St George's Healthcare NHS
NHS Trust

Quality Report

Trust Board
Month 3 - June 2014

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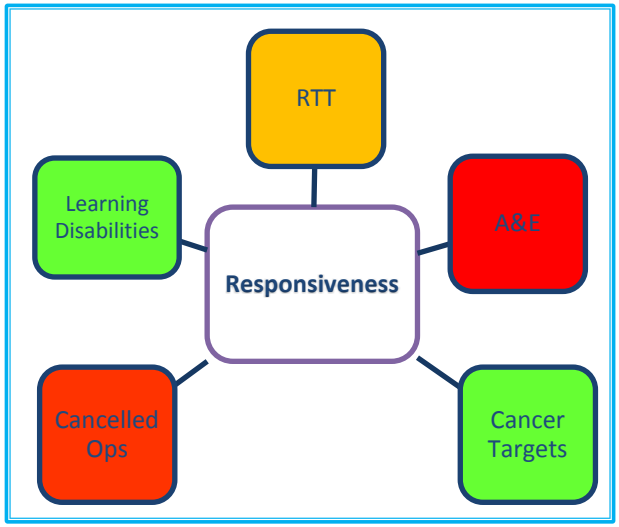
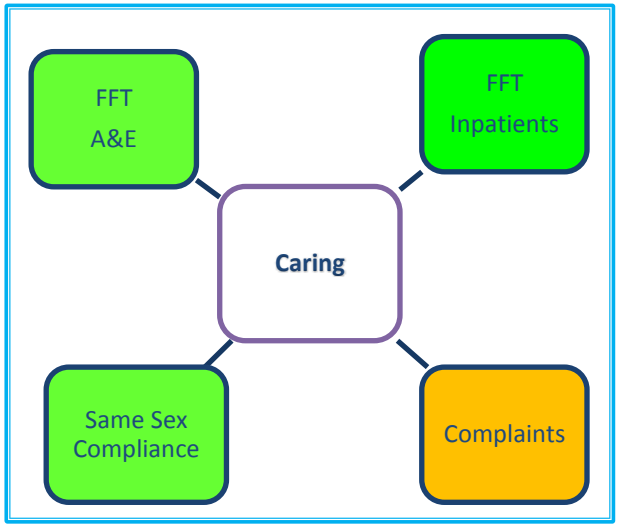
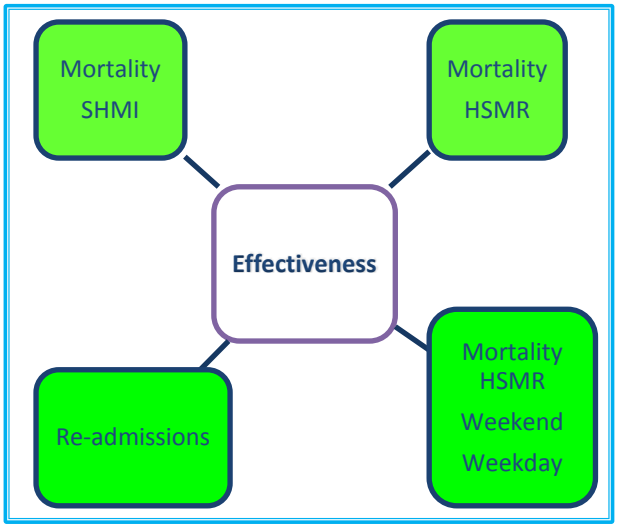
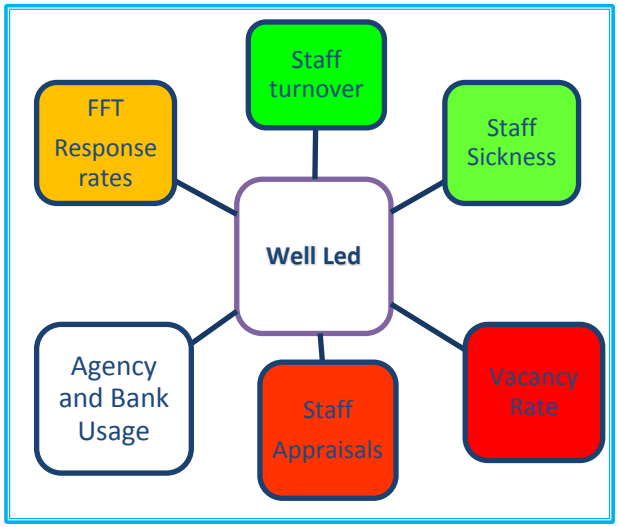
CONTENTS

1. Executive Summary - Key Priority Areas June 2014









The above shows an overview of May 2014 performance for key areas within each domain of the NHS TDA Accountability Framework. These domains as per the direction of change by the NHS TDA correlate to those of the CQC intelligent monitoring framework.

The overview references where the trust may not be meeting 1 or more related targets. (Note Cancer RAG rating is for April 2014 as reported one month in arrears)

This report is produced in line with the trust performance management framework which encompasses the NHS TDA and Monitor regulatory requirements. An overview of this is provided in appendix-A at the end of this report.

2. TDA Accountability Framework KPIs 2014/15: June 14 Performance

Responsiveness Domain					
Metric	**Standard**	**YTD**	**May**	**June**	**Movement**
Referral to Treatment Admitted	90%		90.30%	90.20%	➤
Referral to Treatment Non-Admitted	95%		97.70%		
Referral to Treatment Incomplete	92%		92.17%	92.60%	▲
Referral to Treatment Incomplete 52+ Week Waiters	0		3	4	▲
Diagnostic waiting times > 6 weeks	1%		0.62%	0.57%	▼
A&E All Types Monthly Performance	95%	94.57%	94.46%	95.80%	▲
12 hour Trolley waits	0	0	0	0	➤
Urgent Ops Cancelled for 2nd time (Number)	0	0	0	0	➤
Proportion of patients not treated within 28 days of last minute cancellation	0%	2.60%	1.50%	1.20%	▼
Certification against compliance with requirements regarding access to health care for people with a learning disability	Compliant	Yes	Yes	Yes	➤
	Standard	**YTD**	**April**	**May**	**Movement**
Two Week Wait Standard	93%	97.7%	97.7%	93.5%	▼
Breast Symptom Two Week Wait Standard	93%	98.7%	98.7%	88.8%	▼
31 Day Standard	96%	98.1%	98.1%	97.3%	▼
31 Day Subsequent Drug Standard	98%	100.0%	100.0%	100.0%	➤
31 Day Subsequent Surgery Standard	94%	100.0%	100.0%	95.2%	▼
62 Day Standard	85%	85.3%	85.3%	92.2%	▲
62 Day Screening Standard	90%	93.0%	93.0%	94.0%	▲
Domain Score	**5**				

Safe Domain					
Metric	**Standard**	**YTD**	**May**	**June**	**Movement**
Clostridium Difficile - Variance from plan	0	0	0	0	➤
MRSA bactaraemias	0	2	1	1	▲
Never events	0	0	0	0	➤
Serious Incidents	0	45	15	9	▼
Percentage of Harm Free Care	95%		94.61%	94.73%	▲
Medication errors causing serious harm	0	0	0	0	➤
Overdue CAS alerts	0	1	1	1	➤
Maternal deaths	1	0	0	0	➤
VTE Risk Assessment	95%		96.40%	97.30%	▲
Domain Score	**4**				

Effectiveness Domain					
Metric	**Standard**	**YTD**	**May**	**June**	**Movement**
Hospital Standardised Mortality Ratio (DFI)	100	79.7	80.4	78.7	▼
Hospital Standardised Mortality Ratio - Weekday	100	86.2	86.2	86.2	➤
Hospital Standardised Mortality Ratio - Weekend	100	90.8	90.8	90.8	➤
Summary Hospital Mortality Indicator (HSCIC)	100		81	78	▼
Emergency re-admissions within 30 days following an elective or emergency spell at the Trust	5%	3.4%	3.6%	3.2%	▲
Domain Score	**5**				

Caring Domain					
Metric	**Standard**	**YTD**	**May**	**June**	**Movement**
Inpatient Scores from Friends and Family Test	60		63	62	➤
A&E Scores from Friends and Family Test	46		48	46	▼
Complaints			96	103	▲
Mixed Sex Accommodation Breaches	0		0	0	➤
Domain Score	**5**				

Well Led Domain					
Metric	**Standard**	**YTD**	**May**	**June**	**Movement**
IP response rate from Friends and Family Test	30%		35.20%	37.60%	▲
A&E response rate from Friends and Family Test	20%		9.30%	33.60%	▲
NHS Staff Survey: Percentage of staff who would recommend the trust as a place of work	61%	61%			
NHS Staff Survey: Percentage of staff who would recommend the trust as a place to receive treatment	67%	69&			
Trust turnover rate	13%		12.30%	15.30%	▲
Trust level total sickness rate	3.50%		3.47%	3.58%	▲
Total Trust vacancy rate	11%		12.00%	12.28%	▲
Temporary costs and overtime as % of total paybill			10.69%	7.90%	▼
Percentage of staff with annual appraisal - Medical	85%		84.70%	84.90%	▲
Percentage of staff with annual appraisal - non-medical	85%		75.40%	73.30%	▼
Domain Score	**2**				

Trust Overall Quality Score	**5**

The trusts self-assessment against the NHS TDA Accountability framework in June 2014 is as detailed above with a overall quality score of 5.

This places the trust under the category of low risk with no escalation, and under standard oversight with NHS TDA.

Key: Quality/Excalation Score

1	2	3	4	5
Special Measures		Intervention		Standard Oversight

3. Monitor Risk Assessment Framework KPIs 2014/15: June 14 Performance

Access							
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**May**	**June**	**Movement**
Referral to Treatment Admitted	90%	1	0		90.30%	90.20%	➤
Referral to Treatment Non-Admitted	95%	1	0		97.70%		
Referral to Treatment Incomplete	92%	1	0		92.17%	92.60%	▲
A&E All Types 4 Hour Standard Monthly Performance	95%	1	0		94.46%	95.80%	▲
62 Day Standard	85%	1	0		84.4%	92.2%	▲
62 Day Screening Standard	90%	1	0		93.0%	94.0%	▲
31 Day Subsequent Drug Standard	98%	1	0		100.0%	100.0%	➤
31 Day Subsequent Surgery Standard	94%	1	0		100.0%	95.2%	▼
31 Day Standard	96%	1	0		98.1%	97.3%	▼
Two Week Wait Standard	93%	1	0		97.7%	93.5%	▼
Breast Symptom Two Week Wait Standard	93%	1	1		98.7%	88.8%	▼

Outcomes							
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**May**	**June**	**Movement**
Clostridium Difficile - Variance from plan	0	1	0	0	0	0	▲
Certification of Compliance Leraning Disabilities:							
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?	Compliant	1	0	Yes	Yes	Yes	➤
Does the trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria: ⍰ treatment options; ⍰ complaints procedures; and ⍰ appointments?	Compliant			Yes	Yes	Yes	➤
Does the trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities	Compliant			Yes	Yes	Yes	➤
Does the trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff?	Compliant			Yes	Yes	Yes	➤
Does the trust have protocols in place to encourage representation of people with learning disabilities and their family carers?	Compliant			Yes	Yes	Yes	➤
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?	Compliant			Yes	Yes	Yes	➤
Data Completeness Community Services:							
Referral to treatment	50%	1	0		80%	80%	➤
referral information	50%	1	0		90%	90%	➤
treatment activity	50%	1	0		100%	100%	➤

Trust Overall Quality Governance Score	2	1	➤

Green <1.0
Amber Green= >1 and <2
Amber/Red = >2 and <4
Red= >4

June 2014 Performance against the risk assessment framework is as follows:

The trusts quality governance rating is 'Amber/Green'.

The trust CoSSR position is 3, which rated as 'Green'.

Areas of underperformance for quality governance are:

- Cancer Waits-

  2 Week Breast symptoms

Further details and actions to address underperformance are further detailed in the report.

St George's Healthcare NHS
NHS Trust

Clinical Audit and Effectiveness

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4. Clinical Audit and Effectiveness - Mortality

HSMR (Hospital standardised mortality ratio)						
Lead Director	June	July	Movement	2014/2015 Target	Forecast August '14	Date expected to meet standard
RGW	78	78.7	▲	<100	G	Met

SHMI (Summary hospital-level mortality indicator)				
April 2013	July 2013	Oct 2013	Jan 2014	April 2014
0.82	0.81	0.81	0.81	0.78

Note: Source for HSMR mortality data is Dr Foster Intelligence., published monthly. Data is most recent rolling 12 months available. For July 14 this was April 13 to March 14. SHMI data is published by the Health and Social Care Information Centre 6 months retrospectively. The last 12 month period as published in April is reported and relates to the period October 2012 to September 2013. Publication of January 2013 to December 2014 data is due on 30th July.

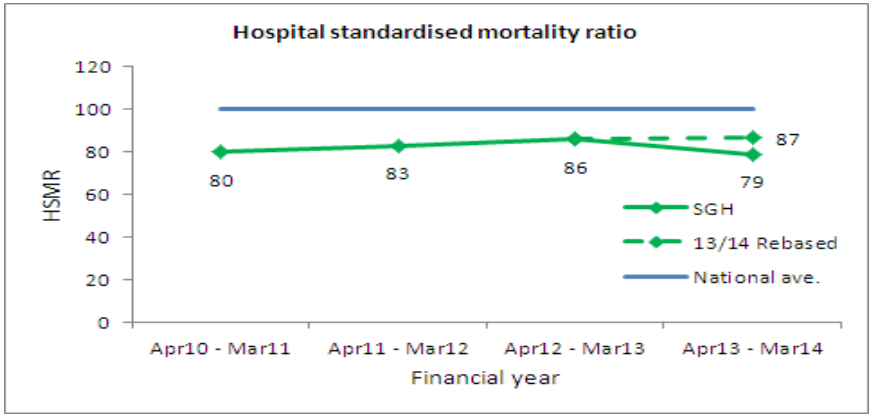
Overview:

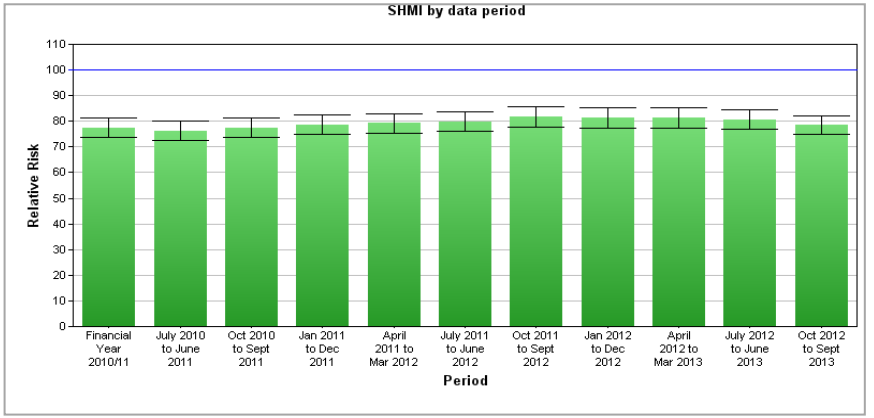
The trust's HSMR for April 2013 to March 2014 is reported as 78.7, and is significantly better than expected. The latest available SHMI score of 0.78 mirrors this strong performance. It should be noted that the HSMR will soon be re-based, so that the underlying risk model takes account of the national average improvement over the financial year. It is expected that our HSMR will be around 87, which as can be seen from the chart below is similar to our HSMR for 2012/13 and remains significantly better than expected.

