<table>
<thead>
<tr>
<th>Status</th>
<th>For information</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td>This is a monthly report, presented alternately to the Trust Board or to the Quality Committee</td>
</tr>
</tbody>
</table>

| Board Lead(s)          | Dr Tony Berendt, Medical Director  
|                        | Mr Andrew MacCallum, Interim Chief Nurse |
| Key purpose           | Strategy | Assurance | Policy | Performance |
### 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. The National Quality Strategy update this month relates to the March 2017 King’s Fund published report on Public satisfaction with the NHS in 2016. This differs from NHS surveys of patients or staff.

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.

5. Issues raised by Oxfordshire Clinical Commissioning Group (OCCG):
   - Test results and discharge summaries timeliness continues to be an area of significant work. In March 80.7% of discharge summaries were sent before or within 24 hours of discharge against a target of 88%. 78.4% of results were endorsed on EPR within 7 days against a target of 82%. Both indicators have therefore fallen short of the OCCG trajectories for March.
   - GP feedback collated from the OCCG DATIX system is reported.

6. Patient Safety and Clinical Risk:
   - No Never Events were reported in March. 7 Serious Incidents Requiring Investigations (SIRIs) were reported in March. 11 SIRIs were sent to the OCCG for closure in March 2017 and 12 SIRIs were closed by the OCCG in the OCCG/OUHFT closure meetings.
   - Five Executive quality walk rounds took place in March 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 October 2015 to September 2016 is 0.94. The SHMI remains within the ‘as expected’ range. The Hospital Standardised Mortality ratio (HSMR) is 100 for period January 2016 to December 2016. The value is ‘within expected’ range.

8. Infection Control:
   - For March 2017 there were 2 cases of C.difficile against an internal monthly ceiling of 5. The OUH has finished the financial year on 53 cases which is 16 cases below the cumulative limit of 69 and an even better performance than the previous year.
   - Candida auris - screening of the Neurointensive care patients continues and there has been a significant increase in the number of new colonised patients in March 2017.
   - The patient notification exercise for informing patients of the risk of Mycobacterium
chimaera following heart valve replacement has been completed.

9. Patient Experience:
   Please refer to section 10 at page 33 onwards.

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 March 2017 Unify submission of staffing
    The safe staffing dashboards include each of the divisional RAG rated staffing levels (appendix 1), against the HR metrics and Nurse Sensitive Quality Indicators for February 2017.
    Reports of the ward by ward, shift by shift RAG rated staffing levels are in appendix 2. Reports in the text are by exception from the divisional dashboards.
    The Trust is preparing to measure the patient acuity levels in the JR Emergency Department in June 2017, in order to review the nurse staffing. The Trust is planning to review the midwifery establishments against the NICE guidance within the next two months.
    The next in-patient acuity review for the previous 6 months is due in June 2017 using the IPAMS tool.
    The pilot of the use of IPAMS in determining theatre staffing levels is underway in JR theatres.

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. In March 2017 the King’s Fund published a report on Public satisfaction with the NHS in 2016. This differs from NHS surveys of patients or staff.

2.2. Since 1983 The National Centre for Social Research’s British Social Attitudes (BSA) survey has asked members of the public – rather than only patients – about their views on, and feelings towards, the NHS and health and care issues generally. The latest survey was carried out between July and October 2016 and asked a nationally representative sample of nearly 3,000 people about their satisfaction with the NHS overall, and of nearly 1,000 people about their satisfaction with individual NHS services.

2.3. The King’s Fund report includes the following comments on the national results as below. The opinions are those of the authors and not the Oxford University Hospitals (OUH) NHS Foundation Trust.

- Public satisfaction with the NHS overall was 63 per cent in 2016. The change in satisfaction since 2015 was not statistically significant.
- Satisfaction with GP services was 72 per cent and, as in previous years, was higher than satisfaction with any other NHS service. Again, the change in satisfaction since 2015 was not statistically significant.
- Satisfaction with NHS dentistry services was 61 per cent in 2016, up by 7 percentage points from 2015. This is one of the highest levels of public satisfaction with these services since the early 1990s.
- Satisfaction with social care services was 26 per cent, unchanged since 2015 and far lower than satisfaction with NHS services. Social care is the only service to have a negative net satisfaction score.
- Satisfaction with outpatient services was 68 per cent in 2016. The change in satisfaction from 2015 was not statistically significant.
- Satisfaction with inpatient services was 60 per cent in 2016. The change in satisfaction since 2015 was not statistically significant.
- Satisfaction with accident and emergency (A&E) services was 54 per cent in 2016. Again, the change in satisfaction from 2015 was not statistically significant.
- Overall satisfaction with the NHS was higher among people aged 75 years or older (74 per cent) than among people under 65 (between 59 and 62 per cent).
The three main reasons people gave for being satisfied with the NHS overall were: the quality of care, the fact that the NHS is free at the point of use, and the range of services and treatments available.

The three main reasons that people gave for being dissatisfied with the health service were: long waiting times, staff shortages and lack of funding.

Chart 1: shows Public satisfaction with the NHS from 1983-2017

![Chart 1](chart1.png)

Question asked: 'All in all, how satisfied or dissatisfied would you say you are with the way in which the National Health Service runs nowadays?'

This question was not asked in 1985, 1988 and 1992

Source: King's Fund analysis of NatCen Social Research's British Social Attitudes survey data

Chart 2: shows Public satisfaction with Inpatient, Outpatient and A and E services

![Chart 2](chart2.png)

Questions asked: ‘From your own experience, or from what you have heard, please say how satisfied or dissatisfied you are with the way in which each of these parts of the National Health Service runs nowadays... being in hospital as an inpatient?... attending hospital as an outpatient?... accident and emergency departments?'

These questions were not asked in 1984, 1985, 1988, 1992 and 1997

Source: King's Fund analysis of NatCen Social Research's British Social Attitudes survey data

2.4. The report explored possible reasons for satisfaction or dissatisfaction by asking a third of the most or least satisfied responders what influenced their opinion with the results shown in Charts 3 and 4 below.
Chart 3: shows reasons for satisfaction with the NHS overall in 2016

Chart 4: shows reasons for dissatisfaction with the NHS overall in 2016
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 5.

Chart 5

3.2. The year-end progress on the Quality Priorities against the goals and targets set out in the Quality Account are shown in Table 1.

Table 1: Year-end on the Quality Priorities

<table>
<thead>
<tr>
<th>Goal</th>
<th>Target</th>
<th>Evaluation</th>
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</thead>
<tbody>
<tr>
<td>Priority 1A: Medication Safety</td>
<td>100% compliance and if required an action plan to address any non-compliance</td>
<td>We did not achieve this. Compliance with the safe and secure storage of medicines standards has improved but not to 100%. It is difficult to finalise a percentage as the data are spread over 250 areas, audits are numbering 43 questions per area with 3 different sub sections. Some compliance issues require the approval of business cases in order to resolve as they involve estates issues such as reconfiguring ward areas. Action plans are being monitored and progress challenged in the Clinical Governance Committee.</td>
</tr>
<tr>
<td>To increase the number</td>
<td>15% increase</td>
<td>We did not achieve this. Work has continued to</td>
</tr>
</tbody>
</table>
Goal | Target | Evaluation
--- | --- | ---
of medication incidents reported (indicative of an open and learning culture) | | encourage the reporting of medication incidents wherever possible. The successful introduction of electronic prescribing (ePMA) may be a factor.
To reduce the proportion of medication incident reported and graded as moderate or above in severity. | 10% reduction overall, 20% reduction with insulin, anticoagulation, antimicrobial and omitted or delayed administration of essential medicines. | We partially achieved this. 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, antimicrobials and delayed and omitted prescribed medicines.

Priority 1B: Improved recognition, prevention and management of patients with Acute Kidney Injury (AKI)

| Priority 1B: Improved recognition, prevention and management of patients with Acute Kidney Injury (AKI) | Development of Trust wide education on AKI | Non-medical health professionals | We achieved this. A Trust wide education programme is now in place. The education provision will be ongoing long term to address the issue of staff turnover.
| | Improve communication with primary care for patients who have suffered AKI | To include AKI 2/3 flags in discharge summaries | We achieved this. All AKI flags are now included in discharge summaries.
| | Pharmacy review of medication in patients with AKI | Increase early review of medication in AKI | We partially achieved this. The medication review tool has been rolled out across the Trust and staff are being educated to implement this.
| | Work with primary care colleagues to improve management of AKI in primary care | Admission avoidance | We achieved this. Primary Care alerts have been live since November 2016 with associated bespoke AKI care bundles in Primary Care. The OUH model is being used in Buckinghamshire.

Priority 1C: Identification and early treatment of Sepsis

| Priority 1C: Identification and early treatment of Sepsis | Prompt recognition of sepsis | Standardised screening for sepsis across the Trust | We achieved this. We have developed and implemented an electronic Sepsis Screening Tool (‘Sepsis Agent’) for adult emergency admissions and inpatients which puts alerts on our computer screens for patients who may be septic. Since then more
<table>
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<tr>
<th>Goal</th>
<th>Target</th>
<th>Evaluation</th>
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<tbody>
<tr>
<td><strong>Prompt antibiotic treatment of sepsis</strong></td>
<td>Antibiotics to be administered within 1 hour of presentation with severe sepsis</td>
<td>We partially achieved this. The proportion of patients with sepsis that receive antibiotics within 1 hour has increased among both emergency admissions and inpatients (62% and 45% - respectively at the end of March 2017 from 44% and 29% at the start of the year).</td>
</tr>
<tr>
<td><strong>Priority 1D: Care 24/7</strong></td>
<td>By Q4 100% of patients in intensive and areas defined as high dependency will be reviewed by consultants twice daily.</td>
<td>We achieved this. Our audit results demonstrate that 100% of our critically ill patients in intensive and high dependency areas have been reviewed twice per day by consultant level doctors and then daily as required within ‘drop down units’.</td>
</tr>
<tr>
<td><strong>Complete our program of work to implement the four critical standards by March 2017.</strong></td>
<td>By March 2017 the bi-annual audits will be complete with data and actions reported to NHS England</td>
<td>We achieved this. We have carried out six monthly audits of more than 250 emergency admissions against these four priority standards. OUH has performed extremely well in these audits, and the most recent published results reflect high standards of care delivered across the Trust.</td>
</tr>
<tr>
<td><strong>Priority 1E: SEND System for recording and viewing patients’ vital signs</strong></td>
<td>Roll out to JR Cardiac Centre and West Wing, Horton ED, NOC Centre for Enablement and Outpatient areas</td>
<td>We achieved this. SEND has been fully rolled out according to plan and is in use.</td>
</tr>
<tr>
<td>The wards and clinicians from any location can access real-time vital sign observation charts and Track and Trigger scores</td>
<td>Clinical staff will use the system to capture patient observations in real-time</td>
<td>We achieved this. SEND is now accessible from every computer in the trust. Clinical staff are using the system to capture patient observations in real-time.</td>
</tr>
<tr>
<td>Nursing time saved recording vital signs and</td>
<td>Nurses can provide better patient care</td>
<td>We achieved this.</td>
</tr>
<tr>
<td>Goal</td>
<td>Target</td>
<td>Evaluation</td>
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<tr>
<td>calculating Track and Trigger scores</td>
<td>due to saving time when using SEND to record patients’ vital signs</td>
<td>A research study of 577 observations of nursing practice found a 17% (35 second) median saving in the time to undertake observations when comparing SEND with the preceding paper system.</td>
</tr>
</tbody>
</table>

