Oxford University Hospitals NHS
NHS Trust

Trust Board Meeting: Wednesday 14 January 2015

TB2015.05

Title	**Board Quality Report**

Status	For information
History	This is a monthly report, presented alternately to the Trust Board or to the Quality Committee

Board Lead(s)	**Dr Tony Berendt, Medical Director**			
Key purpose	Strategy	**Assurance**	Policy	Performance

Executive Summary

1. The Board Quality Report (BQR) presents information that is as contemporary as possible, this may include the last calendar month.

2. In relation to key quality metrics:
    - For **13** of the 53 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 **39** of the 53 quality metrics presented, information for the month of November 2014 is available.
    - Divisional specific information that contributes to organisational results are presented in dashboard format at appendix 1.

3. In relation to patient safety and clinical risk:
    - 5 Serious Incidents Requiring Investigation (SIRI) were reported in December 2014.
    - In December 2014, 1 SIRI report was recommended to the Oxfordshire Clinical Commisisoning Group for closure.

4. In relation to Quality Walk Rounds:
    - There were 4 Quality Walk Rounds in December 2014.

5. In relation to clinical effectiveness & outcomes
    - For the data period September 2013 to August 2014, the OUH HSMR value is 98.8. This value is banded 'as expected' using 95% confidence intervals. This is a reduction from the previous HSMR which was 101.74.

6. In relation to Patient Experience:
    - Patient experience information is presented in a dashboard format, including Family and Friends Test data, complaints, activity, PALS and compliments.

7. In relation to Nursing and Midwifery Safe Staffing:
    - The fill rates for November 2014 were:
        - 94.42% for Registered Nurses/Midwives
        - 94.79% for Care Support Workers (unregistered)

    These levels are similar to that in October 2014. This is in line with the October/November similarities in workforce HR metrics, i.e. vacancy, sickness and maternity/adoption leave levels.

Recommendation

Trust Board is asked to receive this report.

Board Quality Report

1. Purpose

1.1. This paper aims to provide Trust Board with information on the quality of care provided within the organisation, and on the measures being taken in relation to quality assurance and improvement.

1.2. This Board Quality Report will be received for information by relevant Trust Committees (Clinical Governance Committee) following the meeting of the Trust Board.

2. Key Quality Metrics

2.1. A suite of fifty three key quality metrics has been identified for consideration by the Committee, these are listed in dashboard format on pages 4 - 6.

2.2. These metrics have been chosen as they are linked to the quality of clinical care provided across the organisation and data quality is felt to be satisfactory.

2.3 The choice of metrics is kept under review. At the request of the Board, prompted specifically by review of metric CE20 (% of patients having an emergency operation within the time specified according to clinical categorisation), consideration has been given to how to capture and track whether any delay has had any material impact on the quality of care received by patients. Proposals for analysing the impact of delays on the quality of care were approved by the Quality Committee at its meeting in December 2014. The outcome of the analysis undertaken will be reported back to the Quality Committee in the first instance.

2.4 Trend graphs and exception reports have been included for selected metrics where specified thresholds have not been met ('red-rated') or those that are amber-rated having been green-rated in the previous period. Thresholds are drawn from a mixture of sources (national, commissioner and internal).

2.5 Due to the reporting timeframe for the Committee, the detailed sections of the Board Quality Report outlines December information, however validated December information is not available for the Quality Metrics section of the report .

2.6 December information is provided in the body of the report where the information has been available before month end.

Table 1

BQR ID	Rating	Rating Last Period	Descriptor	Period	Threshold Source	Red	Amber
PS01*	97.74% Green	Amber	Safety Thermometer (% patients receiving care free of any newly acquired harm) [one month in arrears]	Nov 14	Internal	95%	97%
PS02*	93.32% Green	Green	Safety Thermometer (% patients receiving care free of any harm - irrespective of acquisition) [one month in arrears]	Nov 14	Internal	91%	93%
PS03*	94.6% Red	Red	VTE Risk Assessment (% admitted patients receiving risk assessment)	Nov 14	National	95%	95.25%
PS04*	7 N/A		Serious Incidents Requiring Investigation (SIRI) reported via STEIS	Nov 14		N/A	N/A
PS05	43 Green	Green	Number of cases of Clostridium Difficile > 72 hours (cumulative year to date)	Nov 14	National	47	N/A
PS06	4 Red	Red	Number of cases of MRSA bacteraemia > 48 hours (cumulative year to date)	Nov 14	National	1	N/A
PS07	83.4% Red	Amber	Antibiotic prescribing - % prescriptions where indication and duration specified [most recently available figure, undertaken quarterly]	Oct 14	Internal	85%	88%
PS08	99.4% Green	Green	Antibiotic prescribing - % compliance with antimicrobial guidelines [most recently available figure, undertaken quarterly]	Oct 14	Internal	93%	95%
PS09	80.04% Amber	Amber	% patients receiving stage 2 medicines reconciliation within 24h of admission	Nov 14	Internal	75%	85%
PS10	96.05% Green	Green	% patients receiving allergy reconciliation within 24h of admission	Nov 14	Internal	94%	96%
PS11	2060 N/A		Total number of incidents reported via Datix	Nov 14		N/A	N/A
PS12	4.56% Green	Green	% of incidents associated with moderate harm or greater	Nov 14	Internal	6.5%	5%
PS13	52 N/A		Total number of newly acquired pressure ulcers (category 2,3 and 4) reported via Datix	Oct 14		N/A	N/A
PS14	5 Green	Green	Falls leading to moderate harm or greater	Nov 14	Internal	8	7
PS15	0	Green	Number of hospital acquired	Aug 14	Internal	1	0

	Green		thromboses identified and judged avoidable [two months in arrears]				
PS16	69.23% N/A		Cleaning Score - % of inpatient areas with initial score > 92%	Nov 14		N/A	N/A
PS17	3.67% Green	Green	% 3rd and 4th degree tears in obstetrics [C&W Division]	Nov 14	Internal	5%	N/A
PS18	99.18% Green	Green	% radiological investigations achieving 5 day reporting standard [CSS Division]	Oct 14	Commissioner	95%	98%
PS19	8 N/A		Number of CAS alerts received	Nov 14		N/A	N/A
PS20	0 Green	Green	CAS alerts breaching deadlines at end of month and/or closed during month beyond deadline	Nov 14	Internal	1	N/A
CE01	0.99 N/A		Standardised Hospital Mortality Ratio (SHMI) [most recently published figure, quarterly reported as a rolling year ending in month]	Sep 14		N/A	N/A
CE02	195 N/A		Crude Mortality	Nov 14		N/A	N/A
CE03	71.71% Red	Red	Dementia - % patients aged > 75 admitted as an emergency who are screened [one month in arrears]	Oct 14	National	80%	90%
CE04a	80.2% Red	Red	Statutory and Mandatory Training - % required modules completed	Nov 14	Internal	85%	95%
CE05	86.18% Amber	Amber	ED - % patients seen, assessed and discharged / admitted within 4h of arrival	Nov 14	National	85%	95%
CE06	86% Green	Green	Stroke - % patients spending > 90% of admission in specialist stroke environment	Nov 14	National	70%	80%
CE07	85.71% Green	Amber	Stroke - % patients accessing specialist stroke environment within 4h of arrival	Nov 14	National	75%	85%
CE08	564 N/A		Transfer Lounge Usage	Nov 14		N/A	N/A
CE09	94.47% Green	Green	% of elective paediatric day cases managed as such (Did not result in an overnight stay) [C&W Division]	Oct 14	Internal	70%	75%
CE10	6.2 Amber	Amber	Vascular - Mean length of stay for patients undergoing elective AAA repair (3 month rolling period) [NOTSS Division]	Oct 14	Internal	8	5
CE11	5.56% Red	Green	Vascular - % mortality following elective AAA repair [NOTSS Division]	Oct 14	Internal	5%	3%
CE12	95.45% Green	Green	Cardiology - % patients receiving primary angioplasty within 60 minutes of arrival at hospital [MRC	Nov 14	Internal	85%	90%

			Division]				
CE13	2.4 Amber	Amber	Cardiology - Mean number of days from referral to admission to cardiology at tertiary centre [MRC Division]	Nov 14	Internal	3	2
CE14	0% Green	Green	Cardiac surgery-% rate of patients with organ space infections following cardiac surgery via the sternum [MRC Division]	Nov 14	Internal	1%	0.5%
CE15	1.79% Green	Green	Cardiac Surgery - % mortality following elective primary CABG [MRC Division]	Oct 14	Internal	6%	4%
CE16	0 Green	Green	Number of unscheduled returns to theatre within 48 hours [NOTSS Division]	Nov 14	Internal	2	1
CE17	98.15% Green	Green	Rheumatology - % relevant patients who have their DAS28 score documented [NOTSS Division]	Oct 14	Internal	95%	98%
CE18	1 Amber	Amber	Number of unscheduled returns to theatre in gynaecology [C&W Division]	Nov 14	Internal	2	1
CE19	554 N/A		Number of patients admitted to SEU wards from SEU triage [S&O Division]	Nov 14		N/A	N/A
CE20	64.95% Red	Amber	% patients having their operation within the time specified according to their clinical categorisation [CSS Division]	Nov 14	Internal	90%	95%
CE21	2.96% Amber	Amber	Neuroscience Intensive Therapy Unit (NITU) readmission rate within 48 hours of discharge [NOTSS Division]	Nov 14	Internal	4%	2%
CE22	80.47% Green	Green	% fractured NOF patients who receive surgery within 36 hours of admission [NOTSS Division]	Sep 14	Commissioner	70%	72%
CE23	19.81% Green	Green	% deliveries by C-Section [C&W Division]	Nov 14	Commissioner	33%	23%
CE24	2% Amber	Green	7 day admission rate following assessment on (and discharge from) paediatric CDU [C&W Division]	Nov 14	Internal	4%	2%
PE01	71 Green	Green	Friends & Family - Net Promoter Score [one month in arrears]	Nov 14	Internal	63	70
PE02	93.63% Amber	Green	Friends & Family - proportion extremely likely or likely to recommend [one month in arrears]	Nov 14	Internal	90%	94%
PE03	80 Amber	Red	Complaints Received	Nov 14	Internal	90	80
PE04	2 Red	Green	Number of complaints received initially graded as RED	Nov 14	Internal	2	1

PE05	266 N/A		PALS contacts made	Nov 14		N/A	N/A
PE06	10 Red	Green	Single sex breaches	Nov 14	National	3	2
PE07	68.29% Amber	Green	% patients EAU length of stay < 12h	Nov 14	Internal	65%	70%
PE08	78.99% N/A		% Complaints upheld or partially upheld [Quarterly in arrears]	Sep 14		N/A	N/A
PE09	0 Green	Red	Number of legal claims received / inquests opened initially graded as RED	Mar 14	Internal	2	N/A
PE10	66% Green	Green	% patients returning feedback forms in specialist surgery outpatients [NOTSS Division]	Nov 14	Internal	45%	60%
PE11	9 N/A		Number of reopened complaints	Nov 14		N/A	N/A

ORBIT Reporting **Board Quality Report**

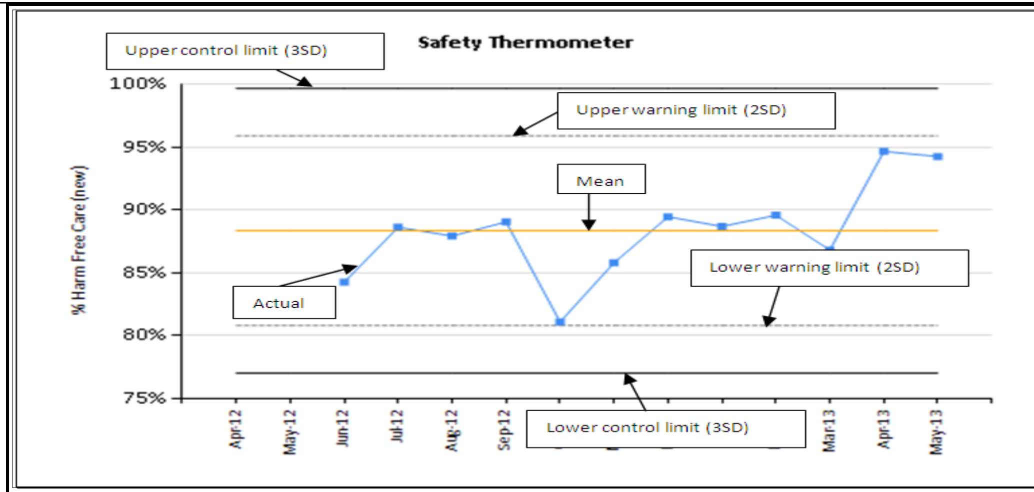
How to interpret charts

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

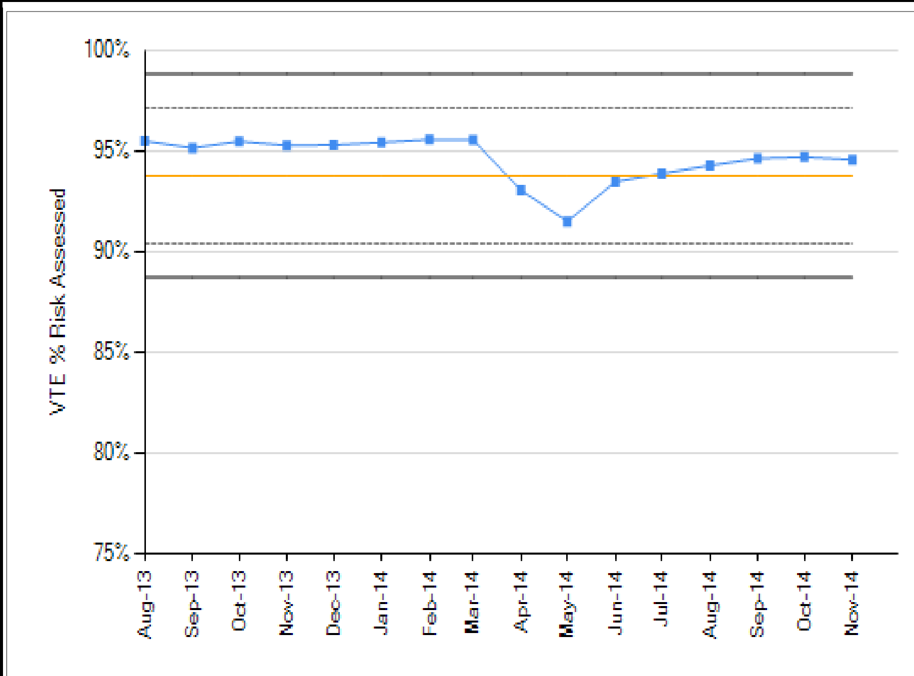
SPC charts show a trend line and allow easy reference to the historical mean for that metric at a time at which it was stable and 'within control'. Where shown, the mean is displayed as a horizontal orange line. In addition, warning limits and control limits are shown where appropriate, above and below 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)*

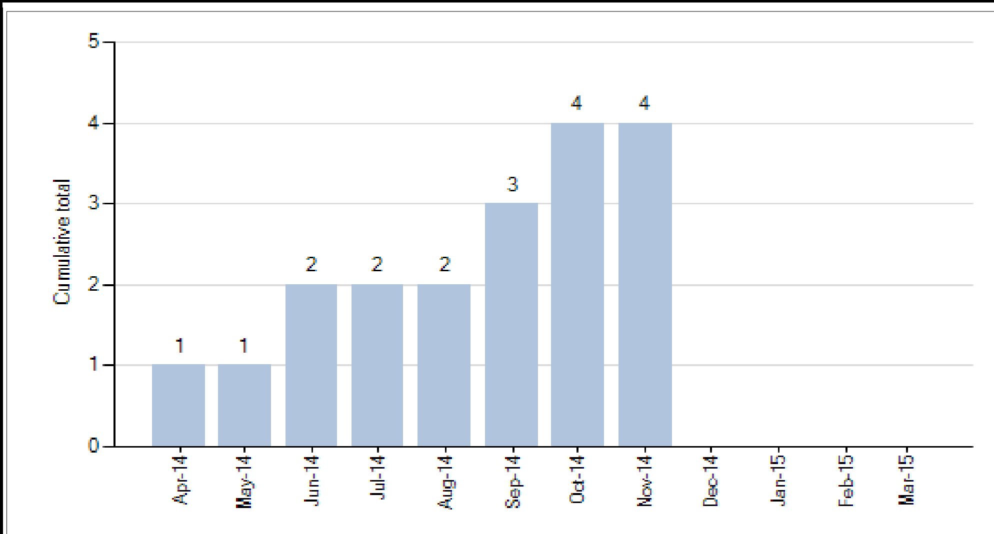

Safety Thermometer
Upper control limit (3SD)
Upper warning limit (2SD)
Mean
Lower warning limit (2SD)
Actual
Lower control limit (3SD)
% Harm Free Care (new)
100%
95%
90%
85%
80%
75%
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Mar-13
Apr-13
May-13

Patient Safety

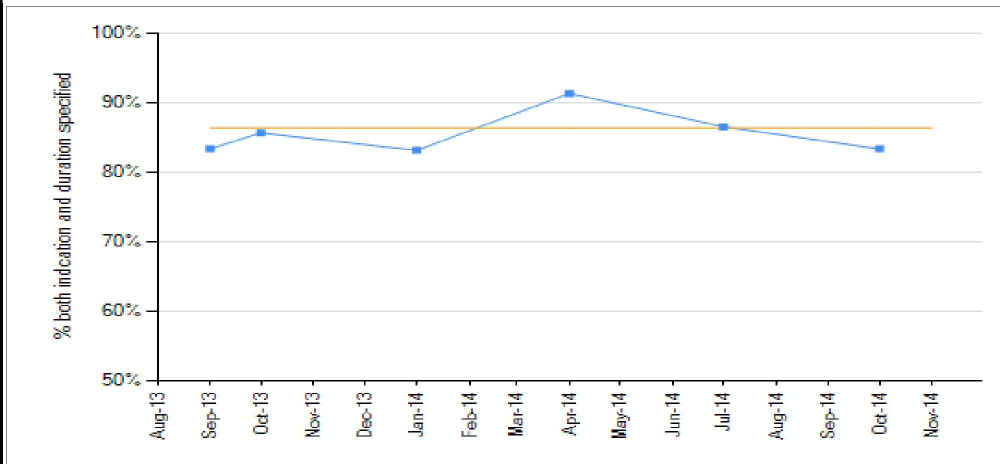
PS03 VTE Risk Assessment (% admitted patients receiving risk assessment)	Narrative
	The deterioration in VTE risk assessments coincides with switching off of assessment functionality within Casenotes system on 09 April. EPR is now the only route for assessment (apart from NOC site where paper is still used). Divisional level performance against this indicator is provided in Appendix 1. Divisional performance is monitored through Divisional performance reporting processes

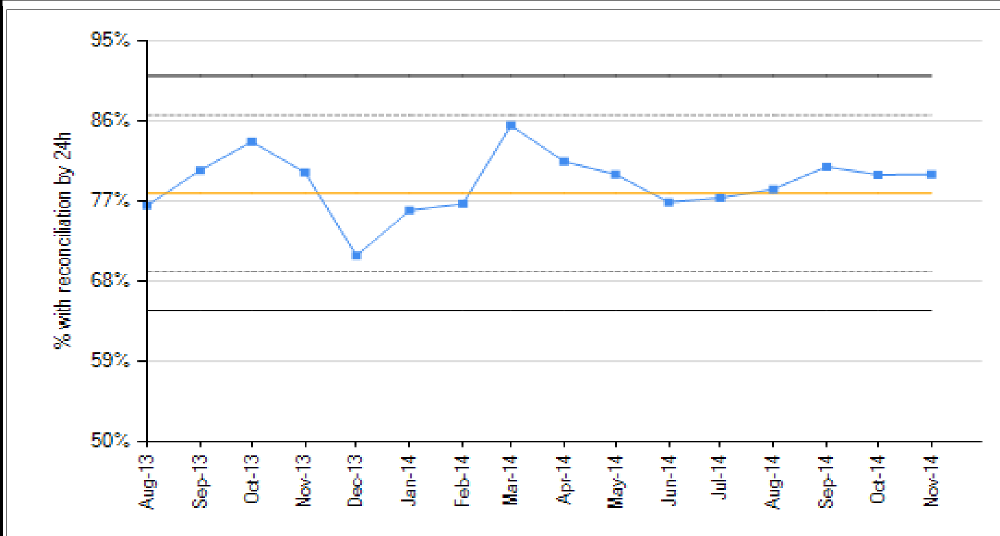
The chart shows the proportion of inpatients within the Trust risk assessed for VTE (either individually or as part of a cohort). The data point for the most recent calendar month may improve up until submission to NHS England as further cohorted patients are identified following clinical coding. Earlier figures are those submitted to NHS England.

