Oxford University Hospitals NHS
NHS Foundation Trust

Trust Board Meeting in Public: Wednesday 9 March 2016

TB2016.25

Title	**Board Quality Report**

Status	For information
History	This is a monthly report, presented alternately to the Trust Board or to the Quality Committee

Board Lead(s)	**Dr Tony Berendt, Medical Director**			
Key purpose	Strategy	**Assurance**	Policy	Performance

Executive Summary

1.	This paper briefs the Board on National developments on Quality related topics and commentary on the progress against the Trust's Quality Strategy and quality assurance and improvement work underway.
2.	A section on National Quality Strategy Updates, Trust Quality priorities and the quality account is included in this report to inform the Board of the national context and progress against our objectives.
3.	Key quality metrics: For six of the 32 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. For a selection of the quality metrics, Divisional specific information that contributes to organisational results is presented in dashboard format within Appendix One.
4.	Matters for attention of the Board: WHO checklist compliance of regular audits is reported to the Trust Board with actions where compliance has been incomplete.
5.	Issues raised by OCCG: Test results and discharge summaries timeliness have been an area of significant work this year. In January 73.4% of discharge summaries were sent before or within 24 hours of discharge and 65% of results endorsed on EPR within 7 days GP feedback collated from the OCCG DATIX system is reported.
6.	Patient Safety and Clinical Risk: No Never Events have been reported in January. 13 Serious Incidents Requiring Investigations (SIRIs) were reported in January. 12 SIRIs were recommended for closure to Oxfordshire Clinical Commissioning Group (OCCG) in January.
7.	Clinical Effectiveness: No new CQC mortality outliers have been reported. OUHFT were informed by the Dr Foster Unit at Imperial College that the Trust is a mortality outlier for the procedure group Coronary Artery By-pass Graft (CABG) (other). The most recent HSMR is 101.2 and the most recent SHMI is 0.99.
8.	Infection Control: 3 cases of C.diff apportioned to the OUHFT were reported for January 2016, against a monthly limit set at six. 52 cases have been identified year to date against a trajectory of 59. There were no MRSA bacteraemia apportioned to the OUHFT in January 2016, however the ceiling for the year was zero avoidable MRSA bacteraemias and 3 occurred earlier in the financial year.
9.	Patient Experience Friends and Family Test feedback: Emergency Department FFT Feedback: the percentage that would not recommend their care has risen to 9.0% from 8.0% in December. Maternity feedback: the percentage recommend for maternity has increased to the usual rate of 94% in January, after a dip in December.

Patient Engagement:

Membership of the Trust's Young People's Executive (YiPpEe) has increased from 6 to 20. On the 15th February 2016, sixteen members of YiPpEe came to the JR for the group's first official meeting.

10. Safe Staffing

The current status of nursing and midwifery staffing across the Trust by ward as well as by shifts is presented including:

- The summary of the January 2016 Unify submission of staffing.
- Current status of nursing & midwifery Nurse Sensitive Indicators

(6 appendices as dashboards).

Updates on:

- The implementation of the Integrated Patient Acuity Monitoring System.
- The implementation of the NMC Revalidation in the Trust due to commence 1st April 2016.
- The status and Trust's preparedness for the implementation of Care Contact Time.

Recent extensive safe staffing research published in February 2016, undertaken in the UK has identified that Registered Nurse ratios to patient beds of 1:6 or less have a significant impact on patient mortality rates.

11. Recommendation

The Board is asked to receive this Quality Report as information provided from within the organisation on the measures being taken in relation to quality assurance and improvement.

Board Quality Report

1. Purpose

1.1. This paper briefs the Board on National developments on Quality related topics and commentary on the progress against the Trust's quality Strategy and quality assurance and improvement work underway.

1.2. An update is provided on progress against the quality priorities described in the Trust quality account.

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

2. National Quality Strategy Updates

The Carter Review

2.1. In February 2016 an independent report for the Department of Health by Lord Carter of Cole entitled Operational productivity and performance in English NHS acute hospitals: Unwarranted variations. This follows an interim report in June 2015.

2.2. The report asserts that there is strong international evidence that good hospital management practices can deliver both improved clinical outcomes and productivity.

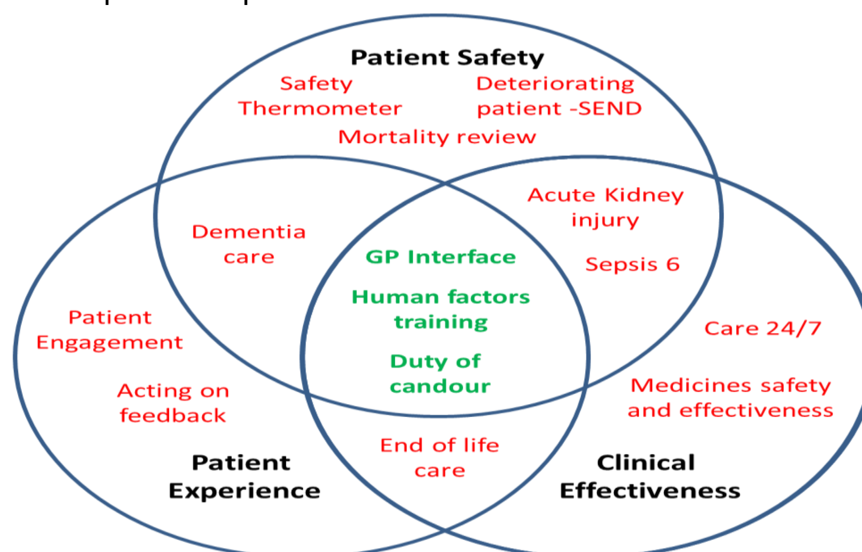
2.3. It recommends that national clinical programmes designed to improve quality and efficiency across care pathways are co-ordinated under a single governance framework led by NHS Improvement to ensure they align with the performance framework.

2.4. It also recommends that NHS England incentivise Trusts to fully utilise digital technology e-rostering and e-prescribing which is in line with OUHFT's 'Go digital' strategy.

2.5. The report makes 15 recommendations designed to reduce unwarranted variation between trusts which it estimates to represent a £5bn efficiency opportunity for the NHS.

3. Update on progress against the Trust Quality priorities

3.1. The Trust has agreed quality priorities in the domains of patient safety, clinical effectiveness and patient experience as shown below



3.2. Updates on the priorities are shown in Table 1.

Table 1

Priority	Progress
Deteriorating patient -SEND	The roll out of SEND electronic track and trigger project is on time and on target. It is fully implemented at the NOC and Churchill and in progress at the Horton.
Mortality review	A trust wide mortality review group distinct from the Clinical Effectiveness Committee is to be formed and meet monthly from March 2016. This committee will consider mortality strategy, outliers and compliance with the latest NHS England mortality governance guidance.
Safety Thermometer	Safety thermometer comprises four types of harm. The current data was reported to the February Quality Committee.
Acute kidney injury (AKI)	An education program on AKI has commenced in advance of roll out of an electronic flag for the three levels of AKI and an accompanying decision support power plan in millennium. A launch in early March is expected.
Sepsis	A clinical lead for sepsis is in place and a working group is in place with enhanced divisional representation. Screening tools for sepsis in ED, maternity and paediatrics are in development. OUHFT Deputy Medical Director is to chair the AHSN sepsis working group. A patient story has been filmed for QC and training purposes.
Dementia care	Dementia screening is in transition from paper to EPR. 23 dementia leaders are in place and training occurs in corporate induction. A dementia quality improvement nurse educator has been appointed who is a mental health nurse and is key to dementia simulation training.
Patient engagement	Established work streams are in place with work focusing around hard to reach groups. Two children from the YiPpEe patient panel are now members of the council of governors.
Acting on feedback	FFT work is described elsewhere in this report
GP interface	As reported elsewhere extensive work with substantial improvement has occurred to ensure test results are endorsed and discharge summaries e-messaged. Success in MRC is more advanced than some other divisions. Work to achieve the CCG trajectory is ongoing but is slower than required.
Human factors training	Currently OXSTAR have trained 800 staff members in the last three years with 100 trained in the last three months.
Duty of candour	Duty of candour is now recorded on DATIX with a new module which provides decision support for all instances of moderate and severe harm. Duty of candour is also discussed and minuted in the Trust SIRI forum following review of all incidents of moderate and greater harm by

Priority	Progress
	Clinical Risk Management. Some incidents are downgraded to minor or no harm as further information becomes available.
End of life care	Improving care of the dying in OUHFT project: a draft project brief has been developed and presented at Cancer Directorate in February. It will then be presented at Surgery and Oncology Divisional Board (with the modifications suggested). Discussions are ongoing with the OUHFT Transformation team to consider evaluation of the project and an economic analysis. It is anticipated that staff recruitment will commence in March. OCCG is progressing work on a 24/7 coordination service for patients nearing the end of their life. OUHFT is delighted to be involved in this work. OCCG is rolling out anticipatory prescribing kits (just in case bags) from April. Palliative Care staff have been involved in the project and look forward to progressing the project in to the acute Trust in the coming year. There is ongoing work on smoothing the transition of patient care between hospital and the community by enabling hospital prescriptions to be regarded as valid by Oxford Health staff until review by the GPs in the days following discharge.
Care 24/7	The Care 24/7 project team, working in close collaboration with clinical services, undertook a baseline assessment in March 2015 on preparedness to meet the NHS England and NHS Improving Quality (NHSIQ) priorities for 7 day working. The baseline assessment and case note audit demonstrate a number of positive findings reflecting high standards of care across the Trust and also improvements made over 2014/15. A gap analysis action plan details progress from the baseline and the work required for the coming months.
Medicines safety and effectiveness	A work stream is considering the top 10 medication safety incidents across the UK and developing an action plan. A timescale for a deep dive to examine missed doses and time critical medication has been agreed and will include a thematic review of lessons from SIRIs.

4. The Quality Account

4.1. Monitor has issued the NHS Foundation Trust Annual Reporting Manual 2015/16. This stipulates the requirements that NHS Foundation Trusts have to publish a quality account each year, as required by the NHS Act 2009, in the terms set out in the NHS (Quality Accounts) Regulations 2010 and any subsequent amendments to those regulations.

4.2. The Quality Report must meet all the requirements of the Quality Account Regulations as well as include a number of additional reporting requirements set

by Monitor and the Quality Report is likely to be presented as a subset of the Annual Report. The deadline is 27th May 2016.

4.3. There is a requirement for governors to choose a 'local indicator' the local indicator is:

- chosen by the Foundation Trust's Council of Governors
- presented in the quality report, &
- subject to local assurance

5. Key Quality Metrics

5.1. 32 key quality metrics linked to the quality of clinical care provided across the organisation are listed in Table 2.

5.2. Quality indicators are validated by the indicator owner before release by the ORBIT information system.

5.3. Where specified thresholds have not been met ('red-rated') or have declined from green to amber trend graphs and exception reports are included. Thresholds are drawn from a mixture of sources (national, commissioner and internal).

