Oxford University Hospitals
NHS Foundation Trust

Trust Board Meeting in Public: Wednesday 17 January 2018

TB2018.06

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 paper briefs the Quality Committee on: National developments on Quality related topics; progress against the Trust's Quality Strategy priorities; key quality metrics and emerging issues.
2.	The National Quality Strategy update considers the Care Quality Comission (CQC) report: The Department of Health remit for NHS Imrpovement 2017/18 and to 2020.
3.	30 Key quality metrics with exception reports : Trust and Divisional information For 7 of the 30 quality metrics, targets were not fully achieved in the last relevant data period; 4 of the 30 metrics have improved; trend data are provided along with exception reports. Appendix 1 shows a selection of the quality metrics by division in dashboard format.
4.	A section on Trust Quality priorities is included in this report to inform the Board of progress against our objectives for 2017/18.
5.	Matters for the attention of the Board: WHO checklist compliance audits show three of the five Divisions demonstrated compliance of less than 100% with actions in place to improve.
6.	Issues raised by Oxfordshire Clinical Commissioning Group (OCCG): Test result endorsement and discharge summary timeliness remain an area for improvement. In November 85.0% of discharge summaries were sent before or within 24 hours of discharge against a target of 95%; and 78.0% of results were endorsed on EPR within 7 days against a target of 90%. Although both indicators have improved slightly they have both fallen short of the OCCG target. GP feedback collated from the OCCG DATIX system is reported.
7.	Patient Safety and Clinical Risk: 6 Serious Incidents Requiring Investigations (SIRIs) were declared in November 2017. 6 SIRIs were sent to the OCCG for closure and 6 SIRIs were closed by the OCCG in the OCCG/OUHFT closure meetings. 5 Executive Quality Walk Rounds occurred in November 2017.
8.	Clinical Audit: 6 Clinical Audits were presented at the Clinical Effectiveness Committee.
9.	Infection Prevention and Control: The OUH remains two cases below the cumulative limit for C.difficile. There have been 2 new cases of colonisation with Candida auris on NITU in November. Two wards at the John Radcliffe site experienced a norovirus outbreak. The EPR surgical site surveillance infection (SSI) tool went live in November and is being piloted in cardiac surgery, neurosurgery and heptobilary surgery.
10.	Patient Experience: There were no exceptions to report in November 2017. One of the Trust's main outpatient departments was selected as the area with feedback for improvement. The key themes included waiting times and comments regarding individual staff. The comments have been fed back to the consultants who led on each patient's care.

	The Outpatient Department Sister and Clinical Coordinator have discussed waiting times with reception staff to ensure that patients are regularly updated about delays. The department with excellent feedback was Wytham Urology Outpatients. The team works well together and has strong team leadership, which helps them to deliver excellent patient-centred care. A peer review process of support is being considered for outpatient areas and is due to be discussed with matrons, in order to provide support and enable improvement Complaints The Trust received 98 new formal complaints in November. This is a decrease from the number received in October (N=105). NOTSS received the highest number of complaints, with (N=25) received in November. The team continued to achieve the required 95% of all complaints acknowledged within the 3 working day timescale in November, achieving 97% in total This report details the issues concerning the Complaints and PALS Team in the information and conversations they have had with patients, families and service users.
11.	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 division. Including: The summary of the November 2017 Unify submission of all planned and actual staffing levels. Care Hours per Patient Day (CHPPD) for November 2017 is reported to highlight the hours of direct nursing care that patients receive. This is uploaded onto the national Unify database, (Appendix 6). Reports of the ward by ward, shift by shift RAG rated staffing levels, (Appendix 5). The Trust has measured the patient acuity levels in the JR Emergency Department. Results have been presented at TME in December. Safe Staffing Dashboards and papers for Trust Board and Quality Committee are under review in relation to the informatics and intuitive data that highlights areas of potential concern for staffing levels and quality indicators. The 6 month establishment review has been carried out, following the review no changes in establishment were deemed necessary, (Appendix 4).
12.	Recommendation The Board is asked to receive and discuss this Quality Report.

Board Quality Report

1. Purpose

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

2. National Quality Strategy Update – The Department of Health remit for NHS Imrpovement 2017/18 and to 2020.

2.1. On 21/12/17 the Department of Health published a letter (from Phillip Dunne, Minister of State for Health) and appendix setting out its remit for NHS Improvement this year and to 2020.

2.2. The remit for 2017/18 includes supporting

2.2.1. the work led by NHS England and the commissioning sector to reduce growth in demand and help ensure that patients have access to care in the most appropriate settings for their need**;**

2.2.2. NHS England in reducing delayed transfers of care to 3.5% by September 2017

2.3. For 2020 amongst other changes is support for the Care Quality Commission (CQC) in introducing a Use of Resources rating for acute trusts, with the first formal ratings from January 2018.

2.4. The document describes a plan to create the safest, highest quality health and care service, seven days a week, supporting the NHS to become the world's largest learning organisation.

2.5. It describes that in 2017/18 NHS Improvement will:

2.5.1. increase the proportion of NHS providers achieving a CQC Good or Outstanding rating and re- duce the proportion of providers in special measures for quality;

2.5.2. work with NHS England to roll out the four priority clinical standards for seven-day hospital services to 50% of the population by April 2018 and to the whole population for five specialist services (vascular, stroke, major trauma, heart attack and paediatric intensive care) by November 2018;

2.5.3. develop further improvement resources to help equip providers to make safe staffing decisions;

2.5.4. lead cross-system work to reduce Gram-negative bloodstream infection rates by 10%;

2.5.5. lead ongoing work to improve patient safety, including:

2.5.5.1. collecting information on what goes wrong in the NHS and using that information to reduce risks to patients;

2.5.5.2. supporting providers to reduce deaths through improvements in transparency, clinical governance and leadership;

2.5.5.3. progressing the Development of the Patient Safety Incident Management System project in order to specify and procure a successor to the National Reporting and Learning System

2.6. For the medium term between now and 2020 the document describes that NHS Improvement will:

2.6.1. work with NHS England to roll out the four priority clinical standards for seven day services in hospitals to 100% of the population by April 2020;

2.6.2. support providers to improve patient safety and create an effective learning culture;

2.6.3. work with NHS England to improve the percentage of NHS staff who report that patient and service user feedback is used to make informed improvement decisions;

2.6.4. work jointly with NHS England and NHS Digital to:

2.6.4.1. support providers in undertaking technological and digital transformation;

2.6.4.2. promote the transparent use of data for service improvement;

2.6.5. work jointly with DH, NHS England, NHS Digital and NIB partners to:

2.6.5.1. support delivery of the National Information Board Framework ‘Personalised Health and Care 2020’

2.6.5.2. implement Dame Fiona Caldicott’s data security standards to improve cyber security pre- paredness and resilience;

2.6.6. promote a stronger culture of research within the NHS provider sector to realise financial and quality benefits;

2.6.7. continue to support providers to develop and publish Board-level service quality improvement plans;

2.6.8. have completed the five-year Patient Safety Collaborative programme, demonstrating the im- pact on safety in the NHS, and supporting 5,000;

2.6.9. implement relevant recommendations from the Accelerated Access Review;

2.6.10. lead cross-system work to reduce Gram-negative bloodstream infection rates by 50% by 2020;

2.6.11. lead the safety work stream of the Maternity Transformation Programme and run the national Maternal and Neonatal Health Safety Collaborative, to make progress towards achieving the national ambition to reduce rates of still- birth, neonatal deaths, maternal deaths and brain injuries occurring during or soon after birth by 50% by 2030, with a reduction of 20% by 2020;

2.6.12. as part of the Learning from Deaths programme, support trusts in implementing recommendation 7 of ‘Learning , candour and accountability’, and contribute to the implementation of other recommendations within the report where relevant.

2.7. The board is asked to note the content of the NHS Improvement remit to 2020.

3. 30 Key Quality Metrics with exception reports

3.1. 30 key quality metrics are listed in Table 1.

3.2. Where specified thresholds have not been met (‘red-rated’) or have declined from green to amber, trend graphs and exception reports are included.

Indicators deteriorating or red rated

3.3. 7 indicators have deteriorated against target or remain red rated since the last reporting and are illustrated in the following exception graphs..

Indicators that have improved since the last reporting period

3.4. 4 indicators have improved against target since the last reporting period:

3.4.1. PS01- Safety Thermometer (% patients receiving care free of any newly acquired harm) and PS02 - Safety Thermometer (% patients receiving care free of any harm - irrespective of acquisition).

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

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

3.4.4. PS16 - CAS alerts breaching deadlines is green with zero alerts breached.

Table 1: Key Quality Metrics

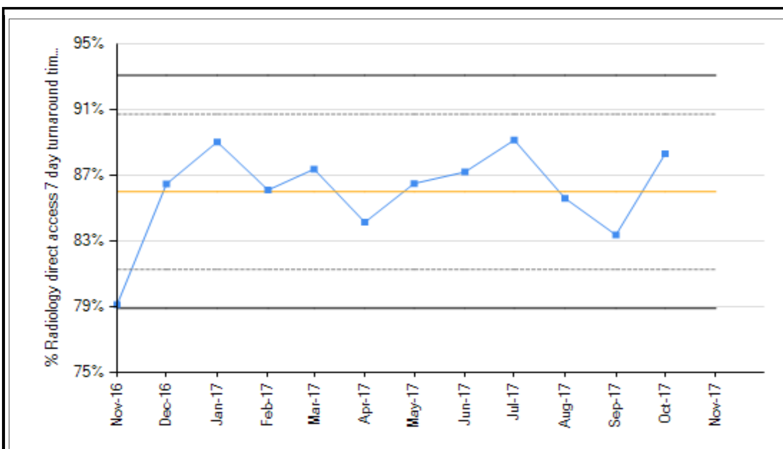
BQR ID	Descriptor	May	June	July	August	Sep	Oct	Nov
PS01	Safety Thermometer (% patients receiving care free of any newly acquired harm)	97.47%	97.18%	97.08%	98.18%	97.58%	96.94%	97.92%
PS02	Safety Thermometer (% patients receiving care free of any harm - irrespective of acquisition)	92.53%	92.65%	92.48%	94.75%	93.18%	92.01%	93.87%
PS03	VTE Risk Assessment(% admitted patients receiving risk assessment)	97.78%	97.63%	97.71%	97.71%	97.46%	97.58%	97.84%
PS04	Serious Incidents Requiring Investigation (SIRI) reported via STEIS	12	7	6	7	4	10	6
PS05	Number of cases of Clostridium Difficile > 72 hours (cumulative year to date)	11	15	23	30	36	38	45
PS06	Number of cases of MRSA bacteraemia > 48 hours (cumulative year to date)	1	1	1	1	1	1	1
PS08	% patients receiving stage 2 medicines reconciliation within 24h of admission	72.41%	74.81%	73.49%	74.75%	70.25%	72.11%	76.19%
PS09	% patients receiving allergy reconciliation within 24h of admission	100%	100%	100%	100%	100%	100%	100%
PS10	% of incidents associated with moderate harm or greater	0.80%	0.51%	0.57%	0.29%	0.29%	0.30%	0.70%
PS11	Total number of newly acquired pressure ulcers (category 2,3 and 4) reported via Datix	45	53	48	40	47	50	N/A
PS12	Falls leading to moderate harm or greater	0	3	3	0	0	0	2
PS13	Cleaning Score - % of inpatient areas with initial score > 92%	36.36%	47.37%	62.07%	40.43%	35.29%	45.16%	38.75%
PS14	% Radiology direct access 7 day turnaround times - Plain Film, CT, MRI & Ultrasound [one month in arrears]	86.52%	87.21%	89.16%	85.61%	83.38%	83.32%	N/A
PS16	CAS alerts breaching deadlines at end of month and/or closed during month beyond deadline	0	0	1	1	1	1	0
PS17	Number of hospital acquired thromboses identified and judged avoidable	2	2	1	6	2	3	1
CE02	Crude Mortality	196	144	175	189	187	204	218
CE03	Dementia - % patients aged > 75 admitted as an emergency who are screened [one month in arrears]	62.53%	72.38%	73.49%	70.22%	71.47%	71.45%	N/A
CE04	Dementia diagnostic assessment and investigation	100%	100%	100%	100%	100%	100%	N/A
CE06	ED - % patients seen, assessed and discharged / admitted within 4h of arrival	86.40%	82.78%	80.76%	84.78%	82.77%	82.05%	82.11%
PE01	Friends & Family test % likely to recommend - ED	87.26%	84.64%	82.81%	86.90%	88.08%	84.85%	79.27%
PE02	Friends & Family test % not likely to recommend - ED	8.19%	9.66%	11.48%	8.50%	7.70%	8.8%	16.81%
PE03	Friends & Family test % likely to recommend - Mat	95.36%	95.58%	96.75%	97.59%	96.56%	96.31%	93.67%
PE04	Friends & Family test % not likely to recommend - Mat	1.69%	0.68%	1.30%	1.61%	1.37%	0.26%	1.81%
PE05	Friends & Family test % likely to recommend - IP	95.33%	96.30%	95.72%	95.84%	95.58%	95.66%	96.06%
PE06	Friends & Family test % not likely to recommend - IP	2.39%	1.58%	1.66%	2.11%	2.11%	1.69%	1.88%

