Oxford University Hospitals
NHS Foundation Trust

Trust Board Meeting in Public: Wednesday 13 July 2022

TB2022.053

Title:	**OUH Quality Account 2021-22**

Status:	**For Discussion**
History:	**15 June 2022 – Trust Board Meeting**
	8 June 2022 – Patient Experience, Membership and Quality
	8 June 2022 – Integrated Assurance Committee
	12 May 2022 – Trust Management Executive
	20 April 2022 – Clinical Governance Committee

Board Lead:	**Interim Chief Medical Officer & Chief Nursing Officer**
Author:	**Andrew Brent, Director of Clinical Improvement, Deputy CMO**
	Rupali Alwe, Deputy Head of Clinical Governance
Confidential:	**No**
Key Purpose:	**Assurance**

OUH Quality Account 2021-22

1. Background

1.1. OUH aims to deliver and assure patients they are receiving the very best quality of care. NHS Improvement requires all NHS Foundation Trusts to produce reports on the quality of care as part of their annual reports. Quality reports allow trusts to be held accountable by the public and other stakeholders.

1.2. Foundation Trusts are required by the Health Act 2009, and in the terms set out in the National Health Service (Quality Accounts) Regulations 2010 ('the quality accounts regulations'*), to publish Quality Accounts each year.

1.3. Consultation has taken place with Oxfordshire Clinical Commissioning Group, NHS England Specialised Commissioning, Health Watch Oxfordshire and the Joint Overview and Scrutiny Committee as well as the Trust governors. Statements on the content of the Quality Account have been obtained from stakeholders and included in the Annual Quality Account.

1.4. The Trust Board accepted the recommendation of IAC to approve the Quality Account for submission, pending the addition of the required Statements. This paper now provides Trust Board with the fully completed, signed and submitted Quality Account for noting and discussion.

1.5. There is no requirement in 2021-22 for the External Auditors to review the Quality Account as per guidance from NHS Improvement.

2. Draft 2020-21 Quality Account

2.1. Appendix 1 details the 2021-22 Quality Account which was submitted to NHSI by their deadline of 30 June 2022.

3. Recommendations

3.1. The Trust Board is asked to note and discuss the final version of the 2021-22 Quality Account which was submitted to NHSI on 30 June 2022.

* SI 2010/279; as amended by the NHS (Quality Accounts) Amendment Regulations 2011 (SI 2011/269, the NHS (Quality Accounts) Amendment Regulations 2012 (SI 2012/3081) and the NHS (Quality Accounts) Amendment Regulations 2017 (SI 2017/744).
(1) Letter to CEOs from NHS England and Improvement dated 28 March 2020, Publications approval reference: 001559.
(2) Revised NHS foundation trust annual reporting manual (FT ARM) updated 10 April 2020.

OUH Quality Account 2021-22

Contents

Grey highlighted text indicates mandated statements from the guidance documents for writing the Quality Account.

Version	Date	Author	Outcome
	20 April 2022 Clinical Governance Committee	RA / AB	Approved
	12 May 2022 TME (paper due 6 May)	RA / AB	Approved
	8 June 2022 IAC (paper due 31 May)	RA / AB	Approved
	8 June 2022 PEMQ	RA / AB	Approved
	15 June Trust Board	RA / AB	Approved

Part 1: Statement on quality from the Chief Executive Officer 2021-22

In our Quality Account we set out how Oxford University Hospitals (OUH) NHS Foundation Trust improves quality and safety through a consistent focus on a safety culture, routinely embedding best practice in the care received by our patients to prevent patients coming to avoidable harm.

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

Patient safety is one of the three key domains of our OUH Quality Strategy and providing high quality, safe, patient-centered care is one of the three objectives in our Trust Strategy 2020-25.

Improving the access, quality and experience of care for all our patients is one of our three strategic objectives for the next five years – with three key themes.

1. Delivering high quality care – becoming 'Outstanding' across all CQC domains and building a culture of clinical effectiveness and improvement.
2. 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 and embedding Safety Huddles, while ensuring safe staffing and a safe environment in which to provide care.
3. 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.

National recognition for quality improvement

OUH won the Changing Culture Award at the *Health Service Journal* (*HSJ*) Patient Safety Awards in September 2021 in recognition of the Trust's Quality Improvement (QI) Hub. The QI Hub supports quality improvement through a programme of teaching, project support and mentorship. It brings together and supports a community of QI practitioners, and shares, celebrates, and disseminates examples of improvement and learning from across the organisation via the fortnightly QI Stand Up forum.

The Hub aims to establish and spread a culture in which our people feel supported to improve patient and staff experience, creating an environment within which excellence will thrive. It aims to help frontline staff drive continuous quality improvements and is open to all staff across the organisation.

As Professor Meghana Pandit, our Chief Medical Officer, says: “Our QI Hub is helping frontline staff develop and deliver continuous improvement through shared learning and collaboration with a patient-centered approach, which enhances patient care and safety.”

This is a great achievement, and it is very encouraging that the hard work of so many staff to embed a patient safety culture at OUH was recognised nationally in this way.

Embedding a patient safety culture

The QI Hub is just one example of a wide range of initiatives which we have put in place to embed a patient safety culture at OUH – other examples include the following.

- Every day Monday to Friday there is a Patient Safety Response (PSR) team meeting involving senior clinical leadership and clinical governance across the OUH to review all new moderate and above incidents. This enables prompt support to staff where needed by way of a PSR team visit and a clear pathway for incident management.
- Every week the Chief Medical Officer and the Chief Nursing Officer send a joint Safety Message email to all OUH staff to raise awareness of important patient safety issues.
- All teams, clinical and non-clinical, are encouraged to hold Safety Huddles either face-to-face or virtually in order to learn from what went well, what did not go so well, and most importantly what lessons can be learned in order to do things differently.
- In September 2021, the Trust marked the World Health Organization’s World Patient Safety Day. Nationally and locally, the focus was on Local Safety Standards for Invasive Procedures (LocSSIP) and promoting the use of LocSSIPs along with the generic WHO Surgical Safety Checklist for Patients Undergoing Elective Surgery. The Chief Medical Officer and the Chief Nursing Officer sent a joint message to all OUH staff to mark the day and to promote the Trust’s LocSSIPs and LocSSIP policy. LocSSIPs are designed by local teams to ensure standard practice is used across the organisation, and the right staff are appropriately trained to enhance patient safety.
- 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.
- Our Reporting Excellence initiative encourages staff to ‘report’ positive events and examples of best practice in order to improve patient care, with a monthly Reporting Excellence award presented by the Chief Medical Officer and publicised to all staff via the Trust’s internal communications and social media channels.
- The Quality Improvement (QI) Stand Up initiative was launched to staff in April 2021. QI Stand Up is an opportunity for staff speakers to present their work to a wider audience during a 30-minute session taking place virtually every fortnight.

- Our DAISY Awards celebrate nurses and midwives working at OUH. Patients, their families and our staff can nominate a nurse or midwife who has made a real difference through outstanding clinical care.

Responding to the COVID-19 pandemic

2021-22 was another year of unprecedented challenges for our staff, both professionally and personally, as the COVID-19 pandemic continued.

On behalf of the Trust Board, I would like to thank all our staff for working together as OneTeamOneOUH to meet these challenges and to deliver compassionate and excellent care to our patients.

Our teams have worked in new and innovative ways, with our health and social care partners in Oxfordshire and beyond, to deliver high quality services throughout the pandemic.

For example, OUH and Oxford Health NHS Foundation Trust staff are working together to tackle Long COVID through a joint service which includes doctors, nurses, psychologists, physiotherapists, and occupational therapists.

Our teams offer both physical and psychological assessments of patients, so they can be referred to the most appropriate treatment and rehabilitation services. This is a comprehensive service to give people living with Long COVID the longer-term care, support, and rehabilitation they need.

Another example is our partnership with Perspectum, one of the many innovative healthcare start-ups based in Oxfordshire, to develop the new Oxford Community Diagnostic Centre (CDC) which opened in January 2022. It is one of 43 CDCs nationally that the Government has funded to provide diagnostic services closer to where patients live.

Not only do patients receive diagnostic tests more quickly but also the Oxford CDC's community location means that people do not need to come to one of our hospital sites for treatment.

Our strategic partnerships with the University of Oxford and Oxford Brookes University also underpin the high quality of treatment we are able to provide for patients at OUH, due to cross-fertilisation between research and delivery of care.

Oxford has been at the heart of many national clinical trials during the COVID-19 pandemic, and the OUH emerges from the COVID-19 pandemic with a strong but leaner and more focused clinical research portfolio.

Like the rest of the NHS, Oxford paused all its non-COVID clinical research activities in March 2020. This hiatus allowed OUH to review its portfolio of clinical research studies. This review was completed in September 2021.

Of the 2,000 studies paused in March 2020 due to the pandemic, 1,100 have been resumed, and the rest closed; half of those closed had already completed their activities before the pandemic and the other half were closed because they were judged unlikely to be able to deliver due to the pandemic.

Following a rigorous assessment and prioritisation process, more than 400 new non-COVID studies have been opened to recruitment since March 2020, meaning that OUH currently hosts a total of more than 1,500 active clinical research studies.

Care Quality Commission report on infection prevention and control

The Care Quality Commission (CQC) carried out an unannounced infection prevention and control (IPC) focused inspection at the John Radcliffe Hospital in May 2021 and their report was published in July 2021.

Positive areas highlighted by the CQC included the following.

- The Trust's IPC teams have the skills and abilities to run the service and manage infection prevention and control.
- Leaders operate effective IPC governance processes and learning across the Trust is focused on supporting patient safety.
- The Trust has an open culture so that patients and staff can raise concerns about infection prevention and control without fear.

After the CQC report was published in July 2021, I thanked all staff for their positive approach to the inspection in May and I highlighted the key role of the IPC team in leadership and expertise throughout the COVID-19 pandemic.

Areas for improvement highlighted by the inspection included the following.

- Not all signs and floor markings were clear.

- In some areas, communal seating was not socially distanced.
- More storage was needed to allow effective cleaning and reduce the risk of cross contamination.

A comprehensive action plan was put in place to address these areas for improvement, and the Trust Board has since made a significant investment to strengthen the staffing and resourcing of the IPC team.

New developments

Our new Critical Care Building at the John Radcliffe Hospital opened to patients in March 2022 following a £29 million development supported by Department of Health and Social Care financing. This new building will not only improve our critical care environment but also help us plan for future demands on our services. It is part of a regional plan to strengthen critical care capacity as the NHS makes preparations for the ongoing impact of the pandemic and COVID-19 recovery.

Following an extensive refurbishment project, the revamped Trauma Building at the John Radcliffe re-opened to both outpatients and inpatients during 2021-22. We're delighted that our Trauma Building is now fully back in use because it offers an improved experience for our patients, and our staff are able to care for them in a purpose-built environment.

A dedicated new centre to care for patients with bleeding and clotting disorders, based at the Nuffield Orthopaedic Centre (NOC), opened in March 2022 after relocating from the Churchill Hospital – the new Oxford Haemophilia and Thrombosis Centre (OHTC) is located on a former ward which has been extensively refurbished, modernised, and re-designed for the Haemophilia and Thrombosis teams and their patients. The space provided by the new centre enhances patient care and experience and provides an improved work environment for staff.

State-of-the-art new radiotherapy equipment for cancer patients at the Churchill Hospital has been installed over the course of 2021-22. Following delivery of a first new linear accelerator machine, also known as a Linac, in September 2021, a second machine is now operational and was used by patients for the first time in March 2022. It makes a real difference to patient care by making personalised radiotherapy treatment faster and easier to plan and deliver. This is the second piece of equipment to be installed as part of a project that will deliver three further Linacs, as well as two CT simulators, in the coming years.

Practical completion of our new Swindon Radiotherapy Centre on the Great Western

Hospital site was achieved in March 2022. Once it opens to cancer patients (anticipated for June 2022) requiring radiotherapy, it will make a huge difference by enabling the same quality of treatment for people closer to where they live.

Our award-winning staff

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 introduction of a day case total hip replacement pathway by a team based at the Nuffield Orthopaedic Centre (NOC) was shortlisted in the Post COVID-19 Sustainable Transformation Award category of the *Health Service Journal* (*HSJ*) Value Awards in September 2021 – this innovative service means that patients needing planned hip replacements can be operated on and return home the same day, if clinically appropriate.
- The Early Phase Clinical Trials Team, based at the Churchill Hospital, won the Excellence in Cancer Research Nursing category of the Royal College of Nursing (RCN) Nursing Awards in October 2021 after introducing a mental wellbeing assessment for early phase trial patients to ensure they receive effective and holistic care from the start of their treatment.
- The OUH Dermatology team based at the Churchill Hospital won their category of the Quality in Care Dermatology Awards in October 2021 for the vital care and emotional support provided to young patients with skin conditions.
- A collaborative project involving OUH, the University of Oxford's Radcliffe Department of Medicine, and the Defence Medical Services was Highly Commended at the *Health Service Journal (HSJ)* Awards in November 2021 – the Defence COVID-19 Rehabilitation and Recovery Service (DCRS), which has helped hundreds of UK Armed Forces personnel with persistent COVID-19 symptoms to recover, was shortlisted for the Military and Civilian Health Partnership Award.
- The OUH Hepatology Specialist Nursing Team won Silver in the Hepatology / Liver Nurse of the Year category of the *British Journal of Nursing* Awards in March 2022 – hepatology and liver nurses play a key role in caring for very unwell patients with a range of life-altering conditions and diseases.
- The Rheumatology team based at the Nuffield Orthopaedic Centre (NOC) received a Best Practice Award from the British Society for Rheumatology in March 2022 – in recognition of their pioneering work supporting patients virtually during the COVID-19 pandemic.

Patients waiting for treatment

Waiting lists for treatment have been severely affected by the COVID-19 pandemic both nationally and locally. In Oxford, we were forced to postpone elective surgery from 17 March 2020 in preparation for the first wave of the COVID-19 pandemic, and by 31 March 2021, 4,934 patients were waiting over 52 weeks for first definitive treatment.Over the last year, with the intermittent return of elective surgery, the OUH has worked tirelessly to improve this position, and by the end of March 2022 the number of patients waiting over 52 weeks had been reduced to 950.

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. Selected 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.

Infection Prevention and Control

Despite the considerable challenges of the pandemic, we have continued to work together with all our clinical, portering, infection prevention and control, procurement and supplies teams, in order to protect our patients and staff from hospital-acquired infections. All hospital acquired infections have undergone a root cause analysis to identify learning and implement improvements where required. This has included review of patients who have contracted COVID-19 while in our care, to see what could be learned and how patient safety systems could be further improved.

Never Events

During 2021-22 we reported four 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 the risk of Never Events and other patient harm incidents.

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

This Quality Account, as well as looking back on how we performed against our standards and priorities in 2021-22, also looks ahead to the priorities for 2022-23. This year, like last year, due to the COVID-19 pandemic we were not able to hold a Quality Conversation Event with the public, stakeholders, and our staff to choose our Quality Priorities. Instead, we have reviewed and refreshed our Quality Priorities with input from stakeholders across the organisation and from the Governors and shared these with key stakeholders including the Governing Body and the Trust Board.

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.

Dr Bruno Holthof

Chief Executive Officer
28.06.22

Introduction

A Quality Account is an annual report to the public from the NHS providers about the quality of the services provided. The Quality Account aims to enhance a trust's accountability to the public for the quality of its NHS services. The Quality Account for OUH sets out where the Trust is doing well, where improvements in quality can be made and the priorities for the coming year.

Part 2: Priorities for future quality and statements of assurance from the Board

Our Quality Priorities for 2022-23

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 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 usually involve our patients, public stakeholders and our staff in choosing our Quality Priorities through our annual public Quality Conversation Event. The Quality Conversation Event scheduled for January 2022 had to be cancelled due to the COVID-19 pandemic.

Discussion with internal stakeholders considered both new proposals – with a particular focus on staff wellbeing and recovery – as well as a review of which of last year's Quality Priorities should be continued into 2022-23.

These draft Quality Priorities were agreed by the Trust Management Executive (TME) followed by the Integrated Assurance Committee (IAC), Trust Board, Governors and external stakeholders.

Our Quality Priorities for 2022-23

The table gives the name and description of each Quality Priority with reasons why we chose these and then gives a description of how success will be evaluated.

Patient Safety

Triangulation of Learning from Claims with Incidents, Inquests and Complaints	Why we chose this Quality Priority	How we will evaluate success
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.	To promote optimal efficiency and learning from potential issues by embedding a combined approach to patient and relative responses, investigations and systemic improvements.	**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 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 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 CNST scorecard.

Reducing Pressure Ulcers	Why we chose this Quality Priority	How we will evaluate success
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.	Pressure ulceration can be an indicator of the quality of care delivered. Reducing acquired Harms is a Trust priority	**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. 4: Review the quality, availability, and reliability of the data sources currently available for gathering appropriate and specific intelligence and make recommendation to improve access and function. **PHASE 2 – DESIGN IMPROVEMENT, PLAN, AND IMPLEMENT** By Q2-Q3 22-23 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. Evidence: Schedule Shared Showcase Events for presentation, dissemination of findings and building communities of practice within the Trust.

Reducing Pressure Ulcers	Why we chose this Quality Priority	How we will evaluate success
		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. Evidence: Case Studies as exemplars. 1: Undertake peer review of identified associated clinical audit for pressure ulcer prevention and wound management. Evidence: MyAssure audit data 2: Review and re-launch Pressure Ulcer Prevention Policy with associated clinical resources through a targeted Awareness Campaign Evidence: Production of associated resources **Phase 3 – Review and Evaluation** By Q4 22-23 1: 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.

Medication Safety – Insulin and Opiates	Why we chose this Quality Priority	How we will evaluate success
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	One in six people in hospital have diabetes and this is increasing. 35% of people with diabetes in OUH are treated with insulin and will be treated in all areas of the Trust.	**Insulin Safety** **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.

Medication Safety – Insulin and Opiates	Why we chose this Quality Priority	How we will evaluate success
is ameliorable or avoidable.		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 Safety Group wants to focus on identifying current themes for learning and will start with a quarterly review of incidents. **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. **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.
Reducing opioid use National and international guidance now recognise the risk of excess prescribing of opioids in the post-operative period. While essential to maintain access to opioids in	To ensure safe monitoring of patients and adequate, but not excessive, discharge prescribing.	**Reducing opioid use** **By 31 March 2023, to reduce opioids use in all adult patients** **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

Medication Safety – Insulin and Opiates	Why we chose this Quality Priority	How we will evaluate success
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.		manage patient's pain expectations). Q1: Draft guideline, developed and tested during Q1. Q2: Revised and approved by the end of Q2. Q3: Introduction to routine practice. 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 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

Medication Safety – Insulin and Opiates	Why we chose this Quality Priority	How we will evaluate success
		staff to determine whether knowledge of the resource and use has increased. Identify user numbers from website pages. **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 5:** To identify a selection of indicators around opioid prescribing and administration in collaboration with ePMA (electronic Prescribing and Medicines Administration) and 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.

Clinical Effectiveness

Results Endorsement	Why we chose this Quality Priority	How we will evaluate success
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'.	This priority aims to increase the number of total results endorsed, streamline the processes involved, reduce variability across the Trust and raise awareness of the importance of results endorsement.	**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 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 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 4:** Implement auto endorsement of negative results i.e. normal MSU and MC&S results. 1: Auto endorsement to be considered

Results Endorsement	Why we chose this Quality Priority	How we will evaluate success
		by Q1 and in place by Q3. **Action 5:** 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. **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 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.

Introduce and Embed Use of a Morbidity Dashboard in Surgical Specialties	Why we chose this Quality Priority	How we will evaluate success
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.	All surgical procedures carry risks of adverse outcomes including the need to return to theatre or be readmitted to hospital as a consequence. Minimising such events is a patient safety priority. We therefore plan to establish a surgical Morbidity Dashboard to track trends in surgical morbidity over time and between specialties. This will allow us to identify and develop a better understanding of areas for improvement and potential solutions.	**Action 1:** Develop and implement Morbidity Dashboard for surgical specialties by end of Q2. **Action 2:** Embed routine review of the Morbidity Dashboard into surgical morbidity and mortality meetings (M+Ms) by end of Q2. **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 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.

Embed QI Methodology More Widely in the Trust	Why we chose this Quality Priority	How we will evaluate success
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.	To share learning and promote widespread adoption of quality improvement across the Trust.	**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 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: No. QI projects registered on Ulysses by month. **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 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.

Patient Experience

Reduce incidents of violence, aggression	Why we chose this Quality Priority	How we will evaluate success
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.	This Quality Priority aims to understand the scale of the problem and the factors that contribute to violence and aggression; and implement interventions to reduce the frequency of these incidents and the impact they have on both patients and staff.	**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 BOB position for sharing and learning opportunities. **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 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.

Transition of Children to Adult Services	Why we chose this Quality Priority	How we will evaluate success
To deliver a consistent Trust-wide service for every child / young person making the move from receiving child-centred 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.	To ensure that all young people we treat receive a quality service to achieve optimum health and psychological wellbeing.	**Action 1:** Audit and feedback: How are we doing now? **1:** Audit EPR Compliance with Ready Steady Go – Hello transition child centred 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 ICS, and Shelford Group). **4:** By 30 April 2022, Scope and benchmark partner working – BOB ICS, NHS South East 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 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

Transition of Children to Adult Services	Why we chose this Quality Priority	How we will evaluate success
		multiple services. • Review and amend Moving to Adulthood / Transition Policy. • Implement reviewed Trust-wide and Divisional practice. **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.

Staff Health and Wellbeing: Growing Stronger Together	Why we chose this Quality Priority	How we will evaluate success
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'.	Focusing on the recovery of our people is essential to keep them safe and healthy at work, help reduce stress, anxiety, and presenteeism and retain an engaged workforce.	**Action 1:** By end March 2023, 85% of our people to have participated in a Wellbeing Check-in. **Action 2**: 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. Deliver 80 team sessions by the end of March 2023. **Action 3:** Complete the Timewise flexible working assessment and action plan by the end of March 2023. **Action 4:** By end June 2022, launch a suite of 'leading self' resources and support for all our leaders to manage their own wellbeing as part of our

Staff Health and Wellbeing: Growing Stronger Together	Why we chose this Quality Priority	How we will evaluate success
		Leading with Care series. **Action 5:** 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. **Action 6:** By end of March 2023 develop an SLA between OH and the organisation, agree KPIs for the service and embed management reporting of these KPIs by the end of the year.

Monitoring and reporting

Regular reports on all Quality Priorities go to the Trust level CGC and from thereto the IAC and the Trust Board.

Statements of assurance from the Board of Directors

A review of our services

During 2021-22 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 in 137 of these relevant health services.

The income generated by the relevant health services reviewed in 2021-22 represents 100% of the total income generated from the provision of relevant health services by Oxford University Hospitals NHS Foundation Trust for 2021-22.

Participation in clinical audits and National Confidential Enquiries

Participation in national clinical audit

Clinical audit is a process for reviewing clinical performance by measuring clinical practice against agreed standards in order to identify and implement improvements to the quality of clinical care. During 2021-22, 60 national mandatory clinical audits and 3 national confidential enquiries covered relevant health services provided by Oxford University Hospitals NHS Foundation Trust.

During that period Oxford University Hospitals NHS Foundation Trust participated in 97% of all the eligible national clinical audits as detailed within Table A and 100% of national confidential enquiries in which we were eligible to participate as presented within Table B of the report.

The national clinical audits and confidential enquiries that Oxford University Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2021-22, are listed below.

Participation in National Clinical Audits during 2021-22

(Table A)

The table describes the national audit issue, who sponsored the audit, what the audit is about and whether the Trust participated in 2021-22.

