St George's Healthcare NHS
NHS Trust

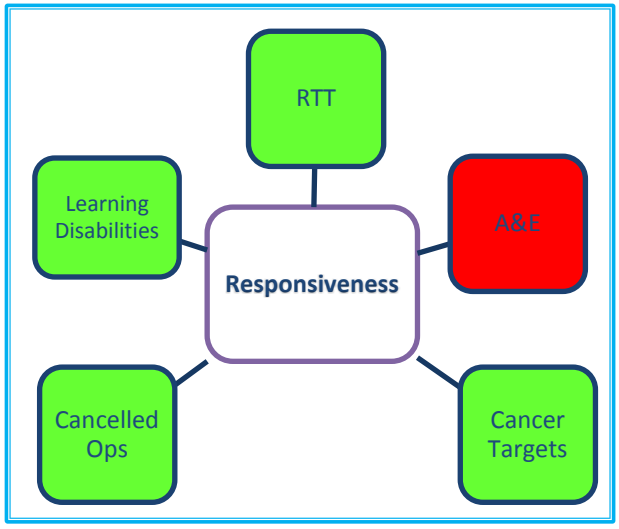
Quality Report

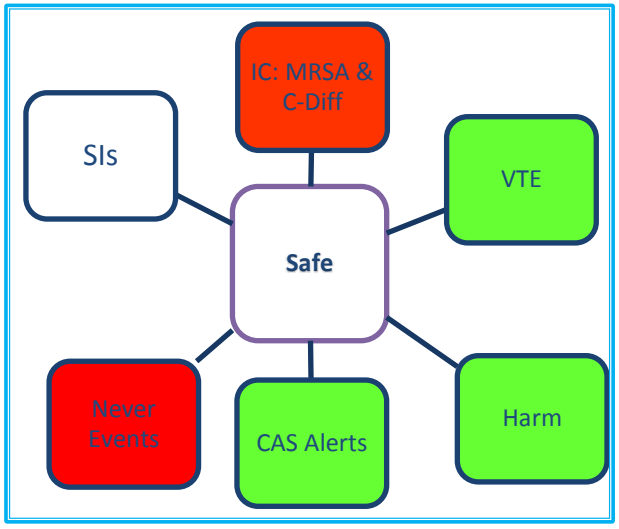
Trust Board
Month 5 - August 2014

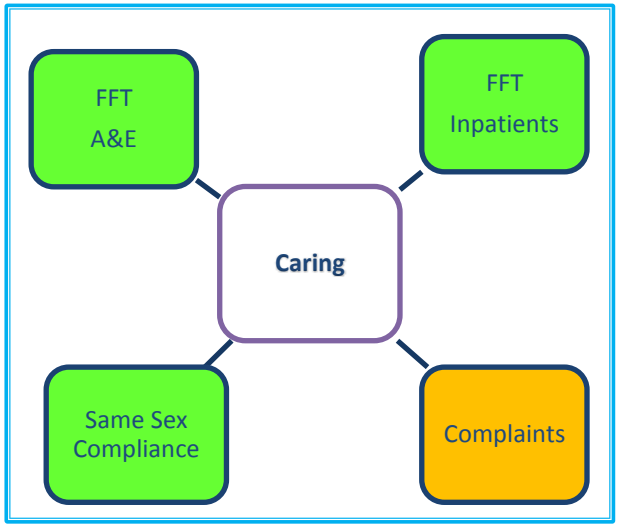
excellent kind responsible respectful

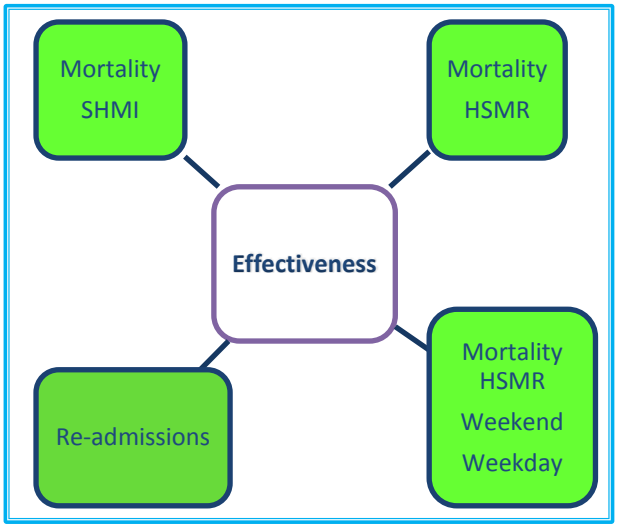
CONTENTS

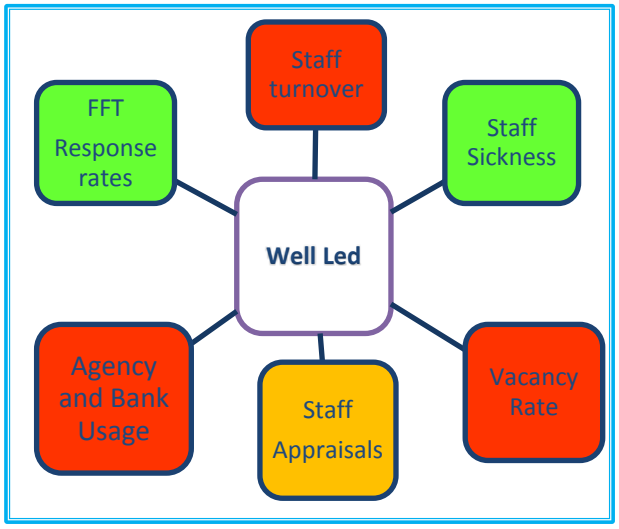
1. Executive Summary - Key Priority Areas August 2014











The above shows an overview of August 2014 performance for key areas within each domain of the NHS TDA Accountability Framework. These domains as per decision 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 July 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: August 14 Performance

Responsiveness Domain					
Metric	Standard	YTD	July	August	Movement
Referral to Treatment Admitted	90%		85.60%	85.2%	⮟
Referral to Treatment Non-Admitted	95%		96.3%	95%	⮟
Referral to Treatment Incomplete	92%		92.02%	NYA*	⮟
Referral to Treatment Incomplete 52+ Week Waiters	0		1	NYA	
Diagnostic waiting times > 6 weeks	1%		0.69%	0.88%	⮝
A&E All Types Monthly Performance	95%	94.94%	95.45%	94.33%	⮟
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%	1.7%	0.00%	0.00%	➤
Certification against compliance with requirements regarding access to health care for people with a learning disability	Compliant	Yes	Yes	Yes	➤
NYA* Not yet available					
	Standard	YTD	Q1	Q2 (July)	Movement
Two Week Wait Standard	93%	95.3%	95.3%	95.3%	➤
Breast Symptom Two Week Wait Standard	93%	95.6%	94.5%	99.4%	⮝
31 Day Standard	96%	98.4%	98.2%	98.9%	⮝
31 Day Subsequent Drug Standard	98%	100.0%	100.0%	100.0%	➤
31 Day Subsequent Surgery Standard	94%	98.3%	97.8%	100%	⮝
62 Day Standard	85%	86.88%	86.8%	86.7%	⮟
62 Day Screening Standard	90%	91.2%	90.4%	93.3%	⮝
Domain Score		5			

Safe Domain					
Metric	Standard	YTD	July	August	Movement
Clostridium Difficile - Variance from plan	0	-3	-1	-1	➤
MRSA bactaraemias	0	3	1	0	⮟
Never events	0	2	1	0	⮟
Serious Incidents	0	80	23	12	⮟
Percentage of Harm Free Care	95%		93.7%	95.06%	⮝
Medication errors causing serious harm	0	0	0	0	➤
Overdue CAS alerts	0	1	1	1	➤
Maternal deaths	1	1	1	0	⮟
VTE Risk Assessment ((July)	95%		97.3%	96.5%	⮟
Domain Score		3			

Effectiveness Domain							
Metric	Standard	Weighting	Score	YTD	July	August	Movement
Hospital Standardised Mortality Ratio (DFI)	100	5	0	79.7	78.7	77.7	⮟
Hospital Standardised Mortality Ratio - Weekday	100	5	0	86.2	86.2	85.1	➤
Hospital Standardised Mortality Ratio - Weekend	100	5	0	90.8	90.8	83	➤
Summary Hospital Mortality Indicator (HSCIC)	100	5	0		80	79	⮟
Emergency re-admissions within 30 days following an elective or emergency spell at the Trust	5%	5	0	3.3%	3.4%	3.5%	➤
Domain Score			5				

Caring Domain							
Metric	Standard	Weighting	Score	YTD	July	August	Movement
Inpatient Scores from Friends and Family Test	60	5	0		66	65	⮝
A&E Scores from Friends and Family Test	46	5	5		43	62	⮝
Complaints		5	0		100	92	⮟
Mixed Sex Accommodation Breaches	0	2	0	4	0	0	➤
Domain Score			4				

Well Led Domain							
Metric	Standard	Weighting	Score	YTD	July	August	Movement
IP response rate from Friends and Family Test	30%	2	0		44.90%	39%	⮟
A&E response rate from Friends and Family Test	20%	2	0		37.70%	27.2%	⮟
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		15.90%	16.3%	⮝
Trust level total sickness rate	3.50%	3	0		3.49%	3.1%	⮟
Total Trust vacancy rate	11%	3	3		13.10%	12.9%	⮟
Temporary costs and overtime as % of total paybill	3.50%	3	3		9.40%	7.5%	⮟
Percentage of staff with annual appraisal - Medical	85%	1.5	0		86.80%	85.2%	⮟
Percentage of staff with annual appraisal - non-medical	85%	1.5	1.5		78.40%	80.8%	⮝
Domain Score			3				

Trust Overall Quality Score	4

The trusts self-assessment against the NHS TDA Accountability framework in August 2014 is as detailed above with a overall quality score of 4. (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: August 14 Performance

Access							
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**July**	**August**	**Movement**
Referral to Treatment Admitted	90%	1	0		85.60%	85.2%	⮟
Referral to Treatment Non Admitted	95%	1	0		96.3%	95%	⮟
Referral to Treatment Incomplete	92%	1	0		92.02%	NYA	➤
A&E All Types Monthly Performance (Quarter to date)	95%	1	1	95.10%	95.45%	94.98%	⮟
				YTD	**Q1**	**Q2 (to date)**	
62 Day Standard	85%	1	0	86.8%	86.8%	86.7%	⮟
62 Day Screening Standard	90%	1	0	91.2%	90.4%	93.3%	⮝
31 Day Subsequent Drug Standard	98%	1	0	100.0%	100.0%	100.0%	➤
31 Day Subsequent Surgery Standard	94%	1	0	98.3%	97.8%	100%	⮝
31 Day Standard	96%	1	0	98.4%	98.2%	98.9%	⮝
Two Week Wait Standard	93%	1	0	95.3%	95.3%	95.3%	➤
Breast Symptom Two Week Wait Standard	93%	1	0	95.6%	94.9%	99.4%	⮝

* NYA Not yet available

Outcomes							
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**July**	**August**	**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			54%	54%	➤
referral information	50%	1			92%	92%	➤
treatment activity	50%	1			92%	73%	⮟

Trust Overall Quality Governance Score					1	1	➤

Green <1.0

Amber Green= >1 and <2

Amber/Red = >2 and <4

Red= >4

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

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

Note: In July and August-14 RTT admitted was excluded from scoring as breaching the target was authorised as part of the national RTT resilience programme.

The trust 's CoSSR position is expected to remain at 3 which is rated as 'Green'. At the time of producing this report it was not yet available and is therefore subject to change.

Areas of underperformance for quality governance are:

- RTT
- ED
- 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.

Clinical Audit and Effectiveness

4. Clinical Audit and Effectiveness: August 2014 - Mortality

HSMR (Hospital standardised mortality ratio)						
Lead Director	August	September	Movement	2014/2015 Target	Forecast October 14	Date expected to meet standard
RGW	77.7	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

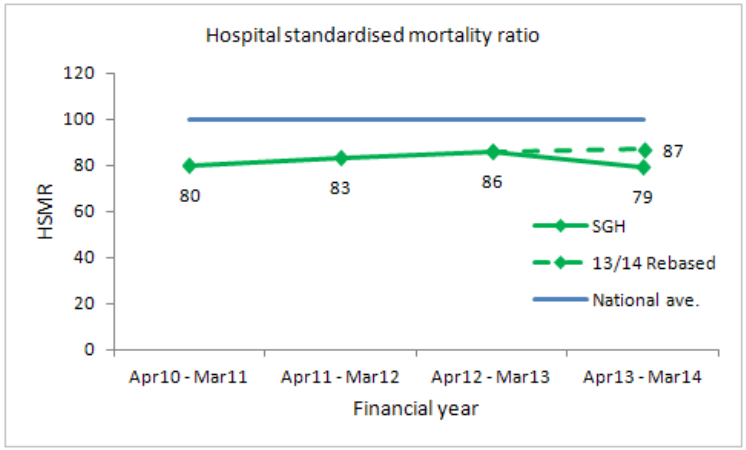
Note: Source for HSMR mortality data is Dr Foster Intelligence, published monthly. Data is most recent rolling 12 months available. For September 14 this was June 13 to May 14. SHMI data is published by the Health and Social Care Information Centre 6 months retrospectively. The last 12 month period as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

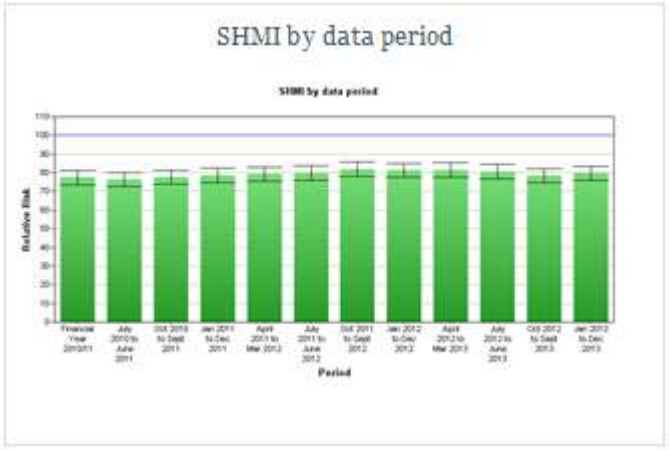
Overview:

Our mortality remains statistically significantly better than expected. In October Dr Foster Intelligence will introduce monthly remodelling of the risk calculations from which 'expected values' are derived. This will take account of the fact that national mortality performance tends to improve over time. If our mortality does not improve at the same rate as the national average our HSMR will appear higher than has been reported in recent months. Provisional data suggests that our remodelled HSMR is still significantly better than expected at 82.7. Our SMR for both emergency weekday admissions and weekend admissions are also significantly better than expected at 85.1 and 83.0 respectively. Going forward the introduction of monthly recalculated data will allow us to report a more consistent and accurate picture of our comparative mortality.

