Oxford University Hospitals NHS Foundation Trust

Quality Account 2022-2023

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Part 1: Introduction

Statement on quality from the Chief ExecutiveOfficer 2022-23

In our Quality Account we set out how Oxford University Hospitals (OUH) NHS Foundation Trust improves quality and safety through a relentless focus on our safety culture, routinely embedding best practice in the care provided to our patients so that avoidable harm is prevented.

Our strategic approach to improving the quality and safety of patient care

Our vision as an organisation is to deliver compassionate excellence for our People, our Patients and our Populations.

This is set out in Our Strategy 2020-2025 which was developed and co-designed with staff, patients and our health and social care partners before being approved by the Trust Board in March 2020 – it was revisited and refreshed in light of the COVID-19 pandemic before being launched in August 2020.

Improving access to care for all our patients is one of our three strategic objectives included in Our Strategy 2020-2025.

Our Quality Strategy aims to deliver high quality healthcare based on national and international comparisons, and to continuously improve our performance using Quality Improvement tools across the three key domains:

- Patient Safety
- Patient Experience
- Clinical Effectiveness

Key themes underpinning our vision and strategic objectives

The three key themes which underpin our strategic objectives in improving the quality and safety of patient care are:

- **Delivering high quality care**
  Becoming ‘Outstanding’ across all CQC domains and building a culture of clinical effectiveness and improvement

- **Continuously improving patient safety**
  Creating a Just Culture across the Trust to encourage staff to report incidents and raise concerns; learning from incidents in order to reduce harm; embedding Safety Huddles; and ensuring safe staffing and a safe environment in which to provide care.

- **Working with patients to improve their health, care and experience.**
  Enabling patients to manage their own health and wellbeing and to personalise their care, particularly for those with long-term conditions; and increasing patient and public involvement.

Our patients as partners

The cornerstone of healthcare is the partnership between patients and their clinical teams, enabling them to collaborate in maximising the patient’s health and wellbeing, weighing up options and sharing in the decision making in often complex situations.

This partnership extends to learning from the lived experience of patients and families and engaging with them to improve our services. The unique perspective and experience as a patient alongside healthcare professionals’ technical knowledge forges a valued partnership in delivering healthcare every day and shaping quality improvements to our services.

A Patient Story is brought to each public Board meeting and the election of patients and the public to our Council of Governors also ensures the patient voice is heard.

Our Clinical Strategy

The Clinical Strategy provides a blueprint for our clinical services, our sites, and our role as an Anchor Institution at the heart of the community which we serve. During 2023-24 we will turn this blueprint into a programme of implementation, working across our teams and with our partners.

Our role as a leading centre for Quality Improvement, education, innovation and research – as well as a provider of excellent local and specialist care – is set out in the Clinical Strategy.

Our Quality Priorities

Staff, partners and stakeholders of OUH gathered at the John Radcliffe Hospital in Oxford in August 2022 and again in January 2023 for our Quality Conversation events to hear an update on the progress made by the Trust in achieving our Quality Priorities for 2022-23 and to contribute to the development of our Quality Priorities for 2023-24.

Following the Quality Conversation events and further input from members of the Trust's Clinical Governance Committee and Trust Board members, our Quality Priorities 2023-24 were approved by the Trust Board in March 2023.

Prioritising patient safety during industrial action

In common with other NHS trusts, industrial action by nurses and junior doctors impacted us at OUH between December 2022 and March 2023 – with further strikes also taking place at the start of 2023-24.

Patient safety and staff wellbeing were our priorities during these periods of industrial action. This included both extensive planning and preparation in advance of strikes and patient harm reviews and Trustwide debriefs after each period of industrial action.

As of April 2023, we had received no reports of patient harm on the days of strike action thanks to our preparedness for, and response to, industrial action as OneTeamOneOUH. However, we remain vigilant and we recognise that the strikes have had a significant impact on patients whose planned surgery or outpatient appointments have been postponed.

Patients waiting for treatment.

We are keen to explore every opportunity to see more patients more quickly and reduce waiting lists. I am grateful to our staff who have worked on these improvements and to our partners with whom we are working to deliver better services to our patients.

We have reduced the number of patients waiting more than two years from a peak of 101 in October 2021 to 26 in March 2022 and to 4 by March 2023. We are committed to reducing further the number of patients waiting for elective treatment in 2023-24.

Harm reviews continue to be performed for patients waiting in excess of 52 weeks, to identify any psychosocial or clinical harm arising from delays. The methodology has evolved in line with the national e-prioritisation policy, which has meant that all patients can now be proactively prioritised electronically based on clinical need. Harm reviews are then discussed in the monthly Harm Review Group (HRG). The harm reviews have allowed services to expedite treatment of patients as necessary. Where moderate or above impact has been confirmed at HRG, these cases are reviewed through the serious incident requiring investigation (SIRI) forum process to identify learning.

Following an agreed protocol, any cancer patient waiting for over 104 days for treatment also has a review conducted of potential for clinical harm from the delay. Details are reported to the Trust's HRG and then to the Patient Safety & Effectiveness Committee.

Preparing for the Patient Safety Incident Response Framework (PSIRF)

We are preparing for the national introduction of a fundamentally different way to manage patient safety and incident reporting in the NHS – the Patient Safety Incident Response Framework (PSIRF).

OUH, in common with all other NHS organisations, will implement PSIRF by October 2023. There is a PSIRF steering group and small implementation team who have

produced an implementation plan with wide stakeholder input including through a PSIRF summit.

The PSIRF Summit took place in February 2023, where proposals for how the new framework is implemented at OUH were presented and discussed by multi-disciplinary teams as well as external stakeholders. The Trust is also liaising closely with other local trusts to ensure consistency of approach.

A PSIRF plan detailing how we will respond to patient safety incidents and a policy describing the governance arrangements for how patient safety will be managed at OUH is being drafted and consulted on ahead of its approval and implementation. Information is being communicated regularly to staff and an extensive programme of training is available prior to the PSIRF launch in October 2023.

Maternity and Newborn Care Development Programmes

During 2022-23 an independent culture and leadership review was commissioned by the Trust into both Maternity and Neonatal (Newborn Care) services.

At the Trust Board meeting in March 2023, Board members were delighted to hear about an impressive range of achievements, including a significant reduction in staff turnover and sickness absence, as our Maternity Development Programme continues to gather pace.

Professor Tony Schapira, who is our Non-Executive Director Maternity and Neonatal Safety Champion, congratulated the whole Maternity team on the ‘tangible progress’ which has been made.

In addition to the ongoing work of the Maternity Development Programme, in January 2023 we were able to reopen our Midwifery-led Units in both Chipping Norton and Wantage, and also in January 2023 the Care Quality Commission (CQC) published the results of the 2022 Maternity Survey which showed a year-on-year improvement.

The Newborn Care report was received by the Trust in October 2022 and shared with staff working in the service. A commitment was made at the time to work with staff to scope out the full impact of the recommendations of the report, which have

been defined into eight key overarching themes under which a number of individual workstreams has been initiated.

The Newborn Care Development Programme is benefiting from the fact that this model has been effectively tested and implemented through the Maternity Development Programme, with lessons learned and great practices yielding positive benefits for service users and staff.

CQC report on Oxford Critical Care

The CQC carried out an inspection of Oxford Critical Care – our Adult Critical Care Unit on the John Radcliffe Hospital site – in November 2022. Their report based on this inspection was published on 6 April 2023 and it identified positive areas of good practice including:

- The service met national standards.
- Many aspects of the care provided to patients were safe and effective.
- Staff were focused on the needs of people receiving care on the unit.
- Safety incidents were reviewed to help make improvements.

However, the CQC also highlighted areas for further improvement including:

- The service did not always have the right staff skill mix, and it did not meet the recommended national guidelines on nursing skill mix in intensive care units.
- Staff fatigue was high, and morale was low.
- Processes for identifying and escalating risk appeared to be inconsistently used.
- Audits were not always completed which meant some information was not being used to measure the quality and safety of the unit, or help it meet challenges.

I would like to thank all staff working in Oxford Critical Care for their positive approach to the CQC inspection. We are already working with the management team and all staff to make improvements, including supporting staff and strengthening processes. Delivery of this improvement will be monitored through the

Trust’s governance processes and a dedicated role has been created to lead the improvement.

Never Events

The Trust has worked hard to improve patient safety and has halved the number of Never Events compared with four years ago. During 2022-23 we reported five clinical incidents classified as Never Events. Each incident underwent a thorough SIRI investigation, and any immediate remedial actions were implemented urgently whilst these incidents were being fully investigated. The final investigation report findings are presented to me and to the Executive Directors. Going forwards, we will continue to enhance our vigilance and further strengthen our patient safety systems and culture, to reduce further the risk of Never Events and other patient harm incidents.

Reporting Excellence goes from strength to strength.

Incident reporting has been a way of learning from errors for many years, but it is just as important that we learn from positive experiences, from the many moments of excellent care that happen every day.

Our Reporting Excellence scheme enables staff to report examples of excellence by individuals or teams which not only improves staff morale for those who are singled out but also helps us all to learn from these events, to share best practice, and to improve the quality of patient care as a result.

We keep a database of Excellence Reports so that we can learn from them and share the general principles across clinical teams.

In January 2023 the Reporting Excellence team said they had received more than 700 nominations during the previous three months, which represented a doubling based on year-on-year comparisons.

Thank you to all staff who have taken the time to nominate and celebrate the compassionate excellence of colleagues, and well done to all those who have been recognised with a Reporting Excellence nomination.

Quality Improvement (QI) Stand-Up events expanded.

We want Quality Improvement (QI) to be a golden thread in all that we do. In the past 12 months we have successfully trained 541 staff in QI, exceeding our target to train 500 staff in 2022-23.

The Quality Improvement (QI) Stand-Up initiative was launched to staff in April 2021 as an opportunity for staff speakers to present their work to a wider audience during a 30-minute session taking place virtually every fortnight.

We have been delighted by the number and range of staff from all areas and professional groups in the Trust that have joined these sessions.

In October 2022 we expanded QI Stand-Up and made it more accessible by circulating a Microsoft Teams calendar invite to all OUH colleagues for each session.

More than 100 staff now routinely attend each QI Stand-Up event. At each session, there are two short QI project presentations at which the presenters discuss their initiative, QI journey, and share learning from what worked and didn't work. The audience is then invited to share insights, feedback and discuss ways to adopt best practice.

Embedding a patient safety culture at OUH

Reporting Excellence and QI Stand-Up are just two examples of initiatives which we have put in place to embed a patient safety culture at OUH – other examples include:

- Patient Safety Response (PSR) team meetings are held every weekday to review all new moderate and above incidents so staff can be supported, and incident management started promptly.
- Safety Messages from the Chief Medical Officer and the Chief Nursing Officer are emailed to all staff once a week to raise awareness of important patient safety issues.
- All teams are encouraged to hold Safety Huddles either face-to-face or virtually every day to focus on what went well, what could have gone better, and what lessons can be learned in order to do things differently.

- Our Oxford Scheme for Clinical Accreditation (OxSCA) programme, which evaluates clinical wards and departments against a set of standards in order to measure quality and demonstrate improvement in the services they provide, is now embedded.
- Our DAISY Awards celebrate nurses and midwives working at OUH because patients, their families and our staff can nominate a nurse or midwife who has made a real difference through outstanding clinical care.

New developments

Our staff have continued to innovate and develop new ways of working this year in order to improve patient safety, patient experience, and clinical effectiveness:

- Following a successful bid for capital funding from NHS England, a second Computerised Tomography (CT) scanner has been installed at the Horton General Hospital in Banbury – this is excellent news for our patients and the staff who care for them because we will now be able to provide a resilient CT service at the Horton.
- Researchers and clinicians at OUH have begun trialling new artificial intelligence (AI) software to help pathologists diagnose prostate cancer – this evaluation of the new technology in a busy clinical setting is a key milestone in the University of Oxford-led ARTICULATE PRO study
- A Varian TrueBeam Linear Accelerator radiotherapy machine has been installed at the Churchill Hospital in Oxford to provide state-of-the-art treatment for cancer patients – its HyperArc capability enables the use of a new technique that allows clinicians to treat patients with brain tumours faster and more efficiently
- OUH has become the first NHS trust in the UK to use Spine Awake Surgery, an innovative way of operating on patients who require lumbar spine surgery this new technique uses a combination of spinal anaesthetic and local analgesia so they can stay awake during the operation and go home the same day, which aids recovery
- Oxfordshire Rapid Intervention for Palliative and End of Life Care (RIPEL), a new partnership between OUH, Sobell House Hospice Charity, Macmillan

Cancer Support and Social Finance which aims to enable more people to be cared for in their own home at the end of their life if that is their choice, had a significant impact in 2022-23 – the Home Hospice service, launched in April 2022, and Hospital Rapid Response service, launched in October 2022, cared for almost 500 patients and saved more than 5,000 hospital bed days

Excellent outcomes for patients captured in clinical audits.

Examples include:

- Sentinel Stroke National Audit Programme (SSNAP): The John Radcliffe Hospital stroke service is performing well above the national average percentage of patients treated by early supported discharge team (ESD), continence plans and Occupational Therapy and Physiotherapy metrics.
- National Cardiac Arrest Audit (NCAA). Intensive Care National Audit & Research Centre (ICNARC)/Resuscitation Council UK (RCUK): Overall 56/104 (54%) cardiac arrests had Return of Spontaneous Circulation for more than 20 minutes; 33 (32%) survived to hospital discharge; these outcomes remain higher than the national average.
- National Cardiac Audit Programme: Adult Congenital Heart Disease Clinical Audit: There have been no procedural complications and no requirement for a second procedure.
- National Gastro-intestinal Cancer Audit Programme (GICAP) (National Bowel Cancer Audit (NBOCA)): Excellent involvement of clinical nurse specialist team; high rate of minimally invasive surgery; parameters assessing quality of surgery are very good – high number of lymph nodes, low rate of positive resection margins; continued improvement in surgical outcome measures adjusted 90 day and length of stay > 5 days; continued improvement in 2-year cancer survival; and reduced rate of unplanned readmissions compared to previous year's data.
- National Lung Cancer Audit: Surgical resection rate remains above the national mean and national standard (OUH was a positive outlier). Also, despite the COVID pandemic, systemic anti-cancer therapy delivered to non-

small cell lung cancer and small cell lung cancer increased from 2019 to 2020.

Innovations introduced and the positive impact of research on patient care.

Oxford is one of the most vibrant places in the world for healthcare research because of the close working relationship between clinicians at OUH and the world-class University of Oxford academics and researchers who work alongside them.

OUH is also at the heart of a research ecosystem as the host organisation for the Oxford Biomedical Research Centre (BRC) and Oxford Academic Health Science Network (AHSN).

This has a positive impact on the quality and safety of patient care because new innovations and treatments are often introduced first in our hospitals and then rolled out to other NHS trusts – some examples of recent innovations include:

- The Oxford AHSN and OUH have developed a package of resources to support other NHS organisations wanting to deliver intravenous (IV) antibiotics to patients in their own homes – we began using elastomeric devices to deliver IV antibiotics in patients' homes in 2019 through 'hospital at home' nursing teams and by April 2023, 230 OUH patients had benefited, with 3,200 hospital bed days freed up and £1 million of costs avoided.
- The introduction of pre-operative assessment triage is taking a more personalised approach to the individual needs of patients awaiting routine orthopaedic surgery so that potential issues are identified and treated early, leading to fewer procedures being postponed later on – its use before hip and knee surgery at the Nuffield Orthopaedic Centre (NOC) has led to better patient management and outcomes, fewer missed appointments, and environmental benefits due to fewer journeys to hospital.
- Researchers and clinicians have begun an evaluation of artificial intelligence (AI) software that could help pathologists diagnose prostate cancer – testing of the technology in a busy clinical setting, now underway at OUH, is a key milestone in the University of Oxford-led ARTICULATE PRO study to help pathologists to detect, grade and measure tumours in prostate biopsies.

- Thousands of people with weakened immune systems, including patients at OUH, have the chance to take part in a landmark new study investigating which people are still at the greatest risk of COVID-19 infection after vaccination – Oxford is one of four main centres for the two-year NIHR-funded STRAVINSKY study which will inform future guidance for immunocompromised patients and clinicians.

Our award-winning teams

Our staff are committed to delivering the highest quality care for our patients. This year we have celebrated their many successes including the following:

- The Hip Fracture Team at the Horton General Hospital in Banbury was named as one of the best in the country in the annual National Hip Fracture Audit – for the 10th year in a row – after meeting best practice criteria in their treatment of 92% of patients.
- An innovative partnership between OUH and University Hospitals Coventry & Warwickshire was recognised in March 2023 when the Coventry-Oxford Network for Transplantation won the Excellence in Delivering Patient Care category at the NHS Blood and Transplant and British Transplantation Society's Awards for Excellence in Organ and Tissue Donation and Transplantation
- Staff from the Haematology team at the Churchill Hospital in Oxford won the Myeloma UK Clinical Service Excellence Programme Award in July 2022, in recognition of their outstanding care for patients with myeloma, an incurable blood cancer
- A project which helps the parents and carers of children with complex medical conditions was shortlisted in two categories of the *Health Service Journal* (*HSJ*) Patient Safety Awards in September 2022 – this collaboration between OUH, the University of Oxford, Helen & Douglas House Hospice and Oxford Simulation Teaching and Research (OxSTaR) uses videos and online resources to support parents and carers at home.
- OUH, alongside the Thames Valley and Northamptonshire Brain Tumour Network, was named as one of six new centres to become a Tessa Jowell

Centre of Excellence in June 2022, in recognition of our world class brain tumour service following rigorous expert-led assessments.

Performance against some national standards is included in this Quality Account but is discussed in detail in the Annual Report.

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.

Professor Meghana Pandit

Chief Executive Officer

12 May 2023

About us and the service we provide

Oxford University Hospitals NHS Trust was formally established on 1 November 2011 when the Nuffield Orthopaedic Centre NHS Trust merged with Oxford Radcliffe Hospitals NHS Trust. On the same date, a revised formal Joint Working Agreement between the Trust and the University of Oxford came into effect. The Trust became a Foundation Trust on 1 October 2015. Oxford University Hospitals NHS Foundation Trust is an acute hospital Trust providing local, regional and some national hospital services to the population of Oxfordshire and beyond. It is registered with the Care Quality Commission and licensed to provide regulated activities by NHS England. The Trust provides a wide range of clinical services, specialist services and super specialist services, including emergency care, trauma and orthopaedics, maternity, obstetrics and gynaecology, paediatric services, newborn care, general and specialist surgery, cardiac services, critical care, cancer, renal and transplant, neurosurgery, maxillofacial surgery, infectious diseases and blood disorders. The Trust also draws patients from across the country for specialist services and leads networks in areas including trauma and vascular.

The Trust consists of four hospitals:

- the John Radcliffe Hospital
- the Churchill Hospital and
- the Nuffield Orthopaedic Centre
- the Horton General Hospital in Banbury

The John Radcliffe Hospital, Churchill Hospital and Nuffield Orthopaedic Centre are located in Oxford, and the Horton General Hospital in Banbury, North Oxfordshire. Most of our services are provided in our hospitals, but some are delivered from 59 other locations across the region, which include outpatient peripheral clinics in community settings, satellite services in several surrounding hospitals and some in patients' homes.

The Trust also delivers services from community hospitals in Oxfordshire, including midwifery-led units; and is responsible for a number of screening programmes, including those for bowel cancer, breast cancer, diabetic retinopathy and chlamydia.

More information on Oxford University Hospitals NHS Foundation Trust and its services is available on the Trust website at www.ouh.nhs.uk

Part 2: Priorities for Improvement and Statements of Assurance from the Board

2.1. Priorities for Improvement

Results and achievements for the 2022-23 Quality Priorities

This section details the Trust's achievements against its quality objectives for 2022-23. While good progress has been made on many of the Quality Priorities for 2022/23, progress on others has been slower than planned due to operational pressures. The Trust continues to engage sensitively with clinical services to try to complete the outstanding actions. In addition, the Medication Safety and Surgical Morbidity Dashboard Quality Priorities have been updated and rolled into 2023/24.

Below is a summary of how we have self-assessed our achievement against each objective. The full detail then follows for each Quality Priority.

Table below shows summary of results and achievements for the 2022-23 Quality Priorities

Domain	Key Deliverables	What we achieved
Patient safety		
Triangulation of Learning from Claims with Incidents, Inquests and Complaints	Identify the core 8 Getting it Right First Time (GIRFT) learning themes that might prevent future claims / complaints.	5 years' claims data checked, triangulated with incidents and complaints, and shared with clinical specialties, along with supporting claims documentation. (18/39 clinical specialties completed). Progress has been slower than planned due to operational pressures and limited organizational memory of historical cases. Divisional Medical Directors continue to engage sensitively with clinical services to try to complete the outstanding reviews in Q4.
Reducing Pressure Ulcers	Reduce the incidence of Category 2 and above Hospital Acquired Pressure Ulceration (HAPU) by 30%	Phase 1 to identify and understand HAPU profile fully achieved with support from Integrated Quality Improvement (IQI) team. Divisional Listening Events held. HAPU Category 3 and above, was 0.05% in 2021-22 and to 0.035% in

		2022-23, demonstrating in excess of a 30% reduction in incidence. A strategic and collaborative approach to reducing harms associated with acquired pressure damage has resulted in a 30% decrease in incidence.
Medication Safety – Insulin & Opiates Insulin Safety Reducing opioids use	Reduction in National Diabetes Inpatient Audit (NaDIA) related harms in the Trust, including a reduction in the number of severe hypoglycaemic events to be in line with or below the national reported average. Reduction in the number of moderate harm incidents relating to insulin prescribing, supply and administration. Once the insulin e-learning has been updated, 80% of staff to have completed the training. Patients with diabetes will be represented in the insulin safety group and feedback obtained from patient groups in collaboration with the Patient Experience Team. Where clinically appropriate, aim to reduce the routine supply of opioids on discharge to an acceptable minimum and to increase the number of patients discharged with multi-modal analgesics.	QP has been rolled into 2023-24 financial year. The Insulin Safety Group continues to meet monthly and review all incidents, including those meeting the NaDIA harm criteria. Insulin incidents are reviewed and trends in errors are being identified. The percentages of hypoglycemia events reported to Ulysses has seen a slight increase from 0.8% to 1.3%. (These are the number of hypoglycemic events under 3mmol/l and compared the number of Ulysses reported) QP has been rolled into 2023-24 financial year. QP has been rolled into 2023-24 financial year. Opioid Stewardship group (OSG) established with a positive multidisciplinary team. Baseline audit of opioid discharge prescribing is complete. Opiate usage data capture form developed & piloted – to be rolled out for key surgical procedures. Next steps are to identify the most common surgical procedures and enlist Enhanced Recovery After Surgery (ERAS) nurses, medical students and other specialties to collect that data by phoning patients at home. This will be labour- and time-intensive but should provide useful normative data.
Clinical effectiveness		
Results endorsement	Increase test endorsement rates (aim for 90% endorsed within 7 days) and reduction in incidents related to	82.2% Results Endorsed within 7 days. Improvement noted from 78.7% in 2021-22. Safety

	missed results.	Message sent as planned. Non-medical requestors identified, and significant progress made in either ensuring competence or alternative process in place. Electronic Patient Record (EPR) change to ICU responsible clinician addressed endorsement rates in ICU.
Introduce & embed use of a Morbidity Dashboard in Surgical Specialties	Specialty dashboards in use in Mortality & Morbidity (M&M) meetings.	The dashboard has been completed and tested which includes all procedures and episodes at OUH. Dashboard pilot completed. Coding discrepancies have been addressed. Roll out of the dashboard to further surgical specialties carried over to new Quality Priority.
Embed Quality Improvement (QI) Methodology More Widely in the Trust	Increase in the number of QI projects registered on Ulysses by month.	A QI Hub register has been established which so far includes >700 staff who have completed QI training or are active in the national Q Community of QI practitioners. This includes participants in the QI Hub Programme and staff who have completed the Trust Quality, Service Improvement and Redesign (QSIR) training programme. Strengthening of QI visibility and monitoring of QI has been fully achieved. Work continues as one of the 4 Quality Improvement workstreams for 2023/24
Patient experience		
Reduce incidents of violence, aggression	Reduction in the number of Violence and aggression incidents	Violence and Aggression Reduction Group meeting monthly with Chief Nursing Officer (CNO) as Chair. Diagnostics via Health & Safety Committee and Trust systems completed. Body Cameras have been deployed in an additional 17 clinical areas following the successful trial in John Radcliffe (JR) Emergency Department in conjunction with the Matrons for these areas and our head of security.
Transition of Children to Adult	Deliver the Inclusive summit with families, staff, and health,	The national picture has changed significantly over the previous 9

Services	education, and social care partners with an aim to finalise and agree transition framework. Develop Trust's Moving to Adulthood / Transition standards of practice or Charter	months, which has altered the deliverables for this Quality Priority. Inclusive summits were held in 2022-23 with steps towards development of a Buckinghamshire Oxfordshire Berkshire West (BOB)wide acute Trust community of practice to prepare for the publication of the national capability frameworks and supporting OUH services to develop their moving to adult services pathways.
Staff Health and Wellbeing: Growing Stronger Together	By the end of March 2023, 85% of our people to have participated in a Wellbeing Check-in. Reduce the backfill cost of temporary staff cover for absence relating to mental health by returning to pre-pandemic levels by 2025; this means a reduction of approximately 5% (£27,585) by March 2023.	At the beginning of March 2023 approximately 27.5% of our substantive staff have had a Wellbeing Check-in. The main challenges experienced are operational pressures. Staff encouraged to record at least one conversation and utilize existing 1-2-1s or appraisal conversations where possible. The Wellbeing Check-in questions have been updated to include a question around basic wellbeing needs being met.

Table 1: Summary of results and achievements for the 2022-23 Quality Priorities.

Patient Safety

Quality Priority: Triangulation of Learning from Claims with Incidents, Inquests and Complaints

Why was this a priority?

Potential safety issues are raised internally through the incident reporting system, and externally through complaints and patient liaison, safeguarding enquiries (under Section 42 of the Care Act 2014), deprivation of liberties safeguards (under the Mental Capacity Act 2005), legal claims, and Coronial inquests. Building on last year's Quality Priority, the aim is to strengthen the triangulation of learning from all these sources, with a particular focus on learning from claims.

How we evaluated success	2022-23 Update on QP
Action 1: Review learning from all claims notified to NHS Resolution in the last 5 years in accordance with GIRFT (Getting it Right First Time) litigation data pack dated May 2021 and 'Learning from Litigation Claims' GIRFT / NHS Resolution best practice published February 2021.	**Action 1: Partially achieved.** 5 years' claims data checked, triangulated with incidents and complaints, and shared with clinical specialties, along with supporting claims documentation.

How we evaluated success	2022-23 Update on QP
	Clinical specialty review of each of the individual claims from the last 5 years underway to identify, share and collate learning supported by Divisional Medical Directors and Clinical Governance & Risk Practitioners (18/39 specialties completed). Completion of the 5-year lookback has been challenging due to: - Clinical operational pressures - Limited organisational memory of some historical cases (may be up to 12 years ago due to 7-year period allowed to bring a case) Feedback from specialties includes: - Some positive learning - Interest in learning claims' outcome - Limited additional added value over existing learning from incidents and complaints processes in many areas.
Action 2: Summarise and triangulate learning from claims with learning from incidents, inquests and complaints. Identify the core 8 GIRFT learning themes that might prevent future claims / complaints. Review GIRFT 4th quartile specialty claims by 31 May 2022. Review GIRFT 1st-3rd quartile specialty claims by 30 September 2022. Claims are being reviewed in order of priority according to GIRFT Litigation Data Pack national benchmarking of the average cost of litigation per activity for each specialty starting with the specialties in Quartile 4 (red).	**Action 2: Partially achieved.** Individual claims have been triangulated with incidents and complaints. Learning themes identified so far are spread fairly evenly across all the 8 major GIRFT learning themes. Quartile 4 specialties: Medicine Rehabilitation and Cardiothoracic Division (MRC) (3 clinical specialties), Surgery, Women's and Oncology (SuWOn) (3) and Clinical Support Services (CSS) (2) Divisions have reviewed and analysed all their Quartile 4 specialty claims. Neurosciences, Orthopaedics, Trauma, Specialist Surgery, Children & Neonatal Division (NOTSSCaN) have reviewed 1 out of 7 clinical specialties. Quarterly review meetings continue with Deputy Chief Medical Officer (CMO), Head of Clinical Governance,

How we evaluated success	2022-23 Update on QP
	Head of Legal Services and Divisional Medical Directors (DMDs). Progress has been slower than planned due to operational pressures. DMDs continue to engage sensitively with clinical services to try to complete the outstanding reviews in Q4.
Action 3: In depth analysis of four clinical specialties with development of training tools and documentation to reduce future claims, incidents and complaints; one specialty each quarter in accordance with order of priority identified by GIRFT Litigation Data Pack and NHS Resolution's Clinical Negligence Scheme for Trusts (CNST) scorecard.	**Action 3: Partially achieved.** 1. Radiology (CSS, complete) In depth analysis of GIRFT Learning from Litigation included in Radiology Away Day, November 2022. Strong governance structures in place to support learning through Radiology, Education and Learning Meetings (REALM) forum. In addition, plan made for annual review of costs associated with legal claims. 2. Spinal Surgery (NOTSSCaN, in progress) Dedicated meeting and detailed discussion have taken place to identify learning, final action plan in progress. 3. Emergency Department (MRC) Review of cases completed. Process provided a useful template for embedding learning into standard clinical governance processes across the Trust going forwards. 4. General Surgery (SuWOn) Review of cases still underway. Other work to embed GIRFT Learning from Litigation into Business as Usual in 2023-2024: 1. Plan agreed with Legal team, Clinical Governance team and Divisional Medical Directors to link Learning from Litigation to closure of claims in real time going forward. Formal Standard Operating Procedure (SOP) in development.

How we evaluated success	2022-23 Update on QP
	2. NHS Resolution Panel solicitor for OUH is booked to deliver MS Teams training on 'Consent to Treatment' to the Divisions. 3. Further training by Legal Services using generic principle/clinical specialty specific case studies to be provided one topic per quarter for each Division. 3. Work completed within Assurance team to incorporate GIRFT data into Divisional information matrix.

Table 2: Update on actions for Quality Priority 2022-23: Triangulation of Learning from Claims with Incidents, Inquests and Complaints

Quality Priority: Reducing Pressure Ulcers

Why was this a priority?

Harms associated with pressure damage can have a lasting effect on patients and their carers and add a significant financial burden to the Health Economy as a whole

How we evaluated success	2022-23 Update on QP
PHASE 1 – IDENTIFY AND UNDERSTAND By Q1&Q2 22-23 1: Review and analyse all HAPU (Hospital Acquired Pressure Ulcer) incidents with staffing, acuity, dependency, length of stay, complaints, and patient experience data from 2021-22, to identify and understand whether co-dependencies and / or commonalities exist. 2: Identify themes and issues related to environmental, clinical, educational, workforce, and resourcing factors from the evidence established from the above action, to establish a baseline and identify learning opportunities. 3: Review National and Shelford data position for benchmarking and further learning opportunities.	**Phase 1: Fully achieved.** Integrated Quality Improvement (IQI) Team support QI Projects underway across the Organisation: • Senior Leadership Enablement QI Project: (1) Ward to Board Dashboard (2) Quality and Safety Boards (3) Oxygen Delivery Devices • Scoping work undertaken • Divisional Listening Events held. • Deep dive analysis of moderate harm HAPU from 2021-22 complete • Harm Free HAPU Summit Meeting Aug 2022 • Development of comprehensive delivery plan reporting to Harm Free Assurance Forum monthly
PHASE 2 – DESIGN IMPROVEMENT, PLAN, AND IMPLEMENT By Q2-Q3 22-23	**Phase 2: Fully achieved.** Case Study exemplars developed.

How we evaluated success	2022-23 Update on QP
1: Establish clear themes and associated interventions for improvement with the clinical Divisional Teams (co-production). 2: Plan and implement interventions identified from Phase 1, using a Quality Improvement (QI) approach. 3: Clinical Divisions to involve and engage staff in pilot areas with QI projects. 4: Develop systems to support effective multi-professional collaborative working practices, in association with pressure ulcer prevention and awareness. This will be achieved through highlighting the unique therapeutic contribution that each profession adds to the process of patient care. 1: Undertake peer review of identified associated clinical audit for pressure ulcer prevention and wound management. 2: Review and re-launch Pressure Ulcer Prevention Policy with associated clinical resources through a targeted Awareness Campaign Evidence: Production of associated resources	• 'Role specific' Pressure Ulcer Prevention e-learning relaunched for nurses, midwives, and allied health professionals (NMAHPs) • Pressure Ulcer Prevention Policy updated with new supporting guidance documents • Showcase event for QI projects held Nov 2022 • Annual Clinical Audit conducted and reported • Chief Nurse Officer (CNO) Research Fellow QI Project scoped and agreed • Medical Device Related Pressure Ulcer: working Group formed
Phase 3 – Review and Evaluation By Q4 22-23 1: Reduce the incidence of Category 2 and above Hospital Acquired Pressure Ulceration (HAPU) by 30% 2. Use data to measure effectiveness throughout the year and redesign and adjust interventions as necessary 2: Establish effective interventions and plan rapid spread Monitor and evaluate further improvements.	**Phase 3 Partially achieved.** HAPU Category 3 and above, was 0.05% in 2021-22 and to 0.035% in 2022-23, demonstrating in excess of a 30% reduction in incidence. Any actions not delivered by end of Q4 will be carried over to 2023-24 and ongoing improvement and actions will be monitored by the Harm Free Assurance Forum through an organisation wide action plan.

Table 3: Update on actions for Quality Priority 2022-23: Reducing Pressure Ulcers

Quality Priority: Medication Safety – Insulin and Opiates

Why was this a priority?

Insulin errors remain widespread around the country despite many local and national initiatives to improve insulin safety. They can be potentially life-threatening and on many occasions the harm suffered is ameliorable or avoidable.

How we evaluated success	2022-23 Update on QP
<u>Insulin Safety</u> **Action 1**: Where the NaDIA (National Diabetes Inpatient Audit) Harm criteria have been met, irrespective of the actual impact to the patient, there will continue to be an investigation of what happened to learn and improve care. All 'Harms' will be reviewed in a multidisciplinary diabetes meeting. The Insulin Safety Group will continue to share learning from these investigations with the Medicines Safety Group. The Insulin	**Action 1: Fully achieved.** The Insulin Safety Group continue to meet monthly and review all incidents, including those meeting the NaDIA harm criteria. Insulin incidents are reviewed and trends in errors are being identified.

