Oxford University Hospitals NHS
NHS Trust

**Trust Board Meeting: Wednesday 12 March 2014**

**TB2014.28**

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| **Title** | **Board Quality Report** |

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| **Status** | For information |
| **History** | This is the monthly Board Quality Report which is considered by the Board's Quality Sub-Committee in the months when Trust Board does not meet. |

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

## Executive Summary

1. The Board Quality Report (BQR) presents information that is as contemporary as possible, often including the last calendar month.

2. In relation to key quality metrics:
   - 2 metrics remain under development (national cleaning score and time to surgery). It is anticipated that these metrics will be reported to Quality Committee in April (March data).
   - 9 quality metrics are 'red rated' as pre-specified targets have not been achieved. A further 5 items are amber rated having been green previously. For these, trend data are provided along with brief exception reports.

3. In relation to patient safety and clinical risk:
   - 13 Serious Incidents Requiring Investigation were reported during Febuary 2014.

4. In relation to Quality Walk Rounds:
   - There were six Quality Walk Rounds covering nine areas during February 2014.

5. In relation to clinical effectiveness:
   - Implementation of the Trust's standardised approach to mortality review continues to progress. Divisional Quality Reports presented to CGC in February 2014 indicate that the review process was applied in 86% of deaths that occurred during Q3.
   - Work continues in order to further embed the process and optimise the sharing of lessons learned.

6. In relation to CQUIN / Quality Account Priorities:
   - Performance continues to be good against the majority of 2013/14 CQUIN goals and Quality Account Priorities.

7. Patient Experience
   - The top positive themes from the Friends and Family Test are:
     - Positive staff attitude.
     - Good general quality of care.
     - Good standard of nursing care.
   - The key themes for improvement from FFT and complaints for the Trust are:
     - Patient care .
     - Staff attitude, behaviour and communication.
     - Delays and difficulty in making an appointment.

8. Care Quality Commission
   - The CQC visited the Trust's four sites on 25th and 26th February on an announced basis and the window for unannounced visits remains open for week commencing 3rd March.

**Recommendation**

The Board is asked to note this report.

# Quality Report

## 1. Purpose

1.1. This paper aims to provide the 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.

1.2. This version of the Board Quality report will be used for reporting to the relevant Governance Committees for the month of March 2014.

## 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. It is envisaged that these data will be available to the Quality Committee in April (March data).

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).

| BQR ID | Rating | Rating Last Period | Descriptor | Period | Threshold Source | Red | Amber |
|---|---|---|---|---|---|---|---|
| PS01 | 97.15% Green | Amber | Safety Thermometer (% patients receiving care free of any newly acquired harm) [one month in arrears] | Feb 14 | Internal | 95% | 97% |
| PS02 | 91.25% Amber | Red | Safety Thermometer (% patients receiving care free of any harm - irrespective of acquisition) [one month in arrears] | Feb 14 | Internal | 91% | 93% |
| PS03 | 95.46% Green | Green | VTE Risk Assessment (% admitted patients receiving risk assessment) | Jan 14 | National | 95% | 95.25% |
| PS04 | 13 N/A | | Serious Incidents Requiring Investigation (SIRI) reported via STEIS | Feb 14 | | N/A | N/A |
| PS05 | 52 Green | Green | Number of cases of Clostridium Difficile > 72 hours (cumulative year to date) | Jan 14 | National | 59 | N/A |
| PS06 | 4 Red | Green | Number of cases of MRSA bacteraemia > 48 hours (cumulative year to date) | Jan 14 | National | 1 | N/A |
| PS07 | 83.2% Red | Amber | Antibiotic prescribing - % prescriptions where indication and duration specified [most recently available figure, undertaken quarterly] | Jan 14 | Internal | 85% | 88% |
| PS08 | 94.8% Amber | Green | Antibiotic prescribing - % compliance with antimicrobial guidelines [most recently available figure, undertaken quarterly] | Jan 14 | Internal | 93% | 95% |
| PS09 | 75.98% Amber | Red | % patients receiving stage 2 medicines reconciliation within 24h of admission | Jan 14 | Internal | 75% | 85% |
| PS10 | 97.49% Green | Green | % patients receiving allergy reconciliation within 24h of admission | Jan 14 | Internal | 94% | 96% |
| PS11 | 1857 N/A | | Total number of incidents reported via Datix | Feb 14 | | N/A | N/A |
| PS12 | 5.09% Amber | Amber | % of incidents associated with moderate harm or greater | Jan 14 | Internal | 6.5% | 5% |
| PS13 | 124 N/A | | Total number of newly acquired pressure ulcers (category 2,3 and 4) reported via Datix | Dec 13 | | N/A | N/A |
| PS14 | 3 Green | Green | Falls leading to moderate harm or greater | Feb 14 | Internal | 8 | 7 |
