St George's Healthcare NHS
NHS Trust

# Quality Report
# Trust Board
# March 2014

## I PATIENT SAFETY

### a) Infection Control

**i) Clostridium difficile**

Financial Year 2013/2014 National Threshold: 45 cases
Total so far this year: 28

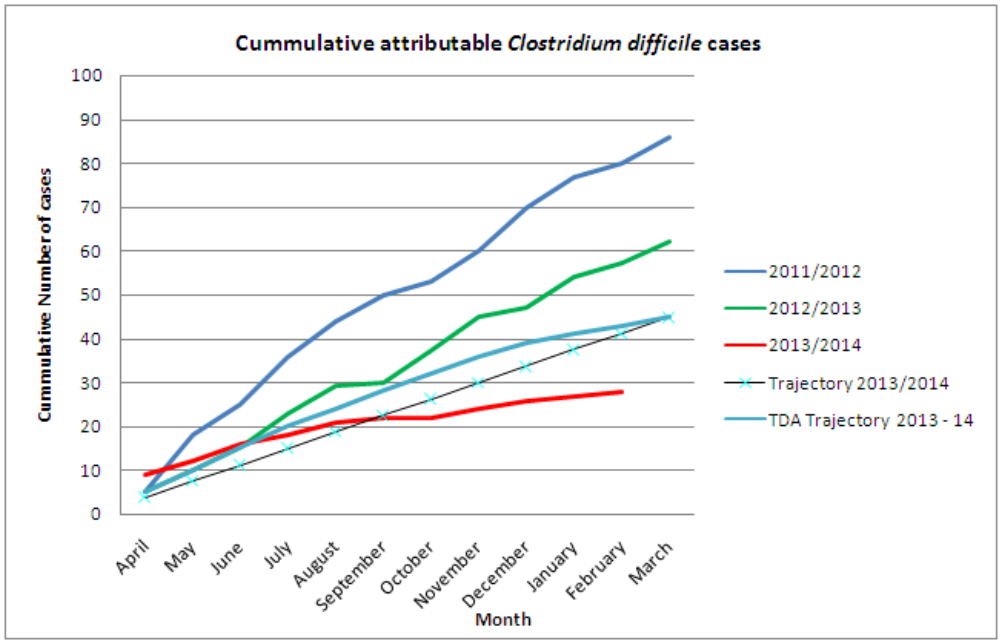
| | |
|---|---|
| April: | 9 cases. |
| May: | 3 cases. |
| June: | 4 cases |
| July: | 2 cases |
| August: | 3 cases |
| September: | 1 case |
| October: | 0 cases |
| November | 2 cases |
| December | 2 cases |
| January | 1 case |
| February | 1 case |
| March | 0 to date |

We remain well below trajectory for the year. The 2014-2015 threshold has recently been set and has been further reduced by approximately 10% to 40 cases for the year.

**ii) MRSA:**

**MRSA:**
The threshold for this is year zero avoidable cases. So far this year there have been 10 cases, six ascribed to SGH.

A synopsis of the root cause analysis on the cases ascribed to St Georges Healthcare Trust is included on the following page.



| Date of specimen | Patient | Ward | Date of Admission | Admission Screen Completed | MRSA Positive on Admission | Decolonisation | Patient Factors | Intravenous Line | Other Factors | Root Cause | Avoidable? |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 31/05/13 | 1 | A | 23/05/13 | Yes | No – but was previously | Yes – given as previous MRSA | Admitted for elective TURP. Massive intropeative MI. Required angiogram and stenting. | Documentation of insertion and some surveillance. Not complete. No evidence of line infection. | Didn't receive appropriate MRSA prophylactic antibiotics as admission screen negative. However timing unlikely to be intra-operative infection. | Not clear – possibly related to coronary angiogram and stenting | Not clear |
| 28/06/13 | 2 | B | 28/06/13 (discharged home 25/06/13) | Yes – but not on previous admission | Yes, but not on previous admission. | No | 87 year old ESKD on haemodialysis, Type II DM PVD and CCF. General decline over past 12 months. Diabetic foot ulcers Very poor prognosis. Decision to palliative care only prior to results | Tesio line. Unable to form a fistula and previous failed brachio-axillary graft. | | Tesio line infection with terminal underlying condition. Blood cultures should not have been taken. | Tesio line infection possibly. General deteriorati on. |
| 12/08/13 | 3 | C | 17/07/13 | Yes | Yes | Yes | 78 yr old Extensive leg ulcers Sacral Wounds Above knee amputation Atrial Fibrillation Hypertension Above knee amputation 9/8/13 Spent months in a Jamaican Hospital | PICC line inserted. | | Extensive surgical wounds, pressure sores and venous ulcers. | No |
| 18/11/13 | 4 | D | 13/11/13 to hospital. 18/11/13 to HDU | Yes | Yes | Yes | Major Trauma – pelvic and femoral fractures. Extensive orthopaedic surgery – long duration and large wounds. | Multiple attempts at line insertion by ambulance staff at the site. | Didn't receive appropriate prophylaxis for MRSA as MRSA status not known at the time. | Not clear – either intropeative infection or cannala site in a patient with polytrauma and already MRSA colonised. | No |
| 14/01/14 | 5 | E | 27/11/13 | Yes | Yes | Inconsistent application. Not always given | Learning difficulties Malnutrition secondary to difficulty in swallowing. Large hiatus hernia NJ fed. | PICC line inserted. For feeding. Patient constantly pulling at line. Line noted to be blocked with erythema and swelling. Not removed by team. Documentation inconsistent | Decisions around palliation had been made and were dependent on outcome of interventions. Decision to withdraw had not been made. | Line infection in complex patient. | Yes |
| 30/01/14 | 6 | F | 30/01/14 prev 24-29/14 | Yes but not on 24th | Yes on 29th | No – as no screening | Diffuse large B cell lymphoma Admitted for chemo as not coping at home. | tender, red and swollen right wrist and pus at site of previous cannulae. | | Line infection – line care and documentation. | Yes |

**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, i.e Post 48 hours.

| | | TOTALS | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MSSA | Post – 48 hours | 13 | 1 | 2 | 5 | 1 | 4 | 2 | 0 | 4 | 1 | 2 | 4 |
| | Pre – 48 hours | 17 | 2 | 3 | 5 | 5 | 2 | 0 | 5 | 7 | 5 | 5 | 6 |

**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.

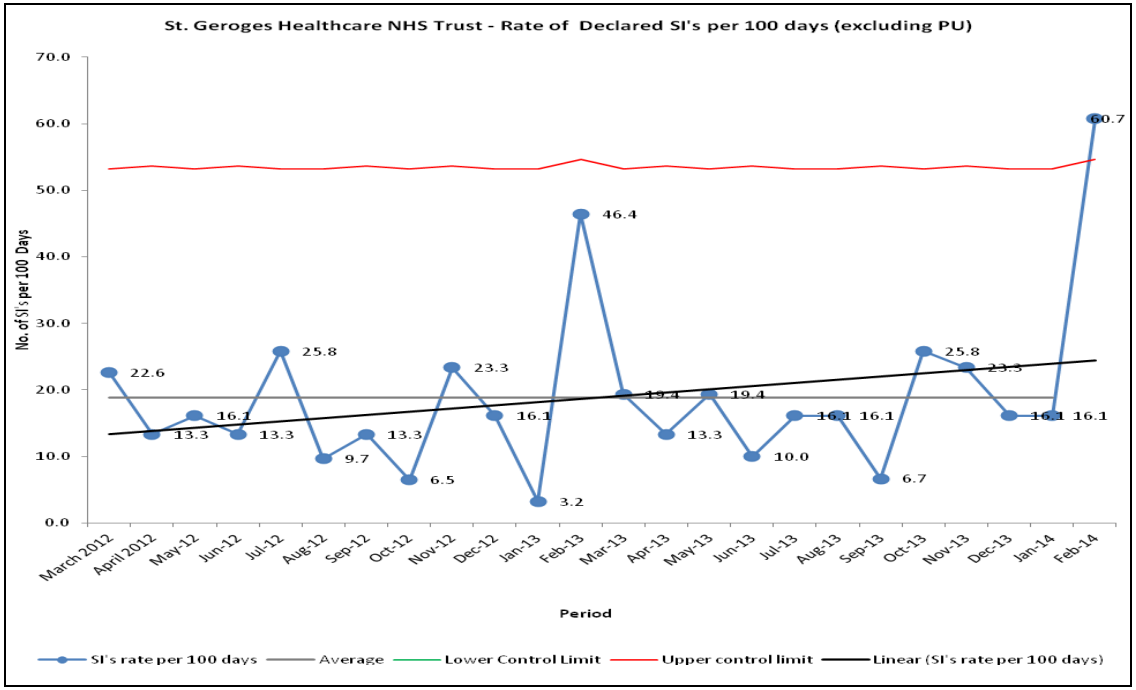
| | | TOTALS | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| E. coli | Post – 48 hours | 33 | 4 | 8 | 6 | 8 | 7 | 3 | 5 | 1 | 4 | 4 | 11 |
| | Pre – 48 hours | 67 | 12 | 10 | 17 | 15 | 13 | 16 | 11 | 21 | 12 | 14 | 16 |

**Carbapenemase Producing Enterobacteriaceae**

The trust recently received guidance from Public Health England on the management of carbapenemase producing Enterobacteriaceae (CPE) which are resistant to almost all antibiotics. This guidance was followed up by a Patient Safety Alert this month requiring the trust to have processes in place by June 2014. While these organisms do represent a serious threat, the guidelines as they stand are extremely challenging to implement and may expose us to a greater risk of increasing other infections e.g. *C. difficile*. Other NHS organisations have expressed concern over the practicality of implementing these guidelines. While representations are being made to national authorities, the trust plans to expand its screening programme for these organisms. An action plan is in the process of being drawn up.

## b) Patient Safety

### Table 1



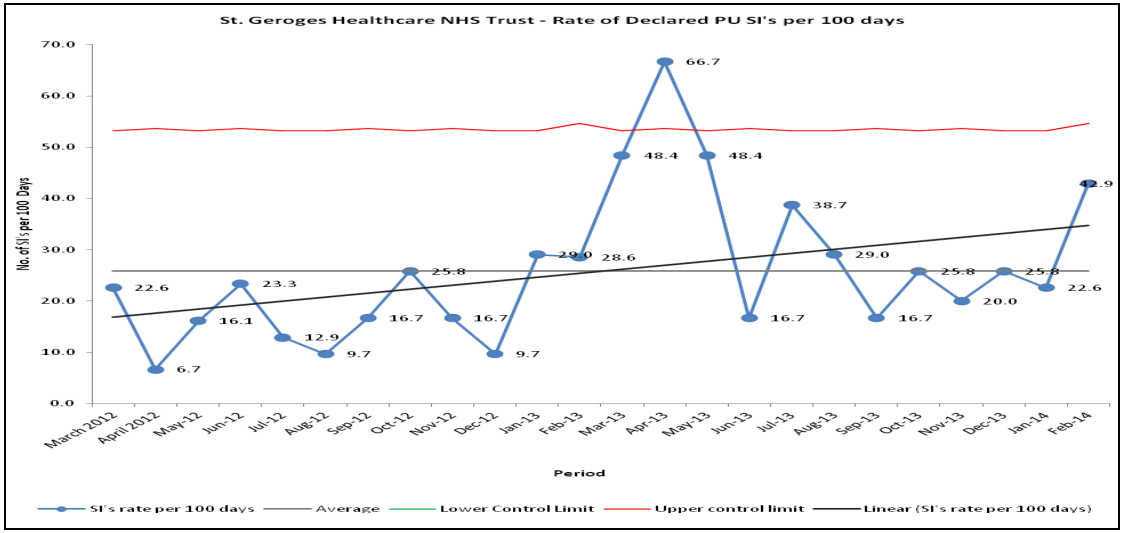

One of the key indicators of patient safety is the serious incident (SI) trends data which the attached graphs show.

The graph in table 1 shows the trend for general serious incidents per 100 days. Last year there was a peak in February and this year there has been a high peak as well.
Looking at the 17 general Sis declared in February there is no particular cluster within divisions. The types of Sis were also examined and this included:

- 2 misplaced NG tube SIs
- 2 breach in LAS handover – mandatory reportable SIs, no harm to patient's involved.
- 2 HCAIs (MRSA, C. diff)
- 3 maternity related SIs
- 2 related to delayed action on test results. The Medical Director is leading work with Care Groups to strengthen systems in this area.

Other categories were scattered. The rise in SIs is a cause for concern and the trend should be carefully watched to ensure any preventable causes are acted on swiftly.

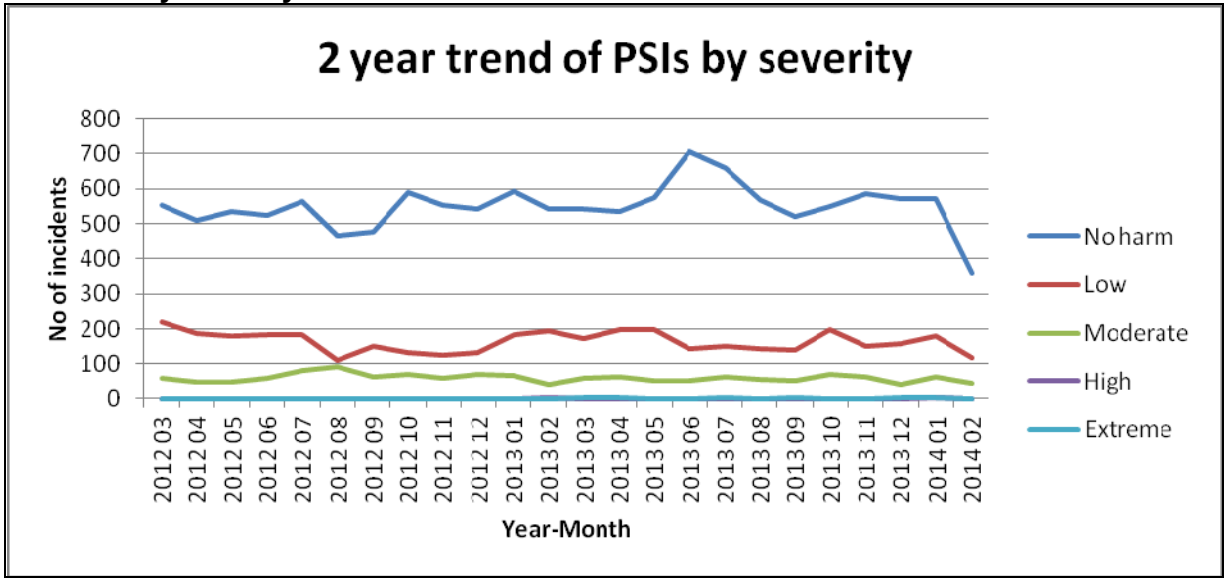
### Table 2




The trend of pressure ulcers showed a peak in April 2013 but this appears to be falling back to previous levels.
February showed a slightly higher rate than the previous 6 months but is still within the control limits of this graph. Although the upward trend continues this has slowed since May last year. A careful watch needs to be kept on this issue to be sure that the reducing trend continues and that the Feb 14 rise is reversed in following months.

