

Trust Board Meeting: Wednesday, 9 January 2012
TB2013.04

Title	Quality Report
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Status	A paper for information
History	A regular monthly report

Board Leads	Professor Edward Baker, Medical Director Mrs Elaine Strachan-Hall, Chief Nurse			
Key purpose	Strategy	Assurance	Policy	Performance

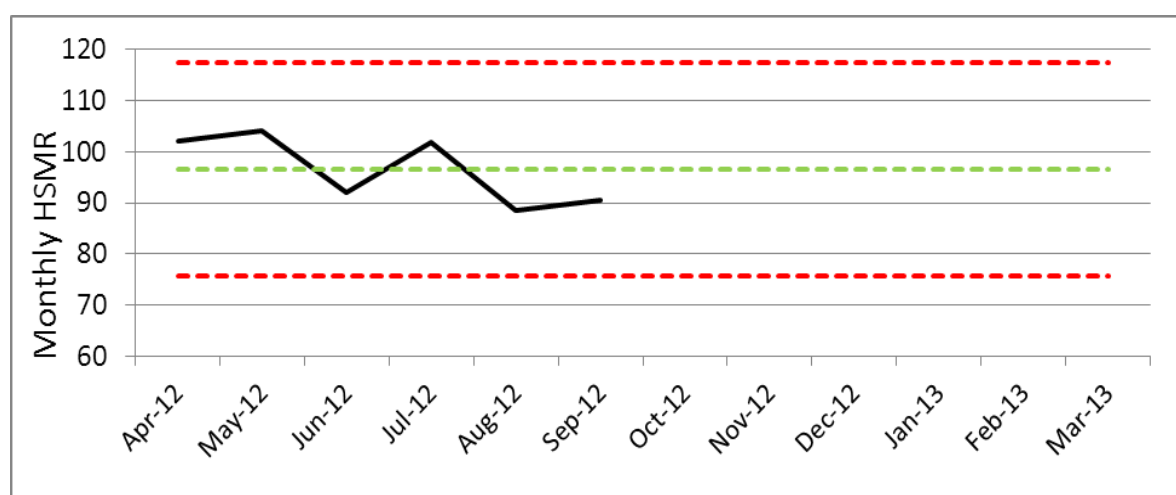
Complaints and Organisational Learning

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

1	Mortality: The SHMI and HSMR are both within expected limits. The next SHMI will be published in January 2013. The HSMR measured by Dr Foster for the OUH is 97.9 for the financial year to date.
2	CAS Alerts: At 30th November 2012 three MDAs continue to breach and remain open.
3	Incidents & SIRIs: There were five Serious Incidents Requiring Investigations reported to the PCT Commissioners in November 2012.
4	Infection Control: The annual threshold for Clostridium difficile is 88 cases identified from specimens taken after three days of admission. There were seven cases on wards within General Medicine during November. The year-to-date total is 58 against a trajectory of 60.
6.	Executive walk rounds: There were seven walk rounds completed in November 2012. This brings the total to 54 walk rounds since April 2012, an average of approximately seven per month.
7.	Complaints: 64 complaints were received during November 2012, 1 of which was graded as red. The patient feedback indicates that 96% of patients would recommend the OUH. This figure may change when reporting moves to comply with Friends and Family guidance.
8.	Patient Experience: Feedback from 'let us know your views' leaflets is low (28 questionnaires completed in November). The majority of patients who responded to these (26, 93%) indicate that they would recommend the hospital to a family member or friend. The largest category of feedback comments relate to appointments, admission or discharge processes (138 comments). Positive comments reflect the caring, friendly and helpful attitude of staff (18) and high quality care received (17).
9.	Patient Safety Thermometer: In November the NHS Patient Safety Thermometer indicated a 'harm free' rate of 92.48%. This is an improvement from the previous month (90.23 %). The 'harm free' rate in November is 97.21%; an improvement from the previous month (96.66%) and the highest rate since Trust-wide data collection began.

HSMR and SHMI update

1. Risk adjusted mortality measures published by the National Health Service Information Centre (NHS IC) and Dr Foster Intelligence for the OUH are within expected limits. The next SHMI will be published by the NHS IC in January 2013.
2. The HSMR as measured by Dr Foster for the OUH is 97.9 for the financial year to date. The monthly HSMR, with mean and control limits is shown in the chart.



