St George's Healthcare NHS
NHS Trust

Quality Report

Trust Board
Month 6 - September 2014

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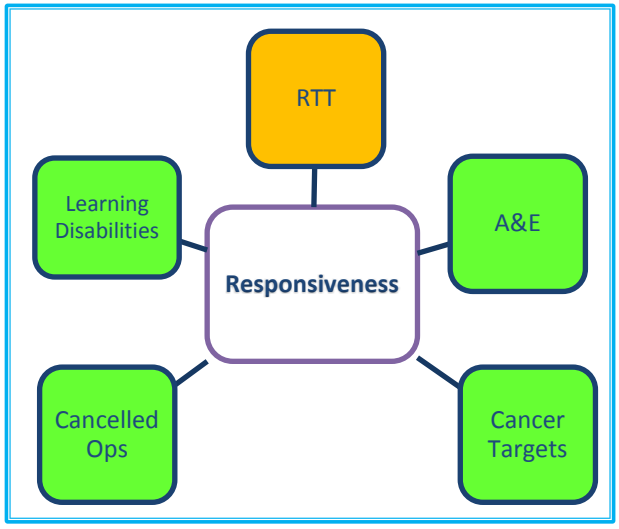
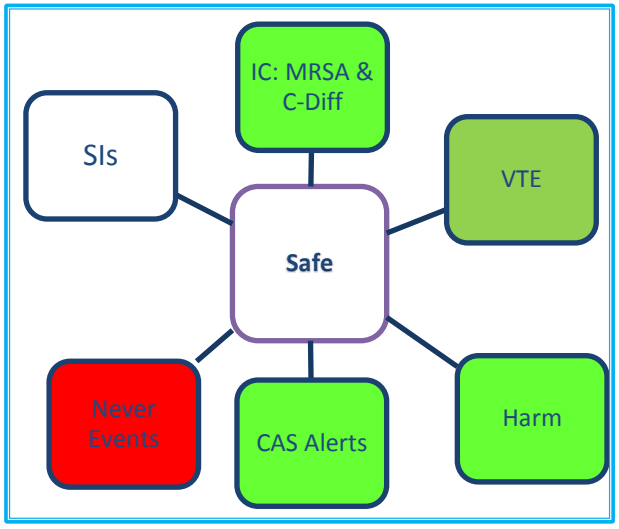
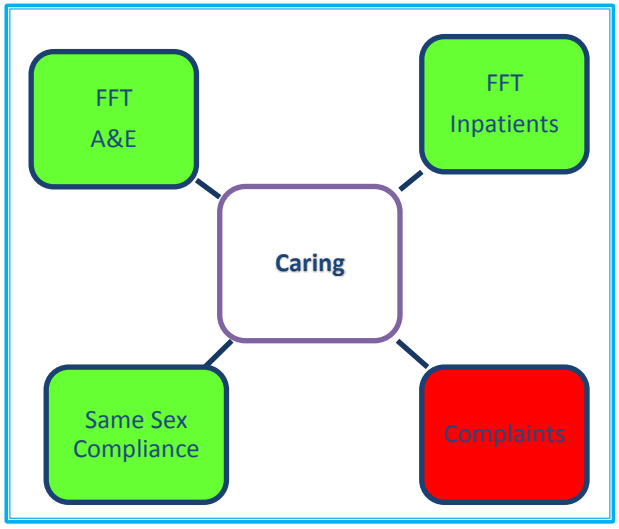
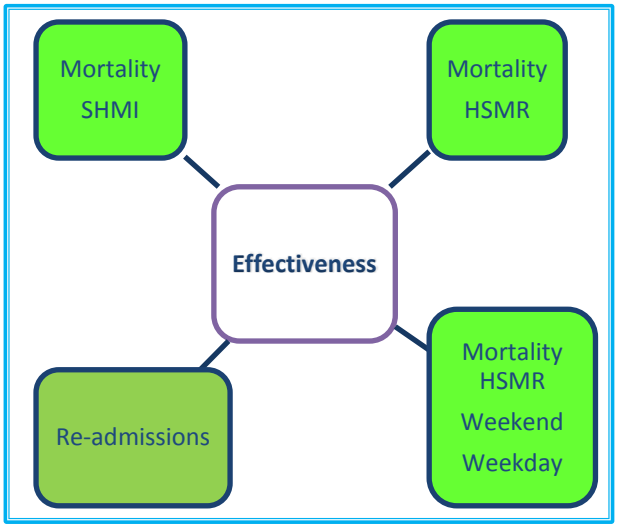
CONTENTS

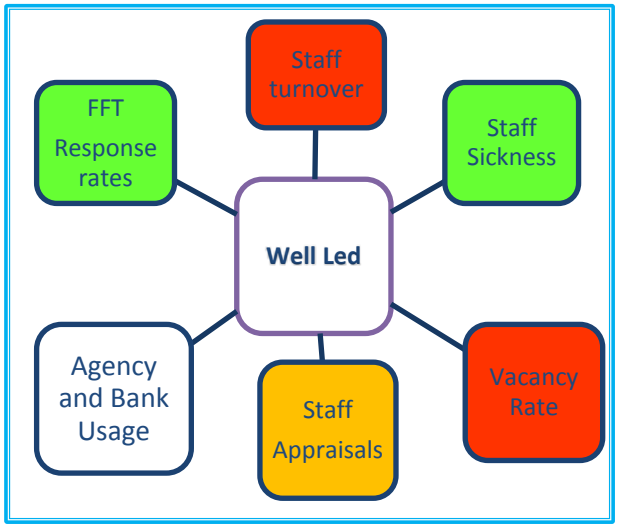
1. Executive Summary - Key Priority Areas September 2014











The above shows an overview of September 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 August 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: September 14 Performance

Responsiveness Domain					
Metric	**Standard**	**YTD**	**August**	**September**	**Movement**
Referral to Treatment Admitted	90%		85.2%	87.9%	
Referral to Treatment Non-Admitted	95%		95%	NYA*	
Referral to Treatment Incomplete	92%		91.36*	91.80%	
Referral to Treatment Incomplete 52+ Week Waiters	0		3	3	↑
Diagnostic waiting times > 6 weeks	1%		0.88%	0.57%	↓
A&E All Types Monthly Performance	95%	95.06%	94.33%	95.7%	↑
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 (Aug)**	**Movement**
Two Week Wait Standard	93%	94.8%	95.3%	94.29%	↓
Breast Symptom Two Week Wait Standard	93%	95.9%	94.5%	98.2%	↑
31 Day Standard	96%	98.4%	98.2%	98.5%	↑
31 Day Subsequent Drug Standard	98%	100.0%	100.0%	100.0%	→
31 Day Subsequent Surgery Standard	94%	98.7%	97.8%	100.0%	↑
62 Day Standard	85%	86.9%	86.8%	87.09%	↑
62 Day Screening Standard	90%	91.9%	90.4%	94.1%	↑
Domain Score			**5**		

Safe Domain					
Metric	**Standard**	**YTD**	**August**	**September**	**Movement**
Clostridium Difficile - Variance from plan	0	-1	-1	-1	→
MRSA bactaraemias	0	3	0	0	→
Never events	0	3	0	1	↓
Serious Incidents	0	99	12	19	↑
Percentage of Harm Free Care	95%		95.06%	94.52%	↓
Medication errors causing serious harm	0	0	0	0	→
Overdue CAS alerts	0	1	1	1	→
Maternal deaths	1	1	0	0	→
VTE Risk Assessment ((July)	95%		96.5%	96.5%	→
Domain Score			**3**		

Effectiveness Domain							
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**August**	**September**	**Movement**
Hospital Standardised Mortality Ratio (DFI)	100	5	0		77.7	77.7	↓
Hospital Standardised Mortality Ratio - Weekday	100	5	0		85.1	84.4	↓
Hospital Standardised Mortality Ratio - Weekend	100	5	0		83	82.2	↓
Summary Hospital Mortality Indicator (HSCIC)	100	5	0		79	80	→
Emergency re-admissions within 30 days following an elective or emergency spell at the Trust	5%	5	0	3.3%	3.5%	3.5%	→
Domain Score			**5**				

Caring Domain							
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**August**	**September**	**Movement**
Inpatient Scores from Friends and Family Test	60	5	0		65	65	→
A&E Scores from Friends and Family Test	46	5	5		62	75	↑
Complaints		5	0		92	94	↑
Mixed Sex Accommodation Breaches	0	2	0	4	0	0	→
Domain Score			**4**				

Well Led Domain							
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**August**	**September**	**Movement**
IP response rate from Friends and Family Test	30%	2	0		39%	46.5%	↑
A&E response rate from Friends and Family Test	20%	2	0		27.2%	26.3%	↓
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		16.3%	17.1%	↑
Trust level total sickness rate	3.50%	3	0		3.1%	3.3%	↑
Total Trust vacancy rate	11%	3	3		12.9%	13%	↑
Temporary costs and overtime as % of total paybill	3.50%	3	3		7.5%	9.34%	↑
Percentage of staff with annual appraisal - Medical	85%	1.5	0		85.2%	86.5%	↑
Percentage of staff with annual appraisal - non-medical	85%	1.5	1.5		80.8%	83.2%	↑
Domain Score			**3**				

Trust Overall Quality Score	4

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

Access							
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**August**	**Sept**	**Movement**
Referral to Treatment Admitted	90%	1	0		85.2%	87.94%	
Referral to Treatment Non Admitted	95%	1	0		95%	NYA	
Referral to Treatment Incomplete	92%	1	0		91.36%	91.80%	
A&E All Types Monthly Performance (Quarter to date)	95%	1	1	95.06%	94.33%	96.2%	⮟
				YTD	**July**	**Aug**	
62 Day Standard	85%	1	0	86.8%	86.7%	87.6%	⮝
62 Day Screening Standard	90%	1	0	91.2%	93.3%	95.1%	⮝
31 Day Subsequent Drug Standard	98%	1	0	100.0%	100.0%	100%	➤
31 Day Subsequent Surgery Standard	94%	1	0	98.3%	100%	100%	➤
31 Day Standard	96%	1	0	98.4%	98.9%	98%	⮟
Two Week Wait Standard	93%	1	0	95.3%	95.3%	93.1%	⮟
Breast Symptom Two Week Wait Standard	93%	1	0	95.6%	99.4%	97.3%	⮟

* NYA Not yet available

Outcomes							
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**August**	**Sept**	**Movement**
Clostridium Difficile - Variance from plan	0	1	0	-1	-1	-1	➤
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 (July and August)	50%	1			58%	53%	⮟
referral information	50%	1			92%	93%	⮝
treatment activity	50%	1			72%	71%	⮟

Trust Overall Quality Governance Score	1	1	➤

Green <1.0

Amber Green= >1 and <2

Amber/Red = >2 and <4

Red= >4

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

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

Note: From July – September 14 RTT admitted has been excluded from scoring as breaching the target has been 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 52+ Week Waits
- Never Event
- Workforce

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

St George's Healthcare NHS
NHS Trust

Clinical Audit and Effectiveness

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4. Clinical Audit and Effectiveness: September 2014 - Mortality

HSMR (Hospital standardised mortality ratio)						
Lead Director	September	October	Movement	2014/2015 Target	Forecast November 14	Date expected to meet standard
RGW	77.7	77.5	➢	<100	G	Met

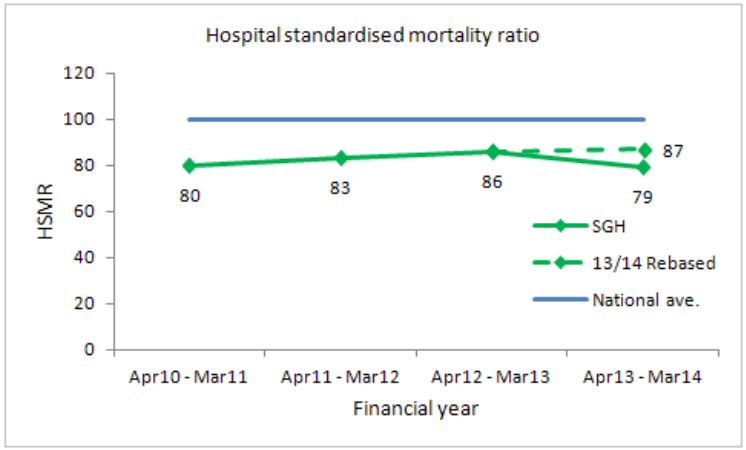
SHMI (Summary hospital-level mortality indicator)				
July 2013	Oct 2013	Jan 2014	April 2014	July 2014
0.81	0.81	0.81	0.78	0.80

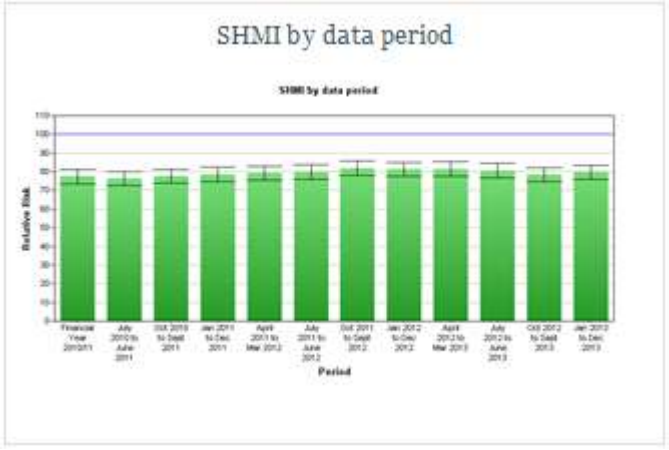
Note: Source for HSMR mortality data is Dr Foster Intelligence, published monthly. Data is most recent rolling 12 months available. For October 14 this was July 13 to June 14. SHMI data is published by the Health and Social Care Information Centre 6 months retrospectively. The last 12 month period as published on 30th July is reported and relates to the period January 2013 to December 2013. The publication of data for April 2013 to March 2014 is expected on 23rd October 2014.

Overview:

Our mortality measured by both the HSMR and the SHMI remains statistically significantly better than expected. Our SMR for both emergency weekday admissions and weekend admissions are also significantly better than expected at 84.4 and 82.2 respectively.

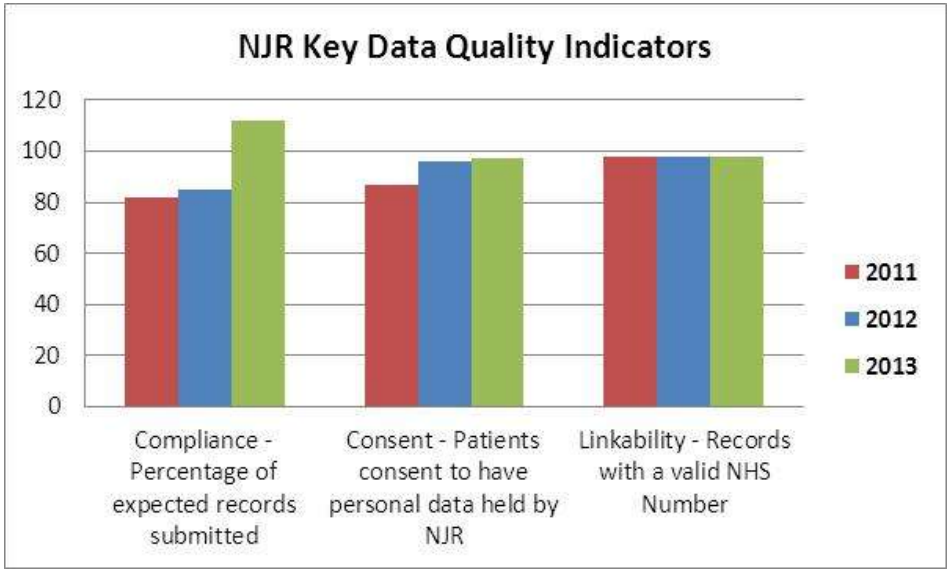
A CQC mortality outlier alert for CABG (other) was received on 11th September. The Dr Foster Unit at Imperial College identified a mortality alert for the period June 2013 to May 2014 with observed mortality of 8.5%, against an expected 3.5%. This equates to 12 deaths, from 141 spells. A signal in this procedure group had already been identified in January 2014 and investigated internally. Analysis of data submitted to the Society for Cardiothoracic Surgery (SCTS) did not demonstrate a mortality signal and showed this to be a complex group of patients with varied procedures. In response to the CQC request for further information the Associate Medical Director for governance led a multi-professional team to investigate cardiac surgery audit data and to complete detailed reviews for each patient. All were very high risk cases and many were tertiary referrals with only 2 local patients. Half of the patients included in the Dr Foster analysis would not have been included in this group on the SCTS as the grouping and risk modelling is much more specific. Importantly 3 cases would have been classified as 'salvage' and therefore excluded from analysis and only considered on an individual basis and a number of other cases would have been included in other procedure groups. Case reviews showed no consistent factors and no systemic care issues. Where any care issue has been identified in an individual patient, these issues are being managed through established governance processes in order to identify and share learning. The CQ has now reviewed the Trust's report and have concluded there 'is no need to undertake further enquiries' and there is 'no evidence of risk'.





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

National Joint Registry (NJR) Report 2014



NJR Key Data Quality Indicators	SGH	National
No. of Procedures in 2013	105 (112%)	205,686 (99.6%)
Consent Rate 2013	97%	91.8%
Linkability 2013	98%	95.1%
Outliers – 90 Day Mortality Hips	Not Outlier	
Outliers – 90 Day Mortality Knees	Not Outlier	
Outliers – Hip Revision Rate	Not Outlier	
Outliers – Knee Revision Rate	Not Outlier	

Compliance, Consent and Linkability are red if lower than 80%, green if 95% or more and amber in between.

Overview

The National Joint Registry was established in 2002 to improve patient care by finding out more about joint replacement implants and surgery. The 'key data quality indicators' of the NJR are compliance, consent and linkability. The chart above shows that for all three measures around data quality St George's performance has improved annually, or has been maintained at a high level. Our performance is also above the national average for these markers. Our patient consent rate was 97% which is better than national average of 91.8%,. Linkability, which is important in linking primary activity and revision activity, our performance is shown as green as it exceeds 95 per cent. As identified as an area for action last year our case submission rate has improved from 85% to 112%. The case submission rate (compliance) is greater than 100% as it is based on an estimate of the expected number of cases derived from Hospital Episode Statistics.

