## Trust Board Meeting in Public: Wednesday 11 July 2018

**TB2018.58**

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

1. This paper briefs the Board on: National developments on Quality related topics; progress against the Trust’s Quality Strategy priorities; key quality metrics and emerging issues.

2. Key quality metrics:
   - Exception graphs and commentary are provided for 5 quality metrics:
     - % Patients receiving stage 2 medicines reconciliation within 24h of admission
     - % Radiology direct access 7 day turnaround times - Plain Film, CT, MRI & Ultrasound
     - Number of hospital associated thromboses (HATs) reported as potentially preventable
     - Dementia - % patients aged > 75 admitted as an emergency who are screened
     - EAU length of stay < 12h
   For a selection of the key quality metrics, performance by division is presented in dashboard format within Appendix 1. These show an increase in declared serious incidents and incidents of moderate and greater harm across all divisions.

3. A program for the assessment of potential harm from long waits is described – this extends the existing 104 day harm reviews carried out for cancer patients to a new process for assessing harm for patients waiting longer than 52 weeks in non cancer specialties. This process is overseen by a group chaired by the Medical Director and an external oversight group shared with commissioners is in discussion.

4. An update on progress against the Trust Quality priorities objectives for 2018/19 is presented including priorities to address adverse incidents such as Positive patient identification and Safety processes for surgery and procedures.

5. Matters for the attention of the Board:
   - WHO checklist compliance audits show three of the five Divisions demonstrated compliance of less than 100% with actions in place to improve.

6. Issues raised by Oxfordshire Clinical Commissioning Group (OCCG):
   - Test result endorsement and discharge summary timeliness remain an area for improvement. In May 85.4% of discharge summaries were sent before or within 24 hours of discharge against a trajectory of 95%; and 79.2% of results were endorsed on EPR within 7 days against a trajectory of 90%. Both indicators have therefore fallen short of the OCCG trajectories for May.
   - Increasing the staff awareness of roles and responsibilities in endorsing results and increasing the visibility of the endorsement button in EPR are some of the methods being used currently to improve this indicator. In Surgery & Oncology Division the trial appointment of a physician’s assistant has made a positive impact on the timeliness of discharge summaries.

7. Patient Safety and Clinical Risk:
   - Three Never Events were declared in May and by exception one in June 2018, detailed in 7.1 below. Significant actions taken in response include:
     - Release of a patient safety alert re PPID
     - Creation of an action plan for PPID
     - An audit of accountable item tracking in orthopaedic theatres
- Review of outpatient services across the Trust with respect to procedural standards or checklists and consent

An overarching Never Event Action Plan is in place (appendix 2) and during July a training session is being held jointly with NHS Improvement and the National Patient Safety Team are visiting the Trust to advise on prevention of Never Events.

6 Executive quality walk rounds took place in May

8. Infection Prevention and Control:
In May 2018 there were 2 cases of OUH apportioned C.difficile against a monthly cumulative limit of 5.

During May a patient was admitted with a suspected viral haemorrhagic fever after referral from a GP. The patient was not found to have VHF but the incident highlighted a number of issues in the management of the VHF pathway.

Following an audit of Churchill sterile service unit a decision was made to temporarily close the unit and use the other existing TSSU's to manage the Churchill workload.

9. Nursing care quality report:
Safe staffing report for May 2018, and an up to date report for nursing & midwifery recruitment

Hospital Acquired Pressure Ulcer (HAPU) prevention – reports on the incidents of category 3 & above HAPUs in the year 2017/18 and the actions being taken to address incidents as a result of medical devices

Falls prevention – demonstrates the falls by 1000 bed days for the last 3 years, interventions with equipment and education in order to enable the prevention of falls with harm.

The Adult Safeguarding report presents the activity of the Adult Safeguarding team including consultations since April 2015, the number of emergency department referrals via EPR in the year 2017/18. Two safeguarding cases are presented as an illustration of the complexity and diversity related to some of the cases referred to the Safeguarding Team

The Complaints & PALS report updates on the issues related to complaints that remain open in excess to the KPI and the actions being undertaken to address this with the divisions.

The Patient Experience report updates on the project for ‘Open Visiting’ and an exception report from CSS division.

10. 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.

2. 30 Key Quality Metrics with exception reports
   2.1. 30 key quality metrics are listed in Table 1.
   2.2. Where specified thresholds have not been met (‘red-rated’) or have declined from green to amber, trend graphs and exception reports are included.
<table>
<thead>
<tr>
<th>BQR ID</th>
<th>Descriptor</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
</tr>
</thead>
<tbody>
<tr>
<td>PS01</td>
<td>Safety Thermometer (% patients receiving care free of any newly acquired harm)</td>
<td>99.25%</td>
<td>98.82%</td>
<td>98.76%</td>
<td>98.23%</td>
<td>97.99%</td>
<td>97.55%</td>
</tr>
<tr>
<td>PS02</td>
<td>Safety Thermometer (% patients receiving care free of any harm - irrespective of acquisition)</td>
<td>95.06%</td>
<td>94.10%</td>
<td>93.02%</td>
<td>93.13%</td>
<td>91.99%</td>
<td>94.00%</td>
</tr>
<tr>
<td>PS03</td>
<td>VTE Risk Assessment (% admitted patients receiving risk assessment)</td>
<td>97.86%</td>
<td>97.05%</td>
<td>96.93%</td>
<td>97.08%</td>
<td>96.92%</td>
<td>N/A</td>
</tr>
<tr>
<td>PS04</td>
<td>Serious Incidents Requiring Investigation (SIRI) reported via STEIS</td>
<td>3</td>
<td>5</td>
<td>13</td>
<td>9</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>PS05</td>
<td>Number of cases of Clostridium Difficile &gt; 72 hours (cumulative year to date)</td>
<td>46</td>
<td>56</td>
<td>68</td>
<td>72</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>PS06</td>
<td>Number of cases of MRSA bacteraemia &gt; 48 hours (cumulative year to date)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PS08</td>
<td>% patients receiving stage 2 medicines reconciliation within 24h of admission</td>
<td>69.76%</td>
<td>74.21%</td>
<td>71.83%</td>
<td>71.36%</td>
<td>72.39%</td>
<td>71.84%</td>
</tr>
<tr>
<td>PS09</td>
<td>% patients receiving allergy reconciliation within 24h of admission</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>PS10</td>
<td>% of incidents associated with moderate harm or greater</td>
<td>0.46%</td>
<td>0.46%</td>
<td>0.69%</td>
<td>0.23%</td>
<td>0.50%</td>
<td>0.72%</td>
</tr>
<tr>
<td>PS11</td>
<td>Total number of newly acquired pressure ulcers (category 2,3 and 4) reported via Datix</td>
<td>56</td>
<td>66</td>
<td>48</td>
<td>60</td>
<td>68</td>
<td>N/A</td>
</tr>
<tr>
<td>PS12</td>
<td>Falls leading to moderate harm or greater</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>PS13</td>
<td>Cleaning Score - % of inpatient areas with initial score &gt; 92%</td>
<td>28.81%</td>
<td>34.29%</td>
<td>48.33%</td>
<td>38.46%</td>
<td>49.40%</td>
<td>43.55%</td>
</tr>
<tr>
<td>PS14</td>
<td>% Radiology direct access 7 day turnaround times - Plain Film, CT, MRI &amp; Ultrasound [one month in arrears]</td>
<td>89.29%</td>
<td>90.97%</td>
<td>88.72%</td>
<td>87.92%</td>
<td>85.00%</td>
<td>N/A</td>
</tr>
<tr>
<td>PS16</td>
<td>CAS alerts breaching deadlines at end of month and/or closed during month beyond deadline</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PS17</td>
<td>Number of hospital acquired thromboses identified and judged avoidable</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>7</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>CE02</td>
<td>Crude Mortality</td>
<td>225</td>
<td>270</td>
<td>210</td>
<td>215</td>
<td>197</td>
<td>171</td>
</tr>
<tr>
<td>CE03</td>
<td>% patients aged &gt; 75 admitted as an emergency who are screened [one month in arrears]</td>
<td>74.77%</td>
<td>66.78%</td>
<td>68.62%</td>
<td>69.73%</td>
<td>68.31%</td>
<td>N/A</td>
</tr>
<tr>
<td>CE04</td>
<td>Dementia diagnostic assessment and investigation</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>N/A</td>
</tr>
<tr>
<td>CE06</td>
<td>ED - % patients seen, assessed and discharged / admitted within 4h of arrival</td>
<td>80.86%</td>
<td>82.83%</td>
<td>81.07%</td>
<td>79.27%</td>
<td>86.30%</td>
<td>88.63%</td>
</tr>
<tr>
<td>PE01</td>
<td>Friends &amp; Family test % likely to recommend - ED</td>
<td>87.17%</td>
<td>87.80%</td>
<td>84.22%</td>
<td>86.36%</td>
<td>86.73%</td>
<td>85.82%</td>
</tr>
<tr>
<td>PE02</td>
<td>Friends &amp; Family test % not likely to recommend - ED</td>
<td>7.33%</td>
<td>7.21%</td>
<td>11.02%</td>
<td>8.68%</td>
<td>7.73%</td>
<td>8.68%</td>
</tr>
<tr>
<td>PE03</td>
<td>Friends &amp; Family test % likely to recommend - Mat</td>
<td>99.25%</td>
<td>96.45%</td>
<td>96.22%</td>
<td>97.34%</td>
<td>98.45%</td>
<td>96.15%</td>
</tr>
<tr>
<td>PE04</td>
<td>Friends &amp; Family test % not likely to recommend - Mat</td>
<td>0.00%</td>
<td>0.76%</td>
<td>1.03%</td>
<td>0.53%</td>
<td>1.04%</td>
<td>0.96%</td>
</tr>
<tr>
<td>PE05</td>
<td>Friends &amp; Family test % likely to recommend - IP</td>
<td>96.49%</td>
<td>97.02%</td>
<td>96.68%</td>
<td>95.09%</td>
<td>95.38%</td>
<td>96.10%</td>
</tr>
<tr>
<td>PE06</td>
<td>Friends &amp; Family test % not likely to recommend - IP</td>
<td>1.90%</td>
<td>1.40%</td>
<td>1.48%</td>
<td>2.53%</td>
<td>2.23%</td>
<td>1.92%</td>
</tr>
<tr>
<td>PE07</td>
<td>Friends &amp; Family test % likely to recommend - OP</td>
<td>94.98%</td>
<td>94.80%</td>
<td>94.48%</td>
<td>94.38%</td>
<td>94.48%</td>
<td>94.51%</td>
</tr>
<tr>
<td>PE08</td>
<td>Friends &amp; Family test % not likely to recommend - OP</td>
<td>2.46%</td>
<td>2.86%</td>
<td>3.21%</td>
<td>2.81%</td>
<td>2.53%</td>
<td>2.92%</td>
</tr>
<tr>
<td>PE14</td>
<td>Single sex breaches</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PE15</td>
<td>% patients EAU length of stay &lt; 12h</td>
<td>50.80%</td>
<td>45.95%</td>
<td>49.53%</td>
<td>47.04%</td>
<td>55.18%</td>
<td>54.61%</td>
</tr>
<tr>
<td>PE16</td>
<td>% Complaints upheld or partially upheld [Quarterly in arrears]</td>
<td>54.96%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>56.41%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*For indicators that are reported a month in arrears, quarterly etc. will show N/A for months they are not applicable.
Exception charts – Red

Chart 1: PS08 % patients receiving stage 2 medicines reconciliation within 24h of admission

The addition of weekend pharmacy staff on acute medical wards on the JR and Horton site on weekends has resulted in a significant increase in compliance over the past few years. Whereas the lack of ward-based pharmacy cover for other areas on weekends is resulting in the target not being met. A cross divisional business case highlighting patient benefits and outcomes was submitted to the divisional business planning group and divisional management for consideration on the 21st June.

