<table>
<thead>
<tr>
<th>Title</th>
<th>Board Quality Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status</td>
<td>For information</td>
</tr>
<tr>
<td>History</td>
<td>This is a monthly report, presented alternately to the Trust Board or to the Quality Committee</td>
</tr>
<tr>
<td>Board Lead(s)</td>
<td>Dr Tony Berendt, Medical Director</td>
</tr>
<tr>
<td>Key purpose</td>
<td>Strategy</td>
</tr>
</tbody>
</table>
### Executive Summary

1. This paper briefs the Board on recent publications relating to the Oxford Biomedical Research Centre’s impact on patient care.

2. A section on Trust Quality priorities is included in this report to inform the Board of progress against our objectives for 2016/17.

3. Key quality metrics:
   - For 6 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 1.

4. Matters for attention of the Board:
   - WHO checklist compliance audits are reported to the Board three of the five Divisions demonstrated compliance of less than 100% with actions in place to improve and more detail provided as to the causes of incomplete checklists.

5. Issues raised by Oxfordshire Clinical Commissioning Group (OCCG):
   - Test results and discharge summaries timeliness continues to be an area of significant work. In May 79.5% of discharge summaries were sent before or within 24 hours of discharge against a target of 92%. 78.9% of results were endorsed on EPR within 7 days against a target of 88%. Both indicators have therefore fallen short of the OCCG trajectories for May.
   - GP feedback collated from the OCCG DATIX system is reported.

6. Patient Safety and Clinical Risk:
   - 12 Serious Incidents Requiring Investigations (SIRIs) were reported in May this included a Never Event relating to insulin administration. 6 SIRIs were sent to the OCCG for closure in May 2017 and 9 SIRIs were closed by the OCCG in the OCCG/OUHFT closure meetings.
   - Five Executive quality walk rounds took place in May 2017.

7. Clinical Effectiveness:
   - There have been no new mortality outliers reported for OUH NHS FT by the Care Quality Commission (CQC) or the Dr Foster Unit at Imperial College.
   - The current Summary Hospital-level Mortality Indicator (SHMI) for the data period January 2016 to December 2016 is 0.94. The SHMI remains within the ‘as expected’ range. The Hospital Standardised Mortality ratio (HSMR) is 98 for period April 2016 to March 2017. The value is ‘within expected’ range.

8. Infection Control:
   - For May 2017 there were 7 post 72 hour cases of C. difficile.
   - A case of M. chimaera infection has been diagnosed in a patient operated on at OUH in 2016. The rate of new acquisition of colonisation with C. auris on the Neurointensive (NITU) appears to be falling following the withdrawal of multi-use surface temperature monitoring probes.
   - Carbapenemase Producing Enterobacteria (CPE). The routine screening of haematology patients has commenced to assess whether there is any acquisition or transmission occurring on the unit.
9. Patient Experience:

The improvement in response rate in inpatients and day cases was maintained in May, at 20.2%.

Patients who were discharged from one of the five areas in the Friends and Family Test (FFT) inpatient SMS pilot were sent a rating SMS but not the follow up SMS message which asks for their comments. No comments were received for these pilot areas during May as a result. This was due to an error in the SMS configuration which was investigated by Healthcare Communications and resolved in mid-June.

The percentage not recommend was above the upper control limit for Surgery and Oncology division in May. Contributing reasons for the increase have been highlighted in the report.

There was a focus on response rates on Children’s and Women’s Division this month, as part of the rotating cycle examining each division’s response rate. A number of initiatives have been introduced to increase feedback.

The results for the National Inpatient Survey 2016 were published on 31st May. The Care Quality Commission (CQC) report showed that the Trust performed ‘about the same as most other trusts’ on all questions except one, on which the Trust performed ‘better than most other trusts’.

Complaints:

The Trust received 84 new formal complaints in May. This is an increase from the number received in April (N=67).

No red complaints were received in May.

NOTSS continue to have the highest number of complaints, with (N=26) received in May.

98% of all complaints received were acknowledged within the required 3 working day timescale.

10. Safe Staffing:

This report provides the Trust Board with an update on the current status of nursing and midwifery staffing across the Trust by ward as well as by shifts.

Including:

The summary of the May 2017 Unify submission of all staffing
93.82% for Registered Nurses/Midwives
88.53% for Nursing Assistants (unregistered)

The safe staffing dashboards include each of the divisional RAG rated staffing levels (appendix 2), against the HR metrics and Nurse Sensitive Quality Indicators for March 2017.

Care Hours per Patient Day (CHPPD) is reported for the first time to the Trust Board and highlights the areas of high acuity (intensive care and high dependency units) and the wards where there are notably low care hours in a 24 hour period (appendix 4).

Reports of the ward by ward, shift by shift RAG rated staffing levels are in appendix 3. Reports in the text are by exception from the divisional dashboards including HR metrics and Nurse Sensitive Indicators.

The Trust is imminently to measure the patient acuity levels in the JR Emergency Department in mid-June 2017, in order to review the nurse staffing on a 24 hour basis.
for 7 days.

The Trust is in the process of undertaking a review of the midwifery establishments against the NICE guidance.

The in-patient acuity review data is currently being validated and will be presented to the August Quality Committee.

The pilot of the use of IPAMS in determining theatre staffing levels is underway in all theatres with the exception of Women’s services.

11. Recommendation

The Board is asked to receive and discuss this Quality Report.
Board Quality Report

1. Purpose

1.1. This paper briefs the Board on National developments on Quality related topics and comments 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 refreshed quality priorities for this financial year, as 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 Trust Board meeting.

2. Oxford Biomedical Research Centre’s impact on patients

2.1. The Oxford Biomedical Research Centre (BRC) was established in April 2007 with funding from the National Institute for Health Research (NIHR). Oxford BRC is based at the Oxford University Hospitals NHS Foundation Trust (OUH) and is a partnership between the OUH and the University of Oxford, bringing together the research expertise of the University of Oxford and the clinical skills of staff at OUH.

2.2. An authoritative evaluation of the impact of the BRC on patient care was published in the journal Health Research Policy and Systems in 2017.

2.3. The authors state that improving the translation of scientific discoveries into health benefits for patients and the population in general has long been an aim of government policy in the United Kingdom and internationally. According to the Cooksey review of United Kingdom health research funding, there are two gaps in the translation of health research into practice: the first is in translating basic and clinical research into the development of new products, technologies and approaches to the treatment of illness and health, and the second is in implementing these products, technologies and service approaches in clinical practice.

2.4. The authors employed the following methods. First, they reviewed documentation from Oxford BRC and literature on the impact of research activity on patient care. Second, they interviewed leaders of the Oxford BRC’s research to identify the direct and indirect impacts they expected their activity would have on local hospitals. Third, this information was used to inform interviews with senior clinicians responsible for patient care at Oxford’s acute hospitals to discover what impacts they observed from research generally and from Oxford BRC’s research work specifically. The authors compared and contrasted the results from the two sets of interviews using a qualitative approach. Finally, they identified themes emerging from the senior clinicians’ responses, and compared them with an existing taxonomy of mechanisms through which quality of healthcare may be affected in research-active settings.

2.5. The research leaders identified a wide range of beneficial impacts that they expected might be felt at local hospitals as a result of their research activity. They expected the impact of their research activity on patient care to be generally positive.
2.6. The senior clinicians responsible for patient care at those hospitals presented a more mixed picture, identifying many positive impacts, but also a smaller number of negative impacts, from research activity, including that of the Oxford BRC.

2.7. Among the total of 44 projects, 16 had impacts related to diagnostics, testing or patient screening, 12 on treatments available, 14 were related to processes for delivering patient care and/or organising hospital services, and two had impacts on staffing for specialist services (see Table 1).

Table 1 Summary of Oxford Biomedical Research Centre (BRC) projects that Research theme/Working group leads indicated had potential impacts on patient care at Oxford University Hospitals NHS

<table>
<thead>
<tr>
<th>Foundation Trust (OUH)</th>
<th>Oxford BRC projects with potential impact on patient care</th>
<th>Potential impact on patient care at OUH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biomedical Informatics and Technology</td>
<td>Gestational diabetes smartphone application</td>
<td>Processes and/or service organisation</td>
</tr>
<tr>
<td></td>
<td>New alerting score based on patients’ vital signs (CALMS-3 Study - Computer Alerting Monitoring System)</td>
<td>Processes and/or service organisation</td>
</tr>
<tr>
<td></td>
<td>Maintenance of database of samples and consent management for Oxford Biobank</td>
<td>Processes and/or service organisation</td>
</tr>
<tr>
<td></td>
<td>System for Electronic Notes Documentation (SEND) project (electronic track and trigger and patient alerting)</td>
<td>Processes and/or service organisation</td>
</tr>
<tr>
<td>Blood</td>
<td>Training and hiring staff and improving infrastructure for clinical programme to do stem cell transplants and run more clinical trials in this area</td>
<td>Treatments</td>
</tr>
<tr>
<td>Cancer</td>
<td>Multi-gene testing service with rapid (1 week) turnaround</td>
<td>Diagnostics, testing, screening</td>
</tr>
<tr>
<td></td>
<td>BRC-funded clinical research posts specialising in sarcoma, gynaecological cancers and melanoma</td>
<td>Staffing for specialist services</td>
</tr>
<tr>
<td>Cardiovascular Clinical Informatics</td>
<td>MRI diagnostic tools for patients with intermittent angina</td>
<td>Diagnostics, testing, screening</td>
</tr>
<tr>
<td></td>
<td>Upgrade for cancer informatics in OUH (enabled by Genomic Medicine Centre (GMC) designation)</td>
<td>Diagnostics, testing, screening</td>
</tr>
<tr>
<td></td>
<td>Molecular diagnostics and genome sequencing services (enabled by GMC designation)</td>
<td>Diagnostics, testing, screening</td>
</tr>
<tr>
<td></td>
<td>Development of integrated logical record for each cancer patient (in progress)</td>
<td>Processes and/or service organisation</td>
</tr>
<tr>
<td></td>
<td>True colours technology for mental health patients across Oxfordshire to aid self-management</td>
<td>Processes and/or service organisation</td>
</tr>
<tr>
<td></td>
<td>Streamlining management of notes/records from multidisciplinary cancer meetings (in progress)</td>
<td>Processes and/or service organisation</td>
</tr>
<tr>
<td>Dementia and Cerebrovascular Disease</td>
<td>Clinical decision support dialogue to make blood orders more efficient</td>
<td>Processes and/or service organisation</td>
</tr>
<tr>
<td></td>
<td>New screening process for acute confusion in medical admissions</td>
<td>Diagnostics, testing, screening</td>
</tr>
<tr>
<td></td>
<td>Fast track carotid surgery</td>
<td>Treatments</td>
</tr>
<tr>
<td></td>
<td>Telemetric home blood pressure monitoring</td>
<td>Processes and/or service organisation</td>
</tr>
<tr>
<td></td>
<td>The first transient ischaemic attack (TIA) and minor stroke clinic in the United Kingdom</td>
<td>Processes and/or service organisation</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Diagnostic programme to identify patients with a genetic basis for their diabetes</td>
<td>Diagnostics, testing, screening</td>
</tr>
<tr>
<td></td>
<td>Pancreatic islet extraction unit</td>
<td>Treatments</td>
</tr>
<tr>
<td></td>
<td>Pancreatic transplants</td>
<td>Treatments</td>
</tr>
<tr>
<td>Functional Neuroscience and Imaging</td>
<td>Imaging protocols (epilepsy)</td>
<td>Diagnostics, testing, screening</td>
</tr>
<tr>
<td></td>
<td>Functional neurosurgery team (part of the BRC) provides a clinical service, including pain deep brain stimulation</td>
<td>Treatments</td>
</tr>
<tr>
<td></td>
<td>Specialist clinic in epilepsy, Parkinson’s disease, motor neurone disease, supported by BRC-funded research fellows</td>
<td>Staffing for specialist services</td>
</tr>
</tbody>
</table>
2.8. An example the publication cites of a development that affected the diagnosis or screening of patients is that Oxford was designated as one of the 11 NHS Genomic Medicine Centres (GMCs) in 2014. One interviewee explained that the Oxford BRC had played an important role in enabling Oxford to achieve this designation, and that it had led to a major upgrade for cancer informatics services as well as boosting OUH's molecular diagnostic and genome sequencing services.

