Trust Board Meeting: Wednesday 9 July 2014

TB2014.73

<table>
<thead>
<tr>
<th>Title</th>
<th>Board Quality Report</th>
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<tbody>
<tr>
<td>Status</td>
<td>For information</td>
</tr>
<tr>
<td>History</td>
<td>This is the monthly Board Quality Report</td>
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<table>
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<tr>
<th>Board Lead(s)</th>
<th>Dr Tony Berendt, Interim Medical Director</th>
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<td>Key purpose</td>
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## Executive Summary

1. **The Board Quality Report (BQR) presents information that is as contemporary as possible, this will often include the information from the last calendar month.**

2. **In relation to key quality metrics:**
   - For 20 of the 54 quality metrics, pre-specified targets were not fully achieved in the last relevant data period. For selected metrics, trend data are provided along with brief exception reports.

3. **In relation to patient safety and clinical risk:**
   - 3 Serious Incidents Requiring Investigation (SIRI) were reported in June 2014.

4. **In relation to Quality Walk Rounds:**
   - There were 4 Quality Walk Rounds in June 2014.

5. **In relation to clinical effectiveness:**
   - The June 2014 Secondary Uses Service (SUS) update, including the Hospital Standardised Mortality Ratio (HSMR), has been re-scheduled by Dr Foster for the 4th July 2014. As a result, some metrics that had been expected for this report are not available.

6. **In relation to the Quality Governance Framework**
   - An internal audit assessment by KPMG of the Trust’s compliance with the Monitor Quality Governance Assurance Framework (QGAF) has been conducted and reported to the Audit Committee. KPMG have confirmed the Trust’s self-assessed quality governance score of 2 (this is a high quality score), and have identified some areas for further improvement.

7. **In relation to CQUINs and Quality Account Priorities:**
   - The Quality Account was published on 30 June 2014.
   - 2014/15 local CQUINs are yet to be agreed with the Oxfordshire Clinical Commissioning Group.
   - Quarter 1 achievements for the three National CQUINs of Dementia, Family and Friends Test, and Pressure Ulcer Prevention, will be reported in September.

8. **In relation to Patient Experience:**
   - The top three positive themes from the Friends and Family Test are:
     - Positive staff attitude
     - Good general quality of care
     - Good standard of nursing care
   - The key themes for improvement from complaints are as follows:
     - Patient Care (a range of issues coded as outcome of medical and surgical care and nursing care)
     - Access to services/appointments
     - Communication, information and consent

## Recommendation

The Trust Board is asked to receive this report.
Board Quality Report

1. Purpose

1.1. This paper aims to provide the Trust Board with information on the quality of care provided within the organisation, and on the measures being taken to improve quality and to provide assurance of it.

1.2. This Board Quality Report will be received for information by relevant Trust Committees (Clinical Governance Committee) following the meeting of the Board.

2. Key Quality Metrics

2.1. A suite of fifty-four key quality metrics has been identified for consideration by the Board. These are reported in dashboard format in Appendix 1.

2.2. These metrics have been chosen as they are clearly linked to the quality of clinical care provided across the organisation and data quality is felt to be satisfactory.

2.3 Trend graphs and exception reports are included in Appendix 1 in relation to selected metrics where specified thresholds have not been met (‘red-rated’) or those that are amber-rated having been green-rated in the previous period. Thresholds are drawn from a mixture of sources (national, commissioner and internal).

2.4 Where possible, data provided to the Board is as contemporaneous as possible.

3. Patient Safety and Clinical Risk

3.1. Information relating to patient safety and clinical risk is provided within the key quality metrics.

3.2. Seven Serious Incident Requiring Investigation (SIRI) reports were recommended to Oxfordshire Clinical Commissiong Group (OCCG) for closure during May 2014.

3.3. Following internal closure of a SIRI report, the report is presented to the OCCG for agreement and endorsement of both the level and quality of the investigation and the appropriateness of the recommendations to prevent a re-occurrence.

3.4. Following discussions with the OCCG, a total of 9 other SIRI reports are “not closed” due to the OCCG and Specialist Commissioning requiring further assurance.

