Oxford University Hospitals NHS
NHS Trust

A summary of the Quality Account

2012/13

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Dame Fiona Caldicott
Chairman

Sir Jonathan Michael
Chief Executive

Statement from the Chief Executive

This is a summary of our 2012/13 Quality Account. The full document can be found on our public website:
www.ouh.nhs.uk/about/publications/documents/quality-account-2013.pdf

"Patients and our staff are at the heart of what we do. Providing world class quality of care is a priority for Oxford University Hospitals NHS Trust.

In this document we have focused on our priorities for quality improvement going forward into 2013/14 and a review of our priorities and quality performance looking back at 2012/13. We will continue to push forward with priorities identified in last year's Quality Account, where some have been achieved but need to be sustained and in others where we have achieved some improvement but still require further work.

During 2012 we consulted with our staff and asked them to identify two quality priorities from each quality domain[1] per service area, applicable to their patients' needs, that they would focus on for the next 12 months. These have been displayed across clinical areas and progress will be reported to the Clinical Governance Committee. In March 2013 we held a *'Let us hear your views'* event where we asked our service users for their ideas and comments on our proposed quality priorities. We were pleased to see that the topics discussed all seemed to resonate with stakeholders and service users. We have organised further events to discuss our progress and receive feedback.

We aim to provide care that offers excellent clinical outcomes for our patients, and to do so with compassion that is evident to those patients and their carers. The central goal of *Delivering Compassionate Excellence*[2] is firmly enshrined in the organisation's values: *excellence, compassion, respect, learning, delivery* and *improvement*. Along with our partners, we have made real progress during the course of 2012/13 in improving further the quality of the care that we provide across our diverse range of services. However, the publication of the Report of the Public Inquiry into events at Mid Staffordshire NHS Foundation Trust by Robert Francis QC in February 2013 served as a stark reminder of the importance of maintaining an unrelenting focus on quality and compassion when delivering healthcare.

The *Francis Report*[3] has provided an important opportunity for reflection and has reinforced for us the vital importance of our ongoing work around the Trust's values.

This Quality Account forms part of our annual report to the public about the quality of our services. It describes our key achievements during 2012/13 and our priorities for quality improvement during the forthcoming year 2013/14.

Quality Strategy

During 2012 we launched our Quality Strategy, which articulates a five year vision for the organisation and aims to deliver continuous quality improvement focusing on the three key areas: patient safety; patient experience; and clinical effectiveness (outcomes). We are currently concentrating on leadership, education and training, the development of robust systems and processes for measurement and monitoring, and robust self-assessment and benchmarking to ensure that we deliver year-on-year improvements in the quality of our services going forward. We will review our progress annually to ensure we are meeting all relevant national quality standards and to ensure that our declared objectives remain relevant, stretching and effective in helping us achieve our vision. We particularly want the experience of our patients to drive changes and improvements in the services we provide.

Our successes

We have had notable successes during this year which include the following.

- The referral to treatment standards for both admitted and non-admitted patients have been consistently met at organisational level and this is also reflected at specialty level.
- The eight key cancer standards have been achieved on a quarterly basis.
- Good progress has been made in relation to infection control, seeing a reduction in both MRSA and *Clostridium Difficile (C.Difficile)* infection rates.
- We won a Health Service Journal Award for 2013 in the category of Improving Care with Technology.
- Our rates of venous thromboembolism (VTE) risk assessment have been consistently above the 90% national target during 2012/13 and we received recognition as one of the most improved trusts in England.
- Services across the Trust have, for the first time, worked to identify and share specific quality improvement priorities at a local level for 2013/14.
- We became a fully operational Major Trauma Centre (MTC), which brought an increase in the number of patients with complex injuries.
- We introduced an award programme to recognise staff members and volunteers who go above and beyond the call of duty in serving our patients. A Trust award ceremony was held in 2012 to share and formally recognise some outstanding and inspiring contributions.

Academic partnerships

One of our strategic objectives is to develop both clinical and academic networks. The formation of the *Oxford Academic Health Consortium* and the *Oxford Academic Health Science Network*[4] will assist in the translation of research into innovative practice. Our partnerships with the University of Oxford and Oxford Brookes University complement and enhance the services we offer, supporting the delivery of teaching, education, training and research. Noteworthy developments over the past year include the following.