Dr Foster provide trusts with a quarterly update of four key mortality measures. This was last published in June and is based on the latest SHMI period (October 2012 to September 2013). For the HSMR and in-hospital mortality following emergency weekday admissions our ratios are significantly better than expected at 86.2 and 86.3 respectively. Our relative risk for in-hospital mortality following emergency weekend admissions is in line with expected at 90.8; as is our rate of deaths in low risk diagnosis groups (1.08 per 1000 spells for conditions normally associated with a very low risk of mortality).

The CQC's July Intelligent Monitoring report is expected to report 'evidence of risk' for in-hospital deaths in Trauma + Orthopaedics conditions and procedures. It is not possible to replicate the CQC approach, however we have investigated the score and determined that it related to signals observed in the diagnosis groups 'Other fractures' and 'Intracranial injury'. Investigations of each have been concluded and closed by the MMC as issues of clinical concern were not identified.

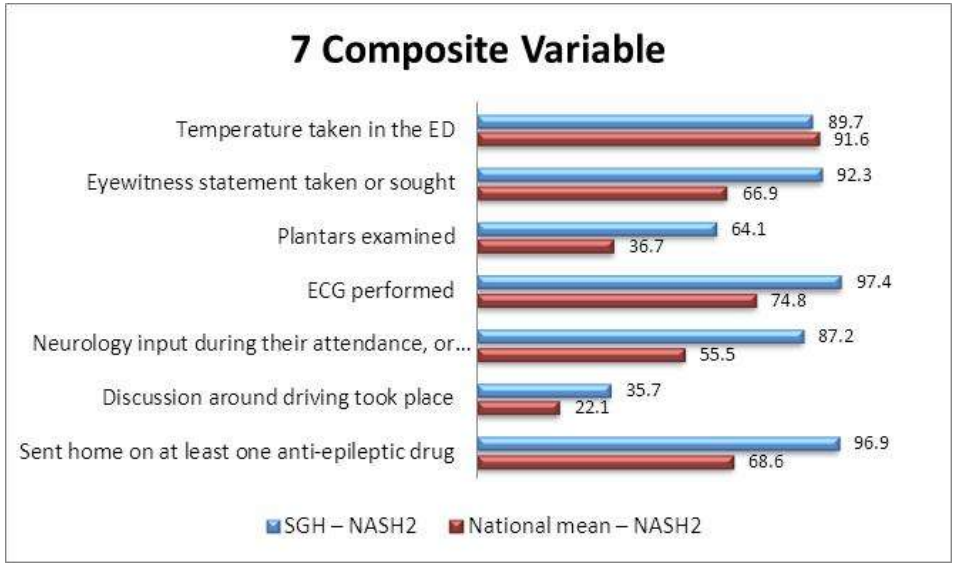
The committee continues to drive forward improvements and has been encouraged by increased local engagement. For example the Emergency Department are now reviewing all deaths using the committee's mortality review forms. Recently these forms and our processes have been shared with colleagues from other trusts such as Milton Keynes Hospital NHS Foundation Trust, Buckinghamshire Healthcare NHS trust and the Royal Melbourne Hospital.





4. Clinical Audit and Effectiveness - National Audits

National Audit of Seizure Management in Hospitals - second round (NASH2)



Overview

The second national audit of seizure management in hospitals measured practice against NICE clinical guideline 137; 'The epilepsies: the diagnosis and management of the epilepsies in adults and children in primary and secondary care'. 154 hospitals participated, with each providing clinical data on at least 30 adult patients who presented with a seizure from January 2013 onwards. Data on both process of care and clinical outcomes, with at least 3 months of follow up data, was required. The trust submitted data on 39 patients.

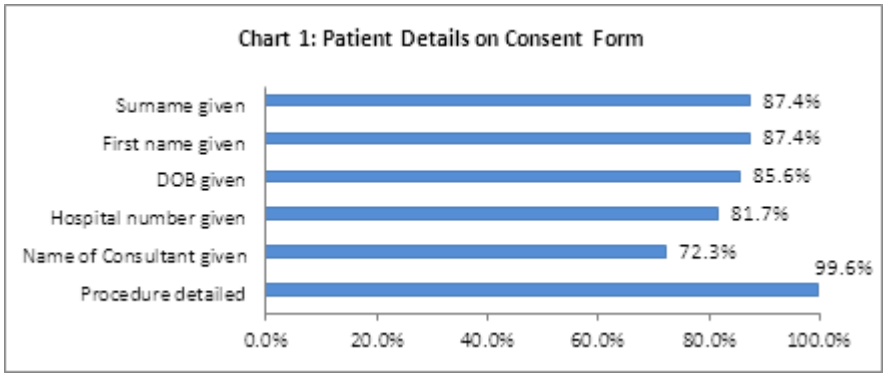
The composite score of seven key standards was 80.5 per cent for St George's; significantly better than the national mean score of 59.5 per cent. In six areas of practice the trust scores are significantly above the national mean, with the scores for two at close to 100 per cent, namely ECG performed and patient sent home on at least one anti-epileptic drug. For the standard relating to temperature taken in the emergency department the trust score of 89.7 per cent is marginally below the national mean of 91.6. The auditor noted that this may be due to thermometers occasionally being absent from the observation trolley, which is an issue that will be raised with the ED.

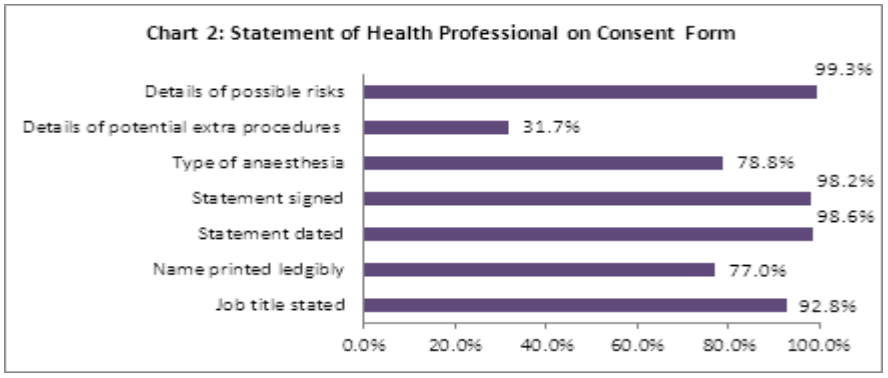
Less than half (35.7%) of our patients had discussion around driving, although this is significantly higher than the national mean of 22.1%. The team suspect that in most cases the advice was given but not recorded and this has therefore been identified as an area for action.

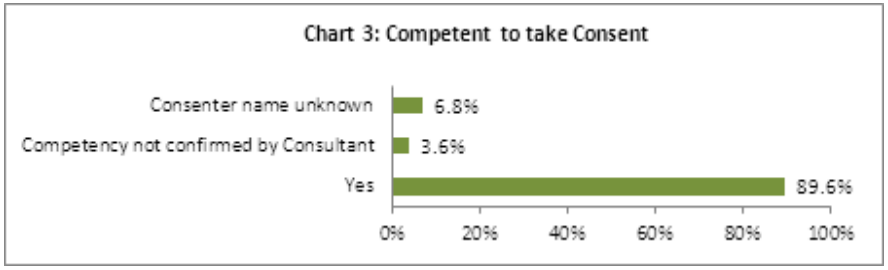
Nationally, there has been a significant shift from lorazepam (42.7% against 59.5% in NASH1) to diazepam (38.1% against 24.0% in NASH1). For SGH, 64.7% of our patients were given diazepam (compared to 50% in the last audit round) and 29.4% were given lorazepam. The pharmaceutical team believe that this is due in part to a recall of lorazepam in May 2013. Additionally there was a shortage of lorazepam in 2010 with a recommendation to switch to IV diazepam. The shortage was not resolved until the end of 2011 and it is believed that this has influenced the sustained change in practice.

4. Clinical Audit and Effectiveness - Local Audits

Trust-wide audit of consent 2013/14







Overview

The trust-wide consent audit was conducted between January and March 2014. A random selection of 278 patients admitted to all wards for both elective and emergency procedures and treatment were included in the audit. The audit measured completeness of documentation of a number of key areas of the consent form and assessment of competency to take consent.

In comparison to the 2012/2013 audit there has been a decline in recording of patient identifiers with performance below 90%. There has been a slight increase in recording of managing consultant; however this is documented in less than 3 out of 4 cases. The new consent form which incorporates questions relating to the discussion of blood transfusion was observed in 111 cases, with details completed in 41 (36.9%).

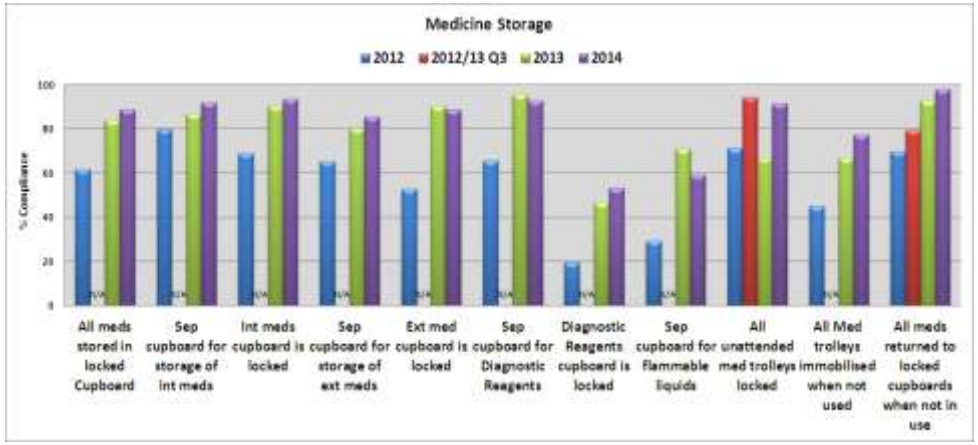
The consent form was signed by the patient, or parent, in all but 1 case. In this instance local procedures are being formalised in line with recent guidance that consent for chest drain insertion should be documented. The number of patients given the carbon copy has increased, with nearly half of carbons removed. Since the last report the consent form has been updated so that the Patient ID is on the front (rather than on the back) and will transfer to the carbon. Old stock is being used up but the new form is starting to be used.

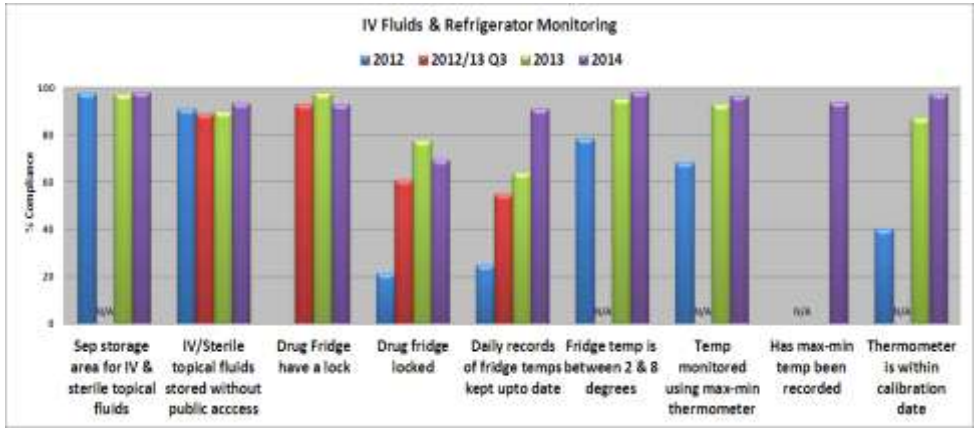
Competency to take consent was assessed as i) Consultant documented consent; ii) clinician that took consent carried out, or was involved in the procedure; or iii) Consultant verified competency retrospectively. In 89.6% (249) competency was established, and there was no instances where the consenter was found not to be competent. However, in 6.8% (19) it was not possible to identify the person taking consent, and in the remaining cases (3.6%, n=10) the managing consultant did not respond to the request for information. For these 29 cases we cannot confirm competency. Consideration should be given in all services to the use of name stamps, to improve compliance with this and other documentation standards.

Divisions have been asked to provide a response to the consent audit to the Patient Safety Committee in 3 months time.

4. Clinical Audit and Effectiveness - Local Audits

Safe and Secure Handling of Medicines Annual Audit





Overview

This is the third annual audit conducted to ascertain compliance with the secure and safe storage of medicines as per the trust medicines management and controlled drugs policies. All clinical areas were asked to participate in data collection which ran from March to May 2014. Responses were received from 122/136 (89.7%) clinical areas; significantly higher than the previous annual audit conducted in March-April 2013 for which we had 94/116 (81%) responses. The reason for this being inclusion of more community areas. Ten areas in the community have reported that they do not store medicines hence they were exempted from the audit.

When compared to the 2013 audit, there is improvement in criteria around disposal of medicines, awareness of the controlled drugs (CD) policy, good adherence to drug fridge monitoring standards, and security.

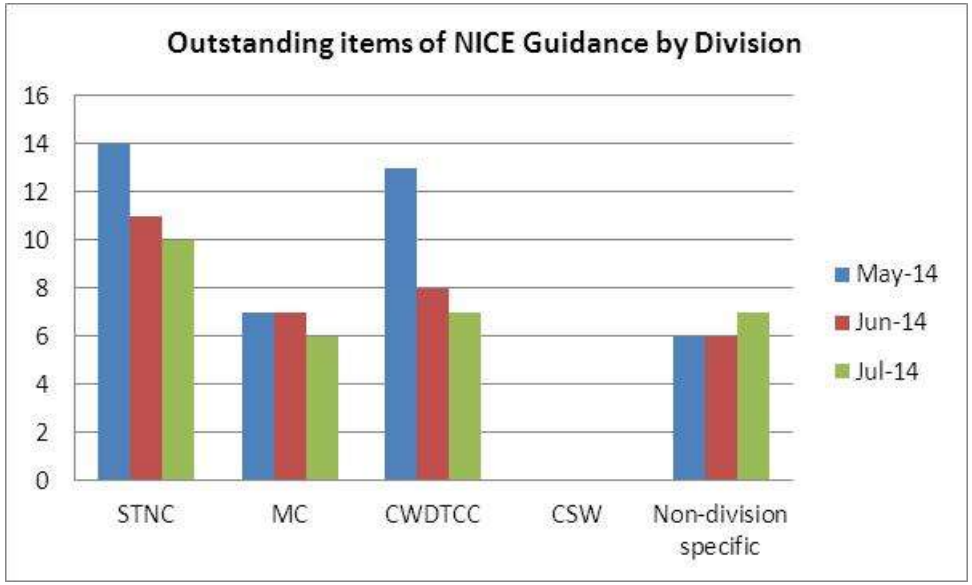
Improvements in 8 of 11 criteria have been reported for medicine storage. However we need to make sure that medicine cupboards and flammable liquid cupboards are locked.

