Trust Board Meeting in public: Wednesday 13 January 2016

TB2016.06

Title	**Board Quality Report**

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

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

Executive Summary

1. This month this report is presented in a revised format requested and approved by Quality Committee.
2. Key changes include the addition of reports on national quality strategy, updates on the Trust quality priorities and the quality report, WHO checklist audit reporting, a revised mortality update and an extended report on issues raised by OCCG. 18 metrics relating primarily to directorate or divisional performance have been removed from the report but will continue to be monitored locally via the relevant orbit reports. The report has been made more concise.
3. A section on National Quality Strategy Updates, Trust Quality priorities and the quality account is included in this report to inform the board of the national context and progress against our objectives.
4. Key quality metrics:
   - For six of the 32 quality metrics, pre-specified targets were not fully achieved in the last relevant data period. For selected metrics, trend data are provided along with brief exception reports.
   - For a selection of the quality metrics, Divisional specific information that contributes to organisational results is presented in dashboard format within Appendix One.
5. Matters for attention of the Board
   - WHO checklist compliance in regular audits is reported to the board with actions where compliance has been incomplete.
6. Issues raised by OCCG
   - GP feedback collated from the OCCG DATIX system is reported.
7. Patient Safety and Clinical Risk:
   - 16 Serious Incidents Requiring Investigations (SIRIs) were reported in November.
   - 17 SIRIs were recommended for closure to Oxfordshire Clinical Commissioning Group (OCCG) in November.
   - There were 2 Executive Quality Walk Rounds undertaken in December 2015.
8. Clinical Effectiveness
   - No mortality outliers have been reported. The most recent HSMR is 103.7
9. Infection Control:
   - Six cases of C.diff apportioned to the OUH were reported for November 2015, against a monthly limit set at six. Four were deemed unavoidable and the two remaining cases are still under review. 43 cases have been identified year to date against a trajectory limit of 47.
   - There were no MRSA bacteraemias apportioned to the OUH in November 2015, however the ceiling for the year was zero avoidable MRSA bacteraemias and two occurred earlier in the year.
   - MRSA screening compliance was 50% for overall compliance with 79% for elective admissions and 45% for emergency admissions.
10. Patient Experience - Friends & Family Test:
    - This report includes details of the % response rates and % positive responses for Inpatients, Outpatients, Maternity, Children's Services and the Emergency Dept.
    - It also includes an update on the Carers' Project and an update on the children's'

patient experience programme

11. PALS and Complaints:
    - The section on complaints analysis for November 2015 highlights by division the number and % of complaints received as well as the thematic overview for the month
    - This is accompanied by a dashboard providing a visual trend for complaints

12. Safe Staffing:
    - This report provides the Trust Board with an update on the current status of nursing and midwifery staffing across the Trust by ward as well as by shifts.
    - The report includes a summary of the November 2015 Unify submission of staffing; for actual levels against planned levels. This is in terms of numbers/percentages, but it has limitations in providing a very uni-facetted view of staffing, that does not include skill mix, level of experience or skill set.
    - Current status of nursing & midwifery Nurse Sensitive Indicators against staffing levels by division against the Trust status (6 appendices as dashboards).

13. Recommendation

Trust Board is asked to receive this Quality Report

Board Quality Report

1. Purpose

1.1. This paper briefs the Trust Board on national developments on quality related topics and commentary on the progress against the Trust's Quality Strategy and quality assurance and improvement work underway.

1.2. An update is provided on progress against the quality priorities described in the Trust quality account.

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

2. National Quality Strategy Updates

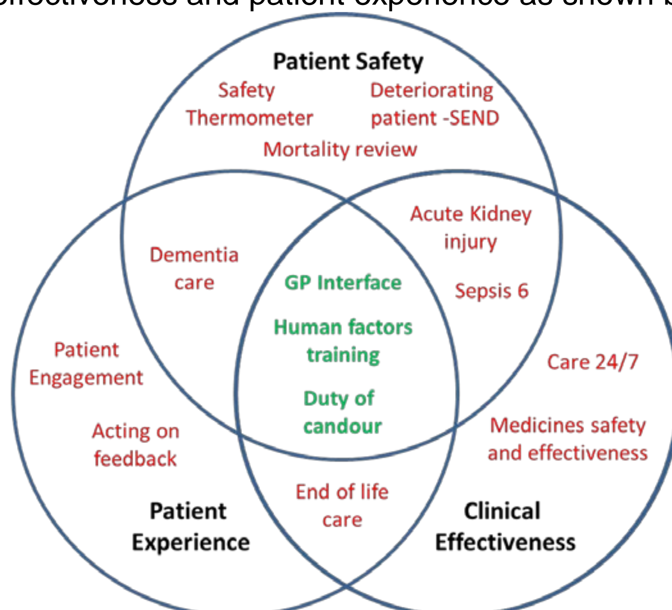
2.1. The Independent Patient Safety Investigations Service, which will operate from April 2016, will offer support and guidance to NHS organisations on investigations into serious patient safety incidents, and carry out certain investigations itself.

2.2. An Expert Advisory Group (EAG) was set up to make recommendations on how the new investigation service should work, and has sought views from a wide range of stakeholders. This consultation is now complete and the feedback is being analysed.

2.3. All Trusts have received a letter from Sir Bruce Keogh requesting an assessment of their mortality review processes against a mortality governance guide and a request to return a mortality analysis toolkit including data on avoidable deaths by February 2016.

3. Update on progress against the Trust Quality priorities

3.1. The Trust has agreed quality priorities in the domains of patient safety, clinical effectiveness and patient experience as shown below



3.2. Updates on the priorities are shown in the table below and have previously been reviewed by Quality Committee.

Table 1

<table>
<tr><th>Priority</th><th>Progress</th></tr>
<tr><td>Deteriorating patient - SEND</td><td>The roll out of SEND electronic track and trigger project is on time and on target. It is fully implemented at the NOC and Churchill and in progress at the Horton.</td></tr>
<tr><td>Mortality review</td><td>For quarter 1, 89% of deaths were progressed through the OUH Standardised Mortality Review process (SMR). The mortality review template has been reviewed and simplified.</td></tr>
<tr><td>Safety Thermometer</td><td>Safety thermometer comprises four types of harm
1) Pressure ulcers - these are discussed at a regular group with the CCG, Incidents are monitored and clinical teams present their RCAs of pressure ulcers to OCCG in a shared quality improvement meeting is now embedded.
2) Catheter acquired urinary tract infection (CAUTI)– OUH NHSFT participates in an AHSN CAUTI prevention group. Patient and staff surveys assessing views and knowledge of CAUTI prevention has been undertaken as part of a gap analysis. Collecting data via EPR is being piloted in three wards. The Trust is also working with OH to look at catheter care into the community.
3) Falls – Falls are one of the nurse sensitive indicators examined as part of safe staffing. A shared workshop has been held with the Shelford group to encourage good practice and Fall Safe nurse educator has been appointed.
4) Venous thromboembolism (VTE) – A new medical VTE lead is in place and new methods for enhancing the speed of assessing preventable HATs are in place. Further education on Novel oral anticoagulants (NOAC) use is planned.
<table><tr><th>Trust Performance</th><th>April 15</th><th>May 15</th><th>Jun 15</th><th>Jul 15</th><th>Aug 15</th><th>Sep 15</th></tr><tr><td>Percentage Assessed</td><td>97.3%</td><td>97.6%</td><td>97.8%</td><td>97.7%</td><td>97.1%</td><td>96.5%</td></tr></table></td></tr>
<tr><td>Acute kidney injury (AKI)</td><td>An education program on AKI has commenced in advance of roll out of an electronic flag for the three levels of AKI and an accompanying decision support power plan in millennium. Currently 45 e-flags would be generated daily and an opportunity exists to have patients remotely reviewed with further nurse support.</td></tr>
<tr><td>Sepsis</td><td>A clinical lead for sepsis is in place and a working group has met twice. Red flag sepsis and its treatment are now part of the microguide app and are taught in Trust medical induction. A sepsis screening tool and care bundle for use in emergency admissions areas is in development.</td></tr>
</table>

Priority	Progress
Dementia care	Dementia screening is in transition from paper to EPR. 23 dementia leaders are in place and training occurs in corporate induction. A dementia quality improvement nurse educator has been appointed who is a mental health nurse and is key to dementia simulation training.
Patient engagement	Established work streams are in place with work focusing around hard to reach groups.
Acting on feedback	FFT work is described elsewhere in this report
GP interface	As reported elsewhere extensive work with substantial improvement has occurred to ensure test results are endorsed and discharge summaries e-messaged.
Human factors training	Currently OXSTAR have trained 800 staff members in the last three years with 100 trained in the last three months.
Duty of candour	Duty of candour is now recorded on DATIX with a new module which provides decision support for all instances of moderate and severe harm. Duty of candour is also discussed and minuted in the Trust SIRI forum following review of all incidents of moderate and greater harm by risk management. Some incidents are downgraded to minor or no harm as further information becomes available
End of life care	A well-attended and well received symposium was held on 10th November 2015. The National Care of the dying audit was repeated in September 2015 across the Trust and the results are expected in early 2016. The Trust is now represented on the OCCG care of the dying group. There is progress towards a “Hospice at Home” support model and the Sobell charity has agreed to support end of life care in OUHFT this will allow support of an adapted business case for 2 years. The CEO has requested an evaluation of the project with an aspiration to demonstrate that it is cost neutral.
Care 24/7	The Care 24/7 project team, working in close collaboration with clinical services, undertook a baseline assessment in March 2015 on preparedness to meet the NHS England and NHS Improving Quality (NHSIQ) priorities for 7 day working. The baseline assessment and case note audit demonstrate a number of positive findings reflecting high standards of care across the Trust and also improvements made over 2014/15. A gap analysis action plan in details progress from the baseline and the work required for the coming months.

Priority	Progress
Medicines safety and effectiveness	A work stream is considering the top 10 medication safety incidents across the UK and developing an action plan around each. This will include errors related e.g. to allergies and methotrexate prescription where e-prescribing provides significant safety nets.

4. The Quality Account

4.1. It is intended that progress with the Quality Report will be reported to the Quality Committee in this section of the report. It is noted that Foundation Trusts provide a Quality Report rather than a Quality Account.

4.2. Monitor has updated the Trust that guidance is to come in December on Quality Reports on 2015/16, including a requirement for governors to choose a 'local indicator'.

5. Key Quality Metrics

5.1. 32 key quality metrics linked to the quality of clinical care provided across the organisation are listed in Table 2 below.

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

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

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

Indicators deteriorating or red rated

5.5. 6 indicators have deteriorated against target since the last reporting cycle or are red rated due to breeching of an annual threshold

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

5.5.2. PS08 - % patients receiving stage 2 medicines reconciliation within 24h of admission

5.5.3. PS17 - Number of hospital acquired thromboses identified and judged avoidable

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

5.5.5. CE04 - Dementia diagnostic assessment and investigation [one month in arrears]

5.5.6. PE14 - Single sex breaches

Indicators improving

5.6. 4 indicators have improved since the previous reported period:

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

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

5.6.3. PS16 - CAS alerts breaching deadlines at end of month and/or closed during month beyond deadline

5.6.4. PE15 - % patients EAU length of stay < 12h

Table 2

BQR ID	Rating	Rating Last Period	Descriptor	Period	Threshold Source	Red	Amber
PS01	97.15% Green	Amber	Safety Thermometer (% patients receiving care free of any newly acquired harm) [one month in arrears]	Nov 15	Internal	95%	97%
PS02	93.33% Green	Amber	Safety Thermometer (% patients receiving care free of any harm - irrespective of acquisition) [one month in arrears]	Nov 15	Internal	91%	93%
PS03	97.75% Green	Green	VTE Risk Assessment (% admitted patients receiving risk assessment)	Oct 15	National	95%	95.25%
PS04	16 N/A		Serious Incidents Requiring Investigation (SIRI) reported via STEIS	Nov 15		N/A	N/A
PS05	43 Green	Green	Number of cases of Clostridium Difficile > 72 hours (cumulative year to date)	Nov 15	National	47	N/A
PS06	2 Red	Red	Number of cases of MRSA bacteraemia > 48 hours (cumulative year to date)	Nov 15	National	1	N/A
PS07	92.77% Red	Amber	Antibiotic prescribing - % compliance with antimicrobial guidelines [most recently available figure, undertaken quarterly]	Oct 15	Internal	93%	95%
PS08	72.56% Red	Red	% patients receiving stage 2 medicines reconciliation within 24h of admission	Nov 15	Internal	75%	85%
PS09	100% Green	Green	% patients receiving allergy reconciliation within 24h of admission	Nov 15	Internal	94%	96%
PS10	1.19% Green	Green	% of incidents associated with moderate harm or greater	Nov 15	Internal	6.5%	5%
PS11	77 N/A		Total number of newly acquired pressure ulcers (category 2,3 and 4) reported via Datix	Oct 15		N/A	N/A
PS12	1 Green	Green	Falls leading to moderate harm or greater	Nov 15	Internal	8	7
PS13	46.43% N/A		Cleaning Score - % of inpatient areas with initial score > 92%	Nov 15		N/A	N/A
PS14	99.49% Green	Green	% radiological investigations achieving 5 day reporting standard [CSS Division]	Oct 15	Commissioner	95%	98%
PS16	0 Green	Red	CAS alerts breaching deadlines at end of month and/or closed during month beyond deadline	Nov 15	Internal	1	N/A
PS17	2 Red	Green	Number of hospital acquired thromboses identified and judged avoidable	Nov 15	Internal	1	0
CE01	0.98 N/A		Standardised Hospital Mortality Ratio (SHMI) [most recently published figure, quarterly reported as a rolling year ending in month]	Mar 15		N/A	N/A
CE02	170 N/A		Crude Mortality	Nov 15		N/A	N/A
CE03	48.32% Red	Red	Dementia - % patients aged > 75 admitted as an emergency who are screened [one month in arrears]	Oct 15	National	80%	90%
CE04	79.94% Red	Amber	Dementia diagnostic assessment and investigation [one month in arrears]	Oct 15	Internal	80%	90%
CE06	88.82% Amber	Amber	ED - % patients seen, assessed and discharged / admitted within 4h of arrival	Nov 15	National	85%	95%

PE01	83.25% N/A		Friends & Family test % likely to recommend - ED	Nov 15		N/A	N/A
PE02	9.97% N/A		Friends & Family test % not likely to recommend - ED	Nov 15		N/A	N/A
PE03	95.07% N/A		Friends & Family test % likely to recommend - Mat	Nov 15		N/A	N/A
PE04	2.19% N/A		Friends & Family test % not likely to recommend - Mat	Nov 15		N/A	N/A
PE05	95.84% N/A		Friends & Family test % likely to recommend - IP	Nov 15		N/A	N/A
PE06	1.51% N/A		Friends & Family test % not likely to recommend - IP	Nov 15		N/A	N/A
PE07	94.34% N/A		Friends & Family test % likely to recommend - OP	Nov 15		N/A	N/A
PE08	2.97% N/A		Friends & Family test % not likely to recommend - OP	Nov 15		N/A	N/A
PE14	8 Red	Green	Single sex breaches	Nov 15	National	3	2
PE15	69.29% Amber	Red	% patients EAU length of stay < 12h	Nov 15	Internal	65%	70%
PE16	47.15% N/A		% Complaints upheld or partially upheld [Quarterly in arrears]	Sep 15		N/A	N/A

Exception charts

Chart 1 – Number of cases of MRSA bacteraemia

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

Narrative

There have been no additional cases of MRSA since the previous 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].

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

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

Narrative

Recurrent funding has been approved to support 7 day ward-based pharmacy clinical services to a number of MRC clinical areas across sites from October 2015. Reconfiguration of weekend working at the CH site has released pharmacists to support a number of clinical areas. Since this change a month-on-month improvement can be seen. EPMA training is underway for medical staff to highlight importance of completion of reconciling medication on admission.

The chart shows the proportion of inpatients for whom second stage pharmacy-led medicines reconciliation is completed within 24 hours of admission. Spot check audit by pharmacy staff once per month. Approximately 600 patients are included in the audit Trust-wide [Owner: P Devenish].

Chart 3 – Number of hospital acquired thromboses (HAT) identified and judged avoidable

PS17 Number of hospital acquired thromboses (HAT) identified and judged avoidable	Narrative
	The number of HATs reported is increasing, probably due to better detection. E-prescribing enables the thrombo-prophylaxis (TP) nurses to check prescriptions and to highlight 'missed' days of TP before sending HAT screen to patient's consultant to complete. New measures in place include: A reminder process for outstanding HAT screens via the Medical Directors office; all 'potentially preventable' HATs are discussed in the SIRI forum. Audits of 'appropriate TP' have started on key wards, in addition to the bi-annual Trust wide VTE audit.

