St George's Healthcare NHS
NHS Trust

Quality Report

Trust Board
Month 4 - July 2014

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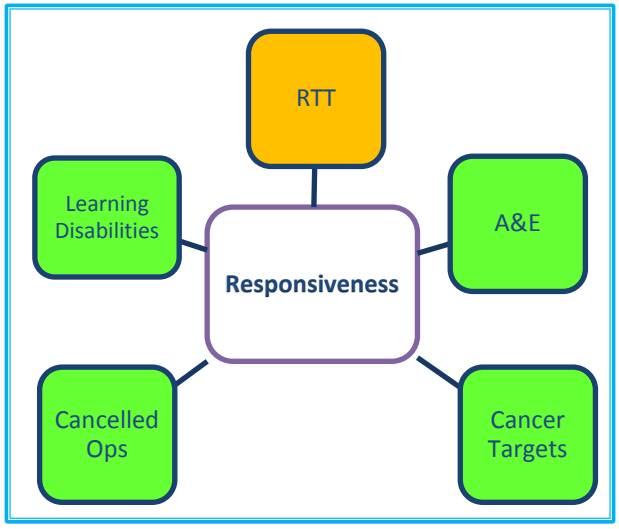
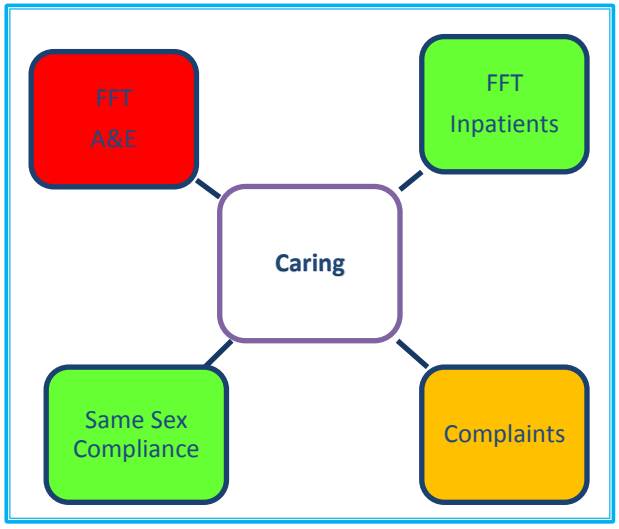
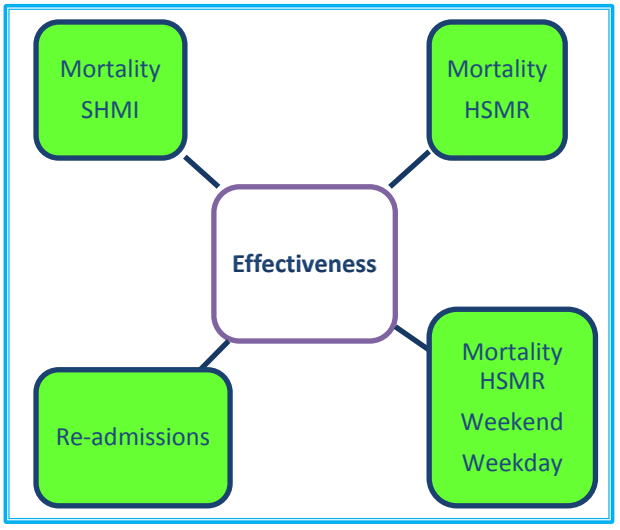
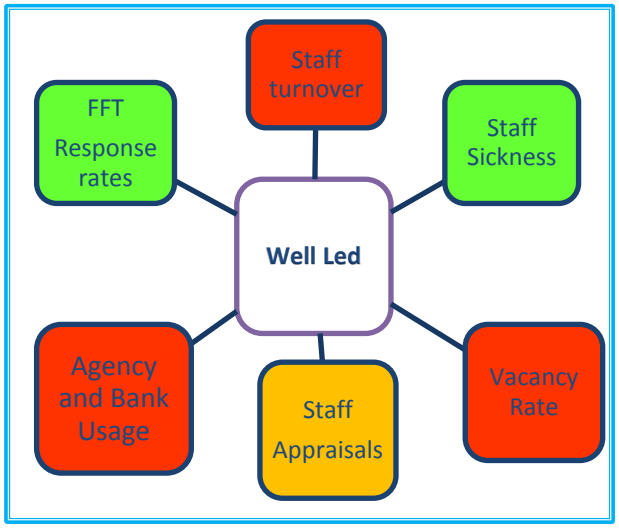
1. Executive Summary - Key Priority Areas July 2014









The above shows an overview of July 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 June 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: July 14 Performance

Responsiveness Domain					
Metric	Standard	YTD	June	July	Movement
Referral to Treatment Admitted	90%		90.20%	85.60%	⮟
Referral to Treatment Non-Admitted	95%		97.20%		
Referral to Treatment Incomplete	92%		92.60%	92.02%	⮟
Referral to Treatment Incomplete 52+ Week Waiters	0		4	1	⮟
Diagnostic waiting times > 6 weeks	1%		0.57%	0.69%	⮝
A&E All Types Monthly Performance	95%	95.11%	95.80%	95.45%	⮟
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%	2.10%	1.20%	0.00%	⮟
Certification against compliance with requirements regarding access to health care for people with a learning disability	Compliant	Yes	Yes	Yes	➤
	Standard	YTD	Q4	Q1	Movement
Two Week Wait Standard	93%	95.3%	98.2%	95.3%	⮟
Breast Symptom Two Week Wait Standard	93%	94.5%	99.0%	94.5%	⮟
31 Day Standard	96%	98.2%	97.1%	98.2%	⮝
31 Day Subsequent Drug Standard	98%	100.0%	100.0%	100.0%	➤
31 Day Subsequent Surgery Standard	94%	97.8%	100.0%	97.8%	⮟
62 Day Standard	85%	86.8%	84.7%	86.8%	⮝
62 Day Screening Standard	90%	90.4%	93.5%	90.4%	⮟
Domain Score			5		

Safe Domain					
Metric	Standard	YTD	June	July	Movement
Clostridium Difficile - Variance from plan	0	0	0	0	➤
MRSA bactaraemias	0	3	1	1	➤
Never events	0	0	0	0	➤
Serious Incidents	0	58	9	13	⮝
Percentage of Harm Free Care	95%		94.7%	93.7%	⮟
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%		95.8%	99.0%	⮝
Domain Score			3		

Effectiveness Domain							
Metric	Standard	Weighting	Score	YTD	June	July	Movement
Hospital Standardised Mortality Ratio (DFI)	100	5	0	79.7	78.7	78.7	➤
Hospital Standardised Mortality Ratio - Weekday	100	5	0	86.2	86.2	86.2	➤
Hospital Standardised Mortality Ratio - Weekend	100	5	0	90.8	90.8	90.8	➤
Summary Hospital Mortality Indicator (HSCIC)	100	5	0		78	80	⮝
Emergency re-admissions within 30 days following an elective or emergency spell at the Trust	5%	5	0	3.3%	3.2%	3.4%	⮝
Domain Score			5				

Caring Domain							
Metric	Standard	Weighting	Score	YTD	June	July	Movement
Inpatient Scores from Friends and Family Test	60	5	0		62	66	⮝
A&E Scores from Friends and Family Test	46	5	5		46	43	⮟
Complaints		5	0		103	100	⮟
Mixed Sex Accommodation Breaches	0	2	0		0	0	➤
Domain Score			4				

Well Led Domain							
Metric	Standard	Weighting	Score	YTD	June	July	Movement
IP response rate from Friends and Family Test	30%	2	0		37.60%	44.90%	⮝
A&E response rate from Friends and Family Test	20%	2	0		33.60%	37.70%	⮝
NHS Staff Survey: Percentage of staff who would recommend the trust as a place of work	61%	2	0	61%			
NHS Staff Survey: Percentage of staff who would recommend the trust as a place to receive treatment	67%	2	0	69&			
Trust turnover rate	13%	3	3		15.30%	15.90%	⮝
Trust level total sickness rate	3.50%	3	0		3.58%	3.49%	⮟
Total Trust vacancy rate	11%	3	3		12.28%	13.10%	⮝
Temporary costs and overtime as % of total paybill	3.50%	3	3		7.90%	9.40%	⮝
Percentage of staff with annual appraisal - Medical	85%	1.5	0		84.90%	86.80%	⮝
Percentage of staff with annual appraisal - non-medical	85%	1.5	1.5		73.30%	78.40%	⮝
Domain Score			3				

Trust Overall Quality Score	5

The trusts self-assessment against the NHS TDA Accountability framework in July 2014 is as detailed above with a overall quality score of 5. (Note: for July-14 RTT admitted has been excluded for scoring as breach of target is authorised as part of the national RTT resilience programme).

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: July 14 Performance

Access							
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**June**	**July**	**Movement**
Referral to Treatment Admitted	90%	1	0		90.20%	85.60%	↓
Referral to TreatmentNon Admitted	95%	1	1		97.20%	1	↓
Referral to Treatment Incomplete	92%	1	0		92.60%	92.02%	↓
A&E All Types Monthly Performance	95%	1	0	95.10%	95.80%	95.45%	↓
				YTD	**Q4**	**Q1**	
62 Day Standard	85%	1	0	86.8%	84.7%	86.8%	↑
62 Day Screening Standard	90%	1	0	90.4%	93.5%	90.4%	↑
31 Day Subsequent Drug Standard	98%	1	0	100.0%	100.0%	100.0%	→
31 Day Subsequent Surgery Standard	94%	1	0	97.8%	100.0%	97.8%	↓
31 Day Standard	96%	1	0	98.2%	97.1%	98.2%	↑
Two Week Wait Standard	93%	1	0	95.3%	98.2%	95.3%	↓
Breast Symptom Two Week Wait Standard	93%	1	0	94.5%	99.0%	94.5%	↓

Outcomes							
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**June**	**July**	**Movement**
Clostridium Difficile - Variance from plan	0	1	0	0	0	0	→
Certification of Compliance Learning 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			80%	80%	→
referral information	50%	1			90%	90%	→
treatment activity	50%	1			100%	100%	→

Trust Overall Quality Governance Score	1	1	→

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

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

The trust's quality governance rating is 'Amber/Green'.

Note: for July-14 RTT admitted has been excluded for scoring as breach of target is authorised as part of the national RTT resilience programme.

