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On 1st November 2011 Oxford Radcliffe Hospitals (ORH) merged with the Nuffield Orthopaedic Centre (NOC) to form the Oxford University Hospitals NHS Trust (OUH). Despite the short-term operational challenges in terms of integrating services and processes, the quality, effectiveness and safety of patient care and patient experience remains at the centre of all we do at the Oxford University Hospitals NHS Trust. Quality is a key focus for the Trust Board. We call this ‘Delivering Compassionate Excellence’ – the kind of care you would like for yourself or your family if you needed health care.

As part of Delivering Compassionate Excellence and as part of the integration process, we reviewed our Trust values with staff, patients and partners. Feedback was received from over 750 people and our new core values of Excellence, Compassion, Respect, Delivery, Learning and Improvement, reflect the basis of how we expect individuals, teams and the Trust to behave, communicate and deliver our services so that there is a strong values-based approach in all aspects of our work.

This is the first Quality Account of OUH; however it is clear we have made progress since publishing Quality Accounts for Oxford Radcliffe Hospitals and Nuffield Orthopaedic Centre in June 2011.

The ORH and NOC had been working together for many years prior to the merger. We recognised risks associated with the transition, prior to the merger, and these were addressed within the Trust Management Executive to specify roles and responsibilities required to ensure effective local implementation of service delivery, while at the same time meeting Trust-wide objectives.

Staff from both ORH and NOC organisations worked throughout 2011/12 to make the merger into OUH happen whilst ensuring the delivery of high-quality care was maintained and remained a priority for all our staff. Our goals of providing the best outcomes, best patient experience and best use of taxpayers’ money are shared and we believe that the formation of Oxford University Hospitals NHS Trust provides a fantastic opportunity for us to contribute to the improvement of the health of our community through quality, innovation and financial sustainability, all underpinned by our core Trust values. We will continue to work in partnership with GPs and partner organisations, to provide high-quality health services, support self-care, innovate to deliver best practice, educate the next generation of clinicians and be a preferred NHS employer.

We believe some of the practical benefits of the merger that will be realised in the short to medium term include:

- a single integrated pathway for patients with spinal problems;
- enhanced rehabilitation services for patients who have suffered traumatic injuries;
- efficiencies in the physical estate of the Trust releasing resources for other purposes;
- increased opportunities to improve interfaces with primary care.

“Quality is a key focus for the Trust Board. We call this ‘Delivering Compassionate Excellence’…”

Statement on quality from the Chief Executive
During 2012/13 the Trust will prepare for Foundation Trust status and we recognise the challenge that lies ahead. The Trust must be financially robust, meeting the operational standards set by the NHS and commissioners, and be seen as the provider of choice for GPs, Clinical Commissioning Groups and patients.

This report outlines some of the activities which we undertook during 2011/12 to improve all aspects of quality and gives our priorities for quality improvements during 2012/13.

The improvements that have been delivered would not have been possible without the commitment and dedication of the staff of the Trust who have worked hard to improve the experience and the outcomes for patients who use our services.

Critical to the ability of the Trust to live up to its commitment to ‘Delivering Compassionate Excellence’ is the ability to deliver technically high-quality clinical care, efficiently and in a manner that recognises the needs and vulnerabilities of patients experiencing illness or injury. The overall patient experience is a critical measure of our success in delivering our commitments. We will consolidate work on the areas identified as priorities in last year’s Quality Account as well as focus on our new priorities. This account therefore includes information relating to last year’s performance against national and local quality measures, as well as identifying our priorities for 2012/13.

The Trust, working in an ever changing healthcare environment, has faced operational and financial pressures which make it all the more important to maintain the focus on safe patient care whilst delivering the required efficiencies and cutting waste, without impacting on patient outcomes.

The Trust has met its financial targets for 2011/12 with a surplus of just over £7million after delivering savings of £55million during the year:

Operational performance during 2011/12 remained satisfactory. More than 95% of patients seen in the Emergency Departments across the Trust were seen and discharged or admitted within four hours of arrival. The Trust achieved the national standard of 95% and 90% of outpatients and inpatients respectively, being treated within 18 weeks of referral. The Trust has also met the two week timescale for urgent cancer-related referrals. However, the 62 day referral to treatment time in respect of screening programmes is currently 1% below the target level of 90%. Service changes are being implemented to ensure that this performance improves.

In December 2011, the Trust implemented a new information system to deliver an electronic patient record (EPR) at its John Radcliffe, Churchill and Horton General Hospital sites. The system was already in use at the Nuffield Orthopaedic Centre. The EPR will ultimately improve the efficiency and safety of services for patients as it will support real-time clinical documentation and provide data for analysis which have the potential for improving efficiency and effectiveness of services. However the introduction of such a major change led to temporary data quality issues which we are actively addressing.

We were pleased that in March 2012 we were allocated £2.8million by the Department of Health towards the expansion of the Newborn Intensive Care Unit (NICU) at the John Radcliffe Hospital. The plan is to double the number of intensive care cots from 10 to 20 in order to improve services for babies across the Thames Valley. It is hoped that work will start on the new unit later on this year and that it will be open early in 2013.

The Board continues to undertake quality visits to wards and departments around the Trust which provide an opportunity for members of the Board to assess the effectiveness of the services delivered with a particular emphasis on their quality and safety. Services based at the NOC were incorporated into the programme after the merger. The Board recognises that raising awareness of risk and safety amongst staff, in particular our clinical staff, will lead to an increase in identification of untoward or avoidable events which in turn will result in a safer environment for patients.
Focusing on what matters to our patients and learning from the experience of people who come into contact with OUH provides a valuable source of information. This helps to inform us not only about the things we do well but also ensures there is an awareness of those areas where improvement is necessary. We have many different mechanisms for obtaining feedback and the Trust strives to ensure that departments take action to correct weaknesses that are identified. An open event was held for patients and members of the public to tell us what matters to them and this helped to inform the key quality priorities for 2012/13.

Learning from others, benchmarking performance with other hospitals, participating in national audits playing a leading role in translational research and implementing best practice are also important mechanisms by which the quality of services is improved. The Trust has participated in more than 40 national audits and other major studies, including audits on cancer, heart disease, diabetes and dementia. We contribute to data for the National Confidential Enquiries into Patient Outcomes and Deaths (NCEPOD) and Patient Related Outcome Measures (PROMs). I am proud that four of our Junior Doctors won the Junior Doctor Clinical Audit of the Year for 2011 and presented their work at the International Forum for Quality and Safety in Healthcare in Paris in the spring of 2012.

This Quality Account from Oxford University Hospitals NHS Trust is intended to improve the Trust’s accountability to the public for the quality of care provided and to demonstrate the continuing commitment of the Board and the staff of OUH to deliver high-quality care through reliable and safe systems and processes.

Sir Jonathan Michael, FRCP
Chief Executive

Statement from the Chairman

The Board of the Oxford University Hospitals remains committed to the delivery of the highest possible quality of care to our patients within the available resources. I have reviewed the content of the Quality Account and confirm its accuracy.

Dame Fiona Caldicott, FRCP
Chairman
Statement of Directors’ Responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Account (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Account) Regulations 2010 (as amended by the National Health Service (Quality Account) Amendment Regulations 2011).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust’s performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review;
- the Quality Account has been prepared in accordance with Department of Health guidance.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

[Signatures]

Date: 26 June 2012.  Chair

Date: 26 June 2012.  Chief Executive
Summary of priorities for 2011/12

LOOKING BACK:
Review of priorities for 2011/12

The following section summarises the priorities stated in each Quality Account from the Oxford Radcliffe Hospitals NHS Trust (ORH) and the Nuffield Orthopaedic Centre NHS Trust (NOC) agreed prior to their merger in November 2011.

Further details can be found on pages 38-52.

## Quality Account priorities for 2011/12

### PATIENT SAFETY

<table>
<thead>
<tr>
<th>Priority</th>
<th>Status</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>The VTE target of 90% assessment (ORH)</td>
<td>not met</td>
<td>An average rate of 78.35% for OUH over the year, improving to 88.8% for the month of March 2012. VTE risk assessment rates at the Nuffield Orthopaedic Centre were in excess of 90% throughout the year.</td>
</tr>
<tr>
<td>Pressure ulcer reduction (ORH)</td>
<td>met</td>
<td>35 Category 3 and 4 pressure ulcers in 2011/12, 56 recorded in 2010/11.</td>
</tr>
<tr>
<td>Improving medicines safety (ORH)</td>
<td>met</td>
<td>Improved focus on insulin management through audit of practice, staff education, strengthened prescribing and revised guidelines</td>
</tr>
<tr>
<td>Infection control targets (NOC)</td>
<td>partially met</td>
<td>NOC met MRSA but exceeded C-Diff by one case.</td>
</tr>
<tr>
<td>Safer care in theatres (NOC)</td>
<td>partially met</td>
<td>95% operations to start on time not achieved. Safer fluid management achieved. WHO surgical safety checklist – 100% compliance at NOC</td>
</tr>
</tbody>
</table>

### CLINICAL EFFECTIVENESS

<table>
<thead>
<tr>
<th>Priority</th>
<th>Status</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality reduction (ORH)</td>
<td>partially met</td>
<td>Small reduction but further actions in place.</td>
</tr>
<tr>
<td>Enhance clinical pathway re-design (NOC)</td>
<td>partially met</td>
<td>Limited progress with integrated spinal pathway – Reflected in CQUIN for 2012/13. Hip and knee pathways fully implemented</td>
</tr>
<tr>
<td>Quality improvement through PROMs (NOC)</td>
<td>met</td>
<td>Extended to encompass all spinal and physiotherapy patients.</td>
</tr>
<tr>
<td>Improved radiology times (NOC)</td>
<td>partially met</td>
<td>Partially met but further actions in place to ensure sustained improvements.</td>
</tr>
<tr>
<td>PATIENT EXPERIENCE</td>
<td>Status</td>
<td>Details</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
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<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Improving communication (NOC and ORH)</td>
<td>partially met</td>
<td>Combined IT system being considered for combined Trust to collect patient feedback electronically. Protocols in place for cancelled operations. Actions in place following patient surveys.</td>
</tr>
<tr>
<td>Discharge within 2 hours of decision to discharge (NOC)</td>
<td>not met</td>
<td>Ongoing work to improve discharge process.</td>
</tr>
<tr>
<td>End of life care (ORH)</td>
<td>partially met</td>
<td>Ongoing work to identify and address the needs of the dying. CQUIN and Quality Account priority for 2012/13.</td>
</tr>
<tr>
<td>Screening for dementia and delirium in emergency admissions (ORH)</td>
<td>partially met</td>
<td>Improved staff training and introduction of screening.</td>
</tr>
<tr>
<td>Patients with learning disabilities (ORH)</td>
<td>met</td>
<td>Launched hospital passport and alert stickers for patient records.</td>
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Highlights and innovation in 2011/12

**Clinical Audit Award**

As part of their training, Junior Doctors undertake clinical audit and quality improvement projects. In 2011/12 four Junior Doctors undertook a clinical audit to see whether Acute General Medicine was achieving the national target of assessing 90% of patients for their risk of venous thromboembolism (VTE).

When they discovered that performance was not as good as it should have been, they instituted measures to influence the process and documented steady improvement to the desired level over several cycles of clinical audit and intervention. Their project won the National Junior Doctor Clinical Audit of the Year for 2011 and was presented at the International Forum for Quality and Safety in Healthcare in Paris in the spring of 2012.

**CASE STUDY**

**Same day admission for Heart Surgery**

Over the last year a pilot project has been ongoing to permit selected patients due for heart surgery, to be admitted on the day of the operation. This initiative aimed to reduce the length of time patients spend away from their family and loved ones, and reduce some of the anxiety they naturally have before a major operation. Of benefit to a busy department with a large throughput of patients, it also allows for more efficient usage of beds, so more patients can have their operations and there are fewer cancellations. Day of surgery admission is not suitable for all patients; approximately one in ten may be admitted by this route. So far it has been very well received by patients, and we are currently asking patients who have been through the process what they thought of it so that we can deliver excellent patient-centred care.

“In my experience patients have been extremely enthusiastic about admission on the day of surgery. Without exception, everyone who has been offered this option has taken it, and the system has run smoothly. We are in the process of evaluating this change so that we can make it the best it can be for patients.”

(Consultant Cardiac Surgeon, Oxford Heart Centre)

**CASE STUDY**

**John Radcliffe designated a Major Trauma Centre**

The John Radcliffe Hospital (JRH) has been designated as a Major Trauma Centre as part of Government plans to consolidate trauma services into networks. JRH became a Major Trauma Centre for Thames Valley region from 2 April 2012, and will provide direct access to specialist teams and state-of-the-art equipment to ensure the most seriously injured and complex patients receive immediate treatment, 24 hours a day, seven days a week. JRH will be supported by a network of other hospitals with smaller trauma units. When it is not possible to reach JRH within 45 minutes, or where the patient needs to be stabilised quickly, the patient will be taken to the nearest hospital with a trauma unit for immediate treatment and stabilisation before being transferred on to JRH. Once discharged from JRH, local trauma units will provide ongoing treatment and rehabilitation for patients. The Trust is investing in staff and equipment over the next six months to support the development of the Major Trauma Centre.
Clinical Psychology for Appearance Related Concerns

Within the Russell Cairns Unit our dedicated clinical psychology service for appearance related concerns has contributed to two National Commissioning Group (NCG) funded specialist teams: the Oxford Craniofacial Unit and the Spires Cleft Lip and Palate Service. This has recently expanded to include provision into a specialist Neurofibromatosis service. The psychologists provide input such as:

- Cognitive and developmental assessment
- Adjustment to diagnosis or treatment
- Preparation for treatment and procedures e.g. anxiety management, psycho-education
- Assessment and intervention for social and emotional difficulties e.g. teasing and bullying, self-esteem, low mood
- Support for decision making and managing hopes and expectations
- Consultation and liaison with other colleagues, both internal and external to the Trust.

We are involved in several research projects including how parents respond to children with cleft palates, and cognitive outcomes in three year olds with craniofacial conditions, which we presented at national and international conferences. We have also developed a DVD with and for young people around the experience of having an alveolar bone graft procedure.

£2.8million for expansion of JR’s Newborn Intensive Care Unit

OUH has been given £2.8million by the Department of Health towards expanding the Newborn Intensive Care Unit (NICU) at the John Radcliffe Hospital (JRH). The plan is to double the number of intensive care cots from 10 to 20 in order to improve services for babies across the Thames Valley. JRH NICU is the designated centre in the Thames Valley Region for providing newborn intensive care support for the most severely ill or premature babies who need significant medical interventions, life support machines and/or surgery to survive. The expansion will be phased to match demand and allow for the appropriate recruitment and training of staff. It is hoped that the new expanded unit will be open early in 2013.

Digital breast screening service – first in region to introduce this

Digital mammography is being implemented across the breast screening programme in the UK and we are the first trust in the region to introduce this service to our patients. Digital breast screening uses computer imaging techniques to produce a much clearer picture of the glandular tissue in the breast which means that significantly more breast cancers can be diagnosed. In addition the digital images are instantly available for doctors to view using a digital reader and this enables faster diagnosis and treatment for those patients with breast cancer.
Oxford Oncology Triage Assessment Team

More than 1,800 cancer patients have benefited over the past year from a new service at the Triage Assessment Area (TAA) in the Cancer and Haematology Centre at the Churchill Hospital. The TAA offers dedicated specialist advice and treatment and a telephone support line. The initial assessment by the TAA takes place over the telephone; patients can call if they are unwell and be reassured they are talking directly to one of the team’s specialist cancer nurses.

Since it opened, the team has seen positive changes in the overall efficiency and cost effectiveness of emergency care within cancer services, including reductions in inappropriate admissions and length of stay, improved times from admission to assessment and treatment, and improvements in the overall patient experience. The service has helped to ensure patients are supported when they need advice and has reduced workload for GPs and emergency services. The service currently runs weekdays. However, due to the service’s success it will be expanding to weekends too.

Cardiac outcomes in the Improving Quality Programme (IQ)

The Improving Quality (IQ) Programme facilitates improvement in the quality and efficiency of patient care by implementing a standardised set of quality measures to evaluate individual Trust performance across clinical pathways: heart attacks (acute myocardial infarction – AMI), heart failure (HF), and coronary artery bypass graft (CABG). A total of 10 trusts were included in the analysis and the participating hospitals were all part of the South Central Strategic Health Authority. We are pleased with the excellent results for our Trust particularly for the Heart Failure Specialist Team who audited twice as many patients as other trusts and had the shortest length of stay. (Please note that the Oxford University Hospitals NHS Trust is abbreviated as OUH in the graphs below).
Priorities for improvement for 2012/13

Our quality improvement priorities for 2012/13 are divided into three areas.

