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

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

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

3. Key quality metrics:
   - For 7 of the 32 quality metrics, pre-specified targets were not fully achieved in the last relevant data period. For selected metrics, trend data are provided along with brief exception reports.
   - For a selection of the quality metrics, Divisional specific information that contributes to organisational results is presented in dashboard format within Appendix 1.

4. Matters for attention of the Board:
   - WHO checklist compliance audits are reported to the Board. Two Divisions demonstrated compliance of less than 100% with actions in place to improve.

5. Issues raised by Oxfordshire Clinical Commissioning Group (OCCG):
   - Test results and discharge summary timeliness continues to be an area of significant work. In July 76.7% of discharge summaries were sent before or within 24 hours of discharge and 75.9% of results endorsed on EPR within 7 days.
   - GP feedback collated from the OCCG DATIX system is reported.

6. Patient Safety and Clinical Risk:
   - No Never Events were reported in July. 16 Serious Incidents Requiring Investigations (SIRIs) were reported in July. 7 SIRIs were recommended for closure to OCCG in July.
   - Five Executive quality walk rounds took place in July and three in August.

7. Clinical Effectiveness:
   - There have been no new mortality outliers reported for OUHFT by the CQC or the Dr Foster Unit at Imperial College.
   - The HSMR is 100 for the financial year 2015/2016 this value is ‘within the expected’ range. The SHMI remains within the ‘as expected’ range. The current SHMI for January 2015 to December 2015 is 0.99.

8. Infection Control:
   - The upper ceiling for OUHFT apportioned cases of Clostridium difficile (C.diff) in 2016/2017 is 69. The cumulative total for this year is currently 25 against an internal cumulative limit of 23. The objective for 2016/2017 is 0 avoidable Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemias. No cases of MRSA bacteraemia were apportioned to the OUHFT during July 2016. Work is ongoing to improve compliance with MRSA screening guidelines and cleaning audits. A number of proactive infection prevention and control (IPC) projects have commenced.

9. Patient Experience:
   - Friends and Family Test:
     - This report includes details and analysis of changes in response rates and recommendation rates for Inpatients and Day Cases, Emergency Departments, Maternity, Children’s Services and Outpatients. National comparisons are given to
show Trust results in a wider context.  
There was an increase in the overall recommend rate for inpatient and day case services, and a decrease in the not recommend rate. However, the response rate decreased in inpatient areas.  
The field work for the National Inpatient Survey programme for 2016 commenced in July 2016.

PALS and Complaints:  
101 new complaints were received in July. This is a very small decrease from the previous month (June N=108).  
NOTSS division continue to receive the highest number of complaints across all six divisions.  
The current challenges and risks faced by the PALS and Complaints Teams related to difficulty recruiting and thus sharing roles between complaints and PALS teams during this difficult period. This may have an impact upon the number of PALS cases that are reported.  
PALS DATIX Web has been implemented this month for PALS cases.

10. Safe Staffing:  
This report provides the Trust Board with an update on the current status of nursing and midwifery staffing across the Trust by ward as well as by shifts.  
Including:  
- May – July 2016 dashboard data for all the divisions and the Trust as a whole on safe staffing and Nurse Sensitive Indicators (Appendices 3 a - f)  
- The summary of the July 2016 Unify submission of staffing  
- The national imperatives highlighted in the recent National Quality Board guidance on safe staffing: Supporting NHS Providers to deliver the right staff, with the right skills, in the right place at the right time (July 2016) - Safe sustainable and productive staffing  
- The Trust’s response to the above guidance

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

1. Purpose
   1.1. This paper briefs the Board on National developments on Quality related topics and commentary on the progress against the Trust’s quality Strategy and quality assurance and improvement work underway.
   1.2. An update is provided on progress against the refreshed quality priorities for this financial year, as described in the Trust quality account.
   1.3. This Quality Report will be received for information by relevant Trust Committees (Clinical Governance Committee) following the Quality Committee meeting.

2. National Quality Strategy Updates
   2.1. On 21/7/16 the Care Quality Commission (CQC) published its annual report and accounts for 2015/16
   2.2. The CQC regulates adult social care, primary medical services and integrated care and hospitals reporting to Parliament via the Department of Health.
   2.3. In 2015/16 almost two-thirds (63%) of services and providers originally rated inadequate improved their rating following a re-inspection in 2015/16. Of the 362 (out of 578) that improved, 75% went from inadequate to requires improvement and 25% went from inadequate to good.
   2.4. At the end of 2015/16, a total of 449 providers were in special measures.
   2.5. The CQC started delivering our new approach to inspection in 2013, starting with NHS acute trust inspections, followed by adult social care services, GP practices and mental health services in 2014.
   2.6. At the end of 2015/16 the CQC had completed their programme of first ratings inspections of acute non-specialist NHS hospital trusts, with a total of 136 inspections. Chart 1 shows the results of these inspections to date.

Chart 1 CQC ratings after inspection
2.7. 57 reinspections and focused inspections of hospitals have taken place.

2.8. The CQC are responsible for enforcing the Ionising Radiation (Medical Exposure) Regulations 2000 (known as IR(ME)R) across the NHS and in independent hospitals and across primary care, including dentistry and chiropractic care in England.

2.9. IRMER - During 2015, the CQC received a total of 1,277 notifications where radiation exposure was much greater than intended. This was an increase of 15.7% compared with 2014 and a continuation of the year-on-year increase the CQC have seen over the last 10 years. The report states ‘this is positive, as it indicates a stronger reporting culture and the confidence of clinical departments in our enforcement methodology. The number should also be viewed in the context of the estimated 45 million medical exposures that take place each year’.

2.10. Controlled Drugs - The CQC are responsible for making sure that health and social care providers, and other regulators, maintain a safe environment for managing controlled drugs in England. During the year the CQC maintained oversight over how controlled drug local intelligence networks are working, and ensured they were effectively reporting and investigating trends and concerns.

2.11. Enforcement action – In the hospital sector the CQC issued 58 enforcement actions of which 36 were warning notices.

3. Update on progress against the Trust Quality priorities

3.1. The place of our priorities in the domains of patient safety, clinical effectiveness and patient experience is shown in Chart 2.
3.2. Updates on the priorities are shown in Table 1. These were presented to the Quality Committee in July 2016.

### Table 1 - Updates on the Quality Priorities as presented to the Quality Committee in July 2016

<table>
<thead>
<tr>
<th>Priority</th>
<th>Progress</th>
</tr>
</thead>
</table>
| Medicines safety | The team have worked with the Datix and Information Teams to develop ways for extracting and sharing reported incident data in a more efficient and timely manner.  
A Multi-disciplinary Team (MDT) has been assembled to review reported incidents, identify themes and learning points.  
Guidance on ‘time critical medicines’ has been updated and will be considered at July Medicines Management Committee. |
| Improved recognition, prevention, and management of Acute Kidney Injury (AKI) | An electronic alert together with an electronic care bundle was successfully launched in Electronic Patient Record (EPR) on April 18th 2016. Around this launch, general awareness of Acute Kidney Injury (AKI) and this electronic alert was increased through Trust wide education.  
An EPR Power plan audit shows modest usage of the AKI-Power plan (1-7th July), with uptake <50% in cases with AKI3 (a trebling of creatinine) but in all cases the appropriate management including repeat blood investigations and ultrasound imaging had been undertaken in good time. A comparison with the hyperkalaemia Power plan shows significant overlap and this will be re-audited for a 1 week period in August 2016.  
However, a quality improvement project looking at 100 patients with an e-alert for AKI being admitted through the emergency department, demonstrated improvements in quality of care in the weeks after the launch.  
The Quality Improvement (QI) nurse team has started education for nurses from Acute General Medicine, and is developing a resource pack to be used by nurse educators in each clinical area at their regular nursing education sessions.  
AKI care bundle for use in response to primary care e-alerts is going through peer review and piloting.  
Education for Oxfordshire General Practitioners (GPs) took place 7th July 2016. |
| Recognition and treatment of sepsis | Prompt recognition of Sepsis:  
The Trust guidelines on management of Sepsis in maternity have been updated.  
A strategy for development and roll out of an electronic sepsis screening tool for inpatients has been agreed.  
Prompt antibiotic treatment of Sepsis:  
Sepsis teaching has been incorporated into training for Infection Control link nurses and foundation nurses. |
<table>
<thead>
<tr>
<th>Priority</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care 24/7</td>
<td>High Dependency Unit (HDU): Work is continuing to assess the number and location of level 2 patients. The Integrated Patient Acuity Monitoring System (iPAMS) tool continues to be rolled out across the Trust. Priority standards: the audit results of 240 emergency admissions against the four priority standards for seven day services have been published. The headline results show Oxford University Hospitals NHS Foundation Trust (OUHFT) with a slip in % compliance from 100% for emergency patients for first Consultant review within a 14 hour period: 86% weekdays, 81% Saturday, and 82% Sunday (100% in 2015). This was discussed at the July 2016 Clinical Effectiveness Committee. The internal OUHFT consultant standards including ‘time to first consultant review’ is set at 18 hours.</td>
</tr>
<tr>
<td>SEND [System for Electronic Notes Documentation] project</td>
<td>Roll out is proceeding according to plan and should be complete by the end of August 2016. SEND is available from every clinical computer within the OUH and from V-workspace. SEND populated charts are available within case notes and the electronic patient record (EPR). The numerical values from SEND are visible within the EPR. A study has shown that SEND reduces the time to record observations from 202 to 167 seconds (p&lt;0.001).</td>
</tr>
<tr>
<td>Human factors (HF) training</td>
<td>18 one-day courses for Multi-Disciplinary Teams (MDTs) across OUHFT booked and almost completely filled, places have been held to allow the Trust to react responsively to needs later in year. Human Factors (HF) and Quality Improvement (QI) advisory group under the leadership of the Deputy Medical Director will meet to monitor and guide progress in HF and QI domains. Two further meetings have been held since the last report. First train the trainer course for OUH HF Ambassadors is booked. HF Lead met with Divisional educational leads to compile a co-ordinated plan across all Divisions. Patient Safety Academy training since 15th June 2016 includes: 3 half day courses (introductions to HF and QI) for 50 OUH staff and 4 QI and incident investigation day for 9 OUH staff. All data from the course feedback and post-course follow up is to be captured and analysed in Oxford Simulation Teaching and Research (OxSTaR).</td>
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1. **Level 2 patient**: Patients requiring more detailed observation or intervention, single failing organ system or postoperative care, and higher levels of care. [http://www.ics.ac.uk/icf/patients-and-relatives/information/about-critical-care/what-is-intensive-care/](http://www.ics.ac.uk/icf/patients-and-relatives/information/about-critical-care/what-is-intensive-care/)

