## Trust Board Meeting in Public: Wednesday 8 March 2017

**TB2017.28**

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

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Executive Summary

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.

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

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.

5. Issues raised by Oxfordshire Clinical Commissioning Group (OCCG):
   Test results and discharge summaries timeliness continues to be an area of significant work. In January 79% of discharge summaries were sent before or within 24 hours of discharge and 81.6% of results endorsed on EPR within 7 days. These are both within the agreed OCCG trajectories.
   GP feedback collated from the OCCG DATIX system is reported.

6. Patient Safety and Clinical Risk:
   No Never Events were reported in January. 5 Serious Incidents Requiring Investigations (SIRIs) were reported in January; one SIRI was downgraded. 5 SIRIs were sent to the OCCG for closure in January 2017 and 9 SIRIs were closed by the OCCG in the OCCG/OUHFT closure meetings.
   Four Executive quality walk rounds took place in January.

7. Clinical Effectiveness:
   There have been no new mortality outliers reported for OUHFT by the CQC or the Dr Foster Unit at Imperial College.
   The current SHMI for the data period July 2015 to June 2016 is 0.96 which is improved from 0.99. The SHMI remains within the ‘as expected’ range. The HSMR is 100 for period November 2015 to October 2016. The value is ‘within expected’ range.

8. Infection Control:
   For January 2017 there were 4 cases of C.difficile against an internal monthly ceiling of 6. The OUHFT currently remains within trajectory for the year. The internal cumulative total for January 2016 is 47 cases against a cumulative limit of 59.
   There was a post 48 hours admission MRSA positive blood culture which has been deemed as avoidable by Oxfordshire Clinical Commissioning Group.
   Candida auris - screening of the Neurointensive care patients continues to identify newly colonised patients.
   Serratia marcescens - the outbreak has now been closed.

9. Patient Experience:
   The improvements in patient feedback for the Emergency Departments continued in January 2017.
The recommend rate is the highest recorded and the not recommend rate is the lowest since this feedback has been received by the Trust. The scores are well above the national average.

The CSS response rate for inpatients and day cases has increased significantly. This report also includes additional analysis of feedback from patients FFT for Outpatients, Inpatients and Day Case areas, in order to explore the data in more depth.

PALS and Complaints:
The Trust received 81 new formal complaints in January. This is an increase from the previous month (n=67).

No red complaints were received in January.

NOTSS continue to have the highest number of complaints, with (N=27) received in January although this has been a slight decrease in complaints when compared with the previous month (n=28). (Appendix 2)

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:
November – January 2017 dashboard data for all the divisions and the Trust as a whole on safe staffing with HR metrics and Nurse Sensitive Indicators (Appendix 4) Reports by exception on the dashboards are by division. The summary of the January 2017 Unify submission of staffing The six month review of acuity and dependency IPAMS data is reported on Appendix 5.

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. **National Quality Strategy Updates**

2.1. The Nuffield Trust has published a research summary of ‘The London Quality Standards – a case study in changing clinical care’

2.2. The London Quality Standards (LQS) were conceived to reduce variation and improve quality of care.

2.3. In 2011, London Health Programmes, a coalition between NHS London and London’s primary care trusts (PCTs), embarked on a London-wide attempt to improve the quality of acute and emergency care. The primary vehicle for improvement was the development and implementation of professional consensus standards, the London Quality Standards (LQS).

2.4. The standards set out the minimum quality of care that patients with medical illnesses should expect when admitted to hospital.

2.5. The key findings below are the opinion of the authors of the report

2.6. The LQS worked well as a means to raise awareness of the deficits in emergency care, and drove forward change at a local level, but primary statistical analysis was unable to establish a link between the implementation of the standards and consistent improvements in patient outcomes.

2.7. While there was strong evidence behind the need for change, there was little evidence available that compliance with the LQS would reliably improve outcomes. Caution should be exercised in developing mandatory input standards where the evidence for the prescribed interventions is limited or partial.

2.8. Where the LQS were implemented, this was heavily driven from the bottom up by clinicians convinced by the case for change, rather than by top-down processes or commissioning mechanisms.

2.9. The authors report their study revealed marked deficiencies within hospitals around complex change management, including: an almost complete disconnection between frontline clinicians and senior managerial staff; a lack of knowledge around, and failure to consistently use, change management/quality improvement tools; a heavy reliance on individuals.

2.10. The combination of rising service pressures and clinician burnout emerged as a major barrier to change.

2.11. The authors state many of the perceived weaknesses in the programme appeared to stem from the insertion of commissioning into the process. Primarily, the commissioners did not appear to understand the workforce and financial implications of complying with the standards.
2.12. In some areas, threatened penalties for non-compliance with the standards were used by some CCGs to drive service reconfiguration. This became a governing motive for some hospitals and pushed aside the original aim of improving patient safety, demotivating some staff. It also proved an unreliable driver, as hospitals eventually came to see the threat as empty. Professional standards that describe complex behaviours should not be used rigidly nor have major penalties attached without a detailed exploration of the potential for unintended consequences and perverse behaviours.

2.13. The use of peer audit was seen as helpful to drive the implementation of the standards.

2.14. Comments from OUH perspective:

   2.14.1. These standards were only applied in London and not in Oxfordshire.

   2.14.2. Important conclusions include the need for an evidence base, where available to support change; the need for consistent use of quality improvement methods; the potentially negative impact on a quality improvement culture of introducing performance penalties; the impact of clinician burnout on quality improvement.

3. **Update on progress against the Trust Quality priorities**

3.1. The place of our priorities in the domains of patient safety, clinical effectiveness and patient experience is shown in Chart 1.

![Chart 1](image)

3.2. Updates on the Quality Priorities against the goals set out in the Quality Account are shown in Table 1. These were presented to the February Quality Committee.
### Table 1: Updates on the Quality Priorities