➤ Patient safety
➤ Clinical effectiveness
➤ Patient experience

Interwoven into these priorities is the need to continue to improve both our customer care and the way we communicate with patients, as identified at the Public Engagement Event on 12th March 2012.

IN SUMMARY:
The quality improvement priorities for 2012/13 are:

Patient safety
- Safe medicines delivered on time

Clinical effectiveness
- Innovation to support better care

Patient experience
- Improving end of life care
- Delivering compassionate excellence

Patient safety
Safe medicines delivered on time

Medicines reconciliation
This is a process designed to ensure that all the medication that a patient is currently taking is correctly documented on admission and at each transfer of care. This encompasses collection of the medication history from a variety of sources, checking that medicines prescribed on admission for the patient are correct and communicating any changes, omissions or unintentional discrepancies to the next person(s) caring for the patient. The process of medicines reconciliation should involve members of the multidisciplinary team led by the pharmacy.

We are working hard to ensure our process of ‘medicines reconciliation’ are robust and modern to ensure efficiency and patient safety. We aim to deliver medicines reconciliation promptly after admission.

Medicines to take home
Feedback from patients has indicated there are delays in receiving medication to take home on discharge. To improve the speed at which patients receive their medication and to ensure this is performed safely, we are taking the following steps:

- Pharmacy will be installing a new robot at the John Radcliffe to dispense medication more efficiently and rapidly. After the installation of the robot we will focus on other aspects which involve the whole multidisciplinary team in order to improve the time between the ‘decision to discharge a patient’ and the actual ‘time of discharge’ from hospital. This will include the completion of discharge documentation by medical teams the day before discharge where possible.

- We are pioneering the use of iPads to communicate the prescription to Pharmacy. Initial feedback has indicated that the time from prescription to delivery of medicines using iPads has been greatly reduced. We will monitor this closely through the Pharmacy Directorate Executive and report our findings to our commissioners.

Medicines storage and security
The safety of medicines is an essential part of patient safety.

- To protect patients our internal policies reflect the guidance from the Department of Health and standards set out by the Royal Pharmaceutical Society ¹. Over the first part of 2012/13 we will audit our performance in relation to medicines safety and security. We will report the findings to the Medicines Safety Group and make improvements where they are required.
In addition as part of the Electronic Patient Record project the Trust will be deploying advanced ePrescribing and Medicines Administration which is built into the software. The likely first areas to deploy this functionality will be the Neonatal and Neuroscience intensive care units and preparatory work is ongoing.

**Monitoring of this priority will be reported to the Clinical Governance Committee on a monthly basis as a standing agenda item. Regular reports will be taken to the Board by the Medical Director.**


*The Safe and Secure Handling of Medicines: A Team Approach.*

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**Clinical effectiveness**

**Innovation to support better care**

Demand for healthcare increases year on year and this trajectory is set to continue as the population ages. Not only do healthcare organisations see and treat more patients, the patients whom they do treat tend to have ever more complex problems. We need to explore all that technology can offer to assist us in order to make healthcare more efficient and to manage medical conditions effectively in the homes of patients.

Oxford is well placed to take a lead in the development and testing of technical innovations in healthcare with extensive experience and expertise within the Trust, the Comprehensive Biomedical Research Centre and the University of Oxford.

During 2012/13, Oxford University Hospitals will work in conjunction with academic partners to rollout two specific technologies.

**Electronic early warning systems**

The NHS uses various systems to monitor the vital signs of patients in hospital. In cases where the condition of a patient deteriorates, there will often have been a period of time during which vital signs (pulse, blood pressure, breathing rate) have been changing. Identifying these changes, which may be subtle, early, may offer an opportunity to intervene and prevent clinical deterioration. These early warning systems rely upon manual observations, calculation and the decision of a practitioner to trigger an action: all three steps can result in error and inaccuracy.

Electronic track and trigger is a project which makes use of handheld and bedside computers to record vital signs, make calculations automatically and prompt specific actions from the healthcare team. Storing observations in electronic form also permits research to improve the mathematical algorithms used. This technology has been developed locally and will be implemented initially in the Trauma service over the course of 2012/13.

**mHealth**

Mobile telephones and smartphones are ubiquitous in modern society and present major opportunities for transforming aspects of healthcare delivery. At the Patient Engagement Event in March 2012 we were asked to explore other means of communication besides sending letters that embrace technology and patient convenience such as the use of mobile phones and email systems. Many patient groups who currently attend hospital clinics to manage their conditions could use mobile phone technology (mHealth) to assist in the management of their conditions, avoid hospital visits and gain empowerment in relation to their own health. One such group of patients is those women who develop diabetes during pregnancy.

During 2012/13, we will undertake a pilot of mHealth technologies to assist pregnant women in managing gestational diabetes from their own homes, with virtual support from the hospital’s multidisciplinary team.

**Monitoring of this priority will be reported to the Clinical Governance Committee on a monthly basis as a standing agenda item. Regular reports will be taken to the Board by the Medical Director.**
Improving end of life care

Improving the experience of patients reaching the end of their lives, and that of their carers, was a priority area in 2011/12. Whilst we made some progress, we recognise that the scale and complexity of end of life care is such that further work is required. We think that patients known to be coming towards the end of their lives should have the opportunity, where practical, to die in a place of their choosing. We believe that too many people in this position currently die within Oxfordshire’s acute hospitals. In addition, we believe that we could do more in the acute sector to recognise patients who are likely to be coming to the end of their lives and communicate with them and their carers more effectively. In doing this, we aim to ensure that patients, where they wish to do so, retain a greater degree of control and choice in relation to decision making and forward planning.

Over the course of 2012/13, we have identified three specific work streams:

Care of the dying

We shall continue to support the use of the Liverpool Care Pathway in addressing the needs of those who are thought to be dying imminently in selected clinical environments across the Trust. We shall continue to explore the best way in which to access single rooms for patients who are dying where this is desired by the patient or family. We need to balance this goal with our need to manage infection control issues effectively. We shall design and implement a discharge checklist for use where the care of patients who are thought to be dying imminently is transferred from the acute hospital to a more appropriate team. We anticipate that this checklist will ensure that this transfer of care occurs smoothly and all necessary plans (for example, provision of medicines and equipment on an ongoing basis) are in place.

Identification of those who may be coming towards the end of their lives

Many patients have frequent contact with hospital services in the year leading up to death including those with chronic but deteriorating conditions. Where a pattern of increased illness and frailty can be identified, there is an important opportunity for the multidisciplinary team to discuss the overall care plan with the patient, and where appropriate, carers. Such discussions can assist patients in making their own plans and permit decision making in relation to the level of medical intervention that the patient would wish to receive in the future, the appropriateness or otherwise of resuscitation, the patient’s preference
as to where he or she might die, and the place for an advance directive should mental capacity become impaired. We aim to pilot and implement a local tool, based on the AMBER Care Bundle developed in London, to prompt the identification of patients who may be in the final phase of their lives, followed by discussion, and communication, of that discussion to other stakeholders (including, for example, the General Practitioner).

**Joint working**

We will ensure that the OUH end of life care group works in close collaboration with NHS Oxfordshire’s end of life care reference group.

Monitoring of this priority will be reported to the Clinical Governance Committee on a monthly basis as a standing agenda item. Regular reports will be taken to the Board by the Medical Director.

**Delivering Compassionate Excellence**

Compassionate excellence is the kind of healthcare you expect for yourself and your family. We aim to provide excellent care with compassion and respect and also to deliver, learn and continuously improve. The recently agreed Trust Core Values of Excellence, Compassion, Respect, Delivery, Learning and Improvement will be used to inform our recruitment, induction, appraisal and leadership practices as well as our general communication and customer care.

This work is being taken forward through our Values into Action programme. This is to ensure that a values-based approach is taken in our practice, our behaviours and our processes so that our Trust Core Values are demonstrated in all aspects of our work. An example of this will be ensuring that our Trust Values and approved behaviours are key elements in developing our new customer care training, to ensure that it supports our aim of delivering positive patient experience.

We recognise that there is a significant nursing contribution to Delivering Compassionate Excellence and in 2012/13 we will bring together a number of workstreams linked to our Trust Values in order to further develop nursing care and culture.

- **Health Care Support Worker Academy.**
  ✓ We will launch the academy in 2012/13.
  ✓ Recruitment to this academy will be based on our values to reflect the fact that this group of staff deliver care.
  ✓ We will measure outcomes of the 1st cohort i.e. experience, skill and competency / patient care standards.

- **New Ward Manager Leadership Development Programme Safe in our Hands**
  - aimed at ensuring frontline leaders have the capacity and capability to lead. This will:
    ✓ deliver productive ward modules
    ✓ incorporate competencies and skills assessments
    ✓ evaluate impact on quality metrics and team measures incorporated within the programme.
    These metrics are:
    - documentation of evidence
    - hydration/nutrition assessment and compliance
    - privacy and dignity
    - estimation of Expected Discharge Date (within four hours of admission to hospital)
    - analysis of breaches of the expected discharge date.

- **Developmental ward programme delivered with our academic partners. It will:**
  ✓ provide a framework for the delivery of a developmental programme for ward areas, aligned with the Trust quality objectives and patient experience strategy
  ✓ be supported by an academic partner (providing coaching and challenge).
We have updated our Nursing and Midwifery Standards; a set of 12 standards with supporting nursing actions. These statements express our commitment to delivering excellence to our patients.

A corresponding set of promises has been agreed as Our Promise to Patients aimed at providing reassurance to patients and the public of our commitment to deliver excellence. Printed cards containing the standards have been given to all nursing, midwifery and support staff and posters displayed in appropriate areas of the Trust. We will ensure that welcome boards are in place at the entrance of each ward on all four sites this year. The boards will display pictures of the team and will display the commitment of the team to each patient.

Monitoring of this priority will be reported to the Clinical Governance Committee on a monthly basis as a standing agenda item. Regular reports will be taken to the Board by the Medical Director.

Delivering Compassionate Excellence

Matron for Specialist Surgery at the Trust explained how she has been working with the team of matrons across the Trust on promoting the standards to both staff and patients. She explained how these standards link in closely with the Delivering Compassionate Excellence values recently launched across the Trust.

“It was important to create useable measurable values and behaviour that staff and patients can relate to and use as part of their working day. The standards highlight what is expected of staff to continue to deliver excellent patient care and they reflect a positive approach to working behaviour. We have been able to engage with the wider organisation on how we can put these values into action as part of our everyday lives. The Trust Values along with the nursing and midwifery standards allow staff to think about the way they enhance the patient experience in a positive structured and measurable way.”
Participation in clinical audits

Participation in national clinical audits and confidential enquiries enables us to benchmark the quality of services that we provide against other NHS trusts, and helps us develop and highlight best practice for providing high-quality patient care.

National Clinical Audit

During 2011/2012 47 national clinical audits and six national confidential enquiries covered NHS services that Oxford University Hospitals NHS Trust provides. During that period Oxford University Hospitals NHS Trust participated in 96% audits and 100% of the national clinical audits and national confidential enquiries which it was eligible to participate in. The national clinical audits and national confidential enquiries, respectively that Oxford University Hospitals NHS Trust was eligible to participate in during 2011/2012, are as follows:

<table>
<thead>
<tr>
<th>ELIGIBLE NATIONAL CLINICAL AUDIT</th>
<th>OUH PARTICIPATED IN</th>
<th>% CASES SUBMITTED</th>
</tr>
</thead>
<tbody>
<tr>
<td>PERI AND NEONATAL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perinatal mortality (MBRRACE-UK)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Neonatal intensive and special care (NNAP)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>CHILDREN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paediatric pneumonia (British Thoracic Society)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Paediatric asthma (British Thoracic Society)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Pain management (College of Emergency Medicine)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Childhood epilepsy (RCPH National Childhood Epilepsy Audit)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Paediatric intensive care (PICANet)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Paediatric cardiac surgery (NICOR – Congenital Heart Diseases Audit)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Diabetes (RCPH National Paediatric Diabetes Audit)</td>
<td>✓</td>
<td>100%</td>
</tr>
</tbody>
</table>

Quality Account 2011/12 | Page 15
<table>
<thead>
<tr>
<th>ELIGIBLE NATIONAL CLINICAL AUDIT</th>
<th>OUH PARTICIPATED IN</th>
<th>% CASES SUBMITTED</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACUTE CARE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency use of oxygen (British Thoracic Society)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Adult community acquired pneumonia (British Thoracic Society)</td>
<td>✓</td>
<td>Data entry closes 31/05/12</td>
</tr>
<tr>
<td>Non-invasive ventilation in adults (British Thoracic Society)</td>
<td>✓</td>
<td>Data entry closes 31/05/12</td>
</tr>
<tr>
<td>Pleural procedures (British Thoracic Society)</td>
<td>✓</td>
<td>100% for Q1 and Q2</td>
</tr>
<tr>
<td>Cardiac arrest (National Cardiac Arrest Audit)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Severe sepsis and septic shock (College of Emergency Medicine)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Adult critical care (ICNARC Case Mix Programme)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Potential donor audit (NHS Blood and Transplant)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Seizure management (National Audit of Seizure Management)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td><strong>LONG-TERM CONDITIONS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes (National Adult Diabetes Audit)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Heavy menstrual bleeding (RCOG National Audit of HMB)</td>
<td>✓</td>
<td>Awaiting data from RCOG</td>
</tr>
<tr>
<td>Chronic pain (National Pain Audit)</td>
<td>✓</td>
<td>62%</td>
</tr>
<tr>
<td>Ulcerative Colitis and Crohn’s disease (UK IBD Audit)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Parkinson’s disease (National Parkinson’s Audit)*</td>
<td>✗</td>
<td>N/A</td>
</tr>
<tr>
<td>Adult asthma (British Thoracic Society)**</td>
<td>✗</td>
<td>N/A</td>
</tr>
<tr>
<td>Bronchiectasis (British Thoracic Society)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td><strong>ELECTIVE PROCEDURES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip, knee and ankle replacements (National Joint Registry)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Elective surgery (National PROMs Programme) inguinal hernia, varicose veins, hip replacement, knee replacement</td>
<td>✓</td>
<td>Inguinal hernia Q1-Q3 = 53% Varicose veins Q1-Q3 = 53% Hip replacement Q1-Q2 = 89% Knee replacement Q1-Q2 = 143%†</td>
</tr>
<tr>
<td>Coronary angioplasty (NICOR Adult Cardiac Interventions Audit)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Peripheral vascular surgery (VSGBI Vascular Surgery Database)</td>
<td>✓</td>
<td>61%</td>
</tr>
<tr>
<td>Abdominal aortic aneurysm, infrainguinal bypass, amputations</td>
<td>✓</td>
<td>87%</td>
</tr>
<tr>
<td>Carotid interventions (Carotid Intervention Audit)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Coronary Artery Bypass Graft and valvular surgery (Adult Cardiac Surgery Audit)</td>
<td>✓</td>
<td>100%</td>
</tr>
</tbody>
</table>

**KEY**

* The Trust did not participate in this audit for 2011/12, though it had done so in 2010/11. The reasons were multi-factorial but included the view that reaudit prior to full implementation of the changes planned following the review of the 2010 National Parkinson’s Audit, would not be beneficial. Furthermore the National Parkinson’s Audit is currently being independently reviewed.

** The Trust did not participate in this audit for 2011/12, though it had done so in 2010/11.

† The figure is greater than 100% as the NOC submitted data on more cases than was required. The figures are derived from Northgate Information Solutions in partnership with Quality Health on behalf of the Department of Health.
<table>
<thead>
<tr>
<th>ELIGIBLE NATIONAL CLINICAL AUDIT</th>
<th>OUH PARTICIPATED IN</th>
<th>% CASES SUBMITTED</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CARDIOVASCULAR DISEASE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Myocardial Infarction and other ACS (MINAP)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Heart failure (Heart Failure Audit)</td>
<td>✓</td>
<td>76%</td>
</tr>
<tr>
<td>Acute stroke (SINAP)</td>
<td>✓</td>
<td>Q1 and Q3 = 100%</td>
</tr>
<tr>
<td>Cardiac arrhythmia (Cardiac Rhythm Management Audit)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>RENAL DISEASE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renal replacement therapy (Renal Registry)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Renal transplantation (NHSBT UK Transplant Registry)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td><strong>CANCER</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lung cancer (National Lung Cancer Audit)</td>
<td>✓</td>
<td>Data entry closes 30/06/12</td>
</tr>
<tr>
<td>Bowel cancer (National Bowel Cancer Audit Programme)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Head and neck cancer (DAHNO)</td>
<td>✓</td>
<td>76%</td>
</tr>
<tr>
<td>Oesophago-gastric cancer (National O-G Cancer Audit)</td>
<td>✓</td>
<td>Data entry closes October 2012</td>
</tr>
<tr>
<td><strong>TRAUMA</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip fracture (National Hip Fracture Database)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Severe trauma (Trauma Audit and Research Network)</td>
<td>✓</td>
<td>55%</td>
</tr>
<tr>
<td><strong>BLOOD TRANSFUSION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bedside transfusion (National Comparative Audit of Blood Transfusion)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Medical use of blood (National Comparative Audit of Blood Transfusion)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td><strong>HEALTH PROMOTION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk factors (National Health Promotion in Hospitals Audit)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td><strong>END OF LIFE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care of Dying in Hospital (NCDAH)</td>
<td>✓</td>
<td>100%*</td>
</tr>
</tbody>
</table>

**KEY**

* The Trust submitted cases for this audit and 100% of required were submitted, however we are aware that a lower number of cases were accepted as valid as the data was not complete. Validated submission data are not currently available.

