Oxford University Hospitals NHS
NHS Foundation Trust

Trust Board Meeting in Public: Wednesday 11 November 2015

TB2015.126

Title	**Board Quality Report**

Status	**For discussion**
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 and Ms Catherine Stoddart, Chief Nurse**			
Key purpose	Strategy	**Assurance**	Policy	Performance

Executive Summary

1. The Board Quality Report 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:

- For eight 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, Division-specific information that contributes to organisational results is presented in dashboard format within Appendix One.

3. In relation to Patient Safety and Clinical Risk:

- 13 Serious Incidents Requiring Investigation (SIRIs) were reported in September.
- Three incidents meeting the criteria for reporting as Never Events were reported in September 2015; one occurred in August, one in September and one was a delayed report of an incident in the prior financial year (January 2015).
- 19 SIRIs were recommended for closure to Oxfordshire Clinical Commissioning Group (OCCG) in September with three being closed with the OCCG during a closure meeting.

4. In relation to Infection Control:

- The OUH NHS Foundation Trust remains below the upper ceiling for *Clostridium difficile* 2015 – 2016 to date.
- Actions are in progress to raise Elective and Emergency MRSA Screening compliance rates Trust wide.

5. In relation to Patient Experience:

- The percentage of patients who would recommend OUH to friends and family in September remains constant at 96-97%.
- The percentage of patients treated as day cases who would recommend their care in the Trust in July (96.0%) is similar to the national average (95.5%).

6. In relation to Safe Staffing:

- This report provides the Trust Board with an update on professional nursing and midwifery national imperatives, reports and efficiencies impacting on the Trust, including:
  - The electronic Integrated Patient Acuity Monitoring System
  - Care Contact Time
  - Implications related to safe staffing following the CQC inspection at Cambridge University NHS FT

- The report includes a summary of the September 2015 Unify submission of staffing for actual levels against planned levels. This is in terms of numbers/percentages, but it has limitations in providing a very uni-facetted view of staffing, that does not include skill mix, level of experience or skill set

- The bi-annual audit of in-patient acuity across the Trust; results taken during a 2 week snapshot in July 2015. There is no indication for change but close monitoring of Nurse Sensitive Indicators in some clinical areas.

- Current status of nursing & midwifery staffing across the Trust including the 6 dashboards

- Nursing & Midwifery revalidation – and update on the NMC requirements, the electronic tool the Trust is developing, the level of Trust preparedness, implementation plan and KPMG audit for assurance

Recommendation

The Trust Board is asked to receive and discuss this report.

1. Purpose

1.1. This paper aims to provide the 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 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 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. The graphic below details the eight indicators that have deteriorated against target since the last reporting cycle. Each is provided with a narrative explanation for this drop in performance, and actions being taken to address.

2.5. The following three indicators have seen an improvement in performance against target thresholds since the previous reported period:

CE03 – Dementia: The % of patients aged >75 admitted as an emergency who are screened,

CE04 – Dementia diagnostic assessment and investigation, and

CE15 – Number of unscheduled returns to theatre within 48 hours.

Table One

BQR ID	Rating	Rating Last Period	Descriptor	Period	Threshold Source	Red	Amber
PS01	96.58% Green	Green	Safety Thermometer (% patients receiving care free of any newly acquired harm) [one month in arrears]	Sep 15	Internal	95%	97%
PS02	92.22% Green	Green	Safety Thermometer (% patients receiving care free of any harm - irrespective of acquisition) [one month in arrears]	Sep 15	Internal	91%	93%
PS03	96.91% Green	Green	VTE Risk Assessment (% admitted patients receiving risk assessment)	Aug 15	National	95%	95.25%
PS04	13 N/A		Serious Incidents Requiring Investigation (SIRI) reported via STEIS	Sep 15		N/A	N/A
PS05	30 Green	Green	Number of cases of Clostridium Difficile > 72 hours (cumulative year to date)	Sep 15	National	35	N/A
PS06	2 Red	Red	Number of cases of MRSA bacteraemia > 48 hours (cumulative year to date)	Sep 15	National	1	N/A
PS07	93.53% Amber	Green	Antibiotic prescribing - % compliance with antimicrobial guidelines [most recently available figure, undertaken quarterly]	Jul 15	Internal	93%	95%
PS08	62.93% Red	Red	% patients receiving stage 2 medicines reconciliation within 24h of admission	Sep 15	Internal	75%	85%
PS09	100% Green	Green	% patients receiving allergy reconciliation within 24h of admission	Sep 15	Internal	94%	96%
PS10	1.9% Green	Green	% of incidents associated with moderate harm or greater	Sep 15	Internal	6.5%	5%
PS11	67 N/A		Total number of newly acquired pressure ulcers (category 2,3 and 4) reported via Datix	Aug 15		N/A	N/A
PS12	5 Green	Green	Falls leading to moderate harm or greater	Sep 15	Internal	8	7
PS13	25.81% N/A		Cleaning Score - % of inpatient areas with initial score > 92%	Sep 15		N/A	N/A
PS14	98.79% Green	Green	% radiological investigations achieving 5 day reporting standard [CSS Division]	Aug 15	Commissioner	95%	98%
PS15	7 N/A		Number of CAS alerts received	Sep 15		N/A	N/A
PS16	0 Green	Green	CAS alerts breaching deadlines at end of month and/or closed during month beyond deadline	Sep 15	Internal	1	N/A
PS17	2 Red	Red	Number of hospital acquired thromboses identified and judged avoidable	Sep 15	Internal	1	0
CE01	0.99 N/A		Standardised Hospital Mortality Ratio (SHMI) [most recently published figure, quarterly reported as a rolling year ending in month]	Dec 14		N/A	N/A
CE02	201 N/A		Crude Mortality	Sep 15		N/A	N/A
CE03	82.81% Amber	Red	Dementia - % patients aged > 75 admitted as an emergency who are screened [one month in arrears]	Aug 15	National	80%	90%
CE04	91.48% Green	Amber	Dementia diagnostic assessment and investigation [one month in arrears]	Aug 15	Internal	80%	90%
CE05	100% Green	Green	Dementia :Referral for specialist diagnosis [one month in arrears]	Aug 15	Internal	80%	90%
CE06	90.59% Amber	Amber	ED - % patients seen, assessed and discharged / admitted within 4h of arrival	Sep 15	National	85%	95%
CE07	89.47% Green	Green	Stroke - % patients spending > 90% of admission in specialist stroke environment	Sep 15	National	70%	80%
CE08	73.68% Red	Green	Stroke - % patients accessing specialist stroke environment within 4h of arrival	Sep 15	National	75%	85%
CE09	6.7 Amber	Green	Vascular - Mean length of stay for patients undergoing elective AAA repair (3 month rolling period) [NOTSS Division]	Aug 15	Internal	8	5

CE10	7.41% Red	Amber	Vascular - % mortality following elective AAA repair [NOTSS Division]	Aug 15	Internal	5%	3%
CE11	90% Green	Green	Cardiology - % patients receiving primary angioplasty within 60 minutes of arrival at hospital [MRC Division]	Aug 15	Internal	85%	90%
CE12	2.1 Amber	Green	Cardiology - Mean number of days from referral to admission to cardiology at tertiary centre [MRC Division]	Sep 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]	Sep 15	Internal	1%	0.5%
CE14	0% Green	Green	Cardiac Surgery - % mortality following elective primary CABG [MRC Division]	Aug 15	Internal	6%	4%
CE15	0 Green	Red	Number of unscheduled returns to theatre within 48 hours [NOTSS Division - NOC Site]	Sep 15	Internal	2	1
CE16	0 Green	Green	Number of unscheduled returns to theatre in gynaecology [C&W Division]	Sep 15	Internal	2	1
CE17	446 N/A		Number of patients admitted to SEU wards from SEU triage [S&O Division]	Sep 15		N/A	N/A
CE18	2.56% Amber	Amber	Neuroscience Intensive Therapy Unit (NITU) readmission rate within 48 hours of discharge [NOTSS Division]	Sep 15	Internal	4%	2%
CE19	80.25% Green	Green	% fractured NOF patients who receive surgery within 36 hours of admission [NOTSS Division]	Sep 15	Commissioner	70%	72%
CE20	22.67% Green	Green	% deliveries by C-Section [C&W Division]	Sep 15	Commissioner	33%	23%
CE21	2.88% Amber	Red	7 day admission rate following assessment on (and discharge from) paediatric CDU [C&W Division]	Sep 15	Internal	4%	2%
PE01	84.42% N/A		Friends & Family test % likely to recommend - ED	Sep 15		N/A	N/A
PE02	8.82% N/A		Friends & Family test % not likely to recommend - ED	Sep 15		N/A	N/A
PE03	95.52% N/A		Friends & Family test % likely to recommend - Mat	Sep 15		N/A	N/A
PE04	0.75% N/A		Friends & Family test % not likely to recommend - Mat	Sep 15		N/A	N/A
PE05	95.99% N/A		Friends & Family test % likely to recommend - IP	Sep 15		N/A	N/A
PE06	1.17% N/A		Friends & Family test % not likely to recommend - IP	Sep 15		N/A	N/A
PE07	91.97% N/A		Friends & Family test % likely to recommend - OP	Sep 15		N/A	N/A
PE08	3.11% N/A		Friends & Family test % not likely to recommend - OP	Sep 15		N/A	N/A
PE14	0 Green	Green	Single sex breaches	Sep 15	National	3	2
PE15	67.63% Amber	Amber	% patients EAU length of stay < 12h	Sep 15	Internal	65%	70%
PE16	77.57% N/A		% Complaints upheld or partially upheld [Quarterly in arrears]	Jun 15		N/A	N/A
PE17	6 Red	Red	Number of legal claims received / inquests opened initially graded as RED	Sep 15	Internal	2	N/A
PE18	65.33% Green	Green	% patients returning feedback forms in specialist surgery outpatients [NOTSS Division]	Aug 15	Internal	45%	60%
PE19	10 N/A		Number of reopened complaints	Sep 15		N/A	N/A

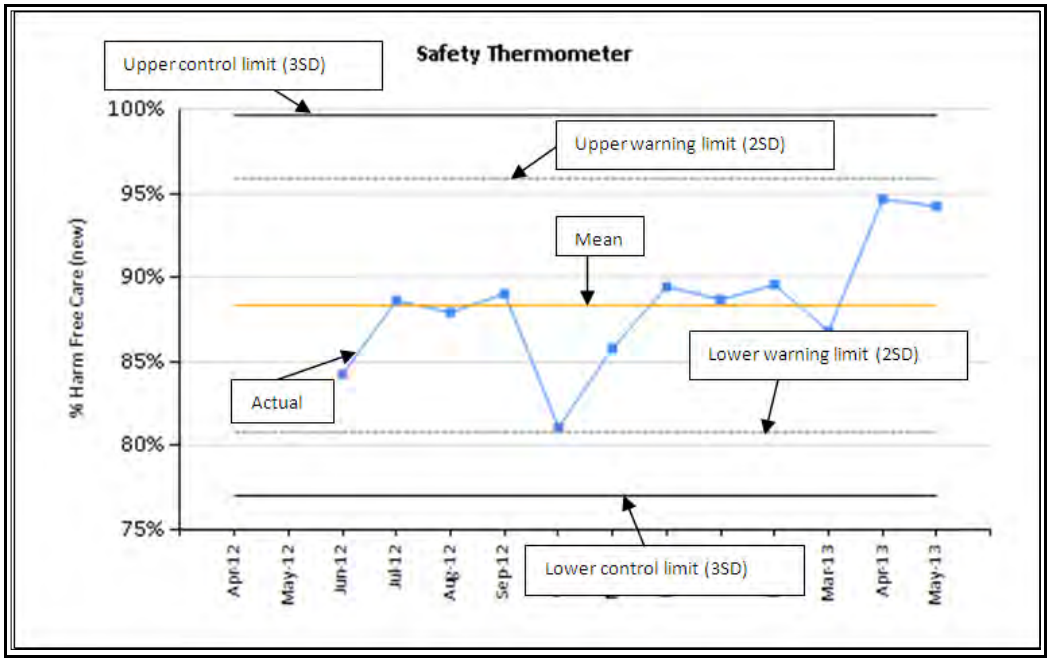
How to interpret charts

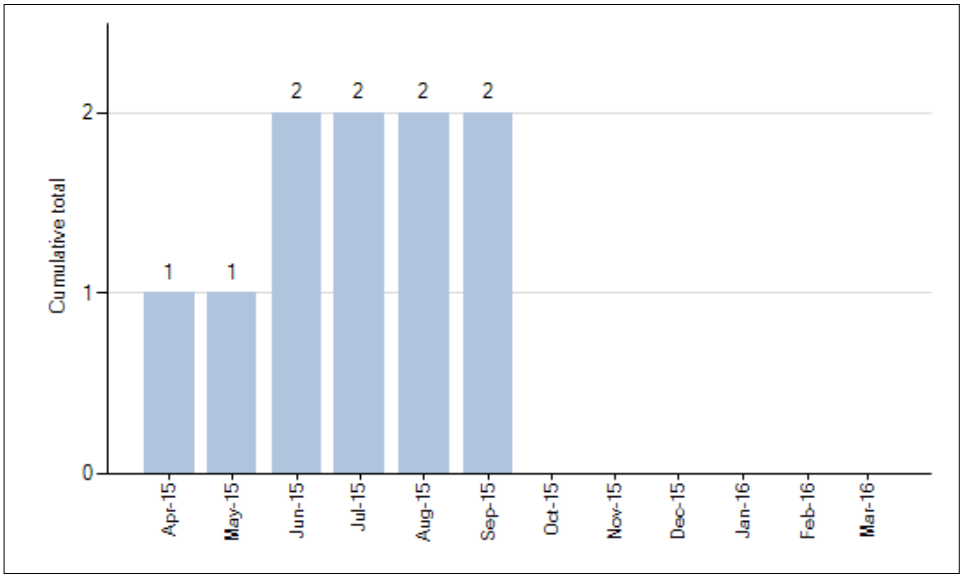
Data are presented in this report in a number of different ways – including statistical For process control (SPC) charts, line charts (without confidence intervals / control limits), histograms and cumulative histograms. Graphics have been selected in order to encourage the analysis of trends and to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

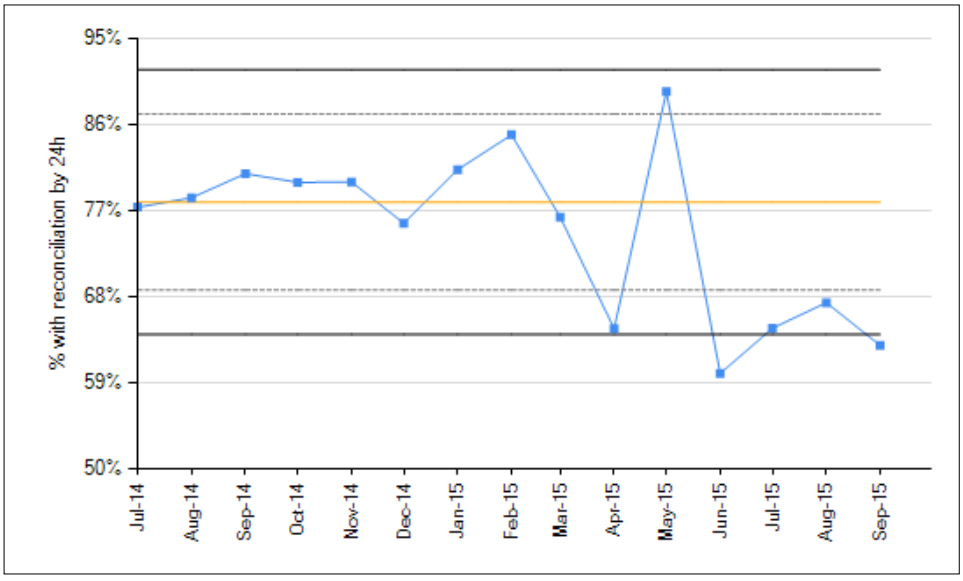
There are other patterns within the data that are likely to reflect real change as opposed to random fluctuation – these patterns are known as special cause variations. They include:

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)



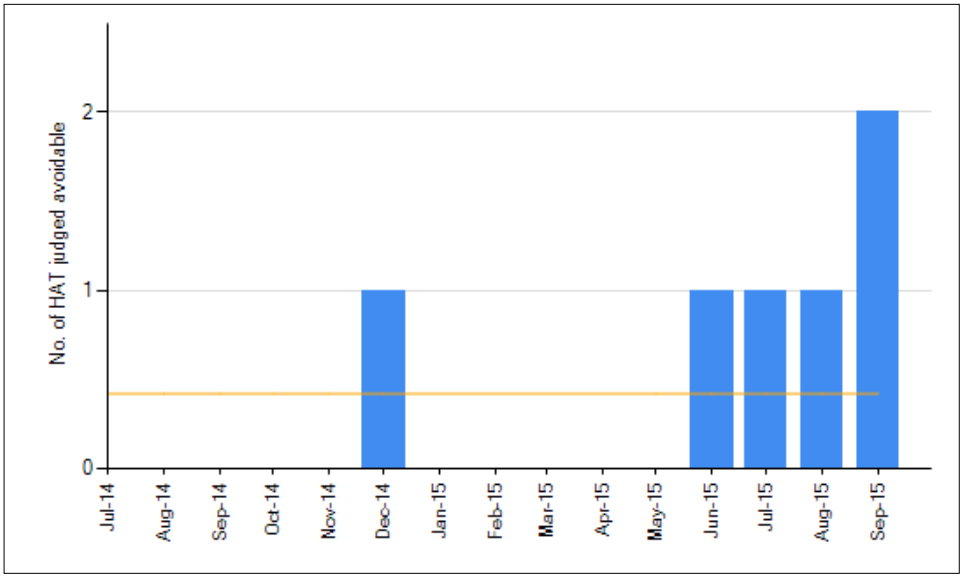
PS06 Number of cases of MRSA bacteraemia > 48 hours (cumulative year to date)	Narrative
	There have been no additional cases since the prior report. This indicator has been red rated since April 2015 and will remain so throughout 2015/16 as the annual ceiling for reported cases of MRSA bacteraemia is zero.

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

PS08 % patients receiving stage 2 medicines reconciliation within 24h of admission	Narrative
	Performance against this indicator is being addressed by the implementation of an agreed action plan with OCCG and Directorate level performance trajectories have been established to meet the target threshold.

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.. [Owner: P Devenish].

PS17 Number of hospital acquired thromboses identified and judged avoidable	Narrative



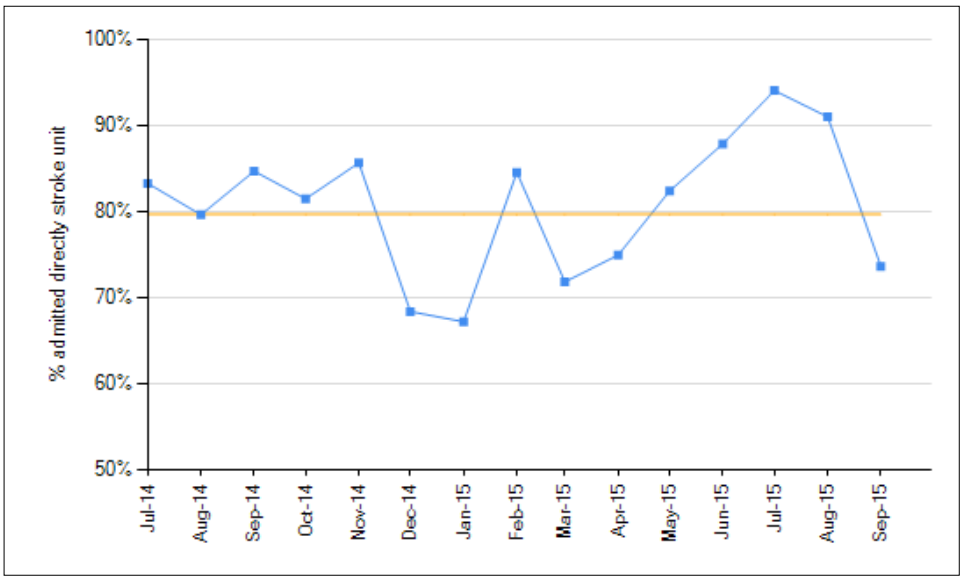
The two September cases related to:

A patient readmitted within 90 days with a diagnosed DVT and PE.
A patient with sickle cell anaemia readmitted within 90 days with hospital acquired DVT probably related to a femoral line.

These cases are subject to SIRI Investigation.

When a hospital-associated thrombosis occurs, screening +/- root cause analysis is triggered. This graph shown the number of hospital acquired thromboses in month that were felt to have been avoidable [Owner: N Curry].

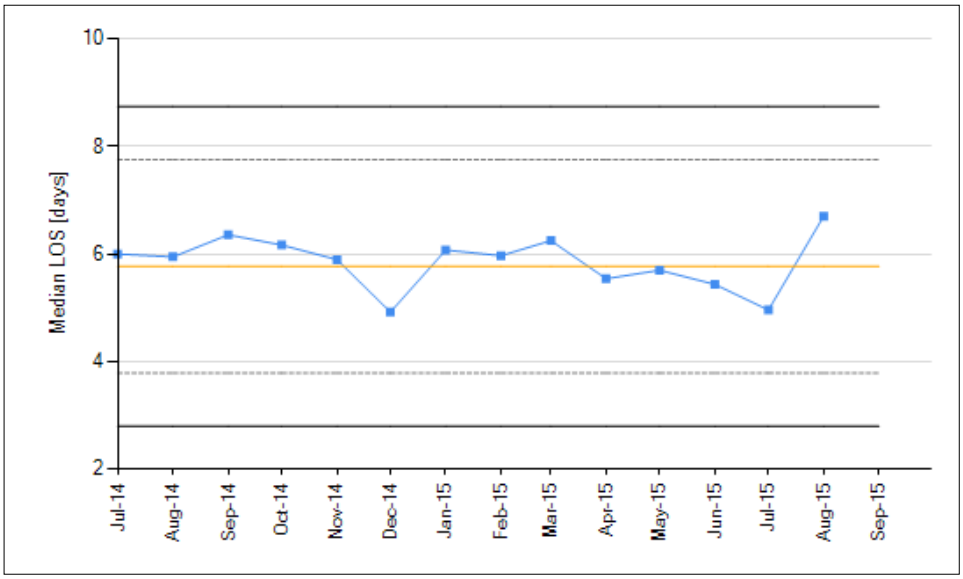
CE08 Stroke - % patients accessing specialist stroke environment within 4h of arrival **Narrative**



This metric has deteriorated in line with overall ED performance. Measures to improve ED performance and flow are under discussion. Better discharge flows for delayed patients on the stroke unit are also being considered.