5.4. A brief explanation on how to interpret exception charts is also provided in the appendices.

Indicators deteriorating or red rated

5.5. 6 indicators have deteriorated against target since the last reporting cycle or are red rated due to breeching of an annual threshold:

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

5.5.2. PS08 – % patients receiving stage 2 medicines reconciliation within 24h of admission

5.5.3. PS17 – Number of hospital acquired thromboses identified and judged avoidable

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

5.5.5. CE06 – ED - % patients seen, assessed and discharged / admitted within 4h of arrival

5.5.6. PE15 – % patients EAU length of stay < 12h

Indicators improving

5.6. 4 indicators have improved since the previous reported period:

5.6.1. PS01 – Safety Thermometer (% patients receiving care free of any newly acquired harm) [one month in arrears]

5.6.2. PS02 – Safety Thermometer (% patients receiving care free of any harm - irrespective of acquisition) [one month in arrears]

5.6.3. PS07 – Antibiotic prescribing - % compliance with antimicrobial guidelines [most recently available figure, undertaken quarterly]

5.6.4. PS16 – CAS alerts breaching deadlines at end of month and/or closed during month beyond deadline

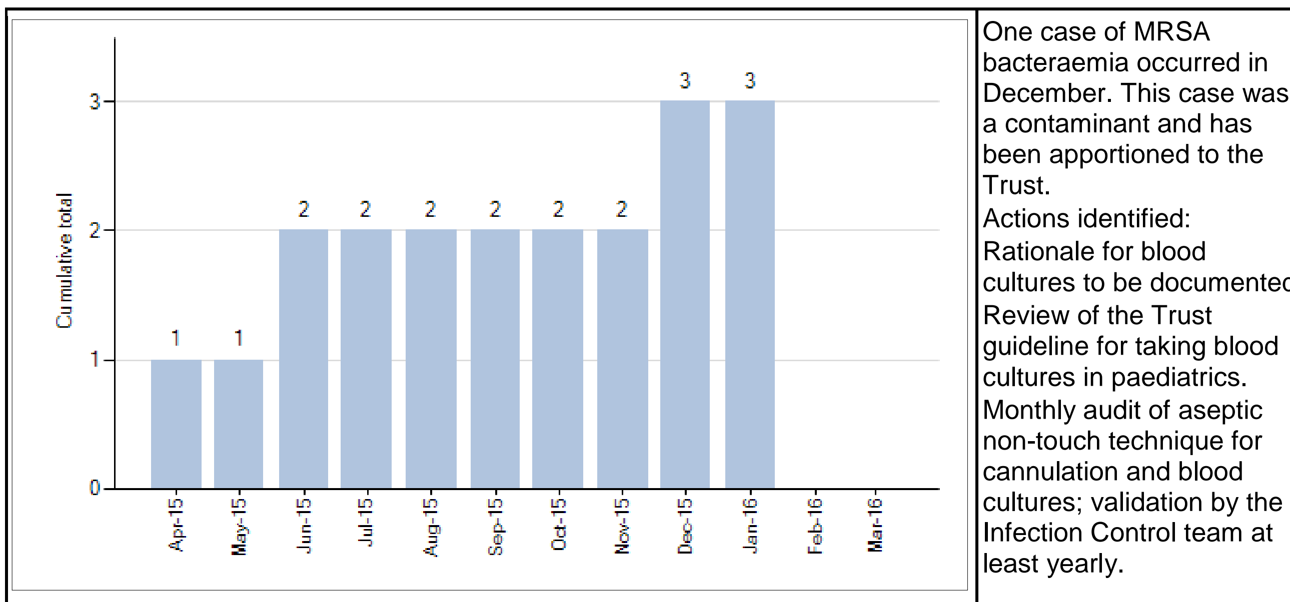
Table 2

BQR ID	Rating	Rating Last Period	Descriptor	Period	Threshold Source	Red	Amber
PS01	97.69% Green	Amber	Safety Thermometer (% patients receiving care free of any newly acquired harm) [one month in arrears]	Jan 16	Internal	95%	97%
PS02	94.97% Green	Amber	Safety Thermometer (% patients receiving care free of any harm - irrespective of acquisition) [one month in arrears]	Jan 16	Internal	91%	93%
PS03	97.57% Green	Green	VTE Risk Assessment (% admitted patients receiving risk assessment)	Dec 15	National	95%	95.25%
PS04	13 N/A		Serious Incidents Requiring Investigation (SIRI) reported via STEIS	Jan 16		N/A	N/A
PS05	49 Green	Green	Number of cases of Clostridium Difficile > 72 hours (cumulative year to date)	Jan 16	National	59	N/A
PS06	3 Red	Red	Number of cases of MRSA bacteraemia > 48 hours (cumulative year to date)	Jan 16	National	1	N/A
PS07	94.42% Amber	Red	Antibiotic prescribing - % compliance with antimicrobial guidelines [most recently available figure, undertaken quarterly]	Jan 16	Internal	93%	95%
PS08	62.41% Red	Red	% patients receiving stage 2 medicines reconciliation within 24h of admission	Jan 16	Internal	75%	85%
PS09	100% Green	Green	% patients receiving allergy reconciliation within 24h of admission	Jan 16	Internal	94%	96%
PS10	0.93% Green	Green	% of incidents associated with moderate harm or greater	Jan 16	Internal	6.5%	5%
PS11	71 N/A		Total number of newly acquired pressure ulcers (category 2,3 and 4) reported via Datix	Dec 15		N/A	N/A
PS12	1 Green	Green	Falls leading to moderate harm or greater	Jan 16	Internal	8	7
PS13	31.58% N/A		Cleaning Score - % of inpatient areas with initial score > 92%	Jan 16		N/A	N/A
PS14	99.41% Green	Green	% radiological investigations achieving 5 day reporting standard [CSS Division]	Dec 15	Commissioner	95%	98%
PS16	0 Green	Red	CAS alerts breaching deadlines at end of month and/or closed during month beyond deadline	Jan 16	Internal	1	N/A
PS17	1 Red	Red	Number of hospital acquired thromboses identified and judged avoidable	Jan 16	Internal	1	0
CE01	0.99 N/A		Standardised Hospital Mortality Ratio (SHMI) [most recently published figure, quarterly reported as a rolling year ending in month]	Jun 15		N/A	N/A
CE02	219 N/A		Crude Mortality	Jan 16		N/A	N/A
CE03	58.4% Red	Red	Dementia - % patients aged > 75 admitted as an emergency who are screened [one month in arrears]	Dec 15	National	80%	90%
CE04	80.21% Amber	Amber	Dementia diagnostic assessment and investigation [one month in arrears]	Dec 15	Internal	80%	90%
CE06	84.42% Red	Amber	ED - % patients seen, assessed and discharged / admitted within 4h of arrival	Jan 16	National	85%	95%
PE01	86.28% N/A		Friends & Family test % likely to recommend - ED	Jan 16		N/A	N/A
PE02	9.04% N/A		Friends & Family test % not likely to recommend - ED	Jan 16		N/A	N/A
PE03	94.32% N/A		Friends & Family test % likely to recommend - Mat	Jan 16		N/A	N/A
PE04	1.48% N/A		Friends & Family test % not likely to recommend - Mat	Jan 16		N/A	N/A

PE05	96.06% N/A		Friends & Family test % likely to recommend - IP	Jan 16		N/A	N/A
PE06	1.36% N/A		Friends & Family test % not likely to recommend - IP	Jan 16		N/A	N/A
PE07	93.45% N/A		Friends & Family test % likely to recommend - OP	Jan 16		N/A	N/A
PE08	3.42% N/A		Friends & Family test % not likely to recommend - OP	Jan 16		N/A	N/A
PE14	0 Green	Green	Single sex breaches	Jan 16	National	3	2
PE15	59.37% Red	Amber	% patients EAU length of stay < 12h	Jan 16	Internal	65%	70%
PE16	53.61% N/A		% Complaints upheld or partially upheld [Quarterly in arrears]	Dec 15		N/A	N/A

Exception charts

Chart 1 – PS06 – Number of cases of MRSA bacteraemia > 48 hours (cumulative year to date)



One case of MRSA bacteraemia occurred in December. This case was a contaminant and has been apportioned to the Trust.

Actions identified:

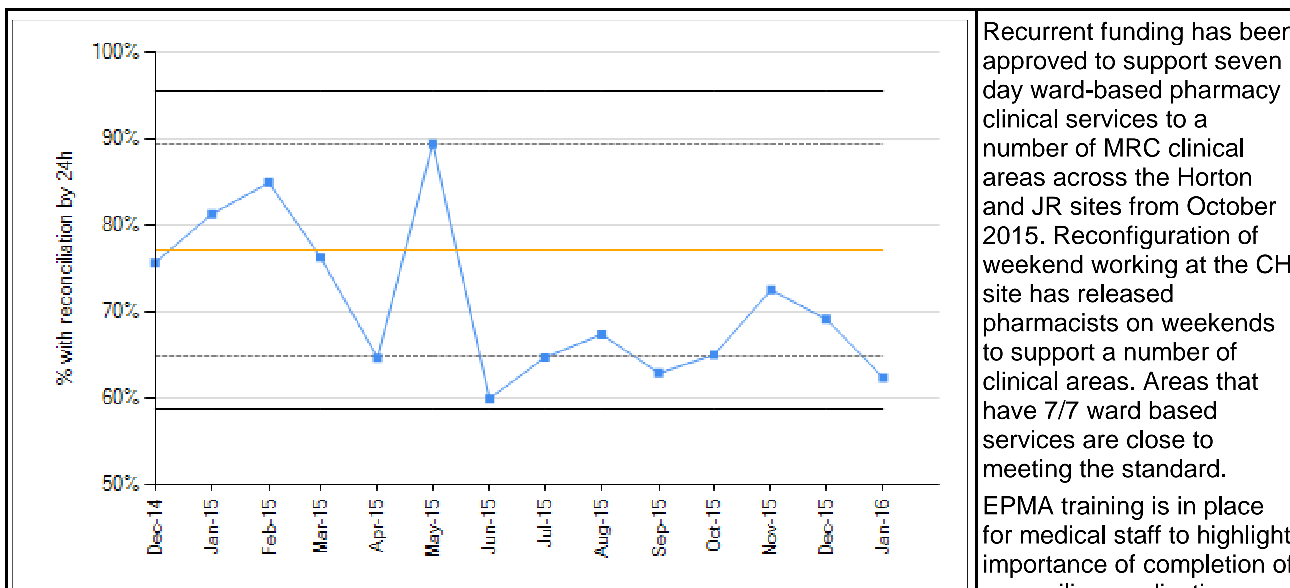
Rationale for blood cultures to be documented

Review of the Trust guideline for taking blood cultures in paediatrics.

Monthly audit of aseptic non-touch technique for cannulation and blood cultures; validation by the Infection Control team at least yearly.

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: S Wells].

Chart 2 – PS08 – % patients receiving stage 2 medicines reconciliation within 24h of admission

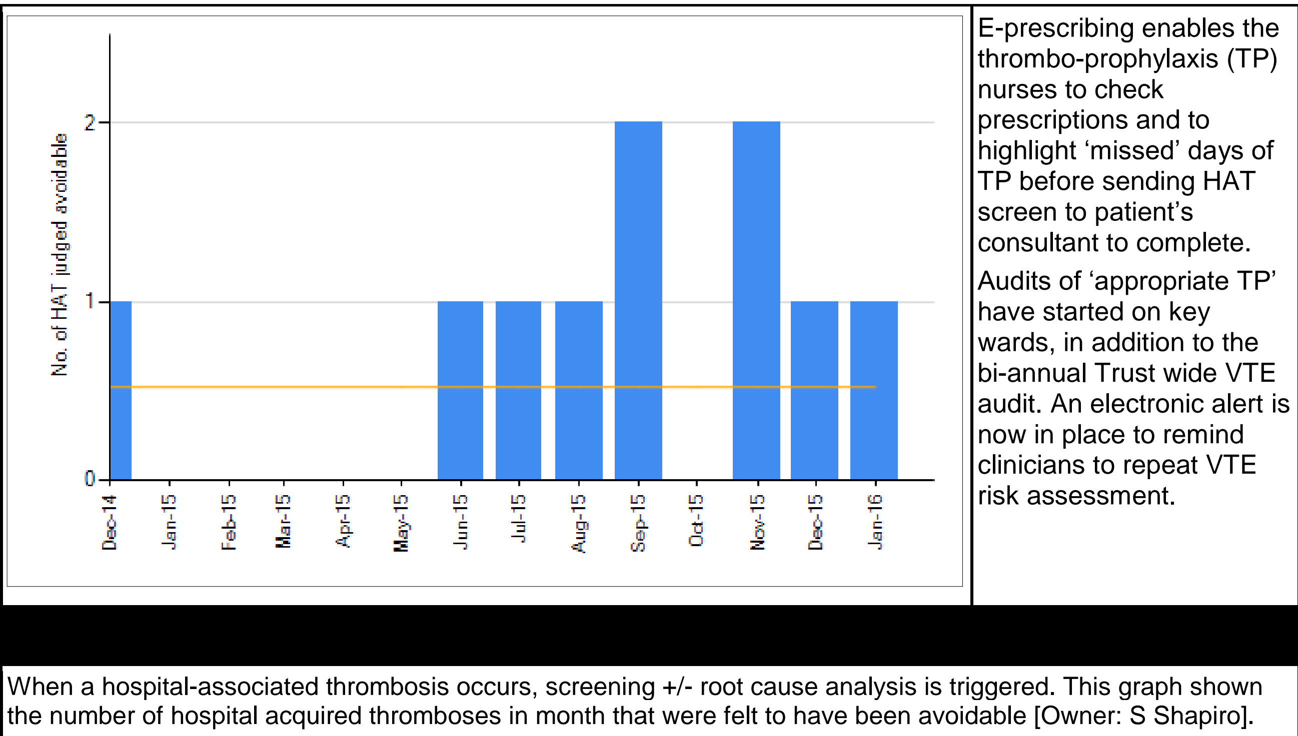


Recurrent funding has been approved to support seven day ward-based pharmacy clinical services to a number of MRC clinical areas across the Horton and JR sites from October 2015. Reconfiguration of weekend working at the CH site has released pharmacists on weekends to support a number of clinical areas. Areas that have 7/7 ward based services are close to meeting the standard.

