)	Yes	100%
Seizure management (National Audit of Seizure Management)	No	This being piloted before being rolled out nationally. We are not one of the pilot sites.
Long term conditions		
Diabetes (National Adult Diabetes Audit)	Yes	100%
Heavy menstrual bleeding (RCOG National Audit of HMB)	Yes	60-95% (varies by month)
Chronic pain (National Pain Audit)	Yes	50 patients
Ulcerative colitis and Crohn's disease (UK IBD Audit)	Yes	100%
Parkinson's disease (National Parkinson's Audit)	Yes	100%
Adult asthma (British Thoracic Society)	No	
Bronchiectasis (British Thoracic Society)	No	
Elective procedures		
Hip, knee and ankle replacements (National Joint Registry)	Yes	80% Q1, data under review
Elective surgery (National PROMs Programme)	Yes	Data collection ongoing
Intra-thoracic transplantation (NHSBT UK Transplant Registry)	Not applicable to the Trust	
Liver transplantation (NHSBT UK Transplant Registry)	Not applicable to the Trust	
Coronary angioplasty (NICOR adult cardiac interventions audit)	Yes	100%
Peripheral vascular surgery (VSGBI vascular surgery database)	Yes	100%
Carotid interventions (carotid intervention audit)	Yes	100%
CABG and valvular surgery (adult cardiac surgery audit)	Yes	100%

Our quality priorities for 2012-13

National clinical audits 2011-12		
Audit title	Participation	% cases submitted
Cardiovascular disease		
Acute myocardial infarction and other ACS (MINAP)	Yes	100%
Heart failure (heart failure audit)	Yes	100%
Acute stroke (SINAP)	Yes	100%
Cardiac arrhythmia (cardiac rhythm management audit)	Yes	100%
Renal disease		
Renal replacement therapy (Renal Registry)	Yes	100%
Renal transplantation (NHSBT UK Transplant Registry)	Yes	100%
Cancer		
Lung cancer (national lung cancer audit)	Yes	44%
Bowel cancer (national bowel cancer audit programme)	Participated in 2010-11 and will do so in 2012-13	
Head and neck cancer (DAHNO)	Yes	100%
Oesophago-gastric cancer (national O-G cancer audit)	Yes	Data collection incomplete
Trauma		
Hip fracture (national hip fracture database)	Yes	100%
Severe trauma (trauma audit and research network)	Yes	Limited submission – aim to improve within three months
Psychological conditions		
Prescribing in mental health services (POMH)	Not applicable to the Trust	
Schizophrenia (national schizophrenia audit)	Not applicable to the Trust	
Blood transfusion		
Bedside transfusion (national comparative audit of blood transfusion)	Yes	100%
Medical use of blood (national comparative audit of blood transfusion)	Yes	100%
Health promotion		
Risk factors (national health promotion in hospitals audit)	No	Trust Clinical Audit Committee felt benefits of audit did not outweigh costs of participation
End of life		
Care of dying in hospital (NCDAAH)	Yes	100%
National confidential enquiries 2011/12		
Cardiac arrest procedures study	Yes	100%
Bariatric surgery study	Yes	100%
Perioperative care	Yes	100%
Surgery in children	Yes	100%

Our clinical audit team reviews findings from the audits and shares best practice. Last year, the team reviewed the findings of 27 national clinical audits. The following examples were identified as having improved the quality of our services:

- Results from the national hip fracture database audit led to investment in additional medical staff to improve medical assessment. The reasons for all hip fracture theatre delays are now tracked, and further audits are carried out on specific delay themes, such as patients taking anti-coagulants. Results, recommendations and implementations from these audits will follow and will be reviewed and monitored by the steering group. There is also an ongoing review of pressure sore acquisition, with rapid cycle audits of pressure relieving equipment use.
- In August 2011, following the national diabetes audit, we launched a pilot campaign, *Think Glucose*, to improve the care of inpatients with diabetes. This multi-professional approach was highly successful in promoting safety and compliance and the programme will be introduced across the Trust in 2012.
- As a result of the Sentinel stroke audit, which every two years looks at the improvements in stroke care, two new assessment tools have been developed to help assess and document patients' mood and cognition (awareness and judgement) following a stroke.

Last year, our clinical audit team also reviewed 84 local clinical audits. The following action was then taken to improve the quality of our services:

- An audit by junior doctors of Heparin (a drug used to thin the blood) infusion management recommended changes to the equipment used to deliver the medicine and how its use is documented.
- Each community service has nominated an annual 'quality improvement topic'. This year, a wide range of clinical topics were chosen to improve care for local patients. These included improving wound care, reducing harm from falls and improving the patients' experience.
- Maternity services reported on their work to improve the information given to women who are considering having their baby vaginally after a previous caesarean section. The results of the audit led to changes in practice and patient information, with a subsequent increase in eligible women opting for a vaginal birth after caesarean.
- Medical and pharmacy staff from general medicine and toxicology looked at the quality of intravenous (IV) fluid prescriptions. The results led to changes in junior doctor training and induction and were one of the drivers for changing to a new Trust-wide drug chart.
- Other projects to note include the falls audit, which continues to show improvement in compliance with use of the STRATIFY falls assessment tool. A patient identification audit has led to improvements in ensuring all required information is included on identity bracelets and a new process to improve response times is being introduced following the complaints audit.
- The department of paediatric cardiology at Evelina Children's Hospital conducted an audit using the Health Protection Agency's protocol for surgical site infection (SSI) surveillance. The aims of the audit were to determine the underlying rate of infection, monitor infections and identify their possible causes. The team implemented several changes including: reviewing and updating the wound management guidelines, introducing a new skin wash protocol, trialling and implementing a new type of wound dressing, and improving the education of staff in theatres, paediatric intensive care and on Savannah Ward. The audit and associated changes have significantly reduced the incidence of post-operative infection in paediatric cardiology – from 12 per cent in January 2010 to 4 per cent in November 2011.

Preventing falls with anti-slip socks

- Community services took part in the Trust consent audit and also ran a local project looking at community consent, called 'the consent quality tool'. The records audit helped the teams to demonstrate where there is good practice in recording clinical entries and patients' views and where improvements are needed.
- In July 2011, we held our annual clinical audit celebration day to showcase clinical audit projects that our clinical teams have undertaken and the improvements in patient care and safety that had been achieved. Over 70 hospital and community audit projects were presented by 140 multi-professional staff from across King's Health Partners.

The urology nursing team audited the effect of a new, anti-slip, slipper sock on patient falls. They found that, as well as reducing the number of falls and injuries from falls, the socks are 30 per cent cheaper than the previous hospital slippers given to patients. From June 2012, every inpatient will be given the new socks.

2.4 Participation in clinical research

Guy's and St Thomas' NHS Foundation Trust is leading a huge amount of health research aimed at improving patient care, developing better treatments and increasing our understanding of disease.

Our Trust is part of King's Health Partners, one of the UK's five Academic Health Sciences Centres. It brings together a world-leading, research-led university, King's College London, and three successful NHS foundation trusts: Guy's and St Thomas', King's College Hospital and South London and Maudsley.

Our aim is to bring together excellent research, teaching and clinical practice for the benefit of patients. We want to make sure that lessons from research, as well as new treatments, are translated more quickly and systematically into improvement in care for our patients. This is about providing a world-class service.

Research carried out last year included studies in allergy, dental, cardiovascular and renal transplantation. Last year, we were awarded more than £7 million in grants from the National Institute for Health Research (NIHR). Research funding was also received from charities and many other organisations.

Last year, more than 26,000 patients took part in 1,016 non-commercial clinical trials and other patient-focused studies. Of this, almost 7,200 were for NIHR portfolio³ studies, an increase of 23 per cent on the previous year, an achievement we are proud of. The Trust had the sixth highest number of projects registered with the NIHR's Comprehensive Local Research Network (CLRN) approved by our Research Ethics Committee, which ensures that patients are safe and research results are disseminated in a timely way. Over 1,200 clinical staff across our clinical directorates were involved in research.

Guy's and St Thomas' staff, as part of King's Health Partners, had their work cited in 1,009 different publications between April 2011 and March 2012.

(3) The National Institute for Health Research (NIHR) Clinical Research Network (CRN) Portfolio is a database of high-quality clinical research studies that are eligible for support from the NIHR CRN in England.

Number of active non-commercial (portfolio) projects – 360

Number of active non-commercial (non-portfolio) projects – 656

Number of non-commercial studies registered – 360

Commercial studies registered – 66 (29 portfolio studies)

Number of recruits in non-portfolio non-commercial trials – 18,000+

Number of recruits in portfolio non-commercial trials – 7,176

Number of recruits in commercial trials – 128

Our research studies by grouping within King's Health Partners

Studies split by group	Commercial active trial totals	Non-commercial active trial totals
Allergy, respiratory, critical care and anaesthetics	14	84
Cancer, haematology, palliative care and therapies	150	196
Cardiovascular	29	60
Child health	11	72
Dental	1	75
Diabetes, endocrine, nutrition, obesity, vision and related surgeries	9	43
Genetics, rheumatology, infection and dermatology	28	155
Imaging and biomedical engineering	–	53
Liver, renal, urology, transplant and gastro/GI surgery	12	78
Medicine	3	122
Orthopaedics, trauma, emergency, ENT and plastics	3	12
Pharmaceutical sciences	1	13
Women's health	2	53
Total	263	1,016

Improving haemophilia treatment

NIHR Biomedical Research Centre

We were one of the National Institute for Health Research's (NIHR) original five comprehensive Biomedical Research Centres established in 2007. In August 2011, we were successful in securing £58.7 million for a further five years of operation.

Since our formation, we have focused on seven research themes: cancer, cardiovascular disease, cutaneous medicine, asthma and allergy, infection and immunity, transplantation, and oral health. We have made significant progress in translational research into important disease areas such as the development of food allergies in children and the identification of gene mutations associated with rare disorders.

We have an excellent Clinical Research Facility (CRF) that in February 2012 received additional NIHR funding of £5.6 million to support clinical studies.

2.5 CQUIN performance

Around the country, commissioners hold the NHS budget for their area and decide how to spend it on hospital and other health services. Each year, our commissioners set us goals to improve quality and innovation; a proportion of our income is conditional on achieving these goals. This system is called Commissioning for Quality and Innovation (CQUIN) payment framework.