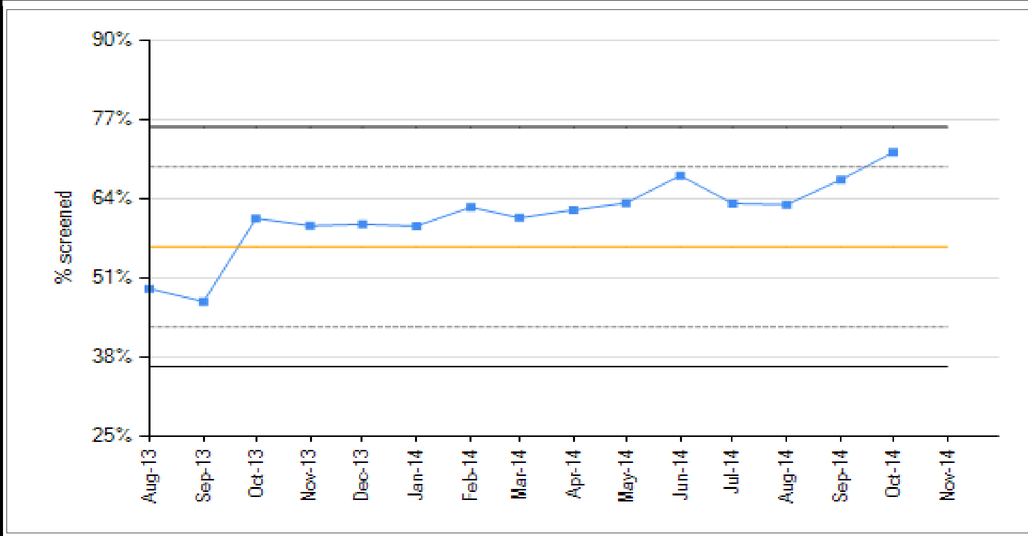
Patient Safety

PS06 Number of cases of MRSA bacteraemia > 48 hours (cumulative year to date)	Narrative
	There are no new cases to report in November 2014. This graph reflects culmulative figures.

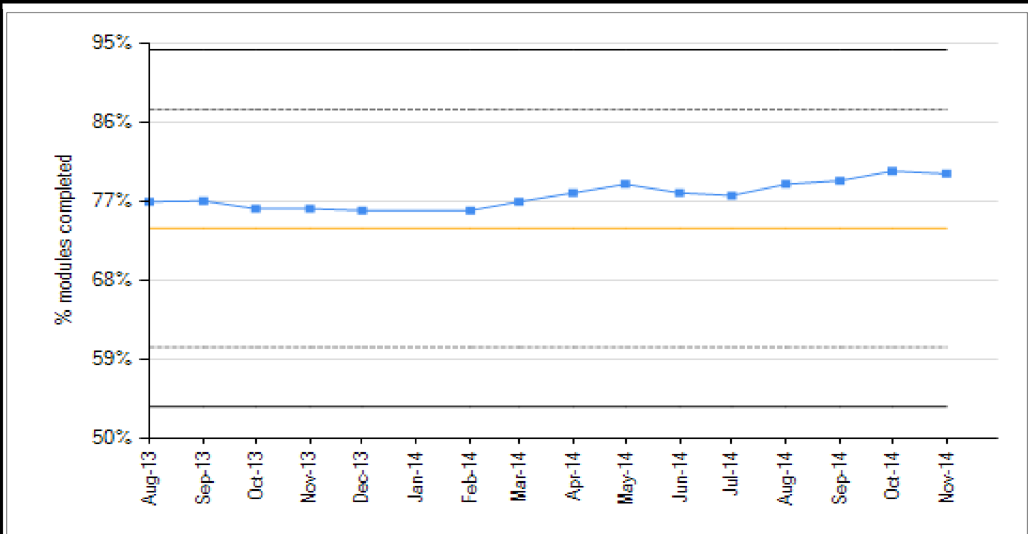
The chart shows the number of cases of MRSA bacteraemia reported via UNIFY (external IT system). If a case is subsequently removed in following consultation with CCG (for example, attributed to a referring hospital), the figure will be modified in future graphs.

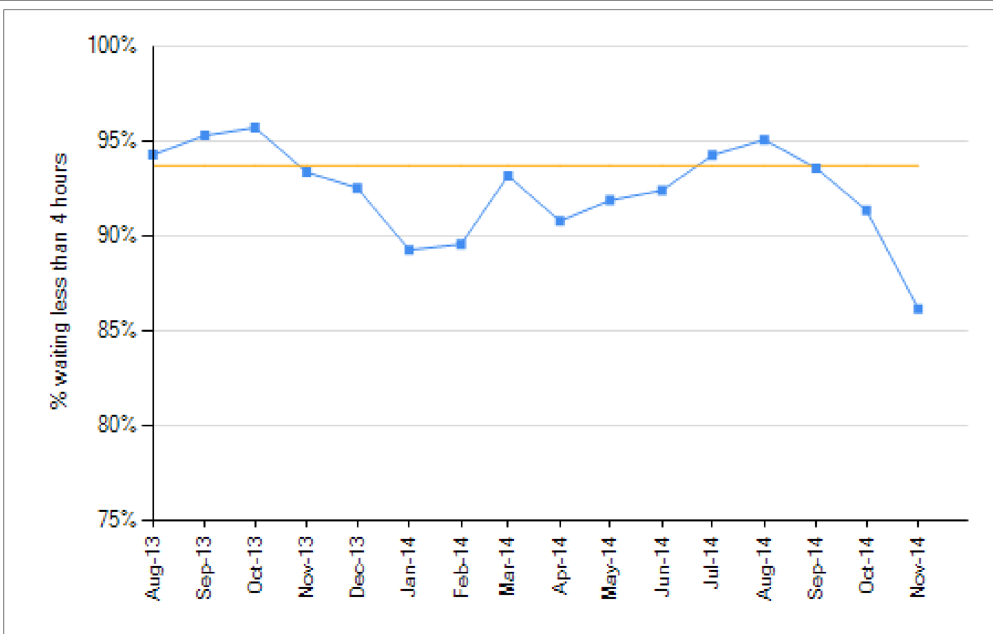
Patient Safety	
PS07 Antibiotic prescribing - % prescriptions where indication and duration specified [most recently available figure, undertaken quarterly]	**Narrative**
	This figure is reported Quarterly. Performance is monitored via the Divisional Performance reporting processes.
Each antimicrobial prescription has to have a clinical reason as to why it is prescribed along with the length of the course written in days/doses.	

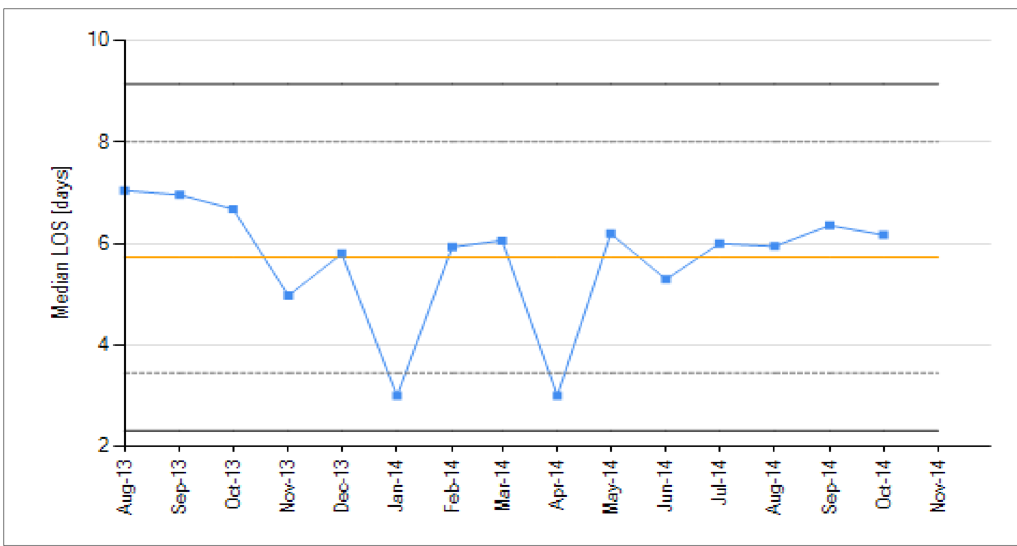
Patient Safety	
PS09 % patients receiving stage 2 medicines reconciliation within 24h of admission	**Narrative**
	This indicator is monitored through Divisional performance reporting processes.
The chart shows the proportion of inpatients for whom second stage pharmacy-led medicines reconciliation is completed within 24 hours of admission. Spot check audit by pharmacy staff once per month. Approximately 600 patients are included in the audit Trust-wide. Please note that this audit was not performed in May 2013 due to capacity issues in pharmacy.	

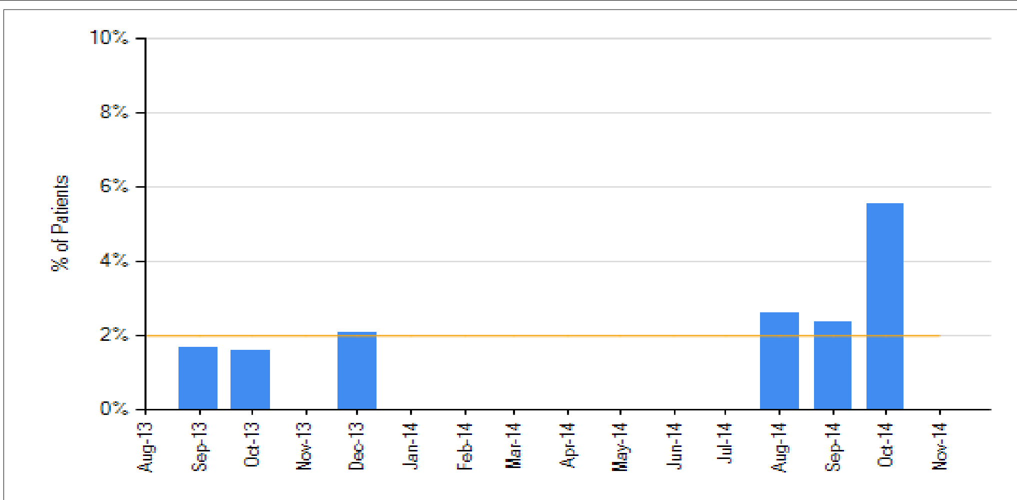
Clinical Effectiveness CE03 Dementia - % patients aged > 75 admitted as an emergency who are screened [one month in arrears]	Narrative
 	Further action underway to achieve the 95% threshold . A number of initiatives have been started to improve the identification and assessment of the relevant patient group.

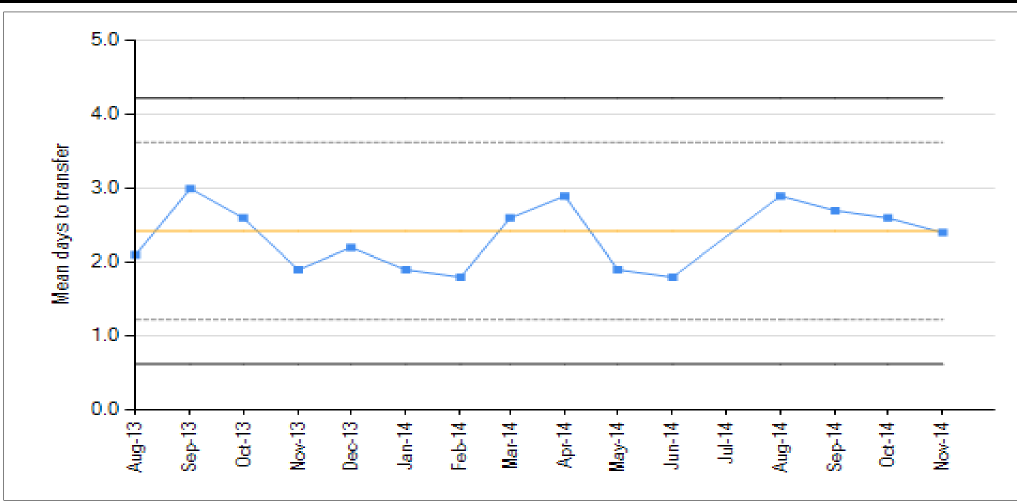
Elderly patients admitted on a non-elective basis should be screened for dementia using a screening question and / or a simple cognitive test. Performance shown in this graph reflects figures submitted monthly to NHS England. These figures are derived from both EPR and local paper-based systems.

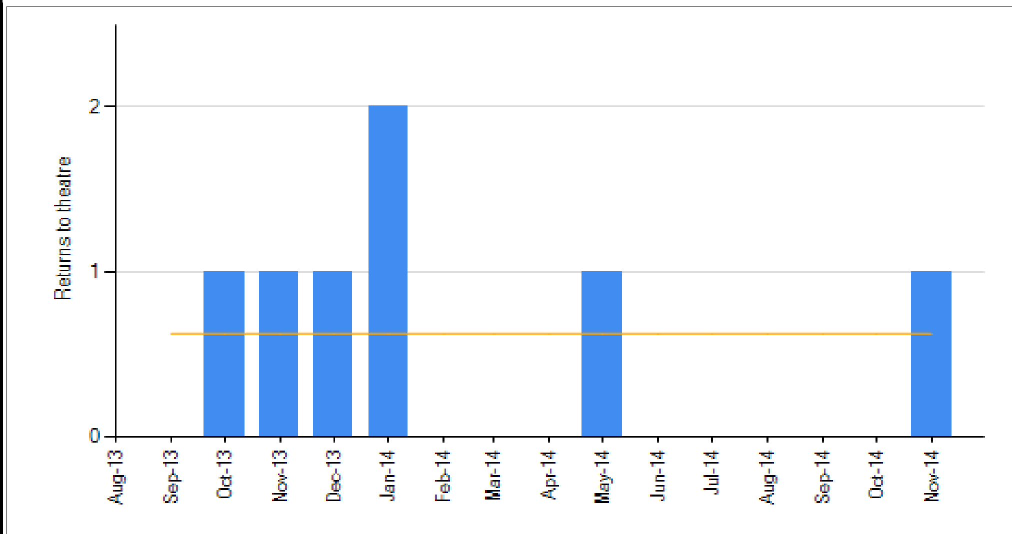
Clinical Effectiveness CE04a Statutory and Mandatory Training - % required modules completed	Narrative
 	A number of initiatives have been put in place to improve compliance with this indicator. Divisional level information is monitored through Divisional performance reporting processes.

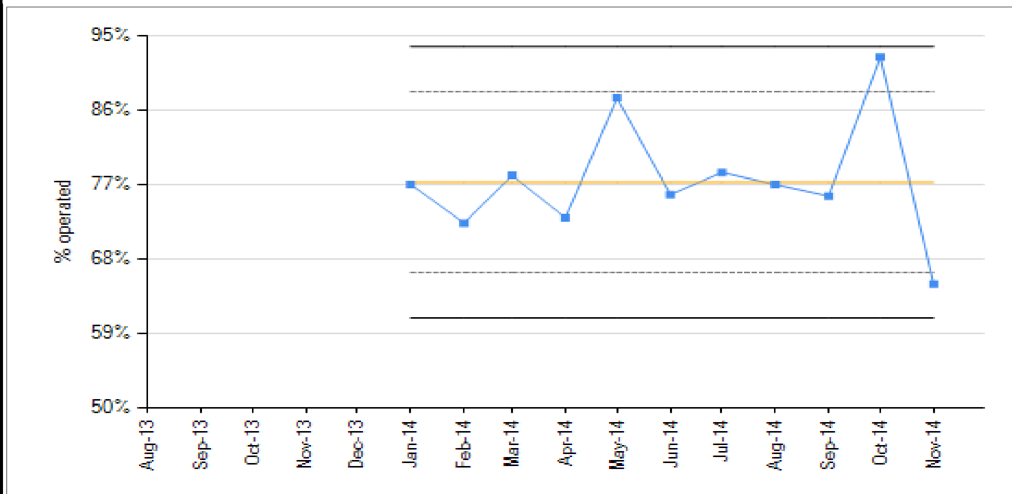
Clinical Effectiveness CE05 ED - % patients seen, assessed and discharged / admitted within 4h of arrival	Narrative
	Compliance has decreased over the last three reporting periods. The results associated with this indicator are multifactorial, including lack of capacity on the JRH site, which has had a follow on affect on patient flow across the whole site. The diverting of patients to the HGH has also had a negative impact on patient flows
% Patients attending ED who are discharged or admitted within 4 hours of arrival.	

