QUALITY REPORT

(CONTAINING THE QUALITY ACCOUNT 2018-19)

Quality Account 2018-19

Contents

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

Version	Date	Author	Outcome
	13 February 2019	Dr Clare Dollery/ Siobhan Teasdale	Draft 2019-20 Quality Priorities reviewed by Quality Committee.
	20 February 2019	Dr Clare Dollery/ Siobhan Teasdale	Draft 2019-20 Quality Priorities reviewed by Clinical Governance Committee.
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5	17 April 2019	Dr Clare Dollery/ Siobhan Teasdale	Draft Quality Account reviewed by Audit Committee.
5	17 April 2019	Dr Clare Dollery/ Siobhan Teasdale	Draft Quality Account reviewed by Clinical Governance Committee.
	25 April 2019	Dr Clare Dollery/ Siobhan Teasdale	Draft Quality Priorities reviewed by Trust Management Executive.
	9 May 2019	Dr Clare Dollery/ Siobhan Teasdale	Draft Quality Account reviewed by Audit Committee.
	20 May 2019	Dr Clare Dollery/Siobhan Teasdale	Draft Quality Account reviewed by Audit Committee

Part 1: Statement on quality from the Chief Executive 2018-19

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

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

Our staff are committed to delivering the highest quality care for our patients and this year we have celebrated their successes which have included the following.

- Winning the Best Healthcare Provider Partnership category at the *HSJ* Partnership Awards for a new test for pre-eclampsia which was a collaborative achievement with the Oxford Academic Health Science Network (AHSN) and Roche Diagnostics.
- Being re-awarded Centre of Clinical Excellence status by Muscular Dystrophy UK for providing outstanding care for people with muscle-wasting conditions.
- Winning a national Unsung Hero Award after a team of four staff at the Cancer and Haematology Centre at the Churchill Hospital developed a system to handle chemotherapy drugs more efficiently and free up nurses' time for patients.
- Winning the Psychiatric Team of the Year award at the Royal College of Psychiatrists Awards in recognition of the groundbreaking work of the Trust's Integrated Psychological Medicine Service.
- Being awarded Stage 2 Baby Friendly Initiative (BFI) accreditation by UNICEF for the efforts of the Maternity and Newborn Care Unit teams at the John Radcliffe Hospital to promote, protect and support breastfeeding.
- Winning two categories at the annual British Medical Association (BMA) Patient Information Awards in recognition of the work of Oxford Medical Illustration (OMI), the in-house design, photography and video production team at OUH, to communicate information to patients in new and innovative ways through the use of video.
- State-of-the-art Endoscopy Department at the Horton General Hospital has been re-accredited by the prestigious Joint Advisory Group (JAG) on Gastrointestinal Endoscopy for the second year in a row.

- Along with many other NHS trusts, we did not achieve the constitutional standards for access (e.g. four hour A&E target and 18 week referral to treatment time targets) this year.

  However, thanks to the efforts of all staff we were able to demonstrate tangible improvements by the end of the financial year.

  - 4.2% year-on-year improvement in the four hour wait aspect of Emergency department performance.
  - Reduction in the number of elective patients on waiting lists for 52 weeks from 203 in August 2018 to eight patients on 31 March 2019.
  - We consistently achieved the two week from GP referral cancer national standard every month through 2018-19.
  - Another four of the cancer performance standards were achieved for the majority of months across 2018-19.

  However, the 62 day standard for cancer treatment has provided our biggest challenge throughout the year. Nationally there has been a decline in achievement of the 62 day standard. This 62 day standard has not been met by the NHS in England in any month since December 2015.

  Following an agreed protocol, any cancer patient waiting for over 104 days for treatment has a review conducted of potential for clinical harm from the delay and details are reported to the Trust's Clinical Governance Committee.

  Performance against some national standards is included in this report, but is discussed in detail in prior sections of the Annual Report of which this Quality Account is a part.

  As a provider of care the Trust is registered and regulated by the Care Quality Commission (CQC). The Trust was inspected by the CQC in 2018-19 for core services, use of resources and the Well-Led domain. The reports of these investigations are awaited.

  Patent safety innovations in the past 12 months included the following.

  - The re-launch of the Safe Surgery & Procedures Group – this group has focused on the development of Local Safety Standards in Invasive Procedures.
  - A Harm Review Group was set up with an external Chair and representation from Oxfordshire CCG to review all patients who

have waited in excess of 52 weeks to assess any clinical and psychosocial harm – the majority of which identified no harm or minor harm, and by the end of March 2019 only eight patients had waited 52 weeks.

- In January 2019 a new weekly Safety Message email, sent to all staff from the Chief Medical Officer and Chief Nursing Officer, was launched to raise awareness of important patient safety issues.
- In March 2019 a Patient Safety Response Team pilot was started on the John Radcliffe Hospital site to review all moderate and above clinical harm incidents daily – this multidisciplinary staff team discusses any incidents in the previous 24 hours and, if required, senior doctors and nurses will visit clinical areas to meet the staff and patient involved to offer support and ensure the safety of all those involved.

Regrettably during 2018-19 we reported 11 clinical incidents classified as Never Events. Immediate actions were taken whilst these incidents were being fully investigated. Due to the higher number of Never Events this year a strategic Never Event Improvement Plan was devised and progress against this is reported regularly to the Trust Management Executive and Quality Committee. Two Never Event Risk Summits were held for staff and stakeholders to co-design approaches to prevent Never Events. OUH received funding from NHS Improvement to facilitate a number of initiatives to support some of the actions in the improvement plan such as running an action plan workshop for key staff to ensure that actions arising from Never Event investigations are the correct ones to change systems to prevent re-occurrence.

