CONTENTS

Part 1: STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE 03

Part 2: PRIORITIES FOR IMPROVEMENT 2016/17 AND STATEMENTS OF ASSURANCE FROM THE BOARD 06

Part 3: PROGRESS AGAINST THE PRIORITIES 2015/16 AND OTHER INFORMATION 57

Statements from NHS England or relevant clinical commissioning groups, local Healthwatch and overview and scrutiny committees
Statement of directors responsibility in respect of the quality report 74
PART 1: STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE 2015/16

In our Quality Report we set out the way Oxford University Hospitals NHS Foundation Trust (OUH) improves quality and safety.

In order to achieve our objective of delivering compassionate excellence to our patients, we work with our health and social care partners to make sure that when we fall short in meeting the standards we expect, we learn from our mistakes to improve services in the future.

In October 2015, OUH was authorised as an NHS foundation trust. A crucial part of Monitor’s assessment of the Trust’s suitability to operate with greater autonomy was scrutiny of our arrangements to govern the quality of the care we provide.

In early 2015 the Trust started a programme to improve its systems to escalate incidents, to speed up reporting, encourage openness and transparency, embed the Duty of Candour and to obtain and disseminate the learning from incidents. Practical developments have included a weekly forum involving clinical representatives from each Division which looks at all serious incidents and considers Trust-wide learning from these.

At OUH we joined the national Sign Up to Safety campaign and for us, a priority area within Sign Up to Safety has been to prevent avoidable patient deterioration and harm in hospital. We have developed an electronic “Track and Trigger” system to help our staff recognise when a patient’s condition deteriorates and to enable prompt action to be taken. The roll out of this ground-breaking system, known as SEND, across all our sites is nearing completion.

Focus has continued during the year on reducing hospital-acquired pressure ulcers and preventing falls. In both areas, support networks have been set up for clinical staff, with tissue viability link nurses and falls champions trained and supported. A new team of quality improvement educators has also been established.

Another area of focus has been our Future Leaders Programme for newly-appointed consultants, which concentrates on improving quality and safety.

We also continued the work we had started the previous year to focus on improving inpatient care for patients who have diabetes. After investment in doctors, nurses and podiatrists to support the care of inpatients with diabetes throughout OUH, a service was established to provide training, advice and input to clinical teams Trust-wide. Welcome improvements have been seen in OUH’s performance in the latest national audit of the care of inpatients with diabetes.
There have been a number of external recognitions of the high quality of care provided in our Trust over the last year. One such was the highlighting in a King’s Fund report of the work of the Oxford Psychological Medicine Service, which has expanded its team and services to patients over the last two years. The report focused on the way the service delivers integrated care for patients.

In 2015/16 the Neurosciences Nursing Team won the Nursing Times Award for Emergency and Critical Care. The award recognised the team’s outstanding patient experience programme. The support for subarachnoid haemorrhage patients after discharge involves all of the team from the Neuro Intensive Care Unit, wards and the community. In genetics, the OUH was designated a Genomics Medicine Centre in 2015, and the OUH-University of Oxford partnership has made major contributions to the ‘100,000 Genomes’ project, with Genomics England.

We have also focused on improving the quality of the patient environment. This year our respiratory inpatient services have been relocated to the John Radcliffe Hospital site from facilities in the old area of the Churchill Hospital. This has the benefit of improving the patient experience and better supporting respiratory care on the John Radcliffe Hospital site.

We very much regret that in 2014/15 six patients and in 2015/16 seven patients receiving care from OUH experienced patient safety incidents categorised by NHS England as Never Events. These are events characterised by the NHS as events that should not happen if procedures are correctly followed.

My predecessor as Chief Executive, Sir Jonathan Michael, commissioned an independent expert in patient safety, Professor Brian Toft, to conduct an external review of the Trust’s investigations into these incidents. Professor Toft’s report concluded that no evidence had been found to suggest that a patient safety problem existed within the Trust and that evidence strongly suggested that the Trust has a proactive safety culture. The review also found that the Trust’s commitment to openness with respect to serious incidents and Never Events was exemplary.

Although this conclusion was welcome, we nonetheless constantly look at ways of improving the culture of patient safety. This year we have extended the training of staff in Human Factors (HF) relevant to patient safety, particularly in simulated and real operating theatre settings. We have also published relevant clinical policies, updated local guidance on the use of the World Health Organization’s surgical safety checklist and revised and publicised surgical safety procedures.

The Trust is held to national standards that help measure the quality of care that we deliver to our patients. During 2015/16, OUH has not consistently achieved the national standard of admitting, discharging or transferring 95% of patients within four hours of arrival at our Emergency Departments. Since December 2015 we have been working closely with health and social care commissioners and providers across Oxfordshire to ensure patients will be cared for in the right place for their needs.

OUH has also not met the standard we agreed for providing rapid discharge summaries to GPs and our internal aim to sign off test results within one week. In both areas there has been substantial improvement – for which we thank our staff – but more work is needed. We have taken action to resolve technical issues and to raise the profile of these important expectations amongst clinical staff Trust-wide.

We have continued to work hard to protect our patients from hospital-acquired infection. The number of patients acquiring Clostridium Difficile during their hospital stay continued to be below the level set for OUH. However, the zero level of MRSA infections deemed ‘avoidable’ was not met, with three cases apportioned to the Trust during 2015/16.
Good progress has been made during the year on providing planned care, diagnostics and cancer treatment within national standards. Where necessary, additional capacity has been put in place and services have responded to changing patterns of demand.

We believe that looking after our staff helps them to provide the high quality care that we want to see being delivered. Activities have continued this year to support staff health and wellbeing, including the training of wellbeing champions to support colleagues’ mental wellbeing and the making of exercise and healthy food choices more easily available.

OUH has joined the international MAGNET accreditation process which, through support for good communication, education and career development, is intended to support its nurses and midwives in promoting clinical quality, improving outcomes for patients and supporting excellence in practice. This Quality Account, as well as looking back on how we performed against our standards and priorities in 2015/16, also looks ahead to next year’s priorities. The quality priorities for 2016/17 build on those we have previously been working on, with new areas of focus such as End of Life Care and some informed by national Commissioning for Quality and Innovation (CQUIN) standards.

OUH was delighted to receive funding from the Sobell House Hospice Charity to raise awareness and skills in services across the Trust in supporting people approaching the end of their lives, and their carers. A programme of End of Life Care development will take place during 2016/17.

Our work to improve quality stems from awareness that high quality care is best for our patients, for their families, for our staff who want to deliver compassionate and excellent care, and for those who fund and commission our services who want to see best use made of NHS resources.

I am responsible for the preparation of this report and its contents. To the best of my knowledge, the information contained in this Quality Account is accurate and a fair representation of the quality of healthcare services provided by Oxford University Hospitals NHS Foundation Trust.
INTRODUCTION

NHS foundation trusts should include a report on the quality of care they provide within their annual report. The quality report incorporates the 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 Foundation 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.

PART 2: PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

Our quality priorities for 2016/17
The Trust is committed to the delivery of compassionate and excellent patient care. Our mission is to provide excellent and sustainable services to the people of Oxfordshire and to patients who come to the Trust in order to access specialist regional, national and international care which may be unique to our Trust. Our quality of care has its foundation in the commitment of our staff to their patients and the focus on future excellence which is the essence of our clinical strategy and our research and training programmes.

How we chose our priorities
Throughout 2015/16 we have been updating our staff, our CCG and other stakeholders about our quality priorities for the year. We have agreed, based on our qualitative look back on progress of the 2015/16 priorities, that work will continue on most of our previous quality priorities – particularly in five areas where we wish to avoid patient harm and deterioration wherever possible, and in our focus on partnership and patient experience.

The Oxford University Hospitals NHS Foundation Trust Sign Up to Safety pledges and corresponding patient safety improvement plan were interwoven with the 2014/15 Quality Improvement priorities and workplans. It is anticipated that the same is continued in 2016/17 to allow the pledges and plans to come to fruition.

Our Divisions have been involved in identifying quality priorities through discussion in our Clinical Governance Committee and have developed Divisional quality plans as part of the business planning process for 2016/17. A patient and public engagement event was held in April 2016.

This section of the report describes a suite of quality priorities for the coming year. These are part of a wider workplan 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 and regulators.

Over the year ahead, we aim to prioritise the delivery of quality improvements across a range of projects and services. There are four high-level Trust-wide quality priorities. There have been several different drivers in the development of these priorities.

- 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.
Our quality priorities for 2016/17 are as follows

1. Preventing harm and deterioration including programmes for:
   - medication safety (in response to audits in 2015/16 and including antibiotic stewardship – a national Commissioning for Quality Improvement and Innovation (CQUIN);
   - Acute Kidney Injury (AKI) – an alert affecting 30 patients per day;
   - recognition and treatment of sepsis (National CQUIN);
   - Care 24/7 (NHS national priority);
   - nationally recognised iPad based ‘Track and Trigger’ SEND project.

2. Following an expert external review of our investigations of Never Events that occurred in the Trust in 2014/15 we are committed to:
   - further Human Factors training to enhance the lessons learned from adverse events;
   - improving our systems for sharing learning within and between teams across the Trust;
   - improving our systems for ensuring knowledge of and compliance with essential policies.

3. More effective care with better patient experience including programmes for:
   - End of Life Care (proposed local CQUIN)
   - Dementia care
   - our Compassionate Care programme to improve patient experience throughout the Trust.

4. Stakeholder engagement and partnership working.

The place of our priorities in the domains of patient safety, clinical effectiveness and patient experience is shown on the following diagram.

Our quality priorities recognise the collaborative system leadership programmes instituted by the Chief Executive Officers (CEOs) across our system.

We are committed to further improvement in our interface with stakeholders such as GPs, other trusts such as Oxford Health NHS Foundation Trust and social care. We seek system solutions to the challenges which face our patients in navigating the healthcare system when they are ill and we want them to be cared for in the right place.
Priority 1: Preventing avoidable harm and patient deterioration in hospital

Why we chose this priority

This priority is the overarching theme underlying workstreams in both patient safety and clinical effectiveness with a central theme of preventing avoidable deterioration of patients in hospital and avoidable healthcare-related harm.

A million people use healthcare services every 36 hours, and the vast majority of them receive safe and high quality care. But things can be omitted or go wrong, and occasionally mistakes are made. Of the 17,784 incidents and near misses reported at OUH in 2015/16 0.25% resulted in severe harm or death.

We are committed to a group of five priorities which all aim to detect patient deterioration at the earliest possible time and provide a rapid response to minimise both harm from healthcare errors and progression of the patient’s illness that could have been avoided by prompt delivery of the best standard of care. This priority seeks to build on last year’s work to create digital systems and innovative data gathering to identify key opportunities to intervene and deliver safe care, the SEND project.

Our aims are to further progress programmes under the following domains.

- Priority 1A Medication safety.
- Priority 1B Improved recognition, prevention and management of patients with Acute Kidney Injury (AKI).
- Priority 1C Identification and early treatment of Sepsis.
- Priority 1D Care 24/7.
- Priority 1E Detecting and acting on deterioration through the iPad based collection of patient observations with ‘Track and Trigger’ analysis – the SEND project.
Priority 1A: Medication safety

Why we chose this priority

Safe and secure medication audits across the Trust suggest there is more work we can do to ensure best practice in safe medication practice at all times. A deep dive into the ‘omission or delay of administering an essential medicine’ has confirmed the importance of this issue and a new workstream is being established to drive improvement. The Medicines Safety Team has been working with and supporting existing specialist multidisciplinary teams to improve medicines safety in their specialist area.

In 2015/16 the team has been supporting the Divisions with Trust investigations and learning where more serious patient harm has been associated with medicines use. This has included reviewing all ‘Serious Incidents’ report investigations to identify themes, and enhance understanding of how and why things went wrong in order to share learning and develop and inform actions to reduce the potential and actual patient harm associated with prioritised workstreams. We are therefore dedicating this to medication safety in all its forms but with an emphasis on:

- safe anticoagulation
- safe use of insulin
- antimicrobial stewardship (National CQUIN)
- prompt antimicrobial administration in severe sepsis (National CQUIN and supports priority 1C).

Our aims

- To improve compliance against safe and secure medicines storage standards.
- To reduce the preventable harm associated with medication use.
- To improve the quantity and quality of medication incident reports in collaboration with the clinical areas.

Monitoring and reporting

- Monthly updates to the Medicines Management and Therapeutics Committee (MMTC).
- Safe and secure medicines audits reported to Clinical Effectiveness Committee (CEC), monthly compliance on key aspects included in Divisional Quality report to the Clinical Governance Committee (CGC).
- Preventable harm; quantity and quality of incident reporting to be monitored by Medication Safety and project groups against progress of improvement plans.
- Regular reports to the Clinical Governance Committee (CGC) and from there to the Quality Committee.

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<tr>
<td>To improve compliance with the safe and secure medicine standards.</td>
<td>100% compliance and if required an action plan to address any non-compliance.</td>
<td>Annual audits of all clinical areas.</td>
<td>Divisions to monitor and report against actions plans. Clinical areas to incorporate standards into matrons’ rounds to be used as part of a Quality improvement programme. Monitored by CGC.</td>
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<tr>
<td>To increase the number of medication incidents reported (indicative of an open and learning culture).</td>
<td>15% increase.</td>
<td>Number of reported medication incidents measured by data extracted from local incident reporting system.</td>
<td>Awareness raising and training about the importance of incident reporting and sharing lessons learnt from actions taken as a result of reporting. Aligns with broader Trust-wide work on continually improving our safety culture.</td>
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<tr>
<td>To reduce the proportion of medication incidents reported and graded as moderate or above in severity.</td>
<td>10% reduction overall, 20% reduction with insulin, anticoagulation, antimicrobials and omitted or delayed administration of essential medicines.</td>
<td>Percentage of reported medication incidents that are harmful as measured by data extracted from local incident reporting system.</td>
<td>Safety and projects groups’ improvement plans will change practice where successful. This will be represented by a reduction in inpatient harm which will be greatest in the prioritised areas.</td>
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Priority 1B: Improved recognition, prevention and management of patients with Acute Kidney Injury (AKI)

Why we chose this priority

AKI is a sudden deterioration in kidney function previously known as acute renal failure. It is not an actual physical injury and usually occurs without symptoms. Many patients are vulnerable to AKI: those with acute, severe illnesses; patients who have been admitted to hospital as an emergency; those who already have chronic kidney disease or other chronic conditions such as diabetes; and elderly patients. AKI also exacerbates the severity of other conditions, increasing the length of time spent in hospital and the risk of death. This priority has been chosen to improve care proactively, and save lives.

In late 2014, NHS England selected AKI as a national quality improvement project, and launched a national campaign (‘THINK KIDNEYS’) to raise awareness, develop educational materials and improve care. AKI is also a project within the Patient Safety Collaborative launched by the Oxford Academic Health Science Network (OxAHSN) in October 2014.

In line with this, AKI was a quality priority in 2015/16. During this past year, we have undertaken a baseline Trust-wide audit; developed an AKI care bundle to improve the management of patients with AKI; developed online educational resources together with a programme of seminars in key clinical areas; and we are launching an automated electronic alerting system to proactively flag up AKI to practitioners.

Our aims

To continue the work undertaken in 2015/16 as follows:
• undertake audit of the management of AKI;
• monitor patients who have alerted with AKI, ensuring that such patients consistently receive appropriate high quality clinical care, and facilitating specialist review if needed;
• ensure efficient and clear communication with primary care for patients who have suffered AKI;
• continue to develop and provide Trust-wide education about AKI;
• work with Oxford Academic Health Science Network (OxAHSN) to share learning and improve quality in our region as well as to undertake benchmarking against other local trusts;
• work with primary care colleagues to launch an electronic alerting system for AKI in primary care, together with a care bundle and educational materials for facilitating the primary care management of AKI, in the hope of avoiding unnecessary hospital admissions.

To successfully deliver this ambitious programme we will establish a multidisciplinary OUH AKI clinical team to oversee this work.

Monitoring and reporting

• Audit reports to the Clinical Effectiveness Committee and onwards to Clinical Governance Committee and from there to the Quality Committee.
• Review of AKI processes within AKI multidisciplinary team, when it has been established.
• Regular, general reports to the Clinical Governance Committee.
GOAL | TARGET | MEASURE | PLAN
--- | --- | --- | ---
Development of Trust-wide education on AKI | Non-medical health professionals | Education programme in place | Leadership of AKI group to develop education programme in collaboration with Quality Improvement nurse educators

Improve communication with primary care for patients who have suffered AKI | To include AKI 2/3 flags in discharge summaries | Review of discharge summaries | ICT sub workstream to evolve system to populate summaries with AKI flags

Pharmacy review of medication in patients with AKI | Increase early review of medication in AKI | Medication review tool in the Electronic Patient Record | ICT sub workstream

Work with primary care colleagues to improve management of AKI in primary care | Admission avoidance | Roll out of electronic alert and use of AKI care bundle in primary care | Shared group with primary care

**Priority 1C: Identification and early treatment of sepsis**

**Why we chose this priority**

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 44,000 deaths are caused by sepsis each year. Some of these deaths may be prevented by early recognition and antibiotic treatment.

In September 2014 NHS England 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 has been set up which leads the work and provides regular reports to the Clinical Governance Committee and from there to the Quality Committee.
- Performance towards each goal will be monitored by auditing patient records.
- Electronic reporting tools will be developed to monitor performance in more detail in order to inform and drive further quality improvement.

GOAL | TARGET | MEASURE | PLAN
--- | --- | --- | ---
Prompt recognition of sepsis | Standardised screening for sepsis across the Trust | We will audit the clinical records of patients eligible for screening. | We will strengthen systems and develop training for sepsis screening using standardised screening tools.

Prompt antibiotic treatment of sepsis | Antibiotics to be administered within 1 hour of presentation with severe sepsis | We will audit the clinical records of patients with sepsis. | We will strengthen patient pathways and develop electronic tools and training to ensure prompt delivery of care bundle including antibiotics.
Priority 1D: Care 24/7

Why we chose this priority

Care 24/7 is the Trust project to implement seven day services on all of our hospital sites. It is underpinned by ten clinical standards published by NHS England in 2013 following the Francis report. We have made significant improvements to how our clinical teams hand over patients out of hours and have a programme to complete this work on all of our hospital sites by the end of March 2017.

NHS England has been monitoring our progress and in the autumn of 2015 identified the Trust as a ‘beacon site’, and invited us to become an ‘early implementer’ meaning that we were likely to have completed the crucial areas of this work by March 2017. This work relates to four of the ten standards considered to have the highest impact on patient outcomes. They include how quickly a consultant reviews a patient after admission, how quickly a patient receives diagnostic tests, how quickly patients get interventions requested by their consultant (such as MRI) and how often a consultant reviews patients on an ongoing basis, particularly those who have been critically ill.

Our aims

- 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.
- Work with clinical teams to define areas in the hospital that are high dependency.
- Carry out six-monthly audits of patient records against the four priority standards as part of the national work programme. The audit data will help us identify improvements we need to make to provide seven day services.

Monitoring and reporting

- The Care 24/7 project is monitored by the Transformation Steering Group and provides regular reports to the Clinical Governance Committee, Trust Management Executive and Commissioners.
- The work to implement the four priority standards will be reported to NHS England following the six monthly audits.

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<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 in intensive and areas defined as high dependency will be reviewed by consultants twice daily.</td>
<td>We will measure this by six-monthly audits of patient records. This data will be submitted to NHS England.</td>
<td>We will work with our clinical teams to define areas within the Trust as high dependency areas. Relevant directorates will prepare action plans.</td>
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<tr>
<td>Complete our programme of work to implement the four critical standards by March 2017.</td>
<td>By March 2017 the bi-annual audits will be complete with data and actions reported to NHS England.</td>
<td>We will measure this by six monthly audits of patient records. This data will be submitted electronically to NHS England.</td>
<td>An audit team will be assembled, records audited in line with the NHS England reporting schedule. Data will be used for action planning by relevant Directorates.</td>
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**Priority 1E: SEND System for recording and viewing patients’ vital signs**

**Why we chose this priority**

Paper-based early warning chart data are prone to recording error, and can be difficult to share or use for quality improvement. The electronic SEND system is an ergonomic, intuitive, efficient early warning scoring system where real-time data are shared in the right way, with the right people whilst minimising recording errors.

