Oxford University Hospitals NHS Trust

TB2013.25

Trust Board Meeting: Tuesday 12 February 2013

Title	**Monthly Quality Report**

Status	A paper for information
History	A regular monthly report

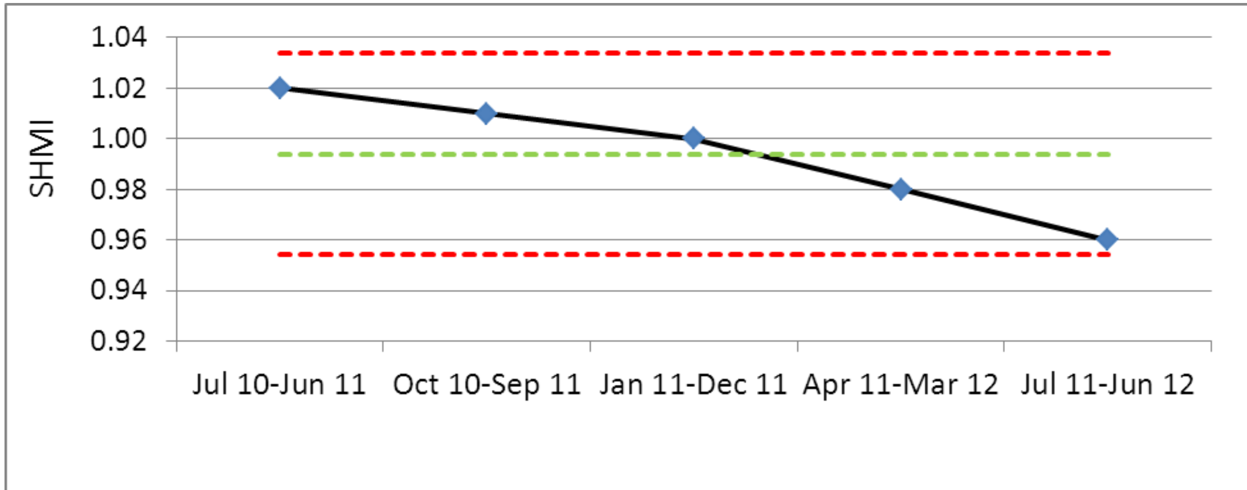
Board Lead(s)	Professor Edward Baker, Medical Director Mrs Elaine Strachan-Hall, Chief Nurse			
Key purpose	Strategy	**Assurance**	Policy	**Performance**

Summary

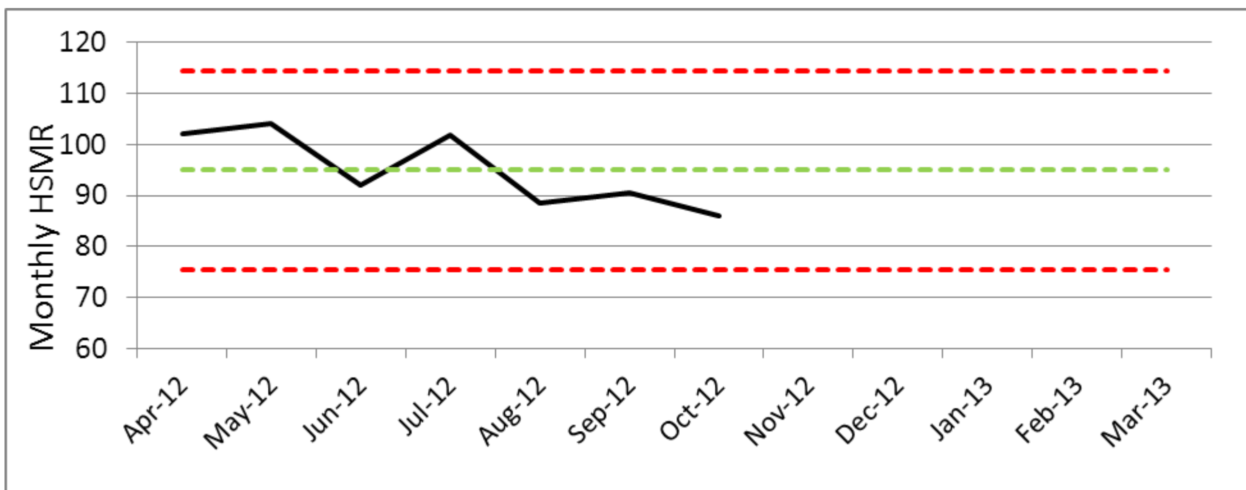
1.	**Mortality:** The SHMI and HSMR are both within expected limits. The latest SHMI published on the 14th January is 0.96.
3.	**Incidents & SIRIs**: One SIRI was reported in December 2012.
4.	**Infection Control:** MRSA bacteraemia and Clostridium difficile rates remain within the trajectory to achieve the annual target.
6.	**Executive walk rounds:** Six walk rounds were completed in December 2012. A total of 60 since April.
7.	**Complaints:** There were 58 new complaints in December 2012, none were graded red, 11 were graded orange, 29 yellow and 18 green.
8.	**Patient Experience**: The number of PALS and complaints about appointments have fallen however the majority of comments via PALS and other sources of feedback relate to appointment issues and admission or discharge. Positive comments reflect the caring, friendly and helpful attitude of staff.
9.	**Patient Safety Thermometer**: In December the NHS Patient Safety Thermometer indicated a 'harm free' rate of 94.55%.
10.	The **patient survey for the emergency department** reflects the context of the IT implementation and identifies room for improvement in waiting times and information. However the Trust was scored above (picker) average for the overall experience and staff working well together.