The Mortality Monitoring Committee continue to drive the proportionate review of all deaths, and this appears to be gaining momentum with an increasing number of specialties utilising the committee's mortality investigation forms to review deaths within their service. This practice has been established for some time in haematology and is now being implemented in senior health, emergency department, neurosurgery and cardiothoracic intensive care. In addition cardiology now use a dedicated proforma to review all deaths following percutaneous coronary intervention (PCI). The new system that we are developing to provide real-time identification of in hospital deaths and provision of scanned patient records will further strengthen our governance of mortality.

Our involvement in the national PRISM2 study, examining the link between avoidable mortality and risk-adjusted mortality indicators, has come to an end following review of 100 randomly selected deaths by external clinical consultants. We look forward to receiving organisation level feedback towards the end of the year and the full report a few months later. The lead researcher for this project will be our guest speaker at the annual trust-wide Clinical Audit Half Day on 20th November.





4. Clinical Audit and Effectiveness: August 2014 - National Audits

Sentinel Stroke National Audit Programme (SSNAP)

HASU Data	Jul-Sept 2013	Oct-Dec 2013	Jan-Mar 2014
Case Ascertainment	A	B	A
Audit compliance	C	B	A
Combined total key indicator level	C	D	D
Combined total key indicator score	66	59	57
Patient-centred key indicators levels			
Domain 1: Scanning	A	A	B
Domain 2: Stroke unit	C	D	D
Domain 3: Thrombolysis	B	B	C
Domain 4: Specialist assessments	D	D	D
Domain 5: Occupational therapy	C	C	D
Domain 6: Physiotherapy	B	C	D
Domain 7: Speech & language therapy	C	C	D
Domain 8: MDT working	C	D	C
Domain 9: Standards by discharge	B	B	B
Domain 10: Discharge processes	C	B	B
Patient-centred total KI level	C	C	D
Patient-centred total KI score	68	64	56
Team-centred key indicators levels			
Domain 1: Scanning	A	A	B
Domain 2: Stroke unit	C	D	C
Domain 3: Thrombolysis	B	B	C
Domain 4: Specialist assessments	D	D	D
Domain 5: Occupational therapy	C	D	D
Domain 6: Physiotherapy	C	D	D
Domain 7: Speech & language therapy	C	D	D
Domain 8: MDT working	C	D	B
Domain 9: Standards by discharge	B	B	B
Domain 10: Discharge processes	D	D	C
Team-centred total KI level	C	D	D
team-centred total KI score	64	54	58

Colour code of score				
A (>80)	B (70-80)	C (60-69)	D (40-59)	E (<40)

Overview: This is the fifth quarterly report of the Sentinel Stroke National Audit Programme (SSNAP) and includes data for patients admitted and discharged from inpatient care between January and March 2014. Trusts are rated for both HASU (hyper acute stroke unit) and SU (stroke unit) from A (excellent) to E (poor) and on a patient-centred and team-centred level. The ratings are standard-based, not relative to other Trusts. St George's results for the HASU and SU are similar and our HASU data for both patient-centred and team-centred domains are on the left. The previous 2 quarters are also indicated. No Trust achieved the A standard for both HASU and SU this quarter.

Overall Performance: The Trust received a D score for both the HASU and SU in both patient- and team-centred ratings. We improved case ascertainment and audit compliance rate and scored A for this quarter. This is a vital component of SSNAP and the recommendation is 100%. For the combined total key indicator level, the trust score is D as per previous quarter. The HASU score influences the SU score. Other trusts such as Barts Health NHS Trust and North West London Hospitals NHS Trust scored A in their overall score for patient-centre key indicators levels. Barts Health NHS Trust, Imperial Healthcare NHS Trust, King's College Hospital and North West London Hospitals NHS Trust scored B in their overall team-centred score.

Analysis: HASU capacity remains the biggest barrier to improved SSNAP performance. Admission to a HASU bed within 4 hours of emergency department arrival and associated quality metrics are a challenge. Repatriation delays from the HASU for both stroke and non-stroke patients limit our ability to admit patients to the HASU in a timely manner. London Ambulance Service stroke calls to the Trust have increased over 10% with no increase in stroke caseload.

Action Plan: A comprehensive action plan has been developed in response to these latest results. The plan is multifaceted and requires engagement and support from other services within the Trust, commissioners , ambulance services and local Trusts. Some of the key actions include:

- Presentation to Trust Board. We have identified metrics to present as part of on-going performance monitoring to raise awareness and suggest quarterly reporting in line with audit publication;
- Monthly data review by the clinical team at Stroke core group;
- Monthly senior management meeting on stroke performance;
- Dedicated clinical time to validate data;
- A new clinical proforma;
- Consultant doubling-up on the HASU;
- 7 day therapy is now up and running

Some actions have already been implemented and the April to June report, which is not yet publically available shows we have improved to B ratings for both the HASU and SU. However, the score is very likely to decline over the winter without a strategy to enforce the Healthcare for London stroke strategy repatriation agreement.

4. Clinical Audit and Effectiveness: August 2014 - National Audits

UK Irritable Bowel Disease Audit (1st January and 31st December 2013)

ADULTS	SGH	National
Number of admissions audited	25	4359 (median 21)
Seen by IBD team during admission	84%	91%
Standard stool culture performed	100%	80%
Prophylactic heparin prescribed	100%	90%
Nutritional screening undertaken	100%	82%
Had surgery not planned before admission	14%	12%
Bone protection prescribed if discharged on steroids	95%	74%
Follow up plan recorded on discharge	100%	93%

PAEDIATRICS	SGH	National
Number of admissions audited	6	298 (median 6)
Seen by paed IBD nurse (emergency admissions)	0%	73%
PUCAI score recorded on day 1 (emergency adm)	80%	55%
Standard stool culture performed	75%	68%
Stool sample sent for C diff toxin	75%	61%
Nutritional screening undertaken	83%	40%
Bone protection prescribed if discharged on steroids	0%	32%
Follow up plan recorded on discharge	100%	93%

Inpatient care for adults and young people with ulcerative colitis
The inpatient care of adults and young people with ulcerative colitis (UC) was examined as part of the UK IBD audit and published in two separate reports. The audit found that substantive improvements have been made in IBD care since the previous round of the audit. Nationally, the rate of mortality has decreased from 1.5% to 0.75%. It is worth noting that the results for both adult and paediatrics should be interpreted within the context that the number of admissions per unit tends to be small, and this is true at St George's with 25 adult cases and 6 paediatric cases entered.

Adult: There were a number of areas where St George's performance was significantly better than the national average, including four areas where we scored 100%. St George's also had higher performance than the national data for the prescription of bone protection in patients discharged home on steroids (95%). There are still some areas for improvement, such as ensuring that all patients are seen by a member of the IBD team during their admission.

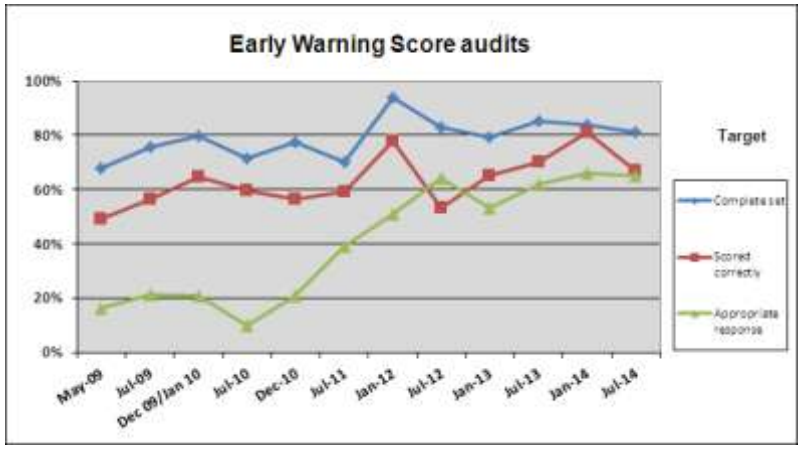
Paediatrics: Our performance was above the national average for five of the key standards measured. As with adults, it is very positive to note that on discharge a follow up plan was recorded in the patients notes for 100 per cent of patients. At the time of this audit we did not have a paediatric IBD specialist nurse in post, hence our failure to meet that criteria for any patient. This role was recruited to in February 2014 and now all inpatients are reviewed by an IBD nurse specialist.

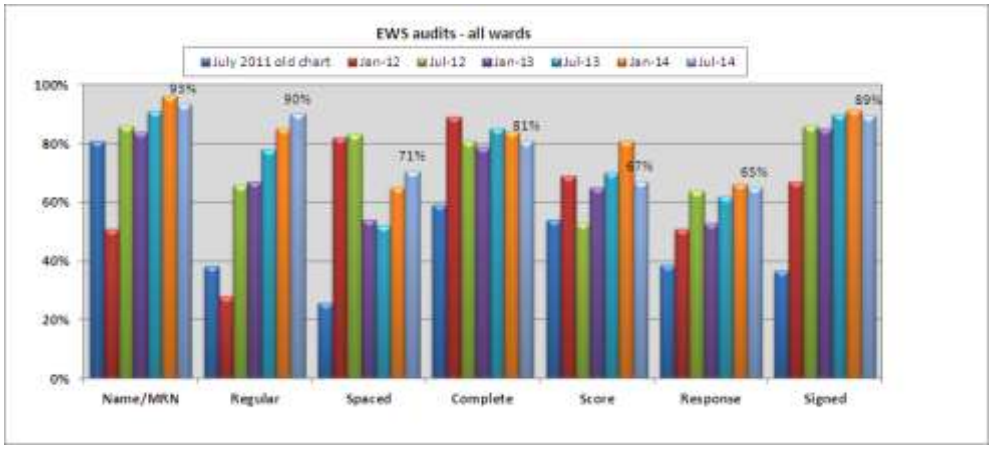
Recommendations are aimed at improving consistency of care and maintaining the progress observed. The report also identifies the need for action around early intervention and assessment in order to prevent admission, avoid re-admission and reduce the need for surgery.

Experience of inpatients with ulcerative colitis throughout the UK
Alongside these reports a survey of experiences of patients admitted to hospital for treatment of UC was published. Results are only available at a national level. Although there were many positive findings, no significant change was observed, meaning that patients with UC have not experienced any significant improvement in their inpatient experience. The report calls for a more concerted effort to address areas that continue to be rated poorly and provides a number of recommendations to guide developments.

4. Clinical Audit and Effectiveness: August 2014 - Local audit

Use of nEWS (national early warning score) audit





Overview

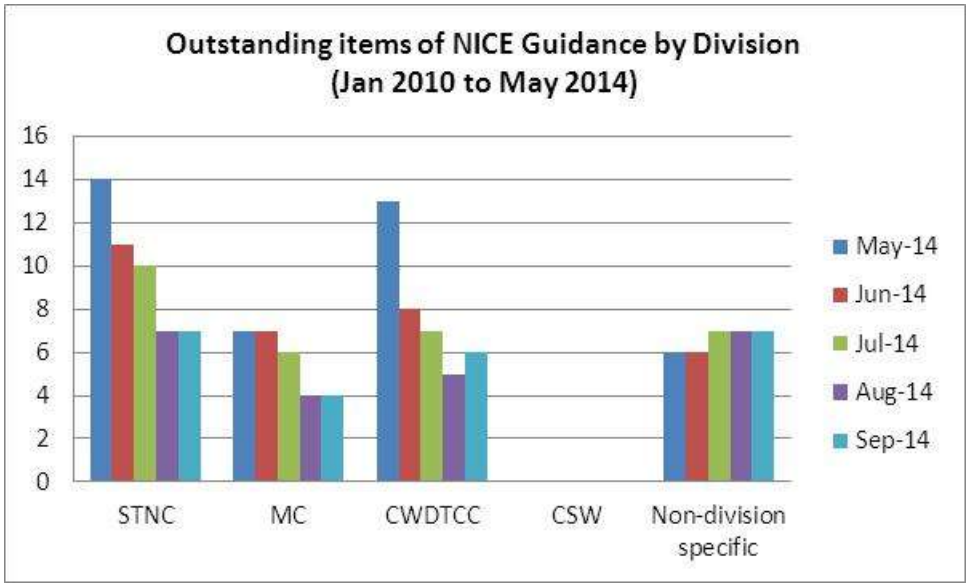
This audit is part of our response to the NICE requirement for Trusts to have a graded response strategy for patients identified as being at risk of clinical deterioration. The latest cycle of audit took place in July 2014. 303 records were audited across 32 wards at St George's and Queen Mary's.

Three principal standards are measured, namely recording a complete set of observations; scoring nEWS correctly; and appropriate response to nEWS trigger. The target for compliance is 80%. Trust-wide we met one of the three standards, with a full set of observations achieved in 80%. This is a decline from the previous audit in January 2014 where we met two of the three standards. Four additional standards are measured and it is positive to note an improvement in both the regularity and correct spacing of observations.

Performance varied significantly between wards and results have been fed back to individual areas for action. All wards now have a nEWS link nurse in place who will have a role in supporting improved practice and in encouraging increased local ownership. The Nursing board has suggested that the Divisional Directors of Nursing and Governance compare results over time with other quality measures, to distinguish between wards that are poorly performing against a range of measures and those struggling with nEWS only. This distinction will help to shape actions appropriate to each area. Where the problem is just nEWS, action would be taken to re-educate staff to improve charting.

Actions are ongoing with continued education for registered nurses on Harm Free Care days (which are being expanded and strengthened further), Nurse Induction and other nEWS training events. General ICU provides a 3 hour training session for health care assistants bi-monthly and nEWS assessment is included as a part of the Band 5 assessment centre. It should be noted that electronic documentation has commenced in some areas and this will support accurate calculation of the warning score. The current roll out plan suggests that electronic recording of observations should be live in all areas by end of April 2015, helping to improve performance trust-wide. Six-monthly re-audit is included in the annual programme for 2014/15.