<table>
<tr><th>How we evaluated success</th><th>2022-23 Update on QP</th></tr>
<tr><td>Safety Group wants to focus on identifying current themes for learning and will start with a quarterly review of incidents.</td><td></td></tr>
<tr><td>Action 2: Review of hypoglycaemia events in inpatients using blood glucose results available via point of care testing and comparing with inpatient Ulysses reports to gauge awareness of hypoglycaemia management across the Trust and target training appropriately. A one-month sample of results will be selected for a baseline audit for review by the end of Q2 22-23.</td><td>Action 2: Partially achieved.
Baseline audit completed.

The percentages of hypoglycemia events reported to Ulysses has seen a slight increase from 0.8% to 1.3%. (These are the number of hypoglycemic events under 3mmol/l and compared the number of Ulysses reported)

Reduction in NaDIA related harms in the Trust, including a reduction in the number of severe hypoglycaemic events.

<table>
<tr><th>Year</th><td>Severe Hypoglycaemia</td><td>DKA*</td><td>HHS*</td></tr>
<tr><td>2019</td><td>8</td><td>4</td><td>1</td></tr>
<tr><td>2020</td><td>1</td><td>6</td><td>4</td></tr>
<tr><td>2021</td><td>9</td><td>7</td><td>4</td></tr>
<tr><td>2022</td><td>6</td><td>4</td><td>2</td></tr>
</table>
*DKA – Diabetic ketoacidosis, HHS – Hyperosmolar hyperglycaemic Syndrome
Content of E-learning has been reviewed, to include learning from incidents, and content is being updated, aiming to be ready for April 2023</td></tr>
<tr><td>Action 3: People with diabetes will be represented on the Diabetes Safety Group. Involvement of patients in identifying ways on improving safety while inpatients and creation of useful material to support inpatients during their stay. Review attendance to the monthly Diabetes Safety Group meetings by the end of Q4 22-23.</td><td>Action 3: Partially achieved.
Advert ready to go out, aim to recruit for Feb/March 2023
Inpatient questionnaire ready to be trialled on the wards.</td></tr>
<tr><td><u>Reducing opioid use</u>

Action 1: Development and review of Trust guidelines for pre-operative assessment to guide post-operative pain management with a particular focus on complex patients who are on oral daily morphine equivalent doses of greater than 120mg pre-operatively (guidelines to include patient defined comfort and functional goals to manage patient’s pain expectations).
Q1: Draft guideline, developed and tested.
Q2: Revised and approved by the end of Q2.
Q3: Introduction to routine practice.</td><td>Action 1: Partially achieved.
Orthopaedic subgroup of the Opioid Stewardship group (OSG) has been established.
Identifying high-risk patients pre-operatively will take more work, and the key stakeholder is now on maternity leave.</td></tr>
</table>

How we evaluated success	2022-23 Update on QP
Q4: Introduction to routine practice.	
Action 2: Establish Trust-wide baseline data of codeine, tramadol, dihydrocodeine, morphine and oxycodone discharge quantities from surgical areas for further education and culture change. Monitor the quantity of opioids supplied on discharge. Where clinically appropriate, aim to reduce the routine supply of opioids on discharge to an acceptable minimum and to increase the number of patients discharged with multi-modal analgesics. Q1 and 2: Identify and monitor baseline data for the quantities of opioids supplied on discharge from surgical areas. Q3 and 4: Introduce changes in practice to reduce routine supply of opioids and evaluate for effectiveness.	**Action 2: Partially achieved.** Baseline data of opioid discharge prescribing is complete. We have developed, and are trialling, a data capture form for collecting patient opioid usage data. We shall then identify the most common surgical procedures and enlist Enhanced recovery after surgery (ERAS) nurses, medical students and other specialities to collect that data by phoning patients at home. This will be labour- and time-intensive but should provide useful normative data.
Action 3: Review and promote the use of the Pain Guidelines available via OUH MicroGuide to improve understanding of pain management and prescribing of pain treatment across the Trust. Q1-2: Identify numbers of users of Pain Guidelines, feedback from clinical staff about their knowledge of the tool, how they use it and how its use could be promoted. Q3: Develop the guidelines based on the feedback from clinical staff and promote the guidelines. Q4: Repeat the scoping exercise gaining further feedback from clinical staff to determine whether knowledge of the resource and use has increased. Identify user numbers from website pages.	**Action 3: Fully achieved.** The Oxford Pain Guide has important information to guide analgesic prescribing in the Trust. It will need continued effort to raise its profile and make sure that ward staff know where to find it.
Action 4: Establish an opioid stewardship group to monitor and oversee the 'Reducing Opioid Use' quality priority and continue collaborative opioid stewardship work with the Academic Health Science Networks. Q1: Scope key stakeholders and develop terms of reference. Q2: Launch meeting.	**Action 4: Fully achieved.** Opioid Stewardship group (OSG) established with a positive multidisciplinary team.
Action 5: To identify a selection of indicators around opioid prescribing and administration in collaboration with ePMA (electronic Prescribing and Medicines Administration) and Information Management & Training (IM&T) reporting teams and test for suitability and validity. Q1 and 2: Identify the prescribing and administration data available in ePMA that could be used to measure aspects of opioid prescribing, administration and safety (e.g., obtain baseline data for the percentage of inpatients who have received naloxone). Q3 and 4: Refine and develop reporting tools.	**Action 5: Fully achieved.** Some alerts will be straightforward to set up while others require more nuance. Time to implement changes will depend on the Electronic Patient Record (EPR) team.

Table 4: Update on actions for Quality Priority 2022-23: Medication Safety – Insulin and Opiates

Clinical Effectiveness

Quality Priority: Results Endorsement

Why was this a priority?

Ensuring that the results of requested tests / investigations are seen and acted upon is important to avoid serious findings being missed and patients coming to harm.

Assurance that a test result has been acted upon is achieved by the requestor endorsing the result on EPR (Electronic Patient Record). This is termed 'Results Endorsement'.

How we evaluated success	How we will evaluate success
Action 1: Identify 5 clinical areas with lower endorsement rates and focus education and awareness to increase results endorsement by at least 10% compared to Nov 2021 levels. 1.Q1: Identify areas and baseline data. Meeting with clinical leads and encourage clinical team attendance at virtual digital surgery and arrange presentations at clinical and governance meetings. Individuals' clinicians to be given access to their personal endorsement rates. 2.Q3: Audit of results endorsement in 5 key areas.	**Action 1: Partially achieved.** Baseline data identified, and Divisional Medical Directors met with team clinical leads and teams. Personal Endorsement rates available via ORBIT which is an electronic reporting tool (ORBIT+). Q1 Action complete. Q3 Audit paused until key aspects of the reporting are fixed e.g., ensure that auto reporting of X-Rays is counted as having been endorsed.
Action 2: Raise awareness with safety messages and grand round presentations and monthly 'Virtual Digital Surgery' with a focus on results endorsement (pools, proxy and encounter). Q1: Results endorsement safety message to go out quarterly. Monthly digital surgeries to be established. Q2-4: Grand Round presentations if reinstated post COVID-19.	**Action 2: Partially achieved.** Safety Message sent as planned. Medical grand rounds not yet reinstated. Digital Surgeries explored but not felt helpful by teams – Digital help provided on 'pro re nata,' (PRN) basis. Q1 action complete. Q2-4 Medical Grand Rounds are still paused
Action 3: Ensure tests requested by non-medical requestors are endorsed. Identify non-medical requestors and if not able to endorse ensure processes for result being actioned by the Clinical Lead. Q1: Identify all non-medical requestors and baseline endorsement rates. Q2: Ensure non-medical requestors competent to endorse or alternative process in place. Q3: Audit results endorsement rates of non-medical prescribers.	**Action 3: Fully achieved.** Non-medical requestors identified, and significant progress made in either ensuring competence or alternative process in place. Q1 Action complete. Q2 Discussions with key Divisions about ensuring non-medical prescribers endorse or have a system in place to endorse results. Q3 Audit seen within the monthly department ORBIT figures.
Action 4: Implement auto endorsement of negative results i.e., normal Midstream specimen of urine (MSU) and Urine Culture (MCS) results. 1: Auto endorsement to be considered by Q1 and in place by Q3.	**Action 4: Fully achieved.** Auto endorsement completed for D1-4 for negative blood cultures. Further areas being explored, but not appropriate at present.
Action 5:	**Action 5: Fully achieved.**

How we evaluated success	How we will evaluate success
1: Ensure all patients in ICU have results endorsed on Electronic Patient Record (EPR). 2: Consider Intensive Care Unit (ICU) patients remaining under referring clinician who remains responsible for endorsing results	Changes to ICU responsible clinician has significantly improved endorsement rates in ICU.
Action 6: Remove EPR access for all clinicians who have left the Trust and implement a new digital leavers' process to remove in future. 1: Review EPR access for those already left by Q2. 2: Implementation digital leavers' process by Q4.	**Action 6: Fully achieved.** Information team continue to remove EPR access for those who have left and have reviewed over 100 'pools' to ensure they are being actively managed. EPR process if a clinician leaves the Trust includes setting up an 'Out of office' in EPR account and setting up a 'Proxy' to ensure colleagues have access to inbox. This is part of the leavers process.
Action 7: Ensure all lead clinicians have EPR pools set up to help manage results and are aware of the processes for managing access to these EPR pools by Q3.	**Action 7: Fully achieved.** All Lead Clinicians now have an EPR pool for their service. These are monitored by the Information Team to ensure they are being actively managed.

Table 5: Update on actions for Quality Priority 2022-23: Results Endorsement

Quality Priority: Introduce and Embed Use of a Morbidity Dashboard in Surgical Specialties

Why was this a priority?

To share learning and promote widespread adoption of Morbidity Dashboard to identify and understand any areas with higher rates of readmissions and returns to theatre across the Trust.

How we evaluated success	How we will evaluate success
Action 1: Develop and implement Morbidity Dashboard for surgical specialties by end of Q2.	**Action 1: Fully achieved.** The dashboard has been completed and tested. The dashboard includes all procedures and episodes at OUH.
Action 2: Embed routine review of the Morbidity Dashboard into surgical morbidity and mortality meetings (M+Ms) by end of Q2.	**Action 2**: **Partially achieved**. Pilots have been completed and identified discrepancies in coding data have been identified that are being addressed to support wider roll out to other surgical specialties.
Action 3: By Q4, develop procedure-specific dashboard for five procedures that can be used by services and Mortality and Morbidity meetings to audit procedure-based outcomes.	**Action 3: Fully achieved.** The dashboard has been redesigned to allow for analysis by procedure.

How we evaluated success	How we will evaluate success
Action 4: By Q4 use the Morbidity Dashboard to identify and understand any areas with higher rates of readmissions and returns to theatre compared with regional and national benchmarks.	**Action 4**: **Not achieved.** Roll out of the dashboard to further surgical specialties, has been carried over to next year's Quality Priorities.

Table 6: Update on actions for Quality Priority 2022-23: Introduce and Embed Use of a Morbidity Dashboard in Surgical Specialties.

Quality Priority: Embed QI Methodology More Widely in the Trust

Why was this a priority?

Building on the success of the QI Hub, which won the *Health Service Journal Changing Culture Safety Award 2021*, this Quality Priority aims to embed the same culture of improvement more widely across the Trust. We will do this by expanding the QI Hub and QI methodology to a wider community of colleagues from all disciplines across the organisation; sharing learning and good practice through this network and through our QI Stand Up forum; and thereby providing a platform for further training, support, mentorship, and system change.

How we evaluated success	How we will evaluate success
Action 1 (Q1): Establish current Trust-wide QI capacity and activity, including the following. 1: Register of QI Hub members (faculty and participants). 2: Register of staff who have completed QI training (including OUH Quality, Service Improvement and Redesign -QSIR training). 3: Inclusivity of QI Hub and QSIR training (departments, professional groups, bands / grades, ethnicity) 4: Register of departmental QI and Audit leads. 5: The number of QI projects registered on Ulysses by month.	**Action 1: Fully achieved.** **1.** A register of QI Hub Programme participants and faculty has been incorporated into a new QI Hub register of the wider OUH QI community. 2. A QI Hub register has been established which so far includes >700 staff who have completed QI training or are active in the national Q Community of QI practitioners. This includes participants in the QI Hub Programme and staff who have completed the Trust Quality, Service Improvement and Redesign (QSIR) training programme. 3. Ensuring diversity and inclusivity is a key priority in establishing the community of Improvers@OUHQIHub. A baseline survey of staff demographics has been completed. Once invited staff have registered at Improvers@OUHQIHub, the OUH HR team will be able to provide a regular, anonymised summary of membership diversity by age group, sex,

How we evaluated success	How we will evaluate success
	professional group, area of work and seniority. As for other staff metrics (e.g., staff survey) information will be shared in a way that does not allow individuals to be identified. We will use the information from the survey to identify staff groups that are less well represented so that we can directly address this through the Trust's QI offer.
Action 2 (Q2-Q3): Strengthen QI Leadership and Support. 1: Engage existing QI and Audit leads with QI Hub to increase QI Hub reach, inclusivity, and support. 2: Encourage and support development of QI Leads in all departments. 3: Develop and implement standardised SOP for registration and presentation of QI projects.	**Action 2: Fully achieved.** A survey of current audit and QI leads has been completed, followed by a gap analysis demonstrating variable provision of leads across the organisation and missing data in a number of areas. We are currently exploring how QI leadership roles might be incorporated into job planning. A standardised SOP for registration of QI projects has been developed.
Action 3 (Q3-Q4): Strengthen QI visibility and monitoring. 1: Establish monitoring of QI activity across the Trust. 2: Audit key metrics to assess impact of interventions. a). No. and inclusivity of QI Hub members. b.) No. (%) staff trained in QI. c.) No. registered QI projects (by quarter). d). No. (%) QI projects using standard QI methodology. e). No. (%) QI projects presented at departmental / Trust level. f.) No. (%) QI projects that achieved project aims. Use data to inform ongoing QI strategy development.	**Action 3: Fully achieved.** A Quality Improvement module has been developed on Ulysses for all QI projects to be registered. A baseline survey of staff demographics has been completed among those who have completed QI Hub or other QI training. This will inform ongoing engagement work to ensure inclusivity. Monthly reports of the number of staff trained and projects registered and presented at QI Stand-Up are included in the Integrated Quality Improvement reports to the Trust Management Executive.

Table 7: Update on actions for Quality Priority 2022-23: Embed QI Methodology More Widely in the Trust

Patient experience

Quality Priority: Reduce incidents of violence & aggression.

Why was this a priority?

Reduce incidents of violence, aggression and / or abuse initiated by members of the public directed towards patients or Trust staff. These incidents may cause significant distress for both patients and staff, either directly, or indirectly as witnesses of such incidents.

How we evaluated success	How we will evaluate success
Phase 1: Diagnostics for completion by end of April 2022. Review via Health & Safety Committee a deep dive into the Divisional positions and identify priority areas. Review staff survey data to triangulate with incident reporting. Review provision of handling violence and aggression training and training needs analysis. Review current wellbeing offers / take up. Review Trust-wide security provision. Review Buckinghamshire Oxfordshire Berkshire West (BOB) position for sharing and learning opportunities.	**Phase 1: Fully achieved.** Violence and Aggression Reduction Group meeting monthly with Chief Nursing Officer (CNO) as Chair. Diagnostics via Health & Safety Committee and Trust systems completed. BOB position under review with attendance at newly formed working group. BOB group in scoping phase and OUH will be submitted required data.
Phase 2: Intervention / Policy review for completion by end of September 2022. Pilot and evaluate interventions to deter individuals from these events and improve patient and staff wellbeing and safety in priority areas – e.g., Emergency Department (ED) body cameras, lone working devices, training, and line manager wellbeing meetings with team members. Undertake pulse surveys to evaluate interventions a / a. Review the Trust Violence and Aggression Policy and develop implementation and communication plan.	**Phase 2: Fully achieved.** All incidents are captured via Ulysses and divisions have access to this data. Body Cameras have been deployed in an additional 17 clinical areas following the successful trial in John Radcliffe (JR) Emergency Department in conjunction with the Matrons for these areas and our Head of Security. Lone Worker devices have been procured for 530+ identified lone workers and we are currently distributing them to our colleagues. The No Excuses campaign to increase public awareness of the Trust zero tolerance of violence and aggression towards are staff is due to be launched in April / May 2023. Monthly Violence and Aggression Reduction task and finish groups continue with representation from Divisions and corporate teams.
Phase 3: Evaluation / Implementation completion by March 2023. Scale-up of interventions that have been shown to have impact. Policy re-launch. Progression of areas identified in diagnostic monitor and evaluate improvements.	**Phase 3** – **Not achieved.** Evaluation phase not started yet due to limited team resource.

Table 7: Update on actions for Quality Priority 2022-23: Reduce incidents of violence & aggression.

Quality Priority: Transition of Children to Adult Services

Why was this a priority?

To deliver a consistent Trust-wide service for every child / young person making the move from receiving child-centered services to adult services.

Scope: Children / young people with long-term condition; ongoing health needs; or receiving health services over the 15-18 age range.

How we evaluated success	How we will evaluate success
Action 1: Audit and feedback: How are we doing now? 1: Audit Electronic Patient Record (EPR) Compliance with Ready Steady Go – Hello transition child centered plan (by 31 May 2022). 2: Identify children / young people with long-term conditions Trust-wide on the moving to adulthood pathway (by 31 May 2022). 3: Further Gap Analysis and benchmarking exercise. By 1 April 2022, establish Trust-wide status on transition / Moving to Adulthood pathway. By 16 April 2022, complete Moving to Adulthood benchmarking (using the Burdett Foundation Trust benchmarking tool, BOB Integrated Care System (ICS), and Shelford Group). 4: By 30 April 2022, Scope and benchmark partner working – BOB ICS, NHS Southeast and Shelford Group, key children's hospitals, Oxfordshire health, education and social care system. 5: By 30 June 2022, collate audit and feed back into 'How well do we currently support children and young people's move to adult services?' 20 from children, 20 from families. One per transition clinic. 6: By 30 September 2022, benchmark, scope and develop business case for overall Trust Transition Lead / Coordinator	**Action 1: Partially achieved.** Delayed; significant emphasis on becoming members of the local and regional networks. 1: In progress. 2: This action needs to be amended to develop a register for children and young people. There needs be a system wide register for Oxfordshire and include children and young people who are tertiary referrals. Oxon system agreed to the Oxfordshire County council (OCC) based children's and adults Dynamic Systems Register (DSR) being used for this on 20/01/22. Work needs to be undertaken to establish. • How this can be effective with Trust EPR. • How the children and adult DSR can work in tandem. • Particular emphasis can be placed on children with learning disability and complex health issues and children with mental health problems and looked after children. 3: Commence when 1 and 2 above have been completed. 4: Complete 5: Complete- Reported at summit on 21/11/2022 6: Currently in progress. As part of the Burdett Network Southeast there are 7 Trusts that have recently employed a Transition Lead Nurse. This post is needed to project manage the implementation of the national Capability standards due to be published in 2023.
Action 2: Improving the services to support moving to adulthood / transition. Aim for end of Q3. **1:** Plan Inclusive summit **2:** Inclusive summit: Families, staff, and health, education, and social care partners. **3:** Co-produce and develop the Trust's Moving to Adulthood / Transition standards of practice or Charter. Include a lead for children receiving multiple services.	**Action 2: Partially achieved.** Inclusive summit held on 21st November 2022 Although national picture has changed significantly over the previous 9 months which has altered the deliverables for this Quality Priority.

How we evaluated success	How we will evaluate success
• Review and amend Moving to Adulthood / Transition Policy. • Implement reviewed Trust-wide and Divisional practice.	Two further summits planned for 30/01/23 and March 2023. At these summits we agreed to 1. The development of a Buckinghamshire Oxfordshire Berkshire West (BOB) wide acute Trust community of practice to prepare for the publication of the national capability frameworks and supporting OUH services to develop their moving to adult services pathways. 2. Trust wide group reporting into Patient Safety & Effectiveness committee (PSEC) and the development of an OUH moving to adult hood register. System and process for supporting children/ young people and families with complex health needs moving to adult services, including people with learning disability
Action 3: How will we ensure / assure the Trust, families, and partners that the Moving to Adulthood service works? It is envisaged that following the delivery of 1-4 in Action 2, that Trust-wide practice would be implemented within 6 months. 1. Monitor compliance with the Trust Moving to Adulthood / Transition standards of practice or Charter. **2.** Regular (need to define and scope this) pulse check with staff, children, and families to check and amend services if necessary.	**Action 3: Not achieved.** In-patient safety partner (PSP) plan to recruit a PSP for moving to adult services.

Table 8: Update on actions for Quality Priority 2022-23: Transition of Children to Adult Services

Quality Priority: Staff Health and Wellbeing: Growing Stronger Together

Why was this a priority?

The aim of this Growing Stronger Together priority is to look after the wellbeing of our people and teams and enable their recovery following the COVID-19 pandemic and transition into a 'new normal'.

How we evaluated success	How we will evaluate success
Action 1: Getting the basics right in relation to wellbeing by end March 2023. This will be delivered through establishing a Trust-wide 'Environment and Estates' enabling group to lead forward on:	**Action 1**: **Fully achieved.** Following on from the launch of the People Plan and the Wellbeing Months of Engagement in July/August 2022, we have been gathering data (via Microsoft (MS) Forms which is

How we evaluated success	How we will evaluate success
a) identifying the main areas and issues where people's basic wellbeing needs are not being met. b) developing an action plan to prioritise addressing the issues identified. c) assigning a timeframe for addressing the priority issues for the identified areas.	publicised on posters with a QR code) on where people's basic wellbeing needs are not being met and what the main kinds of issue are. (a) At the beginning of March 2023, we have 80+ issues logged. Key issues are addressing rest and relaxation space, changing rooms, access to drinking water & issues with traffic with some evenings taking staff nearly an hour to leave the JR site. (b) The Wellbeing Team meeting regularly to review the above issues, group them into key themes and meet with Estates and Facilities to discuss. With the £500k made available from the Trust and approved at Trust management Executive (TME) we have purchased Energy Pods, Sleep Tubes, Wellbeing Nooks and Gym Equipment. Work has started on created Changing Rooms in on Level 3 of the JR. (c) We have agreed the setting up of the 'Creating a Suitable Environment and Estates' Enabling Workstream. This group will meet by the end of March 2023 to create a prioritised list of the main capital wellbeing programmes.
Action 2: By end March 2023, 50% of our people to have participated in a Wellbeing Check-In. These will also enable basic needs to be identified that are not being met to feed into Action 1.	**Action 2: Partially achieved.** At the beginning of March 2023 approximately 27.5% of our substantive staff have had a Wellbeing Check-in. The main challenges experienced are operational pressures. We are encouraging people to record at least one conversation and utilise existing 1-1-2-1s or appraisal conversations where possible. The Wellbeing Check-in questions have been updated to include a question around basic wellbeing needs being met.
Action 3: (a) By end June 2022, to have designed and commenced delivery of a menu of bespoke Post-Traumatic Growth support offering for our teams led by the Psychological Medicine Support for Staff Service. (b)	**Action 3: Partially achieved.** **a.** The Psychological Medicine Staff Support Service Team have been trained up in delivering another team programme called Pro-Social

How we evaluated success	How we will evaluate success
Deliver 60 team sessions by the end of March 2023. (Nb. This figure is based on the current Psychological Medicine Support for Staff service business case funding being renewed from November 2022). (c) Through contacts with teams, the Support for Staff Service to identify where basic needs are not being met and share with the new 'Environment and Estates Enabling Group'.	which focuses on a building a team through a common purpose. This is now offered as part of a menu of team options including debriefings, supervision sessions, reflective practice and psychological education. b. In total, from April to October 2022, the Staff Support Service delivered 30 team sessions. Nb. As the continued funding for the Service was not agreed until end of October it created a hiatus in the Service and two new psychologists had to be recruited. They will be starting in April which will allow the Service to be fully restored. c. The Staff Support Team will use the form provided in the Action 1 Summary to capture any relevant 'Getting the basics right in relation to Wellbeing' and pass it onto the Wellbeing Team and the Enabling Workstream.
Action 4: By end June 2022, launch a suite of Leading with Care – Leading Self resources and support for all our leaders to manage their own wellbeing.	**Action 4: Fully achieved.** A suite of resources for managers/leaders called 'leading self' has been made available and was promoted as part of our Wellbeing Months of Engagement in 2022. It consists of a monthly webinar – 'Self Care Strategies for Busy Leaders in Difficult Times', daily mindfulness sessions, and a range of self-help options.
Action 5: By end March 2023 to have developed 'how to' guides for phase 1 priority areas to support our managers with understanding the basics in relation to: procurement, budget management, HR processes and induction arrangements.	**Action 5: Fully achieved.** Identified owners (Subject Matter Experts - SMEs) for each area and developed templates with Oxford Medical Illustration (OMI) for the How to Guides. Guides now written and being signed off by relevant groups. On Track to publish at the beginning of April.
Action 6: Complete the Timewise flexible working assessment and action plan by the end of March 2023.	**Action 6: Fully achieved.** Timewise have conducted an analysis of our current flexible working arrangements. They met with a selection of stakeholders from across OUH in early July 2022 to present their analysis. A 'vision and action' planning workshop was held in late

How we evaluated success	How we will evaluate success
	July 2022. They then offered two training workshops to managers. The flexible working policy is currently going through consultation.
Action 7: By end of March 2023 develop a Service Level Agreement (SLA) between Occupational Health and the organisation and agree Key Performance Indicators (KPIs) for the service.	**Action 7: Partially achieved.** Our Head of Occupational Health has developed an SLA with her team.

Table 9: Update on actions for Quality Priority 2022-23: Staff Health and Wellbeing: Growing Stronger Together

Choosing quality priorities for 2023-24

The ethos of the Trust and the NHS is a commitment to the delivery of compassionate and excellent patient care. Our quality of care has its foundation in the commitment of our staff to their patients and the focus on future excellence. Contained within this account are commitments to Quality Priorities within the domains of patient safety, clinical effectiveness, and patient experience.

How we chose our priorities

We involve our patients, public, stakeholders and our staff in choosing our Quality Priorities through our annual public Quality Conversation event.

At our Quality Conversation events in August 2022 and January 2023 attendees chose priorities to be maintained and suggested new priorities both from those being developed by the Trust and their own suggestions which shaped our 2023-24 Quality Priorities.

The event, organised by the Trust's Clinical Governance Team and Patient Experience Team, focussed on an update on progress made on Quality Priorities for 2022-23 and refresh of Quality Priorities for 2023-24 as part of the annual planning cycle and the Quality account. These presentations provided insight into why these were Trust priorities and updated on progress made during the year and were arranged under the themes of patient safety, clinical effectiveness, and patient experience.

Our Quality Priorities for 2023-24

Table below gives a brief description of Quality Priorities 2023-24. The full detail then follows for each Quality Priority, states why we chose these as Quality Priorities and then gives a description of how success will be evaluated over the course of the year.

Quality Priority 2023-24	Summary
1(a): Medication Safety - Opiates	National and international guidance now recognises the risk of excess prescribing of opioids in the post-operative period. Opioid stewardship is needed across the Trust to ensure safe monitoring of patients and adequate, but not excessive, discharge prescribing.
1(b): Medication Safety - Insulin	Insulin is recognised as a high-risk medication. The aim of the quality priority this year is to support clinical areas to identify and learn from episodes of severe hypoglycaemia, in order to use this learning to drive a reduction in the number of our patients experiencing severe hypoglycaemia.
2: Care of the Frail Elderly	This quality priority focusses on strengthening the assessment of frail, elderly patients in the Emergency Department (ED) and Same Day Emergency Care (SDEC) settings. It aligns with Commissioning for Quality and Innovation (CQUIN) 'Identification and response to frailty in emergency departments'.
3: Reducing Inpatient Falls	Inpatient falls are an important and potentially preventable cause of morbidity and mortality, especially as a cause of femoral fractures among the elderly. This Quality Priority focusses on strengthening training and implementation of the multifactorial falls risk assessment; addressing key areas for improvement identified in the most recent National Audit of Inpatient Falls; and strengthening assessments and information sharing following a fall.
4: Reducing Unwarranted Hospital Outpatient Cancellations	Cancellation and rearrangement of hospital outpatient appointments may delay patient treatment and follow up, impacting on clinical effectiveness as well as administrative efficiency and patient experience. This quality priority focusses on reducing unwarranted outpatient cancellations to improve clinical care, patient experience, and outpatient and administration efficiency. It aligns with the Integrated Quality Improvement Outpatient workstream.
5: Rolling out and embedding the Surgical Morbidity Dashboard	This Quality Priority builds on our previous year's work by supporting roll out of the recently developed Morbidity Dashboard for more widespread use across the Trust. Monitoring the occurrence of complications, identifying areas of higher-than-expected rates, and assessing if they were avoidable will help teams to improve the quality of care that is delivered.
6: Helping more patients through Tissue Donation for Transplant	This quality priority focusses on increasing clinicians' awareness and knowledge of tissue donation, and the number of referrals for tissue donation that are made, in key clinical areas of the Trust: Emergency Department (ED), Acute General Medicine (AGM) and Palliative

	Medicine. It builds on a successful pilot project in the Emergency Department.
7: Health Inequalities – improving data capture including of ethnicity	Reducing health inequalities is a key objective running through the Trust's Clinical Strategy. Key to understanding, improving and monitoring health inequalities are good quality data on the key determinants of inequality including ethnicity. This quality priority focusses on improving the ethnicity data to support a better understanding of, and interventions to improve, local health inequalities.
8: Empowering patients – building partnerships and inclusion	This Quality Priority focusses on strengthening the Trust's partnerships with patients and their families, particularly those lived experience and voice is not heard, in order to improve patient experience and services.
9: Kindness into Action - improving patient and staff experience	Kindness into Action brings to life the evidence showing how severe bullying harms people's health and wellbeing. Then introduces practical ways to reduce bullying and resolve it when it happens. The programme is designed to support all to adopt new approaches, understand the value of kindness in teams and explore how to lead ourselves and others with kindness.

Table 10: Summary of Quality Priorities 2023-24

Patient Safety

Quality Priority 1(a): Medication Safety – Opiates

Why is this a priority?

National and international guidance now recognises the risk of excess prescribing of opioids in the post-operative period. While essential to maintain access to opioids in the management of acute pain where they are effective and necessary, opioid stewardship is needed across the Trust to ensure safe monitoring of patients and adequate, but not excessive, discharge prescribing.

Aim: By 31 March 2024, to rationalise opioid use in all adult patients at OUH.

What we will do	How we will evaluate success
Action 1 Introduce British Pain Society patient leaflet regarding pain and analgesic use into pre-operative assessment clinics to improve patient education and to manage patient's pain expectations. Q1: Collaborate with pre-operative assessment team to introduce and test patient leaflet as above, looking at patient feedback of understanding and ease of use. Q2: Revised and approved by the end of Q2. Q3: Introduction to routine practice. Q4: Introduction to routine practice.	**Action 1** A test of the patient leaflet within suitable pathways by using patient feedback. Introduce into routine practice and measure the number of surgical specialities that have integrated the information into routine practice.

What we will do	How we will evaluate success
Action 2 Develop leaflet on safe opioid use to be given in every discharge opioid pack. Q1: Identify current national leaflets and assess suitability or need for modification. Q2: Develop modified leaflet and collect patient feedback. Q3: Introduction into routine practice. Q4: Introduction into routine practice.	**Action 2** Collect patient feedback on a proposed safety leaflet. Introduce into routine practice and measure number of areas using it.
Action 3 Collection of sample data of discharge opioid use from 5 different surgical procedures to help inform future procedure-specific opioid discharge prescribing and prescribing culture change. Q1 and 2: Draft and pilot data collection tool. Q3 and 4: Collect data and evaluate results.	**Action 3** Presentation of the data to relevant surgical departments. The procedure specific normative opioid data will help guide the development of educational package for prescribers and support prescribing culture change in surgical areas identified.
Action 4 Review and promote the use of the Oxford Pain Guide available via OUH MicroGuide to improve understanding of pain management and prescribing of pain treatment across the Trust. Q1-2: Identify numbers of users of Pain Guidelines, feedback from clinical staff about their knowledge of the tool, how they use it and how its use could be promoted. Q3: Develop the guidelines based on the feedback from clinical staff and use this to further promote the guidelines. Q4: Repeat the scoping exercise gaining further feedback from clinical staff to determine whether knowledge of the resource and use has increased. Identify user numbers from website pages.	**Action 4** Improvement in the number of users of the Oxford Pain Guide between Q1 and Q4. Incorporation of user feedback into revised guidelines. Evaluate the changes in clinical practice and health outcomes by a re-audit of discharge opioid prescribing from inpatient areas.
Action 5 To identify a selection of indicators around opioid prescribing and administration in collaboration with ePMA (electronic Prescribing and Medicines Administration) and Information Management & Training (IM&T) reporting teams and test for suitability and validity. Q1 and 2: Identify the prescribing and administration data available in ePMA that could be used to measure aspects of opioid prescribing, administration and safety (e.g. obtain baseline data for the percentage of inpatients receiving naloxone). Q3 and 4: Develop and refine reporting tools for ongoing monitoring.	**Action 5** To identify and establish indicators and reporting tools for opioids prescribing and safety

What we will do	How we will evaluate success
Action 6 To develop a system for prescribers to document the intended duration (number of days), the weaning and cessation plan and the review and referral plan for opioids in the patient's healthcare record. Q1-2: Collaborate with ePMA and IM&T team for opioid discharge quantity flags and the addition of mandated duration of opioid prescriptions on discharge in electronic medication system following evaluation Action 2. Q3-4: Pilot plan and review.	**Action 6** Aim for reduction in opioid prescribing at discharge of at least 10% compared with 2022-23 baseline data, without evidence that pain management has been compromised.
Action 7 Establish Trust wide baseline audit of patients being discharged from the emergency department with a supply of opioid prescription exceeding three days of treatment to inform need and plan for education and culture change. Q1-2: Collect data on current Emergency Department (ED) opioid discharge prescriptions. Q3-4: Based on data introduce education and guidance for limited opioid prescribing on ED discharge	**Action 7:** Baseline opioid prescribing pattern in emergency department, and education to limit discharge opioid prescribing.

Table 11: Summary of actions for Quality Priority 2023-24 1(a): Medication Safety – Opiates

Quality Priority 1(b): Medication Safety - Insulin

Why is this a priority?