HSMR and SHMI Q3 Summary

1. The Summary Hospital Mortality Index (SHMI) and Hospital Standardised Mortality Ratio (HSMR) are both within expected limits.
2. The most recent SHMI covering the period July 2011 to June 2012 was published by the NHS Information Centre on 14 January 2013. It is 0.96.
3. Figure 1: Shows all reported SHMI results so far, with mean and control limits.



4. Figure 2 shows the monthly HSMR since April 2012. The HSMR for the year to date is 96.2.



5. A survey has been carried out at the OUH in October of Specialties responsible for most acute admissions namely Trauma, General Surgery, Emergency and Acute General Medicine. The conclusion was that staffing levels at weekends are sufficient and that a safe service is provided at weekends.

6. A sample of records of patients of patients admitted at weekends will be reviewed to examine the way conditions were recorded and subsequently coded.

7. A strategic goal as set out in the OUH Quality Strategy is for the Trust to be one of the top five hospitals in England for low mortality by 2017. The following activity is in place to meet this strategic goal:

   - A mortality reduction meeting was held on 3 January 2013 to examine current position and actions. Further work identified at this meeting will be confirmed over the next month.
   - Revisions have been made to the standardised mortality review process. Divisions will report summary statistics on a quarterly basis within their monthly quality reports.
   - The HSMR for 2012/13 will be reviewed by a notes audit. Work to improve the coding of primary diagnoses and Charlson Index co-morbidity coding to provide accurately coded data is on-going.

Quality Account and CQUIN Q3 Summary

8. The Trust has made progress achieving the CQUINS for 2012/13. The CQUINs for 2013/14 are being developed. These will inform the Quality Account priorities.

9. Draft Quality Account priorities will be discussed at the February Quality Committee meeting. Contribution from the general public will be received at the Patient Engagement Event on 11 March 2013 to determine the final agreed Quality Account priorities.

10. The National Quality Board has advised that the 2012/13 Quality Accounts should include a core set of quality indicators in the following domains (for acute Trusts). This data is already collected by the OUH and is listed in table 1:

Domain 1 Preventing people from dying prematurely	• Summary Hospital Level Mortality Indicator (SHMI) • % admitted whose treatment included palliative care • % admitted whose deaths included in SHMI and whose treatment included palliative care
Domain 3 Helping people to recover from episodes of ill health or following injury	• Patient reported outcomes scores for: o Groin hernia surgery o Varicose vein surgery o Hip replacement surgery o Knee replacement surgery • Emergency readmissions to hospital within 28 days of discharge
Domain 4 Ensuring that people have a positive experience of care	• Responsiveness to inpatients' personal needs • Percentage of staff who would recommend the provide to friends or family needing care
Domain 5 Treating and caring for people in a safe environment and protecting them from avoidable harm	• % of patients risk-assessed for Venous Thromboembolism • Rates of C. difficile • Reduction of patient safety incidents and % resulting in severe harm or death

11. Table 2 (below) summarises current position achieving the CQUIN and Quality Account priorities.

    11.1. CQUIN Dementia screening, assessment and referral is rated red. The following actions have been put in place:

    11.1.1. Renewed efforts have been made to achieve an electronic solution for dementia screening and cognitive assessment

    11.1.2. Currently admission data is collected via ORBIT and a staff member manually checks the completion of assessments assisted by this data download. This is done by visiting the wards concerned and checking patient files. Staff awareness posters have been used to improve assessment figures.

    11.1.3. The clerking proforma is in use in AGM and Geratology and is being extended to SEU and Trauma where the majority of these patients are cared for.

    11.1.4. This new proforma, audited December 2012, was accepted and is now in print.

    11.1.5. Funds have been allocated to support staff training. This will cover attendance at a week-long dementia course for a group of nurses followed by cascade training to all relevant staff.

