Trust Board: Thursday 3 November 2011

TB2011.56

Title	**Quality Report**

Purpose of paper	This report updates the Trust Board on the quality of care drawn from indicators and information collated for the month of September and activity during September and October. The report is divided into four sections: Updates from across the ORH and particularly the six Divisions Safety; Effectiveness; and Patient experience The report also includes updates on activity in the across the ORH aimed at delivering quality improvements and in tackling some areas for specific improvements. The safety and quality scorecard and nursing quality scorecards and the 'three by three' matrix are brought together as appendices.
Board Lead(s)	Mrs Elaine Strachan-Hall, Chief Nurse Professor Edward Baker, Medical Director

Key purpose	Strategy	**Assurance**	Policy	**Performance**
Strategic Objectives	SO1 To provide high quality general acute healthcare services to the population of Oxfordshire SO2 To provide high quality specialist services to the population of Oxfordshire and beyond SO3 To be a patient-centred organisation providing high quality and compassionate care – "delivering compassionate excellence"			
Links to Board Assurance Framework/Trust Key Risks/CQC Registration	Registration with CQC requires compliance with 16 regulations that impact on quality, safety and risks NHSLA Risk management standards			

Resource and financial impact	Not applicable
Consideration of reputational/legal/ equality/diversity/engagement/risk issues	Not applicable

At A Glance ......

	Target (where applicable)	Year to date	September 2011	
Safety				
C Diff infections	71	48	9	Performance on track
MRSA bacteraemia	3	3	1	Performance on track
SIRIS August	-	22	5	
Effectiveness				
	July	August	September	
Safe wards	100%	100%	100%	→
Supportive measures	0	0	0	
Wards receiving intensive support	0	0	0	
Patient experience				
	July	August	September	
Positive feedback	54.3%	63.6%	61.7%	↓
Neutral comment	29%	25.7%	26.2%	↑
Negative comment	16.6%	10.7%	12.1%	↑
Totals rec'd	933	1381	1145	↓
Complaints	47	71	60	↓
% complaints responded to in 25 w'g days	98%	99%	97%	

↓ Reduced numbers and performance improved over previous month	→ no change/no statistical significant	↑ increased numbers and performance worse than previous month

Introduction

1. This report updates the Trust Board on the quality, safety and effectiveness of care drawn from indicators and information collated for the month of September and October (where available).

Safety, quality and risk

2. This section covers a number of areas that are included in the attached scorecard which has variety of indicators relating to safety, quality and risk, including SIRIs, complaints, mortality, safety walk rounds, medication incidents and staff safety.

3. Seven SIRIs were investigated in September and of these, six related to pressure ulcers and the seventh was reported as a pulmonary embolus.

SIRI reference	Nature/Cause
066, 067, 068, 069, 071, 072	Hospital acquired grade 2 sacral pressure ulcer progressed to grade 3, hospital acquired grade 4,3 and 2 pressure ulcer to heels and humerus (plaster cast a contributing factor for the fractured humerus and anti-embolic stockings for one incident relating to the heel).
070	Pulmonary embolus in part one of a death certificate

Quality Walk Rounds

4. During September 2011, 7 programmed walk rounds were completed in the following areas:

   Radiology (HGH)

   Chipping Norton Maternity Unit

   Discharge Lounge (JR)

   MRI (JR)

   Endoscopy (JR)

   Upper GI (CH)

   Colorectal Centre (CH)

5. The issues identified in the walk rounds identified that whilst active recruitment plans were in place for staff, there were challenges with the process in some of the areas and these were being risk assessed and monitored to minimise the impact on services. Improvements to an outpatient waiting area were identified to improve patient privacy. The replacement and updating of equipment for day case unit was reported to be in the business planning cycle.

6. Of particular note as an area of good practice was the environment and facilities associated with the inpatient area (upper GI at the Churchill) and the high level of

patient feedback and satisfaction. The stability and leadership of the nursing team were also considered praiseworthy by the medical staff.

7. Recommendations to improve the monitoring of action plans produced from the walkabouts, include any revisions to the timescales of action to be agreed with the 'Plan Author' and the evidence of completed actions are to be sent to the Safety Quality and Risk Department to ensure an accurate database is maintained.