4. Clinical Audit and Effectiveness: August 2014
- NICE (National Institute of Health and Social Care Excellence) Guidance



Overview

The audit team have recently introduced monthly compliance reports for each division, which details their current position against all relevant guidance requiring action. This information is provided to support divisions to resolve outstanding responses and to assess and manage any issues of risk associated with partial or non-compliance. Initial feedback suggests that this summary report is being used at divisional governance boards to better manage the implementation of guidance. For example, in the Medicine & Cardiovascular division following DGB, general managers now take up compliance issues with care group leads and RAG rate guidance to ascertain unacceptable risks, and those identified with a risk rating of high or extreme will be transferred to their divisional risk register. In turn this information will be provided to the Clinical Effectiveness and Audit Committee for oversight and escalation as appropriate.

There were 21 items of NICE guidance released in June and July 2014 and we have already received 13 responses, demonstrating increased clinical engagement. For guidance issued between January 2010 and April 2014 there are currently 21 items of guidance outstanding; a reduction of 2 from the previous report. The chart above includes an additional month's guidance (May 2014), hence the apparent increase. Following up outstanding NICE guidance and supporting divisions with implementation is ongoing and will continue to be a priority for the Clinical Audit department.

Patient Safety

5. Patient Safety: August 2014
- Incident Profile: Serious Incidents and Adverse Events

Closed Serious Incidents (not PUs)				
Type	June	July	Aug	Movement
Total	8	8	7	⮟
No Harm	6	6	5	⮟
Harm	2	2	2	➤

	SIs Declared by Division (Inc. Pus)				
	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
August	4	2	**3**	3	0

Table 1

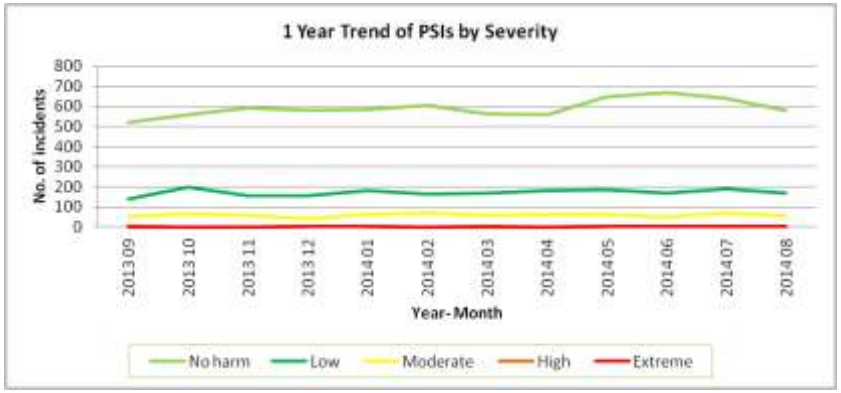
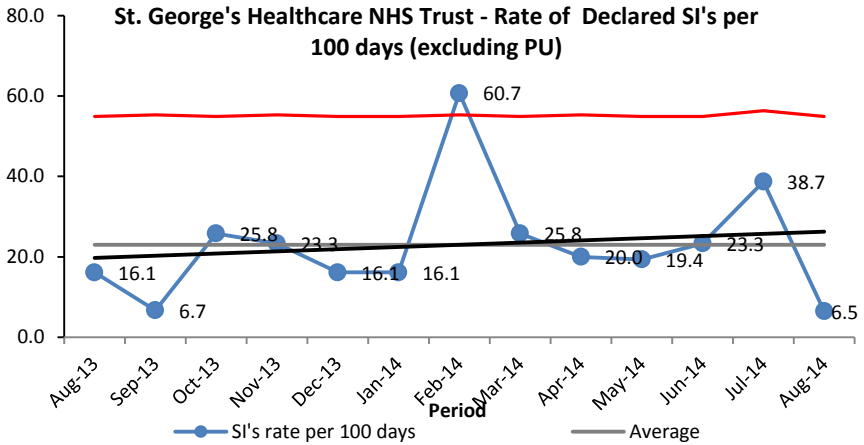


Table 2



Overview:

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

In August the 2 declared SIs related to an unforeseen admission to the neonatal unit and unforeseen complications in cardiac theatres. The root causes of these SIs will be included in the investigation reports.

Regarding the cluster of SIs relating to failure to follow up on test results reported in the July report : the panel to look at all of these SIs has now met for the first time and agreed Terms of Reference and initial steps. Themes are currently being identified and a gap analysis of actions will be undertaken. Two of the regular open safety forum have also focussed on this issue and have gained valuable feedback from staff .

There were two serious incidents that were closed during August where failures contributed to harm. The first related to a death in custody at Wandsworth Prison where a need for further development of initial assessment processes was identified and the need for further staff training for resuscitation. The second related to a patient who had a reaction during surgery which was not fully followed up and so the patient had a repeat reaction when the surgery was rescheduled. A number of actions were identified from this serious incident which are currently being implemented.

5. Patient Safety: August 2014 - Safety Thermometer

% Harm Free Care							
Lead Director	June	July	August	Movement	2014/2015 Target	National Average	Date expected to meet standard
J Hall	94.73%	93.67%	95.06%	↑	95%	93.66%	Sept - 14

	Aug13	Sep13	Oct13	Nov13	Dec13	Jan14	Feb14	Mar14	Apr14	May14	Jun14	Jul14	Aug14
Pressure Ulcers	5.55	5.04	6.54	5.26	6.67	5.31	5.27	3.23	4.44	4.18	3.77	5.02	3.98
Falls	0.46	0.39	0.65	0.07	0.15	0.07	0.43	0.27	0.28	0.14	0.36	0.26	0
Catheter & UTI	1.67	1.16	1.29	1.68	1.6	1.09	1.08	0.69	1.67	0.85	1.14	1.11	1.23
New VTE	0.38	0.39	0.36	0.28	0.36	0.07	0.29	0.34	0.76	0.35	0.21	0.07	0.07
Patients	1315	1289	1391	1426	1379	1375	1386	1456	1441	1410	1405	1533	1458

Overview

This point prevalence audit shows that in August 2014, 95.06% of patients received 'harm free' care, an increase from July (93.67%) and higher than the 95% target. The national average for August is 93.66% . The number of new pressure ulcers increased from 1.37% in July to 1.44% in August. A decline in old pressure ulcers was recorded from 3.91% in July to 2.74% in August and although they are not attributable to the trust they reduce our percentage of harm free care. This decline is the reason we have exceeded the 95% target. New VTEs remain static, there were no falls with harm recorded and new catheter associated UTI's increased from 0.65% in July to 0.89% in August.

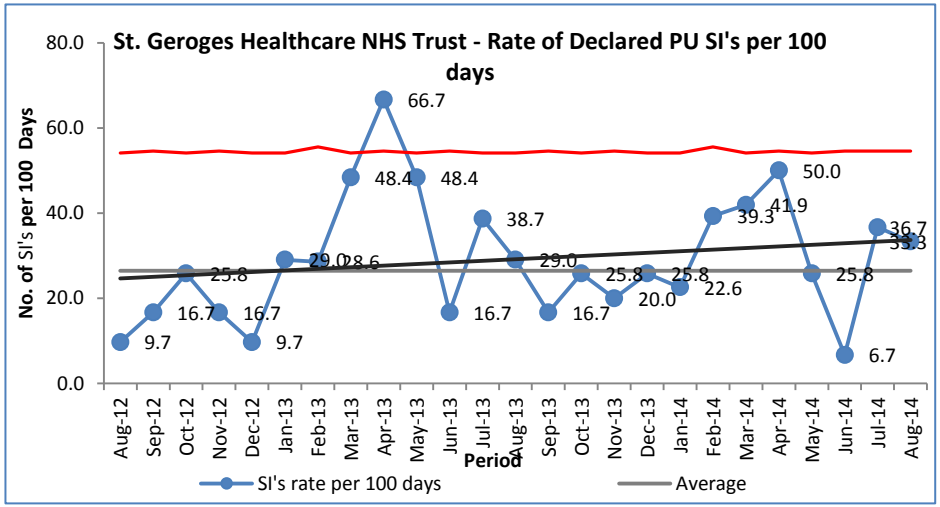
Actions:

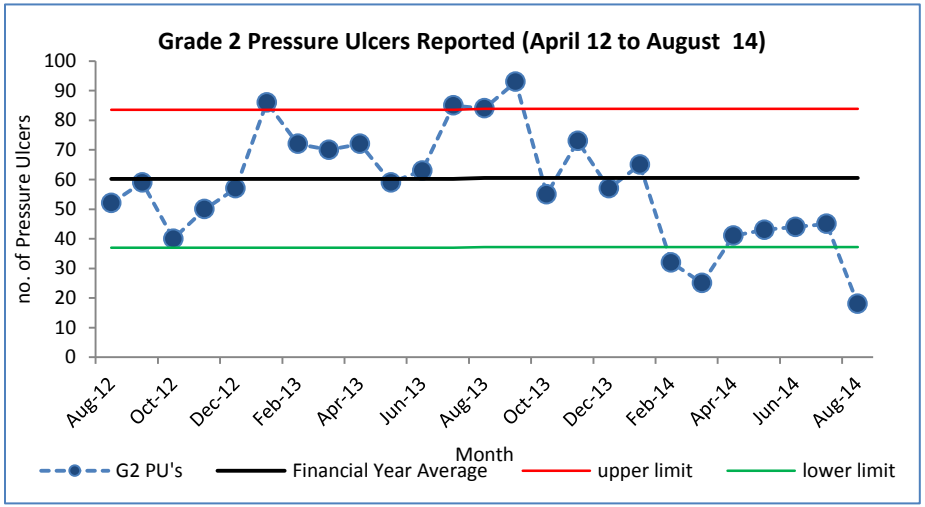
In August the VTE and PU submissions were validated by the relevant clinical nurse specialists who have recognised there are some training issues around data entry. UTI data was validated by Matrons. Plans need to be agreed to take the validation process forward in the community, some data remains un-validated for August. There needs to be a focused piece of work to increase awareness and recording of UTIs. Validation and correct entry of data is a concern that needs to be addressed by the divisional nursing teams. The safety thermometer data was not submitted for August due to human error. This will not affect the CQUIN target as data has been collected and stored. It will be available for public viewing along with the September data.

5. Patient Safety: August 2014
- Incident Profile: Pressure Ulcers

Serious Incident – Grade 3 & 4 Pressure Ulcers										
Type	April	May	June	July	Aug	YTD	Movement	2014/2015 Target	Forecast Sept - 14	Date expected to meet standard
Acute	12	3	1	4	7	27	▲		G	-
Community	3	5	1	7	3	19	▼		G	-
Total All	15	8	2	11	10	46	▼		G	-
Total Avoidable	7	4	**2**	**TBA**	**TBA**			40		-

Grade 2 Pressure Ulcers					
Apr	May	Jun	July	Aug	Movement
19	18	**28**	**28**	**7**	▼
22	25	**16**	**17**	**11**	▼
41	43	**44**	**45**	**18**	▼





Overview:

August showed a reduction in pressure ulcer SI's, noticeably in community services. This is a positive step and it is hoped that this will continue in the coming months. It should be noted that these SI's have not yet had an RCA and therefore have not been classified as avoidable/ unavoidable. There was also a sharp reduction in Grade 2 pressure ulcers, with a total of only 18 incidents (a 40% reduction from July). This represents hard work across all divisions and this should produce a reduction in the number of pressure ulcers deteriorating into SI's.

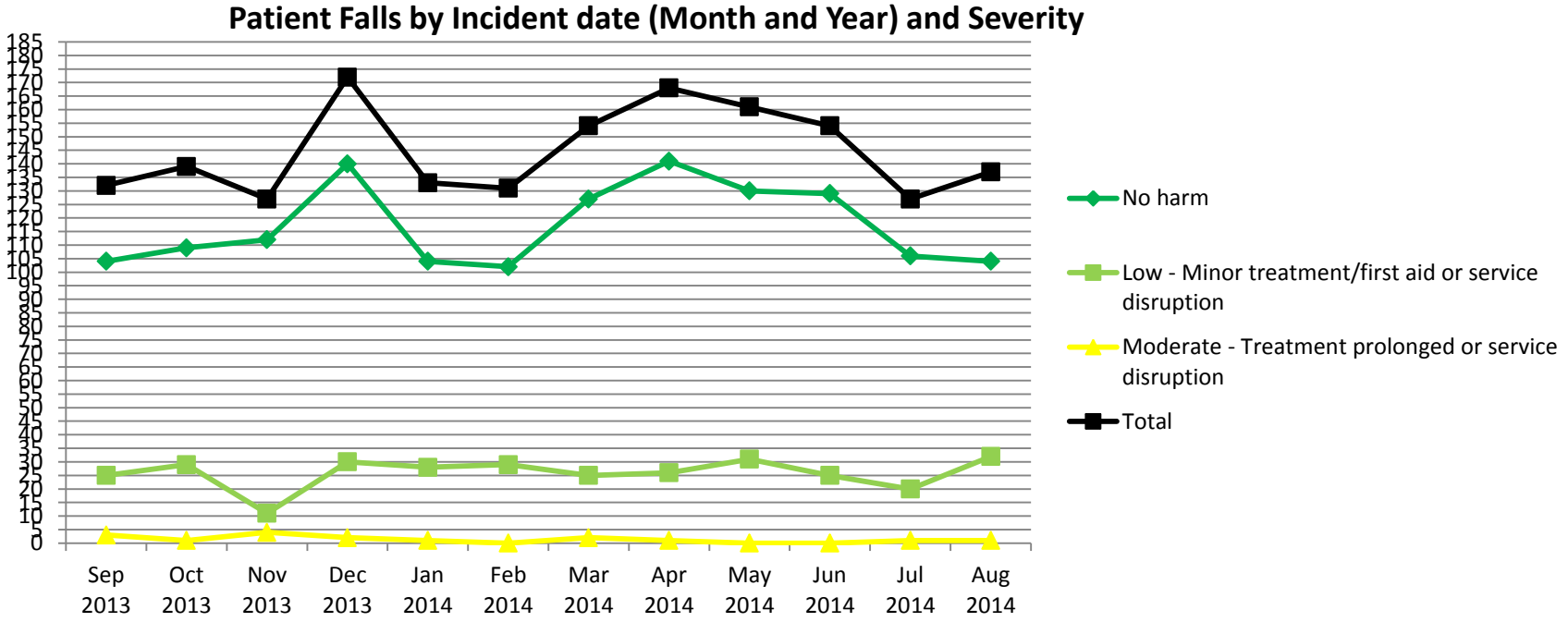
Actions:

- 'Deep dive' meeting held in early September with Surgical team . Well represented by the division (21 staff) , sharing trust wide trends, comparative trends with each division, individual ward performance and thematic review of SI's .
- Themes – improvements required in documentation and assessments ; ensuring agency staff are briefed and engaged and regular removal of TED stockings to inspect the skin underneath, increase education and awareness locally .
- Actions – Focus of work in Neurosurgery , actions identified to take forward within the division to include : closer work with therapists, bedside handovers with agency staff; improved use of patient information leaflet ; whole team approach; share the RCA's with all staff; increase numbers of staff trained and competent .

