Quality Report
Trust Board
January 2014

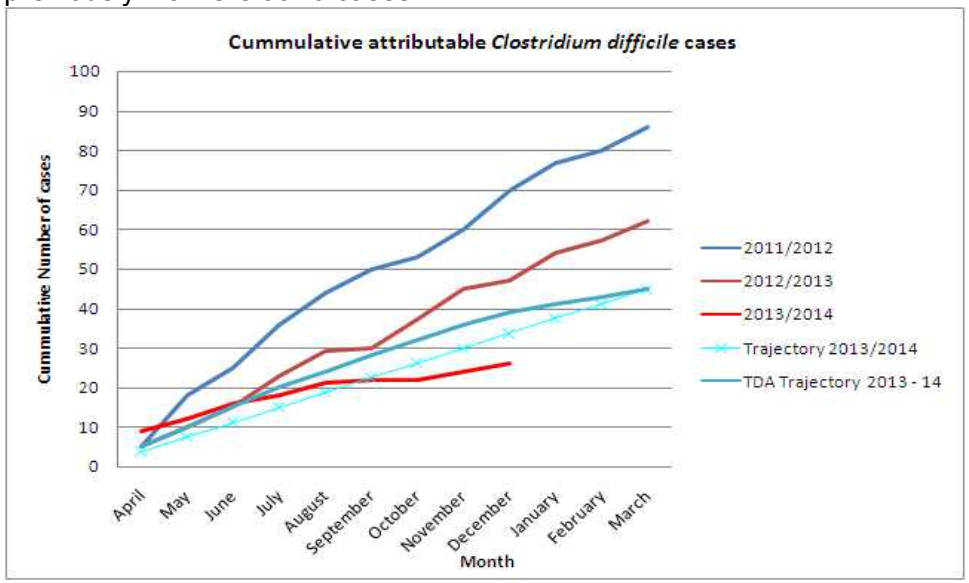
I PATIENT SAFETY
a) Infection Control

i) Clostridium difficile

Financial Year 2013/2014 National Threshold: 45 cases
Total so far this year: 26

April: 9 cases.
May: 3 cases.
June: 4 cases
July: 2 cases
August: 3 cases
September: 1 case
October: 0 cases
November 2 cases
December 2 cases

We remain below our trajectory, we have had the lowest *C. difficile* numbers ever.. This time last year we were at 47 cases and the year previously we were at 70 cases.



ii) MRSA:

MRSA:
The threshold for this is year zero avoidable cases. So far this year there have been seven cases, 4 cases ascribed to SGH.

The previous 5 cases have been detailed before.

6th case: A patient involved in a RTA. Required prehospital treatment on roadside. Known to be MRSA colonised on admission. Developed sepsis at day 4 and MRSA bacteraemia. Exact cause unknown but balance of probabilities it is due to extensive surgery required. The patient did not receive anti-MRSA surgical prophylaxis as status unknown at the time. A peripheral cannula infection site cannot be excluded. This will be recorded against our numbers but unavoidable.

7th case: Patient admitted from a nursing home with MRSA bacteraemia. Pressure sore or catheter infection potential sources. Ascribed to community and PIR completed and accepted by Wandsworth CCG.

MSSA

We are required to report all MSSA bacteraemias although there are no national thresholds. We undertake root cause analyses on all MSSA infections thought to be acquired in the trust. Ie Post 48 hours.

		TOTALS	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
MSSA	Post – 48 hours	20	1	2	5	1	4	2	0	4	1
	Pre – 48 hours	34	2	3	5	5	2	0	5	7	5

E. coli

We are required to report all E. coli bacteraemias although there are no national thresholds. There is no distinction made on the mandatory report between hospital acquired infections although we have separated these in the table below as an indication.

		TOTALS	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
E. coli	Post – 48 hours	46	4	8	6	8	7	3	5	1	4
	Pre – 48 hours	127	12	10	17	15	13	16	11	21	12

b) Patient Safety

Table 1

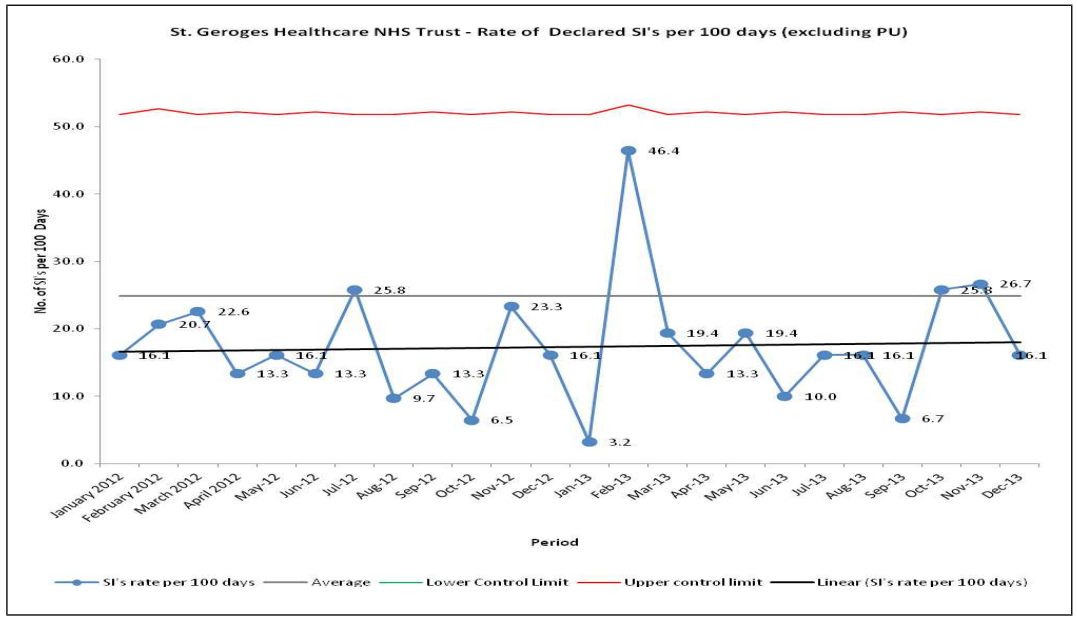


Table 2

One of the key indicators of patient safety is the serious incident (SI) trends data which the attached graphs show.

The graph in table 1 shows the trend for serious incidents excluding pressure ulcers. The previous trendline was showing a reduction but this appears to have stabilied and now shows a very slight increase. The declared SIs for October and November 2013 (15 in total) have been looked at to identify trends. Five related to obstetric incidents, a further 5 related to incidents in the Surgical Division which mainly related to treatment delay/ deterioration. The ongoing trend in surgery is being monitored. The remainder were in a variety of locations and covered a number of issues.

The trend of pressure ulcers showed a peak in April 2013 but this appears to be falling back to previous levels. This is the trend that could be expected when the spotlight is pointed on a particular issue. An initial rise is often caused by an increased awareness and vigilence followed by a fall caused by the measures put in place. Therefore the figures prior to March 13 may well be undereported. Figures have now reduced and close monitoring is being carried out of lower grade pressure sores to ensure this trend continues.

The serious incident reports have begun to record whether a pressure ulcer was avoidable so that the data will be able to show where there are incidences of poor care and where this was not a contributing factor.

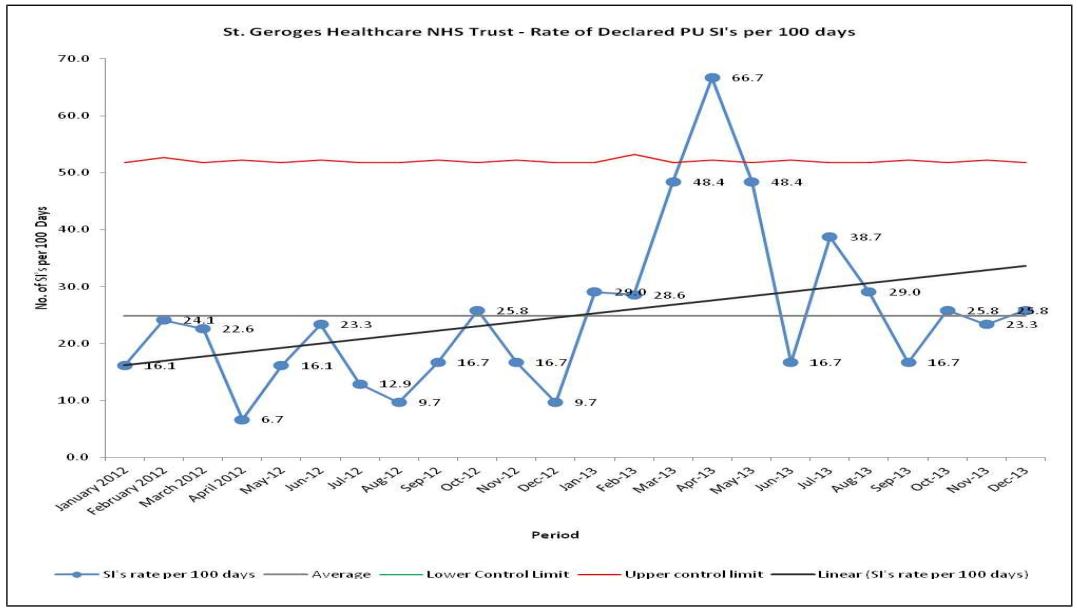
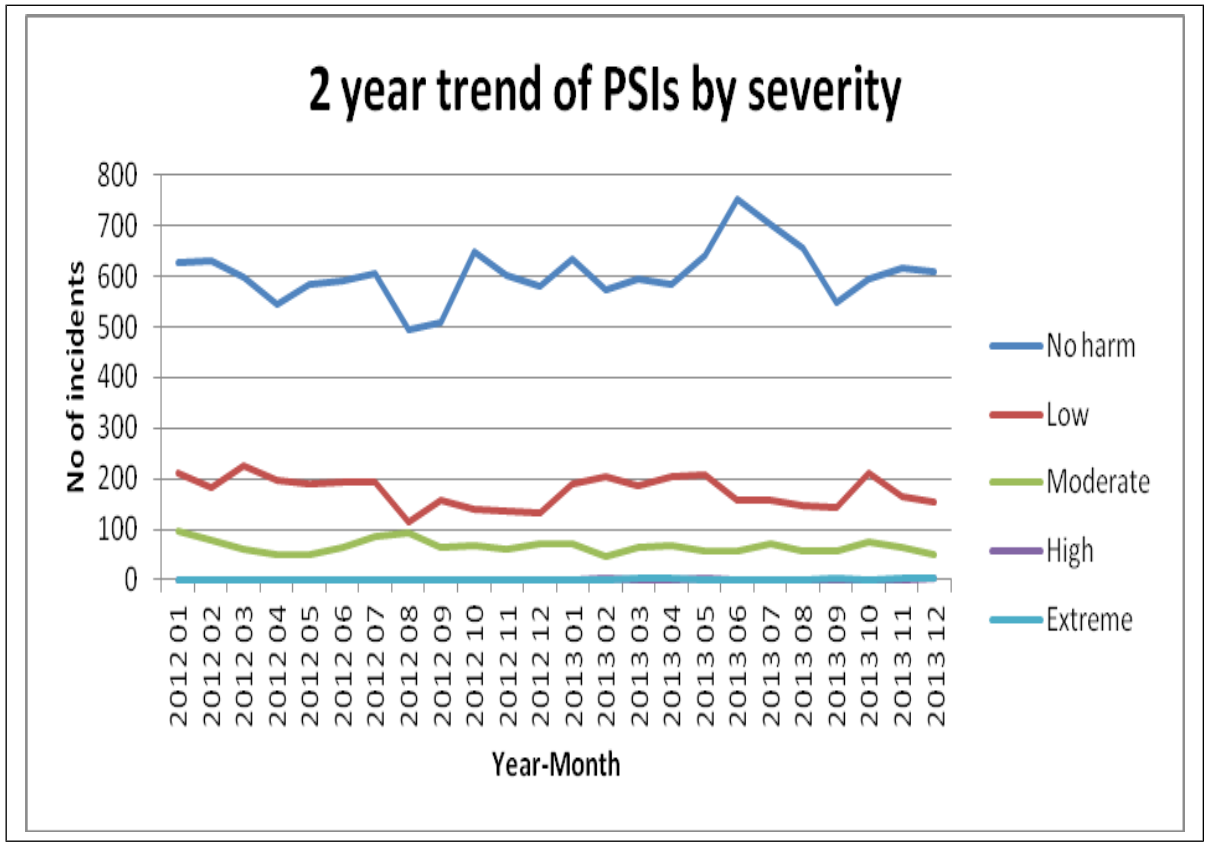


Table 3
Incidents by Severity and Date



The graph in Table 3 shows the measure which is part of the National Outcomes Framework indicator set. It shows the level of severity as a proportion of all reported incidents. In an organisation with a good safety culture you would expect to see a high number of reported incidents overall with a small proportion where incidents are categorised as moderate or severe. The Risk Team have worked with divisions to to ensure that the incidents are categorised correctly and this has shown in reducing figures for high and moderate categories. This trend appears to be continuing which is encouraging for the trust. This will be helpful when reporting to commissioners on Duty of Candour requirements which are currently only required for moderate incidents and above.

