Oxford University Hospitals NHS
NHS Trust

Trust Board Meeting: Wednesday 10 July 2013

TB2013.80

Title	**Quality Report**

Status	For information
History	This is a regular report to the Trust Board

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

Summary

1.	**HSMR/SHMI** – Risk-adjusted mortality measures for the OUH are currently within expected limits.
2.	**Quality Account –** The Quality Account has been prepared in accordance with the associated regulations, and will have been published when the Board meets.
3.	**CQUINS –** CQUINS for 2013/2014 have been agreed with the Clinical Commissioning Group.
4.	**Reported Incidents** – The top six incident categories account for 53% of the total amount reported (17646) in the 12 months from June 2012 to May 2013.
5.	**Serious Incidents Requiring Investigation (SIRIs)** – Nine SIRIs were reported in May 2013, of which 5 were hospital acquired pressure ulcers.
6.	**Quality Concerns raised by staff –** Nil raised in May. An update is provided on issues previously highlighted.
7.	**Executive walk rounds** – Six walk rounds were completed in May 2013.
8.	**Patient Safety** – The NHS Patient Safety Thermometer indicated a 'harm free' rate of 92.11%. This is a 0.4% decline from the previous month (92.51%).
9.	**Central Alerting System** – 12 new alerts received in May 2013. 2 alerts remain open at the end of the month of May 2013. One alert breaches timescales for closure (in common with seventy other Trusts).
10.	**Complaints –** A total of 66 complaints were received during May 2013, two of which were graded as red.
11.	**Friends and Family Test** – There were 924 Friends and Family Test responses from patients in May with 90% of patients stating that they would be extremely likely or likely to recommend their ward / ED. The response rate for eligible patients in May was 11%, down from the response rate in April (>15%).
12.	**Infection Control** – 11 cases of Clostridium difficile have been identified from samples taken after three days of admission. This total represents new cases from 1 April to 31 May 2013 (8 new cases April 2013, and 3 new cases May 2013). The Trust remains within / at its ceiling.

Mortality

Risk adjusted mortality measures

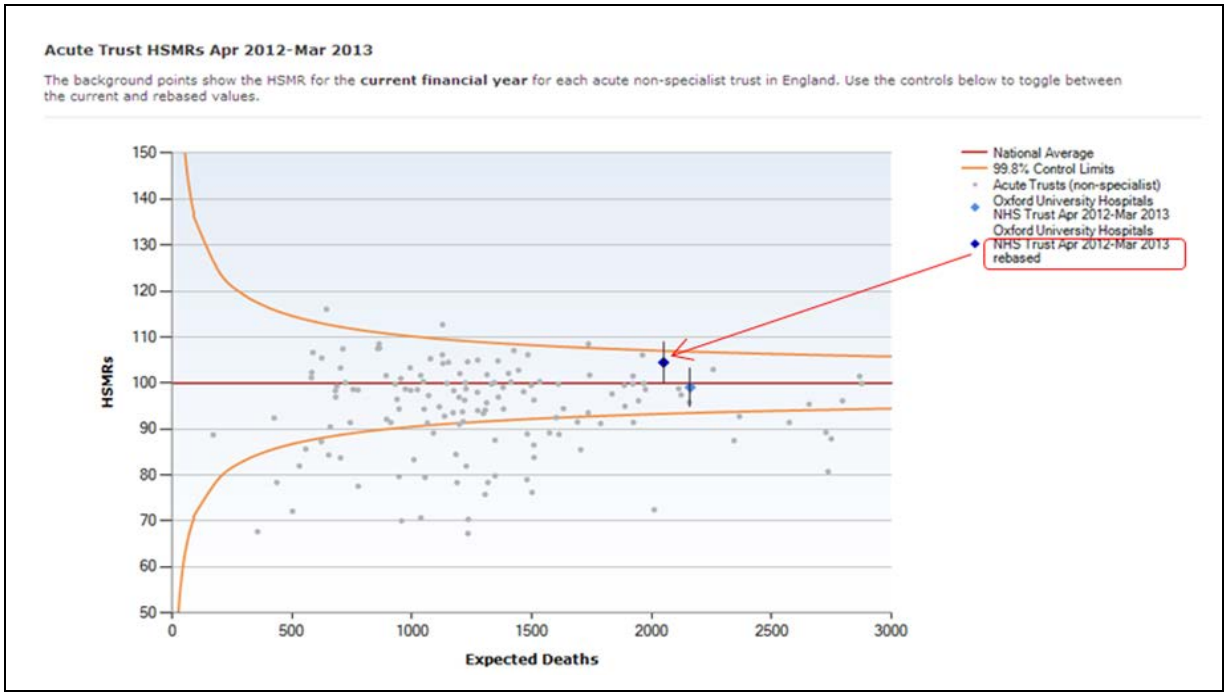
1. All risk adjusted mortality measures are within the expected ranges.