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust Participation 2021-22
Case Mix Programme (CMP): Intensive Care Audit	Intensive Care National Audit and Research Centre (ICNARC)	The Case Mix Programme (CMP) is an audit of patient outcomes from adult, general critical care units (intensive care and combined intensive care / high dependency units). This national audit benchmarks the risk-adjusted mortality and selected indicators of quality delivered by the Trust's four adult critical care units.	Yes
Chronic Kidney Disease Registry	Renal Association / The UK Renal Registry	This is a national registry of patients receiving renal replacement therapy for established renal failure.	Yes
Cleft Registry and Audit Network (CRANE) Database	Royal College of Surgeons – Clinical Effectiveness Unit	This report presents results from the prospective audit of children born with cleft lip and / or cleft palate between 2000 and 2020, in England, Wales and Northern Ireland.	Yes
Elective Surgery (National PROMs Programme)	NHS Digital	This audit looks at the change in patients' self-reported health status.	Yes
Emergency Medicine QIPs: Pain in Children (care in Emergency Departments)	Royal College of Emergency Medicine	The Quality Improvement Programme identifies current performance in EDs against clinical standards and shows the results in comparison with performance nationally to facilitate quality improvement.	Yes *(data collection until October 2022)*
Emergency Medicine QIPs: Infection Control (care in Emergency Departments)	Royal College of Emergency Medicine		Yes *(data collection until October 2022)*

Fracture Liaison Service Database	Royal College of Physicians	Fracture Liaison Services (FLS) are the key secondary prevention service model to identify and prevent primary and secondary hip fractures. The audit has developed the Fracture Liaison Service Database to benchmark services and drive quality improvement.	Yes
National Audit of Inpatient Falls	Royal College of Physicians	The audit provides comprehensive datasets on the quality of falls prevention practice in acute hospitals.	Yes
National Hip Fracture Database	Royal College of Physicians	This audit measures quality of care for hip fracture patients and has developed into a clinical governance and quality improvement platform.	Yes
Inflammatory Bowel Disease (IBD) Audit	IBD UK	The IBD Registry Biological Therapies Audit collected data	No – OUH did not

(IBD Biological Therapies Audit)		on all patients of all ages diagnosed with the ICD-10 codes and receiving biological therapy at any time during the year. The data was requested at three time points: initiation, post-induction review and 12-month review.	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.
Learning from Deaths of People with a Learning Disability (LeDeR) – Learning Disabilities Mortality Review	NHS England and NHS Improvement	The Learning Disabilities Mortality Review (LeDeR) programme was established in May 2015 to support local areas across England to review the deaths of people with a learning disability, to learn from those deaths and to put that learning into practice.	Yes

Maternal, Newborn and Infant Clinical Outcome Review Programme (perinatal mortality surveillance)	MBRRACE-UK led from the University of Oxford	The Maternal, Newborn, and Infant Clinical Outcome Review Programme collects, analyses and reports on national surveillance data and conducts national confidential enquiries to stimulate and evaluate improvements in healthcare for mothers and babies. This report focuses on the surveillance of perinatal deaths from 22+0 weeks gestational age (including fetal losses, stillbirths, and neonatal deaths.	Yes
Maternal, Newborn and Infant Clinical Outcome Review Programme (maternal mortality surveillance and confidential enquiry)	MBRRACE-UK led from the University of Oxford	The Maternal, Newborn, and Infant Clinical Outcome Review Programme collects, analyses and reports on national surveillance data and conducts national confidential enquiries to stimulate and evaluate improvements in healthcare for mothers and babies.	Yes
National Core Diabetes Audit	NHS Digital	National Diabetes Audit collects information on people with diabetes and whether they have received their annual care checks and achieved their treatment targets as set out by NICE guidelines.	Yes
National Adult Diabetes Audit: National Pregnancy in Diabetes (NPID) Audit	NHS Digital	The National Pregnancy in Diabetes (NPID) Audit aims to support clinical teams to deliver better care and outcomes for women with diabetes who become pregnant.	Yes
National Adult Diabetes Audit: National Diabetes Foot Care Audit	NHS Digital	National Diabetes Foot Care Audit enables all diabetes foot care services to measure their performance against NICE clinical guidelines and peer units, and to monitor adverse outcomes for people with diabetes who develop diabetic foot disease.	Yes
	NHS Digital	The National Diabetes	Yes

National Diabetes Inpatient Audit (NaDia) – reporting data on services in England and Wales		Inpatient Audit – Harms (NaDIA-Harms) is a continuous collection of four diabetic harms which can occur during an inpatient stay.	
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme: (Paediatric – Children and young people asthma secondary care)	Royal College of Physicians	This audit programme brings together primary care, secondary care, and pulmonary rehabilitation, along with patient experience and pilot linkage. Its partnership approach with multidisciplinary, collaborative working aims to drive improvements in COPD patient care. The audit programme supports the Department of Health's (DH) aim to improve the quality of services for people with COPD by measuring and reporting the delivery of care as defined by standards embedded in guidance.	Yes
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme: Adult Asthma Secondary Care	Royal College of Physicians		Yes
National Asthma and COPD Audit Programme (NACAP) Chronic Obstructive Pulmonary Disease (COPD)	Royal College of Physicians		Yes
National Audit of Breast Cancer in Older People (NABCOP)	Clinical Effectiveness Unit, Royal College of Surgeons of England	The audit assesses the processes of care and outcomes for women aged over 70 years. The National Audit of Breast Cancer in Older Patients (NABCOP) results help NHS breast cancer services in	Yes

		England and Wales to benchmark and improve the care delivered to these women. NABCOP is run by the Association of Breast Surgery and the Clinical Effectiveness Unit at the Royal College of Surgeons of England. The audit focuses on the patient pathway from diagnosis to the end of primary therapy, for women diagnosed with breast cancer.	
National Audit of Cardiac Rehabilitation (NACR)	University of York	The audit aims to support cardiovascular prevention and rehabilitation services to achieve the best possible outcomes for patients with cardiovascular disease, irrespective of where they live.	Yes
National Audit of Care at the End of Life (NACEL)	NHS Benchmarking Network	The audit has been designed to ensure that the priorities for care of the dying person outlined in the document One Chance to Get it Right are monitored at a national level.	Yes
National Audit of Dementia	Royal College of Psychiatrists	The audit measures the performance of general hospitals against criteria relating to care delivery which are known to impact upon people with dementia while in hospital.	Yes
National Audit of Pulmonary Hypertension	NHS Digital	The audit measures the quality of care provided to people referred to pulmonary hypertension services.	Yes
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Royal College of Paediatrics and Child Health (RCPCH)	The audit aims to address the care of children and young people with suspected epilepsy who receive a first paediatric assessment from April 2018 within acute, community and tertiary paediatric services.	Yes
		The purpose of the audit	Yes

National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit & Research Centre (ICNARC) / Resuscitation Council UK (RCUK)	is to monitor the incidence of, and outcome from, in hospital cardiac arrest in the UK and Ireland.	
National Cardiac Audit Programme: National Audit of Cardiac Rhythm Management	Barts Health NHS Trust	The National Audit of Cardiac Rhythm Management (NACRM) is part of the National Cardiac Audit Programme. The report details activity in cardiac rhythm management device and ablation procedures.	Yes
National Cardiac Audit Programme: Myocardial Ischaemia National Audit Project	Barts Health NHS Trust	The report looks at the care provided to patients who are hospitalised with an acute coronary syndrome (including heart attack).	Yes
National Cardiac Audit Programme: National Adult Cardiac Surgery Audit	Barts Health NHS Trust	This report summarises the outputs of the National Adult Cardiac Surgery Audit (NACSA) for 3 years of data collected between 1 April 2017 and 31 March 2020.	Yes
National Cardiac Audit Programme: National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Barts Health NHS Trust	This project looks at percutaneous coronary intervention (PCI) procedures performed in the UK. The audit collects and analyses data on the nature and outcome of PCI procedures, who performs them and the general health of patients.	Yes
National Cardiac Audit Programme: National Congenital Heart Disease	Barts Health NHS Trust	This report aims to improve the quality of care received by patients from hospital admission through to discharge and ensure that good practice standards are met.	Yes

National Cardiac Audit Programme (NCAP) (National Heart Failure Audit)	The National Institute for Cardiovascular Outcomes	The NHFA deals with the characteristics of patients requiring admission to hospital with heart failure and describes their in-hospital investigation, treatment and access to specialist care as well as discharge and follow-up.	Yes
National Child Mortality Database	University of Bristol	The National Child Mortality Database (NCMD) is an NHS-funded programme delivered by the University of Bristol that gathers information on all children who die in England, to improve and save children's lives in the future.	Yes
National Comparative Audit of Blood Transfusion: 2021 Audit of Patient Blood Management and NICE Guidelines	NHS Blood and Transplant	The National Comparative Audit of Blood Transfusion (NCABT) is a programme of clinical audits which looks at the use and administration of blood and blood components in NHS and independent hospitals in England.	Yes
National Comparative Audit of Blood Transfusion: 2021 Audit of the perioperative management of anaemia in children undergoing elective surgery	NHS Blood and Transplant		Audit did not run due to COVID
	British Society for Rheumatology	The audit aims to improve the quality of care for people living	Yes

National Early Inflammatory Arthritis Audit (NEIAA)		with inflammatory arthritis.	
National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists	The National Emergency Laparotomy Audit aims to look at structure, process, and outcome measures for the quality of care received by patients undergoing emergency laparotomy.	Yes
National Gastro-intestinal Cancer Programme: National Oesophago-gastric Cancer (NOGCA)	NHS Digital	The Oesophago-gastric (stomach) Cancer Audit aims to examine the quality of care given to patients and thereby help services to improve. The audit evaluates the process of care and the outcomes of treatment for all O-G cancer patients, both curative and palliative.	Yes
National Gastro-intestinal Cancer Programme: National Bowel Cancer Audit (NBOCA)	NHS Digital	Colorectal (large bowel) cancer is the most common cancer in non-smokers and second most common cause of death from cancer in England and Wales. Each year over 30,000 new cases are diagnosed, and bowel cancer is registered as the underlying cause of death.	Yes
National Joint Registry (NJR) – Knee Replacement & Hip Replacement	Healthcare Quality Improvement Partnership (HQIP)	The audit covers clinical audit during the previous calendar year and outcomes including survivorship, mortality and length of stay.	Yes
National Lung Cancer Audit (NLCA) – Lung Cancer Clinical Outcomes Publication	Royal College of Physicians	Lung cancer has the highest mortality rate of all forms of cancer in the western world and there is evidence that the UK's survival rates compare poorly with those in the rest of Europe. There is also evidence that, in the UK, standards of care differ widely. The audit was set up in response to the NHS Cancer Plan, to monitor the introduction and effectiveness of cancer services.	Yes

National Maternity and Perinatal Audit (NMPA): NHS Maternity Care for Women with a Body Mass Index of 30kg / m2 or Above – Gap Analysis	Royal College of Obstetricians and Gynaecologists	The audit (NMPA) is a new large-scale audit of NHS maternity services across England, Scotland, and Wales.	Yes
National Neonatal Audit Programme	Royal College of Paediatrics and Child Health (RCPCH)	To assess whether babies requiring specialist neonatal care receive consistent high-quality care and identify areas for improvement in relation to service delivery and the outcomes of care.	Yes
National Paediatric Diabetes Audit (NPDA)	Royal College of Paediatrics and Child Health (RCPCH)	The audit covers registrations, complications, care process, and treatment targets.	Yes
National Perinatal Mortality Review Tool	University of Oxford / MBRRACE UK collaborative	The MBRRACE-UK / PMRT collaboration is pleased to announce the publication of the third annual report of findings from the reviews completed using the National Perinatal Mortality Review Tool (PMRT) from March 2020 to February 2021.	Yes
National Prostate Cancer Audit	Royal College of Surgeons of England	This audit covers organisational elements of the service and whether key diagnostic, staging, and therapeutic facilities are available on site for each provider of prostate cancer services.	Yes
National Vascular Registry	Royal College of Surgeons of England	The audit addresses the outcome of surgery for patients who underwent two types of vascular procedure. The first is an elective repair of an infrarenal abdominal aortic aneurysm. The second is a carotid endarterectomy.	Yes
Neurosurgical National Audit Programme	Society of British Neurological Surgeons	The aim of this programme is to engage units in a comprehensive audit	Yes

		programme that reflects the full spectrum of elective and emergency neurosurgical activity, and to provide a consistent and meaningful approach to reporting on national clinical audit and outcomes data.	
Paediatric Intensive Care (PICANet)	University of Leeds / University of Leicester	PICANet aims to continually support the improvement of paediatric intensive care provision throughout the UK by providing detailed information on paediatric intensive care activity and outcomes.	Yes
Respiratory Audits: National Outpatient Management of Pulmonary Embolism	British Thoracic Society	The aim of the BTS audit programme is to drive improvements in the quality of care and services for patients with respiratory conditions across the UK. The BTS Audit of Outpatient Pulmonary Embolism Management in the UK seeks to identify where improvements can be made in this area to align practice to BTS Quality Standards and other guidance.	No*
Respiratory Audits: National Smoking Cessation 2021 Audit	British Thoracic Society	Audit of smoking cessation activity in NHS acute hospitals using BTS and NICE standards for secondary care.	No*
Sentinel Stroke National Audit programme (SSNAP)	King's College London	The audit collects a minimum dataset for stroke patients in England, Wales and Northern Ireland in every acute hospital, and follows the pathway through recovery, rehabilitation, and outcomes at the point of 6-month assessment. It is the only national stroke register in the world to collect longitudinal data on the processes and outcomes of stroke care up to six months post stroke.	Yes

Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Serious Hazards of Transfusion (SHOT)	The scheme collects and analyses anonymised information on adverse events and reactions in blood transfusion from all healthcare organisations that are involved in the transfusion of blood and blood components in the United Kingdom.	Yes
Society for Acute Medicine's Benchmarking Audit (SAMBA) – annual since 2012	Society for Acute Medicine	The Society for Acute Medicine (SAM) Benchmark Audit (SAMBA) is a national benchmark audit of acute medical care. The aim of SAMBA19 is to describe the severity of illness of acute medical patients presenting to Acute Medicine, the speed of their assessment, their pathway and progress at seven days after admission and to provide a comparison for each participating unit with the national average (or 'benchmark').	Yes
Transurethral Resection and Single Installation Mitomycin C Evaluation in Bladder Cancer Treatment	BURST Collaborative / British Urology Researchers in Surgical Training	The aim of the BURST Research Collaborative is to produce high impact multi-centre audit and research which can improve patient care.	Yes
Trauma Audit and Research Network (TARN)	The Trauma Audit and Research Network	TARN is working towards improving emergency health care systems by collating and analysing trauma care.	Yes
UK Cystic Fibrosis Registry	Cystic Fibrosis Trust	The UK Cystic Fibrosis Registry is a secure centralised database, sponsored and managed by the Cystic Fibrosis Trust. It records health data on consenting people with cystic fibrosis (CF) in England, Wales, Scotland, and Northern Ireland.	Yes

Urology Audits: Cytoreductive Radical Nephrectomy	British Association of Urological Surgeons	This audit includes nephrectomies, nephroureterectomies and partial nephrectomies carried out either through a conventional open incision or through several keyhole incisions (laparoscopic or robotic assisted laparoscopic).	Yes
Urology Audits: Management of the Lower Ureter in Nephroureterectomy	British Association of Urological Surgeons	To determine which surgical technique offers the best cancer control in terms of survival and recurrence; to capture patient profiles at entry; to determine whether the different procedures are performed without significant morbidity.	Yes

***** *Audit participation suspended internally due to clinical pressures.*

Participation in National Confidential Enquiries into Patient Outcome and Death (NCEPOD) 2021-22 (Table B)

The table shows the list of NCEPOD studies that we were eligible for in 2021-22, which hospital sites participated and the percentage of clinical questionnaires, case notes and organisational questionnaires returned.

NCEPOD studies in 2021-22	Sites participating	Clinical questionnaire returned	Case notes returned	Organisational questionnaire returned
Epilepsy Study	John Radcliffe Horton General Hospital	100%	100%	100%
Transition from child to adult health services	John Radcliffe Horton General Hospital Churchill Hospital Nuffield Orthopaedic Centre	Ongoing		

NCEPOD studies in 2021-22	Sites participating	Clinical questionnaire returned	Case notes returned	Organisational questionnaire returned
Crohn's disease	Churchill Hospital John Radcliffe Horton General Hospital	Ongoing		

OUH has participated in 100% National Confidential Enquiries into Patient Outcome and Death (NCEPOD) 2021-22.

Actions taken and benefits for patient care (Table C)

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

Audit	Summary of actions
Myocardial Ischaemia National Audit Project (MINAP) Summary Report 2018-19	• The Trust continues to improve access to immediate care through direct admission for people presenting with ST elevation Myocardial Infarction (MI). OUH continues to achieve excellent treatment times and the prescribing of secondary prevention medication for patients following a heart attack is excellent. There has for the first time in this year's MINAP report been seen the proportion of patients referred to the cardiac rehabilitation team. This highlighted the excellent approach to the care and rehabilitation of patients after heart attack.
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme – COPD outcomes 2017-18 site level reports	• Discussion with Oxford Health NHS Foundation Trust about increasing respiratory nursing team working hours to enable 7 days a week respiratory specialist expertise for COPD patients. • Pilot of Consultant Nurse / medical level COPD ward round like heart failure ward rounds. • GP spirometry results to be made accessible via EPR. Discussion with Divisional Informatics Lead about development of electronic solution. • Establish smoking cessation champion in each area, supported by the 'Here for Health' team as part of the Risky Behaviours national CQUIN. Development of Smoke Free Strategy.
National Vascular Registry	• To continue data submission facilitated through appointment of Data Manager. • Review of Patient Pathway as Multidisciplinary Team (MDT) delays were identified.

Audit	Summary of actions
National Diabetes Audit Core report 1: care processes and treatment targets including structured education programme analysis (2018-19)	• OCCG, OUH and local GPs to continue to work together to share patient level data and accountability for the people with diabetes in Oxfordshire to significantly transform the care and treatment of people with diabetes. • Greater provision of structured education for people with type 1 diabetes, both face to face and virtually through increase in funding and number of course provided each year.
National Adult Diabetes Audit: National Pregnancy in Diabetes Audit	• Reinstate pre-pregnancy clinic led by Diabetes Specialist Nurse (DSN). • Monitor patients by DSN and doctors weekly.
National Prostate Cancer Audit (NPCA)	• Appointment specific staff to the Cancer Management Team for audit. • Improve version of infloflex data management system. • Review electronic links with EPR. • Develop infrastructure to review dataset prior to submission.
National Neonatal Audit Program	• Implementation of Neonatal Unicef Baby Friendly Accreditation with an aim to improve rates of maternal breast milk use.
Respiratory Audits: National Smoking Cessation 2021 Audit	• Disseminate Smoking Cessation Advisor training to pharmacists and technicians.
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	• Undertake a gap analysis. • The first paediatric assessment through the first seizure pathway is being streamlined by the general paediatric team.
National Paediatric Diabetes Audit (NPDA)	• Continue twice yearly recall of NPDA outcomes rather than annually. • Continue additional screening during annual review secondary inputting into Twinkle database. • Continue offering standard of care and education.

Audit	Summary of actions
National Emergency Laparotomy Audit (NELA)	• Address the Perioperative Medicine Lead issue. • Attain surgical buy-in for the Multidisciplinary Pathway action.
National Early Inflammatory Arthritis Audit (NEIAA)	• Ensure that paperwork is available in clinic and completed by staff.
Fracture Liaison Service (FLS) Database	• Improve identification of vertebral fractures through further diagnostic input and MDT involvement. • Improve monitoring outcomes at 16 and 52 weeks.
BAUS Snapshot audit Bladder outflow obstruction (BOO)	• Maintain availability of BOO procedures (Urolift and Rezum) in Horton theatre lists. • Encourage clear documentation of required assessments. • Commence Lower Urinary Tract symptoms clinic.
National Diabetes Audit Report: Care Processes and Treatment Targets (2019-20 data)	• Implement Diabetes MPAGE which has the ability to capture and display the 8 care processes. • Approve Freestyle Libre for people with Type1 Diabetes • Four yearly PCN visits by specialists to GP surgeries and twice-yearly locality meetings to share best practice. • Increase in funding for structured education for T1DM.
National Bowel Cancer Audit 2020 and Surgeon's outcomes 2020	• Continue to improve data submission through identification of digital solutions.
National Audit of Cardiac Rhythm Management Devices and Ablations 2017-19	• Consider use of alternative reporting database as the dataset required to be collected for this mandatory national audit remain complex.
Mental Health (self-harm) 2019-20	• Continue ongoing measures for improvement with more recorded observations for patients at high risk (standard 2). • General focus on the front door assessment and emphasis on early triage which has shown to benefit the mental health patients.

Audit	Summary of actions
Assessing for Cognitive impairment in Older People 2019-20	• Undertake QIP in ED with interventions using education and re-iteration to document.
Care of Children in the ED 2019-20	• Continue with the systems as both JR and HGH performed well above the national average. Audit highlighted the presence of robust Paediatric Safeguarding Team and the work done over the years.
NBSR Surgeon Outcome Bariatric Surgery 2020	• Develop a Tier 3 heavily linked to Oxford Bariatric (Tier 4). • Continue to work with CCG / OCDEM / LA.
National Joint Registry	• Horton General Hospital: introduce coding plan to review all cases coded from 2018 onwards. • NOC: review all cases to compare risks with revisions. • Support outliers through investigation and possible change of practice.
National Ophthalmology Database (NOD) Audit	• Simplify auditing as mandatory input into Medisoft.
British Association of Urological Surgeons (BAUS) and local Percutaneous Nephrolithotomy (PCNL) Surgeon Outcomes 2020	• Resume weekly PCNL theatre lists to help reduce the waiting list for PCNLs.
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Time Matters	• Share report findings with key clinicians and clinical directors – include precise findings for these clinical areas. • Identify leads within each area to ensure key recommendations are implemented or assurance provided that these recommendations are in place. • Ensure standardisation and consistency of care across all clinical areas in particular critical care / emergency department environments. • Identify key areas for audit.
Maternal, Newborn and Infant Clinical Outcome Review Programme (Perinatal Confidential Enquiries – Stillbirths and Neonatal Deaths in Twin Pregnancy)	• Make minor amendment of Multiple Pregnancy Guidelines to cover specific issues with preterm multiples.

Audit	Summary of actions
	• Formally include complications of MC twin pregnancies in PROMPT training; particularly recognition of signs of TTTS. • Amend MAU guideline to state that consultant / foetal medicine team review of all foetal medicine presentations to MAU is needed.
National Diabetes Inpatient Audit Harms (NaDIA-Harms) Audit	• Implement a robust system to identify all people with diabetes on admission to hospital. • Convene a meeting between stroke and diabetes teams to develop solutions to test. • Review cases reported to NaDIA Harms Audit nationally. • Disseminate learning.
Chronic Kidney Disease Registry	• Introduction of new alert mechanisms to prompt clinicians to complete missing data in good time to improve overall completeness of clinical data (ethnicity, co-morbidity, cause of renal failure). • Move to EPR data extraction for registry returns from proton • Include access review as part of monthly dialysis results review meeting. • Continue to monitor the use of tunnelled haemodialysis lines each month in prevalent haemodialysis population.
2018 NCA of the Management of Maternal Anaemia	• Audit local screening uptake at the first trimester / presentation and at 28 weeks ensuring that it exceeds 95%. • Provide written information on how to take oral iron to maximise absorption. • Provide written dietary information to maximise the availability of iron through diet.

The reports of 9 national clinical audits are being developed and waiting for presentation to Clinical Improvement Committee in May 2022.

- National Oesophago-gastric Cancer Audit (NOGCA) 2021
- National Prostate Cancer Audit (2021-22 schedule)
- Mandatory National Joint Registry Clinical Audit (for NOC, JR and HGH)
- Maternal, Newborn and Infant Clinical Outcome Review Programme (Maternal Mortality Surveillance and Confidential Enquiry)
- Intensive Care National Audit and Research Centre: Case Mix Programme Clinical Audit
- National Audit of Breast Cancer in Older Patients 2021 (NABCOP)
- Neurosurgical National Audit Programme Clinical Audit
- National Audit of Cardiac Rehabilitation
- National Cardiac Arrest Clinical Audit

The reports of 25 local clinical audits were prioritised for Trust-wide review by Oxford University Hospitals NHS Foundation Trust's Clinical Improvement Committee in 2021-22. Following these audits, Oxford University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Actions taken and improvements made from local audits (Table D)

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

Audit	Summary of actions
Trust-wide Audit: Do not Attempt Cardiopulmonary Resuscitation / Treatment Escalation Plan (DNACPR / TEP)	• Continue to audit all available data to determine scale of problem for the following 6 months. Aim to target education to specific areas with high numbers of poorly documented cancellations. • Assurance mechanism in place on EPR. Audit now required to ensure this is actively promoted and communicated Trust-wide to ensure increase in acknowledgment on readmission.
Trust-Wide Audit – Pressure Ulcer Prevention Clinical Improvement Audit (NICE CG179 / QS89) and Pressure Ulcer Prevention Policy	• Develop Divisional reports. • Update local action plans. • Include Hospital Acquired Pressure Ulcer (HAPU) reduction as a Trust Quality Priority for 2022-23.
NICE Faltering Growth (QS197)	• Undertake a risk assessment to explore strengthening provision of dietetic support for inpatients and outpatients across the John Radcliffe and Horton General hospitals.
NICE Postnatal Care (QS37)	• Communicate audit results. • Undertake a weekly ‘micro’ audit of 10 care plans by ward manager. • Liaise with IFT to document information shared during ward teaching sessions.
NICE Multiple Pregnancy: Twin and Triplet Pregnancies (QS46)	• Improve documentation of discussion of mode of birth by 28 weeks’ gestation in both DC and MC twin antenatal clinics.
Trust Radiation Audit Programme	• 19 audits were included: OUH successfully carried out 18 out of 19 audits with 15 audit reports completed; three draft audit reports currently under review; and one audit suspended due to winter pressures but later carried out in February 2022. • 92% average compliance has been achieved for the 15 audit reports completed at the time of writing.
CG 165 Hepatitis B	• Overall OUH has met the NICE indications related to Hepatitis B. Testing for HDV, HIV, and HCV co-infection strengthened with more clear documentation for each patient; a

Audit	Summary of actions
	summary proforma at the beginning of each clinic letter could facilitate this. • Post COVID-19 telephone clinics have shown that telephone clinics are feasible for Hepatitis B except for those with language issues (English not native language) and require an annual fibro scan or ultrasound.
NICE Guidance CG128: Autism Spectrum Disorder in under 19	• Waiting time for diagnostic assessment to be reduced by increasing budget for assessment (CCG) and / or staffing (OUH). • Wood's light examination to be used in all physical examinations. Telephone FU appointments to be utilised to ensure <6 weeks of diagnosis.
OUH Transcatheter Aortic Valve Implantation (TAVI) service: Update on Clinical Outcomes 2020	• OUH provides a nationally leading TAVI service receiving cases for 'second' opinion or with additional complexity e.g. ACHD. Complication rates are in keeping with those reported in the UK national audit (BCIS) and international publications. • The service continues to maintain a 'live' database to monitor service metrics including complications. • Regular reviews of service performance using external benchmarking metrics and through the Trust governance processes. • Active engagement in national service issues and clinical research to further improve outcomes.
Trust-wide Audit: The Deteriorating Patient	• Continue to monitor using SEND data: highlight compliance data via Divisional structure on monthly basis. • Consider case for resetting frequency requirements for some patients alongside NEWS2 implementation.
Antenatal Care QS22 (parts viii and ix)	• Change to blue handheld Maternity Records and make changes to EPR accordingly. • Change to blue handheld Maternity Records to facilitate VTE assessment to be recorded in handheld notes at booking.

