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Oxford University Hospitals NHS Trust remains committed to delivering compassionate excellence for our patients. The commitment we have made in our Quality Strategy is that:

"By 2017 we will be recognised as one of the UK’s highest quality healthcare providers. We will have embedded all the fundamental aspects of good quality patient care and the skills and expertise of our staff required to provide that, and will demonstrate a commitment to continuous quality improvement. All our clinical services will be recognised as providing high quality care, while some will be able to demonstrate that they provide the highest quality compared to international benchmarks."1

This Quality Account forms part of our annual report to the public about the quality of our services. It describes our key achievements during 2014/15 and our priorities for quality improvement during the forthcoming year 2015/16. In developing our Quality Account we have identified and shared information across the Trust and 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.

Challenges
As for many NHS organisations, our quality improvement plans are against a background of pressure on services. Providing care within national waiting time standards has been difficult for us in 2014/15, with particular challenges in emergency inpatient services, diagnostic services, radiotherapy, some areas of planned surgery and waits for first cancer treatment. Continued pressure on our inpatient services for people needing urgent care has meant that we have not met the national standard for seeing, treating, admitting or discharging people attending our emergency departments within four hours. Work continues with organisations across Oxfordshire, with input from the NHS Emergency Care Intensive Support Team, to develop services to provide the urgent care people need whilst minimising the use of hospital beds. We have improved and expanded the facilities in our Emergency Assessment Unit at the John Radcliffe Hospital (JR) to support more people going home on the same day and have improved the speed of diagnostic support available there and in our Surgical Emergency Unit (SEU).

Significant improvements were made during 2014 in waiting times for diagnostic tests; waits for MRI scans were a major contributor to this. By October, 97% of MRI scans were being provided within four weeks, enabling the overall standard of a six week wait for diagnostic tests to be met. The Trust took on the provision of radiotherapy services for patients in the Milton Keynes area in late 2013, at short notice, following the withdrawal of another provider. As a result, for the first four months of 2014/15, we were unable to meet the national standard for starting radiotherapy within 31 days, but this was addressed through providing extra capacity.
In much of 2014/15, the national standard for treating patients who are referred by their GP with suspected cancer within 62 days was not met. Changes have been made in several services to improve the situation.

Patients referred for planned care have also waited longer than the ‘18 week referral to treat’ national standards during the year, with particular pressures in specialist surgery. We have invested in our spinal surgery service to reduce long waits experienced by some patients, and have run a significant programme of work to improve the operation of our outpatient clinics, to make better use of the appointment times available.

In August 2014 we undertook an extensive review of breast screening assessments between 2011 and 2014 at the breast screening unit at the Churchill Hospital. After four women were found to have developed breast cancer, despite having had an additional assessment following a suspicious mammogram (breast X-ray), we reviewed the assessment imaging of a further 624 women. Of these, 29 women were recalled and reassessed early, and regrettably, following further tests, six of these women have received a diagnosis of breast cancer. All were immediately referred for treatment in August and September. Representatives from Public Health England and the NHS Breast Screening Programme worked with the Trust to look at our actions in undertaking the recall and to consider the lessons to be learned. A peer review visit to the screening unit run by the NHS Breast Screening Programme has subsequently had a positive outcome.

In the course of the year 2014/15, we declared seven Never Events, which are patient safety events that should be preventable. We have already done much work to strengthen our safety systems, and much more is planned in the coming year linked to the human factors training described below. Our regulators and commissioners are fully aware, and are working with us to support and monitor our actions.

**Progress to become a Foundation Trust**

Assessment of the Trust’s application to be a Foundation Trust has continued through the year. Our quality governance arrangements were examined and tested in detail and improvements agreed, notably to our processes for reporting, investigating and learning from incidents. Monitor’s assessment of the Trust establishes a clear link between the safety and effectiveness of care, the delivery of care within waiting time standards, and being financially viable. All three remain important, and the clear message to clinical leaders within the Trust has been to maintain focus on all three.

**Successes**

The safety of prescribing medicines across our hospitals has improved with the introduction of electronic prescribing. This removes the risk of transcription errors and is linked at the John Radcliffe Hospital to a dispensing robot, which allows pharmacists to spend more time onwards providing advice and specialist support to patients and colleagues.

We continue to control the rate of *C.Difficile* infections, with fewer cases (61) in 2014/15 than the year before (64) or than our 2014/15 ceiling (67). Our rates of surgical site infection are also below the maximum levels set by our commissioners.

Over the course of 2015 we will be increasing the provision of ‘human factors’ training run by OxSTaR (Oxford Simulation Teaching and Research). These courses provide an excellent opportunity to examine the various ‘human factors’ associated with decision making, especially in stressful situations.
Staff receive ‘hands on’ experience in a simulated clinical environment which is designed to improve teamwork by optimising communication skills and situational awareness with the ultimate goal of reducing errors.

I was delighted to see our new children’s outpatient area open at the Horton General Hospital in December 2014. This will allow us to see more children and adults as outpatients at the Horton, and is evidence of our continued commitment to provide high quality care in Banbury. We also improved radiology imaging facilities at the Horton. A new cardiology outpatients department opened at the John Radcliffe, bringing together echocardiograms and outpatient appointments in one place, and now offers patients shorter waiting times, in a new comfortable setting.

Our regulators

The Care Quality Commission conducted a full inspection of the Trust’s four hospitals in February 2014, producing a report in May 2014 which gave OUH a rating of ‘Good’ overall, except for A&E and surgery at the John Radcliffe Hospital, which were rated as ‘requires improvement’. An action plan was agreed with the CQC and is being actively managed in the Trust.

The CQC’s inspectors observed caring and compassionate staff throughout the four hospitals and noted many examples of good team-working. Their reports, and many compliments and awards through the year, are a clear endorsement of the work done every day to provide compassionate and excellent care for our patients.

The improvements delivered this year would not have been possible without the commitment and dedication of the staff at 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.

The future

We have engaged with staff and patients to consider our quality priorities for 2015/16 particularly through events held in January 2015 and through discussion of this quality account. We are focusing our efforts around three domains: patient safety, clinical effectiveness and patient experience. We are fully committed to achieving required levels of national performance and access targets, and we have agreed timescales for sustained delivery of these, built into our contract with commissioners and our agreements with our regulators. But we also seek to innovate and improve our services for patients, and the experience of our colleagues in general practice, above and beyond those basic standards. That is why we have set ourselves ambitious goals for the coming year that are reflected in our Quality Priorities.

To this end we will be focusing our safety related priorities around the Sign Up to Safety national campaign, with a commitment to prevent avoidable harm and patient deterioration in hospital, as well as improving safety by better communication with our patients’ General Practitioners (GPs). We will learn from reviewing the care we gave to patients who die in our hospitals to improve services in the future, and we have three major programmes designed to reduce risk and avoidable harm to patients:

- improving the recognition, prevention and management of acute kidney injury (formerly known as acute kidney failure)
- improving the recognition and early management of patient with sepsis (how the body reacts to severe infection)
- rolling out our new electronic system, developed in our Biomedical Research Centre, for identifying and quickly responding to patients whose physical condition is deteriorating; (the SEND project).

These programmes also have major potential to reduce the length of time patients take to recover and therefore need to stay in hospital. They complement our ongoing priority around Care 24/7, while our dementia care initiative will consider both the safety and experience of patients with dementia. Our patient experience priority is to improve communication, feedback, engagement and complaints management, but we will be working not only on our interactions with patients, but also with our colleagues in other areas of health and social care. Central to achieving these aims is a receptive, responsive and open culture consistent with our commitment to human factors training, the professional and legal duty of candour, and our wish to improve the experience of all our stakeholders.

Despite our challenges, 2014/15 has been a year of great achievement for the Trust. I hope the readers of this Quality Account will be reassured both by the evidence of quality care and improvement, and where we still fall short of our aspiration to deliver compassionate excellence, by our enduring commitment to learn and improve. This Quality Account is a testament to the talent, resilience, hard work and compassion of all our staff, and I commend it to our stakeholders, our wider public and above all, our patients.

Sir Jonathan Michael, FRCP
Chief Executive
The Board of Oxford University Hospitals NHS Trust 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

What is a Quality Account?
Quality accounts are annual reports to the public from NHS providers about the quality of the services provided. They aim to enhance accountability to the public for the quality of NHS services. The Quality Account for Oxford University Hospitals NHS Trust (OUH) sets out where the Trust is doing well, where improvements in quality can be made and the priorities for the coming year.

Our quality priorities are aligned to the domains of patient safety, clinical effectiveness and patient experience. Our five-year Quality Strategy also follows this framework. In addition to use of this framework, we describe how our plans and priorities match with the key questions developed by the Care Quality Commission (CQC) during 2013. These key questions guide the CQC’s inspection process and are described in the table below.

What does this mean?

| Are they safe? | People are protected from physical, psychological or emotional harm. |
| Are they effective? | People’s needs are met, and their care is in line with nationally recognised guidelines. Patients have the best chance of getting better or living independently. |
| Are they caring? | People are treated with compassion, respect and dignity and care is tailored to their needs. |
| Are they responsive to people’s needs? | People get treatment and care at the right time, without excessive delay, and they are listened to in a way that responds to their needs and concerns. |
| Are they well led? | There is effective leadership, governance (clinical and corporate) and clinical involvement at all levels of the organisation. There is an open, fair and transparent culture that listens and learns from people’s views and experiences to make improvements. |
Enabling quality improvements

We have a number of key enablers for the successful delivery of the Quality Strategy.

- Leadership.
- Communication.
- Strong clinical engagement.
- Use of the legal and professional requirement for Duty of Candour² to change culture.
- Application of Trust values and linking them to quality outcomes.
- Education and training in key skills including patient safety, quality improvement and Lean methodology.
- Use of technology, including the electronic patient record (EPR).
- Further development of the Trust's internal peer review programme.
- Benefitting from synergies between the Trust and its academic, NHS and other partners, including via OUH, University of Oxford joint working agreement, the Oxford Academic Health Science Centre (OxAHSC) and the Oxford Academic Health Science Network (AHSN).
- Improved incident reporting, escalation and learning.
- Clear clinical accountability, with a named doctor responsible for a patient’s care.
- Human factors training for safe surgical teams.

National quality indicators

Since 2012 all NHS trusts are subject to a statutory core set of national indicators. The format has been set out by NHS England allowing comparisons to be more easily made between similar organisations. For each indicator, performance is reported together with the national average and the performance of the best and worst performing trusts, with a statement validating the data and describing relevant improvement actions. The data are sourced from the Health and Social Care Information Centre, unless stated otherwise. The indicators for acute trusts are contained within the relevant sections of this report and are:

- Summary Hospital Mortality Indicator (SHMI)
- palliative care coding
- patient reported outcome measures (PROMs)
- readmission rates
- responsiveness of the Trust to personal needs (via patient survey)
- patients who would recommend the Trust to friends and family (FFT)
- staff who would recommend the Trust to friends and family (FFT)
- rate of assessment for venous thromboembolism
- rate of C.Difficile infection
- patient safety incidents resulting in severe harm or death.

NOTES:
Progress on quality priorities for 2014/15

This section describes our quality improvement priorities for 2014/15 and the achievements we made during the year. Some of this work will roll over into 2015/16; this is indicated as further work in the sections below.

<table>
<thead>
<tr>
<th>Domain</th>
<th>CQC questions</th>
<th>Priorities for the Trust</th>
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<tr>
<td>PATIENT SAFETY</td>
<td>Safe Caring Responsive Well led</td>
<td>• A programme of work to review and improve arrangements in place for the management of inpatients outside of normal office hours across the four Trust sites (Care 24/7).</td>
</tr>
</tbody>
</table>
| CLINICAL EFFECTIVENESS | Effective Safe Caring               | • Implementation of the outputs of the risk summits examining the care of adult inpatients with diabetes and pneumonia.  
• Expansion of the provision of physician input into the care of inpatients in surgical specialties. |
| PATIENT EXPERIENCE   | Effective Safe Caring               | • Improvements to timeliness and communication around discharge from hospital.  
• Improvements to the experience of our outpatient services, from booking through to attendance and further correspondence.  
• Develop services to provide integrated psychological support for patients with cancer. |
## Care 24/7

### Our aims

Our goal was to develop a system of care delivery that would support safe, effective and high quality care on all four sites ‘24/7’ – 24 hours a day, seven days a week.

**We aimed to:**

- convene a series of risk summits with staff and commissioners to collaborate and include external perspectives
- gather relevant data including using qualitative research methods (face to face discussions) with key staff groups to determine a starting point (baseline) and monitor impact of changes
- examine staffing models, workflows (for example how we hand over patients between teams) and IT solutions
- agree a model going forward with implementation hoped for February 2015.

### Our actions

**Gathering information and planning**

- A series of consultations with staff and commissioners took place over a three month period.
- These included risk summits and work stream meetings where we set up a ‘nerve centre’ to promote effective communications, workforce and logistics.
- The NHS IQ³ audit was used as a self-assessment tool. This measured our performance against a range of standards for seven day working. A number of audits were undertaken.
- To determine the out of hours workload baseline we carried out a detailed mapping exercise, ran focus groups (supported by the Patient Safety Academy) and shadowed junior doctors and the senior nurse on duty at night (night nurse practitioner).

**Delivery**

- Agreed a Care 24/7 model for each of our hospital sites.
- Designed a new out of hours team with clearer leadership and responsibilities: clinical coordinator (senior nurse), medical and surgical senior doctors (registrar), junior doctors (FY1).
- Designed a new handover process using a new communication tool between daytime and out of hours teams, to ensure handover is efficient and focused on the key important concerns.
- Devised staff handover guidelines to set out standards for practice.
- Provided training for nurses and clinical support workers at night to carry out tasks previously undertaken by junior doctors, such as taking blood, inserting a cannula for an intravenous (IV) medicine or performing an ECG (test that checks the heart).
- Enhanced access to other key services:
  - pharmacy out of hours
  - radiology opinion through remote IT access.

### NOTES:

3. The NHS IQ (Improving Quality) audit works to improve health outcomes by providing improvement and change expertise. See [www.nhsiq.nhs.uk](http://www.nhsiq.nhs.uk)
Care 24/7

Our results
- We piloted the Care 24/7 model at the Horton General Hospital site with a view to roll-out across the Trust during 2015/16.
- Effective handover process with the multidisciplinary team was assisted by our communication tool. Focus areas included: clinical concerns – patients who are unwell or may need to be transferred, staffing, bed management and security. Handover attendance is managed online.
- Junior doctors have been able to spend more time with patients who are unwell since a range of tasks are now carried out by nurses and clinical support workers.

Benefits to patients
- Improved quality of care for sick patients with earlier access to diagnostics tests and treatments as appropriate.
- We are keen for our patients to be discharged ‘Home for Lunch’: our results show that on average patients have been able to leave hospital earlier in the day.

Further work
Care 24/7 is a Trust-wide project that will continue over 2015/16 until all the milestones have been implemented.
- We are planning to increase the provision of physiotherapy and occupational therapy out of hours.
- We will develop the IT system within the electronic patient record (EPR) so that the out of hours clinical coordinator can prioritise doctors to see patients who are deteriorating, as quickly as possible.
- We will develop a live central electronic staff roster with details of skill mix and staff on leave, so that emergency cover can be easily arranged.
- We are developing an electronic referral method to the out of hours team. This will allow ward staff to alert the out of hours team to all patients of concern.
- Our consultants will review patients on intensive care and high dependency areas twice daily.

Consultant:
"The Care 24/7 project has enabled the development of good quality medical and nursing handover – this has resulted in patients being identified before they become too unwell and they are reviewed by senior members of the overnight team promptly.

For example, there was a lady who presented with a possible paracetamol overdose and was refusing medical treatment in A&E initially she was felt to lack mental capacity and was heading towards mental health sectioning. She was mentioned in the handover and the two medical registrars and the medical consultant went to A&E immediately after handover and repeated the capacity assessment. She was deemed to have capacity and she agreed to have treatment for the suspected paracetamol overdose. The handover enabled prompt assessment and avoided further unnecessary evaluations of the patient."

PATIENT SAFETY
CLINICAL EFFECTIVENESS

Implementation of diabetes risk summit

**Diabetes**

| Our aims | We chose to improve the care and management of inpatients with diabetes. This was important due to the high number of our patients admitted for a range of illnesses and procedures who have diabetes: approximately 15% of adult inpatients in the Trust. In some clinical areas over 50% of patients have diabetes.

Deficiencies in quality had been noted in a) a national audit and b) a serious clinical incident which highlighted several areas of learning. We held a risk summit, attended by a large number of clinical specialists, patient representatives and commissioners to agree a series of improvement actions.

Four specific areas of focus were identified at the risk summit.

- To improve staff awareness and knowledge about diabetes.
- To improve the pathways of care for people with diabetes (including using IT to identify and manage patients).
- To implement Think Glucose\(^4\) across the Trust.
- To increase staffing levels of specialists in diabetes care.

| Our actions | We have built on Think Glucose to reform the care of patients with diabetes at the Trust; this work is ongoing.

**Diabetic specialists**

- Specialist nurses have tripled the time available to spend on diabetic inpatients.
- Specialist podiatrists tripled the time available to spend on diabetic inpatients.
- Two consultants now spend time in both diabetes and general medicine and work across different clinical sites.
- We have identified 130 diabetes link nurses from different clinical areas to cascade diabetes training and support best practice on the wards.
- We have set up a multidisciplinary foot team\(^5\) to manage patients with diabetic foot disease.

**Developing staff education**

- We have developed a structured education programme for our staff in collaboration with Oxford Brookes University. The programme is a mixture of online training and assessment and face to face support. The online education package is divided into three tiers, and the first tier is now available for all clinical staff. Priority areas include the Oxford Heart Centre, the management of diabetes in the patients in the renal unit and the management of diabetes in people receiving end of life care. External funding of nearly £50,000 has been obtained to support this work.
- We have carried out multiple face to face education and training sessions for staff (including for junior doctors, nurses and multidisciplinary teams and covering clinical areas such as dermatology, oncology, palliative care, renal, cardiology and cardiothoracic surgery).

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**NOTES:**

4. Think Glucose is a national initiative led by the NHS Institute for Innovation and Improvement to improve inpatient diabetes care. It involves a ‘traffic light’ system to clarify the referral process to specialist teams and has been refined in this instance by the development of clinical software.

5. Multidisciplinary foot teams comprise a range of clinical staff e.g. diabetes specialist doctors, vascular surgeons, orthopaedic surgeons and diabetes podiatrists.
### Our actions

**Review of patient care**

- Carried out a one-day Trust-wide audit of the standard of care of every inpatient with diabetes in the Trust in November 2014. The feet of every inpatient with diabetes were also examined on the same day. As a result, diabetes specialist nurses and the inpatient podiatry team are delivering more specialised teaching and training to ward nurses and other staff.

- Performed an in-depth case notes analysis (a Diabetes Mortality and Morbidity Review) on a selection of patients who developed either a foot ulcer or ketoacidosis\(^6\) whilst in hospital, and on inpatients who required intravenous treatment for low blood sugars.

**Guidance for staff**

- Developed and piloted guidelines for the management of diabetes during surgery.

- Developed clinical pathways, such as the new hypoglycaemia pathway. The launch of this pathway was timed to coincide with ‘World Hypo Day’ in November 2014 when stands throughout the Trust provided staff and the public with the opportunity to experience the symptoms of hypoglycaemia by wearing a special hypo simulation mask and headphones.

- Developed a new risk assessment tool for all diabetic patients. This will ensure a rapid review of patients with potential foot problems.

- Secured external funds to distribute 200 standardised hypoglycaemia (low blood sugar) treatment boxes at the diabetes link nurse training course. (This will tie in with the hypoglycaemia protocol which has recently been released.)

### Our results

**Patients seen by specialists in diabetes**

- Because of the changes we have put in place, the profile of diabetes is increasing throughout the Trust. This has been helped by the joint appointments of consultants in acute general medicine and diabetes, development of a suite of online training programmes for staff, and presentations at a range of meetings.

- Since the interventions arising from the diabetes risk summit, double the number of inpatients with diabetes are being seen by the specialist team, and over 85% of patients within one working day.

- Since January 2015, every hospital site in the Trust now has a dedicated diabetes specialist nurse, with a 25% increase in the number of diabetes nurses at the JR. This cover also allows the delivery of many elements of evidence-based best practice care to people admitted with diabetic emergencies\(^7\).

- 350% more patients with foot disease are being assessed and treated at OUH since the inpatient podiatry team has been established.

**Staff education increased**

- Tailored face to face education has increased with ongoing delivery to nurses and doctors and other healthcare professionals with a doubling in the number of sessions provided per month since December 2014.

We recognise that work is ongoing, and although there are significant developments since the appointment of new staff four months ago, the measurement of the impact of these changes on patients will continue over the forthcoming year.

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**NOTES:**

6. Ketoacidosis is when the body cannot use sugar as there is not enough insulin, and so breaks down fat stores for energy. It is a serious condition that can lead to a diabetic coma or death.

7. These include: a) hyperosmolar non-ketotic state: a serious condition when diabetes is not controlled properly, b) ketonaemia: a high level of ketones in the blood stream, c) hyperglycaemia: a high level of sugar in the blood stream.
## CLINICAL EFFECTIVENESS

### Implementation of diabetes risk summit

<table>
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<tr>
<th>Diabetes</th>
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<tr>
<td><strong>Further work</strong></td>
<td><strong>IT systems</strong></td>
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<tr>
<td></td>
<td>• Further to developing IT systems to identify the patients who have diabetic emergencies, the next step will be to link blood sugar testing with the electronic patient record, which will enable an automatic electronic flag to appear in the notes of diabetic patients, a reduction in errors giving insulin, and safer management of patients having insulin by IV drip where the dosage changes (sliding scales).</td>
</tr>
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|  | **Team support and development** |
|  | • Adapting guidelines for managing diabetic patients having surgery following feedback. |
|  | • Further developing the multidisciplinary foot team to provide a more rapid diabetic foot service. |

|  | **Education** |
|  | • Developing bespoke training modules about diabetes in specific clinical situations for specific clinical staff, made possible by external funding of £5,000. |
|  | • Lessons learnt from the in-depth case note analysis will be fed into the content of the educational programme. |
|  | • Delivering an educational programme for diabetic link nurses: intensive two day courses from April 2015 repeated bi-monthly for the remainder of the year. |
|  | • Distributing 200 standardised hypoglycaemia (low blood sugar) treatment boxes at the diabetes link nurse training course. |
**Pneumonia**

**Our aims**

- Provide consistent high quality care to all patients with pneumonia including those cared for outside the specialist respiratory ward.
- Improve outcomes for patients admitted with pneumonia.
- Develop, implement and audit a care bundle across the Trust in areas where patients with community acquired pneumonia are seen, assessed and admitted. This is to provide clarity and consistency in the way we manage community acquired pneumonia with standardised documentation to support this.
- Faster access to specialist respiratory doctors so that treatment and care decisions are made as early as possible.
- Develop and improve critical care support for patients with acute respiratory conditions.
- Implementation of a standard relating to radiology reporting times for admission, chest X-rays to enable faster diagnosis and early treatment.
- Increase nursing levels in acute general medicine where the majority of patients with pneumonia are cared for.

**Our actions**

We developed a care bundle with clinicians from key specialties including respiratory medicine, microbiology and infectious diseases. Although we have introduced the elements within the care bundle we have not made as much progress using the documentation (forms) as we had hoped. We are, however, piloting the use of the care bundle forms in the emergency department and respiratory medicine.

During 2014/15 we have made a number of significant changes to our service.

- Acute medicine at the JR was the first clinical area in the Trust to implement electronic prescribing (ePMA). The Horton General Hospital is now also live.
- Implemented electronic chest X-ray requesting to speed up diagnosis of pneumonia and initiation of antibiotic treatment.
- Changed our patient assessment models and implemented rapid nurse assessment process and rapid doctor assessment processes. Access to senior clinical decision makers, electronic ordering of chest X-rays, and prompt taking of blood samples for diagnostic tests, has enabled effective treatment to be initiated earlier.
- Increased the nurse to patient staffing ratio in general medicine.
- Developed outreach specialist respiratory doctors available on a daily basis to see referrals from acute admitting team.
- Specialist respiratory doctors and our outreach team support ward staff by providing additional expertise for those patients at the more critical end of the spectrum. For example, specialist respiratory nurses help ward staff to improve ventilation by correcting posture, clearing airways and providing ‘non-invasive ventilation’ to patients with respiratory failure and chronic obstructive pulmonary disease (COPD).

Radiology reviewed the possibility of reporting all admission inpatient chest X-ray films and A&E chest X-ray films within 24 hours. The costs were examined with an outsourcing company and viewed to be too expensive. Currently there are insufficient resources within radiology to offer this service. However clinicians caring for patients can still view the X-rays for themselves at any time.
CLINICAL EFFECTIVENESS

Implementation of pneumonia risk summit

<table>
<thead>
<tr>
<th>Pneumonia</th>
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<tbody>
<tr>
<td>Our results</td>
</tr>
<tr>
<td>• Patients with suspected pneumonia seen by senior doctor within 30 minutes so treatment can be initiated early.</td>
</tr>
<tr>
<td>• Respiratory outreach service in place.</td>
</tr>
<tr>
<td>• Accurate timeline of medications administered measured by ePMA allowing us to collect data to help us measure our adherence to quality standards.</td>
</tr>
<tr>
<td>• Improved nurse to patient staffing ratio in general medicine to care for patients.</td>
</tr>
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</table>

| Further work |
| • Further developments in progress are embedding the care bundle within the electronic care set for pneumonia, which will give a ‘decision aid’ to prescribing and will assist with timely audit of our practice. |
| • In 2015/16 we will be moving our respiratory ward to the JR to improve specialist respiratory outreach and liaison services. This will potentially provide increased access to high level care respiratory beds where the sickest patients are cared for. |
| • We will develop a respiratory ward consultation system at the Horton General Hospital. |
| • We have developed a respiratory strategy and this should be ratified in the near future. |
| • We are developing a common chest referral pathway which will include community acquired pneumonia. |

Expansion of provision of physician input into the care of inpatients in surgical specialties

| Expansion of provision of physician input into the care of inpatients in surgical specialties |
| Our aims |
| We chose this because patients admitted to hospital under the care of surgical teams often have co-existing medical needs. Increasingly frail, older patients are now undergoing routine and emergency surgery and there is an ever growing need for collaborative multidisciplinary working to ensure that all aspects of a patient’s care are well managed. The contribution of medical doctors (referred to as physicians) to the care of these patients has been found to be hugely beneficial through the expert management of underlying complex co-morbidities. |
| Effective working to ensure patients are as fit as they can be before surgery (pre-optimisation), enhanced recovery and proactive discharge planning, all aim to improve the experience of patients, clinical outcomes and service performance. |
| Following a very successful pilot in 2013/14, roll-out of physician input to other services was planned for 2014/15. |

NOTES:
9. A co-morbidity is the presence of one or more additional disorders (or diseases) occurring at the same time as the primary condition necessitating the hospital admission; or the effect of the additional disorders or diseases.
Expansion of provision of physician input into the care of inpatients in surgical specialties

Our actions

We had hoped to increase from a five day to a seven day consultant physician service within our surgical emergency unit (SEU) but due to consultant vacancies this was not possible. We did manage to maintain the five day service with further reduction in length of stay of patients. We continue to provide on-call support on weekends.