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

Areas of underperformance for quality governance are:

- RTT
- Cancer 62 day performance in month
- Infection Control

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

Further details on Sis, Harm Free care and FFT are provided in the trust quality 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	Reporting months		Movement	2014/2015 Target	Forecast August '14	Date expected to meet standard
	July	August				
RGW	78.7	77.7	▼	<100	G	Met

SHMI (Summary hospital-level mortality indicator)				
July 2013	Oct 2013	Jan 2014	April 2014	July 2014
0.81	0.81	0.81	0.78	0.80

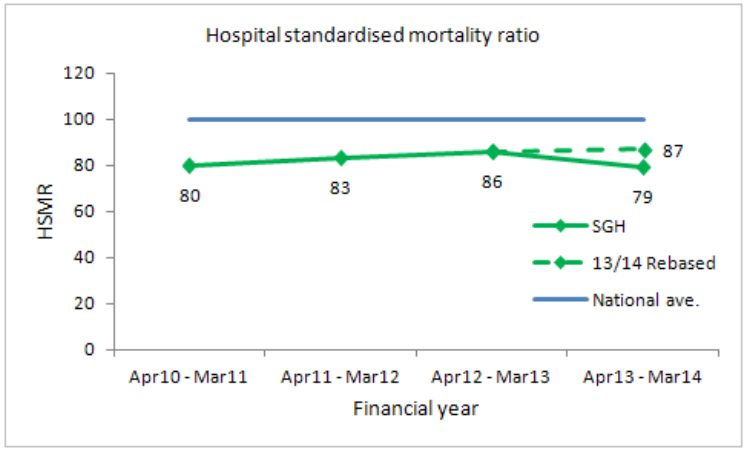
Note: Source for HSMR mortality data is Dr Foster Intelligence., published monthly. Data is most recent rolling 12 months available. For August 14 this was May 13 to April 14. SHMI data is published by the Health and Social Care Information Centre 6 months retrospectively. The last 12 month period as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

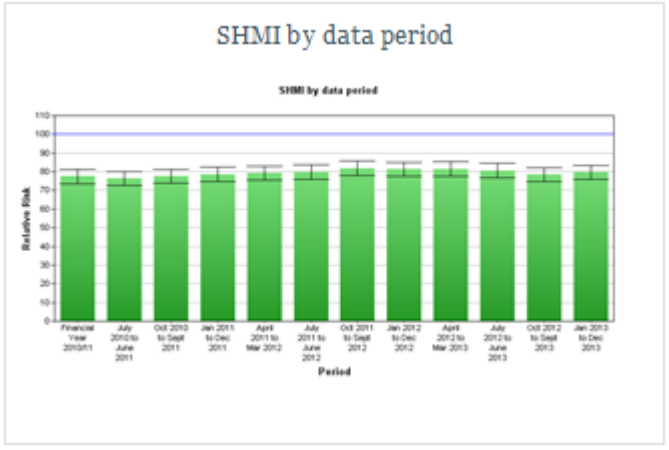
Overview:

The summary hospital-level mortality indicator (SHMI) was published for the period January 2013 to December 2013 on 30th July 2014. Our score of 0.80 is categorised as lower than expected and shows that the trust maintains its strong performance, which is also demonstrated by our HSMR which is significantly better than expected. We are one of 14 trusts identified as a 'repeat outlier' as our mortality rate has been 'lower than expected' for two consecutive years.

Despite this strong performance the trust continues to look at mortality at a more granular level, identifying and investigating signals observed internally at procedure and diagnosis level. This month we have switched to a new Dr Foster tool to carry out this benchmarking . A larger number of procedure and diagnosis groups are visible via the new tool, and consequently it is probable that we will see a larger number of mortality alerts. Initially the same level of analysis will be provided to divisions, however, the Mortality Monitoring Committee will receive a fuller list of alerts in order to provide scrutiny and ensure that mortality alerts that require investigation are not overlooked.

The Mortality Monitoring Committee continue to drive forward work to improve governance and associated learning. A new system enabling the real-time identification of in hospital deaths is to be introduced which will link to scanned patient records. Combining these two initiatives will enable a more timely and efficient review process.





4. Clinical Audit and Effectiveness - National Audits

National Head and Neck Cancer Audit 2013 - Ninth Annual Report (2014)

Comparison against National, LCA and trusts in LCA Network - 2013	National Score	London Cancer Alliance Score	St Georges	Previous audit round (St Georges)	Trust in the LCA score better than St Georges
Discussed at MDT meeting	94.9	95.0	100.0	99.3	-
Interval from biopsy to reporting (≤10days)	63.6	43.3	97.1	No data	Croydon Health Services - 100%
Interval from biopsy to reporting (≤21days)	70.7	46.8	100.0	82.3	Croydon Health Services - 100%
Pre-treatment dietetic assessment	29.9	41.7	50.0	45.5	-
Had Pre-treatment CNS contact	33.7	19.1	90.5	56.7	-
Final pre-treatment T & N staging recorded	81.5	79.7	97.8	95.3	-
Final pre-treatment M staging recorded	83.5	71.7	97.0	95.3	-
Tumours recorded with performance status	68.4	54.6	100.0	100.0	-
CNS present at breaking of bad news	48.3	51.5	48.5	63.8	Lewisham Healthcare NHS Trust - 69.2
Patients seen by CNS prior to 1st treatment by MDT	65.8	68.1	65.5	72.2	Guy's & Thomas NHS - 79.1

Overview: The Ninth Annual Report from the National Head and Neck Cancer Audit was published on 15 July 2014. Data collection for this audit is from 1 November 2012 to 31 October 2013.
Ten measures were identified in this report and the trust scores were above the national and London Cancer Alliance (LCA) scores for eight of these measures. Two measures that relate to CNS scored significantly lower than the previous audit round, but marginally lower than both the National and LCA scores:
a) For CNS present at breaking bad news, the trust score is 48.5% (63.8% in the previous audit round);
b) For patients seen by CNS prior to 1st treatment by MDT, the trust score is 65.5% (72.2% in the previous audit round).

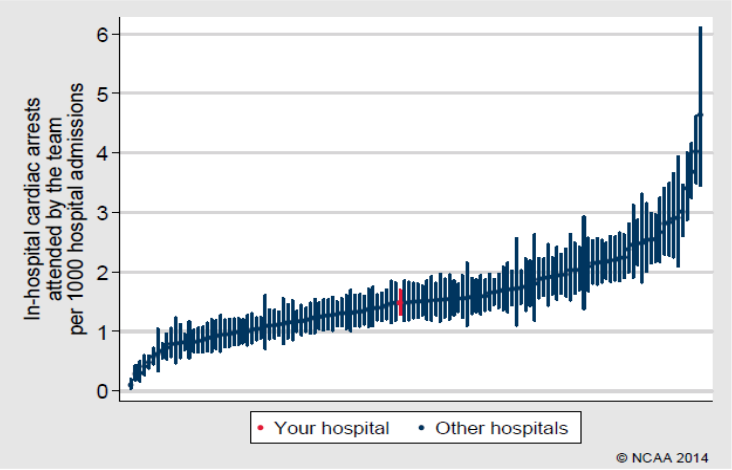
Action Plan:: Following are the proposed action plan which will be discussed at the next Cancer Services meeting for approval:

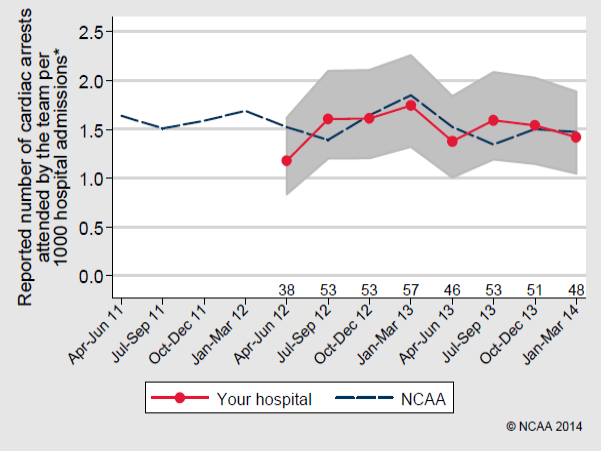
- Explore the re-instatement of the an RMH CNS in the H&N Clinic to support those patients going for primary RT/Chemo-RT .
- All grades of medical staff when they start should be informed of the ideal pathway and who to involve.
- CNS, (and dietetic and SALT), contact numbers are displayed in all clinic rooms in ENT and Maxfax to remind doctors to refer patients and provide ease of referral.
- CNS to see patients when they are told the cancer diagnosis from FNA even if primary tumour has not been identified at that time.
- Letter with CNS information to be given to patients who come to the clinic for diagnosis but not able to see the CNSs.

Surgeon Data: It is now a requirement to publish data by individual surgeons and this will be reported from the 10th annual report (current data collection year – patients diagnosed 1 Nov 2013 -31 Oct 2014). The aims of using consultant level data are to drive up quality, facilitate patient choice and support the requirements of professional revalidation. Also to reassure the public that clinical practice is actively monitored, and overall standards of care are very high.

4. Clinical Audit and Effectiveness - National audits

National Cardiac Arrest Audit 2013/14





*Total includes elective, non-elective, day cases, babies born in hospital and neonates

Overview

NCAA is the national, clinical, comparative audit for in-hospital cardiac arrest. The purpose of NCAA is to promote local performance management through the provision of timely, validated comparative data to participating hospitals. This report covers the period 2013/14 and was published in June 2014. There are a total of 198 cardiac arrests (189 patients ; 606 - 2222 calls) attended by the resuscitation team during the audit period.

The data completeness of this audit was very good with few gaps identified in recording ethnicity and presenting/first documented rhythm. The top two reasons for admission of these patients were medical (n=96) and emergency cases (n=19) which is similar to the national average.

Most of the cardiac arrests were attended in the weekday mornings (08:00 to 19:59; n=77) followed by weekday nights (20:00 to 07:59; n=73) similar to national average. Most of the cardiac arrests (n=65) had taken place between 2-7 days after admission followed by 8-30 days after admission (n=44) which is also similar to national average. Most of the arrests (n=127) happened in a ward.

Resuscitation was on-going for 174/198 arrests when the team arrived to attend the call and in 22 cases ROSC (Return of spontaneous circulation) was achieved before team arrival. In 2 cases the patients were deteriorating and not yet arrested. Following the resuscitation 71 (37.6%) patients were dead and 118 (62.4%) were alive, and on discharge 134 (70.9%) were dead and 55 (29.1%) survived.

Post arrest 59 patients were transferred to ICU/HDU and 30 patients were transferred to CCU. The results indicated that the predicted probability of survival to hospital discharge is similar to the national average and the ratio of observed to predicted survival to hospital discharge is 1.32 which is very good.

Resuscitation Services have taken the following measures to improve:

Closely monitor the numbers of emergency calls and determine what proportion are cardiac arrests and which are peri arrest (patient medical emergencies).

Identify any unusual trends in activity and report this back to individual care groups to investigate.

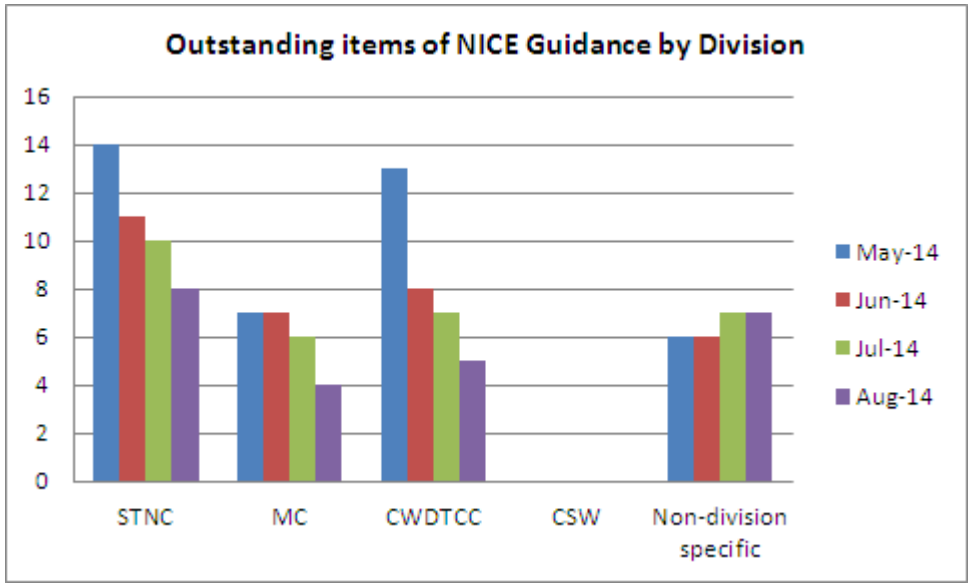
Analyse cardiac arrest data monthly to look at the number of calls and survival, comparing these to previous months.