The report contains a significant amount of clinical data at an aggregated level and does not allow trust level comparison. Comparative data is only provided for assessment of outlier status for mortality and revision rates, and St George's is not an outlier for any of these measures.

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

College of Emergency Medicine Sepsis Audit 2013

Quest. No.	Standard	Timing	Target	SGH	Lower Quartile	National Median	Upper Quartile	Immediate plan	6-month plan	Responsible person
3	Vital signs (Temp, Pulse, RR, BP, O2 sats and mental status(GCS or AVPU) and recorded within 15mins of arrival	arrival	100%	52%	46%	62%	76%	Teaching session (medical and nursing) to improve complete documentation of initial observations	1)Automate data collection (currently being tested in silent-mode) ; 2)Commence sepsis course	NS & Sepsis link nurse
		Fully	100%	66%	80%	94%	98%			
		Fully / partially	100%	94%	97%	100%	100%			Sobi Ganges/AH/NH/NS
4	Capillary glucose measured and recorded within 15mins of arrival	Yes, within 15-20mins	100%	30%	26%	38%	42%	As above	As above	NS & Sepsis link nurse
		Yes	100%	82%	64%	76%	91%			Sobi Ganges/AH/NH/NS
5	High flow oxygen given	Before leaving ED	100%	44%	32%	45%	58%	Teaching session (medical and nursing) to encourage prescription of oxygen and completion of audit form in notes	As above	NS & Sepsis link nurse
		Within 1 hour		44%	16%	29%	42%			
		Not given and reason recorded		38%	6%	14%	34%			Sobi Ganges/AH/NH/NS
8	First IV crystalloid bolus given in the ED	Before leaving the ED	100%	88%	80%	88%	92%	Teaching session to encourage prescription of fluids and completion of audit form in notes	As above	NS & Sepsis link nurse
		Within 1 hour	75%	36%	31%	40%	52%			Sobi Ganges/AH/NH/NS
6	Serum lactate measured prior to leaving the ED	Any time	100%	94%	74%	84%	94%	As above	As above	NS & Sepsis link nurse
		Within 1 hour		70%	37%	49%	66%			Sobi Ganges/AH/NH/NS
7	Blood cultures obtained prior to leaving the ED	Any time	100%	58%	62%	77%	87%	As above	As above	NS & Sepsis link nurse
		Within 1 hour		24%	23%	40%	56%			Sobi Ganges/AH/NH/NS
9	Antibiotics administered in the ED	Before leaving the ED	100%	82%	88%	94%	97%	As above	As above	NS & Sepsis link nurse
		Within 1 hour	50%	26%	20%	32%	44%			Sobi Ganges/AH/NH/NS
10	Urine output commenced in the ED	Before leaving the ED	100%	46%	26%	38%	53%	As above	As above	NS & Sepsis link nurse
		Within 1 hour		20%	2%	7%	14%			Sobi Ganges/AH/NH/NS

Positive outlier compared to National data

Positive result at 75th centile

Poor result- Below 25th centile compared to National data

This audit summary and associated action plan was discussed at the ED Consultant's meeting on 24th September. Nationally results were poor, and the comparison above highlights key areas of performance. General actions include medical and nursing staff to complete the audit table in the ED notes for all septic patients, in order that performance can be measured and monitored. Regular audits are to be performed from October onwards. The ED lead is to hold regular project meetings to ensure progress and delivery on the above actions.

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

British Thoracic Society (BTS) Paediatric Bronchiectasis Report 2013/14

Overview

National incidence of this condition is low and therefore the report and recommendations are on a national level alone. The report identifies two recommendations for action.

BTS Recommendation 1) Children with bronchiectasis should be seen by a paediatric respiratory physiotherapist: Historically paediatric therapy service at St. George's has been poorly resourced, and there are pressures on therapists as they are bound by borough limits and in the main are Wandsworth Community based. Since the appointment of the paediatric respiratory consultant the trust has contributed 1.5 WTE paediatric physiotherapists to the team to increase time available for respiratory physiotherapy and offer some cover for regional work. We now have a nominal lead for Paediatric Respiratory Physiotherapy.

BTS Recommendation 2) A comprehensive investigation for underlying aetiology should be undertaken in all cases: SGH paediatric service routinely perform appropriate investigations for children identified as having bronchiectasis. This would include an immunology work up, serology for ABPA, investigations for reflux and aspiration, pulmonary function. We have the facility to perform nasal nitric oxide to screen for PCD and are able to do sweat testing for cystic fibrosis and CF genetics. Where the reason for bronchiectasis is apparent tests are requested are as required.

Additional actions are planned in order to further improve the service. From December 2014 we are starting a monthly bronchiectasis clinic as part of the respiratory clinic. For these clinics we are expecting the physiotherapist to be available to see children alongside the physician. It is anticipated that the development of a regular clinic will ensure a consistent approach to the performance of routine investigations.

National Heavy Menstrual Bleeding Audit: Final Report

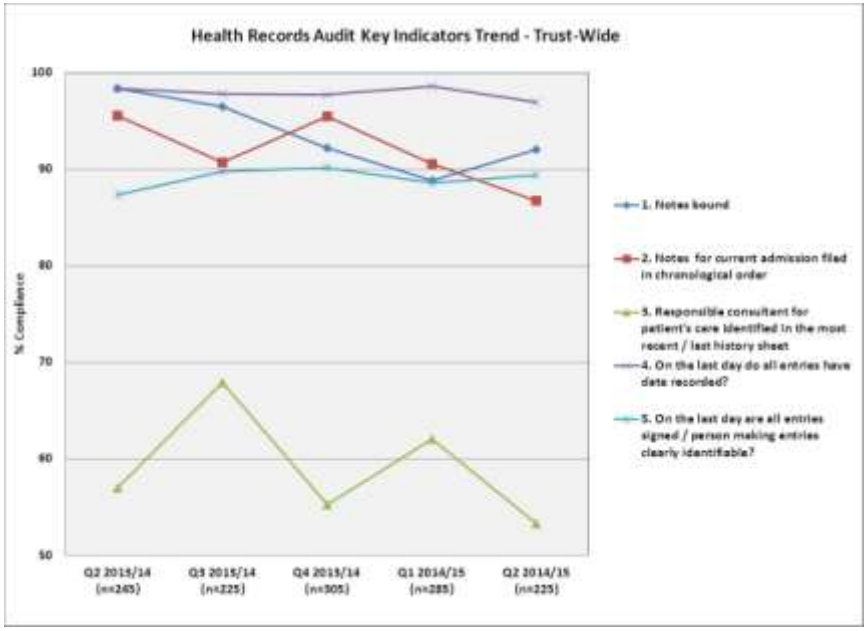
Overview

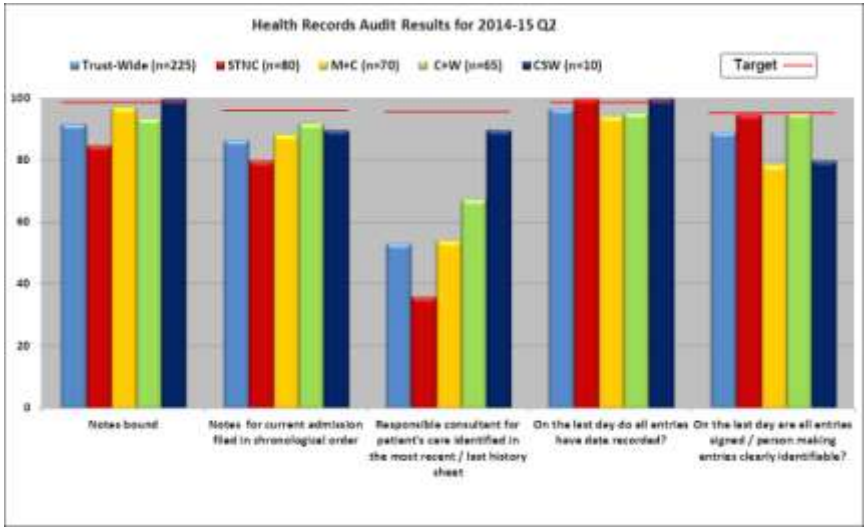
Heavy menstrual bleeding (HMB) is a common condition. It affects about 25% of women aged between 30 and 50 years. About 20% of the 1.2 million referrals to specialist gynaecologists services concern women with HMB. The national HMB audit aimed to use patient-reported outcomes as indicators for the quality of care received in the year after their first referral to a gynaecology outpatient clinic between 01/02/11 to 30/01/13 . These same women received follow up questionnaires one year later. Results for St George's reveal a 92.3% patient satisfaction rate after a first visit to outpatients, slightly higher than the national average.

The report found considerable variation across providers in the treatment of women with HMB. A number of recommendations were made, including earlier consideration of surgical intervention, as clinically appropriate, for women with severe symptoms and poor quality of life. The audit also found that the organisation of gynaecology outpatient clinics should be reviewed as only one-third of hospitals reported that they had a dedicated menstrual bleeding clinic, 90 per cent of which were 'one-stop'. St George's provides a range of clinics including a 'One-stop HMB clinic. Women referred by their GPs undergo a transvaginal ultrasound scan and a clinical consultation, with outpatient hysteroscopy and treatment as appropriate. A range of other gynaecology outpatient clinics also support the care of women, many of whom present with additional problems such as fibroids, endometriosis and/or polyps. The report also recommended additional improvements to patient information. Currently the gynaecology service have a wide range of patient information literature including outpatient hysteroscopy, fibroid treatment and endometrial ablation. The recommendation that written protocols should be more widely available is being considered by the service.

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

Healthcare Records Audit Report Q2 2014/15





Overview

Participation in the ongoing quarterly audit of record keeping standards is mandatory for all inpatient services. In Q2 responses from 22 care groups (n=225) were received. Seven specialties did not complete the audit (Neurosurgery, Neuro & Amputee, Respiratory, CIU, Diabetes & Endocrinology, Rheumatology and Vascular). Late submissions were received from Gastroenterology and T&O and were not included in the analysis. PICU, Paediatric Medicine, Paediatric Surgery and Renal were exempt from this audit as they have implemented electronic documentation.

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

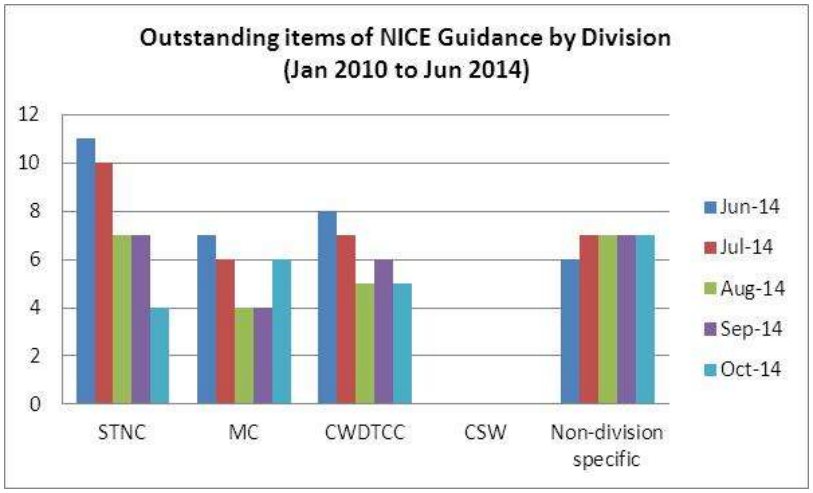
For most of the core standards improvement is required, with significant improvement required in the recording the responsible consultant on the history sheet.

A number of measures have been recommended at trust level, particularly around the improved access to patient labels, use of clinician name stamps, patient identification stickers and dividers in ward ring folders. Where the audit revealed that there is no access to a working label printer this has been reported to divisions for local resolution.

Local action will be required to improve standards and to this end care group results and divisional presentations are produced alongside the trust level report.

Since the Trust is moving towards electronic documentation the Health Records Committee in conjunction with the Clinical Audit team is planning to adapt the current audit tool to ascertain the quality of electronic documentation in addition to paper records. It is envisaged that the effectiveness and impact of this audit will be evaluated in the New Year.

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



Items of NICE Guidance Outstanding		
Division	**Jan10 to Jun13**	**Jan10 to Jun14**
STNC	39	4
M+C	6	6
CWDTCC	18	6
CS	9	0
Non-division specific	14	7
Total	86/363 (23.7%)	22/488 (4.5%)

Overview

There were 20 items of NICE guidance released in July and August 2014 and we have already received 13 responses, demonstrating increased clinical engagement. For guidance issued between January 2010 and June 2014 there are currently 22 items of guidance outstanding; a reduction of 2 from the previous report even with an additional month's guidance (June 2014) included. Significant progress has been made over the last year in compiling a more comprehensive picture of implementation. The table above demonstrates that the amount of guidance outstanding has decreased significantly, and now stands at 4.5 per cent.

Items of NICE Guidance with Compliance Issues (Jan 10 to Jun14)	
Division	**Number**
STNC	7
M+C	12
CWDTCC	11
CSW	0
Non-division specific	5

The monthly compliance reports produced by the audit team are now being used by M+C and CWDTCC divisions to assess risk s associated with non-compliance. It is expected that the outcome of these assessments will be reported to the Clinical Effectiveness and Audit Committee for oversight and escalation as appropriate. This information will be incorporated in future reports. Every 6 months the audit team conduct a review of compliance issues and ask for updated information from clinical leads so that progress and risk can be monitored. The next review will be carried out in December.

Patient Safety

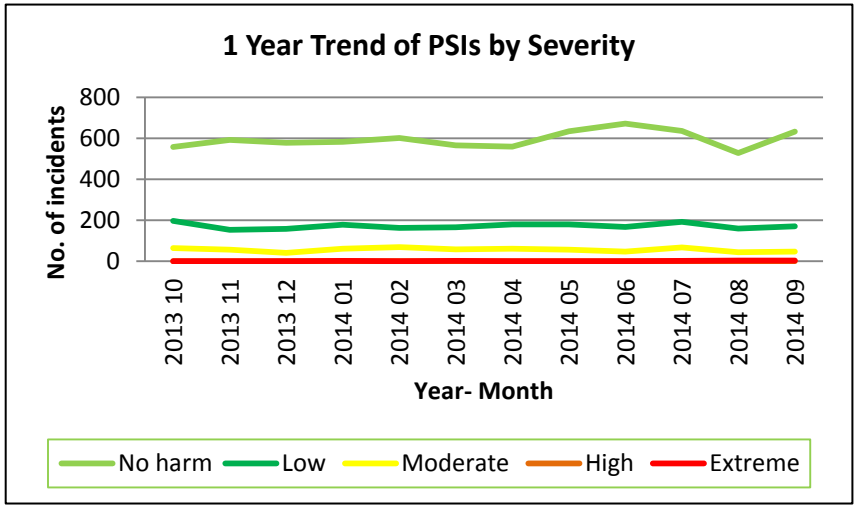
5. Patient Safety
- Incident Profile: Serious Incidents and Adverse Events

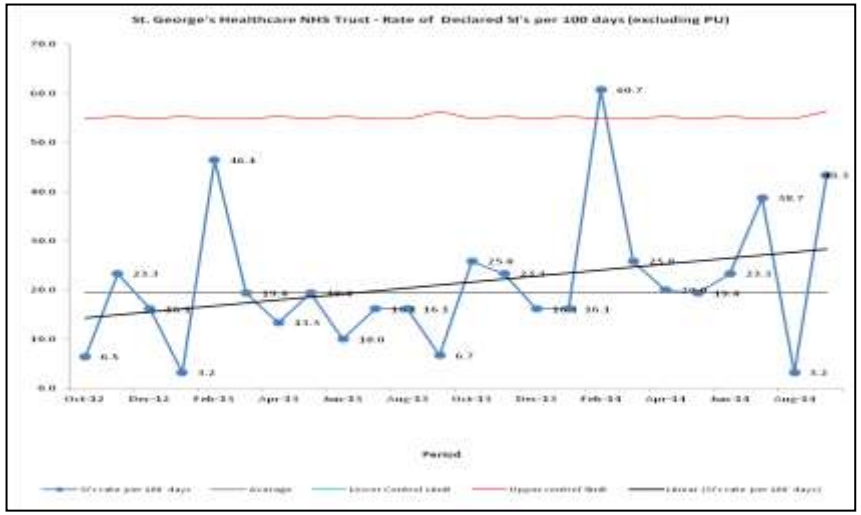
Closed Serious Incidents (not PUs)				
Type	July	Aug	Sept	Movement
Total	8	7	7	➤
No Harm	6	5	2	⮟
Harm	2	2	5	⮝

Table 1

S	Q1 SIs Declared by Division (Inc. Pus)				
	Med & Card	Surgery & Neuro	Community	Children's and Womens	Corporate
July	3	4	**9**	8	0
August	4	2	**3**	3	0
Sept	7	4	**3**	4 + one never event – retained swab	1

Table 2





Overview:

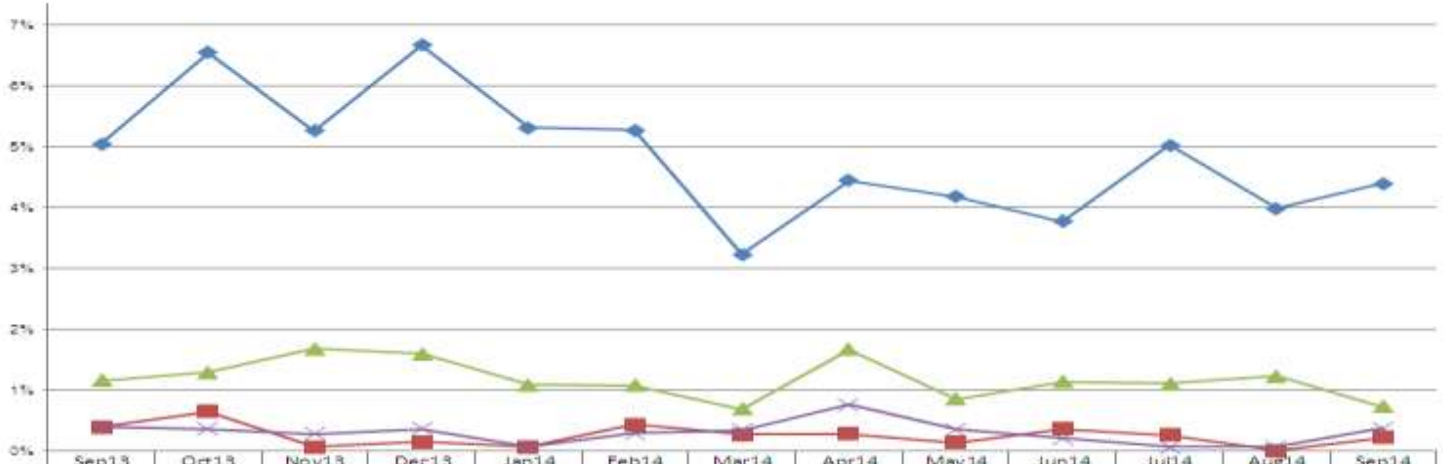
The trend for new -serious incidents excluding pressure ulcers shown in Table 2 above has risen to 12 SIs in September following the dip in August. These have fallen into a number of different categories so it is difficult to identify trends. Where clusters of SIs occur overarching panels are set up to look at the themes and ensure that learning across the trust is enabled. This overarching approach has been taken for the cluster of NG tube SIs, the failure to follow up on test results, deaths in custody and more recently for the requirements of the WHO safer surgery checklist.