Last year, 1.5 per cent of our clinical income depended on achieving quality improvement and innovation goals agreed with Lambeth, Southwark and Lewisham primary care trusts through the CQUIN payment framework. This equates to over £10 million of our total income for 2011-12 and we are pleased to have achieved virtually all the targets and secured more than 90 per cent of this income.

A scientific breakthrough could dramatically improve treatment and quality of life for people with severe haemophilia A within five years. This advance from the Haemostasis Research Unit is also likely to significantly reduce the cost of NHS treatment.

"If the new factor, Factor XIII, works as we expect, the quality of treatment will improve and patients will need fewer injections, allowing them to enjoy a much more normal life style" said Dr Sørensen, who led the study.

First embryonic stem cells

Last year saw the deposit in the UK Stem Cell Bank (UKSCB) of the first clinical grade human embryonic stem cell lines that are free from animal products and intended for publicly funded research. The cells have the potential to become the 'gold standard' lines for developing new stem-cell-based therapies. This first batch of cells is the culmination of nearly 10 years of strategic research by a collaboration between King's College London and the Assisted Conception Unit at Guy's, funded by the Medical Research Council (MRC).

2.6 Statements from the Care Quality Commission

The Care Quality Commission (CQC) is the healthcare regulator responsible for making sure that all services meet the standards set by the Government. It registers care providers and without registration, Guy's and St Thomas' would not be able to provide NHS services.

The CQC registered Guy's and St Thomas' to practice as an NHS hospital and community services provider in 2011-12. There are no conditions or restrictions, allowing us to continue to provide care to our patients across our hospital and community sites. We have had no enforcement action taken against us during the last year.

We are subject to regular unannounced inspections and inspectors can check to see if we are meeting a number of essential standards.

During the last year we were inspected five times:

1 – Dignity and nutrition inspection (April 2011): compliant with standards, with minor concerns.

2 – Pulross Intermediate Care Centre, community inpatient unit inspection (July 2011): compliant with standards.

3 – Guy's Hospital inspection (October 2011): compliant with standards with minor concerns.

4 – St Thomas' Hospital inspection (October 2011): compliant with standards with minor concerns.

5 – Women's services inspection (March 2012): no concerns raised by inspectors (awaiting final report).

We welcome inspections and reviews of our services as these help us to make improvements. Concerns are immediately acted upon, with action plans submitted to the CQC to explain the changes we will be making.

A number of improvements have been made in response to the minor concerns that have been raised with us. These include regular ward rounds by our nursing staff to check on the comfort of each patient, for example whether call bells are in reach, and whether they need any other nursing support or information about their care.

In addition, we have completed a Trust wide review of our nursing documentation and, in response to this, we are developing an improved, individual nursing care plan.

We are also monitoring the 'acuity' of our patients more robustly, and we have introduced an electronic ward acuity tool which is helping the nursing teams to better match staffing levels and experience to the needs of the patients being cared for on the ward at that time.

Our quality priorities for 2012-13

The reports about Guy's and St Thomas' are available on the CQC website:

CQC review of compliance St Thomas' Hospital, report dated May 2011

http://www.cqc.org.uk/sites/default/files/media/reports/RJ1_Guy%27s_and_St_Thomas%27_NHS_Foundation_Trust_RJ122_St_Thomas%27_Hospital_20120522.pdf

CQC review of compliance St Thomas' Hospital, report dated June 2011

http://www.cqc.org.uk/sites/default/files/media/reports/RJ1_Guys_and_St_Thomas_NHS_Foundation_Trust_RJ122_St_Thomas_Hospital_DANI_06042011.pdf

CQC review of compliance St Thomas' Hospital, report dated December 2011

http://www.cqc.org.uk/sites/default/files/media/reports/rj1_guys_and_st_thomas_nhs_foundation_trust_rj122_st_thomas_hospital_20111208.pdf

CQC review of compliance Guy's Hospital, report dated December 2011

http://www.cqc.org.uk/sites/default/files/media/reports/rj1_guys_and_st_thomas_nhs_foundation_trust_rj121_guys_hospital_20111208_v2.pdf

Mortality alerts

The Trust received two Care Quality Commission mortality alerts during the last year. One was for our emergency caesarean rates. We investigated and found that, out of 30 emergency caesarean sections identified, one may possibly have been avoided. The second alert related to coronary artery bypass surgery. Upon investigation, we found no cause for concern. The Care Quality Commission was satisfied with our findings.

The outcomes from these and similar reviews conclude that we are confident that there have been no breaches of our safety system and that no patients have come to harm.

2.7 Data quality

It is essential that we produce accurate and reliable data about patient care. For example, how we code a particular procedure or illness is important as it not only allows us to receive the correct income, but also anonymously informs the wider health community about disease trends.

Last year, we identified weaknesses in control in respect of the Trust's information assurance arrangements. The Trust is implementing an action plan to address these issues and commissioned an independent external reviews of its information assurance processes. This remains an ongoing area of risk which will continue to be monitored rigorously, both internally and externally.

As community sites are not required to upload data, last year only our hospital sites submitted records to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics.

The percentage of records in the published data that included the patient's valid NHS number was 97.1 per cent of inpatients, 97.1 per cent of outpatients, and 77.6 per cent of accident and emergency patients.

The percentage of records which had the patient's valid GP registration code was 97.3 per cent of inpatients, 95.4 per cent of outpatients, and 89.9 per cent of accident and emergency patients.

2.8 Information governance toolkit

Good information governance means keeping the information we hold about our patients and staff safe.

The Information governance toolkit is the way we demonstrate our compliance with information governance standards. All NHS organisations are required to make three annual submissions to *Connecting for Health* in order to assess compliance.

Recently, the Toolkit against which we are measured underwent significant revisions. The latest version is no longer assessed on a percentage basis and is now divided into two broad categories 'satisfactory' and 'non satisfactory'. In 2011-12, our hospital sites were 72 per cent compliant with information governance standards and achieved an overall satisfactory rating.

2.9 Our clinical coding error rate

We were subject to the Payment by Results clinical coding audit by the Audit Commission. The error rate reported in the draft audit for diagnoses and treatment coding (clinical coding) was 22.6 per cent higher than in the previous year. Because of the nature of the sampling, the results should not be extrapolated further than the actual sample audited.

The clinical coding error rate of the Payment by Results audit split by category was:

- primary diagnosis incorrect – 22 per cent
- secondary diagnosis incorrect – 24.2 per cent
- primary procedures incorrect – 16 per cent
- secondary procedures incorrect – 28.2 per cent.

2.10 Safeguarding

Following the integration of hospital and community services, there has been a review of the Trust's safeguarding arrangements. This has led to teams integrating, which has ensured that we work more closely together and has had a positive impact on the robustness of our safeguarding arrangements.

The Trust and its partners are working on new ways of working, such as the introduction of multi-agency safeguarding hubs (MASH), which should greatly improve the assessment and protection of vulnerable children and families.

Children and young people

Children's services were inspected in November 2011 as part of the Care Quality Commission (CQC) inspection. The CQC assessed our policies and procedures, training, dissemination of information and inter-agency working. The CQC found that the service was fully compliant with the required standards.

Adults

Last year saw a significant increase in the number of referrals to the safeguarding adult team. Thanks to the integration of community and hospital services, care is better co-ordinated – to the benefit of patients.

The governance structure for safeguarding adult patients has been strengthened to match children's safeguarding arrangements, with an internal assurance committee chaired by the Chief Nurse. There is also a new training strategy to address national and local changes in safeguarding policy and lessons learnt from serious case reviews. Training is provided at staff induction and remains a key priority.

Our quality priorities for 2012-13

Keeping young victims away from violence

In addition, we have just secured additional investment to increase the size of the team and to appoint a specialist in dementia care.

Maternity

Like our adult services, maternity services have seen a significant increase in complex safeguarding activity. Partnership working has been excellent, with multi-agency plans put in place for mothers and babies.

Young people who come to St Thomas' accident and emergency because they have been attacked by gangs are offered mentoring and activities through an innovative youth work partnership based in the department. The Oasis project, funded by Guy's and St Thomas' Charity, runs till 2013. Academics from Kingston University will measure its success in diverting children from gangs and keeping them safe from assaults.

3

Progress against 2011-12 priorities

Of the 18 targets we set ourselves in last year's Quality Accounts, we have fully achieved 11 (61%), partially achieved 3 (16%) and did not achieve 5 (27%). Details of our progress against priorities are in the following tables. Where a priority is a 2010-11 CQUIN target (denoted by a *) our predictions are based on our end of year submission to the Primary Care Trust. The final position will not be confirmed until June 2012.

How did we do against last year's priorities?

Patient safety		
Our quality priorities and why we chose them	What success will look like	How did we do?
<p>Pressure sore reduction Pressure sores are debilitating and largely avoidable injuries which cost the NHS millions of pounds every year. By working together across King's Health Partners we want to considerably reduce avoidable pressure sores for our patients.</p>	<ul style="list-style-type: none"> - Have no avoidable grade 4 pressure sores this year, as these are the most debilitating and can lead to weeks or months of treatment - Also reduce grade 2 and 3 pressure sores by at least 10 per cent in our hospitals this year and by 80 per cent over two years in the community. 	<p>There have been no attributable grade four pressure ulcers across our hospital or community directorates. The hospital has reported over 10% reduction in grade 2 and 3 pressure ulcers.</p> <p>At the end of the year, the community directorates were expecting to achieve year one of the two year objective of an 80% reduction in grade 2 and 3 pressure ulcers.</p>
<p>Infection control We have made great progress tackling MRSA infection and want to build on this success by reducing the incidence of <i>C.difficile</i>.</p>	<ul style="list-style-type: none"> - Reduce <i>C.difficile</i> hospital acquired cases to no more than 155 this year. 	<p>We have achieved this. We reported a total of 121 cases in year.</p>
<p>Reducing falls Some falls are avoidable. We want to reduce the most serious falls that cause an injury in the community.</p>	<ul style="list-style-type: none"> - Reduce the number of patients who suffer a fracture as a result of a fall in the community by at least 50 per cent, in line with our CQUIN target. 	<p>*We have not achieved this. Although considerable progress was made in the first six months, the later part of the year saw an increase in serious falls across the community. We continue to work hard to reduce serious injury from falls in the community.</p>
<p>Reducing falls Although the Trust has done a lot of work on falls this year, we want to maintain this momentum and improve communication and collaboration between hospital and community services.</p>	<ul style="list-style-type: none"> - Ensure we maintain at least 95 per cent compliance with our falls policy, which sets standards for reducing falls in the Trust - Establish a joint community/hospital falls quality improvement group. 	<p>We have achieved this. We have maintained greater than 95% compliance with our falls pathway, and have established a community/hospital falls quality improvement group.</p>
<p>High risk medicine safety Overall reporting and sharing of learning following a medicines error is good. However, we have identified that our doctors report fewer errors than other staff. We want to improve this by encouraging this critical group of staff to report more. Based on the success of our medicines safety forum, a group that leads the drive for medicines safety and works on a programme of best practice for specific medicines, we want to roll the programme out to include additional high risk medicines.</p>	<ul style="list-style-type: none"> - Increase the number of medical staff reporting medicine related errors by at least 10 per cent - Establish dedicated quality improvement groups for intravenous sedation and allergy medicines - Based on this year's national patient survey, improve satisfaction with the medicines information provided when patients leave hospital by at least three per cent. 	<p>We have partially achieved this. We did not increase medical staff reporting by 10%.</p> <p>We did establish a successful high-risk medicine safety group.</p> <p>We did improve our national patient satisfaction score relating to medicines information by 4.1% against a target of 3%.</p>
<p>Venous thromboembolism (VTE) VTE (a blood clot) is a major contributor to severe illness or death in the UK, accounting for up to 25,000 deaths a year. We have improved our patient assessment for VTE, and following this we want to ensure that the right patients are on the right treatment at the right time.</p>	<ul style="list-style-type: none"> - Ensure at least 90% of adult inpatients have a documented VTE assessment and appropriate treatment, in line with our CQUIN target. 	<p>*We have achieved this. Across London: we are in the top three performing Trusts for VTE risk assessment and report one of the lowest rates of hospital readmission for VTE.</p>