The chart shows the proportion of inpatients for whom a second stage pharmacy-led medicines reconciliation is completed within 24 hours of admission. Approximately 2500 medicines reconciliation tasks are audited monthly. Target 85%

<table>
<thead>
<tr>
<th>W&amp;C</th>
<th>Meds Rec at 24 hrs</th>
<th>Numbers</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td></td>
<td>1/2</td>
<td>50%</td>
</tr>
<tr>
<td>Women's</td>
<td></td>
<td>71/101</td>
<td>70%</td>
</tr>
<tr>
<td>AMR</td>
<td></td>
<td>715/930</td>
<td>77%</td>
</tr>
<tr>
<td>Cardiac</td>
<td></td>
<td>116/177</td>
<td>66%</td>
</tr>
<tr>
<td>Spec Med</td>
<td></td>
<td>31/34</td>
<td>91%</td>
</tr>
<tr>
<td>NOTSS</td>
<td></td>
<td>116/177</td>
<td>66%</td>
</tr>
<tr>
<td>Spec Surg</td>
<td></td>
<td>124/190</td>
<td>65%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>251/310</td>
<td>81%</td>
<td></td>
</tr>
<tr>
<td>S&amp;O</td>
<td></td>
<td>19/29</td>
<td>66%</td>
</tr>
<tr>
<td>Gastro</td>
<td></td>
<td>82/117</td>
<td>70%</td>
</tr>
<tr>
<td>Oncology+Haem</td>
<td>172/284</td>
<td>61%</td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
<td>172/284</td>
<td>61%</td>
</tr>
<tr>
<td>Transplant, Renal &amp; Urol</td>
<td>67/105</td>
<td>61%</td>
<td></td>
</tr>
</tbody>
</table>

Chart 2: PS14 % Radiology direct access 7 day turnaround times - Plain Film, CT, MRI & Ultrasound [one month in arrears]

The KPI was met for routine ultrasound, urgent CT, MRI and ultrasound. Radiology has weekly meetings to review performance and allocation of reporting resources, including home reporting. The trajectory for patients on the 2 week cancer wait is currently working to 7 days to scan and then 7 days to report.

<table>
<thead>
<tr>
<th>Type</th>
<th>Routine</th>
<th>Urgent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plain film</td>
<td>90.6%</td>
<td>58.3%</td>
</tr>
<tr>
<td>CT scan</td>
<td>66.3%</td>
<td>99.3%</td>
</tr>
<tr>
<td>MRI</td>
<td>62.3%</td>
<td>95.8%</td>
</tr>
<tr>
<td>Ultrasound</td>
<td>99.4%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

95% of routine radiology reports received by the requesting clinician within 7 calendar days of the examination date. Target 98%
Benchmarking demonstrates that OUH are now reporting HATs at a similar rate to equivalent Trusts. Additional ‘safety nets’ such as linking eVTE risk assessment outcome to e-prescribing should lead to lower levels of harm from HATs at OUH.

The Quality Committee has requested that this metric reviewed in line with other reporting such that HATs that result moderate or greater harm are reported. 6 potentially preventable HATs were reported in May; all involved minor clinical harm.

Robust quarterly audit of inpatients in April 2018 show ‘appropriate thromboprophylaxis’ is in use Trust-wide at 98.7%.

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. Target 0

MRC- Dementia screening compliance decreased marginally this month to 64.5% from 66.2%; a quality improvement project has been initiated which includes having a prompt on the electronic whiteboards.

NOTSS- Reported 78.6% compliance, a slight increase from March’s figure of 77.2%.

S&O- reported 75.3% compliance in April, decreasing from 84.4% reported in March.

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. Target 90%
The length of stay for EAU remains high with constraints to flow to inpatient wards and also discharging patients directly home from EAU. This will be closely monitored alongside working the Urgent Care Delivery Group which focuses on stranded (>7 days in hospital) and superstranded (>21 days) to ensure each patient's pathway is expedited.

EAU is an assessment area and the majority of patients should either be admitted or discharged promptly following assessment. Target 70%

**Exception charts – Amber**

**Chart 6: PE01 Friends & Family test % likely to recommend.**

The recommend rate for Emergency Departments (EDs) in May 2018 was 85.8% (April: 86.7%) which remains within the expected range (between 81.4% and 91%).

The average recommended rate over the past 12 months is 86.0%.

This is also in line with expected national averages for an Emergency Department.

% likely to recommend – ED. Target 93%
There has been an improvement in patient experience in the Emergency Department via introduction and enforcement of the 10 golden rules which assist patient referral to specialist teams and flow of patients out of the ED.

% Patients attending ED who are discharged or admitted within 4 hours of arrival. Target 95%

3. Update on reviews of harm from extended waits

3.1. A program of harm reviews for patients undergoing care for cancer whose pathways exceed 104 days is well established. This is reported quarterly to the Clinical Governance Committee which in turn reports to the Trust Management Executive and the Quality Committee. No harm has been identified in the reports received for Quarters 1-4 of financial year 2017/18.

3.2. As part of the clinical care of patients experiencing over 52 week waits a systematic process for assessing clinical and psycho-social harm has been established. Each clinical team (doctor or specialist nurse) receives a request for assessment including guidance on types of harm they may be able to identify (i.e. decision support) when the patient passes 52 weeks on their pathway.

3.3. An OUH Harm Review group chaired by the Medical Director will track progress of the harm review process, review any harm identified, and if a clinical harm is suspected or the outcome is equivocal, to ensure this is discussed to enable the appropriate level of harm to be assigned. This sits alongside the current root cause analysis for the reasons of each 52 week breach. Learning arising from the process will be used to ensure patients have their priority systematically reviewed. Where opportunities exist to improve or unblock pathways senior management support can be mobilised.

3.4. Oxfordshire Clinical Commissioning group has agreed in principle to establish a shared external oversight group that can consider the whole process and its outputs. It is planned that this group may be able to triangulate assessments via information held by the patient’s General Practitioner.

3.5. This follows a model developed at Kettering General Hospital described by the CQC as outstanding.
The process was disseminated via Divisional Medical Directors and initiated on 11/6/18. 187 requests for harm review have been distributed to the Clinical teams from 12 specialties and to date 115 have been completed and are due to be reviewed at the inaugural meeting of the OUH Harm review group.

3.7. The process of reviewing harm will, once embedded, also constitute an opportunity to review the patients' pathway, priority and plan of care.

3.8. The EPR team have been requested to embed this process in the electronic patient record.

4. Update on progress against the Trust Quality priorities for 2017/18

4.1. The progress on the Trust’s Quality Priorities against the goals and targets were reported to the Quality Committee in June are set out in table 2.

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

<table>
<thead>
<tr>
<th>a. Preventing patients deteriorating</th>
<th>Cardiac Arrest Reduction</th>
<th>Cardiac Arrest Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why we chose this priority</td>
<td>Our goal is a 25% reduction in general ward areas and a 15% overall reduction (which would include areas within the Heart Centre).</td>
<td>Key clinical areas are being focused on where more cardiac arrests occur. The project team are working closely with these areas to ensure standardized review of trigger scores and appropriate escalation of deteriorating patients.</td>
</tr>
<tr>
<td>How we will evaluate success</td>
<td></td>
<td>At the JR we are undertaking review of the notes of patients who have been the subject of a 2222 call, forming a chronology of the period leading up to the emergency event. This is shared with the multidisciplinary team (who are invited to comment). Any learning is shared across the clinical team.</td>
</tr>
<tr>
<td>Evaluation</td>
<td></td>
<td></td>
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</tbody>
</table>

Antibiotics delivered within one hour of a sepsis flag

In May 64% of inpatients received antibiotics within one hour of alerting for sepsis.

We are piloting a new sepsis escalation strategy and a dedicated sepsis trolley to facilitate rapid treatment of patients with sepsis in the Emergency Department. We aim...
We will improve upon our 2017-18 achievement of 65% patients receiving antibiotics within one hour of alerting for sepsis, and set the target of >90%.
We will develop and deliver a sepsis training package to >50% of regular clinical staff working in the emergency departments by 31 March 2019.

to increase the proportion of patients who receive antibiotics within one hour from the current 72% to our target of 90%.
We are developing a new Trust education strategy for sepsis, and have so far delivered focussed sepsis training to 108 staff in the emergency department.
We have hosted a successful regional patient safety event, following which we are working to further improve our patient information resources.