EPMA training is in place for medical staff to highlight importance of completion of reconciling medication on admission for all admitted patients.

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].

Chart 3 – PS17 – Number of hospital acquired thromboses identified and judged avoidable

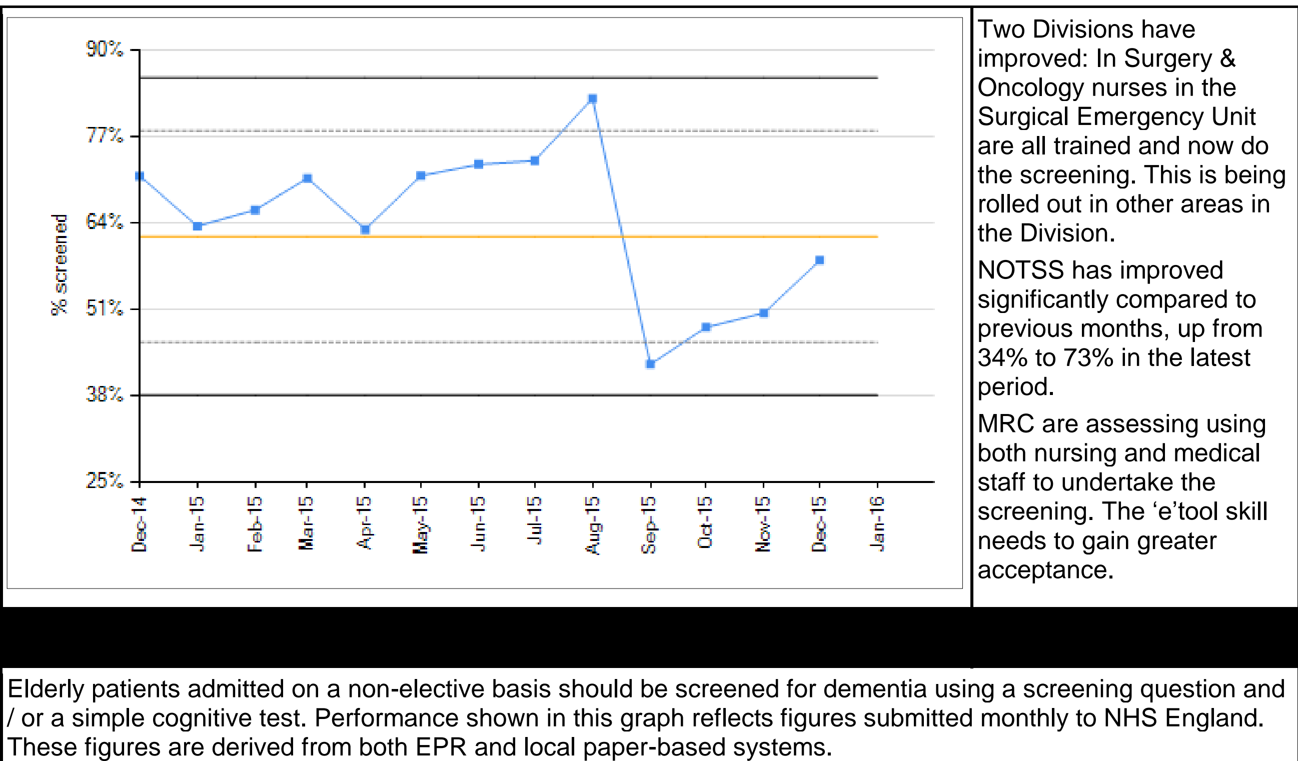


E-prescribing enables the thrombo-prophylaxis (TP) nurses to check prescriptions and to highlight 'missed' days of TP before sending HAT screen to patient's consultant to complete.

Audits of 'appropriate TP' have started on key wards, in addition to the bi-annual Trust wide VTE audit. An electronic alert is now in place to remind clinicians to repeat VTE risk assessment.

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: S Shapiro].

Chart 4 – CE03 – Dementia - % patients aged > 75 admitted as an emergency who are screened [one month in arrears]



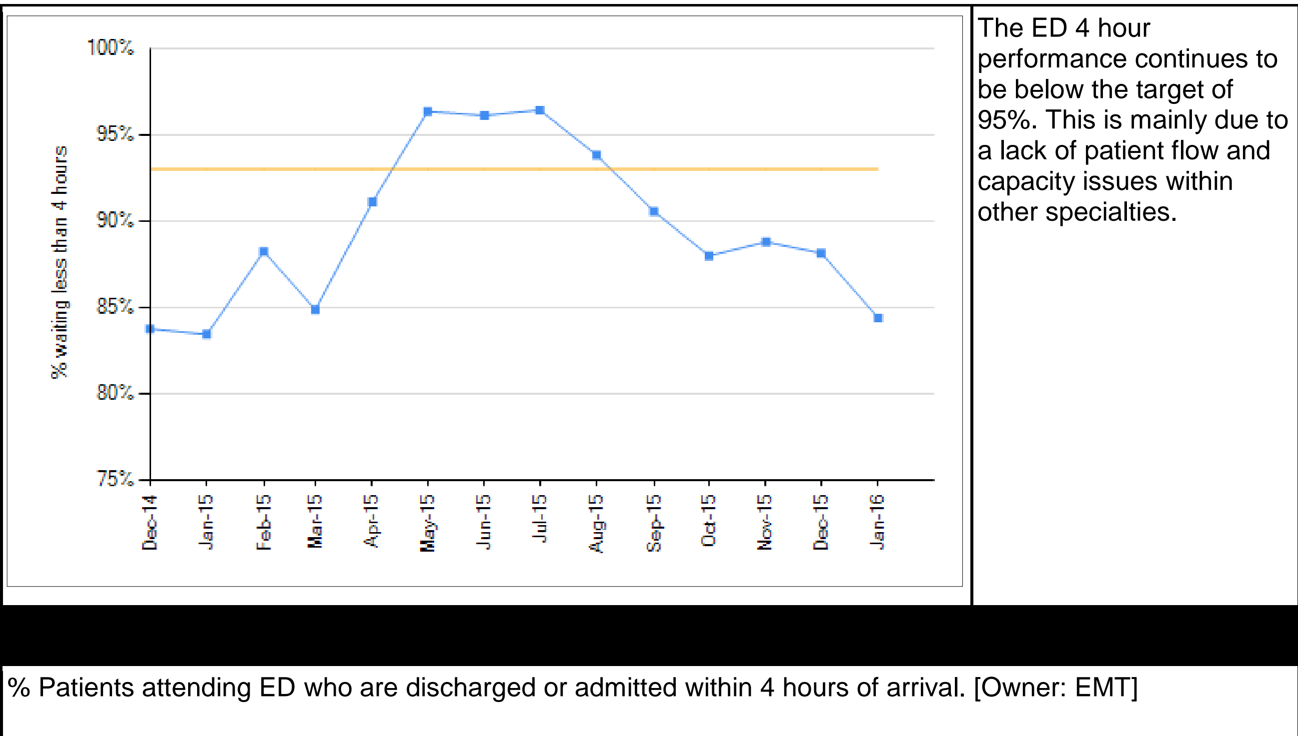
Two Divisions have improved: In Surgery & Oncology nurses in the Surgical Emergency Unit are all trained and now do the screening. This is being rolled out in other areas in the Division.

NOTSS has improved significantly compared to previous months, up from 34% to 73% in the latest period.

MRC are assessing using both nursing and medical staff to undertake the screening. The 'e'tool skill needs to gain greater acceptance.

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.

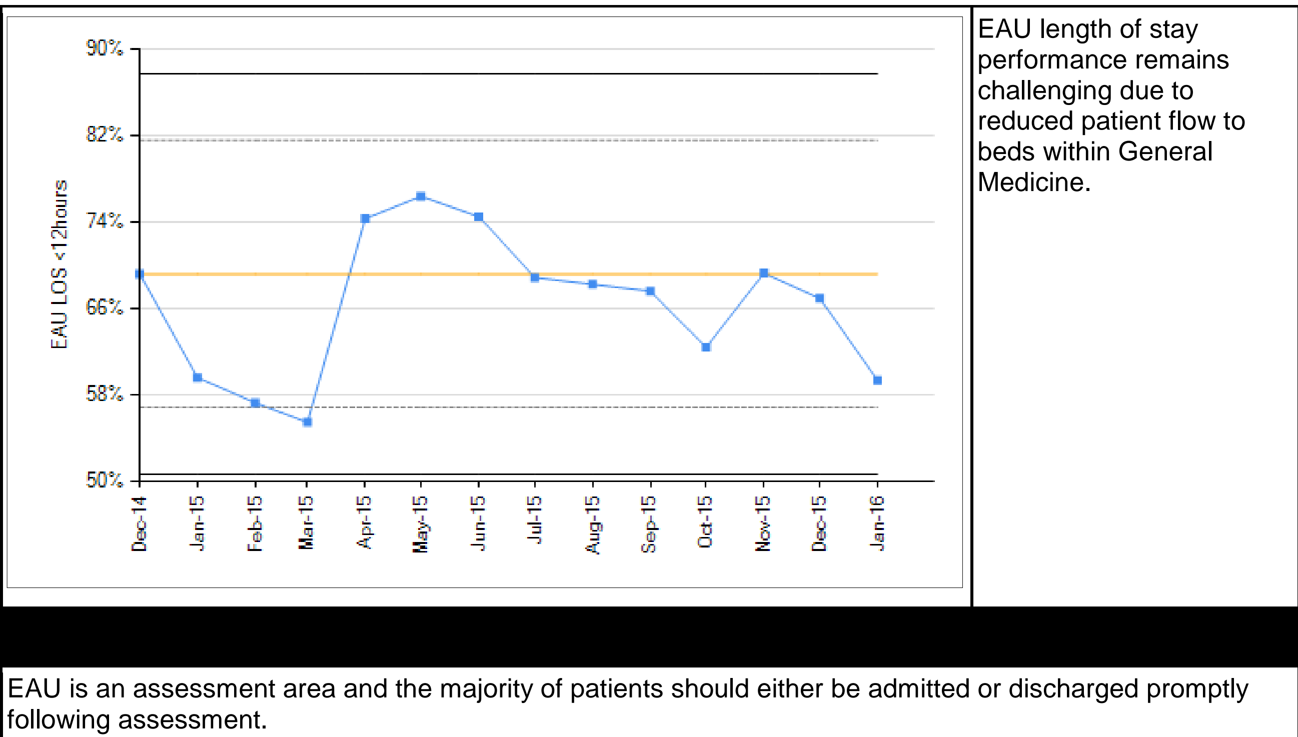
Chart 5 – CE06 – ED - % patients seen, assessed and discharged / admitted within 4h of arrival



The ED 4 hour performance continues to be below the target of 95%. This is mainly due to a lack of patient flow and capacity issues within other specialties.

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

Chart 6 – PE15 – % patients EAU length of stay < 12h



EAU length of stay performance remains challenging due to reduced patient flow to beds within General Medicine.

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

6. Matters for attention of the Board

WHO Compliance

6.1. Table 3 shows the compliance with the WHO checklist by Division and in specific divisional areas. These audits were paper-based. An explanation is given for areas that are not at 100%.