2. Research published in the British Medical Journal reported that mortality rates were 44% higher for patients having elective operations on Fridays in the UK. The paper suggested this may be due to an increased risk of complications within the first 48 hours after surgery and reduced or locum staffing levels at weekends. An analysis of Dr Foster data shows that mortality rates at the OUH for elective surgery on Fridays (April 2009 – February 2013) is within expected limits. A further more detailed analysis of mortality rates by day of the week will be carried out over the next month.

Audits related to HSMR rebasing (2012/13)

3. The annual recalibration (rebasing) of the HSMR by Dr Foster will occur in September 2013, this process effectively increases the HSMR of all Trusts by up to 10 points. The tool provided by Dr Foster to predict rebased HSMR currently estimates the rebased HSMR at the OUH to be 104. As shown in the funnel plot below, this is within the expected range.

Figure 1



Quality Account

4. The Quality Account was prepared in line with the regulations, and was approved on behalf of the Trust Board by the Quality Committee on 12 June 2013.

5. External assurance by Ernst and Young has taken place, with two key performance indicators being assessed:

   - Percentage of patient safety incidents resulting in severe harm or death
   - Rate of Clostridium difficile infections

CQUINS

6. The agreed CQUINs for 2013/14 are described in table 1 below.
7. The Trust must meet half of the six 'pre-qualifier' CQUINs as a gateway to the overall CQUIN scheme. CQUIN values are derived from Oxford Clinical Commissioning Group (OCCG) and 'associate commissioners' for 'local', specialist commissioners for 'specialist', and all three groups for 'national'.
8. The following Quarter 1 (Q1) targets have been confirmed as met by the Clinical Commissioning Group:
    - Baseline Data for elderly patients and DTOC.
    - Medical support for complex patients in surgery.
9. The remaining Q1 targets are expected to have been met by the end of June 2013.
10. Financial targets for national and Local CQUINS targets are outlined in the table below.

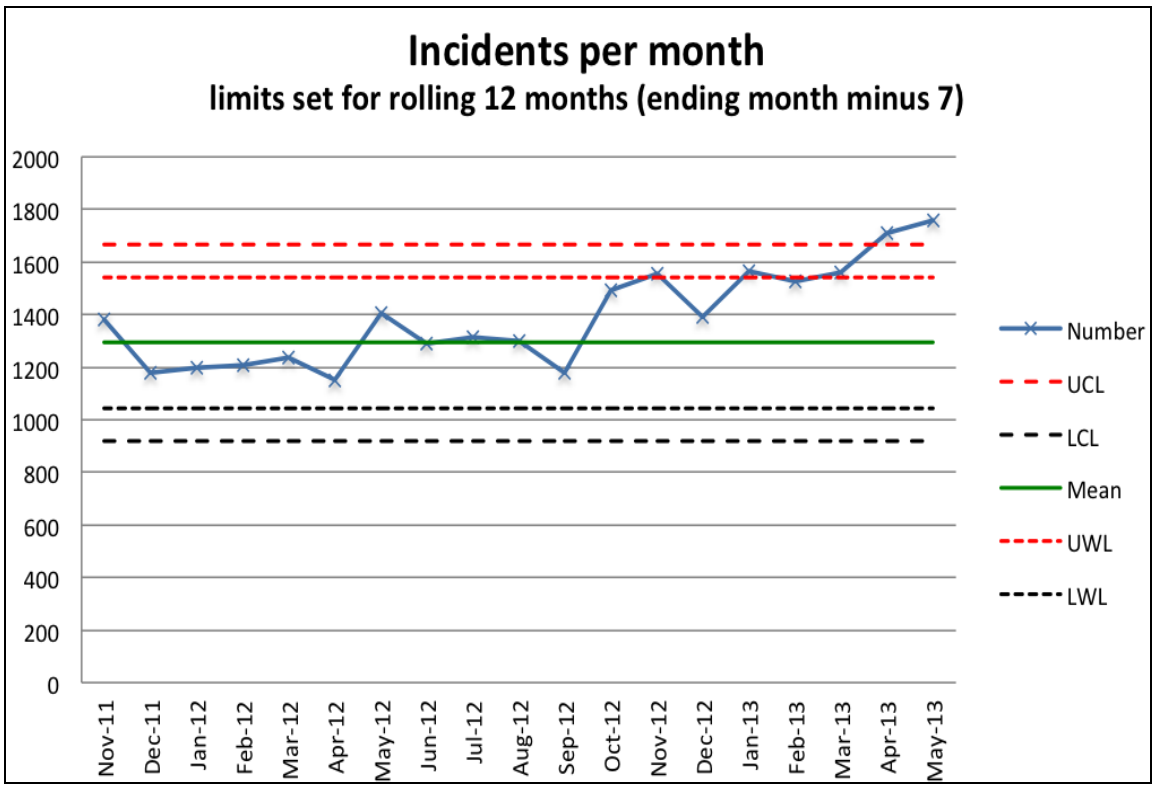
Table 1

Pre-qualifiers	**Update**	**CQUIN Value**
Telemedicine	Suitable equipment being scoped.	n/a
Intra operative fluid monitoring	Ahead of current trajectory.	n/a
Child in the chair	Maintaining a five week wait.	n/a
ICE	Expanded to radiology.	n/a
Reduction in antenatal visits for gestational diabetics	BRC funded study in place.	n/a
Physiological outcomes post MI	Jointly funded study in place.	n/a
National CQUINS:	**Update**	**CQUIN Value**
Friend and Family test	Exceeding target.	£784,677
Safety Thermometer 50% reduction in pressure ulcers	Strategy in place to improve reporting. Potential to adjust the baseline after 6 months.	£784,677
Dementia • Assessment of patients • Leadership • Support for carers	Strategy formulated to improve performance in all three areas. Very high risk in relation to delivery of assessment component.	£784,677