<table>
<thead>
<tr>
<th>b. Safe surgery and procedures</th>
<th>Why we chose this priority</th>
<th>How we will evaluate success</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Safety Standards for Invasive Procedures (NatSSIPs) have been produced to address many of the underlying causes of Never Events (events that should be wholly avoidable due to the consistent application of specific safety checks e.g. WHO surgical safety checklist). The aim is to produce Local Safety Standards for Invasive Procedures (LocSSIPs) and thereby reduce the incidence of avoidable adverse events. The OUH had eight Never Events in 2017-18 and that is why focus on these standards has been chosen to be a Quality Priority.</td>
<td>Establish a new Safety Standards for Invasive Procedures group. Develop the remaining key overarching policies from which the specific LocSSIPs will develop. Develop/review LocSSIPs relevant to the eight Never Events that occurred in 2017-18. Scope other surgical and invasive procedural areas across the Divisions where LocSSIPs should be developed.</td>
<td>The Anaesthetic Chair and Surgery co-chairs for this group are in place and their first planning meeting has been held. The prosthesis verification policy is the main outstanding overarching clinical policy to be finalised. This has been drafted and requires consultation and then approval (aim September 2018) Relevant LocSSIPs for the 8 Never Events include: Stop before you block (in place but for review by the end of September 2018 following the recent Never Events) Adaption of the WHO surgical safety checklist to include a plan for removal of intentionally retained swabs and also adapted to include information on medication likely to affect a patient’s blood sugar levels (Approved at Clinical Governance Committee in June). Stop before you zap for laser treatment (pilot in place) Progress to be made once the group is formed with Divisional representation.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>c. Right patient every time</th>
<th>Why we chose this priority</th>
<th>How we will evaluate success</th>
<th>Evaluation</th>
</tr>
</thead>
</table>
This Quality Priority is key to ensuring safe diagnostic tests, procedures and treatments are identified with the correct patient every time. We chose this priority following a number of incidents, particularly in Radiology where the wrong patient received a test or procedure in the previous year. We are committed to learning from these events.

<table>
<thead>
<tr>
<th>Positive patient identification (PPID)</th>
<th>Audit of the Datix reports that cite wrong PPID processes in radiology will be taking place on a monthly basis.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivery of a campaign to promote PPID across the Trust.</td>
<td>The Chief Nurse and Medical Director have written to all clinical staff to make them aware of the PPID events and policy. An at a glance poster has been shared.</td>
</tr>
<tr>
<td>Questions on PPID will be rotated through the new Matron’s Assurance App during 2018-19. The app is being launched for Matron’s assurance audits.</td>
<td>Posters highlighting PPID have been distributed to outpatient procedure areas with a second wave to be deployed in inpatient areas.</td>
</tr>
<tr>
<td>Achieve a 50% reduction in PPID incidents in Radiology compared to 2017-18</td>
<td>Questions on PPID have been incorporated into the Matron’s assurance app.</td>
</tr>
<tr>
<td>The Divisional Nurse for CSS is establishing a PPID working group and terms of reference are in preparation.</td>
<td></td>
</tr>
</tbody>
</table>

### d. War on waste (Clinical effectiveness) - Go Digital

<table>
<thead>
<tr>
<th>Why we chose this priority</th>
<th>How we will evaluate success</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxford University Hospitals NHS Foundation Trust is one of the UK Global Digital Exemplar Trusts and Go Digital is one of our strategic priorities. This was also one of the 2016-17 priorities that stakeholders voted to continue into 2018-19 at our Quality Conversation public event.</td>
<td>Global Digital Exemplar programme - patient portal</td>
<td>• Workshops have been held to discuss the registration, appointments, survey, messaging and results functions.</td>
</tr>
<tr>
<td></td>
<td>The patient portal will be live in Q4 2018-19 (January-March) for use by OUH staff.</td>
<td>• The technical build of the solution will commence over the summer.</td>
</tr>
<tr>
<td></td>
<td>During Q4 (January-March) 2018-19 a phased release across different departments will allow patients to view appointments, results and contribute information to their health records via the portal.</td>
<td>• The portal is planned to go-live for members of staff at the start of 2019.</td>
</tr>
</tbody>
</table>

### e. War on waste (Clinical effectiveness) – Lean Processes

<table>
<thead>
<tr>
<th>Why we chose this priority</th>
<th>How we will evaluate success</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>We chose this because we want to increase efficiency within the directorates in order to eliminate waste (including respecting patients’ time) and improve patient experience. This will include consideration of streamlining administration processes that meet</td>
<td>The Transformation Team will train a core team of Divisional staff in lean processes. Each directorate will then complete a lean pathway exercise for at least one patient pathway.</td>
<td>The Transformation Team have committed to delivering the Quality Service Improvement and Redesign (QSIR) course at OUH and across the region with partners within the STP. This is a series of modules designed by NHS Improvement, and accredited by the Institute of Healthcare Institute. Over 2018/19 the full five day course will be delivered to five cohorts and is also available as the condensed one day fundamentals version will be delivered to three cohorts of staff. The modules cover:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Leadership Fundamentals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Project Management</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Sustainability of Improvement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Engaging and Working with Others</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Process Mapping</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Creativity in Improvement</td>
</tr>
</tbody>
</table>
In addition to the QSIR programme, the Transformation Team has developed an bespoke one day in-house course OxACT (Oxford Advancing Change Together) and is reinforced by the OUH Oxford Quality Improvement Toolkit. The Transformation Team will support OUH delegates to apply the tools from each module to their quality improvement project. Key lean tools to identify waste include process and value stream mapping, and these have already been used within the gynaecology and maternity directorates to improve processes.

### f. Respect for patients and partners (Patient experience) - Partnership working

<table>
<thead>
<tr>
<th>Why we chose this priority</th>
<th>How we will evaluate success</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>This was the one of the 2017-18 priorities that stakeholders voted to continue into 2018-19 at our Quality Conversation public event.</td>
<td>A Systematic Stranded Patient Review process will be embedded to ensure critical clinical decision-making prevents harm from deconditioning and patients leave hospital for their next destination in a timely way. Use outcomes of Systematic Stranded Patient Review process to advise joint funding priorities and to advise 2018-9 winter plan. Actively participate in the End Pyjama Paralysis campaign and report progress in the 2018-19 Quality report.</td>
<td>2018/19 Objectives will be focused on: Embed integrated system working and effective escalation Ensure consistent approach to discharge and escalation arrangements within the Trust KPIs: Reduced numbers of stranded patients Increase in number of patients discharged home as discharge destination Reduction in impact on HART/domiciliary care and a reduction in the number of patients being readmitted to the Trust.  End Pyjama Paralysis: The 70-day #EndPJparalysis Challenge officially ended on 26 June 2018. The challenge highlighted those patients who are in their day clothes while in hospital, rather than in pyjamas (PJs) or gowns, enhances dignity, autonomy and experience as well as, in many instances, shortening their length of stay. During the 70 day challenge our nursing teams have reported 11,225 patients dressed and mobile by midday and a further 12,950 mobile by midday.</td>
</tr>
</tbody>
</table>

| Home Assessment Reablement Team (HART) | HART’s current percentage of direct face-to-face is 45%, which is unfortunately under the previous achievement of 50%. This is due to the current geographical location of the patients being referred to the service and where HART has capacity which is based on staffing levels. HART are aiming to reach 50% patient contact time by continuing to recruit to the Reablement Support Worker post. HART’s 3 offices are also ensuring there is cross cover across the service. |

### g. Respect for patients and partners (Patient experience) – End of life care

<table>
<thead>
<tr>
<th>Why we chose this priority</th>
<th>How we will evaluate success</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
This was the one of the 2017-18 priorities that stakeholders voted to continue into 2018-19 at our Quality Conversation public event.

An electronic care plan will be in place to document end of life care to ensure clear communication and continuity of end of life care across the Trust.

During the pilot at the Nuffield Orthopaedic Centre (NOC) no end of life care patients were identified to trial the electronic care plan.

A presentation demonstrating the care plan was well received at the End of Life Care Symposium on the 18th May 2018.

The Medical wards at the Horton have agreed to pilot through August 2018, supported by the Hospital Palliative Care Nurse. Formal training on using the care plan on the electronic patient record (EPR) system will take place prior to the pilot. This will ensure staff are clear on when it should be initiated and that families are involved appropriately. The pilot will now take place in August 2018.

5. Matters for attention of the Board

WHO Compliance

5.1. Chart 8 shows the compliance with the WHO checklist by Division and in specific divisional areas. In all cases the audit showed the check list was used. These audits were paper-based and in some instances aspects of the checklist were not completed. Overall Trust compliance with every part of the checklist was 97.6% (657/673). Table 3 provides the narrative where compliance is below 100%.

Chart 8: WHO Checklist compliance by Division/Directorate over time.

![Chart 8: WHO Checklist compliance by Division/Directorate over time.]

Table 3: WHO Checklist exception report

<table>
<thead>
<tr>
<th>Division</th>
<th>Compliance</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>C&amp;W Children’s</td>
<td>98.0%</td>
<td>The single partial compliance was a missing date on a sign out. This has been discussed with the lead consultant to be shared with the team for learning.</td>
</tr>
<tr>
<td></td>
<td>(48/49)</td>
<td></td>
</tr>
<tr>
<td>CSS</td>
<td>96.3%</td>
<td>Radiology achieved 99.1%, PMC 100% and Theatres 95%. There was one non-compliance at CH Radiology where the form was not scanned correctly and therefore no record has been retained.</td>
</tr>
<tr>
<td></td>
<td>(368/382)</td>
<td>Radiology has implemented a check system before the hard copy is destroyed to try to reduce the rate.</td>
</tr>
</tbody>
</table>
these occurrences. There were 13 partial compliances in JR & WW theatres; these were lack of Sign In signature x2, No Time Out signature x2, No Sign Out signature x8, not all questions ticked x3 and procedure details not completed clearly x1. The Clinical Governance Manager has an action plan to work with staff directly in theatres where partial compliances occur to improve understanding and check compliance in month.

<table>
<thead>
<tr>
<th>Division</th>
<th>Compliance</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRC Cardio-thoracic Surgery</td>
<td>90.0% (9/10)</td>
<td>One partial compliance where one box in the debrief section was not ticked. On review the process had been followed but the person had not ticked that box; this has been discussed with the person involved in order to improve compliance.</td>
</tr>
</tbody>
</table>

6. Issues raised by OCCG

6.1. In May 85.4% of discharge summaries were sent before or within 24 hours of discharge compared with 86.6% in April; this falls short of the 95% target.

6.2. 79.2% of test results were endorsed on EPR within 7 days; this compares with 76.1% in April and falls below the 90% target.

6.3. Increasing the staff awareness of roles and responsibilities in endorsing results and increasing the visibility of the endorsement button in EPR are some of the methods being used currently to improve this indicator. In Surgery & Oncology Division the trial appointment of a physician’s assistant has made a positive impact on the timeliness of discharge summaries.