The serious incident reports have begun to record whether a pressure ulcer was considered to be avoidable 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 number of no harm incidents has reduced in february indicating that staff are not reporting incidents that could provide valuable learning before they cause harm. This could have been caused by the fact that the organisation was extrememely busy during this period. Again, this trend needs to be watched.

**Communication**

Communication has been a regular theme in serious incidents and complaints. As such a range of initiatives are on-going within the trust which are summarised below. The initiatives are grouped under the following headings and will be discussed in turn:

1. Clinical Systems for Communication
2. Patient Stories
3. Staff Training and Awareness
4. Patient Communication

**1. Clinical Systems for Communication**

Serious Incidents have shown a consistent theme regarding communication and handover since thematic reviews have been carried out. The following initiatives address clinical systems and processes:

**Handover Policy.** A handover policy was launched early in 2013 with an active roll out in clinical areas that included a baseline assessment of current practice. This identified that without exception all the wards visited had identified processes for both nursing and medical handovers although this process varied. Some key issues were identified for further work:

- Handover for transferring patients particularly was not carried out as robustly as needed. This has led to several supporting workstreams:
  - Developing telephone handover systems. The AMU has been working in conjunction with one of the acute medical wards to pilot a telephone handover system that covers essential elements
  - Acute medicine has reviewed weekend cover to ensure that their input continues at the weekend when patients are transferred to on-going wards until a receiving consultant is available to take handover

- Identifying the whereabouts of outlying patients was identified as an issue. The service improvement team is continuing to work on this issue through the set up of more reliable bed board information linking to the electronic system.
- Medical handover from the Hospital at Night teams to day teams had been set up led by one of the AMU consultants.

**Daily Ward Rounds**. Medical staff also identified the daily ward rounds as an important handover process. Over the last year the trust has begun to implement systems to ensure daily consultant review in all acute services. Care groups have been required to demonstrate that they have systems to ensure this happens through traditional ward rounds or board rounds. Feedback to the medical director and executive management team has demonstrated that this is now getting better but there is still more work to do.

**Follow up of Investigations**. Concern was raised specifically regarding the importance of ensuring the follow up of investigations because of serious incidents where failure to do this had led to patient harm. As a result very specific requirements were added to the handover policy and the medical director is in the process of monitoring this with all the care groups to ensure it has been implemented.

**SBAR Communication** The trust has adopted the SBAR (Situation, Background, Assessment and Response) structured approach to escalation of deteriorating patients. This approach was developed by the military and has been adapted to be used worldwide in healthcare systems. The observation chart now has the SBAR format on the reverse side and the approach is regularly monitored. (The next audit report will be available in April)

The Trust heard this month that a bid for a Darzi fellow has been successful and recruitment will begin shortly. The focus of the work is to further develop systems for safe discharge as the emphasis on earlier discharge can create risks regarding follow on care. Communication will be a key element of the work

**2. Patient Stories**

The development of patient story DVDs has resulted in some stories that relate to a whole patient pathway and issues where communication falls down between trusts and services.

- One story relates to a child who visited A&E and then required admission via an SOS clinic. A range of issues were addressed as a result of this story which included access to phone messages, speed of giving IV antibiotics and communication with patients.
- Another DVD which has just been completed deals with the pathway between the hospital and the community and has stimulated a proposal to carry out a project on safe discharge.
- A range of other DVDs and case studies are being used within services to stimulate improvements to systems and processes including issues of communication.
-

**3. Staff Training and Awareness**

General staff engagement has been a key initiative over the last year through the Listening into Action (LiA) programme. This enables staff to flag up systems and processes that do not support their work and has led to a range of improvements throughout the trust and includes one work stream that focuses particularly on communication.

Additionally a range of awareness raising systems and processes are now in place to help staff to be aware of safety issues including communication:

- A monthly Safety Forum outlines the learning from serious incidents and related issues
- A regular newsletter is widely circulated within the trust
- The pharmacy team send out alerts regarding drug safety issues
- A patient safety App is currently under development thanks to HESL funding. It will be trialled within paediatric medicine and it is then hoped to roll out more widely within the trust
- A student nurse safety forum has been set up with two main aims: firstly to develop safety awareness in the nurses of tomorrow and secondly to take feedback from them on the unsafe practices they may observe on our wards. Feedback is compiled into a newsletter that is distributed to senior sisters, charge nurses and matrons. Plans are in place to run a similar forum for medical students.

A range of specific courses are available that train consultants and junior doctors in good communication. Multidisciplinary simulation training is also carried out to embed the learning and feedback from incidents and emphasises the need for good communication in stressful situations. One example is that the maternity team carry out simulation training regarding post partum haemorrhage.

A programme of Duty of Candour training is carried out with staff who may need to have discussions with patients when an incident of harm occurs. This focuses on practical communication skills and has proved popular with staff who attend. Plans are in place to further develop the training and support for staff who are involved in these conversations.

In addition to the systems above, a series of interns have been seconded to work with the Head of Patient Safety. They are part of a Kings College masters programme in risk communication and have carried out evaluations of patient safety communication within the trust and how it is perceived by clinical staff. This is helping to ensure that patient safety communication is based upon the needs of staff within the trust. There is also a more general review of the internal communication pathway that is currently underway.

**4. Patient Communication**

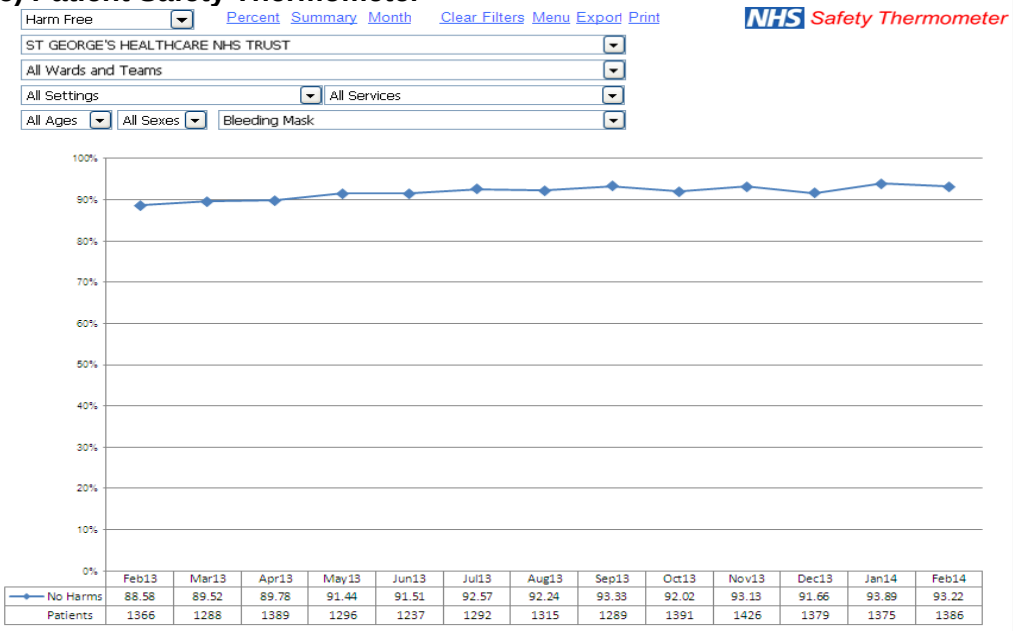
A variety of initiatives are in place to support good communication with patients and the following are just a few recent examples:

- Development of a patient safety leaflet "Keeping you safe during your stay in hospital". This aims to give patients the information they need to keep themselves safe and covers a number of safety initiatives.
- Laminated Placemats for in-patients with information about ward routines and staff. This is receiving very positive feedback.
- The new nursing uniforms has been implemented to ensure that senior staff are clearly visible on the wards

**Conclusion**

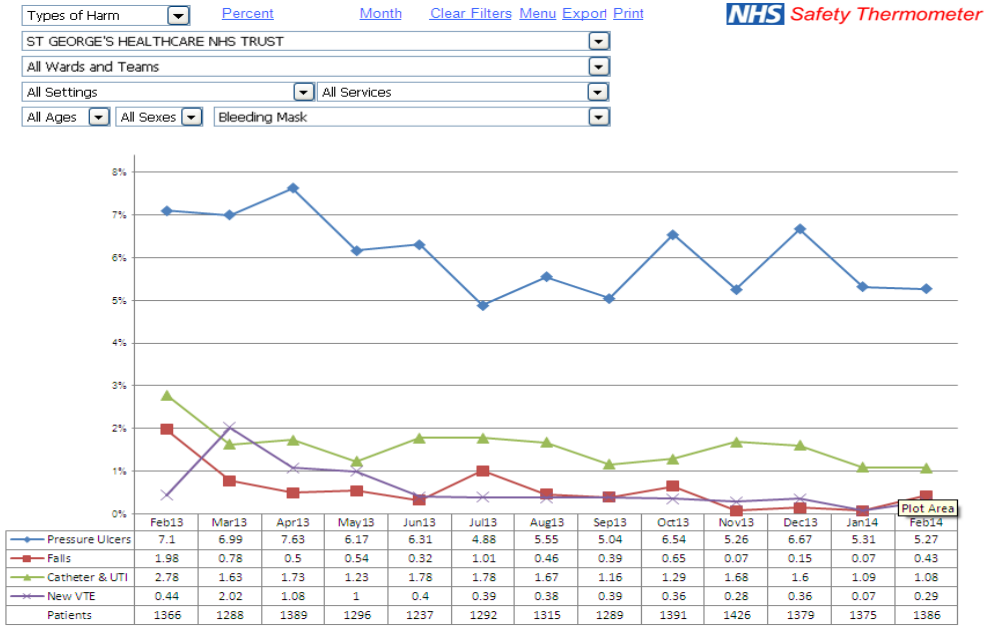
The initiatives above demonstrate the trust commitment to improving systems for communication. Having established systems, the focus now needs to be embedding and ensuring that they are working as envisaged.

## c) Patient Safety Thermometer




| | Feb13 | Mar13 | Apr13 | May13 | Jun13 | Jul13 | Aug13 | Sep13 | Oct13 | Nov13 | Dec13 | Jan14 | Feb14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No Harms | 88.58 | 89.52 | 89.78 | 91.44 | 91.51 | 92.57 | 92.24 | 93.33 | 92.02 | 93.13 | 91.66 | 93.89 | 93.22 |
| Patients | 1366 | 1288 | 1389 | 1296 | 1237 | 1292 | 1315 | 1289 | 1391 | 1426 | 1379 | 1375 | 1386 |

Graph showing all harm free care within the trust




| | Feb13 | Mar13 | Apr13 | May13 | Jun13 | Jul13 | Aug13 | Sep13 | Oct13 | Nov13 | Dec13 | Jan14 | Feb14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pressure Ulcers | 7.1 | 6.99 | 7.63 | 6.17 | 6.31 | 4.88 | 5.55 | 5.04 | 6.54 | 5.26 | 6.67 | 5.31 | 5.27 |
| Falls | 1.98 | 0.78 | 0.5 | 0.54 | 0.32 | 1.01 | 0.46 | 0.39 | 0.65 | 0.07 | 0.15 | 0.07 | 0.43 |
| Catheter & UTI | 2.78 | 1.63 | 1.73 | 1.23 | 1.78 | 1.78 | 1.67 | 1.16 | 1.29 | 1.68 | 1.6 | 1.09 | 1.08 |
| New VTE | 0.44 | 2.02 | 1.08 | 1 | 0.4 | 0.39 | 0.38 | 0.39 | 0.36 | 0.28 | 0.36 | 0.07 | 0.29 |
| Patients | 1366 | 1288 | 1389 | 1296 | 1237 | 1292 | 1315 | 1289 | 1391 | 1426 | 1379 | 1375 | 1386 |

Graph showing all harms within the trust since February 2013

### 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'. Please note the chart on the bottom includes previously acquired pressure ulcers and falls which did not happen whilst in the trust's care

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.

### Progress to Date

The data submitted by nurses and therapists is verified by the Patient Safety Facilitators which ensures that we only submit robust data. The process highlights any areas that may have an increase in a particular harm and alerts staff to any unexpected harm within their area.

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 as the new guidance states that data collection should not be limited to one group of healthcare professionals. This has worked well and therapists have commented on how it has resulted in a more holistic approach to caring for patients.

### Challenges and Benefits of the Safety Thermometer

Two new STs have been proposed for maternity services and medication safety, both of which are being piloted nationally. It is not yet clear if in maternity this will replace the existing tool which is not appropriate for those patients or for other more specialist areas such as neonates. For medications, the guidance states that nurses at the point of care should collect the data, however our belief is that the majority of the required information would need to be collected by pharmacists and doctors given its complexity. It is suggested that this will take no longer than an additional 10 minutes per patient, which would conservatively take an additional 4 hours on an average ward with the current tool already taking several hours to compete. Discussions will continue with the national team and NHS England (London) about next steps and our concerns about the resource implications and appropriateness of some aspects of data collection.