Student Safety Forum

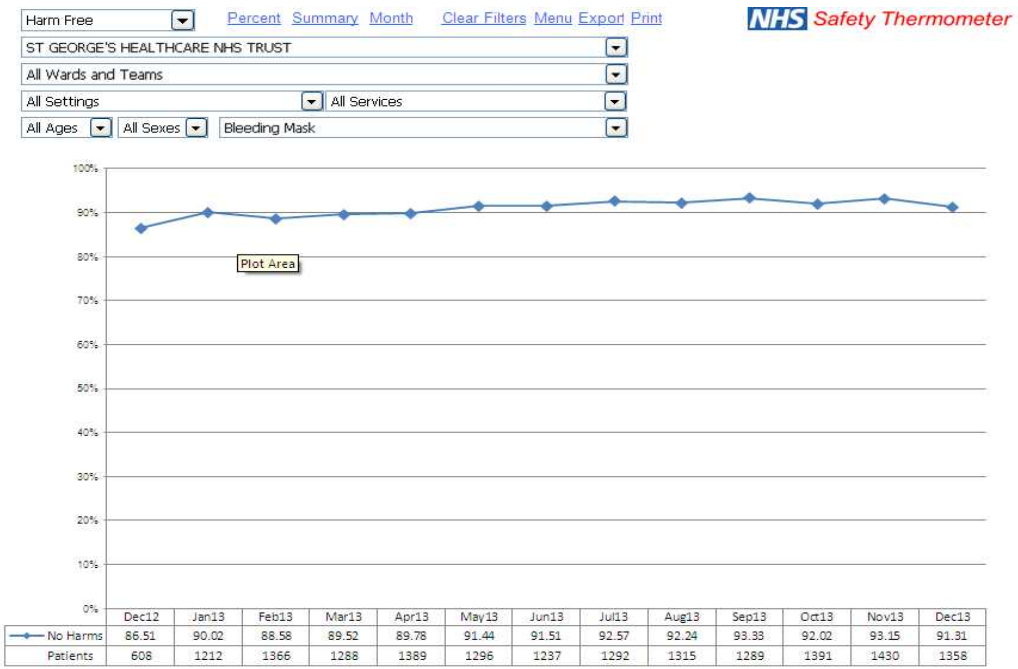
One of the issues that was highlighted by the Francis review was the need to learn from students as a source of rich data about the quality of services. As a result of regular liaison between the Kings faculty and the Head of Patient Safety, it was decided that a nursing student forum should be piloted on a similar model to the Patient Safety Forum that are now well established across the trust. Two forum have now been run with students from Kings and Kingston faculties and a number of issues have been highlighted during the sessions.

Students were asked a series of questions about safe and unsafe practice and used interactive feedback devices to answer the questions anonymously. They were also asked to work in groups to identify the most worrying things they had seen on the wards and to write these on post-it notes which they then mapped on flip charts.
A number of actions have been taken as a result of their feedback:

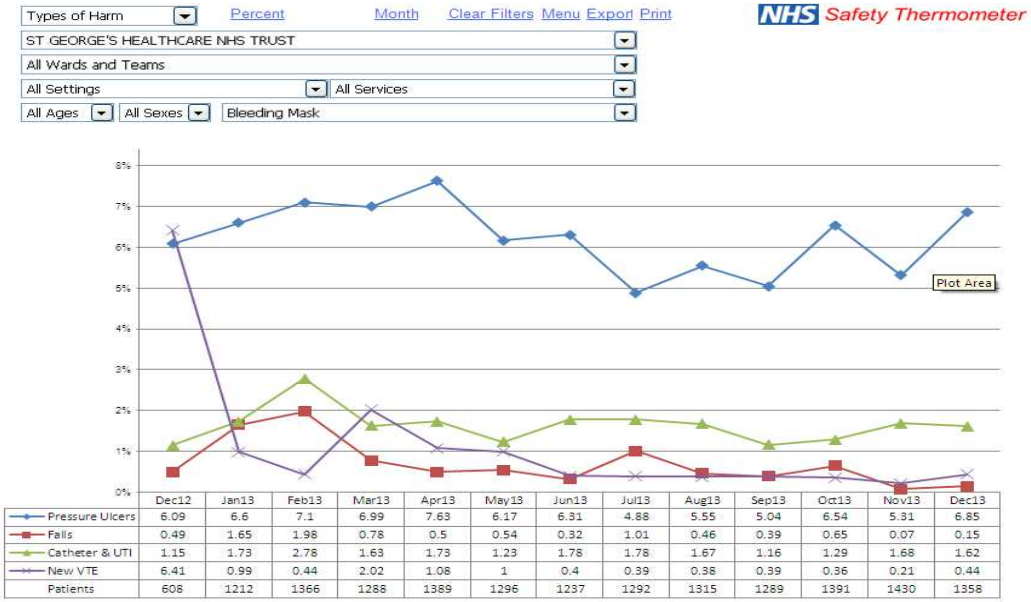
- Students wanted to have feedback on the issues that they had raised so a flow chart has been developed to identify a formal route as to where and how issues are dealt with.
- A newsletter has been sent to all senior sisters charge nurses and matrons with the issues that students raised so that they are able to check with their staff that these practices do not happen on their wards.
- A small number of more serious issues have been followed up with the specific areas

It is planned that the forum will be run three times per year to fit in with the student timetable. Feedback will be given at each session on the impact their feedback. Students also said that they wanted an additional route to raise issues as they happen and the Head of Patient Safety is currently exploring options in conjunction with faculty staff.

c) The Patient Safety Thermometer



	Dec12	Jan13	Feb13	Mar13	Apr13	May13	Jun13	Jul13	Aug13	Sep13	Oct13	Nov13	Dec13
No Harms	86.51	90.02	88.58	89.52	89.78	91.44	91.51	92.57	92.24	93.33	92.02	93.15	91.31
Patients	608	1212	1366	1288	1389	1296	1237	1292	1315	1289	1391	1430	1358



	Dec12	Jan13	Feb13	Mar13	Apr13	May13	Jun13	Jul13	Aug13	Sep13	Oct13	Nov13	Dec13
Pressure Ulcers	6.09	6.6	7.1	6.99	7.63	6.17	6.31	4.88	5.55	5.04	6.54	5.31	6.85
Falls	0.49	1.65	1.98	0.78	0.5	0.54	0.32	1.01	0.46	0.39	0.65	0.07	0.15
Catheter & UTI	1.15	1.73	2.78	1.63	1.73	1.23	1.78	1.78	1.67	1.16	1.29	1.68	1.62
New VTE	6.41	0.99	0.44	2.02	1.08	1	0.4	0.39	0.38	0.39	0.36	0.21	0.44
Patients	608	1212	1366	1288	1389	1296	1237	1292	1315	1289	1391	1430	1358

Graph showing types of harm across the trust. Please note that the sharp decline in VTE was an educational issue that is now resolved.

Background

The Patient Safety Thermometer (ST) tool measures four high-volume patient safety issues allowing teams to measure the proportion of patients that are 'harm free'. The ST CQUIN for 2013/14 has two components. Firstly to capture 6 months' of data across all included areas, this has now been achieved. The second component is a reduction in the numbers of trust acquired pressure ulcers by the end of quarter 4.

Progress to Date

The ST data submitted by Nurses and Therapists (community only) is verified by the Patient Safety Facilitators who ensure that robust data is submitted. This process highlights areas that have an increase in a particular harm and alerts staff to any unexpected harm within their area.

Monthly ST discussions are organised to ensure that all staff have the opportunity to voice their ideas on how as a trust we can provide 'harm free' care, however these are poorly attended as releasing clinical staff to attend remains a challenge. To increase the focus on 'harm free' care the proposal is to present RAG (red, amber, green) reports at divisional governance meetings. Currently, a report on the number of harms is shared with the CQUIN leads, Divisional Directors of Nursing & Governance, Heads of Nursing, Matrons and Wards Managers each month.

The ST has now been rolled out to therapy led services in the community, further increasing the population that we survey.

Challenges and Benefits of the Safety Thermometer

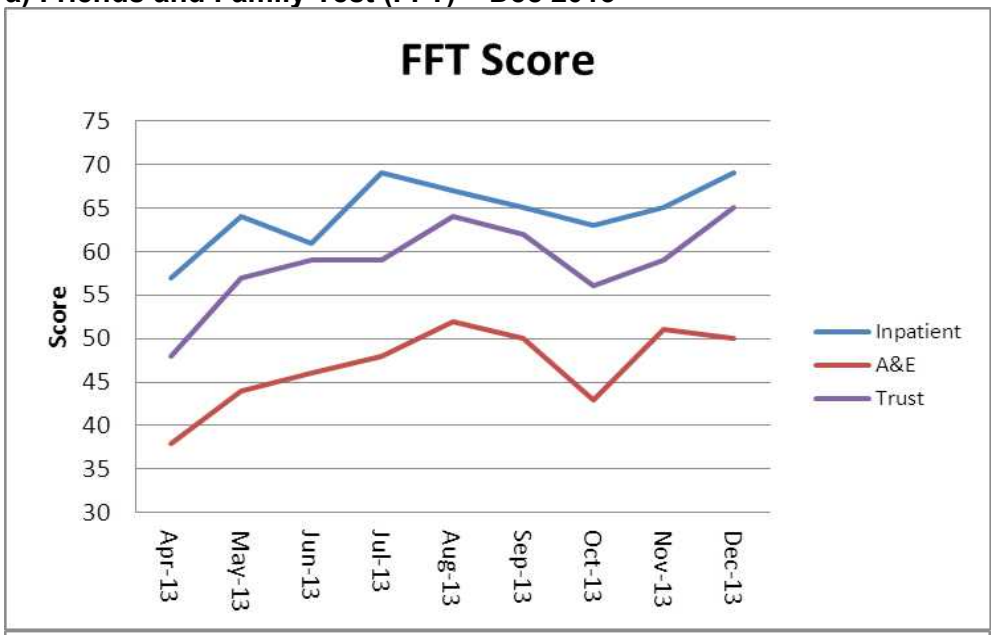
Rolling out the ST to therapy led services has been challenging as they are unfamiliar with recording data on catheters and VTE. However these teams have risen to the challenge, producing their own guides for staff and ensuring that all staff understand their role.