CE09 Vascular - Mean length of stay for patients undergoing elective AAA repair (3 **Narrative**

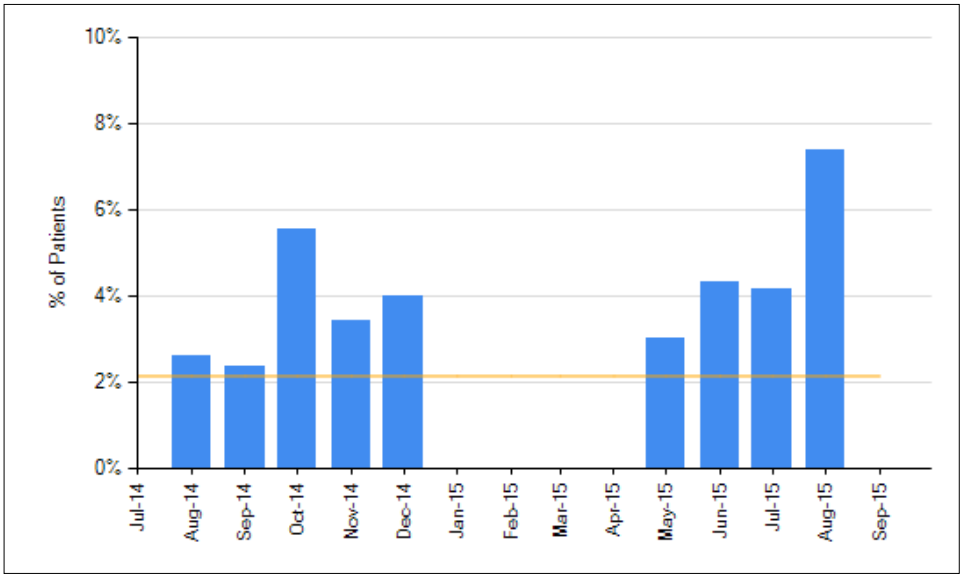
month rolling period) [NOTSS Division]



A small number of patients required longer to be medically fit for discharge following elective AAA repair. No obvious underlying trend has been identified.

Information collected from ORBIT and based on the primary procedure coded and elective admission method.

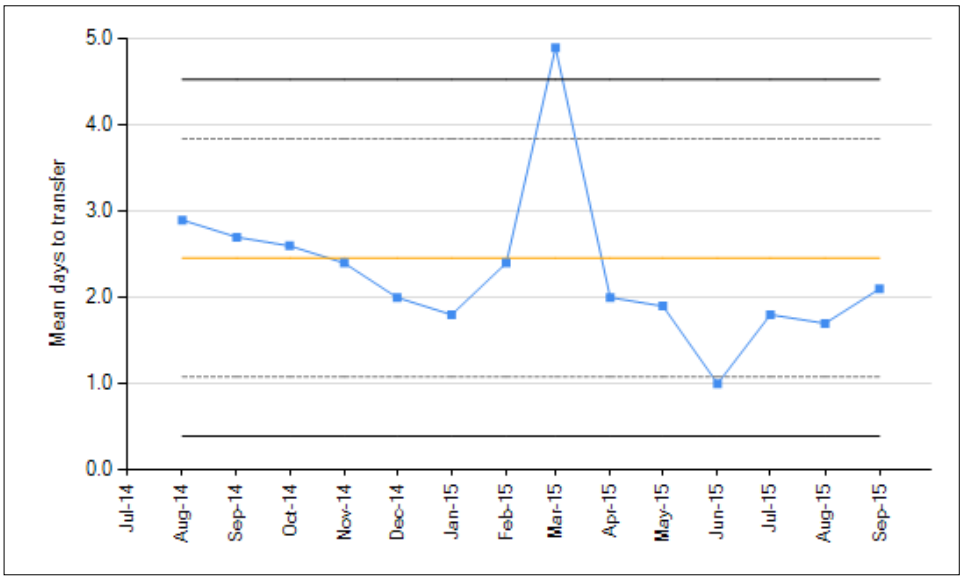
CE10 Vascular - % mortality following elective AAA repair [NOTSS Division]



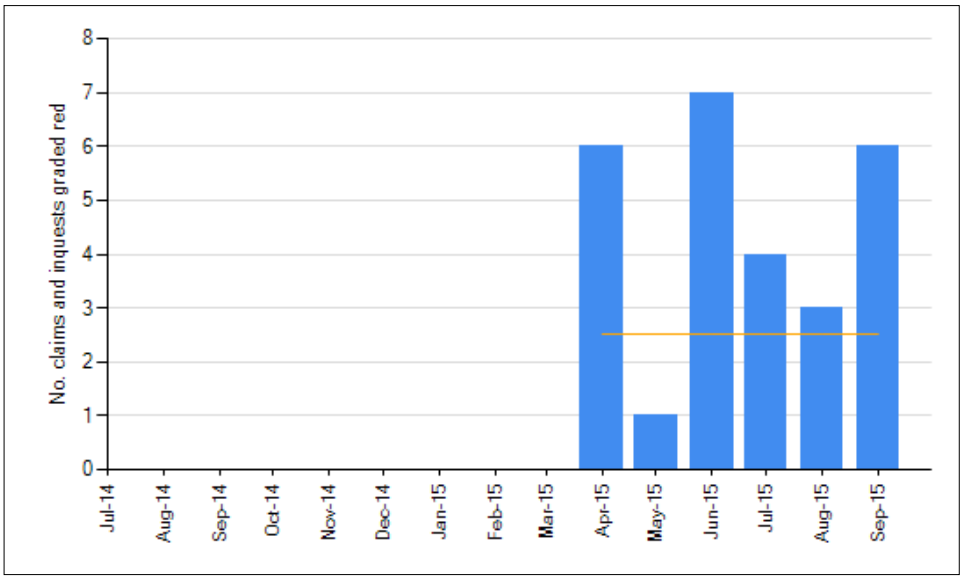
Narrative

In August one patient died after a complex suprarenal endovascular aortic repair. Because the numbers of cases are small and variable this metric is not always valuable

Information collected from ORBIT and based on the primary procedure coded and elective admission method.

CE12 Cardiology - Mean number of days from referral to admission to cardiology at tertiary centre [MRC Division]	Narrative
	This metric triggers deterioration due to patients waiting 2.1 rather than 2 days which does not represent a significant change.

Directorate goal is that patients are transferred within 2 days of referral.

PE17 Number of legal claims received / inquests opened initially graded as RED	Narrative
	The number of red graded claims and inquests opened remains above the current threshold. Although it is acknowledged that there is a long lead time for some claims, there is a need to review the current thresholds based on current and recent activity, as since this metric was newly updated for 2015/16 the threshold has only been met in May 2015.

The chart shows the numbers of new claims received and inquests opened initially rated as 'RED' by the corporate legal department. The number may change (in either direction) following investigation and conclusion of legal process [Owner: S Newman].

3. Patient Safety and Clinical Risk

3.1. Clinical Risk

3.1.1. 13 Serious Incidents Requiring Investigation (SIRIs) were reported in September 2015.

3.1.2 **Never Events**

Since the last Board Quality report (submitted to to Quality Committee in October) a further historical incident that meets the criteria for reporting as a Never Event was reported in September, which related to an incident of wrong site surgery on 13 January 2015. The incident came to light via a legal claim and was not reported at the time:

Never Event description- Wrong site surgery:

A child has been a patient of the Paediatric Haematology/Oncology service since 2009 with a long term condition that has required several long term central venous access lines. On 15 January 2015 the child attended to have a Portacath® removed. The portacath was sited on the left side of the chest but the location was not immediately visible. The procedure took place in the intervention/fluoroscopy suite in Children's Radiology. An incision was made to an old hypertrophied scar that was visible on the right side but no Portacath® was found as the one sited on the right side had previously been removed. The left sided portacath was then identified and removed. A full investigation is in progress.

3.1.3. 19 SIRIs were recommended for closure to Oxfordshire Clinical Commissioning Group (OCCG) in September with three being closed with the OCCG during one closure meeting.

3.1.3. SIRIs in progress/declared

Table Two: SIRIs in progress (data as of 27 October 2015)

Currently open SIRI's by Division							
	S&O	**C&W**	**CSS**	**NOTSS**	**MRC**	**Corporate**	**TOTAL**
Open SIRI's	10	1	4	13	15	1	**44**

Table Three: SIRIs declared during the 2015/16 financial year

SIRI's declared by Month and Division							
	Q1			**Q2**			
Division	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**TOTAL**
S&O	1	3	4	2	2	5	**20**
C&W	4	1	1	2	1	0	**9**
MRC	0	5	5	6	8	3	**31**
CSS	0	1	2	3	1	2	**9**
NOTSS	3	1	7	4	3	3	**25**
Corporate	0	1	0	2	0	0	**3**
TOTAL	**8**	**12**	**19**	**19**	**15**	**13**	**96**

3.1.4. Table Four provides more details of those SIRI's declared to NHS England via the STEIS reporting system in September 2015, including the time in days from the incident occurrence to being reported on Datix, and from Datix reporting to being reported on STEIS.

Table Four

SIRI ref	Division	Description	Incident Date	Datix Date	I-D interval	STEIS Date	D-S interval
2015/112	NOTSS	Retained swab (NE)	26/08/15	26/08/15	0	01/09/15	6
2015/113	NOTSS	Wrong side surgery (craniotomy) (NE)	01/09/15	01/09/15	0	02/09/15	1
2015/114	NOTSS	Lung nodule not followed up	26/08/15	26/08/15	0	04/09/15	9
2015/115	CSS/S&O	Kidney mass not identified or investigated	09/02/15	11/02/15	2	04/09/15	205
2015/116	MRC	Grade 3 Hospital Acquired Pressure Ulcer (HAPU)	27/08/15	27/08/15	0	03/09/15	7
2015/117	S&O	Grade 3 HAPU	01/09/15	01/09/15	0	03/09/15	2
2015/118	S&O	Death following 2 falls in Sobell House	07/09/15	07/09/15	0	11/09/15	4
2015/119	MRC	Missed antibiotics for urosepsis.	02/09/15	02/09/15	0	11/09/15	9
2015/120	MRC	Grade 3 HAPU	03/09/15	03/09/15	0	11/09/15	8
2015/121	S&O	Grade 3 HAPU	01/09/15	01/09/15	0	11/09/15	8
2015/122	S&O	Grade 3 HAPU	31/08/15	31/08/15	0	18/09/15	18
2015/123	S&O	Grade 3 HAPU	04/09/15	04/09/15	0	18/09/15	14
2015/124	CSS/C&W	Wrong Site Surgery (Portacath) (NE)	13/01/15	17/09/15	247	21/09/15	4

3.1.5. A number of SIRI reporting timescales were not reached in September 2015 (over 2 weeks), details of each of these delays are as follows:

Delays in reporting on DATIX:

- 2015/124 – This Never Event was brought to the attention of the clinical governance team following a legal claim. It was not reported on Datix at the time of the incident. The reasons for this will form part of the investigation.

Delays in reporting on STEIS:

- 2015/115 – Initially reported and investigated by S&O Division as a Divisional Level Investigation, however, the investigator discovered issues that related to Radiology requiring CSS Division to undertake a parallel but separate review. Subsequently the Divisional Director for CSS had the case discussed at the M&M meeting which identified a further concerning aspect of care, at which point the two Divisions requested that the investigation be upgraded to the level of a SIRI investigation, at which point the incident was reported on STEIS.

- 2015/122 – Delay in reporting on STEIS due to the process of establishing whether the HAPU was unavoidable.
- 2015/123 – Medical notes filed incorrectly making it difficult for the review process to establish whether the HAPU was unavoidable until the patient's notes were found.

3.1.6. 19 SIRI reports were recommended to OCCG for closure during September 3015. Following internal closure of a SIRI report, the report is presented to the OCCG for agreement and endorsement of the quality of the investigation and the appropriateness of the recommendations and actions to prevent a re-occurrence.

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

3.1.8. One SIRI closure meeting was held in September where three SIRI's were closed with OCCG. Table Five below details those SIRIs which were closed and those Never Events which are open.

Table Five

STEIS Ref	STEIS Summary	Previous meeting notes and actions	Meeting decision	Meeting notes
2015/3725 NEVER EVENT	Patient admitted for orthodontic treatment. Incorrect teeth removed during procedure	ACTIONS: 1. SB to forward CS view (root cause not correctly identified) to WT/CE for action plan revision. 2. OUH to send revised action plan in time for next meeting.	Open pending completion of all actions	Awaiting revised action plan to be sent to OCCG by OUH in October
2014/38753 NEVER EVENT	A 24 year old patient was commenced on intravenous antibiotics for an infective exacerbation of cystic fibrosis. A midline was sited on the second attempt on the 14th November. On the 24th November an X-ray showed a retained guidewire from the unsuccessful midline insertion on the 14th November. This guidewire was removed the following day.	Action: 1. Wording on action plan to be changed to confirm grand round to be arranged and OCCG rep will attend.	Open pending completion of all actions	FURTHER MONITORING Awaiting dates for nursing grand round- OCCG will be advised once this is agreed and scheduled
2014/36993 NEVER EVENT	A nasogastric feeding tube was inadvertently inserted into an 81 year old patient's left lung. The patient was later found unwell, and subsequently died. Following a post-mortem, the misplacement of the nasogastric feeding tube is listed as being directly related to the patient's death.	Actions: 1. CD request nursing to forward list of teaching actions for nurses 2. Policy delayed at Policy Group	Open pending completion of all actions	Policy now approved

STEIS Ref	STEIS Summary	Previous meeting notes and actions	Meeting decision	Meeting notes
2014/25602 SPECIALISED COMMISSIONING	Retained guide wire	Action: 1. CD to bring assurance of governance procedure for stock management to next meeting	CLOSED	
2015/10240 SPECIALISED COMMISSIONING	Inpatient fell whilst walking and was diagnosed with a fracture neck of femur.	Actions: 1. CE to update at August meeting. 2. Discussed at Fallsafe meeting and raised with LW– close. For all new SIRIs going forward. – close	CLOSED	
2015/3788	The patient fell and sustained a fracture to the neck of femur.	CE confirmed equipment was available. Trust Falls Policy does mention dementia patients but will be updated. CE has spoken to Chris Greed to align policies Action: CE to send assurance of Falls risk assessment to SB	CLOSED	

3.3. Quality Walk Rounds

3.3.1. There were five Executive Quality Walk Rounds in October 2015. These are detailed in Table Six below. One Walk Round was cancelled because the Ward Sister was unavailable and has been rearranged to take place in November.

Table Six

Hospital Site	Areas Visited
John Radcliffe Hospital	Tom's Ward (CHOX) Ward 7D (Acute Medicine) Microbiology Laboratories
Nuffield Orthopaedic Centre	Bone Infection Unit
Horton General Hospital	Critical Care Unit

3.3.2. Key issues with the potential to affect quality or patient experience identified during the Executive Quality Walk Rounds included challenges surrounding staff recruitment and retention, the environment including dementia friendly design, staff facilities and refurbishment requirements, use of technology and discharge delays affecting patient flow.

3.3.3. All issues are either included in existing Trust-wide projects or have new local actions associated with them which will be monitored through Divisional governance processes.

4. Clinical Effectiveness

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

4.1.1. The Dr Foster data, published on the 15th October 2015, includes discharges up-to and including July 2015. The benchmark includes data up to April 2015.

4.1.2. There were no new mortality alerts for OUH in the Dr Foster October 2015 update.

4.1.3. The OUH HSMR for the latest 12-month period (August 2014 to July 2015) is 103. This represents a marginal decrease from 103.1 reported in September 2015 (for the July 2014 to June 2015 data period). The value remains 'within expected' range (95% Confidence Intervals 98.6-107.6). The number of observed deaths within the HSMR 56-diagnosis groups has decreased by 18 (from 2070 to 2052) and the number of 'expected' deaths based on OUH activity also decreased by 16.9 (from 2008.5 to 1991.6).

Table Seven – Top 10 Diagnosis groups for observed mortality within the HSMR basket of 56 diagnosis groups (August 2014 to July 2015)

Diagnosis group	Observed (Obs)	Expected (Exp)	Obs – Exp	Relative Risk	Low	High
Pneumonia	369	363.4	5.6	101.6	91.5	112.5
Acute cerebrovascular disease	185	179.1	5.9	103.3	88.9	119.3
Secondary malignancies	106	71.4	34.6	148.5	121.6	179.7
Congestive heart failure, non hypertensive	83	74.9	8.1	110.9	88.3	137.4
Acute and unspecified renal failure	83	72.1	10.9	115.1	91.7	142.7
Cancer of bronchus, lung	68	54.6	13.4	124.5	96.7	157.9
Acute myocardial infarction	67	67.5	-0.5	99.3	77.0	126.1
Septicaemia (except in labour)	63	88.1	-25.1	71.5	55.0	91.5
Chronic obstructive pulmonary disease and bronchiectasis	61	51.2	9.8	119.1	91.1	152.9
Urinary tract infections	58	65.8	-7.8	88.2	66.9	114.0

4.1.4. The following diagnoses and procedures were identified with a lower than expected relative risk when compared to Trusts nationally and taking into consideration case mix:

Table Eight – Diagnosis and Procedure groups within the HSMR basket of 56 diagnosis groups with lower than expected relative risk (August 2014 to July 2015) – Note: expected relative risk is 100 with any figure below 100 indicating a reduced risk of death.

Diagnosis or Procedure group	Observed	Expected	Relative Risk
Peritonitis and intestinal abscess	3	9.6	31
Septicaemia (except in labour)	66	90.1	73
Therapeutic operations on jejunum and ileum	4	11.5	35
Therapeutic transluminal operations on vein	19	34.1	56
Urethral catheterisation of bladder	45	65.6	69

4.1.5. The Summary Hospital-level Mortality Indicator (SHMI), published on the 28th October 2015, for the data period April 2014 to March 2015 is 0.98. This is 'as expected' using the Health and Social Care Information Centre's (HSCIC) 95% confidence intervals, adjusted for over-dispersion. This SHMI value has decreased when compared to the previous release.

4.1.6. For the period April 2014 to March 2015 there were 3193 deaths observed in the SHMI diagnosis groupings compared to the Trust's expected of 3260.1. Of these deaths, 75.45% occurred in hospital (2409) and 24.55% occurred outside hospital, within 30 days of discharge (784).

4.1.7. Rates for spells with palliative care coding as a percentage of total spells and deaths; percentages of deaths within 30 days for elective and non-elective admissions and, the percentage of in-hospital and deaths occurring outside of hospital, have all remained relatively stable, with little change compared to previous releases.

4.1.8. There is a slightly higher percentage of deaths observed in the least deprived groups relative to the percentage of spells attributed to those quintiles.

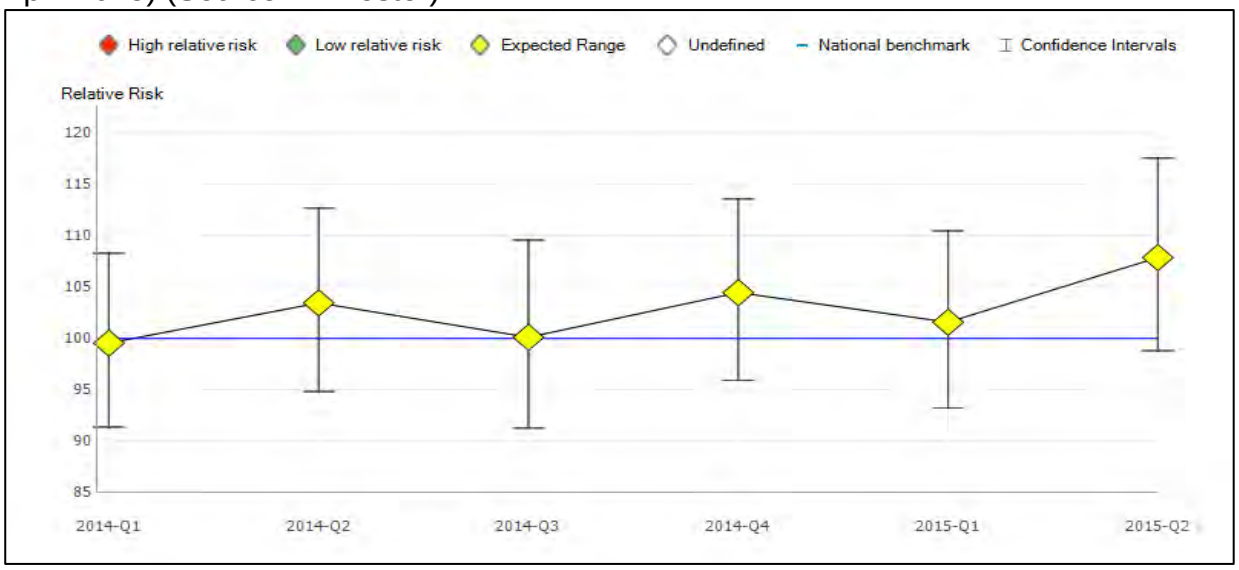
Table Nine – 10 SHMI diagnosis groupings with the most observed deaths

SHMI diagnosis grouping	Spells	Observed (Obs)	Expected (Exp)	Obs -Exp	Relative risk
Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	2229	404	430.1	-26.1	93.9
Acute cerebrovascular disease	1191	208	190.7	17.3	109.1
Secondary malignancies	1000	129	123.8	5.2	104.2
Cancer of bronchus, lung	346	101	84.8	16.2	119.1
Urinary tract infections	1705	94	101.7	-7.7	92.4
Acute & unspecified renal failure	559	93	88.6	4.4	105.0
Congestive heart failure; non hypertensive	565	90	87.5	2.5	102.9

Chronic obstructive pulmonary disease and bronchiectasis	1121	81	74.0	7.0	109.5
Acute myocardial infarction	990	78	78.2	-0.2	99.7
Septicaemia (except in labour), Shock	565	75	105.8	-30.8	70.9

4.1.9. A detailed analysis of the SHMI publication will be presented and discussed at the next Clinical Effectiveness Committee on the 19th November 2015.

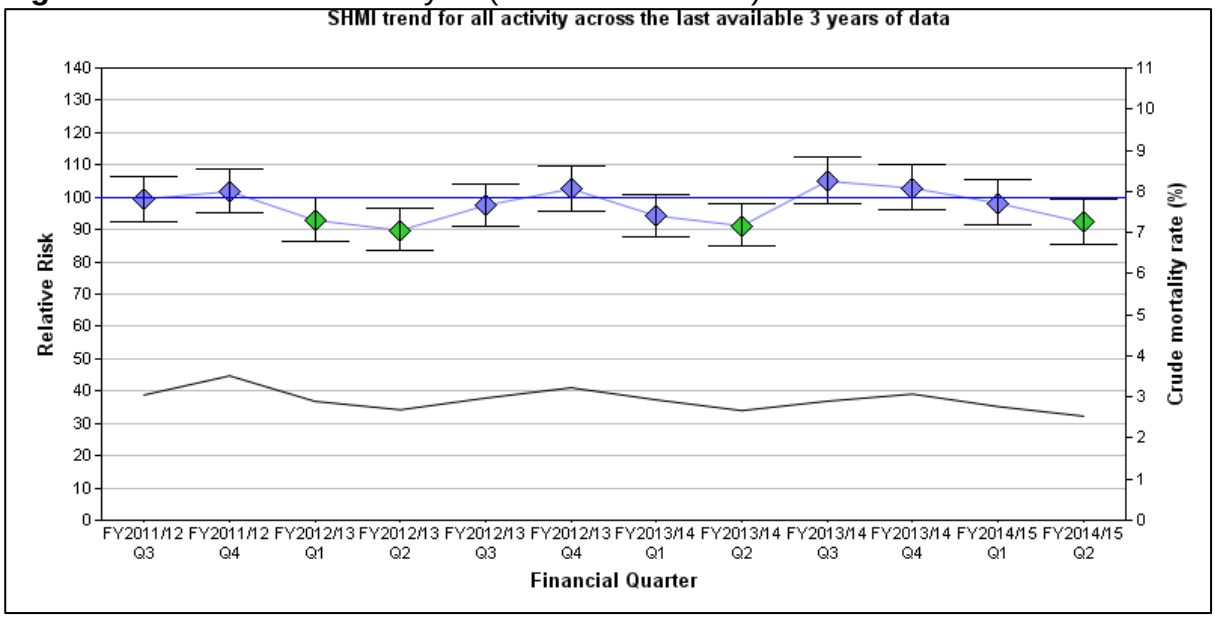
Figure One - HSMR trend analysis (Basket of 56 diagnosis groups, Benchmark month: April 2015) (Source: Dr Foster)



Summary Hospital-level Mortality Indicator (SHMI)

4.1.10. The next SHMI publication is scheduled for the 28th October 2015.

Figure Two: SHMI trend analysis (Source: Dr Foster)



Mortality Investigations

4.1.11. The investigations for the following Dr Foster mortality alerts (published March 2015 to August 2015) were reviewed at Clinical Effectiveness Committee (CEC):

- Deficiency and other anaemia
- Destruction of lesion of retina
- Rest of Ear
- Coronary atherosclerosis and other heart disease
- CABG (other)
- Cancer of kidney and renal pelvis
- Cancer of prostate
- Other perinatal conditions

4.1.12. For Quarter one of 2015/16: 89% of deaths were progressed through the OUH Standardised Mortality Review process (SMR). This is an improvement from the 73% compliance rate reported for the financial year 2014/2015. The main reason for cases not being reviewed within the timescales is reported to be difficulties in locating the patients' notes.