VTE Target = 95% assessed	Exceeded 95% in April and May.	£784,677
Local CQUINS:		**CQUIN Value**
Psychiatric liaison service		£650,132
Baseline data for frail elderly patients + DTOC		£805,297
Medical Support for complex patients in surgery		£1,087,497
Emergency Admission Navigators		£1,397,047
Nursing		£758,747
Diabetic foot disease		£236,041
Diabetic support for young adults (19-25yr old)		£197,250
Learning disability		£236,041
ECIST report – Action Plan		£1,117,750
Specialist CQUINS:		**CQUIN Value**
Clinical dashboards		£756,688
Highly specialised services		£756,688
Renal transplant – cold ischaemia times		£908,025
Haemophilia		£908,025
IV immunoglobulin		£908,025
Major Trauma		£908,025
Neonatal ICU – complex discharge		£908,025
TOTAL		**£15,678,011**

Incident Reporting

Figure 2



Top six categories of incidents from June 2012 to May 2013

Table 2

	Jun 12	Jul 12	Aug 12	Sep 12	Oct 12	Nov 12	Dec 12	Jan 13	Feb 13	Mar 13	Apr 13	May 13	Total
Medication Incidents/ Events	175	157	159	96	241	201	156	185	191	183	241	244	2229
Pressure Ulcers and Skin Integrity	119	140	123	132	135	131	135	204	172	210	266	235	2002
Slips Trips and Falls	206	190	195	201	213	241	245	231	245	222	217	228	2634
Appointment, Admission, Discharge & Patient Transport	66	101	89	67	89	104	94	109	111	94	127	103	1154
Documentation and Records (including EPR)	85	92	75	77	143	126	97	80	107	90	106	119	1197
Communication	112	76	84	53	45	65	53	70	58	60	67	84	827

11. There continues to be an increase in reporting of clinical incidents across the organisation. This is reflective of a positive safety culture.