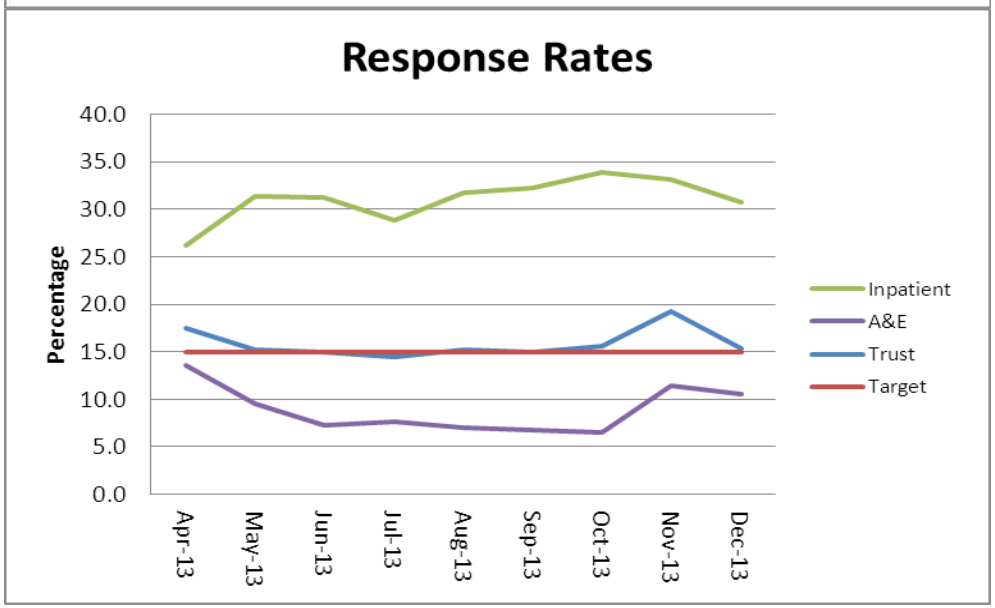
A document to support staff in the provision of 'harm free' care is in development and will shortly be piloted on one of the inpatient wards. This 'purple book' incorporates handy hints for early intervention/prevention of patient harms by staff.

Two new STs have been proposed for maternity services and medication safety, both of which are being piloted nationally. Discussions will continue with the national team and NHS London about next steps and our concerns about the resource implications and appropriateness of some aspects of data collection for the new STs.

II PATIENT EXPERIENCE

a) Friends and Family Test (FFT) – Dec 2013





Commentary

The FFT is the single question asked of patients on discharge about whether they would recommend our hospital wards, accident and emergency department and maternity services to a friend or relative based on their treatment.

In December the Friends and Family Test score for the trust overall was better with the trust score at +65, A&E scored +50 and the adult inpatient wards +69. This is based on a total of 1,345 responses compared to November's figure of 1,813. The scores for maternity were +54 in antenatal, +71 in postnatal community and +77 in postnatal ward. The total number of surveys in maternity was 118.

The minimum return required is 15% overall, rising to 20% in Q4. For December there was a slight decline overall. The trust total was 17.7% (19.2% last month), with adult wards at 30.7% (33.2% last month) and A&E at 10.5% (11.4% last month).

Of the total number of replies the breakdown is as follows; extremely likely 978 (1,180 last month), likely 374 (484 last month), neither/nor 42 (48 last month), unlikely 15 (29 last month) and extremely unlikely 22 (35 last month). There were 11 don't knows (37 last month).

For Maternity this is the second month of collection and unlike other areas there is more than one point of contact measured. The Maternity FFT includes four touch points; antenatal, birth, postnatal ward and postnatal community. The total number of surveys for Maternity was 118 (240 last month). The % return for each in that order in December were 4.2%, 4%, 8.1% and 16.4%.

The coloured bar chart later on is a summary divisional overview for December for all areas collecting FFT data with each answer displayed as an overall proportion of responses. This is helpful to look for any outliers/variance. This data is provided to the divisions by each ward and dept but it is difficult to produce as a chart given the very large number of areas now taking part.

The word cloud top left is for inpatient wards and the one below is for A&E. Below are actual comments supplied by patients. Given the very large numbers this is a very small selection of positive and negative comments which outlines the variety of experiences.

Wards and departments

"Staff checked on me on a regular basis to take my pressure reading and to ensure I was fine. It was very reassuring". 11:08, 1 December 2013

"Night care was faultless day care seems a little disorganised". 10:54, 10 December 2013

"Hospital is OK but I wouldn't recommend going to any hospital". 12:46, 21 December 2013

"Noisy staff at night. One hour sleep due to their loud conversations lack of communication re: moving wards". 21:18, 31 December 2013

A&E

"They were extremely helpful and done everything they possibly could to help and make me comfortable. Explained in detail what the problem was". 12:39, 31 December 2013

"Took about 2hrs for the Dr's to see the patient. Took 2 mins to send the patient home with no examination. Sent patient home to take painkiller. Very reluctant". 15:04, 12 December 2013

"Treated and seen quickly & listened to properly" 15:04, 12 December 2013

"Very hard to get a straight answer some staff very unapproachable" 11:30, 4 December 2013

Maternity

"Competent and caring staff". 10:14, 30 December 2013

"Helpful and efficient service and advice". 09:54, 30 December 2013

Detractors

A&E's 8 extremely unlikely ratings had 4 comments about waiting and attitude. Inpatient areas had 8 extremely unlikely ratings with 4 comments, one positive (staff cheerful and helpful) and other 3 about waiting, attitude, pain control and noise. Maternity had 0 extremely unlikely ratings

Proportion of answers by division

The trust's breakdown for inpatient wards is also displayed on NHS Choices website – the current one is for November data as there is a slight delay in NHS Choices and NHS England displaying the data publically given the volume. This will also now be displayed as part of the Care Connect website which will eventually replace NHS Choices. This is still not well accessed yet by the public with plans in place nationally to review publicity and communication.

The coloured bar chart on the following page is a divisional overview of December data for all areas demonstrating all possible scoring options.

This does demonstrate that the vast majority of patients are extremely likely or likely to recommend us. It is available at ward/dept level detail electronically for staff review to allow for more analysis and investigation but is difficult to display in paper/fixed reports given the amount of detail and the amount of areas as charts are far too busy. It is important to know the number of surveys per area as well as the score as some may have single figures as not many discharges such as critical care, while others may be in the hundreds such as A&E.

What is apparent in this more detailed chart is the amount of responses that are positive overall. The scoring methodology for FFT only assigns a positive score to "extremely likely" to recommend. As is clear in the chart the likely and extremely likely replies are considerable in number. The highest number of extremely unlikely replies remains attributable to A&E with the majority of feedback relating to waiting.

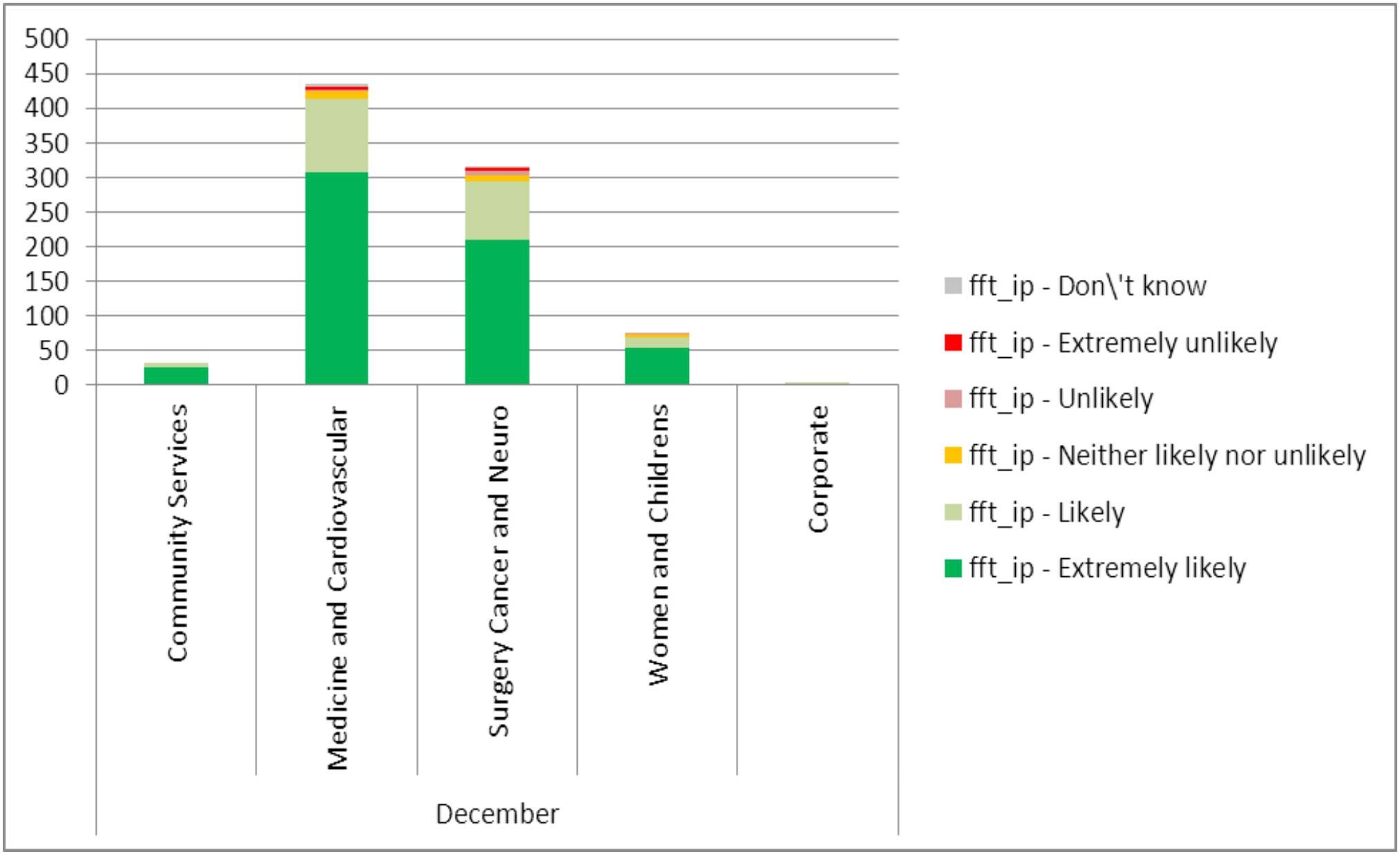
The final table of data relates to the percentage of patients surveyed from April to Dec by ward/department and there is still work to be done in certain areas although this is improving.

The first two months of data collection in maternity have been positive with the number of surveys and the positive comments and scores overall.

Changes are planned for NNU, community and paediatrics to ensure questions are most appropriate. It is also possible that additional questions will be added to the A&E survey as currently it is just the FFT question. The decision was made not to have a lengthy survey as A&E were already struggling to get sufficient surveys and this remains the case albeit much improved lately but still not at the required CQUIN target.