Clinical Effectiveness CE10 Vascular - Mean length of stay for patients undergoing elective AAA repair (3 month rolling period) [NOTSS Division]	Narrative
	The mean length of stay following elective AAA surgery remains below 8 days.
Information collected from ORBIT and based on the primary procedure coded and elective admission method.	

Clinical Effectiveness **CE11 Vascular - % mortality following elective AAA repair [NOTSS Division]**	**Narrative**
 	The percentage of patients dying following AAA surgery remains below 6%.
Information collected from ORBIT and based on the primary procedure coded and elective admission method.	

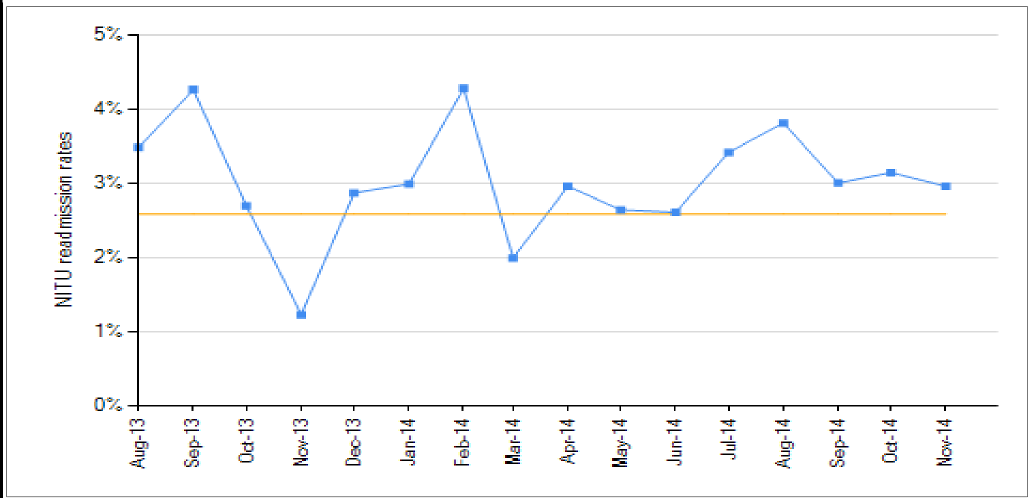
Clinical Effectiveness **CE13 Cardiology - Mean number of days from referral to admission to cardiology at tertiary centre [MRC Division]**	**Narrative**
 	Performance against this indicator is related to capacity issues in the Rapid Assessment nit coming of patients coming from District General Hospitals as a tertiary referral.
Directorate goal is that patients are transferred within 2 days of referral.	

Clinical Effectiveness CE18 Number of unscheduled returns to theatre in gynaecology [C&W Division]	Narrative
	Patient level information indicates that this return was clinically justifiable. This indicator is monitored through Divisional performance reporting processes.
Currently recorded manually.	

Clinical Effectiveness CE20 % patients having their operation within the time specified according to their clinical categorisation [CSS Division]	Narrative
	Performance against this indicator is monitored through Divisional performance reporting processes. Further detail as to the results reported for November to be obtained from the Division.

Clinical Effectiveness

CE21 Neuroscience Intensive Therapy Unit (NITU) readmission rate within 48 hours of discharge [NOTSS Division]



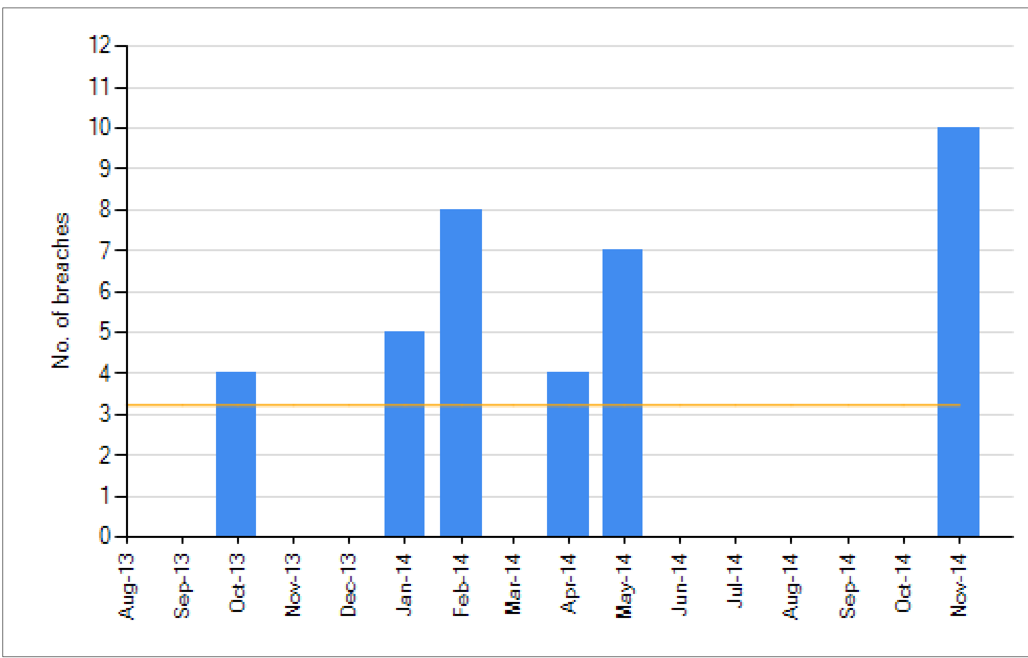
Narrative

Patient level information suggests that the returns to Theatre were justifiable based on the clinical condition of the patients.

One would not expect patients to be readmitted to NITU following discharge. The measure aims to highlight whether patients are discharged too early. Data collected at local level and presented as number of readmissions against number of discharges.

Patient Experience

PE06 Single sex breaches



Narrative

There were 10 Single Sex breaches in November 2014. Each of these breaches will undergo a full RCA to understand how the breach occurred and opportunities to prevent a further reoccurrence. All of the breaches occurred in one unit.

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

3. Patient Safety and Clinical Risk

3.1. Information relating to patient safety and clinical risk is provided within the key quality metrics.

3.2. One Serious Incident Requiring Investigation (SIRI) report was recommended to Oxfordshire Clinical Commissioning Group (OCCG) for closure during December 2014.

3.3. Following internal closure of a SIRI report, the report is presented to the OCCG for endorsement of both the level and quality of the investigation and the appropriateness of the recommendations to prevent a re-occurrence.

3.4. Based on the NHS England Serious Incident Framework, SIRI investigaitons are categorised into two levels. A category 2 investigation cannot be closed until such time as all the recommended actions have been completed.

3.5. Table 1 below outlines the SIRI that has been provided to the OCCG for closure of the investigation and report in December 2014.

Table 1.

SIRI Ref	Division	Description	Internal closure Date
2014/043	MRC	Category 3 Hospital Acquired Pressure Ulcer	19 December 2014

3.7 Table 2 below provides a list of the 5 SIRI's that have been declared during December 2014. Investigations have commenced and will be reported in due course.

Table 2.

SIRI ref	Division	Description
2014/056	CSSD	Missed Diagnosis of Lung Cancer
2014/057	NOTSS	Category 3 Hospital acquired pressure ulcer
2014/058	C & W	Hypoxic Brain injury following intubation
2014/059	C & W	Complications following the insertion of an arterial line
2014/060	S & O	Avoidable hospital acquired thrombosis

4. Quality Walk Rounds

4.1. There were 4 Executive Quality Walk Rounds in December 2014. These are detailed in figure 3 below. One walk round was cancelled at the request of the area manager who was due to be on leave at the scheduled time. This has been rescheduled for January 2015.

Figure 3.

Hospital Site	Areas Visited
John Radcliffe Hospital	Neurosciences Outpatient Department Maternity Ward, Level 5, JR1
Churchill Hospital	Pain Relief unit
Nuffield Orthopaedic Centre	Ward C

4.2 Key issues with the potential to affect quality or patient experience identified during the Quality Walk Rounds included concerns regarding ePMA training of junior doctors, comfort in the patient environment, adherence to infection control policy and a lack of agency nurses to fill vacant shifts requiring staff to move from ward to ward.

4.3 All issues have actions associated with them and these will be monitored through Divisional governance processes.

5. Clinical Effectiveness

5.1 *Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI).*

The Dr Foster tools were updated on 28th November 2014 to reflect the latest data for the period September 2013 to August 2014. This update included the remodelled risks for expected mortality for diagnosis and procedures for the financial year 2013/2014.

5.2 For the data period September 2013 to August 2014, the OUH HSMR value is 98.8. This value is banded 'as expected' using 95% confidence intervals. This is a reduction from the previous HSMR which was 101.74.

5.3 There were 6 new Dr Foster mortality alerts for the data period September 2013 to August 2014; cancer of ovary, cancer of pancreas, conditions associated with dizziness or vertigo, Respiratory failure, insufficiency, arrest (adult), Rest of Nervous system (diagnostic/minor), Rest of Bones and joints of spine. The new mortality alerts are currently under investigation by the responsible specialties.

5.4 Dr Foster informed OUH that due to delays in obtaining and processing the data files, the next update to the Dr Foster tools based on the Hospital Episode Statistics (HES) data will not be available before mid-January 2015.

5.5 There was no SHMI publication during December 2014.

Dr Foster Hospital Guide

5.6 Dr Foster informed OUH that the Hospital Guide will not be published in Spring 2015 as previously communicated. Dr Foster are currently looking at other options in 2015 and will inform OUH once the timing and content is confirmed.

5.7 The Clinical Outcomes Review Committee (CORC) met on the 12th December 2014. In accordance with the recommendations following the review of Effectiveness of the Clinical Governance Committee, this was the last meeting. The new Clinical Effectiveness Committee will assume the remit of CORC from January 2015. The key points of discussion and presentations at the CORC meeting are summarised below.

- *Orthopaedic Surgery National Joint Registry Clinical Audit and Consultant Outcomes, published 28th October 2014.*

  The data in these reports pertained only to the Nuffield Orthopaedic Centre (NOC). The rate of patient consent for inclusion of their data on the National

Joint Registry (NJR) was below the standard. This was stated to be due to the arrangements of the pre-operative departments. The local audit, undertaken since the data submission found the rate of patient consent for inclusion of their data on the NJR to be more than 90%. The data for individual surgeons is not currently available in the public domain due to an acknowledged flaw in the data.

- *Colorectal Surgery Consultant Outcomes (National Bowel Cancer Audit NBOCAP), published 28th October 2014.*

  This report focused on the 90 day adjusted mortality following elective surgery for colorectal cancer. The report stated that there were flaws in the data reported in the audit. It was highlighted that the denominators were not considered large enough to be significant. The report found that the 90 day outcomes are within acceptable range; the OUH mortality is 2.4% and average mortality rate across all Trusts is 4.5% to 5%. The results for individual surgeons were found to be good.

- *Head and Neck Surgery Consultant Outcomes (National Head and Neck Cancer), published November 2014.*

  This is the second year of publication of the Head and Neck consultant outcomes. This is a work in progress and the information published is limited in usefulness. There were flaws noted in the data, for example, two OUH consultants were incorrectly listed on the results table as working at the Royal Berkshire hospital. It was highlighted that there could be 'double counting' in the data as Head and Neck cancer surgery requires two surgeons. There have been two deaths during the data period but the report displays three deaths which were stated to be due to 'double counting'. The report found that nationally there are no surgeons who were outliers.

Consultant Outcomes Publications Update

5.8 An updated scheduled of the consultant outcomes publications and a list of publications which had not been provided to the Committee in time for the meeting was distributed to the Divisional Directors.

Patient Reported Outcome Measures (PROMs)

5.9 This report was on the finalised hip and knee replacement surgery PROMs data for the data period April 2012 – March 2013. The publication displayed that the NOC were marginally below the national average for health improvement for these procedures. The Orthopaedics Directorate will be reviewing the raw HES data to feed back to surgeons and to support service improvements.

5.10 The Best Practice Tariff is dependent on the compliance rates of the national joint registry and the outcomes of primary hip and knee replacement PROMs. From April 2014 to October 2014; a total of 644 episodes were coded to the listed Health Resource Groups, of which a total of £392,890 of income relates to the Best Practice Tariff. The full year income could equate to over £670,000. The Orthopaedic Directorate is currently achieving above 50% compliance. The Committee were informed that in 2015-2016 the percentage of expected compliance is expected to increase.

5.11 *NCEPOD Tracheostomy complications 'On the Right Trach?', data period 25th February 2013 to 12th May 2013, published 13th June 2014*

Following this report the Tracheostomy Steering Group has been created. This is a cross divisional group chaired by the Deputy Chief Nurse. The Group has completed a gap analysis of the recommendations from the report and there are work streams underway to align OUH to the recommendations. There will be a report from the Tracheostomy Steering Group to the Clinical Effectiveness

Committee in March 2015 which will include progress with the Key Performance Indicators.

5.12 *Mortality Review Group Action: Investigation of Cancer of Ovary*

The findings were that OUH are equivalent to UK survival figures for 30 day deaths. It found that the inpatient deaths at Sobell House hospice are included in the figures. There were issues highlighted with community palliative support. The Committee advised that the service discuss community palliative support and the management of naso-gastric tubes with Sobell House. Dr Foster have been requested to provide a list of NHS Trusts with on-site hospices which may be used by OUH for peer group benchmarking.

5.13 The Mortality Review Group (MRG) met on the 18th December 2014. This was the last meeting as per the recommendations in the review of Effectiveness of the Clinical Governance Committee. The new Clinical Effectiveness Committee will assume the remit of MRG from January 2015. The key points of discussion at the MRG meeting are summarised below.

- **Gastrointestinal Haemorrhage**

  An investigation was completed for the SHMI alert for gastrointestinal (GI) bleeding for the periods April 2012 to March 2013 (n=22) and July 2013 to June 2014 (n=42). The review of the health records identified issues with clinical coding. There were cases identified where: the recorded information has influenced the coding of primary diagnosis, co-morbidities were not recorded, death certificate inaccurately recording a GI bleed and a vascular surgery case of an abdominal aortic aneurysm (AAA) repair with an aortic rupture coded as a GI bleed. There have been discussions with the Clinical Coding Manager about the clinical coding issues identified.

- The more recent alert, for overall deaths from GI bleeding for the period June 2013 - July 2014, depicted fewer observed than expected deaths. An independent audit of the overall time to inpatient upper endoscopy for all indications was completed during the same time period as the SHMI alert. This demonstrated that the median number of days to endoscopy was 1. There were 55.3% of endoscopies performed either on the same or the next day (within 24 hours) and 81.2% were performed within 72 hours.

- **Analysis of Quarter 1 2014/2015 Divisional Mortality Reports**

  This analysis was delayed pending the submission of reports from two divisions. There were no details provided on the percentage of reviews completed by the Clinical Support Services Division. Medicine, Rehabilitation and Cardiac (MRC) Division provided a combined mortality report for Quarter 1 and Quarter 2. There were no mortality reviews reported by the Cardiology Clinical Service Unit. MRC advised that the mortality review process has now resumed in the Unit.

- There were seven avoidable deaths reported in total for quarter 1. There were two avoidable cases reported by Surgery and Oncology Division. One of these deaths was a case from Manor Hospital, who are undertaking an independent investigation. The second case related to a delay in the transfer of the patient to the hospital. The Palliative Care team have held discussions with the Ambulance service regarding this case. There were five cases reported as avoidable by MRC. The MRC Divisional Nurse advised the Clinical Governance Committee at the December 2014 meeting that the classification of these deaths as avoidable may not be correct.

- There were three deaths reported to have been investigated as part of a Serious Incident Requiring Investigation (SIRI); a case of a misplaced naso-gastric tube, a patient who developed colonic pseudo-obstruction and a patient who died from liver failure shortly after receiving cyclophosphamide.
- The issues presented in the quarterly Divisional Mortality Reports were diverse and there was varying levels of supporting detail included. This presented difficulties in the identification of common themes. The recurrent issues concerned communication and documentation. The Group agreed that for future quarterly mortality reports the Divisions should identify lessons to be shared across the Trust.
- **Death certification in the Intensive Care Unit (ICU)**

  The Group agreed that the death certificates for patients who die in ICU should continue to be completed by the ICU doctors and not be referred back to the primary team.

6 Infection Control

6.1 ***Clostridium Difficile -*** The objective for 2014/2015 is 67 cases.

6.2 Eight cases of C.*diff* were reported in November 2014, against a monthly limit set at 6 for the month. All cases, including the 6 cases identified in October were discussed at the monthly Health Economy meeting held in December 2014. Representation from the Oxford Clinical Commissioning Group (OCCG) Public Health England (PHE), Oxford Health and OUH Infection Control were present. It was agreed that all cases were unavoidable, though actions were identified in terms of documentation and patient review, particularly within the MRC Division.

6.3 The OUH remained below the cumulative limit for November 2014 (45 cases) and remains on track to meet the C.*diff* objective for 2014/2015.

6.4 The table below outlines the number of cases per month that are apportioned to the OUH Trust.

Table 4. Cases of C. diff per month

	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sept 2014	Oct 2014	Nov 2014
JR, Churchill, NOC	1	6	7	6	3	6	6	8
Monthly Limit	5	5	5	6	6	6	6	6
Cumulative total	1	7	14	20	23	29	35	**43**
Cumulative limit	5	10	15	21	27	33	39	**45**

MRSA bacteraemia

6.5 The OUH has a limit of 0 avoidable MRSA Bacteraemia for 2014 – 2015.

6.6 There were no MRSA Bacteraemia apportioned to the OUH in November 2014**.** Therefore to date 2014 – 2015, there has been 1 avoidable MRSA Bacteraemia apportioned to the OUH.

6.7 Table 5. below MRSA bacteraemia to date by speciality for 2014 / 2015 year to date

Table 5.

Month	Speciality	Avoidable/Unavoidable
April 2014	Medicine Horton	Unavoidable

June 2014	Medicine JR2	Unavoidable
September 2014	Cardiothoracic Surgery, JR2	Unavoidable
October 2014	Haematology,Churchill	Avoidable

Cleaning Audits

6.8 Clinical areas are required to achieve a minimum 92% Compliance with the monthly cleaning audit.

6.9 Table 6. below details the average reported cleaning scores by division and by auditing team

Table 6.

