Trust Board Meeting: Thursday 6 September 2012

TB2012.76

Title	**Quality Report**

Status	A paper for information
History	A regular monthly report

Board Lead(s)	Professor Edward Baker, Medical Director Mrs Elaine Strachan-Hall, Chief Nurse			
Key purpose	Strategy	**Assurance**	Policy	**Performance**

Summary

1. This report updates the Trust Board on the quality of care drawn from a variety of clinical governance and nursing indicators.

2. The report includes updates on activity taking place across the OUH aimed at delivering quality improvement.

3. The following items are highlighted as key changes compared to the previous Quality Report:

1	Three Never Events have been reported since January 2012. The reports for the two completed investigation have been received by the Clinical Governance Committee and sent to NHS Oxfordshire (PCT). The investigation into the third 'never event', which came to light in July 2012 although it occurred in March 2012, has been completed. The investigation report will be completed by the w/c 10th September 2012 and submitted to the Trust Management Executive.
2	There were six SIRIs reported in July 2012 which are outlined in the report. Four relate to pressure tissue damage and all have been reported to NHS Oxfordshire and investigations have commenced. An appointment to the vacant Tissue Viability Nurse post has been made to progress the action plan to further reduce the incidence of avoidable tissue damage. Specific tissue viability training for trauma nurses is also taking place.
3	The Clinical Governance Committee receives a monthly update on progress against Quality Account Priorities and CQUIN requirements. Progress has been made in the implementation of the majority of the CQUINs.
4	A total of 74 complaints were received during July 2012.
5	From 1st August Datix has been used as the database for the recording of patient experience data. Patient feedback remains predominantly positive.
6	**Recommendation:** The Board is asked to receive and note the actions being taken.

Never Events

1. There have been three incidents related to retained swabs reported since January 2012. The reports for the two completed investigations have been received by the Clinical Governance Committee. The investigation into the third, which occurred in March 2012 and came to light in July 2012 will be completed by the 14th September 2012. Action was already in progress to assess staff competencies and review procedures in the relevant clinical areas to mitigate further risk. An independent observation and assessment of the use of the WHO Checklist has been undertaken. The Policy for Swab, Needle and Instrument Counts on swabs was reviewed and a revised policy submitted to the Clinical Governance Committee for comment, the policy is now being amended for final approval. The combined action plan relating to the first two events has been reviewed and monitored by the Clinical Governance Committee.

Patient Safety Policies

2. A paper was submitted to the Clinical Governance Committee on 15th August following a review of safety critical procedural documents, which was requested by Board in June 2012. This review identified 11 procedural documents requiring further detailed review and potential amendment to ensure they are fully satisfactory. The review of these documents is in progress and is planned to be completed by the end of September 2012.
3. A full report will be presented to a future meeting of the Board's Quality Committee.

CQUIN and Quality Account

4. The Clinical Governance Committee receives a monthly update on progress against Quality Account Priorities and CQUIN (Commissioning for Quality and Innovation requirements.) Progress has been made in the implementation of the majority of the CQUINs included in the 2012/13 contract (see table under paragraph 6).
5. CQUIN and Quality Account Priorities

   The Quality Account priorities have been aligned with CQUINs for 2012/13. These are:

   - Electronic Track and Trigger (CQUIN 6A)
   - m-Health (CQUIN 6B)
   - Digital Dermatology (CQUIN 9A)
   - Digital Laboratories (CQUIN 9B)
   - Nursing (CQUIN 13A)
   - Medicines Reconciliation (CQUIN 16)