6.4. Feedback for May received from GPs via the OCCG Datix system is summarised in table 4. The top 3 themes account for 31% (24/77) of all feedback received. The top reported issue accounts for 10% of all the feedback reported. This is the third month in a row that the number of reported issues is below the mean. The role out of voice recognition across the Trust in 2018/19 is designed to reduce outpatient letter turnaround times.

Table 4: GP Feedback – Top thematic areas

<table>
<thead>
<tr>
<th>Theme</th>
<th>Mar-18</th>
<th>Apr-18</th>
<th>May-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delay in GP receiving clinical docs (i.e. OPD/Discharge letters)</td>
<td>8</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Failure to provide sickness certificate</td>
<td>7</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Failure to refer to other specialty under C2C guidelines</td>
<td>0</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Total Reported</td>
<td>93</td>
<td>88</td>
<td>77</td>
</tr>
</tbody>
</table>

Chart 9: Number of GP feedback reports received per month
7. Patient Safety and Clinical Risk

Clinical Risk

7.1. Three Never Events were declared in May and by exception one in June 2018. The Trust is implementing a Never Event Improvement plan in response to these events including a workshop to enhance the learning from investigations with NHS Improvement and a visit from the National Patient Safety Team - these will take place in July 2018. The Never Event Improvement plan is at appendix 2.

7.2. The events include

7.2.1. Wrong patient Never Event: During an endoscopy staff identified part way through the procedure that they were treating a different patient to the one they intended. This is a failure of positive patient identification. It is fortunate that both patients required the same test but processes were not completed appropriately (This was declared in May 2018). Immediate actions have included discussion with divisional and directorate leadership, a walk around in endoscopy and a consultant meeting – a further patient safety alert will be issued and an action plan for positive patient identification is in progress in line with the quality priority for this year. A full investigation is underway.

7.2.2. Retained Foreign object after surgery: A sizing trial cup was retained after use in an orthopaedic operation; the patient had a second operation on the same day to remove the object (This was declared in May 2018). Immediate actions have included discussion with Divisional and Directorate leadership and a rapidly implemented audit of checks and counts. A full investigation is underway.

7.2.3. Wrong procedure: A patient attending an outpatient clinic to have a nerve block had a different form of injections – this was recognised part of the way through the procedure and the correct block carried out (declared May 2018). Immediate actions have included discussion with divisional and directorate leadership, review of the clinic and development of a Local Safety Standard for Invasive Procedure for the clinic and a review of outpatient procedural services across the Trust with respect to procedural standards of checklists and consent. A full investigation is underway.

7.2.4. Retained vaginal pack: A patient undergoing gynaecological surgery who had a vaginal pack intentionally placed by the surgical team but this was not documented in the clinical notes and no plan for removal was documented. The pack was identified by the morning after surgery and removed. Immediate actions have included talking to the staff involved in the procedure about the importance of documentation and the effect it has on patient care/safety.

7.3. Twelve serious incidents requiring investigation (SIRIs) were declared by the Trust in May 2018.

7.4. Twelve SIRIs were submitted for closure (approval) to the Oxfordshire Clinical Commissioning Group (OCCG) in May 2018. It was agreed to close six SIRIs at the May OCCG closure meeting.
Chart 10: SIRIs declared and completed in the last 13 months

Chart 11: SIRIs declared by Division during last 13 months

Chart 12: SIRIs declared by hospital site during the last 13 months

Table 5: SIRIs declared in May 2018

<table>
<thead>
<tr>
<th>SIRI No</th>
<th>Division</th>
<th>Incident summary</th>
<th>Date incident detected</th>
<th>Reported date (Datix)</th>
<th>Date incident detected to date reported on Datix interval</th>
<th>Date declared as a SIRI</th>
<th>Reported date to declared as a SIRI interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>SIRI No</td>
<td>Division</td>
<td>Incident summary</td>
<td>Date incident detected</td>
<td>Reported date (Datix)</td>
<td>Date incident detected to date reported on Datix interval</td>
<td>Date declared as a SIRI</td>
<td>Reported date to declared as a SIRI interval</td>
</tr>
<tr>
<td>---------</td>
<td>----------</td>
<td>------------------</td>
<td>------------------------</td>
<td>-----------------------</td>
<td>----------------------------------------------------------</td>
<td>-------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>1819-005</td>
<td>MRC</td>
<td>A patient on a direct acting oral anticoagulant presented with gastrointestinal haemorrhage and deteriorated in ED prior to reversal and required ICU admission.</td>
<td>30/04/2018</td>
<td>30/04/2018</td>
<td>1</td>
<td>03/05/2018</td>
<td>6</td>
</tr>
<tr>
<td>1819-006</td>
<td>CSS</td>
<td>The Trust received information that a family had noticed 2 lacerations on their relatives cadaver which were not present when viewed after death on the ward.</td>
<td>30/04/2018</td>
<td>30/04/2018</td>
<td>1</td>
<td>03/05/2018</td>
<td>6</td>
</tr>
<tr>
<td>1819-007</td>
<td>Corp</td>
<td>An issue with the NHS.net accounts has been identified which caused delay in patient referrals.</td>
<td>05/03/2018</td>
<td>05/03/2018</td>
<td>1</td>
<td>10/05/2018</td>
<td>48</td>
</tr>
<tr>
<td>1819-008</td>
<td>CW</td>
<td>A blocked external ventricular drain was found with a neurological deterioration of the patient the morning after surgery and emergency re-intervention was required</td>
<td>04/05/2018</td>
<td>04/05/2018</td>
<td>1</td>
<td>10/05/2018</td>
<td>6</td>
</tr>
<tr>
<td>1819-009</td>
<td>CW</td>
<td>There was a delay in acting on a biopsy showing lymphoma.</td>
<td>08/05/2018</td>
<td>08/05/2018</td>
<td>1</td>
<td>10/05/2018</td>
<td>5</td>
</tr>
<tr>
<td>1819-010</td>
<td>SO</td>
<td>A patient being treated for cancer received chemotherapy during her first and second trimester of pregnancy.</td>
<td>02/05/2018</td>
<td>09/05/2018</td>
<td>5</td>
<td>17/05/2018</td>
<td>7</td>
</tr>
<tr>
<td>1819-011</td>
<td>SO</td>
<td>After commencing an endoscopy it was identified that the wrong patient was being treated. This is a Never Event.</td>
<td>11/05/2018</td>
<td>11/05/2018</td>
<td>1</td>
<td>18/05/2018</td>
<td>7</td>
</tr>
<tr>
<td>1819-012</td>
<td>CW</td>
<td>An individual gained unauthorised access to the Newborn Care Unit</td>
<td>19/05/2018</td>
<td>20/05/2018</td>
<td>0</td>
<td>24/05/2018</td>
<td>5</td>
</tr>
</tbody>
</table>
A patient having orthopaedic surgery had a sizing trial cup unintentionally retained – this was removed at a second operation the same day. This is a retained foreign object post procedure Never Event.

25/05/2018 25/05/2018 1 30/05/2018 4

A patient requiring inpatient transfer for urgent spinal surgery for disc prolapse related cord compression deteriorated neurologically while awaiting transfer

24/05/2018 24/05/2018 1 31/05/2018 5

A patient requiring inpatient transfer for urgent spinal surgery for cancer related cord compression was delayed.

24/05/2018 24/05/2018 1 31/05/2018 5

An outpatient scheduled to have a nerve block received a different wrong type of injections. This meets the criteria for wrong site surgery.

15/05/2018 15/05/2018 1 31/05/2018 13

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

The reported date on Datix to the date a SIRI was declared was a mean of 10 working days with a median of 6 working days.

Executive Quality Walk Rounds

7.6. The following Executive Quality Walk Rounds took place in May 2018.

Table 6: Executive Quality Walk Rounds completed in May 2018

<table>
<thead>
<tr>
<th>Hospital Site</th>
<th>Areas to visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Radcliffe Hospital</td>
<td>Cardiology</td>
</tr>
<tr>
<td>Nuffield Orthopaedic Hospital</td>
<td>Bone Infection Unit</td>
</tr>
<tr>
<td>Swindon</td>
<td>Swindon Dialysis Unit</td>
</tr>
</tbody>
</table>
7.7. Key issues arising during the Executive Quality Walk Rounds with the potential to affect quality or patient experience either positively or negatively included:

**Cardiology**

Patient experience and feedback was noted to be extremely positive for this ward. The ward has a strong leadership team who demonstrate resilience and provide excellent support systems for all members of staff both professionally, personally and pastorally. The ward scores above the Trust average for most of the statutory and mandatory courses.

**Bone Infection Unit (BIU)**

The ward’s patient group has a high requirement for psychological support, and the BIU team are positive about the input given by the psychological medicine team. A successful study day had taken place for Clinical Support Workers with the main focus on tissue viability education to empower the staff by improving their knowledge which is essential for the BIU patients who can have complex co-morbidities.

**Swindon Dialysis Unit**

There has been success in developing relationships with transport providers leading to continuous improvement in the provision of transport for renal patients. There is a good nephrology in-reach service and support for in-patients with acute kidney injury (AKI) by the AKI team with the assistance of a daily flagging algorithm in the electronic patient record.

**Surgical Emergency Unit (SEU) Ward-E**

The ward receives patients triaged from the Emergency Department; direct referrals from GPs; and patients post-surgery. Some patients are now being managed virtually to reduce the pressure on bed capacity.

**Laboratory Medicine**

Despite moving towards an electronic patient record (EPR) request, the unit continues to receive some paper requests for blood tests which can take much longer to process, are error prone (due to handwriting on the form and the need for transcription into the laboratory system) and may impact on the rate of endorsement of results in EPR. It was agreed to provide this feedback to the Chief Information and Digital Officer.

**Paediatric intensive care unit (PICU)/Paediatric high dependency unit (PHDU)**

This is a busy yet calm clinical area and the only Paediatric Critical Care unit in the Thames Valley providing critical care to any child within the network covering a wide range of specialities.
8. Clinical Outcomes

Learning from deaths
8.1. The quarterly report on Learning from deaths is covered in a separate paper to the Trust Board.