The Hospital Guide

3. The Hospital Guide was published by Dr Foster on 3 December 2012 and focussed on efficiency and mortality.
4. The OUH was ranked 25th highest out of 147 Trusts for HSMR of emergency admissions at weekends.
5. A survey at the OUH was carried out in September – October 2012 of the specialties responsible for most acute admissions namely Trauma, General Surgery, Emergency and Acute General Medicine. The overall conclusion was that staffing levels are sufficient and that a safe service is provided at weekends.
6. A mortality focus group has been established to examine the Hospital Guide findings in more detail and to oversee further work required to reduce mortality at the Trust. This overarching aim is to meet the strategic goal of being one of the top five hospitals in England for low mortality by 2017 as set out in the Quality Strategy.
7. As part of the mortality review process Divisions will report summary mortality statistics within their monthly quality reports.
8. Emergency readmissions within 28 days and long lengths of stay for surgical patients are shown as being slightly higher than expected. Actions to assess these metrics were agreed at the Dr Foster Steering Group 10 December 2012.

Central Alert System (CAS)

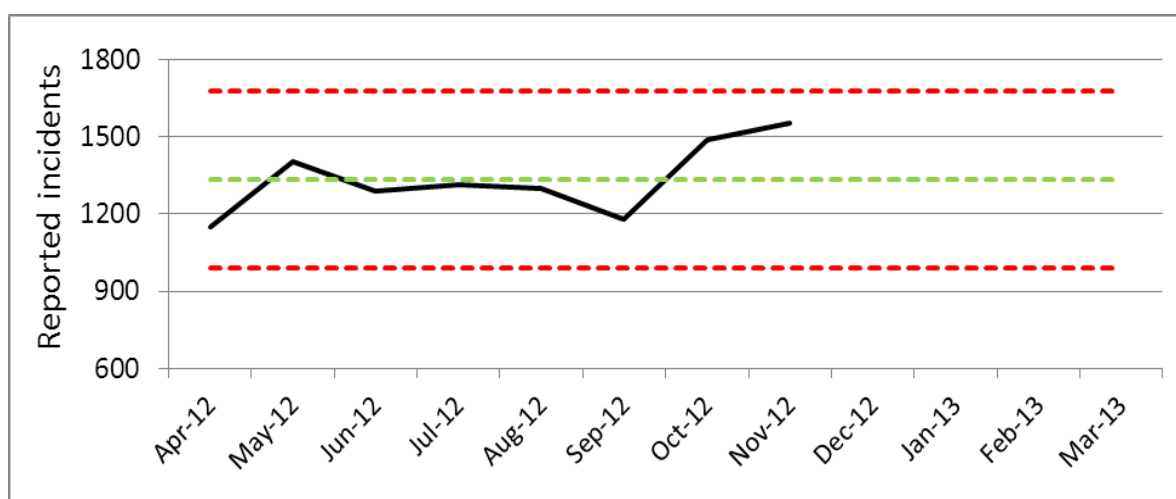
9. Six new Medical Device Alerts (MDAs) were issued in November 2012. As at 30th November 2012, three MDAs continue to breach and remain open.

SIRIs and Incidents

10. Most common categories of incidents reported in November 2012.

Slips/Trips/Falls	239
Medication Incidents/Events	197
Pressure Ulcers and Skin Integrity	132
Documentation and Records (include EPR)	128
Appointments/Admission/Discharge/Patient Transport	105