There has been a review of medical staffing within acute general medicine and geratology to assess the available senior and junior support provided to surgical wards. Expanding this cover beyond SEU has been limited by medical consultant vacancies within medicine but we hope to provide medical consultant support to vascular surgery during 2015/16.

Physicians have provided continued staff education in SEU relating to the identification and management of medical co-morbidities, now embedded within normal practice of doctors in the unit.

Our results

The number of patients being admitted to SEU has continued to increase in 2014/15, but at a less substantial rate than the previous year. The graph below shows the 30 month growth trend.

![Graph showing monthly presentations to the Surgical Emergency Unit]

Despite the increase in admissions to SEU there has been a significant decrease in the length of stay (LOS) for both patients below 75 years and above 75 years. When comparing 2014 to 2013 there has been an overall reduction in average LOS of 10%. These improvements in both groups have been sustained over the two year length of the project and the growth in demand. There is still more work to do with the over 75 year age group to reduce the LOS it from the current 6% decrease to the desired 10%.

Benefits to patients

- Decreased time spent in hospital.
- Enhanced discharge planning around complex medical issues.
- Beneficial collaborative multidisciplinary working. (All team members e.g. Doctors, nurses and therapists working effectively together)
- Enhanced awareness of medical conditions within surgical specialties has improved the management of co-existing conditions

Further work

- Expansion of this service beyond SEU.

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>LOS target 2014</th>
<th>Achieved?</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;75 y</td>
<td>4.0</td>
<td>3.5</td>
<td>3.1</td>
<td>3.2</td>
<td>✓</td>
</tr>
<tr>
<td>&gt;75 y</td>
<td>7.8</td>
<td>6.7</td>
<td>6.3</td>
<td>6.0</td>
<td>✗</td>
</tr>
<tr>
<td>Total admissions</td>
<td>4.6</td>
<td>4.1</td>
<td>3.7</td>
<td>3.7</td>
<td>✓</td>
</tr>
</tbody>
</table>
## PATIENT EXPERIENCE

### Improvements to timeliness and communication around discharge from hospital

<table>
<thead>
<tr>
<th>Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Our aims</strong></td>
</tr>
</tbody>
</table>
| • To ensure that staff, patient and carer expectations are aligned from the earliest point possible by improving communication.  
• To ensure that we communicate effectively and in a timely manner with other healthcare providers (NHS and social care).  
• To ensure that preparations are made in advance of discharge becoming clinically appropriate.  
• To implement a standardised discharge checklist and standards relating to communication around discharge.  
• To develop discharge information with Age UK.  
• To improve joint working with South Central Ambulance Service (SCAS) and Arriva and making appropriate use of transfer lounge facilities.  
• To improve all aspects of the medicines To Take Out (TTO) process within and beyond pharmacy. Baseline work to understand how the TTO process can be monitored in real time.  
• To elicit and act upon patient and carer feedback in relation to discharge. |
| **Our actions** |
| We have implemented Trust-wide generic standardised discharge documentation including the nursing admission discharge booklet and discharge safety checklist for all discharges. Patients are given ‘Planning your discharge’ providing an overview of the discharge process and what happens at each stage.  
We have revised the supported discharge policy and incorporated this into the corporate bed management policy. This work has been in collaboration with our partner trusts and social services. This helps staff to follow an agreed process for discharging and transferring patients across the NHS and Social Care in Oxfordshire.  
We have worked with our partner trusts, commissioners and social services (multidisciplinary team) to produce a ‘management of patient choice policy’. This policy ensures that choice is managed fairly during the discharge process and is relevant to those patients who need to choose a care provider or destination for when they leave hospital.  
We have introduced a new discharge summary process via the electronic patient record. This includes a checklist for nursing processes to support patient safety. The process is also intended to facilitate electronic messaging of summaries to GPs to improve communication. This process has worked well in the emergency departments where 100% of discharge summaries are consistently delivered. There have however been technical problems with e-messaging and difficulties with how our staff interact with the system which have led to a fall in delivery of inpatient summaries in the second half of 2014/15. This is a shared concern for OUH and our GP colleagues and therefore it is a high priority for 2015/16.  
We held regular meetings with the organisations that provide transport services to improve turnaround times and reduce transport delays. Additional transport has been provided as part of a government winter funding scheme. We now have our own vehicle to transport patients between hospitals.  
Actively transferred patients awaiting discharge to the transfer lounge facility. |
## PATIENT EXPERIENCE

### Discharge

<table>
<thead>
<tr>
<th>Our actions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>We reviewed all complaints / incidents from discharge as part of monthly discharge meeting allowing actions to be put in place.</td>
<td>We ran a winter campaign at OUH supported by Age UK. Posters, banners and leaflets were on prominent display in all of our hospitals. We commenced roll-out of electronic prescribing and administration medicines (ePMA) across the Trust completed by May 2015 except for JR maternity services. ePMA will allow us to monitor each stage of the TTO process and link this to the discharge process, such as when the prescription is written, when it is processed in the pharmacy and arrival on ward by time of discharge. This information will help us to locate and act upon any delays in the process. We ran a multi-organisation discharge planning workshop: actions from the workshop will form our 2015/16 discharge priorities. We enhanced weekend working in pharmacy as part of the ‘Care 24/7’ project. We actively reviewed our TTO policy with our commissioners. They were titled: <strong>Keep well</strong> Providing advice on how to keep well over winter <strong>Choose well</strong> Signposting to ensure the appropriate choice of service if required <strong>Plan well</strong> Planning for discharge, encouraging patient and relative involvement</td>
</tr>
</tbody>
</table>
## PATIENT EXPERIENCE

### Improvements to timeliness and communication around discharge from hospital

<table>
<thead>
<tr>
<th>Discharge</th>
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</thead>
<tbody>
<tr>
<td><strong>Our results</strong></td>
</tr>
<tr>
<td>Standardised documentation used for all patient discharges. Consistent approach to discharge planning agreed across the whole system (partner trusts, social services). Whole system policies in place have improved communication between the multidisciplinary team: supported discharge policy and management of patient choice policy (the latter provides guidance on the management of patient choice where patients are required to choose a nursing or residential home). Improved information for patients by the display of winter campaign banners on all sites of the Trust and the availability of patient information leaflets on all wards. Achieved a 15.7% increase in patients using the transfer lounge facilities compared to 2013/14. Received a reduction in complaints and incidents relating to discharge processes. Major performance improvements in turnaround and pick up times from Arriva transport services provided to our patients, particularly in renal and oncology services. Due to technical issues there has been a major delay reporting our performance providing TTOs from the ePMA system. This has been resolved in the early part of 2015/16. We recognise that we need to improve the sending of electronic discharge summaries and TTOs to GPs (via e-messaging) when a patient is discharged, so as to ensure the information is much more complete and arrives in a timely manner. Shared learning with partner organisations. Healthwatch Oxfordshire carried out 'enter and view' visits to talk to patients about a range of issues around discharge planning. We look forward to working with them following their feedback. <strong>• Much improvement in patient experience in relation to hospital transport, particularly for renal dialysis patients from the west of the county.</strong> <strong>• Consistent information about discharge planning is provided for patients on admission and during the hospital stay. Better communication between care providers.</strong> <strong>• Advice on how to stay healthy during the winter months via the winter campaigns</strong> <strong>• Reduction in the number of medication errors, more transparent process as ePMA has been rolled out.</strong></td>
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</tbody>
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<table>
<thead>
<tr>
<th>Benefits to patients</th>
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<tbody>
<tr>
<td>• Develop discharge documentation within our electronic patient record system (run by Cerner Millennium) to include section 2 and section 5. (These are statutory forms that hospitals must use to inform local councils of the proposed date of discharge and that community care services are needed when the patient leaves hospital). <strong>• Complete roll-out of ePMA and be able to formally monitor TTO turnaround times from April 2015. The complete roll-out of ePMA will enable us to monitor when TTOs are written and understand the delays across the Trust. We have set improving the rate of TTOs being written and released by pharmacy as a priority for 2015/16.</strong> <strong>• Develop discharge priorities for 2015/16 following workshop with stakeholders.</strong> <strong>• Track and performance manage completion of delivery of discharge summaries to GPs.</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Further work</th>
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</thead>
<tbody>
<tr>
<td>• Develop discharge documentation within our electronic patient record system (run by Cerner Millennium) to include section 2 and section 5. (These are statutory forms that hospitals must use to inform local councils of the proposed date of discharge and that community care services are needed when the patient leaves hospital). <strong>• Complete roll-out of ePMA and be able to formally monitor TTO turnaround times from April 2015. The complete roll-out of ePMA will enable us to monitor when TTOs are written and understand the delays across the Trust. We have set improving the rate of TTOs being written and released by pharmacy as a priority for 2015/16.</strong> <strong>• Develop discharge priorities for 2015/16 following workshop with stakeholders.</strong> <strong>• Track and performance manage completion of delivery of discharge summaries to GPs.</strong></td>
</tr>
</tbody>
</table>
## PATIENT EXPERIENCE

### Improvements to the experience of our outpatient services, from booking through to attendance and further correspondence

<table>
<thead>
<tr>
<th>Outpatient Services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Our aims</strong></td>
<td>We have been working hard on the outpatient reprofiling project, to improve how we run our outpatient clinics. We know from listening to our patients, staff and commissioners that some of our patients experience difficulties in booking appointments. We know that some of our clinics run late, which causes our patients inconvenience and additional costs for car parking. We want to make improvements so that we can offer a more efficient and high quality service. Key issues include ensuring that:</td>
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<td></td>
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<tr>
<td></td>
<td>• patients reliably know the time and venue of their appointment</td>
</tr>
<tr>
<td></td>
<td>• patients can choose the date and time of their clinic appointment</td>
</tr>
<tr>
<td></td>
<td>• clinics run on time and, if not, patients know how late they are running</td>
</tr>
<tr>
<td></td>
<td>• Friends and Family Test (FFT) is rolled out within the outpatient department (OPD)</td>
</tr>
<tr>
<td></td>
<td>• customer service on the day is good</td>
</tr>
<tr>
<td></td>
<td>• patients are routinely sent copies of clinic correspondence</td>
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<tr>
<td></td>
<td>• Directly Bookable Service (DBS) is piloted (in order for patients and their GPs to view and select available clinic slots at the time of referral) in two services, with plan to roll out to other services by the end of 2014</td>
</tr>
<tr>
<td></td>
<td>• work is carried out to understand the potential switch to sending clinic letters by email.</td>
</tr>
<tr>
<td><strong>Our actions</strong></td>
<td>We have revised how OPD appointments are set up so it is easier for patients book their appointment. This work is nearly completed with just rheumatology and orthopaedics left to do.</td>
</tr>
<tr>
<td></td>
<td>We used a business modelling system for managers to understand the number of referrals into their services. This helps to ensure there is enough capacity to see patients in a timely way and to also control their waiting lists, which reduces backlog and waiting times for appointments.</td>
</tr>
<tr>
<td></td>
<td>We introduced the FFT within the OPD to collect patient feedback on our service.</td>
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<tr>
<td></td>
<td>We began rolling out the Directly Bookable Service (DBS) for direct booking access to outpatient appointments. The technical work within the Trust’s EPR system has been completed. A roll-out programme is in place to introduce this system across the Trust. Close liaison with our commissioners and GPs through a project board is helping iron out issues so the system works well.</td>
</tr>
<tr>
<td></td>
<td>We improved the physical environment for children’s OPD services at the Horton General Hospital.</td>
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<tr>
<td></td>
<td>We set up an OPD quality group to share learning from each other and local patient experience projects. This group has developed and is implementing outpatient pledges and supporting standards. These are aligned with the CQC five key questions to ensure our service in OPD is safe, effective, caring, responsive and well led.</td>
</tr>
</tbody>
</table>

Mr I was diagnosed with a malignant tumour in his throat in December 2013. The tumour was removed and he then underwent chemotherapy and radiotherapy treatment. Mr I praised highly his clinical treatment and care. He noticed a few areas that could be improved, such as clinic waiting times and information about delays, ensuring that he was fully hydrated issues to do with staff attitudes and some issues to do with care not being fully joined up.
## PATIENT EXPERIENCE

Improvements to the experience of our outpatient services, from booking through to attendance and further correspondence

<table>
<thead>
<tr>
<th><strong>Outpatient Services</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Our actions</strong></td>
</tr>
<tr>
<td>We instituted a mission statement to deliver compassionate excellence in our outpatient department:</td>
</tr>
<tr>
<td>“We will ensure the right patient is seen at the right time, on the right pathway of care, together with the right information and gets the right clinical advice, support and treatment at all times.”</td>
</tr>
<tr>
<td>We developed and began rolling out customer care training to all OPD staff.</td>
</tr>
<tr>
<td>We worked with GPs and our commissioners to improve the manner in which clinic letters are sent electronically to GPs within ten days. (This is followed by a paper copy to patients via the Royal Mail.) Introduced a ‘buddy system’ for consultants to electronically approve a colleague’s GP letters during periods of leave. This system avoids a backlog of GP letters which we are keen to avoid since a delay in the GP receiving a letter potentially delays care / treatment to the patient. Regular audits are in place to monitor the turnaround times relating to sending out these letters. This process is closely monitored by the business manager in each service and the audit results are scrutinised by our Data Quality Group.</td>
</tr>
<tr>
<td>An OPD dashboard has been devised for reporting performance to the Board. This comprises 12 measures including % outpatient letters sent electronically to GPs within ten days, % patients seen within 30 minutes of their appointment, % patients sent a text / letter reminder of their appointment, and will complement the quality standards.</td>
</tr>
</tbody>
</table>

| **Our results** |
| We improved the efficiency of our general and specialist outpatient clinic utilisation and standardised booking systems. Revised 1200 clinic templates which have resulted in a more standardised process for booking outpatient appointments and provided more appointment slots for patients. |
| We rolled out DBS to the following services: ear nose and throat; urology; endocrine surgery; gynaecology; pain management and musculoskeletal hub. Positive feedback has been received for those services where it has been rolled out. |
| We created a new children’s OPD at the Horton General Hospital for children on outpatient or ambulatory pathways. |
| We achieved a 55% response Friends and Family Test. The results showed that 95% of outpatients were extremely likely or likely to recommend their care between April 2014 and March 2015. |
| We delivered customer care training to 40 OPD staff in 2014/15. Our approach has been to focus initially on OPD managers to ensure the course meets the specific service needs. |
| We made good progress in sending electronic outpatient letters to GPs within ten days. Hospital doctors are also able to view these electronic letters which avoids time lost retrieving records during an unplanned visit to hospital. |
### Patient Experience

**Improvements to the experience of our outpatient services, from booking through to attendance and further correspondence**

<table>
<thead>
<tr>
<th>Outpatient Services</th>
<th>Booking appointments</th>
</tr>
</thead>
</table>
| Benefits to patients | • Easier to book an appointment due to the increased number of clinic slots.  
• Patients and their GPs can view and select clinic slots at their time of referral for the five specialties using DBS so far. |

**Improved patient experience in OPD**

Our FFT results indicate 97% patients would recommend our OPD service to their friends and family.

**Electronic consultant letters to GPs**

• GPs are able to get patient letters in a timely way, ensuring care continues. No letters are lost.
• Potentially faster treatment, advice and reassurance for some patients visiting A&E as the hospital doctor is able to quickly see any treatment / medication changes made by the consultant at the OPD appointment.
• Since the electronic service has been in place we are able to pinpoint any delays and take immediate actions.

**Further work**

• Continue to roll out DBS and review programme to include Two Week Waits for cancer treatment.
• Complete roll out of GP outpatient letters electronically.
• Continue with roll out of outpatient pledges and supporting standards, monitoring compliance through self-assessment and assurance visits.
• Pursue other efficiency measures to OPD clinics such as electronic check-in for patients.
• Continue to roll out customer care training – our target is 170 staff trained by November 2015.

**Quotes from customer care course**

“I can’t wait to send my staff on this course. I think it is highly beneficial and a very practical way to instill values in our frontline staff” Operational Service Manager

“This will be a really useful training for staff who are aware of their limitation and can build on this in their roles” Operational Manager

“This course makes you realise how important it is to instill the values in other team members” Sister

“There is a definite need for this course. It relates to frontline staff and deals with issues they face on a weekly, even daily basis” Manager.
## Patient Experience

Develop a psychological medicine service to the Oxford Cancer Centre and other areas of the Trust  
(Title refined from ‘Develop services to provide integrated psychological support for patients with cancer’)

<table>
<thead>
<tr>
<th>Psychological medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Our aims</strong></td>
</tr>
</tbody>
</table>
| Following a successful commencement of the psychological medicine service in medicine and gerontology in 2012/13/14, a roll-out to oncology services, maternity and neurosciences was planned for 2014/15.  
We have been keen to counter the notion that ‘mental health’ is something separate that can be ‘outsourced, rather than being part of the core business of the acute trust. Psychological medicine describes psychiatry and psychology provided by, and fully integrated into, the acute trust. This modern approach better addresses the split in care often experienced by patients for their mental and physical health needs. |
| **Our actions**         |
| We expanded the team: the psychological medicine service currently comprises a unified service provided by ten newly appointed psychiatrists and 20 existing psychologists.  
All patients in the Trust have access to a consultant psychiatrist within four hours for urgent referrals and within one working day for routine referrals.  
The Trust has been recognised as a leader in the UK for its integrated psychological medicine (psychiatry and psychology) service. Previously a liaison service was provided by our neighbouring mental health provider. |
| We established a seven day service for medical patients.  
We appointed new consultant psychiatrists who are now working within palliative care. Following a recruitment drive a consultant psychiatrist will start in the Oxford Cancer Centre in July 2015.  
We have worked with Macmillan Cancer Support and they have provisionally agreed to fund three nurse posts completing the psychological medicine team in cancer for three years. We anticipate these posts will be in place in the latter part of 2015.  
Until our full service is in place patients within the Cancer Centre are signposted to their GPs. Also on site is the new Maggie’s Centre – a walk-in charity for general support.  
Macmillan Cancer Support also funds a full time psychologist for 16 – 25 year olds with cancer.  
A consultant psychiatrist has started working at the Women’s Centre and others will join the Children’s Hospital, the renal and transplant services and clinical neurosciences later in 2015. |
# PATIENT EXPERIENCE

## Psychological medicine

| Our results | In medicine and geratology, palliative care and the Women’s Centre, there is an enhanced service where psychiatrists and psychologists work as part of the clinical teams. For example, patients may see these professionals during routine ward rounds. This will be expanded to the Cancer Centre, paediatrics, renal and transplant services and clinical neurosciences in 2015/16 as additional staff are appointed. The psychological medicine team has received accolades for their work:  
- **Gold Team of the Year 2014 OUH award**  
- **Runner up Mental Health Team of the Year 2014 (Royal College of Psychiatrists)**  
- **Team leader Professor Michael Sharpe, Consultant Psychiatrist, was awarded Psychiatrist of the Year 2014 (Royal College of Psychiatrists).** |
| Benefits to patients | When the new service is fully in place in the Cancer Centre OPD, patients with depression and anxiety will be actively identified and offered cutting-edge evidence-based treatment for this as part of their cancer care. This means patients will receive seamless mental and physical care. |
| Benefits to staff | Staff are only able to provide good psychological care if they have the skills and confidence to do so and are also able to manage their own personal distress. The team is developing staff supervision and support for staff in several parts of the Trust. The aim of this is to help staff to better manage the challenges of coping with the sometimes personally distressing aspects of delivering care (often related to patient deaths) and thereby deliver better care to patients. |

## Comments by physicians

- “How did we manage without this service? Top quality help, when you need it. It has been a very supportive and useful service for us.”
- “A fantastic service. The team has been very supportive and helpful, from acute assessment and management to discharge planning. A massive improvement on what was previously available.”
- “A great improvement from previously and enormously appreciated.”
- “Really excellent service as the psychological medicine team not only assesses patients, but helps execute the plan. I am very impressed and always delighted by the help I get as a consultant physician.”
- “A member of the psychiatry team attends our MDT twice a week and their input is extremely useful. From a nursing perspective, psychiatry team are approachable and referring patients is far less challenging than before (when we had psychiatric nurses).”
- “Very responsive service, clear sensible advice well-documented - provide excellent support to relatives.”
- “The team are a breath of fresh air! Always willing to help, advise and guide.”

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**THE NEXT SECTION OF THE QUALITY ACCOUNT WILL SET OUT OUR PRIORITIES FOR 2015/16. FOR MUCH MORE DETAILED INFORMATION ON ALL OTHER QUALITY RELATED PERFORMANCE IN 2014/15, PLEASE TURN TO PAGE 36**
Looking Forward:

Quality Account Priorities for 2015/16

This section of the report describes a selection of quality priorities for the coming year. These are part of a wider work plan to deliver high quality care to all of our patients. All quality improvement work is monitored closely by our Clinical Governance and Quality Committees and we regularly report our performance to our commissioners.

Over the year ahead, we aim to prioritise the delivery of quality improvements across a range of projects and services. There are seven high level Trust-wide quality priorities. There have been several different drivers in the development of these projects: priorities set for the NHS nationally; priorities arising through feedback that the Trust has received from service users and our local Healthwatch organisation; priorities set from a review of incidents and internal audit reports and priorities articulated in our Quality Strategy and Annual Business Plan.

We recognise that some of the quality priorities in our 2014/15 report were not achieved in full and we will continue to push forward with work in these areas. Quality priorities from 2014/15 which have been incorporated into projects for 2015/16 are:

- Care 24/7, a large Trust-wide transformation project (captured in priority 1).
- Improving how we supply TTOs (incorporated into priority 1).
- Improving how we listen and respond to feedback (developed into priority 7).

<table>
<thead>
<tr>
<th>Domain</th>
<th>CQC questions</th>
<th>Quality Priorities for the Trust</th>
</tr>
</thead>
</table>
| PATIENT SAFETY          | Safe Caring Responsive Well led | 1. Preventing avoidable patient deterioration and harm in hospital: Sign Up to Safety.  
2. Partnership working to improve urgent and emergency care.  
3. Improving recognition, prevention and management of acute kidney injury. |
| CLINICAL EFFECTIVENESS  | Effective Safe Caring  | 4. Learning from deaths and harms to improve patient care.  
5. Management of patients presenting with sepsis. |
| PATIENT EXPERIENCE      | Effective Safe Caring  | 6. End of life: improving people’s care in the last few days and hours of life.  
7. Improving communication, feedback, engagement and complaints management: with patients, carers, healthcare staff and social care providers. |
This Venn diagram shows the relationship between the different quality priorities in the Trust and the three domains of quality.

Our interactions with GPs; providing human factors training; and our responsibilities regarding duty of candour (being open), are priorities that impact on all three quality domains.
PATIENT SAFETY

Priority 1: Preventing avoidable patient deterioration and harm in hospital:

Sign Up to Safety

Why we chose this

A million people use healthcare services every 36 hours, and the vast majority of them receive safe and high quality care. But things do go wrong, and mistakes are made. Recent high profile cases (such as the Francis inquiry into failings at the Mid Staffordshire NHS Foundation Trust) show that there is still a lot to do to make sure that everyone is treated safely when they use healthcare services.

This year we will be participating in a range of patient safety initiatives such as Sign Up to Safety\(^\text{10}\) campaign, the Patient Safety Collaborative\(^\text{11}\) and the NHS Safety Thermometer\(^\text{12}\). We are also actively working with other NHS trusts in the region and utilising research through the Oxford Academic Health Science Network (AHSN)\(^\text{13}\).

We are committed to transforming our safety culture and compliance with evidence-based practice interventions.

Our aims

- Reduce the number of unexpected cardiac arrests and unplanned admissions to our critical care units by quickly recognising when a patient’s condition deteriorates.
- Continue to make improvements to the way clinical staff hand over care between teams ‘out of hours’ and ensure that critically ill patients are seen by a consultant twice a day. These will be part of the ‘Care 24/7’ project. (Care 24/7 is a Trust-wide project to meet the NHS England and NHS Improving Quality priorities for seven day working in the Trust).
- Increase our understanding of the safety culture in the Trust and identify ways of improving.
- Continuously evaluate our compliance with policies and procedures. Improving the way our clinical guidelines are developed, approved and stored centrally.
- Improve our processes for maintaining an accurate record of the medication a patient is taking, and communicate this appropriately (medicines reconciliation).
- Improve the efficiency with which patients receive their TTOs on discharge.
- Increase the number of patients receiving ‘harm free care’ as measured by the NHS Safety Thermometer to 95% by the end of 2016. This includes:
  - working towards our target of having no avoidable pressure ulcers by 2016
  - 10% reduction in inpatient falls causing severe harm
  - reducing the rate of urinary catheter associated infection (CAUTI), including training staff to use bladder ultrasound scanners as part of the Oxford AHSN collaborative
  - reducing the incidence of new venous thromboembolism.

Monitoring and reporting

- Regular reports to the Patient Safety and Clinical Risk Committee and from there to the Clinical Governance and Quality Committees.
- Safety and project groups monitor progress with improvement plans.
- The Care 24/7 Project Board monitors the handover process as part of the Trust Transformation Programme and provides regular reports to the Trust Management Executive (TME).

