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Patients and our staff are at the heart of what we do. Providing world class quality of care is a priority for Oxford University Hospitals NHS Trust

We aim to provide care that offers excellent clinical outcomes for our patients, and to do so with compassion that is evident to those patients and their carers. The central goal of Delivering Compassionate Excellence is firmly enshrined in the organisation’s values: excellence, compassion, respect, learning, delivery and improvement. Along with our partners, we have made real progress during the course of 2012/13 in improving further the quality of the care that we provide across our diverse range of services. However, the publication of the Report of the Public Inquiry into events at Mid Staffordshire NHS Foundation Trust by Robert Francis QC in February 2013 served as a stark reminder of the importance of maintaining an unrelenting focus on quality and compassion when delivering healthcare. The Francis Report has provided an important opportunity for reflection and has reinforced for us the vital importance of our ongoing work around the Trust’s values.

This Quality Account forms part of our annual report to the public about the quality of our services. It describes our key achievements during 2012/13 and our priorities for quality improvement during the forthcoming year 2013/14. In developing our Quality Account we have identified and shared information across the Trust, with our doctors, nurses, therapists and management teams, with our service users and those who commission services from us. In some areas, we have not achieved all that we had hoped to, but overall I am impressed with the tangible progress that we have made during the past year.

Quality Strategy
During 2012 we launched our Quality Strategy, which articulates a five-year vision for the organisation and aims to deliver continuous quality improvement focusing on the three key areas: patient safety; patient experience; and clinical effectiveness (outcomes). We are currently concentrating on leadership, education and training, the development of robust systems and processes for measurement and monitoring, and robust self-assessment and benchmarking to ensure that we deliver year-on-year improvements in the quality of our services going forward. We will review our progress annually to ensure we are meeting all relevant national quality standards and to ensure that our declared objectives remain relevant, stretching and effective in helping us achieve our vision. We particularly want the experience of our patients to drive changes and improvements in the services we provide.

Our successes
We have had notable successes during this year which include the following.

- The referral to treatment standards for both admitted and non-admitted patients have been consistently met at organisational level and this is also reflected at specialty level.
- The eight key cancer standards have been achieved on a quarterly basis.
- Good progress has been made in relation to infection control seeing a reduction in both MRSA and Clostridium Difficile infection rates.
- Our rates of Venous Thromboembolism (VTE) risk assessment have been consistently above the 90% national target during 2012/13 and we received recognition as one of the most improved trusts in England.
- Services across the Trust have, for the first time, worked to identify and share specific quality improvement priorities at a local level for 2013/14.
- We became a fully operational Major Trauma Centre (MTC), bringing with it an increase in the number of patients with complex injuries.
- We won a Health Service Journal Award for 2013 in the category of Improving Care with Technology.
- We introduced an award programme to recognise staff members and volunteers who go above and beyond the call of duty in serving our patients. A Trust award ceremony was held in 2012 to share and formally recognise some outstanding and inspiring contributions.

**Academic partnerships**

One of our strategic objectives is to develop both clinical and academic networks. The formation of the Oxford Academic Health Consortium and the Oxford Academic Health Science Network will assist in the translation of research into innovative practice. Our partnerships with the University of Oxford and Oxford Brookes University complement and enhance the services we offer; supporting the delivery of teaching, education, training and research. Noteworthy developments over the past year include the following.

- The Acute Vascular Imaging Centre (AVIC) officially opened alongside the Oxford Heart Centre and the Emergency Department at the John Radcliffe Hospital as a unique, research-funded facility to develop faster and safer treatment for arterial blockages.
- The Nuffield Orthopaedic Centre has been designated as a Centre of Excellence by Arthritis UK to reduce the risk of osteoarthritis in sportspeople and to facilitate safe sport in the wider population.
- A formal Joint Working Agreement with Oxford Brookes University to support collaboration and partnership.

**Key priorities**

Over the year ahead, we aim to deliver quality improvements across a large number and range of projects and services. All are underpinned by our values and the goal of Delivering Compassionate Excellence.

In this Quality Account, we have sought to identify, from this wider pool of quality improvement work, a modest number of key priorities in order to develop a focus at organisational level for the year ahead. This modest number of priorities does not mean that we will not push forward with quality improvement projects in other areas of the Trust’s work. Indeed, the articulation of quality priorities at service level across the organisation has been a key achievement for 2012/13 and we are eager to see delivery against these locally owned projects.

These key priorities at Trust level are consistent with the overarching goals contained within our Quality Strategy and articulated through our Trust values.

**Financial and operational performance**

In the last financial year (April 2012 to March 2013), the Trust met its financial targets and successfully delivered a challenging savings plan and achieved savings of £45.5 million and a surplus of 0.44% of turnover of £822 million. This is a significant achievement and thanks go to all our staff who continue to work hard to improve the quality of care while reducing costs.

Throughout June to December 2012 the Trust consistently met or exceeded the national target of 95% of patients seen and discharged or admitted within four hours of arrival. The winter months (January, February and March 2013) were extremely challenging with increased Emergency Department attendances and admissions and we were disappointed that performance was below target at 89.7%. We have been working hard with Oxford Health, Oxfordshire County Council and Oxfordshire Clinical Commissioning Group to ensure this target is sustained throughout 2013/14.
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. We were pleased to see an increase in the 62 day referral to treatment time in respect of screening programmes to 6.3% above the target level of 90%. There was a slight dip in performance seeing patients in rapid access chest pain clinics following two week onset of chest pain; 99.8% against the 100% target. Service changes are being implemented to ensure that this performance improves.

We aim to be successful in our formal application to become a Foundation Trust in 2013/14. The process we are going through to achieve Foundation status is a rigorous one, and requires us to demonstrate that quality is central to decision making at every level of the organisation. Authorisation as an NHS Foundation Trust would provide real assurance that clinical practices, governance arrangements and financial management are of high quality. We are working with the NHS Trust Development Authority (TDA) that acts on behalf of the Secretary of State for Health in the preliminary assessment of the Trust’s application. Our application will then be passed to Monitor for the final stage of assessment and we hope to be authorised as a Foundation Trust in the latter months of 2013/14.

The improvements delivered this year 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 outcomes for patients who use our services. I thank them for their energy and professionalism.

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

NOTES:
1. Delivering Compassionate Excellence is about being a patient-centred organisation providing high quality, compassionate care with integrity. Regular updates are included in OUH News: www.ouh.nhs.uk/news/ouh-news
2. For the Francis Report go to: www.midstaffspublicinquiry.com/report
3. A formal designation process for the Oxford Academic Health Science Centre is now underway
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 the 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 are robust and reliable, conform to specified Data Quality standards and prescribed definitions, and are 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

Date: 26 June 2013.

Chair

Date: 26 June 2013.

Chief Executive
WHAT IS A QUALITY ACCOUNT?

Quality accounts are annual reports to the public from NHS providers about the quality of the services provided and they aim to enhance accountability to the public for the quality of NHS services. The OUH Quality Account sets out where the Trust is doing well; where improvements in quality can be made; priorities for the coming year; and, how service users, staff and others with an interest in the Trust have been involved in determining the priorities for the coming year.

Quality Account Priorities for 2013/14

We will continue to push forward with priorities identified in last year’s Quality Account, where some have been achieved but need to be sustained, and in others where we have achieved some improvement but still require further work.

Over the year ahead, we aim to deliver quality improvements across a large number and range of projects and services. There have been several different drivers in the development of these projects: the goals set out in our Quality Strategy; priorities set for the NHS nationally; priorities agreed with commissioners as part of our CQUIN contract; and, ideas that have grown organically from service level. All are underpinned by our values and the goal of Delivering Compassionate Excellence.

During 2012 we consulted with our staff and asked them to identify two quality priorities from each quality domain per service area, applicable to their patients’ needs, that they would focus on for the next 12 months. These have been displayed across clinical areas and progress will be reported to the Clinical Governance Committee. Examples of these include reducing the occurrence of pressure ulcers (sores) and improving the way we support patients to recover after illness or surgery.

Discussions with our Commissioners produced a list of CQUIN goals for the forthcoming year. Some have been ‘rolled over’ from last year. Information can be found on page 42.

In March 2013 we held a ‘Let us hear your views’ event where we asked our service users for their ideas and comments on our proposed quality priorities. We were pleased to see that the topics discussed all seemed to resonate with stakeholders and service users. We have organised further events to discuss our progress and receive feedback.

Within each of our priorities we have set ourselves for 2013/14 we have linked several related projects from our consultation process and CQUIN goals. We look forward to developing these over the coming year.

NOTES:

4. Commissioning for Quality and Innovation (CQUIN) payment framework enables commissioners to reward excellence, by linking a proportion of the Trust’s income to the achievement of local quality improvement goals.

5. Patient safety, patient experience and clinical effectiveness (outcomes).
LOOKING FORWARD: Quality Account Priorities for 2013/14

IN SUMMARY:
The quality improvement priorities for 2013/14 are:

**Patient Safety**
- Safer care associated with surgery

**Clinical Effectiveness**
- Use of technology to improve care

**Patient Experience**
- Improving the way we listen and act on feedback
- Improving care for people with cognitive impairment

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Patient Safety

**Safer care associated with surgery**

**WHY WE CHOSE THIS**

In 2012/13 49,950 operations were carried out in our hospitals. The majority of these patients recovered quickly and went home without any complications. Surgical procedures do contain inherent risks and ensuring these risks are managed and mitigated against is a key priority for us. Mitigations include reducing surgical site infection rates, readmission rates and preventing ‘never events’. In 2012/13 we had four incidents referred to as ‘never events’ which all related to retained swabs. In each case, we carried out a detailed investigation and put actions in place. An External Review on safety culture across our Trust theatre departments has also been conducted.

**OUR AIMS**

- Reduce unplanned returns to theatre
- Reduce the waiting times for inpatients needing surgery
- Achieve 100% compliance with the Trust policy for counting swabs used in surgery
- Reduce organ/space infection rate (Mediastinitis) following cardiac surgery by 0.5%
- Develop surgical site surveillance system for all elective and emergency orthopaedic surgery, vascular surgery, WHIPPLES procedure and Deep Brain Stimulators to determine the infection rate
- Achieve 100% compliance with WHO surgical safety check list
- Reduce the number of cancellations for elective surgery

**OUR ACTIONS**

- Lead a programme of work through the Cross-Divisional Theatre Group based on the findings of our external review
- Audit compliance with the Trust swab and all related theatre policies
- Develop a strong senior leadership team in theatres
- Recruit to vacant posts in theatres
- Closely investigate reported incidents through our incident reporting system (Datix)
- Audit infection rates following surgery and carry out a root cause analysis of organ site infections
- Audit the use of the WHO check list and take appropriate steps in cases of non-compliance
- Clinical supervision and teaching sessions to improve knowledge, skills and support
- Display ‘Staff briefing’ notices to communicate key learning points

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Many older people are admitted every year to our trauma services with a broken hip following a fall. Care is often particularly challenging because older people often have more complex health conditions impacting on more than one system. Following surgery, expert medical input to older patients admitted into surgical areas has been shown to reduce the length of time patients stay in hospital, by ensuring co-existing medical conditions are treated effectively. We have agreed a CQUIN covering these issues with our Commissioners.

Each patient needs to make a balanced decision on whether or not to have a procedure as part of their treatment. It is crucial that relevant information is presented to patients in a manner which is easy to understand, setting out the risks and benefits, and alternative treatment options where possible.

- Improve the outcomes for elderly frail patients in surgical areas
- Improve pre-assessment of patients being admitted for surgery
- Improve discharge planning by providing patients with enough information explaining what to expect and who to contact with any questions or worries
- Prevent avoidable readmissions by identifying factors at clinical service level which contribute to these
- Improve patient information in relation to surgery and their likely experience
- Additional information on readmission rates at the OUH can be found on page 24.

- Improve consent processes for patients encompassing patient information, documentation and training
- Improve process of ‘delegated consent’ to ensure a fully trained relevant member of staff obtains this providing full information
- Introduce assessment of capacity, into the consent process, particularly regarding children and patients with a learning disability or cognitive impairment

- Improve the ‘Frailty Team’ by increasing the support provided by physicians to surgical and trauma services so that it becomes a six day service
- Evaluate impact of expanded Frailty Team
- Improve discharge information so patients know what to expect when they leave hospital
- Expand nurse advice phone service ‘hot line’ for patients who have been discharged and reinstate this where it has previously proved successful
- Revise consent process:
  - a) forms to better describe risks and benefits
  - b) accompanying patient information

- Improve consent training for staff and cascade through Trust
- Develop consent tool to prompt and assist appropriate assessment of capacity

Monitoring and Reporting

A project group chaired by an Executive Director will be established to monitor surgical care. Cross-Divisional Theatre Group will manage the theatre action plan.

The project group will monitor consent. We will audit a) compliance with the consent process b) consent training.

Readmission rates will be monitored by our outcomes committee chaired by the Assistant Medical Director. We will identify specific readmission projects based on the 2012/13 data (published in June 2013). Improvements in our readmission rates will be shared using our Quality Newsletter for Staff.

Improvements in care to older patients in surgical areas will be monitored by measuring length of stay. Progress by Divisions contributing to this service will be assessed during performance review meetings.

We will report progress regularly to the Trust Clinical Governance Committee and our Commissioners. Regular reports will be taken to the Quality Committee by the Medical Director.

NOTE:
Clinical Effectiveness

Use of technology to improve care

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<th>OUR ACTIONS</th>
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<td>The use of new technologies shapes our expectations of how healthcare will be delivered. Many people now use electronic media as part of their daily lives. Over the past year we have successfully introduced several new technologies to help patients manage their conditions at home with fewer visits to the hospital. Technologies have also helped speed up some hospital systems, such as the way we dispense medicines and remote visual consultation between doctors treating skin conditions. We want to expand the way we use technologies inside the hospital, with patients and with our community colleagues. We have designed three CQUINs spanning these issues.</td>
<td>• Expand electronic test requesting and reporting to enable faster treatment of conditions in the community and more rapid referral to hospital for specialised tests • Enable virtual assessment by hospital doctors of patients in community care settings to enable early identification of people needing hospital admission and to support colleagues in community to deliver most effective care • Understand how we can improve health outcomes following heart attacks</td>
<td>• Introduce electronic radiology requesting and reporting to GP practices • Expand algorithms supplied with test requests to aid consistent testing of more complex conditions by GPs • Feedback from GPs will be obtained to determine future improvements to algorithms • Use telemedicine to support more accurate assessment of patients who have become acutely unwell in hospital settings • Use iPads to record physical measurements of patients who have had heart attacks to improve long term health outcomes</td>
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Human Factors (HF) encompass all those issues that can influence people and their behaviour and particularly the interaction of humans and technical systems. Evidence shows that HF can be a factor in clinical errors and complaints.

| | Improve the way our staff work together and particularly how we communicate critical information requiring immediate attention and action | Deliver HF training to clinical staff teams; this will include simulations of critical high risk situations as a technological advance • Use of teamwork training based on a successful programme in the aviation industry which has been shown to significantly improve safety levels • Analyse and identify incident and complaints trends at clinical specialty level to identify an active learning culture |

Monitoring and Reporting

A project group will monitor electronic test requesting. Electronic requesting and reporting activity per GP practice will be tracked and feedback collected.

Telemedicine joint project group will coordinate and measure the effectiveness. OUH specific progress will be monitored via Divisional Performance Reviews.

Learning points identified through HF training will be shared through our Quality Newsletter for Staff.

We will report progress regularly to the Trust Clinical Governance Committee and our Commissioners. Regular reports will be taken to the Quality Committee by the Medical Director.

NOTES:
7. For more information on Human Factors go to: www.institute.nhs.uk/images/documents/SaferCare/Human-Factors-How-to-Guide-v1.2.pdf
Patient Experience

**Improving the way we listen to and act on feedback**

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<th>WHY WE CHOSE THIS</th>
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<td>Our patients have told us that they would like us to do more than just listen to them; they want to be part of the conversation. This means having all the information about their diagnosis and treatment options so that they can make informed choices. Our patients want to know what we do with their feedback, comments and complaints. They want to hear about the good stories too as this plays a major role in how they manage their anxieties when receiving hospital care. Evidence also suggests that organisations who listen to their staff provide safer care.</td>
<td>• Build a ‘whole-picture’ understanding of patient experience • Respond to patient and staff feedback so changes in the way we deliver care and organise our services can be demonstrated • Improve the signposting to other information resources such as that provided via Patient UK(^8) • Be in the top quartile of hospitals that patients and staff would recommend to friends and family. (The Friends and Family Test is a national CQUIN)</td>
<td>• Develop a consistent patient feedback system across our hospitals • Continue to use technology, social media and patient feedback websites such as NHS Choices and Patient Opinion to respond quickly to patients and use their experiences to improve our services • Develop mechanism for evaluating feedback based on Trust values and 6 Cs(^9) • Increase the number of patient engagement forums (particularly those embedded at service level) to progress this work • Review and expand information provided to patients on diagnosis and treatment options • Report on success and innovation across the Trust to the media, on our website, through social media and in our publications by the Media and Communications Unit • Work towards capturing patient experience whilst it is happening, by using all means available including new technology, and encouraging patients to give us their feedback so that it can be used as soon as possible to improve the service to patients, and talk to them about what we’ve done • Improve communication with staff through ‘Listening into Action’ project</td>
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**Monitoring and Reporting**

An Inpatient Survey ‘Task and Finish’ Group will coordinate and align Divisional actions based on survey results. Specific local improvements taken following patient feedback will be monitored via Divisional Performance Reviews and reported in Divisional Quality Reports. Learning and actions will be shared through our Quality Newsletter for Staff.

We will report progress regularly to the Trust Clinical Governance Committee and our Commissioners. Regular reports will be taken to the Quality Committee by the Medical Director.

**NOTES:**
8. *Patient UK* provides medical information and support: [www.patient.co.uk](http://www.patient.co.uk)
### Patient Experience

#### Improving care for people with cognitive impairment

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<td>Increasing numbers of older people admitted to hospital have dementia or other forms of cognitive impairment.</td>
<td>• Improve the way we assess and provide care for patients with dementia and other forms of cognitive impairment</td>
<td>• Expand the dementia care service by the appointment of three new consultant liaison psychiatrists</td>
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<td>Over the last year we have made good progress in the way we treat older patients with dementia, and in the environment in which they are cared for.</td>
<td>• Develop exemplary clinical leadership in dementia care from our psychiatric liaison team</td>
<td>• Improve training for staff in relevant clinical areas</td>
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<td>We would like to do more to improve the way we identify, treat and care for older people.</td>
<td>• Provide carers with relevant and useful information on the care, treatment options and further resources in the community</td>
<td>• Improve the number of older people assessed for dementia and other cognitive impairments as set out in the national CQUIN</td>
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<td></td>
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<td>• Further develop the physical environment</td>
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<td>• Establish dementia champions</td>
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<td>• Carry out regular surveys to improve the quality of support and information provided to and feedback received from carers</td>
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#### Monitoring and Reporting

Dementia project team will monitor a) rate of cognitive assessment b) leadership development and training c) audit results of support to carers. Adherence to referral pathway will be monitored via Divisional Performance Reviews.