- The Acute Vascular Imaging Centre (AVIC) officially opened alongside the Oxford Heart Centre and the Emergency Department at the John Radcliffe Hospital as a unique, research-funded facility to develop faster and safer treatment for arterial blockages.
- The Nuffield Orthopaedic Centre has been designated as a Centre of Excellence by Arthritis UK to reduce the risk of osteoarthritis in sportspeople and to facilitate safe sport in the wider population.
- A formal Joint Working Agreement with Oxford Brookes University to support collaboration and partnership.

Financial and operational performance

In the last financial year (April 2012 to March 2013), the Trust met its financial targets and successfully delivered a challenging savings plan and achieved savings of £45.5 million and a surplus of 0.44% of turnover of £822 million. This is a significant achievement and thanks go to all our staff who continue to work hard to improve the quality of care while reducing costs.

Throughout June to December 2012 the Trust consistently met or exceeded the national target of 95% of patients seen and discharged or admitted within four hours of arrival. The winter months (January, February and March 2013) were extremely challenging with increased Emergency Department attendances and admissions and we were disappointed that performance was below target at 89.7%. We have been working hard with Oxford Health, Oxfordshire County Council and Oxfordshire Clinical Commissioning Group to ensure this target is sustained throughout 2013/14.

The Trust achieved the national standard of 95% and 90% of outpatients and inpatients respectively being treated within 18 weeks of referral. The Trust has also met the two week timescale for urgent cancer related referrals. We were pleased to see an increase in the 62 day referral to treatment time in respect of screening programmes to 6.3% above the target level of 90%. There was a slight dip in performance seeing patients in rapid access chest pain clinics following two week onset of chest pain; 99.8% against the 100% target. Service changes are being implemented to ensure that this performance improves.

We aim to be successful in our formal application to become a Foundation Trust in 2014. The process we are going through to achieve Foundation status is a rigorous one, and requires us to demonstrate that quality is central to decision making at every level of the organisation. Authorisation as an NHS Foundation Trust would provide real assurance that clinical practices, governance arrangements and financial management are of high quality. We are working with the NHS Trust Development Authority (TDA) that acts on behalf of the Secretary of State for Health in the preliminary assessment of the Trust's application. Our application will then be passed to Monitor for the final stage of assessment and we hope to be authorised as a Foundation Trust in the latter months of 2014.

The improvements delivered this year would not have been possible without the commitment and dedication of the staff of the Trust who have worked hard to improve the experience and outcomes for patients who use our services. I thank them for their energy and professionalism.

Sir Jonathan Michael, FRCP
Chief Executive

[1] Patient safety, patient experience and clinical effectiveness (outcomes).
[2] Delivering Compassionate Excellence is about being a patient-centred organisation providing high quality, compassionate care with integrity. Regular updates are included in OUH News: www.ouh.nhs.uk/news/ouh-news/default.aspx
[3] For the Francis Report go to: www.midstaffspublicinquiry.com/report
[4] A formal designation process for the Oxford Academic Health Science Centre is now underway.

Statement from the Chairman

The Board of the Oxford University Hospitals remains committed to the delivery of the highest possible quality of care to our patients within the available resources. I have reviewed the content of the Quality Account and confirm its accuracy.

Dame Fiona Caldicott, FRCP
Chairman

Looking Forward: *Quality Account Priorities for 2013/14*

The quality improvement priorities for 2013/14 are:

Patient Safety

Safer care associated with surgery

Clinical Effectiveness

Using technology to improve care

Patient Experience

Improving the way we listen and act on feedback

Improving care for people with cognitive impairment

Patient Safety

Safer care associated with surgery

WHY WE CHOSE THIS	OUR AIMS	OUR ACTIONS
In 2012/13 49,950 operations were carried out in our hospitals. The majority of these patients recovered quickly and went home without any complications. Surgical procedures do contain inherent risks and ensuring these risks are managed and mitigated against is a key priority for us. In 2012/13 we had four incidents referred to as 'never events' which all related to retained swabs. In each case, we carried out a detailed investigation and put immediate actions in place.	• Achieve 100% compliance with the Trust policy for counting swabs used in surgery • Achieve 100% compliance with WHO surgical safety checklist • Reduce organ/space infection rate (Mediastinitis) following cardiac surgery by 0.5% • Develop surgical site surveillance system for a range of procedures to determine infection rates • Reduce the number of cancellations for elective surgery, unplanned returns to theatre and waiting times for inpatients needing surgery • Improve pre-assessment of patients being admitted for surgery	• Audit compliance with key safety policies including Swab, Needle and Instrument Policy and WHO checklist • Develop a staffing structure through building a strong senior leadership team, clinical supervision and teaching sessions and recruiting to vacant posts • Closely investigate reported incidents through our incident reporting system *(Datix)* • Display 'Staff briefing' notices to communicate key learning points
Many older people are admitted every year to our trauma services with a broken hip following a fall. Following surgery, expert medical input to older patients admitted into surgical areas has been shown to reduce the length of time patients stay in hospital by ensuring co-existing medical conditions are treated effectively.	• Improve the outcomes for elderly frail patients in surgical areas • Provide information to patients about their surgery and recovery with enough information explaining what to expect and who to contact with any questions or worries • Prevent avoidable readmissions by identifying factors at clinical service level which contribute to these	• Expand the 'Frailty Team' input to surgical and trauma services so that it becomes a six day service • Improve discharge information so patients know what to expect when they leave hospital • Expand nurse advice phone service for patients who have been discharged

Each patient needs to make a balanced decision on whether or not to have a procedure as part of their treatment. It is crucial that relevant information is presented to patients in a manner which is easy to understand, setting out the risks and benefits, and alternative treatment options where possible.	• Improve the consent processes for patients • Improve process of 'delegated consent' to ensure staff fully trained in the relevant procedure carry this out and provide full information • Introduce assessment of capacity into the consent process, especially for children and patients with a learning disability or cognitive impairment	• Revise a) consent forms to better describe risks and benefits b) accompanying patient information • Improve consent training for staff and cascade through Trust • Develop consent tool to prompt and assist appropriate assessment of capacity

Clinical Effectiveness

Using technology to improve care

WHY WE CHOSE THIS	OUR AIMS	OUR ACTIONS
The use of new technologies shapes our expectations of how healthcare will be delivered. Over the past year we have successfully introduced several new technologies to help patients manage their conditions at home with fewer visits to the hospital. We want to expand the way we use technologies inside the hospital, with patients and with our community colleagues.	• Expand electronic requesting and reporting of tests and X-rays for GPs to enable faster treatment of medical conditions • Enable virtual assessment by hospital doctors of patients in community care settings • Understand how we can improve health outcomes following heart attacks	• Introduce electronic radiology requesting and reporting to GP practices • Expand algorithms supplied with test requests to aid consistent testing of more complex conditions by GPs • Use telemedicine to support more accurate assessment of patients who have become acutely unwell in hospital settings • Use iPads to record physical measurements of patients who have had heart attacks to improve long-term health outcomes

Human Factors (HF)[5] encompass all those issues that can influence people and their behaviour and particularly the interaction of humans and technical systems. Evidence shows that HF can be a factor in clinical errors and complaints.

- Improve the way our staff work together and particularly how we communicate critical information requiring immediate attention and action

- Deliver HF training to clinical staff teams; this will include simulations of critical high risk situations as a technological advance
- Use teamwork training based on a successful programme in the aviation industry which has been shown to significantly improve safety levels
- Analyse and identify incident and complaints trends at clinical specialty level to identify an active learning culture

Patient Experience

Improving the way we listen and act on feedback

WHY WE CHOSE THIS	OUR AIMS	OUR ACTIONS
Our patients have told us that they would like us to do more than just listen to them; they want to be part of the conversation. Our patients want to know what we do with their feedback, comments and complaints. They want to hear about the good stories too as this plays a major role in how they manage their anxieties when receiving hospital care. Evidence also suggests that organisations who listen to their staff provide safer care.	• Respond to patient and staff feedback so changes in the way we deliver care and organise our services can be demonstrated • Improve the signposting to other information resources such as that provided via *Patient UK*[6] • Be in the top quartile of hospitals that patients and staff would recommend to friends and family	• Develop a consistent patient feedback system across our hospitals that captures patient feedback promptly enabling it to be used as soon as possible to improve our service • Continue to use technology, social media and patient feedback websites and respond quickly • Increase the number of patient engagement forums • Evaluate feedback based on Trust Values and *6 Cs*[7] • Report our successes and innovation to the media, on our website, through social media and in our publications • Improve communication with staff through *Listening into Action* project