2.9. The article states that a project that impacted on how care is organised and delivered was the System for Electronic Notes Documentation (SEND) project, an electronic system for patient monitoring and staff alerting that was developed with Oxford BRC support and was being rolled out across OUH's four hospitals at the time of the interview (and is now complete).

2.10. Indirect impacts cited include enabling more clinical trials and other research studies to be carried out, better biobanking, including a tissue database and consent management system (cited by three interviewees) and improved pharmacovigilance and pharmacy support.
2.11. The main mechanism cited through which the Oxford BRC supports human capital development at OUH is funding for staff to do research. Some of the interviewees felt that, by allowing more staff to do research, the Oxford BRC was helping bring about a cultural change through which research was gaining traction and becoming more important in the day to day work of the OUH.

2.12. The interviews carried out with clinicians as opposed to researchers described the following themes of improvement:

2.12.1. Research activity
2.12.2. Formalisation of research roles
2.12.3. Communication and awareness of research
2.12.4. Reputation
2.12.5. Staff recruitment and retention
2.12.6. Patient benefits from staff involvement in research
2.12.7. Access to infrastructure
2.12.8. Novel treatments and technologies
2.12.9. Attitudes to research

2.13. The article describes extensive positive benefits of the BRC which have impacted on patient care.

3. Update on progress against the Trust Quality priorities for 2016/17

3.1. The place of our priorities in the domains of patient safety, clinical effectiveness and patient experience is shown in Chart 1.
3.2. The progress on the Trust’s Quality Priorities against the goals and targets as provided to the Quality Committee in June are set out in table 2.

Table 2: Progress on the Trust’s Quality Priorities 2017/18

<table>
<thead>
<tr>
<th>Quality Priority</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority One: Partnership working</td>
<td>The Commissioning for Quality Innovation (CQUIN) operational delivery networks are on track to deliver the quarter one CQUIN requirements.</td>
</tr>
<tr>
<td></td>
<td>Home Assessment Reablement Team (HART) update: HART are providing 49% of the available support worker hours as patient contact time against a target of 50%.</td>
</tr>
<tr>
<td></td>
<td>OUH Public Health/Health &amp; Wellbeing Strategy update: Several leadership programs for managers have commenced within the Trust; bullying and harassment toolkit training for managers and staff started in April 2017; design and development of appraisal documentation has commenced; unconscious bias workshops are running bi-monthly.</td>
</tr>
<tr>
<td>Priority Two: Safe discharge</td>
<td>The outline plan was presented to the Trust Management Executive (TME) in March 2017. Project governance has been set up including recruitment to the project board.</td>
</tr>
<tr>
<td></td>
<td>Early adopters have been identified engaging three wards across two Divisions.</td>
</tr>
<tr>
<td></td>
<td>The Pharmacy standard operating procedure (SOP) is being finalised.</td>
</tr>
<tr>
<td>Priority three: Preventing</td>
<td>The cardiac arrest reduction strategy has shown some initial</td>
</tr>
<tr>
<td>Quality Priority</td>
<td>Evaluation</td>
</tr>
<tr>
<td>-----------------</td>
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<tr>
<td>patients from deteriorating – delivering time critical care (Heart attack, stroke, blood clots in the lungs, sepsis including the use of the System for Electronic Notification and documentation - SEND system)</td>
<td>success across Acute General Medicine (AGM) and Vascular Surgery. The Recognising Acutely Ill and Deteriorating Patients (RAID) committee have agreed a plan for further rollout across all adult in-patient areas. The proportion of patients with sepsis that receive both prompt antibiotics and an early antibiotic review has increased among both emergency admissions and inpatients (62% and 44%, respectively, in Q4, from 44% and 29% at the start of the year).</td>
</tr>
<tr>
<td>Priority four: Mental health in patients coming to our hospitals</td>
<td>Patients who have attended the emergency department (ED) more than 10 times are discussed at a meeting between OUH and Oxford Health (OH). As a result of this meeting, there are already examples where OUH/OH has worked with partners to reduce frequent attendees. A meeting is planned between OUH and OH to validate the hospital episode statistics (HES) coding data which is a requirement of the CQUIN. Going forward, the validation of HES data codes will be done between OUH and OH at the monthly meeting which reviews frequent attenders. The Emergency Department Psychiatric Liaison Service (EDPS) improvement plan will be closed down and replaced with a CQUIN action plan. This will be shared at the monthly joint Governance meeting between OH and OUH.</td>
</tr>
<tr>
<td>Priority five: Cancer pathways</td>
<td>The roll out of the two week wait directly bookable slots into services is on schedule. Breast, Neuroendocrine and Dermatology are complete. Performance meetings have been established with Urology, Gynaec-oncology, and Colorectal cancer services. Action plans have been agreed and implementation is in progress. The first Head and Neck performance meeting has been held (May 23rd) and actions have been agreed.</td>
</tr>
<tr>
<td>Priority six: Go Digital</td>
<td>Work on the Global Digital Exemplar Programme is underway with scoping work taking place to agree key deliverables by 31.3.18. Once these are clear a project manager(s) will be appointed. There are barriers to be overcome such as the signing of a key contract with Cerner (healthcare information system) and the recruitment of an estimated 65 additional staff who are required to accelerate the programme but Core Clinical Documentation: Standards will be piloted at the Nuffield Orthopaedic Centre (NOC) from 17.7.17</td>
</tr>
<tr>
<td>Priority seven: End of life care (EOLC): improving people’s care in the last few days and hours of life</td>
<td>A work plan for 2017/18 has been developed. It builds on the 2016/17 work plan with additional work that has been identified to support the delivery of the OUH EOLC strategy. The detail of our 2017/18 work plan has been shared with Oxfordshire Clinical Commissioning Group (OCCG) in the monthly EOLC group and OCCG have been sent the minutes and papers from</td>
</tr>
</tbody>
</table>
The Palliative Care team continues to provide a 7 day a week presence in the ED and emergency admissions unit (EAU). Since October 2016, 4 times as many patients have been seen by the team in ED and EAU and 1.5 as many patients across OUH.

Four wards completed accreditation for the EOLC scheme in 2016/17. Further areas will follow in 2017/18.

Approximately 20 responses have been received from the bereavement survey to date. The survey continues until mid-July when it will be evaluated, adapted and continued. This priority remains the Governors chosen area of focus.

**Priority eight: Dementia Care**

Work is ongoing to create an electronic medical clerking proforma broadly similar to the existing paper proforma, which will incorporate the cognitive screen. Proposed modifications to consent forms to prompt consideration of the need for a capacity assessment prior to consent (in patients with dementia/delirium or low cognitive scores) has been drafted and discussed at three divisional governance meetings. The proposed amendments have been approved by the Head of Legal Services, and will be presented to the Trust Clinical Governance Meeting in July 2017 with the aim of Trust roll-out.

**Priority nine: Learning from complaints**

The recent Trust Patient Forum on 21st June identified the need for improved communication as an important element of this Quality Priority.

An inclusive group made up of volunteers from the Forum has been formed to review the complaints and to form the top 10 top tips on communication.

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### 4. Key Quality Metrics

4.1. 32 key quality metrics linked to the quality of clinical care provided across the organisation are listed in Table 3.

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

4.3. 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).

4.4. Charts for MRSA bacteraemias will only be provided in months where an additional bacteraemia has occurred as the target of zero was breached early in the year.

4.5. A brief explanation on how to interpret exception charts is also provided in the appendices.
Indicators deteriorating or red rated

4.6. 6 indicators have deteriorated against target since the last reporting cycle, PS06 MRSA is red rated due to breaching of an annual threshold:

4.6.1. PS06 Number of cases of MRSA bacteraemia > 48 hours
4.6.2. PS08 % patients receiving stage 2 medicines reconciliation within 24h of admission
4.6.3. PS14 % Radiology direct access 7 day turnaround times - Plain Film, CT, MRI & Ultrasound
4.6.4. PS17 Number of hospital acquired thrombososes identified and judged avoidable
4.6.5. CE03 Dementia - % patients aged > 75 admitted as an emergency who are screened
4.6.6. PE15 % patients EAU length of stay < 12h

Indicators deteriorating from green to amber or remaining amber

4.7. 2 indicators have deteriorated from green to amber since the last reporting cycle:

4.7.1. PS02 Safety Thermometer (% patients receiving care free of any harm - irrespective of acquisition)
4.7.2. The NHS Safety Thermometer is a monthly ward snap shot (point prevalence) audit or ‘Safety Census’ undertaken by ward nurses. It assesses each inpatient ward for four common healthcare associated (and often preventable) harms. These are: pressure ulcers, falls, VTE and urinary tract infections. Each of these harms have established associated workstreams to improve patient safety. The aggregated assessment results generate a ‘percentage of harm free care’ for the organisation. The safety thermometer methodology includes reporting of events that happened in the preceding 72 hours. Thus it includes events which happened prior to admission to hospital (such as out of hospital venous thrombo-embolism) where treatment is initiated in the Trust.
4.7.3. The tool provides two measures of ‘Harm Free Care’ (chart 7):
4.7.4. Harm Free Care 1 (HFC 1) - is the ‘overall % of harm free care’ – this includes patients admitted into the OUHFT with a pre-existing pressure sore and/or a catheter related urinary tract infection where treatment was started prior to admission to our hospitals.
4.7.5. New Harm Free Care (HFC 2) - is the % of harm free care which excludes patients admitted to our Hospitals with an existing pressure ulcer or catheter related urinary tract infection where treatment was started prior to admission to our hospitals.
4.7.6. CE06 ED - % patients seen, assessed and discharged / admitted within 4h of arrival
### Table 3: Key Quality Metrics