11. The chart shows the number of incidents reported per month since April 2012, with mean and control limits.



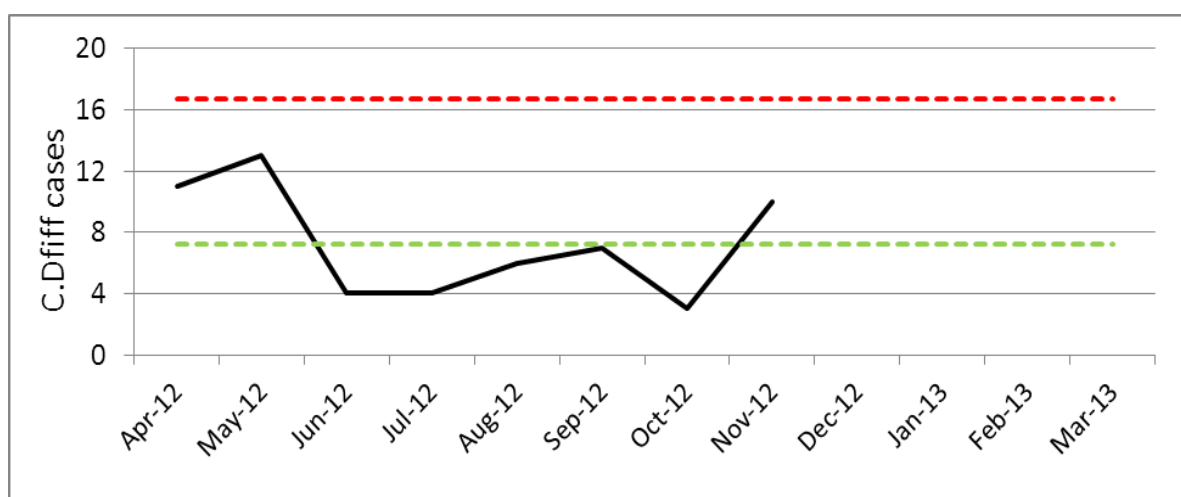
12. Serious Incidents Requiring Investigation that have been reported to the Primary Care Trust in November 2012 are presented below.

SIRI Ref	Division	Area	Date of Incident	Date SIRI Opened	Description
2012/037	NTSS	F Ward	24/10/2012	12/11/2012	Cat 3 pressure ulcers to heels and sacrum
2012/038	S&O	SEU	29/10/2012	16/11/2012	Cat 4 pressure ulcer sacrum
2012/039	EMTA	PAU	19/11/2012	20/11/2012	C diff part 1A death certificate
2012/040	MARS	BIU	13/11/2012	19/11/2012	C diff part 1A death certificate
2012/041	EMTA	Bedford Ward	17/08/2012	26/11/2012	Cat 3/4 pressure ulcer

13. The closure of SIRI investigations within the target set by the PCT is at 100% for November 2012. The Trust is forecast to meet the PCT closure data target for SIRIs set in the PCT contract for 2012/2013.

Infection control

14. The annual upper limit for *Clostridium difficile* is 88 cases identified from stool specimens taken after three days of admission.
15. In November there were 7 cases on wards within General Medicine. An urgent meeting was called with the division. It was agreed to update the C. diff "At a Glance" document and send out to all physicians and wards.
16. Out of the total of 10 cases in November, 6 had active disease, 7 were treated empirically and one had C. diff on admission. Two patients died with active C. diff and both of these cases are part of a SIRI investigation.
17. The chart shows number of C. diff cases per month since April 2012 with the mean and upper control limit. There have been a total of 58 cases against trajectory of 60 for the year to date.



MRSA Bacteraemia

18. There was a MRSA bacteraemia in October 2012 in a patient admitted for palliative care. There have been 2 in total for the year against an annual upper limit of 6.