Insulin is recognised as a high-risk medication. The Trust is required to identify and report rates of the most severe harms associated with insulin as part of the National Diabetes Inpatient Safety Audit (NDISA), a mandatory national audit. The rates of harms have slowly decreased nationally, driven primarily by a reduction in episodes of severe hypoglycaemia, but concerns have been raised about the accuracy of the data reported. Work has been undertaken in previous years within the Trust to ensure accurate reporting within OUH, but in order to improve accuracy nationally the definition of severe hypoglycaemia is soon to change. Trusts will be required to report all episodes of blood glucose below 2.2 mmol/l occurring in people with diabetes over the age of 18. Scoping has suggested over 600 such events occurred in the Trust Jan to Dec 2022. Hypoglycaemia is associated with increased morbidity and mortality as well as increased length of stay. The aim of the quality priority this year is to support clinical areas to identify and learn from episodes of severe hypoglycaemia, in order to use this learning to drive a reduction in the number of our patients experiencing severe hypoglycaemia.

What we will do	How we will evaluate success
Action 1 (Q1): Set up a monthly search within the point of care glucose	**Action 1 (Q1)** Report available which will:

What we will do	How we will evaluate success
software, which will be used to provide feedback on rates of severe hypoglycaemia to ward areas.	• Permit benchmarking in rates of severe hypoglycaemia between wards • Allow wards to track rates of severe hypoglycaemia over time
Action 2 (Q2) Trial a Severe Hypoglycaemia Analysis form (developed during the 2022-2023 Insulin Quality Priority) to support ward areas to identify underlying causes for episodes of severe hypoglycaemia. Use feedback to finalise a form to be used.	**Action 2 (Q2)** Severe Hypoglycaemia Analysis form to be trialled on 3 wards and feedback used to develop a final version.
Action 3 (Q3-4) Support ward teams to develop and test improvement plans for reducing the rate of severe hypoglycaemia on their ward.	**Action 3 (Q3-4)** Support 3 ward areas to develop and test an improvement plan for reducing severe hypoglycaemia.
Action 4 (Q4) Co-develop interventions to reduce episodes of severe hypoglycaemia (glucose less than 2.2mmol/l) on 3-5 wards with the highest rates of hypoglycaemia.	**Action 4 (Q4)** Reduction in no. episodes of severe hypoglycaemia on intervention wards (target 10% reduction).

Table 12: Summary of actions for Quality Priority 2023-24 1(b): Medication Safety – Insulin

Quality Priority 2: Care of the Frail Elderly

Why is this a priority?

Frail, elderly patients make up a substantial proportion of patients presenting to urgent and emergency care settings. Early, comprehensive assessment of these patients can improve outcomes by ensuring the acute care, management pathway and future care plans are all tailored appropriately to the patient's needs. This quality priority focusses on strengthening the assessment of frail, elderly patients in the Emergency Department (ED) and Same Day Emergency Care (SDEC) settings. It aligns with Commissioning for Quality and Innovation (CQUIN)05 'Identification and response to frailty in emergency departments'.

What we will do	How we will evaluate success
Action 1 (Q1) Establish a Frailty multi-disciplinary team to support early assessment of frail, elderly patients in the ED and Acute Ambulatory Unit (AAU). This will be supported in the first year by Commissioning for Quality and Innovation (CQUIN) funds.	**Action 1 (Q1)** Successful recruitment of Frailty multidisciplinary team.
Action 2 (Q1-4): Strengthen documentation of Clinical Frailty Score (CFS)	**Action 2(Q1-4)** Increase to >70% the proportion patients aged 65 years and older

What we will do	How we will evaluate success
among patients aged 65 years and older attending ED or AAU.	attending ED or AAU that have a CFS documented.
Action 3 (Q1-4) Strengthen documentation of Cognitive Assessment among patients aged 65 years and older admitted through ED or AAU.	**Action 3 (Q1-4)** Increase to >80% the proportion patients aged 65 years and older attending ED or AAU that have a documented Cognitive Assessment
Action 4 (Q1-4) Improve the assessment and further management of frail, elderly patients by creating and implementing a system for comprehensive geriatric assessment (CGA).	**Action 4 (Q1-4)** >30% patients aged 65 and over attending ED or AAU to have a CFS documented and, if CFS>5, initiation of a comprehensive geriatric assessment or referral to acute frailty service. [CQUIN metric]
Action 5 (Q1-4) Develop (Q1-2) and collect (Q3-4) metrics to measure the impact of the Frailty MDT on patient care and outcomes including care setting, ceilings of care and re-admissions. Use this data to develop a business case for continuation of the service as business as usual.	**Action 5 (Q1-4)** Development of a business case for continuation of the service to support early assessment and appropriate management of frail, elderly patients in ED and Same Day Emergency Care (SDEC).

Table 13: Summary of actions for Quality Priority 2023-24: Care of the Frail Elderly

Quality Priority 3: Reducing Inpatient Falls

Why is this a priority?

Inpatient falls are an important and potentially preventable cause of morbidity and mortality, especially as a cause of femoral fractures among the elderly. Key to reducing the risk of falls in hospital is a multifactorial falls risk assessment, followed by action to address each of the falls risk factors identified. Early assessment of patients with a suspected serious injury is also important following a fall to ensure timely and appropriate analgesia, investigations and management. This Quality Priority focusses on strengthening training and implementation of the multifactorial falls risk assessment; addressing key areas for improvement identified in the most recent National Audit of Inpatient Falls; and strengthening assessments and information sharing following a fall.

What we will do	How we will evaluate success
Action 1 (Q1-4) Update and roll out education and policies. • Q1: Roll out Hoverjack and Scoop training across the OUH. • Q1: Develop Induction Training on Prevention of Falls for all new staff.	**Action 1 (Q1-4)** Documented delivery and uptake of Hoverjack, Scoop and Induction training. Updated role-specific e-Learning module. Recruitment and engagement of Falls Champions

What we will do	How we will evaluate success
• Q1-4: Expand and roll out 'Preventing Falls in Hospital' e-Learning to key staff groups. • Q2: Re-launch the Trust Falls Champion Group • Q2: Update Falls and Bed Rail policies • Q2-3: Update Inpatient Falls leaflet (Q2) and develop an Easy Read version (Q3) • Q4: Develop Trust homepage for Falls Prevention with key resources for staff	Updated Falls and Bed Rail Policies approved. Update Inpatient Falls leaflets approved and available for use. Updated Intranet/Sharepoint site with key resources for falls prevention. 60% Nursing and Allied Health Professions (AHP) to have completed e-Learning training by March 2024.
Action 2 (Q1-4) Increase Multifactorial Falls Risk Assessment (MFRA) compliance: Quarter1: • Identify 2 wards with the highest number of inpatient falls (1 at Horton, 1 at JR) • Audit baseline MFRA compliance in these 2 wards; promote increased compliance. • Maximize uptake of falls prevention e-Learning among staff on each of these wards • Routine sharing of falls / patients at risk of falls in Safety Huddles and handovers. Quarter 2: • Promote and support increased MFRA compliance using QI methodology. • Audit and feedback MFRA compliance monthly on focus wards Quarters 3-4: • Expand to a further 4 wards with among the highest incidence of inpatient falls. • Continue to promote and support increased MFRA compliance on all 6 wards. • Audit and feedback MFRA compliance monthly on 6 focus wards	**Action 2 (Q1-4)** Quarter 1: • 2 highest incidence wards identified. • Baseline audit of MFRA compliance completed for the 2 wards. • >90% staff on 2 wards completed fall prevention e-Learning. Quarter 2: • Increased MFRA compliance on monthly audit (target 90%) Quarters 3-4: • Baseline audit of MFRA compliance completed for the 4 wards. • >90% staff on 4 wards completed fall prevention e-Learning. • Increased MFRA compliance on monthly audits (target 90%)
Action 3 (Q1-2) Improve front door walking aid access in all major admissions units in line with existing recommendations of the National Audit of Inpatient Falls	**Action 3 (Q1-2)** Audit walking aid availability 7 days a week in JR and Horton ED and EAU (target >90%).
Action 4 (Q1-4) Strengthen early assessment following a fall: • Complete baseline audit of early medical assessment for all inpatient hip fractures (Q1) • Develop and implement tools (e.g., Safety Message) to improve early assessment (Q2) • Re-audit early medical assessment following inpatient hip fractures (Q3,4)	**Action 4(Q1-4)** Target: >90% patients with hip fracture should have had a medical assessment within 30 minutes of a fall.
Action 5 (Q1-4) Improve falls benchmarking and performance:	**Action 5 (Q1-4)** Target: (a) 6 focus wards, and (b) OUH overall, to be in the best quartile

What we will do	How we will evaluate success
• Complete a gap analysis to determine magnitude of under-reporting of falls. • Use results of gap analysis to estimate no. falls per 1000 occupied bed days. • Compare this metric to national benchmarks	nationally for the number of inpatient falls per 1000 occupied bed days

Table 14: Summary of actions for Quality Priority 2023-24: Care of the Frail Elderly

Clinical Effectiveness

Quality Priority 4: Reducing Unwarranted Hospital Outpatient Cancellations

Why is this a priority?

Cancellation and rearrangement of hospital outpatient appointments may delay patient treatment and follow up, impacting on clinical effectiveness as well as administrative efficiency and patient experience. While some cancellations are appropriate, for example to expedite an appointment or because an appointment is no longer required or the patient requests the appointment to be rescheduled, in other cases cancellations arise due to errors or inefficiencies. This quality priority focusses on reducing these unwarranted outpatient cancellations to improve clinical care, patient experience, and outpatient and administration efficiency. It aligns with the Integrated Quality Improvement Outpatient workstream.

What we will do	How we will evaluate success
Action 1 (Q1) Establish a dashboard for monitoring unwarranted hospital outpatient cancellations that includes the following metrics: • No. (%) unwarranted hospital cancellations* within 2, 4 and 6 weeks of appointment • No. (%) patients subject to unwarranted hospital cancellations* >3 times in a year • Average time to next booked appointment (days) following unwarranted cancellation. * Cancellations excluded include 'Added in error', 'Administrative Error', 'Appointment Expedited', 'Outpatient appointment not required', 'Patient booked outside Choose and Book', 'Patient Died (Auto-deceased)', 'Patient Medically Unfit', 'Request raised in error', 'Same day clinic amendment', 'Treatment no longer required'.	**Action 1 (Q1)** Development of dashboard that reports the stated metrics at Trust, Division, Directorate and Specialty level; and by factors associated with health inequalities including index of multiple deprivation, ethnicity, age and gender.
Action 2 (Q2) Establish regular reporting of all metrics within the Divisional and Directorate Performance Reviews; and of one or more chosen metrics within the Integrated Performance Report (IPR).	**Action 2 (Q2)** Inclusion of metrics in Divisional and Directorate Performance Reviews and Integrated Performance Review (IPR). In addition to headline metrics, Directorates to provide assurance that

	the health inequalities dashboard has been systematically reviewed for each specialty and any unwarranted variation documented and, where appropriate, organisational or system levels actions set and delivered.
Action 3 (Q2-4) Develop and implement interventions to reduce the number of unwarranted hospital cancellations.	**Action 3 (Q2-4)** Reduction by >50% in the number of unwarranted hospital outpatient cancellations

Table 15: Summary of actions for Quality Priority 2023-24: Reducing Unwarranted Hospital Outpatient Cancellations

Quality Priority 5: Rolling out and embedding the Surgical Morbidity Dashboard

Why is this a priority?

Surgical morbidity refers to health problems arising as a result of surgical treatment, usually indicating that something has not gone as expected with a patient's recovery. It is common and affects at least 1 in 10 of patients in hospital. It is a very good indicator of quality of care. Complications are also costly to manage and reducing morbidity is therefore a very cost-effective approach to healthcare.

This Quality Priority builds on our previous year's work by supporting roll out of the recently developed Morbidity Dashboard for more widespread use across the Trust. Monitoring the occurrence of complications, identifying areas of higher-than-expected rates, and assessing if they were avoidable will help teams to improve the quality of care that is delivered. We expect that by allowing clinical teams to monitor their outcomes better, the morbidity dashboard will facilitate efforts to improve the safety of patients and help us deliver high quality healthcare.

What we will do	How we will evaluate success
Action 1 (Q1) Pilot use of the Surgical Morbidity Dashboard in selected surgical services with training and evaluation of the value it adds to Morbidity & Mortality (M&M) meetings.	**Action 1 (Q1)** At least 3 surgical services will have been trained and used the Dashboard in their Mortality & Morbidity (M&M) meetings by end of Q1.
Action 2 (Q2) Implement any identified minor improvements to the dashboard if/as required to improve functionality, on the basis of feedback from clinical services in quarter 1.	**Action 2 (Q2)** Feedback collected, evaluated and incorporated as required.
Action 3 (Q2-4) Expand rollout of the dashboard to other surgical services in OUH	**Action 3 (Q2-4)** All major surgical services at OUH are offered training and use the Dashboard for their Mortality & Morbidity (M&M) meetings by end of Q4

Action 4 (Q2-4) Support introduction of selected, additional, procedure-specific complications for 2 services to increase dashboard utility for these services.	**Action 4 (Q2-4)** Dashboard updated to include additional procedure-specific complications for 2 surgical specialties.

Table 16: Summary of actions for Quality Priority 2023-24: Rolling out and embedding the Surgical Morbidity Dashboard

Quality Priority 6: Helping more patients through Tissue Donation for Transplant

Why is this a priority?

As many as 50 lives can be helped by a single donor through the gift of tissues after death. Tissue donation, which is different from organ donation, includes corneas, heart valves, bone, tendons and skin. 70% patients express wishes to donate their organs or tissues after death but only a minority of these currently proceed to donation and knowledge among clinicians about the opportunities for tissue donation is limited. As a result, there is a potentially large, missed opportunity to help more patients through tissue donation. This quality priority focusses on increasing clinicians' awareness and knowledge of tissue donation, and the number of referrals for tissue donation that are made, in key clinical areas of the Trust: Emergency Department (ED), Acute General Medicine (AGM) and Palliative Medicine. It builds on a successful pilot project in the Emergency Department.

What we will do	How we will evaluate success
Action 1 (Q1) Conduct a baseline audit, including: (a) Survey of doctors' and nurses' knowledge of tissue donation, including: • knowledge of tissue donation uses, requirements and pathways. • confidence and experience in discussing tissue donation with patients/next of kin. (b) Audit of the number (%) of deceased adult patients in OUH that had opted into the Organ Donation Register and/or who had "deemed consent".	**Action 1 (Q1)** Completed survey presented in ED, AGM & Palliative Medicine clinical governance meetings.
Action 2 (Q1-2) Develop Trust-wide policy & process for tissue donation referral incl.: • indications and contraindications for referral • approach to communication with patient and next of kin • standardised approach to documentation of patients' wishes regarding tissue donation. • creation of EPR prompt embedded within the "Referral to Bereavement Services" form. • tissue donation referral pathway	**Action 2 (Q1-2)** Ratification of policy by Clinical Policy Group. Agreement and implementation of required EPR changes including: • standardised documentation of patients' wishes re tissue donation. • creation of tissue donation prompt in bereavement referral form

What we will do	How we will evaluate success
Action 3 (Q1-3) Identify Tissue Donation Champions and develop and deliver training for clinicians in ED, AGM and Palliative Medicine, including: • departmental teaching and induction sessions • training day(s) for tissue donation champions • pre- and post-training survey to evaluate clinician knowledge and confidence	**Action 3 (Q1-3)** Record of training sessions delivered including dates and no. staff in attendance. Documented increase in knowledge and confidence.
Action 4 (Q1-3) Improve the information on tissue donation that is available to patients, relatives and clinicians by: • developing a patient information leaflet and web resources • incorporating tissue donation information into bereavement documentation • editing and updating a trust intranet page dedicated to tissue donation	**Action 4 (Q1-3)** Approved patient information leaflet and system for sharing information with next of kin after death.
Action 5 (Q2-4) Focussed effort to support and increase the number of tissue donation referrals in the Emergency Department and two or more medical wards.	**Action 5 (Q2-4)** Aim to increase the number of tissue donation referrals in each clinical area, and to at least double the annual number of referrals overall in OUH.

Table 17: Summary of actions for Quality Priority 2023-24: Helping more patients through Tissue Donation for Transplant

Patient Experience

Quality Priority 7: Health Inequalities – improving data capture including of ethnicity.

Why is this a priority?

Reducing health inequalities is a key objective running through the Trust's Clinical Strategy. Key to understanding, improving and monitoring health inequalities are good quality data on the key determinants of inequality including ethnicity. This quality priority focusses on improving the ethnicity data to support a better understanding of, and interventions to improve, local health inequalities.

What we will do	How we will evaluate success
Action 1 (Q1) Undertake a baseline audit of the current availability and sources of ethnicity data on OUH patients, including: • data directly captured in OUH clinical areas. • data available through existing external data feeds • patterns in data completeness or quality that might inform data improvement work.	**Action 1 (Q1)** Completion of baseline audit.

What we will do	How we will evaluate success
• factors contributing to data quality (e.g., Summary Care Record data quality, policy and practice around data entry workflows, and staff education and training).	
Action 2 (Q1-2) Informed by the baseline audit and in collaboration with the Operational Service Managers (OSMs) and local management teams, formulate a strategy and implementation plan to improve ethnicity data. This will include detailed plans to achieve actions 3 and 4 below.	**Action 2 (Q1-2)** Agreement of action plan by stakeholders including action owners.
Action 3 (Q2-4) Informed by the baseline audit, choose at least 2 clinical areas requiring improvement and implement changes (e.g., workflow changes, training) to improve to >95% the proportion of patients attending the hospital that have their ethnicity verified and documented at their visit.	**Action 3 (Q2-4)** Quarterly audit of ethnicity data capture among patients attending hospital in the chosen clinical areas (target >90%).
Action 4 (Q2-4) Work with the digital team and system partners to optimise the quality and maximize sharing of ethnicity data across partner organisations by ensuring: • OUH data includes all ethnicity data from Primary Care and the NHS Spine • changes made to ethnicity records on OUH or elsewhere are updated across the system	**Action 4 (Q2-4)** Systems in place to ensure OUH and system partners have access to the same high quality ethnicity data.
Action 5 (Q3-4) Identify any inequalities in cancer pathway metrics related to specific demographic groups (e.g., by age, ethnicity, postcode). Develop an action plan to address any opportunities to improve cancer pathways for any disadvantaged group identified.	**Action 5 (Q3-4)** Summary of any inequalities identified. Action plan to address any improvement opportunities identified.
Action 6 (Q1) Accurately define key population demographics among pregnant women/people (including language, ethnicity and postcode) that are associated with: a) late booking for pregnancy care (as defined by NICE & OUH Antenatal Care guidance) b) failure to attend 2 or more antenatal clinic appointments.	**Action 6 (Q1)** Summary of key demographic factors and barriers associated with poorer engagement with antenatal services. Mapping analysis to determine any overlap with known health inequalities e.g. locality specific/place-based.
Action 7 (Q2-3) Identify any gaps in routinely captured data with respect to known social determinants of health within existing electronic maternity records and ensure gaps are	**Action 7 (Q2-3)** Inclusion in BadgerNet of key social determinants of maternal health.

What we will do	How we will evaluate success
addressed in BadgerNet maternity electronic patient record (rollout planned Autumn 2023).	
Action 8 (Q2-3) Working with maternity service users including maternity advocate/community organisers and locality partners in health, use data from Action 6 to identify barriers to care and strategies to overcome these barriers.	**Action 8 (Q2-3)** Development of a strategic plan to address barriers to antenatal care among underserved groups identified.
Action 9 (Q3-4) Pilot at least one intervention from the strategic plan to address barriers to antenatal care	**Action 9 (Q3-4)** Pilot data including evidence of the impact of the intervention on engagement with antenatal care among the group(s) targeted.

Table 18: Quality Priority 7: Health Inequalities – improving data capture including of ethnicity

Quality Priority 8: Empowering patients – building partnerships and inclusion.

Why is this a priority?

This Quality Priority focusses on strengthening the Trust's partnerships with patients and their families, particularly those lived experience and voice is not heard, in order to improve patient experience and services.

What we will do	How we will evaluate success
Action 1 (Q1-4): Further strengthen interpreting and translation services and uptake. Q1: Develop easy to use booking guidelines. Rectify Information Technology (IT) challenges for video interpreting. Q2: Make enhanced training available to staff 24/7 Q3: Develop a Patient Story related to interpreting and present it to Trust Board Q4: Make available on the Trust website and social media an interpreting and translation film with communities' input. Q1-4: Host Listening Events to learn from patients' lived experience of using interpreters.	**Action 1 (Q1-4)** Easy to use booking guidelines available to all staff. IT challenges overcome to facilitate video interpreting. Enhanced training available to staff 24/7 on MyLearning Hub. Patient Story related to interpreting presented to Trust Board Interpreting and Translation film available on Trust website Listening events held with patient groups on lived experience using IT services
Action 2 (Q1-4) Patient and Public Engagement • Re-launch Trust Patient Partnership Groups (PPGs), enabling groups to contribute to the work of their local clinical area and Trust development work. • Recruit a bank of 'experts by experience' (patients, families, and carers) to contribute to service improvement and redesign. • Develop a Trust-wide Quality Improvement (QI) model to learn from lived experience including patients and	**Action 2 (Q1-4)** By end of Q4: • Experts by Experience plan and QI model developed. • 20 experts by experience volunteers recruited. • 10 Experts by Experience completed the Quality, Service Improvement and Redesign (QSIR) fundamentals training.

What we will do	How we will evaluate success
families helping develop QI projects and being involved in training. • Host 2 'Listen Up' roadshows across Oxfordshire in partnership with local stakeholders including Healthwatch, governors and voluntary/advocacy/ community groups.	• 2 'Listen Up' events hosted with local stakeholders
Action 3 (Q1-3) Friends and Family Test (FFT) By Q1: • Promote FFT with both the community maternity teams and families. • Develop the Trust wide 'You said, and we did' approach and incorporate into ward reporting, Divisional Quality Reports and Performance Reviews, Trust Board reports, and external communications via the Trust website and social media. By Q2: • Implement FFT online / via SMS texting for people who do not speak or read English. • Develop interactive FFT dashboard for wards, departments, directorates and divisions. By Q4: • Identify patient groups that the Trust does not hear from via FFT and hold 3 focus days to collect FFT data from these groups. • Extend the Trust interactive FFT dashboard to be a publicly accessible dashboard.	**Action 3 (Q1-3)** • FFT promoted to community maternity teams, families, Maternity Voices Partnership, 5X More and community groups. • 'You said and we did' incorporate into internal reporting and external communications as planned. • FFT developed and made available online / via SMS texting for people who do not speak or read English. • Interactive FFT dashboard for wards, departments, directorates, and divisions developed. • FFT underrepresented groups identified. Report following focus days presented to Trust Board/Integrated Assurance Committee. • Trust interactive FFT dashboard available on the Trust website as a publicly accessible dashboard.

Table 19: Summary of actions for Quality Priority 2023-24: Empowering patients – building partnerships and inclusion.

Quality Priority 9: Kindness into Action(KIA) - improving patient and staff experience.

Why is this a priority?

Kindness into Action is a key deliverable we have committed to within our People Plan as part of Theme 1: Health, Wellbeing and Belonging for all our People and Theme 2: Making OUH a great place to work. Our staff survey continues to tell us that people are experiencing harassment, bullying or abuse from peers, managers and patients, and people do not feel equipped, confident or safe to speak up when they are negatively impacted by other people's behaviours. Leaders and managers have a disproportionate effect on culture, accounting for 70% in the variation in engagement levels between different teams. Our aim is to build a culture of kindness and provide guidance and support to have the conversations needed to resolve things together early.

Our purpose is to deliver a culture change programme in collaboration with Trusts and CCGs (ICB) that would instil a kinder culture within our workplace. Implementing a joined-up collaborative approach within the Trust with nominated resources, through ICS & Trust steering groups, and working with existing teams; Organisational Development (OD), Wellbeing, HR etc. Kindness into Action brings to life the evidence showing how severe bullying harms people's health and wellbeing. Then introduces practical ways to reduce bullying and resolve it when it happens. It demonstrates how kindness also promotes trust - people in high trust organisations experience 50% higher productivity, 76% more engagement plus experience 40% less burnout and 13% less sick days. The programme is designed to support all to adopt new approaches, understand the value of kindness in teams and explore how to lead ourselves and others with kindness.

What we will do	How we will evaluate success
Action 1 (Q1-4) **Training and awareness building** Providing a blended learning approach to training; each leader attending 2 x 60-minute online sessions (2 hours in total), taking Kindness into Action e-learning modules between sessions to enhance learning. 30 date options will be available (per workshop) to enable us to train up to 3,000 Leaders and Managers across the trust, providing 60 sessions over the next 6 months with the specific objectives to**:** • To nurture a kinder culture across our healthcare system • To explore the evidence-base for kindness in healthcare • To clarify what it means to be a kinder leader. • To create teams where people feel safe to speak up. • To launch and practice new approaches to building trust, wellbeing, belonging, equality and inclusion in our teams. • To respectfully resolve bullying and other poor behaviours • To become a safer place to work and to be cared for All staff will also be encouraged to complete the Kindness into Action e-learning to help embed the tools and approaches in the way they work. To allow for more opportunities in having kinder conversations and for informal resolutions.	**Action 1 (Q1-4)** Training uptake among 1800 based on providers best estimate of uptake (approx. 30% of staff) leaders and managers across the Trust, and by division, directorate and CSU (1800) (attendance as of 16/2/23 450 Session A and 252 session B) Quarter 1: • Establish a framework for reporting the take up of training attendance across the Divisions. Integrated Performance Review (IPR) Quarter 2 – 4: • Include reporting of uptake in Divisional Reviews. • Embed monitoring of take up into Integrated Performance Report (IPR) on a monthly basis by Division, to identify 'hot spots' and discuss actions to increase attendance.

What we will do	How we will evaluate success
Action 2 (Q1-2) **Recruitment & Training of KIA Ambassadors** Recruit (Q1) and train (Q2) a minimum of 2 KIA Ambassadors per Division, who will take opportunities in their role to talk about the value of kindness at an individual and team level: • using opportunities to share and promote KIA and Respectful Resolution tools • prompting discussions around acceptable behaviours in meetings or sharing experiences and success stories of applying tools • utilising opportunities to support others in using KIA and Respectful Resolution (RR) tools. Train the Trainer sessions (2 x 3-hour workshops) will be developed and delivered to build capability within OUH (Q2-4). We will establish a forum to gather feedback from Ambassadors, to understand and monitor the help required to embed the new tools.	**Action 2 (Q1-2)** KIA Ambassador training attendance: A minimum of 2 Ambassadors in each Division – to be drawn from senior managers and leaders across a range of roles and services. KIA Ambassador feedback: A minimum of 80% of attendees feel more confident promoting the use of the tools as a result of attending the train the trainer workshops.
Action 3 (Q1-2) **Integration of tools in existing programmes** Building the Kindness into Action and Respectful Resolution (RR) modules into our ongoing Culture and Leadership training, supported by training materials, speaker notes, workbooks. This will include: 1. Face-to-face leadership training 2. Onboarding 3. Values Based Appraisal (VBA) and Values Based Conversation (VBC) 4. Developing 1:1 Feedback Skills Taster – introducing Action, Benefit, Continue (ABC) and Behaviour, Understand, Impact, Listen, Do Differently (BUILD) Quarter 1: Identify programmes across the culture and Leadership Service where KIA and RR tools can be integrated and develop a plan for integration by December 2023. Quarter 2: Review monthly the plan of all courses for integration of content within CLS Heads of Service Meetings to ensure completion by Q2.	**Action 3 (Q1-2)** We will have integrated the tools within existing Culture and Leadership programmes, to ensure there is understanding of the tools and how they relate to other programme agendas by the end of Quarter 2.
Action 4 (Q1-4) **Identification and support for areas of concern** We will work with specific Divisions/Directorates/Clinical Service Units where there have been 'deep dives' into culture, e.g., through external reviews, to identify areas in need of additional support, and specific measures of 'behavioural' improvement, based on recommendations and staff survey data. Training will then be tailored to provide relevant additional support, e.g., kindness charters and targeted Leading with Kindness sessions.	**Action 4 (Q1-4)** Areas in need of additional support based identified and specific actions/training provided to address specific cultural and/or behavioural challenges.
Action 5 (Q1-4) **Monitoring impact through staff surveys** Within themes 1 and 2 (*Health, wellbeing and belonging for all our people* and *Making OUH a great place to work)* of our People Plan we	**Action 5 (Q1-4)** Staff survey metrics related to bullying and harassment

What we will do	How we will evaluate success
have committed to delivering a cultural change programme to address poor behaviours in year 2 and instil a more civil, respectful and kinder culture within our workplaces. We will use the Staff Survey to gather feedback from all our colleagues about what is working well and to highlight what we could improve upon in the areas of bullying and harassment from managers, colleagues and patients. We will use feedback from both the quarterly Pulse and annual survey to inform improvement against specific Staff survey questions, and our OUH People Plan KPI's.	from managers, colleagues and patients including: • improvements in all 3 questions on bullying and harassment (2023 Staff Survey) • improvement in Advocacy and *Making OUH a great place to work* (2023 Staff Survey) • improved performance in quarterly Pulse Surveys (results in Feb, May and Aug 2023) We also monitor and report workforce KPIs as part of our People Plan and monthly IPR reporting, including sickness, turnover, informal resolutions, disciplinary cases.

Table 20: Summary of actions for Quality Priority 2023-24: Kindness into Action - improving patient and staff experience.

Monitoring and reporting

- Regular reports on all Quality Priorities go to the Trust level Clinical Governance Committee (CGC) and from there to the Integrated Assurance Committee(IAC) and the Trust Board.

2.2 Statements of Assurance from the Board

1. During 2022-23 Oxford University Hospitals NHS Foundation Trust provided and sub-contracted 137 relevant health services. Oxford University Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care of these relevant health services. The income generated by the relevant health services reviewed in 2022-23 represents 100% of the total income generated from the provision of relevant health services by Oxford University Hospitals NHS Foundation Trust for 2022-23.

Clinical Audits and National Confidential Enquiries

2. Clinical audit is a process for reviewing clinical performance by measuring clinical practice against agreed standards and as result should lead to the refining of quality of clinical care.

    2.1. During 2022-23, 65 national mandatory clinical audits and 5 national confidential enquiries covered relevant health services provided by Oxford University Hospitals NHS Foundation Trust.

    2.2. During that period Oxford University Hospitals NHS Foundation Trust participated in 92% of all the eligible national clinical audits as detailed within Table 21; and 80% of national confidential enquiries in which we were eligible to participate as presented within Table 22 of the report.

    2.3. The National Clinical Audits and Confidential Enquiries that Oxford University Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2022-23, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Participation in National Clinical Audit

The table below describes the national audit subject and whether the Trust participated in 2022-23.

National programme name	Trust Participation 2022-23	Percentage of Cases Submitted
Breast and Cosmetic Implant Registry (BCIR)	Yes	In progress
Case Mix Programme (CMP)	Yes	100%
Cleft Registry and Audit Network (CRANE)	Yes	100%
Elective Surgery (National Patient Reported Outcome Measures (PROMs) Programme)	Yes	In progress
Emergency Medicine QIPs: Pain in Children (Care in emergency departments)	Yes	100%
Emergency Medicine Quality Improvement Projects (QIPs): Assessing for cognitive impairment in older people (Care in emergency departments)	Yes	100%
Emergency Medicine QIPs: Mental health self harm	Yes	In progress
Falls and Fragility Fracture Audit Programme (FFFAP): National Audit of Inpatient Falls	Yes	In progress
Falls and Fragility Fracture Audit Programme (FFFAP): National Hip Fracture Database (NHFD)	Yes	100%
Falls and Fragility Fracture Audit Programme (FFFAP): Fracture Liaison Service Database	Yes	85.9%
Inflammatory Bowel Disease (IBD) Audit	No[1]	
Learning from lives and deaths of people with a learning disability and autistic people (LeDeR) - Learning Disabilities Mortality Review	Yes	In progress
Maternal, Newborn and Infant Clinical Outcome Review Programme (perinatal mortality surveillance)	Yes	In progress
Maternal, Newborn and Infant Clinical Outcome Review Programme (maternal mortality surveillance and confidential enquiry)	Yes	In progress
Muscle Invasive Bladder Cancer Audit: Muscle Invasive Bladder Cancer at Transurethral Resection of Bladder Audit (MITRE)	Yes	100%
National Adult Diabetes Audit (NDA): National Diabetes Foot Care Audit	Yes	In progress
National Adult Diabetes Audit (NDA): National Diabetes Inpatient Audit Harms (NaDIA-Harms)	Yes	100%
National Adult Diabetes Audit (NDA): National Diabetes in Pregnancy Audit	Yes	100%
National Adult Diabetes Audit (NDA): National Core Diabetes Audit	Yes	100%

National programme name	Trust Participation 2022-23	Percentage of Cases Submitted
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Adult asthma secondary care	Yes	In progress
National Asthma and COPD Audit Programme (NACAP): Paediatric - Children and young people asthma secondary care	Yes	100%
National Asthma and COPD Audit Programme (NACAP): Chronic Obstructive Pulmonary Disease (COPD)	Yes	In progress
National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	In progress
National Audit of Cardiac Rehabilitation (NACR)	Yes	In progress
National Audit of Care at the End of Life (NACEL)	Yes	100%
National Audit of Dementia (NAD): Care in general hospitals	Yes	100%
National Audit of Pulmonary Hypertension (NAPH)	No[2]	N/A
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Yes	100%
National Bariatric Surgery Registry	No[3]	N/A
National Cardiac Arrest Audit (NCAA)	Yes	100%
National Cardiac Audit Programme (NCAP): National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Yes	100%
National Cardiac Audit Programme (NCAP): National Adult Cardiac Surgery Audit	Yes	100%
National Cardiac Audit Programme (NCAP): Myocardial Ischaemia National Audit Project (MINAP)	Yes	100%
National Cardiac Audit Programme (NCAP): National Audit of Cardiac Rhythm Management Devices and Ablation	Yes	100%
National Cardiac Audit Programme (NCAP): National Congenital Heart Disease Audit (NCHDA)	Yes	In progress
National Cardiac Audit Programme (NCAP): National Heart Failure Audit	Yes	100%
National Child Mortality Database	Yes	In progress
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	In progress
National Emergency Laparotomy Audit (NELA)	Yes	98%
National Gastro-intestinal Cancer Audit Programme (GICAP): National Oesophago-Gastric Cancer Audit (NOGCA)	No*	

National programme name	Trust Participation 2022-23	Percentage of Cases Submitted
National Gastro-intestinal Cancer Audit Programme (GICAP): National Bowel Cancer Audit (NBOCA)	Yes	100%
National Joint Registry (NJR) - Knee Replacement & Hip Replacement	Yes	In progress
National Lung Cancer Audit Programme	Yes	100%
National Maternity and Perinatal Audit (NMPA):	Yes	In progress
National Neonatal Audit Programme (NNAP)	Yes	In progress
National Obesity Audit	Yes	In progress
National Ophthalmology Database Audit: (Age-related Macular Degeneration Audit (AMD))	Yes	In progress
National Ophthalmology Database Audit: (Adult Cataract Surgery)	Yes	100%
National Paediatric Diabetes Audit (NPDA)	Yes	100%
National Perinatal Mortality Review Tool (PMRT)	Yes	100%
National Prostate Cancer Audit (NPCA)	Yes	In progress
National Vascular Registry	Yes	In progress
Neurosurgical National Audit Programme	Yes	100%
Paediatric Intensive Care Audit Network (PICANet)	Yes	100%
Perioperative Quality Improvement Programme (PQIP)	Yes	In progress
Renal Audits: National Acute Kidney Injury (AKI) Audit	Yes[4]	N/A
Renal Audits: UK Renal Registry Chronic Kidney Disease Audit	Yes	100%
Respiratory Audits: Adult Respiratory Support Audit	Yes	In progress
Respiratory Audits: Smoking Cessation Audit - Maternity and Mental Health Services	Yes	In progress
Sentinel Stroke National Audit Programme (SSNAP) (2021-22)	Yes	100%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance scheme	Yes	In progress
Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	100%
Trauma Audit & Research Network (TARN)	Yes	100%
UK Cystic Fibrosis Registry	Yes	In progress
UK Parkinson's Audit	Yes	100%

Table 21: The national audit list and whether the Trust participated in 2022-23.

