Oxford University Hospitals NHS
NHS Trust

Trust Board Meeting: Wednesday 13 November 2013

TB2013.120

Title	**Quality Report**

Status	For information
History	This is a monthly paper to the Trust Board (considered by the Quality Committee in those months when the full Trust Board does not meet)

Board Lead(s)	Professor Ted Baker, Medical Director			
Key purpose	Strategy	**Assurance**	Policy	Performance

Executive Summary

1. The November Board Quality Report (BQR) is provided in a revised format following feedback from the Quality Sub-Committee of the Trust Board in October. It presents information that is as contemporary as possible, often including the last calendar month.
2. In relation to key quality metrics:
    - 2 metrics are under development (national cleaning score and time to surgery).
    - For 22 (of 54) quality metrics, pre-specified targets have not been achieved and trend data are provided along with exception reports.
3. In relation to patient safety and clinical risk:
    - 2 SIRIs were reported during October 2013.
4. In relation to Quality Walk Rounds:
    - Quality Walk Rounds took place in 4 clinical areas during October 2013.
5. In relation to clinical effectiveness:
    - The Trust's SHMI position continues to be favourable (0.95) when compared to HSMR.
    - The HSMR figure that will be published in the annual Dr Foster Hospital Guide is anticipated to be a little lower than 2011/12 and 'as expected'.
    - A range of other metrics are likely to be published in the guide and it is likely that OUH will be a statistical outlier for some of these.
6. In relation to CQUIN / Quality Account Priorities:
    - Performance continues to be good against the majority of 2013/14 CQUIN goals and Quality Acount Priorities.
7. In relation to Infection Control:
    - A third case of positive MRSA blood cultures was confirmed during October. This was judged to be unavoidable.
    - Actions continue to reduce the risk posed by Legionella within the water supply to the Trust's retained estate.

Recommendation

Trust Board is asked to receive this report and appendix 1.

Quality Report

1. Purpose

1.1. This paper aims to provide the Trust Board with information on the quality of care provided within the organisation, and on the measures being taken in relation to quality assurance and improvement.

2. Key Quality Metrics

2.1. A suite of fifty four key quality metrics has been identified for presentation. These metrics have been chosen as they are clearly linked to the quality of clinical care provided across the organisation and data quality is felt to be satisfactory. Two of these metrics are still under development and are not being presented this month.

2.2. A Quality Dashboard is provided on pages 4 - 6.

2.3. Trend graphs and exception reports are provided from page 7 onwards in relation to metrics where specified thresholds have not been met. Thresholds are drawn from a mixture of sources (national, commissioner and internal).

3. BQR ID	Latest Rating	Previous Period	Descriptor	Period	Threshold Source	Red	Amber
PS01	97.91% Green	Amber	Safety Thermometer (% patients receiving care free of any newly acquired harm)	Oct 13	Internal	<95%	<97%
PS02	94.11% Green	Amber	Safety Thermometer (% patients receiving care free of any harm - irrespective of acquisition)	Oct 13	Internal	<91%	<93%
PS03	95.19% Amber	Green	VTE Risk Assessment (% admitted patients receiving risk assessment)	Sep 13	National	<95%	<95.25%
PS04	2 N/A		Serious Incidents Requiring Investigation (SIRI) reported via STEIS	Oct 13	No Threshold	N/A	N/A
PS05	31 Green	Green	Number of cases of Clostridium Difficile > 72 hours (cumulative year to date)	Oct 13	National	>41 (YTD)	N/A
PS06	3 Red	Red	Number of cases of MRSA bacteraemia > 48 hours (cumulative year to date)	Oct 13	National	>0	N/A
PS07	85.71% Amber	Red	Antibiotic prescribing - % prescriptions where indication and duration specified [most recently available figure, undertaken quarterly]	Oct 13	Internal	<85%	<88%
PS08	96.29% Green	Green	Antibiotic prescribing - % compliance with antimicrobial guidelines [most recently available figure, undertaken quarterly]	Oct 13	Internal	<93%	<95%
PS09	82.87% Amber	Amber	% Patients receiving stage 2 medicines reconciliation within 24h of admission	Oct 13	Internal	<75%	<85%
PS10	95.21% Amber	Green	% Patients receiving allergy reconciliation within 24h of admission	Oct 13	Internal	<94%	<96%
PS11	2098 N/A		Total number of incidents reported via Datix	Oct 13	No Threshold	N/A	N/A
PS12	5.62% Amber	Amber	% Incidents associated with moderate harm or greater	Oct 13	Internal	>6.5%	>5%
PS13	48 N/A		Total number of newly acquired pressure ulcers (category 2,3 and 4) reported via Datix	Oct 13	No Threshold	N/A	N/A
PS14	8 Red	Green	Falls leading to moderate harm or greater	Oct 13	Internal	8	4
PS15	1 Red	Red	Number of hospital acquired thromboses identified and judged avoidable [two months in arrears]	Aug 13	Internal	>0	N/A
PS16			National Cleaning Score - number of inpatient areas with initial score < 92%			N/A	N/A
PS17	3.9% Green	Green	% 3rd and 4th degree tears in obstetrics [C&W Division]	Sep 13	Internal	>5%	N/A
PS18	97.09% Amber	Red	% Radiological investigations achieving 5 day reporting standard [CCTADP Division]	Sep 13	Commissioner	<95%	<98%
PS19	15		Number of CAS alerts received	Oct 13	No Threshold	N/A	N/A
PS20	1 Red	Red	CAS alerts breaching deadlines at end of month and/or closed during month beyond deadline	Oct 13	Internal	>0	N/A
CE01	0.95 N/A		Standardised Hospital Mortality Ratio (SHMI) [most recently published figure, quarterly reported as a rolling year ending in month]	Mar 13	No Threshold	N/A	N/A
CE02	205 N/A		Crude Mortality	Oct 13	No Threshold	N/A	N/A
CE03	47.16% Red	Red	Dementia - % patients aged > 75 admitted as an emergency who are screened [one month in arrears]	Sep 13	National	<80%	<90%

CE04	77.1% Red	Red	Statutory and Mandatory Training - % required modules completed	Sep 13	Internal	<85%	<95%
CE05	95.32% Green	Amber	ED - % patients seen, assessed and discharged / admitted within 4h of arrival	Sep 13	National	<85%	<95%
CE06	95.83% Green	Green	Stroke - % patients spending > 90% of admission in specialist stroke environment	Sep 13	National	<70%	<80%
CE07	86.05% Green	Amber	Stroke - % patients accessing specialist stroke environment within 4h of arrival	Sep 13	National	<75%	<85%
CE08	395 N/A		Transfer Lounge Usage	Oct 13	No Threshold	N/A	N/A
CE09	72.95% Amber	Amber	Paediatric Surgery - % children having applicable procedures as day case [C&W]	Oct 13	Internal	<70%	<75%
CE10	4 Amber	Green	Vascular - Median length of stay for patients undergoing elective AAA repair [CVT Division]	Sep 13	Internal	>4	>3
CE11	1.67% Green	Green	Vascular - % mortality following elective AAA repair [CVT Division]	Sep 13	Internal	>5%	>3%
CE12	81.82% Red	Green	Cardiology - % patients receiving primary angioplasty within 60 minutes of arrival at hospital [CVT Division]	Aug 13	Internal	<85%	<90%
CE13	3 Red	Amber	Cardiology - mean number of days from referral to admission to cardiology at tertiary centre [CVT Division]	Sep 13	Internal	>3	>2
CE14	0% Green	Green	Cardiac surgery - % patients acquiring organ / deep tissue infection following surgery [CVT Division]	Sep 13	Internal	>1%	>0.5%
CE15	0% Green	Green	Cardiac Surgery - % mortality following elective primary CABG [CVT Division]	Sep 13	Internal	>4%	N/A
CE15	0% Green	Green	Cardiac Surgery - % mortality following elective primary CABG [CVT Division]	Sep 13	Internal	>6%	N/A
CE16	0 Green	Green	Number of unscheduled returns to theatre within 48 hours [MARS Division]	Oct 13	Internal	>0	N/A
CE17	100% Green	Green	Rheumatology - % relevant patients who have their DAS28 score documented [MARS Division]	Oct 13	Internal	<95%	<98%
CE18	0 Green	Red	Number of unscheduled returns to theatre in gynaecology [C&W Division]	Sep 13	Internal	>0	N/A
CE19	477 N/A		Number of patients admitted to SEU wards from SEU triage [S&O Division]	Oct 13	No Threshold	N/A	N/A
CE20			% SEU patients requiring surgery who receive surgery within 24 hours of decision to operate [S&O Division]		Internal	N/A	N/A
CE21	4.38% Red	Amber	Neuroscience Intensive Therapy Unit (NITU) readmission rate within 48 hours of discharge [NTSS Division]	Sep 13	Internal	>4%	>2%
CE22	76.67% Green	Green	% Fractured NOF patients who receive surgery within 36 hours of admission [NTSS Division]	Sep 13	Commissioner	<70%	<72%
CE23	20.11% Green	Green	% Deliveries by C-Section [C&W Division]	Sep 13	Commissioner	>33%	>23%
CE24	0.65% Green	Green	7 day admission rate following assessment on (and discharge from) paediatric CDU [C&W Division]	Oct 13	Internal	>4%	>2%
PE01	70 Green	Green	Friends & Family - Net Promoter Score [one month in arrears]	Sep 13	Internal	<63	<70
PE02	93.06% Amber	Amber	Friends & Family - proportion extremely likely or likely to recommend [one month in arrears]	Sep 13	Internal	<90%	<94%
PE03	60 Green	Amber	Complaints Received	Oct 13	Internal	>90	>80

PE04	1 Red	Red	Number of complaints received initially graded as RED	Oct 13	Internal	>0	N/A
PE05	479 N/A		PALS contacts made	Oct 13	No Threshold	N/A	N/A
PE06	0 Green	Green	Single sex breaches	Sep 13	National	>2	>1
PE07	74.69% Green	Green	% Patients EAU length of stay < 12h	Oct 13	Internal	<65%	<70%
PE08	63.1% N/A		% Complaints upheld or partially upheld	Sep 13	No Threshold	N/A	N/A
PE09	1 Green	Red	Number of legal claims received / inquests opened initially graded as RED	Oct 13	Internal	>1	N/A
PE10	64.67% Green	Amber	% Patients returning feedback forms in specialist surgery outpatients [NTSS Division]	Sep 13	Internal	<45%	<60%

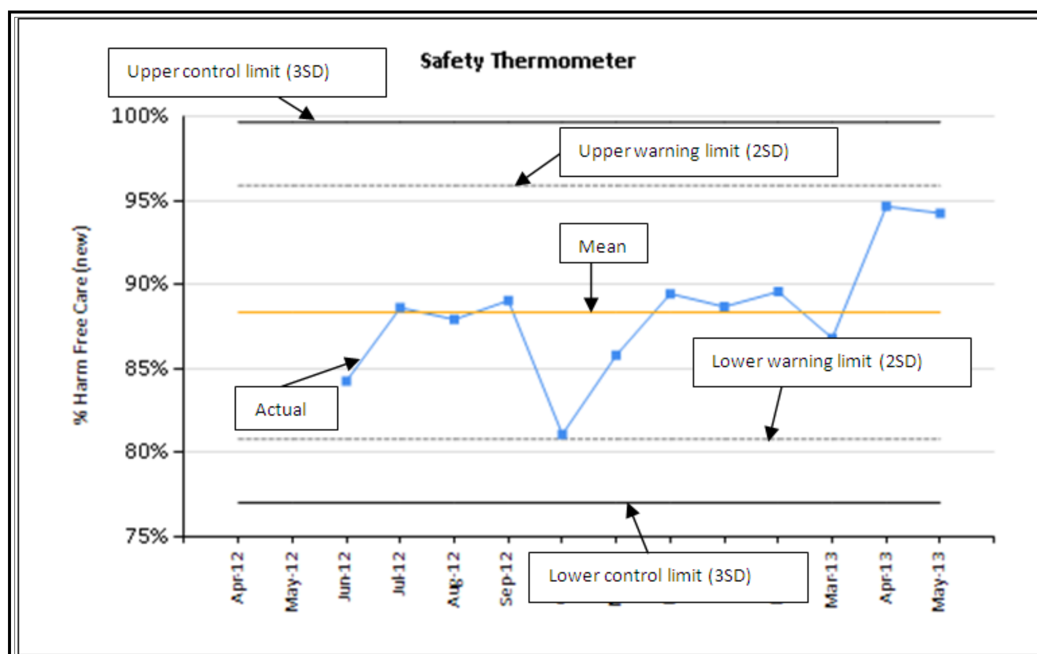
How to interpret charts

Data are presented in this report in a number of different ways – including statistical process control (SPC) charts, line charts (without confidence intervals / control limits), histograms and cumulative histograms. Graphics have been selected in order to encourage the analysis of trends and to identify when a change in relation to the historical position is likely to be 'real' or statistically significant.