[5] For more information on Human Factors go to: www.institute.nhs.uk/images//documents/SaferCare/Human-Factors-How-to-Guide-v1.2.pdf
[6] *Patient UK* provides medical information and support: www.patient.co.uk
[7] National compassionate caring vision for nursing based on six values http://cno.dh.gov.uk/2012/12/04/vision-nursing

Improving care for people with cognitive impairment

WHY WE CHOSE THIS	OUR AIMS	OUR ACTIONS
Increasing numbers of older people admitted to hospital have dementia or other forms of cognitive impairment. Over the last year we have made good progress in the way we treat older patients with dementia, and in the environment in which they are cared for. We would like to do more to improve the way we identify, treat and care for older people.	• Improve the way we assess and provide care for patients with dementia and other forms of cognitive impairment • Develop exemplary clinical leadership in dementia care from our psychiatric liaison team • Provide carers with relevant and useful information on the care, treatment options and further resources in the community	• Expand the dementia care service by the appointment of three new consultant liaison psychiatrists • Improve training for staff in relevant clinical areas • Increase the number of older people assessed for dementia and other cognitive impairments • Further develop the physical environment • Establish dementia champions • Carry out regular surveys of carers to help us improve the information and support we provide

Looking Back: *Progress on Quality Account Priorities for 2012/13*

In summary, the quality improvement priorities for 2012/13 were:

Patient Safety

Safer medicines delivered on time

Clinical Effectiveness

Innovation to support better care

Patient Experience

Improving end of life care

Delivering Compassionate Excellence

Patient Safety

Safer medicines delivered on time

PRIORITY	OUTCOME	SUMMARY
Medicines Reconciliation To deliver patients' medicines promptly after admission.	*Met*	We exceeded each of the quarterly targets for patients having a medicines reconciliation within 24 hours.
Medicines to take home To improve the speed at which patients receive their medicines to take home (TTO) when discharged.	*Met*	iPads have greatly reduced the time for requests to be received and processed by Pharmacy. Our next step will be to work with the community pharmacists to improve long-term compliance with medication regimes. Evidence shows that it is not uncommon for patients to stop taking their medicines after a month or so when their condition improves.
Medicines storage and security To audit our medicines safety and security performance, and make improvements where they are required. To deploy advanced ePrescribing and Medicines Administration as part of the *Electronic Patient Record* (EPR) project.	*Partially met*	Wards are now critically reviewing all security processes with action plans in place to implement improvements where they were identified. Examples include the following. • New doors added to drug cupboards. • New locks placed on doors in medicines storage areas. • Clear procedures for clinical areas that are closed overnight for storing drug cupboard keys. We have not achieved our aim to incorporate ePrescribing into the EPR project; this has been delayed until September 2014, in line with the national programme.

Clinical Effectiveness

Innovation to support better care

PRIORITY	OUTCOME	SUMMARY
Electronic Early Warning System Develop an electronic system for the early recognition of the deterioration in a patient's condition, thus enabling prompt and life-saving interventions to be put in place.	*Met*	We have successfully built a system to enable rapid and secure clinician access and patient information, enabling usability in pressured clinical situations. Important information is entered using touch screens, instantly analysed and plotted onto an on-screen track-and-trigger chart. Immediate feedback is available to doctors who can compare abnormal readings to previous measurements enabling swift actions. This has improved how we recognise when a patient deteriorates, thus decreasing the risk of the patient becoming ill in hospital unrecognised.
mHealth Assess the reliability of monitoring blood glucose levels and adjusting treatment for pregnant diabetic women using smartphone technology.	*Met*	Smartphones were provided to a group of women with gestational diabetes. These had a specially developed 'app' which recorded blood glucose readings sent via Bluetooth from the blood glucose meter. The results were then sent automatically from the phone to the hospital, results electronically plotted on a chart and reviewed by hospital specialists. The hospital diabetic specialist midwife was able to advise the women by text or phone calls to adjust their insulin doses to achieve better glycaemia control. This meant closer monitoring was possible with fewer hospital visits and has given women more control over the management of their condition.