6. Progress meeting CQUIN requirements

CQUIN Topic	Summary Description	Progress	
VTE Risk Assessment (1A)	90% of adult patients admitted to have VTE risk assessment	90% goal met for Q1 2012/13	
Composite indicator on	Performance in relation to five	In progress	

responsiveness to personal needs (2A)	questions in national CQC inpatient survey.		
Implement an IT system facilitating real time feedback from patients (3A)	Agree patient feedback strategy with commissioner including options appraisal of relevant IT systems (Q1).	A business plan to be presented to TME in October 2012.	
Safety Thermometer (4A)	Percentages of relevant patients for whom full Safety Thermometer data are available in each quarter.	Currently ahead of target. Anticipate that 100% will be submitted from Q2 onwards.	
Dementia screening, assessment and referral (5A,B,C)	Over 90% of emergency adult patients aged 75 years and over are asked dementia screening question within 72 hours of admission.	Initial discussions have been held with both EPR and Case-notes teams with a view to establishing an online form with automated prompting for relevant patients.	
Electronic Track and Trigger (6A)	Develop use of electronic track and trigger in year according to trajectory / plan agreed in Q1.	Several IT systems under evaluation.	
m-Health (6B)	Develop use of mobile phone for women with gestational diabetes	Plan agreed in Q1. .	
Oesophageal Doppler Monitoring (7A)	Gap analysis and rollout (as necessary) of ODM technology..	Clinical fellow has been identified to help develop the service Consultant lead Plan for local champions in the different units..	
Child in a Chair (8A)	Reduce waiting times for patients requiring a wheelchair.	Discussions underway with policy makers to determine how best to deliver the objective.	
Digital Dermatology (9A)	Increasing use of technology to remotely diagnose dermatological conditions.	Key deliverables for Q2, Q3 and Q4 identified	
Digital Laboratories (9B)	Increasing use of digital media (ICE system) in laboratory communication with GPs.	Initial download for dashboard successful.	
Medical Support for elderly surgical patients (10A)	Enhanced medical support for elderly surgical patients in order to reduce length of stay.	Description of work (and timing) to be clarified with PCT.	
COPD (11A)	Improved access to, and timeliness of, NIV for patients with COPD.	Work to be developed with A&E, AGM, ICU and Respiratory for all OUH sites	
Cellulitis (11B)	Enhanced outpatient treatment for cellulitis in order to reduce bed days.	Working party (incorporating ED, AGM, Infections diseases) established to carry out a baseline audit	
Liaison Psychiatry (12A)	Agree structure, appoint staff, define and deliver against KPIs.	Full business case for the service is going to SPC for approval on the 9th August 2012.	
Nursing (13A)	Ward manager development programme.	A business case has been agreed.	
Development and roll out of palliative Care Support Tool (15A)	Overall care plan and pilot tool based on Amber care bundle	Advanced Care Planning documents approved by the Clinical Governance Committee	
Medicines Reconciliation (16)	Accurately identifying the medicines that a patient is taking on admission.	Progress has been made to rollout the use of iPads to a larger group across multiple sites.	
DTOC (17A)	Mapping of existing and revised patient pathways (Q1).	Patient pathways have been mapped and accepted by the PCT.	

Serious Incidents Requiring Investigation (SIRIs) July 2012

7. There were six SIRIs in July 2012. The number and types of SIRIs are set out in the table below. These have all been reported as required shire and investigations have commenced.

SIRI Ref	Division	Area	Date of Incident	Date SIRI Opened	Grade	Detail	PCT Closure Date

2012-025	S&O	Churchill Theatres	29/03/2012	10/07/2012	Orange	Swab found in drain site wound on the 06/07/2012	PCT Closure date 3 October 2012
2012/026	S&O	OWLS	02/06/2012	12/07/2012	Orange	Cat 3 pressure ulcer to heel	PCT closure date 24 Sep 2012
2012/027	EMTA	7C	01/04/2012	20/07/2012	Orange	Cat 3 pressure damage to heels	PCT closure date 24 Sep 2012
2012/028	EMTA	Bedford Ward	21/03/2012	20/07/2012	Orange	Cat 3 pressure ulcer to right heel	PCT closure date 24 Sep 2012
2012/029	S&O	SEU E	04/07/2012	20/07/2012	Orange	Cat 3-4 pressure ulcer to left heel	PCT closure date 24 Sep 2012
2012/030	CCTADP	Molecular Haematology	May-11	27/07/2012	Red	False positive sample testing	PCT closure date 2 Oct 2012

8. The Tissue Viability action plan is being updated and interviews for the appointment of a Tissue Viability Nurse have taken place in late August.