<table>
<thead>
<tr>
<th>BQR ID</th>
<th>Descriptor</th>
<th>Dec &amp; Jan</th>
<th>Jan &amp; Feb</th>
<th>Feb &amp; Mar</th>
<th>Mar &amp; Apr</th>
<th>Current reporting period</th>
</tr>
</thead>
<tbody>
<tr>
<td>PS01</td>
<td>Safety Thermometer (% patients receiving care free of any newly acquired harm) (one month in arrears)</td>
<td>97.57%</td>
<td>97.16%</td>
<td>97.25%</td>
<td>97.74%</td>
<td>May 17</td>
</tr>
<tr>
<td>PS02</td>
<td>Safety Thermometer (% patients receiving care free of any harm - irrespective of acquisition) (one month in arrears)</td>
<td>93.87%</td>
<td>93.41%</td>
<td>92.16%</td>
<td>93.01%</td>
<td>May 17</td>
</tr>
<tr>
<td>PS03</td>
<td>VTE Risk Assessment (% admitted patients receiving risk assessment)</td>
<td>96.92%</td>
<td>96.99%</td>
<td>97.10%</td>
<td>97.10%</td>
<td>May 17</td>
</tr>
<tr>
<td>PS04</td>
<td>Serious Incidents Requiring Investigation (SIRI) reported via STEIS</td>
<td>11</td>
<td>8</td>
<td>7</td>
<td>12</td>
<td>May 17</td>
</tr>
<tr>
<td>PS05</td>
<td>Number of cases of Clostridium Difficile &gt; 72 hours (cumulative year to date)</td>
<td>47</td>
<td>51</td>
<td>53</td>
<td>4</td>
<td>May 17</td>
</tr>
<tr>
<td>PS06</td>
<td>Number of cases of MRSA bacteraemia &gt; 48 hours (cumulative year to date)</td>
<td>5</td>
<td>6</td>
<td>6</td>
<td>1</td>
<td>May 17</td>
</tr>
<tr>
<td>PS07</td>
<td>Antibiotic prescribing - % compliance with antimicrobial guidelines [most recently available figure, undertaken quarterly]</td>
<td>95.35%</td>
<td>95.35%</td>
<td>95.35%</td>
<td>95.35%</td>
<td>Jan 17</td>
</tr>
<tr>
<td>PS08</td>
<td>% patients receiving stage 2 medicines reconciliation within 24h of admission</td>
<td>82.35%</td>
<td>70.55%</td>
<td>74.71%</td>
<td>71.99%</td>
<td>May 17</td>
</tr>
<tr>
<td>PS09</td>
<td>% patients receiving allergy reconciliation within 24h of admission</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>May 17</td>
</tr>
<tr>
<td>PS10</td>
<td>% of incidents associated with moderate harm or greater</td>
<td>0.70%</td>
<td>0.81%</td>
<td>0.50%</td>
<td>1.19%</td>
<td>May 17</td>
</tr>
<tr>
<td>PS11</td>
<td>Total number of newly acquired pressure ulcers (category 2,3 and 4) reported via Datix</td>
<td>93</td>
<td>97</td>
<td>86</td>
<td>85</td>
<td>Apr 17</td>
</tr>
<tr>
<td>PS12</td>
<td>Falls leading to moderate harm or greater</td>
<td>2</td>
<td>5</td>
<td>0</td>
<td>4</td>
<td>May 17</td>
</tr>
<tr>
<td>PS13</td>
<td>Cleaning Score - % of inpatient areas with initial score &gt; 92%</td>
<td>50.91%</td>
<td>43.48%</td>
<td>44.19%</td>
<td>34.29%</td>
<td>May 17</td>
</tr>
<tr>
<td>PS14</td>
<td>% Radiology direct access 7 day turnaround times - Plain Film, CT, MRI &amp; Ultrasound</td>
<td>86.48%</td>
<td>89.05%</td>
<td>86.12%</td>
<td>87.39%</td>
<td>Apr 17</td>
</tr>
<tr>
<td>PS16</td>
<td>CAS alerts breaching deadlines at end of month and/or closed during month beyond deadline</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>May 17</td>
</tr>
<tr>
<td>PS17</td>
<td>Number of hospital acquired thromboses identified and judged avoidable</td>
<td>2</td>
<td>8</td>
<td>4</td>
<td>1</td>
<td>May 17</td>
</tr>
<tr>
<td>CE01</td>
<td>Standardised Hospital Mortality Ratio (SHMI) [most recently published figure, quarterly reported as a rolling year ending in month]</td>
<td>0.99</td>
<td>0.99</td>
<td>0.94</td>
<td>0.94</td>
<td>Sep 16</td>
</tr>
<tr>
<td>CE02</td>
<td>Crude Mortality</td>
<td>238</td>
<td>238</td>
<td>205</td>
<td>195</td>
<td>May 17</td>
</tr>
<tr>
<td>CE03</td>
<td>Dementia - % patients aged &gt; 75 admitted as an emergency who are screened [one month in arrears]</td>
<td>59.61%</td>
<td>60.99%</td>
<td>60.26%</td>
<td>59.13%</td>
<td>May 17</td>
</tr>
<tr>
<td>CE04</td>
<td>Dementia diagnostic assessment and investigation [one month in arrears]</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>May 17</td>
</tr>
<tr>
<td>CE06</td>
<td>ED - % patients seen, assessed and discharged / admitted within 4h of arrival</td>
<td>91.05%</td>
<td>82.25%</td>
<td>87.10%</td>
<td>88.84%</td>
<td>May 17</td>
</tr>
<tr>
<td>PE01</td>
<td>Friends &amp; Family test % likely to recommend - ED</td>
<td>89.56%</td>
<td>90.70%</td>
<td>87.73%</td>
<td>88.93%</td>
<td>May 17</td>
</tr>
<tr>
<td>PE02</td>
<td>Friends &amp; Family test % not likely to recommend - ED</td>
<td>6.13%</td>
<td>5.69%</td>
<td>6.66%</td>
<td>5.98%</td>
<td>May 17</td>
</tr>
<tr>
<td>PE03</td>
<td>Friends &amp; Family test % likely to recommend - Mat</td>
<td>96.16%</td>
<td>95.83%</td>
<td>97.42%</td>
<td>95.76%</td>
<td>May 17</td>
</tr>
<tr>
<td>PE04</td>
<td>Friends &amp; Family test % not likely to recommend - Mat</td>
<td>0.23%</td>
<td>0%</td>
<td>0%</td>
<td>0.47%</td>
<td>May 17</td>
</tr>
<tr>
<td>PE05</td>
<td>Friends &amp; Family test % likely to recommend - IP</td>
<td>95.70%</td>
<td>96.54%</td>
<td>95.38%</td>
<td>95.42%</td>
<td>May 17</td>
</tr>
<tr>
<td>PE06</td>
<td>Friends &amp; Family test % not likely to recommend - IP</td>
<td>1.42%</td>
<td>1.37%</td>
<td>1.80%</td>
<td>1.29%</td>
<td>May 17</td>
</tr>
<tr>
<td>PE07</td>
<td>Friends &amp; Family test % likely to recommend - OP</td>
<td>95.07%</td>
<td>94.67%</td>
<td>94.12%</td>
<td>94.21%</td>
<td>May 17</td>
</tr>
<tr>
<td>PE08</td>
<td>Friends &amp; Family test % not likely to recommend - OP</td>
<td>2.49%</td>
<td>2.78%</td>
<td>3.09%</td>
<td>3.10%</td>
<td>May 17</td>
</tr>
<tr>
<td>PE14</td>
<td>Single sex breaches</td>
<td>8</td>
<td>14</td>
<td>0</td>
<td>0</td>
<td>May 17</td>
</tr>
<tr>
<td>PE15</td>
<td>% patients EAU length of stay &lt; 12h</td>
<td>51.05%</td>
<td>50.06%</td>
<td>51.01%</td>
<td>54.15%</td>
<td>May 17</td>
</tr>
<tr>
<td>PE16</td>
<td>% Complaints upheld or partially upheld [Quarterly in arrears]</td>
<td>52.53%</td>
<td>52.53%</td>
<td>52.53%</td>
<td>50.77%</td>
<td>Mar 17</td>
</tr>
</tbody>
</table>
Exception charts - Red

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

<table>
<thead>
<tr>
<th>PS08 % patients receiving stage 2 medicines reconciliation within 24h of admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy provide ward based support to most clinical areas in the Trust five days a week. During this period compliance is above 90%. However as pharmacy provide ward based support limited to a number of medical areas on weekends achieving the target of 80% of a seven day period is a challenge. Support for additional pharmacy ward based services on weekends is required to achieve the 80% goal. Focus on 4 key admission areas is being worked up into a business case.</td>
</tr>
</tbody>
</table>

The chart shows the proportion of inpatients for whom a second stage pharmacy-led medicines reconciliation is completed within 24 hours of admission. The audit captures medicines reconciliation tasks generated on admission by Cerner. Approximately 2500 medicines reconciliation tasks are audited monthly [Owner: P Devenish].

Chart 3: PS14 % Radiology direct access 7 day turnaround times - Plain Film, CT, MRI & Ultrasound

<table>
<thead>
<tr>
<th>PS14 % Radiology direct access 7 day turnaround times - Plain Film, CT, MRI &amp; Ultrasound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall non-compliant with a small upward trend for routine (R) 64.2% and urgent (U) 63.2% scans. In summary for the specific modalities: Plain film (R83.5%, U48%), CT (R85%, U99.5%), MRI (R61%, U98.1%) and Ultrasound (R99.5%, U99.4%). The Radiology Directorate have an action plan in place, which is being reviewed weekly. The trajectory for patients on 2 week cancer wait currently is to work to 7 days to scan and then 7 days to report. Additional capacity with mobile scanning units has been commissioned to support the timely scanning of patients. The Divisional General Manager chairs a weekly Divisional performance meeting which includes reviewing of radiology turnaround times for the cancer pathway in MRI, CT and US.</td>
</tr>
</tbody>
</table>

95% of routine radiology reports received by the requesting clinician within 7 calendar days of the examination date.
Chart 4: PS17 Number of hospital acquired thromboses identified and judged avoidable

PS17 Number of hospital acquired thromboses identified (HATs) and judged avoidable

A deep dive analysis of HATs has been provided for June Quality Committee. Benchmarking suggests that prior to Q2 2015, OUHFT’s reporting of potentially preventable HATs was below expectation and that since changing the reporting process in Q2 2015 there has been increased detection to an expected level. Root cause analysis of these incidents has resulted in new safety measures being implemented.

The latest quarterly pharmacy-led audit of ‘appropriate thromboprophylaxis’ April 2017 shows continued improvement with Trust overall compliance at 98.0% ‘appropriate thromboprophylaxis’.

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 5: CE03 Dementia - % patients aged > 75 admitted as an emergency who are screened

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

Surgery & Oncology: Cognitive screening compliance is at 55%. Current vacancies and annual leave have had an impact on the results. The medical staff have been reminded of the importance of undertaking these assessments.

The Surgery directorate compiles a list of all the patients not assessed to check and understand the cause in order to improve the service.

Medicine, Rehabilitation and Cardiac: compliance rate has increased to 64.52%. Clinical staff continue to complete this assessment on paper and do not update this on EPR. MRC expect the compliance to improve when the Division goes paperless.

Neurosciences Orthopaedic Trauma & Specialist Surgery: There has been a further decline for the month of April; however, there will be a new focus on the Orthopaedic and Neurosciences Directorate by targeting new trainees in order to embed the process of performing cognitive screening.

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 6: PE15 % patients EAU length of stay < 12h

The reasons why the length of stay in this area is not reducing are:

1. Intermittent patient flow to General Medical wards
2. Complex patients waiting full assessment from therapies.
3. There are mental health patients each day who remain on the unit for more than 24hrs so that they can be assessed properly.

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

Exception charts – Amber

Chart 7: PS02 Safety Thermometer

Safety Thermometer has moved from green last month to amber this month. This is predominantly due to a rise in catheter associated urinary tract infection (CAUTI) to 12. Most of these (5) were on Adams and Bedford ward where senior staff are aware that this is high but state that this is not usual because of the types of patients on the ward. This is a reduction from 7 on this ward in the previous month. The remainder are spread throughout the trust. The Infection Prevention team are leading a CAUTI Project to raise awareness of catheter care and implications of CAUTI. This includes training to be carried out by a Quality Improvement (QI) Nurse, the Infection Control Team (ICT), the Continence Service, the Practice Development Nurses (PDN) and Clinical Educators (CE).

The proportion of patients without any documented evidence of a pressure ulcer, (ANY origin, category II-IV), harm from a fall in care in the last 72 hours, a urinary infection (in patients with urinary catheter) or new VTE (developed since admission to this organisation).
Emergency department (ED) performance continues to be challenging. The ongoing challenge is flow to specialist/medical beds and the length of time to be reviewed by a doctor overnight.

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

5. Matters for attention of the Board

WHO Compliance

5.1. Chart 9 shows the compliance with the WHO checklist by Division and in specific divisional areas. These audits were paper-based. Table 4 provides the narrative where compliance is below 100%.

Chart 9: WHO Checklist compliance May 2017
Table 4: WHO Checklist May 2017

<table>
<thead>
<tr>
<th>Division</th>
<th>Compliance</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>C&amp;W</td>
<td>99% (105)</td>
<td>The May data has been sent to the Clinical Director and Divisional Director so that they can have individual 1:1 conversations with those staff who were not compliant. In May there was 1 non-complaint checklist in Maternity – where the ‘sign in’ section was completed but not signed.</td>
</tr>
<tr>
<td>CSS</td>
<td>99%(312)</td>
<td>312 WHO checklists were audited in the Division. The compliance rate was 99%. There were three partial compliances: 2 in JR theatres and 1 in West Wing theatres, the omissions over the checklists were as follows: ‘Sign In’ Signature missing on 3 and 1 had no patient details (some have more than one omission). The Matron and teams have been made aware of the partial compliances and the requirement to carry out all of the checks and complete the recording of the checks.</td>
</tr>
<tr>
<td>MRC Cardiology</td>
<td>95%(20)</td>
<td>Partial compliance relates to one form being incomplete due to a sign out signature being omitted. Specific feedback has been provided to the clinical teams involved, whilst further discussion of this issue is to occur at the directorate governance meeting (July 12th) in order to identify ways to prevent future reoccurrence.</td>
</tr>
</tbody>
</table>

6. Issues raised by OCCG

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

6.2. The latest data for May 2017 show 79.5% of discharge summaries were sent before or within 24 hours of discharge, this is a slight reduction on the April figure of 80.8% and falls short of the agreed OCCG trajectory of 92%.

6.3. For results endorsed on EPR, 78.9% were endorsed within 7 days (note it is possible to review a result and not endorse it). This is a slight increase on April’s performance at 78.1% and not within the agreed OCCG trajectory of 88%.