We will report progress regularly to the Trust Clinical Governance Committee and our Commissioners. Regular reports will be taken to the Quality Committee by the Medical Director.
LOOKING BACK: Progress on quality priorities for 2012/13

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

**Patient Safety**
- Safe medicines delivered on time
  - Medicines reconciliation
  - Medicines to take home
  - Medicines storage and security

**Clinical Effectiveness**
- Innovation to support better care
  - Electronic early warning system
  - mHealth

**Patient Experience**
- Improving end of life care
  - Care of the dying
  - Identification of those near end of life

**Delivering Compassionate Excellence**
- Ward Manager Leadership Programme
- HCA Academy
- Developmental ward programme delivered with academic partners

Patient Safety

Safe medicines delivered on time

**MEDICINES RECONCILIATION**

Our aims: To deliver medicines reconciliation promptly after admission. Our aim was to check that all patients had the correct medication on admission and make sure that any changes, omissions or unintentional discrepancies were communicated with the next person(s) caring for the patient.

Our actions: We set ourselves targets of achievement with our Commissioners:

- **Quarter 2:** 70% of patients have a medicines reconciliation within 24 hours in at least one month per quarter
- **Quarter 3:** 75% of patients have a medicines reconciliation within 24 hours in at least one month per quarter
- **Quarter 4:** 80% of patients have a medicines reconciliation within 24 hours in at least one month per quarter

Our results: We exceeded each of the quarterly targets for patients having a medicines reconciliation within 24 hours.

**MEDICINES TO TAKE HOME**

Our aims: To improve the speed at which patients receive their medicines to take home (TTOs) when discharged.

Our actions: We introduced iPads allowing instantaneous direct ordering by the ward pharmacist of medicines to take home.
We carried out an audit in February 2012 to measure TTO ordering and processing before iPads. This covered wards from all four hospital sites and recorded the time from the Pharmacy staff transcribing the request to the time marked as checked in the dispensary (= total request time). A sample of these audits showed the time for the request to get back to Pharmacy was one hour before the use of iPads.

We have installed a robot into Pharmacy and are now commissioning the software that will allow us to select the drugs, label, check and ‘bag up’. We have been using the robot since the end of June 2012 and this will be followed by rigorous testing, before full implementation, expected September 2013.

**Our results:**

iPads have greatly reduced the time for requests to be received and processed by Pharmacy. This has also freed up time for our Pharmacy staff to spend time supporting patients to understand how to ensure their medicines are taken correctly when they go home, for example when to take them, and what side effects to look out for.

Our next step will be to work with the community pharmacists to improve long term compliance with medication regimes. Evidence shows that it is not uncommon for patients to stop taking their medicines after a month or so when their condition improves.

We anticipate that the robot will prove to be very precise and will further improve the speed and accuracy of our service. To monitor our performance we will re-audit in July 2013, following the robot bedding-in phase and extended roll out of iPads.

### MEDICINES STORAGE AND SECURITY

**Our aims:**
To audit our medicines safety and security performance and make improvements where they are required.

To deploy advanced ePrescribing and Medicines Administration as part of the ‘Electronic Patient Record’ (EPR) project.

**Our actions:**
We completed a programme of medicines safety and security audits across all Divisions of the Trust. Action plans have been produced where required and the Divisions are monitoring these. Action plans have been reviewed and received by the Trust Clinical Governance Committee.

We have not achieved our aim to incorporate ePrescribing into the EPR project; this has been delayed until September 2014, in line with the national programme.

**Our results:**
Wards are now critically reviewing all security processes with action plans in place to implement improvements where they were identified. Examples include the following.

- New doors have been added to drug cupboards.
- New locks have been placed on doors in medicines storage areas.
- Clear procedures have been put in place for clinical areas that are closed over night for the storage of drug cupboard keys.

To facilitate the deployment of ePrescribing into the EPR project we have built 10,000 drug sentences. These are part of the software design for medicine prescriptions and ensure that accurate doses are prescribed.
Clinical Effectiveness

Innovation to support better care

**ELECTRONIC EARLY WARNING SYSTEM**

**Our aims:** The early recognition of the deterioration in a patient’s condition enables prompt and life-saving interventions to be put in place.

We wanted to develop an electronic system for recording and interpreting patients’ vital signs that promotes safe, high quality clinical care.

**Our actions:** We assessed our existing recordings of vital signs (paper charts) during 130 observation periods examining Human Factors associated with this to understand how we needed to design the software. This helped us understand fully the processes of measuring and documenting vital signs, including factors which promote and hinder best practice.

An extensive consultation process followed when we also reviewed research literature to understand how vital signs are used from clinical, managerial and educational perspectives. As part of this review, four commercial vital sign recording tools were assessed and we carried out a clinical trial of one of these systems in more than 1000 patients on two wards in the John Radcliffe Hospital.

We built a system based on the same Human Factors methods that are employed by the aviation and nuclear power industries. This approach ensures that systems are safe, reliable and intuitive.

**The new system includes a number of features**

- Best-in-class barcode scanners have been incorporated into the system to enable rapid and secure clinician access and patient identification, enhancing usability in pressured clinical situations.
- Ergonomically-designed roll stands which integrate the patient monitors and the computer tablet for data entry enable vital sign data to be entered seamlessly at the bedside, allowing clinical staff to interact with patients.

**How it works**

- Vital sign data are entered and reviewed using touchscreen tablets.
- Data are instantly analysed and plotted onto the on-screen track-and-trigger chart. The doctor receives immediate feedback and can compare abnormal vital sign readings to previous measurements.
- The clinician can act swiftly to treat the patient’s condition.

**Our results:** We have greatly improved the recognition of all deteriorating patients thus the risk of becoming ill in hospital, unrecognised, is significantly decreased.

The Francis Report made specific mention that such a tool should become part of clinical practice.

**Feedback:** Recently presented to the Trust’s ‘Recognition of the Acutely Ill and Deteriorating Patient’ Committee, the system was very warmly received, with Dr Paul Altmann, Chief Clinical Information Officer for the OUH, commending the team for their considered approach.

Perhaps most importantly, given the aims of the project, reactions from future users have been extremely positive. “We love it” said Eniola Dada, Clinical Lead for the High Dependency Unit in the Nuffield Orthopaedic Centre.
mHEALTH

Our aims: Diabetes in pregnancy\(^{10}\) (gestational diabetes), if not controlled, can increase the risk of birth complications, such as babies being large for their gestational age. Women with poorly controlled diabetes in pregnancy are at risk of other health conditions.

We wanted to assess the practicality and reliability of remotely monitoring blood sugar results through the use of smartphones, allowing the hospital specialists to ‘virtually’ monitor levels and adjust treatment.

Our actions: We established a working group and developed and tested the software (the ‘app’). Smartphones with the app recorded blood glucose readings sent via Bluetooth from the blood glucose meter. The results were then sent automatically from the phone to a hospital server. Results were electronically plotted on a chart and reviewed by hospital specialists. It was initially tested on a small group of women with gestational diabetes.

We made refinements to the software before rolling out the devices to 50 women with gestational diabetes. The hospital diabetic specialist midwife, on receipt of the blood sugar result, was able to advise the women by text or phone calls to adjust their insulin doses to achieve better glycaemia control.

Our results: This project has been extremely successful; women have been able to Bluetooth daily blood glucose readings and get prompt advice by text or phone from our specialist diabetic midwife. This has enabled their diabetes to be closely monitored and had the added benefit of reducing the frequency of antenatal visits for these women. This is in contrast to the traditional method of managing diabetes which requires women to keep a daily record of their blood glucose readings and review these and their insulin requirements fortnightly at the hospital. Women have found the smartphone app easy to use and have been reassured to get regular communication from the specialist diabetic midwife.

A randomised controlled trial is now in place to compare this method of monitoring with standard clinic care.

Feedback: Zoe, 22 weeks pregnant
“\(^{10}\)I developed gestational diabetes with my last pregnancy and was managed the old fashioned way; writing blood test results in a booklet and seeing the hospital specialist every week. This time I only have to go to the hospital every 2-3 weeks. The kit is very easy to use, it reads the blood sample and I send this daily by Bluetooth to the hospital. I then get a text message from the hospital telling me how to alter my insulin dosage. There also is a setting on the phone to call the midwife urgently or non-urgently. The only thing to remember is to keep the phone charged!

This time I feel far more in control. I can see all my blood sugar readings on a chart so can see trends. If for any case the hospital doesn’t receive my readings they send me a text message. I feel far safer this time knowing the hospital checks my reading every day rather than once a week as was the case in my previous pregnancy.

It also fits in with family life and with two young children it is easier not having to go to the hospital as often.

My advice to women would be to try it!”

NOTE:
10. For more information go to: www.nhs.uk/conditions/pregnancy-and-baby/pages/diabetes-pregnant.aspx#close

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Patient Experience

Improving end of life care

WHY WE CHOSE THIS: Improving the care patients receive at the end of their lives has been and remains a key objective. This relates to a) the way we recognise patients are coming to the end of their lives b) the care we provide in hospital c) the decisions that patients and their family make in relation to where they choose to die and d) the way we work with our partners in the community to provide a seamless service.

CARE OF THE DYING

Our aims: To provide compassionate care addressing the needs of those who are thought to be dying imminently. Our aim was to support the use of the Liverpool Care Pathway (LCP) on a case by case basis in defined services where clinicians felt this was appropriate and where necessary training had been provided.

To design a discharge checklist for patients who are thought to be dying imminently and choose to be transferred from the acute hospital to the place of care of their choice. We anticipated this would enable a smooth transfer of care ensuring all the necessary plans are in place.

To explore how we allocated side rooms where desired by the patient or family.

Our actions: The LCP has been in use on wards including Oncology, Geratology, SEU and the Stroke Unit. Following concerns expressed nationally and in the media with regard to the LCP, we have continued to facilitate its use in those areas where expertise and experience has been established but have not introduced it in other clinical areas. Where it had been used successfully, a key element has been the full involvement of patients and their families in all aspects of decision making. In the event of an improvement in a patient’s condition the use of the LCP has been discontinued.

We successfully designed and implemented a discharge checklist which we have made available on our intranet. We defined criteria to assist the discharge process.

- The patient indicated a wish to be at home.
- Family and carers support this decision.
- Clinical team agrees the patient is being discharged for end of life care.

Our results: We carried out a survey of how we use side rooms and found that where available these are offered to patients at the end of life. The newer buildings incorporating specialty departments had a great number of side rooms. We found the majority of staff recognised the need to offer side rooms to patients at the end of life and would escalate this to senior managers to help arrange this when necessary.

We identified a range of facilities for relatives in terms of comfortable furniture and bedding. This survey has helped us highlight precisely what actions we need to take in the coming year.

The discharge checklist has proved to be a great success and has been positively rated by our staff. It is used when both patients and our clinical team agree on discharge for end of life care. It contains a series of prompts for the following.

- Communication with the patient, family and other professionals in the community who will be involved in providing care.
- Medications – relevant drugs and equipment.
- Equipment – delivered to destination / instruction on how to use.
- Contact details – of hospital / community staff.
- Transport – booked.
- Decisions about resuscitation – family and relevant staff aware.
- How the patient / family can access information.
IDENTIFICATION OF THOSE WHO MAY BE COMING TO THE END OF THEIR LIVES

Our aims: We wanted 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.

Our actions: We developed a local tool ‘Oxford Priorities for Treatment, Information and Care’ (OPTIC), primarily for use in clinical specialties who have more patients at the end of their lives.

Our results: We tested the OPTIC tool with the Acute General Medicine team and are now evaluating the pilot and considering whether to expand its use in this and other relevant clinical areas.

Our palliative care team has actively supported ward staff to deliver care to patients nearing the end of their lives.

JOINT WORKING WITH OUR COLLEAGUES IN THE COMMUNITY

Our aims: We wanted to ensure our ‘End of Life Care Group’ worked in close collaboration with the community End of Life Care Reference Group. This would ensure a common vision and seamless care for patients in Oxfordshire.

Our actions: We have taken an active role in the Oxfordshire End of Life Care Reference Group alongside our colleagues in the community including Oxford Health, ambulance service, social services and Out of Hours Services. We have met monthly and agreed that each quarter the focus of the meeting will be on issues primarily related to OUH.

Our results: We have begun to use the Advance Care Planning documentation, developed by the group, which includes guidance for both patients and healthcare professionals to aid communication and help ensure patients’ wishes regarding care at the end of life are met.

Joint working has had positive results. We have implemented Oxfordshire Advance Care Planning documentation across our health economy.
Delivering Compassionate Excellence

Last year we launched Delivering Compassionate Excellence aimed at further embedding the delivery of excellent care with compassion and respect. We recognised that there was a significant nursing contribution and wanted to pull together a number of work streams linked to our Trust values in order to further develop nursing care and culture. For increased focus we developed a CQUIN around Nursing Leadership with our Commissioners.

CARE SUPPORT WORKER ACADEMY

**Our aims:**
Launch the Care Support Worker (CSW) Academy in 2012/13 to provide a focused induction to clinical areas and to develop skills and knowledge through teaching, mentoring and assessment of competence.

Recruit CSW staff based on Trust values.

Measure outcomes of the first group of CSW who progressed through the Academy.

**Our actions:**
The CSW Academy was launched in May 2012 and 130 people have been through it to date. We increased the teaching component of CSW induction from three days to two weeks. Beginner band 2 portfolio competencies have been introduced and support provided from Practice Development Nurses, Band 4 Assistant Practitioners and Ward Managers.

We have held four open days for the CSW Academy. These have provided an opportunity to discuss our Trust values with prospective candidates and answer any questions related to working at the Trust and how they would be supported to develop knowledge and skills.

We have used values based interviews for all new CSW.

The Saïd Business School has evaluated the CSW Academy and we expect to receive their report in the near future.

**Our results:**
Attendance at the open days has been excellent and these have helped with recruitment.

Values based interviewing has helped us identify applicants who want to learn and whose values are aligned with the Trust’s including showing compassion and respect for others. It has also helped us to direct the right people to the right clinical areas, for example a recent applicant was keen to work with older people, so was referred directly to the Geratology Unit.

Our CSWs have told us they feel better prepared and armed with more knowledge and skills.

Regular drop-in days to clinical areas have helped us to get feedback from managers, mentors and CSWs. This has helped us to understand that we need to do further work to improve the way competencies are completed.

“The Care Support Worker Academy is great and it is really valuable in ensuring that new CSW have the right growing and common knowledge as sometimes this is difficult to acquire in busy clinical environments where supernumerary time may not be assured. It is an excellent development.”

Sister, Neurosciences
Our aims: 
We wanted to develop the leadership capability of clinical sisters/charge nurses within a variety of clinical environments. This leadership programme incorporates role modeling, staff motivational skills and the management of service improvements through influencing skills. By understanding the impact of leadership we hoped aim to improve capabilities.

Develop ‘Productive Ward’ lean working essential modules.

Improving competencies and skills assessment of staff including challenging multidisciplinary practice.

Evaluate the impact on quality metrics and team measures incorporated within the programme.

Our actions: 
We developed the programme and included three Productive Ward modules.

- ‘Knowing How We are Doing’.
- ‘Well Organised Ward’.
- ‘Patient Status At a Glance’ (PSAG) notice board.

These modules promote more efficient working and processes enabling the staff to spend more time in direct patient care.

Team work and communication skills were enhanced using a number of means including a the PASG approach that highlighted key indications in the monitoring of clinical care: these encompassed the completion of initial patient assessments (nutrition and skin care) and identification of potential safeguarding issues such as visual or hearing impairments that could affect both communications and patient understanding.

Quality metrics were identified linked to projects that were carried out as part of the programme.

Each ‘Front Line Leader’ was put through a Skills Assessment Centre to identify specific individual learning needs and feedback for personal development plans.

Feedback from the entire year’s programme is currently being evaluated, analysed and reviewed to advise the Trust Board of lessons learnt and proposed improvements to the programme.

Our results: 
The programme has generally been rated positively by those who participated.

Each Front Line Leader is in the process of completing actions within a plan that was agreed by the relevant matron. Action plans have been linked to the following nursing metrics.

- Nutrition and Hydration.
- Privacy and Dignity.
- Estimated Date of Discharge (EDD).

Competencies and skills assessments were rated positively.

The Trust is developing the programme further in the coming year in order to gain improved alignment with Trust strategies and quality priorities and is seeking feedback from not only attendees but line managers. Feedback from our Commissioners has helped with this process and to re-shape the CQUIN for this coming year.

NOTE:  
11. The Productive Ward focuses on improving ward processes and environments to help nurses and therapists spend more time on patient care thereby improving safety and efficiency. For more information go to: www.institute.nhs.uk/quality_and_value/productivity_series/productive_ward.html
Feedback: Examples from Frontline Leaders action plans include the following.

1. Implementing, improving and sustaining daily multidisciplinary team (MDT) ward rounds, led by senior nurses.
2. The MDT agreeing the EDD in a timely process, discussing this with the patient and relatives, and updating it daily on Casenotes and on the ‘Patient Status At a Glance’ white board.
3. Completion of effective and up-to-date nursing documentation for every patient, to be audited for compliance on a weekly basis.
4. Defining levels of care for staff working in ICU by implementing care bundles that will streamline documentation and nursing intervention and improve patient safety, quality and efficiency of care.
5. Adhering to standards around privacy and dignity in theatres, in particular keeping patients covered until surgeon scrubbed and using exit doors appropriately.
6. Adhering to protected mealtimes at all times, with no interruptions to patient meals.
7. Reducing breaches of the 4 hour ED quality indicator by implementation of the new ‘Transfer from ED’ policy.

Our aims: We wanted to provide a framework to deliver the Developmental Ward Programme that aligned with the Trust’s quality objectives and patient experience strategy.

We chose to focus initially on Clinical Nurse Specialists (CNS) and Consultant Nurses and their job role and ‘value added’ in terms of service improvement and patient experience to enable standardisation and equity as well as career development.

Our actions: We have worked with our educational partners to develop these roles and foster a greater understanding of the job content with the context of the national initiative to modernise nursing careers. This has involved establishing workshops with key stakeholders and setting up clinical supervision sets.

All CNS have been invited to complete a portfolio of evidence against a range of competencies from the complexities of physically assessing patients to planning treatment pathways with the multidisciplinary team.

Our results: The CNS team and Consultant Nurses have been assessed against standard Trust competencies. Clinical supervision and shared learning were incorporated within the assessment process.

Further projects spanning 2013/14 that are in progress.

- Developmental programme for the Practice Development Nurses and Clinical Educators in partnership project with Oxford Brookes University.
- Senior Nurse development programme – using portfolio support and clinical supervision groups.
Patient Safety

Patient Safety Thermometer
Since July 2012, all adult inpatient wards (excluding the short-stay Emergency Assessment Units) have completed the NHS Patient Safety Thermometer on a given day every month. The tool identifies patients who receive ‘harm free’ care by collecting data in relation to four ‘harms’:

- Pressure Ulcers (PU)
- Falls causing harm
- Catheter-related Urinary Tract Infections (CUTI)
- New Venous Thromboembolism (VTE)

We now have data for over 8000 patients giving us a reliable baseline from which to inform and monitor our improvements over the next 12 months and beyond. Over the coming year we plan to introduce the FallSafe Care Bundle across all wards to reduce the number of reported falls. We are keen to do more to reduce the numbers of avoidable pressure ulcers and continue to work with our colleagues in the community to improve preventative measures. In the year ahead we will conduct a review of our Tissue Viability Service and develop a bed and mattress management service.