3.5 The Trust Clinical Governance team remains in regular discussion with counterparts at OCCG about the open SIRI reports, and the quality team at the Trust Development Authority is aware and providing support.

3.6 Table 1 below provides a list of the 3 SIRIs that have been declared during June 2014. Investigations have commenced and will be reported in due course.
4. Quality Walk Rounds

4.1 There were 4 quality walk rounds in June 2014. A further walk round was rescheduled to July 2014 due to conflicts in the Executive lead’s diary.

Table 2

<table>
<thead>
<tr>
<th>Hospital Site</th>
<th>Areas Visited</th>
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<tbody>
<tr>
<td>John Radcliffe Hospital</td>
<td>Childrens ITU and HDU</td>
</tr>
<tr>
<td>Churchill Hospital</td>
<td>Genetics Laboratories</td>
</tr>
<tr>
<td></td>
<td>Physiotherapy and Occupational Therapy</td>
</tr>
<tr>
<td></td>
<td>Urology Outpatients Department</td>
</tr>
</tbody>
</table>

4.2 Key issues with the potential to affect quality or patient experience identified during the Quality Walk Rounds included concerns regarding the environment – namely storage, security, space, aesthetics, maintenance and ensuring a comfortable work environment. Issues around patient flow, capacity, access to medical notes and staff recruitment were also raised.

4.3 All issues have actions associated with them and these will be monitored through Divisional governance processes.

4.4 A review of how to manage actions following quality walk rounds is proposed for the near future.

5. Clinical Effectiveness

5.1 The June 2014 Secondary Uses Service (SUS) update, including the Hospital Standardised Mortality Ratio (HSMR), has been re-scheduled by Dr Foster for the 4th July 2014. This follows the cancellation of the May 2014 update as Dr Foster did not receive the May national data feed from the Health and Social Care Information Centre.

5.2 The Mortality Review Group is a subgroup convened under the Clinical Governance Committee to consider wider mortality-related outcomes and
learning. The group meets monthly and considers relevant mortality related alerts. In the event of a Dr Foster alert, the relevant clinical service is required to review the “trigger” for the alert, and to report to the Group.

5.3 The Chair of the Mortality Review Group has commissioned a review of the group’s function. The first steps of this review will entail visiting other Trusts to benchmark arrangements at other comparable organisations, in particular large teaching hospitals, to gain insights into best practice and ensure the Trust processes are comparable.

5.4 A review of the Mortality Review Group’s Terms of Reference will be included in the Trust Management Executive review of the Clinical Governance Committee and sub committees.

6. Quality Governance Framework

6.1 OUH has undertaken self-assessments against the Monitor Quality Governance Assurance Framework (QGAF) and initially scored 4.5. Higher scores suggest weaker governance frameworks. An external review was carried out in Autumn 2012 by RSM Tenon. Since this time, a significant body of work has been ongoing to improve quality governance. While meeting Monitor’s requirements provides a focus for activity, the improvements in quality governance have been tangible and welcome in their own right.

6.2 OUH’s self assessment in May 2014, received by Trust Board, estimated a score of 2.0.

6.3 Internal Audit (from KPMG) is in agreement that a score of 2.0 is an appropriate assessment of the current OUH position. Unsurprisingly, a number of recommendations to strengthen the position further have been made, and these have been reviewed in draft by the Audit Committee. Trust management responses are being finalised and will be reviewed and overseen by the Audit and Quality Committees.

6.4 The Trust Development Authority (TDA) have now recommended that Monitor carry out a formal review and assessment of the Trust’s QGAF governance functions as part of the Foundation Trust application process.

