Oxford University Hospitals NHS
NHS Trust

Trust Board Meeting in Public: Wednesday 9 September 2015

TB2015.106

Title	**Board Quality Report**

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

Board Lead(s)	**Dr Tony Berendt, Medical Director (**Board lead**)** **Ms Catherine Stoddart, Chief Nurse**			
Key purpose	Strategy	**Assurance**	Policy	Performance

Executive Summary

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

2. In relation to key quality metrics:

- For ten of the 53 quality metrics, pre-specified targets were not fully achieved in the last relevant data period. For selected metrics, trend data are provided along with brief exception reports
- For a selection of the quality metrics, Divisional specific information that contributes to organisational results is presented in dashboard format within Appendix 1.

2. In relation to Patient Safety and Clinical Risk:

- 19 Serious Incidents Requiring Investigation (SIRI) were reported in July 2015
- Seven SIRI Reports were recommended to OCCG for closure during July with three being closed with the OCCG during a closure meeting in July

3. In relation to Infection Control:

- Eight cases of *Clostridium difficile* were apportioned to the OUH in July 2015, of these cases, five were determined to be unavoidable
- Clinical areas continue to work towards universal 92% compliance with the QAT cleaning audit.

4. In relation to Patient Experience:

- The trust received 78 complaints during July 2015, representing a 19.5% drop in complaint numbers from the previous month.
- The patient experience dashboard, including Friends and Family Test, PALS and Complaints data for July is attached as Appendix 2.

5. In relation to Safe Staffing:

- Summary figures submitted to NHS Choices via the Unify platform for July 2015 are included in the body of the report. The fill rates, including temporary staff are: 96.11% for Registered Nurses/Midwives, and 95.54% for Care Support Workers
- The workforce and Nurse Sensitive Indicator data for each Division against Trust data are included in the appendices

Recommendation

Trust Board is asked to receive this report.

Board Quality Report

1. Purpose

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

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

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

2.3. Trend graphs and exception reports are included for selected metrics where specified thresholds have not been met ('red-rated'), or have deteriorated from green-rated to amber-rated in the previous period. Thresholds are drawn from a mixture of sources (national, commissioner and internal). Each metric is provided with a narrative explanation for this drop in performance, and actions being taken to address.

2.4. The following two indicators have seen an improvement in performance against target thresholds since the previous reported period: CE04 – Dementia diagnostic assessment and investigation, and CE16 – Number of unscheduled returns to theatre in gynaecology.

Table One

BQR ID	Rating	Rating Last Period	Descriptor	Period	Threshold Source	Red	Amber
PS01	98.68% Green	Green	Safety Thermometer (% patients receiving care free of any newly acquired harm) [one month in arrears]	Jul 15	Internal	95%	97%
PS02	94.9% Green	Green	Safety Thermometer (% patients receiving care free of any harm - irrespective of acquisition) [one month in arrears]	Jul 15	Internal	91%	93%
PS03	97.63% Green	Green	VTE Risk Assessment (% admitted patients receiving risk assessment)	Jun 15	National	95%	95.25%
PS04	19 N/A		Serious Incidents Requiring Investigation (SIRI) reported via STEIS	Jul 15		N/A	N/A
PS05	23 Red	Red	Number of cases of Clostridium Difficile > 72 hours (cumulative year to date)	Jul 15	National	23	N/A
PS06	2 Red	Red	Number of cases of MRSA bacteraemia > 48 hours (cumulative year to date)	Jul 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	64.74% Red	Red	% patients receiving stage 2 medicines reconciliation within 24h of admission	Jul 15	Internal	75%	85%
PS09	100% Green	Green	% patients receiving allergy reconciliation within 24h of admission	Jul 15	Internal	94%	96%
PS10	1.77% Green	Green	% of incidents associated with moderate harm or greater	Jul 15	Internal	6.5%	5%
PS11	66 N/A		Total number of newly acquired pressure ulcers (category 2,3 and 4) reported via Datix	Jun 15		N/A	N/A
PS12	6 Green	Green	Falls leading to moderate harm or greater	Jul 15	Internal	8	7
PS13	11.11% N/A		Cleaning Score - % of inpatient areas with initial score > 92%	Jul 15		N/A	N/A
PS14	99.69% Green	Green	% radiological investigations achieving 5 day reporting standard [CSS Division]	Jun 15	Commissioner	95%	98%
PS15	8 N/A		Number of CAS alerts received	Jul 15		N/A	N/A
PS16	0 Green	Green	CAS alerts breaching deadlines at end of month and/or closed during month beyond deadline	Jul 15	Internal	1	N/A
PS17	1 Red	Green	Number of hospital acquired thromboses identified and judged avoidable [two months in arrears]	Jun 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	157 N/A		Crude Mortality	Jul 15		N/A	N/A
CE03	72.86% Red	Red	Dementia - % patients aged > 75 admitted as an emergency who are screened [one month in arrears]	Jun 15	National	80%	90%
CE04	92.34% Green	Amber	Dementia diagnostic assessment and investigation [one month in arrears]	Jun 15	Internal	80%	90%
CE05	100% Green	Green	Dementia :Referral for specialist diagnosis [one month in arrears]	Jun 15	Internal	80%	90%
CE06	96.47% Green	Green	ED - % patients seen, assessed and discharged / admitted within 4h of arrival	Jul 15	National	85%	95%
CE07	95.59% Green	Green	Stroke - % patients spending > 90% of admission in specialist stroke environment	Jul 15	National	70%	80%
CE08	94.12% Green	Green	Stroke - % patients accessing specialist stroke environment within 4h of arrival	Jul 15	National	75%	85%
CE09	5.4 Amber	Amber	Vascular - Mean length of stay for patients undergoing elective AAA repair (3 month rolling period) [NOTSS Division]	Jun 15	Internal	8	5
CE10	4.35% Amber	Amber	Vascular - % mortality following elective AAA repair [NOTSS Division]	Jun 15	Internal	5%	3%

CE11	92.31% Green	Green	Cardiology - % patients receiving primary angioplasty within 60 minutes of arrival at hospital [MRC Division]	Jun 15	Internal	85%	90%
CE12	1.8 Green	Green	Cardiology - Mean number of days from referral to admission to cardiology at tertiary centre [MRC Division]	Jul 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]	Jul 15	Internal	1%	0.5%
CE14	0% Green	Green	Cardiac Surgery - % mortality following elective primary CABG [MRC Division]	Jun 15	Internal	6%	4%
CE15	1 Amber	Amber	Number of unscheduled returns to theatre within 48 hours [NOTSS Division - NOC Site]	Jul 15	Internal	2	1
CE16	0 Green	Amber	Number of unscheduled returns to theatre in gynaecology [C&W Division]	Jul 15	Internal	2	1
CE17	473 N/A		Number of patients admitted to SEU wards from SEU triage [S&O Division]	Jul 15		N/A	N/A
CE18	5.74% Red	Red	Neuroscience Intensive Therapy Unit (NITU) readmission rate within 48 hours of discharge [NOTSS Division]	Jul 15	Internal	4%	2%
CE19	74.16% Green	Green	% fractured NOF patients who receive surgery within 36 hours of admission [NOTSS Division]	Jun 15	Commissioner	70%	72%
CE20	20.08% Green	Green	% deliveries by C-Section [C&W Division]	Jul 15	Commissioner	33%	23%
CE21	3.77% Amber	Green	7 day admission rate following assessment on (and discharge from) paediatric CDU [C&W Division]	Jul 15	Internal	4%	2%
PE01	87.46% N/A		Friends & Family test % likely to recommend - ED	Jul 15		N/A	N/A
PE02	6.55% N/A		Friends & Family test % not likely to recommend - ED	Jul 15		N/A	N/A
PE03	95.16% N/A		Friends & Family test % likely to recommend - Mat	Jul 15		N/A	N/A
PE04	0% N/A		Friends & Family test % not likely to recommend - Mat	Jul 15		N/A	N/A
PE05	96.15% N/A		Friends & Family test % likely to recommend - IP	Jul 15		N/A	N/A
PE06	1.1% N/A		Friends & Family test % not likely to recommend - IP	Jul 15		N/A	N/A
PE07	96.94% N/A		Friends & Family test % likely to recommend - OP	Jul 15		N/A	N/A
PE08	1.84% N/A		Friends & Family test % not likely to recommend - OP	Jul 15		N/A	N/A
PE14	0 Green	Green	Single sex breaches	Jul 15	National	3	2
PE15	68.9% Amber	Green	% patients EAU length of stay < 12h	Jul 15	Internal	65%	70%
PE16	77.57% N/A		% Complaints upheld or partially upheld [Quarterly in arrears]	Jun 15		N/A	N/A
PE17	4 Red	Red	Number of legal claims received / inquests opened initially graded as RED	Jul 15	Internal	2	N/A
PE18	94% Green	Green	% patients returning feedback forms in specialist surgery outpatients [NOTSS Division]	Jul 15	Internal	45%	60%
PE19	12 N/A		Number of reopened complaints	Jul 15		N/A	N/A

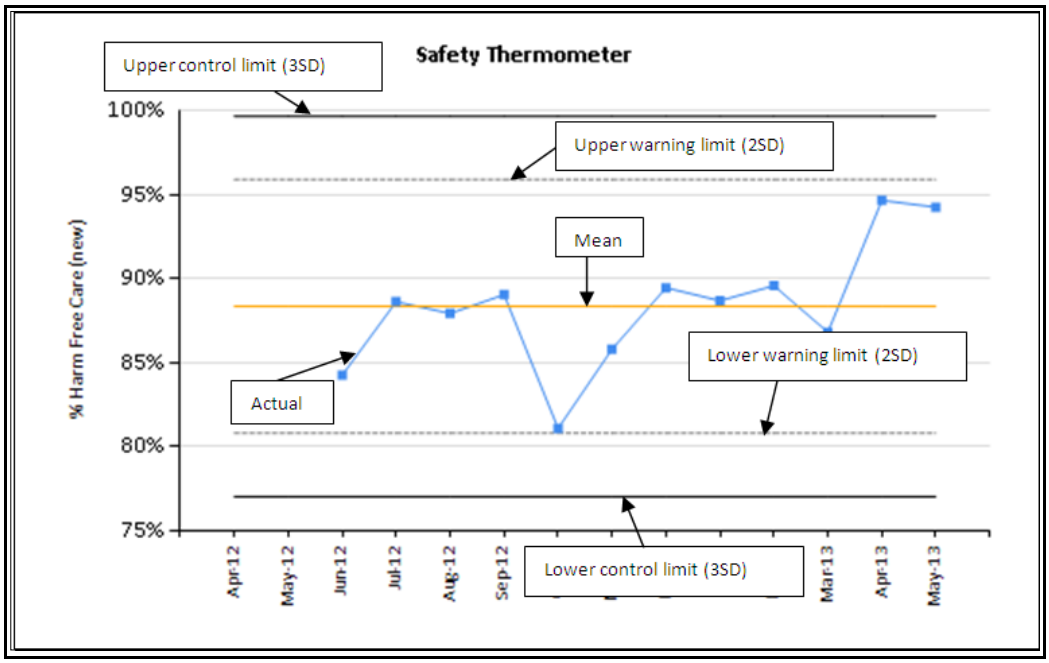
How to interpret charts

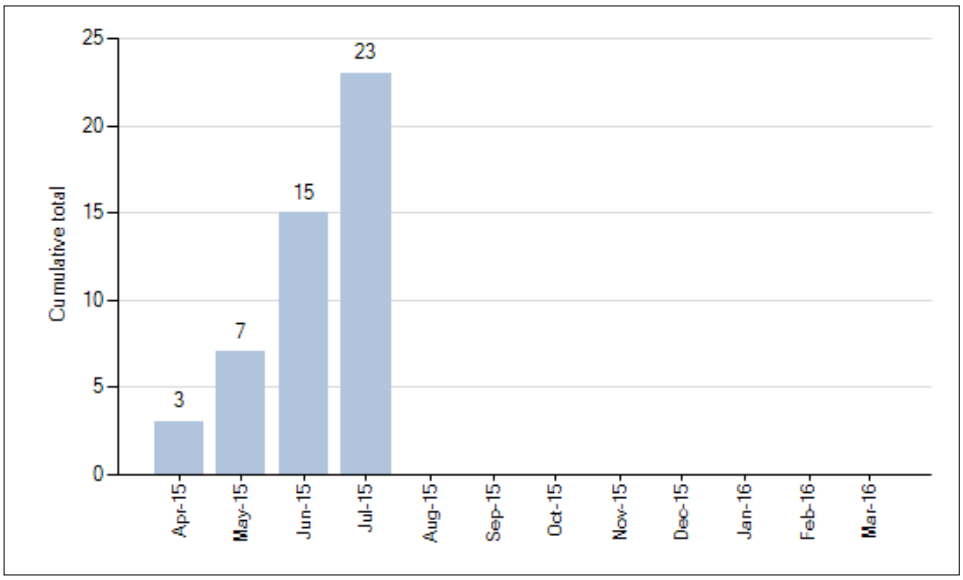
Data are presented in this report in a number of different ways – including statistical For process control (SPC) charts, line charts (without confidence intervals / control limits), histograms and cumulative histograms. Graphics have been selected in order to encourage the analysis of trends and to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

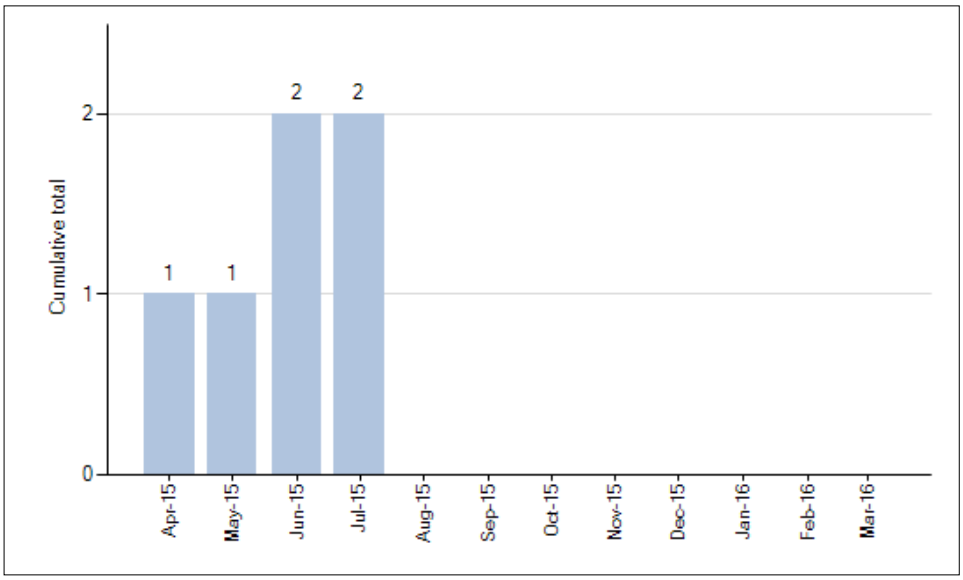
There are other patterns within the data that are likely to reflect real change as opposed to random fluctuation – these patterns are known as special cause variations. They include:

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)

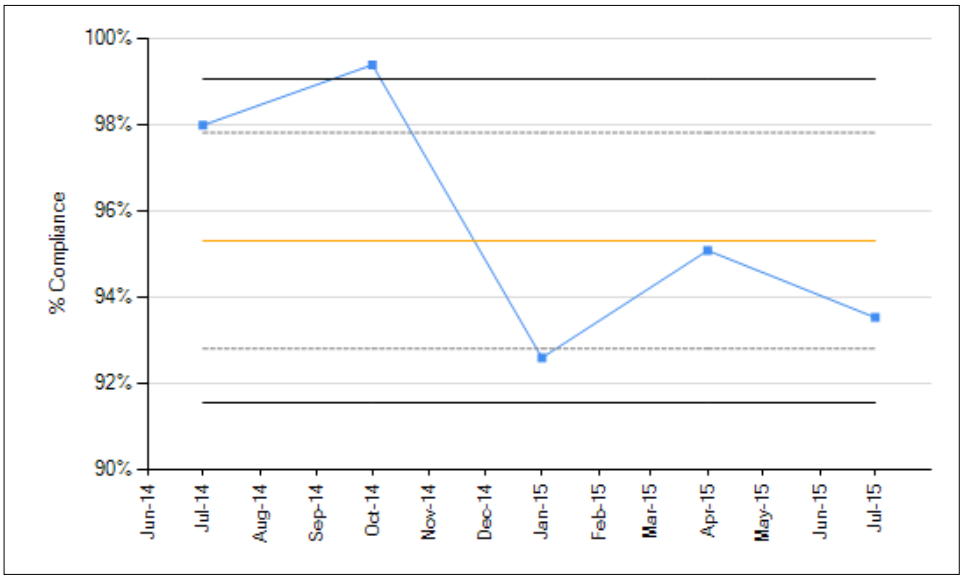


PS05 Number of cases of Clostridium Difficile > 72 hours (cumulative year to date)	Narrative
	YTD this indicator is at the cumulative ceiling of 23 cases therefore is rated GREEN. However, this has been included as an exception in July due to in month reported number of cases being above the in house monthly ceiling rate of six reported cases. Of the eight cases, five were determined to be unavoidable. The remaining cases will be reviewed at the September Health Economy meeting.

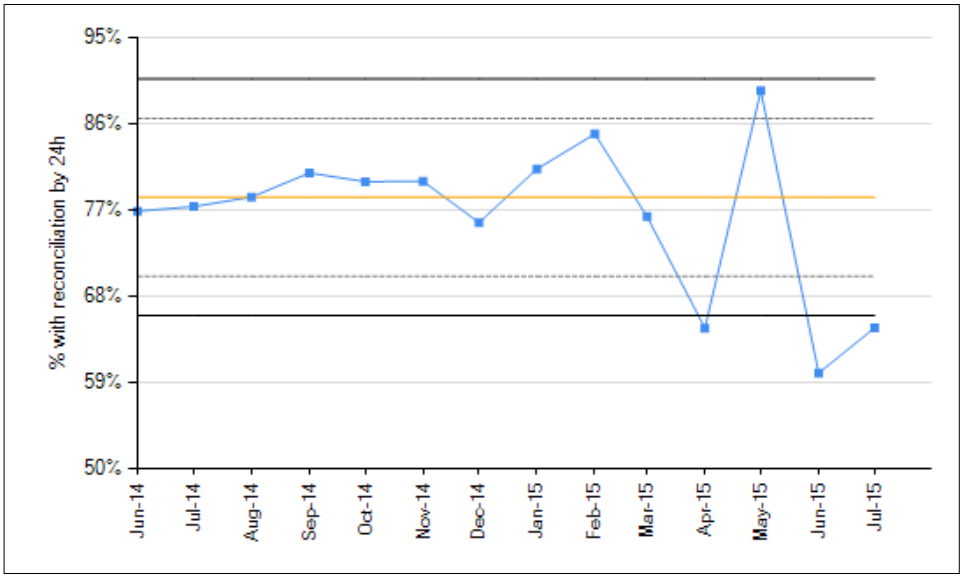
The chart shows the number of cases of C Diff reported via UNIFY (external IT system). The maximum number of cases permitted for 2013/14 is 70. If a case is subsequently removed following consultation with CCG (for example, absence of active disease), the figure will be modified in future graphs. [Owner: S Wells].

PS06 Number of cases of MRSA bacteraemia > 48 hours (cumulative year to date)	Narrative
	The annual ceiling for reported cases of MRSA bacteraemia is zero. There have been no additional cases since the prior report. This indicator will remain an exception through the year as the ceiling has been exceeded.

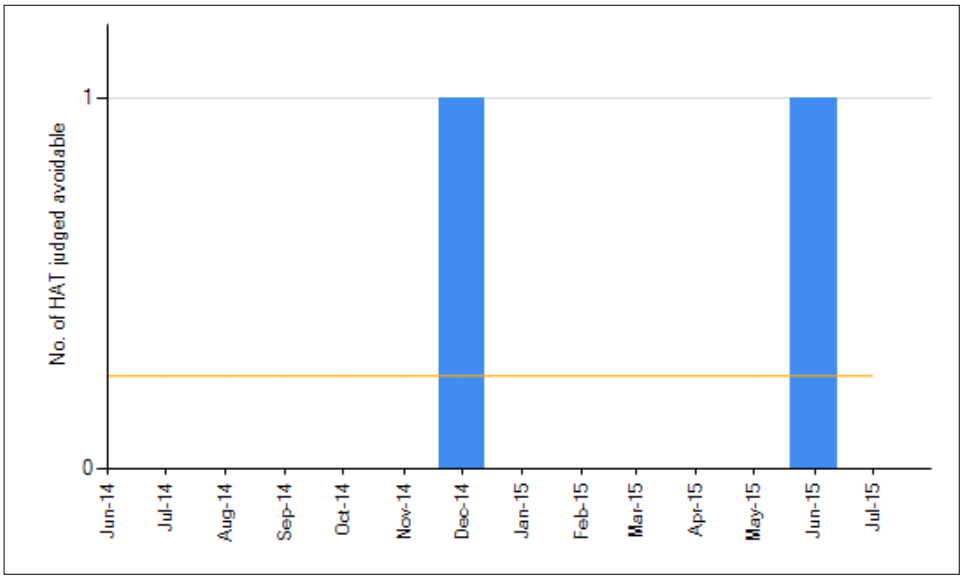
The chart shows the number of cases of MRSA bacteraemia reported via UNIFY (external IT system). If a case is subsequently removed in following consultation with CCG (for example, attributed to a referring hospital), the figure will be modified in future graphs. [Owner: S Wells].