Our collaboration with the University of Oxford underpins the quality of the care that is provided to patients, from the delivery of high quality research, bringing innovation from the laboratory bench to the bedside, to the delivery of high quality education and training of doctors, nurses and other health professionals.

The Trust is committed to improving services by working closely with our partners in the Oxfordshire health and social care system.

- We have continued to reduce 'delayed transfers of care' by working closely with our system partners.
- For the first time this year we set up a system-wide Winter Team,

based at the John Radcliffe Hospital but working across the entire health and social care system in Oxfordshire.

- This winter saw improved A&E performance and an increase in the number of patients being discharged from hospital.

Oxford University Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is without conditions. The Care Quality Commission has taken enforcement action against Oxford University Hospitals NHS Foundation Trust during 2018-19. This was a Section 31 enforcement notice in relation to theatres in the JR2 Theatre Complex.

Oxford University Hospitals NHS Foundation Trust has participated in a special review by the Care Quality Commission relating to the following areas during 2018-19: the follow-up review of the commissioning of services across the interface of health and social care and an assessment of the governance in place for the management of resources. The review looked specifically at how people move between health and social care, including delayed transfers of care, with a particular focus on people over 65 years old. The CQC's follow-up to their system report of 2018 was published in January 2019, and stated that significant work has been done to join up services and improve care for patients.

The Trust has been subject to a number of recent visits from the CQC. They have covered the following.

- Core service reviews: this was an unannounced series of inspections conducted over November and December 2018 and mainly focused on the Maternity, Gynaecology, Urgent Care and Surgery core services. The formal publication of the outcome from this review is still awaited.
- Use of resources (conducted by NHSI using CQC methodology and resources) in December 2018; the outcome from this inspection is still awaited.
- Well-Led Review: the formal publication of the outcome from this review is still awaited.

The Trust uses feedback in a proactive and positive way; whenever a report is received an action plan is developed with executive leadership to address the issues.

We have continued to work hard to protect our patients from hospital-acquired infection and whilst we have finished the year under the assigned upper limit for the number of *C.difficile* infections, the zero level of MRSA infections deemed 'avoidable' was not met, with two cases apportioned to the Trust during 2018-19, one of which was unavoidable. Since the introduction of MRSA screening, mandatory surveillance, post-infection root cause analyses and bundles of care to reduce MRSA transmission, and in line with national data, our MRSA bacteraemia rates have decreased by over 95% in the last decade. We have recently introduced a targeted screening programme to optimise cost-effectiveness, and continue to promote 'aseptic no-touch technique' (ANTT), together with an active programme of education and audit around hand hygiene. This Quality Account, as well as looking back on how we performed against our standards and priorities in 2018-19, also looks ahead to the priorities for 2019-20. This year, like last year, we gave patients, public, stakeholders and our staff a much greater voice in choosing our Quality Priorities. At our Quality Conversation public event in January 2019 we asked the attendees to pick priorities to be maintained and suggest new priorities both from developing areas in the Trust and from their own ideas. These are very strongly represented in the choices of priorities for 2019-20.

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

Introduction

Quality Accounts are annual reports to the public from NHS providers about the quality of the services provided. They aim to enhance accountability to the public for the quality of NHS services. The Quality Account for Oxford University Hospitals NHS Foundation Trust (OUH) sets out where the Trust is doing well, where improvements in quality can be made and the priorities for the coming year.

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

Our Quality Priorities for 2019-20

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

The draft OUH 2019-20 Quality Priorities originated from the OUH 'Quality Conversation' event held in January 2019 which involved patients, Foundation Trust governors and members, staff and other key stakeholders.

They have further evolved through a process of engagement and feedback at various OUH committees including Governors' Patient Experience, Membership and Quality Committee (PEMQ) Quality Committee, Audit Committee and Clinical Governance Committee as well as with the responsible Executives and Leads.

Our Quality Priorities for 2019-20

Patient Safety

	Why we chose this Quality Priority	How we will evaluate success
Reducing Never Events- particularly around safe surgery and procedures.	National Safety Standards for Invasive Procedures (NatSSIPs) have been produced to address many of the underlying causes of Never Events (events that should be wholly avoidable due to the consistent application of specific safety checks e.g. WHO Surgical Safety Checklist). The aim is to produce more OUH Local Safety Standards for Invasive Procedures (LocSSIPs) and thereby reduce the incidence of avoidable adverse events. The OUH had 11 Never Events in 2018-19 and this Quality Priority was voted to continue from last year.	1. A minimum of ten LocSSIPs will be developed over the course of the year. 2. Finalise the remaining overarching procedures and policies relating to Never Events in the next six months, to include: 3. WHO Surgical Safety Checklist Policy. 4. Prosthesis Verification Policy. 5. Aim for 100% compliance with WHO Surgical Safety Checklist. 6. Run an action planning workshop with input from NHSI, Patient Safety Academy and Clinical Governance to ensure robust actions are put in place to prevent recurrence of serious incidents / Never Events. 7. Complete all actions from RCAs following NEs in 2018-19. 8. Demonstrate learning across all Divisions at Governance meetings.
Launching the National Early Warning Score (NEWS 2).	In April 2018 NHS England mandated the implementation of NEWS2 across all acute hospital trusts and ambulance services by March 2019. (Patient Safety Alert NHS/PSA/RE/2018/003).	Identify actions required to ensure, by 30th June 2019, there is Trust-wide adoption of NEWS2; and share examples of local challenges and best practice with the NEWS2 network on request. a. Define a process for the use of Scale 1 (Standard chart). b. Define a process for the assessment and recording 'Acute Confusion.' c. Produce revised escalation guidance. d. Define the process for use of scale 2 (Chart for patients with Type 2 Respiratory Failure). e. Design and deliver a training update for nurses and nursing assistants. f. Design and deliver a communication strategy for the launch of NEWS2. g. Define and deliver the technical requirements for the deployment of NEWS2 within the System for Electronic Notification and Documentation (SEND) platform.
Patient Safety Response Teams.	This award-winning concept has been successfully introduced in another Trust.	A Patient Safety Response Team will be piloted for 8-12 weeks in the JR and West Wing and evaluated before being considered for Trust-wide roll out.