| PS15 | 0 Green | Red | Number of hospital acquired thromboses identified and judged avoidable [two months in arrears] | Sep 13 | Internal | 1 | 0 |
| PS16 | | | National Cleaning Score - number of inpatient areas with initial score < 92% | | | N/A | N/A |
| PS17 | 3.91% Green | Green | % 3rd and 4th degree tears in obstetrics [C&W Division] | Jan 14 | Internal | 5% | N/A |
| PS18 | 99.07% Green | Green | % radiological investigations achieving 5 day reporting standard [CSS Division] | Dec 13 | Commissioner | 95% | 98% |
| PS19 | 11 N/A | | Number of CAS alerts received | Feb 14 | | N/A | N/A |
| PS20 | 0 Green | Green | CAS alerts breaching deadlines at end of month and/or closed during month beyond deadline | Feb 14 | Internal | 1 | 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] | Dec 13 | | N/A | N/A |
| CE02 | 238 N/A | | Crude Mortality | Jan 14 | | N/A | N/A |
| CE03 | 59.86% Red | Red | Dementia - % patients aged > 75 admitted as an emergency who are screened [one month in arrears] | Dec 13 | National | 80% | 90% |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| CE04 | 76% Red | Red | Statutory and Mandatory Training - % required modules completed | Feb 14 | Internal | 85% | 95% |
| CE05 | 89.29% Amber | Amber | ED - % patients seen, assessed and discharged / admitted within 4h of arrival | Jan 14 | National | 85% | 95% |
| CE06 | 100% Green | Green | Stroke - % patients spending > 90% of admission in specialist stroke environment | Feb 14 | National | 70% | 80% |
| CE07 | 88.24% Green | Green | Stroke - % patients accessing specialist stroke environment within 4h of arrival | Feb 14 | National | 75% | 85% |
| CE08 | 521 N/A | | Transfer Lounge Usage | Jan 14 | | N/A | N/A |
| CE09 | 95.32% Green | Green | % of elective paediatric day cases managed as such (Did not result in an overnight stay) [C&W Division] | Jan 14 | Internal | 70% | 75% |
| CE10 | 5.8 Amber | Green | Vascular - Mean length of stay for patients undergoing elective AAA repair (3 month rolling period) [NOTSS Division] | Dec 13 | Internal | 8 | 5 |
| CE11 | 2.08% Green | Green | Vascular - % mortality following elective AAA repair [NOTSS Division] | Dec 13 | Internal | 5% | 3% |
| CE12 | 92% Green | Amber | Cardiology - % patients receiving primary angioplasty within 60 minutes of arrival at hospital [MRC Division] | Dec 13 | Internal | 85% | 90% |
| CE13 | 1.9 Green | Amber | Cardiology - Mean number of days from referral to admission to cardiology at tertiary centre [MRC Division] | Jan 14 | Internal | 3 | 2 |
| CE14 | 0% Green | Green | Cardiac surgery-% rate of patients with organ space infections following cardiac surgery via the sternum [MRC Division] | Jan 14 | Internal | 1% | 0.5% |
| CE15 | 0% Green | Green | Cardiac Surgery - % mortality following elective primary CABG [MRC Division] | Dec 13 | Internal | 6% | 4% |
| CE16 | 2 Red | Amber | Number of unscheduled returns to theatre within 48 hours [NOTSS Division] | Jan 14 | Internal | 2 | 1 |
| CE17 | 100% Green | Green | Rheumatology - % relevant patients who have their DAS28 score documented [NOTSS Division] | Feb 14 | Internal | 95% | 98% |
| CE18 | 2 Red | Amber | Number of unscheduled returns to theatre in gynaecology [C&W Division] | Jan 14 | Internal | 2 | 1 |
| CE19 | 493 N/A | | Number of patients admitted to SEU wards from SEU triage [S&O Division] | Jan 14 | | 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 | 2.87% Amber | Green | Neuroscience Intensive Therapy Unit (NITU) readmission rate within 48 hours of discharge [NOTSS Division] | Dec 13 | Internal | 4% | 2% |
| CE22 | 72.4% Green | Green | % fractured NOF patients who receive surgery within 36 hours of admission [NOTSS Division] | Dec 13 | Commissioner | 70% | 72% |
| CE23 | 24.82% Amber | Amber | % deliveries by C-Section [C&W Division] | Jan 14 | Commissioner | 33% | 23% |
| CE24 | 1.16% Green | Red | 7 day admission rate following assessment on (and discharge from) paediatric CDU [C&W Division] | Jan 14 | Internal | 4% | 2% |
| PE01 | 73 Green | Amber | Friends & Family - Net Promoter Score [one month in arrears] | Jan 14 | Internal | 63 | 70 |
| PE02 | 95.42% Green | Green | Friends & Family - proportion extremely likely or likely to recommend [one month in arrears] | Jan 14 | Internal | 90% | 94% |
| PE03 | 84 Amber | Green | Complaints Received | Jan 14 | Internal | 90 | 80 |
| PE04 | 1 Amber | Amber | Number of complaints received initially graded as RED | Jan 14 | Internal | 2 | 1 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| PE05 | 472<br>N/A | | PALS contacts made | Jan 14 | | N/A | N/A |
| PE06 | 5<br>Red | Green | Single sex breaches | Jan 14 | National | 3 | 2 |
| PE07 | 62.66%<br>Red | Green | % patients EAU length of stay < 12h | Jan 14 | Internal | 65% | 70% |
| PE08 | 13.1%<br>N/A | | % Complaints upheld or partially upheld | Jan 14 | | N/A | N/A |
| PE09 | 4<br>Red | Green | Number of legal claims received / inquests opened initially graded as RED | Jan 14 | Internal | 2 | N/A |
| PE10 | 48%<br>Amber | Green | % patients returning feedback forms in specialist surgery outpatients [NOTSS Division] | Jan 14 | Internal | 45% | 60% |