PS07 Antibiotic prescribing - % compliance with antimicrobial guidelines [most recently available figure, undertaken quarterly]	Narrative
	The Antimicrobial Stewardship team have updated guidelines in July which are taking time to embed into daily practice, and the team are migrating the guidelines from paper-based to a fully electronic guide to ensure better access for clinicians. A point prevalence audit to measure compliance with current guidelines was undertaken in July and reported an overall compliance rate of 94%.

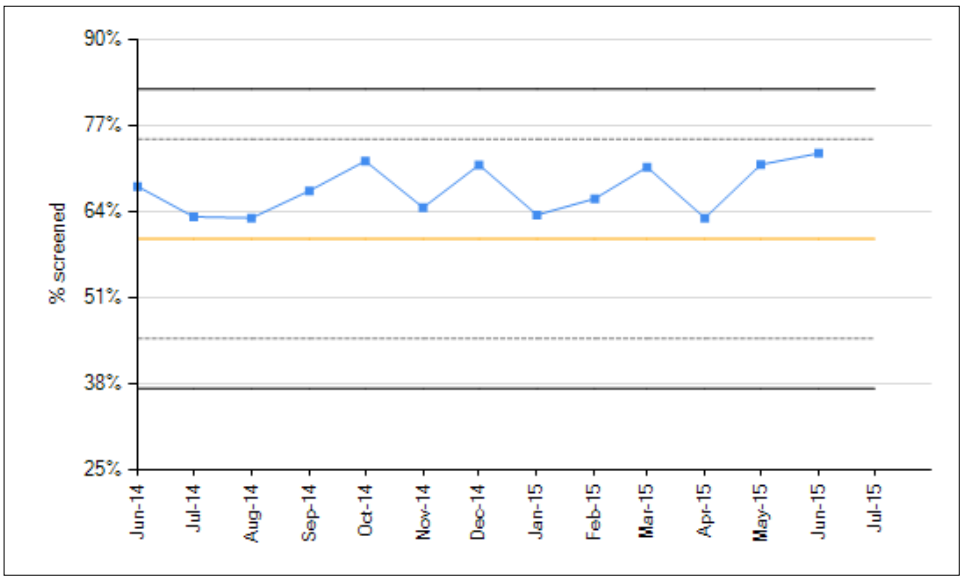
This is a 'snap shot survey' of all inpatient medication charts across the trust. The audit measures compliance with antimicrobial guidelines. There is a rolling programme of anti-microbial audits across the Trust. Different audits are completed and reported each month. The frequency of data points differs and is not monthly. [Owner: S Wells].

PS08 % patients receiving stage 2 medicines reconciliation within 24h of admission	Narrative
	Following a change in reporting in June 2015, this indicator has remained below the target threshold. Currently 87% of stage 1 medicines reconciliations are being completed by ward based clinical pharmacy staff. Partial support for weekend working by ward based clinical pharmacy has been agreed for implementation in October, which should improve results.

The chart shows the proportion of inpatients for whom second stage pharmacy-led medicines reconciliation is completed within 24 hours of admission. Spot check audit by pharmacy staff once per month. Approximately 600 patients are included in the audit Trust-wide. Please note that this audit was not performed in May 2013 due to capacity issues in pharmacy. [Owner: P Devenish].

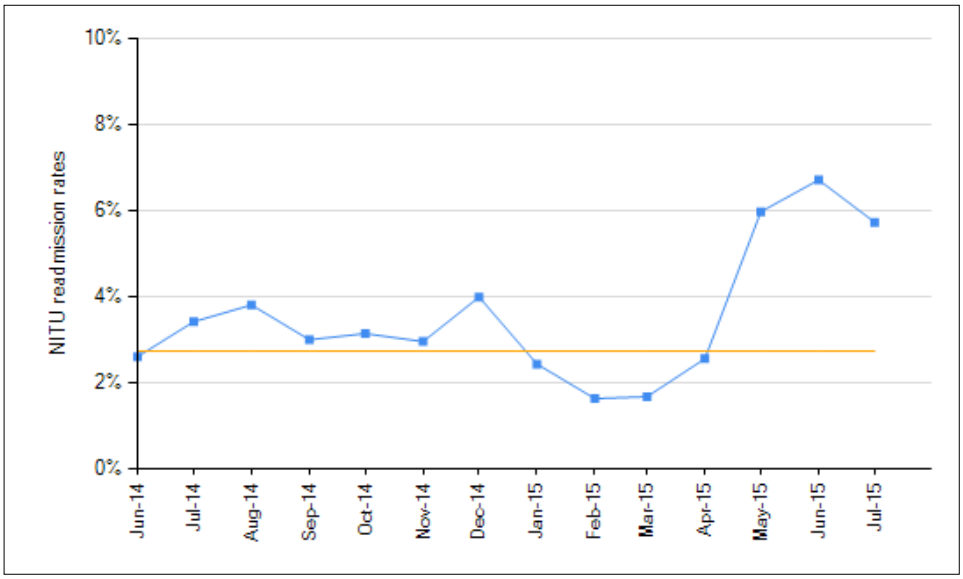
PS17 Number of hospital acquired thromboses identified and judged avoidable [two months in arrears]	Narrative
	The June case is of a cancer patient who developed a pulmonary embolus six weeks after a month long admission for investigation and treatment. Causes are the subject of a SIRI but early review suggests thromboprophyllaxis was not in place throughout their admission.

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].

CE03 Dementia - % patients aged > 75 admitted as an emergency who are screened [one month in arrears]	Narrative
	This indicator has remained red rated in June 2015, it should be noted that a continued improvement in performance from May to June has been reported, with an increase from 71.17% to 72.86%. An action plan is in place within the divisions to ensure the National target of over 90% of emergency patients receiving dementia assessment is achieved over the coming year.

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

CE18 Neuroscience Intensive Therapy Unit (NITU) readmission rate within 48 hours of discharge [NOTSS Division]



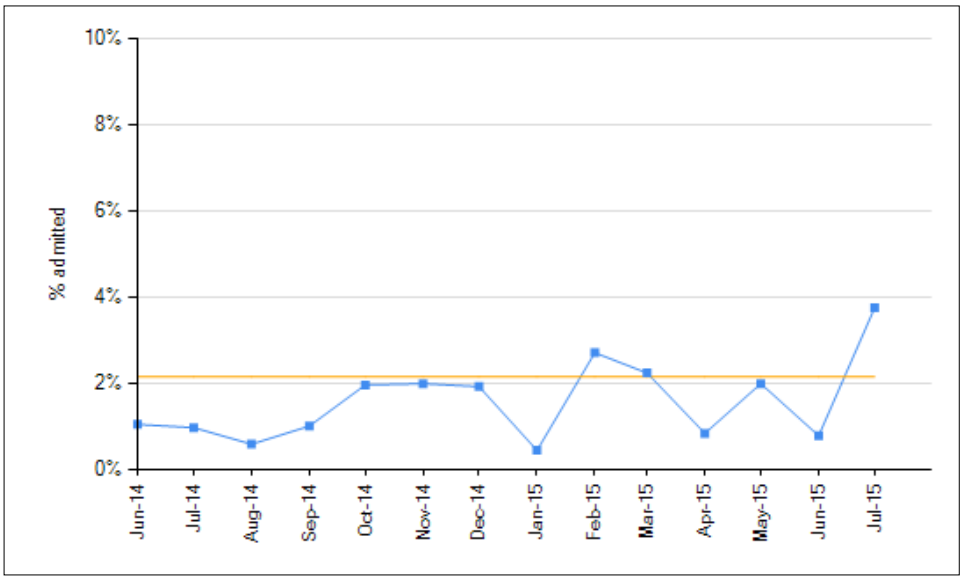
Narrative

Changes have been made to the way the readmission data in NICU is recorded so that it gives a more accurate review of monthly activity on the unit. Previously, monthly data was reflecting a three monthly rolling figure.

There were no readmissions within 48 hours and two readmissions within 7 days in July 2015.

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

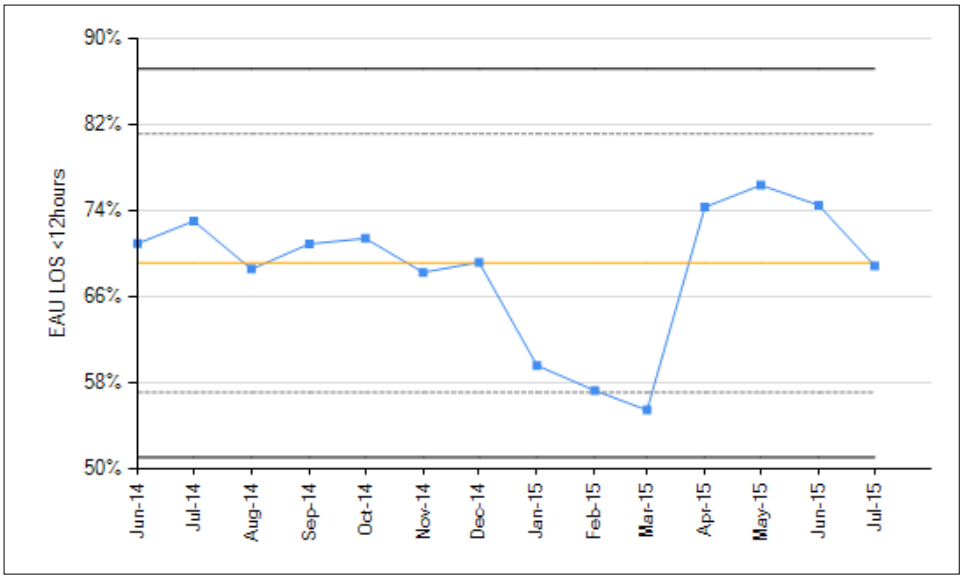
CE21 7 day admission rate following assessment on (and discharge from) paediatric CDU [C&W Division]



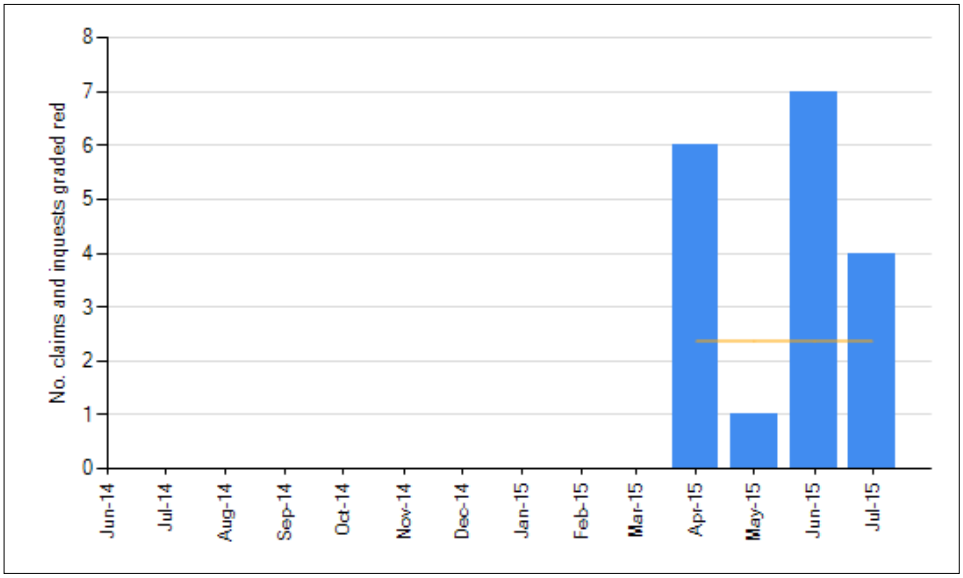
Narrative

The C&W Division report that the patients were returned to CDU not as re-admissions to the inpatient ward, but for antibiotics as ward attenders. However, the Division are undertaking a review of the clinical decisions in relation to the group of patients identified.

Number of patients discharged from CDU and number who are readmitted as emergency inpatients within 7 days to a ward other than CDU.

PE15 % patients EAU length of stay < 12h	Narrative
	The Division is continuing to monitor 12 hour performance in the Emergency Assessment Unit (EAU). Most patients who remain on EAU for longer than this period are usually still under the care of the Emergency Department. A small number of other patients remain due to capacity issues on other wards.

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

PE17 Number of legal claims received / inquests opened initially graded as RED	Narrative
	This metric has been newly updated for 2015/16. The number of red graded legal claims and inquests opened remains above the current threshold. The sign up to safety campaign has aligned with the NHSLA to target clinical events that may result in harm and claims. It is acknowledged there is a long lead time for some claims.

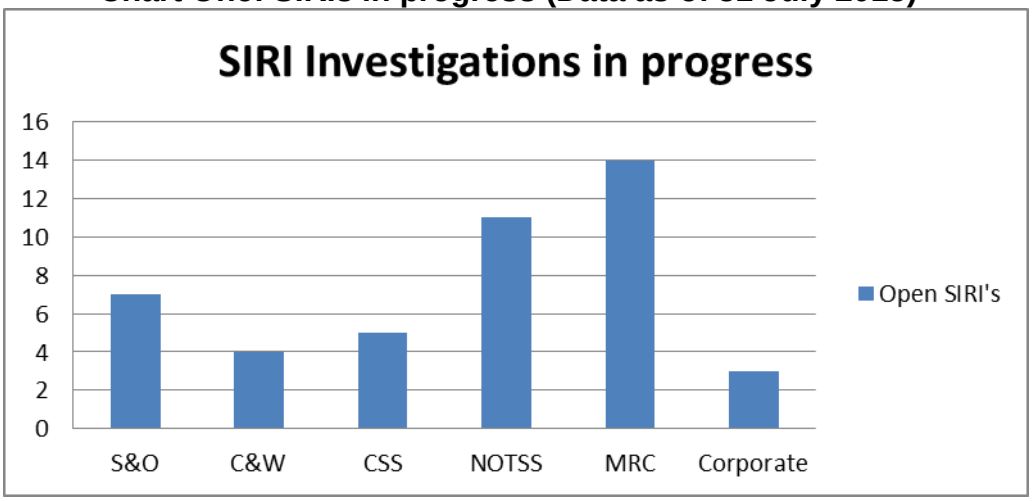
The chart shows the numbers of new claims received and inquests opened initially rated as 'RED' by the corporate legal department. The number may change (in either direction) following investigation and conclusion of legal process [Owner: S Newman].

3. Patient Safety and Clinical Risk

3.1. SIRI update by Divisions

3.1.1 Divisional and corporate teams have taken on an increased work load around the management of SIRI investigations. This section of the Board Quality Report seeks to quantify this activity.

Chart One: SIRIs in progress (Data as of 31 July 2015)



Note: NOTTS and MRC have the highest current number of SIRI investigations to deliver.

Chart Two: SIRIs declared in 2015/16

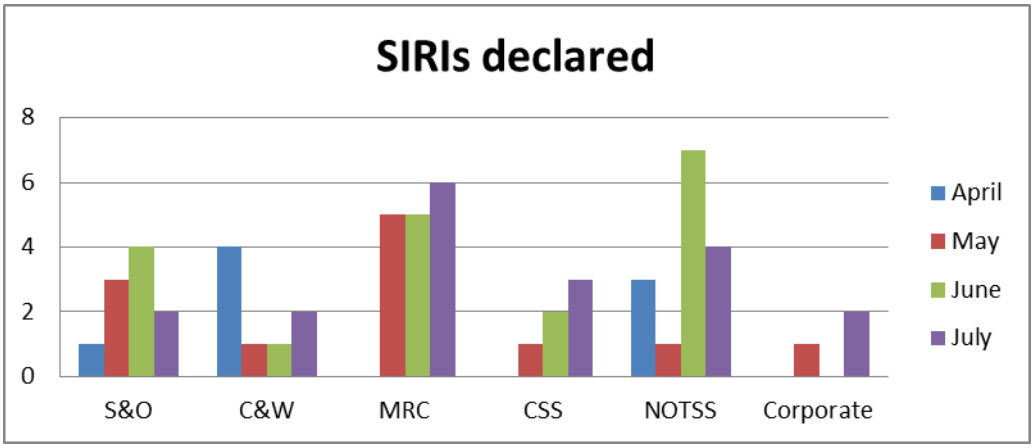


Table Two

SIRI's declared by Month and Division					
	Q1 2015/16			Q2	
Division	**April**	**May**	**June**	**July**	**TOTAL**
S&O	1	3	4	2	**10**
C&W	4	1	1	2	**8**
MRC	0	5	5	6	**16**
CSS	0	1	2	3	**6**
NOTSS	3	1	7	4	**15**
Corporate	0	1	0	2	**3**
TOTAL	**8**	**12**	**19**	**19**	58

3.1.2. SIRIs are allowed 60 working days to be completed in national guidance. It is therefore important to understand those in progress and the rate at which they are declared. The SIRI forum is now a transparent way for the organisation to decide levels of investigation. This report includes only SIRI investigations and does not reflect the Divisional investigations which are also ongoing.

Chart Three: SIRI investigations completed

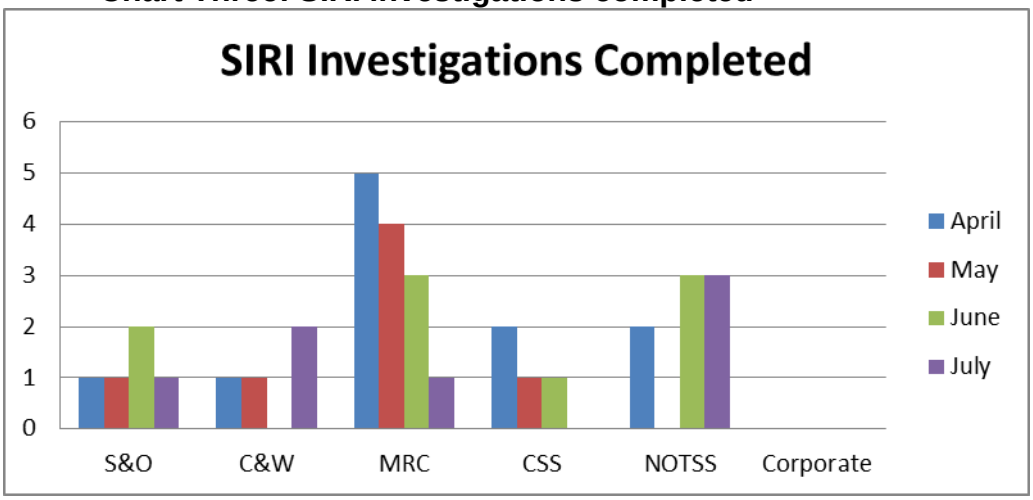


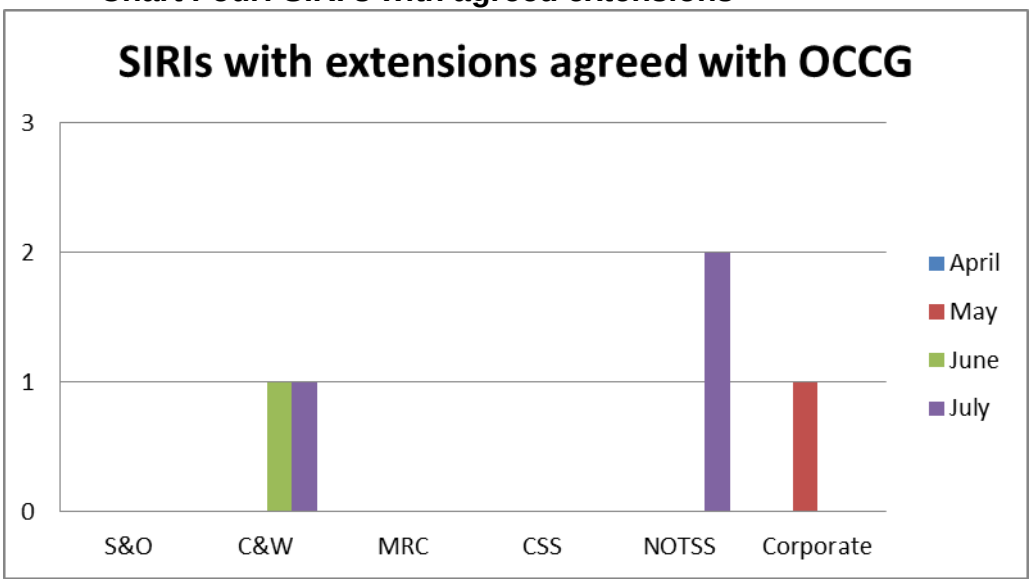
Table Three

SIRI's completed (sent to OCCG) by Month and Division					
	Q1 2015/16			Q2	
Division	**April**	**May**	**June**	**July**	**TOTAL**
S&O	1	1	2	1	**5**
C&W	1	1	0	2	**4**
MRC	5	4	3	1	**13**
CSS	2	1	1	0	**4**
NOTSS	2	0	3	3	**8**
Corporate	0	0	0	0	**0**
TOTAL	**11**	**7**	**9**	**7**	34

3.1.3. The Divisions are commended for completing 34 SIRI investigations this financial year. Some of these will have originated in 2014/15.