9. Clinical Audit

9.1. The following audits were presented at the Clinical Effectiveness Committee (CEC) in May 2018; key areas for improvement and areas of good performance are highlighted:

9.1.1. IV Fluids NICE CG174 and QS66
9.1.2. NG50 Cirrhosis
9.1.3. QS93 Atrial Fibrillation Audit
9.1.4. DNACPR Audit Q3 and A4 2017/2018-
9.1.5. National Diabetes Audit
9.1.6. 2016 Re-audit of Patient Blood Management in scheduled surgery
9.1.7. Falls & Fragility Fracture Audit (FFFA) – Fracture Liaison Service Database Report 2017: Royal College of Physicians the OUH was identified as the highest submitting Fracture Liaison Service in the UK: This indicates that 84% of our local expected case load of patients aged 50 years and over with a new fragility fracture or a newly reported vertebral fracture are systematically and proactively identified to reduce the risk of fracture happening again.

Table 7: Falls & Fragility Fracture Audit
OUH performance on the five core KPI which are particularly indicative of good practice recommended by NICE & National Osteoporosis Society

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Standard %</th>
<th>No. of Cases Audited</th>
<th>Compliance 2016 [year]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data completeness</td>
<td>&gt;80% (national average 40%)</td>
<td>2989</td>
<td>89%</td>
</tr>
<tr>
<td>Estimated case load submitted</td>
<td>&gt;80% (national average 40%)</td>
<td>2989</td>
<td>84%</td>
</tr>
<tr>
<td>Time from fracture to assessment</td>
<td>&gt;80% within 90 days (national average 67%)</td>
<td>2989</td>
<td>73%</td>
</tr>
<tr>
<td>12-16 weeks post fracture monitoring recorded</td>
<td>&gt;80% (national average 41%)</td>
<td>1381</td>
<td>56%</td>
</tr>
<tr>
<td>Commenced bone therapy within 16 weeks</td>
<td>&gt;80% (national average 31%)</td>
<td></td>
<td>53%</td>
</tr>
</tbody>
</table>

10. Infection Prevention and Control (IPC)

C.difficile

10.1. The upper ceiling for OUH apportioned cases of C.diff for 2018 / 2019 is 68.
10.2. During May 2018 there were 2 cases of OUH apportioned C.diff, both of which were deemed unavoidable. However, there were some issues with compliance to the management of the cases relating to inappropriate stool testing/lack of
stool chart in an Upper GI patient and a delay in isolation and treatment of a cardiology patient.

Chart 13: Cases of OUH apportioned C.diff (post 72hrs) per month (May 17 – May 18)

![Chart 13: Cases of OUH apportioned C.diff (post 72hrs) per month (May 17 – May 18)]

Methicillin-resistant Staphylococcus aureus (MRSA Bacteraemia)

10.3. There have been no cases of MRSA bacteraemia in May 2018.

Chart 14: Cumulative No. of MRSA bacteraemias assigned to OUH (May 17- May 18)

![Chart 14: Cumulative No. of MRSA bacteraemias assigned to OUH (May 17- May 18)]

Methicillin-sensitive Staphylococcus aureus (MSSA) Bacteraemia

10.4. Root cause analysis is conducted on post-48 hour MSSA bacteraemia cases and pre-48 hour cases associated with recent admission/instrumentation.

10.5. There was one case of post-48 hour MSSA bacteraemia during May. On further review the source was confirmed as discitis/skin&soft tissue.
Enhanced surveillance of healthcare-associated Gram-negative bloodstream infections (GNBSI)

10.6. NHS Improvement have set a national target of halving of healthcare-associated Gram-negative bloodstream infections (GNBSI) by March 2021. Mandatory reporting now includes E. coli, Klebsiella species and Pseudomonas aeruginosa. The OUH achieved a 9.6% reduction on baseline of OUH apportioned E. coli cases in 2017-18.

10.7. Our E. coli BSI data is available via the PHE Fingertips website, which allows benchmarking against other teaching hospitals (https://fingertips.phe.org.uk/profile/amr-local-indicators).

Table 8: Reducing Gram negative Bloodstream infections (GNBSI) is in the Annual Plan for 2018/19

<table>
<thead>
<tr>
<th>TOPIC</th>
<th>METRIC OF ASSURANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gram Negative Bloodstream Infections-mandate to reduce the number of healthcare associated Gram-negative bloodstream infections by 50%, by financial year 2020 to 2021</td>
<td>(1) See below</td>
</tr>
<tr>
<td>(1)Undertake an in-depth review of cohort of patients to understand issues within patient pathway</td>
<td>(2) RCA tool in use</td>
</tr>
<tr>
<td>(2) Devise RCA tool for all post 48 hour cases</td>
<td>(3) Evidence of meetings between HPB surgeons and Primary care impacting on patient pathways</td>
</tr>
<tr>
<td>(3) Work with general surgeons and GPs for HPB management</td>
<td>(4) Implementation of new guidance on pre-op urine testing in Urology</td>
</tr>
<tr>
<td>(4) Work with Urology to ensure pre-operative UTIs are managed appropriately including choice of antibiotic for TRUS biopsy infections</td>
<td>(5) Evidence of discussion and joint working with Health Economy. Number of GNBSIs.</td>
</tr>
<tr>
<td>(5) Continue to work with Health Economy for joint approach</td>
<td>(6) Number of post 48 hours positive GNBSI per month reported through clinical governance and HIPCC.</td>
</tr>
<tr>
<td>(6) Review number of post-48 GNBSIs (7) CAUTI see action 2 (Lines, Tubes and Devices)</td>
<td></td>
</tr>
</tbody>
</table>

Chart 15: MSSA bacteraemias May 17- May 18 (Post 48hrs Admission)
10.8. We are developing an in-depth understanding of E coli bacteraemias (EC-BSI) across Oxfordshire:

10.8.1. Trend analysis from 1998-2016. This study was been done in collaboration with the NIHR group in healthcare associated infection based in Oxford, and is due to be published shortly in Lancet Infectious Diseases. The data is available at [https://www.biorxiv.org/content/early/2017/11/21/223107](https://www.biorxiv.org/content/early/2017/11/21/223107). 24% of EC-BSIs were healthcare associated i.e. occurred > 48 hours after admission. An increase in EC-BSIs was observed over the time period, which was primarily community rather than hospital associated.

10.8.2. Regional audit data (Thames Valley Microbiology Professional Development Group): 51% of EC-BSIs are associated with urinary tract infection, 18% hepatobiliary and 10% other gastrointestinal infection, in line with national studies.

Chart 16: Pre-48 hours Gram Negative Bloodstream Infections (May 17 – May 18)

Chart 17: Post-48 hour Gram Negative Bloodstream Infections (May 17 – May 18)

May 2018 Infection Prevention and Control Focus Weeks

10.9. This month the IPC Focus Week was held on wards CMU B and C. Both wards were busy, sessions delivered included Hand Hygiene, ANTT, isolation and management of infectious patients. Positive relationships were established and included successful recruitment of an IPC Link Practitioner. CMU-C scored 100% in the cannula audit. Unfortunately both areas had low compliance rates with hand
hygiene; gloves were repeatedly used inappropriately and were regularly the barrier to undertaking hand hygiene. In order to improve Hand Hygiene compliance CMU B and C Wards are undertaking re-audits, until the 95% expected level of compliance is achieved. Some improvements have been observed, hand hygiene compliance score of 69% was reported for CMU B following educational support and Hand Hygiene validation audits carried out by IP&C.

Table 9: IPC Validation Audits May 2018

<table>
<thead>
<tr>
<th>Area</th>
<th>Hand Hygiene score</th>
<th>VIP audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMU B</td>
<td>50%</td>
<td>100%</td>
</tr>
<tr>
<td>CMU C</td>
<td>60%</td>
<td>71%</td>
</tr>
</tbody>
</table>

Estates and Environmental Issues

10.10. Following a further 14 days of monitoring the isolation rooms on John Warin Ward have been handed over. This was achieved on June 22nd and the rooms can now be used as isolation facilities for infectious patients.

10.11. The Trust has appointed a new Authorised Engineer for Decontamination (AE D) for the Retained Estates area. The IPC Manager and the AE D conducted an audit of the Churchill Sterile Services Unit, the results of which were shared with the Division and the Executive Directors. A decision was made to temporarily close the unit and use the other existing TSSU’s to manage the Churchill workload.

Cleaning Scores

10.12. Please see link May Cleaning Scores for detailed breakdown of nursing and client contract performance team scores.

10.13. Where areas do not achieve the minimum score, the failures are logged on the appropriate helpdesk and rectification undertaken to bring the area up to the expected standard. The below cleaning scores relate to the Providers cleaning audit results.

Chart 18: Providers Cleaning Scores for Very High Risk Areas
10.14. Very High Risk Areas (Theatres, ITUs, Haematology, Endoscopy)

10.14.1. At the Churchill Hospital five of the six audits achieved 95%, with two areas exceeding this. No area achieved the 98% audit score set by the Client Contract team.

10.14.2. At the JR site out of the twenty one audit scores, fourteen areas scored above 96% and Kamran’s ward scored 98%. Three areas achieved the score of 95% and four areas were below the expected standard.

Chart 19: Providers Cleaning Scores for High Risk Areas

10.15. High Risk Areas (Inpatient Ward Areas)

10.15.1. The Churchill and the Horton General achieved a score of greater than 95% in all areas.

10.15.2. Thirty five areas were audited at the JR site; five areas were below 95% with 14 areas scoring greater than 96%.

10.15.3. The Soft FM manager reported to the Hospital Infection Prevention and Control Committee (HIPCC) that the John Radcliffe site standards have slightly improved in both very high risk and high risk area. The positive progress has continued and the new management team is working collaboratively to bring in innovation that drives efficiency in cleaning giving the resource the capacity to focus now on the attention to detail and drive up the standards.

10.15.4. HIPCC was informed that at the Churchill standards remains fluid; however there has been some collaborative work undertaken to understand the problems. A new supervisor has been appointed and is working well in retraining staff and liaising with wards and departments to find the optimum time to approach certain tasks.

10.15.5. It was reported that at the Horton General Hospital standards have been variable and the number of audits undertaken by the in house team has increased. However they have not been using the electronic audit tool Synbiotix platform despite the training and equipment being provided, this will be escalated to the Interim Head of Estates as this has not been addressed.

10.15.6. The Nuffield Orthopaedic site standards have improved in the High risk and significant risk areas, but the very high risk areas continue to cause concern, which is being addressed with the management team. The Synbiotix
platform has not been fully used due to a technical problem which is being addressed.