## d) Pressure Ulcer Prevention and Management

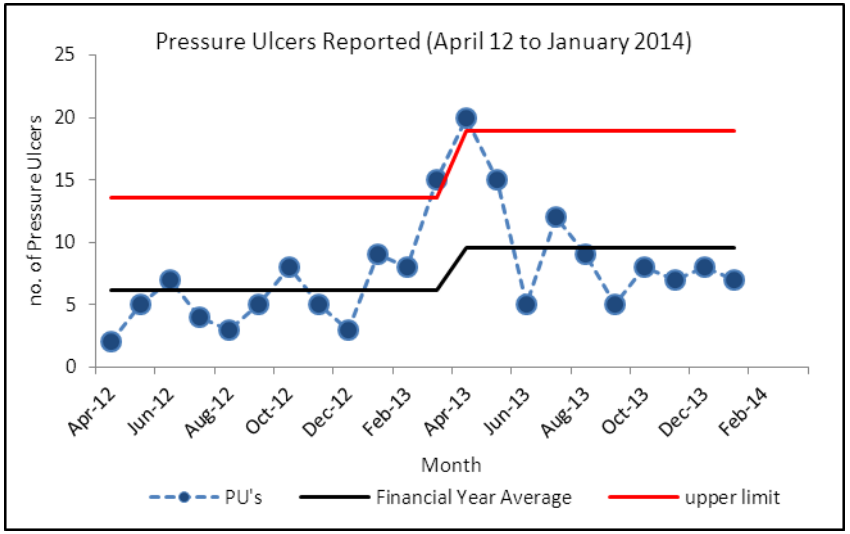



**Table 1 .All declared grade 3 and 4 serious incidents From April 2012 – January 2014**

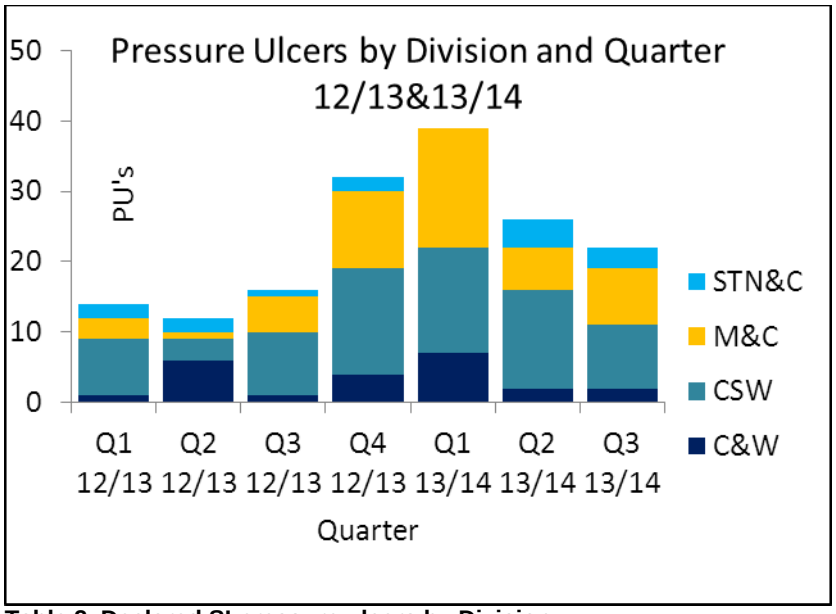



**Table 2. Declared SI pressure ulcers by Division**

**Serious incidents – Grade 3/ 4 pressure ulcers**

Table 1 demonstrates throughout quarter 2 and 3 that there was a slight increase in the number of serious incidents reported during July 2013 which has returned to previous levels in September and has shown a marginal decline throughout quarter 3. In August 2013 a new TVN was appointed who is highly visible and reviews each serious incident as they are reported. There continues to be a drive to promote zero tolerance of avoidable pressure ulcers and between April 2013 – December 2013 there were 89 serious incidents of which 25 were avoidable.

A CQUIN trajectory has been negotiated for 2013/2014 to demonstrate a 10% reduction in avoidable grade 3/ 4 pressure ulcers based on last year's figures of 49. At the end of quarter 3 we are on trajectory (25) to meet the reduction to 44 by the end of March 2014. In January 2014 a second TVN was appointed to the acute team and will enable even greater visibility, increased clinical working and more opportunities for training and education at a local level.
Throughout quarter 2 and 3 the divisions have been working closely to improve performance to reduce the incidence of pressure ulcers. The reduction in 3/ 4 pressure ulcers across the organisation is demonstrated in table 2. Within the divisions there has been increased awareness raised in the Emergency Department to improve compliance with documentation, risk assessment and Datix reporting . The divisions recognise the importance of preventing escalation of grade 2 pressure ulcers and have put in place initiatives to support this strategy including the use of the "Heel Pro" boot and application of preventative dressings.

Training across the trust continues to promote awareness and management of pressure ulcers including grading.
• The pressure ulcer task group continues to meet every 2 weeks to review progress, share innovations across the organisation and plan further initiatives. All serious incidents are reviewed at the pressure ulcer strategy group chaired by the Deputy Chief Nurse.
. • The tissue viability nurses are working regularly in clinical areas to reinforce a firm understanding of pressure ulcers and to advise on interventions promptly .

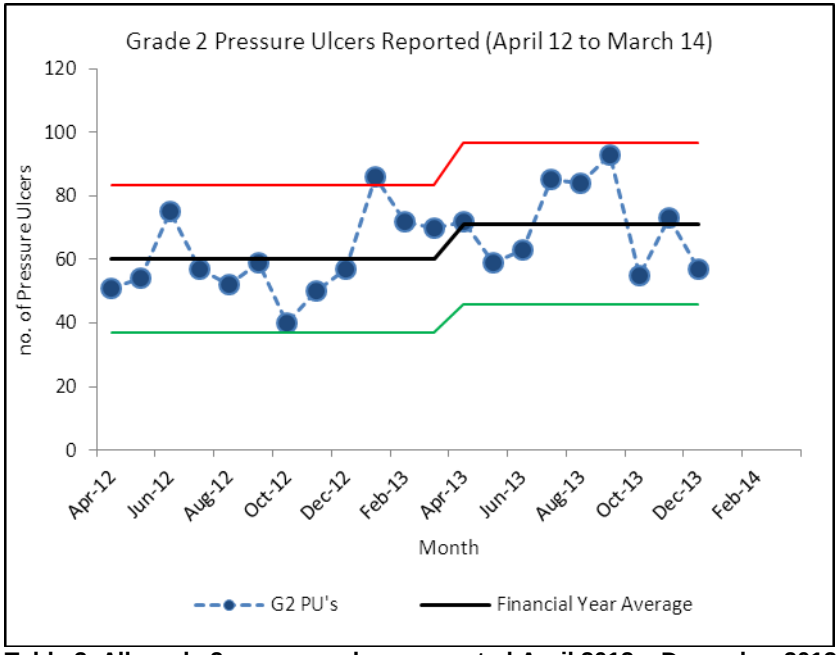



**Table 3. All grade 2 pressure ulcers reported April 2012 – December 2013**

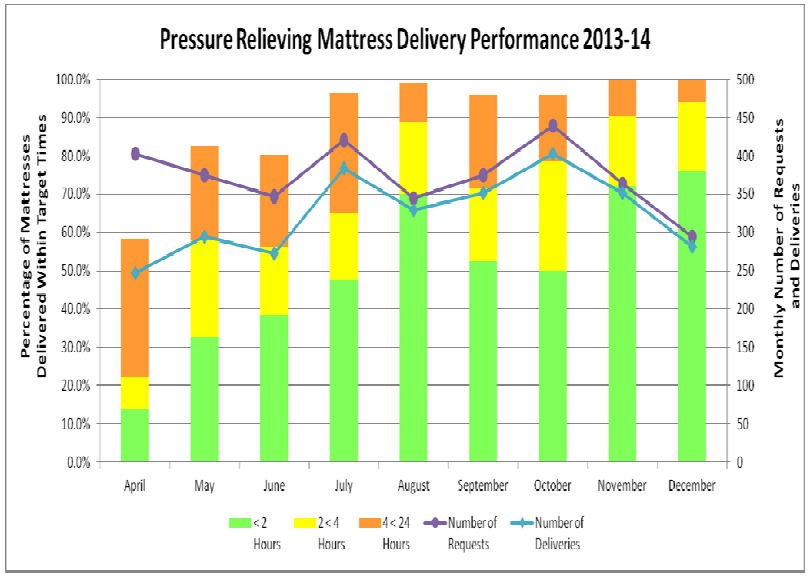



**Table 4 Mattress request and delivery times Q1 -Q3 2013**

## Grade 2 Pressure ulcers

Table 3 demonstrates an overall reduction in grade 2 pressure ulcers during Q2 & 3 as reported on Datix. To ensure the reliability and validity of the grade 2 data, the Tissue Viability Nurses will be reviewing all grade 2 pressure ulcers reported across the organisation throughout 2014. Early recognition and implementation of preventative measures for grade 2 pressure ulcers should prevent further deterioration to grade 3 and 4.

**Equipment**

Table 4 shows the performance in the mattress delivery service for the first 9 months of 2013-14. This clearly shows that the numbers of unfulfilled requests (the difference between the purple and blue lines) have decreased consistently through the year and Q3 is markedly improved from Q1 and Q2. The most positive effect shown is that the percentage of deliveries made within 2 hours has risen from less than 15% to over 70%, with over 90% delivered within 4 hours by the end of Q3. These effects can be attributed to the purchase of new equipment, an additional post, as well as new systems of work and increased dedication and hard work from the team.

**Plans for 2014/2015**

The pressure ulcer task group will continue to drive the prevention of avoidable pressure ulcers by:

- Close monitoring of performance to reduce avoidable pressure ulcers
- Review of all grade 2 pressure ulcers to eliminate inaccurate reporting, using the review process by the TVN's as an opportunity for local training in the clinical area
- Design and development of an e learning package on pressure ulcers for health care assistants and qualified staff
- Audits will continue to be undertaken 6 monthly to monitor compliance with documentation and track improvements or areas for development
- TVN's will work a shift clinically in allocated areas each week alongside clinical staff to educate, advise and offer support
- Close working will continue with external colleagues, via the Pressure Ulcer Forum organised by the Clinical Commissioning Group (CCG)
- Close working will continue with Medical Physics team to ensure mattress provision is maintained at an optimum level and continues to improve. Progress will be reviewed regarding the managed contract for beds and mattresses
- A programme of structured education will be delivered across the organisation at induction, on team days, via simulation and as requested
- The pressure ulcer prevention policy will be reviewed

**e) Medication Safety**

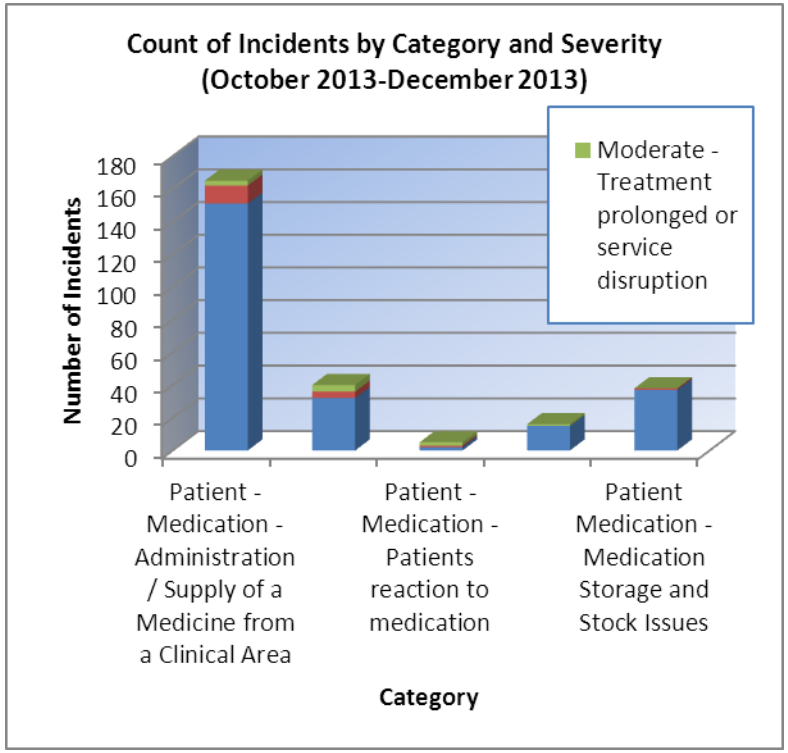
At the last board meeting members asked for more detail on the types of incidents, levels of harm and the type of training offered to staff in relation to medication safety.

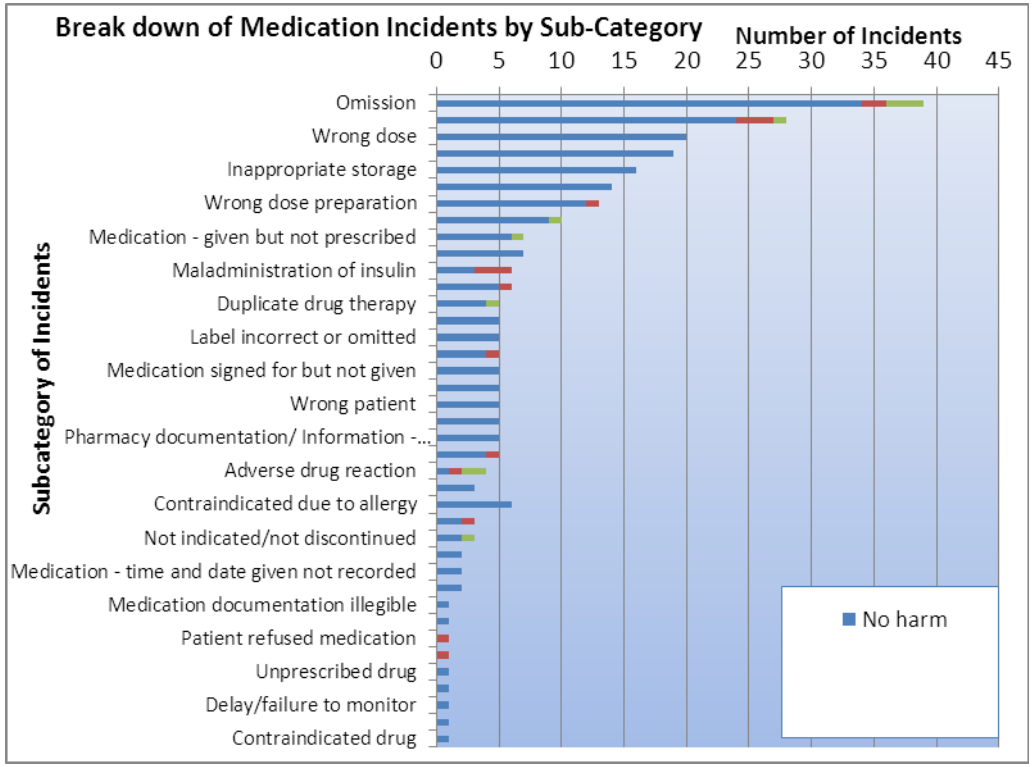
a) Medication incidents – levels of harm

a)

| Medication incidents -reported on Datix | **Q1 (13-14)** | **Q2 (13-14)** | **Q3 (13-14)** |
|---|---|---|---|
| | 274 | 260 | 264 |
| Medication incidents –classification | No harm – 92% | No harm – 93% | No harm – 90% |
| | Low harm – 4.7% | Low harm - 4.2% | Low harm – 6.0% |
| | Moderate harm – 3.3% | Moderate harm – 3.1% | Moderate harm – 4.0% |
| | Severe harm – 0% | Severe harm – 0% | Severe harm – 0% |

b) Medication incidents – type category



c) Medication Safety training – (delivered by the pharmacy team in collaboration with medical and nursing staff)

c)

| | **Frequency of training** | **Number of staff attended training to date** |
|---|---|---|
| **Improving Medication Safety for Nurses** | Bi-monthly | 700 |
| **Harm Free Care training for Nurses** | Monthly (rolled out in March 2013) | 126 |
| **IV and oral medicines administration training for nurses** | On commencing in the Trust (rolled out in April 2012) | IV training: 578<br>IV test: 754<br>Oral training: 155 |
| **FY1 & FY2 safe and practical prescribing training** | On induction | 2013/14 intake:<br>FY1 42; FY2 40 |
| **Pharmacy patient services 'Right First time' training** | Twice yearly (rolled out in April 2013) | 43 |
| **Pharmacist medication chart screening training and test** | On commencing in the Trust (rolled out October 2012) | 48 |

In addition to this there are a number of other initiatives that support a culture of medication safety including:-

- On-going medication safety monitoring visits to clinical areas by the pharmacy team.
- Antimicrobial stewardship rounds with senior pharmacists.
- Annual audit programme – VTE assessment and prophylaxis; antibiotic point prevalence, medicines, reconciliation, prescribing accuracy, safe and secure handling of medicines.
- Real time error log – which identifies, records, resolves, incidents picked up by the final checker before leaving pharmacy.
- In development; an e-learning 'medicines management and prescribing' module which will be rolled out for all new medical prescribers.