3.1.4. Occasionally extensions are requested to the usual timescale for investigation. OCCG have indicated that extensions will only be granted in truly exceptional circumstances going forward. Five extensions have been granted this financial year to end of July. No SIRIs are overdue at OUH.

Chart Four: SIRI's with agreed extensions



3.1.5. SIRIs are closed when approved and discussed with OCCG or NHS England in a monthly SIRI review meeting. 28 have been closed this financial year.

Chart Five: SIRI closure

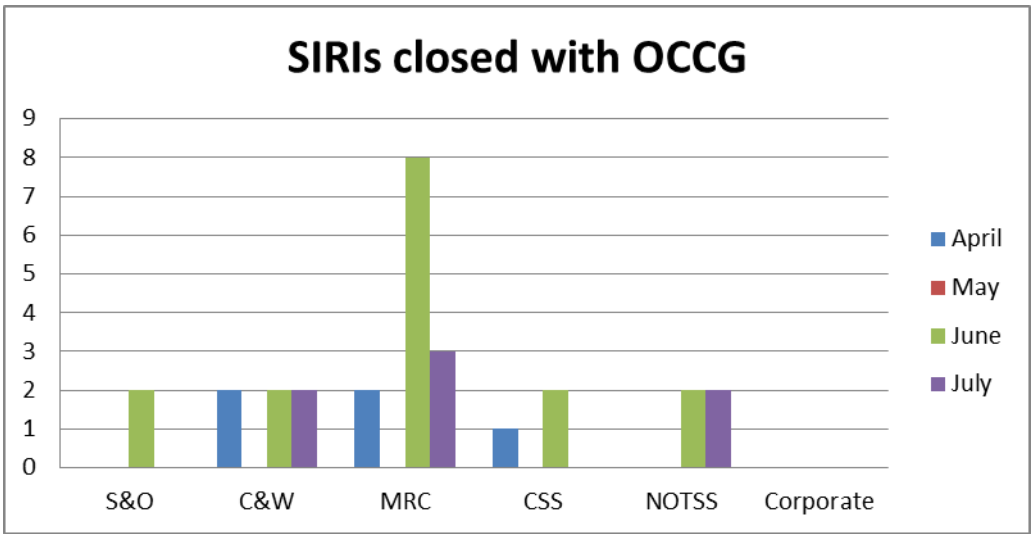


Table Four

SIRI's closed with OCCG by Month and Division					
	Q1 2015/16			Q2	
Division	**April**	**May**	**June**	**July**	**TOTAL**
S&O	0	0	2	0	**2**
C&W	2	0	2	2	**6**
MRC	2	0	8	3	**13**
CSS	1	0	2	0	**3**
NOTSS	0	0	2	2	**4**
Corporate	0	0	0	0	**0**
TOTAL	**5**	**0**	**16**	**7**	28

3.2 SIRI update: reporting and closure metrics.

3.2.1 Table five shows that 19 Serious Incidents Requiring Investigation (SIRIs) have been notified to the Oxfordshire Clinical Commissioning Group (OCCG) in July 2015. Interval days between Incident occurring and reporting on Datix, and from Datix to reporting on StEIS represent working days are also shown in the table.

Table Five

SIRI ref	Division	Description	Incident Date	Datix	I-D interval	STEIS	D-S interval
2015/078	MRC	Discharge medication miscommunication	22/06/15	25/06/15	3	01/07/15	6
2015/079	NOTSS	Hospital Acquired PE.	10/06/15	26/06/15	12	06/07/15	6
2015/080	Corporate	Outpatient fell on an uneven surface.	10/06/15	16/06/15	4	10/07/15	18
2015/081	MRC	Patient discharged from ED and 24 hours later developed a subdural haematoma.	10/06/15	03/07/15	17	10/07/15	5
2015/082	MRC	Discharge on wrong dose of Metformin.	25/03/15	17/04/15	17	10/07/15	60
2015/083	S&O	MRSA bacteraemia.	14/03/15	09/07/15	84	10/07/15	1
2015/084	C&W	Baby death.	08/07/15	08/07/15	0	10/07/15	2
2015/085	Corporate	Visitor fell on the stairs and fractured her tibia.	01/07/15	01/07/15	0	17/07/15	12

2015/086	MRC	Amphotericin administered IV instead of via a nebuliser.	09/07/15	10/07/15	1	17/07/15	5
2015/087	MRC/S&O/SCAS	Grade 3 PU to sacrum	09/07/15	09/07/15	0	17/07/15	6
2015/088	NOTSS	Cluster of errors in intraocular injection therapy.	Multiple dates	Multiple dates	-	17/07/15	-
2015/089	CSS/S&O	Anaphylaxis during oesophagectomy.	26/06/15	26/06/15	0	17/07/15	15
2015/090	C&W	Admission to SCBU after sequential instrument use.	23/04/15	24/04/15	1	21/07/15	62
2015/091	MRC	Peri-prosthetic fracture of knee joint.	20/07/15	20/07/15	0	23/07/15	3
2015/092	S&O	Delayed transfer of a patient who developed severe abdominal pain.	16/06/15	20/07/15	29	23/07/15	3
2015/093	CSS	Unreported lung cancer.	25/02/15	27/04/15	43	28/07/15	66
2015/094	CSS	Bite block spat out	08/07/15	10/07/15	2	29/07/15	13
2015/095	NOTSS	External ventricular drain left unclamped.	25/07/15	25/07/15	0	31/07/15	5
2015/096	NOTSS	Pressure Ulcer	02/03/15	03/07/15	1	31/07/15	20

3.2.2. A number of SIRI reporting timescales were not reached in July 2015, details of each of these delays are as follows:

Delays in reporting on DATIX

- 2015/079 – Delay in the incident occurring and being reported on StEIS was due to the time required to investigate and establish whether the HAT was avoidable or not prior to reporting
- 2015/081 – Incident was highlighted from another hospital resulting in a delay from attendance to reporting
- 2015/083 – MRSA bacteraemia declared at post infection review meeting but not entered onto Datix in a timely way, therefore delaying reporting to StEIS
- 2015/092 – This incident arose through an M&M meeting looking back at a case, hence the delay in reporting initially on Datix, as soon as made aware of the incident timely decision making and reporting on StEIS occurred

Delays in reporting from DATIX to StEIS

- 2015/080 – Delay in reporting on StEIS was due to annual leave within the risk management team and a 10 day gap between SIRI forums reviewing incidents for level of investigation
- 2015/082 – This Incident came to light as a result of a new legal claim, resulting in a retrospective incident review. The consultant reviewing the patient in clinic had also asked for a further investigation. The initial incident review was re-opened as a SIRI
- 2015/085 – Delay due partially to annual leave within the risk management team, compounded by difficulty in obtaining accurate information which required tabling twice at the SIRI forum in order to ascertain whether the SIRI criteria were met
- 2015/089 – Incident initially reported as minor harm. Discussion in HICC suggested that more harm had occurred and the incident was upgraded to a SIRI
- 2015/090 – Incident initially investigated as a Divisional level investigation, request to be upgraded from Divisional investigation to a SIRI by the Division on 16th July due to their initial findings. Called outside of SIRI meeting due to timescale which had already elapsed
- 2015/093 – Incident investigation called as a Divisional level on 4th March, prior to being reported on Datix. Division were late in reporting on Datix, and the level of harm could only be assigned once pathology results were available which required more than one biopsy. Subsequently reported promptly through StEIS
- 2015/094 – Medical Director informed of incident on 10th July when Datix report was made. Delay in declaring on StEIS due to miscommunication
- 2015/96 – Incident identified as a result of a look back exercise within Tissue Viability, when initially reported on Datix belief was that this was a pressure ulcer inherited from the community, and thus not requiring investigation. Further review by tissue viability, highlighted need to declare and undertake SIRI investigation process.

3.2.3. Once an investigation is closed through internal ratification and review processes it is presented to the OCCG and other relevant members of the Commissioning arm for closure.

3.2.4. One of three outcomes (based on the NHS England Serious Incident Framework 2015) will be agreed following a SIRI closure meeting with the OCCG, Specialist Commissioning, Thames Valley Area Team and the Head of Clinical Governance:

- CLOSED – The Commissioners are happy that the investigation is sufficient, and the identified actions are robust. The incident will be closed on STEIS.
- CLOSED WITH FURTHER MONITORING – There are additional issues that the commissioners would like addressed outside of the SIRI process (but these are not sufficient to keep the SIRI open on STEIS). Generally the investigation is sufficient and the actions identified are appropriate. The incident is closed on STEIS.

- NOT CLOSED – The Commissioners do not think the investigation or action plan is sufficient or is adequately completed. The panel request further action is undertaken and the SIRI will remain open until such time as the additional work is concluded.

3.2.5. OCCG have been grouping SIRIs they identify as having a common theme and holding the group open until assurance can be gained that the Trust has taken action to address the perceived defects e.g.: Radiology Backlog, and the Management of Test Results. Themes derived from SIRI Investigations are also routinely reported through the OCCG Quality Review Meeting (QRM).

3.2.6. Seven SIRI reports were recommended to OCCG for closure during July 2015. 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.

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

3.2.8. A SIRI Closure meeting was held with the OCCG on 14 July and table six below demonstrates the current status.

Table Six

SIRI Ref	Division	Description	OUH Closure Date	Reason for non-closure	Status
2015/3725 NEVER EVENT	NOTSS	Patient admitted for Orthodontic treatment. Incorrect teeth removed during procedure	27/04/15	OUH to revise action plan in time for next meeting, incorporating OCCG comments.	Not closed
2014/38753 NEVER EVENT	MRC	Retained guidewire	27/02/15	Milton Keynes CCG happy to close (Patient was from out of the area). OCCG request OUH to provide evidence of nursing grand round learning on this topic and provide outcome of prevalence audit.	Not closed Never Events are not closed until evidence of completion of all actions is available
2014/36993 NEVER EVENT	MRC	Misplaced Nasogastric tube	18/02/15	OUH to provide evidence that teaching/e-learning has been done. Also provide July audit of compliance with policy	Not closed Never Events are not closed until evidence of completion of all actions is available

2014/25602 NEVER EVENT	MRC	Retained guidewire	19/10/14	OCCG awaiting assurance that theatre suites only use traceable official procured stock items. NHSE agree closure once OCCG assured	Not closed Never Events are not closed until evidence of completion of all actions is available
2014/37646 SPECIALISED COMMISSIONING	S&O	A patient presenting with spinal cord compression did not receive a planned treatment schedule of regular doses of dexamethasone following a stat dose. The patient has subsequently developed paralysis that may have been avoidable.	09/02/15	OUH to write a summary of comments following last QRM. OUH to conclude whether pt. could have been cared for at the Churchill Hospital and investigate nursing observations and feedback to next meeting.	Not closed
2014/39480 SPECIALISED COMMISSIONING	CSS	A patient attended for a CT angiogram in 2010 to assess an aortic aneurysm. This scan also showed an abnormality in the upper left lobe of the lung, which was reported to have no clinical significance. A routine scan in September 2014 to reassess an aortic aneurysm showed what appears to be lung cancer in area of the previously seen lung abnormality The delay in diagnosis is likely to impact on the patient's outcome.	18/02/15	Keep open to stay aware of radiology roll-out of new system.	Not closed
2015/10240 SPECIALISED COMMISSIONING	NOTSS	Inpatient fell whilst walking and was diagnosed with a fracture neck of femur.	25/05/15	OUH to obtain update on FallSafe implementation and obtain more understand of why falls assessment wasn't done CCG to discuss the SIRI with falls lead.	Not closed
2014/1978 SPECIALISED COMMISSIONING	NOTSS	Suicide of patient in West Wing.	12/09/14	OUH to check if there is a PFD letter for this death, confirm to CCG and forward if so. Closure will be determined on receipt of this information.	Not closed
2014/20658 2014/30829 2014/5283 2014/20039 2014/27501		These all relate to the endorsement of test results		Keep all open until trajectory is complete- September 15.	Not closed
2015/5594	NOTSS	A severely underweight patient with a new diagnosis of a post cricoid	19/02/15	OUH to provide OCCG assurance that all previous actions have been carried out.	Not closed

		squamous cell carcinoma had a radiologically inserted gastrostomy. The following day her condition deteriorated. She was taken to theatre for an emergency laparotomy but her condition was deemed to be unsurvivable and the procedure was abandoned. She died later that day.			
2015/3970	MRC	A patient underwent a chest CT on 10 February 2012 which showed lung nodules. A follow up scan was recommended and took place on the 1st May 2012; this showed an increase in the size of the nodules. A further scan and referral to a chest physician were recommended but this did not take place. The patient represented to ED in January 2015 with chest pain a CT scan performed at this time showed a 4.5cm mass which is presumed to be metastatic lung cancer.	08/04/15	OUH to provide OCCG assurance that all previous actions have been carried out.	Not closed
2015/2016	NOTSS	The patient was admitted for management of non-traumatic leg haematoma. A suspected deep tissue injury was identified on the patient's heal. This has been reviewed by tissue viability who expects this to breakdown into a category 3 or 4 pressure area. The pressure area damage has been deemed to be avoidable.	02/04/15	Discussed at PU meeting on 12/6/15. OCCG awaiting assurance from OUH, actioned in PU meeting.	Not closed
2015/1055	S&O	Three week history of poor nutrition and recently diagnosed with spinal cord compression. Grade 2 deterioration to Grade 3 on sacrum.	13/03/15	Discussed at PU meeting on 12/6/15 OUH to give assurance that Mental Health issues are being addressed	Not closed

2015/6348	C&W	Primip admitted in labour had a forceps delivery for a bradycardia. The baby was born in very poor condition. The prognosis for the baby was poor due to a likely hypoxic injury and intensive care was withdrawn. The baby died aged four days.	19/04/15	OUH to update action plan to reflect training is mandatory and guidelines will be followed not reviewed. Once updated action plan received agreed close.	Not closed
2015/8192	MRC	Patient noted to have a mid-cerebral aneurysm on a PET scan performed due to lung cancer in Nov 2013. Neuroradiology opinion sought and coils suggested preventing rupture, after lung cancer surgery had taken place. Patient did not have coils sited and presented in Feb 2015 with intracranial haemorrhage. Post-mortem examination revealed ICH likely secondary to MCA rupture.	08/05/15	CCG to take MDT to next QRM meeting, following meeting discussions to be had to close.	Not closed
2015/3788	MRC	The patient fell and sustained a fracture to the neck of femur.	02/04/15	OUH to obtain evidence that risk assessment was reviewed after each fall. Was the care plan for falls appropriate and escalated? Was the equipment available? CCG to discuss with OUH (falls team) What is trust policy for patients with dementia who have falls? OUH to find out if infrastructure assessment can be done on ward, can reasonable adjustments be made to improve line of sight?	Not closed
2015/5808	S&O	An inpatient undergoing treatment for cancer developed a hospital acquired PE.	21/04/15	OUH to obtain more detail on management of incident, escalation process on the ward. Was the patient's choice fully informed? OUH to investigate staffing levels for this ward – more details around safe staffing and agency % at the time of the incident	Not closed

2015/7501	S&O	Patient had a chest X-ray on 7th November 2013. This showed a right lower lobe nodule. A CT scan was suggested but not performed. In January 2015 the patient presented with haemoptysis and underwent a CT which showed a right hilar mass.	17/06/15	OUH to provide more detail before OCCG agree downgrading- perhaps should remain a SIRI as there was a missed diagnosis (radiology discrepancy) rather than a missed test.	Not closed
2015/10514 NEVER EVENT	S&O	A patient underwent a laparotomy and an abdominal hysterectomy. A swab was retained in the abdomen following the procedure necessitating a second procedure to remove it on the same day.	17/06/15	OUH to change date references in action plan to show actual deadlines rather than '6 months' etc. OUH to advocate introduction of theatre induction ready for August 2015 intake of new starters.	Not closed
2015/12724 NEVER EVENT NORTHANTS	NOTSS	A patient underwent spinal surgery to manage symptoms of degenerative changes in the spine. The surgical plan was to revise L4/5. However, due to the patient complex anatomy the procedure was performed on L3/4.	03/07/15	OCCG Need to have full review as to what could have been done to prevent this.	Not closed
2015/2904 MILTON KEYNES		Major nerve damage following spinal surgery		OUH to check if there are any issues regarding culture of team/individual. OUH to check whether there were any radiological issues, access to films from MK Await closure decision from MKCCG prior to any closure decision.	Not closed
2015/10523 SPECIALISED COMMISSIONING OXON	CSS	A patient had an embolisation procedure for a cerebral artery aneurysm. Balloon over inflation caused a subarachnoid haemorrhage.	01/06/15	OUH to enquire why one team member using different equipment/syringe. OUH to provide detail of what training has been carried out in past 5 years for Stop/Pause training at OUH. OUH to confirm all other actions on plan completed.	Not closed

2015/11940	S&O	A patient had a laparoscopic hernia repair and was discharged. The patient was subsequently readmitted unwell and was diagnosed with bowel perforation. Despite treatment the patient died.	01/06/15	OUH/CCG to discuss outside meeting	Down grade requested.
2015/9211	MRC	A patient was admitted with a head injury following a fall at his GP practice. The patient deteriorated and suffered a cardiac arrest. Resuscitation was unsuccessful.	16/06/15	OUH to confirm staffing levels on day. OUH to carry out audit of track and trigger training on EAU. OUH to confirm whether there were any agency staff working at time of incident.	Not closed
2015/10775	MRC	A patient was admitted to the emergency department with a superficial self-harm injury and inflicted a further wound to his neck shortly after arriving in the department.	27/05/15		Closed
2015/10234 BUCKS	NOTSS	A patient absconded from a neurology ward and was found the following morning by the police in another town. The patient was unharmed.	05/06/15		Closed
2015/9632	NOTSS	Patient had reconstructive surgery including a bone graft. Wound dehiscence occurred within 3 weeks of the operation	01/06/15		Report withdrawn
2015/12162	S&O	A patient was prescribed and given warfarin when already receiving Dalteparin. The patient developed a retroperitoneal haemorrhage.	23/06/15		Downgraded
2015/10908	MRC	Grade 4 PU	01/06/15		Closed
2015/16737	S&O/CSS	Theatre availability leading to palliative care	05/08/15		Downgraded

3.2.9. The closure or finalisation of SIRI reports is monitored through Schedule 3 part 4 of the Trust contract on a monthly basis. This reporting indicator is not affected by the closure process and decision making described above. This performance indicator refers strictly to the delivery of a completed report within the agreed timeframe to the OCCG, and as recorded in STEIS.

3.3. Quality Walk Rounds

3.3.1. There were seven Executive Quality Walk Rounds in August 2015. These are detailed in Table seven below.

Table Seven

Hospital Site	Areas Visited
John Radcliffe Hospital	Neonatal unit Trauma ward 3A Post-Acute Unit (ward 7F)
Churchill Hospital	Radiology Department Jane Ashley Colorectal Centre
Horton General Hospital	Brodey Centre Radiology

3.3.2. Key issues with the potential to affect quality or patient experience identified during the Executive Quality Walk Rounds included cohorting of patients requiring treatment, absence of screens and TV systems in patient areas, medication issues associated with ePMA, delays associated with the portering service, processes to keep EPR requestor permissions up to date when requesting investigations.

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

3.3.4. An update on actions arising from Executive Quality Walk Rounds is provided in the Appendices. Actions are given a 'RAG' status: actions beyond their scheduled completion date (red), actions within the expected timeframe (amber), and actions which have been completed since the last report to Quality Committee (green). Actions remain red if an update has not been provided by the relevant Division at the time of writing.

3.4. Quality Account Update

3.4.1. A four page summary of the Trust Quality Account has been completed and uploaded to the clinical governance intranet site and Trust website. Printed copies will be circulated throughout the Trust and will be available at the Trust Annual General meeting and handed out at Trust induction days.

3.4.2. Printed copies of the Quality Account full document are now available from the Medical Directors office and the Clinical Governance Department.