SPC charts show a trend line and allow easy reference to the historical mean for that metric at a time at which it was stable and 'within control'. Where shown, the mean is displayed as a horizontal orange line. In addition, warning limits and control limits are shown where appropriate, above and below the mean. Warning limits are placed at two standard deviations (2SD – dashed black line) and control limits at three standard deviations (3SD – solid black line). If a data point is found beyond the control limit (3SD from the mean) in either direction, the change is statistically significant and is very unlikely to have occurred simply by chance.

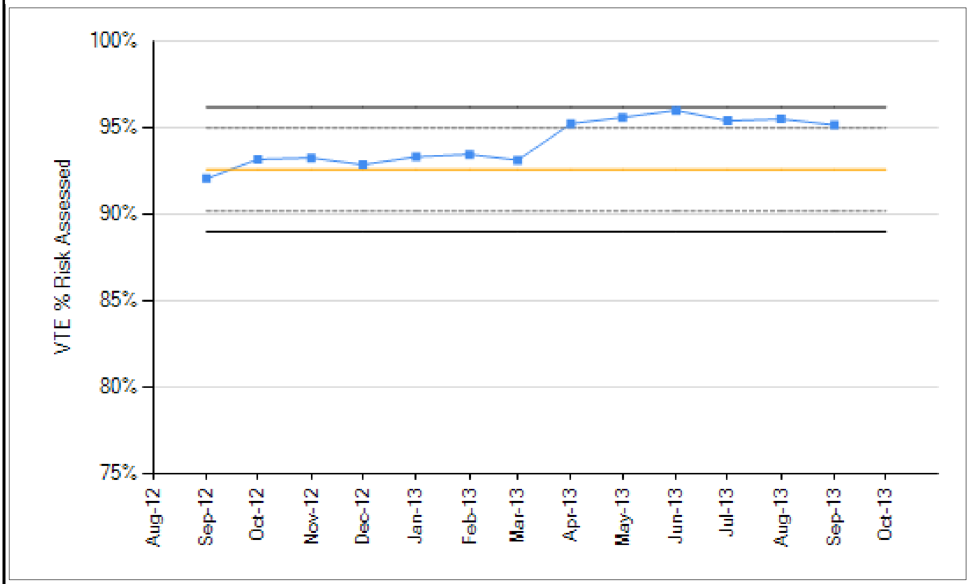
There are other patterns within the data that are likely to reflect real change as opposed to random fluctuation – these patterns are known as special cause variations. They include:

2 consecutive points lying beyond the warning limits (unlikely to occur by chance)
7 or more consecutive points lying on the same side of the mean (implies a change in the mean of the process)
5 or more consecutive points going in the same direction (implies a trend)



Patient Safety

PS03 VTE Risk Assessment (% admitted patients receiving risk assessment)



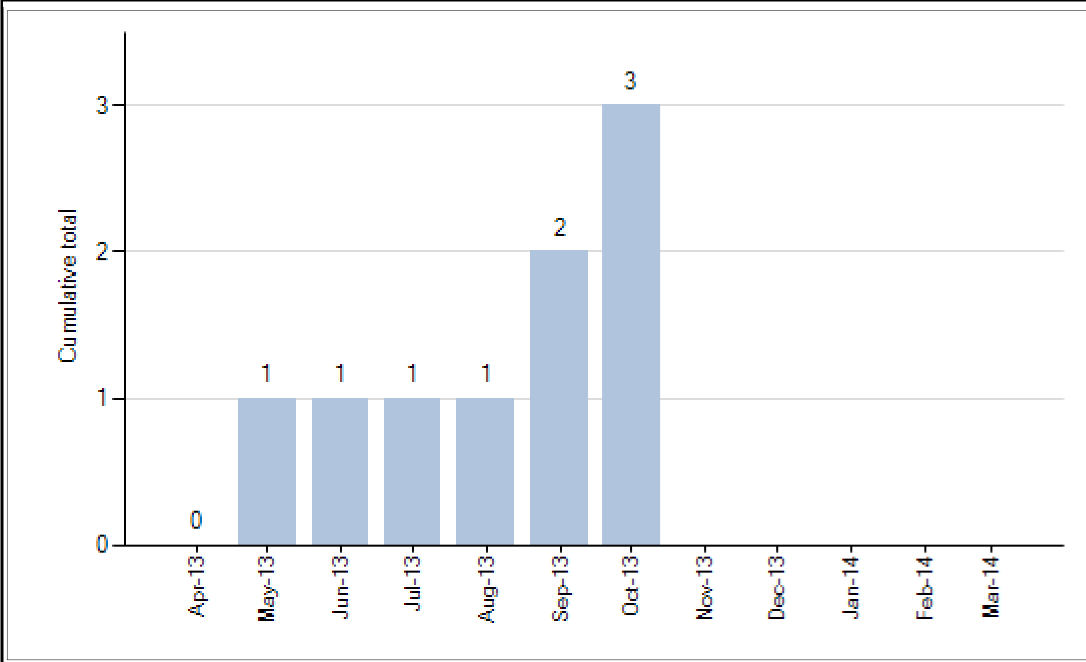
Narrative

A significant improvement in performance occurred in April 2013 when an additional VTE assessment cohort (total length of stay <12 hours) was implemented to reflect Trust policy that prophylaxis, if indicated, should be administered within 12 hours of admission. Control and warning limits will be reset when a sufficient period of stability has been observed. It is noted that performance has been maintained despite the arrival of a 'new house' of junior medical staff in August although there is minimal margin. The mode of assessment is gradually moving from Casenotes to EPR.

The chart shows the proportion of inpatients within the Trust risk assessed for VTE (either individually or as part of a cohort). The data point for the most recent calendar month may improve up until submission to NHS England as further cohorted patients are identified following clinical coding. Earlier figures are those actually submitted to NHS England. [Owner: A Still / I Reckless].

Patient Safety

PS06 Number of cases of MRSA bacteraemia > 48 hours (cumulative year to date)



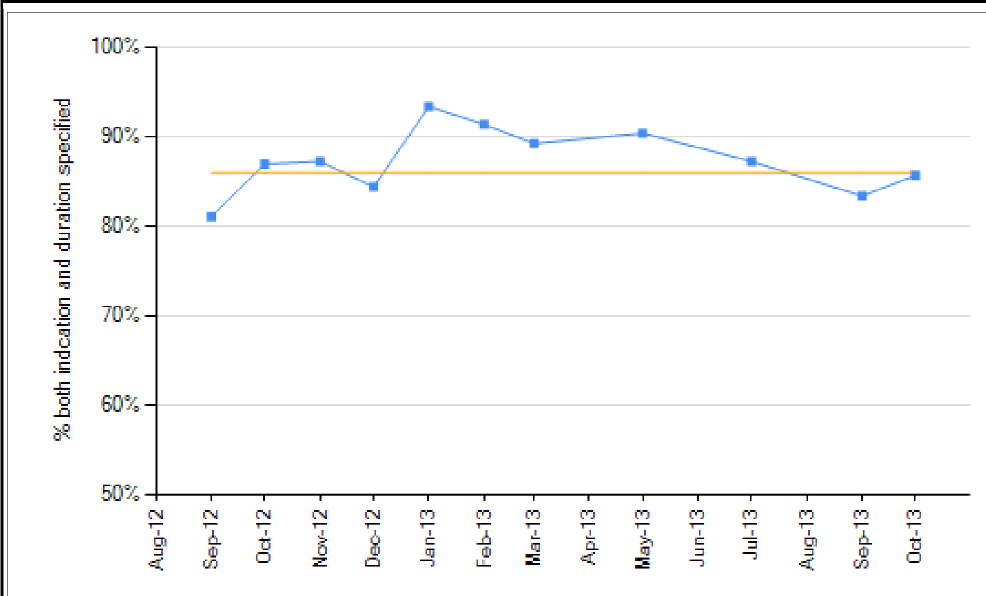
Narrative

Second and third cases of MRSA bacteraemia were reported in September and October. Investigation has determined that neither case was avoidable.

The chart shows the number of cases of MRSA bacteraemia reported via UNIFY (external IT system). If a case is subsequently removed in following consultation with CCG (for example, attributed to a referring hospital), the figure will be modified in future graphs. [Owner: L O'Connor].

Patient Safety

PS07 Antibiotic prescribing - % prescriptions where indication and duration specified [most recently available figure, undertaken quarterly]



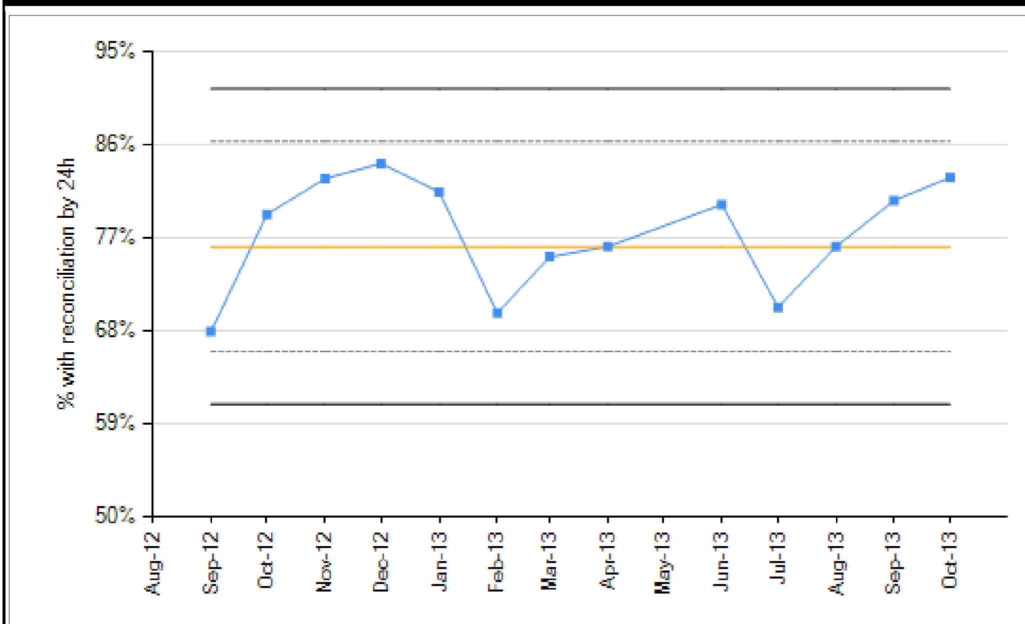
Narrative

These data have been reviewed as part of the pneumonia risk summit.

