Oxford University Hospitals NHS
NHS Trust

Trust Board Meeting: Wednesday 14 May 2014

TB2014.52

Title	**Quality Report**

Status	For information
History	This is the monthly Board Quality Report

Board Lead(s)	**Dr Tony Berendt, Interim 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:

   - For 15 (of 54) quality metrics, pre-specified targets were not fully achieved in the last relevant data period. For selected metrics, trend data are provided along with brief exception reports.

3. In relation to patient safety and clinical risk:

   - 6 Serious Incidents Requiring Investigation (SIRI) were reported in April 2014.

4. In relation to Quality Walk Rounds:

   - There were 3 Quality Walk Rounds in April 2014.

5. In relation to clinical effectiveness:

   - The latest Standardised Hospital Mortality Index (SHMI), for the 12 month period October 2012 to September 2013, was released in late April via the Health and Social Care Information Centre. Reported SHMI is 0.96.

6. In relation to CQUIN / Quality Account Priorities:

   - CQUINS for 2014/15 are currently being negotiated with Oxfordshire CCG.
   - Quality Account Priorities for 2014/15 will be f inalised in the Trust's Quality Account (publication due on 30 June 2014).
   - A draft of the 2013/14 Quality Account has been shared with stakeholders for consultation.

7. Patient Experience:

   - A patient and public engagement event on 24 April 2014 was well attended.
   - The top positive themes from the Friends and Family Test in March 2014 were:
     Positive staff attitude.
     Good general quality of care.
     Good standard of nursing care.
   - The key themes for improvement for the Trust arising from complaints, but with variations within divisions, include:
     Patient Care.
     Access to services/appointments.
     Communication.

8. Risk Summits

   Two risk summits relating to 'out of hours care' (Care 24/7) were convened on 31st March and 11th April. Multidisciplinary staff of varying seniority, from across the Trust, attended to consider the key issues, potential improvement actions and and the path forward.

Recommendation

The Board is asked to receive this report.

Board 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 Board Quality Report will be received for information by relevant Trust Committees (Clinical Governance Committee and Trust Management Executive) following the meeting of the Board.

2. Key Quality Metrics

2.1. A suite of fifty four key quality metrics has been identified for consideration by the Board and is reported in dashboard format on pages 4 – 6.

2.2. 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.

2.3. Trend graphs and exception reports are provided on pages 7 to 11 in relation to metrics where specified thresholds have not been met ('red-rated') and metrics that are amber-rated having been green-rated in the previous period. Thresholds are drawn from a mixture of sources (national, commissioner and internal). No graphics are presented for PS08 (the data period is historical and it has previously been discussed in a Board Quality Report) or for CE04b and CE25 (as these metrics are new this month and there are therefore no trend data).

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]	Apr 14	Internal	95%	97%
PS02	93.01% Green	Green	Safety Thermometer (% patients receiving care free of any harm - irrespective of acquisition) [one month in arrears]	Apr 14	Internal	91%	93%
PS03	95.59% Green	Green	VTE Risk Assessment (% admitted patients receiving risk assessment)	Mar 14	National	95%	95.25%
PS04	6 N/A		Serious Incidents Requiring Investigation (SIRI) reported via STEIS	Apr 14		N/A	N/A
PS05	64 Green	Green	Number of cases of Clostridium Difficile > 72 hours (cumulative year to date)	Mar 14	National	70	N/A
PS06	5 Red	Red	Number of cases of MRSA bacteraemia > 48 hours (cumulative year to date)	Mar 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	81.49% Amber	Green	% patients receiving stage 2 medicines reconciliation within 24h of admission	Apr 14	Internal	75%	85%
PS10	96.6% Green	Amber	% patients receiving allergy reconciliation within 24h of admission	Apr 14	Internal	94%	96%
PS11	1969 N/A		Total number of incidents reported via Datix	Apr 14		N/A	N/A
PS12	4.97% Green	Green	% of incidents associated with moderate harm or greater	Apr 14	Internal	6.5%	5%
PS13	55 N/A		Total number of newly acquired pressure ulcers (category 2,3 and 4) reported via Datix	Feb 14		N/A	N/A
PS14	5 Green	Green	Falls leading to moderate harm or greater	Apr 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	60.26% N/A		Cleaning Score - % of inpatient areas with initial score > 92%	Feb 14		N/A	N/A
PS17	3.28% Green	Green	% 3rd and 4th degree tears in obstetrics [C&W Division]	Mar 14	Internal	5%	N/A
PS18	99.3% Green	Green	% radiological investigations achieving 5 day reporting standard [CSS Division]	Feb 14	Commissioner	95%	98%
PS19	9 N/A		Number of CAS alerts received	Apr 14		N/A	N/A
PS20	0 Green	Green	CAS alerts breaching deadlines at end of month and/or closed during month beyond deadline	Apr 14	Internal	1	N/A
CE01	0.96 N/A		Standardised Hospital Mortality Ratio (SHMI) [most recently published figure, quarterly reported as a rolling year ending in month]	Sep 13		N/A	N/A
CE02	213 N/A		Crude Mortality	Apr 14		N/A	N/A
CE03	62.68% Red	Red	Dementia - % patients aged > 75 admitted as an emergency who are screened [one month in arrears]	Feb 14	National	80%	90%
CE04a	78% Red	Red	Statutory and Mandatory Training - % required modules completed	Apr 14	Internal	85%	90%
CE04b	25% Red		Statutory and Mandatory Training amongst honorary contract holders - % required modules completed	Apr 14	Internal	85%	90%
CE05	93.2% Amber	Amber	ED - % patients seen, assessed and discharged / admitted within 4h of arrival	Mar 14	National	85%	95%
CE06	100% Green	Green	Stroke - % patients spending > 90% of admission in specialist stroke environment	Apr 14	National	70%	80%
CE07	86.67% Green	Amber	Stroke - % patients accessing specialist stroke environment within 4h of arrival	Apr 14	National	75%	85%
CE08	410 N/A		Transfer Lounge Usage	Mar 14		N/A	N/A
CE09	94.46% Green	Green	% of elective paediatric day cases managed as such (did not result in an overnight stay) [C&W Division]	Mar 14	Internal	70%	75%
CE10	5.9 Amber	Green	Vascular - Mean length of stay for patients undergoing elective AAA repair (3 month rolling period) [NOTSS Division]	Feb 14	Internal	8	5
CE11	0% Green	Green	Vascular - % mortality following elective AAA repair [NOTSS Division]	Feb 14	Internal	5%	3%
CE12	90.62% Green	Green	Cardiology - % patients receiving primary angioplasty within 60 minutes of arrival at hospital [MRC Division]	Feb 14	Internal	85%	90%