10.16. An awareness process and plan is been drawn up to facilitate a collaborative approach to audits, with ward and department nursing staff participating in every audit so that all parties are fully aware of the issues that need to be monitored daily and improve the process of reporting shortfalls to the appropriate helpdesk

11. Nursing care quality report

Safe Staffing

11.1. The Trust is required to report the percentage of actual shifts filled against those planned (including those shifts filled by temporary staff) to the National system (Unify). The Trust return for May 2018 was:
90.63% for Registered Nurses/Midwives
89.07% for Nursing Assistants (unregistered staff)

11.2. Every shift is classified against its planned staffing level. Chart 20 shows the recorded shift classifications for May 2018 as per OUH internal policy – Mitigation remains our priority to reduce any risks associated with staffing levels. Vacancies and temporary staffing fill rates mean that staffing needs constant senior oversight. Senior nurse led staffing overview meetings occur twice daily focusing on the mitigation of risk and the deployment of nursing staff across each of the sites. It is important to note the number of shifts reported at minimum level or below post mitigation actions, as a potential risk factor for impacting patient experience and outcomes.

Chart 20: Trust internally reported shift staffing levels May 2018

Care Hours per Patient Day (CHPPD)

11.3. The Trust is also expected to report CHPPD. This reports the number of care hour’s patients receive by registered nurse/midwife and Care Support Workers within a 24-hour period. Appendix 3 indicates each ward level of care hours, separated out into registered nurse care hours; care support worker hours and an overall total ward CHPPD.

11.4. Appendix 4 shows NHSI Model Hospital data, which is still only available up until January 2018. (There is missing data in Model Hospital for September
2018). The data shows that overall the Trust CHPPD total is lower than our Shelford Group peers but higher than the national average. Total registered nurse/midwife hours are high in comparison to our Shelford Group peers, and Care Support Worker hours are significantly lower. This would appear to be in line with the Trust’s vacancy rate for Care Support Workers in particular. It should be noted that as we have a maternity unit and large cross site Intensive Care Units, we will report high numbers of RN care hours, therefore it is important to benchmark not only by Trust, but by ward to ensure benchmarking is meaningful and useful for establishment management.

11.5. The Trust has recently procured additional functionality to its e-roster system which will enable “safe staffing” to be monitored via the e-roster system using CHPPD rather than planned numbers as is the current method.

11.6. The Trust Safe Staffing team are working in conjunction with the Occupational Health department to raise awareness of the importance of staff taking regular breaks whilst on shift. This is expected to aid staff retention by increasing morale and also lower sickness levels. This is in line with recent nursing trade union recommendations.

Trajectory of Band 5 staff nurses in post, based on current 2018/19 nursing establishments for inpatient wards and Departments.

11.7. Chart 21 below shows the current and projected recruitment of band 5 staff nurses for inpatient areas and theatre suites. This assumes a 60% appointment rate from our planned international recruitment, and an 80% uptake for planned UK recruitment via Oxford Brookes University and other UK Universities. Turnover has been assumed based on current band 5 turnover

11.8. The trajectory up to and including month 2 has been adjusted to represent actual appointments at band 5 for each month.

11.9. Registered midwives based at M2 have a planned level 288.88 Whole Time Equivalent against staff In post currently at 268.33 WTE, providing a vacancy factor is 20.550 WTE or 7.11%

11.10. The Trust is participating in a National Nurse Retention direct support programme facilitated by NHS I. An action plan with an aim of a 2% reduction in band 5 turnover over 12 months has been developed through the nursing and midwifery recruitment, retention and education steering group for submission to NHS I on the 4th July 2018. Table 10 indicates the current turnover and demonstrates band 5 registered nurse as the main challenge.

Chart 21: Budgeted Vs Staff in post trajectory for band 5 nurses employed in wards and departments
Table 10: Registered Nursing and Midwifery Turnover

Registered Nursing Turnover

<table>
<thead>
<tr>
<th></th>
<th>FTE</th>
<th>Leavers FTE</th>
<th>Annual Turnover Rate</th>
<th>Apr-18</th>
<th>Mar-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Nursing Turnover</td>
<td>3001</td>
<td>462</td>
<td>15.4%</td>
<td>15.3%</td>
<td>15.5%</td>
</tr>
<tr>
<td>Band 5 Nursing Turnover</td>
<td>1561</td>
<td>335</td>
<td>21.5%</td>
<td>21.6%</td>
<td>21.5%</td>
</tr>
<tr>
<td>Band 6 Nursing Turnover</td>
<td>891</td>
<td>87</td>
<td>9.8%</td>
<td>8.7%</td>
<td>8.7%</td>
</tr>
<tr>
<td>Band 7+ Nursing Turnover</td>
<td>549</td>
<td>40</td>
<td>7.2%</td>
<td>7.7%</td>
<td>8.3%</td>
</tr>
</tbody>
</table>

Registered Midwifery Turnover

<table>
<thead>
<tr>
<th></th>
<th>FTE</th>
<th>Leavers FTE</th>
<th>Annual Turnover Rate</th>
<th>Apr-18</th>
<th>Mar-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Midwifery Turnover</td>
<td>274</td>
<td>41</td>
<td>15.0%</td>
<td>15.9%</td>
<td>15.4%</td>
</tr>
<tr>
<td>Band 5 Midwifery Turnover</td>
<td>34</td>
<td>5</td>
<td>13.8%</td>
<td>16.7%</td>
<td>16.7%</td>
</tr>
<tr>
<td>Band 6 Midwifery Turnover</td>
<td>181</td>
<td>31</td>
<td>17.4%</td>
<td>18.2%</td>
<td>17.8%</td>
</tr>
<tr>
<td>Band 7+ Midwifery Turnover</td>
<td>58</td>
<td>5</td>
<td>8.3%</td>
<td>8.3%</td>
<td>7.0%</td>
</tr>
</tbody>
</table>

Trust nursing workforce vacancy position

11.11. A reporting methodology for wards and departments across OUH has been revised to enable representation of an accurate picture of the Registered Nurse vacancy position. This method includes staff on long-term sickness and maternity leave amongst other absences. The negative reporting of band 6/7 in C and W is due to the WTE distribution within the M2 budget.

Chart 22: Trust nursing workforce band 5 vacancy position (May 2018) for wards and departments.
Nursing and Midwifery Recruitment Update

Recruitment from the UK

11.12 There continues to be strong commitment to focus on the UK recruitment, the numbers of appropriate applicants for each band 5 for the number of posts available within the Trust averages at 2 candidates per advert.

11.13 We continue to work collaboratively with Oxford Health on improving the number of OBU graduates that transition into RN positions within both Trusts and in some cases across both Trusts. The graduate “itchy feet” programme is being led by the Deputy Director of Nursing at OH and Associate Chief Nurse at OUH with full support from the Trusts’ recruitment managers and programme leads at OBU. An evaluation of the numbers who transitioned will take place late September 2018.

Recruiting nurses internationally

11.14 Recruitment of registered nurses worldwide continues, with the Trust returning to India on the 6th October 2018. The nurses have started to arrive in OUH from the previous 2 recruitment events in India and the Philippines in October and December 2017.

11.15 Eight international nurses have so far gone through our in house Objective Structured Clinical Examination (OSCE) training for the final part of the NMC application process. With a further 3 undergoing training at this time. Five of the nurses or 62.5% have successfully passed the OSCE at time of reporting- (this is against the national pas rate of 49%), with the majority being placed on the NMC register and able to practice as an RN within 24 hours of passing the OSCE.

11.16 Our objective is to see at least 200 nurses successfully pass the UK immigration and the NMC requirements and take up RN positions in OUH over the next 12 months.

11.17 An IELTS tutor is currently being taken through the NHSP application process, who will then take forward supporting a number of our nursing assistants who have RN registration outside of the UK to gain IELTS of 7 in all
fields which will be the first stage to the gaining UK RN registration. This will commence with a pilot of 5 as it is envisaged that a smaller group will increase the pass rate.

PJ Paralysis update

11.12. The 70-day #EndPJparalysis Challenge officially ended on 26 June 2018. The challenge highlighted that patients who are in their day clothes while in hospital, rather than in pyjamas (PJs) or gowns, enhances dignity, autonomy and experience as well as, in many instances, shortening their length of stay. During the 70 day challenge our nursing teams have reported 11,225 patients dressed and mobile by midday and a further 12,950 mobile by midday.

Maternity Directorate Exception Report:

11.13. 2.18 The key pressure for the Maternity Directorate that may impact on the quality of service delivery and patients’ experience is the high vacancy rate of midwives over the summer period.

Summer Pressures

11.14. 2.19 As of June 2018, we have a shortfall of midwives equating to 26.4 W.T.E which includes vacancies and staff on maternity leave. This will impact on service delivery due to the need to close beds and birth options for women. The summer pressure is likely to continue or increase over the summer.

11.15. 2.20 The graph below shows the desired clinical midwifery staffing ratio of 1:28 against the predicted number of births over a three year period. The graph demonstrates that the midwifery numbers begin to fall below the agreed midwifery staffing ratio from February 2018. This will impact on service delivery and the provision on the maternity service in spring and summer 2018. OUH FT is working to maintain a midwifery staffing ratio of approximately 1:29.

Chart 24: Desired clinical midwifery staffing ratio of 1:28 against the predicted number of births.

Assumptions of the graph above:

• Clinical midwives - actual in post to October 2017, adjusted as above for non-clinical midwives and postnatal support workers.
• Assumed reduction of 3 WTE per month due to leavers/reduction in hours.

Cause
11.16. A review of the age profile shows that 27% of our current workforce is over 50 years of age. The Royal College of Midwives predicts there is currently a shortfall of 5000 midwives across the UK.
11.17. Band 5 midwives leaving following completion of the Preceptor Programme due to the cost of living, travel, parking and relocating closer to home which impacts on the midwifery skill mix.
11.18. The current uplift in staffing establishments is 20% which accommodates short-term sickness, annual leave and training. However this does not cover the impact of long-term sickness, staff maternity leave and flexible working contracts. This will have a negative impact on real time midwifery ratios.