4.1.14. The Surgery and Oncology Division have been developing a Mortality Database, progress of the project was presented to CEC in October. The Division reported that the trial of the Database was successful. The Database is currently in use in the Surgery, Renal and Gastroenterology Units and will be implemented across the Surgery and Oncology Division.

4.2. Audit – The following audits have been presented at Clinical Effectiveness and reported to Clinical Governance Committee

- British Thoracic Society (BTS) National Adult of Community Acquired Pneumonia, Data period: 1st December 2014 – 31st January 2015, Published: June 2015
- National Emergency Laparotomy Audit (NELA), Data period: December 2013 to December 2014, Published: July 2015
- Sentinel Stroke National Audit Programme (SSNAP) Annual Report, Data period: 1st April 2014 – 31st March 2015
- National Adult Cardiac Surgery Audit, Data period: April 2011- March 2014 data, Published: June 2015 (includes 2015 Consultant Outcomes Publication)
- Cardiac Rhythm Management (CRM) Ablation Audit, Data period: April 2013 – April 2014, Published: March 2015
- Postnatal care (NICE Quality Standard QS37), Data period: June 2015
- UK Cystic Fibrosis Registry, Paediatric service, Annual Data Report 2014, Published August 2015
- Medicines Management: Safe and Secure Storage of Medicines Audit
- Trust wide Clinical Audit: Auto-reporting policy

4.3 **Oxfordshire Clinical Commissioning Group matters**

4.3.1 OCCG have raised two contract query notices related to endorsing of clinical test results and timely e-messaging of discharge summaries. A revised action plan for each aim has been supplied and revised trajectory has been agreed. These areas are discussed in the Clinical Governance Committee and at Divisional performance reviews.

4.3.2 It is noted that DATIX feedback from the GP DATIX system is monitored by the Head of clinical governance**.**

5. Infection Control

5.1. This section of the Board Quality Report provides an update regarding cases of Clostridium *difficile (C.diff)*, Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, and MRSA Screening Compliance and Cleaning score audit performance.

5.1. Clostridium *difficile*

5.1.1. The upper ceiling for OUH apportioned cases of C.diff for 2015 / 2016 is 69.

Table Ten: Cases of OUH Apportioned *C.diff* per month

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
Total	3	4	8	8	3	4	6*					
Monthly limit	5	6	6	6	6	6	6	6	6	6	5	5
Cum total	3	7	15	23	26	30	36					
Cum limit	5	11	17	23	29	35	41	47	53	59	64	69

* Cases to date 29 October 2015

5.1.2. Six cases of C.diff apportioned to the OUH NHS Foundation Trust have been reported to date (29/10/15) in October 2015, against a monthly limit set at 6. Avoidability will be determined at the next Health Economy meeting to be held in November 2015. It should be noted that the monthly total may increase should further positive samples taken in the latter part of October 2015 be reported by OUH Microbiology after this report has been written.

5.1.3. Avoidability for the four cases of C.diff apportioned to the OUH NHS Foundation Trust in September 2015 will also be determined at this meeting.

5.1.4. The OUH NHS Foundation Trust currently sits below the upper ceiling for cases for October 2015 (36 cases in total against a cumulative limit of 41), and sits below the upper ceiling for total cases, 2015/2016.

5.2. 30 day C.diff Mortality review

5.2.1 As per Department of Health guidance (2008), the OUH NHS Foundation Trust undertakes a monthly review to identify deaths within 30 days of diagnosis of CDI to ensure that a common standard of assessment is being applied in terms of cause of death or contribution to death.

5.2.2. Where it is identified that a patient has died whilst an inpatient at the OUH NHS Foundation Trust, or where Infection Control can access information to identify if C.diff was a causative factor for those who have been discharged, a review of the case is undertaken at the relevant M&M meeting and documented in the minutes for Governance purposes.

5.2.3 Infection Control have identified no patients to date who were C.diff positive in October 2015 and who subsequently died within 30 days of the positive result.

5.3. MRSA bacteraemia

5.3.1. The objective for 2015 / 2016 is 0 avoidable MRSA Bacteraemia. There were 0 MRSA Bacteraemia apportioned to the OUH in September 2015.

5.3.2. To date 29/10/15, there were 0 MRSA Bacteraemia apportioned to the OUH NHS Foundation Trust in October 2015, however 2 apportioned MRSA Bacteraemias have been reported to the board earlier in this financial year and therefore the OUH has failed to meet this objective for 2015 / 2016.

5.4. Cleaning audits

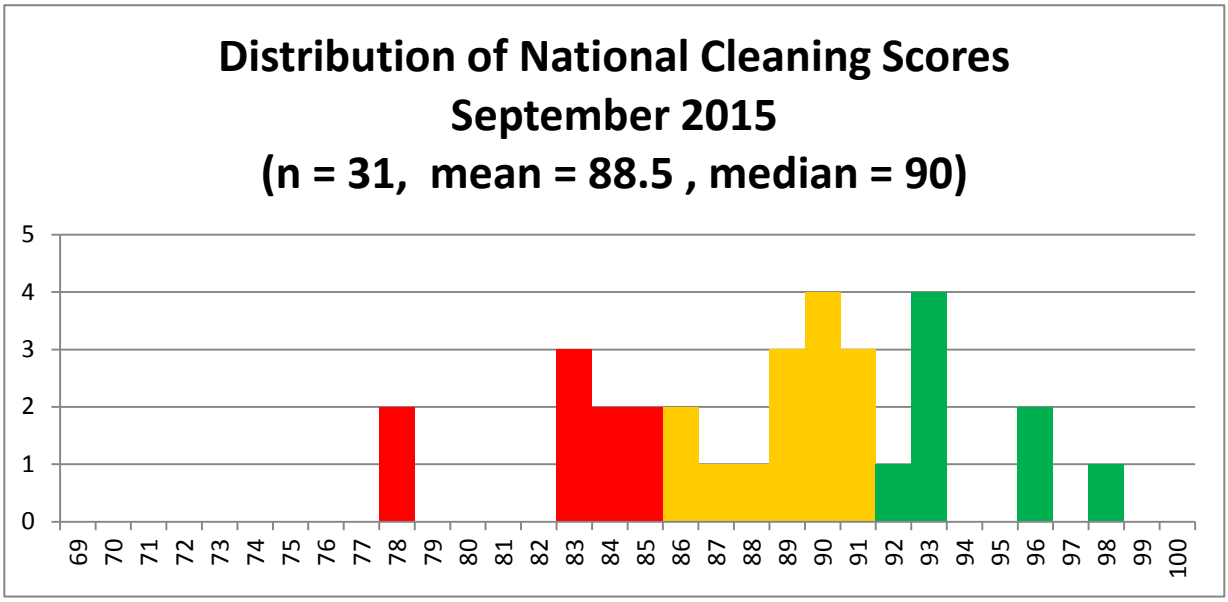
5.4.1. Table Eleven below details the average reported cleaning scores by division undertaken by the OUH Quality Assurance Team (QAT) for September 2015.

Table Eleven

September 2015	
Division	Quality Assurance Team audits
Neurosciences, Orthopaedics, Trauma & Specialist Surgery	84%
Medicine, Rehabilitation & Cardiac	90%
Children's and Women's	90%
Surgery & Oncology	89%
Clinical Support Services	91%
OUH total	**89%**

5.4.2. Figure Three details the distribution of National Cleaning scores from the Clinical areas audited in September 2015 by the OUH QAT.

Figure Three



5.4.3. The clinical areas rated red in the chart above are as follows:

- Ward 6A
- BIU NOC
- Ward A NOC
- Ward D NOC
- Cardiology Ward
- Delivery Suite / Observation Area JR1
- Silver star Unit JR1

- JR Theatres
- Tarver Dialysis Unit, Churchill

5.4.4. Clinical areas are required to achieve a minimum 92% compliance with the monthly cleaning audit undertaken by the OUH Quality Assurance Team (QAT).

5.4.5. At the time of writing this report, the QAT Audit data for October 2015 were not available and therefore these data will be included within the next scheduled report.

5.4.6. As reported in the September 2015 report, cleaning audit failures were reported by the QAT from clinical areas located within all 4 main sites of the OUH NHS FT. When Domestic failures are reported by the QAT, the failure is reported to the respective provider helpdesk and a job number is issued: the service provider then has one hour to rectify the issue. The job tickets are signed off by the ward when complete and the job completion time will automatically generate a contractual pass or fail.

5.4.7. These failures are discussed at the PFI Performance Meeting and areas that continue to be an issue in terms of Domestic cleaning performance are re- audited by the QAT. The audit data are used to highlight key areas of failure so that the service providers are requested to concentrate on the aspects that fail the most each month. The contracts payment mechanism calculates the service failure points and financial deductions which are taken off each month's payment: this is to incentivise the service providers to improve performance.

5.4.8. Audit failures that are deemed to be the responsibility of the "Nursing" team are escalated to the Clinical area Manager or Coordinator at the time of the audit. These failures have also been highlighted by Infection Control at the OUH Clinical Governance Committee meeting to the Divisional Nurses and at the Senior Nurses Meeting, where there is an expectation that it is then fed back to the staff at the ward level.

5.5. MRSA Screening Compliance

5.5.1. At the time of writing this report, MRSA Screening Compliance data for October 2015 could not be provided and will therefore be presented within the next scheduled report.

5.5.2 As reported in the September 2015 report, The OUH NHS Foundation Trust achieved 49.2% overall compliance with MRSA screening, the breakdown being 87.98% (341/300) for elective admissions and 46.13% (4203/1939) for emergency admissions, against an expectation of 100% emergency and elective screening compliance as per OUH MRSA guidelines.

5.5.3 This performance deficit has been highlighted by Infection Control at the OUH Clinical Governance Committee meeting and at the Senior Nurses Meeting where it has been reinforced that screening compliance must be owned and driven at a local level.

5.5.4 In addition, the OUH NHS FT Infection Control Team is placing a greater emphasis on MRSA Screening education when undertaking "face-to-face" Induction and Statutory and Mandatory training in order to raise compliance rates.

5.5.5 OUH NHS FT Infection Control are also in the process of simplifying clinical guidance in regards to the groups of patients who would require either Elective or Emergency MRSA Screening, as discussion with clinical staff has highlighted a potential lack of clarity within the MRSA guideline as being one of the potential causes of poor screening compliance.

6. Friends and Family Test

6.1. Inpatients and day cases:

6.1.1. **OUH:** the percentage of patients who would recommend their care in September remains constant at 96-97%.

6.1.2 **Thematic analysis[1]:** the top themes for inpatients were:

Table Twelve: Thematic Analysis of Inpatient Feedback. Source: Patient perspective.

Positive	**Negative**
• Staff: 613 • General Quality of Care: 353 • Nursing Care: 94 • Information: 60 • Cleanliness: 59 • Food / Catering: 43 • Environment: 28 • Comfortable: 24 • Facilities: 14 • Waiting / Delays: 6	• Food / Catering: 11 • Waiting / Delays: 10 • Staff: 8 • General Quality of Care: 8 • Noise: 7 • Information: 6 • Cleanliness: 6 • Environment: 5 • Discharge: 5 • Staffing levels: 5

[1] For thematic analysis there are two types that are available depending on the survey supplier. Services that use Healthcare Communications are analysed using most common words in positively rated or negatively rated comments. Services with patient perspective have their comments themed manually according to pre-agreed themes; this means that where different words are used to describe the same concept, the themes are consistently coded.

6.1.3. **Thematic analysis:** the most common words for day cases were:

Table Thirteen: Thematic Analysis of Day Case Feedback. Source: Envoy Messenger.

Positive	**Negative**
• Staff: 286 • Friendly: 129 • Care: 122 • Helpful: 82 • Excellent: 80 • Caring: 79 • Efficient: 73 • Good: 73 • Treatment: 71 • Professional: 67	• None found.

6.1.4. There were no negative words found. The minimum occurrence for negative words to show up on Envoy messenger (the results reporting system) is 5. The most common word was communication, which was said three times in a negative comment.

6.1.5. The response rate in September was the highest received to date due to the inclusion of day cases. The increase is because September is the first full month using SMS and Interactive Voice Messaging (IVM) in day cases. The response rate is expected to decrease in October due to stopping IVM and using SMS only. This is because of patient complaints and concerns about the automated IVM service.

6.1.6 **National comparison:** the percentage who would recommend their care in the Trust in July (96.0%) is similar to the national average (95.5%).

6.2. Emergency Departments (EDs):

6.2.1. **OUH:** The response rate in September remains steady at 31%.

6.2.2. The percentage who would recommend their care in September (84%) has decreased slightly. The ratings of care are similar at both EDs: 85% at the John Radcliffe ED and 84% at the Horton ED.

6.2.3 The most common words in positively rated and negatively rated responses are as follows:

Table Fourteen: Thematic Analysis of Emergency Department Feedback. Source: Envoy Messenger.

Positive	**Negative**
• Staff: 191 • Service: 103 • Friendly: 94 • Good: 78 • Helpful: 77 • Care: 74 • Seen: 69 • Quickly: 61 • Excellent: 60 • Efficient: 58	• Waiting: 45 • Hours: 39 • Wait: 33 • Long: 25 • Doctor: 24 • Time: 22 • Pain: 22 • Staff: 20 • Nurse: 20 • Seen: 16

6.2.4. **National comparison:** Using SMS and IVM as the main method for FFT, the Trust's response rate (32%) is the fourth highest in the country.

6.3. Maternity:

6.3.1. **OUH:** The percentage who recommended their care has stayed about the same at 94%, with 1.4% not recommending their care.

6.3.2. The response rate is 15% for the question asked after birth. New supplies of envelopes and questionnaires were distributed and processes have been renewed to ensure that comment boxes are emptied regularly. The patient experience team will contact each team to ascertain the additional support needed to maintain and then increase responses.

Table Fifteen: Thematic Analysis of Maternity Feedback. Source: Envoy Messenger.

Positive	**Negative**
• Staff: 166 • General Quality of Care: 83 • Information: 42 • Facilities: 16 • Comfortable: 10 • Environment: 8 • Waiting / Delays: 7 • Cleanliness: 6 • Communication between staff: 1 • Involvement in care decisions: 1	• Waiting / Delays: 3 • Staffing levels: 3 • Staff: 2 • Communication between staff: 2 • General Quality of Care: 1 • Information: 1 • Food / Catering: 1 • Administration: 1

6.3.3. **National comparison:** the national comparisons shown are a composite score from the questions asked at each of the four stages of care: antenatal (36 weeks); labour and birth; postnatal ward; postnatal community service (10 days postnatal). The Trust's score for percentage recommend (94%) is 92nd out of 116 Trusts with more than 100 responses in August.

6.4. Outpatients:

6.4.1. The introduction of SMS text messaging has vastly increased the responses from approximately 600 responses per month using paper, to 11076 responses per month using SMS and IVM.

6.4.2. The top 10 words associated with positively rated and negatively rated responses were:

Table Sixteen: Thematic Analysis of Outpatient Feedback. Source: Envoy Messenger.

Positive	**Negative**
• Staff: 1243	• Appointment: 108
• Friendly: 867	• Time: 99
• Time: 719	• Wait: 75
• Helpful: 679	• Waiting: 75
• Service: 555	• Seen: 54
• Good: 519	• Long: 49
• Excellent: 465	• Staff: 45
• Efficient: 438	• Hour: 44
• Care: 429	• Doctor: 38
• Appointment: 409	• Consultant: 35

6.5. Electronic feedback

6.5.1. The Trust has stopped using the Interactive Voice Messaging (IVM) system due to the high volume of complaints. Since stopping the IVM calls, no complaints have been made about the FFT survey.

6.5.2. The effect of stopping IVMs on ratings and comments are shown in eighteen below:

Table Seventeen: the effect of stopping IVM on ratings and comments[2]

	Percentage of surveys sent responded to with a rating	Percentage of surveys sent responded to with a comment
Day case with IVM	37%	19%
Day case without IVM	23%	20%
Outpatient with IVM	24%	12%
Outpatient without IVM	14%	12%
ED with IVM	32%	20%
ED without IVM	23%	19%

6.5.3. As predicted, the response rate (measured via those who have given a rating) has decreased. However, there is little effect on the percentage of surveys sent resulting in a comment: as shown in the table above, there is less than a 1% difference.

6.6. Carers' Feedback

6.6.1. A plan is now in place for the Seldom Heard People; Carers project. Carers Oxfordshire are to dedicate 21 hours per week to visiting the Trust and supplying support for carers within inpatients and outpatient areas. This was decided at the last steering group on 1st October, and the work commenced on 13th October when an Outreach Worker from Carers Oxfordshire attended the Dementia Reminiscence Machines training session at the John Radcliffe; she will incorporate the machines into her outreach work, encouraging their use and raising the profile of dementia awareness throughout the Trust. The Outreach Worker has developed a plan for her work at the Trust, including the arrangement of a referral email address and telephone number for Carers Oxfordshire which will be set up shortly. Staff at OUH will be able to use the referral system to put carers in touch with the service.

6.6.2. Carers Oxfordshire will raise awareness of their service both internally and externally through Outreach Worker; she will be available at certain times on certain wards according to demand and will also be available on a more general basis by walking through wards and basing herself in outpatient areas. Carers Oxfordshire will liaise with the Care Navigator lead, the Social Work team, the Therapies teams and sisters and matrons to raise the profile of carers' support and services available. It will also be made clear that the support available is for staff as well as patients and family members, as a further aim of this project is to engage staff in the process of ensuring that carers are supported and listened to.

6.6.3. The Carers' Questionnaire cards are now better presented on the wards but uptake is still very low. The responses were calculated in September, based on 70 questionnaires having been distributed between 1 July and 21 August. 27 (38%) were completed and returned. Of these; 14 (52%) rated their experience as good, 10 (37%) rated their experience as ok, and 2 (7.4%) reported their

[2] These data are from different weeks and gives an overview of the impact of removing IVM on response rates in ratings and in comments.

experience to be poor. One card was not completed fully and it was therefore not possible to use the feedback. Since this collation of data, four further cards have been completed, three rating their experience (two as good, one as poor) and providing a comment, and one simply providing a positive comment. The outreach workers from Carers Oxfordshire and Carers Voice are no longer regularly visiting wards (they continued until end of August) to hand these questionnaires out and speak to carers as the focus has been shifted to the new Carers Surgery plan.

6.6.4. The Patient Experience Team aims to send out the remaining questionnaires to various other General Medicine wards across the Trust to see if more information can be gathered. The Outreach Worker will also use the forms to record important feedback received in her face-to-face work.

6.6.5. The Carers' surgery will be evaluated late January/early February in a review meeting between Carers Oxfordshire, the relevant wards and the Patient Experience Team.

6.7. Complaints

6.7.1. The number of new complaints received during September was 96. This is an increase against the numbers of formal complaints received in August of 2015/16 (n=75). Overall the number of formal complaints received in Quarter 2 (n=246) is a marked decrease in comparison to the marked increase in the number of complaints received in Quarter 1 (n=278) of 2015/16. It is not advisable to draw any conclusions from this figure yet as the numbers of complaints remain higher than the previous year.

6.7.2. There were no extreme (previously coded red) graded complaints received in September 2015, for the sixth consecutive month.

6.7.3. The graphs in the dashboard present the complaints coded by the top four subjects for June to September 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.

Divisional Overview

6.7.4. NOTSS have received the highest number of complaints for the ninth consecutive month (n=35, 36.4%). However, despite the number of formal complaints received increasing in September, the overall percentage of complaints for NOTSS has decreased in comparison to the percentage received in August. This is because the number of overall complaints for the Trust in September increased.

6.7.5. The division's complaints related to the Eye Hospital, Ear, Nose and Throat (ENT), Vascular Service, Specialist Surgery Inpatients (SSIP), Hip and Knee Services, Oral Facial Surgery, Musculoskeletal Triage Service (MSK) and Neurosciences Inpatient and Outpatient Services.

6.7.6. There were ten complaints across the division in relation to appointments – cancellations and/or delays; six of which were graded as 'moderate' as the delay or cancellation caused the patient or relative considerable concern with the remaining four graded as 'minor'.

6.7.7. The division has received five complaints graded as 'high'. This represented 20% of the division's complaints and 35% of all the complaints graded as 'high'. Of these, two complaints related to Clinical Treatment in which the complainants expressed their concerns of inappropriate procedure and inadequate pain relief. Two further complaints related to Communication – both pertaining to communications with relatives/carers. The remaining complaint was related to Patient Care with the complainant raising issues pertaining to a failure to provide adequate care.

6.7.8. S&O received 14 complaints this month (14.6%), of which three were for Oncology and Haematology, five were for Surgery, three were for Gastroenterology, Endoscopy and Theatres and three were for Renal, Transplant and Urology. This number represents a slight increase in the number of complaints received by the Division in August (n=10).

6.7.9. No complaints were raised relating to Appointments.

6.7.10 The four complaints graded as 'high', related to Surgery (n=1), Oncology and Haematology (n=1) and Gastroenterology (n=2), and specifically raised concerns of Admissions and Discharge, Clinical Treatment and Patient Care.

6.7.11 CSS received five complaints this month (5.2%) which represents a slight increase from the previous month (n=4). Of the five received in September, (all graded as moderate) related to Theatres, Anaesthetics and Sterile Services, Pathology and Laboratories, Radiology and Imaging Services and Pharmacy.

6.7.12 One complaint relating to Theatres, Anaesthetics and Sterile Services pertained to values and behaviours and relayed concerns regarding the attitude of medical staff. The remaining concerns related to communications (n=2) – communication with patient/with relatives and carers, one relayed concerns relating to the Mortuary – disposal or retention issues with the remaining complaint related to Admission and Discharge – cancelled/rescheduled surgery/procedure.