**f) Safe Staffing– March 2014**

**Commentary**
Safe staffing relies on good management so that budgeted posts are filled and deployed effectively and the staff employed are available to work. The Trust has a duty to ensure nursing staffing levels are sufficient to maintain safety and provide quality care. There is a growing body of research evidence which shows that nurse staffing levels can make a difference to patient outcomes (mortality and adverse events).

This report outlines recent developments in monitoring nursing & midwifery workforce issues, progress against the recent National Quality Board (NQB) recommendations and details of the daily safe staffing monitoring for February.

Ward leaders and matrons are expected to ensure all available hours on electronic rostering are filled, annual leave is managed appropriately and sickness/absence is managed robustly in accordance with trust policy. This is being monitored via the monthly Safe Staffing and Workforce (SsAW) meetings which proactively review forthcoming rosters and scrutinises specific safety indicators such as skill mix and vacancies etc. The terms of reference for this meeting have been reviewed and a template for reporting to the Nursing board is being developed.

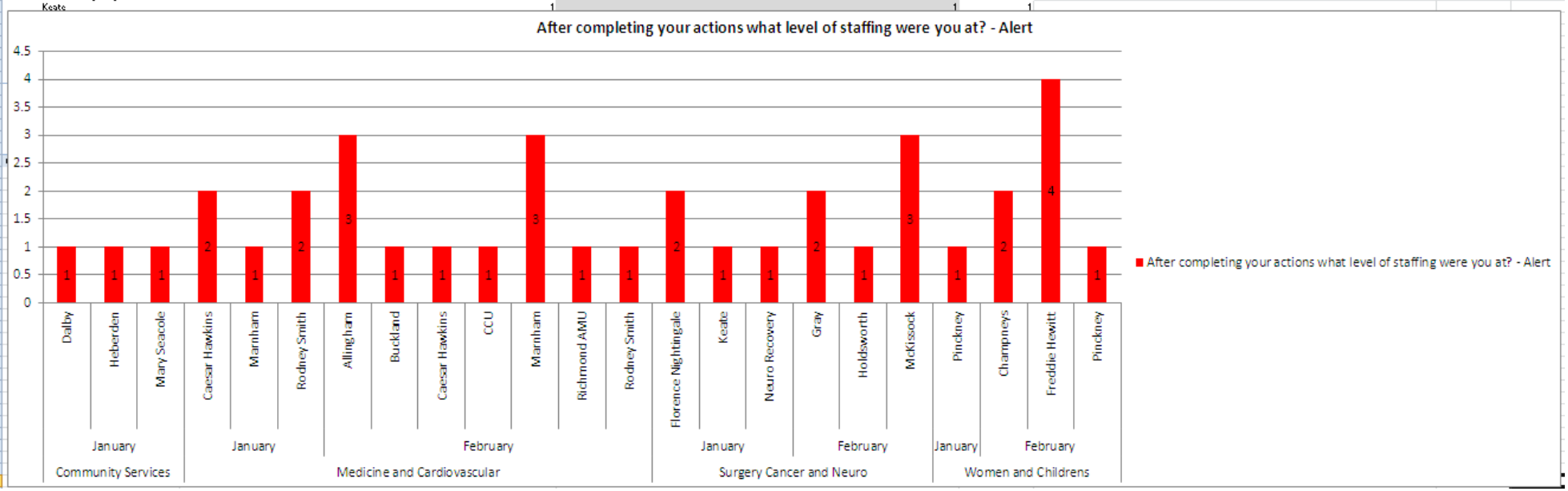
**Establishment reporting**
The Chief Nursing Officer (CNO) for England, Jane Cummings with the National Quality Board (NQB) and the Trust Development Authority (TDA), produced guidance in December 2013 for Trusts which sought to support organisations in making the right decisions to create supportive environments where their staff are able to provide compassionate care. The report identifies the themes, expectations, process, actions and leads. This has been translated into an action plan (please see appendix A) which has been discussed and agreed with relevant finance and HR colleagues. The two key priorities will be monthly workforce reporting to board supported with clinical indicators and six monthly establishment reviews.

Nurse managers will work in liaison with finance, human resources and operational managers at all levels of the organisation in creating and reviewing nursing/midwifery establishments. This review will be undertaken every six months. Working with ward sisters, charge nurses and team leaders, the Divisional Directors of Nursing and Governance and Divisional Directors of Operations will oversee and submit their data to the Chief Nurse. This will then be presented to the Executive Management Team meeting and then to the Trust board by May 2014.The Hurst tool is part of the agreed methodology for the review which also includes professional guidance such as Royal Colleges and local discussion. Trusts are awaiting NICE guidance on this which is expected shortly.

**Safe staffing reporting**
The chart on the following page is an overview of the safe staffing reports for February by division and details the number of concerns reported and the review of risk once actions were taken. The reason for concern could be due to absence or an increase in acuity. It should be noted that although a helpful barometer, this is a subjective assessment and does not mean that care was not safe and appropriate and there is no evidence to suggest that was the case for these areas. Also given the number of shifts worked the numbers are very small indeed, mostly one with no more than 4. Mc Kissock was due to sickness as was Allingham, and Marnham whilst Fredrick Hewitt was also sickness with a small degree of vacancy.

# Daily Safe Staffing - Concerns - Feb 2014

| Count of Answer | Column Labels | | |
|---|---|---|---|
| | After completing your actions what level of staffing were you at? Alert | After completing your actions what level of staffing were you at? Total | Grand Total |
| **Row Labels** | | | |
| **Community Services** | **3** | **3** | **3** |
| **January** | **3** | **3** | **3** |
| Dalby | 1 | 1 | 1 |
| Heberden | 1 | 1 | 1 |
| Mary Seacole | 1 | 1 | 1 |
| **Medicine and Cardiovascular** | **16** | **16** | **16** |
| **January** | **5** | **5** | **5** |
| Caesar Hawkins | 2 | 2 | 2 |
| Marnham | 1 | 1 | 1 |
| Rodney Smith | 2 | 2 | 2 |
| **February** | **11** | **11** | **11** |
| Allingham | 3 | 3 | 3 |
| Buckland | 1 | 1 | 1 |
| Caesar Hawkins | 1 | 1 | 1 |
| CCU | 1 | 1 | 1 |
| Marnham | 3 | 3 | 3 |
| Richmond AMU | 1 | 1 | 1 |
| Rodney Smith | 1 | 1 | 1 |
| **Surgery Cancer and Neuro** | **10** | **10** | **10** |
| **January** | **4** | **4** | **4** |
| Florence Nightingale | 2 | 2 | 2 |
| Keate | 1 | 1 | 1 |



The daily safe staffing audit identifies if wards/departments are safe, have a concern or if there is an alert. It must be completed by 10am in order to provide a suitable amount of time for staffing issues to be escalated through line managers and hopefully be resolved. The audit should be completed once actions have been implemented in order to ensure that the reporting accurately records the initial staffing status, the interventions and the outcome.

At 10am, any area identified on the audit as unsafe triggers an automatic alert email which is sent to the Heads of Nursing, Divisional Directors of Nursing and Deputy Chief Nurse. The Heads of Nursing or DDNGs will inform the patient safety administrator of the final outcome to ensure the audit process is complete. If they are unable to make their area safe (using strategies outlined in the safe staffing policy) they should approach another division and if the risk is still unable to be managed this should be escalated to the Chief Nurse.

An exception report identifying non-compliance with the audit and areas that fail to respond to a safe staffing alert is presented at the Matrons Forum and the Nursing Board and non compliant areas are asked to explain their reasons. This has improved significantly in recent months

The safe staffing audit is completed once a day at present. Further discussion is required to determine if this needs to be completed on a shift by shift basis. Workforce information with relevant clinical indictors will be presented to the board on a monthly basis as part of the NQB recommendations as detailed above. The suggested indicators at the moment are the Safety Thermometer and the Friends and Family Test. The details of this report are being discussed at the moment with workforce and nursing colleagues. There will also be a section within the Chief Nurse's Quality report to the trust board that will refer to safe staffing more specifically.

**External reporting and displaying information**
Staffing information is to be reported externally (probably via the UNIFY system) and is also likely to be available in a format yet to be agreed on a public facing website. No definitive information has been provided which outlines the process for this yet but is expected shortly.

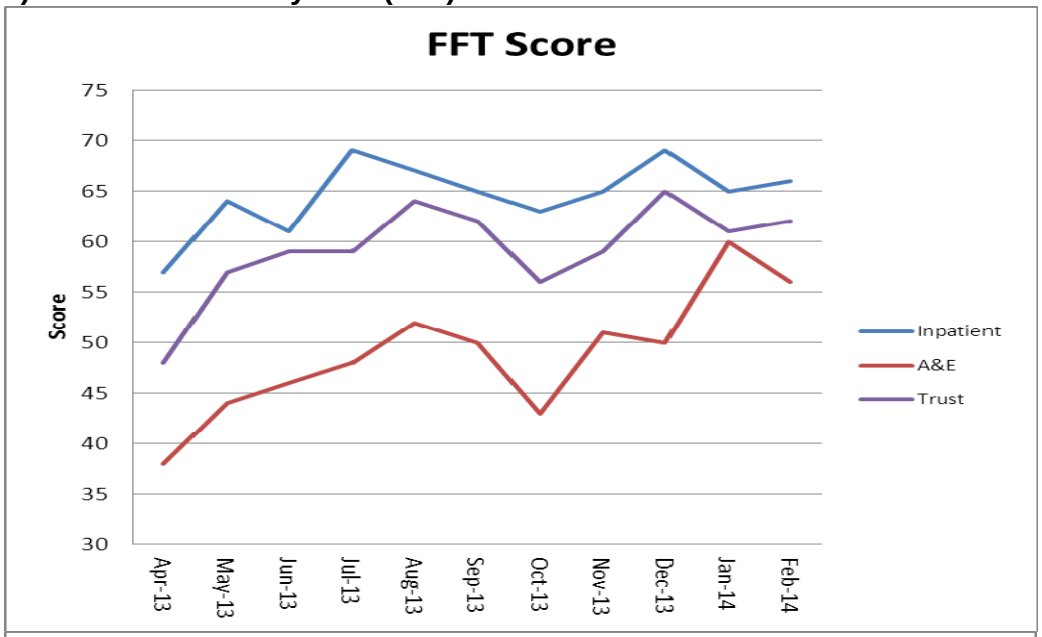
In addition, another requirement of the NQB report is that wards/ departments will display the number of staff who should be on duty versus the actual numbers on duty on a shift by shift basis. The content of the board has been agreed following consultation with senior staff and clinical areas. The boards will be placed at/near the entrance to each ward/department. The boards will also provide information on the nurse to patient ratio and an explanation to the public on why we collect this information and how we monitor staffing on a daily basis.

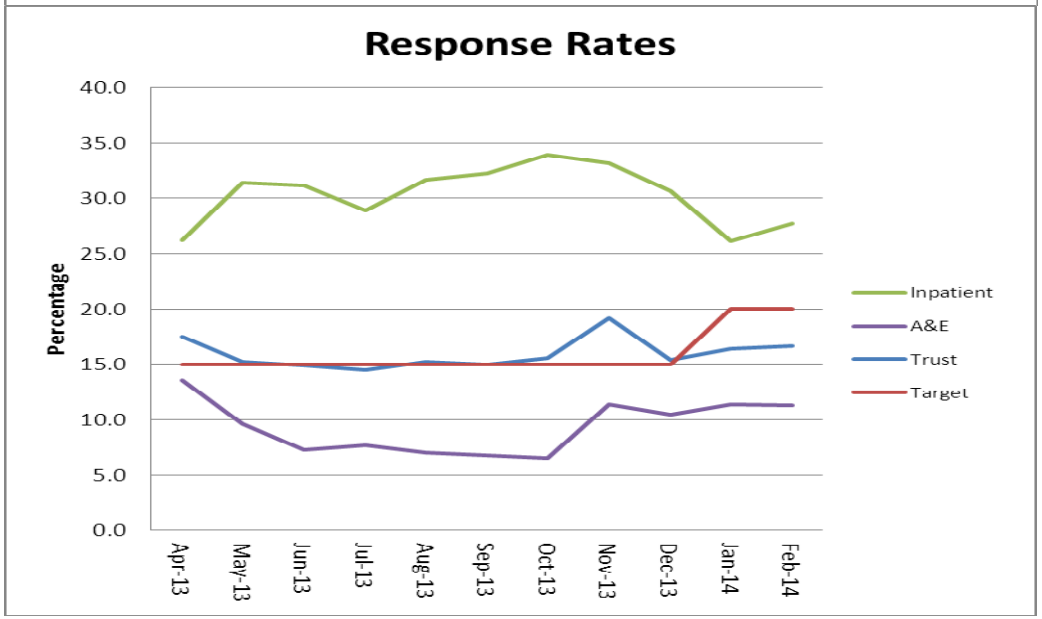
The boards will be ordered collectively to ensure a corporate approach to design and presentation and it is envisaged that all boards will be in place by the end of May 2014. Staff will also be expected to communicate with patients and visitors should any questions or concerns arise but anecdotally this has not yet been an issue in trusts that are already displaying the information elsewhere in the country.

