St George's Healthcare NHS
NHS Trust

Performance & Quality Report

Trust Board
Month 8 – November 2014

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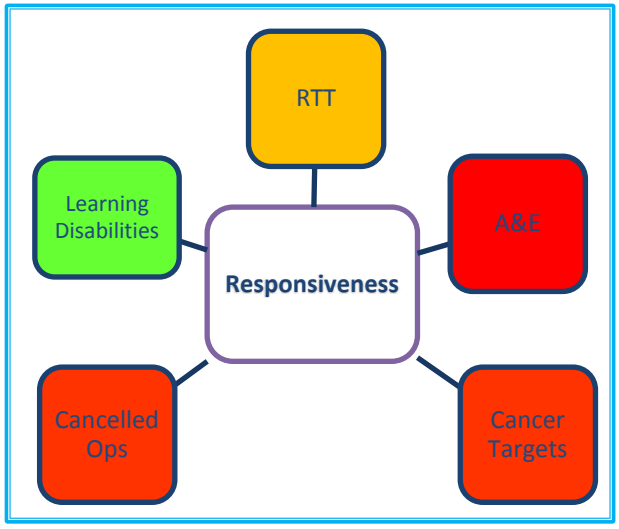
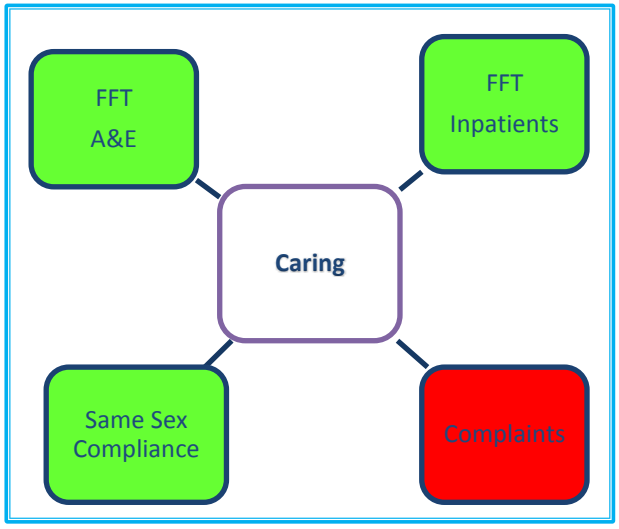
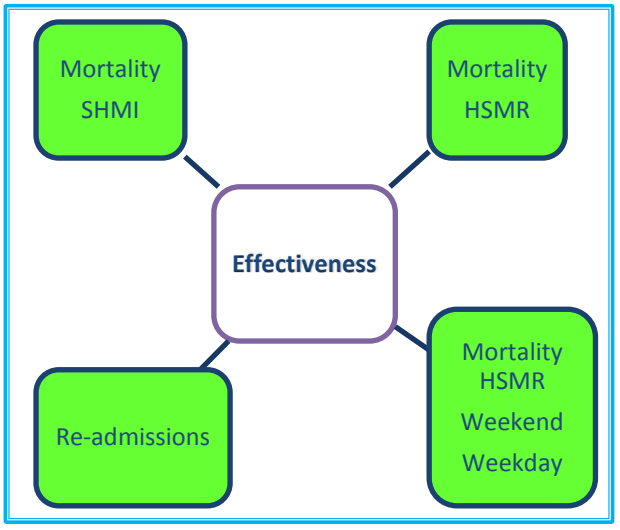
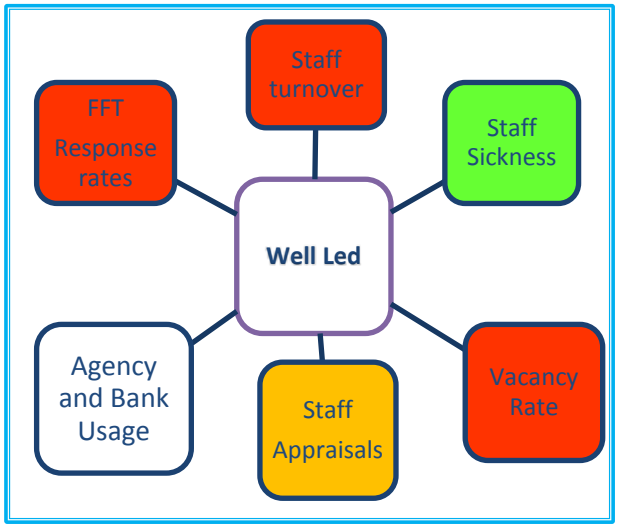
CONTENTS

1. Executive Summary - Key Priority Areas November 2014









The above shows an overview of November 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 Q3 - October 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. Due to the earlier than normal scheduled date of the meeting not all data for November is available. Where unavailable October performance has been reported against.

St George's Healthcare NHS
NHS Trust

Performance against Frameworks

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

Responsiveness Domain					
Metric	**Standard**	**YTD**	**October**	**November**	**Movement**
Referral to Treatment Admitted	90%		85.50%		▼
Referral to Treatment Non Admitted	95%		96.60%		▲
Referral to Treatment Incomplete	92%		91.30%		▼
Referral to Treatment Incomplete 52+ Week Waiters	0		1		▼
Diagnostic waiting times > 6 weeks	1%		0.44%		▼
A&E All Types Monthly Performance	95%	94.91%	94.16%	92.17%	▼
12 hour Trolley waits	0	0	0	0	➤
Urgent Ops Cancelled for 2nd time (Number)	0	0	0		➤
Proportion of patients not treated within 28 days of last minute cancellation	0%	2.20%	2.90%		▲
Certification against compliance with requirements regarding access to health care for people with a learning disability	Compliant	Yes	Yes	Yes	➤
	Standard	**YTD**	**Q2**	**Q3 to Date**	**Movement**
Two Week Wait Standard	93%	94.8%	94.7%	96.0%	▲
Breast Symptom Two Week Wait Standard	93%	95.9%	98.5%	94.3%	▼
31 Day Standard	96%	98.4%	98.7%	96.6%	▼
31 Day Subsequent Drug Standard	98%	100.0%	100.0%	100.0%	➤
31 Day Subsequent Surgery Standard	94%	98.7%	100.0%	98.9%	▼
62 Day Standard	85%	86.9%	86.0%	82.0%	▼
62 Day Screening Standard	90%	91.9%	95.4%	87.0%	▼
Domain Score			**3**		

Safe Domain					
Metric	**Standard**	**YTD**	**October**	**November**	**Movement**
Clostridium Difficile - Variance from plan	0	-3	-1	-3	▼
MRSA bactaraemias	0	3	0	0	➤
Never events	0	3	0	0	▼
Serious Incidents		117	18	17	▼
Percentage of Harm Free Care	95%		94.63%	93.33%	▼
Medication errors causing serious harm	0	0	0	1	▲
Overdue CAS alerts	0	1	1	1	➤
Maternal deaths	1	1	0	0	➤
VTE Risk Assessment	95%		96.84%		▲
Domain Score			**4**		

Effectiveness Domain					
Metric	**Standard**	**YTD**	**October**	**November**	**Movement**
Hospital Standardised Mortality Ratio (DFI)	100		77.5	76.7	▼
Hospital Standardised Mortality Ratio - Weekday	100		87.2	86.08	▼
Hospital Standardised Mortality Ratio - Weekend	100		88.64	83.66	▼
Summary Hospital Mortality Indicator (HSCIC)	100		81	81	➤
Emergency re-admissions within 30 days following an elective or emergency spell at the Trust	5%	3.3%	3.2%	3.5%	▼
Domain Score			**5**		

Caring Domain					
Metric	**Standard**	**YTD**	**October**	**November**	**Movement**
Inpatient Scores from Friends and Family Test	60		67	94	▲
A&E Scores from Friends and Family Test	46		41	89	▲
Complaints			106	68	▼
Mixed Sex Accommodation Breaches	0	4	0	0	➤
Domain Score			**4**		

Well Led Domain					
Metric	**Standard**	**YTD**	**October**	**November**	**Movement**
IP response rate from Friends and Family Test	30%		41.50%	42.00%	▲
A&E response rate from Friends and Family Test	20%		13.70%	14.80%	▲
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%		17.2%		▲
Trust level total sickness rate	3.50%		3.3%		▼
Total Trust vacancy rate	11%		12.9%		▼
Temporary costs and overtime as % of total paybill			7.9%		▼
Percentage of staff with annual appraisal - Medical	85%		86.7%		▲
Percentage of staff with annual appraisal - non-medical	85%		81.5%		▼
Domain Score			**3**		

Trust Overall Quality Score	4

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

Access							
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**Oct**	**Nov**	**Movement**
Referral to Treatment Admitted	90%	1	0		85.5%		
Referral to Treatment Non Admitted	95%	1	0		96.6%		
Referral to Treatment Incomplete	92%	1	0		91.3%		
A&E All Types Monthly Performance (Quarter to date)	95%	1	1	94.91%	94.16%	92.17%	⮟
				YTD	**Q2**	**Q3 TD**	
62 Day Standard	85%	1	1		86.0%	82.0%	⮟
62 Day Screening Standard	90%	1	1		95.4%	87.0%	⮟
31 Day Subsequent Drug Standard	98%	1	0		100.0%	98.9%	⮟
31 Day Subsequent Surgery Standard	94%	1	0		100.0%	100.0%	➤
31 Day Standard	96%	1	0		98.7%	96.6%	⮟
Two Week Wait Standard	93%	1	0		94.7%	96.0%	⮝
Breast Symptom Two Week Wait Standard	93%	1	0		98.5%	94.3%	⮟

* NYA Not yet available

Outcomes							
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**Oct**	**Nov**	**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	50%	1			55%		⮟
referral information	50%	1			88%		➤
treatment activity	50%	1			71%		⮝

Trust Overall Quality Governance Score	1	3	➤

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

November 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.