**ORBIT Reporting** **Board Quality Report** Oxford University Hospitals NHS NHS Trust

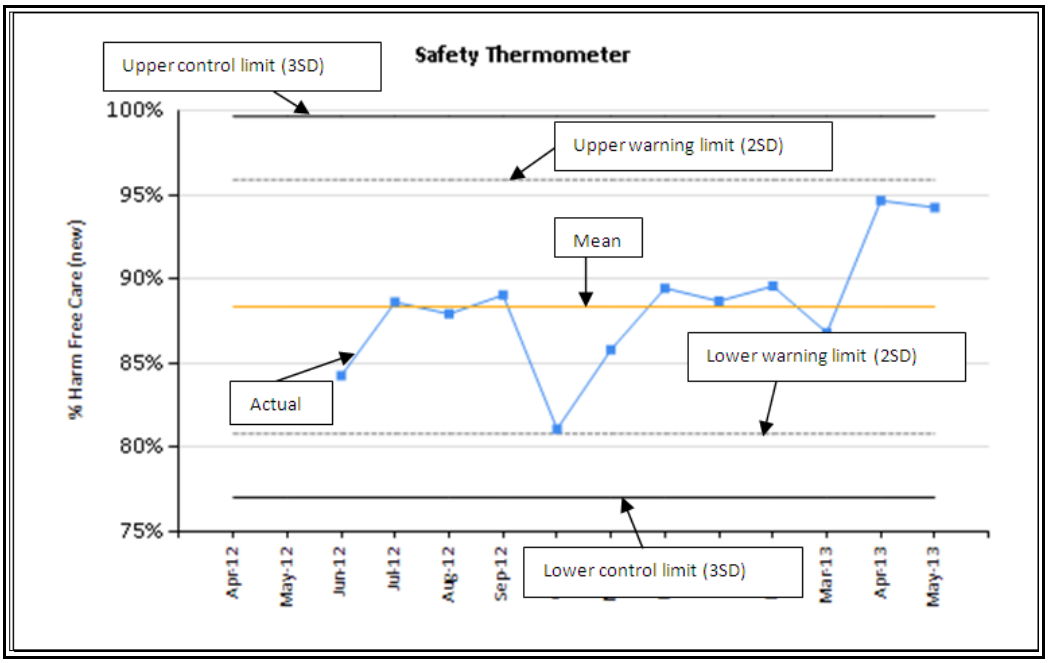
## How to interpret charts

*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.*

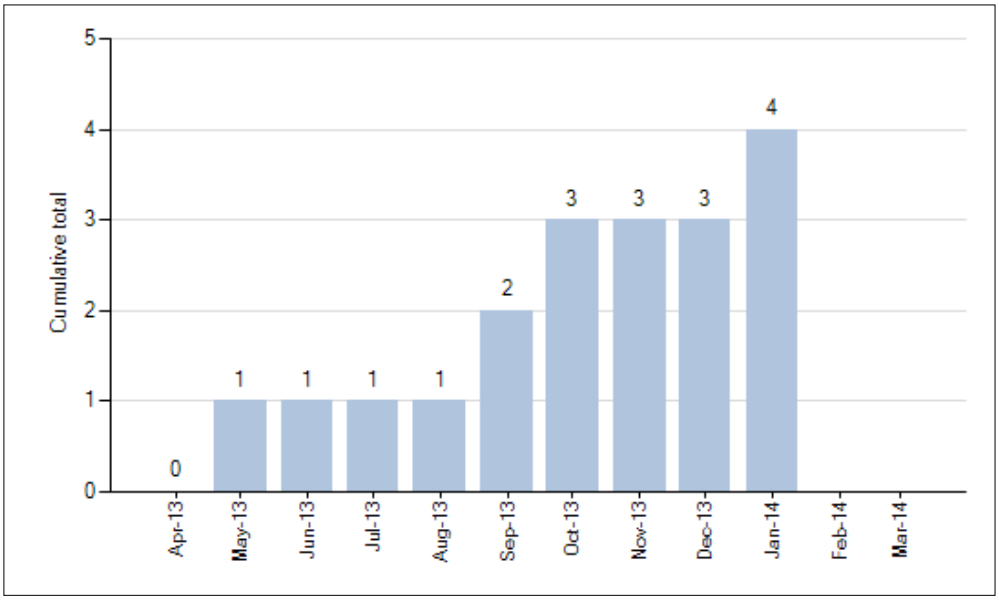
*There are other patterns within the data that are likely to reflect real change as opposed to random fluctuation – these patterns are known as special cause variations. They include:*

*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**

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



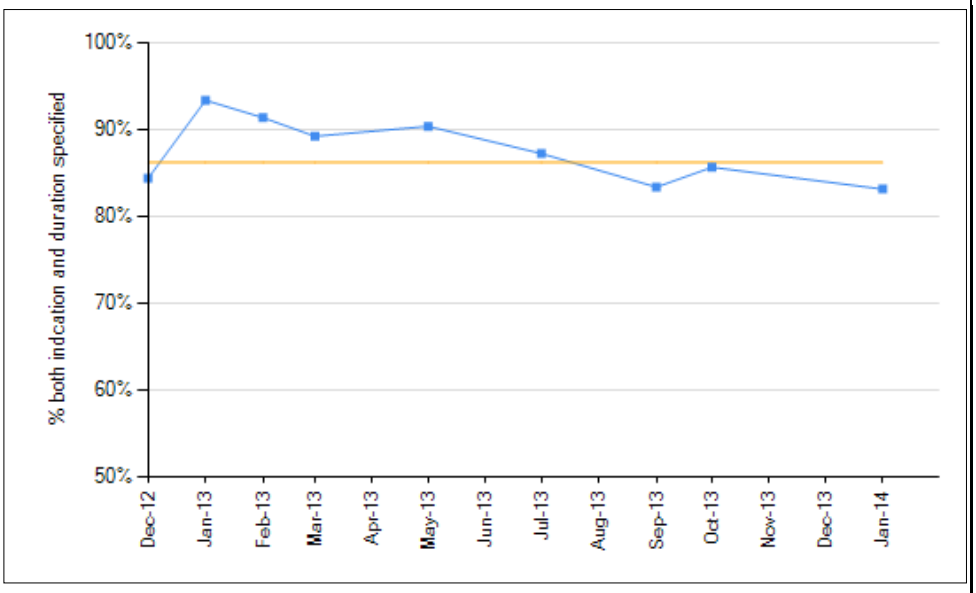

**Narrative**

None of these cases has been judged as avoidable following root cause analysis.

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]**



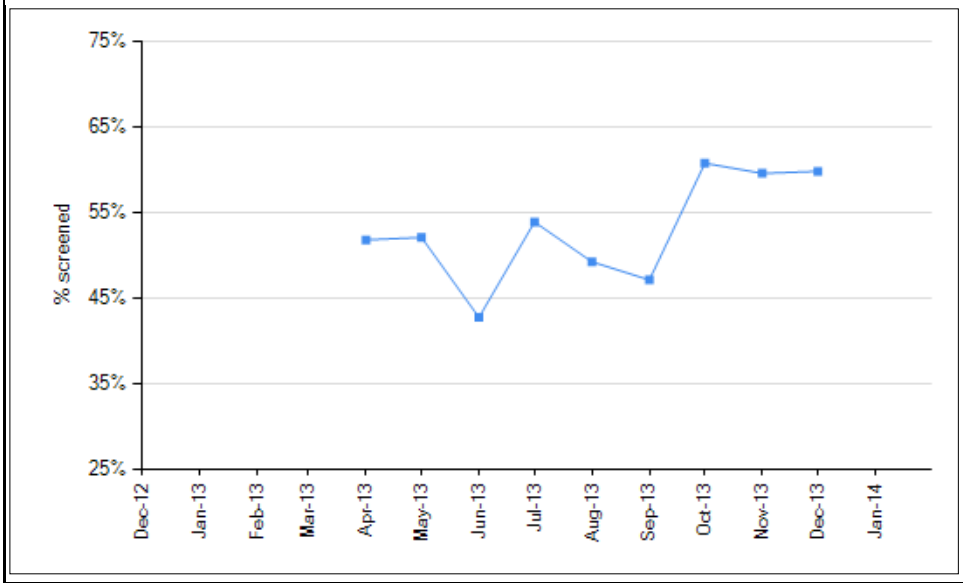

**Narrative**

Quarterly Reporting. Clinical Governance Committee wil consider ward / service level performance at its March meeting.

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].