Patient Experience

Improving end of life care

PRIORITY	OUTCOME	SUMMARY
Care of the dying To provide compassionate care addressing needs at the end of life. This included: • use of a care pathway • discharge checklist for patients dying imminently who choose to be transferred from the acute hospital to the place of care of their choice • exploring allocation of side rooms where desired by the patient or family.	*Met*	Following concerns expressed nationally and in the media with regard to the Liverpool Care Pathway (LCP), we have continued to facilitate its use in those areas where expertise and experience has been established but have not introduced it in other clinical areas. In the event of an improvement in a patient's condition the use of the LCP has been discontinued. We successfully designed and implemented a discharge checklist and made this available on our intranet. We carried out a survey of how we use side rooms and found that where available these are offered to patients at the end of life. We identified a range of facilities for relatives in terms of comfortable furniture and bedding. This survey has helped us highlight precisely what actions we need to take in the coming year.
Identification of those who may be coming to the end of their lives	*Met*	We developed a local tool, *Oxford Priorities for Treatment, Information and Care* (OPTIC), with the Acute General Medicine Team. We have tested it and are considering whether to expand its use in this and other relevant clinical areas. Our palliative care team has actively supported ward staff to deliver care to patients nearing the end of their lives.
Joint working with our colleagues in the community	*Met*	Joint working has had positive results. We have taken an active role in the Oxfordshire End of Life Care Reference Group alongside our colleagues in the community. We have implemented Oxfordshire Advance Care Planning documentation across our health economy.

Delivering Compassionate Excellence

PRIORITY	OUTCOME	SUMMARY
Care Support Worker (CSW) Academy	*Met*	The CSW Academy was launched in May 2012 and 130 people have been through it to date. We have used beginner Band 2 portfolio competencies and staff have been supported through this process by Practice Development Nurses, Band 4 Assistant Practitioners and Ward Managers. We have held four open days for the CSW Academy, providing an opportunity to discuss our Trust values with prospective candidates and answer any questions. Our CSWs have told us they feel better prepared and armed with more knowledge and skills. The Saïd Business School has evaluated the CSW Academy and we expect to receive their report in the near future.
Front Line Leaders Programme *'Safe in our Hands'*	*Met*	We have developed a leadership programme incorporating role modelling, staff motivational skills and service management. Quality metrics were identified linked to projects that were carried out as part of the programme. Each 'Front Line Leader' was put through a Skills Assessment Centre to identify specific individual learning needs and feedback for personal development plans. The Trust is developing the programme further in the coming year.
Developmental Ward Programme delivered with academic partners	*Met*	We have worked with our educational partners to develop Clinical Nurse Specialists (CNS) and Consultant Nurses roles. This has helped to provide a framework to deliver the Developmental Ward Programme aligned with the Trust's quality objectives and patient experience strategy.

Review of other quality performance 2012/13

Patient Safety

Patient Safety Thermometer

The NHS Patient Safety Thermometer has been introduced. The tool identifies patients who receive 'harm free' care by collecting data in relation to four 'harms'.

- Pressure Ulcers (PU)
- Falls causing harm
- Catheter-related Urinary Tract Infections (CUTI)
- New Venous Thromboembolisms (VTE)

We now have data for over 8000 patients, giving us a reliable baseline from which to inform and monitor our improvements over the next 12 months and beyond. Over the coming year we plan to introduce the FallSafe Care Bundle across all wards to reduce the number of reported falls. We are keen to do more to reduce the numbers of avoidable pressure ulcers and continue to work with our colleagues in the community to improve preventative measures. In the year ahead we will review our Tissue Viability Service and develop a bed and mattress management service.

Quality Walk Rounds

Since April 2012 63 Executive-led Quality Walk Rounds have taken place. Action posters enable staff to be informed of the outcomes of these walk rounds and what improvements they can anticipate. During 2013/14 walk rounds will also take place 'out of hours' to provide a round-the-clock view of issues affecting our ability to deliver safe care and a positive patient experience.