12. The top six reported incidents remain static as per previous months.

SIRIs for May 2013

13. Nine SIRIs were reported to the CCG in May 2013 as listed in table below:

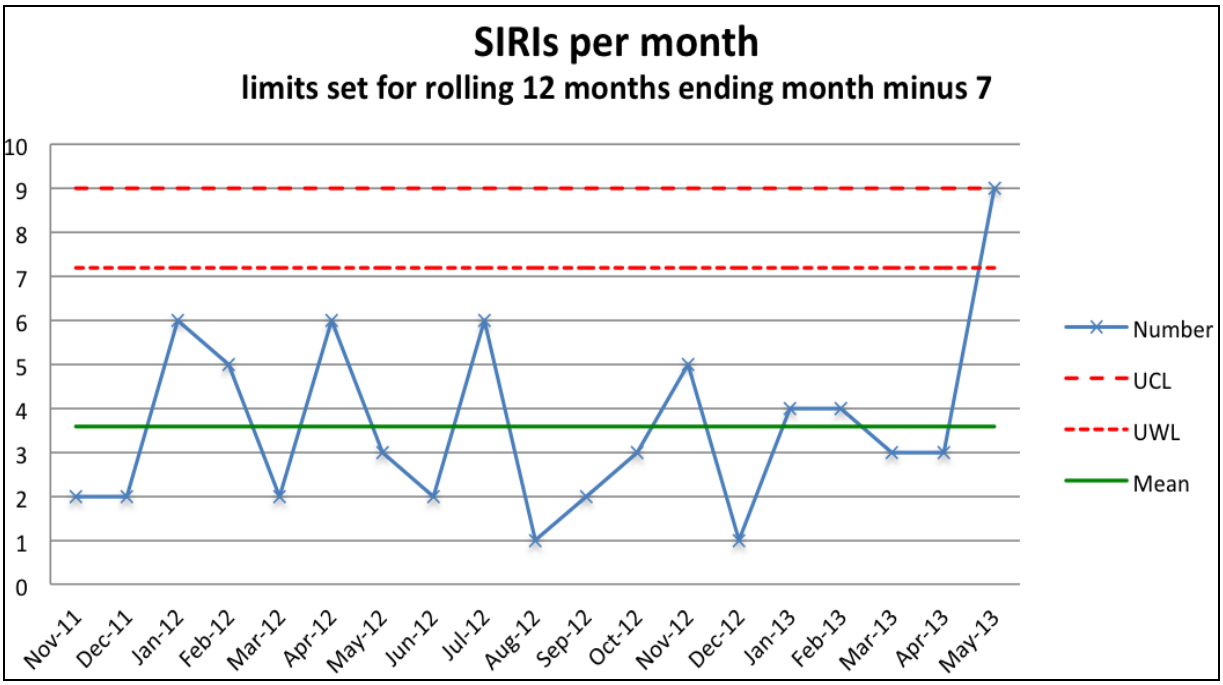
New SIRI's reported by Division

Table 3

SIRI Ref	Division	Dept	Date of Incident	Date SIRI called	Description
2013/015	S & O	SEU	03/03/2013	09/05/2013	Pressure Ulcer
2013/016	NTSS	SSIP	09/03/2013	10/05/2013	Pressure Ulcer
2013/017	C & W	Women's	02/05/2013	13/05/2013	Information Governance
2013/018	EMTA	Adams Ward	06/03/2013	13/05/2013	Pressure Ulcer
2013/019	W&C	Maternity HGH	13/04/2013	28/05/2013	Death of new-born
2013/020	EMTA	7D and 7F	05/04/2013	28/05/2013	Death of patient following fall
2013/021	EMTA	SSW	12/04/2013	28/05/2013	Pressure Ulcer
2013/022	CCTADP	Anaesthetics	25/04/2013	30/05/2013	Patient harm following anaesthetisia
2013/023	EMTA/ MARS	7B/EAU/F WARD/BIU	05-04-2013 and 09-04-2013	31/05/2013	Pressure Ulcer

14. New SIRI's reported for the month of May 2013 indicate an increase in reported hospital acquired pressure injuries. There is an organisation wide action plan in place that is monitored through the Patient Safety Committee.

SIRI investigations launched **Figure 3**



Quality Concerns Raised by Staff

15. No new quality concerns have been raised.

16. The Trust Board was informed about concerns raised in May and June 2013. Updates as follows:

    a. Access to out of hours emergency gynaecology theatres – these concerns are being taken forward as part of an overarching review of prioritisation for emergency theatres on the John Radcliffe Site. A paper from CCTA is due to be presented at the Clinical Governance Committee on 17 July 2013.

b. Volume of work in the Emergency Departments – it is recognised that there have been difficulties in relation to capacity and flow in the ED both locally and nationally. The situation is actively monitored within the Division, efforts continue to improve flow through and from the Trust, and consultant recruitment to ED and Acute Medicine has continued.

c. Ophthalmology clinic management – work is being undertaken by the Operations and Service Improvement Directorate, supported by Newton, to analyse and re-profile clinics in order to ensure that they run at maximum efficiency. Ophthalmology staff members are contributing to this work.

d. Nurse staffing and behaviours in neurosciences – an investigation has been undertaken by a senior nurse external to the Division into the concerns raised. Her report and recommended actions are being considered by the Directorate / Divisional team. A meeting with the Deputy Chief Nurse is planned during July.

e. Concerns put forward by trainees through the General Medical Council annual trainee survey – responses and comments are being sought from the relevant clinical leads and will be considered at Clinical Governance Committee on 17 July 2013.

Executive Walk rounds

17. There have been six Executive walk rounds in May 2013.

18. The key issues with the potential to affect quality or patient experience included a lack of specialist beds following relocation of a ward, and a reduction in bed capacity connected with cessation of emergency surgery at the Horton General Hospital. As a result patients may not have had timely access to specialist clinical staff and are potentially waiting longer than before for emergency surgery. In other areas the impact of vacant clinical posts was highlighted as having an impact on delivering optimum care and service. In one area, during the recruitment process successful applicants have withdrawn before taking up appointment. In two clinical areas within a PFI, an issue with emergency call bells was raised. In both instances the buzzers cannot be heard in all areas of the department and both areas are struggling to resolve the issue with the contractor. All issues have actions associated with them and these will be monitored through Divisional governance processes.

Patient Safety

19. The NHS Patient Safety Thermometer indicated a ‘harm free’ rate of 92.11%. This is a 0.4% decline from the previous month (92.51%). When identifiable ‘old’ harms are removed from the data, the ‘harm free’ rate is 96.83%, improved by 0.08% from the previous month (96.75%).

20. Detail of the 'harm free' care rate for the past 3 months within the OUH is provided in table below:

Table 4	March	April	May
Number of Patients	1148	1107	1103
'Harm Free' Care % *	96.78	96.75	96.83

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

21. There was an increase in the number of pressure ulcers of one between April and May, however there was a decrease over the quarter, reported through the Safety Thermometer, and these present as the majority of 'new' harms in the OUH. The table below details new pressure ulcers by category March to May 2013:

Table 5	March	April	May
Category 2	1.66% (n19)	1.17% (n14)	1.09% (n12)
Category 3	0.17% (n2)	0.09% (n1)	0.36% (n4)
Category4	0	0	0

22. The strategy to reduce pressure ulcers across the health economy was outlined in a separate paper and action plan to the Trust Board in May 2013.

