Oxford University Hospitals NHS
NHS Trust

Trust Board Meeting: Wednesday 8 July 2015

TB2015.79

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 validated information that is as contemporary as possible, where possible this may include the last calendar month.

2. In relation to key quality metrics:
   - Five of the 53 quality metrics, pre-specified targets were not fully achieved in the last relevant data period. For selected metrics, trend data is 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 One.

3. In relation to Patient Safety and Clinical Risk:
   - 14 Serious Incidents Requiring Investigation (SIRI) were reported in May 2015.
   - No Never Events were reported in May
   - No SIRI's were closed with OCCG due to the May closure meeting not going ahead, there are two closure meetings scheduled in June to address this.

4. Safe staffing report
   - This includes the Unify report for May 2015 on actual staffing against planned hours
   - The workforce and Nurse Sensitive Indicator data for each division against the Trust data for March, April & May 2015
   - Dashboards for Trust wide workforce and NSI data for the 12 months from April 2014 – March 2015 and an analysis of the trends

5. Patient Experience
   - The Trust received 100 complaints during May 2015. This is an increase from March and April 2015.
   - The patient experience dashboard including Friends and Family Test, PALS and Complaints Data for May 2015 is attached at Appendix 2.
   - The new national complaints codes developed by the Health and Social Care Information Centre (HSCIC) have been included at Appendix 3. All NHS Trusts must use these codes from 1 April 2015.

Recommendation

The Trust Board is asked to receive this report.

Board Quality Report

1. Purpose

1.1. This paper aims to provide the 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 Quality Committee.

2. Key Quality Metrics

2.1. A suite of fifty three key quality metrics linked to the quality of clinical care provided across the organisation are listed in dashboard format.

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

2.3. Trend graphs and exception reports in relation to 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 are included. Thresholds are drawn from a mixture of sources (national, commissioner and internal).

2.4. Due to the reporting timeframe for the Committee, the detailed sections of the Board Quality Report describe May information, however the Quality Metrics section of the report relates to validated data for April and May as available.

2.5. The graphics below detail the five indicators that have deteriorated in terms of performance against target since the last reporting cycle. Each is provided with a narrative explanation for this drop in performance, and actions being taken to adresss.

2.6. The following eight indicators have seen an improvement in performance against target thresholds since the previous reported period: PS01 – Safety Thermometer (% of patients receiving care free of any newly acquired harm); PS06 – Number of cases of MRSA bacteraemia; PS07 – Antibiotic prescribing (% compliance with antimicrobial guidelines); PS08 - % of patients receiving stage two medicines reconciliation within 24h of admission; CE06 – Emergency Department (% patients seen, assessed and discharged/admitted within 4h of arrival); CE07 – Stroke (% patients spending >90% of admission in specialist stroke environment); CE19 - % of fractured NOF patients who receive surgery within 36h of admission and, PE10 – Number of legal claims received/inquested opened initially graded as red.

Table 1

BQR ID	Rating	Rating Last Period	Descriptor	Period	Threshold Source	Red	Amber
PS01	98.07% Green	Amber	Safety Thermometer (% patients receiving care free of any newly acquired harm) [one month in arrears]	May 15	Internal	95%	97%
PS02	93.63% Green	Green	Safety Thermometer (% patients receiving care free of any harm - irrespective of acquisition) [one month in arrears]	May 15	Internal	91%	93%
PS03	96.47% Green	Green	VTE Risk Assessment (% admitted patients receiving risk assessment)	Apr 15	National	95%	95.25%
PS04	12 N/A		Serious Incidents Requiring Investigation (SIRI) reported via STEIS	May 15		N/A	N/A
PS05	7 Green	Green	Number of cases of Clostridium Difficile > 72 hours (cumulative year to date)	May 15	National	10	N/A
PS06	1 Green	Red	Number of cases of MRSA bacteraemia > 48 hours (cumulative year to date)	May 15	National	1	N/A
PS07	95.09% Green	Red	Antibiotic prescribing - % compliance with antimicrobial guidelines [most recently available figure, undertaken quarterly]	Apr 15	Internal	93%	95%
PS08	89.47% Green	Red	% patients receiving stage 2 medicines reconciliation within 24h of admission	May 15	Internal	75%	85%
PS09	100% Green	Green	% patients receiving allergy reconciliation within 24h of admission	May 15	Internal	94%	96%
PS10	1.99% Green	Green	% of incidents associated with moderate harm or greater	May 15	Internal	6.5%	5%
PS11	77 N/A		Total number of newly acquired pressure ulcers (category 2,3 and 4) reported via Datix	May 15		N/A	N/A
PS12	2 Green	Green	Falls leading to moderate harm or greater	May 15	Internal	8	7
PS13	26.42% N/A		Cleaning Score - % of inpatient areas with initial score > 92%	May 15		N/A	N/A
PS14	98.97% Green	Green	% radiological investigations achieving 5 day reporting standard [CSS Division]	May 15	Commissioner	95%	98%
PS15	4 N/A		Number of CAS alerts received	May 15		N/A	N/A
PS16	0 Green	Green	CAS alerts breaching deadlines at end of month and/or closed during month beyond deadline	May 15	Internal	1	N/A
CE01	1 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	211 N/A		Crude Mortality	May 15		N/A	N/A
CE03	63.09% Red	Red	Dementia - % patients aged > 75 admitted as an emergency who are screened [one month in arrears]	Apr 15	National	80%	90%
CE04	85.8% Amber	Green	Dementia diagnostic assessment and investigation [one month in arrears]	Apr 15	Internal	80%	90%
CE05	100% Green	Green	Dementia :Referral for specialist diagnosis [one month in arrears]	Apr 15	Internal	80%	90%
CE06	96.38% Green	Amber	ED - % patients seen, assessed and discharged / admitted within 4h of arrival	May 15	National	85%	95%
CE07	86.89% Green	Amber	Stroke - % patients spending > 90% of admission in specialist stroke environment	May 15	National	70%	80%
CE08	82.46% Amber	Amber	Stroke - % patients accessing specialist stroke environment within 4h of arrival	May 15	National	75%	85%

CE09	5.5 Amber	Amber	Vascular - Mean length of stay for patients undergoing elective AAA repair (3 month rolling period) [NOTSS Division]	Apr 15	Internal	8	5
CE10	0% Green	Green	Vascular - % mortality following elective AAA repair [NOTSS Division]	Apr 15	Internal	5%	3%
CE11	93.33% Green	Green	Cardiology - % patients receiving primary angioplasty within 60 minutes of arrival at hospital [MRC Division]	Apr 15	Internal	85%	90%
CE12	2.1 Amber	Red	Cardiology - Mean number of days from referral to admission to cardiology at tertiary centre [MRC Division]	Apr 15	Internal	3	2
CE13	0% Green	Green	Cardiac surgery-% rate of patients with organ space infections following cardiac surgery via the sternum [MRC Division]	May 15	Internal	1%	0.5%
CE14	0% Green	Green	Cardiac Surgery - % mortality following elective primary CABG [MRC Division]	Apr 15	Internal	6%	4%
CE15	1 Amber	Green	Number of unscheduled returns to theatre within 48 hours [NOTSS Division - NOC Site]	May 15	Internal	2	1
CE16	0 Green	Green	Number of unscheduled returns to theatre in gynaecology [C&W Division]	May 15	Internal	2	1
CE17	445 N/A		Number of patients admitted to SEU wards from SEU triage [S&O Division]	May 15		N/A	N/A
CE18	5.98% Red	Amber	Neuroscience Intensive Therapy Unit (NITU) readmission rate within 48 hours of discharge [NOTSS Division]	May 15	Internal	4%	2%
CE19	81.6% Green	Red	% fractured NOF patients who receive surgery within 36 hours of admission [NOTSS Division]	Mar 15	Commissioner	70%	72%
CE20	19.4% Green	Green	% deliveries by C-Section [C&W Division]	May 15	Commissioner	33%	23%
CE21	2% Amber	Green	7 day admission rate following assessment on (and discharge from) paediatric CDU [C&W Division]	May 15	Internal	4%	2%
PE01	7.41% N/A		Friends & Family test % not likely to recommend - ED	May 15		N/A	N/A
PE02	81.48% N/A		Friends & Family test % likely to recommend - ED	May 15		N/A	N/A
PE03	0.62% N/A		Friends & Family test % not likely to recommend - Mat	May 15		N/A	N/A
PE04	93.85% N/A		Friends & Family test % likely to recommend - Mat	May 15		N/A	N/A
PE05	0.67% N/A		Friends & Family test % not likely to recommend - IP	May 15		N/A	N/A
PE07	97.13% N/A		Friends & Family test % likely to recommend - IP	May 15		N/A	N/A
PE06	0 Green	Green	Single sex breaches	May 15	National	3	2
PE08	76.4% Green	Green	% patients EAU length of stay < 12h	May 15	Internal	65%	70%
PE09	81% N/A		% Complaints upheld or partially upheld [Quarterly in arrears]	Mar 15		N/A	N/A
PE10	0 Green	Red	Number of legal claims received / inquests opened initially graded as RED	Mar 14	Internal	2	N/A
PE11	70% Green	Green	% patients returning feedback forms in specialist surgery outpatients [NOTSS Division]	May 15	Internal	45%	60%
PE10	9 N/A		Number of reopened complaints	May 15		N/A	N/A