    11.1.6. Funds have been secured to develop a dementia-friendly ward area on Level 7.

Table 2

CQUIN goal	Summary Description	Progress	RAG
VTE Risk Assessment (1A)	90% of adult patients admitted to have VTE risk assessment	On target.	
Composite indicator on responsiveness to personal needs (2A)	Scoring 70.2 or more in the composite measure for patient experience. (Relates to 5 in patient questions)	Picker results expected this month. System to monitor these responses and actions taken per ward will only be possible once patient feedback system is in place (see 3A).	
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). Procure / system in place by Q3	'Friends and Family Test (FFT)' – pilot on 4 wards (1 per site). Trust direction being examined by Divisional Management reps / IT / PCT / patient reps and patient experience leads.	
Safety Thermometer (4A)	Percentages of relevant patients for whom full Safety Thermometer data are available in each quarter.	On target for 100% submission from January 2013.	
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.	Process in place to collect assessment information from areas with the majority of admissions of patients as per CQUIN definition. Proforma developed and being implemented. Discussions with EPR team to expedite electronic solution.	

CQUIN goal	Summary Description	Progress	RAG
Electronic Track and Trigger (6A) ***QA PRIORITY***	Develop use of electronic track and trigger in year according to trajectory / plan agreed in Q1.	On target.	
m-Health (6B) ***QA PRIORITY***	Develop use of mobile phone for women with gestational diabetes	Ahead of target.	
Oesophageal Doppler Monitoring (7A)	Gap analysis and rollout (as necessary) of ODM technology.	On target. Procedures being agreed to assist procurement / training and audit.	
Child in a Chair (8A)	Reduce waiting times for patients requiring a wheelchair.	A plan for reducing waiting times has being shared and agreed with PCT.	
Digital Dermatology (9A) ***QA PRIORITY***	Increasing use of technology to remotely diagnose dermatological conditions.	On target.	
Digital Laboratories (9B) ***QA PRIORITY***	Increasing use of digital media (ICE system) in laboratory communication with GPs.	On target	
Medical Support for elderly surgical patients (10A)	Enhanced medical support for elderly surgical patients in order to reduce length of stay.	Original timescales have slipped. Audit of elderly patients with significant co-morbidities at JR (general surgery and vascular surgery) and NOC sent to the PCT. Plan to extend care to patients as indicated by audit findings. Summary of staffing costs is still required by the PCT.	
COPD (11A)	Improved access to, and timeliness of, NIV for patients with COPD.	On target	
Cellulitis (11B)	Enhanced outpatient treatment for cellulitis in order to reduce bed days.	Agreement to pass 10 patients through Pathway. A longer term options still being explored to further develop an integrated pathway with primary care.	
Liaison Psychiatry (12A)	Agree structure, appoint staff, define and deliver against KPIs.	2 Consultant Psychiatrists appointed and due to start in March 2013.	
Nursing (13A) ***QA PRIORITY***	Ward manager development programme. Health Care Worker Academy (Quality Account priority)	Timescales with this CQUIN have slipped. Outcome measures sent to PCT in Dec 12 confirm trajectories however evidence required by PCT Q3 and Q4 goals that highlighting performance measures / changes in practice. Bi-monthly induction in place for CSW. Beginner portfolios for band 2 CSW have been positively evaluated by staff.	
Standardisation of Spinal Pathway (14A)	Agree clinical spinal pathway with commissioners and role of standardized outcome measures (PROM)	All orthopaedic operative cases (all sites) now using Spine Tango.	

CQUIN goal	Summary Description	Progress	RAG
Development and roll out of palliative Care Support Tool (15A) ***QA PRIORITY***	Overall care plan and pilot tool based on Amber care bundle	Palliative care tool developed and piloted. Deliverables being reviewed within EMTA.	
Medicines Reconciliation (16) ***QA PRIORITY***	Accurately identifying the medicines that a patient is taking on admission.	Medicines reconciliation meeting Q3 CQUIN targets Medicines storage and security audit in Q4 2011/12. Actions plans in place within each Division.	
DTOC (17A)	Mapping of existing and revised patient pathways (Q1).	Patient pathways have been mapped and accepted by the PCT. Plan has been sent to the PCT.	