	November 2014		
Division	Quality Assurance Team audits	Domestic audit scores	Nursing audit scores
Neurosciences, Orthopaedics, Trauma & Specialist Surgery	88%	97%	92%
Medicine, Rehabilitation & Cardiac	89%	93%	96%
Children's and Women's	93%	94%	95%
Surgery & Oncology	90%	95%	94%
Clinical Support Services	91%	93%	92%
OUH total	**90%**	**94%**	**94%**

MRSA Screening Compliance

6.10 The trust achieved 61% overall compliance with MRSA screening, 42% for elective admissions and 51% for emergency admissions. Clinical areas with high turnover of patients have been identified as having lower compliance rates

Table 7 - Compliance with emergency and elective MRSA screening.

	November 2014		
Division	Percentage Screened Electives	Percentage screened emergencies	Percentage of Patients screened
Neurosciences, Orthopaedics, Trauma & Specialist Surgery	89%	59%	77%
Medicine, Rehabilitation & Cardiac	18%	48%	56%
Surgery & Oncology	39%	43%	52%
Clinical Support Services	47%	71%	76%
OUH total	**42%**	**51%**	**61%**

7. Patient Experience

Experience of Patients

7.1 The Patient Experience Team has produced a dashboard for Trust Board (Appendix 1). This includes the Friends and Family Test (FFT) data, complaints activity, management of complaints, PALS activity and compliments. The intention of the dashboard is to provide a Trust wide overview to support divisional analysis. In summary;

Friends and Family Test

Inpatient, ED and Maternity response rates:

7.2 NHS England no longer publishes FFT net promoter scores. Instead the percentage who would recommend their care (extremely likely/likely) and the percentage who would not recommend their care (extremely unlikely and unlikely) are reported.

National comparison:

7.3 The national comparator FFT results for November 2014 were not available at the time of writing this report. The dashboard includes national benchmarking and the comparison with the Shelford Group for October 2014. OUH is also developing mechanisms to benchmark with other comparable Trusts.

7.4 The Trust's inpatient 'recommended' score has been consistently slightly higher than the Shelford Group since June 2014. The national range for inpatient scores in October was between 100% and 77%. The Trust's score was 95%.

7.5 The Trust's maternity 'recommended' score has risen since from 90% to 98% between June and October 2014; although has reduced to 92% in November. The Shelford Groups' score has remained the same at 94%. The national range for maternity scores in October was between 100% and 62%. The Trust's score was 98%.

7.6 The Trust's Emergency Department 'recommended' score has fluctuated between June and October and was consistently higher than the Shelford Group. The 'recommended' score dropped considerably in November to 76%.

Inpatients:

7.7 The 'recommended' score for Medicine, Rehabilitation and Cardiac (MRC) is 95% with a 'not recommended' score of 3% and a response rate of 28%. This is significant, as many MRC patients are frail, elderly with dementia or cognitive impairment. The response rate for the division was very high, at 40%, in June and has dropped since then. However it has been rising since August 2014.

7.8 The 'recommended' score for the Surgery and Oncology (S&O) division was 95%, with a 'not recommended' score of 3% and a response rate of 23%.

7.9 The Neurosciences, Orthopaedics, Trauma and Specialist Surgery's (NOTSS) 'recommended' score is 96%, with a 'not recommended' score of 2% and a response rate of 25%. The complaints have been high for this division and has reduced by 32 from October (n= 43) to November (n=11).

7.10 The Children's and Womens (C&W) division 'recommended' score is 98% with a 'not recommended' score of 2% and a response rate of 27%. Please note this does not include maternity and children's services which will be included in February 2015 BQR.

Emergency Department (ED):

7.11 The 'recommended' score for ED has dropped to 76% in November; this is coupled with the 'not recommended' score' of 2.2% for the same month. This means 21.8% of patients who responded were neither likely nor unlikely to recommend the Trust's EDs. In contrast, the 'recommended' score for September was 87% and the 'not

recommended' score was 7.1%, meaning that respondents neither likely nor unlikely to recommend was 5.9%. Therefore although the 'recommended' score has decreased by 12%, the 'not recommended' score has also reduced; it could be inferred that the patient experience has not significantly worsened within the departments.

7.12 The response rate reduced from 16% in August to 7% in October; and has increased to 10% in November. ED attributes this to the current reliance on face-to-face reminders from management to ensure all staff enable patients to provide feedback when they leave the department.

7.13 The department is becoming increasing busy due to winter pressures and outflow issues, this means patients are waiting longer and they are less likely to want to give any feedback when they are able to leave. Despite this, the department has not noticed an increase in complaints or PALS issues during this period.

Maternity:

7.14 The FFT 'recommended' score for the service increased steadily between June and October, the highest score being 98% in October. The 'recommended' score dropped to 92% in November. The response rate has fluctuated over the previous three months after maintaining between 28% and 29% for two months. The comparison between the nationally best and worst performing maternity services has been described in 9.2.3, above.

7.15 The maternity services are not planning to implement an electronic approach in the pilot phase. This is because of the issues surrounding women opting out of receiving text messages, and not including women in traumatic circumstances. It would not be appropriate for them to receive the FFT survey via a text, for example if a baby is planning to still born, dies shortly after birth or is very unwell.

Outpatients and Day Case:

7.16 The extremely likely and likely scores for the Trust's Outpatients and Day Case were 97% and 98% respectively for October.

FFT CQUIN status:

7.17 All FFT CQUIN targets have been met to date. The target response rate for emergency departments is 20% over quarter 4; and the target response rate for inpatients is 30% for the quarter overall, and 40% for March 2015. The patient experience team is implementing the project plan to support the clinical areas to increase response rates in the emergency departments and for inpatients by the end of quarter 4. The team are also collaborating with the Media and Communications Team to increase the Trust's publicity related to patient feedback received and changes made.

7.18 The Trust is continuing to record feedback on paper questionnaires and using the national 'Monkey Wellbeing' FFT survey for children's services.

7.19 The electronic methodology including text messaging and automated voice messaging will be implemented for patients aged 16 and over for day case, outpatients and the emergency departments by 31 January 2015.

8. Complaints

8.1 The number of new complaints has reduced from 106 in October to 81 in November. It has been noted that the national trend is increasing. This has been identified in the Annual Complaints Report published by Health and social Care Information Centre (HSCIC) earlier this year.

8.2 The number of new complaints has increased within CSS (n= 37), C&W (n= 16) and corporate divisions (n=9) and decreased within NOTSS (n=11), MRC (n=2) and S&O (n=6).

8.3 Access to Outpatient appointments by telephone continues to be a recurrent theme for complaints received by all Divisions and particularly for NOTSS. It is important to compare this with the positive feedback from the outpatients FFT.

8.4 Notably the number of complaints received by the NOTSS division decreased from 43 in October to 11 in November.

8.5 Care/nursing care also features as a theme for all clinical divisions. The complaints received by corporate services included car parking and hotel services.

8.6 There were 2 red graded complaints in November. These were within NOTSS.

Managing complaints

8.7 The Trust continues to meet the target of 95% for acknowledgement of complaints and has surpasses this by achieving 98%.

8.8 The Trust achieved 97% for responding to complainants within 25 working days or agreed timescale against a target of 95%. This is a steady and sustained increase from Quarter 4 2013/14.

8.9 Three complainants within C&W division requested their complaints to be reopened. This compared to two each within S&O, NOTSS and MRC. There were no requests from complainants within CSS or the corporate division to reopen their complaints.

9. Nursing and Midwifery Safe Staffing

9.1 The Trust is required to comply with The National Quality Board (November 2013) and the NICE guidance (July 2014) for Safe Staffing for Adult Inpatient Wards in Acute Hospitals. These include, providing reports to the Trust Board on the levels of nursing and midwifery staffing on a ward by ward/shift by shift basis. They also include ensuring that there are procedures for systematic on-going monitoring of Nurse Sensitive Indicators and formal review of nursing staff establishments for individual wards at least twice a year.

9.2 This report includes 6 dashboards, one for each division and Trust wide. These incorporate Nurse Sensitive Indicators (NSI), incidents and human resource metrics, which illustrate the relationship with Safe Staffing.

9.3 National reporting

9.3.1 The summary of the figures submitted to NHS Choices via the Unify platform for November 2014 are included below (http://www.ouh.nhs.uk/about/saferstaffinglevels.aspx).

9.3.2 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 Care Support Workers.

9.3.3 **November 2014**
The fill rates are:

- 94.42% for Registered Nurses/Midwives
- 94.79% for Care Support Workers (unregistered)

9.3.4 The levels are similar to that in October 2014. This is in line with the October/November similarities in workforce HR metrics, i.e. vacancy, sickness and maternity/adoption leave levels.

9.3.5 The NICE guidance requires aspects of the wards to be considered as they contribute to the individual ward profiles; these include patient factors i.e. patient acuity, ward factors, i.e. layout, side rooms and numbers of beds and nursing staff factors, i.e. skill mixes, ‘red flags’ which include missed breaks, untimely pain management and inadequate preventative measures for pressure relief. The new safe staffing and acuity measurement tool will have an alert system for red flags incorporated. The red flags for this Trust are currently being developed and bench marked against other Trusts, and will be included in the roll out of the new tool at the end of January 2015.

9.4 Trust safe staffing reporting for November 2014

9.4.1 The Trust reviews staffing levels via the ward monitoring system which is reported and scrutinised at least twice daily at the staff and bed capacity meetings. The Trust wide dashboard highlights the number of minimal shifts that remain high, particularly on day shifts, although temporary staffing fill rates are higher at night due to availability and enhanced pay rates.

9.4.2 There are a high number of vacant posts within in-patient areas which has affected levels of staffing and the ability to fill the shifts to agreed levels. The high levels of temporary staffing coupled with high levels of minimum staffing levels can affect the quality of care. This is principally due to reduced continuity through the use of temporary staff, in comparison to permanent rostered staff, and reduced awareness in terms of following Trust policy and procedure. Specialist skills and procedures are limited within the temporary staff group, which means that the onus is largely on the remaining permanent staff to carry out specialist procedures.

9.4.3 The continued and consistent levels of minimal staff on wards reduces the level of resilience to fluctuations in patient acuity and flexibility to cope with changes in activity, as well as affecting staff retention over time. This may mean that beds have to be closed by the directorate, with joint decision making with the operations team, and escalation to executive level for sign off. There are shifts that remain at risk despite all efforts made to mitigate. In these circumstances, staff are moved between wards and departments, skill mix is reviewed, shifts are changed at short notice,and non clinical staff are moved to work clinically. In addition, emergency admissions,for periods of time, may be diverted to other wards and as a last resort, beds are closed upon escalation to the Executive Director. The senior nursing team are very aware of these areas at these times and increased observation and monitoring is put in place by the duty manager to minimise clinical risk and increase patient safety.

9.4.4 The Nurse Sensitive Indicators are being monitored over time and are being developed to enable thematic analysis in order to understand the quality impact of long term staffing deficits. This has been broken down by division in the individual dashboards with a deep dive narrative from each of the divisional nurses.

9.4.5 A co-ordinated recruitment program is in progress nationally and internationally. Retention of staff is proving challenging within some ward and theatre areas, with high turnover rates. Strategies are being progressed reflecting the feedback from the staff survey and other work through the Workforce Optimisation sub groups.

9.5 **Acuity and Dependency Review**

9.5.1 The Acuity and Dependency review of staffing levels has been delayed due to the implementation of Electronic Prescribing, and will take place from 19th January 2015 for two weeks. This process will contribute to the budget setting process for 2015/16.

9.5.2 A permanent electronic acuity and safe staffing measurement tool will begin roll out Trust wide at the end of January 2015. This tool meets the specifications, set by the NICE guidance and National Quality Board. This will greatly assist the triangulation of safe staffing levels, Nurse Sensitive Indicators and HR quality metrics as well as providing a daily or twice daily means of easily measuring patient acuity levels in relation to staff levels and skill mix. This produces automated escalation in the case of staffing deficits and provides reports on staffing levels and establishments against required levels, to meet patient acuity on a continuous basis, rather than as snapshots twice a year.

9.6 **Safer Staffing: A guide to Care Contact Time**

9.6.1 This report was published in November 2014 by NHS England; It is designed to give providers a suite of toolkits to support them in making decisions to secure safe staffing levels and skill mix for their patients. It is also designed to enable commissioners to assure themselves that providers have sufficient nursing and midwifery staff to provide adequate care and staffing capacity and capability to meet the outcomes and quality standards they require and to use appropriate commissioning and contractual levers to bring about improvements. There is not a standardised mandatory approach but it a requirement for all trusts, although NHS England does advocate local consistency in the use of the tools to provide meaningful outcomes over time.

9.6.2 The focus is to highlight that Trusts should not just depend on numbers of staff, but the visibility and patient contact time for nurses and midwives; who may be too encumbered by administrative tasks that detract from direct patient care. The NICE guidance emphasised the need to ensure nursing care and contact time that is sufficient to provide safe patient care, and not focus solely on the number of available staff.

9.7 **Care Contact Time** means:

- **Direct contact care** = providing essential care, i.e. patient hygiene, care of skin integrity, continence management
- **Indirect care** = attendance at MDTs, ward rounds, liaising with families to plan discharge, supporting and mentoring students or newly qualified nurses
- **Non-direct care** = activities such as appraisals, training, roster management and managing stock levels.

9.7.1 All of the above are essential in the provision of high quality care, good patient outcomes, and a good quality learning environment.

9.7.2 The toolkits have been generated through information and data derived from a ‘Care Contact’ pilot that was undertaken in 14 Trusts, information held on a UK nursing data base that generates multipliers for the Safer Nursing Care Tool (SNCT), and details from case studies, in order to measure care contact time

9.7.3 This toolkit is due to be published in the New Year and the Trust will review the requirements and next steps once the toolkit has been published.

9.8 **Conclusion:**

- The Nurse Sensitive Indicator dashboards are designed to allow triangulation in order to understand the overview and impact upon patient quality of care, as well as upon staff retention and well-being.
- There does not appear to be an undue negative quality impact upon patient care at present, however, the challenge of recruitment and retention of nursing staff has a longer term impact upon providing safe care. Staff are moved daily between wards and shifts and there is a high use of temporary staff in all areas including high cost agency, which has a financial impact, as well as an impact on staff satisfaction.
- A significant number of temporary staff are the Trust’s own substantive staff (undertaking extra to contracted hours), which over time causes fatigue, increases sickness levels and a high turnover of junior staff.

10. Recommendation

10.1 The Committee is asked to receive this report.

Tony Berendt
Medical Director

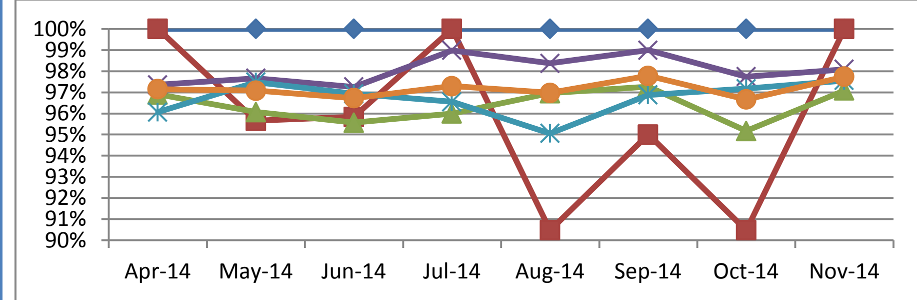
Catherine Stoddart
Chief Nurse

5 January 2015

Appendix 1 Board Quality Report Dashboard

Children's & Women's — Clinical Support Services — Medicine, Rehabilitation & Cardiac — Neuroscience, Orthopaedics, Trauma & Specialist Surgery — Surgery & Oncology — OUH — Unknown

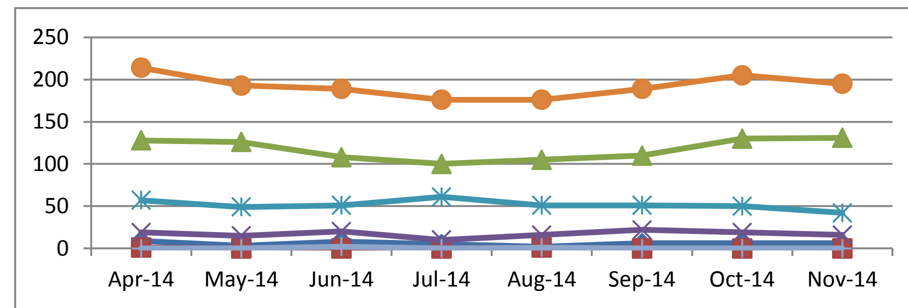
PS01 - Safety Thermometer (% patients receiving care free of any newly acquired harm) [one month in arrears]



RAG threshold	Red	95%	Amber	97%

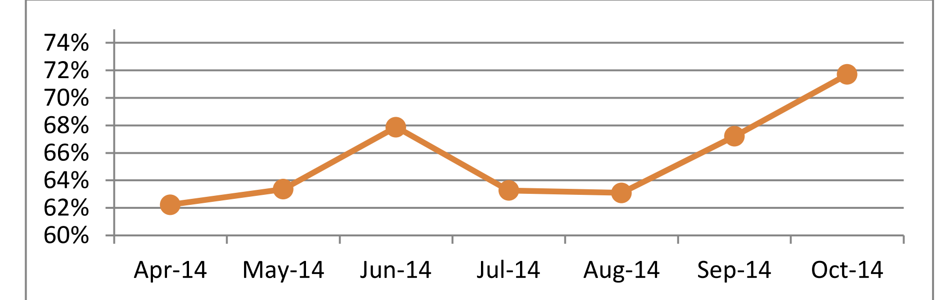
Division	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Trend to date
Children's & Women's	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	
Clinical Support Services	100.00%	95.65%	95.83%	100.00%	90.48%	95.00%	90.48%	100.00%	
Medicine, Rehabilitation & Cardiac	96.90%	96.06%	95.57%	96.00%	96.96%	97.26%	95.17%	97.09%	
Neuroscience, Orthopaedics, Trauma & Specialist Surgery	97.35%	97.67%	97.25%	98.99%	98.37%	98.99%	97.74%	98.09%	
Surgery & Oncology	96.06%	97.48%	96.93%	96.55%	95.05%	96.88%	97.17%	97.56%	
OUH	**97.15%**	**97.08%**	**96.73%**	**97.29%**	**96.98%**	**97.78%**	**96.66%**	**97.74%**	

CE02 - Crude Mortality



Division	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Trend to date
Children's & Women's	9	3	8	5	2	6	6	6	
Clinical Support Services	1	0	0	0	1	0	0	0	
Medicine, Rehabilitation & Cardiac	128	126	108	100	105	110	130	131	
Neuroscience, Orthopaedics, Trauma & Specialist Surgery	19	15	20	10	16	22	19	16	
Surgery & Oncology	57	49	51	61	51	51	50	42	
Unknown	0	0	2	0	1	0	0	0	
OUH	**214**	**193**	**189**	**176**	**176**	**189**	**205**	**195**	

CE03 - Dementia - % patients aged > 75 admitted as an emergency who are screened [one month in arrears] (CQUIN, Trust-wide only)

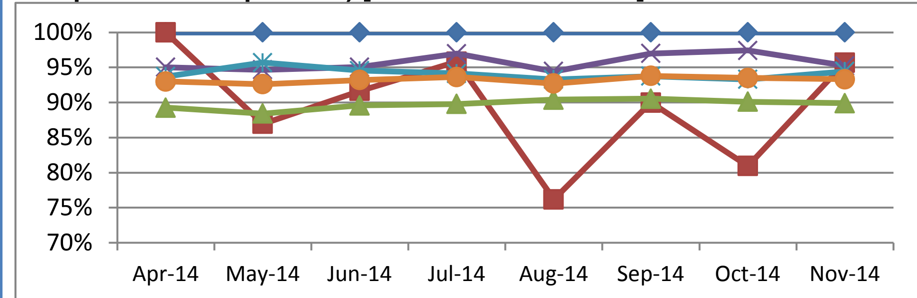


RAG threshold (Trust)	Red	80%	Amber	90%

Division	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Trend to date
OUH	62.23%	63.36%	67.88%	63.27%	63.09%	67.20%	71.71%	

This indicator reports electronic and paper reporting combined. It is proposed to provide Divisional analysis of performance in coming months.