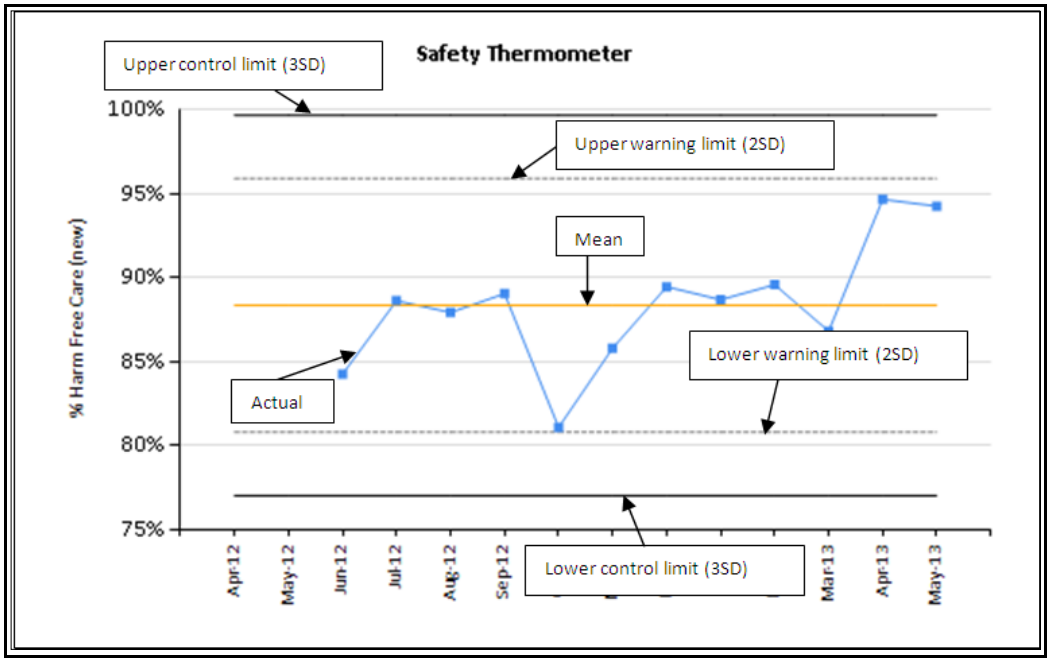
How to interpret charts

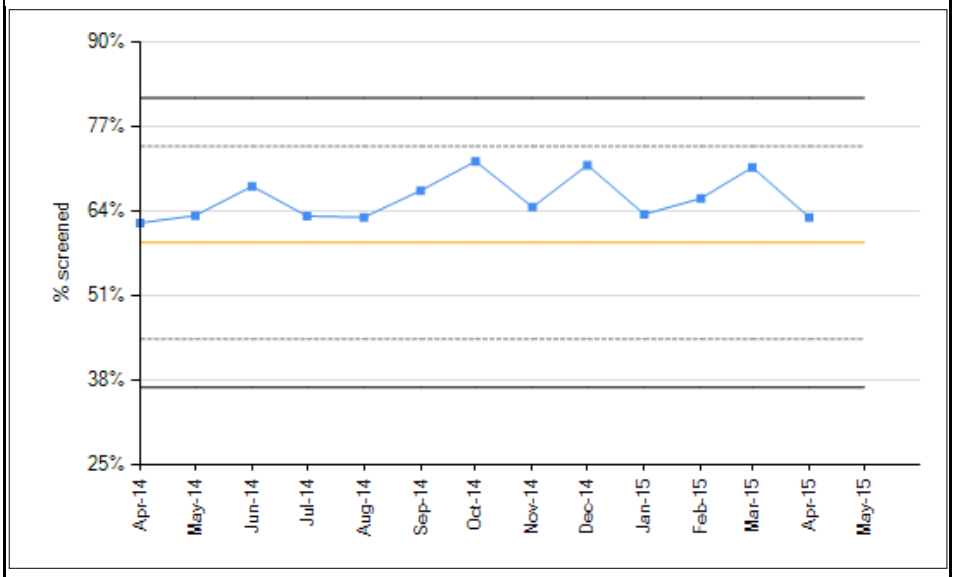
Data are presented in this report in a number of different ways – including statistical For process control (SPC) charts, line charts (without confidence intervals / control limits), histograms and cumulative histograms. Graphics have been selected in order to encourage the analysis of trends and to 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.

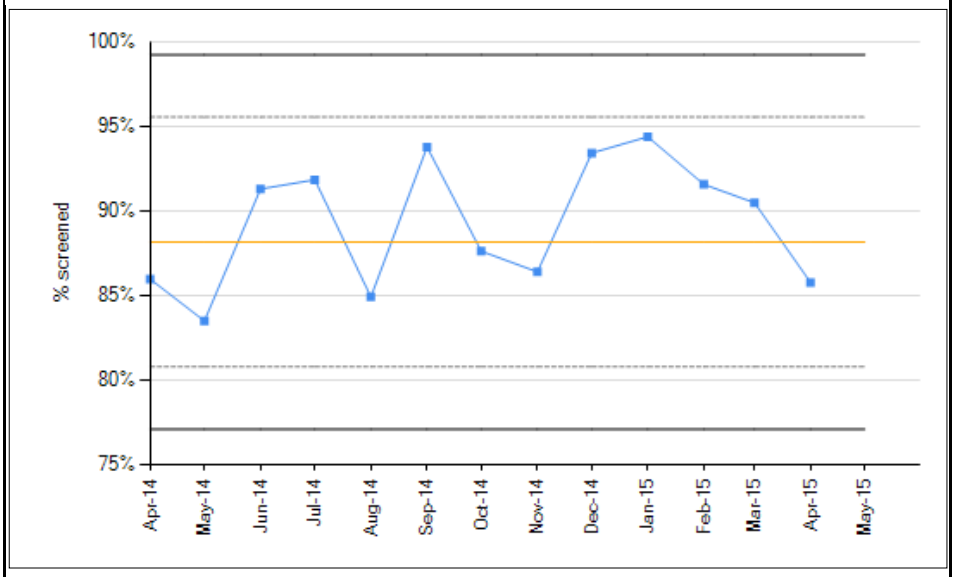
There are other patterns within the data that are likely to reflect real change as opposed to random fluctuation – these patterns are known as special cause variations. They include:

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)