Each antimicrobial prescription has to have a clinical reason as to why it is prescribed along with the length of the course written in days/doses. [Owner: L O'Connor].

Patient Safety

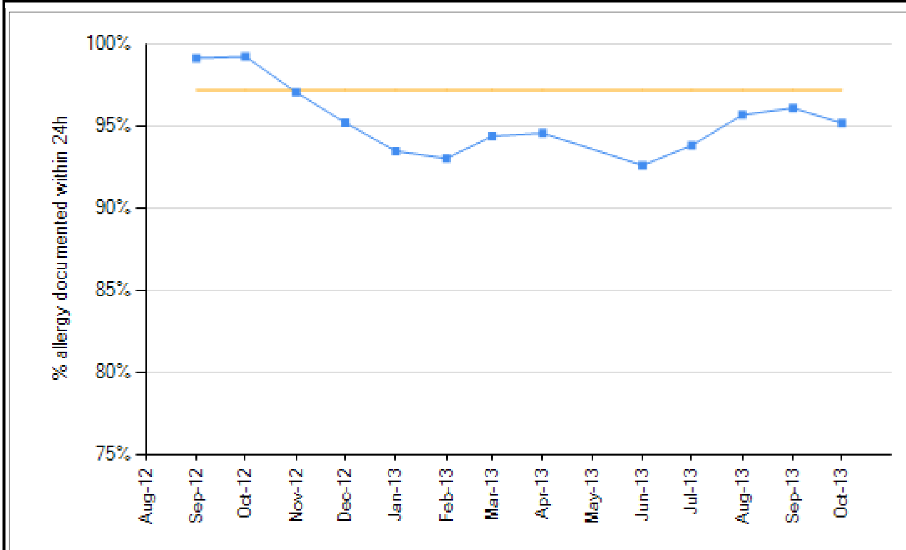
PS09 % patients receiving stage 2 medicines reconciliation within 24h of admission



Narrative

Stage 2 medicines reconciliation involves cross-checking a patient's stated list of medicines against other sources (for example, printed lists or records held in primary care or a community pharmacy). Some of the variation in performance is likely to relate to the audit day – performance during or immediately after a weekend may be less good.

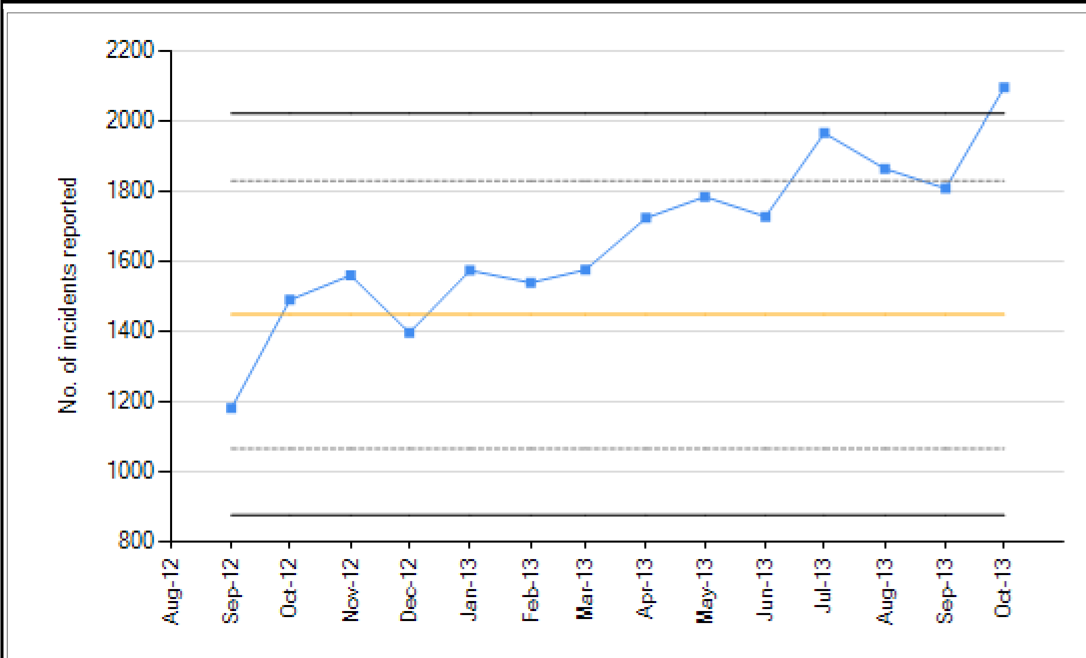
The chart shows the proportion of inpatients for whom second stage pharmacy-led medicines reconciliation is completed within 24 hours of admission. Spot check audit by pharmacy staff once per month. Approximately 600 patients are included in the audit Trust-wide. Please note that this audit was not performed in May 2013 due to capacity issues in pharmacy. [Owner: P Devenish].

Patient Safety	
PS10 % patients receiving allergy reconciliation within 24h of admission	**Narrative**
	Allergy reconciliation involves checking and documenting a patient's stated allergies.

The chart shows the proportion of inpatients within the Division for whom allergy status has been documented at the time of a spot check audit by pharmacy staff once per month. In August 2012, the criteria changed to allergy status documented prior to pharmacy intervention. Please note that this audit was not performed in May 2013 due to capacity issues in pharmacy. [Owner: P Devenish].

Patient Safety

PS11 Total number of incidents reported via Datix



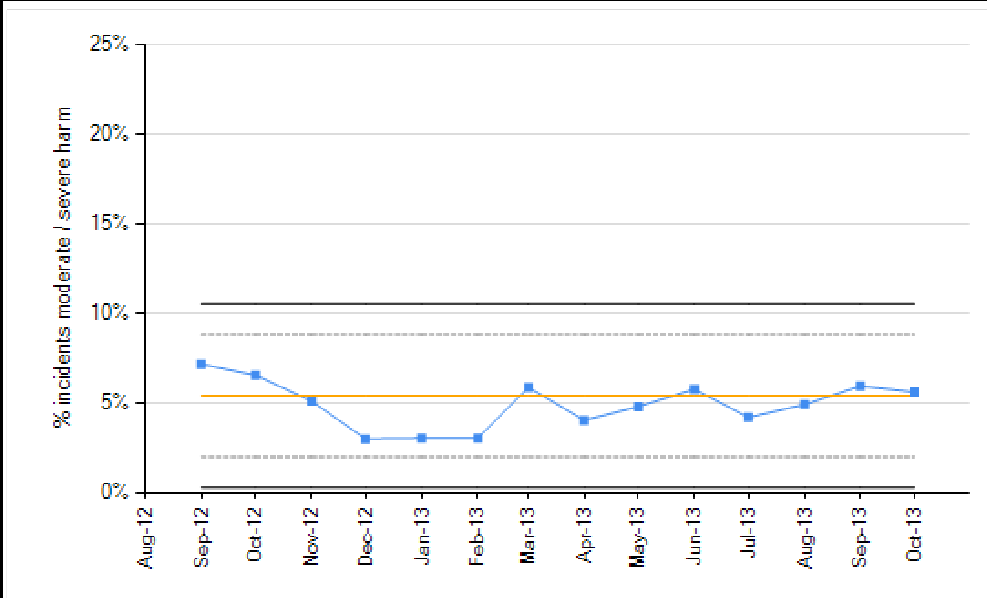
Narrative

The total number of incidents reported has steadily increased over the last year since the Datix electronic incident reporting system became available across the Trust. This increase is to be welcomed and is evidence of an improved reporting culture (see PS12). Control limits will be reset once a period of stability is identified.

The chart shows the number of clinical incidents reported through the Trust's Datix system, expressed in relation to Trust activity [Owner: N Buchan-Brodie].

Patient Safety

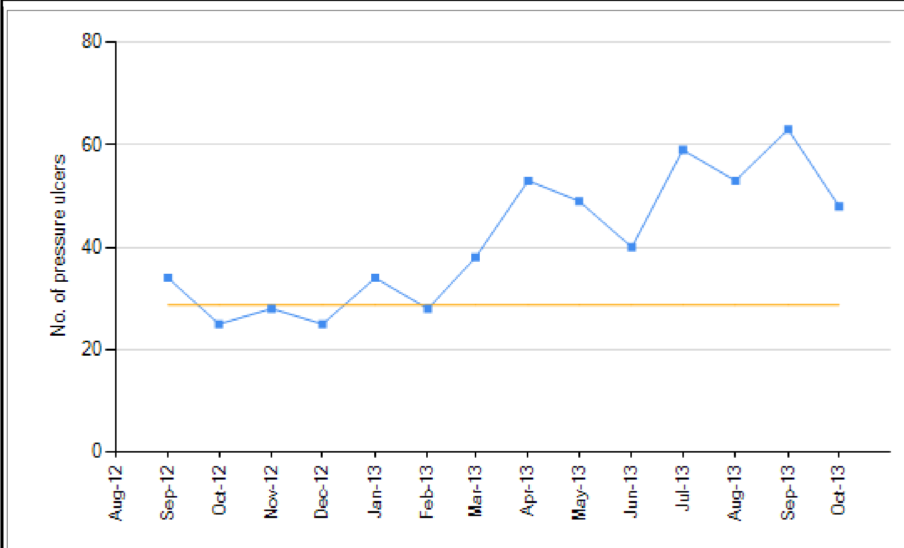
PS12 % of incidents associated with moderate harm or greater



Narrative

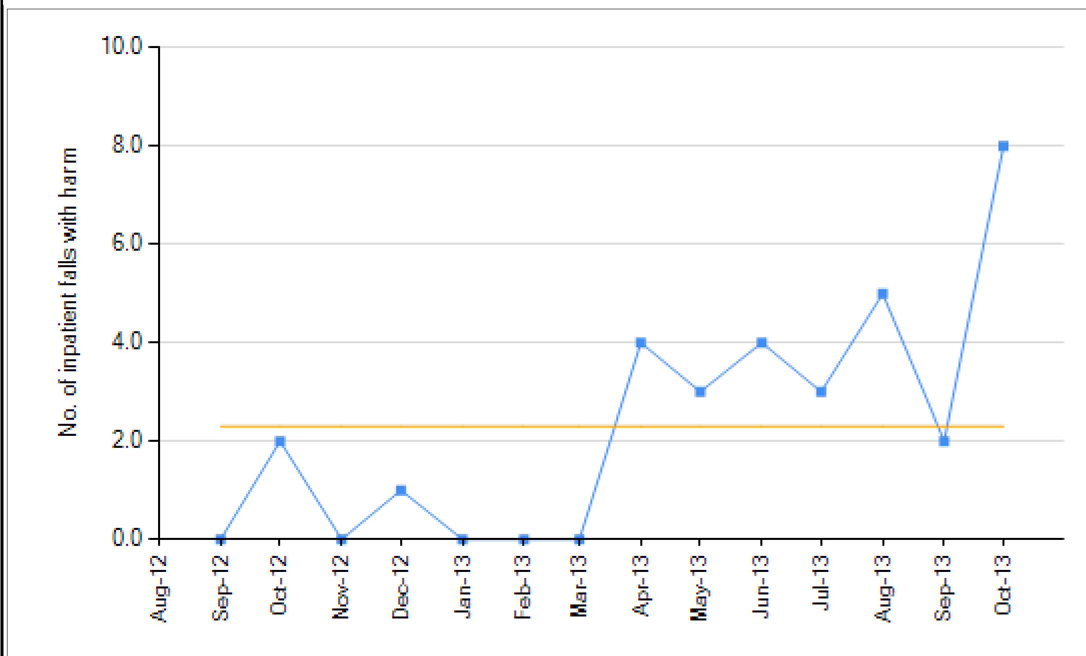
While the total number of incidents reported has increased significantly since autumn 2012, the proportion of incidents resulting in harm has not increased. Although no special cause variation has occurred, the majority of data points since autumn 2012 have been below the historical mean.