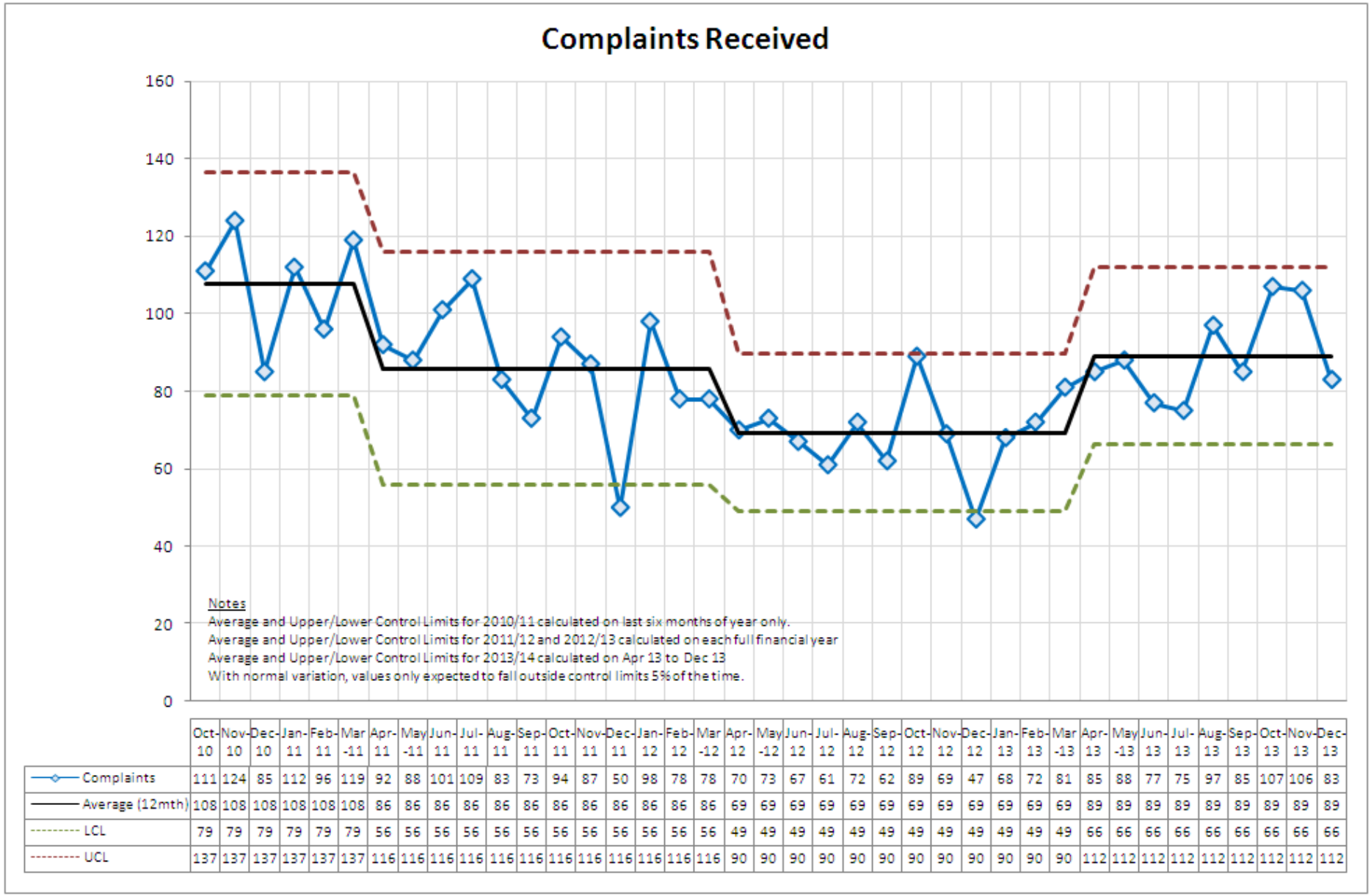
It is planned that reports will go to the Patient Experience Committee, trust board and any other relevant or interested meeting or committee.

Plans are underway to roll this out to day surgery and community by October 2014 but the guidance is still in draft form as all of the detail has not yet been finalised. Next year's CQUIN will also include an element of staff survey in asking how likely they are to recommend the service. This will be launched in Q1 of next year and plans are well underway with HR colleagues.

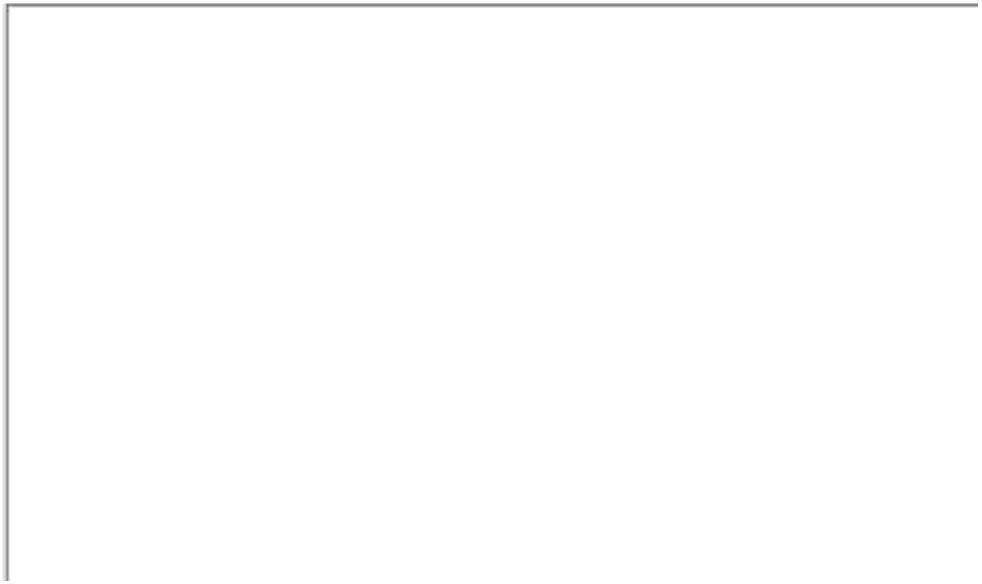

500
450
400
350
300
250
200
150
100
50
0
Community Services
Medicine and Cardiovascular
Surgery Cancer and Neuro
Women and Childrens
Corporate
December
fft_ip - Don\'t know
fft_ip - Extremely unlikely
fft_ip - Unlikely
fft_ip - Neither likely nor unlikely
fft_ip - Likely
fft_ip - Extremely likely

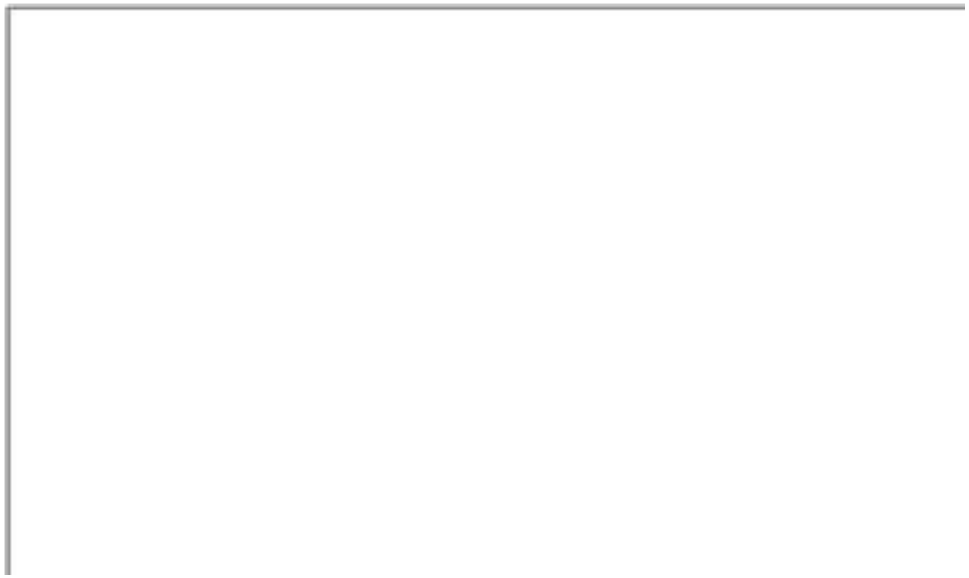
Service	April	May	June	July	August	September	October	November	December	Average
A&E	13.6%	9.6%	7.3%	7.7%	7.0%	6.8%	6.5%	11.4%	10.5%	8.9%
Allingham	49.0%	48.4%	31.3%	47.6%	22.5%	17.5%	11.1%	41.1%	41.2%	34.4%
Amyand	20.4%	14.8%	0.0%	3.7%	10.9%	4.3%	33.8%	33.3%	11.3%	14.7%
Belgrave	38.1%	27.5%	47.7%	25.2%	29.1%	48.5%	37.0%	36.3%	8.7%	33.1%
Benjamin Weir	79.0%	75.8%	58.9%	68.9%	74.4%	54.2%	41.1%	42.7%	54.0%	61.0%
Brodie	19.0%	11.3%	6.3%	23.3%	21.7%	27.3%	15.9%	37.0%	29.6%	21.3%
Buckland	42.7%	43.7%	48.1%	30.1%	24.7%	31.7%	51.3%	44.1%	44.0%	40.0%
Caesar Hawkins		-	-	-	-	-	-	25.6%	22.7%	24.1%
Cardiothoracic Intensive Care (CTICU)	100.0%	33.3%	0.0%	0.0%	0.0%	0.0%	46.6%	0.0%	0%	20.0%
Caroline	42.6%	41.5%	36.0%	48.0%	58.5%	50.4%	49.5%	40.8%	46.1%	45.9%
Cavell	10.0%	26.9%	37.7%	39.6%	33.7%	33.3%	100.0%	48.6%	22.1%	39.1%
CCU	75.0%	86.7%	72.7%	76.5%	83.3%	60.0%	19.2%	100.0%	65.4%	71.0%
Champneys					10.9%	16.9%	19.2%	27.5%	46.4%	24.2%
Cheselden	11.0%	32.1%	41.2%	23.3%	23.8%	43.8%	57.1%	21.6%	21.0%	30.6%
Dalby	31.6%	0.0%	12.9%	45.2%	9.4%	35.3%	53.7%	18.9%	7.7%	23.9%
Florence Nightingale	53.4%	58.9%	89.6%	76.4%	61.8%	44.7%	28.6%	49.1%	41.3%	56.0%
GICU					0.0%	0.0%	28.6%	77.8%	100.0%	41.3%
Gray	5.9%	13.2%	14.6%	11.4%	12.4%	0.6%	15.3%	13.0%	42.3%	14.3%
Gunning	43.9%	40.5%	39.7%	31.3%	11.0%	45.7%	47.4%	45.1%	40.3%	38.3%
Gwynne Holford	100.0%	30.8%	66.7%	27.8%	92.3%	54.5%	88.9%	66.7%	52.6%	64.5%
Heberden	18.2%	19.4%	50.0%	38.6%	15.8%	4.4%	70.0%	37.0%	4.2%	28.6%
Holdsworth	19.2%	17.1%	30.4%	23.8%	5.0%	32.7%	25.4%	33.3%	8.3%	21.7%
Keate	3.9%	25.5%	23.1%	4.6%	43.9%	31.3%	20.8%	25.8%	16.8%	21.7%
Kent	10.5%	17.6%	27.3%	0.0%	22.2%	15.8%	33.9%	17.5%	31.3%	19.6%
Marnham	20.4%	28.2%	25.0%	1.7%	31.3%	23.1%	39.3%	39.5%	23.4%	25.8%
Mary Seacole	34.4%	88.0%	84.4%	34.0%	3.3%	18.4%	48.1%	77.8%	63.8%	50.2%
McEntee	9.3%	22.2%	31.8%	47.4%	18.6%	37.5%	8.0%	47.0%	52.2%	30.4%
McKissock	28.2%	5.1%	19.8%	36.8%	20.2%	23.8%	25.6%	22.4%	7.6%	21.0%
Neuro Intensive Care	0.0%	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	33.3%	0%	25.9%
Richmond	12.7%	12.3%	3.4%	26.2%	49.8%	44.8%	41.1%	42.4%	30.1%	29.2%
Rodney Smith	33.3%	37.7%	6.3%	0.0%	44.6%	31.7%	15.8%	44.4%	24.1%	26.4%
Ruth Myles	44.8%	53.3%	100.0%	84.0%	46.2%	58.3%	20.0%	20.0%	36.8%	51.5%
Trevor Howell	12.8%	50.0%	57.4%	48.5%	43.0%	49.2%	32.9%	48.6%	49.2%	43.5%
Vernon	18.1%	41.2%	28.9%	9.8%	7.8%	38.0%	30.8%	19.8%	4.7%	22.1%
William Drummond	31.0%	27.6%	31.6%	21.8%	27.6%	17.1%	22.5%	13.5%	24.2%	24.1%
Wolfson	90.9%	76.9%	58.3%	53.3%	56.3%	37.5%	54.5%	62.5%	12.5%	55.9%
	April	May	June	July	August	September	October	November	December	Average
A&E	13.6%	9.6%	7.3%	7.7%	7.0%	6.8%	6.5%	11.4%	10.5%	8.4%
Inpatients	26.2%	31.4%	31.2%	28.9%	31.7%	32.3%	33.9%	33.2%	30.7%	31.1%
Combined	17.6%	17.0%	14.9%	14.5%	15.2%	15.0%	15.6%	19.2%	17.7%	16.3%

b) Complaints



	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
Complaints	111	124	85	112	96	119	92	88	101	109	83	73	94	87	50	98	78	78	70	73	67	61	72	62	89	69	47	68	72	81	85	88	77	75	97	85	107	106	83
Average (12mth)	108	108	108	108	108	108	86	86	86	86	86	86	86	86	86	86	86	86	69	69	69	69	69	69	69	69	69	69	69	69	89	89	89	89	89	89	89	89	89
LCL	79	79	79	79	79	79	56	56	56	56	56	56	56	56	56	56	56	56	49	49	49	49	49	49	49	49	49	49	49	49	66	66	66	66	66	66	66	66	66
UCL	137	137	137	137	137	137	116	116	116	116	116	116	116	116	116	116	116	116	90	90	90	90	90	90	90	90	90	90	90	90	112	112	112	112	112	112	112	112	112





COMMENTARY

This report provides an overview of how the trust has managed complaints received in quarter 3 of 2012/2013 including analysis of the data to provide trends and themes with actions planned. This report also provides information on responding to complaints within specified time frames for quarter 3 so far (October and November 2013). More detailed reports go to a variety of other groups and committees

Total numbers of complaints received

There were 296 complaints received in quarter 3 of 2013/2014 a significant increase of 17% on the previous quarter with 254. This is the highest number of complaints received in a single quarter since 2010/2011. The chart on the previous page shows a breakdown by month. As usual, fewer complaints were received in December due to the festive period and public holidays.

