St George's Healthcare NHS
NHS Trust

Quality Report
Trust Board
May 2014

I PATIENT SAFETY

a) Infection Control

i) Clostridium difficile

Financial Year 2013/2014

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 2 cases

We remained below our threshold for the year 2013/15 of 45 cases with a total of 30 hospitals cases for the entire year.

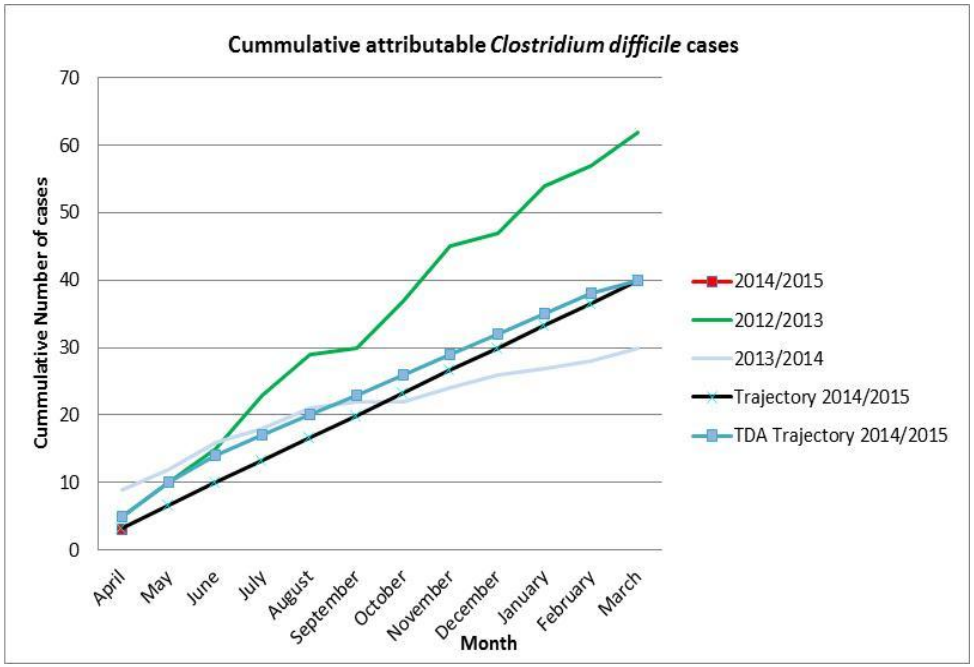
For the year 2014/15 our threshold has been further reduced to 40 cases.

So far for the year we have had 3 cases

March 3 cases.

Work continues on the following Infection Control initiatives: -

- Antimicrobial audit and stewardship.
- Audit against compliance with trust policy (line care).
- Line surveillance ward rounds.
- Environmental audits and cleaning inspections.
- Education and training sessions on a variety of infection prevention and control related topics.
- Root causes analyses of infection cases.



ii) MRSA Bacteraemia

The threshold for last year 2013/14 was zero avoidable cases. There were 10 cases last year, six ascribed to SGH. There has been dispute over a seventh case. Initially ascribed to the community, the community rejected the attribution on the grounds that it was a contaminant. All contaminants are finally attributed to the organisation that took the blood culture, in this case St Georges Hospital. The Trust is disputing this and entered the arbitration process. Analysis of cases attributed to St Georges last year revealed that 2 cases were unavoidable, 2 cases avoidable and 2 cases indeterminate. The threshold for 2014/15 is unchanged at zero.

MSSA

Trusts 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	Mar-14
MSSA	Post – 48 hours	21	1	2	5	1	4	2	0	4	1	2	4	3
	Pre – 48 hours	51	2	3	5	5	2	0	5	7	5	5	6	6

E. coli

Trusts 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	Mar-14
E. coli	Post – 48 hours	65	4	8	6	8	7	3	5	1	4	4	11	4
	Pre – 48 hours	169	12	10	17	15	13	16	11	21	12	14	16	12

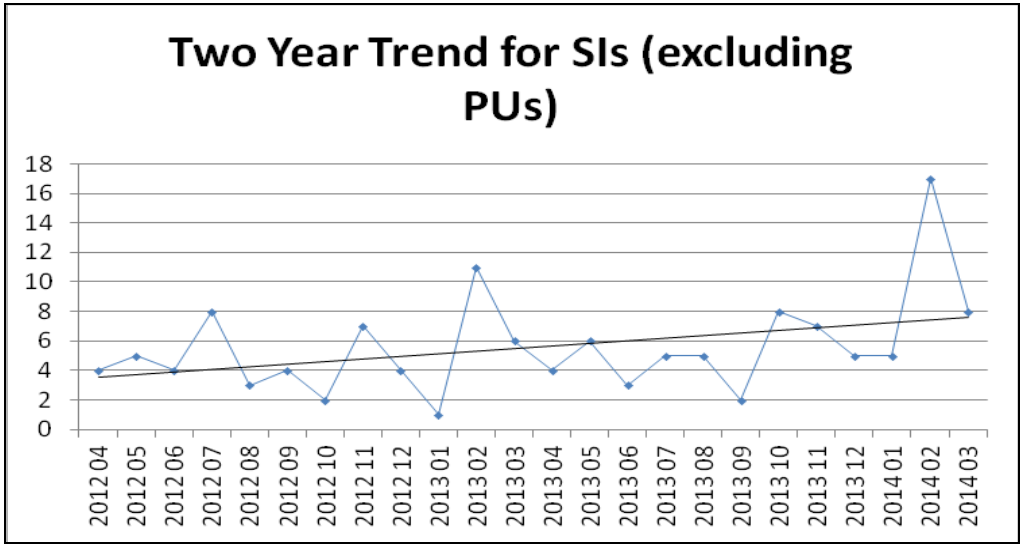
Carbapenemase Producing Enterobacteriaceae (CPE)

In the previous report the new Public Health England toolkit and subsequent Patient Safety Alert on CPE was highlighted. Subsequent to the last report a prevalence audit has shown that 20% of admitted patients would require isolating for 6 days even though only a very small minority of these patients would actually carry CPE. This would be very challenging to achieve and leave the Trust vulnerable to transmission of other infections, as all the isolation rooms would be occupied. While these organisms do represent a serious threat, the response must be proportionate and not cause unintended harm. We are in the process of developing a screening and isolation strategy for high risk areas such as intensive care, renal and haematology units, where CPE risks are the highest. This strategy will be in place by July.

This guidance is subject to an NPSA alert progress against which is regularly reported to the Patient Safety Committee.

b) Patient Safety

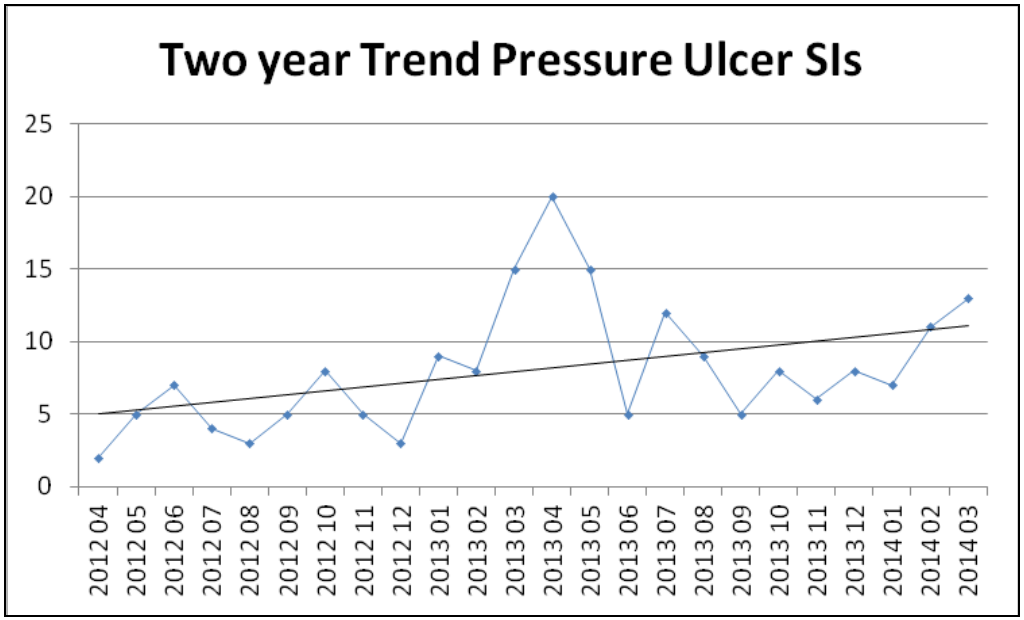
Table 1



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 declared serious incidents is rising. Last year there was a peak in February and this year there has been a peak as well.
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. Analysis of closed serious incidents is included in this report below and demonstrates some of the themes and actions taken to mitigate them.

Table 2

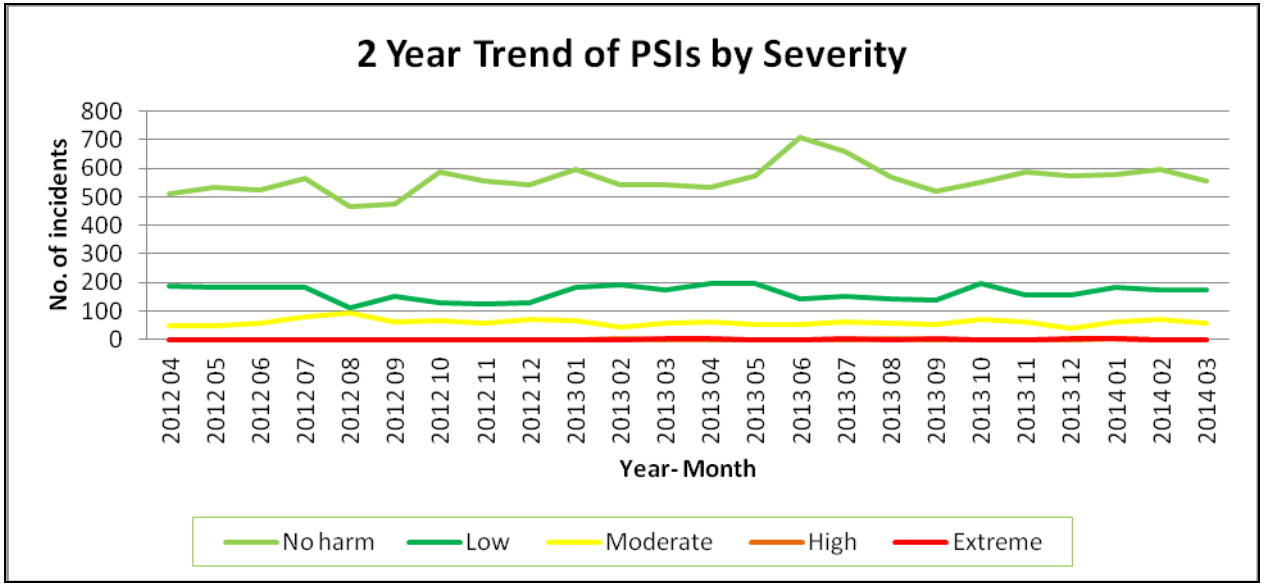


The trend of pressure ulcers showed a peak in April 2013 but this appears to be falling back to previous levels.
February showed a slightly higher rate than the previous 6 months. In quarter four there was a review of Grade 2 pressure ulcers to determine if the grading was correct. As a result of this a number were regraded to grade three. It is felt that this accounts for the rise in pressure ulcers but quarter one figures will need to be watched carefully to ensure that this is the case.

The serious incident reports now record whether a pressure ulcer is 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, an annual report (13/14) looking at our work and perfromance will be prepared for the Patient Safety Committee.

More detailed information on pressure ulcers will be available in the next report.

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 graph shows a fairly consistent rate of reporting. Although numbers are small, the number of high or extreme incidents has risen over the last six months which is consistent with the rise in serious incidents. As numbers are small the trends in high and extreme incidents are difficult to see on the graph.

Serious Incidents (SI) Thematic Review

October 2013- March 2014

1. Introduction

This report represents the sixth 6 monthly serious incident thematic review. Although this is largely a review of SI reports, data has been gathered from a range of sources to corroborate findings. This report will examine these trends and make a number of recommendations as to how to improve learning and practice as a result of these findings. Some of the key issues include:

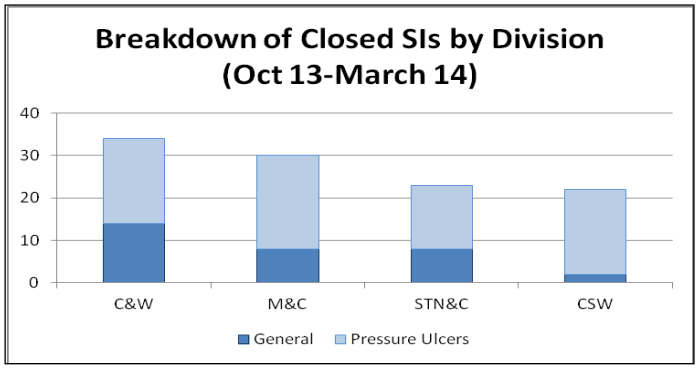
- The numbers of general SIs have begun to rise in contrast to the previous trend. The numbers of pressure ulcer SIs has reduced from a peak in April 2013.
- Pressure ulcers remain the single highest category of serious incident. The data for this will be included in a separate report (in the next report to the Board).
- The average time delay between a serious incident happening and being declared to commissioners) remains at 19 days. Work is on-going to improve this further.
- There were 4 SIs where the death of a patient was contributed to by failures in care and 7 SIs where failures in care contributed to patient harm.
- There continues to be some correlation between the underlying themes of SIs and other data such as clinical audits.
- There has been progress in a number of patient safety related projects and these are reported in the introduction.