PE07	Friends & Family test % likely to recommend - OP	93.99%	94.16%	72.85%	94.21%	93.44%	94.26%	94.64%
PE08	Friends & Family test % not likely to recommend - OP	2.98%	3.00%	2.40%	2.87%	3.38%	3.11%	2.85%
PE14	Single sex breaches	0	0	0	6	4	7	4
PE15	% patients EAU length of stay < 12h	56.14%	54.03%	50.20%	52.34%	51.36%	51.63%	50.80%
PE16	% Complaints upheld or partially upheld [Quarterly in arrears]	N/A	45.09%	N/A	N/A	N/A	50.75%	N/A

*For indicators that are reported a month in arrears, quarterly etc will show N/A for months they are not applicable

Exception charts – Red

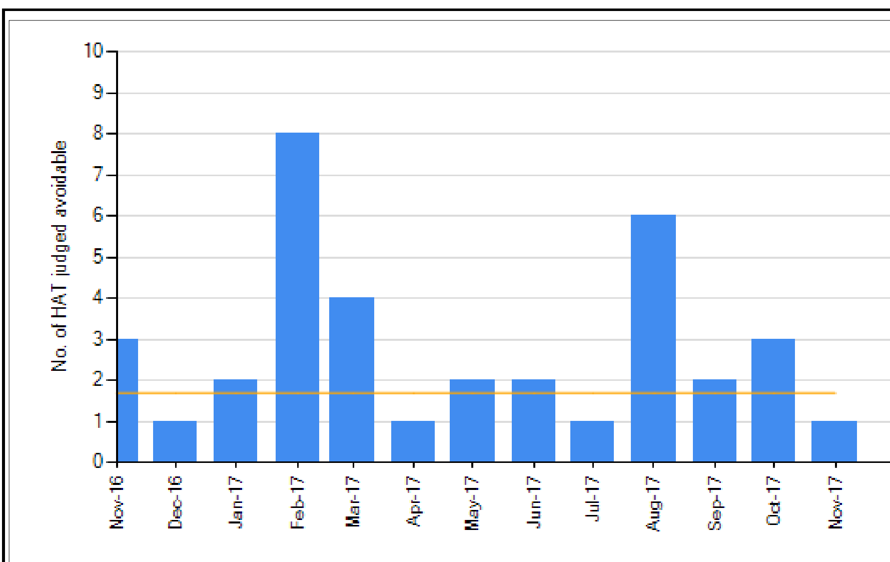
Chart 1: PS14 % Radiology direct access 7 day turnaround times - Plain Film, CT, MRI & Ultrasound [one month in arrears]



Overall non-compliant but with a small improvement for routine (R) 83.4% to 88.3% and urgent scans (U) 70% to 72.5%. The specific modalities: Plain film (R81% to 87%, U57% to 62%), CT (R86% to 90%, U99.4% to 99.5%), MRI (R65% to 73%, U94% to 96%) and Ultrasound unchanged (R99.0%, U99.7%). The Radiology Directorate have an action plan in place, which is being reviewed weekly. The trajectory for patients on 2 week cancer wait, currently is working to 7 days to scan and then 7 days to report. Additional capacity with mobile scanning units has been commissioned and is being used to support the timely scanning of patients, together with home reporting.

95% of routine radiology reports received by the requesting clinician within 7 calendar days of the examination date.

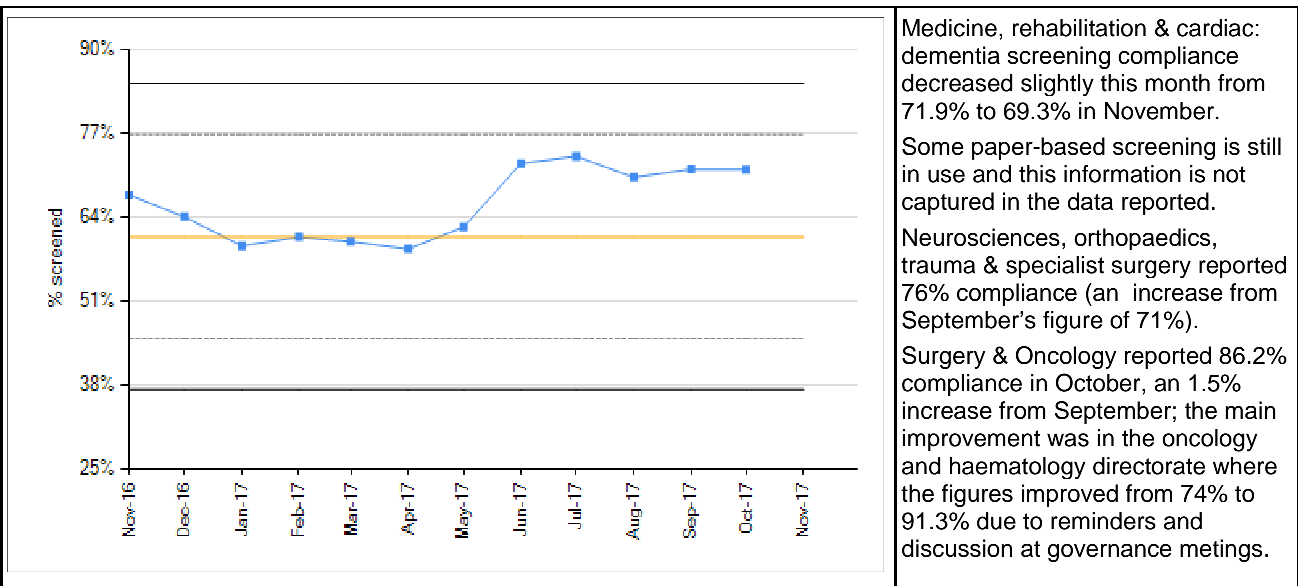
Chart 2: PS17 - Number of hospital associated thromboses (HATs) reported as potentially preventable



There was one avoidable HAT in this period. HAT reporting fluctuates dependent on the time from hospital admission to VTE, and time to complete the HAT screen. Benchmarking suggests that annual reporting of potentially preventable HATs is at an expected level. The latest Trust wide quarterly audit from October 2017 shows maintained improvement of 'appropriate thromboprophylaxis' at 98.0%, and also improvement in prescribing rates of mechanical measures of thromboprophylaxis.

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: S Shapiro].

Chart 3: CE03 Dementia - % patients aged > 75 admitted as an emergency who are screened



Medicine, rehabilitation & cardiac: dementia screening compliance decreased slightly this month from 71.9% to 69.3% in November.

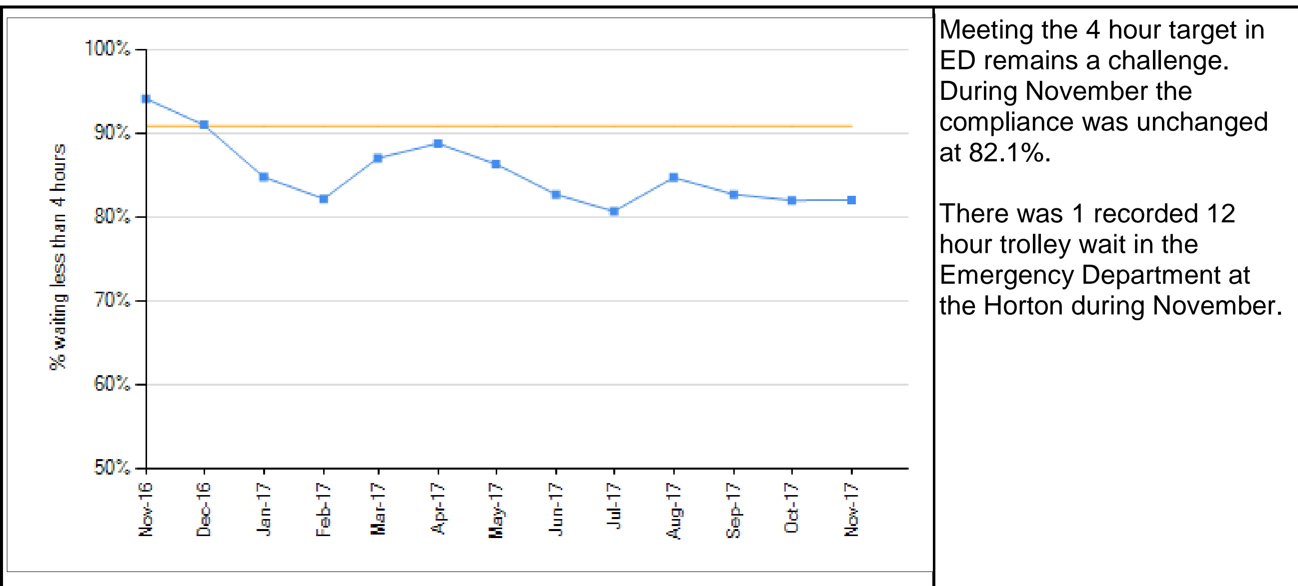
Some paper-based screening is still in use and this information is not captured in the data reported.

Neurosciences, orthopaedics, trauma & specialist surgery reported 76% compliance (an increase from September's figure of 71%).

Surgery & Oncology reported 86.2% compliance in October, an 1.5% increase from September; the main improvement was in the oncology and haematology directorate where the figures improved from 74% to 91.3% due to reminders and discussion at governance metings.