| Priority 2: Patient Safety and Human factors training | 18 one day courses | We achieved this. 18 one-day courses for multi-disciplinary teams across OUH have taken place. There were 216 places on these courses (12 per course) and more than this number were trained with some extra places made available. |
| To deliver human factors training incorporating simulation to healthcare professionals from all Divisions | To deliver a human factors and QI strategy for the OUHFT with the explicit aim of building capability across the Trust and delivering a sustainable programme of quality improvement | We achieved this. The Human Factors (HF) and Quality Improvement (QI) Advisory group meets monthly to monitor and guide progress in Human Factors and Quality Improvement domains. |
| To develop a Human Factors and Quality Improvement Advisory Group and an associated strategy for quality and safety led by the Deputy Medical Director | Four one day ambassador courses to train an additional 50 trainers | We achieved this. Train the Trainer course for OUH HF Ambassadors has been completed and we have trained 50 champions. |
| To deliver training in quality improvement for healthcare professionals and managers from all Divisions | One day Human Factors (HF)/ Quality Improvement (QI) training | We achieved this. Training provided by the Patient Safety Academy has delivered one day HF/ QI training for over 70 staff. |

<p>| Priority 3A: End of Life Care: improving people’s care in the last few days and hours of life | Palliative care staffed to provide daily rounds in ED and EAU | We achieved this 100% of patients recognised to be near to the end of life at ED and EAU had a palliative care review within 24 hours (to the end of March 2017). |</p>
<table>
<thead>
<tr>
<th>Goal</th>
<th>Target</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved feedback from families</td>
<td>95% of families offered a feedback form</td>
<td>We did not achieve this. A bereavement survey has been piloted across a cohort of wards and has been received very positively. The Bereavement team will offer the feedback form from the end of March 2017.</td>
</tr>
<tr>
<td>Swan scheme in place</td>
<td>Symbol Known to and understood by all staff</td>
<td>We partially achieved this. Swan Scheme roll out: Renal, 7A, 7B and Oncology wards have been identified as working towards achieving accreditation by the end of March 2017. The symbol has been chosen: sunflower. Information will be disseminated to all staff via the staff update in April 2017.</td>
</tr>
<tr>
<td>Improved staff confidence, skills and knowledge</td>
<td>75% of staff have undertaken e-learning training</td>
<td>We did not achieve this. Cascade training is now in place: more than 100 senior nursing and medical staff have been now been trained in EOLC. E-learning modules have been agreed and will be rolled out in 2017/18.</td>
</tr>
<tr>
<td>Anticipatory medication</td>
<td>95% of patients have these medicines on discharge</td>
<td>We did not achieve this. Work has progressed within the Trust on this and partnership work continues with Oxford Health NHS FT to advance this priority.</td>
</tr>
<tr>
<td>Joint work on discharge</td>
<td>Understanding blocks to discharges</td>
<td>We did not achieve this. Work on this will roll on to 2017/18.</td>
</tr>
<tr>
<td>Priority 3B: Dementia Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dementia data reviews</td>
<td>90% of patients aged 75 years and over screened for dementia</td>
<td>We did not achieve this. The current dementia screening rates have improved to 60%. Significant work is being carried out to improve compliance and to resolve all assessments into electronic systems where some are currently on paper and not captured in the audit.</td>
</tr>
<tr>
<td>To promote a positive experience for patients</td>
<td>Improvement in qualitative feedback</td>
<td>We partly achieved this. The Trust continues to work closely with Carers Oxfordshire on the Carers Project. The Outreach Worker from the charity regularly attends the Trust’s Dementia Information Café and holds drop-in ‘surgeries’ on the Acute General Medicine wards at the John Radcliffe, as well as taking referrals from Staff. Qualitative data has shown a positive response to these sessions.</td>
</tr>
<tr>
<td>Goal</td>
<td>Target</td>
<td>Evaluation</td>
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<tr>
<td>To promote dementia awareness via training to relevant staff within the hospital</td>
<td>75%</td>
<td>We achieved this. Figures for the relevant staff trained for tier 1 dementia training were 82%.</td>
</tr>
<tr>
<td>To enhance the current knowledge and understanding of dementia through appropriate training to all relevant staff.</td>
<td>Training of 50% of frontline staff</td>
<td>We achieved this. 65% of relevant frontline staff have received training in 2016/17.</td>
</tr>
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</table>

**Priority 3C: The compassionate care programme**

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<tr>
<th>Goal</th>
<th>Target</th>
<th>Evaluation</th>
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<tbody>
<tr>
<td>To provide classroom training sessions for 1500 frontline staff on Delivering Compassionate Care</td>
<td>1500 staff attend classroom sessions in 2016/2017 financial year.</td>
<td>We partially achieved this. 1,441 staff attended classroom sessions in 2016/17. We provided a total capacity of 2,282 places to attendees in the same period. Attendees will often book themselves on to the course but then need to change dates as they juggle course attendance with their work responsibilities and other commitments.</td>
</tr>
<tr>
<td>To evaluate the outcomes of learning leading to longer term behaviour and attitude change of frontline staff.</td>
<td>50% of attendees complete evaluation 3-6 months post-training in 2016/2017 financial year.</td>
<td>We achieved this. Quarterly surveys to attendees measuring training outcomes continue to be circulated and have achieved a 100% return rate. An interim evaluation has been completed and demonstrates a 95% ‘highly satisfied’ response.</td>
</tr>
<tr>
<td>To provide E-Learning training accessible to all staff on concepts underpinning Delivering Compassionate Care</td>
<td>1500 staff access and complete E-Learning Package sessions in 2016/2017.</td>
<td>We did not achieve this. On review the decision was made not to provide this training via E-Learning in 2016/17. A review is in progress to evaluate the best method for delivering this training in 2017/18.</td>
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**Goal**

**Priority 4: Stakeholder engagement and partnership working**

<table>
<thead>
<tr>
<th>Goal</th>
<th>Target</th>
<th>Evaluation</th>
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<tbody>
<tr>
<td>To involve stakeholders in future strategy</td>
<td>Work collaboratively as a healthcare system across Oxfordshire</td>
<td>We achieved this. The Trust continues to participate in the Sustainability and Transformation Plan (STP).</td>
</tr>
<tr>
<td>Goal</td>
<td>Target</td>
<td>Evaluation</td>
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<tr>
<td>To improve communication of patient information to primary care colleagues</td>
<td>To deliver 98% all e-discharge summaries to primary care colleagues within 24 hours of discharge</td>
<td>We did not achieve this. 80% of discharge summaries currently are e-messaged to primary care colleagues within 24 hours of discharge.</td>
</tr>
<tr>
<td>To improve assurance that all test results have been acted upon</td>
<td>To endorse 95% of test results on EPR within seven working days</td>
<td>We did not achieve this. The trajectory has been revised in conjunction with OCCG. The March 2017 target of 82% was not achieved, with only 78% of test results being endorsed within seven working days. However this is an increase from 69% at the start of the year.</td>
</tr>
<tr>
<td>Progress system wide improvement in quality of care</td>
<td>Deliver aims of the delayed transfers of care (DTOC) program</td>
<td>We partially achieved this. It is the Trust’s priority to get patients back to their home environment as quickly and as safely as possible by supporting them for up to 6 weeks in their own home with re-ablement support. It is also the Trust’s aim to prevent hospital admission by supporting patients already in the community to whom we have been alerted by our primary care colleagues. The Trust has 98.6 Whole Time Equivalent re-ablement workers supporting on average 180 patients and clients per day in the community. At the end of March 2017 another 35 staff have been made a conditional offer of employment. The Trust is providing over 350 hours of care per week for those patients who have been identified as requiring a long term care package and who are awaiting our social and health care colleagues to identify local domiciliary care providers to take over these care packages. The Trust is working closely with Oxfordshire County Council on this priority.</td>
</tr>
<tr>
<td>To ensure patients and families have an improved experience of the discharge process from inpatient care</td>
<td>Establish a working group by 30th November 2016. Launch a revised patient discharge booklet by 31st March 2017.</td>
<td>We achieved this. The working group has been established. The revised patient discharge booklet has been launched. Four discharge workshops have run at the John Radcliffe, the Churchill, the Nuffield Orthopaedic Centre and the Horton to reduce the number of delayed transfers of care by earlier and comprehensive discharge planning.</td>
</tr>
</tbody>
</table>
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 2.