**Clinical Effectiveness**

**CE03 Dementia - % patients aged > 75 admitted as an emergency who are screened [one month in arrears]**



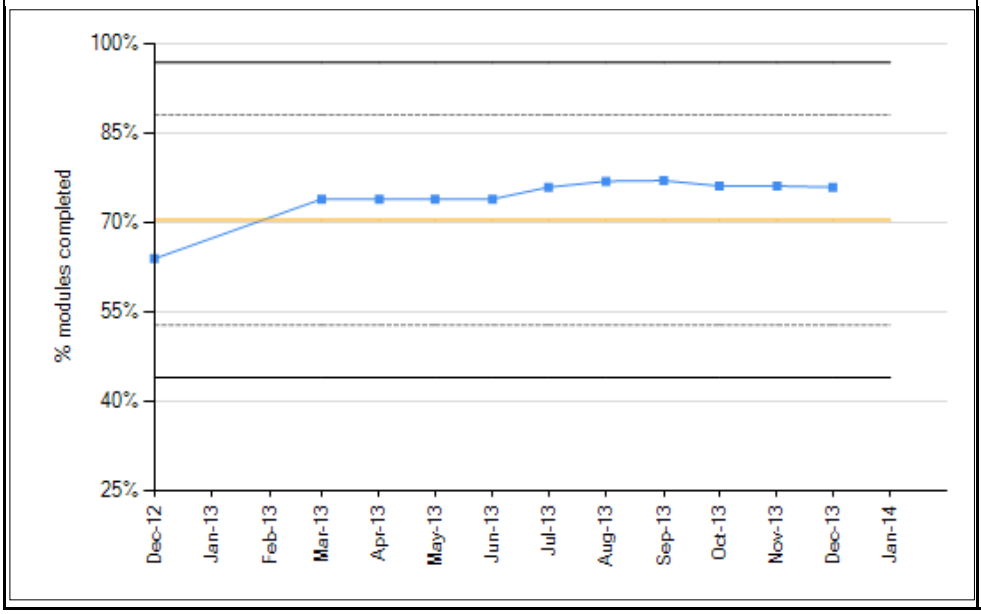

**Narrative**

Performance has improved in recent months but remains below target. Further benchmarked English data are awaited as the denominator in some other organisations appears very different to the OUH figure.

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.

**Clinical Effectiveness**

**CE04 Statutory and Mandatory Training - % required modules completed**

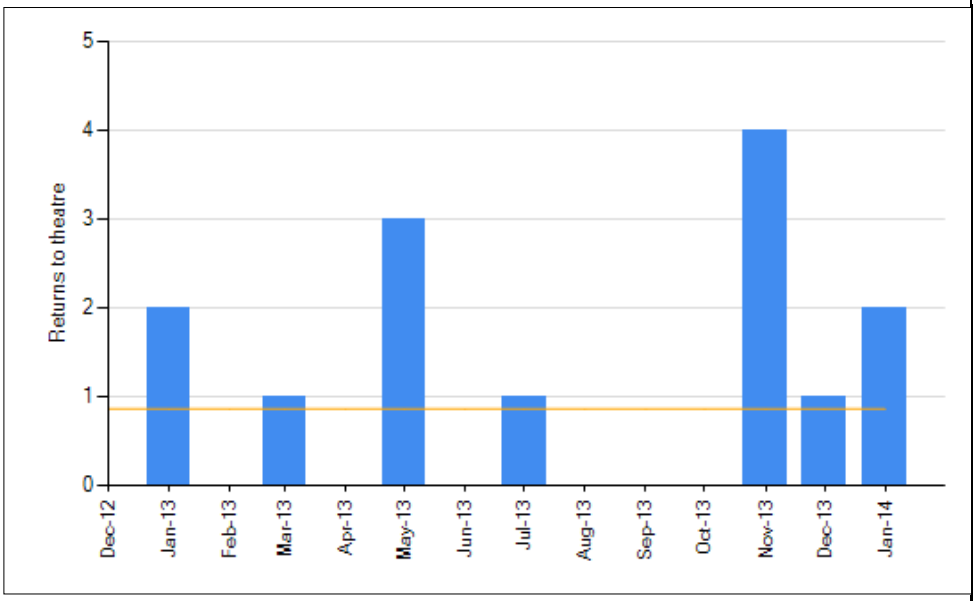



**Narrative**

Results monitored through Divisional Performance Reporting mechanisms.

**Clinical Effectiveness**

**CE16 Number of unscheduled returns to theatre within 48 hours [NOTSS Division]**



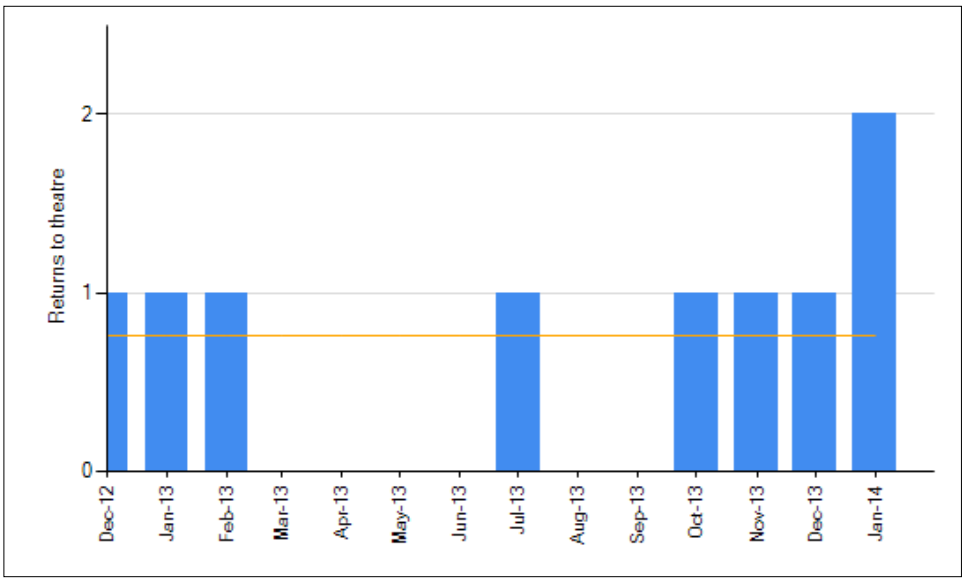

**Narrative**

Results monitored through Divisional Performance Meetings

The chart shows the actual number of unplanned returns to theatres within 48 hours per month. All returns to theatres are reported on Datix for the division. The returns within 48 hours are extracted from the system and reviewed as an outcome indicator.