Quality Walk Rounds
Since April 2012 63 Executive-led Quality Walk Rounds have taken place. The walk round methodology was reviewed in the summer and there is now a greater emphasis on the patient experience as well as patient and staff safety. The development of action posters enables all staff to be informed of the outcomes of the walk rounds and what improvements they can anticipate. During 2013 walk rounds will also take place ‘out of hours’ to enable us to have a round-the-clock view of issues affecting our ability to deliver safe care and a positive patient experience.

Patient Safety Committee
During 2012 the Patient Safety Committee (PSC) was established as a sub-committee of the Clinical Governance Committee.

This Committee, chaired by the Chief Nurse, co-ordinates patient safety activity across the Trust, overseeing the delivery of a patient plan, monitoring safety projects and directing initiatives and campaigns to improve the safety of patient care.

Sub-groups of the PSC are:

- Falls Steering Group
- Pressure Ulcer Group
- Safeguarding Group
- Technologies Appraisal Group
- Recognising Acutely Ill and Deteriorating Patients Group (RAID)
- Venous Thromboembolism (VTE) Group
- Conscious Sedation Working Group

Patient Safety First Campaigns
During 2012/13 the Trust has taken part in campaigns hosted by Patient Safety First, namely Safer Surgery Week and Nutrition and Hydration Week; both served to raise awareness among staff at all levels of these essential aspects of delivering safe care.

Venous Thromboembolism Assessment (VTE)
VTE (the formation of blood clots within the veins) is a condition that contributes to an estimated 25,000 deaths amongst patients in hospital each year; some of which could be avoided. National guidance by the National Institute for Health and Clinical Excellence (NICE) states that 90% of all patients should be assessed for their risk of suffering from a VTE on admission to hospital.

VTE successes
- We are pleased with the progress made to increase our assessment rate. During 2012/13 our hospital reporting system ORBIT (OUH Reporting Business Intelligence Tool) reported that we achieved 92.43% against the national target of 90%, a significant increase on our rate of 78.35% for the previous year. Following this the Trust received third prize for the most improved VTE CQUIN results by Lifeblood, the Thrombosis Charity, and the All Party Parliamentary annual awards for NHS trusts.
Smartphone app to help prevent clots. A nurse and her team at the Churchill Hospital developed an award-winning mobile phone application which could help prevent potentially fatal VTE. The application won first prize in the Lifeblood charity’s national VTE awards 2012 for the best delivery of patient information on VTE.

Incident Reporting

We were pleased to introduce an electronic incident reporting system (Datix) across the Trust on 1st April 2012. The system went fully live on 1st October 2012, which meant that all paper forms were withdrawn as on-line reporting commenced for the whole Trust. Datix was already well established at the Nuffield Orthopaedic Centre (NOC) prior to the merger with the Oxford Radcliffe Hospitals NHS Trust which greatly helped with the roll-out. Since April 2012, over 900 members of staff have been trained to review incidents using the Datix system. In addition our managers have received ‘root cause analysis’ training to ensure incidents are thoroughly investigated and that the causal factors are properly identified.

Electronic incident reporting has enabled us to have real-time assessment of clinical incidents and has greatly helped to identify trends so that we can act quickly to improve patient safety. We are keen to maximise the benefits of this new reporting system and have engaged staff and Datix to help identify and take steps to develop this further.

What we have done so far:

- taken the first steps to becoming a reference site (able to demonstrate industry best practice for using Datix and a leading example of a good adopter of the system)
- undertaken an electronic health check
- implemented learning from other organisations
- engaged and responded to feedback from users.

One of the measures used to determine a safe culture by NHS England[^12] 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.

<table>
<thead>
<tr>
<th>Source: Health and Social Care Information Centre (HSCIC)</th>
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<tbody>
<tr>
<td>OUH 2012/13</td>
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[^12]: Formerly established in October 2012 as the NHS Commissioning Board, NHS England is an independent body contributing to the Government’s vision to modernise the health service: [www.england.nhs.uk](http://www.england.nhs.uk)

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High rates of incident reporting are regarded as a mark of good practice as long as an appropriate balance of no/low harm incidents are reported.

This chart shows that the majority of incidents reported at the OUH caused no harm.

Incident reporting training has helped our staff grade the actual harm or impact accurately.

The table below highlights that despite an increase in reported incidents the percentage causing harm has decreased year on year.

The number and, where available, rate of patient safety incidents reporting within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

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</thead>
<tbody>
<tr>
<td>(i) Number of patient safety incidents</td>
<td>11234</td>
<td>12689</td>
<td>5668</td>
<td>4926 (for acute teaching trusts)</td>
<td>10455</td>
<td>1767</td>
</tr>
<tr>
<td>(ii) Rate (per 100 patient admissions or 1000 bed days)</td>
<td>5.2</td>
<td>6</td>
<td>6.44 (per 100 admissions)</td>
<td>7.03</td>
<td>12.12</td>
<td>2.77</td>
</tr>
<tr>
<td>(iii) Percentage of patient safety incidents that resulted in severe harm or death</td>
<td>1.7</td>
<td>1.3</td>
<td>0.9</td>
<td>0.5</td>
<td>1.6</td>
<td>0</td>
</tr>
</tbody>
</table>

The Trust is required to disclose national data where available. However the 2012/13 HSCIC data included above is only available for the first 6 months of the year. External Audit as part of their work reviewed the full year local data supplied by the Trust. This identified some overstatement of the Trust’s categorisation of Patient Safety Incidents Resulting in Severe Harm or Death with harm being attributed to incidents that did not occur in hospital. As a result of that work the number of Patient Safety Incidents and the Percentage of Patient Safety Incidents that resulted in severe harm or death has been re-reviewed and these have both decreased.

The Unaudited and Audited data for 2012/13 is as follows:

<table>
<thead>
<tr>
<th>TARGETS</th>
<th>Unaudited Data 2012/13</th>
<th>Audited Data 2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Number of Patient Safety Incidents</td>
<td>14,180</td>
<td>13,860</td>
</tr>
<tr>
<td>(ii) Rate (per 100 patient admissions or 1000 bed days)</td>
<td>7.3</td>
<td>7.4</td>
</tr>
<tr>
<td>(iii) Percentage of Patient Safety Incidents that resulted in severe harm or death</td>
<td>0.9</td>
<td>0.4</td>
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</table>

Department managers who review reported incidents are being trained to ensure that the harm accorded to incidents accurately reflects the harm that occurred within the Trust, and was not harm caused outside the hospital. The electronic incident form also provides an explanation for people reporters about how to select the level of harm caused by an incident. Severe harm and catastrophic incidents are reviewed daily by the risk management department and are investigated.
Clinical Effectiveness (outcomes)

Summary Hospital Mortality Indicator (SHMI)

The SHMI was launched in 2011 and reports mortality at trust level across the NHS in England. It covers all deaths of patients admitted to hospital and those that occur up to 30 days after discharge from hospital. Several other mortality measures are published, however the Department of Health is committed to implementing the SHMI as the single hospital-level indicator for the NHS in England and has commissioned the Health and Social Care Information Centre (HSCIC) to produce it. Since it was first published we have been pleased to see our rate continue to fall and have kept within the expected range.

The HSCIC also collects information on the number of patients coded as receiving palliative care as this helps to put the mortality measures into context. At the Oxford University Hospitals NHS Trust significant inpatient palliative care services operate within the Trust (Sir Michael Sobell House Hospice). This contrasts with many other trusts where palliative care facilities are located within the community and are not managed by the acute NHS trust. Approximately 10% of patients who die at the Oxford University Hospitals NHS Trust do so within the hospice. The table below shows the higher rate of palliative care coding at the Trust when compared with the national picture.

<table>
<thead>
<tr>
<th>SOURCE: Health and Social Care Information Centre (HSCIC)</th>
<th>OUH 2010/11</th>
<th>OUH 2011/12</th>
<th>OUH 2012/13</th>
<th>National Average</th>
<th>Highest</th>
<th>Lowest</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) The value and banding of the Summary Hospital Mortality Indicator (SHMI) for the Trust for the reporting period; and</td>
<td>1.02 (95% CI: 0.98-1.05)</td>
<td>0.98 (95% CI: 0.95-1.02)</td>
<td>Latest figure October 2011 – September 2012: 0.96 (95% CI: 0.89-1.12)</td>
<td>1.00</td>
<td>1.26</td>
<td>0.71</td>
</tr>
</tbody>
</table>

| b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty for the Trust for the reporting period. | 23% | 22.9% | 23.84% | 18.6% | 35.82% | 0.34% |

NOTE:
13. For information on how the SHMI is calculated go to: www.hscic.gov.uk/SHMI
In the 2012 Hospital Guide (produced by Dr Foster) our mortality rate as measured by the hospital standardised mortality ratio (HSMR) was published as being higher for emergency admissions over the weekend. (This was for the time period 2011/12.) We analysed our weekend mortality rates and carried out a survey of services responsible for major acute admissions at weekends. Our findings indicated some issues with flow and efficiency / access to support services or registrar level doctors at the Churchill Hospital or Radiology Department at the Horton General Hospital but there were no systematic issues affecting quality or mortality. We reported our findings to the Trust Clinical Governance Committee and also shared these with the Care Quality Commission. We are pleased that our mortality rates for emergency admissions for 2012/13 are within the expected range and show no divergence from those during weekdays. We are also pleased that mortality rates for patients undergoing surgery remain within expected limits for each day of the week.

In addition to this we also audited 1385 admissions for 2012/13 to check if we had recorded and coded accurately all the necessary information about patients’ admissions that would affect how the mortality rates were calculated. We were pleased to note that the documentation and coding had improved when compared to 2011/12 and we are monitoring these closely through national audits of clinical coding levels.

Achieving healthcare acquired infection targets

The Oxford University Hospitals NHS Trust met its challenging targets for both MRSA and Clostridium Difficile (C.Difficile). The rate of C.Difficile per 100,000 bed days for 2012/13 was 19.81 and is shown in the chart below. Information from the HSCIC setting out national averages for comparison is published up to 2011/12.

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<tbody>
<tr>
<td>The rate per 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patient aged two or over during the reporting period.</td>
<td>34.14</td>
<td>24.15</td>
<td>19.81</td>
<td>21.8</td>
<td>51.6</td>
<td>0</td>
</tr>
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</table>

Readmission rates

Evidence shows that nationally approximately 8.3% of all admissions are readmissions within 30 days of discharge. The reasons for this are often complex, without one causal factor.

Our readmission rates have been higher than expected over the past year. We have also had several alerts via the Dr Foster system and more than expected readmissions for certain conditions as noted on Quality Risk Profiles (QRPs) produced by the Care Quality Commission (CQC). In December 2011, we implemented a new electronic patient record (EPR), which replaced our electronic patient administration system (PAS). As part of the stabilisation period, which extended into 2012/13, numbers of elective admissions were recorded as emergency admissions. For a temporary period this will have artificially inflated the reported emergency readmission rates. In addition, a certain proportion of patients treated with chemotherapy will have complications following treatment. As it is not known which patients will develop these complications, and on what day, we cannot plan to admit them in advance.

NOTE:
14. HSMR calculates a ‘risk-adjusted’ mortality ratio from a group of 56 diagnosis groups that account for 80% of deaths. For more info go to: www.drfosterhealth.co.uk/features/what-are-hospital-standard-mortality-ratios.aspx
15. QRPs are tools used by providers of healthcare, commissioners and the CQC to monitor compliance with the CQC essential standards of care. Information is analysed to help identify if standards are being met. For more information go to: www.cqc.org.uk/organisations-we-regulate/registered-services/quality-and-risk-profiles-qrps
We therefore have an open door policy so that if these patients develop complications they can be admitted and treated quickly. Under strict clinical coding rules, when these patients return to hospital they are categorised as readmissions. Several of the alerts on the Dr Foster system have been triggered by our open door policy. We believe it is good practice to enable patients receiving cancer treatments to return if they feel unwell.

Some people, however, return to hospital simply because they have not been given enough information about what to expect following discharge. Relatively easy steps to reduce avoidable readmissions include a) improving information given at discharge so that common symptoms can be anticipated and managed effectively and b) installing a phone advice ‘hot line’ managed by specialist nurses. We are working hard to ensure material provided to patients on discharge accurately describes what to expect, how to access support and when symptoms may be serious requiring urgent attention.

Data from the HSCIC is only available for readmission rates up to 2010/11 and shows our readmission rates broken into two age categories. These time periods relate to the years before the NOC and ORH merged so are depicted separately. The readmissions rate for patients over 15 years of age at the ORH is slightly higher than the national average for both 2009/10 and 2010/11.

**HSCIC data**

The percentage of patients readmitted to a hospital within 28 days of being discharged from a hospital.

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</thead>
<tbody>
<tr>
<td>(i) 0 to 14 (NOC)</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>10.15%</td>
<td>14.34%</td>
<td>6.23%</td>
</tr>
<tr>
<td>(i) 0 to 14 (ORH)</td>
<td>8.74%</td>
<td>8.53%</td>
<td>9.33%</td>
<td>10.15%</td>
<td>14.34%</td>
<td>6.23%</td>
</tr>
<tr>
<td>(ii) 15 or over (NOC)</td>
<td>10.18%</td>
<td>9.86%</td>
<td>10.40%</td>
<td>10.15%</td>
<td>14.34%</td>
<td>6.23%</td>
</tr>
<tr>
<td>(ii) 15 or over (ORH)</td>
<td>11.24%</td>
<td>11.96%</td>
<td>11.72%</td>
<td>11.12%</td>
<td>14.09%</td>
<td>9.18%</td>
</tr>
</tbody>
</table>

Readmission rates published by Dr Foster are available until October 2012 and show readmission rates as a percentage of total admissions for patients 15 years and over as being slightly higher for April to October 2012 than for the same period for the previous year.

**Dr Foster data**

<table>
<thead>
<tr>
<th>Age 0-14</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2011/12</th>
<th>2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2011/2012</td>
<td>5.10%</td>
<td>4.80%</td>
<td>5.20%</td>
<td>4.00%</td>
</tr>
<tr>
<td>FY 2012/2013</td>
<td>10.40%</td>
<td>10.30%</td>
<td>8.20%</td>
<td>4.00%</td>
</tr>
<tr>
<td>Age 15+</td>
<td>2011/12</td>
<td>2012/13</td>
<td>2011/12</td>
<td>2012/13</td>
</tr>
<tr>
<td>FY 2011/2012</td>
<td>7.40%</td>
<td>6.90%</td>
<td>7.20%</td>
<td>7.20%</td>
</tr>
<tr>
<td>FY 2012/2013</td>
<td>7.80%</td>
<td>7.40%</td>
<td>7.50%</td>
<td>8.00%</td>
</tr>
</tbody>
</table>
Helping people recover from illness and injury

Patient recorded outcome measures (PROMs) calculate health improvement from a patient's perspective by asking patients about their health and quality of life before and after their specific operations. Over the last year the Department of Health has changed the way this information is collected to make it easier to identify specific areas for improvement in the care we provide. Over the next year we will work hard to ensure that we can make direct improvements to our services based on PROMs feedback. The data for hip and knee arthroscopy has already enabled us to change the patient care pathway.

Our current participation rates are:

- varicose veins 38.2%
- groin hernia 57.6%
- hip replacement 51.3% (national data)
- knee 144.7% (national data)

National HSCIC data

April 2012 to December 2012, provisional (published 9 May 2013)

<table>
<thead>
<tr>
<th>Provider name</th>
<th>Eligible episodes</th>
<th>All procedures Participation rate</th>
<th>Groin hernia Participation rate</th>
<th>Hip replacement Participation rate</th>
<th>Knee replacement Participation rate</th>
<th>Varicose vein Participation rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENGLAND</td>
<td>175,885</td>
<td>67.10%</td>
<td>55.00%</td>
<td>74.40%</td>
<td>80.10%</td>
<td>39.40%</td>
</tr>
<tr>
<td>OUH</td>
<td>1492</td>
<td>71.40%</td>
<td>57.60%</td>
<td>51.30%*</td>
<td>144.70%*</td>
<td>38.20%</td>
</tr>
</tbody>
</table>
Data collection issues relating to the merger of the two trusts in 2011 have affected the Trust’s overall score. Local data submission shown in the table below indicates that our participation for hip and knee replacement differs to that recorded nationally. For example hip replacement was 86% and knee replacement was 82%. In addition we also collect data for shoulder replacement, 97%, and spinal surgery, 90%.

Local data submitted to Quality Health, the data collection company for orthopaedic procedures, is shown in the table below.

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Eligible episodes</th>
<th>All procedures Participation rate</th>
<th>Groin hernia Participation rate</th>
<th>Hip replacement Participation rate</th>
<th>Knee replacement Participation rate</th>
<th>Varicose vein Participation rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENGLAND</td>
<td>247,702</td>
<td>74.60%</td>
<td>60.60%</td>
<td>82.30%</td>
<td>89.30%</td>
<td>48.9%</td>
</tr>
<tr>
<td>OUH</td>
<td>2,079</td>
<td>31.9%</td>
<td>48.9%</td>
<td>13.20%*</td>
<td>46.10%*</td>
<td>41.60%</td>
</tr>
</tbody>
</table>

* Data collection issues relating to the merger of the two trusts in 2011 have affected the Trust’s overall score. Local data submission shown in the table below indicates that our participation for hip and knee replacement differs to that recorded nationally. For example hip replacement was 86% and knee replacement was 82%. In addition we also collect data for shoulder replacement, 97%, and spinal surgery, 90%.

<table>
<thead>
<tr>
<th>Age 0-14</th>
<th>Monthly Expected</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knee surgery PROM participation request rate</td>
<td>&gt;=80%</td>
<td>85%</td>
<td>91%</td>
<td>86%</td>
<td>81%</td>
<td>86%</td>
<td>83%</td>
<td>75%</td>
<td>73%</td>
<td>89%</td>
<td>63%</td>
<td>84%</td>
<td></td>
</tr>
<tr>
<td>Hip surgery PROM participation request rate</td>
<td>&gt;=80%</td>
<td>87%</td>
<td>90%</td>
<td>88%</td>
<td>80%</td>
<td>82%</td>
<td>89%</td>
<td>82%</td>
<td>85%</td>
<td>95%</td>
<td>80%</td>
<td>90%</td>
<td></td>
</tr>
</tbody>
</table>
The patient experience

Thoughts, opinions and observations of patients and relatives who use our hospitals are very important to us. Our aim is that every patient’s experience is an excellent one and understanding what matters most for our patients and their families is a key factor in achieving this.

Learning from you

Patients’ views and stories are invaluable in helping us improve our service delivery. Our staff recognise the importance of listening to patients and their families to ensure we provide responsive care. As well as involving people in decisions about their own care, we actively seek to learn from your experience of the care and treatment we provide.

We recognise the need to improve communication and information for patients and over the past year we have done the following.