6.4. Feedback for May 2017 received by the OCCG from GPs is summarised in the table 5 below. A total of 132 records of GP feedback were received by the OCCG regarding the Trust in May, this is an increase from last month and above the mean (mean derived from May 16 to May 17).

6.5. The top 3 themes account for 42% of all feedback received over the month.

6.6. ‘Delay in GP receiving Clinical Documents’ has been the highest reported issue for the month with 19% of all the GP feedback. This issue has been the top issue 11 times over the past 18 months.

Table 5: GP Feedback – Top 3 thematic areas

<table>
<thead>
<tr>
<th>Theme</th>
<th>March 2017</th>
<th>April 2017</th>
<th>May 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delay in GP receiving clinical docs (i.e. OPD/Discharge letters)</td>
<td>14</td>
<td>1</td>
<td>25</td>
</tr>
<tr>
<td>Duplicate information sent to practice</td>
<td>7</td>
<td>12</td>
<td>17</td>
</tr>
<tr>
<td>Delay / difficulty in obtaining clinical assistance</td>
<td>3</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td>Total Reported</td>
<td>105</td>
<td>87</td>
<td>132</td>
</tr>
</tbody>
</table>
7. Patient Safety and Clinical Risk

Clinical Risk

7.1. In relation to Patient Safety and Clinical Risk:

7.1.1. 12 Serious Incidents requiring Investigation (SIRI’s) were declared as SIRIs and reported onto STEIS in May 2017.

7.1.2. This included 1 Never Event. – ‘Overdose of Insulin due to abbreviations or incorrect device’

A patient experienced hypoglycaemia related to insulin administration as part of co-treatment with dextrose for hyperkalaemia (raised blood potassium level) in the context of postpartum critical illness. The insulin in the insulin/dextrose infusion is believed to have been an overdose related to failure to use an insulin specific administration device to draw up the insulin. This meets the criteria for a Never Event. The patient has made a full recovery.

7.1.3. 6 SIRI’s were submitted for closure to the Oxfordshire Clinical Commissioning Group (OCCG) in May 2017. All 6 SIRI’s were sent to the OCCG within the agreed timeframe.

7.1.4. 1 SIRI closure meeting took place between the Trust and the OCCG in May 2017 and 9 SIRI’s were closed by OCCG.

7.1.5. There were no SIRIs downgraded in May 2017.

7.2. The following charts provide an update on SIRI activity.
Chart 11: OUH incidents showing level of harm and total numbers for each level of harm

<table>
<thead>
<tr>
<th>Months</th>
<th>No harm</th>
<th>Minor</th>
<th>Moderate</th>
<th>Major</th>
<th>Death</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>May-16</td>
<td>1893</td>
<td>467</td>
<td>14</td>
<td>2</td>
<td>0</td>
<td>2376</td>
</tr>
<tr>
<td>Jun-16</td>
<td>1983</td>
<td>452</td>
<td>14</td>
<td>2</td>
<td>0</td>
<td>2451</td>
</tr>
<tr>
<td>Jul-16</td>
<td>2017</td>
<td>490</td>
<td>13</td>
<td>0</td>
<td>0</td>
<td>2520</td>
</tr>
<tr>
<td>Aug-16</td>
<td>1751</td>
<td>373</td>
<td>15</td>
<td>0</td>
<td>0</td>
<td>2140</td>
</tr>
<tr>
<td>Sep-16</td>
<td>1825</td>
<td>385</td>
<td>20</td>
<td>0</td>
<td>1</td>
<td>2231</td>
</tr>
<tr>
<td>Oct-16</td>
<td>1857</td>
<td>404</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>2267</td>
</tr>
<tr>
<td>Nov-16</td>
<td>1757</td>
<td>386</td>
<td>6</td>
<td>1</td>
<td>0</td>
<td>2150</td>
</tr>
<tr>
<td>Dec-16</td>
<td>1684</td>
<td>404</td>
<td>11</td>
<td>1</td>
<td>0</td>
<td>2101</td>
</tr>
<tr>
<td>Jan-17</td>
<td>1708</td>
<td>406</td>
<td>12</td>
<td>1</td>
<td>0</td>
<td>2127</td>
</tr>
<tr>
<td>Feb-17</td>
<td>1692</td>
<td>396</td>
<td>12</td>
<td>2</td>
<td>0</td>
<td>2102</td>
</tr>
<tr>
<td>Mar-17</td>
<td>1756</td>
<td>414</td>
<td>9</td>
<td>2</td>
<td>0</td>
<td>2181</td>
</tr>
<tr>
<td>Apr-17</td>
<td>1499</td>
<td>407</td>
<td>22</td>
<td>1</td>
<td>0</td>
<td>1930</td>
</tr>
<tr>
<td>May-17</td>
<td>1800</td>
<td>427</td>
<td>16</td>
<td>1</td>
<td>0</td>
<td>2245</td>
</tr>
</tbody>
</table>

7.3. Chart 12 shows that 12 SIRIs were declared and 6 SIRIs were completed in May 2017.

7.4. For the 13 months shown in chart 11 67% of major incidents and 83% of deaths reported on the Datix system were investigated as a serious incident.
7.5. Chart 13 shows that each Division within the Trust (with the exception of Corporate) declared a SIRI. NOTSS and CW declared 4 each, SO declared 2 and CSS and MRC declared 1.

7.6. Chart 14 shows that each Division (with the exception of CSS and corporate) closed at least 1 SIRI. SO and NOTSS closed 2 each whilst CW and MRC closed 1 each.
7.7. Table 6 provides more details of the 12 incidents that were declared as a SIRI and reported onto STEIS in May 2017. It also includes the interval time in working days from the incident detected date to the date the incident was reported on Datix and from the date the incident was reported on Datix to the date the incident was declared as a SIRI.

**Table 6: SIRIs declared in May 2017**

<table>
<thead>
<tr>
<th>SIRI No</th>
<th>Division</th>
<th>Incident summary</th>
<th>Date incident detected</th>
<th>Reported date (Datix)</th>
<th>Date incident detected to date reported on Datix interval</th>
<th>Date declared as a SIRI</th>
<th>Date to declared as a SIRI interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>1718-013</td>
<td>SO</td>
<td>Un-witnessed fall with fracture</td>
<td>27/04/2017</td>
<td>27/04/2017</td>
<td>0</td>
<td>04/05/2017</td>
<td>4</td>
</tr>
<tr>
<td>1718-014</td>
<td>CW</td>
<td>A delay in informing a patient they had cancer</td>
<td>26/04/2017</td>
<td>28/04/2017</td>
<td>2</td>
<td>04/05/2017</td>
<td>3</td>
</tr>
<tr>
<td>1718-015</td>
<td>CW</td>
<td>A delay in acting upon a CT report.</td>
<td>28/04/2017</td>
<td>28/04/2017</td>
<td>0</td>
<td>04/05/2017</td>
<td>3</td>
</tr>
<tr>
<td>1718-016</td>
<td>SO</td>
<td>A delay in being referred for palliative chemotherapy.</td>
<td>28/04/2017</td>
<td>04/05/2017</td>
<td>3</td>
<td>04/05/2017</td>
<td>0</td>
</tr>
<tr>
<td>1718-017</td>
<td>NOTSS</td>
<td>Category 3 hospital acquired pressure damage</td>
<td>28/04/2017</td>
<td>28/04/2017</td>
<td>0</td>
<td>04/05/2017</td>
<td>3</td>
</tr>
<tr>
<td>1718-018</td>
<td>CSS</td>
<td>Missed diagnosis on imaging.</td>
<td>19/10/2016</td>
<td>28/04/2017</td>
<td>137</td>
<td>11/05/2017</td>
<td>8</td>
</tr>
<tr>
<td>1718-019</td>
<td>CW</td>
<td>Category 3 hospital acquired pressure damage</td>
<td>10/05/2017</td>
<td>10/05/2017</td>
<td>0</td>
<td>18/05/2017</td>
<td>6</td>
</tr>
<tr>
<td>1718-020</td>
<td>NOTSS</td>
<td>Phenytoin toxicity following medication error</td>
<td>08/05/2017</td>
<td>12/05/2017</td>
<td>4</td>
<td>18/05/2017</td>
<td>4</td>
</tr>
<tr>
<td>1718-021</td>
<td>NOTSS</td>
<td>Foot became ischaemic following surgery.</td>
<td>14/05/2017</td>
<td>15/05/2017</td>
<td>1</td>
<td>18/05/2017</td>
<td>3</td>
</tr>
<tr>
<td>SIRI No</td>
<td>Division</td>
<td>Incident summary</td>
<td>Date incident detected</td>
<td>Reported date (Datix)</td>
<td>Date incident detected to date reported on Datix interval</td>
<td>Date declared as a SIRI</td>
<td>Reported date to declared as a SIRI interval</td>
</tr>
<tr>
<td>--------</td>
<td>----------</td>
<td>-----------------</td>
<td>------------------------</td>
<td>----------------------</td>
<td>----------------------------------------------------------</td>
<td>-------------------------</td>
<td>--------------------------------------------</td>
</tr>
<tr>
<td>1718-022</td>
<td>NOTSS</td>
<td>Hypoglycaemia following management of hyperkalaemia.</td>
<td>12/05/2017</td>
<td>12/05/2017</td>
<td>0</td>
<td>25/05/2017</td>
<td>9</td>
</tr>
<tr>
<td>1718-023</td>
<td>MRC</td>
<td>Fractured ribs not identified prior to discharge. The patient subsequently developed pneumonia and died.</td>
<td>14/05/2017</td>
<td>16/05/2017</td>
<td>2</td>
<td>25/05/2017</td>
<td>7</td>
</tr>
<tr>
<td>1718-024</td>
<td>CW</td>
<td>Never event See section 7.1.2 for more details</td>
<td>25/05/2017</td>
<td>25/05/2017</td>
<td>0</td>
<td>26/05/2017</td>
<td>1</td>
</tr>
</tbody>
</table>

7.8. The incident detected date to the reported date on Datix was a mean of 12 working days (due to SIRI 1718-018) with a median of 0.5 working days.
7.9. The reported date on Datix to the date a SIRI was declared on STEIS was a mean of 4 working days with a median of 3.5 working days.
7.10. Two metrics are used to measure timeliness in the process of identifying SIRIs, incident date-Datix date, and Datix date-SIRI declaration; the internal aim is to ensure neither of these periods is above 10 working days. The incident date to Datix date was breached once in May for SIRI 1718-018, where following an Oncology morbidity and mortality meeting there were delays in this incident being referred to the radiology discrepancy meeting and being reported onto Datix. The reasons for this delay in reporting will form part of the root cause analysis investigation currently underway.

Quality Walk Rounds

7.11. Five Executive Quality walk rounds took place in May 2017.
7.12. The Walk Rounds are detailed in Table 7

Table 7: Executive Quality Walk round Information

<table>
<thead>
<tr>
<th>Hospital Site/Satellite Unit</th>
<th>Areas visited</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Radcliffe Hospital</td>
<td>Day Surgery and Specialist Surgery Directorate</td>
</tr>
<tr>
<td>John Radcliffe Hospital</td>
<td>Children’s Radiology</td>
</tr>
<tr>
<td>Milton Keynes Satellite Unit</td>
<td>Milton Keynes Satellite Unit</td>
</tr>
<tr>
<td>John Radcliffe Hospital</td>
<td>Newborn Care Unit</td>
</tr>
<tr>
<td>Horton General Hospital</td>
<td>Laburnum</td>
</tr>
</tbody>
</table>

7.13. Key issues arising during the Quality Walk Rounds with the potential to affect quality or patient experience either positively or negatively included:

Day Surgery and Specialist Surgery Directorate

- Patient experience has been improved through creating more consulting rooms from offices which allows patients to wait in reception rather than on trolleys in the Day Surgery.
- The Unit has worked creatively to improve staffing through unconditional employment offers for nursing students.
- The Unit has agreed to review their local induction processes and competencies for reception and administrative staff following mixed views expressed by reception staff.
- It was noted that the Unit was one of the first pilot areas to use Integrated Patient Acuity Monitoring system (IPAMs) model of staffing, acuity and dependency.
- The Unit identified Mondays are consistently the quietest day for activity in Day Surgery and whilst the Nurse Manager ensures staffing levels are set according to activity, there are still minimum costs associated with running the department. It was agreed that the Operational Services manager and Clinical Director would review Day Surgery activity on Mondays to see if this can be increased to maximise efficiency.