Resuscitation training for all qualified nurses includes recognition and management of the deteriorating patient in an attempt to prevent cardiac arrest.

Recently standardised all the defibrillators at the St George's hospital site to a single model from 4 separate models.

Ensure that emergency resuscitation equipment is readily available or accessible in all areas of the trust.

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



Overview

During the last month the Clinical Audit department contacted the clinical leads for all outstanding items of NICE guidance (from Jan 2010 to April 2014) and this has decreased the number of outstanding items from 30 to 23. This work is on-going and will be a priority for the next month.

There were 17 items of NICE guidance released in May and June 2014 and we have already received 11 responses. This is encouraging and indicates that the current process is working well; hence the Clinical Audit department will continue to contact clinical leads directly to ascertain compliance. The Clinical Audit department also prepare and send six monthly NICE compliance reports to the divisions . These reports are used in DGB meetings where any compliance issued can be discussed and addressed.

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Patient Safety

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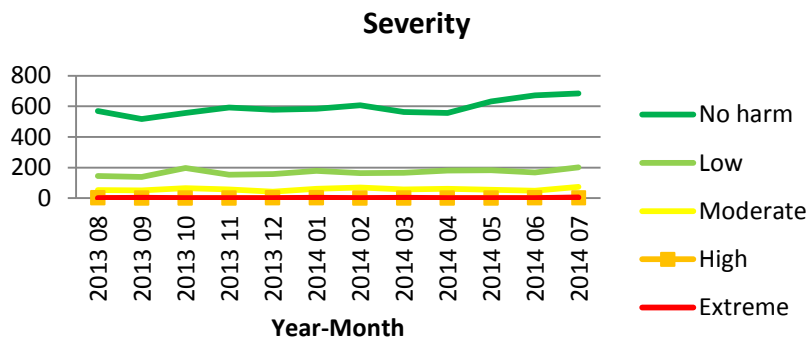
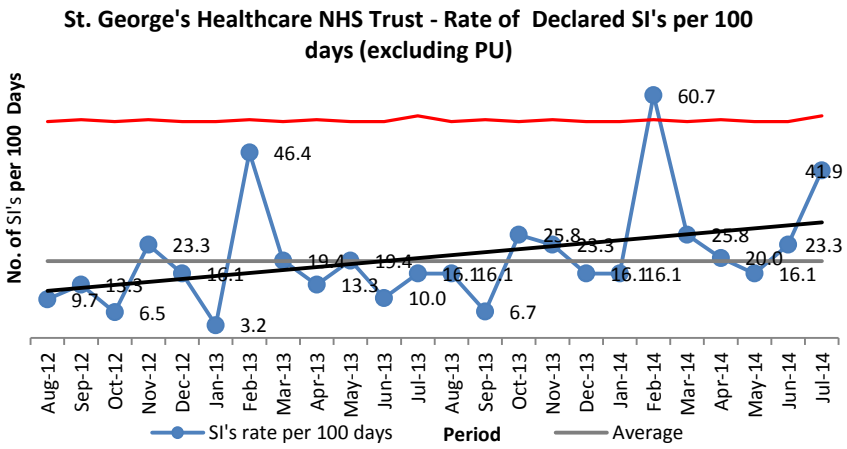
5. Patient Safety
- Incident Profile: Serious Incidents and Adverse Events

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

	Q1 Sis Declared by Division (Inc. Pus)				
Month	Med & Card	Surgery & Neuro	Community	Children's and Womens	Corporate
May	2	2	**7**	4	0
June	1	1	**2**	5	0
July	3	4	**9**	8	0





Overview:

The trend for serious incidents excluding pressure ulcers shown in Table 2 above continues to show a rise. Trends for adverse incidents in Table 1 remain within similar boundaries. It should be notes that as table 1 is based on recent data the Risk Team have not yet moderated whether the severity has been correctly categorised.

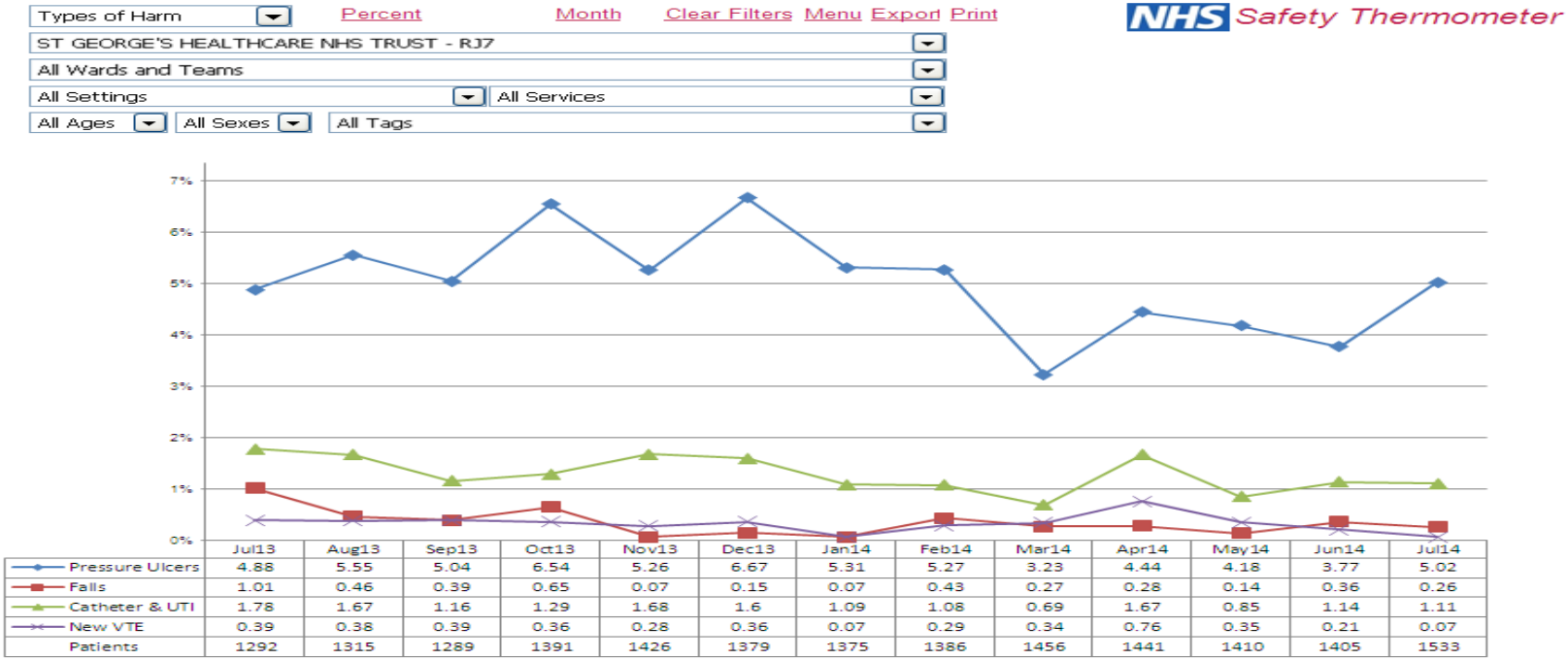
In July the 13 declared SIs covered a number of issues:

- 5 related to maternity including unexpected admissions to NNU, two maternal deaths caused by external factors and a retained swab that does not meet criteria for a never event.
- 4 SIs that relate to delays in acting on test results, images and symptoms. An SI investigation panel has been set up to look at all SIs relating to the follow up of test results to enable actions on thematic trends.
- 2 deaths in custody at Wandsworth Prison. The service team have analysed all relevant actions from serious incidents within the prison over the last 2 years to identify the thematic trends. The themes are then being linked to service improvement work-streams for additional actions.
- 1 unexpected death
- 1unforseen complications

The SI Declaration Meeting monitors all SI declarations and acts to identify any general trends at an early stage. This enables corrective actions to begin immediately where this is needed.

5. Patient Safety
- Safety Thermometer

% Harm Free Care							
Lead Director	May	June	July	Movement	2014/2015 Target	National Average	Date expected to meet standard
J Hall	94.61%	94.73%	93.67%	⮟	95%	93.82%	Sept - 14



	Jul13	Aug13	Sep13	Oct13	Nov13	Dec13	Jan14	Feb14	Mar14	Apr14	May14	Jun14	Jul14
Pressure Ulcers	4.88	5.55	5.04	6.54	5.26	6.67	5.31	5.27	3.23	4.44	4.18	3.77	5.02
Falls	1.01	0.46	0.39	0.65	0.07	0.15	0.07	0.43	0.27	0.28	0.14	0.36	0.26
Catheter & UTI	1.78	1.67	1.16	1.29	1.68	1.6	1.09	1.08	0.69	1.67	0.85	1.14	1.11
New VTE	0.39	0.38	0.39	0.36	0.28	0.36	0.07	0.29	0.34	0.76	0.35	0.21	0.07
Patients	1292	1315	1289	1391	1426	1379	1375	1386	1456	1441	1410	1405	1533

Overview

This point prevalence audit shows that in July 2014, overall 93.67% of patients received 'harm free' care, a slight decline from the 94.73% in June. This performance fell slightly below the national average of 93.82% and still falls short of the newly introduced 95% target. The number of new pressure ulcers increased slightly from 1.35% in June to 1.37% in July. A greater increase in old pressure ulcers was recorded from 2.77% in June to 3.91% in July which is not attributable to the trust however reduces our percentage of harm free care. New VTEs , falls and new catheter associated UTI's are reducing.