Patient Safety First Campaign

During 2012/13 the Trust has taken part in campaigns hosted by Patient Safety First, namely Safer Surgery Week and Nutrition and Hydration Week; both served to raise awareness among staff at all levels of these essential aspects of delivering safe care.

Venous Thromboembolism (VTE) assessment

VTE (the formation of blood clots within the veins) is a condition that contributes to an estimated 25,000 deaths amongst patients in hospital each year, some of which could be avoided. National guidance by the National Institute for Health and Care Excellence (NICE) states that 90% of all patients should be assessed for their risk of suffering from a VTE on admission to hospital.

VTE successes

- We are pleased with the progress made to increase our assessment rate. During 2012/13 our hospital reporting system ORBIT (OUH Reporting Business Intelligence Tool) reported that we achieved 92.43% against the national target of 90%, a significant increase on our rate of 78.35% for the previous year. Following this the Trust received ***third prize for the most improved VTE CQUIN***[8] ***results*** from the thrombosis charity *Lifeblood* and the *All Party Parliamentary Annual Awards* for NHS trusts.
- ***Smartphone app to help prevent clots***. A nurse and her team at the Churchill Hospital developed an award-winning mobile phone application which could help prevent potentially fatal venous thromboembolisms.

Incident reporting

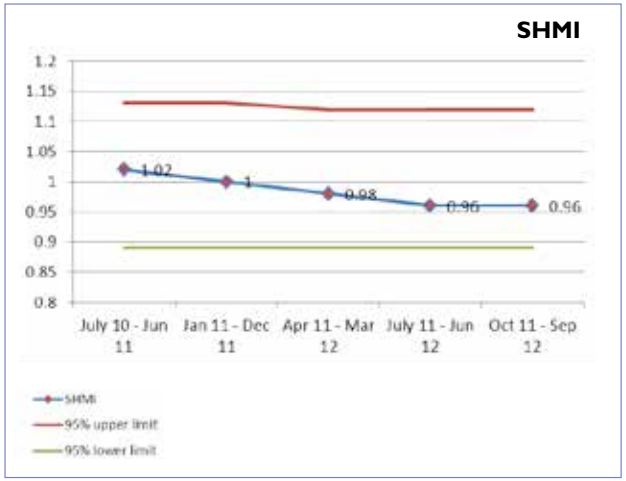
We were pleased to introduce an electronic incident reporting system (Datix) across the Trust on 1 April 2012. The system went fully live on 1 October 2012, which meant that all paper forms were withdrawn as online reporting commenced for the whole Trust. Electronic incident reporting has enabled us to have real-time assessment of clinical incidents and has greatly helped to identify trends so that we can act quickly to improve patient safety.

[8] Commissioning for quality and innovation (CQUIN): 2013/14 guidance www.england.nhs.uk/wp-content/uploads/2013/02/cquin-guidance.pdf

Clinical Effectiveness

Summary Hospital Mortality Indicator (SHMI)

The SHMI was launched in 2011 and reports mortality at trust level across the NHS in England. It covers all deaths of patients admitted to hospital and those that occur up to 30 days after discharge from hospital. Since it was first published we have been pleased to see our rate continue to fall and have kept within the expected range.



In the 2012 Hospital Guide (produced by Dr Foster) our mortality rate as measured by the hospital standardised mortality ratio (HSMR[8]) was published as being higher for emergency admissions over the weekend. (This was for the time period 2011/12.)

We analysed our weekend mortality rates and carried out a survey of services responsible for major acute admissions at weekends. Our findings indicated some issues with flow and efficiency / access to support services or registrar level doctors at the Churchill Hospital or the Radiology Department at the Horton General Hospital, but there were no systematic issues affecting quality or mortality. We reported our findings to the Trust Clinical Governance Committee and also shared these with the Care Quality Commission. We are pleased that our mortality rates for emergency admissions for 2012/13 are within the expected range and show no divergence from those during weekdays.

Achieving healthcare acquired infection targets

The Oxford University Hospitals NHS Trust met its challenging targets for both MRSA and *C.Difficile*.