Children’s Radiology
- The Unit has a child-friendly environment with dedicated staff who focus on the needs of the children and their parents.
- The Unit has established good practice of having a dedicated porter on Tuesday and Thursday which facilitates smooth running of theatre lists.
- The Unit has established a rotational programme to ensure a sub-set of junior staff rotate into specialist children areas to improve their competency and confidence.
- It was identified that the cleaning and storage areas in the inpatient link corridors could be improved. It was agreed that alternative storage space would be identified and cleaning services would be improved with input from Facilities and Estate.

Milton Keynes Satellite Unit
- The unit has a good reputation with well-established clinical links with Oxford and Milton Keynes Hospital.
- The Unit has successfully implemented a Living donor scheme which increases the number of transplants that are undertaken. This does also create additional capacity pressure and space issues for the unit.
- There is a stable team with some vacancies however support is provided from Oxford staff.
- The Unit has been coping exceptionally well and demonstrated excellent end of life care for palliative patients.

Newborn Intensive Care Unit John Radcliffe Hospital
- The Unit is well organised and committed to improving the experience of patients and families.
- Additional psychological support for the staff on the unit is required; it was agreed that the Director of Clinical Services would explore what options were available.
• The good working environment in ITU was noted although it was acknowledged that the environment in HDU is more cramped which has an effect on the ability to maintain privacy.

Laburnum

• The ward was noted to successfully care for patients with a wide range of medical problems including stroke care and cardiac issues due to the availability of appropriate specialist Consultants.
• The ward has been maximising the current usage of the day room to enable the team to have a designated area to have discussions with relatives and carers.
• The ward store room was currently being re-designed to create a safer working environment; the work is expected to be completed shortly.
• The practice development team and ward have been pro-active in additional teaching and education to ensure maximum compliance with the Trust’s Fall safe programme and creating a positive learning experience for student nurses on placement.

8. Clinical Effectiveness

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

8.1. There have been no mortality outliers reported for OUHFT by the CQC or the Dr Foster Unit at Imperial College.
8.2. The SHMI for the data period January 2016 to December 2016 is 0.94. This is rated ‘as expected.’ The SHMI trend is depicted in Chart 16. The SHMI remains within the ‘as expected’ range.

Chart 16: SHMI trend analysis

8.3. The HSMR is 98 for the latest available 12-month period April 2016 to March 2017. The value is ‘within expected’ range (95% CI 94 -102.4).
8.4. The number of observed deaths within the HSMR 56-diagnosis groups is 2804. The HSMR trend is depicted in Chart 17. The HSMR remains ‘within the expected’ range.
Chart 17: HSMR trend analysis

Crude Mortality

8.5. The OUHFT crude mortality by month, site and division is displayed in the charts below. Crude mortality gives a contemporaneous but not risk adjusted view of mortality across OUHFT. Chart 18 and 19 reflect a small increase in mortality in the winter months as a percentage of patient attendances when looked at over 12 months.

Chart 18: Crude Mortality
9. Clinical Audit

9.1. The following audits were presented at the Clinical Effectiveness Committee (CEC) on 11 May 2017; key areas for improvement and areas of good performance are highlighted:

- Validation audit against reported Hand Hygiene Compliance
- Surgical Site Infection (SSI) Audit Proposal for 2017-2018
- Health Records Audits Action Plan
- Consent Audit Action Plan
- Response to NHS Blood & Transplant cumulative sum control chart (CUSUM) trigger for graft loss following Pancreas transplantation
The observed 1-year & 5-year patient and graft survival following pancreas transplantation in Oxford are in line with expected national outcomes. The findings from the report demonstrated no evidence of systematic issues within the pancreas transplant service in Oxford.

- Standardised ratio of emergency readmissions to hospital within 28 days of being discharged following surgery for cervical cancer will be presented at the meeting in July 2017.

- National Diabetic Foot Audit
- Audit of Diabetic Foot Care in Hospital Inpatients
- Elective surgery (National PROMs Programme): Varicose Veins
  The Trust has an improving participation rate of 53.3% in 2015/16 compared to 42.1% in 2014/15. However, in 2015/16 the Trust was a negative outlier for 1 of the 3 outcome measures, reporting a 2.249 adjusted average health gain as measured by the Aberdeen Varicose Vein Questionnaire which will be further reviewed by the unit.

- National Diabetes Inpatient Audit
  Patients experiencing medication, prescription, management and insulin error appear to have increased. Insulin errors appear to have been increased as preparations have similar names. The he order of insulins has now been changed within electronic prescriptions, so that it is easier to select the correct one.

10. Infection Prevention and Control (IPC)

**Clostridium Difficile (C.diff)**

10.1. The upper ceiling for OUH apportioned cases of C.diff for 2017 / 2018 is 69.

10.2. For May 2017 there were 7 cases of C.diff against an internal monthly ceiling of 6. The cumulative limit for the end of May was 11 cases and has not been breached.

10.3. Six of these cases were deemed unavoidable, the seventh was deemed avoidable. There were a number of lapses in care and the results will be reported back to the clinical areas (Chart 21).

10.4. During May the treatment for C.diff was changed to be brought in line with current guidance. The microguide and C.diff guidelines have been amended to reflect this change. The first line treatment is now metronidazole for mild to moderate disease and for severe disease treatment is a combination of metronidazole and vancomycin.
Methicillin-resistant Staphylococcus aureus (MRSA Bacteraemia)

10.5. There have been no incidents of MRSA bacteraemia during May 2017.

Methicillin-sensitive Staphylococcus aureus (MSSA) Bacteraemia

10.6. Root cause analysis is conducted on all cases of MSSA bacteraemias to establish the source, whether it is a healthcare associated infection and to identify any learning.

10.7. In May there were 2 post 48hour MSSA bacteraemias. On completion of RCA one source of infection remains unknown and the second case is thought to be due to septic arthritis.
MRSA Screening Compliance

10.8. The automated MRSA screening request in the electronic patient record went ‘live’ at the end of May. Discussions have been held with the Information Analyst team regarding monitoring compliance.

Candida auris

10.9. The screening of the Neurointensive (NITU) care patients continues to identify newly colonised patients. During May there were 2 new reports of colonisation.

10.10. The rate of acquisition of C. auris appears to be falling following the removal of multi-use surface temperature monitoring probes from the unit.

Chart 24: Epi Curve for Candida auris February 2015 - May 2017
Mycobacterium chimaera

10.11. A patient who had a heart surgery at the OUH in 2016 was admitted to another Trust hospital in May with confirmed M Chimaera heart valve infection. The patient had been aware of the possible risk following receipt of the letter from OUH outlining the world wide risk of this infection in patients who have had certain types of cardio-thoracic surgery.

10.12. Retro fit kits for the heater cooler devices that mitigate aerosolisation are expected to be available in the near future and OUH have asked to be prioritised in the fitting of the units...

10.13. The perfusion department continue to follow all the manufacturers cleaning and disinfection protocols together with all appropriate documentation as stipulated in the PHE guidance of February 2017.

Cleaning Scores – Very High Risk Areas

Contractors Threshold Score 95%

10.14. The Soft FM Client Contract Manager reports that the average scores in May show an upward improvement on all sites in very high risk areas. However, there is still some way to go in some areas to get up to the 98 %. This is attention to detail work rather than significant cleaning concerns.

Contractors Threshold Score 92%

10.15. The average scores in May show an upward improvement on John Radcliffe, Churchill and Horton sites in high risk areas. The NOC scores were pulled down because of poor scores for the office and nurses station areas within the wards.

Chart 25: Contract Client Team Cleaning Audit Scores versus Client Contract Team Target Scores for May 2017. High Risk Areas (inpatient ward areas)
11. Patient Experience

Friends and Family Test (FFT)

Issue with inpatient SMS pilot areas

11.1. Patients who were discharged from one of the five areas in the Friends and Family Test (FFT) inpatient SMS pilot were sent a rating text message but not the follow up text message which asks for their comments. This resulted in no comments being received for these pilot areas during May when patients were surveyed using text messages. This was due to an error in the SMS configuration which was investigated by Healthcare Communications and resolved mid-June. The inpatient extract is configured differently to the extracts for other areas, so other patients contacted by text were not affected.

Increase in Surgery and Oncology (S&O) percentage not recommend

11.2. The percentage not recommend increased in May and was above the upper control limit for S&O (Chart 27). Unfortunately, while patients have given ratings for the questions, there was a lack of response to the follow up question, meaning that it was difficult to understand why patients chose not to recommend the service. The lack of comments was partly due to patients choosing not to leave a comment, and partly because of the error affecting pilot wards outlined in 11.1. The error has been rectified and will result in a fuller picture next month.

11.3. The most significant increase in not recommend was within the Surgery Directorate and Gastroenterology, Endoscopy and Churchill Theatres (GET) Directorate.

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1 The first text asks for the rating and the follow-up text asks for the reason for the rating.

2 The upper control limit is 3 standard deviations from the mean average of the last 12 months of data. The upper control limit is used in a Statistical Process Control (SPC) chart to study how a process changes over time. By comparing current data to these lines, you can draw conclusions about whether the process variation is consistent (in control) or is unpredictable (out of control, affected by special causes of variation).
11.4. The Divisional Nurse was asked to provide context to explain the increase in the not recommend rate:

Within the GET Directorate the comments related to Endoscopy Day Case at the John Radcliffe and highlight a variety of issues including:

- environmental issues;
- expectations of sedation during the procedure;
- and management of pain post procedure.

In two cases the responses were influenced by the perceived attitude and understanding of the staff member, where English was not their first language.

11.5. Although the service could not identify a specific reason for the increase for the negative responses, potential causes are:

- Delays with the ambulance service (South Central Ambulance Service) which is currently being addressed.
- Some lists run late due to emergencies and this occurred several times during this time period;
- The waiting rooms are small and can become crowded following delays;
- Endoscopy is an uncomfortable procedure and patients may therefore be unlikely to recommend.

11.6. Within the Surgery Directorate, Surgical Emergency Unit (SEU) Triage saw an increase in the throughput of patients in May. SEU Triage is an assessment unit for the review of ambulatory patients, in order to ascertain the need for admission to one of the general surgical beds. This area comprises of a relatively confined space, with chairs and trolleys to accommodate patients during the review process. The aim of triage is to move a patient as rapidly as possible to a bed but this is dependent on the capacity of wards available at the time and is not always possible in a timely manner. Negative ratings are more likely when patients have spent a prolonged period of time in this environment.

11.7. With an expected increase in comments next month, due to resolving the error with follow-up messages, it will be possible to look at the themes arising
within comments and to have a clearer picture of how best to make improvements. The ratings in these directorates will be monitored and fed back to the teams to ensure appropriate action.

**Inpatient areas and day case response rates**

11.8. The increased response rate in inpatients and day cases was maintained in May, at 20.2%. This is broken down to inpatients achieving an estimated 24% response rate and day cases an estimated 19%.

**Chart 28– Trust’s inpatient/day case response rate**

11.9. To further improve the response rate, the following changes have been put into place:

- A focus on inpatient and day case wards in each of the five clinical divisions will be included in this report on a rotating basis. After a focus on each division has been reported, only the divisions that have not achieved the target response rate (26%) will be included in the report thereafter. Therefore divisions which do not achieve the target response rate will be regularly re-examined and action plans will be required.

- In order to improve overall response rates in the Trust and ensure that all eligible patients are sent a text message, an improvement has been made to the electronic patient record (EPR) system which removes errors in patients’ mobile phone numbers. With fewer errors, more patients will have the opportunity to give their feedback and this should contribute to a higher response rate.

11.10. Additionally, the following changes are planned:

- The day case response rate could be boosted considerably if automated phone calls were reinstated. The survey provider has fed back that other trusts achieve a response rate of 26% (the national average) and above by using automated phone calls, and, if we used this method, the Trust could

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3 This is an estimate because there is a difficulty in segregating the data in terms of the numbers of inpatient and day case responses and eligible patients.
expect to achieve up to 30% response rate. Additionally, there is a feature whereby respondents have the opportunity to leave a short answerphone message explaining their experience, and this is transcribed by the survey provider to make it easier to select which messages will be most useful. The Patient Experience Team is liaising with procurement and the survey provider to ensure the best quote is provided for this service.