1.1 Progress since the Previous Report

A number of recommendations were made in the October report to improve the process and outcomes from SI investigations. Progress has been made in a number of areas:

- A list of top tips for policy authors has been developed and is being supported by the Policy Ratification Group.
- A patient safety DVD has been produced on the theme of safe discharge. On the basis of this, a successful bid was made for a Darzi fellow to support the development of a safe discharge project.
- The pilot project to develop patient safety priorities within the Medicine and Cardiovascular Division has been completed and the learning has been rolled out at relevant forum.
- The Medical Director has raised the issue of handover particularly regarding outstanding results with Clinical Governance Leads in Care Groups.
- A project to improve communication of patient safety messages by way of a Patient Safety App is in the final stages of completion and will be piloted in the paediatric medicine care group.
- The Harm Free Care training package has been rolled out to nursing staff, using a simulation and scenario based approach to reducing harms.
- The patient safety staff forum continues to spread the learning from SIs. A nursing student forum is now well established and there are plans to set up a similar model for medical students.

2. SI Trends

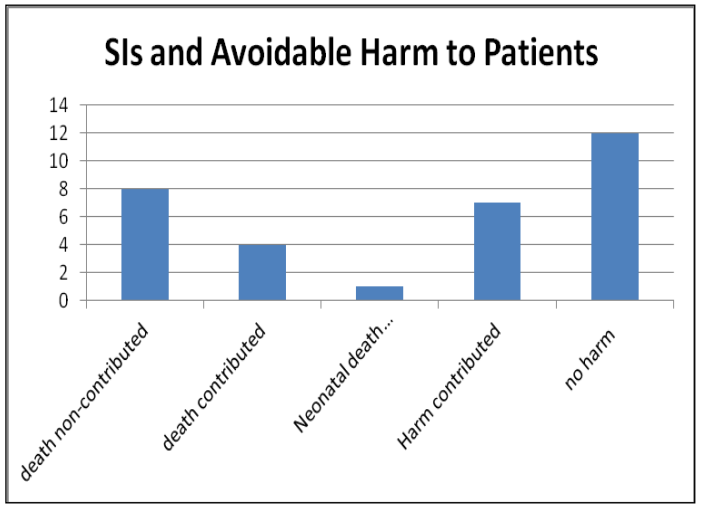


The adjoining graph shows the breakdown of SIs by division and the sub division by pressure ulcers. It shows a different pattern to previous reports:
Medicine and Cardiovascular Division have reduced both pressure ulcers and general SIs.
Women and Children have a consistent number of general SIs but the pressure ulcer SIs have increased. The Surgical Division have increased numbers of both general and pressure ulcer SIs and the Community Division has a consistent number of general SIs and has reduced the number of pressure ulcer SIs.

3. Severity of Incidents Trends

The Keogh Mortality Review (July 2013) announced the need for monitoring avoidable death within hospitals and a national indicator is under development. In order to consider the avoidable nature of some of the SIs within the trust, analysis has been carried out for this report to demonstrate the level of harm and the extent that care and treatment is thought to have contributed to harm. The adjoining graph attempts to capture that data.

Of the 12 SIs relating to patient deaths, in 4 of these there was some contribution towards the death and there were 7 cases of harm where we had contributed to the harm by an act or omission.



The contributed deaths related to the following SIs

- Fall
- Two patients where there was a delay in acting on adverse test results
- A delay in giving antibiotics

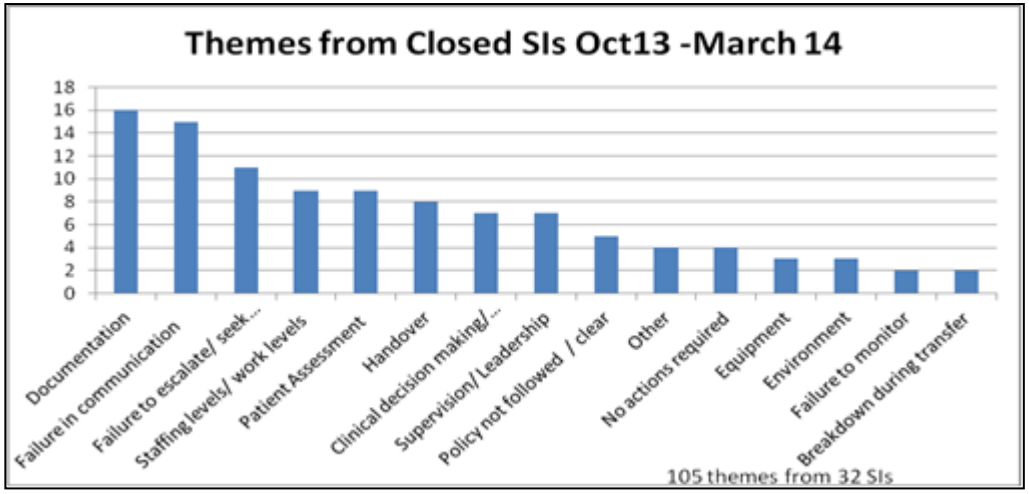
There was also a neonatal death where swift and accurate assessment at the triage stage may have reduced the likelihood of the outcome.

The contributed harms related to the following issues:

- Compartment syndrome
- NG Tube in lungs
- Missed opportunity to identify cancer of the uterus
- Post partum spell in intensive care
- Removal of the wrong skin lesion (never event)
- Admission of newborn to Neonatal Unit
- Wrong site surgery (never event)

4. Thematic Results

The following chart shows the underlying themes identified from October 13 to March 2014.



105 themes from 32 SIs

A number of similar themes continue to be identified through regular analysis. All of these have a number of projects designed to improve reliability in clincal areas and in some cases numbers appear to be decreasing.

As in the previous report, trends for the most frequent themes can be measured over time and compared with other relevant data (see below). Care should be taken to interpret the numbers which are relatively small and are based on the numbers of SIs in relevant categories. The themes are based on the 32 general SIs included in this report.

- The trend for staffing is consistent with the previous two reports (all groups).
- There remains an upward trend for communication and handover themes
- There was a high number of SIs in this report where there was a failure to escalate or seek expert advice

- Documentation figures are broadly consistent with previous reports
- The number of SIs where failure to moniotor is an issue appears to be falling
- The themes related to policies also is lower than in previous reports.

5. Safety Forum

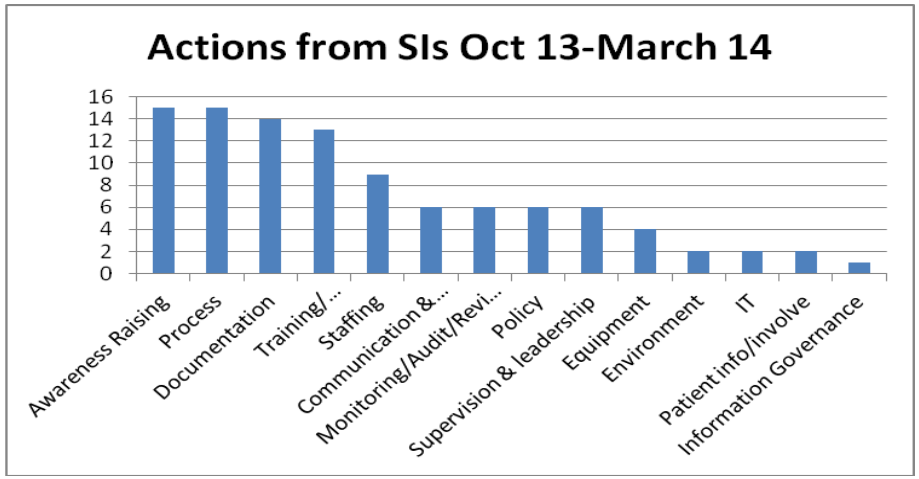
The Safety Forum is now well established as a regular forum to highlight the learning from SIs. Over the last six months the forum have run sessions on the following themes many of which have included elements of patient handover:

- TTOs not fully prescribed
- The lack of consultant to consultant handover when a patient was transferred from another hospital
- Contraindication for anticoagulants not understood by receiving team
- Failure to act on adverse test results
- Use of Smartpumps and risks of using Drug X category rather than using the drug library.
- ID checking

In addition to the forum on the St George's site, the forum are repeated at Queen Mary's Hospital and these forum focus on community issues where possible. A student nurse forum is also now firmly established where students can escalate any safety concerns. A medical student forum is in the planning phase. It is hoped that as well as spreading patient safety messages that this enables us to understand issues of which we might otherwise be unaware.

6. Actions from Serious Incidents

Analysis was carried out of the actions included in SIs compared with the previous reports and to cross reference with the underlying themes where possible. The following graph shows the main actions over this period.



The highest categories of actions are still improving processes and awareness raising as in previous reports. When compared with the analysis from previous reports the numbers of actions which include staffing have remained consistent. The number of staff training and documentation actions have risen since the previous report. Although communication is a frequent themes of SIs, actions to do with this area are generally not as high as expected. What is pleasing to note is that proportion of process actions remain high as it is felt that these actions are much more likely to lead to measurable change.

7. Being Open/ Duty of Candour

The Being Open Policy states that patients or their families should be given the option of involvement at all stages of an incident investigation where there is moderate or serious harm. This has been monitored through the serious incident reports where there is a section to record involvement. It is particularly important that being open conversations are instigated as soon after an incident as possible. The commissioning guidance stipulates a verbal response within 10 working days and this will be monitored through the SI process. Data taken from the SI reports shows that in 30 out of the relevant 31 reports that a discussion was instigated with the patient or family.

Training is ongoing for Being Open/ Duty of Candour and it is hoped that this programme will continue to improve practice in this difficult area. A project to further develop standards in this area is currently being designed to clarify standards.

8. Conclusions

The increasing trend in general SIs is a cause for concern and needs to be watched closely. Communication and documentation remain the highest themes of incidents and when added to the specific handover theme, continue to be a cause for concern. The data relating to avoidable harm should also be used to raise awareness with clinical staff and a newsletter to staff will include some of the key issues identified in this report.

This analysis shows that themes are repeated and while committed staff are implementing excellent initiatives, that support is needed to ensure that they are consistently and widely implemented. There are a number of proposed actions to further develop systems.

9. Recommendations

A number of recommendations are indicated by the findings of this report:

- To monitor changes to intranet policy access to ensure that risks identified in the high risk policies project are fully addressed
- To distribute new handover awareness raising posters as part of the May '14 Patient Safety Week.
- To complete the pilot project to develop a patient safety phone App with feedback from the pilot care group.
- To support communication as part of the Darzi fellow bid for safe discharge.
- To continue to run the newly developed Harm Free care Training and evaluate the impact on clinical skills
- To continue the patient safety staff forum and build on the feedback obtained at these events.
- To amend the MRSA SI template to include a section on "Being Open"

Patient Safety Week May 19th -23rd 2014-04-30
Patient Safety Week will have a different focus from previous weeks. The aim this year is to listen to our staff regarding their patient safety concerns.

The programme for the week is as follows:
Monday 19th May 14.00-16.00 Hyde Park Room, St George's Hospital
The Big Patient Safety Conversation
Staff can take part in this important conversation where they can help us to identify what we need to do to further improve patient safety.

Tuesday 20th May 12.00- 13.00 Patient Safety Forum Lecture Theatre G, St George's
This session will focus on Naso-gastric feeding and the learning from Serious Incidents in this area. The session will be led by Alison Robertson, Chief Nurse.

Wednesday 21st May 12.30- 2pm St John's Therapy Centre
Drop in and have your say with Fiona Hicks Divisional Governance Manager Community Services

Wednesday 21st May 14.30-16.00 Student Nurse Safety Forum Second Floor Grosvenor Wing G2.9
All student nurses are welcome to this forum which aims to raise safety awareness and learn from student experience. No need to book

Thursday 22nd 12.30-13.30 Mapleton Centre Team Room
The Community Big Safety Conversation
Community staff can take part in this important conversation to help us to identify improvements to patient safety.

During the week we will also be visiting clinical areas across the trust so that you can complete cards with suggestions to improve patient safety.

c) Early Warning Score

Through the regular thematic reviews of our serious incidents it is known that regular observation and timely recognition of a change in the clinical condition of a patient is essential to safe practice.

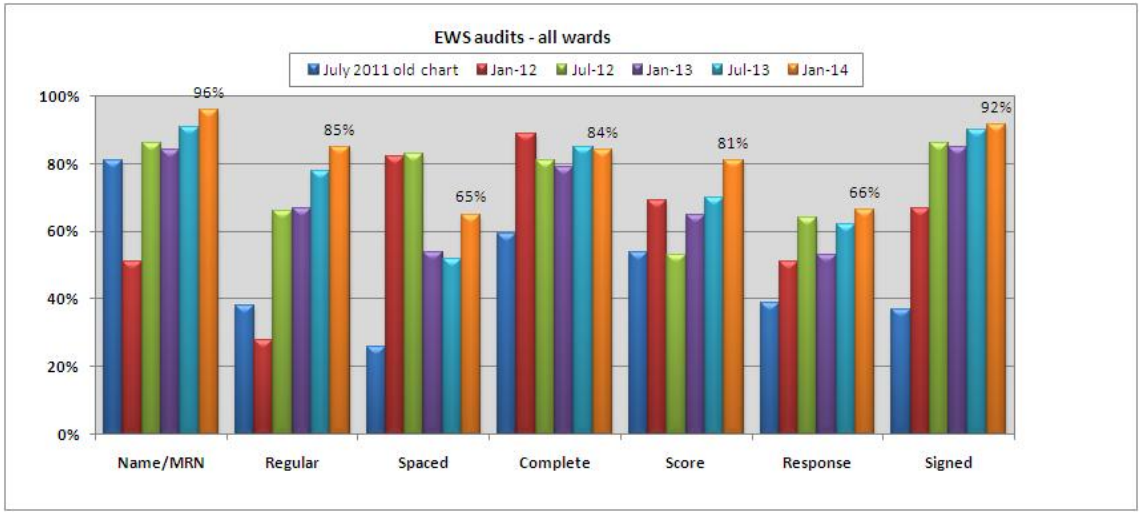
The trust has worked very hard over recent years to ensure that patients have their vital signs regularly monitored and that by adopting the use of the early warning score deteriorating patients are identified. If the score indicates the need to refer to the medical team the practitioner should communicate using the SBAR (situation, background, assessment, recommendation) communication tool to ensure that the information given is clear and the recipient can respond appropriately. Accurate documentation of observations and the recording of any follow up conversations is also vital.