NOTES:
10 For more information see: www.england.nhs.uk/signuptosafety
11 For more information see: www.england.nhs.uk/ourwork/patientsafety/collaboratives
12 For more information see: www.safetythermometer.nhs.uk
13 The AHSN brings together the NHS, universities, business, patients and the public to promote best health for our population and prosperity for our region. For information see: www.oxfordahsn.org
## PATIENT SAFETY

<table>
<thead>
<tr>
<th>GOAL</th>
<th>TARGET</th>
<th>MEASURE</th>
<th>PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>All critically ill patients will be seen and reviewed by a consultant twice daily, including all acutely ill patients directly transferred, or others who deteriorate.</td>
<td>By Q4 100% of patients on intensive and high dependency areas will be reviewed by consultants twice daily.</td>
<td>We will measure this by directorate audits of patient records. Directorates will report their figures to the Care 24/7 project team.</td>
<td>Each of our directorates will prepare an action plan to implement twice daily reviews.</td>
</tr>
<tr>
<td>Improve the way we recognise when patient’s condition deteriorates, so we can take prompt action to treat them.</td>
<td>Roll out electronic track and trigger system in all acute areas of the Trust. Produce a cardiac arrest reduction strategy by March 2016.</td>
<td>We will measure this by number of acute areas in the Trust with electronic track and trigger. Ratified cardiac arrest reduction strategy by 31 March 2016.</td>
<td>Our RAID* committee will lead this work. The first phase of our roll-out programme will prioritise areas with higher levels of cardiac arrest, based on data from the resuscitation department. Resources for the project (including bedside scanner and tablet) will be helped by external funding from the NHS technology fund. Our RAID committee will develop the cardiac arrest reduction strategy and will meet bi-monthly to monitor this work. (recognising acutely ill and deteriorating patients)</td>
</tr>
<tr>
<td>Reduce all harms measured by the Safety Thermometer.</td>
<td>Deliver 95% harm-free care by 31 March 2016.</td>
<td>We will measure this by the monthly Safety Thermometer.</td>
<td>Focused staff training and link nurse support to reduce hospital acquired pressure ulcers. Standardise all specialist pressure relieving equipment. Implement the FallSafe care bundle. Develop and implement the CAUTI care bundle. Intense focus to increase VTE assessment rate including prompts in EPR to carry out VTE assessment within six hours of admission.</td>
</tr>
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# PATIENT SAFETY

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<th>GOAL</th>
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<tr>
<td>Increase the provision of human factor training to staff to improve awareness of the various factors associated with decision making. Phase one will focus on staff who have been involved in Never Events and other serious incidents.</td>
<td>100% of staff involved in Never Events to receive human factors training.</td>
<td>We will check staff training records and ask staff to feedback following training.</td>
<td>Staff will be identified by the Risk Management Team through incident investigations, and training requirements will be included in incident action plans for which the Divisions will take responsibility. The training will be provided by Oxford Simulation Teaching and Research (OxSTaR).</td>
</tr>
<tr>
<td>Improve discharge planning and discharge process (related to providing TTOs).</td>
<td>30% of TTOs written for non-emergency areas and released to pharmacy for dispensing the day prior to patient discharge.</td>
<td>We will measure this using our ORBIT information tool.</td>
<td>We will use a discharge review tool to help clinical teams to write and send the TTOs the day before patients are discharged.</td>
</tr>
<tr>
<td>To ensure acute emergency and elective inpatients (excluding day case, ward attenders and OPD) have had a stage one medicines reconciliation completed within 24 hours.</td>
<td>By 31 March 2016 we will achieve 80% medicines reconciliation in clinical areas visited by pharmacists.</td>
<td>We will measure this using our ORBIT information tool.</td>
<td>We will complete the medicines reconciliation reporting tool (ORBIT). We will establish baseline levels to assess the impact of the ePMA implementation to enable a target to be set in Q2. We will review current practice and establish a workflow plan for attaining the target set.</td>
</tr>
</tbody>
</table>
**PATIENT SAFETY**

**Priority 2: Partnership working to improve urgent and emergency care, including sustained achievement of the four hour ED standard**

### Why we chose this

Demands on emergency care services are growing quickly. The winter months are particularly difficult, with increased admissions of frail elders, and delays in obtaining the community health and social care needed to discharge patients from the hospital promptly. Some people who seek or receive help in hospital could have been helped much closer to home.

At OUH we have not consistently achieved the national target of discharging or transferring 95% of patients within four hours of arrival at A&E. We have been actively working with health and social care commissioners and partner providers to improve working across all organisations in healthcare.

### Our aims

- To work with partners in health and social care to reduce avoidable A&E attendances and emergency admissions. This work will examine and refine the urgent care pathway, producing solutions that will impact the entire system, not just our hospitals. It will also build on the Emergency Care Intensive Support Team (ECIST) action plan.
- To improve how we diagnose and support patients with mental health conditions and alcohol related reasons for attending A&E. Enhance staff training to care for these patients including signposting to liaison mental health teams, aiming for 100% of staff in A&E to be trained.
- To enhance the timeliness and quality of assessment of complex, frail and/or confused patients and to ensure that their ongoing care is in an appropriate setting.
- Achieve a sustainable electronic method of sharing key discharge information, such as care plans, by continuing to develop our electronic discharge system.
- To further develop our ambulatory pathways and our ability to 'signpost' clinicians and patients along those pathways.

### Monitoring and reporting

- Joint performance monitoring via the System Resilience Group.
- Regular reports to the Clinical Governance Committee and from there to the Quality Committee.
- Achievement of four hour ED standard at monthly contract review meeting with commissioners.

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<tbody>
<tr>
<td>Improve the way we diagnose and support patients with mental health and alcohol related conditions.</td>
<td>100% of A&amp;E clinical staff to receive guidance during induction and to know how to access relevant resources.</td>
<td>We will measure this by collecting induction and meeting minutes, email communiques, review meeting with A&amp;E psychiatric service and by collecting patient experience feedback.</td>
<td>Presentations to meetings, both regular and at induction. Email communication. Providing our staff with web-based information. Review of current process with A&amp;E psychiatric service. Development of patient experience feedback system for these patients.</td>
</tr>
</tbody>
</table>

* ED is the emergency department, commonly known as A&E. The standard is that 95% of patients attending ED will be seen, treated, admitted or discharged in under four hours.
PATIENT SAFETY

Priority 3: Improved recognition, prevention and management of patients with acute kidney injury (AKI)

Why we chose this
AKI is a sudden deterioration in kidney function previously known as acute renal / kidney failure. It is not an actual physical injury and usually occurs without symptoms. Patients with other illnesses or chronic conditions such as diabetes, and elderly patients, are vulnerable to AKI. It enhances the severity of other conditions, increasing the length of time spent in hospital and also the risk of death. This priority has been chosen to improve care proactively, and save lives.

NHS England has selected AKI as a national quality improvement project. It is also a project within the Patient Safety Collaborative launched by the Oxford Academic Health Science Network in October 2014.

Our aims
- Measure the percentage of emergency patients with a major risk factor for AKI who have:
  - a medication review
  - kidney blood tests re-checked within 24 hours of admission.
- OUH care bundle implemented; key to this are physiological scoring on admission and senior clinical review within 12 hours of admission.
- Embed the AKI algorithm within the Trust.
- Have an internal alert system from laboratories linked to EPR so that kidney blood test results are immediately visible to the treating doctor.
- Have an electronic system to alert community care providers that a diagnosis of AKI is suspected by kidney blood test results.
- Include key information on discharge correspondence to help the GP with onward management.
- Have an AKI team comprising a dedicated nurse and medical backup. This structure would provide leadership and deliver training.
- Develop a pharmacy role to carry out medication reviews, helping with AKI prevention.

Monitoring and reporting
- Regular reports to the Clinical Governance Committee and from there to the Quality Committee.
- Goals will be agreed within Academic Health Science Network. Deaths from AKI will be examined at the Clinical Effectiveness Committee.

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<tbody>
<tr>
<td>Ensure emergency admissions are screened for AKI.</td>
<td>All emergency admissions are given: • a medication review • kidney blood tests re-checked within 24 hours of admission.</td>
<td>We will measure this by auditing notes of patients admitted in an emergency.</td>
<td>Establish an AKI team. Implement the AKI care bundle and algorithm Development of a pharmacy role to carry our medication reviews. Roll out the EPR alert system.</td>
</tr>
</tbody>
</table>
Priority 4: Learning from deaths and harms to improve patient care

Why we chose this

We consider that the deaths of all patients in our hospitals should be reviewed to ensure that any omissions or actions taken are identified and learnt from to improve care.

A spot-check of compliance with our mortality review process in our hospitals showed that more work was needed to fully embed this into practice. This is our commitment for the coming year.

Our aims

• Achieve a year-on-year reduction in mortality by:
  • raising the profile of the mortality review process across the Trust
  • maximising learning from deaths by ensuring a standard approach is taken
  • improving the way we share lessons learnt from mortality reviews and mortality and morbidity meetings across the Trust
  • improve how we collate internally generated information on our mortality rates, mortality review and learning points by creating a core Trust mortality database.

Monitoring and reporting

• Quarterly mortality reports provided by the Divisions to the Clinical Effectiveness Committee and from there to the Quality Committee.
• Clinical Effectiveness Committee will ensure there is feedback of good practice, learning, actions or concerns identified to governance leads, for them to inform the departments impacted.

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<tbody>
<tr>
<td>Systematic process of reviewing deaths in place across the Trust so we can improve care and achieve a year on year reduction in avoidable deaths.</td>
<td>100% deaths reviewed in line with our mortality review process.</td>
<td>We will carry out compliance audits of our mortality review process in each Division.</td>
<td>We are raising the profile of mortality reviews by implementing a new mortality reduction strategy and by carrying out a review of our mortality review process. Lessons learned from our mortality reviews will be fed back into our proactive strategies to save lives such as our work on AKI and sepsis.</td>
</tr>
</tbody>
</table>
Why we chose this
Sepsis is a common and potentially life-threatening condition whereby severe infection triggers widespread inflammation, swelling and organ failure. In the UK it is estimated that around 35,000 deaths are caused by sepsis each year. Some of these deaths may be prevented by introduction of a sepsis bundle to ensure rapid treatment in the first hours of admission.

In September 2014 the NPSA issued a National Patient Safety Alert to support the prompt recognition of sepsis and the rapid initiation of treatment. All trusts are required to comply with this notice. NHS England has also selected sepsis for national quality improvement work.

Our aims
- Implement a sepsis care bundle to ensure prompt recognition and treatment of sepsis.
- Provide an oversight structure to provide senior leadership and supervision.

Monitoring and reporting
- A Sepsis Quality Group is being set up which will lead the work and provide regular reports to the Clinical Governance Committee and from there to the Quality Committee.
- Deaths from sepsis will be examined at the Clinical Effectiveness Committee.

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<tr>
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<tbody>
<tr>
<td>Ensure prompt recognition and treatment of sepsis.</td>
<td>Standardised sepsis care screening tool to be used in emergency admission areas.</td>
<td>We will audit the notes of patients with sepsis.</td>
<td>We will agree a standardised screening tool and care bundle based on sepsis six. We will provide training for staff in emergency admission areas.</td>
</tr>
<tr>
<td>Rapid administration of IV antibiotics to patients with sepsis.</td>
<td>Patients presenting to emergency admission areas with severe sepsis or septic shock to receive IV antibiotics within one hour of presenting.</td>
<td>We will audit the notes of patients with sepsis.</td>
<td>We will implement our screening tool and care bundle. This will be reinforced through staff training.</td>
</tr>
</tbody>
</table>

NOTES:
PATIENT EXPERIENCE

Priority 6: End of life: improving people’s care in the last few days and hours of life

Why we chose this
The end of life and the time leading up to it are profound and often traumatic experiences, when patients and their families are at their most vulnerable. Our care of families at the start of their bereavement is an important extension of our care for our patients.

During 2014 we phased out the Liverpool Care Pathway in accordance with the recommendations of the national Review Panel. In June 2014 the Government published ‘One Chance to Get it Right’. This document describes the high-level outcomes that must be delivered for every dying person.

Although our end of life care was rated as good by the CQC, the National Care of the Dying Audit for Hospitals Report revealed that we could do better.

Our aims
- Provide compassionate, consistent and reliable care to patients coming to the end of their lives, and to families after the death of their relative, in all areas of the Trust and on all shifts.
- Develop a new end of life (EOL) care strategy aligned with the latest guidance ‘One Chance to Get it Right’. Phase one of the strategy will focus on end of life care at the John Radcliffe Hospital in 2015.
- Continue to examine our practice by repeating the National Care of the Dying Audit in 2015.
- Help our staff deliver care by focusing on staff education.
- Enhance how we work with our community colleagues by providing expert palliative care advice and by receiving feedback to allow us to adjust our service where possible.
- Learn from good practice around the country by hosting an EOL care symposium in 2015/16.

Monitoring and reporting
An End of Life Care Group will oversee the work plan. Regular reports on strategy and implementation plan to the Quality Committee. Regular Divisional Quality Reports to the Clinical Governance Committee will contain progress on implementing the strategy, staff training and patient feedback.

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<tr>
<td>Education and training programme in place for all staff caring for dying patients. This will include communication skills training, and skills for supporting families and those close to dying patients. (This is a recommendation from National Care of the Dying Audit for Hospitals Report)</td>
<td>At least 75% of clinical staff to have completed core modules by 31 March 2016.</td>
<td>Review of training records.</td>
<td>An educational programme comprising eLearning modules will be available on the Trust learning and development intranet site. The educational programme will be supported by the EOL strategy containing guidelines, and EOL champions to drive forward improvements in attitudes and care.</td>
</tr>
</tbody>
</table>

NOTES:
16. See Royal College of Physicians www.rcplondon.ac.uk/sites/default/files/ncdah_national_report.pdf
PATIENT EXPERIENCE

Priority 7: Improving communication, feedback, engagement and complaints management: with patients, carers, healthcare staff and social care providers

Why we chose this

Communicating and engaging
Over the last year we have worked hard to increase how we engage with our service users. Whilst our Friends and Family Test (FFT) results show the majority of patients would recommend our hospital to friends and family, feedback from patients, carers and external partner agencies has shown there is more we need to do.

Key areas of focus are:

• acting on feedback from carers, particularly carers for people with dementia
• privacy and dignity, particularly for patients who are vulnerable
• communication in easy to understand ‘plain English’
• how we manage complaints
• acting on feedback from GPs with patients in our care.

Continue to improve care for people with cognitive impairment
We have made progress over the past year. We have trained over 6,800 of our staff to provide better care for people with dementia and we have recruited dementia champions. We have a new dementia strategy and regularly run a ‘Dementia Café’ at the JR. However we have not met the national target of assessing elderly patients for the risk of dementia. There is also still more to do to meet the Prime Minister’s five year vision17 for the future of dementia care.

Duty of candour
A new statutory regulation on the duty of candour came into effect in November 2014 and sets out healthcare providers’ responsibilities to be open and transparent with people in relation to care and treatment. This complements the existing professional duty of candour for healthcare professionals such as doctors and nurses via the General Medical Council (GMC) and Nursing and Midwifery Council (NMC). We already have a ‘Being Open’ policy which encourages staff to be open when adverse events happen. During 2015/16 we will review and further improve our systems and processes to imbue a culture that encourages candour, openness and honesty at all levels.

Improving the interface between the hospital and the GP for each episode of patient care
Although we have started work to improve our responsiveness to a number of issues raised by GPs during last year about the interface between GP and hospital, we recognise there are still substantial improvements that need to be made in the speed and reliability of:

• the sign-off of results, and communication of these to patients
• the sending of discharge summaries and letters
• accessibility by phone when doctors need to speak to colleagues in other organisations.

Our aims

• Improve the experience for carers when they come to our hospitals. We will improve how we collect their feedback and use this information to improve our care.
• Ensure our Trust-wide privacy and dignity policy fully respects the needs of vulnerable patients.
• Improve how we communicate with patients whose first language is not English or people who have visual or hearing impairments, or learning disabilities. This will include ensuring the letters we send are in easy to understand plain English, developing a new IT communication system for hearing impaired people and redeveloping our internet and intranet sites to publicise our interpreting services.
• Improve how we manage complaints and act on feedback, particularly how we change our services in response to this and how we train our staff.
• Meet the national targets of assessing 90% of patients 75 years and above who have been in hospital for 72 hours or more for dementia.

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- All our staff and clinical environments will be dementia-friendly and all our staff will receive dementia awareness training.
- Strong nursing leadership to drive improvements in our dementia care.
- Manage the emergency care pathway effectively to safeguard and improve the experience for patients with dementia.
- Participate in the AHSN Dementia Clinical Network dementia strategy.
- Support staff to be candid with patients and their families if something goes wrong, and help our staff to understand why things go wrong and how to put them right.
- High reliability in the generation and sending of discharge summaries and letters, and the sign-off of results.
- Streamlined and reliable arrangements in each specialty for contact with GPs to discuss patient issues.
- The Equality and Diversity Group will monitor how we involve patients to develop plain English information, and how we improve interpreting services.
- Dementia Steering Group will monitor AMTS dementia screening and how we implement the dementia strategy.
- Regular reports will be provided to the Clinical Governance Committee and Quality Committee and feedback provided to Healthwatch Oxfordshire.
- A Project Board is being organised jointly with the Oxfordshire Clinical Commissioning Group (OCCG) and GP providers to monitor our interface with GP colleagues.
- All our staff and clinical environments will be dementia-friendly and all our staff will receive dementia awareness training.
- Strong nursing leadership to drive improvements in our dementia care.
- Manage the emergency care pathway effectively to safeguard and improve the experience for patients with dementia.
- Participate in the AHSN Dementia Clinical Network dementia strategy.
- Support staff to be candid with patients and their families if something goes wrong, and help our staff to understand why things go wrong and how to put them right.
- High reliability in the generation and sending of discharge summaries and letters, and the sign-off of results.
- Streamlined and reliable arrangements in each specialty for contact with GPs to discuss patient issues.
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- Dementia Steering Group will monitor AMTS dementia screening and how we implement the dementia strategy.
- Regular reports will be provided to the Clinical Governance Committee and Quality Committee and feedback provided to Healthwatch Oxfordshire.
- A Project Board is being organised jointly with the Oxfordshire Clinical Commissioning Group (OCCG) and GP providers to monitor our interface with GP colleagues.

Monitoring and reporting; monthly project meetings and highlight reports

- Carers’ Project Group will monitor the development of the carers’ feedback strategy.
- Privacy and Dignity Steering Group will monitor progress developing the privacy and dignity policy.

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<tbody>
<tr>
<td>We will have a method of collecting feedback from carers for people with dementia that is easy to use and developed by carers themselves.</td>
<td>Feedback from carers will be reported to the Board and Quality Committee each month from July 2015.</td>
<td>We will measure this by linking feedback received against the content in Board reports.</td>
<td>The survey form will be co-produced by carers (Carers Oxfordshire), Carers Voice and will incorporate the national ‘John’s Campaign’. Carer volunteers will test and refine it. We will monitor how effective this process is at our Dementia Steering Group.</td>
</tr>
<tr>
<td>We will produce a privacy and dignity (P&amp;D) policy that respects the needs of vulnerable people.</td>
<td>First draft by September 2015. Final draft within 2015/16.</td>
<td>Ratified policy by 31 March 2016.</td>
<td>We will develop this policy in association with patient advocacy groups*, Healthwatch Oxfordshire and Foundation Trust members. Our P&amp;D steering group will monitor this process.</td>
</tr>
</tbody>
</table>

NOTES:
18. See www.oxfordahsn.org/our-work/clinical-networks/dementia
19. Abbreviated Mental Test Score (AMTS) helps to rapidly assess elderly people for the possibility of dementia.
20. Carers Voice Oxfordshire helps people to speak up about services and support provided for carers. For more information see www.carersvoiceoxfordshire.org
# PATIENT EXPERIENCE

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<tbody>
<tr>
<td>We will improve the way we manage complaints by having well-trained staff.</td>
<td>100% staff who investigate complaints trained by 31 March 2016.</td>
<td>We will measure this by checking training records.</td>
<td>New complaints management training will be provided to all staff investigating complaints including PALS and complaints department, matrons and clinical leads. This includes mediation and facilitation training for complaint resolution.</td>
</tr>
<tr>
<td>Our staff will be open with patients and families if something goes wrong in line with the ‘Being Open’ policy.</td>
<td>Roll out Datix monitoring of all aspects of duty of candour.</td>
<td>Datix system in place with compliance monitored via performance reviews.</td>
<td>We will amend Datix system to guide staff to carry out and document ‘Being Open’ and offering an apology to patients or relatives after any healthcare acquired moderate or severe harm in line with the legal and professional duty of candour. Our policy will be updated to reflect this.</td>
</tr>
<tr>
<td>We will improve how we communicate the signing off of test results with our GP colleagues.</td>
<td>95% of test results to be signed off within a week of the result being available.</td>
<td>We will measure this with data extracted from EPR.</td>
<td>The Medical Director and Divisional Directors have communicated this priority to all medical staff. It will be monitored via performance reviews and managed in the Divisions.</td>
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</tbody>
</table>

## Other areas of ongoing work
- Diabetes – continued implementation of our diabetes action plan, addressing issues raised in national audits, internal peer review and a risk summit held in 2014/15.
- Dementia – implementation of our dementia strategy, agreed by the Trust Board in November 2014, with a particular focus during 2015/16 on improving both the assessment of patients and the environment in which they are treated, as well as training for staff.
- Medicines management, including antibiotic prescribing.
- Seven day working – Care 24/7 is one of the projects in our Transformation programme. A baseline self-assessment on preparedness to meet the NHS England and NHS Improving Quality priorities for seven day working, supported by an in depth audit of 150 case notes, has demonstrated the progress that has been made.
- Continued development of psychological medicine services – the focus for 2015/6 will be cancer, women’s and children’s services.
Patient safety

Harm-free care

‘Harm-free care’ is defined by the absence of pressure ulcers, harm from a fall, urine infection (in patients with a catheter) and new venous thromboembolism (VTE) – blood clot. In line with national guidance, the Trust has continued to survey every adult inpatient on a given day every month, using the NHS Safety Thermometer to identify patients who receive ‘harm-free care’ in relation to four types of ‘harm’.

- Pressure ulcer
- Fall resulting in harm
- Catheter-associated urinary tract infection (CAUTI)
- New VTE

The Trust was set a challenging Safety Thermometer CQUIN of a 20% reduction in the number of ‘new’ pressure ulcers reported by the end of 2014/15. This was surpassed with an overall reduction of 36.3% achieved as seen in the graph. The establishment of the Trust tissue viability team (a team of nurses with specialist expertise in pressure ulcers) has enabled specialists to provide ward level support. This specialist team has also been able to focus on the education of clinical staff including competency frameworks for clinical support workers who deliver patient care, and for junior nurses, with further plans to expand to all clinicians who have contact with patients.

NOTES:
22. For more information see http://harmfreecare.org/measurement/nhs-safety-thermometer
We joined the NHS England ‘Sign Up to Safety’ campaign in the first quarter of 2015/16. The mission of the campaign is to strengthen patient safety in the NHS and make it the safest healthcare system in the world. By joining we have committed to delivering on five national pledges for improving safety.

1. **Put safety first.** Commit to reduce avoidable harm in the NHS by half and make public our goals and plans developed locally.

2. **Continually learn.** Make our organisation more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe our services are.

3. **Honesty.** Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.

4. **Collaborate.** Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.

5. **Support.** Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress.

We will publish details of what we are going to focus on within each of these pledges on our Trust website. We will develop an extensive safety improvement plan for the next three to five years, to help us be clear about what we want to achieve and when we want to achieve it by.

**Executive Walk Rounds**

57 Executive Walk Rounds (visits) took place in 2014/15. The Trust Board receives an update on how actions are progressing against agreed timescales. The programme of Executive Walk Rounds continues to offer an invaluable opportunity for Executive and Non-executive Directors to see and hear for themselves the challenges faced by staff, and also to learn of the success of various innovations and developments in practice.

**Incident reporting**

Trusts across England upload data relating to incidents reported locally to the National Reporting and Learning System (NRLS). The main purpose of the NRLS is to facilitate learning from patient safety incidents that occur in the NHS. The NRLS allows trusts to compare to similar organisations benchmarking incident reporting rates and the levels of harm associated with incidents. The NRLS publishes information every six months, covering six-month periods as official statistics for incident reporting across the NHS for England and Wales. The most recent information released by the NRLS was for the period from April to September 2014 (published in April 2015).

Different NHS organisations provide different services and, in order to make comparisons as meaningful as possible, the NRLS groups NHS organisations into ‘clusters’. In the most recent NRLS publication on patient safety incident reporting, the number and type of clusters has been reduced from nine to six. Previously OUH was part of the ‘acute teaching’ cluster of around 29 similar organisations. In this latest release, the Trust is now listed in the ‘acute (non-specialist)’ cluster of 140 organisations that provide acute NHS services in England.

The tables in this section show the number of patient safety incidents reported by the Trust during April to September 2014, and the number and percentage of these that resulted in severe harm or death compared to other NHS acute trusts.

Rates of incident reporting continue to increase, however the number of incidents that resulted in severe harm or death have declined. We actively encourage our staff to report clinical incidents so we can learn from mistakes to improve our care. Measures used by NHS England and others to indicate a positive ‘safety culture’ within an organisation include the rate of incident reporting (the higher the better) and the proportion with significant patient harm (the lower the better).

The Trust considers these data are as described for the reasons below.

- The Trust has a process in place for collating data on patient safety incidents (Datix).
- Incident reporting has increased following the implementation of Datix in 2012.
- Data are collated internally and then submitted on a monthly basis to the NRLS.
- Data are compared to peers, highest and lowest performers, and our own previous performance.

The table overleaf details the total numbers of incidents reported to the NRLS for the last two complete financial years. This is presented alongside the most recent figures for the six months from April to September 2014. The official release of incident information for October 2014 to March 2015 is not due to be published until September 2015. A national comparison for April to September 2014 is also provided, showing the highest, lowest and average figures for all 140 ‘acute (non-specialist)’ organisations.
Review of patient safety incidents by Ernst and Young (External Auditors)

The Trust recorded 25 incidents as catastrophic, major etc. in accordance with the correct application of the patient safety criteria and initiated investigations (see table below). These investigations subsequently concluded that in 14 of the 25 incidents the result could be downgraded to a lower level and this was agreed with Oxfordshire CCG. The Trust has investigated the incidents and applied the relevant learning from these in ensuring clinical practice supports optimal patient care. The level of the incident was not retrospectively downgraded by the Trust on the national reporting system.

The Trust has published, in accordance with national requirements, the national results for the first six months of the year which overstate the percentage of such cases. Therefore, the unaudited figure, based on the national results for the first six months of the year, was a rate of 0.3% and the revised, audited figure was a rate of 0.1%.

Following this review we will re-examine our administrative processes to ensure data resubmissions to NRLS include all incidents downgraded following investigation.