5. Patient Safety: August 2014
- Incident Profile: Falls

Falls							
Lead Director	May	June	July	Movement	2014/2015 Target	August-14	Date expected to meet standard
	156	151	125	⇔	100	137	July 2015

Falls with Harm				
No Harm	Moderate	Severe	Death	Falls related Fractures
1409	16	**0**	0	8



Overview: The graph shows the profile of falls across both acute and community services including bed-based care and patients' own homes. It is important to note that this data is sourced from incident reporting and is not individually verified. Preliminary analysis of incident reports in August 2014 shows that a small number of incidents are related to specific active medical problems . There has been no significant change in falls rate.

Actions:

- 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.
- 'Deep dive' meetings for community division and medical divisions to identify themes and review preventative strategies – the majority of incidents are related to toileting and the management of confused patients (delirium and dementia)
- Development of an e-learning package for falls and bed rail risk assessment
- Analysis of the bed and chair sensor pilot on senior health and older persons' rehabilitation unit, QMH

5. Patient Safety: August 2014 - VTE

VTE Risk Assessment

1. Overview: The Trust continues to achieve the national threshold for VTE Screening **during** admission. The target for risk assessment for VTE **during** admission is set at 95%.

Data Source	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Unify2 (extracted from Merlin D/C summaries)	96.31%	96.40%	97.33%	97.28%								

2. Overview: Nursing staff collect data monthly across a range of safety indicators via the safety thermometer. Data is collected for all patients across the Trust on a single day of the month, representing a snapshot in time. Data is obtained from the drug chart and measures the number of **complete** VTE risk assessments (all sections of the form complete). The Trust continues to consistently perform above the national average in this audit.

Data Source	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Safety Thermometer (SGH)	86.67%	86.05%	85.22%	89.94%	86.51%							
National average	85.57%	84.83%	84.83%	84.62%								

VTE Quality Standards (NICE CG92 Venous Thromboembolism: Reducing the Risk)

Overview: NICE has outlined 7 quality standards which should be considered for provision of a high-quality VTE prevention service. Data is collected by the pharmacy team for 10 patients/ward/month. Data collected for quality standard 1 validates the data collected from the two nationally reported data streams; 'RA attempted' reflects the data submitted from Unify, whereas 'RA complete and correct' mirrors data collected via the Safety Thermometer.

Quality Standard (Target)		April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
1. VTE RA 'on admission' **(>95%)**	RA Attempted	-	-	95.8%	99%	95.4%							
	RA complete and correct			92%	89%	82%							
2. Written information 'on admission' **(100%)**		-	-	12.8%	13.2%	21.1%							
3. AES fitted and measured in line with NICE		Stand-alone audit (Co-ordinator: Thrombosis CNS, Date planned: January 2015)											
4. VTE risk re-assessed at 24hr **(70%)**		-	-	68.2%	64%	65.7%							
5. VTE prophylaxis offered in line with NICE **(>98%)**		-	-	94.6%	94.8%	93.1%							
6. Written information 'on D/C'		Stand-alone audit (Co-ordinator: Anticoagulation Pharmacist, Date Planned: January 2015)											
7. Extended prophylaxis in line with NICE		Stand-alone audit (Co-ordinator: Anticoagulation Pharmacist, Date Planned: November 2014)											

(RA = risk assessment, AES = anti-embolism stockings, D/C = discharge)

There are action plans in place to address areas where there are shortfalls from targets, particularly with regards to provision of written information for patients during admission.

Root Cause Analysis (RCA) of Hospital Acquired Thrombosis (HAT)

Data from Jan-Aug 2014 (inclusive)

HAT cases identified to date (attributable to admission at SGH)		55
Mortality rate	Total	21.8% (12/55)
	VTE primary cause of death	3.5% (2/55)
Initiation of RCA process		100%
RCA pending	<28 days since notification	29.1% (16/55)
	>28 days since notification (reminder sent)	27.3% (15/55)
RCA complete		43.7% (24/55)

Overview: The themes identified from the root cause analysis process will be fed back to the Patient Safety Committee.

Trends identified (findings from 24 cases for whom RCA is complete):

- General:
  - 37.5% (9/24) – patients had active cancer
  - 3 cases of thrombosis in obstetric patients
  - 3 cases where root cause unable to be identified due to missing notes
- Adequate prophylaxis received (11/24) – contributing factors to failure of prophylaxis:
  - 7 patients - malignancy +/- complications arising from malignancy
  - 2 patients – low molecular weight heparin (LMWH) held due to surgery
- Inadequate prophylaxis received (10/24) – reasons for inadequate prophylaxis:
  - Mechanical prophylaxis not documented
  - 1 patient – warfarin stopped for endoscopy without any bridging offered
  - Dose of LMWH not escalated appropriately in obesity
  - 2 patients – no evidence of risk assessment

5. Patient Safety - Infection Control

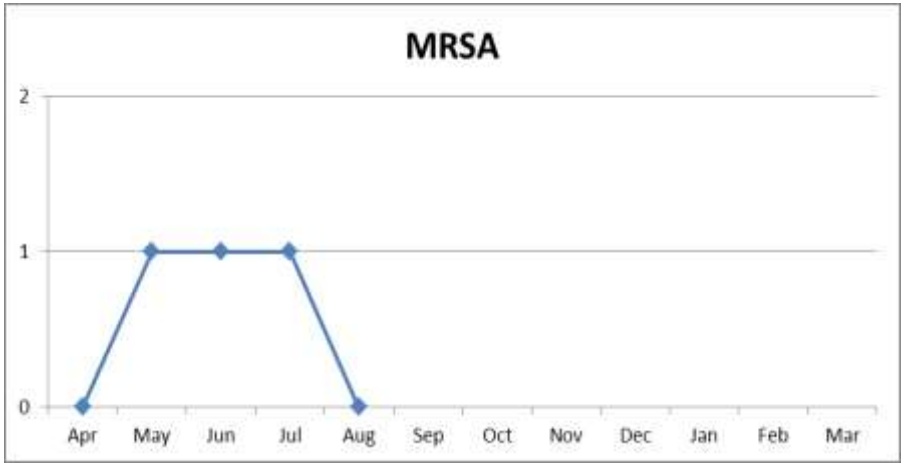
Infection Control						
Type	July	August	Movement	2014/2015 Target	Forecast September - 14	Date expected to meet standard
MRSA	1	0	⇩	0	G	Exceeded
C-Diff	3	5	⇧	40	R	October - 14
MSSA	0	1		NA		
E-Coli	5 (27)	6 (20)		NA		

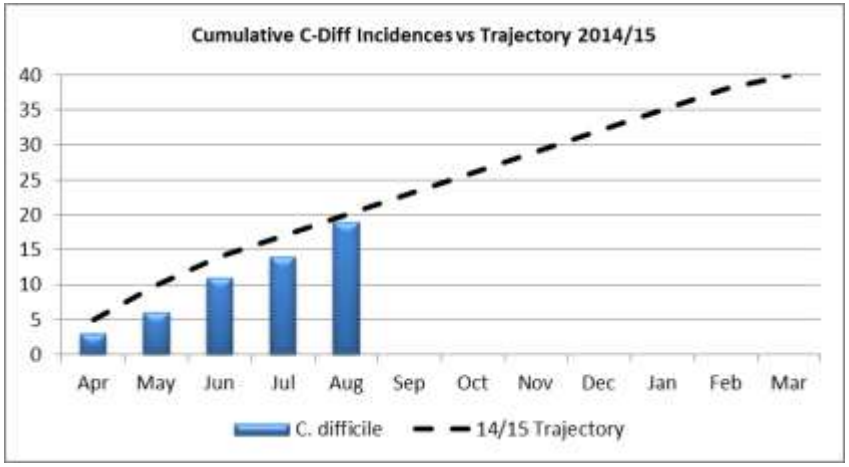
Peer Performance – YTD July 2014				
STG	Croydon	Kingston	King's College	Epsom & St Helier
3	1	0	2	3
19	7	4	33	17
8	14	9	44	29
23 (101)	73	62	246	102

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

In August there were 3 incidences of C-diff against a trajectory of 3 for the month. 19 for the year We remain just on the TDA trajectory but above the annualised trajectory. Focus remains on hand hygiene, antibiotic prescribing and prompt isolation. A analysis of *C. difficile* cases to date is attached.

The trust had 0 cases of MRSA bacteraemia in August and is above 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. All RCA's have been completed. The trust will continue its programme of close monitoring and vigilance to ensure compliance in 2014/15.

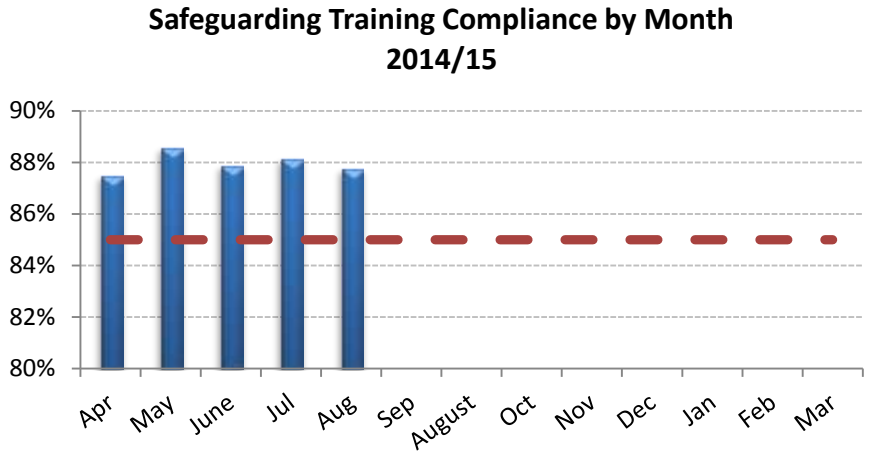


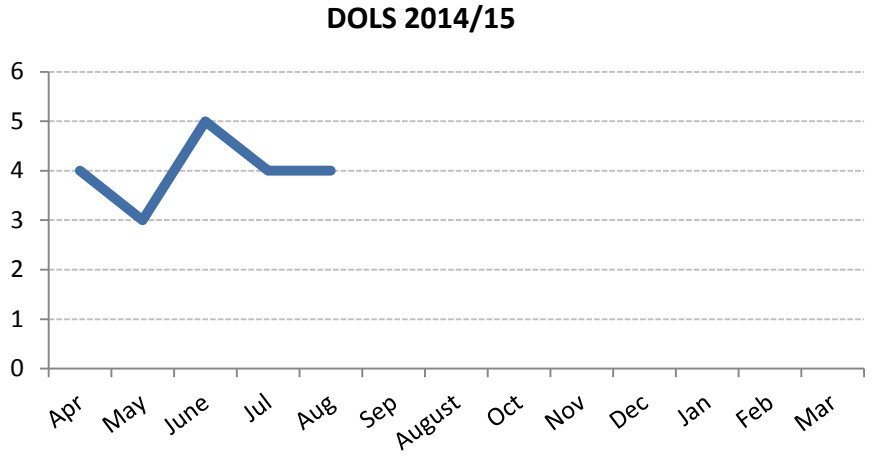


5. Patient Safety: August 2014
- Safeguarding: Adults

Safeguarding Training Compliance - Adults									
Lead Director	April	May	June	July	Aug	Movement	2014/2015 Target	Forecast July - 14	Date expected to meet standard
JH	87.5%	88.58%	87.9%	88.13%	87.77%		95%	A	-

Safeguarding Adults Training Compliance by Division – Aug 14				
Med & Card	Surgery & Neuro	Community	Children's and Womens	Corporate
83.38	85.43	91.44	90.23	88.11





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, Aug 45

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, Aug 4

Actions:

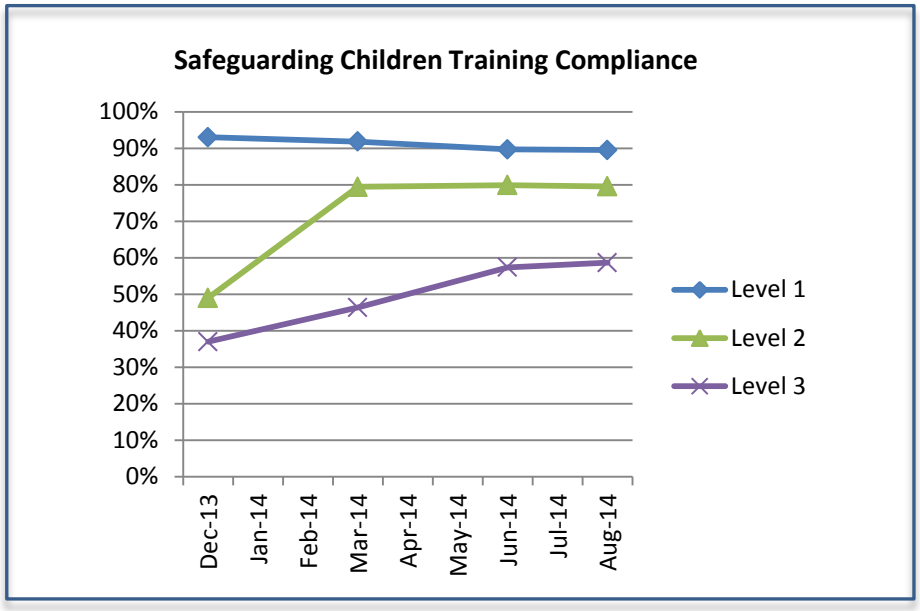
Continue to monitor safeguarding training via WIRED

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. Prepare revised briefing paper with legal team for EMT indicating current positon, impact on resources and future options to manage the governance and workload.

5. Patient Safety : August 2014 - Safeguarding Children

Safeguarding Training Compliance - Children						
August			Movement	2014/2015 Target	Forecast August - 14	Date expected to meet standard
Level 1	Level 2	Level 3				
89.50%	79.53%	58.63%	⇔	85%	G	-



Overview: The compliance with safeguarding children training remains a priority area with level 3 in particular being below the desired level of attainment at 58.63% . Level 1 MAST is currently achieving 89.2% and level 2 79.1%.