Reducing Surgical site infection

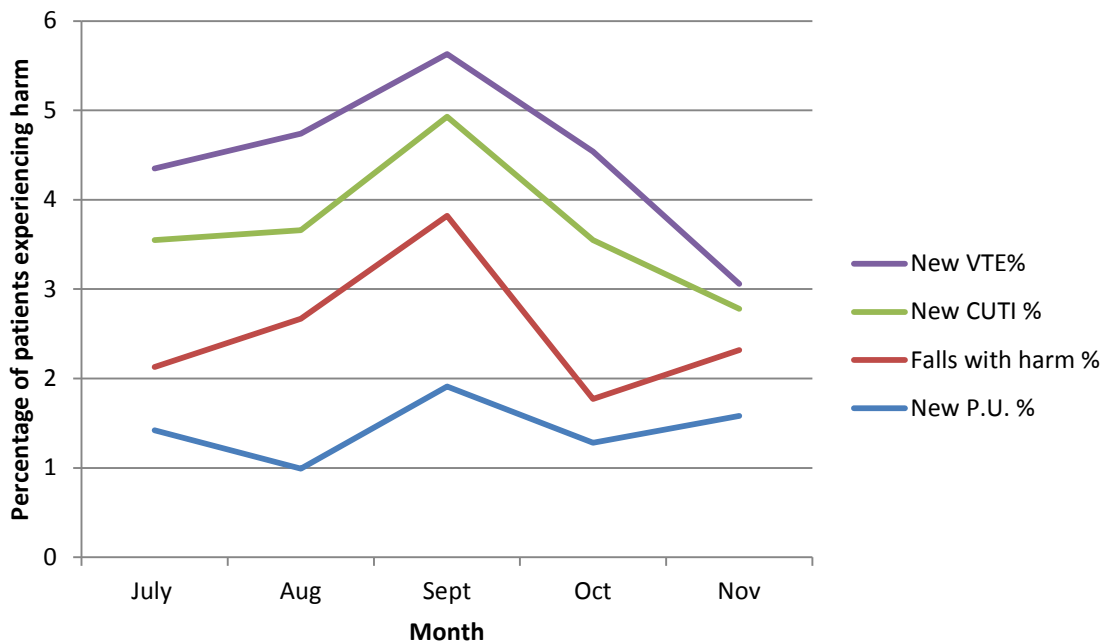
19. Clinical and theatre standards to reduce surgical site infection were approved at the Hospital Infection Control Committee and will be disseminated on 12th December 2012. Audits to assess compliance will start in January 2013.

Patient Safety

20. All adult inpatient wards (excluding EAU) in the OUH are required to complete the NHS Patient Safety Thermometer on a given day every month. 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)
21. In November the NHS Patient Safety Thermometer indicated a 'harm free' rate of 92.48%, an improvement from the previous month (90.23 %). When identifiable 'old'

harms are removed from the data, the 'harm free' rate in November is 97.21%; an improvement from the previous month (96.66%).

- 22. The Safety Thermometer enables identification of the harms caused to patients. The chart below provides a breakdown of the 'new' harms by category, since July 2012.

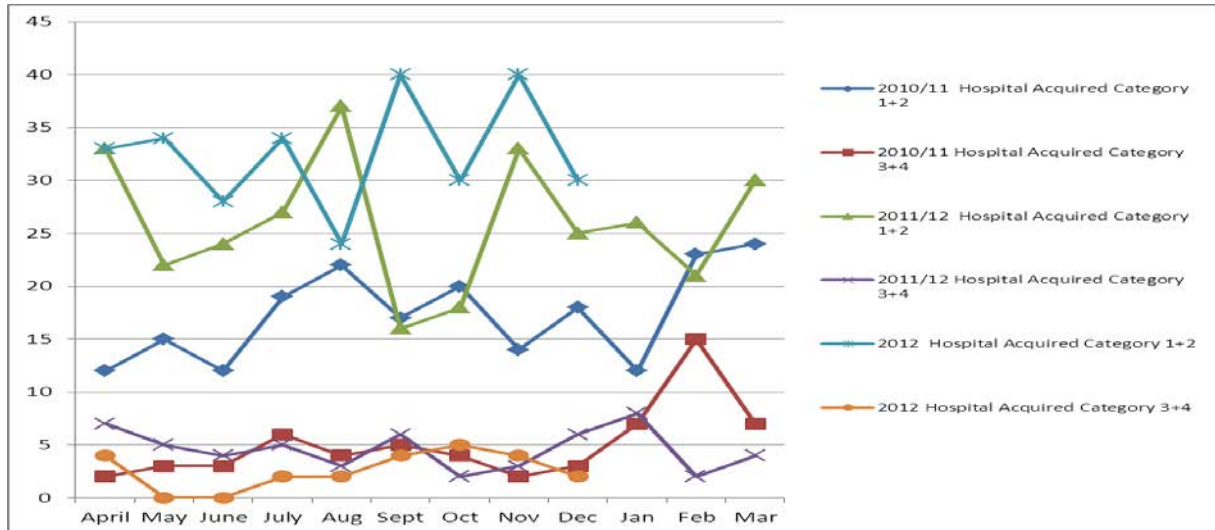


Percentage of 'new' harm by category since July 2012.