### Rate of incidents per 1,000 bed days for OUH.

<table>
<thead>
<tr>
<th>Source: NRLS</th>
<th>Oxford University Hospitals NHS Trust</th>
<th>National comparison for ‘acute (non-specialist) organisations’ Apr-14 to Sep-14 only</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Oct-13 to Mar-14</td>
<td>Apr-14 to Sep-14</td>
</tr>
<tr>
<td>Number of patient safety incidents</td>
<td>36.4</td>
<td>39.4</td>
</tr>
</tbody>
</table>

The table above shows the rates of incidents per 1,000 bed days for the current reporting period (April to September 2014). The NRLS has provided the re-calculated rates for the previous reporting period (October 2013 to March 2014) for comparison. The highest, lowest and average rates are also shown for the current reporting period.

### Patient safety incidents from March 2013 up to and including April 2015.

<table>
<thead>
<tr>
<th>Source: NRLS</th>
<th>Oxford University Hospitals NHS Trust</th>
<th>National comparison for ‘acute (non-specialist) organisations’ Apr-14 to Sep-14 only</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Apr-12 to Mar-13</td>
<td>Apr-13 to Mar-14</td>
</tr>
<tr>
<td>Number of patient safety incidents</td>
<td>8,495</td>
<td>14,875</td>
</tr>
<tr>
<td>Number of patient safety incidents that resulted in severe harm or death</td>
<td>63</td>
<td>46</td>
</tr>
<tr>
<td>Percentage of patient safety incidents that resulted in severe harm or death</td>
<td>0.7%</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

NOTES:

23. The highest percentage for a single provider within the “Acute (non-specialist)” cluster was 82.9% for the six months April to September in 2014 – the next highest is reported in the table above as a more representative comparison of the Trusts within the Acute (non-specialist) cluster.

*now known to be 0.1%
The Trust intends to take the following actions to improve this score and so the quality of its services.

- Sustaining a programme of incident awareness including risk assessment training. This is provided on a monthly basis and is mandatory training for staff of senior clinical practitioner, senior manager grades and the Board. In the last financial year 63 members of staff have been trained.
- Include incident reporting at the corporate Trust induction programme.
- Include lessons learnt from clinical incidents into each ‘Quality Matters’ newsletter for staff.

**Serious Incidents Requiring Investigation (SIRI)**

A SRI is any incident that could have or did lead to serious harm, major permanent harm or unexpected death, or serious damage to or loss of property, and with the potential to generate significant legal, media or other interest, or to seriously compromise the reputation, or integrity of the Trust. SIRIs include major and catastrophic incidents and Never Events. During 2014/15 we agreed with our commissioners to report, within two days, any event that met the criteria for a SRI as per NHS Serious Incident Requiring Investigation Guidance. We also agreed a step by step process to help downgrade any incident from the SRI status, if appropriate, once full information became known. This primarily relates to the level of avoidable harm caused that is ‘unavoidable’ or actual harm of moderate and below.

During 2014/15 we reported 76 SIRIs and the categories of these are shown in the following table.

<table>
<thead>
<tr>
<th>NATURE OF INCIDENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delayed diagnosis*</td>
</tr>
<tr>
<td>Hospital acquired pressure ulcers (HAPU)</td>
</tr>
<tr>
<td>Breach of confidentiality</td>
</tr>
<tr>
<td>Patient falls resulting in injury</td>
</tr>
<tr>
<td>Death following a hospital acquired VTE</td>
</tr>
<tr>
<td>Unexpected death following transfer</td>
</tr>
<tr>
<td>Wrong site surgery</td>
</tr>
<tr>
<td>Items retained in the body during a procedure</td>
</tr>
<tr>
<td>Misplaced nasogastric tube</td>
</tr>
</tbody>
</table>

*Concerns were raised during the last financial year regarding the discovery of a backlog of ‘unread’ test results i.e. X-rays and scans, relating to 13,000 unreported and 27,000 unverified examinations on Composite Radiology Information System (CRIS)24 since 2005. The Trust has initiated a thorough investigation into how this occurred and to identify all patients whose diagnosis was delayed.

The following actions are in progress.

- Bespoke incident awareness including risk assessment training for radiographers delivered.
- Learning from Never Events cascaded through Divisional and local governance structures and the Quality Matters newsletter for staff.
- Weekly review of these reports at the radiology performance meetings and documentation of any actions.
- Senior radiographer managers have carried out spot audits into completed reviews undertaken during this process.
- Report compiled of all the unreported and unverified examinations. (The progress reviewing these examinations is being tracked to assist compiling of the report.)
- Oxfordshire Clinical Commissioning Group (OCCG) informed of the above undertaking.
- Standard operating procedure (SOP) devised on how to undertake the initial screening by senior radiographers and how to get reports signed off by a radiologist.
- Central log per site established for the reporting of these examinations.
- Process established for communication of results, depending upon the review findings and clinical impact.
- Reporting in place via our Datix incident system of any cases which may have led to patient harm, so that further in-depth investigation can be carried out.
- All inpatients have been informed about these delays in line with the ‘duty of candour’.

**Learning from Never Events**

A Never Event is described as a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers. There are 14 types of incidents categorised as such by the NHS England25.

Incidents are considered to be Never Events if:

- there is evidence that the Never Event has occurred in the past and is a known source of risk
- there are existing national guidance or safety recommendations, which, if followed, would have prevented this type of incident from occurring
- occurrence of the Never Event can be easily identified, defined and measured on an ongoing basis.

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NOTES:

24. CRIS is utilised every day within the majority of radiology departments in the UK, driving workflow and radiology business management as part of the hospital IT infrastructure. www.england.nhs.uk/wp-content/uploads/2015/04/never-events-pol-framwrk-apr.pdf

In 2014/15 we reported seven incidents that met these criteria during this financial year.
1. Retained foreign object: guidewire during a heart procedure (this occurred late in 2013 but was reported to the Trust in April 2014)
2. Misplaced nasogastric (NG) tube
3. Wrong site surgery: wrong tooth removal
4. Wrong site surgery: wrong tooth removal
5. Retained foreign object: guidewire from an IV procedure
6. Retained foreign object: swab from surgery
7. Wrong site surgery: wrong spinal disc

Never Events are scrutinised in detail by the Trust and by our commissioners. An investigation team is assembled, staff interviewed, evidence gathered so the root causes can be effectively identified and changes to practice put in place. We put together action plans and the key learning from these incidents. These action plans are discussed fully with our commissioners and progress achieving each action is monitored extremely closely at our Patient Safety and Clinical Risk Committee.

Key actions highlighted from Never Events at the Trust include the following.
• Competency assessment for the insertion and management of NG tubes by nursing staff.
• Human factors training for those involved in the incident. (This training focuses on the interaction of people and technical systems focusing on communication and situational awareness).
• Development and implementation of a SOP for identifying the correct tooth prior to dental extractions. This includes a pause in the procedure for verbal confirmation of the tooth for extraction.
• Development and implementation of a standard process and documentation for inserting IV long lines, including confirmation that all guide wires have been accounted for and inspected by a second person.
• Refinement of the competency assessment framework for IV long line insertions with a guidewire and a review of current practice. Ensure the revised framework meets best practice guidance.
• Requirement to undertake a minimum number of supervised IV long line insertions (with a guidewire). This is considered good practice and could be extended to the medical team.
• Inclusion in ‘The counting of swabs, instruments, needles and miscellaneous items for surgical procedures (including childbirth) policy’ instruction on counting guidewires both inside and outside of an operating theatre.

**Duty of candour**
Medical treatment and care is not risk-free. Errors will happen and nearly all of these will be due to failures in organisational systems or genuine human errors. A duty of candour on organisations registered with the CQC, means that they must ensure that patients, and, where appropriate, their families, are told in an open and honest way when unexpected errors happen which cause a patient harm above a set threshold. Our Trust-wide ‘Being Open’ policy is used as a standard part of our incident investigation process. The duty of candour now formalises this in legislation.

Duty of candour has also been part of professional guidance for many regulated groups and their licensing body for some time. To give clarity a joint statement was released on 13 October 2014 by General Medical Council, Nursing and Midwifery Council, General Chiropractic Council, General Dental Council, General Optical Council, General Osteopathic Council, General Pharmaceutical Council, and Pharmaceutical Society Northern Ireland.

**Safeguarding**
The Trust is committed to building partnerships, knowledge and skills that support robust child and adult safeguarding across the Trust and Oxfordshire and to build learning disability support within the Trust.

Over the previous 18 months we appointed children’s and adults’ safeguarding leads across the Trust to increase education and training capacity.

We provide three levels of safeguarding training. Level 1 is mandatory and this covers child sexual exploitation, female genital mutilation, modern slavery and human trafficking.

The Trust has participated in system-wide responses to safeguarding investigations such as child sexual exploitation, and has been a committed partner to the Children’s Multi Agency Safeguarding Hub (MASH). This has been in operation since September 2014.

The Trust has implemented the electronic Tracking and Flagging system to proactively alert staff when a patient has learning disabilities. This has been implemented to better provide reasonable adjustments and is a response to ‘Healthcare for all’ published in 2008.

NOTES:
26. This is a wire that guides a special tube (catheter) into the body. The catheter is used to guide a tube into the correct position and / or administer medicines and fluids. The guidewire should be removed after the catheter has been successfully put in place.
CLINICAL EFFECTIVENESS (OUTCOMES)

Preventing people from dying prematurely

Summary Hospital Mortality Indicator (SHMI)

The SHMI is the preferred hospital mortality indicator adopted by NHS England. The SHMI is the ratio between the reported number of patient deaths, during admission or within 30 days of their discharge, against the expected number of deaths based upon the characteristics of the patients treated. A SHMI value of less than 1.00 indicates that a trust is performing better than the national average. The SHMI is published quarterly by the Health and Social Care Information Centre (HSCIC) and each publication covers a 12 month rolling reporting period.

The latest SHMI, published on 29 April 2015 (for the reporting period October 2013 to September 2014), was 1.00. This value is banded ‘as expected’ using the HSCIC 95% confidence intervals adjusted for over-dispersion.

The Trust considers these data as described for the reasons below.

- The Trust has a process in place for collating data on hospital admissions, from which the SHMI is derived.
- Data are collated internally and then submitted on a monthly basis to the HSCIC via the Secondary Uses Service (SUS). The SHMI is then calculated by HSCIC.
- Data are compared to peers, highest and lowest performers, and our own previous performance, as set out in the table overleaf.
- The Trust reviews the SHMI in conjunction with other published mortality measures and the information from our internal review of deaths.

The graph opposite displays our SHMI in comparison to other trusts in England (for the data period October 2013 to September 2014).

The following table shows the SHMI compared to the trusts with the highest and lowest values for two reporting periods.

<table>
<thead>
<tr>
<th>Source: HSCIC</th>
<th>October 2013 to September 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>SHMI value</td>
<td>National average</td>
</tr>
<tr>
<td>OUH (Apr-12 to Mar-13)</td>
<td>0.95 (95% CI: 0.89-1.12)</td>
</tr>
<tr>
<td>OUH (Apr-13 to Mar-14)</td>
<td>0.99 (95% CI: 0.90-1.11)</td>
</tr>
<tr>
<td>OUH (Oct-13 to Sep-14)</td>
<td>1.00 (95% CI: 0.90-1.11)</td>
</tr>
</tbody>
</table>

SHMI banding

- 2 - ‘As expected’
- 2 - ‘As expected’
- 2 - ‘As expected’
CLINICAL EFFECTIVENESS (OUTCOMES)

The graph below shows the SHMI for deaths that occur in and out of hospital within 30 days of admission. It presents the latest reported SHMI (green) compared to last year’s publication (purple), and alongside the equivalent reporting period in 2012/13 (blue).

The Trust intends to take a range of actions to improve this rate, and so the quality of its services, by identifying mortality reduction in our Quality Priorities for 2015/16 including ‘learning from deaths and harms to improve patient care’ (see p.30), and adopting standard care bundles for sepsis and for acute kidney injury.

**Palliative care coding**

The HSCIC publishes information on palliative care coding as a contextual indicator to support the interpretation of the SHMI. The palliative care coding information collated nationally by the HSCIC relates to the numbers of patients assigned the palliative (end of life) care coding at treatment specialty or diagnosis level while in hospital.

The graph overleaf displays our rate of palliative care coding in comparison to other trusts in England (percentage of finished provider spells with palliative care coding at treatment specialty or diagnosis level for the data period October 2013 to September 2014).
CLINICAL EFFECTIVENESS (OUTCOMES)

The table below shows the percentage of deaths with palliative care coding compared to the Trust with the highest and lowest values for two reporting periods.

<table>
<thead>
<tr>
<th>Source: HSCIC</th>
<th>October 2013 to September 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>National average</td>
</tr>
<tr>
<td>Combined % of patient deaths with palliative care coded for the Trust</td>
<td></td>
</tr>
<tr>
<td>OUH (Apr-12 to Mar-13)</td>
<td>25.9</td>
</tr>
<tr>
<td>OUH (Apr-13 to Mar-14)</td>
<td>31.1</td>
</tr>
<tr>
<td>OUH (Oct-13 to Sep-14)</td>
<td>31.7</td>
</tr>
</tbody>
</table>

The graph below provides a comparison of the palliative care coding for the latest publication (green) with last year’s publication (purple) and the equivalent reporting period in 2012/13 (blue). It shows a small increase in deaths with palliative care coded by speciality and / or diagnosis.
CLINICAL EFFECTIVENESS (OUTCOMES)

Recovering from ill health and injury

Patient Reported Outcome Measures (PROMs)

Patient Reported Outcome Measures (PROMs) are used to ascertain the outcome following planned inpatient surgery for any of four common procedures (hip and knee replacement, varicose vein surgery and groin hernia surgery). Patients are asked to complete a questionnaire before and after their surgery to self-assess improvements in health from the treatment, rather than using scoring systems or judgements made by the treating clinicians.

The tables in this section show the improvement in health (adjusted health gain) perceived by patients following these four procedures. Comparisons are shown with all health providers who carry out the same procedures in England. The latest data available from the HSCIC are for the previous financial year 2013/14. Data for the financial year 2014/15 will be available in August 2015 and will be published in our 2015/16 Quality Account.
CLINICAL EFFECTIVENESS (OUTCOMES)

Primary (first) knee replacement

<table>
<thead>
<tr>
<th>Knee Replacement</th>
<th>EQ-5D index casemix adjusted health gain</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adjusted average health gain</td>
</tr>
<tr>
<td></td>
<td>2010/11</td>
</tr>
<tr>
<td>OUH</td>
<td>0.307</td>
</tr>
<tr>
<td>2013/14 average</td>
<td>0.323</td>
</tr>
<tr>
<td>Lowest 2013/14</td>
<td>0.215</td>
</tr>
<tr>
<td>Highest 2013/14</td>
<td>0.416</td>
</tr>
</tbody>
</table>

Varicose veins

<table>
<thead>
<tr>
<th>Varicose Vein</th>
<th>EQ-5D index casemix adjusted health gain</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adjusted average health gain</td>
</tr>
<tr>
<td></td>
<td>2010/11</td>
</tr>
<tr>
<td>OUH</td>
<td>0.093</td>
</tr>
<tr>
<td>2013/14 average</td>
<td>0.023</td>
</tr>
<tr>
<td>Lowest 2013/14</td>
<td>0.023</td>
</tr>
<tr>
<td>Highest 2013/14</td>
<td>0.15</td>
</tr>
</tbody>
</table>

Varicose Veins

Patients who benefit most from venous surgery are those who have painful symptomatic varicose veins which are removed at operation. Currently funding to have these procedures is decided by the OCCG on a case by case basis. The majority of patients have ulceration or skin changes, and those with ulcers, may not see an immediate benefit in terms of ulcer healing, which can be a prolonged process.

The Trust considers that the PROMs data are correct for the following reasons.

- The Trust has a process in place for collating data on patient reported outcomes.
- Data are then sent to the approved external company on a monthly basis which collates and calculates PROMs scores and sends it on to the HSCIC.
- Data are compared to peers, highest and lowest performers, and our own previous performance, as set out in the tables in this section.
- The HSCIC advice is that these results are provisional and subject to change until the publication of finalised data expected to be on 13 August 2015.

The Trust intends to take the following actions to improve these scores and so the quality of its services.

- A PROMs Officer appointed by the orthopaedic directorate to improve the completion rates for the pre-operative PROMs questionnaires.
- Detailed review of data by orthopaedic directorate followed by presentation of results and improvement actions within their internal clinical governance structures.
- Orthopaedic teams provided with individual patient reported data to improve individual team responsibility for patient outcomes as measured by PROMs for hip and knee replacement.
- For groin hernias the service will begin a review of cases for patients who do not report an improvement in health to better understand the reasons for this. This information will now be examined on a quarterly basis.
Emergency readmissions within 28 days of discharge from hospital

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

We routinely monitor emergency readmissions as one of the indicators of the efficacy of the provision of care and treatment. In some cases, readmissions may be inevitable and appropriate. The complete circumvention of emergency readmissions would likely be reflected by patients staying longer in hospital and may also lead to an inappropriate degree of risk aversion. As part of our discharge support, patients are encouraged to seek advice directly if they are experiencing symptoms of ill health following a treatment or procedure. Patients can contact the relevant clinical area by telephone but patients may also choose to return to hospital. There are emergency departments at the John Radcliffe and Horton General hospitals but patients known to our services may also be admitted directly to the Churchill.

Data from the HSCIC are not currently available beyond 2012 so we have provided comparable data from Dr Foster. The graphs in this section show our readmission rates measures by Dr Foster for October 2013 to September 2014 compared to other similar trusts in England. (Readmission rates from the HSCIC are contained within appendix 1).

Dr Foster data

Readmission rates published by Dr Foster are available until September 2014 and show readmission rates as a percentage of total admissions for patients 15 years and over as being slightly higher for April to September 2014 than for the same period for the previous year, excluding August 2014 which is lower by 0.5%. Readmission rates as a percentage of total admissions for patients 0-14 years has also increased slightly for April to September 2014, compared to the same period for the previous year, except for August 2014 which is lower by 0.7%.

Dr Foster analyses all hospital data and categorises a readmission as ‘any readmission within 28 days to any specialty’. They do not differentiate between a readmission due to a) a complication or a deficiency in care provided or b) a completely separate admission for another issue. For example a fracture sustained by falling off a bike within 28 days of having a tonsillectomy is categorised as a readmission following the removal of tonsils. This is not linked to the original spell in hospital, whereas an admission for an inflamed wound is potentially a complication following an admission to remove an appendix.
A red alert is triggered when the readmission rate for a particular procedure or clinical condition is over that determined as average. These data are extremely useful as an early warning system and we investigate each alert thoroughly to identify if the readmission is directly linked to the previous spell in hospital, so we can rectify any deficiencies in the care and treatment we provide.

The Trust considers these data are as described for the following reasons.

- The Trust has a process in place for collating data on hospital admissions, from which the readmissions indicator is derived.
- Data are collated internally and then submitted on a monthly basis to the HSCIC via the Secondary Uses Service (SUS). This data is then used to calculate readmission rates.
- HSCIC develops the SUS data into hospital episode statistics (HES).
- Dr Foster takes an extract from HES data to provide benchmarked clinical outcome data.
- Data are compared to peers, highest and lowest performers, and our own previous performance.

The Trust has taken the following actions to improve our readmission rate and so the quality of our services.

- We have a Clinical Effectiveness Committee that monitors readmissions on a monthly basis and identifies any areas of concern.
- Individual specialties investigate the underlying cause of any alert noted on the Dr Foster system. Reports and improvement plans are submitted and monitored by the Clinical Effectiveness Committee. Some of our recent alerts were found to be planned admissions, for instance a) patients returning for chemotherapy and b) potential transplant patients admitted to determine accurate matching when an organ becomes available (as per Trust protocol).
- Ongoing work is in place to improve patient information booklets explaining what to expect on discharge.

Healthcare Acquired Infections

*Clostridium difficile*

The rate of *Clostridium difficile* (C.Difficile or C.diff) per 100,000 bed days for 2014/15 was 13.8. The table below shows how the Trust is performing alongside other trusts in the Thames Valley. These data has been supplied by Public Health England (PHE).

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>C.diff rate per 100,000 bed days</td>
<td>C.diff rate per 100,000 bed days</td>
<td>C.diff rate per 100,000 bed days</td>
<td>C.diff rate per 100,000 bed days</td>
<td></td>
</tr>
<tr>
<td>OUH</td>
<td>24.5</td>
<td>23.2</td>
<td>13.9</td>
<td>13.8</td>
<td></td>
</tr>
<tr>
<td>National England</td>
<td>22.2</td>
<td>17.4</td>
<td>14.7</td>
<td>12.02</td>
<td></td>
</tr>
<tr>
<td>Lowest (Thames Valley)</td>
<td>24.5</td>
<td>12.4</td>
<td>13.9</td>
<td>10.97</td>
<td></td>
</tr>
<tr>
<td>Highest (Thames Valley)</td>
<td>51.2</td>
<td>23.2</td>
<td>18.1</td>
<td>15.14</td>
<td></td>
</tr>
</tbody>
</table>

Data from the HSCIC showing how the Trust compares to other trusts in England is not available for the current reporting period 2014/15. The table opposite contains data up to 2013/14.

The maximum number of cases of C.Difficile for the Trust in 2014/15 was set at 67 and the actual recorded was 61. All cases of C.Difficile are scrutinised at the monthly Health Economy meetings. Two of our cases were categorised as ‘avoidable’ but these were due to the patient having a past history of C.Difficile which affected the sample for testing rather than reflecting deficiencies in the care provided.

The Trust considers that the C.Difficile data are correct for the following reasons.

- The Trust has a process in place for collecting data on C.Difficile cases.
- Data are collected internally and submitted on a daily basis to Public Health England.
- Data are compared to peers (highest and lowest performers).
The Trust will continue to maintain the actions below striving to improve this rate and so the quality of its services.

- Rapid detection of cases.
- Rapid isolation and treatment of cases.
- Tight management of antibiotics and prescribing (antibiotic stewardship).

**MRSA bacteraemia**

We have had seven cases of MRSA bacteraemia, three of which were classed as ‘avoidable’ during this financial year (October, December 2014, January 2015). Each positive bacteraemia result has a ‘root cause analysis’ (RCA) completed. An RCA attempts to identify problems and the root causes of events to target improvement.

Key actions taken as a result of these are listed below.

- Increased focus during training days on the Trust guidelines for peripheral and central (IV) line insertion. This includes how to ensure equipment remains sterile during the procedure, correct hand decontamination and documentation of the condition of the site where the IV line punctures the skin.
- Reinforcing of Trust guidelines to clinical staff on the use of preventive antibiotics and when to contact specialists in infection for advice. For example when a patient is admitted for a procedure but has a co-existing condition (such as leg ulcers) that might make the patient more susceptible to developing an infection such as MRSA.

- Review of the way preventive antibiotics are selected and prescribed.
- Reinforcing to clinical staff the correct methods for preparing the skin before IV lines are inserted.
- Reinforcing to clinical staff the requirement to document a decision to keep an IV line in-situ for more than 72 hours.
- Reviewing skin preparation used in interventional radiology in order to align fully with Trust guidelines.
- Reviewing of individual cases.

**Rates of surgical site infections**

The mediastinitis rate following cardiac surgery remains less than 1%. This is a considerable achievement and is comparable to the leading cardiac surgical units in the UK and the United States. Our rates of surgical site infection following primary total hip replacement and primary total knee replacement are also less than the limit set by our commissioners.

### CLINICAL EFFECTIVENESS (OUTCOMES)

<table>
<thead>
<tr>
<th>SSI Type</th>
<th>Percentage SSI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mediastinitis</td>
<td>0.24%</td>
</tr>
<tr>
<td>Hip replacement</td>
<td>0.55%</td>
</tr>
<tr>
<td>Knee replacement</td>
<td>0.77%</td>
</tr>
</tbody>
</table>

*percentage SSI = number of surgical site infections / total number of procedures x 100 (October to December 2014)*

**NOTES:**

27. Mediastinitis is inflammation of the tissues in the mid-chest, or mediastinum. It can be either acute or chronic. As the infection can progress rapidly, this is considered a serious condition. An organ / space surgical site infection involves any part of the anatomy in organs and spaces other than the incision, which were opened or manipulated during the operation.
**CLINICAL EFFECTIVENESS (OUTCOMES)**

**Venous thromboembolism (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. It is a preventable cause of morbidity and mortality and VTE risk assessment and appropriate preventive measures (thromboprophylaxis) has been a national health priority since 2010. Guidance from the National Institute for Clinical Excellence (NICE) states that at least 95% of all adult inpatients should be VTE risk assessed (weighing their risk of developing a clot against their risk of bleeding) and given appropriate preventative therapy. A recent publication evaluating the benefit of appropriate thromboprophylaxis in the UK has reported that the death rate from pulmonary embolism has fallen by between 8-9% (Catterick & Hunt, 2014).

The graph opposite contains local OUH data and shows the improvement in the VTE risk assessment figures following the implementation of improvement measures over this financial year. The VTE risk assessment figures rose above 95% in December 2014 and have remained above 95% the rest of the financial year. The reduction at the start of 2014/15 from the 2013/14 levels was due to a change to a new method of recording assessments which took some time for staff fully to adjust to.

**VTE risk assessments performed**

<table>
<thead>
<tr>
<th>% of admitted patients risk assessed for VTE, comparison between OUH and national (NHS acute trusts) three year trend</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NHS acute trusts</strong></td>
</tr>
<tr>
<td><strong>OUH</strong></td>
</tr>
<tr>
<td><strong>National average (NHS acute trusts only)</strong></td>
</tr>
<tr>
<td><strong>Lowest performing NHS acute trusts</strong></td>
</tr>
<tr>
<td><strong>Highest performing NHS acute trusts</strong></td>
</tr>
</tbody>
</table>

Comparative data provided by the HSCIC are only available for the first three quarters of 2014/15 (April to Dec 2014). The figures in the tables below do therefore not show the improvement in VTE assessment at the Trust from December 2014.

<table>
<thead>
<tr>
<th></th>
<th>OUH</th>
<th>National (NHS acute trusts only)</th>
<th>Lowest % (NHS acute care providers)</th>
<th>Highest % (NHS acute care providers)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Q1</strong></td>
<td>92.7%</td>
<td>96.1%</td>
<td>87.2%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Q2</strong></td>
<td>94.3%</td>
<td>96.1%</td>
<td>86.4%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Q3</strong></td>
<td>95%</td>
<td>96.2%</td>
<td>81%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: HSCIC

**NOTES:**

28. A DVT is a blood clot (thrombus) in the deep veins of the leg. If the thrombus breaks off (embolizes) and flows towards the lungs, it can become a life-threatening pulmonary embolism (PE), a blood clot in the lungs.