Oxford University Hospitals NHS Trust was not eligible to participate in the following NCAs

- Intra-thoracic transplantation (NHSBT UK Transplant Registry)
- Liver transplantation (NHSBT UK Transplant Registry)
- Prescribing in mental health services (POMH)
During 2011/2012 reports were published on 28 of the 47 National Clinical Audits and two of six of the National Confidential Enquiries. These national reports were reviewed by OUH and actions taken or planned. Examples of reports reviewed are listed.

<table>
<thead>
<tr>
<th>NATIONAL CONFIDENTIAL ENQUIRIES</th>
<th>OUH PARTICIPATED IN</th>
<th>% CASES SUBMITTED</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NATIONAL CONFIDENTIAL ENQUIRY INTO PATIENT OUTCOME AND DEATH (NCEPOD)</strong></td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Surgery in children</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Perioperative care</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Cardiac arrest procedures</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Bariatric surgery</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td><strong>CONFIDENTIAL ENQUIRY INTO MATERNAL AND CHILD HEALTH (CEMACH)</strong></td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Perinatal mortality</td>
<td>✔</td>
<td>100%</td>
</tr>
<tr>
<td>Maternal death enquiry</td>
<td>✓</td>
<td>100%*</td>
</tr>
<tr>
<td><strong>NATIONAL CONFIDENTIAL ENQUIRY (NCI) INTO SUICIDE AND HOMICIDE BY PEOPLE WITH MENTAL ILLNESS (NCI/NCISH)</strong></td>
<td>Oxford University Hospitals NHS Trust was not eligible to participate</td>
<td></td>
</tr>
</tbody>
</table>

* Auditor has changed. 100% data ready for upload to new audit portal when open.

During 2011/2012 reports were published on 28 of the 47 National Clinical Audits and two of six of the National Confidential Enquiries. These national reports were reviewed by OUH and actions taken or planned. Examples of reports reviewed are listed.

### AUDIT TITLE

**Neonatal Intensive and Special Care (NNAP)**

The report for data submitted in 2010/11 was published in October 2011. Following a review of this report action was taken to improve OUH’s input of data onto the Standardised Electronic Neonatal Database. Expansion of the Neonatal Unit in 2012/13 will further reduce the need for transferring babies out of the area.

**Diabetes (RCPH National Paediatric Diabetes Audit)**

The report for data submitted in 2009/2010 was published in May 2011 and refers to the John Radcliffe and Horton General Hospital. Following a review of this report it was noted OUH is performing well and is in the top three trusts in the country for achieving a low risk level of glucose control in children which can potentially avoid complications in early and mid-adult life.

**Emergency use of Oxygen (British Thoracic Society)**

The report for data submitted in 2010/11 was published in January 2011. Following a review of this report action was taken to amend the induction programme for new medical and nursing staff to facilitate an increase in the prescription of oxygen and impaired documentation of levels of oxygen prescribed and administered.

**Non-invasive ventilation adults (British Thoracic Society)**

The report for data submitted in 2010/11 was published in July 2011. Following a review of this report, action was taken in conjunction with South Central Ambulance Service to ensure patients receive oxygen alert cards to facilitate appropriate oxygen treatment pre-hospital. Increased education for doctors joining OUH is planned in August 2012 to ensure that non-invasive ventilation (NIV) is used in accordance with the guidelines.
<table>
<thead>
<tr>
<th>AUDIT TITLE</th>
<th>ACTION FROM REVIEW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe sepsis and septic shock (College of Emergency Medicine)</td>
<td>The first National Report is to be published in April 2012. A review of data submitted by OUH showed a significant improvement in sepsis management from a preliminary audit in 2010. Actions taken include the introduction of an initial assessment using an Emergency Department Sepsis Proforma and multidisciplinary team triage.</td>
</tr>
<tr>
<td>Potential donor audit NHS Blood and Transplant)</td>
<td>The report for data submitted in 2010/11 was published in August 2011. Following a review of this report action was taken to review the identification of potential organ donors and the rate of consent to proceed to donation from relatives of potential organ donors. Trust guidelines on organ donation are to be introduced.</td>
</tr>
<tr>
<td>Ulcerative Colitis and Crohn's disease (UK IBD Audit)</td>
<td>The report for data submitted in 2010/11 was published in January 2011. Following review of this report it was noted that OUH performance was good.</td>
</tr>
</tbody>
</table>
| Parkinson’s disease (National Parkinson’s Audit)                         | The report for data submitted in 2010/11 was published in June 2011. Following a review of this report action was taken to make a number of changes to the Parkinson’s disease service. These include:                                                                                                      - the number of specialist movement disorder clinics within neurology increased with extra clinics in place by February 2012  
  - the care of Parkinson’s patients within Neurology has been channelled into dedicated Parkinson’s clinics with nurse participation in every clinic from October 2011  
  - access to specialist Parkinson’s nurses has been increased by the addition of a Parkinson’s nurse based in the community.  
  - the service aims to improve its documentation of patient’s needs by April 2012. 

The National Parkinson's Audit is currently being independently reviewed and the methodology and audit tool used is currently being revised.                                                                                                                                                                                                                   |
| Bronchiectasis (British Thoracic Society)                                | The report for data submitted in 2010/11 was published in June 2011. A review of the report showed OUH patients have their treatment outcomes documented more consistently than the national average. Many more patients, when compared to the national average, have access to specialist physiotherapy. There is a lower than national average use of inhaled steroids and other inhalers which is consistent with guidelines (i.e. avoidance of unnecessary treatments). |
| Acute Myocardial Infarction and other ACS (MINAP)                        | The report for data submitted in 2010/11 was published in September 2011. A review of the report showed OUH as achieving targets and performing exceptionally well against national picture, however further improvements are sought as we know that the impact of early treatment means better survival ACTION POINTS  
  - Ongoing work continues on ‘call to balloon’ times, in liaison with ambulance services.  
  - Work continues on refining the patient pathway to avoid delay where people present to the Emergency Department.  
  - Discussion continues regarding an increase in cardiologist input and the potential development of a Chest Pain Specialist Nurse role for patients with chest pain at the Horton General Hospital.                                                                 |
**Bedside transfusion**  
*(National Comparative Audit of Blood Transfusion)*  
The report for data submitted in 2011/12 was published in October 2011. A review of the report showed that 96% patients receiving blood were wearing a wristband; that 100% of those wristbands contained four core identifiers deemed as essential, and that in 100% of cases the details matched that on the blood transfused, and on the prescription. Pulse, temperature and blood pressure were measured for 100% of patients pre-transfusion and 94% post-transfusion, although respirations were measured only in 28% pre-transfusion. Staff involved had been trained within the previous three years in 94% of cases. The Blood Transfusion Service continues to facilitate improvements in bedside practice.

**NATIONAL CONFIDENTIAL ENQUIRIES REPORTS**  

**NATIONAL CONFIDENTIAL ENQUIRY INTO PATIENT OUTCOME AND DEATH (NCEPOD)**  

**Surgery in children**  
The report for data submitted in 2010/11 was published in October 2011. Following a review of this report action will be taken to ensure that there are consistent standards for all children receiving surgery at the OUH in line with the recommendations from this confidential enquiry.

**OUH local clinical audit**

During 2011/12 OUH has over 300 local clinical audits. The following list shows examples of local clinical audits completed during 2011/12, a brief description of the activity that was being audited, their overall findings, areas for improvement and the progress made.

<table>
<thead>
<tr>
<th>DIVISION</th>
<th>CLINICAL AUDIT</th>
<th>DETAIL AND ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>C and W</td>
<td>Diabetes – New Patient Pack Audit</td>
<td>The children’s diabetes team developed a ‘new patient pack’ to inform staff of actions required when a child is newly diagnosed with diabetes. This has been audited for effectiveness and following the audit changes have been made to the ‘new patient pack’. The paediatric wards have been informed about the pack’s availability and how to use it. A presentation of audit results has been made to the team, and a poster presented at a Royal College of Paediatrics and Child Health meeting in May 2012.</td>
</tr>
</tbody>
</table>
**Video Telemetry (VT)**

Synchronous video and electroencephalogram (EEG) recording is carried out when there is a desire to correlate the clinical behaviour of a child with their EEG activity; this is known as video telemetry (VT).

The children’s neurology team undertook an audit, on behalf of the British paediatric epilepsy group, of current practice nationally during VT, following the death of a child in England in 2010 during paediatric VT. Results were published in the Archives of Disease in Childhood. As a result there is a plan to draw up national guidelines on VT use.

**Documentation of Verbal Consent, Risks and Benefits for Outpatient Procedures in the medical notes**

The majority of patients who are seen in gynaecology outpatient clinics will receive a diagnostic or treatment procedure. For the majority of these procedures a formal signed consent form is not appropriate, however, verbal consent should be documented. Furthermore the Picker Survey in February 2011 documented that 23% of patients felt that they were not fully informed of the risks and benefits of proposed interventions. Therefore in August 2011 three outpatient clinics were observed, and then the medical notes were examined to assess whether it was documented that patients had given verbal consent, or had the risks and benefits explained, prior to a procedure. In all consultations and prior to all the examinations/procedures it was noted that risks/benefits were discussed and verbal consent had been gained. However of the 70 sets of medical notes examined, only three sets had verbal consent documented.

As a result of this audit action is to be taken to have a ‘consent’ stamp which the practitioner stamps in the medical notes and signs.

**EMTACED**

College of Emergency Medicine consultant sign off

9th December 2010 saw the publication of a new College of Emergency Medicine standard for consultant ‘sign off’ of selected high-risk patients being discharged from the Emergency Department. The OUH has completed an audit against this standard in 2011/12 and submitted the results to the College of Emergency Medicine. A College Report will be issued in December 2012. Local analysis shows OUH to have performed well, however action is ongoing to increase consultant availability.

**NICE Transient Loss Consciousness CG 109**

NICE published *Clinical Guidelines 109 Transient Loss of Consciousness (Blackouts) Management in Adults and Young People* in August 2010 to provide guidance to Emergency Departments on the management of this patient group. The OUH Emergency Department undertook an audit of compliance against the NICE Guidance in 2011. The audit showed a good level of compliance with the NICE Guidance. However the department will continue to heighten awareness of the NICE guidelines.
Missed fractures are difficult to prevent completely as even experienced doctors miss fractures occasionally. Nationally it is estimated between 3.1% and 3.7% of fractures are missed. The Emergency Departments at the John Radcliffe Hospital and Horton General Hospital undertook an audit of missed fractures in 2011 to compare against this national rate. The audit found that the John Radcliffe Hospital missed fracture rate was 2.7% and that Horton General Hospital missed fracture rate 2.8%. However, reducing the incidence of significant missed fractures remains a priority in order to deliver a high-quality service. Teaching of Junior Doctors has focused on bony injuries with long-term serious consequences such as the cervical and thoracic spine and hand. This is also currently a focus of induction for new and locum doctors joining the OUH Emergency Departments. Teaching for other doctors on radiology has taken place. The audit showed that previous issues concerning delays in radiology reporting and fracture clinic appointments at the Horton General Hospital have been addressed.

This audit was undertaken in response to a National Patient Safety Agency (NPSA) alert – The transfusion of blood and blood components in an emergency – published in October 2010. The urgent provision of blood for life-threatening haemorrhages requires a rapid, focused approach as excessive blood loss can jeopardise the survival of patients. Early recognition of major blood loss and immediate effective interventions are vital. The rapid provision of blood requiring effective communication between all personnel involved in the provision and transportation of blood is key. Whilst the OUH was compliant with the alert requirements, the following actions were recommended to further improve quality.

- A review of all crash trolleys to ensure that they all have a major haemorrhage card was completed.
- Increased awareness is ongoing and relates to:
  - the major haemorrhage cards and the protocols on the intranet
  - the need to nominate a specific individual to co-ordinate blood product usage and be responsible for communication with the laboratory.
- Development of massive bleeding protocol specific to paediatrics was completed and introduced in March 2012.
- Increase awareness among nursing and medical staff of local trigger phrase used and consider standard trigger phrase.
  - Awareness raising is ongoing.
  - The term ‘major haemorrhage’ has been agreed.
- Promotion of the regional transfusion committee’s major haemorrhage education day achieved by an event held 21st September 2011.
- Inclusion of major haemorrhage in induction training for medical staff was completed.
### Clinical Coding Audit

A Healthcare Resource Group (HRG) is a grouping consisting of patient events that have been judged to consume a similar level of resource. For example, there are a number of different knee-related procedures that all require similar levels of resource; they may all be assigned to one HRG. The HRG system is used by Payment by Results, an activity-based payment system rolled out throughout the NHS. An HRG is derived for each Consultant Episode (a period of care under one consultant) and Hospital Spell (a period of care from admission to discharge) using clinical coding. An HRG code consists of five characters: two letters followed by two numbers and a final letter. Codes are inputted by staff. It is known errors can occur. An audit was undertaken to measure the error rates in coding. The audit found OUH to have 6.5% of spells with an error that affected the price. This means that 6.5% of spells had either a clinical coding error affecting the HRG or a data entry error (or both). Although the OUH HRG clinical coding performance is better than the national average of a 9.1% error rate (in 2009/10), action continues to try to improve coding accuracy further.

### Head and Neck Dieticians

**Head and neck dieticians**

Cancer patients often require help with feeding whilst undergoing treatment. Previous work has established guidelines for surgical patients and patients undergoing radiotherapy. This audit was undertaken to help clarify which patients need pre-treatment placement of gastrostomy tubes, and which patients are unlikely to need feeding for longer than four weeks and are therefore better managed with nasogastric tubes.

As a result of the audit this year further validation and refinement of the guidelines took place and new guidelines for patients undergoing chemoradiotherapy were completed and presented. The guidelines help to ensure patients get through their treatment as well-nourished as possible, with help where needed but avoiding unnecessary invasive procedures.

### Transfusion-associated Graft-versus-Host-disease (TA-GvHD)

Transfusion-associated Graft-versus-Host-disease is a rare complication of blood transfusion, in which the donor blood cells mount an immune response against the recipient. It is a catastrophic hazard of transfusion and is universally fatal. Prevention is by irradiation of the donor blood. Patients with specific conditions (such as Hodgkin Lymphoma), patients following allogeneic bone marrow transplantation and those who have received specific chemotherapy drugs should only receive irradiated products blood for the rest of their life. The British Committee for Standards in Haematology (BCSH) 2010 guidelines recommend that those at risk of TA-GvHD should be made aware of their need for irradiated blood components and receive appropriate written information and an alert card.
DiViSion CLiniCAL AUDit DETAiL AND ACtion

OUH conducted a regional audit of practice against the BCSH guidelines with patients identified via a chemotherapy e-database. The audit shows poor compliance with the BCSH recommendations on patient information to prevent TA-GvHD. 26% patients were uninformed of the need for irradiated blood, 35% had not received an explanation, 45% were not given written information and 26% did not receive an alert card. Misconceptions regarding TA-GvHD were also identified: five patients discarded their alert card following ‘successful’ treatment, and five did not understand the need to carry the alert card when travelling abroad.

The potential risk of mobile individuals in the NHS with no central transfusion e-database was demonstrated by the audit as 24% of patients had been treated in a different hospital (to where they had been given advice and an alert card), with 48% of those patients receiving a transfusion in that hospital. Of this 48%, 18% felt staff didn't know about TA-GvHD or were doubtful whether they knew.