Progress against 2011-12 priorities

Patient safety (continued)

Childhood immunisations

We can improve our current levels of childhood vaccination locally. Poor vaccination levels can lead to an increase in preventable illness, which has a devastating effect on children and families.

- Increase the number of children aged five years and under receiving vaccination, in line with our CQUIN targets.

*We have not achieved this. Although some localities reported 100% compliance, far above the London average, others did not. For this reason this priority will be carried over into this year's accounts.

Patient experience

Our quality priorities and why we chose them

What success will look like

How did we do?

Improving end of life care

We can do more to improve care in the community and our hospitals for patients nearing the end of their life. Better communication between hospitals, GPs and district nurses, along with the latest evidence-based care, can have a positive impact on patients and carers.

- Increase the number of patients with an advance care plan in place that includes details of their wishes
- Increase the number of patients who, following referral to palliative care, are cared for on the Liverpool Care Pathway (national best practice) in the final stages of their illness, in line with our CQUIN targets.

*We have achieved this. We have made considerable progress in both community and hospital palliative care during the year, this includes an increase in the number of patients cared for on the Liverpool Care Pathway and patients with advanced care plans in place.

A renewed focus on dementia care

We have done some good work on dementia care in the past 12 months. We want to maintain the momentum and focus on this potentially devastating illness which is becoming increasingly common as the population ages.

- Embed the year one Healthcare for London dementia goals, which aim to improve quality of life for people with dementia and their carers
- Review and roll out a work plan to deliver the year two goals.

We have achieved this. Although there is more to do, and in line with our CQUIN targets, we have carried this priority over into this year's accounts.

Improve patient experience responses to the national survey

These questions have been chosen by the Department of Health as key areas for all NHS Trusts in England to focus on.

- Improve percentage patient satisfaction scores by three per cent on questions covering the following areas:
- Privacy and dignity
 - Medicines information
 - Involvement in care
 - Information about concerns
 - Someone to talk to if worried
- This is in line with our CQUIN targets.

We have partially achieved this. We have achieved our targets in four out of the five CQUIN questions.

Improve women's satisfaction with maternity care

Our maternity survey results came out after the public engagement on our priorities for 2011-12. However, our results showed that we need to improve satisfaction with our maternity service.

- Improve patient satisfaction scores across a number of key questions, in line with our CQUIN targets.

*We have achieved this. We have made demonstrable improvements in women's experience of maternity care at our hospital this year.

Improve patient information leaflets

Following the integration of hospital and community services we could have up to three different types of patient information leaflet. This could be confusing for our patients. We will rapidly review the current position and draw up a plan to standardise patient information leaflets across all our services.

- Review current position across Lambeth and Southwark
- Update community information leaflets to reflect integration.

We have partially achieved this. This initiative has changed in year, following a comprehensive review of nearly 200 community patient information leaflets. We therefore are declaring partial compliance this year.

For further information on our quality performance, including benchmarking and data trends, please see our new Patient Safety and Experience Report on our website.

Clinical effectiveness

Our quality priorities and why we chose them	What success will look like	How did we do?
<p>Nutrition and hydration</p> <p>We want to get the essentials of nutrition right for all of our patients, all of the time. This priority was ranked number one by our stakeholders and commissioners and is an area where we believe we can, and should, improve our performance.</p>	<p>Conduct a Trustwide review and develop an action plan to ensure that we are at the forefront of best practice when:</p> <ul style="list-style-type: none"> - assessing our patients - assisting them with eating - weighing them appropriately - providing access to snacks 24 hours a day - documenting and communicating care. 	<p>We achieved this. We undertook a major multi-professional review of food for inpatients. Out of this came a large number of interventions including: new nutrition care plans; new menus, including a multi-cultural menu; and innovative nutrition simulation training for staff.</p> <p>Early indications are that we have significantly improved our patient experience scores for the quality of our food, as shown by our near-time patient feedback results.</p>
<p>Improve communication between district nurses and GPs</p> <p>As a result of the community/hospital integration, we have already begun significant work to improve communication between our hospital and community teams. Following GP and commissioner feedback, we have changed the focus of this priority to improve communication between district nurses and GPs.</p>	<ul style="list-style-type: none"> - Community teams will confirm receipt of GP referrals - Community teams will communicate with a patient's GP after initial assessment and at discharge, in line with our CQUIN targets. 	<p>*We have not achieved this.</p> <p>We set an ambitious target of a 92% improvement in communication, with our final position being 88%. For this reason this priority will be carried over into this year's priorities.</p>
<p>The Productive Series, also known as 'Releasing Time to Care'</p> <p>This aims to equip teams with methods to improve their environment, systems and processes. It helps clinicians to make decisions about using resources more efficiently. We have had considerable success with the 'Productive Ward' and now want to roll this national improvement scheme out to other areas such as operating theatres and community services.</p>	<ul style="list-style-type: none"> - Roll out the 'Productive Operating Theatre' across selected specialities - Start the 'Productive Community' programme - Both programmes will have bespoke performance measures, such as increasing the number of operations that start on time. 	<p>We have achieved this.</p> <p>By year end we have established the 'Productive Operating Theatre' programme across high risk specialities, and made demonstrable improvements in surgical productivity, most notably in orthopaedics'. Further work is underway across other specialities'.</p> <p>We have commenced the 'Productive Community' series.</p>
<p>Establish a dedicated hospital readmissions review group</p> <p>With many changes taking place in health and social care comes the potential risk of increased hospital readmissions. This can be a sign of poor quality care and we want to act early when we see subtle changes in readmission patterns across our specialities.</p>	<ul style="list-style-type: none"> - Identify directorate leads - Review in detail emergency readmission trends across our hospitals, developing local and Trust/community wide action plans where necessary - Embed this process in monthly directorate performance reviews. 	<p>We have achieved this. We have an established 'Clinical Outcomes Group' which reviews key quality indicators.</p>
<p>Develop an individual ward accreditation scheme</p> <p>We want to have the safest wards in the NHS. With our governors and other stakeholders we will independently review and score our wards for safety, and patient and staff experience.</p>	<ul style="list-style-type: none"> - Develop an individual ward accreditation scheme based on Care Quality Commission assessment and rankings. 	<p>We have achieved this.</p> <p>In conjunction with our governors, we have developed and piloted an innovative electronic ward accreditation scheme.</p>
<p>Increasing new birth visits</p> <p>Picking up issues early, and assisting mothers with newborn babies, is a crucial element of good healthcare in the community. We can improve in this area.</p>	<ul style="list-style-type: none"> - Increase the percentage of new born babies who receive a new birth visit (or attempted visit) within 14 days. 	<p>We have not achieved this.</p> <p>Although well above the London average, we have not met our 95% target, and therefore have carried this over into this year's priorities.</p>

Improving dementia care

3.2 Performance

Mortality

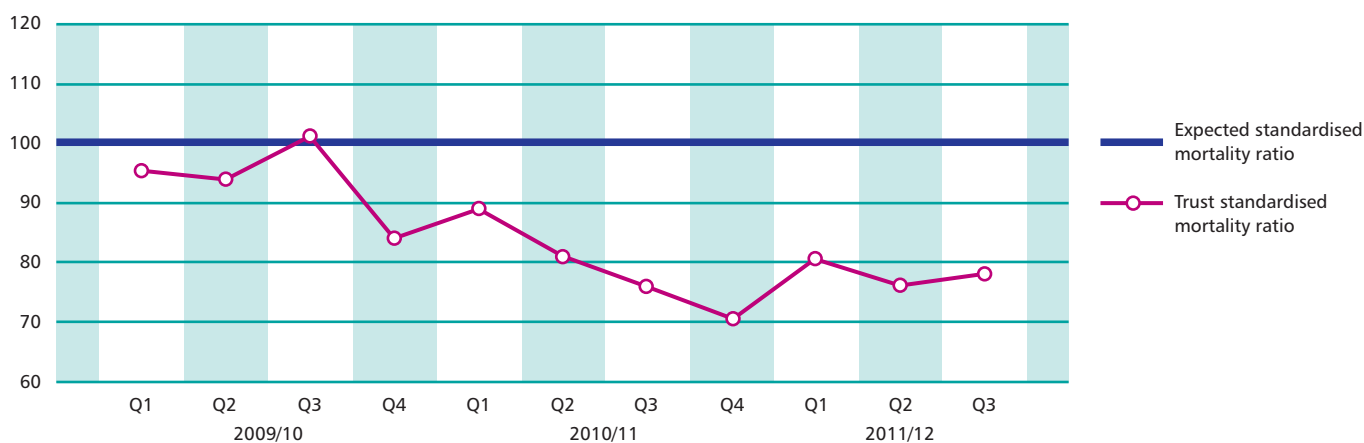
Standardised (or case-mix adjusted) mortality ratios show whether the death rate at a hospital is higher or lower than expected. It is an important marker of quality and safety. As well as internally reviewing all actual deaths that occur every month, we use two external and independent benchmarking tools provided by healthcare intelligence companies CHKS and Healthcare Evaluation Data to monitor mortality.