Significant improvements regarding refrigerator monitoring were observed however the audit highlighted improvements are needed to ensure, where appropriate, drug fridges are locked.

Overall the audit demonstrated some areas of improvements in practice over the last year and will help us to identify priorities for the coming year. The audit has also shown good engagement with the drive to improve drug fridge monitoring.

This audit has been discussed in Medicine Risk Management Committee on the 17th of June 2014 and has been disseminated to Nursing Leads for local action planning. Actions will be monitored through the Medicines Risk Management Ctee and the Nursing Board

4. Clinical Audit and Effectiveness
- NICE (National Institute of Health and Social Care Excellence) Guidance



Overview

During the last month the Clinical Audit department has contacted the leads for all NICE guidance where compliance issues (partial and non-compliant) have previously been reported. Divisional reports indicating responses from leads and summarising the latest position have been disseminated to support evaluation and management of risk, including consideration of entry into the divisional risk register if appropriate. Currently there are 39 items of NICE guidance that have compliance issues (M+C=15; C+W=9; STNC=7; CSD=0; TW=8). This process will be repeated every six months.

For guidance issued between January 2010 and March 2014 there are currently 30 items for which a response is required. This is a slight decrease since last month. To ensure that the backlog continues to reduce the audit team has taken on direct liaison with clinicians for guidance relevant to all the divisions except Community services. To facilitate this divisions have been reminded through the Patient Safety Committee to provide the audit team with the names of clinical leads in a timely manner following the release of new NICE guidance every month to avoid any delays.

Divisions have been asked to use the information to determine if there is risk associated with non-compliance and to inform us of how this is being managed at divisional level. We will then report that information to the Clinical Effectiveness and Audit Committee. We plan to repeat this exercise every 6 months so would then follow up on outcome and progress.

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Patient Safety

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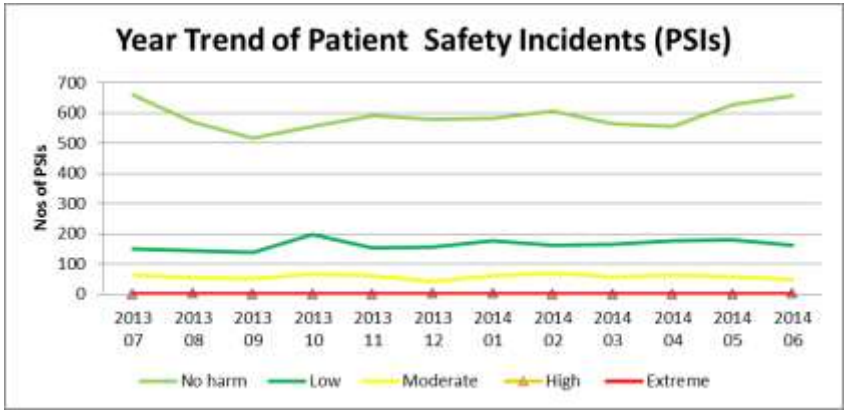
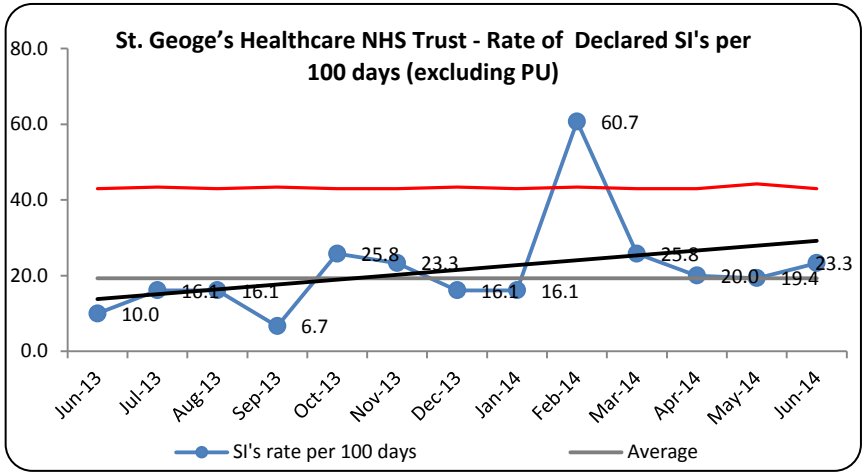
5. Patient Safety
- Incident Profile: Serious Incidents and Adverse Events

Closed Serious Incidents (not PUs)				
Type	April	May	June	Movement
Total	13	11	8	⮟
No Harm	6	6	6	➤
Harm	7	5	2	⮟

	Q1 Sis Declared by Division (Inc. Pus)				
Month	Med & Card	Surgery & Neuro	Community	Children's and Womens	Corporate
April	6	3	**3**	9	0
May	2	2	**7**	4	0
June	1	1	**2**	5	0





Overview:

The trend for serious incidents excluding pressure ulcers shown in Table 1 above has steadied although there is still a slight upward movement. Trends for adverse incidents in table 2 remain within similar boundaries and work is beginning to increase reporting of medication and medical device incidents as highlighted in recent Safety Alerts. Analysis of the rise in SIs has been examined and it could be caused by a number of factors including improved reporting. There is, however, a cluster of 6 serious incidents related to the failure to act on adverse test results since April 2014. Some of these related to deteriorating in-patients while others were about out-patients. In some cases cancer follow up had been delayed by these omissions. In the previous year an increase in this type of incidents had been noted and a number of actions had been taken including trust wide awareness raising at staff forum and the Grand Round. The current cluster demonstrates that further action is required to prevent reoccurrence. An SI investigation panel has been set up to look at the cluster of incidents together so that a more holistic view of systems and processes can be assessed.

Actions:

The Medical Director has instigated the following immediate actions:

- A message has been sent to all doctors that it their legal responsibility to ensure that there is a robust system to review and act on diagnostic tests.
- A gap analysis is being conducted to check whether systems are robust in each area with follow up where these are insufficient
- Radiology: are strengthening their failsafe safety net system. This now includes e mails to the MDT for unexpected cancer results
- Improving consultant attribution on Cerner

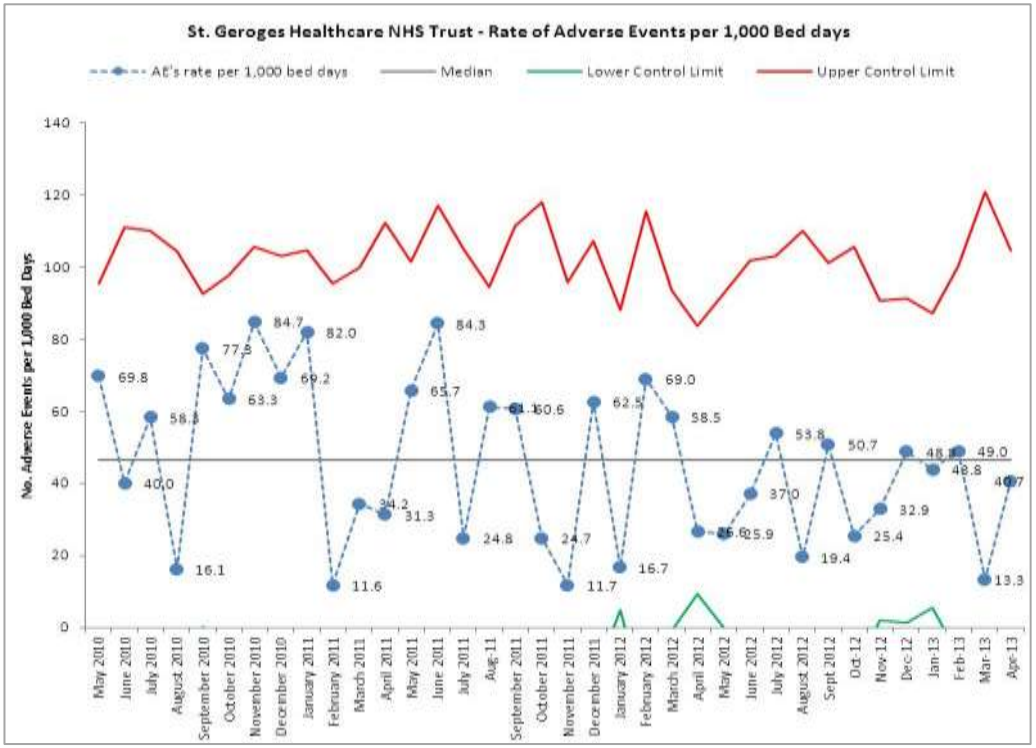
5. Patient Safety
- Patient Safety Week Feedback:

Patient Safety Week in May focussed on feedback from staff regarding safety concerns, adopting a listening approach for staff to raise their concerns which could then identify where additional work was needed. The week was based on the Listening into Action model which has been widely used within the trust to facilitate staff engagement and improvements to staff and service issues. A number of approaches were employed to gain feedback including big safety conversations and visits to clinical areas where postcard feedback was gathered from staff.

The highest issues raised were that of staffing, communication/handover and equipment. The report is being considered at the Quality and Risk Committee and gives details of all issues raised and includes proposals for follow up action. These actions focus on existing strands of work regarding staffing and establishments. The actions are also to highlight key issues around staff recruitment and retention and also outline work required on systems that delay staff working effectively.

5. Patient Safety - Local Audits

Global trigger tool



Background

The Global Trigger Tool for Measuring Adverse Events (GTT) was developed by The Institute of Healthcare Improvement as a method for identifying adverse events (harm) and measuring their rate over time, to tell if changes being made improve the safety of care processes. Within St George's the GTT was implemented in 2010 as a CQUIN and continued as a key performance indicator. The recommended measure is to look at Adverse Events (AE's) per 1000 patient days as shown in the chart. The central line is the mean across the period. The upper and lower control limits are calculated to 3 SD's (standard deviation) and points within the two control limits are considered as normal variations. Points outside of these lines represent extraordinary variation and would require more investigation. Interpretation indicates that our data continues within normal variants although there is less variation in the latter months.

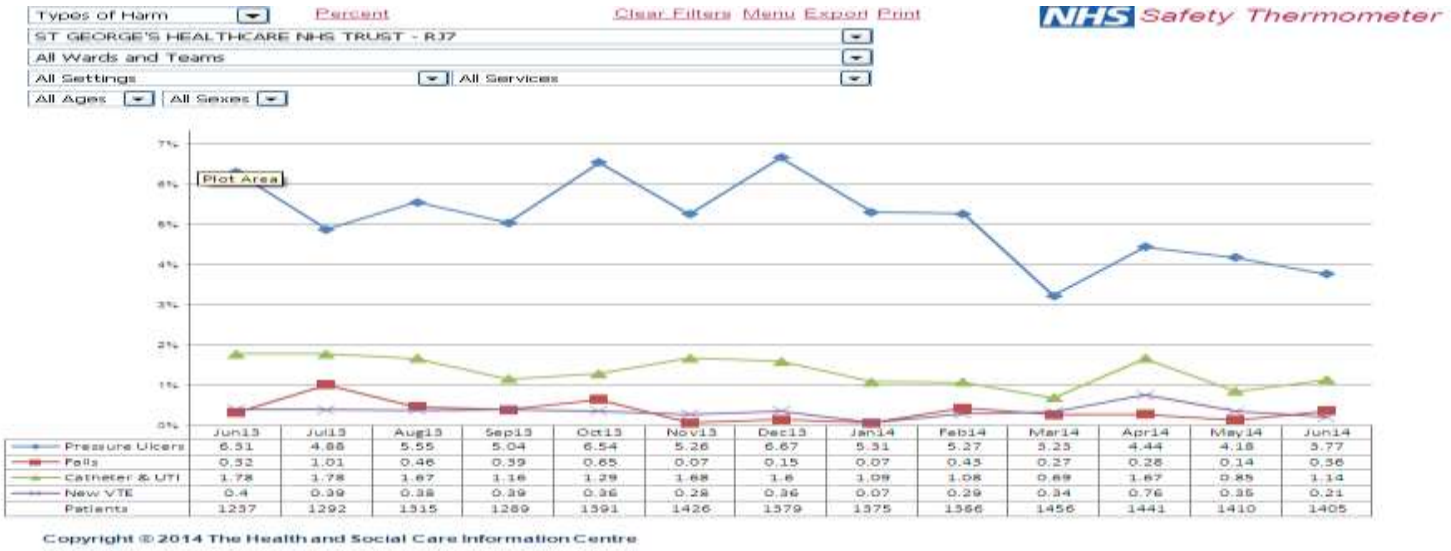
Overview

The five most common adverse events are consistently; complication of treatment/procedure, wound infection, nosocomial pneumonia, decubiti and readmission in 30 days. Although, the rate of overall harm has remained consistent over the three year period studied, comparative results indicate that there has been a small reduction in wound or catheter related infections, nosocomial pneumonia rates have remained consistent and there has been an increase in decubiti related harms.

The strength of the GTT methodology relies on a consistent team and the obvious weakness has been a decreasing number of members of the group. This has resulted in a backlog meaning that data is examined 12 months retrospectively. To address this more members are to be recruited to the group and the review will forgo a year's worth of data to give more recent comparative results. As well as ensuring that the safety reviews are contemporary this will also mean that the VTE, EWS (early warning score) and documentation audits currently undertaken alongside the GTT will be up to date, and therefore more useful in identifying areas for improvement.

5. Patient Safety
- Safety Thermometer

% Harm Free Care							
Lead Director	April	May	June	Movement	2014/2015 Target	National Average	Date expected to meet standard
J Hall	93.31%	94.61%	94.73%	▲	95%	93.5%	Sept - 14



Overview

This point prevalence audit shows that in June 2014, overall 94.73% of patients received 'harm free' care, a slight improvement from the 94.61% in May. This performance remains above the national average of 93.5% but falls short of the newly introduced 95% target. The number reported pressure ulcers and VTEs is reducing whilst falls and UTIs is increasing slightly.