There was a significant increase in complaints being received for the Medicine and Cardiovascular division with particularly high numbers of complaints being received for Accident and Emergency, Cardiovascular, Oncology and Diabetes and Endocrinology

Complaints in Cardiovascular

Themes include waiting times for appointments and cancellations and care and information about care given to patients. The directorate has started to analyse the themes and trends of the complaints with a view to identifying training needs, process issues and any other concerns. This will be reported to the February directorate meeting.

There is an improvement project underway to improve the scheduling of cardiology patients. This includes weekly reviews of the waiting lists, improving the processes with the booking office to improve their communication and scheduling patients as soon as is possible and improving our capacity to deliver the activity. This will take a few months to deliver but hopefully some of the quick wins (including improving communications with patients) will start to improve this for patients.

Part of this improvement project is also focussed around reducing cancellations. Additional bed capacity is coming on stream in January which will assist in the reduction of cancellations. Trolleys are being introduced for some procedures, which will mitigate against the space being used inappropriately for other patients.

COMMENTARY

Complaints in Oncology

There is a working group that has been established since August 2012 to address the multifaceted issues. The divisional chair has now joined this group to help progress elements including space/environment, pharmacy resource, timely prescribing of chemotherapy, preparation and delivery of chemotherapy, and scheduling.

Workforce – the day unit has recruited a new Senior Sister to lead the unit and all nursing posts have been fully recruited to. A new post of lead nurse for chemotherapy has been created and recruited into and a start date is awaited. Three pathway coordinators have been employed since November last year and the Assistant General manager will work with them to develop their roles to affect the pathway positively.

A new footprint for Oncology day unit is being sought with capital projects. This would ensure forward planning to address growth in activity, demand and capacity. A paper has been drafted for EMT.

COMMENTARY

There was a further increase in complaints being received for the Surgery and Neurosciences with a very high number of complaints being received in General Surgery and Trauma and Orthopaedics.

Complaints in General Surgery

Complaints are across a number of subjects including clinical treatment, medical care and communication.

- Work is being undertaken to reduce the backlog of patients waiting more than 18 weeks.
- There have been capacity issues in the breast service, with particular strain on Wednesday clinics. The clinic templates have recently been changed and stricter management of clinics will be introduced to help alleviate pressure.
- Bariatric patients have complex needs and there has been a rise in the level of pre-operative cancellations due to medical reasons which has resulted in complaints.
- Not being seen regularly on the wards by senior clinicians is an issue that is being addressed – there are plans in colorectal to change rotas to free up more time for consultants to do ward rounds.

Complaints in Trauma and Orthopaedics

As a result of complaints received about communication with patients a new central T&O query number is being introduced which will be available from Monday to Friday between 9am and 5pm so patients can get in touch more easily. This team will then liaise with the relevant staff e.g. the patient pathway co-ordinators, secretaries, nurses or consultant teams to ensure patients always have someone to contact. This should be operational by February.

Regarding outpatients:

- Capacity – two new trauma surgeons commence employment in March to help with capacity, with two others planned for the future (within the next 6 months). Physiotherapy provision in clinic is also being increased.
- Bookings – the T&O service is taking over the booking of all T&O new appointments from March. It is hoped this will improve patient experience and ensure capacity is managed efficiently. This will also hopefully ensure patients see the correct consultant the first time of asking.

COMMENTARY
Complaints about the Children and Women's division reduced slightly overall but there a high number of complaints were received for Corporate Outpatient Services and Obstetrics & Gynaecology.

Complaints in Outpatients
As a result of complaints made about waiting times in the outpatient department the following actions have been identified:

- The process of tracking medical records has been redesigned and staff given extra training to track more accurately.
- A designated member of staff in the Corporate Outpatient ENT team handles all SOS referrals and liaises with the ENT service manager on a daily basis to address delays in triage and insufficient capacity.

As a result of complaints about communication a Patient Access Centre will be introduced by the end of quarter 4 to provide a single point of contact for patients who wish to schedule or cancel and appointment.

Complaints in Obstetrics and Gynaecology
As a result of complaints received about communication in gyanecology the following actions have been taken to improve:

- Improved basic signage and information given to patients.
- Doctors and consultants made aware of the importance of clearly communicating clinical actions to patients.
- Staff reminded of the importance of 'living' the trust values in their approach to patients.
- HCA chaperones met with to stress the importance of their role in ensuring patients are clear and comfortable during appointments.

In obstetrics, the complaints received were across a number of subjects and the actions taken include:

- The breast feeding team have been met with to understand the importance of support for patients' overnight- a clear action plan has been developed and relevant individual staff have been met with.
- The care group lead led discussion with staff to go through the management of caesarean section delivery.

Complaints in Community Services
There was an increase in complaints about Older People and Neurorehabilitation with two complaints being received about nursing on Dalby Ward. These were unrelated in terms of themes and staff.

COMMENTARY

Complaints about Estates and Facilities
Complaints increased by five when compared to the last quarter. Transport complaints remain consistent with the main themes being timing and booking of transport and entitlement to escorts. The transport and travel manager and general manager are reviewing each of these. The additional complaints were across a number of areas including smoking at St James' Wing entrance and cost of car parking. As a result of a complaint about signage to pre-operative assessment outpatient services have been asked to send an information sheet detailing directions and where to park. There were complaints made about catering and cleaning over the weekend and this has been rectified with the MITIE and ward teams through education and retraining on the ward processes.

Reopened complaints where complaints were closed in quarters 1 and 2 of 2013/2014
494 complaints were closed between April and September 2013 and of these 8% have subsequently been re-opened. This is the an improvement when compared to 2012/2013 and 2011/2012 when 9% and 11% of complaints were reopened. The only outlier is Acute Medicine and a piece of work will be undertaken to find out why this might be.

Complaints referred to the Parliamentary & Health Service Ombudsman
Five requests for documentation have been received from the Ombudsman's office compared to 17 at the same point last year. These requests pertain to complaints from five different areas: Urology, Cardiology, General Intensive Care, Accident & Emergency and Acute Medicine.

For two of these cases final reports have been now received from the Ombudsman. As previously reported The Ombudsman partly upheld one complaint. The trust accepted the recommendations made in the report and these have been reported to the Quality and Risk Committee. In the second report received the Ombudsman did not uphold any aspect of the complaint and felt that the trust's response was reasonable.

For one of these cases a draft report has been received from the Ombudsman and comments provided. Once the final report is received it will be summarised for QRC.

Complaints performance quarter 3 so far

	Total number of complaints received	Number within 25 working days	% within 25 working days	% within 25 working days or agreed timescales
Children's, Women's, Diagnostics & Therapeutics	44	28	64%	(4) 73%
Medicine and Cardiovascular	65	45	69%	(10) 85%
Surgery, Neuro and Cancer	72	48	67%	(6) 75%
Community Services	15	8	53%	(4) 80%
Corporate Directorates	17	15	88%	(1) 94%
Totals:	213	144	68%	(25) 79%

***Late response with no extension was not Estates and Facilities. Estates and Facilities green in both columns**

COMMENTARY

For complaints received in quarter 3 so far where the target date for completion has been reached (complaints received in October and November 2013), 68% were responded to within 25 working days. This is a decline in performance when compared to quarter 2 with 70%. Accident & Emergency, Urology, Renal, Haematology & Oncology and Offender Healthcare performed particularly poorly.

For the same period, 79% of complaints are planned to be responded to within 25 working days or agreed timescales. The final percentage may change depending on whether all of the agreed extensions are eventually met. This was a decline in performance when compared to quarter 2 with 83%.

Complaints & Improvements department complaint severity rating report summary

As previously reported, in quarter 1 of 2013/2014 a new process for rating formal complaints (red, amber and green) was introduced with actions for escalation and timescales depending on severity. This is vital to ensure that urgent/critical matters are dealt with by relevant senior staff and in a timely way. If there is a concern about a possible SI or safeguarding issue these are discussed with the Risk department and the relevant Safeguarding Lead. This system is an internal flag to ensure critical issues or incidents are escalated and investigated appropriately. It is not an attempt to determine how serious the complainant thinks/feels it is. A summary of ratings for quarter 3 is presented below. A more detailed report will be presented at the February Quality and Risk Committee and Patient Experience Committee.

Quarter 3

- In quarter 3 a total of **three complaints** were rated as **Red/Severe**.

The reasons for the red ratings included:

- Serious incident, A&E Doctor not registered to work at St George's. (SI)
- Death noted, complex case, quicker action needed to be taken in terms of rapid referrals and treatment. Communication issues also noted. Patient and family felt neglected.
- Death noted, patient was vulnerable. Case is still ongoing therefore status may change.

- In quarter 3 a total of **81 complaints** were categorised as **Amber/Moderate**.

The most common reasons for the amber ratings were an adverse injury or outcome, the complaint being complex and/or involving 2/4 services and contact with the media being suggested.

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- In quarter 3 a total of **214 complaints** were categorised as **Green/Minor**.

c) CQC Maternity Survey

Significant improvements since the 2012 survey *Lower scores are better*

		013	**Picker Ave**
Feeding: Did not re		1%	40%
Comment: this tells		*ement which is an*	
increase from 42%		*ncouraging to see a*	
shift in the trend.			
***Action:** Continue w*		*3 which includes*	
antenatal education		*breastfeeding support*	
midwife on the post			
Postnatal Care: Mo		1%	39%
about own recovery			
Comment: 59% of w			
***Action:** There is a p*		*nt information*	
underway. All revis		*mmonly spoken*	
languages to ensur			
Postnatal Care: Not given enough information about emotional changes that may be experienced	60%	49%	42%
Comment: 51% of women did receive enough information.			
***Action:** Patient information updated as above. The team will also audit women's opinions as to what information would be useful.*			

Maternity Services across England have been subject to mandatory Experience Surveys from the care quality commission.

The results from this survey are displayed in a variety of ways.

In summary the results show whilst there is still room for improvement, the work which has been underway for a number of years is becoming embedded.

This work will continue with particular areas identified as requiring more focus shown overleaf.

Results significantly better than the 'Picker average' *Lower scores are better*

	2013	**Picker Average**
Antenatal Care: Not given a choice of where to have baby	9%	16%
The majority of women (81%) were given a choice of birth place.		
Postnatal Care at Home: Did not discuss postnatal checkups of mother's health	2%	8%
Almost all women had mother's health discussed at home.		

* NB picker average – all trusts (the majority) who use Picker to undertake this survey.