3.4.3. Poster templates have been created and endorsed by the Sisters' meeting for use in clinical areas. These describe the Trust-wide priorities and allow the local teams to customise the posters to describe the actions they will undertake. (See appendix 3)

4. Clinical Effectiveness

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

4.1.1. The latest Trust SHMI, published on the 29th July 2015, for the data period January 2014 to December 2014 is 0.99. This SHMI value is banded 'as expected.' The SHMI has decreased from the previous value of 1.00 (for the data period October 2013 to September 2014). There are 8 SHMI diagnosis groupings with 'higher than expected' relative risk of mortality compared to the national benchmark (displayed in the Table below).

Table Eight – SHMI diagnosis groupings with higher than expected relative risk of mortality [lower 95% confidence interval (CI) exceeding 100]

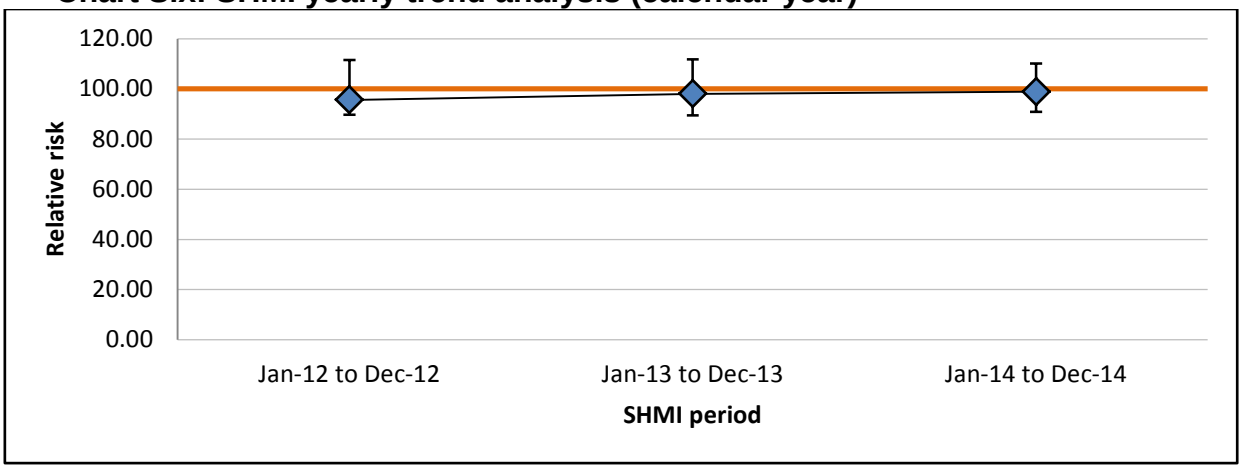
SHMI Diagnosis Grouping	Spells	Observed	Expected	Observed - Expected	Relative Risk	Low 95%CI	High 95%CI
Digestive congenital anomalies, Genitourinary congenital anomalies, Nervous system congenital anomalies, Other congenital anomalies.	1144	10	4	6	276	132	508
Short gestation, low birth weight.	475	18	8	10	223	132	352
Coronary atherosclerosis and other heart disease.	1552	34	19	15	178	123	248
Cancer of other GI organs; peritoneum.	83	25	14	11	172	111	254
Cancer of bronchus, lung.	338	109	85	24	129	106	155
HIV infection.	16	3	1	2	523	105	1528
Respiratory failure; insufficiency; arrest (adult).	72	29	19	10	155	104	223
Cancer of breast.	400	16	9	7	180	102	291

Table Nine – SHMI diagnosis groupings with lower than expected relative risk of mortality [higher 95% confidence interval (CI) below 100]

SHMI Diagnosis Grouping	Spells	Observed	Expected	Observed - Expected	Relative Risk	Low 95%CI	High 95%CI
Allergic reactions, Rehabilitation care; fitting of prostheses; and adjustment of devices, Administrative/social admission, Medical examination/evaluation, Other aftercare, Other screening for suspected conditions (not mental disorders or infectious disease), Residual codes; unclassified, E Codes: All (external causes of injury and poisoning)	2248	4	19	-15	21	6	53
Septicaemia (except in labour), Shock.	547	73	100	-27	73	57	92
Spondylosis; intervertebral disc disorders; other back problems, Osteoporosis.	1423	2	8	-6	26	3	93
Peripheral and visceral atherosclerosis.	551	47	65	-18	72	53	95
Mental retardation, Senility and organic mental disorders.	287	21	33	-12	64	39	97

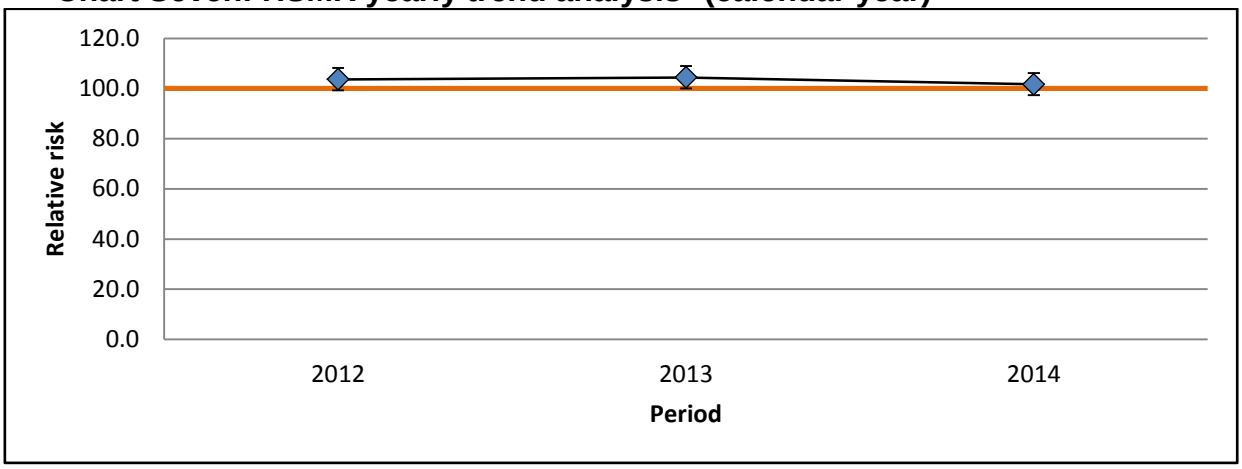
4.1.2. The Clinical Governance Unit has provided Divisional Directors and Clinical Directors with a summary of the SHMI analysis.

Chart Six: SHMI yearly trend analysis (calendar year)



4.1.3. The latest Trust HSMR, published on 14th August 2015, for the data period June 2014 to May 2015 is 103. This HSMR value is banded 'within expected' range (confidence limits 98.6 to 107.5) when compared to hospital trusts nationally and taking into account the Trust case mix.

Chart Seven: HSMR yearly trend analysis[1] (calendar year)



4.1.4. There are no new mortality alerts published By Dr Foster in the August 2015 updates.

4.2. Clinical Outcomes

4.2.1. The clinical effectiveness committee has received reports of compliance with or audits of:

- NICE Quality Standard QS12 Breast Cancer
- Sentinel Stroke National Audit Programme (SSNAP), Inpatient Care Reports, Data period: January 2015 - March 2015 (Quarter 4 2014/2015), Published 10th June 2015
- Consultant standards for inpatient care, Data period: June 2015
- National Oesophago-Gastric Cancer Audit (NOGCA) Upper Gastro-Intestinal Surgery Consultant Outcomes,
- Patient Moving and Handling, Data period: March 2015 – June 2015
- Intravenous fluid therapy in adults in hospital (NICE Clinical Guideline CG174 and Quality Standard QS66)
- Vascular Surgery Consultant Outcomes (National Vascular Registry),
- Trauma Audit and Research Network (TARN) Clinical Report I (Thoracic and Abdominal injuries), Data period: 1st April 2014 to 31st December 2014, Published: March 2015
- National Congenital Heart Disease Audit, Data period: 2011-2014, Published: June 2015
- NICE Quality Standard QS07 Glaucoma
- College of Emergency Medicine: Initial management of the fitting child, Data period: 2014/2015, Published: 29th May 2015
- College of Emergency Medicine: Mental health in the ED, Data period: 2014/2015, Published: 29th May 2015
- College of Emergency Medicine: Assessing for cognitive impairment in older people, Data period: 2014/2015, Published: 29th May 2015
- Screening for cancer in unprovoked VTE
- NICE Clinical Guideline CG144 and Quality Standard QS29

[1] The risk model used for the HSMR calculations is based on risks up to February 2015

5. Infection Control

5.1. Clostridium difficile (C.diff)

5.1.1. The ceiling for 2015 / 2016 is 69 cases.

5.1.2. Eight cases of C.diff apportioned to the OUH were reported for July 2015, against a monthly limit set at six and these were reviewed at the Monthly Health Economy meeting with the OUH, OCCG, Oxford Health and PHE in attendance. Of the eight cases, it was determined that five of the cases were unavoidable. It was agreed that a further review of one remaining case would be required before avoidability could be determined.

5.1.3. The two remaining cases will be reviewed at the September Health Economy meeting. Due to late reporting the Case review documentation could not be made available in time for the meeting on the 10th August 2015. Key areas for improvement identified the following need:

- Improvements in the communication between Nursing and Medical staff when samples have been sent for C.diff testing.
- Improving awareness of the need for a specific request on EPR for C.diff testing if a C.diff infection is suspected, rather than a single request for Microscopy, Culture and Sensitivity (MC&S) testing.

5.1.4. Two outstanding OUH apportioned cases for June 2015 were also discussed at the August 2015 meeting and it was agreed that one case was unavoidable and the other required further follow up in terms of antimicrobial prescribing. Therefore, of the eight OUH apportioned cases reported for June 2015, seven were deemed unavoidable and one is still to be determined.

5.1.5. The OUH currently sits on the cumulative limit for July 2015 (23 cases in total against a cumulative limit of 23), but expects to be below the ceiling for cases 2015/2016.

5.1.6. Table ten below outlines the number of cases per month that are apportioned to the OUH Trust and table five provides more detail for each July case.

Table Ten: Cases of C. diff per month

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

Table 11: July 2015 C. diff cases

Speciality	Details of cases	Avoidable / Unavoidable Cases discussed 10/08/15
General Medicine	75 yr. old patient admitted with a 2-3 week history of worsening ulceration of the Right buttock. The patient had been admitted to the OUH on four admissions in 6 months this year with possible sepsis secondary to chronic leg ulcers and had been previously investigated for Osteomyelitis. The patient was known to have a Grade 4 right necrotic buttock ulcer, but this had not responded to oral antibiotics or Honey dressings. During this admission, the patient was reviewed by a Plastics Consultant, Tissue viability and Podiatry and was assessed as being appropriate for conservative management, with specialist honey dressings, appropriate pressure reliving equipment and regular turning and following a senior review was deemed medically fit for discharge to a Community Hospital, for on-going care. At the end of June, the patient spiked a temperature but Blood Cultures taken at the time were negative. 2 days later (01/07/15) the patient developed loose stool and a stool sample for C.diff testing was collected on 03/07/2015. Oral Vancomycin was started and the Patient was moved to another ward in to a side room. The stool sample was subsequently reported as C.diff positive.	**Case requiring a further review as there were concerns about the accuracy of the stool chart documentation and the appropriateness of antibiotic prescribing. Avoidability will be determined at the Health Economy meeting on the 07/09/15**
General Medicine	84 yr. old patient was admitted to the OUH from home as an emergency with a 6-7 day history of vomiting and diarrhoea (without any abdominal pain), falls and swollen Left knee. The patient had received a Steroid depot injection 4 days previous to this admission. A Stool specimen was sent for C.diff testing on the day after admission, but was not processed by the Microbiology laboratory as the stool was formed; empirical Vancomycin was also not commenced. On the 05/07/15, the patient's stool output increased and a further stool sample was sent for C.diff testing. Oral Vancomycin was commenced and the patient isolated. The stool sample was subsequently reported as C.diff positive. A Flexi sigmoidoscopy performed on the 07/07/15 also indicated a pseudomembranous colitis, confirming a C.diff infection.	**Unavoidable**

General Medicine	85 yr. old patient admitted to the OUH with sepsis, dehydration and on-going diarrhoea. The patient was previously reported as C.diff positive in May 2015. Oral Vancomycin treatment had finished 2 weeks prior to this admission and the patient commenced on loperamide at home), and was found to have a Grade 4 Pressure ulcer. The patient had also been on antibiotic treatment under their GP prior to admission (The Surgery did not provide OUH Infection Control with the reason for this prescription). The patient was diagnosed with a severe pneumonia and septic shock and commenced on IV Antibiotic treatment. The patient was also restarted on oral Vancomycin for relapse of C.diff infection and a Stool sample requested on the 06/07/15 though the test request was only for Microscopy, Culture and Sensitivity (MC&S), rather than for C.diff testing. The sample was sent to the laboratory on the 07/07/15 and a request was subsequently made by the Medical team for C.diff testing in addition to the MC&S request. The patient was reported as C.diff positive on the 09/07/15. Sadly the patient passed away on the13/07/2015. Death certification documented the cause of death as follows : Part 1: Chest infection. Part 2: C.diff, AKI, Grade 4 sacral pressure sore. As per OUH protocol when a patient dies within 30 days of a C.diff positive result, an M&M review will be undertaken.	**Unavoidable**
Renal	79 yr. old patient admitted 02/06/15 with a deep space neck infection. An examination under anaesthetic by the ENT team found an oedematous upper airway and abscess and the patient was subsequently intubated and required a period of invasive ventilation and inotropic support on ITU. As per ID advice managed with IV antibiotics and oral steroids. The patient was transferred from ITU to the Renal ward on the 19/6/15 for on-going renal support and rehabilitation. The patient was found to have an impaired swallow and a decision was made with the patient to become	**Unavoidable**

	Nil By Mouth and then undergo an insertion of Percutaneous Endoscopic Gastrostomy tube for long term nutritional support. The patient opted for ice chips and sponges for mouth comfort, though they accepted that there would be a degree of an on-going risk of aspiration due to their impaired swallow. As a consequence, the patient was treated on multiple occasions for an aspirational pneumonia with IV antibiotics. On the 25/07/15, the patient developed loose stools and was commenced on oral Vancomycin for a suspected C.diff infection. A stool sample was sent for testing and was reported as positive for C diff.	
Trauma / Orthopaedics	75 yr. old presented to A&E with a swollen, hot and painful Right knee. The patient was transferred to the NOC as they had previously received treatment on BIU for a recurrent Prosthetic joint infection (last admission 2014) and had been discharged under the care of their GP on a prolonged course or oral antibiotics (this was a decision made by the patient following consultation and agreement with the BIU service). Blood cultures taken on admission isolated an MRSA with a prosthetic joint septic arthritis thought to be the source. The patient responded well to on-going antimicrobial treatment. 2 weeks into admission developed loose stool and though a sample was sent for C.diff testing, treatment was not commenced until a positive result was reported by the OUH Infection Control service to the ward, rather than upon suspicion as per OUH protocol. This has been investigated by the ward and an error in communication between a junior member of the nursing staff and the on-call Medical SHO was identified. This has been fed back to the BIU Nursing and Clinical teams.	**Unavoidable**
Trauma / Orthopaedics	85 yr. old patient admitted to the OUH after a fall whilst mobilising. An X-ray confirmed a left intertrochanteric fractured neck of femur and the patient underwent surgery. The patient was noted to be suffering from some nausea and vomiting pre-operatively and was commenced on treatment for oral thrush. Post operatively the patient recovered well, but vomiting with some blood present continued.	**Unavoidable**

	An OGD was performed which highlighted Oesophageal ulceration, a hiatus hernia and a further single duodenal ulcer and the patient was commenced on Omeprazole. A urine sample was sent for a suspected Urinary Tract Infection and the patient was commenced on antibiotics. The then patient developed loose stool and oral Vancomycin was commenced for a suspected C.diff infection. Though a stool sample was sent for MC&S, no specific request for C.diff testing was made and a further request was made by the patient's surgical team for a sample to be sent for C.diff testing. A sample was sent, which was reported as negative: Oral Vancomycin was therefore stopped. Subsequently, it was noted that the patient's bloods were grossly deranged with raised inflammatory markers. The patient was vomiting overnight and reported that they had not had their bowels opened for a few days and felt constipated. The patient was reviewed with the Gastroenterology SpR and was also noted to be coughing and had a poor urine output. The patient began to experience loose stool, felt more unwell and their inflammatory markers were noted to be further raised. Oral Vancomycin was restarted and stool sample requested for C diff testing. A CT scan of the Abdomen did not show any obstruction or dilated loops, but did identify a possible acute diverticulitis, liver lesion and renal cyst. The stool sample was subsequently reported as C.diff positive and the patient was transferred to a General Surgical ward for management of Colitis.	
General Medicine	66 yr. old patient admitted to the OUH A stool sample sent after admission tested *C.diff* positive, however the patient was not isolated or treatment commenced until after the positive result was known. A full summary for this patient was not available at the time of writing this report and will therefore be provided in the August Quality report.	**Case requiring review and will be determined at the Health Economy meeting on the 07/09/15**

Maternity	39 yr. old patient admitted to OUH. A stool sample was sent a week after admission and the patient was isolated on suspicion of C.diff diarrhoea and Vancomycin commenced. The patient was subsequently reported as C.diff positive. A full summary for this patient was not available at the time of writing this report and will therefore be provided in the August Quality report.	**Case requiring review and will be determined at the Health Economy meeting on the 07/09/15**

5.2. MRSA bacteraemia

5.2.1. The objective for 2015 / 2016 is 0 avoidable MRSA Bacteraemia.

5.2.2. There were 0 MRSA Bacteraemia apportioned to the OUH in July 2015, however an OUH apportioned MRSA Bacteraemia that was reported in June 2015 was determined to have been avoidable and therefore the OUH has failed to meet this objective for 2015 / 2016.

Table 12: MRSA bacteraemia to date by speciality for 2015/2016

Month	speciality	Avoidable/ Unavoidable	Details of case/Lessons learned
April 2015	Haematology Churchill	Unavoidable	A Post Infection Review (PIR) meeting agreed that the MRSA bacteraemia was unavoidable due to the patient's neutropenia and chemotherapy treatment. The likely source of this MRSA bacteraemia was skin and soft tissue due to severe mucositis affecting the patient's nose and anal area/buttock region. It was agreed that the patient's refusal to wash due to fatigue, despite being offered help from nursing staff, was not thought to have contributed to the development of the bacteraemia. Areas of good practice were recognised which included; follow up blood cultures, appropriate use of Antibiotics, infection control involvement, good documentation of the insertion and care of the PICC line. **Lessons Learnt** If sepsis is suspected, line tips are processed if blood cultures taken at the same time are tested positive. On removal of the line, no line tip was sent to Microbiology for testing.

			Action Ensure clinical staff are aware of the requirement to send line tips together with blood cultures on suspicion of sepsis.
June 2015	Haematology Churchill	Avoidable	A Post Infection Review (PIR) meeting was held on the 01/07/15. It was agreed that the MRSA bacteraemia was avoidable due to a number of lapses in care (details below) It was agreed the likely source of this MRSA bacteraemia was the femoral line which had been accessed by the Therapeutic Apheresis Service for administration of plasma exchange. Areas of good practice were recognised which included; early recognition of sepsis, infection control, involvement, failure to screen on admission did not influence the antibiotic choice (Vancomycin) to treat skin infection and the patient remained well throughout, in relation to the bacteraemia. **Lessons Learnt** • MRSA screening was not undertaken on admission in accordance with Trust MRSA guidance • VIP scoring of Femoral line was not recorded every shift in accordance with Trust Guidelines • Femoral line was in situ for 1 day longer than the recommended duration of (8-10 days) in accordance with Trust Guidelines • Choice of Antibiotic to treat psoriatic skin infection was not within Trust Antimicrobial guidance. **Action** • Ensure clinical staff are aware of the requirement to obtain an MRSA screen on admission and follow up the results • Review the 'procedure summary sheet' with the Therapeutic Apheresis Service to ensure VIP scores are assessed and documented. • Explore options within EPR to increase compliance with electronic VIP scoring • Ensure Clinical team are aware of and adhere to Trust antimicrobial guidance • Ensure clinical staff are aware of and adhere to Trust Guidelines Intravascular Devices in Adults: Guidelines for Management and Aftercare.

5.3. Cleaning audits

5.3.1. Clinical areas are required to achieve a minimum 92% Compliance with the monthly cleaning audit. Table 13 below details the average reported cleaning scores by division and by the OUH Quality Assurance Team (QAT).

Table 13: Cleaning Audit Scores for July 2015

	July 2015		
Division	Quality Assurance Team audits	Domestic audit scores	Nursing audit scores
Neurosciences, Orthopaedics, Trauma & Specialist Surgery	84%	98%	97%
Medicine, Rehabilitation & Cardiac	87%	94%	96%
Children's and Women's	88%	93%	97%
Surgery & Oncology	88%	94%	94%
Clinical Support Services	88%	95%	99%
OUH total	**87%**	**95%**	**97%**

5.4. MRSA Screening Compliance

5.4.1. The trust achieved 52% compliance with MRSA screening, 82% for elective admissions and 48% for emergency admissions. Clinical areas with high turnover of patients have lower compliance with screening emergency admissions. Table 14 below details the compliance with emergency and elective MRSA screening by division

Table 14: Compliance with emergency and elective MRSA screening.