Table 3 – WHO Checklist January 2016

Division	Area	Compliance	Comment
NOTSS	Orthopaedics	100%	
C&W	Division	94%	125 records were audited, 8 were partially compliant (6%). All clinicians who did not fully complete the checklist will receive a letter from the Divisional Director reminding them of their obligations to ensure the WHO checklist is completed.
CSS	Division	98.9%	There were three non-compliances and three partial in WW Theatres. These have been followed up with the respective teams.
MRC	Cardiology	100%	
	Cardiothoracic Surgery	96%	One checklist was partially completed (sign-out not complete), feedback has been provided to all the staff involved.
	Respiratory Intervention	100%	
S&O	Churchill Theatres	100%	

7. Issues raised by OCCG

7.1. The Trust is reporting performance to the OCCG against trajectories agreed for discharge summaries e-messaged within 24 hours of discharge and endorsement of results on EPR.

7.2. Current data for January 2016 show 73.4% of discharge summaries were sent before or within 24 hours of discharge and 65% of results endorsed on EPR within 7 days (note it is possible to review a result and not endorse it). For clinical results endorsement this is an improvement from 62.4% reported last month however for discharge summaries the monthly performance remains the same compared to December 2015.

7.3. Feedback for January 2016 received by the OCCG from GPs is summarised in the tables below. These have been provided alongside data for November and December 2015 in order to contextualise and highlight trends in themes identified by GPs.

7.4. There were 192 separate items of feedback received by the OCCG regarding the Trust’s services in January. This is an increase on the total feedback received in December.

7.5. Feedback related to ‘Delay in GP receiving clinical docs (i.e. OPD/Discharge letters)’ was the most frequently reported type of feedback in January accounting for 22.4% of all feedback received. The top 6 themes combined account for 56% of all feedback received over the month (Table 4).

Table 4 GP Feedback – Top 6 thematic areas

Theme	Nov-15	Dec-15	Jan-16
Delay in GP receiving clinical docs (i.e. OPD/Discharge letters)	19	10	43
Delay / difficulty in obtaining clinical assistance	17	16	20
Duplicate information sent to practice	0	9	12
Failure to note relevant information in patient's record	7	14	12
Communication failure between GP and Hospital / PCT	7	8	10
Request from secondary care for GP to follow up tests/scans/investigations initiated in secondary care	8	8	10

7.6. Table 5 shows GP feedback by stage of care – with ‘Patient Information (records, documents, test results, scans)’ accounting for 38% of the feedback received in January (this is up from 32% reported for December). When all feedback received is ordered by stage of care, the top 5 account for just under 89% of all feedback received.

Table 5 GP Feedback – Top 5 stage of care

Stage of care	Nov-15	Dec-15	Jan-16
Patient Information (records, documents, test results, scans)	43	43	73
Access, Appointment, Admission, Transfer, Discharge	38	30	39
Consent, Confidentiality or Communication	11	17	23
Clinical assessment (investigations, images and lab tests)	17	11	18
Medication	9	16	17

8. Patient Safety and Clinical Risk

8.1. In relation to Patient Safety and Clinical Risk:

- No Never Events have been reported in January.
- 13 Serious Incidents Requiring Investigations (SIRIs) were reported in January.
- 12 SIRIs were recommended for closure to Oxfordshire Clinical Commissioning Group (OCCG) in January.

Clinical Risk

8.2. The following graphs provide an update on SIRI activity.

Chart 7 – SIRIs declared and investigations completed in this financial YTD

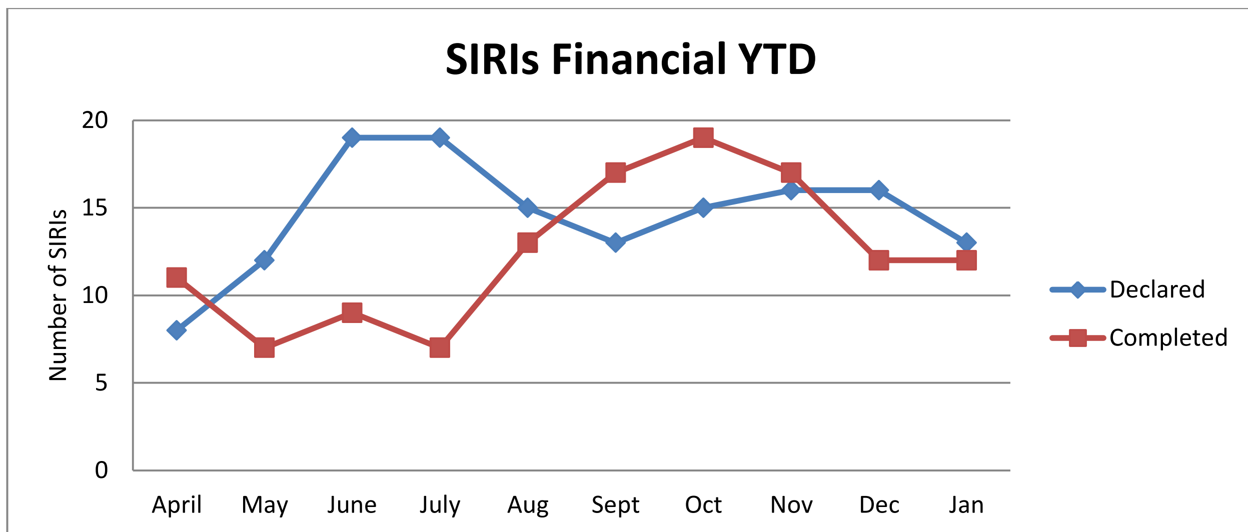


Chart 8 – SIRIs declared during the 2015/16 financial year by Division

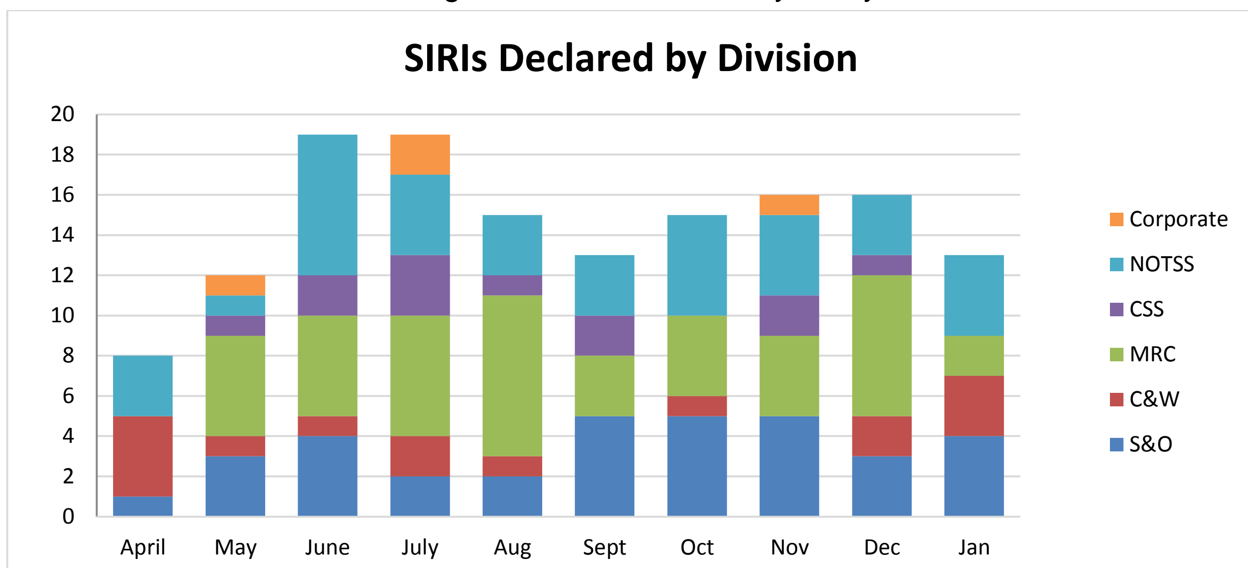


Chart 9 – SIRI Investigations completed

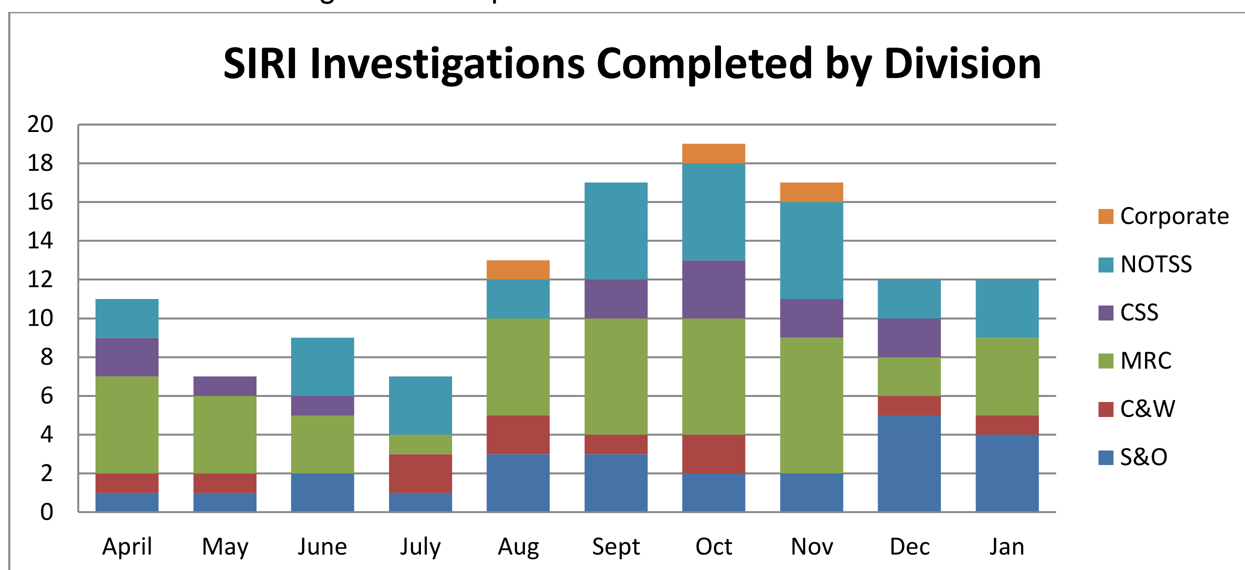
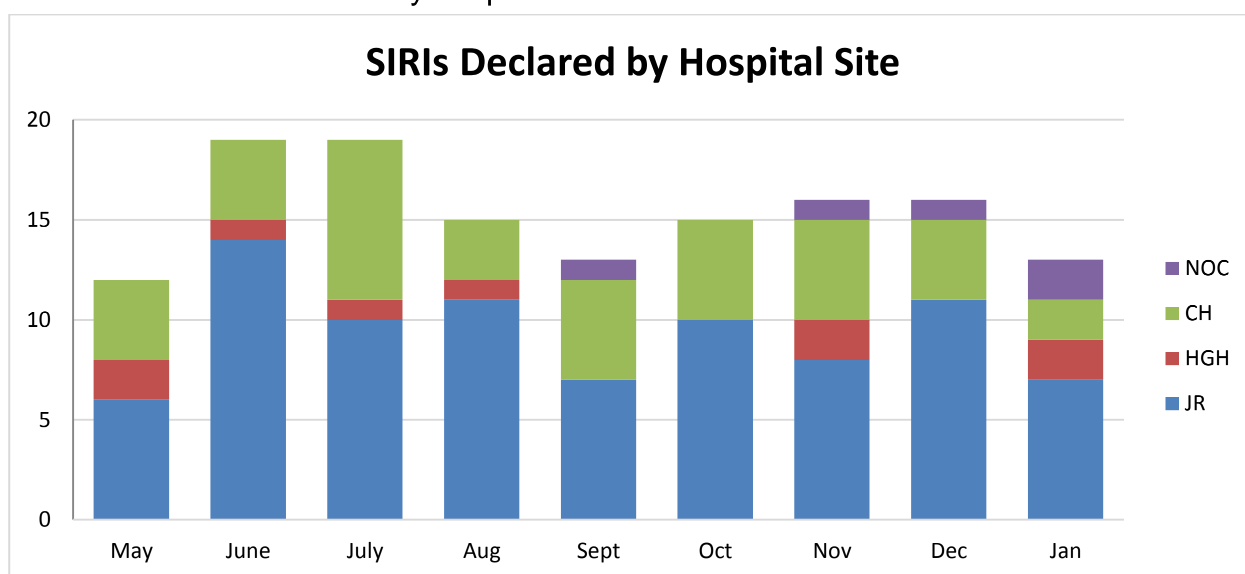


Chart 10 – SIRIs declared by hospital site



8.3. Table 6 provides more details of those SIRIs declared to NHS England via the STEIS reporting system in January 2016, including the time in (working) days from the incident occurrence to being reported on Datix, and from Datix reporting to being reported on STEIS.