29. For information see: [www.ncbi.nlm.nih.gov/pmc/articles/PMC4162339](www.ncbi.nlm.nih.gov/pmc/articles/PMC4162339)
The Trust considers that these data are as described for the following reasons.

- The Trust has a process in place for collecting data on VTE assessments.
- The data are collated internally and reported on a monthly basis to the Department of Health.
- The rates of VTE risk assessment fell in the Trust below the recommended 95% during 2014/15, from April until December 2014. The main reason for this was that the method by which VTE risk assessment was documented was changed. Prior to April 2014, both written and electronic (CaseNotes) systems were used. On 9 April, the only means to document a VTE risk assessment was using a different electronic patient record (EPR) system. A lack of familiarity with the EPR system led to a reduction in overall VTE risk assessment performance.

The actions that we have taken to improve VTE assessment, and so the quality of our services, are as follows.

- Information has been made widely available to all relevant clinical staff about how to complete a VTE risk assessment on EPR. Information was distributed in several ways: locally to inpatient wards and electronically to all clinical Divisions where the information was then cascaded to all doctors.
- Every consultant has been sent a ‘how to’ document to show them how to make an inpatient list on EPR to evaluate their daily VTE risk assessment figures.
- An email and a short PowerPoint presentation was sent to all the clinical Divisions for cascading, to inform all doctors about the dip in VTE risk assessment and that as a Trust this needed to improve.

- Prompts within EPR are set to alert when a patient has been admitted for six hours that a VTE risk assessment is required (if one has not been done). Whenever a clinician logs in to a patient’s electronic medical record this alert continues to fire until the risk assessment has been completed.
- To further improve VTE risk assessment figures, the VTE risk assessment tool on EPR will be compulsory on admission for patients, as it will be directly linked to the electronic prescription chart (ePMA prescription). This will ensure that the risk assessment is completed for 100% of patients that are admitted, and when the risk assessment is completed, the EPR system will direct the clinician to the drug chart to prescribe the appropriate mechanical / and or chemical thromboprophylaxis. This will be built into the EPR system during the forthcoming year.

CLINICAL EFFECTIVENESS (OUTCOMES)
ENGAGING OUR STAFF TO IMPROVE QUALITY

The internal Peer Review Programme
The internal Peer Review Programme was developed in 2013/14 as:
• a way of understanding how our services really work
• a tool to hear the views of patients and staff
• a useful method to identify what works well and what could be improved to support the sharing of good practice and focus on improvements to patient care
• a way to support the delivery of compassionate excellence.

The internal Peer Review Programme in its first phase brought together 57 clinicians, non-medical employees and patient representatives who visited 103 wards and departments across the five Divisions of the Trust. Data packs were prepared in advance of the visits in order to gain an understanding of the Division and to identify initial key lines of enquiry. The reviewers spoke to staff, patients and relatives to gain their views about the Trust, their care and patient experience. They looked at the strengths and areas for improvement at all the sites visited, providing detailed feedback to those areas. This analysis was then collated into Divisional reports, discussed at Quality Summits.

The CQC five ‘key questions’ were used when collating results.
• Is the area safe?
• Is the area effective?
• Is the area caring?
• Is the area responsive?
• Is the area well led?

A number of areas of Trust-wide good practice were found, including caring, responsive and committed staff, compliance with WHO surgical safety checklist, involvement in national and local clinical audits, statutory and mandatory training compliance and positive leadership, multidisciplinary teamwork and support for staff.

Examples of actions included improving the following:
• standards of cleanliness and hand hygiene compliance
• suitability and maintenance of premises and storage
• routine checks of resuscitation trolleys
• medicines management, specifically the process of arranging medicines ‘to take home’ on discharge
• non-medical appraisal rates.

The process was positively evaluated by the staff who participated in the reviews. For the units and wards reviewed, staff stated that it helped them focus on issues that hadn’t been previously identified and that this ‘objective eye’ was a powerful tool to enable improvement.

The next phase of the programme in 2015/16 will move the focus from Divisional level to clinical directorate level in order to provide greater granularity of results and more useful information for individual clinical directorates. In addition the peer review principles are being piloted on a small number of thematic reviews, with the first of these reviews covering elements of the public health agenda.

Quality Improvement Nurse Educators
During 2014/15 we developed a new role for Quality Improvement Nurse Educators and a therapist who will work with ward / department sisters, charge nurses and matrons. These roles will essentially focus on quality improvement in the clinical setting through a systematic approach that is Trust-wide.

Our education team is in the process of recruiting suitable individuals, who will lead on a range of projects including rolling out programmes such as the FallSafe care bundle to reduce the number and severity of inpatient falls, as well as improving nutritional assessments and care planning.

The overall purpose of these roles is to work with and develop clinical staff in order to improve patient safety.

This team will focus on the educational aspect of improving care while working clinically to enable the leadership team to drive the improvement and monitor the impact against agreed milestones.

A key objective of these new roles will be to deliver a ward accreditation programme which will be achieved incrementally over a period of approximately 3-4 years. This ward accreditation programme will provide an objective review of the quality of individual wards in relation to patients and staff experience. It will establish ‘Recognition Awards’ for clinical teams who have achieved higher quality standards in their wards / departments.
THE PATIENT EXPERIENCE

The Trust values

Learning | Respect | Delivery | Excellence | Compassion | Improvement

Compassionate care

The Trust values underpin our drive for continuous improvement in delivering high quality services that exceed our patients’ expectations.

Patients’ views count and therefore patients’ thoughts, opinions and observations about all aspects of 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

The Trust is committed to seeking and acting upon feedback from patients and their friends and family. This is because we want every patient to have the best experience possible, and feedback helps our staff to know what we are doing well (and we should keep on doing) and what we need to change. We also use this information to ensure that our Quality Account reflects the wishes and experiences of people who use our services.

<table>
<thead>
<tr>
<th>WAYS WE GET FEEDBACK</th>
<th>HOW WE USE THIS FEEDBACK</th>
</tr>
</thead>
</table>
| Friends and Family Test (FFT)  
Asks if you would recommend the ward or department to your friends and family | Comments are used to show excellent practice or areas for improvement across the Trust. We feed back our FFT results so teams can tackle issues raised. |
| National patient survey | Gives us examples of what patients say about our wards and helps us plan improvement work over the year. |
| Listening to what you say in person  
(face to face discussions) | We try to resolve any issues as quickly as possible. It helps us see where we need to make improvements to specific aspects of our service. |
| Feedback to Patient Advice and Liaison Service (PALS) | Concerns and issues are fed back to relevant departments in the Trust so improvement can be made. These are collated into themes so we can see if there are one-off or recurrent problems to fix. |
| Letters and emails | Give us an in-depth account of a patient’s experience to help us to understand the issues better. Our Chief Nurse presents, with the patient’s permission, a case study and associated learning to Trust bi-monthly public Board meetings. |
| Feedback on the NHS Choices website | Identified issues that are important to patients in order to develop a privacy and dignity policy. |
| Patient stories | Receives ongoing feedback from public and patient members to contribute to each draft of the privacy and dignity policy. Keen to ensure full collaboration at each stage. |

Privacy and dignity workshop (15 Feb) with voluntary and community groups  
Included: Age UK, Healthwatch Oxfordshire, Guideposts Trust, My Life My Choice, Carers Oxfordshire, Autism Oxford, and patient representatives and partners (Oxfordshire County Council and NHS England) and Trust staff.

Privacy and dignity Task and Finish Group

52
## THE PATIENT EXPERIENCE

<table>
<thead>
<tr>
<th>WAYS WE GET FEEDBACK</th>
<th>HOW WE USE THIS FEEDBACK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engagement with My Life My Choice (self-advocacy group)</td>
<td>Tailor how we engage with people with learning disabilities so their experiences and improvement suggestions are taken into account. Particularly important for developing guidance documents for staff.</td>
</tr>
<tr>
<td>Carers project group</td>
<td>Co-producing a carers’ feedback survey to improve how we hear and act upon the views of patients and carers.</td>
</tr>
<tr>
<td>This is work in partnership with Carers Oxfordshire and Carers Voice</td>
<td></td>
</tr>
<tr>
<td>Seldom Heard People project funded by Health Education Thames Valley (HETV)</td>
<td>Engaging with a wide range of stakeholders helps us understand the needs of people who may experience barriers to accessing services or are not well represented in healthcare decision-making. This work is driven by the Equality and Human Rights Commission.</td>
</tr>
<tr>
<td>Workshop with public participation groups (Nov 14)</td>
<td>Improves how we use the patient voice in developing our services and guidance documents. For example a) practical resources (toolkit) to help the Trust engage with the public and b) a strategy for patient and public involvement. Helps support consultation events for Seldom Heard People.</td>
</tr>
<tr>
<td>Patient partners programme (project funded by HETV)</td>
<td></td>
</tr>
<tr>
<td>Patient partners programme (project funded by HETV)</td>
<td>To produce a public and patient involvement strategy.</td>
</tr>
</tbody>
</table>
**THE PATIENT EXPERIENCE**

**Our successes**  
Over the past year we have achieved the following.

<table>
<thead>
<tr>
<th><strong>Patient experience dashboard</strong></th>
<th>Devised a one-page visual display to present our patient experience feedback. This is populated each month and has made the reporting of patient experience to the Trust’s Quality Committee and Trust Board clearer.</th>
</tr>
</thead>
</table>
| **Patient experience stars** | Awarded to:  
  • maternity services, for improving FFT response rates  
  • the dementia champion in trauma, for improving care for dementia patients  
  • the housekeeper on the gynaecology ward for improving the Friends and Family Test response rates. |
| **Tracking and flagging*** | Implemented for people with learning disabilities in Oxfordshire. This helps us to give the right care at the right time.  
* Tracking and flagging is the process by which the healthcare records of people with a learning disability are flagged so we can ‘track’ a person’s care. We do this to provide reasonably adjusted care. |
| **Dementia support** | • Seven dementia-friendly computers support reminiscence in hospital.  
  • The dementia information café for relatives and carers provides access to information, advice and support from a range of organisations.  
  • A ‘Knowing Me’ care planning document for vulnerable adults was developed with Oxford Health NHS Foundation Trust and Carers Oxfordshire.  
  • The ‘I-care’ was produced to identify carers as part of a county wide project. |
| **Learning disabilities** | • Updated the hospital passport for people with learning disabilities following feedback from carers, people with learning disabilities and healthcare staff. |
| **Bereavement service** | • Received feedback from four regional Islamic funeral directors that the Trust’s bereavement service provides an exemplary service. |

**Ms J** used a new drop-in service within the Trust which is accessible to patients, visitors and staff. She emphasised the effectiveness of implementing current recommended health behaviour change models. These models identify an individual’s triggers and motivations to change and methods to put the change into practice.  
• The service gave Ms J important support to lose weight.  
• This was motivating feedback for the staff, increasing their confidence and enthusiasm.  
• It emphasised the importance of continual professional development, maintaining and updating the team’s knowledge of emerging health behaviour change techniques.
## THE PATIENT EXPERIENCE

<table>
<thead>
<tr>
<th>FFT: inpatients</th>
<th>96% of patients were extremely likely or likely to recommend the ward they stayed on, based on 12,139 responses.</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFT: A&amp;E</td>
<td>87% of patients were extremely likely or likely to recommend the care they received in A&amp;E, based on 8,353 responses.</td>
</tr>
<tr>
<td></td>
<td>Introduced a texting version of FFT in A&amp;E and outpatients to increase the response rate.</td>
</tr>
<tr>
<td>FFT: Outpatients</td>
<td>95% of outpatients were extremely likely or likely to recommend the care they received, based on 1,502 responses.</td>
</tr>
<tr>
<td>FFT: Day-case areas</td>
<td>97% of day-case patients were extremely likely or likely to recommend the care they received, based on 656 responses.</td>
</tr>
<tr>
<td>FFT: Maternity</td>
<td>94% of women were extremely likely or likely to recommend the Trust’s maternity services, based on 4,401 responses.</td>
</tr>
<tr>
<td>FFT: Children’s</td>
<td>Children’s services using ‘Fabio the Frog’ (easy read FFT form for people with learning disabilities).</td>
</tr>
</tbody>
</table>

The figures above are a breakdown of trust FFT scores between April 2014 to March 2015.

The table below shows the Trust’s overall results from the FFT.

<table>
<thead>
<tr>
<th>2014/15</th>
<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>
</tr>
</thead>
<tbody>
<tr>
<td>Number of responses overall</td>
<td>19,954</td>
<td>5,161</td>
<td>849</td>
<td>348</td>
<td>337</td>
<td>402</td>
</tr>
<tr>
<td>Percentage</td>
<td>74%</td>
<td>19%</td>
<td>3%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

We have taken the following actions to improve our FFT rates:

- Implementing text messaging and interactive voice messaging in A&E.
- Use of volunteers and reception staff in A&E, to raise patient awareness about feedback via text messaging and interactive voice messaging, encourage patients to respond, opt-out patients who do not wish to receive a text message, and offer paper questionnaires to those patients.
- The patient experience team visits all adult inpatient wards on a weekly basis to collect comment cards, bring weekly reports to monitor response rates more frequently, and provide encouragement and support to increase or maintain response rates.
THE PATIENT EXPERIENCE

National patient surveys
There were three national patient surveys in 2014: the Inpatient Survey, the Emergency Department Survey and the first National Children’s Survey. The results received from the surveys were very positive.

Inpatient survey

The national Inpatient Survey 2014 was sent to a sample of patients who were discharged from the Trust’s hospital wards in July 2014. The CQC collates and compares results across trusts. At OUH 53% of the sample group responded, which is higher than the average across other trusts at 47%.

The survey showed that 87% of inpatients who responded rated their care overall at 7 or above on a scale of 0-10.

In particular, this survey highlighted delays in bedside call bells being answered. Currently around 45% of bells are answered within two minutes. While recognising there may be unavoidable short delays when wards are particularly busy, we want to ensure all patients are responded to promptly. The Trust will run a series of staff involvement sessions to discuss how response times can be improved.

A&E survey

The A&E results improved significantly on the following questions since the 2012 survey.

- 86% of patients said their care was handed over from ambulance staff to A&E staff within 15 minutes of arrival in 2014, an improvement from 72% in 2012.
- 81% said they were given the right amount of information about their condition or treatment in 2014 compared to 73% in 2012.
- 87% said they did not receive conflicting information from different staff in 2014, compared to 80% in 2012.

National Emergency Department Survey 2014 was sent to a sample of patients who were discharged from the Trust’s Emergency Department in March 2014. The Care Quality Commission (CQC) collates and compares results across trusts. At OUH, 37% of the sample group responded, which is higher than the average across other trusts at 34%.

The survey showed that 83% of Emergency Department (A&E) patients rated their care overall at 7 or above on a scale of 0-10.
THE PATIENT EXPERIENCE

The National Children’s Survey 2014 was sent to a sample of patients discharged in August 2014 and included the perspectives and experiences of parents / carers, children and young people aged 0-15 years. At OUH 36.1% of the sample responded.

The survey showed that 91% of parents / carers and children rated their care overall at 7 or above on a scale of 0-10.

**Childrens survey**

<table>
<thead>
<tr>
<th>Rating</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of respondents</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
<td>3%</td>
<td>4%</td>
<td>11%</td>
<td>20%</td>
<td>25%</td>
<td>35%</td>
</tr>
</tbody>
</table>

The following table shows the Trust’s responsiveness to inpatients’ personal needs. The scores are calculated from five questions in the National Inpatient Survey relating to involvement in decisions about care; being able to talk to staff about worries and fears; privacy when discussing condition or treatment; explanations about medication side effects; explanation of who to contact if patient is concerned about their condition after leaving hospital. These data are available up to 31 March 2014.

<table>
<thead>
<tr>
<th>Financial year or year of survey</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>OUH</td>
<td>75.1</td>
<td>76.9</td>
<td>77.2</td>
</tr>
<tr>
<td>National average</td>
<td>67.4</td>
<td>68.1</td>
<td>not available</td>
</tr>
<tr>
<td>Highest performing Trust</td>
<td>85.0</td>
<td>84.4</td>
<td>not available</td>
</tr>
<tr>
<td>Lowest performing Trust</td>
<td>56.5</td>
<td>57.4</td>
<td>not available</td>
</tr>
</tbody>
</table>

Source: NHS England

In relation to improvements, parents and carers cited a lack of ‘parent and child’ car parking. Less positive comments for children concerned the provision of activities for teenagers awaiting surgery. An action plan in response to these findings will be monitored by the Division.

The Trust considers that these data are as described for the following reason:

- the Trust outsources the collection of patient survey data to a CQC approved contractor.

The actions that the Trust will take in response to the national patient surveys are as follows:

- run a series of staff involvement sessions to discuss how response times to call bells can be improved in order to improve patients’ experiences and so the quality of its services
- consider activities for teenagers awaiting surgery
- examine the provision of ‘parent and child’ car parking.
Mr and Mrs B’s twins were born prematurely in the JR in February 2014 and treated for the next three months in the Neonatal Unit. Despite the difficulty of a premature birth, the parents were overwhelmingly grateful for the care and support provided to them and their daughters who went home in May 2014. The story demonstrated the positive impact on patients when staff behaviours consistently reflect the Trust values.

“One of the nurses took it upon herself to take a photograph and wrote on the back “look Mummy and Daddy I am breathing by myself” love S. A special moment of such thoughtfulness and care that still brings me to tears”.

“The nurses were our mother, sister and best friend and we appreciated normalising conversation”.

“We were constantly cared for and always considered as parents, we were involved in key decisions and kept updated every step of the way. In all interactions we felt important, always the centre of everyone’s attention.”
THE PATIENT EXPERIENCE

Patient Advice and Liaison Service (PALS)

PALS is the first stop for patients, their families and carers who have a query or concern about the hospital or a 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. PALS 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, through leaflets/booklets which can be found across all hospital sites and on the Trust website www.ouh.nhs.uk

How we handle complaints

During 2014/15, the Trust received 1,009 formal complaints. The top three categories of complaints are as follows.

• Care received from our staff – 332 complaints.
• Access to our services – 318 complaints.
• Our communication processes with patients and relatives – 152 complaints.

We know from analysing our complaints that they often cite attitude or behaviour of staff. During 2014/15, 38 frontline managers and staff attended a workshop designed to help understand the impact of behaviours and attitudes on the patient, and to develop an understanding of effective communication styles with people who are vulnerable. This work helped in the design of complaint management training which is being offered to staff on a weekly basis.

Following a review of our complaints process we have made several changes described below.

• New style complaints response letters that are easy to understand and contain less jargon.
• A complainant’s satisfaction survey is carried out with The Patients Association and the NHS Benchmarking Team. Using external organisations helps people feel more confident to speak openly. We anticipate that people who make a complaint will be more satisfied with the outcome.
• All serious complaints are closely examined to see if a clinical incident has occurred. This was an important recommendation from the Francis Enquiry.
• Complaints are coded using the Trust values.

The Healthwatch chapter on Quality within the revised Oxfordshire Health and Wellbeing Board Strategy 2014/15

The Health and Wellbeing Board Strategy sets out the key priorities for the whole health and social care system for Oxfordshire. It is informed by the Joint Strategic Needs Assessment (JSNA) which is jointly developed by the NHS and the Local Authority, and which enables a local area to have a clear understanding of the needs of the whole population and the wider determinants of health. Healthwatch Oxfordshire is part of a network of independent Healthwatch organisations that exist all over England. It exists to:

• provide information about local health and social care services
• listen to views and experiences on the way that health and social care services are delivered
• use those views to influence how services can be improved
• make local people’s views known to influence the way services are designed for the future.

Healthwatch Oxfordshire is therefore a key partner to enable us to better understand patient, carer and the public’s views of our services. Additionally for the first time, this year, Healthwatch Oxfordshire has co-ordinated production of a joint commitment to addressing shared quality priorities from all major NHS and social care commissioners and providers in Oxfordshire, based on analysis of patient and service user feedback to all organisations. The table opposite presents the areas of work for 2015/16 developed as common and shared priorities by local organisations, facilitated by Healthwatch Oxfordshire, shown alongside the service improvement work already being undertaken by the Trust and our partners.
# THE PATIENT EXPERIENCE

<table>
<thead>
<tr>
<th>ALL SERVICES ACROSS OXFORDSHIRE</th>
<th>SERVICE DEVELOPMENTS (THIS INCLUDES WORK STARTED IN 2014/15 AND CARRIED FORWARD TO 2015/16)</th>
</tr>
</thead>
</table>
| Joining up people’s care, when it is being delivered by a range of health and / or social care providers | 1. Oxfordshire Integrated Care Alliance Programme between OUH and partner trust (for older people and those with complex care needs). This includes the supported hospital discharge service (SHDS).  
2. The sexual health service. This encompasses primary, intermediate and tertiary services. |
| Communication between different organisations within the system about patients                  | 1. Oxfordshire Integrated Care Alliance Programme between OUH and a partner Trust (for older people and those with complex care needs).  
2. The Discharge Oversight Group.  
3. The Oxfordshire Care Summary record.  
4. The Oxfordshire collaboration in relation to the implementation of Deprivation of Liberty Safeguards (DOLS) following the Supreme Court's judgment on Cheshire West.  
5. The Safeguarding Children and Adults Multi-agency Safeguarding Hub (MASH). |
| Communication by all parts of the system with patients and carers, both in terms of staff attitudes, involvement of people in decision making about their care and delivery of dignity standards | 1. The development and implementation of the Trust’s privacy and dignity policy. This is being co-produced with patients, the public and partner organisations.  
2. The Oxfordshire NHS collaboration to implement tracking and flagging for people with a learning disability.  
3. The Trust’s dementia information café in partnership with Guideposts Trust, Alzheimer’s Society, the Museum of Oxford, Carers Oxfordshire and Age UK.  
4. The Carers Feedback project. This is being co-produced in partnership with Carers Oxfordshire and Carers Voice. |
| Carer involvement in care planning and care delivery                                              | 1. The Patient Partnership Groups (PP:s) project. This project is supporting the development of PP:s within the Trust. |
| Better treatment of patients with physical and mental health needs, and recognising and addressing the psychological component of all healthcare | 1. The psychological medicine service. This award-winning service offers a specialist central service and training and supports front-line clinicians and their patients. |
| Continuing to build a culture in which staff, carers and patients feel able to raise concerns or complaints without fear of retribution | 1. Complaints investigators training.  
2. The new complaints algorithm.  
3. The learning from complaints project.  
4. The raising concerns policy is being updated in light of Sir Robert Francis reports. |
## THE PATIENT EXPERIENCE

### ALL SERVICES ACROSS OXFORDSHIRE

<table>
<thead>
<tr>
<th>SERVICE DEVELOPMENTS (THIS INCLUDES WORK STARTED IN 2014/15 AND CARRIED FORWARD TO 2015/16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supporting delivery of public education about how to use the NHS wisely and self-care programmes that might help reduce demand</td>
</tr>
<tr>
<td>1. The ‘Here for Health’ team and education programmes.</td>
</tr>
<tr>
<td>2. The sexual health service. This encompasses primary, intermediate and tertiary services.</td>
</tr>
<tr>
<td>OCC specific issue: the timeliness of social services social care assessments and access to care packages and re-ablement services</td>
</tr>
<tr>
<td>1. Oxfordshire Integrated Care Alliance Programme between OUH and partner trust (for older people and those with complex care needs). This includes the supported hospital discharge service (SHDS).</td>
</tr>
<tr>
<td>2. The Discharge Oversight Group.</td>
</tr>
</tbody>
</table>

### OUH SPECIFIC ISSUES

<table>
<thead>
<tr>
<th>SERVICE DEVELOPMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providing high quality, individualised care at OUH, while meeting NHS Constitution pledges on A&amp;E waiting times, cancer treatment times and 18 week referral to treatment targets</td>
</tr>
<tr>
<td>1. Knowing Me care planning document and hospital passports.</td>
</tr>
<tr>
<td>2. The Oxfordshire NHS collaboration to implement tracking and flagging for people with a learning disability.</td>
</tr>
<tr>
<td>3. The Trust’s dementia strategy.</td>
</tr>
<tr>
<td>5. The agreed referral to treatment (RTT) plan.</td>
</tr>
</tbody>
</table>
MANDATORY STATEMENTS OF ASSURANCE FROM THE BOARD

Review of services

- During 2014/15 Oxford University Hospitals NHS Trust provided and sub-contracted 130 NHS services.