Trends for adverse incidents in Table 1 show that the number of moderate incidents appears to be decreasing while there appears to be a rise in extreme incidents which reflects recent SI trends (NB this data is still being validated)

In September, of the 5 closed SIs that resulted in harm, 3 relate to the cluster of incidents where test results were not escalated, 2 relate to deaths in custody. One of the incidents was never event a retained swab within Maternity services this incident is now being fully investigated alongside a wider review into retained swab incidents.

5. Patient Safety: September 2014 - Safety Thermometer

% Harm Free Care							
Lead Director	July	August	September	Movement	2014/2015 Target	National Average	Date expected to meet standard
J Hall	93.67%	95.06%	94.52%	↓	95%	93.72%	Oct - 14



	Sep13	Oct13	Nov13	Dec13	Jan14	Feb14	Mar14	Apr14	May14	Jun14	Jul14	Aug14	Sep14
Pressure Ulcers	5.04	6.54	5.26	6.67	5.31	5.27	3.23	4.44	4.18	3.77	5.02	3.98	4.39
Falls	0.39	0.65	0.07	0.15	0.07	0.43	0.27	0.28	0.14	0.36	0.26	0	0.22
Catheter & UTI	1.16	1.29	1.68	1.6	1.09	1.08	0.69	1.67	0.85	1.14	1.11	1.23	0.73
New VTE	0.39	0.36	0.28	0.36	0.07	0.29	0.34	0.76	0.35	0.21	0.07	0.07	0.37
Patients	1289	1391	1426	1379	1375	1386	1456	1441	1410	1405	1533	1458	1368

Overview

This point prevalence audit shows that in September 2014, 94.52% of patients received 'harm free' care, a decrease from August (95.06%) but still higher than the national average which is 93.72% . The number of new pressure ulcers increased from 1.44% in August to 1.75% in September. An increase in old pressure ulcers was recorded from 2.74% in August to 3.22%; although they are not attributable to the trust they reduce our percentage of harm free care. New VTEs increased from 0.07% to 0.37% and falls with harm recorded increased to 0.22%. There was a decline in new catheter associated UTI's from 0.89% in August to 0.66% in September.

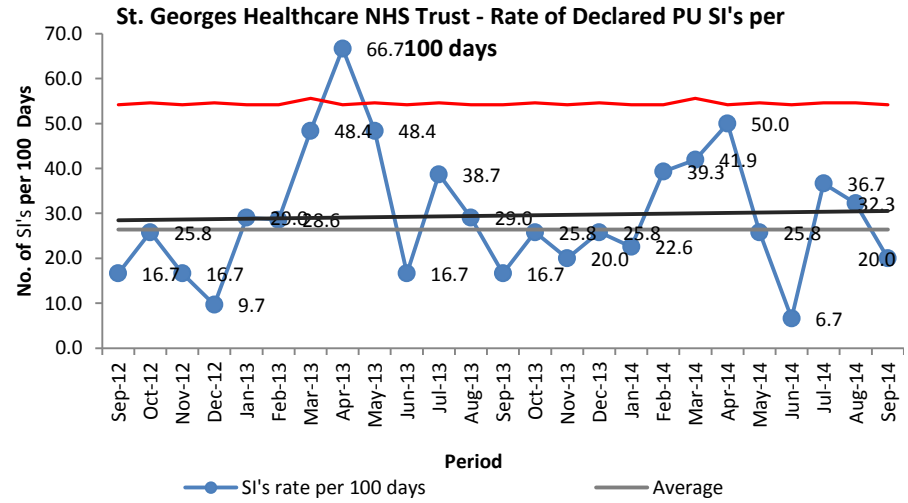
Actions

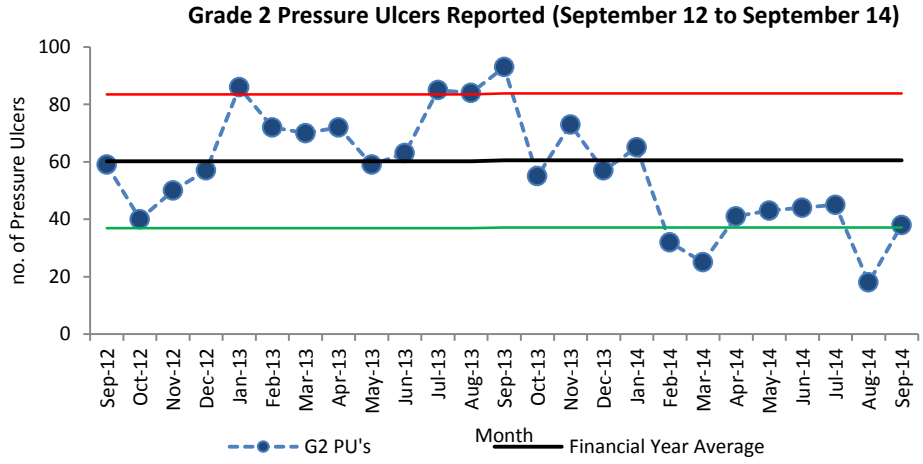
In September the VTE and PU submissions were validated by the relevant clinical nurse specialists who have recognised there are some training issues around data entry. UTI data was validated by Paul Silke, Head of Nursing - Workforce. Plans need to be agreed to take the validation process forward in the community, some data remains unvalidated for September. 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. Yvonne Connolly is the new lead for Safety Thermometer and Kate Hutt and the clinical audit team will be responsible for uploading the data and ensuring the validation process occurs. This is a significant piece of work for clinical audit and divisional support is needed with the validation and entry process to ensure that robust data is submitted during the handover process.

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

Serious Incident – Grade 3 & 4 Pressure Ulcers										
Type	May	Jun	Jul	Aug	Sep	YTD	Movement	2014/2015 Target	Forecast Sept - 14	Date expected to meet standard
Acute	3	1	4	7	4	31			G	-
Community	5	1	7	3	2	21			G	-
Total All	8	2	11	10	6	52			G	-
Total Avoidable	4	2	**5**	**TBA**	**TBA**	**18**		40		-

Grade 2 Pressure Ulcers					
May	Jun	Jul	Aug	Sep	Movement
18	28	**28**	**7**	**26**	
25	16	**17**	**11**	**12**	
43	44	**45**	**18**	**38**	





Overview:

September showed a further reduction in pressure ulcer SI's across acute and community . Total of avoidable SI's are 18 to date against a trajectory of 40 for the year. There was a marked increase in the number of Grade 2 pressure ulcers, which shows early detection and reporting but equally prompt implementation of preventative strategies. This represents hard work across all divisions and increasing awareness . The Divisions continue to drive zero tolerance of avoidable pressure ulcers .

Actions:

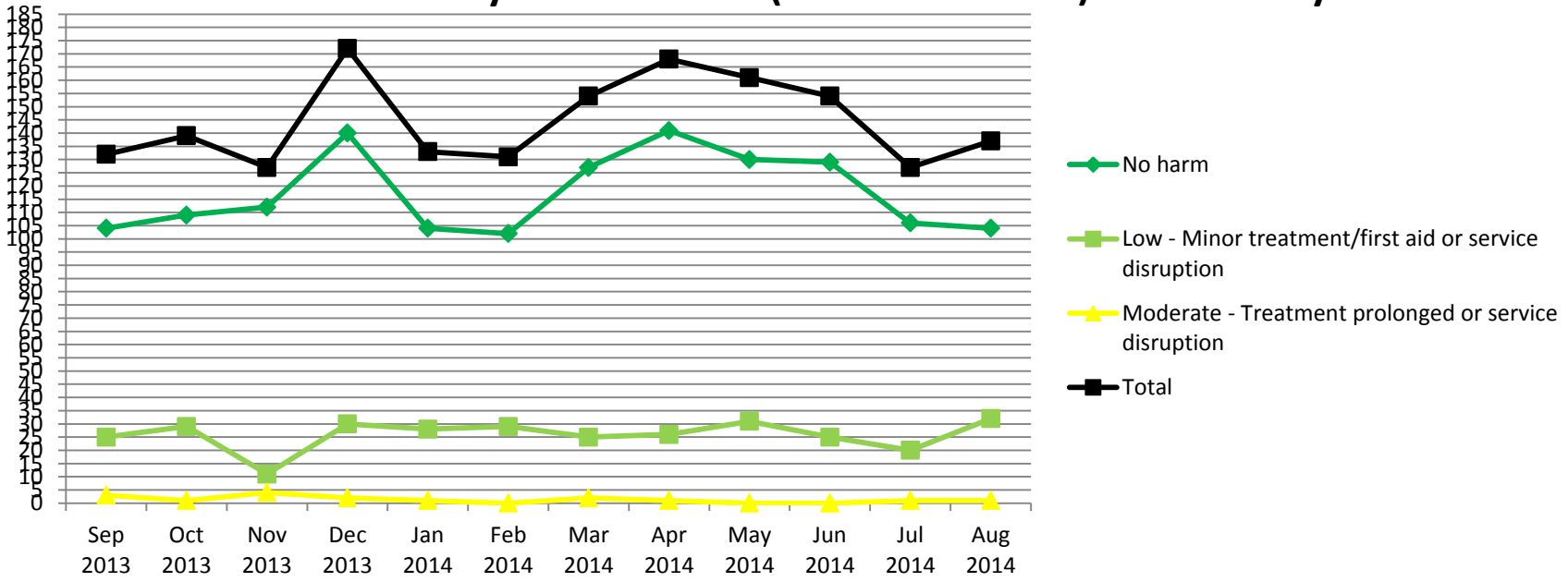
- 'Deep dive' meeting held with surgical division in September which was well attended. The focus was to share organisational and divisional trends and generate actions for improvement. **Key themes** from the SI reports were : Poor documentation ; ensuring agency staff receive local induction and effective handover ; ensure regular skin inspection by all staff specifically under anti embolic stockings; and the need for increased education. **Key Actions** generated for surgical division include : closer working with therapists, close monitoring of training attendance and compliance with protocol and share the learning from SI's at local level .
- Community deep dive meeting scheduled for November 2014
- Visits undertaken to Ashmead; George Potter and Hazel Court nursing Homes to review processes ; training and documentation . Action plans to be developed with support from Pressure Ulcer team in line with CQUIN requirements.

5. Patient Safety: September 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

Patient Falls by Incident date (Month and Year) and Severity



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: September 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, from Sept 2014 EPMA data will be incorporated)	96.31%	96.40%	97.33%	97.28%	96.85%							

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%	86.44%						
National average	85.57%	84.83%	84.83%	84.62%	90.87%							

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%	97.1%						
	RA complete and correct			92%	89%	82%	81%						
2. Written information 'on admission' **(100%)**		-	-	12.8%	13.2%	21.1%	50%						
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%	76.1%						
5. VTE prophylaxis offered in line with NICE **(>98%)**		-	-	94.6%	94.8%	93.1%	92.9%						
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: January 2015)											

(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-Sept 2014 (inclusive)

HAT cases identified to date (attributable to admission at SGH)		64
Mortality rate	Total	20.3% (13/64)
	VTE primary cause of death	4.7% (3/64)
Initiation of RCA process		100%
RCA pending	<28 days since notification	18.8% (12/64)
	>28 days since notification (reminder sent)	29.7% (19/64)
RCA complete		51.5% (33/64)

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

Trends identified (findings from 33 cases for whom RCA is complete):

- General breakdown includes:
  - 33.3% (11/33) – patients had active cancer
  - 6 cases of thrombosis in obstetric patients
  - 6 cases of thrombosis 1-16 days after major trauma
  - 4 cases where root cause unable to be identified due to missing notes
- Adequate prophylaxis received (12/33) – Examples of 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 (13/33) – Examples of 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

5. Patient Safety: September 2014 - Infection Control

MRSA						
Lead Director	August	September	Movement	2014/2015 Target	Forecast Oct - 14	Date expected to meet standard
JH	0	0	>	0	G	October 14

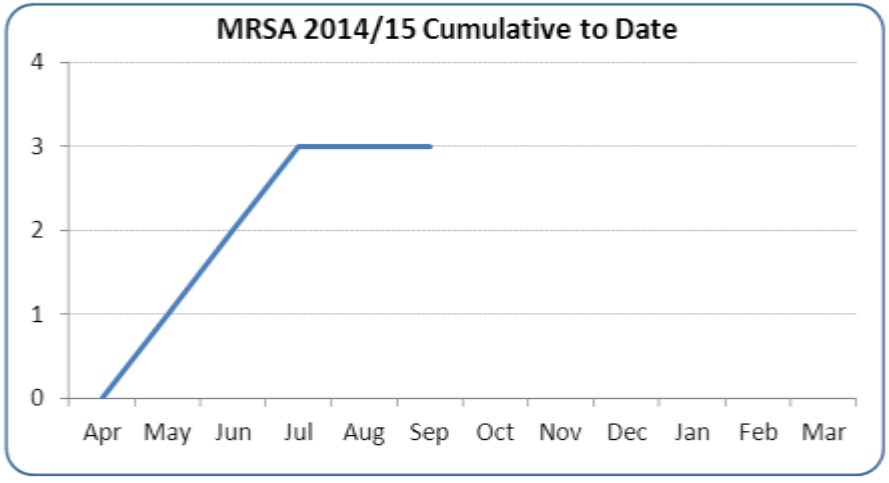
Peer Performance – YTD September 2014				
STG	Croydon	Kingston	King's College	Epsom & St Helier
3	1	0	2	4

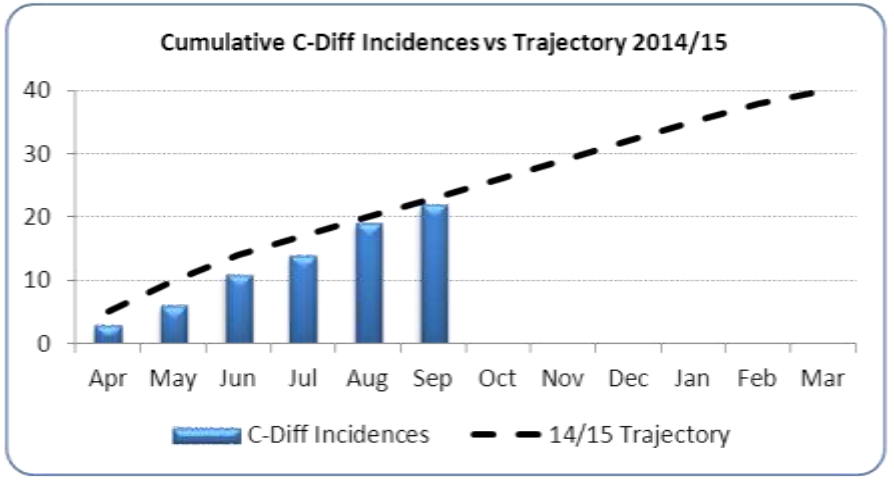
C-Diff						
Lead Director	August	September	Movement	2014/2015 Target	Forecast Oct - 14	Date expected to meet standard
JH	5	3	v	40	G	-

Peer Performance – YTD September 2014 (annual trajectory in brackets)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
22 (40)	8 (17)	4(24)	37 (58)	23 (40)

In 2014/15 the Trust has a target of no more than 40 Cdiff incidents and zero tolerance against MRSA. With a zero tolerance against this target, the trust is non-compliant with 0 incidents in September and 3 incidents year to date. This is still within the de minimis limit of 6 applied to each trust by the NTDA so no penalty score has been applied.

In September there were 3 Cdiff incidents, a total of 22 for the period April to September, This is against a trajectory of 23 and an annual target of 40. Close monitoring will continue to ensure compliance is maintained.