Actions:

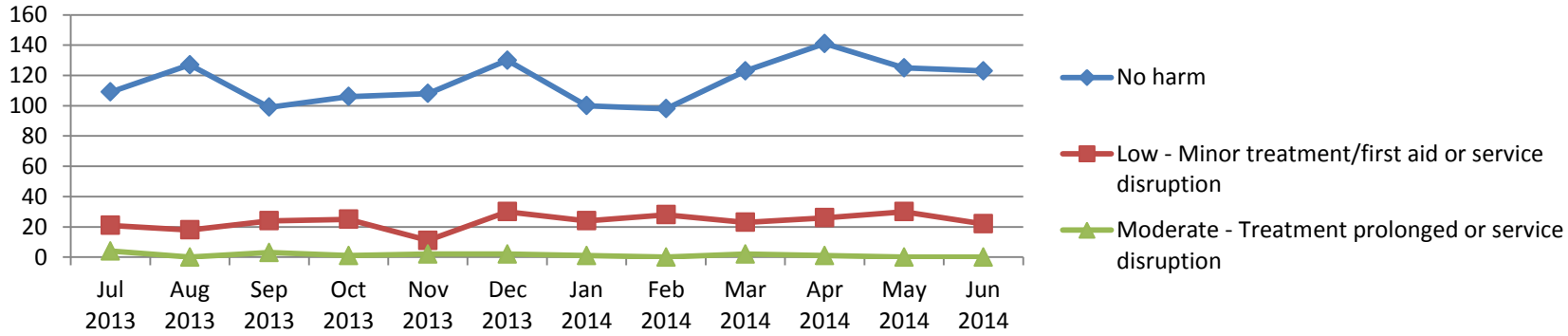
The understanding and awareness surrounding the VTE metrics amongst nurses who collect the data appears limited and VTEs are often reported in error. From July onwards the VTE submission will be validated by the relevant clinical nurse specialists with plans in place to also take this forward for falls and UTI data. The harm caused by pressure ulcers and VTEs has been reducing since April 2014, progress that has been seen in cumulative audits. There will be a focused piece of work with the urinary continence team which will increase awareness of UTIs. The corporate nursing team will also review the current falls strategy and work to establish if it needs to be changed.

5. Patient Safety
- Incident Profile: Falls

Falls						
Lead Director	April	May	Movement	2014/2015 Target	June - 14	Date expected to meet standard
	167	156	⇔	100	151	July 2015

Falls with Harm				
No Harm	Moderate	Severe	Death	Falls related Fractures
1357	22	1	0	7

Patient falls by fall date (Month and Year) and Severity



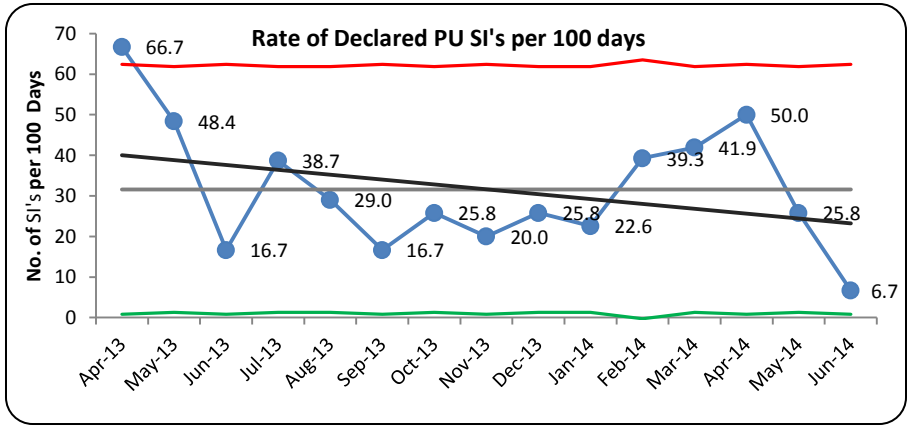
Overview: The graph shows the profile of falls across both acute and community bed-based services including patients' own homes. It is important to note that this data is sourced from incident reporting and is not individually verified. There has been no significant change in the number of falls recorded in the last year. The Trust was 80% compliant with the revised NICE falls guideline; the areas of non-compliance include the use of a falls risk prediction tool in the inpatient pathway, a lack of patient information leaflets and lack of access to exercises classes in the extended care setting. The Falls Prevention Committee has revised the inpatient falls pathway in partnership with the electronic record leads and developed paper based multi-factorial falls risk assessments and care plans, patient information leaflets for falls prevention and the use of bed rails. Exercise in extended care setting is being developed in line with promoting access to exercise to frail older people. The Trust is currently trialling bed and chair sensors to assess their effectiveness and feasibility in two inpatient areas (acute senior health and community bed-based rehabilitation). The Falls Prevention Committee has designed a new bed rail risk assessment tool which will be rolled out electronically together with an e-learning package.

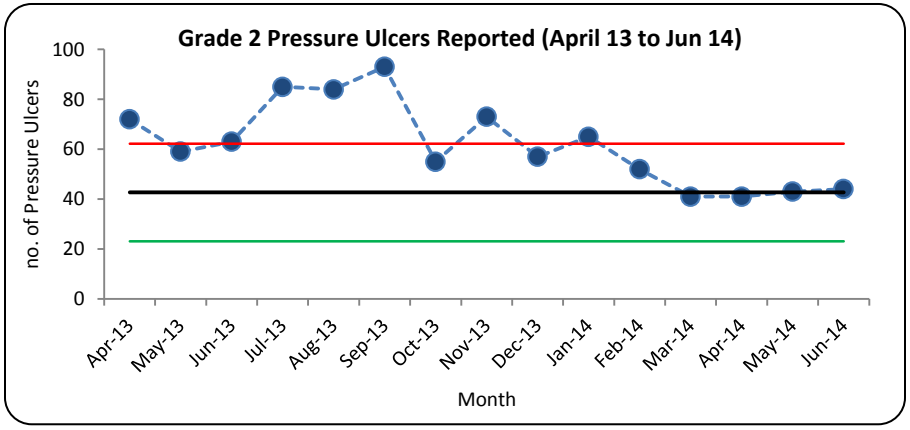
Actions: The Trust will triangulate the data from incident reporting with patient safety thermometer and work with each division to verify their falls rates, identify themes and trends to ensure that action plans are developed with specific emphasis on their specific patient cohort. The Falls Prevention Committee will continue to provide teaching at Inductions, Harm Free Care days, mandatory training days on falls prevention and bed rail risk assessment. A needs analysis of adjuncts designed to reduce risk of falls and harm (ultra-low beds, bumpers and floor mats) will be completed and this data will be used to inform a business case.

5. Patient Safety
- Incident Profile: Pressure Ulcers

Serious Incident – Grade 3 & 4 Pressure Ulcers								
Type	April	May	June	YTD	Movement	2014/2015 Target	Forecast Sept - 14	Date expected to meet standard
Acute	12	3	1	16			G	-
Community	3	5	1	9			G	-
Total All	15	8	2	25			G	-
Total Avoidable	7	TBA	**TBA**			40		-

Grade 2 Pressure Ulcers			
April	May	June	Movement
19	18	**28**	
22	25	**16**	
41	43	**44**	





Overview: **A continued drive to reduce pressure ulcers has seen a marked reduction in SI's throughout Q1 . The key drivers for this include : focussed work on review and validation of grade 2 pressure ulcers on the Acute site since February 2014 . This was achieved by additional resource of 2nd TVN this year ; preventative measures being used; raised awareness and training locally and trust wide . Audit results shows sustained compliance with documentation, further work required on completion of repositioning charts and use of patient information leaflets . Q1 CQUIN evidence submitted and this work will demonstrate an excellent example of integrated working across acute and community services . Medicine Division and Women and Children's division had 89 days without a grade 3 or 4 pressure ulcer declaration 21.4.2014 – 20.7.14**

- **Actions: Focussed work in Q2 with the surgical division and community colleagues to share learning from SI reports and trend charts with divisional teams**
- **Work with community colleagues from 3 residential / nursing homes to achieve CQUIN – undertake a base line review of pressure ulcer care and management with resulting action plan and objectives**
- **Introduce e learning package across the organisation**
- **Keep the divisions informed of performance to ensure it is monitored and sustained**
- **Deliver pilot 2 day programme on pressure ulcer prevention in-house in August with potential to run alternate months**

5. Patient Safety - Infection Control

Infection Control						
Type	May	June	Movement	2014/2015 Target	Forecast July - 14	Date expected to meet standard
MRSA	1	1	⇔	0	G	June - 14
C-Diff	3	5	⇧	40	R	August -14
MSSA	4	1		NA		
E-Coli	3 (21)	5 (24)		NA		

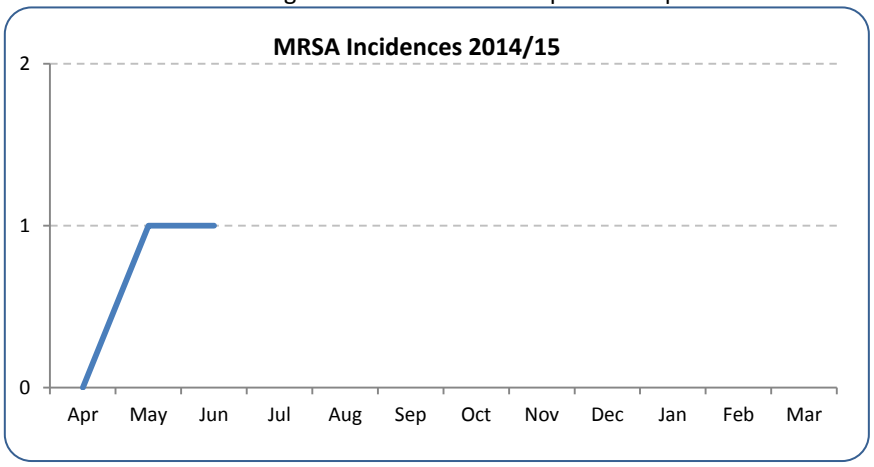
Peer Performance – YTD June 2014				
STG	Croydon	Kingston	King's College	Epsom & St Helier
2	0	0	1	1
11	4	3	24	10
7	1	1	12	3
14 (66)	43	36	85	79

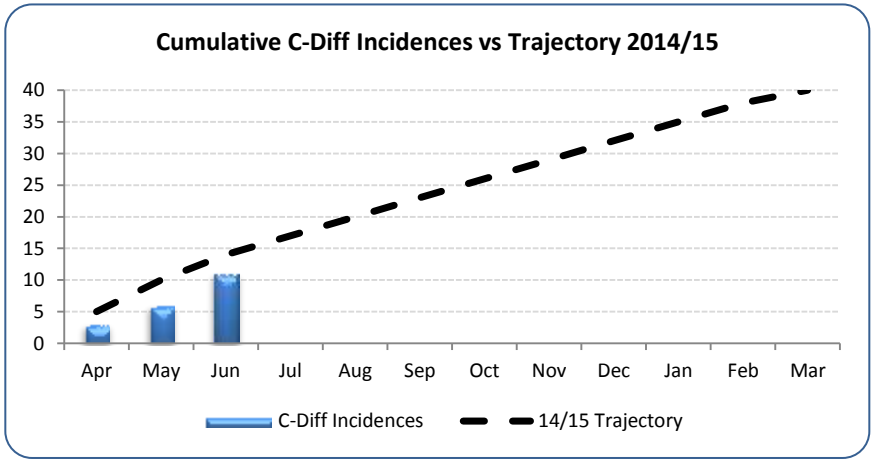
The trust has a target of no more than 40 C-diff incidences in 2014/15 and zero tolerance against MRSA continues.

In June there were 5 incidences of C-diff against a trajectory of 4 for the month. Initial review to date does not identify any key themes, focus remains on hand hygiene, antibiotic prescribing and prompt isolation.

The trust has 1 case of MRSA infection in May and one in June and thus has breached the zero tolerance standard and 2 for the year. However, with the NTDA still applying the de minimis limit of 6, the trust is within threshold before a penalty score is applied. The RCA for the first case identified a number of actions to be taken forward which will be monitored by the Division. The trust will continue its programme of close monitoring and vigilance to ensure compliance in 2014/15.

More widely work has been completed regarding the Trust Response to CPE guidance and this will now be implemented going forward. Focus is also being placed on infection control training rates and actions to improve compliance in this area from 60%.





5. Patient Safety - VTE

VTE Risk Assessment							
Director Lead	April	May	June	Movement	2014/2015 Target	Forecast June - 14	Date expected to meet standard
	96.31%	96.4%	97.33%	⮝	95%	G	-

Current Month by Division				
Med & Card	Surgery & Neuro	Community	Children's and Womens	Corporate

Overview: The Trust continues to achieve the national threshold for VTE Screening. Divisional Data will be available in next months report.

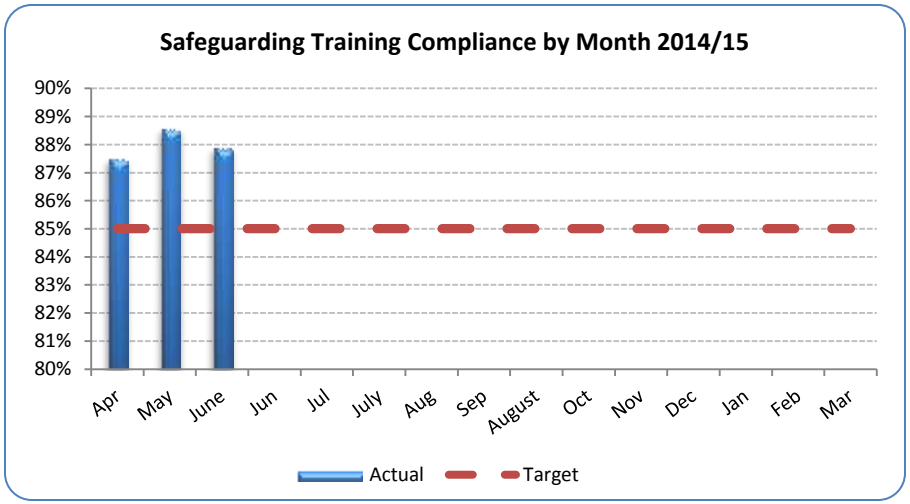
The annual report was presented to the Patient Safety Committee in June 2014 outlining the progress made in this area and further action to be taken. Key areas of focus going forward will be further Training in relation to prophylaxis prescribing, and ensuring that all relevant patient details are recorded. There is an ongoing pressure within the team due to the profile of the Specialist Nursing workforce however this is being proactively managed.

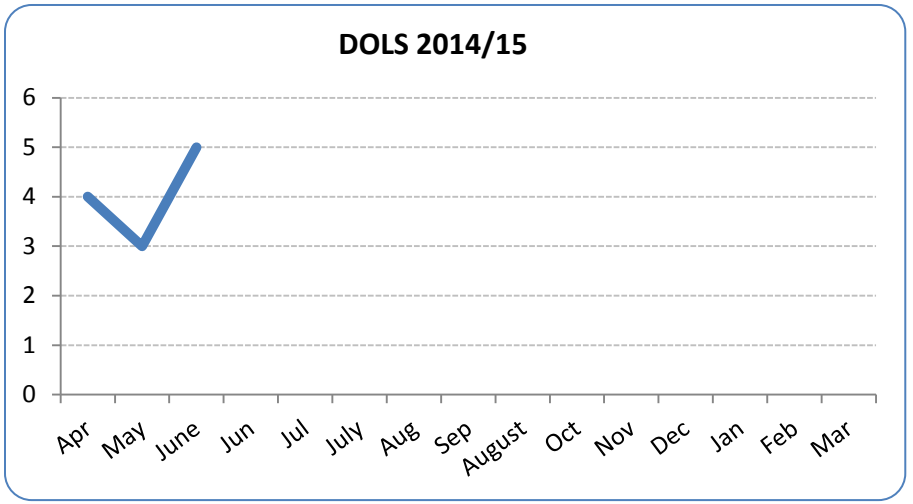
For the period January 2014 to July 2014 there were a total of 51 Hospital acquired VTE Cases. Each case is subject to a Root Cause Analysis and the output of the themed review following completion of the RCA will be fed back to the PSC.