**Our aims**

Designed alongside patients and clinicians, the SEND project aims to improve the recognition of deteriorating patients within Oxford University Hospitals NHS Foundation Trust and beyond.

SEND aims to improve patient care and safety by:
- incorporating the views of patients and families into the design of the displays they will use;
- improving accuracy and speed of data recording;
- eliminating errors in early warning score calculation;
- prompting and supporting appropriate care for each set of vital signs;
- supporting clinical governance and safety auditing.

SEND aims to bring the full benefits of electronic data recording, processing and review to the patient bedside. The design has been developed to aid sharing of data with clinicians and patients; it is integrated with existing clinical workflows, and will maximise staff engagement, efficiency and effectiveness.

**Monitoring and reporting**

- The project will report to the Planning and Information Directorate and via the Rescuing the Acutely Ill and Deteriorating Patient (RAID) Committee to the Patient Safety and Clinical Risk Committee. As a quality priority it will report regulary to the Clinical Governance Committee.

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<tr>
<td>Complete planned roll out across OUH NHS Foundation Trust.</td>
<td>Roll out to John Radcliffe Heart Centre and West Wing, Horton General Hospital ED, Oxford Centre for Enablement and outpatient areas.</td>
<td>Monitor progress of rolling out the system across the Trust according to the project roll out plan.</td>
<td>The implementation team will carry out the system deployment in line with the project roll out plan.</td>
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<td>The wards and clinicians from any location can access real-time vital sign observation charts and ‘Track and Trigger’ scores.</td>
<td>Clinical staff will use the system to capture patient observations in real time.</td>
<td>‘Track and Trigger’ data are gathered to audit usage of the system and provide an overview in each clinical area.</td>
<td>Make SEND accessible from every computer in the Trust. The wards will receive SEND support during roll out.</td>
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<tr>
<td>Nursing time saved recording vital signs and calculating ‘Track and Trigger’ scores.</td>
<td>Nurses can provide better patient care due to saving time when using SEND to record patients’ vital signs.</td>
<td>A research study is measuring time saved between using paper charts and SEND.</td>
<td>Deploy the SEND system onto a stand that incorporates the vital sign monitor and the computer tablet, making it ergonomic and efficient for the clinician to use.</td>
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Priority 2: Patient safety and Human Factors training

Why we chose this priority

The evidence to support Human Factors and quality improvement as a key element in achieving excellence in healthcare is clear. Developing expertise and training healthcare professionals in these domains leads to improvements in patient outcomes. (See footnote Morgan et al ref 1-4 Weaver et al ref 5.)

The Oxford Simulation Teaching and Research (OxSTaR) centre has an established portfolio of training incorporating simulation across OUH for all healthcare professionals. This includes a one-day Human Factors course (which incorporates fully immersive team training in the medical simulator) and a modular programme of training materials to train OUH Human Factors Ambassadors to use them in their clinical areas. So far we have 49 Ambassadors who are now training using these materials in The Horton General Hospital, the Women's Centre, Cardiac and Thoracic Critical Care (CTCC), Adult Intensive Care Unit (AICU) and theatres across OUH.

We can now build on the expertise within our organisation and have an opportunity to develop a robust and sustainable programme of Human Factors, quality improvement training, and project management for all staff in OUH with the clear aim of improving quality and outcomes for our patients.

Our aims

- To deliver Human Factors training incorporating simulation to healthcare professionals from all Divisions.
- To develop an advisory Human Factors-led Quality Improvement unit which can work with existing departments to develop HF-based solutions to patient safety and care quality problems.
- To deliver ‘train the trainer’ courses to build capability and sustainability in Human Factors training across OUH.
- To deliver training in quality improvement for healthcare professionals and managers from all Divisions.

Monitoring and reporting

- Human Factors and Quality Improvement Advisory Group will meet monthly/bimonthly to oversee development.
- Regular reports to the Clinical Governance Committee.

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<tr>
<td>To deliver Human Factors training incorporating simulation to healthcare professionals from all Divisions.</td>
<td>18 one day courses.</td>
<td>Records of attendance Qualitative feedback forms Safety Attitudes Questionnaires.</td>
<td>One day courses to be held in OxSTaR (or in-situ where appropriate). Data to be captured through OxSTaR database.</td>
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<td>To develop a Human Factors and Quality Improvement Advisory Group and an associated strategy for quality and safety led by the Deputy Medical Director.</td>
<td>To deliver a Human Factors and Quality Improvement strategy for OUH with the explicit aim of building capability across the Trust and delivering a sustainable programme of quality improvement.</td>
<td>Activity in QI in year one. Delivery on predefined process and patient outcome objectives in year two.</td>
<td>Develop expert group with monthly/bimonthly meetings and agenda for QI project development, coordinating and collaborating with the Transformation Team and other QI activity around the organisation.</td>
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<tr>
<td>To deliver ’train the trainer’ courses to build capability and sustainability in Human Factors training across the OUH.</td>
<td>Four one day ambassador courses to train an additional 50 trainers.</td>
<td>Records of attendance, qualitative feedback forms and records of staff trained by Human Factors Ambassadors.</td>
<td>One day courses to be offered to all Divisions and held in OxSTaR. Data to be captured through OxSTaR database.</td>
</tr>
<tr>
<td>To deliver training in quality improvement for healthcare professionals and managers from all Divisions.</td>
<td>One day Human Factors Quality Improvement training.</td>
<td>Records of attendance Qualitative feedback forms Records of QI projects initiated after training.</td>
<td>One day courses offered by the Patient Safety Academy Data to be captured through OxSTaR database.</td>
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Priority 3: Better patient experience

Our aims are to further progress programmes under the following domains.

• Priority 3A: End of Life Care
• Priority 3B: Dementia care
• Priority 3C: The Compassionate Care programme

Priority 3A: End of Life Care: improving people’s care in the last few days and hours of life

Why we chose this priority

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 2015 we have developed our End of Life Care Strategy around the principles of the One Chance to Get it Right2 report. 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 revealed that we could do better.

Our strategy as an organisation is based on five priorities: Recognise, Communicate, Involve, Support, Plan & Do.

Priorities of Care for the Dying Person

This will ensure that the possibility that a person may die within the coming days and hours is recognised and communicated clearly, decisions about care are made in accordance with the person’s needs and wishes, and these are reviewed and revised regularly by doctors and nurses. Sensitive communication should take place between staff and the person who is dying and those important to them. The dying person, and those identified as important to them, should be involved in decisions about treatment and care. The people important to the dying person should be listened to and their needs respected.

Care should be tailored to the individual and delivered with compassion – with an individual care plan in place.

Our aims for 2016/17

- Improve the care we are delivering directly to patients and families. Using the resources funded by Sobell House Hospice Charity by September 2016 we will deliver enhanced care to dying patients.
- Seek feedback from every bereaved family to understand how and where we could improve quality of care for the patient and their family.
- The Swan Scheme is a programme of support for bereaved families. It includes elements such as ensuring personal items are respectfully handled; supporting families through the end stages of life and providing anticipatory drugs for all dying patients on their discharge.
- The Trust has commenced the programme in Acute General Medicine and this will be rolled out Trust-wide.
- Work with Oxfordshire Clinical Commissioning Group (OCCG) and Oxford Health NHS Foundation Trust to improve care when a dying patient is being discharged.

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<tr>
<th>GOAL</th>
<th>TARGET</th>
<th>MEASURE</th>
<th>PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional palliative care provided in Emergency Department (ED) and Emergency Assessment Units (EAUs).</td>
<td>Palliative care staffed to provide daily rounds in ED and EAU.</td>
<td>Staff in place and daily rounds 7/7.</td>
<td>Commence implementation September 2016.</td>
</tr>
<tr>
<td>Improved feedback from families.</td>
<td>95% of families offered a feedback form.</td>
<td>Bereavement service audit.</td>
<td>Training and support to ensure feedback forms are distributed and collated and improvements follow.</td>
</tr>
<tr>
<td>Swan Scheme in place.</td>
<td>Symbol known to and understood by all staff.</td>
<td>Swan boxes ordered and in use.</td>
<td>Chief Nurse leading implementation group.</td>
</tr>
<tr>
<td>Improved staff confidence, skills and knowledge.</td>
<td>75% of staff have undertaken e-learning training.</td>
<td>Metrics on target.</td>
<td>Group to design and make available e-learning through Learning and Development.</td>
</tr>
<tr>
<td>Anticipatory medication.</td>
<td>95% of patients have on discharge.</td>
<td>Audit of notes and medications to take away (TTOs).</td>
<td>Group to provide education, and audit of sample of notes.</td>
</tr>
<tr>
<td>Joint work on discharge.</td>
<td>Understanding blocks to discharges.</td>
<td>Paper on understanding issues.</td>
<td></td>
</tr>
</tbody>
</table>

Monitoring and reporting

The End of Life Care Group, chaired by the Medical Director, will oversee the work plan. This group includes representation from OCCG and Oxford Health NHS Foundation Trust.

- Regular reports to the Clinical Governance Committee.
- Updates are reported to the Quality Committee and Trust Board.
Priority 3B: Dementia care

Why we chose this priority

We are committed to providing an excellent standard of care for all patients but we know that we particularly need to ensure that those who are vulnerable and frail are getting the best possible care.

The Trust will build upon its core values of delivering compassionate excellence in the care provided to patients with dementia and cognitive impairment. The goals detailed below link in with the Trust Dementia Strategy which details the Trust’s objectives with respect to dementia care. This is aligned with national dementia guidance and Oxfordshire’s Joint Health and Well Being Strategy 2012-2016.

Key elements of the Trust’s strategy include: early assessment using the modified FAIR model (find, assess, investigate and refer); implementation of personalised care, through the promotion of appropriate and useful resources as well as expert staff; increased leadership, support and education through Dementia Leads and Dementia Champions; education of staff within the Trust on dementia awareness; information and support for carers working with local agencies to provide information that will support people in and outside hospital; and developing dementia-friendly environments.

Our aims

- To cognitively assess patients over 75 years old on admission and to support carers. This will be achieved through the training of more staff in completing the appropriate cognitive screening tools and through the introduction of carers’ information booklets and questionnaires. This will involve working with Carers Oxfordshire.
- To develop training that meets not only the set objectives of the National Framework but also the needs of staff. This will include packages of training that will focus on key topics, such as behaviour that challenges the Mental Capacity Act and Deprivation of Liberty.

Monitoring and reporting

- As a quality priority it will provide regular updates to the Clinical Governance Committee.

<table>
<thead>
<tr>
<th>GOAL</th>
<th>TARGET</th>
<th>MEASURE</th>
<th>PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia data reviews.</td>
<td>90% of patients aged 75 years and over screened for dementia.</td>
<td>Monthly reports.</td>
<td>To provide support and education to staff.</td>
</tr>
<tr>
<td>To promote a positive experience for patients living with dementia and their carers during any engagement with hospital services.</td>
<td>Improvement in qualitative feedback.</td>
<td>Qualitative data from Carers Oxfordshire: 1:1 sessions, Friends and Family Test and the implementation of a new carers’ questionnaire within patient information packs.</td>
<td>To provide support and information to people living with dementia and their carers through the implementation of resources that are current, relevant and appropriate that include information about the hospital, its current initiatives and feedback options.</td>
</tr>
<tr>
<td>To promote dementia awareness via training to relevant staff within the hospital.</td>
<td>75%.</td>
<td>Quarterly review of training records.</td>
<td>To implement training for staff about dementia awareness and encouraging staff to become Dementia Friends.</td>
</tr>
<tr>
<td>To enhance the current knowledge and understanding of dementia through appropriate training to all relevant staff.</td>
<td>Training of 50% of frontline staff.</td>
<td>Training package in place and accessible to staff.</td>
<td>To develop training and resources that will empower staff in managing complex and sometimes difficult cases, whilst implementing evidence-based best practice.</td>
</tr>
</tbody>
</table>
Priority 3C: The compassionate care programme

Why we chose this priority

The purpose of this programme is to promote compassionate care as a core component of patient and carer experience and the delivery of compassionate excellence.

This programme will support the implementation of the Trust’s values into action.

The compassionate care programme will have five elements.

- Team-based customer care training.
- E-learning or film introduction to customer care.
- Person-centred care and dignity campaign.
- Implementing the recommendations of the Trust’s complaints review to deliver a responsive, sensitive and humane complaints process based on early resolution of patients and relatives concerns and complaints. This will include:
  - complainants to be given the opportunity to tell their story at senior leadership meetings such as the Quality Committee if they agree to assist in this way;
  - training and support for investigators to resolve concerns at an early stage. This training will be delivered by the Patients Association and will involve patients.

Our aims

- To provide classroom training sessions for 1500 frontline staff on Delivering Compassionate Care; increasing staff confidence and implementing compassionate excellence into interactions with patients, carers and colleagues.
- To evaluate the outcomes of learning leading to longer term behaviour and attitude change of frontline staff; measuring confidence in responding to concerns and implementing compassionate excellence into their interactions.
- To provide e-learning training accessible to all staff on concepts underpinning Delivering Compassionate Care; increasing staff awareness of compassionate excellence.

Monitoring and reporting

- Quarterly reporting on progress against goals to the Trust’s Workforce Committee and Trust Board.
- Regular reports to the Clinical Governance Committee.

<table>
<thead>
<tr>
<th>GOAL</th>
<th>TARGET</th>
<th>MEASURE</th>
<th>PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>To provide classroom training sessions for 1,500 frontline staff on Delivering Compassionate Care.</td>
<td>1,500 staff attend classroom sessions in 2016/17 financial year.</td>
<td>95% of attendees provide a ‘satisfied to very satisfied’ rating of their response to the classroom session.</td>
<td>Three training sessions per week provided for circa 30 staff.</td>
</tr>
<tr>
<td>To evaluate the outcomes of learning leading to longer term behaviour and attitude change of frontline staff.</td>
<td>50% of attendees complete evaluation 3-6 months post-training in 2016/17 financial year.</td>
<td>90% of attendees note a significant increase in their awareness of behaviour that has an effect on patient experience.</td>
<td>Quarterly surveys to attendees measuring training outcomes.</td>
</tr>
<tr>
<td>To provide e-learning training accessible to all staff on concepts underpinning Delivering Compassionate Care.</td>
<td>1,500 staff access and complete e-learning package sessions in 2016/17.</td>
<td>95% of attendees provide a ‘satisfied to very satisfied’ rating of their response to the e-learning package.</td>
<td>Launch of online modules by August 2016 with circulation through OUH.</td>
</tr>
</tbody>
</table>
Priority 4: Stakeholder engagement and partnership working

Why we chose this priority

In 2015/16, particularly since becoming a Foundation Trust, OUH has prioritised working across the healthcare system with partners and stakeholders. Improving the interface between the hospital and general practice for each episode of patient care also continues to be an area that we wish to improve upon. Although we have undertaken considerable work to improve our responsiveness to a number of issues raised by GPs about the interface between GP and hospital, we recognise there are still substantial improvements that need to be made.

Our aims

- To maximise the benefits to patients from taking a whole system approach to our strategy including the Oxford University, our commissioners, other trusts, Oxford Academic Health Science Network and stakeholders.
- To improve our interface with general practice by continuing to work on rapid electronic distribution of discharge summaries.
- To improve the experience of patients and families as they are discharged from inpatient care.

Monitoring and reporting

These test results and discharge summaries results will be reported by Divisions to the Clinical Governance Committee and via the Quality Report to the Board. Numbers of patients whose transfer of care has been delayed are reported to the Board and the wider health system. Progress of the Sustainability and Transformation Plan (STP) will be monitored at the STP Board.
- Regular reports to the Clinical Governance Committee.

<table>
<thead>
<tr>
<th>GOAL</th>
<th>TARGET</th>
<th>MEASURE</th>
<th>PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>To involve stakeholders in future strategy.</td>
<td>Work collaboratively as a healthcare system across Oxfordshire.</td>
<td>Progress of strategic objectives in the Sustainability and Transformation Plan (STP).</td>
<td>To collaborate with the wider system stakeholders to design the Sustainability and Transformation Plan.</td>
</tr>
<tr>
<td>To improve communication of patient information to primary care colleagues.</td>
<td>To deliver 98% all e-discharge summaries to primary care colleagues within 24 hours of discharge.</td>
<td>E-messaging of discharge summaries.</td>
<td>To work with Divisions and Directorates via performance review meetings to monitor and share best practice in completing discharge summaries.</td>
</tr>
<tr>
<td>To improve assurance that all test results have been acted upon.</td>
<td>To endorse 95% of test results on EPR within seven working days.</td>
<td>Endorsement of results on Electronic Patient Record.</td>
<td>To work with Divisions and Directorates via performance review meetings to monitor and share best practice in endorsing results.</td>
</tr>
</tbody>
</table>
| Progress system-wide improvement in quality of care. | Deliver aims of the delayed transfers of care (DTOC) programme. | Patients cared for in the right place. | • The continued use of beds in care homes for intermediate care.  
• The implementation of a single system across health and social care for the management of post acute patients.  
• Increased domiciliary care capacity to enable patients to return home when they are medically fit to be discharged. |
| To ensure patients and families have an improved experience of the discharge process from inpatient care. | Establish a working group by end of November 2016. Launch a revised patient discharge booklet by end of March 2017. | Establishment of the working group. Production of the revised patient discharge booklet. | Patient Experience Team to establish a working group to focus on improving communication at the critical time of discharge from hospital. |
STATEMENTS OF ASSURANCE FROM THE BOARD OF DIRECTORS

A review of our services

- During 2015/16 Oxford University Hospitals NHS Foundation Trust provided and sub-contracted 141 relevant health services.

- Oxford University Hospitals NHS Foundation Trust has reviewed all the data available to us on the quality of care in 141 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 ensures priorities and actions are identified to enable improvements.

- The income generated by the relevant health services reviewed in 2015/16 represents 100% of the total income generated from the provision of relevant health services by Oxford University Hospitals NHS Foundation Trust for 2015/16.

Participation in clinical audits and National Confidential Inquiries

During 2015/16, 45 national clinical audits and four National Confidential Inquiries covered relevant health services that Oxford University Hospitals NHS Foundation Trust provides.