CE13	2.6 Amber	Green	Cardiology - Mean number of days from referral to admission to cardiology at tertiary centre [MRC Division]	Mar 14	Internal	3	2
CE14	0.49% Green	Green	Cardiac surgery-% rate of patients with organ space infections following cardiac surgery via the sternum [MRC Division]	Feb 14	Internal	1%	0.5%
CE15	0% Green	Green	Cardiac Surgery - % mortality following elective primary CABG [MRC Division]	Feb 14	Internal	6%	4%
CE16	3 Red	Red	Number of unscheduled returns to theatre within 48 hours [NOTSS Division]	Mar 14	Internal	2	1
CE17	100% Green	Green	Rheumatology - % relevant patients who have their DAS28 score documented [NOTSS Division]	Mar 14	Internal	95%	98%
CE18	0 Green	Green	Number of unscheduled returns to theatre in gynaecology [C&W Division]	Apr 14	Internal	2	1
CE19	530 N/A		Number of patients admitted to SEU wards from SEU triage [S&O Division]	Mar 14		N/A	N/A
CE20			*% SEU patients requiring surgery who receive surgery within 24 hours of decision to operate [S&O Division] – replaced by CE25*		Internal	N/A	N/A
CE21	2% Amber	Red	Neuroscience Intensive Therapy Unit (NITU) readmission rate within 48 hours of discharge [NOTSS Division]	Mar 14	Internal	4%	2%
CE22	73.72% Green	Green	% fractured NOF patients who receive surgery within 36 hours of admission [NOTSS Division]	Mar 14	Commissioner	70%	72%
CE23	21.54% Green	Amber	% deliveries by C-Section [C&W Division]	Mar 14	Commissioner	33%	23%
CE24	2.21% Amber	Amber	7 day admission rate following assessment on (and discharge from) paediatric CDU [C&W Division]	Mar 14	Internal	4%	2%
CE25	78.12% Red	Red	% patients having their operation within the time specified according to their clinical categorisation [CSS Division]	Mar 14	Internal	90%	95%
PE01	76 Green	Green	Friends & Family - Net Promoter Score [one month in arrears]	Mar 14	Internal	63	70
PE02	95.57% Green	Amber	Friends & Family - proportion extremely likely or likely to recommend [one month in arrears]	Mar 14	Internal	90%	94%
PE03	80 Amber	Red	Complaints Received	Mar 14	Internal	90	80
PE04	0 Green	Amber	Number of complaints received initially graded as RED	Mar 14	Internal	2	1
PE05	387 N/A		PALS contacts made	Mar 14		N/A	N/A
PE06	0 Green	Red	Single sex breaches	Mar 14	National	3	2
PE07	74.73% Green	Red	% patients EAU length of stay < 12h	Mar 14	Internal	65%	70%
PE08	3.75% N/A		% Complaints upheld or partially upheld	Mar 14		N/A	N/A
PE09	0 Green	Red	Number of legal claims received / inquests opened initially graded as RED	Mar 14	Internal	2	N/A
PE10	68% Green	Green	% patients returning feedback forms in specialist surgery outpatients [NOTSS Division]	Mar 14	Internal	45%	60%