<table>
<thead>
<tr>
<th>Priority</th>
<th>Progress</th>
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</table>
| End of life care (EOLC)          | Additional provision of palliative care:  
Nursing posts are also being recruited to.  
The Bereavement team are preparing a questionnaire to ask relatives how the service can be improved.  
Pilot Swan scheme is taking place on Level 7.                                                                 |                                                                                                                                                           |
| Dementia care                    | Cognitive Testing in people aged over 75 years has increased on average by 4.3% from 59.8% to 64.1%. The most significant increase was by 10% in Surgery and Oncology.  
The team continue to work closely with Oxfordshire Carers both through their clinics and the Dementia Information Café.  
A Patient Perspective film has been made focusing on the carer’s point of view of their experiences whilst being in the John Radcliffe Hospital.  
The Oxfordshire Dementia Awareness Action Group (DAAG) Tier 1 package has been received. This is currently being reviewed for suitability on Corporate Induction.  
In Quarter 1 16/17 752 staff have completed the current Tier 1 Training.  
In Quarter 1 16/17 988 staff completed Tier 2 training and 179 completed Tier 3.  
All Tiers are currently under review.                                                                 |
| Compassionate Care               | 944 employees have attended the training on Delivering Compassionate Care against a goal of 1,500. The Organisational Development team recruited an additional trainer who commenced in June and will train circa 80 employees per month. Quarterly surveys to attendees measuring training outcomes continue to be circulated. |                                                                                                                                                           |
| Stake holder engagement and partnership working (health systems interface) | A Discharge Planning Workshop took place on 30th June 2016. The focus was to look at ways of improving the discharge process and looking at solutions of how to manage delays along the patients’ journey within different areas.  
The workshop will be repeated on a regular basis, ideally every 3 months across different sites.  
The Trust is fully engaged in multi-agency discussions to progress the strategic objectives in the Sustainability and Transformation Plan (STP)  
Information about discharge summaries and test results endorsement is covered elsewhere in this report. |
4. **Key Quality Metrics**

4.1. 32 key quality metrics linked to the quality of clinical care provided across the organisation are listed in Table 2.

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

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

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

**Indicators deteriorating or red rated**

4.5. 7 indicators have deteriorated against target since the last reporting cycle or are red rated due to breaching of an annual threshold; this is the same number of exceptions reported in the previous month:

4.5.1. PS02 – Safety Thermometer (% patients receiving care free of any harm - irrespective of acquisition)

4.5.2. PS05 – Number of cases of Clostridium Difficile > 72 hours (cumulative year to date)

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

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

4.5.5. PS14 – % Radiology direct access 7 day turnaround times - Plain Film, CT, MRI & Ultrasound [one month in arrears]

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

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

**Indicators improving**

4.6. 2 indicators have an improved rating since the previous reported period:

4.6.1. PS07 – Antibiotic prescribing - % compliance with antimicrobial guidelines [most recently available figure, undertaken quarterly] – this indicator has improved (Red to Amber) from the last quarterly figure reported from 91.66% to 94.06%

4.6.2. PE15 – % patients EAU length of stay < 12h – this has improved on last month’s position from 69.17% to 70% (Amber to Green)
<p>| PS01  | 96.94% | Amber | Safety Thermometer (% patients receiving care free of any newly acquired harm) | Jul 16 | Internal | 95% | 97% |
| PS02  | 92.68% | Green | Safety Thermometer (% patients receiving care free of any harm - irrespective of acquisition) | Jun 16 | Internal | 91% | 93% |
| PS03  | 96.73% | Green | VTE Risk Assessment (% admitted patients receiving risk assessment) [one month in arrears] | Jun 16 | National | 95% | 95.25% |
| PS04  | 16 N/A  | N/A   | Serious Incidents Requiring Investigation (SIRI) reported via STEIS | Jul 16 | N/A | N/A |
| PS05  | 25 Red  | Red   | Number of cases of Clostridium Difficile &gt; 72 hours (cumulative year to date) | Jul 16 | National | 23 | N/A |
| PS06  | 2 Red   | Red   | Number of cases of MRSA bacteraemia &gt; 48 hours (cumulative year to date) | Jul 16 | National | 1 | N/A |
| PS07  | 94.06% | Red   | Antibiotic prescribing - % compliance with antimicrobial guidelines [most recently available figure, undertaken quarterly] | Jul 16 | Internal | 93% | 95% |
| PS08  | 69.85% | Red   | % patients receiving stage 2 medicines reconciliation within 24h of admission | Jul 16 | Internal | 75% | 85% |
| PS09  | 100% Green | Green | % patients receiving allergy reconciliation within 24h of admission | Jul 16 | Internal | 94% | 96% |
| PS10  | 0.44% | Green | % of incidents associated with moderate harm or greater | Jul 16 | Internal | 6.5% | 5% |
| PS11  | 73 N/A | N/A   | Total number of newly acquired pressure ulcers (category 2, 3 and 4) reported via Datix [one month in arrears] | Jun 16 | N/A | N/A |
| PS12  | 1 Red   | Green | Falls leading to moderate harm or greater | Jul 16 | Internal | 8 | 7 |
| PS13  | 38% N/A | N/A   | Cleaning Score - % of inpatient areas with initial score &gt; 92% | Jul 16 | N/A | N/A |
| PS14  | 88.08% | Red   | % Radiology routine request 7 day access - Plain Film, CT, MRI &amp; Ultrasound [one month in arrears] | Jun 16 | Commissioner | 95% | 98% |
| PS16  | 0 Green | Green | CAS alerts breaching deadlines at end of month and/or closed during month beyond deadline | Jul 16 | Internal | 1 | N/A |
| PS17  | 1 Red   | Red   | Number of hospital acquired thromboses identified and judged avoidable | Jul 16 | Internal | 1 | N/A |
| CE01  | 0.99% N/A | N/A   | Standardised Hospital Mortality Ratio (SHMR) [most recently published figure, quarterly reported as a rolling year ending in month] | Dec 15 | N/A | N/A |
| CE02  | 208 N/A | N/A   | Crude Mortality | Jul 16 | N/A | N/A |
| CE03  | 64.01% | Red   | Dementia - % patients aged &gt; 75 admitted as an emergency who are screened [one month in arrears] | Jun 16 | National | 80% | 90% |
| CE04  | 81.64% | Amber | Dementia diagnostic assessment and investigation [one month in arrears] | Jun 16 | Internal | 80% | 90% |
| CE06  | 87.6% | Amber | ED - % patients seen, assessed and discharged / admitted within 4h of arrival | Jul 16 | National | 85% | 95% |
| PE01  | 83.31% | N/A   | Friends &amp; Family test % likely to recommend - ED | Jul 16 | N/A | N/A |
| PE02  | 10.26% | N/A   | Friends &amp; Family test % not likely to recommend - ED | Jul 16 | N/A | N/A |
| PE03  | 98.19% | N/A   | Friends &amp; Family test % likely to recommend - Mat | Jul 16 | N/A | N/A |
| PE04  | 0.72% | N/A   | Friends &amp; Family test % not likely to recommend - Mat | Jul 16 | N/A | N/A |</p>
<table>
<thead>
<tr>
<th>PE05</th>
<th>96.39% N/A</th>
<th>Friends &amp; Family test % likely to recommend - IP</th>
<th>Jul 16</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>PE06</td>
<td>1.37% N/A</td>
<td>Friends &amp; Family test % not likely to recommend - IP</td>
<td>Jul 16</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>PE07</td>
<td>93.93% N/A</td>
<td>Friends &amp; Family test % likely to recommend - OP</td>
<td>Jul 16</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>PE08</td>
<td>3.26% N/A</td>
<td>Friends &amp; Family test % not likely to recommend - OP</td>
<td>Jul 16</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>PE14</td>
<td>0 Green</td>
<td>Single sex breaches</td>
<td>Jul 16</td>
<td>National</td>
<td>3</td>
</tr>
<tr>
<td>PE15</td>
<td>70% Green</td>
<td>% patients EAU length of stay &lt; 12h</td>
<td>Jul 16</td>
<td>Internal</td>
<td>65%</td>
</tr>
<tr>
<td>PE16</td>
<td>56.36% N/A</td>
<td>% Complaints upheld or partially upheld [Quarterly in arrears]</td>
<td>Jul 16</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Exception charts

Chart 3 – PS02 – Safety Thermometer (% patients receiving care free of any harm - irrespective of acquisition)

The increase in reported harms are related to old harms (including pre-existing harms acquired prior to admission), in particular pre-existing pressure ulcers and patients with pre-existing catheter associated urinary tract infections. Whilst new harms have fallen month on month – this remains slightly higher than the median of the preceding 12 months. The Tissue Viability Team continues to deliver training and pressure ulcer prevention e-learning is being promoted.

Chart 4 – PS05 – Number of cases of Clostridium Difficile > 72 hours (cumulative year to date)

In June there were 5 cases of C.diff against a limit of 6 and in July there were 6 cases against a limit of 6. However, the cumulative total for C.diff remains above the cumulative limit because of the high number of cases seen in May 2016.

The chart shows the number of cases of C Diff reported via UNIFY (external IT system). The upper ceiling for OUHFT apportioned cases of C.diff in 2016/17 is 69. If a case is subsequently removed following consultation with CCG (for example, absence of active disease), the figure will be modified in future graphs. [Owner: Infection Control].
Chart 5 – PS06 – Number of cases of MRSA bacteraemia > 48 hours (cumulative year to date)

The objective for 2016/2017 is 0 avoidable MRSA bacteraemia. One positive MRSA blood culture occurred during July 2016, this was a pre-72 hour sample and not therefore apportioned to the OUHFT and confirmation has been received to say that it has been assigned to a third party. The cumulative total therefore remains at 2.

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

Chart 6 – PS08 – % patients receiving stage 2 medicines reconciliation within 24h of admission

Pharmacy provides a full ward based clinical service 5 out of 7 days in most areas. The current target is measured based on all inpatient admissions for the month. The attainment when considering only the current 5 day ward based clinical pharmacy services is 87%. Investment in April 2016 has allowed the percentage compliance to be maintained while activity has increased over the same period as measured over a 7 day period.