Audit	Summary of actions
	• Venous thromboembolism VTE assessment to be included on booking printout from EPR.
Hypertension in Pregnancy (NG133)	• Continue using booking form launched in November 2020 to aid with first trimester risk assessment of hypertension risk (plus calculation of indication for aspirin). • Rollout of maternal medical risk assessment (MMRA) tool on GP EMIS system to aid more timely prescription of aspirin. • Application for PGD for community midwives to prescribe aspirin. • Improve awareness among staff dealing with postnatal patients about correct discharge instructions for patients with hypertension Introduce MMRA use by GPs and keep updated.
Diabetes in Pregnancy, Quality Standards 2 and 4-7	• Introduce retinal screening history questions at time of midwife booking. • Implement a standard EPR document for retinal screening history and need for referral to be completed at booking. • Continue to report issues to Sensyne Health. • Review EPR booking and referral form to allow direct referral of patients to Diabetes in Pregnancy Service. • Approach Dietetic Support Team to increase clinic spots with dietitians.
NICE Inducing Labour (CG70 / QS60)	• Disseminate audit results to midwives / obstetricians to improve documentation. • Plan for updated EPR system to allow leaflets to be given electronically to patients (in the intervening time, disseminate audit results to ensure documentation of written IOL leaflet given and / or signposting to 'Mum and Baby' app).
NICE Intrapartum Care for Women with Pre-existing Medical Conditions	• All obstetric cardiac patients to have precordial assessments carried out and recorded during their face-to-face antenatal clinic appointments. • All patients on long-term steroids should continue with steroid therapy in the intrapartum period.

Audit	Summary of actions
	• All patients with heart conditions or chronic kidney disease should have accurate fluid balance in labour. Liaise with anaesthetic colleagues and Maternity Pharmacy.
NICE QS57 Jaundice in Newborn Babies Under 28 Days	• Shared learning, newsletter circulation, daily Safety Huddle discussions. • Discuss audit findings with admin staff when admitting patients. • Undertake weekly 'micro' audit of 10 care plans by ward manager.
NICE Guidance NG72: Developmental Follow-up of Children Born Pre-term (<37 / 40)	• Communicate to the team to measure head circumference and document occipitofrontal circumference. • Communicate to the team to share letters with education if parents agree.
CG83 Rehabilitation after Critical Illness: Adult Intensive Care Unit	• Continue with educational programme for Occupational Therapy delivered on ICU • Review information leaflet and practices around its delivery to patients.
NICE Quality Standard QS185: Hearing Loss in Adults	• Deliver training session with Adult Audiology team members regarding importance of follow-ups to ensure good outcomes for new hearing aid users. • Deliver training with administrative team and clinicians regarding appointment type to be booked. Review appointment types and booking processes.

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. 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). OUH is

also a partner in the Oxford Academic Health Science Centre (AHSC), along with Oxford Health NHS Foundation Trust (OH), Oxford Brookes University and the University of Oxford (OU), since 2014. These partners bid successfully in the latest competition for NIHR / NHSE&I Academic Health Science Centre designation, under a new name – the Oxford Academic Health Partners (OAHP). This designation came into effect from 1 April 2020, for an initial period of five years.

In particular, OUH works in close partnership with OU in clinical research, encompassing major programmes in all areas of medical sciences, including cardiovascular, stroke, dementia, cancer, infection, vaccines, surgery, and imaging, as well as interdisciplinary collaborations in digital health.

Much of this activity benefits substantially from the OUH-OU Biomedical Research Centre (NIHR Oxford BRC) which was awarded funding of £114 million for the period 2017-22, following a competitive bidding process. In the wake of the COVID-19 pandemic, all BRC contracts have been extended by eight months, to 30 November 2022, with additional funding provided *pro rata*. The OUH-OU BRC is working with the separate OH-OU BRC in mental health (which was awarded funding of £12.8 million) and with the OAHP, to develop innovations in areas such as working with 'big data', personalised medicine and tackling the problems of multiple long-term conditions and dementia. The OUH-OU BRC is also supporting enhanced capabilities for working with industry, provision of clinical research facilities (CRF) and good manufacturing practice (GMP) manufacturing capabilities, and for patient and public involvement. The OAHP has been working closely with both Oxford BRCs to develop complementary and synergistic bids in the latest competition for BRC designation for five years from December 2022, the outcome of which should be known in May 2022. A separate bid for NIHR CRF designation and funding for a new CRF run in partnership with OU was successful. This takes effect for five years from September 2022.

During 2021-22, OUH hosted 1,497 active clinical research studies. This is a 75% increase compared to the previous year, during which the majority of studies were paused due to the COVID-19 pandemic, in accordance with direction from the NIHR. However, this figure remains lower than the number of studies reported as active prior to the pandemic. This is because some studies closed early as a direct result of the pandemic and because a comprehensive review of OUH's entire portfolio of studies during the pandemic identified other studies that had in fact completed activity prior to the pandemic and could therefore be closed. The current figure of 1497 active clinical research studies

includes 3,597 new studies that have opened to recruitment at OUH during 2021-22, the vast majority of which do not relate specifically to COVID-19.

The number of patients receiving relevant health services provided or sub-contracted by Oxford University Hospitals NHS Foundation Trust in 2021-22 who were recruited during that period to participate in research approved by a research ethics committee was 17,853 participants recruited to 463 studies which were CRN portfolio registered. This is an 18% increase in participants compared to the previous year, although this is still ~40% less than pre-pandemic recruitment activity, reflecting the increased challenges of recruiting participants to research studies – especially studies not related to COVID-19 – during the ongoing pandemic.

In 2021-22, 151 OUH staff were directly supported by NIHR Oxford BRC funding and 283 staff were funded by the NIHR Clinical Research Network.

In response to the COVID-19 pandemic, between 24 March and 27 May 2020, all OUH clinical research activity was paused, except for studies directly related to COVID-19 and those where patient care is dependent on the research protocol. A staged resumption plan came into effect on 28 May 2020, enabling Principal Investigators (PIs) to request support to resume clinical research studies that had been paused, and to set up new studies, subject to specific conditions being met. A review of the remaining paused studies was completed in September 2021, with R&D contacting PIs proactively where necessary to ensure their studies were recorded as either resumed or closed. These activities have been overseen by an Assessment and Prioritisation Panel, working closely with ten Local Research Oversight Groups, all of which were set up during the pandemic, and continue to play a key role in reviewing and prioritising requests from our PIs for new studies to be set up to recruit at OUH.

By the end of 2021-22, OUH had hosted a total of 87 COVID-19 clinical research studies. 39 of these are sponsored by OU and four by OUH. 30 were classified as UK Government-designated Urgent Public Health (UPH) studies and 63 were new studies, that have been set up from scratch since March 2020. The other 24 were pre-existing studies that have been amended to address COVID-19 research questions or, in a few cases, were essential to support the delivery of COVID-19 research.

All COVID-19 studies which involve OUH patients and / or staff have been reviewed and approved by the OUH / OU COVID-19 Clinical Research Review Group (CRRG). The remit of this group is to ensure that COVID-19 studies at OUH do not overlap, that

resources are used efficiently and that any local priority studies do not impede OUH's commitment to running UPH studies. The CRRG has met weekly since the start of the pandemic. It is co-chaired by the OUH Director of R&D and the Director of the NIHR Oxford BRC. Other members include research nurse managers, R&D and senior clinicians who are actively involved in research as well as patient care in the most relevant parts of OUH (ED, ICU and respiratory).

The following examples illustrate some of the diverse high-impact clinical research studies hosted by OUH, working in close partnership with the University of Oxford (OU).

- RECOVERY, the largest randomised controlled trial of potential COVID-19 treatments in the world. As a result of close collaboration with the sponsor (OU), OUH was the first site to complete set-up activities and recruited the first trial participant the very next day, on 19 March 2020. Since then, over 437 patients have been recruited to RECOVERY at OUH, which is one of 177 sites recruiting in the UK. RECOVERY has already found three effective treatments for COVID-19, discoveries that have vastly improved the care of patients hospitalised by coronavirus worldwide. The study has also proved six other treatments to be ineffective against COVID-19, helping healthcare services to prioritise resources.
- OU and OUH researchers have identified abnormalities in the lungs of long COVID patients who are experiencing breathlessness that cannot be detected with routine tests. The EXPLAIN study is using hyperpolarised xenon MRI scans to investigate possible lung damage in long COVID patients who have not been hospitalised with COVID-19 but who continue to experience breathlessness. Like a previous study in patients who had been hospitalised with COVID-19, initial findings show that there is significantly impaired gas transfer from the lungs to the bloodstream in these long COVID patients when other tests are normal.
- Nearly 700 OUH patients have been recruited to a new trial of a revolutionary new blood test that can detect more than 50 types of cancer before symptoms appear. The aim of the SYMPLIFY study, which is led by OU, is to demonstrate how the Galleri test, which uses sequencing technology to check for the earliest signs of cancer in the blood, could be used to increase cancer detection rates and improve diagnostic pathways. Most of these types of cancer have no recommended screening in the UK today, so these tests could transform cancer patient care within the next five years by improving the chance of early detection, successful treatment and survival.
- OUH clinicians have been working with OU engineers to use artificial intelligence alongside endoscopy to get more accurate assessment of the pre-cancerous condition Barrett's oesophagus in order to identify patients most at risk of

developing cancer. The new AI-driven 3D reconstruction of Barrett's oesophagus achieved 97.2% accuracy in measuring the extent of this condition in real time, enabling clinicians to assess the risk, the best surveillance interval and the response to treatment more quickly and confidently

Our education and training

OUH delivers and supports patient-centred education across all professional groups and services. It is the teaching hospital Trust for the University of Oxford School of Clinical Medicine and has a Postgraduate Medical and Dental Education (PGMDE) Centre. Approximately 75% of the Trust's junior doctors are in one of the University of Oxford's recognised training programmes. More than a third of its consultants and senior Trust doctors are recognised General Medical Council (GMC) trainers. OUH is also a partner in the University of Oxford's School of Nursing and Midwifery alongside Oxford Health NHS Foundation Trust and Oxford Brookes University, as part of the Oxford School of Nursing and Midwifery. OUH is also a placement partner of choice for several allied health professions, pharmacy and healthcare science. Education and practice development roles continue to provide critical support to staff to enable them to deliver high quality services and patient care.

In the last year the corporate Practice Development and Education team has directly delivered:

- 57 active courses
- 32,131 enrolments
- 5,786 individuals completed PD&E
- 96% of learners would recommend our courses

This is in addition to commissioned programmes with external providers locally and nationally. Access to education and training is being further enhanced through the roll out of our new Continuous Professional Development (CPD) Hub which supplements our existing *My learning Hub* education and training platform.

An exciting development planned for 2022-23 is the delivery of the Open University blended Learning Programme for up to 30 students in the first year. The Trust will deliver all practice-based modules, associated theory and placement experience. This reflects the Trust's level of clinical and educational expertise for the benefit of our future workforce.

Postgraduate medical education

In 2021 the OUH Postgraduate Medical Education Strategy was launched with the following 8 themes shown in the infographic below, all of which are underpinned by our Trust values link directly into our overarching OUH Strategy and the NHS People Plan, and support our OUH Quality Priorities for current and future years.

The COVID-19 pandemic continues to impact many aspects of working and training lives. Many trainees require additional training time, especially in ‘craft’ specialties. Generic competences, confidence and wellbeing are all areas highlighted by the General Medical Council (GMC) as needing support – and this national focus on training recovery goes hand in hand with service recovery and ‘people recovery’. HEE and OUH have invested in equipment and projects to support training recovery. We have increased the amount of Simulation-Based Education (SBE) and are also targeting training recovery support for generic professional competences, and for peer support and wellbeing.

Every trainee has a named, trained Educational Supervisor (ES) who provides overall supervision, management, and clinical and pastoral support. Medical learners can also access support from any of the Trust and HEE wellbeing resources including through the Deanery’s Professional Support and Wellbeing Unit.

All trainees have both a Trust and a department induction. For Foundation Year 1 (FY1) doctors there is a hybrid induction of at least 1 week, including practical sessions and shadowing the outgoing post-holder. In 2021 all newly graduating medical students starting work in OUH as work as Foundation Year 1 doctors were offered an additional 5 days of shadowing, funded by HEE. Flexible working and training options are available and we have a Champion of Flexible Training and a Supported Return to Training Champion.

An OUH 'Becoming a Consultant' programme for senior trainees launched in 2022, and we are funding coaching and mentoring initiatives for senior trainees, and training and support for any trainer or trainee who wishes to become a peer mentor.

Junior doctor engagement occurs through several fora including the Medical Education Governance Groups, Junior Doctors' Forum and Medical Workforce Group. We have also attended to individual trainee experiences with listening and feedback groups and events, and regular training reviews with ESs and Programme Directors.

There is an excellent OUH Faculty Development Programme for Educational Supervisors, which we have been asked by HEE to extend regionally. There are also QI and leadership opportunities and programmes available within OUH for trainees and trainers, including our successful multidisciplinary Emerging Leaders Programme; the OUH QI Hub and OxSTaR; and we have just succeeded in a multi-trust bid to run a regional Leaders in Training programme for HEE trainees and educators.

We have a comprehensive Simulation-Based Education (SBE) programme which has been designed in line with postgraduate curricula and the new national Patient Safety Syllabus. We are also contributing to a regional SBE working group to develop a strategy for the effective delivery of SBE across Thames Valley.

OUH is the site for a new Regional Endoscopy Academy which will support multiprofessional learners in gaining endoscopy skills. We have bid successfully for funding from HEE to support immersive endoscopy training for trainees.

The Director of Medical Education reports both to the Board through the CMO and to the Postgraduate Dean. Educational quality and excellence are monitored through annual GMC and HEE surveys, the detailed responses to which are in the public domain. The direction of travel for many of our posts remains one of continuous improvement,

supported if required by local action plans.

We are supporting Future Workforce by taking Physician Associate students from Buckingham New University on clinical placements. The first cohort will graduate in 2022.

Focus on nurse retention

Band 5 staff nurse retention continues to be a key focus for the Trust. The Clinical Workforce Recruitment, Retention and Education steering group works collaboratively to address workforce challenges, and recently set a new target of <12% turnover for all Band 5 nursing. Following a consistent year, the Trust is in a strong position to meet the new target, with turnover at 12.4% in early January 2022 compared to 14.3% in January 2021. A new action plan has been launched by the Clinical Workforce, Recruitment, Retention and Education steering group to continue the focus on Band 5 nurse retention over the coming year.

International nurse recruitment continued to play a significant part in improving the Trust's Band 5 nurse vacancy rate and to support winter pressures. Despite the challenges of the last year, we still had a successful recruitment programme which has now seen over 500 internationally educated nurses join our teams here at OUH since the end of 2020. Further international nurse recruitment continues over the coming year with a target of 200 new internationally educated nurses joining the team by the end of 2022.

Our Peer Review Programme 2021-22

1. Internal Peer Reviews
The Internal Peer Review Programme has been running successfully at the Trust since 2014. The Peer Review Programme was paused during the COVID-19 pandemic and resumed during 2021-22. Since the programme has recommenced, there have been four reviews.

Maternity Clinical Service Unit Peer Review, October 2021
Haematology Clinical Service Unit Peer Review, November 2021
Equality Diversity and Inclusion Peer Reviews, November 2021 and February 2022

2. External Peer Reviews
The National Quality Surveillance Reviews were put on hold as a result of the COVID-19 pandemic.

JACIE – Bone Marrow Transplant – 8 October 2021

An external peer review of the Bone Marrow Transplant Programme was completed on

8th October 2021. This included Oxford and satellite centres in Stoke Mandeville and Reading. The review included our first inspection to confirm that we would be a suitable site for immune effector cell therapy (this includes CART cells). The Trust has received a favourable verbal report which has resulted in a recommendation to the JACIE office for renewal of accreditation.

External screening quality assurance review (ISQAR) – Thames Valley, Abdominal Aortic Aneurysm (AAA) screening programme

The Screening QA Service (SQAS) undertook an interim external quality assurance review with the Thames Valley AAA screening programme at 1.30pm on 28 May 2021. No immediate concerns or urgent recommendations were identified during the review.

National Audit of Care of the End of Life Care – 8 October 2021

A National Audit of End of Life Care was closed on 8 October 2021. The audit received immense participation from NHS acute and community providers in England and Wales, despite the impact of COVID-19 throughout the year, with 171 organisations taking part.

Joint Advisory Group on GI Endoscopy (JAG)

A review of endoscopy services at the Horton took place in December 2021 through the submission of a report card providing all required evidence. No feedback has yet been received, and no feedback is expected unless an organisation fails to demonstrate continued compliance.

Ofsted Apprenticeship Programme October 2021

During October 2021, the Trust welcomed a team of Ofsted inspectors who reviewed delivery of levy-funded apprenticeship programmes, which the Trust has undertaken as an employer provider since 2017. Inspectors used deep dive methodology within chosen specific standards and key judgements. These comprised the quality of the education; personal development; behaviours and attitudes, and leadership and management. Following a verbal report to the executive team and service leads at the end of the visit, the final report was recorded as ‘good’ for all categories.

Our Human Factors training

In 2021-22 the OUH Human Factors and Patient Safety training, which is run in partnership with the University of Oxford’s simulation centre (OxSTaR), changed substantially as a result of the pandemic. The majority of our training during the pandemic

was pivoted to online platforms, and this has continued. In addition, we have developed new human factors courses and materials to align with the National Patient Safety Syllabus, the final version of which was released in April 2021. The human factors programme offers training for staff at introductory and advanced levels and also a programme to support and develop faculty from all Divisions. It is proposed that all of the HF training materials will be made freely available to staff on the intranet and will be linked with new learning hub.

Since the start of the pandemic all of our learning materials developed to support patient and staff safety when dealing with COVID-19 were made freely available on OxSTaR's outward facing website (www.oxstar.ox.ac.uk), and there have been over 44,000 new users on the website from 170 countries, mostly from within the NHS but many from low to middle income healthcare systems.

The vision for the coming year is to capitalise on our experience in using technology to support learning for greater numbers of healthcare professionals, and to increase human factors capabilities across the workforce in OUH.

OUH Integrated Quality Improvement Team

Our Integrated Quality Improvement Programme brings together a critical set of related programmes which will ensure that more of our patients receive timely, safe, compassionate, quality care in the right setting for them, at the same time providing value for money.

The Team provides dedicated programme management, project management and service improvement support working closely with clinicians and other staff. This is achieved through the following actions.

1. Facilitating and supporting improvement projects including quality improvement knowledge.
2. Providing programme and project management, tracking progress, capturing risks, and escalating issues to remove barriers.
3. Coaching, working with local leaders to work with improvement tools and Specific, Measurable, Attainable, Realistic, and have a Timeframe (SMART) metrics to achieve lasting change.
4. Delivering the Quality Service Improvement and Redesign (QSIR) training; running bespoke seminars and providing coaching. Accredited QSIR trainers within the

Improvement Team continue to work with colleagues across Oxfordshire, Buckinghamshire and West Berkshire to deliver the five-day QSIR Practitioner (QSIR P) level course as well as a condensed one-day Fundamentals (QSIR F) course. The aim of this course is to empower staff at a local level to make improvements to clinical services based on NIHR model for improvement. The team now supports the delivery of the new QSIR virtual course, which has been introduced as a direct response to the COVID-19 pandemic. The course is an eight-day programme with smaller two to three hour sessions linking the content between the QSIR F and QSIR P courses.

This ambitious Integrated Quality Improvement Programme contains in the region of 40 projects spanning urgent and emergency care, planned care, (including cancer services) theatres, outpatients, and QI Education. The Integrated Quality Improvement Team also works with the Trust GIRFT lead to support the GIRFT programme nationally.

Key elements in the Integrated Quality Improvement programme include:

1. Urgent Care – development of the Trust-wide Urgent Care Programme
2. Outpatients – three workstreams including Advice and Guidance, Patient Initiated Follow-up, Non-face-to-face Appointments, Remote Bloods, Optimising Appointment Management and Self Check-in
3. Planned Care – Support to Tumour Site Activity Recovery, RTT recovery, Diagnostics and Inpatient Stratification
4. Theatre Productivity Programme – aiming to achieve at least 85% in Theatre Utilisation and Efficiency and no more than 5% in cancellations on the day.

Quality Improvement hub

The Our vision at OUH is ‘Delivering Compassionate Excellence’. The OUH QI Hub is a multi-professional programme established to develop QI capability and continuous, sustained patient-centred improvement by providing shared learning, collaboration, and mentorship. We aim to develop a community of empowered individuals and teams who drive a culture of continuous, sustained improvement that benefits patients, colleagues, and services.

The QI Hub supports a structured educational programme of dedicated fortnightly teaching on QI methodologies including topics such as problem-solving, aim-setting, model for improvement, process mapping, Lean, leadership and patient involvement.

Participants take part in individualised practical workshops together with face-to-face sessions and peer support. They are supported through their QI journey by equipping them with skills, tools and a structure to lead projects. Our QI Faculty have expertise in QI teaching and are representative of multi-professional teams.

In 2019, we started with two cohorts of 12 and 18 participants. 30 QI projects were completed and all projects were presented at the QI seminar. In 2020, despite the COVID-19 pandemic, we adopted a virtual approach and successfully managed to support 40 QI projects. Our main aim remains scaling up the QI activity and adopting change across clinical departments to increase the scope of activity and deliver greater efficiency and productivity across the organisation.

The feedback has been excellent with 100% of participants recommending it. Hub alumni have gone on to undertake further QI projects and leadership roles. We have supported 70 QI projects successfully within 2 years, leading to improvements in patient care and experience, and their work has been presented at national and international meetings.

The OUH QI Hub was awarded the HSJ Patient Safety award for changing culture in 2021.

Getting It Right First Time (GIRFT)

Getting It Right First Time (GIRFT) is a national programme designed to improve medical care within the NHS. GIRFT teams work together with NHS providers to undertake specialty-based ‘deep dive’ reviews investigating data, identifying good practice, discussing challenges, and developing action plans for improvement. OUH has been working with the national and regional GIRFT team to support specialties gaining from the insight and learning from across the system to improve care.

At present 39 specialties at OUH are locally engaged with the GIRFT programme, with some in a second phase of revisits and review following further national guidance. During 2020-21 a total of five deep dive reviews and one revisit took place, including our specialist services in Rheumatology; Plastic Surgery, Burns and Hand Surgery; Neonatology; Neurology; Cardiothoracic Surgery and a revisit to Urology.

During 2020-21 at OUH we have been locally mapping, aligning, and streamlining our GIRFT local processes to increase support and reduce the administrative burden for clinical services and teams. This has included developing a local SOP for services to

guide them through the process and support ongoing tracking and governance of the recommendations and action plans following the visits. Our priority for 2022-23 is to increase the focus of support from our Integrated Quality Improvement team on enabling services to adopt and utilise a QI approach and tools in response to GIRFT recommendations and standardisation of patient pathways.

Reporting Excellence

The OUH Reporting Excellence programme remains the most effective and immediate mechanism by which staff across the Trust can recognise others for exceptional work in their day-to-day practice. Using the simple link on the OUH intranet, more than 1,800 nominations have enabled staff to highlight leadership, compassion, and innovative work that made a difference to patient care and working lives. Individuals, groups of staff or entire teams may be nominated. Each nomination is accompanied by a built-in personal message of appreciation communicated directly back to the individual or team and an immediate acknowledgement to the sender.

This year, Reporting Excellence was fully integrated into Ulysses alongside incident reporting, clinical improvement and other facets of Trust governance activity. The Ulysses Excellence dashboard has been significantly upgraded and modified in the past 12 months to provide easy access to all Divisional, Directorate and now departmental reporting activity. Divisional and Quality leads receive automatically generated monthly summaries and now any staff member can view the overall activity of their own place of work. Categories of nominations are easily identifiable to enable thematic analysis with rich opportunities to explore the working lives and activities of the enormous number of people that make up our hardworking staff. For example, detailed analysis of reports submitted during the COVID-19 pandemic provided deep insight into how teams were functioning and what worked best to support them through that difficult period.

There has been an upswing in reports that specifically feature innovations and ‘workarounds’ encountered across the organisation. These not only send a message of appreciation to an individual or team but speak to patient care and safety in a unique way that directly affects safety and quality. Examples include a new ‘next day’ CT service that enables more rapid diagnosis of serious illness and a rapid access pathway for newborns with potential bowel obstruction. Both initiatives were brought into focus through the Reporting Excellence scheme.

We need look no further for evidence that the organisation is evolving flexible and often groundbreaking strategies to ensure that patients receive the best care possible. Many

reports are submitted at the end of a long shift, a long week, or after a particularly demanding patient encounter. The value of this immediacy cannot be overstated, as these reports are often deeply personal and presented in a forum that is impossible to replicate through any other awards or recognition scheme.

Local teams are now investigating mechanisms to promote the programme to continue to nurture positivity and the ability to deal with the challenges of working in a busy NHS Foundation Trust. Reporting and receiving reports makes people feel happier and more connected and committed to common goals; most messages inspire and encourage. Going forward, it is hoped that promoting the scheme to focus equally on working practices and adaptations that sit ‘below the radar’ will be of great additional and more direct benefit to the quality of care.