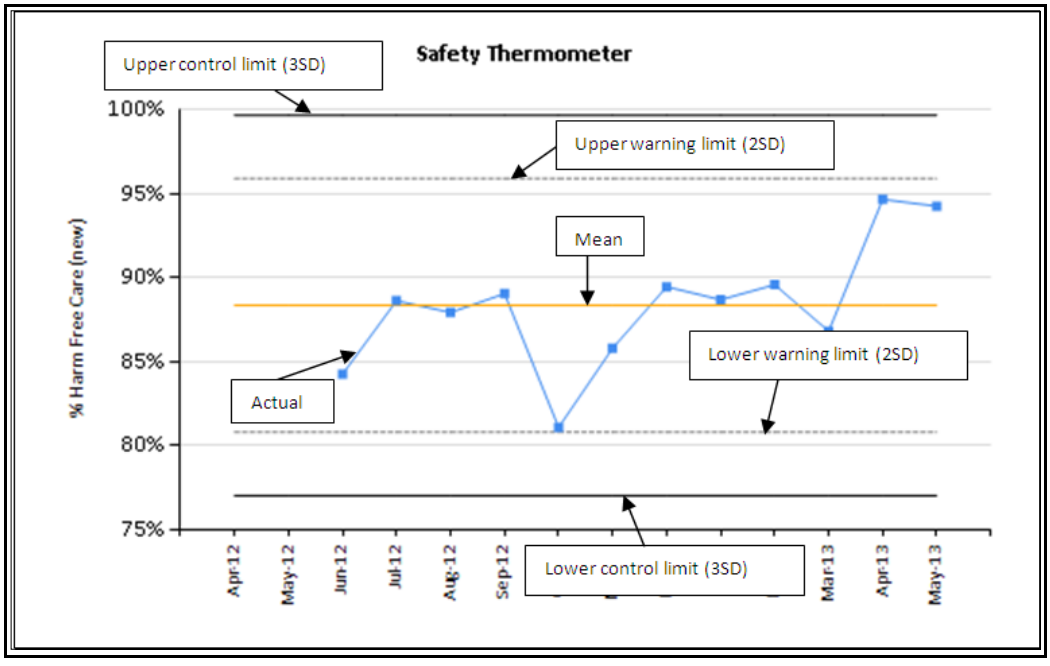
How to interpret charts

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.

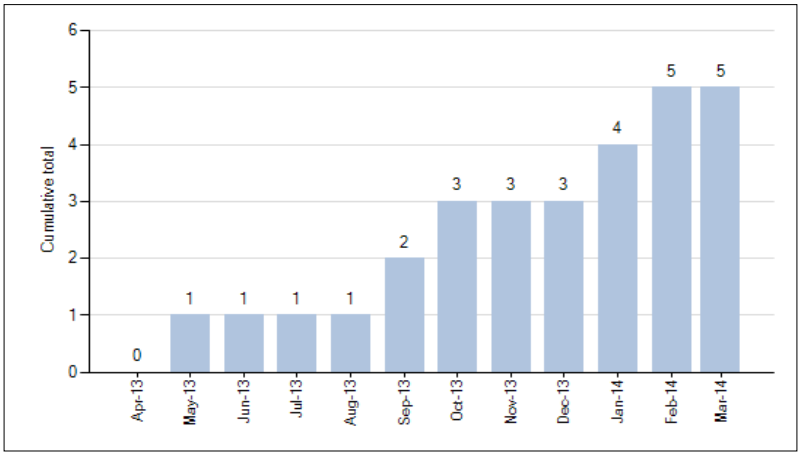
There are other patterns within the data that are likely to reflect real change as opposed to random fluctuation – these patterns are known as special cause variations. They include:

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

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



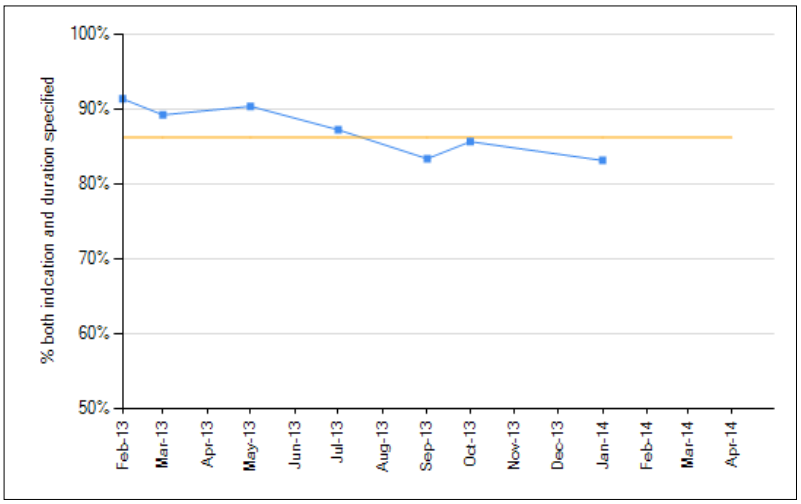
Narrative

Red. All five cases in 2013/14 were judged to be unavoidable but national guidelines promote a 'zero tolerance' approach to reporting of MRSA.