MRSA Bacteraemia 2012/13

9. One patient was diagnosed with MRSA bacteraemia in July. The patient was transferred from her GP directly to the hospital with cellulitis and was a known MRSA carrier.

Clostridium Difficile

10. There were four cases in July 2012. All four patients improved symptomatically after treatment. The Trust is on track to meet the target of fewer than 88 cases for 2012/13. The 2011/12 target was fewer than 144 cases.

Table 1.0 Number of cases of C. diff per month against objective

	Apr 12	May 12	Jun 12	Jul 12	Aug 12	Sep 12	Oct 12	Nov 12	Dec 12	Jan 13	Feb 13	Mar 13
Total	11	13	4	4								
Monthly limit	8	8	8	8	7	7	7	7	7	7	7	7
Cum total	11	24	28	32								
Cum limit	8	16	24	32	39	46	53	60	67	74	81	88

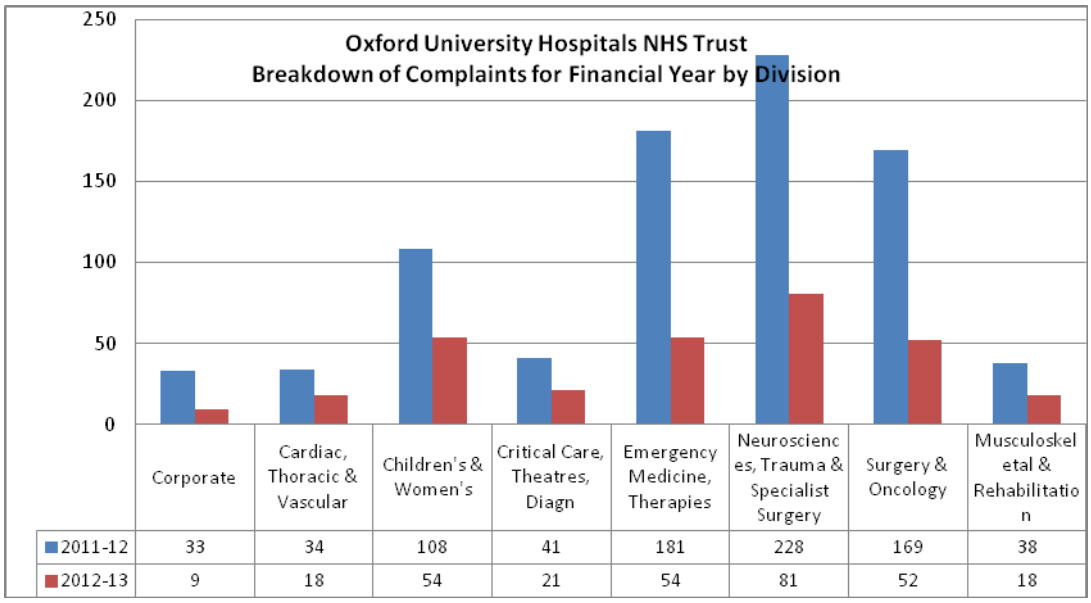
Central Alert System (CAS)

11. As of the 31st July 2012, 13 Medical Device Alerts (MDAs) and 3 National Patient Safety Alerts (NPSA) remain under review. Thirteen were issued in July 2012. Four MDA's were closed in July 2012.
12. As at 31st July 2012 3 MDAs remain open after the set closure date. One Estates and Facilities Alert was due for closure in July 2012, which was completed within the given time frame. One Department of Health (DH) Alert was due for closure in July 2012, and was completed within the given time frame.
13. NPSA: PSA/2011/001 and RRR/2011/003 concern the connectors used for spinal, epidural and regional devices. A review by all divisions using spinal, epidural and regional devices has identified the non-availability of incompatible connectors as a risk to be addressed.