Table 6

SIRI Ref	Division	Description	Incident Date	Datix Date	Incident-Datix Interval	STEIS Date	Datix-STEIS Interval
2016/001	NOTSS	A biopsy of the knee was carried out on an outpatient. Two samples were sent to microbiology for analysis. One culture was negative but	10/11/15	29/12/15	34	07/01/16	7

SIRI Ref	Division	Description	Incident Date	Datix Date	Incident-Datix Interval	STEIS Date	Datix-STEIS Interval
		the other was positive for staphylococcus. The electronic patient records present results in such a way that they are 'on top of each other' Consequently the negative result was seen and it was not realised that there was another result underneath this (hidden) indicating a positive result.					
2016/002	C&W	A woman was transferred in from Wallingford Community Hospital for prolonged second stage of labour. On arrival at the John Radcliffe Hospital fetal bradycardia was noted. An immediate instrumental delivery was carried out but the baby was born in a very poor condition, Despite full resuscitation the baby died.	03/01/16	03/01/16	0	07/01/16	4
2016/003	S&O	A patient developed a category three hospital acquired pressure ulcer on right hallux valgus foot.	15/12/15	15/12/15	0	07/01/16	15
2016/004	NOTSS	In pre-op assessment a patient's blood test was labelled incorrectly with another patient's details. Once this was discovered all blood tests taken on that day were discarded as there were concerns that safety procedures had not been followed. Nineteen patients were affected.	08/01/16	09/01/16	1	15/01/16	5
2016/005	S&O	A 72 year old patient underwent a laparotomy for a perforated duodenal ulcer. He was discharged seven days later without the protein pump inhibitors the consultant had requested. He returned thirteen days later with melena and anaemia. Two days later he was taken to theatre for multiple PR bleeds but suffered a cardiac arrest and died.	24/12/15	08/01/16	9	15/01/16	6
2016/006	MRC	A patient with a history of falls fell whilst transferring from the bed to the commode. The patient sustained a fracture to the pubic rami.	17/01/16	18/01/16	1	22/01/16	5

SIRI Ref	Division	Description	Incident Date	Datix Date	Incident-Datix Interval	STEIS Date	Datix-STEIS Interval
2016/007	C&W	A paediatric patient who had orthopaedic surgery developed multiple pressure areas under bilateral below knee casts which were required to stabilise the lower legs after corrective surgery. Despite mitigating measures being put in place a grade three pressure ulcer continued to develop on the left heel	08/01/16	09/01/16	1	22/01/16	10
2016/008	NOTSS	A patient recovering from surgical correction of a hip dislocation developed a grade 3 pressure ulcer to the right buttock.	15/01/16	15/01/16	0	22/01/16	6
2016/009	C&W	A community midwife lost her diary whilst performing home visits. The diary contained some patient demographics and information for patients visited over a one week period.	12/01/16	14/01/16	2	22/01/16	7
2016/010	S&O	A patient with carcinoma of the tonsils complained of abdominal pain on attendance for an elective endoscopy and PEG insertion at the John Radcliffe hospital. The patient deteriorated post procedure but was transferred to the Churchill Hospital. Several attempts were made to obtain a surgical opinion on site but this did not occur for some hours. Following surgical reviews overnight further surgery was carried out in the early morning of the following day but the patient died a week later.	19/01/16	21/01/16	2	29/01/16	7
2016/011	MRC	A patient had a CT scan in November 2013 which showed a possible Hepatocellular carcinoma (HCC). This was not followed up and the patient was not informed of the results. The patient re-presented in October 2015 and it has been confirmed that he now has multifocal HCC and is not fit for treatment.	19/11/16	21/10/16	2	29/01/16	7

2016/012	NOTSS	A post-operative patient who was triggering was reviewed by a Consultant Physician who requested close monitoring. The patient was not monitored as intended for approximately eight hours and was found unresponsive. Despite CPR the patient died.	21/01/16	21/01/16	0	29/01/16	7
2016/013	S&O	A patient developed category three pressure ulcers to the heels	04/01/16	04/01/16	0	29/01/16	20

8.4. A number of SIRI reporting timescales were not reached in January 2016 over 10 (working) days; details of these delays are as follows:

Delays in reporting on Datix:

8.4.1. 2016/001 – Delay in the recognition of the problem due to the false presentation of results.

Delays in reporting on STEIS:

8.4.2. 2016/003 and 2016/013 - Delay in reporting on STEIS due to process of establishing whether the Hospital Acquired Pressure ulcer (HAPU) was unavoidable.

8.5. The time to notification to DATIX of some incidents remains over 48 hours with a mean of 4 working days (median 1 day). The mean time from DATIX report to entry onto STEIS is currently 8 working days (median 7 days).

8.6. Twelve SIRI reports were recommended to OCCG for approval during November 2015. Following internal approval of a SIRI report, the report is presented to the OCCG for agreement and endorsement of the quality of the investigation and the appropriateness of the recommendations and actions to prevent a re-occurrence.

8.7. OCCG requested that no SIRI closure meetings were held in January and therefore these reports have been considered in the February meeting.

Executive Quality Walk Rounds

8.8. There were five Executive Quality Walk Rounds in February 2016. These are detailed in Table 7. Three further Walk Rounds were rescheduled for March. Two were not convenient for the departments being visited, with another a result of a conflict in the Executive Director's diary.

Table 7 – Quality Walk Rounds

Hospital Site	Areas Visited
John Radcliffe Hospital	Gynaecology Ward Children's Outpatient Department Ward 7C Trauma Outpatients Department
Horton General Hospital	Oak Ward

8.9. Key issues with the potential to affect quality or patient experience identified during the Executive Quality Walk Rounds included a lack of space in outpatient

departments, patient transport, replacement of aging equipment, access to specialist medical support due to the workload of junior doctors and challenges around recruiting specialist staff.

8.10. All issues are either included in existing Trust-wide projects or have new local actions associated with them which will be monitored through Divisional governance processes.

9. Clinical Effectiveness

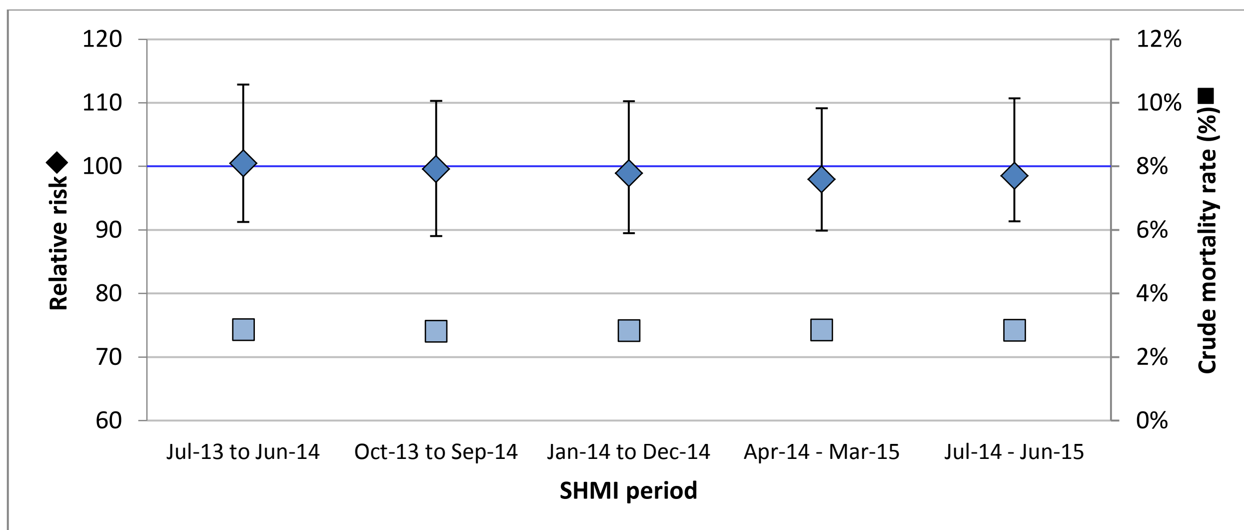
9.1. The Mortality Review Group (MRG) is due to have the inaugural meeting in March 2016. MRG will assume the mortality remit from the Clinical Effectiveness Committee and serve as the oversight group for OUHFT patient mortality. The MRG Chair will be the Deputy Medical Director (Clinical Governance). MRG will report to the Clinical Governance Committee.

Clinical Outcomes – Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR)

9.2. OUHFT were informed by the Dr Foster Unit at Imperial College that the Trust is a mortality outlier for the procedure group CABG (other). A mortality outlier is identified when the mortality rate is significantly in excess of what would be expected, given the risk profile of the patients. OUHFT were advised that, on at least one occasion in the three months to September 2015, the risk-adjusted mortality for the procedure was twice the expected rate. The alert relates to 7 deaths reported for the procedure group during the 12 month period October 2014 to September 2015. All these deaths are now under review and we note had thorough review at the time of death. One was investigated as a SIRI.

9.3. The SHMI for the data period July 2014 to June 2015 is 0.99. This is banded 'as expected.' The SHMI trend is depicted in Chart 11.

Chart 11 – SHMI trend



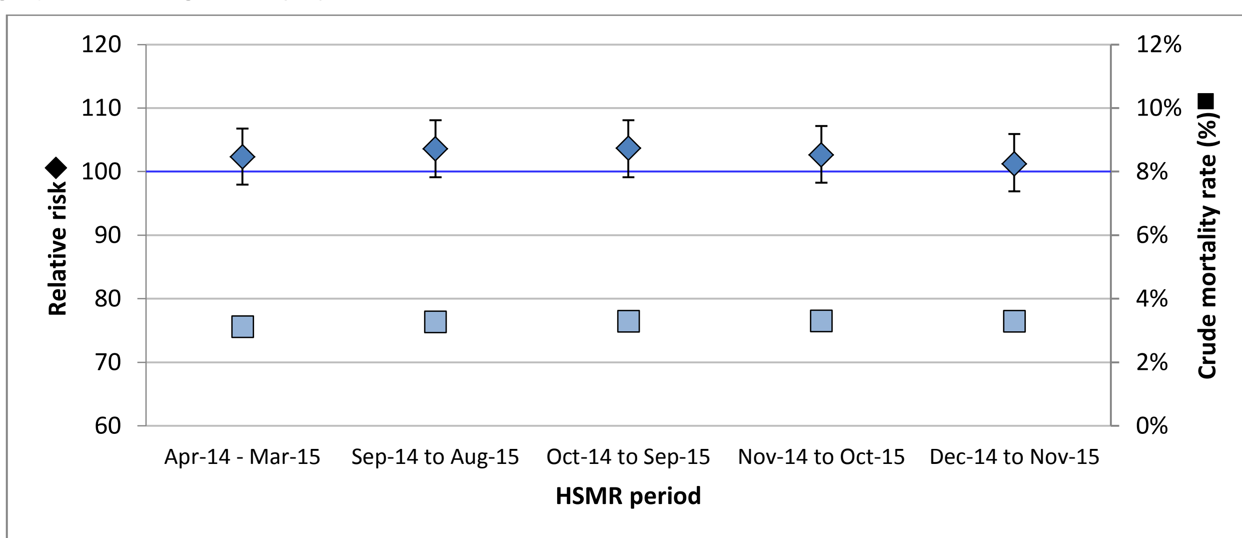
9.4. The SHMI identifies the following diagnoses to be the leading causes of patient mortality at OUHFT in Table 8.