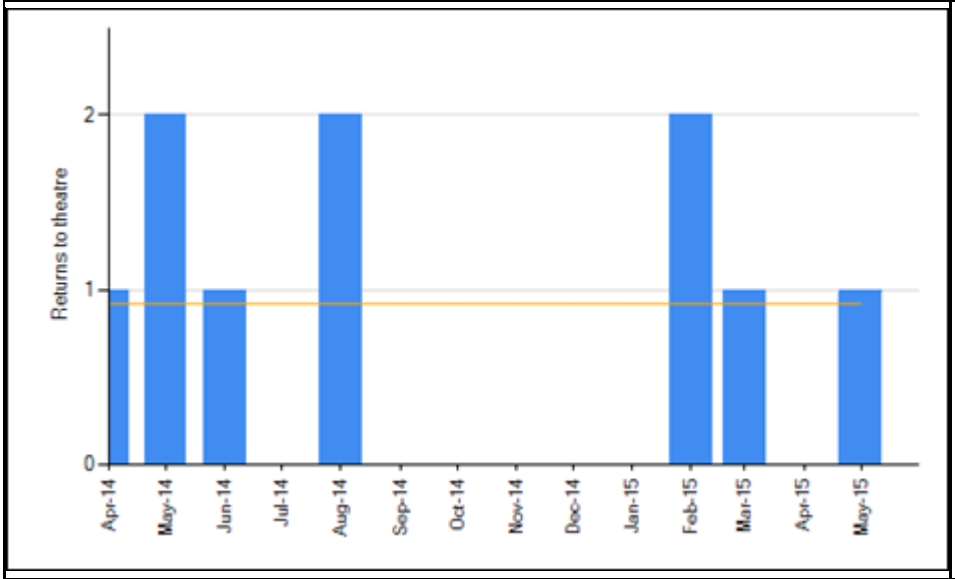


CE03 Dementia - % patients aged > 75 admitted as an emergency who are screened [one month in arrears]	Narrative
	Actions to address improvement in this metric have included the formation of a dementia steering group, which is meeting regularly to discuss performance and planning. Furthermore, improved divisional level reporting and dissemination of results, and more robust utilisation of the electronic record will lead to further improvement.

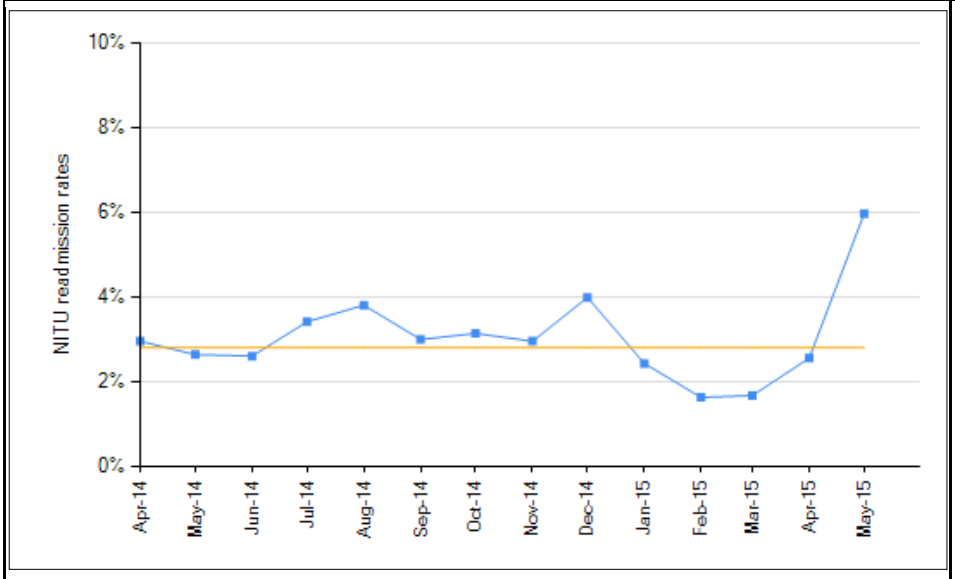
Elderly patients admitted on a non-elective basis should be screened for dementia using a screening question and / or a simple cognitive test. Performance shown in this graph reflects figures submitted monthly to NHS England. These figures are derived from both EPR and local paper-based systems.

CE04 Dementia diagnostic assessment and investigation [one month in arrears]	Narrative
	In April the Surgery & Oncology Division, MRC Division, and the Children's & Women's Division were all rated Green, each achieving 91%. During the same period the NOTSS Division reported a significant drop in the number of patients admitted who were screened, and did not submit data for this indicator in April. This has resulted in an overall trust-wide drop in performance.

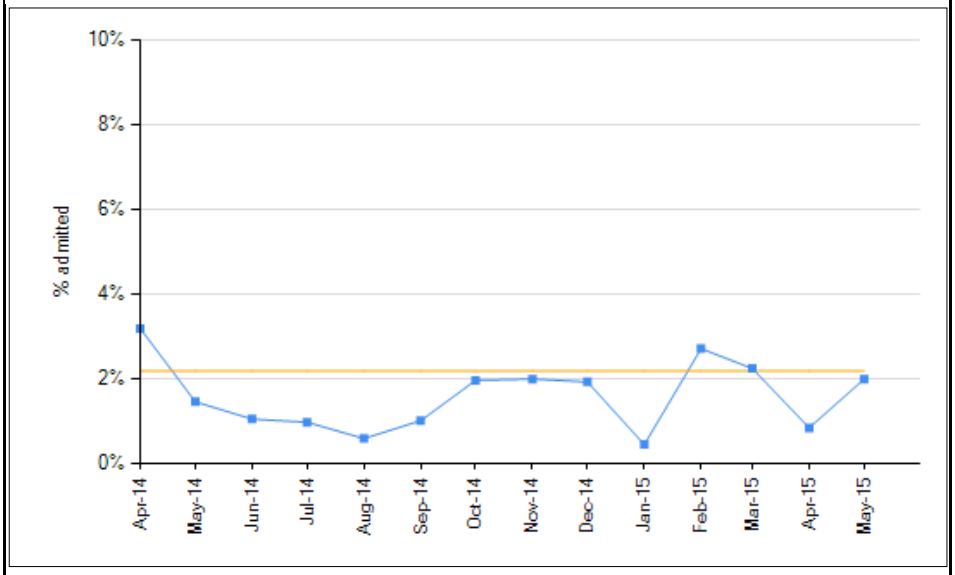
Elderly patients admitted on a non-elective basis should be screened for dementia using a screening question and / or a simple cognitive test. Performance shown in this graph reflects figures submitted monthly to NHS England. These figures are derived from both EPR and local paper-based systems.

CE15 Number of unscheduled returns to theatre within 48 hours [NOTSS Division - NOC Site]	Narrative
	During May there was one unscheduled return to theatre. The patient returned due to a fall on the ward which resulted in a broken kneecap. The patient had been advised by staff not to move, but this advice was not adhered too. As a result the patient returned to theatre for repair surgery of the broken knee.

The chart shows the actual number of unplanned returns to theatres within 48 hours per month. All returns to theatres are reported on Datix for the division. The returns within 48 hours are extracted from the system and reviewed as an outcome indicator.

CE18 Neuroscience Intensive Therapy Unit (NITU) readmission rate within 48 hours of discharge [NOTSS Division]	Narrative
	Four patients were readmitted to NITU in May. The service is reviewing the 'follow-up' provision that it provides for discharged patients however review of these cases suggests that they were not predicatable and could not have been prevented. The unit had over 100% occupation in May and capacity was stretched, but the unit was able to admit the patients with urgent need.

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.

CE21 7 day admission rate following assessment on (and discharge from) paediatric CDU [C&W Division]	Narrative
	Individual cases are currently being analysed. There have been no changes to treatment protocols or staffing to explain the increase.
Number of patients discharged from CDU and number who are readmitted as emergency inpatients within 7 days to a ward other than CDU.	

2.7. Quality Indicator PS11 – Total number of newly acquired pressure ulcers (category 2, 3 and 4) reported via Datix – Is usually reported more than one month in arrears. In this reporting round the figure for May has also been reported with April figures. None of the Grade three pressure ulcers acquired in hospital show evidence when reviewed of being avoidable. There were no Grade Four pressure ulcer incidents reported in May.