The chart shows the proportion of clinical incidents reported through the Trust's Datix system that was ultimately felt to be associated with moderate harm or greater [Owner: N Buchan-Brodie].

Patient Safety	
PS13 Total number of newly acquired pressure ulcers (category 2,3 and 4) reported via Datix	**Narrative**
	The number of pressure ulcers reported via Datix has increased since February 2013.This increase coincides with a major change in reporting practice with staff now being required to report grade 2 pressure damage in addition to grades 3 and 4. See appendix 1 of this Board Quality Report for more detailed narrative. It is now very infrequent that pressure damage not known to OUH is reported by staff at downstream community hospitals (OHFT). This situation was previously commonplace.
Number of pressure ulcers (categories 2, 3 and 4) acquired within OUH and reported through Datix during the month (date of reporting, not necessarily date of incident – includes pressure ulcers reported to OUH by community colleagues). Control limits are not shown as there was a known special cause variation in early 2013 when the reporting of category 2 pressure damage became encouraged[Owner: N Buchan-Brodie / R Betteridge].	

Patient Safety

PS14 Falls leading to moderate harm or greater



Narrative

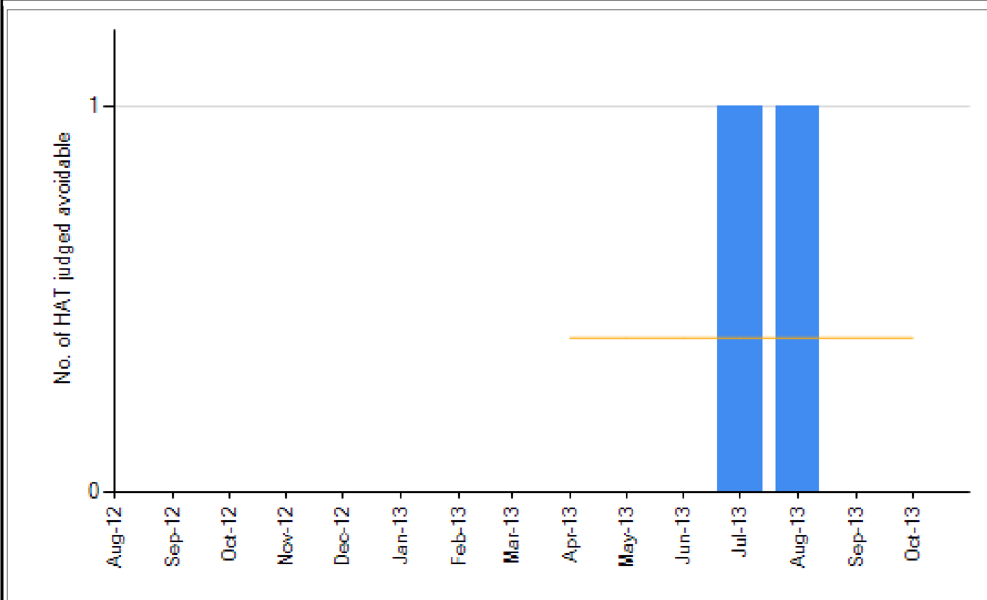
An unusually high number of falls causing harm were reported during October 2013. None of these harms met SIRI criteria.

The eight incident reports will be reviewed and discussed at Trust Clinical Governance Committee on Wednesday 20 November in order to determine any common features (or whether a local change in reporting practice may have occurred in response to an emphasis on falls and related training).

The chart shows the number of inpatient falls leading to harm per month. All falls are reported via the online incident reporting system.

Patient Safety

PS15 Number of hospital acquired thromboses identified and judged avoidable [two months in arrears]



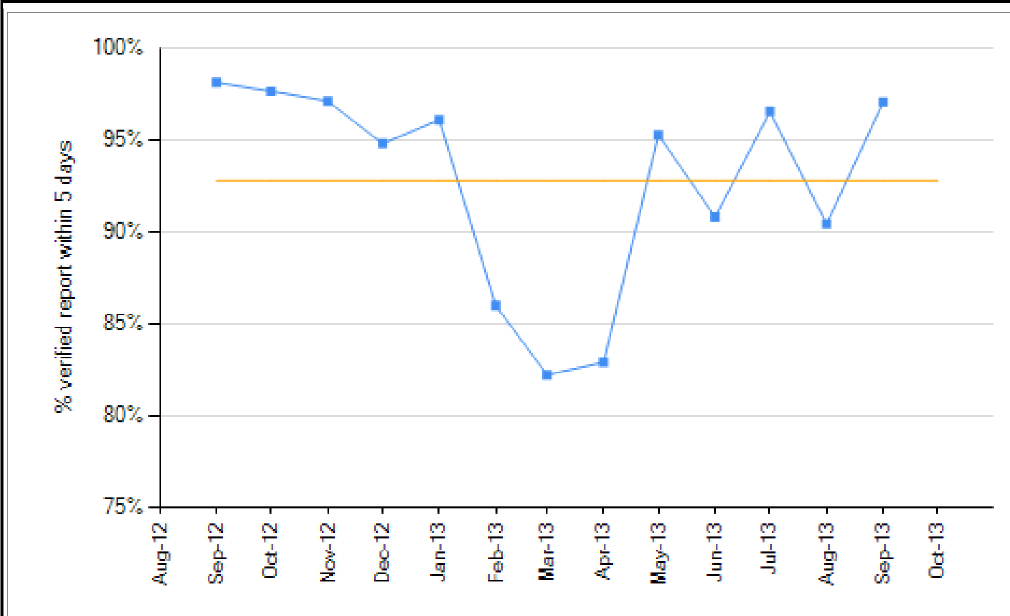
Narrative

The number of hospital acquired venous thromboses that have been judged as potentially avoidable following root cause analysis is low.

When a hospital-associated thrombosis occurs, screening +/- root cause analysis is triggered. This graph shown the number of hospital acquired thromboses in month that were felt to have been avoidable [Owner: N Curry].

Patient Safety

PS18 % radiological investigations achieving 5 day reporting standard [CCTADP Division]



Narrative

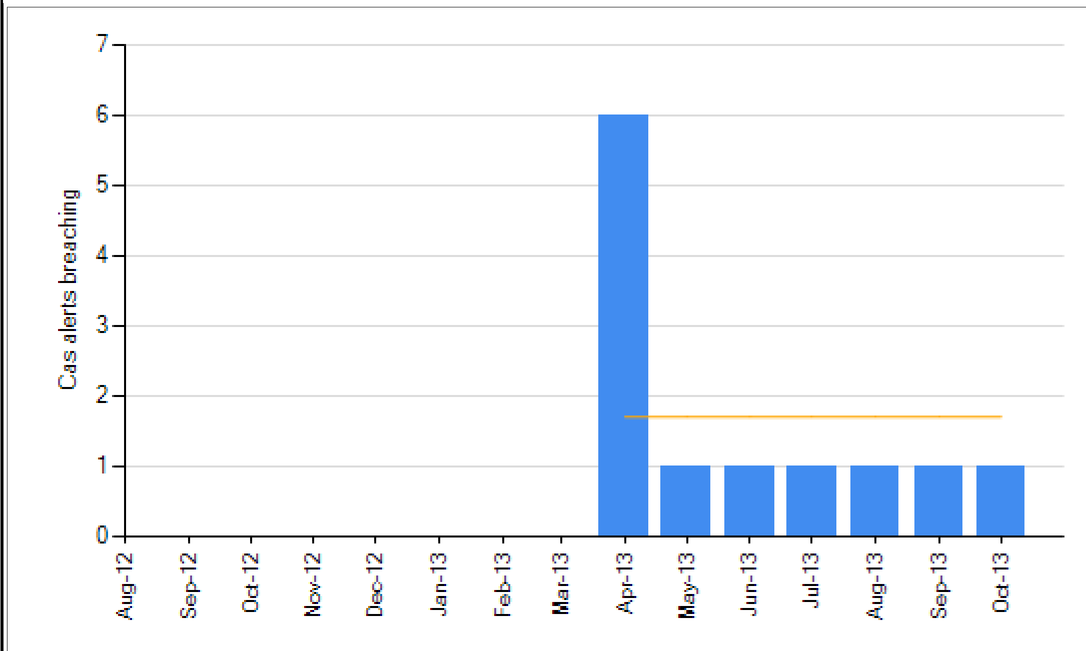
Performance in this area has been unsatisfactory during 2013 with a further backlog of unreported examinations having been identified. This is subject of an ongoing SIRI investigation.

95% of routine examinations should have a verified report within 5 working days of the examination date. Contractual requirement for primary care. Quality goal in other elements of service [Owner: A Middleton].

Patient Safety

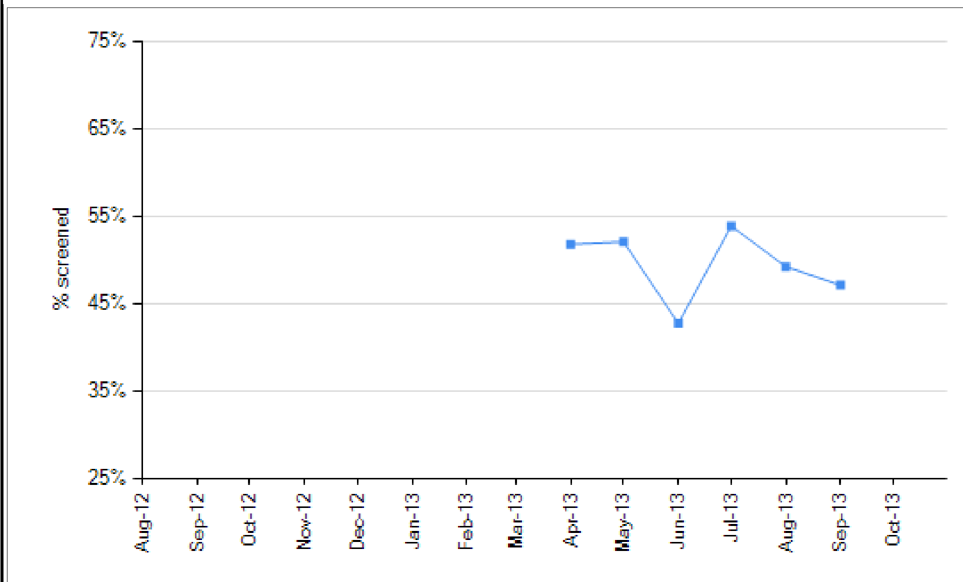
PS20 CAS alerts breaching deadlines at end of month and/or closed during month beyond deadline

Narrative



No CAS alerts have breached relevant deadlines since 04/13. However, one alert (relating to intra-thecal administration of medicines) continued to breach on account of the non-availability of the requisite equipment nationally. The Trust has thoroughly examined the issue and ascertained the position of other NHS organisations. A decision has now been made to close the alert with continual monitoring occurring via risk registers. Oxfordshire CCG is fully supportive of this course of action. The number of breaches will therefore revert to zero in November 2013.