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]



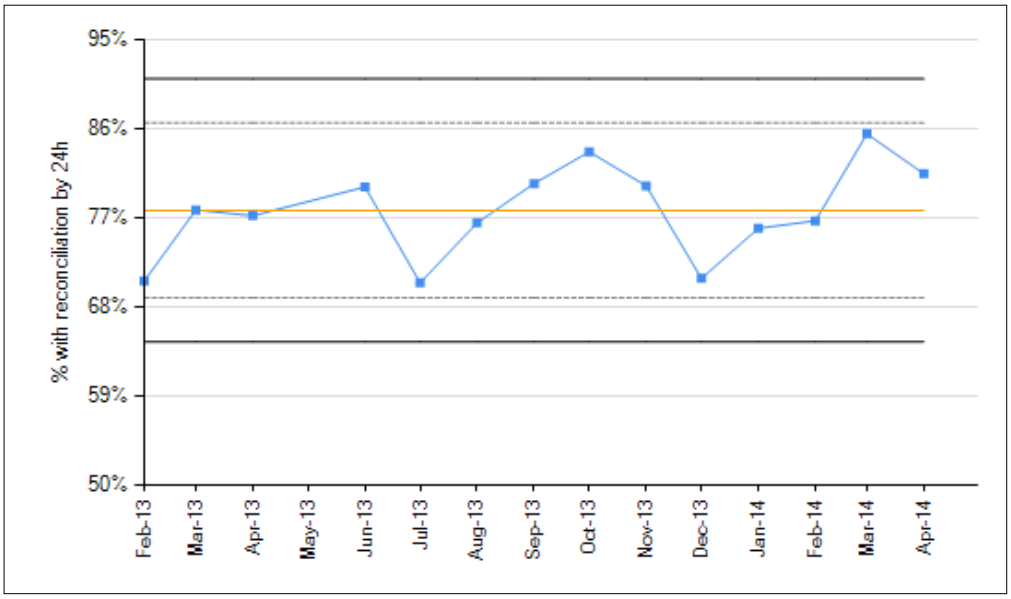
Narrative

Red, previously amber. This has been reported in the BQR previously. Follow up data are anticipated shortly.

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



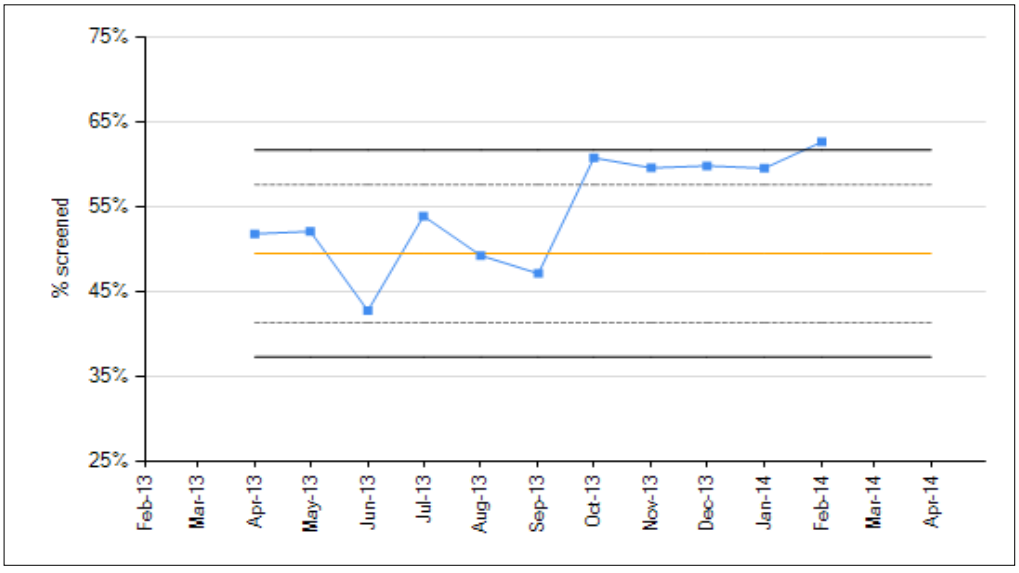
Narrative

Amber, previously Green. Closely monitored through relevant Clinical Governance forums.