3. Patient Safety and Clinical Risk

3.1. Clinical Risk

3.1.1. Table 1 shows that 14 Serious Incidents Requiring Investigation (SIRI's) have been notified to the Oxford Clinical Commissioning Group (OCCG) in May 2015.

Table 1

SIRI ref	Division	Description
2015/047	MRC	Fall from bed resulting in a fractured hip
2015/048	C&W	Milk peritonitis from a Gastrostomy
2015/049	CSS	Missed lung cancer

2015/050	MRC	Burns during surgery
2015/051	Estates S&O	Major power failure
2015/052	S&O/CSS	Theatre availability leading to death
2015/053	MRC	Lack of management plan on discharge
2015/054	S&O/CSS	Theatre availability leading to palliative care
2015/055	NOTSS	Grade 3 pressure ulcer
2015/056	MRC	Grade 3 pressure ulcer
2015/057	MRC	Air introduced into the heart
2015/058	S&O	Grade 3 Pressure Ulcer to sacrum
2015/062	NOTSS	Failed follow up for eye clinic
2015/063	NOTSS	Grade 3 Pressure Ulcer

3.1.2. SIRI investigations are categorised as either a category 1 or category 2 investigation, dependant on the type of event. All Never Event investigations are category 2 investigations, and therefore are kept open by the Commissioning groups until such time as all the actions and recommendations are implemented.

3.1.3. Seven SIRI reports were recommended to OCCG for closure during May 2015. Following internal closure of a SIRI report, the report is presented to the OCCG for agreement and endorsement of both the level and quality of the investigation and the appropriateness of the recommendations and actions to prevent a re-occurrence.

3.1.4. Due to the timeframe for closure meetings with the OCCG, not all reports will have been discussed within the closure month.

3.1.5. It was not possible to hold a SIRI closure meeting in May due to scheduling and unexpected illness. There are therefore two closure meetings scheduled for June with the expectation of closing a significant number of SIRI.

3.2. Executive Quality Walk Rounds

3.2.1. There were five Executive Quality Walk Rounds in June 2015. These are detailed in Table 2 below. One Walk Round was cancelled due to unavailability of the Non-Executive Director and will be rearranged to take place early in July

Table 2

Hospital Site	Areas Visited
John Radcliffe Hospital	Neuro Intensive Care Unit Surgical Emergency Unit 6E Level 7 Maternity Ward and Spires Midwife Led Unit Children's Radiology
Churchill Hospital	Sexual Health Department

3.2.2. Key issues with the potential to affect quality or patient experience identified during the Executive Quality Walk Rounds included challenges surrounding recruitment and retention, the environment; particularly maintenance and Estates response times, and emergency theatre capacity.

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

4. Clinical Effectiveness

4.1. Clinical Outcomes - Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI)

4.1.1. The most recent Dr Foster data updates were published on the 20th May 2015. The Trust HSMR for the latest available 12-month data period of March 2014 to February 2015 is 103.2. This HSMR value is 'within expected' range (confidence limits 98.8 to 107.7) when compared to hospital trusts nationally and taking into account the Trust case mix

4.1.2. The HSMR has increased from 101.8 reported in the previous update for the 12-month data period January 2014 to December 2014. While the 'expected' values for the Trust have changed minimally between the two data periods (from 2,019.8 to 2,023.2), the number of deaths observed for the 56 HSMR diagnosis groups increased by 31 (from 2,057 to 2,088) increasing the ratio of observed to expected cases and therefore the HSMR.

4.1.3. OUH subscribes to Dr Foster Intelligence, a database that allows the trust to horizon scan for adverse mortality rates. It notifies via alerts if mortality is two standard deviations from the mean. The Dr Foster unit at Imperial College issues mortality outlier notifications if an area/disease group is three standard

deviations from the mean. They notify the trust via the CEO. OUH has not received any Dr Foster outliers this year.

4.1.4. There are two new Dr Foster mortality alerts:

- **Other perinatal conditions**, this diagnosis group has a significantly higher than expected relative risk of mortality, with 43 observed compared to 29.4 expected cases
- **CABG (other)**, this procedure group has a significantly higher than expected relative risk of mortality, with 8 observed compared to 2.8 expected cases

4.1.5. An initial analysis of the new Dr Foster mortality alerts has been completed by the Trust Clinical Governance team and discussed with the respective specialties. Dr Foster Intelligence have advised that patient-level and consultant-related details are not currently available on the Quality Investigator tool. The missing data is impeding the extent of investigations that may be completed at this time.

4.1.6. The next SHMI is due to be published in July 2015.

4.2. Mortality Review

4.2.1 The Surgery and Oncology Division are developing an electronic mortality database. A demonstration of the pilot version was held during the June 2015 Divisional Governance meeting. The database is designed to collate all information related to patient deaths, enable documentation of level 1 screening and level 2 mortality reviews, and permit the generation of reports. The database has been successfully piloted in the Surgery Unit. For the next phase of the pilot, the use of the database will be extended to the Gastroenterology and Renal Units.

4.3. The Clinical Effectiveness Committee (CEC) met on the 11th June 2015. The key points of discussion and presentations related to outcomes are summarised below.

4.3.1. **Dr Foster mortality alerts investigations (31st March 2015 updates)**
The investigations into the ‘cancer of other gastrointestinal organs, peritoneum’, and ‘secondary malignancies’ has been completed and investigation into ‘deficiency and other anaemia’ has been partially completed. There have been no avoidable deaths identified in the investigations completed. The Medical Oncology Unit identified one case, in the ‘deficiency and other anaemia’ investigation, with suboptimal care; but different management would have made no difference to the outcome (death unavoidable). This case was discussed at the Morbidity and Mortality meeting. The concerns identified related to a delay in transfusion, discrepancy over blood results, communication with family regarding end of life care and the wrong diagnosis having been recorded in the notes. There were clinical coding queries resultant from the ‘cancer of other

gastrointestinal organs, peritoneum' investigation. These have been reviewed by the Clinical Coding Manager and findings forwarded to the Division.

4.3.2. **Divisional Mortality Reports (Data period: Quarter 4 2014/2015)**
There was variable compliance with the Standardised Mortality Review process noted across the Divisions during quarter 4. The overall analysis of the Divisional quarterly mortality reports submitted for 2014/2015 indicates that 73% of patient deaths had a level 1 or level 2 mortality review completed. This represents an increase when compared to the results of a review of 2013 patient deaths which found that 48% of cases had a level 1 or level 2 review completed. CEC requested that clinicians identify the learning in mortality reviews for Divisional Clinical Governance meetings and for trust wide circulation.

4.3.3. **Mothers and Babies - Reducing Risk Through Audits and Confidential Enquiries across the UK (MBRRACE-UK): Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-2012, published December 2014**
The Unit reported that there were 3 maternal deaths for the 27 000 deliveries over the three year data period. The deaths related to amniotic fluid embolism, subarachnoid haemorrhage and severe pre-eclampsia. The Unit advised that the key actions were to standardise referral pathways for high risk pregnancy services and standard obstetric care, develop a maternal death guideline and epilepsy guideline, promote the use of MEOWS and continue to follow the Trust's policy for SIRI review (including maternal death).

4.3.4. **National Pregnancy in Diabetes audit (Data period: 2013 deliveries)**
The report related to the South East region not individual organisations. The Women's Directorate advised that local data is currently being collated alongside the national submission which will enable OUH results to be reported with the next audit publication. The results for the South East indicated that preconception care was good for women with Type 1 diabetes and neonatal outcomes were better in the region. CEC were advised that there were improvements required. There was poor diagnosis of Type 2 diabetes generally and women with Type 2 diabetes were less prepared for pregnancy.

4.3.5. **NCEPOD Tracheostomy complications, 'On the Right Trach? (Data period: 25/2/2013-12/5/2013, report published 13th June 2014)**
CEC were updated on the work streams the Tracheostomy Steering Group are currently involved in. These relate to Tracheostomy care guidelines, reducing clinical risk, documentation and passports, patient information leaflets, discharge planning, care in the community, training and education.