During that period Oxford University Hospitals NHS Foundation Trust participated in 100% of national clinical audits and 100% of National Confidential Inquiries of the national clinical audits and National Confidential Inquiries in which we were eligible to participate.
### Participation in national clinical audits 2015/16

<table>
<thead>
<tr>
<th>National clinical audit and enquiry project name</th>
<th>Workstream / component (if more than one)</th>
<th>OUH participation</th>
<th>Percentage of cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Health Clinical Outcome Review Programme</td>
<td>Chronic neurodisability</td>
<td>Not collecting data in 2015/16</td>
<td>New project – not applicable</td>
</tr>
<tr>
<td></td>
<td>Young people’s mental health</td>
<td>Not collecting data in 2015/16</td>
<td>New project – not applicable</td>
</tr>
<tr>
<td>Perinatal mortality surveillance</td>
<td>Yes</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths)</td>
<td>Yes</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Maternal, New-born and Infant Clinical Outcome Review Programme</td>
<td>Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity) early pregnancy deaths and pre-eclampsia, plus psychiatric morbidity)</td>
<td>Not collecting data in 2015/16</td>
<td>– not applicable</td>
</tr>
<tr>
<td>Maternal mortality surveillance</td>
<td>Yes</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Diabetes (Paediatric) National Paediatric Diabetes Audit (NPDA)</td>
<td></td>
<td>Yes</td>
<td>Data collection in progress</td>
</tr>
<tr>
<td>Neonatal Intensive and Special Care (NNAP)</td>
<td>Yes</td>
<td>John Radcliffe Hospital (JR) 100%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Horton General Hospital (HGH) 100%</td>
<td></td>
</tr>
<tr>
<td>Paediatric Asthma</td>
<td>Yes</td>
<td>JR 100%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>HGH 100%</td>
<td></td>
</tr>
<tr>
<td>Paediatric Intensive Care (PICANet)</td>
<td>Yes</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>National Bowel Cancer Audit Project (NBOCAP)</td>
<td>Diagnostic / surgery / oncology</td>
<td>Yes</td>
<td>59%</td>
</tr>
<tr>
<td>Elective Surgery (National Patient Reported Outcome Measures (PROMs) Programme)</td>
<td>Groin hernia</td>
<td>Yes</td>
<td>JR and HGH 54%</td>
</tr>
<tr>
<td></td>
<td>Varicose veins</td>
<td>Yes</td>
<td>55%</td>
</tr>
<tr>
<td></td>
<td>Hip / knees</td>
<td>Yes</td>
<td>98%</td>
</tr>
</tbody>
</table>
# Participation in national clinical audits 2015/16

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Inflammatory Bowel Disease (IBD) programme</td>
<td>Inpatient care and experience - adult</td>
<td>Not collecting data in 2015/16 for either the HGH or JR</td>
<td>John Radcliffe Hospital (JR) / Horton General Hospital (HGH) – not applicable</td>
</tr>
<tr>
<td>Inflammatory Bowel Disease (IBD) programme</td>
<td>Biologics - adult</td>
<td>Yes</td>
<td>JR and HGH 100%</td>
</tr>
<tr>
<td>Inflammatory Bowel Disease (IBD) programme</td>
<td>Inpatient care and experience - children</td>
<td>Yes</td>
<td>JR 100%</td>
</tr>
<tr>
<td>Inflammatory Bowel Disease (IBD) programme</td>
<td>Biologics - children</td>
<td>Yes</td>
<td>JR 100%</td>
</tr>
<tr>
<td>Medical and Surgical Clinical Outcome Review Programme</td>
<td>Acute pancreatitis (organisational questionnaire)</td>
<td>Yes</td>
<td>Churchill (CH), JR, HGH 100%</td>
</tr>
<tr>
<td>Medical and Surgical Clinical Outcome Review Programme</td>
<td>Acute pancreatitis (clinical questionnaires (Q) and casenotes (C))</td>
<td>Yes</td>
<td>CH, JR, HGH - Clinical Q 45% Casenotes 18%</td>
</tr>
<tr>
<td>Medical and Surgical Clinical Outcome Review Programme</td>
<td>Physical and mental healthcare of mental health patients in acute hospitals</td>
<td>Yes</td>
<td>CH 20%, HGH 50%, JR 40% Nuffield Orthopaedic Centre (NOC) 0%</td>
</tr>
<tr>
<td>National Complicated Diverticulitis Audit (CAD)</td>
<td>Acute surgical services</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>National Emergency Laparotomy Audit (NELA)</td>
<td>Acute surgical services</td>
<td>Yes</td>
<td>JR 41%</td>
</tr>
<tr>
<td>National Emergency Laparotomy Audit (NELA)</td>
<td>Acute surgical services</td>
<td>Yes</td>
<td>JR 41%</td>
</tr>
<tr>
<td>National Emergency Laparotomy Audit (NELA)</td>
<td>Acute surgical services</td>
<td>Not collecting data in 2015/16</td>
<td>CH 0%</td>
</tr>
<tr>
<td>National Prostate Cancer Audit</td>
<td>Diagnostic / urology / oncology</td>
<td>Yes</td>
<td>94%</td>
</tr>
<tr>
<td>National Oesophago-gastric Cancer Audit (NAOGC)</td>
<td>Diagnostic / surgical and oncology</td>
<td>Yes</td>
<td>69%</td>
</tr>
<tr>
<td>Renal Replacement Therapy (Renal Registry)</td>
<td>Renal services (nephrology)</td>
<td>Yes</td>
<td>93%</td>
</tr>
<tr>
<td>Case Mix Programme (CMP)</td>
<td></td>
<td>Yes</td>
<td>HGH 100%</td>
</tr>
<tr>
<td>Case Mix Programme (CMP)</td>
<td></td>
<td>Yes</td>
<td>JR (Neuro ICU) 100%</td>
</tr>
<tr>
<td>Case Mix Programme (CMP)</td>
<td></td>
<td>No</td>
<td>0% The Philips Carevue system does not currently support cardiothoracic data relating to this audit</td>
</tr>
<tr>
<td>National Cardiac Arrest Audit (NCAA)</td>
<td></td>
<td>Yes</td>
<td>JR 82%</td>
</tr>
<tr>
<td>National Cardiac Arrest Audit (NCAA)</td>
<td></td>
<td>Yes</td>
<td>CH 85%</td>
</tr>
<tr>
<td>National Cardiac Arrest Audit (NCAA)</td>
<td></td>
<td>Yes</td>
<td>HGH 65%</td>
</tr>
</tbody>
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<tr>
<td>Child Health Clinical Outcome Review Programme</td>
<td>Chronic neurodisability</td>
<td>Not collecting data in 2015/16</td>
<td>New project – not applicable</td>
</tr>
<tr>
<td>Major Trauma Audit</td>
<td></td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>National Joint Registry (NJR)</td>
<td>Knee replacement</td>
<td>Yes</td>
<td>Data analysing in progress</td>
</tr>
<tr>
<td></td>
<td>Hip replacement</td>
<td>Yes</td>
<td>Data analysing in progress</td>
</tr>
<tr>
<td>National Ophthalmology Audit</td>
<td>Adult cataract surgery</td>
<td>Yes</td>
<td>Data collection in progress</td>
</tr>
<tr>
<td>National Vascular Registry (NVR)</td>
<td></td>
<td>Yes</td>
<td>Data collection in progress</td>
</tr>
<tr>
<td>Rheumatoid and Early Inflammatory Arthritis</td>
<td>Clinician / patient follow-up</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Clinician / patient baseline</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Falls and Fragility Fractures Audit Programme (FFAP)</td>
<td>Fracture Liaison Service Database</td>
<td>Yes</td>
<td>Data collection in progress</td>
</tr>
<tr>
<td></td>
<td>Inpatient falls</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>National Hip Fracture Database</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>National Audit of Intermediate Care</td>
<td></td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Procedural Sedation in Adults (care in emergency departments)</td>
<td></td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit Programme (SSNAP)</td>
<td></td>
<td>Yes</td>
<td>JR 100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td>HGH 100%</td>
</tr>
</tbody>
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<th>Percentage of cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK Parkinson’s Audit*</td>
<td>Patient management, elderly care and neurology</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Occupational Therapy</td>
<td>The Trust did not register for this aspect of the audit</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>Speech and Language Therapy</td>
<td>The Trust did not register for this aspect of the audit</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>Physiotherapy</td>
<td>Yes</td>
<td>Not enough eligible patients seen to submit the data</td>
</tr>
<tr>
<td>Vital signs in children (care in emergency departments)</td>
<td></td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Venous Thromboembolism (VTE) risk in lower limb immobilisation (care in emergency departments)</td>
<td></td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)</td>
<td></td>
<td>Yes</td>
<td>Data collection in progress</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td>Data collection in progress</td>
</tr>
<tr>
<td>Adult Cardiac Surgery</td>
<td></td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Cardiac Rhythm Management (CRM)</td>
<td></td>
<td>Yes</td>
<td>Data collection in progress</td>
</tr>
<tr>
<td>Congenital Heart Disease (CHD)</td>
<td>Adult</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Coronary Angioplasty / National Audit of Percutaneous Coronary Interventions (PCI)</td>
<td></td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>National Audit of Pulmonary Hypertension (PHT)</td>
<td>National outcomes and tertiary care</td>
<td>Not eligible</td>
<td>OUH patients with PHT are referred to other centres. OUH data forms part of that centre’s submission to the National Audit</td>
</tr>
<tr>
<td>National Heart Failure Audit</td>
<td></td>
<td>Yes</td>
<td>Data collection in progress</td>
</tr>
<tr>
<td>Adult Asthma</td>
<td></td>
<td></td>
<td>Not collecting data in 2015/16</td>
</tr>
</tbody>
</table>
## Participation in national clinical audits 2015/16

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<th>Percentage of cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Use of Oxygen</td>
<td></td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>National Audit of Pulmonary Hypertension</td>
<td>National outcomes and tertiary care</td>
<td>Not eligible</td>
<td>not applicable</td>
</tr>
<tr>
<td>National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme</td>
<td>Pulmonary rehabilitation</td>
<td>Not eligible</td>
<td>not applicable</td>
</tr>
<tr>
<td></td>
<td>Secondary care</td>
<td>Not collecting data in 2015/16</td>
<td>not applicable</td>
</tr>
<tr>
<td></td>
<td>Primary care (data collection limited to Wales)</td>
<td>Not eligible</td>
<td>not applicable</td>
</tr>
<tr>
<td>National Lung Cancer Audit (NLCA)</td>
<td>Lung Cancer Consultant Outcomes publication</td>
<td>Yes</td>
<td>88%</td>
</tr>
<tr>
<td>Non-Invasive Ventilation - Adults</td>
<td></td>
<td>Not collecting data in 2015/16</td>
<td>not applicable</td>
</tr>
<tr>
<td>UK Cystic Fibrosis Registry</td>
<td>Adult</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Paediatric</td>
<td>Yes</td>
<td>98%</td>
</tr>
<tr>
<td>National Diabetes Audit - adults</td>
<td>National Pregnancy in Diabetes Audit</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>National Foot Care Audit</td>
<td>Yes</td>
<td>10% issues with late audit registration led to a delayed data collection.</td>
</tr>
<tr>
<td>National Inpatient Audit</td>
<td>Yes</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>National Diabetes Transition</td>
<td>Not collecting data in 2015/16</td>
<td>New project – not applicable</td>
<td></td>
</tr>
<tr>
<td>Use of Blood in Haematology</td>
<td></td>
<td>Yes</td>
<td>94%</td>
</tr>
</tbody>
</table>
Participation in national clinical audits 2015/16

<table>
<thead>
<tr>
<th>National clinical audit and enquiry project name</th>
<th>Workstream / component (if more than one)</th>
<th>OUH participation</th>
<th>Percentage of cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Blood and Transplant (NHSBT) 2015 Audit of Lower GI Bleeding and the Use of Blood</td>
<td>Yes</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Audit of Patient Blood Management in Scheduled Surgery</td>
<td>Yes</td>
<td>78%</td>
<td></td>
</tr>
</tbody>
</table>

Note*: UK Parkinson’s audit involves five services – Occupational Therapy (OT), Physiotherapy, Speech and language therapy (SALT), Neurology and elderly care. OT and SALT services did not register with the audit, however as a Trust we did take part in the audit.

National Confidential Inquiries into Patient Outcome and Death (NCEPOD) 2015/16

NCEPOD is a study in which currently practising clinicians review the management of patients undergoing medical and surgical care by undertaking confidential surveys and reviewing care provision and resources in the units carrying out the care. Cases that cause NCEPOD concern are referred back to the Medical Director of the Trust concerned in order that appropriate action may be taken. Consultants involved with the case are also notified.

During 2015/16 hospitals were eligible to enter data into four NCEPOD studies. Please find below a summary for those studies in which Oxford University Hospitals NHS Foundation Trust participated.

<table>
<thead>
<tr>
<th>NCEPOD studies in 2015/16</th>
<th>Sites participating</th>
<th>Clinical questionnaire returned</th>
<th>Case notes returned</th>
<th>Organisational questionnaire returned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical and mental healthcare of mental health patients in acute hospitals. (This study is still open and the figures are provisional.)</td>
<td>John Radcliffe (JR), Nuffield Orthopaedic Centre (NOC), Horton General Hospital (HGH), Churchill Hospital (CH).</td>
<td>Nine out of 21 questionnaires returned 43%</td>
<td>Eight out of 21 case notes returned 38%</td>
<td>Expected four questionnaires to be returned In progress</td>
</tr>
<tr>
<td>Acute Pancreatitis</td>
<td>CH, HGH, JR</td>
<td>Five out of 13 questionnaires returned 38%</td>
<td>Two out of 13 case notes returned 15%</td>
<td>Three out of three questionnaires returned 100%</td>
</tr>
<tr>
<td>Sepsis</td>
<td>JR, CH, HGH</td>
<td>Two out of 11 questionnaires returned 18%</td>
<td>Two out of 11 case notes returned 18%</td>
<td>Zero out of three questionnaires returned 0%</td>
</tr>
<tr>
<td>Gastrointestinal Haemorrhage</td>
<td>JR, CH, HGH, NOC</td>
<td>Six out of seven questionnaires returned 86%</td>
<td>Five out of seven case notes returned 71%</td>
<td>Two out of four questionnaires returned 50%</td>
</tr>
</tbody>
</table>
In order to improve participation in future NCEPOD studies the Trust will be taking the following action.

- Identification of the Trust Clinical Lead by the local reporter at the beginning of the study.
- The local reporter within the Clinical Governance Team will contact the relevant clinicians identified to complete the questionnaire and highlight the importance of submitting the required information within the deadline.
- Divisions and the central governance team will provide further support to the clinicians for any issues arising during participation of the study.
- Study findings will be reviewed by the Trust nominated lead for identifying remediable factors in patient care at a Trust level.

The reports of 40 national clinical audits were reviewed during 2015/16 and the Trust intends to take the following actions to improve the quality of the healthcare we provide.

<table>
<thead>
<tr>
<th>NATIONAL CLINICAL AUDIT</th>
<th>ACTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Thoracic Society (BTS) Emergency Use of Oxygen</td>
<td>There is an EPR development underway to create a task for oxygen prescription. Work is underway to embed an online training tool from BTS into the mandatory training programme.</td>
</tr>
<tr>
<td>UK Cystic Fibrosis Registry</td>
<td>The proportion of patients receiving DNase therapy has risen from ~ 45% in 2013 to 52% in 2014. The centre is actively working towards increasing rates of prescription of this drug amongst attending patients.</td>
</tr>
<tr>
<td>Inflammatory Bowel Disease (IBD) Programme Adult</td>
<td>OUH is leading on a global initiative to develop internationally agreed PROMs for IBD.</td>
</tr>
<tr>
<td>Inflammatory Bowel Disease (IBD) Programme Paediatrics</td>
<td>A designated specialist nurse practitioner is leading on the action to improve the completion of Patient-Reported Outcome Measures (PROMs).</td>
</tr>
<tr>
<td>National Joint Registry (NJR)</td>
<td>A Trauma consultant has been proactively reminding surgeons to input their data to NJR and the need to obtain patients’ consent for inclusion in NJR which requires improvement. The data entry process at the Horton General Hospital needs to be reviewed to improve link-ability via the NHS number.</td>
</tr>
<tr>
<td>Paediatric Intensive Care Audit Network (PICANet)</td>
<td>There is an active recruitment and retention programme underway to achieve the designated 7.01 nurses per paediatric critical care bed.</td>
</tr>
<tr>
<td>Diabetes (Adult) - national pregnancy in diabetes</td>
<td>The use of pre-conceptual folic acid by women with pre-existing diabetes is being reviewed by the audit lead.</td>
</tr>
<tr>
<td>National Adult Cardiac Surgery Audit (including 2015/16 consultant outcomes publication, pub 8/9/2015)</td>
<td>The audit findings were that OUH cardiac surgeons performed 2456 operations with an overall survival rate of 97.34%. The data shows very good / excellent surgeon-specific performance by all the surgeons. The report indicated that the OUH surgeons have performed significantly more operations during this three year period (range 452 - 506) than the national average of 334 per surgeon.</td>
</tr>
<tr>
<td>Neonatal Intensive and Special Care (NNAP)</td>
<td>The JR Unit was below average for Retinopathy of Prematurity (ROP) screening but demonstrated continued improvement over the last four years. The Unit are continuing with close monitoring of ROP screening. A marked improvement in the completion of two year follow-up data entry was noted with the JR now having one of the highest rates in the country. The Unit is currently auditing practice to determine whether an improvement can be made in the number of babies admitted with a temperature &lt;36.5°C. The HGH Unit scored particularly well in ROP screening, babies receiving mothers’ milk at discharge, infection rate, information given to parents by medical staff and the completion of two year follow-up data.</td>
</tr>
<tr>
<td>NATIONAL CLINICAL AUDIT</td>
<td>ACTIONS</td>
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</tr>
<tr>
<td>Cardiac Rhythm Management (CRM) Ablation Audit</td>
<td>While data completeness was good it has been identified that all procedures had not been reported. This joint issue was advised to be common to many centres and the database is being replaced.</td>
</tr>
<tr>
<td>Major Trauma: The Trauma Audit and Research Network (TARN)</td>
<td>Increase in plastic surgeon and theatre availability to ensure soft tissue cover for open fractures within 72hrs, improved consultant review of cases with an Injury Severity Score &gt;15 and recruit a clinical lead for acute trauma rehabilitation.</td>
</tr>
<tr>
<td>Major Trauma: The Trauma Audit and Research Network (TARN)</td>
<td>Improved anaesthetic cover implemented since February 2015.</td>
</tr>
<tr>
<td>Royal College of Emergency Medicine (CEM) Moderate or severe asthma in children (care provided in emergency departments)</td>
<td>Low update of peak flow meter usage in children was identified as a weakness in the service. This has been addressed by the purchase of new meters thereby increasing availability and use.</td>
</tr>
<tr>
<td>CEM Paracetamol overdose</td>
<td>There is difficulty interpreting the results of the audit due to the need to analyse subgroups, however the services recognised the drop in overall compliance and have already put changes in place to improve care.</td>
</tr>
<tr>
<td>CEM Fitting child (care in emergency departments)</td>
<td>The resultant actions are for the service to re-inforce the standards for management and documentation with junior staff.</td>
</tr>
<tr>
<td>CEM Mental health (care in emergency departments)</td>
<td>The audit identified a requirement for a mental health assessment room at HGH. This is being added to the local risk register for review with estates.</td>
</tr>
<tr>
<td>CEM Older people (care in emergency departments)</td>
<td>The audit recommended the need for the incorporation of cognitive screening into EPR which is underway.</td>
</tr>
<tr>
<td>Diabetes (Paediatric) (NPDA) 2013/14</td>
<td>The quality of the service is in line with national average; however the data reported by the centre is not in line with that reported internally. The Trust is in discussion with the audit centre to understand the discrepancies.</td>
</tr>
<tr>
<td>Diabetes (Paediatric) (NPDA) 2014/15</td>
<td>This annual audit has highlighted that there continue to be delays in the outpatient services. It is anticipated that the appointment of a new consultant in April 2016 will improve the waiting times.</td>
</tr>
<tr>
<td>Case Mix Programme (CMP) 2013/14 Annual Quality Report</td>
<td>A Trust-wide strategy for the development of adult critical care services was accepted in 2015. This is being implemented and will address the mismatch by opening more critical care beds, both in terms of staffed beds and physical bed spaces and then moving on to build a new adult intensive care and high dependency units. In the future, audit of outcomes and process will be integrated across OUH adult critical care services.</td>
</tr>
</tbody>
</table>
| National Emergency Laparotomy Audit (NELA) | The National Emergency Laparotomy Audit (report published June 2015) has highlighted that there was a flaw in the national analysis. When re-analysed the arrival in theatre in timescale appropriate to urgency rose from 72% to 91%. The Trust action plan has been amended and the key actions from the audit are:  
  - increasing the number of critical care beds and developing a new high dependency unit to address the lack of availability of post-operative critical care beds;  
  - improve timely CT scan reporting by consultant radiologists by reviewing the consultant radiologist’s availability;  
  - ensuring availability of a consultant surgeon and a consultant anaesthetist (e.g. by freeing the consultant surgeon from ward round duties and establishment of a resident consultant anaesthetist during weekends) so that the patients are reviewed preoperatively by both the consultants. |
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - Secondary care workstream - national clinical audit report</td>
<td>Access to respiratory specialist expertise for COPD falls short of NICE Quality Standards recommendations. The service is part provided by Oxford Health NHS Foundation Trust and OUH and a business case to increase the establishment has been submitted, for recruitment in 2015/16. A quality strategy has been developed to resolve all outstanding issues.</td>
</tr>
<tr>
<td>Elective surgery (National PROMs Programme) Groin Hernia</td>
<td>The Unit reported patient satisfaction rates of more than 90%. All patients reported that they returned to their previous level of physical activity. There were 53 patients identified to have been readmitted. The Unit is reviewing the records of these patients to determine if the readmission was related to the procedure.</td>
</tr>
<tr>
<td>BTS Pleural Procedure</td>
<td>The audit did not include activity at the Horton General Hospital which has been agreed to be included next year.</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit Programme (SSNAP)</td>
<td>The John Radcliffe Hospital is due to conduct a stroke ‘perfect week’ to determine the barriers to flow through the pathway. There is on-going review of the Oxfordshire stroke pathway with the Oxfordshire CCG (OCCG), Oxford Health NHS Foundation Trust and other stakeholders. The Horton General Hospital (HGH) advised that the key actions were to improve audit compliance by capturing relevant data on “stroke initial review form” and increasing consultant / registrar input to data entry process. HGH is awaiting the Horton General Hospital acute medicine review.</td>
</tr>
<tr>
<td>BTS Adult Community Acquired Pneumonia</td>
<td>The audit highlighted that improvement was required in compliance with local antibiotic prescribing guidelines. The resultant action is the implementation of the pneumonia care bundle. The care bundle is currently in use in the Emergency Department. The action is to extend use to Acute General Medicine and a recommendation for Trust-wide implementation. The audit findings were to be further discussed at the John Radcliffe Acute General Medicine and Horton General Hospital Medicine clinical governance meetings to increase awareness of early chest X-ray and antibiotic administration. It was recommended that patients with severe pneumonia admitted under non-respiratory specialists should be discussed early (within 24 hours) with a member of the Respiratory team.</td>
</tr>
<tr>
<td>Bowel cancer NBOCAP (including 2015/16 Consultant Outcome Publication)</td>
<td>OUH adjusted 90 day mortality for elective colorectal cancer was 1.2% compared to 3.9% nationally. The Trust is a noted leading centre in laparoscopic surgery with rates of 84% compared to 57% nationally.</td>
</tr>
<tr>
<td>Congenital Heart Disease (Paediatric cardiac surgery) CHD - Adult service only</td>
<td>The service is compliant with the required Data Quality Indicator for adult congenital heart disease.</td>
</tr>
<tr>
<td>National Head and Neck Oncology Audit (DAHNO)</td>
<td>The service has agreed actions to improve the data capture for biopsy reporting interval and for dietetic assessment pre-treatment and to improve the prioritisation and capacity for dental assessments.</td>
</tr>
<tr>
<td>National Oesophago-Gastric Cancer Audit Association of Upper Gastrointestinal Surgeons (AUGIS) - Consultant Outcome Publication 2014-2015</td>
<td>The 30-day and 90-day postoperative mortality were within the acceptable range and clinical activity was noted as satisfactory.</td>
</tr>
<tr>
<td>National Vascular Registry</td>
<td>The multidisciplinary team (MDT) co-ordinator has been designated to improve case ascertainment which is currently below the national average. The formation of a carotid MDT is under consideration by the Unit.</td>
</tr>
<tr>
<td>NATIONAL CLINICAL AUDIT</td>
<td>ACTIONS</td>
</tr>
<tr>
<td>------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Falls and Fragility Fractures Audit Programme (FFFAP): National Audit of Falls</td>
<td>The audit results led the Falls Prevention Group to suggest a review of the Falls Prevention Policy, integration of risk assessments and falls prevention care plans in the Electronic Patient Record (EPR) and continued roll out of the Fall Safe Care Bundle will improve compliance with the standards. These actions are underway and monitored by the OUH Falls Prevention Group.</td>
</tr>
</tbody>
</table>
| Falls and Fragility Fractures Audit Programme (FFFAP): National Hip Fracture Database | The audit found that the 30 day mortality post hip fracture has reduced significantly over the audit period compared to previously. This is inline with the national average of 8.4%  
The Horton General Hospital has reported that no patients developed pressure ulcers (reported if Grade two or above) during their stay. The HGH has maintained the Best Practice Tariff (BPT) standards and retained their position of fourth nationally, highest achievement for meeting all of the BPT criteria.  
The length of stay has reduced at the Horton General Hospital considered to be as a result of the care provided within the standards set out by the BPT and the KPIs that are reported monthly.  
The John Radcliffe Hospital (JR) has improved on all metrics pertaining to orthogeriatric medicine and the nursing staff should be commended on the care provided to reduce the rates of pressure ulcers sustained. The proportion of patients achieving BPT standards has improved. The JR has been identified as an outlier for reoperation within 30 days (2.7%). The service advises that actions have been implemented to reduce wound infection and the need for reoperation.  
A ‘wound care protocol’ after hip surgery is now in place and an ‘oozy wound’ protocol is to be added to the Trauma intranet home page. |
| NCEPOD Severe gastrointestinal haemorrhage | The audit highlighted further work to ensure comparable equipment and nursing support across OUH sites, and establish regular multidisciplinary review process for all deaths within 30 days due to GI bleeding with regular audit of documentation of re-bleed plans and reviewing the local pathway. |
| NCEPOD Sepsis | The Trust has appointed a Sepsis Lead who has established a Sepsis Working Group (SWG). The OUH Sepsis Pathway has been developed with further emphasis on Sepsis Training.  
The Trust is reviewing serious incidents related to sepsis management to identify care gaps and opportunities for improvement. |
| Interventional Cardiology, 2015 COP (1 Jan 2012 – 31 Dec 2014 data), pub Dec 2015 | The audit shows all operators undertaking percutaneous coronary interventions (PCI) procedures within the Trust are performing safely and with outcomes that are within those expected after adjustments made by the risk model. |
| National Lung Cancer Audit (LUCADA), 2014 data, pub Dec 2015 | The change from National Lung Cancer Audit (NLCA) to Cancer Outcomes and Services Dataset (COSD) caused significant challenges this year and it was clear that the data submitted this year were not as accurate as they had been in previous years. The data are now being pulled straight from COSD, rather than uploaded into Lung Cancer Audit Data Set (LUCADA), which requires these fields to be complete in COSD. Throughout the year the Trust had data completeness issues, and delays in pulling together data meant that none of what was uploaded this year was clinically validated. This was a problem across the country and not just in OUH. There was a noted reduction in patients being reviewed by Clinical Nurse Specialists due to incorrect data submission. We aim to increase the proportion of patients seen by a Lung Cancer Specialist Nurse (CNS) with healthcare support workers regularly checking multidisciplinary team (MDT) data and re-encouraging clinicians to use CNS and perform monthly clinical data validation meetings before final records submitted via COSD. |
OUH is in the upper quartile of UK trusts for the number of cystectomies performed. OUH outcomes were found to be comparable or better than UK trusts. The actions for the Unit are the development of the service as a tertiary regional referral centre, development of the minimally-invasive cystectomy (robotic cystectomy) service and improving infrastructure for complete data submission.