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. [Owner: P Devenish].

Clinical Effectiveness

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



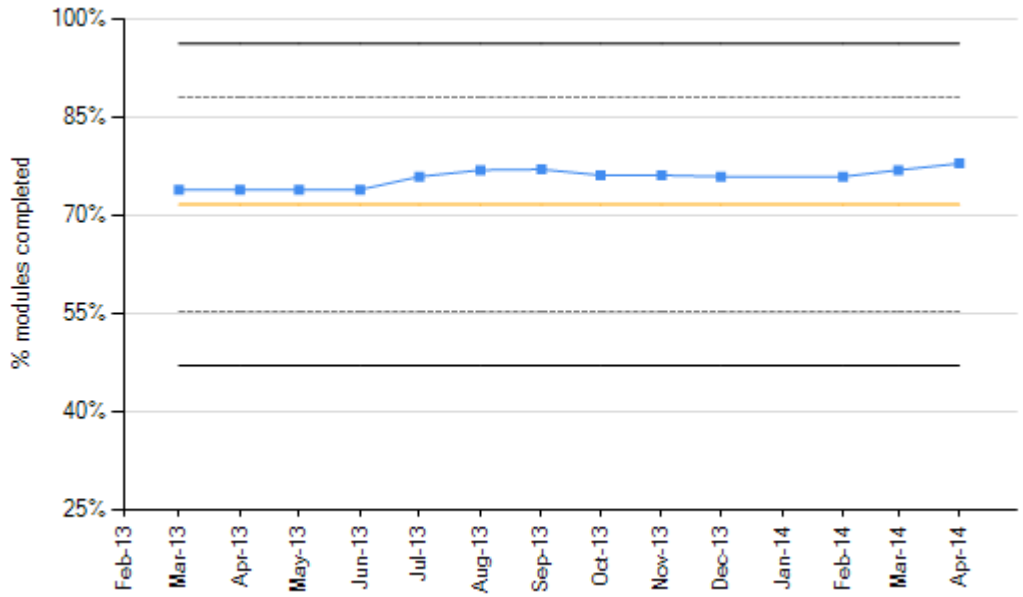
Narrative

Continues as a CQUIN goal into 2014/15. Ongoing changes to IT systems within the Trust are expected to have a positive impact over Q1 and Q2 2014/15.

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

CE04a Statutory and Mandatory Training - % required modules completed



Narrative

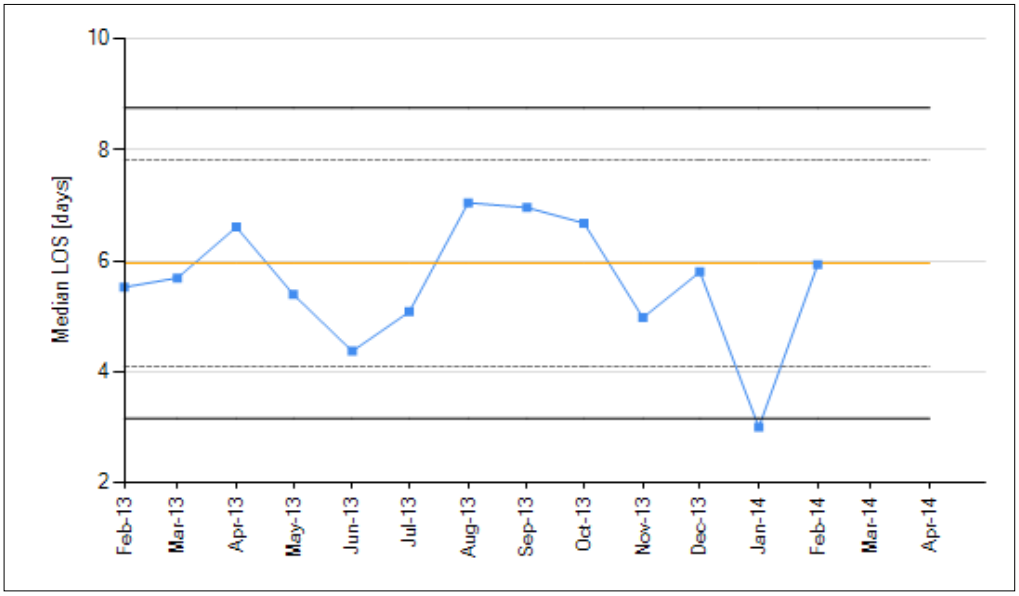
Overall S&M training rates remain below target. Reported at Clinical Governance Committee. See text below in relation to metric CE04b (honorary contract holders).

Note that CE04b has been reported on the dashboard for the first time this month. Honorary contract holders have completion rates of around 25% and have an adverse impact upon the Trust total. There are approximately 1,200 honorary contract holders who are not included within the Divisional figures for reporting of S&M training. This is an area of renewed focus. [Owner: Ian MacKenzie].