- We introduced the ‘Friends and Family Test’. If you stay overnight in one of our hospitals or attend the Emergency Department, you will be given a comment card asking whether you would recommend the ward/department to friends and family (if they needed similar care or treatment). This was introduced at the end of January 2013, ahead of the national deadline (April 2013). Our FFT score for February and March was 66 based on 1044 responses. The score can range from -100 to +100. The percentage of patients who are extremely likely or likely to recommend was 93%.

<table>
<thead>
<tr>
<th>Extremely likely</th>
<th>Likely</th>
<th>Neither likely nor unlikely</th>
<th>Unlikely</th>
<th>Extremely unlikely</th>
<th>Don’t know</th>
<th>Not possible to determine rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>743</td>
<td>240</td>
<td>31</td>
<td>9</td>
<td>14</td>
<td>17</td>
</tr>
<tr>
<td>Percentage</td>
<td>70%</td>
<td>22%</td>
<td>3%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

- We started routinely filming ‘Patient stories’: asking patients to tell us about their experiences in detail. These stories are viewed by clinical teams to help them to understand what they do well (and should carry on doing) and what needs to improve. The Quality Committee discusses the story and the plan for addressing issues and sharing good practice at the monthly Board meeting. This plan is also discussed and agreed with the patient.

- We introduced a new quality improvement and medical education project: medical students interviewed patients on acute general medicine wards. The aims were to gain an understanding of what is working well and what needs to change, and to enable students to engage with patients’ views and preferences about their care. This is carried out twice each year.

- We recruited a Patient Experience and Involvement Manager to coordinate our service and help drive improvements.

- We listened to the views of patients and the public through public meetings including a ‘Let us hear your views’ event in March 2013 and have planned a further meeting for October 2013.

- We improved waiting times and access for outpatient appointments by running additional clinics (for example, on Saturdays and Bank Holidays), and increasing the number of appointments at each clinic session.

NOTE:
16. This is the proportion of patients who would strongly recommend minus those who would not recommend, or who are indifferent.
We set up Patient and Public Involvement Groups in all Divisions. Some Divisions already have well-established forums and other areas have made progress setting up groups. The Trust has held ‘Patient Panel’ meetings since 2004, which discuss issues relating to the whole Trust. The aim of introducing local groups is to make communication between patient representatives and services more direct and to enable issues to be examined in more detail, so that changes can be made more easily where necessary.

We established a Care Support Worker Academy as part of Delivering Compassionate Excellence.

We piloted Values Based Interviewing (VBI) to support the Trust values.

We have increased the number of large font and Easy Read patient information; for example the PALS and Complaints leaflets available on the public website. We will continue to expand these over the year ahead.

National patient surveys

There were two national surveys in 2012: the Inpatient Survey and the Accident and Emergency Survey. The results from both were very positive with 82% of patients rating their care overall at 7 or above on a scale of 0-10.

<table>
<thead>
<tr>
<th>Rating</th>
<th>“I had a very poor experience of care”</th>
<th>“I had a very good experience of care”</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>1%</td>
<td>2%</td>
</tr>
</tbody>
</table>

The Inpatient Survey for 2012 highlighted delays in discharge as an issue for patients, with 87% of patients surveyed saying their discharge was delayed by one hour or more. This key area is being addressed by working with Oxford Health NHS Foundation Trust and Oxfordshire County Council.

The results also showed that OUH was significantly better than other NHS trusts in the following areas.

- Staff introducing themselves (76% said “all staff”, 21% said “some”).
- Being offered a choice of food (81% said “always”, 10.6% said “sometimes”).
- Doctors giving clear answers to questions (73% said “always”; 21% said “sometimes”).
- Risks and benefits of surgery being fully explained (86% said the risks and benefits were explained “completely”, 11% said “to some extent”).
- Results of surgery being explained in a clear way (71% “completely”, 17% “to some extent”).
- Being fully told about side effects of medications at discharge (46% “completely”, 22% “to some extent”).
- Receiving copies of letters sent between hospital doctors and GP (77% did).

Data from the HSCIC in relation to our responsiveness to the personal needs of its patients are shown below. Over half (55%) of the patients who were sent a questionnaire responded. This was higher than the national average. The data is split into the two trusts; NOC (Nuffield Orthopaedic Centre) and ORH (Oxford Radcliffe Hospitals) prior to the merger in November 2011. Data is only available from the HSCIC up to 2011/12.

<table>
<thead>
<tr>
<th>Responsiveness to the personal needs of our patients</th>
<th>2010/11*</th>
<th>2011/12*</th>
<th>2012/13*</th>
<th>National average 2011/12</th>
<th>Highest 2011/12</th>
<th>Lowest 2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>OUH</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>67.4</td>
<td>85.0</td>
<td>56.5</td>
</tr>
<tr>
<td>ORH</td>
<td>71.0</td>
<td>69.3</td>
<td>n/a</td>
<td>67.4</td>
<td>85.0</td>
<td>56.5</td>
</tr>
<tr>
<td>NOC</td>
<td>76.6</td>
<td>76.4</td>
<td>n/a</td>
<td>67.4</td>
<td>85.0</td>
<td>56.5</td>
</tr>
</tbody>
</table>

NOTE:
17. As compared to other NHS trusts who used the same patient survey organisation.
The Accident and Emergency Department Survey for 2012 showed that 48% of patients waited more than 15 minutes to first speak to a doctor. This was partly due to unfamiliarity with a new IT system (which contributed to an increase in process times) and partly due to staff shortages. Familiarity with the IT system has now improved and the department has introduced a training programme for new doctors. Additional consultants have been employed and recruitment for further consultants continues. The department holds a daily meeting to discuss any cases where a patient has waited more than four hours so the reasons can be identified and prevented in future.

The survey also showed positive results for the following questions:

- 76% of respondents had complete confidence and trust in doctors and nurses
- 90% of respondents felt doctors and nurses worked well together
- 87% of respondents rated reception staff as good, very good or excellent.

A range of diverse projects has been carried out over the past year to improve the patient experience:

Mindfulness in maternity

Often one of the greatest challenges of childbirth is learning how to work with pain and the anxiety that fear of pain and the unknown can cause. Mindfulness meditation is increasingly being used as a way of managing pain and reducing stress and anxiety and has the potential, for parents preparing for childbirth, to reduce the risk of postpartum depression and increase ‘availability’ of attention for their baby.

Thanks to winning the British Journal of Midwifery Innovation for Life Award in 2012 and a Higher Education Innovation Funding (HEIF) grant, OUH Maternity Services in conjunction with Professor Williams from the University of Oxford Mindfulness Centre (OMC), and Nancy Bardacke from the University of California had the opportunity to run an exploratory antenatal mindfulness workshop. The workshop received a remarkably positive response and showed that the training was acceptable to couples and midwives in the UK context.

"totally blown away; skills for life"

"just a massively helpful weekend that will have impact for a long time"

"thank you; amazing course and feel moved to have been part of it"

"thank you… before I came I was so fearful of giving birth. I have been given tools I need to change my thought process and the group has been supportive"

"I have struggled to deal with my emotions in a controlled way… I now feel I can"

As a result of the positive impact OUH Maternity Services in conjunction with OMC are now able to build on this work and develop mindfulness training for midwives and workshops for women which will be the first of their kind in the UK. The project is being led by Dr Maret Dymond for the University of Oxford Mindfulness Centre and Dr Sian Warriner, Consultant Midwife at OUH.

The benefits, economically, socially and medically, of this project are long term and based on evidence that good mental health and wellbeing, and not simply the absence of mental illness, have been shown to result in health, social and economic benefits for individuals, communities and populations (DH 2011). Because mindfulness enables participants to see more clearly the patterns of the mind, it helps halt the escalation of negative thinking that might compound pain or depressed mood, and deals with the tendency to be on autopilot. We anticipate that introducing the mindfulness programme in Oxford will have such an effect, having a positive impact on the wellbeing of antenatal women and their families.

"I have found the mindfulness techniques to be indispensable in my daily life. My self-awareness has increased and I am able to manage my stress level which is invaluable with a young baby. During c section, my husband kept reminding me to do my breathing and it has become our cue for identifying when I need some time-out. Even our baby responds if I practice mindful breathing whilst holding him. Quite often it will be enough to calm him down from a screaming fit.”

As part of raising awareness of the benefits of mindfulness of Maternity Services have also been able to facilitate an eight week experiential mindfulness course for staff from June to August 2012.
Patient experience project in Craniofacial Psychology Service

As part of the QIDIS* funded programme of evaluation of how young people make decisions regarding elective surgery, Oxford Craniofacial Psychology Service recently held two focus groups for young people and parents. Patients and their families were approached by letter and telephone in order to enhance participation and to identify a date and time that would be suitable. The groups took place simultaneously over approximately two hours, and were facilitated by two Clinical Psychologists, a Clinical Psychologist in training and a Research Assistant from Great Ormond Street Hospital who will be analysing the data for the national Craniofacial Psychology Special Interest Group.

Both parents and young people expressed their satisfaction with the opportunity to talk in a structured way with others about their experiences of attending the Oxford Craniofacial Service. The success of this approach highlights a way to involve service users and their families in a process which supports the Oxford University Hospitals’ plan of service user participation and feedback.

* NHS Quality Improvement, Development and Initiative Scheme

Home tube feeding for preterm babies

An initiative to discharge preterm babies, still feeding by nasogastric tube (NG) but who are otherwise well, has proved a success. Parents of babies on the Neonatal Unit who are considered safe and able to manage NG feeding and who are keen to take their baby home, are trained to manage NG tube feeding and are assessed before discharge to ensure that they are competent and safe. Following discharge the babies are visited at home by the Neonatal Outreach Team until oral feeding is fully established.

Parents’ experience has been almost universally positive:

“After six long weeks in the hospital, being able to go home whilst still tube feeding was fantastic. The staff at the hospital and the outreach team were very supportive.”

From July until the end of December, 20 babies were discharged, saving 167 low dependency bed days. The Complex Discharge Initiative is a CQUIN and the Neonatal Unit is already achieving its target.

Patient Advice and Liaison Service (PALS)

PALS is a first stop service for patients, their families and carers who have a query or concern about the hospital or service. The team provides an impartial and confidential service and aims to help resolve issues by addressing them as quickly as possible. Where PALS is unable to help, the enquirer is directed to a more appropriate person or department.

The majority of PALS contacts relate to requests for information about hospital processes or putting people in touch with the correct department or individual who can help them.

The service collates comments, suggestions and concerns made either directly to the service or by the patient experience feedback mechanisms available throughout the hospitals. A monthly report is prepared for the Trust Board on key themes for patient concerns and positive/negative feedback.

During 2012/13 PALS dealt with 3,514 requests, compliments and concerns. The main categories related to patient care, communication and cancellations or delays in appointments. There were also compliments to various staff and departments.

PALS is an integral part of the Patient Experience Team and works closely with the Complaints Department to provide a seamless and comprehensive service to patients and their families. PALS can be contacted by telephone, email, letter to the hospital or through the ‘Let us know your views’ leaflets which can be found across all hospital sites, or you can visit the PALS offices in person and meet with a team member.

Full contact details can be found on our website: www.ouh.nhs.uk/patient-guide/pals
How we handle your complaints

The Trust aims to adhere to the ‘Principles of Remedy’ produced by the Parliamentary and Health Service Ombudsman in 2007 and the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, in order to produce reasonable, fair and proportionate resolutions as part of our complaints handling procedures. These include the following.

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

In the financial year 2012-13 the Trust received 860 formal complaints. All complaints are dealt with individually with the complainant and in a manner best suited to resolve the particular concern raised. The main areas for concern were patient care, Communication and delays.

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>Critical Care, Theatres, Diagnostics and Pharmacy</strong></td>
<td>Pharmacy has procured an automated robot that can select medications that have been prescribed to ensure that they are provided in a timely manner.</td>
</tr>
<tr>
<td>There was increased feedback from PALS and Complaints regarding delays in medicine reaching wards for the discharge of patients.</td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Medicine, Therapies and Ambulatory</strong></td>
<td>Regular ad hoc checks on wards will be conducted by the Matron to ensure that patients are being appropriately assisted with all aspects of their personal care and feeding.</td>
</tr>
<tr>
<td>Patients not receiving assistance with personal care or feeding whilst on the wards.</td>
<td></td>
</tr>
<tr>
<td><strong>Surgery and Oncology</strong></td>
<td>A new permanent medical secretary has been employed and measures have been put in place to improve the telephone service provided by the Division.</td>
</tr>
<tr>
<td>Patients having difficulty in contacting the department regarding appointments, referrals and surgery dates.</td>
<td></td>
</tr>
<tr>
<td><strong>Women and Children</strong></td>
<td>The issue has been discussed at staff/team meetings and all staff have been reminded to provide information and instruction to new mothers in a timely and empathetic manner.</td>
</tr>
<tr>
<td>A complainant considered there had been poor communication to new mothers regarding how to handle and feed their newborn babies.</td>
<td></td>
</tr>
<tr>
<td><strong>Musculoskeletal and Rehabilitation</strong></td>
<td>New integrated spinal pathway has been introduced across Orthopaedics and Neurosurgery.</td>
</tr>
<tr>
<td>Patient complained that they had waited too long for spinal surgery.</td>
<td></td>
</tr>
<tr>
<td><strong>Cardiac, Vascular and Thoracic</strong></td>
<td>Staff have been reminded to listen to patients when they raise concerns. The post procedure check list will be amended.</td>
</tr>
<tr>
<td>Concerns raised regarding post procedure care and patient not being listened to.</td>
<td></td>
</tr>
<tr>
<td><strong>Neurosciences</strong></td>
<td>Review carried out of the telephone system and a rota has been established for answering calls from patients.</td>
</tr>
<tr>
<td>Patients having difficulty in contacting departments regarding appointments.</td>
<td></td>
</tr>
</tbody>
</table>

A monthly report is prepared for the Trust Board and the Trust is committed to ‘Listening, Learning and Improving’ and implementing change in the services provided as a result of lessons learned from complaints.
Our promise to patients

Our team of matrons has been working across the Trust on promoting a refreshed set of Nursing and Midwifery Standards. The standards are set out as 12 statements together with the supporting Nursing Actions. The statements express the Trust’s commitment to delivering excellence to our patients. The standards have been printed on pocket-sized cards and given to all nursing, midwifery and support staff.

A corresponding set of promises has been agreed as ‘Our Promise to Patients’, aimed at providing reassurance to patients and public of our commitment to delivering excellence. Posters are displayed in appropriate areas across the Trust to highlight the Trust’s commitment, and ‘welcome’ boards displaying pictures of the staff teams have been introduced at the entrance to each ward.
New developments and innovation in 2012/13

**Major Trauma Centre and specialist acute rehabilitation**

Major trauma is the main cause of death for people under the age of 45 and is a major cause of debilitating long term injuries. More than half of major trauma is caused by road traffic accidents. The John Radcliffe Hospital has been designated a Major Trauma Centre. This means that the most seriously injured and complex patients from across the Thames Valley region are brought to the John Radcliffe Hospital where they have access to specialist teams 24 hours a day, seven days a week. After being designated in April 2012, the John Radcliffe Hospital became fully operational as a Major Trauma Centre in October 2012.

Speedy access to specialist care and rehabilitation will improve patients’ chances of returning to a normal life. The John Radcliffe Trauma Centre is supported by a network of other smaller trauma units at other hospitals which provide stabilisation and ongoing treatment and rehabilitation for local patients as required following major trauma injury. Patients are provided with both one-to-one and group therapy sessions in the physiotherapy gym enabling our therapists to react as early as possible to the recovery needs of patients with serious injury.

The John Radcliffe trauma service currently sees approximately 26,700 outpatients each year and operates on over 2400 inpatients.

**Regional vascular centre expands**

Our expanded vascular centre includes a 20-bed vascular ward, dedicated vascular theatres and interventional radiology suite. Patients requiring specialist vascular treatment are transferred from hospitals across the Thames Valley region for treatment of severe conditions of the vascular system, including life-threatening emergencies such as aortic aneurysms, an abnormal dilation of an artery caused by the pressure of blood flowing through the area.

In February 2013, we opened a new state-of-the-art interventional radiology suite at the Oxford Regional Vascular Unit sited at the John Radcliffe Hospital. Interventional Radiology uses minimally invasive image-guided procedures to diagnose and treat diseases which in many cases would previously have required major open surgery. The images help direct instruments through the body using narrow tubes called catheters, rather than by making large incisions into the body as in traditional surgery. These procedures reduce not only the length of time spent in hospital but also recovery periods for patients.

**New digital mobile machine for Special Care Baby Unit**

Radiology and the Special Care Baby Unit have been provided with a new mobile direct X-ray machine to enable higher quality, instant diagnostic imaging of very sick babies at the cot-side.

The expansion of the Neonatal Unit at the John Radcliffe Hospital will see the number of intensive care cots doubled from 10 to 20, meaning staff at the hospital will be able to provide intensive care for the very sickest babies across the Thames Valley. As the number of intensive care cots doubles there will be a further need for an increase in the number of imaging requests for very sick babies. The new mobile machine works by placing an X-ray plate into a built-in tray situated directly beneath the body of the intensive care cot. This portable plate allows radiographers to provide an instant higher quality diagnostic image without the need to move the babies too much.
Generation games!
An innovative initiative from the Nuffield Orthopaedic Centre’s Sport and Exercise Medicine Department to encourage the over-50s to become more active was launched in January 2013. The service, launched jointly with Age UK Oxfordshire, is called Generation Games, and was commissioned by the Oxfordshire (PCT) Active Ageing Service, initially as a three-year project. This new service is designed to offer a network of exercise opportunities to promote increased participation in regular physical activity by older people in the county.

The programme is linked to a number of research projects in collaboration with the universities of Oxford and Bath to evaluate the effectiveness of Generation Games and its potential to be rolled out at a national level.

Centre of Excellence for arthritis research
The Nuffield Orthopaedic Centre has been appointed a Centre of Excellence by Arthritis Research UK, in an initiative designed to encourage more people to take up exercise safely and reduce the risk of developing osteoarthritis later in life.

Prof Nigel Arden, from the Nuffield Department of Orthopaedics, Rheumatology and Musculoskeletal Sciences, explained: “Arthritis Research UK, who are funding it, decided that there was a need for a centre bridging osteoarthritis with sport and exercise, because the UK was excellent in both, but there was little interaction between the two.

There are two main aims – one is to reduce the risk of osteoarthritis in professional sportsmen, but the bigger aim is to facilitate safe sport among the general population.”

“One of the main aims is to get the message across that exercise has substantial health benefits when considering the person as a whole, and that recreational exercise does not increase the risk of osteoarthritis. There is evidence that sports injuries can increase the risk of osteoarthritis in later life and we will explore ways of allowing both amateur and professional levels to participate without injuring themselves and additionally to reduce the risk of osteoarthritis if injuries do occur.”

Prof Arden hopes that the project will translate into concrete results, such as encouraging currently inactive teenagers to take up sport or exercise, or for keener sportspeople to exercise at a level that will not cause them harm.

We aim to provide excellent care to our patients. We strive for continuous improvement and here we highlight some of the changes and developments to services that we have made over the past year.
Teams in the spotlight!

Award for improving patient safety

A system that enables clinicians to identify patients at the bedside by barcode scanning of their wristband has won three national awards for improving patient safety. Our clinicians use a small hand-held scanning device which generates an instant test request label for specimen samples. With laboratories at the Trust being sent up to 1500 requests a day, this award-winning system reduces the risk of samples being mis-labelled and allows clinicians to track the status of their test requests. It also reduces the amount of time laboratory staff spend querying incomplete information.