Complaints

14. The number of complaints received in July (74) is increased compared to June. This increase was reflected in all but two Divisions (Emergency Medicine, Therapies and Ambulatory (EMTA) and Critical Care, Theatres, Diagnostics and Pharmacy (CCTDP). The number of complaints received by EMTA was significantly reduced on the previous month.

15. The number of complaints received by each division during the last two years is illustrated in the chart below.



	Corporate	Cardiac, Thoracic & Vascular	Children's & Women's	Critical Care, Theatres, Diagn	Emergency Medicine, Therapies	Neurosciences, Trauma & Specialist Surgery	Surgery & Oncology	Musculoskeletal & Rehabilitation
2011-12	33	34	108	41	181	228	169	38
2012-13	9	18	54	21	54	81	52	18

16. The four key themes identified remain patient care/experience, delays/waiting times (appointments, admissions discharge and transport), communication and behaviour.

New Complaints

17. Complaints are initially graded using the Department of Health grading matrix which ranges from red (most serious) through orange and yellow to green (least serious). Grading is reviewed on completion of the investigation. Of the 74 new complaints in July, there were 3 graded red, 5 orange, 35 yellow and 31 green across all Divisions.

18. In July, red complaints were received by Children and Women's Division, Neurosciences, Trauma and Specialist Surgery Division and Musculoskeletal and Rehabilitation Division.

19. The red complaint for Children and Women's concerned delay in the diagnosis of an intra-abdominal mass.

20. The red complaint for Neurosciences concerned a patient who died whilst undergoing revision of a tracheostomy.

21. The red complaint for Musculoskeletal and Rehabilitation related to a patient whose operation was delayed due to need for a blood transfusion.

22. Two red complaints were received in June. A red complaint for Surgery and Oncology was by a family that raised questions about the referral pathway for prostate cancer. A red complaint for Emergency Medicine, Therapies and Ambulatory related to a patient who was being treated for chest problems for a long time before lung cancer was diagnosed.

23. In July 100% of complaints were acknowledged within the statutory 3 workings days. All complaints received a response within 25 working days or a mutually agreed time period in line with the Trust policy.

Divisional updates on key themes and trends received in July 2012

24. The table below indicates the number of complaints received by Division in July and the themes of these complaints.

Division	Complaints received July 2012	Change on previous month					Themes: Please note one complaint may have more than one theme
Cardiac, Thoracic & Vascular	3	+1	0	1	2	0	2 Patient Care/Experience 1 Communication
Children & Women's	14	+4	1	2	6	5	9 Patient Care/Experience 2 Delays/Waiting times 2 Behaviour 1 Communication
Corporate	5	+5	0	0	1	4	2 Patient Care/Experience 1 Delays/Waiting Time 1 Behaviour 1 Equipment/Med Recs
Critical Care, Theatres, Diagnostics & Pharmacy	3	-3	0	0	1	2	3 Delays/Waiting Time
Emergency Medicine, Therapies & Ambulatory	8	-12	0	1	6	1	4 Patient Care/Experience 2 Delays/Waiting time 1 Behaviour 1 Communication
Musculoskeletal & Rehabilitation Services	6	+3	1	0	3	2	2 Patient Care/Experience 2 Delays/Waiting Time 2 Communication
Neurosciences, Trauma & Specialist Surgery	22	+7	1	0	9	12	14 Delays/Waiting time 5 Communication 3 Patient Care/Experience
Surgery & Oncology	13	+2	0	2	6	5	6 Delays/Waiting Times 5 Patient Care/Experience 2 Communication

Divisional Action following complaints

25. All Divisions continue to work with their assigned Complaint Co-ordinators to ensure that lessons learned from complaints are documented and any required changes are implemented.

26. Reports on action taken are made to the Clinical Governance Committee and the Quality Committee.

Patient Experience

27. The patient feedback report for July is compiled from the 'Let Us Know Your Views' leaflets and feedback provided to the PALS team. The transition from Safeguard to Datix as the sole means of recording patient experience feedback is now complete.

28. From the 1 August, all current methods of patient feedback is now being collated and recorded by the PALS team and Datix is used as the sole database.