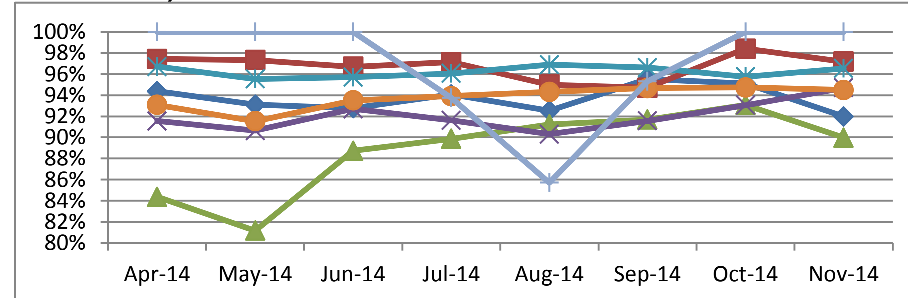
PS02 - Safety Thermometer (% patients receiving care free of any harm - irrespective of acquisition) [one month in arrears]



RAG threshold	Red	91%	Amber	93%

Division	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Trend to date
Children's & Women's	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	
Clinical Support Services	100.00%	86.96%	91.67%	95.83%	76.19%	90.00%	80.95%	95.65%	
Medicine, Rehabilitation & Cardiac	89.26%	88.43%	89.58%	89.78%	90.40%	90.55%	90.11%	89.91%	
Neuroscience, Orthopaedics, Trauma & Specialist Surgery	95.03%	94.67%	95.05%	96.96%	94.44%	96.98%	97.42%	95.22%	
Surgery & Oncology	93.70%	95.68%	94.54%	94.14%	93.29%	93.75%	93.29%	94.43%	
OUH	**93.01%**	**92.60%**	**93.21%**	**93.63%**	**92.70%**	**93.80%**	**93.50%**	**93.32%**	

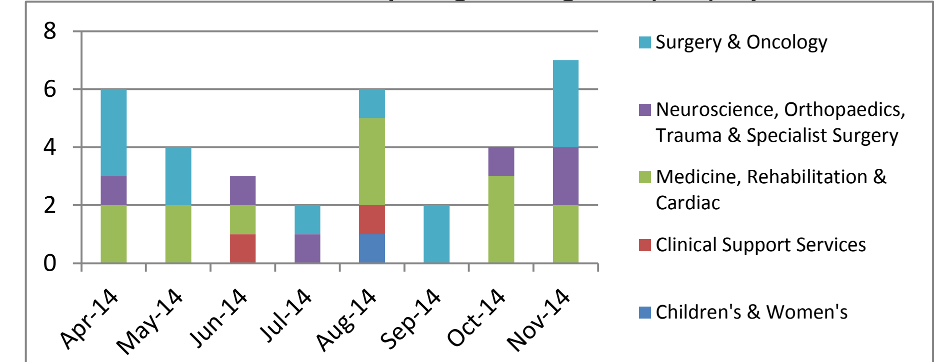
PS03 - VTE Risk Assessment (% admitted patients receiving risk assessment)



RAG threshold	Red	95%	Amber	95.25%

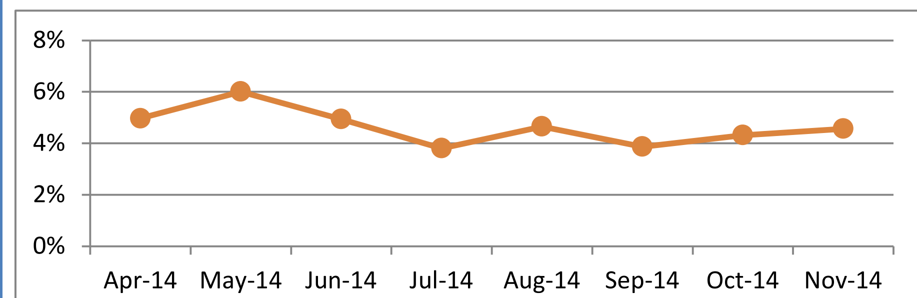
Division	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Trend to date
Children's & Women's	94.37%	93.11%	92.77%	94.06%	92.52%	95.52%	95.12%	91.98%	
Clinical Support Services	97.44%	97.33%	96.69%	97.13%	95.00%	94.71%	98.40%	97.18%	
Medicine, Rehabilitation & Cardiac	84.37%	81.17%	88.74%	89.88%	91.23%	91.69%	93.08%	89.98%	
Neuroscience, Orthopaedics, Trauma & Specialist Surgery	91.55%	90.65%	92.70%	91.61%	90.31%	91.57%	93.05%	94.70%	
Surgery & Oncology	96.71%	95.54%	95.70%	96.05%	96.88%	96.62%	95.76%	96.54%	
Unknown	100.00%	100.00%	100.00%	93.75%	85.71%	95.31%	100.00%	100.00%	
OUH	**93.09%**	**91.54%**	**93.50%**	**93.92%**	**94.31%**	**94.67%**	**94.73%**	**94.49%**	

PS04 - Serious Incidents Requiring Investigation (SIRI) reported via STEIS



Division	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Trend to date
Children's & Women's	0	0	0	0	1	0	0	0	
Clinical Support Services	0	0	1	0	1	0	0	0	
Medicine, Rehabilitation & Cardiac	2	2	1	0	3	0	3	2	
Neuroscience, Orthopaedics, Trauma & Specialist Surgery	1	0	1	1	0	0	1	2	
Surgery & Oncology	3	2	0	1	1	2	0	3	
OUH	**6**	**4**	**3**	**2**	**6**	**2**	**4**	**7**	

PS12 - % of incidents associated with moderate harm or greater (Trust-wide only)

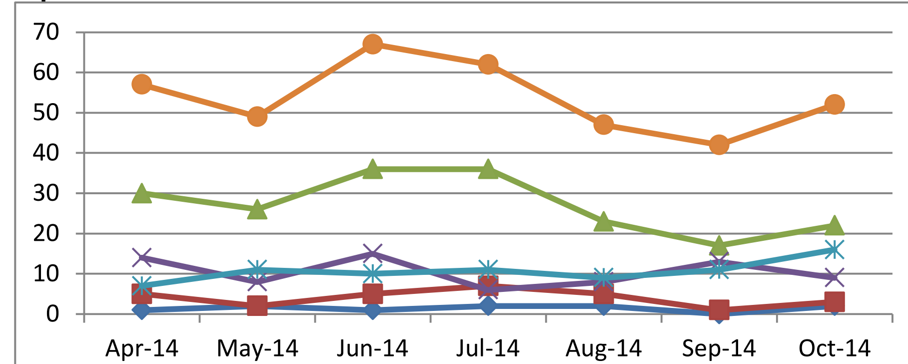


RAG threshold (Trust)	Red	6.5%	Amber	5%

Division	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Trend to date
OUH	4.97%	6.01%	4.94%	3.81%	4.65%	3.87%	4.32%	4.56%	

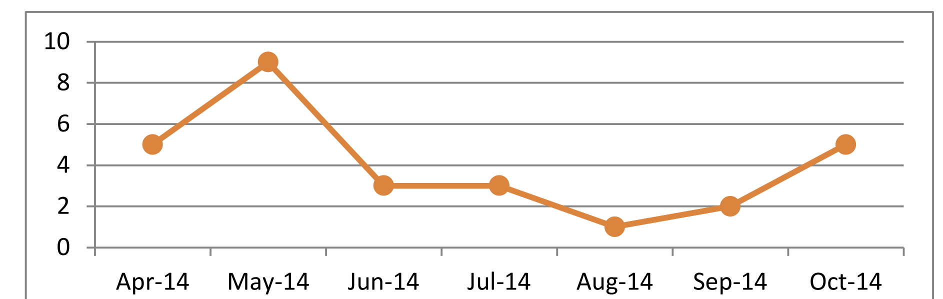
Currently this information is not broken down by division to the Board. It is proposed to include this indicator within ORBIT.

PS13 - Total number of newly acquired pressure ulcers (category 2,3 and 4) reported via Datix



Division	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Trend to date
Children's & Women's	1	2	1	2	2	0	2	
Clinical Support Services	5	2	5	7	5	1	3	
Medicine, Rehabilitation & Cardiac	30	26	36	36	23	17	22	
Neuroscience, Orthopaedics, Trauma & Specialist Surgery	14	8	15	6	8	13	9	
Surgery & Oncology	7	11	10	11	9	11	16	
OUH	**57**	**49**	**67**	**62**	**47**	**42**	**52**	

PS14 - Falls leading to moderate harm or greater (Trust-wide only)



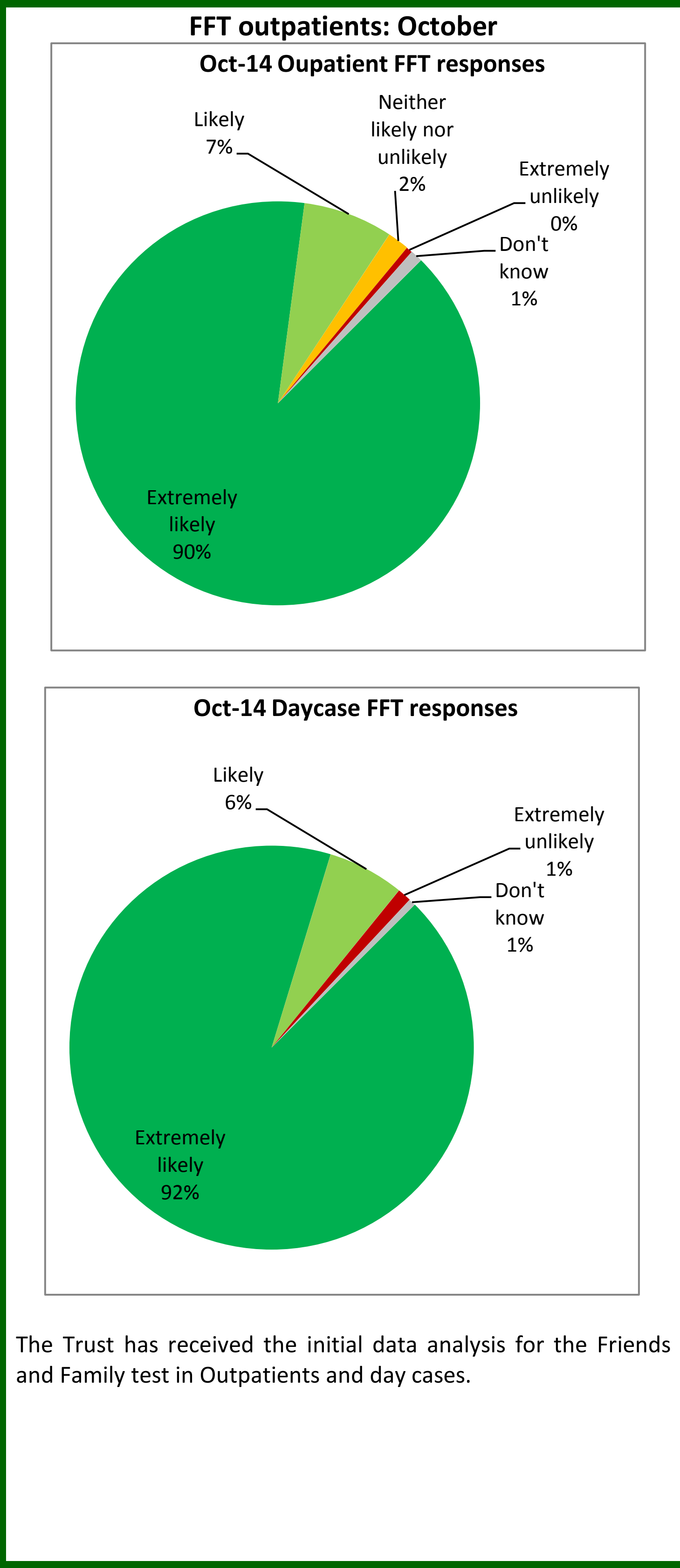
RAG threshold (Trust)	Red	8	Amber	7

Division	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Trend to date
OUH	5	9	3	3	1	2	5	

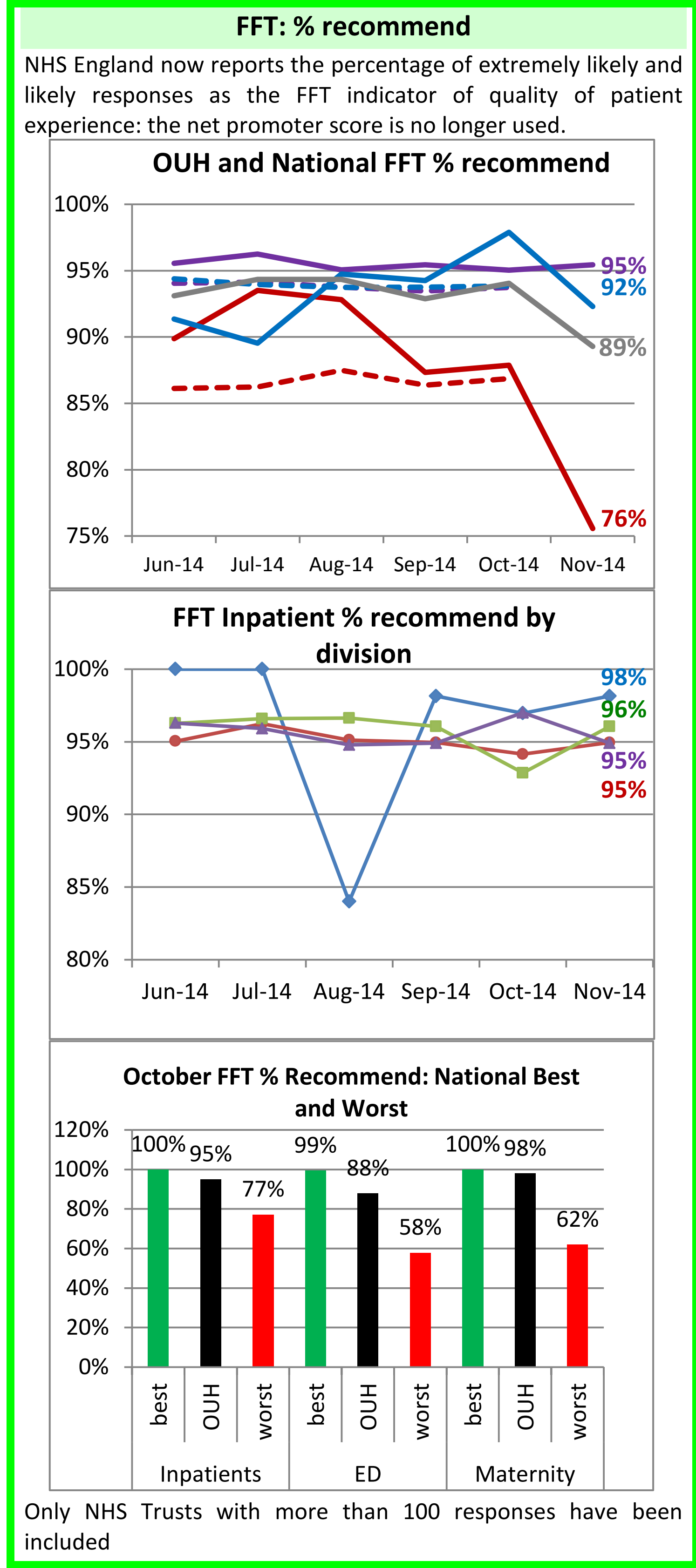
There is inconsistent reporting of falls resulting in harm at a Divisional level. It is proposed to include falls with harm within ORBIT to promote analysis and learning at a divisional level.