The chart shows the proportion of inpatient for whom a second stage pharmacy-led medicines reconciliation is completed within 24 hours of admission. The audit captures medicines reconciliation tasks generated on admission by Cerner. Approximately 2500 medicines reconciliation tasks are audited monthly [Owner: P Devenish].
Radiology continues to work to improve reporting times to these modalities for all patients, covering ~42,000 scans per month. CT, MRI and Ultrasound achieved 92% or greater for routine and emergency scans. The gap was in plain film with 84% compliance for routine and 59% for urgent scans. Radiology teams continue to plan service delivery to meet the demand on this reporting target.

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

The VTE team have attended all 5 divisional Clinical Governance meetings, and the 4 key divisions have sent representatives to the Thrombosis working group in July. VTE team are currently analysing the results of the pharmacy audit of ‘appropriate thromboprophylaxis’. VTE prevention team continue to increase awareness, undertake audit and feedback on performance, and add ‘safety nets’ into EPR systems and processes. The most recent VTE was a pulmonary embolus (PE).
**Chart 9 – CE03 – Dementia - % patients aged > 75 admitted as an emergency who are screened [one month in arrears]**

Elderly patients admitted on a non-elective basis should be screened for dementia using a screening question and / or a simple cognitive test. Performance shown in this graph reflects figures submitted monthly to NHS England. These figures are derived from EPR.

Sustained month on month improvements - up from 59.8% reported for May-16 to 64.0% in Jun-16.

S&O now have a junior medical champion in the surgical emergency unit and ward 5F and this has improved compliance.

MRC performance has increased to 60% in June 2016; the highest since manual data collection ceased in September 2015.

The main challenge is within General Medicine as the specialty admits over 80% of the Division’s eligible patients. Performance is fed back to individual specialties on a regular basis, highlighting the importance of dementia screening as part of admission clerking.
5. Matters for attention of the Board

WHO Compliance

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

Table 3 – WHO Checklist July 2016

<table>
<thead>
<tr>
<th>Division</th>
<th>Area</th>
<th>Compliance</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>NOTSS</td>
<td>WW Theatres</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Orthopaedics</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>C&amp;W</td>
<td>Maternity Theatre JR/HGH</td>
<td>93%</td>
<td>74 checklists were audited and there was full compliance with 69. Of the 5 that were not completed 4 were Obstetrics and one was Children’s, where the sign out was absent. Letters will be sent from the Divisional Director to those involved.</td>
</tr>
<tr>
<td></td>
<td>Gynaecology Theatre JR/HGH</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children’s Theatre JR/HGH</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Children’s critical care &amp; newborn care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CSS</td>
<td>JR Theatres</td>
<td>99.2%</td>
<td>381 WHO checklists were audited in the Division. There were 3 partial compliances JR, 2 in West Wing radiology and Horton radiology. All teams have been made aware of the partial compliance and the need to check completion as part of ‘Sign Out’.</td>
</tr>
<tr>
<td></td>
<td>HGH Theatres</td>
<td></td>
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<tr>
<td></td>
<td>Interventional Radiology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRC</td>
<td>Cardiology</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cardiotoracic Surgery</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Respiratory Intervention</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>S&amp;O</td>
<td>Churchill Theatres</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

6. Issues raised by OCCG

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

6.2. The latest data for July 2016 show 76.7% of discharge summaries were sent before or within 24 hours of discharge, this is down from 78.7% reported for June. For results endorsed on EPR, 75.9% were endorsed within 7 days (note it is possible to review a result and not endorse it). This is compared to last month’s performance at 77.9% for June.

6.3. Feedback for July 2016 received by the OCCG from GPs is summarised in the table 4 below. A total of 111 records of GP feedback were received by the
OCCG regarding the Trust in July, this is a reduction of approximately 28% from the total feedback received last month. The top 5 themes account for 35% of all feedback received over the month.

6.4. ‘Delay in GPs receiving clinical documents (i.e. Outpatient department (OPD)/Discharge letters)’ continues to be the most frequently reported type of feedback in July, however the number of separate items received has fallen to 10 from 30 compared last month.

6.5. Feedback related to ‘Inappropriate prescribing request from secondary care’ is new compared to last month’s most frequently reported themes; the remaining themes were also in last month’s most frequently reported themes.

Table 4 – GP Feedback – Top 5 thematic areas

<table>
<thead>
<tr>
<th>Theme</th>
<th>May-16</th>
<th>Jun-16</th>
<th>Jul-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delay in GP receiving clinical docs (i.e. OPD/Discharge letters)</td>
<td>16</td>
<td>30</td>
<td>10</td>
</tr>
<tr>
<td>Delay / difficulty in obtaining clinical assistance</td>
<td>16</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Failure in referral process</td>
<td>12</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Failure to note relevant information in patient's record</td>
<td>12</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Inappropriate prescribing request from secondary care</td>
<td>11</td>
<td>4</td>
<td>6</td>
</tr>
</tbody>
</table>

7. Patient Safety and Clinical Risk

Clinical Risk

7.1. In relation to Patient Safety and Clinical Risk:

- No Never Events were reported in July.
- By exception a Never Event was reported on 31st August. An incident occurred on in the West Wing (ophthalmic) theatres of the Never Event- wrong site nerve block. A patient was admitted for cataract surgery to their left eye supported by a nerve block. A nerve block was delivered to their right eye in error despite consent and WHO sign in indicating the contralateral eye. Thereafter the error was recognised and the block and surgery were carried out on the patient’s correct eye without complications.
- 16 Serious Incidents requiring Investigation (SIRI’s) were reported onto STEIS (NHSE reporting system) in July 2016.
- 7 SIRI’s were recommended for closure to the Oxfordshire Clinical Commissioning Group (OCCG) in July 2016. All 7 SIRI’s were sent to the OCCG within the agreed timeframe.
- Two SIRI closure meetings took place between the Trust and the OCCG in July 2016 and 9 SIRI’s were closed.
- No SIRIs were downgraded in July
Clinical Risk

7.2. The following graphs provide an update on SIRIs

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

7.3. Chart 10 shows a slight increase in SIRI's declared in July compared to the previous two months and the number of SIRIs completed in July is down in sharp contrast to June which was an exceptional month due to the amount declared in March.

Chart 11 - SIRIs declared by Division during last 13 months

7.4. Chart 11 shows that NOTSS, S&O and C&W declared an equal amount (4) of SIRIs in July
Chart 12 - SIRI Investigations completed by Division during the last 13 months

7.5. Chart 12 indicates MRC and C&W both completed two SIRI investigations in July with CSS, S&O and NOTSS completing one.

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

7.6. Chart 13 shows that the most SIRIs (9) were declared at the John Radcliffe (JR) site compared to the Horton General Hospital (HGH) where one was declared.
7.7. Table 5 provides more details of the SIRIs that were declared via STEIS in July. (16 reported). It also includes the time in non-working days from the incident date to the date the incident was reported on Datix and from the date the incident was reported on Datix to the date the incident was reported on STEIS (these are working days).