* Appendix A on page 33

## II Patient Experience

### a) Friends and Family Test (FFT) – Feb 2014




**Commentary**

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

In Feb the Friends and Family Test score for the trust overall was +62, slightly higher than January. A&E was down slightly with +56 and the adult inpatient wards up slightly with +66. The scores for maternity were +59 in antenatal, +100 in birth (3 surveys) +38 in postnatal ward and +68 in postnatal community. As a percentage this would mean that overall, 94% of people were extremely likely or likely to recommend us.

The minimum return (number of surveys) required previously has been 15% overall but increases to 20% by the end of Q4. For February there was a slight increase overall at 16.7%, with adult wards at 27.7% A&E at 11.3% and Maternity at 12.7%. It is not likely that this will be met for March unless significant changes occur - the particular challenge is A&E which is lowering the overall score albeit Maternity is also still low. The scores will be separated out for next year's CQUIN.

Of the total number of replies (1,182) the breakdown for Feb is as follows; extremely likely 781, likely 321, neither/nor 42, unlikely 13 and extremely unlikely 15. There were 10 don't knows.

For Maternity, this is the fourth 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 down at 80. The % return for each area in the order above in February was 2.3%, 2.1%, 24.7% and 13.6%.

The coloured bar chart later on is a summary divisional overview for February 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 department but it is difficult to produce as a chart given the very large number of areas now taking part.

**Proportion of answers by division**

The trust's breakdown for inpatient wards is also displayed on NHS Choices website – the current one is for January 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 February data for all areas demonstrating all possible scoring options.

This does demonstrate that the vast majority of patients (94%) 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.

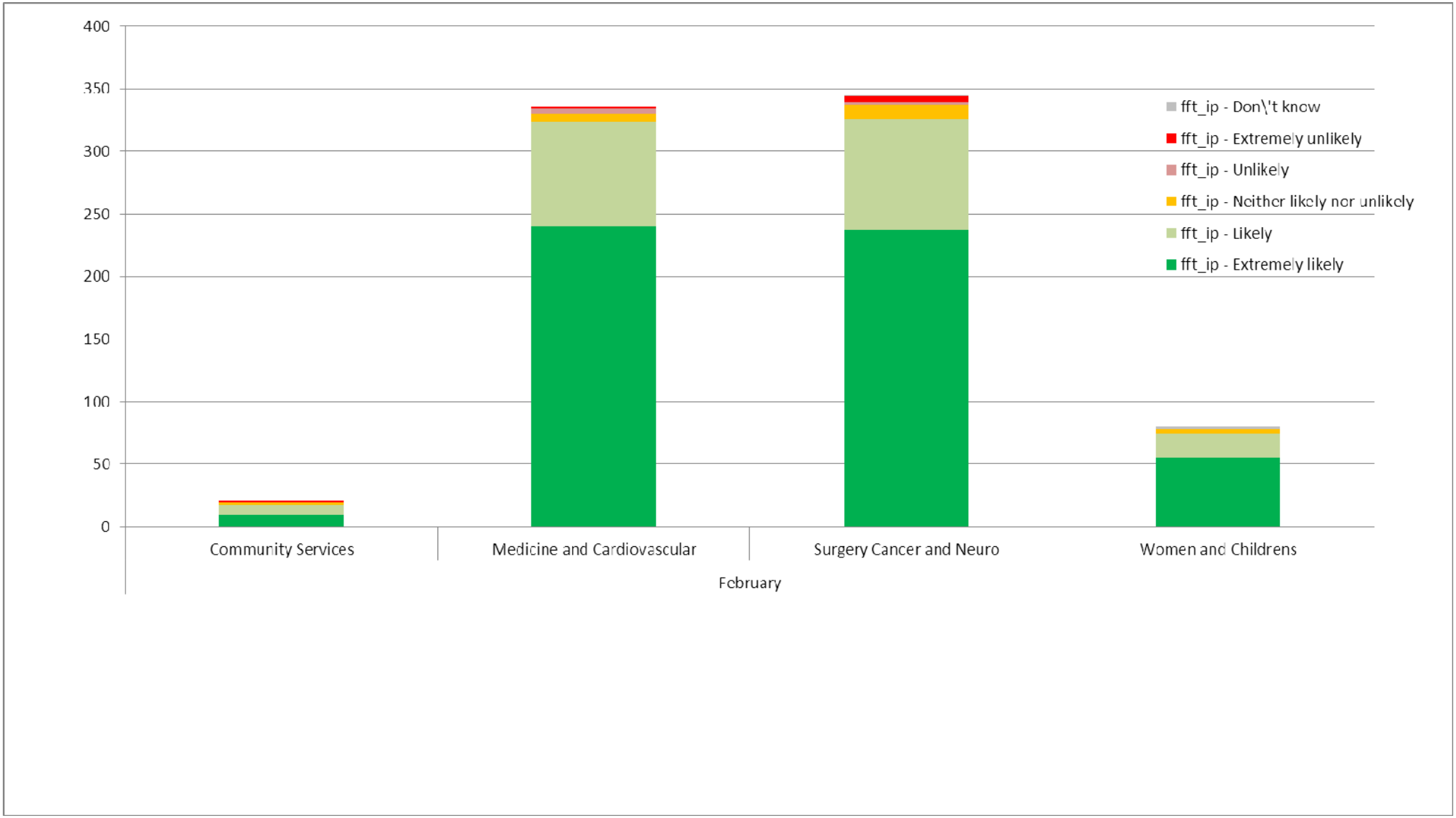
What is apparent in this more detailed chart is the amount of responses that are positive overall. The scoring methodology for FFT only assigns a positive score to "extremely likely" to recommend. As is clear in the chart the likely and extremely likely replies are considerable in number. The highest number of extremely unlikely replies remains attributable to A&E with the majority of feedback relating to waiting. Other common reasons for negative replies for areas generally relate to attitude and information/communication which mirrors complaints feedback.

The table of data on later on relates to the percentage of patients surveyed from April to February by ward/department and there is still work to be done in certain areas although this is improving. Problems with WiFi in some areas is making this issue more difficult at times.

The trust also asks additional questions (9 or 10 depending on the area) on the RaTE system which we ask patients to complete after FFT and changes are planned for NNU, community and paediatrics to ensure their questions are most appropriate. For an overview of results for February for these other questions please see the final page.

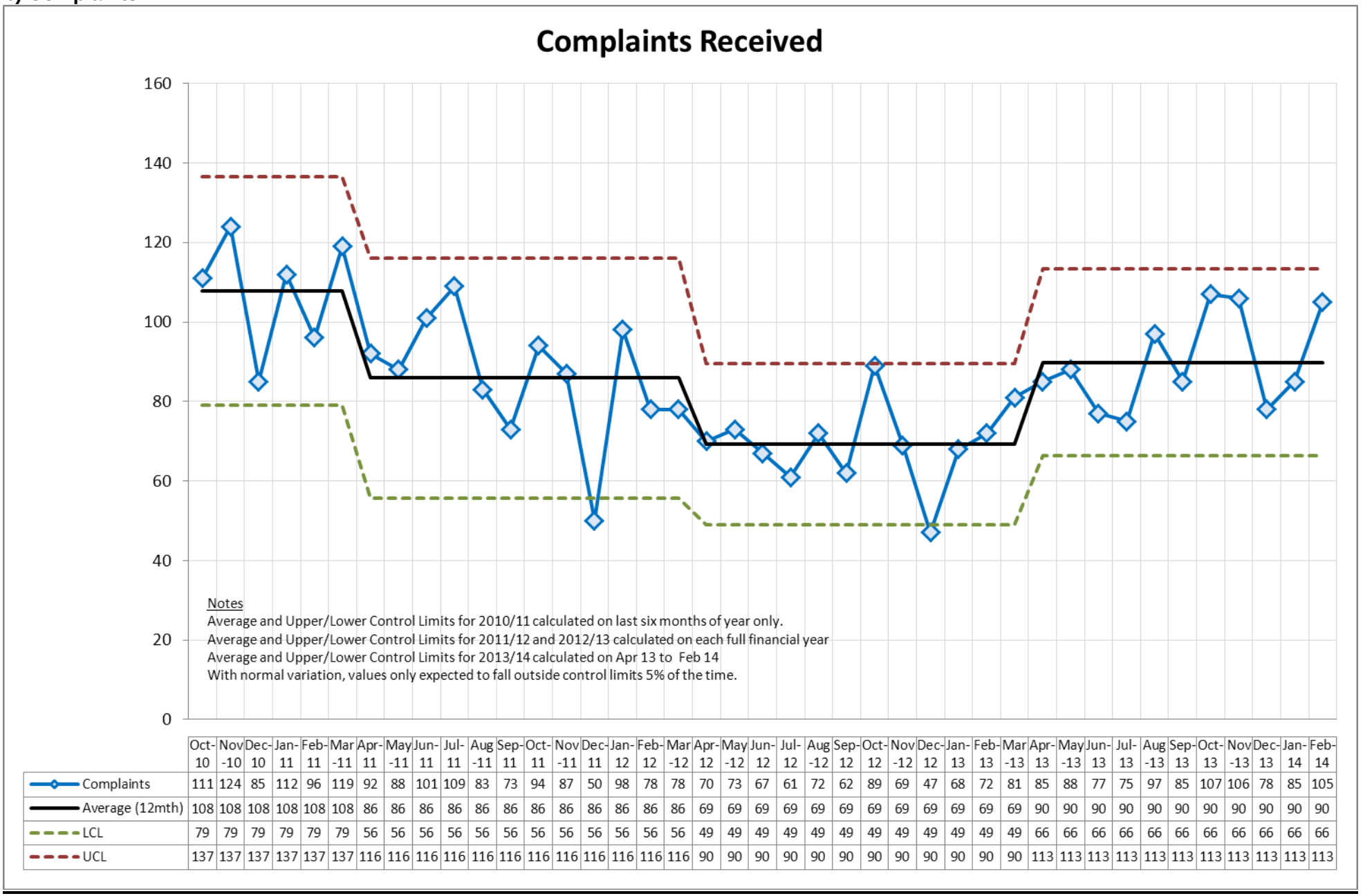
It is planned that reports will go to the Patient Experience Committee, trust board and any other relevant or interested meeting or committee.

Plans are well underway to roll this out to Day Surgery, Outpatients and Community by Oct 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.

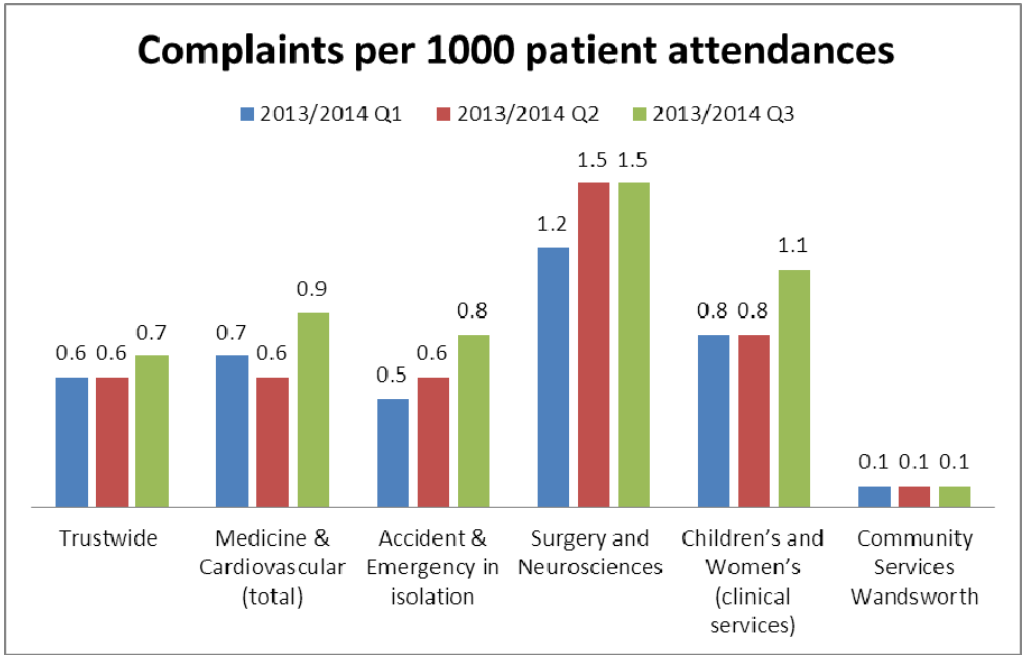

400
350
300
250
200
150
100
50
0
Community Services
Medicine and Cardiovascular
Surgery Cancer and Neuro
Women and Childrens
February
fft_ip - Don\'t know
fft_ip - Extremely unlikely
fft_ip - Unlikely
fft_ip - Neither likely nor unlikely
fft_ip - Likely
fft_ip - Extremely likely