Regular trust wide audits have been in place for some years and the information below summarises the results of the most recent survey. The full report has been presented to the Nursing board and Patient Safety Committee.

Results

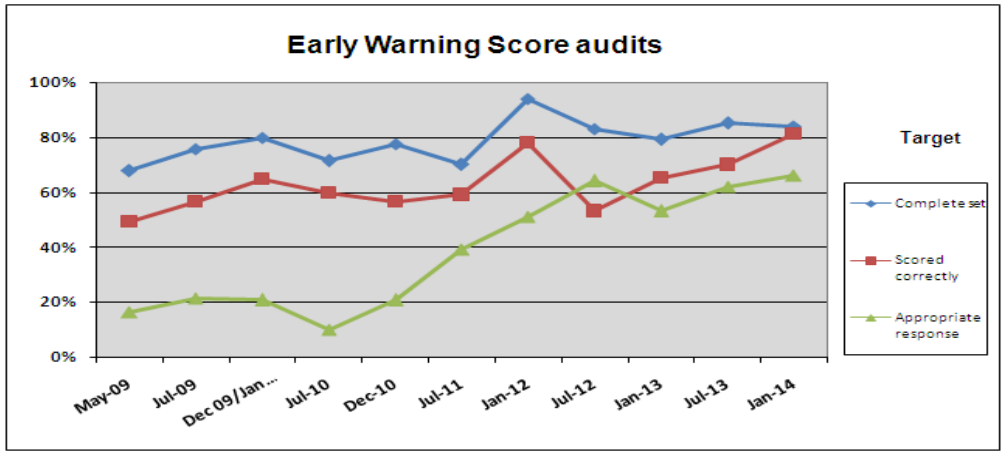
i) All adult wards on SGH and QMH were audited. From the 32 wards, 320 cases were audited in Jan 2014 which is consistent with previous audits. The main measures for the audit were: whether a complete set of observations was recorded, whether EWS was scored correctly (question 5) and, where EWS has triggered a score, an appropriate response has been documented (question 6). The compliance target was 80%.

The following chart summarises the results for all measures and all wards (excluding Duke Elder ward, Moorfields Eye Hospital). This demonstrates that there is variation in compliance between different measures.



The results indicate however that there is improvement in six out of seven measures audited when compared to the previous audit. These results are available at ward level which enables the divisions to identify which areas require additional support in order to improve performance.

ii) The main markers for the success of the EWS were (a) recording a complete set of observations; (b) scoring EWS correctly; and (c) appropriate response. These were achieved in 84%, 81% and 66% of cases respectively in this audit, excluding Duke Elder ward (Moorfields), against the local target of 80%. It is pleasing to note that whilst not yet compliant with the trust's standard there has been steady improvement in the appropriate response marker.



Division	Full set	Score correct	Appropriate response
CWDTCC	80%	80%	100%
CSW	70%	70%	42%
M+C	87%	83%	53%
STNC	84%	81%	73%
ALL	**84%**	**81%**	**66%**

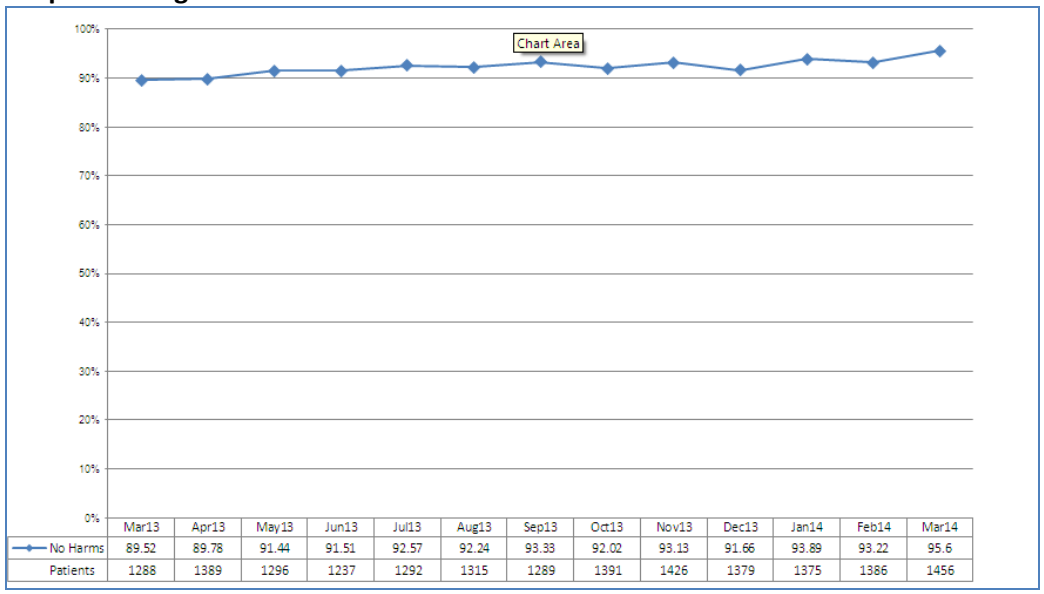
Key: Green >80%; Amber 60-79%; Red <60%

Results by division demonstrate this variation. It should be noted that only one ward was audited in the Children + Women division (Champneys) as this version of the EWS tool is not used in paediatrics or obstetrics. Three wards (Dalby, Heberden and Mary Seacole) were audited in the Community division.

A PowerPoint presentation is available to wards for use in training and this is also utilised in MEERKAT's training and the Harm Free Care study day. Electronic recording of observations commences its rollout soon and this should further improve performance, particularly for accurate scoring. Six-monthly re-audit is included in the annual programme for 2014/15. The full report has been presented to the Patient Safety Committee, Nursing Board and Matrons Forum.

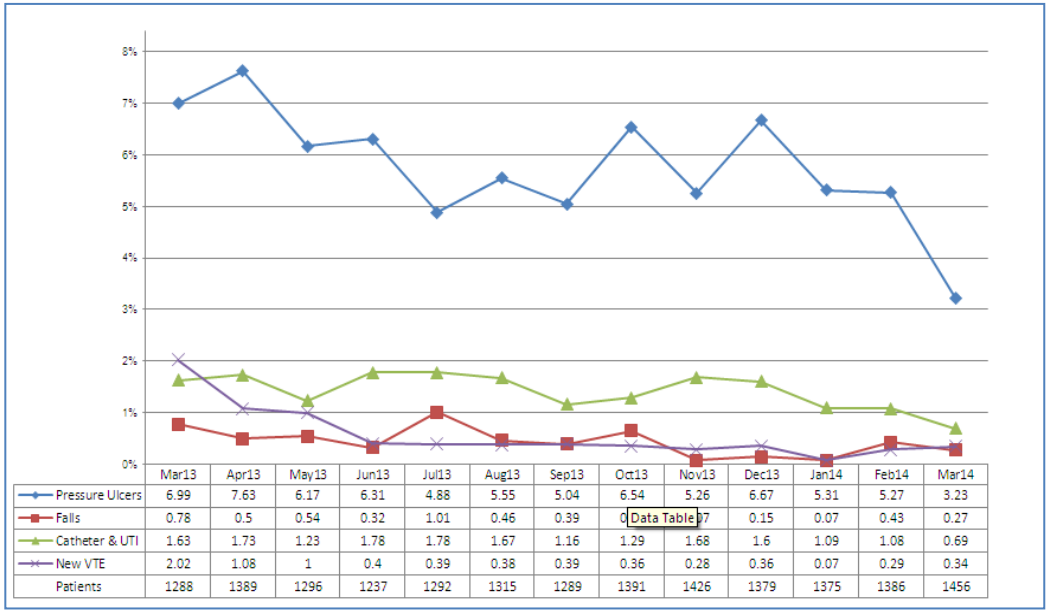
d) Patient Safety Thermometer:

Graph showing all harm free care within the trust - March 2014:



	Mar13	Apr13	May13	Jun13	Jul13	Aug13	Sep13	Oct13	Nov13	Dec13	Jan14	Feb14	Mar14
No Harms	89.52	89.78	91.44	91.51	92.57	92.24	93.33	92.02	93.13	91.66	93.89	93.22	95.6
Patients	1288	1389	1296	1237	1292	1315	1289	1391	1426	1379	1375	1386	1456

Graph showing types of harm recorded:



	Mar13	Apr13	May13	Jun13	Jul13	Aug13	Sep13	Oct13	Nov13	Dec13	Jan14	Feb14	Mar14
Pressure Ulcers	6.99	7.63	6.17	6.31	4.88	5.55	5.04	6.54	5.26	6.67	5.31	5.27	3.23
Falls	0.78	0.5	0.54	0.32	1.01	0.46	0.39	0.[illegible]7	0.15	0.07	0.43	0.27	
Catheter & UTI	1.63	1.73	1.23	1.78	1.78	1.67	1.16	1.29	1.68	1.6	1.09	1.08	0.69
New VTE	2.02	1.08	1	0.4	0.39	0.38	0.39	0.36	0.28	0.36	0.07	0.29	0.34
Patients	1288	1389	1296	1237	1292	1315	1289	1391	1426	1379	1375	1386	1456

Background

The Patient Safety Thermometer (ST) has been fully rolled out across the acute trust and community nursing teams and therapy led services for patients seen in their own home on the day of collection. This national tool measures four high-volume patient safety issues allowing teams to measure the proportion of patients that experience 'harm free' care. The CQUIN for 2013/14 was achieved in full. The 2014/15 CQUIN is still being discussed with commissioners as there is not yet agreement on patients with old/existing ulcers that the trust "inherits". The definition for old harms is that the patient is admitted to the trust (whatever the location) with the harm or that it develops within 72 hours of admission.

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.

In March 1,456 patients were surveyed and 95.6% of patients were 'harm free', this is the highest percentage to date and exceeds the national target of 95%. The national average for March was 93.62%. The second chart on the left shows the four harms for the trust overall. There are some areas that appear to be reporting higher percentages of harm which include an increase in the following:

Harm	March	April
Old pressure ulcers	2.34%	3.19%
New pressure ulcers	1.03%	1.6%
Catheter & New UTI	0.34%	1.04%
New VTE's reported	0.34%	0.76%

Challenges and Benefits of the Safety Thermometer

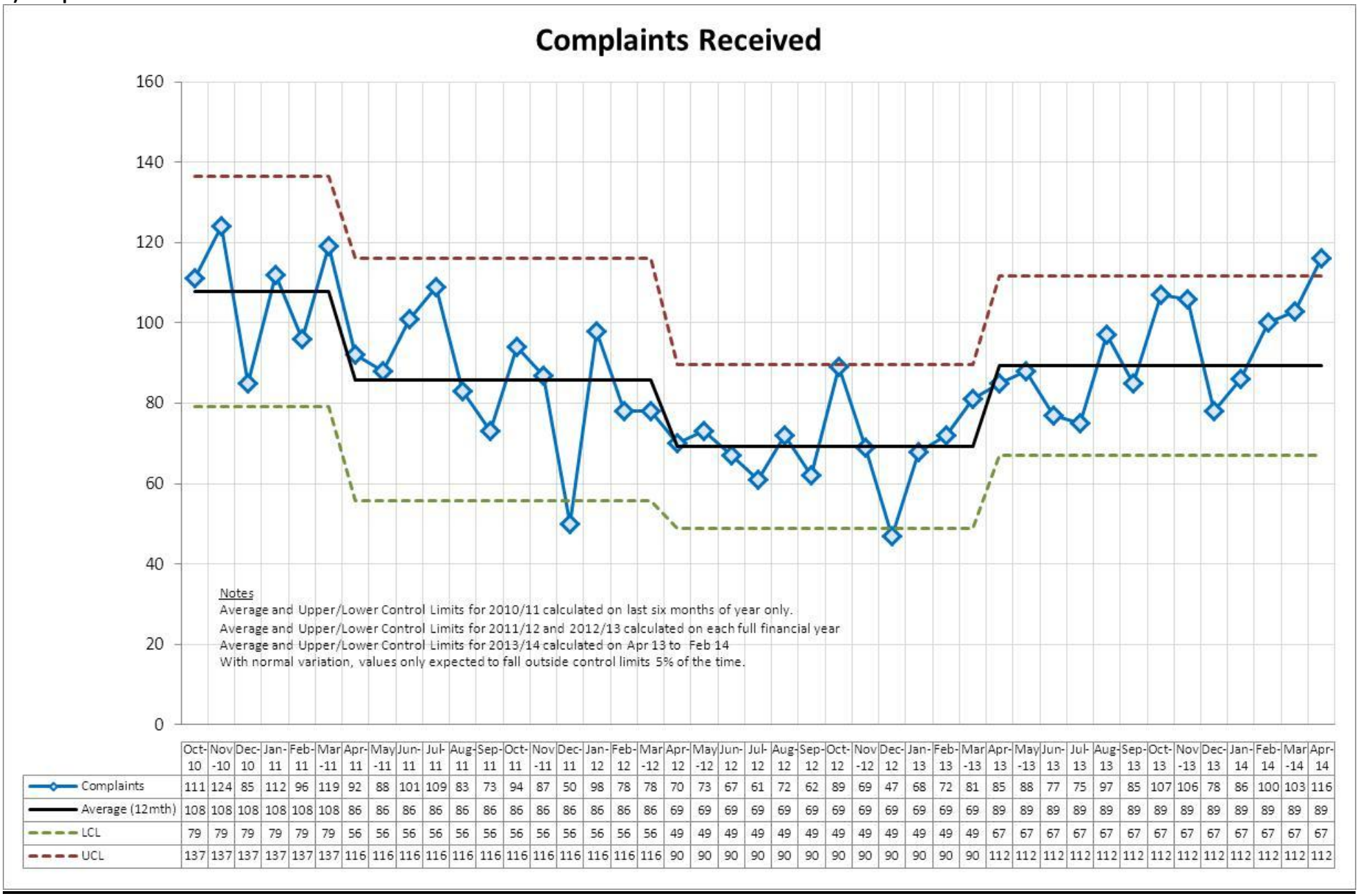
We have seen a significant reduction in the number of pressure ulcers reported (particularly grade 2's) which has been supported by the appointment of a second acute Tissue Viability Nurse.