	June 2015		
Division	Percentage Screened Electives	Percentage screened emergencies	Percentage of Patients screened
Neurosciences, Orthopaedics, Trauma & Specialist Surgery	85%	53%	71%
Medicine, Rehabilitation & Cardiac	81%	49%	50%
Surgery & Oncology	64%	46%	49%
Clinical Support Services	60%	91%	69%
OUH total	**73%**	**60%**	**60%**

5.5. Antimicrobial Prescribing

5.5.1. Table 15 below details the results of a Point Prevalence audit to measure Compliance to current OUH Antimicrobial prescribing guidelines, undertaken in July 2015.

Table 15: Compliance with current OUH Antimicrobial prescribing guidelines

	July 2015		
Division	Number of Prescriptions	Number Compliant with Guidelines	Overall Percentage
Neurosciences, Orthopaedics, Trauma & Specialist Surgery	126	115	91%
Medicine, Rehabilitation & Cardiac	177	159	90%
Children's and Women's	95	92	97%
Surgery & Oncology	248	237	96%
Clinical Support Services	19	19	100%
OUH total	**665**	**622**	**94%**

5.6. Summary of Infection Control

5.6.1. The OUH Trust remains within its objective for *Clostridium difficile* 2015 – 2016 to date.

5.6.2. Two MRSA bacteraemias have been reported by the OUH 2015 – 2016 to date; one avoidable MRSA Bacteraemia and one unavoidable MRSA bacteraemia. The OUH has therefore failed to meets its objective of 0 avoidable MRSA Bacteraemia for 2015 / 2016.

5.6.3. MRSA screening for emergency admissions continues to show low compliance.

5.6.4. Clinical areas continue to work towards universal 92% compliance with the QAT cleaning audit.

6. Friends and Family Test

6.1. Inpatients and day cases:

6.1.1. **OUH data:** The issues of note are that the percentage of patients who would recommend the care they received in July remains constant at 96-97%.

6.1.2. Children's and Women's Division remain the highest rated Division (100%) and the majority of the responses are from Gynaecology Ward at the John Radcliffe Hospital and Gynaecology Day Cases at the Horton General Hospital.

6.1.3. The percentage of patients who would recommend the care they received from clinical areas in NOTSS division has fallen to 91%. This appears to be due to small changes across three wards, however it is not clear why this has occurred. Response rates remain low at 7% overall in July for inpatients and day cases. In the period since the introduction of text messaging and Interactive Voice Messaging (IVM) for day cases on 24th August, the response rate for day cases has risen to 47%.[2]

At the time of writing we are not able to predict the combined responses for day case and inpatients for August.

6.1.4. There are two types of thematic analysis that are available through the current suppliers. Services that use the electronic provider are analysed using most common words in positively rated or negatively rated comments. Services with the comment card provider 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.

Table 16: Thematic analysis: the top themes for inpatients were:

Positive	**Negative**
• Staff: 705	• Waiting / Delays: 15
• General Quality of Care: 548	• Food / Catering: 12
• Nursing Care: 285	• Facilities: 10
• Information: 57	• General Quality of Care: 10
• Food / Catering: 56	• Communication between staff 9
• Cleanliness: 54	• Staffing levels: 9
• Facilities: 32	• Staff: 8
• Environment: 22	• Information: 8
• Comfortable: 19	• Noise: 5
• Waiting / Delays (lack of) : 11	• Nursing Care: 5

[2] This is a percentage of surveys sent to patients by text message or phone. There are no other data currently available from which to make the calculation. If the trust did not have the patient's phone number, these would be excluded from the eligible patients in this calculation. The Trust will make an accurate calculation at the end of the month, and this percentage will be slightly lower.

6.1.5. The most common positive themes are in line with other patient feedback in the Trust. Waiting and delays (15 comments) is the most common negative theme, but proportionally it is much less common than the top positive themes. There were also 11 comments about being treated promptly.

Table 17: Thematic analysis: the most common words for day cases were:

Positive	**Negative**
• Staff: 50 • Friendly: 29 • Care: 29 • Well: 20 • Helpful: 16 • Excellent: 16 • Efficient: 13 • Thank: 13 • Everything: 12 • Kind: 11	• No records were found. The search only includes words with a frequency higher than 3.

6.1.6. The most prevalent words in feedback from day case patients are in line with other patient feedback in the trust. Staff are praised for their friendly and helpful attitudes and care was generally excellent.

6.1.7. **National comparison:** the percentage who would recommend their care in the Trust in June (96.9%) remains above the national average (95.6%).

6.1.8. The response rate in June (8%) is much lower than the national average (27%), and OUH has the lowest response rate in the country. The analysis of national FFT data from 1 April 2015 included eligible day case patients within the inpatient reporting cohort; and this was presented to the Quality Committee in August. The **analysis benchmarked with the best and worst performing Trusts in the country.** The key issues identified with the best performing Trusts;

- There was little or no increase in the number of eligible patients with the addition of day cases
- There were less than 1000 eligible patients in time period
- Some specialist trusts had higher numbers of day case activity in relation to inpatients.

6.1.9. The key issues identified with the worst performing Trusts:

- The Trusts with lower response rates had larger numbers of eligible patients; this included OUH who had the largest number of eligible patients in the group.

- Of the 10 Trusts with the lowest response rates, the increase in number of eligible patients including day cases was significant (more than 133% increase). For OUH this represented an increase of 228% of eligible patients.

6.1.10. The average response rate for other Trusts using text messaging and Interactive Voice Messaging (IVM) for both inpatients and day cases was 27%.

6.2. Emergency Departments (EDs):

6.2.1. **OUH data:** The response rate in July has increased to 28% from 19%; this is the first full month of using text messaging and interactive voice messaging as the main method for seeking feedback. The new method reduces sampling bias (as the invitation to take part in the survey is not initiated by staff), coupled with the higher response rate, the Trust can be more confident in the reliability of the ratings of care.

6.2.2. The percentage who would recommend their care in July (87%) has increased since June (84%). The ratings of care are similar at both EDs: 87.4% at the JR and 87.6% at the Horton.

Table 18: The most common words in positively rated and negatively rated responses are as follows:

Positive	Negative
• Staff: 164	• Waiting: 34
• Service: 95	• Hours: 32
• Seen: 90	• Time: 23
• Friendly: 86	• Wait: 19
• Efficient: 82	• Doctor: 19
• Helpful: 66	• Seen: 18
• Doctor: 66	• Long: 17
• Good: 65	• Pain: 14
• Time: 57	• Home: 13
• Treatment: 57	• Staff: 12

6.2.3. This is consistent with feedback received from other areas of the Trust. While 'waiting' appears to be the top issue in negative responses, "time" and "efficient" appear as top words in positive comments. This suggests that efficiency is something the department does well, but when patients do have to wait, they are likely to comment.

6.2.4. **National comparison:** the most recent data for national comparison is for the month of June, when the Trust achieved a response rate of 19% (SMS/IVM was introduced on 9th June). This makes it difficult to compare the Trust with other Trusts using similar survey methods due to the incomplete month; this analysis will be carried out using July's data. The percentage who recommended their care in June (84%) was lower than the national

average (88%), however the Trust has improved in July, and the Trust can be more confident in the reliability of the ratings for July as more data is included using a more reliable survey method and the higher response rates.

6.3. Maternity:

6.3.1. **OUH data:** The percentage who recommended their care has decreased to 95%, while the number who did not recommend their care remains constant at 0% (there were 4 respondents who were "neither likely nor unlikely" and 5 "don't know").

6.3.2. The response rate remains low at 7% partially due to the administrative distribution problems; in addition, processes have been improved. Reporting requirements have changed3 so that data is reported based on the month received rather than date of care. This may reflect a small decrease as questionnaires sent at the end of the month will be counted in the following month if they arrive after the cut off.

6.3.3. Thematic analysis: the thematic analysis for maternity services is not currently available and will be included in the next report.

6.3.4. National comparison: the national comparisons show 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 percentage recommend for June (99%) puts the Trust at 11th out of 123 NHS Trusts (with more than 100 responses).

6.4. Outpatients:

6.4.1. The increase in the number of responses received during June and July has been maintained: from 351 in May to 562 in June and 653 in July. The five services that returned the most completed questionnaires are Horton physiotherapy (184), Churchill Radiotherapy (76), John Radcliffe Trauma Outpatients (74), and Blenheim Head and Neck (53). The majority of the feedback (68%) comes from these five services.

The introduction of SMS and IVM on 24 August 2015 has provided a better distribution of feedback across the outpatient departments, with 2564 responses received from patients in the first three days of using the new system. Response rates for outpatients are not monitored nationally. The outpatient response rate using electronic feedback is 32%, of surveys sent to patients via text or IVM. The August patient experience data will be presented to the Trust's Quality Committee on 14 October 2015.

6.4.2. The percentage of patients who would recommend their care remains constant at 97%.

[3] According to NHS England guidance: http://www.england.nhs.uk/wp-content/uploads/2014/07/fft-imp-guid-faqs-14.pdf

Table 19: The top 10 words associated with positively rated responses were:

Positive	Negative
• Staff: 158 • Helpful: 147 • Friendly: 130 • Good: 115 • Treatment: 89 • Service: 75 • Care: 63 • Excellent: 61 • Time: 58 • Professional: 57	• Appointment: 7 • Waiting: 5

6.4.3. The positive themes are in line with the themes for other patient feedback in the Trust (positive staff attitude and general good quality of care).

6.4.4. It is markedly notable that the negative feedback related to outpatient experiences has decreased dramatically.

6.4.5. Many of the comments that mentioned waiting a long time also said that they would have liked better communication about the waiting time.

6.4.6. The top words associated with poorly rated responses were (only two were listed):

- Appointment: 7 responses. On further interrogation, themes included notes not being available, clinics running late, efficiency of processes such as appointment letters and difficulty contacting department by telephone, continuity of care with different healthcare professionals, and lack of follow up from service regarding treatment.
- Waiting: 5 responses. Patients commented that they would have liked better communication about the waiting time.

6.5. Electronic feedback

6.5.1 Text messaging and interactive voice messaging was introduced in outpatients and day cases on 24th August 2015.

6.6. Carers' Feedback

6.6.1. The pilot Carers' Questionnaire in partnership with Carers Oxfordshire[4] and Carers Voice[5] has been implemented for two months. Carers are asked to comment specifically in relation to their experience as a carer. This has become particularly important following the implementation of the Care Act6 on 1 April 2015.

6.6.2. To date approximately 70 questionnaires have been distributed between 1 July and 21 August; with 27 (approximately 38%) completed and returned. Of

[4] http://www.carersoxfordshire.org.uk/cms/
[5] http://www.carersvoiceoxfordshire.org/
[6] https://www.gov.uk/government/publications/care-act-2014-statutory-guidance-for-implementation

these; 14 (approximately 52%) rated their experience as ‘good’, 10 (approximately 37%) rated their experience as ‘ok’, and 2 (approximately 7.4%) reported their experience to be ‘poor’. One card was not completed fully and it was therefore not possible to use the carer’s feedback.

6.6.3. The positive feedback themes were that the staff were very caring and helpful; and that surroundings were clean. The negative themes included communication issues and a lack of clarity surrounding treatment plans.

6.6.4. Carers have fedback that they would rather speak about their experience to someone in person or be supported to complete the questionnaire. Therefore to facilitate an increased level of engagement, two external volunteers from Carers Oxfordshire and Carers Voice visit the pilot wards (Post-Acute Unit, the Stroke Unit, Adams and Bedford Ward and the Lionel Coisin Day Hospital) twice weekly. Carers have responded positively to the survey and greatly appreciated talking with the volunteers; and as such the response rates have been 38%.

6.6.5. A review of the pilot is scheduled for 27 August 2015, and will include the patient experience team, the external volunteers, ward managers and matrons.

6.7. Complaints

6.7.1. The number of new complaints received during July was 78. This reverses the trend experienced during Quarter 1 of 2015/16 and represents a 19.5% reduction in complaints from the previous month. It is not advisable to draw any conclusions from this figure yet as the numbers of complaints remain higher than the previous year. The Health and Social Care Information Centre (HSCIC) published the national complaints benchmarking information from 2014-15 on 26 August and the analysis will be included in the PALS and Complaints Annual Report.

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

6.7.3. The graphs in the Patient Experience dashboard present the complaints coded by the top four subjects for April to July 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 seventh consecutive month (n=21, 27%). However in July, the division’s total number of complaints reduced by 36% and the proportion of the Trust’s complaints reduced from 34% in June to 27% in July.

6.7.5. The division’s complaints related to the Eye Hospital, ENT, Vascular Service, Specialist Surgery Inpatients (SSIP), Hip and Knee Services, Oral and Maxilla Facial Services and Neurosciences Inpatient Services.

6.7.6. There were six complaints across the division in relation to appointments or delays in waiting times; all of which were graded as 'moderate' as the delay or cancellation caused the patient or relative considerable concern.

6.7.7. The division has received eight complaints graded as 'high'. This represented 38% of the division's complaints and 32% of all the complaints graded as 'high'. These complaints were in relation to the Vascular Service, Specialist Surgery Inpatients (SSIP), Hip and Knee Services and Neurosciences inpatients. Of these, six complaints related to clinical treatment in which the complainants expressed their concerns of misdiagnosis, delay in treatment and extreme delay in receiving results. The remainder of the complaints related to nursing care and the unprofessional attitude of staff.

6.7.8. S&0 received 12 complaints this month (15.3%), of which three were for Acute Surgery, two for Urology, two for Medical Oncology, two for Clinical Oncology, two for upper and lower GI and one for Renal and Transplant Services. This number represents a reduction of 40% from the previous month; although the number of complaints received by the division has fluctuated over the previous seven months, the overall trend is an increase in complaints received. The figure for July is a significant reduction in a single month although it is not yet possible to draw any conclusions.

6.7.9. Two complaints related to delay in waiting for appointments and both were in relation to Oncology services.

6.7.10. The four complaints graded as 'high', related to Oncology, Acute Surgery and Urology; and specifically raised concern of misdiagnosis and relatives concerns associated with patients' discharge.

6.7.11. CSS received seven complaints this month (9%) which represents an increase of 14% from the previous month. Of these, six (five graded as moderate and one as low) related to Radiology and Imaging Services and one related to the Pain Service.

6.7.12. Three complaints relating to Radiology and imaging Services pertained to clinical treatment; although these related to a delay in either a procedure or reports. The remaining concerns related to facilities, appointments and privacy and dignity. Although the division's complaints increased by one this month, this is compared to an overall reduction across the Trust.

6.7.13. MRC received 18 complaints this month (23%), which represents a reduction of 14%. The complaints related to six services. Eight complaints related to the Trust's Emergency Departments and Emergency Assessment Units; six complaints concerned care within Acute General Medicine (AGM), the remainder were individual complaints relating to sexual health, clinical genetics, physiotherapy and cardiology.

6.7.14. The division received six complaints graded as 'high'; of these two were in relation to AGM and two for the Emergency Department. The remainder were single complaints surrounding individual services. Three complaints related to clinical care; with the main issue being a delay in diagnosis or in treatment.

6.7.15. Two complaints were complex and involved families expressing concern about their relative's care where communication with families, the patient

and between departments was cited as a significant problem. Families expressed that this impacted substantially upon the patients care.

6.7.16. C&W received 15 complaints this month (19.2%). This represents an increase of 26.6% this month; this compares with 11.3% proportion of the Trust's complaints in June 2015.

6.7.17. The complaints related to seven services; and specifically four in Gynaecology, six in Obstetrics and Midwifery, two in Paediatric Medicine and single complaints for the Spinal Service, Ultrasound, Paediatric Cardiology, Paediatric Chest and Respiratory Medicine.

6.7.18. The division received six complaints graded as 'high'; of these two were in relation to Gynaecology, two for Obstetrics and Midwifery and single complaints for the Spinal Service and Paediatric Chest and Respiratory Medicine. The four complaints surrounding appointments, patient care and clinical treatment all commented on the lack of attention of care and diagnosis. The two complaints relating to the values and behaviour of staff both complained about medical staff.

6.7.19. The Corporate division received five complaints this month (6.4%). This represents a reduction of 17% this month. The complaints related to two services; and specifically Estates and Information Governance. The division received one complaint graded as 'high'; three moderate and one low. The complaints involving Estates conveyed concerns relating to smoking at the Churchill Hospital, portering services and unsafe surfaces at the Churchill Hospital. The complaints involving Information Governance related to inappropriate posters in a public office and a medical records request.

6.7.20. **Access**

- There were three complaints (3.9%) in relation to access. The complaints were for NOTSS and C&W. The complaints were about the services for Rheumatology and Neurology, and expressed concerns about the unclear referral pathway and treatment which was recommended and no longer available.

6.7.21. **Admission and Discharge**

- There were five (6.4%) complaints across three divisions relating to admission and discharge. Of these, three were graded high and two, moderate. This contrasted with 11 (11.3%) complaints in June and 22 (22%) in May. The complaints were in NOTSS (Trauma), MRC (Post-Acute Unit) and S&O (SEU and Oncology). All complaints related to discharge.
- The complaints related specifically to medication to take home following discharge, information contained within a discharge summary, long waits, lack of privacy and dignity when discharged, inadequate care packages and a patient's poor health on discharge.

6.7.22. **Appointments**

- There were 10 complaints (12.9%) in total relating to appointments. This compared to 17 (17.5%) in June and 10 (10%) in May. These complaints were across all five divisions and specifically the Paediatric Spinal Service, Radiology and Imaging, Pain Service, Acute General Medicine, Hand and Plastics, Ophthalmology, Oral and Maxilla Facial Services and Medical Oncology. This was a similar experience in June although in May complaints regarding appointments were in relation to services in NOTSS, CSS and S&O only.
- There were a combination of issues with concerns about cancelled appointments, lack of follow up appointments, information sent to a previous address, incorrect information regarding the location of the appointment, and an incorrect discharge.
- There were no complaints received regarding Urology appointments. This is in contrast to the previous month where the service received five complaints in relation to appointments.

6.7.23. **Waiting Times and Trust Administration**

- Two (2.6%) related to waiting times. Three complaints were received in May and two in June in relation to the same subject. The complaints were received by NOTSS (ENT) and S&O (Radiotherapy).Both complaints related to long waiting times.

6.7.24. **Clinical treatment**

- There were 23 (29%) across the five divisions in relation to clinical treatment, outcomes of care and patient care. This compared to 28 (29%) complaints for the previous month in NOTSS, C&W, MRC and CSS and 32 (32%) in May. The complaints again questioned the decision making of clinicians in relation to care and treatment planning, delay in treatment, advice following a procedure, how a procedure was conducted, liaison with other clinical teams and families.
- The seven NOTSS complaints regarding treatment, related specifically to Vascular Services, Trauma, Specialist Surgery and Neurosciences. C and W's five complaints for Gynaecology, Obstetrics and children's services; MRC's five complaints were surrounding clinical treatment in the Emergency Department and Acute General Medicine. The three CSS complaints related to Radiology and Imaging Services and of these, two were associated with delays in Clinical Treatment. The three S&O complaints related to Urology.
- There were 11 complaints rated as high (previously defined as orange complaints, 11 rated as moderate (previously defined as yellow).and one as low (previously defined as green). This is contrast to 17 and 13 identified as high risk in May and June respectively, 14 and 15 defined as moderate risk as moderate risk in in May and June respectively.

6.7.25. **Communication**

- There were nine complaints (11.5%) for NOTSS, C&W, MRC and S&O relating to communication. This was a slight reduction on the two previous months of 17 (17 %) in May and 14 complaints (14.4%) in June.
- The two NOTSS complaints surrounded not knowing who to contact to establish information regarding an appointment and incorrect clinic information sent to a patient.
- The S&O complaint related to emergency surgery.
- The five MRC complaints were for Acute General Medicine (AGM), Emergency Department and Assessment Unit (Horton General Hospital) and Cardiac Surgery. The themes related to communication with patients, their families and between departments.
- C&W was for Children's services.
- The complaints focused on different aspects of communication and related to insufficient or no information, conflicting information, delay in receiving results, communication with families and patients and accurate reporting.

6.7.26. **End of life care**

- One complaint was received specifically in relation to end of life care, and a further five referred to the death of their relative either during treatment or shortly after.
- In total there were six (7.7%) complaints making reference to a patient dying. These were in relation to services within received by MRC (3), NOTSS (2) and S&O (1).
- The complaints related to families experiencing delays throughout the health system, concerns about prioritisation of care, a lack of privacy and dignity when dying, communication and inclusion of families, a lack of attention to individual needs and concerns in relation to inadequate care packages.