These tools, which include the new Department of Health case-mix adjusted measure, demonstrate that our standardised and crude mortality rates remain well below those expected of a Trust of our size with the type of patients, many of whom have complex clinical problems, we see.

We are working hard to improve the care of patients at risk of, or with, dementia or delirium. We have created an expert clinical dementia and delirium team (DaD). We have also launched a new 'forget-me-not' initiative for inpatients with dementia.

A recognisable symbol – the forget-me-not flower – is placed above a patient's bed, a flower sticker is placed in the patient's notes and a blue wrist band is worn by the patient. This ensures that all staff immediately recognise that the patient may be vulnerable and may have additional care and communication needs.

Guy's and St Thomas' standardised mortality



The Dr Foster *Inside Your Hospital Guide* was published in December 2011. Guy's and St Thomas' was cited positively three times in the report. We were one of 12 Trusts in England with the lowest mortality rate, we were recognised for our excellent stroke care, and also for prompt treatment of patients with a hip fracture. We did not feature in any of the adverse sections of this independent report.

The full Dr Foster report is available on the website:

http://drfosterintelligence.co.uk/wp-content/uploads/2011/11/Hospital_Guide_2011.pdf

Infection control

We continue to have very low levels of hospital acquired infection, including MRSA, *C difficile*, norovirus and surgical site infections. We are committed to reducing the levels of hospital acquired infections through a drive for cleanliness and a zero tolerance approach to poor hand hygiene.

MRSA

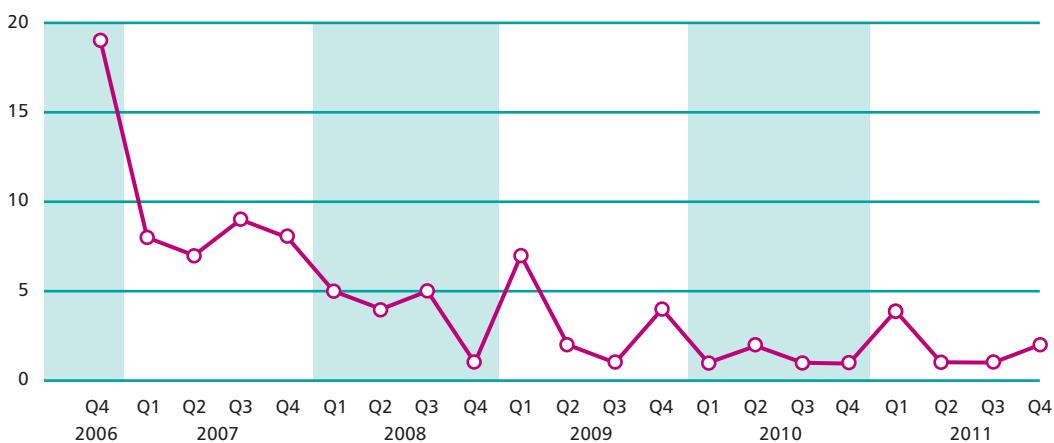
MRSA is an antibiotic resistant infection that can cause an acute illness – particularly if a patient’s immune system is compromised due to an underlying illness or if wounds are infected. It is associated with healthcare but also occurs outside healthcare settings.

Reducing the rate of MRSA infections is a key national target and is indicative of the degree to which hospitals prevent the risk of infection by ensuring cleanliness of their facilities and good infection control compliance by their staff.

Unfortunately we exceeded our MRSA target of no more than seven cases in a year. We had a total of eight cases, two of which were considered unavoidable. In the other six cases, the patients had complex medical conditions which contributed to their infections. We are obviously disappointed to have exceeded this target.

Following a full review of the eight cases, changes are being implemented to reduce further the risk of infection and to ensure that we do all that we can to achieve next year’s target of no more than four cases of MRSA blood infection.

Our MRSA blood infections



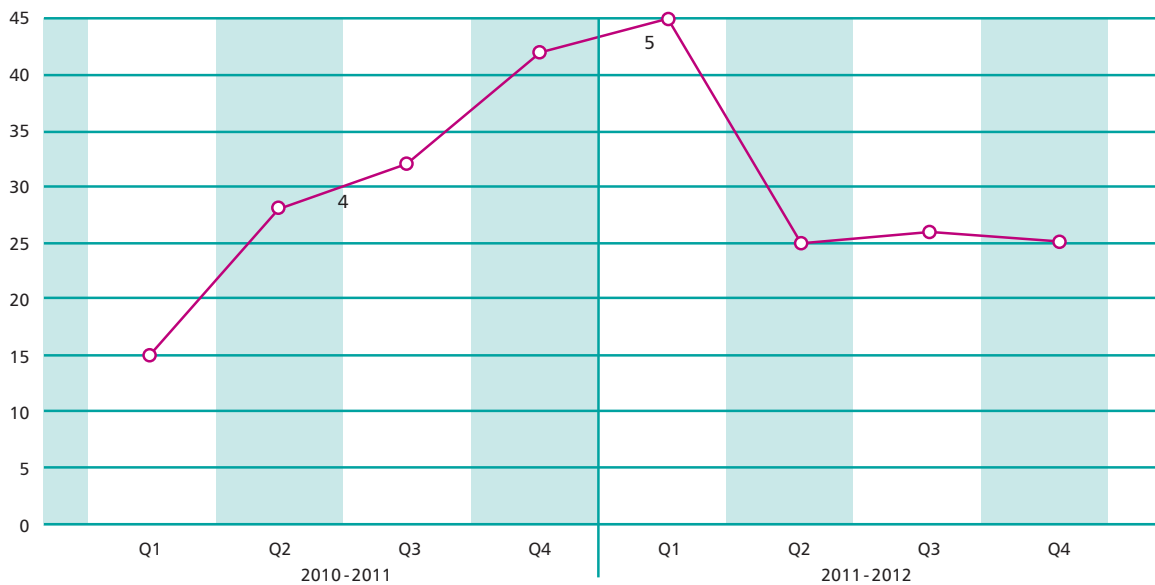
C.difficile

C.difficile is a bacterium that is carried by an unknown percentage of the population and, in the event of it causing infection, can lead to severe disease. It can cause severe diarrhoea and is associated with patients with compromised immune systems, the use of some antibiotics and patients who have had gut surgery.

Last year, we were set a target of no more than 155 cases of *C.difficile* by our commissioners, based on a new testing regime. We had 121 cases in 2011-12, and the number reflects the introduction of a new and significantly more sensitive test which identifies more cases and so is better for patients.

The Trust now tests all positive samples for *C.difficile* DNA to see whether the strains are related. The tests show how well our staff are controlling the spread of infection, and we have found little evidence of cross infection.

C.difficile cases



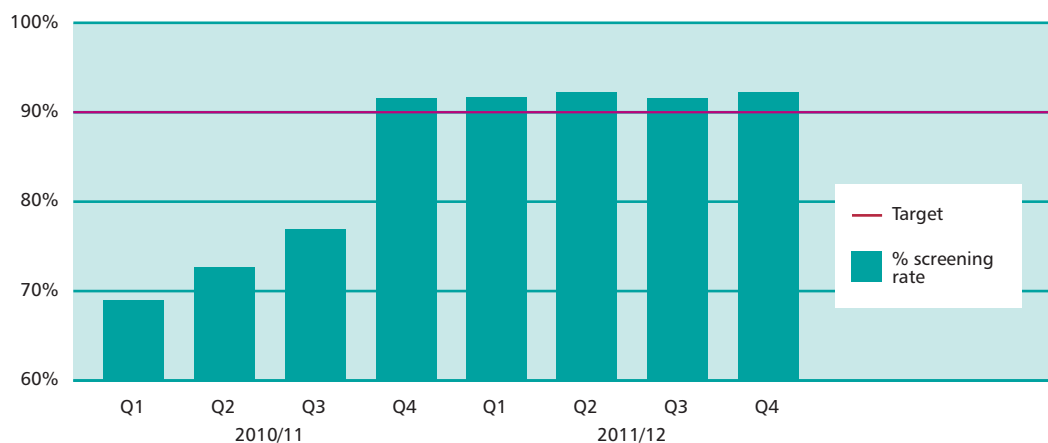
(4) Our reported cases increased in September 2010 following the introduction of a more sensitive test.

(5) In May 2011, we saw an increase in reported cases. DNA testing confirmed that different strains of the bacteria were present, and that our measures to prevent the spread of infection were good.

Venous thromboembolism

Venous thromboembolism (VTE, or blood clots) is a major cause of death in the UK. Some blood clots can be prevented by early assessment. We are working hard to reduce the risk of avoidable blood clots and have met the targets set by the Department of Health. Our clinical staff remain at the forefront of venous thromboembolism care nationally and internationally, including through clinical research and service development.

VTE screening



3.5 Community services

Following the integration of community health services in Lambeth and Southwark into the Trust in April 2011, two directorates (adults and children) have been established. In this document we set out our results and priorities for improvement, which are also outlined in our quality schedule and CQUIN targets, and are monitored through our performance framework and clinical audit programme.

The directorates established a governance framework, which reflects the domains of patient experience, patient safety and clinical effectiveness, and this is reported to the Trust Board.

Last year, the directorate introduced two major work programmes to support patients in their own homes. Their aim is to reduce unnecessary hospital admissions or to reduce a patient's length of stay in hospital, should they need to be admitted to hospital.

Home ward

Home ward helps keeps patients in their own homes. It is being piloted in Bermondsey in Lambeth, and Rotherhithe in Southwark and south east Lambeth. Our community staff, working closely with hospital colleagues, GPs and other care providers, look after patients with complex needs in their own homes, reducing the need for long hospital stays. As patients are nursed at home, with their clinical care managed by local GPs, some hospital admissions are also avoided.

The home ward team receives referrals from GPs, A&E and other clinical teams on the medical wards at both Guy's and St Thomas' and King's College Hospitals. Staff identify those patients who would benefit from care provided by the home ward service.