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

Chart 4 – Dementia - % patients aged > 75 admitted as an emergency who are screened

CE03 Dementia - % patients aged > 75 admitted as an emergency who are screened [one month in arrears]	Narrative
	Last month this data was derived from paper and electronic-based to now being exclusively electronic origin. NOTSS are trialing in 3 directorates increasing nurse involvement in dementia screening as a way to drive up the number of patients screened. If this improves the results this will be rolled out to other directorates.

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.

Chart 5 – Dementia diagnostic assessment and investigation

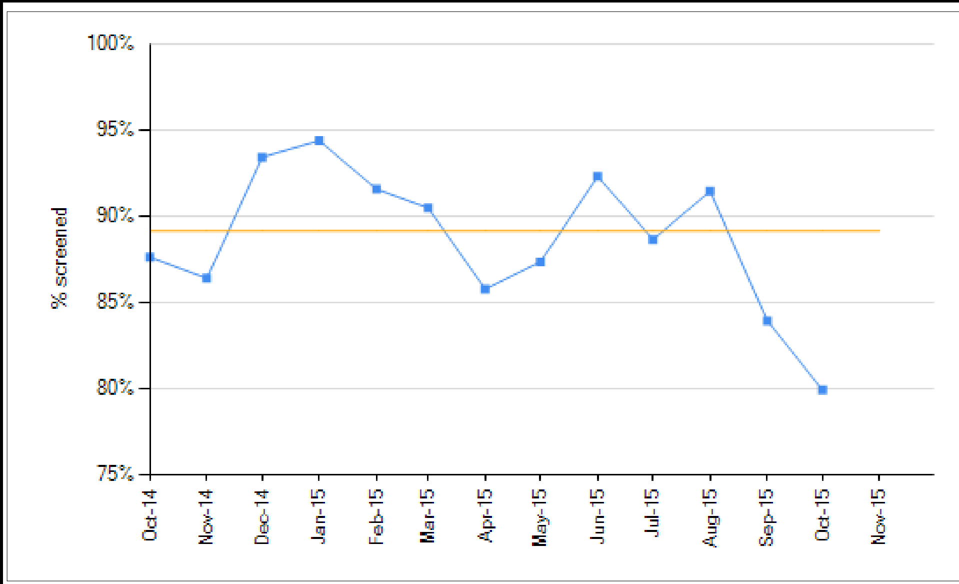
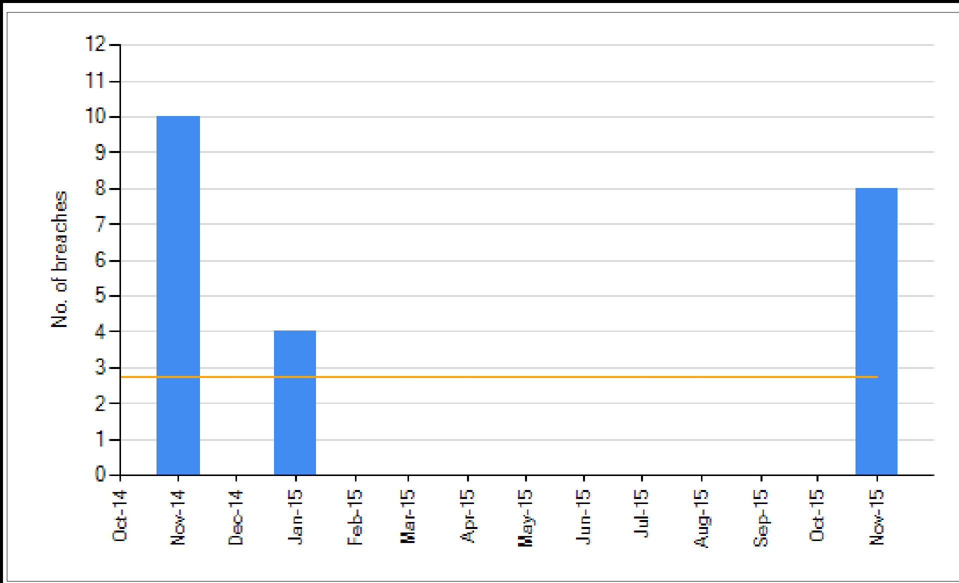
CE04 Dementia diagnostic assessment and investigation [one month in arrears]	Narrative
	From September 2015, data only includes screening completed within EPR which has impacted on performance. The Divisions are reviewing ways they can improve electronic compliance going forward. Where patients have AMTS scores carried out on paper rather than on EPR they will not be reflected in this metric.
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.	

Chart 6 – Single sex breaches

PE14 Single sex breaches	Narrative
	There was one same sex breach incident reported by the Emergency Assessment Unit at the JR which was found not to be clinically justified. This involved eight patients in one area. This is the first reported breach in 10 months. The breach was due to issues with capacity during a very busy clinical time for EAU and the JR. This will be investigated further to establish any lessons learned and any required changes in practice.
The chart shows the number of single sex breaches reported via UNIFY. Those cases judged to be clinically justifiable are not reported here. [Owner: C Heason].	

6. Matters for attention of the Board

WHO Compliance

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

Table 3 – WHO Checklist November 2015

Division	Area	Compliance	Comment
NOTSS	Orthopaedics	100%	
CSS	Overall	98.4%	The non-compliance was 1 non-compliance for JR theatres (emergency case) and 1 for Radiology Churchill; 4 partial non-compliances – missing signatures. Staff who were involved have been informed and reminded of the requirement to ensure that they are completed in full.
MRC	Cardiology	97%	Partial compliance in Cardiology relates to 3 patients who underwent Cardiology Intervention procedures that did not have the final sign out completed by the relevant scrub nurse. Feedback has been provided to the 3 individuals involved.
	Cardiothoracic Surgery	92%	Partial compliance in Cardiothoracics relates to 2 patients where the WHO checklist was not fully completed. Feedback has been provided to those staff involved.
	Respiratory Intervention	100%	
S&O	Churchill Theatres	95%	The audit identified two issues, one sign-in and one at sign-out. Both issues related to the appropriate documenting of the actions completed. Follow up on the audits found that the WHO Process had been followed but not recorded.

7. Issues raised by Oxfordshire Clinical Commissioning Group

7.1. The Trust is reporting performance to the OCCG against trajectories agreed for discharge summaries emessaged within 24 hours of discharge and endorsement of results on EPR.

7.2. Current data shows 61% of results are endorsed on EPR within 7 days (note it is possible to review a result and not endorse it) and 16% of discharge summaries are not sent within 24 hours of discharge.

7.3. Feedback for November 2015 received by the OCCG from GPs is summarised in the tables 4 and 5 below. These have been provided alongside September and October in order to provide trend analysis in themes identified by GPs.

7.4. There were 145 separate items of feedback received by the OCCG regarding the Trust's services in November. This is down from the 166 received in October.

7.5. The top 5 themes reported in November account for 50% of all feedback received over the month. Feedback regarding: 'Delay in GP receiving clinical docs (i.e. OPD/Discharge letters)', 'Delay / difficulty in obtaining clinical assistance', and 'Failure in referral process' remain in the top 5 reported themes for a consecutive month.

7.6. There has been an increase in feedback regarding 'Documentation - delay in obtaining healthcare record / card' and 'Request from secondary care for GP to follow up tests/scans/investigations initiated in secondary care' compared to the previous month.

Table 4 – GP Feedback: Top 5 thematic areas

Theme	Sep-15	Oct-15	Nov-15
Delay in GP receiving clinical docs (i.e. OPD/Discharge letters)	36	21	19
Delay / difficulty in obtaining clinical assistance	20	27	18
Failure in referral process	16	9	14
Documentation - delay in obtaining healthcare record / card	4	3	12
Request from secondary care for GP to follow up tests/scans/investigations initiated in secondary care	10	5	10

7.7. GP feedback is shown by stage of care below – with 'Patient Information (records, documents, test results, scans)' accounting for 29% of the feedback received in November. When all feedback received is ordered by stage of care, the top 5 account for 89% of all feedback received. Compared to previous months, feedback related to medication has fallen (from approximately 11% of all feedback received to just under 7%).

Table 5 – GP Feedback: Top 5 stage of care

Stage of care	Sep-15	Oct-15	Nov-15
Patient Information (records, documents, test results, scans)	67	37	43
Access, Appointment, Admission, Transfer, Discharge	52	44	39
Clinical assessment (investigations, images and lab tests)	21	13	20
Consent, Confidentiality or Communication	23	39	14
Referral	11	9	13

8. Patient Safety and Clinical Risk

8.1. In relation to Patient Safety and Clinical Risk:

- No Never Events have been reported in November
- 16 Serious Incidents Requiring Investigations (SIRIs) were reported in November.
- 17 SIRIs were recommended for closure to Oxfordshire Clinical Commissioning Group (OCCG) in November.

Clinical Risk

8.2. The following graphs provide an update on SIRI activity. The report also includes new reporting on SIRIs by Trust site.

Chart 7 – SIRIs declared and investigations completed in this financial YTD

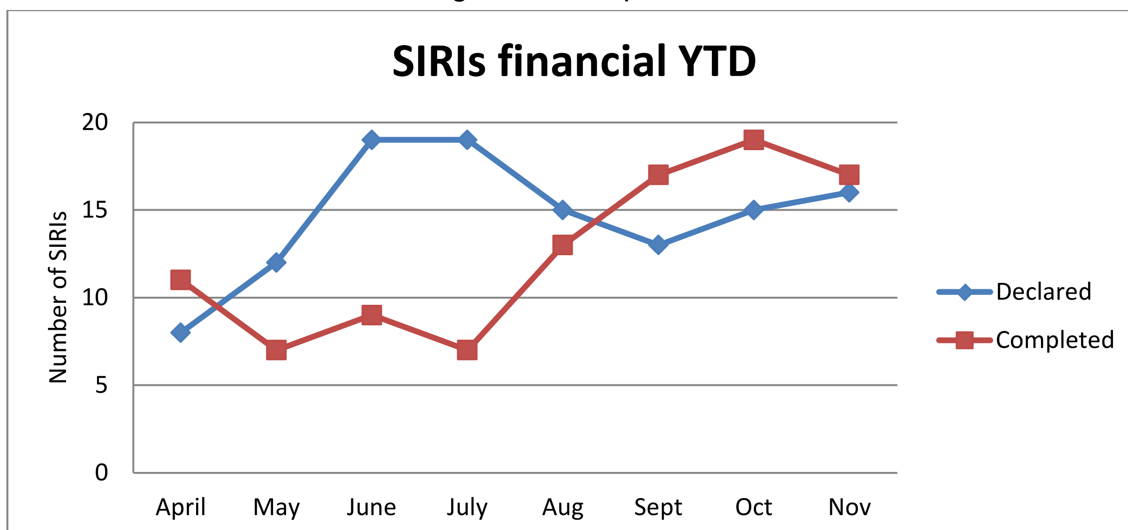


Chart 8 – SIRIs declared during the 2015/16 financial year by Division

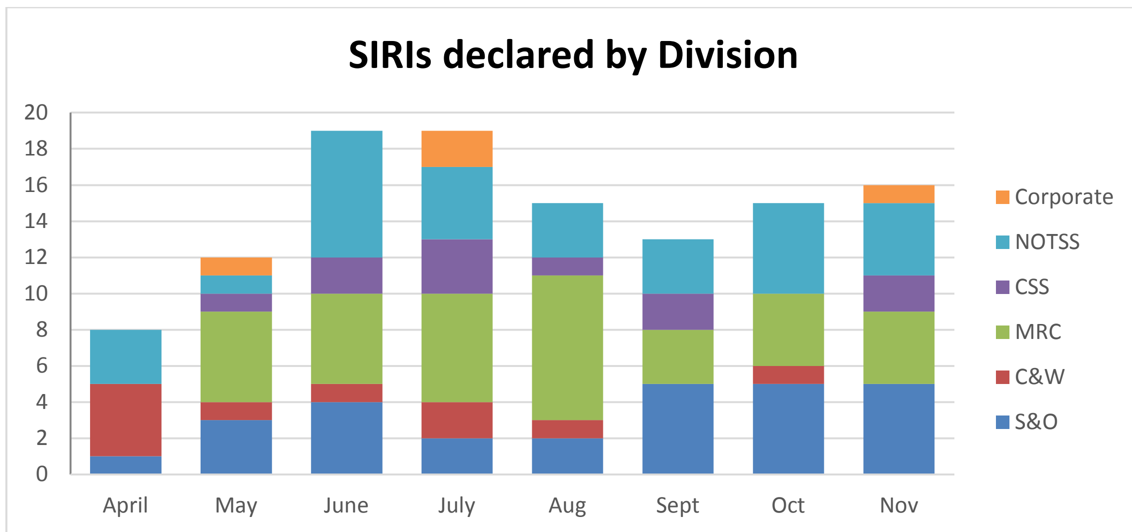


Chart 9 – SIRI Investigations completed

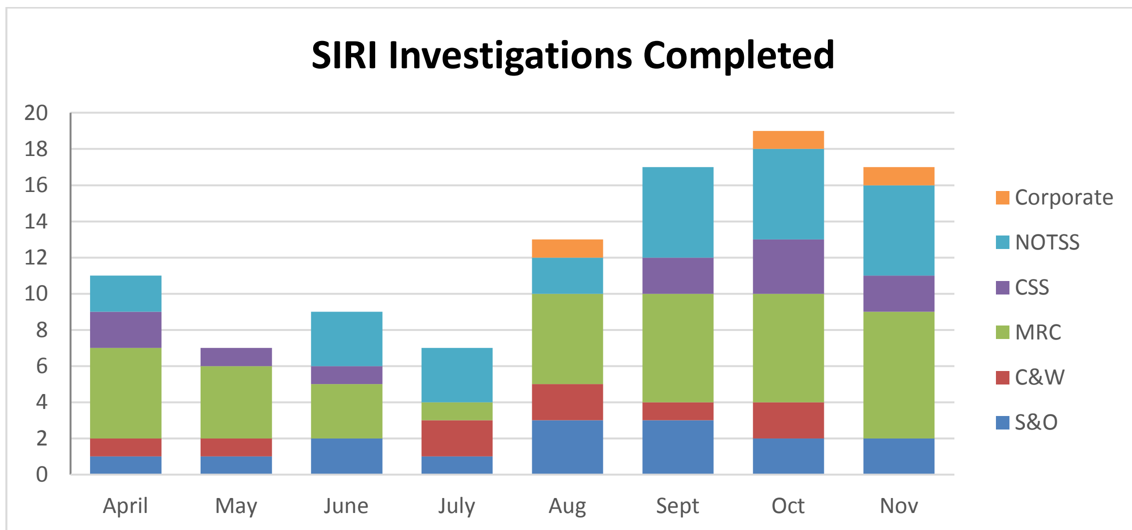
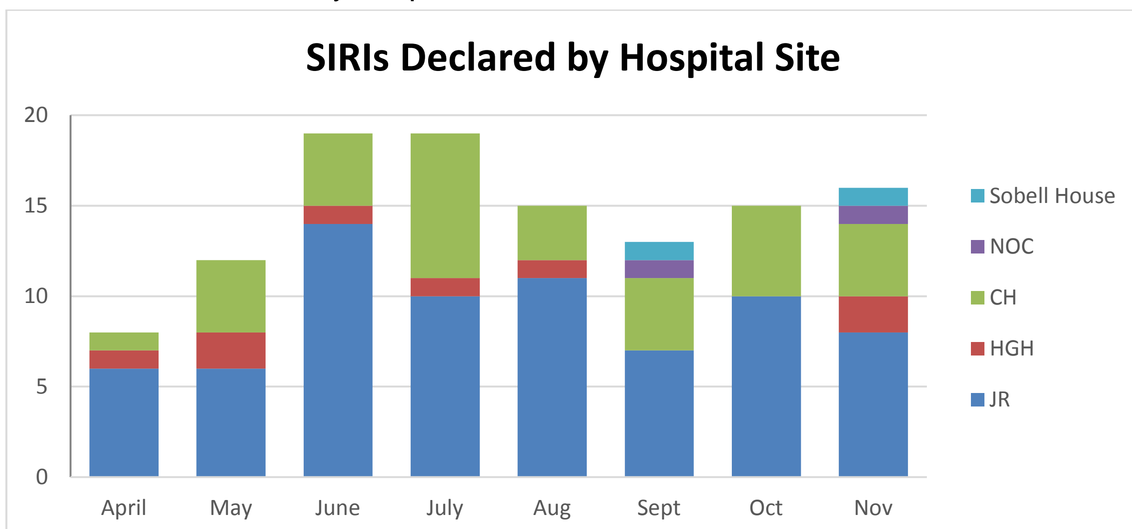


Chart 10 – SIRIs declared by hospital site.



8.3. Table 6 provides more details of those SIRIs declared to NHS England via the STEIS reporting system in November 2015, including the time in (working) days from the incident occurrence to being reported on Datix, and from Datix reporting to being reported on STEIS.