| | A | B | C | D | E | F | G | H | I | J | K | L | M |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | **Service** | **April** | **May** | **June** | **July** | **August** | **September** | **October** | **November** | **December** | **January** | **February** | **Average** |
| 2 | A&E | 13.6% | 9.6% | 7.3% | 7.7% | 7.0% | 6.8% | 6.5% | 11.4% | 10.5% | 11.4% | 11.3% | 9.4% |
| 3 | Allingham | 49.0% | 48.4% | 31.3% | 47.6% | 22.5% | 17.5% | 11.1% | 41.1% | 41.2% | 20.0% | 10.2% | 30.9% |
| 4 | Amyand | 20.4% | 14.8% | 0.0% | 3.7% | 10.9% | 4.3% | 33.8% | 33.3% | 11.3% | 6.9% | 0% | 12.7% |
| 5 | Belgrave | 38.1% | 27.5% | 47.7% | 25.2% | 29.1% | 48.5% | 37.0% | 36.3% | 8.7% | 18.7% | 37.8% | 32.2% |
| 6 | Benjamin Weir | 79.0% | 75.8% | 58.9% | 68.9% | 74.4% | 54.2% | 41.1% | 42.7% | 54.0% | 44.9% | 41.1% | 57.7% |
| 7 | Brodie | 19.0% | 11.3% | 6.3% | 23.3% | 21.7% | 27.3% | 15.9% | 37.0% | 29.6% | 15.8% | 11.1% | 19.8% |
| 8 | Buckland | 42.7% | 43.7% | 48.1% | 30.1% | 24.7% | 31.7% | 51.3% | 44.1% | 44.0% | 25.3% | 40.9% | 38.8% |
| 9 | Caesar Hawkins | | - | - | - | - | - | - | 25.6% | 22.7% | 12.1% | 1.6% | 15.5% |
| 10 | Cardiothoracic Intensive Care (CTICU | 100.0% | 33.3% | 0.0% | 0.0% | 0.0% | 0.0% | 46.6% | 0.0% | 0% | - | - | 20.0% |
| 11 | Caroline | 42.6% | 41.5% | 36.0% | 48.0% | 58.5% | 50.4% | 49.5% | 40.8% | 46.1% | 36.5% | 39.0% | 44.5% |
| 12 | Cavell | 10.0% | 26.9% | 37.7% | 39.6% | 33.7% | 33.3% | 100.0% | 48.6% | 22.1% | 48.3% | 47.9% | 40.7% |
| 13 | CCU | 75.0% | 86.7% | 72.7% | 76.5% | 83.3% | 60.0% | 19.2% | 100.0% | 65.4% | 100.0% | 100.0% | 76.3% |
| 14 | Champneys | | | | | 10.9% | 16.9% | 19.2% | 27.5% | 46.4% | 22.6% | 7.2% | 21.5% |
| 15 | Cheselden | 11.0% | 32.1% | 41.2% | 23.3% | 23.8% | 43.8% | 57.1% | 21.6% | 21.0% | 10.9% | 23.1% | 28.1% |
| 16 | Dalby | 31.6% | 0.0% | 12.9% | 45.2% | 9.4% | 35.3% | 53.7% | 18.9% | 7.7% | 25.0% | 34.3% | 24.9% |
| 17 | Florence Nightingale | 53.4% | 58.9% | 89.6% | 76.4% | 61.8% | 44.7% | 28.6% | 49.1% | 41.3% | 38.8% | 66.7% | 55.4% |
| 18 | GICU | | | | | 0.0% | 0.0% | 28.6% | 77.8% | 100.0% | 25.0% | 20.0% | 35.9% |
| 19 | Gray | 5.9% | 13.2% | 14.6% | 11.4% | 12.4% | 0.6% | 15.3% | 13.0% | 42.3% | 42.9% | 43.0% | 19.5% |
| 20 | Gunning | 43.9% | 40.5% | 39.7% | 31.3% | 11.0% | 45.7% | 47.4% | 45.1% | 40.3% | 29.9% | 31.8% | 37.0% |
| 21 | Gwynne Holford | 100.0% | 30.8% | 66.7% | 27.8% | 92.3% | 54.5% | 88.9% | 66.7% | 52.6% | 11.1% | 50.0% | 58.3% |
| 22 | Heberden | 18.2% | 19.4% | 50.0% | 38.6% | 15.8% | 4.4% | 70.0% | 37.0% | 4.2% | 12.5% | 18.8% | 26.3% |
| 23 | Holdsworth | 19.2% | 17.1% | 30.4% | 23.8% | 5.0% | 32.7% | 25.4% | 33.3% | 8.3% | 0% | 29.8% | 20.5% |
| 24 | Keate | 3.9% | 25.5% | 23.1% | 4.6% | 43.9% | 31.3% | 20.8% | 25.8% | 16.8% | 23.6% | 19.0% | 21.7% |
| 25 | Kent | 10.5% | 17.6% | 27.3% | 0.0% | 22.2% | 15.8% | 33.9% | 17.5% | 31.3% | 14.1% | 8.2% | 18.0% |
| 26 | Marnham | 20.4% | 28.2% | 25.0% | 1.7% | 31.3% | 23.1% | 39.3% | 39.5% | 23.4% | 16.3% | 21.7% | 24.5% |
| 27 | Mary Seacole | 34.4% | 88.0% | 84.4% | 34.0% | 3.3% | 18.4% | 48.1% | 77.8% | 63.8% | 51.0% | 10.3% | 46.7% |
| 28 | McEntee | 9.3% | 22.2% | 31.8% | 47.4% | 18.6% | 37.5% | 8.0% | 47.0% | 52.2% | 56.4% | 65.0% | 35.9% |
| 29 | McKissock | 28.2% | 5.1% | 19.8% | 36.8% | 20.2% | 23.8% | 25.6% | 22.4% | 7.6% | 12.7% | 13.8% | 19.6% |
| 30 | Neuro Intensive Care | 0.0% | 0.0% | 100.0% | 100.0% | 0.0% | 0.0% | 0.0% | 33.3% | 0% | 50.0% | 0% | 25.8% |
| 31 | Richmond | 12.7% | 12.3% | 3.4% | 26.2% | 49.8% | 44.8% | 41.1% | 42.4% | 30.1% | 42.1% | 17.1% | 29.3% |
| 32 | Rodney Smith | 33.3% | 37.7% | 6.3% | 0.0% | 44.6% | 31.7% | 15.8% | 44.4% | 24.1% | 14.3% | 15.8% | 24.4% |
| 33 | Ruth Myles | 44.8% | 53.3% | 100.0% | 84.0% | 46.2% | 58.3% | 20.0% | 20.0% | 36.8% | 5.9% | 15.4% | 44.1% |
| 34 | Trevor Howell | 12.8% | 50.0% | 57.4% | 48.5% | 43.0% | 49.2% | 32.9% | 48.6% | 49.2% | 45.2% | 48.1% | 44.1% |
| 35 | Vernon | 18.1% | 41.2% | 28.9% | 9.8% | 7.8% | 38.0% | 30.8% | 19.8% | 4.7% | 21.4% | 23.9% | 22.2% |
| 36 | William Drummond | 31.0% | 27.6% | 31.6% | 21.8% | 27.6% | 17.1% | 22.5% | 13.5% | 24.2% | 26.1% | 12.0% | 23.2% |
| 37 | Wolfson | 90.9% | 76.9% | 58.3% | 53.3% | 56.3% | 37.5% | 54.5% | 62.5% | 12.5% | 84.6% | 80.0% | 60.7% |
| 38 | **Organisation as reported to DH** | | | | | | | | | | | | |
| 39 | | **April** | **May** | **June** | **July** | **August** | **September** | **October** | **November** | **December** | **January** | **February** | **Average** |
| 40 | A&E | 13.6% | 9.6% | 7.3% | 7.7% | 7.0% | 6.8% | 6.5% | 11.4% | 10.5% | 11.4% | 11.3% | 8.4% |
| 41 | Inpatients | 26.2% | 31.4% | 31.2% | 28.9% | 31.7% | 32.3% | 33.9% | 33.2% | 30.7% | 26.1% | 27.7% | 30.3% |
| 42 | | | | | | | | | | | | | |
| 43 | Combined | 17.6% | 17.0% | 14.9% | 14.5% | 15.2% | 15.0% | 15.6% | 19.2% | 17.7% | 16.4% | 16.7% | 16.3% |
| 44 | | | | | | | | | | | | | |

**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 | Jan-14 | Feb-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 | 78 | 85 | 105 |
| 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 | 90 | 90 | 90 | 90 | 90 | 90 | 90 | 90 | 90 | 90 | 90 |
| 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 | 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 | 113 | 113 | 113 | 113 | 113 | 113 | 113 | 113 | 113 | 113 | 113 |




**COMMENTARY**
**Complaints in Older People and Neurorehabilitation**
There were six complaints received in this care group, one in January and five in February. Two of these were about Dalby Ward into which the investigations are on-going and two about Heberden Ward. In response to concerns raised about discharge from Heberden Ward, a number of actions were taken including the introduction of signs on walking aids to alert staff that they need to go home with the patient.

Two complaints were received about the speciality of community nursing but these related to different teams and themes. As a result of one of these complaints the process for escalating concerns about delays and missed visits has been improved. This is now monitored as part of the weekly quality checks that are undertaken by the clinical team leaders with the nursing teams.

**COMMENTARY**
This report provides an overview of how the trust has managed complaints received in January and February 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. More detailed reports go to a variety of other groups and committees

**Total numbers of complaints received**
There were 85 complaints received in January and 105 complaints received in February. The chart on the previous page shows a breakdown by month. The February figure is particularly high especially when considering the shortness of the month but still falls within the upper control limits.

Due to the timing of the board statistical process control charts are not yet available for quarter 4 by division but these will be included in the next report. However, the commentary throughout this report highlights some areas where complaints being received are high for January and February and themes/actions taken.

**COMMENTARY**
**Complaints in A&E**
Having reduced in December and January, complaints in A&E increased again in February. The main themes are clinical treatment – diagnosis, nursing care and verbal communication. As well as complaints being discussed with the staff members concerned' the team continues to share complaints and learning from these at team days and departmental clinical governance meetings. There is an interactive clinical governance board located within the staff area on the first floor of A&E. Included in this board are anonymised complaints for all staff to read together with the nursing scorecard, governance scorecard and the monthly complaints and compliments.

**Complaints performance quarter 3**

| | 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 | 60 | 32 | 53% | (8) 67% |
| Medicine and Cardiovascular | 89 | 63 | 71% | (12) 84% |
| Surgery, Neuro and Cancer | 102 | 63 | 62% | (16) 77% |
| Community Services | 19 | 10 | 53% | (5) 79% |
| Corporate Directorates | 21 | 19 | 90% | (1) 95% |
| **Totals:** | 291 | 187 | 64% | (42) 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, 64% were responded to within 25 working days. This is 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%.

For complaints received in January performance declined further with 54% within 25 working days and 64% within 25 working days or agreed timescales.

**COMMENTARY**

**Complaints in General Surgery**

The number of complaints being received in General Surgery has decreased slightly but still remains high when compared to other areas. The main themes are clinical treatment (diagnosis and operative procedures) and cancellation of surgery. There is no pattern in terms of the staff members being mentioned.

**Complaints in Outpatients**

The number of complaints being received about outpatients remains high despite the actions outlined in previous board reports. Communication and attitude are definite themes. We await details of actions planned once the investigations have been completed. Recent actions taken as a result of complaints made about outpatients include:

- The procurement of a new reminder solution, which will take updates from the patient administration system on a nightly basis, ensuring that all reminders are based on data which is as up to date as possible. The new solution will have improved information contained within each reminder, and an option to press a button and be connected to a member of staff in the call centre.
- Work is being undertaken with the administrative team managers and senior outpatient nursing teams to clearly outline their leadership responsibilities in circumstances where clinics are not running smoothly.

**Complaints in Corporate Services**

Of the six complaints received in January and February only two relate to patient transport which is a reduction when compared to the previous months in 2013/2014 when the average number received was four per month. The other complaints for corporate services were spread across a number of specialties - catering, carparking, occupational health and PALS.

**Reopened complaints where complaints were closed in quarters 1, 2 and 3 of 2013/2014**

794 complaints were closed between April and December 2013 and of these 8% have subsequently been re-opened. This has been sustained throughout the year so far and continues to represent an improvement when compared to 2012/2013 and 2011/2012 when 9% and 11% of complaints were reopened. General Surgery have performed very well with only 4% of complaints reopened. Of the four complaints closed in Cardiovascular Surgery two were reopened but there is no obvious theme.

**Complaints referred to the Parliamentary & Health Service Ombudsman**

Seven requests for documentation have been received from the Ombudsman's office compared to 21 at the same point last year. These requests pertain to complaints from seven different areas: Urology, Cardiology, General Intensive Care, Accident & Emergency, Acute Medicine, Renal and Acute Medicine.

For four 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 other three reports received the Ombudsman did not uphold any aspect of the complaints and felt that the trust's responses were reasonable.

**Care Connect**

One problem was received via Care Connect but the it was posted to St George's Healthcare NHS Trust in error. The care was in fact received from staff who work for South West London and St George's Mental Health Trust. The PALS team continues to monitor the site daily.

**Service User comments posted on NHS Choices and Patient Opinion**

The Patient Experience Manager and Patient Advice and Liaison Service are responsible for checking and responding to comments posted on the NHS Choices website and the Patient Opinion website.

Comments are passed on to relevant staff for information/action. Often the comments are anonymous so it is not possible to identify the patient or the staff involved, but such comments are still fed back to departments to consider themes and topics.

If a comment is a cause for concern then the individual is given information via the website about how to obtain a personalised response via the Patient Advice and Liaison service (PALS) or the complaints and improvements department.

There were 14 posts made on NHS Choices and Patient Opinion in quarter 3 of 2013/2014 of which seven were positive and seven were negative.

A&E and General Surgery received two negative comments each. The negative comments about A&E were about communication and waiting times. The negative comments about General Surgery were about unavailability of beds and lack of continuity in care. All of these concerns have been shared with the services.

| Area/team | Positive | Negative | Both | Total |
|---|---|---|---|---|
| Accident and Emergency | 2 | 2 | 0 | 3 |
| Coronary Care Unit | 1 | 0 | 0 | 1 |
| General Surgery | 0 | 2 | 0 | 2 |
| Paediatrics | 1 | 0 | 0 | 1 |
| Orthopaedics | 0 | 1 | 0 | 1 |
| Endoscopy | 1 | 0 | 0 | 1 |
| Car Parking/ENT | 0 | 1 | 0 | 1 |
| Phlebotomy | 1 | 0 | 0 | 1 |
| Breast Cancer | 1 | 0 | 0 | 1 |
| Orthopaedics | 1 | 0 | 0 | 1 |
| Obstetrics | 0 | 1 | 0 | 1 |
| Total | 7 | 7 | 0 | 14 |

## c) Improving outpatient Experience

2014 will focus on a major improvement project in our outpatient services. A project initiation document has been presented for approval to the trust Executive Management Team. This document will create a schedule of activities categorised into five work streams aimed at creating sustainable improvement in our many outpatient areas. These actions will be integrated with plans which are already underway to improve outpatients.
This is a significant piece of work which will run over 2 years. Recent stakeholder engagement events with patients, administrative staff and clinicians have highlighted four key areas to be taken forward to unlock the barriers that exist to improve outpatient service efficiency, enhance clinical engagement with the corporate outpatient team and, most importantly, improve the experience of the many thousands of people who use our services. The categories are:

a) **Technology** – to expand the technology and capabilities that will support efficiencies e.g. the use of e-tracking to track patient notes and improve the flow of information, appointment reminder services, self-check-in booths.
b) **Environment** – the outpatient team and patient representatives surveyed the current estate and facilities in the outpatient departments and made a series of recommendations for where and how improvements can be made. These will be costed, priorited and scheduled into the improvement plan.
c) **Business rules** – designed to ensure optimum communication and engagement between the corporate outpatient and clinical teams. A number of metrics will be measured and published monthly to inform services and the outpatient team as to how well they are doing.
d) **Engagement with clinicians** – a formal review of strategies for communication and engagement will be undertaken with clinicians to foster positive working relationships.
e) **Improving Patient Experience** – this will include a review of complaints, mandatory annual customer care training to all staff, regular contact with patients representative groups, introduction of a variety of mechanisms to seek and receive feedback from service users.
It was agreed at the executive management team that one clinical service from each division will be selected to trial this approach prior to corporate roll out. This project will sit within the overall improvement programme and will report progress via its governance structures.