The Chief Medical Officer presents a standout nomination every month in person. Selecting one among many heartfelt and detailed submissions is increasingly challenging. Many additional reports are recognised by her through direct personal communication to the recipient. There is a plan, via Trust-wide communication, to formally recognise and learn from those reports flagging innovation and improvement to cascade learning and knowledge garnered via Reporting Excellence to all areas. By sharing the achievements of some, the whole Trust stands to benefit and pass this on to patients. This is the true spirit of Reporting Excellence: to thank, to motivate, to reinforce excellent work and to introduce new ideas every day. In doing so, our organisation as a whole is continually encouraged to strive for excellence in the future.

Our staff: other examples of outstanding practice

The Horton Hip Fracture Team was one of the best nationally for the ninth year running. The Horton General Hospital met all of its best practice criteria in nearly 92% of patients, while the average nationally is 55% – putting the team in the top three nationally. The national report shows that over 90% of patients admitted to the Horton General Hospital underwent surgery either on the same day, or the day after, significantly surpassing the national average of 69%.

A team at Oxford University Hospitals that makes custom-made orthotic devices such as insoles and splints is making significant sustainability improvements while improving patient care. The Orthotics department, based at the Nuffield Orthopaedic Centre in Oxford, is reducing, reusing, and recycling many of its materials, decreasing our carbon footprint, lessening the impact on the environment, and lowering costs.

A dedicated Psychological Medicine Staff Support Service has been created to support staff working at Oxford University Hospitals – thanks to the support of NHS Charities Together. It forms part of the Trust's Growing Stronger Together – Rest, Reflect, Recover programme to support the health and wellbeing of all staff working at OUH.

Guardian of Safe Working Hours

Doctors in Training: Safe Working Hours

Nationally, 'Doctors in Training' represent 40% of the medical workforce. New terms and conditions of service (TCS) were introduced for this group in 2016 with a significant amendment in 2019. 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 850 Doctors in Training at Oxford University Hospitals NHS Foundation Trust. Additionally, there are a number of locally employed doctors sharing the same rosters, roles and responsibilities.

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.

- 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.

The table shows the number of exception reports, the number of doctors reporting, the number of specialties receiving reports, what the nature of the exception was and the additional hours worked per exception, broken down by quarter and then showing the total.

Exception Reporting		**2021**			**2022**	**Total**
		Apr-Jun	**Jul-Sep**	**Oct-Dec**	**Jan-Mar**	
Number of exception reports		95	123	222	218	648
Number of doctors reporting		31	41	64	60	139
Specialties receiving reports		15	13	24	23	29
Nature of exception	Education	16	6	25	5	52
	Hours & rest	81	119	215	207	622
Additional hours worked per exception report		1.5	1.7	2.6	2.5	2.2

Organisational level data not reliably available as managed at a service level via departmentally commissioned data tools

The table shows the number of locum shifts undertaken by bank and agency staff, broken down by quarter, and the reason for the locum shift.

Locum shifts		**2021**			**2022**	**Total**
		Apr-Jun	**Jul-Sep**	**Oct-Dec**	**Jan-Mar**	
Total		2668	2711	2422	1356	9157
Agency		98	365	209	59	731
OUH Bank		1947	2346	2213	1297	7803
Reason for locum shift	Vacancy	1970	2055	1700	772	6497
	Non-vacancy	698	656	722	584	2660

Oxford University Hospitals NHS Foundation Trust has recognised that the following actions are required to promote safe hours' working hours for Medical and Dental Staff.

- Ongoing reminders from the GSWH that exception reporting is a contractual requirement and a neutral act.
- Implement the Trust Doctors Terms and Conditions of Service so all doctors can exception report using the same system. They will also be rostered in the same way as training doctors giving better parity.

- Implement an electronic rostering system for junior doctors to provide assurance that what is being worked within the department is in line with the work schedules provided; this would also provide oversight of clinical delivery.
- A regular reminder from the GSWH to all doctors on the process for raising a concern where a rota template is not being worked in line with the work schedule.
- Clinical leads to regularly review service requirements against the rota templates.

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 is kept under review to ensure it fully supports this aim. A separate Freedom to Speak Up Annual Report is presented to the Trust Management Executive 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.

Ensuring staff do not suffer detriment

Speaking up about any concern an employee has at work is really important. In fact, it isvital 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.

The Raising Concerns Policy states that 'Provided a member of staff is acting honestly, it does not matter if they are mistaken or if there is an innocent explanation for their concerns'.

Our CQUIN performance

The national *Commissioning for Quality and Innovation* (CQUIN) payment framework was paused in 2021-22 due to the COVID-19.

OUH implementing the priority clinical standards for seven-day hospital services

Seven Day Hospital Services Board Assurance Framework

The 7 Day Service (7DS) clinical standards are made up of 10 clinical standards[1]; four are classed as priority as these are considered to have the largest impact on patient mortality, and the remaining seven focus on continuous improvement. Annual assessments have been carried out at OUH since 2016 using audit, performance metrics and qualitative data; OUH has been consistently rated as an exemplar. During 2021 an assessment was not carried out due to the COVID-19 pandemic following discussion with the National Team, as trusts' primary focus concerned managing critically ill patients and recovery planning to address the large backlog of patients on waiting lists. The mortality index has been used as a litmus of impact of the priority standards; a review of the hospital standardised mortality index (HSMR) for the time period January 2021 to December 2021 reported a lower-than-expected rating overall,

[1] 7 Day Services Clinical Standards, updated Feb 2022 https: / / tinyurl.com / kfzbbnmp

with patients admitted both at weekends and on weekdays in lower or expected ranges as shown in the following table.

HSMR January 2021 to December 2021 ***(source DrFoster)***

Indicator	Observed deaths	Expected deaths	Metric	Banding
HSMR	1991	2139.0	93.1	Lower than expected
Emergency HSMR (weekdays)	1,423	1574.3	90.4	Lower than expected
Emergency HSMR (weekends)	499	513.7	97.1	Within expected range

Going forward an assessment at OUH will be carried out in 2022 against all 10 clinical standards. This will provide an opportunity to refresh how we continue to embed the 7DS clinical standards into 'business as usual', share good practice and carry out deep dives to understand how we can further improve our performance.

The previous assessment of 2020 showed the Trust exceeded the 90% thresholds for weekends and weekdays in relation to the four priority standards:

- patients receiving a review by a consultant level doctor within 14 hours of arrival at hospital
- patients receiving a daily review on the wards and twice daily review in critical careareas
- patients access to diagnostics
- patient access to consultant directed interventions.

The following tables show the percentage of patients who were reviewed by a consultant within14 hours of arrival at hospital on a weekday and the percentage of patients who received a once daily review and a twice daily review. The audited data shows consistent performance during weekdays and weekends.

	Standard 2			**Standard 8**				
	Patients reviewed by a consultant within **14 hours** of arrival at hospital			Patient receiving required **once daily** reviews			Patients receiving required **twice daily** reviews	
	Weekday	Weekend	Overall	Weekday	Weekend	Overall	Weekday	Weekend
Autumn 20	**96%**	**98%**	**97%**	**99%**	**97%**	**96%**	**100%**	**100%**
Autumn 19	94%	97%	95%	96%	98%	97%	100%	100%
Spring 19	95%	97%	96%	100%	93%	98%	100%	100%

A qualitative assessment in 2020 also showed that OUH performed very well against the remaining 7DS clinical standards for continuous improvement.

The national team fed back that our 2019 and 2020 submissions demonstrated a high level of assurance showing the triangulation of qualitative information, audit, and performance data. In recognition of this we delivered a national webinar to help other trusts to complete a comprehensive and accurate 7DS self-assessment.

Statements from the Care Quality Commission (CQC)

Oxford University Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is without conditions.
Oxford University Hospitals NHS Foundation Trust has not participated in any reviews bythe Care Quality Commission during 2021-22.

On 31 March 2022, the Trust had an overall rating of 'Requires Improvement' from the CQC. The CQC carried out two inspections on services provided by the Trust during the 2021-22 year and the results were published in July 2021 and September 2021.
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 the two CQC inspections and during 2021-22 the Trust developed, agreed, implemented, and has monitored detailed action plans to address the CQC conclusions.

Actions taken during 2021-22 included, but were not limited to:

1. continuing focus on staff wellbeing, with fora and initiatives to enable staff to discuss concerns
2. improvements in the use of local audit results to identify areas of focus and enable more effective monitoring of performance
3. continued development of the Integrated Performance Report
4. commissioning of an external culture review across Maternity and Neonatal services
5. a review of the Estates issues within maternity, with a view to developing a longer-term plan
6. search commenced for an electronic patient record system for maternity services.

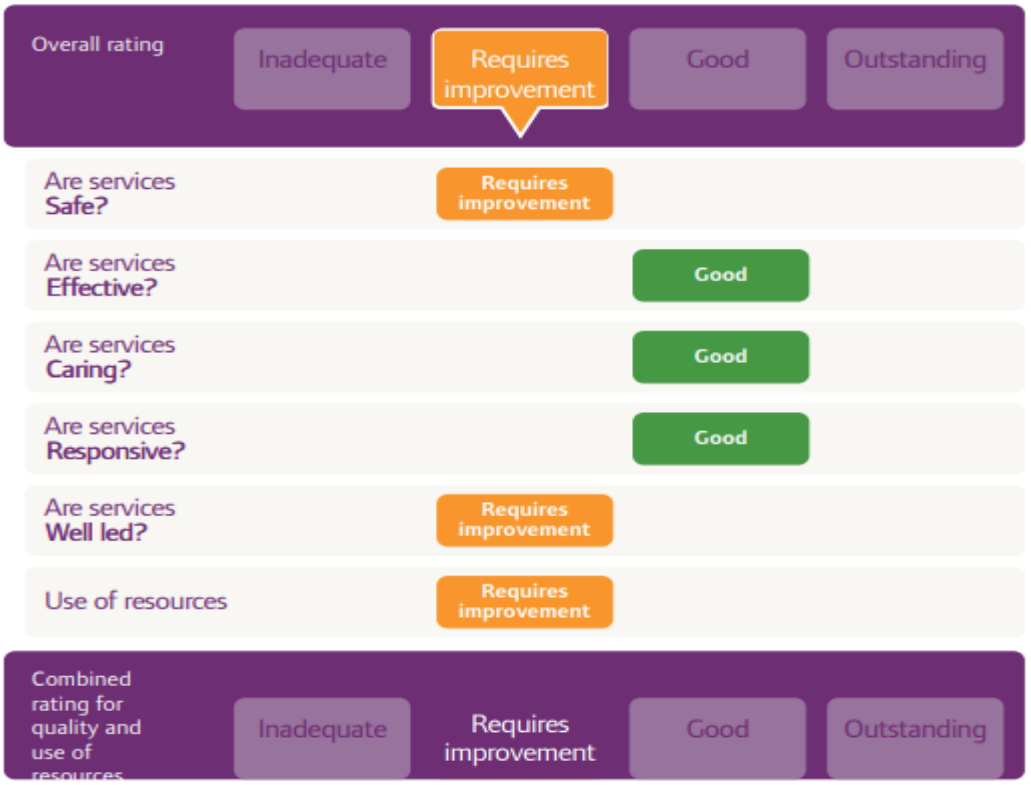
Many of the actions within these plans have been completed, however there are a

range of areas that remain the subject of continuous review and focus. 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.

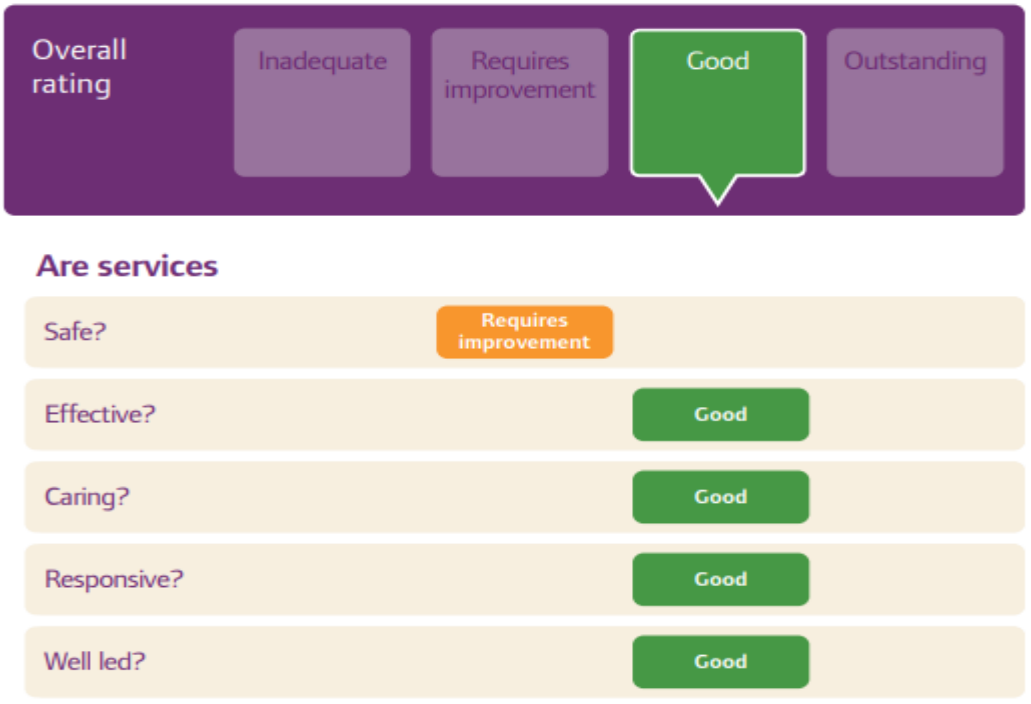
The action plans for the Maternity Services inspection and the Infection Control inspection were reported to the Trust Management Executive (TME) and Integrated Assurance Committee (IAC) and have been subject to monthly monitoring by the Clinical Governance Committee.

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

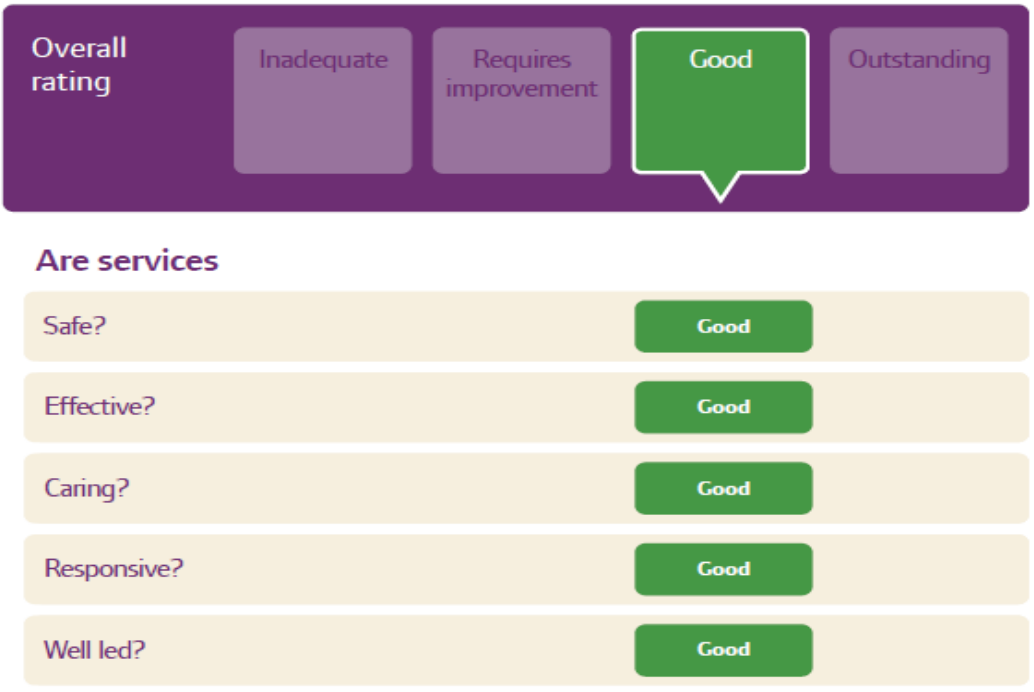
Ratings for John Radcliffe Hospital: last rated September 2021



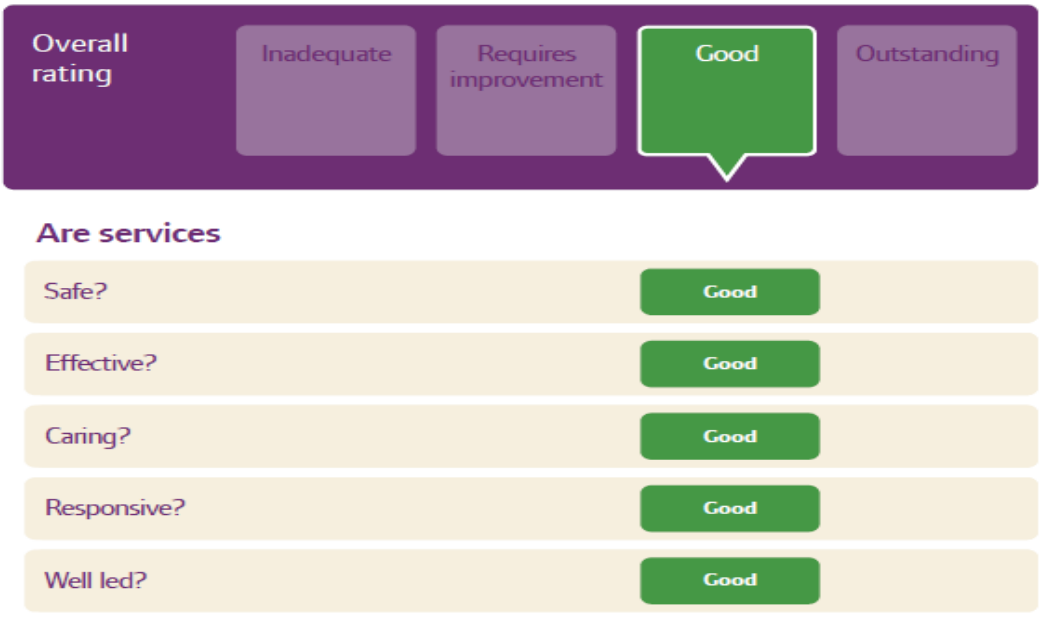
Ratings for Horton General Hospital: last rated June 2019

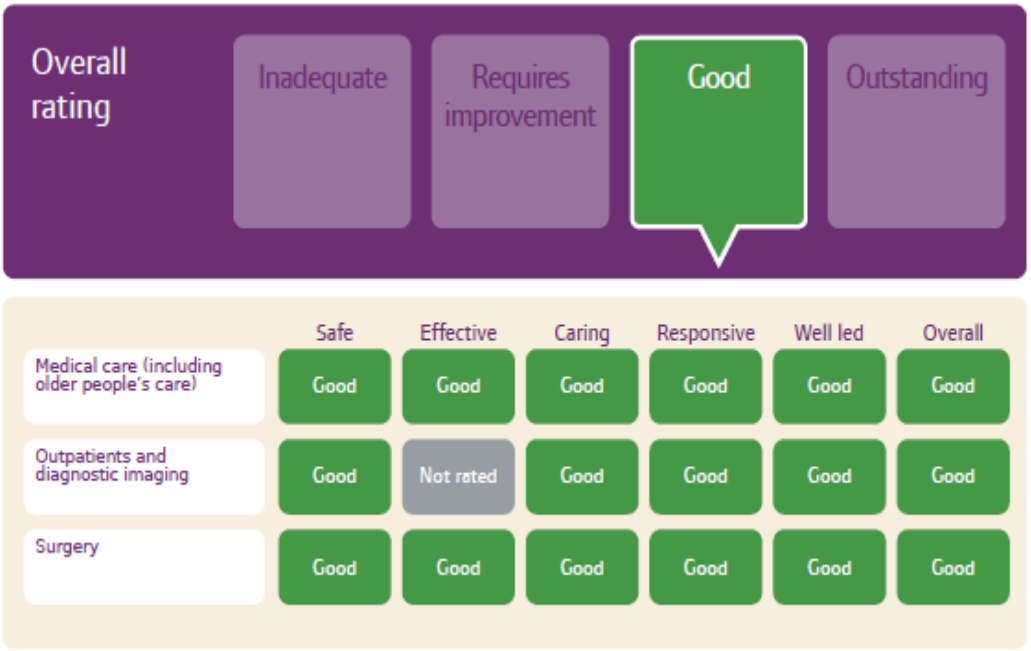


Ratings for Churchill Hospital: last rated June 2019



Ratings for Nuffield Orthopaedic Centre: last rated June 2019





Our data quality

A vital prerequisite for robust governance and effective service delivery is the availability of high quality patient 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 safety of our patients. The collection of data is vital to the decision-making process of any organisation and forms the basis for meaningful planning and helps to alert us to any unexpected trends that could affect the quality of our services. It also helps us identify and target areas that require additional systems training and support to improve the quality of data collection. 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.

- We ensure that the data reported go through a process of sense checks and corrections in order to mitigate the risk of incorrect data being submitted.
- Where system workflows do not support the data to output correctly and the services have opportunity to validate, we incorporate these changes so the reported information is an accurate reflection of the actions taken.
- We proactively monitor and support clinical services to record accurate administrative and clinical related information in line with agreed system workflowsfor the Trust's EPR (Cerner Millennium). We deliver systems training

for all users in accordance with their role within the organisation.

- We provide an operational and out-of-hours service for all system users in the formof a digital service desk which links directly to our EPR service provider. The service desk enables users to report data related incidents and issues that are prioritised and actioned on a daily basis.
- We create and run reports to proactively identify data anomalies that require actionto support clinical and administrative data integrity across EPR and integrated systems.
- We provide quality assurance testing for upgrades and new system enhancements to ensure that the validity, integrity of data and existing system functionality is notcompromised.
- We conduct quality assurance for system build and complete cleansing activities to ensure that inactive and obsolete data are no longer used.

SUS dashboards at month 12, 2021-22

Oxford University Hospitals NHS Foundation Trust submitted records during 2021-22 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 datashows.

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	99.6%	99.7%
General Medical Practice Code	100.0%	99.7%

Outpatients	OUH	National average
Valid NHS number	99.9%	99.8%
General Medical Practice Code	100.0%	99.6%
A&E	**OUH**	**National average**
Valid NHS number	99.1%	98.9%
General Medical Practice Code	99.9%	99.5%

Information Governance Toolkit

Data Security and Protection Toolkit

The Trust submitted its annual Data Security and Protection Toolkit (DSPT) Baseline return for 2021-22 to NHS Digital on 4 March 2022 with 109 out of 110 mandatory requirements answered. Due to the pandemic, the date for final submission of the 2021-22 DSPT was deferred by NHS Digital from 31 March 2022 until 30 June 2022. The Baseline submission does not result in a formal rating of the Trust's data security performanceagainst DSPT standards but is undertaken to demonstrate that work is ongoing incompleting the Toolkit. It is anticipated that the Trust will be rated as 'standards met' by agreeing an action plan with NHS Digital for any requirements which do not meet the required level of assurance.

Clinical coding error rate

Oxford University Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2021-22. Audit Commission ceased to exist from April 2015 and hence this is not applicable to the Trust. Coding department have an ongoing audit programme to ensure coding accuracy.

Oxford University Hospitals NHS Foundation Trust is committed to the timely and accurate recording of clinically coded data.

The Trust continues to recognise the importance of clinical coding and has increased staffing dedicated to collecting and reviewing coded data. These staff are engaged in, but are not limited to, the following workstreams.

1. Clinical Coding Audit
2. Clinical coding data analysis to support improvement and clinical collaboration
3. Validation of coded data with clinical colleagues to improve data quality and improve patient care
4. Assurance of coded data affecting the Payment by Results process
5. Assessing the impact of coded data on the national GIRFT project (Getting It Right First Time)
6. Improvements in clinical coding training
7. Participation in the Mortality reporting process

This work demonstrates the Trust's commitment to the collection, analysis and reporting of high quality coded data.

National core set of quality indicators

Mortality – Preventing People from Dying Prematurely

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 SHMI, published on 26 January 2022, for the data period October 2020 to September 2021, is 0.92. This value is banded 'as expected' using NHS Digital 95% confidence intervals adjusted for over-dispersion.

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

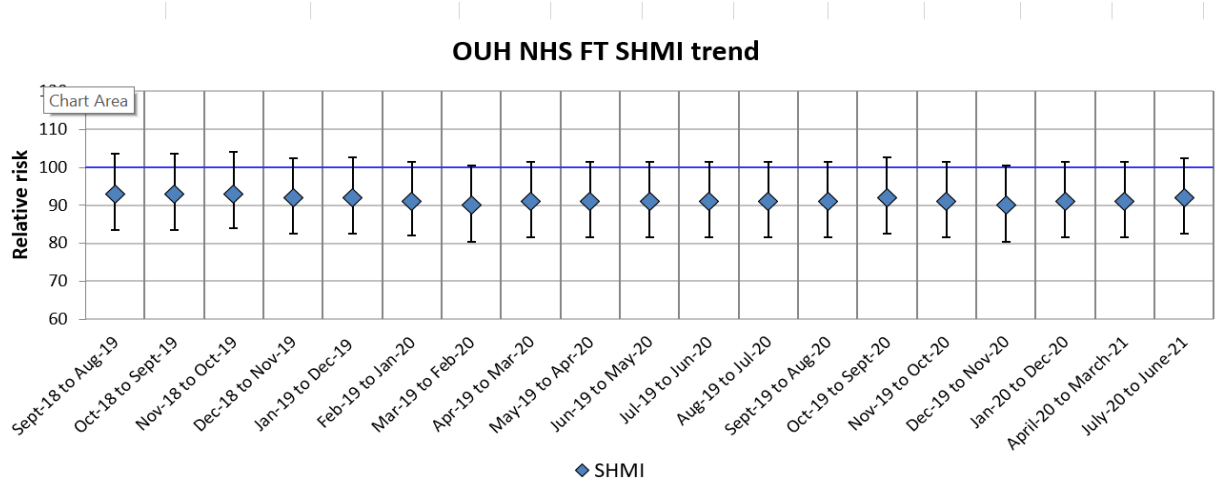
- The Trust has a process in place for collating data on hospital admissions, from which the SHMI is derived.
  - Data are collected internally and then submitted on a monthly basis to NHS Digital via the Secondary Uses Service (SUS). The SHMI is then calculated by NHS Digital.
  - Data are compared 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 Trust takes the following actions to improve the SHMI, and so the quality of its services, by continuing to review the SHMI at the Mortality Review Group (MRG).