Table 8 - SHMI Diagnoses with highest number of deaths

SHMI Diagnosis Groupings	Observed	Expected
Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	432	446.7
Secondary malignancies	150	129.3
Acute cerebrovascular disease	201	190.5

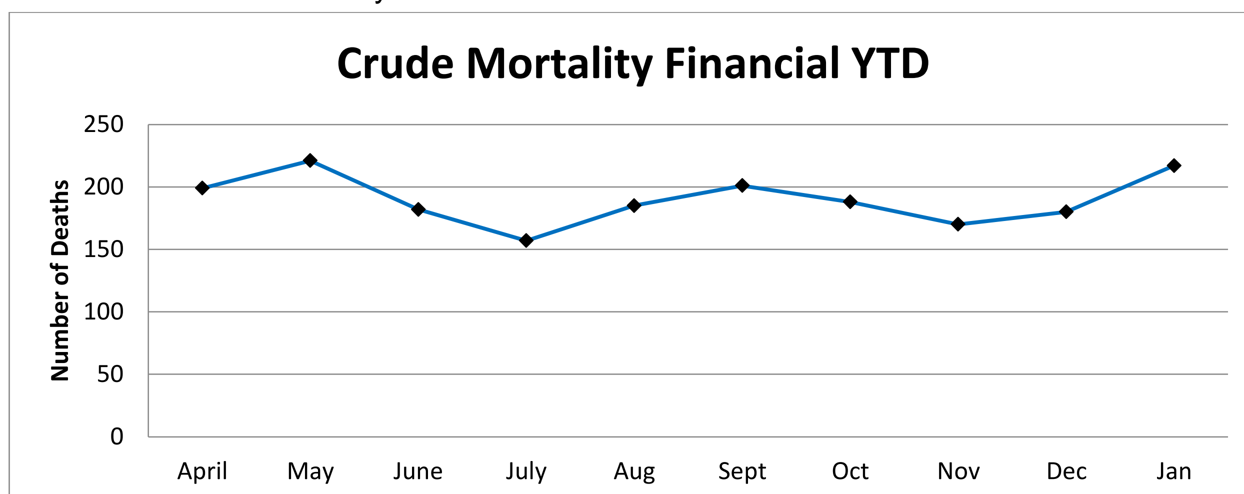
9.5. The Trust's HSMR is 101.2 (for the latest 12-month period December 2014 to November 2015). The value remains 'within expected' range (95% CI 96.8-105.8). The HSMR has decreased from 102.7 reported in January 2016 (for the data period November 2014 to October 2015).The number of observed deaths within the HSMR 56-diagnosis groups is 1972.

Chart 12 – HSMR trend



9.6. Crude mortality gives a contrmporaneous but not risk adjusted view of mortality across the Trust. Some seasonal increase in winter months is usual due to the seasonal nature of some diseases such as influenza and some respiratory conditions.

Chart 13 – Crude Mortality



10. Infection Control

Clostridium difficile (C.diff)

10.1. The upper ceiling for OUHFT apportioned cases of C.diff for 2015 / 2016 is 69.

10.2. Table 9 lists OUHFT apportioned C.diff. cases per month for the financial year to date.

Table 9 – Cases of C. diff per month

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
Total	3	4	8	8	3	4	7	6	3	3		
Monthly limit	5	6	6	6	6	6	6	6	6	6	5	5
Cum total	3	7	15	23	26	30	37	43	49	52		
Cum limit	5	11	17	23	29	35	41	47	53	59	64	69
***30 Day Mortality**	1	1	3	1	1	0	0	2	1	0		

10.3. 3 cases of C.diff apportioned to the OUHFT were reported for January 2016, against a monthly limit set at 6. These cases were reviewed at the February Health Economy meeting with the OUHFT, OCCG, Oxford Health and PHE in attendance.

10.4. Of the 3 cases, it was determined that 2 were unavoidable. The remaining case was deemed avoidable (and therefore seen as a “lapse in care”) due to inappropriate sampling, as the patient did not fulfil the criteria for testing as per OUHFT guidelines.

10.5. 3 OUHFT apportioned cases for December 2015 were also discussed at the February 2016 meeting and 2 of the cases were unavoidable. The remaining case was deemed avoidable due to inappropriate sampling as the patient was known to have a recent C.diff positive result (though > 28 days had lapsed since

the previous positive result) and had remained an inpatient throughout this time and had not responded to first line antibiotic treatment.

30 day *C.*diff Mortality review

10.6. As per Department of Health guidance (2008), the OUHFT undertakes a monthly review to identify deaths within 30 days of diagnosis of CDI to ensure that a common standard of assessment is being applied in terms of cause of death or contribution to death.

10.7. To date no inpatients who were reported as being C.diff positive in January 2016 at the OUHFT have been identified as having died within 30 days of the result being reported.

MRSA bacteraemia

10.8. There was 1 MRSA Bacteraemia apportioned to the OUHFT in December 2015.This was due to a contaminant in a sample taken at OUHFT.

10.9. The ceiling for 2015 / 2016 is 0 avoidable MRSA Bacteraemia. To date, 3 MRSA bacteraemias apportioned to the OUHFT have been reported (April 2015, June 2015 and December 2015), with 2 cases in June and December deemed avoidable. The OUHFT has therefore failed to meet this objective for 2015 / 2016.

Cleaning Audit

10.10. Table 10 details the average reported cleaning scores by undertaken to date by the OUHFT Facilities Monitoring Team to date April – January 2016.

Table 10 – Average reported cleaning scores by Division

Division	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan
NOTSS	87%	82%	84%	84%	86%	84%	87%	87%	NC	85%
MRC	89%	89%	88%	87%	90%	88%	91%	89%	88%	95%
C & W	90%	89%	89%	88%	90%	90%	89%	92%	92%	89%
S & O	91%	90%	87%	88%	89%	89%	91%	89%	89%	91%
CSS	94%	83%	87%	88%	86%	91%	86%	90%	89%	91%
Total	**90%**	**87%**	**87%**	**87%**	**88%**	**88%**	**89%**	**89%**	**90%**	**90%**

Cleaning Audit performance and process

10.11. As a consequence of persistent poor cleaning audit score reporting and a lack of consistent auditing across the Divisions due to the small size of the auditing team the, the Infection Control service will be co-ordinating a meeting with key staff members to review the following:

10.11.1. How the cleaning audits are currently undertaken and how this process can be improved to ensure a consistent approach

10.11.2. Strategies to improve cleaning score performance

10.12. This review is on-going as a meeting with the interim Head of Estates has yet to be held and an update will be provided in the next Governance report.

MRSA Screening compliance

10.13. The OUHFT achieved 52.4% (2599/4957) overall compliance with MRSA screening, 77.3% (747/967) for elective admissions and 46.4% (1852/3990) for emergency admissions. Clinical areas with high turnover of patients have lower compliance with screening emergency admissions. Table 11 details compliance with emergency and elective MRSA screening by Division.

Table 11 – Compliance with emergency and elective MRSA screening, January 2016

Division	Percentage Screened Electives	Percentage screened emergencies	Percentage of Patients screened
Neurosciences, Orthopaedics, Trauma & Specialist Surgery	78%	61%	71%
Medicine, Rehabilitation & Cardiac	88%	48%	49%
Surgery & Oncology	67%	41%	45%
Clinical Support Services	61%	93%	72%
OUHFT total	81%	49%	54%

10.14. As a consequence of a persistently low level of MRSA Screening compliance, the Infection Control service is in the process of co-ordinating a meeting with key staff members in order to derive a strategy to improve screening compliance and to also review how screening compliance is reported. A progress update will be provided in the next Quality report.

Norovirus Outbreak, Bellhouse/Drayson Ward, John Radcliffe Hospital, January 2016

10.15. On the 11/01/16, Bellhouse/Drayson Ward at the John Radcliffe Hospital reported 4 children and 1 staff member with symptoms indicative of a Norovirus type illness.

10.16. Following a review by Infection Control, restrictions on Children's transfer and movement were put in place on the ward as per OUHFT Outbreak policy.

10.17. A total of 6 Children and 1 staff member reported symptoms. A positive Norovirus sample was reported by OUHFT Microbiology (no further testing is undertaken once a positive sample has been reported).

10.18. Restrictions on the ward were formally removed on the 18/01/16 and no beds were closed during the outbreak.

11. Patient Experience

Friends and Family Test (FFT) feedback[1]

11.1. Emergency Department FFT Feedback: the percentage that would not recommend their care has risen to 9.0% from 8.0% in December (Chart 14). This is more than two percentage points above the December national average at (6.9%). The percentage recommend in January (86.3%) is similar to December (87.0%) and the national average (87.4%). In addition, the response rate has increased from 22% to 26% (Chart 15).

Chart 14 – OUHFT ED and national FFT% not recommend (source: NHS England)

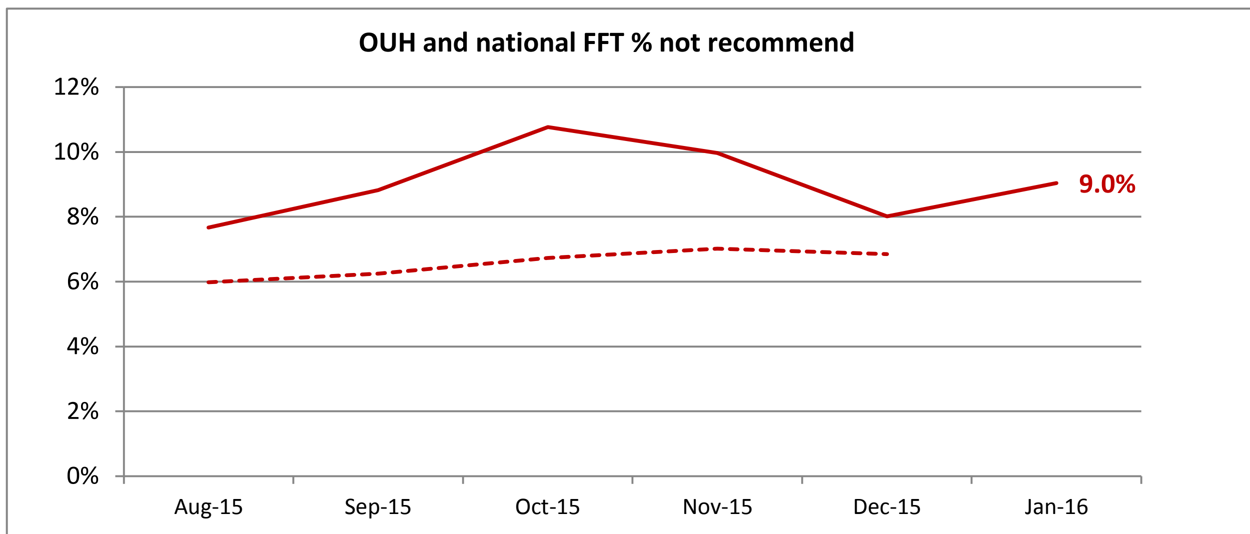
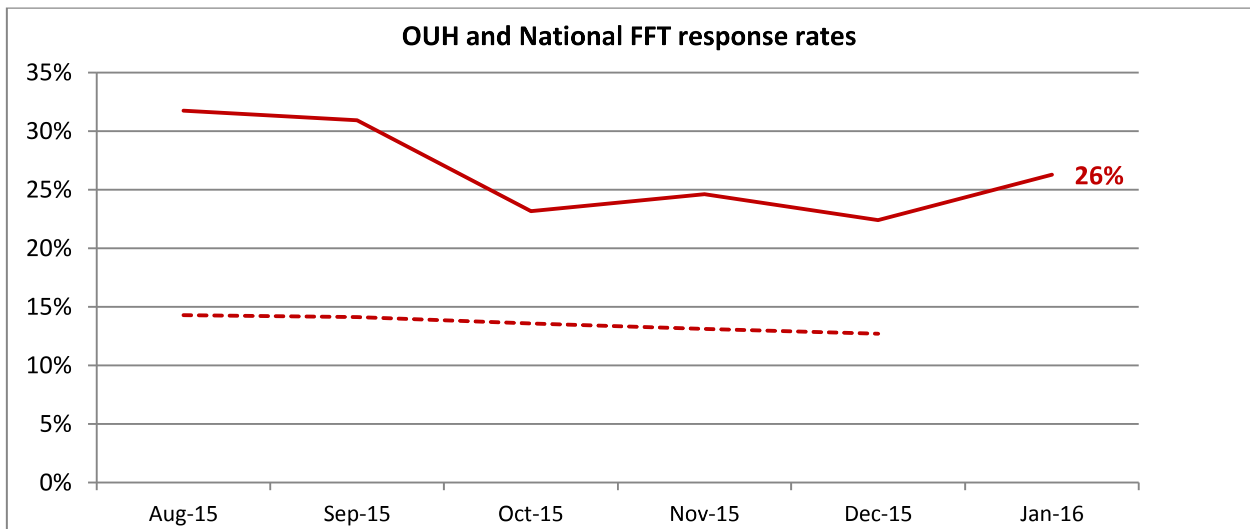


Chart 15 – OUHFT ED and National FFT response rates (source: NHS England)



11.2. Maternity feedback: the percentage recommend for maternity has increased to the usual rate of 94% in January, after a dip in December (Chart 16). The

[1] December data for FFT is provided as this is the most recent data that can be compared nationally.

response rate has risen to 25% in January, which is the highest in the last 6 months and above the national average for December (Chart 17).

