St George's Healthcare NHS
NHS Trust

Performance & Quality Report

Trust Board
Month 7 – October 2014

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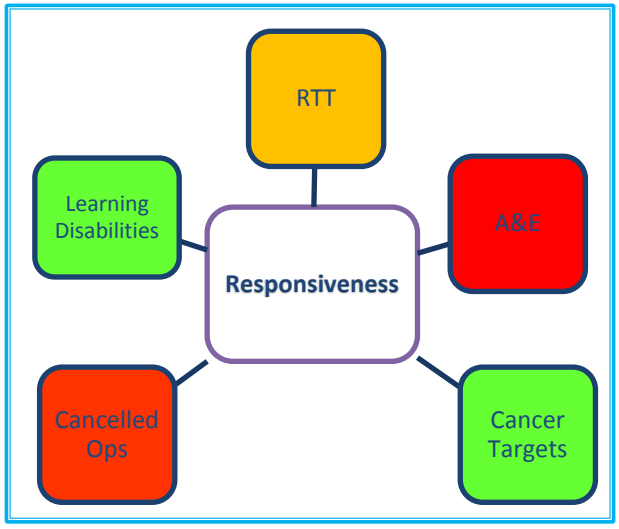
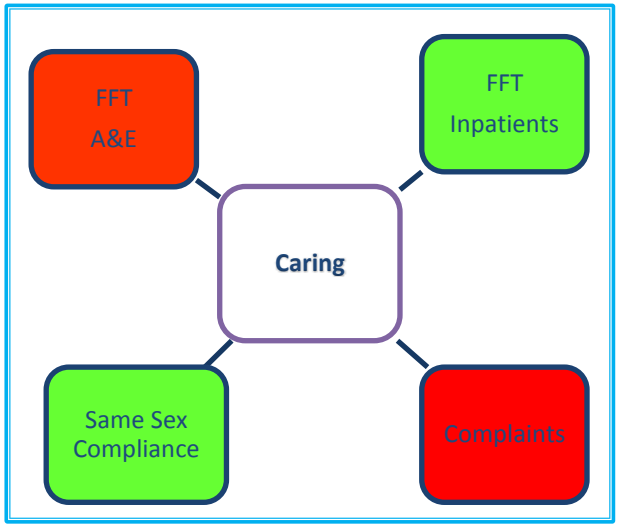
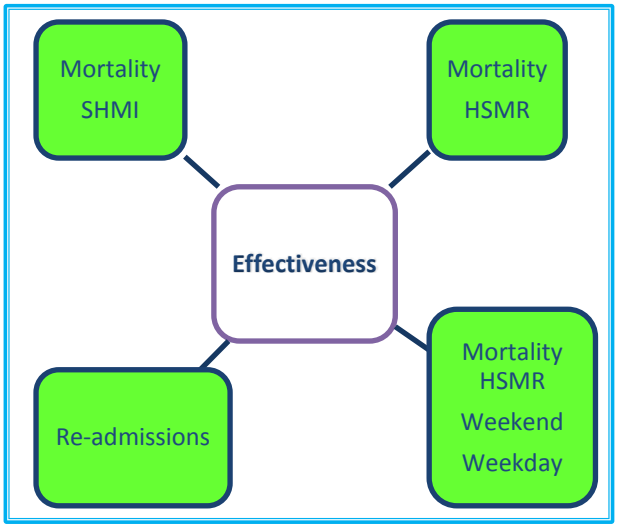
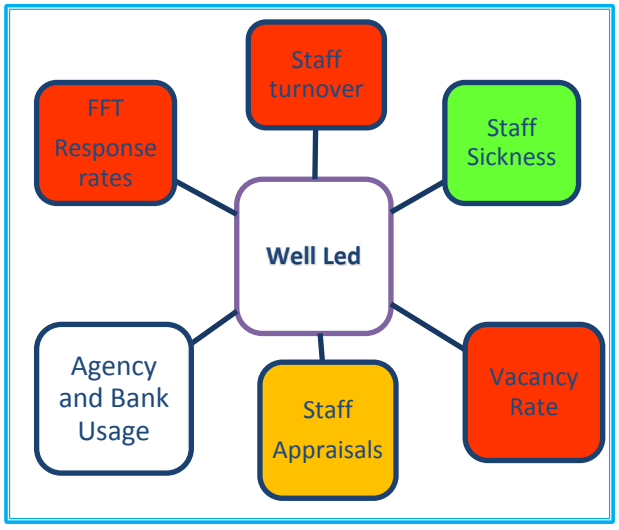
CONTENTS

1. Executive Summary - Key Priority Areas October 2014









The above shows an overview of October 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 Q2 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.

St George's Healthcare NHS
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Performance against Frameworks

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2. TDA Accountability Framework KPIs 2014/15: October 14 Performance (Page 1 of 1)

Responsiveness Domain					
Metric	Standard	YTD	September	October	Movement
Referral to Treatment Admitted	90%		87.90%	85.50%	▼
Referral to Treatment Non Admitted	95%		95.82%	96.60%	▲
Referral to Treatment Incomplete	92%		91.80%	91.30%	▼
Referral to Treatment Incomplete 52+ Week Waiters	0		3	1	▼
Diagnostic waiting times > 6 weeks	1%		0.57%	0.44%	▼
A&E All Types Monthly Performance	95%	94.91%	95.70%	94.16%	▼
12 hour Trolley waits	0	0	0	0	➤
Urgent Ops Cancelled for 2nd time (Number)	0	0	0	0	➤
Proportion of patients not treated within 28 days of last minute cancellation	0%	2.20%	1.90%	2.90%	▲
Certification against compliance with requirements regarding access to health care for people with a learning disability	Compliant	Yes	Yes	Yes	➤
	Standard	YTD	Q1	Q2	Movement
Two Week Wait Standard	93%	94.8%	95.3%	94.7%	▼
Breast Symptom Two Week Wait Standard	93%	95.9%	94.5%	98.5%	▼
31 Day Standard	96%	98.4%	98.2%	98.7%	▲
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%	86.0%	▼
62 Day Screening Standard	90%	91.9%	90.4%	95.4%	▲
Domain Score			4		

Safe Domain					
Metric	Standard	YTD	September	October	Movement
Clostridium Difficile - Variance from plan	0	-1	-1	-1	➤
MRSA bactaraemias	0	3	0	0	➤
Never events	0	3	1	0	▼
Serious Incidents		117	19	18	▼
Percentage of Harm Free Care	95%		94.52%	94.63%	▲
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	95%		96.50%	96.84%	▲
Domain Score			4		

Effectiveness Domain					
Metric	Standard	YTD	September	October	Movement
Hospital Standardised Mortality Ratio (DFI)	100		77.7	77.5	▼
Hospital Standardised Mortality Ratio - Weekday	100		84.4	87.2	▲
Hospital Standardised Mortality Ratio - Weekend	100		82.2	88.64	▲
Summary Hospital Mortality Indicator (HSCIC)	100		80	81	▲
Emergency re-admissions within 30 days following an elective or emergency spell at the Trust	5%	3.3%	3.5%	3.2%	▼
Domain Score			5		

Caring Domain					
Metric	Standard	YTD	September	October	Movement
Inpatient Scores from Friends and Family Test	60		65	67	▲
A&E Scores from Friends and Family Test	46		75	41	▼
Complaints			94	106	▲
Mixed Sex Accommodation Breaches	0	4	0	0	➤
Domain Score			4		

Well Led Domain					
Metric	Standard	YTD	September	October	Movement
IP response rate from Friends and Family Test	30%		46.50%	41.50%	▼
A&E response rate from Friends and Family Test	20%		12.60%	13.70%	▲
NHS Staff Survey: Percentage of staff who would recommend the trust as a place of work	61%	61%			
NHS Staff Survey: Percentage of staff who would recommend the trust as a place to receive treatment	67%	69&			
Trust turnover rate	13%		16.5%	17.2%	▲
Trust level total sickness rate	3.50%		3.4%	3.3%	▼
Total Trust vacancy rate	11%		13.0%	12.9%	▼
Temporary costs and overtime as % of total paybill			9.3%	7.9%	▼
Percentage of staff with annual appraisal - Medical	85%		86.6%	86.7%	▲
Percentage of staff with annual appraisal - non-medical	85%		82.2%	81.5%	▼
Domain Score			3		

Trust Overall Quality Score	4

The trust's self-assessment against the NHS TDA Accountability framework in October 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: October 14 Performance (Page 1 of 1)

Access							
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**Sept**	**Oct**	**Movement**
Referral to Treatment Admitted	90%	1	0		87.94%	85.5%	
Referral to Treatment Non Admitted	95%	1	0		95.82%	96.6%	
Referral to Treatment Incomplete	92%	1	0		91.80%	91.3%	
A&E All Types Monthly Performance (Quarter to date)	95%	1	1	94.91%	95.7%	94.16%	⮟
				YTD	**Q1**	**Q2**	
62 Day Standard	85%	1	0		86.8%	86.0%	⮟
62 Day Screening Standard	90%	1	0		90.4%	95.4%	⮟
31 Day Subsequent Drug Standard	98%	1	0		100.0%	100.0%	⮝
31 Day Subsequent Surgery Standard	94%	1	0		100.0%	100.0%	➤
31 Day Standard	96%	1	0		98.2%	98.7%	➤
Two Week Wait Standard	93%	1	0		95.3%	94.7%	⮟
Breast Symptom Two Week Wait Standard	93%	1	0		94.5%	98.5%	⮝

* NYA Not yet available

Outcomes							
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**Sept**	**Oct**	**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 (August and September)	50%	1			58%	55%	⮟
referral information (September and October)	50%	1			88%	88%	➤
treatment activity (September and October)	50%	1			70%	71%	⮝

Trust Overall Quality Governance Score	1	1	➤

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

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

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

Note: 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:

- A&E 4 Hour Standard
- RTT 52+ Week Waits
- Cancelled Operations
- FFT – A&E
- Workforce

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

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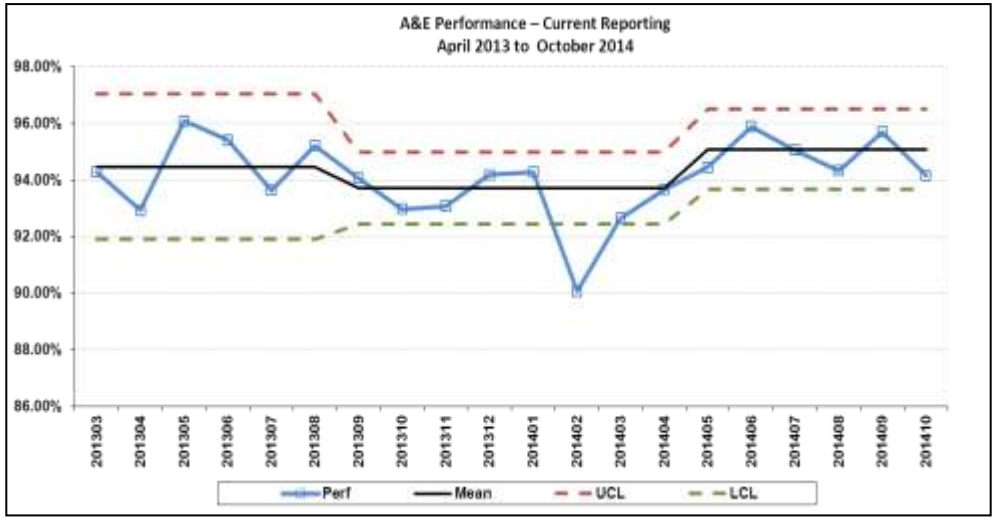
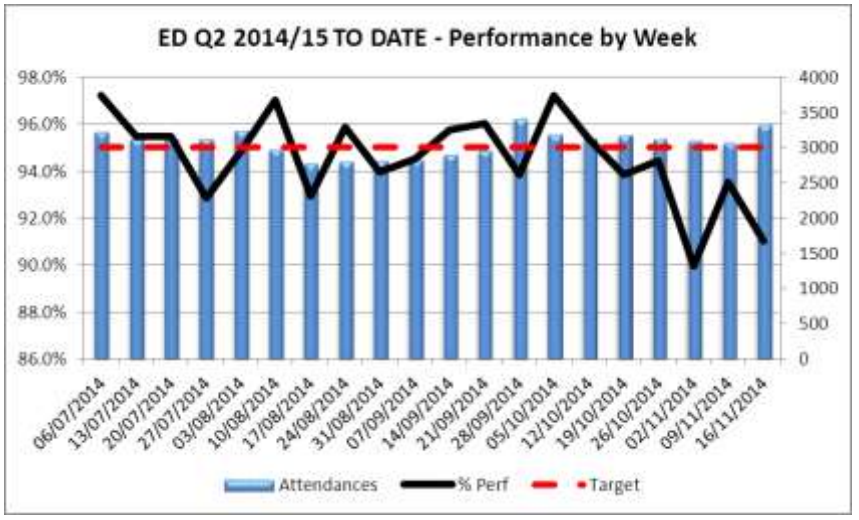
Performance – areas of escalation

4. Performance Area of Escalation (Page 1 of 4)
- A&E: 4 Hour Standard

Total time in A&E - 95% of patients should be seen within 4hrs						
Lead Director	September	October	Movement	2014/2015 Target	Forecast Nov - 14	Date expected to meet standard
FA	95.7%	94.16%	⮟	>= 95%	G	Nov -14

Peer Performance Q3 at 26/10/2014				
STG	Croydon	Kingston	King's College	Epsom & St Helier
95.2.%	94.13%	95.95%	90.24%	96.28%





The ED target is that 95% or more of patients should be seen and discharged within 4 hours of attending the Emergency Department. In October the trust failed to meet the target with 94.16% of patients being seen within 4 hours. The trust has seen a cumulative and sustained performance improvement since March -14. However, the onset of winter pressures has begun to impact across multiple areas, thus impacting on performance. Key noticeable changes include:

- Sharp increase in type-1 activity.
- Increase in the number of ambulance conveyances.
- An increase in the number of high acuity patients with correlating increase in emergency admissions.
- Increase in length of delay for DTOC patients.

The Trust continues to implement and further embed actions to maintain performance improvement as addressed by the trust action plan which focuses on: the wider system, hospital and emergency department, in areas of activity pathways, capacity and supporting management and information. This is further supported and reviewed by commissioners as part of system resilience work being undertaken.

Performance Overview by Type			
	ED	MIU	ED & MIU
	(Type 1)	(Type 3)	(Type 1+3)
Month to Date (October)	*93.52%*	*99.94%*	*94.16%*
Quarter to Date	*93.52%*	*99.94%*	*94.16%*
Year to Date	*94.31%*	*99.84%*	*94.91%*

4. Performance Areas of Escalation (Page 3 of 4) - RTT Incomplete 52+ Week Waiters

Referral to Treatment Incomplete 52+ Week Waiters						
Lead Director	September	October	Movement	2014/2015 Target	Forecast Nov – 14	Date expected to meet standard
SB	3	1	⮟	0	R	Dec-14

Specialty	Patient Type	Date for patient to be treated	Commentary
Cardiology	Inpatient	21/11/2014	Patient was added to the waiting list for treatment on 05/11/2014. The trust can confirm that the patient has now been scheduled for treatment on 21/11/2014. The trust has contacted and confirmed that the patient intends to attend.

All 52+ week waiters reported in September have now been treated and are no longer waiting.

As mentioned last month the trust continues to pro-actively addressing the issue of long waiters and in particular the prevention of 52+ week waiters. The following actions continue to support this:

- Weekly RTT management meetings by care group are now in place which track the PTL and review at patient level, review capacity and escalate long waits.

- A weekly escalation email of long waiters is now sent by the Associate Director of Finance, Contracting and Performance to the Divisional Directors of Operations and Divisional Clinical Chairs to review personally and action those patients waiting for more than 40 weeks.

- A monthly RTT Compliance meeting chaired by an Executive Director is held which reviews; performance by care group with a particular focus on patients waiting 40+ weeks to ensure treatment plans are in place, review/facilitate escalation, provide senior decision making support to drive actions forward, reviews and monitors elective cancellations, their rebooking to target and their impact on RTT performance.

- Recruitment of additional consultants in clinical areas of capacity constraints, such as ENT.
- 2 additional Paediatric ENT Consultants have been appointed, with 1 actively in post from 6th October 2014 and the 2nd due to commence employment from the 1st January 2015
- An additional Head and Neck Consultant has been appointed, and in post full time from 1st November 2014.
- ENT – new Service Manager and an Assistant General manger have been appointed and commenced post as at end August 2014, providing renewed focus to the specialty and actively addressing areas of data quality and capacity.

- Two Executive Director led Task and Finish Groups have been initiated with the first focusing on data quality and IT technical improvements and the second on operational workflow and process improvement. Key workstreams are being identified and actioned upon both in terms of delivering short term ‘quick wins’ and long term strategic service improvement.

4. Performance Areas of Escalation (Page 3 of 5) - Cancelled Operations

Proportion of patients not treated within 28 days of last minute cancellation						
Lead Director	September	October	Movement	2014/2015 Target	Forecast Nov - 14	Date expected to meet standard
CC	1.9%	2.9%	▲	0%	G	Nov - 14

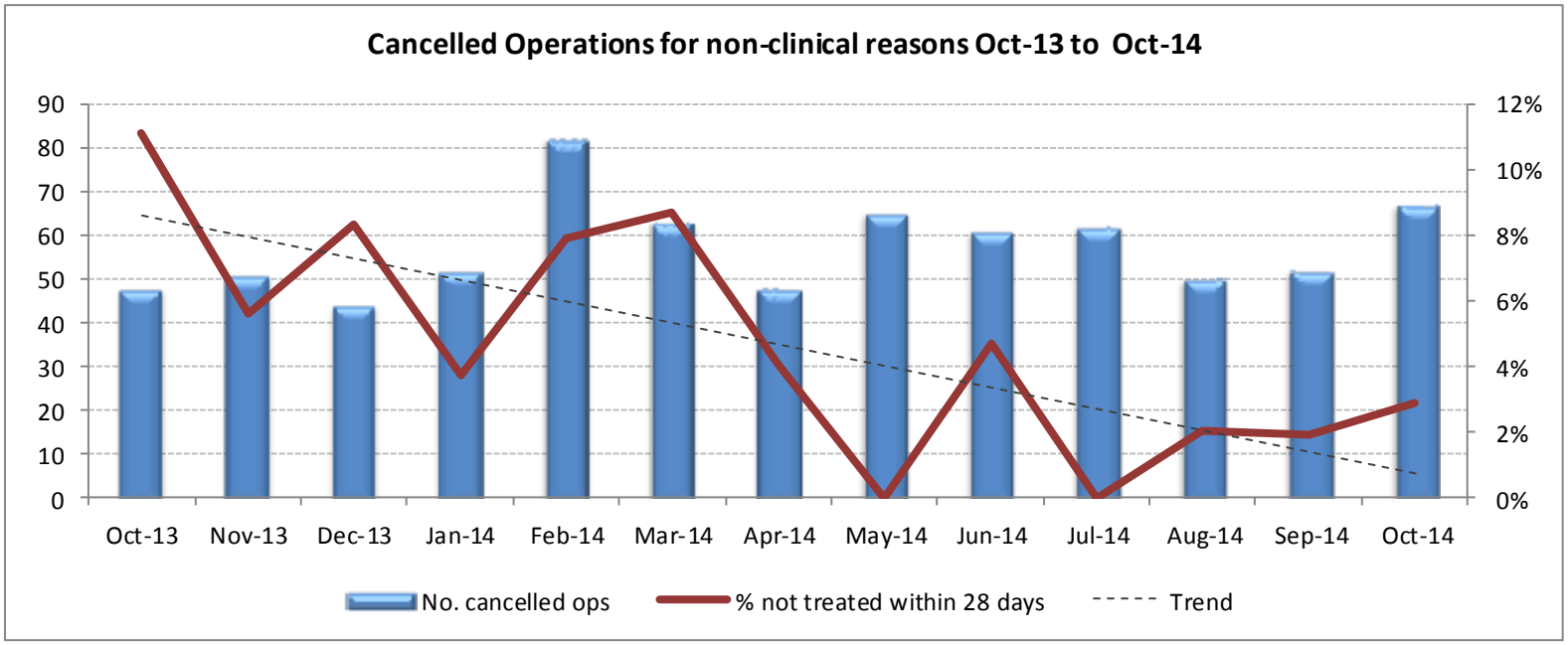
Peer Performance Comparison – Q2 2014/15				
STG	Croydon	Kingston	King's College	Epsom & St Helier
1.2%	5.88%	5.0%	10.75%	1.25%

The national standard is that all patients whose operation has been cancelled for non clinical reasons should be treated within 28 days.

The trust had 69 cancelled operations in October from 4231 elective admissions, 67 of whom were rebooked within 28 days. Two patients were rebooked within 28 days, accounting for 2.9 % of all cancellations.

The breaches were attributable to the Cardiothoracic Clinical Directorate and Surgical Directorate respectively. Key contributory factor s for the cancellations were an increase in emergency/trauma demand and high bed occupancy resulting in a lack of beds for post surgical admission.

