St George's Healthcare NHS
NHS Trust

# MEETING OF THE TRUST BOARD

The next meeting of the Board of St George's Healthcare NHS Trust will take place on
**18 December 2014, 9.00am – 11.00am**
H2.5 Board Room, 2nd Floor, Hunter Wing

**In accordance with the Public Bodies (Admission to Meetings) 1960 Act, the Board resolves to consider other matters in private after this meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business.**
Christopher Smallwood, Chair

| | Item | Presented by | |
|---|---|---|---|
| 1. | **Chair's opening remarks** | | 9.00 |
| 2. | **Apologies for absence and introductions** | | |
| 3. | **Declarations of interest**<br>*For Members to declare if they have any interests as individuals or members of other organisations that might relate to Trust business or items on the agenda.* | **C Smallwood** | |
| 4. | **Minutes of the previous Meeting**<br>*To receive and approve the minutes of the meeting held 27 November 2014* | **TBR (M) 27.11.14 (Public)** | 9.05 |
| 5. | **Schedule of Matters Arising**<br>*To review the outstanding items from previous minutes* | **TBR (MA) 18.12.14 (Public)** | 9.10 |
| 6. | **Chief Executive's Report**<br>*To receive a report from the Chief Executive, updating on key developments* | **M Scott**<br>**TBR 18.12.14/01** | 9.15 |
| 7. | **Quality and Performance** | | |
| 7.1 | **Quality and Performance Report**<br>*To receive assurance regarding actions being taken to improve the quality of care for patients and to review the Trust's operational performance report for Month 8 (November 2014)* | **Jennie Hall/Steve Bolam**<br>**TBR 18.12.14/02** | 9.30 |
| | *To receive a verbal report from the Quality & Risk Committee Seminar held on 17 December 2014* | **Sarah Wilton** | |
| 7.2 | **Adult Safeguarding Report** | **Jennie Hall**<br>**TBR 18.12.14/03** | 9.55 |
| 7.3 | **Finance Report**<br>*To review the Trust's financial performance for Month 8 (November 2014)* | **S Bolam** | 10.05 |
| | *To receive a verbal report from the Finance & Performance Committee meeting held on 17 December 2014* | **Christopher Smallwood** | |
| 8. | **Governance** | | |
| 8.1 | **Workforce and Education Committee report**<br>*To receive an update from the Workforce and Education Committee meeting held on 4 December 2014.* | **W Brewer**<br>**TBR 18.12.14/04** | 10.15 |
| 8.2 | **Risk and Compliance Report**<br>*To review the Trust's most significant risks and external assurances received* | **P Jenkinson**<br>**TBR 18.12.14/05** | 10.25 |

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| **9.** | **General Items for Information** | | |
| **9.1** | **Care and Environment progress report**<br>*To receive a report from the Joint Director of Estates and Facilities and receive assurance on progress with improving care, environment and facilities* | **E Munro**<br>**TBR 18.12.14/06** | **10.35** |
| **9.2** | **Use of the Trust Seal**<br>*To note use of the Trust's seal during the period (November 2014)* | | **10.45** |
| **10.** | **Questions from the Public**<br>*Members of the public present are invited to ask questions relating to business on the agenda. Priority will be given to written questions received in advance of the meeting.* | | **10.50** |
| **11.** | **Meeting evaluation** | | |
| **12.** | **Date of the next meeting -** *The next meeting of the Trust Board will be held on 29 January 2015 at 9.00am in H2.6 Board Room, 2nd Floor, Hunter Wing.* | | |

**Matters Arising/Outstanding from Trust Board Public Minutes**
**18 December 2014**

| Action No. | Date First raised | Issue/Report | Action | Due Date | Responsible officer | Status at 18 December 2014 |
|---|---|---|---|---|---|---|
| 14.221 | 30.10.14 | Report from the Quality and Risk Committee | Proposals to be brought to a future meeting on the appropriate forum to which the Equality & Human Rights Committee should report | tbc | Peter Jenkinson | Date tbc |
| 14.240 | 27.11.14 | Chief Executive's Report | Call centre: statistics to be included in the Performance Report | Ongoing | Steve Bolam | Ongoing |
| | | | Branding: strapline 'rationale' to be reworded and appropriate usage to be agreed | ASAP | Peter Jenkinson | Update to be provided as part of Matters Arising – on agenda |
| | | | Team Brief: all briefs – divisional, corporate and local – to be provided to NEDs | Ongoing | Peter Jenkinson | Ongoing |
| 14.241 | 27.11.14 | Quality and Performance Report | Paper resolving recent electronic appointment cancellations issues to be provided | 29.01.15 | Martin Wilson | To be placed on January Trust Board agenda |
| | | | Emergency Department action plan to be circulated | ASAP | Martin Wilson | Update to be provided as part of Matters Arising – on agenda |
| | | | Date for finalisation of thematic review of failure to act on test results to be provided, together with an update on work done | 18.12.14 | Jennie Hall | Update to be provided as part of Matters Arising – on agenda |
| | | | Greater clarity on themes in Serious Incidents to be provided | Ongoing | Jennie Hall | Ongoing |
| | | | Paper on capacity modelling to be provided | 29.01.15 | Martin Wilson | To be placed on January Trust Board agenda |
| | | | Divisional scorecards to be included in the report | Ongoing | Jennie Hall | Ongoing |

| 14.243 | 27.11.14 | Safeguarding – six monthly update | Updates to be provided on the recent local safeguarding case | TBC | Jennie Hall | Updates to be provided as appropriate |
|---|---|---|---|---|---|---|
| 14.245 | 27.11.14 | Finance Report | Update on tariff consultation to be provided | 18.12.14 | Steve Bolam | Briefing to be provided as part of Matters Arising – on agenda |
| 14.246 | 27.11.14 | Workforce Performance Report | Update on corporate actions designed to reduce staff turnover to be included in future reports<br><br>Benchmarking information regarding staff performance KPIs to be included in future reports | Ongoing<br><br>Ongoing | Wendy Brewer<br><br>Wendy Brewer | Ongoing<br><br>Ongoing |
| 14.248 | 27.11.14 | Business cases: Adult Critical Care Expansion Plan OBC<br><br>Business cases: Children's and Women's Hospital SOC<br><br>Business cases: Children's and Women's 5th Floor FBC | Full Business Case to be considered<br><br>External engagement locally and nationally to be considered and promulgated<br><br>Review of financing plan to be conducted – any material changes to be relayed to Board members before submission to TDA | 29.01.15/ 26.02.15<br><br>ASAP<br><br>ASAP | Jennifer Owen<br><br>CWDT division/ Communications<br><br>Miles Scott/ Steve Bolam | To be placed on January/February Trust Board agenda<br><br>Ongoing<br><br>Update to be provided as part of Matters Arising – on agenda |
| 14.249 | 27.11.14 | Annual Plan and Objectives 2014/15 – Quarter 2 Monitoring | RAG ratings to be included in future reports | Ongoing | Suzanne Marsello/ Karen Larcombe | Ongoing |
| 14.250 | 27.11.14 | Audit Committee report | Quantified Fire Safety progress report to next Audit Commitee meeting | 15.01.15 | Eric Munro | To be placed on January Audit Committee meeting agenda |
| 14.251 | 27.11.14 | Annual Fire Safety report | Report to include a dashboard with data on training, fire warden numbers, etc | 26.03.15 | Eric Munro | To be placed on March Trust Board agenda |
| 14.255 | 27.11.14 | Meeting evaluation/Any Other Business | Discussion on ways to reduce size of Board papers, giving members the information they need to know<br><br>Minutes of all Board sub-committees to be sent to non-executive directors | ASAP<br><br>Ongoing | All executive directors<br><br>Peter Jenkinson/ James Taylor | Update to be provided as part of Matters Arising – on agenda<br><br>Ongoing |

St George's Healthcare NHS
NHS Trust

## REPORT TO THE TRUST BOARD – DECEMBER 2014

| | |
|---|---|
| **Paper Title:** | Chief Executive's Report |
| **Sponsoring Director:** | Miles Scott, Chief Executive |
| **Author:** | Peter Jenkinson, Director of Corporate Affairs |
| **Purpose:**<br>*The purpose of bringing the report to the board* | To update the Board on key developments in the last period |
| **Action required by the board:** | For information |
| **Document previously considered by:**<br>*Name of the committee which has previously considered this paper / proposals* | N/A |

**Executive summary**

**1. Key messages**
The paper sets out the recent progress in a number of key areas:

- Quality & Safety
- Strategic developments
- Management arrangements

**2. Recommendation**
The Board is asked to note the update and receive assurance that key elements of the trust's strategic development are being progressed by the executive management team.

**Key risks identified:**

*Are there any risks identified in the paper (impact on achieving corporate objectives) – e.g. quality, financial performance, compliance with legislation or regulatory requirements?*

Risks are detailed in the report under each section.

| | |
|---|---|
| **Related Corporate Objective:**<br>*Reference to corporate objective that this paper refers to.* | All corporate objectives |
| **Related CQC Standard:**<br>*Reference to CQC standard that this paper refers to.* | N/A |

**Equality Impact Assessment (EIA): Has an EIA been carried out?  Yes**

**If yes, please provide a summary of the key findings**

No specific groups of patients or community will be affected by the initiatives detailed in the report. Where there may be an impact on patients then consultation will be managed as part of that specific programme.

**If no, please explain your reasons for not undertaking an EIA.**

# 1 Quality and Patient Safety

## 1.1 Sign up to safety

St George's has signed up to the Department of Health "sign up to safety" campaign to save 6,000 lives and reduce avoidable incidents by 50% over the next three years. St George's now has to prioritise five specific pledges that will help save these lives at the trust. These pledges will form part of the trust's safety improvement plan over the next three years. We are committed to fully supporting and launching the programme from January 2105. An initial soft launch in eG has asked staff for their input into what these five pledges should be.

## 1.2 Penile Cancer MDT named cancer team of the year

St George's penile cancer team has been named Oncology Team of the Year at the prestigious 2014 Quality in Care Oncology Awards. The team were recognised for the transformation in penile cancer management with centralisation and multi-disciplinary care, with the judging panel commending the real transformation which had put the team well above the others in that category.

## 1.3 St George's – Partners in the African Patient Safety Movement

St. George's NHS Healthcare Trust (SGHT) and the Komfo Anokye Teaching Hospital (KATH) in Ghana have worked together for a number of years to share knowledge and skills and the link was formalised by a Memorandum of Understanding (MoU) in 2008. Further strengthening of the partnership was achieved from 2011 through participation in the World Health Organisation (WHO) African Partnership for Patient Safety Programme (APPS) to promote a patient safety programme.

At the end of the two year programme, KATH had implemented projects on hand hygiene, waste management and WHO Safer Surgery which have resulted in tangible improvements to patient safety. As part of the programme the partnership was successful in bidding for further funding from THET (a health partnership charity) to extend the work to five other hospitals in Ghana. The proposed MoU will enable further work to be carried out on a formal footing and enable the sharing of the finance awarded for this project.

A copy of the MOU is attached at Appendix A; the Board is asked endorse the continuation of this partnership and therefore the continuation of the MOU.

# 2 Strategic development

## 2.1 Foundation Trust (FT) application

The Trust has now completed all requirements of the assessment process. The final decision regarding authorisation will be taken by the Monitor Board in its meeting on 17th December.

## 2.2 Five Year Forward View, £2 billion funding increase and the Dalton Review

The Five Year Forward View is a key document, setting out the key challenges that the NHS needs to address and some ways that this can be achieved. Members of the Trust Board, along with key senior staff, will be discussing the implications of this on our strategic direction at a workshop in December 2014.

A key facet of this report was the acknowledgement of a funding gap for the NHS of £8bn. Therefore it was with great enthusiasm that we received the announcement from the Chancellor that £1.95 billion would be injected into the NHS with effect from 2015/16.

Whilst most of the funding is new to health, £700 million of it will come from reallocating funds which have previously been held centrally by the Department of Health or NHS England. Of this £1.95 billion, £1.5 billion will be added to clinical commissioning group and specialised commissioning allocations. The distribution will be decided at a forthcoming NHS England Board meeting. £200 million will be used to support service reconfiguration along the lines of that set out in the Five Year Forward View. The remaining £250 million will be spent on a mixture of revenue and capital schemes to improve GP services and out of hospital infrastructure. It is thought that whilst some might be spent on improving GP practices, NHS England's wider goal is to support primary care move towards the 'Multispecialty Community Provider' model set out in the Five Year Forward View.

Sir David Dalton's review was published on Friday 5th December 2014. The report complements the Five Year Forward View and provides the means by which new care models can be delivered through a range of organisational forms. The report makes 22 recommendations to national bodies, clinical commissioning groups, NHS leaders and wider organisations across five themes:

i. one size does not fit all
ii. quicker transformational change and transactional change is required
iii. ambitious organisations with a proven track record should be encouraged to expand their reach and have a greater impact across the sector
iv. overall sustainability for the provider sector is a priority
v. v. change must happen – implementation must be supported

As with the Five Year Forward View, the Trust will be reviewing the Dalton Review at the Strategy session in December 2014.

### 2.3 South West London Commissioning Collaborative

The focus of the SW London Collaborative Commissioning (SWLCC) for most of 2014 has been to develop a Five Year Strategic Plan to address the issues identified when NHS England designated the area a challenged health economy. The Five Year Plan has now been agreed by the Clinical Commissioning Groups, SW London boroughs and NHS England, and as a result of this work SW London is no longer labelled a challenged health economy.

The Five Year Plan has been informed by a number of Clinical Design Groups (CDGs), which have had representation from the Trust: urgent and emergency care, integrated care, maternity services and children's services. The focus of the SWLCC from January 2015 will be for the CDGs to begin to work on the implementation plan for the first year of the strategy; there will be additional CDGs for cancer and planned care. The Trust will continue to provide its full support to taking forward the plans with the SWLCC.

### 2.4 Joint working with St. George's University of London – update from the Joint Implementation Board

The Joint Implementation Board (JIB) met again on 9th December to continue to develop the relationship between the Trust and the University in working together to improve standards of health and wellbeing for our communities, through education, research and services. Key topics for discussion included developing a joint Education Strategy and the proposal to develop more integrated working in Cardiology across our two organisations. Support was given for both of these initiatives, which is very positive, and now more detailed work will take place to on the latter two items.

### Branding

The JIB also approved a brand architecture and design to represent and endorse this working relationship. Next steps will be to agree the vision for the partnership, agree

guidelines for the use of the brand and a communications plan for the launch of the brand. It is anticipated that formal launch will be in March 2015.

### 2.5 Collaboration for Leadership in Applied Health Research and Care (CLAHRC)

I am delighted to report that the CLAHRC South London has appointed its latest member of the team, Nick Sevdalis, to the role of Professor of Implementation Science and Patient Safety. Nick will join the CLAHRC team early in 2015. Nick is currently a reader in patient safety at Imperial College London: he has worked at Imperial's Department of Surgery and Cancer (in the Faculty of Medicine) as a specialist in patient safety research for the past decade.

### 2.6 Health Innovation Network (HIN)

Good progress continues to be made, as demonstrated by the following two examples. Within the Musculoskeletal workstream work is ongoing to champion the roll-out of the rehabilitation programme for knee osteoarthritis: 'ESCAPE-pain'. In November 2014, Diabetes workstream launched a toolkit aimed at providing healthcare professionals, commissioners and providers, with a resource to support the provision and delivery of structured education for people with Type 2 diabetes.

### 2.7 Genomic Medicine Centre

At the time of writing we are still waiting to hear the outcome of our bid to become a Genomic Medicine Centre.

### 2.8 IM&T - RiO Community Information System

The RiO Community Information System was successfully transferred from BT to a Capita hosted service over the weekend of the 6th/7th December 2014. The RiO system supplier, Servelec, is now maintaining this system under a direct service contract with St.George's.

## 3 Workforce

### 3.1 Staff engagement - Listening into Action

**Pass it on Event**

At the Pass it on Event on 1 December, the teams that have adopted Listening into Action this year told us of their successes and achievements, and of the challenges and hurdles they had faced. Case studies included:

- The immunisation team talked of how staff morale has improved as a result of staff being listened to.
- The Sterile Services team has been enabled to come up with their own ideas on how to improve the service and how to build a successful team.
- In the Rose Centre, the simplest improvements have made the biggest difference.
- For the Radiology team at Queen Mary's it's been really hard to keep going, but the pagers for patients, identified at their Little Conversation, will be in use in the New Year.
- Staff in the Community Speech and Language Therapy teams are proud of the skills hub they have developed and are proud to own and share it.
- For Audiology, the important lesson has been: "make sure you engage with the right people at the start so that any blockages can be addressed together".

Also present was Sadiq Khan MP who described how impressed he is that time is given to get people to connect. He also praised the combination of treatment and experience that makes St George's world-class.

Listening into Action passes on to the following teams in 2015:

- Children's therapies
- Radiology (St George's)
- Community nursing North
- Community nursing South
- Medical Physics
- St James and Paul Calvert theatres
- Neuro theatres
- Day surgery
- Cardiac theatres
- Patient tracking in chest medicine
- Junior doctors

### 3.2 London Leadership Academy Awards

We were very proud that Teresa Manders won a London Leadership Academy award for Leader of Inclusivity for the year. She now goes forward to national awards that take place in March. Jenni Doman was highly commended in the NHS Patient Champion of the Year category and Chris Anderson was shortlisted for NHS Mentor/Coach of the Year.

### 3.3 Staff survey

An internal awareness campaign by the Human Resources and communications team resulted in a final basic sample response rate (to be reported nationally by NHS England) of 39.1% (of all staff) in comparison to last year's 41.4% (of 4,000 staff surveyed).

## 4 Communications

**'24 Hours in A&E'**

Episode six of 24 Hours in A&E aired on Thursday 4th December and episode seven screens on 11th December. The last episode for the first series will be on 18th December with the series resuming in early January with the remainder of the 18 episodes of the first series.

St George's website has seen a significant increase of traffic throughout the series, with the first episode recording 8,500 visits and 21,500 page views in a single day, twice more than any other recorded day. Our work across our social media channels has resulted in significant though-traffic to the trust's website including 15,500 visits via Facebook and 2,500 visits via twitter since the 30th October. We have utilised our increased social media presence by integrating other corporate objectives in to 24hrs in A&E messaging including staff recruitment and individual communications campaigns such as the community open day and flu vaccinations. Initial qualitative analysis of the social media feeds in relation to 24hrs in A&E activity demonstrates a favorable image and reputation within a very significant percentage of posts or tweets.

**Social media in the NHS**

St George's has been ranked 23rd of all UK NHS providers and the fourth highest rated NHS provider in London for its social media presence in the first comprehensive analysis of social media in the NHS. The analysis is contained in the report 'On the brink of SoMething Special' is the result of six months' research and analysis of NHS social media undertaken by leading consultancy JB McCrea, supported by NHS Providers.

**Staff Recruitment and Retention**

The team ran a Google Adwords campaign to drive targeted visitors (theatres and neurosciences) to our optimised recruitment page to capture contact details with the aim of converting into employees. To encourage nurses to work at St George's we supported the production of videos which captured positive real life stories of life at St Georges. Our recruitment page has been optimised to remove some of the barriers to applying for positions, with the introduction of quick contact form to capture details of potential employees. The team organised a drop in session to improve our understanding of the role of nurses at the trust and the barriers and issues regarding to nursing recruitment. This was attended by 15 nurses across bands 2 -7. Members of the team are attending Nursing and Midwifery workforce planning board and a workforce planning board to provide communications support to internal staff retention and external recruitment activities.

**Flu vaccination**

The internal campaign to promote flu vaccination take-up among staff through online/offline activities continues. Take up stands at 39%. We are supporting a second phase of communications including letters to staff and a new internal campaign.

**Press**

A journalist from The Guardian visited the trust's community midwives and published a piece highlighting the positive work of our midwife-led units and homebirth team. Read the full article here: http://www.theguardian.com/lifeandstyle/2014/dec/04/birth-guidelines-midwives-preaching-converted

**Patient Information Officer**

The trust's new Patient Information Manager is in post to implement and oversee the development of high-quality, clinically accurate and standardised patient information across the trust. The scope of this role includes a commitment to accessibility, patient safety and supporting informed consent. A key early objective will be to launch a phased audit of patient information available at the trust.

**APPENDIX A – MOU**

**Memorandum of Understanding**

## 1. Introduction

St George's NHS Healthcare Trust (SGHT) and the Komfo Anokye Teaching Hospital (KATH) in Ghana hereby agree to build on the existing healthcare link(known as 'the Link') previously formalised by a Memorandum of Understanding (MoU) in 2008. The aim will be to foster cooperation and the exchange of knowledge and skills in the areas of quality assurance and patient safety.

SGHT and KATH share the belief that exchange of s of skills and experience are an important resource in:

- Supporting improvements in health services and systems
- Bringing personal and professional benefits to health workers in the UK and
- Enhancing solidarity between those from different countries

We acknowledge, therefore, a mutual interest in working to support health systems and in building the capacity of health workers in Ghana.

We share a commitment to the following key principles. We will:

- Respond to priorities identified by KATH , in dialogue with SGHT
- Ensure that the link focuses on areas where there is a demonstrable health care need, or need for health system strengthening.
- Ensure that the activities of the Link are in alignment with national and local healthcare priorities and plans.

The agreement to form a Link has the full support of the Board at SGHT and KATH and has been agreed at meetings on 19th December.

## 2. Purpose of the Link

The purpose of this link is to build on existing work that has been done as part of the World Health Organisation (WHO) African Partnership for Patient Safety Programme (APPS) to promote a patient safety programme focussing on hand hygiene, waste management and WHO Safer Surgery. The extension of the programme to five other hospitals in Ghana will be funded by a THET grant awarded to SGHT on behalf of the partnership. SGHT agrees to use the grant to fund the programme as agreed in the successful bid and will release the money as agreed in the associated project plan. KATH agrees to spend any money forwarded to them as part of the programme to support the project plan and will provide receipted evidence to that effect.

### 3. Alignment

In line with the 2005 Paris Declaration on Aid Effectiveness, we acknowledge the importance of ensuring that the Link is in alignment with the healthcare priorities and plans of the Ministry of Health in Ghana and with local health plans in the Kumasi region.

### 4. Coordination, roles and responsibilities

Each organisation will agree a Steering Group to coordinate the work of the link with roles and responsibilities built into the Terms of Reference.
In carrying out the roles and responsibilities described in this section, each side agrees to work with consideration for the other and to foster mutual respect.

### 5. Communication

Our preferred methods of communication are email, phone and conference calls such as Skype or Facetime.

### 6. Planning, development and activities

We are committed to the priorities identified by both organisations as part of the World Health Organisation sponsored programme African Partnership for Patient Safety. This includes work streams on hand hygiene, waste management and WHO Safer Surgery. In the successful bid to THET the KATH SGHT partnership has been successful in securing additional money from THET to spread the learning from the APPS programme to other hospitals within Ghana and these will form the basis of the agreed plans for this partnership.

### 7. Monitoring and Evaluation

We are committed to tracking our progress regularly, to learning from our experiences, and to sharing this information with each other- and with other organisations that might benefit.

### 8. Entry into effect, amendment and termination

This MOU shall come into effect from the date of signature by the heads of the two organisations involved. This MoU shall continue in effect, with modification by mutual agreement, until it is terminated by either party.

### 9. Duration and review

We shall review the operation of this MoU in April 2017 at the end of the THET programme. At that time, we will consider how well the MoU is working and review its progress: we will consider whether the MoU should be extended- and if so, what further deliverables should be identified.