6.7.13 MRC received 20 complaints this month (20.8%) and represents an increase from the number of complaints received in August (n=18). The complaints related to Ambulatory Medicine (n=3), Acute Medicine and Rehabilitation (n=13) and Cardiology, Cardiac and Thoracic Surgery (n=4). Six complaints related to the Trust's Emergency Departments and Emergency Assessment Units.

6.7.14 The division received four complaints graded as 'high'; of these two were in relation to admission and discharge with concerns pertaining to discharge arrangements and inadequate discharge planning. The two remaining 'high' graded complaints were related to patient care and raised issues around care needs not being met.

6.7.15 Three complaints were related to communication with issues of communication with patients, communication failure between departments and incorrect entry on medical records being cited as the issues.

6.7.16 Three further complaints were received in relation to clinical treatment – all were graded as moderate. The issues raised included a delay or failure in treatment/procedure and injury sustained during treatment/operation.

6.7.17 C&W received 15 complaints this month (15.6%). This represents an increase from the number of complaints received in August (n=11).

6.7.18 The complaints related to seven departments; specifically two in Paediatric Cardiology, one in Paediatric Neurology, one in Paediatric

Oncology/Haematology, one in Paediatric Surgery, two in Paediatric Spinal Surgery, seven in Obstetrics and Midwifery, and one in Gynaecology.

6.7.19 The division received seven complaints graded as 'high'; of these four were in relation to Obstetrics and Midwifery, one was for Gynaecology, one for the Paediatric Spinal Service and the remaining one was for the Paediatric Neurology service.

6.7.20 Seven complaints were related to clinical treatment – specifically around the mismanagement of labour, a delay or failure to diagnose, a delay or failure in treatment for infection/procedure, injury sustained during treatment or operation and post-treatment complications.

6.7.21 The remaining eight complaints were graded as moderate (n=5) and low (n=3). The moderate graded complaints were related to Admission and Discharge (n=2), Appointments (n=1), Communications (n=1) and Patient Care (n=1).

6.7.22 The Corporate division received seven complaints this month (7.3%). This was a slight increase on the number received in August (n=5). The complaints related to three services; and specifically Estates, Health and Safety and Information, Clinical Governance and Patient Services. The division received three complaint graded as moderate and four were graded as low. The issues raised were relating to appointments, facilities, restraint and transport.

Cross Trust themes relating to complaints

6.7.23 Access to Treatment/Drugs

- There were three complaints (3.1%) in relation to Access. The complaints were for NOTSS (n=2) and S&O (n=1). The complainants expressed concerns about their treatment being cancelled, access to services and access to the Physiotherapy service.

6.7.24 Admission and Discharge

- There were 15 (15.6%) complaints across five divisions (MRC, NOTSS, S&O, CSS, C&W) relating to Admission and Discharge. Of these, three were graded high (MRC n=2), (S&O n=1) and twelve, moderate. The issues raised included discharge arrangements, cancelled/rescheduled surgery, bed not available, inadequate discharge planning, discharged at an inappropriate hour and transfer arrangements.

6.7.25 Appointments

- There were 15 complaints (15.6%) in total relating to appointments. This remains consistent with the number of complaints received in August (n=15) relating to this subject. These complaints were across three of the five clinical divisions (C&W n=3), MRC n=1) and NOTSS n=10) as well as Corporate (n=1).
- The complaints related to a combination of issues, with concerns about appointment delays and cancellations, appointment letters not being issued or received, appointment cancellations, appointments not kept by staff and appointment failure to provide follow-up.

6.7.26 Clinical Treatment

- There were 19 complaints (19.8%) across four of the clinical divisions in relation to clinical treatment. This compared to 25 (33.3%) complaints for the previous month in NOTSS, C&W, MRC and CSS. The complaints raised concerns around mismanagement of labour, post treatment complications, injury sustained during treatment or operation, inadequate pain management, incorrect treatment and surgery site infection/infection to wound.
- There were 11 complaints rated as high (previously defined as orange complaints and eight rated as moderate (previously defined as yellow). This is higher than other complaints categories.
- The PALS and Complaints Team will review complaints relating to patient care and clinical treatment with the Clinical Governance Team and Legal Services. This will include a comparison with clinical incidents and legal claims of a similar nature. The scope and initial results of this review will be presented to the Trust Management Executive (TME) in the first instance and subsequently Quality Committee on 9 December 2015.

6.7.27 Communication

- There were 18 complaints (18.75%) %) for NOTSS, C&W, MRC, S&O, CSS and Corporate relating to communication. This was a considerable increase in comparison to the number of complaints related to Communications in August (n=7, 9.3%). This should also be reviewed in conjunction with the overall increase for the number of complaints received in September.
- The issues raised included the breakdown in communication regarding appointments, communication with relatives/carers, communication with patients, incorrect entry on medical records, breakdown in communication with staff, and conflicting information.

6.7.28 Patient Care

- There were nine (9.3%) complaints in relation to patient care which is the same number related to this subject received in August. Four were coded as high and five as moderate. The complaints spanned multidisciplinary care.
- Five complaints were received for MRC, with one each for S&O, NOTSS, C&W and Corporate.
- Issues raised were in relation to care needs not being adequately met, failure to provide adequate care and failure to adopt infection control measures.

6.7.29 Values and Behaviours

- There were five (5.2%) complaints relating to the Trust's values and behaviours. Three were for NOTSS Division and related to the attitude of staff (other/nursing and medical staff) with the remaining two being for MRC and CSS associated with the attitude of medical staff. All six were rated as moderate.

6.7.30 Facilities

- There was one (1%) complaint relating to Facilities this month. This was related to safety and security issues.

6.8. Managing complaints

6.8.1. The Trust acknowledged 94 (98%) of all complaints within the target of three working days.

6.8.2. The chart presenting the proportion of complaints closed within 25, days or agreed timescale with the complainant, illustrates Quarters 2, 3 and 4 for 2014-15 and Quarter 1 for 2015-2016. The data is not yet available for Quarter 2. This will be presented in the December Board Quality Report.

6.8.3. The number of reopened complaints continues to be monitored each month. In September there were requests for 10 complaints to be reopened across three divisions (NOTSS, MRC and S&O) in contrast to August when there were requests for eight complaints to be reopened across all divisions. There does not 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 do not feel were answered fully in the original response with others requesting a further investigation. Other complainants require a meeting with senior divisional staff upon receipt of their complaint to discuss the points in the response which is offered to all complainants where appropriate.

6.8.4. Bespoke training has been sought out to equip the Complaints and PALS teams, along with senior representatives from each Division to undergo appropriate Facilitation and Mediation training, which will allow staff to conduct resolution meetings in the most appropriate manner. The first session took place on 29 September with a further session scheduled for 27 October 2015. The feedback from the first session was very positive, with all attendees confirming they felt the session was useful and relevant to their roles in supporting complaints. Further sessions will therefore be commissioned to take place before the end of March 2016.

7. Safe Staffing - Nursing and Midwifery

7.1 The Trust is required to comply with The National Quality Board (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.

7.2 This report includes the safe staffing data for September 2015 and the metrics against each of the 5 divisions (appendices 1 a, b, c, d & e), which incorporates Nurse Sensitive Indicators (NSI), for the months of July - September 2015, by division, against the Trust metrics. The overall Trust wide safe staffing report including individual wards and shifts is highlighted in appendix (appendix 1f)

7.3 This report provides a summary of the ongoing nursing and midwifery professional imperatives around safe nursing and midwifery staffing including:

The electronic-Integrated Patient Acuity Monitoring System, (IPAMS).

NMC Revalidation for Nurses and Midwives

Care Contact Time.

7.4 The report discusses the implications that national directives will have on the Trust's need to ensure compliance in all areas of safe staffing for nursing and midwifery.

7.5 The report provides recommendations as to the further work required in order to provide assurance and compliance.

7.6 It also highlights the progress to date.

National reporting for Safe Staffing September 2015

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

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

7.9 These figures should be understood to include high levels of temporary staff in some clinical areas, as well as the Trust's permanent staff, and does not reflect the skill mix or the experience levels of staff i.e. it will not indicate if they are newly qualified or newly appointed nurses recruited from the EU.

7.10 The Trust is currently experiencing a high turnover of junior Registered Nurses within 12 months of taking up post, and this leads to a constant 'churn' of staff requiring recruitment, orientation and training, and as such impacts on the stability of the workforce and impact on the Trust's resources

7.11 Some of the % will appear satisfactory, although there were between six and 10 beds closed in children's services and one bed closed in the Renal Ward early in September, and four beds closed in Sobell House from the first week of September due to 'at risk' levels of staffing.

7.12 **Unify data - September 2015**
The fill rates including temporary staff are:
95.85% for Registered Nurses/Midwives
91.37% for Nursing Assistants (unregistered)

Acuity and Dependency Review July 2015

7.13 The Acuity and Dependency review of staffing establishment levels was last undertaken manually in January 2015 for two weeks and this has been repeated in the latter two weeks of July, the results are included within an appendix (Appendix paper 2)

Developments in the measurement of patient acuity

Background

7.14 The Trust currently reviews staffing levels via a temporary ward monitoring system (excel spreadsheet) which is reported and scrutinised daily. A Red, Amber, Green rating (RAG) is applied and reviewed at twice daily staff at bed capacity meetings held on each hospital site. These meetings address short notice deficits in staff and addresses the needs of areas with increased acuity and activity. The levels of

'agreed', minimum' & escalation at risk' shifts are established as a template of levels and skill mix for each ward, and the RAG rating is marked against these levels so each ward has a specific agreed staffing requirement.

7.15 The meeting ensures awareness and review of shifts that require 'escalation' in order to allow for mitigation to support these clinical areas. Those shifts reported as minimal level shifts, indicate less resilience in relation to short notice issues such as sudden sick leave or rapid changes in acuity and some aspects of care maybe delayed as a result of the lower levels of staff and skill mix.

Recording of the bi-annual levels of patient acuity

7.16 Each ward manually records two weeks' worth of acuity data twice a year at present, in all of the adult inpatient areas. This assists with the twice yearly establishment reviews and is in line with NICE guidance. It is recognised that two week acuity level snapshots twice a year gives little evidence as to seasonal trends in acuity levels or day to day fluctuations against activity. It therefore gives a limited picture as to the true nature of the clinical areas specific acuity requirements year on year.

Integrated Patient Acuity Monitoring System (IPAMS)

7.17 IPAMS is a permanent electronic acuity and safe staffing measurement tool. It is currently undergoing the last stages of alignment with the Cerner Millennium EPR system as it pulls patient data from that system to populate the IPAMS tool. Some difficulties in this alignment have delayed the roll out and implementation. This has been addressed through the Safe Staffing Lead, IM&T and the supplier Albatross Financials. The testing has taken place on two wards in October with a view to a roll out plan working with the Divisional Nurses.

7.18 The roll out and implementation is planned for mid-November 2015. This tool meets the specifications, set out 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. It also produces an automated escalation in the case of staffing deficits against planned staffing levels to the relevant matron who is required to respond,

7.19 It will provide reports on actual staffing levels against establishments and planned levels of staff, through the measurement of the acuity scores per patient in each adult ward area (excluding maternity) This will provide consistent data over peaks and troughs of activity and acuity.

7.20 The Trust is currently determining the Red Flag Indicators that can provide the detail to the impact of peaks and troughs of staffing levels and skill mix, i.e. cancelled study time, or missed staff breaks.

Care Contact Time – Quality of time nurses spend with patients

7.28 In November 2014 NHS England published a document, “Safer Staffing: A Guide to Care Contact Time.”

7.29 The report follows up on the NICE guidance for Safe Staffing, which recommended monitoring and action to ensure patients receive the optimal level of nursing care and direct contact time with Registered Nurses, Midwives and Nursing Assistants that they require for safe and effective care. The emphasis is not solely based on the numbers of staff within the establishments and on each shift, but the direct contact hours that provides the quality aspects of care with minimal distractions that can detract from essential patient care.

7.30 The provision of ‘Safe Staffing’ entails a more complex approach to not just examining the numbers of staff in ratio to patients, but also the quality of their contact. This also includes examination of the level of staff providing the care, which can range from very experienced ward sisters/charge nurse to new registrants who require supervision and guidance.

7.31 Care Contact time is the time nursing and midwifery staff spend providing direct care, such as patient hygiene, monitoring vital signs, dressing wounds and preventing and managing pressure ulcers. This needs to be balanced with indirect patient care. For example, attendance at multidisciplinary ward rounds, or liaising with families to plan complex discharges and supporting junior staff

7.32 The measurement and understanding of Care Contact time can be used to drive local improvement, support and determine the levels and skill mix of nursing and midwifery establishments but also enable more care from registered patient facing staff through the inclusion of administration staff within ward establishments, who can take up the support services that detract from direct nursing care over the 24 hour period 7 days a week i.e. ward clerk hours and sisters assistants.

7.33 The guidance is intended to support and compliment senior nurses/midwives ‘Professional Judgement’ in determining the skill mix of establishments but also the day to day difficult decision making related to safe staffing, and support the longer term perspective.

The implications for the Trust

7.34 The Trust will need to carry out a Care Contact time assessment of each clinical area to provide a baseline indication of the construction of care provided. (This time will vary depending on patient acuity and speciality.)

7.35 On a ward by ward basis the data collected would then be considered alongside other indicators such as FFT, Staff FFT, NICE Red Flags and locally agreed Nurse Sensitive Indicators.

7.36 ‘Assessment audits of Care Contact time would need to be undertaken using consistent methodology to build upon, and titrated against any changes in service or acuity. In specialist areas these would be undertaken six monthly, and in all other areas if there are incidences of failing Nurse Sensitive Indicators, i.e. Hospital Acquired Pressure Ulcers. Additionally, if the care model is changed, a change in skill mix, or the introduction of new technology.

The use of this tool and its implications will be included within the ward leadership training and development strategy.

The Trust's preparation for Care Contact Time

7.37 The publication of the Care Contact Time document suggested two data collection tools although no mandatory stipulation was made. The Deputy Chief Nurse benchmarked and visited other Trusts including Central Manchester University Hospitals NHS FT in scoping tools that are currently being used.

7.38 The Manchester Clock tool was trialled in some of the surgical ward areas and was found to be user friendly and readily accepted as useful in the data it provided sisters.

7.39 The Trust has developed a template that can process the data collected at ward level by Registered Nurses and Nursing Assistants for periods of their shifts. This includes information of their activities at five minute intervals and includes the levels of interruptions etc. This is translated into percentages of activities that are categorised as direct care or indirect care for each clinical area.

7.40 Further information will become available from NHS England in the near future regarding how often Trusts are required to report nationally on the Care Contact time percentages. However the Trust plans to undertake a baseline audit following a communication strategy with of all clinical areas.

Current status of nursing and midwifery staffing within the Trust

7.41 The Trust continues to have a high percentage of nursing vacancies throughout the Trust and as a result utilises high levels of temporary staffing.

7.42 Approximately a third of shifts across the Trust are the category of 'minimum staffing' and occur mainly on day shifts during the week. The impact of this is described in the narrative with each divisional dashboard in the appendices.

7.43 The graded levels safe staffing are RAG rated and these thresholds are used to determine each shifts status of level of risk according to each ward's patient group needs, and the levels and skill mix required to deliver safe care. The establishments are determined through the measurement of the 6 monthly patient acuity levels which link into the budget setting process.

7.44 However, these are managed day to day through changes in patient activity and acuity which fluctuates and planned levels of staff change as does the levels of actual staff who work the shifts dependent upon variations of activity. The actual levels of staff can be impacted by short notice sickness, unexpected escort duties to radiology or across sites, deteriorating patients and increases in acuity that are not pre-determined, as well as accessibility to temporary staff, i.e. filled vs unfilled shifts.

7.45 The actual staffed shifts are discussed and managed twice a day at staff and bed capacity meetings daily, and as changes occur by the sisters/charge nurses and matrons during the day and at night.

These include:

Agreed establishment levels of staff (green)

If there is a normal establishment allowance of for example 5 RNs + 3NAs for a 30 bedded ward that would be a ratio of 6 patients to 1RN dependent upon the acuity levels of the patients.

Minimum levels of staff (amber)

Should there be a vacancy or short notice sickness reducing the level to 4RNs + 3NAs (ratio of 7.5 patients :RN), for the purposes of that shift, the sister could be included in the numbers for medication rounds although she/he will be undertaking the co-ordination, managing complex discharges, attending the operations capacity meeting and ward rounds as well.

At risk levels of staff for escalation (red)

If there are vacancies and sickness with no or short notice and the temporary staff shifts aren't filled (which is common) the levels of staff maybe 3RNs + 2 NAs (ratio of 10 patients: RN). This requires escalation to ensure safe care although potentially quality of care can be affected and processes such as patient's washes, medication rounds and discharge process would be delayed. The potential mitigation that matrons would seek, would be to move staff from a ward with less acute patients where they have establishment levels of staff on shift, if the skill mix is appropriate.

Many wards however have high levels of new graduate nurses or newly recruited staff from the EU under supervision as well as students to supervise, so this is not always appropriate. Staff that provide the supervision and training are often brought into the numbers, as are the sisters and matrons, and this over time has an impact on the work that they are trying to undertake i.e. managing Datix reports, audits, appraisals, managing staff performance, supervision of the clinical staff etc.

There are times when mitigation is not completely possible and it is difficult to find sufficient staff to provide adequate cover. The only and last resort is to try and close beds to reduce activity, but this is very difficult especially in acute general medicine wards where the pressure for beds is high.

Benchmarking

The recent CQC report for Cambridge University Hospitals NHS Foundation Trust dated 22nd September 2015, in which the CQC found the Trust to be inadequate; one of the risks identified during the inspection included staffing levels and skill mix.

'There was a significant shortfall of staff in a number of areas, including critical care services and those caring for unwell patients. This often resulted in staff being moved from one area of a service to another to make up the staff numbers. Although gaps left by staff moving were backfilled with bank or agency staff, this meant that services often had staff with an inappropriate skill mix, and patients were being cared for by staff without training relating to their specialist health needs. Despite this staff were exceptionally caring.'

The OUH FT does move Registered Nursing and Nursing Assistant staff on a shift by shift basis, but staff are moved between wards on the basis that they undertake more generic duties. Staff are not moved from wards to work in a critical care area such as the Emergency Department for instance, unless they undertake more generic duties that are in support of the specialist staff. This also applies to temporary staff.

Revalidation for Nurses & Midwives

Background

7.46 The NMC holds the register of nurses and midwives who meet their requirements to practice. The organisation exists to protect the public, and ensure that nurses and midwives are, and continue to be, fit to practice.

7.47 Current requirements for confirming nurses and midwives are fit to practice include a three yearly Notification of Practice form. This is completed and signed by the individual, claiming fitness to practice against a number of criteria. These criteria include a number of practice hours completed, a number of continuing professional development hours completed, declaration of good character and good health.

7.48 From April 2016 the NMC requirements are changing for revalidation. These requirements are set out below. They form a portfolio of evidence each nurse and midwife will be required to hold. Every practicing nurse and midwife will be required to obtain a third party, (confirmer), to sign off their fitness to practice against the evidence provided in their portfolio.

The Trust has the responsibility to ensure that all nurses and midwives comply with these requirements. The onus however remains with the individual registrant to ensure that they revalidate every three years and re-register annually. Should nurses and midwives not comply with these requirements, they will lapse their registration and not be able to practice, which in turn presents a risk to the Trust.

7.49 The NMC requirements are:

- Sign off of 450 hours or more clinical practice in 3 years.
- Sign off of 35 hours or more continuing professional development in 3 years of which 20 hours should be participatory learning.
- To have completed an appraisal against the new Code.
- Have completed, obtained sign off and had a discussion with a ‘Confirmer’ who must be a registered nurse, regarding reflective pieces on at least 5 instances of practice related feedback.
- Provided evidence of a professional indemnity arrangement.

The implications and risks for the Trust

7.51 The new NMC requirements come into force from 1st April 2016. Nurses and midwives will need to commence preparation and the development of an evidence portfolio now.

7.52 There will be no grace period provided by the NMC, therefore if nurses and midwives fail to produce their revalidation evidence and have not obtained their third party ‘Confirmer’ sign off and uploaded their details to the NMC website; they will lapse from the register. This means that they would be required to be referred to and assessed by the Registrars Advisory Group at the NMC who will make a decision as to whether the registrant is allowed back on the register with the required evidence. This process can take 2-6 weeks.

7.53 This is also the case if the annual fee paying date is not met. This process commences as of November 2015, whereby nurses and midwives who have not paid their annual fees will lapse one minute past midnight on their expiry date and

the above procedure applies. There were 79 cases during 2014/15 when this occurred in this Trust.

7.54 In either case the Trust would incur temporary staffing costs, whilst these registrants await an NMC decision once they have submitted their portfolio of evidence, as they are unable to work, adding to existing vacancy pressures.

7.55 The OUH FT has approximately 4220 nurses and midwives on its Electronic Staff Record data base. Scoping is in progress to discover how many nurses and midwives are on honorary contracts and will need to attribute their revalidation process to OUH FT. In addition to this there are approximately 300-500 research nurses that will need to revalidate through the Trust.

7.56 The Trust is has worked with its current provider for ELMs e learning and appraisal and developed an electronic tool with the ability to upload evidence in an e-portfolio. The tool would also alert managers and individuals when their staff are due to revalidate. It will attribute a red, amber, green rating as to levels of evidence and stages of revalidation the individual complies with over the time leading up to their expiration date; which provides an indicator of assurance with compliance levels within the trust. The planned implemented and roll out will take place in mid-November 2015.

7.57 A communication plan and strategy is in place and being implemented to increase awareness and create a state of readiness at OUH FT. Thus far there has been good engagement from staff.

7.58 A business case was approved in July 2015 to provide resources to support this process within the Trust as there are significant needs related to training, and the roll out process as well as managing the tool and providing the relevant reports to inform the Trust as well as scrutiny of all new appointments to the Trust in terms of their stage and progress in revalidation (as this covers a 3 year period). A KPMG audit earlier in 2015 has demonstrated a good level of assurance in the Trust's state of preparedness. if the business case is implemented.

8. Recommendations

8.1. The Trust Board is asked to receive and discuss this Board Quality Report, providing information from within the organisation on the measures being taken in relation to quality assurance and improvement.