Figure 4 **% New Harms - Pressure Ulcers**

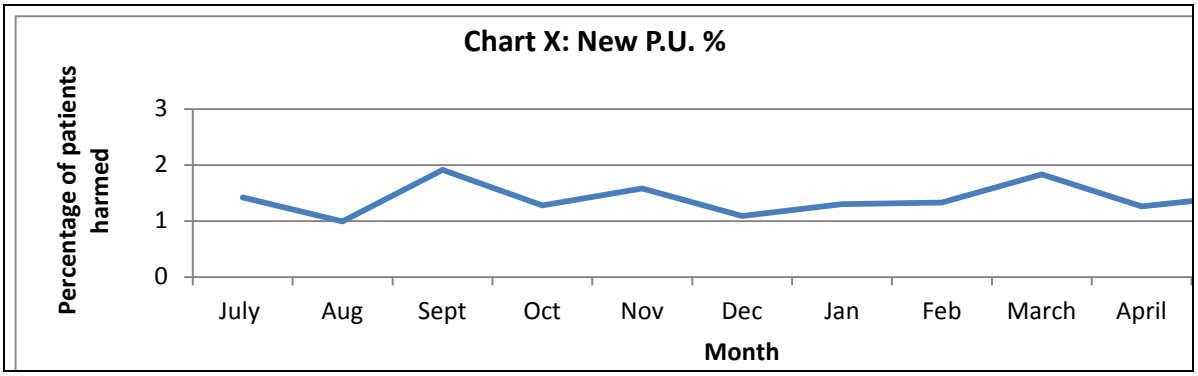


Figure 5 **% New Harms - Falls**

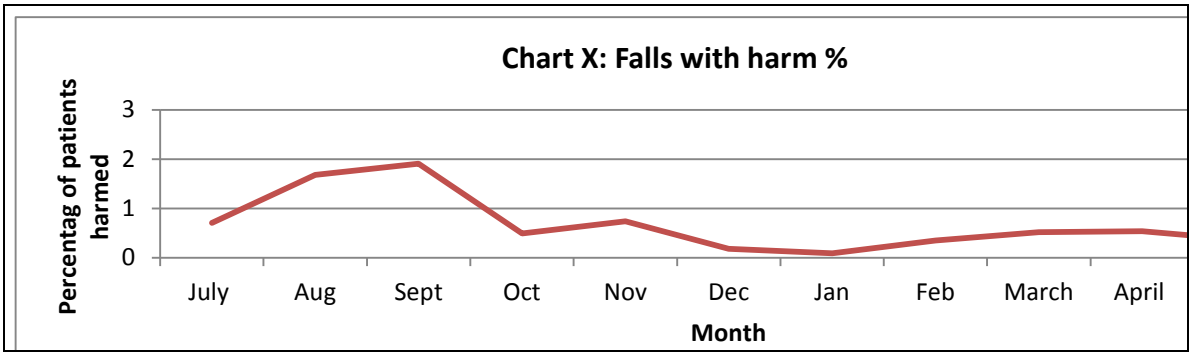


Figure 6 **% New Harms - CAUTI**

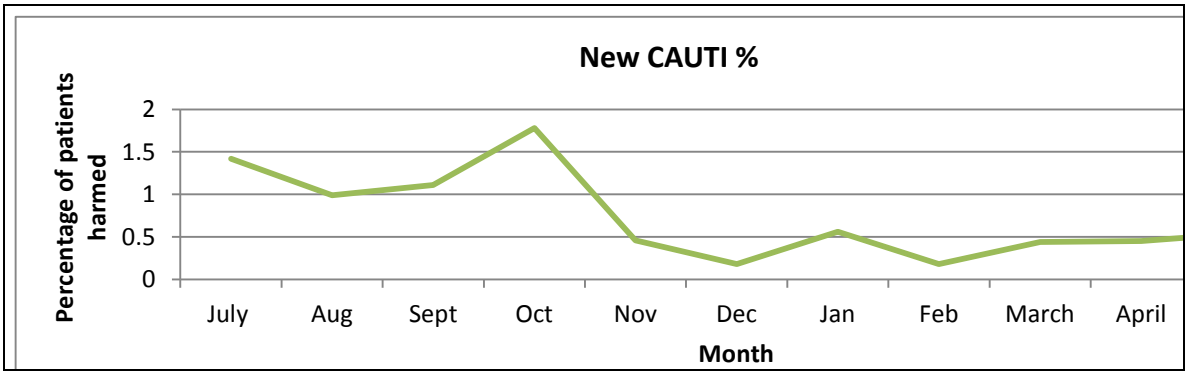
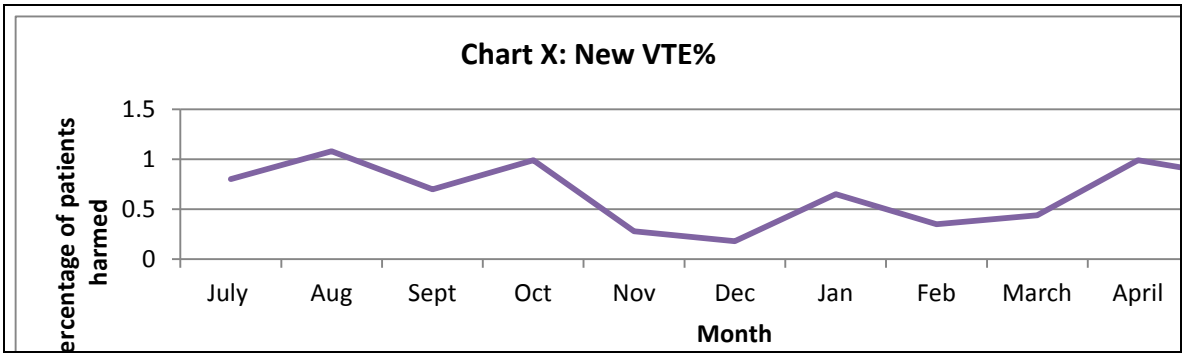