### 10. Signatures

| **For and on behalf of KATH** | **For and on behalf of SGHT** |
| --- | --- |
| Signed: | Signed: |
| Name: | Name: |
| Position: | Position: |
| Date: | Date: |

St George's Healthcare NHS
NHS Trust

## REPORT TO THE TRUST BOARD

| **Paper Title:** | Quality and performance Report to the Board for Month 8- November 2014 |
|---|---|
| **Sponsoring Director:** | Jennie Hall- Chief Nurse/ Director Infection Prevention and Control<br>Ros Given- Wilson- Medical Director<br>Steve Bolam- Director Finance/ Performance and Informatics/ Deputy CEO |
| **Authors:** | Jennie Hall- Chief Nurse/ DIPC<br>Ros Given Wilson- Medical Director<br>Matt Laundy- Infection Control Lead<br>Corporate Nursing Team<br>Trust Safeguarding Leads<br>Steve Bolam- Director Finance/ Performance and Informatics/ Deputy CEO |
| **Purpose:** | To inform the Board about Quality and Operational Performance for Month 8. |
| **Action required by the board:** | To note the report and key areas of risk noted. |
| **Document previously considered by:** | Finance and Performance Committee<br>Quality and Risk Committee |

**Executive summary**

The timeline between the November and December meetings has resulted in an inability to report all elements. Those not within this report will be captured within the Month 9 Report.

Key Points of Note for the Board in relation to November Quality Performance:

**Performance**

The trust is performing positively against performance indicators as per NTDA and Monitor regulatory frameworks. The trusts self-assessment shows a quality score of 4 against NTDA accountability framework which signifies that no intervention is required and shows a quality governance score against Monitor risk assessment framework of 1 which is 'Amber-Green'.

There are a number of performance indicators which have underachieved. This report details reasons why targets have not been met, remedial actions being undertaken and forecasted dates for when performance is expected to be back within target.

**Effectiveness Domain:**

- Mortality and SHMI performance remains strong for the Trust. The most recent 12 month period (September 2013 to August 2014) has been rebased nationally. The result of this is that the HSMR has risen slightly. Dr Foster is reviewing this approach going forward. Of Note following the rebasing St Georges continues to have mortality lower than expected across weekend and weekday emergency admissions.
- The results of the National Epilepsy Audit are included in the report. The Trust results are largely in line with the national average for 11/12 indicators with the remaining indicator reflecting data collection challenges. An action plan has been developed to address the audit findings.
- The report indicates the position with compliance with NICE guidance and the action being taken to decrease the number of outstanding items.

**Safety Domain**:

- The SI profile for November did not indicate any key trends.

- Safety Thermometer performance decreased slightly from October performance and below national performance in the Month with the number of new pressure ulcers being reported decreasing, but an increase in old ulcers. Focus will be placed on the validation of VTE data as this may have contributed to the decrease in overall performance Focussed work streams will continue to support improved performance i.e. pressure ulcers, falls and VTE assessment.

- The pressure ulcer profile for November was consistent with the October position in terms of grade 3 and 4 ulcers with a second month of reduction in grade 2 ulcers. As previously reported to the board a deep dive review has already been completed within both the Surgical and Community Divisions where a number of the Ulcers occurred and actions are being taken forward. The actions include training, use of safety approaches such as "hotspots" to raise awareness and roll out of preventative strategies. The RCA analysis has yet to be completed to understand if the ulcers were avoidable or unavoidable.

- The Trust has now reported 3 MRSA bacteraemia cases and 26 C-Difficile to the end of November. Focus is being placed on existing actions within the Trust i.e. hand hygiene compliance, antibiotic prescribing and prompt isolation. The profile will continue to be closely monitored. .

- Safeguarding Adults activity across Paediatrics and Adults is significant. The Training profile for Safeguarding Children remains a risk given the activity profile, and number of SCR cases that the Trust is involved with across a number of boroughs. Focus is being placed on further action to improve training compliance particularly at level 3.

**Experience Domain:**

- The response rate for FFT declined slightly in November from 23.7% to 23.5% confirming the requirement for us to review our approach to ensure the Trust achieves a strong response rate and delivery of associated CQUINS.
- The complaints summary indicates performance for response rates remains below target but some improvement within the Surgery and Neurosciences Division. Performance management is in place to deliver a sustainable performance in Quarter four, and Divisions have moved to a weekly oversight process.
- The total number of complaints in November decreased from 107 in the previous month to 68. No conclusion can be drawn from a single month but the board will note the reduction in complaint numbers across a range of areas where focussed intervention work has been undertaken following earlier complaints.

**Well Led Domain:**

- The third safe staffing return is included for all inpatient areas. The average fill rate for the Trust is 90.7% across these areas. The return is viewed alongside the Trust information for staffing alerts (Red Flags) which has been implemented across the Trust, and Trust Bank information about the temporary staffing profile and fill rates.
- Work has commenced regarding the recruitment of staff to address the current turnover profile, reduction of vacancy factor to 10%, the establishment review and additional capacity. The numbers of registered staff required are significant over a 12 month period so a central programme is in place to coordinate activity in relation to Nursing/ Midwifery recruitment and retention activity to supplement existing Divisional activity.

**Ward Heat map:**

The Heatmap for the December report is not available at the time of writing this report however it will be included in the January report.

| | |
|---|---|
| | |
| **Key risks identified:**<br>Complaints performance (on BAF)<br>Infection Control Performance (on BAF)<br>The profile regarding the failure to act on clinical test results arising from serious incidents.<br>Safeguarding Children Training compliance Profile | |
| **Related Corporate Objective:**<br>*Reference to corporate objective that this paper refers to.* | |
| **Related CQC Standard:**<br>*Reference to CQC standard that this paper refers to.* | |
| **Equality Impact Assessment (EIA): Has an EIA been carried out?**<br>**If no, please explain you reasons for not undertaking and EIA.** Not applicable | |

St George's Healthcare NHS Trust

NHS

# Performance & Quality Report

## Trust Board
## Month 8 – November 2014



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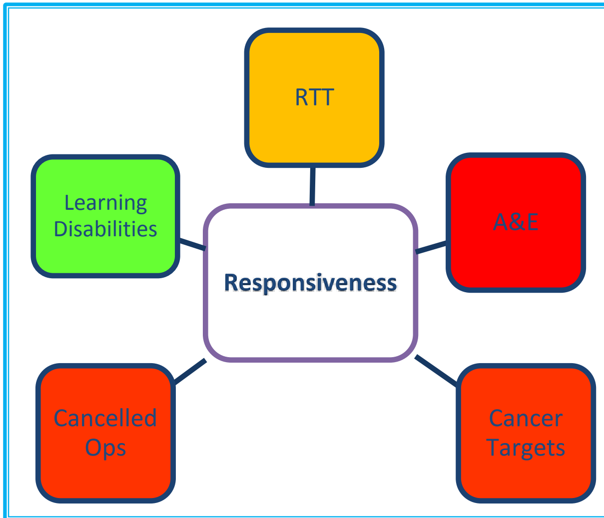
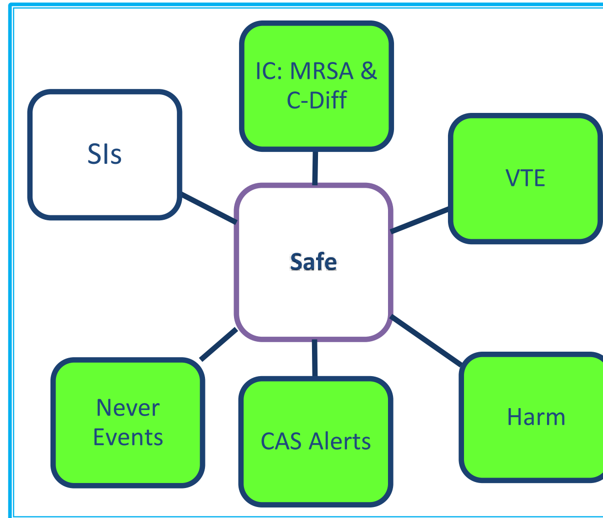
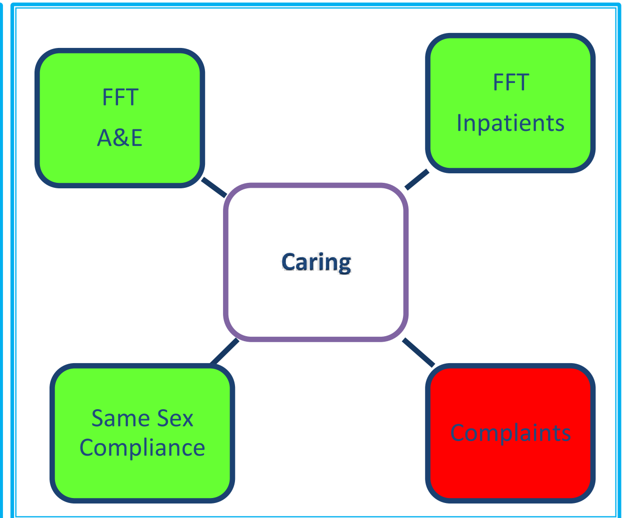
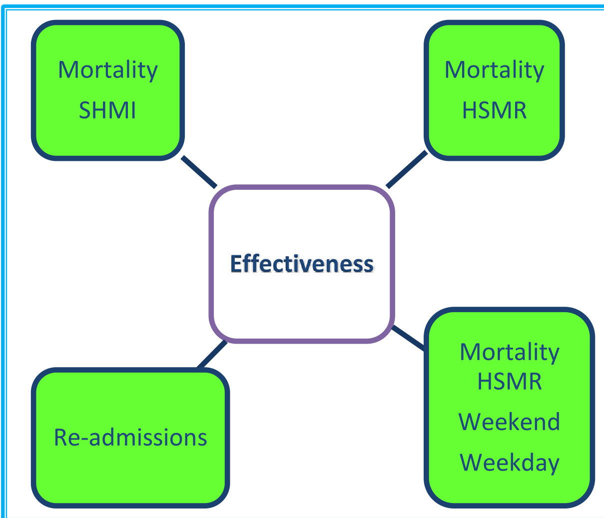
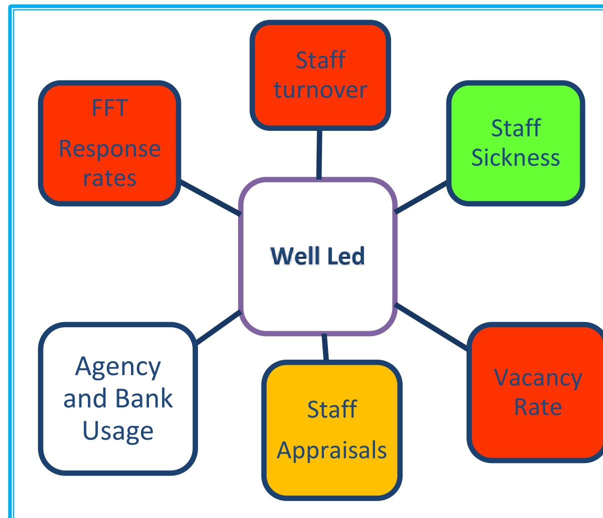
# 1. Executive Summary - Key Priority Areas November 2014




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**

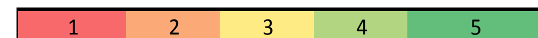
| Metric | Standard | YTD | October | November | Movement |
|---|---|---|---|---|---|
| IP response rate from Friends and Family Test | 30% | | 41.50% | 42.00% | ↑ |
| A&E response rate from Friends and Family Test | 20% | | 13.70% | 14.80% | ↑ |
| NHS Staff Survey: Percentage of staff who would recommend 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/Escalation Score**




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.

# 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 |

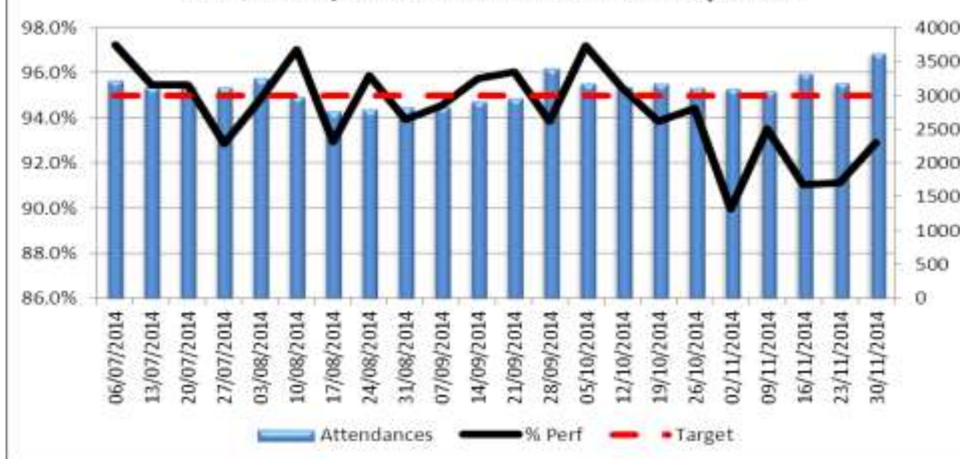
| Peer Performance Q3 at end November 2014 | | | | |
|---|---|---|---|---|
| STG | Croydon | Kingston | King's College | Epsom & St Helier |
| 93.27.% | 93.02% | 95.4% | 89.87% | 95.56% |

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.

**Cancelled Operations for non-clinical reasons Oct-13 to Oct-14**

90 80 70 60 50 40 30 20 10 0

12% 10% 8% 6% 4% 2% 0%

Oct-13 Nov-13 Dec-13 Jan-14 Feb-14 Mar-14 Apr-14 May-14 Jun-14 Jul-14 Aug-14 Sep-14 Oct-14

No. cancelled ops — % not treated within 28 days — Trend

# 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 |

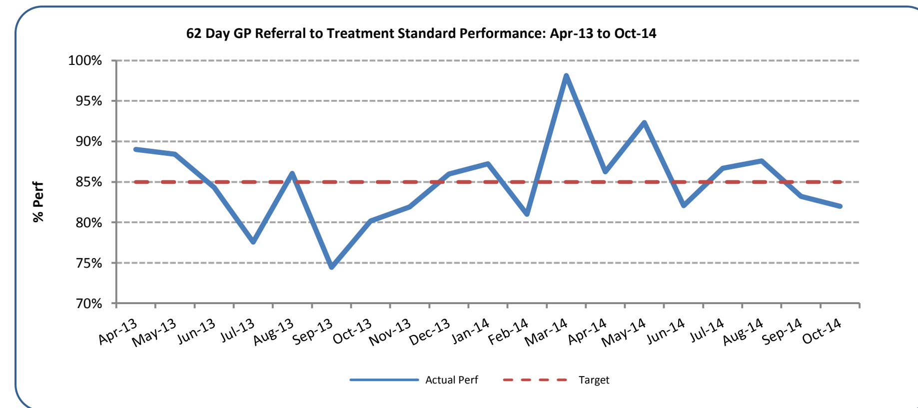
| Peer Performance Latest Published Q2 2014-15 | | | | |
|---|---|---|---|---|
| STG | Croydon | Kingston | King's College | Epsom & St Helier |
| 93.5% | 100% | 95.0% | 98.2% | 100% |

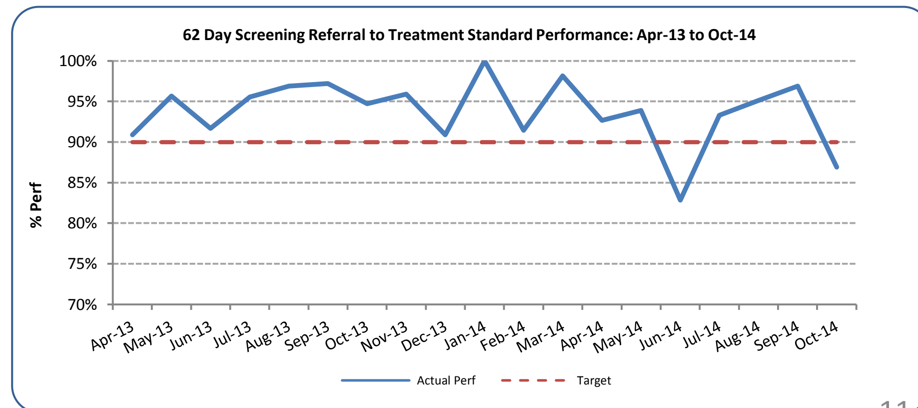
All of the cancer targets were met in Q2 2014. The trust me all the cancer targets in October with the exception of the 62 day targets.

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.



St George's Healthcare NHS Trust

# Corporate Outpatient Services Performance

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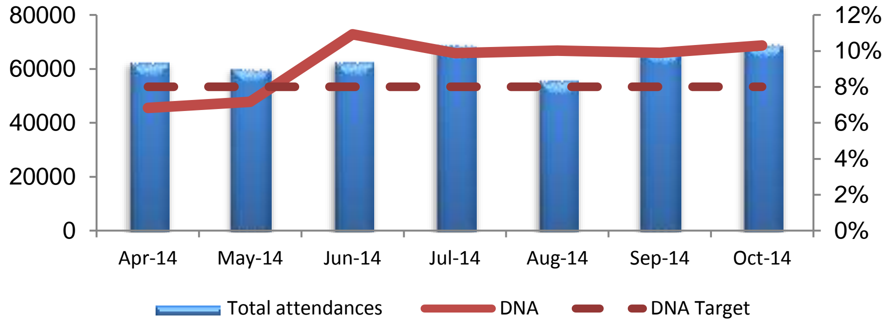
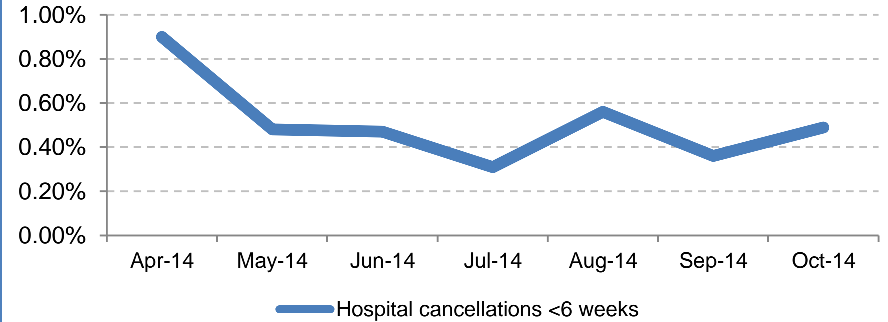
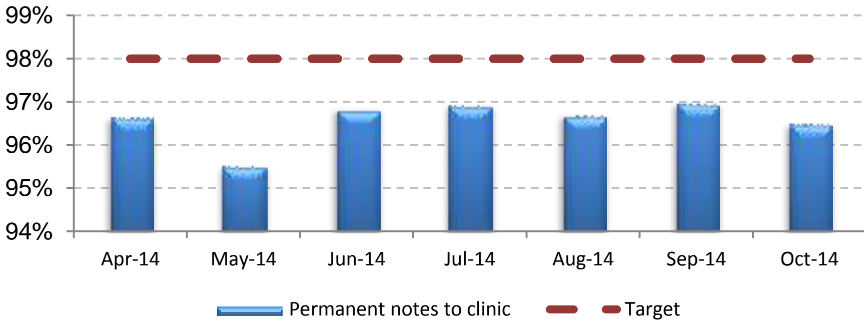
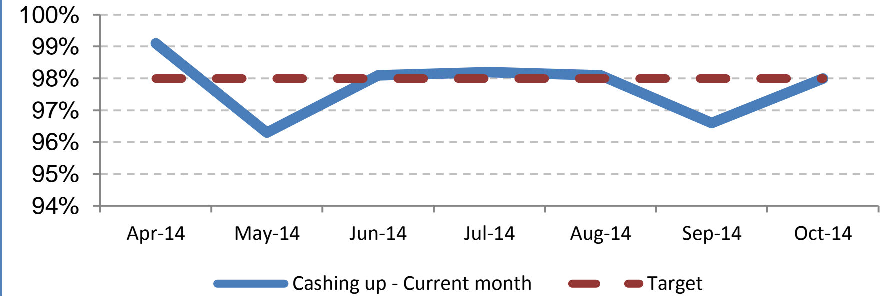
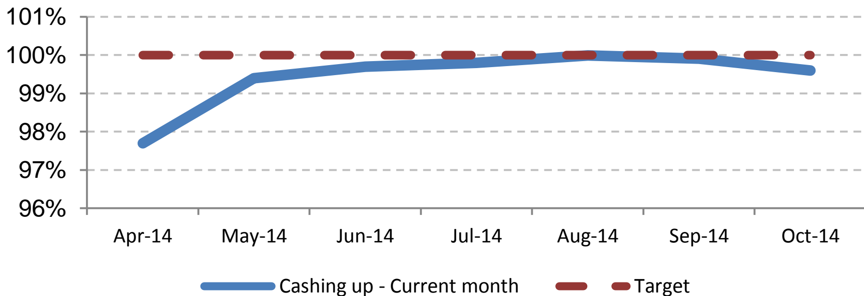
# 4. Corporate Outpatient Services
# - Performance Overview

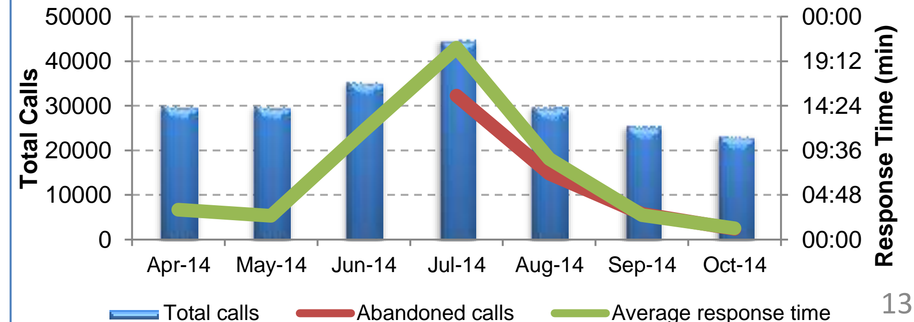


# 4. Corporate Outpatient Services
# - Performance Overview

| | | 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.