29. Patient experience data has been collected from 56 questionnaires and 437 contacts with the PALS team raising a total of 755 issues. When asked, the recommendation rate of the Trust remains consistently high with only one of the 56 respondents (1.8%) indicating that they would not recommend the services offered by the OUH.

The table below provides a summary of the top four feedback issues.

Top 4 patient feedback issues	June	July
Care & service positive feedback	320	347
Concerns about aspects of care offered	128	117
Appointment, treatment and discharge delays	22	68
Environmental concerns	11	35
Source of patient experience reports	**July**	
Let Us Know Your Views (Questionnaires)	56	
Comments & Suggestions Forms	-	
Telephone calls (to PALS)	117	
In person (to PALS)	26	
Patient feedback via e-mails	14	

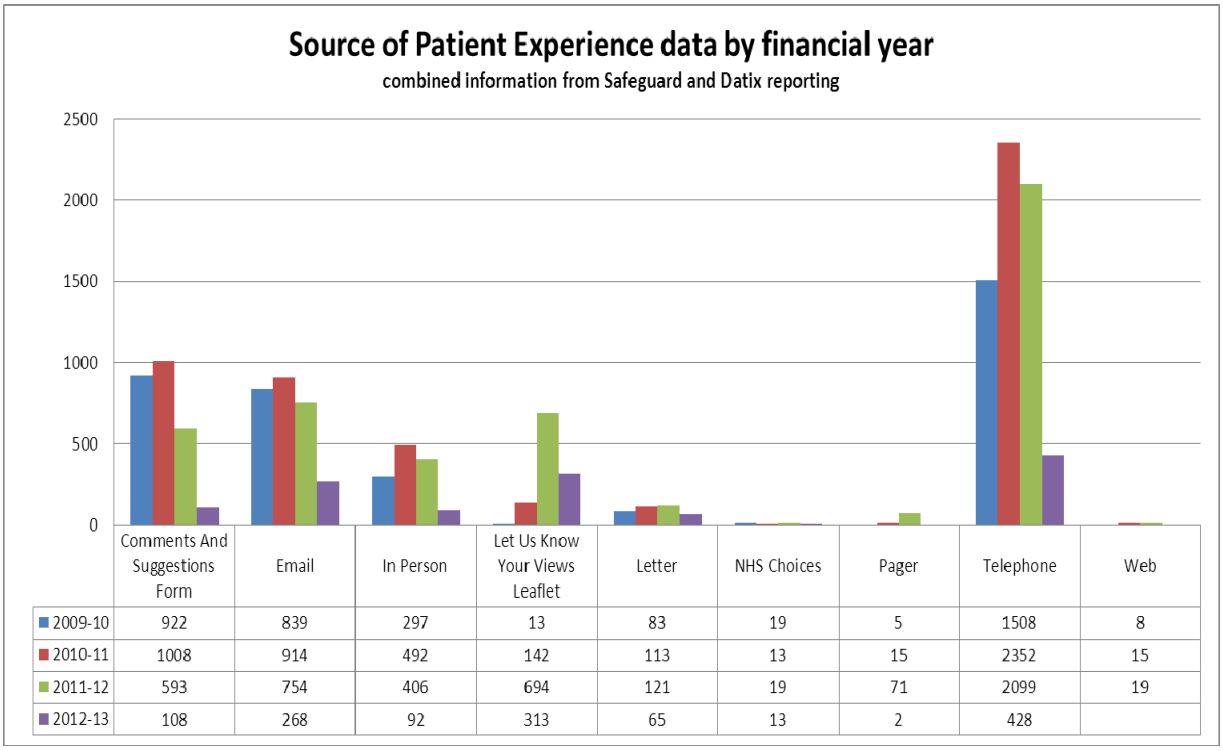
30. Total feedback issues for May, June and July 2012 are shown below:

	May		June		July	
Positive	**1589**	78.7%	**320**	**63.5.%**	**515**	**68.3%**
Neutral	**365**	18.1%	**95**	**18.9%**	**138**	**18.3%**
Negative	**66**	3.2%	**89**	**17.6%**	**101**	**13.4%**