Table 6

SIRI Ref	Division	Description	Incident Date	Datix Date	Incident-Datix Interval	STEIS Date	Datix-STEIS Interval
2015/138	NOTSS	HAPU leading to an amputation	01/10/15	27/10/15	20	03/11/15	4
2015/140	NOTSS	Cat 3 HAPU	30/10/15	03/11/15	3	05/11/15	2
2015/141	S&O	Cat 3 HAPU	26/10/15	26/10/15	0	05/11/15	6
2015/142	S&O	Cat 3 HAPU	27/10/15	27/10/15	0	05/11/15	7
2015/143	CSS	Paraparesis from discitis	24/10/15	30/10/15	5	10/11/15	8
2015/144	NOTSS	Gandolin contrast given into EVD instead of PICC line	03/11/15	04/11/15	1	11/11/15	5
2015/145	MRC	Patient discharged with the wrong insulin	28/10/15	04/11/15	5	11/11/15	5
2015/146	Corporate	West Wing Suicide	14/11/15	16/11/15	2	19/11/15	3
2015/147	NOTSS	Poorly managed diabetes	07/11/15	11/11/15	3	19/11/15	6
2015/148	S&O	Fall with poor communication with the family	11/11/15	12/11/15	1	19/11/15	5
2015/149	CSS	Wrong radiopharmaceutical given	13/11/15	13/11/15	0	19/11/15	4
2015/150	S&O	Cat 3 HAPU	15/11/15	15/11/15	0	19/11/15	4
2015/151	MRC	VTE X 2	10/10/15 31/10/15	22/10/15 18/11/15	9 13	19/11/15	20 1
2015/152	MRC	VTE	04/11/15	04/11/15	0	19/11/15	11
2015/153	S&O	Fall with a subdural haematoma	20/11/15	21/11/15	1	27/11/15	5
2015/154	MRC	Cardiac arrest after falling Alaris pump	23/11/15	24/11/15	1	27/11/15	3

8.4. A number of SIRI reporting timescales were not reached in November 2015 over 10 (working) days; details of these delays are as follows:

Delays in reporting on Datix

8.4.1. **2015/138** – The patient was discharged after a pressure ulcer was reported and then deteriorated requiring readmission and an amputation increasing the level of harm to serious.

8.4.2. **2015/151** – This case required input from nursing, medical and radiology teams and was identified three days beyond the ideal timescale. Overall identification of HATs is improving.

Delays in reporting on STEIS:

8.4.3. **2015/151 & 2015/152** – As above the HAT screening process was longer for these patients (2015/151 was 2 separate incidents that will be investigated as one investigation).

8.5. The time to notification to DATIX of some incidents remains over 48 hours with a mean of 4 working days (median 1 day). The mean time from DATIX report to entry onto STEIS is currently 6 working days (median 5 days).

8.6. Seventeen SIRI reports were recommended to OCCG for approval during November 2015. Following internal approval 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.

8.7. Thirteen SIRIs were closed (approved) with the OCCG or NHS England. Table 7 below details those SIRIs which were closed.

Table 7

STEIS/SIRI Ref	STEIS summary	Meeting decision
2015/2904 2015/004 MILTON KEYNES	Major nerve damage following spinal surgery	**CLOSE**
2015/1055 2015/001	Three week history of poor nutrition and recently diagnosed with spinal cord compression. Grade 2 deterioration to Grade 3 on sacrum.	**CLOSE (WITH FURTHER MONITORING)**
2015/21003 2015/067	The patient was found on the floor of the toilet. Whilst transferring the patient onto the bed, he suffered a cardiac arrest. Resuscitation was commenced however was unsuccessful and the patient died.	**CLOSE**
2015/22503 2015/077 SPECIALISED COMMISSIONING	A patient receiving palliative treatment for widespread metastatic disease was ready to receive the 1st dose of radiotherapy for a liver node which has not responded to chemotherapy. The results of the PET scan showed the node to be a haemangioma and therefore the radiotherapy treatment about to commence was cancelled. This was a serious near miss.	**CLOSE**
2015/23517 2015/083	Confirmed MRSA bacteraemia which has been deemed to be an avoidable hospital acquired infection following a post infective review.	**CLOSE**
2015/24485 2015/090	A baby was delivered following sequential instrument use requiring admission to the neonatal unit due to low Apgar scores at delivery.	**CLOSE**
2015/24271 2015/087	A patient developed a category three pressure area to the sacrum.	**CLOSE**
2015/18456 2015/058	Patient developed a grade 3 pressure area to right side of sacrum.	**CLOSE**
2015/20233 2015/063	Pressure ulcer meeting SI criteria.	**CLOSE**
2015/21017 2015/069	A patient developed a hospital acquired grade three pressure ulcer	**CLOSE**
2015/21016 2015/068	Grade three pressure ulcer hospital acquired on sacrum	**CLOSE**
2015/26015 2015/097	A grade three hospital acquired pressure ulcer to the right heel	**CLOSE**
2015/21648 2015/071	An inpatient on a Geratology ward sustained a fall which resulted in a fracture to the neck of femur.	**CLOSE**

Executive Quality Walk Rounds

8.8. There were two Executive Quality Walk Rounds in December 2015. These are detailed in Table 8 below. Two further walk rounds have been rescheduled for the New Year as the wards to be visited were unable to accommodate the walk rounds at the scheduled time.

Table 8

Hospital Site	Areas Visited
John Radcliffe Hospital	Cardiology Ward
Churchill Hospital	Theatres

8.9. Key issues with the potential to affect quality or patient experience identified during the Executive Quality Walk Rounds included design of the patient pathway for elective surgery and the environment; namely requirements for refurbishment and improvements to bathroom facilities.

9. Clinical Effectiveness

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

9.1. The Trust has received no mortality outlier notifications from the Dr Foster intelligence unit.

9.2. As shown in table 2 on page 8, 170 patients died in the Trust in November and the SHMI is 0.98 (as previously reported- this quarterly metric will be updated by the HSCIC in January).

9.3. The OUH HSMR for the latest available 12-month period (October 2014 to September 2015) is 103.7. This is a marginal increase from 103.6 reported in November 2015 (for the data period September 2014 to August 2015). The value remains 'within expected' range (95% CI 99.2-108.2). The number of observed deaths within the HSMR 56-diagnosis groups is 2069.

Chart 11 – Hospital Standardised Mortality Ratio (HSMR) trend analysis

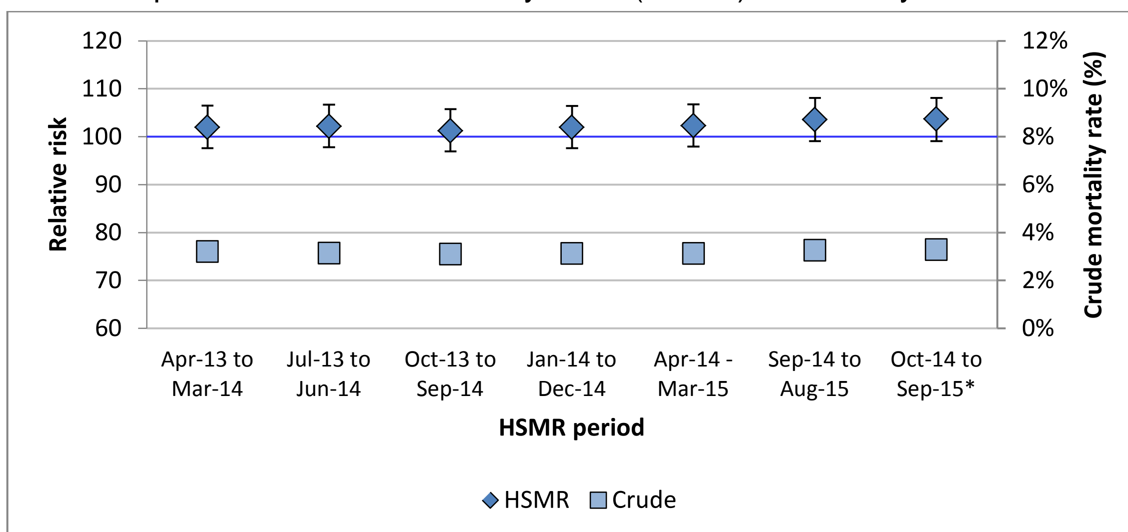
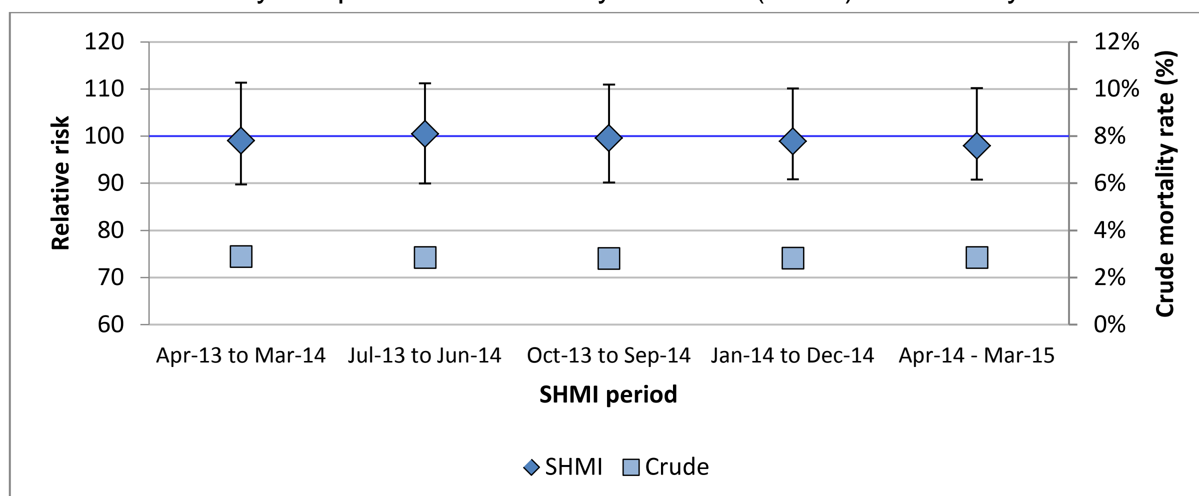


Chart 12 – Summary Hospital-Level Mortality Indicator (SHMI) trend analysis



*The publication of the SHMI for July 2014 to June 2015 is due to be published in January 2016.

Self-assessment of avoidable mortality

9.4. Professor Sir Bruce Keogh has written to all Trust Medical Directors regarding self-assessment of avoidable mortality. He has noted that work conducted by Professor Nick Black and Professor Ara Darzi has determined that about 4% of deaths in hospital are potentially avoidable and that there is no obvious relationship between avoidability and excess deaths over and above average. There is an intention to publish avoidable mortality by trust in the future but the exact form is yet to be determined.

9.5. The Trust is currently compiling a self-assessment of avoidable mortality to be submitted by 31/1/15.

9.6. In addition a Mortality Governance Guide has been supplied and a gap analysis is in progress against this guidance.

9.7. Of note the letter highlights useful areas for trusts to focus on are early warning and escalation systems and application of sepsis bundles which are OUH quality priorities.

OCCG requests following Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015

9.8. OCCG has requested review of four cases who received care from both OUH and Southern Health. In addition the trust has proactively identified 13 other patients with learning difficulties who died in our care in 2015 whose mortality reviews will be examined. OCCG is arranging a county wide meeting in January 2016 to discuss mortality review in patients with learning difficulties at which OUH will be represented. New guidance on mortality review for patients with learning difficulties reflecting findings of the Southern health report has been circulated to Clinical and Divisional Directors.

Clinical Audit

9.9. The following audits have been presented at Clinical Effectiveness Committee (CEC) on the 10th December 2015:

- 9.9.1. Audit of documentation of discharge and management and plans in paediatric patients with Inflammatory Bowel Disease (IBD) admitted to hospital in an acute phase of their illness,
- 9.9.2. Clinical audit of x-ray reporting of nasogastric tube placement,
- 9.9.3. The Deteriorating Patient: compliance with NHSLA criteria (Track and Trigger audit),
- 9.9.4. Colorectal Cancer (NICE Quality Standard QS20)
- 9.9.5. Antenatal Care (NICE Quality Standard QS22),
- 9.9.6. UK Cystic Fibrosis (CF) Registry Annual Report (Adult CF service)

10. Infection Control

Clostridium difficile (C.diff)

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

10.2. Table 9 lists OUH apportioned C.diff. cases per month for the financial year to date.

Table 9 – Cases of C. diff per month

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
Total	3	4	8	8	3	4	7	6				
Monthly limit	5	6	6	6	6	6	6	6	6	6	5	5
Run total	3	7	15	23	26	30	37	43				
Run limit	5	11	17	23	29	35	41	47	53	59	64	69

10.3. 6 cases of C.diff apportioned to the OUH were reported for November 2015, against a monthly limit set at 6. These were reviewed at the Health Economy meeting with the OUH, OCCG, Oxford Health and PHE in attendance where avoidability was determined.

10.4. Of the 6 cases apportioned to the OUH for November 2015, 4 were deemed unavoidable and a final decision on the avoidability of the 2 remaining cases will be determined in January’s meeting, though these cases are also thought to be unavoidable.

MRSA bacteraemia

10.5. There were 0 MRSA Bacteraemia apportioned to the OUH in September, October, or November 2015.

10.6. The ceiling for 2015 / 2016 is 0 avoidable MRSA Bacteraemia. To date, 2 MRSA bacteraemias apportioned to the OUH have been reported (April 2015 and June 2015), with the 1 case in June deemed avoidable. The OUH has therefore not met this objective for 2015 / 2016.

MRSA Screening Compliance

10.7. The OUH achieved 50.56% (2523/4990) overall compliance with MRSA screening, 79.31% (686/865) for elective admissions and 44.93% (1837/4125) for emergency admissions. Clinical areas with high turnover of patients have lower compliance with screening emergency admissions. Table 10 details compliance with emergency and elective MRSA screening by Division.

10.8. Actions to improve MRSA screening compliance include; monthly reporting of MRSA screening compliance across divisions, local targeted feedback by the infection control team raising awareness within clinical areas, raising awareness during Stat/Man and refresher training and exploring prompts for requesting MRSA screening within EPR.

Table 10 – Compliance with emergency and elective MRSA screening, November 2015

Division	Percentage Screened Electives	Percentage screened emergencies	Percentage of Patients screened
Neurosciences, Orthopaedics, Trauma & Specialist Surgery	81.04%	51.58%	66.16%
Medicine, Rehabilitation & Cardiac	88.89%	45.33%	46.76%
Surgery & Oncology	73.25%	35.66%	41.45%
Clinical Support Services	64.41%	84.21%	72.16%
OUH total	79.31%	44.93%	50.56%

Cleaning audits

10.9. The table below details the average reported cleaning scores by Division undertaken by the OUH Quality Assurance Team (QAT) from April 2015 to November 2015.

10.10. 31 wards or departments were inspected in November 2015

Table 11 – Average reported cleaning scores undertaken by the OUH Quality Assurance Team (QAT)

Division	November
NOTSS	87%
MRC	89%
C & W	92%
S & O	89%
CSS	90%
Total	**89%**

NOC Radiology Post-Fluoroscopic guided procedure Infections, October 2015.

10.9. Three infections involving Skin micro flora following Fluoroscopic guided procedures occurred at the NOC. An initial review of the patient histories noted

that there were no common factors that could link the 3 patients from a procedure or consultant perspective. It was also noted that the room air change rate was appropriate for the procedures being undertaken in the room. Some improvements in skin preparation, cleaning and preprocedure hand decontamination have been advised and an action plan is in place. Analysis of the organisms in the three patients shows different organisms in each patient i.e. this is not a cluster.

11. Patient Experience

Friends and Family Test (FFT) feedback

11.1. **Inpatients and Day case:** The percentage of patients who would recommend their care in October remains constant at 95.9% which is similar to the national average (95.5%).

11.2. **National comparison for ED FFT Feedback**: The Trust's response rate in November (25%) is above the national average for October (14%).

11.3. **National comparison for Maternity feedback**: The Trust's score for percentage recommend (96%) The response rate has risen to 20% for when the survey is given to women after they have given birth.

11.4. **FFT feedback - Outpatients:** Interactive voice messaging was stopped in October, and the number of responses fell from 11076 in September to 7032. Despite this, the number of comments is similar (from 5596 to 5572).

Carers' Project

11.5. The Carers' Project has been reviewed following discussions with the Transformation Team. The project consists of the following key elements: A carers' surgery, a carers' policy and the feedback questionnaire.

Children's patient experience update

11.6. The percentage of children/parents who would recommend their care in November 2015 is 95%. There were 155 (4.9%) responses from children or parents/carers for November 2015.