The ST is now embedded and across the trust with information displayed on boards in clinical areas to ensure staff are aware.

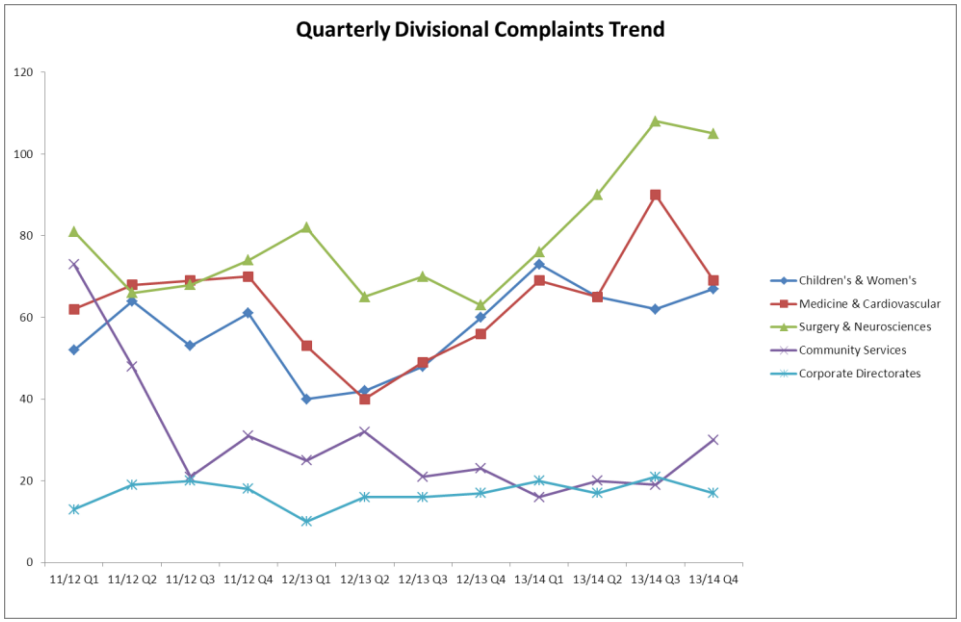
The two new ST's (Medication Safety and Maternity services) are still being discussed with NHS England and are being piloted in some trusts. A team of pharmacists/nurses plan to visit UCLH who are a pilot site to discuss practicalities and how this is progressing there.

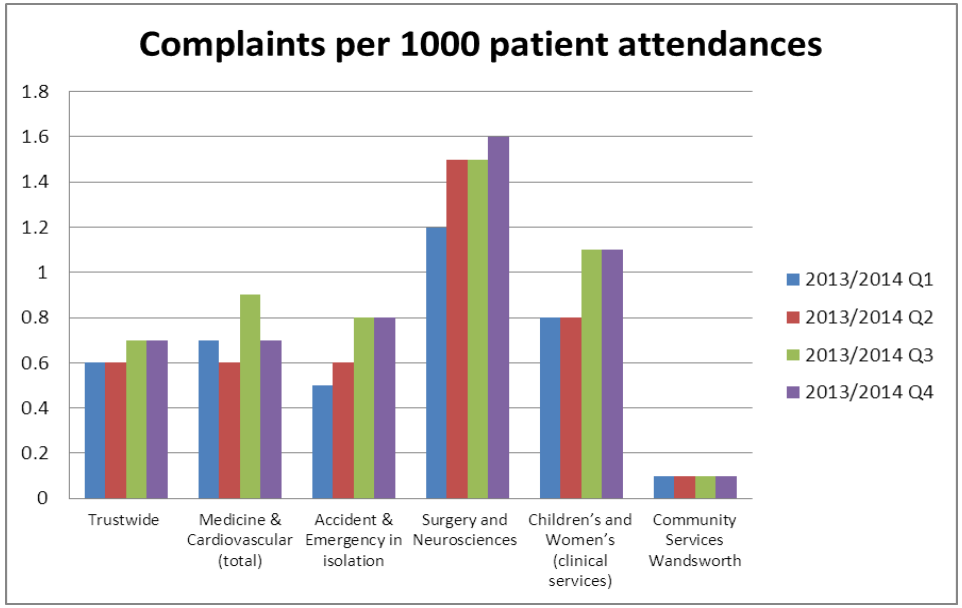
II PATIENT EXPERINCE

a) 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	Mar-14	Apr-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	86	100	103	116
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	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	67	67	67	67	67	67	67	67	67	67	67	67	67
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	112	112	112	112





COMMENTARY

This report provides an overview of how the trust has managed complaints received in quarter 4 of 2013/2014 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 4, complaints per 1000 attendances, a summary of the latest work on RAG rating of complaints and ombudsman activity. More detailed reports go to a variety of other groups and committees

Total numbers of complaints received in quarter 4

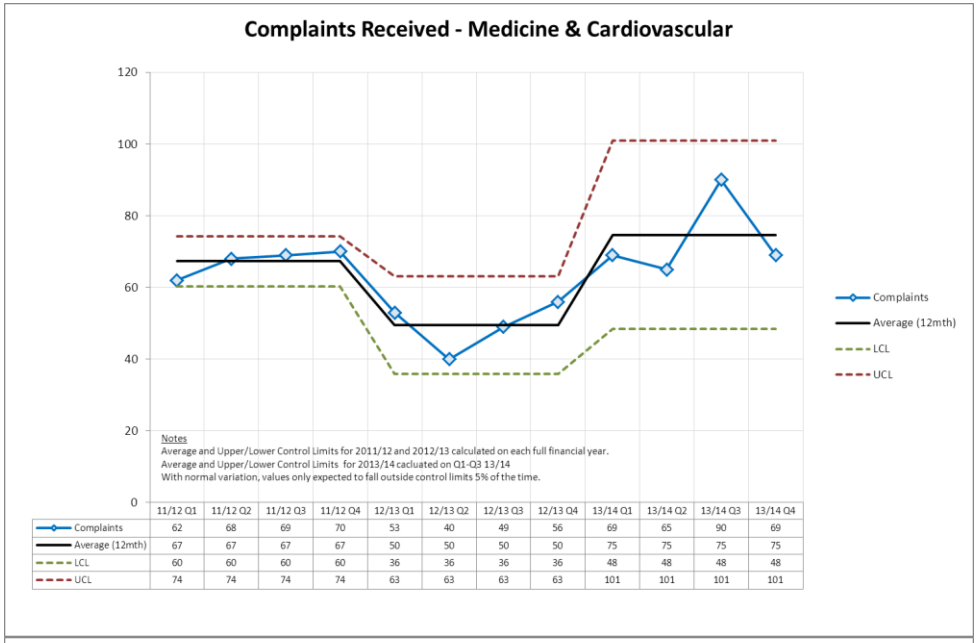
There were 288 complaints received in quarter 4 of 2013/2014 which is a slight decrease on quarter 3 when 300 complaints were received. The chart on the previous page shows a breakdown by month. Complaints being received about the divisions of Surgery & Neurosciences and Children's & Women's and Corporate Directorates remain stable when compared to the previous quarter. There has been a significant increase in complaints received about the division of Community Services and a significant decrease in complaints being received about the division of Medicine & Cardiovascular.

It can be noted that there were 116 complaints received in April which falls outside the upper control limit. The full figures for quarter 1 will be reported to the board in July.

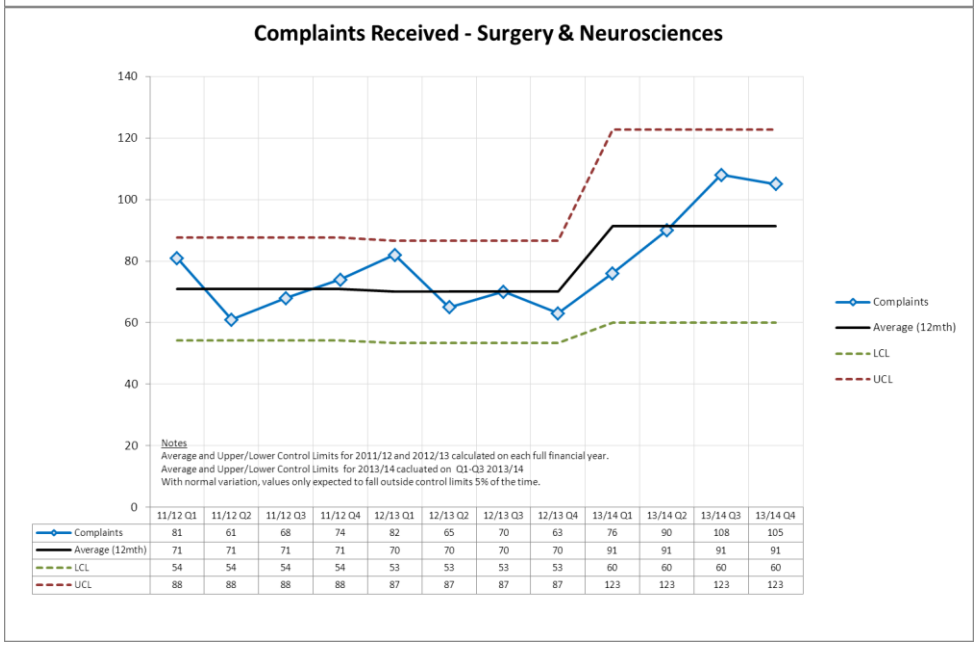
Total number of complaints received in 2013/2014

1083 complaints were received in 2013/2014, an increase of 31% on 2012/2013 when 825 complaints were received. The reason/s for the significant increase in complaints are not clear as complaints have increased across a number of areas and subjects with no obvious specific themes. It is felt that possibly increased publicity (including more posters and leaflets around the trust) may have contributed towards the increase as patients are made more aware about their options and the process for how to complain. The introduction of the Friends and Family Test may have also raised the profile generally as well as the publication of national reports including the report of handling of complaints by NHS hospitals in England by Ann Clwyd MP and Professor Tricia Hart and others. We view all types of patient feedback as positive and we are constantly looking at ways in which we encourage patients, carers and families to give their views.

National statistics will not be published until August 2014 but a survey of London trusts was undertaken and from those who responded (16 trusts) 11 reported an increase of between 3% and 45%. Reasons given include the acquisition of additional hospitals, mergers with mental health trust/community services and a change in the way in which complaints and concerns are being handled.



	11/12 Q1	11/12 Q2	11/12 Q3	11/12 Q4	12/13 Q1	12/13 Q2	12/13 Q3	12/13 Q4	13/14 Q1	13/14 Q2	13/14 Q3	13/14 Q4
Complaints	62	68	69	70	53	40	49	56	69	65	90	69
Average (12mth)	67	67	67	67	50	50	50	50	75	75	75	75
LCL	60	60	60	60	36	36	36	36	48	48	48	48
UCL	74	74	74	74	63	63	63	63	101	101	101	101



	11/12 Q1	11/12 Q2	11/12 Q3	11/12 Q4	12/13 Q1	12/13 Q2	12/13 Q3	12/13 Q4	13/14 Q1	13/14 Q2	13/14 Q3	13/14 Q4
Complaints	81	61	68	74	82	65	70	63	76	90	108	105
Average (12mth)	71	71	71	71	70	70	70	70	91	91	91	91
LCL	54	54	54	54	53	53	53	53	60	60	60	60
UCL	88	88	88	88	87	87	87	87	123	123	123	123

COMMENTARY

Medicine and Cardiovascular Division

Although overall there has been a reduction in complaints being received for the division, the number of complaints being received for Accident and Emergency and Acute Medicine Care Groups remains high.

Accident and Emergency

The most complained about subject is clinical treatment – diagnosis with 9/27 complaints. This is followed by the subjects of nursing care and attitude. These complaints relate to different doctors and nurses and there is no theme in terms of individuals. As previously reported, as well as complaints being discussed with the individuals concerned they are shared at team days, departmental governance meetings and training days. However thus far this has not resulted in a reduction in complaints.

Acute Medicine

The most complained about subject is concerns around discharge with two being received about Caesar Hawkins Ward. The following actions have been taken as a result:

- All staff on the ward have been reminded to ensure that when they are preparing patients for their discharge home, that their property is packed with sensitivity and professionalism. Concerns were raised in January 2014 and discussed in detail in order to disseminate this learning to the staff and to ensure that this situation does not occur again in the future.
- Matron has reminded all of the nursing staff during the daily safety briefing to ensure that all patient lockers have everything removed following each patient discharge. The lockers will now be left open.