OUH performed a higher number of percutaneous nephrolithotomies (PCNL) than the national median. The median length of stay corresponded to the national average.

The Unit reported that data submission for radical prostatectomy was incomplete. This was advised to be due to a lack of support specifically with the submission of follow up data. The Unit reported no concerns with nephrectomy outcomes. Transfusion rates were reported to be at the higher end of the range due to the complexity of the surgery undertaken at OUH. British Association of Urological Surgeons (BAUS) has included a statement on the OUH data page noting this. There was one death reported which was reviewed and attributed to another procedure.

OUH performed well when compared with the Network. The breastfeeding outcomes were reported as outstanding and continue to improve year after year. The areas the Unit identified for quality improvement were the use of non-invasive respiratory support and the prevention of hospital-acquired infection, intestinal and neurological complications.

OUH graft and mortality are in line with UK averages and issues with data submission have been resolved.

The reports of 287 local clinical audits were reviewed by the provider in 2015/16 and the examples below demonstrate some of the actions taken by Oxford University Hospitals NHS Foundation Trust to improve the quality of healthcare provided.

- Oxford Kidney Unit Peritoneal Dialysis Audit led to a programme to educate patients with leaflets and posters and web-based and refresher training (both group and individual training). The audit has also led to further participation in key research trials.
- Management of Acute Right Iliac Fossa Pain audit has led to the consideration of diagnostic laparoscopy in place of computed tomography (CT) scans for young women and the decision to leave a normal appendix in situ during diagnostic laparoscopy.
- Diagnostic testing for BRCA1/2 gene mutations in breast cancer patients through oncology clinic led to improved written communication with outcome letters for patients clearly indicating the individual pathway.
- Audit of the endoscopic mucosal resection of early oesophageal neoplasia in patients requiring anticoagulation confirmed safe practice when warfarin is discontinued five days before the endoscopic intervention and reinstituted on the evening of the procedure day.
- A pathway has been put into place following the completion of the audit of stem cell collection and efficient use of therapeutic advisory service, for the Joint Accreditation Committee of International Society for Cellular Therapy-Europe and European Society for Blood and Marrow Transplantation Standards (JACIE) so that the referring clinician can inform the Unit as soon as possible if a patient requires a mobilising agent if not fit enough to proceed.
- An audit of pain prescriptions was conducted after the electronic prescribing and medicines administration system (ePMA) was introduced in April 2015. There was an improvement in the dosing of ibuprofen prescriptions as well as a 33% improvement in the correct frequency. Correct dosing of morphine has improved significantly. A repeat audit is planned in 2017 following an upgrade in ePMA which will allow further improvements in patient safety.

Local clinical audit

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Local clinical audit (continued)

- Microsatellite Mismatch Repair (MMR) immunohistochemistry is being performed for all cases of colorectal carcinoma and is being requested earlier to facilitate rapid turnaround and appropriate referral of patients to genetics following completion of the Audit of Requests and Reporting of MMR Protein Immunohistochemistry in Colorectal Carcinoma Patients who are less than 50 years of age.
- Re-auditing of the Pre-operative and Pre-procedural Fasting for Elective and Urgent Medical and Surgical Procedures within the Adult Demographic enabled education through posters and discussions with our staff, as well as patients, to encourage patients to take in clear drinks until two hours prior to surgery.
- The use of melatonin in Community Paediatric Practice audit enabled departmental discussion and education through provision of a sleep information leaflet around prescribed tablet formulation of Melatonin, and the patients and the parents were given behavioural management advice regarding sleep.
- Geratology wards have been regularly conducting audits every six months to improve compliance with the Visual Infusion Phlebitis (VIP) scores completed on the electronic patient record (EPR) and have been actively encouraging staff to use the online training module for effective completion of the VIP scores on the EPR.
- An Audit of Pulmonary Embolism (PE) on the medical take highlighted the significance of NICE guidance using a Wells score in confirmation of the PE and indications for imaging. Posters summarising key guidance will now be displayed in the Emergency Departments, inpatient and outpatient areas.
- Investigation into the potential need for short-term outpatient antibiotic therapy services in an acute medicine audit led to a business case for the extension of the short-term outpatient parenteral antibiotic therapy service.
- An audit was conducted to determine the number of discharge letters written during a fixed period for Emergency Assessment Unit (EAU) and helped determine the factors which prevented the letters being written, or being released appropriately to the General Practitioner (GP).
- Delaying the ‘post-antibiotic era’: An audit of antimicrobial prescribing habits on the Neurosciences Intensive Care Unit highlighted the advantages of shortening antibiotic courses even a small amount, with increasing evidence regarding the emergence of resistance, to potentially benefit both the individual patient and the general population.
- A local guideline on perineal care and repair management published in 2013 was reviewed following completion of the Obstetric Anal Sphincter Injuries (OASIS) audit. The guideline will include specific guidance on perineal care during labour and delivery such as perineal protection at crowning being beneficial and warm compression during the second stage of labour reducing the risk of OASIS.
- A documentation proforma for the management of severe Pre-eclamptic Toxemia (PET) to reiterate all the criteria and encourage full documentation was completed following completion of the Management of Severe Pre-Eclampsia audit.
- Early Pregnancy - Record Keeping Audit enabled the design of a new proforma for early pregnancy patients to be used in the clinic and on the ward, which will prompt the clinician to record the necessary information and facilitate safe handover between doctors, and will be introduced in teaching sessions for new staff to the department.
OUR PARTICIPATION IN CLINICAL RESEARCH

OUH is one of the UK’s leading university hospital trusts, committed to achieving excellence and innovation through clinical research. OUH and its research partners aim to find new ways to diagnose and treat our patients locally, and to contribute to healthcare advances nationally and internationally. This is underpinned by bringing together academic research expertise with our clinical teams to translate medical science into better healthcare treatments.

It is a strategic priority of the Trust to continue to increase our research activity, further integrate it with clinical care and increase patient participation and involvement. Research and teaching is carried out in partnership with the University of Oxford Medical Sciences Division, Oxford Brookes University’s Faculty of Health and Life Sciences, and Oxford Health NHS Foundation Trust, combining clinical expertise with academic excellence. Research and clinical facilities are co-located on our hospital sites to foster a culture of collaboration.

OUH hosts the Oxford Academic Health Science Network (AHSN) and is a founder member of the Oxford Academic Health Science Centre (AHSC). In particular, OUH works in close partnership with the University of Oxford in clinical research, encompassing major programmes in all areas of medical sciences, including cardiovascular, stroke, dementia, cancer, infection, vaccines, surgery and imaging. In genetics, OUH was designated a Genomics Medicine Centre in 2015, and the Oxford University Hospitals NHS Foundation Trust partnership between OUH and the University of Oxford has made major contributions to the 100,000 Genomes project, with Genomics England.

Clinical research at OUH is supported by major competitive National Institute for Health Research (NIHR) funding programmes, including the NIHR Oxford Biomedical Research Centre (BRC; £21 million/year), the NIHR Oxford Musculoskeletal Biomedical Research Unit BRU, £2.5 million/year). OUH hosts the NIHR Thames Valley and South Midlands Local Clinical Research Network (LCRN; £13.5 million/year). NHS research income to OUH in 2015/16 was £48 million, with the total research revenues across the OUH-OU partnership exceeding £350 million.

The BRC supports public and patient involvement in research, including regular public lectures, a Patients Active in Research (PAIR) group and Research Priority Setting Partnerships, and the annual BRC Open Day when research themes highlight their work through interactive events, attended by hundreds of people and generating substantial media interest.

In the last year, there have been more than 1,700 active clinical research studies hosted by OUH. During 2015/16 we initiated 351 new studies and hosted 285 studies with commercial partners. In NIHR clinical research network (CRN) studies, OUH is the top-recruiting NHS trust nationally. There are 148 staff who are directly supported by NIHR BRC or NIHR BRU funding and 195 staff supported by the NIHR CRN. Overall, a total of 1,087 staff are involved in the conduct of research at OUH. During 2015/16, OUH’s performance against the NIHR’s 70 day benchmark for the initiation of clinical trials was the best of any of the large research-active hospitals in England. OUH achieved a 100% track record in all four reporting quarters of 2015/16 in recruiting the first patient within 70 days.

The number of patients receiving relevant health services provided or sub-contracted by Oxford University Hospitals NHS Foundation Trust in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee was 18,268.
OUR EDUCATION AND TRAINING

Our objective at OUH is to produce competent and capable staff in order to ensure the workforce has the right skills, behaviours and training, available in the right numbers, to support the delivery of excellent healthcare and health improvement. We aspire to promote educational excellence and ensure that staff education and training reflects the needs of patients, the service, and our trainees and staff, ensuring that they have the right environment in which to learn. By so doing we will deliver education and training which directly benefits quality and patient safety, develops the leadership capability and capacity and retains the best healthcare talent, promotes and support the personal and career development aspirations of our staff whilst improving recruitment and retention.

The postgraduate medical education department oversees the education of 817 junior doctors in 245 separate programmes over four hospital sites. Of our 245 programmes, 224 are graded ‘Excellent’ or ‘Good’ by Health Education England Thames Valley. OUH is working towards compliance with the new GMC recommendations on Recognition of Trainers and 76% of our 455 educational supervisors have undergone training in the last three years. This year we will be introducing a new tri-partite agreement between each trainee, Health Education Thames Valley (HETV) and OUH in order to enshrine our commitment to supporting the delivery of high quality educational supervision.

Postgraduate medical education is strengthened at OUH through its strategic alliance with the University of Oxford. A specific example of this is the Oxford University Clinical Academic Graduate School (OUCAGS) which provides a nexus for world-class medical research and medical education. OUCAGS exists to promote and advance clinical academic careers by supporting and strengthening the clinical academic training of Oxford’s Academic Foundation Doctors, Academic Clinical Fellows, Clinical Research Fellows and Clinical Lecturers. A further example is the Oxford University Medical Education Fellows group which works to promote, coordinate and quality-assure excellence in the medical education of students and doctors.

As a Trust we are training in excess of 500 adult nurses and 100 midwives per year together with a range of other pre-registration professional groups. In the latest return to Health Education Thames Valley we have been rated excellent for the auditing and quality assurance of professional and regulatory body standards in nursing and midwifery; the robustness of processes for induction for learners across all staff groups; assurance of the professional competence of supervisory staff for Allied Health Professionals (AHPs), Healthcare Support Workers and Pharmacists; fitness to practice review processes for these groups; and for proactive engagement and partnership working for nursing and midwifery curriculum development.

In respect of our existing workforce, our aspiration to become a Magnet accredited organisation has significantly revitalised our nursing and midwifery workforce and established us as the national lead for Magnet accreditation in England. The recruitment to a number of Divisional and corporate education posts has enabled us to progress with the development of a number of academic accredited in-house programmes, the first of which Leading Compassionate Excellence will be launched this summer. Our wider workforce, clinical and non-clinical, is supported through investment in both academic and vocational education, including apprenticeships.

Work is ongoing across the organisation to both promote and progress multi-professional education through such routes as the Trust’s non-medical Foundation programme in partnership with FI doctors in training, and through planned learning activities with third year nursing students. The last year has also seen greater links made with Oxford Health NHS Foundation Trust and other external organisations in ensuring training where appropriate can be consistent across the patient pathway, and to establish sustainable ways of ensuring education delivery.
OUR CQUIN PERFORMANCE

Oxford University Hospitals NHS Foundation Trust income in 2015/16 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because the Trust was not eligible to take part in this scheme during this period, due to NHS England’s contracting rules.

STATEMENTS FROM THE CARE QUALITY COMMISSION

Oxford University Hospitals NHS Foundation Trust is required to register with the Care Quality Commission (CQC). The current registration status is registered without conditions. In February 2014, a planned inspection was undertaken by the CQC across the main hospitals of the Trust. The Trust was graded ‘good’ overall, except for Emergency Department and surgery at the John Radcliffe Hospital site which were rated as ‘requires improvement.’ The ratings grid is provided below for the Trust overall and by site.
**Horton General Hospital**

**Overall rating**

<table>
<thead>
<tr>
<th></th>
<th>Inadequate</th>
<th>Requires improvement</th>
<th>Good</th>
<th>Outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent care centre</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical care (including older people’s care)</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Surgery</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Intensive/critical care</td>
<td>Requires improvement</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Maternity and gynaecology</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Services for children &amp; young people</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>End of life care</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Outpatients</td>
<td>Good</td>
<td>Not rated</td>
<td>Good</td>
<td>Good</td>
</tr>
</tbody>
</table>

**Nuffield Orthopaedic Centre**

**Overall rating**

<table>
<thead>
<tr>
<th></th>
<th>Inadequate</th>
<th>Requires improvement</th>
<th>Good</th>
<th>Outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care (including older people’s care)</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Surgery</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Outpatients</td>
<td>Good</td>
<td>Not rated</td>
<td>Good</td>
<td>Good</td>
</tr>
</tbody>
</table>
John Radcliffe Hospital

**OUH Action Plan**

An action plan was agreed with the CQC and was actively managed in the Trust to ensure the actions were completed within defined timescales. The Care Quality Commission has not taken enforcement action against the Trust during 2015/16. OUH has not participated in any special reviews or investigations by the CQC during the reporting period.

The Trust has participated in the Joint Targeted Inspections into Child Sexual Exploitation and Missing Children. The Joint Targeted Inspections includes Care Quality Commission (CQC), Ofsted, Her Majesty’s Inspectorate of Constabulary (HMIC) and Her Majesty’s Inspectorate of Probation (HMIP).

An overview report will be published once the review has concluded.
OUR DATA QUALITY

We see data quality as everybody’s responsibility. Good quality information underpins the delivery of effective patient care and is essential to understanding where improvements need to be made.

This approach helps us to ensure that every staff member seeks to achieve high standards of data quality and aims to ensure that we continue with the ethos of data quality improvement throughout the organisation. The Trust has an established data quality infrastructure which is overseen by the Information Governance and Data Quality Group for monitoring and improvement. An update on the Trust data quality activities and performance is included in the six monthly information governance updates to the Trust Board.

A data quality assurance framework requires the data underpinning all the Trust’s key performance indicators to be rated according to the data quality and the level of assurance.

The Data Quality Strategy aims to provide a robust yet flexible framework within which the Trust can maximise the completeness, accuracy and validity of patient information. It recognises the need to ensure that data are collected for justifiable purposes and used in accordance with sound principles of information management and governance. It endorses the use of mandatory, validated NHS numbers on all patient records as the foundation on which all further information quality considerations must rest. Encompassing the information quality assurance requirements of information governance, it provides a fundamental statement of responsibilities which should underpin all data collection, management and monitoring activities within the Trust, enabling efficient service delivery, performance management and the planning of future services.