<table>
<thead>
<tr>
<th>Priority</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicines safety</td>
<td>Compliance with the safe and secure storage of medicines standards has not achieved 100% of the target but action plans are being monitored and progress challenged in the Clinical Governance Committee. 190 patient related medication incidents were reported in December 2016 (against the target for a 15% increase of 273 per month) (Source, Datix). The 10% overall harm reduction has been achieved and 20% reduction in 3 of the 4 target areas. The target areas that have achieved a reduction are insulin, antimicrobial and delayed and omitted prescribed medicines. Anticoagulation has not achieved a reduction in the number of incidents of moderate and greater harm (Source, Datix).</td>
</tr>
<tr>
<td>Improved recognition, prevention, and management of Acute Kidney Injury (AKI)</td>
<td>A Trust AKI education strategy has been finalised to define how education involving all staff is provided. The associated materials are being rolled out in pilot areas of high AKI incidence. The pharmacy drug review tool has been incorporated into the Electronic Patient Record, and has been piloted successfully. It will be rolled out across the Trust during the final quarter of 2016-17.</td>
</tr>
<tr>
<td>Recognition and treatment of sepsis</td>
<td>Sepsis Agent: the electronic sepsis screening tool is now performing reliably after ‘bugs’ identified during the pilot period have been fixed. Widespread adoption of the Clinical Worklist in PowerChart remains a key priority for inpatients to support this and other work. Admission screening: 91% of emergency adult admissions were screened for sepsis in Q3; with 55% of patients receiving antibiotics within an hour and having their antibiotic prescription reviewed within 72 hours (compared with 52% in Q2). Inpatient screening: 99% of adult inpatients met the local screening criteria target (compared with 75% in Q2) and 45% of patients received antibiotics within an hour and had their antibiotic prescription reviewed within 72 hours (compared with 25.9% in Q2). These figures have meant that the Trust has achieved the CQUIN targets for Q3.</td>
</tr>
<tr>
<td>Care 24/7</td>
<td>100% of patients were reviewed by consultants twice daily in intensive and high dependency areas. The Trust is in a good position to meet the Care 24/7 Quality Priority by the target date, the main area of risk concerned standard 2 (first consultant review in 14 hours). However, audits conducted in October 2016 showed excellent results with an improvement on Standard 2 – review within 14 hours to above 99% (compared with 90% in October 2016). The OUH performs well against other Trusts in relation to diagnostics and interventions and access to intervention (Standards 5 and 6). Further work is being undertaken by the Transformation Team to streamline the Echocardiogram pathway and streamline its services across the Trust.</td>
</tr>
<tr>
<td>SEND [System for Electronic Notes]</td>
<td>SEND has been fully rolled out according to plan and is in use. Work to understand the effects and impact of the roll-out are continuing.</td>
</tr>
<tr>
<td>Priority</td>
<td>Progress</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Documentation project</td>
<td>Human factors training is on target to deliver 18 courses and train 50 champions. The Human Factors course follow up survey has been sent out to 120 participants. There has been just over a 50% response rate. The results are being analysed.</td>
</tr>
<tr>
<td>Human factors (HF) training</td>
<td>Additional staff have been recruited to deliver the EOLC project this includes a Consultant pharmacist a Chaplain and a Medical consultant. The EOLC team is working with adult ICU (Teaching, collecting data to understand patient flows and undertaking patient review). Improved feedback from families: A bereavement questionnaire has been developed and piloted with a plan for the bereavement service to give it to all families from January 2017. Staff confidence, skills and knowledge: Teaching – Adult ICU, Medical Director’s grand round December 2016 and more sessions are planned for AGM registrars and the NOC in 2017. The Education plan has been written with some work on different tiers for different staff groups.</td>
</tr>
<tr>
<td>End of life care (EOLC)</td>
<td></td>
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<tr>
<td>Dementia care</td>
<td>The current dementia screening rates are 64.1% against a target of 90% (compared with 62.5% in the last report) (source, ORBIT+). Significant work is being carried out to improve compliance. Q3 figures for the relevant staff trained for tier 1 dementia training were 61.3% against a target of 75% (this has improved from 47% reported last time). Currently for this financial year 61.2% of frontline staff have been trained against a target of 50% for the year (this compares with 52% in the last report to Quality Committee).</td>
</tr>
<tr>
<td>Compassionate Care</td>
<td>From 10th November – 24th January, 3 training dates for Delivering Compassionate Care were held at the Trust. In total, 42 employees attended the training on Delivering Compassionate Care increasing the numbers trained to 1277. An additional 17 training courses are scheduled until the end of March 2017 (272 spaces) allowing the Trust to meet the objective of over 1500 people trained.</td>
</tr>
<tr>
<td>Stakeholder engagement and partnership working (health systems interface)</td>
<td>The Trust continues to participate in the Sustainability and Transformation Plan (STP) Information about discharge summaries and test results endorsement is covered elsewhere in this report (source, Orbit). A discharge workshop was run at the Horton Hospital to reduce the number of delayed transfers of care by earlier and comprehensive discharge planning.</td>
</tr>
</tbody>
</table>

4. **CQUIN**

4.1. The Trust submitted the Q3 specialised commissioning CQUINs in full and to deadline.
4.2. Performance for Q1 and Q2 was 100% but some targets will be missed in Q4.

4.3. Flu vaccine uptake for front line clinical staff was 65.3% at end January 2017.

4.4. OCCG have noted that the 50% threshold for the flu vaccine CQUIN has been met.

5. **Key Quality Metrics**

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

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

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

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

**Indicators deteriorating or red rated**

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

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

5.5.2. PS14 – % Radiology routine request 7 day access - Plain Film, CT, MRI & Ultrasound [one month in arrears]

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

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

5.5.5. PE14 - Single sex breaches

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

**Indicators improving**

5.6. 3 indicators have improved against target since the last reporting cycle:

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

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

5.6.3. CE06 - ED - % patients seen, assessed and discharged / admitted within 4h of arrival (Amber).

<table>
<thead>
<tr>
<th>BQR ID</th>
<th>Rating</th>
<th>Rating Last Period</th>
<th>Descriptor</th>
<th>Period</th>
<th>Threshold Source</th>
<th>Red</th>
<th>Amber</th>
</tr>
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**Table 2: Key Quality Metrics**
<table>
<thead>
<tr>
<th>Indicator Code</th>
<th>Score</th>
<th>Grade</th>
<th>Description</th>
<th>Baseline</th>
<th>Date</th>
<th>Source</th>
<th>Target</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>PS01</td>
<td>97.57%</td>
<td>Green</td>
<td>Safety Thermometer (% patients receiving care free of any newly acquired harm) [one month in arrears]</td>
<td>Jan 17</td>
<td>Internal</td>
<td>95%</td>
<td>97%</td>
<td></td>
</tr>
<tr>
<td>PS02</td>
<td>93.87%</td>
<td>Green</td>
<td>Safety Thermometer (% patients receiving care free of any harm - irrespective of acquisition) [one month in arrears]</td>
<td>Jan 17</td>
<td>Internal</td>
<td>91%</td>
<td>93%</td>
<td></td>
</tr>
<tr>
<td>PS03</td>
<td>98.92%</td>
<td>Green</td>
<td>VTE Risk Assessment (% admitted patients receiving risk assessment)</td>
<td>Dec 16</td>
<td>National</td>
<td>95%</td>
<td>95.25%</td>
<td></td>
</tr>
<tr>
<td>PS04</td>
<td>11 N/A</td>
<td></td>
<td>Serious Incidents Requiring Investigation (SIRI) reported via STEIS</td>
<td>Dec 16</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>PS05</td>
<td>47</td>
<td>Green</td>
<td>Number of cases of Clostridium Difficile &gt; 72 hours (cumulative year to date)</td>
<td>Jan 17</td>
<td>National</td>
<td>59</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>PS06</td>
<td>5 Red</td>
<td></td>
<td>Number of cases of MRSA bacteraemia &gt; 48 hours (cumulative year to date)</td>
<td>Jan 17</td>
<td>National</td>
<td>1</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>PS07</td>
<td>95.35%</td>
<td>Green</td>
<td>Antibiotic prescribing - % compliance with antimicrobial guidelines [most recently available figure, undertaken quarterly]</td>
<td>Jan 17</td>
<td>Internal</td>
<td>93%</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>PS08</td>
<td>82.35%</td>
<td>Red</td>
<td>% patients receiving stage 2 medicines reconciliation within 24h of admission</td>
<td>Jan 17</td>
<td>Internal</td>
<td>75%</td>
<td>85%</td>
<td></td>
</tr>
<tr>
<td>PS09</td>
<td>100%</td>
<td>Green</td>
<td>% patients receiving allergy reconciliation within 24h of admission</td>
<td>Jan 17</td>
<td>Internal</td>
<td>94%</td>
<td>96%</td>
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</tr>
<tr>
<td>PS10</td>
<td>0.7%</td>
<td>Green</td>
<td>% of incidents associated with moderate harm or greater</td>
<td>Jan 17</td>
<td>Internal</td>
<td>6.5%</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>PS11</td>
<td>93 N/A</td>
<td></td>
<td>Total number of newly acquired pressure ulcers (category 2,3 and 4) reported via Datix</td>
<td>Dec 16</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
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<tr>
<td>PS12</td>
<td>2</td>
<td>Green</td>
<td>Falls leading to moderate harm or greater</td>
<td>Jan 17</td>
<td>Internal</td>
<td>8</td>
<td>7</td>
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<tr>
<td>PS13</td>
<td>50.91%</td>
<td>N/A</td>
<td>Cleaning Score - % of inpatient areas with initial score &gt; 92%</td>
<td>Jan 17</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>PS14</td>
<td>86.48%</td>
<td>Red</td>
<td>% Radiology direct access 7 day turnaround times - Plain Film, CT, MRI &amp; Ultrasound</td>
<td>Dec 16</td>
<td>Commissioner</td>
<td>95%</td>
<td>98%</td>
<td></td>
</tr>
<tr>
<td>PS16</td>
<td>0</td>
<td>Green</td>
<td>CAS alerts breaching deadlines at end of month and/or closed during month beyond deadline</td>
<td>Jan 17</td>
<td>Internal</td>
<td>1</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>PS17</td>
<td>2 Red</td>
<td></td>
<td>Number of hospital acquired thromboses identified and judged avoidable</td>
<td>Jan 17</td>
<td>Internal</td>
<td>1</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>CE01</td>
<td>0.99</td>
<td>N/A</td>
<td>Standardised Hospital Mortality Ratio (SHMR) [most recently published figure, quarterly reported as a rolling year ending in month]</td>
<td>Mar 16</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
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<tr>
<td>CE02</td>
<td>238 N/A</td>
<td></td>
<td>Crude Mortality</td>
<td>Jan 17</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>CE03</td>
<td>64.1%</td>
<td>Red</td>
<td>Dementia - % patients aged &gt; 75 admitted as an emergency who are screened [one month in arrears]</td>
<td>Dec 16</td>
<td>National</td>
<td>80%</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>CE04</td>
<td>100%</td>
<td>Amber</td>
<td>Dementia diagnostic assessment and investigation [one month in arrears]</td>
<td>Dec 16</td>
<td>Internal</td>
<td>80%</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>CE06</td>
<td>91.05%</td>
<td>Amber</td>
<td>ED - % patients seen, assessed and discharged / admitted within 4h of arrival</td>
<td>Dec 16</td>
<td>National</td>
<td>85%</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>PE01</td>
<td>89.56%</td>
<td>N/A</td>
<td>Friends &amp; Family test % likely to recommend - ED</td>
<td>Dec 16</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>PE02</td>
<td>6.13%</td>
<td>N/A</td>
<td>Friends &amp; Family test % not likely to recommend - ED</td>
<td>Dec 16</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>PE03</td>
<td>96.16%</td>
<td>N/A</td>
<td>Friends &amp; Family test % likely to recommend - Mat</td>
<td>Dec 16</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>PE04</td>
<td>0.23%</td>
<td>N/A</td>
<td>Friends &amp; Family test % not likely to recommend - Mat</td>
<td>Dec 16</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>PE05</td>
<td>95.7%</td>
<td>N/A</td>
<td>Friends &amp; Family test % likely to recommend - IP</td>
<td>Dec 16</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>PE06</td>
<td>1.42% N/A</td>
<td>Friends &amp; Family test % not likely to recommend - IP</td>
<td>Dec 16</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
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<tr>
<td>PE07</td>
<td>95.07% N/A</td>
<td>Friends &amp; Family test % likely to recommend - OP</td>
<td>Dec 16</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
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<tr>
<td>PE08</td>
<td>2.49% N/A</td>
<td>Friends &amp; Family test % not likely to recommend - OP</td>
<td>Dec 16</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PE14</td>
<td>4 Red</td>
<td>Green Single sex breaches</td>
<td>Jan 17</td>
<td>National</td>
<td>3</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PE15</td>
<td>51.05% Red</td>
<td>Red % patients EAU length of stay &lt; 12h</td>
<td>Jan 17</td>
<td>Internal</td>
<td>65%</td>
<td>70%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PE16</td>
<td>52.53% N/A</td>
<td>% Complaints upheld or partially upheld [Quarterly in arrears]</td>
<td>Dec 16</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
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Exception charts

Chart 2: PS06 Number of cases of MRSA bacteraemia > 48 hours (cumulative year to date)

In January 2017 there was one avoidable MRSA bacteraemia. It is not thought that this was a clinically significant bacteraemia but more likely to have been a contaminant. Therefore this bacteraemia has been deemed avoidable and apportioned to the OUH.

The yearly limit is 0 avoidable bacteraemia, to date there have been 4 avoidable bacteraemia and 1 unavoidable reported.

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

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

Overall non-compliant for routine (R) 86.5% and urgent (U) 67% scans.

In summary for the specific modalities: Plain film (R81%, U53%), CT (R91%, U99.2%), MRI (R82%, U96%) and Ultrasound (R99.2%, U99.5%). 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 have been commissioned to support the timely scanning of patients.

Work is on going to refit neuroradiology suite with installation which commenced on 17 December 2016 and is on target for re-opening on 30 January 2017. The unit opened as planned on 1 February 2017.

95% of routine radiology reports received by the requesting clinician within 7 calendar days of the examination date.
Electronic-VTE risk assessment for all inpatients was updated 11/12/16. The new version ‘links’ the recommended outcome of the eVTE risk assessment to e-prescribing. This should make documentation of the e-VTE risk assessment more relevant, and make prescription and documentation easier.