Patient Engagement – The Takeover Challenge

11.7. Eight children took part in the Children's Commissioner's Takeover Challenge On Friday 20th November 2015. This included a variety of activities, including discussions on services and ward visits. Young People's Executive (YiPpEe) has recruited 4 new members from the 8 children attending. Two children eligible and who have expressed an interest in representing YiPpEe on the Council of Governors.

12. PALS and Complaints

12.1. The number of new complaints received during November was 98. This is an increase against the numbers of formal complaints received in October of 2015/16 (n=91). This continues the overall trend showing a higher number of formal complaints being received each month.

Divisional Overview

12.2. **NOTSS** have received the highest number of complaints for the eleventh consecutive month (n=30, 30.6%); however this is a slight decrease from the number received in October (n=33, 36.2%).

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

12.4. **S&O** received 18 complaints this month (18.4%), of which four were for Oncology and Haematology, four were for Surgery, one was for Gastroenterology, Endoscopy and Theatres and eight were for Renal, Transplant and Urology. This number represents a further slight increase in the number of complaints received by the Division in September (n=14) and October (n=16).

12.5. **CSS** received three complaints this month (3%) which represents a decrease from the previous month (n=8). Of the three received in November, the areas of concerns related to Theatres, Anaesthetics and Sterile Services, Critical Care, Pre-op Assessment, Pain Relief and Resuscitation and Radiology and Imaging Services.

12.6. **MRC** received 23 complaints this month (23.4%) compared to 22 in October. The complaints related to Ambulatory Medicine (n=2), Acute Medicine and Rehabilitation (n=16) and Cardiology, Cardiac and Thoracic Surgery (n=5). Eight complaints related to the Trust's Emergency Departments and Emergency Assessment Units, which is a slight increase for these areas in October 2015.

12.7. **C&W** received fifteen complaints this month (15.3%) and compares to nine in October. This will be monitored over the coming months with trends to be looked at to identify any issues in Directorates/Departments which are causing the fluctuating numbers. Three of the complaints received were for Children's, with twelve pertaining to Women's, of which 10 were for Gynaecology and two were for Midwifery.

12.8. **The Corporate division** received nine complaints this month (9.1%). This was a significant increase on the number received in October (n=3). The complaints related to facilities, transport and levels of staffing.

Thematic review of complaints for November 2015

Access to Treatment/Drugs

12.9. NOTSS received two complaints (2%) in relation to Access to Treatment/Drugs. The complainants expressed concerns about their cancellation of operation/procedure.

Admission and Discharge

12.10. Ten complaints (10.2%) related to Admission and Discharge; an increase of six from the previous month. The issues related to cancelled/rescheduled surgery, discharged too early, inadequate discharge planning, discharge arrangements and a bed not being ready.

Appointments

12.11. There were ten complaints (10.2%) across four clinical divisions relating to appointments. There was a combination of issues surrounding appointment delays and cancellations, appointment cancellations, and referral delays.

Clinical Treatment

12.12. There were 29 complaints (29.6%) across four of the clinical divisions in relation to Clinical Treatment, compared to 24 in October. The concerns raised were the mismanagement of labour, birth injury, incorrect diagnosis, lack of clinical assessment, failure to follow up on observations/recognise a deteriorating patient, inappropriate procedure and wrong site surgery.

Communication

12.13. There were 22 complaints (22.4%) relating to communication, compared to 17 received in October. The complaints related to communication with relatives/carers, communication with patients, inadequate information provided, bereavement support issues and a delay in giving information/results.

Values and Behaviours

12.14. There were 7 (7.1%) complaints relating to the Trust's Values and Behaviours. The issues related to the attitude of medical staff.

Facilities

12.15. There were 5 (5.5%) complaints relating to Facilities this month. These relate to the maintenance of building/grounds; cleanliness in a clinical area, the lack of availability of wheelchairs and accessible car parking issues.

Consent

12.16. One complaint was received for Consent, alleging that insufficient information had been provided prior to consent being given.

End of Life Care

12.17. One complaint was received regarding End of Life Care and related to the lack of privacy for family/relative.

Prescribing

12.18. One complaint in relation to a prescribing error was received; this was for the NOTSS division.

Staffing Numbers

12.19. Two complaints were received pertaining to issues of Staffing Numbers. These related to insufficient staffing ratios.

Transport

12.20. Three complaints regarding Transport were received and were related to all aspects of transport.

Trust Admin/Policies

12.21. One complaint was received regarding the Trust Admin/Policies and specifically related to the accuracy of health records.

Waiting Times

12.22. Two complaints were received in relation to Waiting Times. These related to the delay for an appointment and the waiting time for an operation/procedure.

13. Safe Staffing – Nursing and Midwifery

Nursing and Midwifery Staffing report to the Trust Board

13.1. 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 report therefore includes the safe staffing data for October 2015 and the metrics against each of the 5 divisions (appendices 3 a, b, c, d & e).

13.2. It also incorporates Nurse Sensitive Indicators (NSI), for the months of September - November 2015, by division, against the Trust metrics. The overall Trust wide safe staffing report including individual wards and shifts is highlighted in appendix 3f

13.3. This report provides a summary of the current status of nursing and midwifery staffing within the Trust

National reporting for Safe Staffing October 2015

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

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

13.6. These figures should be understood to include 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.

13.7. Some of the % will appear satisfactory, although there were between six and 10 beds closed in children's services for safe staffing reasons, and two beds closed on the renal ward for building work during November.

13.8. **Unify data - November 2015**

The fill rates including temporary staff are:

- 96.65% for Registered Nurses/Midwives
- 91.63% for Nursing Assistants (unregistered)

Current status of nursing and midwifery staffing within the Trust

13.9. The Trust continues to have a high percentage of nursing vacancies throughout the Trust but these are significantly reducing through the ongoing EU recruitment campaign which has been successful in gaining approximately 250 staff into post to date and a further 200 in the recruitment process.

13.10. The levels of 'agreed' establishment shifts are slowly increasing although there are still areas where the numbers of consistent levels of 'minimum' staff

level shifts remain a concern when there is a short notice absence due to sickness or an unfilled bank/agency shift and the shift will reduce to being ‘at risk’ requiring mitigation..

13.11. The graded levels safe staffing are RAG rated and these thresholds are used to determine each shift’s status of level of risk according to each ward’s patient group needs, and the levels and skill mix required to deliver safe care.

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

13.13. The establishments are determined through the measurement of the 6 monthly patient acuity levels which link into the budget setting process, last undertaken in July 2015 and is due to be repeated at the end of January 2016 using the newly implemented electronic Integrated Patient Acuity Monitoring System (IPAMS).

14. Recommendations

14.1. The Quality Committee is asked to receive this Quality Report as information provided from within the organisation on the measures being taken in relation to quality assurance and improvement. The Committee is also asked to decide if this proposed version is acceptable for future reporting purposes.

Tony Berendt
Medical Director

Catherine Stoddart
Chief Nurse

January 2016

Report prepared by:
Helen Cobb
Head of Clinical Governance

Appendices

How to interpret charts

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

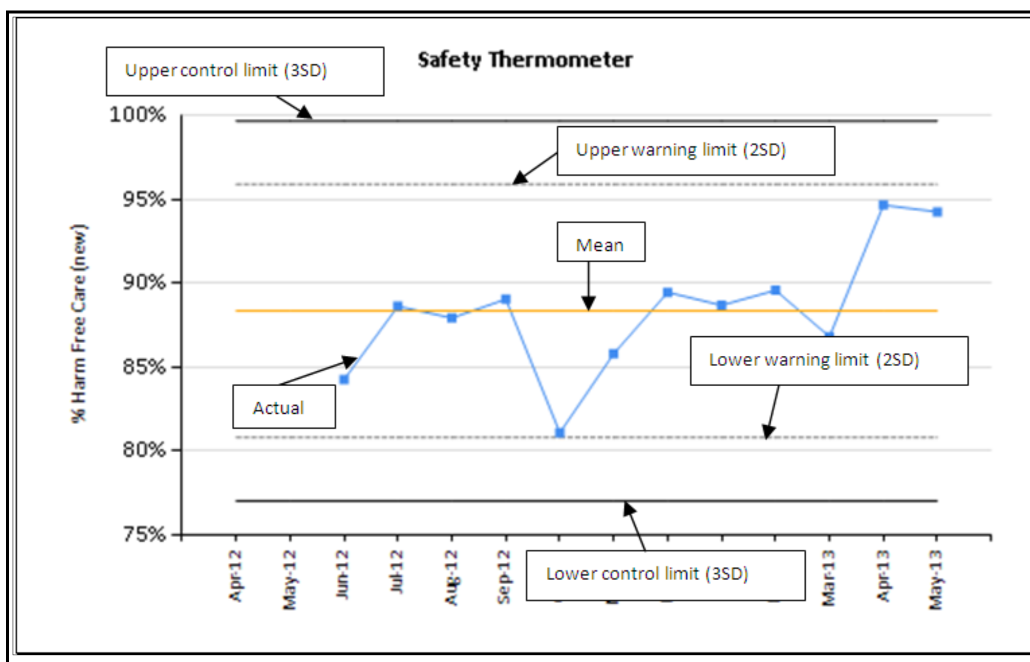
SPC charts show a trend line and allow easy reference to the historical mean for that metric at a time at which it was stable and 'within control'. Where shown, the mean is displayed as a horizontal orange line. In addition, warning limits and control limits are shown where appropriate, above and below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

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

2 consecutive points lying beyond the warning limits (unlikely to occur by chance)

7 or more consecutive points lying on the same side of the mean (implies a change in the mean of the process)

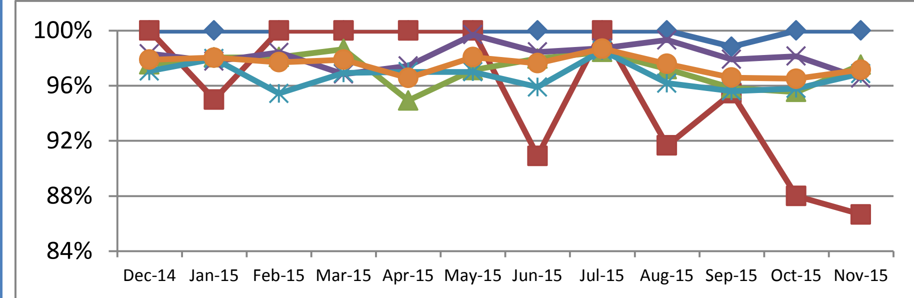
5 or more consecutive points going in the same direction (implies a trend)



Appendix 1 – Board Quality Report Dashboard

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

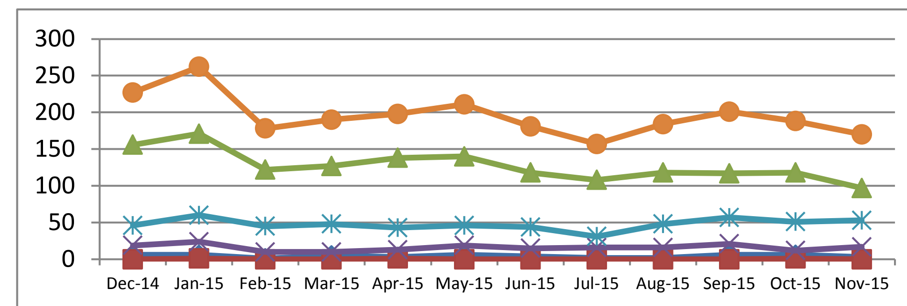
PS01 - Safety Thermometer (% patients receiving care free of any newly acquired harm)



RAG threshold	Red	95%	Amber	97%

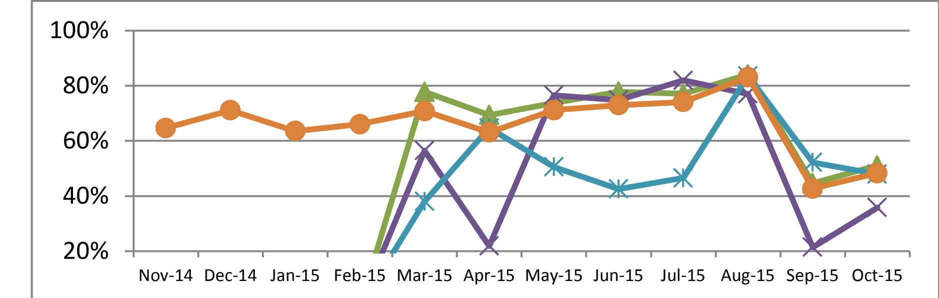
Division	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Trend to date
Children's & Women's	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	98.82%	100.00%	100.00%	
Clinical Support Services	100.00%	95.00%	100.00%	100.00%	100.00%	100.00%	90.91%	100.00%	91.67%	95.45%	88.00%	86.67%	
Medicine, Rehabilitation & Cardiac	97.54%	98.05%	98.07%	98.65%	94.92%	97.12%	97.97%	98.44%	97.20%	95.83%	95.54%	97.52%	
Neuroscience, Orthopaedics, Trauma & Specialist Surgery	98.32%	97.77%	98.40%	96.84%	97.43%	99.69%	98.44%	98.72%	99.31%	97.90%	98.14%	96.54%	
Surgery & Oncology	97.06%	97.95%	95.44%	96.92%	97.00%	97.00%	95.90%	98.55%	96.18%	95.60%	95.80%	96.88%	
OUH	97.89%	98.03%	97.69%	97.89%	96.56%	98.07%	97.63%	98.68%	97.58%	96.58%	96.51%	97.15%	

CE02 - Crude Mortality



Division	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Trend to date
Children's & Women's	6	6	1	5	3	6	4	2	2	6	6	3	
Clinical Support Services	0	1	0	0	1	0	0	0	0	0	1	0	
Medicine, Rehabilitation & Cardiac	156	171	122	127	138	140	118	108	118	117	118	97	
Neuroscience, Orthopaedics, Trauma & Specialist Surgery	19	24	10	10	13	19	15	16	16	21	12	17	
Surgery & Oncology	46	60	45	48	43	46	44	31	48	57	51	53	
OUH	227	262	178	190	198	211	181	157	184	201	188	170	

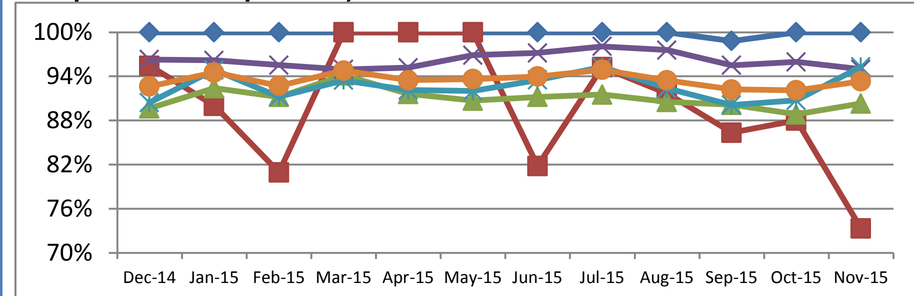
CE03 - Dementia - % patients aged > 75 admitted as an emergency who are screened



RAG threshold (Trust)	Red	80%	Amber	90%

Division	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Trend to date
Medicine, Rehabilitation & Cardiac	n/a	n/a	n/a	n/a	77.76%	69.35%	73.77%	77.84%	77.08%	84.03%	44.67%	51.05%	
Neuroscience, Orthopaedics, Trauma & Specialist Surgery	n/a	n/a	n/a	n/a	56.47%	21.92%	76.53%	74.78%	81.93%	77.01%	21.43%	35.82%	
Surgery & Oncology	n/a	n/a	n/a	n/a	38.04%	64.63%	50.57%	42.55%	46.58%	83.54%	52.17%	47.96%	
OUH	64.66%	71.12%	63.56%	66.02%	70.79%	63.09%	71.17%	72.92%	74.08%	83.09%	42.74%	48.32%	

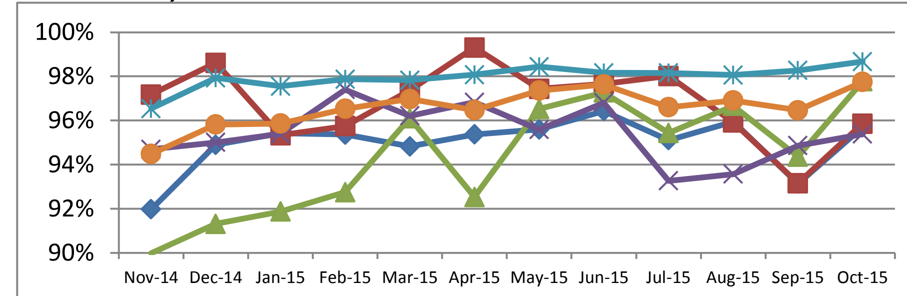
PS02 - Safety Thermometer (% patients receiving care free of any harm - irrespective of acquisition)