OUH will be taking the following actions to improve data quality.

- During 2016/17 the Trust will continue to reinforce a number of measures to strengthen data quality. The data quality activities are also underpinned by a programme of annual external and internal audits.
- Each of the clinical Divisions continues to strengthen its arrangements for securing good quality data, making use of internal audit to identify areas for improvement, and the quarterly compulsory audit programme for each Division is monitored by the Information Governance and Data Quality group.
- In addition to this programme of audits, the Divisions also undertake a monthly programme of validation of key performance data underpinning the referral to treatment 18 week waiting time standard and the cancer waiting time standards. A programme of coding audits is undertaken by the Trust’s Coding Department in collaboration with individual specialties.
- The Trust has embedded the six elements of the data quality diamond into its internal audits to ensure it is covering each aspect within each audit; the elements cover accuracy, validity, reliability, timeliness, relevance and completeness.
- One of the most important elements of improving and maintaining services relies on the opportunity for continuing staff education and training. The training policy underpins the application of all relevant employment policies and ensures that for all staff, including temporary staff, we apply access control, ensure data quality processes are adhered to and put procedures in place to support the consistent capture of quality data into our corporate systems.
- Continued development and review of e-learning programmes, which include dedicated data quality workbooks and e-assessments, takes into account any trends that may be assisted with reminders to staff via e-learning.
OUH submitted records during 2015/16 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

<table>
<thead>
<tr>
<th>Inpatients</th>
<th>OUH</th>
<th>National average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid NHS number</td>
<td>98.6%</td>
<td>99.2%</td>
</tr>
<tr>
<td>General Medical Practice Code</td>
<td>100.0%</td>
<td>99.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatients</th>
<th>OUH</th>
<th>National average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid NHS number</td>
<td>99.7%</td>
<td>99.4%</td>
</tr>
<tr>
<td>General Medical Practice Code</td>
<td>100.0%</td>
<td>99.8%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EMERGENCY DEPARTMENT</th>
<th>OUH</th>
<th>National average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid NHS number</td>
<td>96.5%</td>
<td>95.3%</td>
</tr>
<tr>
<td>General Medical Practice Code</td>
<td>100.0%</td>
<td>99.6%</td>
</tr>
</tbody>
</table>

**Information Governance Toolkit**

Information governance (IG) ensures necessary safeguards for, and appropriate use of, patient, staff and corporate information. The IG Toolkit is an online system that allows NHS organisations and partners to assess themselves against national IG policies and standards. Attainment levels are published on 1 April each year for every organisation submitting an IG Toolkit return. Our IG Toolkit score for 2015/16 was 97% with all requirements at either level two or three, giving the Trust a satisfactory rating (organisations are either rated satisfactory or unsatisfactory). This is colour coded green. To ensure our staff are kept up-to-date we provide training annually.

**Clinical coding error rate**

The Trust was not subject to the Payment by Results clinical coding audit during 2015/16 by the Audit Commission.
National core set of quality indicators

Mortality - 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 23 March 2016 (for the reporting period October 2014 to September 2015) was 1.00. This value is banded ‘as expected’ using the HSCIC 95% confidence intervals adjusted for over-dispersion.

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 SHMI is derived.
- Data are collected 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 below.

The Trust reviews the SHMI in conjunction with other published mortality measures and the information from our internal review of deaths.

The graph below displays the OUH SHMI in comparison to other trusts in England (for the data period October 2014 to September 2015).
The graph below provides a comparison of the SHMI for deaths that occur in hospital and within 30 days of discharge.
Review of patient deaths

Our Trust target is for 100% of patient deaths to be reviewed to ensure that any omissions or actions taken are identified and learnt from to improve care. An analysis of the mortality reports for April 2015 to December 2015 indicate that 85% of deaths were reviewed.

The Trust has established a Mortality Review Group which meets monthly under the chairmanship of the Deputy Medical Director with multidisciplinary and multi-professional membership and the responsibility for mortality reporting to the Board.

In response to the publication of Mazar’s report into Southern Health Mortality Review, joint meetings of the OUH learning difficulties team, OUH Clinical Governance team and Oxfordshire Clinical Commissioning Group (OCCG) have been held to agree an approach to reviewing deaths of patients with learning difficulties. OCCG requested OUH to review four cases from within the Southern Health review report cohort who also received care at OUH. Of these, two patients died at OUH hospitals and two patients died elsewhere. OUH also reviewed the deaths of patients within the learning difficulties database during the 2015 calendar year and there were no initial concerns from review of patient demographics, contemporaneous mortality review and causes of death. OUH is working with OCCG to ensure full reviews of all deaths related to patients with learning difficulties are reported to the CCG.
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 below displays the rate of palliative care coding at OUH in comparison to other trusts in England for the data period October 2014 to September 2015.

### Source: HSCIC

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patient deaths with palliative care coded</td>
<td>31.54</td>
<td>30.88</td>
<td>30.30</td>
<td>26.60</td>
</tr>
</tbody>
</table>
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 procedure in England. The latest data available from the HSCIC are for the previous financial year 2014/15. Data for 2015/16 will be available later in 2016 and will be published in our 2016/17 Quality Account.
Primary (first) hip replacement

<table>
<thead>
<tr>
<th>Hip replacement primary</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>Provisional 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>OUH</td>
<td>0.407</td>
<td>0.432</td>
<td>0.442</td>
<td>0.467</td>
<td>0.440</td>
</tr>
<tr>
<td>2014/15 average</td>
<td>0.437</td>
<td>0.437</td>
<td>0.437</td>
<td>0.437</td>
<td>0.437</td>
</tr>
<tr>
<td>Lowest 2014/15</td>
<td>0.331</td>
<td>0.331</td>
<td>0.331</td>
<td>0.331</td>
<td>0.331</td>
</tr>
<tr>
<td>Highest 2014/15</td>
<td>0.524</td>
<td>0.524</td>
<td>0.524</td>
<td>0.524</td>
<td>0.524</td>
</tr>
</tbody>
</table>

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 the PROMs responses and sends these to the HSCIC;
- data are compared to peers, highest and lowest performers, and our own previous performance, as set out in the tables.

The HSCIC advice is that these results are provisional and subject to change until the publication of finalised data later in 2016.

Primary (first) knee replacement

<table>
<thead>
<tr>
<th>Knee replacement primary</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>Provisional 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>OUH</td>
<td>0.307</td>
<td>0.302</td>
<td>0.298</td>
<td>0.335</td>
<td>0.291</td>
</tr>
<tr>
<td>2014/15 average</td>
<td>0.315</td>
<td>0.315</td>
<td>0.315</td>
<td>0.315</td>
<td>0.315</td>
</tr>
<tr>
<td>Lowest 2014/15</td>
<td>0.204</td>
<td>0.204</td>
<td>0.204</td>
<td>0.204</td>
<td>0.204</td>
</tr>
<tr>
<td>Highest 2014/15</td>
<td>0.418</td>
<td>0.418</td>
<td>0.418</td>
<td>0.418</td>
<td>0.418</td>
</tr>
</tbody>
</table>

Varicose veins

<table>
<thead>
<tr>
<th>Varicose vein</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>Provisional 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>OUH</td>
<td>0</td>
<td>0.066</td>
<td>0.015</td>
<td>0.064</td>
<td>0.095</td>
</tr>
<tr>
<td>2014/15 average</td>
<td>0.095</td>
<td>0.095</td>
<td>0.095</td>
<td>0.095</td>
<td>0.095</td>
</tr>
<tr>
<td>Lowest 2014/15</td>
<td>-0.002</td>
<td>-0.002</td>
<td>-0.002</td>
<td>-0.002</td>
<td>-0.002</td>
</tr>
<tr>
<td>Highest 2014/15</td>
<td>0.154</td>
<td>0.154</td>
<td>0.154</td>
<td>0.154</td>
<td>0.154</td>
</tr>
</tbody>
</table>
Emergency readmission within 28 days of discharge

The Trust routinely monitors 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 a prolonged length of stay and lead to an inappropriate degree of risk aversion. As part of the Trust’s discharge support, patients are encouraged to seek support directly if they are experiencing symptoms of ill health following a treatment or procedure. The method of contact by patients would usually be by telephone but patients may also attend at hospital. There are emergency departments at the John Radcliffe and Horton General hospitals but patients known to the Trust services may also be admitted directly to the Churchill Hospital.

The information on emergency readmissions provided by the HSCIC relates to the percentage of patients readmitted to any hospital in England occurring within 28 days of discharge from a hospital which forms part of the Trust; aged: (i) 0 to 15; and (ii) 16 or over. The last versions of the emergency readmissions information was released by HSCIC in April 2014 for patients aged 0 to 15 years old 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 below. 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.

The emergency readmissions rate at ORH NHS Trust 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)’.

Data from the HSCIC are not currently available beyond 2012 hence we have also provided comparable data from Dr Foster.

Dr Foster readmissions data
Readmission rates published by Dr Foster are available until August 2015 and indicate that readmission rates are 7-8% substantially lower than the HSCIC data period of 2011/12. Readmission rates as a percentage of total admissions for patients 15 years and over were slightly higher in May and July 2015 (0.3%) and lower in June (0.9%) and August 2015 (0.5%) than the same period in the previous year.

<table>
<thead>
<tr>
<th>AGE GROUPS</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</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>(i) 0 to 15 (NOC)</td>
<td>10.32%</td>
<td>10.86%</td>
<td></td>
</tr>
<tr>
<td>(i) 0 to 15 (NOC)</td>
<td>11.97%</td>
<td>11.73%</td>
<td>11.41%</td>
</tr>
</tbody>
</table>

Readmission rates as a percentage of total admissions for patients 0 to 14 years are 7-8%, substantially lower than the HSCIC data period of 2011/12.
The rate has decreased in April (0.8%) and June 2015 (2%) and increased slightly in July (0.1%) and August 2015 (0.6%) compared to the same period the previous year.

Dr Foster analyses all hospital data and categorises a readmission as any readmission within 28 days to any specialty. The analysis does not differentiate between a readmission due to a complication or deficiency in the provision of care or an admission for a new medical issue. For example; a fracture to the leg following an accident within 28 days of removal of the appendix is categorised as a readmission. In general OUH is in the mid-range for readmissions compared to peers.

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 collected internally and then submitted on a monthly basis to the HSCIC via the Secondary Uses Service (SUS). The data are 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.

Cancer assessment unit – triage service

The triage service is a nurse-led service on the Churchill site with facilities to review patients in a dedicated triage area, based in an outpatient clinical setting. There are five beds used to assess patients, and undertake acute interventions as indicated. The service is open seven days a week (Monday to Sunday 8am - 8pm). Patients may be admitted, discharged or referred from this service.

Through access to this service patients can receive expert advice and guidance to support their care needs and reduce the requirement for admission. Currently 75% of calls results in no admission. The other 25% of patients are seen within the assessment area and of these 32% of patients will go home.

Prior to the introduction of the triage service the majority of these patients would have been admitted to hospital.
PATIENT EXPERIENCE

Patients’ views count and help drive learning and improvement. 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. Understanding what matters most for our patients and their families is a key factor in achieving this.

Compassionate care

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

The Trust values:

Learning | Respect | Delivery | Excellence | Compassion | Improvement

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. Feedback helps our staff to know what we are doing well (and we should keep 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 YOUR FEEDBACK</th>
<th>HOW WE USE THIS FEEDBACK</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Friends and Family Test (FFT)</td>
<td>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. Results are frequently displayed in ward and outpatient areas.</td>
</tr>
<tr>
<td>Annual National Inpatient Survey</td>
<td>Gives us examples of what patients say about our wards and helps us plan improvement work for the coming year.</td>
</tr>
<tr>
<td>Listening to what you say in person (face to face discussions)</td>
<td>We try to resolve any issues as quickly as possible. This direct feedback helps us to quickly see where we need to make improvements to specific aspects of our service.</td>
</tr>
<tr>
<td>Feedback to Patient Advice and Liaison Service (PALS)</td>
<td>Concerns, issues, and compliments are fed back to relevant departments in the Trust so improvements can be made. These are collated as it helps to see the feedback broken down into themes so we can see if there are one-off or recurrent problems to fix.</td>
</tr>
<tr>
<td>Letters and emails</td>
<td>Positive feedback from NHS Choices is recorded weekly and feedback is sent out to Divisional leads on a monthly basis.</td>
</tr>
<tr>
<td>Feedback on the NHS Choices website</td>
<td></td>
</tr>
<tr>
<td>Patient stories</td>
<td>Gives 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.</td>
</tr>
<tr>
<td>Engagement with partner, voluntary and community organisations</td>
<td>We engage with voluntary and community groups, covering a wide range of communities and issues. For example: carers, older people, black and minority ethnic groups, mental health, young carers. We also work closely with health and social care partners in Oxfordshire.</td>
</tr>
<tr>
<td>Workshops</td>
<td>We hold workshops to hear the views of individuals, patients, carers, the public and representatives from community and voluntary groups, such as Public Participation Group (PPG) workshops, Seldom Heard Groups, and Quality Priorities events.</td>
</tr>
<tr>
<td>PPI involvement in BRC research studies</td>
<td>To define new areas for research and to comment on research priorities and quality of lay summaries.</td>
</tr>
</tbody>
</table>
Children’s patient experience

- In September 2015, a Project Lead for Children’s patient experience came into a two year post, funded by Health Education Thames Valley.
- The young persons’ public partnership group successfully relaunched as part of Oxford University Hospitals NHS Foundation Trust participating in National Takeover Day.
- Two members are now Governors.
- Feedback so far received from young people and changes made:
  - improved general appearance of Children’s Hospital and waiting areas;
  - improved signage based on feedback, for example improving lift signage in the West Wing.

The table below shows results for OUH in a national context, regarding the five questions in the National Inpatient Survey that relate to responsiveness to patients’ personal needs. We consistently score above the national average due to our commitment to delivering compassionate excellence and our ongoing dedication to person-centered care.

<table>
<thead>
<tr>
<th>RESPONSIVENESS TO INPATIENTS’ PERSONAL NEEDS</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>OUH</td>
<td>69.3</td>
<td>69.9</td>
<td>69.2</td>
<td>71</td>
</tr>
<tr>
<td>National average</td>
<td>67.4</td>
<td>68.1</td>
<td>68.7</td>
<td>68.9</td>
</tr>
<tr>
<td>Highest scoring trust</td>
<td>85</td>
<td>84.4</td>
<td>84.2</td>
<td>86.1</td>
</tr>
<tr>
<td>Lowest scoring trust</td>
<td>56.5</td>
<td>57.4</td>
<td>54.4</td>
<td>59.1</td>
</tr>
</tbody>
</table>

Source: Health and Social Care Information Centre website - [https://indicators.hscic.gov.uk/webview](https://indicators.hscic.gov.uk/webview) - indicator 4.2.

Staff recommendation of our hospitals to family and friends

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, is a strong indicator of staff engagement and motivation. These areas 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 2015/16 acute trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012/13</td>
<td>2013/14</td>
</tr>
<tr>
<td></td>
<td>67%</td>
<td>77%</td>
</tr>
</tbody>
</table>

Recommendation of the organisation as a place to work

<table>
<thead>
<tr>
<th></th>
<th>OUH scores</th>
<th>National scores 2015/16 acute trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012/13</td>
<td>2013/14</td>
</tr>
<tr>
<td></td>
<td>54%</td>
<td>67%</td>
</tr>
</tbody>
</table>
We consider that these data are as described for the following reasons:

- the Trust has a process in place for collating data on the Friends and Family Test;
- data are collated internally and then submitted on a monthly basis to Department of Health.

OUH has taken the following actions to improve this indicator, and so the quality of our services:

- 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 2015 provided a good engagement opportunity for individuals and teams to review the results and determine local priorities for action.

**Staff Survey**

The table below shows our most recent NHS Staff Survey results for indicators KF19 (percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months) and KF27 (percentage believing that Trust provides equal opportunities for career progression or promotion) for the Workforce Race Equality Standard*.

**Please note:** the information given relates to the descriptors provided rather than the numbers, as there was a discrepancy between the two.

<table>
<thead>
<tr>
<th>Key finding</th>
<th>Description</th>
<th>OUH 2015 score</th>
<th>National average 2015</th>
<th>Best 2015 score for acute trusts</th>
<th>Workforce Race Equality Standard</th>
<th>WRES average median for acute trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key finding 26</td>
<td>% of staff experiencing harassment, bullying or abuse from staff in the last 12 months</td>
<td>23%</td>
<td>26%</td>
<td>16%</td>
<td>White - 23% BME - 20%</td>
<td>White - 25% BME - 28%</td>
</tr>
<tr>
<td>Key finding 21</td>
<td>% believing that Trust provides equal opportunities for career progression or promotion</td>
<td>89%</td>
<td>87%</td>
<td>96%</td>
<td>White - 92% BME - 76%</td>
<td>White - 89% BME - 75%</td>
</tr>
</tbody>
</table>

---

**Patient recommendation of our hospitals to family and friends**

<table>
<thead>
<tr>
<th>Results from the Friends and Family Test survey</th>
<th>NOTE: Results are from beginning of April 2015 to September 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFT: inpatients and day cases</td>
<td>97% of patients were extremely likely or likely to recommend their ward, based on 7,709 responses.</td>
</tr>
<tr>
<td>FFT: Emergency Department</td>
<td>85% of patients were extremely likely or likely to recommend the care they received in the Emergency Department, based on 5,596 responses.</td>
</tr>
<tr>
<td>FFT: Outpatients</td>
<td>93% of outpatients were extremely likely or likely to recommend the care they received, based on 16,254 responses.</td>
</tr>
<tr>
<td>FFT: Maternity</td>
<td>95% of women were extremely likely or likely to recommend the Trust’s maternity services, based on 1,685 responses.</td>
</tr>
</tbody>
</table>
The table below shows the Trust’s overall results from the FFT test.

<table>
<thead>
<tr>
<th>April 15 – September 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>23,410</td>
<td>5,486</td>
<td>1,027</td>
<td>502</td>
<td>465</td>
<td>354</td>
</tr>
<tr>
<td>Percentage</td>
<td>75%</td>
<td>18%</td>
<td>3%</td>
<td>2%</td>
<td>1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

We consider that these data are as described for the following reasons:

- the Trust has a robust process in place for collating data on the Friends and Family Test;
- data are collated internally and then submitted on a monthly basis to Department of Health.

We have taken the following actions to improve this indicator, and so the quality of our services:

- Full implementation of text messaging and agent calls across outpatients and day cases. This was implemented in August 2015 after a successful trial in the Emergency Department services. Some patients have been excluded from this automated method due to sensitivity issues and following NHS England guidelines; palliative care patients, sexual health and those who may have had a pregnancy loss.
- Staff and volunteers across the Trust have been encouraged to raise patient awareness about feedback via automated methods, encourage patients to respond, opt out patients who do not wish to receive a text message, and offer paper questionnaires to those patients.
- All team leaders of outpatient and day case areas have been encouraged to use the website where all of the automated feedback is uploaded – Envoy Messenger.
- Training sessions have been held for staff to learn how to use the site and automated reports are easily set up for those who wish to display results and examine comments in detail.
- There are facilities on the site to create ‘You said, we did’ posters and to create action plans around any feedback that requires follow-up.

### National patient surveys

We undertook one national survey for 2015/16 – the National Inpatient Survey. Results are currently embargoed as they will not be published until 8 June 2016.

The nationally mandated sample increased from 850 to 1,250. However, the Trust commissioned an additional sample of 3,492, meaning that a total of 4,742 surveys were sent out. This additional sample has allowed for ward level data to become available without compromising the anonymity of the responses. The Trust’s extended sample results will not be part of nationally published results.

OUH has taken the following actions to improve this indicator, and the quality of our services:

- Ensuring a continued focus on ‘responsiveness to patient needs, as measured via call bells’.
- The Patient Experience Teamworking with the sister and matron of three selected wards to improve responsiveness to patient needs, measured via patient feedback about call bell response times.
- The wards being resurveyed with a mini version of the National Inpatient Survey.
- Replicating successful methods for improving responsiveness across the Trust.
- Incorporating the plan to improve call bell response times into the professional practice model for the Trust as part of the Magnet accreditation process. This is being led by the Chief Nurse.
Infection control

We believe these data are as described for the following reasons:

- the Trust has a process in place for collating data on C difficile cases;
- data are collated internally and submitted on a daily basis to Public Health England;
- all the C difficile cases are presented at the monthly health economy meeting which includes representation from OUH, Oxford Health NHS Foundation Trust, Oxfordshire CCG and Public Health England;

the purpose of this meeting is to review all reported cases of C difficile to ascertain availability, identify lapses in care and develop agreed action plans for quality improvement;

- data are compared to peers, highest and lowest performers, and our own previous performance, as set out below.