St George's Healthcare NHS
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Performance – areas of escalation

3. 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	October	November	Movement	2014/2015 Target	Forecast Nov - 14	Date expected to meet standard
FA	94.16	92.17%	⮟	>= 95%	A	Dec -14

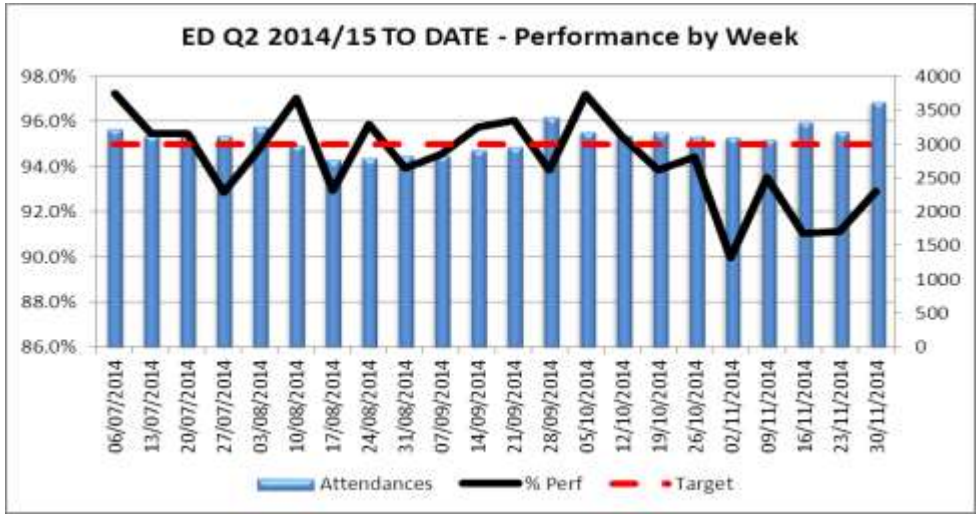
Peer Performance Q3 at end November 2014				
STG	Croydon	Kingston	King's College	Epsom & St Helier
93.27.%	93.02%	95.4%	89.87%	95.56%

The ED target is that 95% or more of patients should be seen and discharged within 4 hours of attending the Emergency Department. In November the trust failed to meet the target with 92.17% of patients being seen within 4 hours.

The onset of winter pressures is having an impact across multiple areas, and subsequently 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 and weekly through system resilience conference calls.



Performance Overview by Type			
	ED	MIU	ED & MIU
	(Type 1)	(Type 3)	(Type 1+3)
Month to Date (November)	91.37%	99.6%	92.17%
Quarter to Date	92.55%	99.82%	93.27%
Year to Date	94.31%	99.83%	94.59%

3. Performance Areas of Escalation (Page 2 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 was scheduled and has been treated on 21/11/2014.

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.

3. Performance Areas of Escalation (Page 3 of 4) - 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

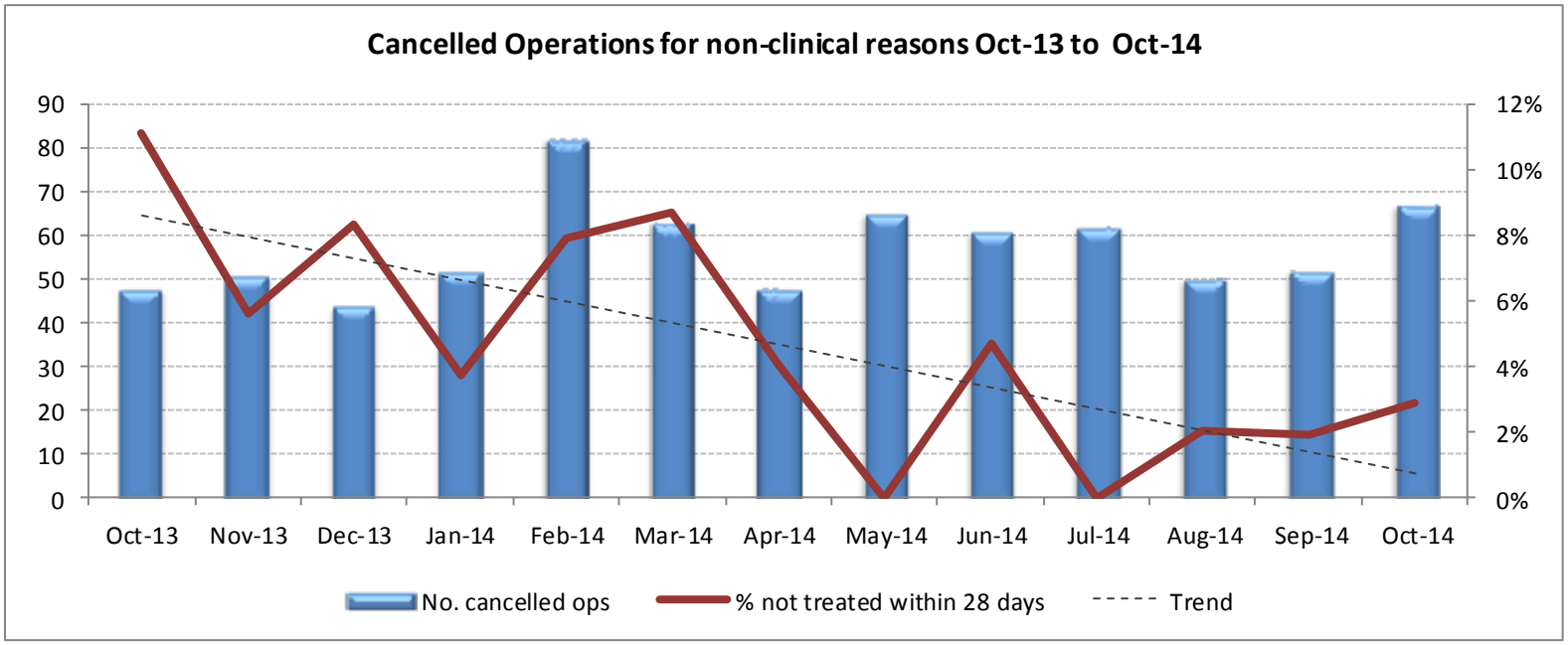
Peer Performance Comparison – Q2 2014/15				
STG	Croydon	Kingston	King's College	Epsom & St Helier
1.2%	5.88%	5.0%	10.75%	1.25%

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.



3. Performance Areas of Escalation (Page 4 of 4)
- Cancer: 62 Day Waiting Time Standards

62 Day Standard						
Lead Director	Q2	Q3 to date	Movement	2014/2015 Target	Forecast Dec – 14	Date expected to meet standard
CC	86.0%	82.0%	⮟	85%	G	Dec- 14

Peer Performance Latest Published Q2 2014-15				
STG	Croydon	Kingston	King's College	Epsom & St Helier
86.0%	75.5%	82.2%	80.7%	76.8%

62 Day Screening Standard						
Lead Director	Q2	Q3 to date	Movement	2014/2015 Target	Forecast Dec - 14	Date expected to meet standard
CC	95.4%	86.9%	⮟	90%	G	Dec- 14

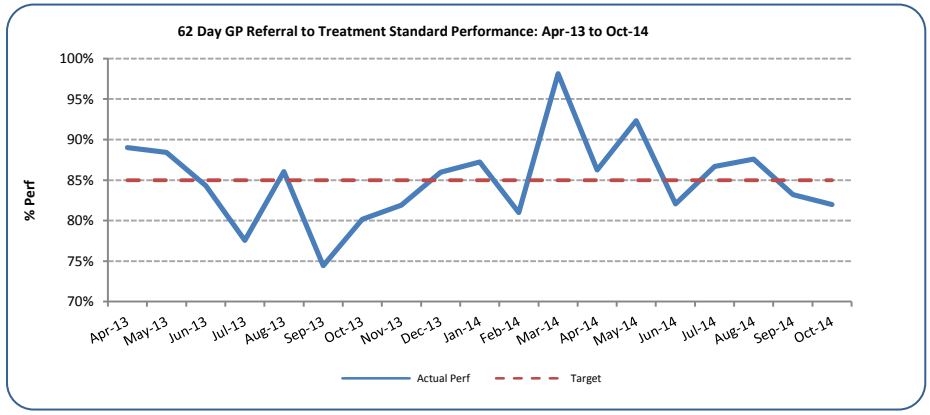
Peer Performance Latest Published Q2 2014-15				
STG	Croydon	Kingston	King's College	Epsom & St Helier
93.5%	100%	95.0%	98.2%	100%

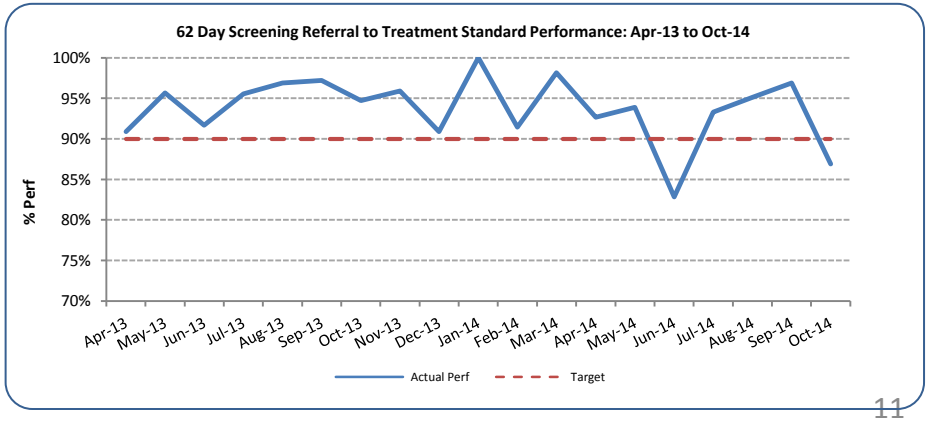
All of the cancer targets were met in Q2 2014. The trust me all the cancer targets in October with the exception of the 62 day targets.

62 day GP Referral to Treatment was not met with a performance of 82% against a target of 85%. Late referrals from other providers continue to be an issue. The trusts performance excluding late tertiary referrals is 89.1% against the target of 85%. The trust is liaising with other providers to improve the timeliness of referrals and is looking forward to agreeing common platform/methodology of reporting and tracking patients via Infoflex as they are transferred from providers.

The trust will continue with its plans to implement a single cancer Management Team and the transfer of monitoring and reporting of QMH activity to St George's cancer informatics system Infoflex to ensure the trust achieves compliance.
Cancer performance continues to be monitored by the Executive Director led Cancer Performance meeting, where performance is scrutinised, issues are escalated and actions for improvement agreed and reviewed.

62 Day Screening Referral to Treatment was not met . The level of activity was less than previous months with 3 breaches in total having a significant impact on performance. Breaches were due to complex diagnostic pathways and late referrals from other providers.