## d) Developing a 'dementia and delirium' team

It has been agreed that there will be further investment to support improving the care of patients with dementia and delirium at St George's. The aim of this team of three nurses will enable the development of a corporate wide approach concentrating specifically on the St George's site but extending their reach into Queen Mary's as appropriate. It is anticipated that the team will not only improve standards of care and carer satisfaction but also reduce in-hospital complications and the length of stay for such patients. Members of this team will also support and contribute to staff training in dementia.
As previously reported the trust has struggled to achieve the requirements of the national CQUIN in dementia (screening of appropriate patients and training sufficient numbers of staff) which has contributed to potentially poorer standards of care as well as significant financial penalties (£300k P.A.). This modest investment will support the delivery of both.

**e) Learning Disability services – evidence of compliance**

As part of the NHS Outcomes Framework the trust is required to comment on compliance on the following criteria in relation to services for people with Learning Disabilities. The trust is compliant for all and the table below provides information in support of this.

| | |
|---|---|
| **Does the trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients?** | YES.<br>We can and do flag patients with LD once we are aware of them e.g. through referral to our LD nurses and we can put alerts on the system but without knowledge of all patients with a LD who may use STGH services there are significant challenges. There is no universal or national system in place to identify someone with a LD. Also not all people with LD want to be labelled as such and evidence suggest that only 25% of people with a LD have a diagnosis. Cerner utilises demographic data from GP's but there is no current requirement to include LD in any data set. Even if local health and social care services (who would normally hold this information) proactively share this info with us (and this would be a large number of boroughs/CCG's) there may be information governance issues about sharing data without consent. For those patients with LD who regularly use our services we can put flags on Cerner to alert staff of admission and any particular needs/ adjustments and we have evidence of utilising health passports to ensure safe and effective care.<br>We do have evidence of flags being effective in alerting both the LD and safeguarding lead to the admission of one particular client who lives in the community with long term safeguarding concerns.<br>In addition with the additional Acute LD nurse post and more integrated working with acute and community teams information sharing and planning has improved. |
| **Does the trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria: · treatment options; complaints procedures; and · appointments?** | YES.<br>Easy read is available and our LD nurses can assist in these areas we also have accessible information in PALS and Complaints we also work with local MENCAP groups that can provide information and support. Many organisations provide easy read information. |
| **Does the trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities** | YES,<br>All services have access to written information ('Getting Care Right' packs) and resources on the intranet, including reasonable adjustments and how the MCA is utilised in practice. This will be regularly reviewed by the LD team we also have access to MENCAP family carer support workers via LD nurses. |
| **Does the trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff?** | YES.<br>On induction LD is part of Adult Safeguarding and Equality & Diversity modules which all staff attend and must pass. In addition on going MAST contains an element of information regarding care of people with LD. With the additional LD post and increase in integrated working between acute and community services, there will be a review of areas that will require additional/more comprehensive training. |

| | |
|---|---|
| **Does the trust have protocols in place to encourage representation of people with learning disabilities and their family carers?** | YES.<br>We have bi-monthly "Our Health Our Hospital" meetings where service users and families attend and provide feedback on their experiences. People with LD are also members of the Access Committee. The trust also supports a work experience programme for students with LD called Project Search. This is very well evaluated and is now in the second year. |
| **Does the trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?** | YES.<br>When any national report/recommendations is/are published a review is undertaken with progress and any actions required. This would usually go to the Patient Experience Committee (PEC) chaired by the Chief Nurse, and any other fora as required. PEC reports to the Quality and Risk Committee<br>A mental capacity audit was undertaken last year. Plans to undertake audit of staff's awareness of care of LD patients and to identify any additional training needs are in place. |

The board is also asked to note the recent changes in service provision in relation to the acute LD service on the Tooting site.

A successful bid to Wandsworth CCG has resulted in an increase in funding for this service and a change in how the service is delivered.

Previously the acute service consisted of one part time Consultant Nurse. This has now increased to two full time posts, a Clinical Nurse Specialist and Liaison Nurse supported by the Lead Nurse for Adult safeguarding and the Head of Community LD Nursing. This now means that there is additional resource and support for patients, carers and staff as well as the resource to review training and education. Staff understanding and application of the Mental Capacity Act (MCA) is an area that has been identified as requiring more focus. It is hoped that with the new model a review of awareness and additional training will be possible.

In addition, monitoring of patients with LD, audit of policies, review of documentation/resources for staff and attendance at key stakeholder meetings and user groups such as Mencap and other LD groups/committees is now possible.

Joint working with the trust's Community LD team has also significantly improved with much closer working between the teams which is having a positive impact on patients who regularly attend the hospital. In some cases early discussion and intervention can either expedite what are frequently complex discharges or indeed avoid an admission if services and support can be reviewed quickly.

There is a LD action plan which is submitted to the Patient Experience Committee where progress is monitored.

**III Clinical audit + effectiveness (patient outcomes)**

**a) National audits**

**National audit of percutaneous coronary interventional (PCI) procedures**

The report, which summarises data between January and December 2012, assesses key aspects of the patterns and quality of care for PCI. The report highlights a number of key findings indicating that aspects of best practice such as procedures involving stent insertion and the use of the radial artery for access (10% in 2004 to over 65% in 2012) are increasingly being met nationally. Also highlighted is the increase in the safety of drug eluting stents being used at a national level (55% in 2006 compared to 76.2% in 2012). This is due to safety issues being better understood.

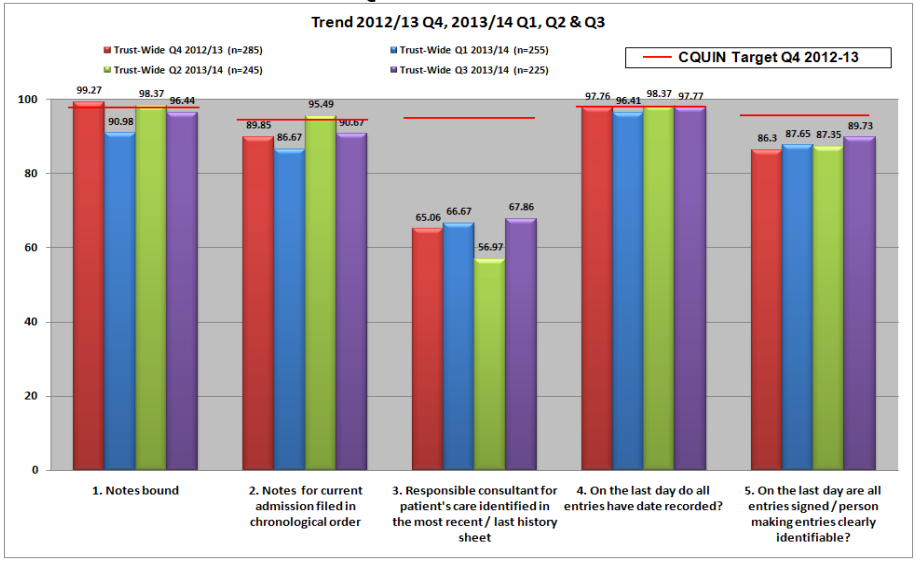
Evidence suggests improved outcomes for patients treated in higher volume PCI centres. This is evident in centres such as St George's that perform over 400 procedures per annum (recommended by British Cardiovascular Intervention Society & British Cardiovascular Society). The report highlights that the overall rate of in-hospital death following PCI has gradually risen over the past few years. For all PCI's in-hospital mortality is 1.9% and 30 day mortality is 2.6%. This is due to a change in case mix.

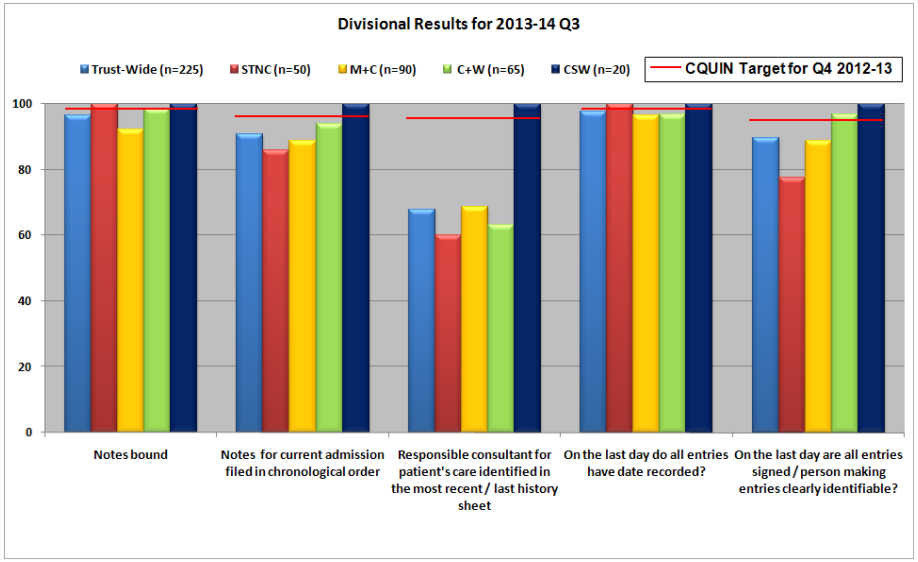
Unit specific data is not provided other than to classify completeness of data submissions. It is evident from the report that we are submitting good quality data. However, through looking at data behind the report two areas for improvement are identified. These are: date/time of symptom on set (84.4%) and date/time of call for help (89.1%).

The data behind this brief report is very difficult to access and does not support trusts to compare performance to their peers. We have fed this back to the national audit team for consideration of attention.

## b) Local audits

## Healthcare records audit Q3 2013/14



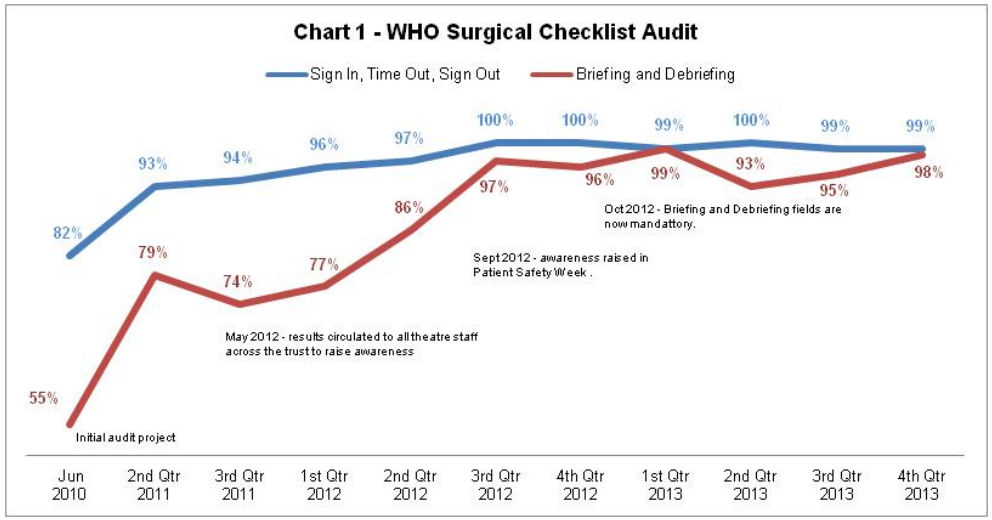

Participation in the on-going quarterly audit of record keeping standards is mandatory for all inpatient services. In Q3 responses from 22 care groups (n=225) were received. Eleven specialties did not complete the audit (Neurosurgery, Neurology, Plastic surgery, T&O, Neuro & Amputee, AMU, Cardiothoracic surgery, Gastroenterology, CTICU, GICU and Gynaecology). Poor compliance with the requirement to complete this short, snapshot audit has been escalated to the Divisional management teams and Executive Management Team who have confirmed that this audit should continue. Service managers are now involved in ensuring clinical teams complete the audit.

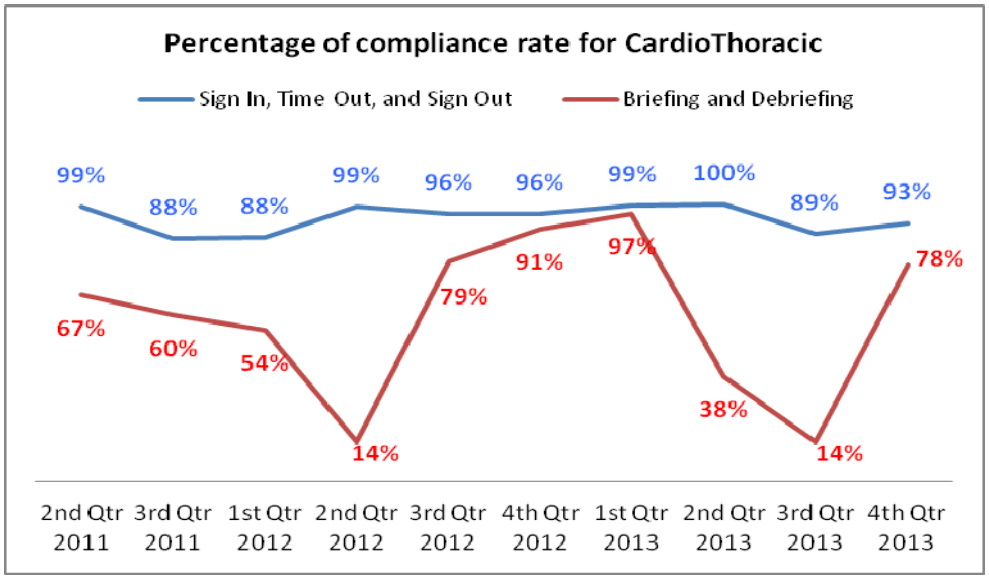
Overall our level of performance does not meet the target set by our commissioners in 2012/13 when this was a local CQUIN. Please note that when considering divisional performance consideration should be paid to the differences in sample size.

For two of the core standards particular improvement is required, namely ensuring the person making the entry is clearly identifiable and recording the responsible consultant on the history sheet. To support this action the history sheet has been redesigned to include prompts for essential information, however these results indicate that this change has not impacted significantly on performance. A number of other measures have been recommended at trust level, particularly around the use of clinician name stamps and patient identification stickers.

However, local action will be required to improve standards and to this end care group results and divisional reports are produced alongside the trust level report. In addition, the clinical lead for this project regularly attends Divisional Governance Boards to present and discuss local results and to try to engage colleagues in monitoring and quality improvement.