4.3.6. **Orthopaedic Surgery Consultant Outcomes (sourced from National Joint Registry), Trauma service (published 28th October 2014)**
CEC were advised that the Trauma Service at the John Radcliffe (JR) and Horton General Hospitals (HGH) are low volume users of total hip

replacements. There were no clinical concerns identified. The service advised that some patient's had been added to the database prior to signing specific consent for this use of their data. Each patient affected has been written to and the Caldicott Guardian has been notified. The only identifier in the database is the NHS number, with no accompanying patient demographics. The system for collection of data on both sites need improvement.

4.3.7. **Sentinel Stroke National Audit Programme (SSNAP), (October to December 2014 data; site specific reports for JR and HGH)**
CEC were advised that the JR overall SSNAP band is "C" and compared to national figures continues to perform above average in the majority of the 10 domains. The JR is due to conduct a stroke 'perfect week' to determine the barriers to flow through the pathway. There is on-going review of the Oxfordshire stroke pathway with the OCCG, OHFT and other stakeholders. The HGH overall SSNAP band is "D." HGH advised that the key actions were to improve audit compliance by capturing relevant data on "stroke initial review form" and increasing consultant / registrar input to data entry process. HGH are awaiting the Horton Acute medicine review and advise that consultant expansion may increase the proportion of patients seen within 24 hours of the clock start.

5. Infection Control

5.1. Introduction

5.1.1. This paper provides an update to the Board regarding cases of *Clostridium difficile* (C.diff), Meticillin Resistant Staphylococcus aureus (MRSA) bacteraemia and Cleaning audit compliance by Division for May 2015

5.2. Clostridium Difficile

5.2.1 The ceiling for 2015/2016 is 69 cases.

5.2.2. The four C.diff cases in May were discussed at the monthly Health Economy meeting held in June 2015, with representation from the Oxford Clinical commissioning Group (OCCG), Public Health England (PHE), Oxford Health and OUH Infection Control. It was agreed that all four cases were unavoidable, though actions were identified in terms of stool output documentation were not being met and therefore this should be fedback Trust wide through the Divisions to ensure that all patients have their stool output recorded on at least a daily basis.

5.2.3. The OUH remained below the cumulative limit for May and remains on track to meet the C.*diff* objective for 2015/2016. Table 3 below outlines the number of cases per month that are apportioned to the OUH Trust and Table 4 provides more detail for each case.

Table 3

	Apr 15	May 15	Jun 15	July 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
Total	3	4										
Monthly limit	5	6	6	6	6	6	6	6	6	6	5	5
Cum total	3	7										
Cum limit	5	11	17	23	29	35	41	47	53	59	64	69

Table 4

Speciality	Details of cases	Avoidable/Unavoidable Cases discussed 8/06/15
Trauma & Orthopaedics	Patient admitted in March 2015 who is a T4 paraplegic, presented with a right-sided trochanteric pressure sore which had been there for about six months developing osteomyelitis. March 2015 underwent elective surgery to excise the pressure ulcer, underlying tissue and affected bone followed by flap formation by plastics team. The patient had been receiving oral antibiotics for 3 months in the community, the antibiotics were stopped for 2 weeks pre-operatively and then ongoing antibiotics advised by the BIU team. The patient experienced ongoing loose stool although it was unclear if this may have been antibiotic related, but stool pattern changed with increased frequency oral vancomycin was commenced but a stool sample was not sent for further 4 days, patient was isolated in a side room.	**Unavoidable**
General Medicine	Patient admitted April 2015 with increased lumber pain and poor mobility, having been treated in community on 6 weeks of IV antibiotics for a spinal abscess. An MRI showed worsening abscess and microbiology were consulted regarding antibiotic choice and possible biopsy discussed with Bone Infection unit. Analgesia introduced and IV Antibiotics chosen to continue. Opiates and pain relief management varied to manage discomfort. May 2015 IV Antibiotics continued via a Peripherally inserted central line (PICC) line.	**Unavoidable**

	The patient was not tolerating food and vomiting, NG feed commenced and dietician involvement sought. Enema and laxatives were started as the patient felt to be constipated. Plan to stop IV ceftriaxone. Microbiology review Day 38/42 of IV Antibiotics. Suggest stop antibiotic and request biopsy for culture. Stool sample requested by team and sent, Type 7 stool continued, ward were informed of C.diff positive result, patient isolated within 2 hours and Drs informed. Antibiotics stopped and oral vancomycin commenced via NG Tube.	
General Medicine	Patient admitted to ED in April 2015 with two day history of pain in bones, rigors and some weight loss. Initially treated for urosepsis with Antibiotics. Further antibiotics were given for a chest infection and a second urosepsis. Became pyrexial 38.5, Bowels open type 6-7 3 x in 24 hours. Nursing staff sent a sample for C diff testing. No clinical review documented by medical staff. Documented by the nursing staff, 'Might need a side room as stool sample shows C diff positive awaits review. Oral vanc prescribed but was not given promptly, it is unclear if this was not available from pharmacy.	**Unavoidable**
Haematology	Patient lives in own home with partner, self-caring. Admitted in May for for chemotherapy for Burkitts. Found to be neutropenic on admission. Developed sudden onset of multiple type 6 stools, abdo pain and temperature spike. Haematology started Antibiotics for neutropenic sepsis, followed by a different antibiotic for possible neutropenic colitis. Stool sample sent to exclude C.diff on and Po vancomycin was commenced, following confirmation of a positive result. Patient Isolated within 1hr of ward being informed of positive sample, however not isolated beforehand as being treated for neutropenic colitis.	**Unavoidable**

5.3. MRSA bacteraemia

5.3.1. The OUH has a limit of '0' avoidable MRSA Bacteraemia for 2015/2016. There have been no MRSA Bacteraemia reported in May.

5.3.2. Table 5 below details the MRSA bacteraemia to date by speciality for 2015 / 2016

Table 5

Month	speciality	Avoidable/ unavoidable	Details of case/Lessons learned
April 2015	Haematology Churchill	Unavoidable	A Post Infection Review (PIR) meeting agreed that the MRSA bacteraemia was unavoidable due to the patient's neutropenia and chemotherapy treatment. The likely source of this MRSA bacteraemia was skin and soft tissue due to severe inflammation and ulcerations of the mucous membranes affecting the patient's nose and buttock region. If sepsis is suspected, line tips are processed if blood cultures taken at the same time are tested positive. On removal of the line, no line tip was sent to Microbiology for testing. Ensure clinical staff are aware of the requirement to send line tips together with blood cultures on suspicion of sepsis.

5.4. Cleaning audits

5.4.1. Clinical areas are required to achieve a minimum 92% Compliance with the monthly cleaning audit. Table 6 below details the average reported cleaning scores by division and by the OUH Quality Assurance Team (QAT).

Table 6

	May 2015		
Division	Quality Assurance Team audits	Domestic audit scores	Nursing audit scores
Neurosciences, Orthopaedics, Trauma & Specialist Surgery	82%	99%	95%
Medicine, Rehabilitation & Cardiac	89%	93%	98%
Children's and Women's	89%	93%	94%

Surgery & Oncology	89%	93%	92%
Clinical Support Services	83%	94%	96%
OUH total	**86%**	**94%**	**95%**

5.5. MRSA Screening Compliance

5.5.1. The trust achieved 54% compliance with MRSA screening, 79% for elective admissions and 49% for emergency admissions. Clinical areas with high turnover of patients have lower compliance with screening emergency admissions. Table 7 below details the compliance with emergency and elective MRSA screening by division and by the OUH Quality Assurance Team (QAT).

Table 7

	May 2015		
Division	Percentage Screened Electives	Percentage screened emergencies	Percentage of Patients screened
Neurosciences, Orthopaedics, Trauma & Specialist Surgery	85%	59%	72%
Medicine, Rehabilitation & Cardiac	77%	47%	48%
Surgery & Oncology	69%	45%	49%
Clinical Support Services	62%	86%	68%
OUH total	**79%**	**49%**	**54%**

5.6. Conclusion

5.6.1. The OUH Trust remains within its objective for *Clostridium difficile* 2015/ 2016 to date. One MRSA bacteraemia has been reported by the OUH to date (at the point of publication of this report).