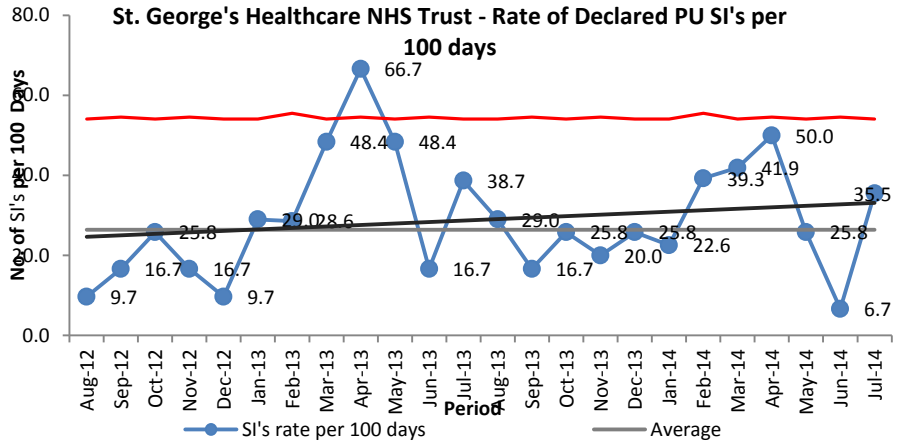
Actions:

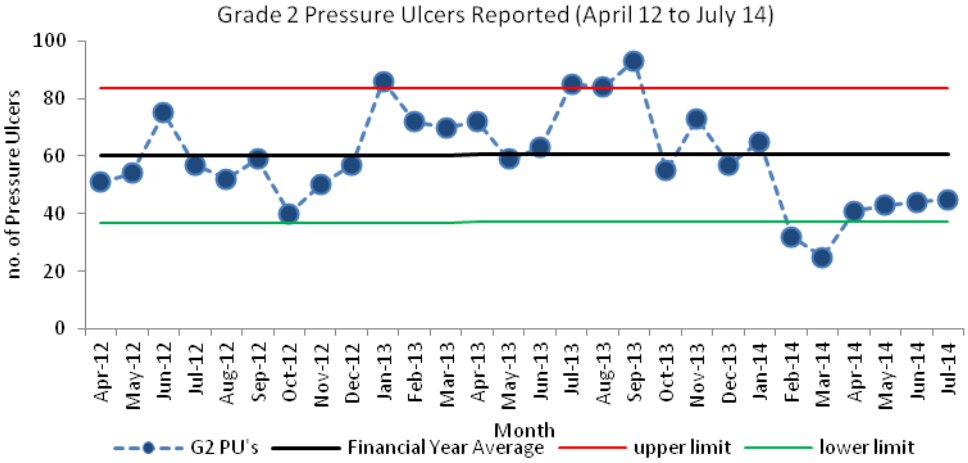
In July the VTE, PU and falls submission was validated by the relevant clinical nurse specialists. UTI data was validated by the Head of Nursing for Workforce. Plans need to be agreed to take the validation process forward in the community. There will be a focused piece of work with the urinary continence team which will increase awareness of UTIs. The corporate nursing team will also review the current falls strategy and to consider if it needs to be changed.

5. Patient Safety
- Incident Profile: Pressure Ulcers

Serious Incident – Grade 3 & 4 Pressure Ulcers									
Type	April	May	June	July	YTD	Movement	2014/2015 Target	Forecast Sept - 14	Date expected to meet standard
Acute	12	3	1	4	20			G	-
Community	3	5	1	7	16			G	-
Total All	15	8	2	11	36			G	-
Total Avoidable	7	3?4	**TBA**	**TBA**			40		-

Grade 2 Pressure Ulcers				
April	May	June	July	Movement
19	18	**28**	**28**	
22	25	**16**	**17**	
41	43	**44**	**45**	





Overview:

A sharp increase is noted in serious incidents in July within the community services. This trend will be monitored closely within the divisions throughout Q2. It should be noted that these SI's have not yet had an RCA and therefore have not been classified as avoidable/ unavoidable. Within the acute divisions medicine have had 2 SI's, surgery 1 and 1 is shared between surgery and CWDT. Grade 2 performance in acute - static but low numbers of SI's demonstrate deterioration of these ulcers prevented within the clinical areas.

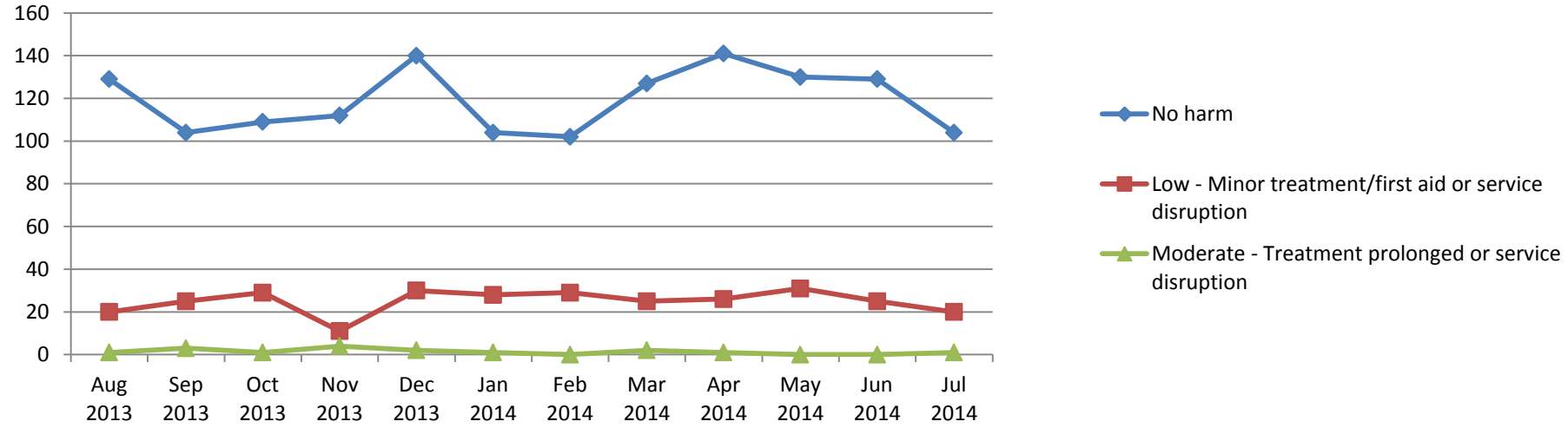
Actions:

- 'Deep dive' meetings planned for early September with community division and surgical division to review trends and preventative strategies .
- CQUIN work underway for Q2 with 3 nursing homes identified for collaborative work. These are Ashmead Nursing Home, George Potter Nursing Home and Hazel Court Nursing Home. We are currently liaising with the CCG to gain consent to visit the Nursing Homes and organise visits to undertake reviews.
- Audit tools revised for community and inpatient services. Spot checks on wards continue by TVN's within medicine.
- Further drive to roll out heel pro boots training as a preventative measure.
- Active participation by TVN 's in the Continence forum to reduce incontinence acquired dermatitis.

5. Patient Safety
- Incident Profile: Falls

Falls						
Lead Director	May	June	Movement	2014/2015 Target	July- 14	Date expected to meet standard
	156	151	⇔	100	125	July 2015

Falls with Harm (since August 2013)				
No Harm	Moderate	Severe	Death	Falls related Fractures
1431	16	0	0	8



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. The updated Bed Rails Policy including the bed rail assessment was published on the Trust intranet in August.

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 - Infection Control

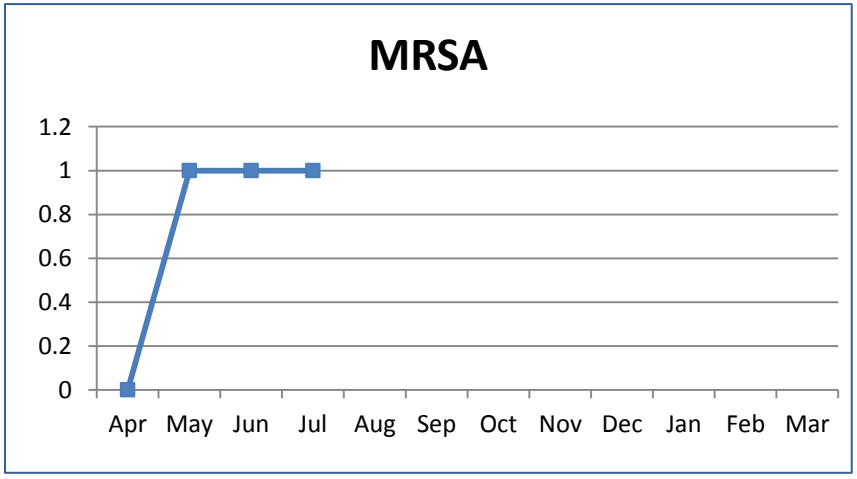
Infection Control						
Type	June	July	Movement	2014/2015 Target	Forecast August - 14	Date expected to meet standard
MRSA	1	1	⇔	0	G	Exceeded
C-Diff	5	3	⇩	40	R	September -14
MSSA	1	0		NA		
E-Coli	5 (19)	5 (27)		NA		

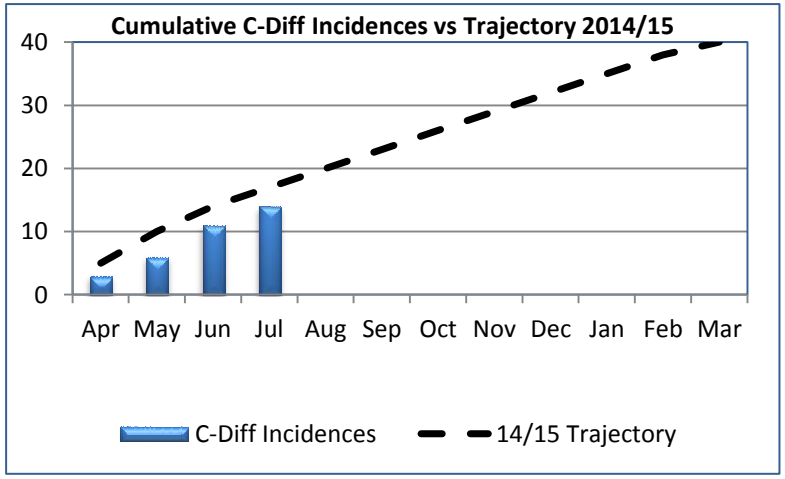
Peer Performance – YTD July 2014				
STG	Croydon	Kingston	King's College	Epsom & St Helier
3	1	0	1	1
14	6	2	30	15
7	2	1	15	3
17 (81)	59	49	121	93

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

In July there were 3 incidences of C-diff against a trajectory of 3 for the month. 14 for the year We remain below the TDA trajectory but above the annualised trajectory. Focus remains on hand hygiene, antibiotic prescribing and prompt isolation.

The trust has 1 case of MRSA infection in June and one in July and thus has breached the zero tolerance standard and 3 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 second RCA has been completed. Most likely due to pin site infection in previously colonised patient and poor handover from another hospital leading to incorrect surgical prophylaxis. The trust will continue its programme of close monitoring and vigilance to ensure compliance in 2014/15.