- The Trust MRG meets monthly under the chairmanship of the Deputy CMO with responsibility for learning from deaths. The MRG has multidisciplinary and multiprofessional membership with clinical representation from all four clinical Divisions.
- If there is an increase in the SHMI, the MRG will task Clinical

Service Units to investigate the diagnoses groups contributing to the increase and review the findings from the investigations. If the investigation identifies any care quality concerns, actions will be implemented and monitored by the MRG.

The graph below shows the OUH SHMI value over time, with the baseline of 100.



Our Trust target is for 100% of patient deaths to be reviewed to ensure that any omissions or actions taken are identified and learnt from to improve care. An analysis of the mortality reports for April 2021 to December 2021 indicate that 96% of deaths were reviewed within eight weeks. MRC and NOTSSCaN Divisions have subsequently reported that the outstanding reviews have now been completed. The Acute Medicine and Rehabilitation Directorate has re-commenced Mortality and Morbidity meetings with the aim of completing all outstanding reviews.

Implementation of Learning from Deaths guidance

During 2021-22, 2,647 OUH patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period.

Total number of deaths 2021-22	Quarter 1 2021-22	Quarter 2 2021-22	Quarter 3 2021-22	Quarter 4 2021-22
2647	627	629	707	684

By 31 March 2022, 1,955 case record reviews and 28 investigations had been carried out in relation to 1,963 deaths that occurred until end of Q3 2022. Q4 deaths will be included in 2022-23 Quality Account.

The table 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 2021-22	Quarter 2 2021-22	Quarter 3 2021-22	Quarter 4 2021-22
Number of case record reviews (Level 2 comprehensive mortality review or structured review)	392	407	363	Will be included in 22-23 Quality account
Number of deaths judged more likely than not to have been due to problems in care	0	0	1	-

One (0.05%) of the 1,963 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. This case is now undergoing a SIRI investigation (Serious Incident Requiring Investigation).

The reviews of deaths which occurred during the fourth quarter are underway and the summary will be included in the next Quality Account.

Data on mortality reviews is collected via the quarterly Divisional mortality reports submitted to the Trust Mortality Review Group.

Case record reviews and investigations from Quarter 4 of 2020-21

276 case record reviews and five investigations were completed after 31 March 2021 which related to deaths which took place in the fourth quarter of 2020-21, before the start of the reporting period. None (0%) of 825 patient deaths reviewed were judged to be more likely than not to have been due to problems in the care provided to the patient.

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

COVID-19 cases

- Adherence to Personal Protective Equipment (PPE), patient screening, social distancing, and staff testing has been audited and the audit results shared with managers and staff to drive improvement. The audit results are included in the monthly Divisional Quality Reports submitted to the Clinical Governance Committee (CGC).
- Inpatient COVID-19 testing is done on the day of admission, day three, and then weekly.
- Ventilation risk assessments completed for all areas and risks added to the Divisional Risk Registers.
- Safety Huddles held to inform ward staff in 'real time' of changes that may affect their clinical practice in relation to COVID-19.

Non COVID-19 cases

- The requirement for a discharge summary to include the documentation of current medications, and a clear plan for recommencing medication that had been stopped during the admission, was highlighted as a theme during the financial year. The importance of the provision of a complete and timely discharge summary was the subject of a Trust-wide weekly Safety Message.
- Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) discussions with patients and families were identified as an area for action following feedback from families that the discussions often felt too rushed. The MRC Division will be reviewing the concerns identified with all staff responsible for putting a DNACPR in place.
- The Child Mortality Review Team will be developing a guideline to assist operational managers and senior professionals with unexpected child deaths. There will be further training for the Emergency Department regarding the management of unexpected child death, with particular emphasis on multi-agency working and processes.
- Reminders have been provided to clinical teams regarding the importance of communication and updating of families when a patient's clinical status changes.
- All areas to ensure VTE assessments are completed and reviewed according to Trust guidelines.

- The challenge of managing complex patients across multiple teams has been highlighted as a theme, particularly when the managing team is relying on specialist advice that is obtained from a variety of people. The importance of the effective use of electronic systems has been identified.
- Important messages such as DNACPR status cannot be added to the patient banner in the Medisoft® system (used by the Ophthalmology Directorate). This has been highlighted to the teams involved and a solution is currently in progress.
- SuWOn Division highlighted the importance of ensuring staff remain up to date on Trust guidance and policies.
- The importance of team debriefs following patient arrests in complex cases is being actioned.
- Work continues to improve compliance regarding oxygen prescribing across the Trust.
- MRC Division to remind all staff about ceilings of care and treatment escalation plans.
- The importance of accurate record keeping using EPR has been highlighted and not 'copy and pasting' from previous entries.
- Work continues to improve timely VTE assessments and prompt reviews during admission.
- The importance of accurate DNACPR endorsement on EPR particularly when a patient is readmitted.
- Reminder to all, including AGM, to calculate CURB scores for community acquired pneumonia and use micro guide to guide treatment.
- The importance of updating family members if a patient has deteriorated and is likely to die, no matter what time it is.
- Improved documentation of discussions with patients about wishes regarding care and risk of operations has been highlighted in SuWOn Division.
- Risks vs. benefits of performing surgery on patients who are deemed to be high-risk (e.g. significant co-morbidities or are in end of life care – vascular service). A focus on Montgomery consent involving the patient and family in decision-making is key.

Medical Examiner system

The Medical Examiners have continued to scrutinise deaths within the acute Trust during 2021-22. This additional scrutiny has revealed the high quality of clinical notes on EPR. Feedback from the bereaved during telephone discussions reflect a generally high degree of satisfaction for the care provided in the Trust. Any concerns raised by MEs or the bereaved are fed back through Learning from Deaths, but the majority of these incidents had already been recognised and referred to the Trust's Patient Safety processes or to the Patient Advice and Liaison Service (PALS).

Medical Examiners and Medical Examiner Officers work closely with the Regional ME, the National ME and the Coroner's Office to extend the service to scrutinise deaths within the local hospices and in the community setting during 2022-23.

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.

Patients are asked to complete a questionnaire before their hip or knee 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. The average health gain for patients who had primary hip replacements during 2021-22 at OUH was 0.44, with a national average of 0.5.

The tables below show the improvement in health (adjusted health gain) perceived by patients following these two procedures. Comparisons are shown with all health providers who carry out the same procedure in England. The latest data available from

NHS Digital are for the financial year 2020-21. The annual data publication for 2021-22 will be available later in 2022 and will be published in the 2022-23 Quality Account.

The average health gain for patients who had primary hip replacements during 2020-21 at OUH was 0.44 with a national average of 0.47. The average health gain for primary knee replacements during 2020-21 was 0.35 with a national average of 0.30.

Primary hip replacement – average health gain	**2016-17**	**2017-18**	**2018-19**	**2019-20**	**2020-21**
OUH	**0.43**	**0.45**	**0.45**	**0.47**	**0.44**
National average	0.44	0.47	0.47	0.47	0.47

Primary knee replacement – average health gain	**2016-17**	**2017-18**	**2018-19**	**2019-20**	**2020-21**
OUH	**0.31**	**0.36**	**0.36**	**0.32**	**0.35**
National average	0.32	0.34	0.34	0.32	0.30

The following processes are in place to monitor and improve PROMs, and thereby the quality of the Trust's services.

- The Orthopaedic Unit reviews the PROMs responses
- Any areas for improvement identified in the PROMs returns are reviewed by the Orthopaedics Unit and an action plan is developed to address these.
- The Orthopaedics Unit then presents the PROMs data and their action plan to the Trust Clinical Improvement Committee (CIC).
- The action plan is then delivered by the Orthopaedic Unit with oversight and monitoring by the Directorate Clinical GovernanceTeam.

Emergency readmissions within 28 days of discharge from hospital

The Trust routinely monitors emergency readmissions through Dr Foster on monthly basis 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 treatment or procedure (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.

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

- The Trust has a process in place for collating data on hospital admissions, from which the readmissions indicator is derived.
- Data are collected internally and then submitted on a monthly basis to 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 table shows OUH discharges and 28-day readmissions and compares them to thehighest and lowest Trust values for two consecutive years.

	2019-20	**2020-21**
	Total	**Total**
OUH discharges	194,652	184,614
OUH 28-day readmissions	20,091 (10.3%)	20,493 (9.2%)
National 28-day readmissions	8.9%	10.7%
Highest NHS trust value	7.3%	16%
Lowest NHS trust value	5.8%	3.1%

For the most recent 12 months of available data (October 2020 to September 2021), the OUH 28-day readmission rate was 9.2%. Final figures for 2021-22 will be included in the next Quality Account.

Dr Foster analyses all hospital data and categorises a readmission as 'any readmission within 28 days to any specialty'. The analysis does not differentiate

between a readmission due to a complication or deficiency in the provision of care or an admission for a new medical issue. The Trust has introduced care pathways whereby a patient is discharged with a scheduled readmission to an ambulatory unit as part of their plan of management. The analysis for readmissions does not exclude these planned readmissions.

A red alert is triggered when the readmission rate for a procedure or condition is over the national average. These data represent an early warning system, and the alerts are investigated by the respective clinical units to identify any learning or improvement areas.

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, and Improvement.

The Trust takes part in the CQC National Survey Programme. The Inpatient, Emergency Department, Children and Young People, Maternity and Under 16s Cancer surveys have been undertaken this year.

Following feedback from the surveys this year the following initiatives and service changes have been made.

1. Patients' food provider, as part of the change in the soft facilities management contract

2. Carers' Policy, including offering free parking, food for carers and opportunities to be involved in care should the carer and patient wish

3. Maternity Health Inequalities Group including Maternity Voices Partnership and Healthwatch Oxfordshire

4. Changes in booking for interpreters – making it easier for clinicians to book interpreters to support patients. This will also contribute to the Trust's Health Equality strategy during 2022

5. Patient Experience contribute to the weekly Inquests, Complaints, Claims, Safeguarding and Serious Incidents (ICCSSI) 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= 126,617) 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 tounderstand a balanced view of patient experience alongside complaints, claims and compliments.

Results from the OUH Friends and Family Test (FFT) survey April 2021 to March 2022	
FFT: inpatients and day cases	*94.6% of patients rated their experience on their ward as very good or good. This is based on 36,542 responses.*
FFT: emergency departments	*77.1% of patients rated their experience within the* emergency department *as very good or good. This is based on 24,042 responses.*
FFT: outpatients	*93.6% of outpatients rated their experience as very good or good.This is based on 67,657 responses.*

Results from the OUH Friends and Family Test (FFT) survey April 2021 to March 2022	
FFT: maternity	*79.4 of women rated their experience of the Trust's maternity services as very good or good. This is based on 102 responses.*

The table below shows the Trust's overall results from the FFT survey for this 12-month period.

April 2020 to March 2021	*Very good*	*Good*	*Neither good nor bad*	*Poor*	*Very poor*	*Don't know*
Number of responses overall	*99,771*	*16,739*	*4,532*	*3,097*	*3,516*	*688*
Percentage	*78%*	*13%*	*4%*	*2%*	*3%*	*1%*

There have been 102,830 comments via the FFT throughout the year.

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. The Childrens' FFT survey can now be distributed via SMS text and the Maternity FFT survey will be available via SMS from June 2022.

The Trust is collaborating with Imperial College NHS FT on the Scale, spread and embed (health.org.uk) project. The Research and Development Committee confirmed and approved the Trust's involvement in March 2022. This project sets out to analyse the free text comments given as part of the FFT survey. The Trust's FFT provider confirmed in March that the online FFT survey has the capacity to deliver in 99 written languages with 44 spoken. This will have a considerable impact in the coming year on the Trust's ability to capture feedback from people who do not speak or read English.

Staff recommendation of our hospitals to family and friends

NHS Staff Survey results

Recommendation of the organisation as a place to be treated (Q21d): the two tables below show OUH scores compared to the national average, highest andlowest scoring trusts over four consecutive years.

OUH scores	2018-19	2019-20	2020-21	2021-22
OUH	**74%**	**78%**	**83%**	**78%**
National average	71%	71%	74%	67%
Highest scoring trust	87%	87%	92%	89%
Lowest scoring trust	40%	40%	50%	43%

Recommendation of the organisation as a place to work (Q21c):

OUH scores	2018-19	2019-20	2020-21	2021-22
OUH	**57%**	**64%**	**70%**	**64%**
National average	63%	63%	70%	58%
Highest scoring trust	81%	79%	84%	77%
Lowest scoring trust	39%	36%	47%	38%

The 2021 key findings from our NHS Staff Survey include the following.

- Highest response rate to date of **57%** (up from 53.1% in 2020).
- When comparing the results to 2020, the Trust saw 11% of the questions improve, 39% remain very similar and 50% declined against some very high results in 2020 following the first wave of COVID-19 and the Trust response to that.
- The Employee Engagement index (EEI) score, out of a score of 10, has declined to 7.0 from 7.2 in 2020 and 7.1 in 2019. Whilst the levels of involvement remained the same, the scores for advocacy and motivation declined this year.
- The areas showing most improvement in the Trust include improved reporting of immediate manager asking my opinion, not experiencing harassment, bullying or abuse from other colleagues, and a slight increase in the last experience of harassment / bullying / abuse being reported.
- The areas showing the most decline since 2020 include in the last 3 months have not come to work when not feeling well enough to perform duties, satisfied with extent the organisation values my work, and would recommend the organisation as a place to work.

- The Trust's focus on wellbeing has led to a significant increase (25%) in staff feeling that the Trust is taking positive action on health and wellbeing. Health and wellbeing is also a Quality Priority again in 2022-23.

Responding to the messages in the survey

The Trust aims to build on the journey of improvement over the last four years and continue to develop an inclusive culture that makes the Trust a great place to work and the continued delivery of compassionate excellence for its patients and population.

With the 2021 staff survey results, the Trust has launched its 'Engagement Promise' which is underpinned by all Divisional leaders being responsible for cascading the results, and Team Leads undertaking 'Time to Talk' conversations with their teams to co-design, embed and own local action plans. The difference this makes to staff will be monitored through the quarterly pulse surveys as well as the annual Staff Survey.

- The Trust will also continue to focus on four key organisational areas for action in 2022-23 as follows.
    - Build on its award winning *Growing Stronger Together – Rest, Reflect, Recover* programme to continually improve the wellbeing of its people
    - Refresh its Equality, Diversity and Inclusion four-year objectives and commence delivery
    - Implement a values-based leadership framework within Trust leadership programmes, and roll out specific training to enable a culture of civility and respect
    - Lead forward a quality priority to tackle physical and verbal violence and aggression towards its people

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 daily to UK Health Security Agency (UKHSA).

Clostridium difficile (C. difficile)

Background

Each year the NHSE&I assigns the Trust an upper ceiling of *C. difficile* cases. The upper ceiling for OUH apportioned cases of *C.difficile* for 2019-20 was 89. Due to the COVID-19 pandemic the NHS standard contract for objectives for 2020-21 removed the consequence for breaching objectives. The Trust finished on 114 cases.

The threshold for OUH apportioned cases of *C. difficile* for 2021-22 was set at 83 cases. This figure was based on the total number of Trust apportioned cases, minus one, for the calendar year of 2019. The threshold does not consider any changes in case mix or Trust activity. This has been raised by the OUH DIPC with NHSE&I 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. Any changes are unlikely within this financial year, but NHSE&I acknowledges this is a very challenging area. At the end of March 2022 the Trust is reporting a total of 107 healthcare associated cases (hospital onset, healthcare associated (HOHA) and community onset, healthcare associated (COHA)).

During 2021-22 Oxford University Hospitals NHS Foundation Trust took a number of actions to improve this indicator, and thereby the quality of our services.

- A root cause analysis (RCA) of each hospital onset, healthcare associated (HOHA) and community onset, healthcare associated (COHA) *C.difficile* case continues to be undertaken on the Trust incident management system (Ulysses)
- Cases are reviewed in real time by the IPC team, pharmacy and by Infection Consultants
- In March 2021 the ‘Seven Key Steps Safety Checklist to remember’ for Preventing Healthcare Associated Infection during COVID-19 was launched and is expected to form part of Safety Huddles. This checklist draws attention to key messages around infection prevention and control practice, and behind each key step there is underpinning information. Each Division reports on compliance to these Seven Steps in their monthly quality report
- An IPC Metrics dashboard has been developed for Divisions to report to Hospital Infection Prevention and Control (HIPC) on a monthly basis which includes exception reporting
- Regular Antimicrobial Stewardship (AMS) ward rounds are conducted at the Churchill and are demonstrating an impact on antibiotic prescribing. AMS ward rounds are also being undertaken at the Horton but without AMS pharmacist

support as this is a very limited resource

- At the Churchill Hospital through October and November 2021, antibiotic prescriptions in haematology / oncology were compared between two 4-week periods before and after the introduction of AMS rounds This showed a drop in total prescribing from 3,143 prescriptions to 2,664 prescriptions.
- AMS review forms part of all patient infection reviews, for both unsolicited and solicited consultations. Patients on all OUH intensive care areas are also regularly reviewed by the Infection team (up to seven times a week).
- The *C.difficile* policy was reviewed and updated in line with NICE guidance on treatment; first line treatment has now switched to vancomycin
- Cases are presented at the Health Economy meeting which includes representation from OUH, Oxford Health, and OCCG. The purpose of this meeting is to review all reported cases of *C.difficile* in terms of responsibility, identify causality and trends, identify lapses in care and develop agreed action plans for quality improvement
- The increase in OUH apportioned cases of *C. difficile* is reflected nationally. Comparing the most recent quarter for which national data is available (July to September 2021) to the same period in the pre-pandemic period (July to September 2019) shows a 9.1% increase in the count of all reported cases and 8.9% increase in incidence rate from 3,639 to 3,969 and 25.6 to 27.9 cases per 100,000 population, respectively. Hospital-onset CDI cases increased by 15.4% from 1,211 to 1,398 which corresponds to an incidence rate increase of 21.5% from 14 cases per 100,000 bed-days to 17.1. Community-onset CDI cases increased by 5.9% from 2,428 to 2,571 while the rate increased from 17.1 to 18.1 per 100,000 population.
- The IPC Business Case to strengthen the establishment of the IPC nurses and antimicrobial stewardship has been approved by the Trust Board, which will enable further work to be undertaken on reducing *C.difficile* in the organisation and across the wider health economy
- Although the total number of *C. difficile* cases in 2021-22 increased to 107, when corrected for caseload, the incidence of *C.difficile* infection has actually **decreased** from 0.71 to 0.54 per 1,000 discharges (p=0.04; Fishers exact test). This represents a reduction of 24.1% (95% CI 0.00-42.2%).

MRSA bacteraemia

In 2020-21 there were eight cases of MRSA bacteraemia. Seven of those patients were in intensive care, five of whom had COVID- 19. In all seven ICU cases, ventilator associated pneumonia (VAP) was considered to be the source of the infection. One of

the actions on the IPC annual plan and also part of the Seven Key Steps was to reduce the incidence of VAP. Intensive care areas are now asked to undertake VAP audits and report to Hospital Infection Prevention and Control Committee.

For the financial year 2021-22 there was a total of 3 HOHA MRSA bacteraemia cases and one COHA. Two of the HOHA cases were in the Neonatal Unit, one was considered to be a VAP and the other skin / soft tissue infection.

The third case occurred in Neuro Intensive Care. Following a case review it was decided that it was not actually an infection but a contaminant, but it will still count in the final numbers of MRSA cases.

The COHA case had recently been in OUH, but there were no omissions in his care that would have contributed to the bacteremia, and therefore the case was not apportioned to OUH.

The approval of the IPC Business Case in March 2022 will support the 2022-23 IPC annual plan to continue to focus efforts on reducing healthcare associate infections within the organisation.

End of Life Care

During 2021-22, 2,706 people died in OUH. Providing care at the end of a person's life is an important part of the provision of healthcare.

To support care at the end of life, an End of Life Care (EOLC) lead was appointed in October 2021. This post is funded by Sobell House Hospice Charity for 3 years. The National Audit of Care at the End of Life (NACEL) reported March 2022. Key findings included the following.

- There is little time to get care right: NACEL demonstrated that patients were very ill on admission. 50% of those who died at OUH were recognised to be dying in the first 24 hours of admission (nationally 24%), and 25% of patients died within 48 hours of admission (nationally 8%).

- The care of patients in OUH continues to benchmark above the national average.

Theme	OUH summary score	National summary score
Communication with the dying person	9.4	7.9
Communication with families and others	8.8	7.0
Involvement in decision-making	9.9	9.5

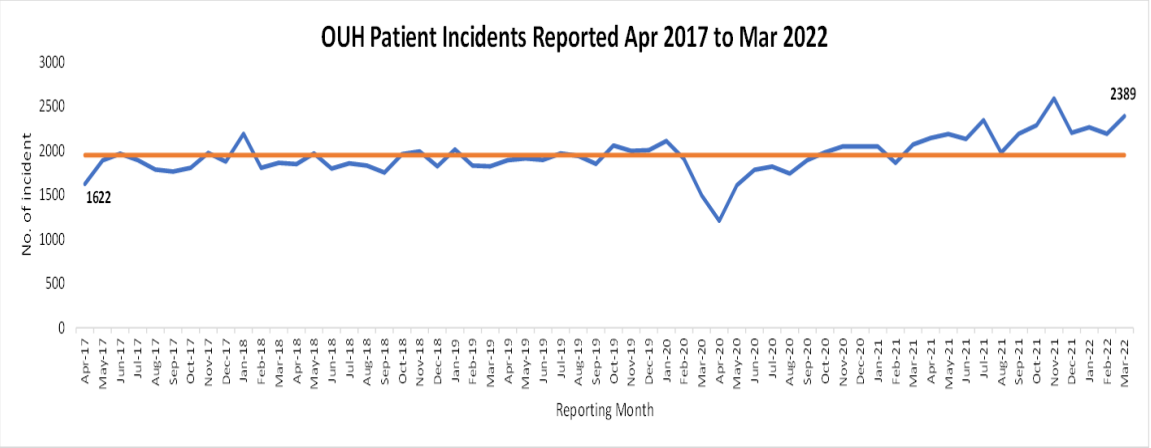
Areas of work for 2022-23 include collecting feedback from families and those important to the patient, highlighting and prompting the use of the OUH information leaflet 'What to expect when someone is dying in hospital' and supporting staff education to feel confident and competent to provide care to dying patients and those at the bedside.

A survey of opioid use in the last 24 hours of life was completed alongside the NACEL audit. Learning has been identified and work begun to improve prescribing and administration of opioids at the end of life.

Patient safety incidents

The number of patient incidents and near misses reported at OUH via our electronic reporting system demonstrates a 22% increase on the previous financial year (2021-22: **26,875**; 2020-21: **22,105**). The mean number of incidents called over the past 5 years has been 23,386 p.a. 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. OUH incident reporting has increased over the past several years from a mean of 1,869 per month in 2017-18 to 2,240 in 2021-22.

The graph below shows an increase in the number of incidents reported over the past year.



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). 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.

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

- Data are compared to peers, highest and lowest performers, and our own previous performance, as the table below shows.
- Data on patient safety incidents are collated on a Trust-wide incident management system.

The table below shows that, since April 2015, OUH has reported a consistent number of incidents per year, which is notably above the national average for acute non-specialised trusts. Source: NRLS, Organisation Patient Safety Incident Reports.

Patient safety incidents reported – OUH

	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Number of patient safety incidents	**17,788**	**17,121**	**17,002**	**17,202**	**18,188**	**14,259**
National average (acute non-specialist trust)	9,465	7,661	10,714	11,338	12,724	**12,547**
Highest reporting trust	24,078	27,991	31,007	45,740	44,025	**37,572**
Lowest reporting trust	3,058	2,880	2,444	1,844	3,444	**3,169**

	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Number of patient safety incidents that resulted in severe harm* or death	**44**	**11**	**16**	**30**	**59**	**123**
National average (acute non-specialist trust)	39	38	37	37	39	**55**
Highest reporting trust	183	190	220	159	183	261
Lowest reporting trust	2	3	0	1	1	4
Percentage of patient safety incidents that resulted in severe harm or death	**0.20%**	**0.06%**	**0.09%**	**0.17%**	**0.32%**	**1.00%**
National average (acute non-specialist trust)	0.40%	0.40%	0.37%	0.36%	0.34%	0.50%
Highest reporting trust	2.00%	1.38%	1.76%	1.35%	1.44%	2.80%
Lowest reporting trust	0.00%	0.02%	0.00%	0.01%	0.01%	0.03%

* As per the NRLS definition.