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Corporate Outpatient Services Performance

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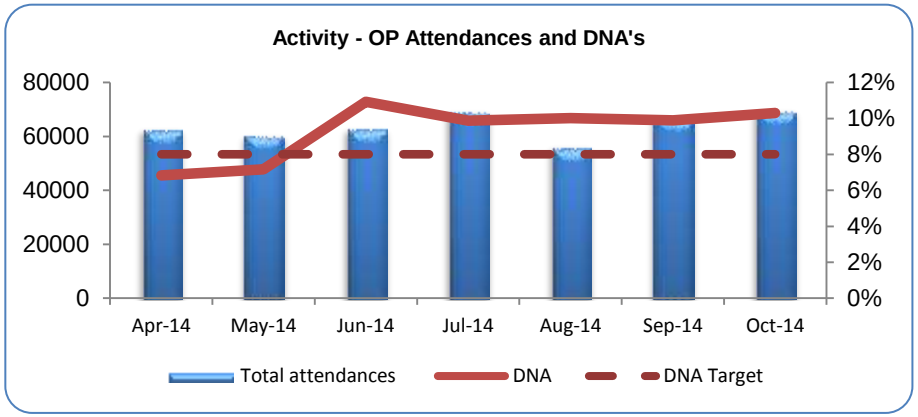
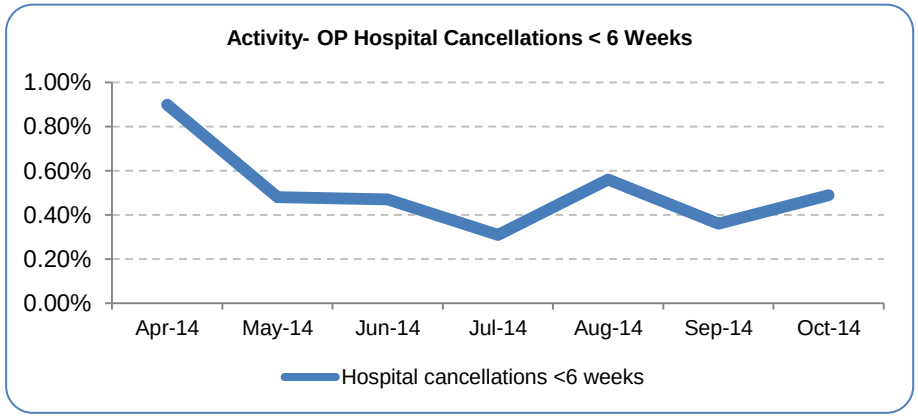
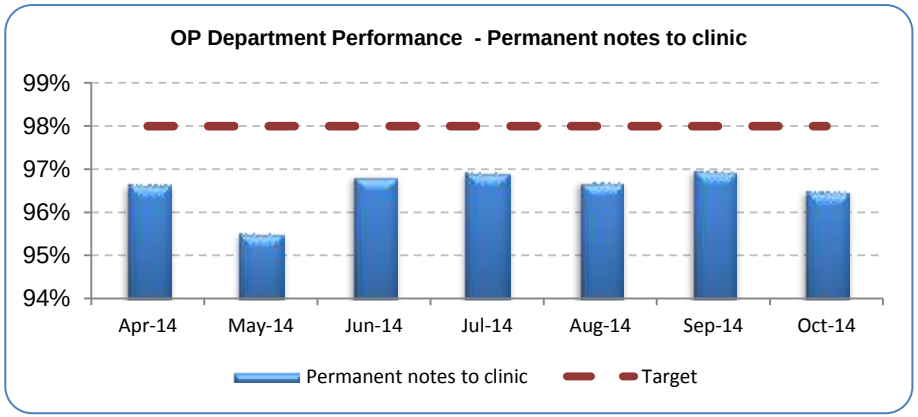
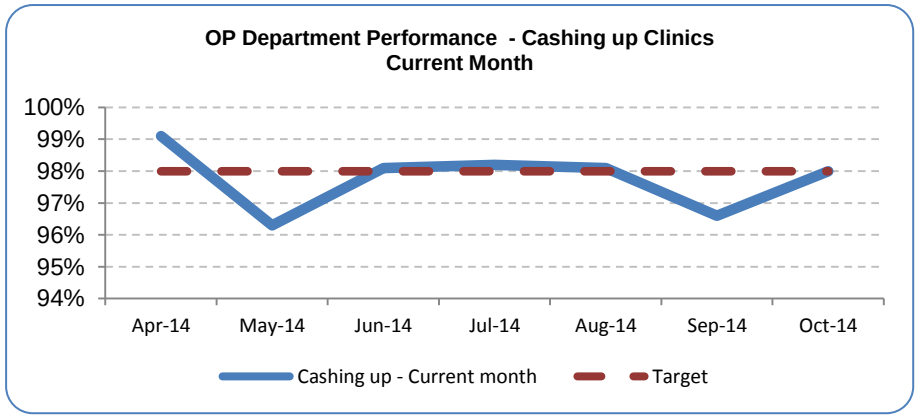
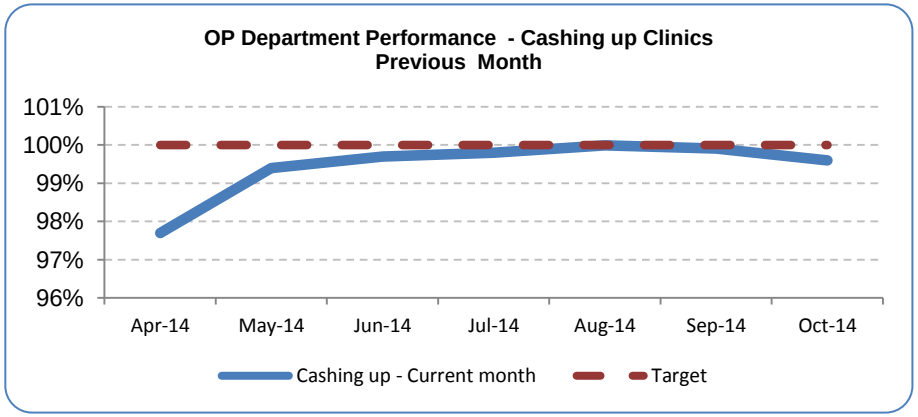
4. Corporate Outpatient Services - Performance Overview

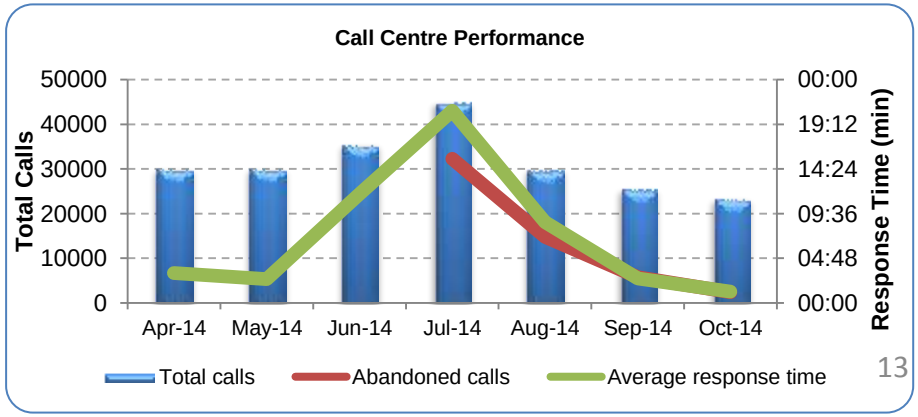












4. Corporate Outpatient Services - Performance Overview

		Target	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14
Activity	Total attendances	N/A	62796	60264	62954	69250	56102	67188	69507
	DNA	<8%	6.84%	7.18%	10.93%	9.87%	10.02%	9.89%	10.30%
	Hospital cancellations <6 weeks	<0.05%	0.90%	0.48%	0.47%	0.31%	0.56%	0.36%	0.49%
OPD performance	Permanent notes to clinic	>98%	96.67%	95.54%	96.85%	96.94%	96.71%	96.98%	96.51%
	Cashing up - Current month	>98%	99.10%	96.30%	98.10%	98.20%	98.10%	96.60%	98.00%
	Cashing up - Previous month	100%	97.70%	99.40%	99.70%	99.80%	99.99%	99.91%	99.60%
Call Centre Performance	Total calls	N/A	30162	30116	35571	45101	30004	25674	23420
	Abandoned calls	<25%				32257	14825	5794	2376
	Mean call response times	<1 minute	03:12	02:34	11:42	20:39	08:41	02:38	01:13

Key Messages:

- Trust OP capacity is not in line with forecasted demand as per business plans.
  - Business plan demand of 666,000 stated against actual trust built capacity of 450,000. This is currently being mitigated by overbooking and scheduling of additional ad-hoc clinics.
- On average 25% of activity is delivered on an ad-hoc basis. This varies between specialties from 2% to 86%.
- Call centre performance improvement continues to be built upon and sustained. CBS action plan on track to deliver key milestones.

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Clinical Audit and Effectiveness

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5. Clinical Audit and Effectiveness - Mortality

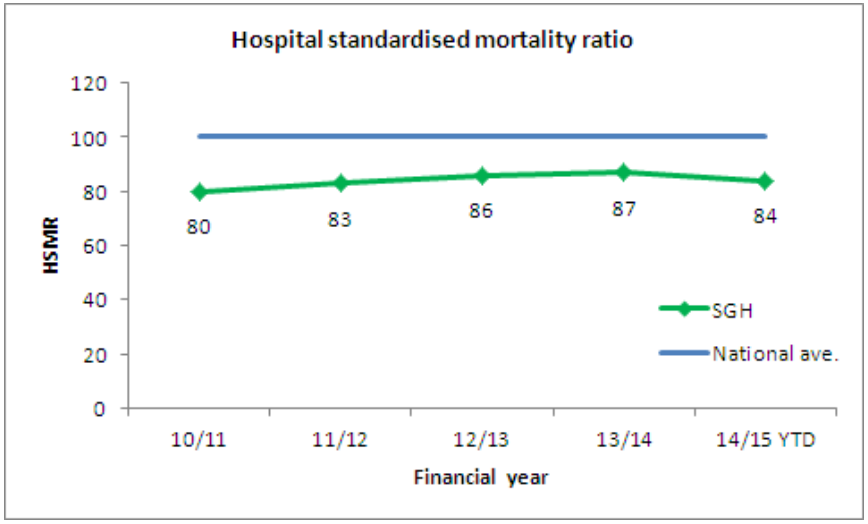
HSMR (Hospital standardised mortality ratio)						
Lead Director	November	December	Movement	2014/2015 Target	Forecast January 15	Date expected to meet standard
RGW	76.7	84.3	↑	<100	G	Met

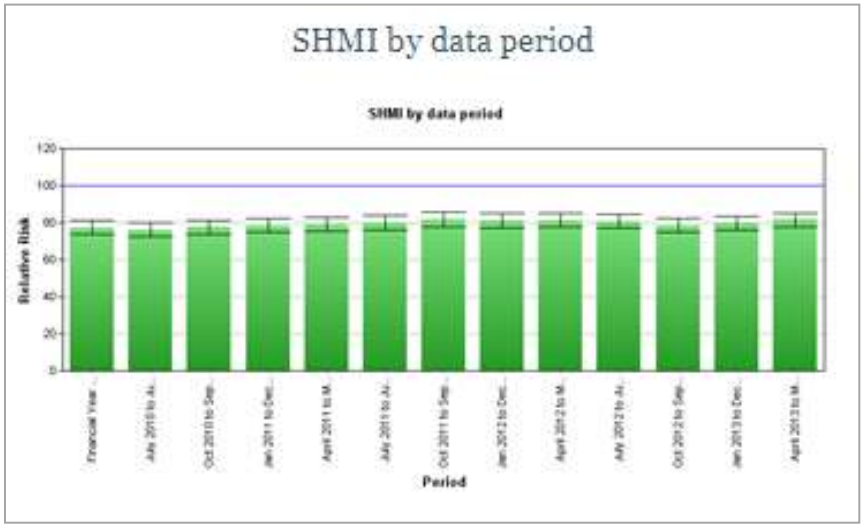
SHMI (Summary hospital-level mortality indicator)				
Oct 2013	Jan 2014	April 2014	July 2014	Oct 2014
0.81	0.81	0.78	0.80	0.81

Note: Source for HSMR mortality data is Dr Foster Intelligence, published monthly. Data is most recent rolling 12 months available. For December 14 this was September 13 to August 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:

Our HSMR for the most recent 12 months (September 2013 to August 2014) as derived from Dr Foster Intelligence shows an increase in comparison to last month's data. This is due to the annual recalculation of the underlying risk model, which takes into account improvements in outcomes nationally over time. Through remodelling the national average is reset to 100, and therefore if mortality locally is not improving as quickly as it is nationally then our mortality will show an increase at the time of this readjustment. Dr Foster are moving towards monthly remodelling which will eliminate this and ensure that data reported is always reflective of current national performance. It should be noted that despite this apparent increase our mortality remains significantly better than expected. For the same period, our mortality for weekday emergency admissions is 86.08 and for weekend emergency admissions is 83.66, both significantly better than expected.