Historical Comparisons: Problem scores with continued Improvements in performance

*Comment - **No** areas were identified as worse than the 2012 results. This shows small, but notable improvement in **ALL** outcomes.*

Antenatal Care	**2010**	**2012**	**2013**
Not spoken to in a way that could be understood	20%	14%	13%
Not involved enough in decisions about care	32%	25%	23%
Labour and Birth			
Did not have skin to skin contact with baby after birth	14%	10%	7%
Not spoken to in a way that could be understood	17%	18%	13%
Not treated with respect and dignity	20%	16%	15%
Did not have confidence and trust in staff	30%	31%	25%
Postnatal Hospital Care			
Length of hospital stay too long or too short	33%	27%	26%
Not given information or explanations needed	57%	53%	44%
Feeding your Baby			
Did not receive support and encouragement	65%	58%	41%
Care at home after the birth			
Saw a midwife too often/seldom	40%	37%	32%
Mother not given enough information about own recovery	66%	60%	41%
Not given enough information about emotional changes that may be experienced	61%	60%	49%

Areas for improvement focus and action

	2010	**2012**	**2013**	**Picker Average**
Antenatal Care: Did not see same midwife most of the time	80%	77%	82%	66%
***Action**: Continue with work started earlier this year on implementing a named midwife for all women. Audit results have shown some improvement from the survey results.*				
Labour and Birth: Not involved enough in decisions about care	34%	26%	27%	26%
***Action:** Share results with staff at unit meeting.*				
Postnatal Hospital Care: Not treated with kindness and understanding	44%	31%	36%	36%

Action: *Share results with staff at unit meetings. Implement 'Listening to Learn' using patient stories to improve care and communication in obstetrics and midwifery. We have submitted a proposal for innovative workshop which focuses specifically on patient experience and staff attitude, and were awarded funding for this from the South London Membership Council.*				
Care at home after the birth: Not given enough information or advice about contraception.	11%	5%	9%	9%
Action*: Information included on new DVD to be given to all mothers on discharge from hospital.*				

d) Dementia Care

Improving Dementia Care

The Dementia policy and strategy is co-ordinated by the Dementia Clinical Lead (Dr Jeremy Isaacs) and the Dementia Strategy Group which meets 6 times a year and has multi-professional and multi-agency representation. The clinical lead reports to the Patient Experience Committee.

What has been achieved:

A clinical guideline for the management of dementia and delirium has been agreed and regular staff training in dementia is in place. Routine screening for dementia in older inpatients and elective surgery patients has also been established. In 2012 the trust launched the Butterfly Scheme (an identification and response scheme for patients with dementia) which is becoming embedded in the clinical areas.

The Wandsworth Dementia Passport (predominantly used by care home residents as a record of their needs) has been launched and a questionnaire for carers of inpatients with dementia is helping the trust to gain insight of their experience of our care (see result charts).

Finally an active joint research programme (with SGUL) in dementia which includes clinical trials is underway.

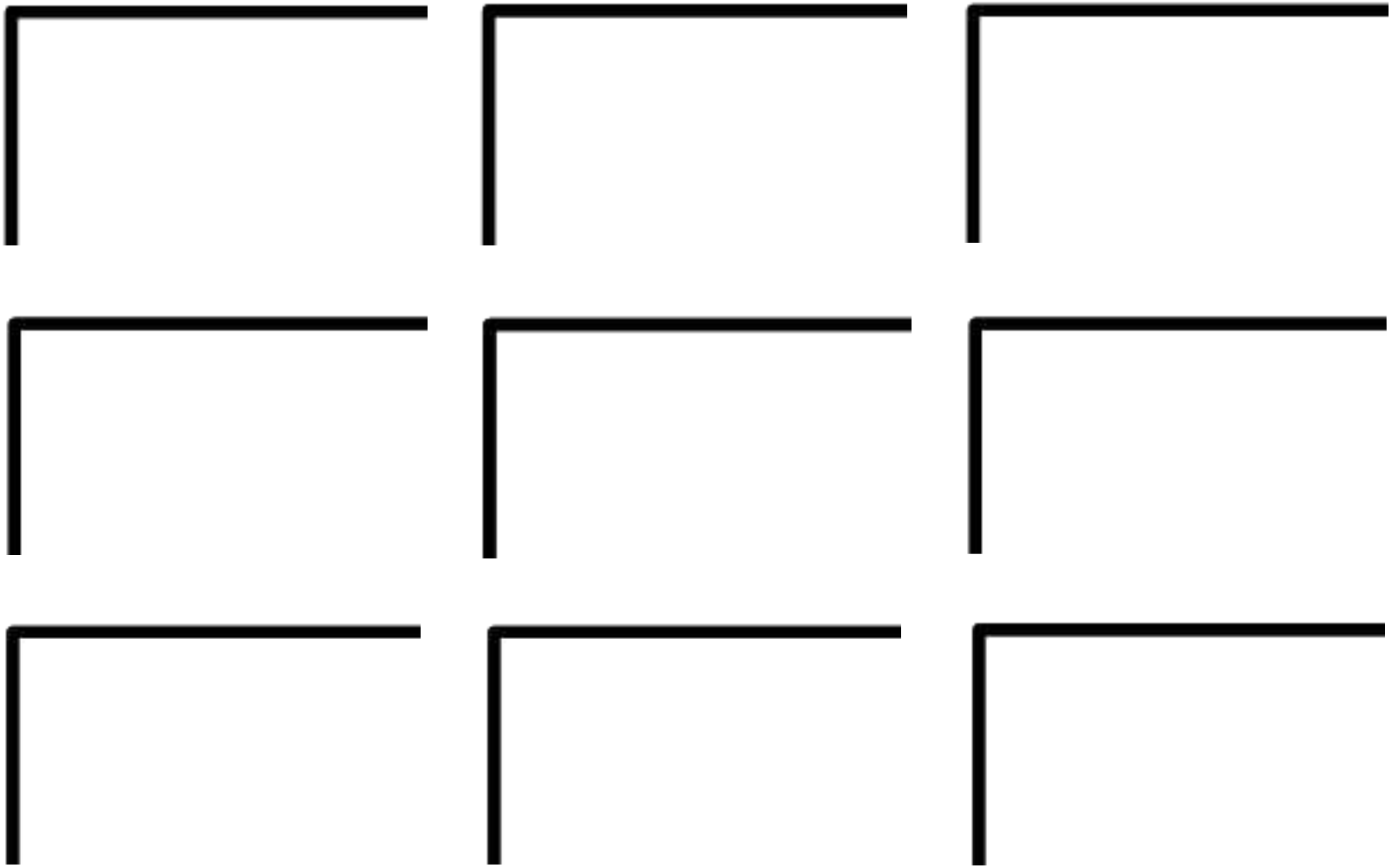
What are we working on now?

The trust is working hard to achieve the measures and milestones with the national dementia CQUIN. This includes delivering ward based dementia training to 40% of staff in acute Medical wards and increasing compliance with dementia screening requirements. Additional nursing capacity has been agreed to support this although it is acknowledged that this is an interim arrangement put in place until a more sustainable solution can be found.

Future Plans

The trust needs to improve its collection, analysis, reporting and dissemination of dementia-related metrics as recommended by the national audit e.g. re-admissions, delayed discharges, falls etc. It is currently not possible to easily disaggregate the data to focus on these indicators for those with a confirmed diagnosis of dementia. However, it is possible within IClip and needs is included within the IT programme.

The dementia lead is also developing a case to support the establishment of a 'dementia and delirium' team to support the trust wide strategy (and national imperative) to improve the care and experience of people with dementia. It is recognised that such teams can have a possible impact in managing the patients journey and decreasing their length of stay. Nationally it has been calculated that a reduction of one day length of stay would correlate to a saving of £11m.
The trust also needs to work proactively in partnership with other health and social care agencies and other local stakeholders to better integrate dementia care in the community.



III Clinical Audit + Effectiveness (Patient Outcomes)

a) National audits

National Clinical Audit and Patient Outcome Programme 2013/14	
National confidential enquiry into patient outcome and death (NCEPOD)	National emergency laparotomy audit
National joint registry	Bowel cancer
Head & neck oncology	Lung cancer
Oesophago-gastric cancer	Myocardial ischaemia national audit project
Cardiac rhythm management	Congenital heart disease
Coronary angioplasty	National adult cardiac surgery audit
National heart failure audit	National vascular registry
National diabetes audit (Adult), includes National diabetes inpatient audit (NADIA)	National paediatric diabetes audit
Inflammatory bowel disease	National COPD audit
Rheumatoid & early inflammatory arthritis	Falls and fragility fractures audit programme
Sentinel stroke national audit programme	Child health clinical outcome review programme
Epilepsy 12 audit	Maternal, newborn and infant clinical outcome review programme (MBRRACE-UK)
Neonatal intensive and special care	Paediatric intensive care (PICANet)
Additional audits in the Quality Account 2013/14	
ICNARC Casemix programme	Emergency use of oxygen
National audit of seizures in hospital	Paracetamol overdose (care provided in EDs)
Severe sepsis & septic shock	Severe trauma (TARN)
National comparative audit of blood transfusion programme	National cardiac arrest audit
Paediatric bronchiectasis	Renal registry
Patient reported outcome measures in elective surgery (PROMS) programme	Moderate or severe asthma in children (care provided in EDs)
Paediatric asthma	

National clinical audits fall into three categories. Firstly there are a range of audits included in the National clinical audit and patient outcome programme (NCAPOP). Participation in these audits is mandated in the NHS standard contract and must be declared in the Quality Account. For 2013/14 there are 26 NCAPOP projects which are relevant to St George's. Some of these, for example NCEPOD, include a number of individual projects. To date we have not participated fully in the adult diabetes audit, but a project group has been convened to facilitate our involvement and will be meeting again in February to review the database required for this audit.

Secondly, there are a number of audits that are not covered in the standard contract, but for which we have to report our participation in the Quality Account. For 2013/14 there are 13 projects which are relevant to the trust. The blood transfusion programme and PROMS cover multiple projects.

The final group of audits are not mandatory and do not feature on the Quality Account, but Trust's are encouraged by professional associations to participate. A decision on whether or not to take part must be made at a local level.

In addition to reporting our participation and level of submissions in the Quality Account, we are required to provide information on the number of audits, both national and local, that have been reported to the Board and any actions taken as a result.

NCAPOP and Quality Account lists for 2014/15 were published at the end of December and are being used to develop our audit programme. The lists feature some new audits, and some projects are coming to and end.
Overall there are at least 8 additional projects relevant to the Trust.

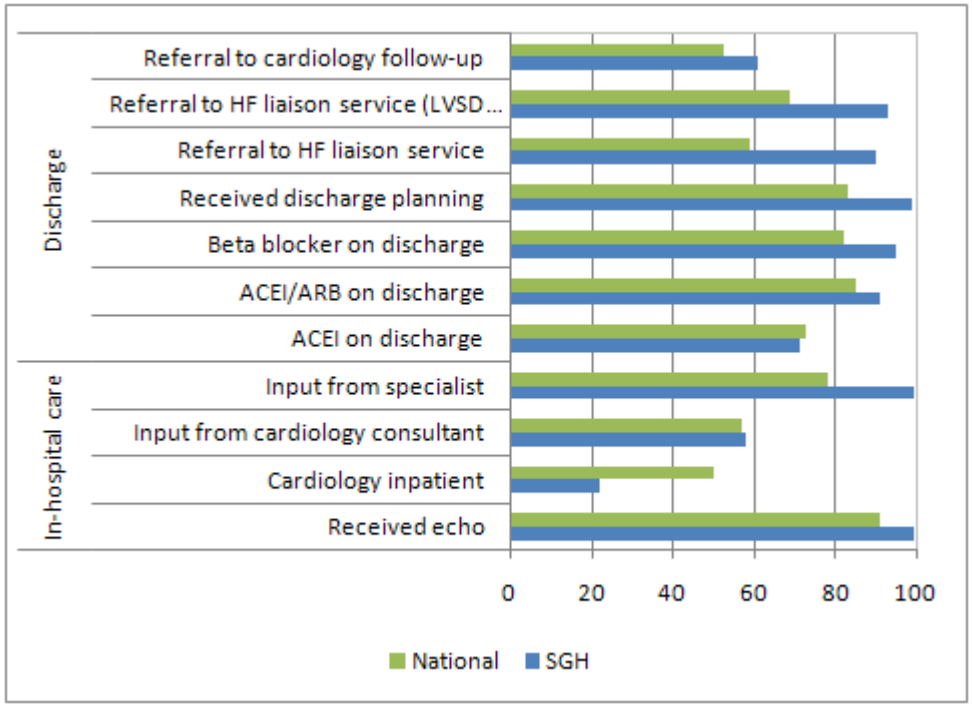
National Paediatric Diabetes Audit (NPDA) Report 2012

St. George's service participation rate has improved on the previous year with 145 cases submitted. Unfortunately NPDA reported data quality issues and for HbA1c criteria excluded 96% of cases submitted; consequently the standard of care provided by our service is not represented. The Trust was unaware of this issue prior to publication of the report.