5.6.2. MRSA screening for emergency admissions continues to show low compliance. Clinical areas, particularly those within the NOTSS Division, continue to struggle to achieve a 92% compliance with the QAT cleaning audit

6. Friends and Family Test

6.1. Inpatient, ED and Maternity response rates:

6.1.1. National comparison: NHS England has noted that response rates have reduced across all areas. They attribute this to:

- The wider roll out of the FFT in acute care settings (including day cases, walk in centres, minor injury units)
- The introduction of the FFT for children and young people.
- The withdrawal of CQUIN payments for achieving certain response rates for FFT.
- The removal of token methods as a means of providing FFT feedback.

6.1.2. The following sections of the report detail the inpatients and day cases response rates:

6.1.3 OUH: the percentage of patients who would recommend our services has remained consistent with the previous indicator on inpatients only; while response rates have fallen to around 8% with the inclusion of day cases in the inpatient reporting requirements. This trend is reflected in all divisions. The response rate is expected to increase following the implementation of texting and interactive voice messaging. NOTSS division has the lowest percentage of patients that would not recommend their care (0%), but also the lowest percentage that would recommend their care (96%); 4% (11 respondents) said they were neither likely nor unlikely to recommend their care. Themes within these comments were that overall care was good but there were not enough staff.

6.1.4. National comparison: the percentage who would recommend their care in the Trust (97%) remains above the national average (96%), while the response rate (8%) is much lower than the national average (26%). The NHS Trust with the highest response rate (65%) is West Hertfordshire Hospitals NHS Trust, which uses paper based questionnaires handed out on discharge. Of the 14 Trusts with a response rate above 50% and more than 100 eligible patients, 7 use paper based questionnaires distributed on discharge, 2 use electronic devices, and 4 use mixed methods (including paper questionnaires, electronic devices, text messaging and telephone surveys).

6.1.5. The following sections of the report detail the Emergency Departments (EDs) response rates:

6.1.6. OUH: The response rate remains low in May (2%), which means the scores are unreliable as the views of the respondents may not be representative of the overall sample group. The percentage who would recommend their care in May (81%) has declined since April (90%). Text messaging and interactive voice messaging resumed on 9th June 2015, at the time of writing this report it is 24%. The OUH Trust will recommence texting which is expected to improve the response rate to the rates previously seen when texting was used.

6.1.7. National comparison: nationally, response rates have dropped since March 2015 (from 23% in March to 15% in May). The reasons are outlined above.

6.1.7. The following sections of the report detail the Maternity response rates:

6.1.8. OUH: The percentage who recommended their care remains constant since April, as does the response rate. The response rate now relates only to the question asked about labour and birth[1], which tends to have a good response, possibly because of the significance of that stage of care, or because of the systems and processes (all women are given a questionnaire with their information pack, and there are comment boxes around the site to make it easy to respond).

6.1.9 There are some additional questions on the friends and family test for maternity:

- During your labour and birth, were you always treated with dignity and respect? 95% of patients said yes, always
- Have you been given information about local antenatal or parent education classes? Of those who said they wanted or needed this information, 76% said they had been given it.
- Did you feel midwives and other health professionals gave you consistent advice about feeding your baby? 78% said yes, always.

6.1.10. National comparison: maternity has shown the smallest decline in response rates in the types of services nationally, which also reflects the OUH results. This may be because the factors listed in section 8.1 above do not apply to maternity services.

6.1.11. Outpatients: 97% of outpatients recommended their care in May, an increase to previous scores after a decline in February. The numbers of responses are low (n=351) so it is unlikely that that this change is significant. Response rates are not reported.

6.1.12. Electronic feedback:There has been a further delay to the project to implement texting and interactive voice messaging in outpatients and day cases, due to concerns over the sensitivity of a text message or phone call to ask for feedback if the patient has received bad news at their appointment. The patient experience team are consulting with patients about their view and with other Trusts about their practice for excluding groups of patients.

6.1.13. The realistic commencement date for texting is 1 August 2015; however this will be backdated to include appointments from 30 June 2015. The Trust received the following feedback from six Trusts about whether they exclude some groups of patients from SMS and phone surveys:

- Most of the Trusts included outpatients and the emergency department. None included children.
- 3/6 Trusts did not exclude any patients. Overall, Trusts said that there were few exclusions from the SMS/phone survey on the grounds of sensitivity, as patients' views on these consultations were particularly important.
- Of the three that did exclude some patients, two excluded women who had a miscarriage, one excluded antenatal appointments, one excluded end of life care.

[1] The nationally reported numbers have changed. The chart in the dashboard has been updated to reflect this.

- Trusts said it was at the clinician's discretion to judge the sensitivity of the situation and discuss with their patient if they wanted to be included.
- None of the Trusts had had any formal complaints, but one Trust had been featured in a national newspaper article where the husband of a women who had had a miscarriage in A&E found the text message they received insensitive.
- All Trusts had carefully considered whether some patients needed to be excluded, and in most cases, the decision had been made by the Chief Executive and Chief Nurse.

6.2. Carers' Feedback

6.2.1. The Carers' Questionnaire is being piloted for three months between June, July and August on the Post-Acute Unit (PAU), Stroke Unit and Adams and Bedford Ward. The questionnaire has been co-produced with Carers Voice and Carers Oxfordshire; and incorporates the national 'John's campaign' logo. This was implemented from 1 June 2015 by the ward volunteers and with support from Carers Oxfordshire and Carers Voice.

6.2.2. The feedback during the development phase has been that carers are more likely to give feedback when engaged in conversation rather than by being directed to a feedback form. The feedback from carers will be included in the monthly Board Quality Report (BQR) from August 2015.

6.3. Complaints

6.3.1. The number of new complaints received during May has increased to 100 and is an increase from 89 for the two previous months.

6.3.2. There were no red graded complaints received in May 2015.

6.3.3. The graphs in the dashboard present the complaints coded by the top five subjects for April and May 2015 by Division. Each Division also has a small number of complaints that have been coded in the graph as 'Other'. This is because they represent much smaller numbers of complaints. Across the divisions, these complaints included two regarding consent, four surrounding end of life care, 15 surrounding the Trusts' Facilities, five in relation to the prescription of medication one for transport, four surrounding Trust Administration and one for waiting times.

6.3.4. These are being addressed by the Divisions as part of normal complaints response.

6.4. Admission and Discharge

6.4.1. There were 22 (22%) complaints across three divisions relating to admission and discharge. These complaints were in NOTSS (Specialist Surgery, (ENT and Eye Hospital) and Neurosciences) MRC (across the division) and S&O (Upper and Lower GI).

6.4.2. NOTSS complaints related to 18 week Referral to Treatment (RTT) time with both NOTSS and S&O complainants expressing concern at

procedures being cancelled either due to other priority patients or a lack of availability of beds.

6.4.3. In contrast the MRC complaints related to discharge and particularly to transport, delayed treatment, health of patients when they were discharged and delayed discharge.

6.5. Appointments

6.5.1. There were 10 (10%) complaints in total relating to appointments. These complaints were in NOTSS, CSS and S&O; and specifically within ENT, the Eye Hospital, Pain Management Service, Urology and Oncology.

6.5.2. The NOTSS complaints related to delays in being given an appointment, with S&O and the Pain Management Service relating to cancelled appointments. Additionally S&O complaints related to methods of making an appointment and communication regarding appointments.

6.6. Clinical treatment

6.6.1. There were 32 (32%) complaints for NOTSS, C&W, MRC and S&O in relation to clinical treatment, outcome of care and patient care. A large number of these questioned the decision making of clinicians in relation to care and treatment planning, delay in treatment, advice following a procedure, how a procedure was conducted, liaison with other clinical teams and families.

6.6.2. The NOTSS complaints regarding treatment were across the division; C and W's complaints were within Gynaecology, obstetrics and children's services; MRC's complaints were surrounding clinical treatment in the Emergency department, Geratology, Physiotherapy and Infectious diseases; S&O's complaints related to Urology.