Appendix 2 Patient experience dashboard

C&W · MRC · NOTSS · S&O · CSS · Corporate · Trust · OUH Inpatients · Shelford Group Inpatients · OUH ED · Shelford Group ED · OUH Maternity · Shelford Group Maternity

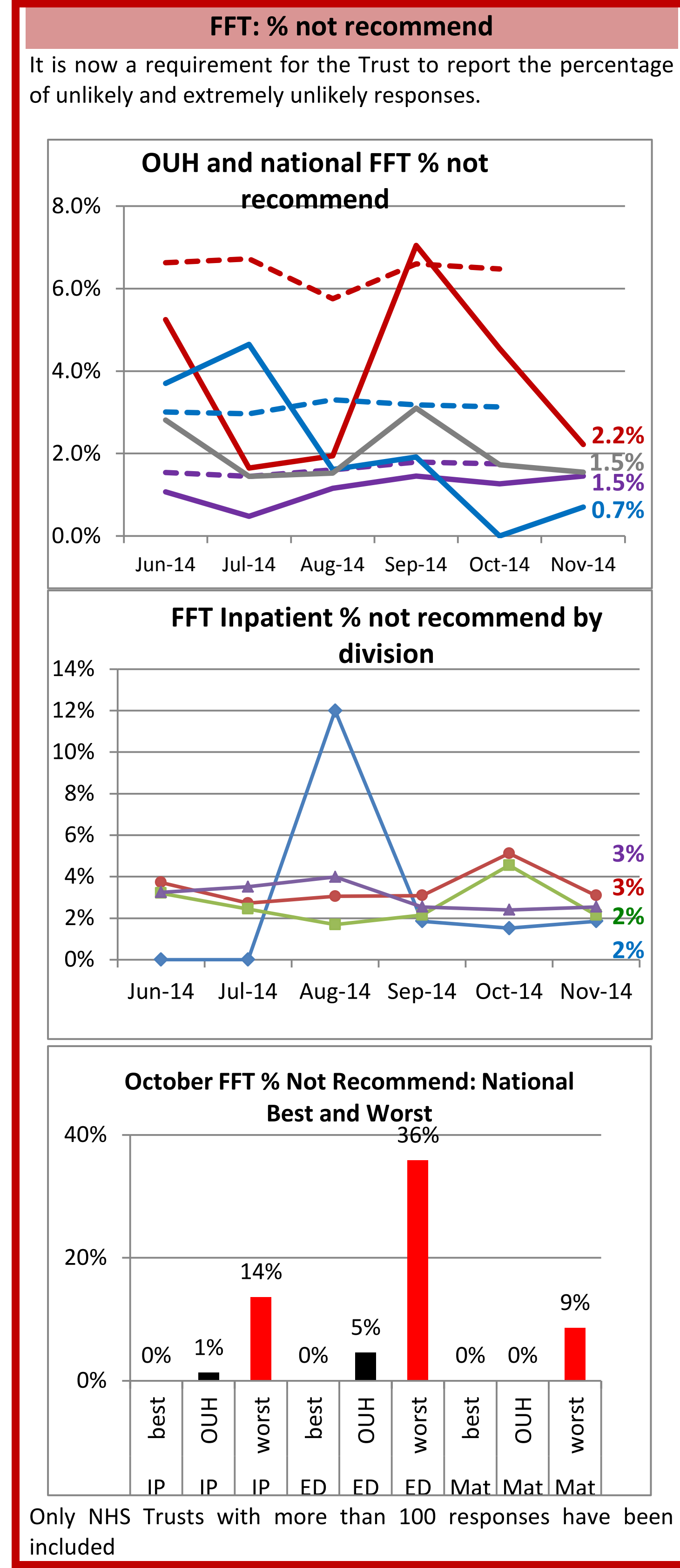


The Trust has received the initial data analysis for the Friends and Family test in Outpatients and day cases.



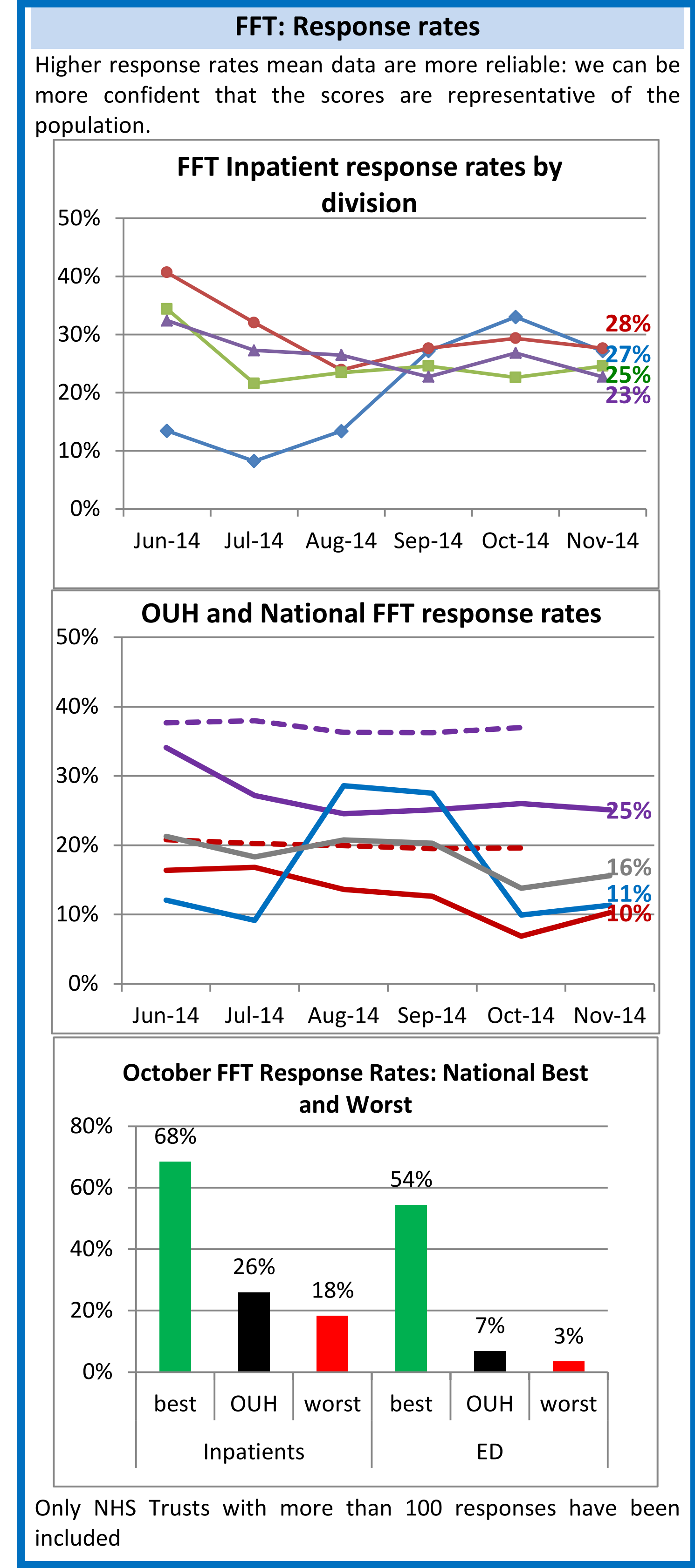
NHS England now reports the percentage of extremely likely and likely responses as the FFT indicator of quality of patient experience: the net promoter score is no longer used.

Only NHS Trusts with more than 100 responses have been included



It is now a requirement for the Trust to report the percentage of unlikely and extremely unlikely responses.

Only NHS Trusts with more than 100 responses have been included



Higher response rates mean data are more reliable: we can be more confident that the scores are representative of the population.

Only NHS Trusts with more than 100 responses have been included

Horton Emergency Department (MRC)
"The doctors on duty that saw me were also really kind, and the whole experience was that of an efficient, friendly A&E department."

ENT Outpatients (NOTSS)
"Complete confidence in the care, felt safe and reassured. She [the nurse] is always cheerful and welcoming, and it was on time. I am not a number in this department, but a person."

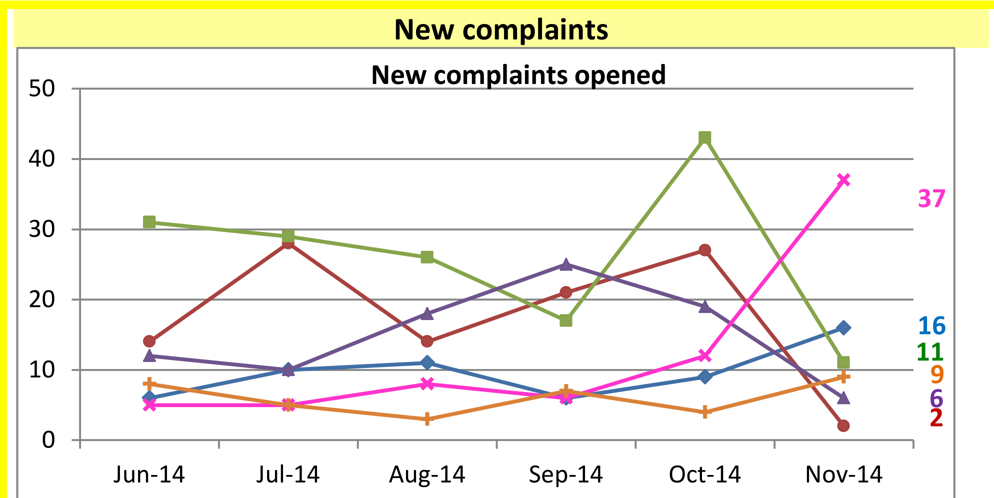
JR Pre-Operative Assessment Outpatients (CSS)
"No waiting. I was treated with respect, courtesy and warmth. Very informative."

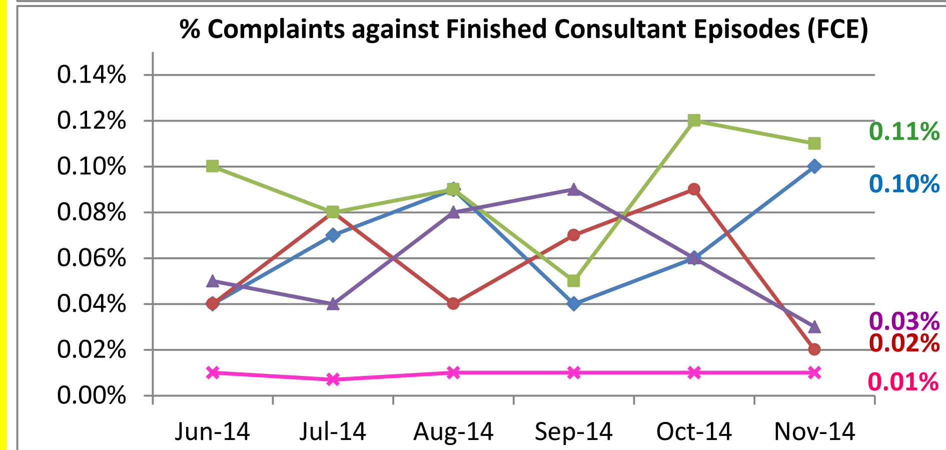
Gynaecology Ward (C&W)
"Excellent, attentive and constant care. Kindness displayed by all staff on ward."

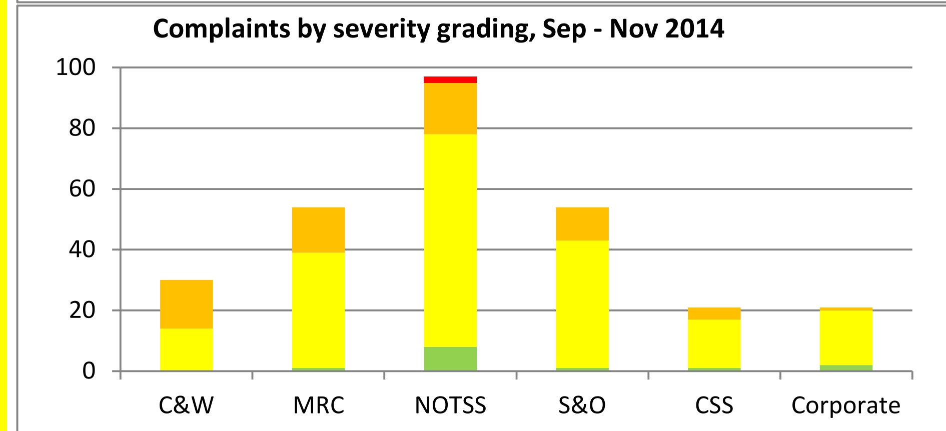
Complaints

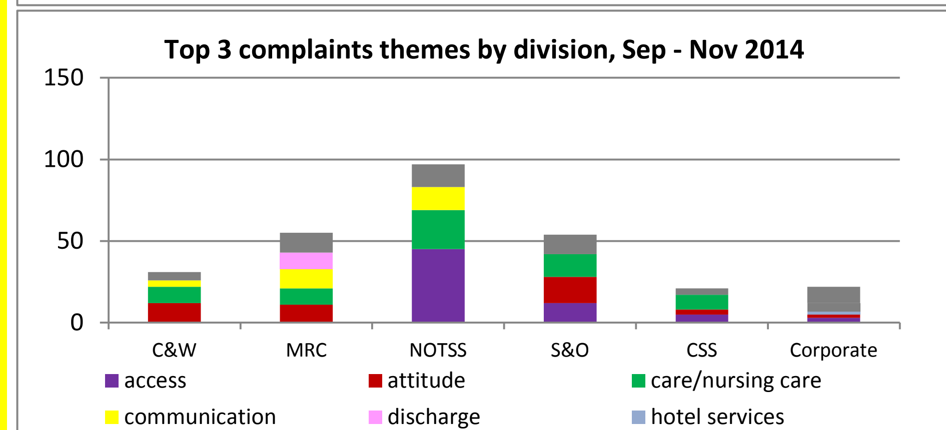
C&W, MRC, NOTSS, S&O, CSS, Corporate, Trust

New complaints

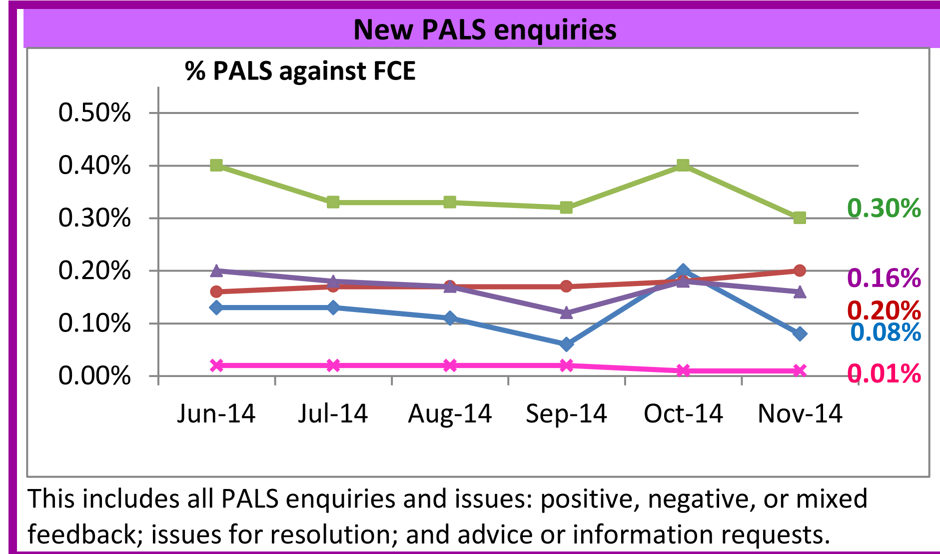






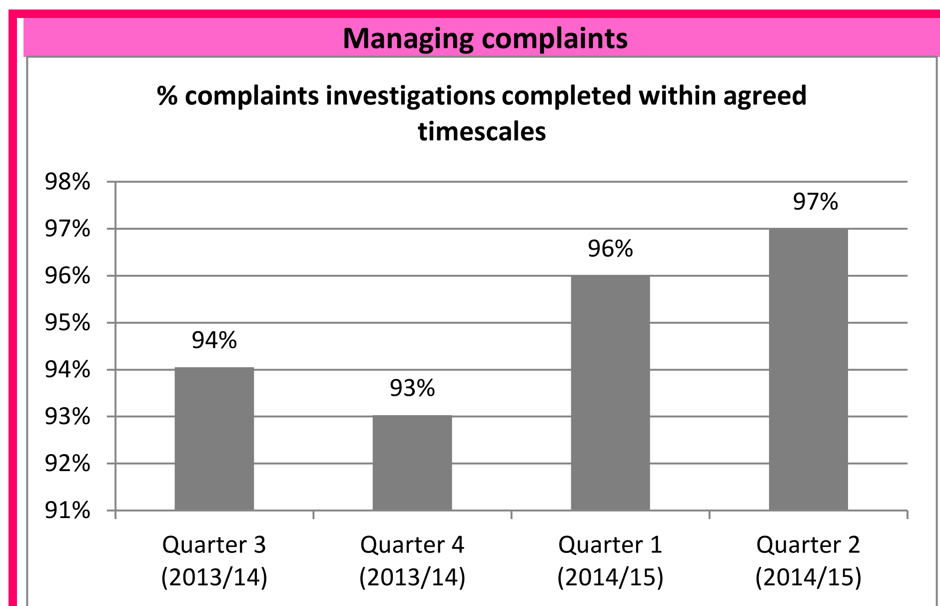


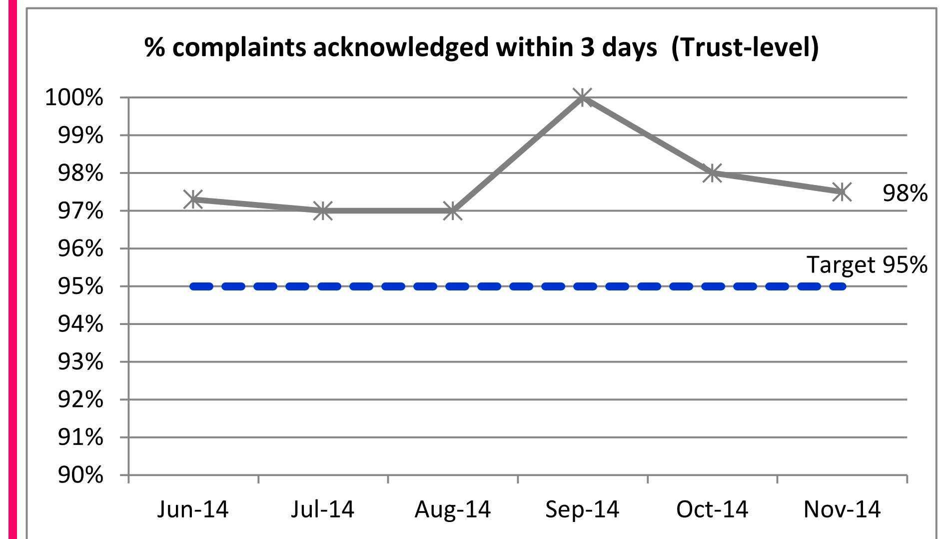
New PALS enquiries



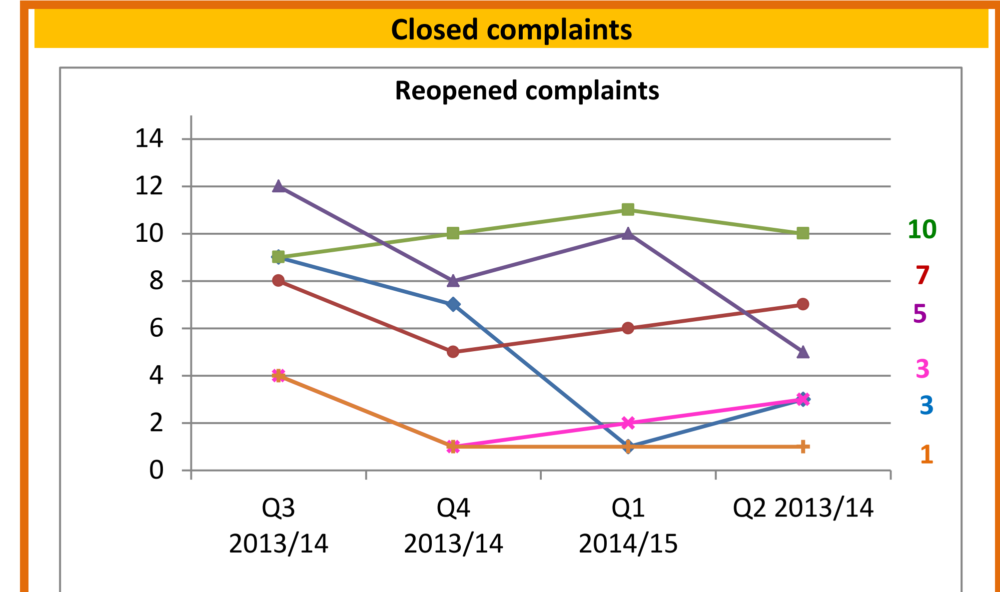
This includes all PALS enquiries and issues: positive, negative, or mixed feedback; issues for resolution; and advice or information requests.