The trust pro-actively monitors its elective programme which includes all cancelled operations closely and prioritises them for re-booking. These are also reviewed with commissioners on a monthly basis.



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Divisional Performance Overview

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5. Divisional KPIs Overview 2014/15: October 14 Performance (Page 1 of 3)

Access Metrics

MetricName	Units	RAG (Mth)	Month					YTD				
			Trust	CSW	MED	SN	WC	Trust	CSW	MED	SN	WC
18 Weeks - Admitted waits	%	R ≤86 G ≥90	85.5	n/a	83.7	85.9	88.1	87.7	n/a	85.5	88.3	90.3
18 Weeks - Non Admitted waits	%	R ≤90, G ≥95	96.6	100	94.6	94.7	96.7	97.3	n/a	n/a	n/a	n/a
18 Weeks - Incomplete Waits	%	R ≤92, G ≥92	91.3	99.9	90.0	90.0	93.0	n/a	n/a	n/a	n/a	n/a
52 Week Waiters	No.	G 0, R >0	1	0	1	0	0	24	n/a	n/a	n/a	n/a
6 Week Diagnostic Waits	%	R ≤92, G ≥92	99.6	n/a	n/a	n/a	n/a	99.4	n/a	n/a	n/a	n/a
Operations cancelled for non-clinical reasons	%	G ≤0.8, R ≥1.5	1.8	n/a	2.1	1.8	1.3	1.5	n/a	1.5	1.6	1.3
Cancelled Operations re-booked within 28 days	%	G ≤5, R ≥15	2.9	n/a	3.2	3.1	0	2.1	n/a	1.9	2.7	0
Urgent Operations cancelled for 2nd Time	TBC	-	0	0	0	0	0	n/a	n/a	n/a	n/a	n/a
A&E Waits (4 hours)	%	R ≤95, G ≥95	94.2	99.9	93.5	n/a	n/a	94.9	99.8	94.3	n/a	n/a
LAS handover within 15mins	%	R ≤95, G ≥99	37	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
LAS handover within 30mins	%	R ≤94, G ≥99	83	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
LAS handover within 60mins	No.	G 0, R >0	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
2 week GP referral to 1st outpatient -breast symptoms *	%	R ≤93, G ≥93	98.9	n/a	n/a	98.9	n/a	98.5	n/a	n/a	n/a	n/a
2 week GP referral to 1st outpatient cancer *	%	R ≤93, G ≥93	95.5	n/a	n/a	95.5	n/a	94.7	n/a	n/a	n/a	n/a
31 day second or subsequent treatment (drugs) *	%	R ≤98, G ≥98	100	n/a	n/a	100	n/a	100	n/a	n/a	n/a	n/a
31 day second or subsequent treatment (surgery) *	%	R ≤94, G ≥94	100	n/a	n/a	100	n/a	100	n/a	n/a	n/a	n/a
31 day standard - from diagnosis to first treatment *	%	R ≤96, G ≥96	99.2	n/a	n/a	99.2	n/a	98.7	n/a	n/a	n/a	n/a
62 day urgent GP referral to treament for all cancers *	%	R ≤85, G ≥85	83.5	n/a	n/a	83.5	n/a	86.1	n/a	n/a	n/a	n/a
62 day urgent GP referral to treament from Screening *	%	R ≤90, G ≥90	0	n/a	n/a	0	n/a	0	n/a	n/a	n/a	n/a

5. Divisional KPIs Overview 2014/15: October 14 Performance (Page 2 of 3)

Outcome Metrics

MetricName	Units	RAG (Mth)	Month					YTD				
			Trust	CSW	MED	SN	WC	Trust	CSW	MED	SN	WC
Incidence of C.Difficile	No.	G ≤3, R ≥4	3	0	1	1	1	25	0	15	6	4
Incidence of MRSA	No.	G 0, R >0	0	0	0	0	0	3	0	2	1	0
Ecoli	No.	-	23	0	18	1	4	172	0	141	17	14
MSSA	No.	-	11	0	7	1	3	45	1	36	5	4
Medication Errors causing serious harm	No.	G 0, R >0	0	0	0	0	0	0	0	0	0	0
Trust Acquired Pressure Sores (G3/4)	No.	G 0, R >0	10	6	2	1	1	63	28	16	11	8
Serious Incidents	No.	G 0, R >0	18	7	3	2	6	116	34	26	18	38
Never Events	No.	G 0, R >0	0	0	0	0	0	2	0	0	1	1
C Sections (only applicable to Womens & Children)	%	G ≤28, R ≥30	22.7	n/a	n/a	n/a	22.7	24.2	n/a	n/a	n/a	24.2
Maternal Deaths	No.	G 0, R >0	0	n/a	n/a	n/a	0	1	n/a	n/a	n/a	1
Admission of full-term babies to neo-natal harm	No.	-	5	n/a	n/a	n/a	5	46	n/a	n/a	n/a	46
SHMI	Rate	G ≤100, R ≥100	81	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
HSMR	Rate	G ≤100, R ≥100	77.5	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
VTE Risk Assessment (data submitted to Unify)	%	R ≤95, G ≥95	96.6	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
CAS Alerts	No.	-	14	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
WHO Surgical Checklist (Qrtly audit: sign in/time-out/sign-out)	%	R <100, G 100	93	n/a	94	93	91	n/a	n/a	n/a	n/a	n/a
Average LOS (elective)	days	-	3.5	n/a	4.6	3.3	2.3	3.7	n/a	4.5	3.6	2.7
Average LOS (non-elective)	days	-	4.6	31.2	4.9	6.7	2.3	4.6	27.1	4.7	6.8	2.7
30 Day emergency readmissions (fr elective)	%	-	1.6	n/a	1.6	1.8	0.4	1.4	n/a	1.3	1.7	1.3

Research

MetricName	Units	RAG (Mth)	Month					YTD				
			Trust	CSW	MED	SN	WC	Trust	CSW	MED	SN	WC
70 day - PI REPORT ..	%	R ≤30, G ≥70	75	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Green Rated Time to target of all Open CLRN Studies	%	R ≤45, G ≥70	51.3	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
TIME TO TARGET - PD REPORT ..	%	R ≤45, G ≥70	43	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Total recruitment at St Georges NHS - cumulative	No.	R ≤150, G ≥320	5177	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

5. Divisional KPIs Overview 2014/15: October 14 Performance (Page 3 of 3)

Quality Governance Indicators

MetricName	Units	RAG (Mth)	Month					YTD				
			Trust	CSW	MED	SN	WC	Trust	CSW	MED	SN	WC
Mixed Sex accommodation	No.	G 0, R >0	0	0	0	0	0	4	0	4	0	0
Staff Turnover	%	G ≤13, R ≥15	17.4	19.9	18.3	15.1	17.7	n/a	n/a	n/a	n/a	n/a
Voluntary Staff Turnover	%	G ≤10, R ≥12	13.9	15.5	15.8	12.3	13.2	n/a	n/a	n/a	n/a	n/a
Sickness/absence rate *	%	G ≤3.5, R ≥5	3.3	4.4	2.9	3.6	3.1	n/a	n/a	n/a	n/a	n/a
Vacancy rate	%	G ≤11, R ≥13	12.2	17.9	11.1	13.4	8.9	n/a	n/a	n/a	n/a	n/a
Percentage of staff appraisal (medical)	%	R <70, G ≥85	86.7	86.4	86.2	87.2	86.3	n/a	n/a	n/a	n/a	n/a
Percentage of staff appraisal (non-medical)	%	R <70, G ≥85	83.6	84.3	86.2	81.1	86.2	n/a	n/a	n/a	n/a	n/a
Complaints - response within 25d *	%	R ≤85, G ≥85	66.0	80	72.7	74.3	42.9	63.0	60	71.0	63.3	58.4

Key Messages:

This section headed 'Access' indicates how effective the trust is at providing patients with the appointments and treatment they need and require in accordance with the national standards and the NHS Constitution.

LAS arrivals to patient handover times, continues to fluctuate. As the end of October and as published on the LAS portal 37% of patients had handover times within 15 minutes and 83% within 30 minutes. It must be noted that St Georges are not outliers in the sector (, overall performance in the sector was 43% for 15 minutes and 91% for 30 minutes, both of which are below the required target of 100%. The trust are unable to validate or analyse in detail the 15 minute handover performance, due to unavailability of information from LAS. This has been raised with commissioner and it is expected that this will be possible from December. With regards to 30 minute handovers, the trust has validated data and recalculates performance to be 98.12%. The portal is to be updated in due course. There were no 60 minute breaches.

The trust is aiming for zero tolerance of avoidable pressure ulcers in 2014/15 and has placed significant importance on prevention and education of PU's . In October the trust reported a total of 10 Grade 3 and O Grade 4 Pressure Ulcers . All grade 3 and 4 pressure ulcers acquired in our care are investigated as serious incidents, and a. full investigation and Root Cause Analysis is produced for each and reviewed at the Pressure Ulcer Strategy group, chaired by the Deputy Chief Nurse.

There were 18 serious incidents reported in the month of September with all SIs in the month completed within deadline.

The Trust met all cancer targets for Q2 and October, with the exception of the 62 day standard which was not met for the month with a performance of 83.5% against a standard of 85%. A predominant factor contributing to underperformance is a high number of late referrals from other providers after breach date. Thus the trust is not able to influence these and accrues shared breached. The trust had 10.5 breaches of the standard in October, with 7.5 being shared breaches from other trusts. Excluding late referrals/shared breaches, the trusts performance would be 93.5% and compliant with the standard.

Data for Complaints is 1 month in retrospect.

St George's Healthcare NHS
NHS Trust

Clinical Audit and Effectiveness

excellent kind responsible respectful

4. Clinical Audit and Effectiveness - Mortality

HSMR (Hospital standardised mortality ratio)						
Lead Director	October	November	Movement	2014/2015 Target	Forecast November 14	Date expected to meet standard
RGW	77.5	76.7	↓	<100	G	Met

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

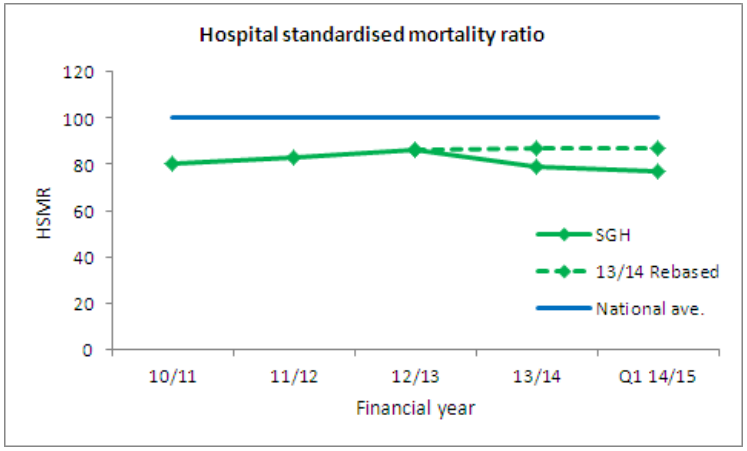
Note: Source for HSMR mortality data is Dr Foster Intelligence, published monthly. Data is most recent rolling 12 months available. For November 14 this was August 13 to July 14. SHMI data is published by the Health and Social Care Information Centre 6 months retrospectively. The last 12 month period as published on 23rd October is reported and relates to the period April 2013 to March 2014. The publication of data for July 2013 to June 2014 is expected in January 2015.

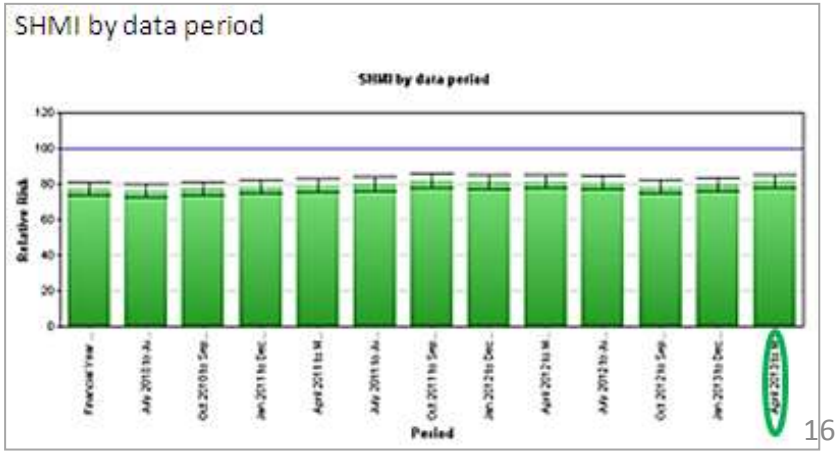
Overview:

The latest SHMI data published in October identified St George's as one of 17 trusts whose SHMI is 'lower than expected'. Furthermore, we were one of 13 trusts named as having lower than expected mortality for two consecutive years.

Data derived from the Dr Foster Intelligence benchmarking tool confirms this position as our hospital standardised mortality ratio remains significantly better than expected. Although technical issues have delayed Dr Foster's implementation of re-based data throughout the benchmarking tools, they did recently publish mortality data for 2013/14 which was recalculated to reflect changes over the last 12 months. This showed that our HSMR was better than expected, as was our mortality for weekday emergency admissions, at 87.2 and 89.4 respectively. Mortality for weekend emergency admissions and deaths in low risk diagnosis groups (defined as deaths per 1000 spells for conditions normally associated with a very low mortality rate) were both within expected range at 88.64 and 0.91 respectively.

National publication of consultant outcomes data is now in it's second year and to date 9 specialties have been published, namely adult cardiac surgery, bariatric surgery, colorectal surgery, interventional cardiology, orthopaedic surgery, thyroid and endocrine surgery, urological surgery, vascular surgery and lung cancer surgery. The data paints a positive picture of outcomes for patients treated at St George's and we are not identified as a negative mortality outlier at either trust or individual consultant level in any specialty. Links to each of the reports are provided on the public website.





4. Clinical Audit and Effectiveness - National Audits

National Hip Fracture Database (NHFD) Report 2014

	St George's	Overall London	Overall National
Number of cases submitted	247	6,058	64,838
Standard 1: Admitted to orthopaedic ward within 4 hours	25.2%	28.4%	47.4%
Standard 2: Surgery on the day of or day after admission	69.6%	73.7%	71.7%
Standard 3: Patients developing pressure ulcers	2.7%	3.6%	2.9%
Standard 4: Senior geriatric review within 72 hours of admission	32.0%	87.4%	81.6%
Standard 5: Bone health medication assessment performed	95.9%	99.1%	96.1%
Standard 6: Specialist falls assessment performed	99.5%	99.0%	94.6%
Abbreviated mental test performed	81.0%	96.1%	93.7%
Best practice tariff attainment	17.0%	58.5%	60.6%
Mortality 2011 to 2013 – Case-mix adjusted	6.8%	N/A	N/A
Return home from home within 30 days – Case-mix adjusted	46.0%	N/A	N/A
Mean length of total trust stay (acute + post-acute) (days)	22.2	21.3	19.8%
30 day follow-up completion rate	0.0%	16.4%	39.7%

Green - Better than National Average
Red - Worse than National Average

Overview

This is the sixth national report and the fourth to include data for St George's. Data was submitted for 247 cases between 1st January 2013 and 31st December 2013. Care is audited against six key standards, as shown in the table which compares Trust results with London and national results.

St George's results demonstrate that for outcome measures, i.e. pressure ulcers and mortality, our performance is above the national average. However, there are a number of process measures for which out results are poor.

The number of fractured neck of femur patients admitted has grown by approximately 25 per cent due to our trauma centre status and the resources required to accommodate this have not yet increased sufficiently. The Trauma & Orthopaedic service have a number of actions underway which it is anticipated will improve the level of service measured by this audit.

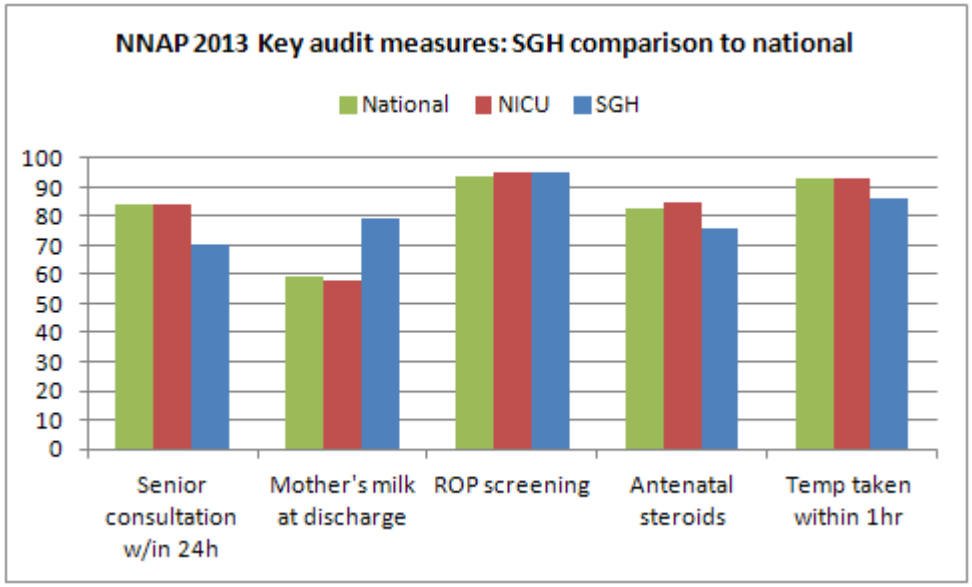
Business cases have been prepared in order to increase consultant numbers. This will support improved discharge planning, facilitating quicker admission to the orthopaedic ward. Another business case has been developed to accommodate additional trauma capacity, thereby reducing delays between admission and surgery.

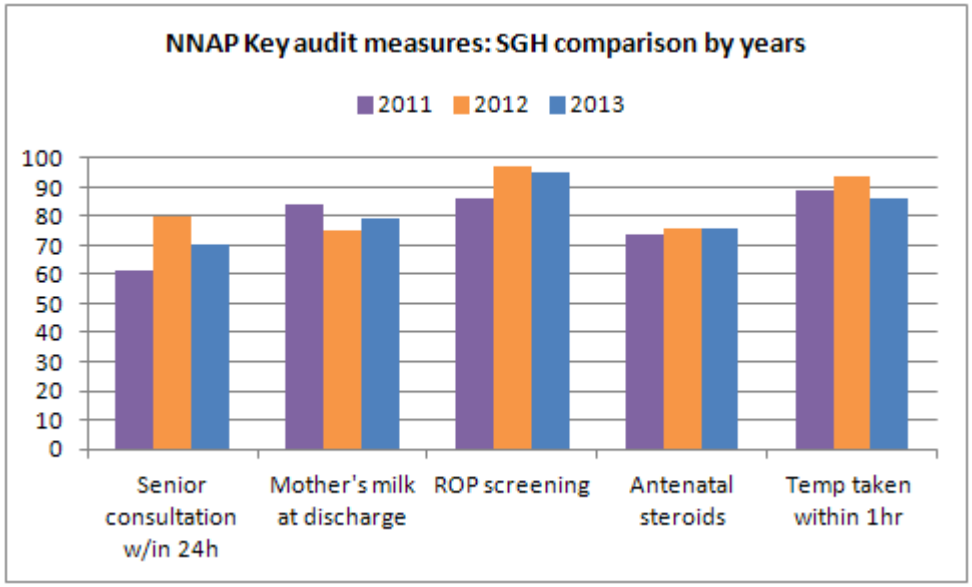
It is expected that an additional ortho-geriatrician will be in post from March 2015. This role will impact on a number of standards, including senior review within 72 hours of admission and medication assessment. Three additional physician assistant posts have also been introduced which through a shared workload will enable improvement in a number of standards such as bone health assessment and conducting the abbreviated mental test. Recruitment of a dedicated trauma co-ordinator who will be responsible for co-ordinating the collation and completion of the trust's NHFD data will ensure robust data entry and an accurate reflection of our service.

Delivery of this action plan and the improvement in standards that are expected to result will enable us to increase our attainment of the best practice tariff.

4. Clinical Audit and Effectiveness - National Audits

Neonatal National Audit Programme (NNAP) 2013





This is the seventh annual report, detailing the care received by 80,000 babies discharged in 2013. The audit aims to assess whether babies requiring specialist neonatal care receive consistent high quality treatment and to identify areas for improvement. St George's, which is classified as a neonatal intensive care unit, submitted 2,111 completed episodes of care to the audit.

A number of key messages are detailed in the national report. Principal among these is the importance of hypothermia. Our data shows the percentage of babies whose temperature is taken within 1 hour or birth has decreased from last year and is now slightly below the national average. Of those babies 3% were hypothermic with a temperature below 36 degrees, and 35% below 36.5 degrees; comparing favourably to the national picture of 12 per cent and 41 per cent respectively.