Figure 7 **% New Harms - VTE**



Central Alerting System (CAS)

23. A total of 12 new alerts were received in May 2013. As of the 31 May 2013, 1 MDAs and 1 NPSA remained open. The remaining open NPSA alert, which was breaching the deadline, related to equipment for making safe connections to spinal and epidural needles, and the lack of suitably tested equipment in the market place. The Trust is contacting those Trusts who have closed the alert to see what approach has been taken.

24. Twelve new Medical Device Alerts (MDAs) were received in May 2013. Ten MDAs were due for closure in May 2013 all of which were closed before the deadline. Two Estates and Facilities Alerts (EFAs) were due for closure in May 2013; one was closed before the deadline and one closed on the day of the deadline.

Table 6 **CAS Alerts received May 2013**

Month	New alerts issued			Open at end of month			Number breaching deadline	Total open
	MDA	NPSA	EFA	MDA	NPSA	EFA		
May 2013	12	0	0	1	1	0	1	**2**

Complaints

25. The number of formal complaints received in May (66) presented as a decrease compared to April (78). Figure 8 below illustrates the complaints trend for the last year. Table 7 illustrates the complaints trend for a three-year period against total OUH activity.

Figure 8 **OUH complaints trend June 2012 – May 2013**

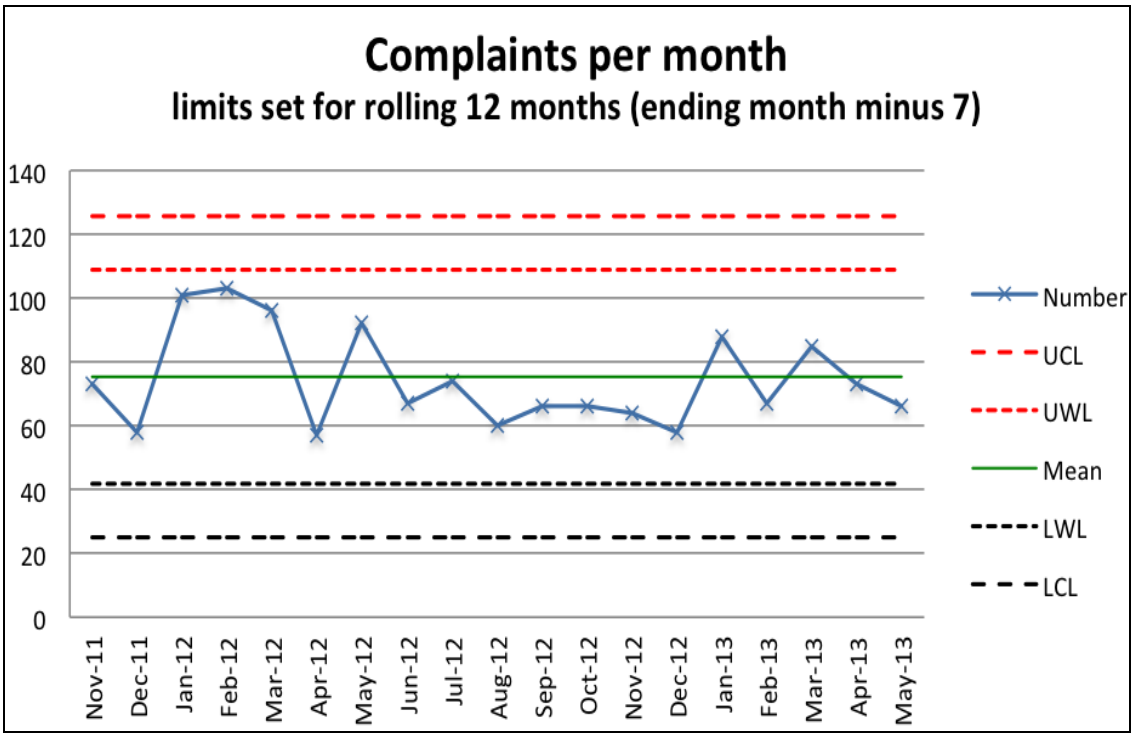


Table 7 **OUH Complaints for 2010/11 – 2012/13 (FY) in context of activity**

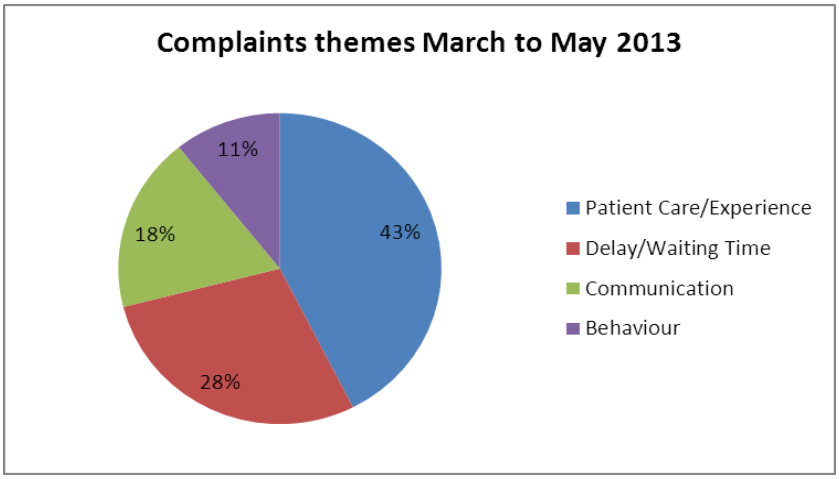
Financial Year	Total OUH activity	% of activity
2010-11	1101845	0.075%
2011-12	1135868	0.076%
2012-13	1145846	0.075%

26. The table below shows the number of Finished Consultant Episodes (FCEs), including outpatient appointments attended, ED attendances and inpatients, per Division, for the period May 2012 to May 2013, together with the corresponding number of complaints received and the corresponding percentages.

Table 8 Complaints and Finished Consultant Episodes (FCEs)

Division	Activity May 2012 to May 2013	Complaints May 2012 to May 2013	%
Cardiac Thoracic & Vascular	60576	41	0.06%
Critical Care Theatres Pharmacy &Diagnostics	172172	62	0.04%
Children & Women's	159810	127	0.07%
Emergency Medicine & Therapies	329256	165	0.05%
Musculoskeletal & Rehabilitation	134585	81	0.06%
Neurosciences, Trauma & Specialist Surgery	256834	198	0.07%
Surgery & Oncology	289812	201	0.06%

Figure 9 Complaints Themes 2013 - YTD



New Complaints – May 2013