**Clinical Effectiveness**

**CE18 Number of unscheduled returns to theatre in gynaecology [C&W Division]**

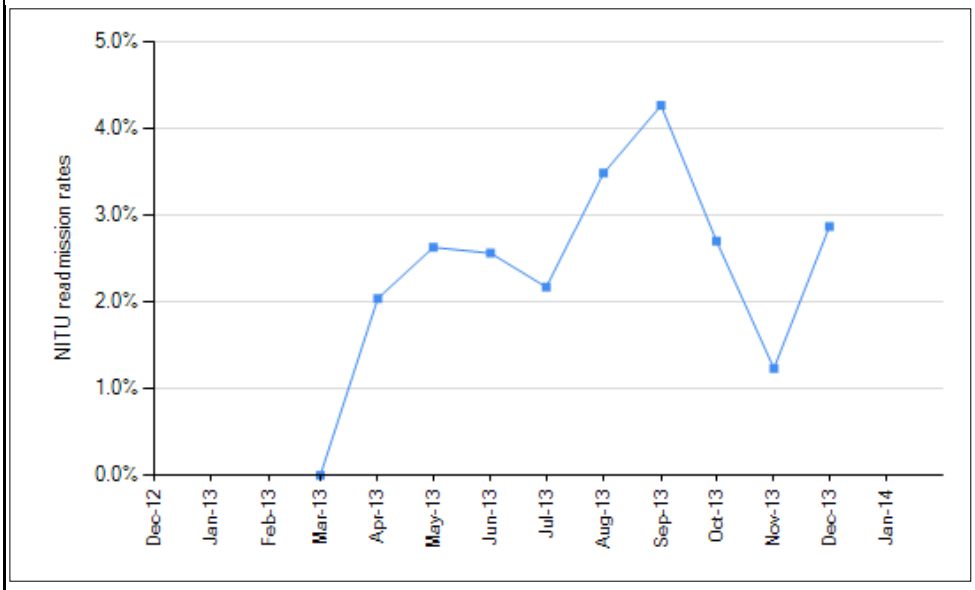



**Narrative**

Results monitored through Divisional Performance meetings.

Currently recorded manually.

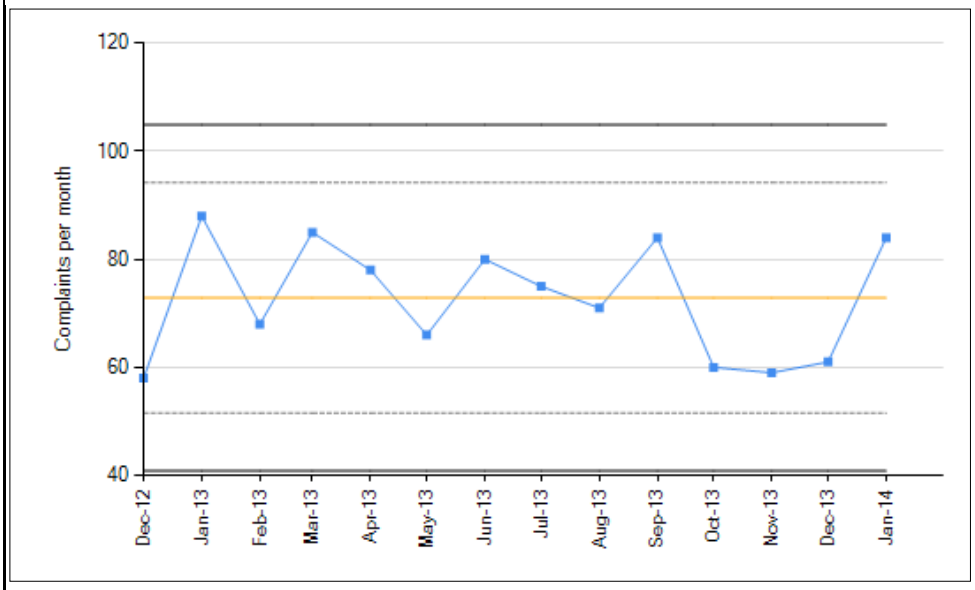
**Clinical Effectiveness**

| CE21 Neuroscience Intensive Therapy Unit (NITU) readmission rate within 48 hours of discharge [NOTSS Division] | Narrative |
|---|---|
|  | Results monitored through Divisional Clinical Governance Mechanisms and considered alongside unit throughput. Numbers are small and volatile. |



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.

**Patient Experience**

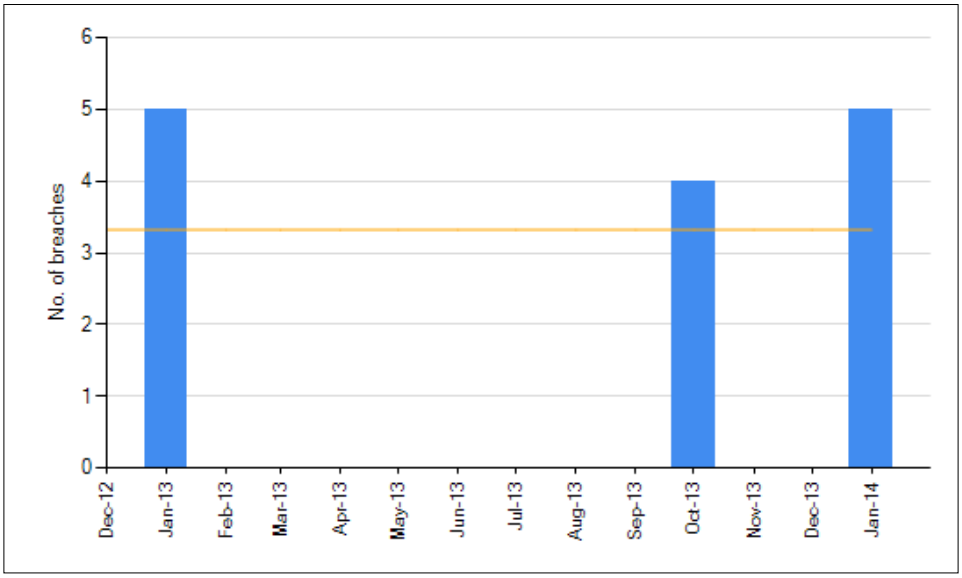
| PE03 Complaints Received | Narrative |
|---|---|
|  | Figure for February not available at the time of writing. Some volatility is to be expected. |



The chart shows the number of new complaints received and logged by the corporate complaints department [Owner: D Dunn].

**Patient Experience**

**PE06 Single sex breaches**



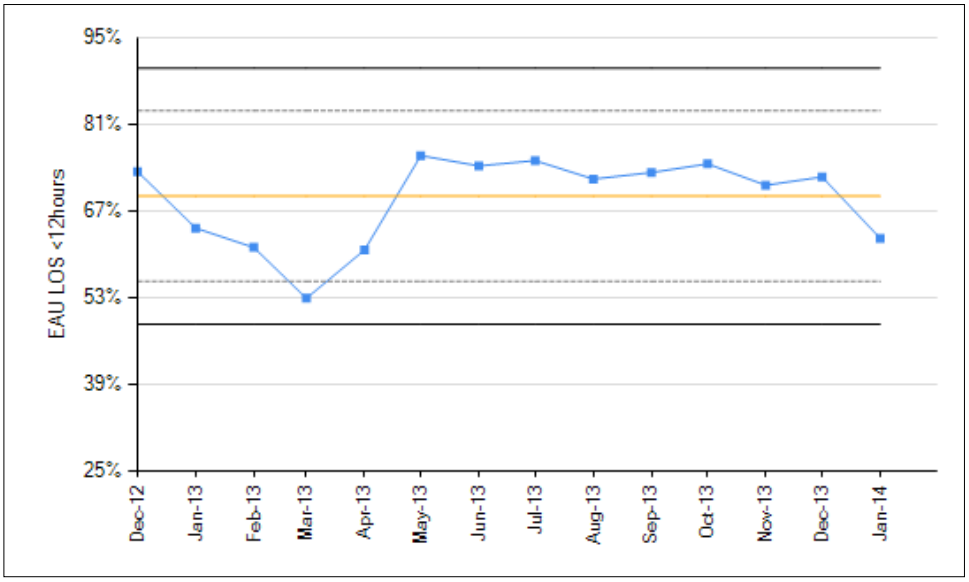

**Narrative**

EAU – Horton Hospital. Issues identified and rectified immediately. 5 patients affected overall.