Chart 16 – OUHFT Materinity and National FFT % recommend (source: NHS England)

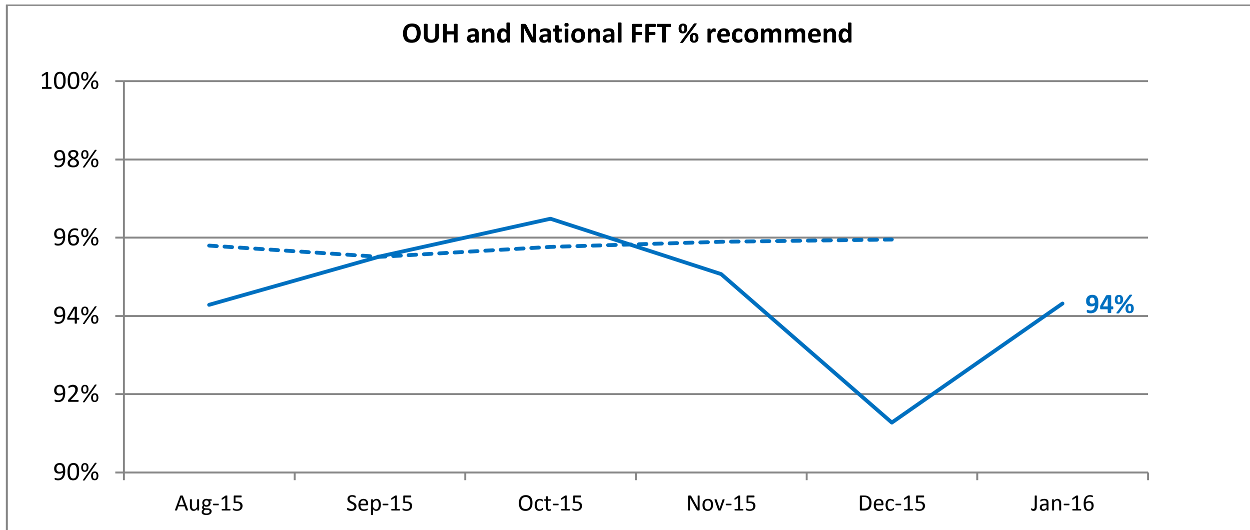
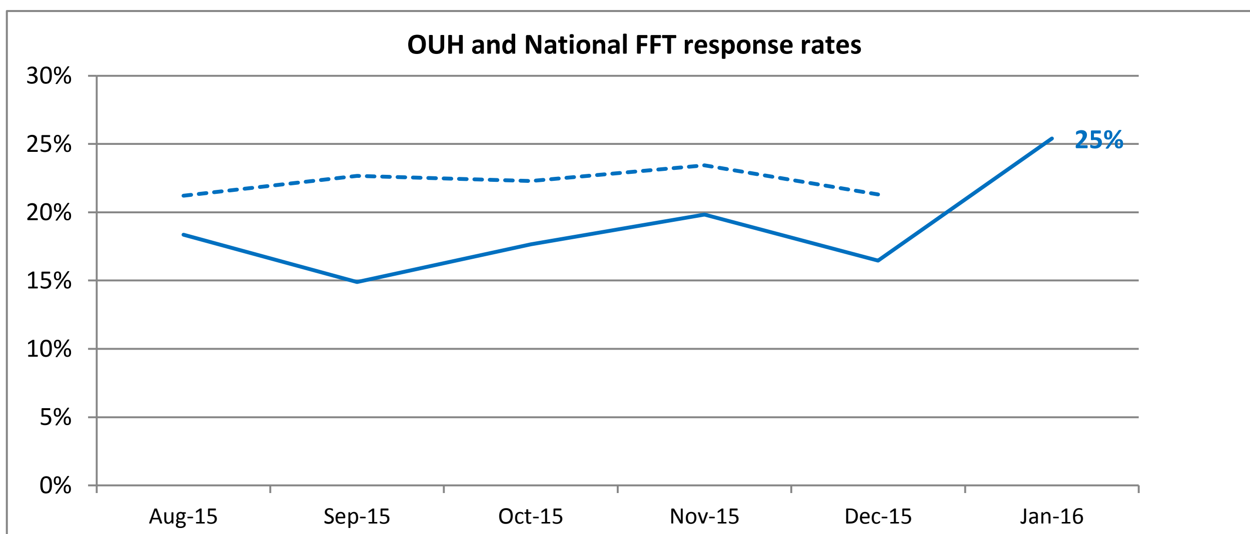


Chart 17 – OUHFT Maternity and National FFT response rates (source: NHS England)



Carers' Project

11.3. The project is on track with the planned timescales. The Carers Oxfordshire Outreach Worker runs carer advice and information surgeries three days per week on Stroke Ward (5b) and Bedford Ward. The evaluation in March will identify key themes and activity.

Children's patient experience update

11.4. A further update regarding Children's patient experience will be provided in the April Board Quality Report.

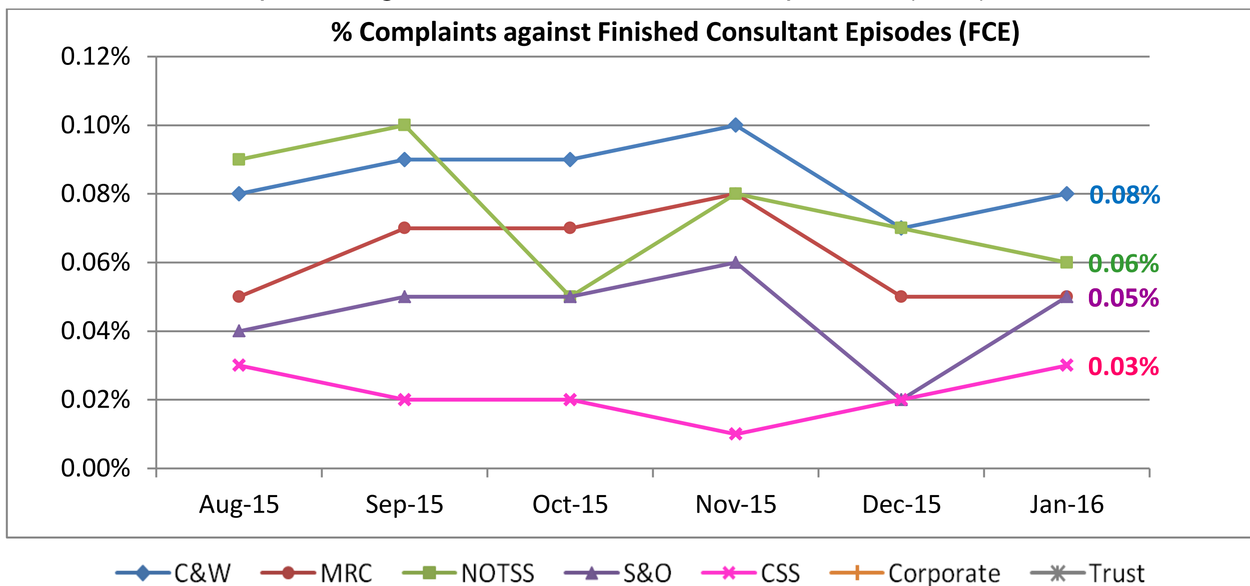
Patient Engagement

11.5. Membership of the Trust's Young People's Executive (YiPpEe) has increased from 6 to 20. On the 15th February 2016, sixteen members of YiPpEe came to the JR for the group's first official meeting. The group gave their feedback on a number of areas, including; surgical research aimed at children and young people, health inequalities in Oxfordshire and restaurant facilities for families to use on site.

12. PALS and Complaints[2]

12.1. The number of new complaints received during January was 82. This is an increase against the numbers of formal complaints received in December (n=75). This reverts to the recent trend showing a higher number of formal complaints being received each month. Charts 18 and 19 below, present the total number of complaints and percentage of complaints for the previous six months.

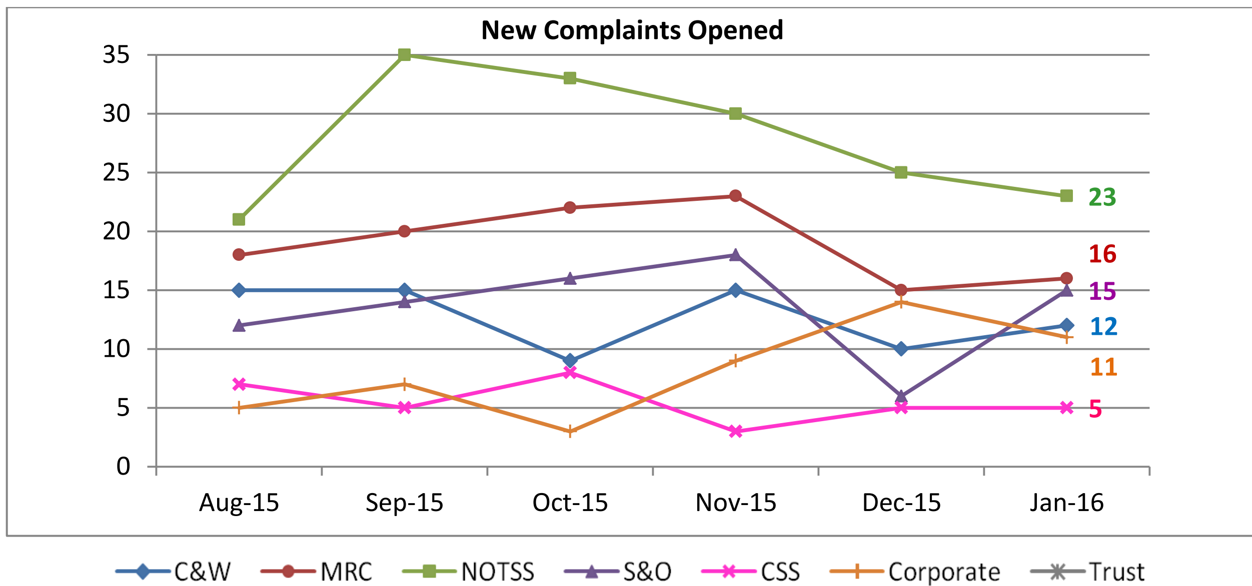
Chart 18 – % Complaints against Finished Consultant Episodes (FCE)



Source OUHFT Complaints Management System

[2] PALS and Complaints data is from January as it is not compared nationally.