Staff Safety

8. There were three physical assaults reported on staff in August and two have been attributed to the medical condition of the patient at the time the incident occurred. The third incident was a non- medically attributed assault within the Trust and the offender was arrested and removed by the police.

9. The Security Manager is working with the Crime and Nuisance Action Team (CANAcT) in conjunction with the Ambulance and Police services about the approach to take with an aggressive patient who regularly attends the Emergency Department.

Dr Foster and HSMR

10. Following the recommendations of the hospital standardised mortality ratios (HSMR) review, the Department of Health has committed to implementing the SHMI (Summary Hospital-level Mortality Indicator) as the single hospital-level indicator for the NHS thus replacing other indicators in current use such as the HSMR and RAMI (risk adjusted mortality index).

11. The HSMR for the ORH for the time period April to June 2011 was 95 and shows a downward trajectory.

12. After rebasing, which increased reported values by 10%, the HSMR for the ORH for the year 2010 -11 was finally reported by Dr Foster as 106 which is within the expected range.

13. The SHMI is similar to the HSMR but the key differences are:

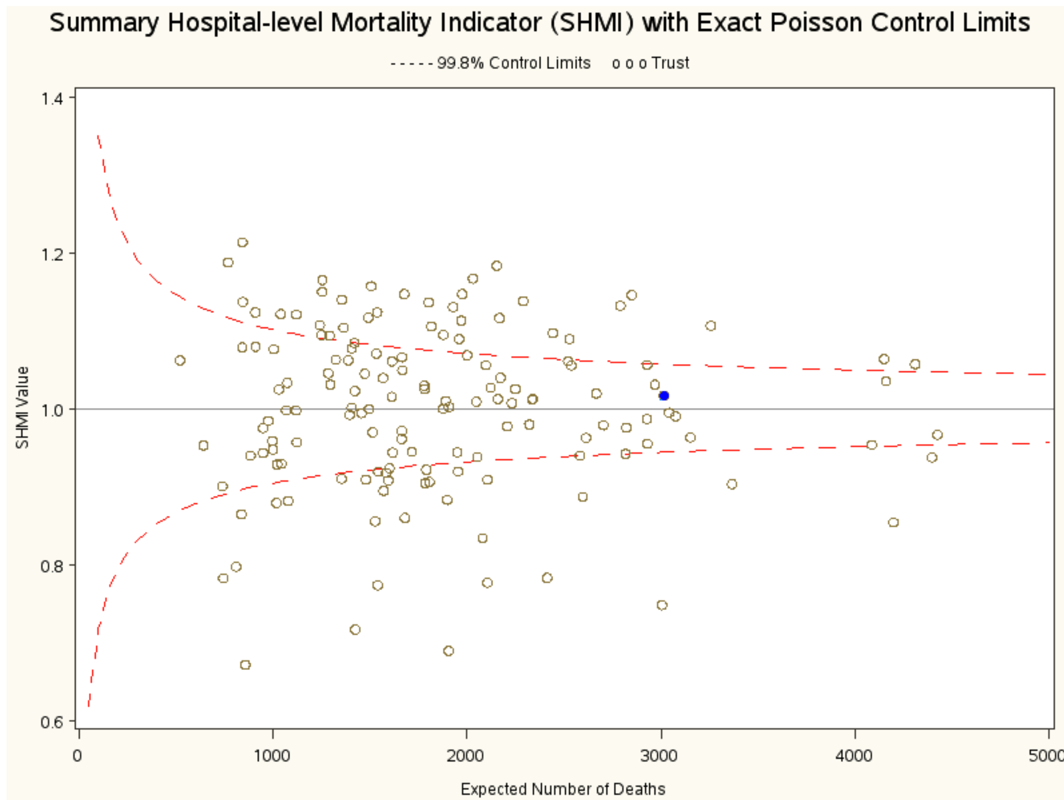
    Inclusion of out of hospital deaths up to 30 days

    Inclusion of 100% of diagnosis groups (HSMR includes only 80%)

    No account is taken of palliative care coding of patients

14. The NHS Information Centre published the SHMI for 2010-11 all acute trusts on 27th October 2011. The SHMI for the ORH was reported as 1.02, well within the expected range. There was a wider spread of results amongst acute trusts for SHMI compared to HSMR.