- The Patient Experience Team will feed into the Electronic Documentation Group, to improve the quality of data which affects FFT response rates: ensuring accurate mobile telephone numbers and discharging patients on the patient records system promptly.

11.11. C&W division’s response rates on inpatient and day case wards are the focus of this month’s report. The overall response rate for the division in May was 6.2% (4.7% for children’s and 12.9% for women’s).

Children’s Directorate

11.12. The Children’s Patient Experience team is working with departments to support them to improve response rates. The following challenges, and related actions, were identified across the directorate:

- FFT will be embedded into routine practice within the Children’s Directorate. A short pilot of staff proactively handing out surveys supported the recommendation that proactive distribution of paper surveys needs to be incorporated into the discharge process. The change in process has had a positive impact on response rates. This information has been shared with the Children’s Directorate’s matrons and sisters, with a view to implementation of this approach during Quarter 2 2017/18.

- SMS feedback is not currently possible in the Children’s Directorate, due to particular Information Governance considerations pertaining to children and young people (CYP). For example, if the parent/guardian telephone number was on the CYP’s record as the contact number for that patient (rather than in the next of kin field), and a text was sent to the parent/guardian instead of the CYP, this could potentially result in patient confidentiality being compromised.

- A pilot of handheld devices in 2016 showed that these had little impact on response rates and so the preferred method is a paper based questionnaire.

- During May 2017, a survey was used to gather auditable data on whether the Directorate is meeting its ‘10 Promises’ to children. This survey is being piloted on Children’s Day Care Ward, and started in June 2017, to evaluate whether a bespoke survey has an impact on response rates. The survey includes the Friends and Family Test question.

- During the pilot, ward staff will follow the same process currently used to provide FFT paper surveys. If successful, an online version will be created, and advertised through the Directorate to offer patients an alternative

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4 The ’10 Promises’ were launched in 2013. There are posters for each promise, on display around the Trust, which illustrate the way in which children view health care and the aspects of care that are important to them.
method to provide feedback. The impact of this will be evaluated in Quarter 3.

Table 8 – Children’s Directorate response rates

<table>
<thead>
<tr>
<th>Department</th>
<th>May 17</th>
<th></th>
<th></th>
<th></th>
<th>Context and actions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number eligible</td>
<td>Number of responses</td>
<td>Response rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children's Ward, Horton</td>
<td>273</td>
<td>10</td>
<td>4%</td>
<td></td>
<td>• The ward clerks have taken responsibility for giving FFT forms out during April 2017.</td>
</tr>
<tr>
<td>Bellhouse Drayson Ward, JR</td>
<td>182</td>
<td>14</td>
<td>8%</td>
<td></td>
<td>• The ward clerk is responsible for handing out FFT forms, but no one takes over when they are not present. Suitable cover arrangements will be put in place during Quarter 2 2016/17.</td>
</tr>
</tbody>
</table>
| Children's Day Care Ward, JR                   | 498    | 15    | 3%    |       | • The department is trialling a new ‘10 Promises’ survey to assess impact on response rate.  
• The housekeeper distributes the FFT survey to the bedside tables prior to patient admissions. |
| Children’s Theatre Direct Admissions (TDA), JR  | 22     | 0     | 0%    |       | • There are low numbers of patients discharged home and FFT is usually given from the discharging ward. The reasons for discharge are refusal of treatment and cancellations. |
| Children's Clinical Decision Unit (CDU), JR     | 412    | 22    | 5%    |       | • This is a small unit with a high patient volume, including inpatients, day cases and outpatients, with direct GP referrals and ED transfers.  
• The hospital Play Specialist (HPS) is responsible for handing FFT forms, but no one takes over when not present. This will be addressed during Quarter 2 2016/17.  
• There is a risk of survey fatigue with regular attendees who may be attending every day for treatment. To reduce this risk the HPS provides these patients with a FFT form on the first, or last, day of their routine treatment schedule. |
<table>
<thead>
<tr>
<th>Ward</th>
<th>Patients</th>
<th>Staff</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kamran’s Ward, JR</td>
<td>244</td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td>Melanie’s Ward, JR</td>
<td>89</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td>Paediatric High Dependency Unit (PHDU), JR</td>
<td>11</td>
<td>1</td>
<td>9%</td>
</tr>
<tr>
<td>Paediatric Intensive Care Unit (PICU), JR</td>
<td>9</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Robin’s Ward, JR</td>
<td>116</td>
<td>19</td>
<td>16%</td>
</tr>
<tr>
<td>Tom’s Ward, JR</td>
<td>163</td>
<td>11</td>
<td>7%</td>
</tr>
<tr>
<td>Children’s Directorate inpatient and day cases</td>
<td>2019</td>
<td>95</td>
<td>4.7%</td>
</tr>
</tbody>
</table>

- Children attend the unit on a regular basis for chemotherapy and they are also asked to complete a survey if they are involved in a clinical trial. As a result, there is a high risk of survey fatigue across all types of patient attendance.
- A bespoke ward survey is being developed, to include the FFT question, which will be completed at various points in patient pathway. This will be used in Quarter 2.

- The FFT feedback forms are on display in the patient day room.
- In April 2017, the ward was part of a pilot to identify ways to incorporate FFT into the discharge process.

- There are low numbers of patients discharged home. There will be a review of the data quality on the electronic patient record system to check whether these patients are discharged home, or discharged to another ward.
- A bespoke survey has been created, including FFT question, for all patients leaving Children’s Critical Care to complete.
- This is currently collected by the health play specialist, but no one takes over when not present. This will be addressed during Quarter 2 2016/17.

- Nursing staff give FFT survey to patients during discharge.
- The Ward Clerk and HPS attach the FFT survey with admission documents and follow up with parents on discharge.

11.13. The Divisional Nurse for Children’s’ and Women’s services considers the poor response rate in children’s services to be partly due to Theatre Direct Admissions, where patients do not stay until discharge and will be removed from the distribution list. Additionally patients on Kamran’s ward are commonly repeat patients undergoing diagnostic procedures or receiving chemotherapy so patients do not respond on each admission.
## Women’s directorate

**Table 9 – Women’s directorate response rates**

<table>
<thead>
<tr>
<th>Department</th>
<th>May 17</th>
<th></th>
<th></th>
<th>Context and actions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number eligible</td>
<td>Number of responses</td>
<td>Response rate</td>
<td></td>
</tr>
</tbody>
</table>
| Women’s Day Surgery Unit, Horton    | 73     | 42       | 58%      | • This is a very high response rate. The department has been commended for the processes they have in place. This exemplary practice has been shared with the other departments in the Directorate.  
• The nurse admitting the patient hands out the questionnaire on admission  
• All staff encourage patients to provide feedback.  
• The ward coordinator leads on FFT and keeps the process in place. |
| Diagnostic Suite, JR                 | 22     | 0        | 0%       | The unit did not previously have a clear process of providing questionnaires to patients booked through theatre direct admissions. This has now been resolved. |
| Gynaecology day surgery              | 77     | 0        | 0%       | Gynaecology day surgery and gynaecology ward operate as one unit. An issue has been identified with labelling of the questionnaires. The forms completed did not always have gynaecology as an identifier. The response rate may have been higher in any one of these areas but it was not possible to identify. This has been addressed for Quarter 2.  
The staff have reviewed the options designed to increase the response rate. The model that is used to achieve high response rates in the Women’s Day Surgery Unit at the Horton will be implemented. |
| Gynaecology ward                     | 293    | 18       | 6%       |                                                                                      |
| Women’s directorate inpatient and day cases | 465    | 75       | 16.1%    |                                                                                      |

**Process for learning from FFT feedback**

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**Oxford University Hospitals NHS Foundation Trust**

**TB2017.64**

**Board Quality Report**

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11.14. Awareness of FFT has been increased through the revised process of providing detailed feedback to areas that have excellent results and response rates and those that have challenges. The Patient Experience Team has had very positive feedback from departments who have been the focus of excellent feedback, and departments who have had feedback for improvement have responded constructively.

11.15. The process for learning from FFT feedback is as follows:

**Table 10 – process for learning from FFT feedback**

<table>
<thead>
<tr>
<th>Exceptional feedback</th>
<th>Feedback for improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>One area selected per month</td>
<td>One area selected per month</td>
</tr>
<tr>
<td>Areas selected for focus will have more than 20 responses and 20% response rate, so that the feedback is more reliable.</td>
<td>Focus on an area with a high not recommend rate (percentage unlikely and extremely unlikely to recommend). Minimum of 4 negative ratings. Review the comments and find a department with a consistent theme in the feedback.</td>
</tr>
<tr>
<td>Many areas within the Trust get over 100% extremely likely and likely to recommend. The percentage of extremely likely to recommend is also used to select a department: those with over 90% are considered.</td>
<td>A different area is selected each month.</td>
</tr>
<tr>
<td>Themes within the feedback are selected and sent to the department/divisional managers to ask if they agree with the themes, and if they can provide any context to the feedback.</td>
<td>Ask which processes are in place that help them to get such exceptional feedback.</td>
</tr>
<tr>
<td>Ask what they are doing to improve and ensure the learning is shared.</td>
<td>Share the learning in a quarterly bulletin</td>
</tr>
</tbody>
</table>

**Exceptional feedback**

11.16. ECG outpatients department at the John Radcliffe (JR) was selected for analysis of exceptional feedback. During May, everyone was either extremely likely or likely to recommend their care, and 93% were extremely likely. The key themes identified from the responses were:

- Efficiency.
- Excellent communication, with information provided in a way that patients could understand.
- Personalised care.
- Friendly, caring, professional and staff.

11.17. A lot of work has gone into improving patient and staff experience in the department. The following processes were identified that help the team to achieve this positive feedback:
• For example, there was a 17% increase referrals for Holter monitoring but no additional monitoring units. To mitigate potential delay and poorer patient experience, the department implemented an effective triaging process.

• Band 3 and 4 Health Scientist Assistants (HSAs) have been asked to monitor and act upon feedback, and have ownership of their areas. They are encouraged to design new processes to improve the department. The Senior HSAs roles have been extended to taking blood samples and weight measurements, and the team is starting to introduce the analysis of these data to the senior HSA roles. The aim of this is to make staff feel valued and supported to develop their skills, while making the department more efficient.

• There is a half-hour morning meeting every day before the clinics start. This meeting is used to discuss the staff rota and the tasks for the day, to ensure that everyone is on board. Sometimes this morning meeting is used for staff training (one per week maximum).

• Once per month, the department holds an open staff meeting, where staff of all grades are encouraged to contribute their thoughts about how to improve the department, discuss any issues, and find solutions. This has been effective for team building.

11.18. The Chief Cardiac Physiologist and ECG Services Lead fed back that everyone in the team was very happy to hear that they have been recognised, especially as the team have worked so hard to improve patient experience. The recognition was a great boost in morale for the team.

11.19. In the following areas, there were 20 or more respondents, a 20% or higher response rate (inpatients and day cases areas only) and 100% of respondents were extremely likely or likely to recommend their care:

• Blenheim ward, Churchill
• Cardiac Angiography Suite, JR
• Cardiac Physiology Outpatients, Horton (also achieved over 90% extremely likely)
• Children’s Outpatients, Horton (also achieved over 90% extremely likely)
• Children’s Outpatients, JR
• ECG Outpatients, JR (also achieved over 90% extremely likely)
• Lichfield Outpatients, JR (also achieved over 90% extremely likely)
• Lionel Cosin Outpatients
• John Warin ward, Churchill (also achieved over 90% extremely likely)
• Mayflower Suite, Horton
• Oxford Centre for Magnetic Resonance, JR
• Telemedicine, Churchill
• Trauma Physiotherapy Outpatients, JR (also achieved over 90% extremely likely)
• Vascular Labs, JR
• Ward 5A, JR
• Ward E, NOC (also achieved over 90% extremely likely)
• Ward F, NOC (also achieved over 90% extremely likely)
11.20. The teams have been congratulated for this excellent feedback and hard work.

Feedback for improvement

11.21. One of the Trust’s outpatient departments was selected for further analysis on feedback for improvement, based on May 2017 feedback.

11.22. There were 149 respondents, with an 85% recommend rate, and a 9% not recommend rate.

11.23. The themes identified in the feedback were:

- Specific comments about staff. Some of these suggested improvements and these have been fed back to the staff via the clinical lead for the department. Some of these comments were very positive and these will also be fed back to staff in July 2017.