<table>
<thead>
<tr>
<th>C DIFFICILE RATES PER 100,000 BED-DAYS</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust attributed (number)</td>
<td>64</td>
<td>61</td>
<td>57</td>
</tr>
<tr>
<td>Total bed-days</td>
<td>454,489</td>
<td>414,213</td>
<td>394,104</td>
</tr>
<tr>
<td>Rate per 100,000 bed-days for specimens taken from patients aged two years and over (Trust attributed cases)</td>
<td>13.9</td>
<td>13.8</td>
<td>14.5</td>
</tr>
<tr>
<td>National average</td>
<td>14.7</td>
<td>12.02</td>
<td></td>
</tr>
</tbody>
</table>

The annual commentary and tables for CDI will be published on 7 July 2016.

Throughout 2015/16 the Infection Prevention and Control Team in partnership with staff has driven forward safer practices in order to minimise preventable infections. Teamwork and a constant focus by staff on antimicrobial stewardship, cleaning, disinfection of surfaces and equipment and hand hygiene audits and training have all contributed to minimising infection rates. The most recent audit of compliance with antibiotic guidance showed a high compliance rate of 92% across the Trust.
PATIENT SAFETY INCIDENTS

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 benchmark 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 number of patient safety incidents and near misses reported at OUH continues to increase and we believe this reflects a positive culture of reporting incidents. 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 that these data are as described for the following reasons:

- we have 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;
- all reported incidents are reviewed each working day by the Clinical Risk Management team. Incidents which have been graded as ‘no harm’ or ‘minor’ but which give rise to concern are discussed with the Divisions and added to the Serious Incident Requiring Investigation (SIRI) forum agenda. Any incidents that are graded as moderate or above are added to the SIRI forum agenda and an initial summary report is requested. As part of this initial review the harm grading is assessed to ensure that the grading is considered correct. Some incidents that have initially been graded as moderate or greater will be downgraded at this stage as it will be apparent from the initial review that the reporter has overstated the patient harm.
- At the SIRI forum the harm level of all incidents presented is discussed and agreed following the standards outlined in the Serious Incident Framework (NHS England).
- After the SIRI forum the harm level is updated in Datix. At the point of the uplift of information to the NRLS the harm grading for the exported incident should be accurate.
- There are occasions when the harm level of an incident is amended after the NRLS uplift. For example, when further results or clinical interventions have occurred some weeks after the initial report which reveals more information about the Trust impact on an incident. If this means a no harm or minor incident is upgraded to a moderate (or greater), or a moderate (or greater) incident is downgraded to minor or no harm, the NRLS is updated by the nominated staff member in the Datix team.
- Data are compared to peers, highest and lowest performers, and our own previous performance, as below:

<table>
<thead>
<tr>
<th></th>
<th>Oxford University Hospitals</th>
<th>National comparison for ‘acute (non-specialist) organisations’ Apr-14 to Mar-15</th>
</tr>
</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>
In June 2015 the Trust introduced a weekly Serious Incident Forum, where all incidents graded as moderate and above, or any ‘no harm’ incidents of concern are taken to discuss. Divisions, frontline staff, executives and leads for specialist areas such as tissue viability, pharmacy, VTE and information governance attend as required. The purpose of the Forum is to:

- provide an open, honest and transparent process in the decision-making of calling SIRIs;
- provide assurance to the Trust Management Executive (TME);
- disseminate Trust-wide learning from SIRIs called through this process.

During 2015/16 176 SIRI have been declared onto the strategic executive information system [STEIS]. This follows a concerted effort to improve timeliness and extent of escalation of incidents. Reporting has increased this year, compared to 2014/15 when 82 SIRIs were declared.

The three most common types of serious incident reported in the Trust are as follows, in descending order of frequency:

- Hospital acquired pressure ulcers
- Falls resulting in injury
- Delays in treatment

From April 2015 the NRLS changed the rates used to compare reporting between trusts from incidents per 100 admissions to rate of incidents per 1,000 bed-days – the table below presents the last three six month periods for which these data are available alongside the average, highest and lowest for the most recent (Oct-14 to Mar-15) NRLS release.

<table>
<thead>
<tr>
<th>Oxford University Hospitals</th>
<th>National comparison for ‘acute (non-specialist) organisations’ Apr-14 to Mar-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct-13 to Mar-14</td>
<td>Apr-14 to Sep-14</td>
</tr>
<tr>
<td>Incident rate (per 1,000 bed days)</td>
<td>Average</td>
</tr>
<tr>
<td>36.4</td>
<td>37.2</td>
</tr>
<tr>
<td>39.4</td>
<td></td>
</tr>
<tr>
<td>41.9</td>
<td></td>
</tr>
</tbody>
</table>

The Trust has taken the following actions to improve this indicator, and so the quality of its services, by:

- staff continuing to attend the monthly Risk Management and Incident Investigation training, and during 2015/16 75 members of staff have been trained;
- working closely with Oxford Simulation, Teaching and Research (OxStaR) to align incident investigation and Human Factors and to target incident investigators.

**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 NHS England.

In 2015/16 OUH reported seven incidents that met these criteria during this financial year, as follows:

- wrong site surgery: wrong spinal disc removal;
- retained foreign object: swab from surgery;
- wrong site surgery: emergency craniotomy;
- wrong site surgery: wrong side Portacath removal (event occurred during 2014/15 but reporting was delayed by clinical team);
- wrong site surgery: wrong site incision for an oesophagectomy;
- wrong site surgery: wrong site nerve block;
- wrong site surgery: wrong site nerve block.

In response to these events and Never Events in prior years the Trust has developed a wide ranging Never Event Action Plan which is regularly monitored both within the Trust and with commissioners. Other actions included the external review described below which is available on the Trust’s website.

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3. The lowest rate for a single provider within the acute (non-specialist) was 3.6 for the six months October 2014 to March 2015; this was for a trust which reported a total of 443 incidents for the period – the next lowest is reported in the table as a more representative comparison.
Toft review into Never Events at Oxford University Hospitals (2014/15)

Professor Toft was commissioned in 2015/16 by the Chief Executive to carry out an external review of the Investigation reports into seven Never Events reported by OUH in financial year 2014/15 (one of which related to an error in the previous financial year).

An overall set of conclusions and recommendations was provided at the end of the review. The review concluded that no evidence had been found to suggest that a patient safety problem exists within the Trust and the evidence strongly suggests that the Trust has a proactive safety culture. Additionally, the review found that the Trust’s commitment to openness with respect to SIRIs and Never Events is exemplary.

Venous thromboembolism

The Trust has met and exceeded the 95% target for VTE risk assessment of patients for 2015/16. Oxford University Hospitals NHS Foundation Trust considers that these data are as described for the following reasons:

- the Trust has a robust process in place for collating data on venous thromboembolism assessments;
- data are collated internally and then submitted on a monthly basis to Department of Health;
- data are compared to peers, highest and lowest performers, and our own previous performance, as set out in the table below.

The Trust has taken the following actions to improve this indicator, and so the quality of its services.

- The investigation of all hospital acquired thromboses (HATs). Discussion of all potentially preventable HATs in the Serious Incident Requiring Investigation (SIRI) forum and dissemination of learning outcomes.
- Improving patient information on admission and discharge (VTE information to be included in generic admission ‘safety leaflet’, exploring the use of bedside TVs, VTE business cards are now included in medications for discharge bags, and VTE information is being added to generic ‘plan well’ discharge leaflet).
- Improving compliance with prescribing and safety checks for anti-embolism stockings.
- Improving electronic VTE risk assessment: alerts for repeat VTE risk assessment being implemented.

<table>
<thead>
<tr>
<th>VTE</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessed</td>
<td>207,862</td>
<td>200,181</td>
<td>231,997</td>
<td>Month 12 (2015/16) is an average of the previous 11</td>
</tr>
<tr>
<td>Admitted</td>
<td>217,965</td>
<td>214,142</td>
<td>239,326</td>
<td>Month 12 (2015/16) is an average of the previous 11</td>
</tr>
<tr>
<td>Assessment rate</td>
<td>95.36%</td>
<td>93.48%</td>
<td>96.94%</td>
<td></td>
</tr>
<tr>
<td>National average</td>
<td>95.76%</td>
<td>96.09%</td>
<td>95.80%</td>
<td>2015/16 based on Q1-Q3</td>
</tr>
<tr>
<td>Best performing trust</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>2015/16 based on Q1-Q3</td>
</tr>
<tr>
<td>Worst performing trust</td>
<td>82.05%</td>
<td>88.45%</td>
<td>80.55%</td>
<td>2015/16 based on Q1-Q3</td>
</tr>
</tbody>
</table>
Emergency Department access: 95% of Emergency Department patients wait fewer than four hours

We consider that these data are as described for the following reasons:

- the Trust has a robust process in place for collating data on ED attendances and four hour breaches;
- data are collated internally and then submitted on a monthly basis to Department of Health;
- data are compared to peers, highest and lowest performers, and our own previous performance, as set out in the table below.

<table>
<thead>
<tr>
<th>EMERGENCY DEPARTMENT</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>No of four hour breaches</td>
<td>89,94</td>
<td>14,017</td>
<td>13,115</td>
</tr>
<tr>
<td>No of attendances</td>
<td>132,838</td>
<td>137,883</td>
<td>132,298</td>
</tr>
<tr>
<td>Performance</td>
<td>93.23%</td>
<td>89.83%</td>
<td>90.09%</td>
</tr>
<tr>
<td>National average</td>
<td>95.69%</td>
<td>93.61%</td>
<td>93.30%</td>
</tr>
<tr>
<td>Best performing trust</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Worst performing trust</td>
<td>88.48%</td>
<td>82.03%</td>
<td>81.20%</td>
</tr>
</tbody>
</table>

Reflecting national trends, Emergency Department (ED) attendances rose at both the Horton General Hospital and John Radcliffe Hospital sites. Increases were seen across all age groups and across all pathways (minor, major, paediatric and critical care). Increased complexity of medical presentation and of additional social and/or psychological need was a further feature of the attending patient group.

The months of January, February and March 2016 were particularly challenging: ED attendances were 12% higher than the equivalent period in 2015, an unprecedented rate of growth that may in part reflect intensifying pressures in primary care as well as the patient and population vulnerability that comes with increased numbers of people living with complex, chronic illness.

The four hour access standard was not achieved. Factors include exceptionally high activity, acuity and complexity levels, outflow block (a failure to transfer care promptly to a clinical setting in the hospital beyond ED), and internal factors as the urgent care pathway reconfigures to a more capable, sustainable model of care. Outflow block from ED reflected very high bed occupancy levels, itself a product of exceptional acute clinical need and the levels of delayed transfers of care (DToC) that remained high despite the successful and ongoing DToC ‘Care Home beds’ initiative.

The Trust has taken the following actions to improve this indicator and so the quality of its services by:

- strengthening the clinical team with additional experienced nursing and medical staff;
- strengthening support services such as portering and radiology;
- advanced ‘point-of-care’ diagnostic approaches are in routine use;
- pathways are ‘ambulatory (non-admitting) by default’;
- physical works and reconfiguration in ED and the Emergency Assessment Units (EAUs) have improved patient experience and supported earlier more effective clinical care.

Looking forward, the service must continue to adapt to better meet growing and different patient needs. Key patient groups include the very young, the very elderly and frail, patients with psychological needs, and patients with severe critical illness. Delivering individualised, patient-centered care across boundaries is key to delivering best care and best value-for-money; we are working intensively with teams within and beyond OUH – including primary care, community health and social care providers and commissioners - to identify innovative solutions to support delivery of best clinical care 24/7.
PART 3: PROGRESS AGAINST PRIORITIES 2015/16 AND OTHER INFORMATION

Progress against priorities for 2015/16
How did we do against last year’s priorities?

This venn diagram shows the relationship between the different quality priorities in the Trust in 2015/16 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 impacted on all three quality domains.

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>CQC QUESTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT SAFETY</td>
<td>Safe Caring Responsive Well-led</td>
</tr>
<tr>
<td></td>
<td>• Preventing avoidable patient deterioration and harm in hospital</td>
</tr>
<tr>
<td></td>
<td>• Partnership working to improve urgent and emergency care</td>
</tr>
<tr>
<td></td>
<td>• Improving recognition, prevention and management of Acute Kidney Injury</td>
</tr>
<tr>
<td>CLINICAL EFFECTIVENESS</td>
<td>Effective Safe Caring</td>
</tr>
<tr>
<td></td>
<td>• Learning from deaths and harm to improve patient care</td>
</tr>
<tr>
<td></td>
<td>• Management of patients presenting with sepsis</td>
</tr>
<tr>
<td>PATIENT EXPERIENCE</td>
<td>Caring Responsive Well-led</td>
</tr>
<tr>
<td></td>
<td>• End of Life Care: improving people’s care in the last few days and hours of life</td>
</tr>
<tr>
<td></td>
<td>• Improving communication, feedback, engagement and complaints management</td>
</tr>
</tbody>
</table>

SIGN UP TO SAFETY
quality priorities / safety culture
PATIENT SAFETY

Priority 1: Preventing avoidable patient deterioration and harm in hospital: Sign Up to Safety

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 at which patients receive their TTOs (medicines to take out) 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 catheter acquired urinary tract infection (CAUTI), including training staff to use bladder ultrasound scanners as part of the Oxford Academic Health Science Network (AHSN) collaborative
  - Reducing the incidence of new venous thromboembolism.

4. 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
### GOAL
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.

### TARGET
By Q4 100% of patients on intensive and high dependency areas will be reviewed by consultants twice daily.

### MEASURE
We will measure by Directorate audits of patient records. Directorates will report their figures to the Care 24/7 project team.

### PLAN
Each of our Directorates will prepare an action plan to implement twice daily reviews.

### HOW DID WE DO?
- We are pleased to confirm that 100% of patients in our intensive care departments receive twice daily clinical reviews by consultants as a minimum.
- There are no designated high dependency units at the Trust however a number of our ward areas also care for very sick patients; during the year ahead we will be carrying out work to define a number of these areas as high dependency. This will be part of the Trust programme of work to implement standard eight of the national clinical standards for seven day working. Standard eight is one of the four ‘critical standards’ considered to have the biggest impact on mortality rates.

### HOW DID WE DO?
- Improve the way we recognise when a patient’s condition deteriorates, so we can take prompt action to treat them.
- Roll out electronic ‘Track and Trigger’ system in all acute areas of the Trust.
- Produce a cardiac arrest reduction strategy by March 2016.
- Number of acute areas in the Trust with electronic ‘Track and Trigger’. Ratified cardiac arrest reduction strategy by 31 March 2016.
- Our intensive care team 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)

### HOW DID WE DO?
- Deteriorating patient – SEND. The roll out of SEND electronic ‘Track and Trigger’ project is on time and on target. It is fully implemented in all acute admission areas except the Emergency Department at Horton General Hospital where it is planned to go live in summer 2016.
- A cardiac arrest reduction strategy has been developed over the past 12 months. Key clinical areas to support development of the strategy were identified and work within these areas has commenced. The key themes of the strategy are education, communication and escalation. The strategy is now being written up for formal approval by the RAID committee and onward submission for approval through the clinical governance structure.
- The RAID committee is reviewing and updating the RAID policy with input from the Quality Improvement Team. This incorporates the ‘Track and Trigger’ system.
- A strategy meeting with the Practice Development Nurses (PDNs) within the Trust was held in order to review all education provision across the Divisions and sites in relation to RAID training and assessment.
- One of the Quality Improvement Nurse Educators has scoped where all the RAID training is being provided within the Divisions. An Education Strategy was presented and signed off at the RAID Committee (January 2016).


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<th>GOAL</th>
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<tr>
<td>• An educational roll out programme has been developed which includes the ‘train the trainer’ model and uses the Plan Do Study Act (PDSA) quality improvement methodology to gather the data.</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 pressure ulcers.</td>
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<tr>
<td>• The use of Situation Background Assessment Recommendation (SBAR) as a model for handover / escalation has been agreed, with a view to wider consultation and roll out. The QI team will be scoping training and education requirements.</td>
<td>• Standardise all specialist equipment.</td>
<td>• Implement the FallSafe Care Bundle.</td>
<td>• Develop and implement the CAUTI Care Bundle.</td>
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</table>

**Deliver 95% harm-free care by 31 March 2016.**

We will measure this by the monthly Safety Thermometer.

- Focused staff training and link nurse support to reduce pressure ulcers.
- Standardise all specialist equipment.
- Implement the FallSafe Care Bundle.
- Develop and implement the CAUTI Care Bundle.
- Intense focus to increase venous thromboembolism (VTE) assessment rate including prompts in the Electronic Patient Record (EPR) to carry out VTE assessment within six hours of admission.

**HOW DID WE DO?**

- The Trust achieved 95.2% harm-free care for new harm (which aligns to hospital acquired harm in most instances) by March 2016.
- When old harm as defined in Safety Thermometer is included, the rate of harm-free care has varied from 94.7 at its highest to 90.1% at the end of 2015/16, which is disappointing.
- The OUH harm reduction quality priority includes aiming towards zero avoidable hospital acquired pressure ulcers, a 10% reduction in inpatient falls resulting in severe harm, reducing the rate of catheter associated urinary tract infections and reducing the incidence of new venous thromboembolism.
- However, progress has been made with specific actions identified to reach the goal and improvement is evidenced in other outcome measures.

**Pressure ulcers**

- The Trust has continued to focus on hospital-acquired pressure ulcers in 2015/16 in order to reduce harms. A thorough process of reporting and investigation has been developed to ensure learning from incidents occurs at all levels.
- Safety Thermometer data demonstrate improved reporting of superficial hospital-acquired pressure ulcers, showing improved recognition and ward level responsibility for the ongoing management of patients at risk.
- An electronic e-learning module was released to support clinical staff in caring for patients at risk of pressure damage. Levels of uptake will be monitored and reported at Trust level.
- Tissue viability link nurses have now been established and are supported with an educational programme and a forum which meets regularly.
GOAL | TARGET | MEASURE | PLAN
--- | --- | --- | ---
**Falls prevention**
- The lead Quality Improvement Falls Prevention trainer has benchmarked, scoped and gathered information via ward visits and data review to inform a gap analysis across the Trust with respect to FallSafe roll out and the level of high impact falls.
- The FallSafe Nurse Educator has completed two Falls Champion training days at the Churchill Hospital and Nuffield Orthopaedic Centre, with a view to wider roll out to the Horton General Hospital General and John Radcliffe hospitals.
- A FallSafe educational roll out programme has been developed, examining data to identify where the key issues and high levels of high impact falls that cause harm, as a priority in terms of the roll out programme.
- The electronic Falls Assessment is now on the Electronic Patient Record (EPR) task list, which provides easier accessibility for clinical staff, with the capability of audit to understand compliance.

**Venous thromboembolism (VTE)**
- See prior section.

**Catheter acquired urinary tract infection (CAUTI)**
- CAUTI meetings are held two monthly to progress the project, work is in collaboration with Oxford Health NHS Foundation Trust and a lead at the Academic Health Science Network (AHSN).
- The Chief Nurse is regional lead for CAUTI.
- Definitions of a CAUTI have been established.
- Three pilot wards are in place with ward sisters or Professional Development Nurses (PDNs) as leads, using the Electronic Patient Record (EPR) to record catheterisation events. This forms the baseline audit for quality improvement.
- Initial surveys of staff practice and education levels as well as patients’ care has identified key issues related to variable practice and a large educational component requirement.

Increase the provision of Human Factors 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.  
100% of staff involved in Never Events to receive Human Factors training. 
We will check staff training records and ask staff to feedback following training. 
Staff will be identified by Risk Management through incident investigations, and training requirements will be included in incident action plans which the Divisions will take responsibility for. The training will be provided by Oxford Simulation Training and Research (OxSTaR).