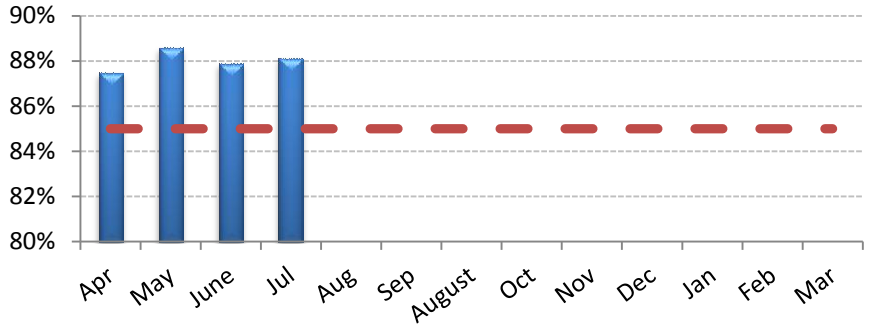


5. Patient Safety
- Safeguarding: Adults

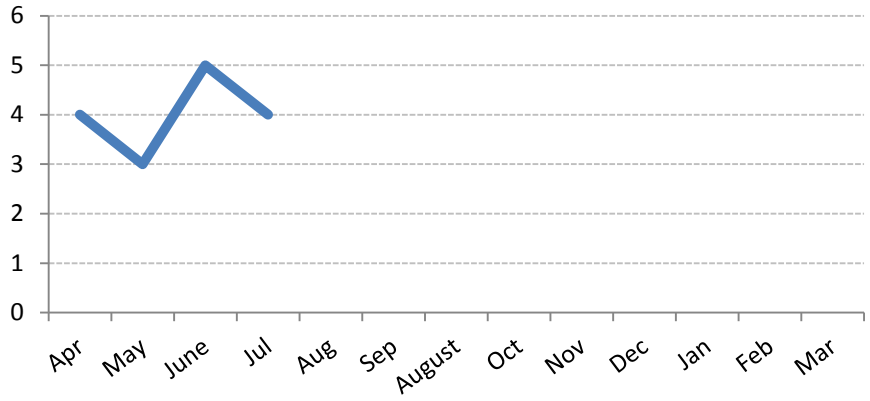
Safeguarding Training Compliance - Adults								
Lead Director	April	May	June	July	Movement	2014/2015 Target	Forecast July - 14	Date expected to meet standard
JH	87.5%	88.58%	87.9%	88.13%		85%	G	-

Safeguarding Adults Training Compliance by Division – July 14				
Med & Card	Surgery & Neuro	Community	Children's and Womens	Corporate
85.43	86.54%	90.42%	89.58%	88.50%

Safeguarding Training Compliance by Month 2014/15



DOLS 2014/15



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, July 84

Currently there is no centrally held record of MCA training but as part of the action plan around MCA following the CQC report, training is being 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, July - 4

Actions:

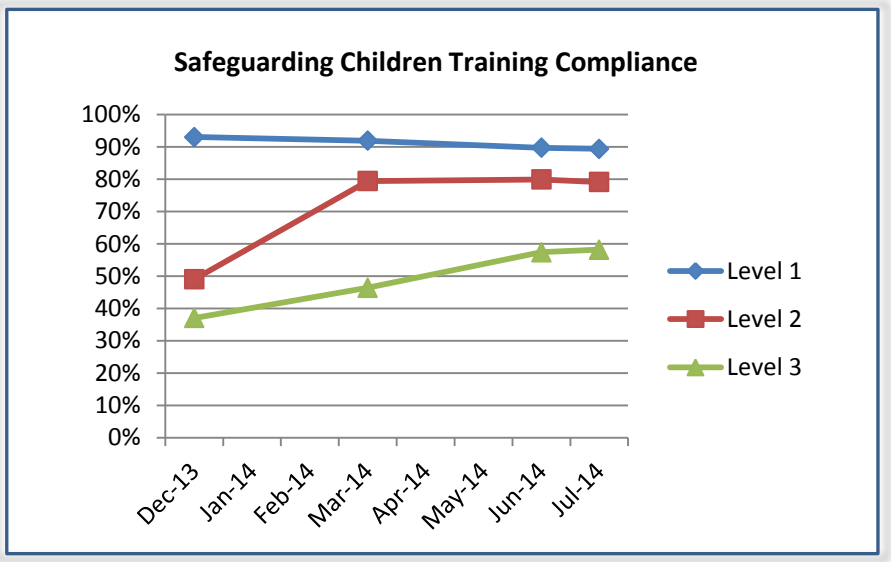
Continue to monitor safeguarding training via WIRED

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 which is still awaited. Meeting planned with legal team in early September to discuss way forward in absence of DH guidance.

5. Patient Safety
- Safeguarding Children

Safeguarding Training Compliance - Children						
July			Movement	2014/2015 Target	Forecast July - 14	Date expected to meet standard
Level 1	Level 2	Level 3				
89.34%	79.10%	58.14%	⇔	85%	G	-



Overview: Safeguarding children training remains an area of practice that requires improvement. The compliance with levels 1 and 2 in broadly unchanged from last month. The priority area is level 3 where practitioners are working directly with children. Currently 58.14% of those staff who require this level of training are compliant, this is concerning. I am advised however that there are a number of recently trained staff yet to be entered onto the system.

Actions: Level 3 staff continues to be our target area. There are additional sessions for level 3 training available in the acute service as well as the programme training sessions in both the acute and the community. The training dates are about to be circulated again to all departmental managers and there will be an advert in e G to highlight the programme and to remind staff to check their training status on WIRED.
Revision of the training strategy is planned.

Serious Case Reviews and Internal Management Reviews: At this time there are 8 serious case reviews that are active in that some of these have not had the final report published as yet due to criminal cases, while the others have action plans in progress. There are 4 cases that are live and the report writing stage is in progress. We have been advised that a further SCR is likely to be called by Croydon which is a case of factitious and induced illness – it is expected that the CEO will be receiving notification of this shortly. 5 of the cases are also in the court arena – 2 of which may go to court in the coming months are likely to receive publicity and one other case that we have been advised by Greenwich locality that may be high profile. It is noted that the number of SCRs that the Trust is contributing towards is unusually high (in comparison to our normal activity) but that in the majority (but not all) of the cases the Trust has diagnosed the non accidental injury or abuse rather than been involved in the care of the children.

Other: Please note that the Kingston locality has recently been subject to Ofsted/CQC inspection which increases the likelihood that Wandsworth will be approached shortly.

St George's Healthcare NHS
NHS Trust

Patient Experience

excellent kind responsible respectful

6. Patient Experience - Stories

Our patients sometimes come to us with the most intimate of needs and our ability to care sympathetically and with dignity leave a lasting positive impression when managed well as demonstrated by numerous compliments and thank you cards on wards. On occasion we do not manage this as effectively as we should and the following patient experience, which formed part of a complaint, demonstrates how important the most basic care is to our patients.
Ms A was a patient who came to one of our surgical wards with a bowel infection that required an inpatient stay. She had worked in a care of the elderly setting in the past and understood the difference that good care could make to patients. While she was an inpatient she identified many staff who were able to demonstrate this caring approach but the attitude of one nurse had led her to complain because she felt so strongly that other patients should not be subject to the care she received.

As part of her care Ms A required an enema to relieve her constipation and this was prescribed for 9pm in the evening. At the nursing handover Mrs A became aware of the night nurses reluctance to give the enema and when it was given at 10pm that night the information given to the Ms A was not consistent with normal requirements . When Ms A went to the toilet she was left there for some time and began to feel unwell with dizziness and rapid breathing and as she could not stand up, she called the emergency bell. The nurse was unhelpful when she came to the toilet and then left her alone on the bed with the curtains around her and no means of calling for help. No observations were taken to check her that she was OK. This left Mrs A feeling extremely vulnerable and she opted to leave hospital earlier than advised as she did not want to risk any reoccurrences. In her complaint she said:

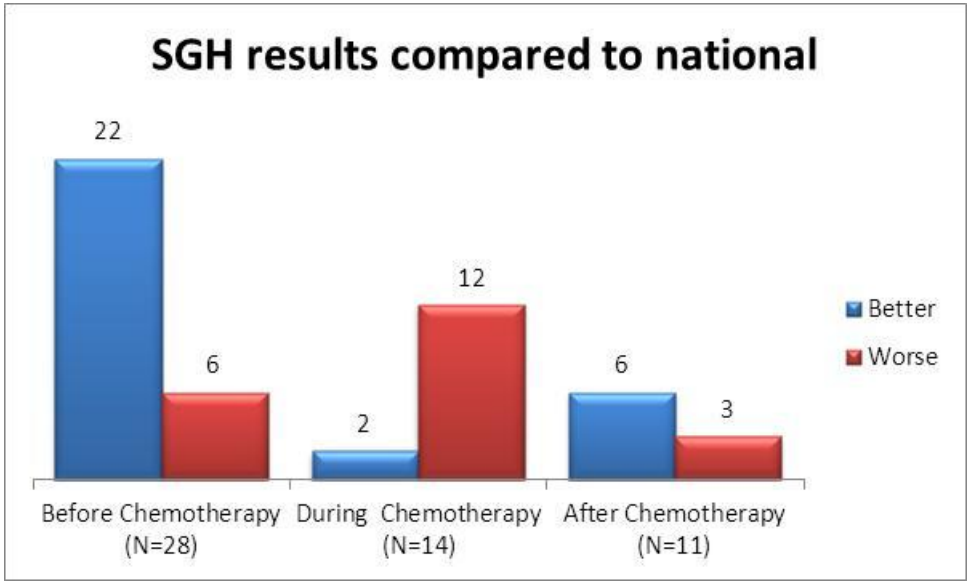
"I should have been given support and help to stand up when I was in the toilet. I should have been checked after getting myself into bed. I should not have been left behind a closed curtain and I should have had my blood pressure checked. I should have had help to understand what was happening to me. None of which happened."

Patricia is a lady who came to St George's from her local hospital needing heart surgery.
She had been seen at her local hospital but they could not identify the problem so she was brought to St George's. " I had a triple by pass, fluid on the lung and a clot beside my heart needing additional surgery. At times I was really ill but the care I received at St George's during my 3 week stay has been second to none."

Patricia recounted one occasion when she was in intensive care and starting to improve: " I really fancied a fizzy drink. The nurse explained that there were no fizzy drinks available on the unit but later, when I noticed one on my table, I discovered that the nurse had been down and bought me one. That is really going the extra mile."

After leaving intensive care Patricia came to Ben Weir Ward. "The staff here work really hard but find the time to encourage you while you are recovering.
I was really worried about having another infection but the ward and bathroom is spotless and the staff are all lovely. I think every hospital should be like this."

6. Patient Experience
- National Audits: National Chemotherapy Patient Survey



Overview

The Chemotherapy Patient Experience Survey was undertaken by Quality Health for the Department of Health and the National Cancer Action Team between February and June 2013. It was carried out in order to obtain information about the specific treatment and information given to chemotherapy patients, supplementing that contained in the national Cancer Patient Experience Survey.

The National report was published in January 2014 and recently the London Cancer Alliance (LCA) produced a question by question comparison by provider Trust. The chart above shows the number of relevant questions in each area of the survey and the number where St George's results were better or worse than the national results. In St George's, the quality of care of patients prior to receiving their chemotherapy was generally better than nationally, but the results were somewhat worse for questions relating to care during treatment. This is also reflected in the comments added by patients to the survey.