- Waiting times in clinic. Two consultants have left the department, and the team is awaiting the appointment of another consultant. The team will ensure that patients are kept informed of delays, so that patients are able to leave the department and return in time for their appointment.

- The department’s waiting room gets very hot in summer due to the glass ceiling. Blinds have already been installed on the inside of the roof to prevent heat getting into the room. From June 2017, the team have agreed to open fire doors to increase air flow.

- Organisation/administration and staffing of reception. Due to vacancies and sickness, secretaries and the unit manager are currently covering the reception on a rotating basis. Notices have been put up to advise patients why there is not always reception cover. Recruitment is progressing as fast as possible. One member of staff has already been recruited and a start date is being arranged. The target date for recruiting another member of staff is July 2017.

11.24. The report from the annual staff Friends and Family Test 2016 highlights several issues experienced by staff in this department, particularly in relation to conflicting demands and team vacancies having an impact on their role.

National Inpatient Survey Update

11.25. The Care Quality Commission published national results for the 2016 National Inpatient Survey on 31st May.

11.26. The Trust’s average question score was 79.9 (a perfect score being 100) which is about the same as 2015 (79.3).

11.27. The Trust has performed better than most other Trusts on the question ‘Did you have confidence and trust in the doctors treating you?’ The Trust scored about the same as most other Trusts on all other questions and worse than most other trusts on no questions.

11.28. A full report detailing any changes since 2015 has been presented to the Trust Management Executive.

The Eye Hospital Project

11.29. This is a Patient Experience Improvement Project, which started in 2016, involving lay and staff steering group members and has the aim of improving the patient experience within the Oxford Eye Hospital.
11.30. Questionnaires were sent out to a sample of 594 eligible patients. 195 questionnaires have been received to date and responses are being collected and analysed. The Steering Group will meet at a workshop in July, facilitated by the Academic Health Sciences Network, to review the data and agree interventions for improvement. The questionnaire will be repeated after a set intervention period to measure impact.

12. PALS and Complaints

12.1. The Trust received 84 new formal complaints in May. This is an increase from the previous month (April n=67) and is also an increase from May last year (n=76).

12.2. Chart 29 shows the recent trends in complaint numbers for the last 12 months. The Neurosciences, Orthopaedics, Trauma and Specialist Surgery (NOTSS) Division has again received the highest number of complaints in May (n=26). There is a full breakdown of each Division’s complaints below.

Chart 29 – New Complaints by month/Division June 2016 to May 2017

12.3. The Trust received no red complaints in May.

12.4. The top five complaint themes for May include: clinical treatment (n=27), access to treatment or drugs (n=8), communication (n=10), values and behaviours (n=11) and admission and discharge (n=7).

12.5. The number of complaints has dropped overall over the last year due to the reduction in complaints for MRC and NOTSS.

Divisional Overview

Neurosciences, Orthopaedics, Trauma and Specialist Surgery (NOTSS)

12.6. NOTSS received 26 new complaints in May and remains the division with the highest number of complaints across the Trust, with 31% of the total complaints received. This is an increase when compared with the number of complaints received by NOTSS in April (n=23). When compared with the divisional activity, there were 0.07% complaints as a percentage of Finished Consultant Episodes (FCEs). The number of PALS contacts also continues to be high in comparison with the other divisions, with 64 contacts recorded in May (0.19% of FCEs).

12.7. The complaints in NOTSS relate to Neurosciences (n=7), Specialist Surgery (n=9) and Trauma and Orthopaedics (n=10).
12.8. 12 of the complaints received by NOTSS in May relate to clinical treatment, which is an increase from the number received in April (n=10). The issues include a delay in treatment/procedure, delay/failure to diagnose, injury sustained during treatment/procedure, a delay/failure to diagnose and a lack of clinical assessment.

12.9. Two of the complaints received relate to appointments, which is a decrease from the number of complaints received in April relating to the same topic (n=4). The issues raised pertain to appointment cancellations and appointment delays.

12.10. Three of the complaints were regarding admission and discharge, with the issues including discharge arrangements and cancelled/rescheduled surgery/procedure.

12.11. Three complaints relate to communication, which is an increase compared with April, when just one complaint related to communication. The issues raised in May were in relation to communication with a patient, incorrect information given and a breakdown in communication regarding an appointment.

12.12. Five complaints relate to values and behaviours, which is an increase in the number of complaints received by the Division for April (n=3). Issues include the attitude of medical staff and the attitude of other staff.

12.13. NOTSS received four reopened complaints in May which is the same number of reopened complaints received in April. The majority of these reopened complaints are requests for further information following the Trust’s initial response. A number of these reopened complaints will be further addressed in a resolution meeting.

12.14. Neurosciences directorate have undertaken considerable work to conclude the number of opened complaints. At the time of writing, the directorate had 29 open complaints. Of these, 15 have been drafted, reviewed by the divisional director and sent to the complaints team for final review and sign off. The directorate have developed a robust plan to conclude the remaining 14 and a future plan to manage the complaints thoroughly and speedily. This has been shared with the divisional leadership team and an update will be reported in the divisional Quality Report at Clinical Governance Committee in July. The backlog has caused the directorate and the complaints teams’ considerable concern and both teams have worked well together, with the leadership of the Interim Chief Nurse, to rectify and resolve the situation.

Surgery and Oncology (S&O)

12.15. S&O received 11 complaints in May, which was 0.04% of all Finished Consultant Episodes (FCEs) and 13% of the total complaints received by the Trust in the month. This is a decrease in the number of complaints received for the division when compared with April (n=14).

12.16. The complaints relate to Oncology and Haematology (n=2), Surgery (n=4), Transplant, Renal and Urology (n=3) and Gastroenterology, Endoscopy, and Churchill Theatres (n=2).

12.17. The complaints include issues related to clinical treatment (n=2) with the concerns raised including an injury sustained during treatment/operation and inappropriate treatment.

12.18. Three complaints regarding communication were received, which is a decrease from the number received in April (n=5). The issues surround
communication with relatives/carers, conflicting information given and a communication failure between departments.

12.19. Two complaints in relation to values and behaviours contained issues around a failure to act in a professional manner and the attitude of nurses/midwives.

12.20. One complaint was received in relation to prescribing, with the issue surrounding an adverse reaction to drugs.

12.21. S&O received one reopened complaint in May. The complainant has requested a meeting to discuss the findings within the initial complaint response.

**Medicine, Rehabilitation and Cardiac (MRC)**

12.22. MRC received 20 new complaints in May, which is an increase from the 11 formal complaints received in April. The complaints received in May equate to 24% of the total complaints received by the Trust during this month. It also equates to 0.06% of all Finished Consultant Episodes in May.

12.23. The complaints relate to Specialist Medicine (n=4), Acute Medicine (n=14) and Cardiac (n=2). Eight of the complaints for Acute Medicine relate to emergency care.

12.24. Three complaints received were in relation to Admission and Discharge with issues including a failure to admit and discharged too early.

12.25. Six complaints were related to Clinical Treatment, with issues including a delay/failure to diagnose, a dispute over diagnosis, a delay/failure to treat an infection, post-treatment complications and a failure to follow-up on observations/recognise a deteriorating patient.

12.26. Three complaints were regarding Communication, with the issues raised being in relation to safeguarding, breaking bad news and a communication failure between departments.

12.27. Three complaints regarding Patient Care were received, with the concerns surrounding food/hydration – left out of reach, cannulas left insitu upon discharge and call bell – failure to respond.

12.28. The Division received no reopened complaints in May requiring further investigation.

**Children’s and Women’s (C&W)**

12.29. C&W received 21 complaints in May; 0.06% of all FCEs and 25% of the total number of new complaints received by the Trust in the month. This is an increase in the number of new complaints received in comparison to the number received in April (n=13). The complaints related to Women’s (n=12) and Children’s Services (n=9).

12.30. Six complaints relating to Access to Treatment/Drugs were received with the issues surrounding the access to physiotherapy, cancelled operation/procedure, treatment delayed and a lack of availability of an operating theatre.

12.31. Nine complaints relating to Clinical Treatment were recorded with the issues related to birthing injuries, a delay/difficulty in obtaining clinical assistance, delay/failure in treating an infection, inadequate pain management, mismanagement of labour and wound dehiscence.

12.32. One complaint regarding communication was received – the issue was in relation to safeguarding.
12.33. Two complaints in relation to Values and Behaviours were received, with the issues surrounding the failure to act in a professional manner and the attitude of medical staff.

12.34. One reopened complaint was received for W&C in May which requires a further investigation/response.

Clinical Support Services (CSS)

12.35. CSS received three complaints in May, which is 3.5% of the total complaints received by the Trust this month. This is a decrease when compared with the number of complaints received in April (n=5). The complaints relate to Radiology and Imaging Services (n=1), Critical Care, Pre-op Assessment, Pain Relief and Resuscitation (n=1) and Pharmacy (n=1).

12.36. One complaint regarding prescribing was logged and was regarding the drugs/medication not available in Pharmacy.

12.37. Two other complaints received were regarding Values and Behaviours and the issues concerned the attitude of medical staff.

12.38. No reopened complaints were received in May for the division.

Corporate

12.39. Corporate division received three complaints in May, which is 3.5% of the total complaints received by the Trust in the month. This is an increase from the number received in April (n=1).

12.40. The complaints related to Facilities with the issues pertaining to car parking – availability.

12.41. One reopened complaint was received requiring a further written response.

13. Safe Staffing – Nursing and Midwifery

13.1 The Trust is required to report Staffing data for adult inpatient wards in acute hospitals. This report therefore includes the safe staffing data for May 2017 and the nurse sensitive indicators and HR quality metrics.

National reporting for Safe Staffing for November 2016

13.2 The summary of the figures submitted to NHS Choices via the Unify platform for May 2017 are included below and can be accessed via the Trust website on (http://www.ouh.nhs.uk/about/saferstaffinglevels.aspx).

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

13.4 Mitigation by exception is discussed below.

Unify data for November 2016

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

93.82% for Registered Nurses/Midwives

88.53% for Nursing Assistants (unregistered)
The Trust wide dashboard illustrates the ward by ward RAG rated staffing levels (appendix 3) for the day and night shifts. It should be noted that areas of increased temporary staff usage have had consistently high levels of minimum level staffing on shifts over the past year.

The Divisional RAG rated staffing (appendix 2) incorporates the human resource metrics and nurse/midwives sensitive indicators. This provides an overall staffing overview but does not include the skill mix, which is reported upon 6 monthly in the acuity reviews the next one is due to be submitted to the Quality Committee in August 2017.

Current status of nursing and midwifery staffing within the Trust
Areas of exception highlighted on the dashboards include (Appendix 2- divisional staffing):

The Adult Intensive Care Units

13.6. The Horton Hospital ICU has a vacancy rate of 30% for registered nurses and nursing assistants, which has increased since last month. The Nurse Sensitive Indicators on both sites however remain within an acceptable range, and active recruitment is underway.

The Neurosciences, Orthopaedics, Trauma & Specialist Surgery Division

13.7. This division has the highest rolling turnover of staff in the Trust which has remained consistent for the last two months. This has largely been due to the decision to hold vacancies when ward 6A was due to move into one of the neurosciences wards, but when that decision was changed, there was a resultant vacancy rate, which has also impacted on the turnover of staff. In addition there is a high use of temporary staff Neurosciences, Blenheim and 6A vascular are wards where shifts have been most at risk for staffing. Hospital acquired pressure ulcers have decreased this month despite this, but there are falls indicating that the vacancy rate, levels of temporary staff and staff turnover is having an effect. Recruitment has been successful to these areas recently and staff are expected to commence into post within the next few months. Further data is currently being collected and analysed, and weekly and daily staffing reviews take place at ward level to move staff and patients to mitigate risk.

The Children’s wards and gynaecology

13.8. The gynaecology directorate had significant vacancies at 20%, but with stable Nurse Sensitive Indicators. Although the vacancy factors in the children’s wards are not significant currently, the areas of note in relation to Nurse Sensitive Indicators include: New Born Care (NBC) a large unit caring for complex babies with high acuity. They had 13 medication incidents and 2 extravasation incidents. It should be noted that NBC undertake all the intravenous medicines for the babies on the maternity wards, who are each brought down to the unit several times a day. There was a category 3-4 Hospital acquired pressure ulcer on Melanie’s ward which is adolescent children.