RAG threshold	Red	91%	Amber	93%

Division	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-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%	98.82%	100.00%	100.00%	
Clinical Support Services	95.45%	90.00%	80.95%	100.00%	100.00%	100.00%	81.82%	95.24%	91.67%	86.36%	88.00%	73.33%	
Medicine, Rehabilitation & Cardiac	89.66%	92.41%	91.20%	94.13%	91.61%	90.71%	91.20%	91.54%	90.54%	90.13%	88.84%	90.32%	
Neuroscience, Orthopaedics, Trauma & Specialist Surgery	96.30%	96.18%	95.53%	94.94%	95.18%	96.88%	97.19%	98.08%	97.59%	95.51%	95.96%	94.97%	
Surgery & Oncology	90.44%	94.88%	91.25%	93.46%	92.13%	92.00%	93.52%	95.27%	92.37%	90.11%	90.76%	95.31%	
OUH	92.65%	94.53%	92.72%	94.80%	93.48%	93.63%	93.99%	94.90%	93.46%	92.22%	92.12%	93.33%	

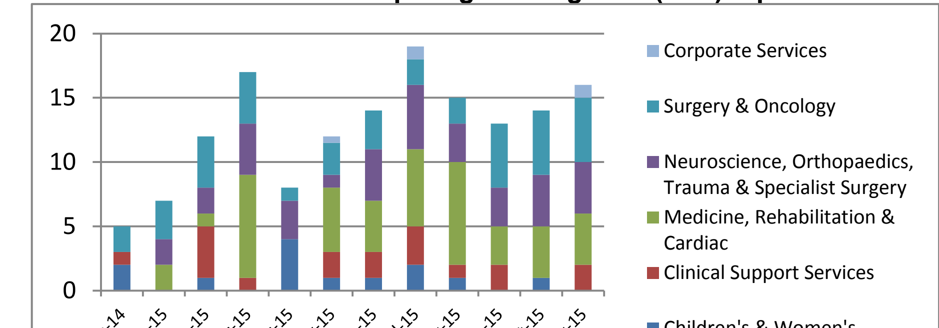
PS03 - VTE Risk Assessment (% admitted patients receiving risk assessment)



RAG threshold	Red	95%	Amber	95.25%

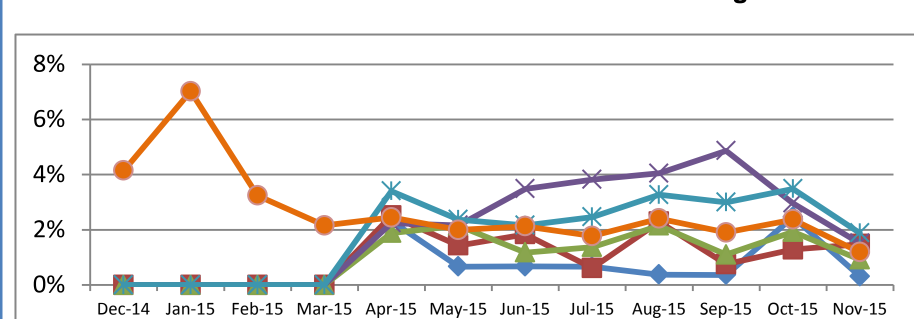
Division	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Trend to date
Children's & Women's	91.98%	94.90%	95.42%	95.36%	94.83%	95.37%	95.60%	96.43%	95.11%	95.95%	93.14%	95.69%	
Clinical Support Services	97.18%	98.61%	95.33%	95.74%	97.37%	99.31%	97.44%	97.66%	98.02%	95.92%	93.16%	95.86%	
Medicine, Rehabilitation & Cardiac	89.98%	91.32%	91.88%	92.76%	96.11%	92.54%	96.52%	97.27%	95.44%	96.67%	94.36%	97.78%	
Neuroscience, Orthopaedics, Trauma & Specialist Surgery	94.70%	95.01%	95.39%	97.40%	96.21%	96.83%	95.59%	96.80%	93.27%	93.58%	94.86%	95.38%	
Surgery & Oncology	96.54%	97.93%	97.56%	97.87%	97.83%	98.08%	98.44%	98.17%	98.15%	98.06%	98.27%	98.67%	
OUH	94.49%	95.82%	95.86%	96.53%	96.97%	96.47%	97.36%	97.63%	96.60%	96.91%	96.47%	97.75%	

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



Division	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Trend to date
Children's & Women's	2	0	1	0	4	1	1	2	1	0	1	0	
Clinical Support Services	1	0	4	1	0	2	2	3	1	2	0	2	
Medicine, Rehabilitation & Cardiac	0	2	1	8	0	5	4	6	8	3	4	4	
Neuroscience, Orthopaedics, Trauma & Specialist Surgery	0	2	2	4	3	1	4	5	3	3	4	4	
Surgery & Oncology	2	3	4	4	1	2.5	3	2	2	5	5	5	
Corporate Services	0	0	0	0	0	0.5	0	1	0	0	0	1	
OUH	5	7	12	17	8	12	14	19	15	13	14	16	

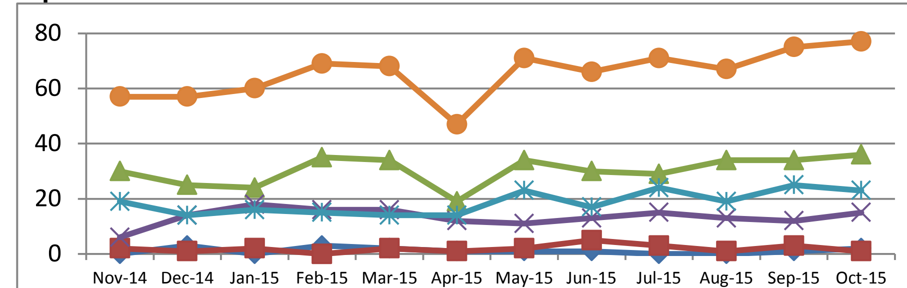
PS10 - % of incidents associated with moderate harm or greater



RAG threshold (Trust)	Red	6.5%	Amber	5%

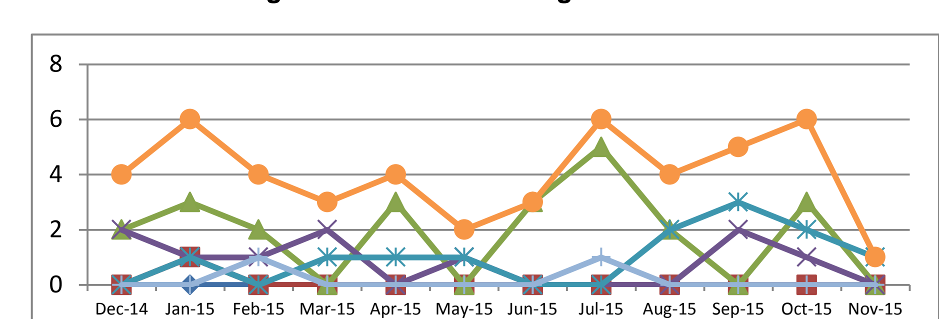
Division	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Trend to date
Children's & Women's	n/a	n/a	n/a	n/a	2.32%	0.67%	0.67%	0.66%	0.38%	0.36%	2.46%	0.31%	
Clinical Support Services	n/a	n/a	n/a	n/a	2.51%	1.43%	1.84%	0.61%	2.29%	0.75%	1.29%	1.48%	
Medicine, Rehabilitation & Cardiac	n/a	n/a	n/a	n/a	1.88%	2.15%	1.17%	1.38%	2.15%	1.10%	1.93%	0.92%	
Neuroscience, Orthopaedics, Trauma & Specialist Surgery	n/a	n/a	n/a	n/a	2.24%	2.16%	3.49%	3.82%	4.05%	4.86%	2.96%	1.51%	
Surgery & Oncology	n/a	n/a	n/a	n/a	3.40%	2.37%	2.16%	2.46%	3.27%	3.00%	3.49%	1.89%	
OUH	4.14%	7.02%	3.24%	2.15%	2.45%	1.99%	2.13%	1.77%	2.40%	1.90%	2.37%	1.19%	

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



Division	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Trend to date
Children's & Women's	0	3	0	3	2	1	1	1	0	0	1	2	
Clinical Support Services	2	1	2	0	2	1	2	5	3	1	3	1	
Medicine, Rehabilitation & Cardiac	30	25	24	35	34	19	34	30	29	34	34	36	
Neuroscience, Orthopaedics, Trauma & Specialist Surgery	6	14	18	16	16	12	11	13	15	13	12	15	
Surgery & Oncology	19	14	16	15	14	14	23	17	24	19	25	23	
OUH	57	57	60	69	68	47	71	66	71	67	75	77	

PS12 - Falls leading to moderate harm or greater



RAG threshold (Trust)	Red	8	Amber	7

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

Appendix 2 Patient experience dashboard:

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

Comments

Friendly, caring, thoughtful staff across all roles make this time of uncertainty and discomfort as positive as possible. Nothing is too much trouble. All our needs have been well met and exceeded. **Tom's Ward, Children's Hospital, John Radcliffe (C&W)**

The care my son has received has been superb. His condition has improved dramatically as has his life. All the staff involved have done their utmost to ensure his improvement continues. Thank you. **Rheumatology, Children's Outpatients, NOC (C&W)**

Caring staff from start to finish. Informed me in detail of the procedure and surgery. Made me feel more comfortable and at ease. Meal was just what I needed after surgery. Staff very attentive. Thank you. **Gynaecology Ward, John Radcliffe (C&W)**

Everyone in ward 6F has been very kind, caring and helpful. My admission was unexpected and a shock to me, but the whole team couldn't have been kinder or more supportive of me or my family. **SEU F, John Radcliffe (S&O)**

I was seen in good time, everything was clearly explained. Next steps were discussed & I am clear as to what is going to happen. I even received a call from the doctor following my visit & this was very impressive. **Cancer and Haematology Outpatients, Churchill (S&O)**

Care was delivered very professionally by people who really understood what I was going through. I never felt lonely and was constantly reassured by the level of support of all disciplines that were around, and never moaned when asked for help. Thank you. **Blenheim Ward, Churchill (NOTSS)**

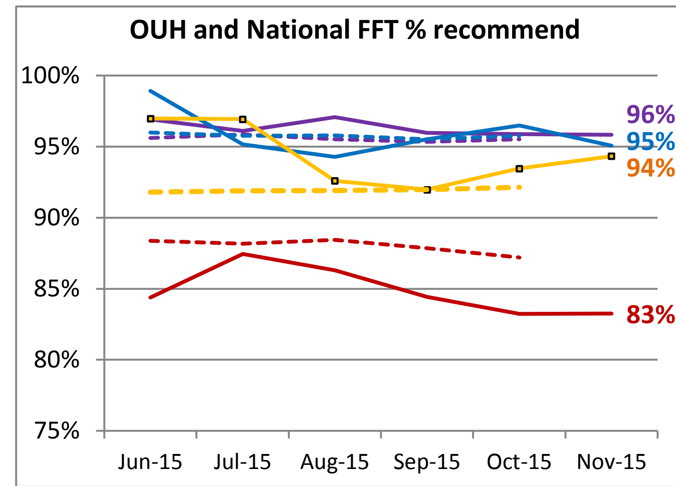
All staff work superbly as a highly skilled team focussed completely on the wellbeing of every patient. They do it with huge friendliness, humour and patience. It is clear that they work with pride to achieve the highest possible professional standards. **Ward 6A, John Radcliffe (NOTSS)**

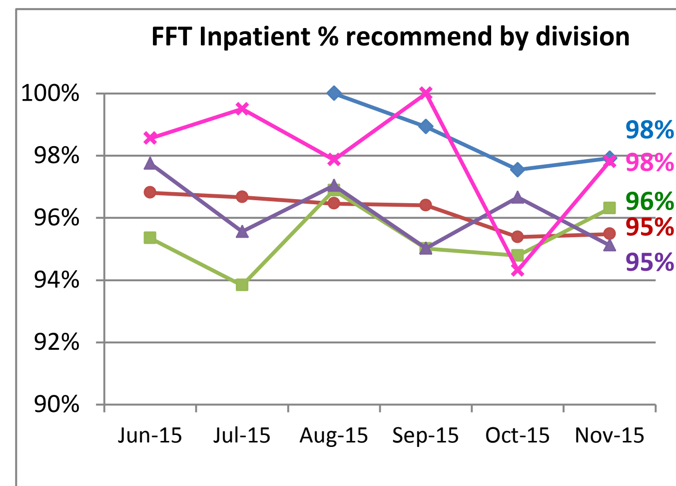
Very well organised and efficient nursing staff. Clearly well qualified and very friendly too. Organisation and choice of meals very good. Plus I was impressed with the range of care available i.e. physios, help at home etc. **Laburnum Ward, Horton (MRC)**

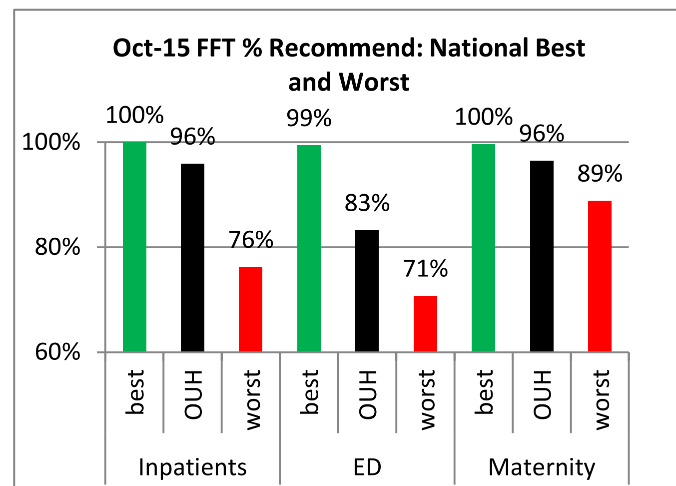
Very efficient, caring and friendly staff. Didn't have to wait long at all. Provided me with a boot for my broken foot to make it comfortable and issued me with an appointment at fracture clinic the next morning. A service!* **Horton Emergency Department (MRC)**

The staff have made me feel comfortable and relaxed by carefully explaining each step of my treatment. **Bagot and Drake Day Case Ward, Churchill (MRC)**

FFT: % recommend

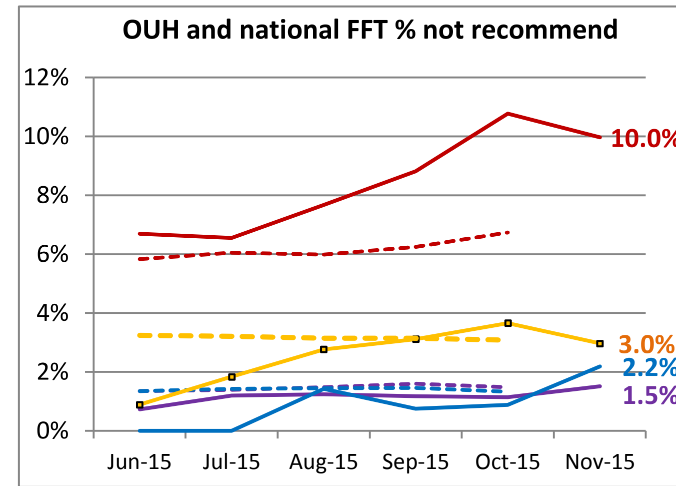


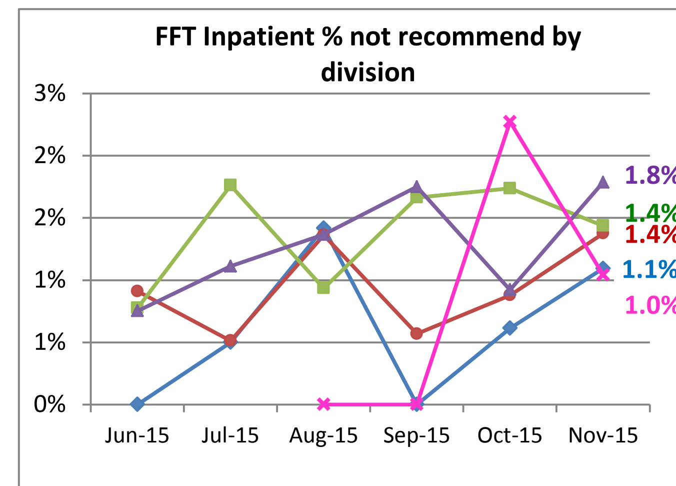


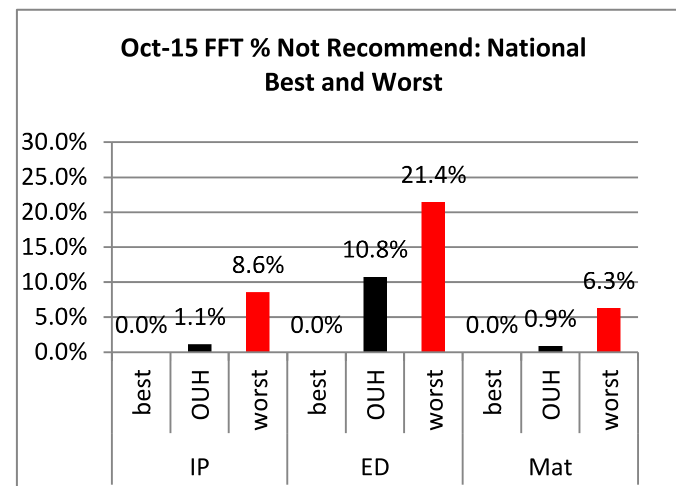


Only NHS Trusts with more than 100 responses have been included.