15. The NHS Information Centre will publish further SHMI data every quarter.



The figure shows SHMI for all acute trusts. ORH result is highlighted.

16. The SHMI will be introduced into the Dr Foster Intelligence tools but as a) it is produced quarterly rather than monthly and b) it will not be possible to drill down to analyse it using the Dr Foster tools, the HSMR will continue to be produced each month by Dr Foster Intelligence.

Control of Infection matters

MRSA Bacteraemia 2011/2012

17. The annual ORH objective for MRSA bacteraemia for 2011/2012 is 6 MRSA positive blood cultures taken 48hrs after admission.

18. The Neonatal unit in September had a baby who was initially thought to be a *staphylococcus aureus* positive blood culture, a blood sample was sent to the reference laboratory, which has reported that it is to be regarded as an MRSA positive blood culture. The baby acquired MRSA colonisation on the neonatal unit which was followed by a positive blood culture.

	Apr 11	May 11	Jun 11	July 11	Aug 11	Sep 11	Oct 11	Nov 11	Dec 11	Jan 12	Feb 12	Mar 12
Total per month	0	1	0	0	0*	1						
Monthly limit	0	1	0	1	0	1	0	1	0	1	0	1
Cum total	0	1	1	1	2	2						
Cum DH allocated limit	0	1	0	2	0	3		4	0	5	0	6

*The one bacteraemia reported in August has now been adjusted as zero. This related to a bacteraemia which Herefordshire PCT wished to be attributed to the ORH and on further challenge from the ORH the bacteraemia has remained with Herefordshire PCT.

Clostridium difficile

19. The table below includes the number of patients who **tested positive after 72hrs** of admission. It does not inform the Trust of the overall burden of *Clostridium difficile*, as it excludes positive cases from samples taken within 72hrs of admission.

	Apr 11	**May 11**	**Jun 11**	**Jul 11**	**Aug 11**	**Sep 11**	**Oct 11**	**Nov 11**	**Dec 11**	**Jan 12**	**Feb 12**	**Mar 12**
Total	5	5	8	7	14	9						
Monthly limit	12	12	12	12	12	11	11	11	11	11	11	11
Cum total	5	10	18	25	39	48						

Cum DH allocated limit	12	24	36	48	60	71	82	93	104	115	126	137

Decontamination Committee

20. The Board were previously informed of changes to the Committee and in October 2011the decontamination committee held the first meeting under its widened remit. Two sub groups have now been formed. The first will develop documentation outlining accountability for decontaminating patient equipment along with an updated cleaning manual. The second group will address the training and competency framework for staff that handle and decontaminate scopes.

21. The Decontamination Committee will meet every month and report to the Hospital Infection Control Committee.

Quality Account

22. The Quality Account for 2010/11 was published on 30th June 2011. Eight priorities were identified for the year ahead. The priorities are summarised as follows;

    Reduction of venous thromboembolism

    Reduction in pressure ulcers

    Improving medicine safety

    Mortality reduction

    Improving communication

    Improving end of life care

    Improving care for patients with dementia and delirium

    Improving care for patients with learning disabilities

23. A second public engagement event was planned for the 19 October with the purpose of providing feedback on the achievements and to start considering the priorities for 2012/13. However due poor expressions of interest from the public, the event was postponed and is planned to be held in January 2012.

24. Overall fair progress has been made with the identified priorities for 2011/12 within the categories of patient safety, clinical effectiveness and patient experience. Over the remaining six months there will be a continual focus on the proposed actions and their impact to ensure the required outcomes for patients are achieved.

Nursing and Midwifery Quality Dashboard and Safer Care Matrix

25. The Safer Care 'three by three' risk matrices are now included in the Appendix showing data for each of the six Divisions and some key points covering all Divisional activities are highlighted on the accompanying sheets.