[1] Inflammatory Bowel Disease (IBD) Audit: OUH did not submit data to the Inflammatory Bowel Disease (IBD) National Audit. National ethical approval for the IBD database does not provide a mechanism for patient consent which conflicts with Oxford's generic ethical consent policy. OUH will be unable to submit external data until the national audit produce e-consent.

[2] National Audit of Pulmonary Hypertension (NAPH) relates to the 8 Nationally commissioned centres - OUH is not one of those; OUH is a shared care partner of one of the 8 centres, the Royal Brompton Hospital. Therefore, OUH's patients can access specialist treatments as part of the shared care arrangements (they fall within the Royal Brompton's service from an audit and compliance perspective).

[3] National Bariatric Surgery Registry: Service is closed to new patients.

[4] The majority of the data for the National Acute Kidney Injury (AKI) Audit was captured in the National Institute for Health and Care Excellence (NICE) 'NG148 Acute kidney injury: prevention, detection and management' clinical audit.

Participation in National Confidential Enquiries into Patient Outcome and Death (NCEPOD) 2022-23 (Table 22)

The table below shows the list of OUH eligible NCEPOD studies in 2022-23, which hospital sites participated, and the percentage of clinical questionnaires, case notes and organisational questionnaires returned.

NCEPOD Studies in 2022-23	Sites Participating	Clinical Questionnaire Returned	Case Notes Returned	Organisational Questionnaire Returned
Community Acquired Pneumonia	John Radcliffe Horton General Hospital	62% (n=21)	100%	Yes
Crohn's Disease	John Radcliffe Horton General Hospital	0% (n=13)	100%	Yes
Transition from Child to Adult Health services	John Radcliffe Horton General Hospital	27% (n=22)	100%	Yes
Testicular Torsion	John Radcliffe Horton General Hospital Churchill Hospital	89% (n=9)	100%	Yes
Endometriosis	John Radcliffe Horton General Hospital Churchill Hospital	NCEPOD commencement awaited	NCEPOD commencement awaited	NCEPOD commencement awaited

Table 22: The list of OUH eligible NCEPOD studies in 2022-23, which hospital sites participated, and the percentage of clinical questionnaires, case notes and organisational questionnaires returned.

2.4 The reports of 54 clinical audits were reviewed by Oxford University Hospitals NHS Foundation Trust in 2022-23 and Oxford University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided. The reports of a small number of national clinical audits are being developed and waiting for presentation to Clinical Improvement Committee in May 2023.

Actions taken and improvements made from national audits.

The table below shows a list of national audits together with a summary of actions taken and benefits for patient care following their review.

Audit	Summary of Agreed actions
Sentinel Stroke National Audit Programme (SSNAP) (2020-21)	• Improved door to needle (DTN) time for tissue plasminogen activator (t-PA) from 0.50 to 0.39 minutes** • Increase Nutritional assessments dietetic input to 0.7 Whole Time Equivalent (WTE). Improvement of 'Percentage of applicable patients screened for nutrition and seen by a dietitian by discharge' metric (Q2 20-21) shows improvement to 69% from 47%** • Increase capacity of Adult Surgical Unit (ASU) by a further 2 beds for outpatient procedures*.
Adult Cardiac Surgery Clinical Audit 2017/20	• Unit survival rates are being maintained** • Bleeding and infection rates are within acceptable range, but improvements on other criteria for coronary artery bypass graft (CABG) are being sought through new national publication's recommendations*.
National Heart Failure Audit (2019-2020)	• Business case in progress includes more nurse and consultant input to heart failure service* • Increase echocardiography provision* • Increase heart failure clinic capacity*
National Audit of Care at the End of Life (NACEL) Clinical Audit (2021-22)	• Raise staff awareness of the need to prescribe anticipatory medication for symptom management when patient recognised to be at considerable risk of dying** • Raise staff awareness of the OUH information leaflet 'What to expect when someone is dying in hospital'; encourage

Audit	Summary of Agreed actions
	staff to offer this to all families and those important to the patient** • Undertake a further NACEL audit of families' experience to inform service improvements**.
National Prostate Cancer Audit (2021-22)	• Increase to ≥85% the proportion of newly referred 2 patients that have their Tumour, Node, Metastasis (TNM) staging recorded in the multidisciplinary team (MDT) outcome. • Increase to ≥80% the proportion of newly referred 2 patients that have their Performance Status recorded. • Improve accuracy of data on the number of unplanned admissions within 90 days of Assisted Radical Prostatectomy (RARP).
National Cardiac Audit Programme (NCAP) (National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)) (2021-22)	• Review reporting database to allow for more accessible data**.
National Cardiac Arrest Audit (NCAA). *Intensive Care National Audit & Research Centre (ICNARC)/Resuscitation Council UK (RCUK)* (2021-22)	• Continue data collection and submission for all eligible events** • Working group to review quarterly reports, identify any clinical risks, areas for investigation and learning and report to Resuscitation Committee** • Resuscitation Committee to review results from working group and identify improvement actions for recommendation to divisions and clinical services across Trust**.
Elective Surgery (National Patient Reported Outcome Measures (PROMs) Programme) (2021-22)	• Repeat hip and knee reports on 2021-22 finalised data next year (*the PROMs data for 2021-22 has not yet been released*).
National Neonatal Audit Programme (NNAP) (2021-22)	• Improve early use of maternal milk* • Endeavour to improve staffing numbers, particularly those qualified in specialty*.
National Early Inflammatory Arthritis Audit (NEIAA); *Year four outlier notification* (2021-22)	• Educate new providers for musculoskeletal hub regarding the importance of prompt Early Inflammatory Arthritis (EIA) referral** • Expand number of new patient slots by redirecting follow up appointments to nurse clinic** • Unblock urgent slots so that they can be used for standard new EIA referrals**.
Paediatric Intensive Care Audit Network (PICANet) (2021-22)/	• Review Recruitment plan for next 5 years - business case for correct establishment based on current and future capacity*

Audit	Summary of Agreed actions
	• Improve 'Time to bedside for Retrievals' rates to > 90%** • Aim for reduction in 'Readmission rates from previous years' to <2%**.
National Gastro-intestinal Cancer Audit Programme (GICAP) (National Bowel Cancer Audit (NBOCA)) (2021-22)	• Improved links between databases, improved personnel support from cancer services team • Confirm emergency data submissions and ensure no missed data**.
National Cleft Registry and Audit Network (CRANE) Clinical Audit (2021-22)	• Business case in progress to explore options for need of Paediatric Dentist, not just for CLEFT but potentially several paediatric specialities within OUH that could make this a viable role and could see the cost split across multiple services*.
National Audit of Cardiac Rehabilitation Quality and Outcomes Report 2021	• Increased number of clinic spaces for assessments* • Increased capacity of gym space* • Develop Digital Cardiac Rehabilitation app* • Routine follow up for percutaneous coronary intervention (PCI) patients**.
Management of Myocardial Infarction 2019-20: National Cardiac Audit Programme (NCAP) Annual Report 2021: 'The way we were - A pre-pandemic stocktake to help the recovery'	**Update on Progress:** • Continue to improve access to immediate care through direct admission for people presenting with ST elevation Myocardial Infarction (MI) • Whilst there is currently no national recommendation to the effect, a 'Domain Expert Group' recommend ≥80% non-ST-Elevation Myocardial Infarction (NSTEMI) patients should be admitted to a cardiac ward
Management of myocardial infarction 2020-21: NCAP Annual Report 2022: 'The Heart in Lockdown'	• Discuss within the Division prioritisation of MI patients for admission to cardiac wards. • Increase staffing of the Cardiac Advanced Nursing Practitioners (ANP) outreach team
National Paediatric Diabatic Audit (NPDA) (2019-2020)	• Improve screening of 7 care processes for >12y and maintain offering and recording of 7 care processes through continuing twice-yearly recall of NPDA outcomes rather than annually* • Continue additional screening during annual review secondary input into Twinkle database* • Continue offering standard of care & education** • Improve recording of urine results*

Audit	Summary of Agreed actions
	• Ensure accurate recording of education provided at all annual review clinics*
Audit Cystic Fibrosis (CF) Registry data 2020	• Improve access to consulting rooms ** • Strengthen CF staffing in line with UK CF Standards of Care**.
National Lung Cancer Audit (2021-22)	• Improve multidisciplinary team data capture** • Improve electronic patient record data capture**
Serious Hazards of Transfusion (SHOT) Annual Report (2021-22)	• Annual review of current e-learning package to incorporate human factor influences. • Work collaboratively with Haemonetics through active development of a transfusion-associated circulatory overload (TACO) risk assessment process to be available at the bedside. • A gap analysis to determine the action plan**.
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) *(Paediatric - Children and young people asthma secondary care)* (2021-22)	• Create an asthma checklist and discharge bundle on Electronic Patient Record (EPR) • Improve smoking cessation advice - refer patients appropriately to 'Here for Health'. • Create Personalised Asthma Action Plan • Develop Asthma / wheeze clerking proforma including discharge checklist. • Improve documentation of smoking exposure on Asthma and Wheeze proforma on EPR • Improve use of steroid on admission.
National Cardiac Audit Programme: Adult Congenital Heart Disease Clinical Audit (2021-22)	• Continue regular audit to ensure continue to achieve high standards**
National Audit of Inpatient Falls (NAIF) (2021-22)	• Appointment of falls practitioner to increase support for staff with falls training/reduce falls**
National Oesophago-Gastric Cancer Audit (NOGCA) (2021-22)	• Multidisciplinary Team to explore possible data inaccuracy** • Continue to deliver good patient care**
National Joint Registry (NJR) Clinical Audit (2021-22)	• Introduce infection bundle and change of antibiotic prophylaxis protocol. • New pathway in JR theatres in place to ensure all patients undergoing NJR eligible operations have forms completed and submitted**.
Maternal, Newborn and Infant Clinical Outcome Review Programme (Maternal mortality surveillance and confidential enquiries) *(Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE-UK) Saving Lives, Improving Mothers' Care – Lessons*	• Develop business case to review capacity of perinatal mental health team; ensure new team able to provide improved liaison and education including to community services; and ensure reliable access to full range of contraception**

Audit	Summary of Agreed actions
learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19)	• Improve Venous thromboembolism (VTE) prophylaxis by updating guidance to include 'Provoked VTE' and 'Unprovoked VTE'; expanding ± modifying existing system for maternity; and adding check boxes to the 'recommendations' section of the Situation-Background-Assessment-Recommendation (SBAR) Communication Tool**.
National Audit of Breast Cancer in Older Patients (NABCOP) (2021-22)	• Improve concordance with Primary Care Prescription Database • Document fitness assessment and triple assessment in a single visit** • Continue NBCOP frailty assessments** • Aim if possible, to reduce re-excision rates** and unplanned chemotherapy-related admissions**
National Heart Failure Clinical Audit (2020/2021)	• Business case in progress to increase staffing and clinic capacity*
National Cardiac Audit Programme: Adult Cardiac Surgery Clinical Audit (2018 – 2021) (2022-23)	• Maintain good survival rates and improve on the soft targets for coronary artery bypass graft*
National Diabetes Audit-Care Processes and Treatment Targets (2021-22)	• Greater provision of structured education for people with type 1 diabetes, both face to face and virtually - increase in funding for structured education for Type 1 diabetes** – progress is that there has been over 50% reduction in number of people waiting; time to wait for structured education course reduced from 2.5 years to 1-3 months.
National Audit of Cardiac Rhythm Management devices and ablations (2022-23)	• Continue to monitor performance and database returns for national audit
National Perinatal Mortality Review Tool (PMRT) (2022-23)	• Evaluate the approach to parental engagement. • Undertake a training needs analysis to ensure that staff are trained and use available PMRT engagement materials. • Review resources allocated to PMRT process to ensure adequate and in line with national recommendation, especially with regards to the neonatal nurse hours and the clerical support • Work with Academic Health Science Networks (AHSNs)/Maternity and neonatal networks to provide external panel members. • Review Maternity and Neonatal governance teams to ensure effective prioritisation of resources for key aspects of care and quality improvement activities,

Audit	Summary of Agreed actions
	as well as promoting `strong` actions targeted at system level changes; audit implementation and impact.
National Comparative Audit of Blood Transfusion Programme: Blood Transfusion Against NICE Guidelines Clinical Audit (2021-22)	• Complete OUH pre-op anaemia guidance • Increase data management support. • Seek funding for additional nursing staff • Move electronic consent management to Electronic Patient Record (EPR) SmartZone • Introduce educational activities.
Pain in Children National Audit *(care of children in pain presenting to emergency department)* (2021-22)	• Ensure performances continues to meet or exceed national standards
National Hip Fracture Database Audit (NHFD) (2022-23)	• Establish Fragility Fracture Improvement Group (FFIG) with stakeholders across the pathway** • Complete a demand/capacity mapping exercise to determine trauma theatre requirements** • Work with Theatre Productivity Steering Group to meet required theatre capacity and maintain theatre productivity above trust targets* • The Fragility Fracture Improvement Group to produce a plan for providing a safe adequately staffed 7-day working pathway, with safe weekend working, including: (1) provision of extra operating capacity at weekends, (2) provision of weekend Orthogeriatric care and (3) the delivery of 7-day ward-based physiotherapy to assist rehabilitation and timely discharge across the JR2 and Horton sites* • Develop a 'Golden Patient' approach in Trauma theatres, prioritising access to theatres for fractured neck of femur patients as appropriate* • FFIG to work with JR Anaesthetic Lead for Trauma to address these three issues: (i) anaesthetic work-flow to develop 'Golden' hip fracture patient first on each trauma list; (ii) assess feasibility of introducing a third anaesthetist to support JR trauma lists; (iii) develop SOPs to guide anaesthetic practice in line with the published guidelines*.
Sentinel Stroke National Audit Programme (SSNAP) (2022-23)	• Increase support unit capacity by further 2 beds* • Introduce weekend therapy service* • Achieve full recruitment* • Prioritise goal setting early in the admission*.

Audit	Summary of Agreed actions
Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE) Perinatal Mortality Surveillance Report 2020 (2021-22)	• Update local guidelines to ensure in line with regional guidelines and pathways produced by Thames Valley Maternity & Neonatal networks** • Review consultant job plans to identify potential gaps in ward cover* • Develop business case to address service gaps* • Update and implement Regional Palliative Care Pathway** • Provide Specialist Midwife for perinatal mortality - will also ensure accurate reporting of gestational age**
Adult Chronic obstructive pulmonary disease (COPD) 2021 organisational audit report (2021-22)	• Collect automated data entry via Electronic Patient Record (EPR) with automatic 'push through' to national Audit. • Work with coding team to understand COPD coding discrepancies • Support non-invasive ventilation (NIV) training and competency on Emergency Assessment Unit (EAU) / Emergency Department (ED) and selected non respiratory wards adjacent to respiratory ward setting* • Support capillary blood gas (CBG) training and competency in EAU/ED and selected non respiratory wards adjacent to respiratory ward setting* • Develop an integrated respiratory team to support the development of community-based COPD/respiratory services
National Paediatric Diabetes Audit Report: Parent and Patient Reported Experience Measures (PREMS) (2021-22)	• Redesign psychology care planning tool to summarise psychological advice provided during clinic appointments and ensure both dietitians are available at clinic. • Update website and clinic boards to display current staff members. • Ensure families are aware of their named patient consultant and discuss with them if or when these needs changing** • Review of consultation techniques to facilitate improved dialogue between patients and staff. • Make laptops or tablets available so survey can be completed in the waiting areas of clinics.
HARD TO SWALLOW? - National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report reviewing the quality of dysphagia care provided to patients with Parkinson's disease (PD) admitted to hospital (2021-22)	• Document the swallow status of all patients with Parkinson's Disease (PD)** • Notify the specialist PD service when a patient with PD is admitted* • Screen patients with PD for swallowing difficulties at admission*

Audit	Summary of Agreed actions
	• Refer patients with PD swallowing difficulties to speech and language therapy* • Ensure patients are able to take the medication or consider other formulations of medication * • Involve Speech and Language Therapist (SALT), pharmacists, dietitians and nutrition team members in any multidisciplinary discussion. *

Table 23: A list of national audits together with a summary of actions taken and benefits for patient care following their review.

*Partially achieved

** Fully achieved

Actions taken and improvements made from local audits.

2.5 Local audit reports are monitored via clinical governance arrangements in Directorates and Divisions and are presented at local clinical governance meetings.

2.6 The reports of 14 local clinical audits were prioritised for Trust-wide review by Oxford University Hospitals NHS Foundation Trust's Clinical Improvement Committee in 2022-23. Following these audits, Oxford University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

The table below shows a list of local audits and the actions taken and improvements that have been made as a result.

Local Audit	Summary of Actions
Trust Wide Audit of Venous Thromboembolism (VTE) Prevention	• Continued development of 'safety nets' including Electronic Patient Record (EPR) solutions following review of incidents or information from audits** • Develop electronic version of the OFTEN risk assessment tool for lower limb immobilisation* • Audit extended VTE prophylaxis after major abdominal surgery/Hip & Knee Replacements • VTE Exemplar Centre Revalidation* • Active involvement in VTE Exemplar Centres Buddy System**.

Local Audit	Summary of Actions
Trust Wide Audit of Auto-reporting Policy	• Recommend requirement to record a written evaluation of any auto-reported examination is included in induction for all junior doctors, physician associates and advanced nurse practitioners (ANPs) in 'high use' areas (cardiothoracic surgery; critical care) • Ensure adequate notice for the divisions to undertake self-audit part of the policy at the next re-audit cycle.
NICE (NG167) COVID-19 Rapid Guideline: Rheumatological Autoimmune, Inflammatory and Metabolic Bone Disorders	• Discuss risks and benefits of treatment** • Improve documentation**.
NICE Tuberculosis (TB) (NG33)	• Liaise with TB nurses/pharmacy and regional TB Control Board to address drug supply issues** • Review participation in TB drug-induced liver injury (TB-DILI) trial* • Create TB nurse pool to flag inpatients for review*.
Trust Wide Audit of Mental Health Act (MHA) Policy	• Feedback to all psychiatrists who may act as Responsible Clinician at consultant meeting • Request support from the Trust's legal team* • Type of demographic information being monitored will be altered on the MHA patient database* • Annual review of MHA policy with all Section 12 doctors in Psychological Medicine Service • Specific teaching on OUH MHA use for new clinicians in Psychological Medicine Service • Contemporaneous colleagues' feedback of any errors • Annual MHA teaching with Psychiatrists, Operational Managers, Section 12 approved trainees • Review of standard operating procedure (SOP) of MHA patient data base • Prompt review on future guidance.
Maternal and Neonatal Outcomes Following Attempted Rotational Instrumental Assisted Birth	• Audit to assess how often rotation of shoulders not allowed before next instrumental pull* • Introduce ROBuST teaching & training package including audit findings and training on use of rotational forceps*.
NICE (NG99) Brain Tumours (primary) and Brain Metastases in Adults:	• 100% compliance - repeat audit to confirm reproducibility*

Local Audit	Summary of Actions
Compliance of OUH Oncological Neurosurgery	
NICE (NG14) Melanoma Clinical Audit	• 100% compliance - repeat audit to confirm reproducibility*
Trust Wide Annual Consent Audit (2021-22)	• Ensure all staff eligible to participate have access to software* • Clinical Governance and Risk Practitioners to pilot software* • Revise audit form*
Trust Wide Health Records Audit (2021-22)	• Ensure all staff eligible to participate have access to software* • Clinical Governance and Risk Practitioners to pilot software* • Revise audit form* • Distribute Record Keeping Policy*
Trust Wide Pressure Ulcer Prevention Clinical Audit	• Develop Trust Action Plan using Quality Improvement* • Develop divisional reports and update local action plans** • Send report to clinical leads**.
Trust Wide Nutrition Clinical Audit	• Develop individualised action plan for the 9 wards which scored <60%* • Undertake Malnutrition Universal Screening Tool (MUST) accuracy audits on sample groups / wards* • Develop a non-compulsory MUST training on My Learning Hub* • Review MUST audit questions to include weekly MUST screening* • Update OUH Nutrition and Hydration Strategy*.
Antenatal Care Audit (NG201)	• Implement a maternity-specific, fully electronic patient record to replace the current hybrid paper/electronic system*.
Cerebral Palsy in Adults (QS191) Mandatory Clinical Audit	• Raise with Buckinghamshire, Oxfordshire & West Berkshire (BOB) Integrated Care Board (ICB) partners the issue of poor compliance with annual review by a healthcare professional with expertise in neurodisabilities of adults with cerebral palsy who have complex needs; explore system solutions.

Table 24: A list of local audits and the actions taken and improvements that have been made as a result.

* Partially achieved

** Fully achieved

Integrated Quality Improvement

The Integrated Quality Improvement Team have a number of functions which serve to achieve our underpinning purpose of improving the quality of our services and the environment in which we work.

There are four essential elements to this work including:

1. QI education, coaching and community building – focus on building organisationwide knowledge, skills and capability in QI through education and developing an inclusive QI faculty, working closely with regional partners

2. QI infrastructure – integrating QI into the trust processes as we work to embed a culture of quality improvement

3. Local QI Initiatives – QI faculty to support initiatives at a local level with those closest to the challenges and opportunities engaged and encouraging the dissemination of learning and results.

4. Growing Support for priority programmes – through management of priority programmes, support staff and service users to apply the Model for Improvement in making changes

These four elements are below, work simultaneously in parallel to each other to enable us to reach the aspired integration of a culture of continue quality improvement and learning into everyday practice at OUH:

- **QI education coaching and community building -** Focus on education and developing an inclusive QI faculty working closely with regional partners.
- **QI infrastructure -** Integrate Quality Improvement into Trust processes to embed a culture of quality improvement.
- **Local QI initiatives -** QI faculty to support QI initiatives through QI hubs, encouraging dissemination of learning and results.
- **Growing support for priority programmes -** Management of priority programmes, supporting staff and service users to apply the Model for Improvement staff in making changes.

To increase the success and sustainability of Improvement initiatives across the trust we have developed a standardised approach, based on evidence of what works when it comes to improvement. This standardised approach has been pulled together in the OUH Improvement Framework.

The 5-Steps, included within the improvement framework, are what guides individuals and teams from an initial Step 1 focused on-Discovery and Diagnosis right through to Step 5- Dissemination and Spread of improvement learning and achievements. The 5-steps included are:

1. Discover and Diagnose – focused on understanding the problem and building a shared purpose for improvement across stakeholders

2. Dream and Design (Planning Change ideas) – opportunity to think differently and explore change ideas and opportunities to test new ways to achieve the shared improvement aim

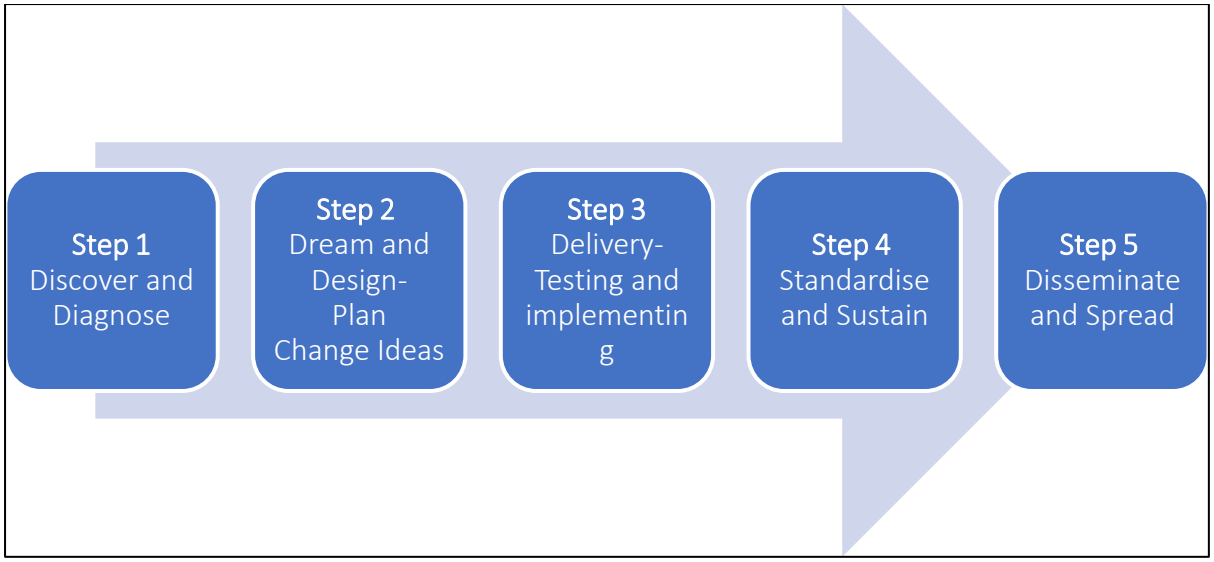
3. Delivery, Testing and Implementing – involves using PDSA cycles to test change ideas in real time, starting small and building as confidence grows that the ideas are leading to the improvement we seek.

4. Standardise and Sustain – focus on sustaining improvement as we transition out of testing and establish business as usual for new ways of work

5. Disseminate and Spread – working to share learning and spreading new ways of working to reduce unwarranted variation and embed sustained improvement on wider scale

The 5-step OUH Improvement Framework includes all the core ingredients of QI, such as the need to listen to the voice of the service user and benefits of iterative testing and design underpinned through the adoption of the Model for Improvement for steps 2 – 4.

The OUH Improvement Framework is represented graphically below and forms the backbone of the Improvement Programme of the trust:



Picture 1: The OUH Improvement Framework

The Integrated Quality Improvement Team have been supporting several trust priority programmes across the trust now using this approach, including but not limited to:

- Outpatients
- Recruitment
- Urgent and Emergency Care
- Theatres
- Cancer Care
- Harm reduction

Outpatients:

Across the NHS there are a record number of patients waiting too long for care. The Outpatients Improvement Programme is therefore a vital arm of the organisation, aiming to reduce unnecessary referrals and follow-up to create capacity and hence reduce those delays. They have digitized many processes and delivered care closer to home.

Successes have included optimising referrals via advice and guidance, reducing unnecessary Face to Face appointments and supporting Patient Initiated Follow Up (PIFU) appointments that empower the users of our services. We are also digitising many processes, releasing precious staff time. For example, we have an aim for 80% of appointment letters to be sent digitally. Delivering care closer to home also increases the capacity to deal with backlogs, for example we have also incorporated

mobile phlebotomy to reduce unnecessary hospital appointments with their associate stress and waste.

Recruitment Process

This is the first Improvement programme we have supported which is targeted directly at staff processes, which are often a source of professional frustration. Recognising that the average time for external applicants to start in post is 53 days (derived from Model Hospital peers), we aim to make the process easier and slicker for all those involved.

Time To Hire is taken from the advertising start date until recruitment checks are completed. This programme is currently in Step 1- the Discovery and Diagnose stage of the Improvement Framework. So far, significant efforts have been made by the recruitment team to clean up the data ensuring recruitment campaigns are concluded. This has presented an opportunity to implement an escalation process that pragmatically ensures time to hire is completed within the SLA timeline.

Urgent and Emergency care

This programme has focused on important and impactful measures such as the time patients remain in ED and the speed of ambulance handovers. We have also worked on improving discharge and are proud of the impact this has had with a significant and sustained use of the Transfer Lounge over the last few months, resulting in 21 patients being discharged via the lounge per week and better flow of patients.

Most recently we have taken this further with work with our BOB ICS partners to refine the Transfer of Care Hub and work with the acute virtual ward. Other achievements this year have included centralised control of beds with Operational Escalation Teleconferences have now moved to MS Teams with improved engagement. Our approach is grounded in observation and staff engagement leading to change ideas for improvement. Issues that were observed that were outside the control of those involved have been escalated where required to tangibly help support patients and staff.

Theatres

This programme has had a focus on increasing productivity at Horton General Hospital to realise its potential as a High Volume, Low Complexity surgical hub through increasing utilisation of the theatre resources, anticipating that this will benefit patients through reducing waiting list times and improving on the day surgery processes. The teams are working collaboratively to address some of the core challenges including later starts/ early finishes and under booked through the Horton Theatres Improvement Forum.

Cancer Care

We aim to support teams to improve access to cancer care by meeting and exceeding national standards. These include time to being seen, diagnosed, and treated, with a reduction in the number of patients waiting over 62 and 104 days. The 5-step process above has been applied to this within each of the tumour type worksteams we have engaged with. This systematic approach with co-production with staff is bearing fruit. Just in urology, for example there have been 6 PDSA cycles in progress and a further 4 in the planning stage and 2 in the study stage.

Examples that have increased productivity through greater efficiency and effectiveness include

- in Upper Gastro-intestinal care we have reduced referrals being sent back to the GP for inadequate information, which lead to rework and further delays.
- Service redesign incudes a new “one stop shop” to support CT and Endoscopy.

For those interventions that have been shown to be successful we have supported their establishment with formal documents and SOPs such as in PTL management processes - Step 4 of the Improvement Framework.

Harm Reduction

A new programme this year has been on Harm Reduction, with a particular focus on Healthcare Associated Pressure Ulcers (HAPU), aiming to reduce category 2 HAPU by 30%. Further information is provided in the Quality Priority section of this document.

Notable Successes of QI projects completed in 2022-23

Notable successes that the Integrated Quality Improvement Team have contributed to with a QI Approach include:

- Reduction in Time to Recruit staff by an average of 10 days. Anticipated benefits include reduced pressure on staff through unfilled posts or use of temporary staff, leading to improved quality of care and £1.6 million recurrent cash-releasing savings through reduced premium rate staff costs.
- Cancer pathway improvements with 81% of referred patients being seen within 2 weeks, against a Trust improvement target of 71%, resulting in reduced anxiety for patients and better outcomes following a prompter initial consultation.
- Harm reduction through the work on Healthcare Associated Pressure Ulcers (HAPUs) has been significant with a 20% drop in Category 2 HAPUs and a 34% drop in Category 3 and 4 HAPUs, resulting in an indicative financial benefit through reduced Length of Stay and bed days saved of £350 per patient per day.
- Reduction in patients who were medically optimised for discharge across OUH by 30% during “Operation Reset”, through engaging hundreds of staff and working across organisational boundaries over a 2-week period.

Quality Improvement

OUH has made a strong commitment to promoting and enabling widespread adoption of Quality Improvement mindset and practice across the Trust. A key enabler to achieving this is building capability, capacity, and establishing a community of improvers with connections across the Trust to share learning and champion QI in everyday practice.

During 2022-23 the Trust Quality Priority to *Embed Quality Improvement Methodology more widely in the Trust* has sought to harness existing and build further our QI capability within the Trust; establish an inclusive community of engaged QI colleagues as the QI Hub Community; and strengthen QI leadership, support, visibility, and monitoring.

QI Education 2022-2023: Developments and Delivery

The core elements of developing our organisational QI capability have been defined in our three-year QI Education strategy. Structured around a comprehensive QI Education Framework, this provides the Trust with a clear road map to diversify the opportunities and routes through which staff can build their QI knowledge, understanding and skills.

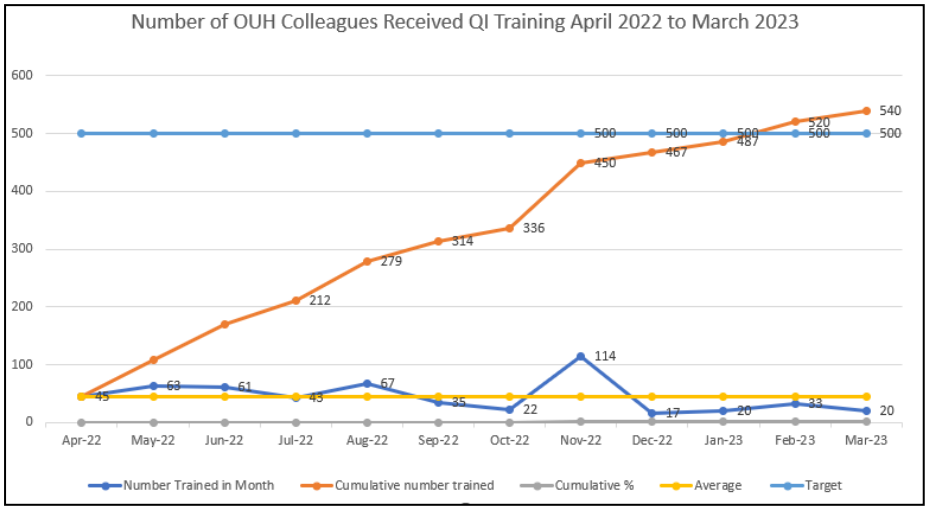
The QI Education Framework comprises 7 levels of QI training with curricula of increasing depth and diversity. The educational levels can be grouped into 3 phases of an education continuum enabling knowledge development from awareness (Level 1) to application in practice (Levels 2-4) and then culminating in learning focused on leading and training others (Levels 4-7). For the 2022-23 we have prioritized focusing on establishing training at Levels 1 – 5 of the QI Education Framework. The below table provides a description of what both the individual staff member and the trust can gain out of each of these training.