Following the audit all but one of the patients who reported they were uninformed received subsequent education, written information and the alert card.

| MR | Audit of turnaround time for Discharge Summaries against a 24 hour target | It is OUH policy that there is a 24 hour standard for the issue of discharge summaries. The musculoskeletal and rehabilitation services undertook an audit against this standard and found that 100% of the inpatient cases audited had a discharge summary issued to the general practitioner within 24 hours. |
| WHO Surgical Safety Checklist | The World Health Organisation (WHO) has developed the WHO Safe Surgery Checklist and it was introduced to the NHS in 2009. By following a few critical steps, healthcare professionals can minimise the most common and avoidable risks endangering the lives and wellbeing of surgical patients. The checklist identifies three phases of an operation, each corresponding to a specific period in the normal flow of work. Before the induction of anaesthesia (‘sign in’), before the incision of the skin (‘time out’) and before the patient leaves the operating room (‘sign out’). In each phase the surgical team must complete the listed tasks before it proceeds with the operation. The Musculoskeletal and Rehabilitation Division undertook an audit of the use of the WHO Surgical Safety Checklist. The audit confirmed the checklist was used for 100% of cases. |
Audit of the Trust compliance with NICE Guidelines on Perioperative Hypothermia CG65

NICE Clinical Guidelines 65 Perioperative Hypothermia was published in April 2008. The guidance covers the care and treatment of people who are having an operation in hospital, to reduce their risk of getting cold before, during or after their operation. Inadvertently getting cold is a common but preventable complication of surgical procedures, which is associated with poor outcomes for patients. Prevention requires the use of simple measures to keep patients comfortably warm, alongside more active interventions such as forced air warming and fluid warming during the operation. Regular measurement and recording of patient temperature is key to prompt identification and treatment where preventative measures have failed. NICE stipulates that any patient whose core temperature drops below 36°C at any stage of the operation pathway (from the hour before induction of anaesthesia until 24 hours after entry into the recovery area) should be warmed using a forced air warming device.

An audit was done to look at the compliance of OUH against the NICE advised management for prevention of hypothermia in the immediate preoperative, intraoperative and postoperative period. The audit found that measurement and documentation of preoperative temperature was well-achieved by most wards. However a small number of patients had a preoperative temperature of less than 36°C and were not given active warming prior to transfer to theatre and prior to induction of anaesthesia. This was in breach of the Guidelines. Therefore more education and training is planned and consideration for the use of forced air warming (FAW) and a fluid warmer for all cases with an anaesthesia time greater than 30 minutes is to be encouraged.

FAW was well utilised in theatre, with nearly 80% of cases lasting over 30 minutes having a FAW device applied. Over 70% of patients were discharged from recovery with a temperature higher than 36°C, with nearly 100% being discharged from the West Wing recovery in accordance to the NICE guidelines. Overall OUH is compliant with the NICE guidelines on inadvertent perioperative hypothermia.

Handover of Patient Care in the Post Anaesthetic Care Unit

Anaesthesia is a dynamic, complex process. Effective handover of a patient’s care in the recovery room is essential for the continuity, quality and safety of patient care. The Association of Anaesthetists guidelines state that ‘the anaesthetist must formally hand over care of a patient to a recovery room nurse or other appropriately trained member of staff’. The Royal College of Anaesthetists proposed the standards that 100% of handovers should:

- include patient name, operation and theatre
- include information on the patient’s underlying medical disorders.
DIVISION | CLINICAL AUDIT | DETAIL AND ACTION
---|---|---

- include information on the anaesthetic technique used including airway management
- have all appropriate prescription charts available including medication, fluids and analgesia
- have a postoperative plan documented
- have a plan for continuing invasive monitoring if required.

OUH undertook an audit against these standards to evaluate the effectiveness of handover between the anaesthetist and PACU staff. The results highlighted some handover deficiencies, although qualitative assessment suggested staff within the PACU are broadly satisfied with current practice. The Trust will undertake further work to enable improvement in post anaesthetic handover.

**CVT**

Audit to assess and complication rates for atrial fibrillation ablation and compare to published data

Atrial fibrillation is the irregular and rapid beating of the upper two chambers of the heart (the atria). Patients with atrial fibrillation may be asymptomatic or they may have symptoms including palpitations, dizziness, breathlessness and fatigue. They have an increased risk of stroke as a result of blood clots forming in the left atrium and then embolising to the brain. Percutaneous radiofrequency ablation is a treatment option for selected symptomatic patients with atrial fibrillation according to NICE – Interventional Procedure Guidance 168 Percutaneous radiofrequency ablation for atrial fibrillation published in April 2006.

Percutaneous radiofrequency ablation is a minimally invasive procedure. A catheter is inserted into the femoral vein and advanced into the heart, using X-ray and computer guidance to ensure correct positioning. The tip of the catheter delivers radiofrequency energy, producing heat that damages the targeted area preventing electrical conduction of the abnormal rhythm.

The OUH cardiac team undertook an audit of their practice regarding ablation for atrial fibrillation against published data focusing on success and complication rates. The audit showed that the overall success rate of catheter ablation of atrial fibrillation in OUH after a minimum of one year follow-up is 94% for paroxysmal AF and 83% for persistent AF, after one or more procedures. The complication rate was found to be 6%. These results were benchmarked against published data of success rates of 76-87% for paroxysmal AF and 50-74% for persistent AF and 4.5-5.9% complications. Therefore OUH practice was demonstrated to be very much in line or possibly better than published literature. The team will reaudit in six-monthly cycles.
Observation audit for mealtime on Cardiothoracic Ward (CTW)

Ensuring a patient receives adequate nutrition and the correct diet is everybody’s business, whether they are a doctor, nurse, manager, housekeeper, patient, caterer, dietitian or health care assistant. Nutrition should be given the importance it deserves, as a vital part of treatment and care for all patients. It is OUH policy that protected mealtimes should be observed. The Cardiothoracic ward at the John Radcliffe Hospital was audited against this standard in May 2010 by the Matron for Cardiac, Vascular and Thoracic Surgery. Patients’ notes were reviewed to check if a Malnutrition Universal Screening Tool (MUST) had been documented, as well as direct observation on the ward. Staff were not aware the audit was taking place.

The Matron was disappointed to find although 80% of notes had the MUST recorded:

- there was not the required emphasis on the importance of mealtimes. For example there were no signs indicating ‘Protected Mealtimes’
- not all patients who required help were readily identified as requiring assistance as the red tray system (patient requires assistance) was not being used
- nursing staff did not always check what patients had ordered or how much they had eaten.

As a result of the audit the following actions were taken.

- Protected mealtime signs were put on all entrances to the ward and all members of the multidisciplinary team were reminded of its importance.
- Staff were reminded that the following must occur:
  - Red tray system used for any patients requiring assistance.
  - Menus checked by nursing staff looking after individual patients to see that meals ordered met their nutritional requirements.
  - Assistance given when required by patients.
  - Trays collected by nursing staff at the end of mealtimes to check how much their patients have eaten.

The ward was then reaudited during Patient Safety Week in January 2012 to confirm that the actions identified had resulted in a consistent change in practice. The reaudit found:

- mealtimes for patients are now not interrupted by unnecessary tasks/procedures
- all patients requiring assistance/monitoring are easily identified
- nursing staff now aware of poor intake and are able to offer appropriate supplements and make earlier referrals to dietician
- all patients requiring assistance receive the help they need to eat and drink.

More audits are planned for the future.
A pancreas transplant is a surgical procedure to replace a malfunctioning pancreas with a healthy one that is obtained from a suitable donor. The pancreas is a narrow organ that is approximately 10cm long and is located behind the lower part of the stomach. The pancreas secretes (releases) a number of hormones into the blood, including insulin, which is produced by small clusters of cells called islets. It also secretes pancreatic juices that help to digest food. Over recent years, there has been a steady increase in the number of pancreas donors and pancreas transplants. In 2010 it was reported pancreas transplant recipients have survival rates of around 97.98% and most pancreas transplants have positive results, with more than 75% of transplants working one year after surgery and continuing to work for an average of eight years. OUH audited their practice in 2011/12.

The audit found outcomes for one year patient and graft survival are in line with expected national outcomes following first grafts. However, the average waiting time for patients in Oxford is 402 days, which is longer than the UK average of 279 days. As a result the following actions have been implemented.

1. Allocation has been discussed nationally in the pancreas advisory group and now there is national sharing of organs. This has led to the waiting time falling.
2. Working closely with Intensive Therapy Unit to improve bed availability
3. The development of bed capacity in the High Dependency Unit (HDU) in the transplant ward for postoperative care.

The Neurosciences, Trauma and Specialist Surgery Division undertook both local audits and a review of clinical data in 2011/12 to review the provision of next day fracture clinics and operations for fractured neck of femur. A review of the audits led to the Division implementing consistent provision of next day fracture clinics on both the John Radcliffe Hospital and Horton General Hospital sites and operating on most patients with a fractured neck of femur within 24 hours, 12 hours faster than the national target. This was achieved through the collaboration with ortho-geriatricians on both sites, surgical-led prioritisation of daily cases and cross cover on both sites of seven day fracture clinics. Also more patients requiring routine surgery such as a wrist or ankle fracture are now operated on as ‘theatre direct admissions’ (without needing a bed first) and when there are more patients waiting for surgery on one site than we would like, they are sent to the other. This integration leaves the OUH Trauma Service well placed to deliver its aspirations as a Major Trauma Centre from April 2012.
**DIVISION** | **CLINICAL AUDIT** | **DETAIL AND ACTION**
---|---|---
NTSS | Critical care support planned neurosurgery patients | The Clinical Director of the Neurosciences, Trauma and Specialist Surgery Division undertook an audit involving a full clinical review of the pathway for patients requiring routine neurosurgery. He found that some patients would benefit from a short stay in a high care environment to enhance their recovery. As a result a new pathway was implemented in the early summer of 2011. Appropriate patients are now moved to a high care environment after surgery for a short period before returning to a ward environment, usually the next day. This change in pathway has led to a reduced length of stay on the ward in a majority of cases, freeing up beds for more patients to receive their neurosurgery.

**Audit development**

In 2012/13 the OUH will develop and implement an annual audit programme that looks at our performance against national, regional and local standards. This will provide a framework that helps us identify where we are doing well and where we need to make improvements. Our robust programme will be based on national priorities such as infection control, patient safety, clinical effectiveness and the priorities agreed with our commissioners.
Information on research

Participation in clinical research

Oxford University Hospitals NHS Trust is one of the most research-active NHS trusts leading the way in providing opportunities for patients to take part in clinical research studies. Participation in clinical research demonstrates our commitment to improving the quality of care we offer and to making our contribution to wider health improvements. Highlighted in a league table published for the first time by the National Institute for Health Research (NIHR) Clinical Research Network in November 2011, Oxford University Hospitals recruited the fifth highest number of patients in England in 2010/11, to the seventh highest number of studies.

Fostering a research-active culture brings a host of benefits for patients, clinicians and the NHS. It drives innovation, gives rise to better and more cost-effective treatments and creates opportunities for staff development. Growing evidence also suggests that NHS organisations that are research-active appear to do better in overall performance, and an organisation’s research activity is linked to improved patient outcomes.

The number of patients receiving NHS services provided or sub-contracted by the OUH in 2011/12 that were recruited during that period to participate in research approved by a research ethics committee was 26,070. This covered 904 studies.

A total of 2,706 clinical staff participated in research approved by a research ethics committee at the OUH during 2011/12. These staff participated in research covering 17 medical specialties.

The Oxford Biomedical Research Centre’s third research open day was held on 14th March 2012. Attendees found out about the diverse range of translational research that is carried out across our hospital sites in partnership with the University of Oxford, research that is making a difference to the way we care for patients locally and across the NHS. There were more than 20 interactive exhibits and displays for staff, visitors and members of the public, including, ‘Test your BMI’, ‘extract DNA from strawberries’, ‘test your reaction times’ and ‘find out about the MRSA quilt’ and lots more.
New cancer drugs

Research in oncology has improved the quality of care for trial participants by providing clear protocols for treatment and for the management of side effects. It has set out a framework for auditing the quality of care, and of the data recorded for patients. A good example of the benefits is seen in the treatment of patients with the skin cancer ‘melanoma’. Clinical trials have provided the means to introduce new drug treatments, such as ipilimumab and vemurafenib, into practice in a controlled way – with training and quality assurance provided by the trial sponsors. That experience has then been transferred to routine care now that the drugs have been licensed.

Oxford research sheds new light on Clostridium difficile infection in hospitals

It has been a widely held belief that most C. difficile infections are spread in hospital from a case with active disease to other patients. C. difficile infection (CDI) is a serious illness which can produce toxins in the colon causing severe diarrhoea and, in the most serious cases, death. Although it has become a significant medical and resource problem in hospitals, nursing and residential homes and in the community, the number of cases has been reducing over recent years. This may be due in part to the success of infection control techniques, but it is still unclear where the source of most current CDI cases is.

To find out more about the behaviour of this bug and reduce the risk of infection even further, researchers in Oxford and Leeds have carried out the largest ever study of its kind to investigate how often cases occurring in hospital can be linked to other known cases. This new, NIHR Biomedical Research Centre Oxford funded, study has found that the vast majority of CDI cases in hospitals are isolated episodes not linked to other known cases. Researchers used forensic DNA techniques to analyse samples across Oxfordshire over a two and a half year period and discovered that no more than 25% of cases were passed on in this way. Tim Peto, Professor of Medicine, Nuffield Department of Medicine, University of Oxford and Consultant in Infectious Diseases said: “We studied 1,300 cases of CDI from patients in hospitals, the community and other healthcare settings and found that three-quarters of cases of C. difficile we analysed were unlinked. This means that most of the cases we diagnose are not passed from other known cases of CDI.

“It is likely that the robust infection control measures taken in hospitals to safeguard against cross infection of CDI have already had a huge impact and that these should continue. What we need to do now though is take this understanding of the pattern of outbreaks to do more research and find out how we can reduce the number of C. difficile outbreaks even further.”
Genetic changes tracked as bacteria become a fatal infection

An unusual case could tell researchers more about the genetic changes that occur when a common bacteria, normally carried without any problems, on rare occasions causes potentially life-threatening infections. Eight mutations occurred in the common bacteria *Staphylococcus aureus* as it turned from an innocuous resident inside one person’s nose into a fatal blood infection, a University of Oxford study has found. The study, which sequenced the complete DNA of the bacteria at regular time intervals, was able to identify for the first time the genetic changes that accompanied the transition to a dangerous infection. Understanding the biological causes of serious bacterial infections could help guide screening in hospitals, and could inform efforts to develop vaccines against such infections. The study is published in the journal PNAS and was carried out in partnership with Oxford University Hospitals NHS Trust through the National Institute of Health Research (NIHR) Biomedical Research Centre, Oxford.

Professor Derrick Crook of the Nuffield Department of Clinical Medicine at the University of Oxford, one of the principal investigators, said: “Sequencing the whole bacterial genome was crucial to detecting these small changes in the DNA code. The genetic variation between bacterial samples was at much too low a level to be detected by conventional means. As DNA sequencing technology continues to get quicker and cheaper, this does point to a role for this technology in monitoring clinical samples for bacterial infections.”

Can daily aspirin help prevent and treat cancer?

A collection of three papers (two published in *The Lancet* and one in *The Lancet Oncology*) add to the growing evidence base suggesting that daily aspirin can be used to help prevent and possibly treat cancer. All three papers are by Professor Peter Rothwell, University of Oxford and John Radcliffe Hospital, and colleagues. The case for using aspirin to prevent cancer continues to build, particularly if people are at increased risk of the disease. It follows the finding that aspirin can reduce the chances of tumours spreading to other parts of the body. Professor Rothwell, research theme leader for the NIHR Biomedical Research Centre, Oxford says: “We are not at the stage of recommending aspirin use in everybody, but the guidelines on use of aspirin in the healthy middle-aged population certainly need to be updated in order to take into account the effects on the risk and outcome of cancer as well as on the risk of heart attacks and strokes.”

Previous studies by this team have established that aspirin reduces the long-term risk of dying from cancer, but that these effects do not appear until about 8-10 years after starting to take a daily low dose of the drug. The short-term effects of aspirin were less certain.

“What we have now shown is that aspirin also has short-term effects, which are manifest after only 2-3 years. In particular, we show that aspirin reduces the likelihood that cancers will spread to distant organs by about 40-50%. This is important because it is this process of spread of cancer, or ‘metastasis’, which most commonly kills people with cancer.”

Professor Rothwell, research theme leader for the NIHR Biomedical Research Centre
Commissioning for Quality and Innovation Framework (CQUIN)

Commissioners hold the budget for their area and decide how to spend it on hospital and other health services. Our commissioners set us goals based on quality and innovation in order to bring health gains for patients, and a proportion of the Trust’s income is conditional on achieving these goals. This system is called the Commissioning for Quality and Innovation (or CQUIN) payment framework. Our commissioners identified and agreed with the Trust a number of schemes for 2011/12.

Use of the CQUIN payment framework

In 2011/12, 1.5% of our income was conditional on achieving quality improvement and innovation goals agreed between the Trust and Oxfordshire PCT.