The clinical lead for the national audit suggests that babies born early have much to gain from breastfeeding as they will be at lower risk of complications of prematurity and less susceptible to allergy and infections. It is positive to note that the percentage of babies discharged from St George's on at least some of their mother's milk remains significantly higher than the national average , at almost 80 percent.

The percentage of parents that have spoken to a senior member of the neonatal team within 24 hours of their baby's admission has decreased and is lower than the national average. This is due in part to insufficient data as this question was not answered for 13 per cent of cases.

Babies born after 34 weeks tend not to be admitted to the neonatal unit if they are well, which means that data regarding temperature, time of consultation and steroids is often absent. This affects a number of our measures, including antenatal steroid cover which appears lower than the national average. The clinical team are looking at ways to address these issues in order to improve our submissions in 2014 which will in turn provide a more accurate and complete picture of care and service delivery at St George's.

4. Clinical Audit and Effectiveness - National Audits

National Congenital Heart Disease Audit Report 2010/13 (NICOR)

The National Congenital Heart Disease Audit (NCHDA) collects data from all centres undertaking congenital cardiac surgery and interventional procedures in the UK and Republic of Ireland. It aims to improve the quality of specialist congenital care by providing reliable data on patient outcomes.

St George's is one of 20 centres who undertake procedures in adult patients with congenital heart disease, which refers to any defect of the heart present from birth. It includes structural defects, congenital arrhythmias and cardiomyopathies. The audit does not include treatment of acquired heart disease which develops after birth.

Congenital heart disease is relatively rare and due to the relatively small number of cases the report provides composite 3 year results for procedures performed between 01/04/10 and 31/03/13.

Data submitted to the audit is subjected to rigorous validation comprising site visits by a clinical auditor and volunteer clinician. Following the validation visit a data quality indicator is calculated, with NICOR's expectation that units will achieve 90 per cent. St George's consistently achieves this standard, with our most recent score being 90.75.

The report highlights that 30 day survival rates for the 57 major surgical and transcatheter cardiovascular interventions undertaken to treat congenital heart disease is above the alert limit for all procedures in all hospitals. St George's conducts seven of these procedures and 30 day survival is 100 per cent for each.

St George's 30 day survival (01/04/10 – 31/03/13)

Procedure	Cases	30 day survival
Aortic valve replacement – non Ross	7	100%
ASD closure (catheter)	56	100%
ASD repair	8	100%
Mitral valve replacement	1	100%
PFO closure (catheter)	124	100%
Subvalvar aortic stenosis repair	1	100%
VSD repair	1	100%

Source: NICOR (National Institute for Cardiovascular Outcomes Research)

4. Clinical Audit and Effectiveness - National Audits

UK Inflammatory Bowel Disease (IBD) Audit

IBD Key Indicators - Adults Crohn's Disease (CD)	SGH	National
Number of patients with CD entered	23	2715
Patients with CD given 160/180 mg of Adalimumab at induction	N<6	77% (1112/1449)
Response to treatment	N<6	87% (195/224)
Remission achieved	N<6	70% (170/244)
Patients with at lease one adverse event	33% (6/18)	11% (180/1667)
Patients with CD on concomitant therapy, 5-ASA at induction	0% (0/24)	17% (481/2813)
Patients with CD, treatment effective and discontinued at follow-up	N<6	11% (45/392)

IBD Key Indicators - Paediatrics Crohn's Disease (CD)	SGH	National
Number of patients with CD entered	9	524
Number of CD follow-up treatments after initial infusion	25	1511
Response to treatment	N<6	77% (53/69)
Remission achieved	N<6	65% (46/71)
Patients with CD treated with infliximab appropriately prescribed in compliance with NICE criterion 1.5 (TA187)	N<6	12% (25/201)
Number of CD patients with PROM data completed at initial treatment	67% (6/9)	19% (88/459)
Number of CD patients with PROM data completed at follow-up treatment	8% (2/25)	5% (71/1511)

Biological Therapies Report September 2014

This audit measures the efficacy, safety and appropriate use of biological therapies (anti-TNFα therapy - Infliximab and Adalimumab) in patients with IBD in the UK and captures the views of patients on their quality of life at intervals during their treatment. This is the third report of the biological therapy element of the audit. This audit provides an opportunity to review treatment against NICE recommendations (TA187). The national results suggest that biological therapies are safe and effective treatments for IBD and are used to good effect in participating sites in the UK. There are some key recommendations in the report for the services to consider.

The site level data analysis only included cases of Crohn's disease. For adults we submitted 23 cases (n=2715 nationally) during 12 September 2011 and 28 February 2014. For paediatrics we submitted 9 cases (n=524 nationally) for the same period.

The data submitted included initial treatments and follow-ups. However due to low numbers local results were not presented for most of the key indicators for SGH and most other hospitals. For the 9 paediatric cases submitted we had 25 follow-up treatments and for 67% (6/9) patients we had the PROM data completed at initial treatment.

Organisational Audit Report September 2014

This report examines the quality of adult IBD services throughout the UK. Participating services were asked to report the status of their own service as at 31 December 2013. The quality of a service is assessed against the *Standards for the healthcare of people who have inflammatory bowel disease.* The report included data on demographics, patient experience, clinical quality, organisation and choice of care, research, education and audit. These results have been circulated to service leads who indicated that there are some building structure issues. In particular we have insufficient toilet facilities in Allingham ward but it is anticipated that this will be addressed in the imminent redevelopment of the ward. They also indicated that the common theme for aspects where improvement is required relates to IBD nurse support. The report recommends that we have 1.5WTE/250,000 population. Currently we have only one adult IBD nurse specialist for SGH and the service indicated that we should have 4 IBD nurses for the population we serve. This recommendation has been reported to the general manager for consideration. For paediatrics we have had 1.2 WTE paediatric IBD nurse specialists since September 2014.

4. Clinical Audit and Effectiveness

London Ambulance Service (LAS) Cardiac Arrest Annual Report 2013/14

Survival per Hospital

Hospital	2011/12*			2012/13*			2013/14*		
	Number of Patients	Survival with ROSC sustained to hospital		Number of Patients	Survival with ROSC sustained to hospital		Number of Patients	Survival with ROSC sustained to hospital	
Barnet	78	7.7%	(2/26)	60	10.0%	(2/20)	58	24.2%	(8/33)
Central Middlesex	37	10.0%	(1/10)	20	0%	(0/8)	21	0.0%	(0/1)
Charing Cross	36	30.0%	(3/10)	48	33.3%	(8/27)	43	47.1%	(8/17)
Chase Farm *	47	23.1%	(3/13)	66	8.0%	(2/25)	24	36.4%	(4/11)
Chelsea & Westminster	44	27.8%	(5/18)	24	17.6%	(3/17)	40	25.0%	(4/16)
Croydon	133	25.0%	(12/48)	117	14.3%	(7/49)	104	8.1%	(2/33)
Darent Valley	17	28.6%	(2/7)	17	33.3%	(2/6)	16	18.7%	(1/6)
Ealing	58	27.6%	(8/29)	63	3.8%	(1/26)	78	18.5%	(5/27)
Hammersmith	158	57.5%	(46/80)	113	40.5%	(32/79)	119	49.4%	(40/81)
Harefield	36	56.7%	(17/30)	41	40.5%	(15/37)	36	40.0%	(12/30)
Hillingdon	100	16.0%	(8/50)	84	33.3%	(14/42)	82	29.7%	(11/37)
Homerton	43	11.1%	(2/18)	58	23.1%	(6/26)	35	10.0%	(1/10)
King's College	159	46.6%	(41/88)	180	32.0%	(32/100)	181	51.1%	(46/90)
King George	66	10.5%	(2/19)	61	6.5%	(2/31)	69	16.7%	(5/30)
Kingston	67	20.0%	(8/30)	63	9.5%	(4/42)	63	4.0%	(1/25)
London Chest	99	66.1%	(39/59)	87	45.8%	(33/72)	107	47.3%	(43/91)
Newham	103	15.6%	(5/32)	68	14.8%	(4/27)	81	11.1%	(2/18)
North Middlesex	82	36.2%	(13/36)	89	18.9%	(10/53)	107	14.3%	(8/42)
Northwick Park	114	13.6%	(8/44)	152	7.7%	(5/65)	127	9.3%	(4/43)
Princess Royal	79	14.8%	(4/27)	64	19.4%	(6/31)	87	31.4%	(11/35)
Queen Elizabeth	128	27.3%	(12/44)	121	34.5%	(20/58)	133	29.6%	(16/54)
Queen's	125	5.3%	(2/38)	166	14.9%	(7/47)	148	12.3%	(7/57)
Royal Free	99	46.7%	(28/60)	115	45.2%	(33/73)	129	36.8%	(31/80)
Royal London	92	34.2%	(13/38)	98	30.8%	(12/39)	100	20.0%	(8/40)
St George's	150	37.4%	(34/91)	171	37.9%	(38/95)	188	42.6%	(46/108)
St Helier	83	7.1%	(2/28)	59	4.3%	(1/23)	59	9.1%	(2/22)
St Mary's	82	23.8%	(5/21)	68	11.1%	(3/27)	73	32.0%	(8/25)
St Thomas'	97	36.6%	(15/41)	89	40.0%	(16/40)	97	42.0%	(21/50)
The Heart	19	76.5%	(13/17)	21	72.2%	(13/18)	24	70.0%	(14/20)
University College Hospital	41	33.3%	(6/18)	62	28.6%	(6/21)	51	42.1%	(8/19)
Lewisham	106	28.2%	(11/39)	100	26.7%	(8/30)	79	20.8%	(5/24)
West Middlesex	103	20.5%	(8/39)	91	25.0%	(9/36)	85	29.0%	(9/31)
Whipps Cross	115	18.2%	(6/33)	98	7.3%	(3/41)	108	21.2%	(11/52)
Whittington	37	22.2%	(2/9)	70	31.0%	(9/29)	51	19.2%	(5/26)
Other Hospitals	8	0.0%	(0/4)	3	-	-	9	50.0%	(2/4)

+ Denominators exclude patients with unknown survival outcomes.
*Please note that Chase Farm A&E closed on the 9th December 2013.

Source: London Ambulance Service

Rhythm + survival per Heart Attack Centre (post ROSC patients with STEMI)

Heart Attack Centre	Number of Patients	Initial Rhythm			Survival to discharge+
		Asystole	VF/VT	PEA	
Hammersmith	42	16.7% (7)	66.6% (28)	16.7% (7)	52.5% (21/40)
Harefield	26	26.9% (7)	65.4% (17)	7.7% (2)	42.3% (11/26)
King's College	44	13.6% (6)	77.3% (34)	9.1% (4)	52.3% (23/44)
London Chest	72	12.5% (9)	72.2% (52)	15.3% (11)	36.6% (26/71)
Royal Free	43	9.3% (4)	76.7% (33)	14.0% (6)	47.6% (20/42)
St George's *	37	13.9% (5)	75.0% (27)	11.1% (4)	51.4% (18/35)
St Thomas'	20	10.0% (2)	85.0% (17)	5.0% (1)	58.8% (10/17)
The Heart	13	-	84.6% (11)	15.4% (2)	61.5% (8/13)

* One patient had no initial rhythm documented.
+ Denominators exclude patients with unknown survival outcomes.

9,805 patients suffered an out-of-hospital cardiac arrest in London during 2013/14. The care that out-of-hospital arrest patients receive from Emergency Medical Services influences their immediate survival chances and long term outcomes. The report presents key information regarding response and treatment by the LAS, factors that may affect survival, and outcomes. The report focuses on the 44.0% of patients (n=4317) where resuscitation was attempted by LAS staff.

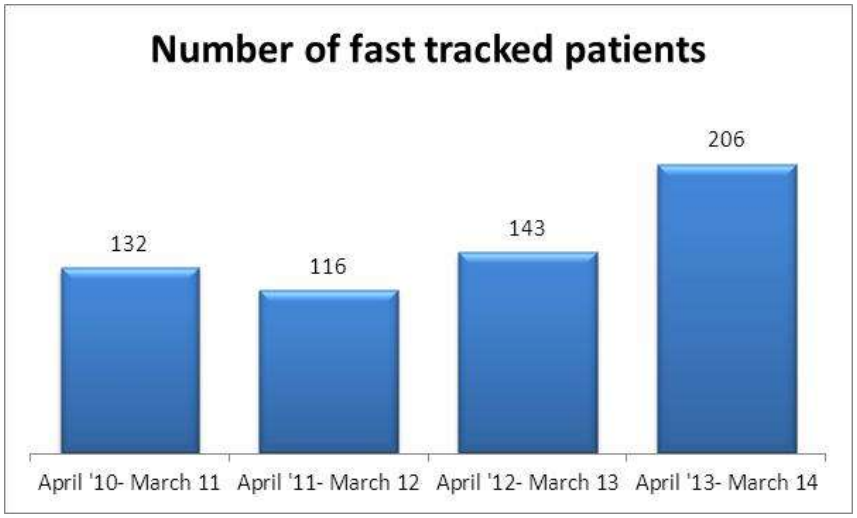
The overall survival rate for all patients where resuscitation was attempted is 10.3% and the Utstein survival (witnessed, initially shockable rhythm of VF or pulseless VT, presumed cardiac aetiology) is 32.4%. For both measures this is the highest rate observed to date.

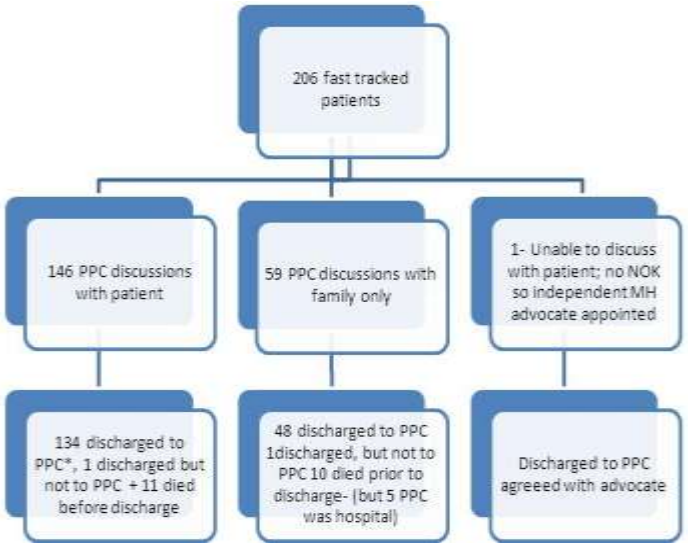
Data is provided on survival rates per hospital, for patients that had return of spontaneous circulation (ROSC) sustained to hospital. It should be noted that in 2013/14 St George's received the highest number of patients overall and the highest number with ROSC; of which 42.6% (n=46) survived to discharge. This rate is increased from 37.4% in 2011/12 and 37.9% in 2012/13.

Patients who have suffered a cardiac arrest of presumed cardiac origin and with ST elevation myocardial infarction (STEMI) on a 12-lead ECG post ROSC are eligible to be conveyed to one of the 8 London Heart Attack Centres (HAC). The HAC will undertake immediate angiography with a view to carrying out rapid primary Percutaneous Coronary Intervention (pPCI) as necessary. During 2013/14 297 patients were treated under this pathway. These patients had a survival rate of 47.6%, which is considerably higher than the survival rate of presumed cardiac patients in general , which was 11.2%. Of the 37 patients admitted to the St George's HAC from LAS, survival outcome was known for 35. Of these, 51.4% (n=18) survived to discharge.

4. Clinical Audit and Effectiveness - Local audit

End of Life Discharge Home Service Report Q2 2014/15





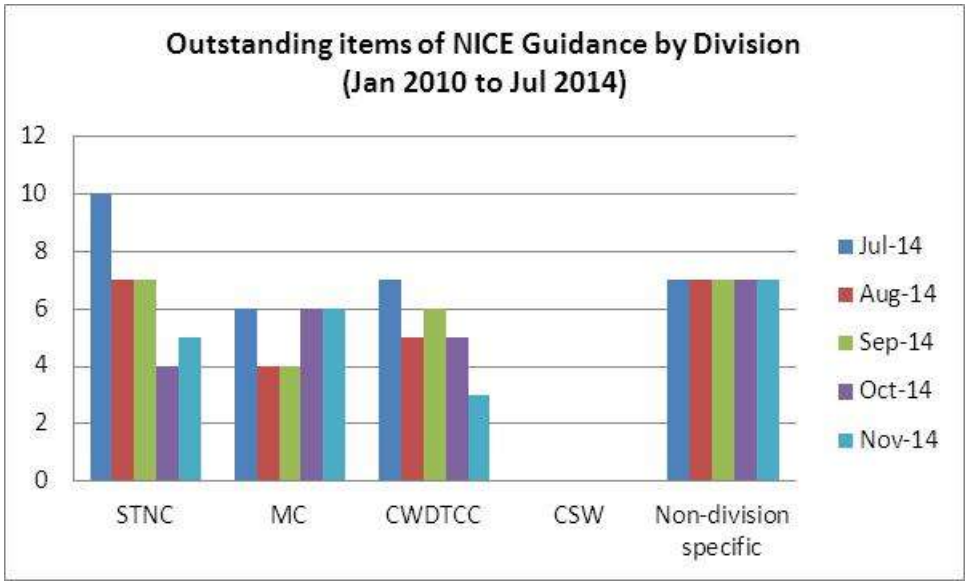
Overview

The end of life discharge home service was designed by the palliative care team at St George's Healthcare NHS Trust in response to the End of Life Care Strategy (DH, 2008) with the aim of improving discharge from hospital for patients approaching the end of their life. The service has now been running for 4 and a half years, with the numbers of referrals to the service rising steadily. However on the 1st April 2013, the revised National Framework for NHS Continuing Healthcare and NHS funded Nursing Care came into effect. These new guidelines stipulate that a patient is eligible for the 'fast track continuing care pathway' if they have a rapidly deteriorating condition that may be entering the terminal phase and thereby extended the scope of the service we provide.

The audit looked at the period April 13 to March 14. The charts shown alongside demonstrate not only an increased demand compared to previous years, but also that we have achieved a high number of patients discharged to their preferred place of care (PPC). The increase in the number of accepted referrals has largely come from those where the prognosis estimate was months or uncertain, in line with the revised National Guidelines. The development of 'ward led fast tracks' for less complex patients, regardless of prognosis could aid the ongoing provision of this service. A pilot of this pathway has already proved successful.

The recommendation of the palliative care team is that capacity to continue to provide the service is managed by the development of "ward led" discharges undertaken by ward based discharge coordinators with support and assistance from the palliative care team. Guidelines to support ward discharge coordinators have been developed by the palliative care team, and they are currently working alongside a Programme Board project looking at improving discharges across the Trust as a means to facilitate ward led 'fast track pathway' discharges.

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



Items of NICE Guidance with Compliance Issues (Jan 2010 to Jul 2014)	
Division	**Number**
STNC	n=7
M+C	n=14
CWDTCC	n=12
CSW	n=0
Non-division specific	n=6

Overview

During November and December the clinical audit team will be focussing on the non-division specific NICE guidance which is outstanding as there has been no change for the past 5 months. The team will also be targeting those divisions where there is lack of movement or an increase in the number of outstanding items of NICE guidance. This focus will help to avoid a return to the trust's previous situation of an increasing and persistent backlog. In December the audit team will also perform the six-monthly review of all guidance with compliance issues, enabling us to develop an accurate picture of implementation and to form an understanding of any risk associated with non-compliance.

There were 18 items of NICE guidance released in August and September 2014 and we have already received 9 responses, suggesting that the increased clinical engagement previously reported has been sustained. For guidance issued between January 2010 and Jul 2014 there are currently 21 items of guidance outstanding; a reduction of 1 from the previous report even with an additional month's guidance (July 2014) included. Following up outstanding NICE guidance and supporting divisions with implementation is ongoing and will continue to be a priority for the Clinical Audit department.