	Why we chose this Quality Priority	How we will evaluate success
Reducing stillbirths.	The NHS recently set out a national ambition to halve the rates of stillbirths by 2030, with a 20% reduction by 2020. 'Saving babies' Lives' care bundle Version 2 (2019). The impact on the families who lose a much-loved baby or mother or those caring for a child with a birth-related brain injury is devastating, especially when the outcome could have been prevented.	Reduction in stillbirth rate by 20% by 31 March 2020. Reducing stillbirth rate from 5.2 per 1000 births to 4.0 per 1000 births by the introduction of the five elements recommended in the 'Saving Babies' Lives' Care Bundle: Element 1 – Reducing smoking in pregnancy. Element 2 – Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction. Element 3 – Raising awareness of reduced fetal movement. Element 4 – Effective fetal monitoring during labour. Element 5 – Reducing the number of preterm births.

Clinical Effectiveness

	Why we chose this Quality Priority	How we will evaluate success
Sepsis care – antibiotics within 1 hour.	Identifying deterioration early can allow prompt treatment to reduce the duration and severity of subsequent illness. This priority was one of the 2018-19 priorities that stakeholders voted to continue into 2019-20 at our Quality Conversation public event in January 2019.	1. Increase from 74% to more than 90% the proportion of sepsis patients receiving antibiotics within an hour by 31 March 2020. 2. Undertake an audit of sepsis in which the first dose of antibiotics was delayed > 1h in order to identify and share learning by 31 March 2020. **3.** Include 'Sepsis' as a subject for learning on a 'Grand Round' by 31 March 2020.
Reducing the number of stranded patients.	This was one of the 2018-19 priorities that stakeholders voted to continue into 2019-20 at our Quality Conversation public event in January 2019.	We will achieve a 16% reduction in the number of patients with an extended Length of Stay (LOS) of over 21 days, to fewer than 110 patients by 31 March 2020.
Digital – Roll-out of the SurgiNet module in Cerner Millennium to support best care for patients undergoing surgery and procedures.	Adding SurgiNet and Anaesthesia modules to the existing Electronic Patient Record (EPR). 1. Reduces potential risk created by 'paper gaps' in clinical information used during the surgical pathway. 2. Enables any problems identified at pre-assessment to flow into the EPR. 3. Provides consistent	By 30 June 2019 the new modules will have been designed by OUH clinicians and administrative staff. By 30 September 2019 modules will have been built by our partner. By 28 February 2020 modules will have been thoroughly tested by OUH clinicians and administrative and technical staff. By 31 March 2020 clinical and administrative staff will have commenced training in the first suite of theatres to go live.

	Why we chose this Quality Priority	How we will evaluate success
	documentation standards for anaesthetic records. 4. Replaces older technical systems which are now difficult to support and are not properly integrated for scheduling of surgical procedures.	

Patient experience

	Why we chose this Quality Priority	How we will evaluate success
Patient portal to support better interaction with hospital services.	The Trust's patient portal offers patients a new route to engage with our services. It went live in its first pilot department (Diabetes) in January 2019. Over the next year the portal will be deployed across other services with increasing functionality that better meets users' needs whilst enhancing the efficiency and efficacy of care.	By 31 March 2020 the portal: - will be available to all services that are ready to deploy it. - will enable patient access to lab, radiology and pathology results with a short delay (that will be determined in consultation with all users). - will enable patients to contribute information through 'clipboard' surveys and secure messaging. - will be accessible through a smartphone application as well as a website.
Care of patients with mental health issues.	National recommendation	The child and adolescent mental health services (CAMHS) and emergency department psychiatric service (EDPS) see 100% of patients within an hour of referral by 31 March 2020. The length of stay of patients with mental health issues in the emergency department will always be under 12 hours by 31 March 2020.
The Home Assessment Reablement Team (HART) services.	This was one of the 2018-19 priorities that stakeholders voted to continue into 2019-20 at our Quality Conversation public event in January 2019.	In 2017 and 2018, the proportion of patients returned to functional independence following hospital discharge reablement was 51% and 57% respectively. By 31 March 2020 we will aim to further increase the proportion of those returning to independent living to 60%.

Monitoring and reporting

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

Statements of assurance from the Board of Directors

A review of our services

During 2018-19 Oxford University Hospitals NHS Foundation Trust provided and sub-contracted 139 relevant health services.

Oxford University Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 139 of these relevant health services.