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 4: CE06 Emergency Department (ED) - % patients seen, assessed and discharged / admitted within 4h of arrival

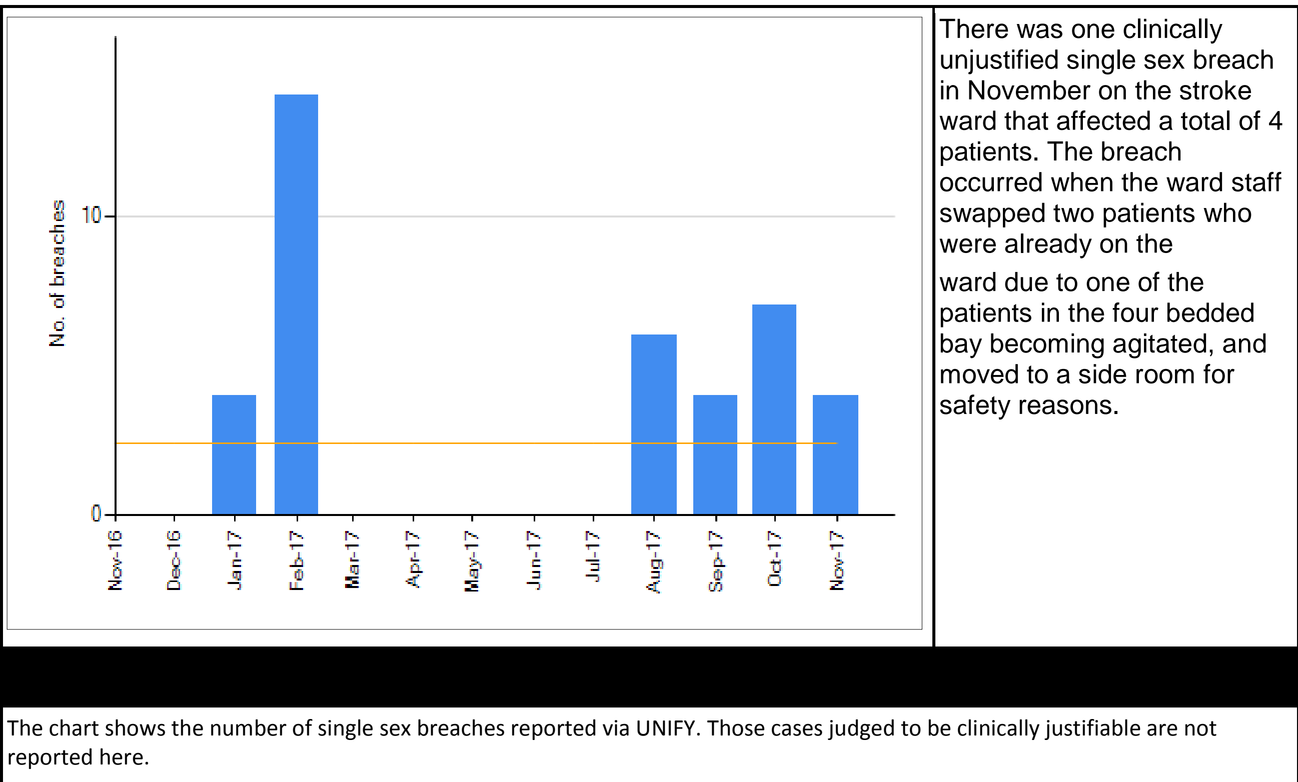


Meeting the 4 hour target in ED remains a challenge. During November the compliance was unchanged at 82.1%.

There was 1 recorded 12 hour trolley wait in the Emergency Department at the Horton during November.

% Patients attending ED who are discharged or admitted within 4 hours of arrival. [Owner: EMT]

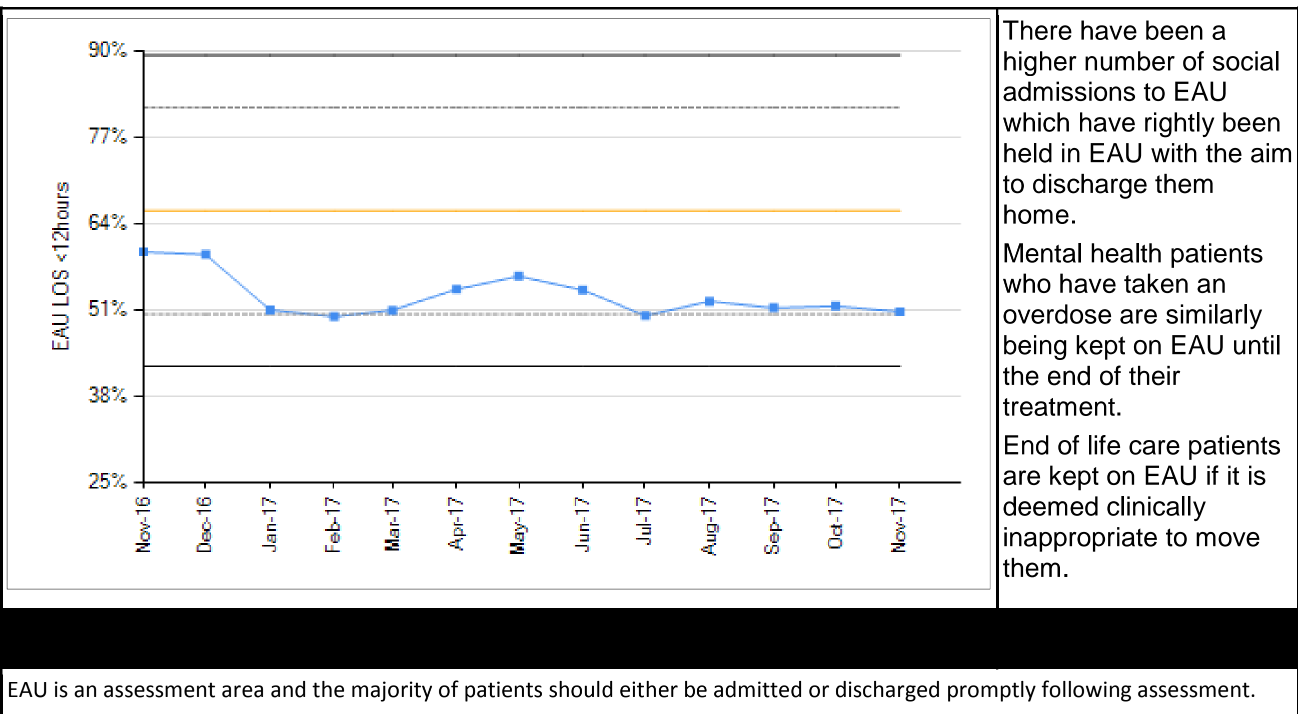
Chart 5: PE14 Single sex breaches



There was one clinically unjustified single sex breach in November on the stroke ward that affected a total of 4 patients. The breach occurred when the ward staff swapped two patients who were already on the ward due to one of the patients in the four bedded bay becoming agitated, and moved to a side room for safety reasons.

The chart shows the number of single sex breaches reported via UNIFY. Those cases judged to be clinically justifiable are not reported here.

Chart 6: PE15 % patients EAU length of stay < 12h



There have been a higher number of social admissions to EAU which have rightly been held in EAU with the aim to discharge them home.

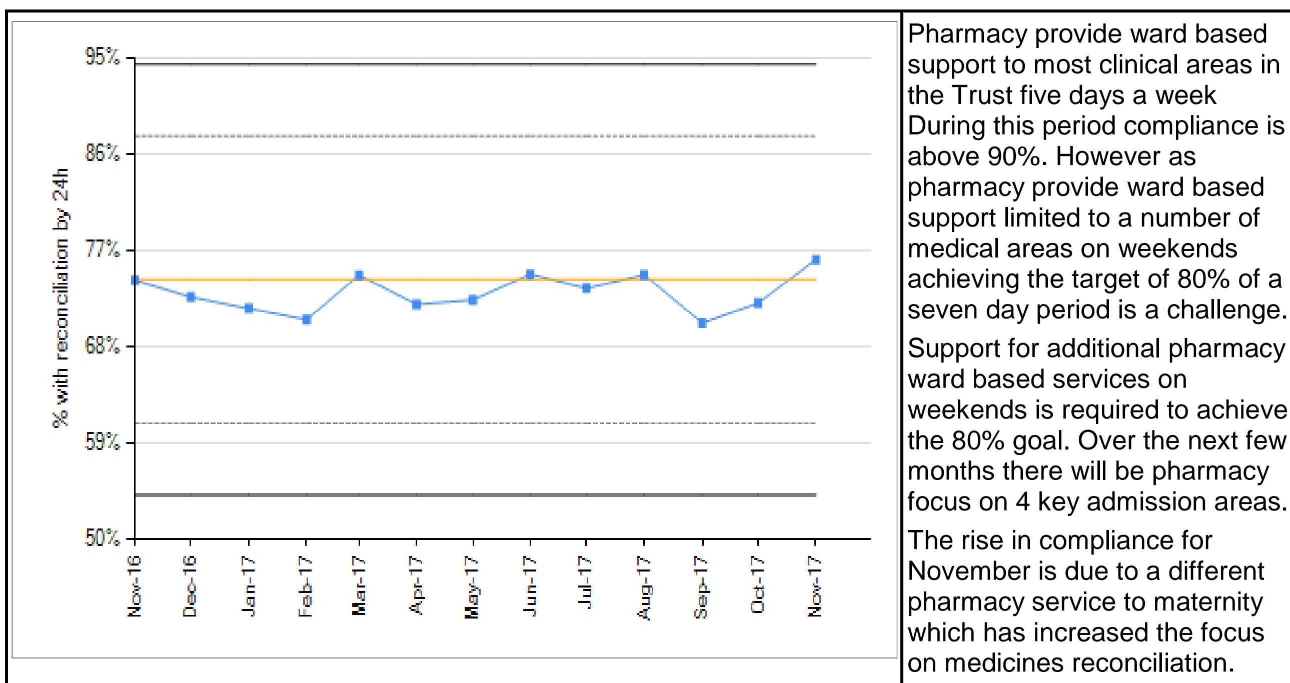
Mental health patients who have taken an overdose are similarly being kept on EAU until the end of their treatment.

End of life care patients are kept on EAU if it is deemed clinically inappropriate to move them.

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

Exception charts – Amber

Chart 7: PS08 % patients receiving stage 2 medicines reconciliation within 24h of admission



Pharmacy provide ward based support to most clinical areas in the Trust five days a week During this period compliance is above 90%. However as pharmacy provide ward based support limited to a number of medical areas on weekends achieving the target of 80% of a seven day period is a challenge.

Support for additional pharmacy ward based services on weekends is required to achieve the 80% goal. Over the next few months there will be pharmacy focus on 4 key admission areas.

The rise in compliance for November is due to a different pharmacy service to maternity which has increased the focus on medicines reconciliation.

The chart shows the proportion of inpatient for whom a second stage pharmacy-led medicines reconciliation is completed within 24 hours of admission. The audit captures medicines reconciliation tasks generated on admission by Cerner. Approximately 2500 medicines reconciliation tasks are audited monthly [Owner: P Devenish].

4. Update on progress against the Trust Quality priorities for 2016/17

4.1. The progress on the Trust's Quality Priorities against the goals and targets are set out in table 2.

Table 2 : Progress on the Trust's Quality Priorities 2017/18

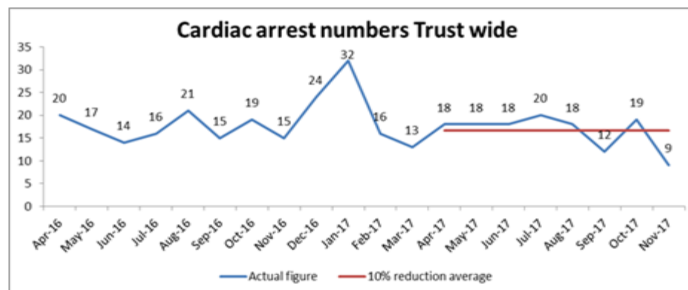
Priority One: Partnership working		
Why we chose this priority	**How we will evaluate success**	**Evaluation December 2017**
This was the top choice from our patient and public consultation event in January. It is also a major strategic aim for the Trust to work with system partners across Oxfordshire in areas such as the sustainability and transformation project (STP) across Buckinghamshire, Oxfordshire and	We will evidence the benefit to patients from taking a whole system approach to our strategy including the University of Oxford, our commissioners, other trusts, our STP area, Oxford Academic Health Science Network and stakeholders. Home Assessment and Reablement Team (HART) service development: we will ensure that the 50% of time is specifically for patient contact. This figure is derived by taking into consideration staff annual	Operational delivery networks (ODN): Hepatitis C: Recent analysis demonstrates a greater than 95% cure rate for this disease at this trust. Haemoglobinopathy: 71 patients underwent an annual review in the first two quarters of the year, out of a patient population of 197 (36%). Auto immune rheumatic disease (ARD) ODN: Data was analysed on all patients that attended the Rheumatology department over a 3 month period from July to September 2017 and then extrapolated to estimate the number of patients seen in 12 months. 82% of ARD patients required a multidisciplinary team (MDT) review. 29% of ARD patients required a change in treatment, which may include changing from a high cost drug..