The quarterly pharmacy led audit of ‘appropriate thromboprophylaxis’ which was initiated in July 2016 provides clinical areas with robust data and upskills pharmacists with regard to VTE prevention—the latest audit from January 2017 shows improvement with Trust overall at 96.7% ‘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].

S&O figures have increased since August from 52% - 71.4%. Initiatives included the identification of dementia champions to provide local support. In Gastro this resulted in 100% compliance over 3 months. Meetings have taken place as part of the doctor’s induction in nephrology in order to improve. NOTSS saw a reduction in their Divisional compliance for this indicator to 62.6%.

MRC trained junior medical staff in cognitive screening on the EPR system. MRC compliance was 63.5% in January 2016.

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.
The Stroke service had mixed sex breaches due to the large volume of stroke patients that required admission to the stroke unit. As a result of this demand stroke patients had to be moved off the stroke unit regularly onto other wards which is a clinical risk for those patients but it is a greater risk to not admit a stroke patient to a stroke ward.

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

Chart 7: PE15 % patients EAU length of stay < 12h

Length of stay for the Emergency Assessment Unit remains challenging due to difficulties relating to patient flow. The MRC leadership team is running three times daily review meetings to improve flow. Patients under psychological medicine have seen improved flows with increased input from Oxford Health Duty Managers.

EAU is an assessment area and the majority of patients should either be admitted or discharged promptly following assessment.
6. Matters for attention of the Board

WHO Compliance

6.1. Chart 8 shows the compliance with the WHO checklist by Division and in specific divisional areas. These audits were paper-based. Table 3 provides the narrative where compliance is below 100%.

Chart 8: WHO Checklist compliance January 2017

Table 3: WHO Checklist January 2017

<table>
<thead>
<tr>
<th>Division</th>
<th>Compliance</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>C&amp;W</td>
<td>93.8%</td>
<td>Consultants responsible have been identified and informed of the incomplete WHO forms. Governance team contact staff responsible and discuss what is required to improve compliance. Any on-going issues are escalated to the Divisional Director.</td>
</tr>
<tr>
<td>CSS</td>
<td>98.8%</td>
<td>In January 2017 there were 332 WHO checklists audited in the Division. The compliance rate was below the KPI at 98.8%. There were four partial compliances; 2 in JR theatres, one where partially complete ‘Sign In’ and the second signatures were omitted from ‘Time Out’ and ‘Sign Out’ sections. 2 in West Wing, one where the procedure details were not clear and checklist not fully completed and the second where ‘Sign Out’ signature was missing and checklist was not fully completed. The teams have been made aware of the partial compliances. All the other areas achieved 100% compliance.</td>
</tr>
<tr>
<td>MRC Cardiology</td>
<td>98%</td>
<td>In Cardiology, one SIGN IN was not done - the nurse had crossed out the section and written ‘PPCI’ - Primary Percutaneous coronary intervention (coronary angioplasty). The SIGN IN section should be done for all cases even emergencies and this was explained to the nurse. The new form designed specifically for ANGIO/PCI (PCI - Percutaneous Coronary Intervention) is more applicable to PPCI which should help with engagement and compliance. This form was launched in February.</td>
</tr>
</tbody>
</table>

7. Issues raised by OCCG

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

7.2. The latest data for January 2017 show 79% of discharge summaries were sent before or within 24 hours of discharge, this is a slight improvement on the
December figure of 77.5% and exceeds the agreed OCCG trajectory of 78%. For results endorsed on EPR, 81.6% were endorsed within 7 days (note it is possible to review a result and not endorse it). This is an improvement on December’s performance at 78.5% and exceeds the agreed OCCG trajectory of 75%.

7.3. Feedback for January 2017 received by the OCCG from GPs is summarised in the table 4 below. A total of 43 records of GP feedback were received by the OCCG regarding the Trust in January, this is below the average for this current financial year (113/month). The top 3 themes account for 30% of all feedback received over the month. For the rest of the feedback there were only 2 responses over 7 categories.

7.4. ‘Delay / difficulty in obtaining clinical assistance’ was the most frequently reported type of feedback in January.

**Table 4: GP Feedback – Top 3 thematic areas**

<table>
<thead>
<tr>
<th>Theme</th>
<th>November 2016</th>
<th>December 2016</th>
<th>January 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delay / difficulty in obtaining clinical assistance</td>
<td></td>
<td>19</td>
<td>5</td>
</tr>
<tr>
<td>Delay in GP receiving clinical docs (i.e. OPD/Discharge letters)</td>
<td>6</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Failure in referral process due to pathway issue</td>
<td>3</td>
<td>6</td>
<td>3</td>
</tr>
</tbody>
</table>

8. **Patient Safety and Clinical Risk**

**Clinical Risk**

8.1. In relation to Patient Safety and Clinical Risk:

8.1.1. There were no Never events declared in January 2017

8.1.2. 5 Serious Incidents requiring Investigation (SIRI’s) were reported onto STEIS in January 2017

8.1.3. 5 SIRI’s were submitted for closure to the Oxfordshire Clinical Commissioning Group (OCCG) in January 2017. All 5 SIRI’s were sent to the OCCG within the agreed timeframe.

8.1.4. One SIRI closure meeting took place between the Trust and the OCCG in January 2017 and 9 SIRI’s were closed by OCCG.

8.1.5. One SIRI was downgraded in January 2017

8.1.6. The incident downgraded was an information governance breach which on investigation did not meet criteria for a SIRI

8.2. The following graphs provide an update on SIRI activity.
Chart 9: OUH incidents showing level of harm and total numbers for each level of harm

![OUH Incidents by Reported Date Showing Level of Harm](chart9.png)

Chart 10: SIRIs declared and completed in the last 13 months

![SIRIs Declared and Completed](chart10.png)

Chart 11: SIRIs declared by Division during last 13 months

![SIRIs Declared by Division](chart11.png)

8.3. Chart 11 shows that each Division within the Trust (with the exception of MRC) declared 1 SIRI.
8.4. To note there were no hospital acquired pressure ulcers declared in this month which could account for the below average number of SIRIs.

Chart 12: SIRI Investigations completed by Division during the last 13 months

8.5. Chart 12 indicates that S&O completed one SIRI while Children’s and Women’s and NOTSS Division completed two SIRIs each.