The income generated by the relevant health services reviewed in 2018-19 represents 100% of the total income generated from the provision of relevant health services by Oxford University Hospitals NHS Foundation Trust for 2018-19.

Participation in clinical audits and National Confidential Enquiries

Participation in national clinical audits

During 2018-19, 67 national mandatory clinical audits and four 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 96% of all the eligible national clinical audits as detailed within Appendix A and 100% of national confidential enquiries in which we were eligible to participate as presented within Appendix B of the report.

The reports of 43 national clinical audits were reviewed during 2018-19 and a summary of the actions the Trust intends to take to improve the quality of the healthcare we provide is described in Appendix C.

Participation in national clinical audits during 2018-19 (Appendix A)

Audit title	OUH Participation	% of cases submitted
Adult Cardiac Surgery	Yes	Ongoing
Adult Community Acquired Pneumonia	Yes	Ongoing
British Association of Urological Surgeons (BAUS) Urology Audit – Cystectomy	Yes	Ongoing
British Association of Urological Surgeons (BAUS) Urology Audit – Nephrectomy	Yes	Ongoing
British Association of Urological Surgeons (BAUS) Urology Audit - Percutaneous Nephrolithotomy (PCNL)	Yes	Ongoing
British Association of Urological Surgeons (BAUS) Urology Audit – Radical Prostatectomy	Yes	Ongoing
Cardiac Rhythm Management (CRM)	Yes	100%
Case Mix Programme (CMP)	Yes	100%
*Hip & Knee Elective Surgery - National Patient Reported Outcome Measures (PROMs) Programme	Yes	114%
Fracture Liaison Service Database	Yes	78%
National Hip Fracture Database	Yes	100%
Inpatient Falls	Yes	100%
Feverish Children (care in emergency departments)	Yes	100%
Inflammatory Bowel Disease programme / IBD Registry	No	---
Learning Disability Mortality Review Programme (LeDeR)	Yes	100%
Major Trauma Audit	Yes	100%
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Yes	100%
Maternal, New-born and Infant Clinical Outcome Review Programme	Yes	100%
Perinatal Mortality and Morbidity Confidential Enquiries	Yes	100%
Perinatal Mortality Surveillance	Yes	100%
Maternal Mortality Surveillance and Mortality Confidential Enquiries	Yes	100%
Myocardial Ischaemia National Audit Project (MINAP)	Yes	100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Yes	Ongoing
**National Audit of Breast Cancer in Older People (NABCOP)	Yes	Ongoing
National Audit of Cardiac Rehabilitation	Yes	100%
National Audit of Care at the End of Life (NACEL)	Yes	100%
National Audit of Dementia	Yes	100%

Audit title	OUH Participation	% of cases submitted
***National Audit of Intermediate Care	No	
National Audit of Percutaneous Coronary Interventions (PCI)	Yes	100%
National Audit of Pulmonary Hypertension	Yes	100%
National Audit of Seizures and Epilepsies in Children and Young People	Yes	95%
National Bariatric Surgery Registry (NBSR)	Yes	95%
National Bowel Cancer Audit (NBOCAP)	Yes	Ongoing
National Cardiac Arrest Audit (NCAA)	Yes	100%
****National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	Yes	15%
*****National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	No	
Use of Fresh Frozen Plasma and Cryoprecipitate in Neonates and Children	Yes	100%
Management of Massive Haemorrhage	Yes	100%
National Congenital Heart Disease (CHD)	Yes	100%
National Core Diabetes Audit	Yes	100%
National Diabetes Foot Care Audit	Yes	Ongoing
National Pregnancy in Diabetes Audit	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	53%
National Heart Failure Audit	Yes	100%
National Joint Registry (NJR)	Yes	87%
National Lung Cancer Audit (NLCA)	Yes	100%
National Maternity and Perinatal Audit (NMPA)	Yes	100%
National Mortality Case Record Review Programme	Yes	100%
National Neonatal Audit Programme (NNAP)	Yes	100%
National Oesophago-gastric Cancer (NAOGC)	Yes	Ongoing
National Ophthalmology Audit	Yes	99%
National Paediatric Diabetes Audit (NPDA)	Yes	100%
National Prostate Cancer Audit	Yes	Ongoing
National Vascular Registry	Yes	77%
Neurosurgical National Audit Programme	Yes	100%
Non-Invasive Ventilation - Adults	Yes	Ongoing
Paediatric Intensive Care (PICANet)	Yes	100%
Perinatal Mortality Review Tool	Yes	100%
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) Antibiotic stewardship	Yes	100%
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) Antibiotic consumption	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Yes	100%

Audit title	OUH Participation	% of cases submitted
Seven Day Hospital Services	Yes	100%
Surgical Site Infection Surveillance Service	Yes	100%
UK Cystic Fibrosis Registry	Yes	99%
Vital Signs in Adults (care in emergency departments)	Yes	100%
Venous thromboembolism (VTE) risk in lower limb immobilisation (care in emergency departments)	Yes	100%

* The expected figures are based upon Hospital Episode Statistic for previous years so if activity increases, the participation can appear as 114% of expected cases submitted.

** The Cancer multidisciplinary teams (MDTs) have faced challenges in terms of providing complete datasets of a high quality and robust analysis, within the context of the additional clinical workload to meet the elective access targets. The data is collected as part of the Cancer Outcomes and Services Dataset (COSD) and the national team oversees this which has made obtaining participation figures difficult until final publication of the report.