Berkshire. We also recognise the value of our services that provide national and international expertise and will work to enhance care in this area particularly for rare diseases. Our CQUIN (Commissioning for Quality and Innovation) programme this year includes partnership networks with other local/regional hospitals to deliver best quality care together for spinal surgery, infection of the liver from a virus (hepatitis C), specific blood disorders and chemotherapy etc.	leave, sickness, maternity leave and travel time between each patient in the community as well as non-patient facing organisational activities. By ensuring the Operational Delivery Networks (ODNs) - collaborations of doctors, nurses, managers and allied professionals - offer opportunities to share learning and develop solutions within and across networks at regional and national levels, to build collaboration and accelerate change for patients. This will be evaluated via achievement of the CQUIN requirements. By fully embedding the OUH Public Health/ Health and Wellbeing Strategy we will continue to improve the organisational infrastructure that underpins staff health and wellbeing. We will implement a management development programme to equip line managers with the skills and capabilities to manage teams and services. This will provide managers with the tools to help create a healthy workplace for staff.	Home Assessment and Reablement Team (HART) service development: For the past 3 months the team has consistently achieved 50% patient contact time. The Centre for Occupational Health and Well Being have continued to run resilience workshops for staff. Since 1st April 2017 1097 members of staff have attended. The flu programme continues to run and to date 65% of front line staff have been vaccinated. The newly launched leadership development training sessions for the Corporate Directorate has delivered 5 cohorts from April 2017.
Priority Two: Safe discharge		
Why we chose this priority	**How we will evaluate success**	**Evaluation December 2017**
Patients have told us that delays caused by their medicines not being ready when they expect to leave the hospital are a source of frustration. We have also had feedback from GPs that this is an area we can improve upon. This was the favourite new priority identified at our patient and public event and will build upon work we did last year to improve medicines safety.	Our aims are to improve the experience of discharge and the accuracy of discharge communication for future medication. We will bring forward the time medicines to take home are reconciled/written, significantly increasing the number of patients discharged before 12 noon, and reduce the number of changes needed on medicines to take home so they are ready at the time of discharge. Furthermore we aim to reduce the overall time it takes to turn around discharge medicines and ensure availability to the patient when they are ready to go home. We will aim to increase the percentage of patients discharged before noon from 8% to 30%. We will examine information from our electronic system (Cerner) and	Once the decision to discharge is known by the pharmacist the time from the to take out (TTO) list to the medications being ready for collection is 85 minutes quicker in the TTO listing cohort. Despite this the peak discharge time remains 15:00 – 16:00 and the time from TTO's being a) ready for collection to b) the patient leaving the ward has increased by 34 minutes. A rapid improvement event for clinical staff from phase one and two sites is being convened to review this and other 'teething problems'. Discharge before 12 noon has increased in the pilot areas from 8% to 14%.

	carry out audits to check our results.	

Priority Three: Preventing patients from deteriorating – delivering time critical care [heart attack, stroke, blood clots in the lungs, sepsis including the use of the System for Electronic Notification and Documentation (SEND)]

Why we chose this priority	How we will evaluate success	Evaluation December 2017
This was the third most popular priority to continue at our patient and public consultation event and is a theme from our analysis of incidents or near misses in 2016/17.	Through a programme of changes supported by the monitoring system SEND and as part of the cardiac arrest reduction strategy we expect to achieve a 10% reduction in cardiac arrests in 2017/18 from 2016/17. We will establish an education and communication programme to fully inform our staff about rapid response treatment for time critical diagnoses which may cause deterioration in hospital. We will work to achieve national priorities to improve care for patients with sepsis as described in the 2017/18 CQUIN.	The resuscitation team are undertaking a review of patients who are subject to an emergency call or suffer a cardiac arrest in order that any learning identified can be taken forward. Themes include: appropriate documentation of observations of patients on continuous monitoring and timely decision making regarding the appropriateness of resuscitation attempts. These have been discussed at weekly harm free meetings and at local governance forums.There is a 17.4% decrease in the instance of cardiac arrest in ward areas (excluding the Emergency Department (ED), The Oxford Heart Centre, and Critical Care) between April and November 2017 when compared with the same time last year. It should be remembered that the numbers in the Heart Centre and the numbers in ED will include pre-hospital arrests. Given these results the 10% reduction in the instance of cardiac arrest is expected to be met. There is a 3.7% reduction in the instance of cardiac arrest overall.



Time critical care, this has been included in all medical induction sessions since August 2017. The recognizing acutely ill and deteriorating patients (RAID) committee in conjunction with the senior clinical leads for heart attack, stroke and blood clots in the lungs have been developing multidisciplinary E-learning

The progress with the sepsis element is demonstrated below:

% of eligible encounters screened:

Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	July 17	Aug 17	Sep 17	Oct 17
97.3%	99.4 %	99.2 %	99.3 %	99.4 %	99.7 %	99.4 %	99.3 %	98.2 %	98. 7%

% of IVAB less than 60 minutes from Alert:

Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	July 17	Aug 17	Sept 17	Oct 17
66.1 %	63.0 %	59.2 %	56.6 %	66.7 %	60.3 %	58.6 %	70.0 %	71.2 %	64.2 %

Priority Four: Mental health in patients coming to our hospitals

Why we chose this priority	How we will evaluate success	Evaluation December 2017
We know that the Emergency	For patients attending ED we will collaborate with Oxford Health to	Of the 16 patients who are in the cohort of frequent attenders to the emergency departments. Currently these

Department (ED) is not the best place to care for patients with mental illness and we will be working with Oxford Health NHS Foundation Trust to find ways to prevent the need to come to ED for some of these patients. We will also work on further improving care for those with mental illness complicating physical illness who are admitted to our hospitals. This was the second most popular suggested new priority at our patient and public event.	achieve the CQUIN target for 2017/18. We aim to reduce by 20% the ED attendances of those within a selected cohort of frequent attenders in 2016/17 who would benefit from psychiatric and psychological interventions. For inpatients, our Psychological Medicine team will identify, train and support medical and nursing champions for psychological and psychiatric care of our patients in all key Trust services.	patients have 7 attendances on average from April through to September 2017, which is a 54% reduction in attendance within this cohort of patients. Education/ training quality initiative: Since April 17, teaching has taken place regularly across all staff disciplines and across all Tiers of training. To date, over 400 members of staff have received training in psychological and psychiatric care of our patients in 2017/18.
Priority Five: Cancer pathways		
Why we chose this priority	**How we will evaluate success**	**Evaluation December 2017**
We plan to review cancer pathways with a focus on reducing the number of, and time between patient encounters (coming to hospital as an in- or outpatient or for tests) in order to consistently improve patient experience, meet cancer targets and provide diagnosis and treatment in a timely manner.	We aim to improve patient experience by increasing the numbers of individuals who are diagnosed and treated for cancer within target. We also aim to avoid unnecessary delays and we have a programme for quality in each cancer pathway. We will Increase the timeliness of first contact or visit for individuals with a suspected cancer so that >93 % of referrals are seen within 14 days. Increase the number of individuals confirmed with cancer who are treated within 62 days from 2 week wait referral to treatment start (Aim: >85% in 2017/18). Increase the number of patients who are treated within 31 days of decision to treat (Aim: 96% or greater in 2017/18).	Performance in relation to our stated aims: • >93 % of referrals seen within 14 days: This was achieved. In September 2017 the performance was 97.7%. • Treatment within 62 days from 2 week wait referral to treatment start: This was met in September 2017 at 85.4%. • Increase the number of patients who are treated within 31 days of decision to treat (Aim: 96% or greater) was achieved in September 2017 with 96.8% treated within 31 days of the decision.
Priority Six: Go Digital		
Why we chose this priority	**How we will evaluate success**	**Evaluation December 2017**
We have been named a 'global digital exemplar' which recognises that we are at the	We will establish a Patient Portal to be used for appointment booking, receipt of letters and review of parts of the clinical record (for limited numbers of	The Global Digital Exemplar programme, launched by NHS England, was delayed in finalising and as such meant the work in earnest suffered a delay of 6 months. The Trust continued with its work programme and upgraded the Trust's Electronic Patient Record System and now has

forefront of the use of digital technology to deliver exceptional treatment and care. As a digital exemplar, we have ambitious plans to accelerate the opportunities that digital technology offers, in line with the ambition of the NHS to be 'paper-free' and for patient records to be held electronically and accessible across different systems. We will leverage electronic health records, data and technology to innovate and join up how we provide patient care across organisational boundaries and support self-care and research. We are committed to ensuring these processes improve our safety, effectiveness and patient experience.	patients). We will deliver a major project for Core Clinical Documentation: this major project will be accelerated to deliver the capability providing the outstanding online documentation required by clinical staff to document electronically in real time into the patient record. It includes Care Plans, Assessments, Decision Support Rules, extended catalogues of orderables (clinical referrals), and 'best practice' clinical pathway guidance.	started to focus up delivery of the patient portal and Core Clinical Documentation both these projects will provide patient and staff benefits - including: better access for patient to Trust services, improved efficiencies for staff as we automate administrative processes.
Priority Seven: End of Life Care: improving people's care in the last few days and hours of life		
Why we chose this priority	**How we will evaluate success**	**Evaluation December 2017**
This was the second most popular priority to continue when we asked our patients and the public at our event in January 2017. We agree that while we achieved a lot last year we can still do more to develop our end of life care in 2017/18.	We will implement further improvements in end of life care as described in our work plan for 2017/18. The work plan is based on our End of Life Care Strategy and builds on last year's work plan. We will deliver and learn from the daily palliative care input to the Emergency Department (ED) and Emergency Admissions Unit (EAU) as part of the End of Life Care Project funded by Sobell House Hospice Charity. We will increase the number of wards with enhanced skills in supporting end of life care. We will continue to gather feedback from bereaved families to understand their experience of care in the Trust and incorporate learning in the work plan.	The work plan for 2017/18 is operational and will be reviewed by the End of Life Care working party again on 12.12.2017. The team continues a 7 day a week presence in ED and EAU. A report on the first year of the Sobell House Hospice Charity funded project is available. 3 wards at the Horton (Juniper, Laburnum and the Critical Care Unit) are currently preparing to accredit as having enhanced skills in supporting end of life care. Training is booked for December and January and this process should be complete for these wards by the end of January. The pilot into gathering feedback from bereaved families has been completed and evaluated. Actions and learning have been identified. The report will be reviewed at the end of life care meeting on 12.12.2017 and then circulated.