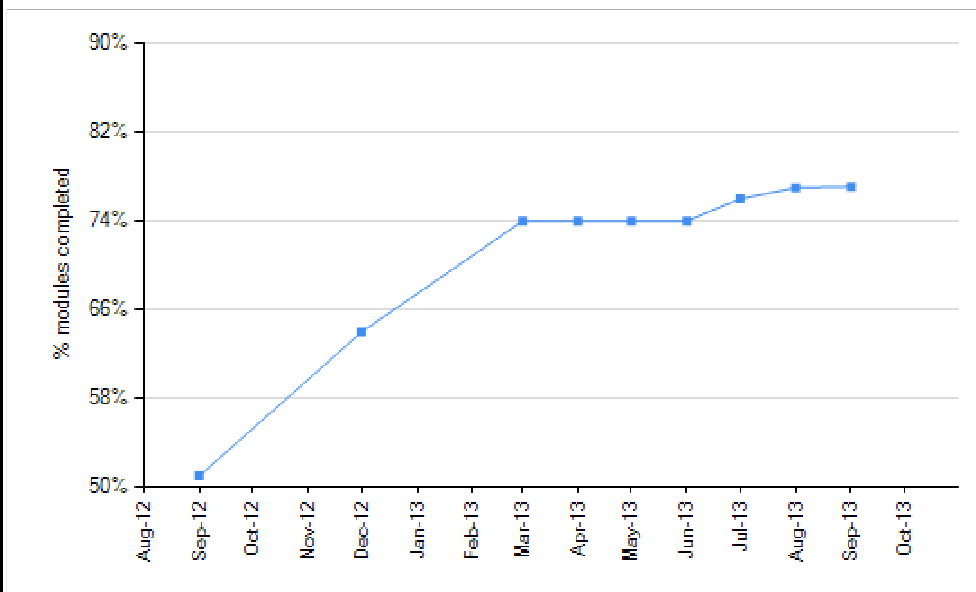
The Trust should acknowledge and, where required, respond to alerts in a timely manner. [Owner: J Spokes]

Clinical Effectiveness	
CE03 Dementia - % patients aged > 75 admitted as an emergency who are screened [one month in arrears]	**Narrative**
	Performance against this metric remains poor as relevant patients are dispersed throughout the organisation and although an appropriate form now exists within EPR, few relevant clinical areas are yet obliged to use EPR. The forthcoming transition of electronic discharge summaries from Casenotes to EPR may lead to a step-change in performance. See narrative within body of this Quality Report.

Elderly patients admitted on a non-elective basis should be screened for dementia using a screening question and / or a simple cognitive test. Performance shown in this graph reflects figures submitted monthly to NHS England. These figures are derived from both EPR and local paper-based systems. [Owner: K Simcock]

Clinical Effectiveness

CE04 Statutory and Mandatory Training - % required modules completed



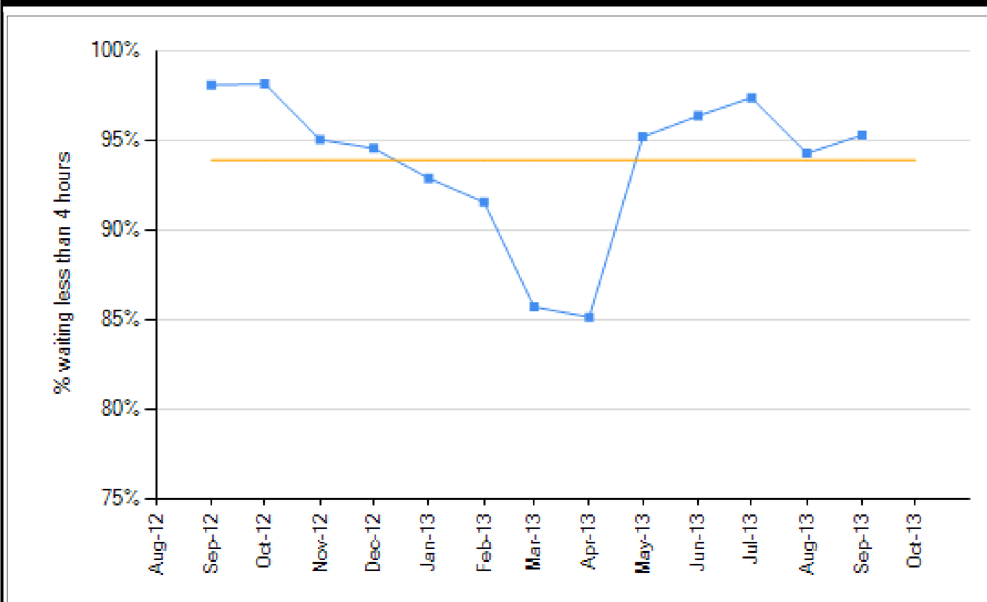
Narrative

Performance remains below desired levels. Data are monitored closely via Divisional performance meetings.

Proportion of mandatory modules completed. [Owner: I MacKenzie]

Clinical Effectiveness

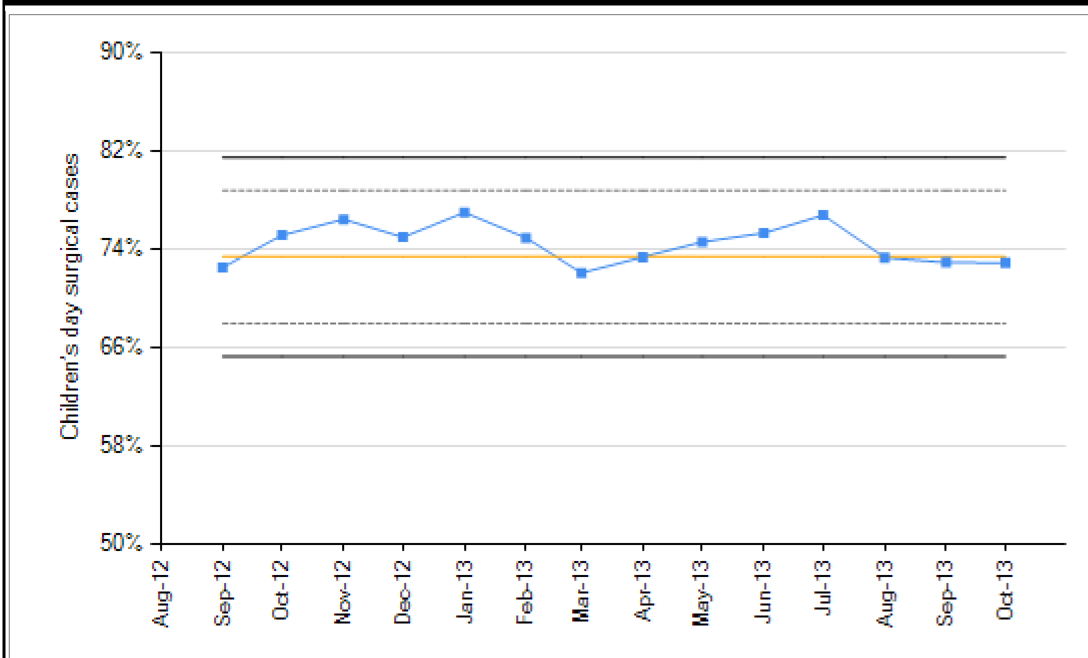
CE05 ED - % patients seen, assessed and discharged / admitted within 4h of arrival



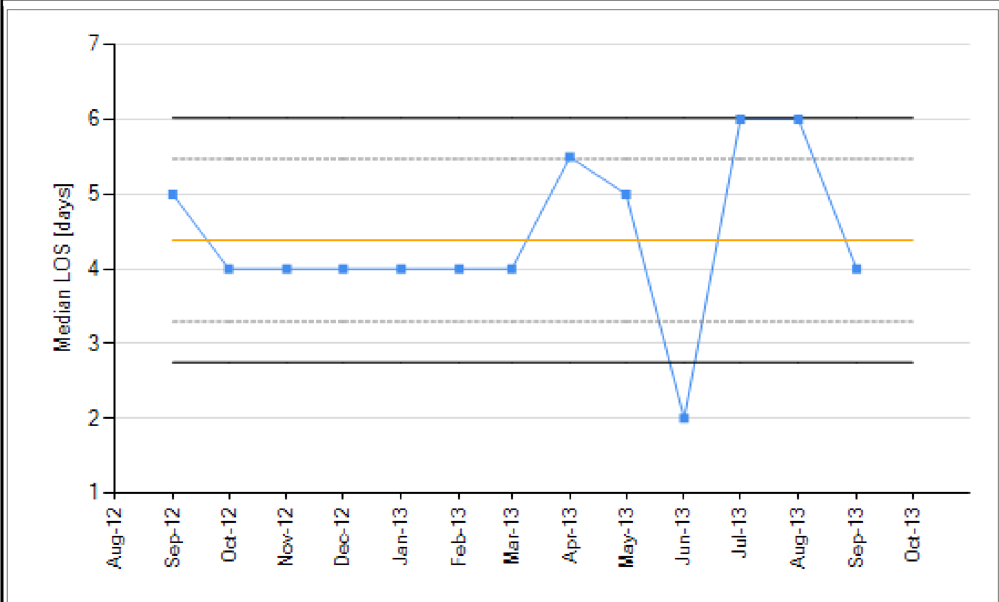
Narrative

The figure for October 2013 was not available at the time of writing but a verbal update will be available at the meeting of Trust Board.

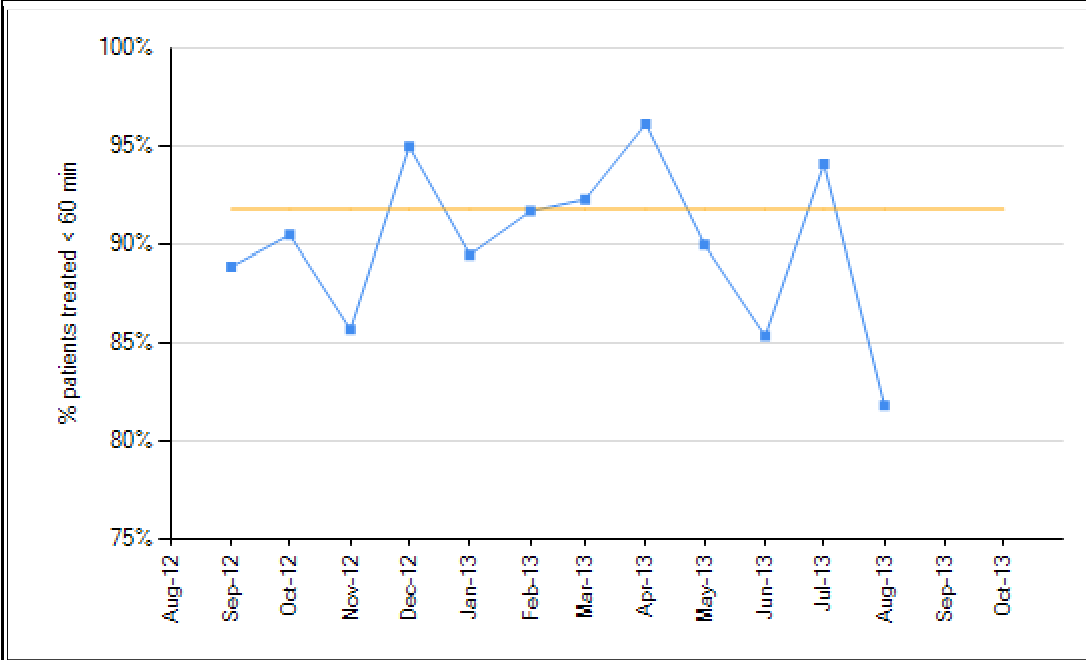
% Patients attending ED who are discharged or admitted within 4 hours of arrival. [Owner: EMT]

Clinical Effectiveness **CE09 Paediatric Surgery - % children having applicable procedures as day case [C&W]**	**Narrative**
	Performance has not deviated from the historical mean but remains below target. Children's Directorate will be asked to undertake focused work examining the gap between this figure and the BADS day case rate, and opportunities to increase the proportion of children and young people having surgery on a daycase basis.