5. Clinical Audit and Effectiveness - National Audits

Epilepsy12 Round 2

Epilepsy12 Indicators		%
Professionals	EP expert input	100
	Specialist nurse input	80
	Tertiary input	50*
Assessment + classification	Appropriate 1st assessment	68*
	Seizure classification	100
	Syndrome classification	90
Investigation	ECG	80
	Appropriate EEG	100
	MRI	80
Management + outcome	Appropriate carbamazepine	100
	Diagnostic accuracy	100
	Water safety discussed	30

* 100% of all relevant cases met the standard

Patient Survey results		SGH	National
What we did well	Staff know what they're doing	100	93
	Test staff friendly and polite	100	96
	Easy to attend clinic	90	81
	Easy to contact epilepsy team	77	72
	Told if clinic running late	70	59
What we didn't do so well	Poor waiting area	67	36
	Staff not good at working together	27	18
	Not enough information about epilepsy	23	18

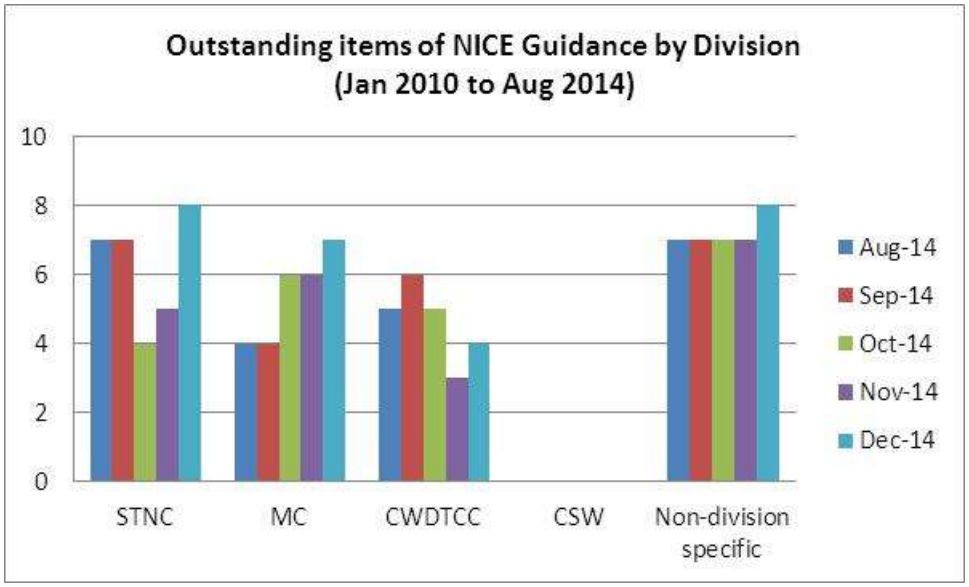
Overview:
Case selection for this audit required significant effort from the lead consultant and nurse. Details of 223 patients with EEG were reviewed, leading to casenote review of 50 patients, with audit details submitted for 22 eligible patients. The national audit team excluded patients that moved out of the area during the follow up period and therefore our results for this round of audit are based on 10 cases. For 11 of the 12 indicators the trust is not an outlier, meaning that our results are in line with the national average. The trust is identified as a negative outlier for discussion of water safety, which is a new criteria. This aspect of care is delivered by the community nursing team and as such has not been routinely documented in the acute hospital record, which is the source of the audit data.

In addition to the clinical audit, a patient survey was also conducted, with all patients attending the clinic being asked to complete a questionnaire. Overall there was a high level of patient satisfaction reported. 93% of our patients were satisfied with the service, compared to 88% nationally. Seven per cent were unsure of their level of satisfaction and no patients reported dissatisfaction; compared to 9% and 3% nationally. A number of areas where we could do better have been identified through this feedback, but unfortunately context is not provided which would have been useful to us in shaping improvements.

An action plan, as summarised below, has been derived following review of the audit and survey results. This will be submitted to the national team by March 2015.

- Audit results have been presented to all specialties and disciplines involved in the care of paediatric epilepsy patients for discussion, recommendations and action planning.
- Changes to the waiting area have been made.
- Explore the context and issues around staff not working well together.
- Amend the epilepsy proforma to include a 'water safety' tick box.

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



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

Overview

For NICE guidance issued between January 2010 and August 2014 there are currently 27 items of guidance outstanding; an increase of 6 from the previous report with an additional month's guidance (August 2014) included. The clinical audit team are working with divisions to decrease the number of outstanding items of guidance as performance is beginning to decline and we must avoid a return to the trust's previous situation of an increasing and persistent backlog. For guidance initially assessed as relevant to STNC and MC we are not being informed of clinical leads on a regular basis, so we will be working with divisional colleagues to remedy this. Support from the Associate Medical Director will enable us to determine our position against guidance relevant to more than one division, further decreasing the backlog.

This month the audit team will also begin the six-monthly review of all guidance where implementation issues have previously been reported essential to understanding any risk associated with non-compliance.

Patient Safety

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

Closed Serious Incidents (not PUs)					
Type	Aug	Sept	Oct	Nov	Movement
Total	7	7	5	8	
No Harm	5	2	3	5	
Harm	2	5	2	3	

S	Q1 SIs Declared by Division (Inc. Pus)				
	Med & Card	Surgery & Neuro	Community	Children's and Womens	Corporate
Sept	7	4	**3**	4 + one never event – retained swab	1
Oct	3	2	**7**	6	0
Nov	5	2	**5**	5	0

Table 1

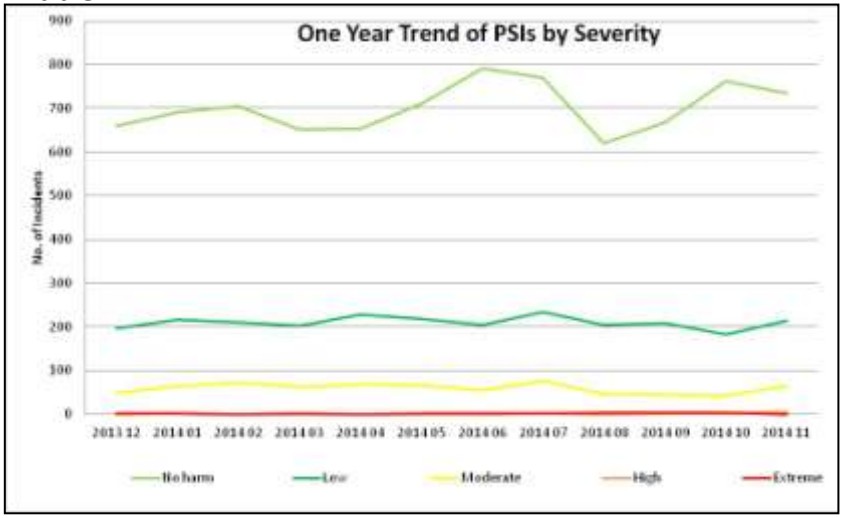
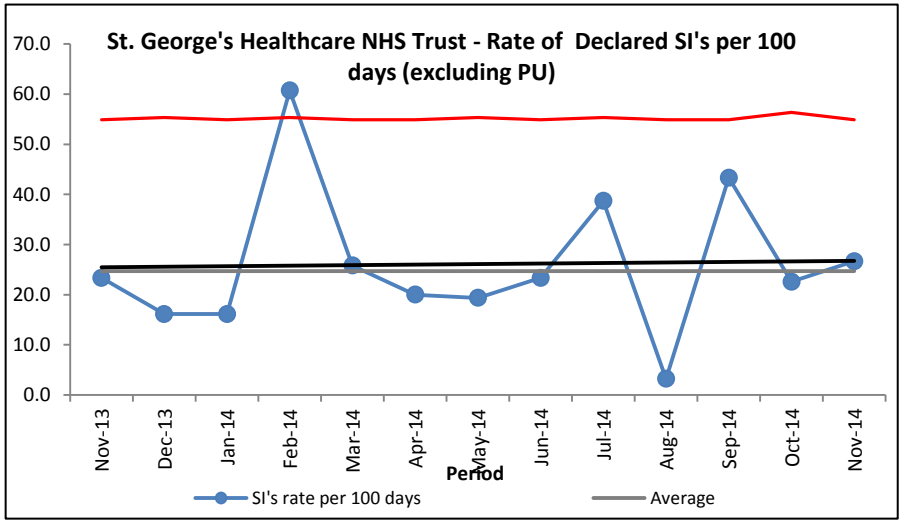


Table 2



Overview:

The annual trend for new -serious incidents excluding pressure ulcers shown in Table 2 above has steadied with 8 SIs in November. Regarding the closed SIs where there was harm : one related to deaths in custody at HMP Wandsworth and the other two related to admission and treatment

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)