5. Patient Safety
- Safeguarding: Adults

Safeguarding Training Compliance - Adults							
Lead Director	April	May	June	Movement	2014/2015 Target	Forecast July - 14	Date expected to meet standard
AW	87.5%	88.58%	87.9%	⮟	85%	G	-

Safeguarding Adults Training Compliance by Division – June 14				
Med & Card	Surgery & Neuro	Community	Children's and Womens	Corporate
84.98%	86.56%	**90.76%**	89.53%	87.69%





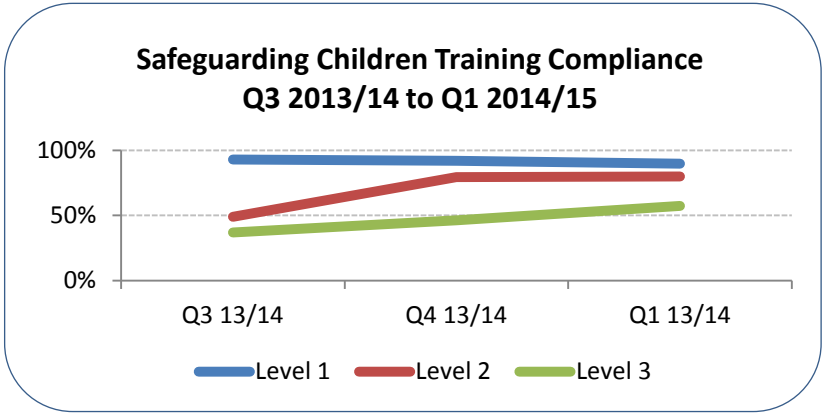
Overview:
There is consistency across the whole Trust with regard to adult safeguarding training which is part of induction and e-MAST training. This awareness is reflected in the high number of referrals to the lead nurse for safeguarding adults.
April – 74, May 76, June 77
Currently there is no centrally held record of MCA training but as part of the action plan around MCA following the CQC report, training will now be delivered and recorded, beginning with Queen Mary's, Roehampton
Since April and the Supreme Court judgement there has been a significant increase in DOLS activity which is to expected and reflected nationwide.
April – 4, May - 3, June - 5

Actions:
Continue to monitor safeguarding training via WIRED
Roll out MCA training across trust, audit effectiveness
Review DOLs activity and impact on resources. Monitor demand on services versus capacity to complete assessments. Produce fresh guidance on DOLS in conjunction with DH guidance.

5. Patient Safety
- Safeguarding Children

Safeguarding Training Compliance - Adults						
Lead Director	April	May	Movement	2014/2015 Target	Forecast June - 14	Date expected to meet standard
	0	1	▲	85%	G	June - 14

Safeguarding Training Compliance - Children					
April	May	Movement	2014/2015 Target	Forecast June - 14	Date expected to meet standard
0	1	▲	85%	G	June - 14



Overview: The evidencing of safeguarding children training data has recently improved due to the introduction of the WIRED system, however training needs analysis continues to be reviewed with the safeguarding team. The information from WIRED (once populated with information of confirmed training data) indicated that training compliance throughout the 3 levels of safeguarding children training was poor, in January 2014 safeguarding children training was entered onto the risk register. An action plan was already in place. Safeguarding children training is monitored by the Children and Young People's Safeguarding Committee.

Actions: An action plan to address the shortfall in safeguarding children training compliance is in place. Additional sessions at level 3 are being funded to compliment the training programme. Compliance at level 3 has improved and is now 57%. The safeguarding children training needs analysis has been reviewed and revised. Level 2 child safeguarding training is available as e learning as well as a face to face training sessions. The Safeguarding Children Training Strategy is due for revision and this will then take into account the recommendations by Intercollegiate guidance regarding safeguarding children workforce competency and training needs.

Serious Case Reviews and Internal Mangement Reviews: There are a total of 4 active SCRs, plus 2 cases where final reports are about to be published and 3 where there are ongoing action plans. There are a number of recent cases where St George's Hospital have been involved with diagnosing NAI, that may be declared as SCRs and one potential SCR for a young person who may have killed himself. Two of the active cases are complex and high profile. St George's Healthcare NHS Trust have had significant involvement in these case. There is likely to be media attention as both cases are in the criminal courts.

St George's Healthcare NHS
NHS Trust

Patient Experience

excellent kind responsible respectful

6. Patient Experience - Stories

Subah is a 29 year old local man who was injured when he jumped from the 9th floor balcony of a burning building. He feels very lucky to be alive. He was brought to St. Georges with spinal injuries and fractures to his right foot and left heel.

He spent four days in ITU and thinking of the care he received there made him quite emotional.
" They held my hand when I was in pain and I asked them to promise me that I would not die. They were so good- they were angels to me."
After four days he was moved to Holdsworth ward and at the time of interview he had been there for two weeks.
"The staff are so friendly you can bond with them and have a laugh. You can tell if they are busy but they do what they can. They should be proud of the care we are given. We are very lucky and grateful"
He was asked if anything could be improved and he said:
"Sometimes at the morning ward round the consultant may ask for particular things to be done such as removing a cast. The nurses may not be able to do this for a while because they are so busy. One staff nurse stayed on for an hour and a half after the end of his shift to make sure I received the care I needed".
"I can't think of things to improve except perhaps some more information for patients would be good."

Tertius "Tosh" Piennar is a 39 year old lift engineer who had a car accident when his van hit a tree near Portsmouth. He was airlifted to St George's via helicopter and at the time of the interview he had been a patient here for four weeks and two days.
"It took an hour to cut me out of the wreckage. I had a fractured femur and fractures and nerve damage to my left arm with the bone sticking out. I had six broken ribs, both lungs were collapsed and a fracture to my collar bone. I also had a brain injury so my face was paralysed on one side. I feel very lucky to be alive.
I only remember bits of when I was in ITU but they made me comfortable and looked after me for just over a week and then I went to the High Dependency Unit before coming to Holdsworth ward. I remember shouting and swearing at one nurse because I was in so much pain but they stayed with me and spent a long time trying to make my arm comfortable.
The therapists have been great. I have a physio to massage my hand and get that moving and a different person to exercise my face so the paralysis has almost gone now. I have a physio for walking and I only need one crutch now.
The nurses are always smiling and bubbly but they work too hard. The students also work hard on the wards and often have to finish assignments after they have ended their shifts.
I still need further surgery to fashion an elbow which is an amazing operation. It has been delayed for over a week now so I think they need more surgeons or theatres".

6. Patient Experience
- Service User comments posted on NHS Choices and Patient Opinion

Overview:
The Patient Experience Manager and Patient Advice and Liaison Service Manager 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 44 posts made on NHS Choices and Patient Opinion in quarter 1 of 2014/2015 of which 31 were positive, 9 were negative and 4 were both. Accident and Emergency received the highest number of posts for any one department with the majority being either positive or mixed. The day surgery unit at St George's Hospital received two positive comments. A number of comments (13/44) were non-specific about which area of St George's or Queen Mary's Hospital they related to.

Below are some examples of comments/stories posted on NHS Choices and Patient Opinion in quarter 1.

Anonymous gave Ear, Nose & Throat at St George's Hospital (London) a rating of 2 stars

ENT Outpatients department
It is so very disorganised and waiting times are dreadful. You can expect to be there several hours for an outpatient appointment with no information on waiting times although you are supposed to be updated on the board in the waiting area. Waiting to see a consultant for 2 hours then told you need tests to wait for a further hour when the tests should have been done to save time on arrival.

The staff are friendly and helpful as they can be but know very little of what's going on or about what services are being delivered there. The nurses are sat round the corner where you can't see them to be able to ask.

Please clean the children's play area! It is filthy! It is quite clear this area is never cleaned or the toys and books. It is the dirtiest I have ever seen !!!

Visited in April 2014. Posted on 14 April 2014

Anonymous gave Accident and emergency services at St George's Hospital (London) a rating of 5 stars

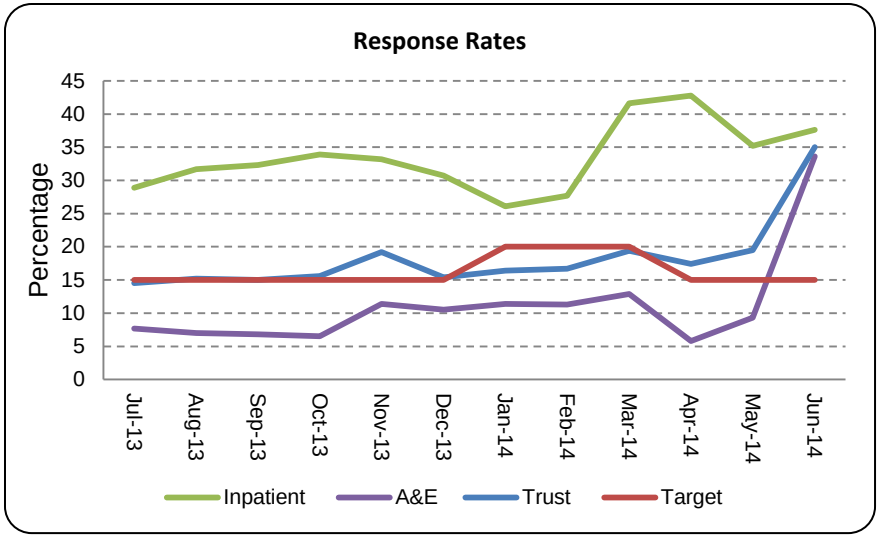
A positive A&E experience
I recently attended A&E at St George's with my partner who had collapsed while were out shopping. We have nothing but praise for the service and care we received from the ambulance crew and all the staff we saw at the hospital. The ambulance came really quickly and took us to St George's, where my partner was seen almost immediately. He had several tests done but we never felt we were left hanging around. The A&E environment was quiet and calm, and all the staff that we dealt with (there were many!) were courteous, friendly, helpful and efficient, and in less than 3 hours (it actually felt like no time at all) we were on our way home. A big thank you to everyone for looking after us so well during a stressful and frightening time - we really appreciated it. How wonderful to have an NHS like this!

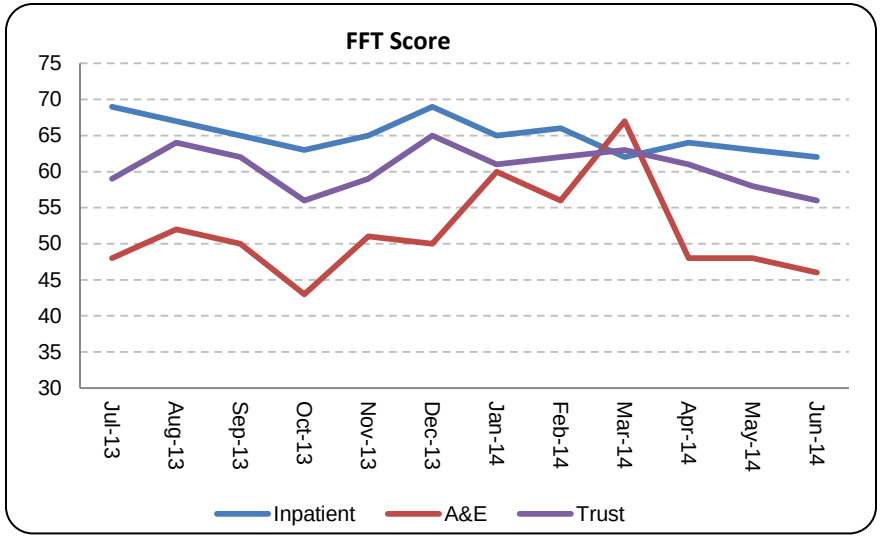
Visited in May 2014. Posted on 21 May 2014

6. Patient Experience - Friends and Family Test

FFT Response Rate							
Domain	April-14	May-14	June-14	Movement	2014/2015 Target	Forecast July- 14	Date expected to meet standard
Trust	19%	19.5%	33.6%	↑	20%	G	-
Inpatient	42.8%	35.2%	37.6%	↑	25%	G	-
A&E	5.8%	9.3%	33.6%	↑	15%	G	-
Maternity	30%	28.7%	35.6%	↑	-		-

	FFT Response Score			
	April-14	May-14	June-14	Movement
	61	58	56	↓
	64	63	62	↓
	48	48	46	↓
	26	31	41	↑





Overview : Q1 CQUIN performance demonstrated marked response improvements in A&E during the month of June 2014 , from 9.3% in May to 33.6% in June , average of 16.7% in Q1. This was achieved by daily monitoring within the division with clear trajectories set to succeed and added resource to support the collection of data during the month. Full attainment of CQUIN across A&E and the inpatient wards was achieved. The Friends and Family Test score for the trust overall was +56 in June , slightly lower than May (58). A&E scored +46 and the adult inpatient wards +62. Roll out to outpatient services, day care services and community is well under way with paper surveys and RaTE hardware being delivered. Awaiting the final guidance for FFT from NHSE with trajectories for these services.

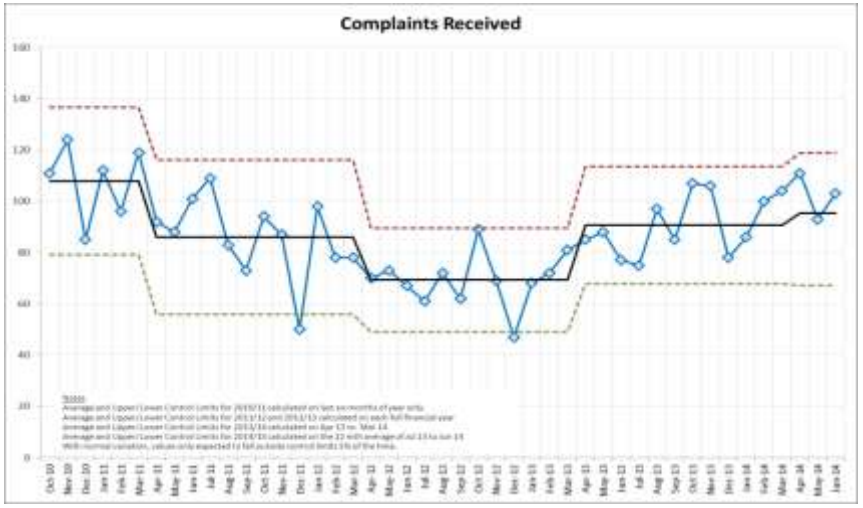
Action : Close monitoring of response rates in A&E to sustain improvements to achieve Q4 CQUIN trajectory of 20% for A&E and 30% for inpatient services, with a drive to achieve 40% for inpatients in March 2015 .