- OUH has reviewed all the available data available on the quality of care in all of these relevant health 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 relevant health services reviewed in 2014/15 represents 100% of the total income generated from the provision of relevant health services by Oxford University Hospitals NHS Trust for 2014/15.
## PERFORMANCE INDICATORS

<table>
<thead>
<tr>
<th>COMMITMENT</th>
<th>STANDARD</th>
<th>2014/15 TRUST ACHIEVEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CANCELLATIONS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancelled operations (28 day breaches)</td>
<td>5%</td>
<td>4.29%</td>
</tr>
<tr>
<td><strong>INFECTION CONTROL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRSA</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>C.Difficile</td>
<td>67%</td>
<td>61%</td>
</tr>
<tr>
<td><strong>REFERRAL TO TREATMENT WAITING TIMES FOR NON-URGENT CONSULTANT-LED TREATMENT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admitted patients to start treatment within a maximum of 18 weeks from referral</td>
<td>90%</td>
<td>86.85%</td>
</tr>
<tr>
<td>Non-admitted patients to start treatment within a maximum of 18 weeks from referral</td>
<td>95%</td>
<td>94.75%</td>
</tr>
<tr>
<td>Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral</td>
<td>92%</td>
<td>91.84%</td>
</tr>
<tr>
<td><strong>DIAGNOSTIC TEST WAITING TIMES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients waiting for a diagnostic test should have been waiting no more than six weeks from referral</td>
<td>99%</td>
<td>99.1%</td>
</tr>
<tr>
<td><strong>EMERGENCY DEPARTMENT WAITS (A&amp;E)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients should be admitted, transferred or discharged within four hours of their arrival at an accident and emergency department</td>
<td>95%</td>
<td>89.8%</td>
</tr>
<tr>
<td><strong>CANCER WAITS – TWO WEEK WAITS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum two week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP</td>
<td>93%</td>
<td>94.9%</td>
</tr>
<tr>
<td>Maximum two week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)</td>
<td>93%</td>
<td>95.5%</td>
</tr>
</tbody>
</table>
## PERFORMANCE INDICATORS

<table>
<thead>
<tr>
<th>COMMITMENT</th>
<th>STANDARD</th>
<th>2014/15 TRUST ACHIEVEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CANCER WAITS – 31 DAYS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum one month (31 day) wait from diagnosis to first definitive treatment for all cancers</td>
<td>96%</td>
<td>95.9%</td>
</tr>
<tr>
<td>Maximum 31 day wait for subsequent treatment where that treatment is surgery</td>
<td>94%</td>
<td>96.1%</td>
</tr>
<tr>
<td>Maximum 31 day wait for subsequent treatment where that treatment is an anti-cancer drug regimen</td>
<td>98%</td>
<td>100%</td>
</tr>
<tr>
<td>Maximum 31 day wait for subsequent treatment where the treatment is a course of radiotherapy</td>
<td>94%</td>
<td>91.5%</td>
</tr>
<tr>
<td><strong>CANCER WAITS – 62 DAYS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum two month (62 day) wait from urgent GP referral to first definitive treatment for cancer</td>
<td>85%</td>
<td>77.7%</td>
</tr>
<tr>
<td>Maximum 62 day wait from referral from an NHS screening service to first definitive treatment for all cancers</td>
<td>90%</td>
<td>93.1%</td>
</tr>
<tr>
<td><strong>CARDIAC ACCESS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reperfusion: primary angioplasty (PPCI)</td>
<td>85%</td>
<td>96.84%</td>
</tr>
<tr>
<td>Patients with two week onset of chest pain seen in rapid access chest pain clinic (RACP)</td>
<td>100%</td>
<td>99.38%</td>
</tr>
<tr>
<td><strong>STROKE CARE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients who have had a stroke who have spent more than 90% of their stay in hospital on a stroke unit</td>
<td>80%</td>
<td>82.1%</td>
</tr>
<tr>
<td><strong>VTE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Venous thromboembolism risk assessments</td>
<td>95%</td>
<td>94.6%</td>
</tr>
</tbody>
</table>
PERFORMANCE INDICATORS

Meeting our targets

MRSA
See the section on Healthcare Acquired Infections p.48

18 week waiting time
Due to the high volume of activity we have been unable to treat all elective patients within the standard 18 week waiting time and, in agreement with our commissioners and the Trust Development Authority (TDA), have implemented a recovery plan to reduce the number of patients waiting over 18 weeks for treatment. This includes operating additional theatre lists over six days a week. All emergency, urgent and cancer patients are treated as a matter of clinical priority.

62 day cancer waits
The 62 day standard refers to the time from the first urgent (suspected cancer) GP referral to the first definitive treatment for cancer. Performance in meeting this standard declined in 2014/15 and an action plan has been put in place to improve waiting times. The Trust does not want any patient to be waiting longer than necessary and is committed to achieving all local and national performance standards. The action plan focuses on quicker diagnosis to offer earlier treatment; the timeliness of referrals from other hospitals where patients have had an initial appointment; and better communication to ensure patients are aware of the reason for an urgent referral and the requirement to take up the appointments offered.

Emergency department performance (A&E)
The Trust has not delivered every week the required standard that 95% of patients should be admitted, transferred or discharged with four hours of their arrival at one of our emergency departments. The demand on our health services has been higher than ever, particularly during the winter months. In November 2014, there was a review of the emergency and urgent care system, covering both health and social care, by the Emergency Care Intensive Support Team. In response to this, the Trust has developed an Urgent Care Improvement Programme to take forward the recommendations from that review. Improvements have been made to internal processes and systems to help address emergency department waiting times. Close collaboration with other Oxfordshire NHS and social care services is in place to shape and improve a whole-system approach to managing patients requiring urgent and emergency care, ensuring that patients are guided to the right service and do not unnecessarily attend the emergency departments at either the John Radcliffe or Horton Hospital. This is a quality priority for 2015/16, see p.28

An important factor governing the Trust’s ability to deliver operational performance standards is the number of patients occupying hospital beds who are medically fit to leave hospital but are delayed in moving to a community bed, nursing home, or home-based care and support. The local healthcare system remains one of the most challenged nationally in relation to delayed transfers of care. The impact of delayed transfers on the Trust’s ability to manage emergency admissions is a concern. A lack of available beds can cause a ‘bottle-neck’ in the emergency departments where we continue to see increasing attendances with emergency care admissions.

Over the past year, a number of improvements have been made to support access and discharge planning, including.

• A joint agency steering group meeting weekly to resolve discharge issues for individual patients who have been delayed.
• Input from social workers and support placement officers at weekends to speed up the discharge process.
• Collaboration with GPs on developing ambulatory care pathways that will improve access to treatment in hospital that does not require admission to a bed.
• Introduction of consultant physicians as part of emergency surgery to support the care of older people in trauma and orthopaedics.
• Opening of additional emergency assessment beds at the John Radcliffe Hospital and Horton General Hospitals.

Cardiac access
We were disappointed this target was missed. During the majority of 2014/15 our average performance was 100% but due to capacity issues in clinics during December 2014 to January 2015 the wait for the rapid access chest pain clinic exceeded two weeks. The dip in performance relates to a 14 day period when 99.4% of patients were seen within 14 days rather than 100%. We are pleased that from February 2015 waiting times are back to two weeks after a change in the clinic flow process that has allowed an increase in capacity.

VTE assessment improvement actions are on p.49
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 hence to highlight best practice in providing high quality patient care, and to drive continuous improvement across all of our services.

During 2014/15, 48 national clinical audits and four national confidential enquiries covered relevant services that Oxford University Hospitals NHS Trust provides. During that period we participated in 100% of the national clinical audits and 100% of the national confidential enquiries in which we were eligible to participate. Also in 2014/15, we undertook 287 registered local clinical audits. Appendix 2 contains a list of national audits, national confidential enquiries and local audits and describes the actions we have taken or are planning to take to improve our services in response to insights from these audits.

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

This national audit of neonatal care looked at a number of areas of neonatal practice including temperature on admission for premature babies, the use of steroids given before premature birth, screening for retinopathy of prematurity (ROP, an eye condition affecting premature babies), breast milk at discharge home, doctors giving information to parents, infection rates, two year follow-up information and babies being looked after in their local residential area. The neonatal unit at the John Radcliffe performed at or above the national average and the special care baby unit at the Horton General Hospital performed well above the national average. The unit at the Horton scored particularly well in its use of antenatal steroids, babies receiving maternal breast milk at discharge, doctors giving information to parents and low infection rates.

Trauma Audit and Research Network (TARN), quarterly themed report: Clinical Report 3 – Core + Head and Spinal Injuries, April 2013 to September 2013 data, published November 2014
The John Radcliffe major trauma centre continues to demonstrate excellence in key trauma service performance measures, such as time from arrival to CT (imaging) of the brain. Our survival rates continue to be better than expected and we plan to improve the way that we monitor this. We are working to improve on our key measure such as the number of patients seen by a consultant within five minutes of arrival after the activation of the trauma team. Our length of hospital stay for patients with spinal injuries has reduced and we believe that this needs to reduce further in line with a national plan for the development of better access to rehabilitation.

Oxford University Hospitals is performing better than the national average for evidence of prescribing oxygen to patients, and this has improved since the inception of this audit. As the Trust moves towards an electronic patient record, it has been possible to better link the oxygen prescription to the observation chart. This linkage will enable nurses to consider the administration of oxygen as they are completing observations. The Trust is piloting the use of tablet computers which alert teams to a deterioration in oxygen saturation in order to enable rapid oxygen treatment to patients. It is hoped that when the planned technological changes are implemented, with an appropriate learning package, the prescribing of oxygen and its delivery will similarly reflect the excellence seen in the documentation of observations.

NICE Quality Standard (QS44) for atopic eczema in children in the dermatology department
The findings of this audit showed that there is 100% compliance with the majority of NICE Quality Standards for atopic eczema in children (2013) relevant to secondary care including:

- offering, at diagnosis, an assessment which includes recording of their detailed clinical and treatment history;
- offering treatment based on recorded eczema severity using a stepped-care plan, supported by education;
- assessing, discussing and recording psychological wellbeing and quality of life of affected children and their families at each consultation;
- referral of infants and young children with moderate or severe atopic eczema to specialist investigation to identify possible food and other allergies, when appropriate.

The potential trigger factors for atopic eczema were documented in 85% cases and sufficient quantities of emollients (moisturisers) were prescribed for children with atopic eczema. All patients referred through the on-call dermatology service with suspected eczema herpeticum are reviewed urgently as per NICE guidelines and receive immediate systemic treatment.
PARTICIPATION IN CLINICAL AUDITS

NICE CG169 – AKI guidelines – compliance with guideline and patient safety
The definition of acute kidney injury has changed in recent years, and detection is now mostly based on monitoring creatinine levels, with or without urine output. The NICE clinical guideline was introduced in 2009 following the finding of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report. This audit was targeted on two main standards in the identification and management of AKI. A group of 50 patients who developed AKI, identified by the data produced from the biochemistry system, over two periods between September 2014 and January 2015 had their notes and electronic patient records reviewed for the AKI standards using the NICE audit tool. Overall, AKI was identified and documented in all notes reviewed. We concluded that we are compliant with the NICE guideline standards on the identification of acute kidney injury. The introduction of AKI electronic alerts in EPR, integration of the AKI care bundle and education may improve the management of these patients. We have chosen this as a priority for 2015/16.

NICE CG83 – Rehabilitation after critical illness – 2014
We reviewed compliance with the standards for assessing patients, identifying rehabilitation problems, setting rehabilitation goals and handing over patient information. All patients received an appropriate rehabilitation assessment, with their risk of developing physical rehabilitation problems identified, across all four critical care units. Nearly all patients (94%) went on to have a rehabilitation assessment prior to their discharge from critical care. In response to this review a Thames Valley Critical Care Network rehabilitation group has been established to develop a standardised documentation process for recording rehabilitation information, and a rehabilitation prescription for non-trauma patients. The adult critical care physiotherapy team will share their documentation processes with the other critical care units.

NICE CG29 – pressure ulcer prevention guidelines and OUH policy on the prevention of pressure ulcers
This audit was able to demonstrate that the overall prevalence of hospital acquired pressure ulcers (HAPU) at the Trust is below the national average when benchmarked. Areas for improvements, however, are the delivery of specific care plans in order to reduce the development of ulcers in patients at risk, and the use of protocols to reposition patients who are immobile. The ambition of the Trust is to work towards zero avoidable HAPU and this will be closely monitored through regular audits. We have chosen this as a priority for 2015/16.

Audit development
The development of the annual audit programme is now well established and supported by the clinical leads across the Trust. The learning from local audits is shared across the directorates and feedback from audits published nationally is discussed at the monthly Clinical Effectiveness Committee.

For a complete list of clinical audits and confidential enquiries please see Appendix 2.
INFORMATION ON RESEARCH

Oxford University Hospitals NHS Trust has been rated in the top five trusts 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.

We continue to work in close collaboration with the University of Oxford to ensure that we fulfill our joint commitment to carrying out world-leading, translational research across our four hospital sites. This research underpins and drives forward changes to clinical practice and ultimately benefits patients locally and across the health service.

The UK Cochrane Centre (UKCC) is to continue its association with the Trust for five more years. We have been awarded a £4m contract to provide the UK Cochrane Centre (UKCC) from April 2015 to March 2020. OUH has hosted the UKCC since 2010. It won the new contract following a competitive tendering exercise.

The UKCC, based in Summertown, Oxford, was established in 1992 and is part of the Cochrane Collaboration, an independent, world-renowned and trusted source of healthcare evidence. Both the Collaboration and the Centre help to produce and disseminate systematic reviews to improve healthcare locally, nationally and worldwide.

Martin Burton, Honorary Consultant Otolaryngologist at OUH and Director of the UKCC, said: “We are delighted that the UKCC will continue its association with Oxford University Hospitals NHS Trust. This decision provides continuity, enables us to strengthen our existing relationships and concentrate on what we do best.”

Speaking about the award of this contract and other related ones, Prof Dame Sally Davies, Chief Medical Officer and Chief Scientific Adviser at the Department of Health, said: “These new awards are important because of the role systematic reviews play in the health research landscape. By removing uncertainties in science and research, systematic reviews help to ensure that only the most effective and best-value interventions are adopted by the NHS and social care providers.”

The second phase of the University of Oxford’s Botnar Research Centre was officially opened by the Duchess of Cornwall on Friday 9 May 2014. The £12m facility, on the site of the Nuffield Orthopaedic Centre (NOC) in Headington, carries out research to improve the treatment of arthritis, osteoporosis and other bone and joint diseases. It brings world-leading research together with NHS clinical practice, accelerating discovery into new treatments and services for patients.

The Botnar Research Centre now comprises 4,000sqm of custom-built research facilities including state-of-the-art laboratories and flexible office accommodation.

It can house up to 250 scientists, clinicians and support staff carrying out pioneering research into conditions such as osteoporosis, osteoarthritis and cancer.

It also houses research supported by the National Institute for Health Research (NIHR) Oxford Biomedical Research Unit, a collaboration between Oxford University Hospitals NHS Trust and the University of Oxford, to translate innovation and discovery in musculoskeletal research into patient benefit.

The number of active studies supported by Oxford University Hospitals NHS Trust was 1,464 as at March 2014 compared to 1,357 the previous year. 17,193 patient participants were recruited to participate in 390 research studies approved by research ethics committee (within the National Research Ethics Service).

156 members of OUH staff are supported by the Biomedical Research Centre (BRC), which breaks down as:

- Research midwife: 6
- Research nurse: 55
- Pharmacist: 2
- Consultant: 68
- Clinical research fellow (CRF): 17
- Cardiographer: 1
- Other clinical: 7
CASE STUDIES

Smartphone-based self-management of gestational diabetes (diabetes in pregnancy)

Gestational diabetes mellitus (GDM) affects between 5% and 16% of all pregnancies in the UK, and has important implications for the health of the mother and baby. There are major lifestyle and resource implications associated with the condition due to the need for intense monitoring and treatment adjustments, such as glucose monitoring, diary keeping and frequent hospital visits.

The newly-developed Oxford GDm-health management system improves not only the management of gestational diabetes mellitus but also reduces the number of hospital clinic visits which women have to attend. The smartphone application has been designed with extensive input from both patients and clinicians and has a Bluetooth-enabled blood glucose meter for the patient, and a secure website, with optimised data presentation and alerting algorithms for healthcare professionals.

The application automatically transmits blood glucose measurements directly to the website, along with comments entered by the patient. It also provides important visual feedback on blood glucose control to the patient and has built-in capability for direct communication between healthcare professionals and the patient, using text messages to support self-management.

New genetic diagnostics tests to improve the utility of genomics in medicine

The NIHR Oxford Biomedical Research Centre Genomic Medicine Theme has developed whole genome sequencing (the whole genome sequencing 500 programme) and exome sequencing projects to identify new genes for rare disease including inherited adenomas, cranial malformation syndromes, cardiomyopathies, myasthenic syndromes, epilepsy and congenital anaemias. These studies have:

a) revealed new genetic causes of disease in families where prior tests had not been informative
b) expanded the repertoire of genes for which diagnostic testing can be offered in people with these conditions.

The NIHR Oxford Biomedical Research Centre is working to make genome-wide sequencing accessible across several medical specialties for clinical diagnosis, clinical trials, translational research and discovery of novel therapeutic targets. A genomic medicine multidisciplinary team (MDT) oversees the clinical use of exome/genome sequencing through highlighting availability and ensuring appropriate sample selection and return of results.

The NIHR Oxford Biomedical Research Centre Genomic Medicine Theme has attracted substantial external funding from the Health Innovation Challenge Fund (HICF) to translate whole genome sequencing into the clinic and is providing the necessary technical expertise and clinical pathways for developing these approaches nationally, with Genomics England.

New interventions for cure of chronic hepatitis C and HIV infection

The NIHR Oxford Biomedical Research Centre has combined basic science advances in viral immunology and genetics to work with other BRCs in national initiatives to optimise the treatment of important chronic viral infections: hepatitis C (HCV) and human immunodeficiency virus (HIV).

In hepatitis C, genetic testing of the HCV genotype is underway. The findings will be significant, as with the major expense of the new drugs, defining their ‘best use’ is an imperative. The findings of the research being undertaken on the major UK strains (notably genotype 3A) will be of specific relevance to the NHS.

In HIV research, the NIHR Oxford Biomedical Research Centre contributes to the leadership of ‘CHERUB’, a pan-BRC consortium seeking to develop new approaches to HIV cure. The development of cure strategies would have a significant impact on HIV patients, allowing patients to avoid lifelong drug therapy which is currently costly and has side effects.
**CASE STUDIES**

**Improving childhood vaccination against group B meningococcus**

Vaccines are particularly important in the defence of the health of young children. Group B meningococcus (MenB) is the last major cause of bacterial meningitis and septicaemia in children, with more than 10,000 cases in England and Wales in the past decade, and it is the leading infectious cause of childhood death in the UK. Immunisation against MenB is a public health priority, but has been challenging because the structure of the virus means it does not generate an adequate immune response.

The NIHR Oxford Biomedical Research Centre Vaccines Theme has led both national and European studies of a new MenB vaccine, in collaboration with industry, which was licensed in Europe and subsequently recommended by the Department of Health’s Joint Committee on Vaccination and Immunisation (JCVI) for immunisation of all infants. A national study, coordinated by the NIHR Oxford Biomedical Research Centre, is investigating the current causes and presentation of meningitis in the United Kingdom.

**Implementing a clinical decision support system improves compliance with restrictive transfusion policies in patients with blood disorders**

Great efforts have been made over the past 20 years to optimise the way patients’ blood conditions are managed and to reduce unnecessary exposure to blood products (transfusions).

A clinical decision support system (CDSS) has been found to reduce unnecessary transfusion in some clinical settings when physicians are advised they are not compliant with the current guidelines. The objective of this study was to assess the impact of a CDSS for blood product ordering in patients with blood disorders. The study was carried out at OUH, Oxford University Clinical Academic Graduate School; NHS Blood & Transplant; the University of Oxford; and the NIHR Oxford Biomedical Research Centre. 97 patients with a variety of blood disorders received 502 red blood cell transfusions and 572 received platelet transfusions during the three periods. CDSS alerts such as the one shown opposite appeared in the patients’ electronic record when the patients’ blood levels were outside OUH guidelines for transfusion.

The implementation of CDSS for blood ordering in haematology supported by education and clinician feedback improved compliance with restrictive transfusion triggers for transfusions in haematology. The next step will be to refine the process to make it simpler to use and more informative for physicians. This has the potential to reduce both the risks and costs associated with transfusion.
GOALS AGREED WITH COMMISSIONERS

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.

This year NHS England has made changes to the way quality and innovation are captured during contracting process. For 2015/16 the Trust will not have access to specific CQUIN-related funding from commissioners, but will progress the quality priorities articulated in this Quality Account.

Use of the CQUIN payment framework
In 2014/15, 2.5% of our income was conditional on achieving quality improvement and innovation goals agreed between the Trust and OCCG. The Oxfordshire Clinical Commissioning Group. Assessed that the Trust achieved a year-end settlement of 55% of the CQUIN value for 2014/15.

We were disappointed that our performance against the CQUINs has slipped when compared to previous years. A number of these key projects have been incorporated in our quality priorities for 2015/16 to ensure they are focused upon.
## GOALS AGREED WITH COMMISSIONERS

<table>
<thead>
<tr>
<th>CQUIN GOAL</th>
<th>COMMENT</th>
<th>MET</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Friends and Family Test</strong></td>
<td>We just missed the participation rate by a few patients in the last quarter of the year. We are using texting, voice messaging and volunteers to increase participation rates.</td>
<td>Partially met</td>
</tr>
<tr>
<td>Implementation and phased expansion of the Friends and Family Test.</td>
<td></td>
<td></td>
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<tr>
<td>NB: this relates to increasing rate of patients completing the Friends and Family Test (participation rate) in A&amp;E and inpatients; not the % of patients that would recommend our services.</td>
<td></td>
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</tr>
<tr>
<td><strong>Safety Thermometer</strong></td>
<td>We reduced the incidence of pressure ulcers by 36.3%.</td>
<td>Met</td>
</tr>
<tr>
<td>Reduction in the prevalence of newly acquired pressure ulcers.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dementia</strong></td>
<td>We missed the target for identifying 90% of patients with dementia who are 75 and over who are in our hospitals for 72 hours or more. There will be intense focus in 2015/16 to meet this target.</td>
<td>Failed</td>
</tr>
<tr>
<td>To incentivise the identification of patients with dementia to prompt appropriate referral and follow-up after they leave hospital.</td>
<td></td>
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<tr>
<td>Element: education</td>
<td></td>
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<tr>
<td>Element: leadership</td>
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<tr>
<td>Element: support</td>
<td>Once identified we have met the targets for assessment and referral to a specialist. We met the targets for clinical leadership and training. Strengthening the support we provide to carers is a key priority for 2015/16.</td>
<td>Met</td>
</tr>
<tr>
<td><strong>Timeliness and communication around discharge</strong></td>
<td>We missed some targets related to how we monitor TTOs. We have identified this as a key area of focus this year and have developed our information system to capture this data.</td>
<td>Partially met</td>
</tr>
<tr>
<td>Ensuring that staff, patient and carer expectations are aligned from the earliest point possible by improving communication.</td>
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</tr>
<tr>
<td>CQUIN GOAL</td>
<td>COMMENT</td>
<td>MET</td>
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<tr>
<td>Care 24/7</td>
<td>Increasing the level of care delivered outside normal office hours and to make an assessment of their appropriateness for the future. We reported on ward rounds and consultant cover during evenings and weekends. Increased diagnostic cover and pharmacy during evenings and weekends.</td>
<td>Met</td>
</tr>
<tr>
<td>Physician input into the care of surgical patients</td>
<td>Effective working including pre-optimisation, enhanced recovery and proactive discharge planning aims to improve the experience of patients, clinical outcomes and service performance. Due to staff vacancies we could not expand this service as envisaged from a five day to a seven day service in SEU or introduce it to vascular or neurosurgery. Recruitment drive is in progress to expand as planned. We did reduce length of stay by 10% for this patient group.</td>
<td>Failed</td>
</tr>
<tr>
<td>Integrated psychological support for patients</td>
<td>Substantial evidence exists that intervention can improve the outcome of patients with significant depressive illness in the context of malignancy. We reported the patients seen by service and by specialty, particularly the % and number seen within urgent and routine timescales. We met with commissioners quarterly to review performance.</td>
<td>Met</td>
</tr>
</tbody>
</table>
CARE QUALITY COMMISSION (CQC)

CQC registration (Statements of Assurance from Board) – in summary

Current registration status Registered without conditions

Any enforcement actions There have been no enforcement actions made by CQC

Periodic reviews and date of last review CQC inspection commenced on 25 February 2014

Rating: good

List of actions proposed to take N/A

Special reviews or investigations / actions proposed The Trust has not been subject to a special review under section 48 of the Health and Social Care Act 2008

The Trust did participate in the CQC’s thematic review of mental health crisis care. From this a national report on the state of mental health care across England is expected to be published.

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 new CQC process for inspecting hospitals focuses on five key questions.

1. Are our services and premises safe?
2. Are the services provided effective and ensure good patient outcomes?
3. Are we caring?
4. Is the organisation responsive to patients’ needs?
5. Is the Trust a well led organisation?

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

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

In February 2014, a planned inspection was undertaken by the CQC across all of the main hospitals of the Trust. The Trust was rated ‘good’ overall, except for A&E and surgery at the John Radcliffe site, which were rated as ‘requires improvement’. An action plan was agreed with the CQC and is being actively managed in the Trust. The CQC’s inspectors observed caring and compassionate staff throughout the four hospitals and noted many examples of good team working.

There are no enforcement orders made by the CQC in respect of Oxford University Hospitals NHS Trust.
DATA QUALITY

Service delivery, performance management and the planning of future services

Data quality
Clinicians and managers depend on good quality data to support and develop the quality of services provided. Data quality at OUH is seen as everybody’s responsibility. It also enables comparison with and benchmarking between different healthcare providers. We have an established data quality process which helps assure ourselves and our Trust Board that our data quality is high.

The aim of our data quality strategy is to have complete, accurate and valid patient information. This information is collected only as needed and held in a safe way according to information governance rules. We use validated NHS numbers on all patient records.

Improving data quality
During 2014/15 we have reinforced a number of measures to strengthen data quality.
• We have a programme of external and internal audits to check data quality. Our internal audits ensure that accuracy, validity, reliability, timeliness, relevance and completeness are all assessed.
• This Quality Account is validated by external auditors including checking of a sample of quality indicators.
• Each clinical Division is subject to a quarterly audit programme where internal audit identifies areas for improvement. Trends are monitored.
• Divisions also undertake a monthly programme of validation of key performance data underpinning the A&E four hour standard, the referral to treatment 18 week waiting time standard and the cancer waiting time standards.
• A programme of coding audits is undertaken by our coding department in collaboration with individual specialties.

Training
Our data quality groups work closely with our training team to ensure that current training meets the needs of the staff. We believe that staff involvement is of paramount importance in this approach. During 2014/15 we have further developed and updated our e-learning programmes.

NHS number and GP Practice Code Validity
The patient NHS number is a unique ten digit number that identifies the patient. It helps health staff find a patients’ health record and also helps identify the same patient in different health organisations and different parts of the country. We monitor the rate that we include NHS numbers in patients’ records extremely closely and work with clinical Divisions to strengthen our performance.

We submitted records during (2014/15) to the Secondary Uses Services30 (SUS) 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 are shown in the following table.

<table>
<thead>
<tr>
<th>Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>for admitted patient care</td>
<td>98.8%</td>
</tr>
<tr>
<td>for outpatients</td>
<td>99.7%</td>
</tr>
<tr>
<td>for accident and emergency</td>
<td>96.8%</td>
</tr>
<tr>
<td>of admitted patients have a valid GP Practice Code</td>
<td>100%</td>
</tr>
<tr>
<td>of outpatients have a valid GP Practice Code</td>
<td>100%</td>
</tr>
<tr>
<td>of patients admitted to the emergency department have a valid GP Practice Code</td>
<td>100%</td>
</tr>
</tbody>
</table>

NOTES:
30. SUS is the single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services. SUS data are held in a secure environment that maintains patient confidentiality to national standards.
Information governance toolkit attainment levels
Information governance (IG) ensures necessary safeguards for, and appropriate use of, patient and personal information. The Information Governance (IG) Toolkit is an online system allowing NHS organisations and partners to assess themselves against Department of Health information governance policies and standard. Our IG assessment score for 2014/15 was 91% with all requirements at level 2 or 3 giving the Trust a ‘Satisfactory’ rating (out of a possible range of ‘Unsatisfactory’ or ‘Satisfactory’). To ensure our staff are kept up to date we provide online and drop-in training sessions.