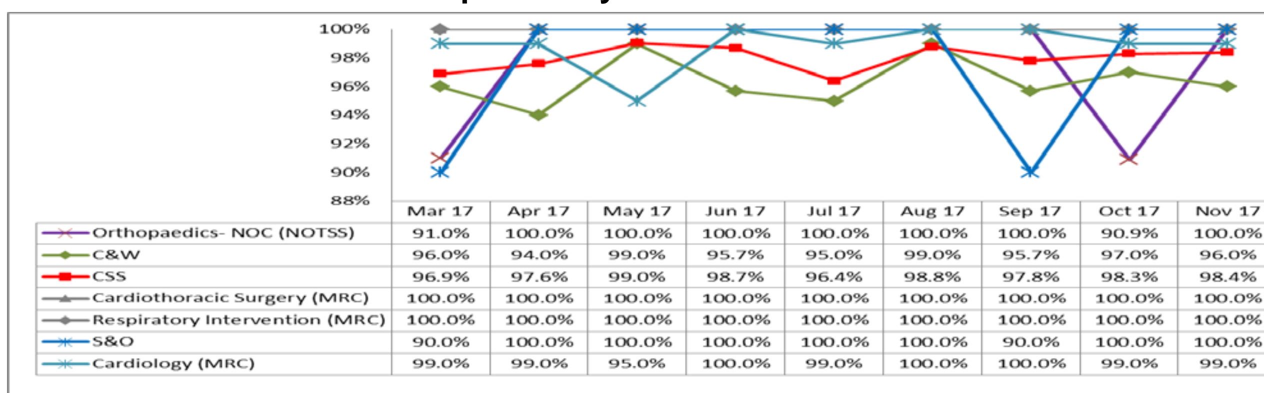
Priority Eight: Dementia Care		
Why we chose this priority	**How we will evaluate success**	**Evaluation December 2017**
We are committed to providing an excellent standard of care for all patients but we know that we particularly need to ensure that those who are vulnerable and frail are getting the best possible care. Dementia is an increasingly common condition and we want to continue to build on last year's progress in this area.	We will implement a paperless process for cognitive screening. A uniform core electronic clerking pro forma should help improve screening because junior doctors will then become familiar with using the same core form regardless of specialty. We will modify our consent forms to prompt consideration of the need for a capacity assessment prior to consent. We will design electronic systems to trigger individualised nursing care plans/bundles once the cognitive screen has been completed and it is positive.	The form for electronic clerking from a cognitive screen/frailty point of view has now been designed and is in the hands of the EPR team so we are not yet paperless. The consent forms have been modified and have been approved at Clinical Governance Committee but are not in use yet as they are currently going through the procurement process.
Priority Nine: Learning from complaints		
Why we chose this priority	**How we will evaluate success**	**Evaluation December 2017**
It is fundamental that we listen to our patients and learn from their experiences therefore we want to make this an explicit priority this year. Communication is one of the top three themes from complaints and this will be an area of focus.	We will carry out an in-depth review of 2016/17 complaints related to communication to better develop actions and stories which will have the greatest impact for staff. We will also review complaints about access to treatment to ensure the Trust is listening to the patient's views on what aspects of access really matter for their experience. This will be used to understand where improvements can be made.	Following the in depth review of 2016/17 complaints related to communication and access to treatment, each of these aspects now has the following sub projects established: • Communication 1. Review of the Delivering Compassionate Care Course 2. 'See it my way' patient stories 3. The Complaints closure project 4. Reporting complaints to Clinical Governance Committee and Trust Board 5. Reception and 'Front of House' • Access to treatment 6. Enabling patients to quickly and easily contact the appropriate department regarding their appointment An action plan with Leads and timescales anticipates completion by 31st March 2018.

5. Matters for attention of the Board

WHO Compliance

5.1. Chart 8 shows the compliance with the WHO checklist by Division and in specific divisional areas. These audits were paper-based. Table X provides the narrative where compliance is below 100%.

Chart 8: WHO Checklist compliance by Division/Directorate over time.



	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17
Orthopaedics- NOC (NOTSS)	91.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	90.9%	100.0%
C&W	96.0%	94.0%	99.0%	95.7%	95.0%	99.0%	95.7%	97.0%	96.0%
CSS	96.9%	97.6%	99.0%	98.7%	96.4%	98.8%	97.8%	98.3%	98.4%
Cardiothoracic Surgery (MRC)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Respiratory Intervention (MRC)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
S&O	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	90.0%	100.0%	100.0%
Cardiology (MRC)	99.0%	99.0%	95.0%	100.0%	99.0%	100.0%	100.0%	99.0%	99.0%

Table 3: WHO Checklist November 2017

Division	Compliance	Comment
CSS	98.41% (372/378)	The compliance rate was below the KPI at 98.41%. Radiology achieved 100% and Theatres 97.6%. There were 6 partial compliances and 0 non-compliances. The partial compliance omissions included the following areas: procedure not recorded, 'Sign In' missing signatures, 'sign in' missing name, 'sign out' missing signatures, and 'sign out' missing name.
C&W	95.9% (119/124)	There were 5 partial compliances where either the 'sign in' or the 'sign out' were missing signatures. Letters have been sent by the Divisional Director to the staff involved in these cases.
MRC	99.3% (136/137)	The 99% score for cardiology was due to one of the forms not being signed by the circulating nurse. However as with other similar form failures the process has been followed and the boxes ticked but the nurse omitted to sign. This has been addressed with the team and will be closely monitored throughout the month.

6. Issues raised by OCCG

6.1. In November 85% of discharge summaries were sent before or within 24 hours of discharge compared with 84.6% in October; this falls short of the 95% target.

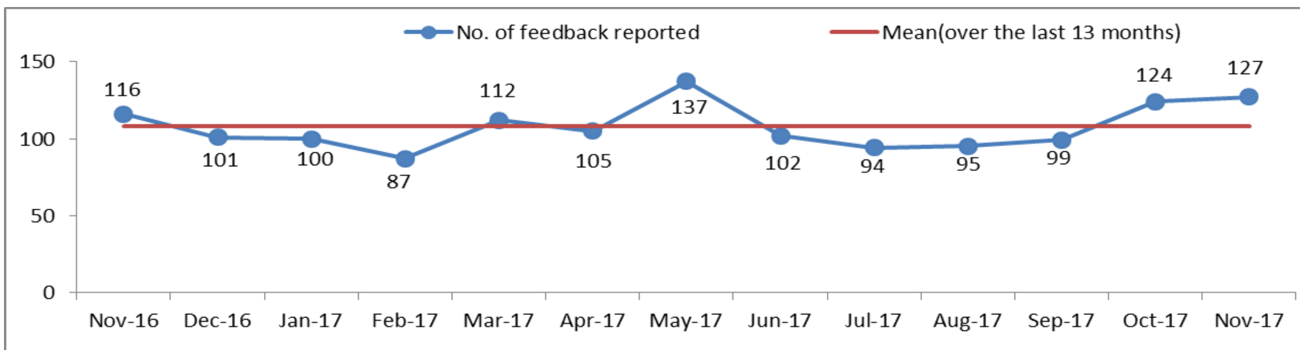
78% of test results were endorsed on EPR within 7 days (note it is possible to review a result and not endorse it) this compares with 76.5% in October and falls below the 90% target.

6.2. Feedback for November received from GPs via the OCCG Datix system is summarised in the table below. The top 3 themes account for 39% (50/129) of all feedback received over the month. Duplicate information sent to practice has been the top reported issue for the past 4 months.

Table 4: GP Feedback – Top 3 thematic areas

Theme	Sep-17	Oct-17	Nov-17
Duplicate information sent to practice	17	20	28
Delay in GP receiving clinical docs (i.e. OPD/Discharge letters)	1	6	13
Request from secondary care for GP to follow up tests/scans/investigations initiated in secondary care	12	10	9
Total Reported	**99**	**124**	**129**

Chart 9: Number of GP feedback reports received per month



7. Patient Safety and Clinical Risk

Clinical Risk

7.1. 6 Serious Incidents requiring Investigation (SIRI's) were declared as SIRIs and reported onto STEIS in November 2017.

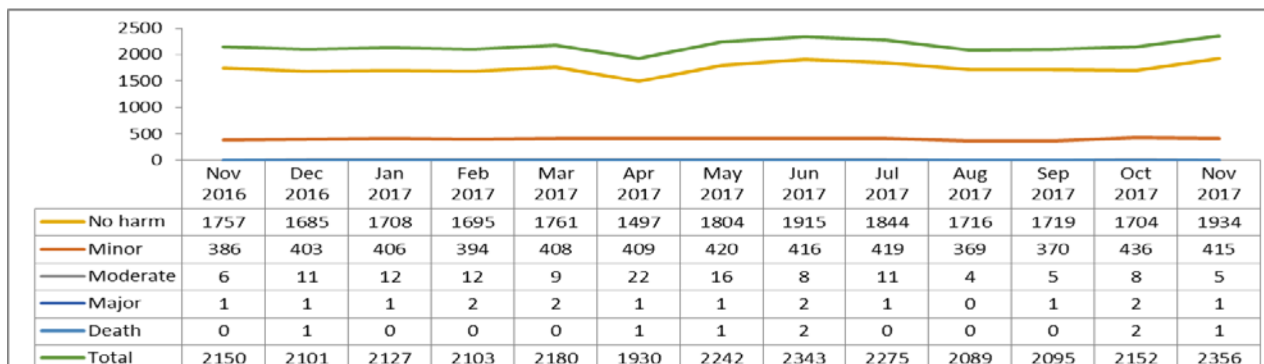
One Divisional investigation was declared in November and upgraded to a SIRI in the same month, this was following a review of the long-term effect on the patient; the harm level was also upgraded to major.

There were no Never Events declared in November 2017.

6 SIRI's were submitted within the agreed timeframe for closure to the OCCG in November 2017 and .6 SIRI's were closed by OCCG.

7.2. The following graphs provide an update on SIRI activity.

Chart 10: OUH incidents showing level of harm and total numbers for each level of harm.



	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017
No harm	1757	1685	1708	1695	1761	1497	1804	1915	1844	1716	1719	1704	1934
Minor	386	403	406	394	408	409	420	416	419	369	370	436	415
Moderate	6	11	12	12	9	22	16	8	11	4	5	8	5
Major	1	1	1	2	2	1	1	2	1	0	1	2	1
Death	0	1	0	0	0	1	1	2	0	0	0	2	1
Total	2150	2101	2127	2103	2180	1930	2242	2343	2275	2089	2095	2152	2356