- 23. Pressure ulcers accounted for the largest percentage of harms in November causing 'harm' to 1.58% (n=17) of the patients surveyed; 1.49% (n=16) were category II, and 0.9% (n=1) category IV. This is the first category IV Pressure Ulcer reported within the Patient Safety Thermometer since Trust-Wide data collection began. The Deputy Chief Nurse is reviewing the Trust's model of delivering an expert tissue viability resource which would also realise a reduction in the incidence of pressure ulcers across the organisation.

Pressure Tissue Damage

- 24. The table below illustrates the trend in reporting of pressure ulcers over the last 3 years. The rise in 2011 was considered to be largely due to better reporting. The trend in 2012/13 indicates that there were more category 1 and 2 ulcers which is thought to be due to better reporting, and fewer of the more serious category 3 and 4. There is still significant scope to reduce the number of patients suffering pressure tissue damage. A work plan to address seven areas of action until March 2014 will be presented to the Clinical Governance Committee in January. The seven areas are: data reporting (now that the safety thermometer is in place); revision of trust policy; equipment replacement; education and training; specialist nursing support; liaison with community (important to address community acquired damage) and a specific focus on heel ulceration.



Executive Safety Walk Rounds

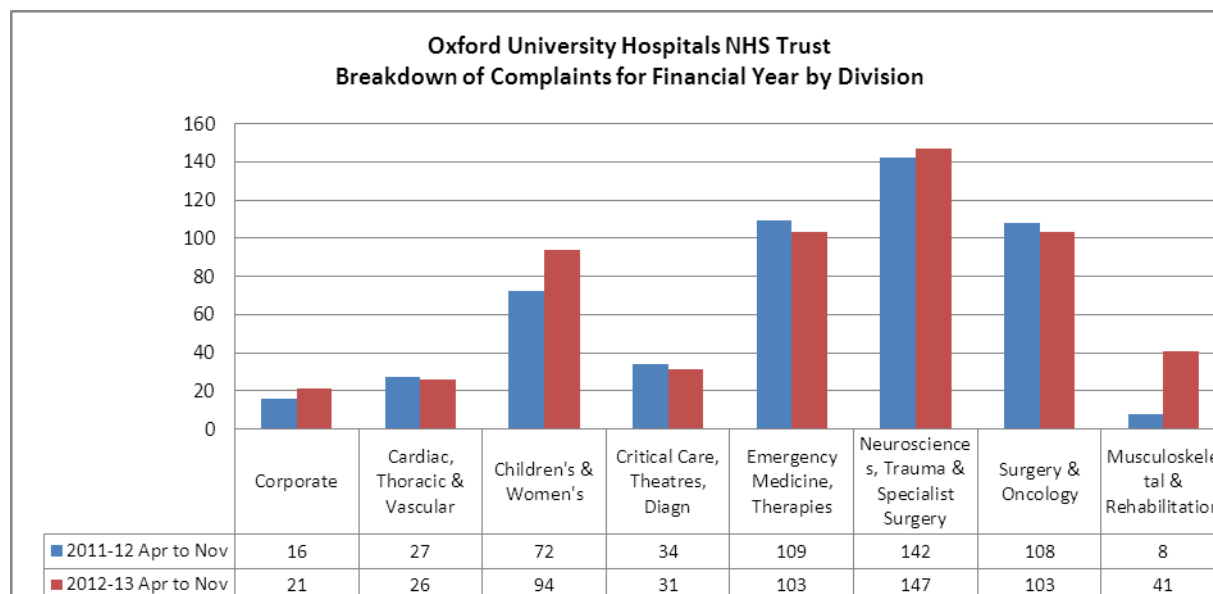
- 25. Seven walk rounds were completed in November 2012. A total of 54 since April.
- 26. The key issues included equipment storage constraints (i.e. the requirement to reconfigure bathrooms and patient day rooms to prevent equipment being stored in corridors) and cleaning issues (i.e. deterioration in cleaning standards at weekends or when temporary staff are used). All issues raised have an associated action to resolve them within a defined time period.
- 27. Good practice in all areas visited was noted. This included recognition of staff for good practice (Adams and Bedford Ward), patient involvement at handover (Ward 5F) and the use of highly visible pegs to secure call bells near to patients.