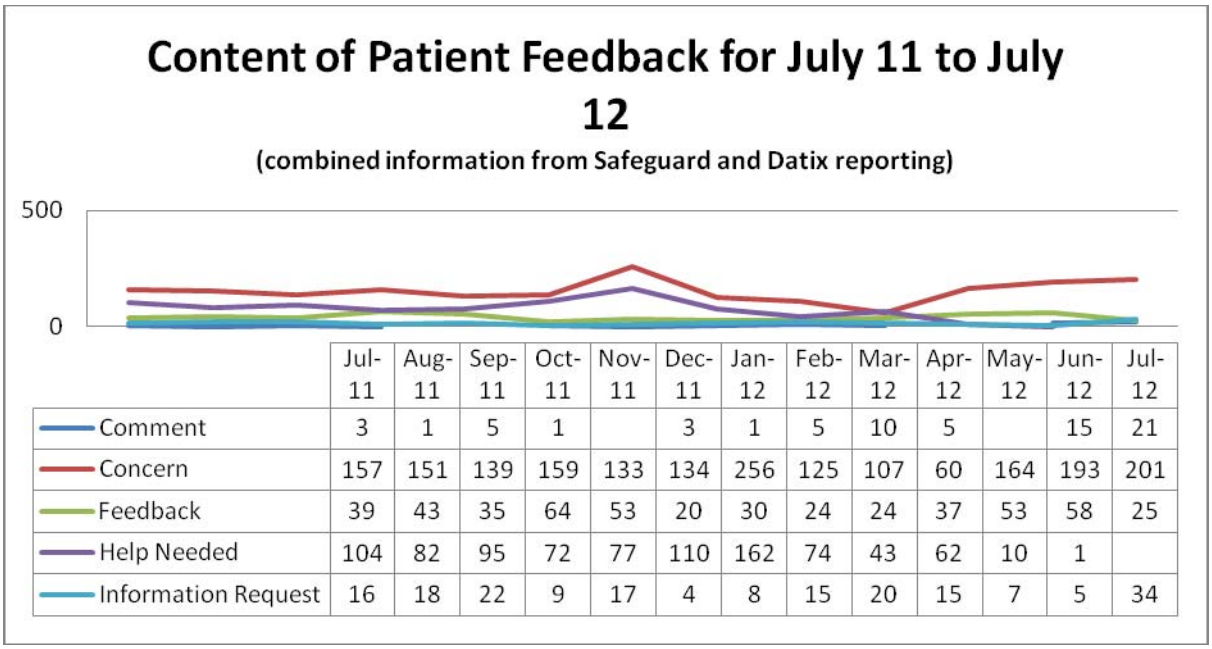
31. Key themes for positive feedback relate to the high standard of technical and diagnostic treatment and the care offered by staff.

32. Key themes for negative feedback relate to delays or cancellations in appointments and treatment or contacting the hospitals to obtain information about appointments, bookings or test results.