Chart 11: SIRIs declared and completed in the last 13 months

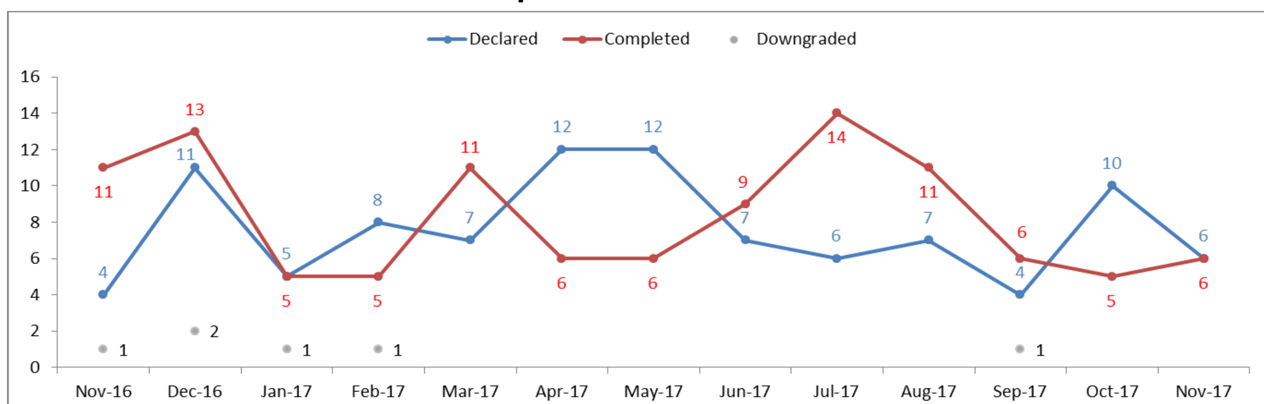


Chart 12: SIRIs declared by Division during last 13 months

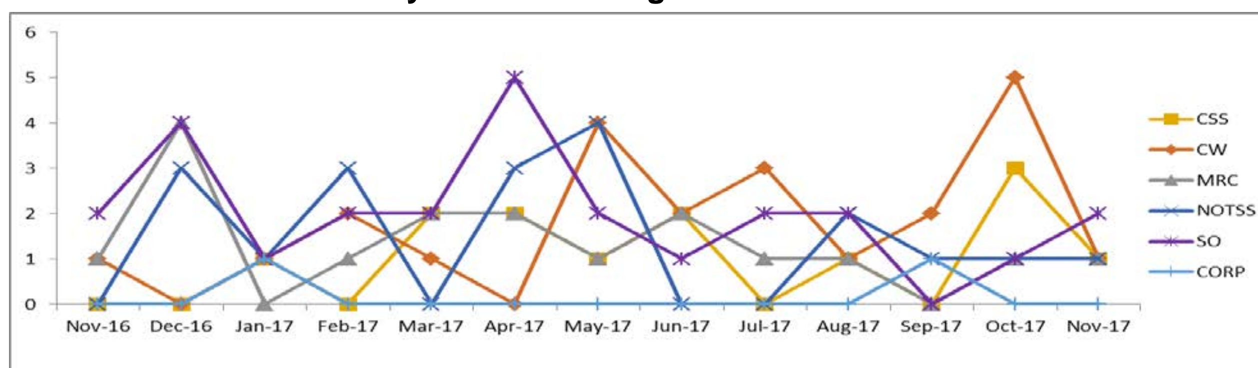


Chart 13: SIRIs declared by Hospital site during the last 13 months

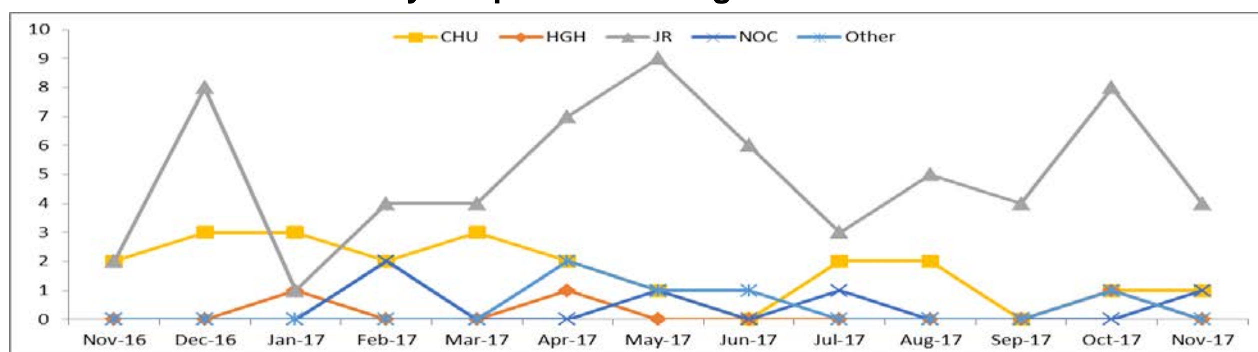


Table 5: SIRIs declared in November 2017

SIRI No	Division	Incident summary	Date incident detected	Reported date (Datix)	Date incident detected to date reported on Datix interval	Date declared as a SIRI	Reported date to declared as a SIRI interval
1718-059	CW	A baby deteriorated following surgery and required transfer for extracorporeal membrane oxygenation.	12/10/2017	24/10/2017	8	09/11/2017	12
1718-060	NOTSS	A patient had a peri-arrest following surgery after deterioration in recovery.	07/11/2017	08/11/2017	1	16/11/2017	6
1718-061	MRC	A trauma patient on warfarin developed a haematoma.	10/11/2017	10/11/2017	0	23/11/2017	9
1718-062	SO	A patient deteriorated and died after an aborted endoscopic intervention.	19/09/2017	13/11/2017	39	23/11/2017	8

SIRI No	Division	Incident summary	Date incident detected	Reported date (Datix)	Date incident detected to date reported on Datix interval	Date declared as a SIRI	Reported date to declared as a SIRI interval
1718-063	CSS	A critically ill ITU patient died after a nitric oxide circuit was dislodged.	17/11/2017	17/11/2017	0	23/11/2017	4
1718-064	SO	A patient received a chemotherapy drug intended for a different individual instead of their own intended chemotherapy.	21/11/2017	21/11/2017	0	23/11/2017	2

7.3. The incident detected date to the reported date on Datix was a mean of 8 working days with a median of 0.5 working days.

The reported date on Datix to the date a SIRI was declared was a mean of 5.8 working days with a median of 6 working days.

7.3.1. SIRI 1718-062, was reported 39 days after the incident occurred because it was declared following discussion in a morbidity and mortality meeting.

7.3.2. SIRI 1718-059 was initially declared as a Divisional investigation within 7 working days of reporting but then upgraded to a SIRI a few days later after further discussion with the directorate. The harm level was also upgraded to major.

Executive Quality Walk Rounds

7.4. The following 5 Executive Quality Walk Rounds took place in November 2017.

Table 6: Executive Quality Walk Rounds completed in November 2017

Hospital Site	Areas to visit
John Radcliffe Hospital	Adams & 7F (Trauma wards)
Churchill Hospital	Pain Management Centre
John Radcliffe Hospital	Oral-Maxillofacial Outpatients
Horton Hospital	Endoscopy Unit
John Radcliffe Hospital	Delivery Suite

Table 7: Executive Quality Walk Rounds cancelled in November 2017

Hospital Site	Areas to visit	Reason for cancellation and remedial action taken
John Radcliffe Hospital	Cardiothoracic Ward	Executive cancellation. Rearranged and completed on 14th December 2017

7.5. Key issues arising during the Quality Walk Rounds with the potential to affect quality or patient experience either positively or negatively included:

Oral-Maxillofacial Outpatients

7.5.1. The accommodation was noted to be tired and dated, including issues with equipment. Previous proposals to invest have been prohibitive but a business case has been approved to replace x-rays with digital x-rays. An issue around staffing retention and high staff turnover was highlighted.

Endoscopy Unit

7.5.2. The unit opened 14 months ago following full refurbishment - the patients and staff feedback is positive. The Staff room has information boards which are up to date; these include the current risk register and compliments for all staff to see. The Endoscopy user group meet twice monthly to discuss any issues relating to nursing, medical or administration.

Adams and 7F (Trauma Wards)

7.5.3. Following the wards relocation the Trust is awaiting a formal report with recommendations about how to bring the Trauma building into line with current fire compliance requirements. The medicines storage on Adams and 7F is sub-optimal; Adams Ward needs cupboards and work surfaces to be built and 7F needs the cupboard locks replacing. This work has been requested.

Delivery Suite

7.5.4. It was noted that refurbishment was needed and an assessment has been carried out. It was agreed to reiterate to the Estates team the importance of the environment to patient experience. The unit now has information boards in the staff room and nurse’s station sharing feedback regarding the recent incidents and the learning outcomes from these for staff.

Pain Management Centre

7.5.5. The service is focusing on supporting patients with the self-management of their chronic pain by providing pain education groups and has seen a reduction in their Did Not Attend rates following the introduction of the text messaging appointment reminder service. The C-arm x-ray machine needs replacing and it was agreed to review and escalate the replacement C-Arm in Divisional and corporate prioritisation of the Trust capital programme.

8. Learning from deaths

8.1. The quarterly report on Learning from deaths is covered in a separate paper to the Trust Board.

9. Clinical Audit

9.1. The following audits were presented at the Clinical Effectiveness Committee (CEC) in November 2017- there are no positive or negative exceptions to report:

9.1.1. NICE QS112 – Gastro-oesophageal reflux in children and young people audit

9.1.2. Trust wide Auto reporting audit

9.1.3. Pressure Ulcer Prevention Clinical Improvement Audit

9.1.4. Trauma Audit and Research Network (TARN) clinical audit

9.1.5. National Heart Failure Audit 2015/16

9.1.6. Senitnel Stroke National Audit Plan for December 2016 – March 2017 and April – July 2017 for the JR site.

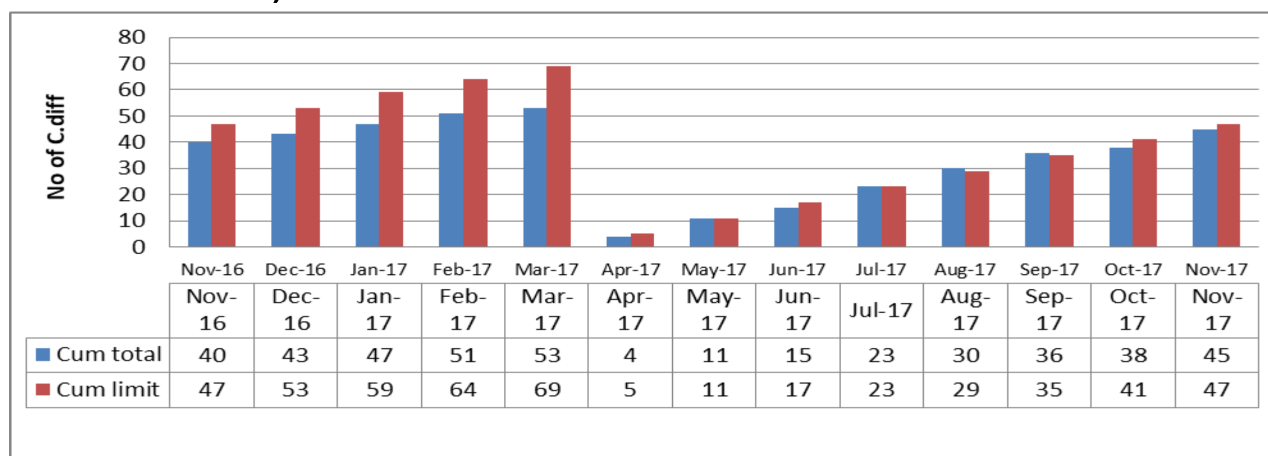
10. Infection Prevention and Control (IPC)

C.Difficile

10.1. The upper ceiling for OUH apportioned cases of C.diff for 2017 / 2018 is 69.

The internally set cumulative limit for the end of November 2017 was 47 cases; the OUH is currently on a total of 45.