Tony Berendt
Medical Director

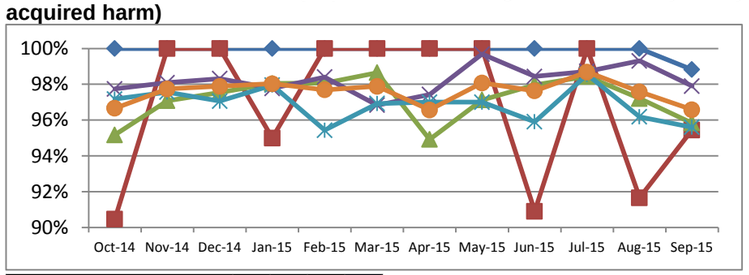
Catherine Stoddart
Chief Nurse

November 2015

Board Quality Report Dashboard

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

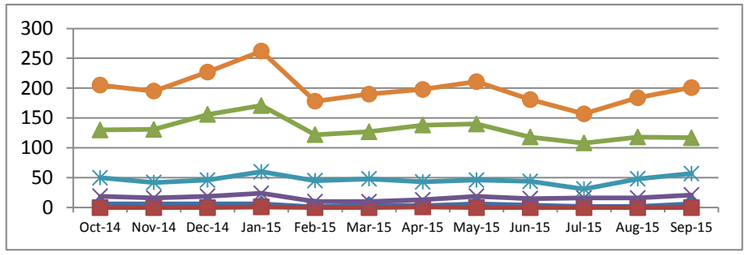
PS01 – Safety Thermometer (% patients receiving care free of any newly acquired harm)



RAG threshold	Red	95%	Amber	97%

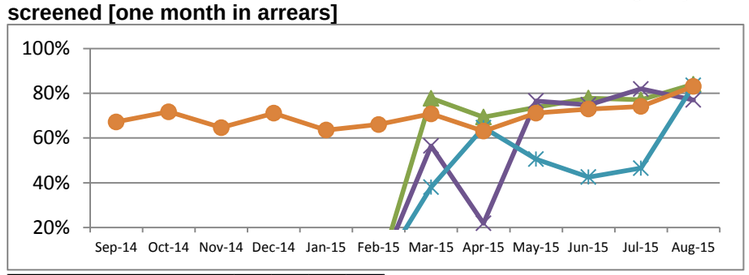
Division	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Trend to date
Children's & Women's	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	98.82%	
Clinical Support Services	90.48%	100.00%	100.00%	95.00%	100.00%	100.00%	100.00%	100.00%	90.91%	100.00%	91.67%	95.45%	
Medicine, Rehabilitation & Cardiac	95.17%	97.09%	97.54%	98.05%	98.07%	98.65%	94.92%	97.12%	97.97%	98.44%	97.20%	95.83%	
Neuroscience, Orthopaedics, Trauma & Specialist Surgery	97.74%	98.09%	98.32%	97.77%	98.40%	96.84%	97.43%	99.69%	98.44%	98.72%	99.31%	97.90%	
Surgery & Oncology	97.17%	97.56%	97.06%	97.95%	95.44%	96.92%	97.00%	97.00%	95.90%	98.55%	96.18%	95.60%	
OUH	96.66%	97.74%	97.89%	98.03%	97.69%	97.89%	96.56%	98.07%	97.63%	98.68%	97.58%	96.58%	

CE02 – Crude Mortality



Division	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Trend to date
Children's & Women's	6	6	6	6	1	5	3	6	4	2	2	6	
Clinical Support Services	0	0	0	1	0	0	1	0	0	0	0	0	
Medicine, Rehabilitation & Cardiac	130	131	156	171	122	127	138	140	118	108	118	117	
Neuroscience, Orthopaedics, Trauma & Specialist Surgery	19	16	19	24	10	10	13	19	15	16	16	21	
Surgery & Oncology	50	42	46	60	45	48	43	46	44	31	48	57	
OUH	205	195	227	262	178	190	198	211	181	157	184	201	

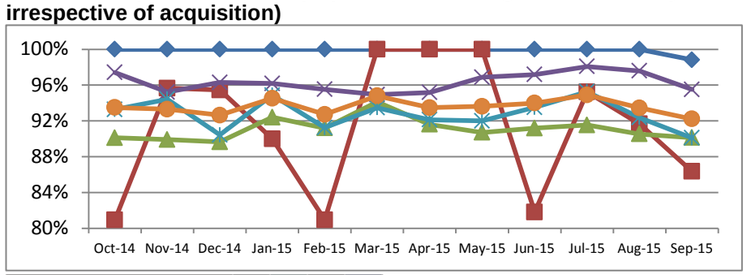
CE03 – Dementia - % patients aged > 75 admitted as an emergency who are screened [one month in arrears]



RAG threshold (Trust)	Red	80%	Amber	90%

Division	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Trend to date
Medicine, Rehabilitation & Cardiac	n/a	n/a	n/a	n/a	n/a	n/a	77.76%	69.35%	73.77%	77.84%	77.08%	84.03%	
Neuroscience, Orthopaedics, Trauma & Specialist Surgery	n/a	n/a	n/a	n/a	n/a	n/a	56.47%	21.92%	76.53%	74.78%	81.93%	77.01%	
Surgery & Oncology	n/a	n/a	n/a	n/a	n/a	n/a	38.04%	64.63%	50.57%	42.55%	46.58%	83.54%	
OUH	67.20%	71.71%	64.66%	71.12%	63.56%	66.02%	70.79%	63.09%	71.17%	72.92%	74.08%	83.09%	

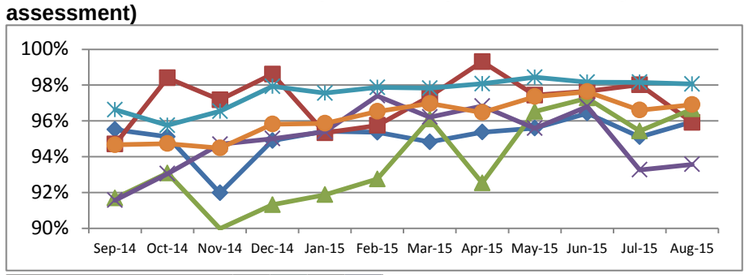
PS02 – Safety Thermometer (% patients receiving care free of any harm - irrespective of acquisition)



RAG threshold	Red	91%	Amber	93%

Division	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Trend to date
Children's & Women's	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	98.82%	
Clinical Support Services	80.95%	95.65%	95.45%	90.00%	80.95%	100.00%	100.00%	100.00%	81.82%	95.24%	91.67%	86.36%	
Medicine, Rehabilitation & Cardiac	90.11%	89.91%	89.66%	92.41%	91.20%	94.13%	91.61%	90.71%	91.20%	91.54%	90.54%	90.13%	
Neuroscience, Orthopaedics, Trauma & Specialist Surgery	97.42%	95.22%	96.30%	96.18%	95.53%	94.94%	95.18%	96.88%	97.19%	98.08%	97.59%	95.51%	
Surgery & Oncology	93.29%	94.43%	90.44%	94.88%	91.25%	93.46%	92.13%	92.00%	93.52%	95.27%	92.37%	90.11%	
OUH	93.50%	93.32%	92.65%	94.53%	92.72%	94.80%	93.48%	93.63%	93.99%	94.90%	93.46%	92.22%	

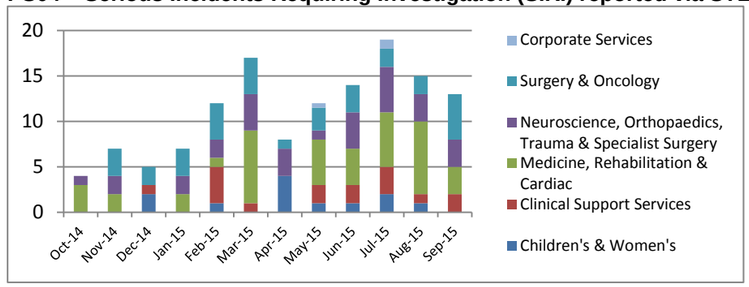
PS03 – VTE Risk Assessment (% admitted patients receiving risk assessment)



RAG threshold	Red	95%	Amber	95.25%

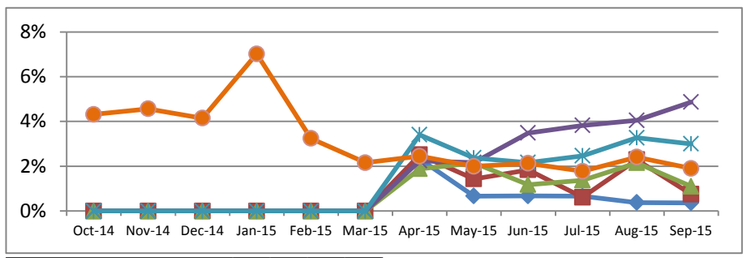
Division	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Trend to date
Children's & Women's	95.52%	95.12%	91.98%	94.90%	95.42%	95.36%	94.83%	95.37%	95.60%	96.43%	95.11%	95.95%	
Clinical Support Services	94.71%	98.40%	97.18%	98.61%	95.33%	95.74%	97.37%	99.31%	97.44%	97.66%	98.02%	95.92%	
Medicine, Rehabilitation & Cardiac	91.69%	93.08%	89.98%	91.32%	91.88%	92.76%	96.11%	92.54%	96.52%	97.27%	95.44%	96.67%	
Neuroscience, Orthopaedics, Trauma & Specialist Surgery	91.57%	93.05%	94.70%	95.01%	95.39%	97.40%	96.21%	96.83%	95.59%	96.80%	93.27%	93.58%	
Surgery & Oncology	96.62%	95.76%	96.54%	97.93%	97.56%	97.87%	97.83%	98.08%	98.44%	98.17%	98.15%	98.06%	
OUH	94.67%	94.73%	94.49%	95.82%	95.86%	96.53%	96.97%	96.47%	97.36%	97.63%	96.60%	96.91%	

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



Division	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Trend to date
Children's & Women's	0	0	2	0	1	0	4	1	1	2	1	0	
Clinical Support Services	0	0	1	0	4	1	0	2	2	3	1	2	
Medicine, Rehabilitation & Cardiac	3	2	0	2	1	8	0	5	4	6	8	3	
Neuroscience, Orthopaedics, Trauma & Specialist Surgery	1	2	0	2	2	4	3	1	4	5	3	3	
Surgery & Oncology	0	3	2	3	4	4	1	2.5	3	2	2	5	
Corporate Services	0	0	0	0	0	0	0	0.5	0	1	0	0	
OUH	4	7	5	7	12	17	8	12	14	19	15	13	

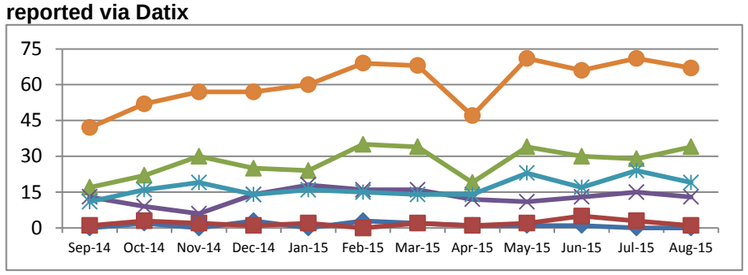
PS10 - % of incidents associated with moderate harm or greater



RAG threshold (Trust)	Red	6.5%	Amber	5%

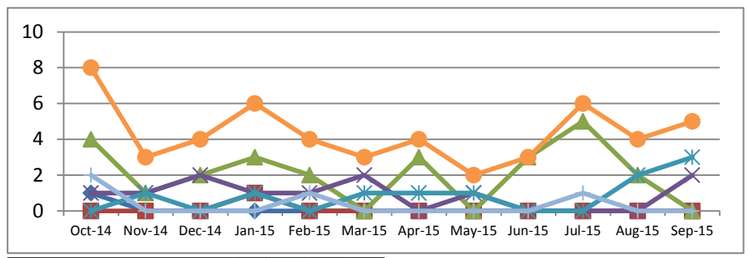
Division	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Trend to date
Children's & Women's	n/a	n/a	n/a	n/a	n/a	n/a	2.32%	0.67%	0.67%	0.66%	0.38%	0.36%	
Clinical Support Services	n/a	n/a	n/a	n/a	n/a	n/a	2.51%	1.43%	1.84%	0.61%	2.29%	0.75%	
Medicine, Rehabilitation & Cardiac	n/a	n/a	n/a	n/a	n/a	n/a	1.88%	2.15%	1.17%	1.38%	2.15%	1.10%	
Neuroscience, Orthopaedics, Trauma & Specialist Surgery	n/a	n/a	n/a	n/a	n/a	n/a	2.24%	2.16%	3.49%	3.82%	4.05%	4.86%	
Surgery & Oncology	n/a	n/a	n/a	n/a	n/a	n/a	3.40%	2.37%	2.16%	2.46%	3.27%	3.00%	
OUH	4.32%	4.56%	4.14%	7.02%	3.24%	2.15%	2.45%	1.99%	2.13%	1.77%	2.40%	1.90%	

PS11 - Total number of newly acquired pressure ulcers (category 2,3 and 4) reported via Datix



Division	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Trend to date
Children's & Women's	0	2	0	3	0	3	2	1	1	1	0	0	
Clinical Support Services	1	3	2	1	2	0	2	1	2	5	3	1	
Medicine, Rehabilitation & Cardiac	17	22	30	25	24	35	34	19	34	30	29	34	
Neuroscience, Orthopaedics, Trauma & Specialist Surgery	13	9	6	14	18	16	16	12	11	13	15	13	
Surgery & Oncology	11	16	19	14	16	15	14	14	23	17	24	19	
OUH	42	52	57	57	60	69	68	47	71	66	71	67	

PS12 - Falls leading to moderate harm or greater



RAG threshold (Trust)	Red	8	Amber	7

Division	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Trend to date
Children's & Women's	1	0	0	0	0	0	0	0	0	0	0	0	
Clinical Support Services	0	0	0	1	0	0	0	0	0	0	0	0	
Medicine, Rehabilitation & Cardiac	4	1	2	3	2	0	3	0	3	5	2	0	
Neuroscience, Orthopaedics, Trauma & Specialist Surgery	1	1	2	1	1	2	0	1	0	0	0	2	
Surgery & Oncology	0	1	0	1	0	1	1	1	0	0	2	3	
Corporate Services	2	0	0	0	1	0	0	0	0	1	0	0	
OUH	8	3	4	6	4	3	4	2	3	6	4	5	

Clinical Support Services Division, (CSS),Safe Staffing Dashboard Inpatient Areas only

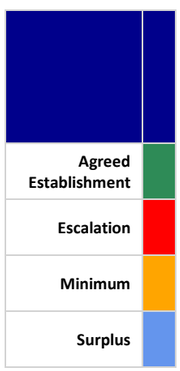
November 2015 Appendix 2a

Oxford University Hospitals NHS
NHS Foundation Trust

CSS				Trust		
	July 15	August 2015	September 2015	July 15	August 2015	September 2015
Total Funded WTE	179.81	179.8	181.8	2956.24	2957.2	2969.6
Vacancy %	6.5%	18.6%	2.5%	9.7%	10.9%	7%
Sickness %	3.6%	5.6%	4.5%	4.4%	4.2%	4.3%
Maternity/Adoption Leave %	6.8%	7.3%	5.1%	3.3%	3.2%	3.1%
Agreed Staffing Levels %	90%	76%	82%	73%	69%	71%
Total number of Medication Nursing Administration Errors or Concerns.	4	4	5	76	59	70
Total numbers of Hospital Acquired Pressure Ulcers	2	1	0	99	90	98
Total Number of Avoidable Grade 3-4 Hospital Acquired Pressure Ulcers.	0	0	0	3	3	6
Total Numbers of Falls	0	1	0	231	168	193
Falls with moderate, major or catastrophic harm	0	0	0	4	3	5

September 2015 Safe Staffing by Inpatient ward for CSS division.

EARLY SHIFT



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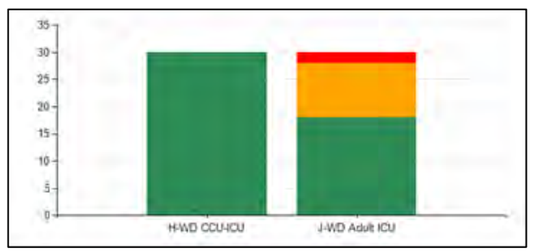
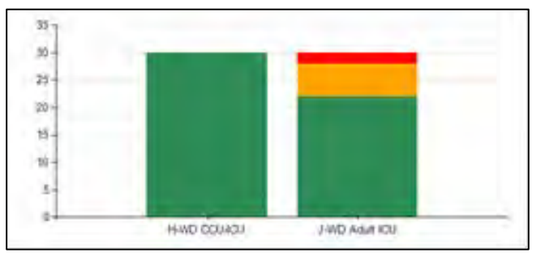
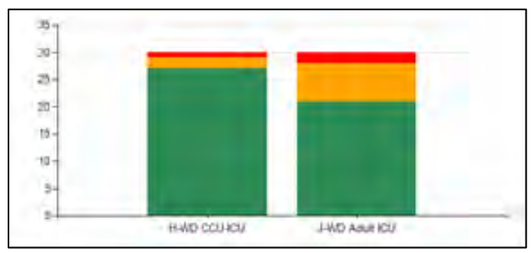


LATE SHIFT



NIGHT SHIFT



Narrative Robust recruitment has taken place across adult critical care areas to reduce the shortfall in nursing numbers. A number of staff left during the summer months and the vacancy rate increased accordingly. A recruitment campaign for band 5 nurses is ongoing. Quality indicators remain stable. This division supports the highest level of maternity/adoption leave in the Trust within in-patient areas and it should be noted that this is not covered by the 20% uplift

Note: 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 20th 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.

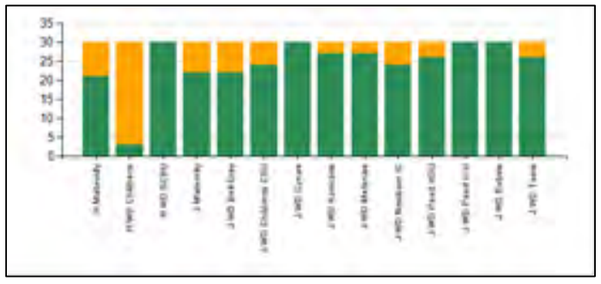
Children's and Women's Division, (C&W),
Safe Staffing Dashboard (In-patient Areas only) November 2015
Appendix 2b

Oxford University Hospitals NHS
NHS Foundation Trust

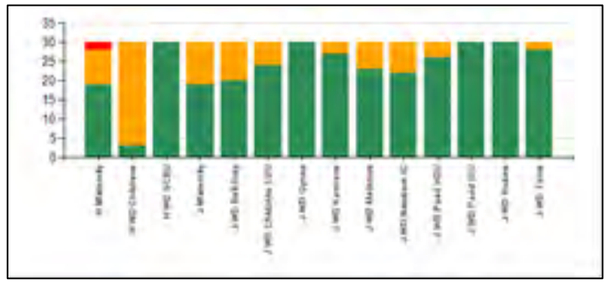
C&W				Trust		
	July 15	August 2015	September 2015	July 15	August 2015	September 2015
Total Funded WTE	765.50	766.5	768.4	2956.24	2957.2	2969.6
Vacancy %	10.0%	11.5%	6.9%	9.7%	10.9%	7%
Sickness %	5.3%	5.1%	4.5%	4.4%	4.2%	4.3%
Maternity/Adoption Leave %	4.2%	3.8%	3.9%	3.3%	3.2%	3.1%
Agreed Staffing Levels %	79%	76%	79%	73%	69%	71%
Total number of Medication Nursing Administration Errors or Concerns.	13	15	15	76	59	70
Total numbers of Hospital Acquired Pressure Ulcers	4	0	4	99	90	98
Total Number of Avoidable Grade 3-4 Hospital Acquired Pressure Ulcers.	0	0	0	3	3	6
Extravasation incidents	0	3	2	3	12	6

September 2015 Safe Staffing by inpatient wards for C&W division.

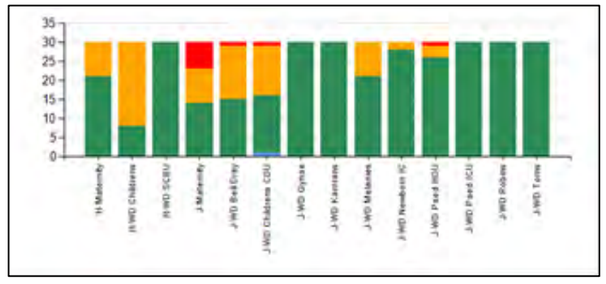
EARLY SHIFT

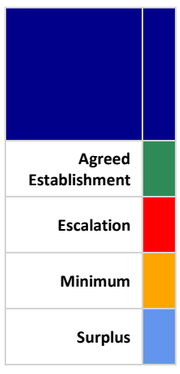


LATE SHIFT



NIGHT SHIFT





Narrative: In most cases the agreed establishment to maintain safe staffing was maintained by moving staff and flexing beds between the wards. This is due in the main to last minute sickness of staff and constraints on the booking of temporary staff and 'no shows' and temporary staff cancellations. Although there was a reduction in the number of vacancies in the Children's Hospital towards the end of September due to recruitment of over 20 wte new graduates, many did not have their PIN numbers and needed a period of induction and orientation. The new-born care and critical care unit and critical care units still have a significant number of vacancies. In order to maintain agreed safe staffing levels it was still necessary, on occasion to close beds and CDU. This is not possible in new born care as there is a commitment to the Network and so some high cost agency staff were used. So where escalation shifts are shown these were also mitigated by the above actions.

In maternity services, there is a flexible approach to covering the high acuity areas, which are determined through the use of the Birth-rate plus tool. In order to respond to activity in Delivery Suite there is a reciprocal arrangement between the staff in the community and hospital whereby staff are allocated to work where the need is greatest.

In Gynaecology staff are moved from the day care or outpatients to maintain safe staffing. Acuity measurement is carried out in Gynaecology. The acuity and dependency tool for Children's is still awaiting final endorsement from NHS England. The extravasation quality indicator, which is the most sensitive to staffing levels in children's has remained fairly static. This is being monitored closely against staffing levels and skill mix, and each incident investigated. NB: These figures relate to selected inpatient areas against specific indicators that are being monitored as nursing

Medicine, Rehabilitation & Cardiac Division, (MRC), Safe Staffing Dashboard (In-patient Areas Only)

November 2015

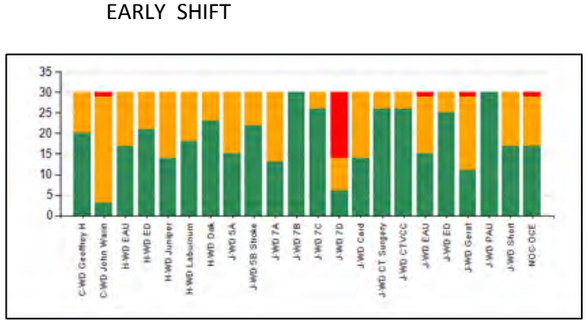
Oxford University Hospitals NHS
NHS Foundation Trust

Appendix 2c

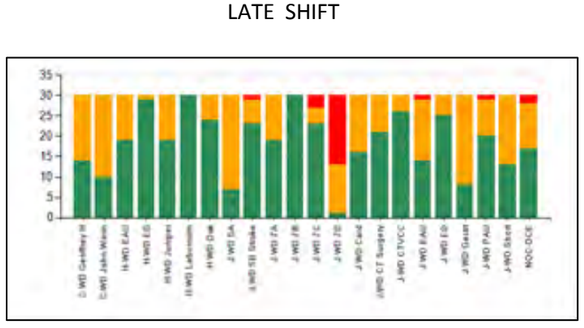
MRC				Trust		
	July 15	August 15	September 15	July 15	August 15	September 15
Total Funded WTE	885.84	886.8	892.8	2956.24	2957.2	2969.6
Vacancy %	8.3%	8.7%	5.9%	9.7%	10.9%	7%
Sickness %	4.2%	3.6%	4.4%	4.4%	4.2%	4.3%
Maternity/Adoption Leave %	2.4%	2.6%	2.2%	3.3%	3.2%	3.1%
Agreed Staffing Levels %	70%	68%	68%	73%	69%	71%
Total number of Medication Nursing Administration Errors or Concerns.	35	16	26	76	59	70
Total numbers of Hospital Acquired Pressure Ulcers	35	38	50	99	90	98
Total Number of Avoidable Grade 3-4 Hospital Acquired Pressure Ulcers	0	1	2	3	3	6
Total Numbers of Falls	127	99	112	231	168	193
Falls with moderate, major or catastrophic harm	4	2	0	4	3	5

September 2015 Safe Staffing by Inpatient ward for MRC division.