Quality improvement initiatives associated with the CQUINS for 2011/12 include:

- improved rates of VTE risk assessments for adult inpatients on admission to hospital
- improved outcomes and experiences of patients within our hospitals
- improved outcomes and experiences of patient care with regard to pressure ulcer care
- improved review of heart failure patient by specialist heart failure teams
- a reduction of caesarean section rates within our maternity units
- improved outcomes and experiences for prosthetics patients at the Nuffield Orthopaedic Centre
- the introduction of a specialist outcome measure for spinal surgery.
Statement on compliance with Care Quality Commission and essential standards of care (CQC)

The CQC is the organisation which regulates and inspects health and social care services in England. The current registration of the Oxford University Hospitals NHS Trust with the CQC is without conditions.

An updated statement of purpose was submitted to the CQC to reflect the merger with the NOC on 1 November 2011 and the OUH is registered to deliver services at the following locations:

The John Radcliffe Hospital  The Churchill Hospital
The Horton General Hospital  The Nuffield Orthopaedic Centre
The Cotswold Maternity Unit  The Wallingford Maternity Unit
Wantage Midwifery Unit

During 2010 the Trust received a planned review of all essential standards and asked the Trust to take improvement actions on four of the standards and compliance actions on two of the standards.

The CQC followed up this review and undertook unannounced visits in July 2011 (the John Radcliffe, the Horton and the Churchill Hospitals) and provided reports later in the year indicating compliance across all standards although with suggestions for continuing improvements on three standards. CQC indicated compliance was in place for outcome 13 Staffing. The revised action plan has been monitored by the Board, the Trust Management Executive and the Quality Committee throughout the year.

<table>
<thead>
<tr>
<th>OUTCOME</th>
<th>IMPROVEMENT ACTIONS</th>
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<tbody>
<tr>
<td>OUTCOME 1 Respecting and involving people who use services</td>
<td>Need to ensure patients receive sufficient and timely information and that communications with patients are improved particularly in relation to appointments and cancellations</td>
</tr>
<tr>
<td>OUTCOME 4 Care and welfare of people who use services</td>
<td>Improvements in escalation facilities, the placement of patients with dementia, continued focus on the delivery of stroke care and the dissemination of clinical guidance</td>
</tr>
<tr>
<td>OUTCOME 7 Safeguarding people who use services</td>
<td>Improvements in training particularly at levels 1 and 2</td>
</tr>
</tbody>
</table>
| OUTCOME 14 Supporting staff | Improvements in attendances and recording of statutory and mandatory training  
Continued work on clinical supervision |
| OUTCOME 16 Assessing and monitoring the quality of service provision | Improvements in the dissemination of learning across the Divisions and on meeting VTE targets |
The CQC also visited the John Radcliffe Hospital in May 2011 to carry out a special review2 as part of the national Dignity and Nutrition Inspection programme (DANI). This focused on outcomes 1 and 5. Outcome 1 looks at how staff respect and involve people (privacy and dignity) and Outcome 5 looks at how food and drink is provided to meet patient’s individual needs. The CQC found that “on the whole staff were kind and respectful to patients” and that “patients felt their privacy was respected”. However the CQC recommended that improvements were made in order to maintain this in terms of information provision and timeliness of some interventions and to take improvement action to improve the systems of recording aspects of nutritional care and nutritional assessments, and to ensure that the support to patients to eat and drink was always provided in an appropriate and timely way.

An action plan was put in place to address the required improvements below. The CQC conducted a follow up visit at the end of November 2011 to check that the actions had been addressed and recorded full compliance in meeting these standards.

2 Special reviews are required under section 48 of the Health and Social Care Act 2008

<table>
<thead>
<tr>
<th>OUTCOME</th>
<th>IMPROVEMENT ACTIONS</th>
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</thead>
<tbody>
<tr>
<td>OUTCOME 1</td>
<td>Improvements on the provision of information and always meeting patient needs in a timely way</td>
</tr>
<tr>
<td>OUTCOME 5</td>
<td>Improvements to the systems to ensure recording of nutritional assessments and care</td>
</tr>
<tr>
<td></td>
<td>Improvements to processes to ensure that patients are always offered assistance to eat and drink in a timely and appropriate way</td>
</tr>
</tbody>
</table>

2 Special reviews are required under section 48 of the Health and Social Care Act 2008
Statement on relevance of Data Quality and our actions to improve the Data Quality

Good quality data are an indicator that an organisation has robust systems and methods of capturing accurate information about their patients. Good data quality is critical to the delivery of effective patient care. It is vital that staff and patients have access to timely, accurate and comprehensive information about the care and treatment that our patients are receiving. Good data quality also underpins the effective use of resources and is thus essential to the Trust in its task of ensuring value for money for taxpayers.

During 2011/12 the Trust has taken a number of measures to strengthen data quality. Each of the clinical divisions has been required to strengthen its arrangements for securing good quality data. The Trust has also continued to make use of internal and external audit to identify areas for improvement. In December 2011, the Trust implemented a new electronic patient record at its John Radcliffe, Churchill and Horton General Hospitals sites. The system was already in use at the Nuffield Orthopaedic Centre, where there has been continuation of the Millennium Adoption Group, an interface between clinical colleagues and the EPR system. The first phase of the implementation of the new system involved the replacement of the core patient administration system and the introduction of clinical systems into the emergency department and maternity services.

As was anticipated, the introduction of such a major change has led to temporary data quality issues. However, as part of the implementation, the Trust will be undertaking a strategic service review of each of its services to address not only the potential for improving efficiency and effectiveness of services but also addressing any underlying data quality issues. This review offers the Trust the opportunity to strengthen the foundations of good data quality in advance of rolling out the additional clinical functions that the system offers. By delivering what is a fully integrated clinical system the Trust can help to ensure that its data quality continues to improve.

The National Data Quality Dashboard is available to help monitor and drive improvements in the quality and completeness of data. The OUH benchmarks well against other trusts as the average results of the overall Commissioning Dataset (CDS) data validity is 93.6% for all CDS submitters and the results of the ORH was 95.3%.

During 2012/13, the measures to progress the data quality infrastructure will be progressed both corporately and in each of the seven Divisions. At a Trust level, a key focus will be the development of an integrated performance framework, incorporating quality will be underpinned by the development of strengthened data quality processes. This will be supported and complemented by the data quality structures and processes within the Divisions.

NHS Number Code Validity

SECONDARY USES SERVICE (SUS)

The SUS is the single source of comprehensive data to enable a range of reporting and analysis of healthcare in the UK. The SUS is run by the NHS Information Centre and is based on data submitted by all provider trusts.

The patient NHS number is the key identifier for patient records and the quality of NHS number data has a direct impact on improving clinical safety.

The ORH submitted records during 2010/11 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient’s valid NHS number was:

- 99.0% for admitted patient care
- 99.4% for outpatient care
- 94.9% for accident and emergency care
INFORMATION GOVERNANCE TOOLKIT
ATTAINMENT LEVELS

The Information Governance Toolkit is a device that supports organisations in managing the data they hold about patients. The score achieved by an organisation reflects how well it has followed the guidance.

It is envisaged that the overall OUH Information Governance Assessment Report overall score for 2011/12 will be 71%. This would give the Trust a level 2 rating however we have not achieved the training requirements for this level, therefore the Trust will have an overall score of level 1. The Nuffield Orthopaedic Centre achieved level 2 compliance in 2010/11 but were notified that due to the merger of both organisations further submissions would not be required.

In order to achieve an overall score of level 2 for 2012-13 information governance training has been incorporated into the electronic patient record (EPR) training programme and is also listed as an essential element of the statutory and mandatory training policy.

CLINICAL CODING

Clinical coding translates the medical terminology written by clinicians to describe a patient’s diagnosis and treatment into nationally standardised codes. This information is vital to the Trust as it supports:

- the delivery, planning and monitoring of patient care services
- the planning and management of the Trust’s resources
- the collection of income.

To strengthen coding, the Trust has established a Clinical Coding Task and Finish Group. This has had two key priorities:

- an audit of the coding of co-morbidities to support the more accurate recording of mortality rates
- developing a good practice guide to help services strengthen their clinical coding

The latest published results for a Clinical Coding Audit carried out by the Audit Commission was during 2011/12. The results were as follows:

**NOC**

The clinical coding accuracy rate for the NOC is shown below as the percentage of procedures and diagnosis recorded incorrectly. The average error rate for the Trust is 3.8 per cent. This is better than the 2009/10 national average of 11 per cent.

<table>
<thead>
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<th>% Procedures coded incorrectly</th>
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<tbody>
<tr>
<td>Primary</td>
<td>2.1%</td>
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<tr>
<td>Secondary</td>
<td>3.4%</td>
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</table>

<table>
<thead>
<tr>
<th>% Diagnoses coded incorrectly</th>
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</thead>
<tbody>
<tr>
<td>Primary</td>
<td>4.0%</td>
</tr>
<tr>
<td>Secondary</td>
<td>4.6%</td>
</tr>
</tbody>
</table>

**ORH**

The clinical coding accuracy rate for the ORH is shown below as the percentage of procedures and diagnosis recorded incorrectly. The average error rate for the Trust is 6.4 per cent. This is better than the 2009/10 national average of 11 per cent.

<table>
<thead>
<tr>
<th>% Procedures coded incorrectly</th>
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<td>Primary</td>
<td>13.9%</td>
</tr>
<tr>
<td>Secondary</td>
<td>5.9%</td>
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</table>

<table>
<thead>
<tr>
<th>% Diagnoses coded incorrectly</th>
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<tbody>
<tr>
<td>Primary</td>
<td>8.5%</td>
</tr>
<tr>
<td>Secondary</td>
<td>4.3%</td>
</tr>
</tbody>
</table>
Progress on Quality Priorities identified for 2011/12

Our priorities last year were:

PATIENT SAFETY
- Venous thromboembolism (VTE) risk assessment
- Pressure ulcer reduction
- Improving medicines safety
- Achieving healthcare acquired infection targets
- Safer care in theatres:
  - operating lists to start on time
  - safe management of intravenous fluids during surgery

CLINICAL EFFECTIVENESS
- Mortality reduction
- Integrated care pathways for spinal conditions and also knee and hip procedures
- Quality improvements through Patient Recorded Outcome Measures (PROMs)

PATIENT EXPERIENCE
- Improving communication including improvement of mechanisms and opportunities for patient feedback
- Caring for vulnerable patients:
  - end of life care
  - patients with dementia and delirium
  - patients with learning disabilities
- Discharge within two hours of patient being 'fit for discharge'

Patient safety
We have made good progress with a number of the specific patient safety priorities we set ourselves in 2011/12 although we recognise that there is further work to do in some areas. This progress is described in the pages that follow. In addition to these priority areas, we are pleased to report progress in relation to three other safety related work streams: incident reporting; our participation in the patient safety first campaign; and, our programme of Executive Walkrounds.

Incident reporting
One of the measures used to determine a safe culture by the National Patient Safety Agency is the rate of reported incidents with a low level of harm. A high rate of incident reporting is felt to be a positive sign, evidence of a culture that embraces learning and improvement. This information is presented as the rate of reported incidents per 100 admissions. These figures were collected separately in 2011/12 for the Nuffield Orthopaedic Centre NHS Trust (NOC) and the Oxford Radcliffe Hospitals NHS Trust (ORH). We are pleased to see that we are in the upper quartile for the NOC and upper half for the ORH when our reporting rate is compared to peers.

High rates of incident reporting are regarded as a mark of good practice as long as an appropriate balance of no / low harm and high harm incidents are reported. The harm profile of incidents reported at OUH reflects the national picture.
– there was more than enough to eat and drink, food arrived on time and snacks were available
– I was able to wash my hands, service was very good, and the ward had a helpful housekeeper who always assisted me
– it was nice to see nursing staff taking away trays and checking what I had eaten

**Patient Safety First**

During 2011/12 we participated in two Patient Safety First campaigns where we focused on hydration, nutrition, pressure area care and patient experience. A range of activities took place on all sites to assess the care we delivered and to determine what improvements we needed to make. Each division summarised the findings of their services within their monthly quality report, which is presented to the Trust’s Clinical Governance Committee. Patient comments included:

We believe it is vital that the frontline staff caring for patients have the opportunity to discuss concerns with Trust Directors. This ensures that the Trust management team are made aware of issues that may affect both the quality of care we deliver to our patients and our maintenance of a safe working environment for our staff. During 2011/12 we carried out 82 ‘Executive Walkrounds’ across the Trust. Feedback from staff and patients has been positive and clinical areas have welcomed these visits. This was also replicated at senior nurse and divisional level to ensure the leadership of the Trust are aware, assured and take actions as indicated.

**Venous thromboembolism or VTE risk assessment**

VTE (the formation of blood clots within the veins) is a condition that causes an estimated 25,000 deaths in hospitalised patients each year, some of which could be avoided. During 2009/10, national guidance on VTE was published by the National Institute for Health and Clinical Excellence (NICE), which stated that 90% of all inpatients should be assessed for their risk of suffering from a VTE on admission at hospital. During 2010/11, systems to promote and record these assessments had not been developed and our assessment rate was therefore low.

**Executive Walkrounds**

Board members at the OUH, both executive and non-executive, support our programme of ‘Executive Walkrounds’.
WE SAID WE WOULD:

- Achieve the 90% VTE assessment national target from a position in 2010/11 of less than 50%
- Generate a monthly report outlining risk assessment performance by specialty
- Monitor and report monthly VTE data by the Medical Director to the Board via the quality report

WHAT WE DID WAS:

- We did not meet our target of 90% at the John Radcliffe, Churchill and Horton. The VTE risk assessment rate over the course of 2011/12 was 78.35% for the combined Trust. Performance improved across the course of the year with 88.8% of admitted patients being risk assessed in the month of March 2012. The introduction of the Electronic Patient Record (EPR), itself a major contribution towards enhanced patient safety, presented short-term challenges to the electronic collection and analysis of these data. VTE assessment rates have been reported to the Clinical Governance Committee for each Division on a monthly basis where actions have been monitored to improve performance.
- We achieved the target of 90% of patients being assessed on admission at the Nuffield Orthopaedic Centre.
- An electronic assessment form has been developed and widely implemented. VTE assessment rates can now be viewed at the touch of a button at any level – from all patients admitted within the Trust to patients cared for by an individual consultant team. This has had a major impact in heightening the profile of active VTE management.
- To improve our performance we have carried out regular observational audits and spot checks to determine whether the VTE risk assessment is repeated at regular intervals, and to ensure that the recommendation made following assessment of the individual patient is implemented. We will continue these activities in 2012/13 to ensure our performance improves.
- Our Thromboprophylaxis Committee meets quarterly and is made up of clinical staff from all specialties. Here we review VTE assessment rates, formulate relevant policies and clinical guidance and examine any incidents relating to venous thromboembolism.

Pressure ulcer reduction

Pressure ulcers are areas of injured skin and tissue. They are categorized as category 1 to 4 to describe how deep the ulcer is, 1 being reddening of the skin and 4 being the most severe. Although our rate of pressure ulcers was no higher than peer hospitals, we challenged ourselves to reduce the occurrence of this significant harm. In 2011/12 the Trust saw a reduction in the numbers of category 3 and 4 pressure ulcers (newly acquired in hospital) from 56 the previous financial year to 35.

WE SAID WE WOULD:

- Implement the use of a root cause analysis tool to assist the understanding of why pressure ulcers occur, so that action could be taken to prevent avoidable occurrences
- Improve the visual assessment of patients’ skin on admission to hospital and improve documentation associated with this
- Provide more staff training to understand the risks and prevention
- Purchase more pressure relieving equipment to prevent the development of pressure ulcers
- Monitor the incidence and Chief Nurse to report to the Board on a monthly basis

WHAT WE DID WAS:

- Develop a system to evaluate why ulcers occur
  We introduced a root cause analysis tool and involved junior nursing staff in serious incident investigations (which have traditionally tended to involve only senior members of staff) into the category 3 and 4 pressure ulcers to help determine the reasons for their development. This approach widened staff understanding of pressure ulcer prevention and management.
• **Increase staff training**
  Clinical areas have introduced a range of local ward based educational programmes for clinical staff. Informal training has used the expertise of link nurses who have special skills and interest in wound management and tissue viability. These focus on assessment of patients, prevention and management and the investigation of pressure ulcers using the root cause analysis tool. The Tissue Viability Nurse Consultant has provided expert advice on the management of pressure ulcers and the quality of educational programmes.

• **Improved assessment of patients’ skin on admission**
  An admission booklet, including the Pressure Ulcer Prediction Score (PSPS) assessment form, has been developed and successfully used in the part of the Trust with patients most at risk of developing pressure ulcers. The booklet contains all the vital assessments of the patient’s condition and has helped to ensure these have been documented correctly. To monitor compliance with this initiative we conduct regular audits in each area where patients are at risk of developing a pressure ulcer.