Actions: Review of the WIRED data demonstrates that at level 3 there are some departments where the level of compliance is notably poor – these are Plastics, Maxillae-facial , the Emergency Department and Obstetrics. The training team will be offering additional level 3 sessions to these departments and asking that departmental managers ensure their staff are aware of the need sign onto a session in order to update their training at the earliest opportunity. In the ED it has been recommended that 2 sessions are held each month to ensure that the teams are competent ASAP and maternity have offered the obstetric team the opportunity to join their monthly level 3 training. The named nurses will meet with the WIRED lead to revisit the training level requirements as some a small number of staff seem to be allocated at level 3 when they probably require level 2.

Serious Case Reviews and Internal Management Reviews: There are 8 active cases. As before a number of the cases have had the SCR reports completed but these reports will not be published until after the criminal matters have been completed. There are 6 cases where we are either preparing reports or have submitted the report and are waiting for feedback. There are 4 cases which are likely to be high profile, in particular a case where 3 children died. This case is before the court again this week and the decision will be made as to whether a plea of manslaughter will be accepted. It is expected that in all 4 cases the SCR reports will not be published until next year. St George's Healthcare NHS staff are likely to be called to court in one if not two of the cases as witnesses.

Other: The Chief Nurse will be meeting with the named professional next week to commence the revision of the service in line with the recommendations from the recent safeguarding team review.

5. Patient Safety: August 2014
Offender Healthcare Service

Introduction and Background

HMP Wandsworth is one of the largest prisons in Western Europe and accommodates up to 1668 prisoners (prisoner turnover 600 month). The largest residential part of the prison accommodates up to 1284 prisoners and accommodates category B prisoners and the Trinity Unit accommodates category C prisoners where there is an emphasis on resettlement.

In 2009 the trust took over the Offender Healthcare Service (OHS) at HMPW from a private provider and has been working on development of the service since. The trust recently formed a consortium which includes South London and Maudsley NHS Foundation Trust and has won the contract to continue to provide services for a further 5 years with a two year optional roll over.

Healthcare services at HMPW currently include: pharmacy, primary care, substance misuse, mental health (in reach and bed based services), a 6 bedded medical wing, sexual health clinics, podiatry, optician services, dentistry, X-ray.

Income: £8.2 m
Staff : 95WTE

Are Services Safe?

OHS Integrated Governance and performance Board
Has been established to provide integrated leadership, management, review and monitoring of the Offender Healthcare Service (OHS) and to seek assurance on regulated activities, both clinical and non-clinical

Incidents: Total 75 April – Sept 2014

- x36 medication errors (prescribing/ detox regime/ omissions) x10 documentation

Deaths in Custody x 6 since Jan 2014 all investigated under Si Policy (x4 hangings)
Reflecting a national trend.
No underlying trend to link recent DiC's
Key issues, limitations of in-reach mental health provision, verification process, Resus competency

Risks
OHS risk register: medication management, records, high staff vacancy and sickness, infection control, prison benchmarking and regime & SLAM, Resus
There are specific action plans in place to manage and mitigate all risks

Safe staffing
There are currently 36.5 WTE vacancies across OHS (38%). There are 17 /51WTE (33%) vacancies in nursing. Daily reporting on safe staffing has been agreed to start Oct 2014 in addition to existing actions.

5. Patient Safety: August 2014
Offender Healthcare Service

Are Services Effective?

Performance Monitoring

Monthly internal performance Board

Quarterly performance meeting with NHS England

KPI's currently being reviewed by NHSE

2nd day screening 94%

68% by primary care nurse/doctor

26% referred on to substance misuse

TB screening 90%

Hep B vaccination 60%

81% have annual poly-pharmacy review

Multidisciplinary working

Well established MDT working and service much more integrated with SLAM and other providers.

Specific Projects

- Workforce and Governance: led by Maggie Elliot, Governance and Workforce Project Lead
- Service Redesign: led by Ele Charles, Service Redesign Project Lead
- Practice Development: led by Sue Wilson, Professional and Practice Lead
- Professional leadership and improving long term care: led by Louise Backhouse, Head of Nursing
- Review of operational policies/procedures: led by Himaya Baksh, Practice, Operations and Governance Manager (POGM)

Are Services Caring?

Complaints

OHS has a relatively low number of complaints but have struggled to meet 25 day target due to staff vacancies .

April 2014 to date - x11 in total; x5 breached.

4 closed within target. 2 open.

None currently red.

Clinical treatment most common subject

PALs

OHS have struggled to manage PALs due to staff vacancies. There is a back log of data entry- back to Jan 2014. Many offenders have left the service or transferred before the PALS concern has been resolved. There is also poor recording of outcomes to concerns. Improvement to PALs response will be led by POGM and will be delivered by December 2014

Her Majesty's Chief Inspectorate of Prisons

HMPW was inspected by HMCIP's (June 2013) and rated as good.

Independent Monitoring Board

IMB (May 2014) recorded that the improvements in Offender Healthcare noted in last year's report have been maintained and there has been a welcome improvement in funding.

5. Patient Safety: August 2014
Offender Healthcare Service

Are Services Responsive?

Access to services

Access to second day screening is very good (94%). Access to routine clinics has been challenging due to National Security Staff Benchmarking and security issues.

Access to complex case management has significantly improved as has the waiting times for dental services.

Complaints

Lessons from complaints are shared with the prison at the partnership board and solutions discussed and actioned.

CQUINS

The Offender Healthcare Service has three CQUIN targets agreed with NHSE – all currently green.

1. Access to mental health assessment at 2nd day screening (target 80% at year end)
2. Hepatitis B Vaccination rate of 90%
3. Successful recruitment to 85% of vacant posts

Clinical

Pharmacy review to improve access led by Chris Evan, Chief Pharmacist

Resus competencies and role of bleep-holders Helen Spencer Hicks, Clinical Team Leader OHS

Review of all procedural documents, Himaya Baksh, POGM

Are Services Well Led?

Visibility of Senior Staff

Four open staff meetings have been held at HMPW by senior managers and the Divisional chair has held one road-show.

Vision & Strategy

The OHS is currently embarking on a significant redesign and integrate all patient pathways led by Ele Charles

- Emergency pathway
- Universal pathway
- Targeted pathway
- Managed care pathway
- Administration hub and single point of contact

A well attended workshop for all staff was held (July 2014) to kick start to project.

Governance arrangements

A new integrated governance and performance board has been set up with representatives from all healthcare providers. All issues are recorded and progress monitored against performance targets

Staff management

Appraisal rates have been low due to staff vacancies. A 10% improvement was recorded last month with an aim to hit 85% by December.

Staff recruitment

Key senior posts filled

Patient Experience

6. Patient Experience: August 2014 - Patient Stories

Ms A is a lady who was admitted to one of our medical wards where she had spent two days since she was admitted via A & E. Although she should have been admitted to an oncology ward she had been sent to an acute medical ward as there were no beds available. She said “when you are ill you don’t care where you are treated as long as you are looked after well.” She said that due to the unfailing support and professionalism of the nurses she had always felt safe on the ward. She said: ”The nurses have been working really hard and are sometimes overburdened and often the staff who are the most knowledgeable are the busiest”

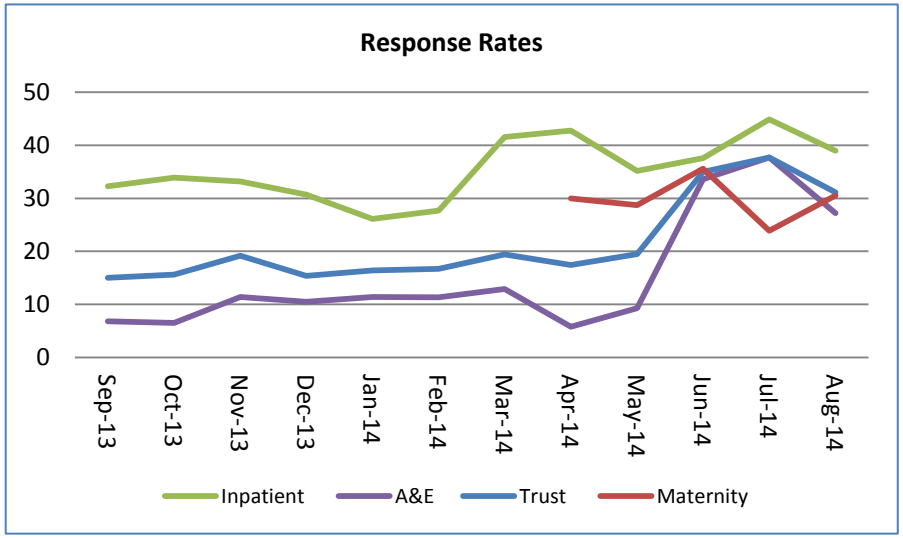
One night she said that she had been concerned because her IV antibiotics were not available as they had been held up in pharmacy. This had been sorted out but it had meant that they were not given until 11.30 that night.

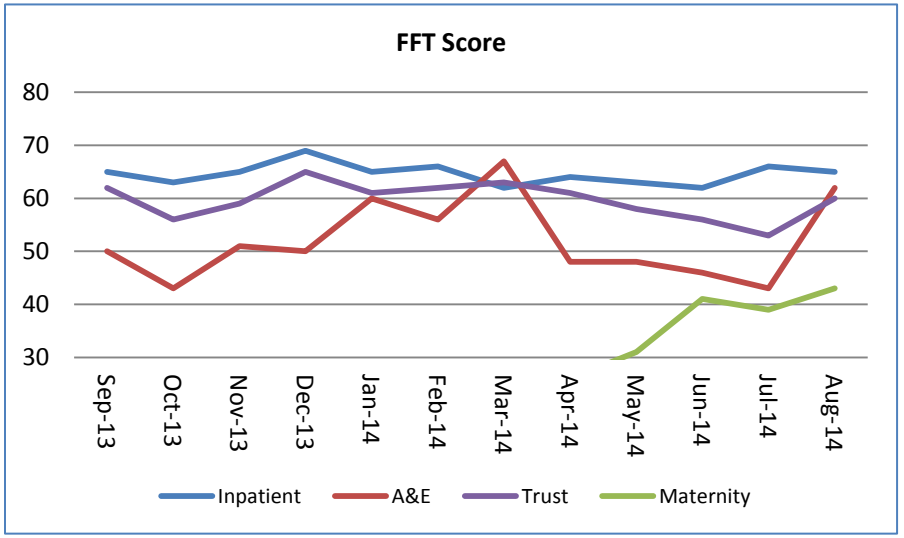
“You need to remember that patients are human but so are the staff and you don’t know what impact things have on them when they get home but they don’t let it affect them while they are at work. No one could have asked more of them but they often go unrecognised for the excellent work they do”

6. Patient Experience: August 2014 - Friends and Family Test

FFT Response Rate							
Domain	June-14	July-14	Aug-14	Movement	2014/2015 Target	Forecast July- 14	Date expected to meet standard
Trust	33.6%	37.7%	31.1%	↓	20%	G	-
Inpatient	37.6%	44.9%	39%	↓	25%	G	-
A&E	33.6%	37.7%	27.2%	↓	15%	G	-
Maternity	35.6%	23.9%	30.5%	↑	-		-

FFT Response Score			
June-14	July-14	Aug-14	Movement
56	53	60	↑
62	66	65	↓
46	43	62	↑
41	39	43	↑





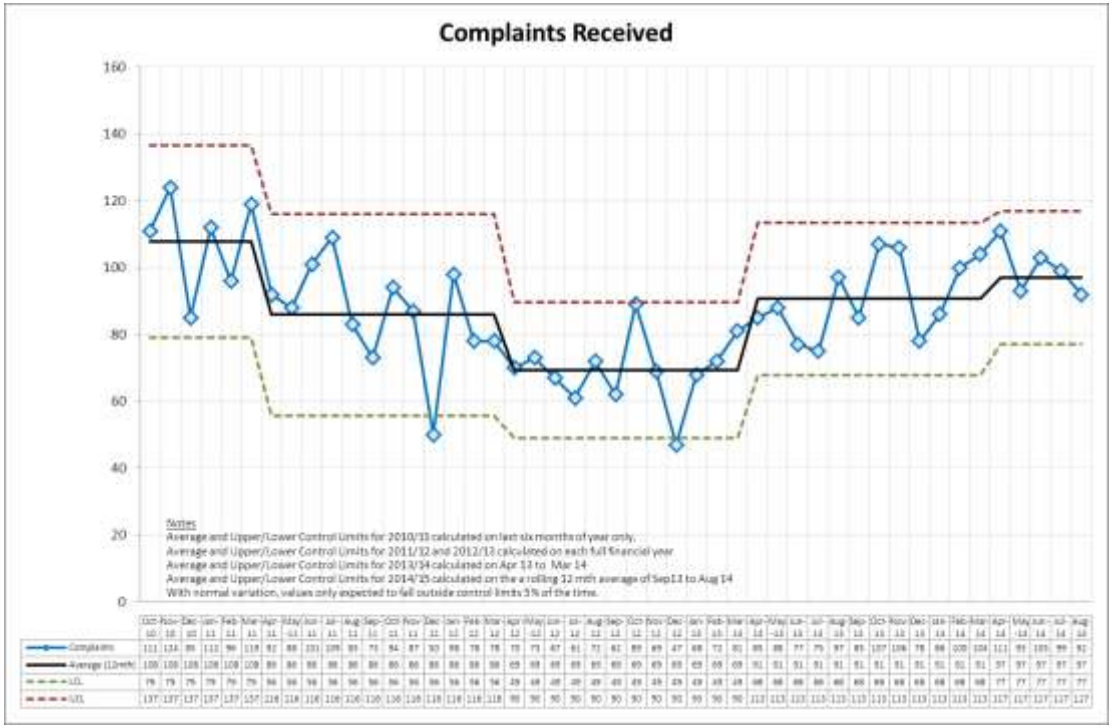
Overview : Response rates dipped in inpatient and A&E areas, but we maintained above our current targets of 25% and 15% respectively. The Friends and Family Test score for the trust overall was +60in August, higher than July (53). A&E scored +62 and the adult inpatient wards +65. Roll out to outpatient 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
- A themed review of responses from FFT across the organisation and also within divisions will be presented at CQRM in October 2014 . This will enable focussed action planning at Divisional level
- Continue to monitor performance in maternity at the 4 touch points ; antenatal, birth, postnatal ward and postnatal community

6. Patient Experience: August 2014 - Complaints Received

Complaints Received						
	April	May	June	July	August	Movement
Total Number received	111	92	100	99	92	-



Overview:

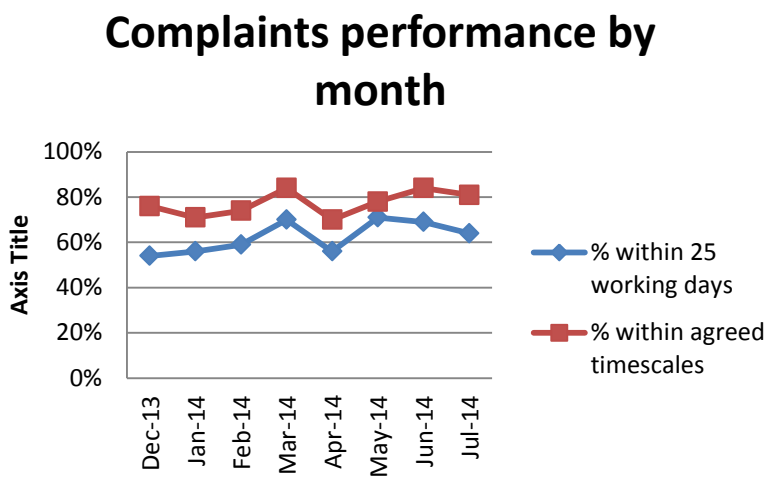
This report provides an update on complaints received since the last board report and information on responding to complaints within the specified timeframes for complaints received in July 2014. The board will receive more detailed information about complaints received in the whole of quarter 2 with divisional breakdowns, analysis of the data to provide trends and themes with actions planned. However, of some actions taken in quarter 2 so far are provided on page 3 of this section of the report.