6.6.3. Of these, 17 were identified as high risk (previously defined as orange complaints), 14 as moderate risk (previously defined as yellow) and one low risk (previously defined as green).

6.7. Communication

6.7.1. There were 17 (17%) complaints for NOTSS, MRC and CSS relating to communication. The complaints focused on different aspects of communication: The NOTSS complaints related to insufficient or no information, or a delay in receiving results.

6.7.2. MRC's complaints surrounded communication with families and patients and the CSS complaints related on accurate reporting, plain English letters and sensitive communication regarding the outcome of a scan and appointments.

6.7.3. The NOTSS complaints were for Neurosciences, spinal service and prosthetics. The MRC complaints were for Acute General Medicine (AGM), Diabetes and Dermatology and the CSS complaints were for Radiology and Imaging.

6.8. Attitude of staff

6.8.1. There were eight (8%) complaints for MRC, NOTSS, CSS, Corporate and S&O relating to the attitude of staff.

6.8.2. The complaints included both clinical and non-clinical staff; and working with patients and families when listening to their concerns.

6.8.3. Some of the patients and families making these complaints were very unwell and were receiving complex care.

6.9. Facilities

6.9.1. There were four (4%) complaints relating to facilities. These were for car parking and smoking.

6.10. Single complaints

6.10.1. There were seven (7%) complaints which have not been reported because they are potentially identifiable.

6.11. Managing complaints

6.11.1. The Trust achieved 94% (n=94) of all complaints received in May that were acknowledged within the target of three working days. This is below the Trust's performance target of 95%. The reasons for not achieving the required target are because an increase in the number of complaints received in May (n= 100). This is an increase of 11 from the previous month. In addition there have been some staffing issues within the complaints team which have now been resolved.

6.11.2. From April 2015, all formal complaints received have been recorded on the new complaints module. This system is compatible with the incident management and legal services systems. The system still requires some modifications to ensure all data can be recorded and reported accurately. Analysis of the complaints will be modified for future reports.

6.11.3. All NHS Trusts are required to use the new national complaints codes from 1 April 2015. This coincides with the changes in the national complaints KO41a data submission and will allow more accurate benchmarking. The complete coding list is presented in Appendix three. The codes enable Trusts to have a more detailed breakdown and overview of the types of complaints and as such give a greater opportunity to understand the nature of patients concerns.

6.11.4. The graphs in the dashboard present the complaints coded by the top 5 subjects for April and May 2015 by Division. Each Division also has a small number of complaints that have been coded in the graph as 'Other'. This is because they represent much smaller numbers of complaints. Across the divisions, these complaints included two regarding consent, four surrounding end of life care, 15 surrounding the Trusts' Facilities, five

in relation to the prescription of medication one for transport, four surrounding Trust Administration and one for waiting times.

6.11.5. The annual complaints submission (KO41a) for NHS England and the Department of Health has been collated and was submitted on 7 May 2015. The number of Trust's complaints increased by 13.7% during the financial year 2014/15 and importantly this was proportionally more than the Trust's annual activity. The national data is not yet available benchmark with other Trusts. This will be important analysis to undertake to understand if this increase is a national trend. The national Health and Social Care Information Centre (HSCIC) report is expected to be published in August 2015 and therefore it is envisaged that this analysis will be included in the Trust's annual PALS and Complaints report on 9 September 2015.

6.11.6. The number of reopened complaints for April and May is included in this month's report. S&O (34%) and CSS (22%) divisions proportionally had the highest number of reopened complaints in Quarter 4 in comparison to the number of new complaints received for the same quarter. S&O have not received any requests to reopen any complaints for previous two months. There doesn't appear to be a pattern to the number of type of complaints needing to be reinvestigated. Some complainants only require further clarification on one or more points which they don't feel where answered fully in the original response and others request a further investigation.

6.11.7. It is important to monitor re-opened complaints to ensure the Trust is working to investigate and resolve the complaint as quickly as possible. Of these 19 re-opened complaints 18 across the two divisions have now been resolved and closed. The reasons for re-opening the complaints include further questions, further difficulties with treatment, requests to meet with clinicians following the Trust letter outlining the investigation.

7. Quality Account

7.1. The annual Trust Quality Account has been prepared in line with regulations, and guidance issued by the Department of Health.

7.2. A programme of internal and external consultation was undertaken to ensure the publication date of 30th June 2015 was met. Key milestones are shown in the table overleaf.

KEY DELIVERABLES					
	Feb-15	**Mar-15**	**Apr-15**	**May-15**	**Jun-15**
Requests for information	12-Feb				
Engagement meeting with Health Watch re: Quality Priorities		18-Mar			
1st Draft to CGC		18-Mar			
1st Draft to Executive + Non-Executive Directors		23-Mar			
1st Proof read			01-Apr		
2nd Draft to QC			15-Apr		
2nd Proof read			20-Apr		
2nd Draft to CCG, HWB, H&WBB, HOSC			23-Apr		
Workshop (TBC) by HWO to discuss QA				Early May	
2nd Draft returned from CCG, HWB, H&WBB, HOSC				Early May	
Typesetting by OMI				Early May	
2nd Draft to Auditors				Mid May	
3rd Proof read				Mid May	
OMI for statements + amendments				25-May	
Indicator testing by Auditors					Early Jun
Final sign-off by QC					10-Jun
Final version to Auditors					By 15-Jun
Final proof read and corrections to typeset version					20-Jun
Draft back from Auditors with their statement					By 29-Jun
OMI paste Auditors statement					29-Jun
Publish: NHS Choices, OUH website, copy to Secretary of State					30-Jun

7.3. The priorities below in Table 8 have been proposed for the forthcoming year. They have been aligned with national CQUINs, goals in the Trust Quality Strategy, Annual Report, National Audit Reports and feedback from our service users and Health Watch Oxfordshire.

Table 8

Domains	Annual Priorities for the Trust
PATIENT SAFETY	Preventing avoidable patient deterioration and harm in hospital: *Sign up for Safety*
	Partnership working to improve urgent and emergency care
	Improving recognition, prevention and management of acute kidney injury
CLINICAL EFFECTIVENESS	Learning from deaths and harms to improve patient care
	Management of patients presenting with sepsis
PATIENT EXPERIENCE	End of life: improving peoples care in the last few days and hours of life
	Improving communication, feedback, engagement and complaints management: *with patients, carers, health care staff and social care providers*

7.4. An early draft of the Quality Account was circulated to the Executive and Non-Executive Directors on 24 March 2015 for comments, particularly with regard to the priorities proposed for 2015/16.

7.5. A second full draft of the Quality Account was presented to the Quality Committee on 15 April 2015 to approve before it was released for external review.

7.6. There have been no changes to the regulations regarding the external audit process for this document. This work was carried out by Ernst and Young as in previous years. A disclosure list was provided by Ernst and Young to assist with the collection of prescribed information. The external audit process entailed:

7.6.1 Reviewing the content of the Quality Account for its compliance with relevant regulations

7.6.2 Reviewing the content of the Quality Account to ensure that it is consistent with other specified information

7.6.3 Undertaking substantive sample testing on two indicators

- Percentage of patient safety incidents resulting in severe harm or death
- Rate of Clostridium difficile per 100,000 bed days

7.6.4 Providing the Trust with a Limited Assurance Report

7.7 The assurance report noted one inaccuracy in the data in the quality account related to reporting of incidents with moderate or greater harm on the NRLS national reporting system. 14 of the 25 incidents reported as major or catastrophic were downgraded in their severity to moderate or below following investigation and agreement with OCCG. The NRLS system was not however updated by the Trust. The effect of this is that the Nationally reported rate of major or catastrophic incidents was 0.3% of all incidents for OUH whereas the revised figure should have been 0.1%. A comment to this effect has been added to the account by the audiotors. Administrative processes have been ammneded to prevent a repetition of this error.

7.8 The final draft of the Quality Account was presented to the Quality Committee on 10 June 2015 for approval under delegated authority of the Trust Board, and was duly signed off.