• **Improved documentation of patients’ skin on admission and regular reviews**
  In high-risk areas we trialed photographing pressure ulcers on admission to hospital with patient/carer’s consent. This has helped us to correctly assess the severity of each pressure ulcer and also produced a visual record to monitor healing. A discharge checklist is in use in high-risk areas of the Trust and provides district nurses with comprehensive details of pressure areas on discharge. This will be implemented throughout the Trust in 2012/13.

• **Regular checks**
  We have also introduced ‘Intentional Rounding’ in many areas within the Trust, where nurses intentionally check up on patients at regular intervals rather than waiting for a nurse call bell to be rung. This has enabled us to more regularly change the position of patients to relieve pressure.

• **Improving availability of pressure relieving aids including mattresses**
  In clinical areas where patients may spend time on trolleys, such as the Emergency Department, heel protectors and specialist pressure relieving mattresses have been purchased for all trolleys. In addition to this a stock of pressure relieving mattresses for beds is available both in clinical areas and also via the Trust Equipment Libraries. Additional specialist mattresses are also hired within four hours when required.

**Improving medicines safety**

**WE SAID WE WOULD:**

- Focus on ensuring insulin is prescribed correctly in accordance with hospital guidelines: we aimed to achieve this through the education targeted at all healthcare professionals who prescribe insulin
- Carry out monthly audits of insulin prescriptions and present the results to clinical services and teams so compliance can be monitored
- Provide monthly reports on progress in the quality report to the Board by the Medical Director and Chief Nurse

**WHAT WE DID WAS:**

- Audited practice and delivered educational sessions to medical staff responsible for prescribing medicines. An educational package, drawing on external resources and refined in-house, has been developed and provides a range of learning modules. One of these modules focuses upon the safe use of intravenous insulin infusions.
  - Specific training on insulin prescription and administration has been incorporated into the compulsory education programme delivered to our junior doctors (Foundation level).
- Improved the clarity and accuracy of prescriptions, through feedback and engagement with the clinical service and teams, supported by a ‘back to basics’ poster campaign.
- Developed closer working relationships between pharmacists and clinicians writing out the prescription charts to enable improvement strategies to be effective.
- Revised our guidelines to improve safety with prescriptions, developed processes to learn lessons
from any related incidents and introduced pre-printed prescription forms and ongoing monitoring tools.

- Reformed the Diabetes Clinical Risk Group to monitor ongoing initiatives to ensure safer insulin use.

**Achieving healthcare acquired infection targets**

MRSA and *Clostridium difficile* were monitored separately for the Oxford Radcliffe Hospitals NHS Trust (comprising the John Radcliffe, Horton and Churchill hospitals) and Nuffield Orthopaedic Centre NHS Trust until 31 March 2012.

**WE SAID WE WOULD:**

- Aim for zero MRSA bacteraemias and *C. difficile* cases (Nuffield Orthopaedic Centre)
- Maintain full compliance with the Hygiene Code at the Nuffield Orthopaedic Centre
- Implement systemic Root Cause Analysis (RCA) and case review processes for all surgical site infections

**WHAT WE DID WAS:**

- The Oxford Radcliffe Hospitals NHS Trust met its challenging objectives for both MRSA and *Clostridium difficile* with a comfortable margin.
- The Nuffield Orthopaedic Centre NHS Trust met its MRSA objective but exceeded the *Clostridium difficile* objective by one case. The objective for *Clostridium difficile* was four cases for the Trust and the number of cases observed by the end the year was five. This represents a lower number of cases than in previous years and, following thorough investigation, it was confirmed that there was no relationship between cases. In other words, affected patients did not acquire the infection from one another.
- We have reported progress with the NHS Hygiene Code on a monthly basis to the Clinical Governance Committee. The code contains information on how clean our hospitals are and how reliably our clinical staff wash their hands.

Compliance with the Hygiene Care Code was a priority for the Nuffield Orthopaedic Centre in 2010/11 and we are pleased to report that full compliance with the NHS Hygiene Code was maintained.

- To ensure infection control concerns are acted upon, all incidents were reported via the Incident/Event Reporting System. This system triggers prompt reviews by the Infection Control Team and appropriate clinical leads. A special system designed to find the root cause of surgical site infections was used.

**Safer care in theatres**

We carry out a large number of operations on all four sites in the Trust. The vast majority of these operations go ahead without any problems but the nature of the work in operating theatres brings with it inherent risks. We are keen to ensure our processes related to our operating department safety are set up to minimise these risks as much as possible.

At the Nuffield Orthopaedic Centre we defined specific objectives for 2011/12.

**WE SAID WE WOULD:**

- Aim to ensure that 95% of operating lists start on time
- Implement a policy to ensure safe management of intravenous fluids during surgery to patients
- Audit our compliance with the World Health Organization (WHO) surgical safety checklist to ensure that the entire checklist is completed, as earlier audits suggested a more systematic approach was required to complete the ‘time out’ section at the end of the operation

**WHAT WE DID WAS:**

**Operating list to start on time**

- Unfortunately our target of 95% of operations to start on time was not achieved. However, a method of standard reporting has been implemented to improve our monitoring of start/finish times and theatre efficiency. An electronic reporting tool will be rolled out in 2012/13 and we will report the
success of this through the monthly quality and performance reviews.

- We did increase the efficiency of our use of theatre time (known as ‘theatre utilisation’) and achieved 86% of available theatre time used against the target we set ourselves of 85%. We are conducting a further review of procedures in theatres across all sites within the Trust with the aim of making further improvements in theatre utilisation.

Safer fluid management during surgery
- We piloted the use of an innovative approach to monitor patients’ fluid status during complex surgery using an ‘Intraoperative Doppler’. The Strategic Health Authority (SHA) is analysing results and we will address the recommendations over the course of 2012/13.
- To ensure more rigorous monitoring of intravenous fluids during surgery, we have added fluid management to the ‘track and trigger’ observation chart.

World Health Organization (WHO) Surgical Safety checklist
- The WHO Surgical Safety Checklist is a core of set safety checks for use in any operating theatre environment. The checklist is a tool for the relevant clinical teams to improve the safety of surgery by reducing deaths and complications.
- At the Nuffield Orthopaedic Centre the WHO Surgical Safety Checklist Audit in 2011 showed 100% completion of sign in, time out and sign out stages. This is an improvement on the 2010 audit which revealed 100% compliance with sign in, 98% compliance with time out and 76% compliance with sign out.
- We are now involved in intensive work to ensure that all surgical services across the Trust apply the WHO Surgical Safety Checklist to the standard of the best performing areas. To do this we will ensure that a programme of regular audits in all relevant areas of the Trust will be completed during 2012/13.

Summary of Safer Surgical Services work with the NOC theatres
This NIHR funded research project has worked with both orthopaedic and ortho-plastics theatre teams, testing two interventional approaches to improving patient safety and efficiency.

- **Standardised operating procedures (w. orthopaedics):**
  - Whiteboards are used as a way of briefing theatre staff so important information identified in the morning is shared amongst those joining the team later, and updated when appropriate. Information for each patient on the whiteboard includes: Order on the operating list; Patient name; Operation details (specialist equipment needed, position of patient during the operation and type of anaesthetic).
  - Comments from staff highlighted that communication within the team improved and issues were flagged earlier.

- **Streamlining processes for efficiency and teamwork training (w. plastics) is ongoing and focuses on:**
  - Non-technical skills (including team-working)
  - WHO compliance
  - ‘Glitch count’ – a way of counting the non-operative problems and events. These include problems with equipment, distractions, incomplete planning and preparation etc.
  - Briefings – a process of communication within the team

Over the period of the last two years, 162 operations in the NOC theatres have been observed and recorded, both before and after these interventions. The teamwork coach who worked with the teams at the NOC said: “there is a very high standard of teamworking, briefing and adherence to checklist procedures in evidence. Excellent leadership is being shown by two consultant surgeons and by one consultant anaesthetist.”
Clinical effectiveness

Mortality reduction

The Trust Board quality reports include regular updates on mortality reduction at the Trust. This year has seen the launch of the Summary Hospital Mortality Index (SHMI) by the NHS Information Centre as a new standard mortality measure. The SHMI is published quarterly and the value for the Trust as reported in November 2011 and January 2012 was 1.02, which is within the expected range. Until now there have been several mortality indicators in use and the most widely used version has been Hospital Standardised Mortality Ratio (HSMR). Both the HSMR and the SHMI allow for comparisons to be made with all hospitals and are used as important indicators of the quality or care being delivered. For the time being the HSMR continues to be published by Dr Foster Intelligence and will be included in the Hospital Guide 2012 version. The Trust’s annual HSMR for 2011/12 was 106.1. This fell within the acceptable range, however, we would like to do more to reduce these measures.

WE SAID WE WOULD:
- Strengthen our documentation and clinical coding by improving the accuracy, depth and identification of co-morbidities to ensure data are of good quality
- Review up to 600 sets of health records so that accurate data on the clinical condition and care of patients at the ORH can be precisely published
- Scrutinise health records for quality of care concerns
- Develop standards to audit the review of patient deaths at Mortality and Morbidity meetings for all clinical specialties
- Revise the patient safety strategy and include the patient safety road map as devised by the Patient Safety Federation (South Central Strategic Health Authority)
- Introduce a range of care pathways and bundles to improve mortality rates

WHAT WE DID WAS:
- Increased collaborative working between clinicians and clinical coders to improve documentation that can enhance accurate clinical coding. We did this by setting up regular clinician and coder meetings in a large number of specialties where notes are jointly reviewed. We have been measuring our coding depth, which looks at how we collect key information on a patient’s condition using the Dr Foster tools, and although we have seen an improvement compared to the previous year we are under-indexing by 25% and need to deliver further improvements. We are cascading these meetings throughout the Trust in 2012/13 and have produced a Clinical Coding Best Practice Guide to improve performance.
- Reviewed 483 health records and adjusted the data in 61% of these to include information on the clinical condition.
- Reviewed notes on a monthly basis, using the national trigger tool to identify avoidable harm to our patients. The results of these audits matched themes we had identified through the incident reporting process.
- Developed a standardised approach to mortality review, using audit tools which can be adapted by each specialty in order to ensure deaths are reviewed and lessons are learnt to improve patient safety. Progress has been made with implementing this process and this will be maintained into 2012/13.
- Implemented a range of care bundles for high-risk conditions. These include the management of ventilated patients, patients with pneumonia, centrally inserted intravenous lines (commonly known as ‘drips’) and patients with urinary catheters. There is still further work to be done in this area which we will carry out in 2012/13.
- The patient safety strategy has not been fully revised within this time period. However recent changes to the structure of the corporate team, with the definition of new roles, provides an opportunity for this work to be completed over the coming months.
Enhance clinical pathway redesign

Clinical pathways are an agreed way of managing the overall patient journey to ensure that all who contribute to patient care work together in the same way. When designing a pathway we try to capture the possible events and actions that represent best clinical practice for patients, and include prompts in our paperwork to ensure these actions are carried out. Enhanced Recovery is a partnership programme that improves the experience and wellbeing of patients undergoing surgery. It is a fundamental principle that this partnership includes the patient in conjunction with every healthcare profession participating in their care, from the initial contact with the GP through to discharge from the hospital.

WE SAID WE WOULD:

- Develop an integrated spinal pathway linking services at the John Radcliffe, Nuffield Orthopaedic Centre and with the Primary Care Trust
- Review patient pathways for non-elective (urgent) admissions
- Review and improve patient pathways implemented through the ‘Enhanced Recovery’ principles, and establish a hip and knee school for patients preparing for surgery

WHAT WE DID WAS:

Spinal pathway

- Currently patients are referred for spinal procedures to one of three departments: orthopaedics (Nuffield Orthopaedic Centre), neurosurgery (West Wing, John Radcliffe Hospital) and paediatrics (West Wing, John Radcliffe Hospital). An integrated pathway will enable the most appropriate entry point for the admission and treatment for patients depending on their condition.
- We have made limited progress developing a spinal pathway. Recognising the scale of this project, it has been defined as a CQUIN (see page 33) within our contract with the PCT for 2012/13.

Enhanced Recovery Programme

- Enhanced Recovery has been fully implemented at the Nuffield Orthopaedic Centre. It encompasses a range of preventative measures and is a way of improving patient experience and wellbeing for those undergoing surgery on hips and knees.
- At the Nuffield Orthopaedic Centre physiotherapists have set up a twice weekly ‘hip school’ for patients about to undergo hip replacement surgery. Here patients will meet members of a multidisciplinary team who will help them prepare for surgery in a number of different ways.
  - The consultant provides information about how the operation will be performed and why it is necessary.
  - A pain nurse discusses the type of medication for pain relief that will be given postoperatively. One of the key features of the Enhanced Recovery Programme is the type of anaesthetic used during surgery. We offer patients a short acting spinal injection that wears off after 3-4 hours, combined with a steroid to reduce inflammation and analgesia on the wards. The combination of the spinal injection, analgesia and steroid enables patients to get out of bed earlier and this early mobilisation speeds up recovery.
  - A physiotherapist will measure each patient for crutches and teach them how to use them, particularly in relation to going up and down stairs. Patients can then take them home and are encouraged to practice with them.
  - An occupational therapist can loan aids, such as long handled shoe horns, helping hand grippers to reach to the ground and raised toilet seats. All these are distributed at the hip school.
  - A ward sister will talk to the patient about what it’s like on the ward and what they might need to bring into hospital with them. Many patients who have been through the ERP say that it makes hospital stays less stressful as they know what to expect and what their role is in the recovery process.
- A knee school will be set up in 2012/13 for patients needing knee replacements.
The Patient Pathway Coordinator (Enhanced Recovery lead) said:

- We believe that it is essential that patients are partners in their own care and this addition of the ‘hip and knee school’ to the ER (enhanced recovery) programme will help patients recover more quickly so that their lives can return to normal as soon as possible
- This is good for everyone involved

PATIENT:
I was very happy to be put on your Enhanced Recovery Programme, which enabled me to leave hospital only two days after my operation.

Fracture Prevention Service opens doors

A newly commissioned Fracture Prevention Service officially opened its doors in January 2012 with a ribbon cutting ceremony at the Oxford Centre for Enablement on the Nuffield Orthopaedic Centre site. A Consultant Rheumatologist worked with the Osteoporosis Specialist Nurse and the National Osteoporosis Society to get the Fracture Prevention Service commissioned by NHS Oxfordshire. The nurse led team aims to see and assess all patients in Oxfordshire over the age of 50 who have fractured a bone, and offers them a bespoke bone health and falls prevention management plan. The service has taken off at a pace and has already seen over 400 patients with new operations starting within the JR trauma outpatient service and Horton wards as well as running community clinics across the county. A robust administration team processes all information and deals with appointments, letters and a telephone follow-up monitoring service. By offering this ongoing support service to patients the team hopes to improve the effectiveness of their treatment recommendations.

Pathway for pain management

- This year the Pain Relief Unit, Oxford celebrates 50 years of excellence in the field of chronic pain medicine. The Pain Relief Unit has been looking forward and working with the Oxfordshire Clinical Commissioners to develop a multidisciplinary patient pathway. This pathway aims to offer the best management for patients with persistent pain. After a detailed assessment and a planned, fixed period of treatment, the patient will be discharged back to primary care. Treatment offered in the pathway will be centred on empowering patients to manage their persistent pain. Treatments include expert advice on how to manage their condition, drug optimisation, psychological support and X-ray guided invasive pain management interventions, amongst several other treatments available. In addition, we now provide support for GPs with an email advice line (oxonpainadvice@nhs.net) and the opportunity to discuss specific patients at our multidisciplinary team meetings.

Quality improvements through Patient Recorded Outcome Measures (PROMs)

Patient Reported Outcome Measures (PROMs) are a series of patient questionnaires launched by the Department of Health to collect information on patients’ quality of life before and after surgery. The four procedures measured are:

- hip replacements
- knee replacements
- hernia
- varicose veins.