Patient Safety

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

Closed Serious Incidents (not PUs)				
Type	Aug	Sept	Oct	Movement
Total	7	7	5	⮟
No Harm	5	2	3	➤
Harm	2	5	2	⮟

S	Q1 SIs Declared by Division (Inc. Pus)				
	Med & Card	Surgery & Neuro	Community	Children's and Womens	Corporate
August	4	2	**3**	3	0
Sept	7	4	**3**	4 + one never event – retained swab	1
Oct	3	2	**7**	6	0

Table 1

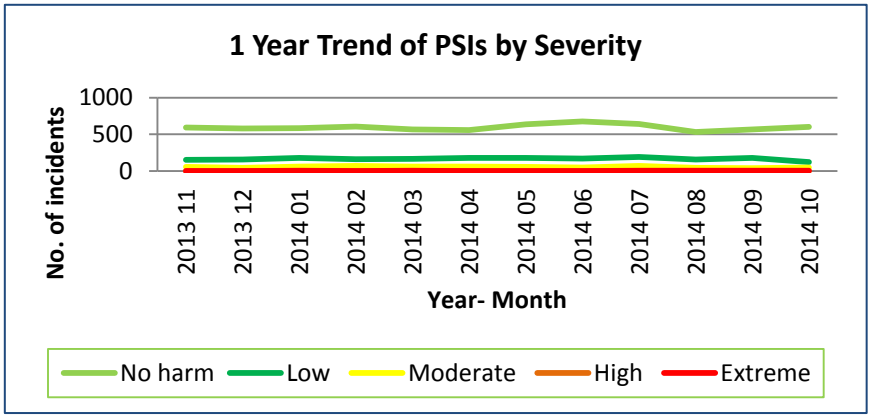
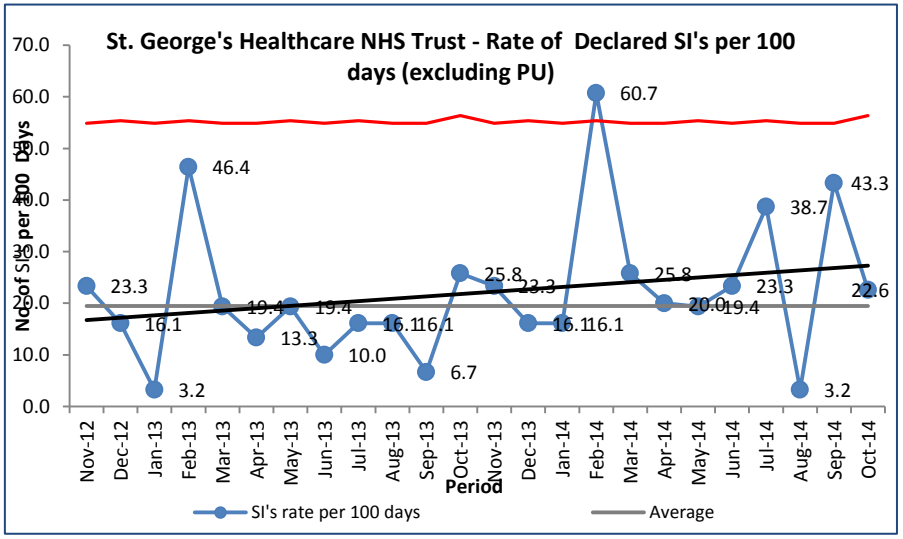


Table 2



Overview:
The trend for new -serious incidents excluding pressure ulcers shown in Table 2 above has steadied at 7 SIs in October following the dip in August. The closed SIs where there was harm both related to deaths in custody at HMP Wandsworth.

Trends for adverse incidents in Table 1 show consistent levels of incidents under each of the severity ratings (NB this data is still being validated)

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

Serious Incident Thematic Review April- September 2014

1. Introduction

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

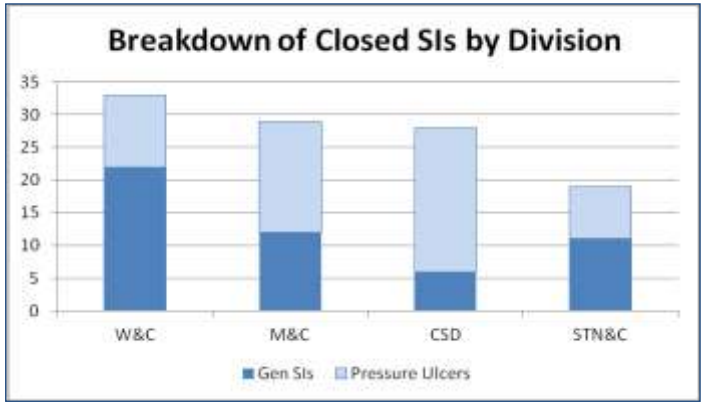
- The numbers of general SIs (excluding pressure ulcers) are rising in contrast to previous trends. Breakdown within divisions is included in the report and the highest rises are in the Surgical and Community Divisions.
- The numbers of pressure ulcer SIs has reduced from a peak in April 2013 although it remains the single highest category of serious incident. The data for this is included in a separate report.
- There appears to be an increase in SIs where there are a cluster of similar SIs. For example there were several reports that related to the failure to follow up on test results or appointments, deaths in custody. This appears to mark a change over the last year where, apart from pressure ulcers, there were fewer clusters of note.
- There continues to be some correlation between the underlying themes of SIs and other data such as clinical audits.

2. Progress since the Previous Report

- A project to improve communication of patient safety messages by way of a Patient Safety App is in the final stages of completion and will be piloted in the paediatric medicine care group.
- The patient safety staff forum continues to spread the learning from SIs. A nursing student forum is now well established and there are plans to set up a similar model for medical students.
- Posters regarding handover awareness were distributed to all clinical areas as part of Patient Safety Week.
- The successful Harm Free care Training is now piloting a mobile approach which is also able to proactively identify potential risks enabling staff in services to prevent the impact on clinical skills.
- Patient Safety Week was conducted in May 2014 where staff gave feedback on their concerns about patient safety issues.

3. SI Trends

The graph below shows the breakdown of closed SIs by division and the sub division by pressure ulcers. Each division shows some reduction in pressure ulcer SIs but all have increased numbers of general SIs compared with the previous report.



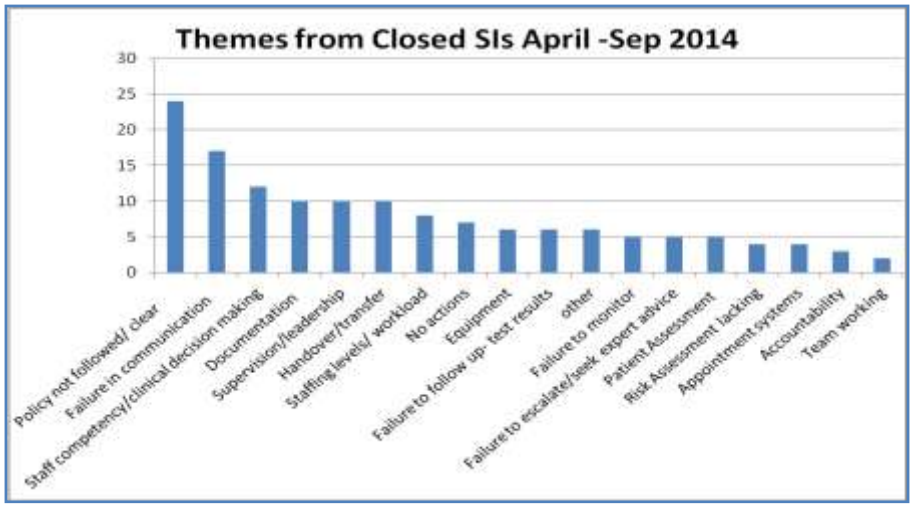
5. Patient Safety
- Incident Profile: Serious Incidents and Adverse Events

4. Themes from SIs

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

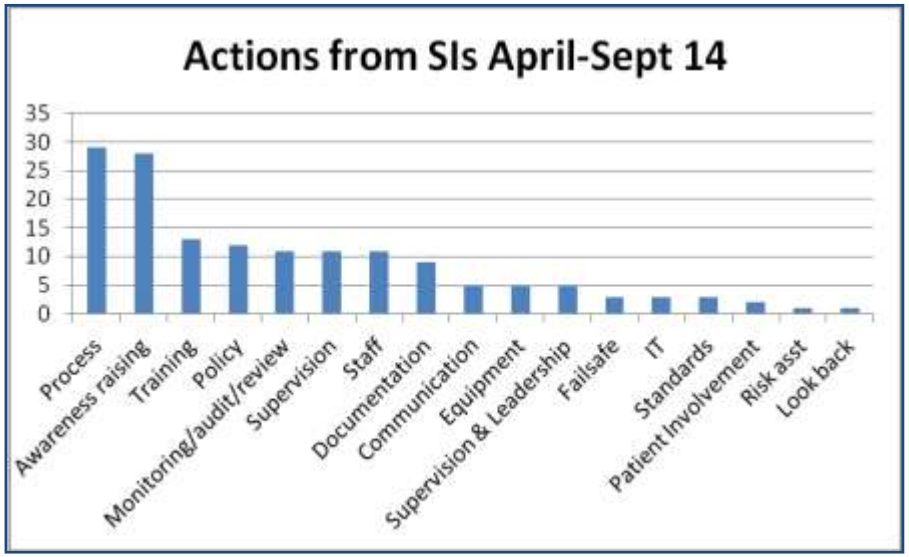
As in the previous report, trends for the most frequent themes can be measured over time and compared with other relevant data (see below). Care should be taken to interpret the numbers which are relatively small and are based on the numbers of SIs in relevant categories. The themes are based on the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

- The trend for staffing is consistent with the previous two reports
- The upward trend for communication and handover themes has steadied but remains one of the highest concerns when coupled with a failure to escalate or seek expert advice
- Documentation figures are broadly consistent with previous reports
- The number of SIs where failure to monitor is an issue is higher than in the previous report and mirrors recent audit data
- The themes related to policies also is higher than in the previous report.



5. Actions from SIs

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



6. Being Open/ Duty of Candour

The Being Open/Duty of Candour Policy states that patients or their families should be given the option of involvement at all stages of an incident investigation where there is moderate or serious harm. Data taken from the SI reports shows that in 44 out of the 51 reports that a discussion was instigated with the patient or family. In the majority of these the process was begun at the beginning of the investigation but in a few cases this was at a later stage. In 7 of the SIs a Being Open conversation was not instigated with good reason and mainly because the incident had not caused harm to the patient.

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

7. Conclusions

The increasing trend in general SIs is a cause for concern and needs to be watched closely. In the meantime the cluster approach where SIs are similar should enable system wide actions.. Policy / process issues are the highest theme in this report but communication and handover are also high themes. The data relating to avoidable harm should also be used to raise awareness with clinical staff and a newsletter to staff will include some of the key issues identified in this report.

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

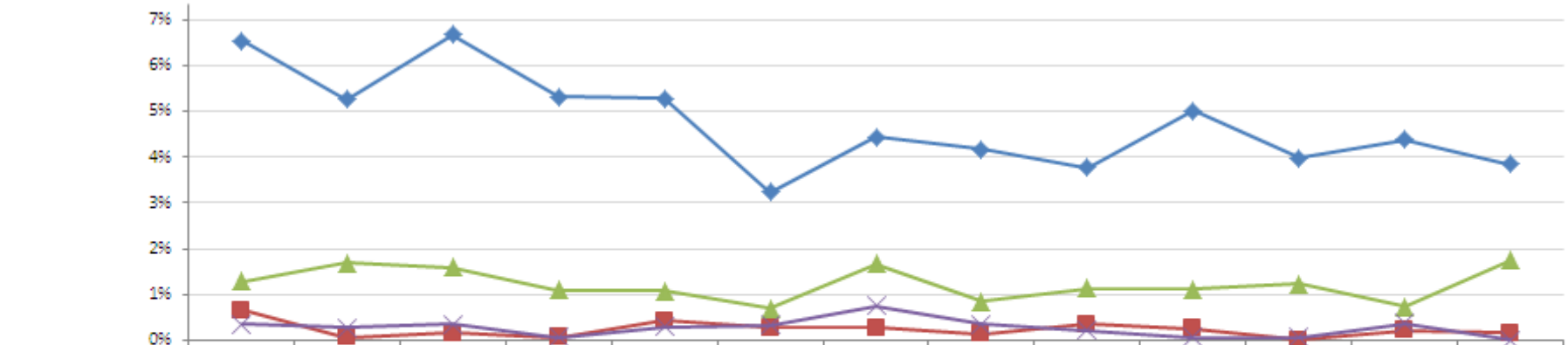
8. Recommendations

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

- To use the Sign up to Safety Project to ensure that staff have targets for avoidable harm and are given regular feedback so they can monitor progress. This should be linked with the Safety thermometer workstream and the patient safety collaborative work.
- To carry out an audit of handover where patients are being transferred from one area to another in the trust using the checklists already in use.
- To monitor changes to intranet policy access to ensure that risks identified in the high risk policies project are fully addressed
- To complete the pilot project to develop a patient safety phone App with feedback from the pilot care group.
- To continue to develop the mobile Harm Free care Training and evaluate the impact on clinical skills
- To continue the patient safety staff forum and build on the feedback obtained at these events.

5. Patient Safety - Safety Thermometer

% Harm Free Care							
Lead Director	August	September	October	Movement	2014/2015 Target	National Average October	Date expected to meet standard
J Hall	95.06%	94.52%	94.63%	↑	95%	93.87%	Nov - 14



	Oct13	Nov13	Dec13	Jan14	Feb14	Mar14	Apr14	May14	Jun14	Jul14	Aug14	Sep14	Oct14
Pressure Ulcers	6.54	5.26	6.67	5.31	5.27	3.23	4.44	4.18	3.77	5.02	3.98	4.39	3.85
Falls	0.65	0.07	0.15	0.07	0.43	0.27	0.28	0.14	0.36	0.26	0	0.22	0.15
Catheter & UTI	1.29	1.68	1.6	1.09	1.08	0.69	1.67	0.85	1.14	1.11	1.23	0.73	1.74
New VTE	0.36	0.28	0.36	0.07	0.29	0.34	0.76	0.35	0.21	0.07	0.07	0.37	0
Patients	1391	1426	1379	1375	1386	1456	1441	1410	1405	1533	1458	1368	1377

This point prevalence audit shows that in October 2014, 94.63% of patients received 'harm free' care; a very similar level to that observed in September (94.52%). Although slightly below our target of 95 per cent, performance is above the national average for October which is 93.87%.

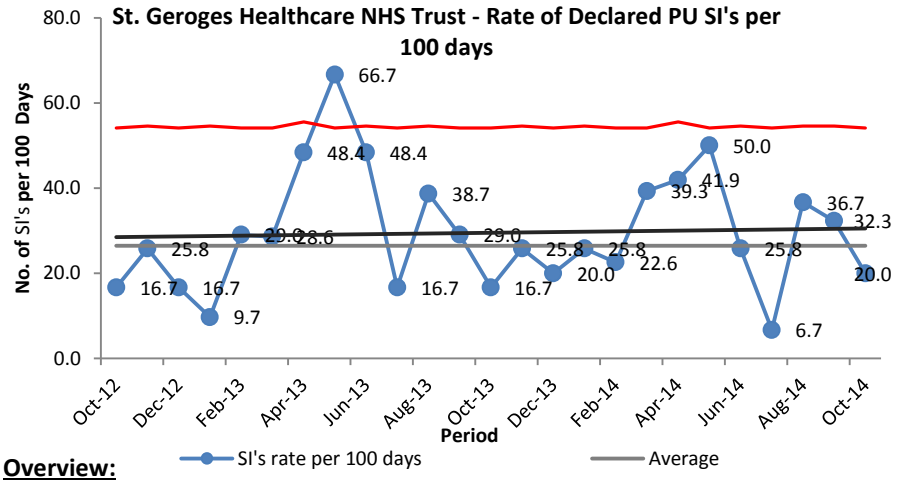
This month the number of both old and new pressure ulcers fell, to 2.83% and 1.38% respectively. The level of falls which resulted in harm changed very little, with the rate of 0.15% representing 2 patients harmed. It is positive to note that there were no new VTEs reported; however our highest level of catheter related UTIs (CAUTIs) was observed at 1.74%. It should be noted that to date verification of CAUTI data has not been as robust as that which takes place for pressure ulcer and VTE harms, where specialist nursing teams are fully engaged in validation. To address this gap a validation process is being piloted in November with the support of one of the urology clinical nurse specialists. It should be noted that some data from community was not validated this month.

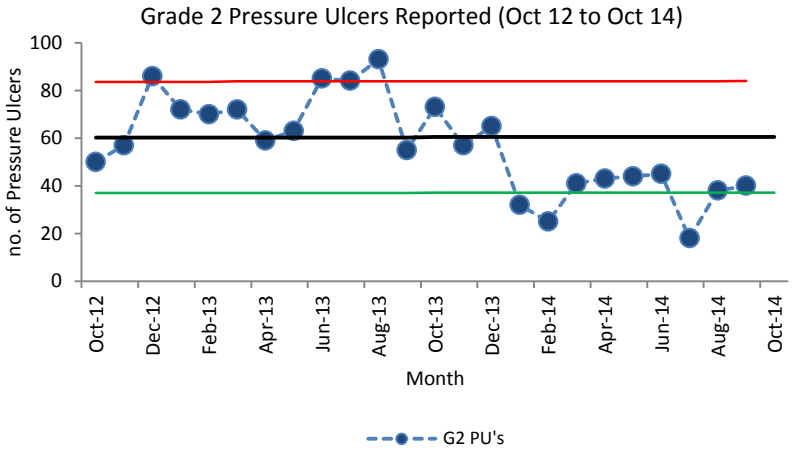
The clinical audit team are currently reviewing all of the data recorded and analysis which can be generated via the Safety Thermometer tool. It is anticipated that additional data will shortly be made available to teams working on specific areas of safety, which will support them to identify areas for improvement and to track the affect of any change in practice. For example, data on catheter usage in addition to harms resulting from UTIs will be valuable in our work with the Safety Collaborative. Additionally, we hope to improve ward level analysis and to more clearly attribute harms.

5. Patient Safety
- Incident Profile: Pressure Ulcers

Serious Incident – Grade 3 & 4 Pressure Ulcers										
Type	Jun	Jul	Aug	Sep	Oct	YTD	Movement	2014/2015 Target	Forecast Sept - 14	Date expected to meet standard
Acute	1	4	7	4	3	34			G	-
Community	1	7	3	2	6	27			G	-
Total All	2	11	10	6	9	61			G	-
Total Avoidable	2	**5**	**3**	**TBA**	**TBA**	**21**		40		-

Grade 2 Pressure Ulcers						
Jun	Jul	Aug	Sep	Oct	Movement
28	**28**	**7**	**26**	19	
16	**17**	**11**	**12**	21	
44	**45**	**18**	**38**	40	





Overview:

October saw a rise in the total number of pressure ulcer serious incidents and grade 2 pressure ulcers within the Community Division

Actions:

- Community deep dive undertaken on 6/11/14 to explore systems and processes within the community services . Themes arising included :

1. Agency staff employed need guidance – checklist to be developed with key directives and regular agency to attend trust training
2. Divisional monthly data report to be shared with Corporate nursing monthly
3. Issues highlighted re patients in own home not known to community services who develop pressure ulcers
4. High incidence of pressure ulcers on Mary Seacole to be investigated further with Matron – staffing / training and patient acuity
5. 2nd meeting scheduled to take place to update on progress and take forward further themes

- Visits completed to Ashmead Nursing Home, George Potter Nursing Home and Hazel Court Nursing Home. Summary of work and recommendations complete to include : pressure ulcer prevention training takes place; RCA training for managers ; introduce patient information leaflet and review guidelines .
- A Listening into Action Borough wide event on 'Reducing pressure ulcers' is being planned for 7th January 2015 in Hunter Wing to engage GP's , community staff, nursing home managers , CCG borough representatives , charity organisations and staff from across the organisation .

5. Patient Safety - 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%	96.60%	96.84%						

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%	85.39%					
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.

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%	94.1%					
	RA complete and correct			92%	89%	82%	81%	88%					
2. Written information 'on admission' **(100%)**		-	-	12.8%	13.2%	21.1%	50%	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%	67.1%					
5. VTE prophylaxis offered in line with NICE **(>98%)**		-	-	94.6%	94.8%	93.1%	92.9%	95%					
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)

Risk assessment rates have dropped on wards where the electronic prescribing system has been launched. This is reflected in the drop in RA attempted on admission. These areas, and areas where roll out is planned, need to be focussed on to ensure standards are maintained when using the new system.