*** OUH did not participate 2018-19 however quality standard audits QS123 'Home care for older people' and NG27 Audit 'Transition between inpatient hospital settings and community or care home settings for adults with social care needs' were completed in 2018-19 and presented to Clinical Effectiveness committee which provided assurance. .

**** The team has now increased their resources to maximise adherence and achieve greater compliance with data submission.

*****Project closed in June 2018 and OUH continues to submit high quality data to the Trauma Audit and Research Network including specific measures in relation to the provision of rehabilitation to major trauma patients.

The reports of 43 national clinical audits were reviewed by the provider in 2018-19 and Oxford University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided. **(**Appendix C)

Description of selected actions:

Audit title	Summary
National Cardiac Audit Programme (NCAP) Annual Report 2018 – MINAP	The Heart Centre offers immediate treatment for heart attacks by direct admission and access to keyhole balloon treatment. The percentage of patients arriving by ambulance with call to balloon time less than 150 minutes is 89% versus national average at 78%. There has been a significant increase to 100% (national average 96%) in the proportion of patients seen or assessed by a member of the Cardiology team during hospital admission due to the Cardiology outreach advanced nurse practitioners at the Horton and John Radcliffe sites.

Audit title	Summary
PICANeT Annual Report 2018	Metrics for Mortality, Ventilator free days, and 48 hour readmissions (currently at less than 1% compared to national average 1.6%) compare favourably with national outcomes. OUH PICU is consistently well within acceptable adjusted mortality rates. There is now a full complement of substantive consultants and junior medical staff. Nursing recruitment and retention continues to be an ongoing challenge as with the rest of OUH and nationally.
Intensive Care National Audit and Research Centre (ICNARC) Case Mix Program (CMP) Annual Quality Report for 2017-18	The risk-adjusted mortality rates (SMR) for the Adult and Churchill Intensive Care Units (ICUs) are 0.82, and 0.67, both greater than two standard deviations (SDs) better than the national benchmark. The SMR for the Neurosciences ICU is 1.07 which is within the expected range. The Cardiothoracic Critical Care unit SMR is greater than three SD better than the national benchmark.
National Hip Fracture Database Annual Report 2018	The Horton General Hospital remains one of the very best performing hospitals in the country for hip fracture care. Both sites continue to perform very well on all metrics pertaining to Orthogeriatric medicine (Horton 100%, John Radcliffe 97% versus national average 90%). Both sites have performed above the national average in newly introduced measures including nutritional assessment, delirium prevention and early mobilisation. Delirium prevention at the Horton was 76%, 70% at the John Radcliffe (JR) with the national average at 70%. Early mobilisation at the Horton was 89%, JR 92% and the national average was 81%. The 30 day mortality at the JR is in line with the national average, and at the Horton is lower than the national average.
Insulin Pump Audit - National Diabetes Audit Programme	The audit shows that 16% of people with Type 1 diabetes seen in OUH adult diabetes clinics were treated with insulin pump therapy compared with 16% across all participating centres. This suggests our rates are on a par with the national average. Patients seen within OUH however have a higher than national average achievement of the 'triple target' – Blood Pressure, Cholesterol and a blood test for diabetic control- HbA1c (28% vs nationally 19 %).
National Neonatal Audit Program – 2018 (2017 data) John Radcliffe Hospital, Neonatal Intensive Care Unit	The Neonatal Intensive Care Unit (NICU) at the JR achieved "Outstanding" outlier status (>3 standard deviations (SD) above average) (91% versus national average of 715) for administration of magnesium sulphate (MgSO4) and "Excellent" outlier status (>2 SD above average) (71% versus national average of 65%) for thermoregulation. (A big improvement from just below average (59%) last year following a successful Quality Improvement project).
Seven Day Services Audit – 4 Priority Standards 24/7	Overall benchmarked results indicate that OUH performs better than the national average in most categories. However, OUH results have dipped at weekends and on the Monday during the 7 day audit period measured. Variation between the previous audit (March 2017) and this, indicates a slight fall in performance time to first review within 14 hours of admission from 97% in March 2017 to 92% in April 2018. However, this remains ahead of the national. The overall proportion of patients who required twice daily consultant reviews and were reviewed twice by a consultant was 100%- exceeding the national average.