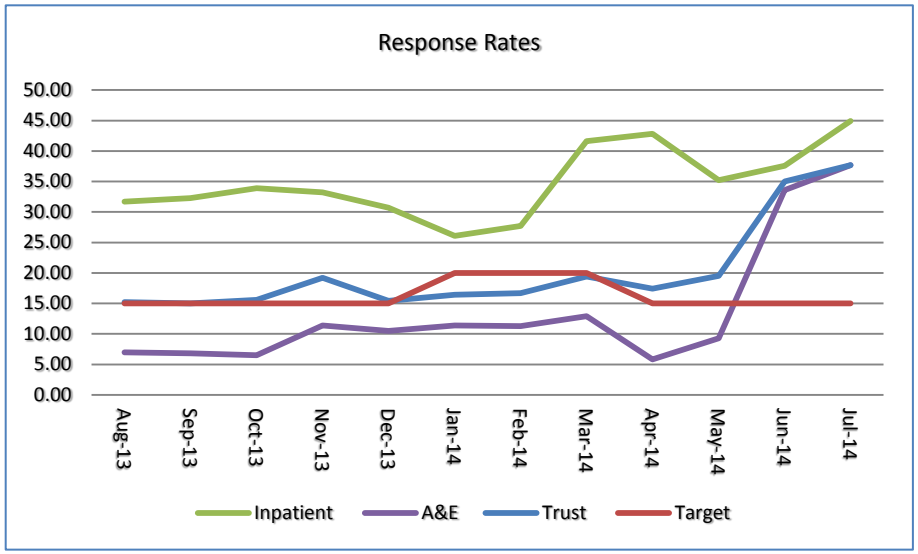
Overall, 85% of SGH respondents rated the chemotherapy service as excellent or very good; this figure was 91% nationally (although none of our patients rated their treatment as poor).

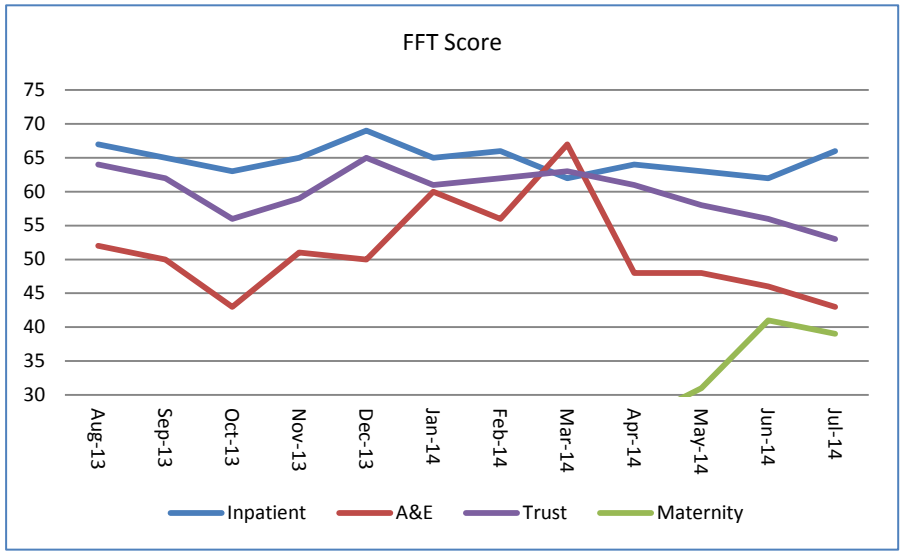
The results have been discussed at the annual meeting of the LCA and locally within the oncology care group. The findings reflected results from earlier local audits and surveys, so actions have already been put into place to improve our services, particularly in relation to waiting times and comfort in the day care unit. A re-audit is currently underway to evaluate the impact of these changes.

6. Patient Experience - Friends and Family Test

FFT Response Rate							
Domain	May-14	June-14	July-14	Movement	2014/2015 Target	Forecast July- 14	Date expected to meet standard
Trust	19.5%	33.6%	37.7%	↑	20%	G	-
Inpatient	35.2%	37.6%	44.9%	↑	25%	G	-
A&E	9.3%	33.6%	37.7%	↑	15%	G	-
Maternity	28.7%	35.6%	23.9%	↑	-		-

	FFT Response Score			
	May-14	June-14	July-14	Movement
	58	56	53	↓
	63	62	66	↑
	48	46	43	↓
	31	41	39	↓





Overview : A&E continued their increased response rates during the month of July 2014, rising to 37.7%. The Friends and Family Test score for the trust overall was +53 in July, slightly lower than June (56). A&E scored +43 and the adult inpatient wards increased to +66. Roll out to outpatient services, day care services and community is well under way with paper surveys and RaTE hardware being delivered. Final guidance from NHS England is being discussed with relevant 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 ; ante-natal, birth, postnatal ward and postnatal community

6. Patient Experience
- New Guidance on Friends and Family Surveys

NHS England recently released new guidance on how we need to conduct our 'Friends and Family Test' patient surveys. We are complaint with the majority of the recommendations on the methodology.
The new requirements will be to:

1. Collect data on 4 demographic characteristics : Age, Gender, Ethnicity and Disability
2. Ask patients to confirm that any text comments they make may be shared / displayed publicly
3. Ensure that our surveys are accessible to a range of patients; including children and young people, people with learning disabilities and people with dementia.

We are updating the RaTE system to allow for this information to be recorded, and to make the surveys more accessible. This work is currently underway, and will be required to be in place by April 2015.

In addition to inpatient wards, A&E and Maternity services, we will need to conduct the Friends and Family survey in the following services:

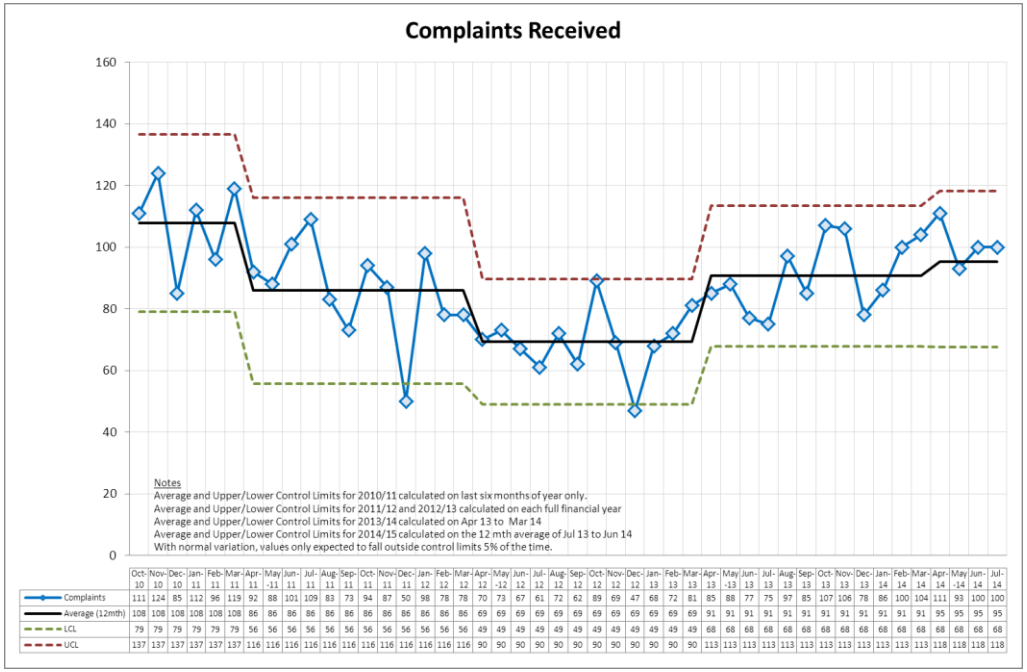
1. Outpatient and Day Case services
2. Community services
3. Minor Injury Units and Walk-In Centres
4. Patient Transport services

Work is already underway on this, as per our Patient Experience CQUINs for this financial year.

All outpatient, day case and community services (including Queen Mary's Outpatients and MIU) will be brought online by the end of October 2014. More detailed information on the above is available on request.

6. Patient Experience - Complaints Received

Complaints Received					
	April	May	June	July	Movement
Total Number received	111	92	100	100	=

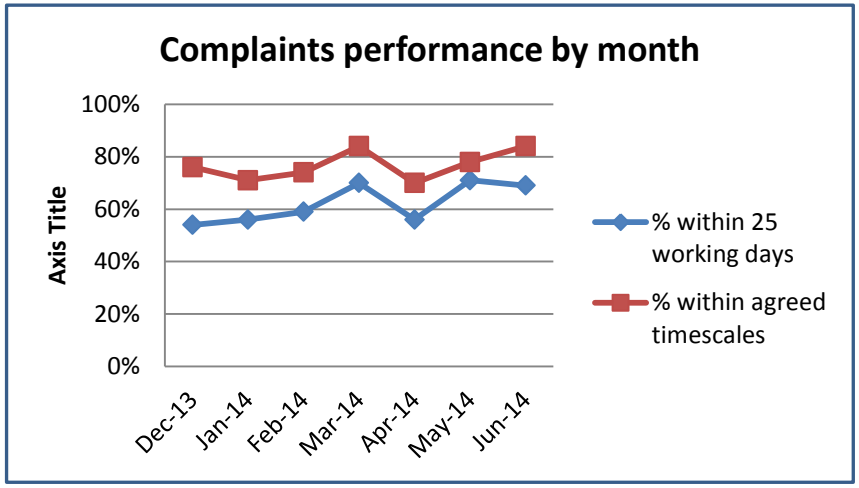


Overview:
This report provides a brief update on complaints received since the last board report (so in July 2014) and information on responding to complaints within the specified timeframes for quarter 1 in its entirety. The board will receive more detailed information about complaints received in the whole of quarter 2 with divisional breakdowns, analysis of the data to provide trends and themes with actions planned and a severity rating report and once quarter 2 has closed.

Total numbers of complaints received in July 2014
There were 100 complaints received in July of 2014, the same number as was received in June. June saw a reduction in complaints being received for transport (only 1 received) but this reduction was not maintained in July with 8 complaints being received. All but one were about transport being late. There was sharp increase in complaints being received about Accident and Emergency with 17 complaints being received in July compared to 9 in June and 8 in May. The most complained about subjects are attitude (across all staff groups) and clinical treatment – diagnosis. Complaints being received about Outpatients and Medical records remains high with a new theme emerging around patients not being able to get through to the Central Booking Service

6. Patient Experience
- Complaints Performance against targets

Performance Against Target **Quarter 1**				
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	92	59	64%	(11) 76%
Medicine and Cardiovascular	70	48	69%	(14) 89%
Surgery & Neurosciences	93	58	62%	(7) 70%
Community Services	26	11	42%	(6) 65%
Corporate Directorates	21	18	86%	(1) 90%
Totals:	302	194	64%	(39) 77%



Overview:
For complaints received in quarter 1 64% were responded to within 25 working days compared to 63% in quarter 4.

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

Actions:
As previously reported, each division has plans in place to improve performance in the coming year. These have not been realised in quarter 1.

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.

The number and nature of comments are reported to the Board quarterly.

Below are some examples of comments/stories posted on NHS Choices and Patient Opinion in quarter 2 so far .

Spencer63 gave Gastrointestinal and Liver services at St George's Hospital (London) a rating of 1 stars

Endoscopic & Endoscopic Departments
I've had a on/off going problem with PR Bleeding since 2012. In 2013 having had a Endoscopy it was diagnosed that whilst I had some polyps removed the rest was done to a few internal haemorrhoids. In the past 3 months not only have I had PR Bleeding but also leaking of faeces.

I'm just a simple bus driver who gets paid weekly wages on an hourly contract and am now unable to fulfil my contracted duties to being off so much.
No one seems to understand this simple but important issue, if it is just haemorrhoids then surely I don't have to wait until the 21st July just to have another Colonoscopy?

But I do, and I know that after that procedure I'll be referred back to the consultant and only then shall my problem be rectified!
"A lot of the consultant's are on holiday at the moment" .That to me means poor management and now affects not only my health but my job. Very disappointed to say the least. Why must a simple procedure take so long?