Chart 13: SIRIs Declared by Hospital Site during the last 13 months

8.6. Table 5 provides more details of the SIRIs that were declared via STEIS in January 2017. It also includes the 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 reported on STEIS.
Table 5: SIRIs declared in January 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>Incident detected date to Datix reported date interval</th>
<th>Date reported on STEIS</th>
<th>Reported Datix to STEIS interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-17/141</td>
<td>NOTSS</td>
<td>A patient suffered a cardiac arrest following surgery</td>
<td>09/01/2017</td>
<td>09/01/2017</td>
<td>0</td>
<td>25/01/2017</td>
<td>13</td>
</tr>
<tr>
<td>16-17/142</td>
<td>CORP</td>
<td>An information governance incident.</td>
<td>16/01/2017</td>
<td>16/01/2017</td>
<td>0</td>
<td>25/01/2017</td>
<td>8</td>
</tr>
<tr>
<td>16-17/143</td>
<td>SO</td>
<td>A patient deteriorated on a ward and had a respiratory arrest</td>
<td>17/01/2017</td>
<td>17/01/2017</td>
<td>0</td>
<td>25/01/2017</td>
<td>7</td>
</tr>
<tr>
<td>16-17/144</td>
<td>CW</td>
<td>A baby had an unexpected admission to the neonatal unit</td>
<td>23/01/2017</td>
<td>23/01/2017</td>
<td>0</td>
<td>31/01/2017</td>
<td>7</td>
</tr>
<tr>
<td>16-17/145</td>
<td>CSS</td>
<td>Following an incidental finding on an image a patient had delays in review and action on radiological investigations.</td>
<td>20/01/2017</td>
<td>23/01/2017</td>
<td>1</td>
<td>31/01/2017</td>
<td>7</td>
</tr>
</tbody>
</table>

8.7. The incident detected date to the reported on Datix date was an average of 0.2 working days with a median of 0 working days.
8.8. The reported date on Datix to the date reported on STEIS was an average of 8.4 working days with a median of 7 working days.
8.9. Delays in reporting on STEIS (over 10 days)
8.9.1. SIRI 16/17-141 time was required to establish the facts behind the incident before an informed decision could be made.

OCCG Closure meetings in November 2016
8.10. One SIRI closure meeting took place between the OCCG and the Trust in January 2017 and 9 SIRIs were closed.

Quality Walk Rounds
8.11. Four Executive Quality walk rounds took place in January 2017.
8.12. The Walk Rounds are detailed in Table 6

Table 6: Executive Quality Walk round Information

<table>
<thead>
<tr>
<th>Hospital Site</th>
<th>Areas to visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Horton General Hospital</td>
<td>Horton Theatres and Sterile Services</td>
</tr>
</tbody>
</table>
8.13. Key issues arising during the Quality Walk Rounds with the potential to affect quality or patient experience either positively or negatively included:

**Horton Theatres and Sterile Services**
- Staff were proud of their management of patients with fractured neck of femur in Horton Theatres, and were keen to maintain this. The Sterile Services department was busy and had a good machine maintenance process with estates; however it was noted to be a challenge to arrange transport between the Horton General and Churchill sites when there were mechanical issues, which affected the turnaround time of equipment.

**Emergency Assessment Unit**
- The Unit had made great progress in creating a ‘Dementia Friendly’ environment, using features such as: improved signage, name badges, dedicated notice boards and special radios. Specific assessment bays had been created which improved patient flow into the department; however it was still difficult to transfer patients out of the department and onto the wards.

**Main Outpatients and Pre-Operative Assessment Centre**
- The nursing team was involved in all relevant clinical governance meetings and Trust-wide groups such as the pre-operative forum.
- An external provider was running a fortnightly echocardiogram clinic, which had cost implications.

**Women’s Centre, Level 5 JR**
- There had been numerous refurbishments in the Women’s Centre. Two of the family rooms had been refurbished. A new multi-purpose area had been developed at the end of the ward to facilitate ‘one-stop-shop’ sessions and breastfeeding support.
- The Centre was commended for continuing to deliver an excellent service throughout a period of substantial change. It was evident that staff worked effectively as a team; they have been positive, resilient and adaptable in managing the increased workload.

9. **Clinical Effectiveness**

**Clinical Outcomes – Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR)**
- 9.1. There have been no mortality outliers reported for OUHFT by the CQC or the Dr Foster Unit at Imperial College.
- 9.2. The SHMI for the data period July 2015 to June 2016 is 0.96. This is rated ‘as expected.’ The SHMI trend is depicted in Chart 14. The SHMI remains within the ‘as expected’ range.
9.3. The HSMR is 100 for the latest available 12-month period November 2015 to October 2016. The value is 'within expected' range (95% CI 95.2 -104.0).

9.4. The number of observed deaths within the HSMR 56-diagnosis groups is 1985. The HSMR trend is depicted in Chart 15. The HSMR remains ‘within the expected’ range.

**Chart 15: HSMR trend analysis**

Crude Mortality

9.5. 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 16 and 17 reflect an unchanging crude mortality as a percentage of patient attendances when looked at over 12 months.
Clinical Audit

9.6. The following audits were presented at the Clinical Effectiveness Committee (CEC) on 12th January 2017; key areas for improvement and areas of good performance are highlighted:

9.6.1. Re-audit of Procedural Sedation in Adults at the Horton
9.6.2. Trust wide DOLS Audit

9.6.3. Trust Wide audit on the Mental Health Act policy
Advice from the Royal College of Psychiatrists is being sought as no nationally agreed standards for audit currently exist.

9.6.4. CG132 Caesarean Section

9.6.5. Re-audit of NICE CG83 – Re-audit of Outcomes 2-9

9.6.6. CG148 Urinary incontinence in neurological disease: assessment and management

9.6.7. National Cardiac Arrest Audit NCCA Quarter 2 Data

9.6.8. SSNAP April – July 2016 Audit Report for HGH


The Special Care baby Unit at the Horton Hospital and the NICU at the JR performed well above the national average and the Thames Valley Network has been identified as one of the exemplar centres nationally.

A reduced mortality was observed, both in babies born locally and in those born in other centres and transferred to OUH and this in part was due to the initiatives with the Academic health science network (AHSN) to ensure that mothers are in the right place to give birth to VLBW babies.
10. Infection Control

**Clostridium Difficile (C.diff)**

10.1. The upper ceiling for OUH apportioned cases of *C. diff* for 2016 / 2017 is 69.

10.2. For January 2017 there were 4 cases of *C. diff* against an internal monthly ceiling of 6. The OUHFT currently remains within trajectory. The internal cumulative total for January 2017 is 47 cases against a cumulative limit of 59.

10.3. Three cases were discussed at the January Health Economy meeting and all found to be unavoidable with no lapses in care.

**Chart 19: Cases of OUH apportioned C.diff per month (January 2016 – January 2017)**

**Methicillin-resistant Staphylococcus aureus (MRSA Bacteraemia)**

10.4. There have been two MRSA bacteraemias during January 2017.

10.5. One MRSA bacteraemia was a pre-48 hour bacteraemia which has been put forward by Oxfordshire Clinical Commissioning Group to be apportioned to a third party. The patient had not had recent hospital admissions or exposure to primary care.