Clinical Effectiveness

CE10 Vascular - Mean length of stay for patients undergoing elective AAA repair (3 month rolling period) [NOTSS Division]

Narrative



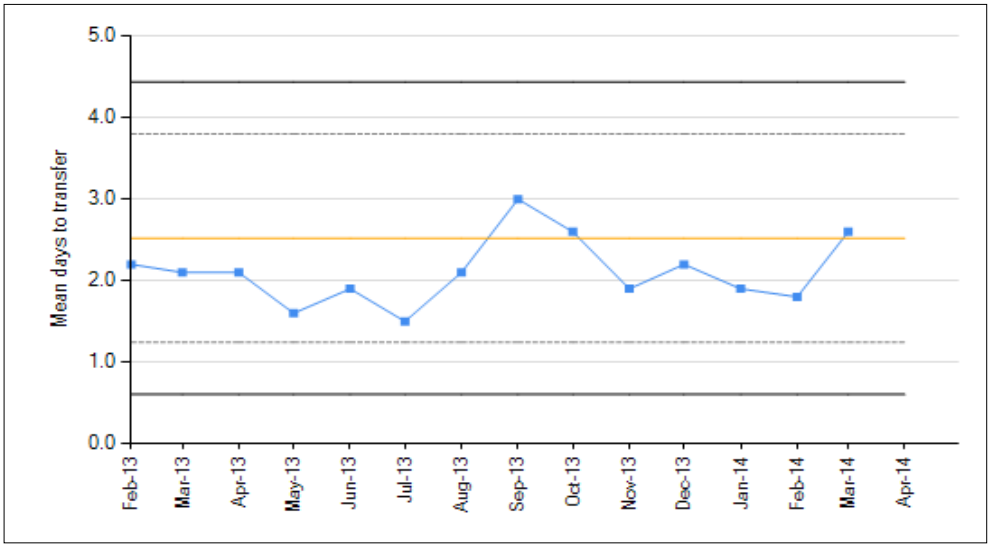
Amber, previously green. Further investigation and discussion at May Clinical Governance Committee.

Information collected from ORBIT and based on the primary procedure coded and elective admission method.

Clinical Effectiveness

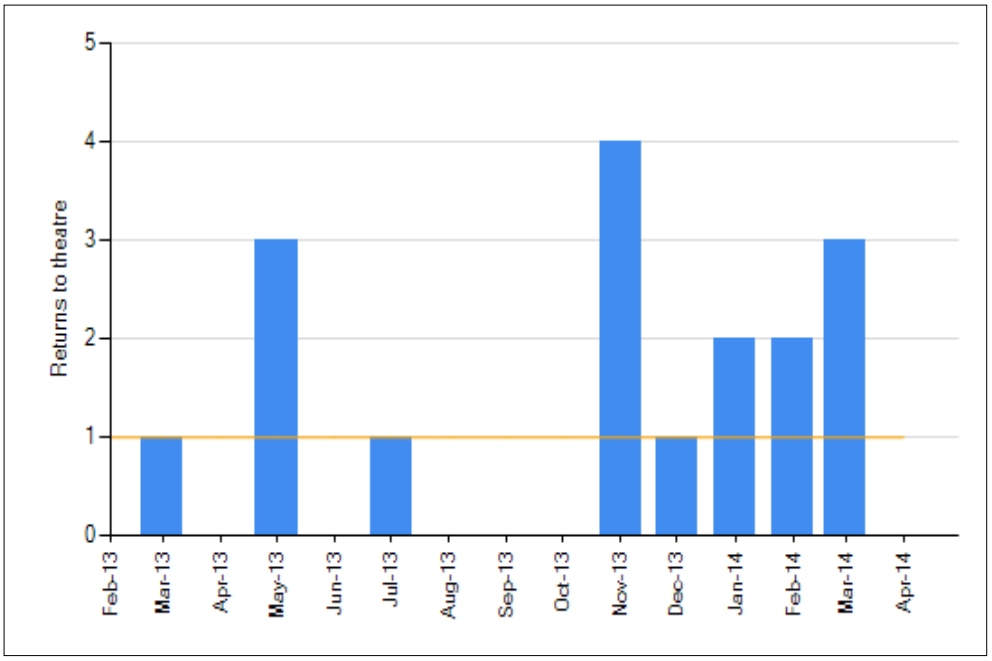
CE13 Cardiology - Mean number of days from referral to admission to cardiology at tertiary centre [MRC Division]

Narrative



Amber, previously green, for discussion at Clinical Governance Committee in May 2014.

Directorate goal is that patients are transferred within 2 days of referral.

Clinical Effectiveness	
CE16 Number of unscheduled returns to theatre within 48 hours [NOTSS Division]	**Narrative**
	No data for April yet available. This will be followed up via May Clinical Governance Committee.
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.	