Readmission rates

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

Our readmission rates have been higher than expected over the past year. In December 2011 we implemented a new *Electronic Patient Record* (EPR), which replaced our electronic patient administration system (PAS). As part of the stabilisation period, which extended into 2012/13, numbers of elective admissions were recorded as emergency admissions. For a temporary period this will have artificially inflated the reported emergency readmission rates.

In addition, a certain proportion of patients treated with chemotherapy will have complications following treatment. As it is not known which patients will develop these complications, and on what day, we cannot plan to admit them in advance. We have an open door policy so that if these patients develop complications they can be admitted and treated quickly. We believe it is good practice to enable patients receiving cancer treatments to return if they feel unwell.

Some people, however, return to hospital simply because they have not been given enough information about what to expect following discharge. We are working hard to ensure material provided to patients on discharge accurately describes what to expect, and how to access support when symptoms may be serious requiring urgent attention.

Helping people recover from illness and injury

Patient recorded outcome measures (PROMs) calculate health improvement from a patient's perspective, by asking patients about their health and quality of life before and after their specific operations. Over the next year we will work hard to ensure that we can make direct improvements to our services based on PROMs feedback. The data for hip and knee arthroscopy has already enabled us to change the patient care pathway.

[8] HSMR calculates a 'risk-adjusted' mortality ratio from a group of 56 diagnosis groups that account for 80% of deaths. For more information, please visit: www.drfosterhealth.co.uk/features/what-are-hospital-standard-mortality-ratios.aspx

The Patient Experience

Learning from you

Patients' views and stories are invaluable in helping us improve our service delivery. Over the past year we have achieved the following.

- We introduced the ***Friends and Family Test.*** The percentage of patients who are extremely likely or likely to recommend us was 93%.
- We started routinely filming ***patient stories***: asking patients to tell us about their experiences in detail. These stories are viewed by clinical teams to help them to understand what they do well (and should carry on doing) and what needs to improve.
- We introduced a new ***quality improvement and medical education project:*** medical students interviewed patients to gain an understanding of what is working well and what needs to change.
- We recruited a ***Patient Experience and Involvement Manager*** to coordinate our service and help drive improvements.
- We listened to the views of patients and the public through ***public meetings***.
- We ***improved waiting times and access for outpatient appointments*** by running additional clinics, and increasing the number of appointments at each clinic session.
- We set up ***Patient and Public Involvement Groups*** in all Divisions.
- We established a ***Care Support Worker Academy***.
- We piloted ***Values Based Interviewing*** to support the Trust values.
- We have increased the amount of ***large font and Easy Read*** patient information; for example the PALS and Complaints leaflets available on the public website.

National patient surveys

There were two national surveys in 2012: the Inpatient Survey and the Accident and Emergency Survey. The results from both were very positive with 82% of patients rating their care overall at 7 or above on a scale of 0-10.

Patient Advice and Liaison Service (PALS)

PALS is a first stop service for patients, their families and carers. The team provides an impartial and confidential service aiming to help resolve issues by addressing them as quickly as possible. During 2012/13 PALS dealt with ***3514 requests, compliments and concerns***. The majority related to requests for information about hospital processes or putting people in touch with the correct department or individual who could help them. The service collated comments, suggestions and concerns made either directly to the service or by the patient experience feedback mechanisms available throughout the hospitals.

Acknowledgements

The Oxford University Hospitals NHS Trust wishes to thank corporate and divisional teams for their contribution to the production of the Quality Account 2012/13. Equally, the Trust would like to acknowledge the invaluable contribution of those who supported the public engagement event on 11 March 2013 and the many individuals and groups that give their time to advise us on how to improve our services on an ongoing basis, throughout the year.

We would like to acknowledge the helpful feedback from the Oxfordshire Clinical Commissioning Group which we have responded to by making the necessary adjustments to our final version of the Quality Account.

Feedback

Readers can provide feedback on the Quality Account and make suggestions for the content of future reports, or request further information. Please contact our Media and Communications Unit.

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*Four hospitals, **one Trust**, one vision*

John Radcliffe Hospital

Nuffield Orthopaedic Centre

Churchill Hospital

Horton General Hospital

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