Number of patients who have an elective day case admission displayed as a percentage of the total number of patients who have had an elective admission under paediatric surgery in the month. Further work is required to reconcile these data with the BADS (British Association of Day Surgery) day case rate reported externally. [Owner: Children's Directorate]

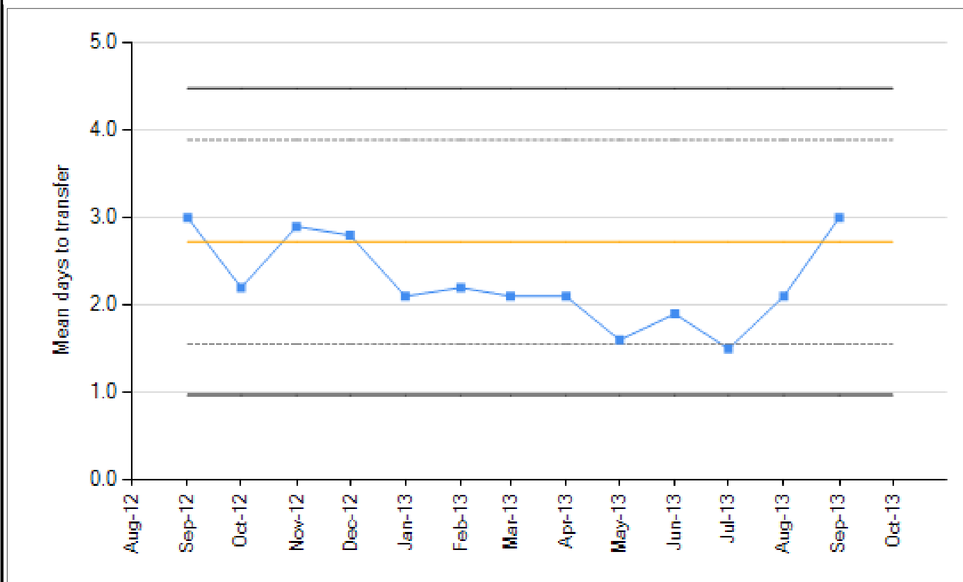
Clinical Effectiveness **CE10 Vascular - Median length of stay for patients undergoing elective AAA repair [CVT Division]**	**Narrative**
	There has been volatility in recent months compared to the historical baseline. This is not thought to be clinically significant.
Information collected from ORBIT and based on the primary procedure coded and elective admission method. [Owner: Specialist Surgery Directorate]	

Clinical Effectiveness

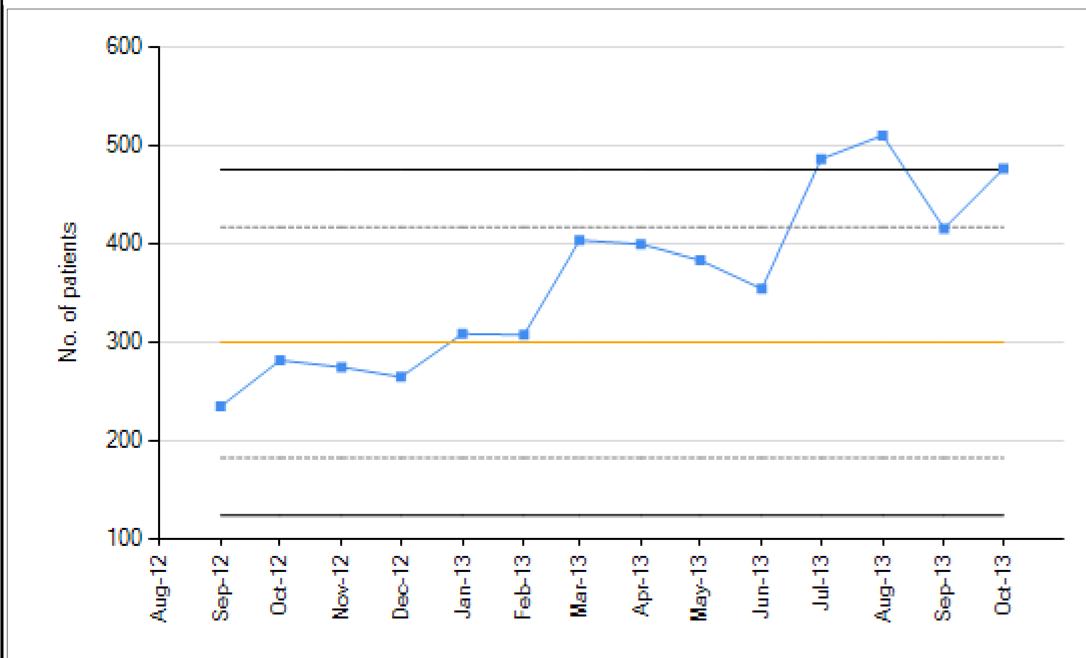
CE12 Cardiology - % patients receiving primary angioplasty within 60 minutes of arrival at hospital [CVT Division]	Narrative
	Benchmarked performance (national BCIS audit) is good.

Information reported through Datacam/Solus and calculated by CTV information team. In 12/13 target was door to balloon (DTB) time <60 minutes for 85% of patients. Data is 2 months in arrears. [Owner: Cardiology Directorate]

Clinical Effectiveness

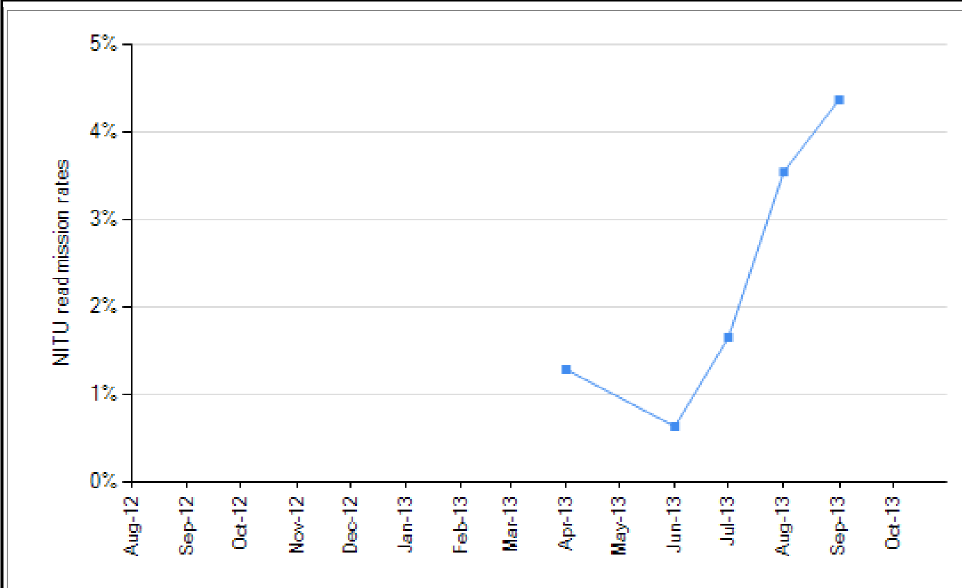
CE13 Cardiology - Mean number of days from referral to admission to cardiology at tertiary centre [CVT Division]	Narrative
	A special cause variation had occurred with a reduction in the time to referral following concerted efforts on the part of the team. However, the time to transfer has now climbed for two consecutive months. This will be monitored on an ongoing basis within the new MRC Division.

Directorate goal is that patients are transferred within 2 days of referral. [Owner: Cardiology Directorate]

Clinical Effectiveness	
CE19 Number of patients admitted to SEU wards from SEU triage [S&O Division]	Narrative
	There has been a significant increase in activity on SEU since the cessation of emergency abdominal surgery at the Horton earlier in 2013.
This is a measure of activity (admission as opposed to assessments) in acute surgery and is of particular interest following changes to the acute surgery model in Banbury in early 2013. [Owner: S&O]	

Clinical Effectiveness

CE21 Neuroscience Intensive Therapy Unit (NITU) readmission rate within 48 hours of discharge [NTSS Division]



Narrative

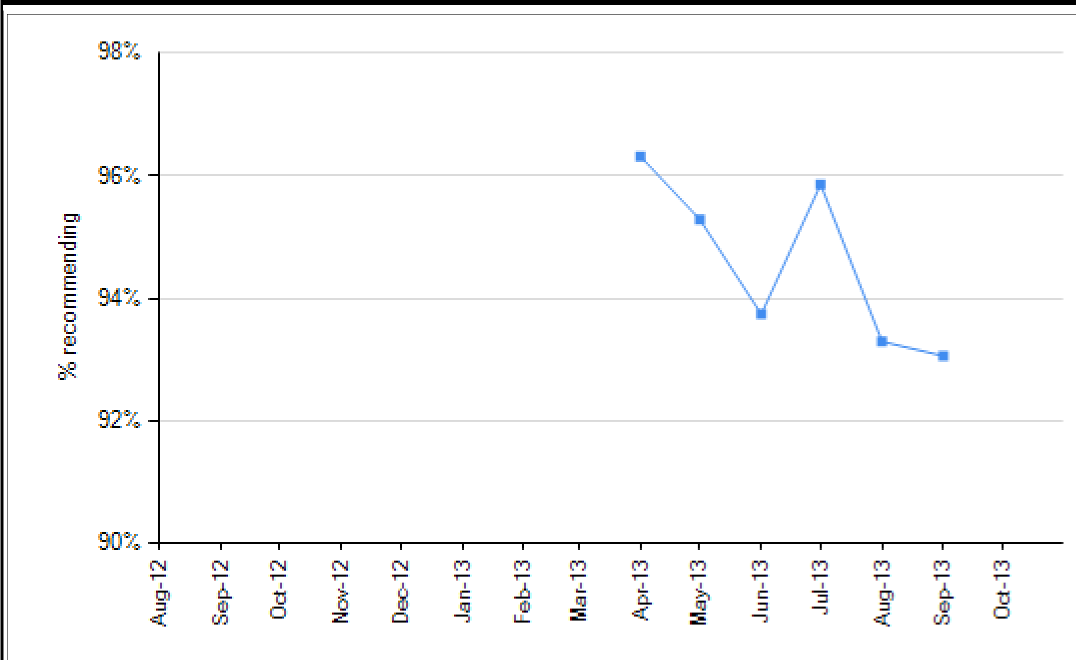
An unusually high proportion of NITU discharges have resulted in early readmission over recent months.

NITU will be asked to discuss the relevant issues at Trust Clinical Governance Committee on Wednesday 18 December.

One would not expect patients to be readmitted to NITU following discharge. The measure aims to highlight whether patients are discharged too early. Data collected at local level and presented as number of readmissions against number of discharges. [Owner: NOTSS Division]

Patient Experience

PE02 Friends & Family - proportion extremely likely or likely to recommend [one month in arrears]



Narrative

Granularity and triangulation with other data related to the experience of patients is provided in the body of the Board Quality Report.

% Patients recommending [Owner: Ella Reeves].

Patient Safety and Clinical Risk

3.1. Information relating to patient safety and clinical risk is provided within the key quality metrics. Related exception reports provide further granularity.

3.2. A 'Never Event' in respect of the insertion of an incorrect lens during a cataract operation (reported in last month's Board Quality Report) is currently under investigation (2013/038).