Complaints

- 28. The number of complaints received in November (64) is a decrease in the number of complaints received compared to the previous month.
- 29. The table below shows the number of Finished Consultant Episodes (FCEs), the number of Outpatient appointments attended and the number of A&E attendances for September 2012 together with the corresponding number of complaints received. In future reports this table will show data for the previous three months.

Ratio of complaints to activity		September 2012
Patient activity	Inpatient, Outpatient and Emergency Department	93,428
	Complaints	96 (0.102%)

- 30. The number of complaints received per Division for the last two years is illustrated in the table below. The data for the MARS Division was collected through the integrated OUH system from November 2012, so the year to year data for this Division is not readily comparable.



31. The four key themes identified remain 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.
32. The table below shows themes recorded for all Divisions for September, October and November 2012. This table has identified that complaints relating to Appointments, Admission Discharge & Transport, Communication and Staff Attitude rose in November in comparison to the previous two months. Complaints relating to Patient Care and Experience decreased.

Division	Patient Care/Exp			Appt Admission Discharge & Transport			Comm			Staff Attitude			Div Total
	Sep	Oct	Nov	Sep	Oct	Nov	Sep	Oct	Nov	Sep	Oct	Nov	
Cardiac Thoracic & Vascular	1	2	2	0	0	2	0	0	2	0	0	0	9
Children & Women's	5	6	7	2	1	4	1	0	1	1	2	4	34
Critical Care Theatres Diagnostics & Pharmacy	2	0	0	0	2	1	1	1	0	0	0	0	7
Emergency Medicine Therapies & Ambulatory	4	14	4	2	0	0	0	2	1	1	0	1	29
Musculoskeletal & Rehabilitation Service	2	1	3	2	3	1	0	0	0	2	1	2	17
Neurosciences Trauma & Specialist Surgery	8	3	2	10	6	4	3	3	4	0	1	2	46
Surgery & Oncology	7	7	8	3	4	8	2	1	4	1	0	2	47
Corporate	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	29	33	26	19	16	20	7	7	12	5	4	11	189

New Complaints – November 2012

33. Of the 64 new complaints, 1 was graded red, 7 orange, 36 yellow and 20 green.
34. The one red complaint was received by Cardiac Thoracic & Vascular Division and is related to an elderly patient admitted from outside Oxfordshire who subsequently fell whilst on the ward. The patient was discharged home but died three weeks later.

The complaint remains open but the investigation is on hold at the patient’s family’s request.

Management of complaints

- 35. In November all complaints were acknowledged within the statutory 3 working days.
- 36. There was full compliance in responding to complaints within the agreed timescales for November, following the 4 breaches recorded for complaints received in October, reported last month. Some complaints for both October and November remain open.

Ombudsman Investigations

- 37. Two complaints to the Ombudsman have not been upheld following provision of information from the Trust.
- 38. The patient feedback report for November is compiled from the ‘Let Us Know Your Views’ leaflets and feedback provided to the PALS team.

Patient Experience

- 39. The majority of comments received relate to issues that need resolving (74%). Additionally, 8% of the feedback in October was negative (without requesting an issue to be resolved). However, 10% of the comments received were positive and responses to questions on the ‘let us know your views’ leaflets are mostly positive.

	October	November
Issue for resolution	279	261
Negative Feedback	58	28
Positive Feedback	54	34
Advice/ information request	22	20
Mixed positive and negative comments	22	9

- 40. The percentage of respondents who said they would recommend the hospital to others remains high, with 26 of the 28 respondents (93%) indicating that they would recommend the services offered by the OUH.