Maternity unit (JR)

13.9. The shifts at risk are largely within the Delivery Suite, and Spires Midwifery Led Unit (MLU), which were mitigated through the movement of staff according to
the activity and acuity of women, indicated through the use of the Birthrate Plus tool which is reviewed four hourly. This is in order to be flexible and provide 1:1 care for women in labour, and midwives are moved from all areas of the maternity service to the Delivery Suite and the Spires. This will include midwives on call both for the hospital maternity service and the community maternity service. The maternity quality indicators are largely highlighted in the Delivery Suite, which is where the births occur, with no births on the wards which would be an adverse indicator. The overall rolling turnover on all the staff on the maternity wards and units is at 21.12% with a sickness rate of 6%.

The Medicine, Rehabilitation & Cardiac Division

13.10. This division has a consistently high rolling turnover of staff, with the division’s highest vacancy factors on Short Stay Ward, Cardiac Critical Care Unit, Emergency Admissions Unit and 7A.

Nurse Sensitive Indicators highlight the issues with this largely elderly frail group of patients with multiple co-morbidities. At the Horton General Hospital there were thirteen falls with harm, as well a category 3-4 hospital acquired pressure ulcer on Laburnum Ward, with relatively high levels of falls, against the rest of the division, with no harm over the last two months. There are discussions about temporary bed closures in order to prevent compromise to care quality, but with attention so as not to cause too much service disruption. Adams and Bedford ward had five low grade hospital acquired pressure ulcers which is consistent with last month; they also had twelve falls without harm which is an increase on last month.

The Acute General Medical and Stroke directorate is working with the Falls Quality Improvement Practice Educator to develop a number of initiatives including ‘Baywatch’ (registered nurses and nursing assistants always being present in a ward bay). This is also intended to improve the use of electronic documentation and a culture of being ‘paper light’ as there is insufficient room for patient files and hard copy nursing notes in the bays. High Impact training from incidents and the Fallsafe Care Bundle are being rolled out and implemented to address these issues, within a particularly elderly frail patient group with cognitive challenges. It should be noted that there has been a significant decrease in high impact falls over the past year, and the work of the Quality Improvement Falls Prevention Educator was noted by the CQC in their recent report.

The Surgery & Oncology Division

13.11. Staffing levels at recommended establishments on Surgery & Oncology wards at the Churchill Hospital continue to be a challenge.

The wards with the highest vacancies include Oncology Ward and Upper GI Ward. A combination of vacancies on specialist wards coupled with a poor fill rate from NHSP (temporary staffing bank), and a high cancellation rate on the same day by temporary workers has led to staffing levels on wards being ‘at risk’ on several occasions, but also consistently registering minimum levels. The risks are mitigated as much as possible by co-locating patients with similar acuity and dependency requirements, the use of non-ward based nurses to support the ward teams during the day and moving staff on a daily basis to the wards with the greatest need. Several wards have beds closed in order to mitigate the reduced levels of staffing until new recruits are in post. Nurse Sensitive Indicator’s highlights include highest levels of falls in division without harm on Haematology Ward,
Urology Ward and Sobell House Hospice, high levels of category 1-2 HAPU on Oncology Ward and SEU, (Surgical Emergency Unit), F.

**Care Hours per Patient Day (CHPPD) (appendix 4)**

13.12. This document highlights the number of care hours patients actually receive by registered nurse/midwife and nursing assistants within a 24 hour period. This is reported by ward, as well as the % of fill rate of the same and submitted to the national Unify database.

13.13. The levels of CHPPD nationally in more generic wards are between 6-8 hours/24 hours per patient day. The highest levels are in the intensive care units and high areas of high dependency care within ward areas i.e. Paediatric High Dependency Unit, Newborn Care and NOC HDU. However, it is notable that there are areas of very low care hours in the Trust including:

13.14. At the Horton General Hospital on Juniper ward 3.8/24 hours and Laburnam 3.7/24 hours as well as Maternity level 5&6 at the John Radcliffe Hospital site at 2.5 &2.7/24 hours and OCE 3.9/24

**Other Safe Staffing reviews**

13.15. The Trust has carried out an exercise to review of the optimal levels of staffing within the John Radcliffe Hospital Emergency Department (ED) using a nationally validated patient acuity tool. The results will be presented in August 2017 Quality Committee.

The next inpatient acuity review is currently being validated and includes six months data, this will also be presented in August 2017 Quality Committee.

The Trust is planning a review of the midwifery establishments utilising the toolkit within the midwifery services NICE guidance in the next two months.

The IPAMS, (Integrated Patient Acuity Monitoring System), tool is being used to measure theatre staffing; roll out to all theatres is almost complete with the exception of Women’s Services Theatres. This is reporting on progress to the Cross Divisional Theatre Group.

Safe Staffing Board and Quality Committee reports and dashboards are under review. The inclusion of indicators such as Friends and Family test, complaints, appraisal rates and staff survey as well as the Perfect Ward project in line with National standards

**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**

**Andrew MacCallum , Chief Nurse**
Report prepared by:
Dr Clare Dollery - Deputy Medical Director
Liz Wright - Deputy Chief Nurse
Helen Cobb - Head of Clinical Governance
Caroline Heason - Safeguarding & Patient Services Manager
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)
Maternity HR Metrics:
- All Falls: 9.68%
- Cat 3&4 HAPU: 0.03%
- RN Rolling Turnover: 21.12%
- Meds: 6.0%
- Extravasation: 0.03%
- Falls with Harm: 0.01%
- Mat/Adoption leave as % of SIP: 3.48%
- Em LSCS as % of total births: 0.04%

May Safe Staffing and HR Metrics:
- Maternity HR Metrics:
  - RN and CSW Monthly Sickness %: 6.0%
  - Vacancy %: 0.0%
  - Agreed: 100%

Maternity HR Metrics:
- Delivery on ward - Levels 5, 6 and 7: 0.0%
- 3rd & 4th deg tears – % of total births: 0.0%
- Delivery on ward - Levels 5, 6 and 7: 0.0%
- 3rd & 4th deg tears – % of total births: 0.0%
- Hospital acquired CTS: 0.0%
- Ventilator and Paerent: 0.0%

Maternity NRIs:
- All Falls: 9.68%
- Cat 3&4 HAPU: 0.03%
- RN Rolling Turnover: 21.12%
- Meds: 6.0%
- Extravasation: 0.03%
- Falls with Harm: 0.01%
- Mat/Adoption leave as % of SIP: 3.48%
- Em LSCS as % of total births: 0.04%

Maternity NRIs:
- Delivery on ward - Levels 5, 6 and 7: 0.0%
- 3rd & 4th deg tears – % of total births: 0.0%
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- 3rd & 4th deg tears – % of total births: 0.0%
- Hospital acquired CTS: 0.0%
- Ventilator and Paerent: 0.0%

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- Meds: 6.0%
- Extravasation: 0.03%
- Falls with Harm: 0.01%
- Mat/Adoption leave as % of SIP: 3.48%
- Em LSCS as % of total births: 0.04%

Maternity NRIs:
- Delivery on ward - Levels 5, 6 and 7: 0.0%
- 3rd & 4th deg tears – % of total births: 0.0%
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- 3rd & 4th deg tears – % of total births: 0.0%
- Hospital acquired CTS: 0.0%
- Ventilator and Paerent: 0.0%
Safe Staffing for Nursing at OUH NHS Foundation Trust
May 2017

Registered Nurses Average Fill = 93.82
Unregistered Nurses Average Fill = 88.53

Safe Staffing Inpatient wards - May 2017 Day shifts

Agreed
Minimum
At Risk

% Staffing Levels

Safe Staffing Inpatient wards - May 2017 Night shifts

Staffing Levels for each Ward showing % of total hours that were filled by Bank and Agency Staff in May 2017

% of total hours filled by Bank and Agency staff

Agreed
Minimum
At Risk

% Staffing Levels
**Care Hours per Patient Day**  
**May 2017**

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Average fill rate - Registered Nurse/Midwife (%) Day</th>
<th>Average fill rate - Nursing Assistant (%) Day</th>
<th>Average fill rate - Registered Nurse/Midwife (%) Night</th>
<th>Average fill rate - Nursing Assistant (%) Night</th>
<th>Cumulative count over month of patients at 23:59</th>
<th>Registered Nurse/Midwife</th>
<th>Nursing Assistants</th>
<th>Total Care Hours per Patient Day</th>
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<td>86.5%</td>
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<td>91.7%</td>
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<td>97.8%</td>
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<td>74.9%</td>
<td>87.0%</td>
<td>100.0%</td>
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<td>6.4</td>
<td>2.0</td>
<td>8.4</td>
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<td>87.2%</td>
<td>97.4%</td>
<td>100.0%</td>
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<td>2.1</td>
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<td>Ward SF</td>
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<td>100.0%</td>
<td>100.0%</td>
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<td>83.9%</td>
<td>94.6%</td>
<td>90.3%</td>
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<td>79.6%</td>
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<td>5.5</td>
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<tr>
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<td>95.2%</td>
<td>93.9%</td>
<td>591</td>
<td>5.1</td>
<td>2.7</td>
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**NOTES**

- **Registered**
- **Nursing Assistant**
- **Tom’s**

- **MRC**
  - John Warin: 89.1% 93.1% 90.6% 100.0%
  - Juniper: 90.8% 92.2% 98.4% 100.0%
  - Laburnum: 97.8% 98.1% 100.0% 98.6%
  - Ward 5A: 78.2% 84.3% 98.4% 100.0%
  - Adult CF: 85.3% 92.0% 96.8% 100.0%
  - Stroke: 89.7% 96.5% 98.5% 100.0%
  - Short Stay: 96.0% 96.2% 99.2% 100.0%
  - Ward 7A: 95.5% 92.7% 96.0% 75.8%
  - Ward 7B: 95.2% 95.2% 100.0% 100.0%
  - Ward 7C: 93.8% 86.4% 95.3% 83.3%
  - Ward 7D: 90.3% 87.8% 97.6% 100.0%
  - Osteo Chest: 88.1% 85.8% 97.4% 98.9%
  - Adam’s: 93.0% 89.3% 95.4% 100.0%
  - Cardiology: 86.6% 83.8% 98.5% 100.0%
  - Cardiothoracic: 83.3% 98.4% 98.7% 83.9%
  - CTVCC: 100.0% 99.0% 99.8% 96.4%
  - OCE: 79.8% 78.9% 98.5% 98.3%

- **Maternity**
  - Maty L5: 95.4% 89.4% 98.7% 98.5%
  - Maty L6: 87.6% 97.7% 100.0% 79.0%
  - Maty LT: 99.3% 74.2% 100.0% 83.9%
  - Maternity OA: 100.0% 95.3% 100.0% 96.8%
  - Spires: 96.7% 97.4% 84.7% 100.0%
  - Delivery: 85.4% 70.6% 95.9% 52.3%

- **CSS**
  - Norton: 94.1% 100.0% 100.0% 100.0%
  - Adult ICU: 97.7% 97.6% 98.0% 89.3%

- **Children’s and Gynae**
  - Horton Children’s: 100.0% 81.3% 93.6% 100.0%
  - Bell Drayson: 98.5% 93.8% 98.4% 85.3%
  - Gyna: 100.0% 100.0% 100.0% 98.3%
  - Kamran’s: 97.2% 100.0% 100.0% 98.2%
  - Melanie’s: 100.0% 87.9% 98.9% 100.0%
  - Newborn ICU: 97.6% 99.1% 99.1% 99.1%
  - Paed HDU: 97.6% 81.8% 98.4% 82.5%
  - Paed ICU: 96.8% 83.3% 91.1% 100.0%
  - Robin’s: 90.0% 78.3% 98.9% 100.0%
  - Tom’s: 88.0% 100.0% 100.0% 100.0%
Appendix 5: Patient experience dashboard

NHS trusts with 100 or more responses have been included.

NHS trusts with 100 or more eligible patients have been included.
Complaints

New complaints

This includes all PALS enquiries and issues: positive, negative, or mixed feedback; issues for resolution; and advice or information requests.

Managing complaints

Reopened complaints

Reopened complaints: Apr 17

% Complaints investigations completed within agreed timescales

% Complaints upheld or partially upheld

% Complaints acknowledged within 3 days