NICE recommends HbA1c levels are under 7.5 as an indicator that diabetes is well managed. There is significant national variance of 2.9% – 33.8% compliance. Nationally just 6% of cases are reported to comply with all eight key care processes.

The paediatric diabetes service has taken action on data quality issues through acquisition of the Twinkle database and clinical leadership to ensure data is accurate and complete. The service are confident that the next NPDA report will present a fair representation of the care provided by St George's.

National heart failure audit 2013

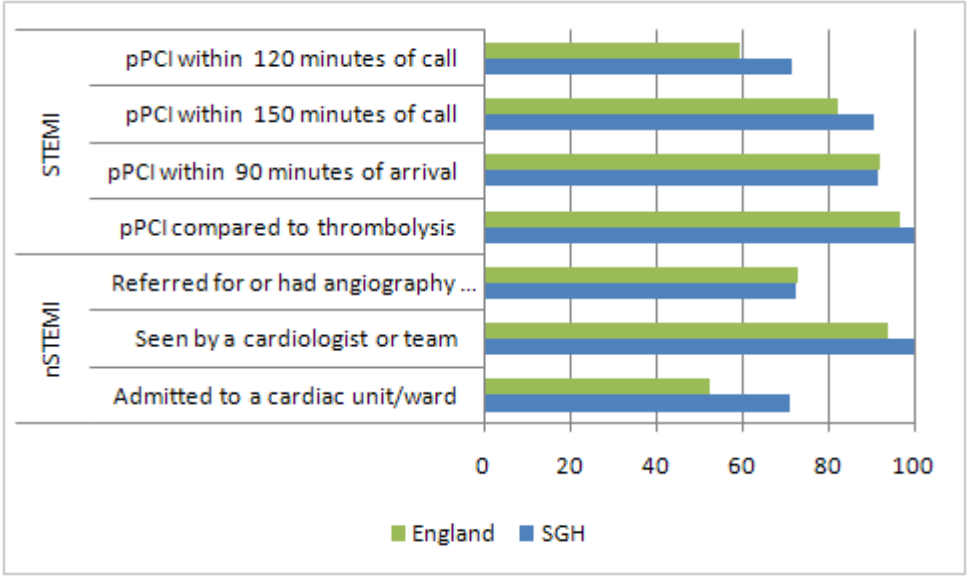


St George's participation in this audit is categorised as 'partial' as only 55.1% of possible cases were submitted. Whilst this is lower than the England average of 61% it does demonstrate improvement on the previous year where our participation was 43.3%. The heart failure team are keen to increase participation further for 2013/14, but are awaiting data form Information Services. This has been escalated to the Divisional Director of Operations.

Our results show that for the majority of key measures of clinical practice we compare favourably to the national average, particularly in regard to referral to heart failure (HF) liaison services. It is also positive that 99.6% of patients receive an Echo, and the same percentage receive specialist input. The percentage of our inpatients treated on a cardiology unit has increased from 13.1% last year to 22.1%, but remains considerably below the national average of 50%.

There is currently a service improvement project underway to design an integrated care pathway for heart failure patients; these results along with the recommendations contained within the national report will further inform that work. In addition there is a service wide project underway aimed at improving participation across all cardiology national clinical audits.

Myocardial ischaemia nation audit project (MINAP) 2013



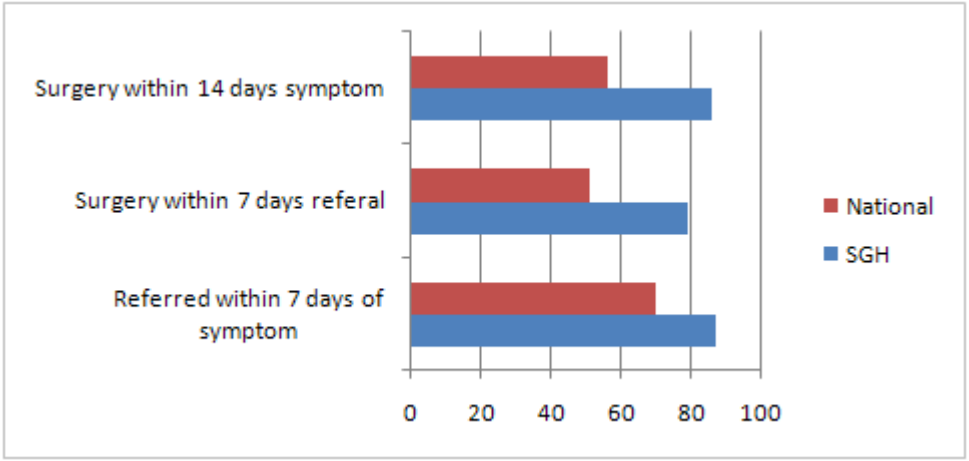
Key results demonstrate that patients treated at St George's receive high quality care, in line with, or better than the average for England.

The proportion of patients with ST elevation myocardial infarction (STEMI) that receive primary PCI (pPCI) compared to thrombolysis remains at 99.8%, above the average for England of 96.6%. Patients receive timely treatment, with 71.4% undergoing PCI within 2 hours of the call for help; in England the average is 59.6%.

Patients that experience a non-STEMI (nSTEMI) also receive a high level of care. The percentage of patients that have or are referred for angiography, including those planned after discharge, is 75.9; comparable to the national average of 75.6%.

national cardiology audit submissions to ensure that more efficient and robust data collection processes can be introduced across the specialty.

Carotid endarterectomy



Key indicators for carotid endarterectomy are based on the NICE Acute stroke and TIA guideline and the national stroke strategy. Nationally an improving picture for carotid surgery is demonstrated, and results for St George's remain above the national average.

The current NICE guideline recommends 2 weeks as the target time from symptom to operation to minimise the chance of a high risk patient with TIA developing a stroke. At St George's 86% of cases met this standard; above the national rate of 56%. Nationally the median time from symptom onset to surgery was 13 days (interquartile range 7-28); at St George's the median delay was 7 days (5,12).

Patients may experience various complications following carotid endarterectomy. As with all other NHS Trusts, St George's has a risk adjusted rate of death/stroke within 30 days that fell within the expected range (0.8%).

National Lung Cancer Audit 2013

With 141 cases submitted for 2012 our participation is categorised as 'amber'. Comparison to national targets and results show that for the majority of key results St George's is performing well and has improved in seven of ten key areas.

One area where we perform less well is for patients receiving CT before bronchoscopy and this has been identified as an area for improvement. Our compliance has decreased from 77.4% to 73.9%, below both the national score of 89.6% and the target of 95%. It is recommended that data collection processes are evaluated to ensure all relevant information is submitted to the audit, and that the patient pathway and clinician practices are reviewed.

Some positive changes relating to clinical nurse specialists are demonstrated by the audit with 79.4% of patients now being seen by a CNS. This is an increase compared to 2012 when the figure was 69.4% and is very close to target of 80%. However, further improvement is required to bring us in line with the national average of 88.7%. A review of the specialist nurse service, ensuring all nursing posts are staffed and clear referral pathways exist would support further improvement.

Best practice is for the CNS to be present at diagnosis, with a national target of 80%. Our precise position is unclear as the quality of data submitted around CNS input is poor, but it suggests that our compliance is significantly below the target. Data collection processes should be reviewed to ensure we have reliable information, which will ensure an accurate representation of our performance and maximise the benefit of participating in this mandatory national audit.

A management meeting is being held on 14th January to discuss the positive aspects of the report, alongside the areas where improvement is required.

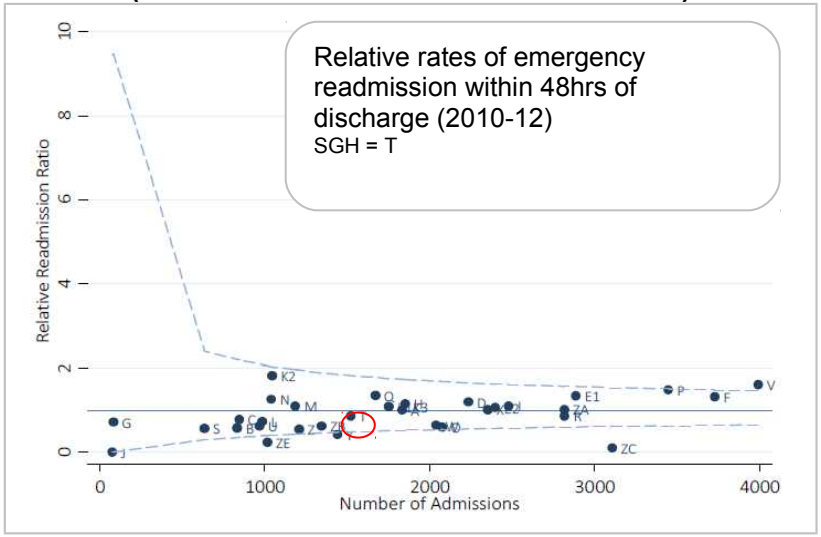
Aortic Aneurysm (AAA)

Trust	Total AAAs	Open	EVAR	Unadjusted Mortality	Risk Adjusted Mortality	Status
LONDON						
Barking, Havering and Redbridge University Hospitals NHS Trust	82	10	72	2.4%	2.9%	▲
Barts Health NHS Trust	129	39	90	3.1%	3.4%	▲
Guy's and St Thomas' NHS Foundation Trust	320	32	288	0.9%	1.2%	▲
Imperial College Healthcare NHS Trust	160	31	129	0.6%	0.8%	▲
King's College Hospital NHS Foundation Trust	174	10	164	0.6%	1.0%	▲
North West London Hospitals NHS Trust	81	11	70	2.5%	3.6%	▲
Royal Free London NHS Foundation Trust	152	10	142	2.0%	4.0%	▲
St George's Healthcare NHS Trust	373	9	364	1.3%	2.2%	▲

St George's is rated positively for case ascertainment; we submitted 373 cases between January 2010 and December 2012, which represents all relevant cases. King's is also rated as 'green', with all other London trusts rated amber or red.

This report focuses on mortality after elective infra-renal abdominal aortic aneurysm surgery. St George's risk adjusted mortality was within the expected range, along with all other London Trusts. A summary of this report has been circulated to the service. No immediate action is required as the results show a positive picture of performance and outcomes.
It is an aim of the National Vascular Registry that future reports describe a wider set of outcomes for patients and health professionals. To this end a new dataset was introduced in December 2013, designed to improve the range of information captured and to reflect changes in clinical practice.

PICANet (Paediatric intensive care audit network) 2013



St George's paediatric ICU (PICU) submits 100 per cent of their activity to this audit. The number of patients admitted has risen from 486 in 2011 to 520 in 2012. The PIM2r mortality index shows the mortality risk for St George's patients remains about the same; approximately 80% of PICU admissions have a <5% mortality risk, and about 5% of cases have a risk of mortality of 15% or greater. The trust's mortality rates remain below the median when compared to the national data set. Just over thirty percent of admissions are planned and readmissions within 24 hours continue to be below the median.