EARLY SHIFT



LATE SHIFT



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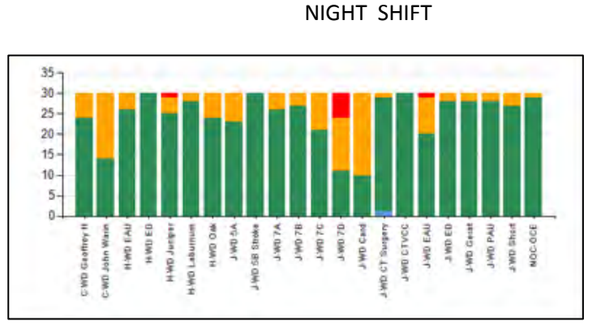


Agreed Establishment

Escalation

Minimum

Surplus

Narrative by Divisional Nurse:

At the time of writing this report the MRC Division has 81 WTE vacant posts for qualified nursing staff at band 5 and 36 WTE vacant posts for unqualified staff (band 4-2). The escalated shifts have been addressed through moving staff from shift to shift between wards and divisions in order to achieve safe cover and to prevent any shift from being left 'At Risk'.

The division continues to encourage 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. There is an on-going educational programme which includes the SKINS care bundle, and a focused approach by the Tissue Viability Team working with clinical staff on a joint action plan in the division with regard to decreasing the levels of Hospital Acquired Pressure Ulcers. The Fallsafe Care Bundle is audited to assess compliance.

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 20th 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), Safe Staffing Dashboard (Inpatient Areas Only) November 2015

Oxford University Hospitals NHS
NHS Foundation Trust

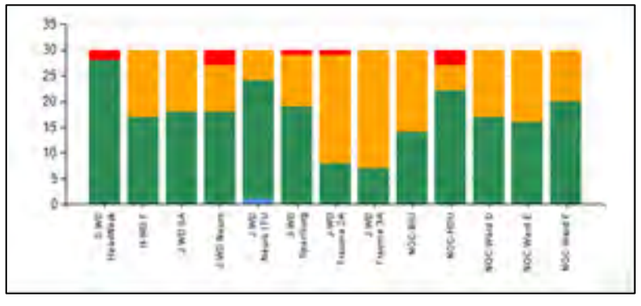
Appendix 2d

NOTSS				Trust		
	July 15	August 2015	September 2015	July 15	August 2015	September 2015
Total Funded WTE	632.72	632.7	632.7	2956.24	2957.2	2969.6
Vacancy %	9.7%	10.3%	6.6%	9.7%	10.9%	7%
Sickness %	4.3%	4.2%	3.6%	4.4%	4.2%	4.3%
Maternity/Adoption Leave %	2.9%	2.9%	2.9%	3.3%	3.2%	3.1%
Agreed Staffing Levels %	77%	75%	64%	73%	69%	71%
Total number of Medication Nursing Administration Errors or Concerns.	16	10	10	76	59	70
Total numbers of Hospital Acquired Pressure Ulcers	19	22	17	99	90	98
Total number of avoidable grade 3-4 hospital acquired Pressure Ulcers	1	1	0	3	3	6
Total Numbers of Falls	72	24	40	231	168	193
Falls with moderate, major or catastrophic harm	0	0	2	4	3	5

September 15 Safe Staffing by Inpatient ward for NOTSS division.

Agreed Establishment
Escalation
Minimum
Surplus

EARLY SHIFT



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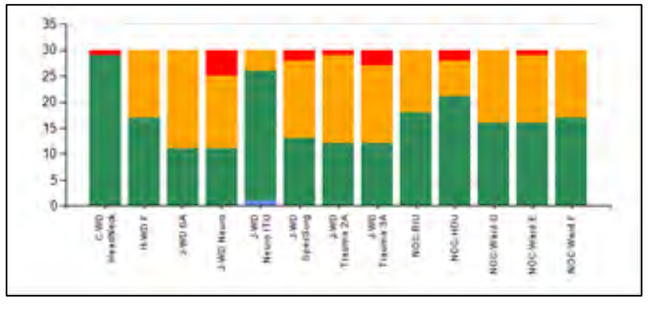
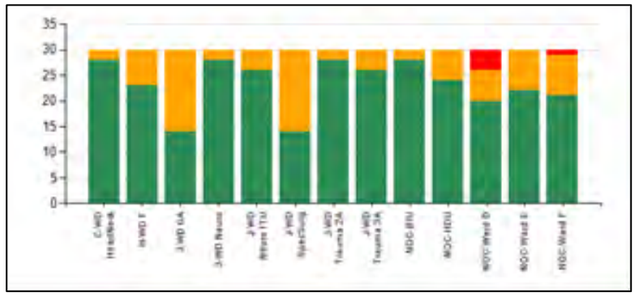


NIGHT SHIFT



Narrative Maintaining staffing levels at minimum or above continues to be a challenge within the NOTSS Division. However due to the EU nurse recruitment campaign agreed staffing levels are expected to increase as intakes of forthcoming cohorts commence in post. Recruitment remains the key focus within the division; there is a drive to ensure the success of the EU recruitment initiative as numbers applying to local registered nurse adverts remains low. There are still high levels of 'minimum' staffing in NOTSS division despite the decrease in vacancy rate in September, this is due to EU staff nurses being in post but working in a supernumery capacity for between 4-6 weeks as they learn a new healthcare system using a second language. In spite of the staffing challenge, quality indicators assure the division that care continues to be safely delivered, although the patient groups within the NOTSS division are often at high risk of falling. Medication errors have decreased, although not consistently so, and the division is monitoring the reporting levels and correlation, using the electronic prescribing and medication administration system.

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 20th 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 (In-patient Areas Only)
November 2015

Oxford University Hospitals NHS
NHS Foundation Trust

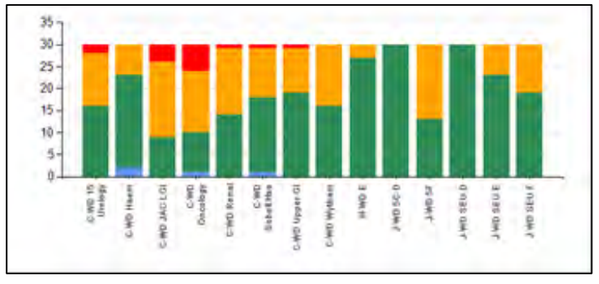
Appendix 2e

S&O				Trust		
	July 15	August 2015	September 2015	July 15	August 2015	September 2015
Total Funded WTE	492.37	491.4	493.8	2956.24	2957.2	2969.6
Vacancy %	13.2%	12.9%	11.1%	9.7%	10.9%	7%
Sickness %	3.7%	3.2%	4.5%	4.4%	4.2%	4.3%
Maternity/Adoption Leave %	2.8%	2.3%	2.6%	3.3%	3.2%	3.1%
Agreed Staffing Levels %	69%	61%	71%	73%	69%	71%
Total number of Medication Nursing Administration Errors or Concerns.	8	14	14	76	59	70
Total numbers of Hospital Acquired Pressure Ulcers	39	29	27	99	90	98
Total Number of Avoidable Grade 3-4 Hospital Acquired Pressure Ulcers.	2	1	4	3	3	6
Total Numbers of Falls	31	42	41	231	168	193
Falls with moderate, major or catastrophic harm	0	1	3	4	3	5

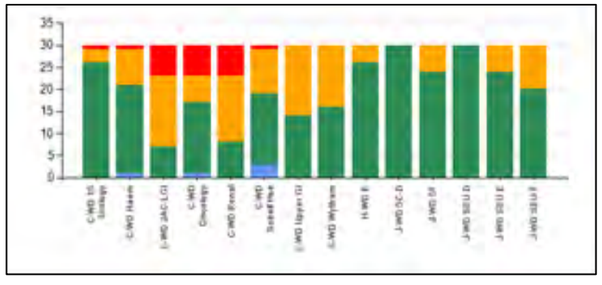
September 2015 Safe Staffing by Inpatient ward for S&O division.

Agreed Establishment
Escalation
Minimum
Surplus

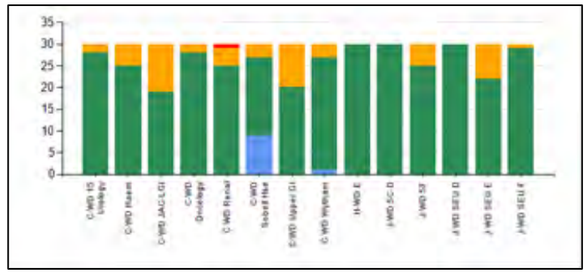
EARLY SHIFT



LATE SHIFT



NIGHT SHIFT



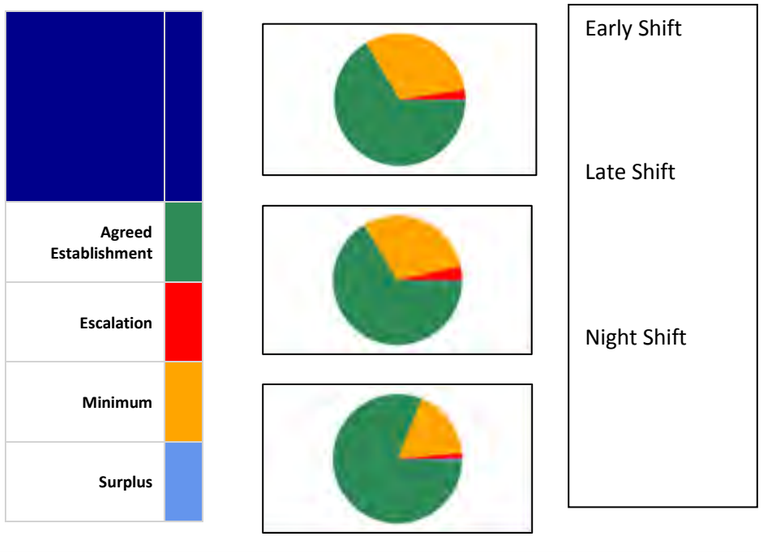
Narrative Recruitment and retention remain a key focus for the Division. S&O wards continue to run on high levels of minimum staffing for a lot of the daytime shifts. To achieve this minimal level of staffing 11 beds were closed beds on CH site for September, study leave cancelled and the ward sister's management time (appraisals, Datix & audits etc.) was reduced. This report does not reflect movement of nursing staff from ward areas to other clinical areas e.g. dialysis units, chemo units and endoscopy units to support staffing levels. The Churchill site continues to work effectively by moving nursing staff to mitigate escalated shifts at the twice daily safe staffing meetings. The Division continues to use agency staff on long lines in key areas – haematology, chemotherapy and dialysis and theatres and at short notice to provide safe care and maintain activity in areas of high vacancy. Hospital Acquired Pressure Ulcers are increasing in S&O and this is a Divisional quality priority. Implementation of the SKINS care bundle is underway with support from the Tissue Viability Team. The clinical indicators for Hospital Acquired Pressure Ulcers and SIRIs are particularly applicable to the correlation of staffing levels. Medication errors or concerns raised continues to rise in line with encouraging reporting of incidents, there was no harm reported. 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 20th 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.

Trust Safe Staffing Dashboard (In-patients only) November 2015
Appendix 2f

Oxford University Hospitals NHS
NHS Foundation Trust

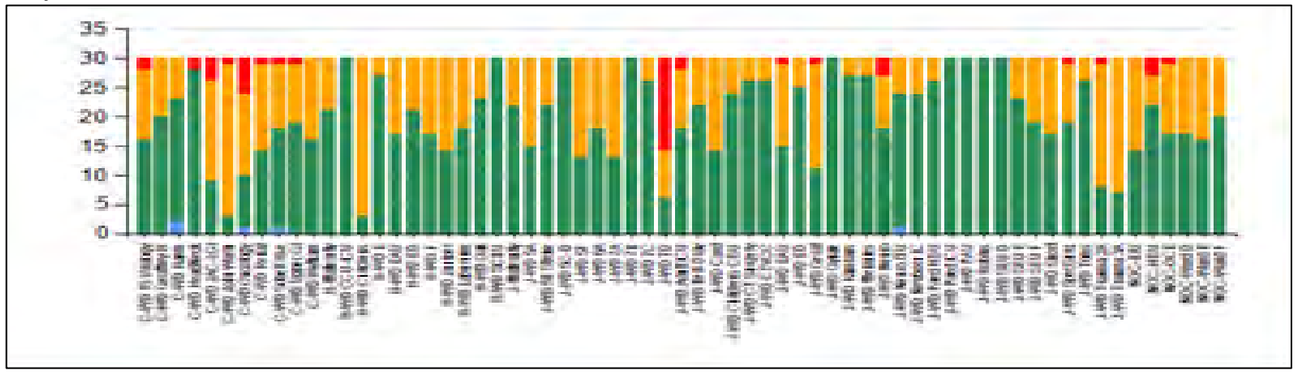
	Trust		
	July 15	August 2015	Sept 2015
Total Funded WTE	2956.24	2957.2	2969.6
Vacancy %	9.7%	10.9%	7%
Sickness %	4.4%	4.2%	4.3%
Maternity/Adoption Leave %	3.3%	3.2%	3.1%
Agreed Staffing Levels %	73%	69%	71%
Total number of Medication Nursing Administration Errors or Concerns.	76	59	70
Total numbers of Hospital Acquired Pressure Ulcers	99	90	98
Total Number of Avoidable Grade 3-4 Hospital Acquired Pressure Ulcers	3	3	6
Total Numbers of Falls	231	168	193
Falls with harm	4	3	5

September 2015 Safe Staffing by Shift: (Inpatient only): Trust.

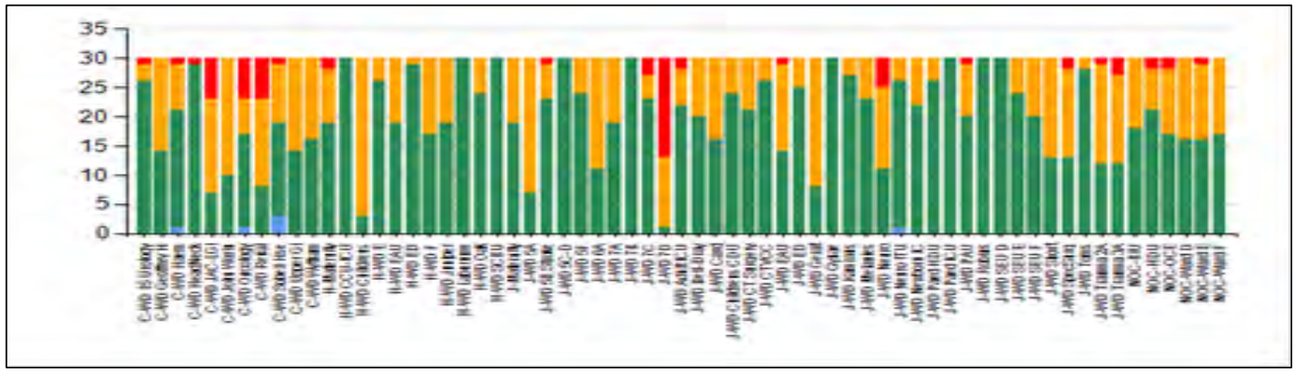


September 2015 Safe Staffing by Inpatient ward: Trust

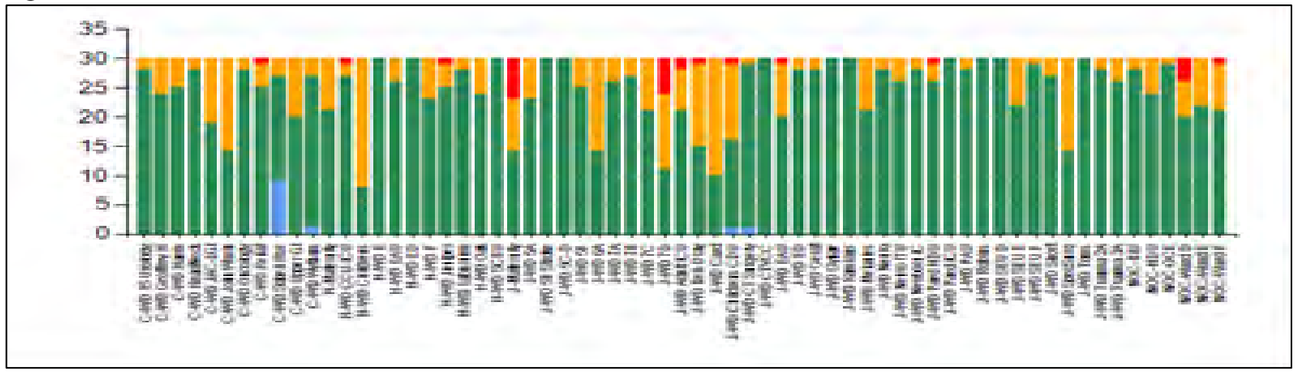
Early Shift



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. There has been a small increase in the levels of 'agreed' staffing levels, principally due to the EU nurse recruitment campaign which is ongoing into 2016. There are however a significant number of red 'escalation' shifts and some clinical areas have high levels of 'minimum' staffing. 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 20th 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.

Trust Safe Staffing Dashboard (In-patients only) November 2015
Appendix 2f

Oxford University Hospitals NHS
NHS Foundation Trust

Appendix 3. Acuity and dependency review of nursing establishments July 2015 - including nurse sensitive indicators Medicine, Rehabilitation & Cardiac Division

Ward	Professional Judgement considerations	The acuity and dependency outcomes
OCE	This ward has a patient group with a high enablement requirement, acuity in the management of tracheostomies and PEG feeds, and a complexity of care including psychological support and discharge arrangements, and high contact with families. Many of the patients require one to one nursing, (specialing), for periods of time OCE has capacity for 34/5 patients. The skill mix has been radically reviewed previously owing to the persistent numbers of vacancies and increasing acuity and dependency of the patients. The establishment now constitutes 72%:28% ratio of registered nurses to Care Support Workers, but includes staff with learning disability and mental health qualifications as well as general nurses, in order to address the cognitive behaviour component of care. .There is on-going work to develop a rotational junior therapist role that forms part of the skill mix. There has been support from the OCE staff in the evolvement of this staff skill mix, and it is gradually addressing the issues related to vacancies. The sister leadership has also been altered and strengthened, with an additional sister in post. The Multi-disciplinary team is largely nurse led. July 15 Quality Metrics. Vacancy Rates: -6% Maternity Rates: 2.85% Sickness Rates: 1.75% All Falls: 13 Falls none with moderate or major harm All Hospital acquired pressure ulcers: 1	Continuing ongoing review of the changes in skill mix.
Gerontology	This is a unit with 39 beds, all as side rooms. The skill mix is 58%:42%, and includes much 1:1 care, (specialing), a complexity of care including end of life, re-enablement, and high levels of medications, with some patients who are on the stroke pathway. Feeding, hydration and the management of new onset delirium, forms a large part of the care requirement, increasing the dependency demand. There is a high level of contact with families.	The skill mix is being reviewed currently. ?

	The skill mix requirement of this specialty continues to be reviewed, specifically with regard to a higher level of therapy, palliation and mental health components. Consideration is being given to rotational posts. Senior staff, including Practice Development Nurses are working with the Support Worker (SWA) Academy to develop therapy competencies in the Nursing Assistant workforce. <u>July 15 Quality Metrics</u> Vacancy Rates: -4.1% Maternity Rates: 0% Sickness Rates: 10.95% All Falls: 21 No falls with moderate or major harm All Hospital acquired pressure ulcers: 0	
Stroke ward	This unit has 19 beds and a fast turnover of highly dependent patients requiring level 2 nursing at times. There have been an increased number of complaints around patient care, and an ongoing assessment is being carried out around the nurse to patient ratios. The skill mix is 67%:33%, and is currently under review along with the stroke pathway which includes beds at the Horton and on OCE. This will include rapid triage through the emergency department to the hyper acute unit, and will encompass a review of the rapid rehabilitation at home, the dietetic and SALT components. The sister leadership has changed and senior management is provided by the matron who is supporting the nursing team. The educational stroke development through the Bucks New University programme is being accessed as well as the development of an in-house accredited stroke care programme for the staff. This will include the capacity to develop stroke specialist nurses. <u>July 15 Quality Metrics</u> Vacancy Rates: 11.8% Maternity Rates: 2.17% Sickness Rates:5.52% All Falls: 4 No falls with moderate or major harm All Hospital acquired pressure ulcers: 3	The stroke pathway and nurse to patient ratios are undergoing a review and a business case will be developed by the MRC division to be presented to the CCG.

7A	This ward has 23 beds and has a 65%:35% split of Registered Nurses (RNs) to Nursing Assistants. There are a high proportion of patients requiring psychological care requiring 1:1 care including those held under the Mental Health Act, many requiring Registered Mental Health Nurses (RMN), with a more mixed age range of patients over the summer and an increased turnover rate. Often the level of patients with cognitive disabilities/dementia are 50% or above on each of these wards. <u>7A July 15 Quality Metrics</u> Vacancy Rates 5.1% Maternity Rates: 2.78% Sickness Rates: 4.24% All Falls: 8 No falls with moderate or major harm All Hospital acquired pressure ulcers: 0 This ward has 21 beds with a skill mix of 69%:31%, due to the patient group having a higher level of acuity including the need for vital sign monitoring.	The skill mixes on these wards were reviewed and increased in 2014/15. Staff feedback has been positive, but there is a constant challenge to manage the turnover of junior staff. The Nurse Sensitive Indicators are monitored closely.
7B	<u>7B July 15 Quality Metrics</u> Vacancy Rates: -1.8% Maternity Rates: 0% Sickness Rates: 2.41% All Falls: 3 Falls with moderate or major harm: 1 All Hospital acquired pressure ulcers: 4, which were at grade 1 or 2.	
7C	This ward has 22 beds and has a 69%:31% skill mix and a high acuity of patients similar to 7B. <u>7C July 15 Quality Metrics</u> Vacancy Rates: 0.2% Maternity Rates: 0% Sickness Rates: 8.92% All Falls: 10 Falls with moderate or major harm: 1 All Hospital acquired pressure ulcers: 4 which were at grade 1 or 2.	