# Clinical Audit and Effectiveness

# 5. Clinical Audit and Effectiveness - Mortality

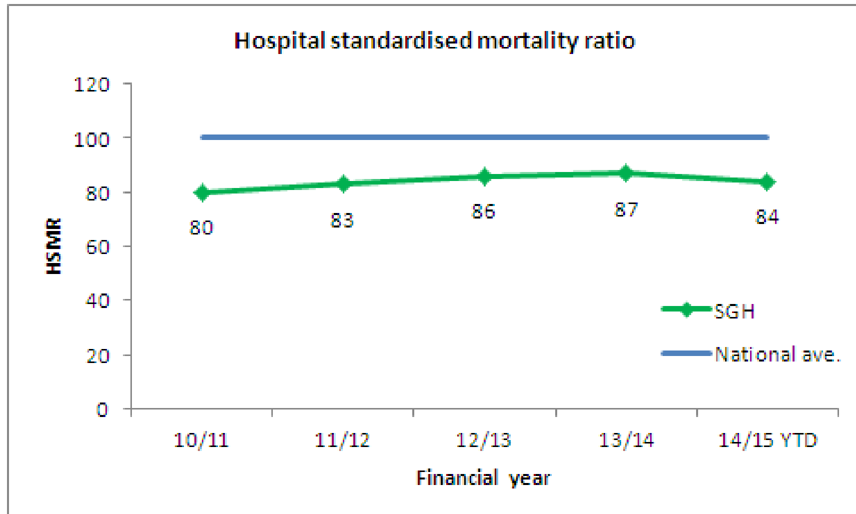
| HSMR (Hospital standardised mortality ratio) | | | | | | |
|---|---|---|---|---|---|---|
| Lead Director | November | December | Movement | 2014/2015 Target | Forecast January 15 | Date expected to meet standard |
| RGW | 76.7 | 84.3 | ↑ | <100 | G | Met |

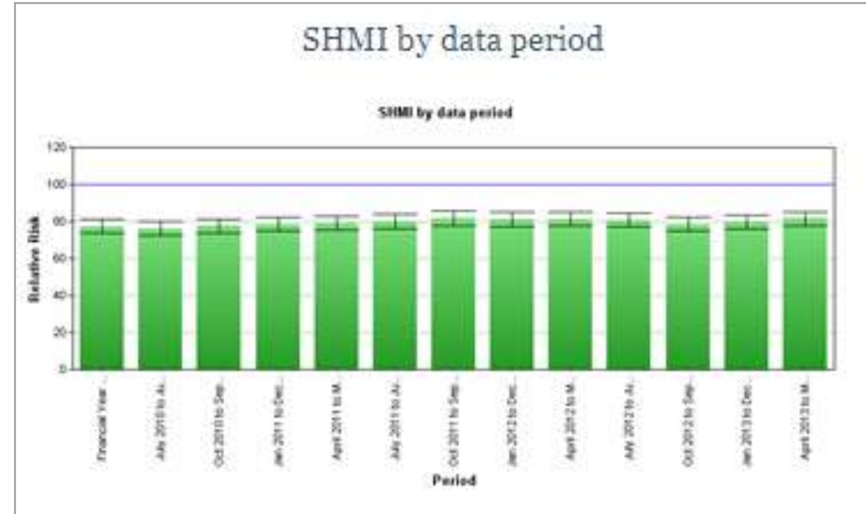
| SHMI (Summary hospital-level mortality indicator) | | | | |
|---|---|---|---|---|
| Oct 2013 | Jan 2014 | April 2014 | July 2014 | Oct 2014 |
| 0.81 | 0.81 | 0.78 | 0.80 | 0.81 |

*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 |

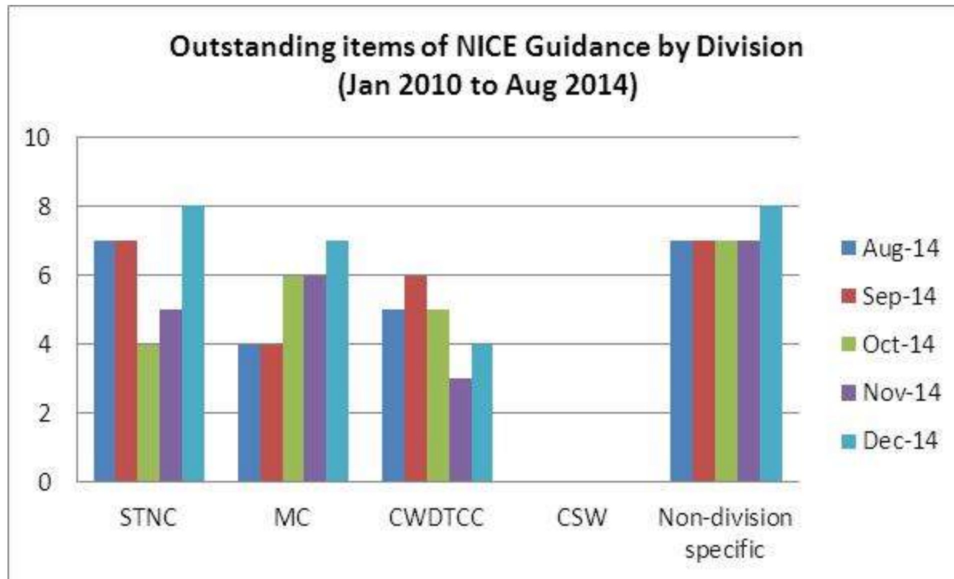
**Overview:**
Case selection for this audit required significant effort from the lead consultant and nurse. Details of 223 patients with EEG were reviewed, leading to casenote review of 50 patients, with audit details submitted for 22 eligible patients. The national audit team excluded patients that 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**

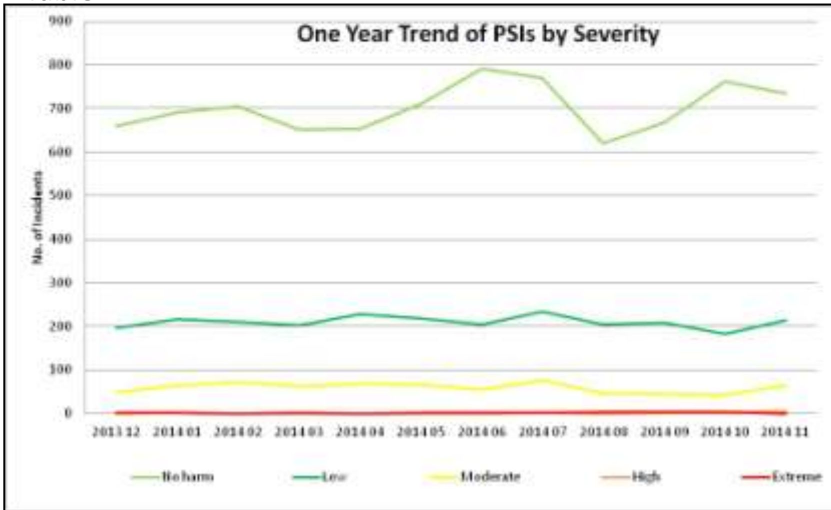
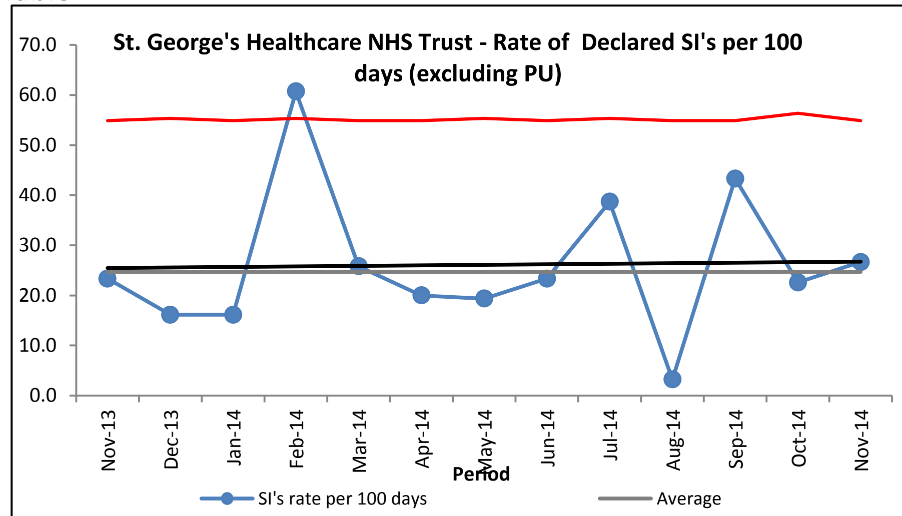



**Table 2**




**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 |

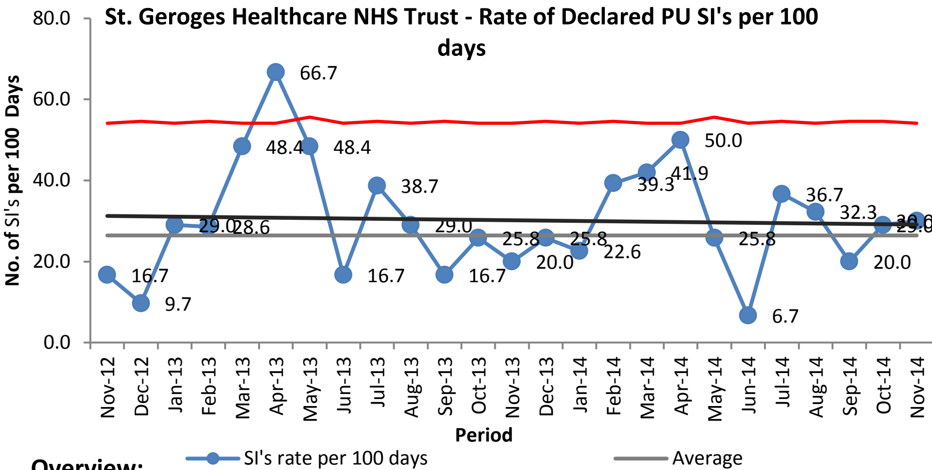
In November 2014 93.75 per cent of our patients received 'harm free' care. This is a decrease from the previous month (94.63%) and below our target of 95 per cent. This represents harm, both old and new, to 90 patients, with 84 patients experiencing 1 harm and 6 with 2 harms.

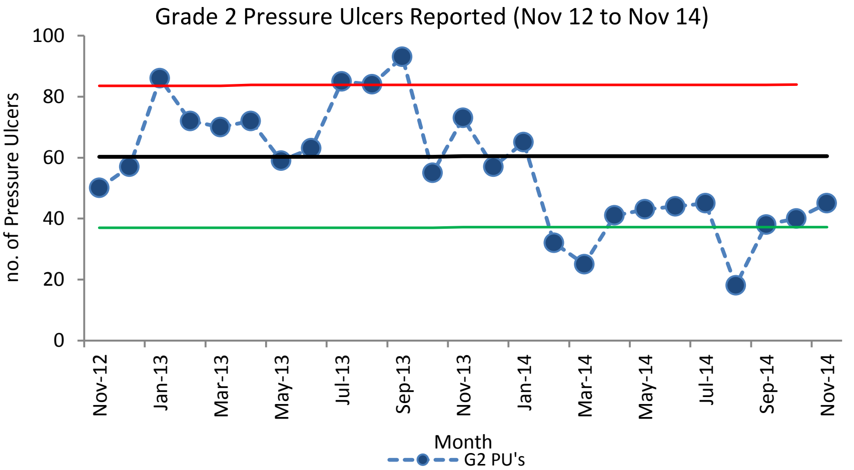
This month the number of new pressure ulcers fell once again to 1.25%, however the number of old pressure ulcers increased to 3.54%. The level of falls remains fairly constant, with a rate of 0.21% this month which represents 3 patients harmed. An increase in the number of new VTEs is observed, and stands 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 |

**Incidents by Incident date (Month and Year) and Severity**

190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
20
10
0

Dec 2013 Jan 2014 Feb 2014 Mar 2014 Apr 2014 May 2014 Jun 2014 Jul 2014 Aug 2014 Sep 2014 Oct 2014 Nov 2014

No harm
Low - Minor treatment/first aid or service disruption
Moderate - Treatment prolonged or service disruption
Extreme - Fatality or permanent service closure
Total

**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 | |

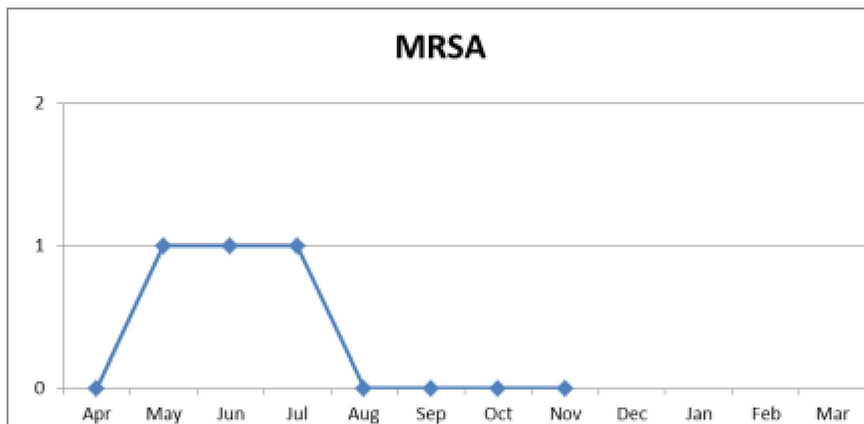
| Peer Performance – YTD October 2014 | | | | |
|---|---|---|---|---|
| STG | Croydon | Kingston | King's College | Epsom & St Helier |
| 3 | 1 | 0 | 2 | 4 |

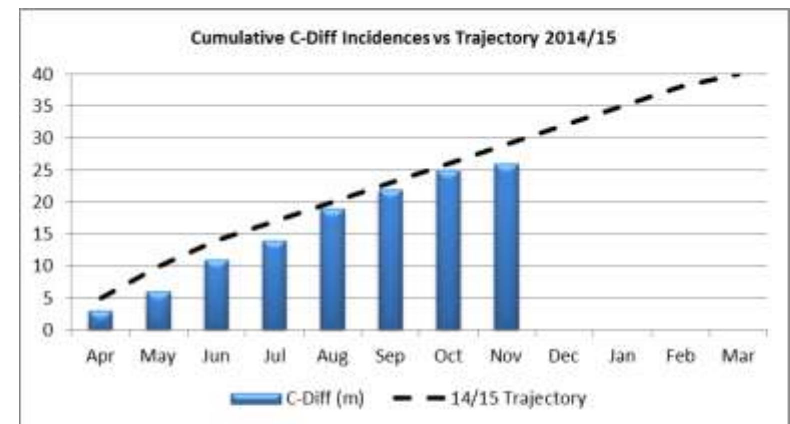
| C-Diff | | | | | | |
|---|---|---|---|---|---|---|
| Lead Director | October | November | Movement | 2014/2015 Target | Forecast Dec - 14 | Date expected to meet standard |
| JH | 3 | 1 | ➤ | 40 | G | - |

| 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.

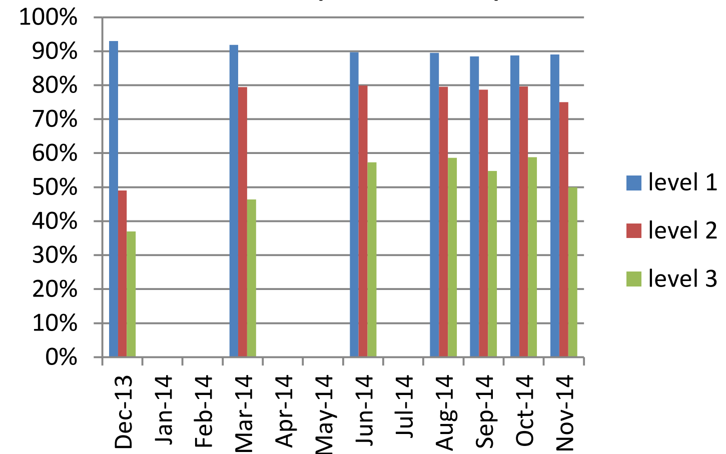
In November there was 1 C. diff incident, a total of 26 for the period April to November. This is against a trajectory of 21 and an annual target of 40. Close monitoring will continue to ensure compliance is maintained.



# 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.

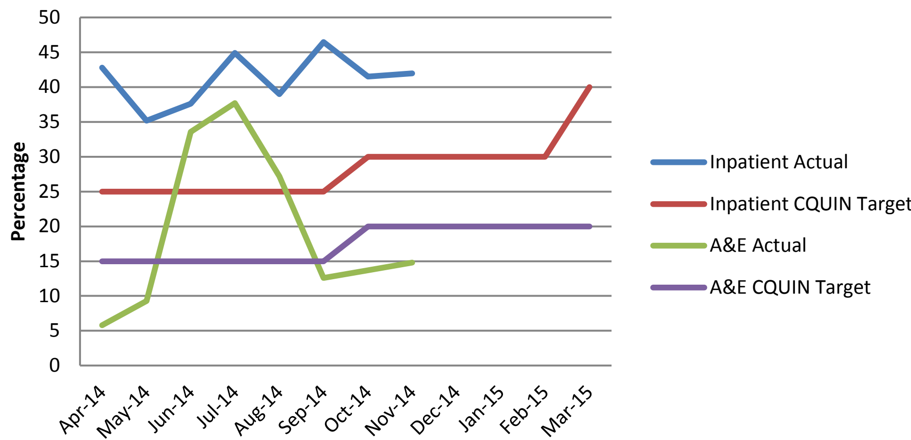
**Other: 1.** ED – consent: there has been an action plan drawn up by the Head of Nursing for the ED to deal with the issues with records and consent that remain problematic in the ED. This will continue to be monitored. **2**. The Chief Nurse is leading a focus group to provide data on FGM required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

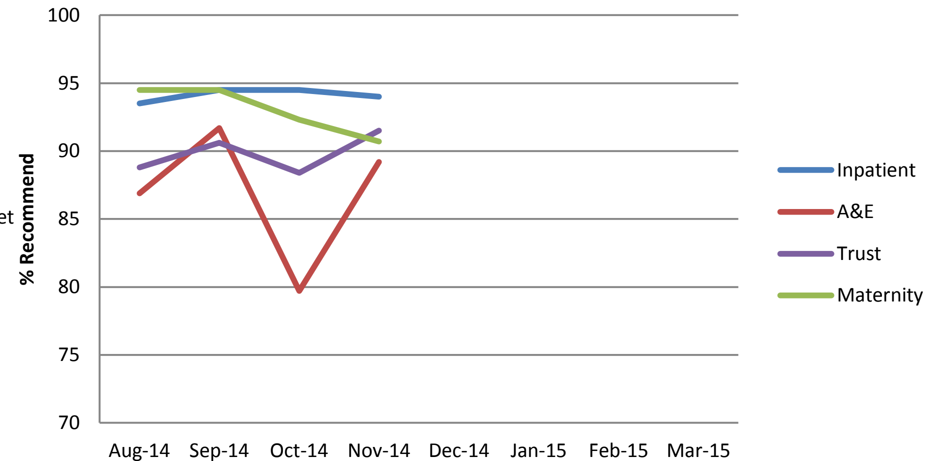
# Patient Experience

# 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 | ⇩ |

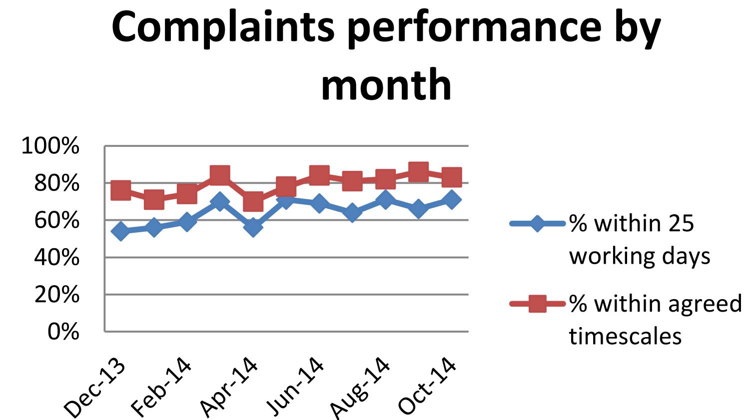
Complaints Received

**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

St George's Healthcare NHS Trust

# Workforce



excellent kind responsible respectful

# 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 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Main 2 Specialties on each ward | | Registered midwives/nurses | | Care Staff | | Registered midwives/nurses | | Care Staff | | | | | |
| Ward name | Specialty 1 | Specialty 2 | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | Average fill rate - registered nurses/midwives (%) | Average fill rate - care staff (%) | Average fill rate - registered nurses/midwives (%) | Average fill rate - care staff (%) |
| 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.

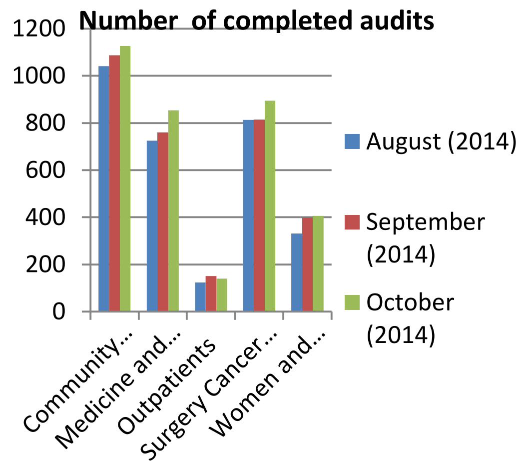
Although some of our wards are operating below 100% the data does not indicate if a ward is unsafe. Safe staffing is much more complex than an observation of percentages and takes in to account many key aspects such as:
Nurses, midwives and care staff work as part of a wider multidisciplinary ward team.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

St George's Healthcare NHS Trust

**REPORT TO THE TRUST BOARD December 2014**

| **Paper Title:** | Safeguarding Report April – September 2014 |
|---|---|
| **Sponsoring Director:** | Jennie Hall, Chief Nurse |
| **Author:** | David Flood, Lead Nurse for Safeguarding Adults |
| **Purpose:** | To review the activity for adult safeguarding across the trust and to provide assurance that this is a significant part of the patient safety agenda. |
| **Action required by the board:** | For information |
| **Document previously considered by:** | Patient Safety Committee Dec 2014 |

**Executive summary**

**1. Key messages**

- Safeguarding vulnerable adults and promoting their welfare is a priority.
- The trust is actively represented in the wider safeguarding arena and is committed to multi-agency working.
- The implementation of the Care Bill is likely to have a significant impact on adult safeguarding practice through a probable widening of thresholds and scope.
- The impact of the Supreme Court judgement relating to Deprivation of Liberty Safeguards (DOLS) has had a significant impact on the number of authorisations under the safeguards that need to be made and will continue to have significant resource implications.
- A new Domestic Abuse practitioner is due to start in January 2015
- Resources are being reviewed as part of business planning in light of the increased activity.

**2. Recommendation**

To note the report for information and to receive this as assurance that focus is given to safeguarding adults at risk

**Key risks identified:**

- To ensure that the Trust continues to meet the compliance standards required by the Care Quality Commission, in particular those related to the Mental Capacity Act and the Deprivation of Liberty Safeguards.
- To ensure that staff access the required level of training.

| **Related Corporate Objective:** | Safeguarding is a fundamental component of the Quality Improvement Strategy. |
|---|---|
| **Related CQC Standard:** | 3. Patients should expect to be safe - patients will be protected from abuse or the risk of abuse and staff will respect their human rights. |

**Equality Impact Assessment (EIA): Has an EIA been carried out? ( Yes / No)**
**If yes, please provide a summary of the key findings**

**If no, please explain you reasons for not undertaking and EIA.**

**Appendix A:**

## 1. EQUALITY IMPACT ASSESSMENT FORM – INITIAL SCREENING

Headline outcomes for the Equality Delivery System (EDS)

- Better heath outcomes for all
- Improved patient access and experience
- Empowered, engaged and well-supported staff
- Inclusive leadership at all levels

| Service/Function/Policy | Directorate / Department | Assessor(s) | New or Existing Service or Policy? | Date of Assessment |
|---|---|---|---|---|
| | | | | 15 Oct 2010 |
| **1.1 Who is responsible for this service / function / policy?** | | | | |
| **1.2 Describe the purpose of the service / function / policy?** *Who is it intended to benefit? What are the intended outcomes?* | | | | |
| **1.3 Are there any associated objectives?** *E.g. National Service Frameworks, National Targets, Legislation , Trust strategic objectives* | | | | |
| **1.4 What factors contribute or detract from achieving intended outcomes?** | | | | |
| **1.5 Does the service / policy / function / have a positive or negative impact in terms of the protected groups under the Equality Act 2010. These are Age, Disability ( physical and mental), Gender-reassignment, Marriage and Civil partnership, Pregnancy and maternity, Sex /Gender, Race (inc nationality and ethnicity), Sexual orientation, Region or belief and Human Rights** | | | | |
| **1.6 If yes, please describe current or planned activities to address the impact.** | | | | |
| **1.7 Is there any scope for new measures which would promote equality?** | | | | |
| **1.8 What are your monitoring arrangements for this policy/ service** | | | | |
| **1.9 Equality Impact Rating [low, medium, high]**<br><br>**2.0. Please give your reasons for this rating** | | | | |

St George's Healthcare NHS
NHS Trust

# Safeguarding Adults
# April 2014 – September 2014

## 1. Introduction

St George's Healthcare NHS Trust has a commitment and responsibility to ensure that all patients receive safe, effective and dignified care. In particular we have a duty under Outcome 7 of Care Quality Commission (CQC) regulations to ensure that those adults most at risk are "protected from abuse and that staff should respect their human rights". In addition the CQC have a duty to monitor the use of the Mental Capacity Act and the Deprivation of Liberty Safeguards and this now forms part of their Key Lines of Enquiry

This report highlights how St George's responds to and reports on allegations of abuse and neglect and how we ensure that safeguarding is integral to everyday practice.