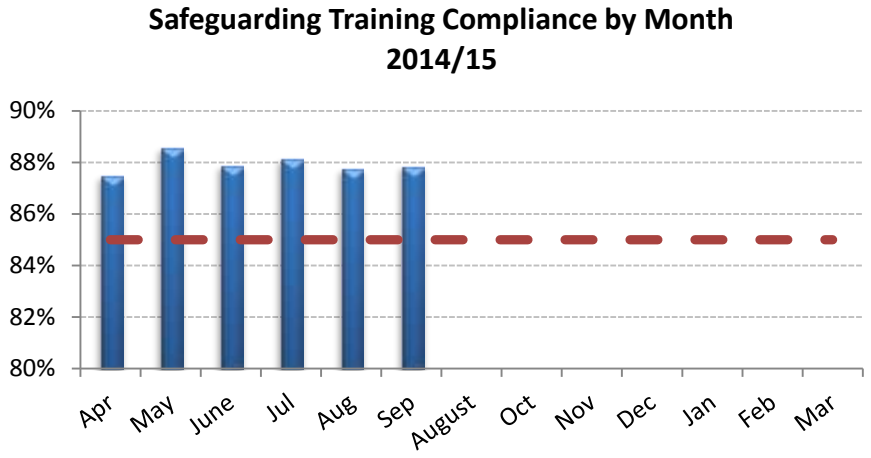


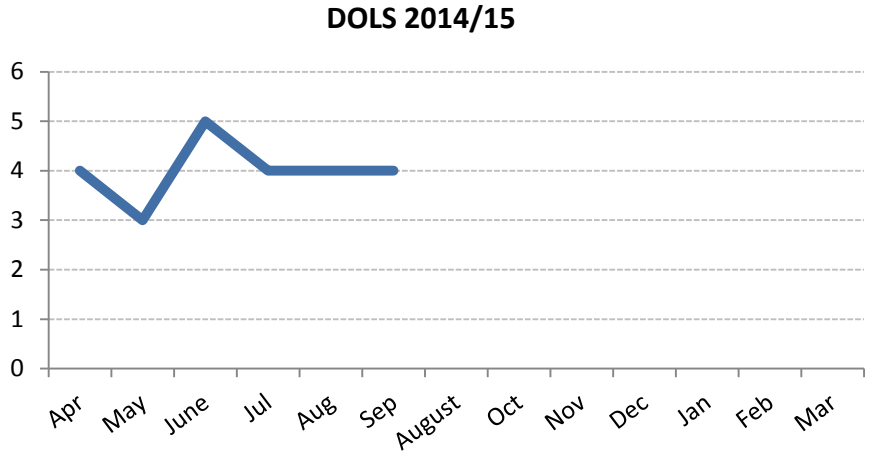


5. Patient Safety: September 2014
- Safeguarding: Adults

Safeguarding Training Compliance - Adults									
Lead Director	May	June	July	Aug	Sep	Movement	2014/2015 Target	Forecast July - 14	Date expected to meet standard
JH	88.58%	87.9%	88.13%	87.77%	87.86		85%	A	-

Safeguarding Adults Training Compliance by Division – Sep 14				
Med & Card	Surgery & Neuro	Community	Children's and Womens	Corporate
83.56	85.55	91.03	89.78	88.46





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, Sep 74

Currently there is no centrally held record of MCA training but as part of the action plan around MCA following the CQC report, training has been delivered and recorded, beginning with Queen Mary's, Roehampton., where 99% staff have been trained

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, Sep - 4

Actions:

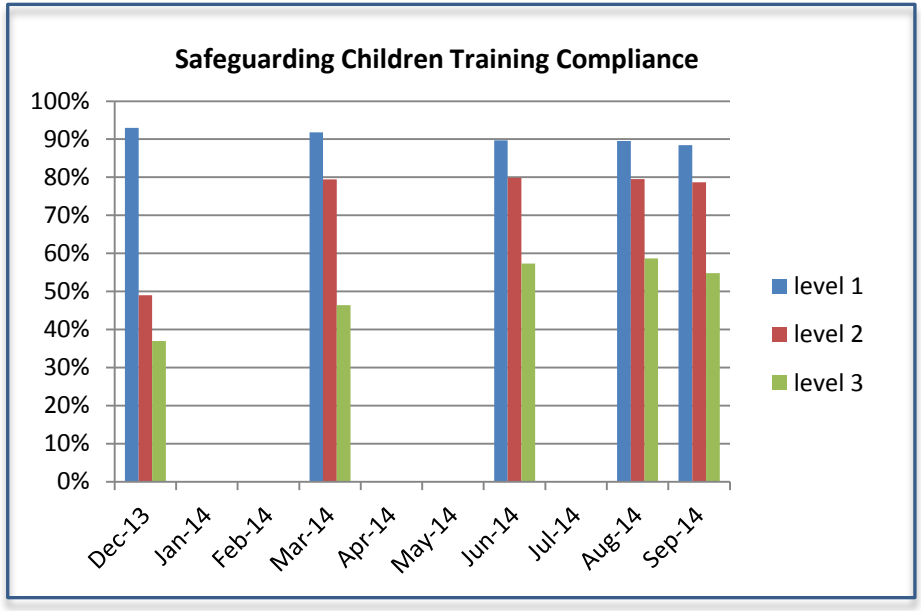
Continue to monitor safeguarding training via WIRED

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 likely Feb 2015 Revised briefing paper with legal team has been produced for EMT In October indicating current position, impact on resources and future options to manage the governance and workload.

5. Patient Safety: September 2014 - Safeguarding Children

Safeguarding Training Compliance - Children						
September			Movement	2014/2015 Target	Forecast October - 14	Date expected to meet standard
Level 1	Level 2	Level 3				
88.44%	78.68	54.82	⇔	95%	A	-



Overview: The Trust is committed to fulfilling the requirements of section 11 of the children act and ensuring that all staff are aware of their responsibility for child safeguarding. To this end ensuring that the workforce are appropriately trained in child safeguarding remains an area that is under constant review. The most recent figures are detailed above.

Action: We have revised the training matrix to reflect the training needs of specific groups so that some specialisms have been upgraded to level 3 and some groups downgraded to level 2. This has altered the figures somewhat, the training department advise that the new influx of staff during the last two months will mean the overall compliance will be reduced while new staff are enlisting on the appropriate training. The Safeguarding Children Strategy is being revised and will take account of the guidance offered by the Intercollegiate Competencies Document and the Skills for Health Staff Guidance. Additional level 3 sessions continue and bespoke training on Female Genital Mutilation and 'See the Adult See the Child' has been arranged for November and December.

Serious Case Reviews and Internal Management Reviews: It is noted that the level of activity in this area has greatly increased.

As previously, there are 6 active cases where IMR , chronologies or briefing reports are being completed - this work is on schedule. A SCR report from Surrey (2013) will be released at the end of October. It is unlikely that there will be any issues for the Trust but the Communication team will be alerted in advance as a precaution. There are 3 other SCR overview reports that have been completed but that cannot be published until after the criminal cases. One of these cases is currently in the court arena. The case involving 3 children who died will now not involve a court case as the plea put forward by the defence of manslaughter has been accepted.

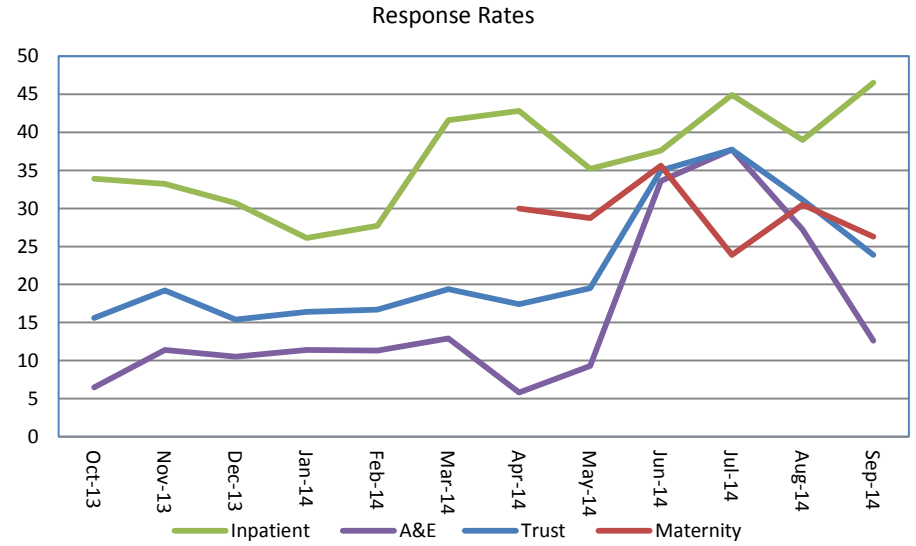
Other: Emergency Department and consent. When a child attends the ED, parents are asked to give signed consent for information sharing. This process has been recently introduced and so a period of embedding of the process is acceptable. Currently, however there are many records where the consent process has not been addressed. Should the failure to complete this important process by staff continue then there will be a significant impact on the ability of the liaison HV to share information effectively. This will be monitored.

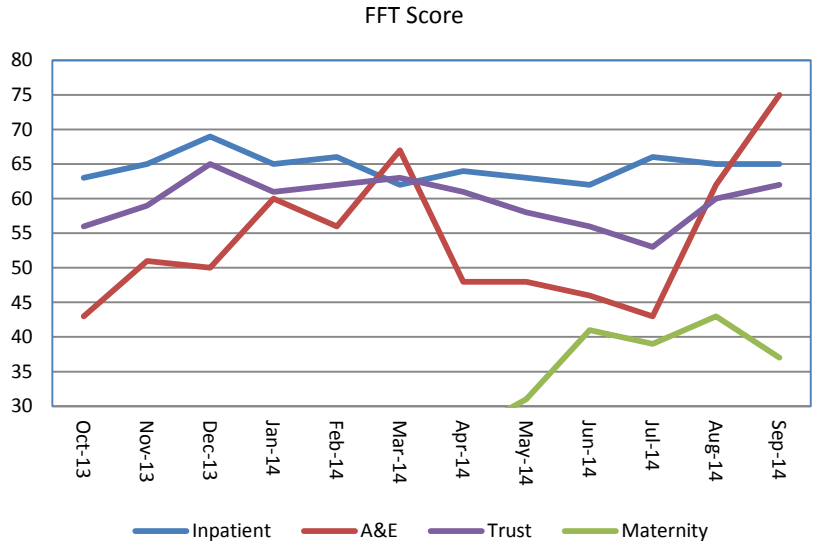
Patient Experience

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

FFT Response Rate							
Domain	July-14	Aug-14	Sep-14	Movement	2014/2015 Target	Forecast	Date expected to meet standard
Trust	37.7%	31.1%	23.9%	↓	20%	G	-
Inpatient	44.9%	39%	46.5%	↑	25%	G	-
A&E	37.7%	27.2%	12.6%	↓	15%	G	-
Maternity	23.9%	30.5%	26.3%	↓	-		-

	FFT Response Score			
July-14	Aug-14	Sep-14	Movement
53	60	62	↑
66	65	65	◆
43	62	75	↑
39	43	37	↓





Overview : Response rates dipped in Maternity and A&E areas, with A&E dropping below our current target of 15%. The Friends and Family Test score for the trust overall was +62 in September, higher than August (60). A&E scored +75 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 and installed. Final guidance from NHS England is being discussed with relevant services. A thematic report was created to summarise patient feedback in inpatient areas, and focus improvement work on key elements of the patient experience.

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

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

6. Patient Experience: September 2014
- New Guidance on Friends and Family Surveys

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

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

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

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

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

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

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

Patient Experience: September 2014
End of Life Care Programme

Introduction and Background

In February 2014 the Care Quality Commission visit highlighted that the trust should ensure that staff are aware of the strategic direction for end of life care. Under the leadership of the Chief Nurse, the Palliative Care team and the Deputy Chief Nurse a programme of work was identified informed by external and internal drivers.

The external driver for this programme are the withdrawal of the Liverpool Care Pathway in 2013 and the subsequent introduction of the five priorities identified for care in the last hours and days of life highlighted by the Department of Health report 'Once chance to get it right'; trust wide compliance with the NICE quality standards 2012; and 'future proofing' actions to comply with the CQC Fundamentals of Care to be introduced in April 2015.

The internal drivers for the programme are the recommendations from CQC visit February 2014, the need to join up with the Cancer strategy, implementing actions from EoLC audit in April 2014 and improvement actions required from the Do not Attempt Resuscitation (DNAR) audit results.

In September a Listening into Action event took place which was well attended. The programme board will cross reference with outcomes from the LiA event and incorporate as required.

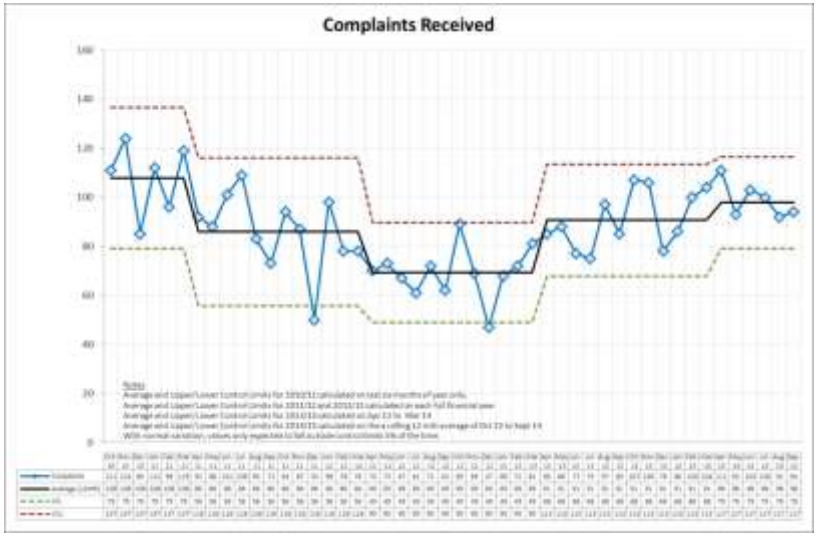
Programme Board
A programme board has been established and met for the first time on 20 October 2014. Key stakeholders as well as senior divisional medical and nursing staff attend ED the programme board to ensure engagement and delivery. A detailed implementation plan will be directing the programme board, supported by the Service Improvement team, to drive the organisational change that is required to deliver on the above outlined drivers.

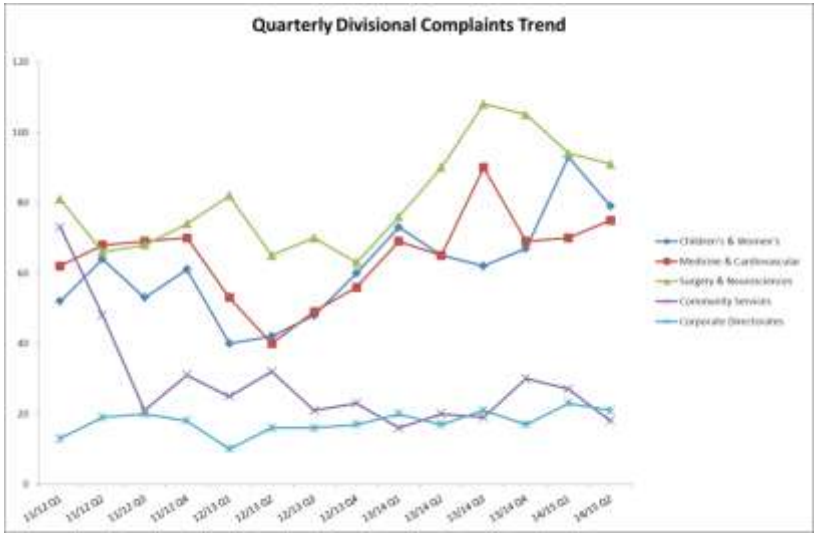
Action
- Finalise the programme of work
- identify workstreams leads

6. Patient Experience: September 2014 - Complaints Received

Complaints Received							
	April	May	June	July	August	Sept	Movement
Total Number received	111	92	100	99	92	94	▲

Complaints by Division : Q2				
Med & Card	Surgery & Neuro	Community	Children's and Women's	Corporate
75	91	18	79	21





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

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

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

This report provides an overview of how the trust has managed complaints received in quarter 2 of 2014/2015 including analysis of the data to provide trends and themes with actions planned. This report also provides information on responding to complaints within specified time frames for complaints received in July and August of 2014, a report of the latest work on severity rating of complaints and posts on NHS Choices and Patient Opinion.

6. Patient Experience: September 2014 - Complaints Received

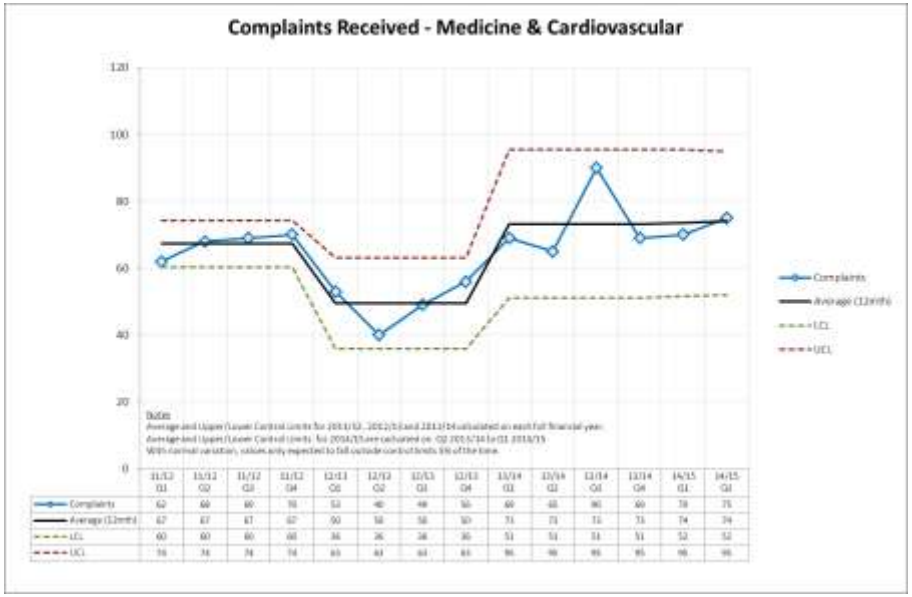
	A&E	Acute Med	Cardio	Children's	CSW - Adult	CSW - Offender	CSW - Older	Corporate	Critical care	Diagnostics	Neuro	Renal, Haem & Onc	Spec Med	Surgery (inc T&O)	SWL Pathology	Theatres	Therapeutics	Women's	Total
Admission arrangements	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Attitude	5	0	2	0	1	0	0	1	0	1	0	0	0	3	0	1	1	0	15
Cancellation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2
Cancellation of surgery	0	0	1	1	0	0	0	0	0	0	0	0	0	2	0	1	0	0	5
Care	6	1	2	2	1	2	2	1	1	1	4	1	0	15	0	2	1	6	48
Car Parking	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	1	0	3
Clinical treatment	10	1	4	3	1	6	0	0	0	2	4	6	3	13	1	0	2	7	63
Communication	5	3	1	0	2	0	0	5	1	2	5	3	4	15	0	0	18	3	67
Discharge arrangements	2	1	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	5
Hotel and site services	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	2
Request for Information	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Other	0	1	0	1	1	0	0	2	0	1	1	1	0	0	0	0	1	1	10
Respect for privacy	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	2
Medical records	1	1	0	0	0	0	0	0	0	0	2	0	0	0	0	0	4	0	8
Transport arrangements	0	0	0	0	0	0	0	9	0	0	0	1	0	0	0	0	0	0	10
Unhelpful	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	2
Waiting times	0	0	2	0	1	0	0	0	0	0	5	0	3	15	0	0	14	0	40
Totals:	30	9	14	7	8	8	2	21	2	7	21	12	10	66	1	4	45	17	284

There were 294 complaints received in quarter 2 of 2014/2015 which is an decrease on quarter 1 when 305 complaints were received. Complaints have decreased in every division except medicine and cardiovascular where from Q1 to Q2 there was an increase of from 70 to 75 complaints. The increase has been due to more complaints being received in the emergency department (23 in quarter 1 and 30 in quarter 2) and in renal, haematology and oncology (6 in quarter 1 and 12 in quarter 2. The number of complaints received for acute medicine reduced significantly from 21 to 9.