7D	This ward has 20 beds and has a high level of elderly care and acuity, and a skill mix of 65%:35%. <u>7D July 15 Quality Metrics</u> Vacancy Rates:-7.4% Maternity Rates: 0% Sickness Rates:2.89% All Falls: 3. No falls with moderate or major harm All Hospital acquired pressure ulcers: 0, This ward has 22 beds and has a 65%:35% ratio, with a patient group with increasing levels of dementia that have a higher level of dependency.	
5A	<u>5A July 15 Quality Metrics</u> Vacancy Rates: -2.1% Maternity Rates: 0% Sickness Rates: 5.83% All Falls: 5. Falls with moderate or major harm: 1 All Hospital acquired pressure ulcers:3 which were at grade 1 or 2. This ward has 38 beds and a skill mix ratio of 65%:35%. The acuity levels have been higher than average in the summer and there is a high turnover of patients. The skill mix of staff and the patient group is being monitored and being monitored and reviewed currently	
Short stay ward	<u>Short Stay Ward July 15 Quality Metrics</u> Vacancy Rates:9.5% Maternity Rates: 3.76% Sickness Rates: 3.71% All Falls: 16 Falls with moderate or major harm: 1 All Hospital acquired pressure ulcers: 3, which were at grade 1 or2 All the level 7 wards, 5A and Short Stay Ward all have a level of low impact falls, and in July there were 4 high impact falls, there have also been a level of low grade pressure ulcers and medication incidents. The challenge is the constant turnover of band 5 staff. There are band 6 staff who provide night staff supervision and Practice Development Nurses to support new	

	staff nurses, provide training to Nursing Assistants and orientation to EU recruited nurses.	
PAU (7F)	This ward receives patients awaiting discharge, many with cognitive disabilities/dementia and complicated discharge planning needs, including high contact with families. The skill mix is 50%:50% and this is being reviewed in respect of the complex needs of this patient group. In the summer there has been an increased level of higher dependency patients with longer stays than usual. <u>July 15 Quality Metrics</u> Vacancy Rates: -14.1% Maternity Rates:0% Sickness Rates: 6.88% All Falls: 6 No falls with moderate or major harm All Hospital acquired pressure ulcers: 2 which were at grade 1 or 2.	The skill mix is being reviewed within the division.
Laburnham	The skill mix is 65%:35% on this 28 bedded ward. The patient group on this ward has a level of acuity that includes patients with respiratory and cardiac conditions as well as general medical patients. There is a Nurse Educator appointed and in post at the Horton site, who provides the education and orientation for new staff. <u>July 15 Quality Metrics</u> Vacancy Rates: 2.8% Maternity Rates:0% Sickness Rates: 2.29% All Falls:3 No falls with moderate or major harm All Hospital acquired pressure ulcers: 0,	The ratios on these three medical/stroke rehabilitation wards were reviewed and increased in 2014/15. No change required to the establishment
Juniper	The skill mix is 65:35% on this 30 bedded ward. The patient group includes those with gastroenterology, liver and Cohn's diseases. There are a number of patients who have delayed discharges due to being from out of area. In the summer the acuity of the patients increased.	No change required to establishment

	<u>July 15 Quality Metrics</u> Vacancy Rates: 17.4% Maternity rates: 0% Sickness Rates: 10.95% All Falls:8 No falls with moderate or major harm All Hospital acquired pressure ulcers: 4, which were at grade 1 or 2.	
Oak	The skill mix is 65%:35% on this 36 bedded ward that includes 12 patients on the stroke pathway as well as general medical patients. This ward's stroke pathway is being reviewed, along with the Stroke ward at the JR and the OCE. In the summer Oak had an increase in the patient dependency and two thirds of the patients required high acuity levels of care. Staff with long standing sickness are being addressed <u>July 15 Quality Metrics</u> Vacancy Rates: 18.4% Maternity rates: 6.69% Sickness Rates:4.22% All Falls 12. No falls with moderate or major harm. All Hospital acquired pressure ulcers: 1 which were at grade 1 or 2.	No change required to establishment, although the stroke patient pathway is being reviewed
Geoffrey Harris	This is a 24 bedded ward that specialises in acute respiratory patients and has a skill mix of 67%:33%, including 2 high care beds. The ward is to move to the JR site (5C) in December 2015, and the acuity will continue to be monitored and reviewed on that site. There are a level of clinical incidents due to the acuity of this patient group, including weaning off ventilation, and acute deterioration of patients. <u>July 15 Quality Metrics</u> Vacancy Rates: 23% Maternity rates: 3.95% Sickness Rates: 9.46% All Falls: 2 . No falls with moderate or major harm. All Hospital acquired pressure ulcers: 1, which was at grade 1 or 2.	No change required to establishment currently

John Warin	This ward is funded for 20 beds. The patient group includes infectious diseases, TB and patients who are homeless and have associated conditions to living rough. This is the designated ward should patients be admitted with suspected Ebola. The skill mix is 68%:32.1%, with some vacancies. In the summer the acuity and dependency has increased along with the turnover of patients. <u>July 15 Quality Metrics</u> Vacancy Rates: 9.9% Maternity rates: 3.59% Sickness Rates:6.01% All Falls: 2. No falls with moderate or major harm All Hospital acquired pressure ulcers: 1, which was at grade 1 or 2.	No change required to establishment
Cardiology ward	This ward is large with 41 beds spanning over 2 areas, including a 6 bedded high dependency unit, and rapid assessment unit, and 25 side rooms. The skill mix ratio is 72%:28% in order to accommodate to the acuity levels of this patient group. The indicators include low grade pressure ulcers and falls, which are being addressed although the reporting culture is good. Vacancies are managed within the Cardiac Centre as a whole, and staff moved between units on a daily basis <u>July 15 Quality Metrics</u> Vacancy Rates: 12.4% Maternity Rates: 2.85% Sickness Rates: 1.75% All Falls: .o falls with moderate or major harm. All Hospital acquired pressure ulcers: 4, which were at grade 1 or 2.	No change required to establishment
Cardiothoracic ward	This ward is made up entirely of 25 single rooms and has a high level of acuity for patients who are received from the Cardio Thoracic Critical Care Unit in the immediate phase of step down. The skill mix is 70%:30%. Thoracic trauma patients are often out lied as the ward is often full. There are high levels of vacancies, although the Cardiac Centre moves staff around daily to address the acuity and to mitigate short notice staff deficits.	No change required to establishment

	<u>July 15 Quality Metrics</u> Vacancy Rates: 17.6% Maternity Rates: 5.27% Sickness Rates: 1.28% All Falls: 3 No falls with moderate or major harm All Hospital acquired pressure ulcers: 2, which were at grade 1 or 2.	
EAU JR & HH	The skill mixes are 76%:24% at the JR and 74.8%:25.2% HH. Additional support is being put into place to support junior nursing staff and to improve clinical education through Practice Educator posts The measurement tool for acuity does not suit this clinical area due to the high turnover. A tool is being sourced that will be appropriate <u>EAU JR July 15 Quality Metrics</u> Vacancy Rates: 3.2% Maternity Rates: 0.50% Sickness Rates: 3.99% All Falls: 2 No falls with moderate or major harm All Hospital acquired pressure ulcers: 0, <u>EAU HH July 15.Quality Metrics</u> Vacancy Rates: -3.2% Maternity Rates: 3.66% Sickness Rates: 5.68% All Falls: 3 No falls with moderate or major harm All Hospital acquired pressure ulcers: 1, which was at grade 1 or 2.	Acuity data needs to be collected from these areas using a different tool which is currently being sourced. This is owing to the turnover and acuity being very different to that of the in-patient wards.

Surgery & Oncology Division

Ward	Professional Judgement considerations	Variations to the establishment
Sobell House	This is a partially funded by a charity and provides hospice facilities for palliative care. The skill mix is 60%:40% and this reflects the patient group who require a level of acute care related to their symptom control and medication, but remain high in their dependency of care. The strengthening of leadership has been effective with a visible deputy matron. The skill mix review in 2014 has proved effective and appropriate, optimising staff to an appropriate skill mix. <u>July 15 Quality Metrics</u> Vacancy Rates: 25.4% Maternity Rates: 0% Sickness Rates:7.51% All Falls: 0 No falls with moderate or major harm. All Hospital acquired pressure ulcers: 16, which were at grade 1 or 2.	No further change required to the establishment The quality metrics are being monitored closely in relation to the vacancy rate and 6 beds are closed at present to reduce the risk factors.
Haematology	The specialist nature of this ward requires a high level of registered nurse to unqualified skill mix related to cancer care and the administration of chemotherapy as well as the care of other patients with other haematology conditions. This skill mix is 82%:18%. The level of acuity is high in these patients especially on deterioration, and in the cases of neutropenia sepsis. Agency staff in general do not have the specialist competencies or the technical skill set to manage this patient group as they require the National Chemotherapy course. The ward's own staff undertake bank work coupled with long line specialist agency workers in order to provide an optimal level of temporary staffing. The nursing workforce has been supplemented with the use of x 5 specialist high cost chemo trained agency nurses until their own newly recruited staff are trained. This patient group require skilled staff in the management of syringe drivers and complex chemotherapy medication required, the majority of patients have a high level of acuity. Benchmarking with the Shelford Group demonstrates that OUH compared to other Trusts has a higher level of band 5 and lower level of skilled band 6 staff in specialist posts. These posts support, train and supervise the more junior workforce.as well as providing a career	No change required to the establishment The career pathway for the staffing staffing establishment is being reviewed

	structure. The lack of a career structure is known to be the reasons for staff attrition to other Trusts to gain a band 6 post. The acuity of patients varies and the level of registered nurse cover is being monitored for trends to ensure adequate support for patients especially out of hours. The quality indicators however are well managed. <u>July 15 Quality Metrics</u> Vacancy Rates:27% Maternity rates:0% Sickness Rates:4.23% All Falls: 7 No falls with moderate or major harm All Hospital acquired pressure ulcers: 2. which were at grade 1 or 2.	
Oncology	This ward cares for patients with cancer of many different tumour sites. There is a wide range of care requirements that includes in-patients with high acuity needs and others who are very high dependency (patients with spinal cord compression), The advancement of specialised treatments such as brachytherapy has resulted in an increasing acuity of patients over the last 2 years. The skill mix is 74%:26%. The ward requires additional staffing to release nurses to provide specialist care (prostate brachytherapy and chemotherapy), palliative care, communication with families, and specifically the administration of medications. Many patients are cared for through to end of life on this ward, and there can be a higher dependency related to palliative care. The ward receives direct admissions from the Triage Unit which has consistently expanded the service due to its increased activity over the past 3 years, enabling patients to be assessed and treated, many avoiding admission. However the haematology and oncology wards cover this service overnight and at weekends. <u>July 15 Quality Metrics</u> Vacancy Rates:16.6% Maternity Rates:0% Sickness Rates: 7.01%	A case of need was developed and approved with an increase in establishment not yet added to the budget until the staff are recruited. . The quality metrics are being closely monitored in relation to the staffing skill mix and levels

	All Falls: 5. No falls with moderate or major harm. All Hospital acquired pressure ulcers: 9, which were at grade 1 or 2. The metrics include an increase in the number of category 2 hospital acquired pressure ulcers and these are being managed and monitored closely	
5F & 5E	This ward covers Gastroenterology and the Day Case unit with patients scheduled for interventional radiology treatments. Many patients are complex cases requiring psychological care, and patients sectioned under the Mental Health Act, as well as those with eating disorders, cyclic vomiting and long term feeding therapy. There are a high number of ward attenders. There are multiple teams of medical staff (11) who attend this ward, and it has a skill mix of 75%:25%. The ward establishment is funded to cover the ward, but also extends to the Day Case Unit The leadership has been strengthened through high visibility of the matron to support staff; however there isn't a co-ordinator between 5F and E. The skill mix and levels of staff do require additional support in relation to ensuring that the establishment of staff is sustainable and to cover 5E as well as the ward. <u>5F July 15 Quality Metrics</u> Vacancy Rates:-0.6% Maternity rates:5.97% Sickness Rates:2.35% All Falls: 0 No falls with moderate or major harm. All Hospital acquired pressure ulcers: 1, which was at grade 1 or 2.	A case of need was developed and approved with an increase in establishment not yet added to the budget until the staff are recruited. The quality metrics are monitored closely
Surgical Emergency Unit (SEU) 5CD	This unit is very complex and has multiple levels of in-patient facilities, and a triage area for surgical emergency cases. It includes wards 5 C/D, 6D, 6E & 6F. 6D includes a Triage area and 10 beds, with a high turnover of patients and an average of 25 ward attenders a day, and on average 8.93 nurse escorts a day. The skill mix ratio is 80%:20% There are x 10 supernumery Surgical Emergency Nurse Practitioner (ENPs) who provide	.No change required to the establishment

6D 6E 6F	emergency assessment expertise to the team within triage. The consultants have changed their ways of working and include both surgeons and a physician based on SEU providing cover for triage and ED. This is in order to provide a more senior level of decision making. On average 74% of patients referred by their GP do not require surgery 5CD has side rooms and requires a high level of patient escorts to diagnostic investigations 5C has now closed and 5D is in transition where posts are being redistributed into vacancies. In the summer there was an increased level of escorts for long periods of time averaging 3 per day Monday-Friday. The patient turnover increased at the time of this acuity audit also. 6D has 10 beds for Triage Emergency. The skill mix ratio is 66%:34% <u>5CD July 15 Quality Metrics</u> Vacancy Rates:12.9% Maternity Rates:2.21% Sickness Rates:4.79% All Falls: 0 All Hospital acquired pressure ulcers: 1, which was at grade 1 or 2. <u>6D July 15 Quality Metrics</u> Vacancy Rates: -24.1% Maternity Rates:0% Sickness Rates: 2.37% All Falls: 1 All Hospital acquired pressure ulcers: 0 6E has a skill mix ratio of 72%:28% and requires 3 nurse escorts per day on average. <u>6E July Quality Metrics</u> Vacancy Rates:10.8% Maternity Rates:0% Sickness Rates:1.35% All Falls: 0 No falls with moderate or major harm	

	All Hospital acquired pressure ulcers: 4, 3 of which were at grade 1 or 2. 1 which was grade ¾. 6F is a female ward which has on average 1-5 level 2 patients per day (high dependency) and 3 nurse escorts. This patient group has a high level of acuity, clinical deterioration, and cardiac arrests. It has a skill mix ratio of 72%:28% The non- nursing ward support is minimal and only covers 8-4pm. <u>6F July 15 Quality Metrics</u> Vacancy Rates:16.7% Maternity Rates: 0% Sickness Rates:2.20% All Falls: 1 No falls with moderate or major harm. All Hospital acquired pressure ulcers: 1 which was at grade 1 or 2.	
Jane Ashley/LGI	This ward has a complex patient group which includes all aspects of Lower GI Surgery, breast and gynae-onc surgery. The skill mix is 68%:32% which is appropriate for this clinical area and it has an effective experienced ward sister providing leadership. The acuity includes a number of patients on parenteral feeding i.e. 14 at any one time, therefore requiring a high skill mix of RNs. <u>July 15 Quality Metrics</u> Vacancy Rates: 23.9% Maternity Rates: 7.55% Sickness Rates:5.90% All Falls: 2. No falls of moderate/major harm. All Hospital acquired pressure ulcers: 0 The indicators demonstrate low levels of incidents and the quality indicators are well managed.	No change required to the establishment The activity levels on this ward is monitored closely against the staffing levels and beds are closed to mitigate risk
UGI	This ward undertakes highly complex surgery with high acuity levels post operatively, including bariatric patients referred from Reading. The skill mix is 77%:23% and this relates to the specialist levels of care required by this	No change required to the establishment

	patient group, many of whom 'step down' from the Intensive Therapy Unit. The levels of quality indicators are low except for low impact falls, and there is strong leadership provided from a very experienced sister. <u>July 15 Quality Metrics</u> Vacancy Rates:4.6% Maternity Rates:9.4% Sickness Rates:3.36% All Falls: 5. No falls with moderate or major harm. All Hospital acquired pressure ulcers: 1, which were at grade 1 or 2.	
Urology	This 20 bedded urology ward undertakes major complex surgery including specialist referrals from other areas in the region; this includes a significant increase in cystectomies and radical prostatectomies. There is a high turnover of patients and consistently high acuity and dependency levels of care. Two new consultants have commenced in post and the referral rate has increased significantly There are usually 4 – 8 urology outliers on the CH site on any given day, and therefore the ward has retained the more acutely unwell patients with higher dependency and highly specialised treatment requirement. Whilst outlying their less acute and less dependent patients to wards unfamiliar with urology care. <u>July 15 Quality Metrics</u> Vacancy Rates:-1.0% Maternity Rates:6.90% Sickness Rates:3.94% All Falls: 2 No falls with moderate or major harm All Hospital acquired pressure ulcers: 0	A case of need was developed and approved with an increase in establishment not yet added to the budget until the staff are recruited.
Renal	The renal ward provides care for a range of conditions, including those requiring dialysis and end of life care. The skill mix is 72%:28% and this reflects the technical nature of the care for this patient group, although these do not include specialist staff.	No change required to the establishment

	There are some low grade pressure ulcers and low impact falls without harm. <u>July 15 Quality Metrics</u> Vacancy Rates:19.2% Maternity Rates: 0% Sickness Rates:1.82% All Falls: 3 No falls with moderate or major harm All Hospital acquired pressure ulcers: 2 of which 1 was at grade ¾.	Beds have been closed during this time to mitigate risk
Wytham	This is a ward with variable levels of acuity due to the nature of variation in activity related to transplant surgery, which cannot be predicted. There is an enhanced monitoring unit that provides level 2 step down of patients from ITU. The patient group includes bowel, kidney and pancreas transplants and so the ratio is 81%:19%. The indicators demonstrate some low impact falls without harm. The sister leadership has changed recently on this ward. <u>July 15 Quality Metrics</u> Vacancy Rates:19.8% Maternity Rates:3.36% Sickness Rates:3.87% All Falls: 1 No falls with moderate or major harm All Hospital acquired pressure ulcers: 0	No change required to establishment The activity (which is less predictable than most wards due to the specialty) is monitored closely against the staffing levels
E Ward Horton Hospital	This 17 bedded ward which also includes a 6 bedded day case area managed by another division. Although a surgical ward, it is currently providing care for medical patients with an average length of stay of 7 days +, throughout the year. However the ward specialties are currently under review. The indicators are generally good and it is not an outlier in this respect, and there is very strong sister leadership, and the senior nursing team have adapted well to managing patients admitted through the medical emergency care pathway. <u>July 15 Quality Metrics</u>	No change required to establishment due to the review of this ward's specialty and winter/summer changes in case mix. Activity is monitored closely against staffing levels

	Vacancy Rates: 28.8% Maternity Rates: 0% Sickness Rates: 0.55% All Falls: 4. No falls with moderate or major harm. All Hospital acquired pressure ulcers: 2, which was at grade 1 or 2.	

Neurosciences, Orthopaedics, Trauma & Specialist Surgery Division

Ward	Professional Judgement considerations	Variations to the establishment
Neurosciences	This large ward has a skill mix split of 69%:31% and is made up of 5 areas including one for high care. It has 89 bed spaces, with the current use of 69 in-patient beds and 12 day case/theatre same day admissions, and 5 beds that open for escalation. The ward has undergone some re-organisation and is now split by specialty i.e. neurology and neurosurgery to facilitate more effective ward management. The split into 4 separate wards was established in April 2015, and this has strengthened local leadership, with sisters for each section, although all working co-operatively to cover staffing. This has helped with the management of patient acuity also. The quality indicators demonstrate a number of low impact falls without harm in a patient group where this is not an uncommon symptom, and for which strategies are put in place to reduce the level of harm. <u>July 15 Quality Metrics</u> Vacancy Rates:17% Maternity Rates:0% Sickness Rates:0.68% All Falls: 12 No falls with moderate or major harm All Hospital acquired pressure ulcers: 2, which are at grade 1 or 2.	
SSIP	The skill mix is 68%:32.1%. This ward has a variety of plastics and specialist surgery. The senior leadership structure has been altered, and a Deputy Matron is based on the ward and covered the out-patient and Day Care Unit. New Senior sisters have been appointed. 30% of the EU nurses have commenced on SSIP which effects skill mix and requires very complex off duty	No necessity to alter the establishments from the acuity review.

	management in order to ensure shifts are covered with experienced staff; inevitably there are some shifts with all EU new starter nurses. In the summer there has been an increase in plastic surgery patients and an increased throughput, increasing the ward's acuity. This increase in plastic surgery patients has been impacted by major trauma. <u>July 15 Quality Metrics</u> Vacancy Rates: 4.6% Maternity Rates: 5.71% Sickness Rates:3.95% All Falls: 10 No falls with moderate or major harm All Hospital acquired pressure ulcers: 2, which are at grade 1 or 2.	
6A	This ward, which includes a triage area, has patients with vascular conditions; and the staff undertake thrombolysis treatment which requires level 2 (high dependency care) and 1:1 ratio of RN to patients during the treatment to provide continuity of care. These are a high risk group of patients for pressure ulcers, however none have been reported for this time period and there have been few low impact falls with no harm. <u>July 15 Quality Metrics</u> Vacancy Rates:14% Maternity Rates: 0% Sickness Rates: 3.80% All Falls: 6 No falls with moderate or major harm All Hospital acquired pressure ulcers: 1, which was at grade 1 or 2.	No necessity to alter the establishments from the acuity review.
Trauma 2A - JR	These wards have 26 beds and include a high acuity patient group, with a staff skill mix of 62%:38%. 2A has acuity levels that are increasing as the patient group changes from moderate trauma i.e. fractures of the neck of femur, to a major trauma case mix. The quality indicators suggest that for this patient group there are a few low grade pressure ulcers and low impact falls for this time period, although there are preventative strategies in place.	The acuity tool indicated at the last measurement in January 2015 an increase in acuity related to major trauma cases and this has been monitored. The skill mix should be altered on 2A and 3A, to increase the levels of RNs at night and reduce the Nursing Assistants. From 3 + 3 to 4 + 2. This needs to be demonstrated

	2A July 15 Quality Metrics Vacancy Rates: 8.6% Maternity Rates: 0% Sickness Rates:4.73% All Falls: 12 No falls with moderate or major harm All Hospital acquired pressure ulcers: 6, which were at grade 1 or 2.	through a case of need at divisional level. Currently the ward uses NHSP to provide those levels but with a significant vacancy factor in order to provide safe levels of care.
3A - JR	3A has a similar case mix of trauma and skill mix of staff. 3A July 15 Quality Metrics Vacancy Rates: 6.5% Maternity Rates: 5.28% Sickness Rates: 4.72% All Falls: 2 Falls with moderate or major harm: 1 All Hospital acquired pressure ulcers: 1, of which 1 was at grade 3 or above.	
F Ward - Horton Hospital	F ward is a 28 bedded ward with 3 unfunded beds that open for escalation and a skill mix ratio of 63%:37%. 50% of the patient mix includes other specialties other than trauma, during the winter months, and the dependency level rises owing to the levels of medical patients admitted. During the summer they have had between 50-75% medical patients, this in turn has increased their usual acuity levels as a result F Ward July 15 Quality Metrics Vacancy Rates: 10.4% Maternity Rates: 0% Sickness Rates: 2.78% All Falls: 6 No falls with moderate or major harm All Hospital acquired pressure ulcers: 2, which were at grade 1 or 2.	
Blenheim	This ward has 15 beds with 3 used for day cases, and as such the patient mix is being reviewed over time with the acuity tool measurement. The skill mix ratio of 72%:28% is due to difficult airway management and patients undergoing major complex head and neck surgery. The quality indicators do not flag any specific issues, with a level of low impact falls.	No necessity to alter the establishments from the acuity review.