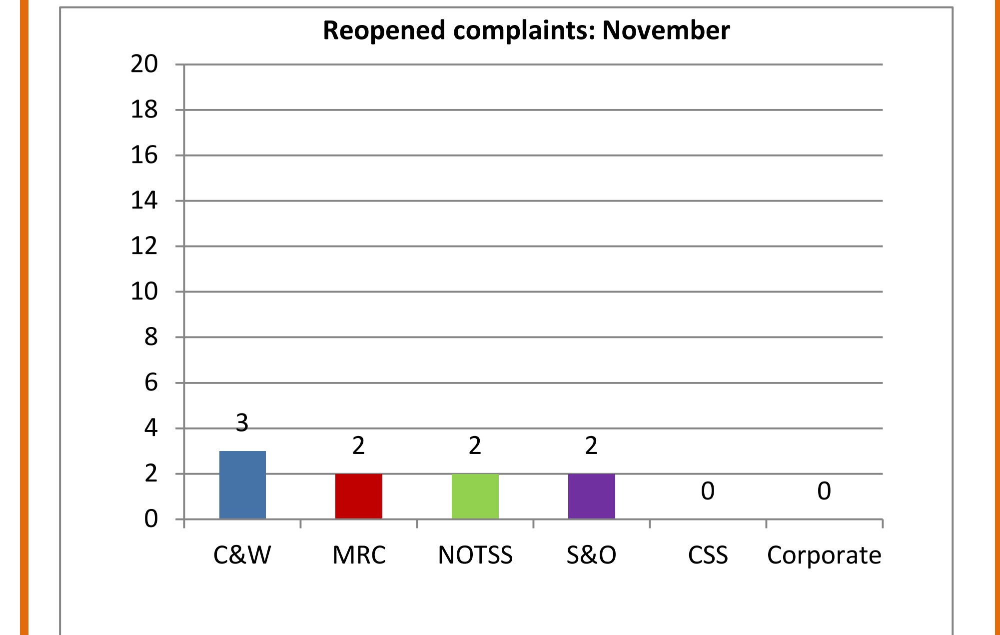
Managing complaints

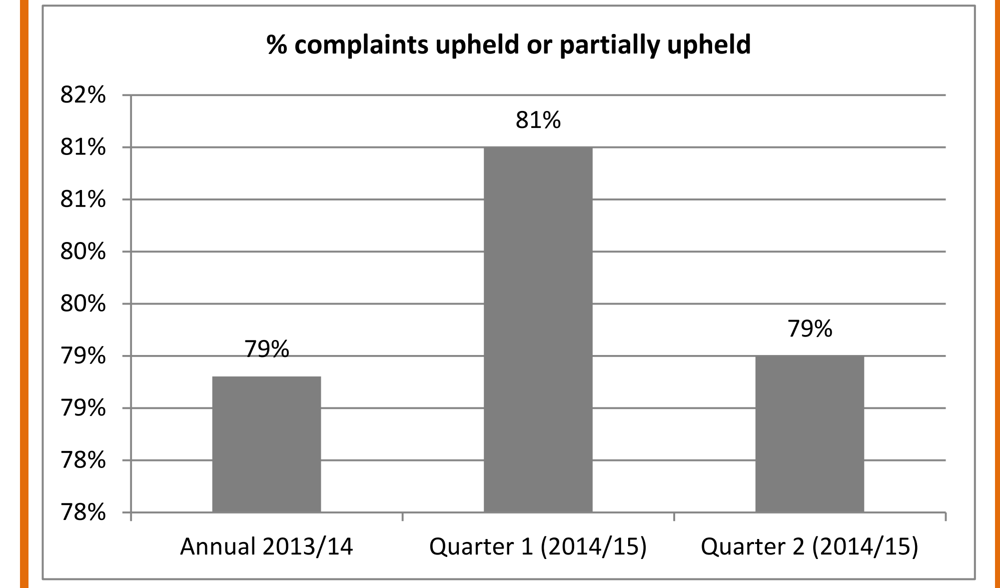




Closed complaints





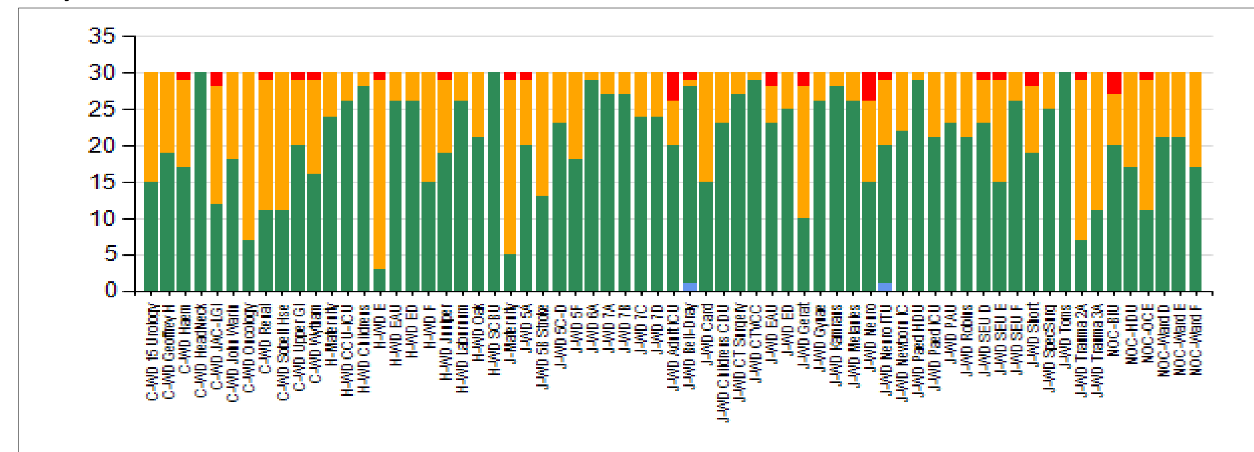


Table

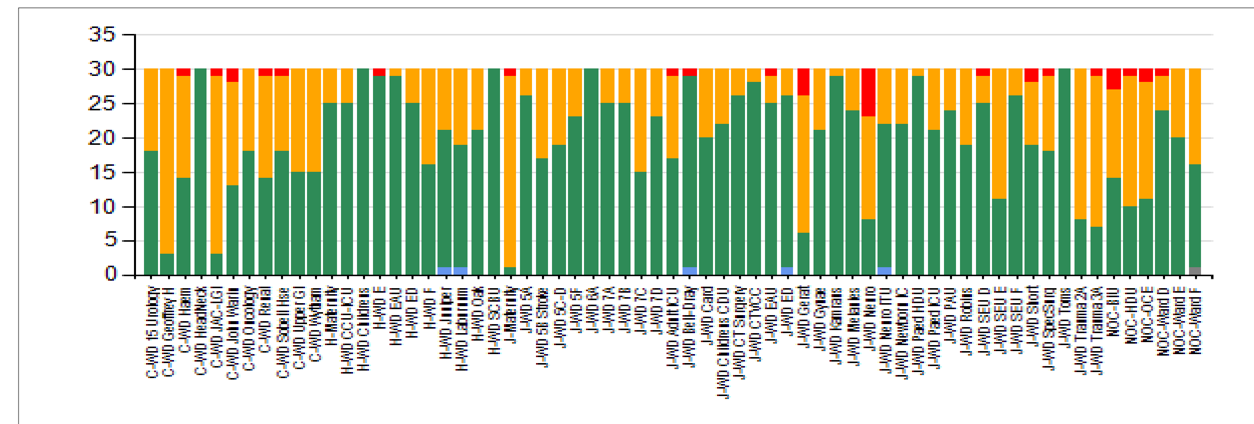
	Trust		
	September 14	October 14	November 14
Total Funded WTE	2932.24	2933.9	2948.4
Vacancy %	11.6%	11.9%	11.9%
Sickness %	5.2%	5.2%	4.6%
Maternity/Adoption Leave %	2.9%	3.6%	3.7%
Agreed Staffing Levels %	64%	71%	71%
Total number of Medication Errors	67	77	68
Total numbers of Hospital Acquired Pressure Ulcers	76	88	98
Total Number of Avoidable Grade 3-4 Hospital Acquired Pressure Ulcers	0	2	11
Total Numbers of Falls	216	232	206
Falls with harm	4	3	1

November 2014 Safe Staffing by ward: Trust

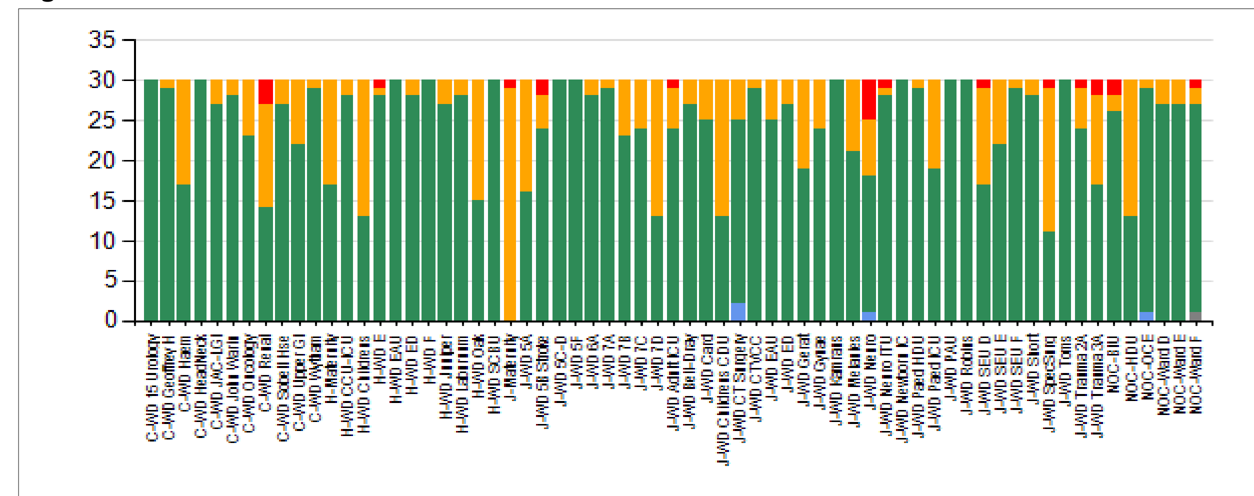
Early Shift



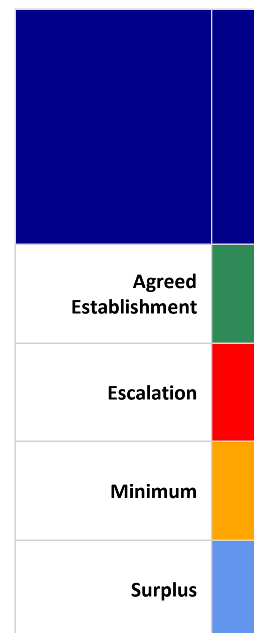
Late Shift



Night Shift



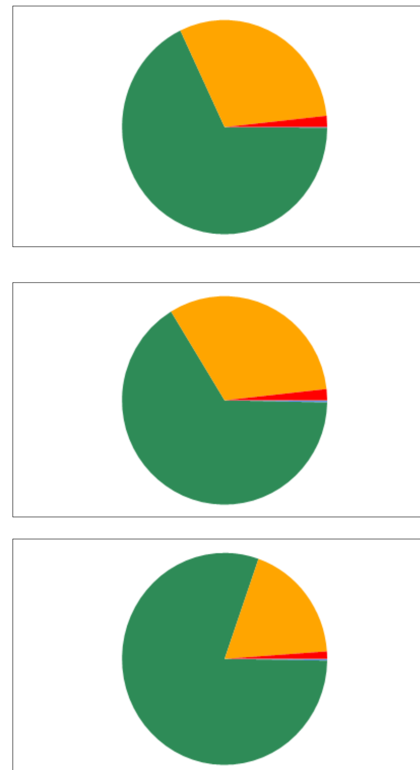
November 2014 Safe Staffing by Shift: Trust.



Early Shift

Late Shift

Night Shift



Narrative

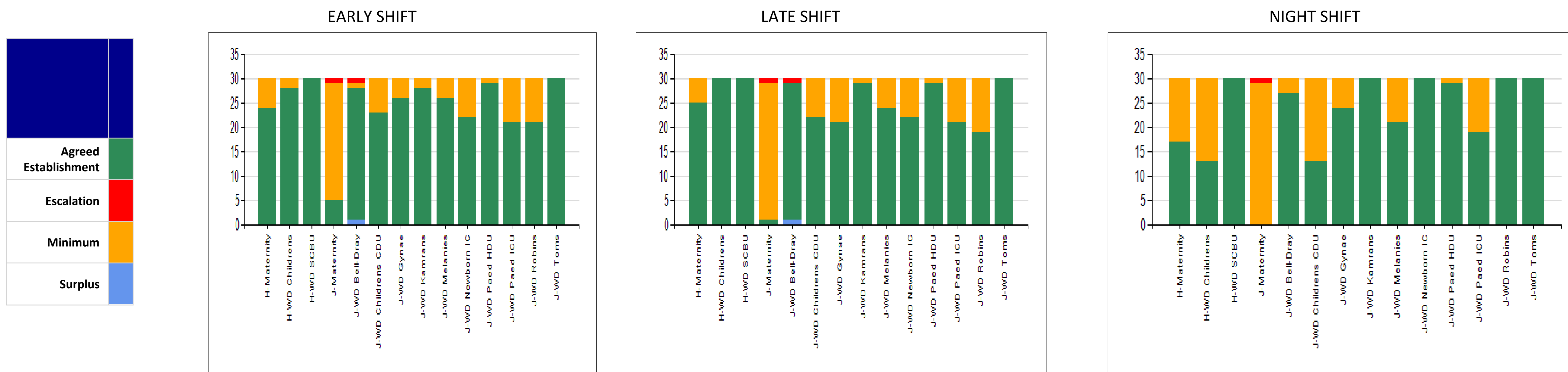
These diagrams demonstrate the shift by shift staffing across the Trust ward by ward as required by the National Quality Board guidance. NB: figures relating selected inpatient areas against specific indicators that are being monitored as nursing sensitive. The figures presented are accurate as of the date the information was retrieved from Datix (on 8th of the month). Any changes to the record after these dates as a result of ongoing review or investigation may not be reflected in figures retrieved after the Safe Staffing cut-off or elsewhere (i.e. Divisional Quality reports). Please note the data represents the total count of incidents observed that meet the indicator criteria for the given period, similar indicators that are constructed/reported differently will not match the figures reported here. Full specification details are included with the Safe Staffing reports.

Children's and Women's Division, (C&W), Safe Staffing Dashboard Inpatient Areas Only Trust Board Report January 2015

Oxford University Hospitals NHS
NHS Trust

C&W				Trust		
	September 14	October 14	November 14	September 14	October 14	November 14
Total Funded WTE	766.75	768.15	768.5	2932.24	2933.9	2948.4
Vacancy %	7%	7.5%	7.9%	11.6%	11.9%	11.9%
Sickness %	5.5%	4.9%	5.4%	5.2%	5.2%	4.6%
Maternity/Adoption Leave %	4%	4.6%	4.4%	2.9%	3.6%	3.7%
Agreed Staffing Levels %	80.8%	81.3%	78.3%	64%	71%	71%
Total number of Medication Errors	11	12	12	67	77	68
Total numbers of Hospital Acquired Pressure Ulcers	3	2	2	76	88	98
Total Number of Avoidable Grade 3-4 Hospital Acquired Pressure Ulcers.	0	0	0	0	0	13
Extravasation incidents	1	2	1	4	3	5

November 2014 Safe Staffing by ward for C&W division.



Narrative by Divisional Nurse

Staff in children's' services have been moved between clinical areas in order to ensure safe staffing cover. In maternity services, there is a flexible approach to covering the high acuity areas, which are determined through the use of the birthrate plus tool. Staff are moved from within the acute sites to cover the delivery suites when activity increases, and the midwives from the community services are moved onto the acute sites to support as required

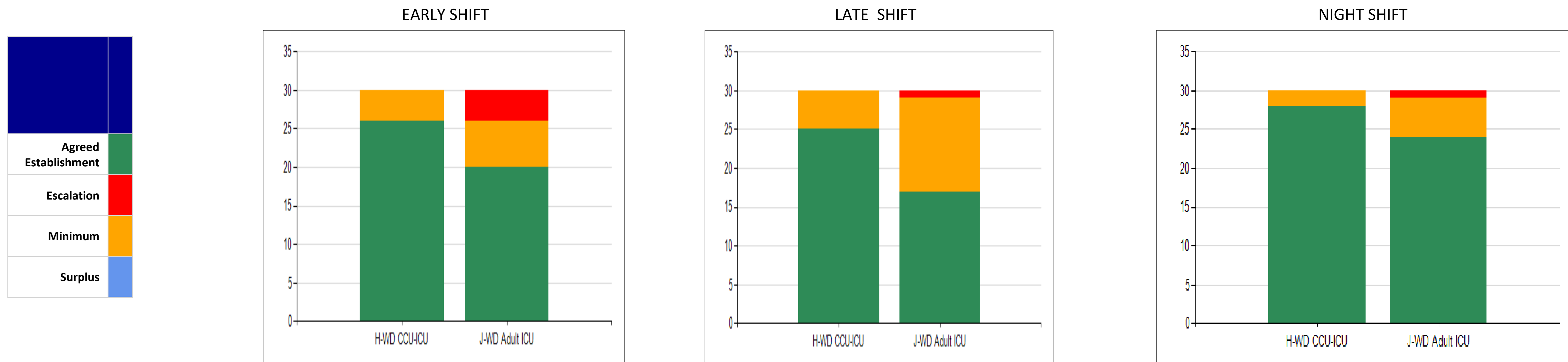
NB: These figures relate to selected inpatient areas against specific indicators that are being monitored as nursing sensitive. The figures presented are accurate as of the date the information was retrieved from Datix (on 8th of the month). Any changes to the record after these dates as a result of ongoing review or investigation may not be reflected in figures retrieved after the Safe Staffing cut-off or elsewhere (i.e. Divisional Quality reports). Please note the data represents the total count of incidents observed that meet the indicator criteria for the given period, similar indicators that are constructed/reported differently will not match the figures reported here.