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

Indicators deteriorating or red rated

4.5. 7 indicators have deteriorated against target since the last reporting cycle, 6 are red rated due to breaching of an annual threshold:

- PS02 Safety Thermometer (% patients receiving care free of any harm - irrespective of acquisition) (Amber)
- PS06 Number of cases of MRSA bacteraemia > 48 hours (cumulative year to date)
- PS08 % patients receiving stage 2 medicines reconciliation within 24h of admission
- PS14 % Radiology direct access 7 day turnaround times - Plain Film, CT, MRI & Ultrasound
- PS17 Number of hospital acquired thromboses identified and judged avoidable
- CE03 Dementia - % patients aged > 75 admitted as an emergency who are screened
- PE15 % patients EAU length of stay < 12h

Indicators improving

4.6. 2 indicators have improved against target since the last reporting cycle:

- CE06 ED - % patients seen, assessed and discharged / admitted within 4h of arrival
- PE14 Single sex breaches

Table 2: Key Quality Metrics

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<tbody>
<tr>
<td>PS01</td>
<td>Safety Thermometer (% patients receiving care free of any newly acquired harm) [one month in arrears]</td>
<td>96.86% Amber</td>
<td>96.64% Amber</td>
<td>97.57% Green</td>
<td>97.16% Green</td>
<td>97.25% Green Mar 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>93.31% Green</td>
<td>91.76% Amber</td>
<td>93.87% Green</td>
<td>93.41% Green</td>
<td>92.16% Amber Mar 17</td>
</tr>
<tr>
<td>PS03</td>
<td>VTE Risk Assessment (% admitted patients receiving risk assessment)</td>
<td>94.64% Red Red</td>
<td>95.98% Green</td>
<td>96.92% Green</td>
<td>96.99% Green</td>
<td>97.1% Green Feb 17</td>
</tr>
<tr>
<td>PS04</td>
<td>Serious Incidents Requiring Investigation (SIRI) reported via STEIS</td>
<td>4 N/A</td>
<td>11 N/A</td>
<td>11 N/A</td>
<td>8 N/A</td>
<td>7 N/A Mar 17</td>
</tr>
<tr>
<td>PS05</td>
<td>Number of cases of Clostridium Difficile &gt; 72 hours (cumulative year to date)</td>
<td>40 Green</td>
<td>43 Green</td>
<td>47 Green</td>
<td>51 Red</td>
<td>53 Green Mar 17</td>
</tr>
<tr>
<td>PS06</td>
<td>Number of cases of MRSA bacteraemia &gt; 48 hours (cumulative year to date)</td>
<td>4 Red</td>
<td>4 Red</td>
<td>5 Red</td>
<td>6 Red</td>
<td>6 Red</td>
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<tr>
<td>PS07</td>
<td>Antibiotic prescribing - % compliance with antimicrobial guidelines [most recently available figure, undertaken quarterly]</td>
<td>95.89% Green</td>
<td>95.89% Green</td>
<td>95.35% Green</td>
<td>95.35% Green</td>
<td>95.35% Green</td>
</tr>
<tr>
<td>PS08</td>
<td>% patients receiving stage 2 medicines reconciliation within 24h of admission</td>
<td>74.23% Red</td>
<td>72.67% Red</td>
<td>82.35% Amber</td>
<td>70.55% Red</td>
<td>74.71% Red</td>
</tr>
<tr>
<td>PS09</td>
<td>% patients receiving allergy reconciliation within 24h of admission</td>
<td>100% Green</td>
<td>100% Green</td>
<td>100% Green</td>
<td>100% Green</td>
<td>100% Green</td>
</tr>
<tr>
<td>PS10</td>
<td>% of incidents associated with moderate harm or greater</td>
<td>0.42% Green</td>
<td>0.62% Green</td>
<td>0.7% Green</td>
<td>0.81% Green</td>
<td>0.5% Green</td>
</tr>
<tr>
<td>PS11</td>
<td>Total number of newly acquired pressure ulcers (category 2, 3 and 4) reported via Datix</td>
<td>79 N/A</td>
<td>68 N/A</td>
<td>93 N/A</td>
<td>97 N/A</td>
<td>86 N/A</td>
</tr>
<tr>
<td>PS12</td>
<td>Falls leading to moderate harm or greater</td>
<td>1 Green</td>
<td>4 Green</td>
<td>2 Green</td>
<td>5 Green</td>
<td>0 Green</td>
</tr>
<tr>
<td>PS13</td>
<td>Cleaning Score - % of inpatient areas with initial score &gt; 92%</td>
<td>47.37% N/A</td>
<td>38.3% N/A</td>
<td>50.91% N/A</td>
<td>43.48% N/A</td>
<td>44.19% N/A</td>
</tr>
<tr>
<td>PS14</td>
<td>% Radiology direct access 7 day turnaround times - Plain Film, CT, MRI &amp; Ultrasound</td>
<td>86.45% Red</td>
<td>79.13% Red</td>
<td>86.48% Red</td>
<td>89.05% Red</td>
<td>86.12% Red</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 Green</td>
<td>0 Green</td>
<td>0 Green</td>
<td>0 Green</td>
<td>0 Green</td>
</tr>
<tr>
<td>PS17</td>
<td>Number of hospital acquired thromboses identified and judged avoidable</td>
<td>3 Red</td>
<td>1 Red</td>
<td>2 Red</td>
<td>8 Red</td>
<td>4 Red</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 N/A</td>
<td>0.99 N/A</td>
<td>0.99 N/A</td>
<td>0.99 N/A</td>
<td>0.94 N/A</td>
</tr>
<tr>
<td>CE02</td>
<td>Crude Mortality</td>
<td>204 N/A</td>
<td>245 N/A</td>
<td>238 N/A</td>
<td>238 N/A</td>
<td>205 N/A</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>65.71% Red</td>
<td>67.51% Red</td>
<td>64.1% Red</td>
<td>59.61% Red</td>
<td>60.99% Red</td>
</tr>
<tr>
<td>CE04</td>
<td>Dementia diagnostic assessment and investigation [one month in arrears]</td>
<td>82.89% Amber</td>
<td>79.51% Red</td>
<td>100% Green</td>
<td>100% Green</td>
<td>100% Green</td>
</tr>
<tr>
<td>CE06</td>
<td>ED - % patients seen, assessed and discharged / admitted within 4h of arrival</td>
<td>94.21% Amber</td>
<td>91.05% Amber</td>
<td>91.05% Amber</td>
<td>82.25% Green</td>
<td>87.1% Green</td>
</tr>
<tr>
<td>PE01</td>
<td>Friends &amp; Family test % likely to recommend - ED</td>
<td>77.82% N/A</td>
<td>89.56% N/A</td>
<td>89.56% N/A</td>
<td>90.7% N/A</td>
<td>87.73% N/A</td>
</tr>
<tr>
<td>PE02</td>
<td>Friends &amp; Family test % not likely to recommend - ED</td>
<td>15.11% N/A</td>
<td>6.13% N/A</td>
<td>6.13% N/A</td>
<td>5.69% N/A</td>
<td>6.66% N/A</td>
</tr>
<tr>
<td>PE03</td>
<td>Friends &amp; Family test % likely to recommend - Mat</td>
<td>96.36% N/A</td>
<td>96.16% N/A</td>
<td>96.16% N/A</td>
<td>95.83% N/A</td>
<td>97.42% N/A</td>
</tr>
<tr>
<td>PE04</td>
<td>Friends &amp; Family test % not likely to recommend - Mat</td>
<td>0.91% N/A</td>
<td>0.23% N/A</td>
<td>0.23% N/A</td>
<td>0% N/A</td>
<td>0% N/A</td>
</tr>
<tr>
<td>PE05</td>
<td>Friends &amp; Family test % likely to recommend - IP</td>
<td>96.17% N/A</td>
<td>95.7% N/A</td>
<td>95.7% N/A</td>
<td>96.54% N/A</td>
<td>95.38% N/A</td>
</tr>
<tr>
<td>PE06</td>
<td>Friends &amp; Family test % not likely to recommend - IP</td>
<td>1.7% N/A</td>
<td>1.42% N/A</td>
<td>1.42% N/A</td>
<td>1.37% N/A</td>
<td>1.8% N/A</td>
</tr>
<tr>
<td>PE07</td>
<td>Friends &amp; Family test % likely to recommend - OP</td>
<td>94.12% N/A</td>
<td>95.07% N/A</td>
<td>95.07% N/A</td>
<td>94.67% N/A</td>
<td>94.12% N/A</td>
</tr>
<tr>
<td>PE08</td>
<td>Friends &amp; Family test % not likely to recommend - OP</td>
<td>3.05% N/A</td>
<td>2.49% N/A</td>
<td>2.49% N/A</td>
<td>2.78% N/A</td>
<td>3.09% N/A</td>
</tr>
<tr>
<td>PE14</td>
<td>Single sex breaches</td>
<td>0 Green</td>
<td>0 Green</td>
<td>8 Red</td>
<td>14 Red</td>
<td>0 Green</td>
</tr>
<tr>
<td>PE15</td>
<td>% patients EAU length of stay &lt; 12h</td>
<td>59.79% Red</td>
<td>59.39% Red</td>
<td>51.05% Red</td>
<td>50.06% Red</td>
<td>51.01% Red</td>
</tr>
<tr>
<td>PE16</td>
<td>% Complaints upheld or partially upheld [Quarterly in arrears]</td>
<td>37.37% N/A</td>
<td>37.37% N/A</td>
<td>52.53% N/A</td>
<td>52.53% N/A</td>
<td>52.53% N/A</td>
</tr>
</tbody>
</table>
Exception charts

**Chart 6:** PS06 Number of cases of MRSA bacteraemia > 48 hours (cumulative year to date)

The yearly limit is 0 avoidable bacteraemia. To date there have been one unavoidable and 5 avoidable MRSA bacteraemias. Of the 5 avoidable, 2 have been thought to be contaminants, 1 due to infected cannula site and 1 where the patient did not have a wash in chlorhexidine prior to theatre. The February case was thought to be due to chest sepsis. This was deemed avoidable by the CCG as the patient was not given MRSA skin decontamination. However, it is considered unlikely that this would have prevented the bacteraemia.

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

Pharmacy provides a full ward based clinical service 5 out of 7 days in most areas. The current target is measured based on all inpatient admissions for the month. Investment in April 2016 has allowed the percentage compliance to be maintained while activity has increased over the same period as measured over a 7 day period. The attainment when considering only the current 5 day ward based clinical pharmacy services is >85%.

The chart shows the proportion of inpatient 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 8: PS14 % Radiology direct access 7 day turnaround times - Plain Film, CT, MRI & Ultrasound

<table>
<thead>
<tr>
<th>Month</th>
<th>% Radiology direct access 7 day turnaround time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar-16</td>
<td>91%</td>
</tr>
<tr>
<td>Apr-16</td>
<td>91%</td>
</tr>
<tr>
<td>May-16</td>
<td>91%</td>
</tr>
<tr>
<td>Jun-16</td>
<td>91%</td>
</tr>
<tr>
<td>Jul-16</td>
<td>91%</td>
</tr>
<tr>
<td>Aug-16</td>
<td>91%</td>
</tr>
<tr>
<td>Sep-16</td>
<td>91%</td>
</tr>
<tr>
<td>Oct-16</td>
<td>91%</td>
</tr>
<tr>
<td>Nov-16</td>
<td>91%</td>
</tr>
<tr>
<td>Dec-16</td>
<td>91%</td>
</tr>
<tr>
<td>Jan-17</td>
<td>91%</td>
</tr>
<tr>
<td>Feb-17</td>
<td>91%</td>
</tr>
<tr>
<td>Mar-17</td>
<td>91%</td>
</tr>
</tbody>
</table>

Overall non-compliant for routine (R) 86.1% and urgent (U) 59.3% scans. In summary for the specific modalities: Plain film (R83%, U45%), CT (R90%, U99.3%), MRI (R74%, U95%) and Ultrasound (R99.3%, U99.3%). 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. 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.