Chart 14: Cases of OUH apportioned C.diff (post 72hrs) per month (November 2016 – November 2017)

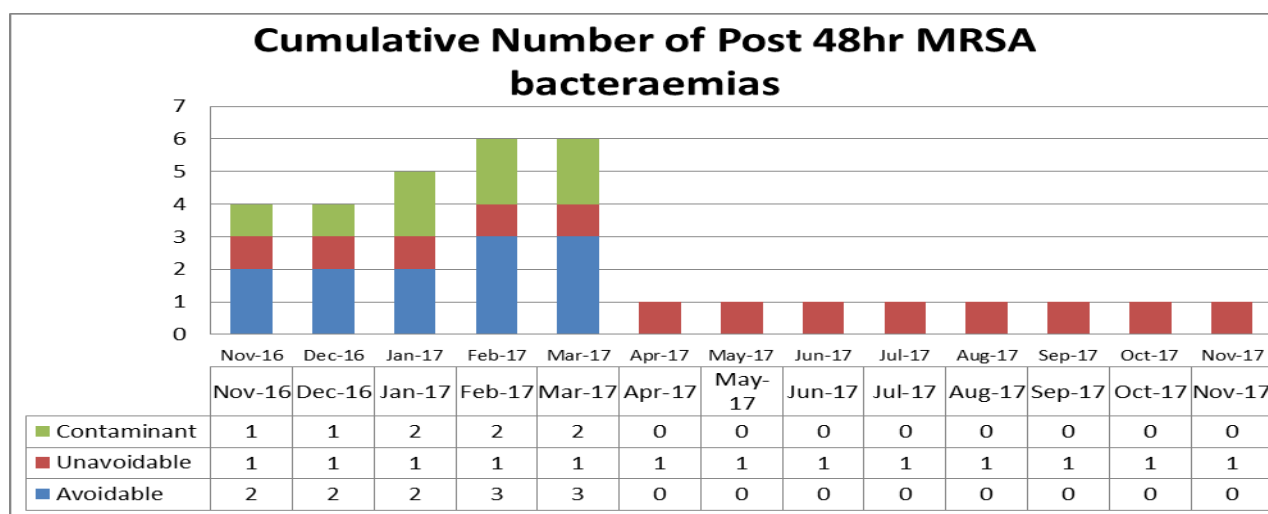


	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Cum total	40	43	47	51	53	4	11	15	23	30	36	38	45
Cum limit	47	53	59	64	69	5	11	17	23	29	35	41	47

Methicillin-resistant Staphylococcus aureus (MRSA Bacteraemia)

10.2. Year to date there has been one unavoidable MRSA bacteraemia in April.

Chart 15: Cumulative number of MRSA bacteraemias assigned to the Trust November 2016- November 2017

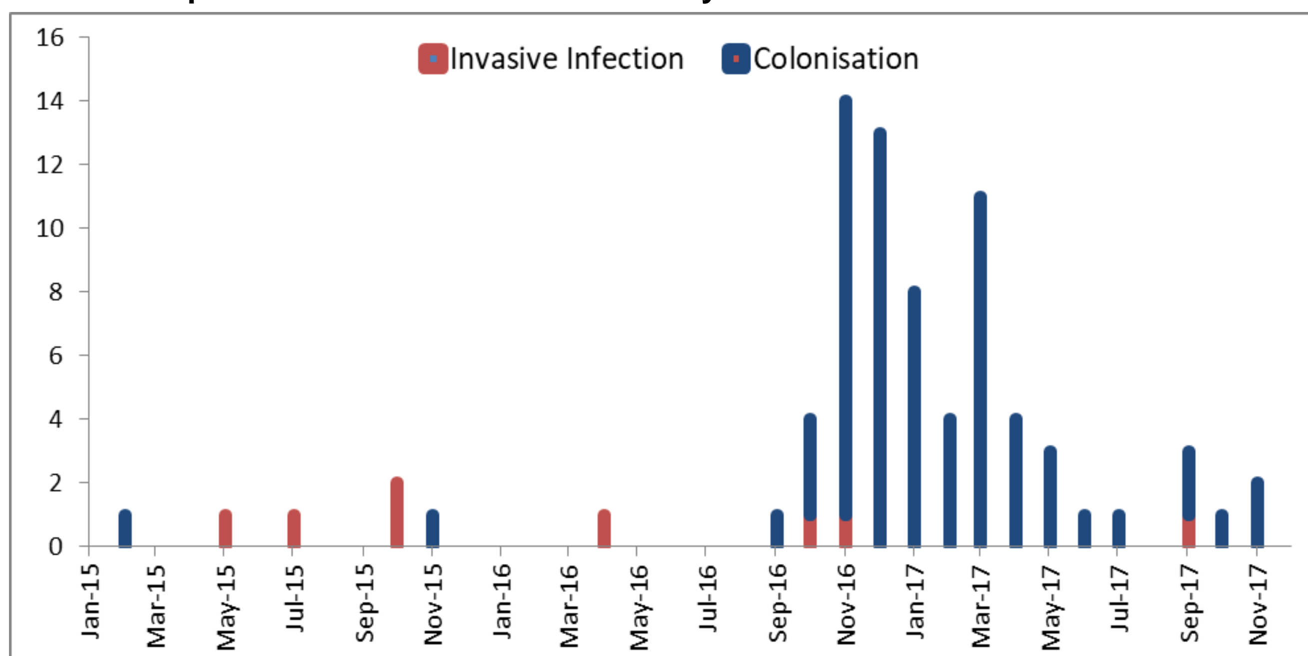


	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Contaminant	1	1	2	2	2	0	0	0	0	0	0	0	0
Unavoidable	1	1	1	1	1	1	1	1	1	1	1	1	1
Avoidable	2	2	2	3	3	0	0	0	0	0	0	0	0

Candida auris

10.3. There have been 2 new cases of patient colonisation with Candida auris on NITU in November.

Chart 16: Epi Curve for Candida auris January 2015- November 2017



Norovirus

10.4. During November Trauma 7F and Complex Medicine Unit (CMU) 7C wards experienced a norovirus outbreak.

This outbreak affected 10 patients and 3 members of staff on CMU 7C and 12 patients and 10 staff on 7F Trauma.

Surgical Site Infection

10.5. The EPR surgical site surveillance infection (SSI) tool went live in November and is being piloted in cardiac surgery, neurosurgery and hepatobilary surgery. The challenge at present is for nursing staff to make the switch from completing wound assessments on paper to on EPR. Ongoing education and training is being delivered by the IPC and Tissue Viability teams.

Enhanced surveillance of healthcare-associated Gram-negative bloodstream infections (GNBSI)

10.6. To support the halving of healthcare-associated Gram-negative bloodstream infections (GNBSI) by March 2021, NHS Improvement have recently extended the mandatory reporting to include Klebsiella species and Pseudomonas aeruginosa. The OUH have been voluntarily submitting this data since April 2017.

National data typically shows a Summer peak in the incidence of pre-48 hour (community associated) E. coli bacteraemia. This is thought to be due to poor hydration.

Chart 17: Pre-48 hours E.coli bacteraemia (April 2017 –November 2017)

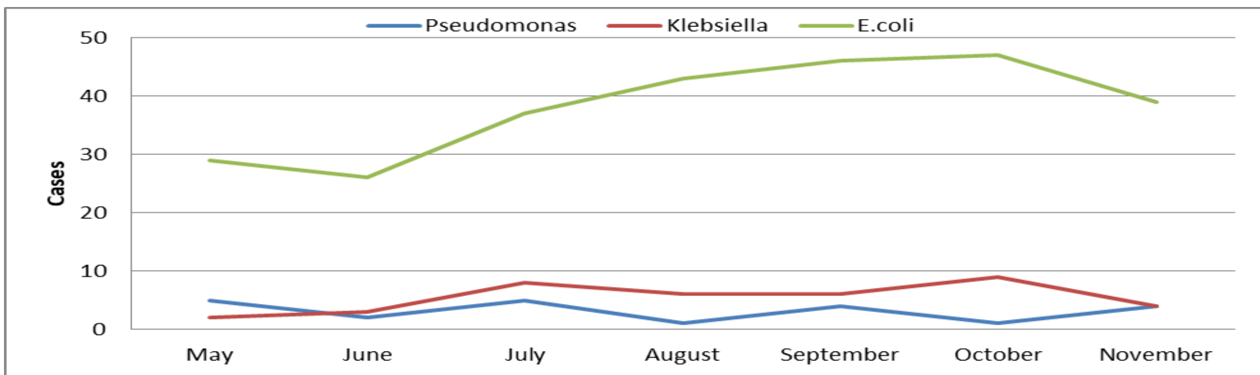
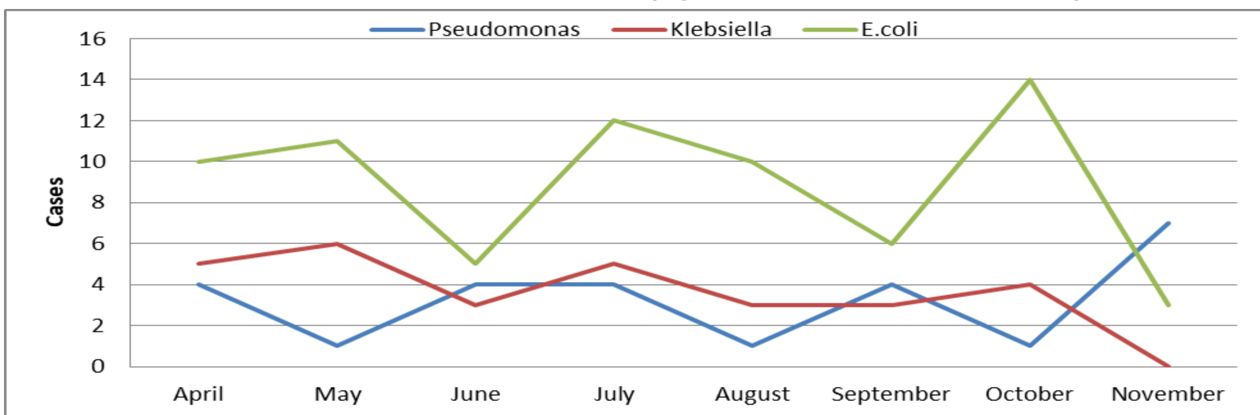


Chart 18: Post-48 hour E.coli bacteraemia (April 2017 –November 2017)