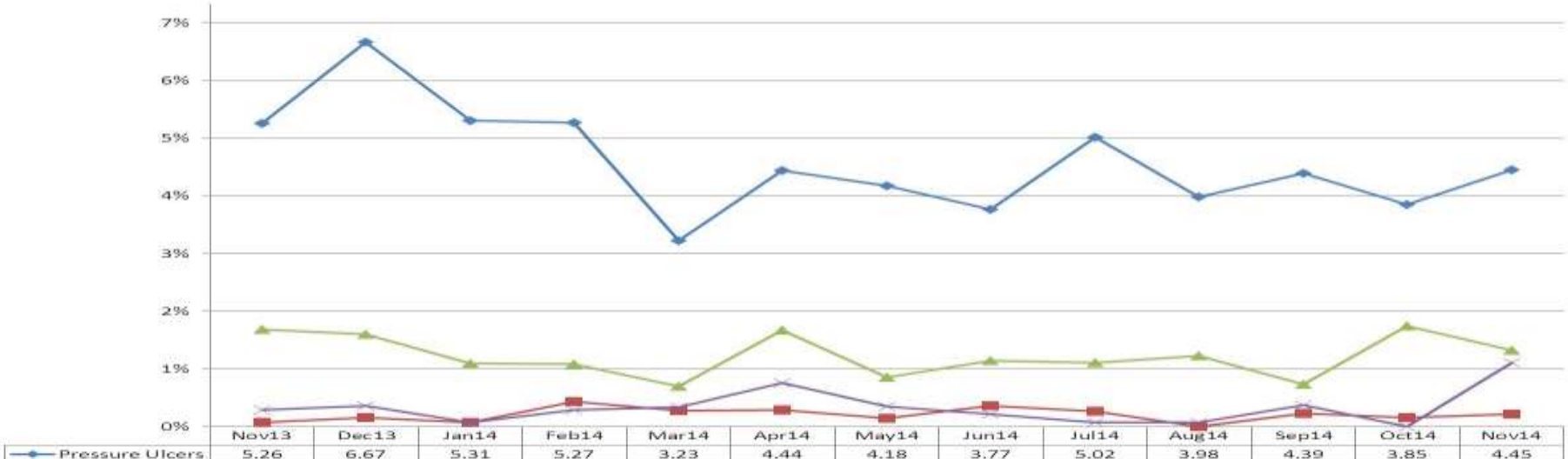
Sign up to Safety

Following the trust sign up to this national campaign to reduce avoidable harm, the trust are now in the process of identifying up to five safety improvement projects to build on existing work and have maximum impact on patient safety. Feedback has been sought from a number of key groups and this will be compiled to ensure that the issues are based on staff and patient feedback. Claims data which has been supplied by the NHS Litigation Authority is also being factored in. If the trust can demonstrate that the improvement work will have an impact on our claims profile, then our contributions to the scheme may be reduced by between 1 and 10%

Once the five topics have been agreed then improvement plans will be submitted to the campaign.

6. Patient Safety - Safety Thermometer

% Harm Free Care							
Lead Director	September	October	November (recalculated)	**Movement**	**2014/2015 Target**	**National Average November**	**Date expected to meet standard**
J Hall	94.52%	94.63%	93.75%	↓	95%	93.88%	March 15



	Nov13	Dec13	Jan14	Feb14	Mar14	Apr14	May14	Jun14	Jul14	Aug14	Sep14	Oct14	Nov14
Pressure Ulcers	5.26	6.67	5.31	5.27	3.23	4.44	4.18	3.77	5.02	3.98	4.39	3.85	4.45
Falls	0.07	0.15	0.07	0.43	0.27	0.28	0.14	0.36	0.26	0	0.22	0.15	0.21
Catheter & UTI	1.68	1.6	1.09	1.08	0.69	1.67	0.85	1.14	1.11	1.23	0.73	1.74	1.32
New VTE	0.28	0.36	0.07	0.29	0.34	0.76	0.35	0.21	0.07	0.07	0.37	0	1.11
Patients	1426	1379	1375	1386	1456	1441	1410	1405	1533	1458	1368	1377	1439

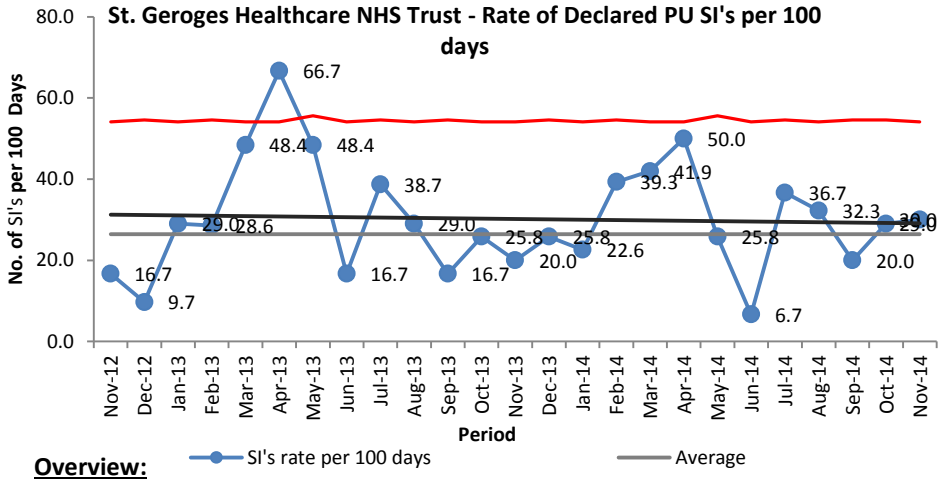
In November 2014 93.75 per cent of our patients received 'harm free' care. This is a decrease from the previous month (94.63%) and below our target of 95 per cent. This represents harm, both old and new, to 90 patients, with 84 patients experiencing 1 harm and 6 with 2 harms.

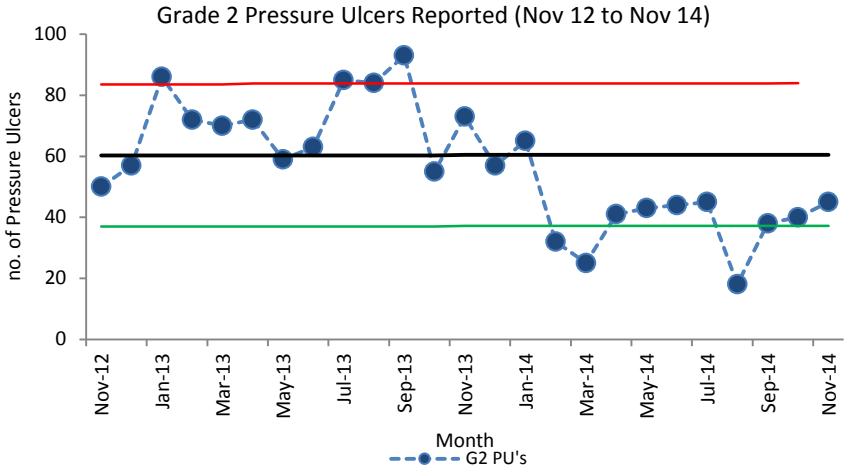
This month the number of new pressure ulcers fell once again to 1.25%, however the number of old pressure ulcers increased to 3.54%. The level of falls remains fairly constant, with a rate of 0.21% this month which represents 3 patients harmed. An increase in the number of new VTEs is observed, and stands at 0.69%, the highest level observed since April 2014. It should be noted that incomplete data validation may have contributed to this apparent increase. Additionally the need to revise the guidance provided to staff has been identified and we will therefore work with the VTE clinical nurse specialists to improve the clarity of instructions, thereby supporting staff to collect accurate data. A slight decrease in the rate of catheter related UTIs (CAUTIs) was observed. A data validation pilot exercise was carried out by a urology clinical nurse specialist this month, and using learning and feedback from that we continue to work on a plan for monthly verification of CAUTI data. Some data from community was not validated this month.

6. Patient Safety
- Incident Profile: Pressure Ulcers

Serious Incident – Grade 3 & 4 Pressure Ulcers										
Type	Jul	Aug	Sep	Oct	Nov	YTD	Movement	2014/2015 Target	Forecast Sept - 14	Date expected to meet standard
Acute	4	7	4	3	5	39			G	-
Community	7	3	2	6	4	31			G	-
Total All	11	10	6	9	9	70			G	-
Total Avoidable	**5**	**3**	**3**	**TBA**	**TBA**	**24**		40		-

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





Overview:

November saw the number of pressure ulcer SI's remain the same across the trust, with a reduction in community services. There was also an increase in the number of Grade 2 pressure ulcers Trustwide, again community services showed a reduction.

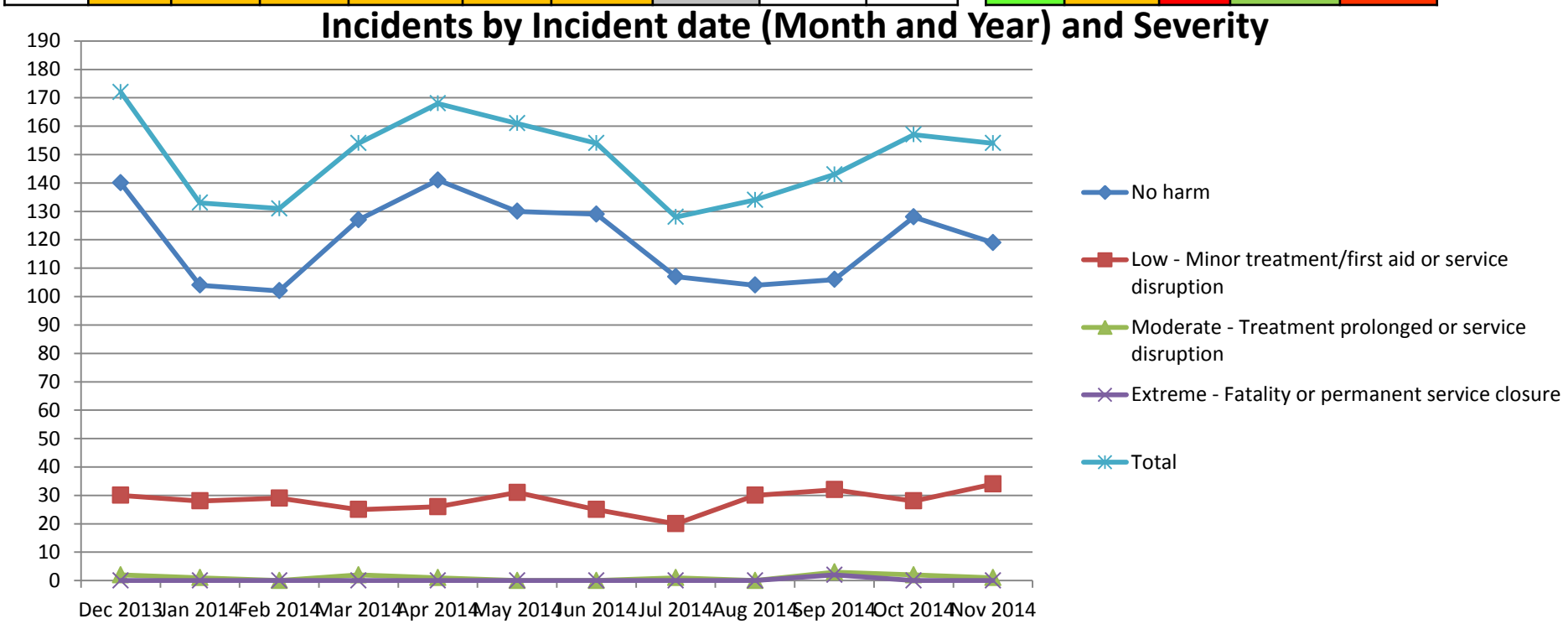
Actions:

- Second community services deep-dive meeting arranged for December 11th to formulate an action plan for a reduction in pressure ulcer SI's.
- Mary Seacole Ward, Queen Mary's Hospital, undertaking the 'No Pressure Ulcers in December' initiative , utilising heightened communication at handover and engaging the entire multidisciplinary team .
- November saw the beginning of the bi-annual Trustwide audit of pressure ulcer paperwork, results pending.
- Roll out of 'Heel-Pro' boots and 'Dermal Pads' continues, providing nurses with more preventative strategies.
- Study days specific to pressure ulcers underway, attended by 27 staff in November and due to run again on 3rd February 2015.
- Planning of 'Hotspots' initiative roll-out across trust to reduce pressure ulcers, particularly those related to mechanical devices.
- Safety Information leaflet circulated trust wide for bank /agency staff to highlight their responsibilities to prevent pressure ulcer damage

6. Patient Safety: November 2014
- Incident Profile: Falls

Falls									
Lead Director	June	July	August	September	October	November	Movement	2014/2015 Target	Date expected to meet standard
	151	151	125	143	157	**154**	⇔	100	July 2015

Falls with Harm				
No Harm	Moderate	Severe	Death	Falls related Fractures
1437	13	**2**	0	7



Overview: The graph shows the profile of falls across both acute and community services including bed-based care and patients' own homes. It is important to note that this data is sourced from incident reporting and is not individually verified. There has been a small decrease in the number of falls over the last month. Preliminary analysis of incident reports in November shows that a small number of incidents are related to specific active medical problems and a small number are miscoded. The majority of falls are un-witnessed occurring during the night and early hours of the morning.

Actions: A review of the Trust falls strategy and dedicated resource to implement best practice in each division/ clinical area is being undertaken. An outline proposal for a falls practitioner post has been discussed with the corporate nursing team. Patient information leaflets on falls prevention and bed rail use are being reviewed by patients for feedback prior to approval. The electronic multifactorial risk assessment has been rolled out into clinical areas which replaces the falls risk prediction tool and is NICE compliant. Further piloting of bed and chair sensors is underway.

6. 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%	94.91%					

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%	86.56%				
National average	85.57%	84.83%	84.83%	84.62%	90.87%	85.50%	85.04%					

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%	85.8%				
	RA complete and correct			92%	89%	82%	81%	88%	78%				
2. Written information 'on admission' **(100%)**		-	-	12.8%	13.2%	21.1%	50%	50%	56%				
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%	64.1%				
5. VTE prophylaxis offered in line with NICE **(>98%)**		-	-	94.6%	94.8%	93.1%	92.9%	95%	92.3%				
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-Dec 2014 (inclusive)

HAT cases identified to date (attributable to admission at SGH)		85
Mortality rate	Total	16.5% (14/85)
	VTE primary cause of death	4.7% (4/85)
Initiation of RCA process		100%
RCA pending	<28 days since notification	22.4% (19/85)
	>28 days since notification (reminder sent)	11.8% (10/85)
RCA complete		65.9% (56/85)

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

Trends identified (findings from 56 cases for whom RCA is complete):

- General breakdown includes:
  - 35.7% (20/56) – patients had active cancer
  - 6 cases of thrombosis in obstetric patients
  - 6 cases of thrombosis 1-16 days after major trauma
  - 6 cases where root cause unable to be identified due to missing notes
- Adequate prophylaxis received 57.1%(32/56) –Examples of contributing factors to failure of prophylaxis:
  - 10 patients - malignancy +/- complications arising from malignancy
  - 7 patients – pharmacological prophylaxis contraindicated
- Inadequate prophylaxis received 25% (14/56) – 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

6. Patient Safety: November 2014 - Infection Control

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

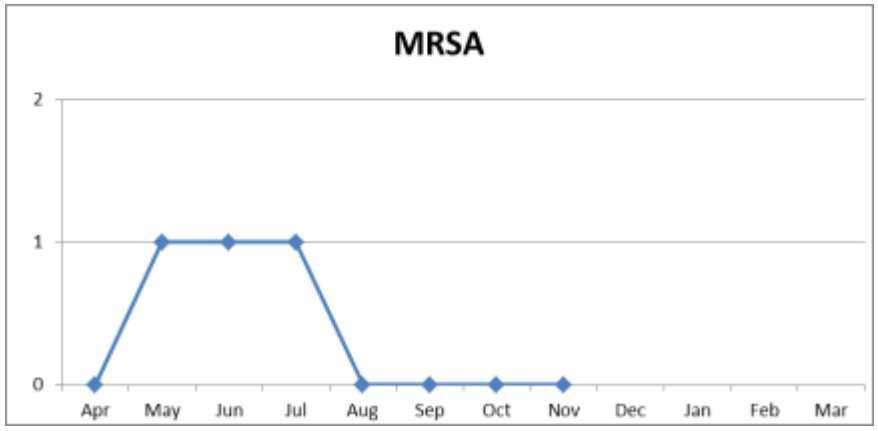
Peer Performance – YTD October 2014				
STG	Croydon	Kingston	King's College	Epsom & St Helier
3	1	0	2	4

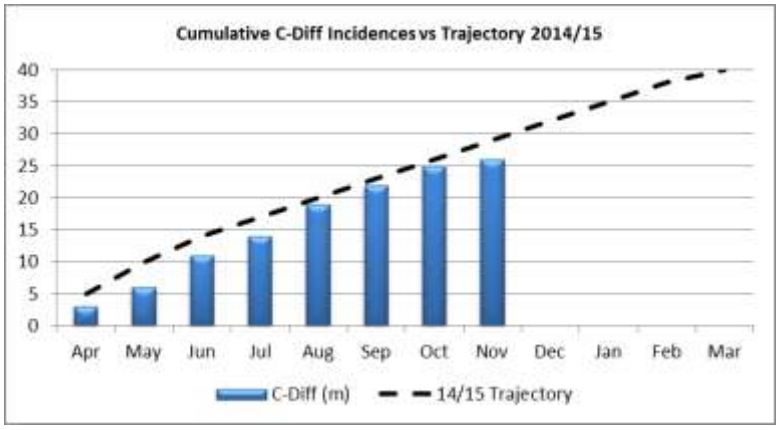
C-Diff						
Lead Director	October	November	Movement	2014/2015 Target	Forecast Dec - 14	Date expected to meet standard
JH	3	1	➢	40	G	-

Peer Performance – YTD October 2014 (annual trajectory in brackets)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
26 (40)	8 (17)	5(24)	42 (58)	24 (40)

In 2014/15 the Trust has a target of no more than 40 C. diff incidents and zero tolerance against MRSA. With a zero tolerance against this target, the trust is non-compliant with 0 incidents in November 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.

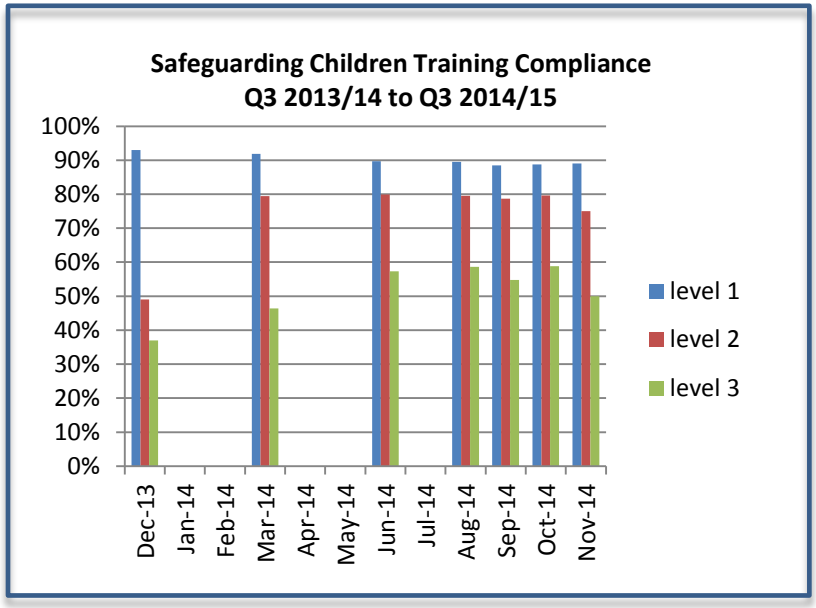
In November there was 1 C. diff incident, a total of 26 for the period April to November. This is against a trajectory of 21 and an annual target of 40. Close monitoring will continue to ensure compliance is maintained.





6. Patient Safety - Safeguarding Children

Safeguarding Training Compliance - Children						
November			Movement	2014/2015 Target	Forecast November- 14	Date expected to meet standard
Level 1	Level 2	Level 3				
89%	75%	50%	⇔	95%	A	-



Overview: The half yearly safeguarding report was presented at both the Patient Safety Committee and the Trust Board. Training compliance particularly at level 3 remains a concern. A meeting chaired by the Chief Nurse and Director of HR taking place in December 2014 will look at training across the trust and will be attended by the safeguarding team to look at future plans and requirements for 2014/15.

Target areas: Training on FGM which was to be delivered by both maternity team and the community team had to be cancelled due to lack of applicants. This will be rescheduled for the New Year.

Serious Case Reviews and Internal Management Reviews: There are eight 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 mother has appeared in court. 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 2015). The Greenwich case went to the criminal court and both parents are due to be sentenced in January 2015. The SCR for Wandsworth has been published – there is a community focused action plan for this case and the perpetrator has been charged and sentenced. A Surrey case from 2012 is about to be published. A new case in which the community staff had involvement has been confirmed as an SCR which will commence in January 2015 hosted by Croydon.