## 2. Safeguarding Structure and Policy

In May 2014 the Care Bill received Royal Assent and the process of implementing the Care Act's various components will follow over the next couple of years. A significant part of the Care Bill relates to safeguarding adults and fresh statutory guidance was published in October this year. Currently this guidance is being examined in more detail at a both national and local level to identify its impact on adult safeguarding procedures.

The guidance states that:

- Safeguarding Adults will for the first time become a statutory local authority responsibility and they will have a statutory duty to establish a local adult safeguarding board (SAB)
- Section 42 lays down a duty for the local authority to make (or cause to make) "enquiries" when they think an adult with care and support needs may be at risk of abuse or neglect and they need to find out what action may be needed
- Under Section 44 there is now a statutory requirement for the SAB to instigate a Safeguarding Adults Review, if certain conditions are met – 1) the adult dies and the SAB suspect the death resulted from abuse or neglect or 2) the adult is still alive and the SAB suspects serious abuse or neglect.
- The SAB has additional powers under section 45 whereby there will be a new statutory duty to provide information to the SAB.
- There will be a duty to provide advocacy.

St George's utilises the Pan-London Adult Safeguarding Procedures which were introduced in 2011 in an attempt to provide a consistent approach and response from all agencies involved in adult safeguarding across London. These procedures will be reviewed in early 2015 when it is likely that a number of aspects of the guidance that remain open to interpretation will be addressed.

It is likely that the scope of adult safeguarding will broaden as the duty to enquire includes areas such as self neglect and the threshold no longer depends on either an eligible care need being identified or on whether significant harm has occurred. There will therefore likely be implications on resources both within health and social services

The Lead Nurse for Adult Safeguarding reports directly to the Deputy Chief Nurse and provides quarterly reports to the Adult Safeguarding Monitoring Committee. In addition a six monthly

report is presented to the Patient Safety Committee and the trust board. Each of the divisions are provided with summary briefings as part of their governance reporting structure on a quarterly basis.

### 3. Safeguarding Alerts April 2014-Sep 2014

There have been a total of 424 referrals to the Safeguarding Lead Nurse over the last 12 months. This compares to a total of 397 reported in the previous 6 months. A number of referrals are made that do not constitute or necessitate a full safeguarding investigation but involve a degree of information gathering and screening. This is in line with both Department of Health and Pan-London governance guidelines.

**Breakdown of referrals**

| | |
|---|---|
| **Neglect** | 89 |
| **Physical abuse** | 44 |
| **Emotional abuse** | 16 |
| **Discriminatory abuse** | 1 |
| **Sexual abuse** | 7 |
| **Institutional abuse** | 0 |
| **Financial abuse** | 29 |
| **Mental Capacity Act/Deprivation of Liberty advice** | 63 |
| **Domestic Violence** | 13 |
| **Discharge advice/concerns** | 63 |
| **Self neglect** | 9 |
| **Pressure Ulcer screening** | 86 |
| **Other (including serious case reviews)** | 4 |

### 3.1 Summary of incidents relating to St George's Healthcare

Three allegations related to concerns about the behaviour of family members/carers towards inpatient's at St George's. In all cases protection plans were put in place to ensure the patients safety and social services were notified of the details of the incidents.

35 alerts relating to care and treatment delivered by St Georges staff were formally referred and investigated (where necessary) by Wandsworth Social Services:

- 30 cases were closed following further information gathering and were deemed to be unsubstantiated.
- 3 cases related to the development of pressure ulcers within St Georges and were investigated via the Serious Incident procedures. All 3 were closed after investigation found the pressure ulcers unavoidable and therefore found to be unsubstantiated.
- 1 case was found to be substantiated. This case involved a complaint from a care manager of a local supported accommodation for people with learning disabilities. Sadly this client had a number of admissions to St Georges following treatment for a fractured arm resulting from a fall at home. On one of the admissions the client was discharged without appropriate assessments and discharge plans being in place which resulted in

an immediate readmission. It was judged that this caused a degree of unnecessary distress and discomfort to the client. The case has been discussed at the appropriate governance forum and the safeguarding lead and clinical nurse specialist for learning disability will share and disseminate at the next Trust safeguarding meeting to ensure learning across the divisions involved in this client's care.
- 1 case remains open and is currently being investigated.

### 3.2 Themes

- Advice is often sought on complex matters some of which are often not of a safeguarding nature. Frequently these cases have a mixed picture involving complex family dynamics, questions over mental capacity/mental health, identification of a decision maker, difficult ethical/professional judgements, safety and/or safeguarding concerns, discharge destination, funding and roles and responsibilities. It is often a case of unpicking each situation as, although some have similar themes, each case has its own unique features. Once unpicked any safeguarding matters relating to neglect or abuse can then be addressed.
- The scope of adult safeguarding continue to broaden and despite the Pan-London procedures being well utilised, there remains the inconsistencies in practice and application between different boroughs and agencies.

**Patient Story**

A 65 year old gentleman with learning disabilities, Mr CD, was admitted from a nursing home after being found by carers on floor. It was initially assumed to have fallen out of bed but the ambulance crew and subsequently the hospital team felt the injuries were consistent with fall and were suspicions of a non-accidental injury. Police and social services were informed and a subsequent joint investigation was commenced. Mr CD spent some time in St Georges where a protection plan was instigated with regard to visitors and contact. A strategy meeting was held with family present where is was agreed that Mr CD would not be returning to the nursing home pending completion of the investigation and a period of rehabilitation. The learning disability nurses and the safeguarding nurses worked closely with Mr CD's family and with local agencies to ensure necessary information was shared safely and Mr CD was supported with his decision making. The investigation led by the police and social services is ongoing

## 4. Partnership Working

The Lead Nurse for Adult Safeguarding is a member of both Wandsworth and Merton Safeguarding Partnership Boards. Wandsworth Borough Council is the trust's 'host' borough and there is a close and effective working relationship between the various leads within health and social care. The Deputy Chief Nurse and the Trust Safeguarding Lead attend the quarterly Partnership Board meetings. The Trust Safeguarding Lead attends the Wandsworth Sub-Groups, one of which he chairs. There are also strong working relationships with our local Clinical Commissioning Groups(CCG) around adult safeguarding and commissioning.

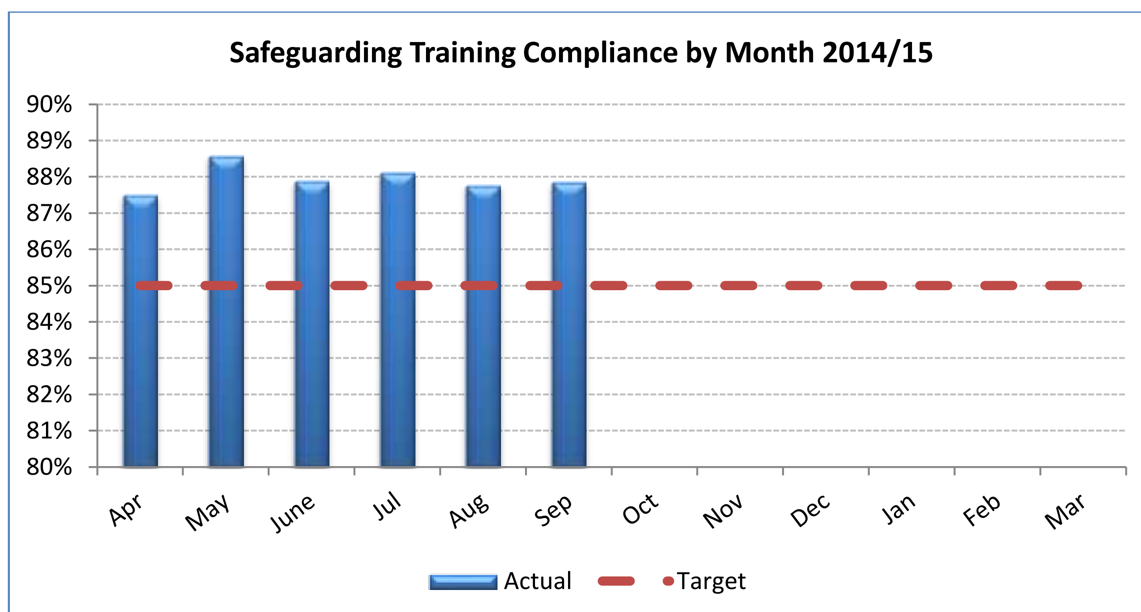
At a local level, the Lead Nurse for Adult Safeguarding attends strategy meetings and case conferences coordinated by local authorities following disclosures of abuse. In addition, members of the ward or community teams who may be caring for the patient at the time attend and provide information (such as medical evidence) to assist in the investigatory process.

## 5. Training

Adult safeguarding basic awareness is part of the e-MAST mandatory training of which all staff complete. Until recently there has been no clear indication as to what the expected levels of training should be delivered to different staff groups (as occurs in children's safeguarding). In September 2014, Skills for Health produced a revised Core Skills Training Framework which proposes two levels of training – Level 1 (basic awareness) for all staff and Level 2 for staff with professional and organisational responsibility for safeguarding adults who need to act on concerns and who need to work within an multi-agency context. St Georges will need to revise its training in line with the guidance, the revised Pan London procedures (due April 2015) and the implications of the new Care Bill.

### 5.1 Training figures

Training figures as a total and for each division are now collated each month and are presented to the Trust Board as part of the Quality Report. As of end of September the training figures were:




## 6. Mental Capacity Act

The Mental Capacity Act (2005) was implemented with a view that adults should always be supported to make their own decisions and that in situations where an adult is deemed to lack capacity then decision makers, such as health and social care practitioners, make a decision in the person's best interest at that time. Following its February 2014 visit the CQC found that at Queen Mary's Roehampton "staff were not sufficiently aware of the Mental Capacity Act 2005" and that this "was impacting on the care delivered to patients." Action has been taken to address this issue at Queen Mary's Roehampton through a rigorous training programme. After a training needs analysis a serious of training sessions were delivered and the total Number of staff trained as 283 of which 192 attended level 1and 88 level 2. The overall attendance is 99% with only three staff not having attended due to long term absence.

There is a clear duty under the Mental Capacity Act (2005) that patients who lack capacity cannot be deprived of their liberty to be treated without appropriate safeguards being in place. The hospital as a 'managing authority' has a responsibility to ensure that all those patients who could potentially meet the criteria of deprivation are referred to the 'supervisory authority' (the

appropriate local authority) for independent assessments. There is a requirement that any assessment or authorisation has to be reported to the Care Quality Commission.

## 7. Deprivation of Liberty Safeguards (DOLS)

The Supreme Court heard two Court of Appeal cases in autumn 2013 and the judgements were made public in March 2014. These judgements resulted in a new "acid test" as to whether someone is subject to a deprivation of liberty and whether the safeguards should be applied. Previous questions over "purpose", "reason", "normality" are no longer relevant. This "acid test" is: *"Is the person subject to continuous supervision and control? And Is the person not free to leave?"*

If the answer to both these questions is yes, then some form of legal safeguard must be in place. In acute hospitals this would normally need to be either a DOLS (assuming lack of capacity) or an application of the Mental Health Act. In some situations where a person is ineligible for both DOLS and the MHA then a direct application to the Court of Protection may be necessary.

At present there has been no further guidance on what "continuous supervision and control" means in practice and the Department of Health(DH) advice has been to contact local DOLS leads and seek legal advice.

The general advice from legal teams and local DOLS leads is that the meaning and scope of DOL has been significantly widened which may have significant implications for acute hospitals.

In 2013/14 there were a total of 4 urgent DOLS authorisations. Since April 2014 there has seen a significant rise to a total of 24 authorisations up to the end of September 2014. However these authorisations are based on a risk based approach where patients within high risk groups with the most significant restrictions in place are indentified and urgent authorisations are made. It is acknowledged that a number of cases would ideally be authorised but this risk based approach is in line with other similar organisations and the national picture.

A briefing report was taken to the Executive Management (EMT) team on 10 November 2014 proposing a number of suggestions to manage DOLs in the absence of DH guidance. EMT authorised the use of a risk based, pragmatic approach where those patients in the high risk groups (1:1 nursing or patient/their families objecting to staying in hospital and when stay in hospital is likely to prolonged) are identified and urgent authorisations are made.

As part of 2015/16 business planning funding is being sought for a sole MCA/DOL practitioner at Band 7 who would lead on MCA/DOLS across the whole organisation including training, audit, and expert advice. The risk of legal challenge would be minimised and CQC action around MCA would likely be met in a timely manner.

## 8. CQC Registration and Assurance

Requirements to have robust policies practice and procedures in place are part of CQC registration. The report produced by CQC, following their visit in February2014, indicated that St George's was compliant with Outcome 7 – "People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening."

The Department of Health has produced a new safeguarding adult's audit tool which assists in ensuring organisations can provide evidence of effective outcomes regarding adult

safeguarding. This was completed in June 2014 and presented to both Wandsworth and Merton safeguarding boards and the respective CCG's. Action from this self assessment reflects the action being taken forward with respect to the Mental Capacity Act that was identified following the CQC inspection earlier this year

## 9. Domestic Abuse

Wandsworth CCG has funding a Clinical Nurse Specialist post and the trust has successfully recruited an experienced Health Visitor into the role. The post holder will start on 12 January 2015 and will work with the Lead Nurse for Adult Safeguarding to develop this role.

## 10. Conclusion

The past six months have seen a further increase in safeguarding activity as outlined above. Under the supervision of the Chief Nurse a review of the adult safeguarding resource will be carried out so that any resource requirements can be taken forward as part of the 2015/16 business planning.

Where allegations or evidence of abuse comes to light whilst patients or clients are under the care of the trust, staff need to feel confident and able to ensure they respond effectively. Most importantly patients should feel safe and their care and treatment should reflect the trust values. The implementation of the Care Bill may have a significant impact on how adult safeguarding concerns are addressed. The widening of its scope and the revised Pan London procedures may present the Trust with challenges on how to resource the growing demands for training and assurance. .....

The board is asked to note this report and continue to support the adult safeguarding agenda.

David Flood
Lead Nurse for Adult Safeguarding
December 2014

St George's Healthcare NHS
NHS Trust

**REPORT TO THE TRUST BOARD** *December 2014*

| **Paper Title:** | Workforce report |
|---|---|
| **Sponsoring Director:** | Wendy Brewer, Director of Workforce and Organisational Development |
| **Author:** | Stella Pantelides, Non-Executive Director, Chair of Workforce and Education Committee |
| **Purpose:** | *To provide a report to the board from the workforce and education committee* |
| **Action required by the board:** | For information |
| **Document previously considered by:** | Workforce and education committee |

**Executive summary**
*Key points in the report and recommendation to the board*

**1. Key messages**

The report provides the board with a summary of the discussion that took place at the workforce and education committee on 4th December 2014.

Subjects covered included:

- The workforce strategy and staff survey action plan
- Education
- Recruitment
- Workforce efficiency.

**Key risks identified:**
*Key workforce risks include:*

- Failure to reduce the unacceptable levels of bullying and harassment reported by staff in the annual staff survey.
- Possible reductions in the overall number of junior doctors available with a possible impact on particular speciality areas.
- Failure to maintain required levels of attendance at core mandatory and statutory training (MAST)

A new risk has been added to the board assurance framework:

- Failure to recruit and retain sufficient staff in relation to annual turnover rates and to safely support future increases in capacity'

| **Related Corporate Objective:**<br>*Reference to corporate objective that this paper refers to.* | **To develop a highly skilled and engaged workforce championing our values that is able to deliver the trust's vision.** |
|---|---|
| **Related CQC Standard:**<br>*Reference to CQC standard that this paper refers to.* | **Are services well led?** |

**Meeting of Workforce and Education Committee of 4 December 2014- Chair's Report**

**Workforce action plan**

Members reviewed progress against the work plan and welcomed the progress that was achieved in the last two quarters, especially in the areas of tackling poor behaviours, reinforcing the values and also in the education arena. It was acknowledged that the areas of most challenge are around resource planning, recruitment/retention and extracting efficiencies from the workforce. A great deal of activity is being undertaken across all areas of the plan, as evidenced by the Q1 and Q2 actions which are expected gradually to begin to be reflected in improved workforce KPIs.

It was agreed that the presentation and content of the work plan had improved significantly over the last six months. Further alignment of objectives to actions would, however, be welcome. It was agreed that this will be undertaken as part of a rethink of the balance between the plan's various components, especially given recent shifts in the labour market that have made workforce planning and resourcing such a critical issue.

**Education**

As the meeting had a focus on Education a number of individuals with educational portfolios attended the meeting to update us on progress with various initiatives and programmes.

MAST

Wendy provided the Committee with an update on those core skills that require face to face learning (safeguarding, resuscitation, manual handling) and whose MAST compliance rates have been relatively low. As this was the subject of a fuller paper and presentation to the Trust Board in November no further details are provided here.

Broadening the Foundation Programme

Sarah Hammond explained that her portfolio included three different aspects: safe medical staffing, alternative workforce and junior doctors. Her focus for the meeting was the progress made in reconfiguring the entire foundation programme to ensure a greater breadth of experience and exposure to community specialties in the foundation programme. As a result, the Joint Education Board had endorsed 3 new community based posts (psychiatry, dermatology) as well as the (consequent) loss of a number of posts in surgery and medicine where performance on a number of measures had been poor.

The Committee welcomed the progress with the broadening of the foundation programme. This was entirely consistent with the trust's strategy and compliant with HEE's recommendation that 100% of all foundation doctors rotate into a 4 month community post by 2017. The Committee also discussed the implications for 'poor performing' areas that will be losing posts. Sarah explained how these areas are being supported to replace these posts with more suitable types of staff (e.g. PAs). The Committee was also assured that Consultants in receipt of consistently poor feedback have this issue raised in their appraisal.

Acclimatisation Pilot/Inter-professional simulation programmes

Members of staff who have been developing these programmes 'show cased' the benefits of both. The acclimatisation programme is intended to support the integration and to improve the retention of staff who join from overseas while the various inter-professional simulation programmes enhance the efficiency and effectiveness of multi-disciplinary teams with a view to improving safety and

strengthening professional relationships and mutual respect between different staff groups . The trust is a leader in this type of training.

Successful HESL bids

The Committee congratulated all those who were involved in securing funding from HESL ( over £400K) for a number of programmes that are in critical areas of staff development (genomics, women's services, developing nurses with dual skills in acute and mental health nursing).

SIFT Funding

Cleave Gass shared with the Committee the disappointing cut of SIFT funding (by £3m) in this year and advised of the national cap on medical students which, for St Gerorge's means a reduction in the number of medical students from 300 to 260. The reduction for St George's is said to be no worse than that for other London teaching hospitals. The funding appears to be deliberately shifting away from London.

GMC Trainee Survey feedback

Cleave shared with the Committee the disappointing feedback from the GMC survey regarding three specialties that were red outliers for bullying and harassment. Efforts are being made to triangulate the very limited information that is available from the GMC with what is known about behaviours in these areas.

**Recruitment**

The paper presented to the Trust Board on 27 November regarding Nursing and Midwifery Workforce Recruitment was discussed in some detail. All divisional representatives confirmed that this was the issue highest on their workforce risk register.

The adoption of a programme management approach with well-defined workstreams (Marketing and Communications, Forward Planning, Substantive Recruitment, Retention and Temporary Staffing) was welcomed as it provided a disciplined approach to monitoring progress and ensuring that there is coherence between the various strands of work.

The size of the task ahead (recruitment of 900 nurses in 12 months) was however such that questions were raised as to whether doing more of the same but in a more co-ordinated way would be enough. A proposal was tabled (to be developed further following consultation with Jennie Hall - the Programme Owner) that we should be looking for a **step change** especially in the area of attraction and marketing. Kate Leach suggested that members of the Committee could take part in workshops (as part of the Marketing and Coms workstream) which could help define a distinctive 'employment offer' that could set St George's apart from the competition. The suggestion was enthusiastically received.

In parallel to any contribution to specific work streams, it was reiterated that the Workforce and Education Committee's primary role was one of governance, i.e. overseeing, on behalf of the trust board, the entire programme and assessing month-by-month progress against the planned numbers.

**Workforce Efficiency**

Two updates were provided, the first on existing workforce schemes and the second on downside mitigations.

Existing schemes

The update provided valuable qualitative insights into the degree of maturity of the workforce schemes and the extent to which these have been drawn down by divisions. The quantitative analysis was, however, not entirely clear and the team was asked to revise and present more clearly:

- initial savings targets for each scheme for 14/15;
- any subsequent revisions to those targets; and
- actual drawdowns to date.

From work conducted as a follow up to the meeting, it would appear that the savings opportunity was gradually reduced from £4.6m at the beginning of 14/15 to £1.2m by Q4.

The key insight from the qualitative analysis was this: Despite the fact that the Workforce Schemes are arguably very well developed, draw down has been disappointing essentially because of the reluctance to upset staff and challenge deeply rooted (and potentially inefficient) working practices, at a time when there is so much pressure on staff.

Examples include:

- The Medical Secretary review has been closed with £0 benefit realised in 14/15;
- The Electronic Rostering project is due to close in May 15 with £0 draw downs year- to-date;
- The Job Planning project had a relatively modest aspiration of saving 1 PA per Care Group in 14/15. Yet only 6 Care Groups have accomplished that with only a trivial contribution to the overall savings target.

Of the initial £4.6m savings target across all workforce schemes for 14/15, it would appear that only £0.76m had been drawn down year to date. This is just over 2/3 of even the latest revised target of £1.2m. These savings are primarily down to improvements in processes that the HR team is largely in control of (Time to Recruit and Bank Development Projects).

As an even more ambitious savings target is planned for 15/16 (£5.8 m) some thought needs to be given as to how divisions are supported and challenged to tackle some of the behaviours that potentially prevent the unlocking of efficiencies.

Downside Mitigations

A paper was tabled that had been considered by EMT setting out the assessed risk of all the workforce related (extreme) downside mitigations that had formed part of various board discussions and Monitor submissions. The Committee was told that EMT's steer was to continue the dialogue with other HR directors at national or a pan- London basis. No further work is planned on developing these schemes on our own.