Table 5

<table>
<thead>
<tr>
<th>SIRI No</th>
<th>Division</th>
<th>STEIS summary</th>
<th>Incident date</th>
<th>Reported date (Datix)</th>
<th>Incident to Datix interval</th>
<th>Date reported on STEIS</th>
<th>Datix to STEIS interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016/075</td>
<td>NOTSS</td>
<td>A patient was prescribed and administered Vancomycin. The levels of vancomycin were not checked as per protocol and the patient developed acute kidney injury (AKI) stage 3</td>
<td>26/06/16</td>
<td>26/06/16</td>
<td>0</td>
<td>01/07/16</td>
<td>5</td>
</tr>
<tr>
<td>2016/076</td>
<td>CSS</td>
<td>A patient had a computerised tomography (CT) scan which showed an incidental finding of a pulmonary embolism (PE). There were delays in the CT being reported and acted upon. The patient presented to the GP 12 days later with shortness of breath where an urgent referral to the OUH was made and a CT pulmonary angiogram (CTPA) showed multiple PE’s.</td>
<td>02/06/16</td>
<td>21/06/16</td>
<td>19</td>
<td>01/07/16</td>
<td>9</td>
</tr>
<tr>
<td>2016/077</td>
<td>CW</td>
<td>A woman presented in spontaneous labour at 40 weeks gestation. Initially there were no concerns but as the labour progressed the mother became pyrexial and there were signs of fetal distress. A category one caesarean section was carried out but the baby was born in a poor condition and died the following day.</td>
<td>20/06/16</td>
<td>20/06/16</td>
<td>0</td>
<td>01/07/16</td>
<td>10</td>
</tr>
<tr>
<td>2016/078</td>
<td>SO</td>
<td>A patient had an unwitnessed fall resulting in a fractured neck of femur (NOF).</td>
<td>24/06/16</td>
<td>24/06/16</td>
<td>0</td>
<td>01/07/16</td>
<td>6</td>
</tr>
<tr>
<td>2016/079</td>
<td>CW</td>
<td>A patient administered a very large amount of insulin with their own insulin pen and then alerted staff. After treatment for hypoglycaemia the patient made a full recovery</td>
<td>24/05/16</td>
<td>25/05/16</td>
<td>1</td>
<td>06/07/16</td>
<td>30</td>
</tr>
<tr>
<td>2016/080</td>
<td>CSS</td>
<td>During an out of hours case a low standard of high level cleaning came to light. This was escalated following the procedure and the activity in theatres for the scheduled cases was risk assessed the following day. However, this</td>
<td>28/06/16</td>
<td>28/06/16</td>
<td>0</td>
<td>07/07/16</td>
<td>8</td>
</tr>
<tr>
<td>SIRI No</td>
<td>Division</td>
<td>STEIS summary</td>
<td>Incident date</td>
<td>Reported date (Datix)</td>
<td>Incident to Datix interval</td>
<td>Date reported on STEIS</td>
<td>Datix to STEIS interval</td>
</tr>
<tr>
<td>---------</td>
<td>----------</td>
<td>---------------</td>
<td>---------------</td>
<td>-----------------------</td>
<td>---------------------------</td>
<td>------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>2016/081</td>
<td>CW</td>
<td>resulted in two patients who had already been anaesthetised having their procedures terminated and rearranged.</td>
<td>27/06/16</td>
<td>27/06/16</td>
<td>0</td>
<td>07/07/16</td>
<td>9</td>
</tr>
<tr>
<td>2016/082</td>
<td>CORP</td>
<td>An adolescent who had undergone surgery to correct a foot deformity developed a grade 3 pressure ulcer to the sole of the right foot under the cast which was applied following surgery.</td>
<td>01/07/16</td>
<td>04/07/16</td>
<td>3</td>
<td>15/07/16</td>
<td>10</td>
</tr>
<tr>
<td>2016/083</td>
<td>SO</td>
<td>A patient with diabetic peripheral neuropathy developed a grade 3 pressure ulcer under a cast</td>
<td>05/07/16</td>
<td>05/07/16</td>
<td>0</td>
<td>15/07/16</td>
<td>9</td>
</tr>
<tr>
<td>2016/084</td>
<td>MRC</td>
<td>A patient recovering from a primary percutaneous coronary intervention following aST-segment elevation myocardial infarction (STEMI) developed hypotension and bradycardia and was reviewed by a junior doctor at 2000hrs. The plan was made to review the patient the following morning with consideration for a pacemaker. Overnight the patient was seen regularly but no evidence of recorded observations is available until 06:00hrs the following day, when observations were essentially unchanged. The patient had a cardiac arrest two hours later and died later that day.</td>
<td>10/07/16</td>
<td>12/07/16</td>
<td>2</td>
<td>15/07/16</td>
<td>4</td>
</tr>
<tr>
<td>2016/085</td>
<td>NOTSS</td>
<td>A patient with a long term condition had three admissions within 6 weeks. The patient developed bilateral pulmonary emboli after the third admission. Review of this incident has shown that the required thromboprophylaxis was not prescribed during the patient’s first admission but was given correctly for the latter two admissions.</td>
<td>03/03/16</td>
<td>09/05/16</td>
<td>67</td>
<td>22/07/16</td>
<td>54</td>
</tr>
<tr>
<td>SIRI No</td>
<td>Division</td>
<td>STEIS summary</td>
<td>Incident date</td>
<td>Reported date (Datix)</td>
<td>Incident to Datix interval</td>
<td>Date reported on STEIS</td>
<td>Datix to STEIS interval</td>
</tr>
<tr>
<td>---------</td>
<td>----------</td>
<td>---------------</td>
<td>---------------</td>
<td>-----------------------</td>
<td>--------------------------</td>
<td>------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>2016/086</td>
<td>NOTSS</td>
<td>Post-mortem specimens from two patients were found to be incorrectly labelled in the laboratory. The error was identified and corrected.</td>
<td>18/07/16</td>
<td>18/07/16</td>
<td>0</td>
<td>22/07/16</td>
<td>5</td>
</tr>
<tr>
<td>2016/087</td>
<td>CW</td>
<td>A woman was booked for a laparoscopic bilateral salpingo-oophrectomy due to chronic abdominal pain. While performing the laparoscopy the surgeon did not believe the organs were diseased to the extent that was described on pre-operative testing so did not proceed to remove the ovaries as planned. The patient has since complained that the operation performed was not the operation for which she had given her consent. A further operation has been scheduled for later in the year.</td>
<td>06/05/16</td>
<td>08/07/16</td>
<td>63</td>
<td>27/07/16</td>
<td>14</td>
</tr>
<tr>
<td>2016/088</td>
<td>NOTSS</td>
<td>A patient with a chronic cough had a chest X-ray reported as showing a hilar mass; delays in accessing and acting on the report and delays in the subsequent pathway caused a delay of two months in diagnosing a probable lung cancer.</td>
<td>18/07/16</td>
<td>19/07/16</td>
<td>1</td>
<td>29/07/16</td>
<td>9</td>
</tr>
<tr>
<td>2016/089</td>
<td>SO</td>
<td>An oncology patient developed a category 3 hospital acquired pressure ulcer to the elbow.</td>
<td>17/07/16</td>
<td>17/07/16</td>
<td>0</td>
<td>29/07/16</td>
<td>10</td>
</tr>
<tr>
<td>2016/090</td>
<td>SO</td>
<td>A post-operative patient developed a category 3 hospital acquired pressure ulcer to the sacrum.</td>
<td>15/07/16</td>
<td>15/07/16</td>
<td>0</td>
<td>29/07/16</td>
<td>11</td>
</tr>
</tbody>
</table>

7.8. The incident date to the reported on Datix date was an average of 10 days due to 3 incidents that were not detected until 19, 67 and 63 days from the initial incident date with a median of 0 days

7.9. The reported date on Datix to the date reported on STEIS was an average of 13 working days and a median of 9 working days

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

7.11. Delays in reporting onto Datix
- 2016-076 - Hospital acquired thrombosis (HAT): Delays related to reporting and acting on an incidental finding of PE from a CT scan which was requested for another purpose.
- 2016-085 - Delay in the detection of this HAT incident was compounded by the fact that the patient had three hospital admissions which all needed investigation of thromboprophylaxis.
• 2016-087 - The incident date is documented as the date that the operation took place, this was raised as a complaint in May and a meeting was held with the patient. The Division reviewed the complaint and a decision was made that this was an incident that required investigation and a Datix form was submitted on 8 July 2016.

7.12. Delays in reporting on STEIS
• 2016-079 - This incident required background research with legal, safeguarding, social services and discussions with the multi-disciplinary team.
• 2016-085 - The delay relates to the time taken for the patient’s consultant to complete the hospital acquired thrombosis (HAT) initial investigation screen to determine if this was an avoidable HAT. Timely feedback from HATS has been raised with this Division.
• 2016-087 - Information required to ascertain the level of investigation was debated amongst the multi-disciplinary team which delayed the decision for this to be declared a SIRI.
• 2016-090 - This was originally reported as a category 2 hospital acquired pressure ulcer (HAPU) but after a review by the tissue viability team it was upgraded to a category 3 HAPU. This review by the specialist team meant that the incident fell just beyond the 10 days.

OCCG Closure meetings
7.13. Two SIRI closure meetings took place between the OCCG and the Trust in July 2016 and 9 SIRIs were closed.

Table 6 - Closed SIRIs

<table>
<thead>
<tr>
<th>SIRI No</th>
<th>STEIS No.</th>
<th>Incident summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016/004</td>
<td>2016/1377</td>
<td>In pre-op assessment a patient’s blood test was labelled incorrectly with another patient’s details. Once this was discovered all blood tests taken on that day were discarded as there were concerns that safety procedures had not been followed. Nineteen patients were affected.</td>
</tr>
<tr>
<td>2016/029</td>
<td>2016/7055</td>
<td>A patient being conservatively managed on a medical ward following traumatic fractures had a fine bore nasogastric tube inserted. The patient was subsequently identified as having a large pneumothorax. The cause of the pneumothorax is not certain.</td>
</tr>
<tr>
<td>2016/030</td>
<td>2016/7057</td>
<td>A patient with type one diabetes was outlying on a trauma ward. The patient had an elevated blood glucose on her morning reading but insulin was omitted in error until the afternoon when the patient had a blood glucose of &gt;27mmol/l and raised ketones.</td>
</tr>
<tr>
<td>2016/040</td>
<td>2016/7724</td>
<td>A patient who was admitted for a left femoral endoprosthetic replacement for a pathological proximal femoral fracture developed a category 3 hospital acquired pressure ulcer to the sacrum.</td>
</tr>
</tbody>
</table>
A patient who was admitted with confusion and poorly controlled diabetes developed a category 3 hospital acquired pressure ulcer to the right heel.

An 80 year old patient admitted for spinal surgery developed a category 3 hospital acquired pressure ulcer to her back.

A patient admitted with critical limb ischemia and a necrotic foot developed a category 3 hospital acquired pressure ulcer over the sacrum.

A patient with metastatic cancer was admitted for an ascitic drain. Due to an incorrect risk assessment on admission the patient was not given dalteparin during her admission. The patient developed a pulmonary embolus 28 days after discharge.

A patient admitted with critical limb ischemia and sepsis developed a hospital acquired grade 3 pressure ulcer to the sacrum.

Quality Walk Rounds

7.14. There were 5 Executive Quality Walk Rounds that took place in July 2016 and three that took place in August.

7.15. Robin’s Ward, ward 7A and the Emergency Department walk rounds were detailed in the August report to Quality Committee.

7.16. Two Walk Rounds in August were postponed due to unavoidable competing priorities. The Walk Rounds are detailed in Table 7.

Table 7 – Executive Quality Walk round information

<table>
<thead>
<tr>
<th>Hospital Site</th>
<th>Month of visit</th>
<th>Areas to visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Radcliffe Hospital</td>
<td>July</td>
<td>Robin’s Ward 7A Main Endoscopy, L2</td>
</tr>
<tr>
<td>Horton Hospital</td>
<td>July</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>Churchill Hospital</td>
<td>July</td>
<td>Pharmacy Procurement and Distribution Unit</td>
</tr>
<tr>
<td>NOC</td>
<td>August</td>
<td>Ward D &amp; Rheumatology Day Unit</td>
</tr>
<tr>
<td>Churchill Hospital</td>
<td>August</td>
<td>Dermatology (Postponed)</td>
</tr>
<tr>
<td>John Radcliffe Hospital</td>
<td>August</td>
<td>Children’s Critical Care Mortuary (Postponed)</td>
</tr>
<tr>
<td>Horton Hospital</td>
<td>August</td>
<td>Day Case Unit</td>
</tr>
</tbody>
</table>
7.17. Key issues arising during the Quality Walk Rounds with the potential to affect quality or patient experience either positively or negatively included:

Main Endoscopy Level 2 JR
- Staff are highly motivated and staffing levels are good.
- Expansion building work is currently underway which will provide an extra treatment room and some temporary office space before the space is converted into a seventh endoscopy room in approximately 2 years’ time.

Pharmacy Procurement and Distribution Unit
- A very busy unit with lots of activity and staff are working in a difficult environment.
- The many environmental issues are being addressed via the usual Divisional Governance processes.
- A Divisional risk is being escalated to the Corporate Risk Register: ‘Inability to continue to supply stock medicines to wards and medicines to all the Trust’s dispensaries’.