	Level 1 **Introduction (Awareness)**	**Level 2** **QI Essentials**	**Level 3** **QI Foundation (QI in Action)**	**Level 4** **QI Champion**	**Level 5** **QI for Managers and Sponsors**
What this means for those who complete the training	*"I have been introduced to what QI is and opportunities to learn and apply QI in the Trust"*	*"I understand basic QI principles and behaviours to help me start exploring improvement opportunities"*	*"I can apply QI principles and tools to my own project"*	*"I have a good of understanding QI championing and encouraging others to have a go, through role modelling, mentoring, and helping to deliver basic QI training"*	*"I strategically lead QI in services and divisions"*
What this training provides for the Trust	All staff aware of the value the Trust places on QI and the opportunities available for participation, learning and improvement.	Staff understand and able to apply key improvement principles to actively participate in improvement projects in their area.	Staff can apply the fundamental improvement characteristics to their daily work beginning to make focused improvements	Establishing a network of active champions to promote and encourage improvement projects engaging and supporting others from their	Senior staff will be equipped to establish the right conditions for culture of improvement to flourish and lead local improvement enabling teams and services to

				service or team along the way.	continually improve.

Table 25: Five levels of QI Educational framework

In the past twelve months we have successfully trained 541 staff in QI exceeding the Trust target to train 500 staff across 2022-23. The combined run and line chart below shows the accumulative number of staff trained over 2022-23 and on a separate line the number of staff trained broken down monthly across 2022-23.



Graph 1: Number of OUH colleagues who received QI training from April 2022 to March 2023

This has included staff accessing a range of QI training across the first 4 levels outlined within the QI Education Framework and meeting key milestones for roll out within the strategy. Education offers developed over 2022-23 have included:

Level 1: Introduction to QI (eLearning) OUH would like to thank our partners at Oxford Health NHS Foundation Trust for developing and sharing their introduction e-Learning module. This brief interactive eLearning will be open access for all staff through OUH My Learning Hub this is in process of being embedded to be locally accessible to all staff with the aim of being accessible in Q1 2023-24.

Level 2: QI Essentials (Bite-sized workshop) is our level 2 training session which builds upon the level 1 eLearning Introduction to QI and is aimed at staff who want to begin to explore QI and understand more about the basic principles. This has been tested with Shared Decision-Making Councils and has just been opened out to wider staff groups.

Level 3: QI in Action training is aimed at staff who are actively engaging in improvement within their day-to-day roles, staff have been able to access this learning through multiple routes. Including QSIR Fundamentals, QI Hub Programme and as an embedded element of Emerging Leaders Programme.

QSIR Fundamentals

During 2022-23 185 staff have accessed our one-day *QSIR Fundamentals* introduction to QI. Focused on core QI principles, skills, and tools the workshop provide a foundational knowledge for colleagues supporting or engaged in QI projects within their teams or services.

QI Hub Program

The OUH QI Hub Program has continued to run successfully for the 3rd year. There have been 2 cohorts run over the year supporting 35 projects and 41 participants. The projects from the first cohort were presented at the QI Hub presentation event, which was chaired by the Director of Improvement. The second cohort is due for completion by April 2023. Key projects included Hospital Passport, improving education for international nurses, improving handover and medication, and QI Lite.

Level 4: QI Champions is focused more on developing QI knowledge and skills required by those that are responsible for leading, enabling and encouraging others to participate in QI and to integrate QI into their day-to-day work.

During 2022-23 Accredited QSIR trainers within the Integrated Improvement Team continued to work with colleagues across Oxfordshire, Buckinghamshire and West Berkshire Integrated Care Board (BOB ICB) to transition from a 5 session QSIR virtual program back to the delivery of a hybrid delivery model of the five-day QSIR Practitioner programme. Three cohorts of staff have been supported to undertake the programme, completing an improvement project in parallel to the didactic sessions to support application of knowledge in practice. A total of 74 colleagues from across BOB ICB have completed the 5-day training, including 30 from OUH.

In addition, 4 colleagues have also completed the assessment and accreditation process to become QSIR Associates, joining the BOB QSIR Faculty in alignment with the expectations of **level 6** on the QI Education Framework.

Level 5: QI for Managers and Sponsors is focused on building understanding and knowledge with those in management and leadership roles, enabling them to support others to undertake improvement in their teams or services. During 2022–23 we have been in the development and testing phase of this training, delivering sessions to 40 senior colleagues across OUH. During the coming year this training will be accessible to a wider cohort of colleagues to book through MyLearningHub, our virtual learning platform.

QI Hub Community Building

In the past 12 months several foundational steps have been taken to begin establishing an inclusive community of engaged QI colleagues as the QI Hub Community. These steps include:

- Establishing a monthly Trust wide QI Forum of diverse colleagues from across the divisions and services to inform and drive forward how we build towards QI being at the heart of how we support improvement in everyday practice at OUH.
- A formal invite has been shared with colleagues from across the Trust who have either completed QI training in the past 5 years or demonstrated an interest in support QI at the OUH.
- Development of nominated link roles from the IQI Team into the Trust Divisions, linking with the Research and QI Divisional Leads and identified division QI leads.
- Throughout 2022 -23 the IQI team have established regular QI Clinics as bookable opportunities for all staff to access support and guidance as they undertake QI within their own teams and services.
- As we work to establish a community of improvers at OUH, we are also collaborating with the Head of Patient Experience to increase input from patients and carers with experience in our QI work. This work will continue through 2023 -24.

QI Stand Up

Introduced in April 2021 QI Stand Ups provide an opportunity for sharing QI initiatives across the Trust. Colleagues are invited to share Quality Improvement

projects whether completed or in progress via short presentations and are available for all within the Trust to view, 89 projects have been presented since the launch, 53 of those have been during this year. QI Stand Ups allow learning and sharing more widely of QI initiatives and their successes and learning, whilst promoting a collaborative approach to QI across the Trust.

OxSTaR QI work for OUH

The Human Factor and safety training we offer in OxSTaR informs our understanding of patient safety concerns in the workplace and the design of quality improvement projects to mitigate risk.

We continue to support the Foundation year doctors (FY2) in the delivery and design of their Quality Improvement projects that align with the Trust quality priorities. We celebrate their achievements by hosting a QI symposium which gives them a platform to present their work.

The Hill Digital Innovation Hub, Market Access Accelerator & Innovation Pipeline

MAA (The Market Access Accelerator)

The Market Access Accelerator (MAA) is a 6-month intensive programme which focuses on helping, supporting and to scale innovative technologies which can improve patient care and reduce the pressure and burdens on frontline staff.

In 2022 6 companies graduated from the programme and have gone on to achieve:

MindHealth AI

Personalised, preventative healthcare for your employees and patients.

- Winners of the Innovate UK, Women in Innovation Awards.
- FELIX partner.
- Accepted onto Digital Health Launchpad Programme
- Won a grant from Innovate UK to support our research and development into first-of-its-kind predictive technology to support healthy behaviour change.

Goggleminds

Delivering virtual reality (VR) simulation training to healthcare professionals and students worldwide.

- Interviewed by BBC Newsnight, on the importance of collaboration and support to drive innovation in healthcare.
- Pilot within OUH
- Winner of Start Up Wales, Medtech Start Up Company

EnrichMyCare

A personalised healthcare platform for children and young people with disabilities.

- Finalists for this year's Medilink Midlands Business Awards
- Awarded with CPI's Health Technology Regulatory and Innovation Project Award for our regulatory compliance
- Commenced Pilot Study
- Received Ethics approval for a focus group study
- Attended Digital Healthcare Show
- Awarded with CPI's Health Technology Regulatory and Innovation Project grant funding award.
- Accepted South East Health Technologies Alliance accelerator programme

Digostics

Oral glucose tolerance home-testing services for the detection of diabetes.

- Pilot of point of care testing kit at University Hospital of Southampton
- Won an Innovate grant to investigate the feasibility of adding a c-peptide digital home test
- Granted a CE Mark
- Accepted to join the Johnson & Johnson Innovation JLABS incubator in New York city
- Invited to showcase at MediWales' BioWales
- Showcasing at Arab Health 2023
- Exhibited in Lisbon for World Diabetes Congress.

Virtual Health Labs

Provide digital health solutions designed to help people make one or more behaviour changes likely to be associated with improved health, wellbeing, independence and quality of life.

Lister App

Purpose: Helping clinicians capture, manage and prioritise their jobs list to complete tasks more efficiently and successfully:

- Accepted onto innovation fellowship at Mid and South Essex NHS Foundation Trust (Previously applied in 2019 and was not shortlisted)
- Accepted onto Digital Health Launchpad Programme

The Trust is still engaging with all 6 companies for potential future work and/or us of their products and took equity in each of the start-ups which forms part of the Trust's capital investment portfolio.

Pipeline

The Hill's innovation pipeline process ensures the most promising digital ideas are championed to grow and scale, and directed to the right support within the Trust.

This programme contributes to the overarching objectives of facilitating the adoption of digital innovation into the Oxford University Hospitals NHS Foundation Trust (OUH) and ensuring our processes are optimal to lead new approaches into the Trust's innovation decision-making. Our connections to the broader ecosystem developed through our other programmes, mean we are aware of digital innovations available in the broader ecosystem and are able to match these to identified needs.

The pipeline is currently progressing 25 companies through the 6 stages to adoption; successful outcomes in the last 12 months include:

Cardiolyse

Cardiolyse is a Medical CE-certified (class 2a) company that has designed a digital prognostic tool for the management of heart related disease. Prof Betts and his team were impressed by the Cardiolyse technology and were eager to facilitate a

feasibility pilot which would address the challenge of patient follow-up after catheter ablation for atrial fibrillation (AF) by obtaining electrocardiography (ECGs) in a safe, timely and less costly manner using Cardiolyse's technology.

To enable successful delivery of the pilot, TheHill's were successful in securing over £250k from the Digital Health Partnership Award (DHPA) which is designed to help NHS organisations in England to accelerate the adoption of digital health technologies supporting patients with long term conditions, this funding enabled a 6 month pilot of the which has been overwhelmingly positive, with 100% of patients feeling safe at home being monitored by Cardiolyse, and 100% feeling that being monitored at home by Cardiolyse has improved their quality of life.

CPIP Cerebral Palsy Integrated Pathway

Cerebral Palsy Integrated Pathway was established in 2013 in Scotland after it was identified across Europe that through the effective implementation of a patient management system, the chance of getting a dislocated hip or requiring major orthopaedic surgery reduces dramatically. OUH Clinicians (Dr Amedeo Castello & Jen Smith) devised an appendix tool which is currently being incorporated into CPIP database. This additional tool will support clinicians across the UK to explore alternative interventions and/or referral routes for their patients. It is anticipated that this will Reduced inequality of access to care due to geography of available secondary, tertiary, and quaternary services, reduce time to referral/treatment with consequent avoided disease/deformities progression and need for more surgery and reduce pain/spasms and therefore need for medications.

Concentric

Concentric Health is a digital consent and shared decision-making web application revolutionising how consent for a procedure or treatment is gained and recorded. Usage of Concentric's product in the NHS has grown, with the BOB ICS adopting the system through the NHSX Adoption Fund in October 2021. We have also supported them to secure integrations with hospital systems through the Fast Health Interoperability Resources (FHIR) API, Get It Right First Time (GIRFT) and single sign-on, further removing barriers to care. Following a successful procurement exercise Concentric is currently being rolled out for use in OUH's Ophthalmology department, with Trust-wide use anticipated after the initial test period.

Our participation in clinical research

As one of the United Kingdom's leading university hospital trusts, OUH is committed to achieving excellence through clinical research. Along with the related areas of education and innovation, research is central to World-Class Impact, one of OUH's five strategic themes and is key to achieving all three of its Strategic Objectives; for Patients, People and Populations. Together with its research partners, OUH aims 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.

OUH hosts the Oxford Academic Health Science Network (AHSN), as well as the NIHR Thames Valley and South Midlands Local Clinical Research Network (LCRN). Along with Oxford Health NHS Foundation Trust (OH), Oxford Brookes University (OBU) and the University of Oxford (OU), OUH is also a partner in the Oxford Academic Health Partners (OAHP) – one of the eight NIHR/NHSE/I designated Academic Health Science Centres in England.

OUH's close partnership with OU, encompasses major programmes in all areas of medical sciences, including cardiovascular, stroke, dementia, cancer, infection, vaccines, surgery and imaging, as well as inter-disciplinary collaborations in digital health. During 2022-23 there has been significant investment in the development of research led by Nurses, Midwives and Allied Health Professionals (NMAHPs) at OUH, working closely with OBU. This will help build a robust evidence base to drive improvements in broader aspects of patient care, as well as creating new career pathways for OUH staff.

Much of this activity benefits substantially from the NIHR Oxford Biomedical Research Centre (Oxford BRC), which has been based at OUH and run in partnership with OU since 2007. The Oxford BRC has been awarded further funding of £86.7m for five years from 1 December 2022, following a competitive bidding process. The Oxford BRC funds innovation across 15 research themes and a core team that supports researchers in areas such as patient and public involvement and engagement, business development, training and education and ethics. A complementary and synergistic bid submitted by OH, in partnership with OU, secured an award of £35.4m

for the NIHR Oxford Health BRC in the same competition, which will support 11 research themes focused on brain health.

OUH bid successfully for NIHR Clinical Research Facility (CRF) designation and has been awarded seed funding of £1m for five years, from September 2022. The new Oxford CRF is another partnership with OU, which lays the foundation to deliver a wider range of early phase studies – many with Oxford BRC funding – for the benefit of patients, as well as to train and develop a new generation of doctors, nurses and allied health professionals in early phase experimental medicine trials. The Oxford CRF will work closely alongside the NIHR Oxford cognitive Health CRF, a partnership between OH and OU, to maximise opportunities for local patients and researchers.

During 2022-23, OUH hosted 1619 active clinical research studies. This is a 8% increase compared to the previous year and includes 313 new studies that have opened to recruitment at OUH during 2022-23.

The number of patients receiving relevant health services provided or sub-contracted by Oxford University Hospitals NHS Foundation Trust in 2022-23 who were recruited during that period to participate in research approved by a Research Ethics Committee was 23,365 participants recruited to 496 studies which were CRN portfolio registered. This is a 31% increase in participants compared to the previous year, although it is still 9% less than pre-pandemic recruitment activity, reflecting the ongoing challenges of recruiting participants to research studies in an environment that is still significantly impacted by consequences of the COVID-19 pandemic.

In 2022-23, 162 OUH staff were directly supported by NIHR Oxford BRC funding and 235 staff were funded by the NIHR Clinical Research Network.

The following examples illustrate some of the diverse high-impact clinical research studies and facilities which OUH is involved in, in many cases working in close partnership with OU:

- OUH and the medical imaging technology company Polarean Imaging plc, have entered into a research collaboration to study the long-term effects of COVID-19 in patients still experiencing breathlessness months after infection. Polarean produce an investigational drug-device combination product using hyperpolarised xenon gas to enhance magnetic resonance imaging (MRI) in

pulmonary medicine. This technology will enhance ongoing research at OUH, such as the EXPLAIN Study into the possible long-term impact on the lungs of long COVID.

- OUH is leading the RAPID-PROTECTION study, in collaboration with the Universities of Oxford and Cardiff. People with impaired immune systems are taking part in this multicentre clinical trial which is investigating COVID-19 vaccinations in combination with Evusheld, a new antibody treatment used for the prevention of COVID-19 infection. Evusheld has been shown in clinical trials to prevent COVID-19 infection for up to a year, but, although it is known to be effective against the Omicron variant, it is not yet known how long this protection lasts.
- An injectable cure for potentially fatal inherited heart muscle conditions could be available in a few years after a team of researchers led by Prof Hugh Watkins, the Oxford BRC's Theme Lead for Genomic Medicine, was announced as the winner of a major award from the British Heart Foundation. At £30m, it one of the largest non-commercial grants ever given. Prof Watkins's CureHeart team aim to develop the first cures for inherited heart muscle diseases by editing or silencing the faulty genes that cause them.
- A new Acute Multidisciplinary Imaging and Interventional Centre (AMIIC) has been opened at the John Radcliffe Hospital. This refurbished centre is a purpose-designed research facility embedded in a clinical hospital environment, specifically adjacent to the Emergency Department and Heart Centre. It is the first facility in the world to host a hybrid photon-counting CT scanner with an interventional suite, supported by an artificial intelligence facility.
- The NIHR has launched five new Blood and Transplant Research Units (BTRUs). Three of them are based in Oxford. The £20m programme, co-funded by NHS Blood and Transplant, is aimed at providing new technologies, techniques or insights that will benefit donation, transfusion and transplantation, and that can be delivered at scale. The three units at the University of Oxford are Precision Cellular Therapeutics, Data Driven Transfusion Practice and Genomics to Enhance Microbiology Screening.
- A new NIHR BioResource aimed at investigating inflammatory bowel disease

(IBD) in children has opened, with the first participant recruited at the Oxford Children's Hospital. Led by senior Oxford BRC researcher Professor Holm Uhlig, the new Paediatric Inflammatory Bowel Disease (PIBD) BioResource, with a national panel of volunteers who have consented to participate in health research, will drive research into Crohn's disease and ulcerative colitis in children.

Reporting Excellence

The OUH Reporting Excellence Programme, now in its seventh year, is a true testament to the power of gratitude in motivating both those giving to and receiving timely positive feedback from their professional colleagues. Whether sending a missive thanking an administrator for sorting out a file organising system or celebrating frankly heroic examples of going above and beyond for a patient, Reporting Excellence is now well established as the most effective means of conveying these messages to colleagues across the Trust. The intranet-based system enables immediate and often heart-felt words of appreciation to get to those that deserve it, day in and day out. The recognition of outstanding efforts occurs at any hour of the day or night, demonstrating that showing appreciation is as much about the nominator as it is the recipient. Staff want to reach out and connect with their colleagues to say 'thank you' and 'well done', often at the end of busy and exhausting shifts. By thanking the nominator immediately for taking part, we further reinforce the concept that excellence is all around us, we are part of it as observers but also as participants.

The numbers of nominations speak for themselves. In the second half of 2022 there was an increase of 22% in the frequency of reports compared to earlier in the year, bringing the past 12 months' total to nearly 2300 reports. The reports regularly exceeded 200 in a month by October and in January 2023 alone there were over 300 reports. These represent periods of ever-increasing demands on all staff, and it seems clear that when the going gets tough, the tough… report excellence!

The Ulysses dashboard tells the story: integration of the scheme into the platform from its inception has enabled meaningful feedback on not only the numbers of nominations but divisional breakdowns and identification of themes. Data derived from the summary reports at the end of each month are circulated to Divisional leaders

providing access to the many examples of outstanding individual and team efforts soon after they occur. These, in turn, can be shared across all areas such that the news of new innovations and extraordinary efforts can be shared in a timely way to maximise the positive effects on service and patient care.

The Reporting Excellence homepage is in the top five most frequently visited pages on the Trust Clinical Governance section of the intranet. The system is accessible, easy and worthwhile as an equal partner in maintaining quality and aligning with trust values. Thus Reporting Excellence is not just a simple means to say thank you but is considered alongside the patient safety and quality portals as integral to providing best practice and continually striving for excellence through adaptation and innovation.

The team behind Reporting Excellence have worked hard to make the system accessible and promote learning opportunities from good practice. This past year, a Quality Improvement initiative within the Oxford Heart Centre examined the use of Reporting Excellence in identifying key themes underpinning high-quality work. This was presented by the authors at the OUH QI Standup forum, and the project findings subsequently published in the British Journal of Anaesthesia. It is clear that all across the Trust there are many examples of teams working innovatively to develop systems to optimise safety and the patient care experience. Themes such as adaptability, resilience, professionalism and healthy team dynamics have the potential to strongly influence organisational culture and staff engagement. With these outcomes, there is much to look forward to for all of us, easily ‘paid forward’ with a simple click on the Trust homepage Reporting Excellence link. Encouragement and reinforcement of the ongoing use of this simple tool, supported at all levels of leadership starting with the CEO, can only strengthen the Trust’s commitment to excellence and growth.

Our CQUIN performance

The key aim of the CQUIN framework is to secure improvements in quality of services and better outcomes for patients, whilst also maintaining strong financial management. Under the published NHS Payment System for 2022-23, a proportion of Oxford University Hospitals NHS Foundation Trust income in 2022-23 was intended to be conditional on achieving quality improvement and innovation goals agreed between Oxford University Hospitals NHS Foundation Trust and any person or body they

entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework. Nationally this variable element has not been enacted to date, although the NHS Payment System 2022-23 has not been formally updated to reflect this. As a result, Oxford University Hospital NHS Foundation Trust income in 2022-23 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework as Trusts were operating under block contracts for this element of income.

Statements from the Care Quality Commission (CQC)

Oxford University Hospitals NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is without conditions.

On 31 March 2023 the Trust had an overall rating of 'Requires Improvement' from the CQC. The CQC carried out one inspection on services provided by the Trust during the year 2022-23 and the results were pending at the time of writing this report. The outcome will not alter the service rating as it was inspected but not rated. The Trust also took part in CQC Dynamic Monitoring Assessment conversations with the regulators.

During 2022-23 the Executive Directors engaged with CQC inspectors in a range of different ways, including attendance at quarterly engagement meetings, support for focused deep dive activities, inspection support, registration of new locations, scrutiny of findings from Trust notifications and enquiries and engagement at Trust Board meetings. The Trust reports to the Clinical Governance Committee any CQC regulatory activity undertaken with the Trust. This includes open enquiries that the Trust are actively exploring with the CQC. The Head of Accreditation and Regulation has monthly keeping in touch calls with the CQC Relationship Officer for the Trust, which were reported to the Clinical Governance Committee.

The Trust uses every opportunity for feedback in a proactive and positive way: whenever a report is received an action plan is developed with executive leadership to address the issues. Following results of the inspection in 2022 the Trust will develop, agree, implement, and monitor a detailed action plan to address the CQC conclusions. In November 2022 the CQC stood down quarterly engagement meetings with the

Executive Directors in recognition of the national demands on acute hospital providers and in keeping with their new approach to regulation. However, all other forms of engagement for the purpose of assurance have continued.

Actions taken during 2022-23 included, but were not limited to:

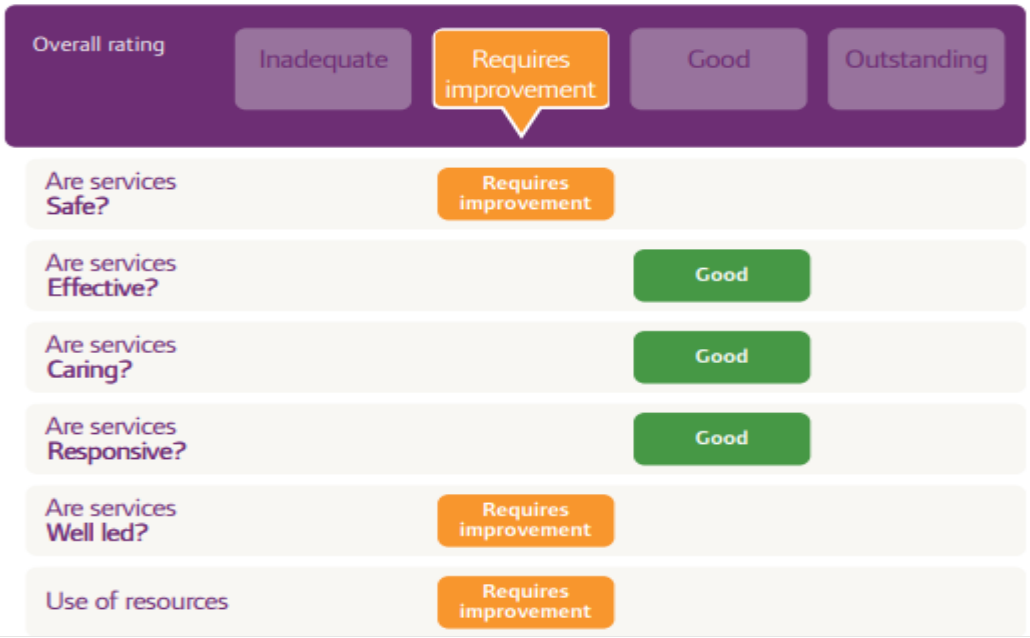
- Commissioning and delivery of phase two of the culture and leadership review for Newborn Care.
- Commencement of maternity and neonatal development programmes with implementation of local solutions.
- Continuing focus on embedding staff wellbeing aligned to the People Plan 2022-2025, with fora and initiatives to enable staff to discuss concerns.
- Quarterly engagement meetings completed with Executive Directors in May, and August 2022.
- Received positive feedback about maternity services that had been shared with our CQC Relationship Officer in April 2022.
- Held a winter pressure planning meeting in October 2022, with which our BOB ICS partners also supported as part of our system wide collaborative working approach.
- Received 61 new CQC enquiries or notifications between 01 January to 31 December 2022.
- Closure from the perspective of CQC, of the Trust CQC Maternity action plan that resulted from the unannounced inspection of maternity services in 2021. Two actions relating to estates and capital remain the subject of continuous review and focus and are monitored through existing governance processes.
- Onsite inspection and a suite of regulatory meetings to support for the successful registration of OUH Swindon Radiotherapy Centre.
- Engagement with CQC administered surveys for adult inpatients (results published Sept 2022) and maternity services (results published January 2023).
- Notification of changes to the Executive Team in accordance with regulatory requirements.

- Undertook regular notifications covering: Deprivation of Liberty Standards (DoLS) applications, section 42 activities, allegations of abuse and IR(ME)R related incidents in accordance with regulatory requirements.
- On 09 November 2022 the Trust welcomed four CQC inspectors, who undertook an unannounced inspection of the JRH Adult Critical Care Unit in response to whistleblowing concerns. The factual accuracy response has now been submitted, and the final report is awaited.
- One pharmacy engagement meeting which took place virtually in November 2022.

There are a range of areas that remain the subject of continuous review and focus for the Trust. These include statutory and mandatory training, appraisal rates, medicines management, and infection control (for example, that relate to the current Requires Improvement (RI) rating in the ‘safe’ category). In addition, the Trust has continued to work on actions in relation to the national waiting time standards that relate to the current RI rating in the ‘responsive’ category.

CQC ratings grid as published in the reports June 2019 and September 2021 are provided in the following pages for each site

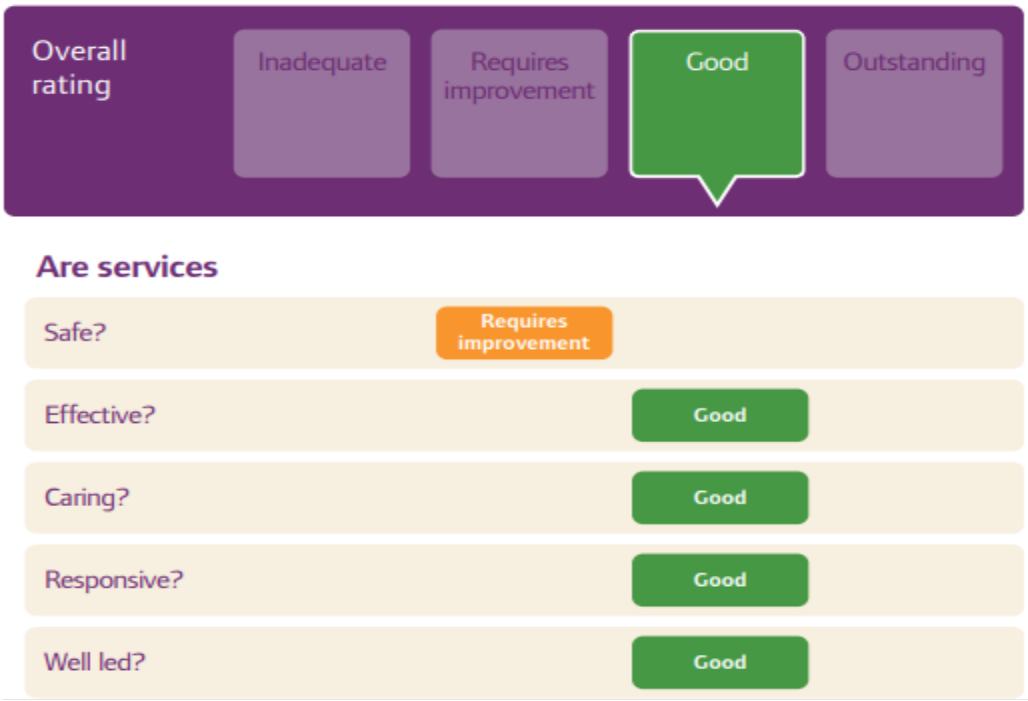
Ratings for John Radcliffe Hospital: last rated September 2021



Picture 2: CQC Ratings for John Radcliffe Hospital: last rated September 2021 part 1.

Picture 3: CQC Ratings for John Radcliffe Hospital: last rated September 2021 part 2.

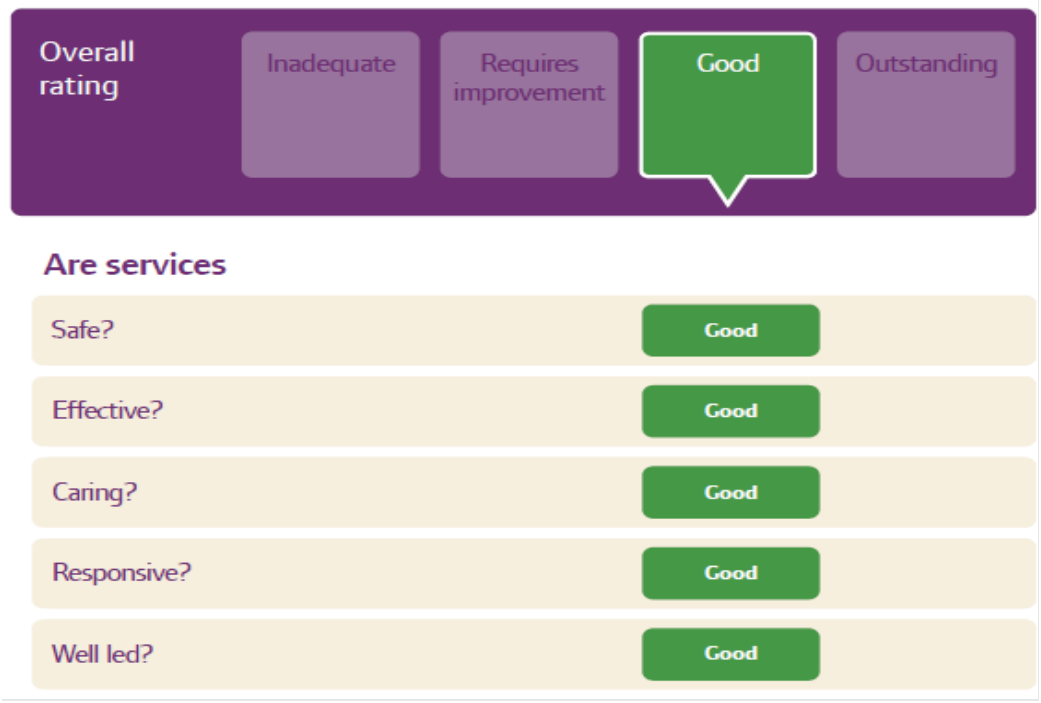
Ratings for Horton General Hospital: last rated June 2019



Picture 4: CQC Ratings for Horton General Hospital: last rated June 2019 part 1.

Picture 5: CQC Ratings for Horton General Hospital: last rated June 2019 part 2.

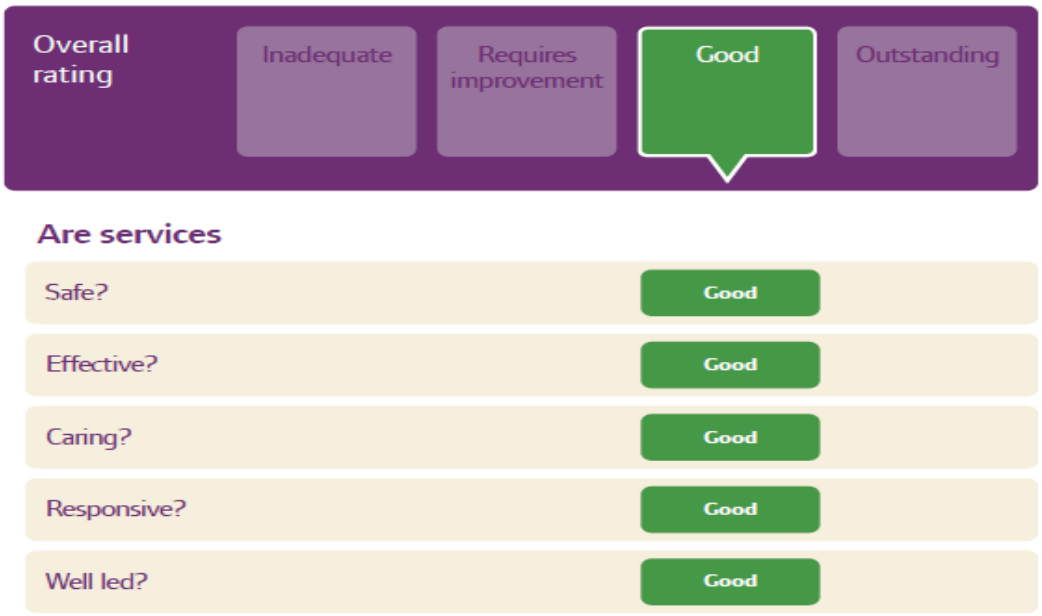
Ratings for Churchill Hospital: last rated June 2019



Picture 6: CQC Ratings for Churchill Hospital: last rated June 2019 part 1.

Picture 7: CQC Ratings for Churchill Hospital: last rated June 2019 part 2.

Ratings for Nuffield Orthopaedic Centre: last rated June 2019



Picture 8: CQC Ratings for Nuffield Orthopaedic Centre: last rated June 2019 part 1.

Picture 9: CQC Ratings for Nuffield Orthopaedic Centre: last rated June 2019 part 2

Our Peer Review Programme 2022-23

Internal Peer Reviews

The Internal Peer Review Programme has been running successfully at the Trust since 2014. During 2022-23 and following a period of pause due to the pandemic, the Assurance Team focused on developing and strategically planning future peer reviews and promoting the Peer Review Programme.