6.7.27. **Patient Care**

- There were six (7.7%) complaints concerning patient care and is in comparison to four (4.1%) complaints for the previous month. In relation to patient care, three were coded as high and three as moderate. The complaints spanned multidisciplinary care and were in contrast to the previous month where all complaints related to nursing care.
- Three complaints were for S&O, two for C&W and one for NOTSS.
- All complaints were multifaceted and contained elements of coordination of care, communication with patients and their families surrounding care plans; and specifically issues surrounding nutrition,

patient centred care, discharge arrangements, medication and follow up care.

6.7.28. **Attitude of staff**

- There were 11 (14.1%) complaints relating to the attitude of staff. This is in contrast to four (5.2%) complaints for the previous month and represents a marked increase. Of these, three were rated as high, seven as moderate and one low. The complaints were across C&W (1), MRC (6) and NOTSS (3) and Corporate (1).
- The complaints included five complaints related to doctors, one nurse and four for Trust staff. The complaints related to abrupt behaviour, lack of compassion, intolerance and a lack of empathy with patients and families when listening to their concerns and delivering their care.

6.7.29. **Facilities**

- There were four (4.1%) complaints relating to facilities again this month. These were again for car parking and smoking. The three complaints relating to car parking were in relation to the JR site, the NOC and the Churchill. One related to difficulty in finding a car parking space and the remaining two related to inefficient systems and equipment not working properly.

6.8. Managing complaints

6.8.1. The Trust acknowledged 76 (97%) of all complaints within the target of three working days.

6.8.2. During Quarter 1, the Trust completed 82% (n= 231) of complaints within 25 days or the timescale agreed with the complainant. This has reduced from 97% to 82% over the previous 12 months.

6.8.3. The contracted Key Performance Indicator (KPI) with the Oxfordshire Clinical Commissioning Group (OCCG) is that 95% of complaints should be concluded within 25 days or within an agreed timescale with the complainant.

6.8.4. It is important to note that some investigations will take over 25 days to conclude; and the NHS Complaints Regulations 2009 reflect this by permitting extensions to be negotiated with complainants. The importance of concluding complaints in a timely manner has been highlighted within national complaints reports published during 2014[7][8][9][10][11].

[7] http://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/hwe-complaints-report.pdf
[8] http://www.ombudsman.org.uk/__data/assets/pdf_file/0008/28817/My-expectations-for-raising-concerns-and-complaints-summary-leaflet.pdf
[9] http://www.ombudsman.org.uk/__data/assets/pdf_file/0004/28876/Complaints_about_acute_trusts_2013-14_and_Q1,-Q2_2014-15.pdf
[10] http://www.cqc.org.uk/content/complaints-matter
[11] http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/350/350.pdf

6.8.5. The preliminary analysis of completed complaints which was undertaken by the PALS and Complaints Manager, has established that of the 102 complaints closed in June 2015; 49 (48%) were closed within 25 days, 32 (31%) were closed within an agreed timescale which included an extension agreed with the complainant, and the remaining 21 (20.5 %) were closed in excess of 25 days and without an agreed timescale with the complainant.

6.8.6. The analysis has also established that opportunities to agree extensions with complainants were missed; this was most notable at the final stages of the complaint investigation and sign off prior to sending the resolution letter to the complainant.

6.8.7. It is envisaged that the following actions will increase compliance with the OCCG KPI:

- The PALS and Complaints Manager has recently recruited to the vacant Complaints Coordinators posts
- The PALS and Complaints Manager will document extensions on the electronic complaints system to enable proactive monitoring of the length of time to resolve complaints; escalating to the Divisional Nurse and Head of Patient Experience when appropriate
- The Complaints Coordinators will undertake further work with the divisions to prioritise draft resolution letters
- The Complaints Coordinators will ensure that complainants are kept updated in relation to their complaint and estimated dates for concluding complaints are agreed.

6.8.8. From April 2015, all formal complaints received have been recorded on the new electronic complaints module. This system is compatible with the incident management and legal services systems.

6.8.9. All NHS Trusts are required to use the new national complaints codes from 1 April 2015. The complete coding list was presented to Trust Board in May 2015. The codes enable a more detailed overview of the types of complaints and as such provide Trusts with a greater opportunity to understand the nature of patients concerns.

6.8.10. The annual Hospital and Community Services Complaints Collection (KO41a)[12] for NHS England and the Department of Health has been collated and was submitted on 7 May 2015. The number of complaints for the Trust increased by 12.8% during the financial year 2014/15 and importantly this was proportionally more than the Trust's annual activity. The national data was published by the Health and Social Care Information Centre (HSCIC) on 26 August. The PALS and Complaints Team will analyse and benchmark this national data for inclusion in the Trust's annual PALS and Complaints report. This will be presented to Quality Committee on 14 October 2015 and Trust Board on 11 November 2015.

6.8.11. From 1 April 2015, all NHS Trusts are required to submit the KO41 (a) return to the HSCIC on a quarterly basis. The Quarter 1 data was

[12] http://www.hscic.gov.uk/datacollections/KO41a

presented to the Executive Directors Meeting on 25 August 2015, prior to the submission on 28 August 2015. The national data will published on 4 November 2015; and a benchmarking analysis will be included in the Board Quality Report (BQR) in December 2015.

6.8.12. The number of reopened complaints continues to be monitored each month. In June 12 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.

6.8.13. Bespoke training has been sourced to equip the Complaints and PALS teams with improved skills, along with senior representatives from each Division including appropriate facilitation and mediation training. This will allow staff to conduct resolution meetings in the most appropriate manner. Training will be conducted on 29 September and 27 October 2015.

6.8.14. The revised PALS and Complaints Policy will be presented to the Trust's Policy Group in October 2015 and as an appendix to the Trust's Annual PALS and complaints Annual Report. The policy will include the ratified complaints algorithm and the actions from the 'Complaints Matter' report presented to the Executive Directors on 10 February 2015.

7. Safe Staffing - Nursing and Midwifery

7.1. Nursing and Midwifery Staffing report to the Trust Board

7.1.1 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 the provision of reports to the Trust Board and Quality Committee on the levels of nursing and midwifery staffing on a ward by ward and shift by shift basis.

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

7.2. National reporting

7.2.1. The summary of the figures submitted to NHS Choices via the Unify platform for July 2015 can be found at the link given below[13].

[13] The data can be accessed via the Trust website on http://www.ouh.nhs.uk/about/saferstaffinglevels.aspx)

7.2.2. This report incorporates the actual hours worked against the planned rostered hours for nursing and midwifery staff, for day and night shifts, separating Registered Nurses and Care Support Workers.

7.2.3. 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.

7.2.4. It should also be noted that these figures should not be considered in isolation as they are not linked to activity and therefore limited in their value to understand the true staffing levels and skill mixes.

7.2.5. The Trust is currently experiencing a turnover of registered junior nurses of circa 17% within 12 months of taking up post. This leads to a constant 'churn' of staff requiring recruitment, orientation and training, and as such impacts on the stability of the workforce and patient care.

7.3. Data for July 2015

7.3.1. The fill rates including temporary staff are:

- 96.11% for Registered Nurses/Midwives
- 95.54% for Care Support Workers (unregistered)

7.4. Update on developments within the Trust

Acuity and Dependency Review update

7.4.1. The Acuity and Dependency review of staffing establishment levels was last undertaken manually in January 2015 for two weeks; and was repeated in the latter two weeks of July. The results are currently being collated and validated with the Chief Nurse.

Electronic acuity patient tool

7.4.2. A permanent electronic acuity and safe staffing measurement tool, entitled the Integrated Patient Acuity Monitoring System (IPAMS) is currently being configured to all the wards. Some adjustments have been implemented to align with in-patient areas identified on EPR, and this has resulted in some delays in implementation. It is currently being tested in two ward areas.

7.4.3. The midwifery in patient ward areas will be configured so that the data is available for reporting on UNIFY according to planned against actual staffing levels. The midwifery in patient wards use the 'Birthrate Plus' system for measuring acuity. This is undertaken through a separate system.
This system will provide:

- Daily acuity reporting (or more frequently if required)
- Measurement of planned against actual staffing on a real time basis
- Escalation to the senior nurses as shifts fall short of staff determined against patient acuity
- The ability to document audit responses to escalations and red flags

- More accurate trend analysis of staffing levels against patient acuity and reporting
- The ability to determine the levels of high acuity patients i.e. at level 2 high dependency in ward areas on a day by day basis across the trust.

7.5 Current status of nursing and midwifery staffing within the Trust

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

7.5.2. The majority of shifts across the Trust are at the category of 'minimal staffing'.

7.5.3. The levels of RAG (Red, Amber, Green) rated shifts are determined according to the needs of each ward's patient group with the levels and skill mix required to deliver safe care.

- **Agreed** refers to the establishment level which has been determined according to a nationally recognised evidenced based tool, the Safer Nursing Care Tool (SNCT). This is reviewed every six months.

- **Minimal** refers to the absence of one or two staff due to short notice absence, and a number of temporary staff to cover vacancies which currently vary but are significant in most areas. This level of staffing will depend on the skill mix of the staff left on the ward, and mitigation will be through ad hoc staff lent from other areas that have agreed levels (reducing them to minimum too) of nursing staff working on the ward. Additionally, other staff are drafted into cover parts of the shift i.e. Practice Development staff who are usually supervising new staff or matrons.

7.5.4. Wards operating on consistent levels of minimal staffing with temporary staff can experience the deterioration in the quality of care provided, complaints increase as well as causing increased staff stresses, and these are highlighted on the associated dashboards.

- **Escalation** shifts are those that have multiple staff on short notice absence. These cause significant mitigation through escalation to senior nursing staff in the division. This will be as above and if it is not possible to fully mitigate then escalation is to the Director of Clinical Services to close patient beds and reduce activity in order to maintain safe care.

7.5.5. Mitigation is usually possible to enable basic care to be undertaken and to ensure safe care. The numbers of staff already include a proportion of temporary staff, sometimes one or two per shift, who will most likely have generic nursing skills and not specialist skills such as those required to administer chemotherapy.

7.5.6. **The European (EU) Nursing recruitment** to date has resulted in 200 nurses commencing in post in the Trust, with only 6 leaving for personal or competence reasons. They have undergone both corporate and local induction in their clinical areas with supernumery status until they are found

to be competent and safe to confidentially manage their own caseload. This is usually between four to six weeks in most clinical areas.

7.5.7. 100 more nurses are due to commence in the Trust and cohorts are inducted every two weeks. The recruitment levels are very low due to the national shortage of registered nurses and the local challenges Oxford faces in terms of the high cost of living.

7.5.8. Seven further EU recruitment drives are planned between September and December 2015.

7.5.9. Non EU recruitment has not been undertaken to date due to the current national migrant restrictions.

7.5.10. **Recruitment strategies** include a focus on widening access to staff who are already working in the Trust or living locally. This includes enabling Nursing Assistant staff to undertake transition programmes through the Open University to attain registration over a three year period while still working at the Trust; these levels are increasing year on year.

7.5.11. Additionally, the Trust is collaborating with Oxford Brookes University to facilitate 'Back to Nursing' Programmes.

7.5.12. The principle challenge is the constant turnover of junior nursing staff, which is circa 17% throughout the Trust.

7.6. Conclusion – Safe Staffing

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

7.6.2. The majority of shifts are at minimal levels which means that care is adequate to maintain safety, but proves challenging for staff in managing the workload on a daily basis and achieving quality of care.

8. Recommendations

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

Tony Berendt
Medical Director

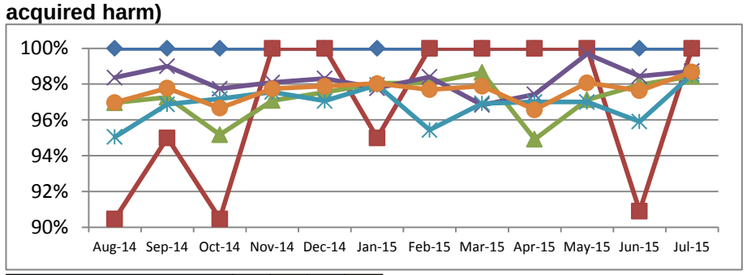
Catherine Stoddart
Chief Nurse

September 2015

Board Quality Report Dashboard – Appendix 1

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

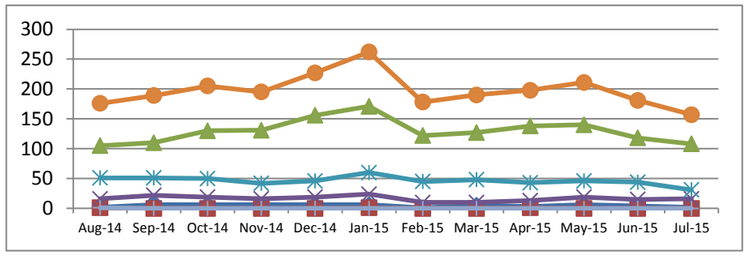
PS01 - Safety Thermometer (% patients receiving care free of any newly acquired harm)



RAG threshold	Red	95%	Amber	97%

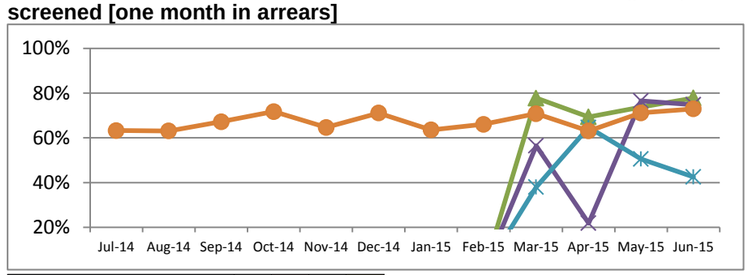
Division	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Trend to date
Children's & Women's	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	
Clinical Support Services	90.48%	95.00%	90.48%	100.00%	100.00%	95.00%	100.00%	100.00%	100.00%	100.00%	90.91%	100.00%	
Medicine, Rehabilitation & Cardiac	96.96%	97.26%	95.17%	97.09%	97.54%	98.05%	98.07%	98.65%	94.92%	97.12%	97.97%	98.44%	
Neuroscience, Orthopaedics, Trauma & Specialist Surgery	98.37%	98.99%	97.74%	98.09%	98.32%	97.77%	98.40%	96.84%	97.43%	99.69%	98.44%	98.72%	
Surgery & Oncology	95.05%	96.88%	97.17%	97.56%	97.06%	97.95%	95.44%	96.92%	97.00%	97.00%	95.90%	98.55%	
OUH	**96.98%**	**97.78%**	**96.66%**	**97.74%**	**97.89%**	**98.03%**	**97.69%**	**97.89%**	**96.56%**	**98.07%**	**97.63%**	**98.68%**	

CE02 - Crude Mortality



Division	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Trend to date
Children's & Women's	2	6	6	6	6	6	1	5	3	6	4	2	
Clinical Support Services	1	0	0	0	0	1	0	0	1	0	0	0	
Medicine, Rehabilitation & Cardiac	105	110	130	131	156	171	122	127	138	140	118	108	
Neuroscience, Orthopaedics, Trauma & Specialist Surgery	16	22	19	16	19	24	10	10	13	19	15	16	
Surgery & Oncology	51	51	50	42	46	60	45	48	43	46	44	31	
Unknown	1	0	0	0	0	0	0	0	0	0	0	0	
OUH	**176**	**189**	**205**	**195**	**227**	**262**	**178**	**190**	**198**	**211**	**181**	**157**	

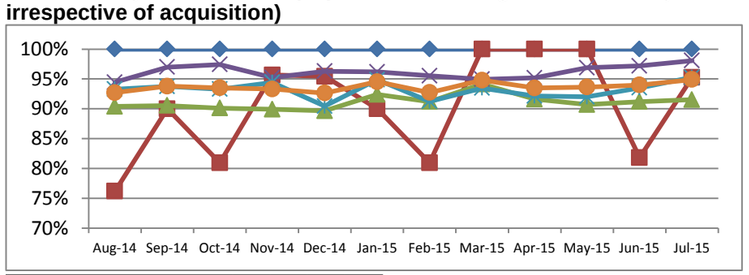
CE03 - Dementia - % patients aged > 75 admitted as an emergency who are screened [one month in arrears]



RAG threshold (Trust)	Red	80%	Amber	90%

Division	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Trend to date
Medicine, Rehabilitation & Cardiac	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	77.76%	69.35%	73.77%	77.84%	
Neuroscience, Orthopaedics, Trauma & Specialist Surgery	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	56.47%	21.92%	76.53%	74.78%	
Surgery & Oncology	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	38.04%	64.63%	50.57%	42.55%	
OUH	63.27%	63.09%	67.20%	71.71%	64.66%	71.12%	63.56%	66.02%	70.79%	63.09%	71.17%	72.92%	

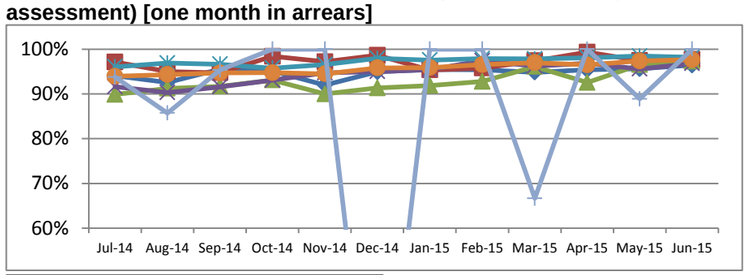
PS02 - Safety Thermometer (% patients receiving care free of any harm - irrespective of acquisition)



RAG threshold	Red	91%	Amber	93%

Division	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-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%	100.00%	
Clinical Support Services	76.19%	90.00%	80.95%	95.65%	95.45%	90.00%	80.95%	100.00%	100.00%	100.00%	81.82%	95.24%	
Medicine, Rehabilitation & Cardiac	90.40%	90.55%	90.11%	89.91%	89.66%	92.41%	91.20%	94.13%	91.61%	90.71%	91.20%	91.54%	
Neuroscience, Orthopaedics, Trauma & Specialist Surgery	94.44%	96.98%	97.42%	95.22%	96.30%	96.18%	95.53%	94.94%	95.18%	96.88%	97.19%	98.08%	
Surgery & Oncology	93.29%	93.75%	93.29%	94.43%	90.44%	94.88%	91.25%	93.46%	92.13%	92.00%	93.52%	95.27%	
OUH	**92.70%**	**93.80%**	**93.50%**	**93.32%**	**92.65%**	**94.53%**	**92.72%**	**94.80%**	**93.48%**	**93.63%**	**93.99%**	**94.90%**	

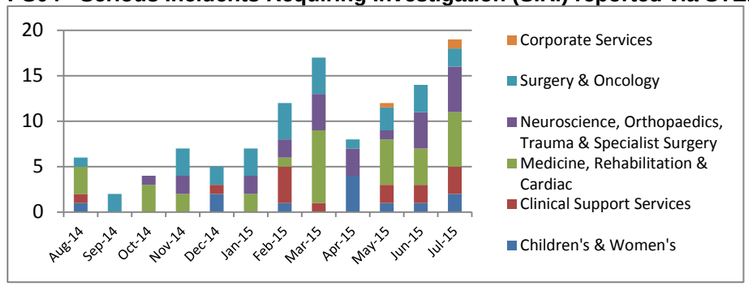
PS03 - VTE Risk Assessment (% admitted patients receiving risk assessment) [one month in arrears]



RAG threshold	Red	95%	Amber	95.25%

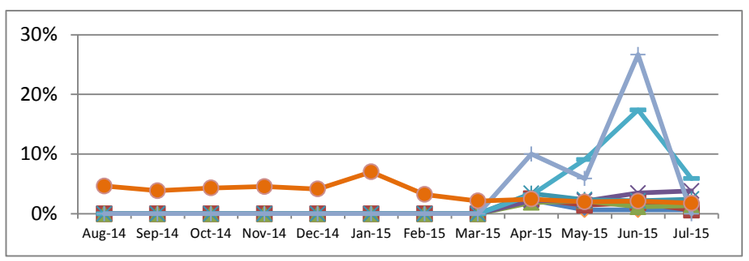
Division	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Trend to date
Children's & Women's	94.06%	92.52%	95.52%	95.12%	91.98%	94.90%	95.42%	95.36%	94.83%	95.37%	95.60%	96.43%	
Clinical Support Services	97.13%	95.00%	94.71%	98.40%	97.18%	98.61%	95.33%	95.74%	97.37%	99.31%	97.44%	97.66%	
Medicine, Rehabilitation & Cardiac	89.88%	91.23%	91.69%	93.08%	89.98%	91.32%	91.88%	92.76%	96.11%	92.54%	96.52%	97.27%	
Neuroscience, Orthopaedics, Trauma & Specialist Surgery	91.61%	90.31%	91.57%	93.05%	94.70%	95.01%	95.39%	97.40%	96.21%	96.83%	95.59%	96.80%	
Surgery & Oncology	96.05%	96.88%	96.62%	95.76%	96.54%	97.93%	97.56%	97.87%	97.83%	98.08%	98.44%	98.17%	
Unknown	93.75%	85.71%	95.31%	100.00%	100.00%	n/a	100.00%	100.00%	66.67%	100.00%	88.89%	100.00%	
OUH	**93.92%**	**94.31%**	**94.67%**	**94.73%**	**94.49%**	**95.82%**	**95.86%**	**96.53%**	**96.97%**	**96.47%**	**97.36%**	**97.63%**	