The chart shows the number of single sex breaches reported via UNIFY. Those cases judged to be clinically justifiable are not reported here. [Owner: C Heason].

**Patient Experience**

**PE07 % patients EAU length of stay < 12h**



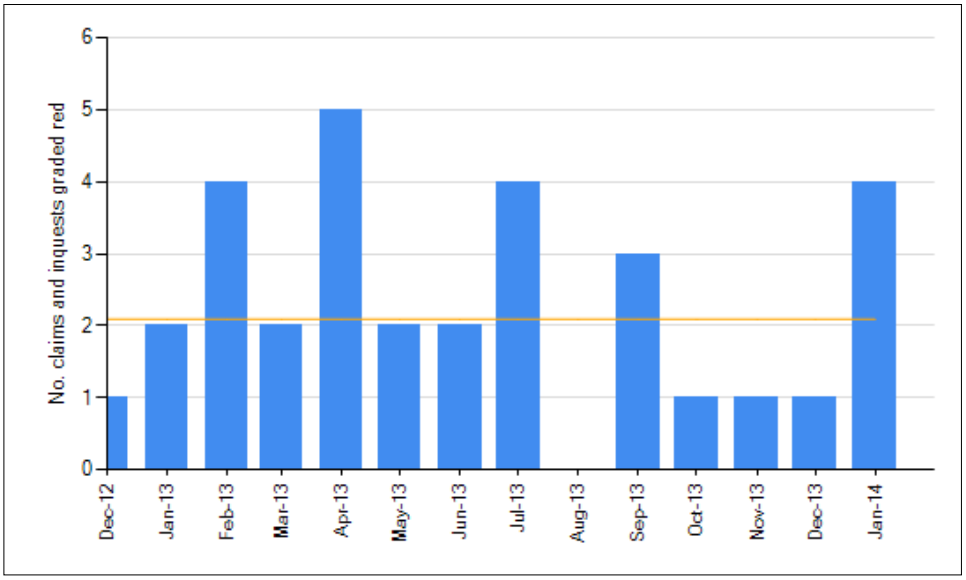

**Narrative**

Results monitored through Divisional Performance meetings.

EAU is an assessment area and the majority of patients should either be admitted or discharged promptly following assessment.

**Patient Experience**

**PE09 Number of legal claims received / inquests opened initially graded as RED**



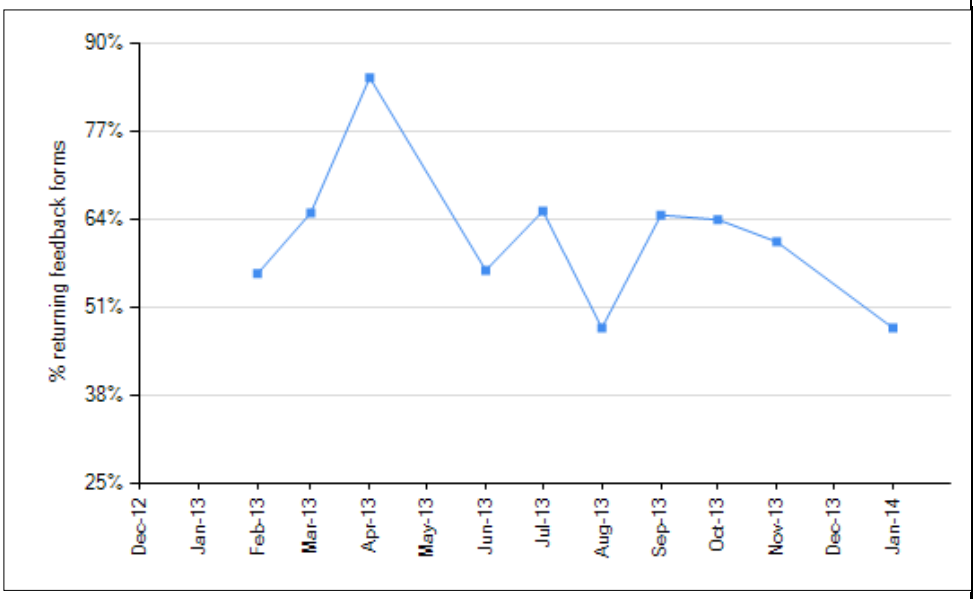

**Narrative**

Details have been reviewed at Clinical Governance Committee. No linkage between incidents and wide timespan (legal claims can date back some years).

The chart shows the numbers of new claims received and inquests opened initially rated as 'RED' by the corporate legal department. The number may change (in either direction) following investigation and conclusion of legal process [Owner: S Newman].

**Patient Experience**

**PE10 % patients returning feedback forms in specialist surgery outpatients [NOTSS Division]**




**Narrative**

Response rates monitored through Divisional Clinical Governance functions.

Feedback forms are available to all patients in specialist surgery outpatient departments and patients are encouraged to complete. Data, both positive and negative, are reviewed to identify area of good practice and areas for improvement. Data are collected locally on number of forms completed and returned against total number of outpatients per month.

## 3. Patient Safety and Clinical Risk

3.1 Information relating to patient safety and clinical risk is provided within the key quality metrics.

3.2 Figure 1 below outlines the detail of the 13 Serious Incidents Requiring Investigation (SIRIs) that were declared during February 2014.

3.3 Four SIRI Investigations were closed in February 2014 with the CCG. One investigation breached its closure deadline by one day and a further investigation continues to breach but Commissioners are being kept fully informed.