SP 4.12.14

St George's Healthcare NHS
NHS Trust

**REPORT TO TRUST BOARD** *December 2014*

| **Paper Title:** | Risk and Compliance report for Board incorporating:<br>1. Board Assurance Framework<br>2. External assurances including the CQC Intelligent Monitoring Report |
|---|---|
| **Sponsoring Director:** | Peter Jenkinson, Director of Corporate Affairs |
| **Author:** | Sal Maughan, Head of Risk Management |
| **Purpose:** | To update the Board about compliance activity/risks and related developments occurring across the Trust and provide assurance about the management of risk. |
| **Action required by the committee:** | To note the report |
| **Document previously considered by:** | Quality and Risk Committee (QRC) |

**Executive summary**

**Key Messages**

Board Assurance Framework (BAF):

- The most significant risks on the BAF are detailed.
- Four new risks have been included which supersede one extreme risk (now closed) regarding capacity: these four new risks identifying each separate aspect of the organisational risk of insufficient capacity.

External Assurances including the CQC Intelligent Monitoring Report:

- External assurances received during the period are detailed within the report, with no significant issues identified
- The Care Quality Commission Intelligent Monitoring report, published on 4th December is included and assurance regarding the newly identified risks included in the report.

**Risks**

The most significant risks on the Board Assurance Framework are detailed within the report.

| **Related Corporate Objective:**<br>*Reference to corporate objective that this paper refers to.* | All |
|---|---|
| **Related CQC Standard:**<br>*Reference to CQC standard that this paper refers to.* | All 16 core Essential Standards of Quality and Safety |

**Equality Impact Assessment (EIA): Has an EIA been carried out? Yes**
**If yes, please provide a summary of the key findings**

St George's Healthcare NHS
NHS Trust

## 1. Risks - Board Assurance Framework (BAF):

This report identifies the extreme risks on the BAF with the details of the most significant risks provided in Table 1. An executive overview of the BAF is included at Appendix 1. The rating is prior to controls being applied to the risk. Risks are reduced once there is evidence that controls are effective.

**Table one: highest rated risks**

| Ref | Description | C | L | Rating ↓↑ |
|---|---|---|---|---|
| 3.2-05 | The Trust does not deliver its cost reduction programme objectives | 5 | 5 | 25 → |
| 01-12 | Bed capacity may not be sufficient for the Trust to meet demands from activity, negatively affecting quality, throughout the year. | 5 | 4 | 20 new |
| 01-13 | Theatre capacity may not be sufficient for the Trust to meet demands from activity, negatively affecting quality, throughout the year. | 5 | 4 | 20 new |
| 01-14 | Staffing to support capacity may not be sufficient for the Trust to open the increased bed, critical care and theatre capacity and to meet demands from activity, negatively affecting quality, throughout the year. | 5 | 4 | 20 new |
| 01-15 | Critical care capacity may not be sufficient for the Trust to meet demands from activity, negatively affecting quality, throughout the year. | 5 | 4 | 20 new |
| 01-07 | Risk to patient safety and experience as a result of potential Trist failure to meet 95% Emergency Access Standard | 4 | 4 | 16 → |
| A513 | Failure to achieve the National HCAI targets | 4 | 4 | 16 → |
| 02-02 | Risk of diminished quality of patient care as a result of Cost Improvement Programmes (CIPs) | 4 | 4 | 16 → |
| A410-02 | Failure to sustain the Trust response rate to complaints | 4 | 4 | 16 → |
| 3.3-05 | The Trust faces higher than expected costs | 4 | 4 | 16 → |
| 03-01 | Ability to demonstrate compliance with Regulatory Reform (Fire Safety) Order 2005 | 4 | 4 | 16 → |
| 03-02 | Failure to demonstrate full Estates compliance | 4 | 4 | 16 → |
| 03-03 | Ability to deliver capital programme and maintenance activity within required timeframes | 4 | 4 | 16 → |
| 01-08 | Risk to patient safety due to inconsistent processes and procedures for the follow up of diagnostic test results | 4 | 4 | 16 → |
| 3.7-06 | Failure to meet the minimum requirements of the NTDA Accountability Framework: Quality Indicators/Access Metrics. | 4 | 4 | 16 → |

### 1.1 New risks proposed for inclusion

There have been no newly identified risks on the BAF during the reporting period; however one extreme risk has now been separated into four risks to more accurately capture the nature of each aspect of this overarching risk. The controls are included at Appendix 2.

**Table two: new risks**

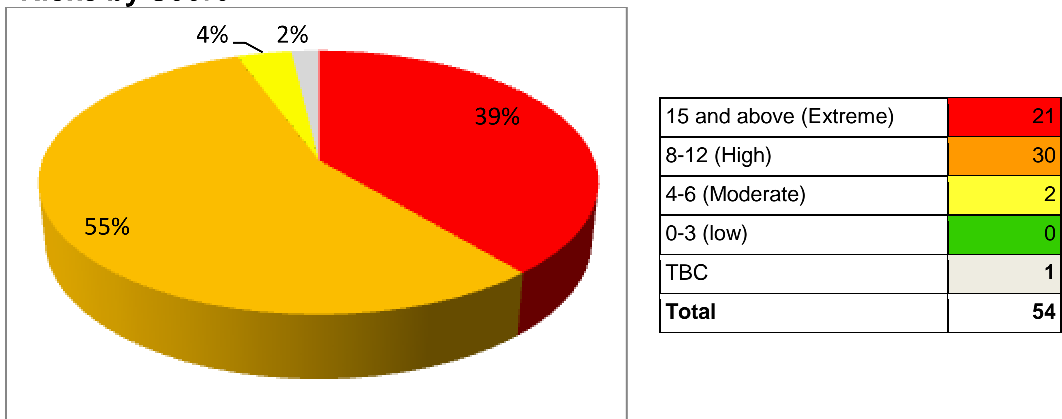
| Ref | Description | Source | C | L | Rating | Exec |
|---|---|---|---|---|---|---|
| 01-12 | **Bed capacity** may not be sufficient for the Trust to meet demands from activity, negatively affecting quality, throughout the year. | Previous capacity risk reviewed and aspects of risk separated to better reflect risks and | 5 | 4 | 20 | MW |
| 01-13 | **Theatre capacity** may not be sufficient for the Trust to meet demands from activity, negatively affecting quality, throughout the year. | | 5 | 4 | 20 | MW |
| 01-14 | **Staffing to support** capacity may not be sufficient for the Trust to open the increased bed, critical care and | | 5 | 4 | 20 | MW |

| | theatre capacity and to meet demands from activity, negatively affecting quality, throughout the year. | controls | | | | |
|---|---|---|---|---|---|---|
| 01-15 | **Critical care** capacity may not be sufficient for the Trust to meet demands from activity, negatively affecting quality, throughout the year. | | **5** | **4** | **20** | **MW** |

### 1.1 Summary of risks by score and domain

Figures one and two demonstrate there are 21 extreme risks on the BAF (a score of 15 or above) which equates to 39% of the total risks. Of these, 17 sit within the domains of Quality and Regulation and Compliance. Of the total risks on the BAF 35% relate to the Finance and Operations and 35% to Quality.

**Fig 1: BAF Risks by Score**




| 15 and above (Extreme) | 21 |
|---|---|
| 8-12 (High) | 30 |
| 4-6 (Moderate) | 2 |
| 0-3 (low) | 0 |
| TBC | 1 |
| **Total** | **54** |

**Fig 2: BAF Risks by Domain**

| | | | | | | Total |
|---|---|---|---|---|---|---|
| 1. Quality | 10 | 8 | 0 | 0 | 1 | 19 |
| 2. Finance & Operations | 4 | 15 | 0 | 0 | 0 | 19 |
| 3. Regulation & Compliance | 7 | 1 | 1 | 0 | 0 | 9 |
| 4. Strategy Transformation & Development | 0 | 3 | 0 | 0 | 0 | 3 |
| 5. Workforce | 0 | 3 | 1 | 0 | 0 | 4 |
| **Total** | **21** | **30** | **2** | **0** | **1** | **54** |

### 1.2 Changes to risk scores

There have been no changes to risk scores during the reporting period.

### 1.3 Closed risks

There have been two risks closed during the reporting period, due to these having been superseded by four new risks:

**Table three: closed risks**

| Ref | Description | Rating | Rationale |
|---|---|---|---|
| A602.1-O1 | Pressures on internal capacity may result in the Trust being unable to meet demands from activity, negatively affecting quality, throughout the year. | **20** | Superseded by four new risks which encompass ICU capacity also. |
| A411-01 | Insufficient ICU capacity to handle an increasing workload | **15** | |

## 2. Assurance Map

The Trust Assurance Map is a schedule of all external visits, inspections and reporting which captures on-going actions in response to external reviews and those underway to prepare for forthcoming visits. The assurances received from these external inspections help inform the board as to continued compliance with regulatory requirements including Care Quality Commission Essential Standards of Quality and Safety. The following section provides a summary of all external visits and inspections during the reporting period.

### 2.1 Care Quality Commission (CQC)

#### 2.1.1 CQC Intelligent Monitoring Report – November 2014

The CQC published its most recent intelligent monitoring report on 1st December 2014. The report shows a reduction in the overall number of risks as compared to the previous report, (July 2014) and highlights two elevated risks and three risks. The assurances related to each risk identified in the report were presented to the Board in November. A summary of the risks and assurances provided is provided in table four below and the full intelligent monitoring report is included at appendix 3:

**Table four: St. Georges CQC Intelligent Monitoring Report Risks: October 2014**

| Level of Risk | Indicator | Assurance/Actions on-going |
|---|---|---|
| Elevated Risk | Emergency readmissions with an overnight stay following an elective admission (01/04/2013 – 31/03/2014) | Using Dr Foster reported data:<br><br>**Re-admissions Month Trend** - our re-admission profile by month from Aug-13 to May-14 shows our re-admission rate as having a high elevated risk from Oct-13 to Feb-14. However, from March onwards this has reduced back to within expected range and for April and May our re-admissions are below that of the national average which is positive and should lead to the risk being re-evaluated.<br><br>This data is monitored via the performance team and any alert raising significant concern is escalated through performance reporting. |
| Elevated Risk | The proportion of cases assessed as achieving compliance with all nine standards of care measured within the National Hip Fracture data base (01/01/2013 – 31/12/2013) | Standards with which the Trust is not compliant in this most recent audit (Dec 2013):<br>1. Admission to Orthopaedic ward within 4 hours<br>2. Surgery on day of admission<br>3. Senior geriatric review within 72 hours of admission<br>4. Bone health medication assessment performed<br><br>An action plan is in place to address each standard which is overseen by the Care Group Lead and General Manager and is monitored by the Care Group Governance Meeting. |
| Risk | Incidence of Methicillin-resistant Staphylococcus aureus (MRSA) (01-Aug-13 to 31-Jul-14) | The Trust has now reported 3 MRSA bacteraemia cases to the end of October.<br><br>This is currently an extreme risk on the BAF: A513-01 and detailed assurance is provided to the Board through the Quality report. |
| Risk | In-hospital mortality – trauma and orthopaedic conditions (01/04/2012 – 18/06/2014). | The trust monitors mortality across all procedure and diagnosis groups and this routine internal benchmarking has identified a signal in the CCS diagnosis group 'crushing injury or internal injury'. This represents 8 deaths over a 12 month period (June 2013 – May 2014). Following discussion at the Mortality Monitoring Committee (MMC) on 17th September an investigation is currently underway which includes review of each case and examination of clinical coding. The outcome of |

| | | |
|---|---|---|
| | | this investigation will be reported to the MMC for discussion and identification of learning as appropriate. There are currently no other alerts related to either trauma or orthopaedics. |
| Risk | NHS Staff Survey - KF10. The proportion of staff receiving health and safety training in last 12 months (01-Sep-13 to 31-Dec-13) | As recorded on the Trust 'Wired' system: H&S compliance is currently 88% and the Trust standard is to achieve 85% compliance.<br><br>It is possible this has been identified as a risk is due to the difficulty we have (in common with many other Trusts) that the Staff Survey question asks about annual training, whereas the requirement is to complete H&S training every 3 years. |

### 2.2 Care Quality Commission mortality outlier alert for acute myocardial infarction

Analysis performed by the Care Quality Commission previously indicated significantly high mortality rates for acute myocardial infarction and in July 2014 the CQC wrote to the Trust to advise that this outlier alert had been passed to the Trust's local inspection team who would follow up on progress with implementing the planned actions in order to be certain that the high mortality rates in this area had been recognised, explanations explored and appropriate actions taken by the trust in a timely manner to ensure the future safety of patients.

The inspection team has now confirmed that they are satisfied that sufficient action has been taken to reduce the risks to patients in relation to issues identified by our review of the alert. As a result, this outlier case has now been closed.

### 2.3 Care Quality Commission – Compliance Action plan update

There is an on-going action plan to address the two identified issues of non-compliance during the CQC inspection in February 2014 (mandatory actions). All actions on the compliance action plan have now been completed, however monitoring the effectiveness these actions will continue. The action plan is due to be presented to the Commissioners and the NTDA at a quarterly review meeting in January 2015, alongside the improvement action plan to address issues where the CQC recommended action be considered (non-mandatory actions). Good progress is being made against the improvement plan.

### 2.4 Summary of external assurance and third party inspections Dec 2014

The full Trust Assurance Map is presented to the Quality and Risk Committee bi-monthly for monitoring and scrutiny. The QRC seeks assurance, on behalf of the Trust Board, around the progress and appropriateness of actions in place to address any issues of non-conformities identified through an external or third party inspection or peer review. A summary of the findings of external inspections is presented here to the Board and, by exception, any significant risks arising out of external inspections identified by QRC will also be included.

#### 2.4.1 Major Trauma Dashboard – Q2 2014/15

The Trust has now received its Quarter 2 2014/15 Major Trauma Centre dashboard final report and no major concerns were noted and no action is required.

#### 2.4.2 Major Trauma Peer Review

The national peer review for all Major Trauma Centres (MTCs) and Networks will commence in Jan 2015. St Georges Hospital Major Trauma Centre / Network date for peer review is 12th March 2015 and preparations are underway.

#### 2.4.3 G4S Mock CQC Internal Audit – October 2014

G4S conducted an internal mock CQC compliance audit in late October 2014. The purpose of this internal audit was to ensure that internal systems are compliant with quality standards set out in

the CQC framework. The results of this internal review have been shared with G4S and services were found to be adequate – a detailed report with any issues requiring action will follow.

### 2.5 Forthcoming Inspections – December 2014

#### 2.5.1 London Fire and Emergency Planning Authority (LFEPA)

The LFEPA are conducting monthly visits to the trust to audit units that have not previously been inspected. The LFEPA have also informed the trust that they will be undertaking a follow up visit in February 2015. The purpose of this visit is to re-inspect Grosvenor and Lanesborough wings' which were issued with Enforcement and Deficiency Notices in February 2013. There is a detailed action plan in place to address the issues highlighted in these notices. The plan is on target and is monitored by the Health, Safety and Fire Committee. The potential consequence of a failure to comply with the regulations is also recorded as a risk on the BAF.

**Conclusion**

In conclusion, each risk contained on the CQC Intelligent Monitoring (IM) report had been identified through the Trust's internal assurance systems and where appropriate, actions and/or further monitoring is underway in relation to each highlighted risk. The IM report has not identified any concerns or risks of which the Trust was previously unaware.

There are detailed action plans in place to address the issues identified through external inspections, and these are monitored by the QRC. This monitoring includes oversight of the action plan in response to the CQC inspection of February 2014, against which good progress has been made. The Trust Board can be assured that no significant risks have been identified through external inspections reports received during the reporting period.

**Appendix 1: Executive Overview of Board Assurance Framework**
**Domain: 1. Quality**

| Strategic Objective/Principal Risk | Lead | Jul 2014 | Aug 2014 | Sept 2014 | Oct 2014 | Nov 2014 | Dec 2014 | In month change | Change/progress |
|---|---|---|---|---|---|---|---|---|---|
| **1.1 Patient Safety** | | | | | | | | ↓↑ | |
| A602.1-O1 Pressures on internal capacity may result in the Trust being unable to meet demands from activity, negatively affecting quality, throughout the year. | MW | 20 | 20 | 20 | 20 | 20 | n/a | **Closed** | Superseded by new risks: 01-12; 01-13; 01-14; 01-15 |
| 01-12 **Bed capacity** may not be sufficient for the Trust to meet demands from activity, negatively affecting quality, throughout the year. | MW | | | | | | 20 | **NEW** | Formerly A602.1-01 Risk score 20 |
| 01-13 **Theatre capacity** may not be sufficient for the Trust to meet demands from activity, negatively affecting quality, throughout the year. | MW | | | | | | 20 | **NEW** | Formerly A602.1-01 Risk score 20 |
| 01-14 **Staffing to support** capacity may not be sufficient for the Trust to open the increased bed, critical care and theatre capacity and to meet demands from activity, negatively affecting quality, throughout the year. | MW | | | | | | 20 | **NEW** | Formerly A602.1-01 Risk score 20<br><br>Links to Workforce Risk 5.1-01 |
| 01-15 **Critical care** capacity may not be sufficient for the Trust to meet demands from activity, negatively affecting quality, throughout the year. | MW | | | | | | 20 | **NEW** | Supersedes A411-O1: Risk score 15 |
| A411-O1: Insufficient ICU capacity to handle an increasing workload | SC | 15 | 15 | 15 | 15 | 15 | n/a | **Closed** | Closed – superseded by new risk:01-15 |
| A513-O1: Failure to achieve the National HCAI targets for MRSA and C Diff | JH | 16 | 16 | 16 | 16 | 16 | 16 | → | |
| O1-01 A risk to patient safety of inappropriate antimicrobial prescribing due to conflicting and out of date guidance being available within the Trust. | JH | 12 | 12 | 12 | 12 | 12 | 12 | → | |
| 01-02: 01-02 Lack of established process for use, provision, decontamination and maintenance of pressure relieving mattresses | JH | 9 | 9 | 9 | 9 | 9 | 9 | → | |
| 01-03 Lack of embedded process for use, provision and maintenance of bed rails | JH | 12 | 12 | 12 | 12 | 12 | 12 | → | |
| 01-04 Risk to patient safety should the organisation fail to meet its | JH | 12 | 12 | 12 | 12 | 12 | 12 | → | |

| statutory duties under Section 11 in respect of number and levels of staff trained in safeguarding children. | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 01-05 Risk to patient safety arising from a lack of standardised and centralised decontamination practice across several areas of the Trust. | JH | 12 | 12 | 12 | 12 | 12 | 12 | → | |
| 01-06 Risk to patient safety as patients waiting greater than 18 weeks on elective waiting lists | MW | 15 | 15 | 15 | 15 | 15 | 15 | → | |
| 01-07 Risk to patient safety and experience as a result of potential Trust failure to meet 95% Emergency Access Standard | MW | 16 | 16 | 16 | 16 | 16 | 16 | → | |
| 01-08 Risk to patient safety due to inconsistent processes and procedures for the follow up of diagnostic test results | RGW | 16 | 16 | 16 | 16 | 16 | 16 | → | |
| 01-09 Risk to patient safety due to a lack of a Trust wide visible training needs analysis, and lack of a system for ensuring these have been met in relation to Medical Devices | JH | | | | 12 | 12 | 12 | → | |
| 01-10 Risk to patients, staff and public health and safety in the event the Trust has failed to prepare adequately for an Ebola incident. | | | | | | 10 | 10 | → | |
| 01-11 Risk that patients will potentially receive sub-standard care due to reduced availability of prison staff to support and inadequate healthcare response to clinical emergencies | | | | | | | tbc | | |

| **Strategic Objective/Principal Risk** | **Lead** | **Jul 2014** | **Aug 2014** | **Sept 2014** | **Oct 2014** | **Nov 2014** | **Dec 2014** | **In month change** | **Change/progress** |
|---|---|---|---|---|---|---|---|---|---|
| **1.2 Patient Experience** | | | | | | | | | |
| A410-O2: Failure to sustain the Trust response rate to complaints | JH | 16 | 16 | 16 | 16 | 16 | 16 | → | |
| 02-02 Risk of diminished quality of patient care as a result of Cost Improvement Programmes (CIPs) | JH | 16 | 16 | 16 | 16 | 16 | 16 | → | |
| 02-03 Risk of poor patient experience due to long delays when trying to contact central booking service | | | | | 12 | 12 | 12 | → | |

**Domain: 2. Finance & Performance**

| **Strategic Objective/Principal Risk** | **Lead** | **Jul 2014** | **Aug 2014** | **Sept 2014** | **Oct 2014** | **Nov 2014** | **Dec 2014** | **In month change** | **Change/progress** |
|---|---|---|---|---|---|---|---|---|---|

| 2.1 Meet all financial targets | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 2.2-O5 Tariff Risk – Emergency Threshold Tariff.<br>The Trust's income and service contribution is reduced due to application of 30% tariff to emergency activity exceeding the contract thresholds | SB | 9 | 9 | 9 | 9 | 9 | 9 | → | |
| 2.1-O5 Tariff Risk -<br>The tariffs applicable to Trust clinical services are adversely changed as a result of:-<br>•National Tariff changes<br>•Local Tariff changes<br>•Specialist Commissioning changes<br>• Transfer of tariff responsibilities to Monitor | SB | 12 | 12 | 12 | 12 | 12 | 12 | → | |
| 1.2-O5 Volume Risk – Decommissioning of Services<br>Activity and associated income/contribution will be lost from services decommissioned due to:-<br>• risks to the safe delivery of care<br>• changing national guidance<br>• centralisation plans | SB | 9 | 9 | 9 | 9 | 9 | 9 | → | |
| 3.3-O5 Cost Pressures *<br>The Trust faces higher than expected costs due to:-<br>•unforeseen service pressures<br>•higher than expected inflation | SB | 16 | 16 | 16 | 16 | 16 | 16 | → | |
| 3.2-O5 Cost Reduction slippage*<br>The Trust does not deliver its cost reduction programme objectives:-<br>•Objective 3: to detail savings plans for the next two years | SB | 20 | 20 | 20 | 20 | 25 | 25 | → | |
| 2.3-O5 Tariff Risk – CQUIN Premium<br>Trust income is not maximised due to failure to deliver required performance against CQUIN quality standards. | SB | 12 | 12 | 12 | 12 | 8 | 8 | → | |
| 1.3-O5 Volume Risk – Tendering of services<br>Activity and associated income/contribution will be lost due to:-<br>• Competition from Any Qualified Providers<br>• Service Line Tenders | SB | 9 | 9 | 9 | 9 | 9 | 9 | → | |
| 1.1-05 Volume Risk – Competition with other providers<br>Activity and associated income/contribution will be lost due to competition from other service providers resulting in reductions in market share * | SB | 9 | 9 | 9 | 9 | 9 | 9 | → | |
| 2.4-O5 Tariff Risk – Performance Penalties & Payment | SB | 12 | 12 | 12 | 12 | 12 | 12 | → | |

| Challenges*<br>Trust income is reduced by:-<br>- contractual penalties due to poor performance against quality standards and KPIs<br>- payment challenges | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 3.4-O5 The Trust faces higher than expected costs due to higher marginal costs - higher than expected investment required to deliver service increases. | SB | 9 | 9 | 9 | 9 | 9 | 9 | → | |
| 3.5-05 - Cashflow Risks – Forecast Cash balances will be depleted due to delays in receipt of:-<br>Major Charitable donations towards the C&W development.<br>Land Sales receipts<br>Loan Finance | SB | 9 | 9 | 9 | 9 | 12 | 12 | → | |
| 3.6-05 - Cashflow Risks – Operational Finance<br>Forecast Cash balances will be depleted due to:-<br>Adverse Income & Expenditure performance<br>Delays in receipt of SLA funding from Commissioners | SB | 9 | 12 | 12 | 12 | 16 | 16 | → | |
| 3.9-05 Minimise financial impact of Better Care Fund | SB | 12 | 12 | 12 | 12 | 9 | 9 | → | |

| **Strategic Objective/Principal Risk** | **Lead** | **Jul 2014** | **Aug 2014** | **Sept 2014** | **Oct 2014** | **Nov 2014** | **Dec 2014** | **In month change** | **Change/progress** |
|---|---|---|---|---|---|---|---|---|---|
| **2.2 Meet all operational & performance requirements** | | | | | | | | | |
| 3.7- 06 Failure to meet the minimum requirements of the NTDA Accountability Framework: Quality and Governance Indicators/Access Metrics. | SB | 12 | 12 | 12 | 12 | 16 | 16 | → | |
| 3.8 – 06 Low compliance with new working practices introduced as part of new ICT enabled change programme | SB | 12 | 12 | 12 | 12 | 12 | 12 | → | |
| 3.9 – 06 Risk of inappropriate deployment of e-prescribing and electronic clinical documentation | SB | 12 | 12 | 12 | 12 | 12 | 12 | → | |
| 3.10-06 Risk of failure to effectively manage exit from national Cerner programme | SB | 10 | 10 | 10 | 10 | 10 | 10 | → | |
| 3.11 - 06 Poor environment in ICT department/on site data centre may lead to interruptions or failure of essential ICT services | SB | 16 | 16 | 16 | 16 | 12 | 12 | → | |
| 3.12-06 3.12- O6 Risk to patient safety due to data quality issues with Patient Administration System (PAS), Cerner, inhibiting ability | SB | | | 15 | 15 | 9 | 9 | → | |

| to be able to monitor patient pathways and manage 18 week performance. | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|