Clinical coding audit
Clinical coding translates the medical terminology written by the clinicians to describe the patient’s complaint, problem, diagnosis, treatment or reason for seeking medical attention, into national standardised codes. This information is used to monitor trends in health outcomes and also helps the Trust receive the correct payment for the care and treatment we provide.

In 2014/15 we were the subject of the Payment by Results clinical coding audit by the Audit Commission. Two areas were examined; diagnostic cardiology and endoscopy.

<table>
<thead>
<tr>
<th>% diagnoses coded incorrectly</th>
<th>% Procedures coded incorrectly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary 4.5%</td>
<td>Primary 7.5%</td>
</tr>
<tr>
<td>Secondary 7.1%</td>
<td>Secondary 15%</td>
</tr>
</tbody>
</table>

There was an increase in procedures coded incorrectly compared to last year, and actions to address the recommendations from this audit have been put in place.
Workforce profile

Oxford University Hospitals NHS Trust (OUH) is one of the largest providers of healthcare in the UK and is a leading teaching Trust. Employing in excess of 11,000 staff across all professions and disciplines, the Trust’s annual expenditure on pay accounts is approximately 58% of the total operating budget.

The largest single staff group is nursing and midwifery, which accounts for one third of the overall workforce, whilst medical and dental employees comprise just over 16%. The relative size of all main staff groups is shown in the diagram, right.

Over half of all staff are within the 26 to 45 age group, whilst one third are between the ages of 46 and 65. Predominantly, the workforce is female and just over one fifth are male. The majority of staff (almost two thirds) are employed on a full-time basis and the Trust operates a range of flexible working practices.

Recruitment and retention

Throughout 2014/15, and consistent with the workforce plan, substantive workforce capacity has increased. However, current capacity still represents a shortfall against the budgeted establishment, which was increased to match the 2013/14 out turn level. Within the context of staff recruitment and retention, the term ‘turnover’ is used to refer to the totality of ‘leavers’ from the organisation. This includes those moving within the sector (i.e. leaving OUH to continue employment in another NHS trust), those moving to a different sector and those leaving employment (e.g. due to ill health or retirement). The current overall turnover rate of 13.2% reflects an upward trend over the course of this financial year, which is commensurate with many other trusts of similar size and complexity.

The net increase in substantive workforce has been achieved through a marked rise in recruitment activity (and efficiency) across all main staff groups. However, as a consequence of continued retention issues in key areas, such as adult nursing, theatres and therapies, this increase in activity is not keeping pace with turnover. Therefore, shortfalls in capacity are being met (or partially met) through the continued use of bank and agency staffing.

In addressing the challenges associated with staff recruitment and retention there is no single remedy, or ‘quick fix’ solution, but actions are being taken which aim to address the key issues influencing the Trust’s ability to attract, recruit and retain good staff in the right numbers. Informed by a recruitment and retention summit conducted in 2014, combined with the analysis of other direct feedback obtained from staff via, for example, national and local staff surveys, and exit interviews, current initiatives and actions are focused in six key areas, namely:

- increasing substantive workforce capacity through continued national and international recruitment
- mitigating high cost of living
- applying targeted recruitment and retention incentives
- widening participation
- improving professional development opportunities and career advancement
- creating and sustaining the right environment.
Within the context of current and significant national staff shortages, which are predicted to continue for the foreseeable future, combined with the impact of additional pressures associated with the Trust’s geography and the local economy, reducing turnover and increasing and sustaining substantive staff capacity will remain challenging. The situation within OUH is consistent with similar problems being faced by most other NHS providers, which only serves to intensify the competition for staff in a static or diminishing health labour market.

**Engagement**

**Staff engagement**
The degree to which staff are effectively ‘engaged’ with the organisation is a key success criterion in meeting the Trust’s objectives and in ensuring the knowledge, skills, experience and innovation of teams and individuals are utilised to greatest effect. It is widely recognised that a workforce that is engaged, empowered and well led will provide better care and a more positive experience for patients and service users. Effective staff engagement is achieved in a variety of ways, but the principal enabler is establishing and maintaining an organisational culture which is built on shared values and common goals – this begins with the recruitment process.

**Values into Action**
Delivering Compassionate Excellence has been a key driver for several initiatives, under the banner ‘Values into Action’. These include Value Based Interviewing (VBI) which aims to test candidates’ alignment with the Trust’s core values, prior to final appointment. Throughout 2014/15 VBI continued to be applied and is now being widely employed in recruitment to all staff groups. The number of trained VBI interviewers continues to grow, with almost 300 members of staff trained in the technique across a broad range of directorates. The independent VBI evaluation report to be published in April 2015 positively reinforces the VBI technique as a valid selection tool in support of the overall recruitment and selection process.

Value Based Conversation (VBC) takes the VBI principles, skills and techniques, and applies them in the broader context of managers having quality ‘value based conversations’ with their staff in the workplace. A total of 228 individuals have attended the VBC training. Awareness videos for both VBI and VBC support ongoing promotion of the benefits of these initiatives.

OUH is continuously improving the quality of patient care through greater alignment of individual and organisational values. In adopting a value based approach to ‘customer care’ the aim is to encourage person-centred compassion and empathy in their interaction between staff and patients, families and visitors. The design of the ‘Delivering Compassionate Care’ programme, which is principally aimed at frontline staff, is in progress, and pilots in endoscopy, outpatients and theatres have started. One of the programme’s objectives is to provide staff with a better understanding and appreciation of vulnerability and the impact that staff behaviours and attitudes have on a vulnerable person.

**NHS Staff Survey**
OUH participates in the NHS Staff Survey, the outcomes of which are primarily intended for use by NHS organisations to consider feedback from staff regarding their experiences in the workplace. The findings of the Staff Survey are used in several ways, namely:

- as a measure of staff engagement, informing the Trust at organisational level on what is being done well and where to focus attention on improvement;
- at a directorate and Divisional level, to provide data on staff experience alongside indicators such as patient surveys, peer reviews, complaints and compliments, to inform and shape integrated plans to improve quality and patient experience;
- as a way to benchmark with comparable organisations.

The annual Staff Survey is structured around four of the seven pledges to staff associated with the NHS Constitution. In the 2014 National Staff Survey, 70% of OUH staff agreed or strongly agreed they would recommend their hospital to family and friends as a place to be treated, against a national average for all acute trusts of 65%. Staff motivation at work also ranked highly. Survey outcomes are considered alongside the feedback received from the Staff Friends and Family Test to form the basis of ‘Listening Events’ with OUH staff who are invited to contribute to the development and implementation of local Divisional and corporate improvement plans in response to issues raised. These events are now also more closely considering the link between staff and patient feedback.

The annual NHS Staff Survey is independently administered on the Trust’s behalf by Quality Health, such that it is statistically representative and confidential. All outcomes data are independently submitted to the Survey Co-ordination Centre.
STAFF

Staff Friends and Family Test
The degree to which staff are willing to recommend their organisation both as a place for their friends and families to be treated, and as a place to work, are strong indicators of staff engagement and motivation. These key areas of ‘advocacy’ are included within the annual NHS Staff Survey and also tested as part of the quarterly Staff Friends and Family Test (Staff FFT), which was first introduced in June 2014. The results, including free text comments provided by individuals, are reported at the Workforce Committee and disseminated through Divisional management structures.

With respect to the two key advocacy questions associated with the annual NHS Staff Survey, compared with the national scores the Trust’s performance is as follows.

Recommendation of the organisation as a place to be treated:

<table>
<thead>
<tr>
<th></th>
<th>OUH scores</th>
<th>National scores 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>67%</td>
<td>2013/14</td>
</tr>
<tr>
<td>2013/14</td>
<td>77%</td>
<td>2014/15</td>
</tr>
<tr>
<td>2014/15</td>
<td>70%</td>
<td>65% Highest 89% Lowest 38%</td>
</tr>
</tbody>
</table>

Source: HSCIC

Recommendation of the organisation as a place to work:

<table>
<thead>
<tr>
<th></th>
<th>OUH scores</th>
<th>National scores 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>54%</td>
<td>2013/14</td>
</tr>
<tr>
<td>2013/14</td>
<td>67%</td>
<td>2014/15</td>
</tr>
<tr>
<td>2014/15</td>
<td>58%</td>
<td>58% Highest 78% Lowest 32%</td>
</tr>
</tbody>
</table>

Source: HSCIC

The Trust strives to improve these scores, and therefore the quality of its services, by:
- using both the national Staff Survey and Staff FFT data to inform the internal peer review process;
- more widely publicising the data through local communication channels at ward level, to ensure it is more visible to staff;
- inviting staff to contribute to the development and implementation of local Divisional and corporate improvement plans.

Staff Survey focus groups held in early 2014 provided a good engagement opportunity for individuals and teams to review the results and determine local priorities for action.

Listening into Action
Listening into Action continues to be encouraged and applied as a conversation tool at local and corporate levels, enabling teams to become more directly involved in making change happen in their areas. Listening into Action events at Trust and divisional level in early 2014/15, will look in more detail at the results of the patient and staff experience data together, including the most recent Staff FFT outcomes.

Equality and diversity
The Trust complies with the Equality Act 2010 public sector equality duties and uses the Equality Delivery System (EDS2), developed within the NHS, as a means by which to review and improve the organisation’s equality performance. EDS2 grading is scheduled for July 2015 to allow targeted work to continue in areas which have been identified for improvement and for a robust evidence base to be gathered.

During 2014/15, the Trust has been developing an Equality, Diversity and Inclusion Strategy for 2015/18. This will be supported by an implementation plan and include the alignment of EDS2 and the new Workforce Race Equality Standard (WRES), which was introduced within the NHS in April 2015. The WRES has been developed to support trusts in meeting all their legal duties under the Equality Act and to support the delivery of EDS2.

All Trust workforce policies and procedures are ‘impact’ assessed prior to implementation, by means of an equality analysis, to ensure that any implications relating to equality and diversity are considered. Where it is required, corrective action is taken.

In May 2014, the Trust was accredited with the ‘two ticks’ disability symbol employer status for a further twelve months. This accreditation recognises commitment to good practice in employing disabled people. A further review of practice in this area will be undertaken in May 2015.

The Trust’s local target is for 90% of all staff to be recognised as ‘competent’ in their awareness of equality and diversity issues through level one training and subsequent competency-based assessment. The current level of attainment is 88%. The ‘Living Out Our Values’ message is being incorporated within equality and diversity training sessions and further work in this area will be carried out in 2015/16. Training sessions continue to be offered on a monthly basis across the four main hospital sites. Across the organisation, there are now 32 trained Bullying and Harassment Support Colleagues. The role of these Colleagues is to support individuals who consider they are experiencing inappropriate behaviour by others, but who may not wish to raise the matter formally.
STAFF

Staff health and wellbeing

A focused programme of sustainable initiatives under the umbrella of ‘staff health and wellbeing’ was delivered during 2014/15. Overseen by the Health and Wellbeing Steering Group, work has been undertaken to promote healthier lifestyle choices for all employees. The Trust Executive and all Divisions have embedded public health priorities within their business plans, and three key aims underpin the strategic and operational planning and delivery, namely: promoting healthy lifestyles to our patients, visitors and staff; creating a hospital environment that promotes health; and making population health integral to what we do.

The key areas have focused on delivering work programmes developed from staff feedback, staff surveys and NICE-led public health guidance. Initiatives are aimed at supporting staff to make small healthy changes, and concentrate on increasing physical activity by, for example, using newly designed walk to work and cycle routes; encouraging stair walking; pedometer challenges; lunchtime walks; charity physical activity events, and a range of onsite activity classes. Staff are also encouraged to join their local leisure facilities using reduced gym membership. The Trust has signed up to the Department of Health Responsibility Deal pledge to provide healthier staff restaurant menus and provide healthier choices.

Committed to improving mental health and wellbeing, the Trust promotes ‘managing stress, building resilience and promoting mental health’ training for all staff and, for 2015/16, has prioritised creating a ‘Mentally Healthy Workplace’, in conjunction with NHS employers. This initiative will be led by the Centre for Occupational Health and Wellbeing, which already provides access to reactive care, through counselling and psychiatric specialist support. This support will be further enhanced by the forthcoming implementation of an Employment Assistance Programme (EAP), which will offer staff a range of confidential advice and counselling services, and a new mindfulness research project is programmed for 2015.

In support of all of the Trust’s health and wellbeing initiatives, and to encourage ‘making the healthier choice the easier choice’ in all work areas, a number of staff are being trained as Health Champions. This will complement the successful ‘drop-in’ health promotion centre for patients, visitors and staff, which offers expert healthy lifestyle advice, information and signposting to external organisations.

Sickness absence management

The Trust’s sickness absence rate is lower than the average for the NHS, but higher than the local target of 3%. Over the past year, significant improvements have been made to the way in which sickness absence is managed. This is largely due to the application of a more robust absence management procedure, improved links to occupational health services, an increased focus on health and wellbeing initiatives, and the implementation the FirstCare absence management system, which fully integrates with local absence procedures and processes.

The introduction of an EAP in 2015 will complement the FirstCare system and further support a move away from an emphasis which is on absence management, and towards a greater focus on attendance improvement. Improved reporting of sickness absence, in real time (through FirstCare), combined with bespoke online accounts for each line manager, has enabled managers to act more quickly and consistently in supporting staff who are absent to return to health and work in less time than they have previously.

Divisional Attendance Improvement Meetings are held monthly in each clinical Division, where actions are identified to address the priorities specific to each Division. In addition, a Trust-wide Attendance Improvement Group meets each quarter to address pan-organisation priorities and enable sharing of best management practice.

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**Staff**

**Learning and development**

**Statutory and mandatory training**
All members of staff are required to complete certain categories of statutory and mandatory training, dependent on their role and specialisation. Over the past year statutory and mandatory training compliance continued to increase and the Trust’s target of 90% is expected to be achieved in 2015/16. To support the increase in compliance a number of system developments have been completed to enhance the management information and the learning experience. In particular, the shift away from more traditional teaching methods to the provision of e-learning modules has proved highly popular with staff and is increasing compliance. These developments were externally recognised when the Trust won the Best Public Sector Project in the UK Cloud Awards 2015 and when it was a finalist in the 2014 E-Learning Awards.

**Annual appraisal**
Following its launch in 2014, the electronic appraisals system is now being embedded in the organisation. This provides for a simpler and more convenient method by which to conduct and record the annual appraisal review, and reduces the associated administration burden. The online system utilises standardised templates for generic roles, while also remaining flexible to support individual needs.

Further appraisal training has been provided for both managers and staff, the aim of which is to ensure the appraisal conversation leaves individuals with a sense of recognition for their contribution, together with a clear personal development plan which is aligned to their individual objectives.

**Leadership and talent development**

The Trust has continued to support managers through the engagement and support of both the national and local Leadership Academy. Managers and leaders have accessed all the nationally-provided leadership programmes, from Nye Bevan (for senior leaders) through to the online e-learning Edward Jenner programme (for first-time / aspirant leaders). In October 2014, the Trust Board endorsed a proposed Leadership and Talent Development Strategic Framework, which aims to establish a means by which OUH will attract, identify, develop and retain leadership capability of the highest quality, at every level of the organisation. The principal objectives are to:

- define the leadership skills and behaviours needed to deliver organisational success and embed ‘compassionate excellence’ in the provision of the highest standards of patient care;
- ensure there is a diverse, capable and expanding leadership population across all levels and professions within the organisation;
- develop the collective multi-professional leadership capabilities across healthcare boundaries, which are underpinned by key leadership qualities, namely: service leadership; people / personal leadership; quality leadership; collaborative leadership;
- maximise and lever external resources available in the wider NHS at both local and national levels;
- implement a talent development framework that will identify existing and rising leadership capability;
- identify appropriate resources required for effective leadership and talent development.

The Framework will support the development of a number of leadership programmes in 2015.

OUH has been successfully re-accredited to host trainees from the NHS Graduate Training Scheme across a range of disciplines, including general management and finance. This has seen an increase in the number of trainees taking placements at the Trust.
Emergency readmissions within 28 days of discharge from hospital

The information on emergency readmissions provided by the HSCIC relates to the percentage of patients readmitted to a hospital in our Trust, within 28 days of being discharged (from a hospital which forms part of the Trust) during the reporting period; aged 0 to 15; and 16 or over.

The last version of the emergency readmissions information was released by HSCIC in April 2014 for 0 to 15 year old patients and in March 2014 for patients aged 16 years or older. The publications related to the reporting period up to 2011/12 and values are displayed in the table opposite. A section of the reporting period relates to the time before the Nuffield Orthopaedic Centre (NOC) and Oxford Radcliffe Hospitals (ORH) merged, hence the figures are depicted separately on the table.

Our emergency readmissions rate, for the reporting period up to 2011/12, was 9.52% for patients up to 15 years of age and 11.41% for patients over 16 years of age; both values were banded by HSCIC as the ‘national average lies within expected variation (95% confidence interval)’.

Source: HSCIC (released April 2014)

The next data download to the HSCIC is in September 2015.

<table>
<thead>
<tr>
<th>Age groups</th>
<th>Age groups</th>
<th>Age groups</th>
<th>Age groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) 0 to 15 (NOC)</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>(i) 0 to 15 (ORH)</td>
<td>8.51%</td>
<td>9.25%</td>
<td>9.52%</td>
</tr>
<tr>
<td>(ii) 16 or over (NOC)</td>
<td>10.32%</td>
<td>10.86%</td>
<td></td>
</tr>
<tr>
<td>(ii) 16 or over (ORH)</td>
<td>11.97%</td>
<td>11.73%</td>
<td>11.41%</td>
</tr>
</tbody>
</table>
The national clinical audits and national confidential enquiries respectively, which Oxford University Hospitals NHS Trust was eligible to participate in during 2014/2015, are as follows:

<table>
<thead>
<tr>
<th>ELIGIBLE NATIONAL CLINICAL AUDITS</th>
<th>OUH PARTICIPATION</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>Yes</td>
<td>100%</td>
</tr>
<tr>
<td><strong>CHILDREN</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy 12 audit (Childhood Epilepsy)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Diabetes (Paediatric) (NPDA)</td>
<td>Yes</td>
<td>*closes Tuesday 30 June, expected to be 100%</td>
</tr>
<tr>
<td>Paediatric Intensive Care Audit Network (PICANet)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td><strong>ACUTE CARE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>British Society for Clinical Neurophysiology (BSCN) and Association of Neurophysiological Scientists (ANS) Standards for Ulnar Neuropathy at Elbow (UNE) testing</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Fitting child (care in emergency department)</td>
<td>Yes</td>
<td>81%</td>
</tr>
<tr>
<td>Case Mix Programme (CMP)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Mental Health (care in emergency department)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>National Cardiac Arrest Audit (NCAA)</td>
<td>Yes</td>
<td>100%. All patients since 2011</td>
</tr>
<tr>
<td>National Emergency Laparotomy Audit (NELA)</td>
<td>Yes</td>
<td>29.5% Churchill Hospital and 46.7% John Radcliffe Hospital</td>
</tr>
<tr>
<td>Older people (care in emergency department)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Pleural Procedure</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>ELIGIBLE NATIONAL CLINICAL AUDITS</td>
<td>OUH PARTICIPATION</td>
<td>% CASES SUBMITTED</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td><strong>LONG-TERM CONDITIONS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult community acquired pneumonia</td>
<td>Yes</td>
<td>Data submitted for part 1 and part 3 but not yet validated. Data entry closed 31 May 2015</td>
</tr>
<tr>
<td>Diabetes (adult)</td>
<td>Yes</td>
<td>*closes 7 August 2015</td>
</tr>
<tr>
<td>Inflammatory Bowel Disease (IBD) Programme</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>National Audit of Intermediate Care</td>
<td>Yes</td>
<td>93%</td>
</tr>
<tr>
<td>National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>National Vascular Registry</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Rheumatoid and Early Inflammatory Arthritis</td>
<td>Yes</td>
<td>above average</td>
</tr>
<tr>
<td><strong>ELECTIVE PROCEDURES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective surgery (National PROMs Programme)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td><strong>CARDIOVASCULAR DISEASE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Congenital Heart Disease (paediatric cardiac surgery) (CHD)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Cardiac Rhythm Management (CRM)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Coronary Angioplasty / National Audit of PCI</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>National Adult Cardiac Surgery Audit</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>National Heart Failure Audit</td>
<td>Yes</td>
<td>*closed June 2015</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit Programme (SSNAP) post-acute organisational</td>
<td>Yes</td>
<td>80-89% Horton General Hospital and &gt;90% John Radcliffe Hospital for Q2</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit Programme (SSNAP) – clinical</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

---

**Legend:**
- **OUH:** University Hospitals
- **% CASES:** Percentage of cases submitted
<table>
<thead>
<tr>
<th>ELIGIBLE NATIONAL CLINICAL AUDITS</th>
<th>OUH PARTICIPATION</th>
<th>% CASES SUBMITTED</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RENAL DISEASE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renal replacement therapy (Renal Registry)</td>
<td>Yes</td>
<td>Data submitted for Q1 and Q2. Expected to be 100%</td>
</tr>
<tr>
<td><strong>CANCER</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bowel cancer (NBOCAP)</td>
<td>Yes</td>
<td>Data being validated. Expected to be &gt; 90%</td>
</tr>
<tr>
<td>Lung cancer (NLCA)</td>
<td>Yes</td>
<td>Data entry closed June 2015. Expected to be 100%</td>
</tr>
<tr>
<td>National Prostate Cancer Audit</td>
<td>Yes</td>
<td>Unknown. All records have been collected. Submission in progress</td>
</tr>
<tr>
<td>Oesophago-gastric cancer (NAOGC)</td>
<td>Yes</td>
<td>&gt; 90%</td>
</tr>
<tr>
<td><strong>TRAUMA</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major Trauma: The Trauma Audit &amp; Research Network (TARN)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>National Joint Registry (NJR)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Falls and Fragility Fractures Audit Programme (FFAP)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td><strong>BLOOD TRANSFUSION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Comparative Audit of Blood Transfusion Programme</td>
<td>Yes</td>
<td>83% patient information and consent and 100% sickle cell disease</td>
</tr>
<tr>
<td><strong>NATIONAL CONFIDENTIAL ENQUIRY INTO PATIENT OUTCOME AND DEATH (NCEPOD)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCEPOD – Tracheostomy</td>
<td>Yes</td>
<td>90% across all parameters</td>
</tr>
<tr>
<td>NCEPOD – Lower limb amputation</td>
<td>Yes</td>
<td>6 (86%), 4 (57%) case notes, 100% organisational questionnaires</td>
</tr>
<tr>
<td>NCEPOD – GI Haemorrhage</td>
<td>Yes</td>
<td>5 (100%), 4 (80%) case notes, 50% organisational questionnaires</td>
</tr>
<tr>
<td>NCEPOD – Sepsis</td>
<td>Yes</td>
<td>22% (clinical questionnaires) and 0% organisational questionnaires</td>
</tr>
<tr>
<td>We anticipate improvement in our disappointing submission rates in 2015/16 following a review of processes for data collection and submission.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)</td>
<td>Yes</td>
<td>No maternal deaths during this period</td>
</tr>
</tbody>
</table>
There was no data collection during 2014/15 for the following audits:

<table>
<thead>
<tr>
<th>Audits</th>
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<tbody>
<tr>
<td>Procedural Sedation in Adults</td>
</tr>
<tr>
<td>UK Parkinson’s Audit (previously known as National Parkinson’s Audit)</td>
</tr>
<tr>
<td>Non-invasive Ventilation – adults</td>
</tr>
<tr>
<td>National Audit of Dementia</td>
</tr>
</tbody>
</table>

Oxford University Hospitals NHS Trust was not eligible to participate in the following national clinical audits

<table>
<thead>
<tr>
<th>Audits</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Kidney Disease in Primary Care</td>
<td>Audit only applies to Primary Care</td>
</tr>
<tr>
<td>National Ophthalmology Audit</td>
<td></td>
</tr>
<tr>
<td>Pulmonary Hypertension (Pulmonary Hypertension Audit)</td>
<td></td>
</tr>
<tr>
<td>Prescribing Observatory for Mental Health (POMH)</td>
<td>Audit only applies to Mental Health</td>
</tr>
<tr>
<td>Prescribing Observatory for Mental Health (POMH)</td>
<td></td>
</tr>
<tr>
<td>Prescribing Observatory for Mental Health (POMH)</td>
<td></td>
</tr>
</tbody>
</table>
During 2014/15 reports on **29 National Clinical Audits** and one **National Confidential Enquiry** were published, reviewed by OUH and actions taken or planned. Examples of reports reviewed and actions taken are listed below.