3.3. 2 Serious Incidents Requiring Investigation were declared during October 2013 as follows:

SIRI Ref	Division	Area	Date of Incident	Date SIRI Called	Description
2013/041	S&O	Wytham	05/07/2013 Identified 13/10/2013	21/10/2013	Failure to act on laboratory results in a patient who subsequently died
2013/042	EMTA	SSW & 6A	15/10/2013	28/10/2013	Category 3 Pressure Ulcer (scarum)

3.4. 100% of SIRIs due for closure during October 2013 were closed by the agreed deadline.

3.5. A detailed update on work being undertaken within the Trust in respect of hospital acquired pressure ulcer prevention is provided, as previously requested, as appendix 1. An action plan had previously been considered by Trust Board in May 2013.

4. Quality Walk Rounds

4.1. There were 4 Quality walk rounds in October 2013. Four further Quality Walk Rounds were cancelled either due either to unavailability of the executive lead at short notice or inappropriate timing for the area to be visited; all have been rescheduled. The Walk Rounds took place as follows:

Hospital Site	Areas Visited
Horton General Hospital	Day Surgery
Churchill Hospital	Theatre Direct Admissions, Day Surgery & Theatres Dermatology Outpatients
Nuffield Orthopaedic Centre	Oxford Centre for Enablement

4.2. Key issues with the potential to affect quality or patient experience identified during the Quality Walk Rounds included concerns regarding: vacancies and recruitment; the challenges of discharging patients with complex needs outside of Oxfordshire; and, the impact of the physical environment on maintaining privacy and dignity.

4.3. All issues have actions associated with them and these will be monitored through Divisional governance processes. Detailed information outlining the issues raised and associated actions arising from Quality Walk Rounds is

considered alternate months by the Quality Committee (last presented in October 2013).

5. Clinical Effectiveness

5.1. SHMI for the 2012/13 financial year has been published as 0.95. An analysis of OUH SHMI data prepared for us by Dr Foster Intelligence has confirmed that this figure equates to outcomes that are statistically better than the national mean, for the fourth consecutive reporting period, when conventional 95% confidence limits are applied.

5.2. Dr Foster Intelligence has completed its annual rebasing exercise (adjusting the number of expected deaths according to its model). OUH has been advised that the 2012/13 HSMR for OUH (to be published in December in the annual Dr Foster Hospital Guide) will be 105, compared to 107 for 2011/12, and within the expected range.

5.3. It is likely that Dr Foster will publish a number of other metrics in the annual Hospital Guide. It is understood that OUH may be identified as a statistical outlier for deaths associated with neoplasms, both during the week and at weekends. Work is being undertaken such that the potential reasons for this are better understood ahead of publication.

5.4. A risk summit was held on 07 October to examine processes and outcomes in relation to the care of adult inpatients with diabetes. The summit was attended by approximately fifty member of staff along with representatives of both patients and commissioners. A number of workstreams have been defined and a follow-up meeting is planned for late November. A risk summit examining pneumonia had been held on 24 September and a follow-up meeting took place on 30 October. A progress report on both summits will be presented to TME in December 2013 and the Board (or its Quality Sub-Committee) in due course.

6. Experience of Patients

6.1. Information relating to the experience of patients is provided within the key quality metrics and related exception reports.

6.2. The table overleaf provides a breakdown of metrics pertinent to the experience of patients for the month of September 2013. The Net Promoter Score is calculated as the proportion of patients extremely likely to recommend minus those who are neutral or negative in their propensity to recommend.

Experience of patients – by Division

Table 1 below presents the figures for Friends and Family Test and Complaints for September 2013.

		Net Promoter Score	% Extremely Likely and likely	% Extremely un likely and likely *	% Response rate	Number of complaints	% against Finished Consultant Episodes (FCE) activity	% of total Trust complaints
Trust overall		64	94	3	14	84	0.05%	
Corporate		Not applicable				3	N/A	3.6
EMTA	ED for both sites	61	94	3	11	19	0.07	22.6
	In patient	55	92	3	27			
MARS		86	99	1	30	9	0.08	10.7
NTSS		68	94	2	12	21	0.1	25
Sand O		74	95	3	17	17	0.07	20.2
CVT		73	94	3	26	4	0.08	4.8
CCTDP		Not applicable				4	0.0008	4.8
C and W		83	100	0	9	7	0.0005	8.3

Please note * the figures for ‘Neither likely or unlikely’ or ‘Don’t Know’ have not been included

6.3. All complaints received in October were acknowledged within 3 days.

6.4. The Parliamentary and Health Service Ombudsman (PHSO) requested details in relation to one case during October. One final report was received in October from PHSO in relation to a case involving alledged poor communication. PHSO did not uphold the complaint.

6.5. The top three positive themes raised through the Friends and Family Test (FFT) were: positive staff attitude; good general quality of care; and, good standard of nursing care. Positive feedback was also received about short waiting times in the Emergency Departments.

6.6. The response rate for the Friends and Family Test in September was 14% (19% for inpatient areas and 9% for ED).

6.7. The table overleaf describes some of the Trustwide actions arising as a result of information received relating to the experience of patients:

6.8. The top positive themes from the Friends and Family Test are:

- Positive staff attitude.
- Good general quality of care.
- Good standard of nursing care.
- Positive feedback about short waiting times in the emergency departments

6.9. The key themes for improvement across the trust are

- Delays and difficulty in making an appointment
- Poor and uncoordinated discharge
- Staff attitude, behaviour and communication

The Trust wide actions and projects to improve patient and carer experience and address the main Trust wide themes are presented in Table 2 below:

Key Themes	Outcome needed	Actions	Timeline and milestones for improvement	Trust Lead
Appointments	1. All routine outpatient appointments within 6 weeks 2. All urgent and 2-week appointments within 2 weeks 3. Reduce follow up appointments	Outpatient re-profiling Project	1. Live from 18 Nov 2013 with ENT initially (rollout to other specialties progressing as planned) 2. Dashboard to measure improvement 3. Patient Experience dashboard	Deputy Director of Clinical Services
Discharge	1. Coordinated well-planned discharge home 2. Coordinated well-planned transfer of care to community hospitals or social care 3. Improve and increase patient flow, reduced length of stay and delayed discharges 4. Improve patient experience and safety	*'Live well, Choose well, Plan well'* campaign	1. Trust wide training in development by Discharge Oversight Group 2. Standardisation of discharge procedures	Deputy Director of Clinical Services
Staff attitude and behaviour, communication	1. Working with and including patients and their families in patients care, including timely information. 2. Clear communication between hospital departments. 3. Proactive support to patients and their families to resolve concerns and problems	Customer Care - Service Excellence Programme	1. £180K secured from Health Education Thames Valley to deliver Trustwide programme over 18 months. 2. Tiered education programme to be developed in conjunction with Workforce Directorate, staff, patient groups and carers between Nov 2013 and Jan 2014. 3. Compassionate Care charter with patient experience metrics. Dec 2013 – March 2014. 4. Friends and family test extended to include compassionate care metrics from March 2014. 5. Divisional level analysis by	Safeguarding Adults and Patient Services Manager

			divisional patient groups from April 2014.	

7. Quality Account / CQUIN

7.1. This section sets out performance against the 2013/14 quality priorities defined in the Trust Quality Account.

7.2. The majority of quality priorities in the Quality Account have been aligned with OCCG CQUINs.

7.3. The majority of the quality priorities are meeting project timelines. The dashboard below summarises perceived performance at the end of October 2013.

7.4. More detailed information on performance is considered alternate months by the Quality Committee (last presented in October 2013).

Progress Against Priorities for 2013/14 as set out in Quality Account

PATIENT SAFETY		
Safer Care Associated with Surgery		RAG
Theatres	Structure to manage actions	
	Leadership and supervision	
	Staffing - recruitment	
	Communication	
	Compliance with policies	
	Safety – incidents	
	Infection control	
	Theatre performance	
	Strengthening pre-operative assessment	
Frail patients	Expand Frailty Team	
	Evaluate impact of expanded service	
	Improving patient information on discharge	
	Follow up after discharge	
	Readmission rates	
Consent	Revise process	
	Improve consent training	
	Develop Mental Capacity Act audit tool	
	Project group to monitor actions	
CLINICAL EFFECTIVENESS		
Using technology to improve care		

Electronic radiology and ICE	Expanding electronic radiology requesting
	Expand ICE algorithms
	Feedback from GPs
	Requesting and reporting activity reported back to GPs
	Monitoring and project support
Telemedicine	Introduce telemedicine
	Monitoring and project support
iPads after MI to record data	Introduce technology and recruit patients
Human Factor training	Deliver HF training
	Use teamwork training
	Analyse incident trends
EXPERIENCE OF PATIENTS	
Improving the way we listen to and act on feedback	
Patient feedback and engagement	Introduce patient feedback system
	Respond promptly to feedback
	Evaluating feedback
	Patient engagement – increasing patient forums
	Improving patient information
	Improving communication with patients
	Improving communication with staff
	Coordination and monitoring
Improving care for people with cognitive impairment	Expand the dementia care service
	Improve training
	Meet target for cognitive (dementia) assessment
	Develop environment
	Establish dementia champions
	Support to carers
	Monitoring actions

7.5. A meeting is scheduled for 08 November 2013 to agree the formal position against performance on CQUIN goals as at the end of Q2.

7.6. The Trust is performing well for the majority of CQUINs set by Oxfordshire CCG. Four projects are currently rated as red:

7.6.1. Telemedicine: OHFT has experienced problems setting up multi-user contracts for the devices (single devices will be used by multiple staff members in community hospitals). Multipe user contracts will not be used at the OUH since each of the six consultants will be provided with a

device. OHFT have been exploring an Android platform with SKYPE, and an iPhone platform with FaceTime. A decision on which devices to use has delayed procurement and project milestones.

7.6.2. Physiological outcomes post MI (myocardial infarction): Recruitment has been delayed due to technical problems. AztraZenca have injected funds to resolve the technical issues. The study is at the Ethics Committee and the research team expect recruitment to start shortly.

7.6.3. Safety thermometer: CQUIN target is to reduce incidence of pressure ulcers measured by ST to 0.65%. The result for Q1 is 1.44% and for Q2, 1.21%. There is potential to adjust (increase) the baseline for Q3. Reporting via Datix has increased as we attempt to achieve consistency in reporting.

7.6.4. Dementia: 48.8% identification against a target of 90% of non-elective admissions ≥ 75 years of age, admitted for >72 hours. EMTA / MRC Division has secured additional resource to manage the CQUIN on a Trustwide basis from 1 October 2013. The Dementia Lead has been actively promoting the screening process and proforma with medical colleagues including neurosciences, oncology, general surgery and infectious diseases with presentations being arranged at neurosurgical and respiratory meetings.

7.7. A CQUIN dashboard is provided below:

Progress Against 2013/14 OCCG CQUINs

CQUIN goal	Summary Description	Progress	RAG
Telemedicine – whole system care close to home	Linking acute hubs in Community with OUH via telemedicine. This is a joint project with OHFT.	Complications setting up multi-user contracts have delayed progress against Q2 milestones.	
Intra operative fluid monitoring	Use IOFM 80% agreed procedures. Q2 target = 50 per month / total of 150.	Continuing to exceed the monthly target for Q2. Performance for Q2 = total of 262.	
Child in a chair (Specialist wheelchairs)	Maintain 5 week wait from referral to assessment	Q2 performance 94-98%.	
Gestational diabetes	Reduction in antenatal visits for gestational diabetic women	Recruitment to study in progress.	
Physiological outcomes post MI	Use of iPads to record cardiac data for long-term disease prevention	*AstraZeneca* have provided funds to overcome technical issues. Recruitment delayed but expected to start shortly.	
Friend and Family test	Expansion of test to maternity by end of October 2013. >Q1 or 20% increase in response rate in ED and acute inpatient areas by end Q4.	FFT rolled out to maternity. Overall resppnse rate for Q2 is 16%. Work in progress to improve participation.	
Safety Thermometer	50% reduction in pressure ulcer prevalence	Not possible to achieve Q1-2 target.	
Dementia	Identification, assessment,	Q2 48.8% against 90% target.	

