Oxford University Hospitals
NHS Foundation Trust

Quality Conversation Event and Proposed Quality Priorities 2024-2025

Council of Governors

January 2024

Overview of Quality Priorities and process

OUH aims to deliver and assure patients they are receiving the very best quality of care.

NHS England requires all NHS Foundation Trusts to produce reports on the quality of care as part of their Annual Reports.

Quality reporting allow Trusts to be held accountable by the public and other stakeholders.

The Quality Account contains commitments to areas of work referred to as **Quality Priorities**.

Quality Priorities all have an Executive Lead as well as an Operational Lead. Clear, measurable target objectives are included in the report.

The Quality Conversation Event took place on 11 December 2023.

The Quality Conversation Event 11 December 2023

- The Quality Conversation Event held on 11 December 2023 was attended by 77 stakeholders, these included members of the public, Hospital Governors, Patient Safety partners, OUH Trust Board and other staff, representatives from the Integrated Care Board, Maternity voice partnerships, HealthWatch, Care Oxfordshire and NHSE.
- Feedback about the event has been very positive.
- Posters were displayed and films shown of the current Quality Priorities.
- A list of the proposed Quality Priorities was given to each attendee.
- Each table had informative discussions and chose two of the following:

    1 - Current priorities

    2 - Proposed priorities

    3 - Each table also added two ideas

Quality Priorities 2023-24 (current)

Patient safety	Reducing inpatient Falls	Care of the Frail Elderly	Medication safety – Insulin and Opiates
Clinical effectiveness	Reducing Unwarranted hospital Outpatient Cancellations	Rolling out and embedding the surgical morbidity dashboard	Helping more patients through tissue donation for transplant
Patient experience	Health Inequalities- improving data capture including ethnicity	Empowering patients- building partnerships and inclusion	Kindness into Action- improving patient and staff experience

Proposed Quality Priorities 2024-2025 discussed

Patient Safety

1. Medicine Safety Framework
2. Learning from Deaths
3. Patient Safety Incident Response Framework (PSIRF) workstreams

Clinical Effectiveness

4. Outreach service from Oxford Critical Care
5. Reducing maternal and neonatal morbidity
6. Fragility fractures
7. Optimising and innovating radiology reporting triage and performance processes

Patient Experience

8. Patient experience with PSIRF
9. Joy at work- improving retention
10. Raising awareness and understanding of D/deaf patients and their specific needs

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Quality Priorities for 2024-25 have been chosen incorporating feedback from the event and alignment with the overall Trust priorities.

These include some current priorities rolled over and some new priorities.

Patient Safety

Quality Priority	Description
Care of the frail elderly	Frail, elderly patients make up a substantial proportion of patients presenting to urgent and emergency care settings. Early, comprehensive assessment of these patients can improve outcomes by ensuring the acute care, management pathway and future care plans are all tailored appropriately to the patient's needs. This quality priority focusses on strengthening the assessment of frail, elderly patients in the Emergency Department (ED) and Same Day Emergency Care (SDEC) settings. It aligns with CQUIN05 'Identification and response to frailty in emergency departments'.
Reducing inpatient falls	Inpatient falls are an important and potentially preventable cause of morbidity and mortality, especially as a cause of femoral fractures among the elderly. Key to reducing the risk of falls in hospital is a multifactorial falls risk assessment, followed by action to address each of the falls risk factors identified. Early assessment of patients with a suspected serious injury is also important following a fall to ensure timely and appropriate analgesia, investigations and management. This Quality Priority focusses on strengthening training and implementation of the multifactorial falls risk assessment; addressing key areas for improvement identified in the most recent National Audit of Inpatient Falls; and strengthening assessments and information sharing following a fall.
Medicines Safety Framework	A comprehensive Medicines Safety Framework is required to integrate a range of metrics and indicators to understand medicines safety over time. Examples of medication safety indicators that might be included in this framework include: • Administration of naloxone and flumazenil as antidotes. • Time to dispense time critical medicines. • Delayed and omitted doses of time critical medicines. • Patients on insulin with severe episodes of hypoglycaemia. • Use of high-risk injectable ready-to-administer medicines. • Time taken to complete medicines reconciliation. • Proportion of patients with completed medicines reconciliation. • Safe and secure medicines management audit.

Clinical Effectiveness

Quality Priority	Description
Outreach service from Oxford Critical Care	Develop and pilot an Outreach service for the Trust, co-ordinated and overseen by Oxford Critical Care. This will improve the recognition of deteriorating patients, improve speed and quality of decision making, improve bed length of stay, and provide a platform for improved nursing retention
Reducing maternal and neonatal morbidity	We will focus on 3 indicators that are associated with obstetric intervention and that are more common following a delayed induction of labour process: Obstetric anal sphincter injury (OASI), Severe post-partum haemorrhage (PPH) rates, Term admission to the special care baby unit (SCBU) for normal babies. The project will focus on improving timely intervention during induction of labour There will also be specific interventions: Continue focussed advanced training and engagement for obstetricians and midwives in reducing OASI and prevention of PPH High Acuity Risk Management (HARM) programme to manage heavy obstetric workload safely as adverse outcomes are more likely at times of high acuity
Surgical Morbidity Dashboard	This Quality Priority builds on our previous year's work by supporting roll out of the recently developed Morbidity Dashboard for more widespread use across the Trust. Monitoring the occurrence of complications, identifying areas of higher-than-expected rates, and assessing if they were avoidable will help teams to improve the quality of care that is delivered. We expect that by allowing clinical teams to monitor their outcomes better, the morbidity dashboard will facilitate efforts to improve the safety of patients and help us deliver high quality healthcare.

Patient Experience

Quality Priority	Description
Patient Experience with PSIRF	We will understand and develop an improvement plan for compassionate engagement of patients, families and carers who have been involved in serious patient safety incidents. This will be based on the NHSE / HSIB / Learn Together document outlining the 9 principles of Engaging and involving patients, families and staff following a patient safety incident. We co-produce with Patient Safety Partners suitable tools to capture patient experience and improve our understanding of this part of the patient's journey.
Fragility Fracture Pathways, including fractured neck of femur pathway	The results of the National Hip Fracture Database (NHFD) demonstrates that at the John Radcliffe site there is a need to shorten the time taken for hip fragility patients to access surgery. The Horton site has delivered care that regularly meets the National Standards. This Quality Priority aims to combine a number of quality improvement (QI) workstreams to improve performance (time taken to get to theatre) and therefore reduce morbidity and mortality
Health Inequalities	Reducing health inequalities is a key objective running through the Trust's Clinical Strategy. Key to understanding, improving and monitoring health inequalities are good quality data on the key determinants of inequality including ethnicity. This quality priority includes work to improve ethnicity data to support a better understanding of, and interventions to improve, local health inequalities. It also focusses on understanding better how health inequalities impact on cancer and antenatal care. Poor engagement with antenatal care is a major risk indicator for adverse maternal and perinatal outcomes. As part of this quality priority we will explore local demographics and barriers associated with low engagement with antenatal care, and co-develop strategies to overcome these barriers with maternity service users including maternity advocate/community organisers and locality partners in health.

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Detailed action plans are now being developed for each Quality Priority.

The process is overseen through the Clinical Governance Committee.