Excellence in oncology care

Our oncology team working with head and neck cancer patients was commended in the 2012 Quality in Care Programme’s ‘Excellence in Oncology’ awards. They were recognised for their good practice and collaboration between themselves and patient groups, providing and implementing clinical guidelines on appropriate post-operative enteral tube feeding following head and neck cancer surgery.

Brain doctors on TV

A team of film makers spent the better part of nine months at the John Radcliffe Hospital researching and filming a three part documentary for BBC 2. They wanted to capture on film the daily emotional challenges faced by patients and their families having to make life changing decisions about surgery and treatment for injuries and diseases of the brain. Viewers were also given an insight into the inner workings and daily lives of the medical and surgical teams who look after patients with injuries and diseases of the brain at the John Radcliffe Hospital.

The communications team worked closely with medical, nursing and therapy staff to ensure that they were comfortable being filmed for the programmes. Extra care was also taken around gaining consent from patients and their families, who bravely revealed their sometimes harrowing yet uplifting stories as they came to terms with life changing decisions about their care.

Innovation in kidney surgery

Doctors and surgeons at the Churchill Hospital have become the first in the UK to receive funding for an innovative surgical procedure for patients with difficult tumours on a solitary kidney. This surgery involves removing the diseased kidney, cooling it to 4°C, removing the tumour(s) and then reattaching it via an incision in the groin. In the past the only option for some difficult tumours has been to have the solitary kidney removed and to receive dialysis whilst waiting for a kidney transplant. This breakthrough offers a much better quality of life for the patient.
Review of services

- During 2012/13 the Oxford University Hospitals NHS Trust provided and sub-contracted 130 NHS services.
- The OUH has reviewed all the available data on the quality of care in all of these services. Services review indicators of quality using dashboards, scorecards and reports so that their performance can be analysed on a monthly basis. This enables services to identify priorities and actions needed to deliver improvements.
- The income generated by the NHS services reviewed in 2012/13 represents 100% of the total income generated from the provision of NHS services by the Oxford University Hospitals NHS Trust for 2012/13.

Performance indicators

The data presented provides an overview of performance on certain aspects of the care pathway achieved by the organisation comparing 2012/13 with 2011/12. 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 to 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.

* NHS Oxfordshire (PCT) became Oxford Clinical Commissioning Group (OCCG) April 2013.

NOTES (for table overleaf):

1 ED 4 performance in Quarter 4, 2012/13
ED 95% of patients seen within four hours from arrival/transfer/discharge: Quarter 2 and Quarter 3 achieved targets, and below target at 89.7% for Quarter 4. January, February and March were extremely challenging, with increased Emergency Department attendances and admissions. Clinical opinion indicates an increase in complex presentations in frail elderly patients. Over 100 escalation beds remained open in the last quarter, the number of patients who are delayed remains 9% above target which has had significant impact on flow of the pathway.

The Trust is actively working with colleagues from Oxford Health, Oxfordshire County Council and Oxford Clinical Commissioning Group to ensure the ED target is sustained throughout 2013/14.

In the first part of Quarter 1, 2013/14, weeks 5 and 6 the Trust returned to delivering 95%, though activity in the first five weeks of the quarter is significantly above plan.

** Cancelled operations
Following the implementation of the Electronic Patient Record (EPR) the Trust has been unable to report cancelled operations where patients have waited over 28 days to be readmitted for surgery. Internal validation of the data is happening weekly to ensure patients are rebooked for surgery in a timely way. The Trust will be able to report for Quarter 1 in 2013/14 by using an in-house reporting database.

*** Cancer target
No patients needed more specialist treatment during 2012/13

**** Cardiac access
We have had a combination of problems that have led to the breach of the 2 Week Wait in three patients referred to the Rapid Access Chest Pain Clinic, in April. Contributory factors are:
- an increase in the number of referrals
- a finite ability to increase capacity due to a reduction in clinical staff supporting the service over the course of the past year
- an increase in the number of patients attending the Emergency Department with chest pain, who are then redirected to their GP for referral, on the advice of the Emergency Department.

The referral criteria are being refined so that the rapid access service is preserved for patients who present with possible cardiac chest discomfort. A referral form is being revised and will reflect the 2010 NICE guidance on the management of new onset chest pain. In the first part of 2013/14 data collection has shown an improved referral rate capacity in clinic sessions at both the JR and the Horton. Additional clinics have been established to cover the loss of all Bank Holiday sessions and we are confident that these measures will prevent further breach in this target. An audit on referral rates has been put in place.

Diagnostic waits of 6 weeks or more
At the end of March 2040 patients were waiting over six weeks in orthopaedic non-obstetric ultrasound and MRI. There is a recovery plan in place which is on track to achieve zero “over six week waits” by the end of June 2013.

Admin and capacity issues in ENT and Ophthalmology
The Trust has had difficulties in booking outpatient appointments over the last few months particularly within ENT and Ophthalmology due to lack of outpatient capacity. These issues have been addressed in the short term. The Trust has started a major change programme across all outpatients, reviewing demand and capacity of all services and clinics, reviewing and changing all clinic templates and standardising clinic slots. This is a 12 month programme of work with ENT and Ophthalmology clinics as part of the first phase, with the aims of ensuring that there are enough clinics slots to:
- support 2 Week Wait and urgent referrals
- see all routine patients within six weeks to support 18 weeks
- reduce unwarranted follow-ups.
**New targets:** Several new, more rigorous performance targets have been applied for the reporting period (2012/13). They are as follows

<table>
<thead>
<tr>
<th>TARGETS</th>
<th>2011/12</th>
<th>2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td>C. Difficile</td>
<td>205</td>
<td>88</td>
</tr>
<tr>
<td>RTT admitted 95th percentile</td>
<td>27.7</td>
<td>23</td>
</tr>
<tr>
<td>Cardiac access – Reperfusion: Primary Angioplasty (PPCI)</td>
<td>75%</td>
<td>85%</td>
</tr>
<tr>
<td>Patient with two week onset of chest pain seen in Rapid Access Chest Pain Clinic</td>
<td>98%</td>
<td>100%</td>
</tr>
</tbody>
</table>
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.

During 2012/13, 43 national clinical audits and five national confidential enquiries covered NHS services that Oxford University Hospitals NHS Trust provides. During that period Oxford University Hospitals NHS Trust participated in 100% of the national clinical audits and 100% of the national confidential enquiries in which it was eligible to participate. Also in 2012/13 OUH has undertaken 301 local clinical audits.

Several areas of good practice are demonstrated by our clinical audit results.

- **Adult community acquired pneumonia**: rates of early senior medical review following admission were higher than nationally. Inpatient mortality rates were slightly lower than national average.
- **Acute coronary syndrome or acute myocardial infarction ‘heart attack’**: year on year improvement of 7% in the proportion of patients with treatment within 150 minutes call for help.
- **Coronary angioplasty**: the Oxford team is in the top 25% of UK PCI centres for the number of procedures carried out annually. Mortality and complication rates are also very low.
- **Bronchiectasis**: performance exceeds national average in most aspects of care, for example provides a multidisciplinary clinic with regular specialist nurse and physiotherapy input and a home intravenous antibiotic service.
- **Pain control**: nationally recommended multidisciplinary team working is an integral part of the Oxford Pain Relief Unit method of working.

Audit development

In 2013/14 we will develop and implement an annual audit programme that monitors our performance against national, regional and local standards. This will provide a framework that will help 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.

For a complete list of Clinical Audits and Confidential Enquiries please see Appendix 1.
Participation in clinical research

Oxford University Hospitals NHS Trust has been rated in the top five for research activity in the UK 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.

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 2012/13 was 14,807. These were recruited during that period to participate in research approved by a research ethics committee, National Institute for Health Research (NIHR) portfolio. This covered 292 studies.

A total of 132 clinical staff, supported by the Biomedical Research Centre (BRC) participated in research approved by a research ethics committee at the OUH during 2012/13.

The BRC covers 14 clinical themes and one ‘Bioresource’. These encompass a substantial portfolio of assets, including patient cohorts, tissue banks, recallable cohorts with Biobanks and large-scale genetics, all of which can provide genetically specified patient material for drug target discovery programmes, and/or selected participants for experimental medicine. The BRU (Biomedical Research Unit) covers three additional clinical themes and two underpinning platforms including Biomedical Informatics, Imaging, and Biobank of clinical samples and data.

There are a total of 132 BRC posts, 181 posts funded through the comprehensive local research network and 40 BRU staff involved in research projects across the Trust. All three groups of staff are funded in whole or in part.

Centre expansion strengthens musculoskeletal research

The expansion of the Botnar Research Centre facilities on the NOC site will help enhance the treatment of musculoskeletal injuries, strengthen the fight against bone cancer and improve arthritis care. Research teams moved into the £6m second phase of the centre in January 2013.

It makes the University of Oxford research facility one of the largest musculoskeletal research centres in Europe, doubling its size to ensure it continues to compete with leading institutions on the world stage, with 4000sqm of custom built research facilities including state-of-the-art laboratories, and flexible office accommodation to house up to 250 scientists and clinicians working on genetics and cell biology, orthopaedic engineering and surgery, clinical research and epidemiological studies.

Phase 2 is the culmination of a seven year fundraising campaign by the NOC Appeal, the same independent charity that previously raised more than £5m to build the original Botnar Research Centre. NOC Appeal director Jeanette Franklin, who was made an MBE for her fundraising work, said: “This is a dream. It started back in the early 1990s when we set a target of raising £1m towards building the first phase of the Botnar. That became £5m and the centre opened its doors in 2002. Our vision always included a second phase and it is wonderful to see research teams moved in.”

Professor Andrew Carr, Divisional Director at the NOC, Director of the Botnar Research Centre and the NIHR Oxford BRU said: “Since it opened in 2002, the Botnar Research Centre has established itself as a world leading centre for musculoskeletal research. This extension will strengthen our efforts and provide our researchers and clinicians with the best possible facilities”.

NOTE: 18. For more information go to: http://oxfordbrc.nihr.ac.uk
World first in liver transplant technique

An Oxford surgeon and medical engineer have pioneered a surgical procedure whereby a donated human liver has been kept alive outside a human being and then successfully transplanted into a patient in need of a new liver. So far the procedure has been performed on two patients on the liver transplant waiting list and both are making excellent recoveries.

Currently transplantation depends on preserving donor organs by putting them on ice – cooling them to slow their metabolism. But this often leads to organs becoming damaged. Professor Peter Friend, a consultant surgeon who is Director of the Oxford Transplant Centre at the Churchill Hospital and Professor of Transplantation at University of Oxford, has jointly developed a new device that enables the donor liver potentially to be preserved at body temperature outside the human body for up to 24 hours.

He has been researching the technology since 1994 alongside Professor Constantin Coussios of University of Oxford’s Department of Engineering Science, one of the machine’s inventors and Technical Director of OrganOx, the University spin-out created to bring the device from bench to bedside. The results from the first two transplants, carried out at King’s College Hospital in February 2013, suggest that the device could be useful for all patients needing liver transplants.

Developing new therapies for Parkinson’s disease

A new brain stimulation therapy could help suppress tremors in people with Parkinson’s disease. The non-invasive technique has been pioneered by Oxford researchers supported by the Oxford Biomedical Research Centre. The research shows that Transcranial Alternating Current Stimulation (TACS) is effective in tremor suppression. TACS works through electrode pads placed on the surface of the patient’s head; an electrical current cancels out the brain signal causing the tremor. This does not carry the risks associated with Deep Brain Stimulation which is currently used to treat physical tremors.

This preliminary study was conducted with 15 patients with Parkinson’s disease at Oxford’s John Radcliffe Hospital. Professor Peter Brown, who led the study, said: “We are very hopeful this research may, in time, lead to a therapy that is both successful and carries reduced medical risks.”

State-of-the-art lung imaging techniques move a step closer

A pioneering lung imaging technique that could improve diagnosis and treatment of conditions such as asthma is being developed in Oxford. Researchers led by Professor Fergus Gleeson have started the first UK patient trials of xenon imaging. Xenon imaging provides greater detail on how the lung is functioning, as well as its structure. Hyperpolarized xenon gas – an inert gas inhaled by patients prior to a scan – fills the lung space and can be imaged by specially adapted MRI equipment. Unlike imaging techniques such as CT scans, xenon imaging does not use ionising radiation so poses less risk to patients undergoing repeated monitoring for long term conditions. It is hoped the technique will help clinicians select the most effective treatment programme for individual patients based on their responsiveness, or target therapies at diseased areas of the lung.

Working Memory Training Programme for children

During the last year the Russell Cairns Unit has been carrying out a study led by Dr Andrew Sheridan on the effectiveness of the Cogmed Working Memory Training Programme with children who have been seen in the Neuropsychology Department in recent years. The aim of the programme is to improve short term information storage capacity, which in turn can have downstream effects on concentration and listening skills, as well as potential effects on school work (literacy and numeracy). This comparatively new Paediatric Neurorehabilitation approach has established efficacy within child populations in general and recently there has been a burgeoning evidence base within clinical populations: therefore, this is an exciting piece of work that combines research with an opportunity to improve the cognitive abilities of children in the selected clinical group.
Commissioning for Quality and Innovation Framework (CQUIN)

Commissioners hold the budget for their areas and populations (e.g. Oxfordshire) 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 CQUIN payment framework. Our Commissioners identified and agreed with the Trust a number of schemes for 2012/13.

Use of the CQUIN payment framework

In 2012/13, 2.5% of our income was conditional on achieving quality improvement and innovation goals agreed between the Trust and Oxfordshire PCT. The Oxfordshire Clinical Commissioning Group assessed that the Trust achieved an end of settlement of 69% of the CQUIN value for 2012/13.

Goals agreed with Commissioners (CQUIN)

<table>
<thead>
<tr>
<th>CQUIN Goal</th>
<th>Met</th>
<th>Partially met</th>
<th>Failed</th>
</tr>
</thead>
<tbody>
<tr>
<td>VTE Risk Assessment (1A)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Composite indicator on responsiveness to personal needs (2A)</td>
<td></td>
<td></td>
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<tr>
<td>Implement an IT system facilitating real time feedback from patients (3A)</td>
<td></td>
<td></td>
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<tr>
<td>Safety Thermometer (4A)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dementia screening, assessment and referral (5A,B,C)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electronic Track-and-Trigger (6A)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>mHealth (6B)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oesophageal Doppler Monitoring (7A)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child in a Chair (8A)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Digital Dermatology (9A)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Digital Laboratories (9B)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicals for elderly surgical patients (10A)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COPD (11A)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cellulitis (11B)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liaison Psychiatry (12A)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing (13A)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standardisation of Spinal Pathway (14A)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Development and roll-out of Palliative Care Support Tool (15A)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicines reconciliation (16)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DTOC (17A)</td>
<td>Abandoned</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Work to produce a joint cellulitis pathway with colleagues in the community highlighted complexities with types of intravenous antibiotic medicines needed for successful treatment and training that were beyond the scope of a 12 month project.
### Quality Improvement Initiatives Associated with the CQUINS for 2013/14

#### High impact innovations (pre-qualifying CQUIN)
- Telemedicine to provide whole system care delivery close to home
- Intra-operative Doppler Monitoring
- Child in a Chair
- Digital first:
  - ✓ Management of gestational diabetes
  - ✓ Physiological outcomes after a heart attack
  - ✓ ICE (electronic laboratory and radiology ordering and reporting)

#### National CQUIN
- Friends and Family Test – *increasing patient response rate and staff via staff survey*
- NHS Safety Thermometer – *focus on pressure ulcer reduction*
- Dementia – *assessment, leadership and support/advice for carers*
- VTE – *target has been increased to 95%

#### Local CQUIN
- Psychiatric Liaison
- Baseline data for frail elderly patients
- Medical outreach for complex elderly patients in surgery
- Emergency Admission Navigators
- Nursing (and CSW development)
- Patients with learning disabilities (who present with seizures)
- Diabetic foot disease
- Supporting young adults with diabetes
- Emergency Care Intensive Support Team (ECIST) report action plan
Statement on compliance with Care Quality Commission (CQC) and essential standards of care

The Trust is governed by a regulatory framework set by the Care Quality Commission (CQC) which has a statutory duty to assess the performance of healthcare organisations. The CQC requires that hospital trusts are registered with the CQC and therefore licensed to provide health services.

The CQC provides assurance to the public and commissioners about the quality of care through a system of monitoring a trust's performance across a broad range of areas to ensure it meets essential standards. The CQC assessors and inspectors frequently review all available information and intelligence they hold about a hospital.

The regulations are grouped into six key areas, each of which has a number of expected outcomes against which the organisation is measured.

Essential standards
- Involvement and information on services
- Personalised care, treatment and support
- Safeguarding and safety
- Suitability of staffing
- Quality and management
- Suitability of management

The CQC expects compliance across all these standards and focuses on outcomes to measure how well these standards are being met, with particular emphasis on the views and experiences of people who use the services.

You can find out more about the standards here: www.cqc.org.uk

Oxford University Hospitals NHS Trust is required to register with the Care Quality Commission. It is currently registered without conditions.

During 2012/13 the CQC undertook two reviews within the Trust. In October 2012 an inspection on Dignity and Nutrition for Older People was undertaken at the Horton General Hospital. The CQC found that the Horton General Hospital was meeting all of the essential standards of quality and safety inspected which included; outcome 1 (Respecting and involving people who use services), outcome 5 (Meeting nutritional needs), outcome 7 (Safeguarding people who use services from abuse), outcome 13 (Staffing) and outcome 21 (Records).

In February 2013 a planned review of compliance was undertaken by the CQC at the John Radcliffe Hospital. The inspection focused on outcome 4 (Care and welfare of people who use services), outcome 8 (Cleanliness and infection control), outcome 13 (Staffing) and outcome 14 (Supporting workers). The CQC made a judgment that the Trust was compliant for each of these outcomes reviewed.

There are no enforcement orders made by the CQC in respect of Oxford University Hospitals NHS Trust.
Statement on relevance of Data Quality and our actions to improve Data Quality

The collection of data is vital to the decision making process of any organisation. It forms the basis for meaningful planning and helps to alert us to any unexpected trends that could affect the quality of our services. Reliable, accurate and relevant high quality data are a key organisational requirement and the Trust is committed to continually improving Data Quality across all of its services.

Most data are gathered as part of the everyday activity of front line and support staff who work throughout the Trust in a huge variety of settings. It’s important that we accurately capture and record the care we provide.

Good quality data are an indicator that an organisation has robust systems and methods of capturing accurate information about their patients and are 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 it is thus essential to the Trust in its task of ensuring value for money for the taxpayers.

During 2012/13 we have continued to reinforce 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. We have also continued to make use of internal and external audit to identify areas for improvement. Since December 2011, following the implementation of the new Electronic Patient Record system, relevant live dashboard reports have been available to enable divisions to monitor and manage daily activity affecting Data Quality.