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. 12 SIRI investigations were recommended to OCCG for closure during April 2014. These investigations have been closed through the new SIRI closure panel process.

3.3. The key themes and trends that are identified from the recommendations following SIRI investigations are reported to the Quality Committee and the Clinical Governance Committee on a bi-monthly basis.

3.4. Table 1 below provides an outline of the six Serious Incidents Requiring Investigation (SIRI) that have been declared during April 2014 and are under investigation.

Table 1

SIRI ref	Division	Date of Incident	Description
2014/017	NOTTS	27/03/2014	Category 3 Pressure Ulcer
2014/018	S & O	03/04/2014	Patient arrested following displacement of a venous needle during dialysis
2014/019	S & O	06/04/2014	Category 3 Pressure Ulcer
2014/020	MRC	21/03/2014	Deep tissue injury
2014/021	MRC	20/01/2014	Fractured right hip following fall
2014/022	S & O	31/03/2014	Possible medication incident

4. Quality Walk Rounds

4.1. There were 2 quality walk rounds in April 2014. Table 2 identifies the areas within the Trust where a quality walk round was undertaken.

Table 2

Hospital Site	Areas Visited
John Radcliffe Hospital	Mortuary Specialist Surgery Inpatients Ward
Other	Wantage midwife-led Unit

4.2. Key issues with the potential to affect quality or patient experience identified during the Quality Walk Rounds included concerns regarding the environment, storage, equipment maintenance and challenges recruiting staff.

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

5. Clinical Effectiveness

5.1. The latest Standardised Hospital Mortality Index (SHMI), for the 12 month period October 2012 to September 2013, was released in late April by the Health and Social Care Information Centre and is 0.96.

5.2. Five out of 104 diagnosis groups had a higher than expected SHMI at OUH for the period July 2012 to June 2013. These outcomes are being investigated and discussed by the Clinical Outcomes Review Group and the Mortality Review Group.

6. Experience of Patients

6.1. The following section contains detail of the feedback from patients through the Friends and Family Test, Complaints and Patient Advice and Liaison Service during March 2014.

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

6.3. The combined response rate for Emergency Departments (EDs) has increased to 27%, 45% at the Horton General Hospital (HGH) ED and 18% at the John Radcliffe (JR) ED. This is the highest response rate recorded for both departments and has been due, in part, to the introduction of 'coin drop ' boxes in the JR ED, high profile leadership and a team approach.

6.4. The overall Trust response rate for both inpatients services and ED was 23%. The Trust secured 100% of the 2013/14 FFT CQUIN in relation to the Friends and Family Test.

6.5. The maternity FFT response rate has fallen slightly to 8.4%.

6.6. The 2014/15 CQUIN guidance has been published. This clarifies the FFT requirements for this forthcoming year.

- Quarter 1

  The staff FFT commenced 1 April 2014.

  The achievement of over 15% response rates in ED and maintenance of over 30% response rates for adult inpatients services

- Quarter 3

  FFT delivered in outpatient and day case departments by 1 October 2014.

  The achievement of over 20% in ED, before the end of Q3, and for the duration of Q4.

  The achievement of 40% response rates for adult inpatient services before the end of Q3 and for the duration of Q4.

6.7. The Patient Experience business case has been approved by the Trust Management Executive (TME). The Trust will be tendering for a Trust wide patient experience system in order to successfully meet the CQUIN requirements for 2014/15. It is anticipated that the new system will be in place during September 2014.

6.8. The top positive themes from the Friends and Family Test in March 2014 were:

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

The key themes for improvement from complaints were:

- Patient Care
- Access to services/appointments
- Communication

6.9. Table 3 overleaf provides a breakdown of the metrics related to the experience of patients in the month of March 2014.

Table 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	67	95%	2%	23%	293	83	23	**0.08%**	*N/A*
	Inpatient and ED (CQUIN)	68	95%	2%	28%					
MRC	ED for both sites	60	93%	2%	27%	56	23	7	**0.07%**	28%
	Inpatient	65	95%	2%	29%					
C & W	Inpatients	76	94%	6%	8%	10	8	3	**0.05%**	10%
	Maternity	65	97%	0%	8%					
Corporate		*N/A*				26	6	0	*N/A*	7%
CSS (CCTDP)		*N/A*				18	3	0	**0.002%**	4%
NOTSS		81	96%	2%	29%	142	31	9	**0.1%**	37%
S & O		82	97%	1%	31%	41	12	4	**0.04%**	14%

6.10. The Trust-wide actions and projects to improve patient and carer experience are presented in table 4 overleaf:

[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 388 PALS contacts for March 2014, which includes advice and information requests. The table does not report PALS contacts relating to advice or information requests (i.e. sign-posting) or positive feedback only.
[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.