Total numbers of complaints received in August 2014

There were 92 complaints received in August of 2014, a reduction when compared to July when 99 complaints were received. Following the significant increase complaints being received about Accident and Emergency in July (17), in August complaints reduced significantly to 5. There were no complaints received about the subject of attitude for any staff group and the neither were there any complaints about the subject of medical care. In August, a high number of complaints were received from patients who were unable to get through to the Central Booking Service. Complaints in Trauma and Orthopaedics increased from 5 in July to 10 in August with the main themes being clinical treatment – diagnosis and medical care. Further analysis of these complaints is planned. Complaints about General Surgery reduced from 8 in July to 3 in August. Following actions reported to the July board complaints about transport reduced from 8 in July to 2 in August.

6. Patient Experience: August 2014
- Complaints Performance against targets

Performance Against Target **July 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	20	10	50%	(4) 70%
Medicine and Cardiovascular	30	19	63%	(7) 87%
Surgery & Neurosciences	31	19	61%	(5) 77%
Community Services	7	5	71%	(0) 71%
Corporate Directorates	11	10	91%*	(0) 91%*
Totals:	99	63	64%	(17) 81%



***Late response was for switchboard. Estates and Facilities 100% for both targets**

Overview:
For complaints received in July 2014 64% were responded to within 25 working days which is the same percentage as in quarter 1.

For the same period, 81% of complaints are planned to be responded to within 25 working days or agreed timescales which is a slight improvement on quarter 1 when 77% were planed to be responded to within agreed timescales. 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 yet been realised in August. However, it can be noted that there has been progress in reducing the backlog of overdue complaints and the biggest outlier, the Surgery and Neurosciences Division, has been instructed to tackle their outliers by the middle of October. When the backlog is cleared this will allow us to focus more effectively on dealing with complaints as they come into the divisions.

6. Patient Experience: August 2014 - Complaints actions and themes

Medicine and Cardiovascular Division

Renal, Haematology, Oncology and Palliative Care Directorate
An analysis of trends in complaints, received has shown difficulties that patients have experienced in contacting the service to change, or make appointments, and further have experienced dissatisfaction arising from the relocation of the anti-coagulation clinic. The directorate has implemented a dedicated telephone number for patients to make and change appointments, and is also involved in associated process mapping work with the Improvement Programme. With respect to anti-coagulation, the directorate is liaising with the trust estates and facilities team about improving the waiting area environment.

Cardiac Surgery Care Group
Following a concern raised regarding patient confidentiality, staff training has been undertaken to reiterate to staff the importance of communications taking place directly with individual patients, except where there is explicit consent from a patient to permit communication regarding their care and treatment with a named relative or representative.
Following a complaint relating to a delay in accessing an outpatient appointment a new robust system for weekly review of all patients who have yet to be given an appointment date has been implemented. This is in conjunction with the central bookings team providing up to date information to ensure that all patients get a timely appointment. This is also improving communication between the two departments.

Specialist Medicine Directorate
Following complaints regarding outpatient cancellations and patients not being informed, a new template has been agreed and no changes can be implemented without authorisation from the General Manager. It has been explicitly stated that patients will be called by local teams as CBS are delayed in responding to cancellations. This will ensure that patients are kept informed of any changes, and that changes will only be agreed if absolutely required.

Women's, Children's. Diagnostics and Therapeutics Division

Outpatients and Medical Records Care Group
In the July board paper it was reported that a robust action plan had been established to address the on-going concerns in outpatients with actions including customer care training for staff and the management team having greater presence within the departments to address and resolve issues that arise in real time. These actions led to a reduction in complaints being received in July but in August complaints increased significantly again. However, this was due to a different issue connected to the merging of the two outpatient call centres. The following actions have been taken:

1. Five additional members of staff have been recruited and trained. These staff are now actively handling calls within the call centre.
2. The shift patterns of staff working in the call centre have been reviewed to ensure that there are sufficient numbers of staff on duty at peak times for telephone calls.
3. Additional space has been secured to allow for growth in the call centre team.
4. Five further additional members of staff have been recruited and are currently being trained to handle calls within the call centre.
1. The trust has consulted other call centre providers to ensure that our current processes are reviewed and optimised.
2. The trust is in the process of implementing queue management software to our call centre, to ensure that calls are directed to the most appropriate agent and can therefore be dealt with more quickly. It is hoped that this will result in shorter queues, even at our busiest periods.

As a result of the increase staffing numbers and new shift patterns, call response times have already reduced, with the mean response time currently being approximately 2-3 minutes and it is anticipated that these steps will enable the trust to return to delivering its target of answering 95% of calls within 1 minute. The assistant general manager for corporate outpatient services continues to monitor the call centre performance and work with the call handling team to improve the experience for people who call the trust.

6. Patient Experience: August 2014
- 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.

Jlo211 gave Sleep Medicine at St George's Hospital London) a rating of 1 stars

Mmmmmmm
Pointless. I knew I needed to collect equipment to be tested for sleep apnoea so why is this not issued at the first appointment? Have waited 6 months for this appointment only to have the same conversation I already had with my GP. Now I have to wait 3 months until the next appt to collect the equipment and another two weeks to see the doctor. The best part of a year? Shocking. I hope that the NHS covers those people as yet I diagnosed who are driving vehicles whilst half asleep!! So dissatisfied.

Visited in June 2014. Posted on 02 July 2014

Giovanna B gave Pharmacy at St George's Hospital (London) a rating of 1 stars

Very poor service and rude staff! What's shame!
I just came from the pharmacy and after and a hour waiting the pharmacist told me that the medicine was not in stock! Please, please do your job properly! That is a pharmacy, where people do need medication to stay well.

Visited in August 2014. Posted on 22 August 2014

Roger Wilks gave Nephrology at St George's Hospital (London) a rating of 5 stars

Outstanding care and treatment. A full five star rating.
I received a kidney transplant at St George's on July 9th 2014 and must praise all of the doctors and nurses involved in my care and treatment on Buckland Ward without exception for their expertise, professionalism and sensitivity throughout. The staff really were of the highest calibre and I can't thank them enough for what was a truly life changing experience. It must also be said that the high quality of care also followed through to the domestic staff who were consistently friendly, sensitive to the needs of patients and even provided hot crisp toast, (not lukewarm and floppy), which in my experience of being an inpatient really must be a first. Remarkable! I was an inpatient for seven days in total which also included an unplanned second admission due to fluid loss and I must also say that the excellence of the service continued in to the outpatient clinic which I was fortunate enough to experience for two weeks prior to my eventual transfer to St Helier, Carshalton. Thank you one and all for giving me a truly wonderful experience of hospital and giving me my life back. At the time of writing, my renal function is still steadily improving, (now six weeks post op), and this coming Friday I am having the stent and PD catheter removed so that really will be a watershed moment as it will be an official farewell to dialysis and freedom from "plugging in" four times a day. Hooray!

The fact that this has been such a positive experience for me across the board provides palpable evidence of the profound systemic success of this valuable Renal Department which I believe is really quite a rare achievement in cash strapped contemporary healthcare. In fact when care and treatment is this good it is utterly appropriate and deserved that the NHS is the envy of the world.

Before I run out of superlatives completely I must close with a final message to the renal staff. Please keep doing what you are doing as it is quite fantastic and Thank You so much for everything.

Visited in July 2014. Posted on 18 August 2014

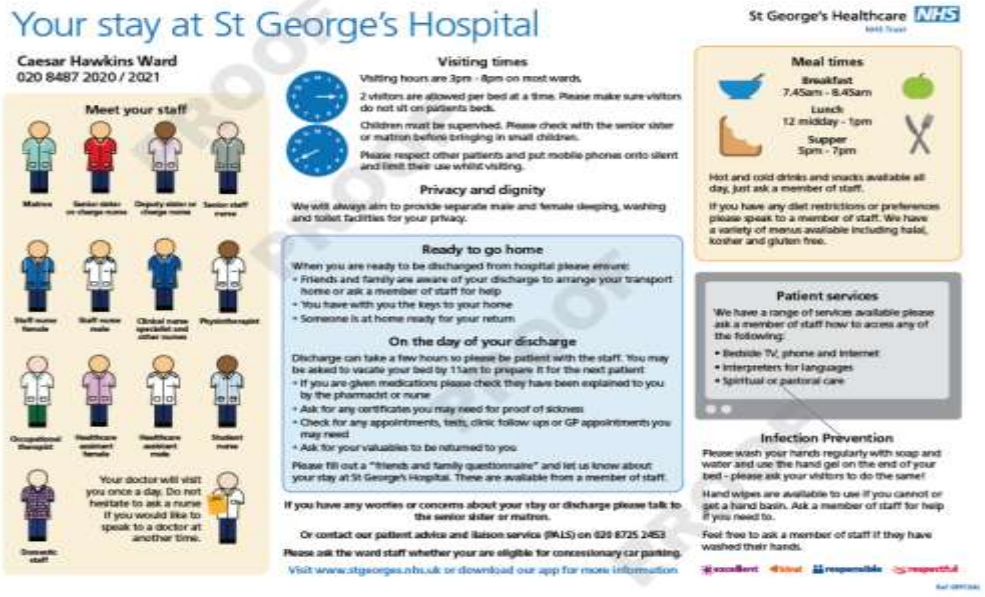
Nutrition: August 2014
- Current Position and Key Actions

Mandatory Food Standards for hospitals were introduced in August 2014 and hospitals will now be ranked on NHS Choices for food quality. The standards include:

- Hospitals should screen patients for malnutrition and all patients should have a food plan
  - · Hospitals should provide patients with assistance to support eating and drinking including initiatives such as protected meal times;
  - · Hospital canteens must promote healthy diets for staff and visitors – the food offered will need to comply with government recommendations on salt, saturated fats and sugar;
  - · Food must be sourced in a sustainable way in line with Government Buying Standards

A The latest patient inspections data has been published on NHS Choices and shows how each hospital performs on:

Quality of Food	Choice of Food
Menu approved by a dietitian	Fresh fruit always available
Food available between meals	Choice at breakfast
Cost of food services per patient per day	



Placemats on each bedside table – visual information for patients

Nutrition: August 2014
- Current Position and Key Actions

Key Actions

1. Nutrition assessments in place for all patients within 24 hours of admission , regular twice yearly audits undertaken as part of the Protected Mealtime audit. 87% compliance in April 2014 for nutrition assessment within 24 hours . Care plan is integrated into assessment document, needs further work to ensure they are individualised .
2. Volunteers assist with mealtimes 90% of patients helped in a timely way (Apr 14) and red tray system in place to identify patients requiring assistance . Placemats on each bedside table providing visual information for patients (above)
3. Policies in place for Nutrition and Hydration, Nutrition support and Paediatric policy in development. Governance structures embedded with reports to Nutrition strategy and active Nutrition operational groups held monthly for both adults and children . Regular reports to Patient Experience Committee . Focus on Hydration Awareness in August with displays , quizzes and challenges in acute and QMH settings .
4. Patients are involved at PEC ,and lead the PLACE assessments . Also involved in Quality inspections
5. A range of snacks , soups and sandwiches available 24/7 . Maternity has a dedicated a la carte menu available 24 hours
6. Dietitians are closely involved in setting the menus, training staff and review of assessment tools
7. Education available at Nurse Induction and HCA Induction , Nutrition Link nurses study day twice a year , included in Harm Free care study day
8. All catering specifications are based on the government buying standards. There are a range of healthy foods and snacks for patients and staff as part of the standard menu . All full fat drinks have been replaced in the vending machines with diet/ low sugar options.
9. A sustainable food management plan is in place and is being revised due to changes in guidance
10. 20 different menus are now in operation across the trust including the provision of cultural meals including Halal, Asian Vegetarian, Kosher, and African and West African meals and a set of menus for dysphagia for those patients with different swallowing needs and a set of paediatric menus.