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)		75
Mortality rate	Total	17.3% (13/75)
	VTE primary cause of death	4% (3/75)
Initiation of RCA process		100%
RCA pending	<28 days since notification	14.7% (11/75)
	>28 days since notification (reminder sent)	24% (18/75)
RCA complete		61.3% (46/75)

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

Trends identified (findings from 46 cases for whom RCA is complete):

- General breakdown includes:
  - 30.4% (14/46) – 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 (23/46) – Examples of contributing factors to failure of prophylaxis:
  - 7 patients - malignancy +/- complications arising from malignancy
  - 4 patients – pharmacological prophylaxis contraindicated
- Inadequate prophylaxis received (14/46) – Examples of reasons for inadequate prophylaxis:
  - 4 patients - Prophylaxis not offered in high risk patients
  - 4 patients - Dose of LMWH not escalated appropriately in obesity
  - 2 patients – no evidence of risk assessment

5. Patient Safety: September 2014 - Infection Control

MRSA						
Lead Director	September	October	Movement	2014/2015 Target	Forecast Nov - 14	Date expected to meet standard
JH	0	0	➤	0	G	November 14

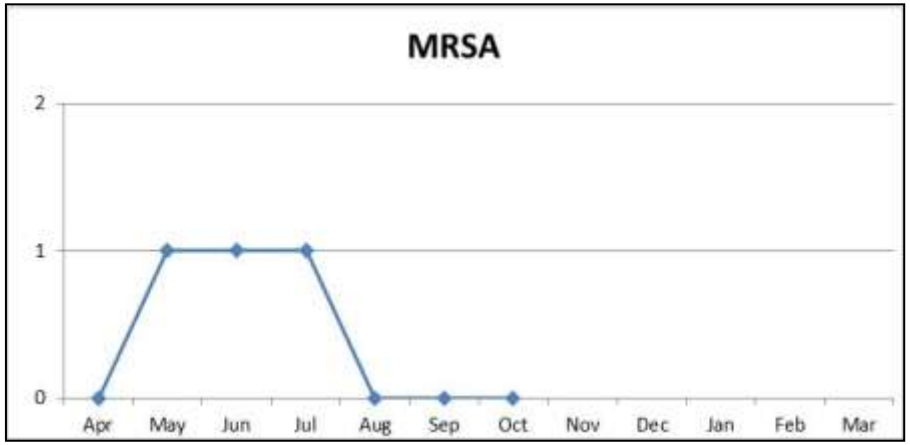
Peer Performance – YTD October 2014				
STG	Croydon	Kingston	King's College	Epsom & St Helier
3	1	0	2	4

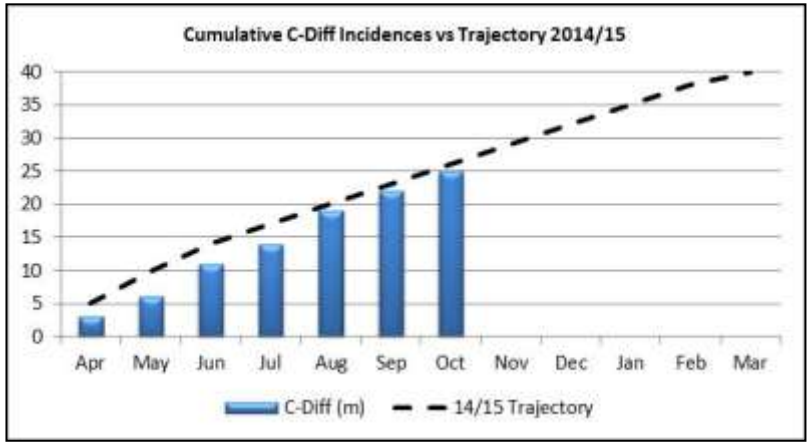
C-Diff						
Lead Director	September	October	Movement	2014/2015 Target	Forecast Nov - 14	Date expected to meet standard
JH	3	3	➤	40	G	-

Peer Performance – YTD October 2014 (annual trajectory in brackets)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
25 (40)	8 (17)	5(24)	42 (58)	24 (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 October 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 October there were 3 C. diff incidents, a total of 25 for the period April to October. This is against a trajectory of 23 and an annual target of 40. Close monitoring will continue to ensure compliance is maintained.

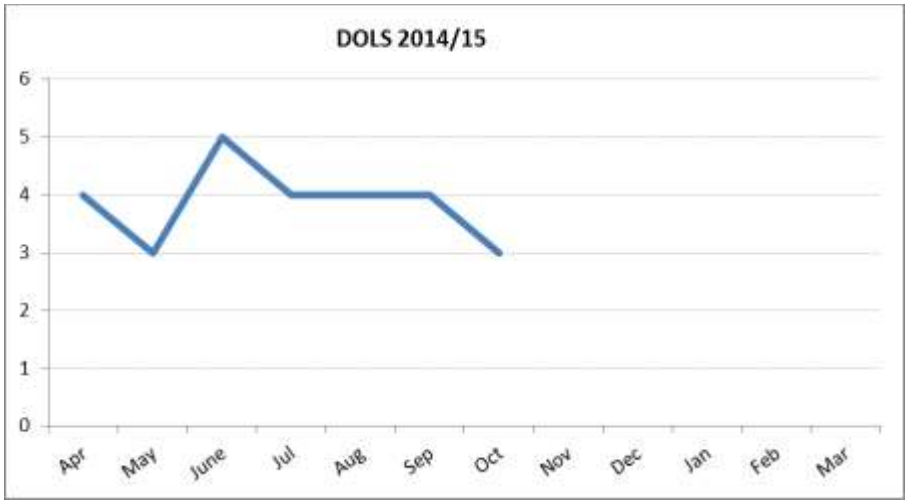




5. Patient Safety
- Safeguarding: Adults

Safeguarding Training Compliance - Adults									
Lead Director	June	July	Aug	Sep	Oct	Movement	2014/2015 Target	Forecast July - 14	Date expected to meet standard
JH	87.9%	88.13%	87.77%	87.86%	87.86%		95%	A	-

Safeguarding Adults Training Compliance by Division – Sep 14				
Med & Card	Surgery & Neuro	Community	Children's and Womens	Corporate
82.87	85.37	92.18	90.2	88.42



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 Oct 76

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, Oct -3

Actions:

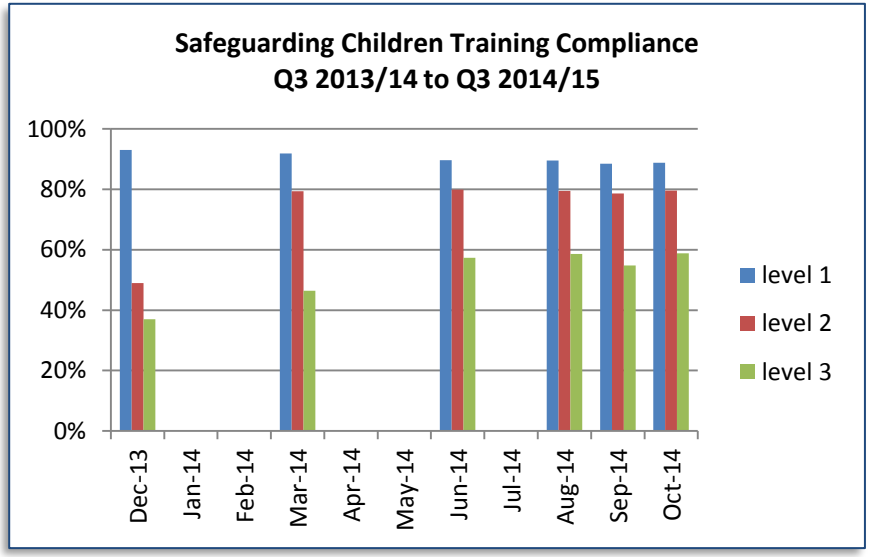
Continue to monitor safeguarding training via WIRED

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 November indicating current position, impact on resources and future options to manage the governance and workload.

5. Patient Safety
- Safeguarding Children

Safeguarding Training Compliance - Children						
October			Movement	2014/2015 Target	Forecast October - 14	Date expected to meet standard
Level 1	Level 2	Level 3				
88.77%	79.63%	58.82%	⇔	95%	A	-



Overview: The first draft of the revised Safeguarding Children Training Strategy has been prepared and is about to be circulated for comment. At the recent Safeguarding Training Group (Acute) meeting, the training programme dates for the acute service for 2015 were put in place. There has been a review of the uptake of face-to-face versus e-learning for Level 2, and was evident that there seemed to be a greater commitment to e-learning. It was agreed that e-learning would be encouraged, but that 6 face-to-face sessions at level 2 would be offered, along with bespoke sessions as required. The statistics for compliance with training are: Level 1 88.77%; level 2 79.63%; level 3 58.82%

Target areas: The Clinical Lead for Obstetrics has emailed all the Obstetric staff to remind them of their requirement to complete Level 3 training. Two areas of practice have been identified for raising awareness sessions in addition to the planned programme – the Specialist Perineal Midwife is leading 2 sessions for all staff on FGM and child and adult safeguarding teams will combine to deliver a session on See the Child See the Adult.

Serious Case Reviews and Internal Management Reviews: There are seven current cases. The IMR for the Kingston case has recommenced with most of the staff interviews having been completed. The submission date for this IMR is January 2015 with the final report publication due in June. The court appearance took place on the 18th November of the parent. An IMR for the Croydon case has been submitted, but this SCR is now on hold due to the criminal case. Briefing reports and chronologies have been submitted to Surrey for 2 cases and a third case for Islington, where a briefing report and chronology is required and is underway. The SCR for Sutton is on hold while the criminal matter is pending (February 20115). The Greenwich case is currently in court and 2 staff members have been called as witnesses. The SCR for Wandsworth has been published – there is a community focused action plan for this case. Finally, a Surrey case from 2012 is about to be published.

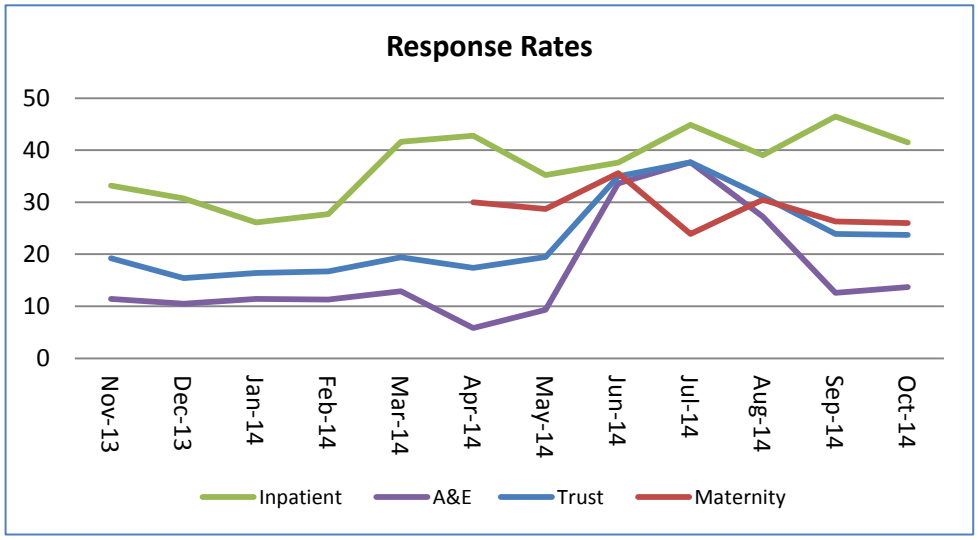
Other: 1. ED – consent: It was previously noted that there have been difficulties in achieving signed consent from parents for information sharing when a child attends the ED. The process of signed consent was introduced in August – so it is still a relatively new aspect of patient care. A meeting has been held with the Head of Nursing for the ED, the liaison HV and the named doctor and nurse which resulted in a plan being drawn up to tackle some of the problems. This will continue to be monitored. 2. The Deputy Chief Nurse is leading a focus group to provide data on FGM required by the government, and to look at the Trust's response to this issue.

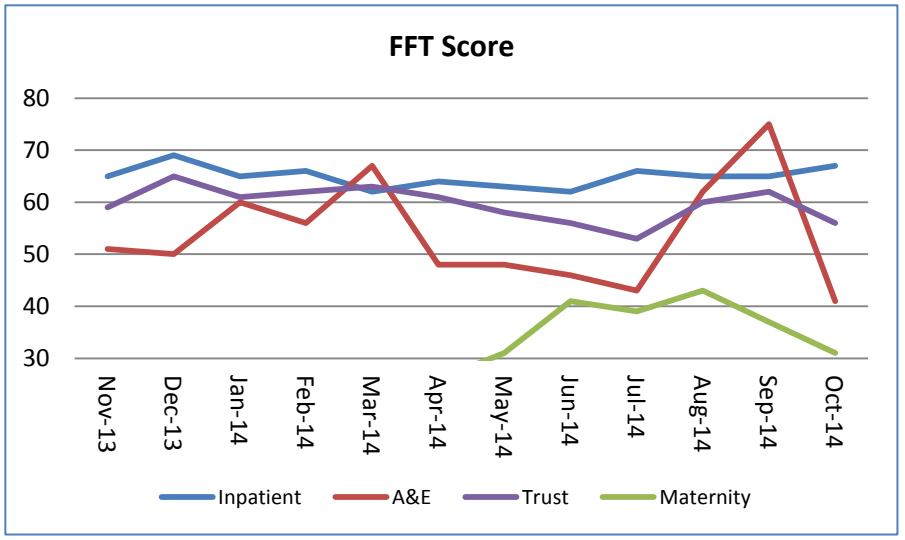
Patient Experience

6. Patient Experience - Friends and Family Test

FFT Response Rate							
Domain	Aug-14	Sep-14	Oct-14	Movement	2014/2015 Target	Forecast Nov- 14	Date expected to meet standard
Trust	31.1%	23.9%	23.7%	↓	30%	G	-
Inpatient	39%	46.5%	41.5%	↓	30%	G	-
A&E	27.2%	12.6%	13.7%	↑	20%	G	-
Maternity	30.5%	26.3%	26%	↓	-		-

	FFT Response Score			
Aug-14	Sep-14	Oct-14	Movement
60	62	56	↓
65	65	67	↑
62	75	41	↓
43	37	31	↓





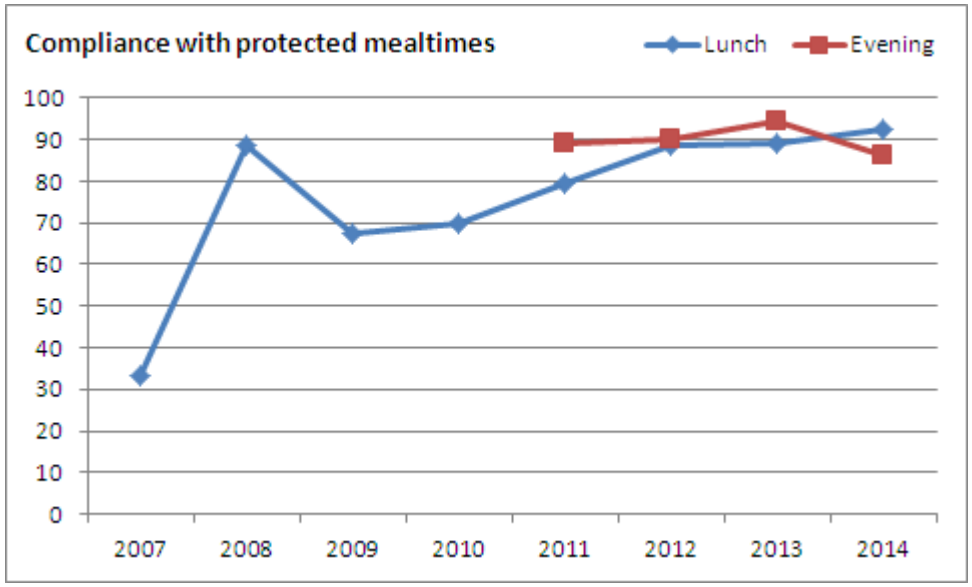
Overview : Response rates further dipped across inpatient areas, but we maintained above our current trajectory of 30%. A&E response rates have improved slightly but remain below the 2015 trajectory of 20% . The Friends and Family Test score for the trust overall was + 56 in October, lower than September (62). A&E scored +41 and the adult inpatient wards +67. Roll out to outpatient services, day care services is now complete and community services have completed a Division wide annual survey with report being finalised. Process to be set up to ensure community services are surveyed at an appropriate frequency using tablets and paper surveys.

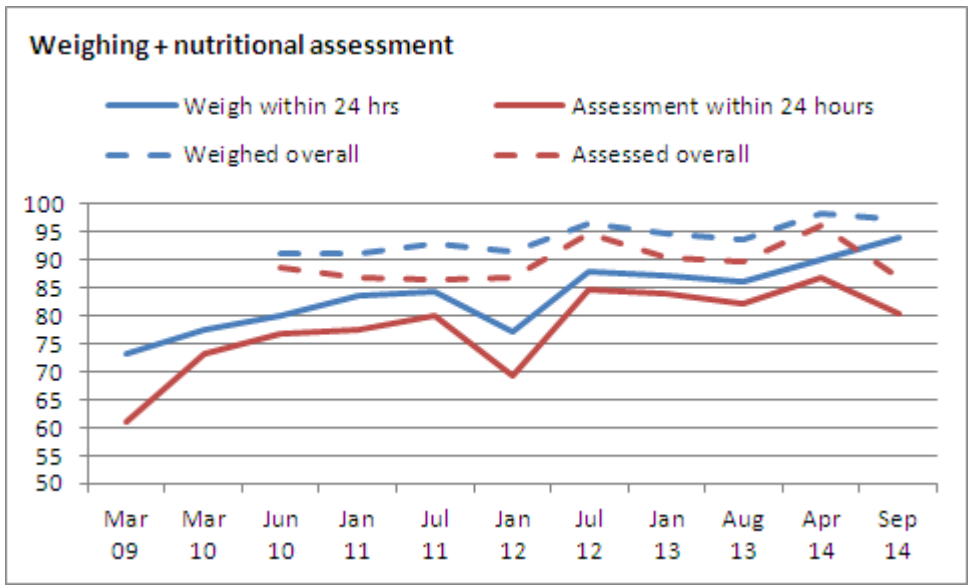
Action : Close monitoring of response rates in A&E to sustain improvements to achieve Q4 CQUIN trajectory of 20% for A&E and 30% for inpatient services, with a drive to achieve 40% for inpatients in March 2015 .

• Key themes for improvement from Patient Experience survey are : Noise at night , Improving information given on side effects of medication and involving patients in decisions on discharge . Divisional and ward performance heat maps were shared in October at several fora to focus and drive improvements. These include a trust wide discharge workstream ; education programme rolled out and monitored by pharmacy on side effects and DVD'S , noise volume meters , feedback from patient representative visits and Shhhhh posters displayed in clinical areas .

6. Patient Experience

Protected mealtimes audit October 2014





This snapshot audit of a lunchtime meal service was conducted on 39 wards between 29th September and 14th October 2014.

On 36 wards (92.3%) there were no non-clinically urgent interruptions, which is the best performance observed to date. Measures around providing assistance to patients show that in the majority of instances staff are providing adequate and timely support to patients. On 93.5 per cent of wards patients requiring assistance were helped with their meal in a timely way. These results are reinforced by the fact that 99.0 per cent of patients surveyed said that they had the help they needed at mealtimes.

It is positive to note that results for weighing within 24 hours of admission shows our strongest performance to date, however there has been a decline in relation to the timely nutritional assessment of patients. Performance around follow-up of those identified as at risk has been maintained at around 92 per cent, with appropriate review at approximately 90 per cent.

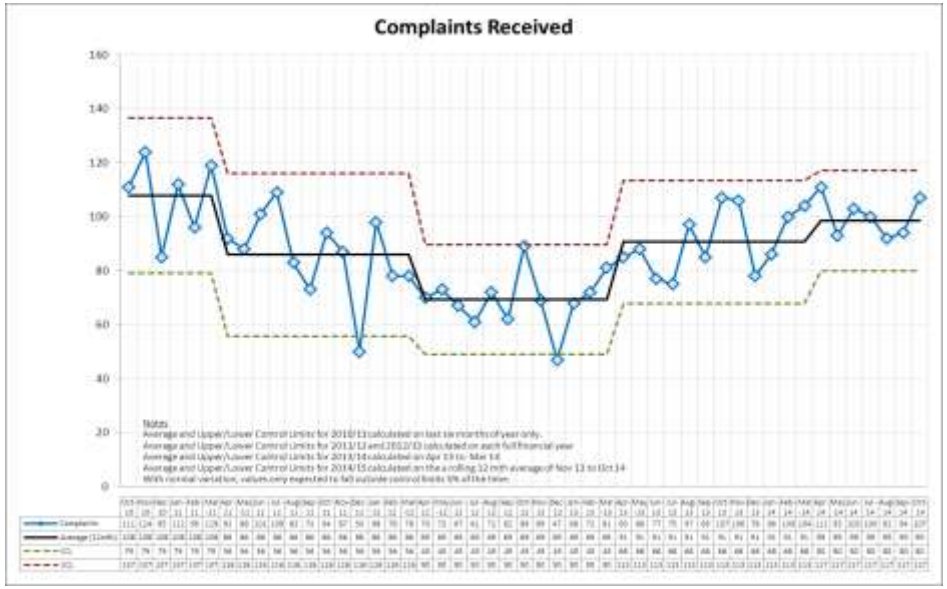
Ward analysis across 9 key measures shows that ten wards were fully compliant, which is a noticeable increase from the 4 observed at the last lunchtime audit. Seventeen wards were shown to have improved, 8 maintained the same level of performance and 12 performed less well.

Local action will be key to maintaining good performance and to making improvements where required. Ward sisters and matrons have been asked to review practice to ensure that there is a robust approach to nutritional screening and support. On some wards additional aspects of care that require improvement include preparing patients for the mealtime, particularly around access to commodes and handwashing, and use of nutrition boards to identify patients requiring assistance, so that the right level of support can be provided.

This regular audit will be repeated in the spring of 2015 and will focus on the evening meal service.