Visited in June 2014. Posted on 01 July 2014

Anonymous gave General Surgery at St George's Hospital (London) a rating of 5 stars

My short stay at St Georges
I had elective surgery for my gallbladder as I had been suffering with gallstones and my local Maidstone Hospital wouldn't remove them as I have a brain aneurysm and the anaesthetic could cause the aneurysm to rupture.

Large liver cysts were also found, which made surgery a little more difficult but I felt safe and in very good hands, despite my nervousness as my sister had sadly died from a brain aneurysm, 3yrs earlier.

The surgeon and my anaesthetists were lovely and reassuring and post op, my stay on Cavell Ward was nothing less than fantastic. I was cared for by the fabulous nurses there, whom I can't praise highly enough.

My experience of St George's Hospital has definitely been a 5 Star Review. Faultless.

Visited in August 2014. Posted on 03 August 2014

St George's Healthcare NHS
NHS Trust

Workforce

excellent kind responsible respectful

7. Workforce
- Safe Staffing profile for inpatient areas

Safe Staffing and Quality Indicators Report - July 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 Services	Cardiothoracic Intensive Care Unit	86.3%	-	92.9%	97.0%	-	0	1	100	0	0
	Carmen Suite	93.8%	82.6%	99.3%	90.3%	-	0	0	100	0	0
	Champneys Ward	93.0%	41.5%	98.1%	90.6%	50	0	0	100	0	0
	Delivery Suite	96.4%	90.8%	97.1%	93.5%	-	0	0	100	0	0
	Fred Hewitt Ward	90.6%	99.5%	90.3%	107.1%	-	0	0	100	0	0
	General Intensive Care Unit	82.0%	38.8%	90.2%	100.0%	-	0	0	84.2	0	0
	Gwillim Ward	103.6%	87.7%	105.3%	56.5%	59	0	0	100	0	0
	Jungle Ward	76.8%	0.0%	-	-	-	0	0	-	0	0
	Neo Natal Unit	73.8%	80.8%	81.8%	93.5%	94	0	0	100	0	0
	Neuro Intensive Care Unit	93.2%	75.9%	98.5%	92.4%	-	1	0	92.9	0	0
	Nicholls Ward	89.7%	54.4%	83.3%	65.7%	-	0	1	100	0	0
	Paediatric Intensive Care Unit	62.9%	59.1%	76.2%	93.5%	71	0	0	83.3	0	0
	Pinckney Ward	83.0%	42.7%	93.3%	100.0%	-25	0	0	100	0	0
Children & Women's Diagnostic and Therapy Services Total		**84.1%**	**70.6%**	**90.2%**	**83.2%**		**1**	**2**		**0**	**0**
Community Services	Dalby Ward	85.2%	108.0%	96.8%	100.0%	100	0	0	95.7	3	0
	Heberden	79.0%	101.2%	91.0%	98.0%	57	0	0	75	4	1
	Mary Seacole Ward	89.8%	92.4%	98.1%	97.7%	32	0	0	65.8	10	1
Community Services Total		**85.5%**	**101.5%**	**95.7%**	**98.4%**		**0**	**0**		**17**	**2**
Medicine and Cardiovascular	A & E Department	93.8%	94.1%	95.5%	91.3%	41	0	0	-	4	0
	Allingham Ward	94.6%	97.1%	92.7%	98.7%	60	0	0	90.9	8	1
	Amyand Ward	92.1%	104.9%	94.9%	98.9%	-9	0	0	89.3	9	0
	Belgrave Ward AMW	85.1%	86.8%	99.9%	100.0%	54	0	0	100	4	0
	Benjamin Weir Ward AMW	84.1%	75.1%	92.7%	100.0%	81	0	0	100	5	0
	Buckland Ward	95.6%	88.4%	98.9%	102.2%	82	0	0	100	0	0
	Caroline Ward	87.9%	85.8%	98.4%	0.0%	74	0	0	100	2	0
	Cheselden Ward	87.9%	89.9%	96.9%	100.0%	77	0	0	95.5	4	0
	Coronary Care Unit	102.6%	100.0%	101.3%	100.0%	56	0	0	100	0	0
	James Hope Ward	92.4%	87.0%	100.1%	-	85	0	0	100	0	0
	Marnham Ward	89.8%	113.4%	95.0%	101.2%	50	0	0	80	2	0
	McEntee Ward	75.5%	94.2%	100.0%	100.0%	80	0	0	100	3	0
	Richmond Ward	83.9%	86.5%	96.5%	97.2%	54	0	1	89.3	8	0
	Rodney Smith Med Ward	88.9%	92.9%	99.0%	101.4%	73	0	0	85.7	5	0
	Ruth Myles Ward	107.4%	73.6%	129.9%	49.3%	91	0	0	100	0	0
	Trevor Howell Ward	97.1%	87.5%	97.9%	98.7%	56	0	0	94.4	1	0
	Winter Ward (Caesar Hawkins)	83.5%	102.2%	91.3%	100.0%	53	0	0	95.5	8	0
Medicine and Cardiovascular Total		**90.4%**	**91.8%**	**97.2%**	**95.2%**		**0**	**1**		**63**	**1**
Surgery & Neurosciences	Brodie Ward	83.0%	106.2%	98.9%	100.0%	-	0	0	77.4	4	1
	Cavell Surg Ward	91.9%	81.9%	92.0%	97.0%	59	0	0	96.3	0	1
	Florence Nightingale Ward	93.2%	83.3%	97.3%	99.5%	72	0	0	100	1	0
	Gray Ward	86.2%	82.1%	99.0%	81.2%	65	0	0	100	1	0
	Gunning Ward	90.9%	91.7%	96.3%	105.0%	21	0	0	100	1	0
	Gwynne Holford Ward	83.4%	104.0%	93.6%	100.1%	60	0	0	100	11	0
	Holdsworth Ward	94.3%	93.6%	98.1%	99.7%	64	0	0	84.6	3	0
	Keate Ward	91.5%	96.6%	100.0%	100.0%	84	0	0	100	2	0
	Kent Ward	84.4%	96.9%	93.8%	101.1%	33	0	0	100	5	0
	Mckissock Ward	85.4%	80.3%	94.8%	100.0%	70	0	0	95.5	1	0
	Vernon Ward	87.1%	84.8%	98.4%	100.0%	66	0	0	93.8	2	0
	William Drummond HASU	90.1%	66.7%	93.6%	83.9%	76	0	0	100	3	0
	Wolfson Centre	80.8%	101.9%	100.0%	100.0%	69	0	0	96.3	0	0
Surgery & Neurosciences Total		**88.4%**	**91.4%**	**96.2%**	**97.3%**		**0**	**0**		**34**	**2**
Trust Total		**87.2%**	**90.1%**	**93.6%**	**94.0%**		**1**	**3**		**114**	**5**

[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 Jul 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 above relate to staffing numbers at ward/department level submitted nationally on Unify in July 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. With the July submission the trust achieved an average fill rate of 90.4%. 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:

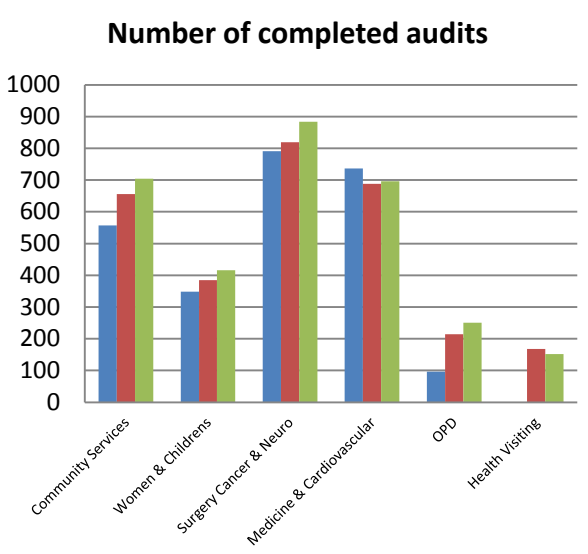
Nurses, midwives and care staff work as part of a wider multidisciplinary ward team. The demand on wards can change quickly and it will always be a clinical judgement as to whether to bring more staff in or reduce the amount the staff as per requirement.

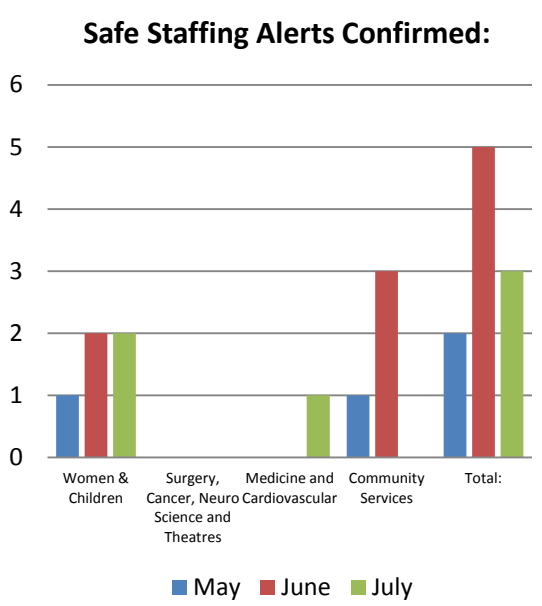
- The data does not take into account the on-going considerations for ward managers in ensuring that on each shift there is the right level of experience and expertise in the ward team.
- The nature of each ward varies. The number and type of patients seen on some wards will be relatively consistent. 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, for example reduced demand.
- 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.

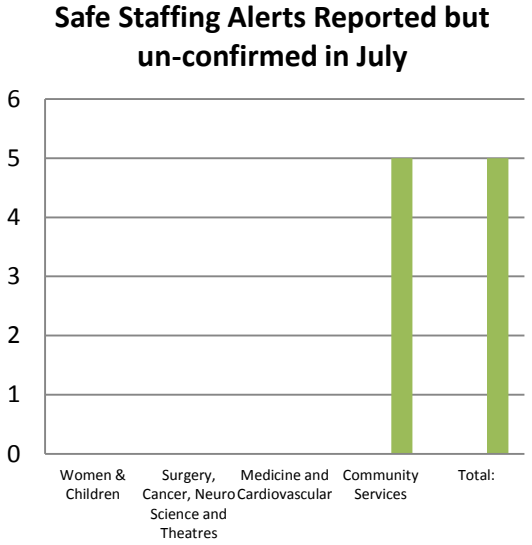
Actions

- The first establishment programme board meeting took place on 2nd August 2014 and as taking forward the recommendations from the review.
- A financial analysis has been undertaken and shared with the Divisional Directors of Operations and Divisional Director of Nursing and Governance to confirm that the legacy cost pressure funding for ward nursing overspends in 13/14 was allocated to increase the nursing budgets. This allocation still left a gap of £1.2m from the establishment review which will be funded from reserves and allocated in M5.
- The next establishment review will focus on changes in ward based areas and start in September 2014. The report will be presented at the November 2014 board meeting.
- Work has commenced on a wider workforce programme which focuses on key target areas. This is a centrally led programme complimenting existing divisional and HR programmes.