Oxford University Hospitals NHS Trust

Clinical Support Services Division, (CSS), Safe Staffing Dashboard Inpatient Areas only Trust Board Report January 2015

CSS				Trust		
	September 14	October 14	November 14	September 14	October 14	November 14
Total Funded WTE	170.31	170.57	170.57	2932.24	2933.9	2948.4
Vacancy %	8.9%	8.7%	9.5%	11.6%	11.9%	11.9%
Sickness %	6.7%	5.5%	6.1%	5.2%	5.2%	4.6%
Maternity/Adoption Leave %	4.5%	5%	4.7%	2.9%	3.6%	3.7%
Agreed Staffing Levels %	79.4%	86%	77.7%	64%	71%	71%
Total number of Medication Errors	4	7	4	67	77	68
Total numbers of Hospital Acquired Pressure Ulcers	2	2	2	76	88	98
Total Number of Avoidable Grade 3-4 Hospital Acquired Pressure Ulcers.	0	0	0	0	0	13
Total Numbers of Falls	0	0	0	216	232	206
Falls with moderate, major or catastrophic harm	0	0	0	4	3	1

November 2014 Safe Staffing by ward for CSS division.



Narrative by ITU Matron

Robust recruitment plans are in place across adult critical care areas to reduce the shortfall in nursing numbers, intakes of band 5 nurses are due to start in February and March 2015. In addition to this there are job adverts closing for band 2, 5, 6 & 7 nursing staff in January. Sickness levels are above the trust KPI and team leaders are undertaking return to work interviews as per the Firstcare and Trust policy, there are a number of staff on long term sick, all of which are being managed proactively in conjunction with HR as necessary. AICU/CICU have operated above 100% capacity in adult critical care services for the previous 7 months, these levels of activity could be contributing to sickness levels, morale and retention. A business case to support the expansion of funded capacity in ICU is being presented to the Trust Management Executive in January 2015.

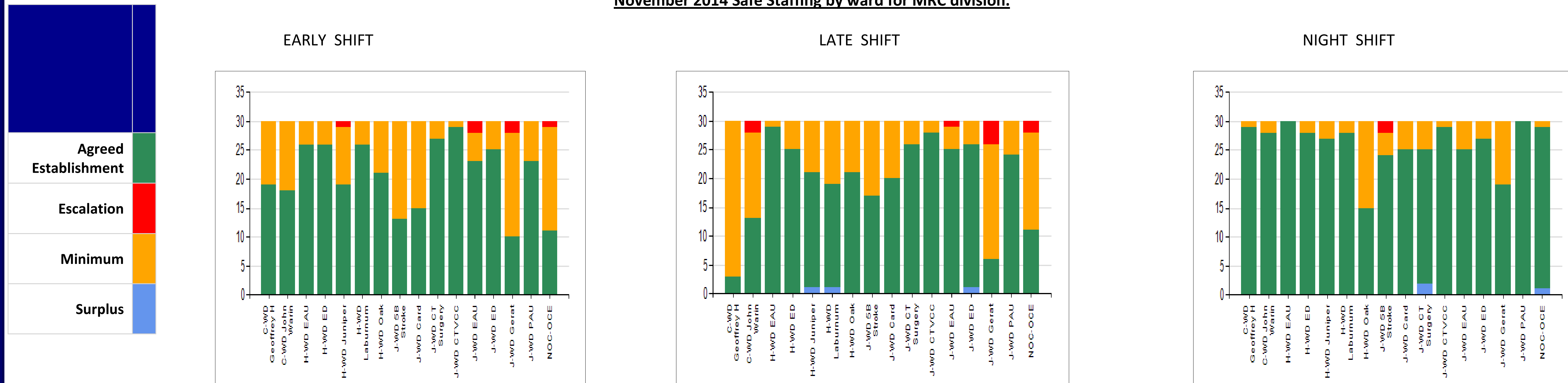
NB: These figures relate to selected inpatient areas against specific indicators that are being monitored as nursing sensitive. The figures presented are accurate as of the date the information was retrieved from Datix (on 8th of the month). Any changes to the record after these dates as a result of ongoing review or investigation may not be reflected in figures retrieved after the Safe Staffing cut-off or elsewhere (i.e. Divisional Quality reports). Please note the data represents the total count of incidents observed that meet the indicator criteria for the given period, similar indicators that are constructed/reported differently will not match the figures reported here. Full specification details are included with the Safe Staffing reports.

Oxford University Hospitals NHS
NHS Trust

Medicine, Rehabilitation & Cardiac Division (MRC) Dashboard Inpatient Areas Only -Trust Board Report January 2015

MRC				Trust		
	September 14	October 14	November 14	September 14	October 14	November 14
Total Funded WTE	900.54	900.54	900.54	2932.24	2933.9	2948.4
Vacancy %	14%	14%	14%	11.6%	11.9%	11.9%
Sickness %	4.8%	5.5%	5%	5.2%	5.2%	4.6%
Maternity/Adoption Leave %	1.9%	2%	2.8%	2.9%	3.6%	3.7%
Agreed Staffing Levels %	59%	72%	73.8%	64%	71%	71%
Total number of Medication Errors	13	28	26	67	77	68
Total numbers of Hospital Acquired Pressure Ulcers	32	35	50	76	88	98
Total Number of Avoidable Grade 3-4 Hospital Acquired Pressure Ulcers	0	2	2	0	2	11
Total Numbers of Falls	139	120	124	216	232	206
Falls with moderate, major or catastrophic harm	1	2	1	4	3	1

November 2014 Safe Staffing by ward for MRC division.



Narrative by Divisional Nurse

Greater numbers of staff from clinical areas have been recruited onto NHSP, (Trust bank). Safe staffing is maintained using a combination of NHSP and high cost agency. However the divisional turnover rate continues to be a challenge especially band 5 and below. The division is encouraging staff to increase their culture of reporting medication incidents, however in recent months there has been a notable improvement in reporting and a decrease in the number of medication incidents with harm. During September to November, four patients had grade 3/4 avoidable pressure ulcers declared and validated. All have been investigated as SIRI's with associated actions which are being added to the MRC divisional quality priorities. Common root causes identified for the development of hospital acquired pressure ulcers include, the assessments are not being undertaken in a timely manner in EAU and this may be due to the pressure of activity and patient flow, inaccurate Pressure Ulcer Risk Assessment scoring, inconsistency of subsequent skin review and delays in the instigation of appropriate preventative care plans when patients are deemed at risk. These are all being addressed through an educational programme and focused approach by the Tissue Viability Team. The falls with harm relate to patients who have been attempting to mobilise independently between bed and chair/toilet/bathroom. The 'Fallsafe care bundle' is in the process of being rolled out and implemented across the division

NB: These figures relate to selected inpatient areas against specific indicators that are being monitored as nursing sensitive. The figures presented are accurate as of the date the information was retrieved from Datix (on 8th of the month). Any changes to the record after these dates as a result of ongoing review or investigation may not be reflected in figures retrieved after the Safe Staffing cut-off or elsewhere (i.e. Divisional Quality reports). Please note the data represents the total count of incidents observed that meet the indicator criteria for the given period, similar indicators that are constructed/reported differently will not match the figures reported here. Full specification details are included with the Safe Staffing reports.

Neurosciences, Orthopaedics, Trauma & Specialist Surgery (NOTSS) Division Dashboard Inpatient Areas Only - Trust Board Report January 2015

Oxford University Hospitals NHS
NHS Trust

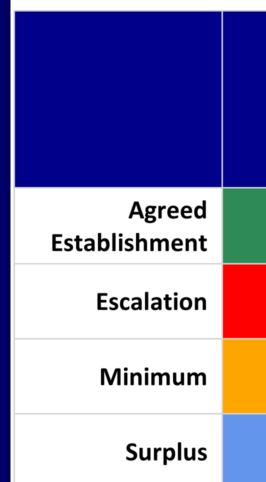
NOTSS				Trustwide		
	September 14	October 14	November 14	September 14	October 14	November 14
Total Funded WTE	606.11	606.11	620.27	2932.24	2933.9	2948.4
Vacancy %	12.9%	12.7%	12.3%	11.6%	11.9%	11.9%
Sickness %	5.2%	4.9%	4%	5.2%	5.2%	4.6%
Maternity/Adoption Leave %	2.3%	2.6%	2.3%	2.9%	3.6%	3.7%
Agreed Staffing Levels %	60%	66%	65%	64%	71%	71%
Total number of Medication Errors	49	48	35	67	77	68
Total numbers of Hospital Acquired Pressure Ulcers	24	23	15	76	88	98
Total number of avoidable grade 3-4 hospital acquired Pressure Ulcers	0	0	0	0	0	13
Total Numbers of Falls	27	50	36	216	232	206
Falls with moderate, major or catastrophic harm	0	1	0	4	3	1

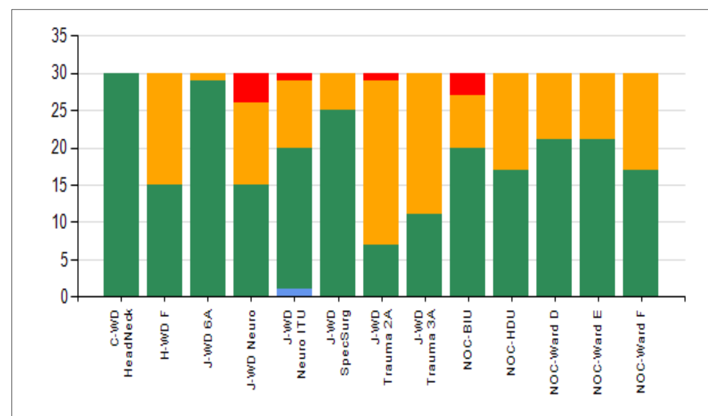
November 2014 Safe Staffing by ward for NOTSS division.

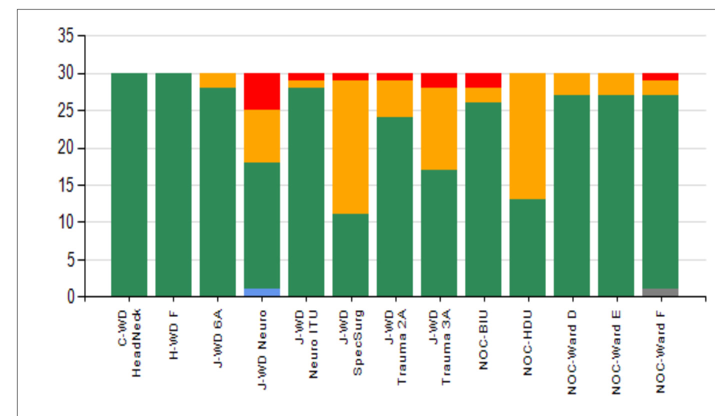
EARLY SHIFT

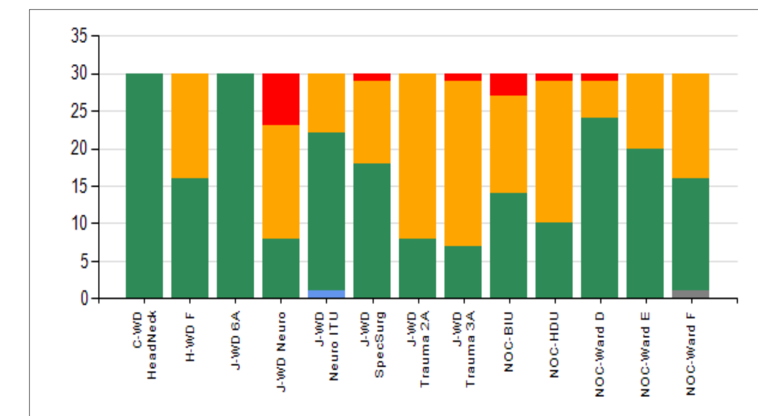
LATE SHIFT

NIGHT SHIFT









Narrative by Divisional Nurse

Maintaining staffing levels at minimum or above continues to be a challenge within the NOTSS Division. Recruitment remains the key focus within the Division, with the divisional vacancy rate reported at just over 12% for the quarter; there is a drive to ensure the success of the EU recruitment initiative as numbers applying to local registered nurse adverts remains low. However a recruitment campaign remains in place nationally. Despite the staffing challenge, Quality indicators assure the Division that care is continues to safely delivered. The Division has completed its 6 month implementation of the Fall Safe Bundle across all inpatient areas and is pleased to report that the 1 fall with harm in this quarter was investigated and found to be unavoidable. Fall numbers will continue to be high within NOTSS due to the high risk patient groups found in the majority of its specialties**,** and indicators are demonstrating that falls are being reported more accurately within the division and those patients that fall are "falling safer". Electronic prescribing has been rolled out across Neurosciences, and Orthopaedics and this has been with some significant challenges, mainly attributed to the high use of temporary workers from nurse agencies that require training and access to be able to administer medication safely. Access to training is being addressed within the Trust, and the Division remains positive to this challenge to ensure that the training is successfully rolled out. The increase in the number of medication incidents is one if NOTSS's quality priorities for 2014/15 and the Division has observed a decrease in the number of medication incidents reported in November. This was highlighted at the Clinical Governance Committee in December2014 by the Divisional Nurse as there has been focus on the use of E prescribing

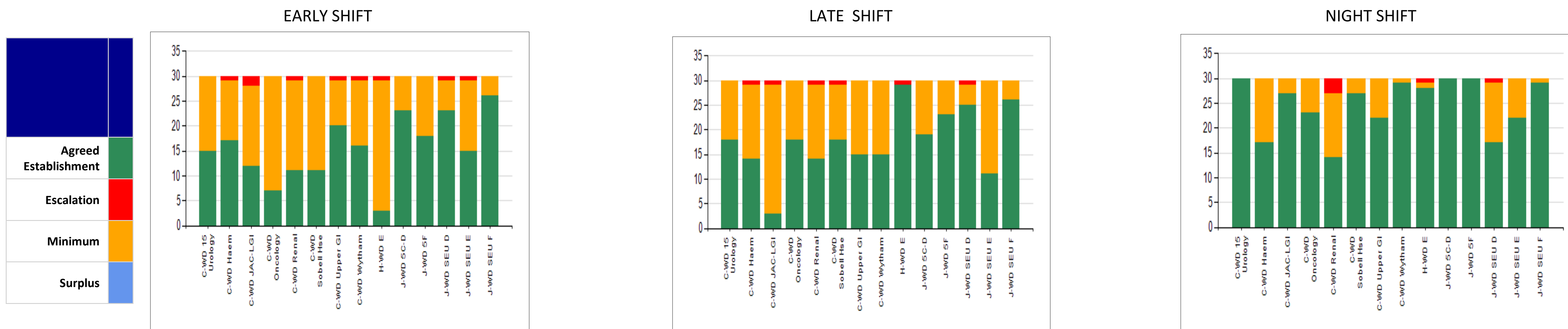
NB: These figures relate to selected inpatient areas against specific indicators that are being monitored as nursing sensitive. The figures presented are accurate as of the date the information was retrieved from Datix (on 8th of the month). Any changes to the record after these dates as a result of ongoing review or investigation may not be reflected in figures retrieved after the Safe Staffing cut-off or elsewhere (i.e. Divisional Quality reports). Please note the data represents the total count of incidents observed that meet the indicator criteria for the given period, similar indicators that are constructed/reported differently will not match the figures reported here. Full specification details are included with the Safe Staffing reports.

Surgery & Oncology Division (S&O) Safe Staffing Dashboard Inpatient Areas Only - Trust Board Report January 2015

Oxford University Hospitals NHS Trust

S&O				Trust		
	September 14	October 14	November 14	September 14	October 14	November 14
Total Funded WTE	488.53	488.53	488.53	2932.24	2933.9	2948.4
Vacancy %	12.7%	12.7%	12.3%	11.6%	11.9%	11.9%
Sickness %	4.6%	4.9%	4%	5.2%	5.2%	4.6%
Maternity/Adoption Leave %	3%	2.9%	3%	2.9%	3.6%	3.7%
Agreed Staffing Levels %	58%	65%	64%	64%	71%	71%
Total number of Medication Errors	7	13	16	67	77	68
Total numbers of Hospital Acquired Pressure Ulcers	13	28	29	76	88	98
Total Number of Avoidable Grade 3-4 Hospital Acquired Pressure Ulcers.	0	0	1	0	0	13
Total Numbers of Falls	47	62	43	216	232	206
Falls with moderate, major or catastrophic harm	3	0	0	4	3	1

November 2014 Safe Staffing by ward for S&O division



Narrative by Divisional Nurse

S&O wards continue to run on minimum staffing for long periods, in particular on the day shifts. The Churchill site continues to work effectively by moving nursing staff to mitigate at risk areas at the twice daily safe staffing meetings. This continues to be challenging in terms of staff cover, and reducing clinical risk and ensuring patient safety. The division will continue to use agency staff on long term placements to provide continuity of care in areas of either high vacancy or where substantive staff are unable to work additional hours to support the clinical teams. Temporary staff shifts are requested as early as possible however there has been poor bank and agency fill rates (including high cost agency) The Trust is working with the Trust Bank and agencies to enable maximum fill rates, including increasing the bank rates for band 5 staff.

NB: These figures relate to selected inpatient areas against specific indicators that are being monitored as nursing sensitive. The figures presented are accurate as of the date the information was retrieved from Datix (on 8th of the month). Any changes to the record after these dates as a result of ongoing review or investigation may not be reflected in figures retrieved after the Safe Staffing cut-off or elsewhere (i.e. Divisional Quality reports). Please note the data represents the total count of incidents observed that meet the indicator criteria for the given period, similar indicators that are constructed/reported differently will not match the figures reported here. Full specification details are included with the Safe Staffing reports.