**HOW DID WE DO?**
- 207 members of staff attended Human Factors training in 2015/16. A review of the training records shows that there has been multidisciplinary attendance to the training, not only from those areas involved in Never Events, but the wider Trust.
- 46 Human Factors ambassadors have been trained to deliver Human Factors training at the clinical frontline.

Improve discharge planning and discharge process related to providing medicines to take out (TTOs).  
30% of TTOs written for non-emergency areas and released to pharmacy for dispensing the day prior to patient discharge. 
We will measure this using our ORBIT medicines reconciliation reporting tool.

**HOW DID WE DO?**
- 28% of TTOs across the Trust were written and released to pharmacy for dispensing the day prior to patient discharge – narrowly missing this goal.
- For the period 2015/16 the Trust produced in excess of 47,000 TTOs of which just over 13,300 were written and released to pharmacy for dispensing the day prior to patient discharge.
- Medicine, Rehabilitation and Cardiac Division released just under 32% of their TTOs to pharmacy the day prior to discharge meeting the aim.
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<tr>
<td>To ensure acute emergency and elective inpatients (excluding day case, ward attenders and outpatients) have had 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 (ORB1T). We will establish baselines 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>
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**HOW DID WE DO?**

- By 31 March 2016 we had achieved 80% medicines reconciliation in clinical areas visited by pharmacists.
- Pharmacy currently provides, in the main, a five out of seven day ward-based clinical service.
- During 2016/17 the medicines reconciliation reporting tool was developed, reviewed and implemented. This tool now provides the monthly report for this metric.
- The tool now reports on ALL medicines reconciliation tasks fired for admitted patients, which is a significant change in audit completion from 2014/15 which required manual once monthly spot audit checks.
- Recent investment in weekend working service for most medical wards at the John Radcliffe Hospital, all wards at The Horton General Hospital and a small number at the Churchill Hospital has improved ward-based pharmacy services for the seven day service. Medicines reconciliation is higher in these areas.
**Priority 2: Partnership working to improve urgent and emergency care, including sustained achievement of the four hour Emergency Department (ED) standard**

**Our aims**

- To work with partners in health and social care to reduce avoidable Emergency Department 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 the Emergency Department. Enhance staff training to care for these patients including signposting to liaison mental health teams, aiming for 100% of staff in Emergency Department 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.

- To 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.

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<td>Improve the way we diagnose and support patients with mental health and alcohol-related conditions.</td>
<td>100% of Emergency Department 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 and emails • have a review meeting with the Emergency Department Psychiatric Service • collecting patient experience feedback.</td>
<td>We will achieve this by: • presentations to meetings, both regular and at induction; • email communication; • providing our staff with web-based information; • review of current process with Emergency Department Psychiatric Service; • development of patient experience feedback system for these patients.</td>
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**How did we do?**

- 100% of ED clinical staff completed a local induction which gives them information on the ED Community Safety Practitioner role and how to refer when patients present from alcohol intoxication or dependency.
- 100% of ED clinical staff complete a local induction which covers the mental health pathway.
- Monthly clinical meetings are held with the Emergency Department Psychiatric Service (EDPS – Oxford Health NHS Foundation Trust ) to improve the way we diagnose and support patients. Attendees include the ED Matron, EDPS Psychiatrist, ED Specialist Doctor and ED Community Safety Practitioner.
- Multi-agency shared management plans are held on the patient record system in OUH. The multi-agency management plans are support by the GP, Turning Point (drug and alcohol services in Oxfordshire), mental health services and EDPS. The patient is aware of the management plan and is asked to agree to the plan.

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5. 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.
Priority 3: Improved recognition, prevention and management of patients with Acute Kidney Injury (AKI)

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.

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| Ensure emergency admissions are screened for AKI. | All emergency admissions are given:  
  - medication review;  
  - kidney blood tests re-checked within 24 hours of admission. | We will measure this by auditing notes of patients admitted in an emergency. | • Establish an AKI team.  
  • Implement the AKI Care Bundle and algorithm.  
  • Development of a pharmacy role to carry out medication reviews.  
  • Roll out the EPR alert system. |

How did we do?

- A Task and Finish Group was established to plan and implement the necessary changes in Trust-wide working related to AKI.
- A Trust-wide audit required by the Clinical Governance Committee has been completed. Although AKI was correctly identified in 97% of Trust-wide patient notes, the cause of AKI and assessment of severity of AKI was poorly recorded. It is anticipated that this will improve with the e-alert system.
- An electronic alert system for automatically identifying AKI and AKI severity was launched in April 2016.
- The AKI Care Bundle has been updated and is available on the intranet. This covers the initial management steps and when to seek specialist advice. In order to aid its use, the Care Bundle has been embedded into EPR and will be triggered automatically in patients with an AKI e-alert.
- The electronic alert system will update the patient records with AKI stage, to aid coding and quality of information provided on discharge summaries.
- Educational resources to inform staff have been distributed, together with a programme of seminars in key clinical areas.
- AKI Group members have actively participated in OxAHSN stakeholder events, which aim to share learning and improve quality in our region.
- Beyond the Thames Valley, benchmarking against other NHS England trusts is being conducted, with visits to Salford, Sheffield and the national THINK KIDNEYS campaign quality improvement meeting.
- Quality Improvement Projects are being undertaken around the roll out of the Trust-wide electronic alert for AKI in various different clinical areas. The AKI Group is also examining larger scale outcomes, such as progression to higher AKI stage and AKI-related mortality.
- Resources have been agreed for an additional medicines review by pharmacists after an AKI alert, with a planned start for this work in the summer 2016. AKI pharmacist review to be documented in a bespoke EPR note. Quality improvement work to be undertaken around this implementation.
CLINICAL EFFECTIVENESS

Priority 4: Learning from deaths and harms to improve patient care

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.

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<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>
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HOW DID WE DO?

- An analysis of the Divisional mortality reports for April to December 2015 indicate that 85% of deaths were formally reviewed.
- The quarterly Divisional mortality reports were reviewed at the Clinical Effectiveness Committee which is attended by clinicians representing the different medical specialties. The learning points highlighted in the mortality reports are disseminated by the clinical membership within their respective clinical areas. The Clinical Effectiveness Committee has commissioned working groups to review specific areas of concern identified in the mortality reports.
- The Trust has established a Mortality Review Group which meets monthly with multidisciplinary and multi-professional membership and the responsibility for clear mortality reporting to the Board.
- The Group is reviewing the mortality process and proposals for a revised Mortality Reduction Strategy.
Priority 5: Management of patients presenting with sepsis

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.

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<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 agree a standardised screening tool and Care Bundle based on sepsis six. We will provide training for staff in emergency admission areas.</td>
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HOW DID WE DO?

- The Sepsis Group is now established; this is an inter-disciplinary group with representatives from pharmacy, nursing, Quality Improvement, different medical specialties and patient involvement.
- The group has signed up to the UK Sepsis Trust for information and is involved in the UK Sepsis Nurses Forum, which is national forum.
- A paper sepsis screening tool has been agreed and has been rolled out from January 2016. Initially this will be used in the Emergency Departments, Emergency Assessment Unit, Medical Admissions Unit and Surgical Emergency Unit.
- Separate versions of the sepsis screening tool have been developed for paediatrics and maternity.
- Electronic tools for sepsis identification using the electronic patient record are currently being explored.
- Work is underway to develop a Sepsis Power Plan to facilitate delivery of the Sepsis Care Bundle.
- A baseline audit of sepsis management has been undertaken.
- An educational strategy and roll out programme is in progress and will be presented at the next Sepsis Working Group meeting.
- Educational material which includes presentations, and the use of an educational quiz game, has been developed ready for roll out.
- Sepsis training for doctors has been incorporated into induction, foundation doctor (first year after graduation) and medical student teaching. Excellent feedback has been received from the monthly induction talk.
- OUH is an active participant in the newly formed OxAHSN Sepsis Group and one of the team is its chair. The QI Nurse Educator has benchmarked with other hospitals and has visited Great Western Hospital in Swindon with some information sharing and network opportunities.
- The filming of a patient story related to this subject has taken place with the aim of using the film for educational purposes, and include e-learning as part of the education programme.
- The Plan Do Study Act (PDSA) improvement cycles for sepsis have been commenced with the data being presented at various forums.
- The ED sepsis grab bags were implemented in November 2015.
Priority 6: End of Life: improving people’s care in the last few days and hours of life

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.

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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.</td>
<td>At least 75% of clinical staff to completed core modules by 31 March 2016.</td>
<td>Review of training records.</td>
<td>An educational programme comprising e-learning modules will be available on the Trust Learning and Development intranetsite. The educational programme will be supported by the EOL strategy containing guidelines, and EOL champions to drive forward improvements in attitudes and care.</td>
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Recommendation from National Care of Dying Audit for Hospitals Report

**HOW DID WE DO?**

- The lead for this workstream is a palliative care consultant from Sobell House working with the Clinical Lead, according to the five key national End of Life Care Priorities.
- The End of Life Care Group is chaired by the Medical Director, adding conspicuous executive commitment to this area of work, and is attended by stakeholders including the CCG.
- An End of Life Care symposium took place in November 2015. Over 200 staff attended to learn from national speakers. The symposium was open to health and social care partners across Oxfordshire and was well attended with 200 attendees and a lot of positive feedback. One of the Trust’s consultants was a speaker at the symposium, and has been reappointed as National Clinical Director for End of Life Care.
- Training packages have been developed but not yet rolled out. Training is to be arranged for staff in two modules for clinical and non-clinical staff and will adopt a tiered approach.
- A National Care of the Dying Audit has been undertaken to look at deaths in the Trust. A report on the findings of this audit will be presented at the Trust Clinical Effectiveness Committee in June 2016.
- A survey had been sent out to relatives of those who had died in OUH. Feedback had been positive.
- The Sobell House Hospice Charity and the Trust have approved £650k for the next two to three years to employ staff to drive forward face to face care. A team will be put together to provide seven days a week cover. This will comprise medical, nursing and pharmacy staff.
- The Trust received feedback from four regional Islamic funeral directors that the Trust’s Bereavement Service provides an exemplary service.

6. See Royal College of Physicians www.rcplondon.ac.uk/sites/default/files/ncdah_national_report.pdf
Priority 7: Improving communication, feedback, engagement and complaints management: with patients, carers, healthcare staff and social care providers

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, redeveloping our intranet site and 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.
- To meet the national targets of assessing 90% of patients over 75 who have been in hospital for 72 hours or more for dementia.
- 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 Network7 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.

7. See www.oxfordahsn.org/our-work/clinical-networks/dementia
GOAL
We will have a method of collecting feedback from carers for people with dementia that is easy to use and developed by carers themselves.

TARGET
Feedback from carers will be reported to the Board and Quality Committee each month from July 2015.

MEASURE
We will measure this by linking feedback received against the content in Board reports.

PLAN
The survey form will be co-produced by carers (Carers Oxfordshire), Carers Voice8 and will incorporates 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.

HOW DID WE DO?
• A questionnaire designed by the Carers Project Group in 2015 is used on wards to collect feedback from carers. However, after hearing from carers that they would prefer face to face advice rather than filling out a questionnaire, a new project stream was developed; an Outreach Worker from Carers Oxfordshire is available three days per week to speak 1:1 with carers, providing advice and emotional support.

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<tr>
<td>• We will produce a Privacy and Dignity Policy that respects the needs of vulnerable people.</td>
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<td>• First draft by September 2015. Final draft within 2015/16.</td>
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<tr>
<td>• Ratified policy by 31 March 2016.</td>
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<td>• We will develop this policy in association with patient advocacy groups*, Healthwatch Oxfordshire and Foundation Trust members. Our Privacy and Dignity Steering Group will monitor this process.</td>
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*Carers Oxfordshire, Carers Voice, Oxfordshire MIND, Patient Voice, My Life My Choice8, Healthwatch Oxfordshire ‘Dignity in Care’ campaign.

8. Carers Voice Oxfordshire helps people to speak up about services and support provided for carers. See: www.carersvoiceoxfordshire.org

HOW DID WE DO?
• The Trust’s Privacy and Dignity Policy has been revised using a model of co-production with a wide range of stakeholders.
• It was ratified by the Trust in November 2015.
• The groups that contributed were: Age UK, Carers Oxfordshire, Unlimited (physical disability organisation), Healthwatch, Guideposts Trust, Alzheimer’s Society, Oxfordshire County Council, My Life My Choice (learning disability self-advocacy organisation), Patient Voice and Public Partnership Groups, Oxfordshire Mind.
• A new Patient and Public Involvement Strategy has been developed and approved by the Quality Committee. The Strategy outlines the Trust’s objectives over the next three years and aims to increase the involvement in all areas of the Trust’s work and expand the diversity of those involved.
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<tr>
<td>We improve the way we manage complaints by having well trained staff.</td>
<td>100% staff trained who investigate complaints by 31 March.</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>
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**HOW DID WE DO?**

- 100% of the Complaints and PALS teams were trained in complaints mediation in 2015/16.
- The training sessions in 2015 were attended by five matrons, two deputy matrons, 16 consultants, the Head of Patient Experience and the Head of Midwifery. Numbers trained are monitored by the Complaints team after each session.
- Since April 2015, all complaints are now coded using the national complaints coding categories. A detailed analysis of the complaints is then written each month and presented to the Trust Board / Quality Committee. This helps to identify particular themes and trends.

Our staff will be open with patients and families if something goes wrong in line with the Being Open Policy.

- Roll out DATIX monitoring of all aspects of Duty of Candour.
- DATIX system in place with compliance monitored via performance reviews.
- 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.

**HOW DID WE DO?**

- Since the introduction of the Duty of Candour, this area has attracted significant attention with changes incorporated in the monitoring of incidents resulting in moderate or greater harm.
- The Trust's incident reporting and risk management system (Datix) was modified in August 2015 to capture the required information, to provide supportive information about the Duty of Candour, and assist with the monitoring of the Duty of Candour.
- Incidents continue to be reviewed on a daily basis by Clinical Risk Management with all incidents reported with suspected moderate or greater actual harm followed up specifically to: 1) ascertain the correct level of harm and if so, 2) advise the area of the requirements regarding the Duty of Candour.
- This is further monitored at the weekly SIRI forum as a standing agenda item. Each incident that potentially meets the requirement for Duty of Candour is discussed to ascertain whether the patient or their representative has received: an apology in person, information regarding what has happened and what further enquiries will take place from an appropriate member of staff. In addition, details regarding whether a letter has been sent to the patient or their representative are also recorded.
- Clinical Governance also report on compliance regarding the Duty of Candour on a monthly basis (Schedule 4) with each incident potentially meeting the requirement for Duty of Candour checked for evidence that this has taken place from a range of sources, including: SIRI forum minutes, SIRI log and Datix. The final return is signed off by the Head of Clinical Governance prior to submission to the Trust's reporting systems (ORBIT).
GOAL
We will improve how we communicate the signing off of test results with our GP colleagues.

TARGET
95% of test results to be signed off within a week of the result being available.

MEASURE
We will measure this with data extracted from EPR.

PLAN
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.

HOW DID WE DO?

• In March 2016 the Trust-wide endorsement of test results was 66% by the end of the financial year with ongoing work to enhance monitoring of performance at Directorate and Divisional level. The highest achieving Division achieved 90% sign-off within seven days.

• Achieving the 95% target has been challenging, with a concerted effort to achieve improvements in this measure. It is possible to see and act on test results without endorsing the result. OUH sees endorsement as best practice showing that the person who reviews them has signed them off.

• Significant improvements in reporting on this data from the electronic patient record (EPR) and ORBIT have been developed, including early development work to incorporate results endorsement data onto the new information system (Tableau); this will improve reporting on this indicator locally and make it easier to identify areas of good performance or those requiring improvement.

Other areas of ongoing work in 2015/16 included:

Diabetes

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.

• The NaDIA audit took place on 29 September 2015. There was a 15% prevalence of inpatients with diabetes (170 patients) within the Trust which is in line with the national average. There were consistent improvements in the quality of diabetes care across nearly all metrics. Overall patient satisfaction with inpatient diabetes care continued to rise from 85.7% to 86.2%, remaining above the national average of 84.1%

• The significant improvement in the quality of care for inpatients with diabetes has come about through investment in workforce, re-writing and implementing the diabetes statutory mandatory training and using IT to improve communication between clinicians and visibility of diabetes data.

• Diabetic Foot Audit – 181 inpatients with diabetes were identified on the day of audit, of which 175 had their feet assessed. 43 were found to have an active diabetic foot problem. This gives a prevalence of 24%. All the metrics had improved substantially from the audit of the previous year with some further work to do. It is felt that the changes achieved from last year to this year have been reached by the increased presence of the Podiatry Team on the wards. The Tissue Viability Team has also played a key part in highlighting issues of Pressure Damage on the wards.

Dementia

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.

• An educational strategy has been drafted and approved through the Dementia Steering Group (March 2016).

• The tier two dementia simulation training that is currently in place continues until May 2016 with five events in total; this includes peer discussion and facilitation. These are being evaluated with a view to further development to incorporate Mental Capacity Assessment, and DOLS training to form part of a whole day’s training with aims and outcomes well defined.

• Podcasts and Apps, and other simulation aids, are being developed and procured to enhance other training materials.

• The Dementia Information Café has proved successful with carers’ attendance, but this is being benchmarked with a highly effective Dementia Café in Bristol, in order to maximise its user friendliness before roll out to other hospital sites in the Trust.

• The Trust now has eight dementia-friendly computers and two tablets supporting reminiscence in hospital.

• The Dementia Leads who were trained through Worcester University are ensuring parity of education provision across the Trust and are supporting well-defined Leads and Champions in areas.

• A new post was created for a Quality Improvement Nurse Educator in Dementia and End of Life Care. The post holder started in February 2016 and will help to lead on education and dementia awareness throughout the Trust.
Seven day working – Care 24/7

HOW DID WE DO?

- 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.
- The out of hours handover process is fully embedded on one of our four sites (Horton General Hospital) and is being implemented across our three remaining hospitals starting with the Churchill Hospital and Nuffield Orthopaedic Centre during 2015/16. A phased implementation process has enabled us to iron out any teething issues as we go along.
- Positive feedback has been reported by the out of hours team and compliance visits have noted improved communication at handover meetings underpinned by the Situation, Background, Assessment and Recommendation (SBAR) tool and adherence to the new handover guidance.
- The SBAR tool and video showing best practice is now part of the junior doctors’ induction programme and all resources are available on our intranet.
- Extended skills training revisions for managing a deteriorating patient and advance life support have been provided to fully equip the out of hours team across the Churchill site.

Medicines management, including antibiotic prescribing

HOW DID WE DO?

- This workstream has reviewed the most common medication safety incidents reported in England and within the Trust with regard to numbers and harm caused. The main themes were similar in both settings. Four areas have been prioritised for action.
  1. Anticoagulants
  2. Insulin
  3. Antimicrobials
  4. Omission or delay of administering an essential medicine.
- The medicines safety team has been working with and supporting existing specialist multidisciplinary teams to improve medicines safety in the first three areas. A ‘deep dive’ into the final area has confirmed the importance of this issue and a new workstream is being established to drive improvement. The overlap between these first three and the omission or delay of essential medicines has not been lost and is essential in managing sepsis.
- The team has been supporting the Divisions with Trust investigations and learning from where more serious patient harm has been associated with medicines use. This has included reviewing all ‘Serious Incidents’ reports to identify themes, share learning and develop and inform action plans to reduce the potential and actual patient harm associated with these prioritised workstreams.

Other services

HOW DID WE DO?

- Continued development of psychological medicine services – the focus for 2015/16 will be cancer, women’s and children’s services.
- Cancer: 0.5 whole time equivalent (WTE) psychiatrist appointed into post. We are appointing three Macmillan funded specialist nurses and starting to develop comprehensive depression care for cancer outpatients.
- Women’s: 0.5 WTE psychiatrist appointed into post. Implementing systematic mental healthcare through specialist midwives.
- Children’s: additional WTE psychiatrist appointed to supplement existing psychological support, developing comprehensive psychosocial care for children’s services.
- Continuing development of these services remains a focus for the Trust.
Our performance against Monitor Risk Assessment Framework indicators

A number of national measures are used by Monitor to make an assessment of governance at NHS foundation trusts. Performance against these indicators is used by Monitor as a trigger to detect potential governance issues. As a Foundation Trust, we are required to report on these indicators either monthly or quarterly.

Our performance against these indicators can be seen in the table below.