Workforce

7. Workforce: August 2014
- Safe Staffing profile for inpatient areas

Fill rate indicator return
Staffing: Nursing, midwifery and care staff

Org: RJ7 St George's Healthcare NHS Trust

Period: July_2014-15

Please provide the URL to the page on your trust website where your staffing information is available

http://www.stgeorges.nhs.uk/about/performance/safe-staffing-levels/

Validation alerts (see control panel)	Hospital Site Details		Ward name	Main 2 Specialties on each ward		Day				Night				Day		Night	
						Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff					
	Site code *The Site code is automatically populated when a Site name is selected	Hospital Site name		Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
	RJ701	St George's Hospital (Tooting) - RJ701	Cardiothoracic Intensive Care Unit	170 - CARDIOTHORACIC SURGERY	320 - CARDIOLOGY	7792.62	6583.28	86.00	0.00	7210.50	6514.00	253.00	230.50	84.5%	0.0%	90.3%	91.1%
	RJ701	St George's Hospital (Tooting) - RJ701	Carmen Suite	501 - OBSTETRICS		1584.00	1465.83	426.00	363.00	1364.00	1320.00	341.00	319.00	92.5%	85.2%	96.8%	93.5%
	RJ701	St George's Hospital (Tooting) - RJ701	Champneys Ward	502 - GYNAECOLOGY		1864.50	1735.50	414.00	252.00	682.00	660.00	363.50	352.50	93.1%	60.9%	96.8%	97.0%
	RJ701	St George's Hospital (Tooting) - RJ701	Delivery Suite	501 - OBSTETRICS		3937.50	3785.00	817.50	756.00	3756.00	3409.00	737.00	649.00	96.1%	92.5%	90.8%	88.1%
	RJ701	St George's Hospital (Tooting) - RJ701	Fred Hewitt Ward	420 - PAEDIATRICS		721.50	1178.25	851.75	924.00	1069.50	1104.00	805.00	793.50	163.3%	108.5%	103.2%	98.6%
	RJ701	St George's Hospital (Tooting) - RJ701	General Intensive Care Unit	192 - CRITICAL CARE MEDICINE		6683.00	5661.50	448.50	198.50	6336.50	5921.50	126.50	126.50	84.7%	44.3%	93.5%	100.0%
	RJ701	St George's Hospital (Tooting) - RJ701	Gwillim Ward	501 - OBSTETRICS		2149.00	2052.50	981.00	987.50	1418.00	1517.00	1474.00	704.00	95.5%	100.7%	107.0%	47.8%
	RJ701	St George's Hospital (Tooting) - RJ701	Jungle Ward	171 - PAEDIATRIC SURGERY	420 - PAEDIATRICS	1893.50	1607.00	0.00	0.00	0.00	0.00	0.00	0.00	84.9%	#DIV/0!	#DIV/0!	#DIV/0!
	RJ701	St George's Hospital (Tooting) - RJ701	Neo Natal Unit	420 - PAEDIATRICS	192 - CRITICAL CARE MEDICINE	9211.5	6476.92	302.5	247.5	7844	5863.25	242	395	70.3%	81.8%	74.7%	163.2%
	RJ701	St George's Hospital (Tooting) - RJ701	Neuro Intensive Care Unit	192 - CRITICAL CARE MEDICINE	150 - NEUROSURGERY	4978.17	4668.02	389.50	301.17	4795.50	4668.50	391.00	399.50	93.8%	77.3%	97.4%	102.2%
	RJ701	St George's Hospital (Tooting) - RJ701	Nicholls Ward	171 - PAEDIATRIC SURGERY	420 - PAEDIATRICS	2888.75	2288.30	432.00	384.25	2002.00	1831.75	352.00	352.00	79.2%	88.9%	91.5%	100.0%
	RJ701	St George's Hospital (Tooting) - RJ701	Paediatric Intensive Care Unit	192 - CRITICAL CARE MEDICINE	420 - PAEDIATRICS	4073.50	2330.86	1021.75	586.75	3576.50	2564.25	414.00	377.25	57.2%	57.4%	71.7%	91.1%
	RJ701	St George's Hospital (Tooting) - RJ701	Pinckney Ward	420 - PAEDIATRICS		2473.00	1996.00	408.00	220.00	1794.00	1702.00	172.50	172.50	80.7%	53.9%	94.9%	100.0%
	RJ701	St George's Hospital (Tooting) - RJ701	Dalby Ward	300 - GENERAL MEDICINE		1596.00	1355.25	2085.50	2109.75	1081.00	1046.50	1414.50	1380.00	84.9%	101.2%	96.8%	97.6%
	RJ701	St George's Hospital (Tooting) - RJ701	Heberden	300 - GENERAL MEDICINE		1706.75	1454.75	2093.00	2243.25	1150.00	1092.00	1334.00	1345.50	85.2%	107.2%	95.0%	100.9%
	RJ731	Queen Marys Hospital (Roehampton) - RJ731	Mary Seacole Ward	400 - NEUROLOGY	314 - REHABILITATION	2778.00	2390.75	2702.25	2651.25	1782.50	1758.83	1827.75	1803.50	86.1%	98.1%	98.7%	98.7%
	RJ701	St George's Hospital (Tooting) - RJ701	A & E Department	180 - ACCIDENT & EMERGENCY		10387.00	9612.92	1583.50	1283.00	9047.50	8403.42	1069.50	921.50	92.5%	81.0%	92.9%	86.2%
	RJ701	St George's Hospital (Tooting) - RJ701	Allingham Ward	100 - GENERAL SURGERY		2045.75	1586.75	909.50	970.00	1104.00	1046.50	1058.00	1046.50	77.6%	106.7%	94.8%	98.9%
	RJ701	St George's Hospital (Tooting) - RJ701	Amyand Ward	300 - GENERAL MEDICINE		2416.00	1735.75	1570.25	1548.00	1449.00	1029.50	1161.50	1177.50	71.8%	98.6%	71.0%	101.4%
	RJ701	St George's Hospital (Tooting) - RJ701	Belgrave Ward AMW	320 - CARDIOLOGY		2681.00	2349.75	1363.00	1169.25	1792.50	1700.50	425.50	402.50	87.6%	85.8%	94.9%	94.6%
	RJ701	St George's Hospital (Tooting) - RJ701	Benjamin Weir Ward AMW	320 - CARDIOLOGY		2693.50	2349.50	622.00	542.50	1713.50	1575.50	241.50	253.00	87.2%	87.2%	91.9%	104.8%
	RJ701	St George's Hospital (Tooting) - RJ701	Buckland Ward	361 - NEPHROLOGY		2012.50	1663.25	552.00	420.00	1092.50	1069.50	368.00	379.50	82.6%	76.1%	97.9%	103.1%
	RJ701	St George's Hospital (Tooting) - RJ701	Caroline Ward	170 - CARDIOTHORACIC SURGERY		1950.00	1602.00	800.00	615.00	1437.50	1368.25	0.00	23.00	82.2%	76.9%	95.2%	#DIV/0!
	RJ701	St George's Hospital (Tooting) - RJ701	Cheselden Ward	100 - GENERAL SURGERY		1906.50	1730.75	385.50	344.25	1081.00	1045.75	241.50	241.50	90.8%	89.3%	96.7%	100.0%
	RJ701	St George's Hospital (Tooting) - RJ701	Coronary Care Unit	320 - CARDIOLOGY	170 - CARDIOTHORACIC SURGERY	2020.25	2088.25	280.75	290.75	1782.50	1748.00	138.00	138.00	103.4%	103.6%	98.1%	100.0%
	RJ701	St George's Hospital (Tooting) - RJ701	James Hope Ward	320 - CARDIOLOGY		1484.75	1263.75	150.00	127.50	460.00	448.50	0.00	0.00	85.1%	85.0%	97.5%	#DIV/0!
	RJ701	St George's Hospital (Tooting) - RJ701	Marnham Ward	300 - GENERAL MEDICINE		2461.50	2124.00	1168.25	1433.50	1782.50	1759.00	849.50	826.50	86.3%	122.7%	98.7%	97.3%
	RJ701	St George's Hospital (Tooting) - RJ701	McEntee Ward	300 - GENERAL MEDICINE		1795.75	1367.00	885.75	1003.75	724.50	713.00	1035.00	989.00	76.1%	113.3%	98.4%	95.6%
	RJ701	St George's Hospital (Tooting) - RJ701	Richmond Ward	300 - GENERAL MEDICINE		5583.50	4707.45	3200.50	2678.09	4051.50	3830.08	2587.50	2655.25	84.3%	83.7%	94.5%	102.6%
	RJ701	St George's Hospital (Tooting) - RJ701	Rodney Smith Med Ward	302 - ENDOCRINOLOGY		1931.50	1647.75	1015.75	930.66	1081.00	1069.50	747.50	736.00	85.3%	91.6%	98.9%	98.5%
	RJ701	St George's Hospital (Tooting) - RJ701	Ruth Myles Ward	303 - CLINICAL HAEMATOLOGY		1500.00	1349.50	581.50	643.50	1035.00	1035.00	387.00	375.50	90.0%	110.7%	100.0%	97.0%
	RJ701	St George's Hospital (Tooting) - RJ701	Trevor Howell Ward	370 - MEDICAL ONCOLOGY		2088.00	1918.75	997.50	890.00	1092.50	1081.00	851.00	851.00	91.9%	89.2%	98.9%	100.0%
	RJ701	St George's Hospital (Tooting) - RJ701	Winter Ward (Caesar Hawkins)	300 - GENERAL MEDICINE		1976.00	1584.00	855.75	848.50	1476.00	1332.50	713.00	613.50	80.2%	99.2%	90.3%	86.0%
	RJ701	St George's Hospital (Tooting) - RJ701	Brodie Ward	150 - NEUROSURGERY		1303.50	1031.50	747.00	735.50	1069.50	1057.50	0.00	0.00	79.1%	98.5%	98.9%	#DIV/0!
	RJ701	St George's Hospital (Tooting) - RJ701	Cavell Surg Ward	100 - GENERAL SURGERY		2271.00	1967.48	868.33	600.50	1343.00	1046.50	463.50	345.00	86.6%	69.2%	77.9%	74.4%
	RJ701	St George's Hospital (Tooting) - RJ701	Florence Nightingale Ward	120 - ENT		2638.00	2706.00	766.50	658.00	2139.00	2093.00	138.00	126.50	102.6%	85.8%	97.8%	91.7%
	RJ701	St George's Hospital (Tooting) - RJ701	Gray Ward	100 - GENERAL SURGERY		2524.75	1978.34	1066.00	971.50	1364.00	1358.50	352.50	363.00	78.4%	91.1%	99.6%	103.0%
	RJ701	St George's Hospital (Tooting) - RJ701	Gunning Ward	110 - TRAUMA & ORTHOPAEDICS		2410.25	2160.04	1051.67	956.63	1575.25	1519.00	424.25	421.50	89.6%	91.0%	96.4%	99.4%
	RJ701	St George's Hospital (Tooting) - RJ701	Gwynne Holford Ward	400 - NEUROLOGY		1488.00	1261.00	1312.25	1331.50	713.00	702.00	1012.50	1012.50	84.7%	101.5%	98.5%	100.0%
	RJ701	St George's Hospital (Tooting) - RJ701	Holdsworth Ward	110 - TRAUMA & ORTHOPAEDICS		1917.00	1700.50	804.00	695.25	1069.50	1035.00	713.00	711.50	88.7%	86.5%	96.8%	99.8%
	RJ701	St George's Hospital (Tooting) - RJ701	Keate Ward	160 - PLASTIC SURGERY		1798.50	1706.50	612.50	592.50	1104.00	1092.50	103.50	115.00	94.9%	96.7%	99.0%	111.1%
	RJ701	St George's Hospital (Tooting) - RJ701	Kent Ward	400 - NEUROLOGY		2255.00	1961.00	1506.75	1626.75	1587.00	1518.00	1242.00	1242.00	87.0%	108.0%	95.7%	100.0%
	RJ701	St George's Hospital (Tooting) - RJ701	Mckissock Ward	150 - NEUROSURGERY		2223.98	1764.50	1277.75	1010.50	1529.50	1447.75	529.00	540.50	79.3%	79.1%	94.7%	102.2%
	RJ701	St George's Hospital (Tooting) - RJ701	Vernon Ward	101 - UROLOGY		2746.50	2374.00	900.00	740.25	1419.00	1366.00	341.00	341.00	86.4%	82.3%	96.3%	100.0%
	RJ701	St George's Hospital (Tooting) - RJ701	William Drummond HASU	400 - NEUROLOGY		3120.00	2705.50	845.00	588.50	2898.00	2608.00	713.00	587.50	86.7%	69.6%	90.0%	82.4%
	RJ701	St George's Hospital (Tooting) - RJ701	Wolfson Centre	400 - NEUROLOGY	314 - REHABILITATION	1734.00	1333.50	1760.00	1749.76	713.00	715.67	1092.00	1092.00	76.9%	99.4%	100.4%	100.0%

7. Workforce: August 2014
- Safe Staffing profile for inpatient areas

Overview

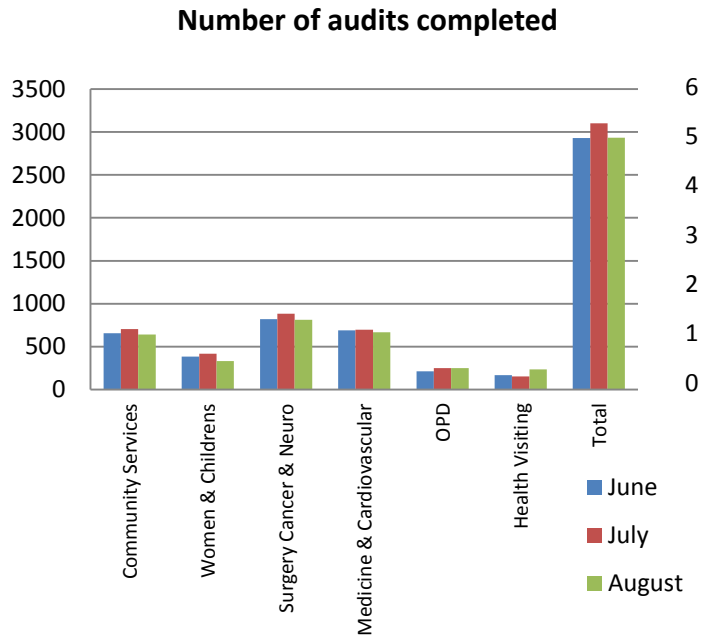
The information provided on the table above relate to staffing numbers at ward/department level submitted nationally on Unify in August 2014. In line with new national guidance this table shows the number of filled shifts for registered and unregistered staff during day and night shifts. With the August submission the trust achieved an average fill rate of 89.3% a reduction from the July submission. 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.