**Business
as usual –
despite riots**

Enhanced rapid response

Enhanced rapid response in Lambeth and Southwark offers 're-ablement' and other support so that patients can regain, and maintain their independence. Staff support people struggling to cope at home, typically following a fall or short-term illness, and aim to prevent admission to hospital.

The service operates seven days a week, and provides an easy referral process which means that staff are normally able to respond within two hours. The team is based in St Thomas' A&E; working closely with GPs and other colleagues. They help with a patient's discharge from A&E or admission wards, or support patients already at home who are at risk of being readmitted to hospital.

Both home ward and the enhanced rapid response service are being evaluated. Early feedback from patients and clinicians is positive, most notably on the responsiveness of these services and the outcomes that are being achieved for our patients.

Working with adults with learning disabilities

Excellent support for our most vulnerable patients is our priority. A hospital 'passport' to help patients with learning disabilities communicate effectively with clinical staff has been developed by our adults with learning disabilities team.

The passport is a simple record, completed by the holder with the support of carers and family members, which can be taken to hospital appointments. It gives details of conditions such as diabetes, epilepsy or mental health problems; medication, mobility or communication aids the person may use; details of allergies and specific clinical needs; information about consent; and personal information such as unusual behaviour, food likes and dislikes and habits.

This information gives staff immediate help in making better clinical decisions that take into account the patient's needs.

At risk to their own personal safety, community staff continued to provide maternity, district nursing and palliative care to local residents throughout the London riots in the summer of 2011. These staff received a special award at our Trust awards ceremony in November.

3.6 National targets

Referral to treatment time

Midway during the year, we identified that we had more people on our referral to treatment (RTT) pathway for patients requiring admission to hospital – the target that measures maximum waiting times – than previously reported. This resulted in the Trust undertaking a detailed internal review with expert advice.

A comprehensive action plan was developed to tackle the longest waits, which are concentrated in a small number of specialist areas. We remain on track with this plan, and are treating around 500 extra patients a month.

As a result of the way that this target is measured – and while we are treating more patients who have waited over 18 weeks each month – we do not expect to achieve the RTT target for admitted patients until the end of September 2012.

Most of our patients are seen much more quickly – last year more than half of our inpatients waited seven weeks or less compared with a national average of eight weeks. We are currently treating about 85 per cent of our admitted patients within 18 weeks against a target of 90 per cent. However, the majority of patients are treated as non-admitted cases and, of these, over 96 per cent are treated within 18 weeks.

Last year, we treated a record number of patients requiring a planned admission as a day case or inpatient – a total of 100,000 which was an overall increase of 11 per cent on the previous year. We have also seen a significant improvement in our waiting times for diagnostic tests, particularly in endoscopy, where all patients can now be seen within six weeks.

We do not want any of our patients to have a long wait for treatment. We are working hard to ensure that all our patients are seen as soon as possible by our highly skilled and often very specialised staff. Our overall understanding of what affects our waiting lists has greatly improved this year, and will help us to manage this more effectively in future.

During the year, we began preparing for the Olympics and Paralympics to ensure that we will be able to deliver business as usual during the 2012 Games. We recognise the difficulties that patients and staff will face travelling in London during this period and are also planning to create an Olympics legacy for the Trust that celebrates health and well-being.

Getting
ready for
the
Olympics

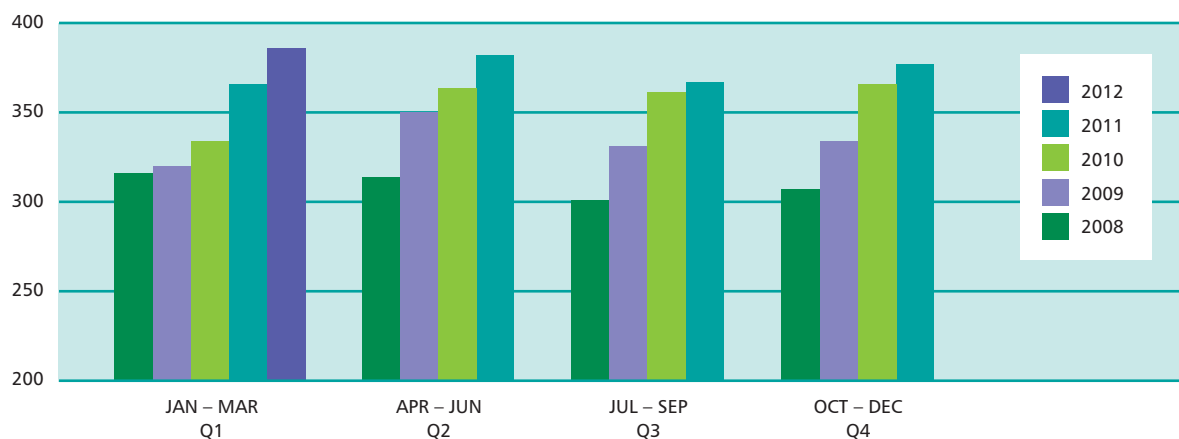
Accident and emergency

We continue to experience significant increases in demand for our accident and emergency services at St Thomas'. Despite this, we met the national target of diagnosing, treating, discharging or admitting 95 per cent of patients within four hours.

We are reviewing in detail how patients move through our accident and emergency department and beyond to see how best we can meet future demand and while improving services.

This work will include a new Urgent Care Centre at Guy's to treat patients who do not need emergency treatment, and other developments to ensure sure that patients requiring emergency care move swiftly and smoothly through our hospitals.

Percentage of patients seen and treated within four hours in A&E



Cancer targets

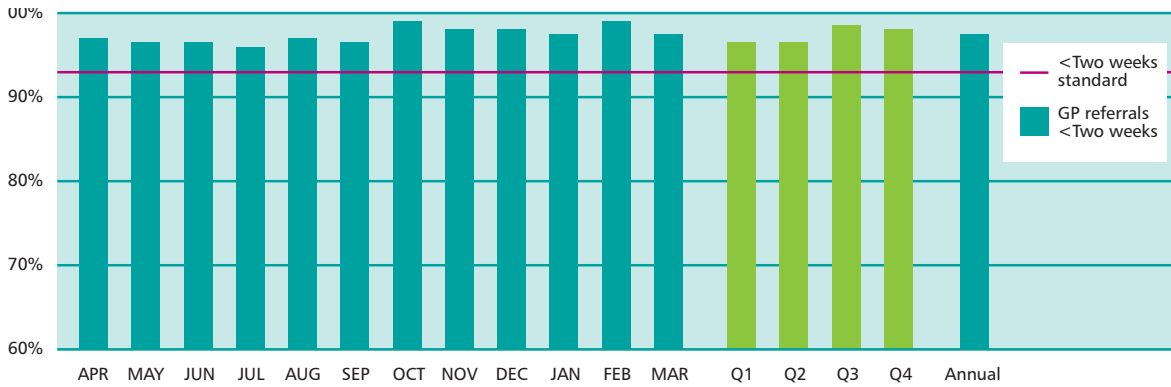
Clinical evidence demonstrates that the sooner patients with cancer symptoms are assessed, diagnosed and treated, the better their clinical outcomes and survival rates.

Last year saw significant improvements in our performance against the national cancer targets.

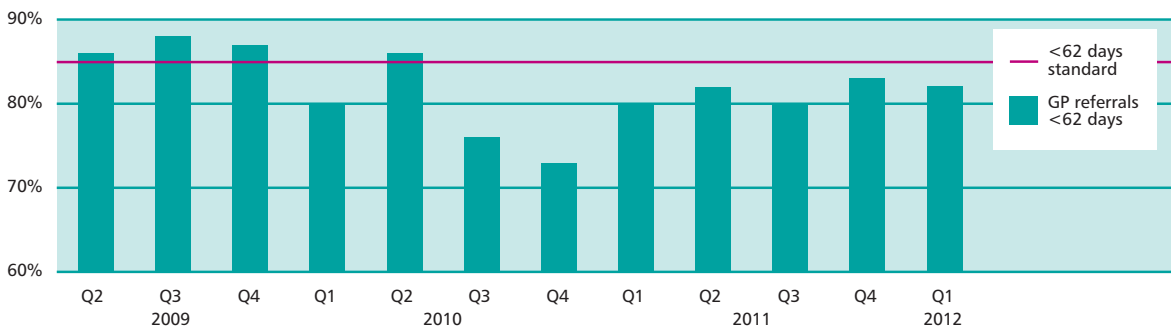
In common with trusts receiving referrals from other hospitals, we struggled to achieve the maximum 62-day referral to treatment target. We met this target for patients already registered at Guy's and St Thomas', but we did not meet this for patients referred to us later in their pathway from other hospitals. We are working with the hospitals that refer patients to us to ensure that delays are minimised for these patients.

As part of our drive to reduce cancer waiting times, we're investing in a new four-bed endoscopy suite to increase our diagnostic capacity. We have also invested in a state-of-the-art Tomotherapy machine to provide additional radiotherapy, and we are investing in our cancer day unit to increase capacity for chemotherapy.

Percentage of urgent GP cancer referrals seen within two weeks in 2011-12



Percentage of urgent GP cancer referrals receiving first treatment within 62 days



Our patient experience

Last year, as part of the Care Quality Commission’s (CQC) patient survey programme, we undertook postal surveys of our inpatients and outpatients. As part of our CQUIN programme, we focused on improving the care of women using our maternity services and commissioned a postal survey to see whether we were achieving our planned improvements.

Although we have more work to do, we are pleased that we have maintained our London position in the inpatient survey and improved our performance in the outpatient and maternity surveys. We have also achieved four out of the five hospital CQUIN targets which relate to the national patient survey.

Progress against 2011-12 priorities

The national outpatient survey

We scored very well in the 2011 national outpatient survey. When reviewing the summary scores for the key themes listed in the CQC benchmarking report, our total score makes us the highest scoring Trust amongst our London peers.

Areas of good performance included communication, and also doctor-patient interaction. Work is under way to improve our performance in areas such as clinic waiting times, medicines information, and reception and arrival services.