**Domain: 3. Regulation & compliance**

| Strategic Objective/Principal Risk | Lead | Jul 2014 | Aug 2014 | Sept 2014 | Oct 2014 | Nov 2014 | Dec 2014 | In month change | Change/progress |
|---|---|---|---|---|---|---|---|---|---|
| **3.1 Maintain compliance with all statutory & regulatory requirements** | | | | | | | | | |
| A534-O7:Failure to provide adequate supporting evidence for all the CQC Essential standards of Quality and Safety | PJ | 5 | 5 | 5 | 5 | 5 | 5 | → | |
| A509-O8: Trust unable to achieve readiness for FT status by planned authorisation date as per agreed TFA | PJ | 15 | 15 | 15 | 15 | 15 | 15 | → | |
| A537-O6:Confidential data reaching unintended audiences | RGW | 15 | 15 | 15 | 15 | 15 | 15 | → | |
| A610-O6: The Trust will not attain the nationally mandated target of 95% of all staff receiving annual information governance training | RGW | 15 | 15 | 15 | 15 | 15 | 15 | → | |
| 03-01Risk of premises closure, prosecution and fines as a result of non-compliance with fire regulations in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO) | EM | 16 | 16 | 16 | 16 | 16 | 16 | → | |
| 03-02 Risk of premises closure, prosecution and fines as a result of failure to demonstrate full compliance with Estates and Facilities legislation | EM | 16 | 16 | 16 | 16 | 16 | 16 | → | |
| 03-03 Lack of decant space will result in delays in delivering the capital programme. | EM | 16 | 16 | 16 | 16 | 16 | 16 | → | |
| 03-04 Delay to the ability to deliver the capital programme and maintenance activity due to clinical and capacity demands preventing access for estates and projects works. | EM | 16 | 16 | 16 | 16 | 16 | 16 | → | |
| 03-05 Trust wide risk to patient, public and staff safety of Legionella | EM | | | 12 | 12 | 12 | 12 | → | |

**Domain: 4. Strategy, transformation & development**

| Strategic Objective/Principal Risk | Lead | Jul 2014 | Aug 2014 | Sept 2014 | Oct 2014 | Nov 2014 | Dec 2014 | In month change | Change/progress |
|---|---|---|---|---|---|---|---|---|---|
| **4.1 Redesign pathways to keep more people out of hospital** | | | | | | | | | |
| 01-O8 Prolonged strategic uncertainty in SW London. | SM | 12 | 12 | 12 | 12 | 12 | 12 | → | |

| Strategic Objective/Principal Risk | Lead | Jul 2014 | Aug 2014 | Sept 2014 | Oct 2014 | Nov 2014 | Dec 2014 | In month change | Change/progress |
|---|---|---|---|---|---|---|---|---|---|
| **4.2 Redesign & configure our local hospital services to provide higher quality care** | | | | | | | | | |
| A533-O8: Reconfiguration of healthcare services in SWL result in unfavourable changes to SGHT services and finances | SM | 8 | 8 | 8 | 8 | 8 | 8 | → | |

| Strategic Objective/Principal Risk | Lead | Jul 2014 | Aug 2014 | Sept 2014 | Oct 2014 | Nov 2014 | Dec 2014 | In month change | Change/progress |
|---|---|---|---|---|---|---|---|---|---|
| **4.5 Drive research & innovation through our clinical services** | | | | | | | | | |
| 05-05 Research does not form a key part of St. George's future activity which may result in the loss of funding and an inability to recruit and retain staff. | RGW | 8 | 8 | 8 | 8 | 8 | 8 | → | |

**Domain: 5. Workforce**

| Strategic Objective/Principal Risk | Lead | Jul 2014 | Aug 2014 | Sept 2014 | Oct 2014 | Nov 2014 | Dec 2014 | In month change | Change/progress |
|---|---|---|---|---|---|---|---|---|---|
| **5.1 Develop a highly skilled & engaged workforce championing our values** | | | | | | | | | |
| A518-O4:Failure to reduce the unacceptable levels of bullying & harassment reported by staff in the annual staff survey | WB | 12 | 12 | 12 | 12 | 12 | 12 | → | |
| A516-O4: Possible reductions in the overall number of junior doctors available with a possible impact on particular specialty areas | WB | 4 | 4 | 4 | 4 | 4 | 4 | → | |
| A520-O4: Failure to maintain required levels of attendance at core mandatory and statutory training (MAST) | WB | 12 | 12 | 12 | 12 | 12 | 12 | → | |
| 5.1-01 Failure to recruit and retain sufficient staff to manage turnover rates and support future increases in capacity | WB | | | 12 | 12 | 12 | 12 | → | |

| | | | | | |
|---|---|---|---|---|---|
| JH | Jennie Hall | Chief Nurse | PJ | Ros Given-Wilson | Medical Director |
| SC | Sofia Colas | Divisional Director of Operations – CWS | RGW | Steve Bolam | Director of Finance Performance & Information |
| PJ | Peter Jenkinson | Director of Corporate Affairs | SM | Suzanne Marsello | Interim Director of Strategy |
| MS | Miles Scott | Chief Executive | TK | Wendy Brewer | Director of Human Resources |
| DH | Eric Munro | Director of Estates & Facilities | MW | Martin Wilson | Director of Delivery & Performance |

## Appendix 2 – Board Assurance Framework: New Risks

<table>
<tr><td>Principal Risk</td><td colspan="6">01-12 Bed capacity may not be sufficient for the Trust to meet demands from activity, negatively affecting quality, throughout the year.</td></tr>
<tr><td>Description</td><td colspan="6">Requirement for high activity volumes in some specialities in order to meet patient and commissioner needs, and to deliver income margin as part of Trust Cost Improvement Programme.<br>Potential for commissioner challenges and financial penalties<br>Unlimited demand on A&E which impacts on increase in emergency admissions & capacity for elective admissions affecting 28 day rebook timeframes.<br>Potential subsequent impact on patient pathways & patient safety. Delayed patient repatriation to host hospitals block beds for emergency/elective activity.<br>Winter pressures relate to flu and winter vomiting viruses that increase demand on side rooms and closure of beds.<br>Reduced numbers of discharges at weekends and on bank holidays causing capacity problems.<br>Adverse reputation</td></tr>
<tr><td>Domain</td><td colspan="3">1. Quality</td><td colspan="2">Strategic Objective</td><td>1.1 Patient Safety</td></tr>
<tr><td></td><td>Original</td><td>Current</td><td>Updated Nov 14</td><td colspan="2">Exec Sponsor</td><td>Martin Wilson</td></tr>
<tr><td>Consequence</td><td>5</td><td>5</td><td>5</td><td colspan="2">Date opened</td><td>01/11/2012 (split into 4 component capacity risks November 2014)</td></tr>
<tr><td>Likelihood</td><td>4</td><td>4</td><td>4</td><td colspan="2">Date closed</td><td></td></tr>
<tr><td>Score</td><td>20</td><td>20</td><td>20</td><td colspan="3"></td></tr>
<tr><td>Controls & Mitigating Actions</td><td colspan="4">Controls:<br>Director of Delivery and Improvement appointed to lead organisation's work on (in year and next year) capacity planning and delivery. Supported by full time Programme Manager dedicated to capacity.<br>Significant additional bed capacity being developed in 2014/15 and 2015/16. This includes development of additional physical capacity in Q3 and Q4, and gains in patient flow from the Improvement Programme.<br>Equivalent total bed capacity realisable by year end - 169 beds.<br>Operational Capacity Planner (OCP) developed to plan and track progress on all capacity creation and release schemes. Reviewed weekly at OMT and EMT. OCP managed by Programme Manager and includes 4 key areas: staffing, clinical pathway; physical capacity; and commercial / contracting arrangements.<br>Business Planning for 2015/16 commenced with focus on</td><td>Assurance</td><td>Participation in System Resilience Group that has reviewed Trust's capacity plans. Additional funds secured through SRG 1 & 2 non elective winter funds.<br>Monitor FT assessment process has scrutinised Trust Capacity Plan<br>ECIST reviews (September 2013 and May 2014)<br>Negative assurance:<br>- 4 hour operational standard performance<br>- RTT backlog of patients- cross ref BAF Risk 01-06<br>- Cancelled elective surgery during periods of significantly high activity i.e. Feb 2014</td></tr>
</table>

| | | | |
|---|---|---|---|
| | aligning divisional activity and capacity plans.<br>If delivered as planned, capacity pressures will substantially diminish and performance and CIP targets can be met.<br>There are however risks with respect to the timing and delivery of both aspects of the plan. To control these risks, we have:<br>Ensured that maximum possible resource is deployed towards the improving patient flow programme so that optimal delivery can be achieved<br>A structured approach to appraising the options for creating further physical capacity for 2015-16 and beyond. This work is underway.<br>Increased capital project management capability<br>**Mitigations:**<br>• Seek additional external capacity<br>• Cap demand for services | | |
| **Gaps in controls** | | **Gaps in assurance** | Lack of critical path currently identified for all forecast building schemes. |
| **Actions next period:** | Realisation of new physical bed capacity<br>Development of critical path for all forecast building schemes, and embedding the holding to account of Senior Responsible Owners for delivery of agreed schemes.<br>2015/16 business planning accelerated | | |

| **Principal Risk** | **01-13 Theatre capacity** may not be sufficient for the Trust to meet demands from activity, negatively affecting quality, throughout the year. | | | | |
|---|---|---|---|---|---|
| **Description** | Requirement for high activity volumes in some specialities in order to meet patient and commissioner needs in particular to deliver 18 week RTT standards, and to deliver income margin as part of Trust Cost Improvement Programme.<br>Potential for commissioner challenges and financial penalties<br>Adverse reputation | | | | |
| **Domain** | **2. Quality** | | | **Strategic Objective** | **1.1 Patient Safety** |
| | **Original** | **Current** | **Updated Nov 14** | **Exec Sponsor** | Martin Wilson |
| **Consequence** | 5 | 5 | 5 | **Date opened** | 01/11/2012 (split into 4 component capacity risks November 2014) |
| **Likelihood** | 4 | 4 | 4 | **Date closed** | |
| **Score** | 20 | 20 | 20 | | |
| **Controls & Mitigating Actions** | **Controls:**<br>Director of Delivery and Improvement appointed to lead organisation's work on (in year and next year) capacity planning and delivery. Supported by full time Programme Manager dedicated to capacity.<br>Theatre Capacity Plan for 2015 to 2018 developed by Director of Delivery and Improvement with senior leadership from SNCT leadership team. Plan reviewed by extraordinary OMT and regularly reviewed by EMT.<br>Additional capacity being realised through:<br>3. Increased in session utilisation within existing theatre sessions<br>4. All day operating sessions within day surgery<br>5. Extended day operating in main theatres<br>6. Commissioning the planned Hybrid theatre as an additional theatre<br>7. Building 6 additional theatres on site (part in conjunction with Moorfields)<br>8. Offsite capacity options (NHS and independent sector)<br><br>The above require significant additional staff (see next risk)<br>Operational Capacity Planner (OCP) developed to plan and track progress on all capacity creation and release schemes. Reviewed weekly at OMT and EMT. OCP managed by | | | **Assurance** | Internal theatres capacity plan and tactical implementation plan developed by Director of Delivery and Improvement. Approved by Executive Management Team. Reported to Finance and Performance committee.<br>Participation in System Resilience Group that has reviewed Trust's capacity plans. Additional funds secured through SRG 1 elective RTT funds.<br>Monitor FT assessment process has scrutinised Trust Capacity Plan<br>Negative assurance:<br>- RTT backlog of patients- cross ref BAF Risk 01-06<br>- Cancelled elective surgery during periods of significantly high activity i.e. Feb 2014 |

| | | | |
|---|---|---|---|
| | Programme Manager and includes 4 key areas: staffing, clinical pathway; physical capacity; and commercial / contracting arrangements.<br>Business Planning for 2015/16 commenced with focus on aligning divisional activity and capacity plans.<br>Specific theatre capacity analysis and plan developed linked to a longer term theatres strategy currently in development..<br>Ensured that maximum possible resource is deployed towards the improving patient flow programme so that optimal delivery can be achieved<br>A structured approach to appraising the options for creating further physical capacity for 2015-16 and beyond. This work is underway.<br>Increased capital project management capability<br>**Mitigations:**<br>• Seek additional external capacity<br>• Cap demand for services | | |
| **Gaps in controls** | Maintenance of theatres behind plan for a number of years, leading to a risk that theatres will break down. | **Gaps in assurance** | Admitted backlog of over 18 week waiters greater than sustainable.<br>Non-admitted backlog numbers not being reduced at planned rate.<br>Theatre performance data dashboards not yet fit for purpose with divisional clinical teams. |
| **Actions next period:** | Day Surgery Unit extended day to commence, including reallocating 14 sessions worth of activity from main theatres<br>Estates risk assessment undertaken to ensure good shared understanding of theatres maintenance needs and programme.<br>Implementation plan for medium term theatres plan to be developed by divisional leadership team.<br>Star chamber held by Director of Finance and Director of Delivery and Improvement with each divisional leadership team to ensure that planned activity numbers are robust. 2015/16 business planning accelerated. | | |

<table>
<tr><td>Principal Risk</td><td colspan="5">01-14 Staffing to support capacity may not be sufficient for the Trust to open the increased bed, critical care and theatre capacity and to meet demands from activity, negatively affecting quality, throughout the year.</td></tr>
<tr><td>Description</td><td colspan="5">Trust is planning to open significant additional beds (10% + of current stock), theatre sessions (16% + of current lists), and critical care beds (c30% of current bed stock) however this will require significant additional staffing (nursing, medical, other clinical and other support staff). In many of these staff groups there are already high vacancy levels so staffing will be a significant challenge.<br>Additional staff are required for high activity volumes in some specialities in order to meet patient and commissioner needs in particular to deliver emergency services, 18 week RTT standards, and to deliver income margin as part of Trust Cost Improvement Programme.<br>Potential for commissioner challenges and financial penalties<br>Adverse reputation</td></tr>
<tr><td>Domain</td><td colspan="3">9. Quality</td><td>Strategic Objective</td><td>1.1 Patient Safety</td></tr>
<tr><td></td><td>Original</td><td>Current</td><td>Updated Nov 14</td><td>Exec Sponsor</td><td>Martin Wilson (as exec lead for capacity)<br>Jennie Hall (as exec lead for nursing and safe staffing)<br>Wendy Brewer (as exec lead for staffing and recruitment)</td></tr>
<tr><td>Consequence</td><td>5</td><td>5</td><td>5</td><td>Date opened</td><td>01/11/2012 (split into 4 component capacity risks November 2014)</td></tr>
<tr><td>Likelihood</td><td>4</td><td>4</td><td>4</td><td>Date closed</td><td></td></tr>
<tr><td>Score</td><td>20</td><td>20</td><td>20</td><td></td><td></td></tr>
<tr><td>Controls & Mitigating Actions</td><td colspan="3">Controls:<br>Operational Capacity Planner (OCP) developed to plan and track progress on all capacity creation and release schemes. Reviewed weekly at OMT and EMT. OCP managed by Programme Manager and includes 4 key areas: staffing, clinical pathway; physical capacity; and commercial / contracting arrangements.<br>Director of Delivery and Improvement appointed to lead organisation’s work on (in year and next year) capacity planning and delivery. Supported by full time Programme Manager dedicated to capacity, who is mapping total additional staffing required by week for each new scheme.<br>Chief Nurse and Director of Human Resources working closely together to lead recruitment to staff new schemes and to reduce existing staff turnover.<br>Business Planning for 2015/16 commenced with focus on aligning divisional activity and capacity plans.<br>Mitigations:<br>• Seek additional external temporary staffing capacity and also external physical capacity with own staffing</td><td>Assurance</td><td>Workforce updates given to Trust Board. Nursing staffing plan considered by Trust Board.<br>Participation in System Resilience Group that has reviewed Trust’s capacity plans. Additional funds secured through SRG 1 & 2 non elective winter funds, and through SRG 1 elective RTT funds.<br>Monitor FT assessment process has scrutinised Trust Capacity Plan<br>ECIST reviews (September 2013 and May 2014)<br>Negative assurance:<br>- 4 hour operational standard performance<br>- RTT backlog of patients- cross ref BAF Risk 01-06<br>- Cancelled elective surgery during periods of significantly high activity i.e. Feb 2014<br><br>Internal theatres capacity plan and tactical implementation plan developed by Director of Delivery and Improvement. Approved by Executive Management Team. Reported to Finance and Performance committee.</td></tr>
</table>

| | | | |
|---|---|---|---|
| | • Cap demand for services | | |
| **Gaps in controls** | | **Gaps in assurance** | |
| **Actions next period:** | New physical capacity schemes come on line.<br>Enhanced programme of staff recruitment underway.<br>Star chamber held by Director of Finance and Director of Delivery and Improvement with each divisional leadership team to ensure that planned activity numbers are robust.<br>2015/16 business planning accelerated. | | |

<table>
<tr><td>Principal Risk</td><td colspan="6">01-15 Critical care capacity may not be sufficient for the Trust to meet demands from activity, negatively affecting quality, throughout the year.</td></tr>
<tr><td>Description</td><td colspan="6">Requirement for high activity volumes in some specialities in order to meet patient and commissioner needs in particular to support emergency services and deliver 18 week RTT standards. Also any shortage in critical care capacity will impact on trust's ability to deliver income margin as part of Trust Cost Improvement Programme.<br>Potential for commissioner challenges and financial penalties and adverse reputation</td></tr>
<tr><td>Domain</td><td colspan="3">10. Quality</td><td colspan="2">Strategic Objective</td><td>1.1 Patient Safety</td></tr>
<tr><td></td><td>Original</td><td>Current</td><td>Updated Nov 14</td><td colspan="2">Exec Sponsor</td><td>Martin Wilson</td></tr>
<tr><td>Consequence</td><td>5</td><td>5</td><td>5</td><td colspan="2">Date opened</td><td>01/11/2012 (split into 4 component capacity risks November 2014)</td></tr>
<tr><td>Likelihood</td><td>4</td><td>4</td><td>4</td><td colspan="2">Date closed</td><td></td></tr>
<tr><td>Score</td><td>20</td><td>20</td><td>20</td><td colspan="3"></td></tr>
<tr><td>Controls & Mitigating Actions</td><td colspan="4">Controls:<br>Director of Delivery and Improvement appointed to lead organisation's work on (in year and next year) capacity planning and delivery. Supported by full time Programme Manager dedicated to capacity.<br>Critical Care Business Case for 4 additional neuro beds and 9 additional general ITU beds developed by divisional leadership team and shortly to be considered by Trust Board.<br>Trust Capacity Plan for 2015 to 2018 developed by Director of Delivery and Improvement with senior leadership from SNCT leadership team. Plan reviewed by extraordinary OMT and regularly reviewed by EMT.<br>Additional capacity for winter 2014/15 being considered through redevelopment of a store room and staff room adjacent to coronary care unit. This will require additional staff (see next risk)<br>Operational Capacity Planner (OCP) developed to plan and track progress on all capacity creation and release schemes. Reviewed weekly at OMT and EMT. OCP managed by Programme Manager and includes 4 key areas: staffing, clinical pathway; physical capacity; and commercial / contracting arrangements.<br>Business Planning for 2015/16 commenced with focus on Increased capital project management capability<br>Mitigations:<br>• Seek additional external capacity<br>• Cap demand for services</td><td>Assurance</td><td>Monitor FT assessment process has scrutinised Trust Capacity Plan<br>Negative assurance:<br>- RTT backlog of patients- cross ref BAF Risk 01-06<br>- Cancelled elective surgery during periods of significantly high activity i.e. Feb 2014</td></tr>
<tr><td>Gaps in controls</td><td colspan="4"></td><td>Gaps in assurance</td><td></td></tr>
</table>

| **Actions next period:** | Business case for 13 additional beds to be considered by Trust Board.<br>Design plans and costs for 3/4 additional beds in coronary care to be considered and where appropriate – approved.<br>Star chamber held by Director of Finance and Director of Delivery and Improvement with each divisional leadership team to ensure that planned activity numbers are robust. 2015/16 business planning accelerated. |
|---|---|

**Appendix 3**

Care Quality Commission

# Intelligent Monitoring Report

Report on
St George's Healthcare NHS Trust

December 2014

To view the most recent inspection report please visit the link below.
http://www.cqc.org.uk/Provider/RJ7

CQC has developed a new model for monitoring a range of key indicators about NHS acute and specialist hospitals. These indicators relate to the five key questions we will ask of all services – are they safe, effective, caring, responsive and well-led? The indicators will be used to raise questions about the quality of care. They will not be used on their own to make judgements. Our judgements will always be based on the result of an inspection, which will take into account our Intelligent Monitoring analysis alongside local information from the public, the trust and other organisations.

**What does this report contain?**

This report presents CQC's analysis of the key indicators (which we call 'tier one indicators') for St George's Healthcare NHS Trust. We have analysed each indicator to identify two possible levels of risk.

We have used a number of tests to determine where the thresholds of "risk" and "elevated risk" sit for each indicator, based on our judgement of which statistical tests are most appropriate. These tests include CUSUM and z-scoring techniques. Where an indicator has 'no evidence of risk' this refers to where our statistical analysis has not deemed there to be a "risk" or "elevated risk". For some data sources these thresholds are determined by a rules-based approach - for example concerns raised by staff to CQC (and validated by CQC) are always flagged in the model.

NHS Trusts that have had an inspection at the time of producing this update of Intelligent Monitoring have not been assigned a banding; all other indicator analysis results are shown in their report. "Recently inspected" is stated for these trusts.  This is to reflect the fact that CQC's new comprehensive inspections will provide its definitive judgements for each organisation.