Consequence
11.19. The service is regularly mitigating this risk by utilising the on call staff to maintain staffing levels; this is in line with the current Trust escalation policy.
11.20. A detailed review of staff measuring acuity of the whole service will be performed by July 2018 to review staffing levels. New staffing roles will be considered to address the continuing shortfall of midwives.
11.21. Senior Management and non-frontline midwives, for example educators, will be working clinically over the summer to further support the service.
11.22. The main annual recruitment time is during the spring/summer months to attract the midwifery students qualifying in September each year. This year we have offered all Oxford Brookes Students a midwife position. The maternity services have actively recruited throughout the year. In May, 40 midwives have been recruited, however they will not be in post until September to October 2018. A local agreement is in place to recruit over our establishment to ensure there is provision to cover vacancies throughout the year.

Non-Medical Education
11.23. External funding for non-medical education has been further reduced this year by 40%, which follows a 71% reduction in 2017/18. With the inclusion of Agenda for Change Bands 1-4, non-medical prescribing and the exclusion of conference fees the impact is likely to be in the region of 60%. This has left the Trust with income of just £263,266 against a current demand for education costed at £1,663,451.
11.24. The inability to fund education provision will affect the ability for the Trust to meet the minimum level required to support staff is damaging both to morale and ongoing recruitment and retention.
11.25. Action is being taken to reduce the impact of the funding reductions by prioritising, qualifications in speciality, (£191,647) and the running and development of in-house accredited programmes to reduce costs from commissioning externally, (£91,500).
11.26. In addition work progresses to utilise other funding streams such as the
apprenticeship levy, (although this is of limited use for clinical programmes at
present), Charitable Funds and League of Friends. Although this approach will
provide an approach to funding some of the gaps, the limited funds available
will lead to disproportionate investment across the organisation, for example the
proportion of QIS programmes requiring support is as follows, children and
women's services 38%, clinical support services 40% the remaining is across
medical, rehabilitation and cardiac services, surgery and oncology and
neurosciences, orthopaedic, trauma and specialist surgery.

11.27. This current situation requires further planning in order to provide a strategic
approach to managing the funding of educational programmes, as the likelihood
is that the funding will continue to reduce in coming years.

11.28. The principle action is to mitigate these risks, through in the first instance, the
development of a 5 year integrated education and workforce plan to support
commissioning for 2018/19 onwards. This needs to be across all non-medical
professional groups to complement entrants at the point of registration, and
those across the wider workforce. The educational planning needs to reflect
changes in practices and the services with a focus on staff development.

11.29. Secondly the Trust needs to manage the expectations of staff and consider
how this can be best managed in an ever extending period of austerity. Across
most organisations there is an expectation that staff provide some contribution
to their personal and professional development. This should now be formally
considered through a review of the study leave policy and tighter controls on the
submission of study leave requests to ensure completion of both Statutory and
Mandatory training and appraisal before support is given to undertake further
training and education.

11.30. Thirdly, review current internal faculty of education staff in order to maximise
opportunities to enhance provision, reduce costs from commissioning third party
providers and exploit potential for income generation.

Clinical Care Quality Updates

Hospital Acquired Pressure Ulcer (HAPU)

11.31. The graph below shows the incidence in HAPU from 1st April 2017 to 31st
May 2018

From November 2017 there has been a steady increase in the number of
reported category 2-4 HAPU. An e-learning module was introduced for all
nurses working clinically from November 2017, which may have resulted in
early incidence increase, however the continued increase in reported incidents
is unaccounted for at present. It is surmised that current pressure on the staffing
level may be in part responsible for the increased incidence since
December 2017. The Trust wide improvement plan for Pressure Ulcer
Prevention has been reviewed and updated to support clinical areas address
issues and monitor standards of care. The annual pressure ulcer prevention
audit is currently underway and the report is due for publication by the end of
July 2018, which will give more details of care delivery standards.

NHS Improvement has released Guidance documents related to pressure ulcer
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Analysis completed by the end of July 2018.
Falls Prevention - Falls Per 1000 Bed Days

11.32. The point prevalence of falls per 1000 bed days is collected monthly using information available to the Trust on its Orbit data system. The data includes years 2015/16 up until May 2018.

Chart 26: Number of falls per 1000/bed days April 2015 – May 2018

Chart 27: Falls by month Q1
Update on recent interventions and action;

11.33. The Falls Prevention Practice Educator is working with the Communications Team to raise awareness of the new Hi/low beds on site at the Horton General Hospital Site, 8 at the John Radcliffe Site. Additionally she is working with the Learning and Development Department to upload the video on ELMs in order to monitor the number of staff who have watched the multi-professional falls prevention video that surrounds a patient story and includes the key learning aspects of the FallSafe Care Bundle. This is available on the OUH YouTube channel. [https://www.youtube.com/watch?v=3nHGdqGcWWc](https://www.youtube.com/watch?v=3nHGdqGcWWc)

Falls prevention education is included on corporate induction programmes

The Falls Prevention E-Learning Package is now in use, recommended by the Royal College of Physicians.

Two FallSafe Practical Skills Workshops are scheduled for November 2018 at John Radcliffe Site and Horton General Hospital sites.

An education package targeting contract staff in the cleaning, portering and ward catering services is planned to raise awareness.

There is clinical collaboration with the senior physiotherapy and manual handling teams as well as the Falls Prevention Practice Educator and the EPR team, to install and introduce a strength and balance assessment and training
for the older people, to enable patients to become mobile as soon as possible, and lower the risk of deconditioning.

A senior physiotherapist has commenced within the Quality Improvement Team and specifically works with the Falls Prevention Practice Educator one day a week. This is to contribute to the falls prevention work and liaise with the physiotherapy teams in particular, as well as to complete the risk assessments of the bathrooms trustwide in order to reduce the level of risk of patient falls.

**Priority focus in falls prevention:**

11.34. Use the Datix reporting System to identify wards that have a significant numbers of repeat fallers, and then provide education for staff on risk management solutions for 2018/19.

11.35. Link with the MDTs in order to collaborate on a more multifactorial approach to falls prevention and ensure all colleagues understand the principles of FallSafe. Update and finalise the revised Bedrails Policy to include an Adult Inpatient Bedrails Decision Tool. Ongoing work with increasing knowledge, awareness and skills for the assessment of Postural Hypotension, to improve compliance.

**Tracheostomy management in the Trust, education and quality of care**

11.36. The Tracheostomy Management Group was established in 2014 following the NECPOD report ‘On the Right Trach?’ in order to develop the Trust’s compliance according to the gap analysis undertaken in alignment with the report's recommendations. The group oversees the workstreams that manage the risks and addresses the compliance associated with the management, safety and care of patients with tracheostomies.

**Actions undertaken to improve safety**

11.37. Tracheostomy patients are now cared for in designated ‘cohort ward’ areas where staff have access to appropriate training, equipment and specialist support to provide safe, high quality care for this vulnerable group, as well as regular exposure to managing tracheostomies in order to maintain their skills.

11.38. The Trust Guidelines have been updated to comply with National Safety Standards for Invasive Procedures and a comprehensive education programme has been developed to support staff in gaining the skills and confidence to deliver high quality care. Attendance on the tracheostomy study day is essential training for staff on the cohort ward areas, with 255 staff trained in FY2017-18. This is now underpinned by an eLearning package which supports staff education and assessment of knowledge.

11.39. Incidents related to tracheostomy care are monitored and reported quarterly. A review of incidents FY2017/18 identified two areas for intervention: management of tracheostomy airway emergencies and the management of pressure ulcers and skin integrity at the stoma site.

11.40. High fidelity simulation training for tracheostomy airway emergency management has been delivered for senior nursing staff from Neuro Intensive Care Unit. This training has been developed and delivered by the Quality Improvement Therapist and Tracheostomy Clinical Skills Nurse with OxStar in response to reported incidents on the unit. Feedback has been very positive with high levels of satisfaction.
11.41. Pressure and skin integrity incidents related to this medical device have been subject to review with a specialist working group. Suturing techniques have been discussed with medical and surgical leads and current advice on dressings has been updated with the introduction of specialist dressings where clinically indicated.

11.42. Incidents will continue to be monitored quarterly at the Tracheostomy Management Group to assess the impact of training and the changes that are required in practice.

Chart 30: Demonstrates the issues of reported incidents on levels of harm related to tracheostomies in Q1 2018/19

Adult Safeguarding

Safeguarding Adults Exception Report

11.43. The Chief Nurse is the Executive Lead for Children and Adult Safeguarding. The Head of Adult Safeguarding attends the Oxfordshire Safeguarding Adults Board (OSAB) on her behalf.
Safeguarding Adult activity

11.44. The appendix 5 shows the safeguarding activity provided to support the Trust’s clinical teams. Chart 1\(^1\) shows the number of consultations and Chart 2 shows the referrals from the Trust’s emergency departments\(^2\) (ED).

11.45. Over the previous year, 2378 referrals in total to the team have been received from ED (290 in May 2018) and following review have either been signposted to Children’s Safeguarding, Community Safety Practitioner or supported by the Safeguarding Adults Team. The Team has received 1265 (115 in May 2018) referrals for consultation.

Domestic Abuse

11.46. The Oxfordshire Multiagency Risk Assessment Conference (MARAC)\(^3\) \(^4\) for families at high risk of domestic abuse is well established. A risk has been identified for families at standard or medium risk of domestic abuse. To reduce this risk, Thames Valley Police are introducing a new multiagency process called the Multi-agency Domestic Abuse Repeat Perpetrator (MARDAP) for medium and standard risk. This is based on the collaborative work between the University of Northumbria and Northumbria Police. Additionally the Trust has developed a Domestic Abuse strategy for patients, visitors and staff which will be completed by 31st August 2018.

Sc. 42 Enquiries

11.47. At the time of writing, there are 12 open Sc. 42 enquiries with one new Sc. 42 enquiries received in April 2018 and two so far in May 2018. Chart 3, below shows the number of concerns and Sc. 42 enquiries relating to the Trust’s care over the previous 22 months. Chart 4, below shows the outcome of Sc. 42 enquiries for the 12 months.

11.48. Following the expressed concern at the delay in receiving Sc. 42 enquiries once a concern has been raised, this was jointly audited by the Trust and OCC Safeguarding Team; and was presented to the Oxfordshire Safeguarding Adults Board (OSAB) Performance, Information and Quality Assurance Sub group (PIQA)\(^5\). An escalation process is now in place should Sc. 42 enquiries be delayed.