7.9 The Quality Account was published on 30 June 2015 in line with the national requirement and is available on the OUH website at

http://www.ouh.nhs.uk/about/publications/documents/quality-account-2015.pdf

8. Safe Staffing - Nursing and Midwifery

8.1. The Trust is required to comply with The National Quality Board (NQB November 2013) and NICE guidance (July 2014) for Safe Staffing for Adult Inpatient Wards in Acute Hospitals. This includes, providing reports to the

Trust Board/Quality Committee 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.

8.2. This report includes the safe staffing data for May 2015 and the metrics against each of the 5 divisions (appendices 4 a, b, c, d & e), which incorporates Nurse Sensitive Indicators (NSI), for the months of March - May 2015, by division, against the Trust metrics. The overall Trust wide safe staffing report including individual wards and shifts is highlighted in appendix (appendix 4f)

8.3. It should be noted that these metrics **only apply to the in-patient clinical areas** that the Trust is required to report on, and so this data is likely to be different to other trust metrics that may be inclusive of day and outpatient areas.

8.4. National reporting

8.4.1. The summary of the figures submitted to NHS Choices via the Unify platform for May 2015 are included below but can be accessed via the Trust website on (http://www.ouh.nhs.uk/about/saferstaffinglevels.aspx).

8.4.2. 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.

8.4.3. The May 2015 fill rates are:

- 96.06% for Registered Nurses/Midwives
- 96.90% for Care Support Workers (unregistered)

8.5. Update on national imperatives for Safe Staffing

8.5.1. **Care Contact Time** is a national requirement from mid-summer 2015, and requires the measurement of the proportion of time Registered Nurses and Care Support Workers on wards spend in direct and indirect patient contact care activities. This is a means of measuring the amount of time within a shift that patients' receive direct care. The Trust is currently piloting the Manchester Clock system which requires nurses and CSWs to record their activities at 5 minute intervals for a shift in the week as well as at a weekend. This will be collated to report on the percentage of time staff spend with patients in direct and indirect care i.e. speaking with families and planning discharges. All wards will undertake this process at least once a year, or if there is a change in the patient group or services.

http://www.england.nhs.uk/wp-content/uploads/2014/11/safer-staffing-guide-care-contact-time.pdf

8.5.2. **Safe Staffing** NICE guidance for A&E and Midwifery will proceed in implementation although all other NICE guidance with respect to staffing in

specialist areas has been brought to a halt currently through government directive.

8.6. Update on developments within the Trust

8.6.1. The Acuity and Dependency review of staffing establishment levels was undertaken manually in January 2015 for two weeks. This demonstrates that the vast majority of clinical in-patient areas have appropriate staff establishments, although there are three areas highlighted that require further reconfiguration and investment in order to address the quality of care issues and changes in service activity. This case for change was presented and approved at the Trust Management Executive in May 2015.

8.6.2. The nursing levels are monitored constantly and mitigation addressed through the almost constant movement of staff and use of non-ward based staff for whole or part shifts.

8.7. Electronic patient acuity tool

8.7.1. A permanent electronic acuity measurement tool that incorporates all aspects of safe staffing reporting and meets the NICE and NQB specifications, has been procured and is currently in the initial stages of configuration and roll out across the Trust. This will replace the temporary system currently in place, and provide a more comprehensive daily reporting system of safe staffing against establishments, as well as daily acuity levels for every patient. It has the capability to escalate automatically to senior nursing staff, providing a more reliable monitoring and reporting system, including the proportion of temporary staff and skill mix on the wards on a daily basis.

8.8. Current status of nursing and midwifery staffing within the Trust

8.8.1. The Trust continues to have a high percentage of nursing vacancies throughout the Trust and as a result utilises high levels of temporary staffing. The overall levels of minimal staffing remains a challenge particularly on day shifts and a proportion of beds in key areas of escalation have been closed, although most were reopened in May.

8.8.2. It should be noted that the initial impact of the EU nurse recruitment programme is beginning to be realised with a gradual increase in the levels of 'Agreed' staffing in all divisions month on month. The EU recruitment is shortly to cease for the summer and following a review of the vacancies, a focus on recruitment will be made particularly in specialist areas and areas with a consistently high turnover rate. Recruitment during the summer holiday period in the EU is very limited, so this will re-recommence in September.

8.9. Twelve month overall trend review of staffing levels in the Trust - April 2014 – March 2015

8.9.1. This report also includes a 12 month analysis (appendix 5a&5 b) of the staffing data including the trends of the Nurse Sensitive Quality Indicators.

8.9.2. **Staffing metrics (appendix 5a)** - The trend for the staffing metrics indicates that the overall levels of 'agreed to establishment' staffing has gradually begun to increase in the last two months, although the current data presented is only until March 2015. This is due largely to the level of EU nurse recruitment.

8.9.3. However the 'agreed levels' of staffing include significant levels of bank and agency staff who are requested largely for the primary reason of vacancies, and other secondary issues such as short notice sickness. The quality of the skill mix therefore is diluted as agency staff, who do not operate to the same level of their licence owing to lack of familiarity with specialties i.e. chemotherapy, and cannot operate the electronic systems of the Electronic Patient Record or medication administration to the same level, although training is being put in place. This places much more pressure on the substantive staff on the shifts.

8.9.4. It is also notable that over the twelve months the levels of maternity/paternity/adoption leave is at 3.4%, which is not covered in the uplift and the overall sickness rate is 4.1%.

8.9.5. Study leave based on 6 days over the year and an average of 7 weeks leave for staff, results in an additional 7.4%, which equates to a total of 23.5%. The uplifts vary from 18% - 21% across the divisions.

8.9.6. In addition to this the current overall nursing vacancy rate for inpatient clinical areas is 12%. The outcome has been an overall dependency on temporary staffing, which over time impacts on the resilience of the systems and permanent clinical staff in post.

8.9.7. The night shifts are more attractive to temporary staff due to the increased rates of pay and suitability for child care reasons, resulting in better levels of 'agreed staffing'. The challenge remains to cover the day and in particular the afternoon shifts. There is a 'shift unfilled rate' for temporary staff requests, and this causes significant and consistent levels of minimal staff levels.

8.9.8. The newly procured Integrated Patient Monitoring System (IPAMS), is an electronic tool for measuring safe staffing and patient acuity, and this will provide more detailed reporting on the exact levels of temporary staff against the acuity levels of patients, within the overall establishment of staff, with automatic escalation at a pre-determined threshold.

8.9.9. **Nurse Sensitive Indicators (appendix 5b)** - There have been consistent levels of medication errors, all categories of Hospital Acquired Pressure Ulcers (HAPUs) and all falls, although the changes in the processes of visual validation by the Tissue Viability Team for the category 3 & 4 HAPUs, has provided more accurate data, that excludes moisture lesions and varicose ulcers for instance, and this has resulted in an apparent drop in category 3 & 4 HAPUs since November 2014.

8.9.10. In addition, the levels of high impact falls causing moderate or catastrophic harm have reduced significantly due to the implementation of the Fallsafe Care Bundle in some divisions, with plans for wider roll out across the Trust.

8.10. Conclusion

8.10.1. The first year of data collection of safe staffing metrics and Nurse Sensitive Indicator data has been gradually refined and triangulated. The Nurse Sensitive Indicators provide the divisions with intelligence on the effect of variations in levels and skill mix of staffing in relation to the quality of care.

8.10.2. The processes of reporting and gaining more refined data will provide greater context, through the implementation of the new patient acuity tool, which will provide continuous daily indicators and automatic escalation. It is anticipated that this will provide improved trend data upon which the Trust can act more intuitively with increased transparency.

9. Kirkup Report 2015 – GAP Analysis of Maternity Services

9.1. An overview of the recommendations from the Kirkup report, and a gap analysis for the Trust, has been submitted for consideration by the Board [reference P*aper* ***TB2015.86***].

10. Recommendations

10.1. The Trust Board is asked to receive this Board 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

29 June 2015