7. CQUINs and Quality Account

7.1 The 2013/14 Quality Account was published on 30 June 2014, as per our statutory obligations.

7.2 Local CQUINs for 2014/15 are yet to be agreed with the Clinical Commissioning Group.

7.3 The National CQUINs applicable to Oxford University Hospitals NHS Trust for 2014/15 are:
  ➢ Friends and Family Test (FFT)
7.4 Locally proposed CQUINs for 2014/15 are as follows:
- Timeliness and communication around discharge
- Care 24/7
- Physician input into the care of surgical patients
- Integrated Psychological Support for Patients

7.5 Evaluation of the CQUIN Quarter 1 achievements against agreed milestones will be reported in September 2014.

8. Experience of Patients

8.1 Information relating to the experience of patients is provided within the key quality metrics and associated exception reports.

8.2 Table 3, below provides a breakdown of the metrics related to the experience of patients in the month of May 2014. The Friends and Family Test (FFT) Net Promoter Score is calculated as the proportion of patients extremely likely to recommend the Trust’s services minus those who are neutral or negative in their recommendation.
### Table 3.

<table>
<thead>
<tr>
<th>Trust overall</th>
<th>Friends and Family Test</th>
<th>Complaints and PALS</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Net Promoter Score(^1)</td>
<td>Number of PALS contact(^2)</td>
</tr>
<tr>
<td></td>
<td>% Extremely Likely and Likely</td>
<td>Number of Formal Complaints(^3)</td>
</tr>
<tr>
<td>Inpatient, ED and maternity</td>
<td>69</td>
<td>94%</td>
</tr>
<tr>
<td>Inpatient(^6)</td>
<td>78</td>
<td>97%</td>
</tr>
<tr>
<td>MRC ED for both sites(^7)</td>
<td>56</td>
<td>91%</td>
</tr>
<tr>
<td>Inpatient</td>
<td>70</td>
<td>96%</td>
</tr>
<tr>
<td>C &amp; W Inpatients</td>
<td>63</td>
<td>90%</td>
</tr>
<tr>
<td>Maternity</td>
<td>67</td>
<td>94%</td>
</tr>
<tr>
<td>Corporate</td>
<td>Not applicable</td>
<td>46</td>
</tr>
<tr>
<td>CSS (CCTDP)</td>
<td>Not applicable</td>
<td>11</td>
</tr>
<tr>
<td>NOTSS</td>
<td>83</td>
<td>97%</td>
</tr>
<tr>
<td>S &amp; O</td>
<td>82</td>
<td>97%</td>
</tr>
</tbody>
</table>

8.3 The overall\(^8\) maternity FFT response rate is 7% in May. The Acting Chief Nurse has met with the Head of Midwifery to develop a plan in order to improve response rates and increase staff awareness of the FFT in Womens services. This includes alternative methods to comment cards for feedback and working with the Patient Experience Team to enhance promotion and advertising the FFT in the clinical areas.

8.4 The top three positive themes from the Friends and Family Test are:

- Positive staff attitude
- Good general quality of care

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\(^1\) FFT score is a net promoter score which is calculated as follows:
Proportion of respondents who would be extremely likely to recommend (response category: “extremely likely”) MINUS Proportion of respondents who would not recommend (response categories: “neither likely nor unlikely”, “unlikely” & “extremely unlikely”).

\(^2\) The figures for ‘neither likely nor unlikely’ or ‘don’t know’ have not been included.

\(^3\) There were a total of 298 PALS contacts for May 2014, which includes advice and information requests. The table does not report PALS contacts relating to advice or information requests (i.e. sign-posting) or positive feedback only.

\(^4\) Formal complaint: A complaint made to the organisation that warrants a formal investigation and written response from the Chief Executive.

\(^5\) Informal complaint: A complaint made to the organisation that requires investigation with a response directly from the Clinic Division.

\(^6\) CQUIN target response rate for inpatients in Quarter 1 = 25%

\(^7\) CQUIN target response rate for emergency departments in Quarter 2 = 15%

\(^8\) Women are asked questions about four stages in their maternity care: antenatal care, labour and birth, postnatal ward, and postnatal community care.
• Good standard of nursing care

8.5 The key themes for improvement from complaints are as follows:
• Patient Care (a range of issues coded as outcome of medical and surgical care and nursing care)
• Access to services/appointments
• Communication, information and consent

8.6 Figure 1, below, presents the Trust complaints received during 2013/14, by subject. Please note complaints can extend over more than 1 subject code and therefore will exceed the total number of complaints received.