95% of routine radiology reports received by the requesting clinician within 7 calendar days of the examination date.

Chart 9 : PS17 Number of hospital acquired thromboses identified and judged avoidable

4 potentially preventable Hospital Acquired Thromboses (HATs) were reported in March 2017. 2 of the HATs were reported as moderate harm and 2 as minor harm. 1 HAT occurred during admission and 3 within 90 days of admission. The updated electronic venous thromboembolism (eVTE) risk assessment with direct link to e-prescribing (introduced Dec 2016) should make documentation of the e-VTE risk assessment more relevant, and make prescription and documentation easier. The latest quarterly pharmacy-led audit of ‘appropriate thromboprophylaxis’ January 2017 shows improvement with Trust overall compliance at 96.7% ‘appropriate thromboprophylaxis’. The pharmacy led audit of ‘appropriate thromboprophylaxis’ is due to be repeated in April 2017. The updated VTE E-Learning for Nurses went live in March.

When a hospital-associated thrombosis occurs, screening +/- root cause analysis is triggered. This graph shows the number of hospital acquired thromboses in month that were felt to have been avoidable [Owner: S Shapiro].
**Chart 10:** CE03 Dementia - % patients aged > 75 admitted as an emergency who are screened [one month in arrears]

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.

NOTSS: the Divisional Medical Director encouraging the junior doctors to be compliant with this screening. The new intake of doctors will join in August 2017 and this will be the target group.

MRC trained junior medical staff in cognitive screening on the EPR system. MRC compliance was 58% in February 2017; with Acute General Medicine at 59%.

---

**Chart 11:** 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 at least three mental health patients each day who remain on the unit for more than 24hrs.

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

WHO Compliance

5.1. Chart 12 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 12: WHO Checklist compliance March 2017

<table>
<thead>
<tr>
<th>Division</th>
<th>Compliance</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>NOTSS (NOC)</td>
<td>91%</td>
<td>Out of 32 audits done on Ward D, Ward F and the Bone Infection Unit - 3 were partially compliant due to 2 points missed on the ‘sign-in’ sections and one on the ‘sign-out’ section. Each individual theatre practitioner and anaesthetist involved has had these omissions discussed with them in order to learn and improve future compliance.</td>
</tr>
<tr>
<td>C&amp;W</td>
<td>96.0%</td>
<td>Consultants responsible have been identified and informed of the incomplete WHO forms. The Governance team contact staff responsible and discuss improvements required. Any on-going issues are escalated to the Divisional Director. The non-complaint checklists were: 2 in Gynaecology and 1 Maternity.</td>
</tr>
<tr>
<td>CSS</td>
<td>99.7%</td>
<td>In March 2017 there were 326 WHO checklists audited in the Division. The compliance rate was below the KPI at 96.90%. There were ten partial compliances: 8 in JR theatres and 2 in West Wing theatres, the omissions over the checklists were as follows: ‘Sign In’ Signatures missing on 5, ‘Time Out’ signature missing on 1, ‘Sign Out’ signatures missing on 4 and two had no procedure stated. The Matron and teams have been made aware of the partial compliances and the requirement to achieve compliance and review each form at the end of each case. All the other areas achieved 100% compliance.</td>
</tr>
<tr>
<td>Cardiothoracic Surgery (MRC)</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>Respiratory Intervention (MRC)</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>S&amp;O</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>Cardiology (MRC)</td>
<td>98.0%</td>
<td>Both failures in cardiology involved sign outs not being completed and staff members involved in the failures were spoken to.</td>
</tr>
<tr>
<td>Cardiology (MRC)</td>
<td>98.0%</td>
<td>There were two instances of partial non-compliance which were brought to the attention of the staff involved. The Matrons and teams will now review each WHO checklist at the end of each case.</td>
</tr>
</tbody>
</table>

Table 3: WHO Checklist March 2017
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 March 2017 show 80.7% of discharge summaries were sent before or within 24 hours of discharge, this is a slight improvement on the February figure of 79.6% but this falls short of the agreed OCCG trajectory of 88%.

6.3. For results endorsed on EPR, 78.4% were endorsed within 7 days (note it is possible to review a result and not endorse it). This is an decline on February’s performance at 79.9% and not within the agreed OCCG trajectory of 82%.

6.4. Feedback for March 2017 received by the OCCG from GPs is summarised in the table below. A total of 106 records of GP feedback were received by the OCCG regarding the Trust in March, this is an increase from last month but is still below the monthly average of 158 a month (Jan 15 to Mar 17).

6.5. The top 3 themes account for 24% of all feedback received over the month.

6.6. ‘Delay in GP receiving Clinical Documents’ has been the highest reported issue for the past two months and the highest reported since January 2015 with 20% (234/1444) of all the GP feedback.

Table 4: GP Feedback – Top 3 thematic areas

<table>
<thead>
<tr>
<th>Theme</th>
<th>January 2017</th>
<th>February 2017</th>
<th>March 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delay in GP receiving clinical docs (i.e. OPD/Discharge letters)</td>
<td>5</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td>Request from secondary care for GP to follow up tests/scans/investigations initiated in secondary care</td>
<td>8</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Failure in referral process due to pathway issue</td>
<td>6</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Total Reported</td>
<td>98</td>
<td>81</td>
<td>106</td>
</tr>
</tbody>
</table>

7. Patient Safety and Clinical Risk

Clinical Risk

7.1. In relation to Patient Safety and Clinical Risk:

- There were no Never Events declared in March 2017.
- 7 Serious Incidents requiring Investigation (SIRI’s) were reported onto STEIS in March 2017.
- 11 SIRI’s were submitted for closure to the Oxfordshire Clinical Commissioning Group (OCCG) in March 2017. All 11 SIRI’s were sent to the OCCG within the agreed timeframe.
- 2 SIRI closure meetings took place between the Trust and the OCCG in March 2017 and 12 SIRI’s were closed by OCCG.
- There were no SIRIs downgraded in March 2017.

7.2. The following graphs provide an update on SIRI activity.
Chart 13: OUH incidents showing level of harm and total numbers for each level of harm

![Graph showing incidents by level of harm]

<table>
<thead>
<tr>
<th>Date</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>Mar-16</td>
<td>1842</td>
<td>442</td>
<td>26</td>
<td>1</td>
<td>3</td>
<td>2314</td>
</tr>
<tr>
<td>Apr-16</td>
<td>1692</td>
<td>394</td>
<td>15</td>
<td>0</td>
<td>0</td>
<td>2101</td>
</tr>
<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>14</td>
<td>1</td>
<td>1</td>
<td>2140</td>
</tr>
<tr>
<td>Sep-16</td>
<td>1824</td>
<td>386</td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>2231</td>
</tr>
<tr>
<td>Oct-16</td>
<td>1858</td>
<td>403</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>12</td>
<td>1</td>
<td>0</td>
<td>2101</td>
</tr>
<tr>
<td>Jan-17</td>
<td>1707</td>
<td>404</td>
<td>12</td>
<td>2</td>
<td>0</td>
<td>2127</td>
</tr>
<tr>
<td>Feb-17</td>
<td>1685</td>
<td>422</td>
<td>9</td>
<td>2</td>
<td>0</td>
<td>2103</td>
</tr>
<tr>
<td>Mar-17</td>
<td>1749</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2182</td>
</tr>
</tbody>
</table>

Chart 14: SIRIs declared and completed in the last 13 months

![Graph showing SIRIs declared and completed]

Chart 15: SIRIs declared by Division during last 13 months

![Graph showing SIRIs by division]
7.3. Chart x shows that each Division within the Trust (with the exception of NOTSS and Corporate) declared a SIRI. CSS, MRC and SO declared 2 each with C&W declaring 1.

Chart 16: SIRI Investigations completed by Division during the last 13 months

Chart 17: SIRIs Declared by Hospital Site during the last 13 months

7.4. Table 5 provides more details of the SIRIs that were declared via STEIS in March 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 March 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 declared as a SIRI</th>
<th>Reported Datix to STEIS interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-17/154</td>
<td>MRC</td>
<td>A patient who had self-harmed absconded before requested mental health assessment.</td>
<td>26/02/2017</td>
<td>25/02/2017</td>
<td>0</td>
<td>02/03/2017</td>
<td>5</td>
</tr>
<tr>
<td>16-17/155</td>
<td>SO</td>
<td>Delay in escalating deterioration after surgery</td>
<td>28/02/2017</td>
<td>28/02/2017</td>
<td>1</td>
<td>9/03/2017</td>
<td>10</td>
</tr>
<tr>
<td>16-17/156</td>
<td>CW</td>
<td>A patient had an intra-operative cardiac arrest during a procedure.</td>
<td>24/02/2017</td>
<td>14/02/2017</td>
<td>0</td>
<td>9/03/2017</td>
<td>11 (based on date incident detected) see note below</td>
</tr>
<tr>
<td>16-17/157</td>
<td>CSS</td>
<td>After elective extubation a patient requiring intensive care lost their airway and had an arrest prior to insertion of a tracheostomy</td>
<td>10/03/2017</td>
<td>14/03/2017</td>
<td>3</td>
<td>16/03/2017</td>
<td>3</td>
</tr>
<tr>
<td>16-17/158</td>
<td>SO</td>
<td>A patient sustained a hospital acquired category 3 pressure ulcer.</td>
<td>21/03/2017</td>
<td>20/03/2017</td>
<td>0</td>
<td>23/03/2017</td>
<td>4</td>
</tr>
<tr>
<td>16-17/159</td>
<td>MRC</td>
<td>A patient sustained a hospital acquired category 3 pressure ulcer.</td>
<td>15/03/2017</td>
<td>15/03/2017</td>
<td>1</td>
<td>23/03/2017</td>
<td>7</td>
</tr>
<tr>
<td>16-17/160</td>
<td>CSS</td>
<td>A patient developed category 3 pressure damage to the chin following surgery in the prone position</td>
<td>15/03/2017</td>
<td>21/03/2017</td>
<td>5</td>
<td>30/03/2017</td>
<td>8</td>
</tr>
</tbody>
</table>

7.5. The incident detected date to the reported on Datix date was a mean of 1.4 working days with a median of 1 working day.