CQUIN goal	Summary Description	Progress	RAG
	referral		
	Clinical leadership & training	Met target	
	Support provided for carers	Met target	
VTE	95% assessed	Final figure for September awaited (>95% April to August)	
	Agreed no of RCA for hospital acquired thrombosis (HAT)	1 HAT in Q2 presented to CRMC in September 2013.	
Psychiatric liaison service	Integrate service by beginning Q4	On course.	
Baseline data for frail elderly patients + DTOC	DTOC audit and whole system audit of delayed discharges	Met target.	
Medical Support for complex patients in surgery	Improve quality of care and reduce LOS for these patients	Met target.	
Emergency Admission Navigators	Navigators in post. Reporting against core dataset and revisions to role if necessary.	Recruited to 3 posts. Potential to get back on track in Q3 – service 10.00 -22.00 hrs 7 days per week.	
Nursing	60 nurses to attend leadership programme – focus on outcomes	Met target.	
	Reduce staff turnover band 2-5	Met target.	
Diabetic foot disease	Virtual MDT diabetic foot clinic to prevent and manage foot problems.	Met target.	
Diabetic support for young adults	Improve outcomes of young adults with diabetes	Met target.	
Learning disability (LD)	Improve the outcomes of patients with LD who present with seizures.	Met target.	
ECIST report (Emergency Care Intensive Support Team)	Improve emergency and urgent care performance.	Agreement needed with OCCG on action plan.	

7.8. The Specialist Commissioning CQUINS for 2013/14 are as follows:

7.8.1. Specialised clinical dashboard

7.8.2. Highly specialised services

7.8.3. Renal transplant – cold ischaemia time

7.8.4. Haemophilia

7.8.5. Intravenous immunoglobulin

7.8.6. Major trauma

7.8.7. Neonatal intensive care – complex discharge

8. Infection Control

8.1. Information relating to infection control is provided within the key quality metrics. Related exception reports provide further granularity.

8.2. The three cases of MRSA bacteraemia identified since April 2013 were each categorised as unavoidable.

8.3. Legionella continues to be identified in water samples from the Churchill and John Radcliffe retained estate and the Churchill PFI. The clinical risk is managed by taking all showers with poisitive results out of use. To reduce the risk further, refurbishment work on showers will be carried out over the next six months.

9. Concerns raised by Staff

9.1. Quality concerns raised by staff outside normal line management routes are reported in the minutes of Clinical Governance Committee, considered by both Trust Management Executive and Quality Committee.

10. Recommendations

10.1. Trust Board is asked to receive this report and the supplementary report on Tissue viability and Pressure damage (appendix 1).

10.2. Further comments are invited in relation to the revised format of the report.

Prof Edward Baker
Medical Director

Report prepared by:

Dr Ian Reckless
Assistant Medical Director

November 2013

Appendix 1

Hospital Acquired Pressure Ulcer (HAPU) Report

Introduction

1. One of the strategic drivers for the Trust is to be a patient-centred organisation, providing high quality, compassionate care with integrity and respect for patients and staff – **“delivering compassionate excellence”**
2. A key patient safety objective is to reduce the number of patients developing avoidable hospital acquired pressure ulcers (AHAPU).
3. Pressure ulcers can have serious implications for our patients, their carers and families.
4. This report provides an overview of the actions being undertaken to address AHAPU within the Oxford University Hospitals NHS Trust.
5. The overall aim is to reduce avoidable pressure ulcers across the health economy.

Background

6. Pressure ulcers (sometimes known as pressure sores, or bed sores), occur when the skin and underlying tissues become damaged by unrelieved pressure. In very serious cases, the underlying muscle and bone can also be damaged. People who are unable to move or feel some or all of their body due to illness, paralysis or advanced age are at particular risk of developing pressure ulcers. Pressure ulcers are categorised depending on severity of tissue damage:

   Category 1: Intact skin with non-blanching redness of a localised area usually over a bony prominence. May indicate skin at risk.
   Category 2: Partial thickness loss of dermis, presenting as a shallow open ulcer or blister with a red/pink wound bed, without slough. This is superficial skin damage.
   Category 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed
   Category 4: Full thickness tissue loss with exposed bone, muscle or tendon.

7. In 2010, the Department of Health defined Avoidable & Unavoidable Pressure Ulcers as follows:

   Avoidable Pressure Ulcer: “Avoidable” means that the person receiving care developed a pressure ulcer and the provider of care did not do one of the following: evaluate the person’s clinical condition and pressure ulcer risk factors; plan and implement interventions that are consistent with the persons needs and goals, and recognised standards of practice; monitor and evaluate the impact of the interventions; or, revise the interventions as appropriate.”

   Unavoidable Pressure Ulcer: “Unavoidable” means that the person receiving care developed a pressure ulcer even though the provider of the care had evaluated the person’s clinical condition and pressure ulcer risk factors; planned and implemented interventions that are consistent with the persons needs and goals; and recognised standards of practice; monitored and evaluated the impact of the interventions; and

revised the approaches as appropriate; or the individual person refused to adhere to prevention strategies in spite of education of the consequences of non-adherence”

Measurement

8. There are two primary data sources in relation to the occurrence and severity of pressure ulcers – Datix incident reporting (incidence) and the NHS Safety Thermometer (prevalence).
9. This table below provides an overview of the Pressure Ulcer incidents reported via Datix during Q1 and Q2 2013/14. HAPUs account for 30% of the total number of pressure ulcers reported on Datix.

All Cat 2 – 4 PU Reported	Inherited PU	HAPU
1040	724	316

10. The NHS Safety Thermometer process reports on a monthly basis and is based on a snapshot survey of the majority of inpatient wards across the NHS in England. It provides a point prevalence for pressure ulcer damage (category 2, 3 and 4).

11. Point prevalence data is monitored on a specified day. However if a patient with a pressure ulcer has been an in-patient for longer than a month, this will result in them being double-reported across two data collection periods as a new harm. No allowance is made for unavoidable pressure ulcers or improvements in a pressure ulcers over time.

12. A CQUIN related to pressure ulcers has been nationally mandated, with the aim of reducing all pressure ulcers across the health economy. The CQUIN requires a 50% reduction in all Category 2-4 pressure ulcers based on the information provided through the Safety Thermometer. This has been negotiated locally with the Oxfordshire Clinical Commissioning Group for OUH to be a 50% reduction in hospital acquired pressure ulcers whether avoidable or unavoidable. This target has not been achieved in the first 6 months of this year by the OUH.

SAFETY THERMOMETER PREVALANCE DATA PER MONTH

	April	May	June	July	Aug	Sept	Mean
Category 2	1.17%	1.09%	1.3%	0.75%	1.13%	1.52%	**1.16%**
Category 3	0.09%	0.36%	0.19%	0%	0.09%	0.09%	**0.13%**
Category 4	0%	0%	0%	0%	0%	0.09%	**0.01%**
Total	**1.26%**	**1.45%**	**1.48%**	**0.75%**	**1.22%**	**1.7%**	**1.29%**

13. Incident reporting through the OUH Datix system provides data on each and every ulcer on a once only basis and therefore is more accurate for internal monitoring purposes. Below are the incidents of HAPU using Datix reports and throughput

data. This indicates that 998 individuals per 1000 will not develop pressure damage whilst an inpatient.

INCIDENTS PER 1000 BED DAYS

	April	May	June	July	August	September	Total
Category 2	1.06	1.26	0.98	1.3	1.38	1.55	1.26
Category 3	0.15	0.09	0.24	0.13	0.07	0.11	0.13
Category 4	0.03	0.28	0.03	0.05	0.05	0.03	0.08
Total	**1.24**	**1.36**	**1.25**	**1.52**	**1.5**	**1.69**	**1.47**

Pressure Ulcers as Serious Incidents Requiring Investigation (SIRI)

14. The table below shows the number of Category 3 and 4 HAPU, that following investigation, were deemed to be 'avoidable' and therefore reported as SIRIs.

15. Last year approximately 19 AHAPU were reported in to the Trust from an external Provider with no matching Datix entry. This demonstrated poor internal reporting. Since April 2013 there have been no such incidents reported that do not have an internal Datix entry.

	April	May	June	July	Aug	Sept	Total
Category 3&4 AHAPU	1	5	0	1	1	2	**10**
Incidence % Cat 3-4	0.01	0.05	0	0.01	0.01	0.02	**0.02%**
Per 1000 Bed Days	0.03	0.13	0	0.03	0.03	0.05	**0.04**
Reported in by other Provider	0	0	0	0	0	0	**0**

16. As predicted, focus on increased reporting of pressure ulcers has increased the number reported on Datix. In Q1 and Q2 the same numbers of Category 2-4 ulcers were reported (316) as for the whole of 2012/13 (278). The Trust is aiming to report consistently for **all** categories of pressure ulcers with the aim that improvement strategies are anticipated to demonstrate an increase in the level of pressure ulcers identified at an earlier stage i.e. categories 1 & 2. The impact of more timely interventions reduces the risk of the avoidable pressure ulcers developing in to categories 3 & 4.

Actions being undertaken to improve the pressure ulcer prevention within OUH

17. The Tissue Viability Advanced Nurse Practitioner working within the Musculo-Skeletal and Rehabilitation Division (MARS) has been seconded in a part time capacity to support the development and improvement of the tissue viability function and service across the Trust. An action plan has been initiated that addresses six key areas in order to enable the required improvements in pressure ulcer prevention strategies, including:

- Improving tissue viability service – Successful business case agreed to expand the Tissue Viability Team to provide Divisional and corporate guidance, specialist advice, monitoring and education.
- Improved data management and compliance with reporting for all categories Trust wide to aid the development of local action plans.
- Development of explicit policies, protocols and guidelines, which are auditable for local compliance.
- Improved education programmes including support worker academy course involvement. Link nurse competency framework has been developed and is currently being disseminated. Further Tissue Viability related competencies are under development.
- Standardised usage and purchasing of specialist equipment that is managed and sustainable. Foam mattress audit planned for the end of November 2013.
- Oxfordshire wide partnership working with NHS organisations as well as the private sector. The Trust continues to establish working in partnership with a Pan- Oxfordshire Tissue Viability Group which is chaired by the Oxford Health Tissue Viability Lead Nurse and co-chaired by the OUH Tissue Viability Lead. This involves key stakeholders with a view to sharing resources, including educational programmes, standardising the wound care formulary, joint protocols in wound care and improvements in transfer of care. The terms of reference address the whole patient pathway. This will progress to identify and include private care providers such as those from care home and private/social care provision in patients' homes.

Conclusion

18. Increasing awareness of the need to report all pressure damage has had the predicted effect of increasing reported incidence. It is anticipated that the strategies being developed and rolled out will reduce the severity and number of avoidable Hospital acquired pressure ulcers.

Recommendations

19. The Trust Board are asked to note the data reported within this paper and the actions being taken to reduce AHAPU within the OUH with the ambition to prevent Avoidable Hospital Acquired Pressure Ulcers.

Liz Wright
Acting Chief Nurse

Report prepared by:

Ria Betteridge
Lead Advanced Nurse Practitioner, Tissue Viability

November 2013