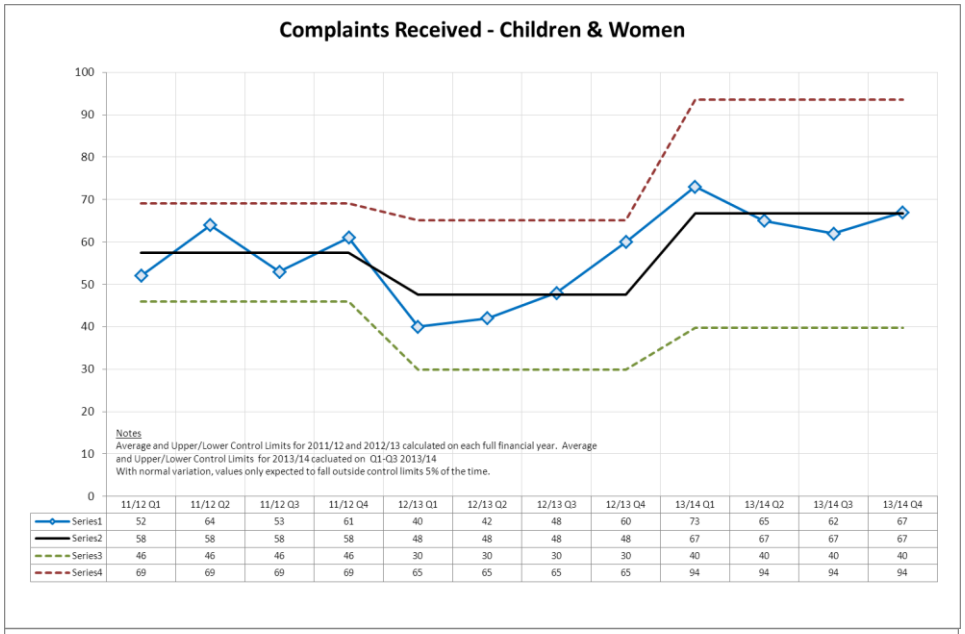
Surgery and Neurosciences Division

Urology

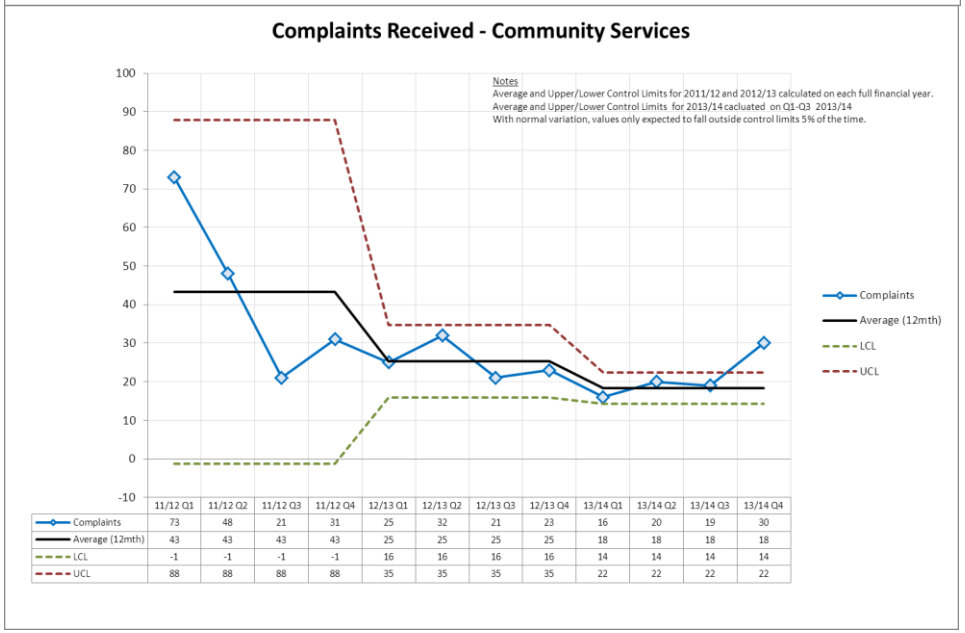
A high volume of complaints were received in Urology in Quarters 3 and 4 of 2013/2014. The themes of these complaints are varied however; the team is focusing on improving written and verbal communication and have instigated a service improvement project with Corporate Outpatients, as these are consistent issues raised by complainants.

ENT/Audiology

There are issues about a lack of timely follow-up appointments, which the ENT/Audiology service is addressing through the provision of additional Saturday clinics in the first instance but also some pathway redesign. The consultant body have agreed that the audiologists can follow up the more simple hearing patients – this cohort do not need to return to see a consultant for a review. The patient pathway has been streamlined for those patients presenting with dizziness and tinnitus which should free up some available capacity for the more complex audiology patients.



	11/12 Q1	11/12 Q2	11/12 Q3	11/12 Q4	12/13 Q1	12/13 Q2	12/13 Q3	12/13 Q4	13/14 Q1	13/14 Q2	13/14 Q3	13/14 Q4
Series1	52	64	53	61	40	42	48	60	73	65	62	67
Series2	58	58	58	58	48	48	48	48	67	67	67	67
Series3	46	46	46	46	30	30	30	30	40	40	40	40
Series4	69	69	69	69	65	65	65	65	94	94	94	94



	11/12 Q1	11/12 Q2	11/12 Q3	11/12 Q4	12/13 Q1	12/13 Q2	12/13 Q3	12/13 Q4	13/14 Q1	13/14 Q2	13/14 Q3	13/14 Q4
Complaints	73	48	21	31	25	32	21	23	16	20	19	30
Average (12mth)	43	43	43	43	25	25	25	25	18	18	18	18
LCL	-1	-1	-1	-1	16	16	16	16	14	14	14	14
UCL	88	88	88	88	35	35	35	35	22	22	22	22

COMMENTARY

Children and Women Division

Outpatients

Despite previous actions reported and the continuation of the project the outpatient experience, complaints about outpatients increased significantly from 18 in quarter 3 to 29 in quarter 4. Communication of all kinds, attitude and waiting times continue to be themes. Recent/planned actions taken to improve include:

- Outpatient reception and nursing teams reminded of the importance of keeping patients informed of delays and their reasons with a warning that further instances of poor communication will be addressed formally through the appropriate trust procedures.
- Over the course of this and next calendar year, all notes for adult and paediatric patients attending the trust will become scanned. This will prevent notes becoming misplaced and reduce delays for patients as a result. It is hoped that this will mean patients attending the trust have a more positive experience and safer care.
- A new Head of Nursing has been appointed and will lead on resolving issues informally and preventing the need to complain by speaking to patients before they leave the clinic and more "Don't take your troubles home" posters have been put up in clinics.

Community Services Division

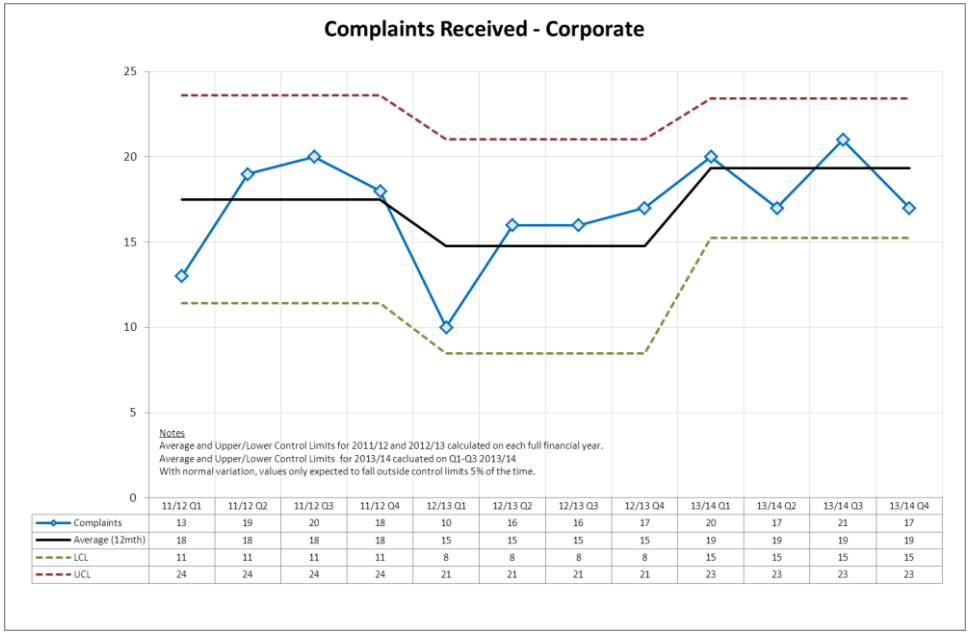
Children's Services

Four complaints were received for Children's Services in quarter 4 compared to none in quarter 3. Two of these concerned a specific School and are in the process of being investigated. Actions taken to date include senior staff in the division visiting the school to discuss the best way to get the necessary medical and nursing staff onsite. The trust's Executive Management Team has also made the decision to integrate all children's therapies under the chief therapist specifically to allow the removal of historical geographical referral acceptance criteria so that staff are able to assess and deliver care based on need irrespective of location.

Offender Healthcare

An increase in complaints being received in Offender Healthcare has resulted in a number of actions including:

- All patients with complex needs will be allocated a lead nurse who will devise a care plan and conduct regular reviews with patients. This will be actioned by Head of Healthcare for the OHS by June 2014.
- The OHS Healthcare Administration Team is reviewing the current process to follow up routine review appointments with the patient and external provider. This will be actioned by Head of Healthcare for the OHS by June 2014.



	11/12 Q1	11/12 Q2	11/12 Q3	11/12 Q4	12/13 Q1	12/13 Q2	12/13 Q3	12/13 Q4	13/14 Q1	13/14 Q2	13/14 Q3	13/14 Q4
Complaints	13	19	20	18	10	16	16	17	20	17	21	17
Average (12mth)	18	18	18	18	15	15	15	15	19	19	19	19
LCL	11	11	11	11	8	8	8	8	15	15	15	15
UCL	24	24	24	24	21	21	21	21	23	23	23	23

Complaints performance quarter 4

	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	67	39	58%	(8) 70%
Medicine and Cardiovascular	69	53	77%	(11) 93%
Surgery & Neurosciences	105	56	53%	(16) 69%
Community Services	30	16	53%	(6) 73%
Corporate Directorates	17	16	94%	(0) 94%*
Totals:	288	180	63%	(41) 77%

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

COMMENTARY

Transport

Actions being taken in response to complaints received about transport include:

- A review of patients returning late from outpatient clinics to the transport lounge is being undertaken. If patients arrive after 6pm which is when the lounge is meant to close and outpatient activity is expected to be completed, this can result in longer waits.
- The control centre team for transport is being restructured to improve the planning of journeys through better trained staff and a more robust management structure.

Catering

- As a result of a complaint received about catering on Amyand Annexe both nursing and catering teams have been retrained in the provision of meals and beverages.
- As a result of a complaint received about catering on Gray Ward, ward staff have been reminded of the availability of snack boxes 24 hours a day and in addition the catering hostesses have been re-trained to ensure that these options are made known to patients on their arrival.

COMMENTARY

Quarter 4

For complaints received in quarter 4, 63% were responded to within 25 working days compared to 64% in quarter 3.

For the same period, 77% of complaints are planned to be responded to within 25 working days or agreed timescales compared to 79% in quarter 3. The final percentage may change depending on whether all of the agreed extensions are eventually met.

2013/2014

For complaints received in 2013/2014 68% were responded to within 25 working days against a target of 85% which is the same as in 2012/2013 and 2011/2012.

For the same period, 82% of complaints have been responded to within 25 working days of agreed timescales against the target of 100% compared to 84% in 2012/2013; hence the trust has not improved at contacting complainants to negotiate an extension.

Reopened complaints where complaints were closed in 2013/2014

1053 complaints were closed in 2013/2014 and of these 7% have subsequently been re-opened thus far. This has been an improvement when compared to 2012/2013 and 2011/2012 when 9% and 11% of complaints were reopened. The only significant outlier is Acute Medicine with 17% of complaints being re-opened. The Patient Experience Manager will be undertaking a piece of work with the General Medicine management team to review the reasons for re-opened complaints.

Complaints referred to the Parliamentary & Health Service Ombudsman

Seven requests for documentation were received from the Ombudsman's office in 2013/2014 compared to 21 in 2012/2013. These requests pertain to complaints from seven different areas: Urology, Cardiology, General Intensive Care, Accident & Emergency, Acute Medicine, Renal and Acute Medicine.

In one case the request for documentation was a request for information and not related to a complaint about St George's Healthcare NHS Trust.

For five of these cases final reports have now been 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 four reports received the Ombudsman did not uphold any aspect of the complaints and felt that the trust's responses were reasonable.

In one case the Ombudsman is investigating the complaint.

Care Connect

Two problems have been received via Care Connect but both of these were 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. This has been raised as an issue with the team at Care Connect. 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 26 posts made on NHS Choices and Patient Opinion in quarter 4 of 2013/2014 of which 15 were positive and 11 were negative.

A&E received five positive comments and no negative comments. Themes included the good care and communication from staff and the speed at which patients were seen and treated. There were three negative comments received about neurosurgery relating to poor communication from nurses and doctors and cancellation of surgery.

Area/team	Positive	Negative	Both	Total
Accident and Emergency	5	0	0	5
Gynaecology	1	0	0	1
General Surgery	0	1	0	1
Cardiology	2	0	0	2
Orthopaedics	1	0	0	1
Maxillofacial	1	0	0	1
Car Parking	0	1	0	1
Day Surgery Unit	0	1	0	1
Breast Clinic	1	0	0	1
ENT	1	1	0	2
Imaging	0	1	0	1
Neurosurgery	0	3	0	3
Caesar Hawkins	0	1	0	1
Maternity	1	1	0	2
Urology	0	1	0	1
ICU	1	0	0	1
Non specific	1	0	0	1
Total	15	11	0	26

Complaints & Improvements Department Severity Report

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 4 is presented below. A more detailed report will be presented at the May Quality and Risk Committee and the June Patient Experience Committee.

- In Quarter 4 a total of 12 complaints we categorised as Red/Severe.

The reasoning for the red ratings included:

- Vulnerable patient, possible neglect.
- Adverse outcome.
- Complex case as more than one service involved.
- Two registered as serious Incidents as well as complaint cases.
- Death noted.

- In Quarter 4 a total of 104 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.

- In Quarter 4 a total of 169 complaints were categorised as Green/Minor.

b) **CQC inpatient adult survey 2013**

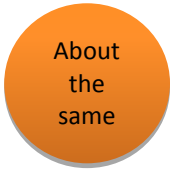
This patient experience survey is repeated annually and is helpful in showing how well the trust performs over time against a range of questions. The cohort for the 2013 survey were sampled from patients aged 16 or older who had spent at least one night in hospital (excluding maternity and psychiatry). The trust response rate was 47% (49 national).