The high number of complaints received about therapeutics relate in the most part to complaints about outpatients which decreased from 49 in quarter 1 to 42 in quarter 2 and it is anticipated that there will be a further reduction in quarter 3 as a result of the actions taken in the central booking service as reported in August and the wider outpatient improvement programme.

The high number of complaints received about the directorate of surgery is largely attributable to the number of care groups in the directorate (there are 7). Trauma and orthopaedics and general surgery care groups receive the highest number of complaints with clinical treatment – diagnosis, medical care and waiting times for appointments being themes.

6. Patient Experience: September 2014
- Complaints – Medicine and Cardiovascular



Cardiology
Waiting times on admission are a concern to many patients. Analysis shows there are two aspects to this; the wait itself and the communication of the wait. Investigating the service process, admission times are fixed meaning that some patients have shorter waits than others if they are first on the procedure list. Some patients may experience a longer wait as a patient from the previous day's operating may not have been discharged meaning their bed may not be available. The cardiac catheter laboratory manager, along with the care group lead and the scheduling staff and looking at how variable admission times can be implemented without interrupting the flow of patients to the catheter laboratory due to pre-assessment requirements.

Specialist Medicine
Analysis of recent complaints has suggested that patients have had a problem getting through to Endoscopy bookings. This is both related to the time actually waited and a lack of information about when a call might be answered. The service manager for the area is investigating the possibility of a call-queuing system. This would reduce the number of times a patient calling would experience an engaged tone, and be made aware of the likely wait. It has been determined that the telecoms system can support this and its implementation is now being planned.

Emergency Medicine
ED has recognised that there are a significant number of complaints received and has implemented a structure to support responding to and understanding these complaints. A patient experience committee has been set up and 2 patient representatives attend. This meeting receives summaries of all complaints received and takes advice from the patient representatives as to how best address issues raised. The outcomes from this meeting are fed into the Patient Experience and Improvement Committee where the emergency department's senior management are able to ensure that complaints are considered fully and actions identified and implemented where necessary.

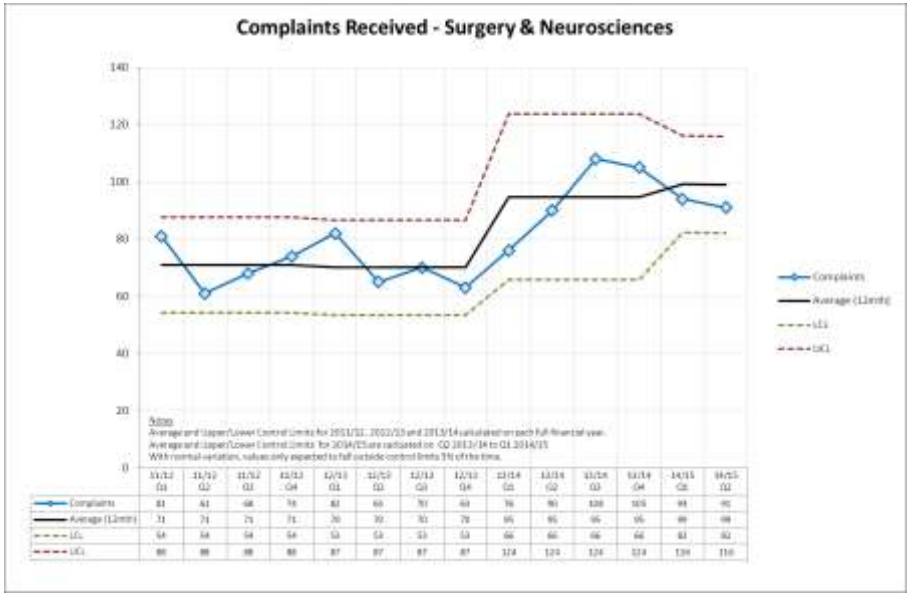
One further measure to support patient communication is the implementation of a General Manager drop-in session. Patients who raise a complaint are advised that they can see the General Manager during this time, with the aim that their concerns are addressed quickly and satisfactorily, removing the need for escalation. It should be noted that for patients for whom this time is not convenient, other times are arranged.

Looking at the themes in the complaints received, two main areas are attitude and time waited.

Examples that have been implemented to address this include:

- Training and development for Band 7 staff on conflict management. This is an external programme to support staff in working with their teams to manage locally tension and conflict and reduce situations escalating.
- The Head of Nursing is leading a development programme for Band 5 staff, supported by the Assistant General Manager. This programme looks at attitudes and behaviours, and aims to enhance communication skills amongst this important staff group.
- The comprehensive action plan agreed at Board level and monitored rigorously outlines several actions designed to reduce the time patients wait in A&E, either to be seen initially or through to their discharge or admission. The 4-hour ED access target is currently achieving at over 95% and these actions continue to work to sustain and improve on this figure.

6. Patient Experience: September 2014
- Complaints – Surgery and Neurosciences



Neurosciences

- Neurosciences is to pilot managing its own outpatient department booking system to improve patient experience.
- A twitter account is being set up to manage patient issues in real time. Two managers will lead on this and be the key point of contact and respond on behalf of the service.

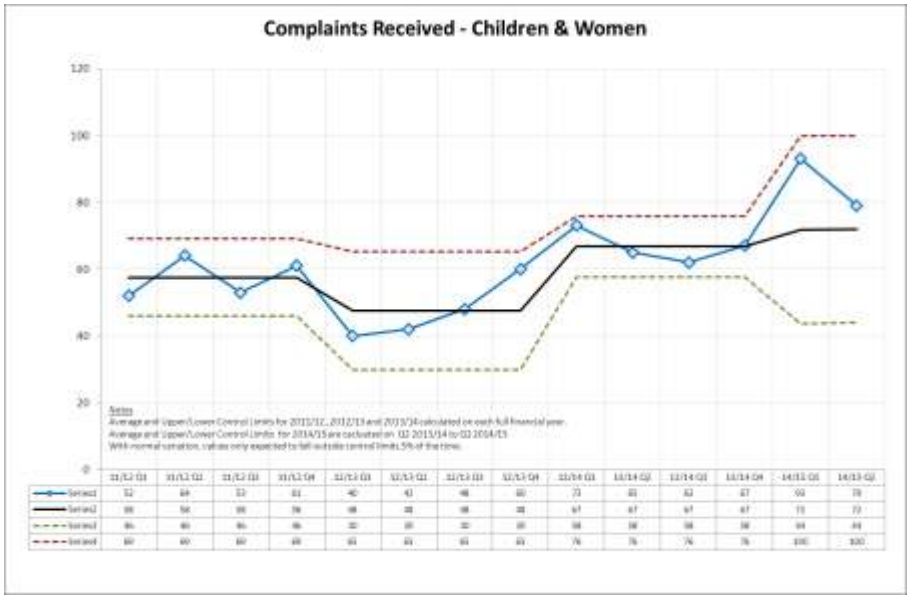
Theatres

A complaint received in quarter 2 related to the plastics hand unit and also comments regarding poor care in day surgery. The main issue regarding the Day Surgery Unit was lack of leadership. Actions include the introduction of a red badge stating "Nurse in Charge" which is worn by the most senior nurse on duty in each area of day surgery. The introduction of the red badge has improved the visibility of those in charge. In addition, the team leader of recovery now wears a red tunic uniform and makes rounds through each area throughout the day. Increased visible leadership will give patients greater confidence in the team and also give them more opportunity to express any concerns they may have at the time.

Complaints Management – divisional level

- The divisional director of nursing and governance has commenced weekly meetings with relevant general managers and heads of nursing to update on progress with complaints.
- Local complaints review meeting now running in most care groups to discuss performance, thematic review and agree any associated actions.
- All care groups to review local processes and the need for any additional training.
- Complaints are discussed at every Divisional Governance Board in terms of volume and performance. Presentations are given on completed complaints where there is generic learning and the patient story videos continue to have an impact and generate constructive discussion and identification of actions.
- Immediacy of contact with the complainant is seen as a priority and is supporting the frequent de-escalation of concerns and the ability to hone in on specific and fewer issues than those initially described within the complaint.
- As a result of complaints within the surgical directorate, much of the procedural information is currently being reviewed, and gaps identified. This is part of a wider piece of work trust wide, and secondary to feedback from both the Picker National In-patient and Cancer survey.
- Complaints across the division have been subject to rigorous review and validation by a number of senior staff. This process, whilst occasionally extending the turnaround time (which the division continues to manage assiduously), has lead to an improvement in the quality of the responses.
- One of the main themes of the Friends and Family Test responses and a number of previous patient experience feedback systems have highlighted noise at night as their primary concern. The division has instituted a number of changes which have included the purchase of noise monitoring systems within the ward environment, and other measures including silent bin lid closers, which is part of a bigger piece of work across the trust.
- Communication continues to be the leading category of complaints received, the division has put in place a number of measures to address this – including staff attending SAGE and THYME communications course, supported by Macmillan. Where communication is an issue this is addressed with individuals in ward teams who are encouraged to reflect on the impact of their behaviour if this does not reflect the trust values of kindness, excellence and respect.

6. Patient Experience: September 2014
- Complaints – Children's, Women's, Diagnostics, Therapeutics and Critical Care



Diagnostics
There is no real theme from the complaints received regarding imaging, however 2 complaints have been received that both relate to mammography and the associated discomfort that can come from this. The team is reviewing the information that is issued to patients regarding this procedure to ensure that it adequately outlines what this procedure involves and the associated side effects.

Critical Care
Critical care receive few complaints and in Q2 these totalled two, which is significantly less than the number received in Q1. As there were few complaints in this area no themes were identified. However the team continues to monitor more broadly for any emerging themes within complaints.

Children's Services
Poor communication and poor nursing care are the two themes that have featured in complaints in Q2. The team within paediatrics is currently participating in a programme of change called Children's Futures; this aims to bring about improvements in all aspects of care through staff engagement and shifting the culture of the team. Through this it is anticipated that improvements in communication and nursing care will be achieved.

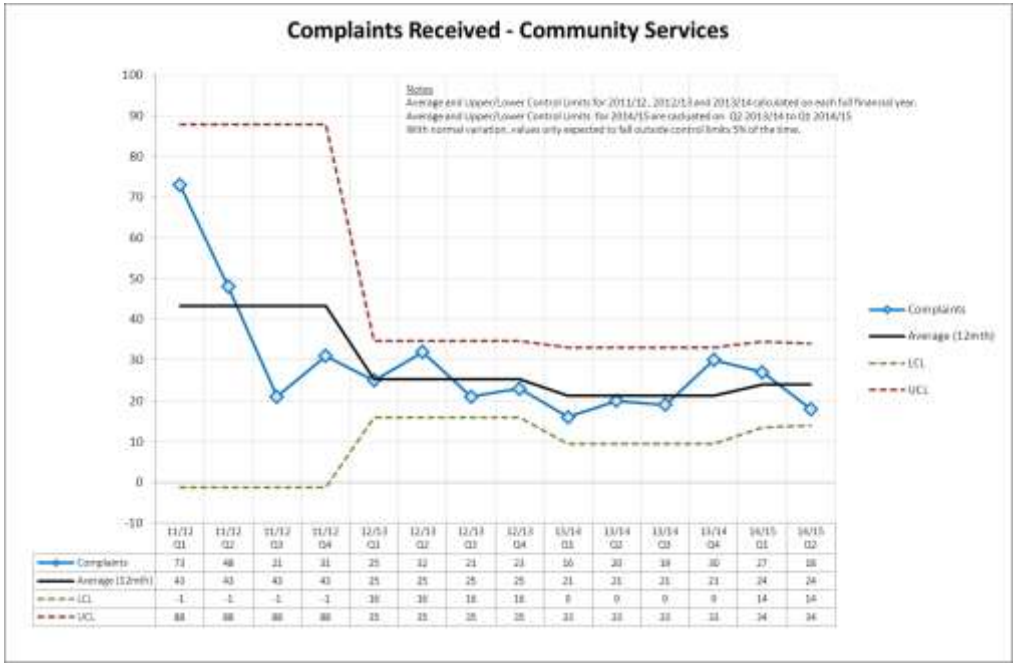
Women's Services
Communication and clinical outcomes are the key themes that have arisen in Q2 within the Women's directorate. The deputy director of midwifery is leading on improving communication within the midwifery teams by discussing all complaints and the associated actions with the midwifery teams. In addition individual staff members referred to in complaints have individualised action plans to assist in improving behaviours and attitude. The care group lead for gynaecology has addressed concerns regarding clinical outcomes with individual consultants.

To ensure widespread learning across the directorate all complaints are discussed at the fortnightly gynaecology risk meetings which are attended by all members of the team.

Corporate Outpatient Service
The complaints received regarding the Corporate Outpatient Service (COS) do not have a particular theme; they range from staff attitude within the service to dissatisfaction with scheduling. Complaints within this service have almost halved between Q1 and Q2 which relates to significant reductions in the cancellation of appointments related to a lack of notes.

A specific service improvement project regarding COS was launched in July 2014, which continues to bring about improvements in COS and the overall patient experience within the service.

6. Patient Experience: September 2014
- Complaints –Community Services Division



The number of complaints being received for the Community Services Division reduced again in quarter 2. No themes were evident but actions were implemented in relation to some complaints received, some of which are detailed below.

Adult Services

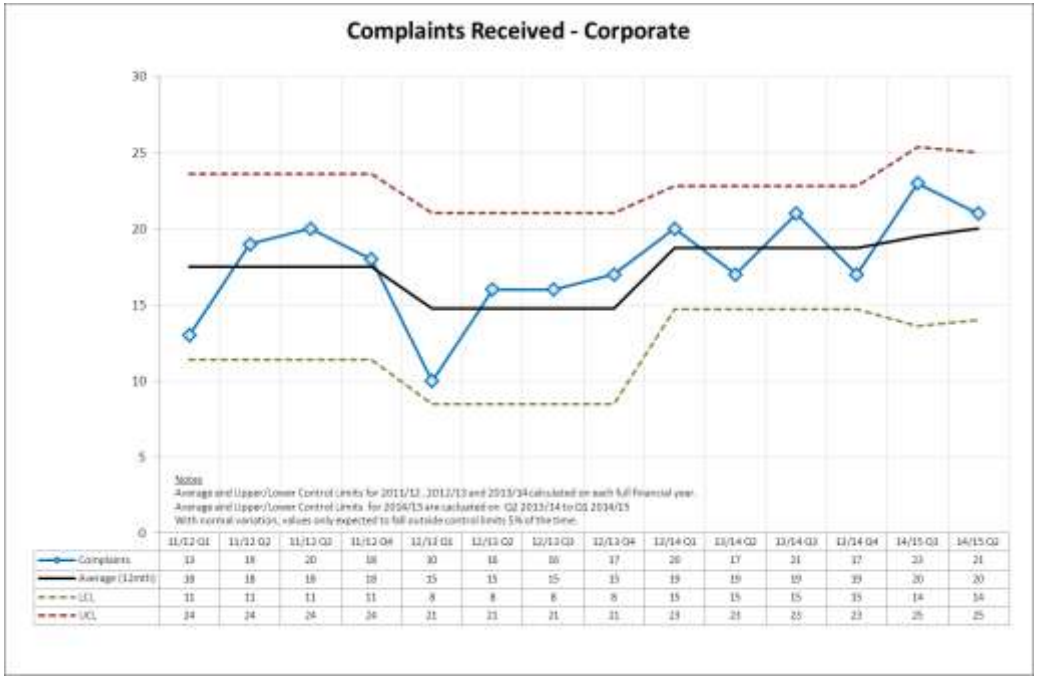
A patient went into the radiology department and asked the receptionist if they could book their scan. The patient was told that they would need to wait and receive the date for scan by post and that the consultant should have known this. As a result of this complaint a memorandum was sent to all consultants to remind them of the process that patients should only be told to go to the radiology department to hand in request forms for an appointment. The date will subsequently be sent out in the post. This should prevent patients being given conflicting information resulting in confusion.

Offender Healthcare

In response to complaints a number of actions have been taken, some general and some more specific including:

- Every quarter, a group of randomly selected prisoners are sent invitations to meet with the head of offender healthcare to provide feedback on healthcare services/
- A healthcare professional regularly attends to prisoner wing forum to obtain feedback.
- Each November prisoners are invited to complete a prisoner survey and the results are compared to the previous year.
- Standardised guidance is being produced for a clinicians to promote best practice and provide training for all clinicians in ear care.
- A patient information leaflet will be made available to patients presenting with ear wax impactation. This is being produced by the clinical lead nurse for the offender healthcare service and will be completed by the end of October.