FFT: % not recommend

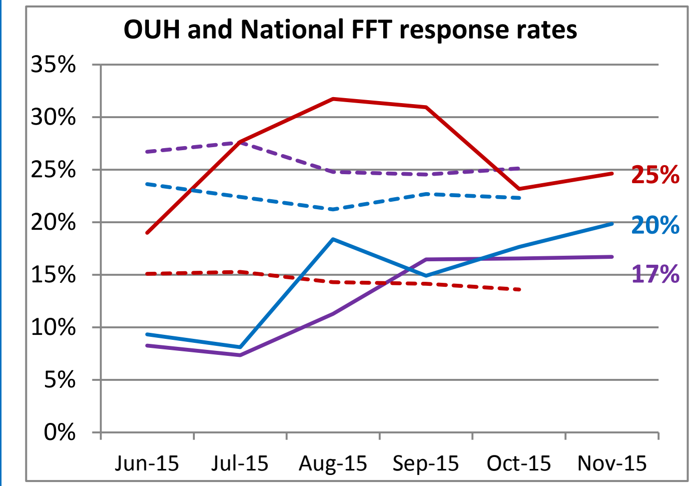


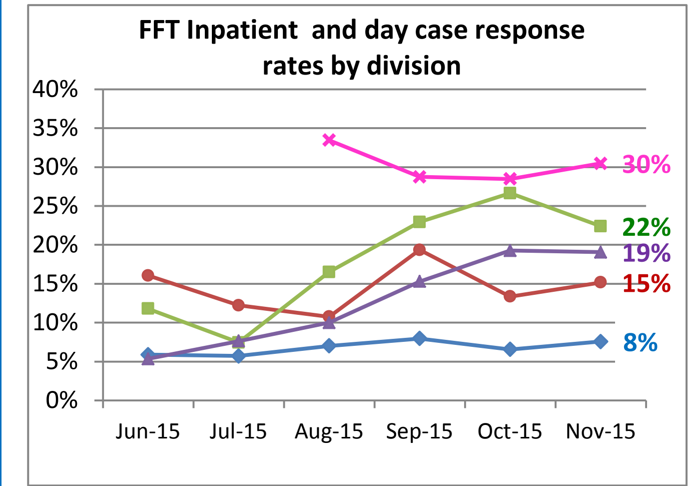


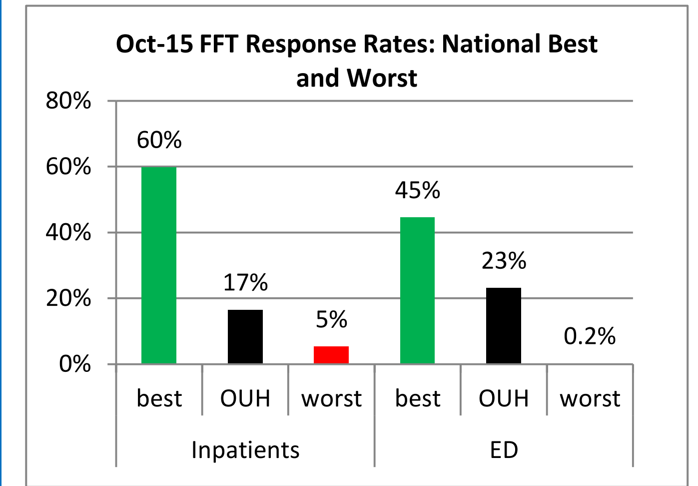


Only NHS Trusts with more than 100 responses have been included.

FFT: Response rates

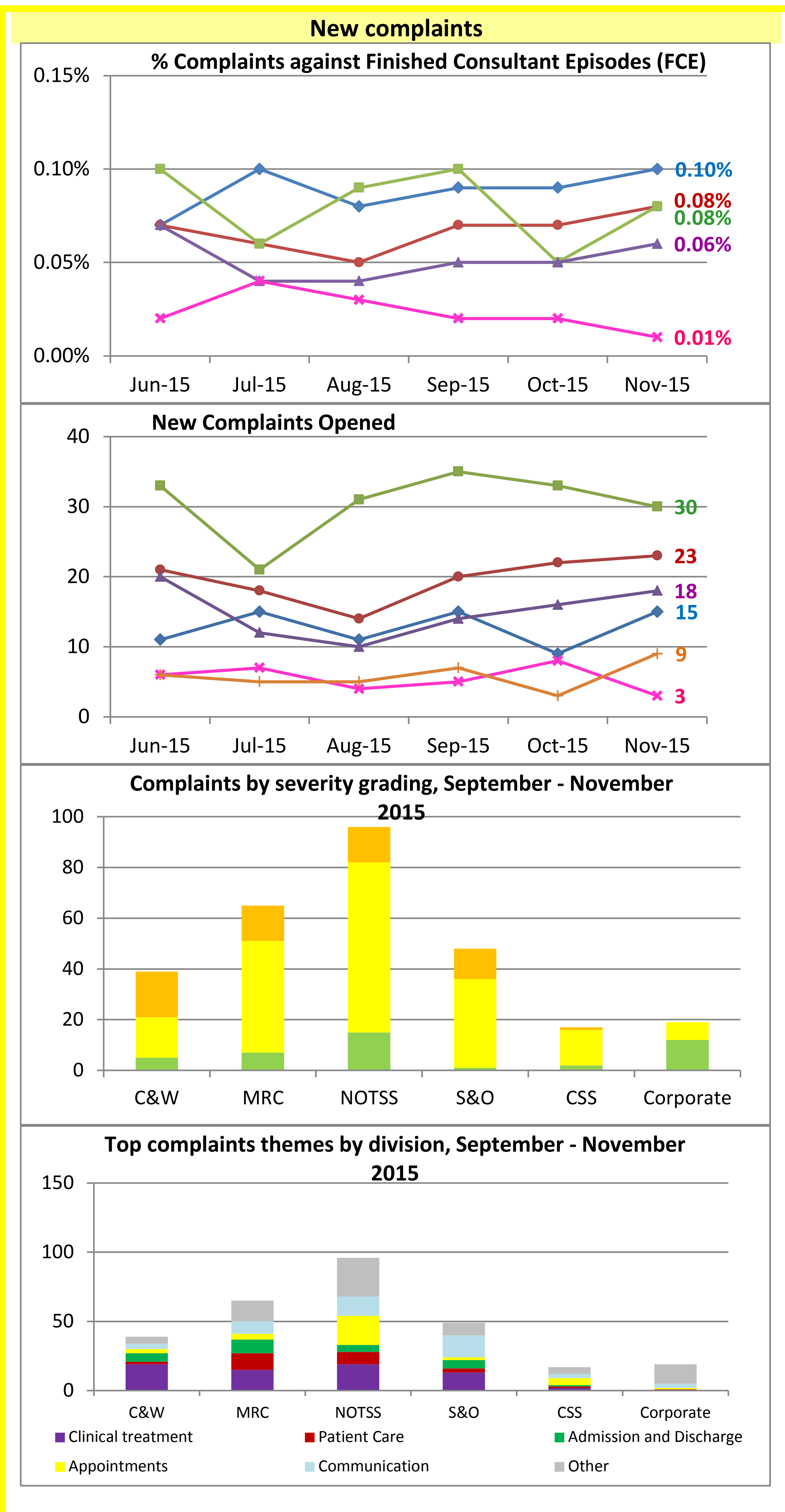


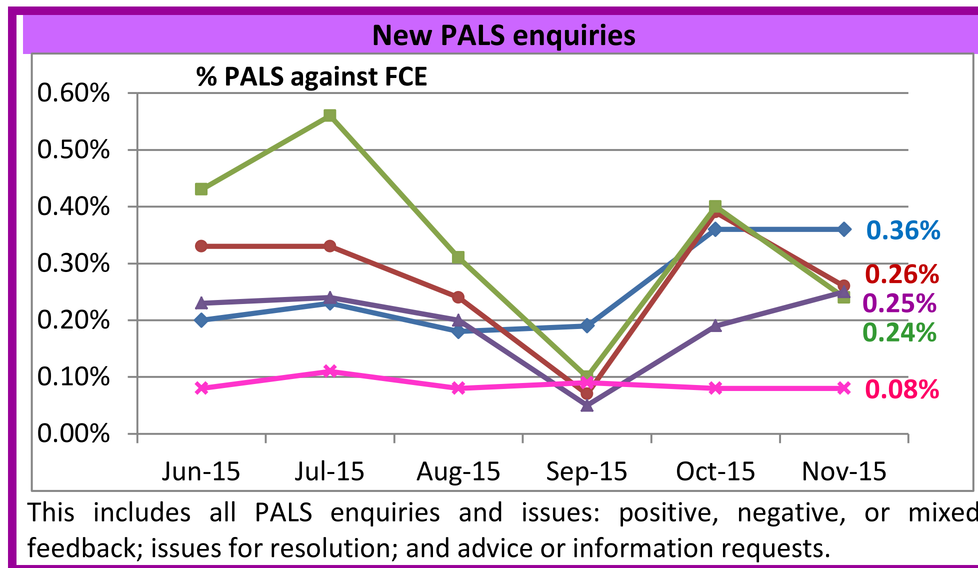




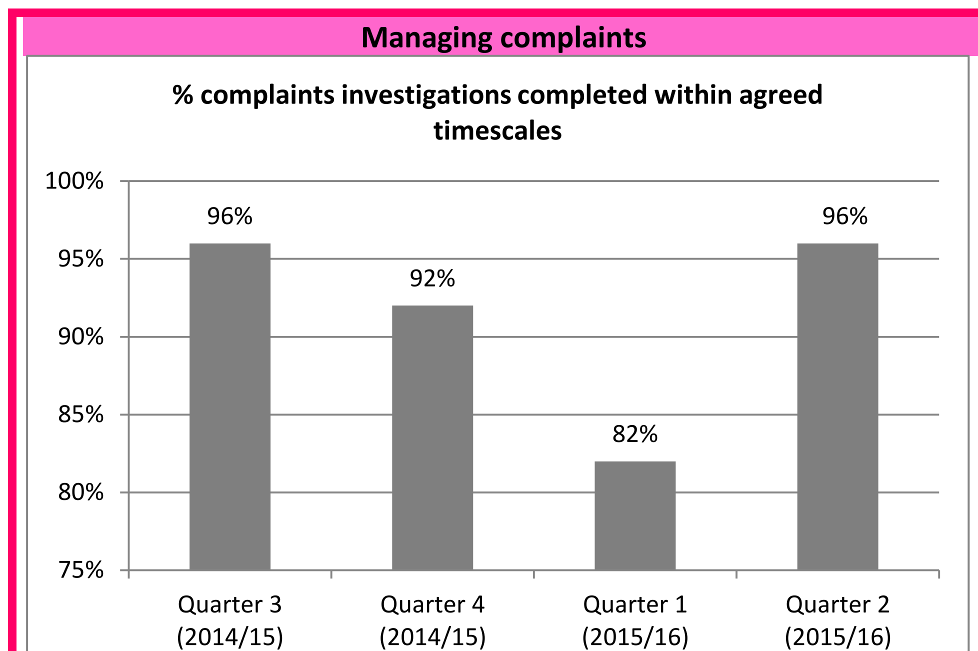
Only NHS Trusts with more than 100 eligible patients have been included.