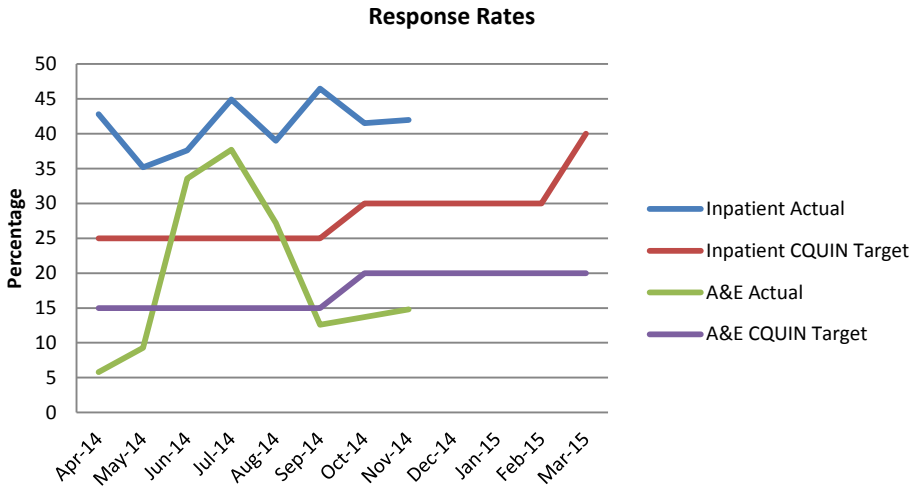
Other: 1. ED – consent: there has been an action plan drawn up by the Head of Nursing for the ED to deal with the issues with records and consent that remain problematic in the ED. This will continue to be monitored. **2**. The Chief Nurse is leading a focus group to provide data on FGM required by the government, and to look at the Trust's response to this issue.

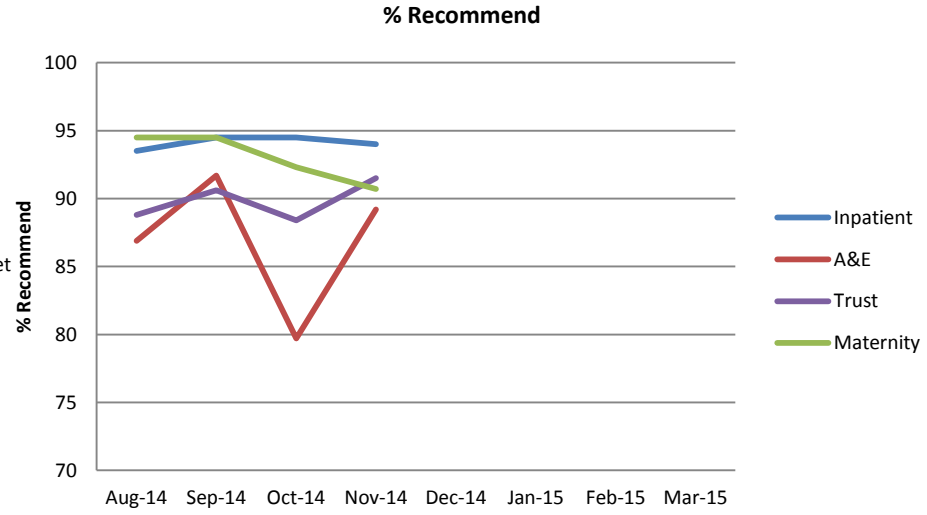
Patient Experience

7. Patient Experience - Friends and Family Test

FFT Response Rate							
Domain	Sep-14	Oct-14	Nov-14	Movement	2014/2015 Target	Forecast Nov- 14	Date expected to meet standard
Trust	23.9%	23.7%	23.5%	↓	30%	G	-
Inpatient	46.5%	41.5%	42%	↑	30%	G	-
A&E	12.6%	13.7%	14.8%	↑	20%	G	-
Maternity	26.3%	26%	20.7%	↓	-		-

	Percentage responses Recommend			
Sep-14	Oct-14	Nov-14	Movement	
94.5	94.5	94	↓	
91.7	79.7	89.2	↑	
94.5	92.3	90.7	↓	
90.6	88.4	91.5	↑	





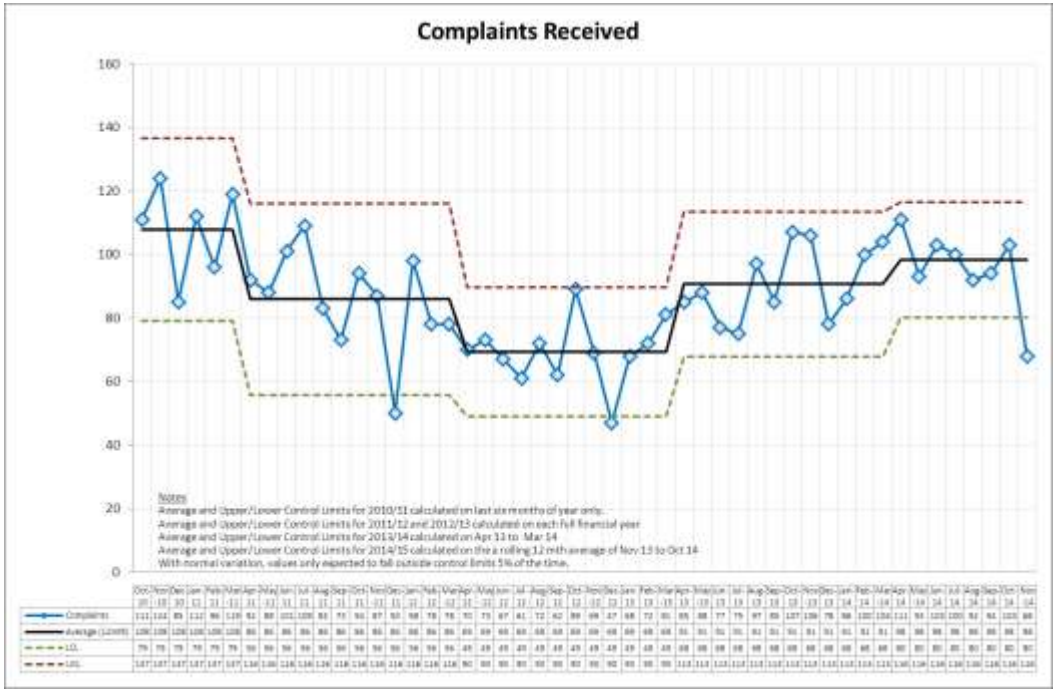
Overview : NHS England changed the way that FFT data would be reported in October 2014. We have update all reports to match the new scoring criteria. The Trust now has a single score based on the percentage of respondents that said they were "Extremely likely" or "Likely" to recommend a particular service. The real time reports now reflect this, and the new scoring method has been communicated to key staff.

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

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

7. Patient Experience - Complaints Received

Complaints Received									
	April	May	June	July	Aug	Sept	Oct	Nov	Movement
Total Number received	111	92	100	99	92	94	107	68	↓



Overview:

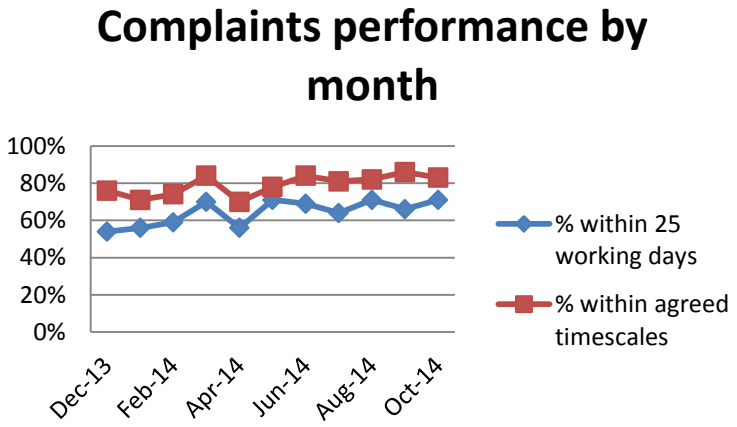
This report provides a brief update on complaints received since the last board report (so in November 2014) and information on responding to complaints within the specified timeframes for complaints received in October. The board will receive more detailed information about complaints received in the 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 November 2014

There were 68 complaints received in November of 2014, a significant reduction when compared to October when 103 complaints were received. Of note complaints about Accident and Emergency reduced from 8-4, Cardiology from 5-1, Estates and Facilities from 8-2, Neurosurgery from 6-0, Outpatients from 17 to 5, Obstetrics and Gynaecology from 10-5 and Trauma and Orthopaedics from 9-4.

7. Patient Experience
- Complaints Performance against targets

Performance Against Target **October 2014**				
Division	**Total number of complaints received**	**Number within 25 working days**	**% within 25 working days**	**% within 25 working days or agreed timescales**
Children's & Women's	35	25	71%	(3) 80%
Medicine and Cardiovascular	17	11	65%	(3) 82%
Surgery & Neurosciences	31	24	77%	(3) 84%
Community Services	11	7	64%	(2) 82%
Corporate Directorates	9	7	78%	(1) 89%
Totals:	103	73	71%	(12) 83%



Overview:

For complaints received in October, 73% were responded to within 25 working days compared to 66% in September, quarter 2 66% were responded to within 25 working days compared to 64% in quarter 1. The reason for the decline in performance for Corporate Directorates is that due to an administrative error a complaint was overlooked when first received and sent to the directorate very late. Attempts are being made to contact the patient to agree and extension.

For the same period 83% of complaints are planned to be responded to within 25 working days or agreed timescales, a slight decline in performance when compared to September when 86% of complaints were responded to within this timescale. The final percentage may change depending on whether all of the agreed extensions are eventually met.

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. There are still two months left of quarter 3 for response times and so it is still possible that this will be achieved.

7. 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..

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

Radiology

I have always had superb care from the Oncology department but I was extremely worried when I had to cancel my Bone scan, CT scan and Oncology outpatient appointments as I was too ill to attend. I thought I would have endless trouble rebooking everything. However each department answered the telephone almost immediately and I was offered alternative appointments a week later. I felt a nuisance for having to cancel, but I was treated with kindness and courtesy by the people answering the telephone. I have had regular scans for seven years now and both Nuclear Medicine and CT scanning are highly efficient with no waiting and kind competent staff who make you feel they care what happens to you. Scans are reported on quickly and booked to coincide so that I do not have to attend twice.
I do not think I could have better treatment anywhere.

Visited in November 2014. Posted on 13 November 2014

Anonymous gave Gynaecology at St George's Hospital (London) a rating of 1 stars

Gynaecology secretary - extremely slow and not bothered

I have been referred for a scan and for several weeks the secretary could not find my files, so I had to have them re-faxed several times, after which I was promised to be contacted with a scan date. Still not happened and I am sick of tired of the service, I am writing a complain to the local MP.