In early 2019 the Trust amended its approach to impact grading for incidents, to conform to NRLS advice. This involved a transition from healthcare-related impact grading, where avoidability was considered, to a literal grading of the impact, where the impact on the patient is reflected regardless of whether the harm was avoidable or not. This has meant an increase in the number of incidents reported with 'Death' or 'Severe harm' as the impact. (The table above shows 59 such cases in 2019-20, which was the annual total for the three previous years combined). This result reflects a change in categorisation only, there are no concerns that a greater number of 'Death' and 'Severe harm' incidents are occurring.

Data from the NRLS is available 6 month in arrears and is now only available once a year as NHS England prepares to transition to a new system in the next year. The data from 2021-22 will be released in September 2022.

123 incidents entailing Severe impact or Death were uploaded to NRLS in 2020-21, a substantial increase on the previous year's total of 59. However a large proportion of this increase (42 cases) is due to nosocomial COVID-19 infection, which did not affect previous years. Leaving aside these cases, there is still an increase of 22 cases (37%).

No obvious themes in terms of incident type or Trust department have been identified to explain this increase, which may have been an effect of increased communication around NRLS impact grading during the period.

All incidents were reviewed very soon after being reported as the Patient Safety Response team reviews all new Moderate and above impact incidents each working day, and all were considered through the SIRI Forum process. A root cause analysis was undertaken for majority of the Severe incidents.

Oxford University Hospitals NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of our services.

The Serious Incident Requiring Investigation (SIRI) Forum is a weekly meeting where frontline staff, executives and leads for specialist areas such as Tissue Viability, Pharmacy, VTE and Information Governance attend as required. During 2021-22 there were 2,189 documented attendees compared to 2020-21 where there were 1,227 documented attendees. This substantial increase reflects both that several meetings at the start of 2020-21 were not held because of the COVID-19 pandemic and decisions were still made via email or smaller group discussions, and also that the virtual meetings, instigated since May 2020, have become increasingly popular, especially with clinicians who are now able to attend for individual discussions without significantly affecting clinical duties and with those who do not work on the John Radcliffe site.

The Trust undertakes a Patient Safety Response meeting each weekday morning. The group is chaired by the CMO or a deputy from an agreed pool, including senior medics and the Head of Clinical Governance. The group reviews all incidents reported with, or upgraded to, moderate or above impact since the last meeting. In addition to identifying questions that should be addressed by 72-hour reports for incidents to be considered for discussion at the SIRI Forum, or downgrading the impact where necessary, the meeting may send a delegation to departments to ensure that there is suitable support for staff members and patients.

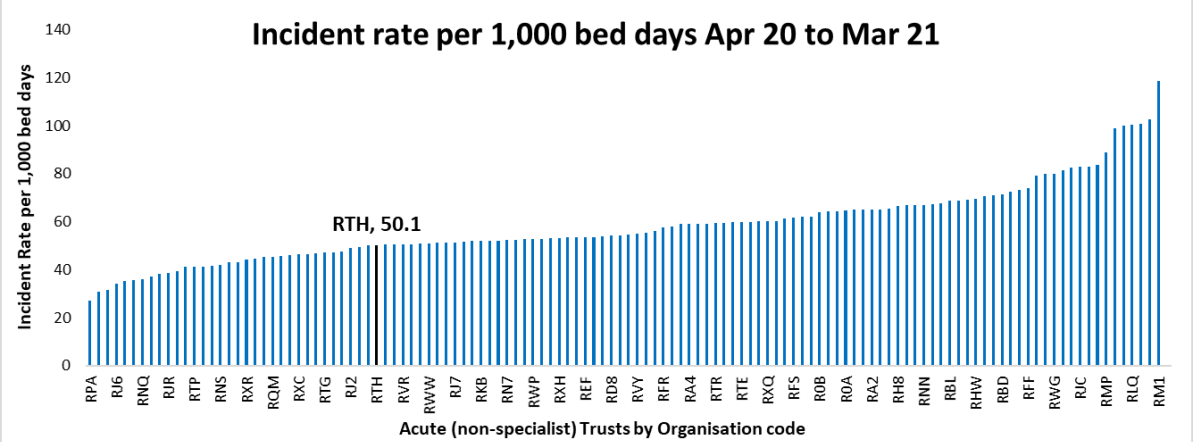
During 2021-22, 99 SIRIs were declared on the Strategic Executive Information System (STEIS) with 8 being subsequently reclassified as a different investigation type, giving a total of 91. This is a 60% increase in SIRIs on 2020-21, in which 57 SIRIs were identified, excluding reclassifications; however, it is in line with the number reported in 2018-19, which was 109 excluding reclassifications. No specific area of concern has been identified to account for this fluctuation in totals.

The table and graph below show the incident rate per 1,000 bed days for organisations who report in to the NRLS. The OUH rate demonstrates 50 incidents per 1000 bed days, which is below the national average for this reporting period. In June of 2020 OUH changed the incident reporting system from Datix to Ulysses; this necessarily diverted resources to implementation of the new software and away from uploading incidents to the NRLS but this change does not reflect the number reported in the local incident reporting system.

Source: NRLS, Organisation Patient Safety Incident Reports

Incidents per 1,000 bed days

Incident rates – acute non-specialist trust									
	Apr 16 Sep 16	**Oct 16 Mar 17**	**Apr 17 Sept 17**	**Oct 17 Mar 18**	**Apr 18 Sep 18**	**Oct 18 Mar 19**	**Apr 19 Sep 19**	**Oct 19 Mar 20**	**Apr 20 Mar 21**
Incident rate (per1,000 bed days)	**44**	**40**	**44**	**44**	**48**	**49**	**50**	**54**	**50**
National average	41	41	43	43	45	46	50	51	58
Highest reporting rate	72	69	112	124	107	96	104	110	119
Lowest reporting rate	21	23	23	24	13	17	26	16	27

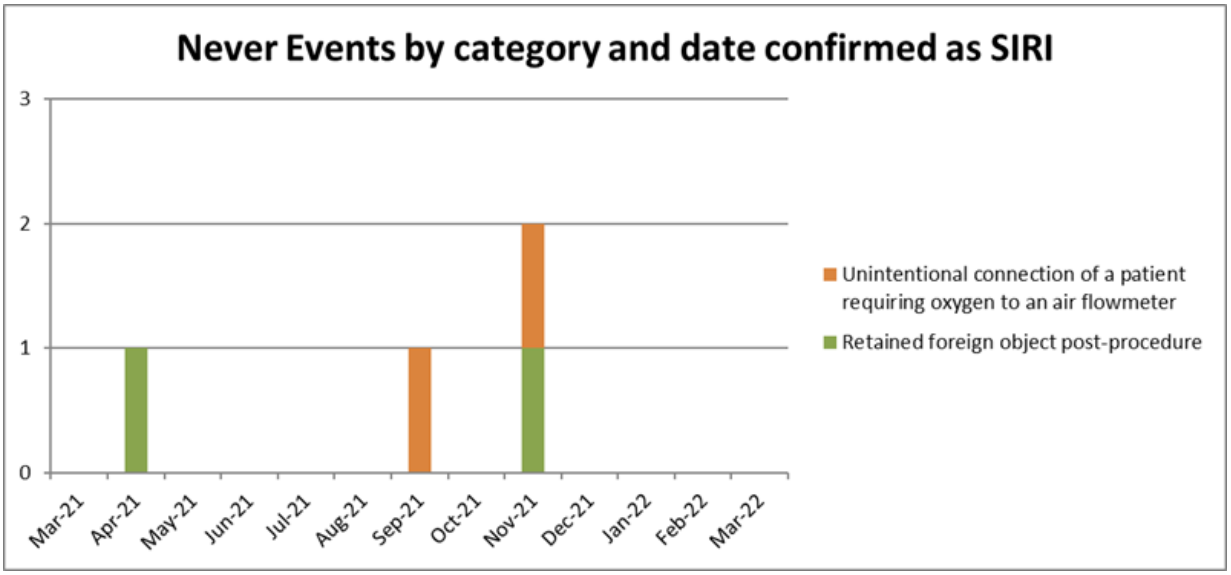


Never Events

A Never Event is described as a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers. There are 16 types of incidents categorised as such by NHS England, although one has been temporarily suspended (undetected oesophageal intubation), and one does not affect acute trusts such as OUH (failure to install

collapsible shower or curtain rails).

This graph demonstrates that four Never Events were confirmed between April 2021 andMarch 2022, inclusive.



In 2021-22, four Never Events were reported compared to two in 2020-21 and seven in 2019-20.

The four Never Events for 2021-22 were as follows.

- Two retained foreign object post-procedure: one was a swab which was inadvertently left in situ following an instrumental delivery and suturing and discovered 10 days postnatally by medical staff. The other was a vaginal pack unintentionally retained following gynae-oncology surgery. It was discovered at home by the patient the following day.
- Two unintentional connection of a patient requiring oxygen to an air flowmeter: two hypoxic patients requiring oxygen were unintentionally connected to medical air (one in NOC Recovery, and the other in Head & Neck Ward). These were identified within a short time of each other, and addressed in a single investigation.

The learning and improvements stemming from these incidents are as follows, with a particular focus on the system changes made to reduce the probability of recurrence:

- Vaginally retained items
- Production of a new delivery room specific LocSSIP for invasive procedures.
- Implementation of a Perineal Compress SOP incorporating a requirement that the perineal compress should be part of a formal count and formally

documented; and a link to the swabs and needles LocSSIP. Training on counting swabs is to be added to the preceptee induction programme and the new doctor induction programme.

- The operation note on EPR should mandatorily ask about the presence or absence of a vaginal pack (VP) which should reduce the risk of it not being mentioned due to human factors.
- Clarification of lines of responsibility for informing the patient about any retained vaginal pack and the significance of the VP sticker; and removal of the VP stickers.
- Development of an Enhanced Recovery After Surgery (ERAS) pathway that details the significance of VP stickers and the management of vaginal packs. The ERAS pathway discharge checklist will include checking for documentation of vaginal packs and removing these as per documented instructions from the surgical team.

- Connection to air flowmeters
  - All clinical areas with airports have been inspected, with removal of wall air flowmeters by the ward managers and Clinical Engineering, and closure of all wall air plugs with second generation caps.
  - There will be education for staff via qualitative research to air / oxygen understanding by those areas identified by Clinical Engineering.
  - Statutory and mandatory training package on oxygen / air to be re-instated.
  - A safety message has been sent out to all OUH staff about the risk of inadvertent connection to medical air via a flowmeter.

How learning from Never Events has been shared at all levels in the organisation and externally

Internally

- The learning has been reported at committees within the Trust. This includes the Patient Safety and Effectiveness Committee (which replaced Patient Safety and Clinical Risk Committee during 2021-22), CGC and IAC.
- The Never Event reports have been discussed within departments.
- In 2019, a new process was adopted, by which all Never Event investigations are presented to the CEO, CMO and CNO following completion. The

investigation team summarises the incident and main findings, and the Divisional and local management discusses progress against the action plan, and further learning. Clinicians involved in the Never Events also attend, and positive feedback concerning the process has been received from all sides.

- Patient safety alerts have been placed on the front page of the intranet where appropriate.
- Never Event root cause analysis reports are sent to governance staff in all Divisions, not just that in which the incident occurred, on completion, for immediateconsideration regarding sharing learning.
- All SIRI root cause analysis reports are uploaded to the Trust intranet on completion.
- Safety messages have been sent to all OUH email accounts and posted on the Trust intranet each week since February 2019. These messages are brief and can cover any patient safety issue, such as an introduction to a recent change in procedure locally or nationally, confirmation of best clinical practice, or a celebration of recent outstanding activity; they are often inspired by learning opportunities raised in incident investigations and mandated in investigation action plans. By the end of March 2022, 165 of these messages had been disseminated.
- The Clinical Governance Department has started a Quarterly one-page bulletin – Safety Healthcare Improvement News Edition (SHINE) which portrays key aspects of learning throughout the quarter from incidents and mortality reviews as well as other useful information such as new / revised Trust-wide documents published. This is distributed to Divisional leadership and shared at Divisional Clinical Governance meetings.

Externally

- The CQC and NHS Improvement are informed of a Never Event when it occurs, and a 72-hour report is sent to them for information.
- OCCG, and NHS England and Improvement review all completed root cause analysis reports, and they complete assurance reviews on evidence packs and visit once action plans are complete (pandemic allowing) to ensure that learning has been sufficiently embedded, before closing the incident on STEIS.

Duty of Candour (DoC)

Duty of Candour is a statutory requirement that patients are contacted when they have

been involved in a clinical incident which has resulted in Moderate or greater impact. As soon as reasonably practicable after becoming aware that a notifiable patient safety incident has taken place, a registered person must notify the relevant person that the incident has occurred. This discussion must be given in person, provide an account which is complete and accurate, advise on any further investigation into the incident which might be required, and include an apology. This must be followed by a written notification to the relevant person.

OUH compliance with Duty of Candour in 2021-22

This table demonstrates that Duty of Candour continues to be addressed for all patient incidents of Moderate impact or above.

	Verbal	Letter
Q1 2021-22	125 / 125 (100%)	125 / 125 (100%)
Q2 2021-22	166 / 166 (100%)	166 / 166 (100%)
Q3 2021-22	268 / 268 (100%)	267 / 268 (99.6%)
Q4 2021-22	280 / 283 (98.9%)	275 / 283 (97.2%)

There can be complications relating to DoC, such as a patient's contact details being out of date, which can delay the completion of one or both elements. All cases requiring DoC are monitored in the Trust's weekly SIRI Forum and Divisional representatives supply updates on progress to confirm that these cases are being actively managed, and report when the obligations have been concluded. Completion of DoC and wherever possible a copy of the relevant correspondence is recorded both in the Trust incident management system and in the patient's notes.

The criteria for reporting maternity and neonatal incidents were expanded during 2021-22, and the number of incidents increased accordingly from Q3 onwards. To allow an effective review of these, dedicated pro forma questionnaires were created on Ulysses relating to different incident types (e.g. massive post-partum haemorrhage; admission of a neonate to intensive care). As the volume of incidents means that these questionnaires can take time to complete, verbal DoC is completed as soon as possible after the incident has been called, and written DoC is completed later, once a review of the questionnaire has confirmed that the impact grading is valid; this accounts for the small disparity between the written and verbal DoC completion in Q4.

Venous thromboembolism (VTE)

Venous thromboembolism (VTE) is the collective term for deep vein thrombosis (DVT) and pulmonary embolus (PE). A DVT is a blood clot which blocks the blood flow in one or more veins of the leg. A PE occurs when a blood clot breaks free from the DVT and travels to the lungs where it blocks the blood supply to part of the lung.

The Trust has met and exceeded the 95% target for VTE risk assessment of patients for 2020-21.

Oxford University Hospitals NHS Foundation Trust considers that this data is as describedfor the following reasons.

- The Trust has a robust process in place for collating data on venous thromboembolism assessments.
- Data are collated internally and then submitted on a quarterly basis to the Department of Health.
- National figures for VTE % were suspended for 2021 and resubmission recommenced in October 2021 therefore there will be no national figures published until the end of Quarter 1 – June 2022
- Data for previous years are compared to peers, highest and lowest performers,and our own previous performance, as set out in the table below.

VTE	2018-19	2019-20	2020-21	2021-22
OUH VTE assessment rate	98%	98%	98%	98.16%
National average	96%	96%	*	*
Best performing trust (all acute trusts)	100%	100%	*	*
Worst performing trust (all acute trusts)	78%	79%	*	*

Oxford University Hospitals NHS Foundation Trust has taken the following actions toimprove this indicator, and thereby the quality of its services.

1. In response to COVID-19 the VTE Prevention team and the EPR team have worked closely to adapt the e-VTE risk assessment recommended outcome and e-prescribing following publication of new interim guidelines for VTE Prevention in those with suspected or proven COVID-19.

2. Trust-wide audit of appropriate thromboprophylaxis continues quarterly and good quality data have helped drive improvements in patient safety.

3. All identified hospital associated thrombosis (HAT) incidents are reported. Potentially preventable HATs are discussed in the SIRI Forum and learning outcomes are disseminated.

4. OUH participated in the national GIRFT Thrombosis Survey 2020-21. Outcome of OUH unit level report has been incorporated into the VTE Prevention Teamwork plan for 2022-23.

5. e-Learning VTE prevention and safe anticoagulation modules have been incorporated into My Learning Hub. A member of the VTE Prevention Nursing Team is acting as a SME ensuring that modules are regularly reviewed and updated.

6. Anticoagulation (Medicine Safety) was chosen as a Quality Priority for 2021-22 The following actions have been taken to date.

    a) Safety Nets now live in EPR include:

    - Alerts in EPR to highlight that dalteparin prophylaxis requires reviewing if platelet count is below 50
    - Oral Anticoagulation Counselling form within EPR
    - Message sent to admitting Consultant if a VTE RA has not be completed on 3 occasions. The message states “The VTE RA alert has been dismissed by a prescriber on 3 occasions for (patient’s details) and is now overdue. Please ensure the VTE risk assessment is performed and appropriate thromboprophylaxis prescribed”.

    b) Monthly Anticoagulation and VTE Prevention Training MDT education and training in a Bitesize format via MS Teams.

    Increase engagement for Anticoagulation and VTE Prevention in local training programmes for foundation doctors, pharmacists, and nurses. Including extra sessions on FY 1 foundation training.

    c) Revised peri-operative medicines information leaflet (MIL) for managing patients on anticoagulation. Divided into pre- and post-op phases for each group of anticoagulant medication. Including advice on consenting patients whilst their anticoagulation is held.

d) Provision of a patient information leaflet for patients on Warfarin undergoing a procedure or surgery who require bridging therapy. Currently in draft for revision by working party.

e) Monthly review of Ulysses incidents related to anticoagulation including monitoring of those related to peri-op management to review trends and act upon any recurrent issues.

f) Cardiology Quality Improvement Project to improve the data held by the Oxfordshire Anticoagulation Service for patients with mechanical heart valves. Updating valve type and / or position for 175 patients where this was previously unknown. Enabling the service to provide improved quality of care for this patient group.

g) Provision of pre-operative Warfarin counselling for patients undergoing mechanical heart valve replacement surgery. Ensuring patients are fully informed about this important medication pre surgery and are aware how to safely manage once they are discharged home after surgery.

Part 3: Other information

Progress against OUH Quality Priorities for 2021-22

The table gives the name and description of each Quality Priority, states why we chose these as Quality Priorities and then gives a description of how success was evaluated over the course of the year, followed by the evaluation.

Patient Safety

Quality Priority: Triangulation of Complaints, Claims, Incidents and Inquests	Why we chose this Quality Priority	How we will evaluate success	Evaluation
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. The aim is that by 31 March 2022, where relevant, all complaints / legalclaims / inquests / section 42 cases have an associated incident report created as soon as possible. All complaints and legal claims that have been	To promote optimal efficiency and learning from potential issues by embedding a combined approach to patient and relative responses, investigations and systemic improvements.	**Action 1:** An Incidents, Complaints, Claims, Safeguarding & Inquests Scrutiny Group will take place a minimum of three times every four weeks in FY 2021-22, with involvement of the Trust's corporate patient safety, legal, safeguarding and complaints teams. **Action 2:** Data around the following issues will be shared with attendees at or in advance of each meeting to allow the relevant team to follow up (e.g. is there already, or ought there to be, an incident raised on the OUH system correlating with a Coronial inquest into a patient death?) • New orange / red	**Actions: *Fully achieved*** The data collated for Quarter 1 of FY 2021-22 show that the nominated actions associated with this QP have been completed. In light of this positive report, the ICCSIS stakeholders will now progress with the following actions: • The monthly report of new red-graded claims and complaints supplied to SIG will be expanded to include learning from recently completed investigations, of any grade, which might provide learning that could stop future claims or complaints

Quality Priority: Triangulation of Complaints, Claims, Incidents and Inquests	Why we chose this Quality Priority	How we will evaluate success	Evaluation
identified as entailing the highest (red) risk will be reviewed toidentify learning to their history to reduce the possibility of recurrence.		graded legal claimsreceived during the week • New orange / red graded complaints received during the week • Section 42 referrals received during the week • Deprivation of liberty safeguards opened during the week • New orange / red graded Coronial inquests and investigations received during the week • All Serious Incidents Requiring Investigation (SIRI) called within the last week • All incidents considered at the previous week's SIRI Forum agenda-setting meeting, regardless of whether they were eventually discussed; this will include all OUH incidents called at Moderate or above impact • Friends and Family Test data from the previous week to give an experience	elsewhere. • A deep dive into a random selection of completed (partially) upheld complaints from Quarter 4 FY 2020-21 was completed, to see whether recorded incidents for the relevant patients show any potential gaps that might have stopped the complaint being raised had they been addressed through the incidents. The audit did not identify a sufficient number of cases from which to draw any conclusion. A separate review took place of all 86 complaints reported in November 2021. All incidents reported for the patients named in the complaints were reviewed, to see whether any incidents were reported matching the concerns of the complaint: in one case a relevant incident was raised after the date that the complaint was received, from which it is inferred that this incident came to light through the ICCSIS discussions; the incident itself did not

Quality Priority: Triangulation of Complaints, Claims, Incidents and Inquests	Why we chose this Quality Priority	How we will evaluate success	Evaluation
		perspective adding intelligence, themes and context to distinct incidents / complaints/claims/ safeguarding/inquests. Attendees may bring further information from other sources which they feel could be useful to the discussion	require any further investigation.

Safety Huddles	Why we chose this Quality Priority	How we will evaluate success	Evaluation
A Safety Huddle is a short multidisciplinary briefing, held at a predictable time and place, and focused on the patients most at risk.	When effective, Safety Huddles provide the opportunity to reduce harm and celebrate success.	A standardised method to run and record Safety Huddles has been developed and implemented across the Trust. **Action 1:** We will audit Huddle documentation. Success will be determined by 75% or greater documentation of Huddles on 75% or more of intervention wards. We will build the environment in the electronic patient record (EPR) with human factors testing and input from key wards where Safety Huddles can be recorded. This will also provide an audit trail for evaluation.	**Action 1: *Fully achieved*** An SOP has been developed for the use of the Clinical Worklist and illness severity, patient information, action list, situational awareness and contingency plans, and synthesis by receiver (IPASS) for the documentation of Safety Huddles. This is being supported by the inclusion of a RAID Huddle tab on the

Safety Huddles	Why we chose this Quality Priority	How we will evaluate success	Evaluation
		Action 2: We will audit emergency calls and cardiac arrest rates in intervention areas. Success will be defined as a lower event rate in the year following the implementation and wash-in period. The following **PDSA** cycle will be used in order to ensure the effectiveness of this model: • Trial in three wards – these will be selected based on the data provided by 2222 calls / incident reporting and through making contact with clinical areas. • Re-build based on experience and feedback. • Select 10 wards for rollout – based on maximum reduction in cardiac arrests. • Roll out to 10 wards through training professional development nurses (PDNs). • Audit success of rollout. The focus will be on adult inpatient areas for the first year. This focus is supported by emergency call data and	electronic patient whiteboards in clinical areas. **Action 2: *Partially achieved*** Based on the data from clinical areas (period 2019-21) and feedback from staff, RAID committee members have established the format in 10 ward areas (Ward 6A (Vascular), Neuroscience Ward, Short Stay Medical Wards, Gastro and Cardiology ward areas); this is now in a bedding-in period in these areas with further work being required to refine the process prior to a continued rollout across the Trust. There have been expressions of interest from other clinical areas. We are keen to ensure the next areas are not on the JR site. The instance of 2222 calls in these areas are being monitored and evaluation in progress for the use of the whiteboards in terms of documentation for the purposes of audit. Further work is required to ensure a multidisciplinary approach to the RAID Huddle.

Safety Huddles	Why we chose this Quality Priority	How we will evaluate success	Evaluation
		incident reporting.	