<table>
<thead>
<tr>
<th>Performance indicators</th>
<th>Performance 2015-16 Annual</th>
<th>Quarterly Trend</th>
<th>Last update</th>
</tr>
</thead>
<tbody>
<tr>
<td>28 day breaches as a % of last minute cancellations</td>
<td>= 0%</td>
<td>3.0%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Incidence of MRSA bacteraemia</td>
<td>= 0%</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Rates of Clostridium difficile</td>
<td>&lt; 6%</td>
<td>57</td>
<td>15</td>
</tr>
<tr>
<td>18 week Admitted</td>
<td>&gt; 90%</td>
<td>85.6%</td>
<td>87.1%</td>
</tr>
<tr>
<td>18 week Non admitted including Audiology</td>
<td>&gt; 95%</td>
<td>93.9%</td>
<td>95.1%</td>
</tr>
<tr>
<td>RTT - Incomplete % within 18 weeks</td>
<td>&gt; 92%</td>
<td>92.4%</td>
<td>93.2%</td>
</tr>
<tr>
<td>Supporting measures: number of diagnostic waits ≤5 weeks</td>
<td>&gt; 99%</td>
<td>99.6%</td>
<td>99.8%</td>
</tr>
<tr>
<td>4 Hour Target Sirep Months</td>
<td>&gt; 95%</td>
<td>89.1%</td>
<td>94.3%</td>
</tr>
<tr>
<td>2 week maximum wait for urgent suspected cancer referrals from GP to first outpatient appointment</td>
<td>&gt; 93%</td>
<td>94.3%</td>
<td>94.9%</td>
</tr>
<tr>
<td>Proportion of patients with breast symptoms referred to a specialist who are seen within two weeks of referral</td>
<td>&gt; 93%</td>
<td>95.4%</td>
<td>98.2%</td>
</tr>
<tr>
<td>31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers</td>
<td>&gt; 96%</td>
<td>97.4%</td>
<td>97.7%</td>
</tr>
<tr>
<td>31-Day Wait For Second Or Subsequent Treatment: Surgery</td>
<td>&gt; 94%</td>
<td>95.2%</td>
<td>96.0%</td>
</tr>
<tr>
<td>31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments</td>
<td>&gt; 98%</td>
<td>99.3%</td>
<td>100.0%</td>
</tr>
<tr>
<td>31-Day Standard for Subsequent Cancer Treatments (Radiotherapy)</td>
<td>&gt; 94%</td>
<td>97.7%</td>
<td>98.8%</td>
</tr>
<tr>
<td>Maximum waiting time of 62 days from urgent referral to treatment for all cancers</td>
<td>&gt; 85%</td>
<td>84.0%</td>
<td>81.4%</td>
</tr>
<tr>
<td>Extended 62-Day Cancer Treatment Targets (following detection via national screening programme of hospital specialist)</td>
<td>&gt; 90%</td>
<td>95.1%</td>
<td>91.1%</td>
</tr>
<tr>
<td>% of eligible patients receiving primary angioplasty within 90 minutes of arrival at interventional centre door</td>
<td>&gt; 90%</td>
<td>94.9%</td>
<td>97.2%</td>
</tr>
<tr>
<td>2 week maximum wait for rapid access chest pain clinic</td>
<td>TBC</td>
<td>100.0%</td>
<td>-</td>
</tr>
<tr>
<td>Percentage of stroke patients who spend at least 90% of their time on a stroke unit</td>
<td>&gt; 85%</td>
<td>90.6%</td>
<td>84.1%</td>
</tr>
<tr>
<td>% of all adult inpatients who have had a VTE risk assessment</td>
<td>&gt; 95%</td>
<td>97.2%</td>
<td>97.2%</td>
</tr>
</tbody>
</table>
STATEMENTS

Appendix 1: Statements from commissioners, local Healthwatch organisation and Overview and Scrutiny Committees

2015/16 limited assurance report on the content of the quality reports and mandated performance indicators

Independent auditor’s report to the Council of Governors of Oxford University Hospitals NHS Foundation Trust on the Quality Report
To be carried out 18 April 2016

Oxfordshire CCG statement on Oxford University Hospitals NHS Foundation Trust 2015/16 Quality Accounts
To be added once CCG have had Quality account for review and responded

Response from Healthwatch Oxfordshire to Oxfordshire University Hospitals NHS Foundation Trust Quality Accounts
To be added once Healthwatch have had Quality account for review and responded
Statement of directors’ responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation Trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation Trust boards should put in place to support the data quality for the preparation of the Quality Report.

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16 and supporting guidance;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2015 to 3 May 2016;
  - papers relating to Quality reported to the board over the period April 2015 to 3 May 2016;
  - feedback from NHS England dated 17 May 2016;
  - feedback from Oxfordshire Clinical Commissioning Group received 17 May 2016;
  - feedback from local Healthwatch organisations dated 9 May 2016;
  - feedback from Overview and Scrutiny Committee dated 13 May 2016;
  - the Trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 14 October 2015;
  - the (latest) National Patient Survey May 2014;
  - the (latest) National Staff Survey September to November 2015;
  - the Head of Internal Audit’s annual opinion over the Trust’s control environment dated May 2016;
  - CQC Intelligent Monitoring Report dated May 2015;
  - the Quality Report presents a balanced picture of the NHS foundation Trust’s performance over the period covered;
  - the performance information reported in the Quality Report is reliable and accurate;
  - there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, 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 Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review;
  - the Quality Report has been prepared in accordance with Monitor’s annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

Date: 25 May 2016. Chair

Date: 25 May 2016. Chief Executive
Statement from Health Overview Scrutiny Committee (HOSC) on the Oxford University Hospitals NHS Foundation Trust (OUHFT) 2015/16 Quality Account

The OUHFT Quality Account 2015/16 and priorities for 16/17 were sent to HOSC members and presented at the April meeting. HOSC members really appreciated the opportunity to hear about the work of OUHFT and to ask questions about specific priority areas.
Statement from Oxfordshire Clinical Commissioning Group (OCCG)

OCCG has reviewed the Oxford University Hospitals NHS Foundation Trust (OUH) Quality Account and believes that the information it provides is accurate. The OUH is a large NHS organisation that provides many services. The CCG 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. The Trust works well with the CCG and other stakeholders in Oxfordshire.

OCCG is committed to commissioning high quality care for the population of Oxfordshire. OCCG is therefore extremely pleased to see that the priorities set out for 2016/17 are aligned to the CCG’s priorities.

OCCG is disappointed that the lack of progress in the 2015/16 priority relating to improving the timeliness of discharge summaries and the management of test results, this has led to the CCG taking formal contractual action. The CCG hope the Trust will prioritise addressing these issues in order to minimise the impact on the functioning of the wider health economy. The CCG is pleased that the Trust has made significant improvements in reducing the difficulties their patients have had in booking appointments and contacting the Trust by phone.

The CCG believes the Trust has been open in identifying many of their challenges, including the number of Never Events. The CCG are pleased that the Trust commissioned an independent report to investigate these incidents. The report concluded that no evidence had been found to suggest that a patient safety problem existed within the Trust and that the evidence strongly suggested that the Trust has a proactive safety culture. The review also found the Trust’s commitment to openness with respect to serious incidents and Never Events to be exemplary. The report made a number of recommendations. It would have been helpful to have a more detailed summary of progress in achieving improvements in the Quality Account.

The emphasis that the Trust gives to clinical audits and NICE guidance demonstrates that the Trust is focused on delivering evidence-based best practice. The Account would benefit from being more explicit about the results of the audits, and about actions which have been taken to improve performance where this is required. This would give greater assurance to OCCG and to the public on the quality of the Trust’s services. The provision of actual patient numbers alongside percentages would provide additional clarity on the impact of the Trust’s action.

The CCG welcomes the Trust’s commitment to recruitment, retention and development of clinical staff. The account details the work the Trust has undertaken relating to the education of staff.

The Oxford University Hospitals NHS Foundation Trust Quality Account is presented in a clear format that allows the reader to navigate the document and generally avoids the use of jargon. OCCG looks forward to continuing to work with OUH to deliver high quality care for the patients of Oxfordshire. Overall, OCCG believes that this Quality Account gives readers confidence that the Trust is being open and honest about the quality of services across the organisation and is committed to driving continuous quality improvement.

Sula Wiltshire
Director of Quality, Lead Nurse,
Oxfordshire Clinical Commissioning Group
Dr Bruno Holthof,
Chief Executive,
Oxford University Hospitals Trust

Dear Bruno,

Ref OUHFT Quality Account for 2016/17

May 9th 2016

Thank you for inviting us to comment on the Trust’s Quality Account for 2016/17. It was interesting to read the progress made on last year’s objectives as well as plans for this year. A considerable amount of work, and engagement has gone into the priorities for 2015/16, and to plan this year’s priorities. I have a few comments on the progress on last year’s objectives as well as on the year ahead.

Although it was reassuring that the Toft review did not reveal a pervasive patient safety problem, we would be interested to understand how the Trust has learned from these incidents and what measures are in place to prevent any Never Events occurring in 2016/17.

In terms of next year’s priorities, the clinical goals look both challenging and innovative. I will be particularly interested in seeing how the SEND initiative progresses, what impact this has on patients, and whether this technology will increase patient care time, reducing staff time spent on paperwork.

Our staff team is looking forward to attending the compassionate care program in the next few weeks to learn more about what compassionate care looks like for OUHFT.

Overall, the patient experience section of the quality account seems to focus on compassion, dementia care, engaging with primary care and responding to call buttons. Though all of these areas seem areas for possible improvement, when we were working on dignity in care at the hospital, it wasn’t necessarily compassion from staff that was lacking from their experiences, rather it was communication, in all aspects of their experience. Indeed, the issues raised about OUHT with Healthwatch Oxfordshire this year have primarily related to:

- Communication problems, including:
  - Difficulties with booking or cancelling appointments, or problems with associated letters
• Difficulties in understanding when discharge will occur or how to access ongoing care and ‘what happens next’
  • Lack of communication between wards or hospitals
  • Being unable to contact the Patient Advice and Liaison service, or being unsatisfied with their intervention.
• Care that lacks personalisation
  • Staff not adhering to care plans
  • Not being able to recognise or accommodate the needs of patients (such as dietary, mobility or communication needs)
• Discharge
  • Long waits for prescriptions
  • Discharged at ‘inappropriate hours’

I wonder, then, whether there is scope within the next year to put a priority forward to getting the basics right when it comes to communication, care, and the experience of all patients along the focused work on patients with dementia.

We look forward to working with you as one of your stakeholders as the year’s quality plans progress.

Yours sincerely

Carol Moore
Executive Director
Healthwatch Oxfordshire
Dear colleague

NHS England South (South Central) has reviewed the Oxford University Hospitals NHS Foundation Trust (OUH) Quality Account, from the perspective of NHS England as the specialist commissioner for the Trust, and considers that it provides an accurate picture of the quality challenges the Trust faces and improvements made during the year.

The Trust has strengthened its clinical governance team and function and this has helped to strengthen improvements in the Trust’s safety culture that were started in the previous year. It is disappointing that, despite work done in 2014/15, there were seven Never Events in 2015/16. However, NHS England welcomes the further work carried out by the Trust on this, particularly the independent review, and notes the Trust’s clear commitment to tackling the issues in a positive and open manner.

The quality priorities have been identified against well-defined and appropriate rationales and it is good to see the further detail included that provides assurance of clear project plans and goals. It would have been preferred to have seen more outcome type measurements included.

We are pleased to see good participation in national clinical audits and evidence of changes made as a result. Local clinical audit activity and follow up also provides assurance of the Trust’s focus on clinical effectiveness.

The OUH Quality Account is clear about where the Trust’s major challenges lie and is open about where standards have not been met. Despite it being highlighted in the previous year, the OUH has also not met the standard agreed for providing rapid discharge summaries to GPs, although there has been improvement and we note that the continuing work is included among the priorities for 2016/17. Some of the NHS Constitution standards have not been met, notably the Accident & Emergency 4 week wait and some referral to treatment (RTT) standards.

Overall, we think that this document provides an accurate reflection of the quality of services provided by the Trust and support the ambition for further improvement identified in the quality priorities.

Yours sincerely

Jan Fowler, Director Nursing & Quality
NHS England, South Central
Dear Governors,

External Assurance on the Trust's Quality Report

We are pleased to present our findings following our review of the Trust’s 2015/16 Quality Report. The purpose of this report to Governors is to set out the work that we have performed, our findings and conclusions and any recommendations for improvement concerning the content of the Trust’s Quality Report and our testing on mandated and local indicators.

We would like to take this opportunity to thank the employees of the Trust for their assistance during the course of our work.

Yours faithfully

Maria Grindley
Director
For and on behalf of Ernst & Young LLP
Enc.
Contents

1. Executive summary .................................................................................................... 0
2. Detailed findings ......................................................................................................... 1
Appendix A Limited assurance report ........................................................................ 3
1. Executive summary

1.1 Responsibilities

As part of our overall engagement as external auditors by the board of governors of Oxford University Hospitals NHS Foundation Trust we are also required to perform an independent assurance engagement in respect of Oxford University Hospitals NHS Foundation Trust’s Quality Report for the year ended 31 March 2016 (the ‘Quality Report’) and certain performance indicators contained within the report. Our review is undertaken in accordance with the detailed guidance issued by Monitor for each financial year.

Monitor’s ‘Detailed Guidance for External Assurance on Quality Reports 2015/16’ sets out the work that we are required to complete on the Trust’s Quality Report for the year ended 31 March 2016, which is published as part of its Annual Report.

As auditors we are required to:

► review the content of the Quality Report against the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16, which is combined with the quality accounts requirements in Monitor’s document ‘Detailed requirements for quality reports 2015/16’;
► review the content of the Quality Report for consistency against the other information published by the Trust;
► undertake substantive sample testing on two mandated performance indicators and one locally selected indicator;
► provide the Trust with a Limited Assurance Report confirming that the Quality Report meets Monitor’s requirements and that the two mandated indicators are reasonably stated in all material respects;
► provide the Trust’s Governors with a report setting out the findings of our work including the content of the quality report, mandated indicators and the locally selected indicator.

1.2 Key findings

We have reviewed the Trust’s Quality Report and found that:

► its content is in line with Monitor’s requirements; and
► it is consistent with other information published by the Trust.

We have also undertaken testing on two mandated indicators and there was a requirement to review one local indicator. The two mandated indicators tested are:

► percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period
► percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge

We have not tested a local indicator as one was not identified by the Trust due to authorisation taking place on 1 October 2015.

For the percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge we found no evidence to suggest that this mandated
indicator have not been reasonably stated in all material respects. Further details of our findings are in Section 2.2.

For the indicator “Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period” there were two patients erroneously included in our sample of 25 cases tested. As the error impacts both the numerator and the denominator, there would not be a material impact on the indicator reported. Further details of our findings are in Section 2.2.

As a result of our findings from the work we have performed, we will issue an unqualified Limited Assurance report to the Trust. This will conclude that, nothing has come to our attention, which leads us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the ‘NHS Foundation Trust Annual Reporting Manual’ and supporting guidance
- the quality report is not consistent in all material respects with the sources specified in the Detailed Guidance for External Assurance on Quality Reports 2015/16.
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the ‘NHS Foundation Trust Annual Reporting Manual’ and supporting guidance and the six dimensions of data quality set out in the ‘Detailed Guidance for External Assurance on Quality Reports’.

A copy of this report is provided in Appendix A.

2. Detailed findings

2.1 Content of the Quality Report

Compliance with the requirements of the Annual Reporting Manual

We have reviewed the content of the Quality Report against the requirements set out by Monitor in their Annual Reporting Manual.

In all regards we found that the Trust met these requirements.

Consistency with other specified documents

The Quality Report is also reviewed for consistency with the following documents:

- Board minutes for the period April 2015 to May 2016;
- papers relating to quality, reported to the Board during the same period;
- feedback from Commissioners;
- feedback from local Healthwatch organisations;
- feedback from the Overview and Scrutiny Committee;
- the Trust’s complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009;
- feedback from other named stakeholder(s) involved in the sign off of the quality report;
- the latest national and local patient survey;
Detailed findings

- the latest national and local staff survey;
- the Head of Internal Audit’s annual opinion over the Trust’s control environment; and
- Care Quality Commission intelligence monitoring report.

Our review concluded that the contents of the Quality Report published by the Trust are consistent with these documents.

2.2 Testing of mandated performance indicators

In 2015/16, we have performed testing on the following two mandated indicators:

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period
- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge

The results of our testing of these two indicators are detailed below.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period</td>
<td>We identified two patients where the pathways were complete and therefore should not have been included in the population. Both patients were identified in the ‘less than 18 weeks’. As this means, there would be an amendment to both the numerator and the denominator, there would not be a material impact on the indicator reported. The Trust undertakes validation checks on the indicator data with a validation team validating patients less than 18 weeks and the clinical and managerial teams in the divisions validating patients on more than 18 weeks pathways. The Trust carries out monthly spot checks of approximately 20 patients with open pathways which are reported to the data quality group. It is usual for this exercise to identify 1-2 patients where their data needs to be updated. We are therefore able to conclude that the indicator has been reasonably stated in all material respects.</td>
</tr>
<tr>
<td>Percentage of patients with a total time in A&amp;E of four hours or less from arrival to admission, transfer or discharge</td>
<td>For our sample testing of 25 patients – 13 breaches and 12 non breaches, we were able to verify the data used to calculate the indicator to supporting information. We are therefore able to conclude that the indicator has been reasonably stated in all material respects.</td>
</tr>
</tbody>
</table>

2.3 Locally selected indicator

In 2015/16, Monitor’s guidance also requires the testing of a locally selected indicator. Due to the transition to Foundation Trust status, a local indicator had not been agreed for the initial period.
Limited assurance report

Appendix A Limited assurance report

Limited assurance report on the content of the quality reports and mandated performance indicators

Independent auditor’s report to the council of governors of Oxford University Hospitals NHS Foundation Trust on the quality report

We have been engaged by the council of governors of Oxford University Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Oxford University Hospitals NHS Foundation Trust’s quality report for the year ended 31 March 2016 (the ‘Quality Report’) and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2016 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period
- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge

We refer to these national priority indicators collectively as the ‘indicators’.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the ‘NHS Foundation Trust Annual Reporting Manual’ issued by Monitor.

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 report is not prepared in all material respects in line with the criteria set out in the ‘NHS Foundation Trust Annual Reporting Manual’ and supporting guidance
- the quality report is not consistent in all material respects with the sources specified in Monitor’s Detailed requirements for quality reports 2015/16; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the ‘NHS Foundation Trust Annual Reporting Manual’ and supporting guidance and the six dimensions of data quality set out in the ‘Detailed Guidance for External Assurance on Quality Reports’.
We read the quality report and consider whether it addresses the content requirements of the ‘NHS Foundation Trust Annual Reporting Manual’, and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period April 2015 to May 2016
- papers relating to quality reported to the Board over the period April 2015 to May 2016
- feedback from Commissioners, dated 17/5/16
- feedback from local Healthwatch organisations, dated 9/5/16
- feedback from Health Overview and Scrutiny Committee dated 13/5/16
- the trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 14/10/15
- the latest national patient survey, dated May 2014
- the latest national staff survey, dated 2015
- Care Quality Commission Intelligent Monitoring Report, dated May 2015
- the Head of Internal Audit’s annual opinion over the trust’s control environment, dated May 2016
- NHS England, dated 17/5/16; and
- any other information included in our review.

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

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Oxford University Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting Oxford University Hospitals NHS Foundation Trust’s quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2016, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Oxford University Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.
Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – Assurance Engagements other than Audits or Reviews of Historical Financial Information, issued by the International Auditing and Assurance Standards Board (‘ISAE 3000’). 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
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation
- comparing the content requirements of the ‘NHS Foundation Trust Annual Reporting Manual’ to the categories reported in the Quality Report.
- reading the documents.

A limited assurance engagement is smaller 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 affect 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 of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the ‘NHS foundation trust annual reporting manual’. 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 Foundation 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 2016:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the ‘NHS Foundation Trust Annual Reporting Manual’ and supporting guidance
Limited assurance report

- the Quality Report is not consistent in all material respects with the sources specified in Monitor’s Detailed requirements for quality reports 2015/16; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the ‘NHS Foundation Trust Annual Reporting Manual’ and supporting guidance.

Ernst & Young LLP
Reading
25 May 2016