On admission, each patient will be asked to fill in a short questionnaire before surgery. A few months later, depending on the type of operation, a followup questionnaire is sent to the patient (an ‘after operation questionnaire’) to fill in and send back. The information patients give helps us to measure and improve the quality of health services.
WE SAID WE WOULD

- Increase our collection of PROMs at the Nuffield Orthopaedic Centre to encompass all spinal and physiotherapy patients

WHAT WE DID WAS:

- Implemented PROMs in the following areas, and monitored participation monthly as part of the divisional key performance indicators:
  - knee surgery
  - hip surgery
  - shoulder surgery
  - spinal surgery
  - physiotherapy.
- Benchmarked our performance against other hospital sites for spinal surgery. We are currently extending this for other specialties.
- Developed joint pathways with General Practitioners using decision making tools and advice/education relating to conservative management. Joint implementation is being progressed with the Musculoskeletal Hub Service, Nuffield Department of Orthopaedics, Rheumatology and Musculoskeletal Sciences (University of Oxford) and Biomedical Research Unit (BRU).
- Conducted a trial of electronic capture of PROMs (pilot phase) through our IT system. The analysis of results is underway.
- In addition to PROMs we have continued to capture information on spinal procedures using ‘Spine Tango’ an international spine registry which collects a range of information on spinal conditions and treatment options. The information collected measures pain score, complications, length of stay, patient and surgeon satisfaction and the need for further intervention. This is completed in three stages during preoperative assessment (by the patient and the surgeon), within the perioperative unit (by the surgeon only) and postoperatively (by the patient and the surgeon). Anonymised and encrypted data is sent to a central secure spinal registry database.

The system allows analysis of outcomes and comparisons with national and international units. Key positives from this year’s results show that the length of stay at the Nuffield Orthopaedic Centre is shorter than at other hospitals within the peer group.

Improved radiology turnaround times

In the 2010/11 Quality Account the PCT requested further details in relation to improving diagnostic turnaround times at the Nuffield Orthopaedic Centre.

The Radiology department at the NOC has worked hard to improve the turnaround times for all referral to reporting measures. There are specific challenges to ensure consistent performance on these measures, including the links between the various radiology IT systems and the Electronic Patient Record (EPR). These linkages (which involve an outside provider in Radiology and the Trust IT and EPR system) have been challenged recently with the implementation of EPR across all the Trust sites. However, the department has been working hard to maintain the smooth delivery of the diagnostic testing and reporting for the referrals received. There are clear benefits from using the electronic reporting systems and other IT support software, such as digital dictation and voice recognition.

The target of 95% compliance for an urgent MRI within two working days has been the most challenging target to maintain. The MRI scanner is due for planned replacement. We have reappointed to the 6th Consultant Radiologist position and are actively looking at the job plans within the department to give consistent cover across the week to support improvement for this measure.
Patient experience

Improving communication

The Trust welcomes all feedback from patients. There are several ways in which patients and their relatives can give their views: via the Trust website; by completing a ‘Let us know your views form’; by completing a questionnaire if asked; or by talking to staff or the Patient Advice and Liaison Service (PALS). The need to continually improve communication, information and the way in which we invite and use feedback is well recognised.

In addition we have listened to the views of patients and the public through regular patient feedback and specific meetings in the community3, including the ‘Have Your Say’ event in September 2011, and the public engagement event in March 2012. Access to communications was seen as an area where patients, with particular protected characteristics may be disadvantaged, if their specific communication needs are not met.

We will continue to actively promote the use of interpreting/translating services, including sign language, to ensure patients receive appropriate communication and are better able to advise us of their needs. We will also increase the number of patient documents in ‘Easy Read’ format, to improve access to frequently used patient information. We will continue to hold patient and public events to obtain feedback, identify issues and make improvements to the patient experience for patients who may otherwise be disadvantaged, due to their individual needs, related to their protected characteristics. Further details on all our Equality Objectives can be found on our internet pages.

WE SAID WE WOULD

- Strengthen the current system of collecting patient feedback in all areas. One of the ways we aimed to do this was by collating patient questionnaire responses via an IT system and reporting back to individual teams, directorate board meetings and to the Integrated Governance Committee
- Review the way we communicate, particularly in relation to the process of consent for tests and operations, delays within appointments, admission process, treatment and discharge from hospital
- Improve how our staff directly communicate with our patients
- Improve the way we communicate to our patients if surgery needs to be cancelled

WHAT WE DID WAS:

- Launched our questionnaire ‘Let us know your views’ at the John Radcliffe, Churchill and Horton General Hospitals. In the light of the merger of the NOC and ORH the procurement of the IT system to collect patient feedback was delayed. One system will now be considered for the merged Trust.
- Observational visits by Matrons to seek patients’ views.
- Incorporated patient feedback themes and actions into monthly Divisional Quality Report presented to the Clinical Governance Committee.
- Improved a range of our patient information leaflets on tests and procedures.
- Acted on results from our in-patient and out-patient surveys.
- Carried out a pilot at the Nuffield Orthopaedic Centre for three months which involved giving a pledge to every patient by letter that they will not be cancelled more than once for an appointment or an admission. The resource associated with this pilot is now to be re-evaluated.
- Implemented a protocol concerning how we communicate to patients if surgery is cancelled. In addition we implemented the ‘Choose and Book’ system at the Nuffield Orthopaedic Centre in March 2012.

3 The Department of Health has created a framework known as ‘The Equality Delivery System’ (EDS). It was designed to help NHS organisations to meet the requirements contained within the Equality Act (2010). These relate to four goals: (i) better health outcomes for all; (ii) improved patient access and experience; (iii) empowered, engaged and well-supported staff; and, (iv) inclusive leadership at all levels. Specific engagement work around EDS has taken place.
• Made improvements to the discharge process such as Allied Health Professional / Nurse led discharge and improving transporting of medicines between Pharmacy and the NOC.
• Staff attend regular review meetings with the PCT and patient transport provider to address any issues around delayed transport to take patients home.
• Conducted open meetings with the public to help define our quality priorities for 2010/11 and 2011/12.

There were two national patient surveys in 2011, Inpatient and Outpatient.

Each year five questions from the national in-patient survey make up the national CQUIN relating to patient experience. In 2011 the ORH score was slightly better than the national average. However the overall score was slightly lower than the previous year hence the CQUIN target was not met. The overall score for the NOC was better than the national average with an improvement in 4 of the 5 questions; hence the CQUIN was partially met.

Generally the feedback from both Inpatient and Outpatient surveys were positive but we recognize there are always areas for improvement.

Inpatient survey for 2011 – highlighted that planned admission dates were seen as an issue for patients at the ORH, including not being given a choice, and the date being changed. This key area is being addressed by the Divisional team over the coming months. The NOC scored significantly better than average on 65 of the survey questions, significantly worse on 4 (three of which were around admission dates), and about average on 28 of the questions.

Outpatient Survey 2011 – resulted in actions at the ORH to monitor the details of patients who do not receive notification of changes to appointments and to ensure that all patients do not leave hospital without being given a follow up appointment. The information on the website has been reviewed and more useful patient information has been added to new electronic screens in the outpatient department.

Examples of patient feedback and the OUH responses

<table>
<thead>
<tr>
<th>PATIENTS SAID</th>
<th>CHANGES MADE / ONGOING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Neurosciences, Trauma and Specialist Surgery</strong></td>
<td>The division worked with the EPR team to address issues and temporarily increased staffing within the outpatient departments.</td>
</tr>
<tr>
<td>There was increased feedback from PALS about issues associated with the introduction of the EPR system and outpatient departments.</td>
<td></td>
</tr>
<tr>
<td><strong>Genitourinary Medicine</strong></td>
<td>A patient information leaflet is being produced to assist in explaining the reason to patients. The patient feedback used in GUM services has highlighted problems in communications; in response to these comments, the use of the electronic board and the reception staff to communicate delays is being taken forward.</td>
</tr>
<tr>
<td>Need to improve communication when patients need to be moved to another clinical area.</td>
<td></td>
</tr>
<tr>
<td>Acute General Medicine, John Radcliffe Hospital. Loss of hearing aids and dentures.</td>
<td>As a result of patient feedback in Acute General Medicine, highly visible baskets are now used to store hearing aids and dentures.</td>
</tr>
<tr>
<td><strong>Surgery and Oncology</strong></td>
<td>Mapping of patient demand and the provision of additional clinics has been carried out to enable staff to respond to these demands. A system of hourly checks to the outpatient telephone voice mail has also been implemented.</td>
</tr>
<tr>
<td>Negative feedback about the booking of Urology outpatient appointments.</td>
<td></td>
</tr>
<tr>
<td><strong>Musculoskeletal and Rehabilitation</strong></td>
<td>Patients were reassured that the implant was not used by the NOC.</td>
</tr>
<tr>
<td>Adverse national publicity about specific type of metal hip implant increased number of contacts to PALS.</td>
<td></td>
</tr>
</tbody>
</table>
Discharge within two hours of patient being ‘fit for discharge’

WE SAID THAT WE WOULD:
• Implement a new protocol at the Nuffield Orthopaedic Centre, put in place a staff training programme to deliver this and monitor feedback: audit the use of the protocol and report delays though the incident reporting process.

WHAT WE HAVE DONE:
• This challenging goal was not achieved but we continue to work hard to improve the discharge process, including those elements of it which rely upon co-operation with other providers such as patient transport and referral to social services.

Dignity Action Day

The Trust participated in Dignity Action Day, a national initiative led by the Dignity in Care Campaign and its key partners to bring staff and members of the public together to make a difference to those in care. The campaign’s aim is to stimulate a national debate around dignity in care and create a care system where there is zero tolerance of abuse and disrespect in adults. Two of the initiatives were as follows:

Red pegs

To improve privacy and dignity, clips are being used to secure patients’ curtains. Following the success of the trial at the NOC the pegs have now been rolled out across the John Radcliffe, Churchill and Horton General Hospital sites. The large red pegs have the word ‘Engaged’ printed on them making them clearly visible to staff and patients alike. The pegs are a sign that care is in progress and no-one should enter the curtained area, ensuring that patients are treated with dignity and respect when receiving treatment requiring privacy. The Trust’s former Nursing and Quality Project Lead said:

“Treating all patients with dignity and respect is the first statement of the twelve standards adopted in the OUH Nursing and Midwifery Standards. The use of a red dignity peg is intended to make staff stop and think before entering closed curtain areas.”

Drop-in sessions in Neuro

The Neuro Inpatient Ward (NIPS) and the Neuro Intensive Care Unit (Neuro ICU) at the John Radcliffe Hospital recently held a tea and cake drop-in afternoon involving patients and relatives as well as nurses, doctors, physiotherapists and occupational therapists and other members of the care team. The team shared their experiences of how they work to respect people’s privacy and dignity and how they might improve this in the future. Several former patients were invited to come back and tell the team about their experiences whilst they were inpatients on the wards. The day was also supported by a representative from the charity Headway, which works to improve people’s lives after brain injury.

The Senior Staff Nurse on Neuro ICU said: “Dignity Action Day is about recognising how important it is to treat patients and colleagues with dignity and respect. Most of us do this without thinking but it doesn’t hurt to stop and think about how we behave and the impact it can have on others.”
End of life care

**WE SAID WE WOULD:**
- Provide excellent care for patients who die within our hospitals by developing consistency in our approach to using identified pathways to treat patients effectively. We said we would achieve this by:
  - Implementation of specific care pathways for patients who die in hospital
  - Developing a discharge checklist for those with terminal disease who choose to go home
  - Auditing our practice to identify further areas for improvement

**WHAT WE DID WAS:**
- Set up an ‘End of Life Care Working Party’, comprised of senior clinicians and managers from across the Trust, who met regularly to review the provision of end of life care and lead future developments at the Trust.
- Modify the Liverpool Care Pathway (LCP) for the Dying Patient, specifically for use in this Trust. This pathway aims to ensure that dying patients, and their families, receive the highest quality of care addressing their individual needs. We piloted the LCP on several wards at the John Radcliffe, Churchill and Horton and these wards continue to make use of it.
- The Hospital Palliative Care Team attended an intensive training programme on the implementation of the LCP, which they will use to support the wider use of this pathway during 2012/13.
- Developed a short user-friendly discharge checklist based on the ‘Liverpool Integrated Rapid Discharge of the Dying Pathway’. The implementation of this checklist across the Trust will be a priority for 2012/13.
- Developed a tool to encourage staff to consider the possibility that patients under their care may be nearing the end of life, stimulating appropriate discussions and decision making in conjunction with the patient and their carers.

Screening for dementia and delirium in emergency admissions

**WE SAID WE WOULD:**
- Provide education and training for staff in mental health disorders in older people
- Establish early identification of older patients with dementia, who are hospitalised with an acute condition
- Provide verbal and written information to patients and carers on their diagnosis and follow-up plans

**WHAT WE HAVE DONE:**
- All medical students, foundation doctors and core medical trainees have training on dementia and delirium. Similar training is given to nurses in geratology, general medicine, orthogeriatrics and general surgery. Dementia forms part of the general and geratology nursing appraisal.
- A consecutive patient survey of rates of delirium, cognitive impairment and known dementia is underway in Acute General Medicine and is due to finish in June 2012. This is a follow up to a previous pilot survey undertaken in 2010.
- Rates of screening for cognitive impairment using the abbreviated mental test score (AMTS) and CAM (delirium screen) have been audited in admissions to Acute General Medicine (Aug-Oct 2011) prior to introduction of the post-take ward round proforma.
- A post-take ward round proforma has been introduced (end 2011) that includes recording of known dementia and includes the AMTS and the CAM.
- Rates of screening using the AMTS and CAM have also been audited in Acute Geratology and Community Geratology.
- Delivered an enhanced psychiatric liaison service: during 2011, the original proposal for an enhanced psychiatric liaison service for older people reached an advanced stage of development following input by multiple stakeholders.
However, clinical commissioners elected to pursue an alternative, more generic approach to provision of liaison psychiatry services across the age spectrum, and a revised proposal is being developed by the Oxfordshire Clinical Commissioning Group working with providers (Oxford Health and OUH).

**Patients with learning disabilities**

**WE SAID THAT WE WOULD:**

- Make reasonable adjustments to our service to ensure that all people who have a learning disability do not receive a service that is below the standard given to any other patient
- Continue our work to: identify people with a learning disability; listen to and involve relatives and carers; provide information that is accessible for patients with a learning disability and; ensure hospital passports are available
- Include a monthly progress on this priority by the Medical Director and Chief Nurse within the quality report to the Board

**WHAT WE DID WAS:**

- The hospital passport was produced and launched in 2011 with the aim to improve the experience of patients with learning disabilities and to also improve the communication between patients, carers and hospital staff. The focus for the use of the passport has been on planned admissions to hospital and to encourage forward planning and the identification of care needs between carers and the hospital team, for example when a patient attends a pre-admission clinic. It also serves as a focal point for communication and agreement and can be seen as a 'contract' between the carer, the patient and the hospital team.
- In addition to this, alert stickers have been produced and are in use for patient notes where people with learning disabilities give consent to be identified as having particular needs. Specific teams have had bespoke training which has included partnership working with the ‘Power Up Theatre Group’ which is part of the My Life My Choice advocacy group for people with learning disabilities.
Performance indicators

The data presented provides an overview of performance on certain aspects of the care pathway achieved by the organisation comparing 2011/12 with 2010/11. These are national standards and data are reported monthly as part of the contract with the PCT. Action plans are in place to ensure achievements of the targets for quarter 1 (April – June 2012). As agreed with the PCT data has been reported for the Oxford Radcliffe Hospitals NHS Trust and the Nuffield Orthopaedic Centre NHS Trust separately until March 2012.