7. Workforce
- Safe Staffing alerts







Overview: The safe staffing audit is completed on a daily basis across the trust (except in Wandsworth Prison). The purpose of the audit is to identify areas that are unsafely staffed (known as alerts) and to ensure through a process of escalation that this situation is remedied. Escalation is through the nursing line management structure. Alerts are raised to senior nurses through a daily report from the RATE system. The safe staffing policy provides guidance on interventions that can be undertaken to make areas safe. The total number of safe staffing audits completed in the trust on a month by month basis were: May 2529, June 2930 and in July 3103. The number of final alerts reported was reduced from 5 in June to 3 in July, there are a further 5 outstanding for which clarification is required. The number of alerts (identifying that a ward is unsafely staffed) reduced to a concern (ward is safely staffed but some care needs will not be completed) has increased over the previous three months following on the day investigation. This indicates that senior nurses have better engagement in the review of these incidents.

Actions: To commence the audit in HMS prison Wandsworth – awaiting final clarification on the criteria for safe staffing in the prison from the DDNG which will be followed up again by 22 August. Continue daily reporting of alerts and daily checks that alerts are reviewed by a senior nurse. Continue monthly reporting on number of alerts not actioned by a senior nurse and hold the DDNG's accountable.

St George's Healthcare NHS
NHS Trust

Heatmap Dashboard
Ward View

excellent kind responsible respectful

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	FALLS (WARD LEVEL)	SERIOUS INCIDENTS (WARD LEVEL)
Children & Women's	CARDIOTHORACIC INTENSIVE CARE UNIT	1.0	0.0	0.0	100.0			10.4	0.0	0.0
	CARMEN SUITE	0.0	0.0	0.0	100.0			5.7	0.0	0.0
	CHAMPNEYS	0.0	0.0	0.0	100.0	50.0	19.3	11.9	0.0	0.0
	DELIVERY	0.0	0.0	0.0	100.0			4.1	0.0	3.0
	FREDDIE HEWITT	0.0	0.0	0.0	100.0			5.2	0.0	0.0
	GENERAL ICU/HDU	0.0	0.0	0.0	84.2			13.6	0.0	2.5
	GWILLIM	0.0	0.0	0.0	100.0			9.7	0.0	0.0
	JUNGLE	0.0	0.0	0.0				24.2	0.0	0.0
	NEONATAL ICU	0.0	0.0	0.0	100.0			22.2	0.0	0.0
	NEURO ICU	0.0	1.0	0.0	92.9			5.0	0.0	0.0
	NICHOLLS	1.0	0.0	0.0	100.0			19.8	0.0	0.0
	PICU	0.0	0.0	0.0	83.3			30.9	0.0	0.0
	PINCKNEY	0.0	0.0	0.0	100.0			19.2	0.0	0.0
Medicine & Cardiovascular	ALLINGHAM	0.0	0.0	1.0	90.9	51.7	37.2	4.6	8.0	1.0
	AMYAND	0.0	0.0	0.0	89.3	0.0	16.4	3.1	9.0	0.0
	BELGRAVE	0.0	0.0	0.0	100.0	52.3	41.5	9.1	4.0	0.0
	BENJAMIN WEIR	0.0	0.0	0.0	100.0	80.0	84.4	13.9	5.0	0.0
	BUCKLAND	0.0	0.0	0.0	100.0	82.3	78.5	3.9	0.0	0.0
	CAESAR HAWKINS	0.0	0.0	0.0	95.5	52.6	14.2	7.8	8.0	0.0
	CARDIAC CARE UNIT	0.0	0.0	0.0	100.0	55.6	100.0	0.0	0.0	0.0
	CAROLINE	0.0	0.0	0.0	100.0	74.2	35.1	9.4	2.0	0.0
	CHESELDEN	0.0	0.0	0.0	95.5	74.2	33.0	8.3	4.0	0.0
	DALBY	0.0	0.0	0.0	95.7	100.0	3.4	2.2	3.0	0.0
	EMERGENCY DEPARTMENT	0.0	0.0	0.0		41.5	37.7	5.6	4.0	0.0
	HEBERDEN	0.0	0.0	1.0	75.0	57.1	19.4	6.6	4.0	1.0
	JAMES HOPE	0.0	0.0	0.0	100.0	86.2	68.2	6.2	0.0	0.0
	MARNHAM	0.0	0.0	0.0	80.0	0.0	2.0	2.9	2.0	0.0
	MCENTEE	0.0	0.0	0.0	100.0	80.0	63.6	11.4	3.0	0.0
	RICHMOND	1.0	0.0	0.0	89.3	53.8	39.2	10.1	8.0	1.0
	RODNEY SMITH	0.0	0.0	0.0	85.7	72.7	20.0	4.4	5.0	0.0
	RUTH MYLES	0.0	0.0	0.0	100.0	91.3	62.2	8.1	0.0	0.0
	TREVOR HOWELL	0.0	0.0	0.0	94.4	55.6	55.1	4.4	1.0	0.0
Surgery & Neurosciences	BRODIE NEURO	0.0	0.0	1.0	77.4	63.6	27.5	5.7	4.0	1.0
	CAVELL	0.0	0.0	1.0	96.3	59.8	56.6	9.9	0.0	0.5
	FLORENCE NIGHTINGALE	0.0	0.0	0.0	100.0	72.5	66.7	6.5	1.0	0.0
	GRAY WARD	0.0	0.0	0.0	100.0	65.0	34.8	11.9	1.0	0.0
	GUNNING	0.0	0.0	0.0	100.0	18.5	90.2	6.0	1.0	0.0
	GWYN HOLFORD	0.0	0.0	0.0	100.0	60.0	55.6	4.8	11.0	0.0
	HOLDSWORTH	0.0	0.0	0.0	84.6	64.0	43.9	3.8	3.0	0.0
	KEATE	0.0	0.0	0.0	100.0	84.5	71.8	4.8	2.0	0.0
	KENT	0.0	0.0	0.0	100.0	33.3	7.5	7.7	5.0	0.0
	MARY SEACOLE	0.0	0.0	1.0	65.8	31.8	42.6	6.2	10.0	1.0
	MCKISSOCK	0.0	0.0	0.0	95.5	70.0	18.2	11.9	1.0	0.0
	VERNON	0.0	0.0	0.0	93.8	66.0	78.5	9.5	2.0	0.0
	WILLIAM DRUMMOND HASU	0.0	0.0	0.0	100.0	75.9	23.4	11.8	3.0	0.0

8. Ward Heatmaps
-Narrative regarding the Heatmap.

The Heat map indicates some areas where a number of indicators are flagging a concern. We still need to add in the staffing indicators to the heat map, this could not be achieved for the month of August although the data is available. Key Points to note from the scorecard:

For Areas within the Women's and Children's , Diagnostics and Therapies Division:

- **Incidence of C. Difficile:** 2 cases – 1 on Nicholls Ward and 1 on Cardiac ICU. RCA for Cardiac ICU indicates this case was felt to be avoidable. A wider RCA is being completed in regard to CDT within Cardiac ICU and this case will be reviewed as part of this. RCA for Nicholls Ward pending
- **Incidence of MRSA:** 1 MRSA Bacteraemia reported in NICU in July 2014. The root cause analysis regarding this infection is currently being completed.
- **% harm free care:** The only area reported to be non-compliant with the target in the safety thermometer report was General ICU, This score was reached as 1 patient had an old grade 2 pressure ulcer, which was not acquired under the care of the trust. 1 patient had a severe fall and although this did not happen on GICU, it did happen whilst the patient was under the care of the trust so is a harm that is attributable to the trust. 3 patients did not have a fully completed VTE risk assessment completed and 1 patient had not started appropriate prophylactic treatment. A total of 19 patients were surveyed
- **Friends and Family:** Champneys is the only area that is currently reporting against this target, other areas are capturing this information but as yet are not required to report. Additional work needs to be completed with the team to ensure compliance in terms of response rate
- **Ward staffing unfilled duty hours:** The key areas of concern remain within paediatrics. Active recruitment continues across all areas within paediatrics and a large number of new starters are expected to start in September and October. Beds were closed in Frederick Hewitt in July due to staffing problems and 3 HDU beds on Holdsworth ward were also closed which led to a reduction in staff and affected the unfilled hours. Despite the high levels of unfilled hours, there was only 1 safe staffing alert reported in July 2014 for PICU
- **Serious Incidents:** As reported to the Board**.**

For Areas within the Medical and Cardiovascular Division:

- **Infection control** - RCA now completed on C difficile case for Richmond – patient likely to have been admitted with infection, no actions required.
- **Pressure Ulcers** – RCAs are being completed for the 2 cases.
- **Harm Free care** – Areas flagging are all within Acute medicine. The scores relate to patients admitted with UTIs or who are catheterised – high numbers on Heberden particularly. There is a need to start monitoring and understanding data related to acquired UTIs and target those areas. Matrons are leading on this work.
- **FFT** – The Division is investigating low numbers of uptake. - across acute medical wards - particularly Marnham and Dalby where satisfaction score also low. The Matrons are addressing the uptake of FFT with Ward Managers on a individual basis.
- **Falls** – Allingham had 1 patient fall several times, Rodney Smith Ward had reported diabetic patient with peripheral neuropathy who had fallen a couple of times. Ben Weir have identified need for HCA on Night duty when most falls occurring which is being implemented using bank staff as necessary. The Wards are looking at reasons for falling, making sure they are addressing things like patients being properly hydrated. Patient's at risk identified on PSAG boards to be highlighted at handover. Specials used if necessary - following completion of risk assessment.
- **SIs –** relate to 2 PUs on Allingham & Heberden and SI re failure to escalate a sick patient on Richmond.
-

8. Ward Heatmap Continued:

-

Surgical, Theatres, Cancer and Neurosciences Division:
Trust acquired pressure ulcers – there has been a definite increase in the division in Q1 of pressure ulcers. Actions taken - session in august led by the TVN's focusing with the senior divisional team, matrons, ward sisters on recent data, root cause, trends and learning from any areas of good practice across the organisation. This will be followed by refresher training. A number of staff involved in recent SI's are being managed more formally and a reminder has been given in relation to the processes that were put in place to flag at risk patients, matrons and HoN's will spot check these.

Harm free care- the key issues were catheter associated infections 3 out of 4 were hospital acquired, pressure ulcers and falls (all of which were no harm). Actions- There will be increased work to ensure that catheter care is appropriate in those areas that are under performing and that appropriate review takes place. Falls work is on-going in those areas like Gwynne Holford and Kent where the patient group are high risk and work is being done on timely risk assessment, different ways of managing repeat fallers and use of specials as necessary. Antibiotic stewardship work needs to increase in certain areas as does feedback of e coli blood results and harm free care data to all disciplines.

F&F –satisfaction- Gunning- this relates to one patient that complained about pain control and noise at night. Noise meters are being acquired to raise the profile of this and staff are being reminded of the impact of their behaviour, workload and emergency work compounds this. Increased band 6 recruitment means that there will be improved out of hours leadership.

F&F- response rates- Neurology areas were working towards the wrong target this has now been rectified, In addition the patient cohort are difficult to survey and this is a recurring theme.

Falls- as above- levels for Kent and GH are not unusual and possibly not unexpected given the nature of the specialities and the balance between active rehabilitation and managing the risk and patient safety appropriately. Work is high profile and on-going as described above.

SI's – these are pressure ulcers