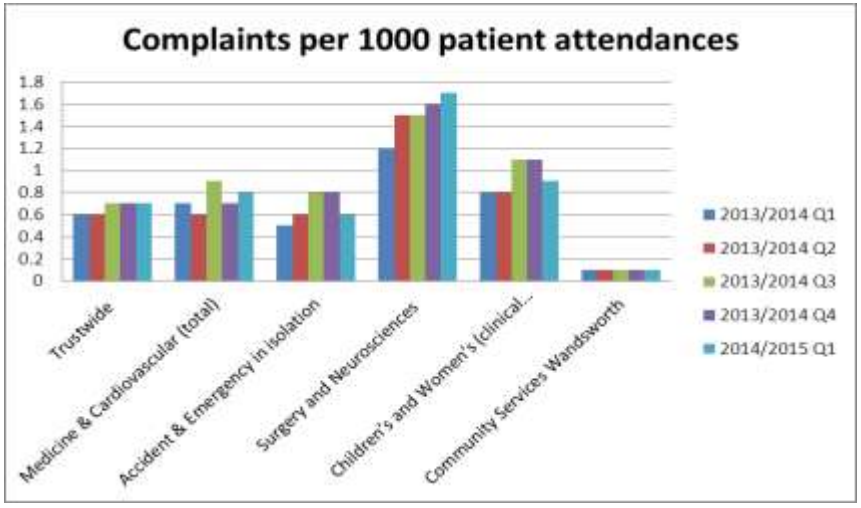
- Identify and share key themes from responses at various fora and committees
- Focussed attention this year on action planning to improve scores
- Continue to monitor performance in maternity at the 4 touch points ; antenatal,birth, postnatal ward and postnatal community

6. Patient Experience - Complaints Received

Complaints Received				
	April	May	June	Movement
Total Number received	111	92	103	

Complaints by Division : Q1				
Med & Card	Surgery & Neuro	Community	Children's and Women's	Corporate
70	94	**27**	93	21





Overview:

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 set out the rights of complainants and the expectations on the trust to investigate and respond in an appropriate and timely manner. Best practice is that each complainant is contacted to discuss their complaints and negotiate both the process of resolution and the timescale.

The trust has chosen to maintain a 25 working day response time and the target is that 85% of complaints should be responded to within this timescale. If a complaint is not responded to within 25 working days an extension must have been agreed with the complainant. The target is that 100% of complaints should be responded to within 25 working days or agreed timescales.

The aim in investigating complaints is to learn from what was a poor experience and to identify and take action that will prevent a similar occurrence. This is part of the continuous quality improvement processes in place within the trust.

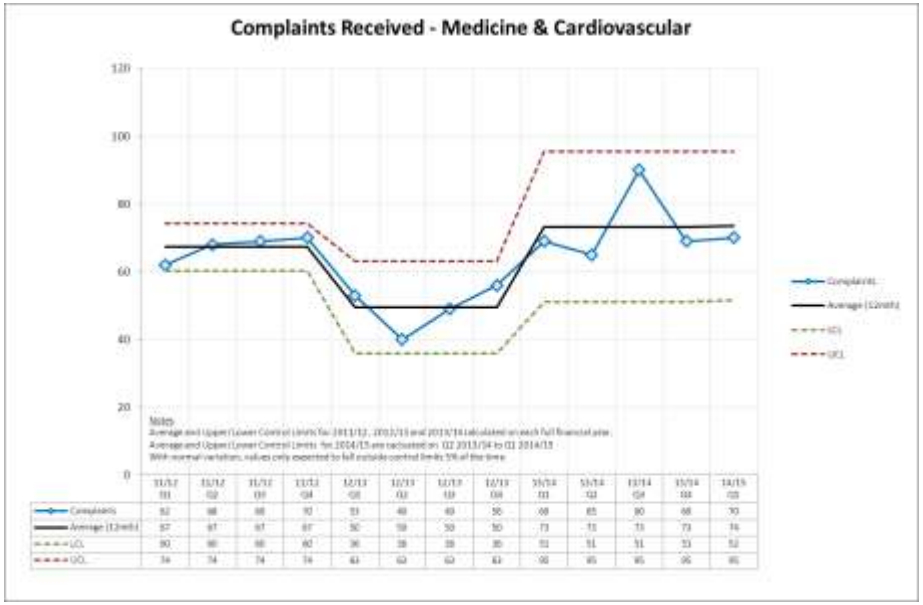
This report provides an overview of how the trust has managed complaints received in quarter 1 of 2014/2015 including analysis of the data to provide trends and themes with actions planned. This report also provides information on responding to complaints within specified time frames for complaints received in April and May of 2014, complaints per 1000 attendances, a report of the latest work on severity rating of complaints and posts on NHS Choices and Patient Opinion.

6. Patient Experience - Complaints Received

	Accident and Emergency	Acute Medicine	Cancer (not for Oncology wards)	Cardiovascular	Children's	CSW - Adult Services	Community Services - Childrens Services	CSW - Offender Healthcare	CSW - Older People and Neurorehab	Corporate Directorates	Critical Care Directorate	Diagnostics	Neurosciences	Renal, Haem & Onc	Specialist Medicine	Surgery (inc. T&O)	Theatres	Therapeutics	Women's	Total
Admission arrangements	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	3
Attitude	2	1	0	1	0	1	0	0	0	3	1	2	1	0	1	3	0	3	1	20
Cancellation	0	0	0	0	0	1	0	0	0	0	0	0	1	0	0	1	0	3	0	6
Cancellation of surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	2	1	6
Care	1	4	0	0	0	0	1	1	1	1	0	1	2	1	0	4	0	2	3	22
Car Parking	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Clinical treatment	3	2	0	3	1	1	0	3	2	0	0	0	8	1	2	10	1	1	6	44
Communication	13	13	1	7	4	7	1	0	4	4	0	3	12	4	4	30	1	36	7	151
Discharge arrangements	1	0	0	1	0	0	0	0	1	1	0	0	1	0	0	1	0	0	0	6
Hotel and site services	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	2
Other	1	1	0	0	0	0	0	1	0	2	1	0	1	0	0	2	0	0	1	10
Medical records	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	7	0	10
Transport arrangements	0	0	0	0	0	0	0	0	0	8	0	0	0	0	0	0	0	0	0	8
Unhelpful	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
Waiting times	0	0	0	1	0	2	0	0	0	0	0	0	0	0	0	8	0	4	0	15
Totals:	23	21	1	13	5	12	2	5	8	21	2	7	26	6	7	64	3	60	19	305

There were 305 complaints received in quarter 1 of 2014/2015 which is an increase on quarter 4 of 2013/2014 when 289 complaints were received. There was a decrease in complaints being received in the Surgery and Neurosciences division. There was an increase in complaints received about Corporate Directorates largely due to transport and a significant increase in complaints received about the Children's & Women's division due to complaints about outpatients which increased from 29 to 49.

6. Patient Experience
- Complaints – Medicine and Cardiovascular



Accident and Emergency and Acute Medicine
Analysis has shown that between Q4 13/14 and Q1 14/15 a significant increase has been seen in complaints relating to verbal communication and this rise sits specifically in Acute Medicine and the Emergency Department. Actions taken to address this include work to improve communication of staff towards patients to ensure patients are kept up to date in terms of their treatment plans and the discharge process.

There has been ongoing work to ensure that full explanation of the purpose of Acute Medical Unit is given to patients and that they are moved to wards earlier in the day. Where appropriate, certain staff have been given specific retraining or made aware of departmental policies to ensure that these are followed and patient care and understanding is not compromised.

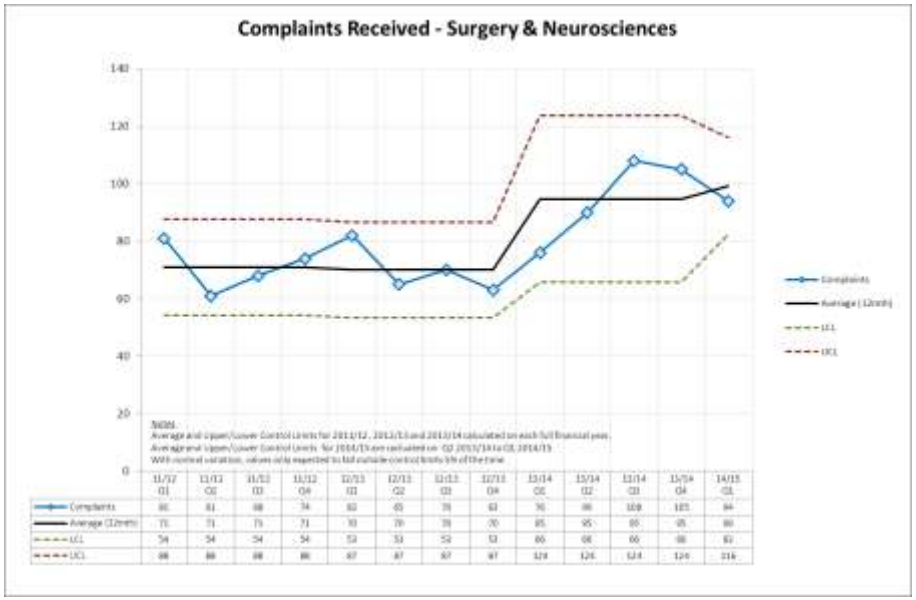
The division has seen a fall in the complaints received relating to Clinical Treatment – diagnosis. This improvement has been seen in the Emergency Department. Action taken has included education and training at induction for junior doctors and new starters, additional training for a specific individual regarding assessment of pain and shared learning at Emergency Department clinical governance meetings.

Cardiovascular
Following complaints regarding access and cancellations the cardiology team has reconfigured the day case and the elective unit. The purpose built day case unit opened in January 2014 and a five bed elective unit opened in February. The unit has the capacity to treat up to 19 patients a day. In addition there are now staged arrival times to reduce the amount of time patients wait prior to their procedure. Senior resource has been appointed to oversee the transformation of the operational systems that underpin the patient pathway processes, to ensure that patients are booked in a timely way and receive their treatment when scheduled.

Poor information regarding when appropriate treatment should be commenced has been raised. An action from this was that new processes, now in place, would prevent such an occurrence from happening again. Each hospital employs a dedicated MDT (multi-disciplinary team) co-ordinator whose sole role it is to police all patients who are referred into this specialty. Patients now have their pathway and treatment signed off from the MDT and each discussion is well documented.

Specialist Medicine
Analysis of complaints showed that the attitude of the secretarial staff was a concern and had been raised in several complaint responses within the gastroenterology team. This has been picked up as a team and all staff have now had customer service training and clear objectives have been set as part of a rigorous appraisal process. Since this action there has been no mention of these secretaries in complaints.

6. Patient Experience
- Complaints – Surgery and Neurosciences



A number of actions are being taken across the division including improved consultant ward rounds, non-medical prescribing pharmacists, new Surgical Assessment Unit to facilitate improved patient pathways, electronic documentation, improvements in out of hours neurosurgical consultant ward rounds, and governance leads in all care groups. Some specific actions are outlined below.

Neurosciences

- A 'Listening into Action' initiative introduced locally, focusing on customer care and trust values. A local awards system links into this and MDT communication training in the simulation lab being planned
- Review of scheduling for the neurosurgery day unit, patient information and overall patient experience
- Due to cancellations increasing again previous service improvement work being reinvigorated
- Monthly complaints review meeting – review themes and associated actions & log of actions
- Improved information in clinic appointment letters for neurosurgery and neurology
- Consultant of the week model of ward rounds will be in place by October 2014 in neurology. Neurosurgery is working towards the same.

Trauma and orthopaedics

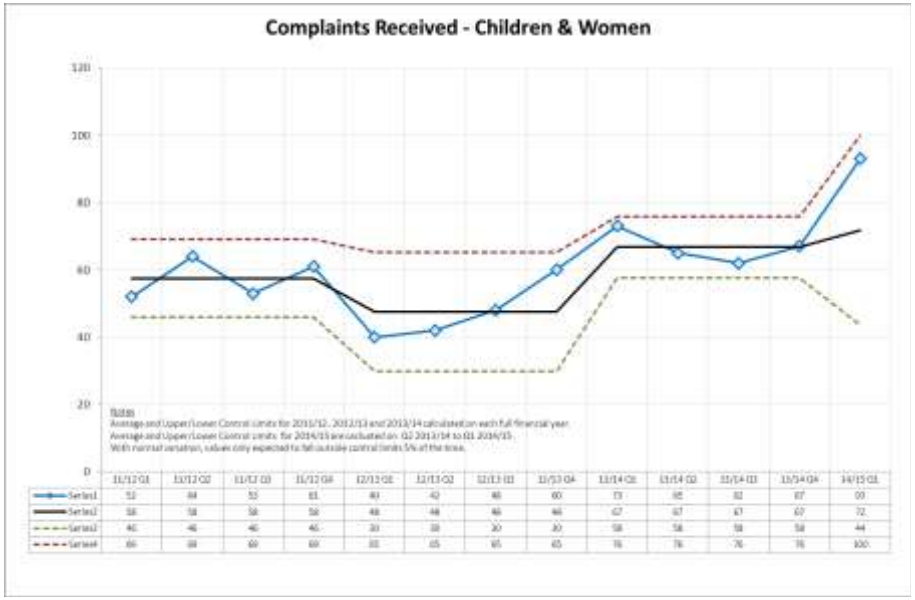
A comprehensive business plan and range of actions are being undertaken, some of which involve collaborative working with the corporate outpatient service and include:

- Triage systems for X-rays - X-ray requests for follow up appointments are being managed more proactively
- Queries mail boxes for secretaries and patient pathway co-ordinators have b been introduced.
- Hotline for patient queries, self-check in booths, new OPD clinic coordinator role.

General Surgery and Urology

- A standard letter/leaflet is being created to be given to patients who are cancelled on the day (theatre and outpatients), with information regarding what happens next. Every patient cancelled on the day is to receive a telephone call within one working day from a member of the management team to apologise, ensure they have received the letter and answer any queries.
- Patient information leaflets will be updated, which include advice on discharge and action will be taken to ensure they are available on all wards and in the surgical admissions lounge.
- A leaflet is being developed to be given to patients in clinic when they are added to the admitted waiting list, to inform them of what to expect next.
- Demand and capacity in breast outpatients is being reviewed as part of the service improvement work which commenced in May 2014.
- A service improvement project is underway in urology to improve patient experience in outpatients, with a key focus on patient flow.
- Twice daily consultant ward rounds through 'consultant of the week' with a focus on clear communication on the ward round and at discharge and improved supervision of juniors.
- Complaints to be sent to care group leads on receipt, rather at review stage to ensure senior clinical input to the investigatory stage.
- Improved communication of themes, actions and outcomes to care group - with particular focus on consultants.