7.6. The reported date on Datix to the date a SIRI was reported on STEIS is a mean of 6.9 working days with a median of 7 working days.

7.7. There was one ‘over 10 day’ delay in reporting the incident onto Datix or reported date to declaring a SIRI.

7.8. To note SIRI 16-17/156 has a reported date (when the Datix form was filled in) of 14/2/17 but an incident detected date of 24/2/17. This is because this incident was presented at two different mortality and morbidity meetings, where the decision was taken to take the incident to the SIRI forum.

**OCCG Closure meetings in March 2016**

7.9. Two SIRI closure meetings took place between the OCCG and the Trust in March 2017 where 12 SIRIs were closed.
Response to Patient Safety Alert

7.10. The Patient Safety Alert NHS/PSA/RE/2016/006 “Nasogastric Tube misplacement: continuing risk of death and severe harm” was published on 22 July 2016. Earlier to this alert a number of National Patient Safety Agency (NPSA) alerts were produced in 2005, and three further alerts between 2011 and 2013 which were as a result of ongoing incidents some of which caused severe harm or were fatal. Examination of the incident reports by NHS Improvement clinical reviewers identified key areas of concern which have been highlighted in this Patient Safety Alert, requiring self-assessment by Trusts in order to take forward actions that address these areas of concern and provide Trust Boards with the necessary assurance.

- The Trust has a compliant action plan which includes all the aspects highlighted in the alert:
  - Named Executive Director for this alert
  - Processes for robustly checking nasogastric tube placement with radiological imaging, and reporting by radiologists who are competency trained, and treating medical staff who understand the process in order to avoid errors
  - The use of pH testing of aspirate with CE marked pH test strips by Registered Nurses
  - The use of fine bore naso-gastric tubes that meet NPSA guidelines (radio opaque for their entire length and externally visible markings).
  - Bedside documentation that includes all safety critical checks
  - Appropriate training for staff who are managing patients with fine bore naso-gastric tubes
  - Presentation to the Trust Board through the Board Quality Report on the actions taken to address the Patient Safety Alert
  - OUH Never Event re: misplaced nasogastric tube occurred in November 2014; the nasogastric tube policy was immediately reviewed and revised, a standard operating procedure was introduced for x-rays for nasogastric tube placement with immediate reporting by radiologists to confirm that a fine bore nasogastric feeding tube is in the correct place before feeding commences and there was a review of nursing competency and training for the insertion of fine bore nasogastric feeding tubes.

Quality Walk Rounds

7.11. Five Executive Quality walk rounds took place in March 2017.

7.12. The Walk Rounds are detailed in Table 6

<table>
<thead>
<tr>
<th>Hospital Site/Satellite Unit</th>
<th>Areas visited</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Radcliffe Hospital</td>
<td>6B – Stroke ward</td>
</tr>
<tr>
<td>Chipping Norton</td>
<td>Cotswold Midwifery Led Unit</td>
</tr>
<tr>
<td>Nuffield Orthopaedic Centre</td>
<td>Ward A</td>
</tr>
<tr>
<td>John Radcliffe Hospital</td>
<td>West Wing Theatres</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:

6B Stroke Unit, John Radcliffe Hospital
- The Unit has been commended for having good multidisciplinary team working and feedback from patients on the Unit was very positive.
- There is currently a lack of extra storage space on the Unit; medications are currently being kept in the storage room. The Operational Service Manager will review the storage and space utilisation on the unit to resolve this issue. As an interim measure, the Matron for Acute General Medicine will explore options for purchasing a lockable, mobile pharmacy trolley for medication storage.
- The Unit is supportive of training in ambulatory assessment; all Band 6 nurses are now Stroke Specialist Deputy Sisters which has allowed them to develop advanced skills in ward management.

Cotswold Midwifery Led Unit, Chipping Norton
- The Unit has new delivery beds and the feedback from the community midwives is very positive. Improvements have also been made to the lounge following a donation from the League of Friends. These improvements were felt to have a positive impact on the quality of care and patient experience.

Ward A, Nuffield Orthopaedic Centre
- Staff on the ward are satisfied with their area of work and do not have any concerns relating to patient safety.
- There are some concerns with patient experience relating to prolonged waiting times on the Unit. The model of finalising, and the ordering of theatre lists will be reviewed.

West Wing Theatres, John Radcliffe Hospital
- The governance team are embedded in West Wing Theatres, and engaging with staff and sharing learning from incidents. The team are also in the process of implementing a new safe staffing management toolkit.
- There is a robust education strategy in place, which takes into consideration all roles and options for potential career progression.
- The theatres are clean and there is a rotation of deep cleaning in place for each theatre, however discussions with Carillion are on-going to improve the cleaning standards of the corridors and support areas of theatres.

Churchill Theatres, Churchill Hospital
- There is good utilisation of theatre capacity. Information on theatre utilisation per specialty, audits, WHO checklists and incidents are displayed outside the staff room. A project is on-going for this information to be made available electronically via Orbit plus electronic dashboards.
- There are on-going challenges with the Private Finance Initiative (PFI) building. Three key challenges are: damage to flexible medical gas pipelines,
ventilation system revalidation and operating light mechanical failure results. Each of these has the potential to result in theatre closures. It was agreed that the Chief Finance Officer would ascertain when funding would be available for replacing equipment.

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 October 2015 to September 2016 is 0.94. This is rated ‘as expected.’ The SHMI trend is depicted in Chart 18. The SHMI remains within the ‘as expected’ range.

Chart 18: SHMI trend analysis

8.3. The HSMR is 100 for the latest available 12-month period January 2015 to December 2016. The value is ‘within expected’ range (95% CI 96.2 -104.9).

8.4. The number of observed deaths within the HSMR 56-diagnosis groups is 2064. The HSMR trend is depicted in Chart 19. The HSMR remains ‘within the expected’ range.

Chart 19: 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 an unchanging crude mortality as a percentage of patient attendances when looked at over 12 months.

Chart 20: Crude Mortality

![Crude Mortality Chart](chart20.png)

Chart 21: Crude Mortality by Division

![Crude Mortality by Division Chart](chart21.png)
8.6. The following audits were presented at the Clinical Effectiveness Committee (CEC) on 9 March 2017; key areas for improvement and areas of good performance are highlighted:

- **The Deteriorating Patient Quarter 1 and Quarter 2 2016/17 Data**
  The data for this audit has been extracted directly from System for Electronic Notification and Documentation (SEND) for the first time and the senior leaders are able to monitor their compliance directly within the SEND system and can therefore be quickly alerted to issues requiring further investigation and improvement, including being able to recognise themes and trends.

- **Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Audit 2016**
  The Trust is complying with the South Central Unified DNACPR policy and scored over 80%.

- **Venous Thrombo Embolism (VTE) Prophylaxis Data Collection – February 2017**

- **NICE Quality standards (QS) 19 : Bacterial Meningitis in Children and Young People**

- **2016 Sentinel Stroke National Audit Programme (SSNAP) Acute Organisational Audit Report for John Radcliffe (JR) & Horton (HGH) – combined report**
  Stroke services at the JR scored 7 out of 10, placing the site in the top 31% nationally for performance across the 10 criteria while Stroke services at the Horton scored 3 out of 10, placing the site in the bottom 14% nationally for performance across the 10 criteria. The stroke unit at the Horton is currently awaiting the outcome of a consultation process.

- **Paediatric Intensive Care Audit (PICANet)**

- **Elective Surgery- National Patient Reported Outcomes Measures (PROMs) Programme: Groin Hernia**

- **National Lung Cancer Audit (NLCA) : Annual Report**

- **Lung Cancer Clinical Outcomes Publication 2016**
  The Trust has been highlighted by the National Lung cancer Audit lead as a model for excellent practice with the length of stay data comparing favourably with the national data, 30-day survival adjusted is 98.7% compared to the
national average of 97.9% and 90-day survival adjusted is 94.8% compared to the national average of 96.2% which reflects the quality of care given and that the Trust is a relative low volume high resection rate unit.

- Intensive Care National Audit & Research Centre (ICNARC) Case Mix Programme Annual Report 2015-16 Neurosciences Intensive Care Unit (NICU) data

9. Infection Prevention and Control (IPC)

**Clostridium Difficile (C.diff)**

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

9.2. For March 2017 there were 2 cases of *C.diff* against an internal monthly ceiling of 5. The internal cumulative total for March 2017 is 53 cases against a cumulative limit of 69.

9.3. Both cases were discussed at the March Health Economy meeting and deemed unavoidable with no lapses in care.

9.4. The OUH has finished the financial year on 53 cases which is 16 cases below the cumulative limit of 69 and an even better performance than the previous year.

**Chart 23: Cases of OUH apportioned C.diff per month (March 2016 –March 2017)**

<table>
<thead>
<tr>
<th>Month</th>
<th>Mar-16</th>
<th>Apr-16</th>
<th>May-16</th>
<th>Jun-16</th>
<th>Jul-16</th>
<th>Aug-16</th>
<th>Sep-16</th>
<th>Oct-16</th>
<th>Nov-16</th>
<th>Dec-16</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>Mar-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Cdiff</td>
<td>57</td>
<td>3</td>
<td>14</td>
<td>19</td>
<td>25</td>
<td>30</td>
<td>37</td>
<td>39</td>
<td>40</td>
<td>43</td>
<td>47</td>
<td>51</td>
<td>53</td>
</tr>
</tbody>
</table>

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

9.5. There have been no incidents of MRSA bacteraemia during March 2017.
Methicillin-sensitive \textit{Staphylococcus aureus} (MSSA) Bacteraemia

9.6. 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.

9.7. In March there were 6 post 48hour MSSA bacteraemia. Of note, one is currently being investigated as potential peripheral line infection and a second is a possible contaminant.

9.8. As reported last month work around reducing blood culture contaminants has commenced. The results of the survey monkey will be available next month.

Chart 25: MSSA bacteraemias March 2016-March 2017 (Post 48hrs Admission)
MRSA Screening Compliance

9.9. As reported last month, the EPR support is not yet in place to assist nursing staff to identify which patients require screening. However, considerable progress has now been made with this by the EPR team.
9.10. As consequence MRSA screening compliance has not been measured for March.