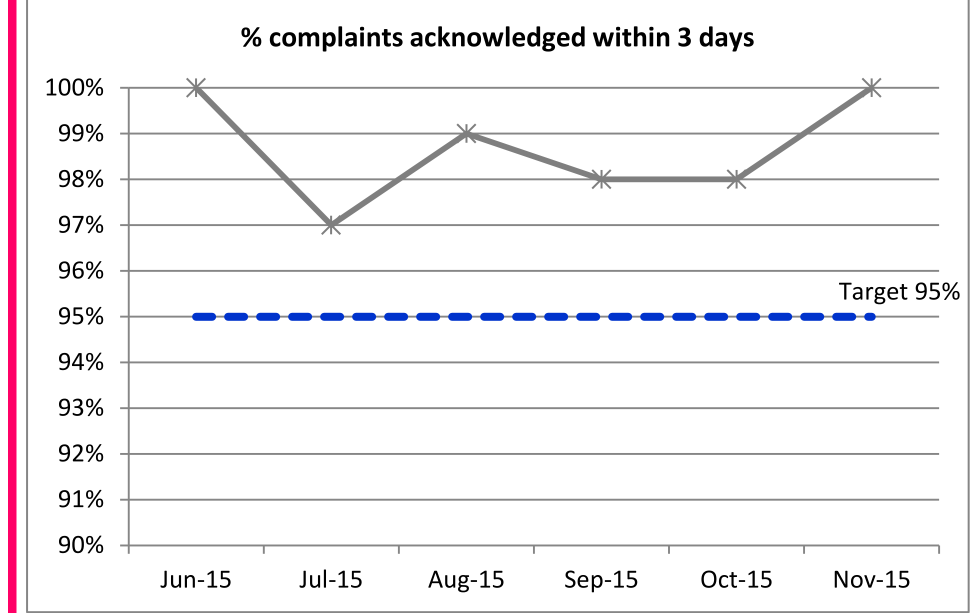
Complaints

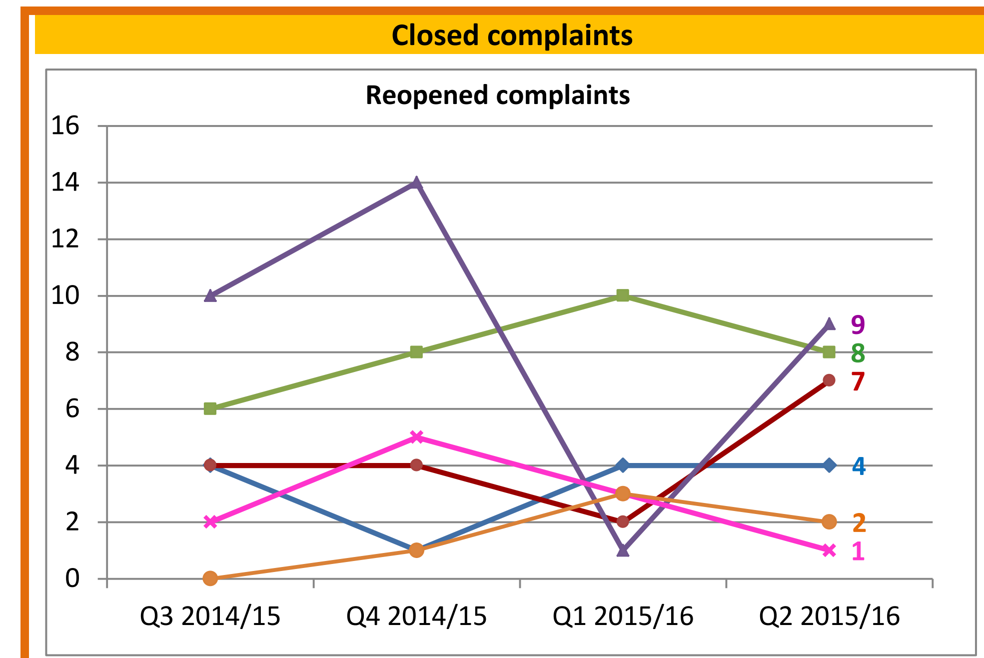


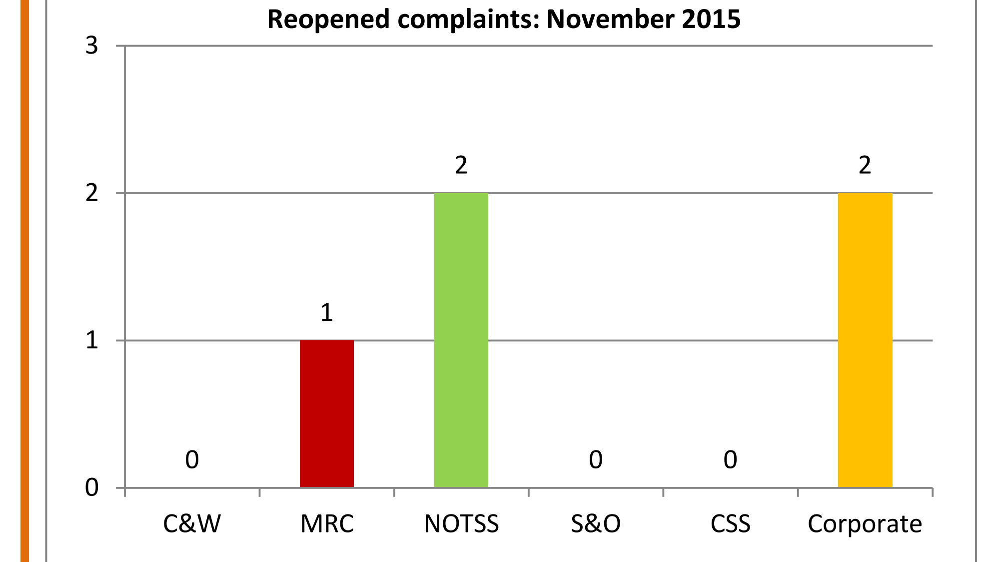


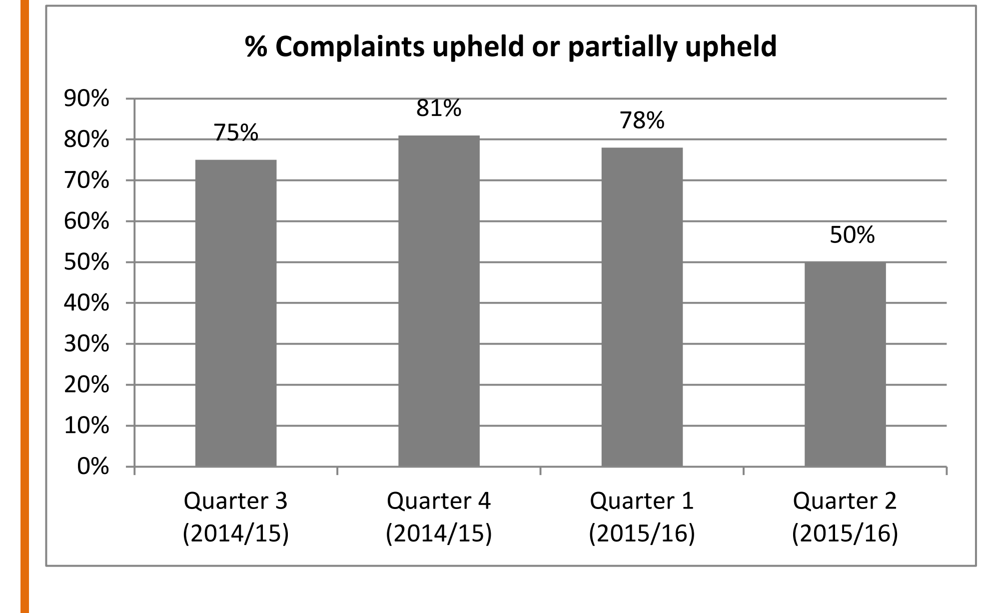
This includes all PALS enquiries and issues: positive, negative, or mixed feedback; issues for resolution; and advice or information requests.











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

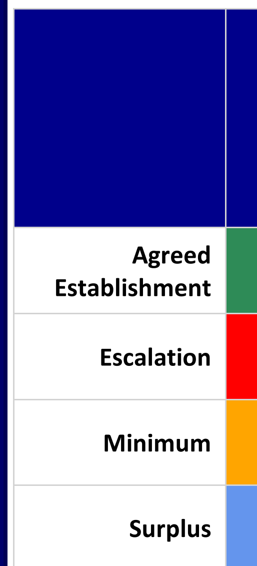
January 2016

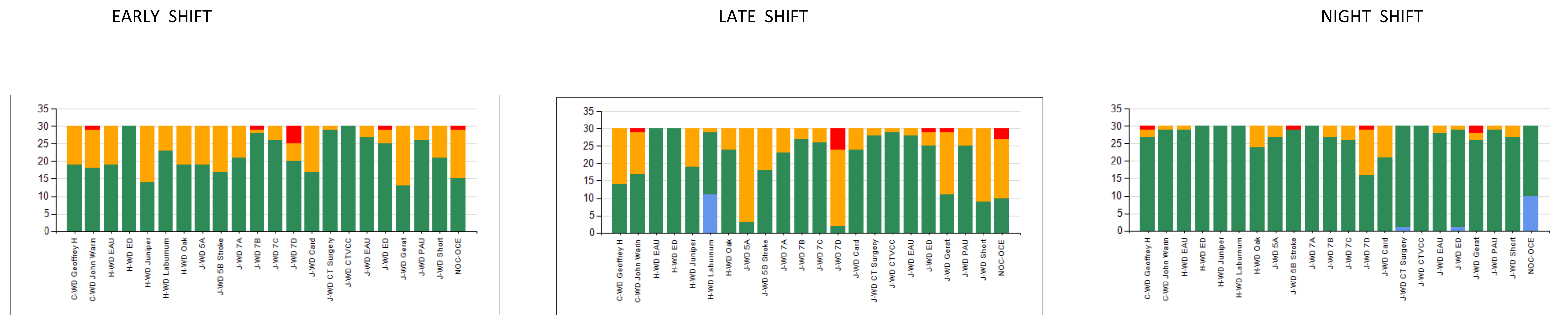
Appendix 3a

Oxford University Hospitals NHS
NHS Foundation Trust

MRC				Trust		
	September 15	October 15	November 15	September 15	October 15	November 15
Total Funded WTE	892.8	895.8	899.7	2969.6	2960.0	2964.7
Vacancy %	5.9%	4%	2.6%	7%	6.4%	5.5%
Sickness %	4.4%	4.7%	4.5%	4.3%	4.2%	4.4%
Maternity/Adoption Leave %	2.2%	2.3%	2.1%	3.1%	3.1%	3.1%
Agreed Staffing Levels %	68%	72%	77%	71%	74%	78%
Total number of Medication Nursing Administration Errors or Concerns.	26	21	18	70	53	71
Total numbers of Hospital Acquired Pressure Ulcers	50	49	43	98	101	92
Total Number of Avoidable Grade 3-4 Hospital Acquired Pressure Ulcers	2	0	0	6	5	6
Total Numbers of Falls	112	91	203	195	190	297
Falls with moderate, major or catastrophic harm	0	3	2	5	5	3

November 2015 Safe Staffing by Inpatient ward for MRC division.





Narrative by Divisional Nurse:

The levels of 'agreed' staffing has consistently improved over the last three months, as well as the levels of vacancy and sickness. The escalated shifts have been addressed through moving staff from shift to shift between wards and divisions in order to achieve safe cover and to prevent any shift from being left 'At Risk'.

The division continues to encourage staff to increase their culture of reporting medication incidents, however in recent months there has been a notable improvement in reporting and a decrease in the number of medication incidents with harm. There is an on-going educational programme which includes the SKINS care bundle, and a focused approach by the Tissue Viability Team working with clinical staff on a joint action plan in the division with regard to decreasing the levels of Hospital Acquired Pressure Ulcers.

There are a significant number of falls being reported within the division. The Falls Safe Care Bundle is being implementation and an educational programme is being rolled out across the division taking into account the newly appointed nurses.

Red escalation shifts were mitigated in November by a number of strategies. Mainly moving staff between areas or staff staying late or for an extra shift. The bed/staffing bleep holder, sister and any staff on planned administration time were included in the numbers as were the supernumery workers who were supposed to be on orientation

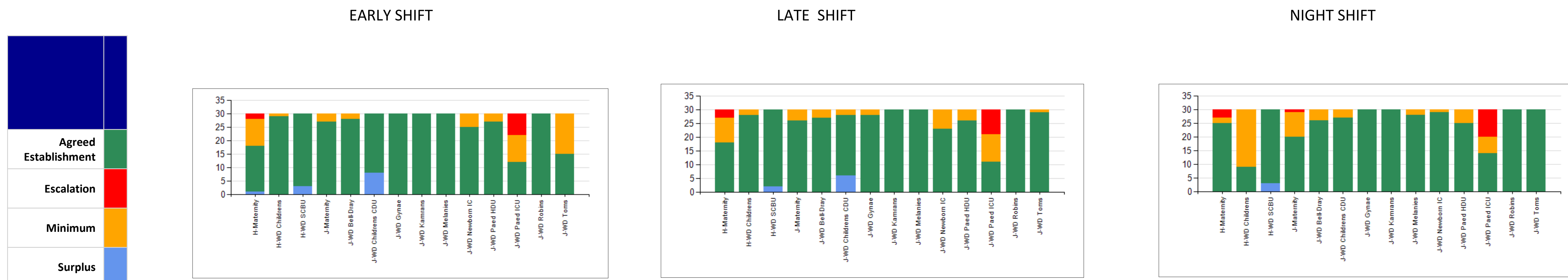
NB: These figures relate to selected inpatient areas against specific indicators that are being monitored as nursing sensitive.

Children's and Women's Division, (C&W),
Safe Staffing Dashboard (In-patient Areas only) January 2016
Appendix 3b

Oxford University Hospitals NHS
NHS Foundation Trust

C&W				Trust		
	September 15	October 2015	November 2015	September 15	October 2015	November 2015
Total Funded WTE	768.4	768.2	767.2	2969.6	2960.0	2964.7
Vacancy %	6.9%	5.3%	5.5%	7%	6.4%	5.5%
Sickness %	4.5%	4.6%	4.7%	4.3%	4.2%	4.4%
Maternity/Adoption Leave %	3.9%	4.2%	4.6%	3.1%	3.1%	3.1%
Agreed Staffing Levels %	79%	82%	86%	71%	74%	78%
Total number of Medication Nursing Administration Errors or Concerns.	15	10	23	70	53	71
Total numbers of Hospital Acquired Pressure Ulcers	4	6	4	98	101	92
Total Number of Avoidable Grade 3-4 Hospital Acquired Pressure Ulcers.	0	0	2	6	5	6
Extravasation incidents	2	1	4	6	2	6

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



Narrative In most cases the agreed establishment is maintained by moving staff and flexing beds between the wards. There are closed beds on the JR and Horton sites which accounts for higher numbers of agreed level shifts, than if the beds had consistently remained open. Where escalation shifts are shown these have been mitigated by a pooling of bank and agency staff who are directed to one area and then distributed as required to maintain safe staffing. NICU remains an area of concern in terms of staffing and is reliant on specialist staff provided by an agency, this is being monitored closely in view of the impacts of the agency cap.

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 Beds closed throughout children's services to mitigate the red escalation shifts and matrons worked in the numbers, as did supernumery workers who were supposed to be on orientation. Pooled temporary staff (indicated by blue surplus) were allocated where required when available. Staff were also moved between areas, and between shifts.

NB: These figures relate to selected inpatient areas against specific indicators that are being monitored as nursing sensitive.

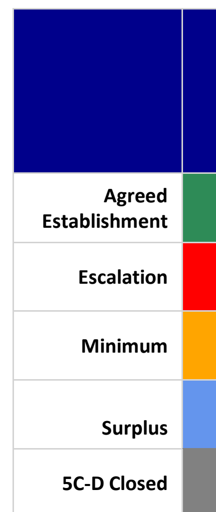
Surgery & Oncology Division, (S&O), Safe Staffing Dashboard (In-patient Areas Only)
January 2016

Oxford University Hospitals NHS
NHS Foundation Trust

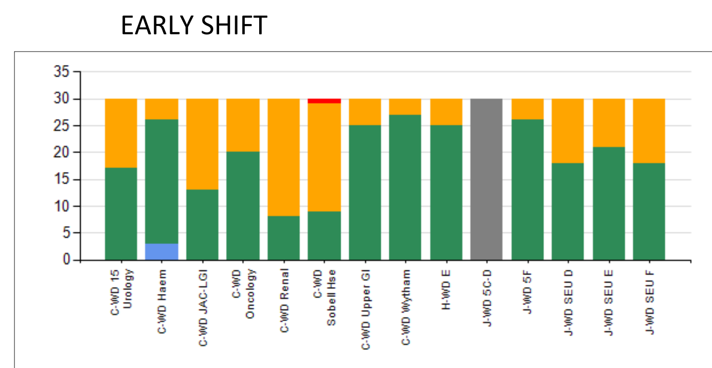
Appendix 3c

S&O				Trust		
	September 15	October 2015	November 2015	September 15	October 2015	November 2015
Total Funded WTE	493.8	478.2	478.2	2969.6	2960.0	2964.7
Vacancy %	11.1%	8.2%	5.6%	7%	6.4%	5.5%
Sickness %	4.5%	3.2%	3.6%	4.3%	4.2%	4.4%
Maternity/Adoption Leave %	2.6%	2.6%	2.2%	3.1%	3.1%	3.1%
Agreed Staffing Levels %	71%	71%	71%	71%	74%	78%
Total number of Medication Nursing Administration Errors or Concerns.	14	10	12	70	53	71
Total numbers of Hospital Acquired Pressure Ulcers	27	28	25	98	101	92
Total Number of Avoidable Grade 3-4 Hospital Acquired Pressure Ulcers.	4	4	2	6	5	6
Total Numbers of Falls	41	53	40	195	190	297
Falls with moderate, major or catastrophic harm	3	1	1	5	5	3

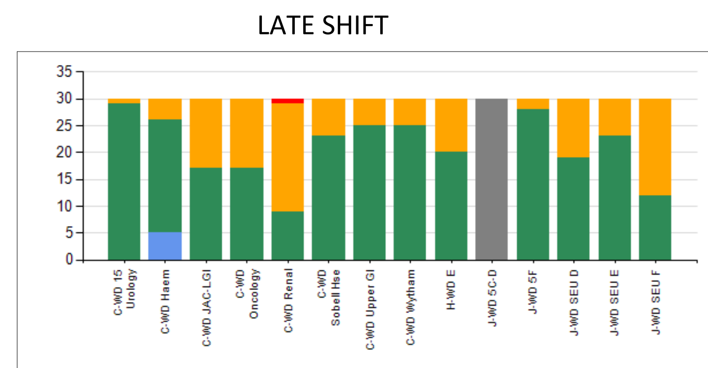
November 2015 Safe Staffing by Inpatient ward for S&O division.



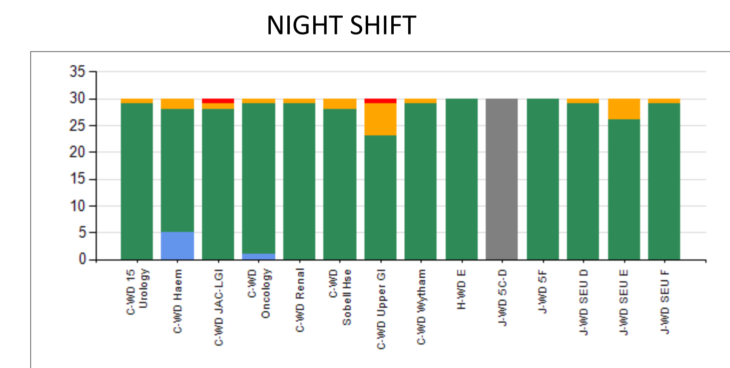
EARLY SHIFT



LATE SHIFT



NIGHT SHIFT



Narrative Recruitment and retention remain a key focus for the Division, and the vacancy rate is consistently reducing. However, S&O wards continue to run on high levels of minimum staffing for a lot of the daytime shifts. 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. Hospital Acquired Pressure Ulcers are reducing gradually through consistent training and validation of category 3 & 4 ulcers. Implementation of the SKINS care bundle is underway with support from the Tissue Viability Team. Medication errors are being monitored closely, there were none with harm reported.

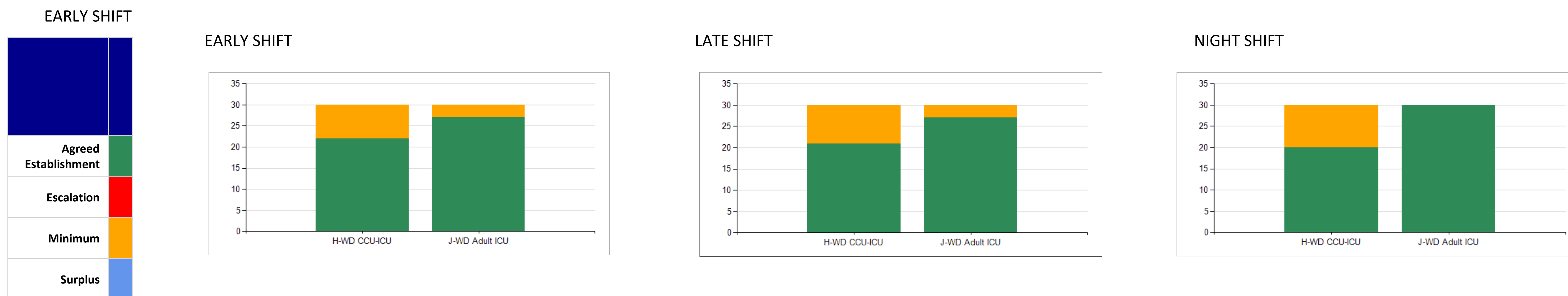
Red escalation shifts were mitigated by bed closures in the renal ward and the bed/staffing bleep holder and sister being included in the numbers, also any supernumery workers who were supposed to be on orientation.