Visited in November 2014. Posted on 25 November 2014

Workforce

8. Workforce: November 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/

			Day				Night				Day		Night	
Ward name	Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - 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				
Cardiothoracic Intensive Care Unit	170 - CARDIOTHORACIC SURGERY	320 - CARDIOLOGY	7488.02	6706.42	18.00	0.00	6950.00	6575.75	298.25	240.25	89.6%	0.0%	94.6%	80.6%
Carmen Suite	501 - OBSTETRICS		1478.50	1397.51	337.50	274.50	1332.00	1309.00	342.00	308.00	94.5%	81.3%	98.3%	90.1%
Champneys Ward	502 - GYNAECOLOGY		1782.00	1677.00	450.00	386.50	660.00	660.00	330.00	308.00	94.1%	85.9%	100.0%	93.3%
Delivery Suite	501 - OBSTETRICS		3913.75	3672.02	765.00	637.50	3956.00	3344.50	475.00	473.00	93.8%	83.3%	84.5%	99.6%
Fred Hewitt Ward	420 - PAEDIATRICS		1429.00	1678.71	149.50	170.50	1755.00	1576.25	128.50	115.00	117.5%	114.0%	89.8%	89.5%
General Intensive Care Unit	192 - CRITICAL CARE MEDICINE		7300.50	6217.25	264.50	236.00	6880.00	6415.75	69.00	69.00	85.2%	89.2%	93.3%	100.0%
Gwillim Ward	501 - OBSTETRICS		2507.00	2207.75	758.50	661.50	2208.00	1527.00	572.00	561.00	88.1%	87.2%	69.2%	98.1%
Jungle Ward	171 - PAEDIATRIC SURGERY	420 - PAEDIATRICS	909.00	947.50	8.00	0.00	0.00	0.00	0.00	0.00	104.2%	0.0%	#DIV/0!	#DIV/0!
Neo Natal Unit	420 - PAEDIATRICS	192 - CRITICAL CARE MEDICINE	8693.00	6827.00	132.00	0.00	8226.00	6182.75	300.00	33.00	78.5%	0.0%	75.2%	11.0%
Neuro Intensive Care Unit	192 - CRITICAL CARE MEDICINE	150 - NEUROSURGERY	4779.50	4465.27	343.00	263.00	4660.00	4450.50	344.00	341.50	93.4%	76.7%	95.5%	99.3%
Nicholls Ward	171 - PAEDIATRIC SURGERY	420 - PAEDIATRICS	2563.00	2238.26	348.50	326.75	1724.00	1650.00	171.00	143.00	87.3%	93.8%	95.7%	83.6%
Paediatric Intensive Care Unit	192 - CRITICAL CARE MEDICINE	420 - PAEDIATRICS	2880.08	3511.85	770.00	589.51	3897.50	3558.50	382.50	356.50	121.9%	76.6%	91.3%	93.2%
Pinckney Ward	420 - PAEDIATRICS		2353.25	2118.50	416.50	345.00	1890.50	1794.00	0.00	0.00	90.0%	82.8%	94.9%	#DIV/0!
Dalby Ward	300 - GENERAL MEDICINE		1507.00	1296.50	1880.48	1908.48	1047.50	989.00	1426.00	1344.00	86.0%	101.5%	94.4%	94.2%
Heberden	300 - GENERAL MEDICINE		1608.97	1153.34	1812.00	1953.50	1072.50	989.00	1367.00	1299.50	71.7%	107.8%	92.2%	95.1%
Mary Seacole Ward	400 - NEUROLOGY	314 - REHABILITATION	2644.50	2470.58	3050.00	2162.19	1814.50	1691.50	1812.50	1752.00	93.4%	70.9%	93.2%	96.7%
A & E Department	180 - ACCIDENT & EMERGENCY		10022.25	9302.26	2590.00	1908.92	9225.00	8404.70	1185.00	1104.00	92.8%	73.7%	91.1%	93.2%
Allingham Ward	100 - GENERAL SURGERY		1831.98	1926.20	900.00	874.76	1372.50	1233.00	890.00	828.00	105.1%	97.2%	89.8%	93.0%
Amyand Ward	300 - GENERAL MEDICINE		1978.00	1719.00	1447.50	1103.50	1128.00	1093.00	927.50	874.50	86.9%	76.2%	96.9%	94.3%
Belgrave Ward AMW	320 - CARDIOLOGY		2485.50	2290.76	1497.00	1019.00	1755.00	1678.50	370.00	368.00	92.2%	68.1%	95.6%	99.5%
Benjamin Weir Ward AMW	320 - CARDIOLOGY		2604.00	2206.00	722.00	448.50	1565.00	1522.00	512.50	471.50	84.7%	62.1%	97.3%	92.0%
Buckland Ward	361 - NEPHROLOGY		1864.47	1660.00	639.75	374.00	1051.00	1038.50	357.50	356.50	89.0%	58.5%	98.8%	99.7%
Caroline Ward	170 - CARDIOTHORACIC SURGERY		1897.50	1670.00	919.00	610.50	1380.00	1345.50	87.00	80.00	88.0%	66.4%	97.5%	92.0%
Cheselden Ward	100 - GENERAL SURGERY		1705.48	1616.98	450.00	358.00	1014.00	954.50	271.50	245.50	94.8%	79.6%	94.1%	90.4%
Coronary Care Unit	320 - CARDIOLOGY	170 - CARDIOTHORACIC SURGERY	2038.50	2186.25	16.00	164.50	2100.00	2034.00	112.50	126.50	107.2%	1028.1%	96.9%	112.4%
James Hope Ward	320 - CARDIOLOGY		1427.50	1310.50	187.50	141.00	460.00	460.00	0.00	0.00	91.8%	75.2%	100.0%	#DIV/0!
Marnham Ward	300 - GENERAL MEDICINE		2600.00	2491.50	1236.00	1264.50	2261.00	2104.00	826.50	858.00	95.8%	102.3%	93.1%	103.8%
McEntee Ward	300 - GENERAL MEDICINE		1624.00	1430.00	758.50	670.50	752.50	747.50	816.00	782.00	88.1%	88.4%	99.3%	95.8%
Richmond Ward	300 - GENERAL MEDICINE		5376.50	4714.50	3620.98	2745.74	3920.00	3770.50	2640.00	2539.75	87.7%	75.8%	96.2%	96.2%
Rodney Smith Med Ward	302 - ENDOCRINOLOGY		1978.00	1700.75	1117.00	907.75	1035.00	977.50	856.50	831.25	86.0%	81.3%	94.4%	97.1%
Ruth Myles Ward	303 - CLINICAL HAEMATOLOGY		1208.00	1301.00	345.00	437.00	1027.50	977.50	103.50	103.50	107.7%	126.7%	95.1%	100.0%
Trevor Howell Ward	370 - MEDICAL ONCOLOGY		2090.00	1756.50	1110.50	983.00	1060.00	989.00	1007.50	943.00	84.0%	88.5%	93.3%	93.6%
Winter Ward (Caesar Hawkins)	300 - GENERAL MEDICINE		1870.50	1525.26	923.75	788.75	1417.50	1292.00	557.50	529.00	81.5%	85.4%	91.1%	94.9%
Brodie Ward	150 - NEUROSURGERY		1244.00	1054.50	899.50	687.76	1047.50	977.50	37.50	34.50	84.8%	76.5%	93.3%	92.0%
Cavell Surg Ward	100 - GENERAL SURGERY		2041.00	2090.72	972.50	641.50	1085.00	1000.50	357.50	345.00	102.4%	66.0%	92.2%	96.5%
Florence Nightingale Ward	120 - ENT		2242.50	1929.00	886.50	590.50	1380.00	1356.00	149.50	183.50	86.0%	66.6%	98.3%	122.7%
Gray Ward	100 - GENERAL SURGERY		2496.50	2208.00	1359.50	983.50	1345.00	1243.00	726.00	682.00	88.4%	72.3%	92.4%	93.9%
Gunning Ward	110 - TRAUMA & ORTHOPAEDICS		2230.75	1975.51	1118.00	967.83	1058.50	1034.50	830.00	806.17	88.6%	86.6%	97.7%	97.1%
Gwynne Holford Ward	400 - NEUROLOGY		1380.00	1401.00	1381.00	1409.00	690.00	667.50	1264.00	1207.00	101.5%	102.0%	96.7%	95.5%
Holdsworth Ward	110 - TRAUMA & ORTHOPAEDICS		1803.00	1820.00	924.00	1087.76	1272.50	1219.00	1201.75	1159.50	100.9%	117.7%	95.8%	96.5%
Keate Ward	160 - PLASTIC SURGERY		1825.00	1718.50	683.00	560.50	1073.50	1081.00	217.00	195.50	94.2%	82.1%	100.7%	90.1%
Kent Ward	400 - NEUROLOGY		2033.50	2104.50	1378.50	1407.00	1743.50	1634.50	1152.50	1104.00	103.5%	102.1%	93.7%	95.8%
Mckissock Ward	150 - NEUROSURGERY		2003.50	1794.50	1124.50	1003.50	1393.50	1347.00	412.50	379.50	89.6%	89.2%	96.7%	92.0%
Vernon Ward	101 - UROLOGY		2506.00	2178.00	907.50	715.50	1332.00	1265.00	438.00	407.00	86.9%	78.8%	95.0%	92.9%
William Drummond HASU	400 - NEUROLOGY		3008.00	2589.00	900.00	644.00	2772.50	2547.00	690.00	623.00	86.1%	71.6%	91.9%	90.3%
Wolfson Centre	400 - NEUROLOGY	314 - REHABILITATION	1692.00	1367.00	1871.50	2117.00	690.00	667.00	1340.00	1311.00	80.8%	113.1%	96.7%	97.8%

8. 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 November 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. As of the 11 December the trust achieved an average fill rate of 90.7%, a slight reduction from 91.1 % on the October submission. Further data validation is continuing ahead of the Unify deadline of 12 December 2014 which may improve the percentage slightly.

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:

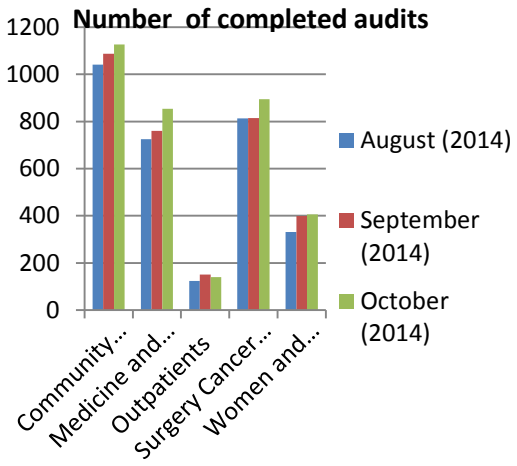
Nurses, midwives and care staff work as part of a wider multidisciplinary ward team. The demand on wards can change quickly and it will always be a clinical judgement as to whether to bring more staff in or reduce the amount the staff as per requirement.

- 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 and the remit has been extended to oversee the Trust wide Nursing/ Midwifery Workforce programme. This will include HR, Finance 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 a reduction vacancy factor, reduction in turnover, staffing required for the 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.

8. 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 to ensure we are reporting as accurately as possible.