10.6. The second MRSA bacteraemia was post 48 hours. This was not thought to be a clinically significant MRSA bacteraemia but more likely to have been a contaminant.

10.7. Currently there have been 4 avoidable and 1 unavoidable post 48 hour MRSA bacteraemias apportioned to the OUH against a target of zero.

**Methicillin-sensitive Staphylococcus aureus (MSSA) Bacteraemia**

10.8. Numbers of post-48 hour bacteraemia remain consistently similar each month.

10.9. Root cause analysis is conducted on each case. For the 3 cases this month in January, 2 cases are of unknown source and the third has had multiple previous *Methicillin-sensitive Staphylococcus aureus* infections.
Graph 20: MSSA bacteraemias January 2016-January 2017 (Post 48hrs Admission)

MRSA Screening Compliance
10.10. A revised MRSA protocol was approved mid-month. This was prior to the implementation programme, including the establishment of the EPR decision tools, to support the screening programme. Compliance with MRSA screening will therefore not be measured until the tools and communication required to support the new policy have been established.

Candida auris
10.11. The screening of the Neurointensive care patients continues to identify newly colonised patients but no invasive infections (chart 20).
10.12. Changes in Candida auris rates in November onwards reflect the introduction of screening in appropriate areas.
10.13. The national response to C. auris continues to be co-ordinated by Public Health England, and the OUH infection prevention and control (IPC) team have contributed to national briefings and guidelines.
Chart 21: Epi Curve for Candida auris January 2015 - January 2017

Serratia marcescens

10.14. This outbreak has been declared closed.

Norovirus

10.15. During January there was an outbreak of Norovirus on ward 7D. The outbreak involved 11 patients and 4 members of staff.

Influenza

10.16. Nationally the influenza rates in January have remained high, and within the Thames Valley rates of influenza like illness (ILI) in Oxfordshire have been higher than in adjacent areas. The Trust continues to admit a number of patients with confirmed influenza or influenza like illness (ILI). Graph 22 shows the distribution of cases in the Thames Valley.

Graph 22: Influenza distribution across the Thames Valley

Cleaning Scores

10.17. There has been some improvement in the cleaning scores for Carillion.
10.18. G4S at the Churchill and the Nuffield Orthopaedic Centre are awaiting the arrival of ipads and then Synbiotix (an audit tool) will be rolled out.
10.19. Nursing staff in the Children’s hospital have started to receive training in using Synbiotix.

10.20. Infection Prevention and Control contact the relevant contractor for areas demonstrating poor audit score compliance and review the area with the clinical staff, the soft FM manager and the Client Contract team.

Chart 23: Contract Client Team Cleaning Audit Scores versus Contract Client Team Target Scores (January 2017)
11. Patient Experience

11.1. The Patient Experience Team is working collaboratively with the Complaints team and Safe Staffing Teams to triangulate the available data and nursing metrics, with the aim of providing a deeper understanding on the staff and patient experience in the Emergency Departments (EDs). This is part of the deep dive work that has results in two reports for the EDs and Children’s services. For future reports, these teams will meet monthly to review the data in detail for the Trust overall.

Emergency Departments

11.2. The improvements in the level of positive feedback for the Emergency Departments continued in January 2017. The recommend rate is the highest recorded and the not recommend rate is the lowest since this feedback has been received by the Trust. The scores are well above the national average. (Chart 24; Chart 25). The Matron has confirmed that these scores reflect the considerable work within the Emergency Departments and across the Trust to support the departments during a time of increased national and local pressure.

Chart 24 – Emergency Departments percentage recommend.

<table>
<thead>
<tr>
<th>% Recommend: ED</th>
</tr>
</thead>
<tbody>
<tr>
<td>95.0%</td>
</tr>
<tr>
<td>90.0%</td>
</tr>
<tr>
<td>85.0%</td>
</tr>
<tr>
<td>80.0%</td>
</tr>
<tr>
<td>75.0%</td>
</tr>
<tr>
<td>70.0%</td>
</tr>
<tr>
<td>65.0%</td>
</tr>
<tr>
<td>60.0%</td>
</tr>
<tr>
<td>55.0%</td>
</tr>
<tr>
<td>50.0%</td>
</tr>
<tr>
<td>45.0%</td>
</tr>
<tr>
<td>40.0%</td>
</tr>
<tr>
<td>35.0%</td>
</tr>
<tr>
<td>30.0%</td>
</tr>
<tr>
<td>25.0%</td>
</tr>
<tr>
<td>20.0%</td>
</tr>
<tr>
<td>15.0%</td>
</tr>
<tr>
<td>10.0%</td>
</tr>
<tr>
<td>5.0%</td>
</tr>
<tr>
<td>0.0%</td>
</tr>
</tbody>
</table>

| OUTH ED         |
| National ED     |
| 12-Month Mean Average (OUH) |
| OUTH Lower Control Limit (-3SD) |
| OUTH Upper Control Limit (+3SD) |

Chart 25 – Emergency Departments percentage not recommend

<table>
<thead>
<tr>
<th>% Not Recommend: ED</th>
</tr>
</thead>
<tbody>
<tr>
<td>20.0%</td>
</tr>
<tr>
<td>15.0%</td>
</tr>
<tr>
<td>10.0%</td>
</tr>
<tr>
<td>5.0%</td>
</tr>
<tr>
<td>0.0%</td>
</tr>
</tbody>
</table>

| OUTH ED         |
| National ED     |
| 12-Month Mean Average (OUH) |
| OUTH Lower Control Limit (-3SD) |
| OUTH Upper Control Limit (+3SD) |

11.3. The themes in the ED comments in October 2016 and January 2017 have been compared in Chart 26 and Chart 27, to highlight the improvements in FFT.
scores.\textsuperscript{1} Overall, there is a higher proportion of positive to negative comments in January than in October: the ratio has improved from a 3:1 ratio of positive to negative comments in October, to a 9:1 ratio in January. The other areas with significant improvements are:

11.3.1. Admissions: improved from a 2:1 ratio of positive to negative comments to a 10:1 ratio.

11.3.2. Waiting times: improved from a 2:1 ratio of positive to negative comments to a 6:1 ratio.

11.3.3. Implementation of care: improved from a 4:1 ratio of positive to negative comments to a 15:1 ratio.

11.3.4. Staff attitude: improved from a 4:1 ratio of positive to negative comments to a 13:1 ratio. This appears to be a slight increase in the number of positive comments and a large decrease in the number of negative comments.