Candida auris

9.11. The screening of the Neurointensive (NITU) care patients continues to identify newly colonised patients. A significant number of newly colonised patients were identified in March, and investigations are underway to see if this is a significant change in acquisition rate, or if it relates to activity on the unit.
9.12. Public Health England has visited the unit to undertake further environmental sampling.
9.13. The Modernising Medical Microbiology (MMM) group are now working with the IPC team to investigate a number of epidemiological hypotheses using the IORD (Infections in Oxford Research Database).
9.14. MMM are also working with the IPC team to sequence a number of isolates to further inform IPC initiatives.

Chart 26: Epi Curve for Candida auris January 2015 - March 2017

Mycobacterium chimaera

9.15. Mycobacterium chimaera is a non tuberculous mycobacterium. This type of mycobacterium is widespread in the environment, including tapwater, and is usually associated clinically with respiratory disease or with disseminated disease in the immunocompromised patient.
9.16. It is now recognised that M. chimaera has caused severe infections in a small proportion of patients who have had cardiac surgery. UK and international investigations have implicated heater cooler units used for cardiopulmonary bypass, transmitting infection from their water tanks via generation of a contaminated aerosol with particles reaching the operative field.

9.17. The risk remains low, for example <1 case per 100,000 coronary artery bypass graft procedures. The highest risk group is patients who have undergone valve replacement or repair, whose risk is currently estimated at 1 case per 5000 procedures. However, M. chimaera infection can be difficult to diagnose, requires specific treatment, and has a high mortality.

9.18. M. chimaera infections following cardiothoracic surgery can have long latency periods. The time between surgery and development of symptoms ranged from 2-58 months. The upper limit is unknown.

9.19. As of 17 March 2017, there were 28 cases of M. chimaera infection in the UK following surgery on cardiopulmonary bypass, of which 15 were known to have died. The median interval between surgery and diagnosis is 19 months but ranges from 3 to 68 months. There have not been any cases seen in association with surgery at the OUH.

9.20. In February 2017 NHS England instructed Trusts to contact GP practices for patients at risk (identified by clinical coding) asking GPs to identify those few patients for whom notification would not be appropriate, such as those in receipt of end of life care. Following both demographic checks and validation by GPs patient letters were prepared and distributed to patients. The distribution commenced on 27th March and was completed by April 3rd 2017.

9.21. The OUH has provided a patient help-line, and the IPC, cardiothoracic, cardiology and infectious diseases teams are working together on managing any patients that present with concerns that they may have M. chimaera.

9.22. The notification process has had significant resource implications for staff in IPC, the Information Team, and the Corporate and CardiacDirectorates. Progress with the notification process was further impeded by an error in the NHS England Framework document in the diagnostic codes to be notified.

**Cleaning Scores**

9.23. The cleaning scores remain below standard in the children’s hospital. To this end the Infection Prevention and Control team have been meeting weekly with Carillion Senior Patient Experience Manager to monitor progress.

9.24. The Churchill site is giving significant cause for concern. The Contract and Performance team have undertaken a detailed review of the areas which have scored significantly below the standard and there is a correlation with the number of discharge cleans which have been completed.

9.25. The Synbiotix platform should be fully operational across all four sites next month.
Cleaning Partnership Group

9.26. The Cleaning Partnership Group met in March. It was agreed at this meeting that in future the cleaning scores that are reported in the Clinical Governance and Quality Reports would be the contract scores. This proposal will be presented to the Hospital Infection Prevention and Control Committee in April.

Chart 27: Very High Risk Areas (intensive care areas, operating theatres) Contractors Threshold Score 95%

[Bar chart showing scores for different areas.]

Chart 28: High Risk Areas (inpatient ward areas) Contractors Threshold Score 92%

[Bar chart showing scores for different areas.]

10. Patient Experience

Friends and Family Test (FFT)

10.1. This report includes an analysis of the FFT data by focusing in more depth on particular departments, within the context balanced with the perspective of the clinical staff from that area. The report highlights opportunities for learning from positive as well as constructive feedback.
10.2. Departments which are explored in more depth are selected systematically using the following methodology:

• Learning from positive feedback received from FFT
  o The departments selected will have over 20 responses, and for inpatients and day cases, over 15% response rate.
  o As there are many areas with 100% extremely likely and likely responses, these areas will be ranked by response rate.
  o All departments with 100% extremely likely and likely will be listed in the report. However, only one department from an inpatient/day case area, and one from outpatient area will be selected for a deeper review, to highlight good practice and the reasons.
  o Areas with less than 90% extremely likely responses will be excluded.
  o The relevant clinical and operational leaders will be contacted to congratulate them on the feedback, discuss the themes within the feedback, and ask if there is any practice they wish to share which has led to such a positive response from patients.
  o A different area will be selected for focus each month.

• Learning from constructive feedback from FFT
  o The departments selected will have over 20 responses, and for inpatients and day cases, over 15% response rate.
  o One department will be selected from an inpatient/day case area and one department will be selected from an outpatient area.
  o Areas with fewer than 4 ratings will be excluded.
  o The departments with the highest percentage not recommend will be selected.
  o The relevant leaders will be contacted to make them aware of the comments, discuss the themes within the feedback, and ask if there are any actions being taken to improve the feedback.

• The emergency departments and maternity teams will be included in the more in depth focus if an exception (positive or negative) is triggered on the Statistical Process Control (SPC) charts. If a department within an inpatient area, day cases or outpatients is identified as the main cause of an exception on the SPC charts, this department will be selected for further analysis instead of using the process outlined above.

• The analysis and learning will be shared in a quarterly bulletin to clinical leaders, for discussion and sharing with clinical staff.

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1 Response rates are not monitored in outpatients.

2 The control chart is a graph used to study how a process changes over time. Data are plotted in time order. A control chart always has a central line for the average, an upper line for the upper control limit and a lower line for the lower control limit. These lines are determined from historical data. 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).
Emergency Departments

10.3. There were no exceptions to report in March: the percentage recommend, and percentage not recommend and response rate were in line with the previous month.

Maternity Services

10.4. The Head of Midwifery, Deputy Chief Nurse, Public Engagement Manager, and Patient Experience Manager, met with patient experience leaders from NHS Improvement (NHSI) and NHS England (NHSE) to discuss the Friends and Family Test in maternity services. This follows the interest by NHSI and NHSE into Trusts who are seeking to change the process, accessibility for women and appropriateness of the questions asked in feedback. The Trust discussed a number of options and welcomes benchmarking across other maternity services, as to the optimal method of obtaining meaningful feedback. The Trust will meet with its commissioners to discuss alternative options but include the key question of recommendation.

Inpatient areas and day case areas

10.5. Learning from constructive FFT feedback: no areas which met the criteria for constructive feedback were identified for further focus in March.

10.6. Learning from positive FFT feedback: The following areas had over 20 responses, over 15% response rate, 100% recommend rates, and over 90% rating extremely likely in March:

- Jane Ashley and Colorectal Ward, Churchill.
- Day Case Unit, Churchill.
- Pain Management Day cases, Churchill.
- Respiratory Day Case Unit, Churchill.
- Ward D, NOC.
- X Ray Day Case (Radiology), Surgery & Diagnostics Centre, Churchill.

10.7. The following areas had 100% recommend rates, over 20 responses, and over 15% response rate in March:

- Rheumatology Day Unit, NOC.
- Urology Ward, Churchill.

10.8. Jane Ashley and Colorectal ward were identified as the areas for further analysis based on excellent feedback, with 100% recommend, 92% extremely likely, and 33% response rate. This was achieved despite staffing levels being a challenge and a change of ward sister. The following themes were identified within the feedback:

- Personalised, responsive, compassionate care.
- Good communication and information.
- Helpful, professional and friendly staff attitude.
- Good ward environment (clean and quiet).
10.9. The current ward sister identified the following key areas that contributed to this excellent feedback:

- The staff in the team are dedicated, professional, and passionate about the care they provide. They are always seeking to improve their knowledge. There is a good atmosphere on the ward.
- The layout of the ward, and being in the new building lends itself to an environment that is clean and quiet.
- It is an elective surgery ward, which is a more controlled environment than wards admitting emergency patients.
- During times of staffing pressure, the ward has been authorised to shut some beds, which has helped staff to function to their best ability and provide a good safe patient experience.

10.10. Learning from improvement: Lichfield at the John Radcliffe improved from 88% recommend in January to 93% recommend in March. The following actions have been put in place to achieve this:

- Improved communication with patients, by nurses checking on patients regularly to update them on progress with their care.
- A housekeeper has been assigned to the role of ensuring patients are given an opportunity to provide feedback.
- Improved team working, by merging teams of nurses to cover inpatient, day case, and outpatients in rotation.
- Change of management structure.

Outpatient Departments

10.11. Learning from constructive FFT feedback: one of the Trust’s main outpatient departments was selected as an area for analysis on constructive feedback in March, with 90% recommend rate (the Trust average is 94%) and 7% not recommend rate. The following themes were identified:

- Waiting times and communication in relation to this.
- Individual staff feedback.

10.12. There is a comprehensive action plan in place to improve, including:

- Weekly meetings between the Clinical Co-ordinator and the Deputy Operational Service Manager to discuss issues.
- Review of doctors’ rotas to ensure the correct numbers of doctors are allocated to each clinic.
- Checking the doctors’ rotas with the doctors six weeks in advance of the clinics.
- Ensuring that clinics start promptly.
- Electronic Screens have been installed in the department to keep patients up to date.
- Staff members inform patients on arrival if there is a waiting time for their appointment.
- Individual staff have received feedback relating to their performance
- The feedback about waiting times will be shared in the next staff meeting.
10.13. Learning from positive FFT feedback: the following areas had 100% recommend rates, over 90% extremely likely, and over 20 responses:

- Cardiac Physiology at the Horton.
- Pre-Operative Assessment at the Horton.
- Physiotherapy at the John Radcliffe.
- Children's Outpatients Department at the Horton.

10.14. The following areas had 100% recommend rates and over 20 responses:

- Electrocardiogram outpatients.

10.15. The Children’s Outpatients Department at the Horton was identified as the area for further analysis based on excellent feedback, with 100% recommend rate, 92% extremely likely, and 101 responses. The following themes were identified within the feedback:

- Compassionate, person-centred care
- Good communication and detailed information
- Helpful, professional and friendly staff attitude
- Environment suitable for children (e.g. toys and games in waiting area)

10.16. The Horton Children’s Outpatients Department Sister and the Children’s Safeguarding and Patient Experience Lead identified the following processes that contribute to this excellent feedback:

- The team is small and all staff are passionate about the children and their families having a positive experience.
- There is a lead person in the team who ensures that the feedback is collected consistently and changes are implemented.
- The Children’s Patient Experience Project Lead liaises with the team regularly and presents the results visually to help teams to interpret their feedback.