Whilst the delivery of EPR was a significant technical achievement, as anticipated, Data Quality issues arose in the post-implementation period. These have been addressed through a consolidation process to identify and prioritise issues at an individual service level and to develop appropriate action plans. A strategic review process is ongoing to review standard operating procedures, definitions and the system-build to ensure that services are operating in an optimal manner. The roll-out of the clinical functionality is progressing. This will yield significant patient safety and quality benefits as well as improved efficiency.

Specific EPR challenges have occurred in Maternity and the Emergency Department.

- Problems with the Maternity module in December 2011 meant that the service could not use the full application, and information reporting required considerable manual intervention. In March 2013 the application was successfully re-implemented with strong clinical leadership and the system is now being used as intended. GP requested tests are available from the electronic record, and the final roll-out of the intrapartum phase (already technically live) will commence on 8th July 2013.
- The Emergency Department quality indicators have now been built and are in use. Training of relevant staff has improved Data Quality. The adoption of more streamlined workflow processes will improve the timeliness and quality of data by reducing the steps in the process and is expected to go live with ePrescribing in June 2014.

We are committed to creating a positive culture in respect of all individuals who are employed in our hospitals. One of the most important elements of improving and maintaining service relies on the opportunity for continuing staff education and training. The training policy underpins the application of all relevant employment policies and ensures that for all staff including temporary staff, we apply access control, ensure Data Quality processes are adhered to and put procedures in place to support the consistent capture of quality data into our corporate systems.

Training for the administrative element of the Electronic Patient Record is available via its e-Learning Management System (e-LMS), an electronic competency-based training system, in the form of e-assessments which can be utilised by line managers as a means of ensuring staff have regular refresher training. This can then be embedded into each relevant member of staff’s appraisal to ensure training is continued post commencement.

The measures to improve the Data Quality infrastructure have been taken forward both corporately and in each of the seven Divisions. At a Trust level, a key focus has been in the development of a Data Quality assessment framework which applies to all data generated by the Trust in all of its activities.

This assesses the level of assurance and Data Quality of the information underpinning the key measures of our performance across all its activities including quality.
The initial focus has been those performance indicators included in the Trust’s integrated performance report. These have been applied to all performance indicators incorporating quality and will be underpinned by the development of strengthened Data Quality processes. We aim to upload the Data Quality scoring evidence to the HealthAssure tool. This will continue to be supported and complemented by the Data Quality structures and processes within the Divisions.

**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.

**NHS Number Code Validity**

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 NHS Number Code Validity is monitored by the Data Quality Group, and the Data Quality and Electronic Patient Record user group continues to raise awareness to Divisions and to identify necessary actions to strengthen performance.

We submitted records during 2012/13 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 as at month 7
- 99.6% for outpatient as at month 7
- 96.9% for accident and emergency care as at month 7
- 99.9% of admitted patients have a valid GP practice code
- 99.9% of outpatients have a valid GP practice code
- 99.7% of patients admitted to the emergency department have a valid GP practice code

These figures continue to be an improvement on the performance using the previous electronic patient administration system.

The overall Data Quality dipped temporarily during implementation of the Electronic Patient Record but has continued to improve since April, and in October 2012 stood at 97.7% compared to performance in October 2011 of 95.4%.

**Information Governance Toolkit attainment levels**

The Information Governance Toolkit is an online system that requires NHS trusts and their partners to assess themselves against national standards for Information Governance policies and systems.

The purpose of completing the assessment is to demonstrate that the organisation is handling and processing personal and corporate information confidentially and securely.

It is anticipated that our Information Governance assessment score for 2012/13 will be 80% with all requirements at level 2 or above, giving the Trust a ‘Satisfactory’ rating (out of a possible rating of ‘Unsatisfactory’ or ‘Satisfactory’). Key to achieving this is ensuring that training requirements are met; to ensure that compliance with training standards is strengthened in 2013/14 the Trust will further develop its Information Governance Training Programme and Training Needs Assessment, and will make additional training resources available on its e-LMS.

**Clinical coding**

Clinical coding translates the medical terminology written by the clinicians to describe the 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 services
- the collection of income.

The Coding Task and Finish Group was established to strengthen the links between clinicians and coders with the overall aim of improving both depth and accuracy of coding. The following has been achieved and coding activity continues to be developed.

- At least one liaison clinician for clinical coding in each Division.
- A good practice guide for clinicians.
- Coders explaining the importance of coding in the junior doctors’ inductions.
- Regular consultant coding meetings in many services to validate the coding against the information in the hospital notes. This continues to be expanded.
- Appointment of a coding auditor to perform regular audits across all Trust Directorates.

A clinical coding audit by the Audit Commission was carried out in December 2012. Oxfordshire Primary Care Trust shared the data with the Trust and we were pleased that the results were very good, and an improvement on the previous year.

**% Procedures coded incorrectly**

Primary 6.5%
Secondary 8.6%

**% diagnoses coded incorrectly**

Primary 5.0%
Secondary 5.0%
Our staff

During 2012 we have continued to focus on staff engagement through our strategy of Delivering Compassionate Excellence to support improvements in the quality of patient care. Staff engagement ensures that all aspects of quality of care, patient safety, clinical effectiveness and patient experience are embedded in the practice and behaviours of our Trust staff.

Value Based Interviewing

With the development of new Trust values, we commenced a pilot on Value Based Interviewing (VBI) which seeks to ensure that our values can be reflected in the day-to-day care provided, through the design and delivery of VBI as part of our recruitment process. We are working with the National Society for the Prevention of Cruelty to Children (NSPCC), who have already implemented VBI in their organisation to train our staff in the approach.

The pilot aims to show that VBI can:
- support decisions about recruitment that align our values
- provide robust evidence to minimise ‘gut feel’
- help obtain more information about candidates’ suitability
- contribute to Safer Recruitment and Selection practice internally and externally.

Staff Recognition Award Scheme

We are proud to recognise the contribution our staff make to the success of our organisation and introduced a Staff Recognition Award Scheme in 2012. The categories of awards included Excellence, Compassion, Good Thinking!, Leader, Innovator and Volunteer. The first annual award ceremony, held on Wednesday, 12th December 2012 at the Four Pillars Hotel, Sandford, was a great success.

Valuing our staff

The results of the 2012 staff survey again showed improvement in our overall staff engagement indicator which increased from 3.68 to 3.73 (out of 5). Local and organisational plans will be developed and actions aligned with those issues identified in the staff survey. The results of the survey are fed back to staff and Trade Union Representatives. The key findings from the survey are shown below.

<table>
<thead>
<tr>
<th>KEY FINDING FROM NHS STAFF SURVEY 2011 FOR Ouh</th>
<th>2012 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>77%</td>
</tr>
<tr>
<td>Levels of staff engagement (score out of 5)</td>
<td>3.73</td>
</tr>
<tr>
<td>Staff recommendation of the Trust as a place to work or receive treatment (score out of 5)</td>
<td>3.62</td>
</tr>
<tr>
<td>% staff appraised</td>
<td>77%</td>
</tr>
<tr>
<td>% staff receiving job relevant training, learning and development</td>
<td>81%</td>
</tr>
<tr>
<td>% staff able to contribute to improvements at work</td>
<td>72%</td>
</tr>
<tr>
<td>Staff motivation (score out of 5)</td>
<td>3.86</td>
</tr>
<tr>
<td>Job satisfaction</td>
<td>3.64</td>
</tr>
</tbody>
</table>
The Friends and Family Test question – Staff Survey

An important measure of quality is the readiness for staff to recommend the hospital in which they work. This is measured as the percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends. The table below shows the results for the Oxford University Hospitals NHS Trust since 2010 and has been divided to show individual values for the ORH and NOC prior to the merger. National average data is available from the HSCIC for 2012.

<table>
<thead>
<tr>
<th>Percentage of OUH staff who would recommend the Trust to their family or friends</th>
<th>National average 2012</th>
<th>Highest 2012</th>
<th>Lowest 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>OUH 2010</td>
<td>OUH 2011</td>
<td>OUH 2012</td>
<td>OUH 2012</td>
</tr>
<tr>
<td>OUH</td>
<td>n/a</td>
<td>74.586</td>
<td>67.546</td>
</tr>
<tr>
<td>ORH</td>
<td>85.549</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>NOC</td>
<td>67.254</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

Whilst we were pleased that our result remains higher than the national average we noted a decrease on the previous year. To address this each Division in the Trust has reviewed the results to identify the impact of their individual action plans carried out between the surveys in 2011 and 2012. Further plans for 2013/14 are in place to produce improved results in the coming year. A report will be provided to the Trust Management Executive and the Trust Board on specific themes relating to each Division and also overarching Trust initiatives aimed at raising the level of staff engagement in the coming year.

The Four Staff Pledges

The Four Staff Pledges in the NHS Constitution will help create and maintain a high skilled and motivated workforce capable of improving the patient experience. We are committed to delivering these and some examples are provided below.

**PLEDGE 1**

Provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities

The survey indicated that:

- staff felt able to contribute towards improvements at work
- staff agreed that their role makes a difference to patients.

However we need to need to make continued improvements in:

- work life balance
- work pressure felt by staff.

**PLEDGE 2**

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

The survey indicated that there was:

- an increase in support from immediate managers
- an increase in staff receiving job related training, learning or development
- an increase in staff receiving infection control training.
- an increase in staff receiving equality and diversity training.

**PLEDGE 3**

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

The survey indicated that:

- there was an increase in staff receiving health and safety training
- staff felt that the incident reporting procedures were fair and effective
- a low number of staff had experienced physical violence
- a low number of staff reported errors or near misses.
**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

The survey indicated that:

- staff felt able to contribute towards improvements at work
- staff job satisfaction had increased.

**Example**

The Trust has established a group to take forward its Health and Wellbeing Strategy. An appointment has been made to the role of Health and Wellbeing Manager. A series of workshops have been provided for staff on risk assessment, and training provided in stress management. The Occupational Health Department is being rehoused and refurbished to provide better accommodation and facilities for staff. The department has also achieved Safe, Effective Quality Occupational Health Service (SEQOHS) accreditation.

**Example**

‘Listening into Action’ (LiA) – The Trust is participating in an initiative called ‘Listening into Action’. This is described as a leading approach to engaging and empowering staff around priority outcomes for patients. We will use this approach to ensure that priorities are delivered, by moving towards new ways of working where all the right people commonly join forces to focus on ambitious outcomes and take collective action to make them happen. This means engaging with the right people around delivering better outcomes for our patients and staff in line with Delivering Compassionate Excellence. Eleven pioneering teams are in the first wave and are seeking to make improvements in the following areas.

---

<table>
<thead>
<tr>
<th>TEAM</th>
<th>MISSION</th>
<th>PROPOSED OUTCOMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Therapies</td>
<td>Examine the 48 hours pathway within the Emergency Assessment Unit</td>
<td>New Emergency Assessment Unit Pathway</td>
</tr>
<tr>
<td>Endoscopy</td>
<td>Improve communication between Endoscopy Department and patients</td>
<td>Reduce waiting times, improve information processes to reduce DNA and cancellations, improve staffing levels, training sessions for booking staff, use stickers to identify patients with diabetes, use of suggestion boxes and adding room numbers to patient wristbands</td>
</tr>
<tr>
<td>Eye Hospital</td>
<td>Improve patient experience – reducing waiting times</td>
<td>Provide training for staff in how to track notes, prep the clinic notes in advance, improve staff allocation to clinics to ensure that phones are answered and emails checked, start clinics on time, ensure equipment is available in clinics</td>
</tr>
<tr>
<td>Geratology</td>
<td>Improve patient experience for outpatients and day patients</td>
<td>Issues identified were transport, heating, computer software, availability of notes / referral letters, lack of wheelchairs, clinic room re-stocking, obtaining results and communication with managers</td>
</tr>
<tr>
<td>TEAM</td>
<td>MISSION</td>
<td>PROPOSED OUTCOMES</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Horton Day Case Unit</td>
<td>Shape the future of day care services at the Horton General Hospital</td>
<td>Currently collecting information to understand existing pattern of day cases, by site, by specialty, postcode and length of stay to help inform and shape future provision</td>
</tr>
<tr>
<td>Paediatric Pain Management</td>
<td>Develop a pain service for children</td>
<td>Business Case developed for establishing a Paediatric Acute Pain Team</td>
</tr>
<tr>
<td>Pharmacy – robotics</td>
<td>Support patients to get the most from their medicines by releasing staff to wards and near-patient working through the introduction of robotics</td>
<td>Increased efficiencies in the use of resources, skill mix review, increase safety and operating efficiencies</td>
</tr>
<tr>
<td>Pre-op Assessment</td>
<td>Radically improve the pre-operative assessment process for patients undergoing surgery in OUH</td>
<td>Engagement with clinicians, nursing teams and theatres in review of assessment process and use of IT systems</td>
</tr>
<tr>
<td>Patient experience Cross Trust Handover</td>
<td>Patient experience in acute medicine – a quality improvement and medical education project Improve efficiencies in Cross Trust Handover</td>
<td>Improved patient experience Introduction and use of EPR to improve efficiencies</td>
</tr>
</tbody>
</table>

**System change teams**

In addition to the above, system change teams have been reviewing the induction, recruitment and appraisal processes for staff. Other system changes include sharing good practice in communication and efficiencies through the implementation of the Electronic Patient Record system.
APPENDIX 1

The national clinical audits (NCA) and national confidential enquiries respectively, which Oxford University Hospitals NHS Trust was eligible to participate in during 2012/13, 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><strong>PERI AND NEONATAL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neonatal intensive and special care (NNAP)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td><strong>CHILDREN</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paediatric pneumonia (British Thoracic Society)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Paediatric asthma (British Thoracic Society)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Paediatric fever (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 congenital heart disease</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Paediatric intensive care (PICANet)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Paediatric Inflammatory Bowel Disease (IBD)</td>
<td>✓</td>
<td>4th round commenced January 2013 No data collection in 2012</td>
</tr>
<tr>
<td>Diabetes (RCPH National Paediatric Diabetes Audit)</td>
<td>✓</td>
<td>100%</td>
</tr>
<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>100%</td>
</tr>
<tr>
<td>Non-invasive ventilation in adults (British Thoracic Society)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Cardiac arrest (National Cardiac Arrest Audit)</td>
<td>✓</td>
<td>100% for Q1 and Q2</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>Fractured neck of femur (College of Emergency Medicine)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Renal colic (College of Emergency Medicine)</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>(Data incomplete for some cases)</td>
<td></td>
<td></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>Data collection started Jan 2013 Not yet completed</td>
</tr>
<tr>
<td>Parkinson’s disease (National Parkinson’s Audit)</td>
<td>✓</td>
<td>60%</td>
</tr>
<tr>
<td>(Data submitted by Neurosciences and Therapies but not Geratology)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Audit of Dementia (NAD)</td>
<td>✓</td>
<td>75%</td>
</tr>
<tr>
<td>Adult asthma (British Thoracic Society)</td>
<td>✓</td>
<td>135%</td>
</tr>
<tr>
<td>(20 cases required, 27 submitted)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bronchiectasis (British Thoracic Society)</td>
<td>✓</td>
<td>93%</td>
</tr>
</tbody>
</table>
**ELIGIBLE NATIONAL CLINICAL AUDIT**

<table>
<thead>
<tr>
<th><strong>ELECTIVE PROCEDURES</strong></th>
<th><strong>OUH PARTICIPATED IN</strong></th>
<th><strong>% CASES SUBMITTED</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip, knee and ankle replacements (National Joint Registry) MARS</td>
<td>✓</td>
<td>100% of patients who provided consent</td>
</tr>
<tr>
<td>Elective surgery (National PROMs Programme) inguinal hernia, varicose veins, hip replacement, knee replacement</td>
<td>✓</td>
<td>Inguinal hernia Q1 and Q2 = 65%</td>
</tr>
<tr>
<td></td>
<td>✓</td>
<td>Varicose veins Q1 and Q2 = 23%</td>
</tr>
<tr>
<td></td>
<td>✓</td>
<td>Hip replacement Q1 and Q2 = 34%*</td>
</tr>
<tr>
<td></td>
<td>✓</td>
<td>Knee replacement Q1 and Q2 = 137%*</td>
</tr>
<tr>
<td>Coronary angioplasty (NICOR Adult Cardiac Interventions Audit)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Peripheral vascular surgery (VSGI Vascular Surgery Database)</td>
<td>✓</td>
<td>Q1 to Q3 = 78%</td>
</tr>
<tr>
<td>Abdominal aortic aneurysm, infrainguinal bypass, amputations</td>
<td>✓</td>
<td>Q1 to Q3 = 97%</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>

**CARDIOVASCULAR DISEASE**

<table>
<thead>
<tr>
<th></th>
<th><strong>% CASES SUBMITTED</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Myocardial Infarction and other ACS (MINAP)</td>
<td>✓</td>
</tr>
<tr>
<td>Heart failure (Heart Failure Audit)</td>
<td>✓</td>
</tr>
<tr>
<td>Acute stroke (SINAP)</td>
<td>✓</td>
</tr>
<tr>
<td>Cardiac arrhythmia (Cardiac Rhythm Management Audit)</td>
<td>✓</td>
</tr>
</tbody>
</table>

**RENAL DISEASE**

<table>
<thead>
<tr>
<th></th>
<th><strong>% CASES SUBMITTED</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Renal replacement therapy (Renal Registry)</td>
<td>✓</td>
</tr>
<tr>
<td>Renal transplantation (NHSBT UK Transplant Registry)</td>
<td>✓</td>
</tr>
</tbody>
</table>

**CANCER**

<table>
<thead>
<tr>
<th></th>
<th><strong>% CASES SUBMITTED</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung cancer (National Lung Cancer Audit)</td>
<td>✓</td>
</tr>
<tr>
<td>Bowel cancer (National Bowel Cancer Audit Programme)</td>
<td>✓</td>
</tr>
<tr>
<td>Head and neck cancer (DAHNO)</td>
<td>✓</td>
</tr>
<tr>
<td>Oesophago-gastric cancer (National O-G Cancer Audit)</td>
<td>✓</td>
</tr>
</tbody>
</table>

**TRAUMA**

<table>
<thead>
<tr>
<th></th>
<th><strong>% CASES SUBMITTED</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip fracture (National Hip Fracture Database)</td>
<td>✓</td>
</tr>
<tr>
<td>Severe trauma (Trauma Audit and Research Network)</td>
<td>✓</td>
</tr>
</tbody>
</table>

**BLOOD TRANSFUSION**

<table>
<thead>
<tr>
<th></th>
<th><strong>% CASES SUBMITTED</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>National Comparative Audit of Blood Transfusion</td>
<td>✓</td>
</tr>
<tr>
<td>• Blood sampling and labelling</td>
<td></td>
</tr>
<tr>
<td>• Use of anti D</td>
<td></td>
</tr>
<tr>
<td>• Management of patients in Neuro Critical Care Units</td>
<td></td>
</tr>
</tbody>
</table>

**KEY**

* Data collection issues relating to the merger of the Nuffield Orthopaedic Centre and Oxford Radcliffe Hospitals trusts in 2011 have affected the Trust’s overall score. Local data indicate our participation for hips and knee replacement is higher than recorded nationally.
* The Trust submitted cases for this audit and 100% of required were submitted, however, we are aware a lower number of cases were accepted as valid as the data was not complete. Validated submission data are not currently available.
** The Trust submitted data on 696 cases. The National Audit team has given an estimate of 894 expected cases based on Hospital Episode Statistics (HES) for 2011.
*** Deadline for submission of the data missed. The Trust will be carrying out its own analysis in order to compare performance with national and regional results.
Oxford University Hospitals NHS Trust was not eligible to participate in the following NCAs

- Paediatric cardiac surgery (NICOR Congenital Heart Disease Audit)
- Intra-thoracic transplantation (NHSBT UK Transplant Registry)
- Pulmonary hypertension (Pulmonary Hypertension Audit)
- National audit of psychological therapies (NAPT)
- Prescribing in mental health services (POMH)

### NATIONAL CONFIDENTIAL ENQUIRIES

<table>
<thead>
<tr>
<th>ENQUIRY INTO PATIENT OUTCOME AND DEATH (NCEPOD)</th>
<th>OUH PARTICIPATED IN</th>
<th>% CASES SUBMITTED</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCEPOD – Alcoholic Liver Disease</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>NCEPOD – Subarachnoid Haemorrhage</td>
<td>✓</td>
<td>89%*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ENQUIRY INTO SUICIDE AND HOMICIDE BY PEOPLE WITH MENTAL ILLNESS (NCI/NCISH)</th>
<th>OUH PARTICIPATED IN</th>
<th>% CASES SUBMITTED</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Review of Asthma Deaths (NRAD)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Child health programme (CHR-UK)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Maternal, infant and newborn programme (MBRRACE-UK)</td>
<td>✓</td>
<td>Data period starts 1\textsuperscript{st} Jan 2013</td>
</tr>
</tbody>
</table>

* Questionnaires were returned for 24 out of 27 eligible cases (health records were submitted for 22 out of 27).