Ward D & Rheumatology Day Unit
- The retention of newly qualified and international nursing staff continues to be an important issue; the development of further skills and courses specific to Orthopaedics is being planned.
- There were well displayed quality metrics and safety crosses in a location visible to staff, patients and visitors

7.18. The Walk Rounds which took place in Children’s Critical Care and the Day Case Unit will be reported in the next report.
8. **Clinical Effectiveness**

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

8.1. There have been no mortality outliers reported for OUHFT by the CQC or the Dr Foster Unit at Imperial College.

8.2. The SHMI for the data period January 2015 to December 2015 is 0.99. This is rated ‘as expected’. The SHMI trend is depicted in Chart 14. The SHMI remains within the ‘as expected’ range.

**Chart 14 – SHMI trend analysis**

8.3. The HSMR is 100 for the financial year 2015/2016. The value is ‘within the expected’ range (95% CI 96.1 -105.1).

8.4. The number of observed deaths within the HSMR 56-diagnosis groups is 1938. The HSMR trend is depicted in Chart 15. The HSMR remains ‘within the expected’ range.

**Chart 15 – HSMR trend analysis**
Crude Mortality

8.5. The OUHFT crude mortality by month, site and division is displayed in the charts below. Crude mortality gives a contemporaneous but not risk adjusted view of mortality across OUHFT. Chart 16 and 17 reflect an unchanging crude mortality as a percentage of patient attendances when looked at over 12 months.

**Chart 16 – Crude Mortality**

![Chart 16 - Crude Mortality](image)

**Chart 17 – Crude Mortality by Division**

![Chart 17 - Crude Mortality by Division](image)
Clinical Audit

8.6. The following audits were presented at the Clinical Effectiveness Committee (CEC) on the 14th July 2016; key areas for improvement or areas of excellent results are highlighted:

8.6.1. VTE prophylaxis Trust wide audit – action plan update
8.6.2. Health Record Keeping Standards Trust wide audit
8.6.3. Consent Trust wide audit
8.6.4. Care 24/7 Trust wide audit
8.6.5. Manual Handling risk assessment Trust wide audit
8.6.6. MBRRACE-UK Perinatal Mortality Surveillance Report

OUHFT mortality rates are 10% less than the National average. The Unit are revising tools for the review of still births to ensure that the circumstances related to the cases are considered. National Audit of Percutaneous Coronary Intervention

The Unit has performed consistently well in this audit. For emergency patients presenting with ST-elevation myocardial infarction, the door-to-balloon time (DTB) of less than 90 minutes was met in 94% of cases (National average 90%) with a DTB of less than 60 minutes achieved in over 90% of cases (National average 77%).

8.6.7. End of Life Care (EoLC) Audit: Dying in Hospital
8.6.8. National Comparative Audit of Blood Transfusion programme (NHSBT) Audit of the use of blood in Lower Gastrointestinal bleeding
8.6.9. British Society of Paediatric Endocrinology and Diabetes Paediatric Endocrinology Peer Review
8.6.10. The Unit achieved a good peer review. The multidisciplinary team and biochemistry meetings were highlighted as areas of good practice.
9. **Infection Control**

**Clostridium difficile (C. diff)**

9.1. The upper ceiling for OUHFT apportioned cases of Clostridium difficile (C. diff) in 2016/2017 is 69.

**Chart 19 – Cumulative Total & Cumulative Limit of C. diff July 15- July 16**

9.2. In July 2016 there were 6 cases of C. diff against an internal monthly ceiling of 6. However, because of the large number of cases in May the cumulative total is 25 cases against the cumulative limit of 23.

**30 day C. diff Mortality review**

9.3. As per Department of Health guidance (2008), the OUHFT undertakes a monthly review to identify deaths within 30 days of diagnosis of Clostridium difficile. A review then identifies if C. diff was a causative factor and cases are discussed within existing Morbidity and Mortality meetings.

9.4. Late out of hospital deaths are identified by the Infection Control Service by interrogating the NHS Spine.

9.5. There have been no deaths where C. diff was recorded on the death certificate during July 2016.

**MRSA bacteraemia**

9.6. The objective for 2016/2017 is 0 avoidable MRSA bacteraemia. One positive MRSA blood culture occurred during June 2016, this was a pre-72 hour sample and not therefore apportioned to the OUHFT and confirmation has been received to say that it has been assigned to a third party.
Cleaning Audit Performance and Process

Table 8 – Number of Cleaning Audits undertaken by Contract Verification Team during May & June 2016 per division achieving ≥92%

<table>
<thead>
<tr>
<th>Division</th>
<th>Number areas audited</th>
<th>≥ 92% areas achieving ≥ 92%</th>
<th>Overall % areas achieving ≥ 92%</th>
<th>Number areas audited</th>
<th>≥ 92% areas achieving ≥ 92%</th>
<th>Overall % areas achieving ≥ 92%</th>
</tr>
</thead>
<tbody>
<tr>
<td>NOTTS</td>
<td>7</td>
<td>3</td>
<td>43%</td>
<td>9</td>
<td>1</td>
<td>11%</td>
</tr>
<tr>
<td>MRC</td>
<td>6</td>
<td>2</td>
<td>33%</td>
<td>15</td>
<td>5</td>
<td>33%</td>
</tr>
<tr>
<td>C&amp;W</td>
<td>5</td>
<td>2</td>
<td>40%</td>
<td>9</td>
<td>3</td>
<td>33%</td>
</tr>
<tr>
<td>S&amp;O</td>
<td>5</td>
<td>2</td>
<td>40%</td>
<td>14</td>
<td>8</td>
<td>57%</td>
</tr>
<tr>
<td>CSS</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>3</td>
<td>2</td>
<td>67%</td>
</tr>
</tbody>
</table>


9.7. Carillion will commence using the Synbiotix software platform for audits of compliance from 1st September and it is understood from the Soft FM Client Contract Manager that the cleaning contractor and Horton have also agreed to use this tool; the date for this has yet to be agreed.

9.8. It was proposed at the July Senior Nurse meeting that nursing staff also use this tool. This proposal was agreed and two areas have volunteered to trial the tool. The Soft FM Client Contract Manager has been invited to the next Senior Nurse Meeting and has been asked to provide ward sisters/matrons a flow sheet on the escalation process.
9.9. It is intended that a cleaning partnership meeting (with reps from each site for contracts, nurses, and supervisors) will be formed with the aim of providing a means of co-ordinating a cross-site driver to improving data and cleaning scores.

9.10. The Director of Assurance and a non-executive director have accompanied the Infection Control Manager and the Contract Verification team on a cleaning audit in order for them to understand the process and issues.

**MRSA Screening Compliance**

9.11. The OUHFT achieved
- Elective Admissions 76% (762/1000)
- Emergency Admissions 53.9% (2259/4191)

**Table 9** – Compliance by Division with emergency and elective MRSA screening for July 2016

<table>
<thead>
<tr>
<th>Division</th>
<th>Percentage Screened Electives</th>
<th>Percentage screened emergencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurosciences, Orthopaedics, Trauma &amp; Specialist Surgery</td>
<td>82.1%</td>
<td>63.5%</td>
</tr>
<tr>
<td>Medicine, Rehabilitation &amp; Cardiac</td>
<td>93%</td>
<td>49.7%</td>
</tr>
<tr>
<td>Surgery &amp; Oncology</td>
<td>58.9%</td>
<td>59.3%</td>
</tr>
<tr>
<td>Clinical Support Services</td>
<td>61.5%</td>
<td>87.2%</td>
</tr>
</tbody>
</table>


9.12. Work continues to move the extraction of MRSA screening compliance from EPR rather than the Infection control software system.

9.13. The focus continues with individual areas with high turnover rates and low compliance such as Emergenct Assessment Unit (EAU) and Surgical Emergency Unit (SEU) triage.

9.14. The MRSA policy is currently under review and will be updated to reflect the implementation of modified admission MRSA screening guidance for NHS (2014) from the Department of Health and also from drawing evidence from local data collection of MRSA positive screens.

**Proactive Infection Prevention & Control (IPC) Work**

9.16. The Infection Control annual study day was held in July and was attended by over 100 delegates from all sites. The evaluation forms all reported excellent feedback.
9.17. The Infection Prevention and Control team now have access to the OUHFT Quality twitter account.

9.18. The second IPC quarterly newsletter will be available at the end of August.

9.19. The use of Hand Hygiene apps for hand hygiene auditing is being trialled.

9.20. An audit of the number of patients with catheter associated urinary tract infections was conducted in collaboration with the Quality Improvement team in June. The results will be available for the September Clinical Governance paper.

9.21. It is planned that the OUHFT will participate in the Europe wide Public Health England Point Prevalence survey this autumn.

9.22. Governance ward rounds have commenced with the IPC team and matrons. These ward rounds will focus on environmental issues, hand hygiene, MRSA screening, use of EPR for recording cannulas, reducing risk of catheter associated urinary tract infection, aseptic non-touch technique.

10. Patient Experience

Emergency Department (ED) FFT Feedback:

10.1. The Trust continues to have a lower recommend rate and higher not recommend rate than the national average (Chart 21; Chart 22). Trusts using SMS for FFT tend to have a higher not recommend rate. This is because the sampling methods for SMS are more robust. Any sampling bias is reduced as staff do not invite individual patients to take part in the survey, compared to paper questionnaires or hand-held devices.

Chart 21

![Chart 21: OUH and National FFT % Recommend: ED](image)

The most recently available national data are from June 2016.
10.2. At 24%, the Trust received the 11th highest response rate for ED in June, out of 141 Trusts nationally, and the response rate is consistently above the national average (Chart 23).

10.3. Charts 24 and 25 show the recommend and not recommend rates for Trusts also using SMS/Smart phone app as an FFT feedback method. When the Trust’s recommend rates are reviewed alongside others that use SMS as a feedback method, it compares well. Of the eight Trusts using SMS as their main
method of feedback, the average recommend rate is 81% and the average not recommend rate is 11.7%.

Chart 24 - Recommend Rates of Trusts Using SMS/Smart Phone App

Chart 25 - Not Recommend Rates of Trusts Using SMS/Smart Phone App

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Footnotes:

4 Trusts using SMS for 90% or more of the responses were included. This Trust uses SMS for 99.5% of responses.

Inpatient and Day Case FFT Feedback by Division:

10.4. Inpatient and Day Case FFT are reported together. The percentage recommend has increased overall this month and the percentage not recommend has decreased (Chart 26; Chart 27). Both are better than the national average for June. The Trust’s recommend rate has been above the national average in the last 12 months, except during May 2016.