London teaching hospitals	Overall score 2011 (out of 90)	Overall score 2009 (out of 100)
Guy's and St Thomas' NHS Foundation Trust	72.0 (1st)	76.9 (3rd)
Imperial College Healthcare NHS Trust	70.9 (2nd)	74.1 (7th)
King's College Hospital NHS Foundation Trust	69.9 (3rd)	78.3 (1st)
University College London Hospitals NHS Foundation Trust	69.8 (4th)	77.4 (2nd)
Chelsea and Westminster Hospital NHS Foundation Trust	69.4 (5th)	74.2 (6th)
Royal Free Hampstead NHS Trust	69.2 (6th)	75.4 (5th)
Bart's and The London NHS Trust	68.9 (7th)	76.1 (4th)
St George's Healthcare NHS Trust	68.1 (8th)	76.9 (3rd)

The national inpatient survey

We maintained our position as second highest performing teaching hospital Trust in London in the inpatient survey published in April 2012, and were within the top 20 acute trusts in England. In the majority of the areas covered, our performance remained the same, with improvements reported in pain management, providing single sex accommodation and the number of patients who rated their care highly.

However, there are areas where our own near-patient feedback tell us that we need to improve, including reducing noise at night, explaining test results and not speaking in front of patients as if they were not there. As well as improving how we communicate patients, work is under way to address the issues raised in local surveys, comments and complaints and with our patient advice and liaison service (PALS).

London teaching hospitals	Overall score 2011 (out of 100)	Overall score 2010 (out of 100)
University College London Hospitals NHS Foundation Trust	78.3 (1st)	79.2 (1st)
Guy's and St Thomas' NHS Foundation Trust	77.6 (2nd)	77.1 (2nd)
Imperial College Healthcare NHS Trust	76.7 (3rd)	75.2 (5th)
St George's Healthcare NHS Trust	74.2 (4th)	76.1 (3rd)
Chelsea and Westminster Hospital NHS Foundation Trust	74.0 (5th)	74.0 (6th)
King's College Hospital NHS Foundation Trust	73.9 (6th)	75.3 (4th)
Royal Free Hampstead NHS Trust	73.6 (7th)	72.7 (8th)
Bart's and The London NHS Trust	73.1 (8th)	73.1 (7th)

National patient experience survey

Patient experience question	Baseline 2010/11 data	2011/12 Inpatient survey final scores
Were you as involved as you wanted to be in decisions about your care?	70.2	71.4 ●
Did you find someone to talk to about worries and fears?	56.9	62 ●
Were you given enough privacy when discussing your condition or treatment?	81.1	84.7 ●
Were you told about medication side effects to watch for?	45.1	49.2 ●
Were you told who to contact if you were worried?	74	81.2 ●
Overall / composite score for the 5 indicators	65.5	69.7

Though performance improved from the 2010-11 baseline, we did not achieve the local target of 72.2

Our maternity patient experience CQUIN

The results for the 2010 national maternity survey indicated that we needed to improve women’s experiences and satisfaction of our maternity service.

In line with our CQUIN targets, we choose to monitor our patients’ satisfaction with their maternity care using three questions, which reflect women’s experience of treatment and care at different stages along their care pathway:

- pregnancy: overall experience of care
- labour: whether women were left alone at a time when this concerned them
- postnatal care: whether women were treated with kindness and understanding.

Maternity staff developed a comprehensive action plan to drive improvements. Actions included dedicated user feedback workshops; intensive staff training; early roll out of near-time patient feedback and a formal repeat of the national survey to monitor the impact of the programme.

We are pleased that we have achieved our objectives this year, improving our patient experience targets by 3 per cent, with the ‘involvement in care’ result improving by 10 per cent.

Patient and public involvement

We are committed to engaging and involving our patients, the public and our stakeholders in the development of our services. This is to ensure that patient's views are represented and that we build our services around their needs. We have had active public participation across our major building and service projects, including the design of our new outpatient centre at St Thomas', planned improvements to our accident and emergency department, and the development of a new sexual health clinic in the community.

As well as involving our patients in new service developments, we are pleased to have an active patient voice across our services, including from local community groups such as: the Lambeth Community Care Centre Friends; local resident associations; pensioner action groups; and colleagues in Southwark and Lambeth LINKs. We also work closely with specialist patient associations which provide direct feedback on our services. These groups include the Kidney Patients Association, The Evelina Childrens' Heart Organisation and The Lane Fox Respiratory Unit Patients Association.

Our Trust governors also play an active and invaluable part in improving our patients' experience through their 'Patient Experience Working Group'. They participate in ward inspections, offer advice and challenge us on key issues such as improving patient dignity, tackling complaints, and improving patient transport and catering. They act as important critical friends in developing our annual quality priorities.

Near-time patient feedback and national surveys

Last year we introduced a new system to capture patient feedback using an electronic survey. This was rolled out across the Trust in both inpatient and outpatient areas. Since the project began, over 4500 patients, carers and visitors have completed surveys via our touch screen kiosks, tablet PCs, website and our smart phone app. We have also trained over 130 student nurses to directly support patients or carers completing the surveys in areas such as elderly care. The system enables us to supplement the high level data provided by the national survey with a more detailed ward level picture of the experience our patients have, and gives our ward sisters local information so they can lead and co-ordinate improving the patient experience at ward level.

Results from the near patient experience system are reviewed and actioned weekly at our Safe in Our Hands meetings, where over 100 nurses, therapists and managers meet to discuss a range of patient experience and safety matters. We also triangulate this information with complaints, PALs queries and compliments, and this forms an important part of our ward and directorate performance reviews.

Results from near patient feedback indicate that overall satisfaction rates amongst our patients remain high at around 87%. Patients consistently rate the clinical care, privacy and dignity, same-sex accommodation and cleanliness highly. Areas where we need to improve include waiting times in outpatients, providing patients with consistent information and the quality of our food. We are working hard to improve these areas in the coming year.

We also want to make it easier for patients to tell us what they think, and we are increasing the number ways they can do this. We are also rolling out the near patient experience system to our community directorates as part of this year's CQUIN programme.

Improving care of older patients

Today older people are cared for across all specialities in our hospital, not just on our elderly care wards. Last year we wanted to create a 'hub' of excellence across our existing elderly care wards, aiming to share the expertise and knowledge of this valuable staff resource for the benefit of older people across the organisation.

To achieve this, last summer, we set about modernising our four elderly care wards, both physically by transforming the environment, and also by investing in staff. We embarked on an intensive eight week programme, which included a bespoke training package for the multi-professional teams using the latest simulation training and

equipment, actors and manikins to promote individualised, dignified care. The programme was formally evaluated by King's College London, and so far, the outcomes for our patients and staff have been positive, with the programme shortlisted for several national awards.

Patient experience standards

As a key element of our quality strategy, we developed joint hospital and community patient experience standards. In developing these standards, our patient experience team analysed over 4,500 pieces of feedback captured over an 18-month time period. We distilled this feedback into a list of eight priority standards that are monitored via our near-time patient experience surveys.

1 – We will see you within 30 minutes of your appointment time, or keep you informed if we cannot do so

2 – We will offer you a choice of appointment dates with reasonable notice

3 – We will care for you in a clean and comfortable environment

4 – We will make sure that our staff have the knowledge and expertise to give exceptional care

5 – We will treat you as an individual, listen to your views and treat you with privacy and dignity

6 – We will give you clear, high quality information about your condition, its treatment and our services.

7 – We will keep noise and disturbance to a minimum while you are an inpatient

8 – We will make sure that you have the support or advice you need before you are discharged from our care

Learning from complaints

We take complaints very seriously; they form a crucial part of our learning from patient feedback. Since 2009/10 we have seen a 15% decrease in the number of complaints related to clinical care. Complaints are also received relating to non-clinical aspects of care, including transport, catering and the attitude of staff. We are working hard to learn from the feedback and to reduce complaints further across all areas. At the beginning of the 2011 we identified an issue with a delay in responding to complaints, including a backlog of complaints which were overdue. We immediately put steps in place to address this, and reviewed the entire complaints process. By the end of the year we had made considerable progress to reduce the backlog.

Responding to complaints

Whilst attending an outpatient appointment, a patient complained about the attitude of the receptionist, the lack of information regarding their visit and the noise from local building works during the appointment.

As a result, we spoke to the patient to understand their concerns better and offered a full apology. To improve services, the receptionist was coached by their manager and received 'customer-services' training and increased supervision. A review of pre-outpatient information was conducted and we continue to work hard to minimise disruption from essential building work.

Following up patients at home

In response to comments from patients, the ward sisters in orthopaedics recently introduced a follow-up call to patients once they have left hospital.

The calls not only demonstrate that the ward staff are thinking about patients and their recovery, but also uncover post-operative problems, delays or gaps in after-care, therefore helping to avoid re-admission to hospital. They also highlight where improvements could be made.

Patients are rung 24 to 72 hours after they have left hospital to find out how they are; how they found the hospital discharge process; whether they have any questions about their medication; and whether they have any suggestions that might help staff to improve the service.

Comments are displayed on the ward and stories shared at handovers. Feedback is important so that staff hear positive comments and know that the care they deliver is worthwhile, but also so they learn to use negative comments constructively to tackle any shortcomings.