6. Patient Experience - Complaints Received

Complaints Received								
	April	May	June	July	August	Sept	Oct	Movement
Total Number received	111	92	100	99	92	94	107	▲

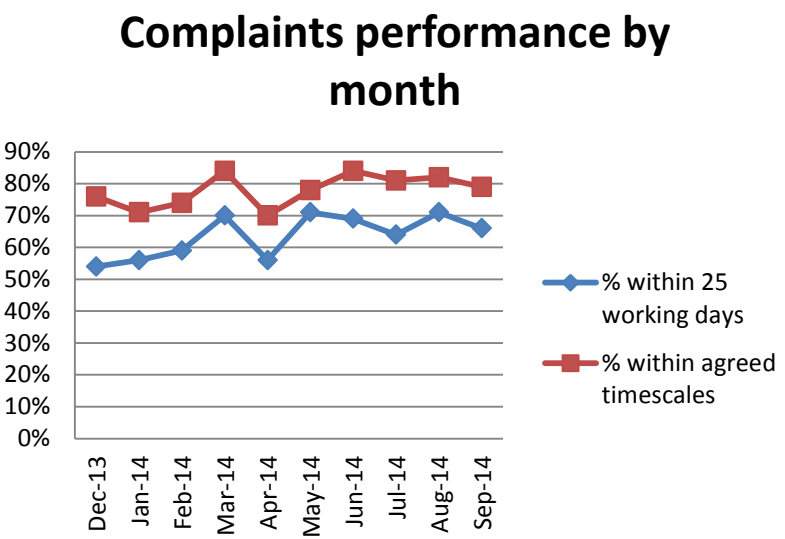


Overview:
This report provides a brief update on complaints received since the last board report (so in October 2014) and information on responding to complaints within the specified timeframes for quarter 2 in its entirety. The board will receive more detailed information about complaints received in the whole of quarter 3 with divisional breakdowns, analysis of the data to provide trends and themes with actions planned and a severity rating report and once quarter 3 has closed.

Total numbers of complaints received in October 2014
There were 107 complaints received in October of 2014, an increase of 14 % on September when 94 complaints were received. Having reduced in the month of September from 22 in August, complaints about outpatients and medical records care group increased again in October to 17. Themes were cancellation of appointment, waiting time for appointment and missing medical records. Complaints about transport increased from 2 in both August and September to 6 in October with late/non arrival of transport being the main theme.

6. Patient Experience
- Complaints Performance against targets

Performance Against Target **Quarter 2**				
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	81	45	56%	(14) 73%
Medicine and Cardiovascular	75	51	68%	(13) 85%
Surgery & Neurosciences	91	63	69%	(11) 81%
Community Services	17	11	65%	(2) 76%
Corporate Directorates	21	19	90%	(2) 100%
Totals:	285	189	66%	(40) 80%



Overview:

For complaints received in quarter 2 66% were responded to within 25 working days compared to 64% in quarter 1. All areas made improvements or stayed about the same on this target except for Children and Women's Division which saw a decline in performance.

For the same period 80% of complaints are planned to be responded to within 25 working days or agreed timescales, a slight improvement on quarter 4 when 77% of complaints were responded to within this timescale. The final percentage may change depending on whether all of the agreed extensions are eventually met. Children's and Women's and Medicine and Cardiovascular Divisions saw a decline in performance with the other divisions seeing an improvement.

Actions:

Referring to the trajectories for improvement reported to October board, all divisions have committed to improving performance significantly by the end of quarter 3 and meeting the trust targets of 85% and 100% respectively by the end of quarter 4.

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

Overview:
The Patient Experience Manager and Patient Advice and Liaison Service Manager are responsible for checking and responding to comments posted on the NHS Choices website and the Patient Opinion website.

Comments are passed on to relevant staff for information/action. Often the comments are anonymous so it is not possible to identify the patient or the staff involved, but such comments are still fed back to departments to consider themes and topics.

If a comment is a cause for concern then the individual is given information via the website about how to obtain a personalised response via the Patient Advice and Liaison service (PALS) or the complaints and improvements department.

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

Below are some examples of comments/stories posted on NHS Choices and Patient Opinion since the last board report..

Ann Kerr gave Imaging services at St George's Hospital (London) a rating of 5 stars
MRI scan Atkinson Morley
I attended the MRI suite in Atkinson Morley lower ground floor on Monday 20th Oct for a 7pm scan. When it was my turn, I got changed into the hospital gown which is always a challenge! I told the radiographer (I didn't catch her name) how I felt about the scanner, being enclosed etc. She was very calm, gentle and reassuring and said we would work it out to position me in the most comfortable way. Into the scanning room and I lay on the bed where preparations were made. She suggested removing the pillow from under my head so that I had more clearance then I was ready to slide into the tube. She reassured me as the bed started to move and went around to the back so that I would see her when I looked up. I was given the option of an eye mask which I declined. There was a cooling breeze which was quite soothing. When she was satisfied that I was ok she and her colleague went to start the scan. At no point did I feel the slightest urge to press the panic button, indeed I felt very calm throughout what was probably a 40 minute scan. I was so grateful to her for making me feel at ease, she was a great communicator with a lovely voice and manner. I cannot thank her enough and only wish I knew her name.

Visited in October 2014. Posted on 24 October 2014

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

6. Patient Experience
- Complaints and PALS Action Plan 2014/15

Complaints and PALS 2014/2015 action plan

The purpose of the action plan is to target three key target areas to focus on the reduction of the numbers of complaints generated, to improve the current performance in the management of complaints, and to strengthen the learning from complaints resulting in an improved patient experience. Thresholds to achieve within 2014/15 are being finalised and will be reported against to the Board during 2014/15.

Aim:	Outputs	By When	By Who	Progress
To Reduce the number of Complaints received in the Trust through identification of Issues at an earlier point of the Patients Journey:				
To review the function of the corporate complaints team to ensure appropriate focus, support of Divisions and use of resources.	• Appropriate resources and trained team in place. • Ability to deliver the Performance standards for complaints. • Support of the Divisional Teams to manage complaints. • Leadership of the approach to learning from complaints.	October 2014	Sarah Duncan	On 3rd November 2014 all permanent staff will be in place with return from secondment. C&I staff attend weekly divisional complaints meetings to increase visibility to Divisions. LIA event to be held with Divisions regarding learning from Complaints
Training: To deliver training to front line staff to support effective and timely management of concerns raised.	• More Confidence for staff to be proactive in the management of complaints. • Reduction in the number of visitors / patients accessing PALS and making formal complaints.	February 2015	Sarah Duncan/Ayesha Campbell/Catherine Jones	Increase capacity for training sessions – customer care and responding to complaints training will both be available monthly rather than bi-monthly. There will be increased promotion of the availability of the courses once the dates have been set (starting November 2014).
To focus on areas where high volume complaints are generated. **To be visible with the Divisions in supporting the areas concerned and providing specialist advice where needed.**	• Identification of the Root cause of complaints • Trust support in addressing the issues effectively. Trust Divisional Governance Leads leading this action. • Effective communication with users of services (Patients/ staff) about work that is being done. • To specifically link with the Outpatient Service Improvement Programme to support the delivery of an improved patient experience.	Ongoing with evaluation of the approach on a quarterly basis.	C&I team and Sarah Duncan Trust Divisional Governance Leads	All staff investigating complaints are to attend the trust's root cause analysis training run by the risk team. Complaints manager has met all teams in divisions and is collating feedback to discuss how C&I can improve the service provided. Sarah Duncan is in regular contact with Hannah Hamilton providing reports on complaints/PALS numbers and themes

6. Patient Experience
- Complaints and PALS Action Plan 2014/15 continued.

Aim:	Outputs	By When	By Who	Progress
To Improve the timeliness and quality of our responses achieving a sustainable performance within the Trust:				
To increase the number of staff who are competent in handling complaints and writing responses	• To have a cohort of staff who can effectively write complaint responses thereby reducing the time for the Trust to respond. • To increase confidence amongst Trust staff in addressing complaints both simple and complex. • To increase Divisional capacity for the management of complaints.	February 2015.	Sarah Duncan/DDNGs Sarah Duncan/Ayesha Campbell/Catherine Jones DDNGs	Each division to identify complaints "champions" who are skilled in investigating complaints and writing responses. These staff can assist those who require development. Via training as mentioned above.
To reset and agree Divisional performance targets within 14/15 which are realistic and deliver the Trust standards by the end of 2014/15.	• To reset trajectories and performance manage accordingly within the governance framework.	March 2015	DDNGs/DDOs/GMs	Targets now reset. Reported to the Board In October 2014. Divisions now being performance managed to deliver against the target in Quarter 4
Strengthen Learning from Complaints:				
To Strengthen the Divisional/ Corporate requirement for reporting back on actions	• Strong Local Processes in place to ensure review and learning from complaints within clinical areas/ teams. • Clear Visibility of actions available which were taken in response to complaints and evidence portfolio available.	October 2014	Sarah Duncan/DDNGs/DGMs	Sarah to attend DDNGs meeting in November to discuss the setting up of a central database on a shared server to enter/monitor actions. Increased focus by complaints team on recording actions from complaint responses onto DATIX.
To use a range of approaches to support effective learning from complaints.	• To generate a range of approaches in practice to review individual complaints e.g. fishbowl technique. • Sharing of learning across Clinical areas to support proactive management of issues prior to complaints arising. • Stronger engagement of all professional groups.	Ongoing with Quarterly reporting of progress	Sarah Duncan Divisions	Arrange workshop with investigating managers from divisions in Q4. Arrange Listening into Action event for complaints (Sarah has had initial discussion with Liz Woods) in Q4. The centralised database of actions. Champions for each profession.
Increase the Boards understanding of complaint themes.	• Refresh Quality report to focus on actual complaints and actions taken. • Patient Stories to the Board each Month.	Immediate	Sarah Duncan	NHS Choices stories (positive and negative) form part of Quality report. Quality report contains actions and themes.

6. Patient Experience
- Complaints and PALS Action Plan 2014/15 continued.

In addition to the above more volunteers will be recruited for PALS so that there is additional support for busy times. – 2 volunteers interested at present.
There will also be a PALS rebranding and re-launch – when guidance released by Department of Health following the recommendation made in a report published in October 2013 by the Department of Health following a review of the NHS complaints system which was co-chaired by the Rt Hon Ann Clwyd MP for the Cynon Valley and Professor Tricia Hart, Chief Executive, South Tees Hospitals NHS Foundation Trust. – On 20 October 2014 the Department of Health have confirmed that:
"The Department of Health, with key partners, is to undertake a small-scale project to review different aspects of PALS and to identify if there are any areas where more substantial work may need to be commissioned. This work will begin in late-autumn 2014 and, it is envisaged, will cover areas such as whether the remit given to PALS when they were first introduced remains either applicable or effective in the current NHS"

6. Patient Experience:
- National Cancer Patient Experience Programme 2013/14

Introduction

The 2013/14 National Cancer Patient Experience Survey Programme was published in November 2014. The programme questionnaire included three sections where patients could make comments in their own words about the cancer care they had received. These were under the following headings:

Was there anything particularly good about your NHS cancer care?
Was there anything that could have been improved?
Any other comments?

Aim and Objectives:

The aim of this report is to understand patients' experiences during their stay in the trust, and identify areas for improvement.

Methodology:

The clinical auditor went through each patient's comments and the data are sorted into range of categories. Ten category headings were generated from the data (see Table 1 below). This is further split into positive and less than positive comments. Comments pertaining to GP and other hospitals (St Richard's Hospital, Royal Marsden and St Helier) were excluded in this analysis.

6. Patient Experience:
- National Cancer Patient Experience Programme 2013/14

Results:
Three hundred and sixty six (366) patients shared their experiences (316 in the last audit round). The overall percentage for positive comments has increased to 69% (62% in the previous audit round).

Table 1 shows the Trust results indicating improvements in seven of the ten of the categories identified.

Categories on Nurses and Information show significant improvement in this audit round.

Scores on which further progress needs to be made are on catering, Macmillan Nurse and service/system.

Table 2 shows the breakdown by tumour group. Seven (12 in total) tumour groups show significant increase in percentage for positive comments. Colorectal and Other tumour groups show marginal or no increase while Brain/CNS, Prostate and Urological tumour groups show marginal drop in percentage for positive comments.

Table 1	% of Positive Comments		
	2012	2013	
Catering	20%	17%	↓
Communication	22%	23%	↑
Doctors	75%	86%	↑
Environment	15%	26%	↑
Information	27%	42%	↑
MacMillan Nurse	86%	81%	↓
Nurse	48%	77%	↑
Service/System	70%	68%	↓
Staff	85%	92%	↑
Treatment	63%	70%	↑

Table 2	Number of responses		Positive comments		
	12/13	13/14	12/13	13/14	
Brain/Central Nervous System	15	11	65%	61%	↓
Breast	45	80	54%	63%	↑
Colorectal	35	44	66%	67%	↑
Gynaecological	11	8	56%	83%	↑
Haematological	59	47	72%	81%	↑
Head & Neck	10	12	53%	63%	↑
Lung	36	42	67%	73%	↑
Other	10	18	65%	65%	-
Prostate	13	16	77%	74%	↓
Skin	20	19	50%	71%	↑
Upper GI	6	9	45%	74%	↑
Urological	56	60	67%	63%	↓

6. Patient Experience:
- National Cancer Patient Experience Programme Patient Comments 2013/14

Following are some comments received in this audit round.

Positive comments:

Nurses (positive comments – 77% compared to 48% in the last audit round)**:**

"*… some of the nurses are amazing and caring and explain everything clearly and kindly*" – Breast Team.

"*This was my first hospital stay and I was very impressed by the nursing staff who were always pleasant, kind, accommodating and very efficient, even after or during a 12 hour shift*" – Colorectal/Lower Gastrointestinal Team

Staff/Team (positive comments – 92% compared to 85% in the last audit round)**:**

"*My care was absolutely impeccable and I could not have felt more cared for and involved with my treatment. It was all very positive and empowering, from the porters, the cleaners, the cheerful women who constantly brought around food and drinks, to the dedicated and very overworked nurses. The care was wonderful"* – Lung Team

"*… All staff were supportive and kept me informed of what was happening*" – Prostate Team.

"*Every person I saw was always good and helpful to me, trying to make me so less worried and feel better*" – Head and Neck Team

Doctors (positive comments – 86% compared to 75% in the last audit round)**:**

"*Excellent care from my cancer surgeon. Not only a really good surgeon but explained the situation very clearly and was very positive about my cure. Practically down to hear and a good communicator and his attitude helped keep my spirits up"* – Colorectal/Lower Gastrointestinal Team

"I feel that I received excellent and quick care from all the doctors and nurses that I saw. I couldn't have asked for better care from the staff at St George's Hospital" – Skin Team

"I was particularly impressed with the quality of my colorectal surgery by the surgeon…" – Upper Gastrointestinal

Information (positive comments – 42% compared to 27% in the last audit round)**:**
"Overall treatment had been very good, consultants etc. informative, I was kept up to date of treatment" – Lung Team

"The consultants and surgeons were excellent and gave all information in detail as requested and explained clearly and took time with these explanations" – Skin Team

6. Patient Experience:
- National Cancer Patient Experience Programme Patient Comments 2013/14

Treatment (positive comments – 70% compared to 63% in the last audit round):
"*The hospital treatment was excellent. Thank you*". Brain/CNS

"I am grateful for all the treatments that I had had with the NHS. Without them I would be in a sorry state" – Breast

"Overall treatment has been very good, consultants etc. informative, I was kept up to date of treatment" – Lung

Communication (positive comments – 23% compared to 22% in the last audit round)**:**
"I think liaison between doctors and myself were particularly good" – Haematological

"The joined up care between the different departments of the hospital and with my GP's surgery with everyone always knowing what was happening" – Breast.

Less than positive comments
Service/System (positive comments – 68% compared to 70% in the last audit round)**:**
Majority of these comments for Service/System category were related to waiting time.

"… some waiting times particularly when collecting chemotherapy tablets are far too long and have little reference to appointment times. My longest wait was around 4hrs" – Colorectal/Lower Gastrointestinal Team

"*Sad to say hospital is lax in admin. Follow up appointments usually require a phone call(s) from me. Example: appointment will be made for you to see consultant in one week, "how about five or six", only after a phone call. Three operations to date, all appointments rescheduled"* – Urological Team

Following are additional comments from the Service/System category:
"*CT scanning facility at St George's was not carried out in a dignified fashion. Men and women waiting in a crowded, inadequate waiting area in various stages of undress. Not good and completely unnecessary. Members of the public seemed to have free/accidental access to the same waiting room*" – Colorectal/Lower Gastrointestinal team.

"Day of discharge was painfully slow, partly due because I was on a different ward. Urology registrars carrying out discharge didn't prescribe adequate pain relief. Paracetamol for major abdominal surgery. No physio whilst in hospital or post discharge. No guidance regarding wound change dressing until I was leaving ward and one of the nurses asked if I had letter for GP/nurse. It was an afterthought. Discharge process very disjointed" – Other Team

6. Patient Experience:
- National Cancer Patient Experience Programme Patient Comments 2013/14

MacMillan Nurse (positive comments – 81% compared to 86% in the last audit round):
"More communication from the Macmillan nurses, as when you completed the radiotherapy and want help and assistance, you are like moving back and forth between your appointed nurse, who can't answer questions as you are then under the nurses at the hospital where the treatment is given and they don't make them clear before the treatment starts" – Breast

"I would have liked the Macmillan nurse to see me more and to ask if I have any problems, as I didn't just kept to myself. I think she should have asked how I was, I suffer from anxiety and depression" - Haematological.

Catering (positive comments – 17% compared to 20% in the last audit round):
"… breakfast, the cornflakes is stale, bread sometimes not desirable. Cup of tea in plastic cups difficult to handle if you have an IV drip. Lunch and dinner is not gastronomic. There are times you do not get what you ordered or it's too little or none at all" – Colorectal/Lower Gastrointestinal

"…food of consistently poor quality" – Lung Team

Recommendation/Action Plan

Oversight is provided by the Cancer Clinical Directorate at their monthly meeting.

Via this group each tumour type clinical lead and CNS have been asked to produce an action plan for their tumour type, taking account of the scores, the comments and any outstanding actions from last year's action plan. These will be presented to the Cancer Clinical Directorate in January and the Cancer Lead Nurse will pull them together into an over-arching action plan. Delivery of the plan will be monitored by Cancer Clinical Directorate.