6. Patient Experience
- Complaints – Children's, Women's, Diagnostics, Therapeutics and Critical Care



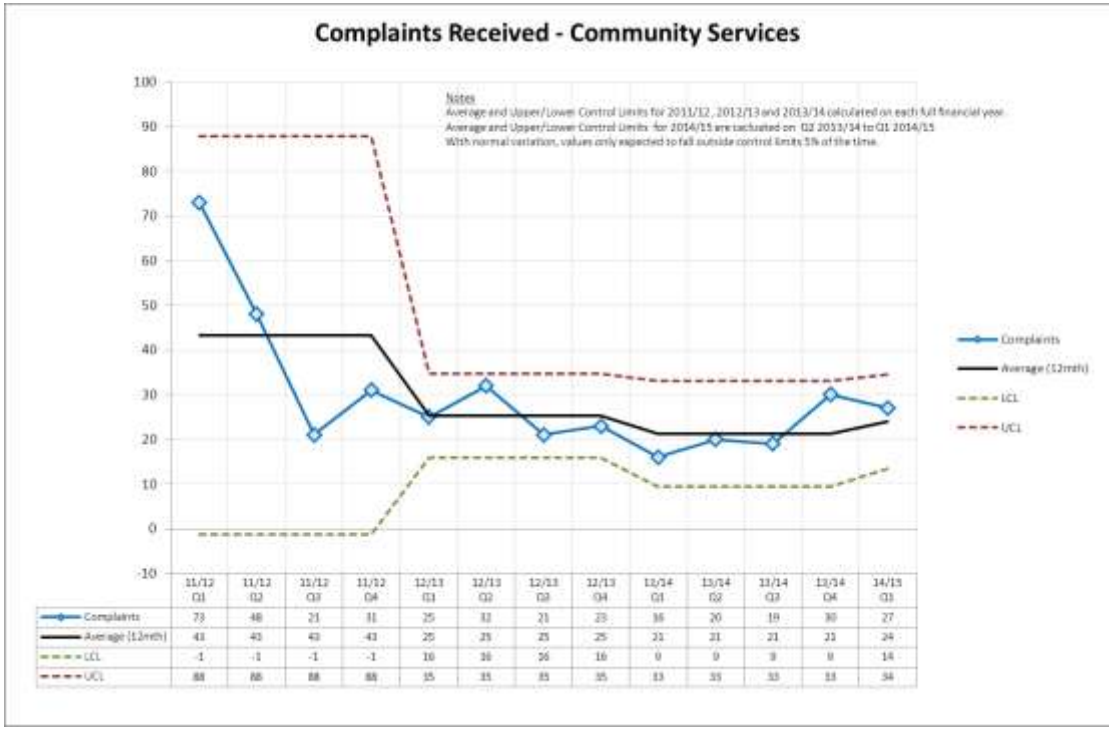
Going forward the plan is to ensure that the division achieves actions is to replicate the process of the serious incident action plan monitoring. Directorates will be expected to identify the key actions that they have agreed in complaints and these will be recorded centrally and directorates will be monitored against this on a quarterly basis.

Outpatients
Despite previous actions reported complaints about outpatients increased significantly again from 29 in quarter 4 to 49 in quarter 1. The team is working on a number of measures to reduce the overall number of complaints as this the directorate with the largest volume of complaints in the division. A robust action plan has been established to address the on-going concerns and these actions include recruitment of additional permanent staff, customer care training for staff, management team to have greater presence within the departments to address and resolve issues that arise in real time and prevent formal complaints, improved notes tracking to increase availability of notes in clinics and an early escalation system has been implemented to highlight missing notes to specialities.

Children's Services
Themes are focused on nursing care and communication. In regard to nursing care this relates in part to the flow of information and how this is delivered to patients and families. An external consultant is working with the team to review and start to change the 'culture' of the paediatric wards. This piece of work will focus on behaviours, leadership and professional expectations, which it is hoped will address some of the issues raised in complaints. Staff have also been receiving customer care training from the Patient Advice and Liaison Service and the directorate has proactively scheduled further training dates for new starters who are due to join in August/September. As regards written communication, the RCP7 project has been looking at appointments as this has been recognised as an area for improvement. The drive is towards ensuring patients leave the ward with an appointment.

Women's Services
There have been a number of complaints that relate to clinical treatment and communication, some of this relates to managing individual patient expectations and how staff have managed this. The team has addressed issues with individual staff members and highlighted the need to ensure that explanations given to women are consistent. The team continues to capture patient feedback in real time through the use of a postcard system, where patients are asked to write their comments – good and bad. These are then pulled together into themes and the consultant midwife is in the process of putting an action plan together in response to the feedback. The team is also in the process of rolling out a teaching DVD to staff. This has been created with the use of actors who have recreated real incidents and the plan is to show it to staff to aid learning, discussion and reflection; this idea has been given an innovation award.

6. Patient Experience
- Complaints –Community Services Division



	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	14/15 Q1
Complaints	73	48	21	31	25	32	21	23	16	20	19	30	27
Average (12mth)	43	43	43	43	25	25	25	25	21	21	21	21	24
LCL	-1	-1	-1	-1	16	16	16	16	9	9	9	9	14
UCL	88	88	88	88	35	35	35	35	33	33	33	33	34

Senior Health

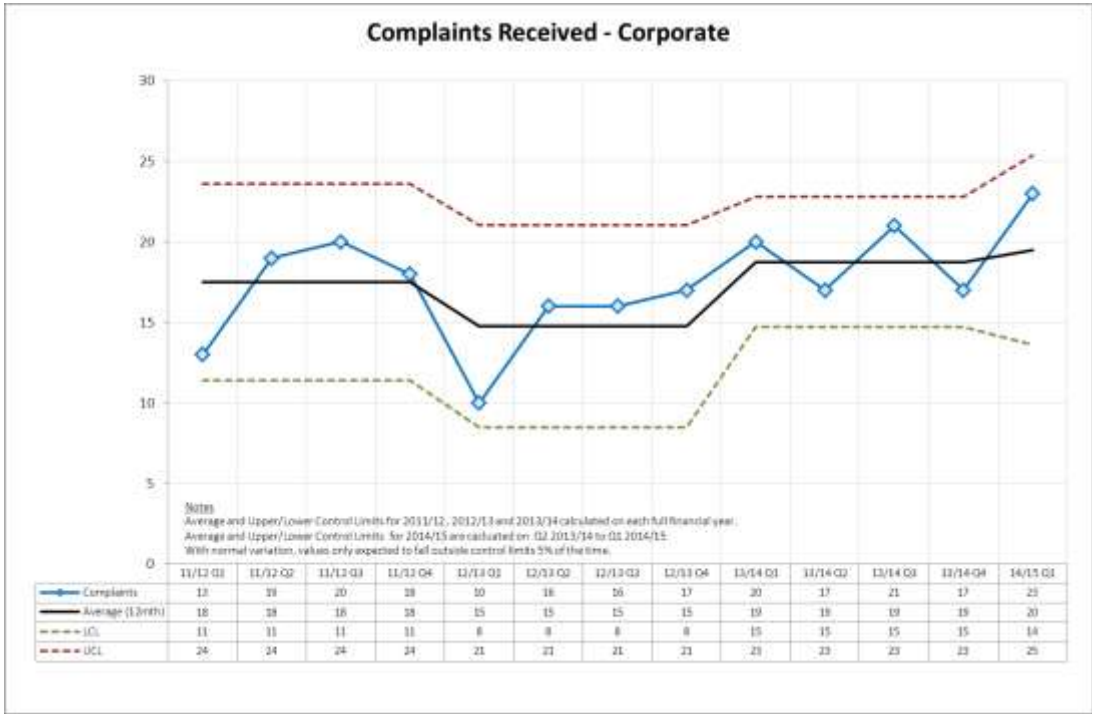
In response to complaints received about nursing care and communication on Dalby Ward the matron and ward sister have spoken to the nurses at the ward meeting and at nursing handovers and have reinforced the importance of documentation and effective communication. All nurses on Marnham Ward are currently receiving further training in mouth care as part of new nurses' local induction to the ward and at meetings and study days for existing ward staff.

Children

In response to complaints received about a specific school a number of actions have been taken including:

- Work with the school to review new admissions before the child starts in the school so that appropriate care plans can be put in place. The arrangements for this are currently being discussed with the school and Local Authority and will be in place by September 2014.
- Funding to be secured for a permanent specialist nurse with expertise in care of children with complex conditions.
- There is now an on call paediatric registrar based at St George's Hospital to advise on care for very sick children.
- There will be a review of the policy for parents about when a child is too sick to be in school and what the health team will do if a child becomes critically ill in school. This will be given to all families at the beginning of the autumn term.

6. Patient Experience
- Complaints – Corporate Services



	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	14/15 Q1
Complaints	13	19	20	18	10	16	16	17	20	17	21	17	23
Average (12mth)	18	18	18	18	15	15	15	15	19	19	19	19	20
LCL	11	11	11	11	8	8	8	8	15	15	15	15	14
UCL	24	24	24	24	21	21	21	21	23	23	23	23	25

Car Parking
There has been an increase in complaints about car parking relating to the cost of parking and lack of spaces. The cost related complaints usually occur when patients have had to wait longer than expected to be seen at their appointment. Refunds are offered in these circumstances.

Demand for car parking spaces is on the increase and this has resulted in increased complaints. A review of all the cars parked in the visitors' car parks has taken place and a high number of staff were found to be parking there. To address this we have ensured we control the number of staff permits allocated by applying the policy and criteria for parking on the hospital site and have reduced the permits offered to staff in the ballot.

Transport
A large number of complaints were received in May. The attitude of one driver was responsible for three of the complaints in May and as a result the driver will not be working for our contract again.

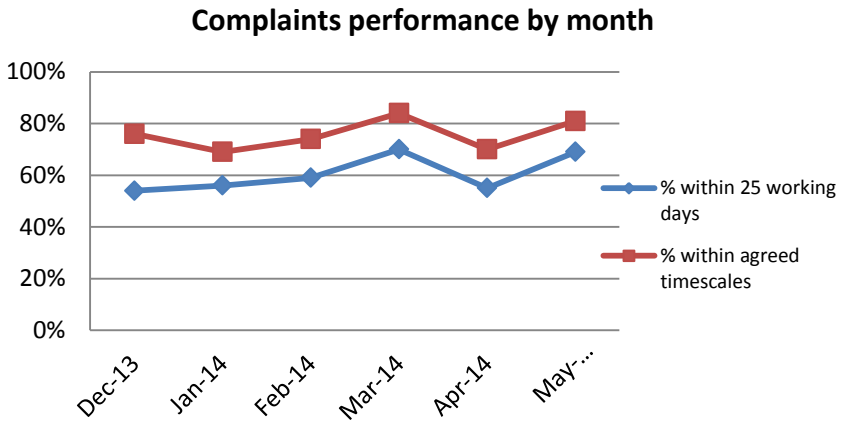
To resolve the issues arising with transport and in an attempt to reduce complaints a complete review of the service has taken place and the following actions taken:

- New management team in place to improve the service
- The offsite control centre in Sutton closed on 11 July and a new service is operating in Barking.
- Four new ambulances have been provided to help with demand
- A revised customer service training programme is taking place in July and August
- Nine extra drivers have been recruited.
- Ten more drivers are to be recruited and the interviews are taking place presently.

In addition to the above, workshops are taking place with divisions to plan the future transport service when the current contract expires in June 2015.

6. Patient Experience
- Complaints Performance against targets

Performance Against Target **(complaints received in April and May of 2014)**				
Division	**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	59	38	64%	(10) 81%
Medicine and Cardiovascular	38	24	63%	(8) 84%
Surgery & Neurosciences	70	40	57%	(5) 64%
Community Services	17	8	47%	(4) 71%
Corporate Directorates	18	15	83%	(1) 89%
Totals:	202	125	62%	(28) 76%



Overview:
For complaints received in quarter 1 where targets have been reached, 62% were responded to within 25 working days compared to 63% in quarter 4.

For the same period, 76% of complaints are planned to be responded to within 25 working days or agreed timescales compared to 77% in quarter 4. The final percentage may change depending on whether all of the agreed extensions are eventually met.

Actions:
Each division has plans in place to improve performance in the coming year. Examples of these include:

Medicine and Cardiovascular Division: Strict governance and monitoring of delivery through a standing agenda item in weekly team meetings, dedicated resource to support investigations and drafting, and compliance presentation at monthly Divisional Governance Board.

Surgery and Neurosciences Division: The division is committed to improving performance at a rate of around 10% per month to August and a number of actions were put in place in May to achieve this. For example, new complaints received in General Surgery, Urology and Plastics are being investigated by the Assistant General Managers and Service Managers freeing up the General Manager to focus on reducing the backlog of complaints.

Women's and Children's Division: The division plans to be compliant with the agreed 85 % within 25 working days and 100% for extensions by the end of Q2, this will be achieved through a month on month incremental increase in performance by 5% each month. The plan is to achieve this by focused work within individual directorates.

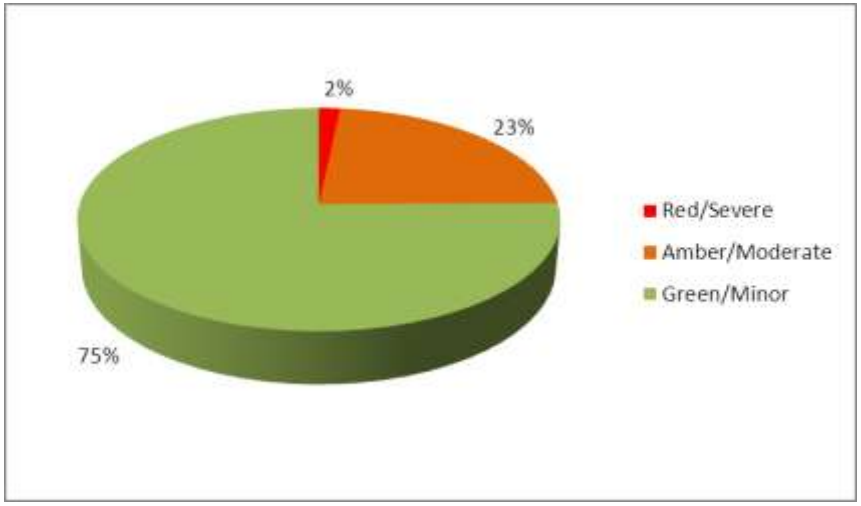
Community Services Division: The division aims to achieve 100% compliance with both targets by the end of quarter 4. Actions include to review the increase in complaints for 2013/2014 to identify themes and reduce complaints being received in the coming year and additional staff training in complaint investigation and writing of responses.

6. Patient Experience
- Complaints Severity Overview

The Complaints and Improvements Co-ordinators make an initial assessment of each complaint and grade them in accordance with the matrix below. It is the responsibility of the General Manager/Head of Nursing investigating the complaint to adjust the grading if necessary following the investigation.

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 serious incident (SI) or safeguarding issue these are discussed with the risk department and the relevant safeguarding lead(s) for children or adults.

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

In Quarter 1 a total of 5 complaints we categorised as Red/Severe.

- The reasoning for the red ratings included:
- Death noted.
- Serious Injury/ Serious Adverse Outcome.
- Vulnerable patient, possible neglect.
- Complex case as more than one service involved.
-

In Quarter 1 a total of 71 complaints were categorised as Amber/Moderate.
The most common reasons for the amber ratings were an adverse injury or outcome and the complaint being complex and/or involving 2/4 services.