Let us know your views November 2012 with September 2012 trend line

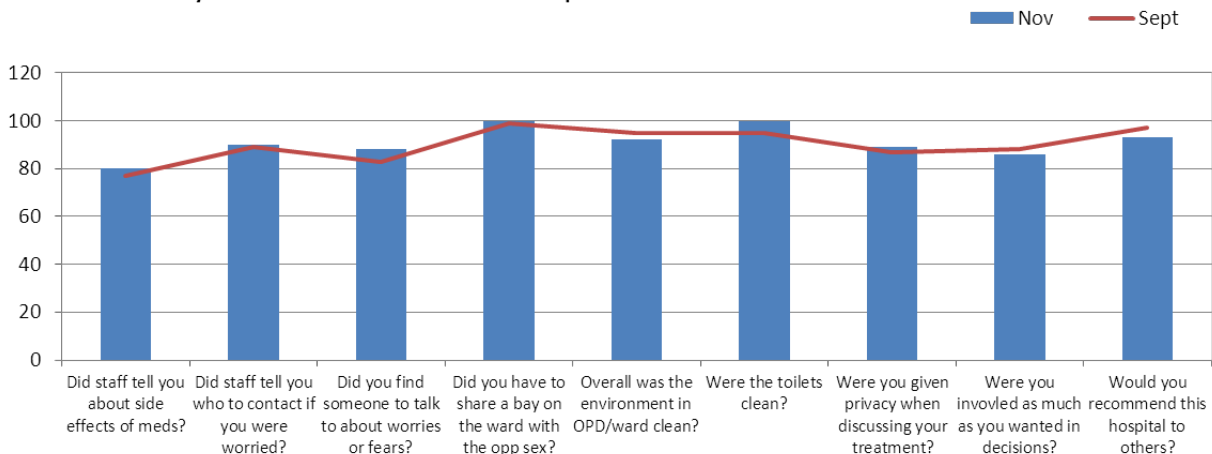


Figure 1 - scores on questions on 'Let us know your views' questionnaire. Higher scores indicate positive responses; for questions marked with * a score has been calculated which is not equivalent to a percentage.

41. There were 32 'let us know your views' leaflets returned this month (see Figure 1), compared to 58 returned last month. Some of these were only returned with a comment. Due to low return rates, it is not useful to compare previous months' scores, and care must be taken when drawing conclusions from the data. Implementation of the trust-wide patient feedback system will improve this.
42. The table below provides a summary of the top four feedback issues collated from telephone calls (170) questionnaires (32), written feedback and PALs contacts (114).

Top 4 patient feedback issues	
Caring, friendly and helpful attitude/high quality care	35
Appointment, treatment and discharge delays	138
Communication/Consent/Confidentiality Including difficulty contacting department (15) and incorrect information (9)	36
Clinical concerns	21

43. Most of the feedback is about ENT (11) and ophthalmology (23) about appointments. There were also 9 comments for the division relating to difficulty contacting department. The following changes have been made in ENT:
- A new email account has been set up which is monitored daily (queries are responded to within 48 hours)
 - Managers audit telephone calls 3 times per week to ensure that all telephone calls are answered and messages responded to within 48 hours.
 - Increasing administrative support.
44. There were 21 issues relating to clinical concerns¹. This is highest in the EMTA division (10) and will be reviewed further.
45. 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.
46. The key issues during November are those of pressure tissue damage, hand hygiene compliance and environmental cleaning scores. Several pressure ulcers developed prior to admission or developed despite all preventative measures being taken.
47. To improve hand hygiene within theatres, the Clinical Director will be sending a letter to all anaesthetic consultants, details of which will be cascaded to their teams, detailing what is acceptable hand hygiene practice. A 'hand hygiene information station' is to be developed in theatres and using a UV light box will highlight the importance to staff. Matron for CCTA will undertake audits with sisters in theatres during December and challenge poor practice.

¹ This has appeared in the report for the first time as a result of the way the data is coded in order to give more detail.

48. Cleaning remains closely monitored where standards are not met. Raising concerns with cleaning through the helpdesk, liaising with senior Estate and Facilities staff and reviews of cleaning contracts are in place.

Conclusions and recommendations

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

Professor Edward Baker, Medical Director

Elaine Strachan-Hall, Chief Nurse

Appendices attached

Appendix 1 Nursing Dashboard