**Children’s Feedback**

10.17. The percentage of children, and parents or carers, recommending the care received was 100% in March 2017, with a small decline in response rate. The children’s recommendation and response rates for the previous 12 months are presented in Charts 29 and 30

**Chart 29 – Children's Recommendation Rate**

![Chart 29 - Children's Recommendation Rate](chart_image)
10.18. There has been a general decline in FFT responses from children, and their parents/carers, over the last 6 months, which can be seen in Chart 30. Only December 2016 had a response rate above the 12-month average.

10.19. The Children’s Patient Experience Project Lead has been in contact with the Patient Experience team at Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH), where they have an average monthly response rate of 23%.

10.20. The aim is to identify successful FFT collection methods used by GOSH that can be trialled within the Children’s Directorate, with any methods used being monitored on a monthly basis for impact.

10.21. Based on information received from GOSH, Melanie’s Ward is trialling giving out feedback forms when discharge documentation is completed during April 2017. Prior to the trial, staff were not actively giving FFT out to patients and this is reflected in their responses: in March 2017, the ward received 2 FFT forms -response rate of 2.6% -which is similar to the Children’s Directorate rate. Since the start of the trial, 6 FFT forms have been received, suggesting that the trial is successful so far. The full impact of this trial will be evaluated after two months.

10.22. The Project Lead also attended the Children’s Sister’s Management Day in April 2017, to share the FFT results for the year and discuss the recent decline in response rate. Successful FFT collection methods in different wards and departments were identified and shared: for example, in Children’s outpatients at the Horton staff hand out FFT forms when children are checking in as part of height and weight checks, and on Robin’s ward, all staff share the responsibility of giving out forms which ensures that they are handed out regularly. This will also shared with ward staff to increase awareness of the benefits of FFT collection.

11. Complaints

11.01. The Trust received 105 new formal complaints in March. This is an increase from the previous month (February n=82). However, it remains on a par with the number of formal complaints the Trust received in March 2016 (n=106).
11.02. Chart 31 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 March (n=33), with an increase from the previous month (n=29).

Chart 31 - New Complaints by month/Division April 2016 to March 2017

11.03. The Trust received no red complaints in March.

11.04. The top five complaint themes for March include: clinical treatment (n=33), appointments (n=17), communication (n=15), values and behaviours (n=13) and access to treatment or drugs (n=7). There has been an increase in complaints regarding values and behaviours this month. This is discussed in further detail within the divisional overview below.

Divisional Overview

Neurosciences, Orthopaedics, Trauma and Specialist Surgery (NOTSS)

11.05. NOTSS received 33 new complaints in March and remains the division with the highest number of complaints across the Trust, with 31.4% of the total complaints received in March. This is a marginal increase when compared with the number of complaints received by NOTSS in February (n=29). When compared with the divisional activity, there were 0.09% 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 78 contacts received in March (0.21% of FCEs). This is a decrease in the number of contacts received in comparison to February (n=104).

The complaints in NOTSS relate to Neurosciences (n=12), Specialist Surgery (n=13) and Trauma and Orthopaedics (n=8).

11 of the complaints received by NOTSS in March relate to clinical treatment, which is an increase from the number received in February (n=4). The issues include a delay/failure in observations, delay/failure in treatment for infections, delay/failure in treatment/procedure and inappropriate treatment.

Nine of the complaints received relate to appointments, which is an increase from the number of complaints received in February relating to
the same topic (n=6). The issues raised pertain to appointment cancellations, appointment delays and patient not on waiting list. Five complaints relate to communication, which is a decrease compared with February, when six complaints related to communication. Issues raised include a breakdown in communication, a communication failure between departments, communication with a GP and a delay in reporting results. Seven complaints relate to values and behaviours, which is an increase in the number of complaints received by the Division for February (n=3). Issues include the attitude of administration/clerical staff, attitude of the medical staff and attitude of nursing/midwifery staff. NOTSS received five reopened complaints in March which is an increase in comparison to the number of reopened complaints received by the Division in February. 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.

Surgery and Oncology (S&O)

11.06. S&O received 13 complaints in March, which was 0.04% of all Finished Consultant Episodes (FCEs) and 12.4% of the total complaints received by the Trust in the month. This is the same number of complaints received for the division when compared with February. The complaints relate to Oncology and Haematology (n=8), Surgery (n=2), Transplant, Renal and Urology (n=1) and Gastroenterology, Endoscopy, and Churchill Theatres (n=2). The complaints include issues related to clinical treatment (n=4) with the concerns raised including a delay/failure in treatment/procedure and inadequate pain management. Two complaints regarding communication involved issues with communication with relatives/carers and a communication failure within a department. The complaint related to admission and discharge (n=1) was pertaining to delayed treatment. Two complaints in relation to values and behaviours contained issues around the attitude of medical staff and a failure to act in a professional manner. Two complaints were received in relation to appointments with the issues to address being appointment not kept by staff and appointment – cancelled. S&O received no reopened complaints in February.

Medicine, Rehabilitation and Cardiac (MRC)

11.07. MRC received 29 new complaints in March, which is an increase from the 17 received in February. The complaints received in March equate to
28% of the total complaints received by the Trust during this month. It also equates to 0.08% of all Finished Consultant Episodes in March. The complaints relate to Specialist Medicine (n=7), Acute Medicine (n=16) and Cardiac (n=6). Six of the complaints for Acute Medicine relate to emergency care.

One complaint relates to Access to Treatment/drugs with the main issue being around the access to services.

Two complaints received were in relation to Admission and Discharge with issues including discharged too early and waiting on a trolley.

Six complaints pertained to Appointments, with the issues including appointment delay and appointment – booking system.

Eight complaints were related to Clinical Treatment, with issues including a delay/failure in observations, delay/failure to diagnose and a delay/failure in treatment/procedures.

Four complaints were regarding Communication, with the issues raised including a communication failure within the department, inadequate information provided and incorrect/no information given.

Four complaints regarding Patient Care were received, with the concerns surrounding care needs not adequately met and a failure to monitor/observe.

Two complaints pertaining to Privacy/Dignity/Wellbeing (PDW) were received, with the issues raised including discrimination/equalities – disability and storage of personal provisions.

Three complaints were received in relation to Trust Values and Behaviours, with the issues all pertaining to the attitude of nursing staff being raised.

The Division received four reopened complaints in March requiring further investigation. Complainants have requested resolution meetings with relevant staff to be organised as the next step forward.

**Children’s and Women’s (C&W)**

11.08. C&W received 11 complaints in March; 0.07% of all FCEs and 10% of the total number of new complaints received by the Trust in the month. This is a decrease in the number of new complaints received in comparison to the number received in February (n=17). The complaints related to Women’s (n=8) and Children’s Services (n=3).

Four complaints relating to Access to Treatment/Drugs were received with the issues surrounding cancelled operation/procedure, lack of delivery suite/theatre and delayed treatment.

One complaint regarding Admission/Discharge was received with the issue around cancelled/rescheduled clinic/appointment.

Five complaints relating to Clinical Treatment were recorded with the issues including birth injury, delay/failure in observations and inadequate pain management.

One complaint regarding communication was received – the issue was in relation to communication with a patient.
Two reopened complaints were received for W&C in March which require further investigation/response.

**Clinical Support Services (CSS)**

11.09. CSS received ten complaints in March, which is 10% of the total complaints received by the Trust this month. This is an increase when compared with the number of complaints received in February (n=4). The complaints relate to Theatres, Anaesthetics and Sterile Services (n=2), Radiology and Imaging Services (n=6), Pathology and Laboratories (n=1) and Pharmacy (n=1).

One complaint was received regarding appointments with the issue coded against appointment – delay.

Four complaints regarding Clinical Treatment were received, with the issues including screening errors and a delay/failure to diagnose.

Two complaints regarding communication were logged and were both coded against communication with patient.

Two complaints regarding values and behaviours were received – attitude of nursing/midwives.

No reopened complaints were received in March for the division.

**Corporate**

11.10. Corporate division received nine complaints in March, which is 7% of the total complaints received by the Trust in the month.

Eight of the complaints related to Facilities with the issues pertaining to car parking – payment methods and availability, cleanliness – non-clinical and maintenance of building/grounds.

One was related to values and behaviours with the issue being around the attitude of administrative/clerical staff.

One reopened complaint was received requiring a further written response.

**Safe Staffing – Nursing and Midwifery**

11.10. The Trust is required to report Staffing data for adult inpatient wards in acute hospitals. This report therefore includes the safe staffing data for March 2017 and the metrics.

**National reporting for Safe Staffing for November 2016**

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

11.12. 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.

**Unify data for November 2016**

11.13. The fill rates of actual shifts against those planned (including temporary staff) are:
93.47% for Registered Nurses/Midwives
86.31% for Nursing Assistants (unregistered)

The Trust wide dashboard illustrates the ward by ward RAG rated staffing levels (appendix 2) for the day and night shifts. The Divisional RAG rated staffing (appendix 1) incorporates the human resource metrics and nurse/midwives sensitive indicators. This provides and overall staffing overview but doesn’t include the skill mix, which is reported upon 6 monthly in the acuity reviews.

**Current status of nursing and midwifery staffing within the Trust**

Areas of exception highlighted on the dashboards include (Appendix 1 - divisional staffing):

**The Adult Intensive Care Units**

11.14. The Horton Hospital ICU has a significant vacancy rate of 27.5% for registered nurses and nursing assistants, but well managed Nurse Sensitive Indicators with only one medicines error reported for the HGH ICU, seven medicines errors at the JR Adult ICU and two category 2 hospital acquired pressure ulcers (HAPU).

**The Neurosciences, Orthopaedics, Trauma & Specialist Surgery Division**

11.15. This division has significant levels of vacancies and a rolling turnover of staff in some Neuroscience wards being at its highest between 31.7% and 34.81%. Recruitment initiatives have included Facebook advertising, discussion regarding career prospects with 3rd year students in universities as well as developing marketing material for posts in the Trust.

The Nurse Sensitive Indicators that are reported by exception including an aggregate of multiple incidents and are illustrated on the dashboard appendices: that of the NOC Bone Infection Unit which had seven falls without harm and one category 2 HAPU. Neurosciences red ward has seven falls without harm and neuroscience blue ward had eight falls without harm. Neuroscience has patients who are prone to falls due to their conditions but rarely with any harm. 6A had one medication error, six category 2 HAPUs and two falls without harm. 2A Trauma had two category 2 HAPUs and four falls without harm.