26. The summary safer care box is included below:

All Wards	Safe Staffing > 85%	Staffing 70 - 85%	Staffing below 70%
Intensive Support (More than 3 Red)			
Supportive measures (3 Red)			
Safe Care (fewer than 3 Red)	37	36	12

Patient Experience

27. The following table provides a summary of the top five feedback issues;

Top 5 patient feedback issues	**August**	**September**
Care & service positive feedback	659	716
Concerns about aspects of care offered	236	224
Communication problems related to admissions, clinics and follow-up	43	49
Appt, treatment & discharge delays	121	113
Concerns about cleanliness of facilities (including smoking)	108	43
Source of patient experience reports	September	
Telephone calls (to PALS)		162
Comments & Suggestion Forms		53
Questionnaires completed via Hospedia patient bedside system		150
E-mails (via PALS)		71
In person (to PALS)		52
Let Us Know Your Views (Questionnaires)		53
Letters & Web feedback		10

28. Total feedback score for June, July and August are shown below.

	July		August		September	
Positive	507	54.3%	878	63.6%	707	61.7%
Neutral	271	29%	355	25.7%	299	26.2%
Negative	155	16.6%	148	10.7%	139	12.1%

29. The combined feedback from Hospedia and Let Us Know Your Views record a Trust wide recommendation rate of 98% and these two sources of patient feedback provide a very positive account of services. However three principle areas for further improvement are identified as decisions with care and treatment, staff informing patients about side effects of medicines and opportunities to talk with staff about worries and concerns.

Complaints and Organisational Learning

2011/2012	Apr 11	May 11	Jun 11	July 11	Aug 11	Sep 11	Oct 11	Nov 11	Dec 11	Jan 12	Feb 12	Mar 12
Complaints	56	61	51	47	71	60						
Cumul.	56	117	168	215	286	346						
2010/2011	67	63	88	61	50	75	62	62	72	68	68	56
Cumul.	67	130	218	279	329	391	453	515	587	655	723	779

30. Sixty new complaints were received in September which represented a 16% decrease over the August figure. The decrease was particularly reflected in the Children's and Women's and Surgery and Oncology Divisions.

31. The key themes identified in the complaints received in the Trust in September were patient care/experience, behaviour, communication, and delays/waiting times.

32. Complaints received within the Trust are managed in accordance with the ORH Complaints Policy; 97% of complaints were responded to within 25 working days, or extended if complex, with the consent of the complainant for this time period. No breaches were reported.

33. In September the Ombudsman's Office requested further documentation from the Trust after a complainant resubmitted their complaint following further local resolution.

NICE Guidance

34. NICE guidelines covering clinical (CGs), interventional procedure (IPGs), technology appraisal (TA), public health (PHG) and medical device (MTGs) are issued each month. These are sent to the appropriate Clinical Director within the Division to review for relevance, applicability and compliance. The Clinical Director is responsible for returning the compliance statement and for delivering implementation of recommendations and for the audit of implementation. A Clinical Implementation Lead (CIL) may be assigned within the Directorate.

35. If partial compliance has been declared, the CIL is responsible for undertaking the gap analysis and preparing an action plan for full compliance. Delivery against the actions will be monitored through Divisions' reports to the Clinical Audit Committee. Recommendations for any non-compliance must be reported via the Division's monthly quality reports to the Clinical Governance Committee and then to the Trust Board for ratification.

36. There were 12 new NICE guidelines issued in July 2011 (see below). The Trust has declared full compliance for seven guidelines.

37. Of the five that were reported as not applicable; two medical devices guidelines were not recommended for use by NICE and the three interventional procedures declared not applicable was because the Trust did not perform these procedures.

Guideline	July
CGs	Two issued and Trust fully compliant
IPGs	Four issued. One declared fully compliant and three not applicable.
TA	Four issued and Trust fully was compliant
PHG	None issued
MTGs	Two issued. Devices not supported by NICE

Conclusions and recommendation

38. The Board is asked to receive the report which highlights the wide range of activity across the organisation.

39. The Board is asked to note the actions being taken across the Trust.

Mrs Elaine Strachan–Hall, Chief Nurse
Professor Edward Baker, Medical Director