6. Patient Experience: September 2014
- Complaints – Corporate Services



	11/12 Q1	11/12 Q2	11/12 Q3	11/12 Q4	12/13 Q1	12/13 Q2	12/13 Q3	12/13 Q4	13/14 Q1	13/14 Q2	13/14 Q3	13/14 Q4	14/15 Q1	14/15 Q2
Complaints	13	19	20	18	10	16	16	17	20	17	21	17	23	21
Average (12mth)	18	18	18	18	15	15	15	15	19	19	19	19	20	20
LCL	11	11	11	11	8	8	8	8	15	15	15	15	14	14
UCL	24	24	24	24	21	21	21	21	23	23	23	23	25	25

Car Parking

There has been an increase in complaints received about car parking charges. For each of these complaints the patient has not been aware of the concessions available if patients are delayed or are attending for regular treatment. The concession policy is regularly circulated to clinical areas to ensure patients are made aware of these. The concessions policy is being revisited and consultation is taken place with patient representations to ensure we meet their needs.

Transport

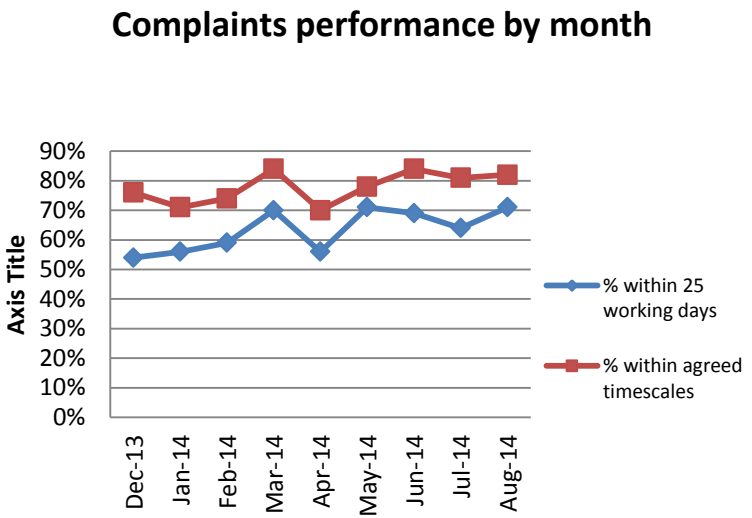
The number of complaints received in September remained low with two complaints being received (as in August compared to eight in July). A number of actions have been taken recently including:

- In April 2014 the Royal Marsden served notice that they would no longer undertake the transfers to and from their hospital sites for treatment. The transfers were to be undertaken by G4S. There has been a review of the booking of transport to and from the Royal Marsden following complaints of long waits to get patients back after treatment. Patients regularly transfer to and from the Royal Marsden for treatment which can vary from 20 minutes to over 4 hours. When the procedure is short, the wards are advised to book a wait and return journey so the ambulance will wait with the patients. For longer treatment sessions the ambulance will take the patient to the Royal Marsden and will move onto other patient journeys. The staff escorting the patients are asked to keep transport control updated on how long the procedure will last so the return journey can be booked with as much notice as possible to reduce the waiting time.
- Workshops are taking place with divisions to plan the future transport service when the current contract expires in June 2015. The clinical workshops have taken place and the requests will form part of the tender. The tender will have a variety of options included for each bidder to provide a cost for. This will include a dedicated service for renal dialysis which is separated from the non renal requests. The projected growth for clinical activity for the 3 years of the service will be included in the tender.

6. Patient Experience: September 2014 - Complaints performance against targets

Performance Against Target **(complaints received in July and August of 2014)**				
Division	**Total number of complaints received**	**Number within 25 working days**	**% within 25 working days**	**% within 25 working days or agreed timescales**
Children's & Women's	52	34	65%	(5) 75%
Medicine and Cardiovascular	53	35	66%	(11) 87%
Surgery & Neurosciences	56	37	66%	(8) 80%
Community Services	12	7	58%	(2) 75%
Corporate Directorates	17	15	88%	(0) 88%*
Totals:	190	128	67%	(26) 81%

* Estates and Facilities 100%



Overview:

For complaints received in quarter 2 where targets have been reached, 67% were responded to within 25 working days compared to 64% in quarter 1. For the same period, 81% of complaints are planned to be responded to within 25 working days or agreed timescales compared to 77% in quarter 1. The final percentage may change depending on whether all of the agreed extensions are eventually met.

6. Patient Experience: September 2014 - Complaints performance against targets

Actions:
As reported to the July board, all divisions have actions in place to improve and ensure compliance with the trust targets of 85% and 100% respectively by the end of the financial year. Updates are provided below.

Medicine and Cardiovascular Division: Between Q1 and Q2 the medicine & cardiovascular division has seen a small improvement against the target to complete responses within 25 working days, from 63% to 66%. Achievement against 25 working days or agreed timescales has stayed static at 87%. Delivery has decreased since Q4 of 2013-14 but remains improved from Q2 2013-14. Actions reported at the Board in July, including strict governance and monitoring of delivery through a standing agenda item in weekly team meetings, dedicated resource to support investigations and drafting, care group level discussions to sustain consultant engagement and compliant presentation at monthly Divisional Governance Board will continue to support sustained achievement of the locally set targets. In addition, efforts will be made to bring forward timescales to allow for iterations from the complaints team and the chief executive or delegate. The division aim to achieve 75% and 92% by the end of Q3 and the trust targets, sustainably, by the end of Q4.

Surgery and Neurosciences Division: Following a deteriorating performance in April 2014 with 25 day response times at 46% the surgery division set themselves an improvement trajectory to achieve the 85% for 25 day turnaround by mid-August 2014. Although this wasn't achieved performance improved from 46% to 67% in July. The division has reset their improvement trajectory at achieving 85% for 25 day turnaround times by the end of October. Volume of complaints has been reducing since their peak in Q3/4 2013-14. The division has made a significant commitment to maintaining this downwards trend and achieving the new trajectory, which is being met in part by the following actions:- continued reporting and monitoring at DGB with care group level challenge where performance is poor. Complaints meetings and thematic review within most specialities and improved consultant engagement and senior leadership of the complaints process. Timelines are appropriately set given the governance process in relation to complaints sign off. There is recognition that a number of new managers have recently taken up post and that complaints training would be of value to support them with this process- this will be discussed with the complaints team.

Women's and Children's Division: The division planned to be compliant with the agreed 85 % within 25 working days and 100% for extensions by the end of Q2 but based on the available data, (just less than two months – July 2014 and August 2014), although performance has improved for this period in comparison to Q1 for both targets ,compliance will not be achieved by the end of quarter 2. The challenge is now to improve this further to achieve the trust targets. based on the improved performance from quarter 1 to quarter 2 of 11% for both 25 days and extensions the division will now use this as the measure of achievable improvement incrementally for the remaining quarters. The aim therefore will be to achieve 75% and 89% respectively by the end of quarter 3 and full compliance in quarter 4

In addition to the weekly spreadsheet being sent to directorates from complaints and improvements the divisional director of nursing also sends a weekly follow up email to the respective teams regarding complaints that are approaching 20 and 25 working days, these are also highlighted at the weekly team brief. The most challenged area in terms of meeting the target within the division remains the women's directorate. The directorate has recently struggled with a reduction in management resource which has contributed to this performance; this has now been resolved and it is anticipated that there will be a marked improvement in performance as a result. The other key message for the directorates is to ensure that extensions are obtained in a timely manner and provide sufficient time for thorough investigations and responses to be completed.

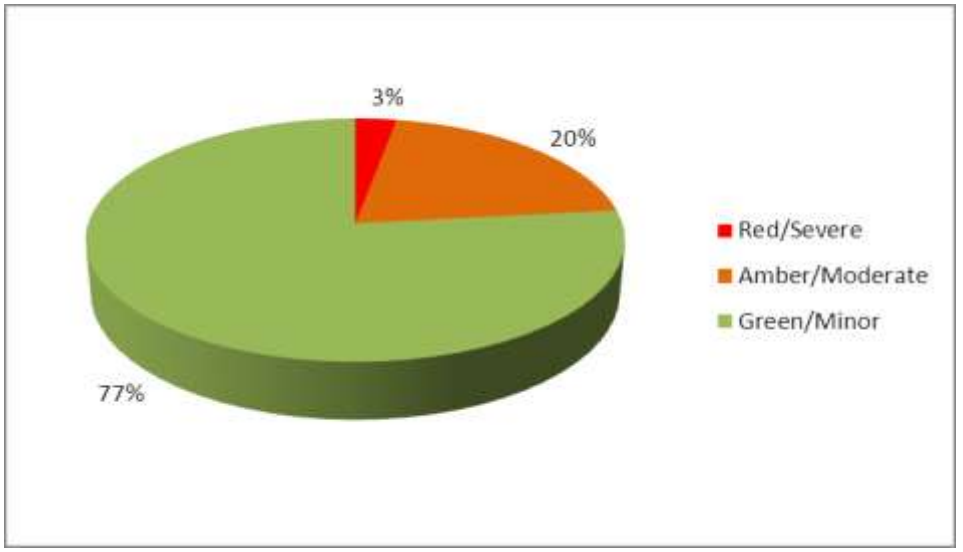
Community Services Division: The division still aims to achieve 100% compliance with both targets by the end of quarter 4 although will not meet 85% and 100% in quarter 2 as was planned., the aim now is to achieve this in quarter 3. All complaint responses are sent to the divisional director of nursing and governance by day 20 (if response target is 25 working days). Managers review complaints immediately and in complex cases contact complainant promptly and negotiate extension . The deputy head of offender healthcare is to meet with the patient experience manager and complaints manager to develop a more streamlined process to improve response times for Offender Healthcare complaints. The Divisional Governance Board holds directorates to account regarding response times.

6. Patient Experience: September 2014 - Complaints Severity Rating Overview

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

This is vital to ensure that urgent/critical matters are dealt with by relevant senior staff and in a timely way. If there is a concern about a possible serious incident (SI) or safeguarding issue these are discussed with the risk department and the relevant safeguarding lead(s) for children or adults.

This system is an internal flag to ensure critical issues or incidents are escalated and investigated appropriately. It is not an attempt to determine how serious the complainant thinks/feels it is.



A summary of ratings for quarter 2 is presented below. A more detailed report will be presented at the Quality and Risk Committee and the Patient Experience Committee.

In Quarter 2 a total of 8 complaints we categorised as Red/Severe.
The red severity cases have been examined to decipher if they should still remain red after investigation and response completed. However some of the cases are still open therefore the total figure for red severity cases may change and will be reflected in the end of year final report.

The reasoning for the red ratings included:

- Death noted.
- Serious Injury/ Serious Adverse Outcome.
- Vulnerable patient, possible neglect. Safeguarding issues.
- Complex case as more than one service involved.
-

In Quarter 2 a total of 58 complaints were categorised as Amber/Moderate.
The most common reasons for the amber ratings were an adverse injury or outcome and the complaint being complex and/or involving 2-4 services.

In Quarter 1 a total of 218 complaints were categorised as Green/Minor.

6. Patient Experience: September 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.

There were 40 posts made on NHS Choices and Patient Opinion in quarter 2 of 2014/2015 of which 28 were positive, 7 were negative and 5 were both. The Minor Injuries Unit at Queen Mary's Hospital received the highest number of posts for any one department of which 5 were positive and 1 was mixed. There were no negative comments about the unit.
Below are some examples of comments/stories posted on NHS Choices and Patient Opinion since the last board report in September.

Anonymous reviewed Queen Mary's Hospital, Roehampton (St George's Healthcare Services)
2 and a half hour wait
This morning, for my gynaecology appointment, arrived early. During the course of my wait, someone else complained about their wait and another had discovered their child's name had been crossed off the list before they had been seen by the intern - I take it the young man was an intern or similar, who knows - who had taken over from the new receptionist while she had lunch, which led to me to check on my appointment, only to be told by a confused receptionist, after a two and a half hour wait, that my doctor had gone. As the reception area was tiny, and I have normal hearing, and no one called my name (I did not leave the room), I can only surmise that there must be a systems failure in place and that my notes were filed away before being called. No one, came out to check on those waiting, different clinics going on in a small area and different agendas. I was told that another appointment would be sent out after a half hearted indignant apology (where is the training?). £5.00 parking and feeling very upset. Who can I complain to?

Visited in October 2014. Posted on 10 October 2014

Alvaro **g**ave General Surgery at St George's Hospital (London) a rating of 5 stars
Outstanding Service and Representation of Hospital Values
Having arrived initially with stomach cramps at A&E in the early our of Monday morning I had the opportunity to experience various services throughout the hospital. The nurses and doctors took the time to listen to my concerns and successfully diagnosed me with appendicitis. All through this process they were caring, compassionate and kept myself and my fiancé informed at all times. The process was speedy and thorough. Once I eventually made it through the surgery and onto the Vernon Ward the staff exceeded all my expectations and were outstanding. Anytime of day or night they were responsive to my every need and request and as a result I recovered quickly and safely. I would highly recommend this hospital and thank all the wonderful staff who took care of me. I would be most grateful if this could be passed on to the staff on the Vernon Ward.

Visited in September 2014. Posted on 20 September 2014

6. Patient Experience: September 2014
- The Dementia Carers questionnaire – data for 2014/15 Q1 & Q2

Background:

- The dementia carers' questionnaire was introduced in 2013/14 as part of the National Dementia CQUIN
- It was retained in the 2014/15 CQUIN
- It is worth 30% of the CQUIN ~ £250k this year
- We are required to present results to the Board every 6 months

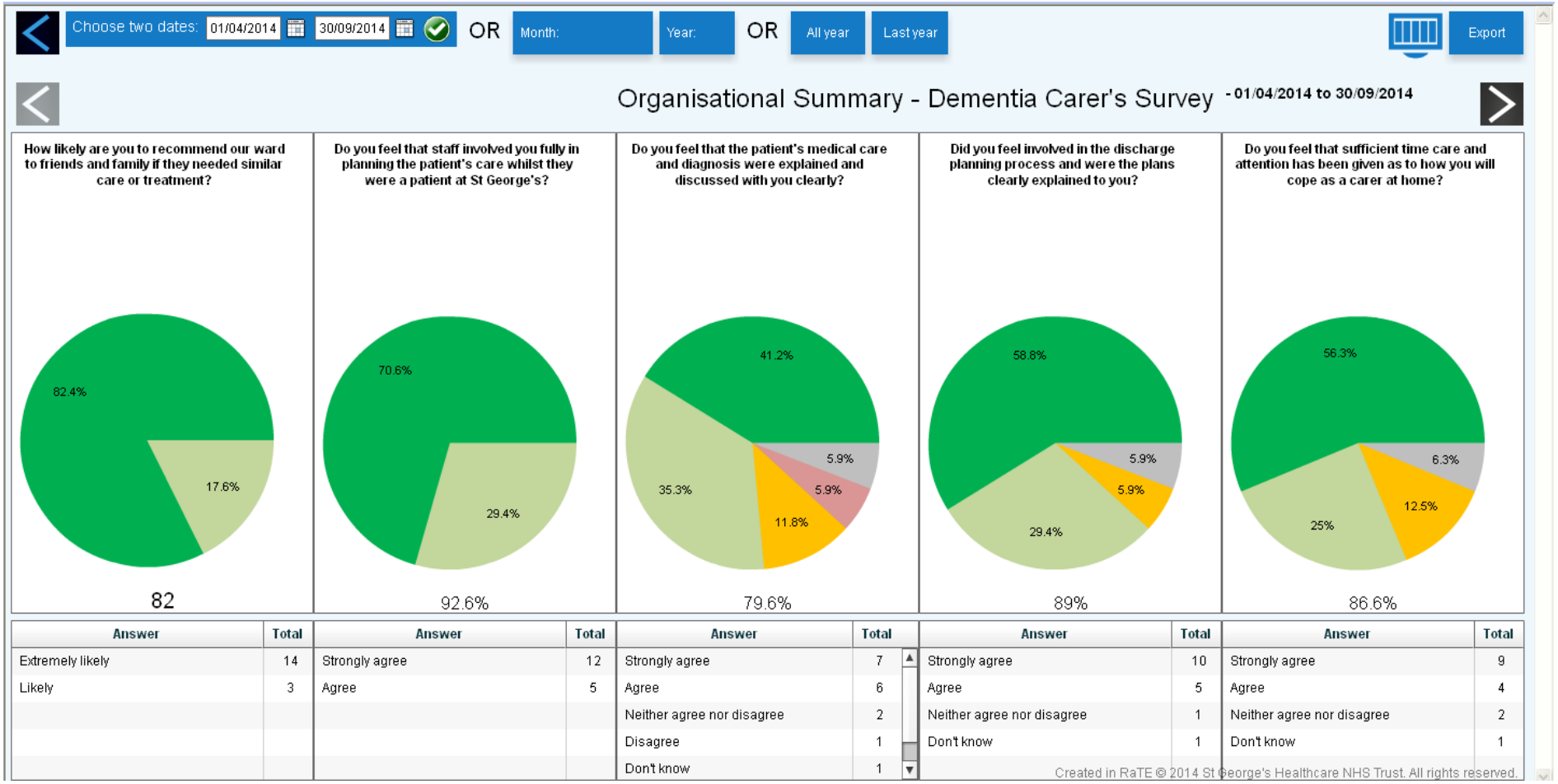
Practicalities:

- The questionnaire is on the ward-based tablets
- It asks informal (i.e. family) carers of people with dementia about their experience of the care their relative has had
- It should be done towards the end of the admission

Comments:

- The questionnaire was completed by 17 carers in Q1/2
- Only Dalby, Heberden and Buckland have administered it so far this year
- We plan to increase the number of completed questionnaires to >25 in Q3/4 by raising awareness through divisional governance leads
- In general, carers feel involved in the process of care
- We are still not good enough at providing information about the Butterfly scheme, Dementia passport and local services
- Wandsworth CCG has produced a local dementia services guide which we will make available on the wards
- Our new dementia assessment nurses will raise awareness of dementia resources on wards and ensure that they are in use

6. Patient Experience: September 2014
- The Dementia Carers questionnaire – data for 2014/15 Q1 & Q2



Answer	Total
Extremely likely	14
Likely	3

Answer	Total
Strongly agree	12
Agree	5

Answer	Total
Strongly agree	7
Agree	6
Neither agree nor disagree	2
Disagree	1
Don't know	1

Answer	Total
Strongly agree	10
Agree	5
Neither agree nor disagree	1
Don't know	1

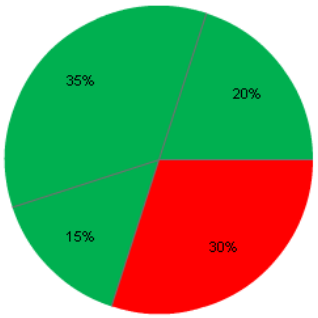
Answer	Total
Strongly agree	9
Agree	4
Neither agree nor disagree	2
Don't know	1

6. Patient Experience: September 2014
- The Dementia Carers questionnaire – data for 2014/15 Q1 & Q2

Choose two dates: 01/04/2014 30/09/2014 OR Month: Year: OR All year Last year Export

Organisational Summary - Dementia Carer's Survey - 01/04/2014 to 30/09/2014

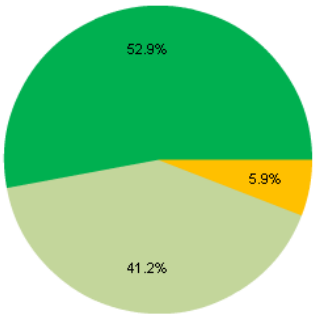
Have you been offered information about any of the following whilst at St George's?