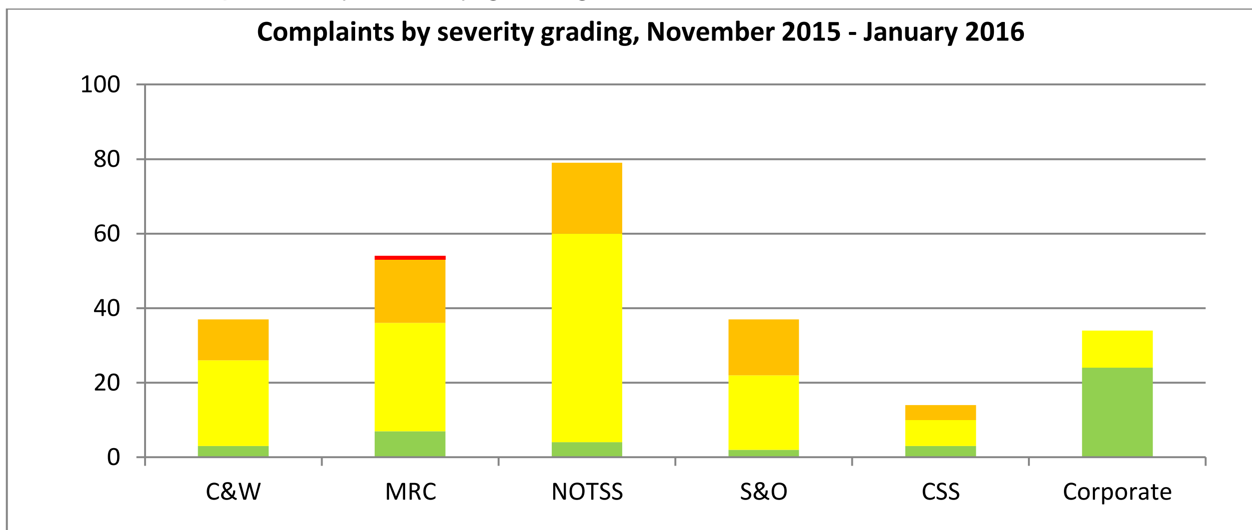
Chart 19 – New Complaints Opened



Source: OUHFT Complaints Management System

12.2. There were no extreme (previously coded red) graded complaints received in January 2016. The chart below presents the complaints by severity grading for between November 2015 and January 2016.

Chart 20 – Complaints by severity grading, Nov 2015 – Jan 2016

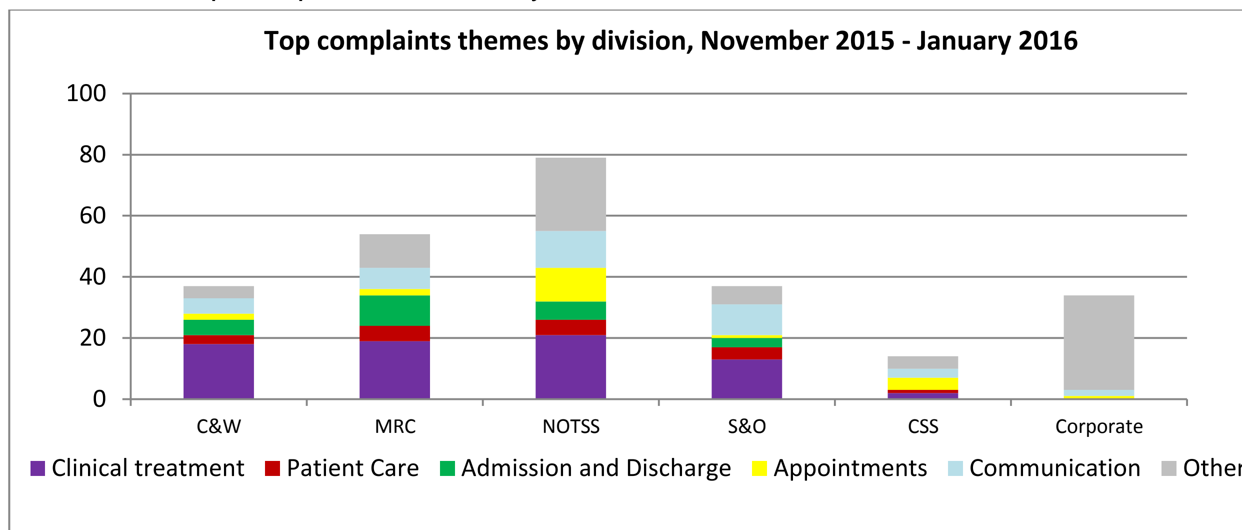


Source OUHFT Complaints Management System

Divisional Overview

12.3. The Chart 21 presents the top complaints themes by division from between November 2015 and January 2016.

Chart 21 – Top complaints themes by division, Nov 2015 – Jan 2016



Source: OUHFT Complaints Management System

12.4. NOTSS received the highest number of complaints for the thirteenth consecutive month (n=23, 28%[3]). This is a slight decrease from the number received in December (n=25) and represents a slight decrease against FCEs; please refer to Charts 18 and 19. The Division's complaints are related to Neurosciences (n=6), Specialist Surgery (n=11), Trauma (n=2) and Orthopaedics (n=4).

12.5. S&O received 15 complaints this month (18% of the overall number received Trust-wide), which concerned Oncology and Haematology (n=4), Surgery (n=5), Renal, Transplant and Urology (n=4) and Gastro, Endoscopy and Theatres (n=2). This number represents an increase in the number of complaints received by the Division in December (n=8), with an increase against FCEs; refer to Charts 18 and 19.

12.6. CSS received five complaints this month (6% of the overall number of complaints received by the Trust). The number of complaints received by CSS in January is the same number that was received in December 2015. Of the five received in January, the areas of concerns related to Theatres, Anaesthetics and Sterile Services (n=1), Critical Care, Pre-op Assessment, Pain Relief and Resuscitation (n=1), Radiology and Imaging Services (n=2) and Pharmacy (n=1).

12.7. MRC received 16 complaints this month (19.5% of the overall number of complaints received by the Trust) which represents a slight increase compared to 15 received in December. There was no change against FCEs; refer to Charts 18 and 19. The complaints related to Ambulatory Medicine (n=3) and Acute Medicine and Rehabilitation (n=13), of which 7 complaints were related to the Trust's Emergency Departments/Emergency Assessment Units.

[3] The percentage is of the total number of complaints.

12.8. C&W received 12 complaints this month (14.6% of the overall number of complaints received by the Trust) and compares to 10 in December. There was a slight increase shown against FCEs; refer to Charts 18 and 19. The complaints received were for Children's (n=6), and Women's (n=6).

12.9. The Corporate division received 11 complaints this month (13.4%). This was a decrease on the number received in December (n=14). There has been a steady increase in the number of complaints relating to car parking issues over the past three months which will continue to be monitored by the Complaints team and highlighted to the Interim Director of Estates.

13. Safe Staffing – Nursing and Midwifery

13.1. The Trust is required to comply with The National Quality Board (November 2013) and NICE guidance (July 2014) for Safe Staffing for Adult Inpatient Wards in Acute Hospitals. This report therefore includes the safe staffing data for December 2015 and the metrics against each of the 5 divisions (appendices 3 a, b, c, d & e).

13.2. It also incorporates Nurse Sensitive Indicators (NSI), for the months of November – January 2015/16, by division, against the Trust metrics. The overall Trust wide safe staffing report including individual wards and shifts is highlighted in appendix (appendix 3f)

National reporting for Safe Staffing January 2016

13.3. The summary of the figures submitted to NHS Choices via the Unify platform for January 2016 are included below but can be accessed via the Trust website on (http://www.ouh.nhs.uk/about/saferstaffinglevels.aspx).

13.4. This report incorporates the actual hours worked against the planned rostered hours for nursing and midwifery staff, for day and night shifts, separating Registered Nurses and Nursing Assistants.

13.5. These figures include all staff both permanent and temporary staff.

13.6. The Trust has been achieving the standards set for the national 'Agency Cap', of agency usage below 8% of the overall nursing workforce, and reduced the use of Non Framework nursing agency significantly.

Unify data – January 2016

13.7. The fill rates of actual shifts against those planned (including temporary staff) are:

96.76% for Registered Nurses/Midwives

94.41% for Nursing Assistants (unregistered)

Current status of nursing and midwifery staffing within the Trust

13.8. The Trust continues to have a significant percentage of nursing vacancies in key areas such as Paediatric and Neonatal ICU.

13.9. The EU recruitment campaign continues although there will be 25 per month coming into the Trust once the current candidates who have accepted offers of employment have been exhausted, which includes 20 starting in post every two weeks. This recruitment is continuing into the 2016 due the consistent turnover of

junior staff nurses and requirement for specialist staff. The Associate Chief Nurse, Workforce is meeting with the Divisional Nurses to review their status quo with regard to recruitment needs and turnover, to determine the priorities for ongoing recruitment.

13.10. The Integrated Patient Acuity Monitoring Tool System (IPAMS) has been rolled out and implemented during the months of December 2015/January 2016 with support on the wards from the Lead Nurse for Safe Staffing & Revalidation. A review of the data was undertaken with the Divisional Nurses, to determine the issues that needs to be addressed in order to gain full compliance before the previous system can be switched off.

13.11. The bi-annual acuity & dependency review has been deferred by a month until this compliance and data quality can be improved. The sustainability is being managed through developing Super Users across all sites, and is just being implemented.

13.12. The tool is highlighting useful data with regard to the numbers of level 2 (high dependency) patients and in some cases level 3 (intubated or multi – organ support) patients who are managed on the wards for several shifts or part of a shift.

13.13. It is anticipated that Trust committees will receive reports from IPAMS from April 2016, following refinement of the reports.

National directives for Safe Staffing and Revalidation update

13.14. **Safe staffing**

Recent research undertaken in the UK was published in the BMJ (9 February 2016)

Registered nurse, healthcare support worker, medical staffing levels and mortality in English hospital trusts: a cross-sectional study

This highlights work undertaken in secondary care using data from 137 hospitals, with staffing measured as beds per staff member, and in a subsection of 31 hospitals as patients per ward nurse.

Conclusion: ward based registered nurse (RN) staffing is significantly associated with reduced mortality for medical patients. There is little beneficial associations with Nursing Assistants (NA) staffing. Higher doctors staffing levels is also associated with reduced mortality. Trusts with 6 or less patients per RN in medical wards had a 20% lower risk of death compared with Trusts with over 10 patients per nurse. The corresponding reduction for surgical wards/patients was 17%

13.15. Revalidation

The Trust has launched its bespoke designed revalidation tool, designed in collaboration with Southern Health NHS FT and Enterprise Study (current ELMS supplier) with overwhelmingly positive feedback from staff regarding its usability.

Many staff required to revalidate on 1 April 2016 have submitted their applications to the NMC, some of whom have been requested randomly to submit evidence. The Trust's NMC Revalidation Policy has been distributed for consultation and comment.

The communications strategy is well underway with hard to reach staff being addressed i.e. long term sickness, those on maternity leave etc. Divisional

Nurses are monitoring the compliance within their divisions and staff who fall short of the required Continuous Practice Development levels are being facilitated by line managers. A Quality Assurance Forum is being established to commence in early March in order to review borderline or complex cases, to provide advice on actions.

13.16. Care Contact Time Directive

In November 2014 NHS England published a document, "Safer Staffing: A Guide to Care Contact Time."

The report was in response to the NICE guidelines for Safe Staffing, which recommended monitoring and measurement of the quality of contact that patients received with different levels of nursing and nursing assistant staff with an emphasis on the level and quality of direct contact rather than just the number of available staff i.e. patient hygiene needs. This needs to be balanced with indirect patient care i.e. attendance on multidisciplinary ward rounds, or liaising with families to plan discharge and supporting junior staff.

The guidance is not intended to replace the professional judgement of nursing and midwifery leaders in making difficult staffing decisions on a daily basis and with a longer term perspective.

The Trust's preparation and project planning for the implementation of the Care Contact Time directive has included the 'Manchester Clock tool' which was trialled on a number of clinical areas and was found to be user friendly in collecting data over shifts through observing the time and activities of Registered Nurses and Nursing Assistants.

The Trust has designed an excel based data input tool where the data collected can be collated to provide the Care Contact time percentages for each clinical area. The Trust will need to carry out a Care Contact time assessment of each clinical area to provide a baseline indication of the construction of care provided. (This time will vary depending on acuity and speciality.)

On a ward by ward basis the data collected would then be considered and triangulated alongside other indicators such as FFT, Staff FFT, NICE red flags and locally agreed metrics.

Although there has been no formal recent directive the Trust has prepared in readiness and will implement this over time once the IPAMS project has been well embedded and is fully compliant, probably after April 2016.

14. Recommendations

14.1. The Board is asked to receive this Quality Report as information provided from within the organisation on the measures being taken in relation to quality assurance and improvement.

Tony Berendt, Medical Director
Catherine Stoddart, Chief Nurse

25/02/2016

Appendices

How to interpret charts

Data are presented in this report in a number of different ways – including statistical For 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)