Audit title	Summary
Trauma Audit and Research Network (TARN) Clinical Report 3 2017: Head and Spine injuries	Median length of stay has improved for patients with an Injury severity score <15, from eight days in 2016-17 to seven days from April 2017 to March 2018. For patients with an Injury severity score >15, length of stay remained constant at nine days. The survival rate has improved to +0.57 additional patient survivors per 100 patients (from 0.30 previously), according to outcome at 30 days or discharge. Patients admitted with an open fracture injury are receiving stabilisation within 24hrs of injury in 96% of cases, and soft tissue cover in 79% of cases. This is currently the best performance of any major trauma centre in the country.
National Lung Cancer Audit 2017	OUH continues to have a lung cancer resection rate of 27.4% -one of the highest resection rates in the country. One year survival rates have increased to 49% from 43% (national average 37%). The number of patients with small cell carcinoma who receive chemotherapy is above the national average. 89% patients at OUH receive chemotherapy (68% National average).
Falls & Fragility Fracture Audit (FFFA) – Fracture Liaison Service Database Report 2017: Royal College of Physicians	OUH supported this audit and was the highest submitting Fracture Liaison Service in the UK. The team meet the national average for time to assessment (74%), DXA (Dual-energy X-ray absorptiometry) scan (55%) and just above national average for monitoring at 16 weeks (49%). However focus on improving identification of vertebral fractures, reducing time to DXA, improving documentation of falls risk, reducing monitoring timings and improving monitoring outcomes at 16 and 52 weeks was required which has been addressed through a robust action plan.
2016 Re-audit of Patient Blood Management in scheduled surgery	Overall the audit found that OUH compared favourably with national standards and acted to minimise transfusion use in accordance with best practice. There was an improvement in a single unit approach to post-operative transfusion from 27% - 59%. There has been improved intraoperative use of cell salvage (38% - 59%).
Stroke in Adults: Sentinel Stroke National Audit Programme (SSNAP)	The John Radcliffe Hospital Stroke Service (JRH) improved to the top rating of "A". New Advanced Nurse Practitioners have been recruited to support this achievement and improve other areas. The delivery of Occupational Therapy continues to be an area of sustained excellent practice. There was improvement in the Thrombolysis domain with an increase in the percentage of patients treated with clot busting drugs.
National Cardiac Arrest Audit (NCAA)	The National Cardiac Arrest Audit (NCAA) report showed fewer cardiac arrests per 1000 admissions (1.04) than the available national comparator (1.6) and a decrease in comparison with the same period last year (both Quarter 2). More individuals survived to hospital discharge than predicted for all three included hospitals. The percentage (28.2%) remains higher than nationally (18.4%).
National Oesophago-gastric Cancer Annual Report (NOGCA)	86% of patients were discussed at the multidisciplinary team meeting. Between 2012-13 and 2016-17, the proportion of patients receiving active treatment (endoscopic or surgical treatment) for high-grade dysplasia increased from 70% to 75%. 90% of patients had an initial CT scan to assess the spread of cancer. Survival rates after surgery remain at a high, with over 96% of patients alive 90 days after surgery.

Audit title	Summary
National Audit of Breast Cancer in Older People (NABCOP)	The audit demonstrated that OUH local guidelines are compliant with national guidelines and treat all women the same irrespective of age. It is recommended that each patient is assigned a named breast Clinical nurse specialist to provide relevant information, and psychological support, and help guide the patient and her family through their diagnosis, treatment and follow-up [NICE 2009a; 2009b]. OUH has 100% compliance in both age groups which is well above the national average (63% and 56%).
National Bowel Cancer audit 2018 and Surgeon's Outcomes 2018	OUH has an active engagement with the screening programme. We have consistently lower than national 90 day (1.4%) and two year mortality rates (13%) for those undergoing major resections. Rectal surgery showed excellent removal of cancer demonstrated by the high negative Circumferential Resection Margin (CRM) rate (49%). OUH has a very low rate of patients still having a stoma 18 months after their operation (29% versus national figure of 52%), a priority identified by the National Bowel Cancer audit team impacting Quality of Life.

The reports of 271 local clinical audits were reviewed by Oxford University Hospitals NHS Foundation Trust in 2018-19 and Oxford University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Description of actions taken following review of the local clinical audits (Appendix D)

Paper name	Summary
NG50 Cirrhosis	The majority of patients treated for cirrhosis had imaging surveillance for Hepatocellular carcinoma (HCC) (91%) and screening endoscopies for varices (83%). However, the audit has highlighted the need to improve on documentation of risk stratification scores and surveillance of varices. There are now actions in place to improve varices and cancer surveillance, creating a surveillance pathway where the subsequent ultrasound scan or gastroscopy is requested by the relevant department at the time of current investigation.
QS126 Motor Neurone Disease (MND)	The MND Association produces a set of auditable standards against which each care centre is expected to assess their care every two years. The results for OUH were positive across the domains of recognition and referral (96%), cognitive assessments (100%), organisation of care, (87%) psychological support (93%), saliva management (100%), equipment and adaptations (94%), gastrostomy, communication (93%) and non-invasive ventilation (94%). Information packs have been reviewed to include recommended information leaflets regarding end of life and therapy exercise sheets. The findings highlighted some gaps in the Care Centre documentation, which have already been altered and the need for a physiotherapist in the core

Paper name	Summary
	team.
Validation audit against reported Hand Hygiene Compliance	The Validation audit is undertaken by the Infection Prevention and Control (IPC) team in all inpatient wards and Day Treatment units across all four OUH sites at least once in the financial year 2017-18. No area achieved a 100% score; Cardiac Day Unit achieved the highest score of 93%. One area only achieved 7% and underwent an intense hand hygiene education programme and in a re-audit in December achieved 68%.The team conducted 72 hand hygiene audits this year which is 32 more than last year.
Venous thromboembolism (VTE) Prophylaxis Audit	The audit demonstrates overall 99% improvement in compliance with patients receiving appropriate thromboprophylaxis (TP). Actions have included: feedback of robust data around appropriate thromboprophylaxis, upskilling of pharmacists in VTE prevention, the linking of an updated electronic VTE risk assessment to electronic-prescribing in December 2016, and education around mechanical TP thromboprophylaxis undertaken by the VTE prevention nurses.
NG60 HIV testing: increasing uptake among people who may have undiagnosed HIV	The Sexual Health service performs a continuous audit of HIV screening. The current data for Quarter 2 2018 show 83% of patients are offered HIV testing and 69% of patients accept testing.
QS122 Bronchiolitis in children audit	This audit demonstrated 98% compliance with the clinical standard 'Children with bronchiolitis are not prescribed antibiotics to treat the infection'. A need for additional training around the use of the Patient Information Leaflet and of the need for accurate documentation in the healthcare record was identified. The recommendation therefore is that clinicians will ensure the information is being relayed to parents and carers, that it is understood and that the content of the conversation is clearly documented in the healthcare records.
QS123 Home Care for Older People	The records maintained by the Home Assessment Reablement Team (HART) service demonstrated that all support workers have had supervision within the time frame. 92 % have a home care plan that identifies how their personal priorities and outcomes will be met.
QS25 Asthma	OUH results were largely comparable to national results, although results were low for the prompt administration of oral corticosteroids to these patients, recording peak expiratory flow rates on admission and the percentage completing five days of oral steroids. There was improvement in the proportion discharge on inhaled corticosteroids since the last audit: now >95%, and also there has been some improvement in the number with objective testing 26% to 35% though this remains less than the national average. The asthma outpatient service at OUH is good, with follow up of patients better than national average. Nearly 53% of patients have a hospital review within four weeks of discharge. A direct access acute airways service to pre-emptively treat and triage acutely deteriorating asthma has