Workforce

7. Workforce: October 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	7840.00	6734.75	73.25	73.25	7153.00	6607.00	299.00	299.00	85.9%	100.0%	92.4%	100.0%
Carmen Suite	501 - OBSTETRICS		1563.00	1439.83	465.00	307.50	1364.00	1331.00	341.00	253.00	92.1%	66.1%	97.6%	74.2%
Champneys Ward	502 - GYNAECOLOGY		1882.50	1796.50	473.50	332.50	704.00	693.00	341.00	340.00	95.4%	70.2%	98.4%	99.7%
Delivery Suite	501 - OBSTETRICS		3926.50	3704.81	930.00	690.00	3718.00	3410.50	682.00	593.50	94.4%	74.2%	91.7%	87.0%
Fred Hewitt Ward	420 - PAEDIATRICS		1601.50	1501.27	207.00	153.75	1603.25	1281.25	184.00	138.00	93.7%	74.3%	79.9%	75.0%
General Intensive Care Unit	192 - CRITICAL CARE MEDICINE		7438.50	6365.50	184.00	281.00	6877.00	6436.25	103.50	69.00	85.6%	152.7%	93.6%	66.7%
Gwillim Ward	501 - OBSTETRICS		2538.00	2129.00	960.00	645.75	2057.00	1606.00	836.00	594.00	83.9%	67.3%	78.1%	71.1%
Jungle Ward	171 - PAEDIATRIC SURGERY	420 - PAEDIATRICS	1105.00	1049.23	0.00	34.50	0.00	0.00	0.00	0.00	95.0%	#DIV/0!	#DIV/0!	#DIV/0!
Neo Natal Unit	420 - PAEDIATRICS	192 - CRITICAL CARE MEDICINE	6696.5	5381.75	146.5	24	5896	4843	0	0	80.4%	16.4%	82.1%	#DIV/0!
Neuro Intensive Care Unit	192 - CRITICAL CARE MEDICINE	150 - NEUROSURGERY	4903.50	4521.26	356.50	266.50	4634.50	4541.50	356.50	308.00	92.2%	74.8%	98.0%	86.4%
Nicholls Ward	171 - PAEDIATRIC SURGERY	420 - PAEDIATRICS	2797.50	2522.00	225.50	151.75	1948.00	1750.00	231.00	165.00	90.2%	67.3%	89.8%	71.4%
Paediatric Intensive Care Unit	192 - CRITICAL CARE MEDICINE	420 - PAEDIATRICS	3088.00	2627.11	0.00	0.00	3403.75	2672.75	0.00	0.00	85.1%	#DIV/0!	78.5%	#DIV/0!
Pinckney Ward	420 - PAEDIATRICS		2442.25	2278.75	465.00	322.00	1817.00	1771.00	0.00	0.00	93.3%	69.2%	97.5%	#DIV/0!
Dalby Ward	300 - GENERAL MEDICINE		1512.00	1400.00	1975.75	2027.75	1069.50	1046.50	1282.50	1259.50	92.6%	102.6%	97.8%	98.2%
Heberden	300 - GENERAL MEDICINE		1686.00	1295.67	1926.50	2400.00	1104.00	1000.50	1539.92	1515.42	76.8%	124.6%	90.6%	98.4%
Mary Seacole Ward	400 - NEUROLOGY	314 - REHABILITATION	2767.00	2485.40	2838.00	2294.33	1794.00	1746.50	1828.50	1805.50	89.8%	80.8%	97.4%	98.7%
A & E Department	180 - ACCIDENT & EMERGENCY		9976.25	9407.50	2668.00	2184.50	9173.50	8626.17	1506.50	1574.17	94.3%	81.9%	94.0%	104.5%
Allingham Ward	100 - GENERAL SURGERY		1885.50	1867.50	958.48	1173.98	1219.00	1206.50	1207.50	1196.00	99.0%	122.5%	99.0%	99.0%
Amyand Ward	300 - GENERAL MEDICINE		1976.50	1791.50	1463.50	1104.75	1081.00	1065.00	781.25	781.25	90.6%	75.5%	98.5%	100.0%
Belgrave Ward AMW	320 - CARDIOLOGY		2584.50	2317.73	1567.50	1054.66	1759.50	1699.75	368.00	368.00	89.7%	67.3%	96.6%	100.0%
Benjamin Weir Ward AMW	320 - CARDIOLOGY		2683.50	2316.25	821.00	502.16	1690.50	1598.50	515.25	515.25	86.3%	61.2%	94.6%	100.0%
Buckland Ward	361 - NEPHROLOGY		1977.00	1742.00	574.00	425.00	1104.00	1058.00	391.50	380.00	88.1%	74.0%	95.8%	97.1%
Caroline Ward	170 - CARDIOTHORACIC SURGERY		1933.50	1714.43	946.50	663.75	1449.00	1380.50	34.50	57.50	88.7%	70.1%	95.3%	166.7%
Cheselden Ward	100 - GENERAL SURGERY		1942.50	1775.75	465.00	353.50	1085.00	1023.50	276.00	280.00	91.4%	76.0%	94.3%	101.4%
Coronary Care Unit	320 - CARDIOLOGY	170 - CARDIOTHORACIC SURGERY	2070.75	2315.50	0.00	153.00	2070.00	2035.50	149.50	172.50	111.8%	#DIV/0!	98.3%	115.4%
James Hope Ward	320 - CARDIOLOGY		1724.50	1482.25	176.50	161.50	529.00	494.00	0.00	0.00	86.0%	91.5%	93.4%	#DIV/0!
Marnham Ward	300 - GENERAL MEDICINE		2426.00	2431.97	987.50	1050.00	2047.00	1967.50	953.50	919.00	100.2%	106.3%	96.1%	96.4%
McEntee Ward	300 - GENERAL MEDICINE		1728.50	1462.96	810.00	680.25	730.00	730.00	793.50	793.50	84.6%	84.0%	100.0%	100.0%
Richmond Ward	300 - GENERAL MEDICINE		5691.75	4964.31	3779.33	2798.77	4247.25	4045.33	2620.83	2690.83	87.2%	74.1%	95.2%	102.7%
Rodney Smith Med Ward	302 - ENDOCRINOLOGY		1932.00	1758.26	1168.50	1077.67	1104.00	989.00	1058.00	1012.00	91.0%	92.2%	89.6%	95.7%
Ruth Myles Ward	303 - CLINICAL HAEMATOLOGY		1315.00	1395.25	356.50	789.50	1058.00	1012.00	494.50	414.00	106.1%	221.5%	95.7%	83.7%
Trevor Howell Ward	370 - MEDICAL ONCOLOGY		2067.00	1982.83	1274.00	1097.50	1081.00	1081.00	1196.50	1185.00	95.9%	86.1%	100.0%	99.0%
Winter Ward (Caesar Hawkins)	300 - GENERAL MEDICINE		1921.50	1691.00	945.00	786.50	1460.50	1380.00	471.00	459.50	88.0%	83.2%	94.5%	97.6%
Brodie Ward	150 - NEUROSURGERY		1294.50	1129.00	930.00	766.50	1069.50	1046.50	11.50	11.50	87.2%	82.4%	97.8%	100.0%
Cavell Surg Ward	100 - GENERAL SURGERY		2166.00	1970.50	960.00	693.75	1092.50	1046.50	356.50	356.50	91.0%	72.3%	95.8%	100.0%
Florence Nightingale Ward	120 - ENT		2194.00	2029.25	937.50	679.51	1437.50	1449.00	233.00	244.50	92.5%	72.5%	100.8%	104.9%
Gray Ward	100 - GENERAL SURGERY		2716.50	2357.02	1215.00	897.00	1375.00	1331.50	603.92	603.92	86.8%	73.8%	96.8%	100.0%
Gunning Ward	110 - TRAUMA & ORTHOPAEDICS		2376.00	1924.70	1168.00	941.40	1115.00	1000.50	791.75	739.00	81.0%	80.6%	89.7%	93.3%
Gwynne Holford Ward	400 - NEUROLOGY		1467.00	1403.00	1415.00	1230.00	713.00	713.50	1023.50	1012.00	95.6%	86.9%	100.1%	98.9%
Holdsworth Ward	110 - TRAUMA & ORTHOPAEDICS		1896.00	1738.01	966.00	924.50	1138.50	989.00	995.50	991.00	91.7%	95.7%	86.9%	99.5%
Keate Ward	160 - PLASTIC SURGERY		1747.50	1758.00	697.50	520.75	1081.00	1069.50	138.00	138.00	100.6%	74.7%	98.9%	100.0%
Kent Ward	400 - NEUROLOGY		2206.50	1989.25	1424.50	1524.25	1541.00	1516.00	1127.00	1126.00	90.2%	107.0%	98.4%	99.9%
Mckissock Ward	150 - NEUROSURGERY		2088.00	1841.80	1102.50	876.50	1449.00	1355.00	402.50	414.00	88.2%	79.5%	93.5%	102.9%
Vernon Ward	101 - UROLOGY		2707.50	2397.00	1050.00	714.00	1364.00	1319.00	374.00	374.00	88.5%	68.0%	96.7%	100.0%
William Drummond HASU	400 - NEUROLOGY		3099.00	2774.26	930.00	832.50	2852.00	2714.50	713.00	667.50	89.5%	89.5%	95.2%	93.6%
Wolfson Centre	400 - NEUROLOGY	314 - REHABILITATION	1768.50	1320.51	1899.50	2010.50	713.00	690.00	1322.50	1334.00	74.7%	105.8%	96.8%	100.9%

7. Workforce: October 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 October 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 October submission the trust achieved an average fill rate of 91.1%, a slight improvement from 90.85 % on the September submission. It was noted by the Trusts Development Authority that St George's is on an upwards trajectoy. Work is continuing with divisions to improve the accuracy of the report.

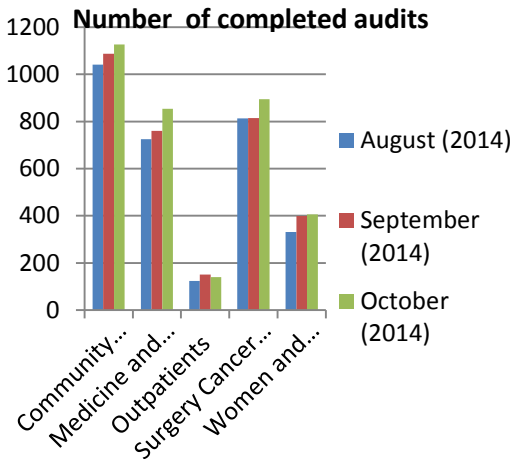
Although some of our wards are operating below 100% the data does not indicate if a ward is unsafe. Safe staffing is much more complex than an observation of percentages and takes in to account many key aspects such as:
Nurses, midwives and care staff work as part of a wider multidisciplinary ward team. 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 establishment review. The remit of the board is being extended to oversee the Trust wide Nursing/ Midwifery Workforce programme. This will include HR and Divisional representation to support coordination of activities with existing programmes of work.
- A detailed 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 results of the spring 2014 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 2014 an acuity and dependency review was carried out and wards have reviewed 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
- Safe Staffing alerts



Overview: The purpose of the daily safe staffing audit is to identify areas that are unsafely staffed (known as alerts) and to ensure through a process of escalation that this situation is remedied. Alerts (identifying that a ward is unsafely staffed) are raised to senior nurses through a daily report on the RATE system. The safe staffing policy provides guidance on escalation and interventions that can be undertaken to make areas safe. Red flag events which assist nurses in identifying possible alerts have been added to the safe staffing policy and the guidance has been sent to all wards and departments. The total number of safe staffing audits completed over the past three months were: August 3033, September 3211 and October 3420. The number of final alerts reported decreased from 7 in September to 5 in October. There is one outstanding alert for September which clarification is required. The number of alerts reduced to a concern (ward is safely staffed but some care needs will not be completed) has decreased during the previous three months following on the day investigation (August 23, September 10, October 6). There has been a significant improvement in closing down alerts in the same day. All alerts in October have been closed on the same day. This is due to a change in escalation as wards are informed that failure to close down alerts will result in escalation to the deputy chief nurse.

19 nursing related safe staffing concerns were raised on Datix compared to 14 in September. Only one matched a similar entry on the RATE system. Some of the issues raised on Datix should have been recorded as an alert or as a minimum a concern on the daily safe staffing audit.

Actions: To aim to commence the audit in HMS prison Wandsworth by 31 December 2014. Continue to update safe staffing policy as required. Continue to urge senior nurses to close down alerts by 5pm on the same day. Raise the link between datix and the rate system with the nursing body.

St George's Healthcare NHS
NHS Trust

Heatmap Dashboard
Ward View

TargetStatusDesc
- AMBER
- DATA NOT YET AVAI..
- GREEN
- RED

		INCIDENCE OF C.DIFFICILE	INCIDENCE OF MRSA	TRUST ACQUIRED PRESSURE SO..	PERCENTAGE OF HARM FREE CARE	PATIENT SATISFACTION (FRIENDS & FA..	FRIENDS & FAMILY RESPONSE RA..	WARD STAFFING: UNFILLED DUT..	FALLS (WARD LEVEL)	SERIOUS INCIDENTS (WARD LEVEL)	SICKNESS/ ABSENCE RATE - (WARD)	VACANCY RATE - (WARD)
Children & Women's	CARDIOTHORACIC..	0.0	0.0	0.0	92.9			11.2	0.0	0.0	3.3	11.5
	CARMEN SUITE	0.0	0.0	0.0	100.0			10.8	0.0	0.0	2.5	32.0
	CHAMPNEYS	0.0	0.0	0.0	100.0	68.8	84.2	7.0	0.0	0.0	9.3	31.2
	DELIVERY	0.0	0.0	0.0	100.0			9.3	0.0	5.0	3.9	10.3
	FREDDIE HEWITT	0.0	0.0	0.0	100.0			14.5	0.0	0.0	4.2	0.6
	GENERAL ICU/HDU	0.0	0.0	1.0	100.0			9.9	0.0	1.0	3.5	8.0
	GWILLIM	0.0	0.0	0.0	100.0			22.2	0.0	0.0	6.3	6.3
	JUNGLE	0.0	0.0	0.0				1.9	0.0	0.0	1.2	-32.1
	NEONATAL ICU	0.0	0.0	0.0	100.0			19.5	0.0	0.0	2.6	9.0
	NEURO ICU	0.0	0.0	0.0	100.0			6.0	0.0	0.0	1.9	6.1
	NICHOLLS	0.0	0.0	0.0	100.0			11.8	0.0	0.0	7.3	-4.8
	PICU	0.0	0.0	0.0	100.0			18.4	0.0	0.0	4.9	-1.5
	PINCKNEY	0.0	0.0	0.0	100.0			7.5	0.0	0.0	1.3	-111.5
Medicine & Cardiovascular	ALLINGHAM	0.0	0.0	0.0	80.8	79.2	34.7	-3.3	4.0	0.0	2.1	9.0
	AMYAND	0.0	0.0	0.0	85.7	33.3	4.2	10.6	8.0	0.0	5.8	3.9
	BELGRAVE	0.0	0.0	0.0	96.6	34.5	72.4	13.4	3.0	0.0	3.1	26.3
	BENJAMIN WEIR	0.0	0.0	0.0	100.0	75.0	56.1	13.6	0.0	0.0	5.0	3.0
	BUCKLAND	0.0	0.0	0.0	100.0	78.8	64.2	10.9	0.0	0.0	1.4	4.1
	CAESAR HAWKINS	0.0	0.0	0.0	95.2	60.5	29.7	10.0	0.0	0.0	7.4	11.1
	CARDIAC CARE U..	0.0	0.0	0.0	100.0	87.5	84.2	-9.0	0.0	0.0	1.1	-20.4
	CAROLINE	0.0	0.0	0.0	100.0	69.7	54.5	12.5	0.0	0.0	0.5	9.2
	CHESELDEN	0.0	0.0	0.0	100.0	86.0	40.7	8.9	0.0	0.0	1.7	7.6
	DALBY	0.0	0.0	1.0	91.3	80.0	26.3	1.8	0.0	1.0	12.5	14.8
	EMERGENCY DEP..	0.0	0.0	1.0		39.4	13.7	6.6	0.0	1.0	2.6	15.1
	HEBERDEN	0.0	0.0	0.0	66.7	100.0	2.9	0.7	0.0	0.0	11.5	35.3
	JAMES HOPE	0.0	0.0	0.0	100.0	81.0	105.3	12.0	0.0	0.0	0.0	4.8
	MARNHAM	0.0	0.0	0.0	96.2	57.1	41.7	0.7	0.0	0.0	7.9	12.8
	MCENTEE	0.0	0.0	0.0	100.0	70.3	58.7	9.7	0.0	0.0	3.9	5.5
	RICHMOND	0.0	0.0	0.0	92.6	100.0	10.0	11.3	0.0	1.0	2.2	9.9
	RODNEY SMITH	0.0	0.0	0.0	74.1	58.3	22.2	8.1	0.0	0.0	4.1	9.8
	RUTH MYLES	0.0	0.0	0.0	100.0	100.0	69.0	-12.0	0.0	0.0	3.8	30.4
	TREVOR HOWELL	0.0	0.0	0.0	94.4	70.4	36.5	4.8	0.0	0.0	2.3	7.4
Surgery & Neurosciences	BRODIE NEURO	0.0	0.0	0.0	93.3	73.9	76.7	10.6	0.0	0.0	7.1	-5.2
	CAVELL	0.0	0.0	0.0	100.0	57.1	31.4	11.1	0.0	0.0	6.3	-14.5
	FLORENCE NIGHTI..	0.0	0.0	0.0	100.0	79.5	60.8	8.3	0.0	0.0	6.2	18.2
	GRAY WARD	0.0	0.0	0.0	100.0	59.5	24.7	12.2	0.0	0.0	3.7	17.7
	GUNNING	0.0	0.0	0.0	96.0	48.7	50.0	15.5	0.0	0.0	7.4	29.5
	GWYN HOLFORD	0.0	0.0	0.0	96.0	25.0	266.7	5.6	0.0	0.0	0.9	16.4
	HOLDSWORTH	0.0	0.0	1.0	94.1	63.0	75.3	7.1	0.0	1.0	10.2	27.6
	KEATE	0.0	0.0	0.0	95.0	69.2	92.2	4.9	0.0	0.0	0.0	22.0
	KENT	0.0	0.0	0.0	89.7	73.5	36.5	2.3	0.0	0.0	3.7	16.1
	MARY SEACOLE	0.0	0.0	4.0	59.0	67.9	0.0	9.7	0.0	4.0	9.3	-7.1
	MCKISSOCK	0.0	0.0	0.0	100.0	100.0	1.7	11.0	0.0	0.0	2.6	6.6
	VERNON	0.0	0.0	0.0	100.0	61.8	22.3	12.6	0.0	0.0	10.2	20.8
	WILLIAM DRUMMO..	0.0	0.0	0.0	100.0	75.0	18.2	11.2	0.0	0.0	3.4	10.7

8. Ward Heatmaps:
Women's and Children's , Diagnostics and Therapies Division

For Areas within the Women's and Children's , Diagnostics and Therapies Division Q2:

Infection Control

Clostridium Difficile

During quarter 2 there were a total of three clostridium difficile (C.Difficile) cases within the division; two occurred within the Cardiothoracic Intensive Care Unit (CTICU) and another one on Nicholls ward. Concerns have been raised regarding the number of C. Difficile cases that have occurred within CTICU throughout the year period, as a result a wider review of the C. Difficile cases has been completed. Cross contamination was not found to be a contributory factor, as all cases have been of a different subtype. Poor antibiotic stewardship did contribute to one of the cases in this period. The Head of Nursing and Matron for the area are in the process of developing a robust action plan for infection control, as although cross contamination has not deemed to be a problem in these cases the saving lives data does indicate some challenges in regard to maintaining and sustaining good inflectional control procedures.

MRSA Bacteraemia

There has been one MRSA bacteraemia in this period, which occurred on Neuro Intensive Care (NICU). This patient was particularly sick and as a result it has not been possible to identify the root cause of the MRSA; however it was not felt that this was a result of line contamination. Scores for hand hygiene are generally good within this area, with some additional focus required on the decontamination of equipment. The adult critical care areas are in the process of introducing cross audit of areas for infection control to ensure that the audit process is robust and consistent.

Trust Acquired Pressure Ulcers

Two grade 3 pressure ulcers were reported in quarter 2, both of which were in the adult critical care; one in General Intensive Care Unit (GICU) and one in NICU. Of the two pressure ulcers the one acquired on GICU was deemed to be unavoidable due to the poor clinical picture of the patient and the one on NICU was felt to be avoidable, with a primary issue being incorrect assessment of the pressure ulcer. The adult critical care areas continue to monitor their own performance against other similar sized units in regard to the prevalence of pressure ulcers and roll out a number of local preventative initiatives such as the 'hot spots' initiative; where staff are encouraged to identify the less obvious potential pressure points.

Percentage of Harm Free Care

All three adult critical care areas and the paediatric intensive care units did not achieve the desired target for harm free care during this period. The main factor that has contributed to this has been the presence of old grade 2 pressure ulcers and care provided elsewhere within the trust, such as a patient fall. VTE scoring does however continue to be an area that requires additional focus within the adult critical care areas. VTE assessment has been discussed at care group meetings and ward round reminders have been reinstated to improve compliance.

8. Ward Heatmaps:
Women's and Children's , Diagnostics and Therapies Division continued

Friends and Family

Although many of the wards in the division capture discharge data from patients it is only Champneys Ward that currently reports the response rate and satisfaction score in line with Friends and Family. Throughout this period Champneys have failed to achieve the 25 % target response rate, a number of factors contribute to this, however fundamentally the team on the ward need to ensure that this is captured. The Head of Nursing, Matron and Ward Sister now have a robust plan to ensure that the responses rate improves. Of the limited responses captured on Champneys Ward the satisfaction score has generally been very positive.

Ward Staffing

A number of areas, primarily within the paediatric areas have reported high unfilled duty hours. This position has gradually improved over the quarter with the arrival of a number of new starters and a reduction in the number of vacancies. During periods of particularly high vacancy and sickness four beds were closed on Frederick Hewitt during the quarter to ensure safety and to minimise risk.
During this period a total of five safe staffing alerts were raised, all of which were within the paediatric wards.

Work has also been completed to ensure that the rota templates accurately reflect staffing and monthly divisional rota management and sickness meetings have been introduced.

Serious Incidents

There were a total of 12.5 serious incidents reported in this period; this includes 2.5 pressure ulcers as discussed. The remaining ten include eight related to the unexpected admission of a newborn to the neonatal unit. The final two relate to maternal deaths that occurred on GICU; however whilst these deaths occurred on GICU the events leading up to the deaths were not attributable to the Trust's care.

Areas of Concern

Although the midwifery areas have not flagged against any of the patient safety and patient experience measures there have been a significant number of complaints during this period; with poor communication featuring highly within the complaints. This is being explored further with the Director of Midwifery and General Manager for the service and measures being put in place to address this.

Areas of Good Performance

The neonatal unit consistently provides a high standard of patient and parent care, with consistently low infection rates, good performance in relation to the safety thermometer, where applicable and good response and action in relation to any areas of concern. This is despite a number of vacancies in throughout the quarter.

8. Ward Heatmaps:
Surgical, Theatres, Cancer and Neurosciences Division

For areas within the Surgical, Theatres, Cancer and Neurosciences Division Q2 :

The report gives an overview of the Q2 divisional ward performance by providing an analysis of key quality indicators followed by a summary of best performing areas and those of concern. It aims to give a brief description of data triangulated to inform this decision and the framework used to support any associated improvements.