Central Alert System (CAS Q3)

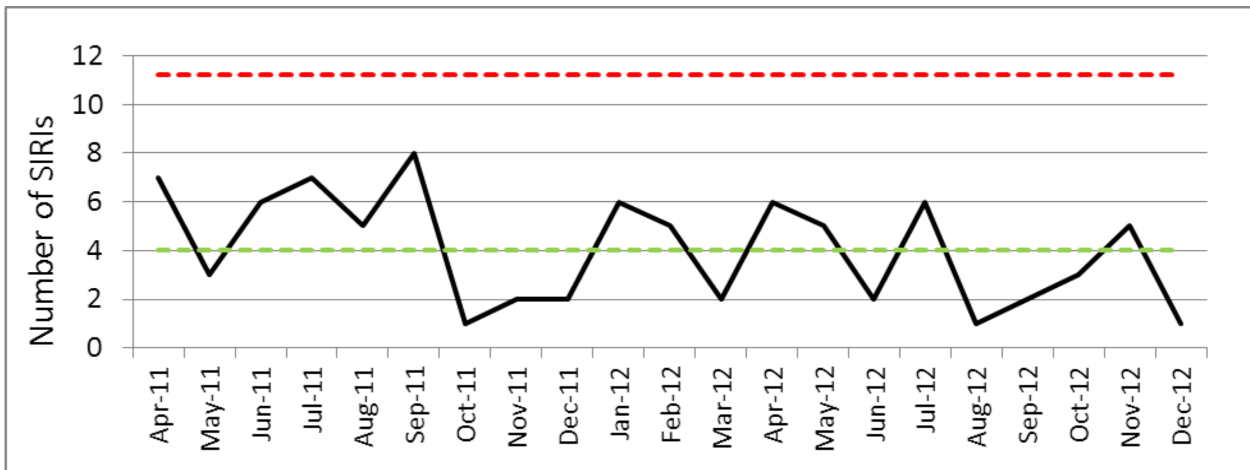
12. There was an increase in the number of CAS alerts breaching the required deadline during the first two quarters of 2012. These predominantly related to medical equipment. Medical Device Alerts within the Trust was raised with OUH by the PCT, the SHA and the Care Quality Commission. Steps taken to address the backlog have resolved the issue.
13. Three new Medical Device Alerts (MDAs) were issued in December 2012. Three MDAs were due for closure in December 2012; all were closed within the given time frame.
14. No alerts now breach their closure deadline.

Incidents for December 2012

15. One Serious Incident Requiring Investigation (SIRI) was reported in December 2012.

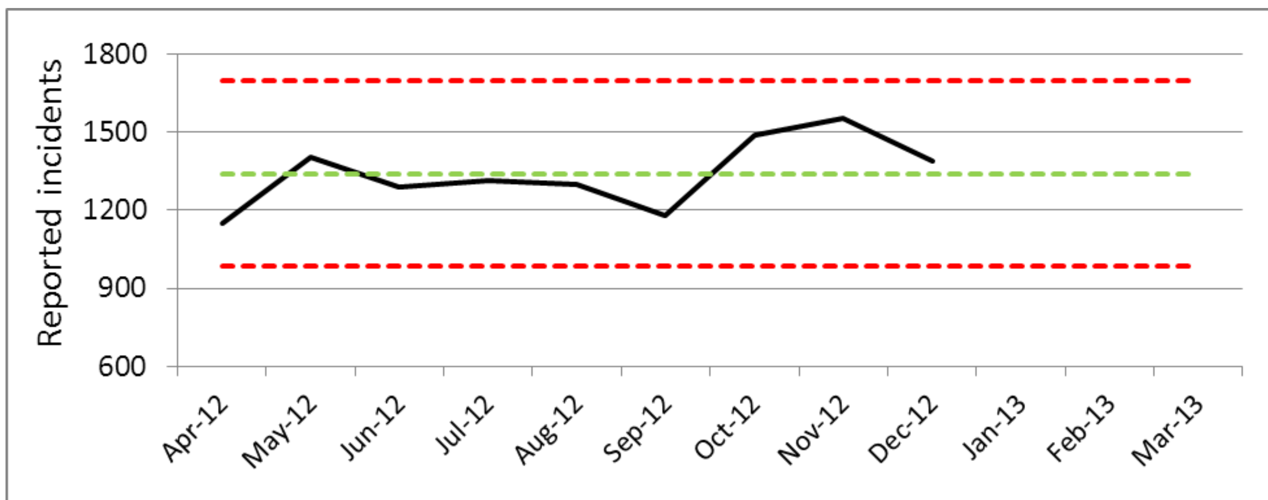
SIRI Ref	Division	Area	Date of Incident	Date SIRI Opened	Description
2012/043	CCTADP	WW Theatres	26/09/2012	19/12/2012	Breast surgery undertaken by visiting surgeon without the correct medical record availability.

16. Figure 4 below shows the number of Serious Incidents Requiring Investigation (SIRIs) reported by month since April 2011. The PCT has a set a guide of an average of 5 per month.