To support the development of the next generation of Peer Reviews, the Assurance Team carried out a surveillance exercise which included a review of performance reports, learning from previous visits, and outcomes from the OxSCA programme. The development consultation work also included intelligence received from engagement with service managers and the leadership team and data gathering from published reports.

During quarter three and four of 2022-23, a steering group was formed with subject matter experts and theatre specialists to plan and design a peer review tool which specifically focuses on Theatres as the next phase of the Peer Review Programme.

To facilitate the promotion of the Peer Review, August 2022, a Quality Conversation Event took place in conjunction with the Clinical Governance Team and the presentation of the Quality Priorities. The Peer Review presentation included video interviews recording the experiences of peer review from different perspectives. The videos included Clinical and Non-Clinical staff, patient representatives and Executive and Non-Executive Directors. The event was promoted on the Trust social media platforms and was well received from the attendees.

Accreditation, Regulation and Reviews (External Reviews)

The accreditation, regulation and national peer review programme of external oversight, resumed gradually in 2022-23 following the pause from the Covid-19 Pandemic. A blend of on-site visits, inspections, remote reviews, audits and National peer review programmes resulted in the activity summarised as follows:

CLEFT Palate Peer Review

A deep dive review of Spires Cleft Service took place in March 2022. A final report was shared with the Trust which identified some areas for improvement.

The National Early Inflammatory Arthritis Audit (NEIAA)

The Trust took part in the National audit, which aims to improve the quality of care for people living with inflammatory arthritis. The data was reviewed in June 2022 and resulted in four recommendations.

Neonatal Infection Prevention and Control Peer Review

An inspection of the Neonatal service was carried out by NHSE and UKHSA in December 2022, which resulted in eight recommendations.

UKAS (United Kingdom Accreditation Service) Microbiology ISO15189:20112

An inspection of Microbiology took place in April 2022 following a significant delay. Following the inspection there were twenty-two actions and five recommendations from the visit.

Accreditation for Clinical Immunology

An accreditation visit covering Quality in Primary Immunodeficiency Services (QPIDS) took place in May 2022. Following the assessment, the service has met the accreditation standards and has been awarded accreditation.

Lloyd's Register (LRQA) – Radiotherapy and ISO9001:2015

An audit to assess the compliance of the quality management system and recertification inspection visit for ISO 9001:2015 was carried during June 2022.

There was objective evidence seen to show that the department have maintained their controls on the Quality Management System and therefore re-certification is recommended to ISO 9001:2015.

There was also good evidence to show that the Swindon site has achieved the required standard and will be added to the certificate as an additional location.

SEND (Special Education Needs and Disability) Pilot Inspection

The Assurance Team and Electronic Patient Records team supported the Children's Directorate during a pilot of 'Special Education Needs and Disability' (SEND) inspection methodology. This activity was a joint venture between the Care Quality Commission and Ofsted, with all activities taking place between June and July 2022.

The results have been used to inform process.

Environmental Agency Inspection

An inspection by the Human Tissue Authority for the renewal of the Trust Post-mortem Licence was carried out in July 2022. The Licence for Post-mortem was maintained following the inspection, which resulted in both major and minor findings, which are being progressed.

Osteosarcoma Cellular Pathology

The Cellular Pathology NOC site osteosarcoma service was assessed in November 2022. As a result, there were 16 findings reported to the trust and evidence to clear the findings was submitted in January 2023

UKAS Microbiology

UKAS Biochemistry were re-accredited in quarter three of 2023 with no major or minor findings reported and continued compliance.

Human Applications Licence (Human Tissue Authority)

An inspection of the Oxford Cell and Tissue Bank (OCB) was carried out in quarter three by the Human Tissue Authority (HTA). There were three major findings from the report and a CAPA plan was submitted to the HTA in February 2023, outlining how these will be addressed.

PLACE (The Patient Led Assessment of the Care Environment) Based Review

The Trust undertook the national Patient Led Assessment of the Care Environment (PLACE) between October 2022 and January 2023. All communal and external areas, 10 meal services, 27 wards and 13 outpatient departments were assessed across the Trust. Overall, the assessors found the Trust to be clean and well cared for, and they were confident in the environment providing a good experience of patient care.

Oxfordshire Safeguarding Children's Board (OSCB) and Oxfordshire Safeguarding Adults Board (OSAB)

An annual self-assessment and peer review delivered by the Local Authority and Oxfordshire Safeguarding Children and Adults Boards was completed in December

2022. OUH have achieved the full level of compliance in the OSCB/OSAB review.

Southeast Paediatric Spinal Quality Service Review

The quality service review took place in NOTSSCaN Division in January 2023. The outcomes of the visit are in the process of being addressed.

Clinical Trials Aseptic Service Unit Audit (CTASU)

An audit by regional Pharmacy Specialist Quality Assurance service, under EL97(52) for an unlicensed aseptic unit was carried out in February 2023. The audit reviewed the aseptic preparation of medicines carried out at the Churchill Hospital, Pharmacy, Clinical Trials Aseptic and no deficiencies were found.

Data quality & Information Governance

A vital pre-requisite to robust governance and effective service delivery is the availability of high-quality data across all areas of the organisation. This underpins the effective delivery of patient care and is essential to both improvements in the quality of care and for patient safety. We are committed to pursuing a high standard of accuracy, timeliness, reliability and validity, within all aspects of data collection in accordance with NHS data standards and expect that every staff member seeks to achieve these standards of data quality.

Oxford University Hospitals NHS Foundation Trust will be taking the following actions to improve data quality and information governance:

- A review of the tools used to audit and track access to the Electronic Patient Record and other Digital systems is under way.
- Improvements to our process for responding to requests made under the Freedom of Information Act has resulted in a significant improvement of response rates and times, and as a result we are now in a position to regularly meet the mandated target of answering 80% of requests within 20 working days.
- A new Data Quality Operational Management Group has been established to oversee and monitor the quality and completeness of information and identify and set standards and targets for ensuring data quality and completeness supports delivering safe, high quality and efficient care to patients and a positive experience for OUH staff.

Data Security and Protection Toolkit

Oxford University Hospitals NHS Foundation Trust's submission of the Data Security and Protection Toolkit for the most recent reporting period of 2021-22 reported an overall assessment of "Standards Met", which was agreed by NHS Digital. This provides significant assurance to other parties who may wish to share data with us. Baseline submission for 2022-23 does not result in a formal rating of the Trust's data

security performance against Data Protection Toolkit (DPT) standards but is undertaken to demonstrate that work is ongoing in completing the Toolkit.

The final submission is made on 30 June 2023, and we are again working towards achieving “Standards Met”.

Records submission

Oxford University Hospitals NHS Foundation Trust submitted records during 2022-23 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data shows.

SUS dashboards month 12 2022-23

The table shows the information by inpatients, outpatients and A&E demonstrating OUH compliance compared to the national average.

Inpatients	**OUH**	**National average**
Valid NHS number	99.5%	99.6%
General Medical PracticeCode	100%	99.7%
Outpatients	**OUH**	**National average**
Valid NHS number	99.8%	99.8%
General Medical PracticeCode	100%	99.5%
A&E (type 1 only)	**OUH**	**National average**
Valid NHS number	98.7%	98.8%
General Medical PracticeCode	100%	99.2%

Table 26: The information by inpatients, outpatients and A&E demonstrating OUH compliance compared to the national average.

Payments by Results (PbR)

OUH was not subject to the Payment by Results (PbR) clinical coding audit during 2022-23 by the Audit Commission.

Learning from Deaths

During 2022-23, 2,719 OUH patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period.

The table below shows number of deaths that occurred in the Trust reviewed by quarter and the total number of deaths.

Total number of deaths 2022-23	Quarter 1 2022-23	Quarter 2 2022-23	Quarter 3 2022-23	Quarter 4 2022-23
2,719	659	682	759	619

Table 27: The number of deaths that occurred in the Trust reviewed by quarter and the total number of deaths.

The table below shows the number of case record reviews by quarter and the number of deaths judged more likely than not to have been due to problems in care.

	Quarter 1 2022-23	Quarter 2 2022-23	Quarter 3 2022-23	Quarter 4 2022-23
Number of case record reviews (Level 2 comprehensive mortality review or 1 structured review)	321	269	321	Will be reported in Quality Account 2023-24
Number of deaths judged more likely than not to have beendue to problems in care	0	0	0	Will be reported in Quality Account 2023-24

Table 28: The number of case record reviews by quarter and the number of deaths judged more likely than not to have been due to problems in care.

By 31 March 2023, a total of 2026 case record reviews had been carried out in relation to 2,100 deaths that occurred until the end of Q3 2023. No death, representing 0.00% of 2,100 of the patient deaths during the reporting period, was judged to be more likely than not to have been due to problems in the care provided to the patient. Quarter 4 data will be included in the 2023-24 Quality Account. The reviews of deaths which occurred during the fourth quarter 2022/23 are underway and the summary will be included in the next Quality Account. These

numbers have been compiled using the quarterly Divisional mortality reports submitted to the Trust Mortality Review Group.

Summary of some of the learning and impact of actions from case record reviews & investigations

Work continues to improve oxygen prescribing compliance. Safety messages in relation to this have been shared across the organisation.

The importance of accurate DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) endorsement on Electronic Patient Record (EPR) has also been highlighted, particularly when a patient is readmitted. A trust level safety message was issued in response to this.

Work continues to ensure Venous Thromboembolism (VTE) assessments are completed and reviewed according to Trust guidelines. Compliance is monitored monthly via the Clinical Governance Committee. Each clinical area is responsible for reviewing compliance with issues raised at local governance meetings and the implementation of an action plan if required.

Reminders have been disseminated via Divisional governance meetings and safety huddles to clinical teams regarding the importance of communication and updating of families when a patient's clinical status changes. This is particularly important when a patient has deteriorated and is likely to die.

The importance of accurate record keeping has been highlighted, including not 'copying and pasting' from previous entries in the electronic patient record, which can lead to errors and confusion if the clinical picture changes. This learning has been cascaded via safety huddles and organisation level safety messages.

Earlier referral to the palliative care team to optimise pain control was highlighted by the spinal team following completion of one structured mortality review. The palliative care lead has met with ward staff in several areas to raise the importance of this and support and educate staff on palliative care referrals.

An issue has been raised with the current use of systems for completing mortality reviews. When an electronic level 1 review is completed, and further review (Level 2 or Structured Judgement Review (SJR) is required it was noted that the system does

not automatically flag these cases. Systems are now in place to ensure that deaths requiring further review are identified. This is monitored at the monthly Mortality Review Group meetings.

The vital role of Hospital Passports for patients with Learning Disabilities has been highlighted at Mortality Review Group, as a source of guidance regarding support structures important to the individual. These documents provide a snapshot of the patient to underpin assessment of normal behaviors and coping mechanisms as well as guidance regarding appropriate interventions. This issue has been highlighted and shared across the Trust in the quarterly governance newsletter.

The quarterly and annual Learning from Deaths reports are presented to the Trust Board and are available online - Board meetings and papers - Oxford University Hospitals (ouh.nhs.uk)

Case record reviews and investigations from Quarter 4 of 2021-22

During Quarter 4 of 2021-22 there were 684 inpatient deaths reported at OUH. 98% (672) cases were reviewed within 8 weeks. Of these reviews, there were 320 (47%) comprehensive Level 2 reviews and 13 (2%) structured mortality reviews completed. None of the patient deaths representing 0% of 684 reviewed from the fourth quarter of 2021-22 were judged to be more likely than not to have been due to problems in the care provided to the patient. These numbers have been estimated using the quarterly Divisional mortality reports submitted to the Trust Mortality Review Group.

Care at the end of life

During 2022-23, 2,657 adults over 18 years of age died in OUH. Providing care at the end of a person's life is an important part of the provision of healthcare. Work this year to improve care at the end of live has included:

a. An End-of-Life Care (EOLC) lead was appointed in February 2022. This post is funded by Sobell House Hospice Charity for 2.5 years.
b. The 'What to expect when someone is dying in hospital' leaflet was updated and republished. It is available to all staff (intranet) and families (Trust

website).

c. An audit of care at the end of life for those dying of Parkinson's disease was conducted, learning identified, and teaching opportunities used to spread better practice.

d. A survey of prescribing of continuous subcutaneous infusions (CSCI) via syringe drivers was conducted on the Surgical Emergency Unit (SEU), learning identified and presented at Surgical Emergency Unit (SEU) governance.

The National Audit of Care at the End of Life (NACEL) reported February 2023.

Description	National summary score	Submission summary score
Communication with the dying person	8.0	9.4
Communication with families and others	7.1	9.4
Involvement in decision making	9.2	9.6
Individual plan of care	7.6	8.2
Needs of families and others	5.5	6.0
Families' and others' experience of care	6.3	6.8
Workforce/specialist palliative care	8.1	5.0
Staff confidence	7.5	7.3
Staff support	7.1	6.9
Care and culture	7.6	7.6

Table 29: The National Audit of Care at the End of Life (NACEL) reported February 2023

- The care of patients in OUH continues to benchmark above the national score (first four rows).
- The care of families and others is also benchmarked above the national score but is much less good than we aspire to (6.0 and 6.8). Staff must include those important to the patient in conversations and enquire about their needs.
- The workforce score remains below the national score (5.0) because of the lack of face to face 7 days a week palliative care team presence in Churchill Hospital, Nuffield Orthopaedic Centre and Horton hospital.

Staff confidence, staff support, and 'care and culture' scores are broadly in line with national scores. However, 40% of staff who responded had not had any education and training in providing care at the end of life in the previous 3 years. OUH recognizes the need to move toward ensuring all staff are fully equipped to care for patients at the end of life.

2.3 Reporting against core indicators

Reporting against core indicators

Indicator	Measure	Current period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source
Summary Hospital level Mortality Indicator (SHMI)	Ratio of observed mortality as a proportion of expected mortality	January 2022-December 2022	0.96 *(CL[1] 0.90-1.1)*	January 2021-December 2021	0.92 *(CL[1] 0.90-1.1)*	1.19	0.70	1.00	NHS Digital
	Percentage of patient deaths with palliative care coded at diagnosis	January 2022-December 2022	55.58%	January 2021-December 2021	52.55%	N/A	N/A	N/A	NHS Digital
The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period	No. (rate per 1,000 bed days)	financial year 2021-2022 (Data for 2022-23 is not yet available from the national body)	18,123	financial year 2020-2021	14,259	49,603	3,441	14,368	NRLS (The National Reporting and Learning System)

Indicator	Measure	Current period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source
The number and percentage of such safety incidents that resulted in severe harm or death	No. (rate per 1,000 bed days)	financial year 2021-2022 (Data for 2022-23 is not yet available from the national body)	120	financial year 2020-2021	123	216	3	55	NRLS (The National Reporting and Learning System)
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period		financial year 2022-2023	98.1%	financial year 2021-2022	98.2%	N/A	N/A	N/A	ORBIT
Clostridium difficile cases	Target ≤104	financial year 2022-2023	141	financial year 2021-2022	107	N/A	N/A	N/A	ORBIT
Percentage of patients readmitted within 28 days of being discharged	Readmissions data	October 2021 to September 2022	10.6%	October 2020 to September 2021	9.2%	16%	3.1%	10.7%	Dr Foster
Trust's responsiveness to	Score out of 10 trust wide	2021	7.1	2020	7.4	8.5	6.3	7.1	CQC Inpatient

Indicator	Measure	Current period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source
the personal needs of its patients: • To what extent did staff looking after you involve you in decisions about your care and treatment?									Survey 2021.
• Did you find someone on the hospital staff to talk to about your worries and fears?	Score out of 10 trust wide	2021	7.9	2020	8.1	9.2	6.4	7.6	CQC Inpatient Survey 2021.
• Were you able to discuss your condition and treatment without being overheard?	Score out of 10 trust wide	2021	6.8	2020		9.3	5.3	6.3	CQC Inpatient Survey 2021.
• Thinking about any medication you were to take home, were you given any of the following?	Score out of 10 trust wide	2021	5.2	2020	5.3	6.2	3.6	4.6	CQC Inpatient Survey 2021.
Did hospital tell you whom to contact if you were worried about your condition or	Score out of 10 trust wide	2021	8.5	2020	8.8	9.7	6.2	7.6	CQC Inpatient Survey 2021.

Indicator	Measure	Current period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source
treatment after you left hospital?									
Staff employed by, or under contract to the Trust who would recommend the Trust as a provider of care to their family or friends	% (If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation)	2022	74%	2021	78%	Not Applicable	Not Applicable	Not Applicable	NHS National Staff Survey

Table 30: Reporting against core indicators.

Notes:

CL - Confidence Limit.

Summary Hospital-level Mortality Indicator (SHMI)

The Summary Hospital-level Mortality Indicator (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.

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 NHS Digital via the Secondary Uses Service (SUS). The SHMI is then calculated by NHS Digital.
- Data are compared to the national benchmark, and our own previous performance, as set out in the table overleaf.
- The Trust reviews the SHMI in conjunction with other published mortality measures and the information from our internal review of deaths.

The SHMI, published on 28 April 2023, for the data period January 2022 to December 2022, is 0.96. This value is banded 'as expected' using NHS Digital 95% confidence intervals adjusted for over-dispersion. The Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) confirmed that the Trust continued to compare favourably with national mortality benchmarks. This means that there were fewer deaths than expected using the rate predicted for the hospital.

OUH is unusual as an acute Trust in incorporating two hospices (Sobell House and Katherine House Hospice). Since benchmarked acute hospital Trusts do not have embedded hospices, this impacts on the reported SHMI. NHS Digital are working on a solution to report OUH SHMI without hospice data. This has already been done for the Hospital Standardised Mortality Ratio (HSMR). Including the two hospices, the HSMR for OUH is **92.8** for February **2022 to January 2023**. The HSMR has decreased and remains banded as '**lower than expected**' (95% CL 90.9 – 99). The HSMR for February **2022 to January 2023**. without Hospice data is 84.5. Once available, we

aim routinely to report the OUH SHMI both with and excluding hospice data.

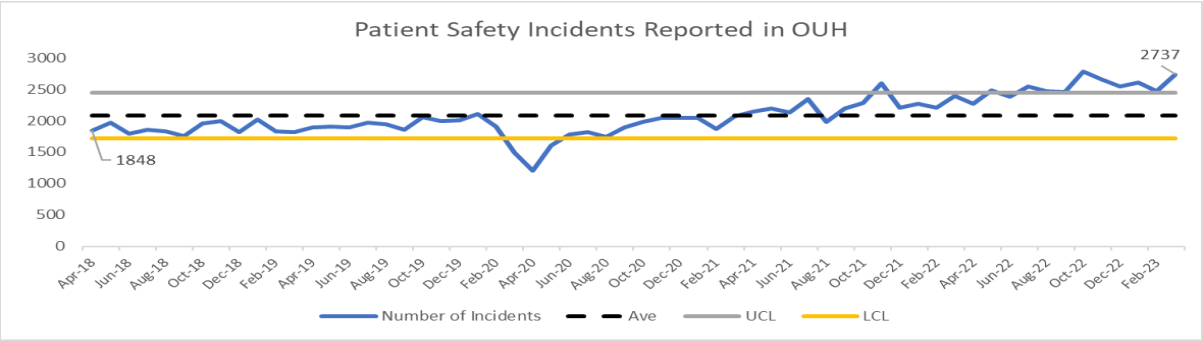
Our Trust target is for 100% of patient deaths to be reviewed to ensure that any omissionsor actions taken are identified and learnt from to improve care. An analysis of the mortality reports for April 2022 to December 2022 indicate that 96% of deaths were reviewed withineight weeks. All the outstanding reviews have since been completed.

Safety Incidents & Serious Incidents Requiring Investigation

All Incidents

It is crucial that we learn from every incident and near miss that happens, to address concerns and continually learn. OUH actively encourages staff to report clinical incidents and near misses so that lessons can be learned in order to improve 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). Graph 2 below shows the number of patient incidents reported per month by OUH since April 2017, which has been above the mean of 2072 for the past 18 months. The number of incidents reported has seen a rising trend.

There was a reduction in the expected rate of incident reporting in April to June 2020, reflecting the cancellation of elective surgery and some outpatient activity as the Trust changed its clinical focus to concentrate on the COVID-19 pandemic.



Graph 2: The number of patient incidents reported per month by OUH since April 2017

Trusts across England upload data relating to patient incidents reported locally to the National Reporting and Learning System (NRLS) to allow NHS England to view

incidents and to identify trends at a national level. This also allows trusts to benchmark the data with similar trusts.

The Trust reports externally all unintended or unexpected incidents which could or did lead to harm via the NHS National Reporting and Learning Service. Table shows that the number of patient safety incidents and the number of incidents confirmed to have entailed severe impact or death (the data for 2022-23 is not yet available from the national body).

	2017-18	2018-19	2019-20	2020-21	2021-22
Number of patient safety incidents	**17,002**	**17,202**	**18,188**	**14,259**	**18,123**
National average (acute non-specialist trust)	10,714	11,338	12,724	12,547	14,368
Highest reporting trust	31,007	45,740	44,025	37,572	49,603
Lowest reporting trust	2,444	1,844	3,444	3,169	3,441
Number of patient safety incidents that resulted in severe harm or death	**16**	**30**	**59**	**123**	**120**
National average (acute non-specialist trust)	37	37	39	55	58
Highest reporting trust	220	159	183	261	216
Lowest reporting trust	0	1	1	4	3
Percentage of patient safety incidents that resulted in severe harm or death	**0.09%**	**0.17%**	**0.32%**	**1.00%**	**0.66%**
National average (acute non-specialist trust)	0.37%	0.36%	0.34%	0.50%	0.42%
Highest reporting trust	1.76%	1.35%	1.44%	2.80%	1.70%
Lowest reporting trust	0.00%	0.01%	0.01%	0.03%	0.03%

* As per the NRLS definition.

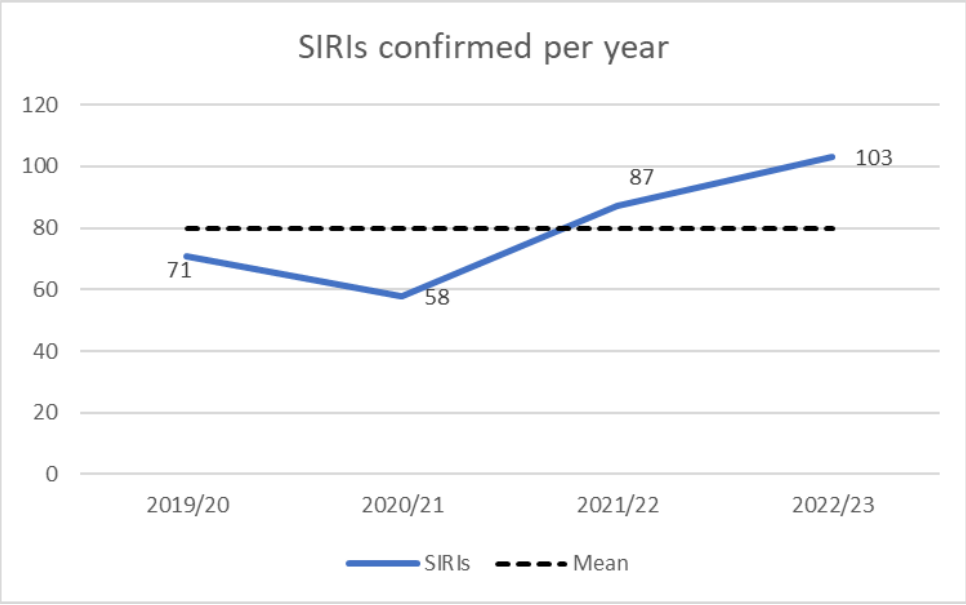
Table 31: The number of patient safety incidents and the number of incidents confirmed to have entailed severe impact or death.

In addition to the review of all incidents by senior staff in each department, all incidents reported with Moderate or above impact are reviewed each working day in a Patient Safety Response meeting, to confirm what immediate steps need to be taken or what information is required to be collected, as well as identifying whether any extra support is required for the staff involved. In 2022-23 our staff reported 30,393 patient safety incidents and near misses, 70.87% resulting in no impact or minor impact, 4.04% resulting in moderate impact, 0.19% resulting in major impact, and 0.25% with an impact of death (the management of deaths in the Trust is discussed above). All impact gradings ae confirmed through the Trust's incident

management process and follow the National Reporting & Learning System guidance.

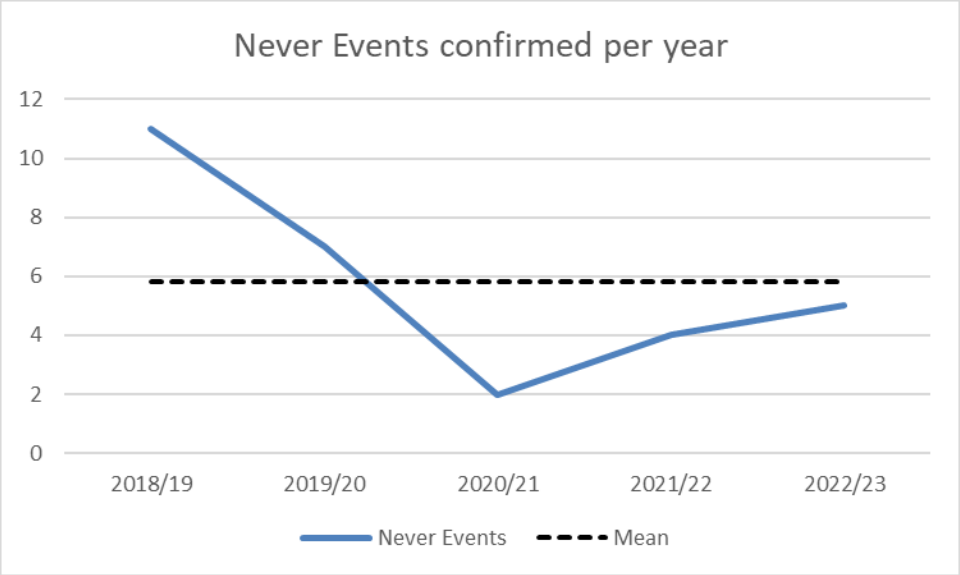
Serious Incidents Requiring Investigation (SIRIs)

Graph 3 below shows the number of SIRIs called over the past 4 financial years, excluding subsequent reclassifications agreed with the ICB. In line with national guidance SIRIs are reported to a national database and an in-depth investigation is completed to identify learning and any actions. Every investigation is shared with our commissioners for review on completion and offered to the patient involved or their next-of-kin. The number of SIRIs reported has risen 18% from the previous financial year and is 23 above the 4-year mean. It should be noted that this mean has been impacted by 2020-21, which saw a drop in incidents and the SIRIs identified against them, because of the reduction in clinical activity. Some of the 2022-23 SIRI investigations are ongoing, and so it is possible that further reclassifications will be agreed.



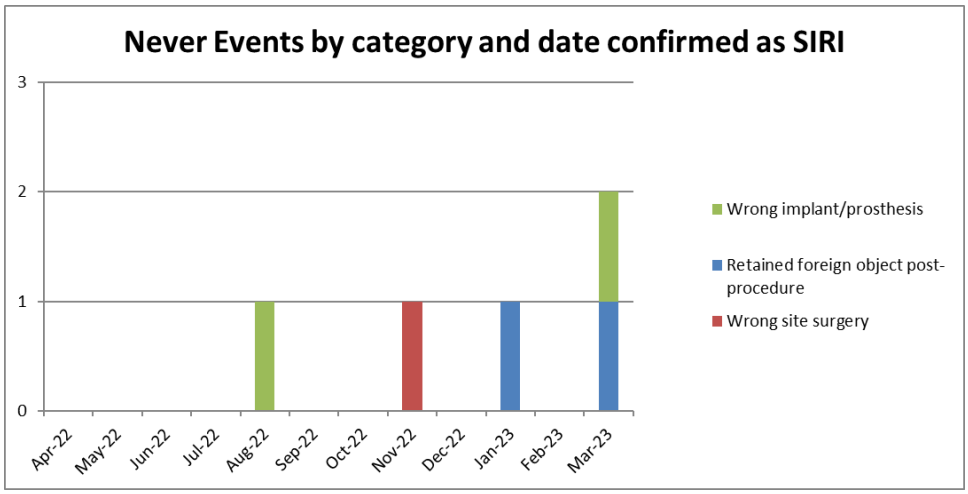
Graph 3: SIRIs confirmed per year.

Graph 4 below shows that the Trust reported 5 Never Events in 2022-23, which is the 4-year mean. Never Events are a sub-group of the SIRIs defined by criteria published by NHS England.



Graph 4: Never events confirmed per year

Graph 5 below shows the categories of the Never Events identified.



Graph 5: Never Events by category and date confirmed as SIRI

Patient Safety Incident Response Framework (PSIRF)

PSIRF sets out new guidance on how NHS organisations respond to patient safety incidents and ensures compassionate engagement with those effected. It supports key principles of a patient safety culture, focusing on understanding how incidents happen, rather than apportioning blame, allowing for more effective learning and ultimately safer care for patients. The Trust is in process of implementing PSIRF in line with the NHS timetable for national roll out of PSIRF.

You can find out more about PSIRF on the NHSE website NHS England » Patient Safety Incident Response Framework where a helpful short video can be found explaining PSIRF and its aim.

Venous thromboembolism (VTE)

The Trust has met and exceeded the 95% target for VTE risk assessment (RA) of patients for 2022-23. The thrombosis teams continue to provide robust assurance for these figures with ongoing rolling audit, discussion of incidents at SIRI and feeding back data from GIRFT to all hospital departments.

Highlights of the new work the VTE Prevention and Anticoagulation Teams have conducted in 2022-23 include:

1. **Feedback to staff:** Compliance figures for the VTE Prevention and Anticoagulation 'My Learning Hub' packages are sent by the SME quarterly to clinical risk practitioners and divisional leads and have been incorporated into the accreditation in OxSCA.
2. **Palliative care work package:** There is ongoing collaborative work with the Palliative Care team regarding VTE Prevention and Anticoagulation in the end-of-life patient; this will include modification to the exiting electronic VTE RA to support decision making in palliative care pathway.
3. **Lower limb immobilisation work package:** The VTE prevention team are working towards an electronic risk assessment tool for patients with lower limb immobilisation/plaster casts; and harmonising clinical practice across the OUH with a more robust audit process being put in place for the new NICE quality standard.
4. **Peri-operative anticoagulation safety work package:** There is a revised peri-procedure guideline for Interventional Radiology and the peri-operative anticoagulation guidance is now integrated into the peri-operative WHO checklist. A new endoscopy guideline also encompasses the peri-operative Medicines Information Leaflet (MIL). A patient information leaflet (PIL) has been finalised for patients on Warfarin undergoing a procedure or surgery who require bridging therapy.

5. **Cardiology Quality Improvement Project work package**: to improve the data held by the Oxfordshire Anticoagulation Service for patients with mechanical heart valves continues. The valve type and/or position has been updated for 175 patients where this was previously unknown, enabling the service to provide improved quality of care for this patient group. We are now in the second phase – which involves investigating inappropriate International Normalised Ratio (INR) ranges and ensuring these data are available on EPR to clinicians.
6. **Patient education:** The team has developed patient education videos: 'What to expect at a DVT diagnostic clinic appointment' and 'What to expect from your Warfarin'. Found here: https://www.youtube.com/watch?v=I0RUK1eEaJQ

Infection Prevention and Control

Oxford University Hospitals NHS Foundation Trust considers that these data are as described for the following reasons:

- The Trust has a process in place for collating data on *C.difficile* and MRSA cases.
- Data are collated internally and submitted on a daily basis to UK Health Security Agency (UKHSA).

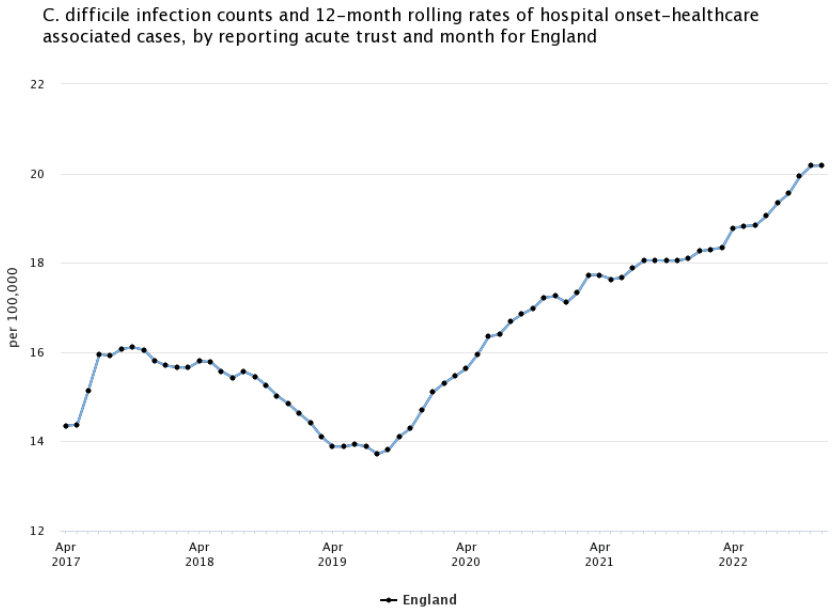
Clostridium difficile

Each year NHSE assigns the Trust an upper ceiling of *C. difficile* cases.

The threshold for OUH apportioned cases of C. difficile for 2022-23 has been set at 104 cases. The threshold does not consider any changes in case mix or Trust activity. This was raised by the OUH DIPC with NHSE who have taken this forward together with UKSHA as a working group to look at the methodology for calculating thresholds and how metrics around activity could be incorporated. No progress noted to date. At the end of the financial year March 2023, the Trust is reporting a total of 141 healthcare associated cases (hospital onset, healthcare associated, and community onset healthcare associated see appendix 1 for definitions).

The trajectories set for healthcare associated C. difficile infection (CDI) and E. coli blood stream infection (BSI) were both exceeded this year. These figures are not corrected for OUH activity. When corrected by number of discharges, the number of CDI cases is very similar to 2020/21 (0.0084 cases/discharge), with 2021/22 being lower at 0.0064 cases/discharge, and the current year 0.0082 cases/discharge. The winter period was especially challenging in terms of the management of SARS-CoV-2 infection, Group A Streptococcus and influenza at the same time, and we saw an increase in sepsis alerts and consequent antimicrobial prescribing which is the main risk factor for C. difficile infection. A number of interventions designed to improve infection prevention and control and the clinical management of patients with diarrhoea were introduced at the beginning of Q4 which will take time to produce results. These were communicated to the Trust staff via Safety messages, guideline updates, and updates on MicroGuide. Antimicrobial stewardship (AMS) rounds at the Churchill hospital continue to correlate with low CDI rates on that site and AMS rounds are currently being introduced on all Trust sites. The national picture is similar; when comparing the October to December 2022 with October to December 2019 (prior to the first wave of the COVID-19 pandemic) hospital-onset CDI cases increased by 24.2% from 14.4 to 17.9 cases per 100,000 bed-days. The national increase is currently being explained by system pressures, and work is on-going both across the ICB and nationally to look at any other possible contributory factors.