**The Children’s wards and gynaecology**

11.16. This directorate has significant vacancies and a rolling turnover of staff in the gynaecology ward at 29.9%, but with well controlled quality indicators, with just one fall without harm.

Robins ward has a rolling turnover of 33.24%, however the quality metrics include 3 medicines errors. There was one extravasation in Paediatrics ICU, and 2 extravasation incidents in New Born Care (NBC), as well as 6 medicines errors in March. It should be noted that NBC undertake all the intravenous medicines for the babies on the maternity wards, who are brought down to the unit several times a day. There was one HAPU on Bellhouse Drayson ward as well as one fall without harm, and one medicine error.
Maternity unit (JR)

11.17. The shifts at risk are largely within the Delivery Suite, 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. This is in order to 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 MLU. 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 and include one fall without harm, one medicines error, and the emergency caesarean sections in relation to the number of births were 11.8%. Instrumental deliveries were 16% of the total number of births and seven 3\textsuperscript{rd} and 4\textsuperscript{th} degree perineal tears, and on the Spires unit there were two tears. The overall rolling turnover on all the staff on the maternity wards and units is at 4.39%.

The Medicine, Rehabilitation & Cardiac Division

11.18. This division has a high rolling turnover of staff, notably on Short Stay ward at 25.4%, some of the level 7 wards are at their highest at 24.21%. Nurse Sensitive Indicators highlight the issues with this largely elderly frail group of patients. At the Horton General Hospital there were ten falls without harm, and seven category 2 HAPUs on Juniper ward. Laburnham had five category 2 HAPUs, and six falls without harm. HGH EAU had one medicines error and 3 category 2 hospital acquired pressure ulcers.

At the JR, ward 6C (Short stay ward) had two category 2 HAPUs and eight falls without harm. The stroke unit had one medication error, two category 2 HAPUs and seven falls, none with harm.

7A had two medicines errors, three category 2 HAPUs and one category 3 HAPU and three falls. JR EAU had 3 medicines errors, one category 2 hospital acquired pressure ulcer and 6 falls without harm. 7C had 1 medication error and five category 2 HAPUs and six falls, none with harm. 7B had two medication errors, two category 2 HAPUs and one fall without harm.

Cardiothoracic Critical Care had two medication errors, five category 2 HAPUs. Cardiology had eight falls without harm, one HAPU and one medication error.

Adams & Bedford ward had 18 falls, none with harm, one medicines error and one category 2 hospital acquired pressure ulcer.

The Acute General Medical 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). High Impact training from incidents and the roll out of the Fallsafe Care Bundle are being rolled out and implemented to address these issues, within a particularly elderly frail patient group with cognitive challenges.

The Surgery & Oncology Division

11.19. Staffing levels at recommended establishments on Surgery & Oncology wards at the Churchill Hospital continue to be a challenge.
A combination of vacancies on specialist wards coupled with a poor fill rate from NHSP, 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. This risk has been 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 levels of staffing until new recruits are in post. The highest rolling turnover is on ward 5F at the JR which is 29.19% and 28.41% on the renal ward at the Churchill Hospital.

Nurse Sensitive Indicators highlights include Haematology which had two medication errors, four category 2 HAPUs and three falls, none with harm. Oncology ward had two medication errors, two category 2 HAPUs and one category 3 HAPU and five falls without harm. Sobell House had nine category 2 HAPUs and nine falls without harm. 5F had three falls without harm.

The Division is actively deploying different recruitment techniques – principally using Facebook advertising as an initiative, recruitment fair participation and the ‘recommend a friend’ initiative, to actively address recruitment concerns. Actions taken on feedback include more opportunities for in-house professional development and are aimed at improving retention.

Safe staffing acuity review

11.20. The Trust is preparing to review of the correct levels of staffing within the JR Emergency Department (ED) in June using a nationally validated patient acuity tool.

11.21. The next inpatient acuity review is due in June 2017 for the previous 6 months.

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

11.23. The IPAMS tool is being used to measure theatre staffing, and a pilot is currently underway in the JR theatres. This is reporting on progress to the Cross Divisional Theatre Group.

12. Safe staffing: Report from Guardian of Safe (Medical) Working

Purpose

12.01. The Quarterly Report on Safe Working Hours for doctors in training (Q1: Jan-Mar.2017) is presented to the Board with the aim of providing context and assurance around safe working hours for OUH Junior Doctors.
Background

12.02. The new ‘2016 Terms and Conditions of Service’ for junior doctors requires trust boards to receive safe working hours’ reports no less than quarterly.

12.03. The new ‘2016 Terms and Conditions of Service’ for junior doctors requires trust boards to provide an aggregated report within their annual quality account for scrutiny by external bodies, such as HEE (local office), the GMC and the CQC.

12.04. Locally, as per the national ‘Implementation Timeline’, the new contract became operational for Foundation Year 1 doctors in December 2016. It is expected that transition will be complete for all applicable doctors by October 2017 (there are exceptions for trainees employed on long-term contracts).

12.05. A number of new processes to ensure compliance with the new contract have become operational via the ‘Junior Doctors 2016 Contract Implementation Project Board’. These processes include, but are not limited to; rota compliance testing, work schedule production, exception reporting and educational supervisor updates.

12.06. OUH is one of the largest providers of training for junior doctors in the country, and therefore faces a number of challenges related to; scale, heterogeneity and scattering when trying to ensure and demonstrate safe working hours’ practices across approximately 100 different junior doctor rotas.

12.07. A number of tools to facilitate compliant rota production and safe rostering have been commissioned by OUH; these tools are not being used by all departments; some departments appear to prefer their own custom solutions for rostering. Custom solutions for rostering present a risk to safe hours working practices.

Quantitative Report

12.08. The suggested report template provided by NHS Employers, recommends that these quarterly reports are constructed around data related to the following areas:

- Exception reports (with regard to working hours)
- Work schedule reviews
- Locum bookings
- Locum work carried out by trainees
- Vacancies
- Fines

12.09. Whilst data arising from doctors on the new contract is becoming available, the majority of junior doctors at OUH are still employed on the 2002 contract and data associated with this group is not centralised.

12.10. High level data

- Number of doctors in training (approx. total): 850
- Number of doctors in training (WTE): N/A
- Number of junior doctor rotas (approx.): 95
• Number of doctors in training on the new contract (total): 128
• Amount of time in job plan for guardian: 8 hours / week
• Admin support provided to the guardian: Via the MDO
• Amount of time in job plan for educational supervisors: 1 hour / trainee / week
• Typical time in job plan for clinical supervisors: 0 hour / trainee / week

Table: 7 Exception reports (with regard to working hours)

<table>
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<th>Jan.1</th>
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12.11. Work schedule reviews

No work schedule reviews have taken place in this quarter.

12.12. Locum bookings / Locum work carried out by trainees
Data not available

12.13. Vacancies

Data not available

12.14. Fines

One exception report has been submitted for a working time regulation breach (72 hour maximum in one week). The educational supervisor has yet to agree an outcome with the trainee. If agreed, this claim will incur a fine.

Qualitative Report

12.15. Exception reports (with regard to working hours)

12.15.1. The national 2016 GMC annual trainees report stated that 60% of junior doctors believe they work beyond their scheduled hours at least weekly.

12.15.2. If 60% of all OUH junior doctors submitted one exception report each week, there would be around 500 exception reports per week.

12.15.3. Current trends at OUH would suggest that once all junior doctors are on the new contract, there would be around 40 exception reports per week for around 70 hours of additional work.

12.15.4. To date less than one quarter of OUH junior doctors on the new contract have submitted an exception report.

12.15.5. The average frequency of submitting exception reports is around 2.5 reports per trainee per year.

12.15.6. These estimated figures raise questions around the difference between expected and actual reporting rates.

12.15.7. The medical director’s office has stated that the submission of exception reports is viewed as a neutral act and can be helpful in the construction of work schedules.

Work schedule reviews

12.15.8. Work scheduling is the new contracted process (analogous to consultant job planning), to provide schedules of work that are safe for patients and safe for doctors.

12.15.9. OUH junior doctors on the new contract have been provided with work schedules; informal feedback suggests that the information provided is an improvement when compared to that provided on the old contract.

12.15.10. Whilst junior doctors have acknowledged the progress made with work scheduling, they have raised concerns around timeliness of publication and credibility of content.

12.15.11. For work schedules to have credibility, it will be essential that medical staffing and medical education work with junior doctors on work schedule production.
Locum bookings / Locum work carried out by trainees

12.15.12. Governance arrangements relating to locum work carried out by junior doctors has changed and is now subject to the same working hours safeguards as non-locum work.

12.15.13. It is nationally recognised, that monitoring this activity will be challenging and relies upon self-declaration by junior doctors. There are potential conflicts of interest related to additional pay and safe working hours, for both employers of locums and the locums themselves.

12.15.14. There is no national or local mechanism to collect this data.

Vacancies

12.15.15. Subjectively, it is recognised that most rotas are affected by vacancies; objectively however, vacancy data is not reliably collated at any level from Deanery to trust department.

12.15.16. The central collection of vacancy data is an essential requirement for the OUH annual junior doctor workforce report.

Fines

12.15.17. To date, no fines have been administered.

Conclusion

12.16. To date, quantitative data relating to safe hours working is limited to that generated through exception reporting. A modest number of exception reports have been submitted, with only one reporting against new contract-defined safe working hours’ regulations (awaiting supervisor review). No immediate safety concerns have been raised.

12.17. GMC data suggests that there is a discrepancy between the predicted and actual number of exception reports at OUH.

12.18. A significant number of exception reports remain open without an agreed outcome between the junior doctor and their supervisor. Whilst there is an OUH programme of communication with educational supervisors, training relating to supervisor responsibilities is not yet part of the HEE(LO) supervisor training package and therefore the new supervisor responsibilities are viewed by some as an OUH imposition, rather than a nationally contracted responsibility.

12.19. For these reports to be of value for junior doctor workforce planning there needs to be central collection and coordination of data relating to rota gaps and locum usage.

12.20. Departments need to engage with the trusts standardised electronic rostering tools to aid central collection and coordination of data relating to junior doctor rotas.

13. Recommendations

13.01. 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, Interim Chief Nurse

Report prepared by:
Clare Dollery
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)