Chart 26 - OUH and National FFT % Recommend: Inpatient/Day Case

![Chart showing OUH and National FFT % Recommend: Inpatient/Day Case]

Chart 27 - OUH and National FFT % Not Recommend: Inpatient/Day Case

![Chart showing OUH and National FFT % Not Recommend: Inpatient/Day Case]
10.5. The recommend rate for CSS has decreased and the not recommend rate has increased (Chart 28; Chart 29) however, there were a small number of responses in CSS overall and only two people out of 48 did not recommend their care in July. Neither of these people gave a clear reason as to their choice of response. CSS division has the lowest number of patient direct services which are eligible to ask patients for feedback, and when the number of people responding is low, the overall result is affected by a small number of responses.

Chart 28 - FFT Inpatient and Day Case % Recommend by Division

Chart 29 - FFT Inpatient and Day Case % Not Recommend by Division
10.6. There has been a decrease in response rates to 17% (Chart 30). This is attributable to inpatient wards where there was a 14% response rate in July (down from 19% in June). Day Case areas had a response rate of 20% in July, the same as June.

**Chart 30 - OUH and National FFT Response Rate: Inpatient/Day Case**

10.7. There were 32 wards with a response rate below 15%, and 22 wards with a response rate of 15% and over. This reflects in part the lack of availability of questionnaires during July. The Patient Experience Team will provide support to those wards with a response rate lower than 15%.

10.8. The Patient Experience Team is working with the Surgical Emergency Unit (SEU) to pilot the use of SMS/Smart phone App for seeking FFT feedback in inpatient services.

**Outpatient feedback:**

10.9. Response rates are not monitored for Outpatients, but there were 409 fewer responses in July than in June.

**Maternity FFT feedback for the question asked at birth:**

10.10. The response rate remains lower than the national average (Chart 31). The Maternity Senior Management and the Patient Experience Teams have concluded that the current survey methodology, which relies on staff to hand out questionnaires at four points during a woman’s maternity has not been effective.
10.11. The Head of Midwifery has suggested that agent calls would be a more appropriate method of contacting women. The intrusiveness and non-personal nature of SMS and automated phone calls would not be suitable for use within this service. The new suggested method would be to contact women once only. A paper will be presented to the Trust’s Management Executive (TME) on 22 September.

10.12. The percentage not recommend for Maternity has below the national average since May after a small rise in April (Chart 32).

Chart 31 - OUH and National FFT Response Rate: Maternity

Chart 32 - OUH and National FFT % Not Recommend: Maternity
Children’s Feedback:

10.13. There was no change in the feedback for Children’s services. The recommend rate remains 99% overall.

National Inpatient Survey

10.14. The National Inpatient Survey 2016 will survey patients who were in hospital in July 2016. Fieldwork starts in September 2016 and the results will be published in May or June 2017. It is a postal survey with two reminders. The mandatory national sample includes 1250 patients, but for the second year, the Trust has commissioned an additional sample of 4500-5000 patients, which will allow for ward level feedback. Divisions fed back that they found ward-level feedback useful in the 2015 survey.

Patient Experience Team projects:

10.15. The Patient Experience Team (PET) works with partner organisations and lay people on a range of projects to support improvements to the experience of patients and carers across health and social care. Current projects include:

10.16. Carers Charter: a charter is being developed which will be a cross-organisational statement of intent to provide support to carers; it will clearly outline what carers can expect from organisations. Project partners include the Clinical Commissioning Group, Oxford Health NHS Foundation Trust, Oxfordshire County Council, Carers Oxfordshire, Oxfordshire Family Support Network, Carers Voice and six carers who have experience of caring for people with dementia, learning disabilities, physical disabilities and mental health problems. Young carers were also represented. Twenty one people attended the first meeting showing the high level of commitment to this work. A workshop will be held in October with project partners and carer representatives allowing carers to develop the content of their Charter.

10.17. The Eye Hospital Project: plans to make improvements to the patient experience through trialling and evaluating improvements over the coming year. Following meetings, a baseline questionnaire has been designed and is out for review with the Project Group which includes two Chairs of GP Locality Forums, Patient Voice, Healthwatch, and a range of internal staff from the Eye Hospital and Specialist Surgery directorate, PALS and Complaints.

10.18. BME Complaints Project: the Patient Experience Team is working with OxINAHR (Oxford Institute of Nursing and Allied Health Research) on a two year research project on the experience of people from black and minority ethnic (BME) communities in making complaints. There is evidence that fewer people from BME groups make complaints and their experience is less favourable than that of non-BME groups. The findings from the project will support service improvements.

10.19. The Swan Scheme: the Swan End of Life Care Project Group has held two monthly workshops so far. The scheme aims to improve the experience of patients at the end of their lives, and the experience of relatives and carers during this time. Chaired by the Head of Patient Experience, this group includes senior nursing staff, and the Bereavement and Chaplaincy Teams.

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6 The CQC do not allow survey providers to release data in groups of less than 30 people.
10.20. Young Person’s Executive (YiPpEe): this group represents the interests of children and young people as patients. Recently, one member of YiPpEe has completed a trial of the work experience programme being developed for members by the Children’s Patient Experience Project Lead. The member spent half a day in a number of areas over the course of a week. They were able to spend time in both children and adult clinical areas. Based on feedback from staff involved it was a positive experience and will be offered to other members in the future.

11. PALS and Complaints

11.1. 101 new complaints were received in July. This is a very small decrease from the previous month (June N=108).

11.2. Chart 33 below shows the recent trends in complaint numbers for the last 12 months for all six divisions. This shows a significant decrease in complaints for the NOTSS and MRC divisions in July, and a significant increase in complaints in the S&O division this month; this is discussed in further detail in the analysis below. NOTSS continue to have the highest number of complaints (N=26) across the Trust for 12 months.

Chart 33 - New complaints opened

11.3. There were three red graded complaints received in July. Two of the red complaints were for the S&O division; one complaint was investigated as a SIRI and a written response is being sent to the family to answer the outstanding questions. The second complaint is not being investigated as a SIRI but a meeting will be held with the family at the end of August. The third red complaint is for the MRC division; the SIRI report has been sent to the family and a formal response will be sent to answer the family’s outstanding concerns.

11.4. The top five complaint themes for May to July 2016 include; Clinical Treatment, Communication, Admission and Discharge, Appointments, and Patient Care;
the complaints coded as ‘Other’ relate to themes with only a small number of complaints. Clinical Treatment (N=79) and Communication (N=52) continue to be the top two themes identified in complaints from May to July 2016.

Divisional Overview

11.5. **NOTSS** received 25 complaints in July (25% of the total complaints across the Trust). This is a significant decrease from the previous month (N=39). There has been a small drop in activity from the previous months, which may account for the decrease in complaints. The division’s complaints relate to Neurosciences (N=5), Specialist Surgery (N=9), Musculoskeletal (N=9) and Trauma (N=3). There has been a decrease in Neurosciences complaints (June, N=11).

11.6. **S&O** received 25 complaints this month; 24.7% of the overall number received Trust-wide. This is a significant increase from the previous month (June, N=10) and is the highest number of complaints received by the division in the last 12 months. There has not been an increase in activity reported. All three of the following directorates have seen an increase in complaints; Surgery (N=6), Renal, Transplant, and Urology (N=7) and Gastroenterology, Endoscopy and Theatres (N=8). The only directorate without a rise in complaints is Oncology and Haematology (N=4). Clinical Care (N=10) and Communication (N=7) were the two main themes amongst the complaints.

11.7. A more in-depth analysis of the S&O complaints showed that Urology was responsible for all seven complaints, and Gastroenterology and Surgery had the second highest proportion of the complaints amongst the division. The complaints were related to delay/failure in acting on reports/treatment/procedure. Three of the Urology complaints related to administrative procedures/cancellation of appointments.

11.8. **CSS** received six complaints in July; 5.9% of the overall received Trust-wide. Four of the complaints received related to Radiology and Imaging, one complaint related to the Pain Service and one complaint related to Pharmacy.

11.9. **MRC** received 21 complaints this month; 20.7% of the overall complaints received by the Trust, which is a significant decrease from the previous month (N=33). MRC had a noticeable drop in complaints in May (N=16). The complaints related to Ambulatory Medicine (N=4), Acute Medicine and Rehabilitation (N=13) and Cardiac Services (N=4). Seven of the complaints related to the Trust’s Emergency Departments/Emergency Assessment Units; this is a small decrease from the previous month (N=11).

11.10. **C&W** received 15 complaints this month; 14.8% of the overall number of complaints received by the Trust. Five of the complaints related to Children’s Services and ten of the complaints related to Women’s Services.

11.11. **Corporate** received eight complaints in July: 7.9% of the total complaints received by the Trust. This is the same as the previous month, but considerably higher than those received in quarter four. One of the complaints received related to the Trust’s car parking.
Challenges and Risks

11.12. There is difficulty recruiting to the PALS team and the Complaints Coordinators will be taking on some of the additional PALS work to help with this increasing demand and lack of staff during this time.

11.13. This may impact upon the number of PALS cases that are reported, which we anticipate to be lower than previous months.

11.14. PALS DATIX Web has been implemented this month for PALS cases. The subject codes and sub-subject codes have been updated on this new module to mirror those used in the Complaints module. This will facilitate the identification of key themes and trends more easily.

12. Safe Staffing – Nursing and Midwifery

12.1. The Trust is required to report Staffing data for adult inpatient wards in acute hospitals. This report therefore includes the safe staffing data for July 2016 and the metrics (May - July 2016) against each of the 5 divisions (Appendices attached).

National reporting for Safe Staffing for July 2016

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

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

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

Unify data for July 2016

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

- 94.93% for Registered Nurses/Midwives
- 88.16% for Nursing Assistants (unregistered)

12.6. These percentages have decreased begun to decrease incrementally over the last 3 months in line with decreased recruitment from the EU and the continuing turnover rate for nurses/midwives. The highest attrition being band 5 staff nurses and nursing assistants.

12.7. The National Quality Board (NQB), first published guidance in November 2013 on safe staffing, including national reporting and the requirements for NHS providers to provide Trust Boards with assurance on skill mix and levels of nurse staffing, which are also transparent on the Trust’s websites. The NQB have now published updated guidance:

Supporting NHS Providers to deliver the right staff, with the right skills, in the right place at the right time (July 2016) - Safe sustainable and productive staffing (https://www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf)

12.8. This builds upon the previous guidance and incorporates the Carter Review’s expectations of reducing variability by benchmarking nationally as well as measuring productivity through patient safety outcomes.
12.9. “NHS provider boards are accountable for ensuring their organisation has the right culture, leadership and skills in place for safe, sustainable and productive staffing. They are also responsible for ensuring proactive, robust and consistent approaches to measurement and continuous improvement, including the use of a local quality framework for staffing that will support safe, effective, caring, responsive and well-led care”

12.10. It provides examples of three key NQB expectations in order to triangulate the approach to staffing decisions:

**Expectation 1 - Right staff**

12.11. “Trust Boards should ensure that there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients at all times, across all care settings in NHS provider organisations.