During 2012 reports were published on 46 National Clinical Audits and two National Confidential Enquiries. These national reports were reviewed by OUH and actions taken or planned. Examples of reports reviewed are listed.

#### AUDIT TITLE

<table>
<thead>
<tr>
<th>ADULT COMMUNITY ACQUIRED PNEUMONIA (BRITISH THORACIC SOCIETY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of the report published in 2012 showed that results were largely in line with national averages. Rates of early senior medical review following admission were higher in OUH than nationally. Inpatient mortality rates were slightly lower than national average. Areas for improvement are:</td>
</tr>
<tr>
<td>- documentation of scoring of pneumonia severity</td>
</tr>
<tr>
<td>- compliance with local antibiotic prescribing guidelines that have recently been reassessed.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ADULT CRITICAL CARE (CASE MIX PROGRAMME ICNARC CMP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of the report published in 2012 showed that mortality for both the general adult intensive care units in Oxford is low. Data on the quality of care show that discharge to the wards is commonly delayed. Hospital acquired infections remain tightly controlled. Several audits and service evaluations are ongoing with the common goal of decreasing morbidity and improving patient experience. Data from specialist critical care units such as the Neuro ICU is reviewed quarterly at divisional level but not presented as an annual report by the CMP. There is a strong and consistent performance in all quality indicators and outcomes.</td>
</tr>
<tr>
<td>AUDIT TITLE</td>
</tr>
<tr>
<td>-------------</td>
</tr>
</tbody>
</table>
| Emergency Use of Oxygen (British Thoracic Society) | After reviewing of the report published in 2012 the service will take steps necessary to fully implement the policy on Emergency Use of Oxygen including:  
- training for nurses on treating oxygen as a drug  
- training for medical staff on oxygen prescribing  
- integration of oxygen prescribing with electronic track-and-trigger system for identification of critically ill medical patients when this is available. |
| National Joint Registry (NJR) | Review at the Nuffield Orthopaedic Centre of the report published in 2012 showed patient consent was confirmed in 95% of cases. The service continues to carry out regular audits in the pre-operative assessment clinic (POAC) to ensure consent rates are nearly 100%. Feedback was provided to clinicians and staff in the POAC to help maintain these standards. There were no concerns identified relating to clinician practice at the Trust.  
- All return to theatres / readmissions are discussed in the monthly clinical governance meeting and when necessary appropriate actions implemented.  
- All morbidity and mortality data is presented, collated in the monthly clinical governance report.  
- The use of MoM hip resurfacings is practically 0% and this supports national recommendations.  
- The use of patella-femoral replacement (PFR) has significantly reduced. |
| Non-invasive ventilation – adults (British Thoracic Society) | After reviewing of the report published in 2012 the service will continue to reduce length of stay for this group of patients by early identification of patients needing Non-invasive Ventilation (NIV). Use of NIV when appropriate in ED and EAU at the John Radcliffe Hospital will be encouraged and training in its use made available to all staff.  
More accurate collection of acute NIV data will be ensured by identifying those admitted for NIV setup from community and other trusts. |
| Bowel cancer (NBOCAP) | After reviewing the report published in 2012 the service will improve the quality of data submitted to this national audit by the use of the following.  
- Accurate recording of all cases of colorectal cancer as opposed to only those having surgical treatment. Improvements to be made to the cancer multidisciplinary team reporting system (July 2013).  
- Accurate recording of CT and MRI scan reporting dates (July 2013). Formal clinical sign-off of data before submission to NBCA to verify above (July 2013).  
- Securing a Trust-funded data manager to support collection of these data (July 2013). |
### Audit Title: Head and neck oncology (DAHNO)

1. Procedures have been put in place to ensure a DAHNO record on the Trust’s Infoflex system is opened for each patient as they are referred. Data is gradually added to this (as, for example, the full pathology results from an operation become available or a patient completes a course of radiotherapy).

2. Patient records will be uploaded to the DAHNO database in smaller batches to facilitate checking, better completeness and quality of the data. Records from 1.11.12 to 30.4.13 will be submitted by mid-May, and 1.5.13 to 31.7.13 by mid-August.

3. The aim is to move to monthly submission. This is facilitated by new functionality in the DAHNO central database which permits much easier searching for ‘missing’ items of data which means work on completeness of records can continue after submission until the final annual deadline of the third week in November each year.

### Audit Title: Lung cancer (NLCA)

The 2012 national audit reported overall significant improvement in performance at OUH. The chemotherapy service for small cell lung cancer has been reviewed and the Trust now meets the best practice target.

### Audit Title: Acute coronary syndrome or acute myocardial infarction (MINAP)

The service will continue to work with ambulance services and peripheral hospitals to reduce the time taken for ambulance transfer to the John Radcliffe Hospital for patients with ST Segment Elevation Myocardial Infarction (STEMI) for Primary Percutaneous Coronary Intervention. This work has resulted in a year on year improvement of 7% in the proportion of patients with treatment within 150 minutes of call for help.

The service is also working to increase the proportion of patients presenting to the Horton General Hospital with Non-ST Segment Elevation Myocardial Infarction (NSTEMI) who are reviewed by a Consultant Cardiologist.

### Audit Title: Coronary angioplasty

The annual activity at OUH places the Oxford team in the top quartile of UK PCI Centres for procedural volume. Outcome measures demonstrate performance beyond the national risk-adjusted model with very low mortality and complication rates. The unit also has the lowest door to balloon time for STEMI in MINAP rankings.

### Audit Title: Heart failure (HF)

A total of 736 records of heart failure admission data were submitted to the National Institute for Cardiovascular Outcomes Research (NICOR) for the period April 2011 to March 2012 compared with a minimum requirement of 240. Between 97 to 100% of patients were discharged when appropriate on evidence based medications to treat their heart failure and 96% had the appropriate investigation of an echocardiogram to guide their treatment.

The service is exploring ways for the heart failure team and specialist nurses to access information on diagnosis more quickly. The aim is that all patients will be seen prior to discharge.
In line with the recommendations from the report published in 2012, the department continues to work to improve collection of data on resuscitation calls and continues to see an improvement in reporting. The department also runs education sessions for clinical staff in order to continue to improve the recognition of the sick patient. Implementation of a system for reviewing medical notes post cardiac arrest is an objective for this year.

### National Cardiac Arrest Audit (NCAA)

The performance of the Oxford Bronchiectasis Service exceeds the national average in almost all aspects of care. It provides a multidisciplinary clinic with regular specialist nurse and physiotherapy input and a home intravenous antibiotic service. Improvements will be made in the recording of the degree of patients’ breathlessness and consideration for referral to exercise and rehabilitation programmes where available.

### Bronchiectasis (British Thoracic Society)

In response to the National Diabetes Inpatient Audit it is intended that a Diabetes Quality Group will be set up to oversee care of diabetic patients in hospital, to improve quality and deal with issues that arise.

### Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)

The report from 2010/11 showed that the service at OUH reported the third lowest level in the country of HbA1c test that shows the patient’s average level of blood sugar (glucose) over the previous three months. The percentage of patients with HbA1c levels in the target range (31.9%; national average 15.7%) again increased. Since October 2012 the service has been using a new database which will allow it to provide data on all of the care processes.

### Diabetes (Paediatric) (NPDA)

IBD biological therapy audit report published in June 2012 was generic and not site specific and hence no specific recommendations can be made with regards to the following:

- Paediatric Biological therapy usage at Oxford Children’s Hospital.
- Paediatrics IBD inpatient management was satisfactory on most fronts.

Oxford Paediatric Gastroenterology performed as follows on the key indicators.

- 100% of patients were seen by a Paediatric Gastroenterologist during their admission, were weighed and had stool samples sent off.
- Approx 90% of children with Crohn’s disease were seen by the paediatric dietitian and concerted attempts made so that all children get dietetic input during their inpatient stay.
- Nearly three quarters of children had their pubertal scores recorded, and 60% with Crohn’s disease had their smoking status recorded. The IBD working group has devised a diagnostic and annual review proforma for use with all children using the service which will improve such data recording.

### Inflammatory bowel disease (IBD) Round 3 Includes: Paediatric Inflammatory Bowel Disease Services

<table>
<thead>
<tr>
<th>AUDIT TITLE</th>
<th>ACTION FROM REVIEW</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>National Cardiac Arrest Audit (NCAA)</strong></td>
<td>In line with the recommendations from the report published in 2012, the department continues to work to improve collection of data on resuscitation calls and continues to see an improvement in reporting. The department also runs education sessions for clinical staff in order to continue to improve the recognition of the sick patient. Implementation of a system for reviewing medical notes post cardiac arrest is an objective for this year.</td>
</tr>
<tr>
<td><strong>Bronchiectasis (British Thoracic Society)</strong></td>
<td>The performance of the Oxford Bronchiectasis Service exceeds the national average in almost all aspects of care. It provides a multidisciplinary clinic with regular specialist nurse and physiotherapy input and a home intravenous antibiotic service. Improvements will be made in the recording of the degree of patients’ breathlessness and consideration for referral to exercise and rehabilitation programmes where available.</td>
</tr>
<tr>
<td><strong>Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)</strong></td>
<td>In response to the National Diabetes Inpatient Audit it is intended that a Diabetes Quality Group will be set up to oversee care of diabetic patients in hospital, to improve quality and deal with issues that arise.</td>
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<tr>
<td><strong>Diabetes (Paediatric) (NPDA)</strong></td>
<td>The report from 2010/11 showed that the service at OUH reported the third lowest level in the country of HbA1c test that shows the patient’s average level of blood sugar (glucose) over the previous three months. The percentage of patients with HbA1c levels in the target range (31.9%; national average 15.7%) again increased. Since October 2012 the service has been using a new database which will allow it to provide data on all of the care processes.</td>
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</tbody>
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- Nearly three quarters of children had their pubertal scores recorded, and 60% with Crohn’s disease had their smoking status recorded. The IBD working group has devised a diagnostic and annual review proforma for use with all children using the service which will improve such data recording. |
## Audit Title: Pain Database

The Oxford Pain Relief Unit took part in the National Pain Audit 2010/12. This was designed to examine the provision and functioning of pain clinics in England and Wales. The National Pain Audit Report published in December 2012 was primarily aimed at national institutions to aid the commissioning of pain services in England and Wales. A key recommendation in the audit was the need for multidisciplinary pain teams to include: doctors, nurses, physiotherapists and psychologists. This type of multidisciplinary team working is already an integral part of the Oxford Pain Relief Unit method of working. The audit also identified the desire by patients nationally to better understand their pain conditions. The Oxford unit is in the process of developing an educational session for patients to attend to aid better understanding of their conditions and their treatments.

## Audit Title: Sentinel Stroke National Audit Programme (SSnAP)

The Emergency Department and Stroke Medicine teams meet weekly to improve direct access to the Stroke Unit within four hours by reviewing any barriers to identification/transfer of stroke patients.

Extra staff are being appointed to extend stroke rehabilitation services to include weekends and thus provide a 7/7 service by 1st March 2014.

The Early Supported Stroke Service that currently serves primarily Oxford city only will be extended to provide a countywide service by 1st March 2014.

The Stroke Service will improve documentation of medical/nursing care by August 2013 including development of an admissions booklet to capture key data.

## Audit Title: Neonatal intensive and special care (NNAP)

Following review of the report published in 2012, the service has identified the following areas for improvement:

- Data entry on antenatal steroid usage was improved at the Horton General Hospital for 2012. Accuracy of figures on both Horton and John Radcliffe sites will be reviewed in 2013 once obstetric Electronic Patient Records are well established.

- Data entry for Retinopathy of Prematurity Screening improved at the Horton General Hospital for 2012. The process for booking screening was reviewed and discussion with ophthalmology regarding improving data collection processes for whole network occurred in January 2013.

- Consultant discussions with parents are occurring at the Horton General Hospital but were poorly documented on the audit tool. This was highlighted to all consultants in December 2012 and data entry for 2012 is being scrutinised to improve results for 2012 audit.

- Two year follow-up for neonatal patients – regional data only is given but highlights that patients are not routinely seen for detailed neurodevelopmental assessment and collection of specific follow-up information is not happening. This is not funded currently. A pilot study of health visitor data collection is occurring elsewhere in the network but the data for 2012 are also likely to be poor until funding is better established.

## Audit Title: Paediatric asthma (British Thoracic Society)

Following review of the report published in 2012 the service will:

- continue using the Trust asthma care plans and raise staff awareness of their use
- introduce a discharge check list for every asthmatic patient
- include BTS asthma guidelines into teaching for junior doctors.
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<tr>
<th><strong>AUDIT TITLE</strong></th>
<th><strong>ACTION FROM REVIEW</strong></th>
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<tbody>
<tr>
<td><strong>Severe sepsis and septic shock (College of Emergency Medicine)</strong></td>
<td>Following review of the report published in 2012 the Emergency Department will:</td>
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<tr>
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<td>• use the existing sepsis pathway and proforma</td>
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<td>• continue to promote sepsis education amongst medical and nursing staff and include an induction pack for new starters</td>
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<td></td>
<td>• emphasize that the clinician who is the first point of contact with the patient takes responsibility for initiating the proforma; this will include ongoing education for sisters and triage nurses</td>
</tr>
<tr>
<td></td>
<td>• routinely measure urine output routinely in patients with lactate &gt; 4</td>
</tr>
<tr>
<td></td>
<td>• critically review sepsis protocols.</td>
</tr>
<tr>
<td><strong>Pain management (College of Emergency Medicine)</strong></td>
<td>The Emergency Department will review guidance to ensure that it is reflective of current / best practice. This will include the following.</td>
</tr>
<tr>
<td></td>
<td>• Review current patient group directions (PGD) for triage nurses to administer analgesia to ensure that it can meet the needs of patients in moderate pain. Management of severe pain requires intervention by medical staff.</td>
</tr>
<tr>
<td></td>
<td>• Review of process for administering analgesia at triage through PGD and medical prescribing to improve timing of analgesia.</td>
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<td></td>
<td>• Review of process and format used for documentation to provide evidence of re-evaluation of analgesia.</td>
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<table>
<thead>
<tr>
<th><strong>NATIONAL CONFIDENTIAL ENQUIRIES REPORTS</strong></th>
<th><strong>ACTION FROM REVIEW</strong></th>
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<tbody>
<tr>
<td><strong>NATIONAL CONFIDENTIAL ENQUIRY INTO PATIENT OUTCOME AND DEATH (NCEPOD)</strong></td>
<td>A number of actions have been instigated following the NCEPOD audit to ensure that the Oxford Bariatric Service provides quality care for patients receiving bariatric surgery. This will also ensure compliance with BOMSS Service Standards and Commissioning Guidance Working Party – Standards (2012) and the NHS Commissioning Board Clinical Commissioning Policy: complex and specialised obesity surgery (2012).</td>
</tr>
<tr>
<td><strong>Bariatric surgery</strong></td>
<td><strong>ACTIONS</strong></td>
</tr>
<tr>
<td></td>
<td>• Referral routes are to be established to extended members of the bariatric team to include respiratory, diabetes and cardiology. In addition protocols are being developed to address the assessment and management of common associated conditions such as sleep apnoea and diabetes.</td>
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<td></td>
<td>• In-house education programmes have been developed to include specialist knowledge required to care for bariatric surgical patients, to address weight bias and stigma and provide an environment which is sensitive to the needs of bariatric patients.</td>
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<tr>
<td></td>
<td>• All patients seeking bariatric surgery are currently assessed by a specialist clinical psychologist and this assessment includes recognised screening tools.</td>
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<tr>
<td></td>
<td>• Protocols are currently awaiting approval via the directorate board for the emergency cover and management of bariatric surgical patients who present at the Oxford University Hospitals.</td>
</tr>
</tbody>
</table>
**Cardiac arrest procedures**

The Trust Resuscitation Service is continuing a programme for educating clinical staff on the need to consider and record the CPR status for all patients who are admitted to the hospitals. The service audits the decision making process including the involvement of consultants and the appropriateness of the decisions. It also audits how patients’ clinical conditions are monitored and the processes that ensure prompt action when a patient’s condition deteriorates. Feedback on performance is provided to clinical services. Procedures have been reviewed to ensure there is an agreed plan for airway management during cardiac arrest. The service has in place a continuous review of defibrillator provision and a replacement programme to reduce risk of equipment failure and shortage.

**OUH local clinical audit**

During 2012/13 OUH has undertaken 301 local clinical audits. The following list shows examples of local clinical audits completed during 2012/13, 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>
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</table>
| **MARS**          | Neurodisability Assessment Clinic Review at the Oxford Centre for Enablement | The Neurodisability Assessment Clinic undertook a mixed-methodology review of the service between July and October 2012. This consisted of a staff survey, patient survey and review of attendance rates and arrangements. The results are largely positive including:  
  • 94% of the referrals to the clinic were deemed appropriate  
  • staff felt that in the majority of cases there was sufficient time available for preparation, patient contact and keeping the clinic to time  
  • all patients reported feeling that there was sufficient time with the team and that they felt listened to  
  • all but one patient said they had received enough information about the clinic prior to attending. |
<p>| Orthotics         | Clinic Review at the Oxford Centre for Enablement                              | A review of the patients seen in Orthotics as part of the clinic cover to same-day referrals was undertaken over a six week period (22nd October 30th November 2012). The purpose was to gather data on the clinic demand against current availability to help clarify the efficiency of this service and to assist in any future changes. These clinics are known as walk-in clinics as patients can be seen on the same day until capacity is reached at which point the patients would join the usual referral pathway. 89% of the walk-in referrals were seen on the same day with a range of between 6-8 patients seen on the busiest session, Friday am. Overall the volume of slots allocated indicates Orthotics is offering an acceptable level of same day referrals with the majority of sessions used efficiently. Inevitably with the majority of patients being sent to Orthotics between 09:30 and 12:30 capacities will be reached on occasions hence the 11% who could not be seen. |</p>
<table>
<thead>
<tr>
<th>DIVISION</th>
<th>CLINICAL AUDIT</th>
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<tbody>
<tr>
<td>Swab and Instrument Counts Audit in Orthopaedic Theatres at the NOC</td>
<td>The swab counts audit is carried out monthly in orthopaedic theatres and is reported as a quality indicator for the Musculoskeletal and Rehabilitation Division. The audit sample involves the observation of 20 procedures per month; the observer inspects appropriate counting and recording of strings, swabs, sutures and instruments in perioperative records and on the theatres white board records any interruptions to the counts, observes if the swabs are opened during the count and that the scrub nurse and circular both conduct and check the counts loudly. 100% compliance has been achieved consistently on a monthly basis.</td>
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</table>
| Audit of Diagnostic Testing and Screening using MRI in the Oxford Sarcoma Service | An audit was undertaken by the Oxford Sarcoma Service of patients who were referred for an urgent MRI under the 2 Week Wait rule between July and October 2012. The audit aimed to identify if the requests for the scans were timely and appropriate. It also examined if the results were followed up and patients were contacted within two weeks. 17 requests were identified during that period.