27. Of the 66 new complaints, 2 were graded red as follows:

- Parents believe poor care during labour contributed to death of baby;
- Elderly gentleman admitted to the JR Hospital following a fall at home, he was transferred to community hospital with undiagnosed fractures.

Management of complaints

28. In May, all complaints were acknowledged within the statutory 3 working days.

Ombudsman Investigations

29. There was one request from the Parliamentary and Health Service Ombudsman in May.

30. This request was from the wife of a deceased patient with on-going concerns regarding her husband's clinical oncology out-patient consultation on 27 February 2012 and subsequent emergency admission to the JR resulting in emergency surgery due to a sigmoid perforation and abscess. The patient was terminally ill and passed away soon after admission.

Patient Experience

31. Patient feedback data has been collated from 1222 items of feedback; this includes Friends and Family Test.

The majority of comments (n=183) received excluding Friends and Family Test relate to issues that required resolution (61%). 12% of the feedback comments were positive and 13% in May were constructively critical (without an issue to resolve).

Table 9 Types of comments received March – May 2013

Type	March		April		May	
Issues that required resolution	169	66%	201	53%	183	61%
Positive Feedback	36	17%	79	21%	36	12%
Constructively critical Feedback	31	11%	56	15%	40	13%
Advice/ information request	19	5%	23	6%	21	7%
Mixed positive and negative	6	1%	8	2%	8	3%
Other	0	0.4%	9	2%	10	3%

32. Table 10 below provides a summary of the top four feedback topics from the above data. More detail will be presented in August within the patient experience report.

Table 10 Top four patient feedback issues

Top four patient feedback issues	March	April	May
Appointment, treatment and discharge delays	89	118	91
Communication, consent and confidentiality	43	48	36
Caring, friendly and helpful attitude/high quality care	42	88	37
Car parking issues	4	11	12

33. There were 924 Friends and Family Test responses from patients in May, 1335 in April, and 635 in March; 90% of patients said they would be extremely likely or likely to recommend their ward/ED in May (presented in figure 10, below). The response rate for May was 11%, down from the response rate in April (>15%). Individual clinical areas are being actively supported to increase their response rates.