17. The closure of SIRI investigations within the target set by the PCT is at 100% for December 2012.

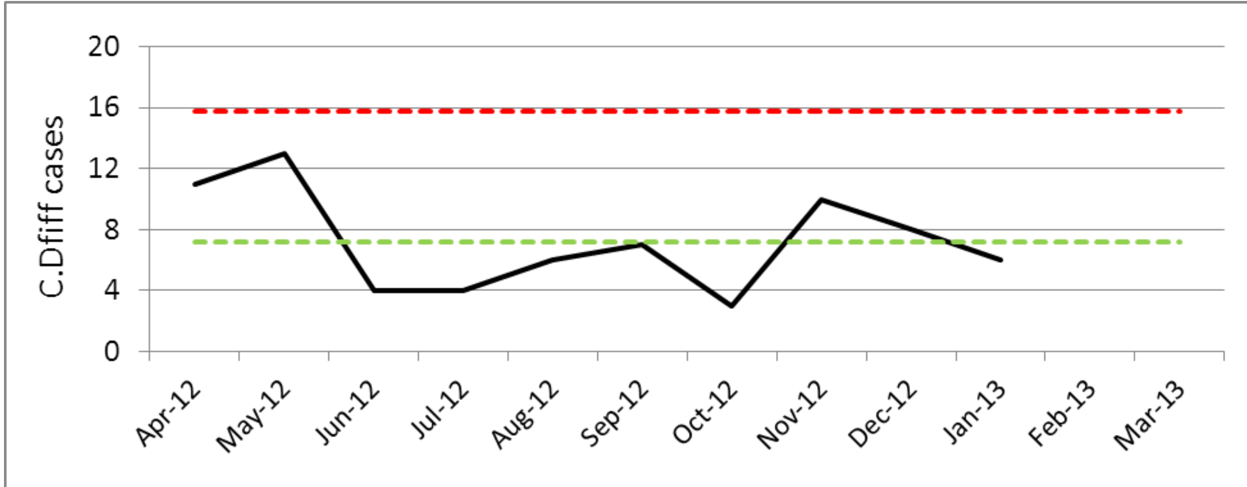
18. Figure 5 below shows the total number of incident reports per month since April 2012.



Healthcare Infection

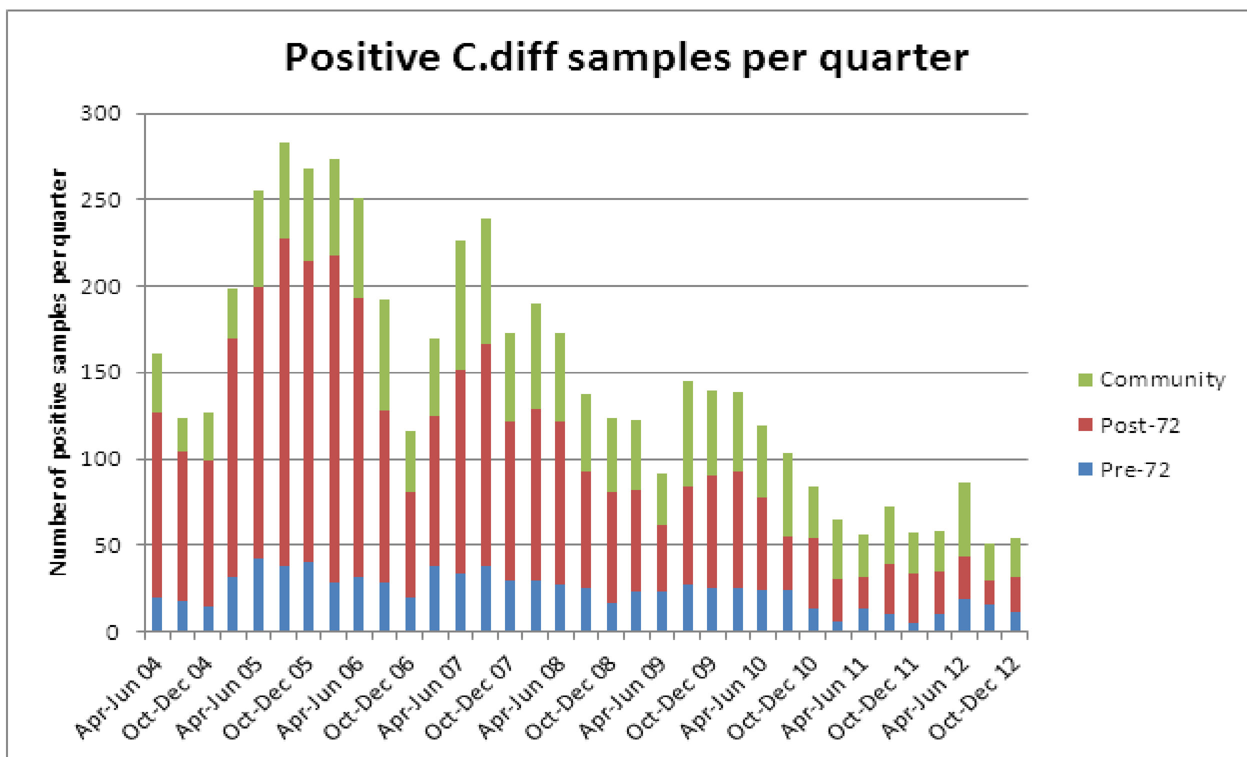
Clostridium difficile

19. Figure 6 below shows the number of C. diff positive samples per month since April 2012.



20. There were 8 reported cases of C. diff in December. This means that the cumulative total for the year is 66 against a trajectory of 67.