70%

Answer	Total
The butterfly scheme	4
Local support and advice	7
The dementia passport	3
None of the above	6

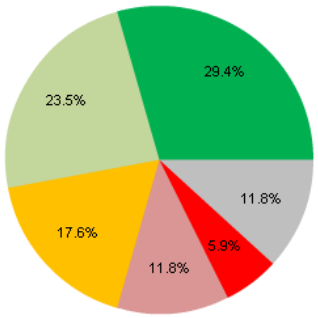
St George's Hospital?



86.7%

Answer	Total
Strongly agree	9
Agree	7
Neither agree nor disagree	1

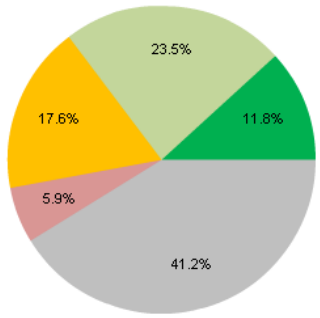
The GP?



66.6%

Answer	Total
Strongly agree	5
Agree	4
Neither agree nor disagree	3
Disagree	2
Strongly disagree	1

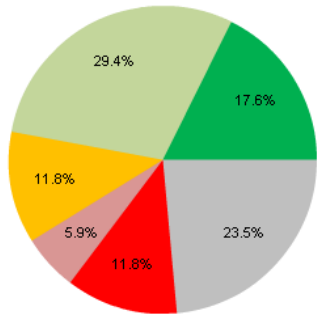
Community services? e.g. dementia advisor memory clinic community nurses or therapists



67.5%

Answer	Total
Strongly agree	2
Agree	4
Neither agree nor disagree	3
Disagree	1
Don't know	7

Social services?



61.5%

Answer	Total
Strongly agree	3
Agree	5
Neither agree nor disagree	2
Disagree	1
Strongly disagree	2

Workforce

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

Fill rate indicator return

Staffing: Nursing, midwifery and care staff

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/

Ward name	Main 2 Specialties on each ward		Day				Night				Day		Night	
			Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff					
	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 (%)
Cardiothoracic Intensive Care Unit	170 - CARDIOTHORACIC SURGERY	320 - CARDIOLOGY	7301.83	6276.80	86.50	86.50	6555.00	6278.00	276.00	265.00	86.0%	100.0%	95.8%	96.0%
Carmen Suite	501 - OBSTETRICS		1531.50	1411.00	345.00	322.00	1320.00	1288.00	330.00	275.00	92.1%	93.3%	97.6%	83.3%
Champneys Ward	502 - GYNAECOLOGY		1818.50	1663.50	315.00	253.50	660.00	649.00	330.00	330.00	91.5%	80.5%	98.3%	100.0%
Delivery Suite	501 - OBSTETRICS		3897.00	3550.25	810.00	698.00	3704.00	3308.00	660.00	626.00	91.1%	86.2%	89.3%	94.8%
Fred Hewitt Ward	420 - PAEDIATRICS		950.75	1286.51	699.25	639.25	1299.50	1115.50	596.25	537.50	135.3%	91.4%	85.8%	90.1%
General Intensive Care Unit	192 - CRITICAL CARE MEDICINE		6477.00	6026.52	0.00	253.50	6290.50	6263.75	0.00	92.00	93.0%	#DIV/0!	99.6%	#DIV/0!
Gwillim Ward	501 - OBSTETRICS		2477.00	2119.75	630.00	591.50	1331.00	1386.00	726.00	649.00	85.6%	93.9%	104.1%	89.4%
Jungle Ward	171 - PAEDIATRIC SURGERY	420 - PAEDIATRICS	1133.00	979.50	0.00	0.00	0.00	0.00	0.00	0.00	86.5%	#DIV/0!	#DIV/0!	#DIV/0!
Neo Natal Unit	420 - PAEDIATRICS	192 - CRITICAL CARE MEDICINE	7483.5	6651.5	106.5	219	6562	6062.17	0	187	88.9%	205.6%	92.4%	#DIV/0!
Neuro Intensive Care Unit	192 - CRITICAL CARE MEDICINE	150 - NEUROSURGERY	4758.00	4263.76	287.50	279.25	4496.50	4335.50	345.00	293.33	89.6%	97.1%	96.4%	85.0%
Nicholls Ward	171 - PAEDIATRIC SURGERY	420 - PAEDIATRICS	2697.60	2460.04	198.50	198.50	1804.00	1727.00	165.00	165.00	91.2%	100.0%	95.7%	100.0%
Paediatric Intensive Care Unit	192 - CRITICAL CARE MEDICINE	420 - PAEDIATRICS	3871.00	2505.68	593.00	574.75	3461.50	2602.50	345.00	274.25	64.7%	96.9%	75.2%	79.5%
Pinckney Ward	420 - PAEDIATRICS		2405.00	1942.50	287.50	287.50	1748.00	1702.00	11.50	11.50	80.8%	100.0%	97.4%	100.0%
Dalby Ward	300 - GENERAL MEDICINE		1502.50	1251.75	2585.25	2106.50	1035.00	1012.00	1426.00	1403.00	83.3%	81.5%	97.8%	98.4%
Heberden	300 - GENERAL MEDICINE		1626.50	1302.75	2579.25	2119.50	1046.50	1011.50	1391.50	1368.50	80.1%	82.2%	96.7%	98.3%
Mary Seacole Ward	400 - NEUROLOGY	314 - REHABILITATION	2679.50	2380.50	2780.00	2301.95	1725.00	1656.00	1748.00	1736.00	88.8%	82.8%	96.0%	99.3%
A & E Department	180 - ACCIDENT & EMERGENCY		9808.50	9131.92	1855.50	1530.50	8945.00	8517.68	1242.00	1107.00	93.1%	82.5%	95.2%	89.1%
Allingham Ward	100 - GENERAL SURGERY		1914.00	1742.94	1166.50	935.26	1035.00	1034.00	977.50	954.50	91.1%	80.2%	99.9%	97.6%
Amyand Ward	300 - GENERAL MEDICINE		1928.00	1739.25	1663.50	1187.25	1058.00	1001.50	828.00	839.50	90.2%	71.4%	94.7%	101.4%
Belgrave Ward AMW	320 - CARDIOLOGY		2628.25	2232.09	1350.00	971.50	1690.50	1609.25	356.50	356.50	84.9%	72.0%	95.2%	100.0%
Benjamin Weir Ward AMW	320 - CARDIOLOGY		2604.00	2253.50	660.00	422.00	1633.00	1483.50	447.00	447.00	86.5%	63.9%	90.8%	100.0%
Buckland Ward	361 - NEPHROLOGY		1854.00	1701.00	574.50	485.25	1058.00	1035.00	402.50	391.00	91.7%	84.5%	97.8%	97.1%
Caroline Ward	170 - CARDIOTHORACIC SURGERY		1858.50	1678.90	757.50	646.25	1380.00	1364.50	11.50	11.50	90.3%	85.3%	98.9%	100.0%
Cheselden Ward	100 - GENERAL SURGERY		1903.50	1712.25	345.00	304.75	1069.50	1058.00	264.50	264.50	90.0%	88.3%	98.9%	100.0%
Coronary Care Unit	320 - CARDIOLOGY	170 - CARDIOTHORACIC SURGERY	2164.50	1997.41	187.45	170.92	1920.50	1840.00	184.00	161.00	92.3%	91.2%	95.8%	87.5%
James Hope Ward	320 - CARDIOLOGY		1665.00	1415.25	165.00	157.50	506.00	494.50	0.00	0.00	85.0%	95.5%	97.7%	#DIV/0!
Marnham Ward	300 - GENERAL MEDICINE		2474.75	2099.14	1503.75	1473.48	1828.50	1748.50	1069.50	1092.50	84.8%	98.0%	95.6%	102.2%
McEntee Ward	300 - GENERAL MEDICINE		1629.00	1395.00	628.50	650.00	770.50	770.50	782.00	747.50	85.6%	103.4%	100.0%	95.6%
Richmond Ward	300 - GENERAL MEDICINE		5543.75	4571.66	3300.00	2688.61	3887.00	3746.71	2597.20	2584.78	82.5%	81.5%	96.4%	99.5%
Rodney Smith Med Ward	302 - ENDOCRINOLOGY		1866.00	1735.75	1164.50	988.50	1035.00	1012.00	747.50	723.50	93.0%	84.9%	97.8%	96.8%
Ruth Myles Ward	303 - CLINICAL HAEMATOLOGY		1536.00	1280.00	701.50	675.50	1000.50	920.00	492.75	469.75	83.3%	96.3%	92.0%	95.3%
Trevor Howell Ward	370 - MEDICAL ONCOLOGY		1826.00	1677.50	1366.00	1325.33	1257.50	1230.50	1452.00	1388.50	91.9%	97.0%	97.9%	95.6%
Winter Ward (Caesar Hawkins)	300 - GENERAL MEDICINE		1917.00	1680.75	900.00	726.17	1426.00	1405.00	529.00	529.00	87.7%	80.7%	98.5%	100.0%
Brodie Ward	150 - NEUROSURGERY		1260.00	1054.50	907.50	765.00	1035.00	1013.00	0.00	0.00	83.7%	84.3%	97.9%	#DIV/0!
Cavell Surg Ward	100 - GENERAL SURGERY		2294.00	2026.34	616.50	646.75	1286.25	1069.42	402.50	299.00	88.3%	104.9%	83.1%	74.3%
Florence Nightingale Ward	120 - ENT		2421.50	2173.00	690.00	739.50	1686.75	1616.75	11.50	137.50	89.7%	107.2%	95.9%	1195.7%
Gray Ward	100 - GENERAL SURGERY		2222.00	2078.50	911.00	974.00	1331.00	1287.00	363.00	374.00	93.5%	106.9%	96.7%	103.0%
Gunning Ward	110 - TRAUMA & ORTHOPAEDICS		2312.45	2015.55	932.00	855.26	1448.25	1321.25	390.25	386.50	87.2%	91.8%	91.2%	99.0%
Gwynne Holford Ward	400 - NEUROLOGY		1460.00	1335.00	1519.00	1212.00	690.00	644.00	970.25	958.25	91.4%	79.8%	93.3%	98.8%
Holdsworth Ward	110 - TRAUMA & ORTHOPAEDICS		1893.25	1755.00	900.00	702.25	1092.50	1081.00	729.50	716.25	92.7%	78.0%	98.9%	98.2%
Keate Ward	160 - PLASTIC SURGERY		1701.00	1618.00	710.00	581.00	1035.00	1035.00	138.00	138.00	95.1%	81.8%	100.0%	100.0%
Kent Ward	400 - NEUROLOGY		2139.00	1789.00	2150.50	1771.00	1391.50	1344.98	1391.50	1379.00	83.6%	82.4%	96.7%	99.1%
Mckissock Ward	150 - NEUROSURGERY		2122.25	1771.25	1453.75	1091.00	1403.00	1288.00	492.60	504.17	83.5%	75.0%	91.8%	102.3%
Vernon Ward	101 - UROLOGY		2562.50	2323.00	802.50	759.50	1353.00	1254.00	440.00	451.00	90.7%	94.6%	92.7%	102.5%
William Drummond HASU	400 - NEUROLOGY		2973.00	2527.58	690.00	592.26	2760.00	2548.00	690.00	692.50	85.0%	85.8%	92.3%	100.4%
Wolfson Centre	400 - NEUROLOGY	314 - REHABILITATION	1716.00	1328.00	2184.00	1793.25	701.50	690.00	1230.50	1242.00	77.4%	82.1%	98.4%	100.9%

7. Workforce: September 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 September 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 September submission the trust achieved an average fill rate of 90.85%, a slight improvement from 89.3% from the August submission. There is still some work to do with divisions to improve the accuracy of the report, e.g. by reducing the staffing template on eRoster if beds are closed.

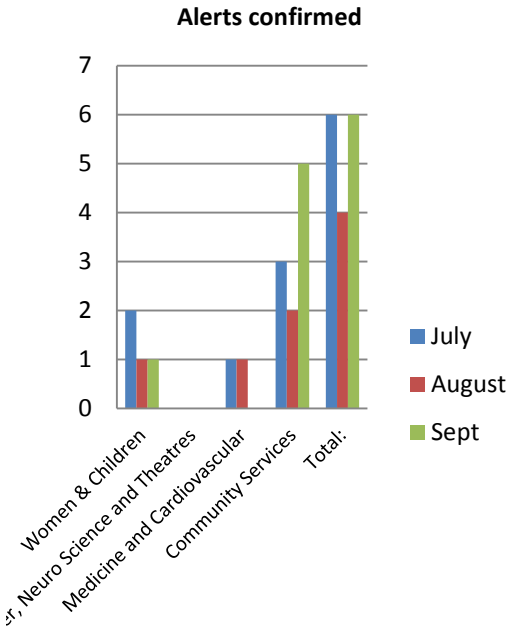
Although some of our wards are operating below 100% the data does not indicate if a ward is unsafe. Safe staffing is much more complex than an observation of percentages and takes in to account many key aspects such as:
Nurses, midwives and care staff work as part of a wider multidisciplinary ward team. 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.

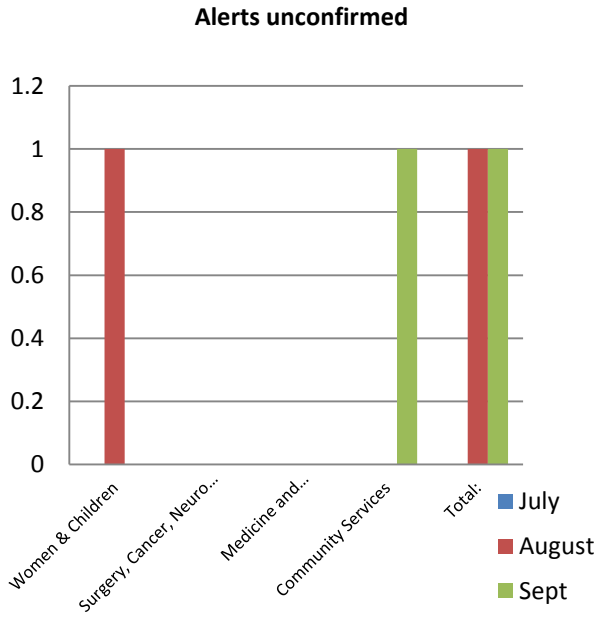
- The data does not take into account the on-going considerations for ward managers in ensuring that on each shift there is the right level of experience and expertise in the ward team.
- The nature of each ward varies. The number and type of patients seen on some wards will be relatively consistent.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

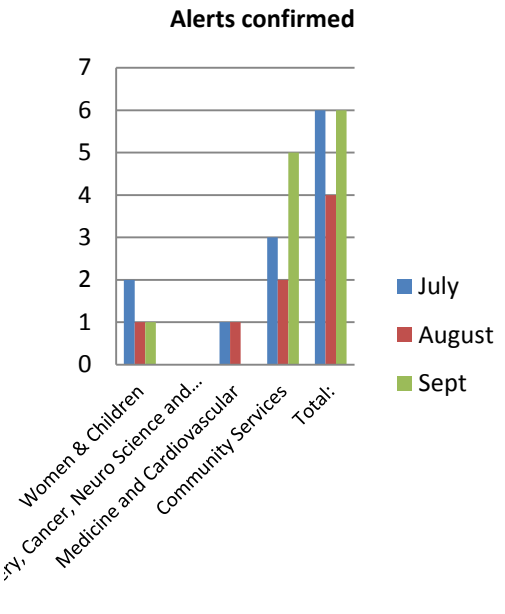
Actions

- 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.
- In September an acuity and dependency review was carried out and wards are reviewing their establishments in readiness for the report to be presented at the November 2014 board meeting.
- A number of actions will be taken forward with the divisions to improve the accuracy of the safe staffing report.

7. Workforce: September 2014
- Safe Staffing alerts







3162 safe staffing surveys were completed in September 2014 completed currently once a day. From 1 November 2014 the prison healthcare team will commence safe staffing recording and all areas will be expected to report on safe staffing twice/day.

The data above shows that the number of validated alerts over the previous three months has been 6 confirmed alerts for July, 4 for August with 1 (CWDT) still be finalised and 6 for September with 1 (CSD) still to be validated.

To work towards same day decisions on safe staffing alerts, the escalation process has been changes slightly to ensure if no action has been taken by 3pm that this is escalated to the Deputy Chief Nurse. This action is being taken to improve compliance in following up safe staffing alerts.

The safe staffing alerts are now being triangulated with staffing incidents reported on the Datix system. For September, 6 incidents were reported as unsafe staffing levels. None of these were identified as safe staffing concerns in the safe staffing audit. To understand why this is the case this information will be cascaded through the nursing leadership at Nursing board and Matron's forum to analyse and respond to.