Table 4

Key Themes	SMART Actions	SMART outcome	Time line for completion	Lead
Discharge delays, safety and information	Revised discharge documentation and rollout discharge checklist. Developing MDT led discharge procedure: rolled out on Acute General Medicine (AGM) &Trauma. Real time bed state being launched from May 2014. Developing ORBIT to monitor and review when TTOs are written. System for ordering medicines on hand held devices has been reintroduced.	Standardised discharge documentation for all inpatients - reduction in number of complaints, incidents & safeguarding alerts related to discharge. Improve and increase patient flow, and discharge. Improve the timeliness of TTOs being written up	Audit in May 2014 June 2014 May 2014 October 2014 75% of inpatient medications at JR by end of July 2014.	Deputy Director of Clinical Services Clinical Director for Pharmacy
Appointments	All redesigned clinic appointment scheduling profiles to be signed-off and submitted by 31/05/2014 New demand & capacity information to be provided through ORBIT to the services to assist with planning.		End of May 2014 September 2014.	Deputy Director of Clinical Services

Key Themes	SMART Actions	SMART outcome	Time line for completion	Lead
Staff attitude and behaviour, communication	Pilot of FFT question in Patient Access Centre, Blue Outpatients completed. Develop detailed specification for toolkit, introductory training, compassionate care course. Select provider patient experience IT provider. Run both compassionate care and customer care training	Increased awareness of the impact of staff communication and attitude on patient experience evidenced through patient feedback.	Complete May 2014 June 2014 September 2014	Patient Services Manager
Dementia	Develop and present the Trust Dementia strategy and business case at the Trust management Executive in May and Trust Board in July 2014. This strategy will clarify the Trusts vision and work plan and to support the compassionate, safe and personalised health care and support for patients with Dementia and their family.	The delivery of compassionate, safe and personalised health care and support for patients with Dementia and their family	TME, 22 May 2014 Trust Board Seminar in June Trust Board in July 2014	Clinical Lead for Dementia

7. Quality Priorities / CQUIN

7.1. This section sets out performance against the 2013/14 quality priorities defined in the Trust Quality Account, and the proposed 2014/15 priorities.

7.2. The priorities for 2013/14 were arranged in the domains of patient safety, clinical effectiveness and the experience of patients.

7.3. Evaluation of the achievements in 2013/14 against the priorities has been performed, and the key highlights are:

Patient Safety -'safer care associated with surgery'.

- Improved compliance with the WHO surgical safety checklist, University partners have achieved funding for a patient safety academy, development of a leadership program for nursing staff, and improved consent processes.

Patient Experience – 'improving the way we listen to and act on feedback' and 'improving care for people with cognitive impairment'.

- Roll out of the national Friends and Family Test (FFT); agreement of Patient Experience Strategy; staff attending the Dementia Leaders programme; and, introduction of consultant liaison psychiatrists to improve the care provided to patients with a cognitive impairment.

Clinical Effectiveness – 'using technology to improve care'.

- Roll out of a new electronic system for the requesting of tests by colleagues in Primary Care ('ICE'); and, development of a new system for collecting, collating, analysing and reacting to markers of physiological deterioration.

7.4. A Patient Engagement event on 24 April 2014 was well attended by patients and members of the Oxfordshire public, who were given the opportunity to both view the proposed quality priorities for 2014/15 and to comment on their experiences in our busy outpatient departments.

7.5. Those present generated a lively discussion on the proposed priorities, and provided valuable insight into the patient experience whilst receiving outpatient treatment from our services.

7.6. The priorities proposed for 2014/15 are:

- Timeliness and communication around discharge
- Care 24/7
- Physician input into the care of surgical patients
- Integrated psychological support for patients with cancer
- Implementation of the outcomes from the diabetes and pneumonia risk summits.
- Improvement in the outpatient experience.

7.7. A final CQUIN position for 2013/14 is yet to be agreed with the Commissioners. It is estimated that 70-80% of income was achieved. A verbal update may be available at the Board meeting.

8. Risk Summits

8.1. Care 24/7 risk summits were held on 31 March and 11 April 2014. Three workstreams were identified for further work to be undertaken following this event, as follows:

- Development of a 'nerve centre' concept
- Work force investment and develpment
- Developing and implementing appropriate support services and forward planning

8.2. A project board has been identified and plans to meet in June 2014. Leads for each of the three workstreams, along with site leads, will be identified prior to the first meeting, and with the support of the transformation team, will drive forward each of the above work streams.

8.3. Progress will be reported to Clinical Governance Committee and Trust Management Executive.

9. Quality Account

9.1. The 2014/2015 Quality Account is currently in draft form and has been sent to commissioners and other stakeholders for comment.

10. Recommendations

10.1. The Trust Board is asked to receive this report.

Dr Tony Berendt
Interim Medical Director

Report prepared by:
Annette Anderson
Head of Clinical Governance

May 2014