21. Figure 7 below illustrates the number of cases of C. diff over time. Despite the change to a more sensitive test in April 2012, the number of cases continues to fall. Samples are divided into those taken within 72hrs of admission, samples taken after 72hrs of admission and finally samples from GP surgeries/community hospitals.



MRSA Bacteraemia

22. The OUH Trust had its third MRSA bacteraemia in December 2012. This was identified from a baby who was transferred from another hospital with MRSA colonisation. The source of the bacteraemia remains unclear. No lapses in care were identified

Executive Walk rounds

23. Six walk rounds were completed in December 2012. A total of 60 since April.
24. The key issues included concerns with the fabric of the environment and equipment storage constraints, with associated delays to the completion of Estates works. This includes the conversion of two bathrooms to storage areas in PFI buildings. All issues raised have an associated action to resolve them within a defined time period.
25. Good practice in all areas visited was noted: all areas were calm and well organised regardless of being busy. Improvements to the work and rest environment including provision of a staff resource room have been appreciated.

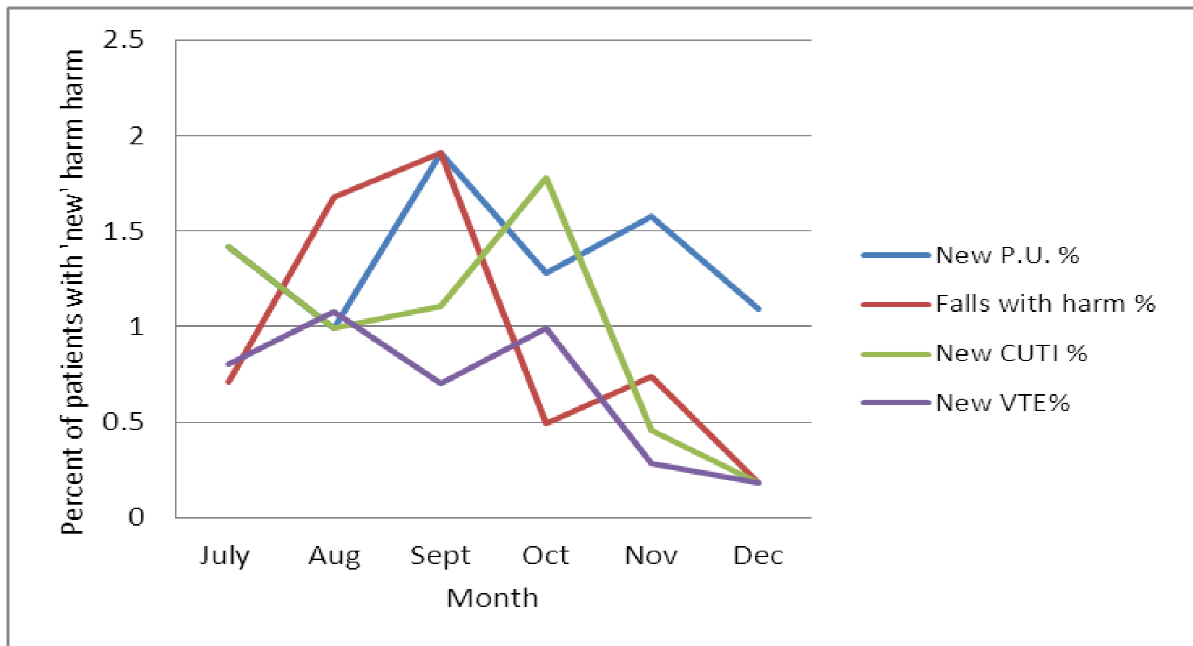
Patient Safety

26. All adult inpatient wards (excluding EAU) complete the NHS Patient Safety Thermometer on a given day every month since July 2012. The tool identifies patients who receive ‘harm free’ care by collecting data in relation to four ‘harms’:
    - Pressure Ulcers (PU)
    - Falls causing harm
    - Catheter related urinary tract infections (CUTI)
    - New venous thrombo-embolisms (VTE)
27. Detail of the ‘harm free’ care rate for Quarter 3 within the OUH is provided below. Nationally; for all NHS care providing organisations the ‘harm free’ rate was 92.3%.

	Oct	**Nov**	**Dec**
Patients	1013	1077	1101
‘Harm Free’ Care % *	96.66	97.21	98.37

*’Harm free’ rate when ‘old harms’ are removed from the data.