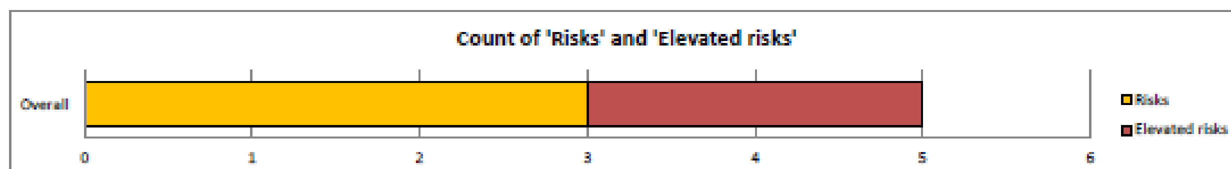
Further details of the analysis applied are explained in the accompanying guidance document.

**What guidance is available?**

We have published a document setting out the definition and full methodology for each indicator. If you have any queries or need more information, please email enquiries@cqc.org.uk or use the contact details at www.cqc.org.uk/contact-us

## St George's Healthcare NHS Trust

Trust Summary




| Priority banding for inspection | Recently inspected |
|---|---|
| Number of 'Risks' | 3 |
| Number of 'Elevated risks' | 2 |
| Overall Risk Score | 7 |
| Number of Applicable Indicators | 91 |
| Percentage Score | 3.85% |
| Maximum Possible Risk Score | 182 |

| | |
|---|---|
| Elevated risk | Composite indicator: Emergency readmissions with an overnight stay following an elective admission (01-Apr-13 to 31-Mar-14) |
| Elevated risk | The proportion of cases assessed as achieving compliance with all nine standards of care measured within the National Hip Fracture Database. (01-Jan-13 to 31-Dec-13) |
| Risk | Incidence of Meticillin-resistant Staphylococcus aureus (MRSA) (01-Aug-13 to 31-Jul-14) |
| Risk | Composite indicator: In-hospital mortality - Trauma and orthopaedic conditions and procedures |
| Risk | NHS Staff Survey - KF10. The proportion of staff receiving health and safety training in last 12 months (01-Sep-13 to 31-Dec-13) |

## St George's Healthcare NHS Trust

Tier One Indicators

| Section | ID | Indicators | Observed | Expected | Risk? |
|---|---|---|---|---|---|
| Never Events | STEISNE | Never Event incidence (01-Sep-13 to 31-Aug-14) | 4 | - | No evidence of risk |
| Avoidable infections | CDIFF | Incidence of Clostridium difficile (C.difficile) (01-Aug-13 to 31-Jul-14) | 26 | 43.74 | No evidence of risk |
| | MRSA | Incidence of Meticillin-resistant Staphylococcus aureus (MRSA) (01-Aug-13 to 31-Jul-14) | 8 | 3.36 | Risk |
| Deaths in low risk diagnosis groups | MORTLOWR | Dr Foster Intelligence: Mortality rates for conditions normally associated with a very low rate of mortality (01-Apr-13 to 31-Mar-14) | Within expected range | - | No evidence of risk |
| Patient safety incidents | NRLSL03 | Proportion of reported patient safety incidents that are harmful (01-Jun-13 to 31-May-14) | 0.27 | 0.28 | No evidence of risk |
| | NRLSL04 | Potential under-reporting of patient safety incidents resulting in death or severe harm (01-Jun-13 to 31-May-14) | 16 | 58.15 | No evidence of risk |
| | NRLSL05 | Potential under-reporting of patient safety incidents (01-Jun-13 to 31-May-14) | 9959 | 10521.7 | No evidence of risk |
| Central Alerting System | COM_CASIM | Composite of Central Alerting System (CAS) safety alerts indicators (01-Apr-04 to 31-Aug-14) | - | - | No evidence of risk |
| | *CASIM01A01* | *The number of alerts which CAS stipulated should have been closed by trusts during the preceding 12 months, but which were still open on the date CQC extracted data from the CAS system (01-Sep-13 to 31-Aug-14)* | *0 alerts still open* | - | *No evidence of risk* |
| | *CASIM01B01* | *The number of alerts which CAS stipulated should have been closed by trusts more than 12 months before, but which were still open on the date CQC extracted data from the CAS system (01-Apr-04 to 31-Aug-13)* | *0 alerts still open* | - | *No evidence of risk* |
| | *CASIM01C01* | *Percentage of CAS alerts with closing dates during the preceding 12 months which the trust has closed late (01-Sep-13 to 31-Aug-14)* | *< 25% of alerts closed late* | - | *No evidence of risk* |
| Venous Thromboembolism | VTERA03 | Proportion of patients risk assessed for Venous Thromboembolism (VTE) (01-Apr-14 to 30-Jun-14) | 0.97 | 0.95 | No evidence of risk |
| Mortality: Trust Level | SHMI01 | Summary Hospital-level Mortality Indicator (01-Apr-13 to 31-Mar-14) | Trust's mortality rate is 'Lower than expected' | - | No evidence of risk |
| | COM_HSMR | Dr Foster Intelligence: Composite of Hospital Standardised Mortality Ratio indicators (01-Apr-13 to 31-Mar-14) | - | - | No evidence of risk |
| | *HSMR* | *Dr Foster Intelligence: Hospital Standardised Mortality Ratio (01-Apr-13 to 31-Mar-14)* | *Lower than expected* | - | *No evidence of risk* |
| | *HSMRWKDAY* | *Dr Foster Intelligence: Hospital Standardised Mortality Ratio (Weekday) (01-Apr-13 to 31-Mar-14)* | *Lower than expected* | - | *No evidence of risk* |
| | *HSMRWKEND* | *Dr Foster Intelligence: Hospital Standardised Mortality Ratio (Weekend) (01-Apr-13 to 31-Mar-14)* | *Within expected range* | - | *No evidence of risk* |



Indicators displaying * represent a suppressed value between 1 and 5

| Section | ID | Indicators | Observed | Expected | Risk? |
|---|---|---|---|---|---|
| | COM_CARDI | Composite indicator: In-hospital mortality - Cardiological conditions and procedures | - | - | No evidence of risk |
| | HESMORT24CU | In-hospital mortality: Cardiological conditions (01-May-13 to 30-Apr-14) | - | - | No evidence of risk |
| | MORTAMI | Mortality outlier alert: Acute myocardial infarction (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | MORTARRES | Mortality outlier alert: Cardiac arrest and ventricular fibrillation (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | MORTCABGI | Mortality outlier alert: CABG (isolated first time) (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | MORTCABGO | Mortality outlier alert: CABG (other) (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | MORTCASUR | Mortality outlier alert: Adult cardiac surgery (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | MORTCATH | Mortality outlier alert: Coronary atherosclerosis and other heart disease (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | MORTCHF | Mortality outlier alert: Congestive heart failure; nonhypertensive (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | MORTDYSRH | Mortality outlier alert: Cardiac dysrhythmias (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | MORTHVD | Mortality outlier alert: Heart valve disorders (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | MORTPHD | Mortality outlier alert: Pulmonary heart disease (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | COM_CEREB | Composite indicator: In-hospital mortality - Cerebrovascular conditions | - | - | No evidence of risk |
| | HESMORT21CU | In-hospital mortality: Cerebrovascular conditions (01-May-13 to 30-Apr-14) | - | - | No evidence of risk |
| | MORTACD | Mortality outlier alert: Acute cerebrovascular disease (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | COM_DERMA | Composite indicator: In-hospital mortality - Dermatological conditions | - | - | No evidence of risk |
| | HESMORT35CU | In-hospital mortality: Dermatological conditions (01-May-13 to 30-Apr-14) | - | - | No evidence of risk |
| | MORTSKINF | Mortality outlier alert: Skin and subcutaneous tissue infections (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | MORTSKULC | Mortality outlier alert: Chronic ulcer of skin (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | COM_ENDOC | Composite indicator: In-hospital mortality - Endocrinological conditions | - | - | No evidence of risk |
| | HESMORT29CU | In-hospital mortality: Endocrinological conditions (01-May-13 to 30-Apr-14) | - | - | No evidence of risk |
| | MORTDIABWC | Mortality outlier alert: Diabetes mellitus with complications (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | MORTDIABWOC | Mortality outlier alert: Diabetes mellitus without complications (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | MORTFLUID | Mortality outlier alert: Fluid and electrolyte disorders (case status as at 19-Nov-14) | - | - | No evidence of risk |


Indicators displaying * represent a suppressed value between 1 and 5

| Section | ID | Indicators | Observed | Expected | Risk? |
| --- | --- | --- | --- | --- | --- |
| Mortality | COM_GASTR | Composite indicator: In-hospital mortality - Gastroenterological and hepatological conditions and procedures | - | - | No evidence of risk |
| | HESMORT27CU | In-hospital mortality: Gastroenterological and hepatological conditions (01-May-13 to 30-Apr-14) | - | - | No evidence of risk |
| | MORTALCUV | Mortality outlier alert: Liver disease, alcohol-related (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | MORTBILIA | Mortality outlier alert: Biliary tract disease (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | MORTGASHAE | Mortality outlier alert: Gastrointestinal haemorrhage (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | MORTGASN | Mortality outlier alert: Noninfectious gastroenteritis (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | MORTINTOBS | Mortality outlier alert: Intestinal obstruction without hernia (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | MORTOGAS | Mortality outlier alert: Other gastrointestinal disorders (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | MORTOLIV | Mortality outlier alert: Other liver diseases (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | MORTOPJEJ | Mortality outlier alert: Operations on jejunum (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | MORTPERI | Mortality outlier alert: Peritonitis and intestinal abscess (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | MORTTEPBI | Mortality outlier alert: Therapeutic endoscopic procedures on biliary tract (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | MORTTEPLGI | Mortality outlier alert: Therapeutic endoscopic procedures on lower GI tract (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | MORTTEPUGI | Mortality outlier alert: Therapeutic endoscopic procedures on upper GI tract (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | MORTTOJI | Mortality outlier alert: Therapeutic operations on jejunum and ileum (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | COM_GENIT | Composite indicator: In-hospital mortality - Genito-urinary conditions | - | - | No evidence of risk |
| | HESMORT31CU | In-hospital mortality: Genito-urinary conditions (01-May-13 to 30-Apr-14) | - | - | No evidence of risk |
| | MORTUTI | Mortality outlier alert: Urinary tract infections (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | COM_HAEMA | Composite indicator: In-hospital mortality - Haematological conditions | - | - | No evidence of risk |
| | HESMORT28CU | In-hospital mortality: Haematological conditions (01-May-13 to 30-Apr-14) | - | - | No evidence of risk |
| | MORTDEFI | Mortality outlier alert: Deficiency and other anaemia (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | COM_INFEC | Composite indicator: In-hospital mortality - Infectious diseases | - | - | No evidence of risk |
| | HESMORT26CU | In-hospital mortality: Infectious diseases (01-May-13 to 30-Apr-14) | - | - | No evidence of risk |
| | MORTSEPT | Mortality outlier alert: Septicaemia (except in labour) (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | COM_MENTA | Composite indicator: In-hospital mortality - Conditions associated with Mental health | - | - | No evidence of risk |
| | HESMORT33CU | In-hospital mortality: Conditions associated with Mental health (01-May-13 to 30-Apr-14) | - | - | No evidence of risk |
| | MORTSENI | Mortality outlier alert: Senility and organic mental disorders (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | COM_MUSCU | Composite indicator: In-hospital mortality - Musculoskeletal conditions | - | - | No evidence of risk |
| | HESMORT36CU | In-hospital mortality: Musculoskeletal conditions (01-May-13 to 30-Apr-14) | - | - | No evidence of risk |
| | MORTPATH | Mortality outlier alert: Pathological fracture (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | COM_NEPHR | Composite indicator: In-hospital mortality - Nephrological conditions | - | - | No evidence of risk |
| | HESMORT30CU | In-hospital mortality: Nephrological conditions (01-May-13 to 30-Apr-14) | - | - | No evidence of risk |
| | MORTRENA | Mortality outlier alert: Acute and unspecified renal failure (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | MORTRENC | Mortality outlier alert: Chronic renal failure (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | COM_NEURO | Composite indicator: In-hospital mortality - Neurological conditions | - | - | No evidence of risk |
| | HESMORT34CU | In-hospital mortality: Neurological conditions (01-May-13 to 30-Apr-14) | - | - | No evidence of risk |
| | MORTEPIL | Mortality outlier alert: Epilepsy, convulsions (case status as at 19-Nov-14) | - | - | No evidence of risk |


Indicators displaying * represent a suppressed value between 1 and 5

| Section | ID | Indicators | Observed | Expected | Risk? |
|---|---|---|---|---|---|
| | COM_PAEDI | Composite indicator: In-hospital mortality - Paediatric and congenital disorders and perinatal mortality | - | - | No evidence of risk |
| | *HESMORT32CU* | *In-hospital mortality: Paediatric and congenital disorders (01-May-13 to 30-Apr-14)* | - | - | *No evidence of risk* |
| | *MATPERIMOR* | *Maternity outlier alert: Perinatal mortality (case status as at 19-Nov-14)* | - | - | *No evidence of risk* |
| | COM_RESPI | Composite indicator: In-hospital mortality - Respiratory conditions | - | - | No evidence of risk |
| | *HESMORT25CU* | *In-hospital mortality: Respiratory conditions (01-May-13 to 30-Apr-14)* | - | - | *No evidence of risk* |
| | *MORTASTHM* | *Mortality outlier alert: Asthma (case status as at 19-Nov-14)* | - | - | *No evidence of risk* |
| | *MORTBRONC* | *Mortality outlier alert: Acute bronchitis (case status as at 19-Nov-14)* | - | - | *No evidence of risk* |
| | *MORTCOPD* | *Mortality outlier alert: Chronic obstructive pulmonary disease and bronchiectasis (case status as at 19-Nov-14)* | - | - | *No evidence of risk* |
| | *MORTPLEU* | *Mortality outlier alert: Pleurisy, pneumothorax, pulmonary collapse (case status as at 19-Nov-14)* | - | - | *No evidence of risk* |
| | *MORTPNEU* | *Mortality outlier alert: Pneumonia (case status as at 19-Nov-14)* | - | - | *No evidence of risk* |
| | COM_TRAUM | Composite indicator: In-hospital mortality - Trauma and orthopaedic conditions and procedures | - | - | Risk |
| | *HESMORT37CU* | *In-hospital mortality: Trauma and orthopaedic conditions (01-May-13 to 30-Apr-14)* | - | - | *Risk* |
| | *MORTCRAN* | *Mortality outlier alert: Craniotomy for trauma (case status as at 19-Nov-14)* | - | - | *No evidence of risk* |
| | *MORTFNOF* | *Mortality outlier alert: Fracture of neck of femur (hip) (case status as at 19-Nov-14)* | - | - | *No evidence of risk* |
| | *MORTHFREP* | *Mortality outlier alert: Head of femur replacement (case status as at 19-Nov-14)* | - | - | *No evidence of risk* |
| | *MORTHIPREP* | *Mortality outlier alert: Hip replacement (case status as at 19-Nov-14)* | - | - | *No evidence of risk* |
| | *MORTINTINJ* | *Mortality outlier alert: Intracranial injury (case status as at 19-Nov-14)* | - | - | *No evidence of risk* |
| | *MORTOFRA* | *Mortality outlier alert: Other fractures (case status as at 19-Nov-14)* | - | - | *No evidence of risk* |
| | *MORTREDFB* | *Mortality outlier alert: Reduction of fracture of bone (case status as at 19-Nov-14)* | - | - | *No evidence of risk* |
| | *MORTREDFBL* | *Mortality outlier alert: Reduction of fracture of bone (upper/lower limb) (case status as at 19-Nov-14)* | - | - | *No evidence of risk* |
| | *MORTREDFNOF* | *Mortality outlier alert: Reduction of fracture of neck of femur (case status as at 19-Nov-14)* | - | - | *No evidence of risk* |
| | *MORTSHUN* | *Mortality outlier alert: Shunting for hydrocephalus (case status as at 19-Nov-14)* | - | - | *No evidence of risk* |
| | COM_VASCU | Composite indicator: In-hospital mortality - Vascular conditions and procedures | - | - | No evidence of risk |
| | *HESMORT23CU* | *In-hospital mortality: Vascular conditions (01-May-13 to 30-Apr-14)* | - | - | *No evidence of risk* |
| | *MORTAMPUT* | *Mortality outlier alert: Amputation of leg (case status as at 19-Nov-14)* | - | - | *No evidence of risk* |
| | *MORTANEUR* | *Mortality outlier alert: Aortic, peripheral, and visceral artery aneurysms (case status as at 19-Nov-14)* | - | - | *No evidence of risk* |
| | *MORTCLIP* | *Mortality outlier alert: Clip and coil aneurysms (case status as at 19-Nov-14)* | - | - | *No evidence of risk* |
| | *MORTOFB* | *Mortality outlier alert: Other femoral bypass (case status as at 19-Nov-14)* | - | - | *No evidence of risk* |
| | *MORTPVA* | *Mortality outlier alert: Peripheral and visceral atherosclerosis (case status as at 19-Nov-14)* | - | - | *No evidence of risk* |
| | *MORTREPAAA* | *Mortality outlier alert: Repair of abdominal aortic aneurysm (AAA) (case status as at 19-Nov-14)* | - | - | *No evidence of risk* |
| | *MORTTOFA* | *Mortality outlier alert: Transluminal operations on the femoral artery (case status as at 19-Nov-14)* | - | - | *No evidence of risk* |


Indicators displaying * represent a suppressed value between 1 and 5

| Section | ID | Indicators | Observed | Expected | Risk? |
|---|---|---|---|---|---|
| Maternity and women's health | MATELECCS | Maternity outlier alert: Elective Caesarean section (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | MATEMERCS | Maternity outlier alert: Emergency Caesarean section (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | MATSEPSIS | Maternity outlier alert: Puerperal sepsis and other puerperal infections (case status as at 19-Nov-14) | - | - | No evidence of risk |
| Re-admissions | MATMATRE | Maternity outlier alert: Maternal readmissions (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | MATNEORE | Maternity outlier alert: Neonatal readmissions (case status as at 19-Nov-14) | - | - | No evidence of risk |
| | COM_ELRE_ON | Composite indicator: Emergency readmissions with an overnight stay following an elective admission (01-Apr-13 to 31-Mar-14) | - | - | Elevated risk |
| | *HESELRE_ON* | *Emergency readmissions with an overnight stay following an elective admission (Cross sectional) (01-Apr-13 to 31-Mar-14)* | *1105* | *904.45* | *Risk* |
| | *HESELRECU_ON* | *Emergency readmissions with an overnight stay following an elective admission (CUSUM) (01-Jan-14 to 31-Mar-14)* | *-* | *-* | *Elevated risk* |
| | COM_EMRE_ON | Composite indicator: Emergency readmissions with an overnight stay following an emergency admission (01-Apr-13 to 31-Mar-14) | - | - | No evidence of risk |
| | *HESEMRE_ON* | *Emergency readmissions with an overnight stay following an emergency admission (Cross sectional) (01-Apr-13 to 31-Mar-14)* | *3625* | *3359.59* | *No evidence of risk* |
| | *HESEMRECU_ON* | *Emergency readmissions with an overnight stay following an emergency admission (CUSUM) (01-Jan-14 to 31-Mar-14)* | *-* | *-* | *No evidence of risk* |
| PROMs | PROMS52 | PROMs EQ-5D score: Groin Hernia Surgery (01-Apr-13 to 31-Mar-14) | Not included | Not included | Not included |
| | PROMS_HIP | Composite of hip related PROMS indicators (01-Apr-13 to 31-Mar-14) | Not included | Not included | Not included |
| | *PROMS53* | *PROMs EQ-5D score: Hip Replacement (PRIMARY) (01-Apr-13 to 31-Mar-14)* | *Not included* | *Not included* | *Not included* |
| | *PROMS54* | *PROMs Oxford score: Hip Replacement (PRIMARY) (01-Apr-13 to 31-Mar-14)* | *Not included* | *Not included* | *Not included* |
| | PROMS_KNEE | Composite of knee related PROMS indicators (01-Apr-13 to 31-Mar-14) | Not included | Not included | Not included |
| | *PROMS55* | *PROMs EQ-5D score: Knee Replacement (PRIMARY) (01-Apr-13 to 31-Mar-14)* | *Not included* | *Not included* | *Not included* |
| | *PROMS56* | *PROMs Oxford score: Knee Replacement (PRIMARY) (01-Apr-13 to 31-Mar-14)* | *Not included* | *Not included* | *Not included* |
| Audit | NHFD01 | The proportion of cases assessed as achieving compliance with all nine standards of care measured within the National Hip Fracture Database. (01-Jan-13 to 31-Dec-13) | 0.16 | 0.6 | Elevated risk |
| | SSNAPD02 | SSNAP Domain 2: overall team-centred rating score for key stroke unit indicator (01-Apr-14 to 30-Jun-14) | Level C | - | No evidence of risk |

| Section | ID | Indicators | Observed | Expected | Risk? |
|---|---|---|---|---|---|
| Compassionate care | IPSURTALKWOR | Inpatient Survey Q34 "Did you find someone on the hospital staff to talk to about your worries and fears?" (Score out of 10) (01-Jun-13 to 31-Aug-13) | 6.02 | - | No evidence of risk |
| | IPSURSUPEMOT | Inpatient Survey Q35 "Do you feel you got enough emotional support from hospital staff during your stay?" (Score out of 10) (01-Jun-13 to 31-Aug-13) | 6.92 | - | No evidence of risk |
| Meeting physical needs | IPSURHELPEAT | Inpatient Survey Q23 "Did you get enough help from staff to eat your meals?" (Score out of 10) (01-Jun-13 to 31-Aug-13) | 6.96 | - | No evidence of risk |
| | IPSURINVDECI | Inpatient Survey Q32 "Were you involved as much as you wanted to be in decisions about your care and treatment?" (Score out of 10) (01-Jun-13 to 31-Aug-13) | 7.35 | - | No evidence of risk |
| | IPSURCNTPAIN | Inpatient Survey Q39 "Do you think the hospital staff did everything they could to help control your pain?" (Score out of 10) (01-Jun-13 to 31-Aug-13) | 8.2 | - | No evidence of risk |
| Overall experience | IPSUROVERALL | Inpatient Survey Q68 "Overall..." (I had a very poor/good experience) (Score out of 10) (01-Jun-13 to 31-Aug-13) | 8.01 | - | No evidence of risk |
| | FFTNHSESCORE | NHS England inpatients score from Friends and Family Test (% change) (01-Aug-13 to 31-Jul-14) | 0.3% Short Term - 1.6% Long Term | - | No evidence of risk |
| Treatment with dignity and respect | IPSURRSPDIGN | Inpatient Survey Q67 "Overall, did you feel you were treated with respect and dignity while you were in the hospital?" (Score out of 10) (01-Jun-13 to 31-Aug-13) | 8.87 | - | No evidence of risk |
| Trusting relationships | IPSURCONFDOC | Inpatient Survey Q25 "Did you have confidence and trust in the doctors treating you?" (Score out of 10) (01-Jun-13 to 31-Aug-13) | 8.95 | - | No evidence of risk |
| | IPSURCONFNUR | Inpatient Survey Q28 "Did you have confidence and trust in the nurses treating you?" (Score out of 10) (01-Jun-13 to 31-Aug-13) | 8.43 | - | No evidence of risk |
| A&E Survey | AESURWAIT | A&E Survey Q7: From the time you first arrived at the A&E Department, how long did you wait before being examined by a doctor or nurse? (01-Jan-14 to 31-Mar-14) | 5.9 | - | No evidence of risk |
| | AESURCONFID | A&E Survey Q14: Did you have confidence and trust in the doctors and nurses examining and treating you? (01-Jan-14 to 31-Mar-14) | 8.66 | - | No evidence of risk |
| | AESURPRIV | A&E Survey Q18: Were you given enough privacy when being examined or treated? (01-Jan-14 to 31-Mar-14) | 9.25 | - | No evidence of risk |
| | AESURATTENT | A&E Survey Q19: If you needed attention, were you able to get a member of medical or nursing staff to help you? (01-Jan-14 to 31-Mar-14) | 7.57 | - | No evidence of risk |
| | AESURREASS | A&E Survey Q22: If you were feeling distressed while you were in the A&E Department, did a member of staff help to reassure you? (01-Jan-14 to 31-Mar-14) | 6.6 | - | No evidence of risk |
| | AESURPAIN | A&E Survey Q30: Do you think the hospital staff did everything they could to help control your pain? (01-Jan-14 to 31-Mar-14) | 8.02 | - | No evidence of risk |
| | AESURCONT | A&E Survey Q41: Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the A&E Department? (01-Jan-14 to 31-Mar-14) | 6.48 | - | No evidence of risk |
| | AESURDIGRES | A&E Survey Q42: Overall, did you feel you were treated with respect and dignity while you were in the A&E Department? (01-Jan-14 to 31-Mar-14) | 8.96 | - | No evidence of risk |