12.12. There should be an annual strategic review, with evidence that this is developed using a triangulated approach (evidence based tool, triangulated approach and benchmarking with peers. Taking account of all healthcare professional groups and is in line with financial plans. This should be followed with a comprehensive staffing report to the board after six months to ensure that workforce plans are still appropriate. Reviews should also occur after any service change or where quality or workforce concerns are identified”.

12.13. This includes:
- Evidence workforce planning
- Professional Judgement
- Compare staffing with peers

**Expectation 2 - Right skills**

12.14. “Boards should ensure clinical leaders and managers are appropriately developed and supported to deliver high quality, efficient services, and there is a staffing resource that reflects a multiprofessional team approach. Decisions about staffing should be based on delivering safe, sustainable and productive services. Clinical leaders should use the competencies of the existing workforce to the full, further developing and introducing new roles as appropriate to their skills and expertise, where there is an identified need or skills gap”

12.15. This includes:
- Mandatory training, development and education
- Working as a multi-disciplinary team
- Recruitment and retention

**Expectation 3 – Right place and time**

12.16. “Boards should ensure that staff are deployed in ways that ensure patients receive the right care, first time, in the right setting. This will include effective management and rostering of staff with clear escalation processes, from local service delivery to reporting at board, if concerns arise.

12.17. Directors of Nursing, Medical Directors, Directors of Finance and Directors of Workforce should take a collective leadership role in ensuring clinical workforce planning forecasts reflect the organisation’s service vision and plan, while supporting the development of a flexible workforce able to respond effectively to future patient care needs and expectations”
12.18. This includes:
- Productive working, eliminating waste
- Efficient deployment and flexibility
- Efficient employment and minimising agency

12.19. The NQB also recommends that wider measures are utilised in order to monitor the impact of staffing on quality, and that the metrics used are aligned to a 'single version of the truth' to reduce the burden and ensure effective oversight.

12.20. Care Hours per Patient Day (CHPPD) form part of this guidance and are recommended to be used in triangulation with quality metrics for effective and appropriate benchmarking. This should include the board reading and hearing both patient and staff voices and the findings and learning from incidents and SIRI investigations that may suggest issues with quality indicators.

The Trust response to the NQB (2016) guidance

12.21. The Trust will build upon the current six monthly comprehensive patient acuity review in relation to skill mix and levels of staffing, to triangulate metrics with patient and staff ‘voices’. This will take into consideration the significant changes that have progressed in the Trust through the recent transformation of services. As well as develop a benchmarking process with relevant peer organisations (data from May 2016 onwards) within and outside of the Shelford Group. Staff development, appraisal and education will also form part of the review of the support and development of staff, as well as the overall multidisciplinary skill mix in clinical areas.

13. Recommendations

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

Tony Berendt
Medical Director

Catherine Stoddart
Chief Nurse
Appendices

How to interpret charts

Data are presented in this report in a number of different ways – including statistical. For process control (SPC) charts, line charts (without confidence intervals / control limits), histograms and cumulative histograms. Graphics have been selected in order to encourage the analysis of trends and to identify when a change in relation to the historical position is likely to be ‘real’ or statistically significant.

SPC charts show a trend line and allow easy reference to the historical mean for that metric at a time at which it was stable and ‘within control’. Where shown, the mean is displayed as a horizontal orange line. In addition, warning limits and control limits are shown where appropriate, above and below the mean. Warning limits are placed at two standard deviations (2SD – dashed black line) and control limits at three standard deviations (3SD – solid black line). If a data point is found beyond the control limit (3SD from the mean) in either direction, the change is statistically significant and is very unlikely to have occurred simply by chance.

There are other patterns within the data that are likely to reflect real change as opposed to random fluctuation – these patterns are known as special cause variations. They include:

2 consecutive points lying beyond the warning limits (unlikely to occur by chance)
7 or more consecutive points lying on the same side of the mean (implies a change in the mean of the process)
5 or more consecutive points going in the same direction (implies a trend)
Appendix 2 Patient experience dashboard:

**FFT: % recommend**

- **OUH and National FFT % Recommend**
  - 98% 96% 97% 99% 100% 98% 96% 94% 92% 90% 88% 86% 84% 82% 80% 78% 76% 74% 72% 70% 68% 66% 64% 62% 60% 58% 56% 54% 52% 50% 48% 46% 44% 42% 40% 38% 36% 34% 32% 30% 28% 26% 24% 22% 20% 18% 16% 14% 12% 10% 8% 6% 4% 2% 0%
  - 08/15 09/15 10/15 11/15 12/15 01/16 02/16 03/16 04/16 05/16 06/16 07/16

- **FFT Inpatient and Day Case % Recommend by Division**
  - June 2016 FFT Percentage Recommend: National Best and Worst
    - IP/DC: 100% 96%
    - ED: 99% 98%
    - Mat: 100% 94%
    - OP: 98% 94%

- **June 2016 FFT Percentage Recommend: National Best and Worst**
  - NHS Trusts with 100 or more responses have been included.

**FFT: % not recommend**

- **OUH and National FFT % Not Recommend**
  - 10.3% 3.3% 1.4% 0.7% 0.0% 2.0% 4.0% 6.0% 8.0% 10.0% 12.0% 14.0%
  - 08/15 09/15 10/15 11/15 12/15 01/16 02/16 03/16 04/16 05/16 06/16 07/16

- **FFT Inpatient and Day Case % Not Recommend by Division**
  - Jun 2016 FFT Percentage Not Recommend: National Best and Worst
    - IP/DC: 0.0% 2.1%
    - ED: 10.6% 10.7%
    - Mat: 37.7% 8.1%
    - OP: 9.5% 3.2%

- **June 2016 FFT Percentage Not Recommend: National Best and Worst**
  - NHS Trusts with 100 or more responses have been included.

**FFT % recommend**

- **OUH and National FFT Response Rate**
  - 99% 90% 96% 96% 97% 90% 92% 94% 96% 98% 100%
  - 08/15 09/15 10/15 11/15 12/15 01/16 02/16 03/16 04/16 05/16 06/16 07/16

- **FFT Inpatient and Day Case % Response Rate by Division**
  - June 2016 FFT Response Rates: National Best and Worst
    - IP/DC: 66%
    - ED: 19%
    - Mat: 5%
    - OP: 44%

- **June 2016 FFT Response Rates: National Best and Worst**
  - NHS Trusts with 100 or more eligible patients have been included.
Complaints

New complaints

New PALS enquiries

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

Closed complaints

Managing complaints

% complaints investigations completed within agreed timescales

% complaints acknowledged within 3 days

% complaints upheld or partially upheld
**Children’s and Women’s Division, (C&W), Safe Staffing Dashboard (In-patient Areas only) July 2016**

**Appendix 3A**

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**July 2016 Safe Staffing by inpatient wards for C&W division**

**DAY SHIFT (Early, Late, Long Day)**

**NIGHT SHIFT**

**Narrative:** It should be noted that the reporting has changed; The Trust now extracts reports from IPAMS – this is more objective, has pre-determined thresholds and is reported through Qlikview. The levels of ‘Agreed’/’Minimum’ & ‘At Risk’ staffing are more explicit and reflect the actual staffing levels through an evidence based tool, therefore the % levels of Agreed staffing will appear significantly lower but it is reflective of the actual levels.

**Childrens Directorate:** Staff have also been moved between areas, with appropriate use of temporary staff in order to mitigate escalation shifts. The level of ‘agreed staffing’ continue to decrease in July for the reasons stated above and this reflects the actual staffing levels. However sickness, maternity and vacancy levels remain consistent. The national Safer Nursing Care Tool for Children’s acuity and dependency has been developed and provides a greater level of evidence than the current RCN guidance, the intention is to implement in September. Horton Childrens Ward: The situation remains unchanged, due to high levels of long term sickness which has decreased the nurse to patient ratio, requiring 4 bed closures to mitigate the safe staffing levels. This is on the Divisional Risk Register. Incidents: All quality indicators are monitored against staffing levels and this includes an increase in medication errors and extravasation incidents.

**Maternity** – an escalation process is in place to cover periods of high activity/staffing issues. The individual wards for the maternity wards and suites have been separated in the IPAMS reporting system, and this has demonstrated the individual areas where escalated shifts that are ‘At Risk’ are high. If there are available staff in the individual maternity units that are moved to cover the areas with reduced staffing or higher acuity. At night there are on call midwives available and when clinically indicated, community midwives are called to cover alongside the Midwifery Lead or Consultant led units. Women can be asked to move to either the JR or HH if the activity is high on a particular site.
### CSS July 2016 Appendix 3B

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### July 2016 Safe Staffing by Inpatient ward for CSS division

**DAY SHIFTS (Early, Late, Long Day)**

**NIGHT SHIFTS**

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**Narrative:** It should be noted that the reporting has changed; The Trust now extracts reports from IPAMS – this is more objective, has pre-determined thresholds and is reported through Qlikview. The levels of 'Agreed'/Minimum & 'At Risk' staffing are more explicit and reflect the actual staffing levels through an evidence based tool, therefore the % levels of Agreed staffing will appear significantly lower but it is reflective of the actual levels.