![Trust Complaints received during 2013/14 by subject](image)

**Figure 1: Source OUH NHS Trust Complaints Management System**

8.7 The Trust-wide actions and projects to improve patient and carer experience are presented below:
• The Trust-wide Discharge Assurance Oversight Group, led by the Deputy Director of Clinical Services, coordinates compliance with the discharge policy across the Trust. A revised discharge checklist is being implemented across the Trust and the use of this will be audited in Quarter 2, to ensure it has been implemented effectively. Additionally, a nurse-led discharge process is being implemented on the Trauma and Acute General Medicine wards by 31 August 2014.
• The Outpatient Re-profiling Project is on schedule to complete the redesign of all clinic appointment scheduling profiles by the 30 September 2014. More than 1,000 clinic appointment scheduling profiles have now been reviewed and redesigned. Benefits will be reported to each service 3 months after their final profiles have been implemented with the final overall benefits report to be published once all services have completed their implementation.
The implementation of a patient- and family-centred, emergency and planned healthcare approach, for patients with dementia, is a key priority for the Trust. The Acting Chief Nurse and the Trust’s Clinical Lead for Dementia are drafting the Trust’s dementia strategy, which will clarify the Trusts vision, education and activity plan, for patients with dementia and their families.

The Trust is commissioning a customer care programme and complaints management training, through a Health Education Thames Valley (HETV) bid. The complaints investigation and administration training is to be based on the NHS complaints regulations 2009, and the recent Trust complaints review, as well as further recent national guidance in relation to complaints management. It is anticipated that the training will be delivered during September 2014. The Trust wide customer care programme, for both clinical and administrative staff, will be incorporated into the Values into Action programme, and will therefore embed the Trust’s values into every day practice in relation to customer care. The secured funding will finance a project manager to complement the existing Values Based Interviews project manager and the delivery of face to face training. This is led by the Chief Nurse Designate and the Director of Organisational Development and Workforce.

This brief analysis of the Trust’s received complaints will be expanded in the annual patient experience report. The Chief Nurse Designate will present this report to the Trust Board on 10 September 2014.

9. Infection Control

9.1 Six cases of C.difficile diarrhoea were reported during May 2014. These cases were reviewed with OCCG and Public Health England, and of them, five cases were considered ‘unavoidable’. Further clarification was requested in relation to the remaining case. Seven cases of C.difficile diarrhoea were reported during June 2014. In keeping with standard procedure, these cases will be reviewed with OCCG and Public Health England for a decision on ‘avoidability’.

9.2 One case of MRSA bacteraemia was reported during June 2014 and was determined to have been unavoidable through the joint review process.

9.3 The cleanliness of the environment in areas where patient care is delivered is assessed using the National Cleaning Score (NCS). NCS has several domains – domestic, nursing and estates. Domestic teams and nursing staff undertake regular self-assessment of the relevant domain. The Trust’s quality assurance team visits a sample of patient care areas each month, inspects the area and produces an NCS against all three domains. Over half of the Trust’s patient care areas are visited each month.

9.4 The NCS is inevitably subjective to an extent, and it is somewhat difficult to define or explain the difference between a score, for example, of 91 and 88. The Quality Committee has previously agreed a threshold for reporting of 92.
The headline figure across the Trust for the proportion of areas achieving this goal each month is included within the Board Quality Report metrics.

9.5 Figure 2, below provides additional granularity and incorporates an additional 5-point margin (amber).

![Distribution of National Cleaning Scores June 2014 (n=71, mean = 91, median = 92)](chart)

9.6 All results are fed back to ward managers and matrons. Where issues are identified by the quality assurance team that lead to immediate safety concerns, these are escalated without delay with support of the appropriate team (for example infection control).

10. Recommendation

10.1 The Board is asked to receive this report.

Dr Tony Berendt
Interim Medical Director

Report prepared by:

Annette Anderson
Head of Clinical Governance

July 2014