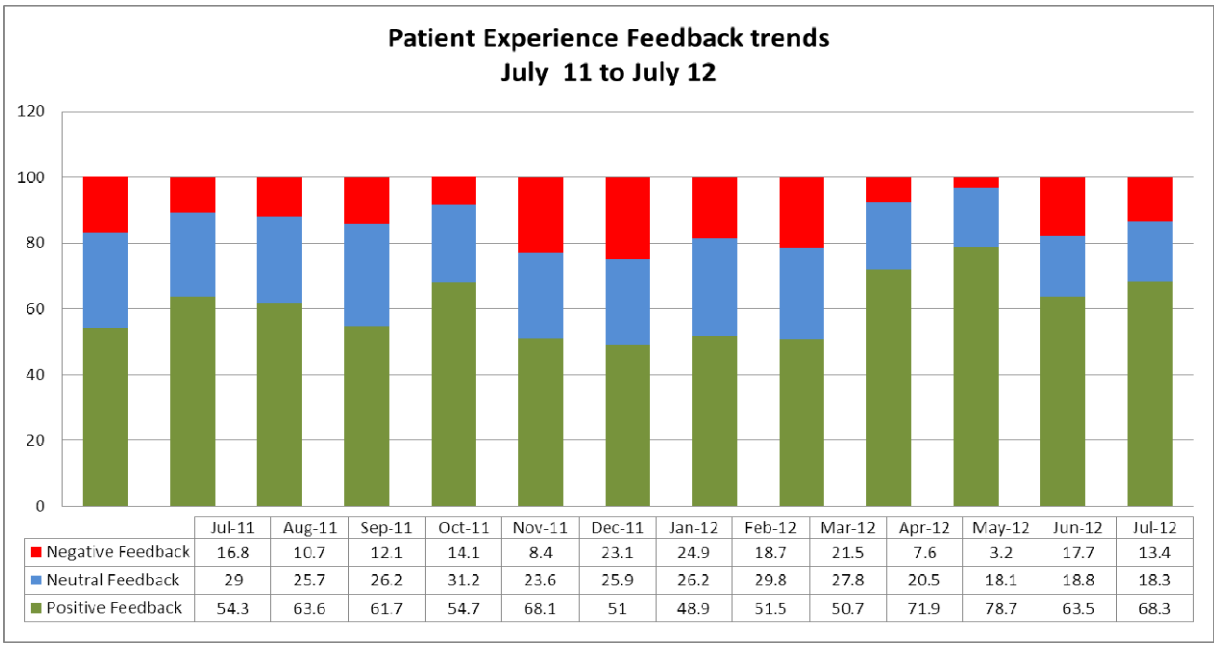
33. Key environmental concerns relate to the cleanliness of toilets in the public areas and the presence of smokers and cigarette stubs around the John Radcliffe main entrance.



	Comments And Suggestions Form	Email	In Person	Let Us Know Your Views Leaflet	Letter	NHS Choices	Pager	Telephone	Web
2009-10	922	839	297	13	83	19	5	1508	8
2010-11	1008	914	492	142	113	13	15	2352	15
2011-12	593	754	406	694	121	19	71	2099	19
2012-13	108	268	92	313	65	13	2	428	



	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12
Comment	3	1	5	1		3	1	5	10	5		15	21
Concern	157	151	139	159	133	134	256	125	107	60	164	193	201
Feedback	39	43	35	64	53	20	30	24	24	37	53	58	25
Help Needed	104	82	95	72	77	110	162	74	43	62	10	1	
Information Request	16	18	22	9	17	4	8	15	20	15	7	5	34



	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12
Negative Feedback	16.8	10.7	12.1	14.1	8.4	23.1	24.9	18.7	21.5	7.6	3.2	17.7	13.4
Neutral Feedback	29	25.7	26.2	31.2	23.6	25.9	26.2	29.8	27.8	20.5	18.1	18.8	18.3
Positive Feedback	54.3	63.6	61.7	54.7	68.1	51	48.9	51.5	50.7	71.9	78.7	63.5	68.3

Nursing and Midwifery Quality Dashboards

34. The seven quality dashboards are provided as an appendix showing data for each of the Divisions and key points covering all Divisional activities are highlighted on the accompanying sheets. The indicators on these dashboards largely relate to the issues which are sensitive to nursing interventions such as pressure tissue damage, and harm from medication errors and falls.

35. In terms of nurse staffing, each ward has completed a staffing profile for each shift and identified the optimum or agreed staffing for safe, quality nursing and midwifery care; the minimum staffing required to deliver safe care and the "at risk" level of staffing where specific risk assessment and intervention takes place, such as the provision of additional support from senior staff, moving staff from other areas and reducing beds or activity in order to provide safe care. The correlation with nurse sensitive indicators suggests that such intervention is required and is successful, in that there is little correlation with harm events.