There are no clear themes or interventions to reduce the rate of rise of E. coli infections. The changes in patient demographics with an ageing population (18.6% of the total population were aged 65 years or older in the 2021 census compared with 16.4% at the time of the previous census in 2011) and more people at risk because of comorbidity or treatment such as immunosuppression are likely to contribute to the increase. The nationally set trajectories for Klebsiella spp. BSI and Pseudomonas aeruginosa BSI were met.



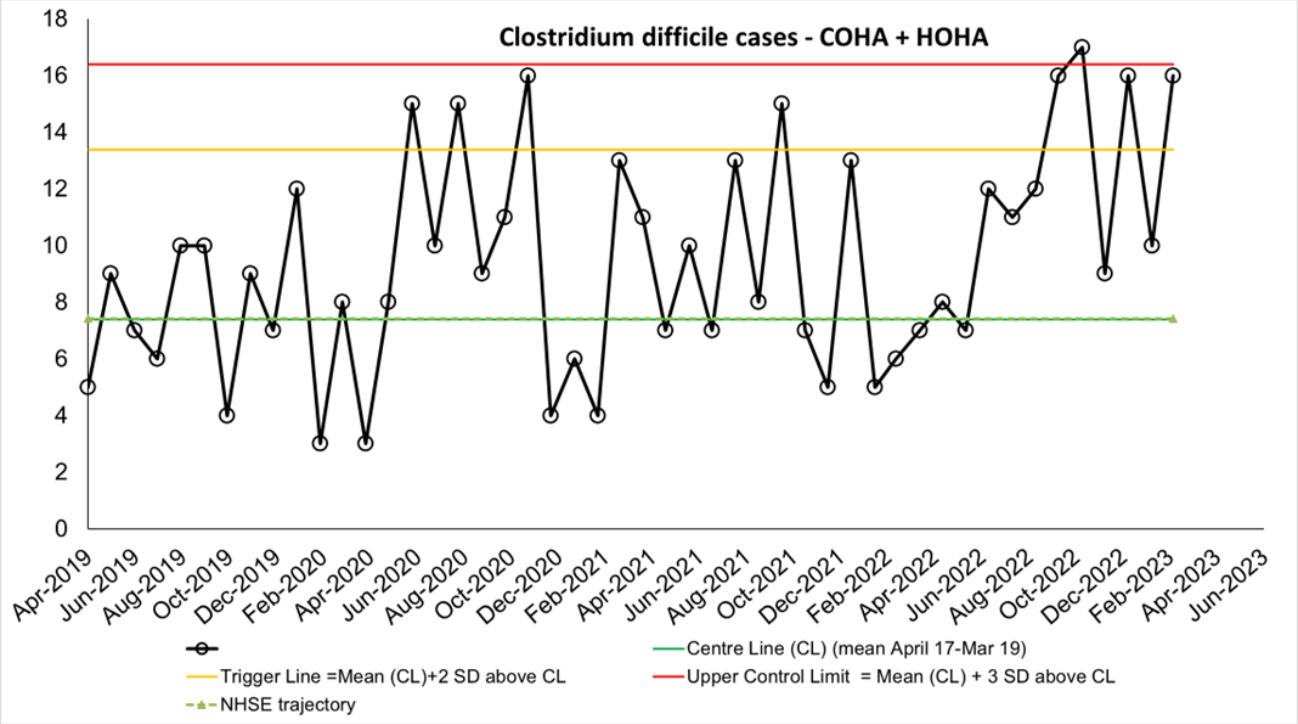
Graph 6: C.difficile infection counts and 12-mont rolling rates of hospital onset-healthcare associated cases, by reporting acute trust and month for England

During 2022-23 Oxford University Hospitals NHS Foundation Trust implemented a number of actions to improve this indicator, and thereby the quality of our services. The impact of these changes is likely to take several months.

- It is now Trust policy to isolate symptomatic patients that are toxigenic strain positive (TS) but faecal toxin (FT) negative. A Safety Message was released in December to remind staff of the importance of avoidance of C. difficile infection, early diagnosis and management, and to communicate the changes
- Laboratory comments on positive samples and MicroGuide have been updated to reflect these changes.
- C. diff pop-up created on EPR to remind people to request C. diff if suspecting C. diff and sending a faecal sample.
- Ward training on cleaning of commodes/review of enhanced cleaning requests. All commodes and bedpans now to be cleaned with sporicidal wipes.
- Attendance at NHSE national meeting in early December to review the national increase in C. diff numbers. The outcome from that meeting was reported as not being able to explain the 25% increase in rates to a newly emergent strain and or antibiotic prescribing.

- Spot check of the management of GDH positive but faecal toxin negative patients
- An audit of relapsed/recurrent cases from April 1st 2022 to Jan 31st 2023 showed good adherence to CDI treatment guidance on MicroGuide, with no missed opportunities to treat. Cases received fidaxomicin appropriately.

Graph 7 below shows Statistical Process Control (SPC) chart of OUH apportioned C.difficile infection counts.

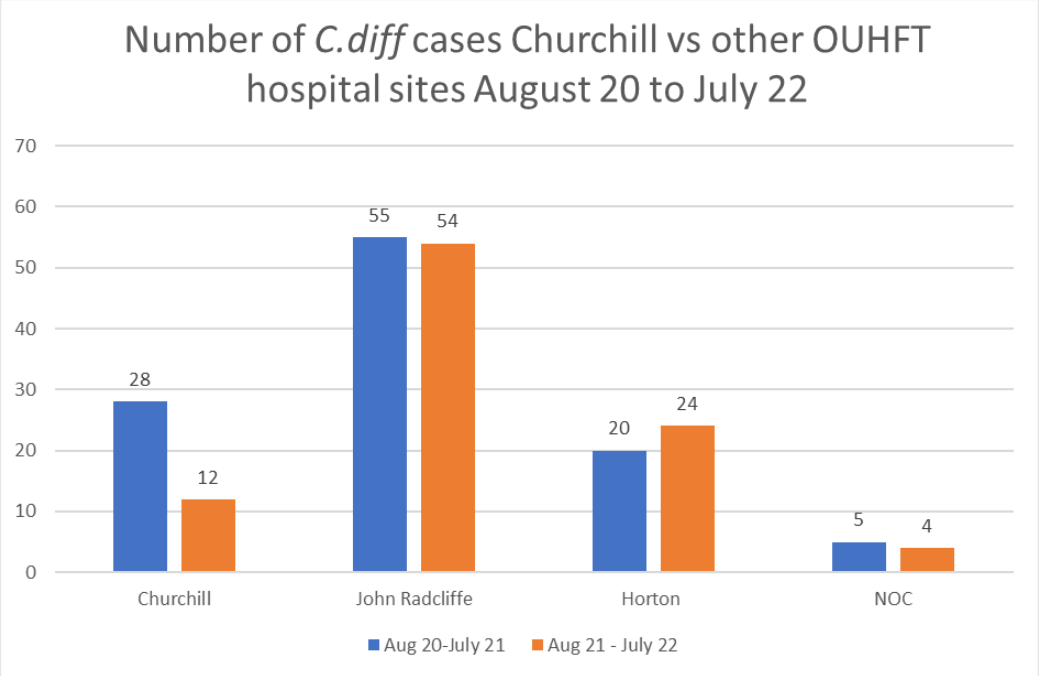


Graph 7: Statistical Process Control (SPC) chart of OUH apportioned C.difficile infection counts.

Antimicrobial Stewardship

- Regular weekly multi-disciplinary antimicrobial stewardship rounds commenced at the Churchill hospital in August 2021 and continue. The impact of the AMS rounds is reflected in:
    - Significant 4.2% decrease in broad-spectrum antibiotic in comparison with other hospital sites which has 21% increase in consumption (p-values 0.000428).
    - Decrease in the broad-spectrum antibiotic consumption in 9 out of 12 months in comparison with previous year on the Churchill site.
    - Comparing the number of *C. difficile* cases, the Churchill site shows a statistically significant reduction in annual incidence in association with

the introduction of weekly AMS rounds P = 0.008 (corrected for activity (discharges)). Graph 8 below



Graph 8: Number of C.difficile cases Churchill vs other OUHFT hospital sites August 202 to July 2022

- The data highlights that the majority of cases in 2022-23 have been on the John Radcliffe site and if the current trend continues a doubling of the HOHA (Hospital Onset Healthcare Associated*) rate for the JR site is expected. We know that the Influenza epidemic from December 2022 was associated with a rise in the number of sepsis alerts, and an increase in antibiotic usage mainly on the JR site. January and March 2023 saw a high number of HOHA cases attributable to the JR site. The impact of the changes made to the management of C. difficile in December has yet to be realised.

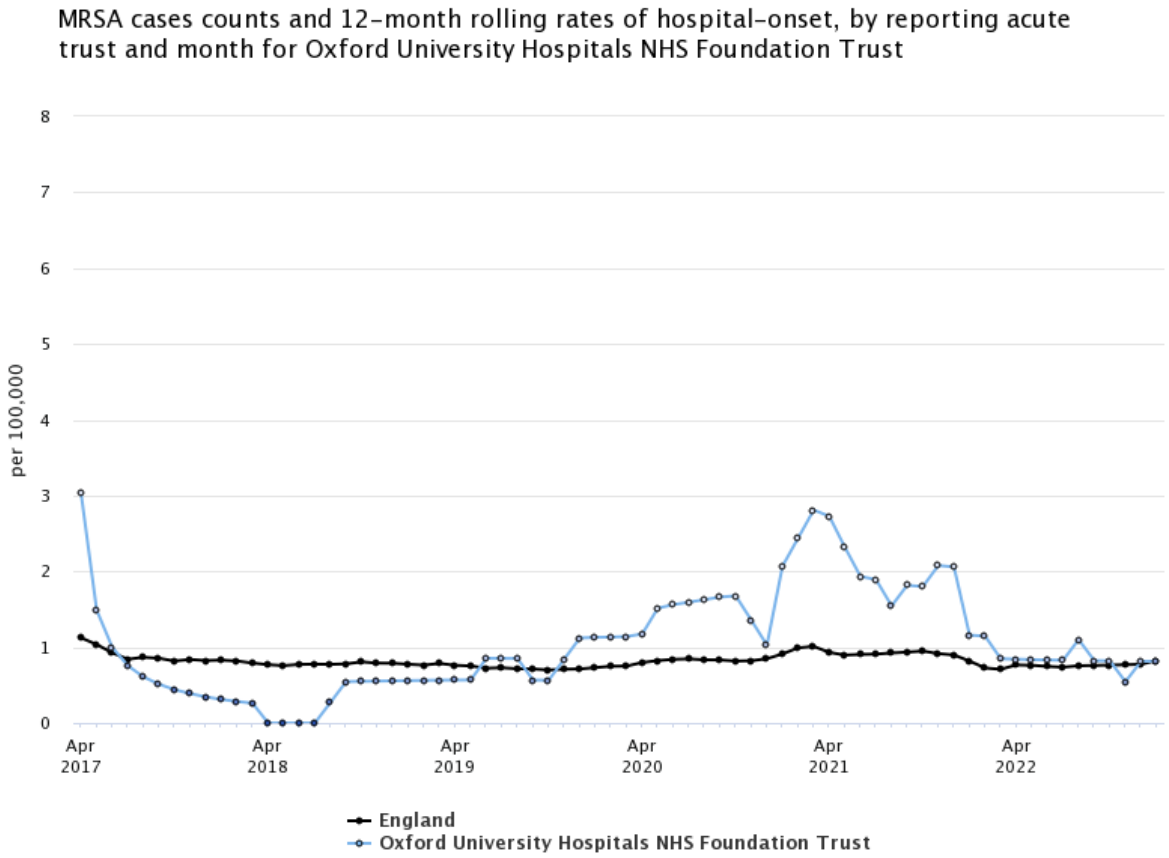
- The IPC business case to strength the establishment of the IPC nurses and antimicrobial stewardship was approved by the Trust Board, last year. The AMS team are now providing a 6-day service.

* cases detected in the hospital two or more days after admission

MRSA (Methicillin-resistant Staphylococcus aureus) Bacteraemia

For the financial year 2022-23 at the end of March there were 3 HOHA and 1 COHA (Community Onset Healthcare Associated*) cases in the OUH (2021- 22 there were 3 HOHA and 1 COHA). Numbers have stabilised back to rates comparable with other Trusts across England post-pandemic.

All cases undergo a root cause analysis and are discussed at the quarterly Health Economy meeting where learning and preventable actions, if any, are identified.



Graph 9: MRSA cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month for Oxford University Hospitals NHS Foundation Trust

***** cases that occur within community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks

Patient Reported Outcome Measures (PROMs)

PROMs are used to ascertain the outcome following planned inpatient surgery for the procedures of hip and knee replacement. 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 Trust considers that the PROMs data are as described 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 NHS Digital.
- Data are compared to peers, highest and lowest performers, and our own previousperformance, as set out in the tables.

Total hip replacement:

Year	Modelled records	Adjusted health gain	Outlier status
2016-17 final	543	12.347	Not an outlier
2017-18 final	543	12.083	Negative outlier (95%)
2018-19 final	457	14.323	Not an outlier
2019-20 final	426	14.33	Not an outlier
2020-21 final	153	11.563	Negative outlier (95%)

Table 32: Total hip replacement per year, 2016-2021

Patients are asked to complete a questionnaire before their hip replacement procedure, and again six months afterwards (to allow patients enough time to recover from the procedure). The difference between pre- and post-operative scores is the patient's self-reported health gain or improvement in health.

Total knee replacement:

Year	Modelled records	Adjusted health gain	Outlier status
2016-17 final	324	6.932	Not an outlier
2017-18 final	628	9.7	Positive outlier (95%)
2018-19 final	508	8.906	Positive outlier (95%)
2019-20 final	514	8.542	Not an outlier
2020-21 final	198	7.488	Not an outlier

Table 33: Total knee replacement per year 2016-2021

- 97% of respondents reported improvement for hip replacements.

- 94% of respondents report an improvement for knee replacements.
- At least 90% of respondents felt better after their operation.
- The majority of patients thought the results of their operation were excellent, very good or good (93% of hip replacement patients and 87% of knee replacement patients).
- Participation rates for February 2023 can be seen below were as follows:
    - 89% for hip
    - 103% for knee

Please note that in some cases the participation rate figure can be over 100%. If this is the case, it may reflect an increase in clinical activity over and above that recorded by Hospital Episode Statistics (HES). There could be a variety of reason for this, e.g. an increase in referrals; or bringing activity that as formerly attributed to Independent Hospitals in-house.

The Trust takes the following actions to improve the PROMs, and so the quality of its services.

- The Orthopaedic Unit reviews the PROMs responses and presents this to the Trust Clinical Improvement Committee (CIC).
- If there are negative responses identified in the PROMs returns, these are reviewed by the Orthopaedics Unit to determine if actions are requiredThe actions are monitored by the Directorate Clinical GovernanceTeam.

Emergency readmissions within 28 days of discharge from hospital

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, advice is provided to patients regarding how to seek support if they are experiencing symptoms of ill health following a treatmentorprocedure (contacting the patient's GP, 111, 999 or contacting the treatment unit). Emergency departments are situated at the JR and Horton, but patients known to the Trust's services may also be admitted directly to

the Churchill Hospital.

The last readmissions data from NHS Digital is for 2020-21 and is for readmissions within 30 days of discharge. Therefore, Dr Foster has provided more recent data for readmissions within 28 days of discharge. For the most recent 12 months of available data (August 2021 to July 2022), the OUH 28-day readmission rate was 10.4%. Final figures for 2022-23 will be included in the next Quality Account.

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 monthly to NHS Digital via the SUS. The data are then used to calculate readmission rates.
- NHS Digital develops the SUS data into Hospital Episode Statistics (HES).
- Dr Foster takes an extract from HES data to provide benchmarked clinical outcome data.
- Data are compared to peers, highest and lowest performers, and our own previous performance.

The Trust takes the following actions to improve this indicator and so the quality of its services:
Negative (higher than expected) readmission rates are investigated by the respective Division.

If the investigation identifies any care quality concerns, actions are implemented and monitored by the Divisional Clinical Governance Team and reported to the Trust Clinical Governance Committee.

Patient experience

The Trust is fully committed to putting patients, carers, and families at the heart of everything that we do. We aim to provide timely, compassionate, and inclusive access to services, care and treatment. We also want to ensure that our patients' thoughts and observations about their care and treatment are heard. The Trust collects information about patient experience through several formal and informal mechanisms, including: the Friends and Family Test, the National NHS Patient Survey Programme, Patient Stories, Patient Participation Groups (PPGs), as well as ad hoc surveys and a dedicated patient feedback email. All feedback is sent to the relevant clinical service area and drives improvement plans.

The drive for continuous improvement in our services to our patients, their friends and family is underpinned by the Trust Values of Learning; Respect; Delivery; Excellence; Compassion; Improvement.

The Trust takes part in the CQC National Survey programme. The Inpatient, Emergency Department, Maternity and under 16's Cancer surveys have been undertaken this year. The clinical hospitality team have used feedback from the surveys and Friends & Family Test (FFT) to monitor the quality and patients experience of food in the soft facilities management contract.

The Trust undertook the national Patient Led Assessment of the Care Environment (PLACE) between October 2022 and January 2023. All communal and external areas, 10 meal services, 27 wards and 13 outpatient departments were assessed across the Trust. Overall, the assessors found the Trust to be clean and well cared for, and they were confident in the environment providing a good experience of patient care.

The national Shared Decision Making CQUIN is running in collaboration with five clinical teams across the Trust. The available patient survey data to date suggests that patients feel involved in weighing up options and decisions about their care.

The number of interpreters has significantly increased this year, making it easier for patients and clinicians to discuss healthcare.

The Patient Experience team continues to contribute to the weekly inquests, complaints, claims, safeguarding and serious incidents (ICCSIS) group giving a roundup of the weekly FFT feedback.

The Friends and Family Test (FFT) has been adopted nationally across all aspects of NHS healthcare. All trusts use the recommend rate to gauge patient satisfaction with their services. The Trust is delighted that overall, across the year 91% patients (n= 132,820) told us that they rated their experience as very good, or good. The FFT survey also asks patients to comment on their care. This feedback is shared with the respective wards and departments. The comments are also themed for the Trust Board and help the Board to understand a balanced view of patient experience alongside complaints, claims and compliments.

Results from the OUH Friends and Family Test (FFT) survey April 2022 to March 2023	
FFT: inpatients andday cases	95.2% of patients rated their experience on their ward as very good or good. This based on 39,941 responses.
FFT: emergency departments	76.3% of patients rated their experience within the emergency department as very good or good. This is based on 21,794 responses.
FFT: outpatients	93.3% of outpatients rated their experience as very good or good. This is based on 83,057 responses.
FFT: maternity	87.4% of women rated their experience of the Trust's maternity services as very good or good. This is based on 768 responses.

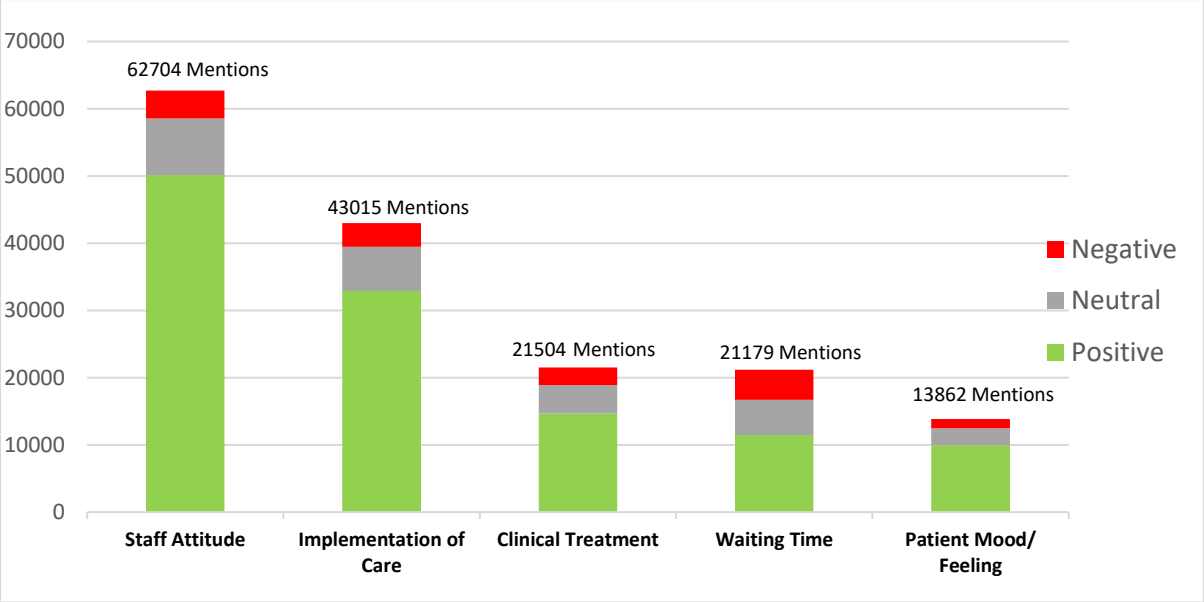
Table 34: Results from the OUH Friends and Family Test (FFT) survey April 2022 to March 2023

The table below shows the Trust's overall results from the FFT survey for 2022-23.

April 2022 to March 2023	***Very good***	***Good***	***Neither good nor bad***	***Poor***	***Very poor***	***Don't know***
Number of responses overall	114,334	18,486	4,984	3,233	3,777	746
Percentage	79%	13%	3%	2%	3%	1%

Table 35: The Trust's overall results from the FFT survey for 2022-23

There have been 106,944 comments via the FFT throughout the year. The graph below shows the mix of positive and negative sentiment among comments relating to the 5 most mentioned themes: Staff Attitude, Implementation of Care, Clinical Treatment, Waiting Time and Patient Mood/Feeling.



Graph 10: shows the mix of positive and negative sentiment among comments relating to the 5 most mentioned themes: Staff Attitude, Implementation of Care, Clinical Treatment, Waiting Time and Patient Mood/Feeling.

The FFT data and information generated are submitted to NHS digital as part of the national submissions programme. The Patient Experience Team introduced significant improvements to enable the test to run more smoothly and to enable wards and departments to access their feedback more easily, to help them learn and improve their services. Children's FFT and the maternity FFT survey (Question 3) is now distributed via by SMS text.

The Trust is continuing to collaborate with Imperial College NHS FT on the Scale, Spread and Embed (health.org.uk) project to develop an interactive dashboard for the wards, directorates and divisions to analyse their feedback to Inform quality improvements projects to improve patient experience.

NHS England Learning Disability Improvement Standards.

The Learning Disability standards have been developed to help NHS Trusts measure the quality of care provided to people with learning disabilities, autism or both. The outcomes have been developed by individuals and their families, keeping their

experiences the focus for the standards. There are 4 standards (the first three apply to all NHS Trust's and the fourth to specialist NHS Trust's):

- respecting and protecting rights
- inclusion and engagement
- workforce
- learning disability services standard (aimed solely at specialist mental health trusts providing care to people with learning disabilities, autism or both)

Further information about the standards can be found here. OUH submit an annual self-assessment alongside accessible patient questionnaires and staff questionnaires.

The Trust has support for people with learning disabilities through the Learning Disability Liaison nurse team, availability of reasonable adjustments and a Changing Places Toilet. The number of patients with a learning disability flag continues to increase and monitoring the percentage of people with learning disabilities that are quickly readmitted has indicated that this is less than the general population.

The Trust is focussing on identifying and tracking people with learning disabilities on waiting lists; further improving the way we identify people with a learning disability and add a flag to ensure clinicians are aware; and implemented a Trust model of assurance using the NHS England Reducing deaths of people with learning disabilities in NHS acute Trusts improvement tool.

Staff recommendation of our hospitals to family and friends

The Trust continues to demonstrate our intent to achieve our vision – "Together we make OUH a great place to work where we all feel we belong" through the delivery of our People Plan. During 2022-2023:

- We have continued to improve the wellbeing of our people by addressing key priority areas to support the staff. By the end of March this year we installed wellbeing equipment including energy pods, sleep tubes and wellbeing nooks across our main Trust sites. Mid-year we will be undertaking a survey to ensure our initiatives are having a positive impact. Ground surveys for outdoor gym equipment are complete and once planning permission is granted, we will look to install these this in 2023. Work on physical wellbeing will continue

in 2023/2024 and will run in parallel with an increased focus on psychological wellbeing, including relaunching our Staff Support Service, as outlined in the People Plan.

- In autumn 2022 we initiated the roll out of a BOB (Bucks, Oxon & Berks) ICS-wide Civility and Respect programme – Kindness into Action - to address physical, verbal violence and aggression towards our people. 658 managers have completed or part-completed this training to date with further training scheduled. A comms campaign and dedicated Intranet site for Kindness into Action was implemented with the establishment of Kindness Ambassadors to support the use of the tools at a local level. Additionally, the tools and models in providing effective feedback have been incorporated into revised versions of existing workshops and resources, and we are developing a new set of workshops to support people in developing feedback skills. Kindness into Action will form a key pillar where we have requests for bespoke support aligned to our staff survey results.
- We have created a new onboarding programme for managers. The programme is designed to be completed in the first six months in a management role. It includes a welcome to the Trust, training on key systems, processes, and signposting to useful resources. A pilot programme has been completed and the first cohort will begin in summer 2023. The programme is delivered through My Learning Hub (OUH's interactive learning platform) and a SharePoint site. The use of SharePoint and My Learning Hub create usage data and allow for timely collection of feedback. This programme is complemented by an onboarding programme for all new employees which follows a similar structure.
- We have continued to develop additional resources to support our people to hold quality appraisal conversations within the window, including a How to Guide that directs people to the process and relevant resources. The My Learning Hub site contains a wide variety of resources to support effective completion of quality appraisals, including workshops for appraisees on 'making the most of your appraisal' as well as for managers on 'how to conduct an effective appraisal' alongside scheduled drop-in sessions. A communications campaign for all staff is in place to encourage completion of

appraisals, which references the importance of quality conversations. Values Based Conversations training also supports quality appraisals and has been running throughout 2022/2023.

- For further information please refer to our People Plan 2022 –2025

Part 3: Other information

Our performance with NHS Oversight Framework indicators

Oxford University Hospitals NHS Foundation Trust's (OUH) Performance Management and Accountability Framework governs the oversight and the delivery of the Trust's strategic and performance goals. The Framework provides a focus from Board to ward on Corporate Governance, Risk Management, Accountability and Performance Management, which is integrated across Trust Divisions (Clinical and Corporate). Performance against relevant indicators

Indicator	Target	Trust Performance 2022-23	Trust Performance 2021-22
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	≥92%	67%	75%
Patients waiting for consultant-led treatment (RTT[1])	<58,256	72,744	57,599
Patients waiting over 52 weeks (RTT[1])	<950	2,226	971
Patients waiting over 78 weeks (RTT[1])	0	60	161
Patients waiting over 104 weeks (RTT[1])	0	4	26
ED performance within 4 hours (all types) (ED[2])	≥95%	62.1%	73.3%
All cancers: 62-day GP Referral to Treatment standard	≥85%	57.8%	69.7%
All cancers: 62-day Screening to First Treatment standard	≥90%	57.7%	70.2%
Diagnostic activity levels (elective)	n/a	227,990	202,621
Maximum 6-week wait for diagnostic procedures	≥99%	92.4%	92.7%
Clostridium difficile infection cases	≤104	141	107
Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia cases	0	4	4
LOCAL PRIORITIES			
Venous thromboembolism risk assessment	>95%	98.1%	98.2%
Hospital Acquired Thrombosis (HAT)	0	8	12
Hospital Acquired Pressure Ulcers (HAPUs) Category 3 & above per 1,000 admissions	0.035%	0.03%	0.05%
Reported incidents of violence and aggression against staff[3]	0	1366	1111
Incident of violence and aggression (rate per 10,000 bed days)	n/a	44.61	38.34
Results Endorsed within 7 days	90%	82.2%	78.7%

Table 36: Performance against relevant indicators and national average

[1] Referral to Treatment (RTT) pathway

[2] Emergency Department (ED)
[3] Reported rate on Trust's incident management system.

Elective care

Elective activity in 2022-23 delivered an increase in the number of services for patients waiting for cancer treatments, patients with a high clinical priority and our longest waiting patients. In collaboration with system partners within the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB), supported by specific elective care funding streams, and using capacity available within the Independent Sector and from insourcing, we were able to increase elective inpatient activity relative to 2021-22 (+5.6% / +5,014) and increase patient services delivered in an outpatient setting by 6.1% / +72,238).

Patients on a RTT waiting list at OUH increased by 26.3% from March 2021-22 to March 2022/23. This was higher than the 16.6% increase recorded nationally, measured to March 2023.

- OUH elective inpatient and day case activity increased in 2022/23 at a rate lower than the national average (5.6% vs 10.1%).
- OUH outpatient activity increased in 2022/23 at a rate above the national average (6.1% vs 5.7%).

The targeted approach to focusing treatment for patients, based on their clinical prioritisation and long-waiting patients, enabled a reduction in the number of patients waiting more than 104 weeks (two years) from 26 to four patients, and a reduction in the number of patients wating more than 78 weeks from 161 to 60 patients.

In late 2022-23, industrial action resulted in the cancellation of patients scheduled for an elective or day case admission to the hospital and patients scheduled to attend in an outpatient setting.

The Trust has worked closely with staff to ensure that patient safety was always paramount, whilst supporting the right of staff to take industrial action if they chose to do so. We worked with colleagues to ensure that staffing was maintained at safe levels and to minimise the rescheduling of planned appointments, procedures and operations.

Emergency care

The proportion of patients seen within four hours in our Emergency Departments decreased from 73.3% in 2021-22 to 62.1% for ‘all types’ in 2022/23 and we recorded a higher proportion of patients spending more than 12 hours in an Emergency Department, which increased from 4.4% in 2021/22 to 6.8% in 2022-23. ED performance was below the national average for ‘all types’ (62.1% vs 70.8%). In 2022-23, attendances at Emergency Departments and emergency admissions increased by 1.4% and 2.1% respectively, compared to 2021-22. The increase in ED attendances was consistent with the national experience in increasing emergency activity.

Cancer Treatment within 62 Days

OUH cancer activity is above pre-pandemic levels and the national average (16% vs 13%). In 2022-23 compared to 2021-22, OUH delivered 3.5% more cancer activity for our patients. On average across 2022-23, OUH achieved one out of the nine national standards. The number of patients waiting more than 62 days on a cancer pathway for the GP standard reduced from 226 to 205 (21 fewer patients). but remained above the target of fewer than 120 patients by the end of March 2023. This should be seen in the context of a 15.2% increase in cancer referrals to two week wait pathways (including the Breast Symptomatic pathway) in 2022-23 compared to the previous financial year (+3,897 patient referrals).

We achieved the 28-day Faster Diagnosis standard (78.3% vs 75%). The remaining standards were not achieved and are the focus of specific initiatives within the Trust’s Improvement Programme. The achievement of the 28-day Faster Diagnosis standard has been supported by the Trust investment in increasing diagnostic capacity as well as capacity from the Community Diagnostic Centre.

Diagnostic Test within 6 Weeks

An important part of elective treatment for patients includes diagnostic pathways.12.5% more diagnostic activity was noted in 2022-23 compared to 2021-22.

- OUH diagnostic activity increased at a lower rate compared to the national average in 2022-23 (9.8% vs 10.2%), including emergency and elective activity.
- Full year diagnostic performance against the standard measuring patients waiting within six weeks was 15.5 percentage points better than the national average (92.4% vs 76.6%).

Further information and additional indicators are included in the Performance Analysis section in the Trust Annual report 2022/23, including comparisons with the pre-COVID-19 period in 2019/20 and references to the national average where possible.

Freedom to Speak Up

The Trust takes very seriously its responsibility for ensuring all members of staff feel confident and supported in being able to speak up when they believe the highest standards of care and service are being compromised or could be compromised. Processes are in place to ensure that our staff feel able and safe to raise concerns and have confidence they will be listened to and their concerns acted upon.

Where such issues are raised, they are generally addressed quickly and efficiently through our established processes as outlined in the Trust's Freedom to Speak Up – Raising Concerns (Whistleblowing) Policy. Under the terms of the Policy our Freedom to Speak Up (FtSU) Lead Guardian has a guardianship role in support of any employee who wishes to raise an issue of concern. Speaking up should be something that everyone does and is encouraged to do. Our Trust Policy was recently updated in line with the National Guardian's Office recommendations, to ensure it fully supports this aim. A separate Freedom to Speak Up Annual Report is presented to the Trust Management Executive (TME) and the Trust Board by the FtSU Guardian. We have a nominated Non-Executive Director responsible for Freedom to Speak Up so that speaking up is represented independently at Trust Board level. In addition, we have a nominated Executive Director lead for Freedom to Speak Up.

The purpose of the FtSU role is to work with all staff to support the organisation in becoming a more open and transparent place to work and where staff are encouraged and enabled to speak up safely. In 2022, the FTSU Team received the High Commendation Award at the HSJ National FTSU Awards.

Ensuring staff do not suffer detriment.

Speaking up about any concern an employee has at work is really important. In fact, it is vital because it will help the Trust to keep improving our services for all patients and the working environment for our staff. Staff may feel worried about raising a concern, and the Trust understands this, but this should not deter individuals from raising their concerns. In accordance with our duty of candour, our senior leaders and entire Board are committed to an open and honest culture. We will look into what staff say and staff will always have access to the support they need. If a

member of staff raises a concern under the Raising Concerns Policy, they will not be at risk of losing their job or suffering any form of reprisal as a result. The Trust does not tolerate the harassment or victimisation of anyone raising a concern. Any such behaviour is a breach of the Trust's values and if upheld following investigation could result in disciplinary action.

Rota Gaps and the Plan for Improvement

Nationally, 'Doctors in Training' represent 40% of the medical workforce. New terms and conditions of service (TCS) were introduced for this group in 2016. The 2016 TCS include governance processes that require partnership working between Doctors in Training and their employing Trusts to ensure safe hours' working practices and to enable enhanced executive supervision of this group.