Demographic characteristics

Gender	**Male 48%**				**Female 52%**	
Age	16 – 35 11%	36 – 50 12%			51 – 65 22%	66+ 55%
Ethnicity	White 74%	Multiple 2%		Asian/British 7%	Black/British 9%	Other 9%
Religion	No 19%	Christian 66%	Muslim 5%	Hindu 4%	Other 4%	Prefer not to say 2%
Sexual Orientation	Straight 92%	Gay/Lesbian2%	Bisexual 0%	Other 1%	Prefer not to say 5%	

There were 70 questions grouped into 10 sections. The number of questions in each section varied. Each section (and question) is given a score out of 10.

The trust did not perform well for that particular sections/question compared to other trusts.



The trust is performing about the same for the particular section/questions compared to other trusts.

The trust is better for that particular section/question compared to other trusts.

Unlike the Chief Inspector of Hospital inspections trusts are not awarded an overall rating. It is believed that this would be misleading as the survey assesses a number of different aspects of people's experiences and trust's performance varied across these.

St George's Healthcare NHS Trust – Adult Inpatient Survey

Category	2013 Score	Specific issues contained within each section
Emergency Department		
Waiting list and planned admissions		**7.6** Waiting to get a bed
Waiting to get to a bed		
The hospital ward		**5.9** Noise from other patients **7.0** Help with eating **7.7** Noise from Staff **5.2** Quality of food
Doctors		
Nurses		

It can be seen from the results that St George's has maintained the same position as the 2012 survey in that all categories are rated in the 'as expected' category. This is a stark contrast to the 2009 survey which had over 25% of questions rated in the bottom 20% (worse performing category).

It should be noted that there was one question in the operations and procedures category; Patients reported that they were not told sufficiently well what to expect following their procedure.

It is however important to look beyond the composite category score to identify if there are any issues that require action for improvement.

The comment box to the right of the score highlights where further focus could be given.

The report is being presented to the Patient Experience Committee in June for further discussions as to how best to take these results forward. One suggestion would be to take specific issues forward.

The qualitative comments also provide a rich source of feedback.

Care and Treatment		**6.0** Talking about worries and fears **6.3** Getting help (response to call bells)
Operations and Procedures		**6.5** Expectations after operation (worse than expected) **7.7** Being told how operation and procedure had gone
Leaving Hospital		**5.4** delays to discharge **4.6** Information about side effects from information **5.6** Being told what to look out for 'danger signals'
Overall views and experiences		**1.8** asked to give views **2.0** information about complaints

c) Day Case Survey, 2013

St George's Day Case unit participated in a voluntary patient experience survey, carried out by the Picker Institute. This is the second Day Case survey of its kind and the survey ran for 16 trusts nationwide.
A total of 832 eligible patients from St George's were sent a questionnaire, of which 364 returned a completed questionnaire, giving a response rate of 44% [down from 48% in 2012]. Patients were asked a total of 74 questions, including 12 questions relating to how patients rated the care they received overall.

In comparison to other Trusts St George's results were significantly better in the following areas:

Question	Trust	Average
Before visit: given choice of dates for surgery	47%	36%
Before visit: given information about condition or treatment	83%	78%
Discharge: given written/printed information about what they should or should not do after leaving hospital	91%	77%
Discharge: told who to contact if worried	94%	87%
Discharge: receiving copies of letters sent between hospital doctors and GP	81%	73%

Results that were better when compared with the Trust 2012 results for the following questions:

- Surgery: Questions before surgery were more fully explained
- Nurses: not talking in front of patients
- Discharge: fully told purpose of medications
- Discharge: informed who to contact if worried
- Discharge: given written/printed information about what they should or should not do after leaving hospital
- Hospital: toilets were clean

Results that were worse when compared with the Trust 2012 results for the following questions:

- Surgery: Results not explained in a clear way
- Care: not always enough privacy when being examined or treated
- Nurses: Did not always get opportunity to talk to when needed
- Length of stay too long/too short

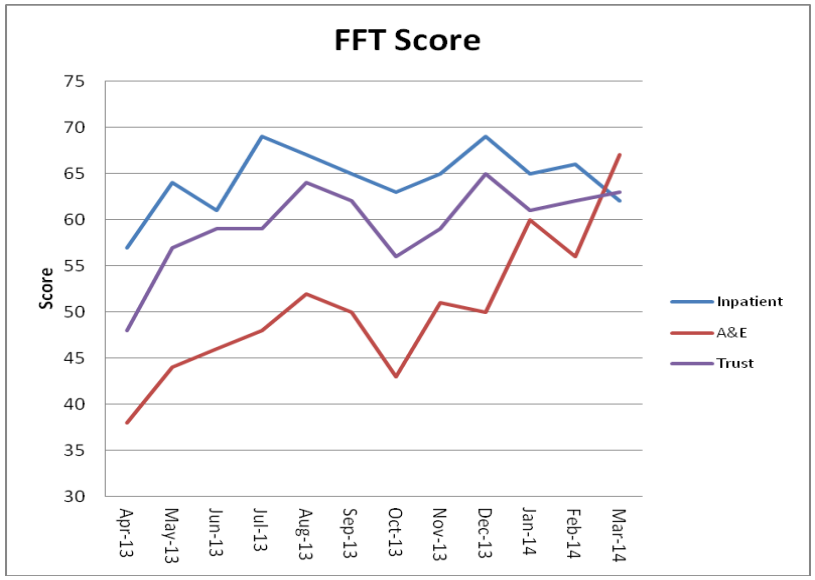
Results that were worse when compared with the Trust 2012 results

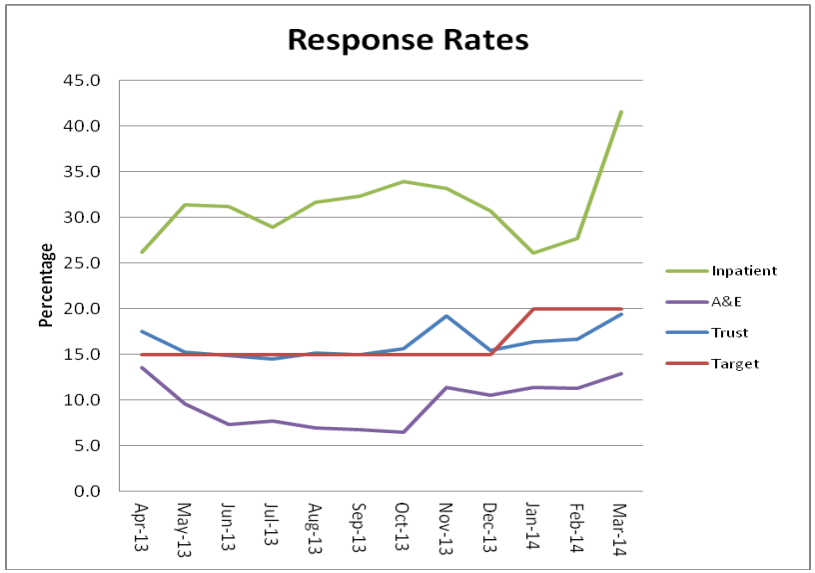
Areas where there is room for improvement:

- Care: 46% said they wanted more opportunity to talk to a doctor
- Care: 34% of patients said they wanted to be more involved in decisions about their care
- Care: 28% say staff did not do everything to help control pain
- Discharge: 50% of respondents were concerned about delays in discharge (for either more than one hour or information given about the delay).

An action plan has been developed to focus efforts around 3 main themes:
Ensuring patients feel they have the opportunity to talk to a nurse/doctor
Providing optimal pain control post operatively
Reducing delays in discharging patients

d) Friends and Family Test (FFT) – March 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 March, the Friends and Family Test score for the trust overall was +63, slightly higher than February (62). A&E hit their highest score to date with +67 and the adult inpatient wards down slightly with +62. The scores for maternity were +80 in antenatal, +100 in birth (3 surveys) +17 in postnatal ward and +67 in postnatal community. As a percentage this would mean that overall, 93% of people were extremely likely or likely to recommend us.

The minimum return (number of surveys) required previously was 15% overall but this increased to 20% by the end of Q4. For March there was a significant increase overall to 19.4%, with adult wards considerably higher at 41.6%, A&E at 12.9% and Maternity at 8.9%. This means that the trust did not meet this part of the CQUIN requirement.

Of the total number of replies (2,098) the breakdown for March is as follows; extremely likely 1,347, likely 610, neither/nor 71, unlikely 20 and extremely unlikely 29. There were 21 "don't knows."

For Maternity, this is the fifth 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 March was 3.6%, 1.3%, 26% and 3.9% respectively. The Director of Midwifery is aware and an action plan is being prepared to improve performance. Early indications are that there has already been an improvement in April.

The coloured bar chart later on is a summary divisional overview for March 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 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 February 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 March data for all areas demonstrating all possible scoring options.

This does demonstrate that the vast majority of patients (93%) 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 due to a low number of 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.

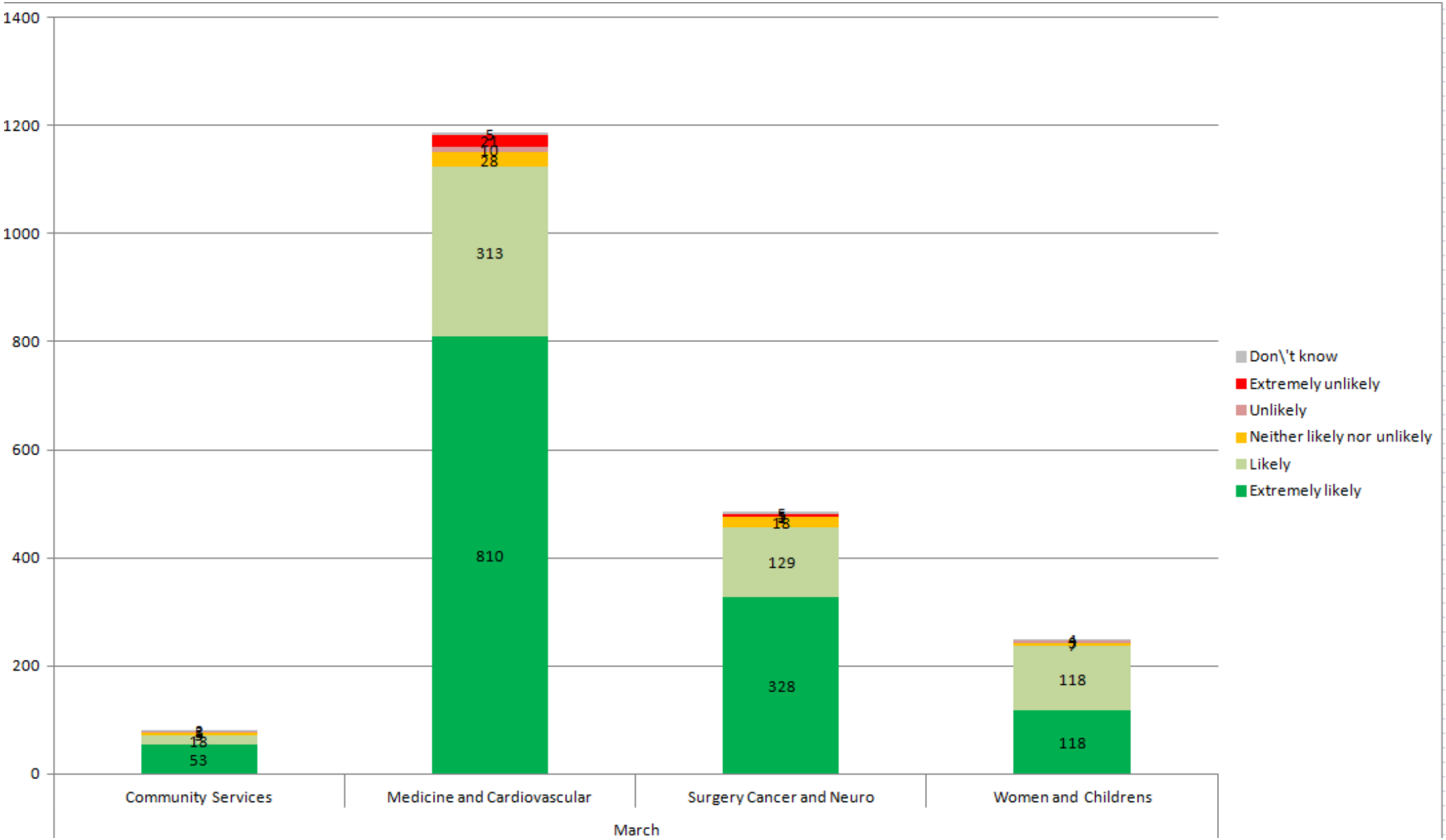
The table of data on later on relates to the percentage of patients surveyed from April 2013 to March 2014 by ward/department and there is still work to be done in certain areas although this is improving. Problems with WiFi in some areas is making this issue more difficult at times.

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 March for these other questions please see the final page. The % score is weighted and relates to positive answers such as yes, definitely, always and mostly.