Recruitment campaign plans continue within adult critical care services, as there is a significant increase in the vacancies for July, as well as sickness and maternity leave, all compounding on the levels of ‘Agreed staffing’

Long term agency staff are utilised to ensure optimal levels that comply with level 3 and level 2 patient requirements, and the JR and CH sites using their staff fluidly between to two sites dependent upon demand. At risk shifts are mitigated by careful bed management and movement of staff as well as use of temporary staff if available. The levels of medication errors continue to be monitored closely.
Medicine, Rehabilitation & Cardiac Division, (MRC), Safe Staffing Dashboard (In-patient Areas Only)

July 2016

Appendix 3C

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<th>May 2016</th>
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<td>Vacancy %</td>
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<td>Sickness %</td>
<td>3.7%</td>
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<td>3.2%</td>
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<tr>
<td>Maternity/Adoption Leave %</td>
<td>2.8%</td>
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<tr>
<td>Agreed Staffing Levels %</td>
<td>85%</td>
<td>66%</td>
<td>64%</td>
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<tr>
<td>Total number of Medication Nursing Administration Errors or Concerns</td>
<td>26</td>
<td>22</td>
<td>28</td>
</tr>
<tr>
<td>Total numbers of Hospital Acquired Pressure Ulcers</td>
<td>59</td>
<td>39</td>
<td>50</td>
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<tr>
<td>Total Number of Avoidable Grade 3-4 Hospital Acquired Pressure Ulcers</td>
<td>2</td>
<td>4</td>
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<tr>
<td>Total Numbers of Falls</td>
<td>106</td>
<td>116</td>
<td>101</td>
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<tr>
<td>Falls with moderate, major or catastrophic harm</td>
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July 2016  Safe Staffing by Inpatient ward for MRC division

<table>
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<tr>
<td>Total number of Medication Nursing Administration Errors or Concerns</td>
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<tr>
<td>Total numbers of Hospital Acquired Pressure Ulcers</td>
<td>2</td>
<td>4</td>
<td>0</td>
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<tr>
<td>Total Number of Avoidable Grade 3-4 Hospital Acquired Pressure Ulcers</td>
<td>102</td>
<td>69</td>
<td>91</td>
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<tr>
<td>Total Numbers of Falls</td>
<td>180</td>
<td>203</td>
<td>184</td>
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<tr>
<td>Falls with moderate, major or catastrophic harm</td>
<td>4</td>
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<td>2</td>
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</tbody>
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Narrative:

It should be noted that the reporting has changed; The Trust now extracts reports from IPAMS – this is more objective, has pre-determined thresholds and is reported through Qlikview. The levels of ‘Agreed’/’Minimum’ & ‘At Risk’ staffing are more explicit and reflect the actual staffing levels through an evidence based tool, therefore the % levels of Agreed staffing will appear significantly lower but it is reflective of the actual levels.

MRC has had a few shifts within the medical wards at the John Radcliffe recorded as ‘At Risk and escalated’, this was mitigated appropriately and no harm occurred to patients as a result. Agreed levels of staffing increases at night due to a higher temporary staff fill rate; however it should be noted that the ‘Agreed levels’ for June are significantly lower and reflect the true situation, as the acuity and staffing is inputted with a threshold level, evidence based tool from June. Sickness, maternity/adoption leave remain consistent and well managed, however the vacancy rate has increased. There is monitoring of the Nurse Sensitive Indicators in alignment with the quality of the staffing. Hospital acquired pressure ulcers have increased but there have been no category ¾ this month. There is a plan to use the approach of high impact training regarding the whole SIRI process; with the learning from each incident devolved to band 5 staff nurses and nursing assistants. This will be rolled out across the divisions following a positive response by staff in another division.

The Falls Safe programme is being implemented with close monitoring of trends and the impact of the interventions in individual ward areas. Short stay ward for instance has had intensive training in Fallsafe with significant improvements in the way falls are prevented and managed.
### Neurosciences, Orthopaedics, Trauma & Specialist Surgery (NOTSS), Safe Staffing Dashboard (Inpatient Areas Only)

**July 2016**

**Appendix 3D**

<table>
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<td>Sickness %</td>
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<td>4.0%</td>
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<tr>
<td>Maternity/Adoption Leave %</td>
<td>1.5%</td>
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<td>2.0%</td>
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<td>Agreed Staffing Levels %</td>
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<td>85%</td>
<td>66%</td>
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<tr>
<td>Total number of Medication Nursing Administration Errors or Concerns</td>
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<td>17</td>
<td>22</td>
<td>70</td>
<td>66</td>
<td>87</td>
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<tr>
<td>Total numbers of Hospital Acquired Pressure Ulcers</td>
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<td>10</td>
<td>16</td>
<td>102</td>
<td>69</td>
<td>91</td>
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<tr>
<td>Total number of avoidable grade 3-4 hospital acquired Pressure Ulcers</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>6</td>
<td>4</td>
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<tr>
<td>Total Numbers of Falls</td>
<td>42</td>
<td>45</td>
<td>48</td>
<td>180</td>
<td>203</td>
<td>184</td>
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<tr>
<td>Falls with moderate, major or catastrophic harm</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
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<td>2</td>
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#### July 2016 Safe Staffing by Inpatient ward for NOTSS division

**DAY SHIFT (Early, Late, Long Day)**

| Staffing Level Assessments by Ward: July 2016 - Day shift (Early, Late, Long Day) |
|-------------------------------|--------------------------------------------------|
| **Agreed Establishment**      | **Escalation**                                   |
| **Minimum**                   | **Surplus**                                      |
| **Narrative:**                |                                                  |

It should be noted that the reporting has changed; The Trust now extracts reports from IPAMS – this is more objective, has pre-determined thresholds and is reported through Qlikview. The levels of ‘Agreed’/’Minimum’ & ‘At Risk’ staffing are more explicit and reflect the actual staffing levels through an evidence based tool, therefore the % levels of Agreed staffing will appear significantly lower but it is reflective of the actual levels.

Escalation shifts remain at a minimum and continue to be managed proactively by the directorates, reviewing acuity and activity on a shift by shift basis, and implementing mitigation; no harm resulted from the levels of staffing.

The HR metrics remain consistent, however it should be noted that ‘Agreed levels of staffing’ are significantly lower than 3 months ago and decreasing. Quality indicators continue to be monitored closely and have noted to be increasing, to ensure that impact of minimal and escalation shifts remains manageable and without harm. There have been consistent levels of falls including those with harm in the last 3 months. The numbers of medication errors and hospital acquired pressure ulcers have also increased. The areas where these have increased are receiving intensive support, including the plan to use the approach of high impact training regarding the whole SIRI process; with the learning from each incident devolved to band 5 staff nurses and nursing assistants. This will be rolled out across the divisions following a positive response by staff in another division.
## Surgery & Oncology Division, (S&O), Safe Staffing Dashboard (In-patient Areas Only)
### July 2016
### Appendix 3E

<table>
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<tr>
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<th>S&amp;O</th>
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<tr>
<td>Total Funded WTE</td>
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<td>Vacancy %</td>
<td>8.8%</td>
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</tr>
<tr>
<td>Sickness %</td>
<td>3.4%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Maternity/Adoption Leave</td>
<td>3.3%</td>
<td>3.3%</td>
</tr>
<tr>
<td>Agreed Staffing Levels %</td>
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<td>64%</td>
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<td>Total number of Medication Nursing Administration Errors or Concerns</td>
<td>10</td>
<td>11</td>
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<tr>
<td>Total numbers of Hospital Acquired Pressure Ulcers</td>
<td>30</td>
<td>17</td>
</tr>
<tr>
<td>Total Number of Avoidable Grade 3-4 Hospital Acquired Pressure Ulcers</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Total Numbers of Falls</td>
<td>29</td>
<td>39</td>
</tr>
<tr>
<td>Falls with moderate, major or catastrophic harm</td>
<td>0</td>
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</table>

### July 2016 Safe Staffing by Inpatient ward for S&O division

**DAY SHIFT (Early, Late, Long Day)**

**NIGHT SHIFT**

**Narrative:** It should be noted that the reporting has changed; The Trust now extracts reports from IPAMS – this is more objective, has pre-determined thresholds and is reported through Qlikview. The levels of ‘Agreed’/’Minimum’ & ‘At Risk’ staffing are more explicit and reflect the actual staffing levels through an evidence based tool, therefore the % levels of Agreed staffing will appear significantly lower but it is reflective of the actual levels.

The Division continues to embed learning from the monitoring of the Nurse Sensitive Indicators including previous HAPU, high impact falls and medication incident investigations. There have been 3 category 3/4 pressure ulcers in July.

SEU have piloted the implementation of high impact training regarding the whole SIRI process; with the learning from each incident devolved to band 5 staff nurses and nursing assistants. This had an impressive response from staff and will be rolled out across the other directorates and potentially divisions.

The recruitment and retention strategies within the division are under review. The turnover rates have not dropped however recruitment over the summer months has been reduced partly because of reduced intakes of EU nurses and therefore vacancy rates have not decreased at the anticipated rate. Levels of ‘Agreed staffing’ continues to decrease. Higher agreed staffing levels at night reflect higher fill rates of temporary staff at night.
## Trust Safe Staffing Dashboard (In-patients only) July 2016

### Appendix 3F

<table>
<thead>
<tr>
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<th>May 2016</th>
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</thead>
<tbody>
<tr>
<td>Total Funded WTE</td>
<td>2968.7</td>
<td>2986.9</td>
<td>2989.7</td>
</tr>
<tr>
<td>Vacancy %</td>
<td>5.6%</td>
<td>7.5%</td>
<td>8.0%</td>
</tr>
<tr>
<td>Sickness %</td>
<td>4.0%</td>
<td>3.7%</td>
<td>3.5%</td>
</tr>
<tr>
<td>Maternity/Adoption Leave %</td>
<td>2.9%</td>
<td>3.5%</td>
<td>3.8%</td>
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<tr>
<td>Agreed Staffing Levels %</td>
<td>85%</td>
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<td>64%</td>
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<tr>
<td>Total number of Medication Nursing Administration Errors or Concerns.</td>
<td>70</td>
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<tr>
<td>Total numbers of Hospital Acquired Pressure Ulcers</td>
<td>102</td>
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<tr>
<td>Total Number of Avoidable Grade 3-4 Hospital Acquired Pressure Ulcers</td>
<td>2</td>
<td>6</td>
<td>4</td>
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<tr>
<td>Total Numbers of Falls</td>
<td>180</td>
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<tr>
<td>Falls with harm</td>
<td>4</td>
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### July 2016 Safe Staffing by Shift: (Inpatient only): Trust

**Narrative:**

It should be noted that the reporting has changed; The Trust now extracts reports from IPAMS – this is more objective, has pre-determined thresholds and is reported through Qlikview. The levels of ‘Agreed’/’Minimum’ & ‘At Risk’ staffing are more explicit and reflect the actual staffing levels through an evidence based tool, therefore the % levels of ‘Agreed’ staffing will appear significantly lower but it is reflective of the actual levels.

These diagrams demonstrate the shift by shift staffing across the Trust ward by ward as required by the National Quality Board guidance.