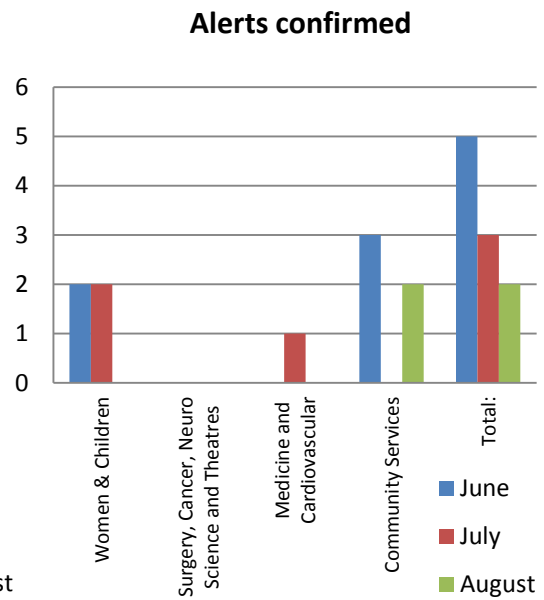
- The data does not take into account the on-going considerations for ward managers in ensuring that on each shift there is the right level of experience and expertise in the ward team.
- The nature of each ward varies. The number and type of patients seen on some wards will be relatively consistent.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

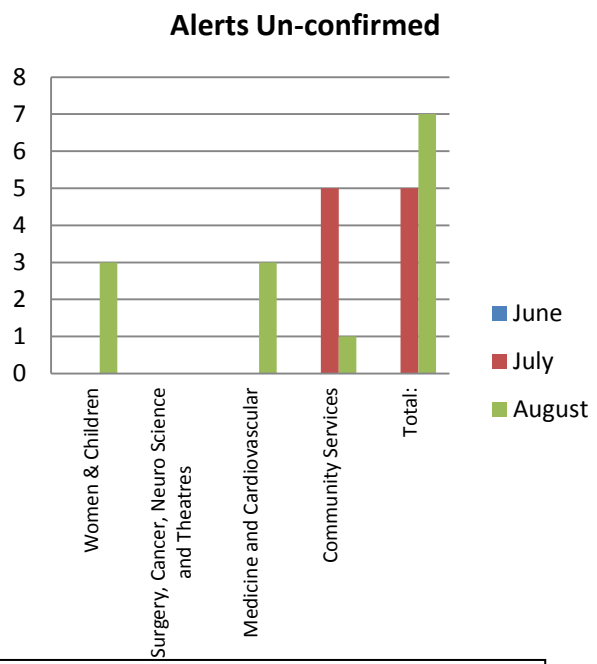
Actions

- The Nursing programme board is now driving forward the recommendations from the review. The remit of the board is being increased to coordinate a Trust wide Nursing/ Midwifery Recruitment and retention programme. This will include HR and Divisional representation to support coordination of activities with existing programmes of work.
- A high level plan has now been developed to indicate the numbers of registered staff required over the next 12 month period taking into account, vacancy factor, turnover, increased capacity and the establishment review. Focus will now be on delivery of the plan and ensuring there is clear sight of progress against the plan and risk.
- 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. This action is now completed.
- 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.

7. Workforce : August 2014 - Safe Staffing alerts







Overview: The safe staffing audit is completed on a daily basis across the trust. Wandsworth Prison have agreed criteria for safe staffing and training in the prison will be completed by the end of September. 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 escalation and interventions that can be undertaken to make areas safe. The total number of safe staffing audits completed over the past three months were: June 2930, July 3103 and August 2933. The number of final alerts reported increased from 3 in July to 6 in August, there are a further 8 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. The main risk is the failure to close down alerts on a daily basis. Work is required to improve the escalation system.

Actions: To aim to commence the audit in HMS prison Wandsworth by 1 October 2014. Continue to update safe staffing policy as required. Continue to urge senior nurses to close down alerts by 5pm on the same day.

Heatmap Dashboard
Ward View

8. Ward Heatmaps: August 2014

		INCIDENCE OF C.DIFFICILE	INCIDENCE OF MRSA	TRUST ACQUIRED PRESSURE SORES	PERCENTAGE OF HARM FREE CARE	PATIENT SATI SFACTION (F RIEND..	FRIENDS & FAMILY RESPONSE RATE	WARD STAFFING: UNFILLED DUTY HOURS	FALLS (WARD LEVEL)	SERIOUS INCIDENTS (WARD LEVEL)	VACANCY RATE	WARD SICKNESS
Children & Women's	CARDIOTHORACIC INTENSIVE CARE U..	1.0	0.0	0.0	100.0			13.1	0.0	0.0	10.0	3.9
	CARMEN SUITE	0.0	0.0	0.0	100.0			6.6	0.0	0.0	39.8	2.2
	CHAMPNEYS	0.0	0.0	0.0	100.0	80.0	4.3	9.7	0.0	0.0	24.7	6.7
	DELIVERY	0.0	0.0	0.0	100.0			7.0	0.0	1.0	15.4	2.7
	FREDDIE HEWITT	0.0	0.0	0.0	100.0			-16.0	0.0	0.0	11.7	2.9
	GENERAL ICU/HDU	0.0	0.0	1.0	87.5			12.4	0.0	1.0	7.5	4.8
	GWILLIM	0.0	0.0	0.0	100.0			12.6	0.0	0.0	-4.0	5.7
	JUNGLE	0.0	0.0	0.0				15.2	0.0	0.0	-20.3	1.4
	NEONATAL ICU	0.0	0.0	0.0	100.0			26.2	0.0	0.0	15.7	3.4
	NEURO ICU	0.0	0.0	1.0	91.7			4.9	0.0	1.0	6.7	2.4
	NICHOLLS	0.0	0.0	0.0	0.0			14.4	0.0	0.0	20.1	7.4
	PICU	0.0	0.0	0.0	0.0			35.5	0.0	0.0	10.4	6.9
	PINCKNEY	0.0	0.0	0.0	100.0			15.6	0.0	0.0	-92.4	2.3
Medicine & Cardiovascular	ALLINGHAM	0.0	0.0	1.0	92.3	52.9	28.3	9.1	5.0	1.0	14.7	6.1
	AMYAND	0.0	0.0	0.0	89.7	33.3	5.0	16.8	3.0	0.0	6.7	7.7
	BELGRAVE	0.0	0.0	0.0	100.0	71.4	15.4	10.2	7.0	0.0	27.8	2.0
	BENJAMIN WEIR	0.0	0.0	0.0	100.0	67.9	47.5	10.4	6.0	0.0	9.1	0.6
	BUCKLAND	0.0	0.0	0.0	100.0	94.1	22.7	12.2	2.0	0.0	16.0	3.0
	CAESAR HAWKINS	1.0	0.0	0.0	82.4	66.7	12.4	12.8	5.0	0.0	14.8	3.3
	CARDIAC CARE UNIT	0.0	0.0	0.0	100.0	75.0	100.0	-1.0	0.0	0.0	-24.1	1.0
	CAROLINE	0.0	0.0	0.0	100.0	56.8	35.9	13.8	3.0	0.0	-3.8	4.3
	CHESELDEN	0.0	0.0	0.0	89.5	83.3	52.5	7.0	0.0	0.0	10.1	2.5
	DALBY	0.0	0.0	0.0	86.4	40.0	83.3	4.6	6.0	0.0	17.6	11.0
	EMERGENCY DEPARTMENT	0.0	0.0	0.0		0.0	0.0	8.5	3.0	0.0	12.6	2.9
	HEBERDEN	0.0	0.0	0.0	75.0	66.7	33.3	2.4	7.0	0.0	17.3	6.7
	JAMES HOPE	0.0	0.0	0.0	100.0	90.6	100.0	12.2	0.0	0.0	12.8	0.6
	MARNHAM	0.0	0.0	1.0	84.0	36.4	18.3	1.9	2.0	1.0	18.2	6.2
	MCENTEE	0.0	0.0	0.0	100.0	76.9	56.5	8.3	3.0	0.0	13.7	5.4
	RICHMOND	2.0	0.0	0.0	94.1	58.8	32.2	10.1	9.0	0.0	16.8	3.0
	RODNEY SMITH	0.0	0.0	0.0	89.3	66.7	48.6	8.2	5.0	0.0	6.9	4.9
	RUTH MYLES	1.0	0.0	0.0	100.0	100.0	0.0	2.9	0.0	0.0	30.4	1.4
	TREVOR HOWELL	0.0	0.0	1.0	89.5	52.9	41.5	5.7	6.0	1.0	3.0	2.4
Surgery & Neurosciences	BRODIE NEURO	0.0	0.0	0.0	93.3	81.8	50.0	9.5	3.0	0.0	3.8	6.2
	CAVELL	0.0	0.0	0.0	100.0	39.0	43.6	19.9	2.0	0.0	18.2	2.8
	FLORENCE NIGHTINGALE	0.0	0.0	0.0	100.0	67.9	77.3	1.7	1.0	0.0	21.1	3.6
	GRAY WARD	0.0	0.0	0.0	100.0	63.7	43.1	12.0	1.0	0.0	-14.5	4.6
	GUNNING	0.0	0.0	0.0	96.4	50.0	89.6	7.4	3.0	0.0	11.1	6.8
	GWYN HOLFORD	0.0	0.0	0.0	96.3	90.9	100.0	4.8	6.0	0.0	7.3	4.0
	HOLDSWORTH	0.0	0.0	0.0	95.2	60.0	54.8	8.0	3.0	0.0	19.0	6.9
	KEATE	0.0	0.0	0.0	100.0	70.6	30.4	3.1	1.0	0.0	26.3	0.5
	KENT	0.0	0.0	1.0	100.0	51.4	50.7	3.7	7.0	1.0	14.8	2.4
	MARY SEACOLE	0.0	0.0	0.0	85.4	61.1	0.0	5.3	8.0	0.0	-12.0	8.5
	MCKISSOCK	0.0	0.0	1.0	100.0	50.0	25.0	14.3	5.0	1.0	13.1	11.8
	VERNON	0.0	0.0	0.0	100.0	65.2	50.4	10.8	6.0	0.0	25.5	1.3
	WILLIAM DRUMMOND HASU	0.0	0.0	0.0	100.0	77.8	16.8	12.8	4.0	0.0	14.1	0.4

8. Ward Heatmaps: August 2014

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

GICU

I grade 3 pressure ulcer on heel, deemed as unavoidable, and liable to be part of the initial injury. There is on-going work across critical care in regard to pressure ulcers, this includes a number of projects such as 'hotspots' and work being carried out with the ICU's at the Freeman Hospital in Newcastle. This pressure ulcer also accounts for the serious incident attributed to GICU (2nd red flag).

The safety thermometer score relates to old pressure ulcers not acquired within ITU and 1 missing section on 1 patient's VTE paperwork. There is on-going work within the unit with the Senior Pharmacist and junior medical staff to improve compliance with VTE assessment.

Champneys

FFT response rate 4.3 – additional work required with substantive staff to ensure that this questionnaire is administered at times when there is significant reliance on temporary staff

Vacancy rate of 24.7% - on going recruitment – with new starters awaited and attendance at the monthly trust assessment days

Sickness rate 6.7% - introduction of bi monthly sickness meetings across the division to ensure adequate HR support in relation to sickness management and application of policy.

Surgical, Theatres, Cancer and Neurosciences Division:

Kent

Trust acquired pressure sore and SI one of the same. Grade 3 – unavoidable
Falls – one patient fell on three occasions – now specialled. Remaining four falls were four different patients.

(NB For Vernon they have 1 red flag for Falls for a total of 6 falls but there were only actually 3 Falls in total and 1 patient has been reported for the same fall 4 times. Unfortunately whilst all the DATIX are seen immediately by myself or the Matron by the time a more formal review can be completed the deadline for the submission externally has gone and inaccurate data is therefore already reported. Internal data improves the picture and acknowledged risk but that doesn't help the external Trust picture.

Mckissock

Trust acquired pressure sore and SI one of the same. Grade 3 went from grade 2 – 3 in 72 hours probably avoidable poor documentation.

Falls – Five different patients – unfortunately nature of the patients.

Actions for Neuro.
In relation to the pressure ulcers there is a big drive on Kent and Mckissock to improve all documentation and the initial assessment when the patient is admitted to the ward.

As regards the falls, where possible patients are co-horted with the use of specials, in an attempt to decrease the HCA spend on specials and to improve safety. There is ongoing education for the staff continually raising the awareness of the patient's needs. E.g. head injury likely increased risk of falling due to the nature of their illness. There is an inherent challenge with patients undergoing rehab to balance the continuing move towards independence preventing falls. Falls Assessments are done well in neuro but the assessment and the care plan has it's limitations.

8. Ward Heatmaps: August 2014

Community Division:

Mary Seacole

FFT – In August Mary Seacole Ward asked 18 patients the survey, 72% said they were extremely likely to recommend. 16% were likely to recommend. Each Month the results reviewed and shared with staff.

Harm free care - Most of the harms are inherited , less harms reported this month than the previous 3 months (41 patients surveyed. 2 old grade 3 and 1 old grade 2 (inherited) pressure ulcers were reported. 2 patients had a new catheter associated UTI (trust acquired) and 3 had old catheter associated UTI.)The red is the harm that relates to the ward and is significantly lower than the previous 3 months. Mary Seacole ward Band 6/7 staff are doing a thorough senior review of 6 patients every day on top of individual nurses reviews.

Falls - Following an increase in falls in April 2014 (16 falls) we set up a small working group to look at the issues for Mary Seacole. This group is led by Lou Briggs and we have now reduced Falls month on month. We had 8 falls on a 42 bed rehabilitation ward in the month of August we are continuing to look at ways to reduce falls .

For Areas within the Medical and Cardiovascular Division:

Allingham – 1 grade 2 PU deteriorated to grade 3 giving 2 flags, 1 for PU and 1 for it being an SI. RCA in process, not yet known whether avoidable. 5 falls – all patients assessed and independent in their care. 3 of the patients have alcoholic liver disease. No additional actions identified as being needed.

Amyand – Harm free care audit identified 5 patients that had not started VTE prophylaxis. Action – VTE assessment added to PSAG board to highlight need to team. Only 5% patients surveyed in FFT – large number of patients unable to complete the survey due to frailty. Action – where appropriate family members asked to complete survey during visiting times. 16.8% unfilled duty hours – accurate and relates to vacancies from maternity leave and requests for specials unfilled. Staffing levels considered safe.

Caesar Hawkins – RCA for c diff infection showed it was likely to have been unavoidable with no care issues identified. Harm free care audit showed 5 falls within the month giving 2 flags – 1 for Harm free Care percentage and 1 for number of falls. Falls associated with postural hypotension and slips. Actions – ensuring patients have call bells and reminding them to ask for help. Ensuring patients well hydrated. CAUTI x 2, both patients admitted with infections. FFT 12.4% returns - new housekeeper in post to help collect patient feedback.

Marnham – 1 grade 3 PU giving 2 flags. RCA completed and shows probably was unavoidable. Harm free care audit identified – VTE assessments not completed. Action – Ward sister has discussed this with Cons and to be reviewed daily on board rounds. CAUTI – 2 patients had acquired UTIs. Training sessions set up for next 2 team days on catheter care and EWS. FFT 18.3% - staff reminded at handover and allocated the task on daily basis.
Trevor Howell – 1 grade 3 PU giving 2 flags. RCA has shown most likely to be unavoidable as patient was very poorly on end of life care and refusing care. Harm free care audit identified VTE and falls. 3 of the falls were found to be unavoidable others were related to vaso vagal events. Action - Matron reviewing previous events to see if they could have been anticipated and therefore prevented. Matron has discussed completion of VTE assessments with Care Group lead and taken to Consultant meeting.