Medication Safety: Insulin and Anticoagulation	Why we chose this Quality Priority	How we will evaluate success	Evaluation
Insulin Safety 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.	One in six people in hospital have diabetes and this is increasing. 35% of people with diabetes in OUH are treated with insulin and will be treated in all areas of the Trust.	By 31 March 2022 all instances of two of the National Inpatient Diabetes Audit (NaDIA) Harms (severe symptomatic hypoglycaemia requiring rescue treatment and diabetic ketoacidosis (DKA) developing as an inpatient) will be explored to identify institutional learning. **Action 1:** We will contribute to the development and testing of automated processes for identification of NaDIA Harms. Automated identification will allow rapid investigation and also tracking of rates of Harms as well as benchmarking against similar Trusts. This will be our method for identification in the future. **Action 2**: We will develop a formal mortality and morbidity process for the	**Action 1: *Fully achieved*** OUH is one of 3 sites developing an automated approach to identification of harms for the new National Diabetes Inpatient Safety Audit (NDISA). At a local level, we have automated alerts within EPR which communicate to the diabetes specialist team when a person has a ketone level greater than 3 mmol / l or a blood glucose measurement less than 3 mmol / l. **Actions 2, 3 and 4: *Fully achieved*** A regular insulin safety group has

Medication Safety: Insulin and Anticoagulation	Why we chose this Quality Priority	How we will evaluate success	Evaluation
		investigation of these Harms. **Action 3:** Where the NaDIA Harm criteria have been met, irrespective of the actual impact to the patient, there will be an investigation of what happened in order to learn and improve care. **Action 4:** Initially all 'Harms' will be reviewed in a Diabetes Safety meeting. This will be used to guide the development of investigation templates similar to those used for Hospital Acquired Thrombosis. **Action 5:** A multidisciplinary diabetes safety group will be set up to review the NaDIA Harm reports, identify learning and actions to improve care. **Action 6:** People with diabetes will be represented on the Diabetes Safety Group.	been convened monthly, at which incidents are reviewed prospectively commenced 23 July 2021. To support this, analysis of GIRFT recommendations has been undertaken, and presented to Division in July. **Action 5: *Fully achieved*** An insulin safety group has been convened which consists of members of the diabetes specialist team and medicines safety pharmacists. This reports to the recently convened Medicines Safety Group. **Action 6: *Partially achieved*** A person with diabetes has been identified and agreed to attend the Diabetes Safety Group. Work in progress to find a solution about how best to obtain their

Medication Safety: Insulin and Anticoagulation	Why we chose this Quality Priority	How we will evaluate success	Evaluation
			input while maintaining patient identifiable information confidentiality.
Anticoagulation Safety We aim to improve the safe prescribing and administration of anticoagulation in the hospital inpatient setting or via contact with ED / Ambulatory Assessment Unit (AAU) with smooth transition to community settings on discharge.	Errors related to use of anticoagulants are widespread despite local and national guidance and initiatives to improve patient safety. Anticoagulants are an ever increasingly complex area where suboptimal use can cause serious patient harm.	**Action 1:** VTE prevention We aim to reduce the number of missed doses of Daltaparin thromboprophylaxis by 10% compared to amalgamated data from the last 5 years.	**Action 1: *Partially achieved.*** Multidisciplinary education resources are now in place with monthly teaching sessions for Nurses and Midwives on their induction programme and *ad hoc* teaching sessions for clinical areas on request. Extra sessions in FY1 induction 2, 1 hour sessions at induction then a 1 hour follow-up in February. Monthly Bitesize online teaching for 2021 now completed and continuing quarterly in 2022. EPR changes have progressed well with updated VTE treatment Powerplan live from 10 January 2022 and EPR Message to Consultant for 3 dismissed VTE RA Now live Feb 2022 Anticoagulation Counselling Form now live in EPR
		Action 2: Anticoagulation We aim to optimise the	

Medication Safety: Insulin and Anticoagulation	Why we chose this Quality Priority	How we will evaluate success	Evaluation
		peri-operative management of patients on oral anticoagulants. We will introduce an updated medicines information leaflet (MIL) (Perioperative management of oral anticoagulants). We will introduce a patient information sheet for patients on Warfarin. We will increase multidisciplinary educational resources and training. We aim to perform a baseline audit of Ulysses incidents related to peri-operative anticoagulation prior to introduction of these measures and will compare with a follow-up audit. We aim to improve the peri-operative pathway for patients requiring new mechanical heart valves or repair of mechanical heart valves. Improve documentation about type of valve on database. Investigate improved inpatient support with dosing post-operatively. Optimise anticoagulation support on hospital	January 2022. **Action 2: *Partially achieved*** MIL (Perioperative management of oral anticoagulants) Fully approved January 2022. PIL draft form for review with working party. From August 2021 Anticoagulation Inpatient Safety Nurse to return to ward-based reviews where possible for patients with high INR to provide more 'at the elbow' teaching and guidance. Aim to improve visibility of the role in the Trust Ongoing but limited by only 1 nurse available trust wide. Joint working with VTE prevention Team online teaching and increased FY1 training. Baseline audit of Ulysses incidents related to anticoagulation over 4 months (Jan-April 2021) performed and re-audit now planned Jan-Apr 2023 – 1 year post revised

Medication Safety: Insulin and Anticoagulation	Why we chose this Quality Priority	How we will evaluate success	Evaluation
		discharge.	MIL and staff training increase. Ongoing – monthly review of incidents by Anticoagulation Team with feedback into Medicines Safety Group quarterly. Anticoagulation Team working on a QIP for patients undergoing Mechanical Valve Repair / Replacement requiring Warfarin therapy. Completed with Anticoagulation service now involved in pre-op pathway with provision of pre-op counselling for Warfarin management. Inpatient Safety Nurse also available to support with Warfarin dosing and discharge planning for patients with new MVR if referred by ward teams – limited as only 1 nurse available Trust-wide. Outpatient Anticoagulation Database (RAID) reviewed, and data obtained for Therapeutic Time in Range, documentation for

Medication Safety: Insulin and Anticoagulation	Why we chose this Quality Priority	How we will evaluate success	Evaluation
			type of valve and if bridging therapy required if goes sub-therapeutic. Completed June 2021 – presented at Cardiac Grand Round – improved information for 178 patients where position or type of valve previously unknown.

Clinical Effectiveness

To Minimise the Occurrence of *C.difficile* and MRSA in OUH	Why we chose this Quality Priority	How we will evaluate success	Evaluation
C.difficile – objectives or 'upper limits' for numbers of infections associated with healthcare provision are set by NHS England and Improvement 2019-20. The purpose of this is to keep a really strong focus on keeping the numbers of infections down and protecting patients fromharm. In 2020-21 the OUH objective was met (89 cases). In 2020-21 there were no objectives set; OUH worked to the 2019-20 objectives and have now exceeded the year's	People who are already weak or frail can sometimes become seriously ill as a result of contracting these serious infections in hospital.	**Action 1:** Record numbers and present these through the hospital Infection Prevention and Control Committee (HIPCC) and CGC. **Action 2:** All cases to have an incident report form submitted with root cause analysis completed by the clinical area. This will be reported in Clinical Governance papers and completion of the action log evidenced.	**Action 1: *Fully achieved*** Numbers continue to be reported monthly. Draft dashboard ready to be presented at HIPCC. **Action 2: *Partially achieved*** Incident reports are now being submitted with root cause analyses being completed by the clinical area. Plans in place to pull action plans from Ulysses and this will by phase 2 of the HIPCC reporting

To Minimise the Occurrence of *C.difficile* and MRSA in OUH	Why we chose this Quality Priority	How we will evaluate success	Evaluation
cumulative total. There is no upper limit for MRSA bacteraemia; this is called 'zero tolerance'. Numbers of infections have been driven very low in recent years and the expectation is that this will continue through strong infection prevention and control (IPC) management. In 2019-20 there were a total of four cases of MRSA bacteraemia apportioned to OUH. In 2020-21 there were eight cases.		**Action 3:** Thematic analysis identifies that ventilator associated pneumonia (VAP) is a common theme in the MRSA bacteraemia cases in 2020-21. Task and finish group to be convened to: review VAP bundles and delivery of them review standard and delivery of mouthcare to all patients in the Trust. **Action 4:** Launch of the Seven Key Points to Prevent Healthcare Associated Infections (HCAI). **Action 5:** Intensive Therapy Unit (ITU) capacity to return to normal in terms of bed	metrics once dashboard up and running **Action 3: *Fully achieved*** Task and Finish group convened. VAP audit presented to HIPCC, bundle updated and shared with other ICU, will be available on My Assure and form part of the dashboard reporting to HIPCC. Project Group to be established to review mouthcare. **Action 4: *Fully achieved*** Seven Key Points to Prevent HCAI during the COVID-19 pandemic now launched. Trust internal auditors BDO findings report good knowledge across the MDT around 7 steps, identifies some actions around VAP and that standardised reporting mechanism to HIPCC required. **Action 5*: Partially achieved*** surveillance in ICU settings continues on

To Minimise the Occurrence of *C.difficile* and MRSA in OUH	Why we chose this Quality Priority	How we will evaluate success	Evaluation
		spacing and staffing following the operational pressures of the COVID-19 pandemic.	a quarterly basis. Impact of COVID-19 has been limiting ability of ICUs to return to normal capacity.
		Action 6: IPC Business Plan to be submitted to bring team establishment in line with Shelford Group including an anti-microbial stewardship (AMS) team.	**Action 6: *Partially achieved*** Business case presented at TME in December. Recommendation from CFO to prepare paper for January TME seeking approval to begin recruitment process ahead of presentation to Investment Committee.
		Action 7: Improvement in AMS Embed AMS activities within the Infection Consult Services. Regular audit of antibiotic use with result feedback to clinical teams. Surgical teams to re-instate acute surgical management of appendicitis and acute cholecystitis rather than conservative management with antibiotics. AMS team to provide	**Action 7: *Partially achieved*** Perfect month for AMS being planned for the Horton. Request placed to Microbiology to replace Ceftriaxone in the following autotext on MSSA reports with Cefazolin (narrower spectrum) 'Staph aureus isolates that are proven to be sensitive to flucloxacillin will also be sensitive to coamoxiclav and

To Minimise the Occurrence of *C.difficile* and MRSA in OUH	Why we chose this Quality Priority	How we will evaluate success	Evaluation
		education and tools to support ward Pharmacy teams to continue to promote intravenous (IV) to oral (PO) switch, challenge duration of antimicrobial prescriptions and query prescriptions for fluoroquinolones and other broad spectrum agents like ceftriaxone Review options for computer-based pre-screening of certain antimicrobials within EPR to flag inappropriate use to medical / AMS team and to consider other ways of optimising digital pathways to support AMS. Introduce a 72 hour auto stop to antibiotic prescriptions ensuring that prescribers review the need for antimicrobials. Pharmacy and Infection teams to raise awareness of the safety warnings associated with fluoroquinolone antibiotics such as Ciprofloxacin, discourage their use and advise on suitable alternatives if required. Expand the use of elastomeric administration devices in 2022. In the ambulatory setting, improve AMSoverview of prescriptions with	ceftriaxone’

To Minimise the Occurrence of *C.difficile* and MRSA in OUH	Why we chose this Quality Priority	How we will evaluate success	Evaluation
		particular focus on ceftriaxone avoidance and promotion of alternatives such as elastomeric administration of narrower spectrum agents. Develop penicillin allergy de-labellingpathways. **Action 8:** Review of insertion and ongoing care of intravascular devices.	**Action 8: *Partially achieved*** Ongoing CLABSI surveillance in ICUs and Haematology and Oncology. Divisions continue to report IPC metrics, agreement at Patient Safety and Effectiveness Committee that IPC metrics will be presented at HIPCC. Point prevalence audit conducted by IPC Team on peripheral cannula and urinary catheters to establish documentation and view compliance

Transition of Children to Adult Services	Why we chose this Quality Priority	How we will evaluate success	Evaluation
The aim is to provide a framework bywhich the Trust can ensure that children and young people receive a quality service when transitioning from child-centred services to services for adults. This includes all young peoplewith long-term conditions cared for in OUH.	To ensure that all young people we treat receive a quality service in order to achieve optimum health and psychological wellbeing.	**Action 1:** Compliance with Transition from Children to Adult Services Policy. Include identification of lead service for patients that are under multiple services. **Action 2**: Develop a Trust-wide multidisciplinary group to develop good practice on Transition from Children to Adult Services led by a Transition Co-ordinator. **Action 3:** Data Audit – EPR Ready Steady	**Action 1: *Partially achieved.*** Early work has been undertaken with the services and the information team to identify robust and sustainable processes to capture data of lead service. Further meetings planned with the Chief Nursing Officer, Information NIO and team to identify best practice to do this. Divisional triumvirates have been asked to identify services involved in transition to adulthood care to complete the new Preparing for Adulthood database**.** **Action 2: *Fully Achieved*** Trust wide MDT Children Young Person (CYP) to Adult Transition Group has been established with core membership from all Divisions and key stakeholders. ToR have been developed and shared with all the key stakeholders. **Action 3: *Partially achieved.*** Data Audit – EPR

Transition of Children to Adult Services	Why we chose this Quality Priority	How we will evaluate success	Evaluation
		Go – Hello compliance. **Action 4:** Patient feedback from children andadults – inclusive of all backgrounds. Children will be asked about their experience of transitioning to adult services. The Trust's well established children's patient group, YiPpEe, will assist with this. **Action 5:** Staff feedback.	Ready Steady Go – Hello compliance. The functionality is available on EPR to identify patients on the Ready Steady Go – Hello programme. Further work in progress to capture accurate data. **Action 4: *Partially achieved.*** Patient story presented to Trust Board and summit planned for March to May 2022. Current GAP analysis being undertaken across the Trust. The purpose of this is to establish no. of clinical services running transition clinics, benchmarked against national Burdett Foundation standards and the staff view of their service and how it could be improved. **Action 5: *Fully achieved.*** All staff feedback in our action log from the transition of children to adult services being captured that allows the staff to be supported, good practices to be shared and for

Transition of Children to Adult Services	Why we chose this Quality Priority	How we will evaluate success	Evaluation
		Action 6: Partner feedback – include general practitioners (GPs) as some patients will betransitioned to GP services.	incidents to be addressed in a supportive manner. **Action 6: *Fully achieved*** There have not been any emails or letters or correspondence, complaints or Ulysses reports received from system partners.

Clinical Activity Recovery	Why we chose this Quality Priority	How we will evaluate success	Evaluation
Managing patients on elective waiting lists is critical to the recovery of planned clinical care. A national system was introduced to clinically prioritise patients whose admission for planned surgery had been disrupted by the pandemic. Risk (RCS) codes are assigned setting out a timeframe for treatment to be deferred: P1 – within 24 hours P2 – within 1 month P3 – within 3 months P4 – over 3 months.	Due to the effects ofthe COVID-19 pandemic, more patients are waiting longer for surgery. This priority will help minimise harm to these patients from delayed treatment.	During 2021-22 patients on inpatient surgical waiting lists will be clinically reviewed and allocated a timeframe for treatment as set out in the national priority scoring system with treatment scheduled within these agreed timeframes. An investigation will be carried out for any patient who comes to harm due to delayed treatment. Our electronic patient record will be used to record and collate this information. **Action 1:** 90% of patients in identified cohortsto have RCS codes.	**Action 1: *Partially achieved*** Clinical prioritisation is well-established at OUH, and data are being submitted in

Clinical Activity Recovery	Why we chose this Quality Priority	How we will evaluate success	Evaluation
			line with national expectations. 70% of patients are identified as having RCS codes as of 2 January 2022. 90% target currently not met possibly due to impact of lengthy delays developing the new EPR workflow. The new workflow will enable the RCS form to be completed in real time, making the entire process more efficient for clinicians (action 4).
		Action 2: 85% P2 patients have had their treatment within their 4 week time allocation.	**Action 2: *Partially achieved*** The percentage of patients categorised at P2 and admitted within 4 weeks is 65-79% (Oct-Dec 2021). Lapsed P codes are scrutinised at weekly PTL and Assurance meetings including plans to address shortfall in capacity.
		Action 3: We will investigate any incidentwhen harm has occurred due to a patientwaiting for longer than the time frame documented in the P category.	**Action 3: *Partially Achieved*** To date 3 Divisional level investigations are in progress for harm associated with lapsed P categories. These relate to spinal cases and the investigations have not yet concluded. Data indicates 13

Clinical Activity Recovery	Why we chose this Quality Priority	How we will evaluate success	Evaluation
			cases where harm has been noted on the RCS form but there are no associated Ulysses incident forms, NB instructions on the RCS form instruct clinicians to complete a Ulysses incident form only if Moderate or above harm is suspected; these have been forwarded to the services for confirmation. 12 of the 13 do not have a TCI, one has a TCI for 19 January 2022. There are no current SIRIs specifying lapsed P- categories.
		Action 4: Clinical prioritisation to be fully integrated with our electronic patient record through improvements to electronic workflows and interface with commissioning systems to record procedures.	**Action 4: *Not yet achieved*** The optimal workflow agreed in March 2021 has been beset with technical issues and as of 19 January 2022 is not yet live. The introduction of D-codes for diagnostic investigations added an extra layer of complexity to the technical process. Cerner engineers have been working intensively with EPR and Information Teams to enable the new workflow to be released and data

Clinical Activity Recovery	Why we chose this Quality Priority	How we will evaluate success	Evaluation
			quality to be accurate. Detailed testing has taken place; the latest of which indicates that the issues were resolved in CERT (test domain) and a plan was to release this into PROD (live domain) on 15 January 2022. However, the go-live had to be aborted due to technical issues and is currently being reinvestigated for resolution. The new workflow will initially address inpatient diagnostics D-codes, but further technical work will be required for diagnostics carried out in the outpatient. Further reporting issues may arise with plans to integrate Blueteq with EPR which will improve the efficiency of the prior approval process.

Patient Experience

Digital Innovations	Why we chose this Quality Priority	How we will evaluate success	Evaluation
Due to the pressure on outpatient waiting lists	This priority will build upon	During 2021-22 the use of digital solutions will	

Digital Innovations	Why we chose this Quality Priority	How we will evaluate success	Evaluation
and space, a digital channel shift is required..	progress made in 2020-21, with the implementation of self-service for vaccinations and video consultations.	be expanded to help support of the recovery plans for outpatient services and to transform how patients interface with the Trust. **Action 1:** Reduce the number of patient outpatient letters sent, and shift to digital solutions so that >50% are moved to non-paper based (source = Letter Production) **Action 2:** Implement self-service solutions so that patients can re-schedule or cancel their appointments online. We will aim to achieve a >10% increase in self-service clinics (source = patient application). **Action 3:** Ensure the electronic patient record (EPR) is configured to enable accurate appointment	**Action 1: *Fully achieved*** Digital solution is live. 100% of appointment letters directed to Letter Production were made available to patients digitally (878,000 YTD). 90,000 of 515,000 patients who viewed their digital letter on the portal also elected for a printed copy. 50% of letters are not viewed on the portal. **Action 2: *Partially achieved*** The delivery of cancel and reschedule is being worked on. Funding received in December to enable work to commence. Staff utilised self-service booking for over 45,000 vaccinations. **Action 3: *Fully achieved*** There were 160,000 non F2F appointments to end

Digital Innovations	Why we chose this Quality Priority	How we will evaluate success	Evaluation
		types and clinics and increase the number of outpatient appointments to video or telephone. We will aim to achieve a <25% increase in total number of virtual appointments (source = Cerner / Appointment Type). **Action 4:** Automate processes in scheduling to support services to reduce administration and clerical staff time and prioritise patients correctly. We will aim to achieve a <10% increase in automated processes (source = Automation Software). **Action 5:** Increase use of the Patient Portal by establishing an automated process where patients can register for the solution. We will aim to achieve a <100% increase in registered and active users (source = Cerner Patient Portal).	March 2021. YTD 2021-22 – 745,218 virtual consultations to end December 2021 **Action 4: *Partially achieved*** Endoscopy has seen an increase of up to 75% of patients contacted booked for procedures by using the DrDoctor messaging booking platform. Also trialled an IP waiting list census within Adult ENT / Plastics and TNO on the DrDoctor platform. **Action 5*: Partially achieved*** Services are assisting patients to register for the Patient Portal. 2021-22 registrations are over 125% increase on 2020-21 registrations. The semi-automated registration process is under review to enable wider adoption in 2022-23.

Staff Health and Wellbeing: Growing Stronger Together	Why we chose this Quality Priority	How we will evaluate success	Evaluation
The aim of this Growing Stronger Together priority is to look after the wellbeing of our people and teams and enable their recovery followingthe COVID-19 pandemic and transition into a 'new normal'.	Focusing on the recovery of our people is essential to keep them safe and healthy at work, help reduce stress,anxiety, and presenteeism and retain an engaged workforce. This priority will build on the success of our Wellbeing Strategy and Quality Priority from 2020-21 as well as allow for new and innovative interventions to support the wellbeing of our people.	The below six actions form part of a wider Growing Stronger Together programme plan. **Action 1:** By end March 2022, 85% of our people to have participated in a wellbeing conversation with their line manager. **Action 2:** Recovery, Readjustment and Reintegration (R3P) Programme to be developed to enable post traumatic growth for teams; with 20 sessions offered by end December 2021.	**Action 1: *Partially achieved*** Manager Wellbeing Check-in briefings were delivered between September and November 2021 with c560 managers attending. The Head of Wellbeing also presented to the Clinical Directors as part of their Leadership Development Programme and to team and Divisional meetings across the Trust to promote the Wellbeing Check-in. As of 3 December 1,327 check-ins have been recorded, approximately 9% of our people. These Wellbeing Check-ins are being welcomed although are impacted by winter / service pressures. **Action 2: *Partially achieved*** From April to end November 2021 we have delivered 32 sessions. In December 2021 and January 2022, we have another 10 sessions scheduled. Feedback has been positive, especially the chance to meet socially distanced in

Staff Health and Wellbeing: Growing Stronger Together	Why we chose this Quality Priority	How we will evaluate success	Evaluation
			person. **Action 3:** Review and agree home working and flexible working policies byend March 2022.	**Action 3:** ***Partially achieved*** The Trust launched its new Remote Working Policy on 13 October 2021. It is designed for people who are not patient / customer-facing and don't require Trust-specific equipment. The Interim Agile Working Policy was updated 24 November 2021 which now includes a section on Health and Wellbeing. Flexible Working Procedure: Timewise conducted a review of our Flexible Working Procedure and a revised draft document will be circulated in January 2022 for consultation
			Action 4: Test out the fit of our new leadership behaviours framework as we transition into a 'new normal' as part of our leading with care pathway by September 2021.	**Action 4:** ***Partially Achieved*** Head of Leadership is currently creating a suite of leadership programmes as part of our leading self – teams – organisation and system approach. A bigger launch of leading Self resources in the new year along with the refreshed Values-Based Conversations workshop are in

Staff Health and Wellbeing: Growing Stronger Together	Why we chose this Quality Priority	How we will evaluate success	Evaluation
			progress. **Action 5:** *Partially Achieved* Workforce plans were developed for all areas and submitted to the BOB ICS as part of the annual operational planning round in May 2021. Each Division subsequently worked at a more granular level to identify particular hotspots that may need additional actions to address workforce pressures. In addition, the Trust commissioned four 'deep dives' into known areas of workforce pressure. These areas were: Juniper Ward in MRC; Theatres across all Divisions; SEU; and A&C staffing. **Action 6:** *Fully achieved* Images of teams published in *Stories from the COVID-19 pandemic - #OneTeamOneOUH* and *Beyond Words... Images from the COVID-19 Pandemic*. Annual Staff Recognition Awards launched in December 2021.
		Action 5: All Divisions to have workforce plans in place to address sustainable staffing issues by October 2021.	
		Action 6: Recognition, celebration and commemoration event(s) by end December 2021.	

Staff Health and Wellbeing: Growing Stronger Together	Why we chose this Quality Priority	How we will evaluate success	Evaluation
			OUH poem has been commissioned with funding from Oxford Hospitals Charity. Poet Beth Calverley will engage and develop her text with individuals and teams from across the Trust in January 2022.

Quality Improvement (QI) Stand Up	Why we chose this Quality Priority	How we will evaluate success	Evaluation
Multiple QI projects have been delivered across OUH and many are in progress. These improve the safetyand experience of patients. QI 'Stand Up' is a forum where QI projects will be shared with multidisciplinary colleagues across OUH to share learning.	To share learning and promote widespread adoption of quality improvement across theTrust.	Four speakers will present their QI projects each month. They will discuss their initiative, QI journey and share learning from their successes and failures. The audience is invited to share insights, feedback, and discuss ways to scale and spread QI in other areas of theTrust. **Action 1:** Set up fortnightly and then weekly QI presentations and monitor attendance and number of projects presented.	**Action 1: *Fully achieved*** QI Stand Up has been established and running successfully at OUH. 4 projects have been presented each month since April. The speakers from a range of multi-professional backgrounds including medical, nursing, and allied health professionals

		Action 2: Seek evaluation from attendees and presenters to measure thebenefit of attending QI Stand Up April 2021 to July 2021 **Action 3:** Monitor the number of QI projects being registered on Ulysses to explore if the number of projects registered increases over the year. **Action 4:** Enable scale and spread of at least three QI projects out of every 30 undertaken, across at least two Directorates.	presented their QI at the Stand Up All the sessions were chaired by the CMO and senior Trust management. The average attendance has been between 60-70 staff. Attendees came from all professional backgrounds. QI projects have been registered on Ulysses since April 2021. Following a gradual increase in QI project registration between July and November 2021, the number of project registrations fell in December and January, coinciding with the latest COVID-19 peak. **Action 2, 3 & 4:** ***Partially Achieved*** A small number of QI projects have been scaled and spread to new clinical areas. Formal evaluation has been delayed by the COVID-19 pandemic. Planned next steps are to undertake a formal evaluation of the programme and further enable scale and spread of QI projects.

2021-22 Performance against the relevant indicators

Our 2021-22 performance against the relevant indicators and performance thresholds set out **in the oversight documents issued by NHS Improvement are summarised below.**

The table shows the performance of key indicators by quarter for the year and the sum total for the previous year.

	Target	2019-20 Annual	2020-21 Annual	2021-22 Q1	Q2	Q3	Q4	Full year
Rates of *C. difficile*		89	114	29	28	27	23	107
18 Week Incomplete	>92%	80%	61%	74%	76%	75%	76%	75%
4 Hour Target	>95%	83%	85%	83%	74%	69%	67%	73%
Maximum wait of 62 days from urgent referral to treatment for all cancers	>85%	68%	76%	71%	74%	71%	63%	70%
Extended 62-Day Cancer Treatment Targets (following detection via national screening programme of hospital specialist)	>90%	60%	69%	74%	74%	79%	52%	70%
Supporting measures: number of diagnostic waits <6 weeks - DiagWaits	>99%	97%	79%	93%	93%	89%	89%	91%

Emergency Department (ED) access: 95% patients wait fewer than four hours

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

- The Trust has a robust process in place for collating data on ED attendances and four-hour breaches.
- Data are collated internally and then submitted monthly to the Department of Health.

- The Trust is regularly and independently audited to ensure accuracy of the figures.
- Data are compared to peers, highest and lowest performers, and our own previous performance, as set out in the table below.

Emergency Department	2018-19	2019-20	2020-21	2021-22
Four hour Breaches	20,588	27,939	18,379	46,063
Attendances	160,714	165,011	126,306	172,101
Performance	87%	83%	85%	73%
National average	88%	84%	89%	77%
Best performing trust	100%	100%	100%	100%
Worst performing trust	62%	66%	74%	58%

Oxford University Hospitals NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of its services.