34. The Friends and Family score (net promoter score) was 67 for May, 67 for April, 71 for March, and 65 in February (presented in figure 11; below). The percentage of patients who said they would be extremely likely or likely to recommend their ward/ED was 90%

Figures 10 & 11 **Family and Friends Test Results and Score**

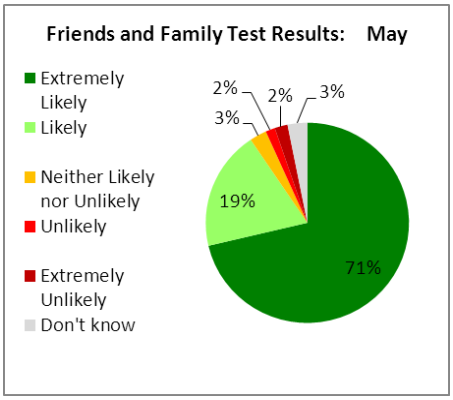


Figure 10: Responses *(n=924, don't know is excluded from NPS calculations*)*

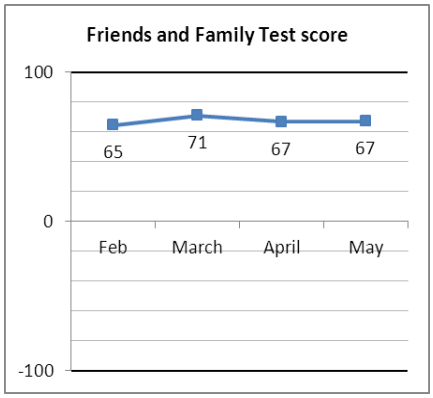
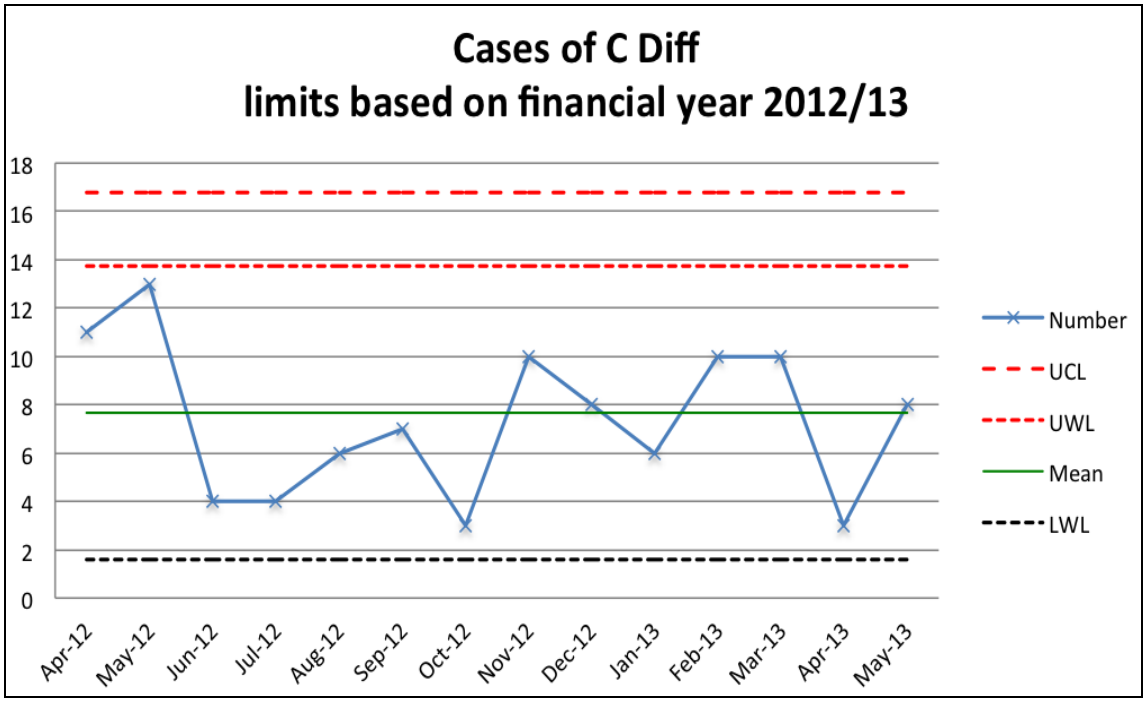


Figure 11: The Friends and Family Test Score *(net promoter score *, NPS = extremely likely minus [unlikely + neutral + extremely unlikely])*

Infection Control

Figure 12

Number of Clostridium Difficile Cases per month 2012/2013 & 2013 – YTD



35. The OUH Trust has had 11 cases of Clostridium difficile identified from samples taken after three days of admission. The Trust remains within its objective to date. However, one case may be removed following review with Oxfordshire Clinical Commissioning Group (OCCG) as the patient did not have active disease or require any treatment.

MRSA bacteraemia

36. The OUH Trust had one MRSA bacteraemia in May 2013. The patient was admitted having fallen at home, following which the patient required rehabilitation prior to discharge. During this admission, the patient developed an MRSA bacteraemia

Quality Scorecards

37. The seven divisional quality scorecards are not being presented to the Trust Board this month. The relevant metrics (ward level hand hygiene, falls, pressure ulcers) are being monitored within Divisions and reported to the Clinical Governance Committee thorough Divisional Quality Reports. The format of the Divisional Quality Report, and in time the Trust Board Quality Report, is being revised. A new report format is anticipated for the September Board / Quality Committee meeting.

Recommendations

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

Professor Edward Baker, Medical Director

Elaine Strachan-Hall, Chief Nurse

July 2013