NB These figures relate to selected inpatient areas against specific indicators that are being monitored as nursing sensitive.

Clinical Support Services Division, (CSS),Safe Staffing Dashboard Inpatient Areas only
January 2016 Appendix 3d

CSS				Trust		
	September 15	October 2015	November 2015	September 2015	October 2015	November 2015
Total Funded WTE	181.8	182.8	184.6	2969.6	2960.0	2964.7
Vacancy %	2.5%	16.4%	15.2%	7%	6.4%	5.5%
Sickness %	4.5%	3.5%	5.1%	4.3%	4.2%	4.4%
Maternity/Adoption Leave %	5.1%	5.6%	6.7%	3.1%	3.1%	3.1%
Agreed Staffing Levels %	82%	93%	82%	71%	74%	78%
Total number of Medication Nursing Administration Errors or Concerns.	5	0	1	70	53	71
Total numbers of Hospital Acquired Pressure Ulcers	0	0	1	98	101	92
Total Number of Avoidable Grade 3-4 Hospital Acquired Pressure Ulcers.	0	0	0	6	5	6
Total Numbers of Falls	0	1	1	195	190	297
Falls with moderate, major or catastrophic harm	0	0	0	5	5	3

November 2015 Safe Staffing by Inpatient ward for CSS division.



Narrative

This division supports the highest level of maternity/adoption leave in the Trust within in-patient areas and it should be noted that this is not covered by the 20% uplift.

The recruitment cycle and turnover of staff has meant that there is a higher vacancy factor in the latter two months. Recruitment is ongoing both externally and staff wishing to gain ITU experience.

The Adult ITUs operate to support each other across sites and will move staff between the Churchill and the JR to ensure adequate cover.

NB: These figures relate to selected inpatient areas against specific indicators that are being monitored as nursing sensitive.

Neurosciences, Orthopaedics, Trauma & Specialist Surgery, (NOTSS), Safe Staffing Dashboard (Inpatient Areas Only)

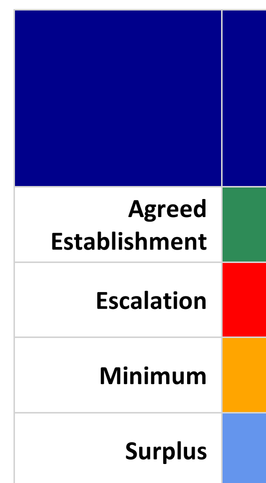
January 2016

Oxford University Hospitals NHS
NHS Foundation Trust

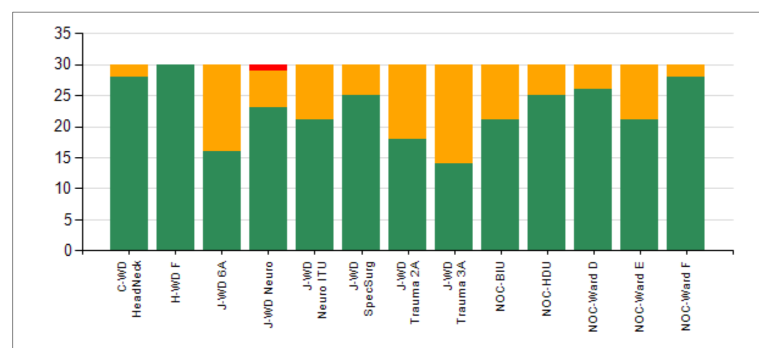
Appendix 3e

NOTSS				Trust		
	September 15	October 2015	November 2015	September 15	October 2015	November 2015
Total Funded WTE	632.7	635	635	2969.6	2960.0	2964.7
Vacancy %	6.6%	7.8%	5.6%	7%	6.4%	5.5%
Sickness %	3.6%	4%	4.3%	4.3%	4.2%	4.4%
Maternity/Adoption Leave %	2.9%	2.6%	2.6%	3.1%	3.1%	3.1%
Agreed Staffing Levels %	64%	71%	76%	71%	74%	78%
Total number of Medication Nursing Administration Errors or Concerns.	10	12	14	70	53	71
Total numbers of Hospital Acquired Pressure Ulcers	17	18	19	98	101	92
Total number of avoidable grade 3-4 hospital acquired Pressure Ulcers	0	1	2	6	5	6
Total Numbers of Falls	40	41	49	195	190	297
Falls with moderate, major or catastrophic harm	2	1	0	5	5	3

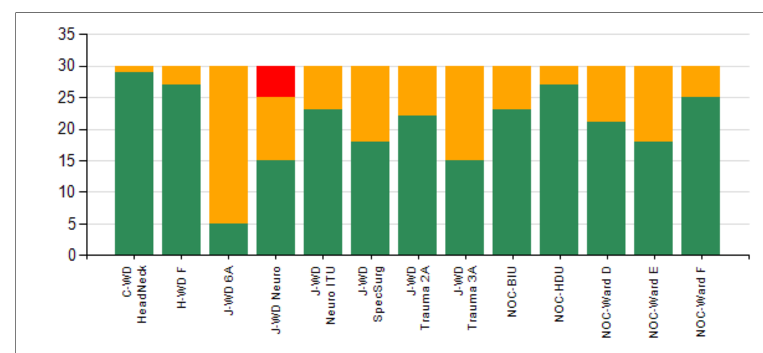
November 15 Safe Staffing by Inpatient ward for NOTSS division.



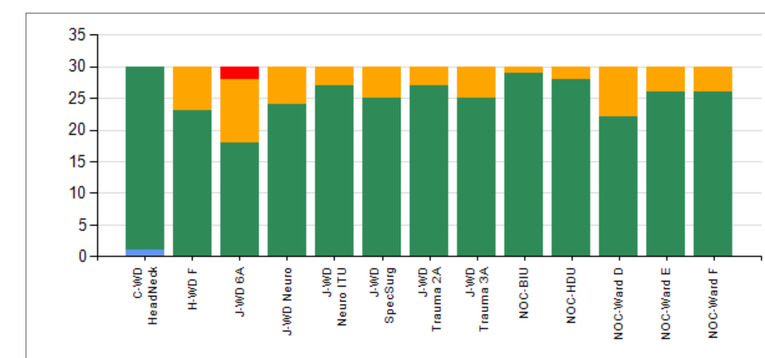
EARLY SHIFT



LATE SHIFT



NIGHT SHIFT



Narrative Maintaining staffing levels at minimum or above continues to be a challenge within the NOTSS Division. However due to continued EU recruitment agreed staffing levels have consistently increased.

There are still high levels of minimum staffing in NOTSS division despite the decrease in vacancy rate in September, this is due to EU staff nurses being in post but working in a supernumery capacity in order to undergo an induction period of time. In spite of the staffing challenge, quality indicators assure the division that care continues to be safely delivered. i.e.. high number of falls, mainly within neurosciences, but numbers of high impact falls remain low proportionally to the Trust figures, although the patient groups within the NOTSS division are often at high risk of falling.

Red escalation shifts are covered through the movement of staff between wards and shifts almost constantly, and the next level of mitigation has involved supernumery staff such as Sisters or Practice Development staff to work in the numbers on the wards, including missing their administration days and other staff agree to work additional hours or shifts through bank.

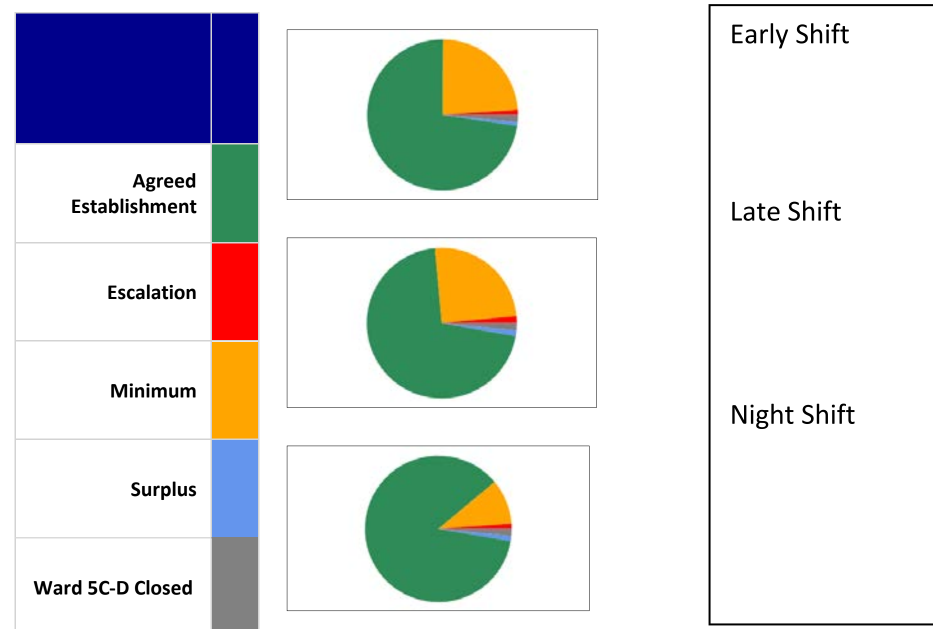
NB: These figures relate to selected inpatient areas against specific indicators that are being monitored as nursing sensitive.

Trust Safe Staffing Dashboard (In-patients only) January 2016
Appendix 3f

Oxford University Hospitals NHS
NHS Foundation Trust

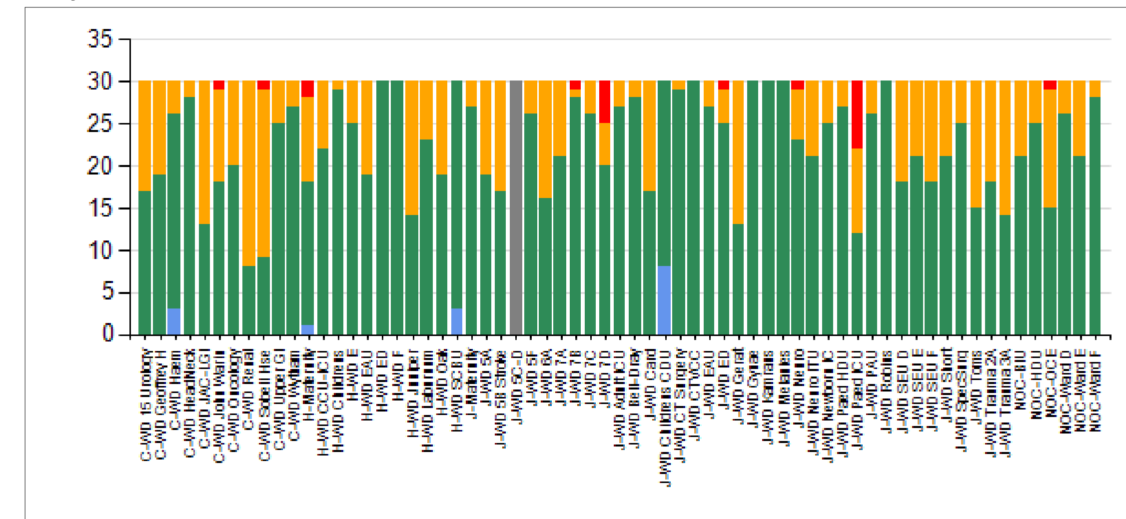
	Trust		
	Sept 15	Oct 2015	Nov 2015
Total Funded WTE	2969.6	2960.0	2964.7
Vacancy %	7%	6.4%	5.5%
Sickness %	4.3%	4.2%	4.4%
Maternity/Adoption Leave %	3.1%	3.1%	3.1%
Agreed Staffing Levels %	71%	74%	78%
Total number of Medication Nursing Administration Errors or Concerns.	70	53	71
Total numbers of Hospital Acquired Pressure Ulcers	98	101	92
Total Number of Avoidable Grade 3-4 Hospital Acquired Pressure Ulcers	6	5	6
Total Numbers of Falls	195	190	297
Falls with harm	5	5	3

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

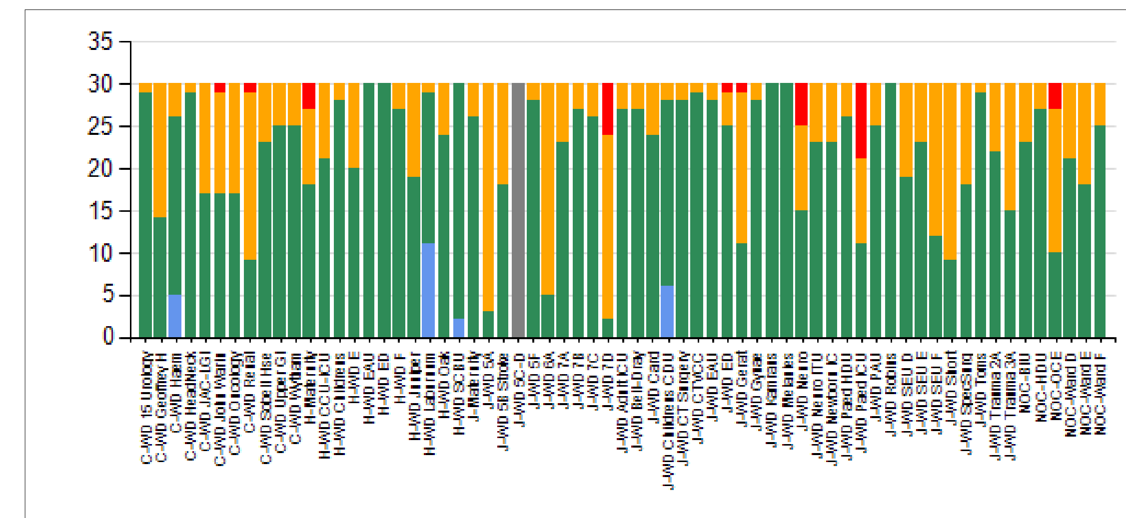


November 2015 Safe Staffing by Inpatient ward: Trust

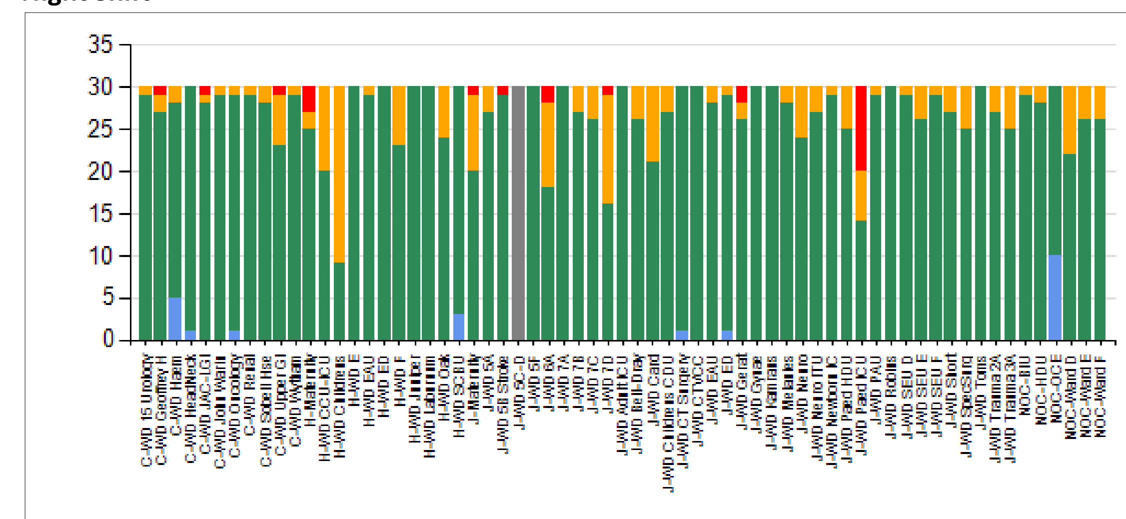
Early Shift



Late Shift



Night Shift



Narrative These diagrams demonstrate the shift by shift staffing across the Trust ward by ward as required by the National Quality Board guidance. There has been a steadily growing increase in the 'agreed' staffing levels and this is due to the EU recruitment drive which is ongoing. However it should be noted that mitigation for amber shifts it is often not possible as the shift went to 'Minimum' amber from originally being green, due to staff being moved to mitigate an escalated red shift. Additionally effectively through the same mitigation an escalation red shift and a green shift would mitigate to two amber shifts due to the movement of staff. NB: figures relating selected inpatient areas against specific indicators that are being monitored as nursing sensitive.

Trust Safe Staffing Dashboard (In-patients only) January 2016
Appendix 3f

Oxford University Hospitals NHS
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