**Figure 1.**

| SIRI Ref | Division | Department | Date of Incident | Date SIRI Reported | Description |
|---|---|---|---|---|---|
| 2014/002 | S&O/CSS | Radiology USS | 29/01/2014 | 14/02/2014 | Delay in follow up after DNA for scan - leading to delay in diagnosis |
| 2014/003 | S&O | SEU | 02/01/2004 | 06/02/2014 | Cat 3 PU heels |
| 2014/004 | MRC | Dermatology | 11/12/2013 | 06/02/2014 | Nail bed infiltration following failure to arrange FU appointment |
| 2014/005 | CSS/MRC | AICU/ED | 26/11/2013 | 14/02/2014 | CXR not acted upon |
| 2014/006 | NOTSS | SSIP | 10/02/2014 | 19/02/2014 | Cat 3-4 sacrum |
| 2014/007 | S&O | NA | 15/01/2014 | 06/01/2014 | Cat 3 both heels |
| 2014/008 | MRC | 5B | 18/02/2014 | 20/02/2014 | Unexpected death during transfer |
| 2014/009 | NOTSS | Neurosciences | 13/02/2014 | 21/02/2014 | Allegations of assault |
| 2014/010 | MRC | Cardiology Ward | 18/01/2014 | 24/02/2014 | Cat 4 PU bilateral heels |
| 2014/011 | MRC | PAU | 16/02/2014 | 24/02/2014 | Cat 3 PU right elbow |
| 2014/012 | MRC | Cardiology Ward | 16/02/2014 | 24/02/2014 | Cat 4 PU bilateral heels |
| 2014/013 | MRC | Ward 7D | 30/01/2014 | 24/02/2014 | Cat 4 PU bilateral heels |
| 2014/014 | MRC | Ward 7B | 04/02/2014 | 24/02/2014 | Cat 4 PU bilateral heels |

## 4. Quality Walk Rounds

4.1 There were 9 quality walk rounds in February 2013. One Walk Round was cancelled due to sickness of the Executive Lead. The Quality Walk Rounds took place as follows. Figure 2 reflects the areas within the Trust where a quality walk round was completed.

**Figure 2.**

| Hospital Site | Areas Visited |
|---|---|
| John Radcliffe Hospital | Ear, Nose and Throat Outpatients<br>Oral Maxillofacial and Restorative Dentistry Outpatients<br>Ward 5F<br>Radiology |
| Nuffield Orthopaedic Centre | Physiotherapy<br>Occupational Therapy<br>Hydrotherapy |
| Churchill Hospital | Continuous Ambulatory Peritoneal Dialysis<br>Churchill Intensive Care Unit |

4.2 Key issues with the potential to affect quality or patient experience identified during the Quality Walk Rounds included concerns regarding: management and storage of medicines; cleaning standards and the timeliness to undertake environmental works; and, procurement of items to improve the patient experience.

4.3 All issues have actions associated with them and these will be monitored through Divisional governance processes.

## 5. Clinical Effectiveness

5.1 The HSMR for the financial year to date (April13 – Dec13) is 92.18 and is currently ranked as 'better than expected'. However, this figure has not yet been subjected to the annual rebasing process. Starting from the end of March 2014, the HSMR will be rebased each quarter rather than annually. Each rebasing to likely cause the HSMR for most Trusts to increase marginally, the exact extent of the increase depending on each Trust's case-mix.

## 6. Mortality Review Group

6.1 An analysis of the SHMI indicator by hospital site shows that the SHMI for the Horton site is higher than for the other three sites. SHMI is not published at site level and it is by no means clear that the Horton would be a statistical outlier even if data were published. A number of actions are in progress in relation to the Horton including examination of the model of medical care (an interest has been expressed in collaborating with the Royal College of Physicians *Future Hospitals* Programme) and an audit of the documentation and coding of comorbidities in a sample of patients treated under Trauma and Medicine at the Horton.

6.2 A review of clerking proformas across the Trust showed that these are now in use in many areas and that most have specific provision for documenting comorbidities. Moving forward, EPR forms will provide the means for achieving this in a more standardised way.

6.3 Significant progress has been made with the implementation of the standardised mortality review process. Divisional reports on deaths reviewed in Quarter 3 of 2013/14 were reported the Clinical Governance Committee on 19th February 2014. These reported that 86% of deaths were reviewed using the process (standardised screening or a formal review). No deaths were reported as 'avoidable' but a considerable number of actions and learning points were identified. The Group will consider how best to disseminate this information.

## 7. Experience of Patients

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

7.2 Figure 3 below provides a breakdown of the various metrics for the month of January 2014.

7.3 The combined response rate for Emergency Departments (EDs) is below target. The Horton ED achieved a response rate of 28% and JR ED was 2.4%. An action plan is in place to improve response rates (and a CQUIN payment is reliant on improved response rates during Q4).

7.4 The maternity FFT response rate has increased from 4% in December to 9% in January 2014 although FFT in this area was only initiated in October 2013.

**Figure 3.**

| | | Friends and Family Test | | | | Complaints and PALS | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Net Promoter Score[1] | % Extremely Likely and likely | % Extremely unlikely and unlikely[2] | Response rate | Number of PALS contacts suggesting improvements[3] | Number of Formal Complaints[4] | Number of Informal Complaints[5] | % complaints against Finished Consultant Episodes (FCE) activity | % of total Trust complaints |
| Trust overall | Inpatient, ED and maternity | 69 | 95% | 2% | 17% | 302 | 85 | 21 | **0.08%** | *Not applicable* |

[1] FFT score is a net promoter score which is calculated as follows:
Proportion of respondents who would be extremely likely to recommend (response category: "extremely likely") MINUS Proportion of respondents who would not recommend (response categories: "neither likely nor unlikely", "unlikely" & "extremely unlikely").
[2] The figures for 'neither likely or unlikely' or 'don't know' have not been included.
[3] There were a total of 487 PALS contacts for January 2014, which includes advice and information requests. This is an increase in activity since December. The table reports contacts relating to service improvements only: a total of 302 for the Trust.
[4] Formal complaint: A complaint made to the organisation that warrants a formal investigation and written response from the Chief Executive.
[5] Informal complaint: A complaint made to the organisation that requires investigation with a response directly from the Clinical Division.

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Inpatient and ED (CQUIN) | 69 | 95% | 2% | 19% | | | | | |
| MRC | ED for both sites | 59 | 93% | 3% | 11% | 47 | 18 | 4 | **0.06%** | 21% |
| | Inpatient | 66 | 94% | 1% | 27% | | | | | |
| C & W | Inpatients | 81 | 97% | 0% | 21% | 19 | 12 | 6 | **0.08%** | 14% |
| | Maternity | 65 | 97% | 1% | 9% | | | | | |
| Corporate | | *Not applicable* | | | | 50 | 5 | 2 | *Not applicable* | 6% |
| CSS (CCTDP) | | *Not applicable* | | | | 16 | 2 | 1 | **0.01%** | 2% |
| NOTSS | | 76 | 97% | 1% | 27% | 120 | 32 | 5 | **0.11%** | 38% |
| S & O | | 77 | 97% | 1% | 30% | 50 | 16 | 3 | **0.06%** | 19% |

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

- Positive staff attitude.
- Good general quality of care.
- Good standard of nursing care.