In Quarter 1 a total of 230 complaints were categorised as Green/Minor.

St George's Healthcare NHS
NHS Trust

Workforce

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7. Workforce
- Safe Staffing profile for inpatient areas

Safe Staffing and Quality Indicators Report - June 2014

		DAY		NIGHT							
Division	Ward	% Fill Rate - Registered Nursing Staff[1]	% Fill Rate - Unregistered Nursing Staff[2]	% Fill Rate - Registered Nursing Staff[3]	% Fill Rate - Unregistered Nursing Staff[4]	FFT Score (Patient)[5]	MRSA BSIs[6]	C. Diff Positive Cases[6]	Safety Thermometer[7]	Falls[8]	Pressure Ulcer Incidences[9]
Children & Women's Diagnostic and Therapy Service	Cardiothoracic Intensive Care	86.2%	-	93.2%	96.2%	-	0	0	-	0	0
	Carmen Suite	97.4%	92.1%	98.4%	93.3%	50	0	0	-	0	0
	Champneys Ward	89.9%	38.0%	98.4%	100.0%	68	0	0	100	0	0
	Delivery Suite	95.6%	80.6%	97.5%	93.3%	-	0	0	100	0	0
	Fred Hewitt Ward	89.5%	87.9%	91.7%	61.5%	40	0	0	100	0	0
	General Intensive Care Unit	88.6%	55.1%	94.6%	87.5%	-	0	0	100	0	0
	Gwillim Ward	99.1%	62.6%	104.1%	56.8%	19	0	0	100	1	0
	Jungle Ward	82.6%	-	-	-	-	0	0	-	0	0
	Neo Natal Unit	77.7%	89.8%	81.2%	106.7%	-	0	0	-	0	0
	Neuro Intensive Care Unit	91.9%	83.3%	97.9%	92.8%	-	0	0	-	0	0
	Nicholls Ward	60.3%	39.1%	78.7%	45.8%	-	0	1	100	0	0
	Paediatric Intensive Care Unit	67.2%	56.7%	78.2%	93.3%	-	0	0	-	0	0
	Pinckney Ward	73.6%	78.2%	96.0%	100.0%	73	0	1	100	0	0
Children & Women's Diagnostic and Therapy Services Total		**83.4%**	**66.1%**	**90.8%**	**78.8%**		**0**	**2**		**1**	**0**
Community Services	Dalby Ward	60.3%	91.2%	97.8%	97.5%	80	0	0	86.4	5	0
	Heberden	85.9%	104.2%	90.8%	98.3%	44	0	0	81.8	5	0
	Mary Seacole Ward	91.9%	95.5%	98.0%	97.8%	44	0	0	67.4	8	1
Community Services Total		**79.4%**	**97.0%**	**95.9%**	**97.9%**		**0**	**0**		**18**	**1**
Medicine and Cardiovascular	A & E Department	93.6%	90.7%	95.3%	88.4%	50	0	0	-		0
	Allingham Ward	86.1%	105.2%	97.0%	98.8%	64	0	0	95.8	7	0
	Amyand Ward	96.4%	99.6%	101.5%	100.4%	6	0	0	92.3	4	0
	Belgrave Ward AMW	89.2%	89.9%	100.0%	100.0%	76	0	0	97.1	5	0
	Benjamin Weir Ward AMW	86.5%	76.9%	93.0%	100.0%	90	0	0	92.9	5	0
	Buckland Ward	90.4%	81.7%	98.9%	100.0%	78	0	0	95.2	9	0
	Caroline Ward	91.4%	83.1%	100.0%	100.0%	63	0	0	100	3	0
	Cheselden Ward	93.7%	88.1%	98.9%	100.0%	90	0	0	95.7	5	0
	Coronary Care Unit	102.8%	116.1%	101.8%	100.0%	100	0	0	100	0	0
	James Hope Ward	99.3%	100.0%	97.6%	-	80	0	0	100	0	0
	Marnham Ward	92.6%	104.7%	98.1%	97.8%	70	0	0	92.6	2	0
	McEntee Ward	84.3%	86.7%	100.0%	98.1%	75	0	1	100	6	0
	Richmond Ward	87.8%	87.4%	97.0%	98.7%	53	0	0	95.9	12	0
	Rodney Smith Med Ward	92.5%	99.8%	94.7%	99.9%	59	0	0	100	7	0
	Ruth Myles Ward	90.0%	88.3%	96.4%	100.0%	50	0	1	92.3	0	0
	Trevor Howell Ward	96.5%	82.3%	95.8%	96.4%	63	0	0	88.9	2	0
	Winter Ward (Caesar Hawkins	89.5%	102.2%	98.3%	100.0%	37	0	0	-	8	0
Medicine and Cardiovascular Total		**90.2%**	**93.5%**	**97.1%**	**98.0%**		**0**	**2**		**75**	**0**
Surgery & Neurosciences	Brodie Ward	87.0%	97.7%	95.1%	100.0%	-	0	1	88	1	1
	Cavell Surg Ward	90.7%	98.3%	92.2%	97.6%	51	0	0	84.6	3	0
	Florence Nightingale Ward	98.6%	82.1%	98.3%	100.0%	73	0	0	100	2	0
	Gray Ward	82.7%	68.7%	84.3%	86.5%	57	0	0	100	2	0
	Gunning Ward	97.5%	75.3%	108.4%	84.2%	32	0	0	100	0	0
	Gwynne Holford Ward	93.6%	102.8%	100.1%	101.0%	86	0	0	92.6	7	0
	Holdsworth Ward	90.2%	90.3%	101.9%	95.1%	53	1	0	95.5	3	0
	Keate Ward	95.6%	89.8%	98.9%	100.0%	65	0	0	93.8	1	0
	Kent Ward	84.7%	101.3%	100.0%	100.0%	67	0	0	90	5	0
	Mckissock Ward	81.0%	80.9%	95.9%	100.0%	50	0	0	95.7	3	0
	Vernon Ward	87.2%	92.0%	97.5%	100.0%	75	0	0	92.3	1	0
	William Drummond HASU	87.0%	68.0%	93.1%	92.1%	91	0	0	100	2	0
	Wolfson Centre	76.6%	95.8%	100.0%	99.1%	67	0	0	92.9	7	0
Surgery & Neurosciences Total		**88.1%**	**88.3%**	**95.8%**	**95.3%**		**1**	**1**	**94.72**	**37**	**1**
Trust Total		**87.2%**	**87.5%**	**94.1%**	**93.9%**		**1**	**5**		**131**	**2**

1 This is the total percentage of all Registered Nursing day time shifts rostered during the month, which were covered by either substantive, bank or agency staff
2 This is the total percentage of all Unregistered Nursing day time shifts rostered during the month, which were covered by either substantive, bank or agency staff
3 This is the total percentage of all Registered Nursing night shifts rostered during the month which were covered by either substantive, bank or agency staff
4 This is the total percentage of all Unregistered Nursing night shifts rostered during the month which were covered by either substantive, bank or agency staff
5 This score is a proportion calculated from patient responses, and ranges from -100 to +100 (Rate)
6 Data for C.Diff and MRSA BSI cases is for the previous month (during Jun 2014)
7 Percentage of "Harm Free" patients - those without any acquired pressure ulcers, falls , VTEs or UTIs (Rate)
8 All falls, regardless of any harm incurred (Datix)
9 Pressure ulcers include all grade 3 and 4 ulcers, identified more than 72 hours after admission (Datix)

7. Workforce
- Safe Staffing profile for inpatient areas

Overview

The information provided on the table underneath relate to staffing numbers at ward/department level submitted nationally on Unify in June 2014. In line with new national guidance this table shows the number of filled shifts for registered and unregistered staff during day and night shifts. The trust's first submission was 87%, 3% lower than the 90% that has been set as a national benchmark. Since May more work has been done to improve the data quality and with the June submission the trust achieved an average fill rate of 90.1%. Although some of our wards are operating below 100% the data does not indicate if a ward is safe. Safe staffing is much more complex than an observation of percentages and takes in to account many key aspects such as:

Nurses, midwives and care staff work as part of a wider multidisciplinary ward team. The demand on wards can change quickly and it will always be a clinical judgement as to whether to bring more staff in or reduce the amount the staff as per requirement.

- The data does not take into account the ongoing considerations for ward managers in ensuring that on each shift there is the right level of experience and expertise in the ward team.
- The nature of each ward varies. The number and type of patients seen on some wards will be relatively consistent. The number and type of patients seen on other wards will vary more dramatically, meaning that there could be greater change from the planned level and the average will be somewhere in the middle of the highs and lows of this variation.
- There needs to be the operational context of the reasons for staffing levels month on month, e.g. in June the post natal ward had a reduced number of shifts filled as the number of deliveries were reduced. This in turn had a knock on effect on the neonatal intensive care unit.
- Higher than 100% fill rates relate to areas which require more staff than they are profiled for. This could be because the patients the team are looking after are exceptionally unwell or require one to one nursing or supervision.
- Lastly St George's Healthcare NHS Trust has a safe staffing policy and a system in place for monitoring staffing levels on a daily basis. Nursing and midwifery clinical leaders visit their clinical areas across the trust at least once a day to ensure safe staffing and staff are encouraged to escalate any concerns they have to the chief nurse on duty. The acuity/dependency of patients (how sick or dependent they are) is also monitored closely as this ultimately affects the type and amount of care patients need. If concerns are raised about staffing levels, the clinical leaders may make the decision move members of staff across the trust so that the area is safely staffed. This ensures that our patients are well cared for.

Actions

- The actions from establishment review will be taken forward as a programme of work for which an initiation plan has been written and a programme board has been planned for 2nd August.
- A financial analysis has been undertaken and shared with the Divisional Directors of Operations and Divisional Director of Nursing and Governance to establish how much of the funded legacy cost pressures of £1.5m is available to increase the nursing budgets. Assuming that all the £1.5m available the remaining cost pressure for the nursing establishment increase is £1.6m for which £1m are available. This work will be concluded by the end of July 2014.
- The next establishment review is being scoped and will start in November 2014.

St George's Healthcare NHS
NHS Trust

Heatmap Dashboard
Ward View

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8. Ward Heatmaps

		INCIDENCE OF C.DIFFICILE	INCIDENCE OF MRSA	TRUST ACQUIRED PRESSURE SORES	PERCENTAGE OF HARM FREE CARE	PATIENT SATISFACTION (FRIENDS & FAMILY)	FRIENDS & FAMILY RESPONSE RATE	WARD STAFFING: UNFILLED DUTY HOURS
Children & Women's	CARDIOTHORACIC INTENSIVE CARE U..	0.0	0.0	0.0	100.0			10.3
	CARMEN SUITE	0.0	0.0	0.0	100.0			3.1
	CHAMPNEYS	0.0	0.0	0.0	100.0	67.6	26.6	14.2
	DELIVERY	0.0	0.0	0.0	100.0			5.2
	FREDDIE HEWITT	0.0	0.0	0.0	100.0			11.8
	GENERAL ICU/HDU	0.0	0.0	0.0	100.0	100.0	11.1	9.7
	GWILLIM	0.0	0.0	0.0	100.0			16.5
	JUNGLE	0.0	0.0	0.0	0.0			17.4
	NEONATAL ICU	0.0	0.0	0.0	100.0			19.9
	NEURO ICU	0.0	0.0	0.0	100.0			5.6
	NICHOLLS	1.0	0.0	0.0	100.0			38.4
	PICU	0.0	0.0	0.0	100.0			28.5
	PINCKNEY	1.0	0.0	0.0	100.0			17.1
Community Services	DALBY	0.0	0.0	0.0	86.4	80.0	14.3	17.0
	HEBERDEN	0.0	0.0	0.0	81.8	50.0	31.3	4.3
Medicine & Cardiovascular	ALLINGHAM	0.0	0.0	0.0	95.8	64.0	41.7	5.6
	AMYAND	0.0	0.0	0.0	92.3	5.6	24.7	1.1
	BELGRAVE	0.0	0.0	0.0	97.1	76.5	11.6	6.7
	BENJAMIN WEIR	0.0	0.0	0.0	92.9	90.0	29.1	12.4
	BUCKLAND	0.0	0.0	0.0	95.2	78.3	64.8	7.4
	CAESAR HAWKINS	0.0	0.0	0.0	100.0	36.8	17.4	3.8
	CARDIAC CARE UNIT	0.0	0.0	0.0	100.0	100.0	66.7	0.0
	CAROLINE	0.0	0.0	0.0	100.0	63.3	27.7	7.0
	CHESELDEN	0.0	0.0	0.0	95.7	90.0	11.9	4.9
	JAMES HOPE	0.0	0.0	0.0	100.0	80.0	43.8	1.0
	MARNHAM	0.0	0.0	0.0	92.6	70.0	41.7	2.9
	MCENTEE	1.0	0.0	0.0	100.0	75.0	32.7	9.7
	RICHMOND	0.0	0.0	0.0	95.9	53.1	29.8	8.0
	RODNEY SMITH	0.0	0.0	0.0	100.0	58.8	28.3	3.8
	RUTH MYLES	1.0	0.0	0.0	88.9	50.0	13.3	6.7
	TREVOR HOWELL	0.0	0.0	0.0	88.9	62.5	57.1	6.4
Surgery & Neurosciences	BRODIE NEURO	1.0	0.0	1.0	88.0	36.4	30.6	7.6
	CAVELL	0.0	0.0	0.0	84.6	50.7	59.0	7.0
	FLORENCE NIGHTINGALE	0.0	0.0	0.0	100.0	73.0	54.9	3.7
	GRAY WARD	0.0	0.0	0.0	100.0	57.1	35.4	18.4
	GUNNING	0.0	0.0	0.0	100.0	32.3	85.1	6.5
	GWYN HOLFORD	0.0	0.0	0.0	92.6	85.7	70.0	0.8
	HOLDSWORTH	0.0	1.0	0.0	95.5	53.4	98.3	6.1
	KEATE	0.0	0.0	0.0	93.8	65.2	55.0	4.3
	KENT	0.0	0.0	0.0	90.0	66.7	22.5	5.0
	MCKISSOCK	0.0	0.0	0.0	95.7	69.2	19.4	12.9
	VERNON	0.0	0.0	0.0	92.3	75.0	56.4	8.5
	WILLIAM DRUMMOND HASU	0.0	0.0	0.0	100.0	91.3	16.4	12.4

The Quality report contains the first version of the ward scorecard, the KPI framework will be further strengthened with an Increase in workforce and safety indicators. This initial scorecard has been circulated to Ward managers to be used alongside the information that can access from the Rate system regarding audit performance and patient feedback about discharge arrangements. Where quality inspections have occurred within individual clinical areas this information can be triangulated to provide an overall picture of the area for the local team and support actions that need to be taken such as placing an area in supportive measures or equally highlight where practice needs to be celebrated.

The nursing board will seek assurance about actions Divisions are taking in response to this information each month.

Within the board report it is anticipated that the information will be presented as a trend for individual clinical areas.

Further work will be undertaken to understand how we can strengthen the KPI framework for Community service areas.