- **Analysis of Q2 Performance Indicators**

Quality Indicator	Performance Summary	Associated Actions
Infection control	Good performance throughout Q2. Only 1 CDT on Keate ward which the RCA identified as unpreventable.	General learning - need robust communication between A&E and wards so clear infection control status described and early isolation.
Pressure Ulcers	An overall increase in pressure ulcers from Q1 (46) to Q2 (56). The main increases being seen in grade 1's (8-16) and grade 3's (5-9). Grade 2's consistently high at approx. 30/month. RCA's indicate key issue relate to multiple handovers, delayed assessment or lack of all-over assessment and failure to document. Main areas of concern Neurosciences, Gray & Holdsworth	Deep dive exercise in September with good divisional attendance. Focus on volumes, thematic review and learning from good practice. Action plan in place with emphasis on training, increased awareness of PU prevention, use of patient leaflets and documentation. Monitoring in place at both local & divisional level. Key area of improvement for the division.
% of harm Free Care	An overall reduction in red flags during Q2. Key issues relate to CAUTI and pressure ulcers although some data inaccuracies. Key areas of concern Neurosurgery & Gunning	Neurology CNS piloting validation of CAUTI. Local feedback and learning in place with good staff engagement. Issues relate to catheter removal and positioning. Pressure ulcer plans as above.
F&F- satisfaction	A very limited number of responses indicate patient dissatisfaction with services. Comments relate to noise at night, pain control (1 patient), waits for TTA's and parking. Areas for focus are Gunning and Cavell	Ward boards in place to display results and actions being taken ("this is what you told us, this is what we have done"). Noise meters rotated through wards. Discharge process work stream commenced.
F&F- response	Consistent performance in surgery directorate. Areas requiring further focus are McKissock, Kent and William Drummond in particular who failed to achieve 25%	Enlist support of volunteers, review ward process and ensure clarity around purpose of F&F across the ward teams.
Unfilled hours	A number of areas indicating unfilled shift levels below 90% during Q2. Vacancy factor and use of specials above establishment has contributed to this. Increased scrutiny has led to better recognition of issues and permanent solutions being put in place via e roster.	Successful recruitment in neurosciences and surgery has reduced vacancy level. Daily vigilance in relation to data and timely correction. More work required at weekends as not always possible to track staff when allocated centrally.
Falls	Good performance overall. Reduced volume of incidents and no associated harms. Higher level of incidents associated with Neurosciences, predominantly head injury & neuro-rehabilitation.	Falls work focused on early risk assessment, identification of high risk/vulnerable patients and repeat fallers. Profile maintained via flag systems. High associated use of specials to support safety. Recruitment of additional HCA's to facilitate increased safety and reduced temporary staff spend.
S.I's	All SI's for the period relate to pressure ulcers	See pressure ulcer actions above
Vacancy rates	Vacancy levels consistently high. Data not always reflective of actual situation, although improvement in vacancy factor due to successful cross divisional recruitment. Areas of risk continue to be Theatres, although not represented here.	Local and international recruitment. Clarity around extend of vacancy factor has been helpful. Considering retention initiatives.Q3 should see recently recruited staff in post and vacancy reduction.
Sickness	Sickness throughout Q2 on or below the trust target of 3.5%. key areas of concern are Neurosurgery, Cavell and T&O.	To continue to monitor monthly. Good HR support and proactive plans and monitoring in place at ward level.

8. Ward Heatmaps:
Surgical, Theatres, Cancer and Neurosciences Division

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

Ward Performance by exception
A range of data was used to support decisions around best performing wards and those requiring further work. In addition to the heat-map this consisted of complaints performance and thematic review, mock CQC inspections, saving lives audits, patient experience visits and EWS audits.
Monitoring is light touch and takes place through 1:1's and local meetings at ward and care group level. This is overseen by directorates and ultimately via DGB/DMB where data is shared by exception and areas of risk highlighted. A divisional level quality/performance meeting is due to start in December. Ward teams will report on a rotational basis in relation to scorecards and key audit data. It is hoped this will enable better oversight, the ability to support and challenge more directly those areas that are consistently underperforming and recognise and share good practice from those areas that demonstrate consistently good performance or improvements.
For Q2 the areas of note are as follows:-

Areas for focused action;

Gunning – based upon falls, pressure ulcers, harm free care, sickness & Friends and family satisfaction levels

Cavell – based upon vacancy factor, unfilled hours, pressure ulcers, harm free care

Mckissock & Brodie- A consistent level of complaints focused upon fundamental care and communication related issues, harm free care, falls, sickness and unfilled hours

Best performing or most significantly improved areas;

Keate, Florence and Holdsworth perform consistently well despite recent challenges in relation to staffing. Holdsworth and Florence in particular support a highly dependent cohort of patients and throughout Q2 a number of high risk patient with challenging behaviours requiring RMN support.

Gray- Despite significant vacancy factor in the senior team, moving wards in the summer and a high level of outliers

Strong, visible leadership in place in these areas impacting positively on overall performance.

8. Ward Heatmaps:
Medical and Cardiovascular Division

For Areas within the Medical and Cardiovascular Division:

The heat map is a useful tool for recording data about performance indicators on the wards relating to patient safety and experience. This is the first quarter of information and without trend charts or some form of statistical analysis it is difficult to provide a more scientific report. The following is based on information from the heat map, knowledge of the individual clinical areas and professional judgment.

Overall wards performing well in this time period with no red alerts, low sickness and vacancies and good feedback through FFT are; CCU, Caroline, Ben Weir, Cheselden and McEntee. Factors in common to them are they are either relatively small, specialist areas (CCU & McEntee) or have a high percentage of elective procedures – Caroline, Ben Weir and Cheselden.

Wards that have more flags for patient safety issues from falls and trust acquired pressure ulcers and percentage of harm free care are the medical and senior health wards where the patient group tend to be older with more co morbidities and more vulnerable to complications following admission to hospital. Falls and infection or pressure ulcers may be present on admission. In this time period wards with higher red alerts and average to higher vacancies / unfilled hours are; Dalby, Heberden, Allingham, Caesar Hawkins, Marnham and Richmond.

Ruth Myles, a small 13 bedded specialist haematology ward has had flags related to infection control which on investigation were identified to be unavoidable. Higher vacancies and moderate sickness with a number of unfilled shifts could be leading to lower than expected patient satisfaction scores in September.

Actions:
Heat map used at all nursing levels to review individual ward performance through line management structure.
DDNG meeting with Matron and ward leaders of wards scoring under 90% on Safety Thermometer to review root causes of harm and any actions needed.
Recommendations of Nursing Review of establishments are being put in place. Funding in ward budgets for additional 41wte posts.
All areas actively recruiting to reduce reliance on temporary staff.

Below is a breakdown by ward of Q2 performance.

8. Ward Heatmaps:
Medical and Cardiovascular Division

Ward	Performance Summary
Acute Medicine: Allingham	1 SI – death following a fall, 2 PUs, 16 falls, Sept vacancy 14.7, FFT – missed target once, scores average. Low unfilled hours, higher vacancies and low sickness.
Amyand	No IC flags, 1 PU, 16 falls, Struggle to get FFT percentage and lower scores. Average to high unfilled shifts, low vacancies & sickness.
Caesar Hawkins	1 c diff, No PUs, 21 falls, missed FFT target twice, scores average. Average unfilled hours, moderate vacancies & sickness.
Marnham	No IC flags, 1 PUs, 7 falls, FFT – missed target twice, average score. High vacancy, low unfilled hours, moderate sickness.
Rodney Smith	No IC flags, No PUs, 15 falls, FFT – missed target once, moderate score. Low unfilled hours, low vacancies and moderate sickness.
Richmond	3 C diff, No PUs, 27 falls, FFT – missed target once, average scores, average unfilled hours, average vacancies, low sickness.
Dalby	No IC flags, no PUs, 15 falls, FFT – 1 missed target, average scores, average unfilled hours, average vacancy, high sickness.
Heberden	1 C diff, 1 PUs, 15 falls, FFT – 1 missed target, good scores. Average unfilled hours, high vacancy, high sickness.
Specialist medicine: McEntee	No IC flags, no PUs, 10 falls, FFT – good scores and hits. Good to average unfilled hours, moderate vacancy, low sickness.
RHO Buckland	No IC flags, 1 PUs, 5 falls, FFT – good scores, 1 missed target. Average unfilled hours, moderate vacancy, low sickness.
Ruth Myles	2 C diff, no PUs, 3 falls, FFT – average scores, 1 missed target. Average unfilled hours, high vacancy, moderate sickness.
Trevor Howell	No IC flags, 1 PUs, 7 falls, FFT – good hits & scores. Low unfilled hours, low vacancy, moderate sickness.
CVT: Cheselden	No IC flags, no PUs, 8 falls, FFT – good hits & scores, low unfilled hours, low vacancy, low sickness.
Belgrave	No IC flags, no PUs, 15 falls, FFT – good scores, missed target once, average unfilled hours, high vacancy low sickness.
Ben Weir	No IC flags, no PUs, 14 falls, FFT – good hits & scores. Average unfilled hours, low vacancy & sickness.
Caroline	No IC flags, no PUs, 9 falls, FFT – good hits & scores. Average unfilled hours, low vacancy & sickness.
CCU	No IC flags or PUs, no falls, FFT – good hits & scores, low unfilled hours, low vacancies & sickness.

8. Ward Heatmaps: September 2014
Community Services Quality Scorecard

Domain	*Patiend Safety & Experience*											
	Indicator	Frequency	2014/2015 Target	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Direction
				Quarter 1 2014/15			Quarter 2 2014/15			Quarter 3	
Patient Safety	**SI's REPORTED**	Monthly		3	7	2	9	3	4	7	↑
Patient Safety	**Number of SI's breached**	Monthly	0					0	0	0	→
Patient Safety	**Grade 3 & 4 Pressure Ulcers**	Monthly		3	4	1	7	3	2(2 Grade 3) 1 grade 4 shared and being investigated	6	↑
Patient Safety	**Grade 4 Pressure Ulcers**	Monthly							1	0	↓
Patient Safety	**Number of Fall of No Harm and Low Severity**	Monthly		37	31	21	14	17	15	14	↓
Patient Safety	**Number of moderate falls**	Monthly	0	0	0	0	0	0	0	0	→
Patient Safety	**Number of major falls**	Monthly	0	0	0	0	0	0	0	0	→
Patient Safety	**Number of falls resulting in death**	Monthly	0	0	0	0	0	0	0	0	→
Patient Safety	**MRSA**	Monthly	0	0	0	0	0	0	0	0	→
Patient Safety	**CDiff (cumulative)**	Monthly	40	0	0	0	0	0	0	0	→
Patient Safety	**CAS ALERTS - Number ongoing (Trust)**	Monthly		13	16	13	12	15	8		↑
Patient Safety	**CAS ALERTS - Number not completed within due date (Cumulative) Trust**	Monthly	0	1	1	1	1	1	1	1	→
Patient Safety	**Number of Quality Alerts**	Monthly		8	3	6	5	3	7	6	↑
Safeguarding	**% 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	92.81% as at 11th Nov 2014	↑
Safeguarding	**% 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	92.65% as at 11th Nov 2014	↑
			Level 2 95%	78.4%			80.91% as at 8th Sept 2014		81.27% as at 7th Oct 2014	83.86% as at 11th Nov 2014	↑
			Level 3 95%	74.2%			78.42% as at 8th Sept 2014		73.97% as at 7th Oct 2014	77.87% as at 11th Nov 2014	↓
Patient Outcomes	**Mortality SHMI ratio (Trus)**	Monthly	<100	<100	<100	<100	<100	<100	<100	<100	→
Patient Experience	**Active Claims**	Monthly		2	0	1	0	0	2	1	
Patient Experience	**Number of Complaints received**	Monthly		26 April (12), May (5) June (9)			17			11	↓
Patient Experience	**Number of Complaints responded to within 25 days**	Monthly	85%	46% April (50%), May (40%) June (33%)			44%			66%	↓

8. Ward Heatmaps:
Community Services Quality Scorecard continued

Patient Experience	**Number of Complaints responded to within 25 days with an agreed extension**	Monthly	95%	54%			50%			100%	
Patient Experience	**FFT Score (Mary Seacole and MIU)**	Monthly		Mary Seacole Score = 68							http://www.qualityobservatory.nhs.uk/index.php?option=com_cat&view=it
Patient Outcomes	**Catheter related UTI (Trust)**			0.00	1.56	1.43	0.00	1.47	1.41	1.47	http://www.nsic.gov.uk/searchcatalogue?pro
	Number of new VTE (Trust)		National 0.005	0.76	0.35	0.21	0.07	0.07	0.37	0.00	
Workforce	**Sickness Rate -**	Monthly	3.50%	5.37%	5.06%	5.48%	3.82%	4.0%	4.2%	**4.44%**	
Workforce	**Turnover Rate-**	Monthly	13%	14.87%	14.76%	14.98%	16.48%	17.1%	18.0%	**19.90%**	
Workforce	**Vacancy Rate-**	Monthly	11%	12.45%	13.10%	14.61%	14.67%	15.7%	15.9%	**17.92%**	
Workforce	**Appraisal Rates - Medical**	Monthly	85%	54.05%	62.07%	71.43%	78.57%	80.8%	78.3%	**84.26%**	
Workforce	**Appraisal Rates - Non-Medical**	Monthly	85%	79.64%	77.36%	74.80%	77.80%	81.1%	79.5%	**86.36%**	

8. Ward Heatmaps:
Community Services Quality Scorecard

Serious Incidents: In October there were 7 Sis declared (I DiC HMPW, 6 PU). There has been an increase in the number of Sis declared in October compared to 3 the month previous.

Pressure Ulcers: Reduction in the incidence of pressure ulcers is a key focus in 2014/15. In October there were 6 pressure ulcers acquired in our care, 6 Grade 3's and 0 Grade 4 (2 Community nursing, 4 Mary Seacole ward QMH). A senior nursing meeting was held early Nov 2014 to review the incidence of pressure ulcers in our care and to identify what more can be done to protect patient skin integrity and to reduce the likelihood of pressure ulcers. In addition Head of Nursing (Patient Experience) is meeting with matrons of the services and undertaking clinical observation within patent homes and MS ward with a view to understand context and challenges of care delivery. A further senior nursing meeting is planned Nov 2014 to agree care improvement plans.

Falls: 25% decrease in number of falls in October, majority of which (9) were recorded for Mary Seacole ward (42 beds). All reported falls were low or no harm.

Complaints: There were 11 complaints received in Community Services in October (4 x OHC, 2 community, 5 QMH OPD). 66% were responded to within 25 working days. This is an increase in performance of response time and a decrease in the number of complaints received.

Quality Alerts: 6 quality alerts were received (2 OPD QMH, 2 x heart failure services, 1 x OHC, 1 community nursing). A letter was circulated from CSD DDNG to Wandsworth GPs regarding patient referrals and heart failure nursing services vacancy management reiterating continuation of services and patient care delivery.

Safeguarding Children Training: There are three level of Child Safeguarding training and as at the 11th November, 92.67% of staff received Level 1 training, 83.86% Level 2 training and 77.89% Level 3 training. There has been an overall increase in the number of staff trained across all levels.

Human Resources: Medical appraisals are currently at 78% in September and plans are in place to ensure all outstanding appraisals are completed. This has risen to 86% in October.

Data set not available until 19 November 2014

Appendices

Appendix.A – Trust Performance Management Framework Overview 2014/15 (Page 1 of 4)

The Performance Management Framework

The trust is realigning its Performance Framework with the requirements of the NHS trust Development Authority (TDA) and Monitor. The performance report has been updated to cover the new requirements of the TDA Accountability Framework for trusts and to include greater visibility of performance at Divisional level, alongside trust wide aggregate performance.

The TDA Accountability Framework

The accountability framework covers three domains – Quality, Finance and Delivering Sustainability. A set of indicators has been identified in each domain and delivery will be evaluated against a threshold and aggregated for each domain.
Performance against these indicators will determine a score for each domain. These domain scores in turn contribute towards an overall Escalation score for each trust. The trusts will be rated in one of five categories –

Standard Oversight – The organisation has developed a sound FT application and received a 'Good or Outstanding' rating from CIH

Standard Oversight: Limited or no delivery issues

Intervention: The organisation has some delivery issues including clinical and/or financial challenges

Intervention: The organisation has significant delivery issues clinical and/or financial challenges

Special Measures: The organisation has significant delivery issues, including serious clinical and/or financial challenges or concerns.

The trust is also required to sign a self certifications on a monthly basis at Board level covering compliance with Monitor's license requirements and a set of Board Statements .

Appendix.A – Trust Performance Management Framework Overview 2014/15 (Page 2 of 4)

The Performance Management Framework of the trust

The trust continues to operate the revised Performance Framework presented to the Board and Finance and Performance Committee in April 2014. This has been refreshed to ensure the indicators included within the TDA Accountability Framework for NHS trust's are reported against and to ensure that Divisional contributions to the trusts aggregate reported performance are more visible.

The diagrams illustrate the components of the trust's Performance Management Framework. The trust operates escalation processes with Divisions that reflect the National escalation processes and the recommendations in Monitor's toolkits for implementing Service Line Management.

Quarterly Performance Reviews at Divisional Level, regular meetings with our commissioners, weekly Executive management Team meetings to address potential risks are all part of the trusts Performance Management strategy.

- Escalation actions following Divisional reviews have focused on the action plan for recovering A&E 4 hour waits, financial performance within SNT and MedCard Divisions and Cancer performance to look at how delivery of the 62 day target can be improved and sustained.

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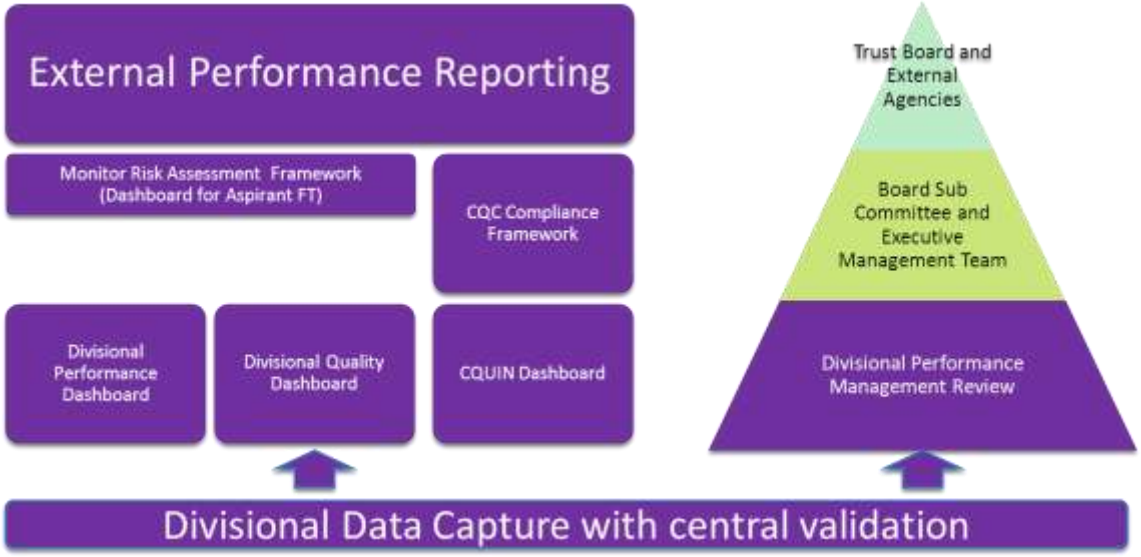

Appendix.A – trust Performance Management Framework Overview 2014/15 (Page 3 of 4)

The Performance Management Framework of the trust

The performance management arrangements includes quarterly reviews for each Division which review and challenge Divisional progress, with an opportunity for Divisions to share with the Executive team issues of concern.

The trust has extended this process by reporting divisional performance against the metrics within the TDA Accountability Framework, to the Finance and Performance committee on a monthly basis. The trust reports on the vast majority of these metrics within the existing quarterly review process. Work continues to ensure that the Divisional scorecards and the trust scorecard fully reflect all the metrics within the TDA Accountability Framework.

Example 1 Monthly Divisional Reports

A score and RAG rating is applied to the domains within each Division by the Senior Management Team, who use the information provided at the reviews to make a judgement about the Divisions performance and determine where remedial action plans and escalation is required. Work continues to apply a scoring system to our performance framework at Divisional level and to roll that up into an integrated scorecard for each Division and for the trust on a monthly basis.

Appendix.A – trust Performance Management Framework Overview 2014/15 (Page 4 of 4)

The Accountability Framework

The TDA will assess delivery across three domains as shown in the diagram :

- Quality
- Finance
- Sustainability

Against each domain trusts will report against a series of metrics. These are listed in detail in Section 8 : definitions and metrics

For 2014/15 trusts will be scored using escalation levels 1 to with one being the highest risk rating and 5 the lowest. This is being done to ensure consistency with the CQC's approach to assessing risk.

1. Special Measures
2. Intervention due to significant delivery issues
3. Intervention due to some delivery issues
4. Standard Oversight- limited or no delivery issues
5. Standard Oversight : Organisation has a developed a sound FT application and received a 'Good or Outstanding rating from CIH.

The trust is also required to sign off self certifications on a monthly basis at Board level covering progress against FT milestones, and compliance with Monitor's license requirements

Key Elements of the Oversight Model