	<u>July 15 Quality Metrics</u> Vacancy Rates: 0.9% Maternity Rates: 1.18% Sickness Rates: 0.71% All Falls: 6 No falls with moderate or major harm All Hospital acquired pressure ulcers: 1 which was at grade 1 or 2.	
NOC wards	These wards have a skill mix of 66%: 34%, and have a stable workforce managing largely elective surgery and treatment. However they all have the lowest uplift of the Trust at 18% (for study, sick and annual leave) other clinical areas across the Trust are 20% or 21% Ward C opens and closes dependent upon patient activity levels, and these beds will probably be annexed to F ward in the near future. Bed occupancy has decreased over the summer months. <u>NOC C July 15 Quality Metrics</u> Vacancy Rates: 27.8% Maternity Rates: 5.85% Sickness Rates: 0.55% All Falls:0 Wards D, E and F are relatively stable with some vacancies. <u>NOC D July 15 Quality Metrics</u> Vacancy Rates: 15.2% Maternity Rates: 2.5% Sickness Rates: 6.8% All Falls: 3 No falls with moderate or major harm All Hospital acquired pressure ulcers: 0, <u>NOC E July 15 Quality Metrics</u> Vacancy Rates: 13% Maternity Rates: 3.4% Sickness Rates:8.35% All Falls: 1 No falls with moderate or major harm All Hospital acquired pressure ulcers: 0	No necessity to alter the establishments from the acuity review. Although there is some consideration to support a twilight shift as part of the shift pattern on the BIU when vacancies are filled. The quality metrics are being monitored closely on BIU

	<u>NOC F July 15 Quality Metrics</u> Vacancy rates: 7.7% Maternity Rates: 0% Sickness Rates: 6.94% All Falls: 7 No falls with moderate or major harm. All Hospital acquired pressure ulcers: 0 The Bone Infection Unit (BIU) has 26 beds with 40% as side room beds. It is more fragile in terms of levels of vacancies against agency/NHSP fill rates, with less resilience due to the level of acuity of the patients, and a high level of intravenous antibiotics administered. <u>BIU July 15 Quality Metrics</u> Vacancy Rates: 21.5% Maternity Rates: 3.71% Sickness Rates: 0.32% All Falls: 2 All Hospital acquired pressure ulcers: 2, which was at grade 1 or 2. Extravasation incidents are a sensitive indicator on BIU however there have not been any incidents reported in this month.	

Children's & Women's Division

Ward	Professional Judgement considerations	Variations to the establishment
Childrens' Services	Childrens' in-patient wards have a national acuity tool that has been out to national consultation and OUH were contributors to the data collection. The Trust will be utilising the tool for purposes of assurance in the future. The current staffing model reflects the RCN staffing guidance. Critical care staffing model reflects the Paediatric Intensive Care Standards The New Born Care Unit is aspiring to meet the British Association of Perinatal Medicine (BAPM), OUH isn't an outlier as a benchmark nationally. There are levels of extravasation incidents which are being monitored across the children's' wards, as this forms a specific quality indicator for children's in-patient services. <u>Bellhouse Drayson Ward July 15 Quality Metrics</u> Vacancy Rates: 16.1% Maternity Rates: 0% Sickness Rates: 6.56% Extravasation Incidents: 0 All Hospital acquired pressure ulcers: 0 <u>Robins Ward July 15 Quality Metrics</u> Vacancy Rates:26.3%% Maternity Rates: 0% Sickness Rates: 3.69% Extravasation Incidents: 0 All Hospital acquired pressure ulcers: 1 which was at grade 1 or 2.	No necessity to alter the establishments. There have been beds closed intermittently during July and staff redistributed to mitigate risk

	<u>Kamran's Ward July 15 Quality Metrics</u> Vacancy Rates: -0.4% Maternity Rates:15.9% Sickness Rates: 0.48% Extravasation Incidents: 0 All Hospital acquired pressure ulcers: 0 <u>Toms Ward July 15 Quality Metrics</u> Vacancy Rates: 8% Maternity Rates: 2.24% Sickness Rates: 6.3% Extravasation Incidents: 0 All Hospital acquired pressure ulcers: 1 which was at grade 1 or 2. <u>Melanie's Ward July 15 Quality Metrics</u> Vacancy Rates: -3.9% Maternity Rates: 4.84% Sickness Rates: 4.84% Extravasation Incidents: 0 All Hospital acquired pressure ulcers: 0 <u>Neonatal Unit July 15 Quality Metrics</u> Vacancy Rates: 28.7% Maternity Rates: 5.28% Sickness Rates: 4.11% Extravasation Incidents: 0 All Hospital acquired pressure ulcers: 0 <u>PITU July 15 Quality Metrics</u> Vacancy Rates: 5.4% Maternity Rates: 6.28% Sickness Rates:4.76% Extravasation Incidents: 0 All Hospital acquired pressure ulcers: 0,	

	<u>HH SCBU July 15 Quality Metrics</u> Vacancy Rates: 27.4% Maternity Rates: 0% Sickness Rates: 1.4% Extravasation Incidents: 0 All Hospital acquired pressure ulcers: 0 <u>HH Childrens Ward July 15 Quality Metrics</u> Vacancy Rates:1.6% Maternity Rates: 4.83% Sickness Rates: 6.87% Extravasation Incidents: 0 All Hospital acquired pressure ulcers: 0	
Midwifery Services	OUHT Midwifery staffing establishments have been developed using the Birth Rate acuity tool for ratios of midwives to mothers and to monitor the acuity in the delivery suite. Midwives are moved constantly according to the changes in acuity and this includes from the community midwifery service, as the community and in-patient services are managed as one service. Currently across the whole service the staffing status is: • By 2.11.15 when all newly recruited midwives are in post there will be no midwifery vacancies, although recent and anticipated resignations require further recruitment to commence 23rd September The ratio of Midwives to mothers is currently 1:31.3 which is a red flag to the threshold of 1:31, but once all new recruits are in post in November this will reduce to 1:29 The NICE Midwifery Staffing Guidelines were published on 27 February 2015. The Senior midwifery team are reviewing the establishments in line with the recommendations. <u>JR Maternity January 15 Quality Metrics</u> Vacancy Rates currently (in September): -7.7% Maternity Rates: 3.65% Sickness Rates: 4.94%	

	Extravasation Incidents: 0 HH Maternity January 15 Quality Metrics Vacancy Rates currently (in September): -4.4% Maternity Rates: 8.37% Sickness Rates: 14.54%. Extravasation Incidents: 0	
Gynaecology JR	This ward has a skill mix of 65%:35%. This ward is made up of 20 beds with an emergency direct access service for GP referrals, suspected ectopic pregnancies and high levels of ward attenders. Otherwise this group of patients do not tend to have co-morbidities and are generally well. There is a ratio at night of 1 RN: 9.5 patients, and this is justified through Professional Judgement due to the wellness of this patient group and that major surgery is undertaken early in the day. The matron has put in place twilight shifts to support days of high levels of surgery, as the acuity later in the night does not warrant an additional RN all night as the care is judged to be safe. The shift pattern is currently under review to include a twilight shift on every day of the week. During the summer months there has been decreased theatre activity, but an increase in ward attenders and women seen through the triage service. July 15 Quality Metrics Vacancy Rates: 1.6% Maternity Rates: 1.69% Sickness Rates: 0.75% All Falls: 0 All Hospital acquired pressure ulcers: 0	No necessity to alter the establishments from the acuity review.

Clinical Support Services

Ward	**Professional Judgement considerations**	**Variations to the establishment**
	The areas of ITU and theatres are not measured against acuity or dependency as all patients are either level 2 or 3 and the skill mix is determined by the Intensive Care Society guidelines	

Appendix 4 Patient experience dashboard:

C&W MRC NOTSS S&O CSS OUH inpatients National Average Inpatient OUH ED National Average ED OUH maternity National Average Maternity OUH Oupatients National Average Outpatients

Comments

We feel valued. Every single member of staff is caring and kind. We are always amazed that the doctors and nurses never rush or make us feel we are taking up too much of their time, despite having enormous workloads at times. They are exceptional at making us comfortable under difficult and sometimes scary circumstances. ***Kamran's Ward, JR, C&W division***

The midwives at the Cots' birth centre are simply amazing. Their knowledge, bedside manner and support are second to none. I can't believe I would ever say this but I am actually looking forward to giving birth. My attitude is 100% down to them. ***Cotswold Birthing Unit, C&W division***

Everyone from recovery to ward F were fantastic. Nothing was too much trouble, everyone was friendly and helpful - wants to interact and speak with you. The care was very good and I felt so looked after. It really helped towards my recovery. ***NOC Ward F, NOTSS Division***

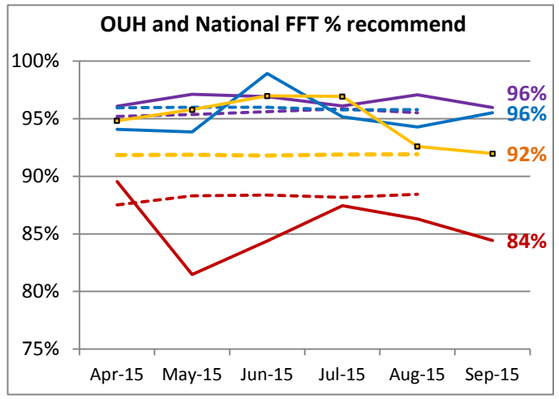
Excellent care. Seen straight away. Treated with care and respect. All staff highly trained. Cannot thank you all enough. ***John Radcliffe Emergency Department, MRC Division***

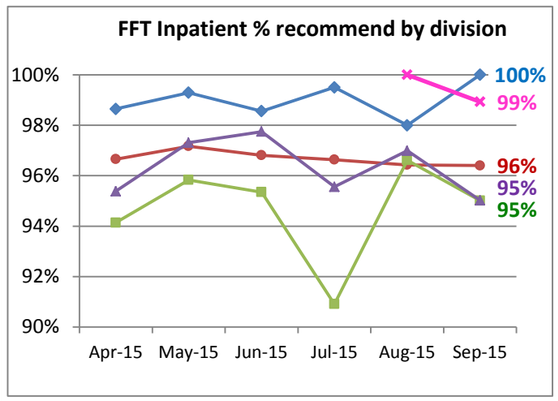
The treatment is exemplary. All the staff are very well trained and a pleasure to deal with. The consultant is the best I've ever seen and I've seen many! ***Milton Keynes Renal Dialysis Unit Outpatients, S&O division***

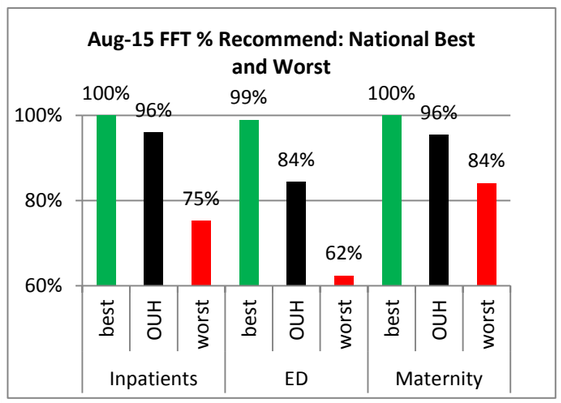
The nurses are amazing, caring and so reassuring. The facilities on offer especially when you have been fasting are fantastic and the admin staff are also helpful and friendly. Overall what could be a horrible experience and time is made so much better and easier thanks to the staff. ***Bagot and Drake ward, Churchill, MRC division***

Really friendly staff. Explained the whole process beforehand, and then as we were going through. Great at allaying all fears, and added a touch of humour which helped me relax. ***Oxford Centre for Magnetic Resonance, JR, CSS division***

FFT: % recommend

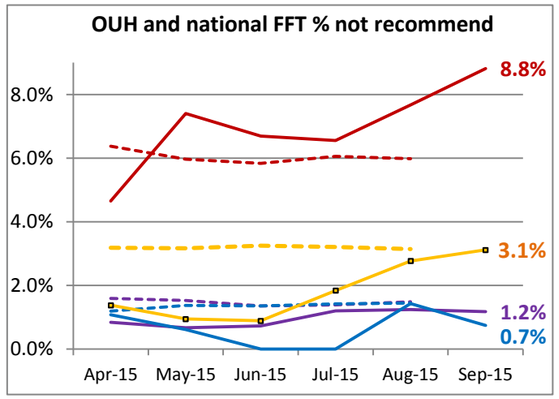


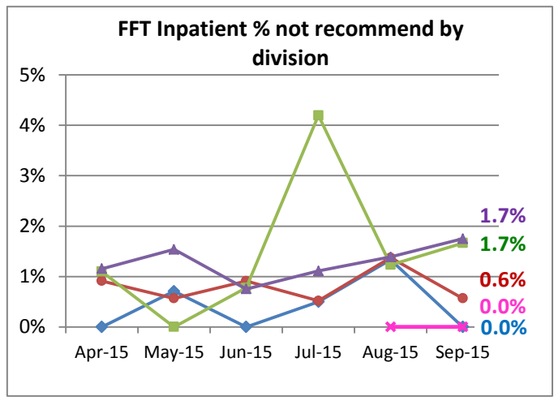


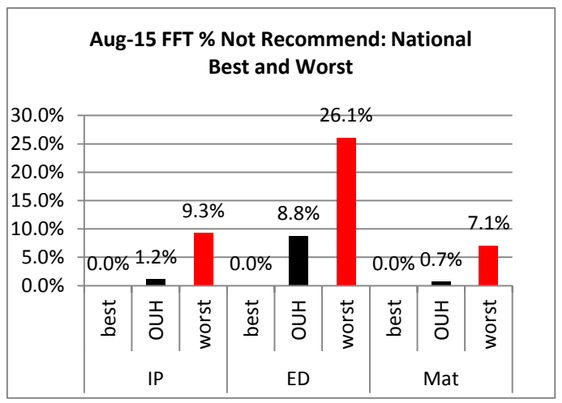


Only NHS Trusts with more than 100 responses have been included.

FFT: % not recommend

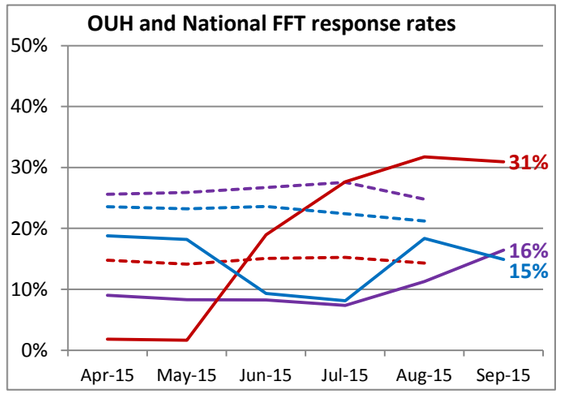


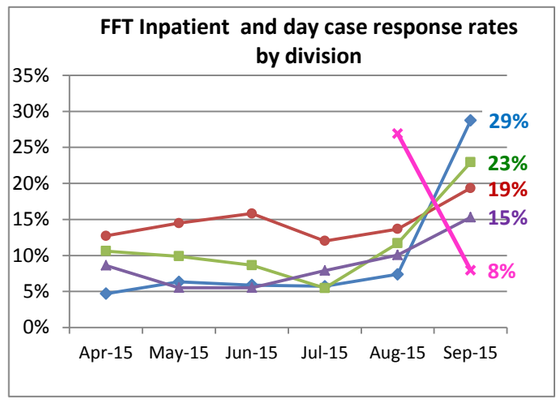


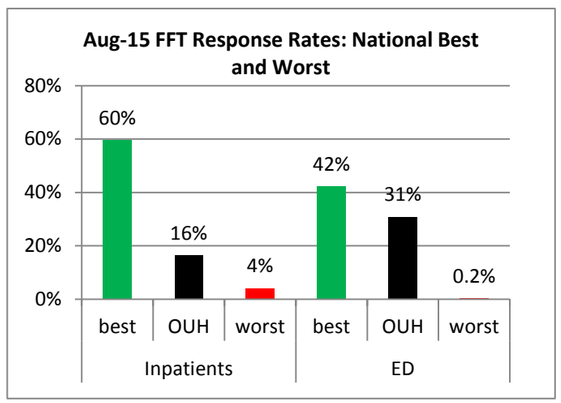


Only NHS Trusts with more than 100 responses have been included.

FFT: Response rates



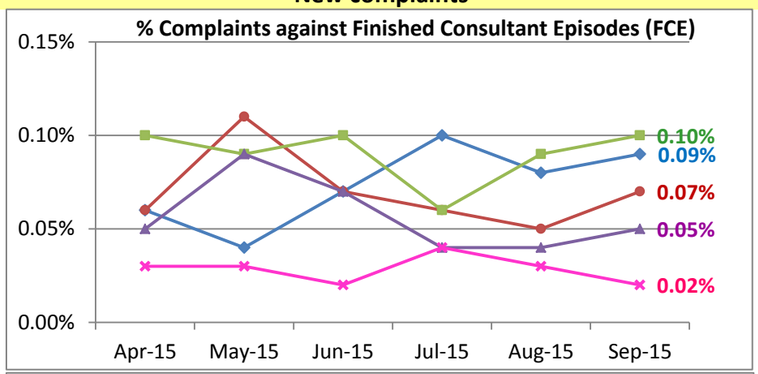


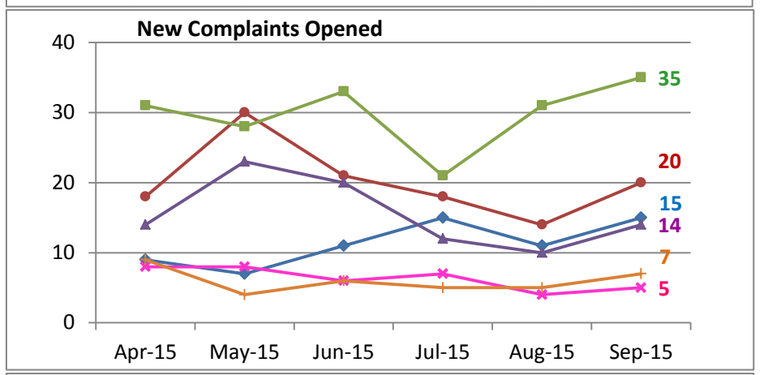


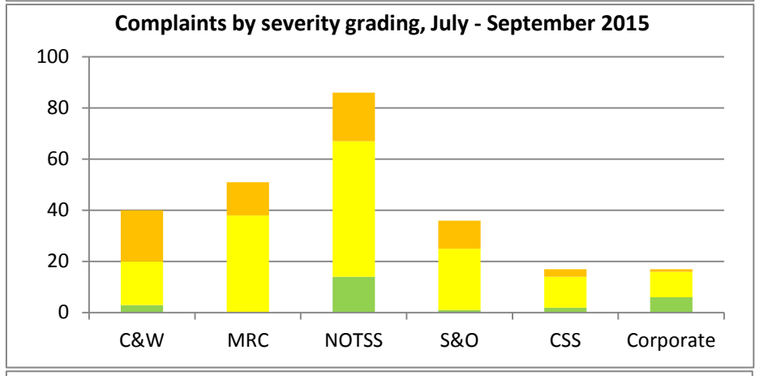
Only NHS Trusts with more than 100 eligible patients have been included.

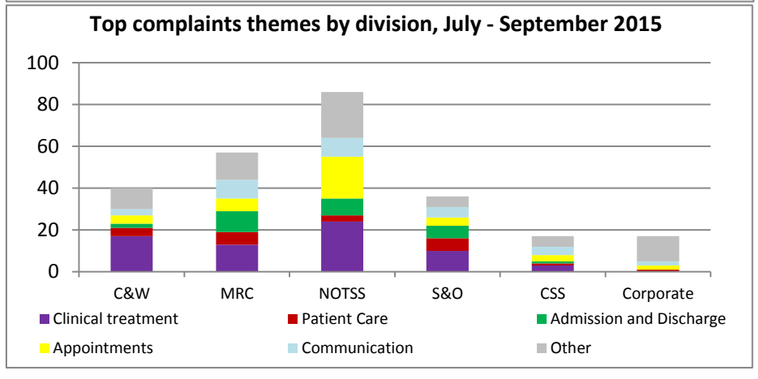
C&W MRC NOTSS S&O CSS Corporate Trust

New complaints

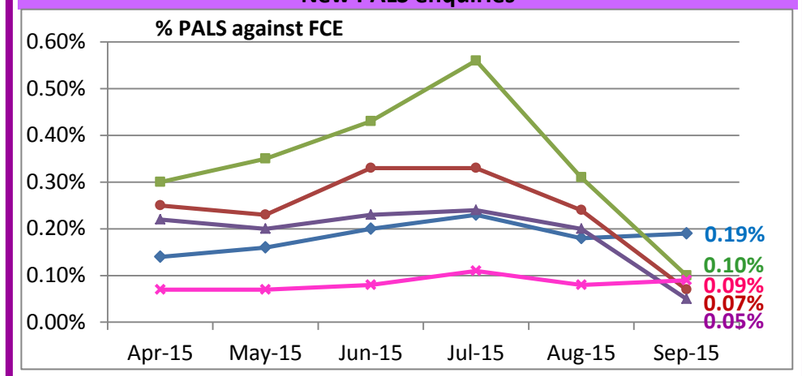






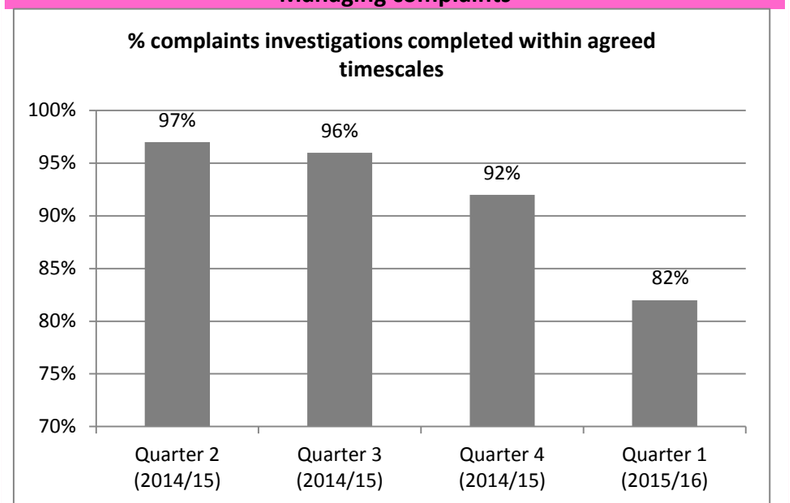


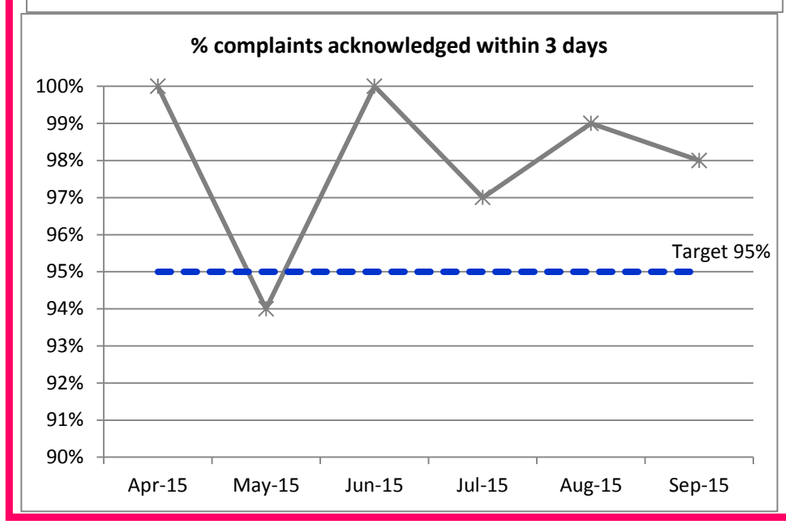
New PALS enquiries



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

Managing complaints





Closed complaints