Heatmap Dashboard
Ward View

		INCIDENCE OF C.DIFFICILE	INCIDENCE OF MRSA	TRUST ACQUIRED PRESSURE SORES	PERCENTAGE OF HARM FREE CARE	PATIENT SATISFACTION (FRIENDS & FAMILY)	FRIENDS & FAMILY RESPONSE RATE	WARD STAFFING: UNFILLED DUTY HOURS	FALLS (WARD LEVEL)	SERIOUS INCIDENTS (WARD LEVEL)	VACANCY RATE	WARD SICKNESS
Children & Women's	CARDIOTHORACIC INTENSIVE CARE U..	0.0	0.0	0.0	76.5			9.2	0.0	1.0	9.5	3.3
	CARMEN SUITE	0.0	0.0	0.0	100.0			6.5	0.0	0.0	35.9	3.0
	CHAMPNEYS	0.0	0.0	0.0	100.0	90.9	9.2	7.3	1.0	0.0	24.7	6.8
	DELIVERY	0.0	0.0	0.0	100.0			9.8	1.0	4.0	15.0	2.4
	FREDDIE HEWITT	0.0	0.0	0.0	100.0			-0.9	0.0	0.0	4.9	4.2
	GENERAL ICU/HDU	0.0	0.0	0.0	100.0			1.0	0.0	0.0	7.2	6.8
	GWILLIM	0.0	0.0	0.0	100.0			8.1	0.0	0.0	0.8	4.5
	JUNGLE	0.0	0.0	0.0				13.5	0.0	0.0	-22.3	2.1
	NEONATAL ICU	0.0	0.0	0.0	100.0			7.3	0.0	0.0	14.1	3.7
	NEURO ICU	0.0	0.0	0.0	100.0			7.2	0.0	0.0	7.0	4.0
	NICHOLLS	0.0	0.0	0.0	100.0			6.5	0.0	0.0	16.6	5.6
	PICU	0.0	0.0	0.0	100.0			28.0	0.0	0.0	7.1	2.4
	PINCKNEY	0.0	0.0	0.0	100.0			11.4	0.0	0.0	-105.1	3.5
Community Ser..	MARY SEACOLE	0.0	0.0	1.0	82.5	37.5	74.4	9.6	10.0	1.0	-8.2	9.0
Medicine & Cardiovascular	ALLINGHAM	0.0	0.0	0.0	87.0	65.7	74.5	8.4	3.0	1.0	14.7	1.1
	AMYAND	0.0	0.0	1.0	88.9	85.7	22.6	13.0	4.0	1.0	3.9	2.7
	BELGRAVE	0.0	0.0	0.0	96.9	52.9	52.6	14.2	4.0	0.0	26.3	2.3
	BENJAMIN WEIR	0.0	0.0	0.0	100.0	96.1	63.8	13.8	3.0	1.0	0.0	2.5
	BUCKLAND	0.0	0.0	1.0	93.8	70.6	50.0	7.1	3.0	1.0	15.2	1.7
	CAESAR HAWKINS	0.0	0.0	0.0	82.6	60.0	81.6	9.0	8.0	0.0	11.1	4.8
	CARDIAC CARE UNIT	0.0	0.0	0.0	100.0	68.2	37.3	6.4	0.0	1.0	-27.7	0.3
	CAROLINE	0.0	0.0	0.0	85.2	68.3	50.6	7.6	4.0	0.0	-7.9	1.6
	CHESELDEN	0.0	0.0	0.0	100.0	85.2	40.3	6.8	4.0	0.0	6.0	2.6
	DALBY	0.0	0.0	0.0	81.8	66.7	40.9	11.8	6.0	0.0	12.2	16.5
	EMERGENCY DEPARTMENT	0.0	0.0	0.0		66.8	12.6	7.2	0.0	2.0	13.9	1.5
	HEBERDEN	1.0	0.0	0.0	87.0	64.3	51.9	12.7	4.0	0.0	24.7	10.5
	JAMES HOPE	0.0	0.0	0.0	100.0	84.0	91.0	11.5	1.0	0.0	4.8	0.0
	MARNHAM	0.0	0.0	0.0	96.6	71.0	82.1	6.7	3.0	0.0	24.1	4.8
	MCENTEE	0.0	0.0	0.0	94.4	75.0	58.5	6.5	4.0	0.0	13.7	1.3
	RICHMOND	0.0	0.0	0.0	96.2	48.6	15.8	11.3	10.0	0.0	12.9	2.9
	RODNEY SMITH	0.0	0.0	0.0	96.3	53.3	34.8	7.3	5.0	0.0	9.8	5.4
	RUTH MYLES	1.0	0.0	0.0	83.3	33.3	46.2	10.3	3.0	0.0	25.7	5.3
	TREVOR HOWELL	0.0	0.0	0.0	88.9	73.7	54.3	4.7	0.0	0.0	5.5	5.4
Surgery & Neurosciences	BRODIE NEURO	0.0	0.0	0.0	86.2	78.6	40.0	11.6	4.0	0.0	-5.2	6.6
	CAVELL	0.0	0.0	1.0	100.0	56.9	51.3	12.1	2.0	1.0	20.7	0.3
	FLORENCE NIGHTINGALE	0.0	0.0	0.0	61.3	61.3	75.7	3.0	1.0	0.0	21.1	8.1
	GRAY WARD	0.0	0.0	0.0	96.4	51.4	31.3	2.4	1.0	0.0	-14.5	4.3
	GUNNING	0.0	0.0	1.0	90.9	28.0	65.4	9.9	1.0	2.0	32.0	6.1
	GWYN HOLFORD	0.0	0.0	0.0	96.2	80.0	66.7	10.6	3.0	0.0	9.0	3.0
	HOLDSWORTH	0.0	0.0	0.0	100.0	56.5	76.7	7.8	3.0	0.0	24.1	9.4
	KEATE	1.0	0.0	0.0	100.0	72.2	96.0	5.9	1.0	0.0	22.7	0.4
	KENT	0.0	0.0	0.0	96.7	70.4	45.9	11.1	7.0	0.0	12.4	1.2
	MCKISSOCK	0.0	0.0	0.0	91.3	55.6	40.0	14.9	1.0	0.0	9.8	8.4
	VERNON	0.0	0.0	0.0	96.9	60.0	42.0	7.2	4.0	0.0	23.2	6.0
	WILLIAM DRUMMOND HASU	0.0	0.0	0.0	100.0	100.0	17.0	10.6	5.0	0.0	10.7	3.5

8. Ward Heatmaps: September 2014

Women's and Children's , Diagnostics and Therapies Division

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

% of harm free care

CTICU - 17 patients were surveyed. 3 new grade 2 and 1 new grade 3 pressure ulcers were reported. 2 patients did not have a fully completed VTE risk assessment and 2 patients had not started appropriate prophylaxis following risk assessment. The team continue with focused work on the prevention of pressure ulcers and it is recognised that due to the acuity of some of the patients within this care setting that some pressure ulcers are unavoidable. The team will be discussing compliance in relation to VTE assessment at the next care group meeting and are reinstating ward round reminders in regard to VTE assessment in order to improve compliance.

Friends and family Response Rate

Champneys ward noted to have a persistently low response rate against this standard. Despite attempts to improve this the team continue to struggle to consistently achieve compliance with this. The Head of Nursing , Matron and Ward Sister have been asked to give further focus to this in order to improve compliance.

Ward Staffing: Unfilled Duty Hours

PICU is reporting 28% of unfilled hours this is despite no safe staffing alerts being received for this area in for September 2014. Additional work is required to with the e- roster team to ensure that the fill rates accurately reflect the staffing on the unit. This work is planned to happen in October 2014.

Serious Incidents

CTICU – this refers to the same grade 3 pressure ulcer that was reported in the safety thermometer return
Delivery – this refers to 3 unexpected admissions to NNU and 1 never event that refers to a retained swab.

All of the above incidents are currently being investigated and the root cause analysis is awaited.

Vacancy Rate

The data regarding vacancy rates is questionable and needs further investigation as the -105.1% in Pinckney is not reflective of current vacancy and Carmen suite at 35.9% also appears to be abnormally high.

Sickness

A number of areas are reporting higher the an average sickness rates. A directorate wide meeting regarding sickness was held in September which demonstrated good sickness management in most areas of the division. Additional meetings will be held as the need dictates.

8. Ward Heatmaps: September 2014

Surgical, Theatres, Cancer and Neurosciences Division

For areas within the Surgical, Theatres, Cancer and Neurosciences Division:

The narrative focuses on those areas with 3 or more red flags but provides comments on other indicators where appropriate:-

Brodie Neuro
Harm free care - flag relates to 3 acquired UTI's – all staff reassessed in terms of catheter care technique and bag positioning- results disappointing as 100% previously. Increased vigilance and oversight from senior team will continue.
Sickness- overall improvements being seen- monthly sickness meetings in place and 3 individuals on LTS now on a phased return.
Unfilled hours- remain an issue for neuro although no red flags. The causes of this have been difficulty in attracting temporary staff, high vacancy factor now recruited into and substantive staff slowly coming on line. Frequent use of escalation areas and specials increasing shift volume above establishment.

Cavell (new 5 day ward except for datix information which is associated with the colorectal ward or new Gray).
Vacancy rate- currently appears high but all posts recruited into.

Gray (colorectal ward)
Pressure Ulcer - grade 3 reported relating to general lack of rigour around initial assessment and delays to starting required treatment- Pressure Ulcer action plan in place following focused session with surgical team reviewing themes and numbers & accountability. Followed up by repeat training sessions.
SI - relates to the above PU.

Florence Nightingale
Harm free care-Lack of clarity around what this 61% relates to, although we suspect data errors as the rate system has a zero entered.
Vacancy rate- Again all vacancies recruited into (8 in total- all pending new starters).
Sickness- long terms and being managed.

Gunning ward
Pressure Ulcers –as above grade 3 reported relating to general lack of rigour around initial assessment and delays to starting required treatment- Pressure Ulcer action plan in place following focused session with surgical team reviewing themes and numbers & accountability. Followed up by repeat training sessions.
SI - relates to the above PU and 1 fall with no associated harm.
Vacancies- 12 in total (4 vacancies and 8 pending new starters).
Sickness- attributable to long term sickness and one staff member being recently medically retired.

Keate
CDT- RCA presented to HCAI and deemed unavoidable.
Vacancies – all appointed into with imminent start dates.

McKissock
Harm free care- relates to lack of documentation of 1 VTE assessment- work being completed at care group level to improve this generally- monitoring in place via DGB.

William Drummond
FFT response rate- cohort of patients often not able to respond which is impacting upon scores- trying the use of a volunteer to see if we can improve this and continue to raise staff awareness.
Falls - Patients highlighted on PSAG boards and identified at handover.

8. Ward Heatmaps: September 2014
Medical and Cardiovascular Division

For Areas within the Medical and Cardiovascular Division:

Allingham: 3 reds – A fall leading to the patient's death is currently being investigated as an SI. Learning and recommendations will come from that. Higher vacancies as new posts in budget for additional beds opening Nov 14 - 4 of 9 posts recruited into. Red for harm free care.

Amyand : 3 reds – Acquired pressure ulcer is being investigated (PUs automatically score two reds). RCA not yet known. Red for harm free care.

Buckland: 3 reds – Acquired pressure ulcer is being investigated. 15% vacancies – 4 of 7 posts have had offer letters sent out.

Emergency department: 3 reds – FFT = 12.6%. Problems with Wi-Fi connectivity have now been resolved. Staff had stopped collecting information during this time. Progress being made with texting as an alternative to collecting information from patients in the department. Due to start Nov14. 2 SIs are being investigated in ED – one patient fall that led to patient dying and one patient that died from sepsis following administration of out of date TPN. Blood results do not appear to have been followed up on. Vacancies 13.9% - All 24 posts recruited to, some slowness in recruitment process in getting staff in post.

Heberden: – 4 reds – C diff currently being investigated. High vacancy and sickness. Monthly HR meeting with head of nursing, matron and ward leaders to review staff sickness. Recruitment into senior health wards continues to present a challenge. Band 7 ward leader has left this month and not yet replaced. Junior sister being supported by Matron to run the ward. Practice educator post vacant and out to advert. Head of Nursing working closely with the Matron to ensure patients kept safe. Red for harm free care.

Dalby :3 reds – 6 falls in month which continues to be fewer than last quarter. Matron has reinforced importance of not leaving patients unattended even for a minute particularly when they have 1:1 care. Ward sickness of 16.5% being managed as above. Red for harm free care related to patient falls, UTIs – both admitted with and acquired and VTE assessments not completed. Medical staff now complete the VTE aspect of harm free care audit.

Ruth Myles : 4 reds – C diff shown to be unavoidable with no care issues identified. Harm free care score due to VTE performance. Higher percentage of vacancies. 2 of 4 posts now filled 2 on maternity leave. 5.3% sickness related to 1 staff on long term sick and one maternity related sickness. Matron has reported low FFT score relates to 1 of 6 patients in month who responded as unlikely to recommend the unit with a comment that bed spaces are too small.

8. Ward Heatmaps: September 2014
Community Services Quality Scorecard

Patient Safety & Experience									
Indicator	Frequency	2014/2015 Target	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Direction
			Quarter 1 2014/15			Quarter 2 2014/15			
SI REPORTED	Monthly		3	7	2	9	3	4	›
Number of breaches	Monthly	0					0	0	›
Grade 3 & 4 Pressure Ulcers	Monthly		3	4	1	7	3	2(2 Grade 3) 1 grade 4 shared and being investigated	›
Grade 4 Pressure Ulcers	Monthly					1		1	›
Number of Fall of No Harm and Low Severity	Monthly		Data not validated					15	
Number of moderate falls	Monthly	0	0	0	0	0	0	0	›
Number of major falls	Monthly	0	0	0	0	0	0	0	›
Number of falls resulting in death	Monthly	0	0	0	0	0	0	0	›
MRSA	Monthly	0	0	0	0	0	0	0	›
CDiff (cumulative)	Monthly	40	0	0	0	0	0	0	›
Number of Quality Alerts	Monthly		8	3	6	5	3	7	˄
% of staff compliant with safeguarding adults training	Monthly	95%	91.1%			92.01% as at 8th Sept 2014		91.21% as at 7th Oct 2014	˅
% of staff compliant with safeguarding childrens training	Monthly	Level 1 95%	91.7%			92.62% as at 8th Sept 2014		91.97% as at 10th Oct 2014	˅
		Level 2 95%	78.4%			80.91% as at 8th Sept 2014		81.27% as at 7th Oct 2014	˄
		Level 3 95%	74.2%			78.42% as at 8th Sept 2014		73.97% as at 7th Oct 2014	˅
Dementia Training	Monthly	<100	13.56% as at 8th September 2014					16.90% as at 7th Oct 2014	˄
Mortality SHMI ratio (Trus)	Monthly	<100	<100	<100	<100	<100	<100	<100	›
Active Claims	Monthly		2	0	1	0	0	2	
Number of Complaints received	Monthly		26 April (12), May (5) June (9)			18			˅
Number of Complaints responded to within 25 days	Monthly	85%	46% April (50%), May (40%) June (33%)			44%			˅
Number of Complaints responded to within 25 days with an agreed extension	Monthly	95%	54%			50%			˅
FFT Score	Monthly		63 based on CSD 2013/14 annual survey						
Sickness Rate -	Monthly	3.50%	5.37%	5.06%	5.48%	3.82%	4.0%	4.16%	˄
Turnover Rate-	Monthly	13%	14.87%	14.76%	14.98%	16.48%	17.1%	17.97%	˄
Vacancy Rate-	Monthly	11%	12.45%	13.10%	14.61%	14.67%	15.7%	15.92%	˄
Appraisal Rates - Medical	Monthly	85%	54.05%	62.07%	71.43%	78.57%	80.8%	78.26%	˅
Appraisal Rates - Non-Medical	Monthly	85%	79.64%	77.36%	74.80%	77.80%	81.1%	83.60%	˄

8. Ward Heatmaps: September 2014
Community Services Quality Scorecard

Patient Safety:

Serious incidents (4): 2 grade 3 pressure ulcers , one grade 4 (shared investigation community nursing and Buckland ward) (Mary Seacole ward QMH, community nursing). Any patient which has been identified being at high risk of PU development or has a minimum grade 2 PU has a senior staff review (TVN and/or clinical team leader) to ensure adequate assessment and preventative measures have been maximised. A deep dive into pressure ulcer management is scheduled for November 2014. 1 death in custody (DIC) at HMPW continues to be investigated.

Quality Alerts: Making a Difference alerts (MAD) enables GPs to express concerns regarding service provision**.** MAD alerts are responded to individually. For September, 6 MAD alerts expressed concern regarding community nursing staffing levels and concern for effective patient care delivery due to vacancy. Community nursing has reviewed and realigned the distribution of staff across the Wandsworth locality and continues to actively recruit to vacant posts and monitor the starter/leaver ratio. CSD are working with Wandsworth CCG to remodel the community adult health service and associated workforce due for implementation by Q42014/15.

Safeguarding: L2 and L3 rolling programme of bespoke safeguarding training is provided by the CSD child safeguarding lead. Staff are identified to attend the training however at times due to caseload pressures and variations to staff, attendance cannot be guaranteed.

Patient experience:

FFT: community services rolled out pilot FFT to all services inline with CQUIN requirement (by Oct 1 2014) to be reported November 2014. Work continues to consider how best to implement FFT in line with national guidance (by end of December 2014) considering the variety of services and the nature and longevity of patient on some caseloads.

Annual patient survey: CSD commenced an internal annual patient survey during September. Results (including comparison to 2013 and 2012) are currently being analysed with first draft report expected December 2014.

Workforce:

Turnover and vacancy management: Offender healthcare, Provider Older care group (incudes community nursing and Mary Seacole ward) have the highest vacancy levels (36.8%, 17.8% respectively) and turnover levels (23%, 21% respectively). A division wide recruitment and retention project commenced September which includes monitoring vacancies and turnover, tracking recruitment and creating local recruitment campaigns.

Appraisals: Following service area targeting the division has successfully increased non medical and medical appraisal rate from 54% (April 2014) to 83.6% and 78% respectively.