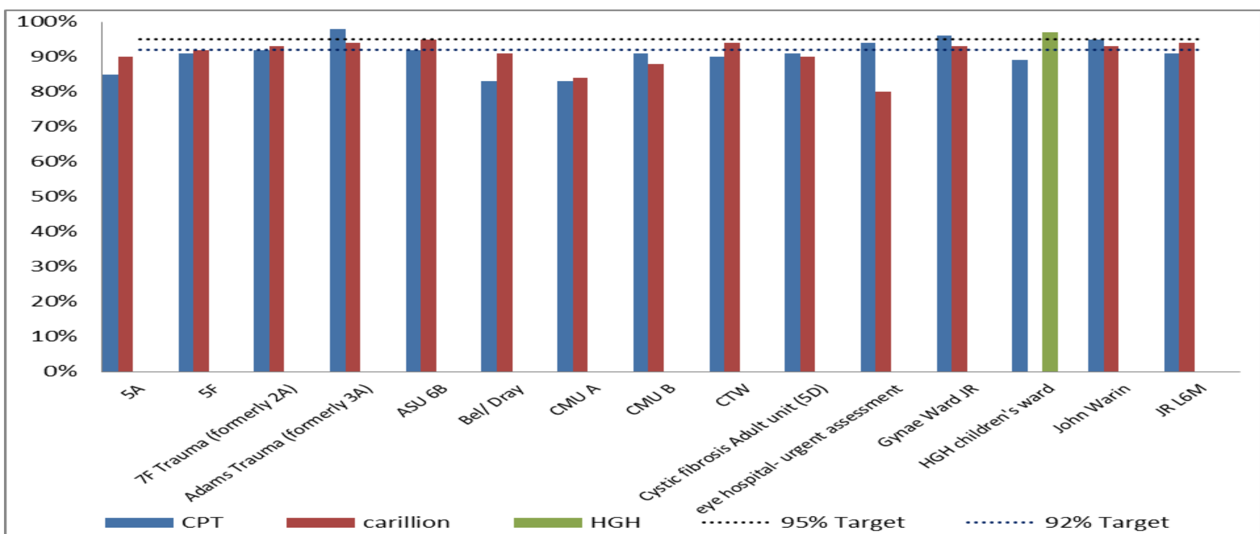


Cleaning Scores

10.7. Contract Client Team Cleaning Audit Scores versus Client Contract Team Target Scores for November 2017

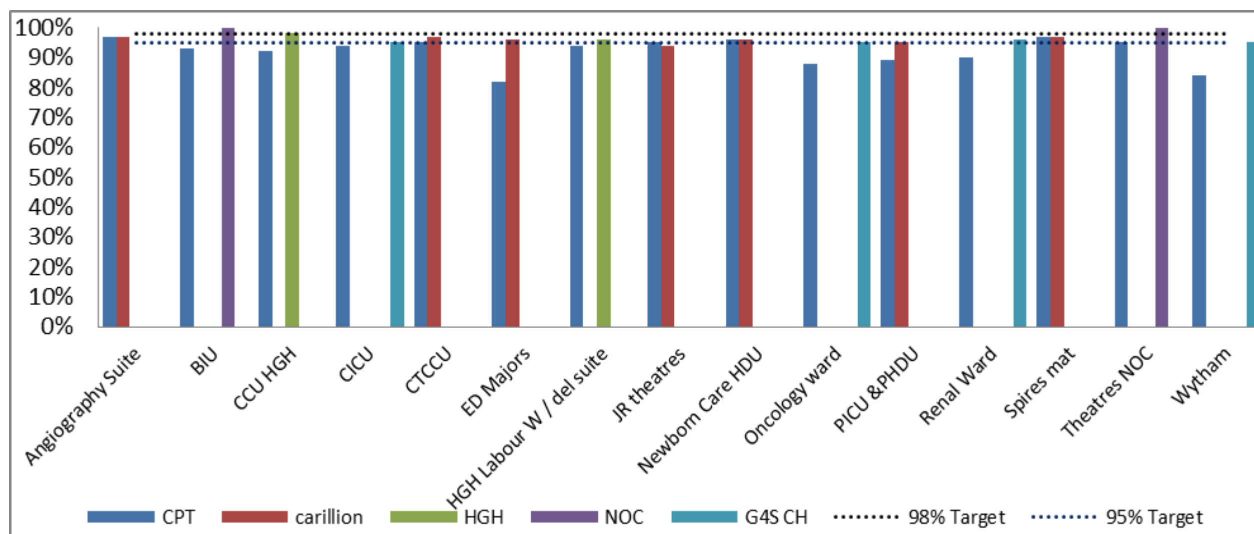
High Risk Areas (inpatient ward areas)

Chart 19: Contractors Threshold Score 92%, Client Contract Team Threshold Score 95%



Very High Risk Areas (intensive care areas, operating theatres)

Chart 20: Contractors Threshold Score 95%, Client Contract Team Threshold Score 98%



11. Patient Experience

Friends and Family Test (FFT)

11.1. There were no exceptions to report in November 2017.

Learning from FFT Feedback

11.2. The process for learning from FFT feedback is in Appendix 3.

Department with feedback for improvement

11.3. One of the Trust's main outpatient departments was selected as the area with feedback for improvement in November, as 5% of patients (15/333) reported that they were unlikely or extremely unlikely to recommend their care.

11.4. Appointments for patients from many specialties are held in this department. The key themes were:

- Waiting time in the clinic
- Communication issues
- Staff attitude issues
- Implementation of care

11.5. Patients' constructive comments for the department were fed back to the Operational Service Managers and Clinical Directors for each specialty referred to, in order to be fed back to the relevant consultants.

11.6. The Outpatient Department Sister and the Senior Clinical Coordinator have developed a plan to improve the way that waiting times are communicated to patients when they are waiting, to improve their expectation:

- Patients will be informed of any waiting times by reception staff when they book into their appointment.
- Patients will be kept updated of any changes every half hour.

Departments with excellent feedback

11.7. In the following departments, 100% patients were extremely likely or likely to recommend their care, with more than 20 responses and a 20% response rate or more:

- Maxillo Facial Day Surgery (also achieved over 90% extremely likely)
- 6C Short Stay Ward
- Cardiac Nuclear Medicine Day Case
- Urology Ward
- Oncology Ward
- Upper Gastrointestinal (UGI) Ward
- Neurology Purple area
- Ward 6B Stroke
- Respiratory Daily Diagnostic Unit
- Trauma (Ward 7F) (also achieved over 90% extremely likely)
- Transplant Wytham Outpatients (also achieved over 90% extremely likely)
- Children's Outpatients, Horton (also achieved over 90% extremely likely)
- Mayflower Suite (also achieved over 90% extremely likely)
- Physiotherapy Outpatients JR
- Lionel Cosin Day Hospital (also achieved over 90% extremely likely)
- Jackie Walton Vascular Studies Unit (also achieved over 90% extremely likely)

11.8. Wytham Urology Outpatients department was selected as the department with excellent feedback in November. 100% of patients recommended their care (60/60) and 95% were extremely likely to recommend their care (57/60). Key themes within the feedback were:

- Caring, friendly staff put patients at ease when they felt nervous while remaining professional.
- Excellent communication, with information being given in a way patients could understand, and questions fully answered.
- Welcoming reception staff.
- Efficiency, with patients seen on time or early for their appointments.

11.9. The department identified the following processes that help them to receive such excellent feedback:

- The team take the time to adequately prepare patients before their treatment.
- The nurses and support staff work together to make sure patients are well cared for.
- Strong team leadership. There is an open door policy where staff members are encouraged to talk to the team leader if they experience any issues. If there are issues between individuals, they are encouraged to talk to each other with the team leader mediating and facilitating the discussion.
- There are regular team meetings: each morning, to discuss tasks for the day; and once a week, for a more general discussion about the department.

11.10. However, there was one comment from a female patient who mentioned that she did not feel comfortable waiting in a mixed-sex waiting area in a hospital gown.

- Patients are routinely told that the waiting area is mixed sex and offered the opportunity to wait in a private room or the changing area. However, this will be reiterated in the next staff meeting, to ensure that this is made clear to patients, in case the comment reflects a misunderstanding.

11.11. The Deputy Chief Nurse has suggested the introduction of a peer review programme whereby matrons from departments with positive feedback on certain aspects of care could work with matrons who are struggling to achieve good feedback on the same issues.

Patient Experience Team projects:

11.12. An update on the team's progress on key projects is provided below:

Eye hospital project:

Following a meeting with the Matron for Specialist Surgery in November, the PET understood that there were four newly recruited volunteers in place, working on the busiest clinic days (Tuesday and Thursday). However, a department visit highlighted that there were fewer volunteers in the department than expected and that the days covered were not consistent. The Deputy Chief Nurse and Public Engagement Manager are working with the Matron for Specialist Surgery to ensure the maximisation of volunteers' roles, particularly in the context of staff shortages and capacity issues within the department.

12. PALS and Complaints

12.1. The PALS and complaints section centres on two issues raised by patients over the previous six months. These concerns have been resolved for individual patients, however, the problems within the system remain, meaning patients and relatives continue to raise issues of a similar nature.

Gynae-Oncology/Gynaecology

12.2. This service recently transferred to the management of W&C, from S&O. There are two issues which are currently affecting patients.

12.2.1. Delays in complaint issues being investigated and responded to within the required timescales. This was due in part to the complexities caused by the handover of the medical team to Gynaecology and the nursing teams remaining within S&O. A recently appointed Gynaecology Matron has consequently been tasked with investigating and coordinating the complaints

12.2.2. In addition, the Gynaecology surgical service is reporting there is now an eight month wait for elective surgery, which is causing concern for patients. To combat and alleviate this, the service is extending theatre lists, operating on Saturdays and working longer days.

Car Parking

12.3. Complaints and PALS have seen an increase in recent months with the number of concerns raised (x3 formal complaints, x4 PALS enquiries) regarding the car parking service. This relates, predominantly, to the rudeness of the staff in the car parking team, most often the issue will stem from the patient attempting to

pay to leave the car park. All staff in the team are to undergo Conflict Resolution training, if they have not yet completed this, to equip them to deal with vulnerable people in a more positive manner and the issues will continue to be monitored.

13. Safe Staffing – Nursing and Midwifery

13.1. The Trust is required to report nursing and midwifery staffing data for adult inpatient wards in acute hospitals. This report therefore includes the inpatient ward staffing data for November 2017.

National reporting for Inpatient Safe Staffing for November 2017

13.2. The summary of the figures submitted to NHS Choices via the Unify platform for November 2017 are included below and can be accessed via the Trust website on (http://www.ouh.nhs.uk/about/saferstaffinglevels.aspx).

This report incorporates the actual hours worked against the planned rostered hours for nursing and midwifery staff, for day and night shifts. These figures include all staff both permanent and temporary.

It is important to note that high levels of minimum staffing, and not just the 'at risk' shifts could impact on the quality of patient care, as well as staff morale, retention rates and turnover.

Unify data for November 2017

13.3. The Trust-wide fill rates of actual shifts against those planned (including the fill rates of temporary staff) are:

94.33% for Registered Nurses/Midwives

89.96% for Nursing Assistants (unregistered)

The Trust -wide dashboard illustrates the ward by ward RAG rated staffing levels (Appendix 5) for the day and night shifts

Overview of staffing levels

13.4. Vacancies, low temporary staffing fill rates, short notice sickness and short notice temporary staffing cancellations are all elements that have contributed to the 'at risk' and 'minimum' staffing levels reported in November. Mitigation of the risks associated with this continue to be the key priority several times a day. In addition the Divisional Nurses monitor staffing levels and skill mix weekly against workforce, capacity and activity, and any impact on quality metrics. Patient flow continues to be monitored closely with twice daily site based operational management reviews of the impact on the flow in the Emergency Department and performance. The Trust was successful in a winter monies bid to implement an incentive scheme for staff to work additional hours to maintain capacity predominantly across the JR site. A verbal report will be delivered by the Chief Nurse on staffing of temporary areas at the Board meeting.

Care Hours per Patient Day November 2017 (CHPPD) (Appendix 6)

13.5. This document highlights the number of care hours patients receive by registered nurse/midwife and nursing assistants within a 24 hour period. It is one of the recommendations within Lord Carter's review into productivity and efficiency, and is calculated by dividing the total number of actual nursing hours

worked, by the number of patients in bed at midnight over the month indicated. This is reported by ward nationally via the Unify platform.

The average levels of acceptable CHPPD nationally in more generic surgical and medical wards has been between 6-8 hours within a 24 hour patient day. The highest levels are in the intensive care units and high dependency care areas due to the requirement for 1:1 care for level 3 patients and 1:2/3 for level 2 patients.

Other Safe Staffing reviews

13.6. The Trust has carried out an exercise to review of the optimal levels of staffing within the John Radcliffe Hospital Emergency Department (ED) using a nationally validated patient acuity tool. This has been presented at TME at in December, and will now form part of a wider multi-professional workforce review.

13.7. The presentation of data provided in the Safe Staffing reports to Trust Board and the Quality Committee is currently under review, working with informatics to develop a more intuitive dashboard that identifies early areas of potential concern for staffing and quality. The inclusions of indicators such as Friends and Family test, complaints, appraisal rates and staff survey are planned in line with Lord Carter's recommendations. This will also fulfil Magnet recommendations.

13.8. The 6 month inpatient ward establishment review, (Appendix 4), was carried out in line with the NICE Safe Staffing for Inpatient Areas, (2014), guidelines. All areas were found to have the correct establishments following this review and no changes were made.

14. Recommendations

14.1. The Board is asked to receive this Quality Report.

Dr Tony Berendt, Medical Director
Sam Foster, Chief Nurse

Report prepared by:
Andrew Carter, Associate Chief Nurse for Workforce
Helen Cobb - Head of Clinical Governance
Dr Clare Dollery - Deputy Medical Director
Caroline Heason - Safeguarding & Patient Services Manager
Liz Wright – Deputy Chief Nurse

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)