All requests were made and handled appropriately. 88% of results were reported to patients within two weeks (15 out of 17 patients); 12% of the results (2 out of 17 patients) had their results in over two weeks, in one of these cases this was due to the fact that Radiology were awaiting results of a further investigation; in the other case, the rationale was not documented and this was raised with the team and the audit will be repeated in 2013. |
| Commissioning Quality for patients with rheumatoid arthritis metrics | A study was undertaken to determine the effectiveness of metrics developed to measure outcomes for patients undergoing treatment for rheumatoid arthritis. Four hospitals took part in this study including the Nuffield Orthopaedic Centre (NOC) and data collection was carried out in two phases in 2010 to determine baseline results then and in 2011 to measure progress against the identified metrics; the results were published in May 2012 by the National Commissioning Group for Rheumatoid Arthritis. Notable improvements were measured at the OUH.

1. Disease damage was measured in 83% of the eligible patients in 2011 vs. 61% in 2010.
2. Comorbidities were assessed in 86% (compared with 65% in 2010).
3. Complications were assessed in 61% (compared with 31% in 2010).
4. The need for cross referral within the multidisciplinary team was assessed in 90% (compared with 92% in 2010).
5. The impact of RA was assessed in 72% in 2011 cases vs. 91% cases in 2010.
6. Improvement in Disease Activity Score monitoring was noted to be 88% in 2011 vs. 74% in 2012. |
Compared to 2010, improvements were noted in four out of six annual review categories. In 2013, a patient experience survey developed by the National Commissioning Group for Rheumatoid Arthritis will be piloted and the NOC will also be taking part in this.

**Do we comply with NICE guidelines in use of biologic therapies for RA?**
Assessment of compliance with TA195

Biological agents are used in the management of active rheumatoid arthritis in patients who have not had an adequate response to conventional treatment with disease modifying agents. The use of biological therapies is carefully monitored to ensure their effective use. The Rheumatology Unit undertook this audit to measure compliance with 16 NICE criteria for the management of active rheumatoid arthritis with biological therapies. All patients on these therapies are regularly reviewed in a specialist led biologics clinic and compliance was excellent in 12 areas which mainly related to clinical care of patients. We demonstrated the need for the reappointment of a dedicated database administrator to support the service, and recommended clearer documentation of disease activity scores in the clinic letters. Further analysis of the cost data is planned. We perform an annual audit of the use of biological therapies in patients with inflammatory rheumatology disorders to include rheumatoid and psoriatic arthritis and ankylosing spondylitis.

**Audit of early management of rheumatoid arthritis 2011/12**

Rheumatoid arthritis is an inflammatory joint disease causing joint damage and disability. Early treatment to bring the disease under control results in the prevention of joint damage and improved long term function. This audit measured compliance with NICE criteria for the management of early rheumatoid arthritis. 80% of patients with new RA were seen within two months of referral and 97% offered treatment with disease modifying drugs. Our action points include a review of the pathway for patients presenting with new-onset inflammatory arthritis and guidelines have been sent to general practitioners to support early identification and referral. We are also reviewing the multidisciplinary education of patients with new rheumatoid arthritis to increase the availability of educational sessions on a rolling monthly programme.

**Audit of Hospital Acquired Pressure Ulcers (HAPU) incorporating NICE Guidelines CG29**

In order to reduce Hospital Acquired Pressure Ulcers (HAPU), audit is undertaken to evaluate the care of patients who develop pressure damage within the Division. The audit includes all patients who develop significant tissue damage (Category 2 and above). An investigation is undertaken locally to ascertain the root cause of the pressure damage. Aggregate analysis is completed in order to ascertain whether there is commonality in the root causes, and the incidents are assigned to Avoidable or Unavoidable. As a result of audit the following actions have been implemented.
1. Mandatory update sessions for nurses on the prevention of pressure damage.
2. Early reporting of pressure damage on a web-based event reporting system accessible by all ward areas.
3. An investigation technique known as ‘Root Cause Analysis’ is to be undertaken by clinical staff of all Category 2 and above ulcers to identify causes and contributory factors.

The audit for 2012/13 to date, demonstrates that protocols implemented following previous audit have led to a 60% reduction in HAPU for the Division.

Audit of the Implementation of Intentional Rounding

Intentional Rounding, a concept that involves health professionals carrying out regular checks with individual patients at set intervals, was introduced to the Division 18 months ago and was rolled out to all clinical areas in April 2012. Research suggests that Intentional Rounding by healthcare professionals improves patient outcomes and reduces harms through the provision of reliable care. Audit was undertaken six months post-implementation to assess compliance with the process.

The audit results demonstrated high uptake, but low consistency in the relevant documentation. Therefore an action plan was developed to help ensure Intentional Rounding is embedded within the Division.

- Intentional Rounding documentation to be standardised across the Directorate.
- Audit Tool to be further developed to encompass cross referencing with adjunctive documentation.
- Further education and support given to clinical areas.

A subsequent audit is currently in progress.

<table>
<thead>
<tr>
<th>SandO</th>
<th>Access for Haemodialysis</th>
<th>85% of our patients have the best form of access for their treatment. Referral patterns for surgery are being improved.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MRSA infections</td>
<td>No MRSA infection in patients with Tunneled Dialysis Lines.</td>
</tr>
<tr>
<td></td>
<td>Survival on Renal Replacement 2010</td>
<td>The audit showed 90% for OUH compared to 89% for the UK.</td>
</tr>
<tr>
<td>EMTA</td>
<td>Narrowband UVB Phototherapy Audit</td>
<td>This was a re-audit of an important dermatology service for patients with inflammation of the skin. Many improvements were noted from the previous audit in 2007 using British Association of Dermatologists guidelines. However, recommendations include enhanced communications between phototherapy and clinic booking staff so that notes and information can be easily found. A structured discharge summary proforma was also suggested, to further enhance clarity and communication for subsequent care.</td>
</tr>
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</table>
This was a re-audit using a questionnaire of patient experiences during their attendance in Dermatology. Feedback was overwhelmingly positive, but it was noted that there should be further communication about clinic waiting times and more seating available. In general though, patients felt that they were treated well and received good explanations.

Counselling of patients should include the risks of Fragile X premutation associated disorders, e.g. premature ovarian failure and Fragile X-associated tremor/ataxia syndrome (FXTAS; a late onset neurodegenerative disorder associated with problems with movement, memory, and the autonomic nervous system) as well as the risk of expansion to a full mutation in the next generation. We examined the medical notes of 30 patients in July 2012 and found that there was an improvement in the number of patients informed adequately since the previous audit in 2009. Two patients did not have evidence of the consultation in their notes. The plan of action was to clearly document the consultation in the notes in future and also mention the reasons for not discussing these risks at that consultation, if appropriate.

Carriers of DMD / BMD (muscular dystrophy) are known to be at risk from heart involvement. It is recommended that all carriers of DMD/BMD should have ECHO and ECG at diagnosis or after age 16 years and at least every five years thereafter.

Notes of 44 individuals referred for DMD/BMD were obtained and the audit completed in December 2012. Of these individuals, 11 patients were identified as being at risk of cardiac complications related to carrier status. 82% were offered appropriate advice and screening. The action plan was to be aware of individuals seen many years previously, as these individuals were most likely not to have received the recommended advice. A re-audit is planned in five years.

Microsatellite instability (MSI) is a characteristic feature of >90% of colorectal tumours developing in patients with hereditary non-polyposis colon cancer. We examined whether our current pathway of requesting MSI in families at moderately increased and high risk of developing bowel cancer is functioning effectively. We reviewed 129 families referred for an increased risk of developing bowel cancer and identified 85 families in which the test had been performed from May 2011 to May 2012. These tests had been appropriately requested in these families. 11% of the tests showed MSI-high (hereditary bowel cancer less likely in the family) compared to the expected 5-10% likely to show this result. In seven patients this test had an effect on their screening programme.
In 12 patients, this resulted in further testing and mutations in genes causing bowel cancer were identified. The audit found that the pathway was functioning effectively. The plan is to continue to use MSI as first choice for any family at moderately increased risk of bowel cancer on clinical assessment as before. It was found that the test is most likely to be effective in colon or endometrial samples and it is recommended that these only are tested.

<table>
<thead>
<tr>
<th>CCTDP</th>
<th>Imaging in the Investigation of Haematuria: audit and service evaluation</th>
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<tr>
<td></td>
<td>In 2009, the departments of Radiology and Urology and representatives from the primary care trusts in Oxfordshire reached a consensus on what tests should be performed for the investigation of haematuria (blood in the urine). Under this pathway, patients undergo ultrasound and/or CT examinations according to their age and the type of haematuria (visible or non-visible) and can be referred directly by their GP for their imaging tests. We prospectively audited adherence with the agreed pathway from November 2009 to November 2010. All patients were then followed for a further year, to assess the diagnostic accuracy of the imaging tests. A standard of 100% was set for adherence to the protocol. In total, just over 850 patients were included in the audit. For the two categories where patients only had one imaging test, adherence to the pathway was over 90%. In the two categories where patients had a combination of ultrasound and CT, adherence was much lower, 80 and 50%. Staff admitted to finding it confusing arranging several tests for each patient. In these two categories, ultrasound did not identify any abnormalities over and above CT; the pathway has been modified so those patients now only undergo CT, which should improve adherence. A re-audit will take place next year.</td>
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</table>

| Data submission to the iliac angioplasty and stent national registry | This is ongoing submission of data from all iliac angioplasty procedures undertaken in the Trust. This allows the vascular radiologists to benchmark their performance against national and alert levels. Service provision in Oxford is safe, with complication rates significantly below alert levels set nationally. |
| Diagnostic work-up in patients with Subarachnoid Haemorrhage and negative CT-Angiography | This audit was performed to evaluate compliance with the internationally recognised American Heart Association / American Stroke Association (AHA/ASA) Guidelines for the Management of Aneurysmal Subarachnoid Hemorrhage. All patients with a negative CT angiogram (i.e. one that did not demonstrate an aneurysm) were then scheduled for interventional digital subtraction angiography, in accordance to the currently considered “gold standard” of care for the diagnosis of intracranial vessel abnormalities. Neuroradiology are therefore compliant with national guidelines. |
### Epidural complication trigger scores

Epidural analgesia is an effective method of pain relief used during and after a variety of surgical procedures. While it can give excellent pain relief it may lead to risk of complications including small chance of developing permanent paralysis. An early warning tool to detect possible complications has been developed and trialed. Its purpose is to initiate prompt examination of the patient by trained specialised medical staff. It has proved to have a high sensitivity in identifying problems.

### Pre-operative fasting

Anaesthetic guidelines suggest that the patients should be fasted from solid foods for six hours and clear liquids for two hours before a procedure under sedation or anaesthesia. The audit highlights that many patients are being unnecessarily over-fasted well beyond recommended period. 70% of patients are fasted from solids for longer than 12 hours, 15% for longer than 18 hours. 70% of patients were fasted from clear fluids for longer than four hours and 25% were fasted for longer than 12 hours prior to elective procedure under anaesthesia. A Trust-wide Pre-operative Fasting Policy is being written up to improve patient experience.

### Cost effective anaesthetic care

It is possible to give a more cost effective anaesthetic care without compromising on safety and efficacy. An initial audit showed that only 33% of estimates of costs of common medications were within 20-25% of the true cost. Following a teaching session cost accuracy improved, with 57-86% of estimates falling within the accuracy range.

### Fitting and use of Brevet Tx stockings

Brevet Tx stockings are one of the common methods used to prevent formation of blood clots in the legs while a patient is still during and after surgery. The audit assessed rates of proper sizing, proper fit and patient comfort when using anti DVT stockings.

In 33% of patients’ stockings the correct size was not used. Education of ward staff has led to improvements in sizing.

### Sterile Services External Audit

Sterile Services are audited annually by a notified external body on behalf of the MHRA against International and European standards (ISO 13485 ISO 9001 EEC EN 93/42). The findings show that medical instruments are correctly processed and that the Trust has correct procedures in place to ensure such sterilised instruments can be used safely on patients.
Patients who suffer a heart attack are treated urgently with a procedure to open the blocked coronary artery, and then recover on the Coronary Care Unit. An echocardiogram is an ultrasound of the heart that gives important information on how well the heart is working following the heart attack, and if any complications have occurred. Prior practice was to transfer patients to the echocardiography department for their scan. A clinical audit showed that for some patients this led to delays and extra days in hospital, or patients were discharged home to return later for a scan.

A new service was implemented whereby scans were undertaken at the patient’s bedside on the Coronary Care Unit within two to three days of the heart attack. This meant all patients could be discharged on time, and with full information regarding the function of their heart, implications for recovery and return to driving and work.

Identifying this issue and implementing a successful solution ensures that patients treated in Oxford following a heart attack have an accurate and timely assessment of heart function ensuring optimal ongoing management.

This is a prospective continuous audit on all head injury patients admitted to the John Radcliffe Hospital. The audit commenced in 2008 and has recruited over 700 patients to date. The audit is used to evaluate and improve the management of these patients from the point of injury to discharge from hospital. In addition the audit looks at the functional recovery one, three and five years post injury. Results from OxHEAD have been presented at national and international meetings, as well as locally and within the South Central Critical Care Network and Thames Valley Trauma Network to feedback and improve on early management and transfer systems. Outcome data is encouraging, for example 31% of head injury patients admitted to the Neurosciences ICU show good recovery and 34% show moderate recovery at one year. The audit demonstrates full compliance with NICE guidance; for example 47% of patients admitted to the Neurosciences ICU do not undergo an operative intervention, supporting our role as a tertiary centre to care for non-operative as well as operative head injury patients.
The Oxford University Hospitals (OUH) NHS Quality Account for 2012/13 has been reviewed by the Quality and Performance sub-committee of the OCCG Governing Body. In the interests of working together, OCCG forwarded these comments to the OUH and is pleased that the Trust took these comments on board and has updated their document accordingly. OCCG considers that the report produced contains accurate information and follows the template specified by the Department of Health. It should be noted that the version reviewed by OCCG was not the final version as the performance for some national indicators have not yet been published and the OUH is still awaiting information.

OCCG welcomes the key priorities set out by the OUH and that the four goals selected are all stretching yet achievable goals. The fact that these goals link to some of the CQUIN objectives set out by the Trust also demonstrates that the OUH has a shared understanding with Commissioners as to how quality can be improved.

The language used within this document is patient friendly. OCCG would like to commend OUH’s effort in trying to make this document helpful for readers and also for their plans to develop a shorter version of this document for patients.

OCCG aims to make sure that Oxfordshire has high quality, safe and clinically effective healthcare. The role played by the OUH is key in this ambition and OCCG welcomes the openness of this Quality Account and, in particular, the section where the OUH states the areas where they are not doing so well. OCCG is already working with the OUH to reduce the waiting times for diagnostic tests, to ensure that the capacity of outpatient clinics is managed well and the Emergency Department runs more effectively. OCCG works with a range of providers in Oxfordshire and believes it essential that all organisations communicate quickly and effectively with each other to ensure continuity of care. OUH needs to improve the speed of this communication and OCCG looks forward to working with OUH to improve performance, continuity of care and patient experience.

The purpose of Quality Accounts is to encourage boards and leaders of healthcare organisations to assess quality across all of the services they offer. OCCG looks forward to working with Oxford University Hospitals to address many of the issues in the future and hopes that the Trust will benefit from clinical commissioning.

Statements also requested from:
- HealthWatch Oxfordshire
- Hospital Overview Scrutiny Committee
Independent Auditors’ Limited Assurance Report to
the Directors of Oxford University Hospitals NHS Trust
on the Annual Quality Account

We are 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 2013 (“the Quality Account”) and certain performance indicators contained therein as part of our 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, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 (“the Regulations”).

Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the following indicators:

- Percentage of patient safety incidents that resulted in severe harm or death on pages 21 and 22; and
- Rate of clostridium difficile infections on page 24.

We refer to these two indicators collectively as “the indicators”.

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 Regulations).

In preparing the Quality Account, the 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; 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.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2012/13 issued by the Audit Commission on 25 March 2013 (“the Guidance”); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2012 to June 2013;
- papers relating to the Quality Account reported to the Board over the period April 2012 to June 2013;
- feedback from the Commissioners dated 04/06/2013 and 12/06/2013;
- feedback from Local Healthwatch dated 19/06/2013;
- the Trust’s complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated 12/06/2013;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey dated 16/04/2013;
- the latest national staff survey dated 28/02/2013;
- the Head of Internal Audit’s annual opinion over the trust’s control environment dated 08/05/2013;
- the annual governance statement dated 06/06/2013;
• Care Quality Commission quality and risk profiles dated April 2012 (10/04/2012), June 2012 (06/06/2012), July 2012 (05/07/2012), August 2012 (07/08/2012), October 2012 (05/10/2012), November 2012 (06/11/2012), December 2012 (05/12/2012), February 2013 (06/02/2013) and March 2013 (06/03/2013);

• the results of the Payment by Results coding review dated December 2012; and

• any other relevant information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the “documents”). Our responsibilities do not extend to any other information.

This report, including the conclusion, 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. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Oxford University Hospitals NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the Guidance. Our limited assurance procedures included:

• evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;

• making enquiries of management;

• testing key management controls;

• limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;

• comparing the content of the Quality Account to the requirements of the Regulations; and

• reading the documents.
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.

Limitations

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.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Oxford University Hospitals NHS Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Ernst & Young

Apex Plaza, Forbury Road, Reading, RG1 1YE
25 June 2013
Acknowledgements and feedback

Acknowledgements

The Oxford University Hospitals NHS Trust wishes to thank corporate and divisional teams for their contribution to the production of the Quality Account 2012/13. Equally, the Trust would like to acknowledge the invaluable contribution of those who supported the public engagement event on 11th March 2013 and the many individuals and groups that give their time to advise us on how to improve our services on an ongoing basis, throughout the year.

We would like to acknowledge the helpful feedback from the CCG 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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