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



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

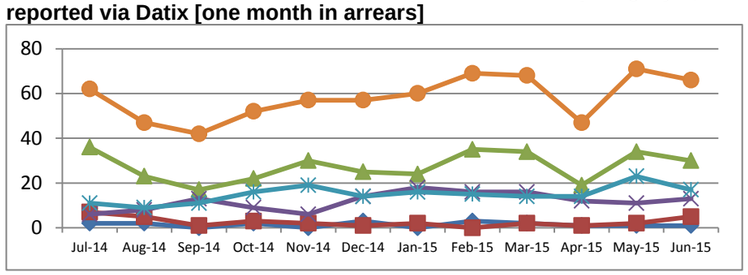
PS10 - % of incidents associated with moderate harm or greater



RAG threshold (Trust)	Red	6.5%	Amber	5%

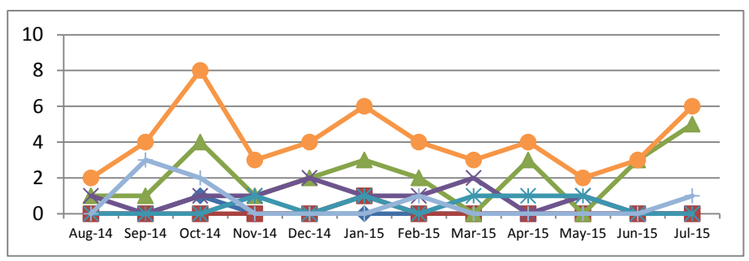
Division	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Trend to date
Children's & Women's	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	2.32%	0.67%	0.67%	0.66%	
Clinical Support Services	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	2.51%	1.43%	1.84%	0.61%	
Medicine, Rehabilitation & Cardiac	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	1.88%	2.15%	1.17%	1.38%	
Neuroscience, Orthopaedics, Trauma & Specialist Surgery	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	2.24%	2.16%	3.49%	3.82%	
Surgery & Oncology	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	3.40%	2.37%	2.16%	2.46%	
Corporate Services	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	3.13%	9.09%	17.39%	5.88%	
Operations & Service Improvement	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	10.00%	5.88%	26.67%	0.00%	
OUH	4.65%	3.87%	4.32%	4.56%	4.14%	7.02%	3.24%	2.15%	2.45%	1.99%	2.13%	1.77%	

PS11 - Total number of newly acquired pressure ulcers (category 2,3 and 4) reported via Datix [one month in arrears]



Division	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Trend to date
Children's & Women's	2	2	0	2	0	3	0	3	2	1	1	1	
Clinical Support Services	7	5	1	3	2	1	2	0	2	1	2	5	
Medicine, Rehabilitation & Cardiac	36	23	17	22	30	25	24	35	34	19	34	30	
Neuroscience, Orthopaedics, Trauma & Specialist Surgery	6	8	13	9	6	14	18	16	16	12	11	13	
Surgery & Oncology	11	9	11	16	19	14	16	15	14	14	23	17	
OUH	**62**	**47**	**42**	**52**	**57**	**57**	**60**	**69**	**68**	**47**	**71**	**66**	

PS12 - Falls leading to moderate harm or greater



RAG threshold (Trust)	Red	8	Amber	7

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

Appendix 2 Patient experience dashboard: :

C&W MRC NOTSS S&O CSS Corporate OUH IP and DC National Average Inpatient OUH ED National Average ED OUH maternity National Average Maternity OUH Outpatients Trust

Comments

I found the sessions informative, supportive and very useful. I liked the knowledge and support from staff without them being pushy or judgemental. **Bicester Community Midwife Team Antenatal Care (C&W)**

The staff were professional and friendly. I was in hospital over a weekend (Friday to Monday). The teams were attentive, friendly and chatty. They made my stay comfortable. **Juniper ward, Horton (MRC)**

The professional was very pleasant and helpful and made me feel at ease. I have a slight disability and she was patient and helped me. **Echocardiograph outpatients, John Radcliffe(MRC)**

Nurse and Doctor were very kind and understanding with my son who has Autism. Also very efficient and thorough, managed to Diagnose my sons condition and explain everything in great detail. Thank you very much. **John Radcliffe Emergency Department (MRC)**

Kind, friendly, helpful staff, who did all they could to take the unpleasantness out of my surgery. Smooth, organised, professional procedure. I have been very impressed. **Churchill Day Surgery Unit (S&O)**

Excellent in every way. Caring, took time to explain and reassure me about my post-op treatments. I can't imagine being taken better care of everything was fantastic. I am very grateful, thank you. **Plastics Outpatients, John Radcliffe (NOTSS)**

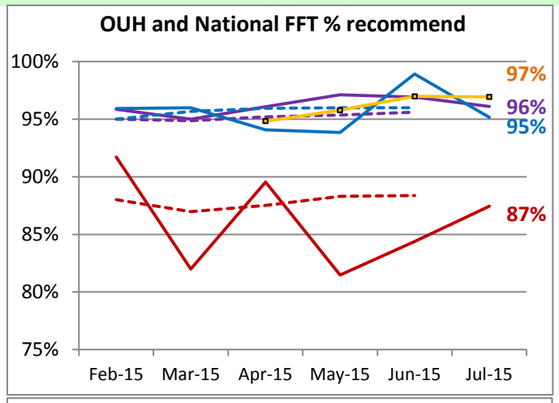
Very helpful advice, easy to access. Good feedback on what I am already doing and building blocks to continue. Very friendly and supportive. **Here for Health drop-in service, John Radcliffe (corporate division)**

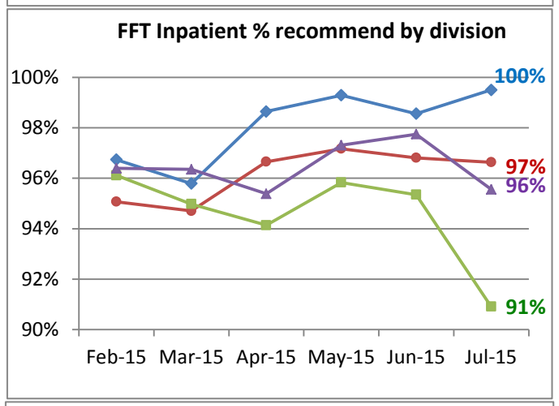
All staff were very kind and made you feel very safe and not afraid of those big machines, every day asked how I was feeling. No complaints, only gratitude. Thank you. **Radiotherapy, Horton (S&O)**

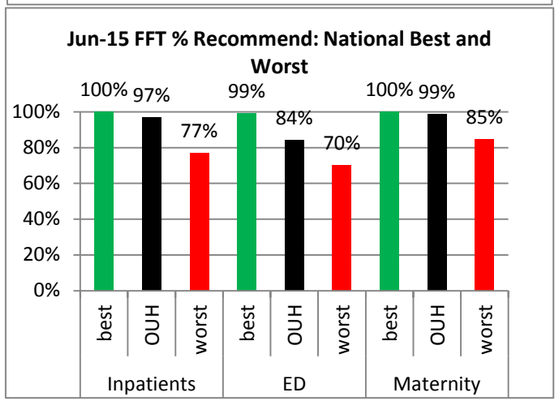
Fantastic level of care. All staff very professional yet always friendly and approachable. Felt very homely. Siblings enjoyed the play room. Felt homely. Very pleased with everything. **Bellhouse Children's Ward, John Radcliffe (C&W)**

Excellent staff, clear, friendly, caring and good listeners. Great results, less pain, life back. **Pain management Service, Churchill (CSS)**

FFT: % recommend

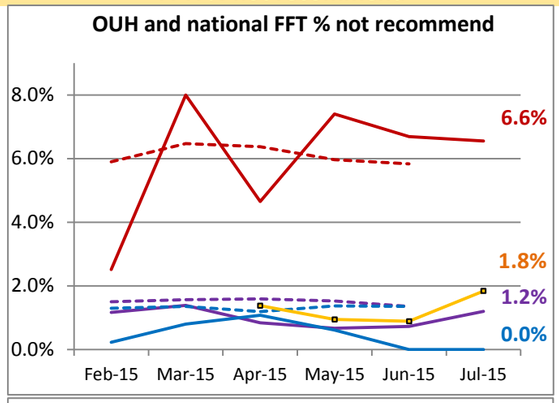


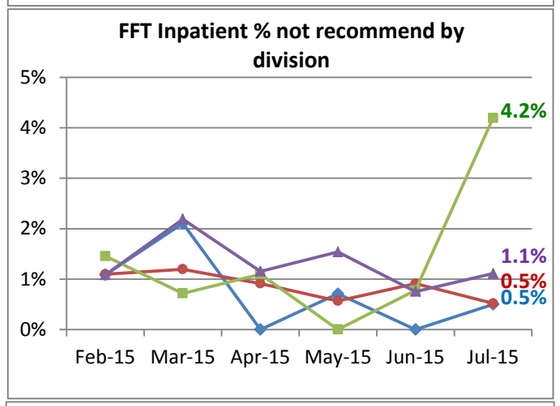


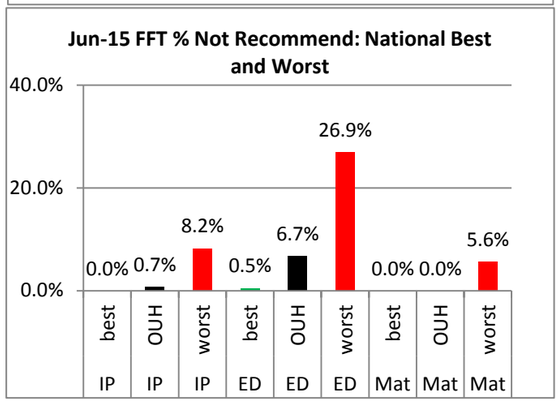


Only NHS Trusts with more than 100 responses have been included.

FFT: % not recommend

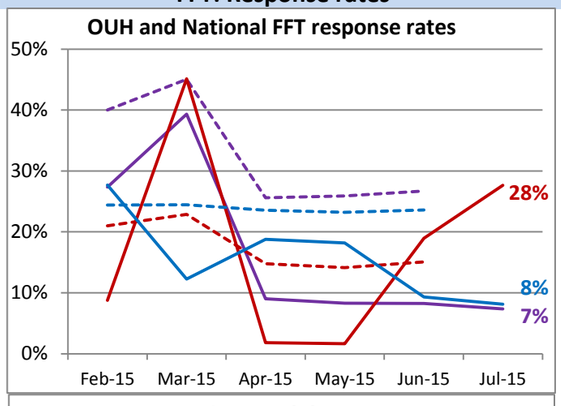


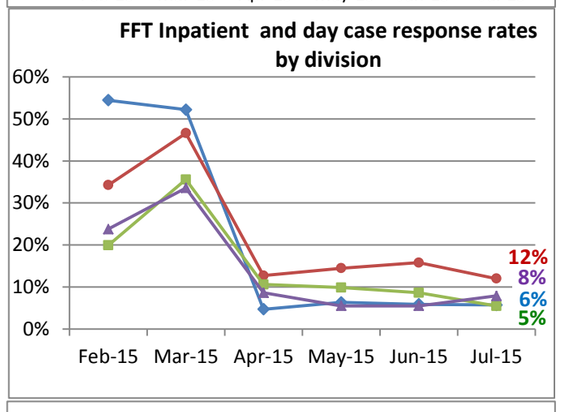


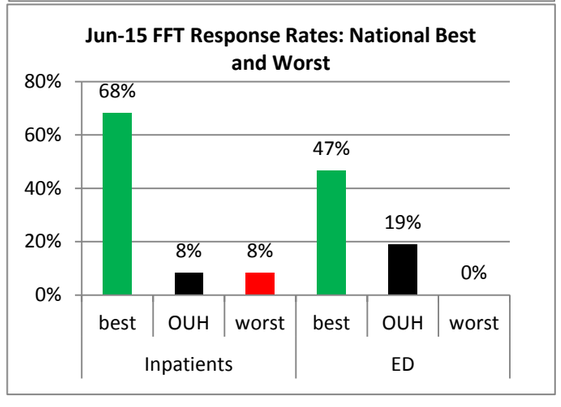


Only NHS Trusts with more than 100 responses have been included.

FFT: Response rates





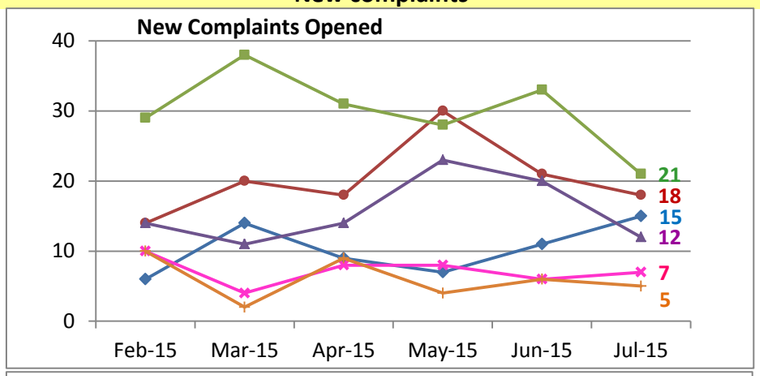


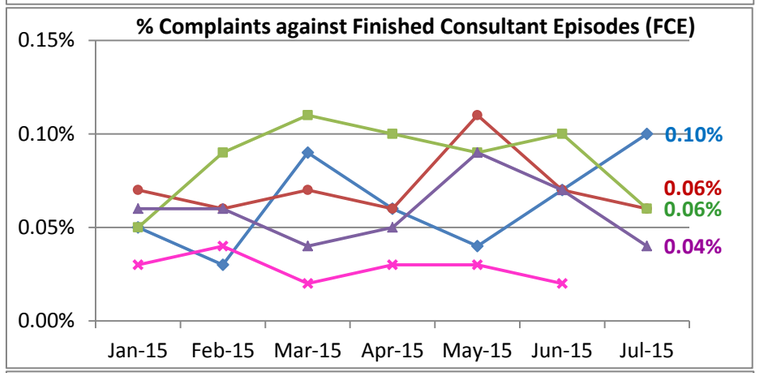
Only NHS Trusts with more than 100 eligible patients have been included.

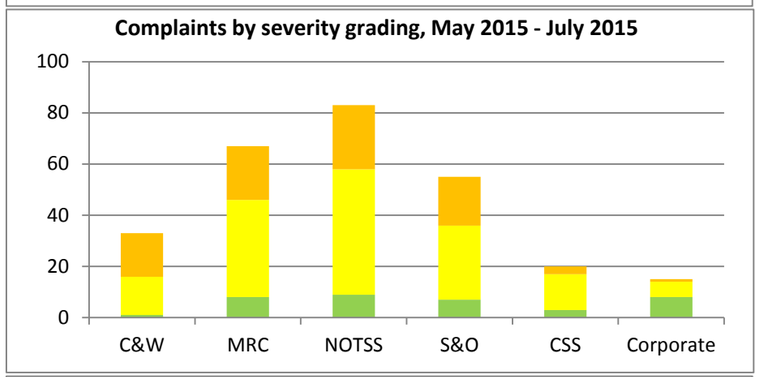
Complaints

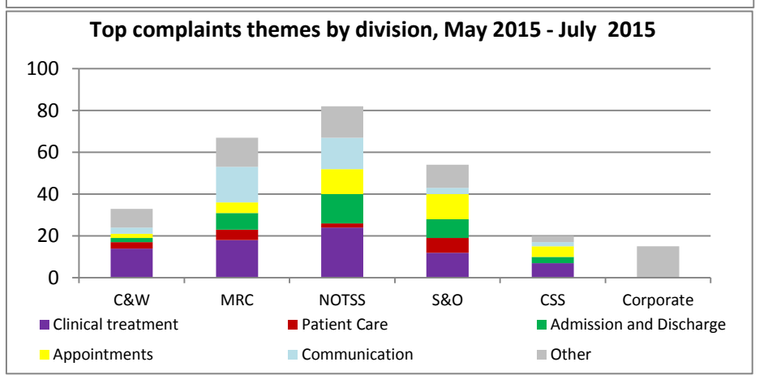
C&W MRC NOTSS S&O CSS Corporate Trust

New complaints

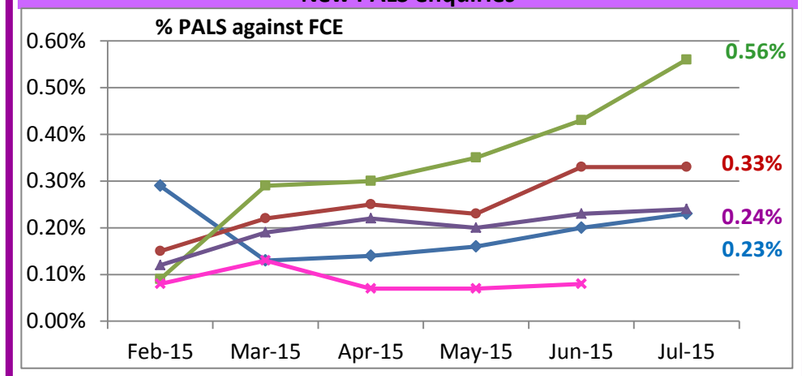






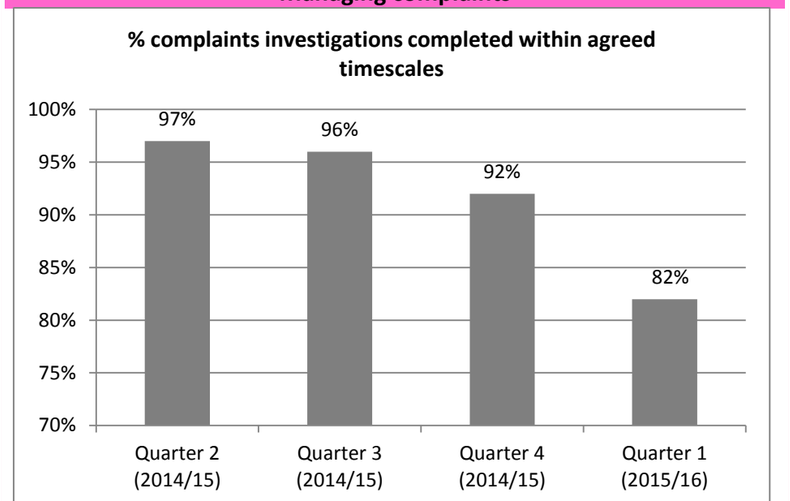


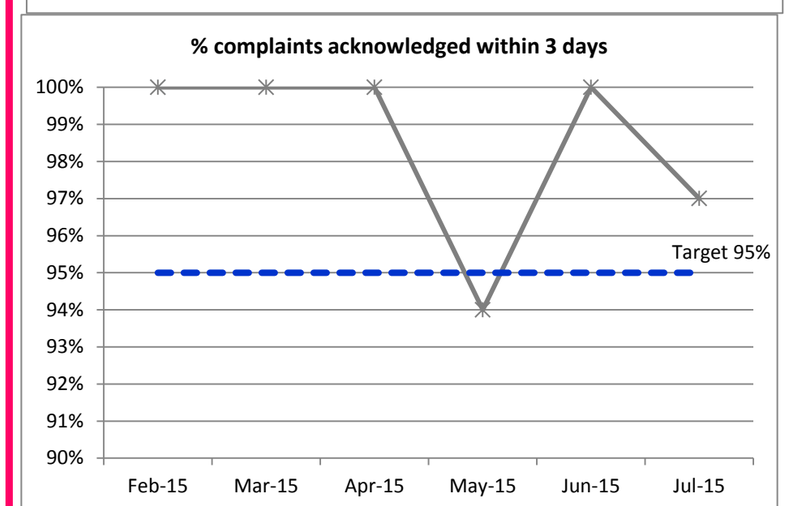
New PALS enquiries



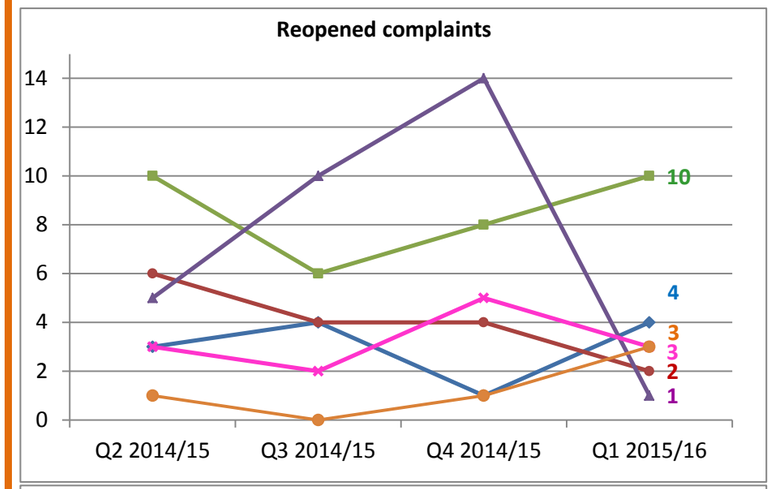
This includes all PALS enquiries and issues: positive, negative, or mixed feedback; issues for resolution; and advice or information requests.