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\(^1\) The safeguarding adult consultations will include support to clinical teams for domestic Abuse, radicalisation, homelessness, sexual abuse, financial abuse, physical abuse, psychological abuse, Mental Capacity Act, DOLS applications, modern slavery and honour based abuse.

\(^2\) The ED referrals are placed on the patient’s EPR. These are reviewed on a daily basis by the team. The referrals include Domestic Abuse, radicalisation, Alcohol and drug abuse, self-harm, self-neglect and neglect.

\(^3\) [http://www.reducingtherisk.org.uk/cms/content/marac](http://www.reducingtherisk.org.uk/cms/content/marac)

\(^4\) [http://www.safelives.org.uk/knowledge-hub/spotlights](http://www.safelives.org.uk/knowledge-hub/spotlights)

\(^5\) OSAB is supported by five multiagency sub groups. These are the Joint Training Sub Group (Joint with the Oxfordshire Children’s Safeguarding Board OSCB), Policies and Procedures Sub Group, Safeguarding Adults Review Group (SAR), the Mental Capacity Forum and the Vulnerable Adults Mortality Group (VAM).
Liaison Hub:

11.49. There are no new concerns relating to the safeguarding issues for Hub patients' beds with the Trust.\(^6\)

Homelessness

11.50. Supporting people who are homeless can be complex especially when planning discharge. The Trust is working with OCC Trailblazers to implement the Homelessness Reduction Act (2017).\(^7\)

11.51. MRC will lead the development and implementation of a Homelessness pathway to ensure patients' discharge is well managed whilst also ensuring that they do not stay in hospital longer than they need to.

Home Assessment and Re-enablement Team (HART)

11.52. The Home Assessment and Re-enablement Team (HART)\(^8\), is a Trust service that provides a short period of care and support to patients in Oxfordshire as they regain their independence and confidence in the skills they need to live at home safely.

11.53. OCC Safeguarding Team has highlighted the need to strengthen Trust oversight into any safeguarding concerns raised in relation to HART. To this end, MRC and the Trust's Adult Safeguarding Adults Team have put in place a system to confirm, monitor and audit safeguarding concerns raised for by the HART service and OCC in relation to HART.

Safeguarding Adults Training

11.54. This remains below the Key Performance Indicator (KPI) of 90% and is shown in Chart 5. A plan is in place with the Safeguarding Children’s Teams and the Trust’s Learning and Development Team to increase compliance.

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS):

11.55. At the time of writing, there are 19 inpatients for whom a DOLS application has been made. The number of DOLS applications made is shown in Chart 6. Of these, five have been assessed and authorised and 14 pending assessment.

11.56. The local and national challenges surrounding the implementation and documentation of the MCA are well recognised and have previously been reported. The work to increase compliance across the county is being led by the Oxfordshire Safeguarding Adults Board (OSAB) MCA forum, of which the Trust is a key partner.

11.57. As part of the implementation plan, a consultant trainer who previously worked as the MCA advisor for the Care Quality Commission (CQC) will be working with the Trust and clinical divisions for 15 days in total between 31st July 2018 and 31st March 2019 to increase knowledge and clinical application of the act. The initial task and finish group met on 19th June and will be

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\(^6\) There is increased scrutiny by CQC into the safeguarding issues surrounding Hub beds and although the commissioned service is monitored by MRC, this section will be included in this monthly paper.


\(^8\) [https://www.ouh.nhs.uk/patient-guide/inpatients/hart.aspx](https://www.ouh.nhs.uk/patient-guide/inpatients/hart.aspx)
Safeguarding Adults Reviews (SAR)

11.58. No SARs were declared in May.

Safeguarding Adults Peer Review

11.59. The Trust Safeguarding Adults, MCA including DOLS Peer Review is a component of the CQC action plan following the unannounced inspection of the Oxford Centre of Enablement (OCE) in 2017.

11.60. The Peer Review is currently being planned by the Assurance and Safeguarding Adults Team with a view to running the review over the summer and a Quality Summit is being planned for early September (Date to be confirmed).

Complaints and PALS;

11.61. As reported previously to Trust Board, there remain concerns over the length of time some complaints are open for. Reasons for delays in responding to complaints varies from Division to Division, however, it is clear from the data gathered during Q3 and Q4, whereby the KPI of closing all complaints within 25 working days or agreed timescale was not reached (Q3 – 92%, Q4 – 83%) – the KPI requirement is 95%.

11.62. A piece of work was therefore undertaken to examine all existing open complaints, to ascertain how long they had been open for, and to ensure that all overdue complaints were highlighted to the Divisional Management teams for them to take all steps necessary to ensure the concerns were fully investigated and responded to as quickly as possible.

11.63. In addition to this, work has begun on introducing a new KPI whereby all complaints are investigated and responded to within 25 working days or x1 agreed extension of no more than an additional 15 working days. The extension must be agreed by the relevant Divisional Nurse/Divisional Director/Divisional Manager prior to the Complaints Co-ordinator approaching the complainant to discuss. Should the additional 15 working days extension be breached, then this will be escalated to the Chief Nurse accordingly.

11.64. At the time of writing this report there are 154 open complaints spanning all Divisions. 4 of these complaints were first received between September and November 2017, and are with the NOTSS Division for investigation and closure.

Table 11: Open complaints by Division

<table>
<thead>
<tr>
<th>Period complaints open during</th>
<th>Total no. of complaints still open</th>
<th>Division responsible</th>
<th>No. per Division</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sept 2017 – Nov 2017</td>
<td>4</td>
<td>NOTSS</td>
<td>4</td>
</tr>
<tr>
<td>Dec 2017 – Feb 2018</td>
<td>7</td>
<td>NOTSS C&amp;W</td>
<td>3 4</td>
</tr>
<tr>
<td>March 2018 – June 2018</td>
<td>143</td>
<td>C&amp;W CSS Corporate</td>
<td>31 9 12</td>
</tr>
</tbody>
</table>
11.65. The priority will be to ensure the four complaints that remain open for NOTSS from September to November 2017 are investigated and responded to as quickly as possible, followed by the seven complaints that are under investigation by C&W and NOTSS from between December 2017 and February 2018.

11.66. The Complaints and Patient Services Manager will continue to monitor the open complaints each week, and will provide updates accordingly

Patient Experience

Open visiting policy update:

11.67. In May, the Trust consulted with its staff and the public on the development of an Open Visiting Policy and Visitors Charter via a staff and public survey. The staff survey received 251 responses and the public survey had 263 responses. A report summarising the feedback was presented to the Trust Management Executive on 28th June.

11.68. Staff were concerned that open visiting could interfere with staff duties, prevent patient rest/sleep, and compromise patients' privacy and dignity. However, staff also recognised benefits, such as receiving assistance from visitors with feeding and personal care, improving communication between staff and visitors/patients, better emotional and physical support for patients from visitors, and a reduced number of telephone calls (with questions and requests for updates) to wards. Most staff said the maximum number of visitors should be two.

11.69. While all 53 of the public respondents who had recently (past six months) been inpatients said they had no issues with the visiting times, 25% of the visitors (32 people) said that they did experience issues. This was due to a lack of flexibility and not being able to fit visiting in around other commitments, not being able to support their relative at meal times or with washing/dressing, and not being present when doctors were doing rounds. However, there were several positive comments about staff being very flexible and accommodating.

11.70. The feedback shows that:

11.70.1. staff members and members of the public share the opinion that visitors should not prevent clinical work from taking place
11.70.2. there should not be an unlimited number of visitors per patient and this opinion is shared by staff and members of the public
11.70.3. both staff and patients can see great potential benefits for patients and visitors, particularly in terms of wellbeing and reducing stress and anxiety.
11.70.4. A pilot of open visiting is proposed for a period of two weeks (towards the end of July) on two ward/day case areas on each of the four hospital sites. The official launch of Trust-wide opening visiting will be at the Annual General Meeting in September.
Exceptions in the CSS feedback:

11.71. The percentage recommend for the CSS division for May was lower than usual and the percentage not recommend was higher than usual: both were outside of the expected range for the division.

11.72. Although the percentage recommend was lower and the percentage not recommend was higher, this is based on only four responses, two of which provided positive comments (suggesting a mistake by the patients when providing the rating), one gave no comment, and one mentioned waiting time.

11.73. All other metrics for other service areas were within the expected range (Appendix 6).

Same Sex Accommodation exception report

11.74. The national Delivery of Same Sex Accommodation (DSSA) was first introduced in 20109. The Trust has a DSSA policy and reports each month to NHS digital if there are any non-justified same sex accommodation breaches. The fine for a non-clinically justified same sex accommodation breach is £250 per patient per day. The Chief Nurse is the lead Executive for The Trust; and the Head of Adult Safeguarding monitors the Trust’s performance and coordinates the monthly submission to NHS Digital.

11.75. The Trust’s Hyper Acute Stroke Unit is the area of particular risk for DSSA because of the need to meet emergency four hour stroke pathway. Although currently most breaches in the Hyper Acute Stroke Unit are clinically justified in order to maximise patient safety, the Stroke Team have local mitigations in place to reduce the occurrence of same sex breaches to maximise patient’s dignity.

11.76. The Trust has two local agreements in place with Oxfordshire Clinical Commissioning Group (CCG).

11.76.1. All breaches of same sex accommodation in Adult Critical Care or Intensive Care Units are locally reportable to the CCG.

11.76.2. A same sex accommodation breach is clinically justifiable at night because of the contraindications to a patient’s health if they are unnecessarily transferred to another area.

11.77. NHS England and NHS Improvement are updating the guidance on DSSA and wrote to the Chief Nurses in Wessex and Thames Valley advising of this change on 11th June 2018. This will mean that no local arrangements will be accepted. This will have considerable impact on the Trust’s DSSA breach reporting to NHS Digital. The Trust has already reviewed the changes in guidance and has a conference call scheduled for 5th July 2018 to discuss the local implications and action plan. This will be reported to the Trust’s Quality Committee on 8th August.

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12. Recommendations

12.1. The Board is asked to receive this Quality Report.

Dr Tony Berendt, Medical Director and Sam Foster, Chief Nurse

Report prepared by:
Andrew Carter, Associate Chief Nurse for Workforce
Helen Cobb - Head of Clinical Governance
Dr Clare Dollery - Deputy Medical Director
Caroline Heason - Safeguarding & Patient Services Manager
Dr Robert Stuart – Guardian of Safe Working Hour
Liz Wright – Deputy Chief Nurse
Appendices

How to interpret charts

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