- Performance against the national standard for the percentage of patients on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from referral was 74.9% at the end of 2021-22. During 2021-22, the number of patients wating over 52 weeks reduced from 4,934 in March 2021 to 971 patients in March 2022.
- The indicator measuring A&E attendances where the patient was admitted, transferred or discharged within four hours of their arrival at an A&E department was 73% at the end of 2021-22. In 2021-22, A&E attendances increased by 36.3% compared to 2020-21.
- The indicators measuring 62-day cancer standards from GP referral and from screening programmes to treatment were both 70% in 2021-22. These standards are the focus of specific initiatives within the Trust's Improvement Programme.
- Performance against the indicator measuring diagnostic wait times for tests within six weeks was 91% at the end of 2021-22.

Other notable achievements

Although it was a challenge to deliver all the 2021-22 Quality Priorities in full due to the impact of the pandemic, it is important to recognise that there were other notable Trust achievements during 2021-22.

Long COVID service

The Long COVID service is run jointly by Oxford University Hospitals (OUH) NHS Foundation Trust and Oxford Health NHS Foundation Trust. People in Oxfordshire who are experiencing long-term symptoms after getting COVID-19 are benefitting from an integrated service combining the expertise of Oxford's two NHS trusts. Specialists from the two trusts are able to triage each patient referred to them by GPs and then refer them to the most appropriate service, whether that is hospital- or community-based support.

'Building a Greener OUH' to reach Net Zero by 2040

Building a Greener OUH 2022-2027 puts the Trust on a path to achieving net zero carbon emissions by 2040, in line with NHS England's carbon neutral target. It sets out actions that will be taken across key areas, including procurement and supply chains; medicines; digital transformation; estates and facilities; and travel and transport.

New Critical Care Building open to patients

Patients needing critical care support have moved into the new Critical Care Building at the John Radcliffe Hospital in Oxford. This is part of a regional approach for managing critical care demand and activity through both the COVID-19 pandemic, as well as supporting and alleviating future seasonal pressures.

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

Statement from Oxfordshire Clinical Commissioning Group (OCCG)

OUH Quality Account – OCCG response 2021- 22

NHS
Oxfordshire
Clinical Commissioning Group

Jubilee House
5510 John Smith Drive
Oxford Business Park South
Cowley
Oxford
OX4 2LH

Telephone: 0300 561 1873

30 May 2022

NHS Oxfordshire Clinical Commissioning Group (OCCG) has reviewed the Oxford University Hospitals NHS Foundation Trust's (OUH) Quality Account and believe that it is accurate and meets the requirements of a Quality Account. The OCCG recognises that OUH undertakes a vast range of services, and due to the continuation of the COVID-19 pandemic, pressure on most services remain high. It is also recognised that the Quality Account represents only part of the significant work undertaken by the Trust to evaluate and improve patient safety, the effectiveness of treatments patients receive, and the quality of care provided through patient feedback. An important additional service covered in the 2021-22 Quality Account includes tailoring care to provide support for patients with Long COVID in Oxfordshire.

OCCG commends OUH for proactively seeking out examples of excellent patient care and shared learning, and embedding this into Trust culture, as is evident from the QI Stand Ups and DAISY awards. OCCG would also like to emphasise the continued highly positive hip fracture performance at the Horton General Hospital. It is a strong desire of OCCG that performance at the other Trust sites matches this level of

performance. Another positive is the Trust's significant investment in estates and equipment over the past 12 months to improve patient care and experience, as well as improving the working environment for staff.

C. difficile infections have increased at OUH, as is the case nationally. Following the unannounced CQC inspection and published report in July 2021, specifically looking at Infection Prevention and Control (IPC), the Trust now has implemented a comprehensive action plan based on an approved IPC business case. Overall, OUH's CQC rating remains as 'Requiring Improvement'. However, OCCG recognises that there are detailed action plans in place to address the CQC conclusions. Most of these actions are complete, with those outstanding remaining subject to continuous review and focus.

Oxford University Hospitals is embedding the Quality Improvement (QI) methodology and a learning organisational culture that comes from incidents and complaints. Areas of focus include: reducing pressure ulcers, improving medication safety (with focus on insulin and opioids), improving the timely and accurate endorsement of results, introducing a Morbidity Dashboard in surgical specialties (to ID and understand areas with higher rates of re-admissions and returns to theatre), and addressing better staff health and wellbeing, to name a few. The Trust has seen a significant recent improvement in their long-standing challenge for timely endorsement of test results; OCCG is keen that this trend is improved and sustained in the long term.

Oxford University Hospitals participated in 97% of the 60 National Mandatory Audits for which the Trust was eligible. This equates to three National Audits outstanding, of which two remain suspended due to COVID-19 pressures (both respiratory). All 25 local audits for 2021-22 have been completed with action plans for improvement in place.

OUH reports a 22% increase in patient safety incidents on previous years (this includes incidents and near-misses) despite a reduction in the expected rate of incident reporting. The number of incidents only (excluding near misses) are down from previous years but is still above the national average for comparative trusts. OCCG acknowledges that the results reflect a change in categorisation to conform to NRLS advice as part of the reason for this observation. Further work around better understanding these trends will be welcomed by OCCG for 2022-23 as we move into the Integrated Care System. Incidents per 1,000 bed days remains below the national average for Oxford University Hospitals.

The Serious Incident process has highlighted some challenges in patients progressing through a cancer pathway, from identification (endorsement of results, appropriate referral), to cancer tracking and clear ownership and interaction with the MDTs. OUH

has also identified challenges in accessing appropriate theatre capacity, which has been seen to have an impact upon patient safety. OCCG is keen to see improvements in general cancer-related patient safety challenges and in planning for long-term theatre capacity management. The significant improvements to the Oxford Critical Care Unit will support this work.

It is extremely encouraging to see that the number of patients waiting for more than 52 weeks has significantly decreased over the past year. The significance of this achievement is recognised by OCCG, with appreciation of the challenges balancing recovery plans for the services with continued COVID-19 pressures. OUH has a harm review process in place which systematically reviews harm to patients waiting longer than expected by national standards.

There has been no CQUIN scheme for 2021-22 for providers to participate in or to achieve. Re-introduction of the CQUIN scheme is expected for 2022-23.

The OUH Quality Account represents a clear demonstration of the Trust’s activity and the quality of its services, with action plans for improvement work where indicated. We recognise the continuation of challenges over the past 12 months, and greatly value the close working relationship that OUH and OCCG have enjoyed during this time.

NHS England Specialised Commissioning statement on Oxford UniversityHospitals NHS Foundation Trust 2021-22 Quality Accounts

Specialised Commissioning – South East
NHS England
Premier House
60 Caversham Road
Reading
Berkshire RG1 7EB

england.admin-seast-transcomm@nhs.net
sarah.vaux@nhs.net

18 May 2022

Dr Bruno Holthof
Chief Executive Officer
Oxford University Hospital NHS Foundation Trust

David Barron
Director of Specialised Commissioning and Health & Justice – South East Region
NHS England & NHS Improvement

Dear Bruno

Re: 2021-22 Oxford University Foundation Trust Quality Account

Thank you for sharing the Oxford University Hospitals NHS Foundation Trust (the Trust) 2021-22 Quality Account with NHS England and NHS Improvement as the commissioner of specialised services.

2021-22 was another year of unprecedented challenges, as the COVID-19 pandemic continued. I would like to convey my thanks to the whole team in recognition of the hard work and dedication applied during the last year. Resilience, flexibility and adaptability has been shown by many at all levels, with the continuation of key services to support patient care despite unprecedented demand and uncertain times.

I am pleased to see patient safety is one of the three key domains of the OUH Quality Strategy and providing high quality, safe, patient-centred care is central to the Trust's

objectives in the Trust Strategy for 2020-25.

The key themes of becoming ‘Outstanding’ across all CQC domains, building a culture of clinical effectiveness and improvement is key to delivering high quality care. Alongside the creation of a ‘Just Culture’ striving to continuously improve patient safety, engaging and encouraging staff to report incidents and raise concerns, ensures learning from incidents to reduce harm. Active participation with patients to improve their health, care, and experience is a key driver in improving outcomes for our patients. These priorities are well-matched to those of South East, Specialised Commissioning.

The Quality Account demonstrates positive achievement in the improvement of patient and staff experience through the Health Service Journal Changing Culture Award in recognition of the development of a Quality Improvement (QI) Hub.

The Quality Account also provides evidence of a focus of embedding a patient safety culture, through the many approaches with staff such as Safety Huddles, PSR team meetings and the Reporting Excellence initiative. The work of the dedicated Integrated Quality Improvement Team across the whole organisation will ensure more patients receive timely, safe, compassionate, quality care in the right setting supporting a risk management, learning culture across the Trust. The Quality Improvement Hub through an educational approach is a positive approach to ensure that culture is embedded further in a sustainable way to the benefit of patients and staff. Both these initiatives alongside the participation of 39 specialties in the national GIRFT programme serves to enhance the care delivered to patients.

I am pleased that staff are given the opportunity to recognise others for exceptional work in day-to-day practice, noting that more than 1,800 nominations for the OUH Staff Recognition Awards 2021 have enabled staff to highlight work that made a difference to patient care and working lives. This in addition to other improvements outlined in the account will serve to support the improvements required by the CQC directly related to staff wellbeing.

I note the Trust continues to work on the areas ‘Requiring Improvement’ particularly in the ‘Safe’ category as outlined in the September 2021 CQC report, the safe provision of care is paramount in all settings. The 2022-23 Quality Strategy includes a wide range of initiatives to achieve that improvement, including in data quality, information governance and against the national core set of quality indicators and PROMs.

91% patients indicated that they rated their experience as ‘very good’, or ‘good’ in 2021-22; this is a positive result regarding patient experience. The improvements that have been made as a result of individual patient feedback will increase that response rate further. Staff Survey results are well above the national average as a good place to work, the focus on wellbeing has led to an increase in staff feeling that the Trust is taking positive action on health and wellbeing, and I am pleased to see this is a continued focus for 2022-23.

There are demonstrable patient safety response measures in place to action incidents including Never Events with defined learning and improvements with a particular focus on system and process changes to reduce the probability of recurrence, with learning

shared at all levels in the organisation and externally. Measures are in place to ensure Duty of Candour continues to be addressed for all patient incidents of Moderate impact or above.

New and innovative interventions have been initiated and continue to support both patients and staff as we learn to live with the continued effects of COVID-19. The work that has been applied to COVID-19 studies involving OUH patients and staff, alongside the specific focus on education and training in this area, will ensure those affected receive the best possible care and outcomes for the condition. Again, I would like to thank the teams at OUH for their innovation and dedication in supporting both patients and colleagues in the management of the chronic effects of the virus.

You note a positive visit by the Care Quality Commission (CQC) focused on infection prevention and control (IPC). There are a number of areas which require further improvement; however, there is a comprehensive action plan in place to address these, and I am assured that IPC is a priority for the Trust Board having made a significant investment to strengthen the staffing and resourcing of the IPC team.

The development and mobilisation of the new Critical Care Building at the John Radcliffe Hospital earlier this year is a positive development for the Trust as well as the region in delivering care to the most unwell patients, ensuring that sufficient capacity is available to support fluctuation in demand. This, alongside other capacity and service developments supporting specialised services, such as the re-opening of the Trauma Building at the John Radcliffe, the dedicated new centre to care for patients with bleeding and clotting disorders at the Nuffield Orthopaedic Centre (NOC), the purchase of new state-of-the-art radiotherapy equipment for cancer patients and the practical completion of the new Swindon Radiotherapy Centre, all serve to enhance the care to specialised patients. I don't underestimate the complexity and demand this provision has placed on the organisation whilst managing everyday business.

The waiting list demands impacted by the pandemic have been challenging, however the Trust has managed to achieve great progress in reducing waits for treatment for both the local and tertiary population, despite IPC and staffing challenges.

The achievement of 12.4% turnover in January 2022 against a target of 12% turnover for all Band 5 nursing staff, in addition to the recruitment of 500 international nurses, means staffing is in a strong position to continue to reduce waiting lists further.

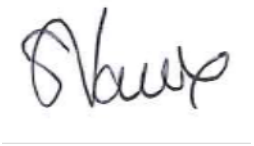
The recognition of the need to ensure an enhanced focus on reducing Never Events in the forthcoming year and going forward is central to the safety of and positive outcomes for our patients.

The reintroduction of the peer review programme in 2021-22 is positive, alongside the already extensive participation in clinical audit such as cardiac, neurosurgery, CHD and the National Neonatal Audit Programme and the actions taken on the findings such as the rehabilitation after critical illness: Adult Intensive Care Unit programme will support the quality objectives outlined in the statement during 2022-23.
There has been significant achievement against the Quality Priorities set for 2021-22 in a situation of notable challenge; this is a credit to the teams working within the

organisation, their dedication, commitment, and focus.

South East, Specialised Commissioning is in support of the Quality Priorities in place for 2022-23 and the evaluation criteria set against them.

We look forward to continuing to work collaboratively with the Trust in its achievements during the coming year in order to support the quality improvements identified.



Sarah Vaux

Director of Nursing Specialised Commissioning and Health & Justice, Direct Commissioning – South East Region
NHS England & NHS Improvement

Governor Response to Quality Account

The Council of Governors was pleased to read this detailed and accessible record of the work that the Trust has undertaken and planned to ensure that standards for the quality and safety of treatment and care are maintained and improved.

All governors have had the opportunity to comment on the report. The Council of Governors' Patient Experience, Membership and Quality Committee has additionally met virtually with the Trust's Director of Clinical Improvement to discuss key aspects of the Quality Account and to receive more detailed explanations of specific aspects of the document. It has been revised based on governor feedback where relevant.

During the financial year 2021/22 the Council of Governors has been able to re-introduce its own scrutiny of service quality through the Patient Experience, Membership and Quality Committee which had been scaled back due to the pandemic. It hopes to continue to develop and strengthen this work during 2022/23 with specific non-executive directors now identified as links between the Committee and the Board who will be in regular attendance at its meetings.

Governors welcomed the level of detail provided in the document and were pleased to see that it was generally presented in an accessible and comprehensible way with an appropriate level of detail. The Council also 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.

The Council strongly supported the Trust's commitment within its strategic objectives to increase patient and public involvement and this is an area of work which the Patient Experience, Membership and Quality Committee looks forward to hearing more about during the coming year.

The ongoing challenges in relation to urgent and emergency care were highlighted and governors were pleased to understand that this remained a major priority area for the Trust.

Governors also noted that the need to reduce the number of patients waiting for elective care for lengthy periods remained a significant priority, particularly in the wake of the pandemic, but welcomed the very significant reduction in patients waiting for over a year from almost 5000 to 950 which had been delivered during the 2021/22 financial year.
The Council was pleased to see the work that the Trust had undertaken to embed a strong safety culture, including the use of Safety Huddles, Quality Improvement initiatives and the work of the Patient Safety Response Team. The extent of the Trust's involvement with national studies was also welcomed.

The efforts that the Trust continued to take to improve staff wellbeing were also recognised. The Council of Governors greatly values the contribution made by all staff and strongly supports these initiatives.

The Council welcomes the developments described in the Quality Account and is pleased to note 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 acknowledge the ongoing commitment of all staff to maintain and develop high standards of compassionate, innovative and high-quality care in the context of the need to recover following the pandemic and to continue to reduce waiting times.

Graham Shelton
Lead Governor

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

Statement from Healthwatch Oxfordshire

healthwatch Oxfordshire
Your voice on health and care services

Sent by email to Dr Bruno Holthof
Chief Executive Officer
Oxford University Hospitals NHS Foundation Trust
bruno.holthof@ouh.nhs.uk

24th May 2022

Dear Dr Holthof,

Oxford University Hospitals NHS Trust Quality Account
Thank you for letting Healthwatch Oxfordshire have sight of the Trust's Quality Account 2021-22 prior to publication.

Our comments and suggestions on the document are as follows:

- Healthwatch Oxfordshire would be assured if there was an overarching commitment to:
    - the inclusion of patient stories as part of learning and informing development throughout the report
    - involving patients, and for young people their families, in co-production activities including service design and development and how this will be achieved to ensure all community voices are heard
- Transition of children to adult services section – Healthwatch Oxfordshire welcome the positive action of establishing an inclusive summit.
- Throughout the document there are references to telephone access / digital exclusion / telephone follow-ups etc. The public would be assured of equality of access:

- to see a commitment by the Trust to the provision of interpreters available for all patient contact.
- an explanation of how the Trust provides alternative means of contact for those who are more generally digital excluded.

2021-22 was again a difficult year for the community, staff, and patients. Again, we thank all staff at the Trust for their continuing commitment to provide a quality and safe service to the community of Oxfordshire.
Yours sincerely,

Rosalind Pearce, Executive Director

Response to Healthwatch OXFORDSHIRE following the statement received on 24th May 2022:

Healthwatch Oxfordshire would be assured if there was an overarching commitment to:	
• the inclusion of patient stories as part of learning and informing development throughout the report	OUH has produced seven stories for the Trust Board over the 13 months and the links are below March 2021: Story from the Lotus Team (ouh.nhs.uk) May 2021: Learning from a Serious Incident Requiring Review (SIRI) (ouh.nhs.uk) July 2021: Staff story (ouh.nhs.uk) September 2021: Experience of being supported by the Oxford Fetal and Maternal Medicine Unit (FMMU) (ouh.nhs.uk) November 2021: Patient Perspective: Making the Transition from Children's to Adult Services: Preparing for Adulthood (ouh.nhs.uk) March 2022: Patient Story: FIT for Discharge. Frances, Irene, and Terry's story (ouh.nhs.uk) May 2022: Patient Perspective: Charlie's Story (ouh.nhs.uk)
• involving patients, and for young people their families,	The Trust has a very active children and young people's forum called YiPpEe. We also have

in co-production activities including service design and development and how this will be achieved to ensure all community voices are heard	two young people from YiPpEe who are young people's governors. Following the children and young people survey in 2020-21, YiPpEe attends a presentation on the results with senior members of NOTSSCaN Division.
Transition of children to adult services section – Healthwatch Oxfordshire welcome the positive action of establishing an inclusive summit.	Thank you for your support – we are really excited about this Quality Priority. The inclusive summit will focus on the draft Transition / moving to adult framework and checking / reviewing it with young people, families, advocacy groups, and statutory partners.
Throughout the document there are references to telephone access / digital exclusion / telephone follow-ups etc. The public would be assured of equality of access: • to see a commitment by the Trust to the provision of interpreters available for all patient contact.	We are committed to equity of access for our patients, and the OUH Digital Strategy recognises 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 companies 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.

	The team has joined the Asylum Welcome Access to Health group – our focus is on interpreting and translation and feedback of lived experience

Statement from Health, Overview and Scrutiny Committee

Cllr Jane Hanna OBE

Chair, Health Overview and
Scrutiny Committee

13 June 2022

Dr Andrew Brent

Deputy Chief Medical Officer
Oxford University Hospitals NHS FT

Dear Dr Brent

Re: Oxford University Hospital's Draft Quality Account 2021-22 and Priorities for 2022-23 – Response from the Health Overview and Scrutiny Committee

Many thanks for attending Committee on 10 June and presenting to us the key elements of your Quality Account. I and the Committee continue to recognise the significant impact of Covid-19 on OUH's work over the past year. We remain acutely aware of the pressures on you and your teams and the impacts which this has had on workloads and on physical and mental health across OUH. As such,

this Committee remains very grateful for the work which OUH does and for your time in bringing details of it before the Committee.

Before I set out some of the points raised by the Committee, firstly I would wish to say how grateful I am that you agreed that we needed to develop a simple protocol on how we handle Quality Accounts moving forward so we can best support the Committee and the Trust in what feels like a very short period of time. This must include a shared agreement on the publication of the Quality Account with the Committee's agenda and in the public domain. Secondly, the Committee note the challenges associated with selecting such a small number of Quality Priorities and the potential for areas not deemed a priority to be seen as not important. We wish to state that we recognise that difficult decisions must be made and that other quality and safety indicators will be given as much attention throughout the year.

Points raised and responded to at Committee:

1. Staffing and whether there was alignment of staffing needs as part of the plans in which to deliver the stated objective;

2. Clearer definitions of patient harm;

3. The need to see clear clinical and patient outcomes associated with the priorities – Key Performance Indicators are essential;

4. The impact of Antimicrobial Resistance across the Trust;

5. National Staff Survey – the Committee was concerned to see a decline in positive staff scores in some clinical specialties. We hope that the Trust has plans in place to improve such scores;

6. The Committee noted the cancellation of previous Quality Conversation events but were encouraged to hear of one being planned for August.

You will also recall that a question was raised on how to ensure quality *across the NHS system*, as we progress with moving into formal BOB ICS arrangements next month. I would very much welcome the Trust considering this point and sharing its reflections with the Committee on how that could be achieved and what the benefits of thinking in this way could be.

I and the Committee are supportive of your priorities for 2022-23 and we remain very keen to continue to support OUH and the wider health and social care system in the coming year. We have a challenging work programme ahead of us this year but this must not prevent OUH coming to talk to HOSC if there are matters or proposals which OUH would like the Committee's engagement on.

Yours sincerely
Cllr Jane Hanna OBE
Chair, Oxfordshire Joint Health Overview and Scrutiny

Committee

mailto:jane.hanna@oxfordshire.gov.uk

Contact: Helen Mitchell, Interim Health Scrutiny Officer Helen.mitchell@oxfordshire.gov.uk

Response to the Health Overview and Scrutiny Committee following the statement received on 13 June 2022

Reflections to the Health Overview and Scrutiny Committee	
• Staffing and whether there was alignment of staffing needs as part of the plans in which to deliver the stated objective	Each of the Quality Priorities has a designated Lead. The Quality Priorities provide focus and momentum around a particular issue, which would support a business case for further resource if that were required.
• Clearer definitions of patient harm	OUH has very clear definitions of harm provided through the National Reporting and Learning System (NRLS). OUH follows the NRLS impact guidance which is clearly stated in our Incident Reporting and Investigation Policy.
• The need to see clear clinical and patient outcomes associated with the priorities – Key Performance Indicators are essential.	Thank you for the helpful feedback. There has been a greater focus on benchmarking, metrics and milestones in developing this year's Quality Priorities, however we recognise that this remains a work in progress. Some of the Quality Priorities have been chosen because they are not currently the subject of existing local or national data reporting, so the first step is to carry out a more detailed description of the current status and any available benchmarks, without which it is difficult to set target performance indicators. Others, like triangulation of results and embedding QI, focus on establishing a culture of learning and improvement, but are harder to link to specific clinical and patient outcomes. We are nevertheless committed to setting process and outcome performance metrics that are as specific as possible and will continue to strengthen these as required.

• The impact of Antimicrobial Resistance across the Trust.	The Trust has comprehensive antimicrobial guidelines and an Antimicrobial Stewardship Programme to reduce as far as possible the generation of Antimicrobial Resistance through antibiotic pressure. Antimicrobial Stewardship review forms part of all patient infection reviews, for both unsolicited and solicited consultations. Patients on all OUH intensive care areas are also regularly reviewed by the Infection team (up to 7 times a week). The Infection Prevention and Control (IPC) business case to strength the establishment of the IPC nurses and Antimicrobial Stewardship has been approved by the Trust Board, which will enable further work to be undertaken on reducing *C.difficile* in the organisation and across the wider health economy.
• National Staff Survey – the Committee was concerned to see a decline in positive staff scores in some clinical specialties. We hope that the Trust has plans in place to improve such scores.	This year we have agreed 'Our Engagement Promise' as part of our response to the 2021 Staff Survey results. This focuses on improving the Staff Survey follow-up conversations through a Trust-wide approach to engagement. All Divisional leaders are responsible for cascading the results, and team leads are required to undertake 'Time to Talk' conversations with their teams to co-design, embed and own local action plans. We have developed a Ulysses module to ensure co-created action plans are SMART and documented, monitored and regularly updated and progressed. This will help teams to see the positive difference these actions are making throughout the year. Our Divisional Performance Governance Reviews include updates on what action is being taken to make improvements based on the Staff Survey results. We recognise there are still areas for improvement in order to make OUH a great place to work for our people. When looking at the wider context of the 2021 Staff Survey results, there has been a general decline across the NHS in England. When we compare our results to the national average scores, overall our

	people have fedback a more favourable experience.

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 themselves of 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 www.england.nhs.uk/financial-accounting-and-reporting/quality-accounts-requirements-2021-22
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 2021 to May 2022.
- Papers relating to Quality reported to the Board over the period April 2021 to May 2022
- Feedback from commissioners dated 31 May 2022 (Oxfordshire Clinical Commissioning Group), 18 May 2022 (NHS England Specialised Commissioning).
- Feedback from Governors dated 10 June 2022.
- Feedback from local Healthwatch Oxfordshire dated 24 May 2022.
- Feedback from Overview and Scrutiny Committee dated 13 June 2022
- 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 2020 Survey published on 19 October 2021
- The (latest) national and local Staff Survey conducted in 2021.
- CQC inspection report dated June 2019.

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.

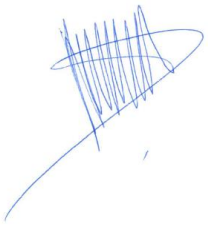
The data underpinning the measures of performance reported in the Quality Report are robust and reliable, conforms to specified data quality standards and prescribed definitions, and are subject to appropriate scrutiny and review.

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 with the above requirements in preparing the Quality Report.

By order of the Board

NB: sign and date in any colour ink except black



Dr Bruno Holthof

Chief Executive Officer

28.06.22

Professor Sir Jonathan Montgomery

Chair

28.06.22