Paper name	Summary
	recently been set up at John Radcliffe emergency department.

The national clinical audits and confidential enquiries that Oxford University Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2018-19, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Confidential Enquiries into Patient Outcome and Death (Appendix B)

NCEPOD studies in 2018-19	Clinical questionnaire returned	Case notes returned	Organisational questionnaires returned
***Peri-operative Management of Surgical Patients with Diabetes Study**	52%	46%	100%
Pulmonary Embolism	93%	93%	100%
Acute Bowel Obstruction	100%	Ongoing	100%
Long Term Ventilation	Ongoing	Ongoing	Ongoing

*Data collection for this NCEPOD study was completed in 2017-18 following which processes have been changed.

In order to improve participation in future NCEPOD studies the Trust has taken the following actions with resultant improvement in participation.

- NCEPOD have now moved to an online questionnaire which is assigned directly to the clinician by the local reporter for the Trust. This allows compliance to be monitored on a regular basis. A live dashboard which reflects compliance with the NCEPOD study is sent weekly to the Divisions.

- The Clinical Audit Governance Manager and Clinical Governance Facilitator have introduced systems and processes to ensure progress against NCEPOD studies is monitored at monthly checkpoints and any lack of progress is identified swiftly and escalated appropriately.

- The Trust Clinical Effectiveness Committee has responsibility for oversight, review and action of NCEPOD studies and is apprised of progress on a quarterly basis.

Our participation in clinical research

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

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

The OUH-University of Oxford (OU) Biomedical Research Centre (BRC) had previously been awarded funding of £113.7 million for the period 2017-22, following a competitive bidding process. The OUH-OU BRC is working with the new Oxford Health NHS Foundation trust (OH)-OU BRC in mental health (which has been awarded funding of £12.8 million) and with the Oxford AHSC, to develop innovations in areas such as working with 'big data', personalised medicine and tackling the problems of multiple long-term conditions and dementia. Through a cross-cutting Theme in Partnerships for Health, Wealth & Innovation, the OUH-OU BRC is also supporting enhanced capabilities for working with industry, provision of clinical research facility (CRF) and good manufacturing practice (GMP) manufacturing capabilities,

and for patient and public involvement.

In the last year, there have been more than 2,088 active clinical research studies hosted by OUH. During 2018-19 the Trust initiated 363 new studies and hosted 446 studies with commercial partners. There are 205 OUH staff who are directly supported by the National Institute for Health Research Biomedical Research Centre (NIHR BRC) funding and 299 staff supported by the National Institute for Health Research Clinical Research Network (NIHR CRN). During 2018-19 the NIHR withdrew the longstanding '70 day' metric used to assess performance in initiating clinical research for interventional trials. The times taken to recruit the first participant, and the reason for any delays, must still be reported, but these are no longer defined in relation to the binary 70 day metric.

The number of patients receiving relevant health services provided or sub-contracted by Oxford University Hospitals NHS Foundation Trust in 2018-19 who were recruited during that period to participate in research approved by a research ethics committee was 29,716 participants recruited to 512 studies which are CRN portfolio registered.

Examples of the impact on patients of research published or announced during 2018-19 include:

- Infection: Genome sequencing techniques to diagnose and track *Clostridium difficile*, TB (Mycobacterium) and new NHS infections, with greater accuracy and speed

The Oxford BRC Infection Theme pioneered new techniques using Whole-Genome Sequencing (WGS) for mycobacteria, including tuberculosis (TB), to identify particular bacteria causing infections, relatedness in contact/outbreak mapping, and resistance determinants to anti-tuberculosis drugs. These new techniques greatly accelerate the laborious and time-consuming techniques used in traditional microbiology labs, from 4-12 weeks down to seven days. WGS for TB is now rolled out nationally in the NHS through the Regional Centre for Mycobacteriology (RCM) at Birmingham, with implementation of an analysis and reporting pipeline through Oxford (ISO15189-2012 accredited) and integration with Public Health England.

Similar WGS techniques have been applied by OUH researchers to understand *Clostridium difficile* (C diff) infections that have been the causes

of major outbreaks and disruption in many NHS hospitals. The research revolutionised the understanding of *Clostridium difficile* infections, showing that many infections in hospital are related to infection in the community rather than in-hospital transmission. In emerging infections that pose major challenges to NHS hospitals, research using WGS provides the ability to rapidly understand the source and transmission, exemplified by OUH's solving of outbreaks *Candida auris* fungal infections in intensive care patients, (New England Journal of Medicine 2018).