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

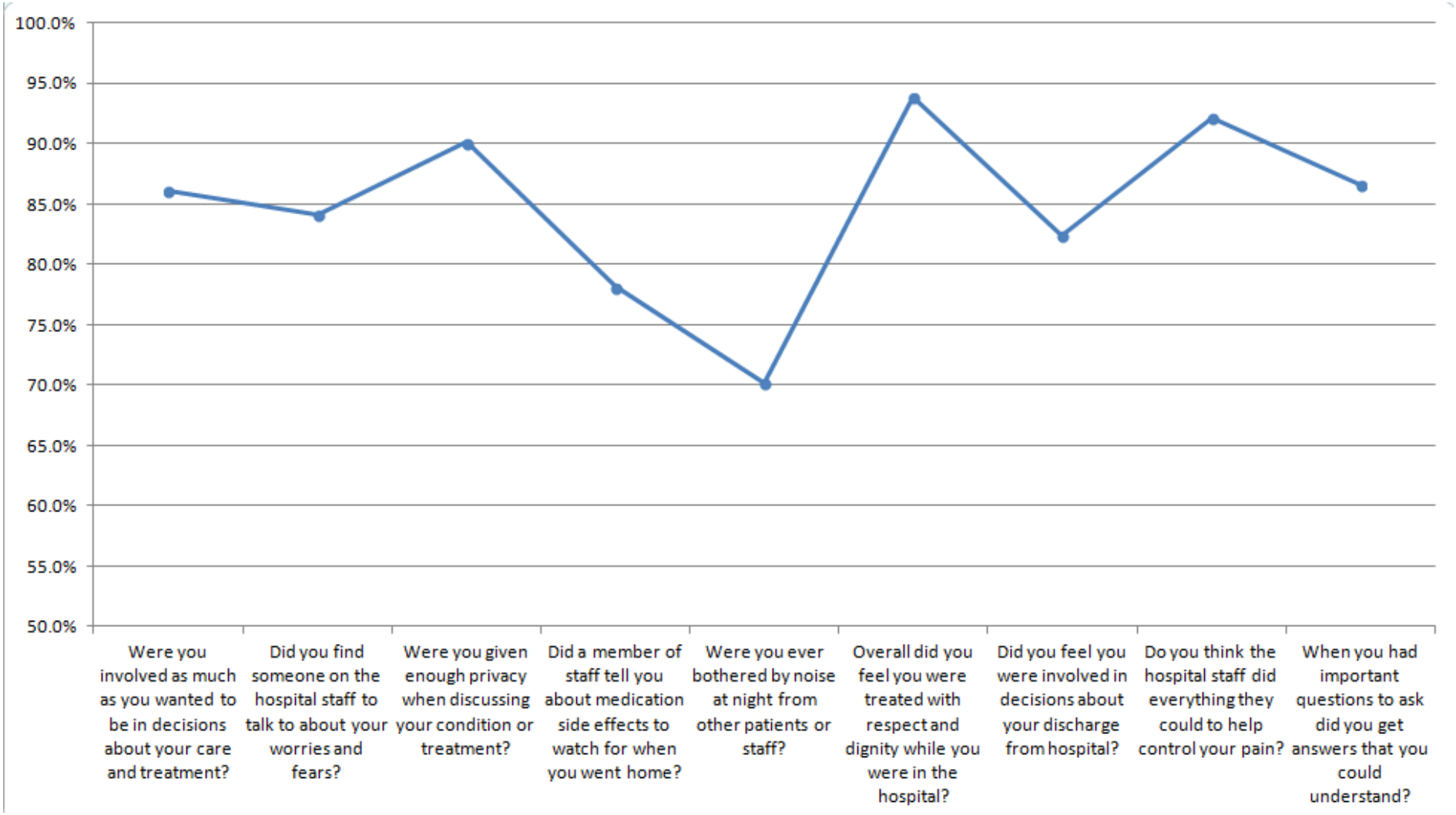
Plans are well underway to roll FFT out to Day Surgery, Outpatients and Community by Oct 2014 but the guidance is still in draft form as all of the detail has not yet been finalised.

Next year's CQUIN will also include an element of staff survey in asking how likely they are to recommend the service. This was trialled in Q4 13/14 and has now been launched this Quarter.


1400
1200
1000
800
600
400
200
0
53
810
313
328
129
118
118
Community Services
Medicine and Cardiovascular
Surgery Cancer and Neuro
Women and Childrens
March
Don\'t know
Extremely unlikely
Unlikely
Neither likely nor unlikely
Likely
Extremely likely

Service	April	May	June	July	August	September	October	November	December	January	February	March	Average
A&E	13.6%	9.6%	7.3%	7.7%	7.0%	6.8%	6.5%	11.4%	10.5%	11.4%	11.3%	12.9%	9.7%
Allingham	49.0%	48.4%	31.3%	47.6%	22.5%	17.5%	11.1%	41.1%	41.2%	20.0%	10.2%	96.4%	36.4%
Amyand	20.4%	14.8%	0.0%	3.7%	10.9%	4.3%	33.8%	33.3%	11.3%	6.9%	0%	65.2%	17.0%
Belgrave	38.1%	27.5%	47.7%	25.2%	29.1%	48.5%	37.0%	36.3%	8.7%	18.7%	37.8%	44.3%	33.2%
Benjamin Weir	79.0%	75.8%	58.9%	68.9%	74.4%	54.2%	41.1%	42.7%	54.0%	44.9%	41.1%	40.8%	56.3%
Brodie	19.0%	11.3%	6.3%	23.3%	21.7%	27.3%	15.9%	37.0%	29.6%	15.8%	11.1%	30.6%	20.7%
Buckland	42.7%	43.7%	48.1%	30.1%	24.7%	31.7%	51.3%	44.1%	44.0%	25.3%	40.9%	79.7%	42.2%
Caesar Hawkins		-	-	-	-	-	-	25.6%	22.7%	12.1%	1.6%	11.6%	14.7%
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%	36.5%	39.0%	41.5%	44.2%
Cavell	10.0%	26.9%	37.7%	39.6%	33.7%	33.3%	100.0%	48.6%	22.1%	48.3%	47.9%	42.4%	40.9%
CCU	75.0%	86.7%	72.7%	76.5%	83.3%	60.0%	19.2%	100.0%	65.4%	100.0%	100.0%	45.5%	73.7%
Champneys					10.9%	16.9%	19.2%	27.5%	46.4%	22.6%	7.2%	24.6%	21.9%
Cheselden	11.0%	32.1%	41.2%	23.3%	23.8%	43.8%	57.1%	21.6%	21.0%	10.9%	23.1%	22.3%	27.6%
Dalby	31.6%	0.0%	12.9%	45.2%	9.4%	35.3%	53.7%	18.9%	7.7%	25.0%	34.3%	69.2%	28.6%
Florence Nightingale	53.4%	58.9%	89.6%	76.4%	61.8%	44.7%	28.6%	49.1%	41.3%	38.8%	66.7%	24.7%	52.8%
GICU					0.0%	0.0%	28.6%	77.8%	100.0%	25.0%	20.0%	-	35.9%
Gray	5.9%	13.2%	14.6%	11.4%	12.4%	0.6%	15.3%	13.0%	42.3%	42.9%	43.0%	41.9%	21.4%
Gunning	43.9%	40.5%	39.7%	31.3%	11.0%	45.7%	47.4%	45.1%	40.3%	29.9%	31.8%	58.1%	38.7%
Gwynne Holford	100.0%	30.8%	66.7%	27.8%	92.3%	54.5%	88.9%	66.7%	52.6%	11.1%	50.0%	16.7%	54.8%
Heberden	18.2%	19.4%	50.0%	38.6%	15.8%	4.4%	70.0%	37.0%	4.2%	12.5%	18.8%	86.7%	31.3%
Holdsworth	19.2%	17.1%	30.4%	23.8%	5.0%	32.7%	25.4%	33.3%	8.3%	0%	29.8%	56.8%	23.5%
Keate	3.9%	25.5%	23.1%	4.6%	43.9%	31.3%	20.8%	25.8%	16.8%	23.6%	19.0%	70.8%	25.8%
Kent	10.5%	17.6%	27.3%	0.0%	22.2%	15.8%	33.9%	17.5%	31.3%	14.1%	8.2%	25.3%	18.6%
Marnham	20.4%	28.2%	25.0%	1.7%	31.3%	23.1%	39.3%	39.5%	23.4%	16.3%	21.7%	89.3%	29.9%
Mary Seacole	34.4%	88.0%	84.4%	34.0%	3.3%	18.4%	48.1%	77.8%	63.8%	51.0%	10.3%	35.3%	45.7%
McEntee	9.3%	22.2%	31.8%	47.4%	18.6%	37.5%	8.0%	47.0%	52.2%	56.4%	65.0%	93.1%	40.7%
McKissock	28.2%	5.1%	19.8%	36.8%	20.2%	23.8%	25.6%	22.4%	7.6%	12.7%	13.8%	21.9%	19.8%
Neuro Intensive Care	0.0%	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	33.3%	0%	50.0%	0%	60.0%	28.6%
Richmond	12.7%	12.3%	3.4%	26.2%	49.8%	44.8%	41.1%	42.4%	30.1%	42.1%	17.1%	32.1%	29.5%
Rodney Smith	33.3%	37.7%	6.3%	0.0%	44.6%	31.7%	15.8%	44.4%	24.1%	14.3%	15.8%	77.3%	28.8%
Ruth Myles	44.8%	53.3%	100.0%	84.0%	46.2%	58.3%	20.0%	20.0%	36.8%	5.9%	15.4%	100.0%	48.7%
Trevor Howell	12.8%	50.0%	57.4%	48.5%	43.0%	49.2%	32.9%	48.6%	49.2%	45.2%	48.1%	60.5%	45.4%
Vernon	18.1%	41.2%	28.9%	9.8%	7.8%	38.0%	30.8%	19.8%	4.7%	21.4%	23.9%	32.3%	23.1%
William Drummond	31.0%	27.6%	31.6%	21.8%	27.6%	17.1%	22.5%	13.5%	24.2%	26.1%	12.0%	36.9%	24.3%
Wolfson	90.9%	76.9%	58.3%	53.3%	56.3%	37.5%	54.5%	62.5%	12.5%	84.6%	80.0%	90.9%	63.2%

Organisation as reported to DH	April	May	June	July	August	September	October	November	December	January	February	March	Average
A&E	13.6%	9.6%	7.3%	7.7%	7.0%	6.8%	6.5%	11.4%	10.5%	11.4%	11.3%	12.9%	9.7%
Inpatients	26.2%	31.4%	31.2%	28.9%	31.7%	32.3%	33.9%	33.2%	30.7%	26.1%	27.7%	41.6%	31.2%
Maternity	-	-	-	-	-	-	-	-	-	-	-	-	-
Combined	17.6%	17.0%	14.9%	14.5%	15.2%	15.0%	15.6%	19.2%	17.7%	16.4%	16.7%	21.6%	16.8%


100.0%
95.0%
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85.0%
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50.0%
Were you involved as much as you wanted to be in decisions about your care and treatment?
Did you find someone on the hospital staff to talk to about your worries and fears?
Were you given enough privacy when discussing your condition or treatment?
Did a member of staff tell you about medication side effects to watch for when you went home?
Were you ever bothered by noise at night from other patients or staff?
Overall did you feel you were treated with respect and dignity while you were in the hospital?
Did you feel you were involved in decisions about your discharge from hospital?
Do you think the hospital staff did everything they could to help control your pain?
When you had important questions to ask did you get answers that you could understand?

e) **Dementia carers' questionnaire 2013/14**

The dementia carers' questionnaire was introduced from mid-2013 as part of the 2013/14 National Dementia CQUIN. It is administered by ward staff to informal carers of patients with dementia at the point of discharge.

The first question is the Friends & Family test which carers complete on behalf of patients with dementia. Several dementia carer specific questions then follow. Results from 2013/14 demonstrate improved performance between the first and second halves of the year. The major area where improvement is still required is in providing carers with information about dementia services. Insufficient numbers of carers are being informed about the Butterfly Scheme (used to identify and respond to the needs of inpatients with dementia), the dementia passport or equivalent and local services for people with dementia.

These issues will be addressed during 2014/15 by performing further staff training on the Butterfly scheme, and supporting use of the scheme on wards that have hitherto been slow adopters. We will ensure that all wards have blank versions of the Wandsworth dementia passport, the Alzheimer's Society's "This Is Me" document (for non-Wandsworth patients) and the Alzheimer's Society's Dementia Services guide.

These aims will be achieved through the deployment of 3.0 WTE band 6 dementia nurses who are currently being recruited.
We will also share feedback from the questionnaire about partner agencies such as social services and primary/community care via the Wandsworth CCG Older Adults Mental Health & Dementia Clinical Reference Group and the LB Merton Dementia Executive Steering Group.
Presentation of the full results is scheduled for the Patient Experience Committee in June.

III Clinical Audit + Effectiveness (Patient Outcomes)

Section 3a: national audits
National Diabetes Inpatient Audit

Bedside questionnaire	National % 2013	SGH% 2013	SGH% 2012
Receiving renal replacement therapy	4.2	7.1	10.0
Admitted with active foot disease	9.1	7.4	13.3
Foot risk assessment within 24 hours of adm.	37.6	18.6	20.0
Appropriate blood glucose testing	6.4	6.4	6.4
Visited by a member of the diabetes team	34.5	19.3	18.1
Admitted with active foot disease seen by the foot team within 24 hours	59.3	70	53.8
Medication errors	37	34.1	52.8
Prescription errors	21.8	21.6	41.7
Management errors	22.3	19.3	22.2
Insulin errors	20.7	26.1	26.4
Mild hypoglycaemic episode(3.0-3.9 mmol/L)	20	15.5	21.4
Severe hypoglycaemic episode (<3.0mmol/L)	9.2	6.7	12.9
Patient Experience (Percentage of patients reporting…)			
Hypoglycaemia	20.1	16.9	24.5
Hyperglycaemia	22.7	32.0	30.0
Timing of meals suitable	70.2	47.2	55.5
Choice of meals suitable	63.7	46.1	42.1
They could take control of their diabetes care	54.9	33.4	56.6
Staff were aware of their diabetes	82.1	78.3	80.6
Staff knew enough about diabetes	67.5	50.2	61.5
Staff could answer their questions	79.5	58.6	67.2
Staff were very good at working as a team	44.2	33.8	37.8
Staff provided enough emotional support	84.4	68.2	67.1
Satisfied or very satisfied with overall care	86.1	82.0	83.9

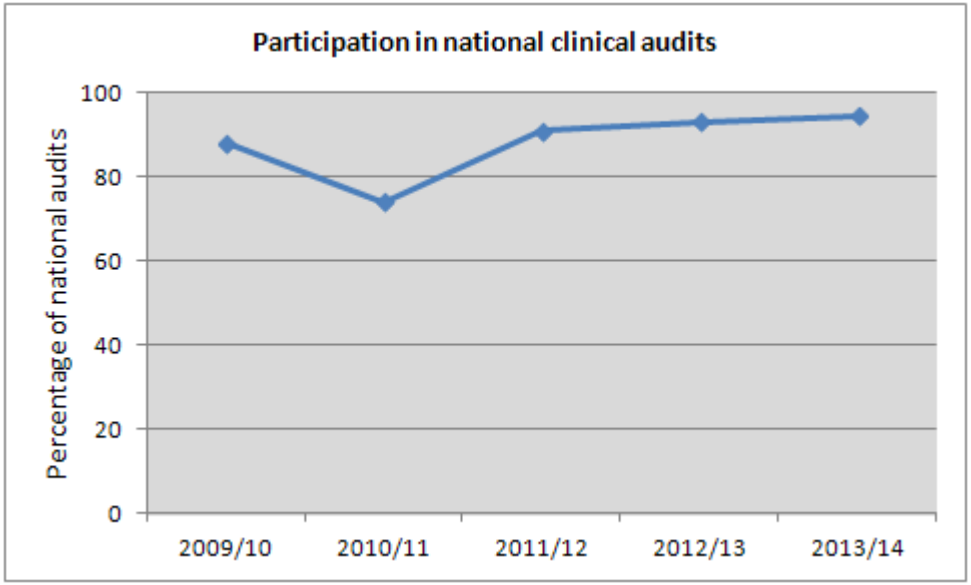
The National Diabetes Inpatient audit was conducted in September 2013. The audit comprised an organisational audit, a bedside audit of casenotes looking at diabetes care and management, plus a questionnaire completed by patients about their inpatient experience.