Indicators displaying * represent a suppressed value between 1 and 5

| Section | ID | Indicators | Observed | Expected | Risk? |
|---|---|---|---|---|---|
| Access measures | COM_AD_A&E | Composite indicator: A&E waiting times more than 4 hours (01-Jul-14 to 30-Sep-14) | - | - | No evidence of risk |
| | *AD_A&E13* | *Proportion of patients spending more than 4 hours in Type 1 only A&E departments from arrival to discharge, transfer or admission (01-Jul-14 to 30-Sep-14)* | *0.05* | *0.05* | *No evidence of risk* |
| | *AD_A&E14* | *Proportion of patients spending more than 4 hours in Type 2 only A&E departments from arrival to discharge, transfer or admission (01-Jul-14 to 30-Sep-14)* | *Not included* | *Not included* | *Not included* |
| | *AD_A&E15* | *Proportion of patients spending more than 4 hours in Type 3 only A&E departments from arrival to discharge, transfer or admission (01-Jul-14 to 30-Sep-14)* | *0* | *0.05* | *No evidence of risk* |
| | COM_RTT | Composite indicator: Referral to treatment (01-Jul-14 to 31-Jul-14) | - | - | No evidence of risk |
| | *RTT_01* | *Monthly Referral to Treatment (RTT) waiting times for completed admitted pathways (on an adjusted basis): percentage within 18 weeks (01-Jul-14 to 31-Jul-14)* | *85.6%* | *88.4%* | *No evidence of risk* |
| | *RTT_02* | *Monthly Referral to Treatment (RTT) waiting times for completed non-admitted pathways: percentage within 18 weeks (01-Jul-14 to 31-Jul-14)* | *96.3%* | *95.8%* | *No evidence of risk* |
| | *RTT_03* | *Monthly Referral to Treatment (RTT) waiting times for incomplete pathways: percentage within 18 weeks (01-Jul-14 to 31-Jul-14)* | *92.0%* | *93.2%* | *No evidence of risk* |
| | DIAG6WK01 | Diagnostics waiting times: patients waiting over 6 weeks for a diagnostic test (01-Jul-14 to 31-Jul-14) | 0.006 | 0.017 | No evidence of risk |
| | WT_CAN26 | All cancers: 62 day wait for first treatment from urgent GP referral (01-Apr-14 to 30-Jun-14) | 0.87 | 0.85 | No evidence of risk |
| | WT_CAN27 | All cancers: 62 day wait for first treatment from NHS cancer screening referral (01-Apr-14 to 30-Jun-14) | 0.9 | 0.9 | No evidence of risk |
| | WT_CAN22 | All cancers: 31 day wait from diagnosis (01-Apr-14 to 30-Jun-14) | 0.98 | 0.96 | No evidence of risk |
| | CND_OPS02 | The proportion of patients whose operation was cancelled (01-Apr-14 to 30-Jun-14) | 0.016 | 0.008 | No evidence of risk |
| | CND_OPS01 | The number of patients not treated within 28 days of last minute cancellation due to non-clinical reason (01-Apr-14 to 30-Jun-14) | 0.028 | 0.051 | No evidence of risk |
| | AMBTURN06 | Proportion of ambulance journeys where the ambulance vehicle remained at hospital for more than 60 minutes (01-Apr-14 to 30-Apr-14) | 0.024 | 0.024 | No evidence of risk |
| Discharge and Integration | DTC40 | Ratio of the total number of days delay in transfer from hospital to the total number of occupied beds (01-Apr-14 to 30-Jun-14) | 0.006 | 0.023 | No evidence of risk |
| Patient-led assessments of the care environment | COM_PLACE | Composite of PLACE indicators (29-Jan-14 to 17-Jun-14) | - | - | No evidence of risk |
| | *PLACE01* | *PLACE score for cleanliness of environment (29-Jan-14 to 17-Jun-14)* | *0.96* | *0.97* | *No evidence of risk* |
| | *PLACE02* | *PLACE score for food (29-Jan-14 to 17-Jun-14)* | *0.88* | *0.89* | *No evidence of risk* |
| | *PLACE03* | *PLACE score for privacy, dignity and well being (29-Jan-14 to 17-Jun-14)* | *0.87* | *0.87* | *No evidence of risk* |
| | *PLACE04* | *PLACE score for facilities (29-Jan-14 to 17-Jun-14)* | *0.93* | *0.92* | *No evidence of risk* |

| Section | ID | Indicators | Observed | Expected | Risk? |
|---|---|---|---|---|---|
| Reporting culture | NRLSL08 | Consistency of reporting to the National Reporting and Learning System (NRLS) (01-Oct-13 to 31-Mar-14) | 6 months of reporting | - | No evidence of risk |
| | COM_SUSDQ | Data quality of trust returns to the HSCIC (01-Apr-14 to 30-Jun-14) | - | - | No evidence of risk |
| | *SUSA&E02* | *Percentage of Secondary Uses Service (SUS) records for Accident and Emergency care with valid entries in mandatory fields. (01-Apr-14 to 30-Jun-14)* | *92.8%* | *96.7%* | *No evidence of risk* |
| | *SUSAPC02* | *Percentage of Secondary Uses Service (SUS) records for inpatient care with correct entries in mandatory fields. (01-Apr-14 to 30-Jun-14)* | *95.9%* | *97.3%* | *No evidence of risk* |
| | *SUSOP02* | *Percentage of Secondary Uses Service (SUS) records for outpatient care with valid entries in mandatory fields. (01-Apr-14 to 30-Jun-14)* | *94.2%* | *97.3%* | *No evidence of risk* |
| | FFTRESP02 | Inpatients response percentage rate from NHS England Friends and Family Test (01-Aug-13 to 31-Jul-14) | 34.8% | 32.9% | No evidence of risk |
| Partners | MONITOR01 | Monitor - Governance risk rating (09-Sep-14 to 09-Sep-14) | Not included | Not included | Not included |
| | MONITOR02 | Monitor - Continuity of service rating (09-Sep-14 to 09-Sep-14) | Not included | Not included | Not included |
| | TDA03 | TDA - Escalation score (01-Jun-14 to 30-Jun-14) | 4. Standard oversight (limited/no delivery issues) | - | No evidence of risk |
| | NTS12 | GMC National Training Survey – trainee's overall satisfaction (26-Mar-14 to 08-May-14) | Within the middle quartile (Q2/IQR) | - | No evidence of risk |
| Staff survey | STASURBG01 | NHS Staff Survey - The proportion of staff who would recommend the trust as a place to work or receive treatment (01-Sep-13 to 31-Dec-13) | 0.68 | 0.65 | No evidence of risk |
| | NHSSTAFF04 | NHS Staff Survey - KF7. The proportion of staff who were appraised in last 12 months (01-Sep-13 to 31-Dec-13) | 0.84 | 0.83 | No evidence of risk |
| | NHSSTAFF06 | NHS Staff Survey - KF9. The proportion of staff reported receiving support from immediate managers (01-Sep-13 to 31-Dec-13) | 0.64 | 0.65 | No evidence of risk |
| | NHSSTAFF07 | NHS Staff Survey - KF10. The proportion of staff receiving health and safety training in last 12 months (01-Sep-13 to 31-Dec-13) | 0.64 | 0.75 | Risk |
| | NHSSTAFF11 | NHS Staff Survey - KF15. The proportion of staff who stated that the incident reporting procedure was fair and effective (01-Sep-13 to 31-Dec-13) | 0.64 | 0.62 | No evidence of risk |
| | NHSSTAFF16 | NHS Staff Survey - KF21. The proportion of staff reporting good communication between senior management and staff (01-Sep-13 to 31-Dec-13) | 0.29 | 0.29 | No evidence of risk |

| Section | ID | Indicators | Observed | Expected | Risk? |
|---|---|---|---|---|---|
| Staffing | ESRSIC | Composite risk rating of ESR items relating to staff sickness rates (01-Aug-13 to 31-Jul-14) | - | - | No evidence of risk |
| | *ESRSIC01* | *Proportion of days sick due to back problems in the last 12 months (01-Aug-13 to 31-Jul-14)* | *0.002* | *0.003* | *No evidence of risk* |
| | *ESRSIC02* | *Proportion of days sick due to stress in the last 12 months (01-Aug-13 to 31-Jul-14)* | *0.005* | *0.007* | *No evidence of risk* |
| | *ESRSIC03* | *Proportion of days sick in the last 12 months for Medical and Dental staff (01-Aug-13 to 31-Jul-14)* | *0.009* | *0.035* | *No evidence of risk* |
| | *ESRSIC04* | *Proportion of days sick in the last 12 months for Nursing and Midwifery staff (01-Aug-13 to 31-Jul-14)* | *0.041* | *0.042* | *No evidence of risk* |
| | *ESRSIC05* | *Proportion of days sick in the last 12 months for other clinical staff (01-Aug-13 to 31-Jul-14)* | *0.038* | *0.046* | *No evidence of risk* |
| | *ESRSIC06* | *Proportion of days sick in the last 12 months for non-clinical staff (01-Aug-13 to 31-Jul-14)* | *0.038* | *0.039* | *No evidence of risk* |
| | ESRReg | Composite risk rating of ESR items relating to staff registration (31-Jul-14 to 31-Jul-14) | - | - | No evidence of risk |
| | *ESRREG01* | *Proportion of Medical and Dental staff that hold an active professional registration (31-Jul-14 to 31-Jul-14)* | *1* | *0.99* | *No evidence of risk* |
| | *ESRREG02* | *Proportion of Nursing and Midwifery staff that hold an active professional registration (31-Jul-14 to 31-Jul-14)* | *0.97* | *0.99* | *No evidence of risk* |
| | ESRTO | Composite risk rating of ESR items relating to staff turnover (01-Aug-13 to 31-Jul-14) | - | - | No evidence of risk |
| | *ESRTUR01* | *Turnover rate (leavers) for Medical and Dental staff (01-Aug-13 to 31-Jul-14)* | *0.06* | *0.1* | *No evidence of risk* |
| | *ESRTUR02* | *Turnover rate (leavers) for Nursing and Midwifery staff (01-Aug-13 to 31-Jul-14)* | *0.18* | *0.12* | *Risk* |
| | *ESRTUR03* | *Turnover rate (leavers) for other clinical staff (01-Aug-13 to 31-Jul-14)* | *0.17* | *0.12* | *No evidence of risk* |
| | *ESRTUR04* | *Turnover rate (leavers) for all other staff (01-Aug-13 to 31-Jul-14)* | *0.13* | *0.11* | *No evidence of risk* |
| | ESRSTAB | Composite risk rating of ESR items relating to staff stability (01-Aug-13 to 31-Jul-14) | - | - | No evidence of risk |
| | *ESRSTA01* | *Stability Index for Medical and Dental staff (01-Aug-13 to 31-Jul-14)* | *0.98* | *0.94* | *No evidence of risk* |
| | *ESRSTA02* | *Stability Index for Nursing and Midwifery staff (01-Aug-13 to 31-Jul-14)* | *0.85* | *0.9* | *No evidence of risk* |
| | *ESRSTA03* | *Stability Index for other clinical staff (01-Aug-13 to 31-Jul-14)* | *0.86* | *0.9* | *No evidence of risk* |
| | *ESRSTA04* | *Stability Index for non clinical staff (01-Aug-13 to 31-Jul-14)* | *0.88* | *0.91* | *No evidence of risk* |
| | ESRSUP | Composite risk rating of ESR items relating to staff support/ supervision (01-Aug-13 to 31-Jul-14) | - | - | No evidence of risk |
| | *ESRSUP01* | *Ratio of Band 6 Nurses to Band 5 Nurses (01-Aug-13 to 31-Jul-14)* | *0.56* | *0.4* | *No evidence of risk* |
| | *ESRSUP02* | *Ratio of Charge Nurse/ Ward Sister (Band 7) to Band 5/6 Nurses (01-Aug-13 to 31-Jul-14)* | *0.22* | *0.18* | *No evidence of risk* |
| | *ESRSUP03* | *Proportion of all ward staff who are registered nurses (01-Aug-13 to 31-Jul-14)* | *0.78* | *0.68* | *No evidence of risk* |
| | *ESRSUP04* | *Ratio of consultant doctors to non-consultant doctors (01-Aug-13 to 31-Jul-14)* | *0.66* | *0.66* | *No evidence of risk* |
| | *ESRSUP05* | *Ratio of band 7 Midwives to band 5/6 Midwives (01-Aug-13 to 31-Jul-14)* | *0.36* | *0.26* | *No evidence of risk* |
| | ESRSTAFF | Composite risk rating of ESR items relating to ratio: Staff vs bed occupancy (01-Aug-13 to 31-Jul-14) | - | - | No evidence of risk |
| | *ESRRAT01* | *Ratio of all medical and dental staff to occupied beds (number of beds per staff) (01-Aug-13 to 31-Jul-14)* | *3.43* | *4.6* | *No evidence of risk* |
| | *ESRRAT02* | *Ratio of all nursing staff to occupied beds (number of beds per staff) (01-Aug-13 to 31-Jul-14)* | *2* | *2.23* | *No evidence of risk* |
| | *ESRRAT03* | *Ratio of all other clinical staff to occupied beds (number of beds per staff) (01-Aug-13 to 31-Jul-14)* | *1.65* | *2.07* | *No evidence of risk* |
| | *ESRRAT04* | *Ratio of all midwifery staff to births (number of births per staff) (01-Aug-13 to 31-Jul-14)* | *23.88* | *28.23* | *No evidence of risk* |
| | FLUVAC01 | Healthcare Worker Flu vaccination uptake (01-Sep-13 to 31-Jan-14) | 0.44 | 0.59 | No evidence of risk |

| Section | ID | Indicators | Observed | Expected | Risk? |
| --- | --- | --- | --- | --- | --- |
| Qualitative intelligence | WHISTLEBLOW | Whistleblowing alerts (18-Jul-13 to 29-Sep-14) | 0 | - | No evidence of risk |
| | GMC | GMC - Enhanced monitoring (01-Mar-09 to 22-Jul-14) | - | - | No evidence of risk |
| | SAFEGUARDING | Safeguarding concerns (23-Sep-13 to 22-Sep-14) | - | - | No evidence of risk |
| | SYE | CQC Share Your Experience - the number of negative comments is high relative to positive comments (09-Sep-13 to 08-Sep-14) | 10 | 9.11 | No evidence of risk |
| | NHSCHOICES | NHS Choices - the number of negative comments is high relative to positive comments (01-May-13 to 30-Apr-14) | 24 | 17.89 | No evidence of risk |
| | P_OPINION | Patient Opinion - the number of negative comments is high relative to positive comments (28-May-13 to 27-May-14) | 1 | 4.01 | No evidence of risk |
| | CQC_COM | CQC complaints (23-Sep-13 to 22-Sep-14) | 42 | 46.02 | No evidence of risk |
| | PROV_COM | Provider complaints (01-Apr-13 to 31-Mar-14) | 1083 | 868.37 | No evidence of risk |

St George's Healthcare NHS Trust

**REPORT TO THE TRUST BOARD 18th December 2014**

| | |
|---|---|
| **Paper Title:** | Care & Environment Report |
| **Sponsoring Director:** | Eric Munro, Joint Director Estates & Facilities |
| **Author:** | Sharon Welby, Assistant Director of Capital Projects |
| **Purpose:** | To update the Board on progress with improving care and the environment across the Trust |
| **Action required by the board:** | For information |
| **Document previously considered by:** | None |

**Executive summary**

1. **Key messages:** Improvements to the Hospital Environment & Medical Equipment from 1st September to 10th December 2014

**Capital Developments:**

**Paediatric Step Down Unit, Ocean Ward, 5th floor Lanesborough Wing: Project Value £35,000**
A five bedded paediatric step down unit has been provided within an existing clinical space on Ocean Ward. This has included the installation of new clinical bed head services and decoration throughout. A dedicated parent's room in still under construction.

**Dragon Children's Centre: Project value £6,000**
A new paediatric clinical service has been provided in the children's outpatient department. A room that was once an office has been converted into a 2nd paediatric phlebotomy room. The project consisted of the installation of a clinical wash hand basin with compliant clinical taps and associated IPS, new vinyl flooring and general decoration throughout.

**GICU 1st floor St James Wing: Project value £5,000**
To strip out an existing en-suite shower room and install benching, data and electrical sockets to provide work stations for five staff.

**Richmond Ward AAA St James Wing: Project value £10,000**
To convert an existing doctor's office into a clinical waiting area. This involved stripping out a wash hand basin, worktops and cupboards and painting the room ready for the waiting room chairs to be moved. The existing waiting area will now be converted into a clinical area, consisting of two curtained cubicles with recliner chairs for patient assessment and examination, whilst maintaining privacy and dignity. A new wash hand basin has been installed on the adjacent corridor, to comply with infection control requirements.

**Richmond Ward Annexe 1st floor St James Wing: Project value £8,000**
A large office has been converted into two smaller offices. The works included the formation of a new stud wall, installation of fitted worktop and associated power and data. The two rooms will provide the necessary accommodation for the junior doctors who have been displaced from the AAA area on Richmond Ward, which was converted to provide additional clinical space.

**Porters Lodge ground floor Lanesborough Wing: Project value £1,500**
Two additional work stations have been provided within the existing footprint of the porters lodge. New worktop, data and electrical outlets were provided.

**Nicholls Ward 5th floor Lanesborough Wing: Project Value £6,000**
A disused bathroom has been stripped out and completely refurbished to provide a new Admissions and Discharge Lounge. New lighting, flooring and decorations were provided.

**New Departure Lounge ground floor Grosvenor Wing: Project Value £100,000**
A new departure lounge has been created where patients can wait in a pleasant environment before leaving hospital. The project involved some refurbishment works to convert the waiting area into a space that suitable for patients to wait while discharge arrangements can be made. The works included the installation of three sets of automated doors a new reception desk, pharmacy provision, new wash hand basins and new furniture. The main windows have been fitted with one way solar film and roller blinds.

**Transport Lounge – ground floor Grosvenor Wing: Project Value included above**
A small new office was created for the Manager as his previous office was used to create a corridor and to house the doors leading to the Departure Lounge corridor along with new fully compliant entrance doors being installed to the Transport Lounge.
The lounge will be staffed by two qualified nurses and one healthcare assistant from 08:30 to 21:00, Monday to Saturday.

**Neonatal Unit: Project Value £120,000.**
We have completed the enabling works and provided a new Seminar Room, Junior Doctors Room, Sisters Office and Patient Sitting Room. This is in preparation for the second phase of the project to deliver additional cot capacity.

**166 Roehampton Lane: Project Value £313,000**
Refurbishment of college accommodation to support the relocation of Paediatric out-patient services currently based at QMR.

**Capital medical equipment purchased from 19th August to 10th December 2014:**

| Description of Investment | Total costs incl VAT | Reason for purchase |
|---|---|---|
| Ventilators for Paediatric ICU | £ 116,160 | Replacement of old ventilators and moving towards standardisation of equipment. |
| Mortuary body storage system | £ 15,600 | Temporary refrigeration unit required to relieve increased pressure on service during the winter months. |
| Ultrasound scanner for Neuro ITU | £ 9,000 | Replacement of obsolete and unreliable machine. |
| Rapid infusion system for A&E | £14,338 | To replace unreliable equipment. |
| Ultrasonic bronchoscope for Endoscopy | £60,458 | To cope with increased referrals requiring EBUS. |
| Video laryngoscope for Day Surgery Unit | £7,230 | To enable intubation of complicated airways in the DSU rather than having to book main theatres. Improves patient waiting times. |
| Ultrasound scanners for cardiac theatres | £22,560 | To replace obsolete equipment and to improve patient waiting times. |

| | | |
|---|---|---|
| Gamma Camera for LBW scanning dept. | £247,000 | Replacement of old gamma camera, to enable high quality diagnostic Nuclear Medicine studies |
| Utero renal fiberscopes (x2) for urology | £27,000 | To cope with increased service demands and to replace end of lease scope |
| Anti gravity treadmill | £41,000 | Allows rehab to commence earlier whilst patient has a weight bearing restriction and reduces pain levels |
| Video laryngoscope for A&E | £7,230 | To enable intubation of complicated airways for trauma patients in A&E |

In addition to above various purchases have been made for the continuation of the multi-parameter monitor standardisation project.

2. **Recommendation:** The report is for information purposes only. The Board are asked to note the improvements to the environment and medical equipment since **August** 2014.

**Key risks identified:**

None

| | |
|---|---|
| **Related Corporate Objective:** | Strategic Aim no.6 - Continually improve our facilities and environment. Objective 19 - To continually improve efficiency of Estates and Facilities Services |
| **Related CQC Standard:** | Regulation 15 |

**Equality Impact Assessment (EIA): Has an EIA been carried out? ( Yes)**
**If yes, please provide a summary of the key findings If no, please explain you reasons for not undertaking and EIA.**

**Appendix A**

## 1. EQUALITY IMPACT ASSESSMENT FORM – INITIAL SCREENING

Headline outcomes for the Equality Delivery System (EDS)

- Better heath outcomes for all
- Improved patient access and experience
- Empowered, engaged and well-supported staff
- Inclusive leadership at all levels

| **Service/Function/Policy** | **Directorate / Department** | **Assessor(s)** | **New or Existing Service or Policy?** | **Date of Assessment** |
|---|---|---|---|---|
| | | | | |
| **1.1 Who is responsible for this service / function / policy?**<br>Eric Munro | | | | |
| **1.2 Describe the purpose of the service / function / policy?**<br>To improve the environment of the estate. | | | | |
| **1.3 Are there any associated objectives?**<br>Patient Led Assessment of the Care Environment (PLACE) | | | | |
| **1.4 What factors contribute or detract from achieving intended outcomes?**<br>N/A | | | | |
| **1.5 Does the service / policy / function / have a positive or negative impact in terms of the protected groups under the Equality Act 2010. These are Age, Disability ( physical and mental), Gender-reassignment, Marriage and Civil partnership, Pregnancy and maternity, Sex /Gender, Race (inc nationality and ethnicity), Sexual orientation, Region or belief and Human Rights**<br><br>No | | | | |
| **1.6 If yes, please describe current or planned activities to address the impact.** | | | | |
| **1.7 Is there any scope for new measures which would promote equality?**<br>N/A | | | | |
| **1.8 What are your monitoring arrangements for this policy/ service**<br>N/A | | | | |
| **1.9 Equality Impact Rating**<br><br>**2.0. Please give your reasons for this rating** | | | | |