## WHO Theatre checklist audit



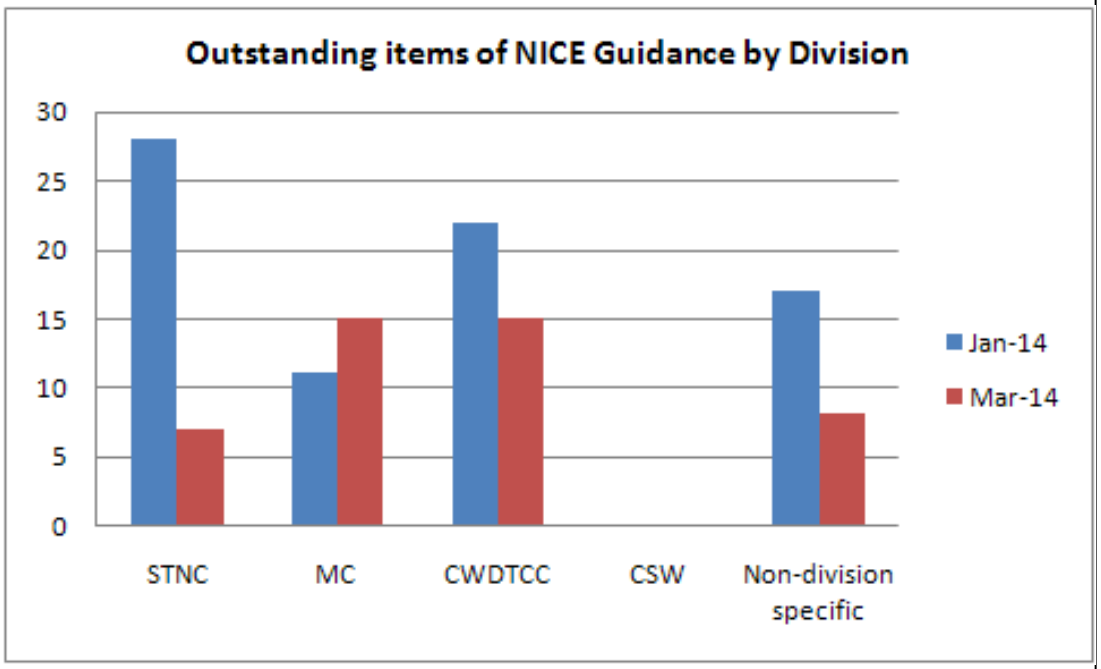

This audit is conducted to determine the extent to which the WHO safer surgical checklist has been implemented in theatres and to identify areas where improved compliance is required.

There has been a marginal increase in the number of specialties which are fully compliant, with 13 scoring 100%, compared to 11 last quarter. There has been no change for Sign in, Time out, Sign out with 99% adherence sustained from Q3. There has been a marginal increase for Briefing and Debriefing checks, with compliance increasing from 95% to 98%.

It should be noted that there has been significant improvement in this area for the Medicine and Cardiovascular division with their compliance increasing from 78% to 93%. This is due in part to the improvement seen in Cardiothoracic theatres, however, the Care Group lead has acknowledged further work is needed to eliminate the variance in compliance rates observed.

This audit report is being discussed at Care Group level , led by Band 7 theatre team leaders. An extended 'Sign out' compliance will be monitored with ad hoc mini audits commencing April 2014.

**c) NICE (National institute for health and care excellence) guidance**



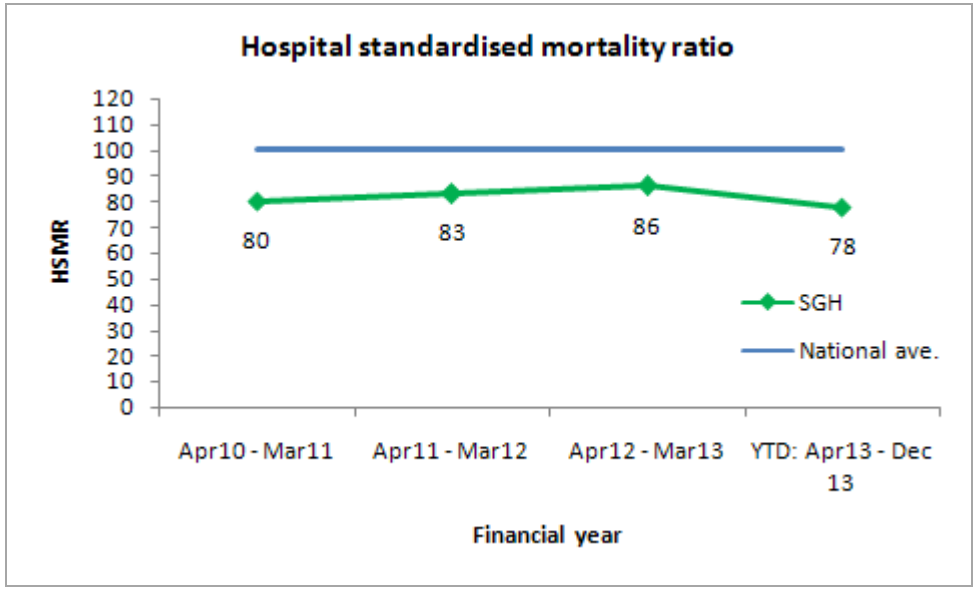

The Clinical Audit (CA) team continue to prioritise work to reduce the number of items of NICE guidance where compliance is unknown. For guidance issued between January 2010 and November 2013 there are 45 responses outstanding. In the January Quality report which looked at a shorter period (January 2010 – September 2013) we reported 76 items outstanding. This demonstrates that significant progress has been made, due in large to significant improvements in the Surgical division. We are continuing to support divisions in order to eliminate this backlog and in some areas have taken over liaison with clinicians to hasten progress.

To improve the monitoring of implementation prospectively a proposal to strengthen the dissemination and monitoring process will be presented to the next Clinical Effectiveness and Audit Committee (CEAC) meeting. It is suggested that the audit team will liaise with confirmed leads to ascertain compliance, reducing the administrative burden for both divisions and CA. Divisions will retain a vital role in allocating ownership of guidance and in resolution of any response or compliance issues. Once agreed at CEAC this proposal will be submitted to the Executive Management Team for their support.

## d) Mortality

| SHMI publication | Reporting period | Ratio | Banding |
|---|---|---|---|
| January 2013 | July 2011 – June 2012 | 0.80 | Lower than expected |
| April 2013 | October 2011 – September 2012 | 0.82 | |
| July 2013 | January 2012 to December 2012 | 0.81 | |
| October 2013 | April 2012 to March 2013 | 0.81 | |
| January 2014 | July 2012 – June 2013 | 0.81 | |

Source: Health and Social Care Information Centre (HSCIC)




Source: Dr Foster Intelligence

In January 2014 our summary hospital-level mortality indicator (SHMI) was published for the period July 2012 to June 2013. Our score of 0.81 is categorised as lower than expected and shows that the trust maintains its strong performance, which is also demonstrated by our HSMR (hospital standardised mortality ratio) which is significantly better than expected. We are one of 12 trusts identified as a 'repeat outlier' as our mortality rate has been 'lower than expected' for two consecutive years.

The Mortality Monitoring Group (MMG) continues to interrogate benchmarking data and require investigation of any procedure or diagnosis groups where Dr Foster real-time monitoring data suggests our outcomes are significantly different to expected. Progress of key investigations is summarised below. It should be noted that these signals are internally derived.

- Coronary angioplasty: The service have conducted a clinical review of 72 deaths observed between July 2012 to June 2013. The full report of findings and recommendations is currently being finalised and will be presented to MMG and as appropriate in due course.
- Intracranial injury: The service reviewed 55 deaths observed between September 2012 and August 2013 and presented their findings in February. This showed there to be no issues of concern in terms of acute management, neurosurgical management or subsequent management. The review is considered complete. The investigation provided a model of best practice in terms of both depth of review and clinical engagement.
- AMI CQC outlier alert action plan: Following action by the Information team to implement a programme of work to increase clinician and coding engagement the action plan in response to the CQC mortality outlier alert has now been signed off as complete.

Over the next few months we will be taking part in the PRISM2 study to formulate a measure of avoidable mortality and to shape a nationally agreed mortality review process. This national study will involve a team of external researchers reviewing 100 randomly selected in-hospital deaths. The trust is eager to act as an early implementer of this work and is keenly awaiting the publication of a nationally agreed structured proforma.

## Appendix A National Quality Board (NQB) action plan

| Theme | Expectation | Process | Action(s) | Lead(s) | RAG |
|---|---|---|---|---|---|
| **Accountability and Responsibility** | Boards take full responsibility for the quality of care provided to patients and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability. | Boards ensure there are robust systems and processes in place to assure themselves that there is sufficient staffing capacity and capability to provide high quality care to patients on all wards, clinical areas, departments, services or environments day or night, every day of the week. | ESR data to be cleansed and validated by May 2014. | Workforce lead and finance lead | O |
| | The Chief Executive should ensure that the organisation has the right number of staff with the required knowledge and skills to provide safe and effective patient care. | The Executive team should ensure that policies and systems are in place. | Agree the design of monthly workforce reports for the trust board by April 2014. The trust board will review this information in conjunction with quality indicators. | Workforce Lead with Finance Lead | R |
| | The Chief Nurse should ensure there is an uplift in planned establishments to allow for planned and unplanned leave, ensure absence is managed effectively and develop the nursing and midwifery leadership team to ensure that they understand the principles of workforce planning and can use evidence based tools (informed by their professional judgement) to develop workforce plans and make staffing decisions on a day to day basis'. | | Monthly nursing reports will include data on compliance with completion of the daily safe staffing audits and identify exceptions in the form of concerns and alerts specifying any actions taken. Report format to be agreed by April 2014. | DCN and HoN Workforce | O |
| | The Director of Workforce (HR) ensures that human resources support and policies are available to secure sufficient staffing capacity and capability to provide high quality care to patients and ensures that there are systems and processes in place to capture accurate data on establishment, staffing levels and skill mix, staff movements, training and turnover in order to inform decisions on workforce planning. | Boards should sign off establishments (as overseen by Chief Nurse) for all clinical areas, articulate the rationale and evidence for agreed staffing establishments, and understand the links to key quality and outcome measures. | Review establishments twice a year with a Trust agreed methodology. The first review to be completed by May 2014 and every six months subsequently. | DDNGs with HR and Finance Leads | O |

| | | | | | |
|---|---|---|---|---|---|
| | The Director of Finance ensures that finance decisions which could have an impact on staff capacity and capability and patient outcomes are taken with consideration of staffing and workforce planning implications, and that these are reflected in any advice provided for decision to the Board, linking proposals to patient outcomes and quality. | The Director of Nursing and their team routinely monitor shift-to-shift staffing levels, including the use of temporary staffing solutions, seeking to manage immediate implications and identify trends. | Chief Nurse and Director of HR and OD to report to the board monthly on staffing. (First report to public board before June 2014). These reports would highlight those wards where staffing frequently falls short of what is required to provide quality care to patients, the reasons for the gap, the impact and the actions being taken to address each issue. To discuss quality indicators alongside workforce information. | Workforce Lead & Finance Lead with DCN and HoN Workforce | R |
| | The Director of Finance ensures that finance decisions which could have an impact on staff capacity and capability and patient outcomes are taken with consideration of staffing and workforce planning implications, and that these are reflected in any advice provided for decision to the Board, linking proposals to patient outcomes and quality. | The Director of Nursing and their team routinely monitor shift-to-shift staffing levels, including the use of temporary staffing solutions, seeking to manage immediate implications and identify trends. | | | |
| | | | Need to design new monthly workforce reports by May 2014. | Director of HR and OD | O |
| | | | Ensure business planning and budget setting processes invlolve relevant nursing and midwifery staff. Process to be agreed by September 2014. | Director of Finance | O |
| **Accountability and Responsibility** | The Director of Finance ensures that finance decisions which could have an impact on staff capacity and capability and patient outcomes are taken with consideration of staffing and workforce planning implications, and that these are reflected in any advice provided for decision to the Board, linking proposals to patient outcomes and quality. | | DDNGs to monitor, react to and report on daily staffing concerns or action and report to nursing board monthly. To commence in March 2014. | DDNGs | |
| | | | Ensure business planning and budget setting process invlolves relevant nursing and midwifery staff. To be agreed by September 2014. | Chief Nurse Director of Finance and Director of HR and OD | |

| | | | | | |
|---|---|---|---|---|---|
| | | | DDNGs to monitor and report on daily staffing and any concerns or action and report to nursing board monthly. To commence in March 2014. | DDNGs | |
| **Evidenced based decision making** | Evidence-based tools are used to inform nursing, midwifery and care staffing capacity and capability | Senior nursing and midwifery staff and managers actively seek out data that informs staffing decisions | NICE will be reviewing the evidence base and accrediting tools in this area. To await guidance and implement. No date identified at present. | DCN and HoN Workforce | R |
| **Supporting and fostering a professional environment** | Clinical and managerial leaders foster a culture of professionalism and responsiveness where staff feel able to raise concerns. | The organisation supports and enables staff to deliver compassionate care | Review current development programmes by September 2014; introduce band 6 development programme June 2014. Liaise post recruited to May 2014. LiA programme continues in 2014/15 | Deputy Director of Education | |
| **Supporting and fostering a professional environment** | A multi professional approach is taken when setting nursing, midwifery and care staffing establishments. Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties. | Director of Nursing leads the process of reviewing staffing requirements | Staffing establishments take account of the need to allow nursing, midwifery and care staff the time to undertake continuous professional development, mentorship and supervision roles. This is to be included as part of 6 monthly reviews. | DDNGs | R |
| | | Papers presented to the Board are the result of team working and reflect an agreed position. | Supervisory status for ward leaders will be reviewed and monitored locally. Trust board to agree by May 2014. | DDNGs | R |
| | | | See actions under accountability and responsibility in relation to methodology and and reporting. | CN, DCN, Director of HR and OD, Finance Lead, Workforce lead. | R |
| **Openness and transparency** | Boards receive monthly updates on workforce information, and staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review. | | See actions under accountability and responsibility in relation to methodology and and reporting. | | R |

| | | | | | |
|---|---|---|---|---|---|
| **Openness and transparency** | Senior nursing and midwifery staff and managers | | Safe staffing boards will be displayed outside each ward area. Information for patients and the public will outline which staff are present and what their role is | DDNGs | R |
| **Planning for future workforce requirements** | Providers of NHS services take an active role in securing staff in line with their workforce requirements | | Review and revise recruitment processes for staff by September 2014 | Director of HR and OD | O |
| | | | Review appraisal process and training and development opportunities for staff by September 2014. | Deputy Director of Education | G |