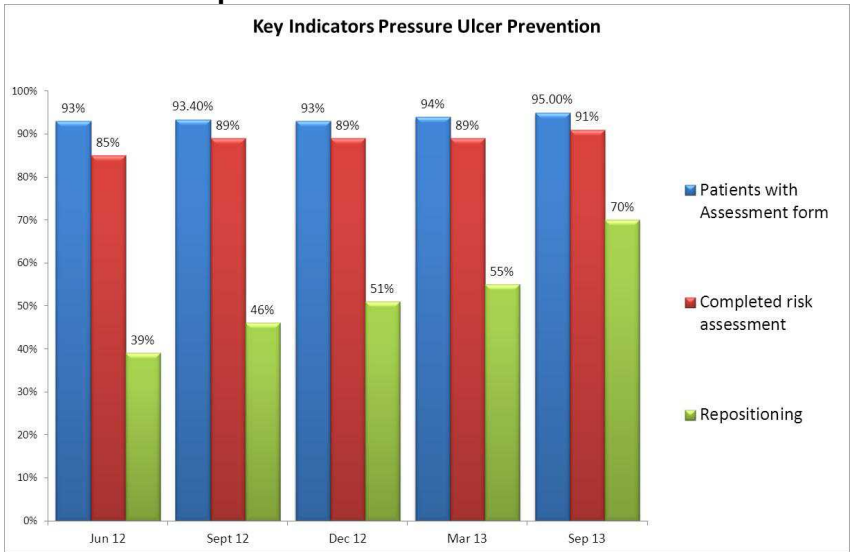
Reported data completeness for outcome at 30 days shows continued improvement. In 2010 no data were reported, in 2011 14.5% of outcomes were reported and for this report, covering 2012 activity, 68% were submitted.

The report shows medical and nurse levels for 2012 to be below Paediatric Intensive Care Society (PIC) standards, although audit of staffing levels measured against patient dependencies at specific times were within PIC safe staffing levels. The PICU clinical director and matron are aware of the issues in the PICANet report and business cases are in progress to meet PIC staffing compliance.

b) Local audits

OVERVIEW: The Clinical Audit Half Day was held on 6th December 2013 and was attended by over 140 people. Sixty-eight posters were displayed and there were six oral presentations showcasing the audit work undertaken to improve the care we provide. This year's guest speaker, Professor Ben Bridgewater (Director of Outcomes Publication, HQIP) delivered a very informative and thought provoking talk on "Publishing named clinician outcomes and experience: why and how?". Copies of this presentation and the online handbook are available on the new clinical audit intranet page.

Pressure ulcer prevention audit

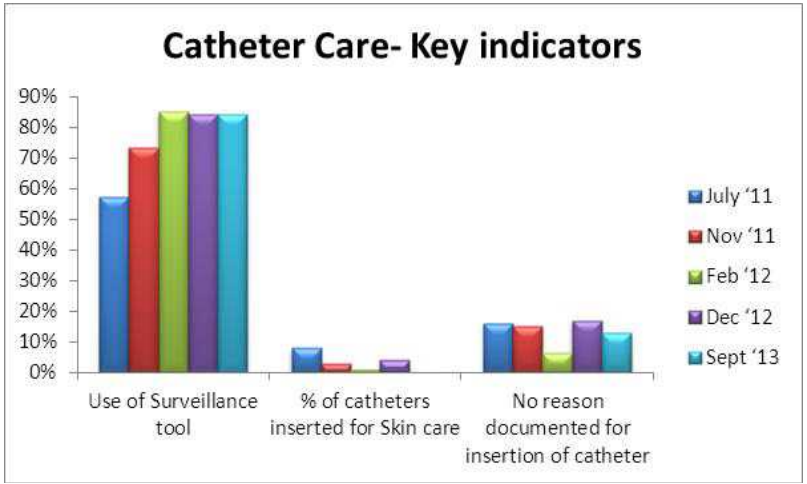


Regular audits have shown that use of the Pressure Ulcer Prevention (PUP) documentation is now embedded into the admission procedure and continued training of staff has improved recognition of pressure ulcers and proactive management.

This audit showed that 95% of cases had a PUP tool in the nursing documentation folder and 91% had completed assessments, although fewer (77%) had the assessments within the last 4 days. Documentation of care of patients with, or at risk of developing, a pressure ulcer had improved: 92% had an appropriate mattress on the bed and repositioning was documented in 70%.

Staff training in PUP is on-going and the audit results have been used to target areas where improvement is most needed and to highlight some general points that were noted in the audit process. In particular staff will be reminded that the use of a pressure relieving mattress of any sort never replaces the need to turn patients and even if a patient is "self-positioning" documentation is needed to provide assurance that the patient is changing position regularly. Also some areas were assiduous in documenting reassessment of pressure ulcer risk on a weekly basis. This needs to be done every 4 days as per the Trust policy.

Catheter care audit

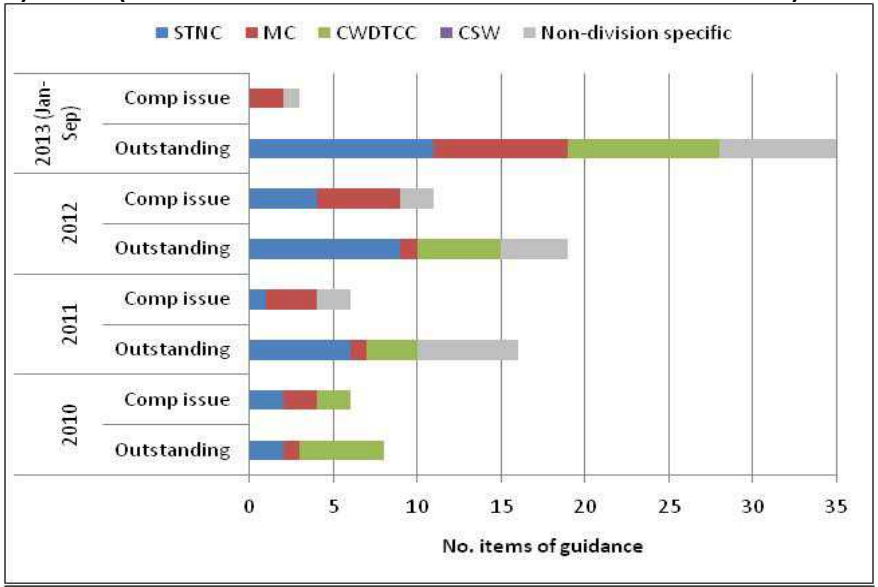


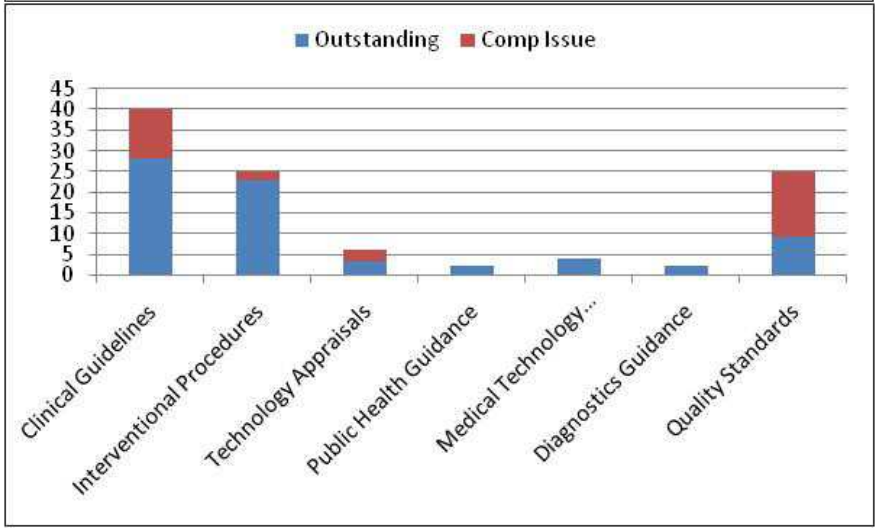
Between 2011 and 2013, catheter care was a CQUIN requirement for the Trust and audits were carried out quarterly. Since then audits have continued on a regular basis to check that progress has been maintained. All patients with a urinary catheter should have a surveillance tool to ensure that catheters are inserted appropriately, and for valid reasons and that they are monitored regularly and reassessed on a regular basis.

The results of this audit showed that the use of the surveillance tool has remained steady at 84% since December 2012, however documentation of the reasons for using a catheter has greatly improved and use of catheters for skin care only has been eliminated.

However 13% of patients have no reason documented and, we also need to improve completion of the insertion checklist. To facilitate improvements performance by ward has been provided so poor performing areas can be addressed and we are investigating the possibility of including the insertion checklist into some care pathways.

c) NICE (National institute for health and care excellence) Guidance





There are 104 items of guidance outstanding for 2010 (n=14), 2011 (n=22), 2012 (n=30) and the first three quarters of 2013 (n=38). Of this number, we are awaiting initial responses for 76 items and require updated information on compliance for 28.

A detailed paper outlining the backlog and divisional approaches was presented to the Executive Management Team in November and was discussed at the Clinical Effectiveness and Audit committee. Since that time the Clinical Audit (CA) team have taken the following action to help address the backlog:

- Sent a list of items of NICE guidance which have compliance issues to Divisional Governance Managers (DGMs). This will be updated every 6 months and support provided if necessary.
- Continue to send a list of new and outstanding items of NICE guidance to DGMs every month for follow up to ascertain compliance. CA have offered support to tackle the current backlog.
- Taken the lead on following up all the non division specific items of NICE guidance which have compliance issues or responses outstanding.

Engagement continues to be variable across divisions. The date of most recent response from each division is given below and provides an indication of the level of engagement.

M+C Division:	20/12/2013
CSW Division:	19/12/2013
CWDTCC Division:	14/11/2013
STNC Division:	03/10/2013

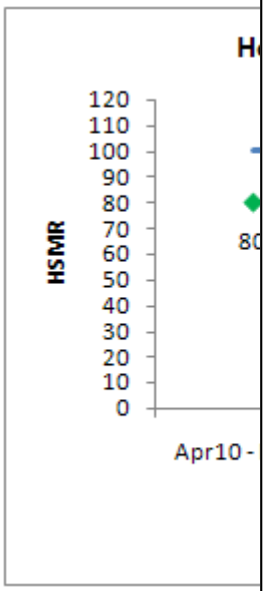
The most significant backlog continues to be observed in the Surgery, Theatres, Neuroscience and Cancer division (28 outstanding responses, 7 compliance issues). There are currently no outstanding items in the Community Services Division.

The CA team will report trends for each division in the future so that progress can be tracked.

d) Mortality

SHMI publication	
Jan 12	J
Apr 12	C
Jul 12	J
Oct 12	A
Jan 13	J
Apr 13	C
Jul 13	J
Oct 13	A

Source: HSCIC



The most recently available data shows that St George's mortality remains significantly better than expected. The trust's SHMI, for the period April 2012 to March 2013, is 0.81; categorised as 'lower than expected'. We continue to monitor and scrutinise the hospital standardised mortality ratio (HSMR) data provided by Dr Foster Intelligence, and our overall mortality remains significantly better than expected. This position was published in the Dr Foster Hospital Guide 2013, issued on 6th December.

Monthly analysis of HSMR by diagnosis and procedure group is ongoing. Investigation of the signal suggesting significantly higher than expected mortality in the PTCA (coronary angioplasty) diagnosis group is in progress. Terms of reference for the investigation and current service provision were discussed and agreed at the Executive Management Team (09/12/13). The mortality monitoring group continues to provide oversight and to scrutinise the most recently available data, which shows that for the most recent 3 months (August to October 2013) deaths at St George's are in line with expected numbers (11 and 11.6 respectively).The service is fully engaged with the review and have made significant progress in reviewing the 72 cases identified. Full casenotes are being reviewed, alongside catheter lab records. To date issues with individual operators have not been identified. It is anticipated that the casenote reviews will be completed in January and the report will be finalised in February.

The mortality monitoring group has prepared a summary of its activity in 2013 which is to be shared with consultants across the organisation. This identifies that the group face a challenge in ensuring that all deaths following an elective admission are reviewed fully and in a timely manner. The review system will be updated in 2014 to address this and will involve a systematic and robust escalation process. In addition the group will be actively promoting the proportionate review of all deaths, central to which will be the record of death form.