11.3.5. Environment: improved from a 1:1 ratio of positive to negative comments to a 3:1 ratio.

Chart 26 – Emergency Department themes – October 2016

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{chart26}
\caption{Emergency Department Comment Themes October 2016}
\end{figure}

\textsuperscript{1} Thematic analysis for day cases, outpatients, and ED are carried out using ‘sentiment analysis’, the process of computationally identifying and categorising opinions expressed in a piece of text, especially in order to determine whether the writer's attitude towards a particular topic, product etc. is positive, negative, or neutral. Neutral comments are not included in the analysis in this report. This coding process is 75\% accurate. Comments about inpatient and maternity services are coded manually. Comments are coded according to the many themes that may be raised by one person. Therefore, there will be more themes than individual responses.
Outpatients

Additional analysis has been carried out to highlight the results for January 2017 within the Outpatient departments in order to explore the data in more depth. The team have focused on departments where 50 responses or more were recorded, to ensure that data has reliability, and calculating the percentiles for each based on recommendation rates, four departments have been identified as being in the bottom 10th percentile for not recommendation rates.²

All four departments are within the Neurosciences, Orthopaedics, Trauma and Specialist Surgery (NOTSS) Division; the Oxford Eye Hospital (OEH) (see 11.12 for details on the OEH Patient Experience project), the Oxfordshire Musculoskeletal Hub (MSK) Hub, the John Radcliffe (JR) Ear Nose and Throat (ENT) department and the JR Oral & Maxillofacial Surgery department. The not recommend rate for these departments ranged from 6 to 9 percent. The average not recommend rate in Outpatients was 2%. Table 7 shows the numbers of responses received by each department.

The Matron for Specialist Surgery (covering Oral Surgery, the Eye Hospital and ENT) has confirmed that FFT reports are reviewed each month and shared with respective teams; any items requiring improvement are investigated for trends and teams create action plans as a result.

The Matron for the Nuffield Orthopaedic Centre has been informed regarding the MSK Hub results, along with the Administration Manager and comments will be included in April’s report.

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² A percentile (or a centile) is a measure used in statistics indicating the value below which a given percentage of observations in a group of observations fall. For example, the 20th percentile is the value (or score) below which 20% of the observations may be found.
Table 7 – Numbers of responses received by each outpatients department

<table>
<thead>
<tr>
<th></th>
<th>Oral Surgery</th>
<th>MSK Hub</th>
<th>ENT</th>
<th>Eye Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numbers of Recommend</td>
<td>95</td>
<td>156</td>
<td>156</td>
<td>562</td>
</tr>
<tr>
<td>Numbers of recommend ratings</td>
<td>10</td>
<td>15</td>
<td>11</td>
<td>36</td>
</tr>
<tr>
<td>% not recommend</td>
<td>9</td>
<td>8</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Overall numbers</td>
<td>109</td>
<td>181</td>
<td>173</td>
<td>625</td>
</tr>
</tbody>
</table>

This is the first time reporting on this, so trends will be identified going forward, so the data represents exception reporting.

Inpatients and Day Cases

The same method as above has been applied to Inpatient (IP) and Day Case (DC) areas and two have been identified as being in the 10th percentile for not recommend rates; Lichfield Day Surgery Unit at the JR and the Respiratory Day Case Unit at the Churchill. Both of these DC departments had a 4% not recommend rate (average for IP and DC is 1%).

See 0 for the response for Lichfield DSU. The Matron for Ambulatory Medicine is aware of this reporting and a comment will be included in the April’s BQR.

Table 8 shows the numbers of responses received by each department.

Table 8 - Ratings received by each day case department

<table>
<thead>
<tr>
<th></th>
<th>Lichfield DCU</th>
<th>Respiratory DCU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numbers of Recommend</td>
<td>80</td>
<td>46</td>
</tr>
<tr>
<td>Numbers of Not recommend</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>% not recommend</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Overall numbers</td>
<td>92</td>
<td>50</td>
</tr>
</tbody>
</table>

Maternity Feedback

There were no exceptions to report for January 2017.

The PE Team will be presenting proposed changes to FFT for maternity in April’s Board Quality Report, as NHS England is keen for the Trust to test new ways of seeking feedback from women.
Children’s Feedback

11.4. The percentage of children, and parents or carers, recommending the care provided was 99% in January 2017, although there was a decrease in response rate between December 2016 and January 2017. This decrease was in part due to the Horton missing the final courier before the data cut-off point and partly due to sickness and annual leave over the Christmas period. The children’s recommendation and response rates for the previous 12 months are presented in Charts 28 and 29.

Chart 28 – Children’s Response Rate

![Chart 28 – Children’s Response Rate]

Chart 29 – Children’s Recommendation Rate

![Chart 29 – Children’s Recommendation Rate]

11.5. At present the Horton Children’s Department send questionnaires in the internal complete questionnaires on a monthly basis, which has resulted in their submissions missing the final courier of the month before data cut-off on the 27th. The Children’s Patient Experience Project Lead has now requested that the team post questionnaires on a weekly basis and will monitor this.

11.6. In November 2016, approximately 145 FFT forms from the Horton missed this cut-off date due to late posting by the clinical areas, which contributed to the reduction in recommendation rates for children’s services in November 2016. Table 9 illustrates the impact this can have on recommendation rates.
Table 9 – Children’s Recommendation Rates: November 2016 to January 2017 by total number received (% recommend in brackets). Source: Envoy Messenger

<table>
<thead>
<tr>
<th>Month</th>
<th>Likely / Extremely Likely</th>
<th>Neither likely nor unlikely</th>
<th>Unlikely / Extremely unlikely</th>
<th>Don’t Know</th>
<th>Total feedback received</th>
<th>1 patient represents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nov 2016</td>
<td>71 (95.95%)</td>
<td>2 (2.7%)</td>
<td>1 (1.35%)</td>
<td>0</td>
<td>74</td>
<td>1.35%</td>
</tr>
<tr>
<td>Dec 2016</td>
<td>509 (98.26%)</td>
<td>6 (1.14%)</td>
<td>3 (0.57%)</td>
<td>0</td>
<td>518</td>
<td>0.19%</td>
</tr>
<tr>
<td>Jan 2017</td>
<td>91 (98.91%)</td>
<td>0</td>
<td>0</td>
<td>1 (1.09%)</td>
<td>92</td>
<td>1.09%</td>
</tr>
</tbody>
</table>

Response Rates

11.7. The response rate in CSS was above the upper control limit in January 2017. This principally came from two areas: the Churchill Pain Management Day Case and Churchill Radiology. There has been no apparent change in practice or process in relation to FFT; future trends will be monitored. For Radiology, since they receive only paper based questionnaires, this could have been due to a delay in sending questionnaires over the Christmas period resulting in December 2016 feedback being collated in January 2017.


National Survey Programme Timetable

11.8. National Inpatient Survey 2016: The survey supplier, with facilitation by the Patient Experience (PE) Team, will present the initial findings at a meeting in March, at which there will be staff and patient/public representatives for each division allowing for coproduction of action plans. Results will be disseminated via Divisional Governance Meetings. The PE Team will report to the Quality Committee with headline results in the spring, and share internally before publication.