28. The chart below provides a breakdown of the ‘new’ harms by category, since July 2012.



29. Although there was an improvement on the previous month, pressure ulcers accounted for the largest percentage of ‘new’ harms in December causing ‘harm’ to 1.09% (n=12) of the patients surveyed; 0.82% (n=9) were category II, and 0.27% (n=3) category III. The work plan for the Tissue Viability Working Group to address seven areas of action by March 2014 was outlined to Trust Board and presented to Clinical Governance Committee in January 2013.

30. Nationally harm from new Pressure Ulcers contributes to the largest percentage of ‘harms’, harming 1.17% of patients receiving NHS care in December.

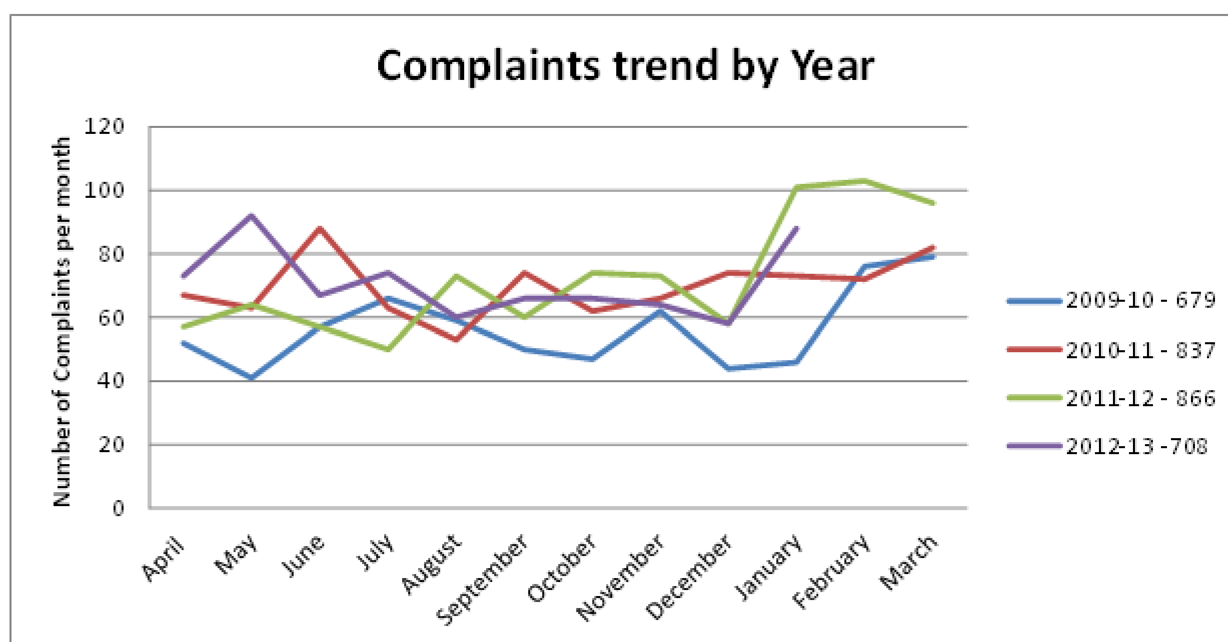
31. It has been confirmed that to meet the 2013/2014 CQUIN associated with the NHS Patient Safety Thermometer a 50% reduction in pressure ulcers across the whole health economy is required. The Trust is working in collaboration with Oxford Health and the Clinical Commissioning Group in order to develop an improvement strategy.

Complaints

32. Fifty-eight complaints were received in December 2012. The table below demonstrates the rate of complaints as a percentage of overall activity.

Activity Jan 12 to Jan 13	0	58976	154474	21394	320077	253025	291327	133837
Complaints Jan 12 to Jan 13	31	51	154	50	176	261	189	80
Complaints as a % of Activity		0.08%	0.10%	0.20%	0.05%	0.10%	0.06%	0.06%

33. The number of complaints received per Division for comparable periods over the last two years is illustrated below.



34. The four key themes identified in December include patient care/experience, delays/waiting times (appointments, admissions discharge and transport), communication and behaviour. All Divisions have received complaints in one or more of these categories.

35. Complaints relating to appointments, admission, discharge & transport, rose slightly in December in comparison to the previous two months. Complaints relating to patient care and experience increased in December compared to November but remained lower than in October. Communication and Staff Attitude decreased compared to November.

New Complaints – December 2012

36. Of the 58 new complaints, none were graded red, 11 were graded orange, 29 yellow and 18 green.

Management of complaints

37. In December all complaints were acknowledged within the statutory 3 working days.

38. The trust responded to complaints within the agreed timescales for December. There was a breach in the agreed response time for one complaint received in October, reducing the compliance rate to 93% for that month.