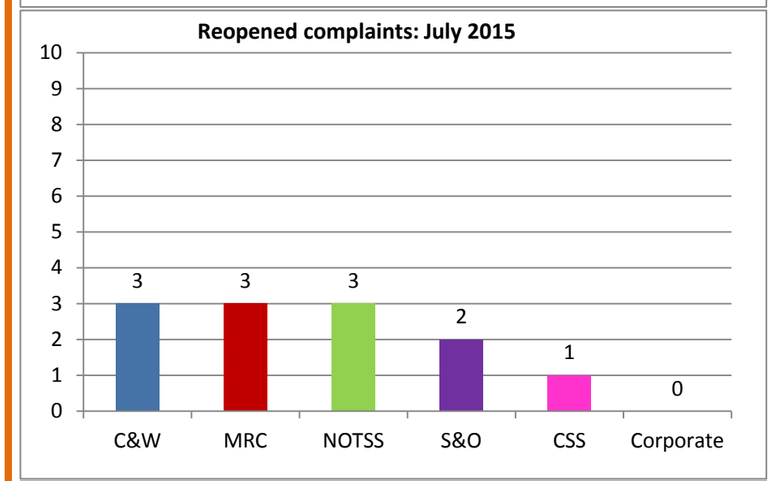
Managing complaints

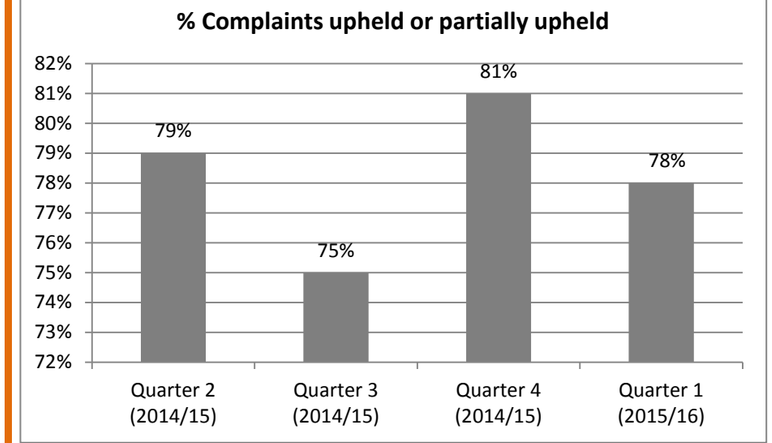




Closed complaints







Oxford University Hospitals NHS
NHS Trust

Children's and Women's Division, (C&W), Trust Board Quality Report September 2015

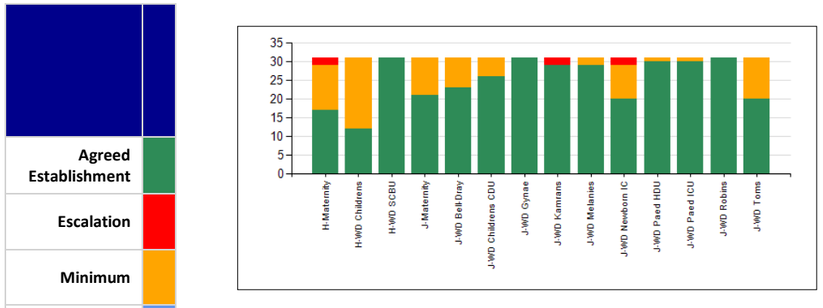
Safe Staffing Dashboard Inpatient Areas Only

Appendix 2A

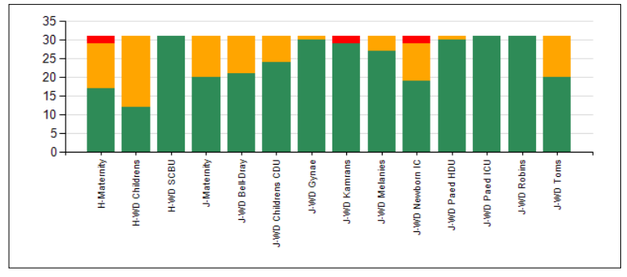
C&W				Trust		
	May 15	June 15	July 2015	May 15	June 15	July 2015
Total Funded WTE	755.61	770.50	765.50	2953.1	2966.20	2956.24
Vacancy %	7.9%	10.3%	10.0%	11.3%	11.4%	9.7%
Sickness %	4.58%	5.3%	5.3%	4.21%	4.4%	4.4%
Maternity/Adoption Leave %	4.41%	4.3%	4.2%	3.3%	3.5%	3.3%
Agreed Staffing Levels %	82%	79%	79%	73%	74%	73%
Total number of Medication Nursing Administration Errors or Concerns.	19	15	13	70	82	76
Total numbers of Hospital Acquired Pressure Ulcers	4	6	4	108	99	99
Total Number of Avoidable Grade 3-4 Hospital Acquired Pressure Ulcers.	0	0	0	4	2	3
Grade 3-4 Hospital Acquired Pressure Ulcers.						
Extravasation incidents	3	0	0	10	4	3

July 2015 Safe Staffing by INPATIENTward for C&W division.

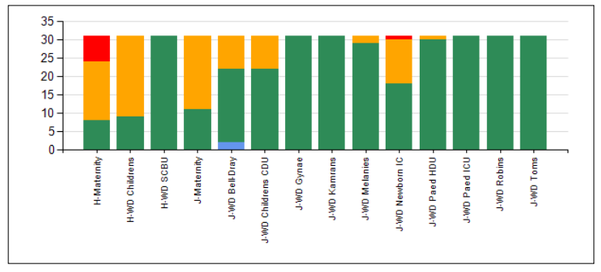
EARLY SHIFT



LATE SHIFT



NIGHT SHIFT



Narrative In most cases the agreed establishment is maintained by moving staff and flexing beds between the wards. Where escalation shifts are shown these have been mitigated by a number of actions including moving staff between clinical areas in order to ensure safe staffing cover overall and on occasions relocating CDU to one of the inpatient wards. Although it might appear that there is a surplus in one area and minimum in others this is due to the allocation of temporary staff, they are all booked to one ward and distributed where required according to staffing deficits, acuity, and dependency. 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 currently awaiting final endorsement from NHS England. The extravasation quality indicator, which is the most sensitive to staffing levels, has remained static.

.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.

Oxford University Hospitals NHS
NHS Trust

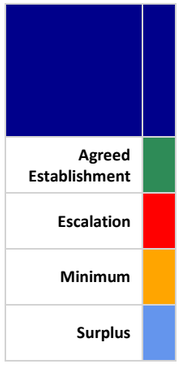
Clinical Support Services Division, (CSS), Safe Staffing Dashboard Inpatient Areas only Trust Board Quality Report September 2015

Appendix 2B

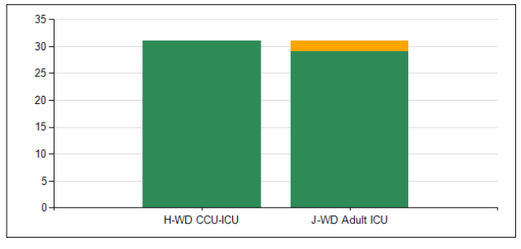
CSS				Trust		
	May 15	June 15	July 2015	May 15	June 15	July 2015
Total Funded WTE	180.67	178.81	179.81	2953.1	2966.20	2956.24
Vacancy %	19.8%	17%	6.5%	11.3%	11.4%	9.7%
Sickness %	4.81%	3.1%	3.6%	4.21%	4.4%	4.4%
Maternity/Adoption Leave %	6.69%	7.5%	6.8%	3.3%	3.5%	3.3%
Agreed Staffing Levels %	84%	90%	90%	73%	74%	73%
Total number of Medication Nursing Administration Errors or Concerns.	4	4	4	70	82	76
Total numbers of Hospital Acquired Pressure Ulcers	1	3	2	108	99	99
Total Number of Avoidable Grade 3-4 Hospital Acquired Pressure Ulcers.	0	0	0	4	2	3
Total Numbers of Falls	1	4	0	190	193	231
Falls with moderate, major or catastrophic harm	0	0	0	2	3	4

July 2015 Safe Staffing by Inpatient ward for CSS division.

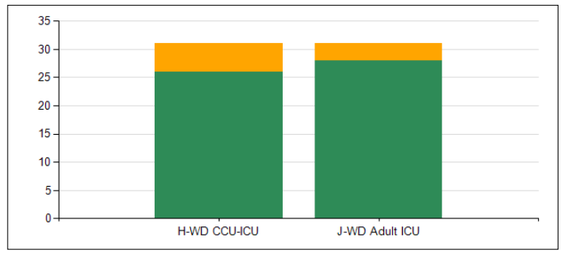
EARLY SHIFT



EARLY SHIFT



LATE SHIFT



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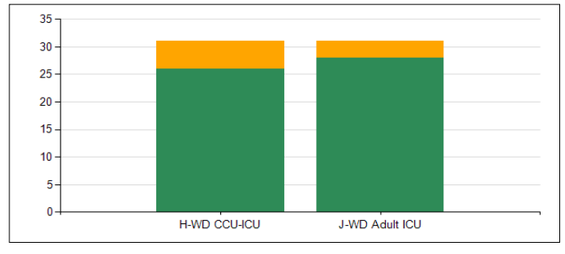


Narrative Robust recruitment has taken place across adult critical care areas to reduce the shortfall in nursing numbers and this is clearly showing in the increasing levels of agreed level shifts and significantly lowered vacancy rates for July. A recruitment campaign for band 5 nurses is ongoing. Quality indicators remain stable. This division supports the highest level of maternity/adoption leave in the Trust in patient areas and it should be noted that these shifts are not covered for temporary staff.

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.

Oxford University Hospitals NHS
NHS Trust

Medicine, Rehabilitation & Cardiac Division, (MRC), Safe Staffing Dashboard Inpatient Areas Only

Trust Board Quality Report September 2015

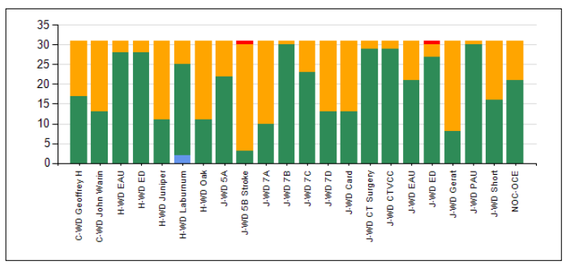
Appendix 2C

MRC				Trust		
	May 15	June 15	July 15	May 15	June 15	July 15
Total Funded WTE	893.84	892.84	885.84	2953.1	2966.20	2956.24
Vacancy %	11.3%	9.8%	8.3%	11.3%	11.4%	9.7%
Sickness %	4.68%	4.7%	4.2%	4.21%	4.4%	4.4%
Maternity/Adoption Leave %	2.41%	2.9%	2.4%	3.3%	3.5%	3.3%
Agreed Staffing Levels %	75%	74%	70%	73%	74%	73%
Total number of Medication Nursing Administration Errors or Concerns.	24	20	35	70	82	76
Total numbers of Hospital Acquired Pressure Ulcers	47	41	35	108	99	99
Total Number of Avoidable Grade 3-4 Hospital Acquired Pressure Ulcers	3	0	0	4	2	3
Total Numbers of Falls	115	108	127	190	193	231
Falls with moderate, major or catastrophic harm	0	3	4	2	3	4

July 2015 Safe Staffing by Inpatient ward for MRC division.

Agreed Establishment
Escalation
Minimum
Surplus

EARLY SHIFT



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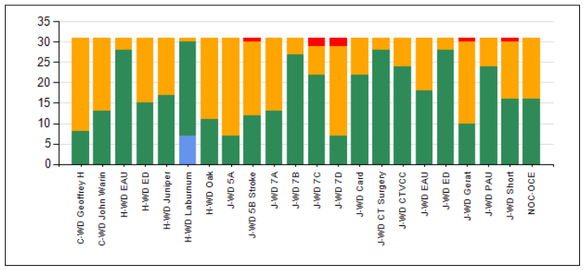

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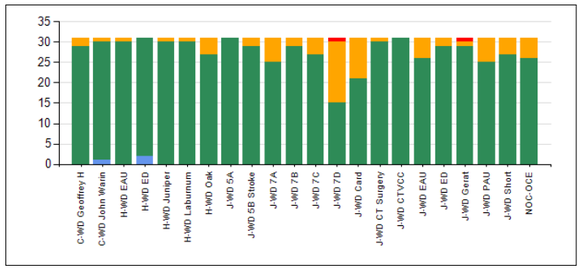


Narrative The number of nursing vacancies have reduced although the division is still reliant on maintaining safe staffing through a combination of NHSP bank and agency. The division continues to run on high levels of minimum staffing during the day shifts although the levels of agreed staffing have improved in line with the reduced vacancies largely through the EU nurse recruitment campaign. Night shifts are more regularly filled with temporary staff than days. 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. There is concern regarding the increase in falls with harm which the division is currently reviewing. However, the overall trend of quality indicators has demonstrated improvement in quality of care. The escalated shifts have been addressed through moving staff from shift to shift between wards and divisions in order to achieve safe cover

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), Division

Safe Staffing Dashboard Inpatient Areas Only Trust Board Quality Report September 2015

Oxford University Hospitals NHS Trust

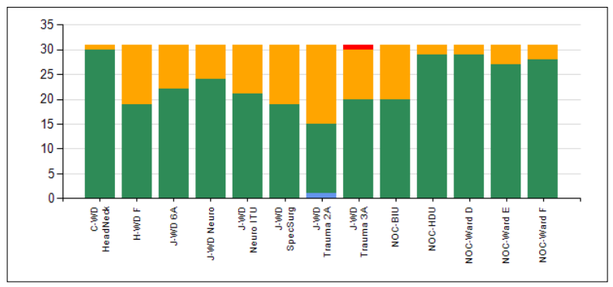
Appendix 2D

NOTSS				Trust		
	May 15	June 15	July 2015	May 15	June 15	July 2015
Total Funded WTE	629.59	631.68	632.72	2953.1	2966.20	2956.24
Vacancy %	12.4%	12.1%	9.7%	11.3%	11.4%	9.7%
Sickness %	3.43%	3.9%	4.3%	4.21%	4.4%	4.4%
Maternity/Adoption Leave %	2.82%	2.9%	2.9%	3.3%	3.5%	3.3%
Agreed Staffing Levels %	68%	70%	77%	73%	74%	73%
Total number of Medication Nursing Administration Errors or Concerns.	5	22	16	70	82	76
Total numbers of Hospital Acquired Pressure Ulcers	21	20	19	108	99	99
Total number of avoidable grade 3-4 hospital acquired Pressure Ulcers	0	1	1	4	2	3
Total Numbers of Falls	36	41	72	190	193	231
Falls with moderate, major or catastrophic harm	1	0	0	2	3	4

July 15 Safe Staffing by Inpatient ward for NOTSS division.

Agreed Establishment
Escalation
Minimum
Surplus

EARLY SHIFT



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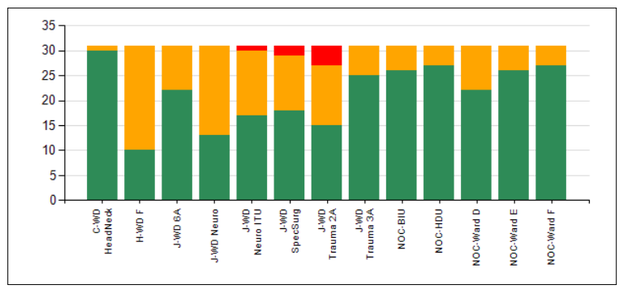

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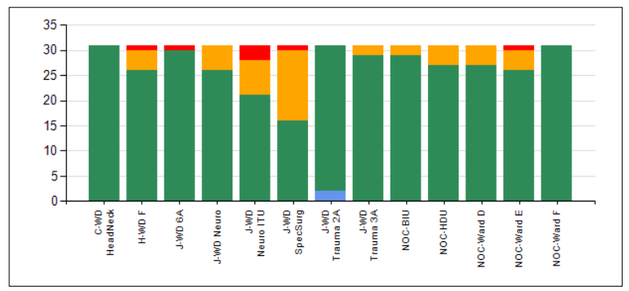


Narrative Maintaining staffing levels at minimum or above continues to be a challenge within some areas of the NOTSS Division. However due to EU recruitment agreed staffing levels are gradually increasing. Agreed levels of shifts have increased to 77% in July. Recruitment remains the key focus within 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. In spite of the staffing challenge, quality indicators assure the division that care continues to be safely delivered. The escalated shifts are principally within Neuro, Trauma and Specialist Surgery and have been addressed through moving staff from shift to shift between wards and divisions in order to achieve safe cover. 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. The levels of falls in the division remain relatively high, but this is expected due to the nature of some of the patients on Neurosciences. Falls with harm remain low due to the implementation of the Fallsafe care bundle.

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 Inpatient Areas Only

Oxford University Hospitals NHS
NHS Trust

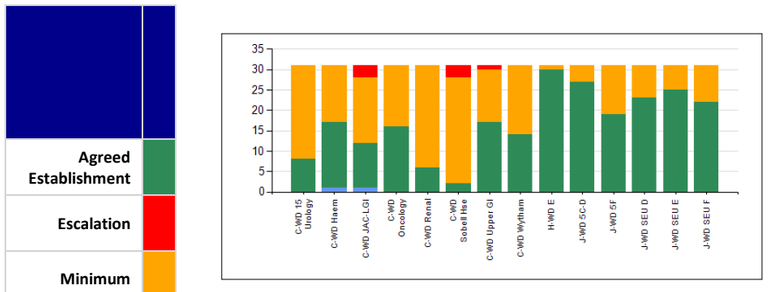
Trust Board Report September 2015

Appendix 2E

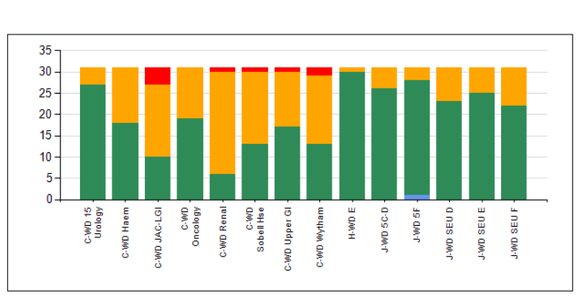
S&O				Trust		
	May 15	June 15	July 2015	May 15	June 15	July 2015
Total Funded WTE	493.37	492.37	492.37	2953.1	2966.20	2956.24
Vacancy %	13.4%	13.7%	13.2%	11.3%	11.4%	9.7%
Sickness %	3.56%	3.6%	3.7%	4.21%	4.4%	4.4%
Maternity/Adoption Leave %	2.41%	2.9%	2.8%	3.3%	3.5%	3.3%
Agreed Staffing Levels %	65%	66%	69%	73%	74%	73%
Total number of Medication Nursing Administration Errors or Concerns.	18	21	8	70	82	76
Total numbers of Hospital Acquired Pressure Ulcers	35	29	39	108	99	99
Total Number of Avoidable Grade 3-4 Hospital Acquired Pressure Ulcers.	1	1	2	4	2	3
Total Numbers of Falls	36	37	31	190	193	231
Falls with moderate, major or catastrophic harm	1	0	0	2	3	4

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

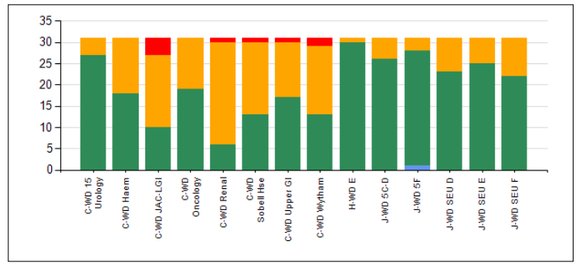
EARLY SHIFT



LATE SHIFT



NIGHT SHIFT



Narrative Recruitment and retention remains 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, with an overall 69% agreed staffing levels in July. This level of staffing was achieved in part by closing beds, cancelling study leave and reducing the ward sister's management time. 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 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 continue to rise in line with encouraging the reporting culture of incidents, there was no harm reported. We continue to collate and monitor the medication incidents related to the EPR prescribing and administration of medicines.

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.