11.9. Maternity Department Survey 2017: The sample of at least 300 women attending in February will be drawn in March/April 2017. The Head of Midwifery will lead on any improvements to be implemented, with support from the PE Team.
11.10. **National Emergency Department Survey 2016 (NAE16):** the survey work will close in March. Once all of the results have been processed in April they will be shared with the service leads to allow for action plans to be put in place.

11.11. **Children and Young Peoples Inpatient/Day case Survey (NCYP16):** the initial mailing of questionnaires were sent in February 2017. The survey will close in June 2017 and reports will be received in the same month. The Children’s PE Project Lead will support teams to analyse results and implement changes in a timely manner, with input from Young People’s Executive (YiPpEe) members.

**Patient Experience Team projects:**

11.12. An update on the team’s progress on key projects in January 2017 is provided below:

- **Introducing the SMS FFT survey for Inpatient wards:**
  - SMS has been introduced as the main survey method for the Surgical Emergency Unit (SEU). The response rate has improved slightly for SEU overall when compared to the three months preceding SMS implementation; with 15.1% in September – November 2016 and 17.9% in December 2016 to January 2017. This is also an improvement on the response rate for the preceding year, December 2015 – November 2016 which was 9.6%. There has been excellent staff engagement and good staff feedback about the new survey method, as this survey automates the process and relieves the burden upon staff to hand out the paper survey Trust-wide rollout will occur in Quarter 1 2017/18.

**PALS and Complaints**

11.13. The Trust received 81 new formal complaints in January. This is an increase from the previous month (December n=67). It is, however, on a par with the number of formal complaints the Trust received in January 2016 (n=83).

11.14. Chart 30 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 January (n=27), albeit a decrease from the previous month (n=28).

**Chart 30 – New Complaints by month/Division February 2016 to January 2017**

11.15. The Trust received no red complaints in January.
11.16. The top five complaint themes for January include: clinical treatment (n=25), appointments (n=12), communication (n=9), values and behaviours (n=9), and admission and discharge (n=8). There has been an increase in complaints regarding clinical treatment and admission and discharge this month. This is discussed in further detail within the divisional overview below.

12. **Safe Staffing – Nursing and Midwifery**

12.1 Nursing and Midwifery Staffing report to the Trust Board

The Trust is required to report Staffing data for adult inpatient wards in acute hospitals. This report therefore includes the safe staffing data for January 2017 and the metrics (November – January 2017) against each of the 5 divisions, with women’s separated from children’s services, (Appendix 3).

12.2 National reporting for Safe Staffing for January 2017

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

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 (Appendix 4).

12.3 Unify data for January 2017

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

- 95.24% for Registered Nurses/Midwives
- 86.94% for Nursing Assistants (unregistered)

12.4 Current status of nursing and midwifery staffing within the Trust

The Trust continues to experience a high churn of band 5 staff nurses within 12 months which remains at 17.6% across the Trust. This has reduced from 26% in 2014. The Associate Chief Nurse for Workforce has undertaken an in depth analysis of the reasons, and made proposals for career progression and retention which was presented to the Nursing & Midwifery Board in January 2017 and will be shared with the Trust Management Executive in February 2017.

It should be noted that staff are moved every shift between directorates and across divisions due to short notice sickness, and anecdotally this is often a cause of short notice sickness because of the anticipation of being moved. There are a number of reasons staff provide for dissatisfaction at work, and the Trust is planning more targeted approach to the questions asked in the local staff survey to establish key areas of staff give for the high churn annually at the junior level.

12.5 Areas of exception highlighted on the dashboards include:
1. **The Adult Intensive Care Units** – The Horton Hospital ICU has a significant vacancy rate but well managed Nurse Sensitive Indicators.

2. **The Neurosciences, Orthopaedics, Trauma & Specialist Surgery Division** has significant levels of vacancies and high turnover in Neurosciences Red, Trauma ward and SSIP. The Nurse Sensitive Indicators are well managed.

3. **The Children’s wards and gynaecology** – has significant vacancies in gynaecology and is heavily reliant on temporary staff at present between substantive appointments. New Born Care has a high turnover and vacancy rate also. The Nurse Sensitive Indicators are well managed.

4. **Maternity unit** has significant sickness levels at 6.11% and a turnover of 13.19% with most Midwifery Indicators highlighted with the most acute area of the Delivery Suite. The staffing levels are constant reviewed on the levels of acuity on the ‘Birth Rate Plus’ system which monitors the acuity of women every four hours. In order to provide 1:1 care for women in labour midwives are moved from all areas of the maternity service to delivery suite and the Spires MLU as required. This will include midwives on call both for the hospital maternity service and the community maternity service.

5. **The Medicine, Rehabilitation & Cardiac Division** has a high turnover of staff with significant vacancies in John Warrin ward, Osler Chest and Cardiology. Nurse Sensitive Indicators are well controlled with high levels of fall but none with harm, but hospital acquired pressure ulcers on the medical wards at the Horton Hospital site. The Acute General Medical directorate is working with the Falls Quality Improvement Team to work through a number of initiatives to address this within a particularly elderly frail patient group with cognitive challenges.

6. **The Surgery & Oncology Division** has a significant vacancy level and turnover in Upper GI ward, The Oxford Colorectal ward, Oncology and Renal wards, which are reliant on temporary staffing. There are falls with harm, and medication incidents noted on haematology, as well as hospital acquired pressure ulcers on Sobell Ward.

12.6 Safe staffing acuity review
This is presented as appendix 5 and forms the bi-annual acuity & dependency review. The Trust has attained good compliance with the use of IPAMS for staffing levels and the acuity & dependency facility also. However, as wards have moved or any part of their service altered, the data has been limited to the latter period of stability post change. Otherwise the majority of wards have provided six months data, which has been validated through the directorate matrons, Divisional Heads of Nursing, and signed off by the Nursing & Midwifery Board in January and Presented to Quality Committee in February 2017.
This highlights ward by ward the specialty, ward configuration, skill mix, Care Hours per Patient Day for October and quality metrics, to demonstrate the triangulation of data in determining the correct establishments.

The IPAMS tool for determining the acuity & dependency for children’s in-patients services is just in the process of roll out across the Trust, and developing in levels of compliance. This will provide indicators as to the correct levels of nursing establishments ward by ward, which has not been undertaken in the Trust previously.

The review of the correct levels of staffing within the Emergency Departments (ED) is currently in the planning as the only validated tool available is manual, and requires some resources to observe each of the Emergency Department’s areas, 24 hours a day for 7 days.

13. **Recommendations**

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

**Tony Berendt**  
Medical Director

**Catherine Stoddart**  
Chief Nurse

*Report prepared by:*  
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Liz Wright  
Rob Stuart  
Helen Cobb  
Caroline Heason
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)