<table>
<thead>
<tr>
<th>National clinical audit publications January to December 2014 presented to Trust Committees</th>
<th>Summary from report – best practice and actions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sentinel Stroke National Audit Programme (SSNAP)</strong>, Horton and July - Sep 2013, published January 2014</td>
<td>Specialist assessments continue to remain a key priority for the Horton General Hospital and scanning within 1 hour of arrival will need to be reviewed. Physiotherapy and speech and language therapy (SALT) will continue to be further reviewed with discharge.</td>
</tr>
</tbody>
</table>
| **Sentinel Stroke National Audit Programme (SSNAP)**, John Radcliffe: Jul - Sep 2013, published January 2014 | The key actions are:  
  • improve direct access to stroke unit  
  • revise the swallow screen tool to increase patients assessed. |
<p>| <strong>National Audit of Seizure Management in Hospitals (NASH2)</strong>, 30 consecutive cases from Jan 2013, John Radcliffe and Horton (reported separately), published January 2014 | NASH 2 set out the minimum mandatory requirements for management of patients with a seizure in A&amp;E. JR site and the Horton are in the average range when compared to all other hospitals. |
| <strong>Cardiac Rhythm Management</strong> Jan - Dec 2012 data, published January 2014 | Our practice is very much in line with other similar centres in the UK. |
| <strong>Renal Registry</strong> 2012 calendar year data, 16th Annual Report, published January 2014 | No variances in this audit which require action. These data show that Oxford has an excellent renal transplant record, making it an extremely economical service |
| <strong>National Paediatric Diabetes Audit</strong> 2011-12 (Core Report) published December 2013 and Complications Report published February 2014 | Action plan in place including a large-scale change to the clinic set-up and to ensure all patients see a dietitian once a year. |
| <strong>National Diabetes Inpatient Audit</strong> (NaDIA) Trust-wide audit on 17 September 2013, published March 2014 | Diabetes quality group established to progress service improvement initiatives. |
| <strong>BTS Paediatric Bronchiectasis</strong> John Radcliffe Oct - Nov 2013 data, published March 2014 | Children with bronchiectasis and ongoing symptoms will be seen by a respiratory physiotherapist to be taught chest clearance. Improvements will be made to physiotherapy access both locally and nationally. |
| <strong>Trauma Audit &amp; Research Network (TARN) Quarterly themed report:</strong> Core + Thoracic Injuries, data period 1 Apr 2013 to Dec 2013 except measures 3 and 4 which are 1 Apr 2011 to 31 Dec 2013, published March 2014 | Provided new training courses. Provided latest specialist equipment in A&amp;E. Improved reporting processes, mortality and morbidity meetings and increased links with our pre-hospital care partners. |
| <strong>BTS Paediatric Asthma Audit</strong> Nov 2013 data, published April 2014, JR Datix 2600, HG Datix 2596 | Appropriate use of diagnostic chest X-rays and antibiotics are given to children. The paediatric service would benefit from a designated specialist nurse to facilitate effective discharge planning. |
| <strong>National Adult Cardiac Surgery Audit</strong> (SCTS) consultant outcomes, published April 2014 (Apr 2010 - Mar 2013 data) | National activity remains high and the risk profile of patients continues to increase. Mortality rates continue to fall and Oxford cardiac surgery identified as a good unit with good surgeon-specific outcomes. |
| <strong>National Review of Asthma Deaths</strong> (NRAD), deaths from asthma occurring between Feb 2012 - Jan 2013, published May 2014 | The service will be working to develop a difficult asthma clinic with a specialist nurse in attendance, and will provide asthma education to patients. |</p>
<table>
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<tbody>
<tr>
<td><strong>National Care of the Dying Audit</strong> of Hospitals (NCDAH), May 2013 data, published May 2014</td>
<td>End of Life Care set as a priority for 2015/16.</td>
</tr>
<tr>
<td><strong>National Emergency Laparotomy Audit</strong> (NELA) – Organisational Report, July - October 2013 Data collection period, JR and CH, published May 2014</td>
<td>Will develop a pathway for all emergency laparotomy patients to include management of sepsis and enhanced recovery.</td>
</tr>
<tr>
<td><strong>NCEPOD Tracheostomy complications ‘On the Right Trach?’</strong> data period 25/2/13 - 12/5/13, report published June 2014</td>
<td>Gap analysis carried out. Multidisciplinary, cross Divisional steering group established to ensure compliance against recommendations.</td>
</tr>
</tbody>
</table>
| **Sentinel Stroke National Audit Programme (SSNAP)**, JR, Jan - Mar 2014 data, published July 2014 April - June 2014 data, JR and HGH published October 2014 | • Improve direct access to stroke unit through weekly breech meetings and specialist nurse to liaise regularly with the ED co-ordinator.  
• Increase Speech and Language Test (SALT) provision.  
• Improve recording of mood and cognition screening. This needs to be done at daily multidisciplinary meetings. |
| **TARN – Clinical Report II** (orthopaedic), data period 1 April 2013 - 31 March 2014, published August 2014 | Compliance with the major trauma protocols continues to increase. Consultant involvement is high with almost all open and pelvic fractures managed by orthopaedic trauma consultants. 7% increase in our compliance with the provision of soft tissue cover for open fractures, within 72 hours. |
| **National Joint Registry** 11th Annual Report, Jan - Dec 2013 data, published September 2014 | Lower audit participation consent rates, however, no other concerns were noted (either within the Trust or the individual surgeon level data). Steps to improve the audit participation consent rates. |
| **National Hip Fracture Database** Jan - Dec 2013 data. JR and HGH: Trauma and Geratology, published September 2014 | The audit results were able to confirm that the service delivered is in line with the national average. |
| **National Lung Cancer Audit Report** (Mesothelioma), 2008 - 2012 data, published September 2014 | This important national audit assessed the quality of current care for patients with mesothelioma. The OUH remains committed to reviewing the following:  
• Measuring the time from referral to diagnosis, aiming to be better than the national average of 28 days  
• Auditing the number of patients who are suitable for chemotherapy and are offered chemotherapy  
• Auditing the number of patients who are seen by a lung nurse specialist during their treatment and when they are told the diagnosis of mesothelioma |
<p>| <strong>Lung Cancer Consultant Outcomes from the day National Lung Cancer Audit</strong> published October 2014 | The audit results showed that OUH had one of the highest resection rates in the whole of England with zero 30 deaths. The Trust has been an example of excellent practice, and it is estimated that over 5,000 more lives per year could be saved in patients with lung cancer if all centres adopted similar resection rates to the Trust. |
| <strong>Adult Coronary Interventions / Angioplasty / PCI</strong> 2013 calendar year data, national audit report, JR and HGH published December 2014 | The Trust is performing well within the indices presented in the clinical audit. The call-to-balloon (CTB) target of 150 minutes is met in 80% of cases. The door-to-balloon time, which reflects factors that OUH can influence, is amongst the fastest in the country at 26 minutes (time to receive treatment when a patient arrives at the hospital). |</p>
<table>
<thead>
<tr>
<th>National clinical audit publications January to December 2014 presented to Trust Committees</th>
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</thead>
<tbody>
<tr>
<td><strong>Inflammatory Bowel Disease (IBD): Inpatient care and experience (adult – JR and HGH), Jan - Dec 2013 data, published June 2014</strong></td>
<td>The JR performs well: it is one of only five out of 173 centres in the UK that meets all key indicators of care and is one of the busiest in the country. The service is committed to increasing specialist nursing support, diabetic provision and integrating psychological medicine sessions (mental and physical health) into IBD care.</td>
</tr>
<tr>
<td><strong>Inflammatory Bowel Disease (IBD): Organisational audit (adult), data collection period: 3/2/14 - 31/3/14, published September 2014</strong></td>
<td>Compared to other UK hospitals the OUH was able to demonstrate that patients have access to dedicated specialist nurses and dietetic support. Patients were cared for by specialist teams and young patients are also supported through the transition to adult care.</td>
</tr>
<tr>
<td><strong>NHS Blood &amp; Transplant data period 04/2004 - 03/2014, published September 2014:</strong></td>
<td>The number of patients waiting for kidney transplant in Oxford has been stable and the waiting time for a kidney transplant is 852 days which is shorter than the national average waiting time. The one and five year patient and graft survival following a kidney transplant in Oxford is comparable to the rest of the country.</td>
</tr>
<tr>
<td><strong>Corolectal Surgery Consultant Outcomes from the National Bowel Cancer Audit (NBOCAP), published October 2014</strong></td>
<td>90-day outcomes are within acceptable range. However the service will ensure that robust data collection and validation are undertaken for future audits.</td>
</tr>
<tr>
<td><strong>National Paediatric Diabetes Audit (NPDA), data period 2012 - 13, Part 1: Care Processes and Outcomes, published October 2014</strong></td>
<td>HbA1c levels less than 58 mmol/mol indicate good glycaemic levels and as such are defined by NICE as excellent diabetes control. The Trust continues to have good HbA1c outcomes; sixth in the country of 210 units.</td>
</tr>
<tr>
<td><strong>Oesophageal Cancer National Audit reports: for patients diagnosed Apr 2012 - Mar 2013, treatment intent palliative published 30 Sep 2014, and patients managed with curative intent, published November 2014</strong></td>
<td>Newly diagnosed cancer ascertainment rate recorded in the audit was in the range 61-80%. 8.2% of cancers were diagnosed at an early stage compared to 5.4% nationally, and the numbers of endoscopic procedures undertaken for early stage disease has increased significantly over the past 3-4 years.</td>
</tr>
<tr>
<td><strong>Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP) published December 2014</strong></td>
<td>Improvements have been made to hospital and ambulance transfer times. Oxfordshire and surrounding counties remain constrained by geography. Work continues to educate and support ambulance personnel with early diagnosis and rapid transfer of patients for PCI to demonstrate continued improvement in call (for help) to arrival (of the ambulance at the hospital door) time. Explore a business case to support expansion of the Cardiology Advanced Nurse Practitioner outreach role. Aim is to facilitate early intervention, treatments and ongoing management by cardiology medical teams for people with heart attacks and other heart problems.</td>
</tr>
<tr>
<td>National clinical audit publications January to December 2014 presented to Trust Committees</td>
<td>Summary from report – best practice and actions</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>TARN, clinical report III</strong> (Head &amp; Spinal Injury), data period 1.4.14 to 30.9.14, published December 2014</td>
<td>This report demonstrates a significant increase in data completeness, which has increased to 104.4% (for the period 1st April 2014 to 30 September 2014) from the previous score of 88.3% (for the period 1 April 2013 to 31 March 2014). For patients with head and spinal injuries, work is continuing to improve the documentation to evidence and educate medical teams about the definition of trauma injury severity score. Work will continue to highlight elderly non-traumatic cases within the neuro department and spinal patients with the decrease of consultant attendance to spinal cord injuries.</td>
</tr>
</tbody>
</table>
During 2014/15 OUH has undertaken 287 registered local clinical audits. The following list shows examples of local clinical audits completed during 2014/15, 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>Title</th>
<th>Audit summary / actions</th>
</tr>
</thead>
</table>
| Clinical Support Services      | Audit of the Microbiology / Infectious Diseases Bacteraemia Consult Service for the management of patients with bacteraemia due to multidrug resistant (MDR) E. coli | Areas for improvement include:  
  • laboratory SpR / consultant use of ePR to document advice given regarding bacteraemia patients  
  • change of consult template to include ‘Responsible Consultant’, ‘Course length / Stop date’ and ‘Follow-up sections’  |
| Clinical Support Services      | Audit of lymph node yield                                             | This demonstrated optimal performance in local practice.                                                                                                                                                                                                                                                                                                |
| Clinical Support Services      | Trust fire, resuscitation and radiation protection policy             | A communication strategy is required to ensure all staff are aware of the Radiation Protection Advisor (RPA) personnel.                                                                                                                                                                                                                                    |
| Clinical Support Services      | Thames Valley regional audit of compliance with the Public Health England toolkit for detection and control of carbapenamase-producing Enterobacteriaceae (CPE) | Full compliance in the laboratory procedures and only minor non-compliances in infection control. Adjustments needed to increase the isolation facilities and compliance with CPE colonisation screening.                                                                                                      |
| Medicine, Rehabilitation and Cardiac | Secondary prevention following coronary artery bypass grafting (CABG): are we compliant with the guidelines? | Plans are in place to improve the training of junior doctors in secondary prevention post-CABG and to regularly distribute the latest guidelines to the multidisciplinary team.                                                                                                      |
| Medicine, Rehabilitation and Cardiac | Use of laxatives in conjunction with regular opioid use on medical wards and general surgical | Areas for improvement include:  
  • better use of the Bristol Stool Chart  
  • identify a separate section on drug charts for opioids to encourage laxative prescription / or flag-up system to encourage doctors to assess need for laxatives  
  • drafting a local protocol / medicine information leaflet.  |
| Medicine, Rehabilitation and Cardiac | NICE CG134 Anaphylaxis                                                | A&E and the adult allergy clinic have developed a patient information leaflet to be given to patients on discharge. Work is also underway reviewing the paediatric patient pathway.                                                                                                         |
| Medicine, Rehabilitation and Cardiac | NICE CG32 Nutrition                                                  | Areas for improvement have been identified as:  
  • the Malnutrition Universal Screening Tool (MUST) to be completed within 12 hours of admission  
  • all patients identified to be at risk of malnutrition to have a nutrition care plan.  |
| Medicine, Rehabilitation and Cardiac | NICE CG42 Dementia                                                   | The following are new initiatives derived from the audit:  
  • a feedback questionnaire for carers of patients with cognitive impairment is being used within Trauma  
  • a new style questionnaire is being developed in conjunction with Carers Oxfordshire. This is a quality priority for 2015/16.  |
<table>
<thead>
<tr>
<th>Division</th>
<th>Title</th>
<th>Audit summary / actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery and Oncology</td>
<td>An audit of blood transfusions within Sobell House</td>
<td>A form will be developed specifically for blood transfusions. This will have all information in one place and will help inform if further transfusions are likely to be of benefit or whether alternative intervention would be more appropriate.</td>
</tr>
<tr>
<td>Surgery and Oncology</td>
<td>Achievement of International Normalised Ratio (INR) levels in a haemodialysis subset of patients</td>
<td>This audit was undertaken to assess whether warfarinised patients currently undergoing haemodialysis are achieving therapeutic INRs. Only 5/12 patients achieved a time in the therapeutic range. Changes in how warfarin is prescribed in the haemodialysis unit have been proposed to improve care.</td>
</tr>
<tr>
<td>Surgery and Oncology</td>
<td>Peritoneal dialysis (PD) audit</td>
<td>PD catheter insertion outcomes are in line with the renal association standards. Peritonitis and exit site infection rates are low and have been stable over the last five years. Ongoing training of patients and staff remains a priority.</td>
</tr>
<tr>
<td>Surgery and Oncology</td>
<td>Audit into the dosing of Dalteparin for the treatment of venous thromboembolism in pregnancy</td>
<td>Compliance with documenting risk factors for VTE was good and had improved from the previous audit.</td>
</tr>
<tr>
<td>Surgery and Oncology</td>
<td>Documentation of preferred place of care: re-audit</td>
<td>The Sobell House Specialist Palliative Care Team was only slightly under the gold standard 90% threshold for documenting that the preferred place of care (PPC) discussion was offered. This was an improvement on the previous audit undertaken in November 2013.</td>
</tr>
<tr>
<td>Surgery and Oncology</td>
<td>Communication between the Early Phase Trials Team and patients’ GPs / referring consultants</td>
<td>The following initiative will improve the communication: • draw up formal plan of when letters should be dictated • at the weekly Trials meeting checks will be made to ensure letters have been done, if applicable.</td>
</tr>
<tr>
<td>Surgery and Oncology</td>
<td>Compliance with deep vein thrombosis (DVT) extended prophylaxis guidelines</td>
<td>Posters were produced and displayed to increase awareness of the NICE guideline. A re-audit showed a significant improvement in compliance.</td>
</tr>
<tr>
<td>Surgery and Oncology</td>
<td>Management of diabetes in the last days of life</td>
<td>Following actions have been identified: • improve documentation of past medical history and co-morbidities in the front section of patients’ notes • check that local guideline has been incorporated into usual practice by re-audit • check by re-audit that advice on insulin dose reduction is appropriate for patients who may live a few more days.</td>
</tr>
<tr>
<td>Children's and Women's</td>
<td>NICE QS37 Postnatal care</td>
<td>Improvements will be put in place for the following: • individualised care plans • patient information regarding formula feeding • discussion of safe sleeping at every postnatal contact.</td>
</tr>
<tr>
<td>Children's and Women's</td>
<td>NICE CG150 Headache in Paediatric Practice</td>
<td>The paediatric service has developed a standardised assessment form giving clinicians a more structured and comprehensive approach to their evaluation of these patients. A headache diary will be given to eligible patients as part of their follow-up.</td>
</tr>
<tr>
<td>Division</td>
<td>Title</td>
<td>Audit summary / actions</td>
</tr>
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</tr>
<tr>
<td>Surgery and Oncology</td>
<td>NICE CG166 Ulcerative colitis</td>
<td>Good to excellent (71-100%) compliance with the audit standard. For future data collection a table of criteria and associated risk of colectomy label has been produced. This will be used on admission and placed in the medical notes.</td>
</tr>
<tr>
<td>Trust-wide</td>
<td>WHO surgical safety checklist</td>
<td>The results of the audit have shown that the Trust is within reach of achieving the ‘gold’ standard of 100% compliance in all aspects. Each clinical areas will be reviewing their documentation process to increase compliance.</td>
</tr>
</tbody>
</table>
| Trust-wide         | Health Record Keeping Standards                | The ‘gold’ standard for high quality documentation will be when all indicators achieve 90% compliance. The Trust is working to exceed the minimum compliance level by:  
• ensuring clear documentation of the decision-making process and steps to make this more intuitive  
• ensuring that discharge planning is in place. Independent assurance by the Discharge Assurance and Oversight Group will confirm this.                                                                                                                                                                                                                                                                                                                                                                                                 |
| Trust-wide         | Consent                                        | Each Division collected data in order to demonstrate compliance with the consent process, in all cases. All clinical areas are reviewing their documentation process to improve the compliance.                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Trust-wide         | Consultant standards for inpatient care        | Each clinical area will be reviewing their documentation processes to ensure:  
• clear documentation that patients are assigned to a named consultant on admission  
• the consultant has seen the patient within 18 hours of admission.                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| Trust-wide         | Venous Thromboembolism (VTE)                   | The Trust will be working to make the following improvements.  
1. Promote the availability of the VTE business cards for every adult patient at discharge  
2. Improve VTE risk assessment figures and times taken to risk assessment. The risk assessment tool will be mandated on EPR once EPR changes are possible (end 2015).  
3. Implement EPR method of ensuring VTE risk assessment is followed once completed  
4. Compliance with anti-embolism stockings  
5. Work with patient safety to develop admission cards for adult patients  
6. Improve access for Divisions to VTE awareness business cards for every adult patient at discharge.                                                                                                                                                                                                                                                                                                                                                                                                               |
APPENDIX 3: STATEMENTS

Statement of Directors’ Responsibilities in respect of the Quality Account

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (in line with requirements set out in Quality Accounts legislation).

In preparing their Quality Account, Directors should take steps to assure themselves that:

• the Quality Account presents a balanced picture of the Trust’s performance over the reporting period
• 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 they are working effectively in practice
• the data underpinning the measure of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review
• the Quality Account has been prepared in accordance with any Department of Health guidance.

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

By order of the Board

Date: 30 June 2015. Chair

Date: 30 June 2015. Chief Executive
EXTERNAL REVIEW STATEMENTS

Statement from Health Overview and Scrutiny Committee (HOSC)

Dear Ruth,

Re: Quality Accounts 2014-15

HOSC considered OUHT Quality Account 2014/2015 at its meeting on 23rd April 2015 noting with approval improvements in a wide range of services.

Questions were asked about whether quality improvement priorities for 2015/16 will differ from the current year, and why there are no longer “top priorities”? We were informed that patient safety, clinical effectiveness and patient experience will be the main priorities aiming to improve the handover processes between Health and Social Care, as well as progressing topics from 2013/14.

To be sure of a focus on getting the basics right, the Committee requested to see the final quality report highlighted as part of Oxfordshire’s Joint Strategic Needs Assessment, with special mention of the importance of improving the A&E waits, and were assured all topics will be met by the end of this year.

It was noted that there was only one reference to cancer and to psychological services which it considered to be of high importance. HOSC was assured cancer treatment was being validated and that the Trust will meet most of the targets which are monitored.

Though there were comments about the report being difficult to read, HOSC accepted that the executive summary was very readable and welcome the final report.

Yours faithfully,

Cllr Yvonne Constance OBE
Chairman Oxfordshire Joint Health Overview & Scrutiny Committee

Ruth McNamara
Interim Clinical Governance Manager (Quality Account)
Oxford University Hospitals Trust

21 May 2015

Statement from Oxfordshire Clinical Commissioning Group (OCCG)

OCCG has reviewed the Oxford University Hospitals (OUH) Quality Account and believe that the information it provides is accurate. The OUH is a large NHS organisation that covers many services and, as a consequence, OCCG recognises that this document will never fully be able to provide the public with full assurance about the quality of NHS services. This Quality Account does highlight many of the challenges faced by the Trust and describes areas of quality improvement work which have been undertaken.

OCCG is committed to commissioning high quality care for the population of Oxfordshire. OCCG is therefore extremely pleased to see that one of the priorities set is around partnership working to improve urgent and emergency care. In order to achieve the NHS constitution standard for A&E waits, organisations need to improve how they work together. OCCG is pleased to see that the OUH has priorities that match up with national CQUINs around acute kidney injury and sepsis despite this not being a contractually obligation.

OCCG feels that one of the biggest quality challenges facing the OUH is their interface with patients and primary care and it is good to see that this is being addressed for 2015/16. Discharge summaries are often not sent in a timely manner and OUH clinicians do not always follow up on the tests that they request. This is covered by one of the priorities set by OUH, but OCCG feel that the OUH could be more explicit in describing the safety aspect of this problem and why it is important. OCCG also believe that the OUH priority set in last year’s Quality Account focusing on the difficulties patients face booking appointments remains an important issue. The priorities set for both 2014/15 and 2015/16 would benefit greatly from outcomes being more measurable.

The OUH has been open in identifying many of their challenges, including the high number of Never Events. The work currently being undertaken to provide human factors training for more staff is welcomed by the CCG.

It is important to note successful quality improvement within the Trust. The improvement to the diabetes pathway as a result of increased staffing levels and training means that patients with diabetes are getting better care. The emphasis that the Trust gives to clinical audits and NICE guidance also shows that the Trust is focused on delivering evidence-based best practice.

The Oxford University Hospitals Quality Account is laid out in a good format that allows the reader to navigate through the document and the language avoids the use of jargon. OCCG look forward to continue to work together with the OUH to deliver high quality care for the patients of Oxfordshire.

Overall, OCCG believe that this Quality Account should give readers confidence that the Trust is being open and honest about the quality of services being provided across the organisation and is committed to driving continuous quality improvement.
Sir Jonathan Michael,
Chief Executive,
Oxford University Hospitals Trust.

May 8th 2015

Dear Sir Jonathan,

Ref OUHT Quality Account for 2015/16

Thank you for inviting us to comment on the Trust’s Quality Account for 2015/16. The issues raised about OUHT with Healthwatch Oxfordshire this year have primarily related to:

1. The Trust’s ongoing failure to meet NHS Constitution pledges on:
   - The A&E four hour wait.
   - 18 week referral to treatment time targets.
   - 62 cancer treatment time targets.
   - Patients being offered a binding date within 28 days following operations cancelled for non-clinical reasons.
   - Making patients’ transition as smooth as possible between services.
   - Putting patients and their carers at the heart of decision making about care that affects them.
   - Failures and delays in patients receiving copies of correspondence about their care.

2. The Trust’s ongoing failure to work successfully with its partners to resolve the poor performance on hospital discharge.

3. Poor communication at all stages of the patient pathway between clinicians, between organisations and with patients - particularly but by no means exclusively with those patients who have specific access needs.

In addition, through the Trust’s active involvement in our multi-agency Quality and Patient Experience leads meeting, we have jointly identified with you and other partners a set of 8 quality improvement priorities for the whole Oxfordshire health and social care system, based on our collective analysis of service user feedback.

These shared priorities are to improve:

- How well care is joined up, when it is being delivered by a range of health and/or social care providers.
- Communication between different organisations within the system about individual patients.
- Communication by all parts of the system with patients and carers, both in terms of staff attitudes, involvement of people in decision making about their care and delivery of dignity standards.
- Carer involvement in care planning and care delivery.
- Treatment of patients with physical and mental health needs.
- How well the psychological component of all healthcare is recognised and met.
- How able staff, carers and patients feel to raise concerns or complaints without fear of retribution.
- Public education about how to use the NHS wisely and how to look after oneself when that is the most appropriate thing to do.

In this context Healthwatch Oxfordshire welcomes the fact that the Quality account references these joint priorities. We also welcome the commitments made in the 2015/16 Quality Account to:

- Improve clinical handover in the hospital and interface with GPs.
- Improve discharge co-ordination and sharing of discharge information.
- Improve communication with patients and carers.
- To enhance the quality and timeliness of assessments for the frailest patients.
- Make pathways clearer.
- Assess and support the MH needs of patients.
- Reduce A&E attendances and avoidable admissions.

Healthwatch Oxfordshire was however extremely disappointed to learn that many of the Trust’s longstanding failures to meet NHS Constitution pledges were not successfully addressed through the delivery of the 14/15 Quality Account priorities. We would also like to have seen a much clearer focus and much higher priority on improving performance against these basic NHS Constitution pledges in the Quality Account for 2015/16.

We have established a good relationship with the Trust since 2014/15 and you have been open to working with us on patients’ behalf. We were glad to see an ongoing commitment to working with us and we look forward to continuing to both support and challenge you in the year ahead, in the interest of helping you get these basics right for local people.

Yours sincerely

Rachel Coney
Chief Executive
INDEPENDENT AUDITORS’ LIMITED ASSURANCE REPORT TO THE DIRECTORS OF OXFORD UNIVERSITY HOSPITALS NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required to perform an independent assurance engagement in respect of Oxford University Hospitals NHS Trust’s Quality Account for the year ended 31 March 2015 (“the Quality Account”) and certain performance indicators contained therein as part of our work 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 2015 subject to limited assurance consist of the following indicators:
• Percentage of patient safety incidents that resulted in severe harm or death on pages 38-40; and
• Rate of clostridium difficile infections per 100,000 bed days on pages 50-51.

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.

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 2014/15 issued by the Department of Health; 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 2014 to June 2015;
• papers relating to quality reported to the Board over the period April 2014 to June 2015;
• feedback from the Commissioners dated 01/06/2015;
• feedback from Local Healthwatch dated 08/05/2015;
• the Trust’s complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated 10/09/2014;
• feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
• the latest national patient survey dated 21/05/2015;
• the latest national staff survey dated 11/03/2015;
• the Head of Internal Audit’s annual opinion over the trust’s control environment dated 27/04/2015;
• the annual governance statement dated 03/06/2015; and
• the Care Quality Commission’s quality and risk profiles dated July 2014, December 2014 and May 2015; and
• any other relevant information included in our review.
INDEPENDENT AUDITORS’ REPORT

INDEPENDENT AUDITORS’ LIMITED ASSURANCE REPORT TO THE DIRECTORS OF OXFORD UNIVERSITY HOSPITALS NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

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. 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 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 2014:

• 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 testing 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 LLP
Apex Plaza, Forbury Road, Reading, RG1 1YE
29 June 2015.
ACKNOWLEDGEMENTS AND FEEDBACK

Acknowledgements
Oxford University Hospitals NHS Trust wishes to thank corporate and Divisional teams for their contribution to the production of the Quality Account 2014/15. Equally, the Trust would like to acknowledge the invaluable contribution of those who supported the public engagement event on 4 June 2015 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. Please contact our Media and Communications Unit.

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