128 inpatients were identified with diabetes at the time of the audit, which represents 16.8% of all inpatients. Of these 43.5% had Type 2 diabetes treated with insulin. Nationally these figures were 15.7% and 34.5% respectively.

The organisational audit revealed that SGH has fewer specialist nursing and dietitian hours per week per patient than the national average, but more consultant and podiatry hours. This correlates with the results of the bedside audit which shows SGH to have fewer patients visited by members of the diabetes team but also fewer admitted with active foot disease and better management of those who are. Results also showed a reduction in medication errors from previous years and fewer patients experiencing a hypoglycaemic episode, although we report more insulin errors (prescription or management) than nationally.

The patient experience questionnaire was completed by 81 patients. Overall 82% reported that they were satisfied or very satisfied with the overall care of their diabetes whilst in hospital. This is a little less than in 2012 (83.9%) and the national average (86.1%) The main areas of concern would appear to be in the timing and suitability of meals and staff knowledge of diabetes. Action is already underway to tackle these problems and funding from an external source is being used to finance a part time Band 6 nurse to conduct a project looking at the development of an inpatient diabetes team.

Quality account: Participation in clinical audit



Reporting participation in national clinical audits is a mandatory element of the Quality Account. During 2013/14 the trust took part in 94.4% of relevant projects; our highest level of involvement to date. Furthermore, we maintained our 100% participation in national confidential enquiries.

There were two relevant audits in which we did not participate:

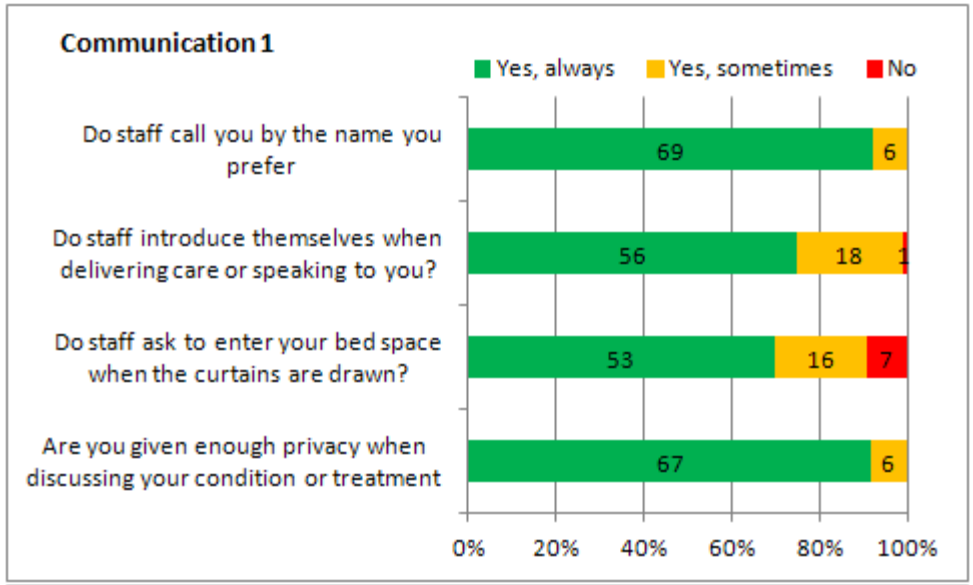
- Diabetes - although we conducted the inpatient aspect of the national diabetes audit, we did not take participate in the core part of this mandatory project. The service are currently considering both external and internal IT solutions that will enable our participation in 2014/15;
- Rheumatoid & early inflammatory arthritis audit – this new national audit began in February 2014 and requires audit at various stages of the patient journey. The trust is registered but to date no data has been submitted, however a meeting is planned between the clinical and audit teams to formulate a process for participation in 2014/15.

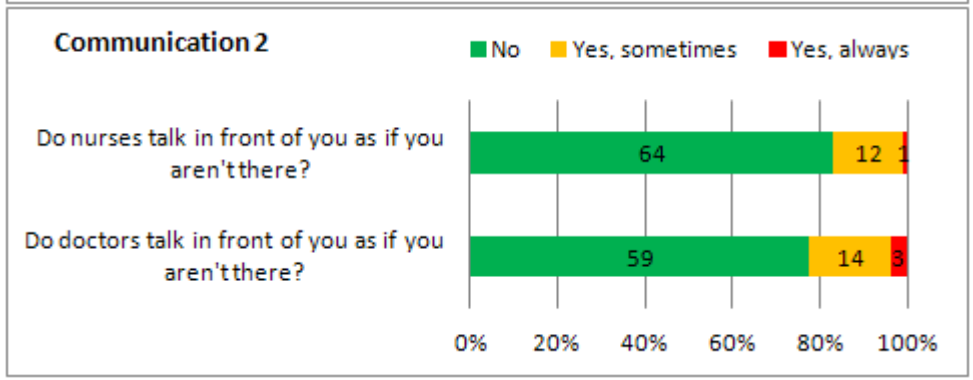
In the report we are also required to state how many audits were reviewed by the board. We declared that 23 national and 13 local audits have been considered and we have highlighted actions taken as a result of a number of these audits.

Section 3b: local audits

The Clinical Audit Programme 2014/15 was approved by the Patient Safety Committee in March 2014. It incorporates all national audits agreed for the Quality Account, and projects that are used to derive nationally published consultant level outcomes data. Also included are trust level priorities, for example around patient safety and experience. A number of projects for each division are also incorporated, but it is accepted that there will be additions to the core programme during the year.

Privacy & Dignity Audit – Adult inpatients at St George's Hospital





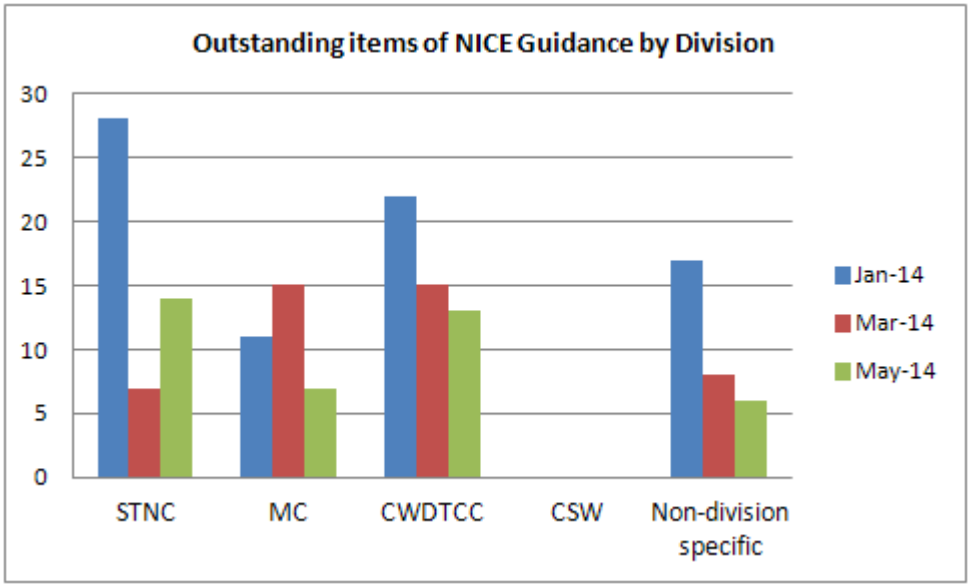
This project was conducted to ascertain the extent to which patients in adult wards at St George's Hospital experienced care that protected their privacy and dignity. A number of important aspects were measured including communication, provision of support, delivery of care and the impact of the ward environment. It is part of a wider project which will encompass outpatients, paediatric ward and clinics, and community services.

Communication is identified as a theme in many complaints and incidents and so this was a principal focus of the survey. The results were largely positive and over 90% of patients reported they always receive sufficient privacy when discussing their care. However there are aspects of practice where some simple steps and improved consistency would have a positive impact on patients' experience of privacy and dignity. Divisional reports have been prepared in order to support local action.

The survey also measured whether staff deliver care in a way that supports patients privacy and dignity. 91.2% of patients said that they received help with their personal care when needed. Furthermore, 87.7 per cent reported that staff always explain and ask permission before helping. However, a significant number of patients reported that their needs y do not always have their needs attended to quickly enough. This is detailed in the full report to facilitate improvement.

Eighty per cent of patients surveyed reported that they were always treated with kindness and compassion, and the remaining 20% said this happened at least sometimes. Over half (53.4%) rated the care they were receiving as excellent, 43.8% as good and 2 patients (2.7%) as fair. No patients said they received poor care.
The full report will be presented to the Patient Experience Committee in June.

Section 3c: NICE (National institute for health and care excellence) GUIDANCE



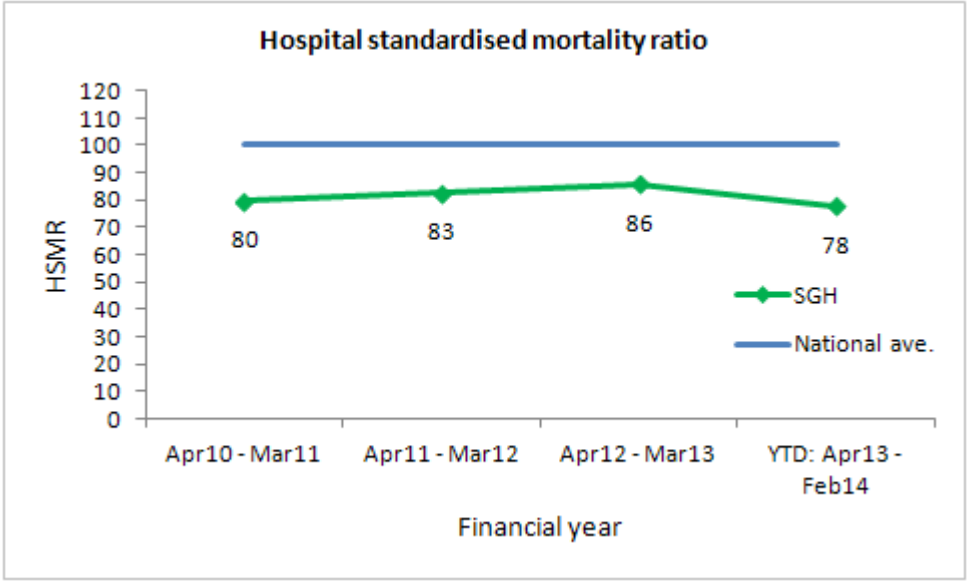
Significant progress has been made over recent months in establishing the implementation status of NICE guidance. For guidance issued over the last four years we are now following up the status of only forty items, most of which are from 2013. In March the Clinical Effectiveness and Audit Committee agreed that the audit team would continue to have a more active role in this process. The team are actively supporting the Medicine and Cardiovascular division and the Surgical division and continue to manage the process for non-division specific guidance.

Having reduced the number of items of outstanding guidance and introduced a more robust system to prevent the backlog recurring, over the coming months our focus will be on determining progress with the items for which compliance issues have been reported. Currently there are 36 items of guidance for which we are either partially, or not compliant.

Section 3d: Mortality

SHMI publication	Reporting period	Ratio	Banding
April 2013	October 2011 – September 2012	0.82	**Lower than expected**
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	
April 2014	October 2012 – September 2013	0.78	

Source: Health and Social Care Information Centre (HSCIC)



Source: Dr Foster Intelligence

The summary hospital-level mortality indicator (SHMI) was published for the period October 2012 to September 2013 in April 2014. Our score of 0.78 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 13 trusts identified as a 'repeat outlier' as our mortality rate has been 'lower than expected' for two consecutive years.

In April we welcomed the first of the clinical researchers from the PRISM2 study, which is concerned with formulating a measure of avoidable mortality and a nationally agreed review process. To date 30 of our 100 randomly selected in-hospital deaths have been reviewed and we look forward to receiving feedback from the national team.

The Mortality Monitoring Committee continue to review internally derived mortality signals which are generated through benchmarking our outcomes to the national average using the Dr Foster platform. The group have now received the report of the investigation into higher than expected mortality in the Coronary angioplasty (PTCA) procedure group and this will be discussed in May. The paper, which has been presented to the Clinical Quality Review meeting, summarises the clinical review of 72 deaths observed between July 2012 and June 2013. The reviewers considered the major contributor to this mortality signal was case selection and case mix variables, but identified the need to strengthen several aspects of the PCI service. Specific actions will be agreed and monitored by the divisional governance structure. Those being considered include review of the out of hospital cardiac arrest pathway, review of the cardiogenic shock management pathway, increased multidisciplinary consideration of treatment options, greater opportunity for governance, education and research, and redistribution of activity.