36. The key issues during July are those of: maintaining safety where staffing falls below optimum by the use of temporary staff and (in Children's), by the planned movement of staff as part of a plan for managing staff during the summer period; addressing the acquired pressure tissue damage in Trauma services through a staff education programme and improved compliance on nutritional assessments through divisional nurse intervention and re-audit.

37. The issue of hand hygiene compliance in the critical care units related to lapses in 'bare below the elbow' from visiting staff and intensive action is being overseen by the Divisional Director and reported to the Clinical Governance Committee.

Outcomes

38. Both the Summary Hospital Mortality Index (SHMI) and Hospital Standardised Mortality Ratio (HSMR) remain within expected limits.

39. The latest SHMI is 1.00 for the time period January – December 2011. This value is reduced from 1.01 (October 2010-September 2011).

40. The observed and expected number of deaths broken down by each of the 140 diagnosis groups used in the SHMI is provided by the NHS Information Centre. It is not currently possible to drill down to patient or specialty level using this or the Dr Foster Intelligence SHMI tool.

41. The HSMR for the financial year April 2011 – March 2012 is 97.7.

42. The Trust continues to undertake a review of issues that influence the standardised mortality ratios.

43. Audit of clinical coding

    43.1 Significant progress was made by Divisions to complete the HSMR audits by the data freeze deadline (25 July 2012). The effect of this project on the HSMR will not be realised until rebasing occurs in September 2012.

    43.2 A project report was produced for the August Dr Foster Steering Group and Clinical Governance Committee. This detailed by specialty the numbers of audits completed; the percentage that required additional co-morbidity data to be resubmitted and the percentage that required a change in primary diagnosis.

    43.3 As a result of this project Oncology and Clinical Haematology have developed a proforma to collect co-morbidities for patients who attend for blood transfusions and chemotherapy. In addition the IT system 'Aria' is being examined to determine the possibility of collecting this information.

44. The Trust is continuing to develop its process for a standardised review of mortality across all specialties.

45. Speciality mortality review data will be included within the Divisional monthly Quality Reports.

Quality Account Update

46. The Trust Quality Account was published by NHS Choices on 29 July 2012 in accordance with the regulations and is available on the OUH public website[1].

47. Review of the Quality Account by the Audit Commission confirmed that the document was consistent with the regulations. As part of external assurance three key performance indicators (KPIs) were assessed by the Audit Commission and a report and actions identified during these assessments will be sent to Trust in the near future. Two of these KPIs were mandated by regulation (urgent cancer waits and VTE assessments) and one was a locally agreed performance indicator (bedside blood transfusion).

48. Sample testing of the performance indicators identified that all three performance indicators were reasonably stated in all material respects.

49. Clarification was requested in relation to:

    48.1 A clear audit trail to individual patient documentation of VTE assessments on the NOC site.

    48.2 The transfer of key data from internal sources to capture tools for bedside transfusion returns is subject to stringent quality control processes.

[1] Quality Account: http://www.ouh.nhs.uk/about/publications/documents/OUH_Quality_Account_2011-12_FINAL.pdf

50. This information has been provided by the MARS Division and the Blood Transfusion Department. The Audit Commission's final report is anticipated in the near future.

51. A summary of the Quality Account has been prepared to complement the full document. This will be uploaded onto the Trust Website and Intranet. Printed and electronic copies will be cascaded to staff through the Divisional structures.

Executive Quality Walk Rounds

52. During July2012, six walk rounds were completed in the following areas:

- Trauma Unit (John Radcliffe)
- Medical Assessment Unit (MAU) and ECG (Horton)
- Physiotherapy and Occupational Therapy (Nuffield Orthopaedic Centre)
- Neurosciences Inpatients (West Wing)
- Delivery Suite (Women's Centre)
- Gynaecology Ward (Women's Centre)

Key Issues Identified

53. The key issues identified and good practice noted will be reported in full to the Quality Committee with a note of actions taken.

Conclusions and Recommendations

54. The Board is asked to receive the report and note the actions being taken.

Professor Edward Baker, Medical Director
Elaine Strachan-Hall, Chief Nurse

September 2012

Appendices attached
Appendix 1 Nursing Dashboard