Ombudsman Investigations

39. The Ombudsman requested information on one complaint relating to the aftercare provided following a Spinal Cord Stimulator insertion.

Patient Experience

40. Patient experience data has been collected from 102 telephone calls, 19 'let us know your views' questionnaires, 5 comments/suggestions form, 43 attendances to the PALS office in person, and 114 instances of feedback in written form

41. The majority of comments received relate to current issues that need resolving (76%)

42. Additionally, 8% of the feedback in October was negative (without an issue to resolve). However, 10% of the comments received were positive.

Issue for resolution	139	76%
Positive Feedback	18	10%
Negative Feedback	15	8%
Advice/ information request	10	5%
Interpreting Requests	1	1%
Other	1	1%

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

Top 4 patient feedback issues	
Caring, friendly and helpful attitude/high quality care	16
Appointment, treatment and discharge delays	74 (down from 138)
Communication/Consent/Confidentiality	22 (down from 36)
Negative attitude (disinterested/rude)	11
Source of patient experience reports	
Telephone	102
Letter	8
Let us know your views Leaflet	18
In person	12
Feedback emails	17
Email	36
Comments/suggestion form	5
Not specified	5

44. Issues with appointment systems feature in PALS feedback although the numbers have reduced from 138 in November to 74 in December, which may have been affected by Christmas. The number of PALS contacts relating to ENT and ophthalmology have reduced; for ENT there were 4 comments in December, a reduction from 11 in November; ophthalmology received 11 in December and 23in November. There were also 3 comments for ophthalmology relating to difficulty contacting department. The number of formal complaints for the Neurosciences, Trauma and specialist Surgery Division has also decreased, from 13 in September to 5 in December. Consultant and administrative capacity has been increased in this division and audits on unanswered calls continue. All complaints and service related issues are discussed within the monthly governance meetings.
45. Four wards started to pilot the Friends and Family Test[1] (FFT) in December and from 28th January, all inpatient wards are piloting in order to test the methodology. A project team has been established, including the communications team and the external data entry supplier.

2012 Emergency Department Patient Survey

46. The National Emergency Department Survey was last conducted in 2008 and was repeated in 2012. A random sample of 850 patients who attended the department between January and March 2012, were sent the questionnaire and 361 people responded giving a response rate of 34%. (Postal survey with 2 reminders).
47. Picker Institute Europe ran the survey for 65 out of 140 Trusts. This Trust performed better than the Picker average on 6 questions; worse on 6 questions and average on 48 questions.

Positive results

48. Amongst the positive results are the following:
    - 76% of respondents had complete confidence and trust in doctors and nurses.
    - 90% of respondents felt doctors and nurses worked well together.
    - 87% of respondents rated reception staff as good, very good or excellent.
    - 77% of respondents gave an overall score of 7+ out of 10.

Results showing a need for improvement:

49. This Trust scored less well than other Trusts on the length of wait. 5.2/10, which is reflective of the time period for sampling which coincided with the introduction of the new IT system. The patient journey/ experience was therefore significantly affected and the length of stay question responses reflect this.
50. In addition there is room for improvement when compared with other trusts on four areas of information giving:
    - Being told about the side effects of new medication
    - Being given enough information about their condition or treatment.
    - Being fully informed about when to resume normal activities.

[1] Patients who have had an overnight stay and Emergency department patients (over the age of 16) will be asked whether they would recommend the ward to a family or friend.

- Being told about the danger signs to look for and taking into account the family or home situation

51. The Emergency Department have identified and begun key improvement activity led by the Clinical Lead and improvements will be monitored through existing governance systems and quarterly Key Performance Indicators.

Nursing Metrics

52. 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.
53. The data relating to pressure ulcers and harm from falls will differ from that reported via the NHS Safety Thermometer as they are collected in different ways; the Safety Thermometer being a point prevalence survey on a given day each month.
54. The key issues during December are those of pressure tissue damage, antimicrobial stewardship and harm from falls. Several pressure ulcers developed prior to admission or developed despite all preventative measures being taken. Issues with antimicrobial prescribing are being addressed through clinical leadership and raising awareness at appropriate forums such as Grand Rounds and Consultant meetings. Several of the falls with harm resulted in fractures and have been, or are in the process of being investigated. The use of bedrails is indicated as a contributory factor in one fall. A procedural document providing guidance on the use of bedrails has been drafted; ratification and dissemination of this will be expedited for Trust wide implementation in March 2013.

Conclusion and Recommendations

55. The Board is asked to receive the report which highlights the range of activity across the organisation.
56. The Board is asked to note the actions being taken.

Professor Edward Baker, Medical Director

Elaine Strachan-Hall, Chief Nurse

February 2013