The transition of all Doctors in Training to the 2016 TCS was completed in February 2020. At any one time there are about 900 Doctors in Training at Oxford University Hospitals NHS Foundation Trust. Additionally, there are locally employed doctors sharing the same rosters, roles, and responsibilities, with the local contract now mirroring safe hours' working practices of the national 2016 TCS.

Oxford University Hospitals NHS Foundation Trust has taken the following actions to ensure compliance with the 2016 TCS, and so the quality of its services, by:

- All Doctors in Training are provided with compliant 'Work Schedules' and an electronic process to report exceptions when there is variance to rostered hours.
- The Board receives quarterly and annual reports from the Guardian of Safe Working Hours. The Guardian's reports are informed by workforce data relating to the Doctors in Training as well as feedback from the Junior Doctors Forum.

Exception Reporting		2022			2023	Total
		Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	
Number of exception reports		262	372	354	216	1204
Number of doctors reporting		64	119	98	71	220
Specialties receiving reports		18	25	24	21	30
Nature of Exception	Education	21	31	22	16	90

Exception Reporting		2022			2023	Total
		Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	
	Hours & Rest	252	355	347	213	1167
Additional hours worked per exception report		1.6	1.5	1.5	1.5	1.5

Table 37: Exception reporting 2022-23

Vacancies	2022			2023	Total
	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	
Unfilled training post	Organisational level data not reliably available as managed at a service level via departmentally commissioned data tools.				
Other					
Total					

Table 38: Vacancies 2022-23

Locum Shifts		2022			2023	Total
		Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	
Total		3849	4492	3465	4259	16,065
Agency		736	1493	1493	989	4,711
OUH Bank		3113	2999	2522	3270	11,904
Reason for locum shift	Vacancy	2286	3297	2550	3264	11,397
	Non-vacancy	1563	1195	915	995	4,668

Table 39: Locum shifts 2022-23

Oxford University Hospitals NHS Foundation Trust has recognised that the following actions are required to promote safe hours' working:

- The Oxford University Hospitals NHS Foundation Trust (OUH) complies with the safe working hours framework for NHS doctors and dentists in training but has acknowledged the need to improve its assurance framework.
- OUH is implementing a standardised process for data relating to safe working hours, with each division expected to review their data quarterly and produce reports on their performance in promoting safe hours' working.

- The guardian of safe working hours will assess how the divisions support safe working hours to provide better oversight for the deployment of the junior doctor workforce and meet contractual requirements.

Annex 1: Statements from commissioners, Governors, local Healthwatch Oxfordshire organisation and Overview and Scrutiny Committees

Governors Statement

Oxford University Hospitals
NHS Foundation Trust

The Council of Governors was pleased to read this detailed and accessible account of work that the Trust has undertaken and planned to ensure the quality of services and show improvements, which provides an important record that aims to improve public accountability for the quality of care.

This year has been one of continued challenges as we recover and face on-going consequences of the COVID-19 pandemic, alongside other challenges during 2022/23. Throughout this period, it has been inspiring to see the strength and resilience of staff. We want to acknowledge the hard work and commitment of all of our staff, who have responded and taken on the challenges to deliver the highest quality of care for all our patients. This can be seen by the improvements made throughout the year that are demonstrated by considerable progress against last year's Quality Priorities. Governors agreed that there was much to be proud of. The Council of Governors are optimistic that the quality priorities for 2023/4 would drive further improvements, welcoming in particular the focus on care of the frail elderly and on making it possible for more patients to receive tissue donation for transplant.

All governors have had the opportunity to comment on the report, with a detailed discussion at the Patient Experience, Membership and Quality Committee, joined by the Deputy Chief Medical Officer, who summarised the report and invited the Committee to comment on the draft Quality Account. Feedback from the Committee was incorporated into the final version where relevant.

The Council noted the level of openness and transparency demonstrated by the content of the Quality Account and was pleased to see specific actions outlined to match the Trust's aspirations. Governors particularly sought assurance regarding the seriousness with which Never Events were investigated and the processes that were in place to ensure a strong safety culture.

Governors welcomed the continued improvement to the format of the document, and it was agreed that the information within Quality Account came together well as a united document. It could be seen that tremendous work had gone into simplifying the structure which made it much easier to engage with. The Patient Experience, Membership and Quality Committee reflected on the value of Quality Account in supporting engagement with patients, staff, and the public and agreed that it was an important document to show improvements in services. To do this more easily, governors welcome the plans to prepare a short summary of the Quality Account and poster of the Quality Priorities.

The Council remain fully committed to putting patients, carers, and families at the heart of everything the Trust does, and governors remain focused on ensuring that patients' thoughts and observations about their care and treatment are heard. During the Covid-19 pandemic many of the usual channels for hearing about care and treatment, such as patient participation groups, had fallen away. Governors remain committed to the importance of such groups and will play a part where possible to build them back up. Other events such as the Quality Conversation had continued to be an important forum for involving patients, the public and staff.

The Council acknowledges the developments described in the Quality Account and notes the recognition by the Trust of areas where further improvements are required and to see the plans in place for these. Governors will continue to monitor work to improve patient care before, during and after treatment through their committees.

Overall, the Council wishes to thank and acknowledge the ongoing commitment of all staff to provide high standards of compassionate, innovative and high-quality care in the context of the need to recover following the pandemic and to continue to respond to the challenges to reduce waiting times.

Graham Shelton
Lead Governor

Sally-Jane Davidge
Chair of the Patient Experience, Membership and Quality Committee

NHS England Specialised Commissioning statement on Oxford University Hospitals NHS Foundation Trust 2022-23 Quality Accounts

Professor Meghana Pandit
CEO
Oxford University Hospitals NHS Foundation Trust

Via email to: Meghana.Pandit@ouh.nhs.uk

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

24 May 2023

Dear Professor Pandit

Quality Accounts for Oxford University Hospitals NHS Foundation Trust

The Quality Accounts for Oxford University Hospitals NHS Foundation Trust demonstrate that the Trust is committed to providing high quality care to patients accessing its services. The Quality Strategy has identified three key domains to improve patient care which include improving patient safety, engaging with patients and their families to learn from lived experience and achieving an 'outstanding' rating against all Care Quality Commission domains.

The Trust is encouraging of a Quality Improvement (QI) culture with an ambition to increase the number of QI projects registered, and staff being offered opportunities to develop QI skills to encourage a culture of service improvement and development. This is also supported by an extensive programme of clinical audit to review clinical performance against agreed standards, which should lead to the refining of quality of clinical care.

It is acknowledged that the Trust has made good progress against the Quality Priorities (QP) identified for 2022-2023. However there are still some areas, as a result of operational pressures, where the QP have not been met. It is important to note that these areas still remain a priority for the Trust and have been incorporated into the QP for 2023-24.

Specialised Commissioning look forward to continuing to engage with the Trust to ensure that patients accessing specialised services can continue to benefit from high quality care with excellent outcomes for now and in the future.

Yours sincerely

Sarah Vaux

Director of Nursing, Direct Commissioning

Direct & Specialised Commissioning Quality Team (DSCQT) NHS

England - South East Region

OUH Quality Account Response The Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB)

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

Meghana Pandit
Chief Executive Officer
Oxford University Hospitals NHS Foundation Trust

Sent via email to:
meghana.pandit@ouh.nhs.uk

Sandford Gate, Second Floor
East Point Business Park
Oxford
OX4 6LB

rachael.corser@nhs.net

06 June 2023

Dear Meghana

RE: OUHFT Quality Account Response BOB ICB

The Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) has reviewed the Oxford University Hospitals NHS Foundation Trust (OUHFT) Quality Account and believe that it is accurate and meets the requirements of a Quality Account.

The account sets out a summary or achievement against the 2022-23 quality priorities. The ICB was pleased to note that the Trust has fully or partially achieved on the majority of its priorities for last year. Where actions have not been achieved, or there remains work to be done, these have been carried forward into next year's workplan.

We particularly commend the work on pressure ulcers. Preventing pressure ulcers is an important patient safety issue and a key marker of good quality care. We look forward to the same focus being applied to the prevention of falls in the coming year.

It is excellent to see that the endorsement of test results has significantly improved in 2022-23. Endorsement rates were chosen by the Trust as a way of ensuring clinical test results were reviewed and acted upon. This is a longstanding quality issue, with rates remaining static for some time. It is excellent to see that the Trust has persisted with its efforts in this area and that the renewed energy and the new

approaches have paid off and that patients are now receiving safer care as a result.

2022-23 was another unprecedented year for the NHS. The challenges it faced were greater than ever before, particularly in the areas of workforce and urgent care and at the same time as addressing the backlog of patients created by the covid 19 pandemic and managing the impact of industrial action.

The ICB is pleased to note the innovation to support staff wellbeing in the 2023-24 Quality Priorities. This priority recognises the crucial importance of supporting the workforce. Initiatives to improve staff wellbeing and reduce violence and aggression are vital to having a happy safe workforce and to OUHFT being an employer of choice. It is fantastic so see the reporting excellence and the peer review system going from strength to strength. Both of these initiatives have very positive impact on staff morale.

The National Quality Board has refreshed the definition of quality in its *Shared Commitment to Quality,* adding 'well led' 'sustainable' and 'equitable' to the established domains of safe effective and with a positive experience. The Buckinghamshire, Oxfordshire & Berkshire West ICS system is committed to understanding and reducing variation and inequalities. The OUHFT quality priority of improving data capture is an important enabling step. Improved data collection will support the vital next steps of understanding and addressing inequalities in access to, and outcomes of, healthcare.

Everybody should have access to high-quality care and outcomes, and the Buckinghamshire, Oxfordshire & Berkshire West ICS system is committed to understanding and reducing variation and inequalities.

During 2022-23 OUHFT has identified examples where language barriers and access to translation services have been factors within patient harm; The Buckinghamshire, Oxfordshire & Berkshire West ICS ICB would encourage OUHFT to build on their planned improvement work to ensure that language issues should not be a barrier to patient safety.

The mortality rates at OUHFT remain stable and compares well. The learning from deaths programme and the medical examiner structure is well established and the Trust is supporting the roll out across the system. The strength of the Trust's

approach will be very valuable as the ICB brings the system together to look at wider mortality.

The rate of C.Difficile remains high and presents a challenge, both to the Trust and to the wider health economy. The Trust has demonstrated understanding of the challenges involved and has taken action to address these. They have worked collaboratively with the wider health economy. The ICB welcomes the planned QI focus on healthcare acquired infections.

Maternity care has been a national focus in 2022-23 and the Trusts response to this has been comprehensive. The maternity action plan which followed the CQC visit has now been completed. Standalone Midwifery Led Units (MLUs) have reopened and are providing care to labouring women as well as antenatal and postnatal care where appropriate. OUHFT declared full compliance with Year 4 Maternity Incentive Scheme. In addition, the Maternal Medicines Network is now fully resourced and working well.

The new NHS Patient Safety Strategy represents a significant change to the way the NHS understands and learns from incidents. The Patient Safety Incident Response Framework (PSIRF) sets out a new approach to developing and maintaining effective systems and processes for responding to patient safety incidents. The focus is on improving patient safety with an emphasis on how incidents happen and the factors which contribute to them. The Trust has had a real focus on developing a culture of quality improvement and this is an excellent foundation for PSIRF. The strong link with Quality Improvement within the Trust will mean that safety incidents will lead to real and sustained changes in practice. The ICB has been working closely with the Trust on this hugely positive change to the way in which we understand patient safety. PSIRF also aims to better support those affected by patient safety incidents. The Trust's priority of empowering patients is in line with the aims of PSIRF and should support those affected by a patient safety incident. It could be further strengthened by factoring in the role of patient safety partners and the guidance on Involving Patients in Patient Safety.

The publication of the Trust Clinical Strategy clearly sets out the five-year vision for the Trust. We welcome the Trust becoming an anchor organisation, with all the

potential benefits that will bring to patients, staff, the system and the wider community.

The OUHFT Quality Account is an accurate description of the Trust's activity and the quality of its services. We recognise the considerable challenges of the last 12-months, and value the close and evolving working relationship that OUHFT and the ICB have enjoyed over this time. We look forward to the further collaboration over the coming year as we increasingly work as a part of the Buckinghamshire, Oxfordshire & Berkshire West ICS system as well as integrating services locally to improve the outcomes for the populations we serve.

Yours sincerely

Rachael Corser
Chief Nursing
Officer

Statement from Healthwatch Oxfordshire

healthwatch Oxfordshire
Your voice on health and care services

Sent by email to Professor Meghana Pandit, Chief Executive Officer, Oxford University Hospitals NHS Foundation Trust
meghana.pandit@ouh.nhs.uk

2nd June 2023

Dear Professor Pandit,

Oxford University Hospitals NHS Trust Quality Account 2022–3

Thank you for letting Healthwatch Oxfordshire have sight of the Trust's Quality Account
2022-23 prior to publication.

Looking back over Healthwatch Oxfordshire's comments on Quality Accounts in previous years, we welcome the progress made to date on actions and the Trust's continuing commitment to '*putting patients, carers, families at the heart*' of everything you do.

The commitments and actions outlined throughout the 2022-3 Quality Accounts clearly lay out the path to ensuring that this happens. We welcome the planned re-lunch of Patient Participation Groups, aspiration to bring experts by experience, patient stories, and examples of lived experience, and develop 'Listen Up' roadshows. The value of bringing patient stories into building improvements to services is clear, and the action plans map how this will be achieved.

It is positive to see that the Friends and Family Test is being developed to increase its uptake and access to those who do not speak English. We also welcome improvements to the interpreting and translation support given to people with language and communication needs, something that we have highlighted in previous years.

We welcome progress and improvements to waiting times noted in the report. Effective communication to patients about waiting times and other aspects of care is key.

On page 40 onwards on the Quality Priority around opiates and medicines, we note there is no mention of the Medicine's Helpline in discussions about medicines taken home following a hospital stay. This could be an additional support to people in this target. (Highlighted in our recent report '*Leaving Hospital with Medicines*', Jan 2023).

Page 50. Highlights the work towards increasing uptake of tissue donation for transplant, and development of a patient information leaflet. We hope that there will be work with patients including those from diverse and multi-ethnic backgrounds, to support understanding of any cultural or religious barriers that may exist, and to support development of information that is culturally sensitive.

It is positive to see the clear focus on tracking and understanding health inequalities- and impact on access, uptake and treatment. In particular, including the commitment to embed and improve data collection around ethnicity. We welcome the application of this especially in the light of the MBRRACE-UK report, and work towards ensuring consistency of approach across the Trust and staff teams. It is positive to see the progress towards addressing barriers to antenatal care among underserved groups - and plans for piloting approaches, with patient input.

We note reference to the work of the Patient Experience Team on page 82, and commend the efforts made to bring patient, carers and those with lived experience into service development. Healthwatch Oxfordshire has developed strong links with this team, and as a result welcome efforts to ensure the Trust

embeds more proactive responses to our reports and insights shared.

We remind the Trust that not all patients are digitally connected, and many cannot communicate via telephone or video, and that preferred methods of consultation may be face to face. Continued commitment to ensuring this is addressed would be important to note.

We would also urge you to ensure the final Quality Document is accessible, clear, jargon and acronym free and in plain English to ensure that members of the public can easily understand it – including clearly explaining data tables, scoring and comparative sources.

On a final note, I draw attention to the reports Healthwatch Oxfordshire has produced over the last year with focus on OUH services, based on what we have heard from

patients, families and staff. Some of these reports give further qualitative insights into the areas addressed in the OUH Quality Report.

All reports from 2022-3 can be seen here https://healthwatchoxfordshire.co.uk/reports including:

- Enter and View visit reports: for example, visits to John Radcliffe Children's Hospital, Churchill Hospital Renal Dialysis Unit, Accident and Emergency Departments at John Radcliffe and Horton.
- Research Reports: Leaving Hospital with Medicines (Jan 2023), Maternal Mental Health support (June 2023 - summary of 45 responses from Oxfordshire residents who responded to a Healthwatch England national survey)
- What you told us about hospitals. Summary of what we have heard. April 2022- May 2023
- Video: Women's Experience of Maternity Services.
- Outreach summary report: Healthwatch Oxfordshire outreach at Oxford University Hospitals 2022-3 (March 2023).

Finally, we thanks all staff at the Trust for their continuing commitment to provide a quality and safe service for the community of Oxfordshire.

Yours sincerely,

Dr. Veronica Barry,
Executive Director- Healthwatch Oxfordshire.

Response to Healthwatch OXFORDSHIRE following the statement received on 2nd June 2023:

It is positive to see that the Friends and Family Test is being developed to increase its uptake and access to those who do not speak English. We also welcome improvements to the interpreting and translation support given to people with language and communication needs, something that we have highlighted in previous years.	We are committed to equity of access for our patients, and the OUH Digital Strategy recognizes that a range of solutions is required according to different patient needs. No preferential treatment is given to those able to use digital solutions and we ensure that those unable to interact digitally have equal access to our services, for example by phone and through face-to-face clinic appointments. The Trust also recognises the importance of impartial and independent interpreters being available for patients. We have contracts with two independent nationally accredited providers to provide interpreting services via telephone, video or in person; and with a third provider for British Sign Language and deaf / blind interpreting. We have recently worked to establish a new Tetum translation service to better cater for Tetum-speakers in our community. We have a Quality Improvement project to 1. increase staff understanding of and knowledge about booking an interpreter 2. empower patients and their families to request an interpreter 3. increase staff understanding of how to work with a patient and their interpreter. We have a project within the Maternity Health Equalities Group focusing on interpreting and maternity services. This project is looking at translated information and the importance of information in increasing health equity, developing more flexible ways of accessing interpreters for both service users and clinical staff. The team has joined the Asylum Welcome Access to Health group – our focus is on interpreting and translation and feedback of lived experience.
On page 40 onwards on the Quality Priority around opiates and medicines, we note there is no mention of the Medicine's Helpline in discussions about medicines taken home following	OUH has a Patient Medicines Helpline which is provided through our Medicines Information (MI) service in Pharmacy. The 'Leaving Hospital with Medicines' Jan 2023 report has confirmed the need to strengthen and promote the service for

a hospital stay. This could be an additional support to people in this target. (Highlighted in our recent report 'Leaving Hospital with Medicines', Jan 2023).	the benefit of our patients and the actions below are planned for 2023/24: • Medicines Information team will develop a Quality Improvement (QI) project to promote the Patient Medicines Helpline service • Work with a patient group (via Patient Experience team) to improve the written communication and instructions for patients about medicines taken home to ensure they are "presented in a more human friendly way, a more patient friendly way". • Develop a project to look at **how** we provide the information about medicines (written/verbal/digital), **who** provides the information and **when** in the patient journey • Promote use of patient's own medicines (PODs) including outside of OUH to remind patients (and SCAS) to bring them in • Review communication between ward areas and Discharge lounge and Pharmacy to facilitate smooth discharge with medicines • MI to support the Discharge Medicines Service (DMS) referral process. Consent and details of community pharmacy to be obtained as part of medicines reconciliation by clinical pharmacy teams. • Input into the QI work being done to improve the discharge summary information.
Page 50. Highlights the work towards increasing uptake of tissue donation for transplant, and development of a patient information leaflet. We hope that there will be work with patients including those from diverse and multi-ethnic backgrounds, to support understanding of any cultural or religious barriers that may exist, and to support development of information that is culturally sensitive.	The Tissue Donation Team recognise the importance of ensuring cultural and religious differences are understood and respected in all communications, as well as the need to ensure that all communities have equal opportunities to donate tissue and benefit from tissue donation. The team will work with national leads for tissue donation to optimise communication and access.
We remind the Trust that not all patients are digitally connected, and many cannot communicate via telephone or video, and that preferred methods of consultation may be face to face. Continued commitment to ensuring this is addressed would be important to note.	We are committed to equity of access for our patients. The OUH digital strategy recognises that a range of solutions are required according to individual patient needs. We are committed to ensuring that all patients have equal access to our services including through face-to-face clinic appointments where this is required or preferred.

Table 40: Response to Healthwatch OXFORDSHIRE following the statement received on 2nd June

Statement from Health, Overview and Scrutiny Committee

Issue	Commentary
Staff safety and wellbeing	- HOSC is aware that emotions for patients and families and staff will be heightened during a time across the health and care system which is recognised as totally unprecedented. - It is deeply regrettable that against this backdrop staff safety is far from assured when doing their work. HOSC commends OUH's recognition that there are clinical and non-clinical causes to this, which require different approaches. For non-clinically caused harassment of staff it would wish to see close working with the police to ensure that the trust's commitment to staff safety is being fully followed through - The fact only 28% of staff have undertaken the wellbeing check open to them may be suggestive of multiple things, both positive and negative: that staff feel resilient enough already, that they have insufficient time, or that they do not have faith in its value. With the pressures staff are under this level of take-up merits greater understanding and if this is not a mandatory national check whether there is value in exploring further with staff not taking up the checks whether there is anything else that might be helpful within local resources available.
Transitions between children's and adult's care	- This work is vital and is welcomed as a priority
Ethnicity and inequalities	- HOSC welcomes the depth of work which is being undertaken to ensure that data collection on ethnicity is not simply collected for the sake of it, but is used to ensure that this translates into better patient outcomes. The Trust is encouraged to make use of data from all suitable sources, including Public Health.
Acronyms	- It is asked that the Quality Account is checked to ensure acronyms are introduced in full the first time they are used throughout the document
Staffing levels and profile	- Given the high cost of employing locums the overall number is important to the Trust's level of resources. If possible, getting clarity on the number of locums employed beyond September 2022 would be valuable. - HOSC supports the development of career pathways, but it also recognises that as people skill-up and are promoted other people need to be attracted into the roles they vacate. Equally, it is important that staff are encouraged to stay working for the Trust so the investment made in staff is realised. The focus of the Trust through its People Strategy is deemed extremely important, but owing to its critical strategic importance there may be value in including some of its key measures as part of the Quality Account.

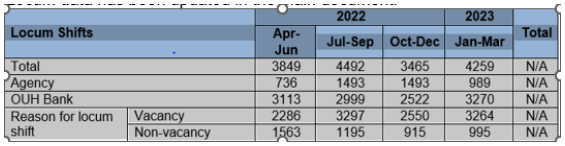
Issue	Commentary
Mortality rates Medicines Safety	- Check consistency of figures within the document; both 2800 and 318 are referenced. Whilst there may be reasons for the differences the discrepancy is sufficiently large as to be worthwhile double-checking for accuracy. - Hosc welcomes that as part of the overall patient safety quality improvements that whilst the priority improvements are focused on specific medicines listed that these would be updated to include any medicine safety area that was brought to the attention of OUH as high risk.
Waiting times	- In addition to the publication of average (mean) waiting times, overall patient experience would be illustrated more fully by including both median and maximum waiting times also. - HOSC welcomes the offer of the OUH operations Director to meet with the sub-group of HOSC on recovery of clinical backlogs which are of great concern as part of a national issue of recovery. It would be helpful to know whether the national picture reported in the HSJ that March 2023 saw a rise in people being referred into the system and a marked increase in volume of those treated was also seen in Oxfordshire, the impact of this and whether April figures are also showing this.
Avoiding and managing complaints	- Although it is hard to make specific suggestions in relation to the avoidance of complaints and improvement of their management owing to the differences in the way they are handled, HOSC recommends that two overarching themes be incorporated so far as possible: ensuring that the Trust listens to complainants (high-level ones in particular), and ensuring there is a learning culture within the organisation to develop mitigations to the causes of those complaints. The Trust is asked to give consideration to it's development of new Quality Priorities on patient feedback to include complainants in a standardised evaluation about their experience of the process and indeed that being extended to members of staff who are complained about.
Overall comments	- HOSC wishes to thank OUH for it's quality report and for briefing the committee and again to extend our thanks to all who are working in the NHS or working with the NHS during a time of unprecedented pressures. - A learning culture is viewed as critical and welcomed by HOSC to the safety and wellbeing of all patients and staff. Whilst the Trust's priorities are laudible and have clear energy and commitment behind them, one measure by which they must be judged is whether they deliver improved outcomes. The resources of the trust, particularly staff time, are fungible, and work devoted to broader priorities can reduce the time and capacity available for front-line clinical activity. It is important that the Trust continues to monitor closely the quality improvements as absolutely vital to system recovery and patient

Issue	Commentary
	safety. With this in mind HOSC would also advise that OUH liaison with stakeholders includes whether there are any processes which are not serving a purpose of improved patient or staff safety and wellbeing and are disproportionately time intensive and costly to the Trust.

Table 41: Statement from Health, Overview and Scrutiny Committee

Response to Health, Overview and Scrutiny Committee following the statement received on 19th May 2023

Issue	Commentary	OUH Response
Staff safety and wellbeing	HOSC is aware that emotions for patients and families and staff will be heightened during a time across the health and care system which is recognised as totally unprecedented. - It is deeply regrettable that against this backdrop staff safety is far from assured when doing their work. HOSC commends OUH's recognition that there are clinical and non-clinical causes to this, which require different approaches. For non-clinically caused harassment of staff it would wish to see close working with the police to ensure that the trust's commitment to staff safety is being fully followed through - The fact only 28% of staff have undertaken the wellbeing check open to them may be suggestive of multiple things, both positive and negative: that staff feel resilient enough already, that they have insufficient time, or that they do not have faith in its value. With the pressures staff are under this level of take-up merits greater understanding and if this is not a mandatory national check whether there is value in exploring further with staff not taking up the checks whether there is anything else that might be helpful within local resources available.	Details of key measures of People Plan have been added to the revised version of Quality Account. A short paragraph and link to the People Plan has been inserted. Currently 28% of wellbeing check-ins have been recorded on the system, whereas the true number of these discussions occurring will be significantly higher, as many managers will include wellbeing check-ins as part of their regular 1-2-1s with team members. Consequently, we have introduced a wellbeing conversation prompt in the appraisal system, followed by a tick-box for managers to confirm a wellbeing conversation has been completed. We would therefore expect to see an increase in the current percentage by the end of the appraisal window in July 2023.

Issue	Commentary	OUH Response
Transitions between children's and adult's care	- This work is vital and is welcomed as a priority	
Ethnicity and inequalities	- HOSC welcomes the depth of work which is being undertaken to ensure that data collection on ethnicity is not simply collected for the sake of it, but is used to ensure that this translates into better patient outcomes. The Trust is encouraged to make use of data from all suitable sources, including Public Health.	The Trust agrees with HOSC that ethnicity data from all sources should be used. This year's Quality Priority to reduce Health Inequalities includes plans to ensure OUH data includes all ethnicity data from Primary Care and the NHS Spine; and that changes made to ethnicity records in OUH or elsewhere are updated across the system.
Acronyms	- It is asked that the Quality Account is checked to ensure acronyms are introduced in full the first time they are used throughout the document	Thank you for the feedback. We have tried to ensure all acronyms are spelled out in full the first time they are used.
Staffing levels and profile	- Given the high cost of employing locums the overall number is important to the Trust's level of resources. If possible, getting clarity on the number of locums employed beyond September 2022 would be valuable. - HOSC supports the development of career pathways, but it also recognises that as people skill-up and are promoted other people need to be attracted into the roles they vacate. Equally, it is important that staff are encouraged to stay working for the Trust so the investment made in staff is realised. The focus of the Trust through its People Strategy is deemed extremely important, but owing to its critical strategic importance there may be value in including some of its key measures as part of the Quality Account.	Locum data has been updated in the main document. 
Mortality rates	- Check consistency of figures within the document; both 2800 and 318 are referenced. Whilst there may be reasons for the differences the discrepancy is sufficiently large	Mortality figures have been updated in the document for clarity and consistency.

Locum Shifts		2022 Apr-Jun	2022 Jul-Sep	2022 Oct-Dec	2023 Jan-Mar	Total
Total		3849	4492	3465	4259	N/A
Agency		736	1493	1493	989	N/A
OUH Bank		3113	2999	2522	3270	N/A
Reason for locum shift	Vacancy	2286	3297	2550	3264	N/A
	Non-vacancy	1563	1195	915	995	N/A

Issue	Commentary	OUH Response
Medicines Safety	as to be worthwhile double-checking for accuracy. - HOSC welcomes that as part of the overall patient safety quality improvements that whilst the priority improvements are focused on specific medicines listed that these would be updated to include any medicine safety area that was brought to the attention of OUH as high risk.	The Medicine Safety Group (MSG) and its sub-groups (Injectable Safety Improvement Group, Insulin Safety Group, and time limited working groups formed to address specific medication safety priorities) are actively addressing medicine related safety challenges. The MSG meets monthly, chaired by a Deputy Chief Medical Officer with an aim to mitigate medication risks identified locally and from national organisations; reduce incidents resulting in harm; drive improvement work in line with the Trust's quality priorities and safety work-streams; and promote medicines safety learning and education. One of the key focuses is on better utilising and presenting data to support overall monitoring and understanding of risk across the organisation, in particular the improvement work with Ulysses integrated governance database system to revise medication incident categorisation and risk register development.
Waiting times	- In addition to the publication of average (mean) waiting times, overall patient experience would be illustrated more fully by including both median and maximum waiting times also. - HOSC welcomes the offer of the OUH operations Director to meet with the sub-group of HOSC on recovery of clinical backlogs which are of great concern as part of a national issue of recovery. It would be helpful to know whether the national picture reported in the HSJ that March 2023 saw a rise in people being referred into the system and a marked increase in volume of those treated was also seen in Oxfordshire, the impact of this and whether April figures are also showing this.	• The month end reportable median waiting times data are available via the national statistics website: Statistics » Consultant-led Referral to Treatment Waiting Times (england.nhs.uk) • For March 2023, the median average waiting times for admitted pathways was 11.9 weeks (ranked 43rd of 141 trust's nationally – this is above the national average, close to the upper quartile and better than Regional, Shelford Group and Similar Sized Trusts average waiting times) • For March 2023, the median average waiting times for non-admitted pathways was 8.5 weeks (ranked 93rd of 168 Trust's nationally – this is slightly below average however better than the Regional and Shelford Group average waiting times) • It would not be appropriate to provide the maximum waiting time as this could lead to a patient confidentiality (information governance) breach as well as it would not give you much context of patient experience (our longest waiting patient could be their choice for example). • Using the same national statistics website, March 2023 for OUH did see

Issue	Commentary	OUH Response
		a rise in clock starts (not necessarily referrals) compared to previous months (ranked 20th out of 171 Trusts highest volume of clock starts) yet has not triggered any special cause of concern from within a SPC lens • OUH had a higher volume of clock starts than average within Region, ICS and other similar sized Trust but less than the Shelford Group average. • Unfortunately, April 2023 figures are not officially reported yet so unable to provide.
Avoiding and managing complaints	- Although it is hard to make specific suggestions in relation to the avoidance of complaints and improvement of their management owing to the differences in the way they are handled, HOSC recommends that two overarching themes be incorporated so far as possible: ensuring that the Trust listens to complainants (high-level ones in particular), and ensuring there is a learning culture within the organisation to develop mitigations to the causes of those complaints. The Trust is asked to give consideration to its development of new Quality Priorities on patient feedback to include complainants in a standardised evaluation about their experience of the process and indeed that being extended to members of staff who are complained about.	The Trust has a robust process of investigating, supporting, and empowering complainants, and learning from complaints. This includes enabling patients and their relatives to raise their concerns in a number of ways, and each complainant is supported by a named Complaints Co-ordinator, who will discuss the issues with the complainant where possible, to fully understand the concerns and ensure these are investigated appropriately. To enable Trust wide learning from complaints, the Trust tracks and triangulates themes through discussion in the weekly Inquest, Complaints, Claims, Serious incident and Safeguarding (ICCSIS) triangulation meeting which reports into the weekly Serious Incident Group. The complaints interactive dashboard created monthly enables the clinical Divisions to understand themes and hotspots and this is reported in the monthly Quality Report to Clinical Governance Committee. The Trust has previously undertaken projects to seek feedback from complainants and worked alongside the NHS Benchmarking team, and this has always had a low response rate. We do place considerable importance on the working relationship between the complainant and the complaints coordinator, ensuring that the complainant has a named supporter throughout the process and enabling the complainant to raise concerns or give feedback throughout. We welcome the suggestion

Issue	Commentary	OUH Response
		of seeking feedback from staff and thinking through how staff could and should be better supported when a complaint has been made about them too.
Overall comments	- HOSC wishes to thank OUH for it's quality report and for briefing the committee and again to extend our thanks to all who are working in the NHS or working with the NHS during a time of unprecedented pressures. - A learning culture is viewed as critical and welcomed by HOSC to the safety and wellbeing of all patients and staff. Whilst the Trust's priorities are laudible and have clear energy and commitment behind them, one measure by which they must be judged is whether they deliver improved outcomes. The resources of the trust, particularly staff time, are fungible, and work devoted to broader priorities can reduce the time and capacity available for front-line clinical activity. It is important that the Trust continues to monitor closely the quality improvements as absolutely vital to system recovery and patient safety. With this in mind HOSC would also advise that OUH liaison with stakeholders includes whether there are any processes which are not serving a purpose of improved patient or staff safety and wellbeing and are disproportionately time intensive and costly to the Trust.	

Table 42: Response to Health, Overview and Scrutiny Committee following the statement received on 19th May 2023.

Annex 2: 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. NHS Improvement 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 themselvesof the following.

The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance provided on. https://www.england.nhs.uk/financial-accounting-and-reporting/quality-accounts-requirements/

The content of the Quality Report is not inconsistent with internal and external sources of information including the following.

- Board minutes and papers for the period April 2022 to May 2023.
- Papers relating to Quality reported to the Board over the period April 2022 to May 2023
- Feedback from commissioners dated 26 May 2023 (Oxfordshire Clinical Commissioning Group), 24 May 2023 (NHS England Specialised Commissioning).
- Feedback from Governors dated 21 June 2023.
- Feedback from local Healthwatch Oxfordshire dated 02 June 2023.
- Feedback from Overview and Scrutiny Committee dated 19th May 2023
- The Trust's Complaints Report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated June 2021.
- The National CQC Inpatient 2021 Survey published in September 2022
- The (latest) national and local Staff Survey conducted in 2022.
- CQC inspection report dated September 2021

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 are robust and reliable, conforms to specified data quality standards and prescribed definitions, and are subject to appropriate scrutiny and review.

The Quality Report has been prepared in accordance with NHS Improvement'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 to the best of their knowledge and belief they have complied withthe above requirements in preparing the Quality Report.

By order of the Board

NB: sign and date in any colour ink except black

Professor Meghana Pandit
Chief Executive Officer
28.06.2023

Professor Sir Jonathan Montgomery
Chair
28.06.2023