7.6 The key themes for improvement from FFT and complaints for the Trust, but with variations within divisions, include:

- Patient care .
- Staff attitude, behaviour and communication.
- Delays and difficulty in making an appointment.

7.7 A patient experience briefing report is being prepared for divisions, including all the patient experience feedback from FFT, PALS enquiries and complaints, in relation to patient care, staff attitude and discharge.

## 8. Quality Account / CQUIN

8.1 This section sets out performance against the 2013/14 Quality Priorities and CQUIN's targets for Quarter 3. CQUIN's targets and Quality Priorities are closely related.

8.2 The majority of the CQUINS are meeting project timelines. Table 4 below sets out the Quarter 3 CQUIN performance.

8.3 Four CQUIN's failed to meet the required milestone in quarter 3, however three of them are considered to be on track for achievement in quarter 4.

8.4 The four areas are Telemedicine, Dementia screening, Emergency Admission Navigators, and Learning & Disability. The achievement of the quarter 3 target for ECIST is still under review.

**Table 4.**

| CQUIN goal | Summary of Q3 goals where known | Comment | Rag |
|---|---|---|---|
| **Telemedicine –** whole system care close to home | Q3 Use system, measure no of times equipment used e.g. no of consultations | Start date is dependent on OUHT procuring devices. This has been held up by communication with OHIS. | |
| **Intra operative fluid monitoring** | Q3 – an average of 50 procedures a month use IOFM | Met | |
| **Child in a chair (Specialist wheelchairs)** | Quarterly reporting that demonstrates that a maximum 5 week wait is maintained for all patients (adults and children) that are waiting for a wheelchair. | Met | |
| **Gestational diabetes** | Q3 Patient satisfaction | Met | |
| **Physiological outcomes post MI** | No specific Q3 goal | Met | |
| **ICE** | Roll over & expand to include radiology requesting / reporting | Over 80% of GPs in Oxfordshire report to the OUH using ICE | |
| **Friends and Family test** | By Quarter 3, OUH need to demonstrate phased expansion (30%) | FFT rolled out to maternity in September before required date of October. Low response rate noted in maternity although this is not the target. OUH must improve response rate in A&E and inpatients to achieve goal for Q4. Embargoed results of staff survey tend to show likely achievement of staff goal. | |
| **Safety Thermometer** | Reduce pressure ulcer prevalence by 50% over 6 month period. Measures Q3/Q4 | Measured on six monthly basis but appears to be a small improvement since October. | |
| **Dementia** | Identification – 90% | Identification has improved to 60% in December | |
| | Assessment – 90% | Assessment – achieved | |
| | Referral – 90% | Referral – achieved | |
| | Clinical leadership and training | Met | |
| | Supporting carers | Met | |
| **VTE** | 95% risk assessments on admission | Met | |
| | Q3 target - 75% of HAT will be subject to 'initial standardised screening review' | Met | |
| **Psychiatric liaison service** | No targets | Met | |
| **Baseline data for frail elderly patients + DTOC** | Q3 – Conduct audit and analyse results and agree action plan with commissioners. | Met | |
| **Medical Support for complex patients in surgery** | Quarter 3-4: (50%)<br>• Expand service to provide input six days per week<br>• Collect minimum data set*<br>• Improve performance measures in relation to process measures identified and agreed in Q1 | Q 3 & 4 target, therefore met | |
| **Emergency Admission Navigators** | Quarter 2 – 3 (50%)<br>• Operation of admission navigator role 1000 to 2200 seven days per week | | |

| | | | |
|---|---|---|---|
| | • Collection of core data (to be agreed with commissioners) and quarterly reporting & delivery against agreed outcomes<br>• Make revisions where necessary to ensure service is meeting proposal (commissioners will cross reference with feedback from GPs produced via Datix) | | |
| **Nursing** | Outcomes<br>From Quarter 2 onwards, every two months, a peer review audit will be undertaken by nurses with each other's ward against the criteria developed in the audit. | Met | |
| | Staffing<br>In Quarter 3/4, set a trajectory (agreed by CCG) so that fewer staff leave the organisation. | Met - Money awarded in Q4 | |
| | Discharge<br>The principles from High Impact Actions, Ready to Go or 7 ways to no delays to be adopted and incorporated into the nurse leadership programme. | Met - Money awarded in Q4 | |
| | Length of Stay<br>Maintain or reduce a length of stay of 4.3 days for all admission types during 2013/14. The method of measurement will be based on Dr Foster Intelligence software. | Met - Money awarded in Q4 | |
| **Diabetic foot disease** | – Collect baseline data for 3 months.<br>– Test IT videoconferencing software. | Met | |
| **Diabetic support for young adults** | Deliver care pathway | Met | |
| **Learning disability (LD)** | Suggested Plan for Q3<br>1. Establish a potential mechanism for flagging these patients in ED. This will be examined jointly with ED.<br>2. Examine the feasibility for additional Epilepsy Specialist Nurse resource to review additional referrals to Neurology team. | Mechanism for flagging patients not established | |
| **ECIST report (Emergency Care Intensive Support Team)** | Q3 – Deliver actions against ECIST action plans | Results yet to be agreed | |

8.5 The Quality Account 2012/13 has set quality priorities in three domains:

a) Patient Safety
b) Clinical Effectiveness
c) Patient Experience

8.6 The majority of the quality priorities have met project timelines. Table 5 below summarises Q3 performance.

**Table 5.**

| **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 | |
| | Strenthening 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 MCA 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 | |
| **PATIENT EXPERIENCE** | | |
| **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 national target for cognitive (dementia) assessment | |
| | Develop environment | |
| | Establish dementia champions | |
| | Support to carers | |
| | Monitoring actions | |

8.7 Although the Trust is on track to meet its quality priority for Telemedicine, the CQUIN milestone for Quarter 3 was not achieved.

## 9. Infection Control

9.1 The OUH Trust remains beneath its ceiling for C Diff.

## 10. Care Quality Commission Inspection

10.1 The Care Quality Commission (CQC) is in the process of undertaking a scheduled inspection of Trust services. The CQC visited the Trust's four sites on 25th and 26th February on an announced basis and the window for unannounced visits remains open for week commencing 3rd March.

10.2 Feedback at the time of a CQC inspection is limited but no immediate compliance or enforcement actions were notified.

10.3 The formal report of the inspection and the CQC's judgements are expected in April.

## 11. Concerns raised by Staff

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

11.2 Two concerns raised by staff were noted at February Clinical Governance Committee relating to the care of patients.

11.3 Both concerns are currently being investigated and will be reported through the appropriate channels.

## 12. Recommendation

12.1 The Trust Board is asked to note this report.

**Professor Edward Baker**
**Medical Director**

Report Prepared By:

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March 2014