Progress against 2011-12 priorities

- Target fully achieved
- Target partially achieved
- Target not met

Our performance against national and core quality standards

Existing indicators		National standard	2011/12 Final	2010/11 Final	2009/10 Final
A&E access	% patients discharged within 4 hours in A&E and MIU	>95%	95.6% ●	95.9% ●	97.6% ●
Cancelled operations	% elective operations cancelled on day of operation	<0.8%	0.50% ●	0.67% ●	0.70% ●
	% cancellations not re-admitted within 28 days	<5%	4.1% ●	0.0% ●	0.9% ●
Health and well-being	Patients seen within 48 hours of referral to GUM clinic	>99%	100.0% ●	100% ●	100.0% ●
	Ethnic coding of inpatients	>90%	92.2% ●	91.7% ●	91.9% ●
Clinical quality	Call to balloon time for primary angioplasty – % under 150 minutes	>80%	92.2% ●	87.2% ●	58.1% ●
MRSA screening	% compliance with MRSA screening for elective admissions		98.7% ●	99.0% ●	93.4% ●
Infection control	MRSA bacteraemia reduction	<7	8 ●	4 ●	16 ●
	<i>C.difficile</i> acquisitions in over 2's	<155	121 ●	118 ●	73 ●
	% clinical staff compliant with hand hygiene (monthly audit)	>98%	98.9% ●	97.7% ●	97.5% ●
	MRSA screening of non-elective admissions		94.8% ●	95.7% ●	
18 week referral to treatment times	% admissions within 18 weeks	>90%	85.4% ●	90.4% ●	90.6% ●
	% non-admissions within 18 weeks	>95%	95.4% ●	95.6% ●	96.2% ●
Cancer access	Urgent GP referrals seen within 2 weeks	>93%	97.4% ●	96.6% ●	97.0% ●
	Breast symptomatic referrals seen within 2 weeks	>93%	94.5% ●	96.2% ●	93.2% ●
	Cancer treatments started within 1 month of decision to treat	>96%	97.2% ●	96.2% ●	99.4% ●
	Cancer treatments started within 2 months of urgent GP referral	>85%	83.5% ●	79.2% ●	85.2% ●
	Treatments started within 2 months of screening programme referrals	>90%	94.1% ●	97.0% ●	99.0% ●
	Subsequent surgical treatment within 1 month	>94%	95.5% ●	93.2% ●	97.8% ●
	Subsequent chemotherapy treatment within 1 month	>98%	99.2% ●	99.6% ●	99.6% ●
	Subsequent radiotherapy treatment within 1 month	>94%	96.2% ●	94.3% ●	
Infant health	Smoking during pregnancy	<5%	3.7% ●	3.8% ●	4.8% ●
	Breastfeeding initiation	>90%	93.7% ●	90.6% ●	87.0% ●
Clinical indicators	Hospital mortality – unadjusted counts of deaths (monthly average)	<90	81 ●	91 ●	93 ●
	Standardised mortality ratio (earlier years re-based)	<85	79.1 ●	72.3 ●	93.6 ●
	Readmission rate (emergency readmissions within 28 days)	<4.5%	5.3% ●	5.4% ●	4.7% ●
	Quality of stroke care – % patients with >90% stay in stroke unit	>90%	91.7% ●	94.5% ●	82.1% ●
	Venous thromboembolisms – % patients screened	>90%	92.0% ●	92.7% ●	
	10% reduction in patient slips trips and falls with harm (per month)	<5	2.1 ●	3.1 ●	
	Pressure ulcer acquisitions – 10% reduction (per month)	<12.7	6.5 ●	13.0 ●	
	Smoking cessation referrals per month	>150	184 ●	150 ●	120 ●
Maternity	% Caesarean births	<27%	27.4% ●	27.6% ●	28.4% ●
	Health assessments completed within 12 weeks	>80%	93.4% ●	93.0% ●	87.0% ●
	Dedicated midwife during labour	>90%	98.0% ●	98.0% ●	99.0% ●

Community Indicator Summary.

Following integration, this is the first year of combined Lambeth and Southwark data.

Indicator	Target	Q1	Q2	Q3	Q4
District nurse: referral to patient contact (<24hrs)	>95%	60%	58%	82%	86%
Health visitor – % infants breastfeeding at 6 – 8 weeks	>75%	65%	72%	72%	76%
Health visitor new birth visits within 14 days*	>95%	80%	85%	89%	91%

* figure excludes where receipt of birth notification is greater than five days.

Statement of Directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 as amended to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that 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:

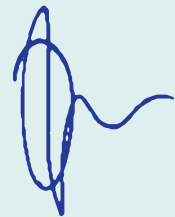
- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2011-12;
- the content of the quality report is not inconsistent with internal and external sources of information including:
 - Board minutes and papers for the period April 2011 to June 2012
 - Papers relating to quality reported to the Board over the period April 2011 to June 2012
 - Feedback from the commissioners dated 18/05/2012
 - Feedback from governors dated 02/05/2012
 - Feedback from LINKs dated 04/05/2012
 - Feedback from Lambeth Overview and Scrutiny Committee 08/05/2012
 - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 31/05/2012;
 - The [latest] national inpatient survey 10/05/2012
 - The [latest] community services survey 04/2012
 - The [latest] national staff survey 03/2012
 - The Head of Internal Audit's annual opinion over the trust's control environment dated 03/2012
 - CQC quality and risk profiles dated 20/04/2012
- the quality report presents a balanced picture of the NHS foundation 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; and the quality report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the quality report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)).

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

On behalf of the Board of Directors.



Sir Hugh Taylor
Chairman
30 May 2012



Sir Ron Kerr
Chief Executive
30 May 2012

Independent Auditor's Assurance Report to the Council of Governors of Guy's and St Thomas' NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Guy's and St Thomas' NHS Foundation Trust to perform an independent assurance engagement in respect of Guy's and St Thomas' NHS Foundation Trust's Quality Report for the year ended 31 March 2012 (the "Quality Report") and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the Council of Governors of Guy's and St Thomas' NHS Foundation Trust as a body, to assist the Council of Governors in reporting Guy's and St Thomas' NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2012, to enable the Council of Governors to demonstrate that it has discharged its governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Guy's and St Thomas' NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2012 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

1. MRSA
2. Cancer 62 day waits

We refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has

come to our attention that causes us to believe that:

3. the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
4. the Quality Report is not consistent in all material respects with the sources specified in the Detailed Guidance for External Assurance on Quality Reports 2011/12; and
5. the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports*.

We read the Quality Report and considered whether it addresses the content requirements of the *NHS Foundation Trust Annual Reporting Manual*, and considered the implications for our report if we became aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the documents specified within the detailed guidance. We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the "documents"). Our responsibilities do not extend to any other information.

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

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

6. Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
7. Making enquiries of management;
8. Testing key management controls;
9. Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
10. Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report; and
11. reading the documents.

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*.

The nature, form and content required of Quality Reports are determined by DH/Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts. In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Guy's and St Thomas' NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2012:

12. the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
13. the Quality Report is not consistent in all material respects with the sources specified in the detailed guidance; and
14. the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports*.



Deloitte LLP
Chartered Accountants
Reading

30 May 2012

LINK Southwark Response to the Guy's and St Thomas' Hospital Foundation Trust (including Community Services) Quality Account 2011-2012

We appreciate that compilation of a Quality Account (QA) from a complex and large Foundation Trust such as Guy's and St Thomas' requires efforts from many hands at the Trust. On the whole, the report and its achievements is impressive and the LINK appreciates these services available to Southwark residents.

However, two general but key issues that arise from the Quality Account is that the language is not very reader-friendly and data is not provided in some important areas. As a result a conclusion cannot be drawn for the current year because data is not provided as at time of writing.

Generally on the whole, explanation of terms and initiatives are good and simple, however possible considerations to increase accessibility of the QA could be a brief explanation as to how CQC mortality alerts take place, the meaning of 'secondary uses' services and explanation of some of the graphs (with specific reference to Standardised Mortality Relative Risk).

LINK is pleased to see that our responses to your Quality Accounts are considered in future work approaches. We are delighted that Guy's and St Thomas' NHS Foundation Trust has taken part in the Diabetes (RCPH National Paediatric Diabetes Audit) Audit this year amongst other things, as per our suggestion to last years Quality Accounts (2010-2011).

1. Quality Account Priorities 2012-13

Patient safety

- Clarity is needed on how the quality priority of "increasing visits to our new community new birth centre" translates into an increased percentage of new born babies who receive a visit to at least 95% by the end of March 2013.
- While we appreciate and have noted the current/forthcoming priorities, it could be suggested to include other information relating to patient safety that is not covered in the quality priorities. This can be brief and will show to the public (and the more informed public)

consideration of patient safety in the wider sense and that they are keeping abreast of new/best practice. For example there does not seem to be any reference to:

- compliance with the WHO Surgical Safety Check. This has been widely discussed from the Department of Health, the Royal College of Surgeons to being featured in reports from the National Patient Safety Agency. Recent research from Imperial College suggests that compliance may be below rates reported. Will Guy's and St Thomas' be contributing to WHO Surgical Safety Check week?
- Best practice relating to the responsible consultant being present in the operating theatre during surgery even when a junior doctor is authorised to operate. What is Guy's and St Thomas' record?

Clinical effectiveness

- We generally support the clinical effectiveness priorities, including reducing waiting times for outpatients for their first appointment. During our outreach we have received feedback relating to and support this measure.
- More information about how you intend to measure your priority of 'improving our ward sisters'.
- We recognise the importance of this increasing child immunisation rates: It has been suggested that perhaps LINK could work with Guy's and St Thomas' NHS Foundation Trust towards achieving this objective.

Patient experience

- Improving staff communication with patients – how will success rather than process be measured?
- There is lack of detail how Guy's and St Thomas' intend to improve the care of vulnerable patients (dementia related). It could be a possibility to link the priority of *patient experience response to surveys* to this priority.
- Influential factors to patient experience which are not referred to in the report relate to:
 - the quality of the food and whether the food is actually consumed or not, especially relating to older people
 - the widespread problem in London where non-critical patients are kept in ambulances longer than necessary influenced by the 4 hour A&E target. This

also has the knock-on effect of fewer ambulances being available. Is this an issue for Guy's and St Thomas'?

2. Previous Targets 2010-2011/ Additional comments

We note that the priorities that have not been achieved have been rolled over to the next year.

Other comments

- At time of LINK receiving the Quality Accounts report there was no statutory statement of assurance from the Board, but we hope that as stated a local context will be provided to this forthcoming information.
- **Consent audit:** while results are not yet available, this issue will become increasingly important especially when loss of capacity is considered and also end of life care.
- We support the use of **Patient Passports** for people with learning disabilities and suggest that this could be valuable to other groups such as patients post operative discharge, as informed by the report of the London Cardiovascular project 'Report of the London Cardiovascular – Patients Perspective'.
- While we note the introduction of **hourly rounds** in response to CQC concern of patient call bells not being answered in a timely manner, these rounds do not necessarily fix this issue. Consideration of wider factors may be needed.
- We are concerned that while the Trust has achieved its CQUIN CQC national patient experience performance target relating to medication side effects, the base level is low at 45% given the importance of knowing potential medication side effects. This should require a higher level of achievement.
- Public and patient involvement is referred to in the report as 'engaging and involving' stakeholders, yet it does not demonstrate involvement in decision making.
- In addition, it is stated that reports to the Trust Boards are referred to in terms of financial performance rather than quality. Quality should be the central component of activity especially in reports to the senior officials.

May 4 2012

Lambeth LINK Response to Guy's and St Thomas' Hospital Quality Accounts for 2011/2012

Lambeth LINK welcomes the opportunity to respond to the Guy's and St Thomas NHS Foundation Trust Quality Accounts 2011/2012.