<table>
<thead>
<tr>
<th>PERFORMANCE INDICATOR</th>
<th>2011-12</th>
<th>2010-11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Four hour maximum wait in the Emergency Department from arrival to admission, transfer or discharge</td>
<td>95%</td>
<td>NA</td>
</tr>
<tr>
<td>Cancelled operations</td>
<td>5%</td>
<td>0.84%</td>
</tr>
<tr>
<td>MRSA (actual number of cases)</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>C. Difficile (actual number of cases)</td>
<td>205</td>
<td>5</td>
</tr>
</tbody>
</table>

**Referral to Treatment Time**

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Target*</th>
<th>NOC</th>
<th>JR, HG &amp; CH</th>
<th>OUH</th>
<th>JR, HG &amp; CH</th>
<th>NOC</th>
</tr>
</thead>
<tbody>
<tr>
<td>RTT admitted performance</td>
<td>90%</td>
<td>95.63%</td>
<td>89.76%</td>
<td>90.03%</td>
<td>93.57%</td>
<td></td>
</tr>
<tr>
<td>RTT non-admitted performance</td>
<td>95%</td>
<td>97.96%</td>
<td>96.71%</td>
<td>96.28%</td>
<td>97.31%</td>
<td></td>
</tr>
<tr>
<td>RTT incomplete performance</td>
<td>92.66%</td>
<td>95.60%</td>
<td>95.65%</td>
<td>92.94%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RTT admitted – median</td>
<td>&lt;=11.1</td>
<td>13.6</td>
<td>7.98</td>
<td>7.95</td>
<td>10.16</td>
<td>15.2</td>
</tr>
<tr>
<td>RTT admitted – 95th percentile</td>
<td>&lt;=27.7</td>
<td>18</td>
<td>22.69</td>
<td>21.47</td>
<td>27.85</td>
<td>23.4</td>
</tr>
<tr>
<td>RTT non-admitted including audiology – median</td>
<td>&lt;=6.6</td>
<td>6.7</td>
<td>3.25</td>
<td>3.73</td>
<td>3.19</td>
<td>6.5</td>
</tr>
<tr>
<td>RTT non-admitted including audiology – 95th</td>
<td>&lt;=18.3</td>
<td>15.4</td>
<td>16.11</td>
<td>17.23</td>
<td>17.3</td>
<td>14.8</td>
</tr>
<tr>
<td>RTT incomplete – median</td>
<td>&lt;=7.2</td>
<td>5.8</td>
<td>6.03</td>
<td>6.12</td>
<td>6.57</td>
<td>5.9</td>
</tr>
<tr>
<td>RTT incomplete – 95th percentile</td>
<td>&lt;=36.1</td>
<td>20.4</td>
<td>16.86</td>
<td>17.43</td>
<td>21.84</td>
<td>20.8</td>
</tr>
</tbody>
</table>

**Cancer Access**

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Target</th>
<th>NOC</th>
<th>JR, HG &amp; CH</th>
<th>OUH</th>
<th>JR, HG &amp; CH</th>
<th>NOC</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 week GP referral to 1st outpatient</td>
<td>93%</td>
<td>100%</td>
<td>96.68%</td>
<td>87.40%</td>
<td>100.00%</td>
<td></td>
</tr>
<tr>
<td>2 week GP referral to 1st outpatient – breast symptoms</td>
<td>93%</td>
<td>NA</td>
<td>97.40%</td>
<td>74.80%</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>31 day second or subsequent treatment – surgery</td>
<td>94%</td>
<td>100%</td>
<td>97.25%</td>
<td>95.45%</td>
<td>100.00%</td>
<td></td>
</tr>
<tr>
<td>31 day second or subsequent treatment – drug</td>
<td>98%</td>
<td>NA</td>
<td>99.33%</td>
<td>99.83%</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>31 day diagnosis to treatment for all cancers</td>
<td>96%</td>
<td>100%</td>
<td>97.65%</td>
<td>97.50%</td>
<td>100.00%</td>
<td></td>
</tr>
<tr>
<td>Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (radiotherapy treatments)</td>
<td>94%</td>
<td>(only applies for Q4)</td>
<td>NA</td>
<td>96.02%</td>
<td>87.57%</td>
<td>NA</td>
</tr>
<tr>
<td>62 day referral to treatment from screening</td>
<td>90%</td>
<td>NA</td>
<td>84.68%</td>
<td>86.80%</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>62 day referral to treatment from hospital specialist</td>
<td>85%</td>
<td>NA</td>
<td>100.00%</td>
<td>93.60%</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>62 day urgent GP referral to treatment of all cancers</td>
<td>85%</td>
<td>90.24%</td>
<td>87.39%</td>
<td>77.00%</td>
<td>97.87%</td>
<td></td>
</tr>
</tbody>
</table>

**Cardiac Access**

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Target</th>
<th>NOC</th>
<th>JR, HG &amp; CH</th>
<th>OUH</th>
<th>JR, HG &amp; CH</th>
<th>NOC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reperfusion: Primary Angioplasty (PPCI)* (technique for treating coronary heart disease and angina)</td>
<td>75%</td>
<td>NA</td>
<td>96.90%</td>
<td>76.70%</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Patients with 2 week recent onset of chest pain seen in rapid access chest pain clinic</td>
<td>98%</td>
<td>NA</td>
<td>100%</td>
<td>100%</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Stroke Care</td>
<td>60%</td>
<td>NA</td>
<td>83.46%</td>
<td>81.33%</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Access to GUM clinic</td>
<td>48 hour access to Genitourinary Medicine (GUM) clinic</td>
<td>98%</td>
<td>NA</td>
<td>99.80%</td>
<td>99.70%</td>
<td>NA</td>
</tr>
</tbody>
</table>

**NOTES:**

* This is up to the 27th of November 2011, we have submitted year to date averages ever since as a result of the difficulties faces with the ED EPR implementation
* This is up to December 2011 for ORH
* This is up to February 2012 for ORH
* This is for the period covering 01/04/2011 to 31/03/2012
* These figures are for Performance from 01/04/2011 to 31/10/2011
* OUH Performance is for the period 01/11/2011 to 29/02/2012
In 2011, the Trust has continued to prioritise improvement in staff engagement by approving a strategy of ‘Delivering Compassionate Excellence through Staff Engagement’.

<table>
<thead>
<tr>
<th>Values into Action</th>
<th>Staff Survey</th>
<th>Listening into Action</th>
<th>Patient Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value based behaviours</td>
<td>Local Action Planning</td>
<td>Increase leadership capability</td>
<td>Focus on patient experience as component in quality measurement</td>
</tr>
<tr>
<td>Recruitment, Induction, Appraisal, Performance, Training, Communications, Reward and Recognition</td>
<td>Appraisal, Training, Communications and link with local feedback from Patient Survey, complaints, compliments</td>
<td>Structured &amp; sustainable – ‘working in new way’ to impact patient care</td>
<td>Visible senior leadership &amp; input</td>
</tr>
</tbody>
</table>

Staff have been directly involved in the development of our new Trust values, and for the first time all staff were given the opportunity to take part in the staff survey. Staff are involved in the development of action based behaviours that will be used to put our ‘Values into Action’ through new recruitment, induction, appraisal, performance, training, communication, recognition and rewards schemes.

Staff will also be involved in our Listening into Action Patient Experience work so that through learning from staff experience and patient perceptions we are able to Deliver Compassionate Excellence.

The Trust is also committed to delivering the NHS Constitution and its five pledges to staff and examples of how it is doing so are below.

**STAFF PLEDGE 1**

**To provide all staff with clear roles, responsibilities and rewarding jobs for teams**

The results of the 2011 staff survey showed improvements in our overall staff engagement indicator. A comparison of the relative position of the OUH against the Association of UK University (AUKUH) Trusts indicates that when measured against the number of improved factors, the Trust is one of the five Trusts in the country that has shown the most improvement. The ranking for the Trust on this measure is 4 out of 41.

The survey indicated that:
- people felt valued by their work colleagues
- staff felt that their role made a difference to patients
- staff felt that the incident reporting procedures were fair and effective
- a low number of staff had experienced physical violence.
However, we need to make continued improvement around:

- access to appraisal, training,
- work life balance
- aspects of health and wellbeing.

Local and organisational plans are focused on aligned attention and action on issues arising from our staff survey. The results of the survey are fed back to staff and Trade Union Representatives. A summary of a comparison of relevant key findings is below.

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>2011 Score</th>
<th>2010 Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>% staff feeling satisfied with the quality of work and patient care they are able to deliver</td>
<td>78</td>
<td>74</td>
</tr>
<tr>
<td>Levels of Staff Engagement (score out of 5)</td>
<td>3.68</td>
<td>3.66</td>
</tr>
<tr>
<td>Staff recommendation of the Trust as a place to work or receive treatment (score out of 5)</td>
<td>3.66</td>
<td>3.62</td>
</tr>
<tr>
<td>% staff appraised</td>
<td>73</td>
<td>69</td>
</tr>
<tr>
<td>% staff receiving job relevant training, learning and development</td>
<td>74</td>
<td>78</td>
</tr>
<tr>
<td>% staff able to contribute to improvements at work</td>
<td>62</td>
<td>63</td>
</tr>
</tbody>
</table>

**Staff Pledge 2**

To provide all staff with personal development, access to appropriate training for their jobs and line management support to succeed.

**Example 1**

**MARS Investors in People Assessment**

During January 2012 the MARS Division was successfully re-assessed against the Investors in People Standard which sets out best practice for learning and development. Key strengths identified as part of the assessment included:

- Coaching practices within the wards;
- The investment in leadership development including the use of 360 degree feedback tools to support the organisational values;
- The management and reporting of statutory and mandatory training;
- The effectiveness of managers in supporting their staff.

**Example 2**

**Statutory and mandatory training**

This year has seen a comprehensive review of how statutory and mandatory training is delivered and reported which will set the foundations for the introduction of a competence based approach to the training delivery. During the last quarter of the year competencies have been developed for all the statutory and mandatory training programmes using benchmarking and best practice. The benefits of this new approach include:

- measuring competence rather than attendance, focusing on the outcomes of the training to enhance the patient experience and the capabilities of our staff;
- giving staff the opportunity to demonstrate they are currently competent thereby negating the need to be re-trained. This reduces the time required for refresher training and enables more time to be spent delivering front line services to patients;
- giving increased access for staff to access training and competency assessment through new programmes and wider access by staff using PCs and the internet recognising that the organisation is a 24 hour service.
**STAFF PLEDGE 3**

To provide support and opportunities for staff to maintain their health and wellbeing and safety.

**EXAMPLE 1**

*Health and Wellbeing Strategy*

In the last year, the Trust has agreed a Health and Wellbeing Strategy and established a new group that is made up of representatives from Divisions, Corporate Directorates and Trade Union representatives. The aim of this group is to make sure that as one of the largest employers in Oxfordshire, and as a provider of healthcare, the Trust is committed to leading by example on staff health and wellbeing. Taking an evidence based approach, using findings from the staff survey and from activity/trend information from Occupational Health and from safety teams, the group is tasked with making sure that the needs of the staff are met in different ways.

**EXAMPLE 2**

“For staff, by staff”

The philosophy which underpins the strategy is one of self-help and individual responsibility, supported by a corporate framework that enables, supports and promotes a healthy lifestyle, culture and good practice in relation to workplace risks to health. A ‘for staff, by staff’ approach is encouraged in that staff who want to lead and run health and wellbeing activities will be supported to do so. Consequently, practical support has been given to staff who have run informal ‘rounders’ matches with teams from across the Trust!

**STAFF PLEDGE 4**

To engage staff in decisions that affect them and the services they provide and empower them to put forward ways to deliver better and safer services for patients and their families.

**EXAMPLE 1**

*Equality and Diversity Data*

In early March 2012 we hosted a panel of internal representatives and people from relevant external groups to evaluate our performance in Equality and Diversity.

The panel used the NHS Equality Delivery System (EDS) to undertake the analysis. The panel was able to represent the interests of patients and staff across all the protected characteristics as defined within the Equality Act 2010. One of our Equality and Diversity objectives was developed specifically to address this issue for both patient and staff data as follows.

- To improve the capture and analysis of workforce and patient information by protected characteristic, by 2013:
  - 95% of patient records to include age, sex and race.
  - 95% of staff records to include data on disability, religion and sexual orientation. (Note, data on age, sex and race is already over 95%. Ethnicity data is currently being sought to ensure accuracy of the data held).
EXAMPLE 2

Learning from feedback

Equality and Diversity objectives developed following feedback from the panel in March 2012 focused on bullying and harassment, and the need for managers to support and motivate their staff to work in culturally competent ways within a work environment free from discrimination. Two of our Equality and Diversity objectives reflect the need to make improvements in these areas as follows:

- To increase awareness of Equality and Diversity across the Trust by reviewing and improving the Equality and Diversity training in 2012:
  - ensuring staff competence is assessed
  - ensuring that at least 90% of staff have completed Equality and Diversity training by 2013.
- To reduce, year on year, the amount of bullying, harassment or abuse at work experienced by staff from other staff (as reported in the staff survey).

STAFF PLEDGE 5

To support all staff in raising concerns at the earliest available opportunity about safety, malpractice or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Public Interest Disclosure Act 1998

EXAMPLE 1

‘Raising Concerns at work’

A revised policy came into effect on 1 April 2011 that was based on the recommendations from the Social Partnership forum in conjunction with Public Concern at Work. It included a specific ‘Pledge of Action’ to ensure that the policy was adhered to, and to assure staff that their concerns will be taken seriously and introduced a dedicated email and phone numbers for staff, as well as a ‘front page’ link from the Trust intranet home page. The Board receives a quarterly update on the number of concerns raised.

EXAMPLE 2

‘If you see something say something’

To support the introduction of a new Staff Pledge in the NHS Constitution which came into effect in March 2012, the Trust has undertaken a desktop review of its practices and updated its communication and advice pages. We have introduced a new campaign called “If you see something say something” and made sure that communications have gone out via OUH News and new posters. The intranet has also been updated ensuring that the new NHS national hotline number is publicised as well as our own local procedure.
NHS Oxfordshire (NHSO) has reviewed the Oxford University Hospitals NHS Trust Quality Account for 2011/12.

There is evidence that the Trust has relied on both internal and external assurance mechanisms to produce this report. NHSO is satisfied that this Account meets the nationally mandated criteria for a Quality Account and that this document does not contain any inaccuracies to the best knowledge of the PCT.

NHSO monitors a wide range of information relating to the quality of care provided by the OUH and meets with the OUH Medical Director and Chief Nurse on a monthly basis to look at ways of improving quality of care for patients.

NHSO has worked closely with the OUH on agreeing stretching CQUIN initiatives and is pleased to see that these align with the Quality Account priorities set out for 2012/13. This indicates that the Trust is actively engaged in quality improvements with NHSO and reinforces the good working relationship with the PCT. The priorities stated by the OUH will, if successfully implemented, have a positive impact on quality. The aim to improve end of life care will link with work being done by Oxford Health. This demonstrates the Trust is also committed to contributing to quality improvement goals across the Oxfordshire health economy. An Oxfordshire wide CQUIN to reduce the number of patients who have had their discharge delayed has also been agreed.

The OUH scored slightly lower in the national patient experience CQUIN than last year. It is difficult to draw any conclusions from this survey as local OUH data is currently insufficient to provide a clear understanding. As a result, NHSO is working with OUH to develop a local patient experience CQUIN aimed at gathering more sophisticated information on the patient experience of services provided.

Screening for dementia and delirium remains a work in progress with the target being met only partially in 2011/12. A CQUIN is in place for 2012/13 to develop a psychiatric liaison service which should lead to improvements in these areas.

OUH continues to work on a number of patient safety initiatives including the WHO surgical checklist and reducing pressure ulcers and NHSO supports this work.

OUH has made some noteworthy improvements, with the Trust being the first in South Central to introduce a digital breast screening service and also one of the first Trusts to successfully extend the breast screening age range. The OUH is also performing more consistently against the national targets (18 week wait, cancer wait, A&E) and this has been a good improvement from last year.

This quality account is presented in an understandable and consistent format and provides a comprehensive view of the quality of clinical services in the OUH. NHSO would like to congratulate the Trust for this.

The primary purpose of Quality Accounts is to encourage boards and leaders of healthcare organisations to assess quality across all the services they offer. This document achieves this and NHSO is looking forward to continued close working with the OUH as we move towards commissioning across Clinical Commissioning Groups and the National Commissioning Board.
Independent Auditor’s Limited Assurance Report

I am required by the Audit Commission to perform an independent assurance engagement in respect of Oxford University Hospitals NHS Trust’s Quality Account for the year ended 31 March 2012 (“the Quality Account”) as part of my work under section 5(1)(e) of the Audit Commission Act 1998 (the Act). NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010 and the National Health Service (Quality Account) Amendment Regulations 2011 (“the Regulations”). I am required to consider whether the Quality Account includes the matters to be reported on as set out in the Regulations.

Respective responsibilities of Directors and auditors

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Account) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Accounts presents a balanced picture of the trust’s performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and

- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors’ responsibilities within the Quality Account.

My responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to my attention that causes me to believe that the Quality Account is not consistent with the requirements set out in the Regulations.

I read the Quality Account and conclude whether it is consistent with the requirements of the Regulation and to consider the implications for my report if I become aware of any inconsistencies.

This report is made solely to the Board of Directors of Oxford University Hospitals NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010.

Assurance work performed

I conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the NHS Quality Accounts Auditor Guidance 2011/12 issued by the Audit Commission on 16 April 2012. My limited assurance procedures included:

- making enquiries of management;
- comparing the content of the Quality Account to the requirements of the Regulations.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

contd…
**Limitations**

The scope of my assurance work did not include consideration of the accuracy of the reported indicators, the content of the quality account or the underlying data from which it is derived.

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

**Conclusion**

Based on the results of my procedures, nothing has come to my attention that causes me to believe that the Quality Account for the year ended 31 March 2012 is not consistent with the requirements set out in the Regulations.

**Maria Grindley**  
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27 June 2012
Acknowledgements

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We would like to acknowledge the helpful feedback from the PCT which we have responded to by making the necessary adjustments to our final version of the Quality Account.

Feedback

Readers can provide feedback on the report and make suggestions for the content of future reports, or request further information. Please contact our Media and Communications Unit:

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