We have received the above, which now includes its Chief Executive statement. We agree with him that "there's no time to be complacent..", except that we would apply it all hospitals. Guy's and St Thomas' (GSTT) is not being complacent in investing in a new outpatient centre (page 28), when it scored the highest ranking amongst London Acute Teaching Hospitals in the National Outpatient Survey in 2011. Though it was third in 2009 on a higher score.

We are particularly pleased that GSTT has taken our previous comments to heart and began with its successes in 2011-2012 rather than its hopes for 2012-2013. Incidentally, we note that GSTT have selected "Patient Safety" as one, perhaps THE priority for 2012-2013. We approve this but note that the other emergency services always prioritise staff safety as well as public safety. Hospitals need cover during epidemics as well as between them.

Our greatest interest is focussed on "How Did We Do?, progress against 2011-2012 priorities." 12 against the 18 predicted were achieved, i.e. coloured green, is good. However, three predicted "partial compliance" by year end and three "not achieved", i.e. coloured red, are noted. Why are good results described in colours and bad ones only words, not colours (Amber or Red)? We are not sure what number 17 Patient Experience (Maternity) with its green prediction means when the comment in the box is "other results unknown", i.e. all but one of the priorities are predicted and therefore unknown.

The venous thromboembolisms result is very good and we hope your next priority will be to equal the second and in future years the first (University College London). What does UCL do to achieve this result?

Nevertheless we will remember the outpatient survey, with which the comment began. Carry on with the good and try to make North Lambeth and Southwark's hospitals the best in the country.

There are two projects covered in your report that

Annex – Feedback on our 2011/12 Quality Accounts

we would highlight that respond to concerns of LINK members and show a positive response which are the patient passports for Adults with Learning Difficulties and the Dementia Forget Me Not initiative.

Format of Quality Accounts

Lambeth LINK made the comment last year that Quality Accounts are public facing documents and the content should therefore be written in a more accessible format.

We are encouraged to note in this year's Quality Accounts that our comments have been taken on board and acronyms are spelt out and NHS speak such as "CQUINs" and "NHS Safety Thermometer Tool" are explained.

May 4 2012

Feedback from Lambeth Overview and Scrutiny

Lambeth Council's Health and Adult Services Scrutiny Sub Committee would like to thank Guy's and St Thomas' NHS Foundation Trust for the invitation to submit a statement on the Trust's draft Quality Account 2011/12. The committee would also wish to acknowledge the earlier invitation to participate in the Quality Accounts Stakeholder Group.

It has not been possible to formally consider the draft Quality Accounts within the timeline requested and the Committee is not therefore submitting a response. However the Committee would wish to acknowledge the good working relationship that exists between the Scrutiny Committee and the Foundation Trust.

Health and Adults Service's Scrutiny Sub Committee, London Borough of Lambeth

Elaine Carter

Lead Scrutiny Officer
Scrutiny Team
Finance and Resources
London Borough of Lambeth

May 8 2012

Feedback from Guy's and St Thomas' Trust Governors

Congratulations on a very comprehensive and interesting document. Some suggestions:

1. Patient experience priorities. Add more detail on how to improve care for vulnerable patients – what will you actually do?
2. P22, 3.3 Infection control – you mention norovirus at the top – is it worth mentioning the incidence of norovirus infections and their control?
3. P30, 8 patient experience standards – no. 4 – include training for staff, as this is relevant for receptionists and telephonists who also have contact with patients.
4. I would have expected to see something about complaints. Need to handle them promptly. Any trends?

Jenny Cobley

Governor

May 2 2012

Other Trust Governor Feedback

- Not enough mention of Evelina Children's Hospital.
- General editing and typo correction.
- Request definition on what 'Lambeth and Southwark safeguarding children boards are'.
- Generally excellent
- The respiratory medicine audit results have 'TBC' against many of them.
- The case histories are listed, but missing in the draft.

NHS South East London response

The draft Guy's and St Thomas's Hospitals NHS Foundation Trust (GSTT) Quality Report 2011/12 was reviewed by a number of local commissioning stakeholders, including representatives from NHS Lambeth, NHS Southwark and NHS SE London. The coordination of feedback has been undertaken by NHS SE London, which welcomes the opportunity to respond to this document.

GSTT are to be commended on a comprehensive document which highlights not only areas of excellence but those areas where work has been required during the year e.g. complaints. The development of a quality strategy during the year is a very positive reflection of the priority that GSTT places on quality issues and is welcomed.

It is good to see how the Quality Account priorities have developed over the past three years. These Quality Accounts clearly set out how the Trust has prioritised its key delivery areas for 2011/12, for both acute and community services, including good stakeholder engagement. It would have been helpful to present graphical current local data information on all the priorities in order to more clearly demonstrate why they were chosen and what success would look like in the next year in a similar way to how performance has been presented e.g. MRSA and VTE screening.

In respect of one of the patient safety priorities, to 'improve staff knowledge', it would have been helpful to include more information for clarity on the actions to be taken and the measures to be used to determine how this will be met.

Given the importance of serious incidents and in particular Never Events, we would have liked to see how these events informed the patient safety priorities. NHS SEL recognises the work being done to fully implement the WHO surgical safety checklist across the organisation.

The national outpatient survey results are to be commended and progress has been made in respect of the national inpatient survey. There is excellent work being undertaken in respect of ongoing GSTT patient survey processes which will be rolled out to the community services in this next year. Some recognition of the areas of concern within the national inpatient survey which continue to be a challenge, and actions being taken to address these, would have given a more

rounded picture, particularly as these issues have also been identified in the internal survey.

GSTT has made good progress against last years' targets and quality priorities and is to be congratulated on progress, particularly in the area of MRSA infections, CDifficile (Cdiff) infections and screening for blood clots, which are national priorities. The Trust has led the way with Cdiff assessments by introducing a new, more sensitive Cdiff test. Accident and Emergency and 18-week targets were — and continue to be — particularly challenging. The implementation of action plans is ongoing.

It is very encouraging to see where audits have led to improved quality of services within the Trust. It would be helpful to understand how the Board have been involved in national and local audit reviews, particularly given the national Quality Account guidance requirement for information on the proportion reviewed by the Board.

It is very positive to see the progress against last years' priorities and we welcome the ongoing excellent relationship we have as local commissioners with GSTT and are committed to working closely to ensure the ongoing delivery of high quality services throughout this next year. NHS SE London has processes for regularly reviewing quality issues with GSTT via regular Clinical Review Meetings (GSTT 'Quality' meetings), as well as a number of other quality review mechanisms and these will continue.

Jane Fryer, Medical Director, NHS SE London.

Summary of our CQUIN programme 2012-13

		Value
Dementia screening (National CQUIN)	Dementia screening programme – all emergency admissions aged 75 and over to be screened and assessed, and a care plan agreed	£1.7m
NHS safety thermometer (National CQUIN)	National data collection relating to pressure ulcers, falls, urinary tract infection and venous thromboembolism (VTE)	£1.55m
VTE prevention (National CQUIN)	Extension of 2011/12 targets – 92% of patients assessed and thromboprophylaxis provided where appropriate	£1.55m
Patient experience (National CQUIN)	Improve 2011/12 national patient experience survey (5 key questions) and local survey results	£1.55m
Dementia staff training and antipsychotic prescribing (London CQUIN)	Implement a Trust wide dementia training programme and reduce antipsychotic prescribing through specialist review of patients prior to discharge	£1.62m
Cancer staging (London CQUIN)	Stage of tumour reported for new cancer patients through multi-disciplinary meetings	£0.59m
End of life care (Local CQUIN)	Sustain and roll out the AMBER care bundle, with all new referrals on the GOLD register. Also training and education for staff	£1.62m
COPD care bundle (London CQUIN)	Patients admitted with COPD as their primary diagnosis to be discharged with a completed care bundle	£1.62m
Extended HIV screening (Local CQUIN)	Roll out HIV testing to all acute medical admissions, unless patients opt out, and refer patients to HIV services	£1.62m
Alcohol screening (Local CQUIN)	Implement alcohol screening in specific outpatient clinics	£1.62m
Specialist services		
HIV	Increase patient registration with GPs and home delivery of antiretrovirals. Also improve communication with GPs	£373k
PICU	Develop PICU & HDU capacity plan, and reduce out of region transfers	£373k
NICU	Reduce inappropriate admissions, and increase community neonatal nurses	£373k
Quality dashboard	Provide extensive data (187 items) based on the Outcomes Framework	£160k
Total		£16.3m
Community services		
Alcohol intervention	Reproductive and sexual health staff and health visitors to identify increasing and higher risk drinkers	£341 K
Dementia care	Improve the care for people with dementia provided by community health care staff	£341 K
End of life care	Use the GOLD patient register and Liverpool Care Pathway where a death at home is planned	£201 K
GP communications	Improve communication between district nurses and GPs	£140 K
Patient facing time	Increase reported 'patient facing time' in health visiting and district nursing	£341 K
Patient experience	Improve user experience through the introduction of near time patient feedback	£150 K
Community acquired pressure ulcers	Reduce the number of community acquired pressure ulcers	£150 K
Immunisation	The health visitor team to increase the proportion of MMR 2 and pre-school booster immunisations	£341 K
Total		£2.0 m



contacts

Chief Executive

If you have a comment for the Chief Executive, contact:

Ron Kerr, Chief Executive

Tel: 020 7188 0001

Email: chief.executive@gstt.nhs.uk

Patient Advice and Liaison Service (PALS)

If you require information, support or advice about our services, contact:

PALS

Tel: 020 7188 8801 (St Thomas')

or 020 7188 8803 (Guy's)

Email: pals@gstt.nhs.uk

Membership

If you are interested in becoming a member of our NHS Foundation Trust, contact:

Tel: 020 7188 7346

Email: members@gstt.nhs.uk

Recruitment

If you are interested in applying for a job at Guy's and St Thomas', contact:

The Recruitment Centre

Tel: 020 7188 0044

<http://jobs.gstt.nhs.uk>

Further information

If you have a media enquiry or require further information, contact:

Anita Knowles, Director of Communications

Tel: 020 7188 5577

Email: anita.knowles@gstt.nhs.uk

www.guysandstthomas.nhs.uk

Guy's and St Thomas' NHS Foundation Trust

Guy's Hospital Great Maze Pond London SE1 9RT

St Thomas' Hospital Westminster Bridge Road London SE1 7EH

Tel: 020 7188 7188

www.guysandstthomas.nhs.uk