- Urological Surgery: Establishing Optimal Treatment Strategies for Prostate Cancer
    - Research by Oxford urology surgeons has had international impact on the management of prostate cancer, including high-profile studies on the utility of screening tests (published in JAMA 2018), and the justification for surgery vs. conservative treatment (the ProtecT Trial, two papers in the New England Journal of Medicine in 2016). Research has also advanced clinical management through the development of robotic surgery, intraoperative imaging techniques for image-guided surgery and new technologies to treat cancer, such as high-intensity focussed ultrasound (HIFU) and ultrasound-directed drug delivery. These advances led to the spin-out company OxSonics Ltd.

- Imaging: Oxford's research facilities in imaging are co-located and/or embedded in the OUH's hospitals, and have produced advances and innovations that have both international impact and direct benefits for local NHS patients.

    - In neuroimaging, world-leading expertise in functional MRI (fMRI) results from the pioneering work of the Oxford Centre for Functional Magnetic Resonance Imaging of the Brain (FMRIB). This is now a key part of Oxford's recently awarded Wellcome Trust Centre for Integrative Neuroimaging (WIN), providing insights into pain, analgesia, dementia, recovery from stroke and stratification of patients undergoing functional neurosurgery.

    - In cardiovascular disease, Oxford MRI expertise is world-recognised, with both technical advances (such as licencing of Oxford-developed techniques to Siemens), involvement of OUH

clinicians in international leadership, and impact on international clinical guidelines. Cross-disciplinary research collaborations have applied new MRI techniques, originally developed for the heart, to the diagnosis of liver disease, through a new Oxford spin-out company, Perspectum Diagnostics. In cardiac CT imaging, basic science research involving OUH patients led to the discovery of new imaging techniques to predict the risk of heart attacks (published in the Lancet in 2018), leading to a new spin-out company, Caristo Diagnostics.

- In respiratory disease, researchers at the OUH's Churchill Hospital have pioneered the use of hyperpolarised xenon MRI imaging to evaluate lung function, and have spun out companies to implement advances in imaging of lung nodules detected on CT scans (Mirada Medical and Optellum).

- Oxford's leadership in medical imaging and artificial intelligence to accelerate and improve image analysis in the NHS is reflected in the recent award of ~£15m from Innovate UK for the Oxford-led National Consortium for Intelligent Medical Imaging (NCIMI), a collaboration involving multiple NHS trusts and imaging companies nationally.

Our education and training

In 2018-19 there were 825 trainee doctors working at OUH; of these 573 (69%) were tariff-funded and their training was subject to quality management by the local office of Health Education England (HEE). There were 448 educational supervisors at OUH who were all compliant with the GMC 'Recognition of Trainers' policy. All recognised educational supervisors can expect to find this role reflected in their job plans and remunerated at the agreed tariff. In addition, the corporate Practice Development and Education Team continues to support the development and sustainability of education faculty throughout the Trust for non-medical staff. In 2018-19 work has progressed well in support of system working.

In the 2018 General Medical Council (GMC) trainee survey, the majority of trainees at OUH (78%) expressed 'Overall Satisfaction' with their training experience in Oxford; there were only six outliers (clinical oncology, neurosurgery, obstetrics and gynaecology Foundation Year 2 (F2), ophthalmology, paediatric surgery and radiology F2). Workload was only reported as an outlier in three cases: neurosurgery, obstetrics and gynaecology and ophthalmology. Satisfaction with the level of clinical supervision received was reported by trainees in over 92% of the OUH training programmes; outliers were ophthalmology, obstetrics and gynaecology, radiology F2 and renal medicine. This information has been fed back to the relevant departments and those responsible for training. Divisional Education Leads will be responsible for ensuring that 'turn around' action plans are in place and for monitoring progress in the areas of concern listed above.

Neurosurgery is still under GMC Enhanced Monitoring and was visited again by HEE and GMC in February 2019. An updated performance improvement plan has been agreed, actions implemented and a further monitoring period is in progress.

Regarding non-medical training, OUH and Oxford Health NHS Foundation Trust have been successful in becoming a joint Excellence Centre, part of the National Skills for Health and Justice national initiative. In addition, the team is currently working to secure a Quality Kite Mark. The proposal in the immediate term is to standardise Care Certificate training across the local sector, develop system wide career pathways for health and social care for the support workforce, enhance access to and opportunities for training

including apprenticeships and develop a learning culture via leadership development.

The Trust's in-house academic programmes continue to flourish with interest to develop further programmes remaining high. The current programme progressing through to validation is the Post Graduate Certificate in Perioperative Practice, (open to theatre nurses and operating department practitioners). Our latest post graduate programme is Intensive Care which commenced in January 2019 with 14 staff registered. Two masters' level modules from the Renal and Urology Programme - the Deteriorating Patient and Work Based Learning - will be made available to all nurses working in critical care areas as standalone modules from April 2019 together with ten places for staff from the non-medical Foundation Programme as part of a pilot group. This now brings our number of accredited post graduate programmes to six, these include Neuroscience (multi-professional), Ophthalmology (nursing), Leading Compassionate Excellence (nursing and midwifery), and Renal and Urology (nursing).
In January 2019 the Trust celebrated the start of its 50th Cohort of the Care Certificate with over 1200 learners supported since 2015 and our Overseas Nursing Programme, that supports overseas nurses to register in the UK and work within the Trust, grows from strength to strength.

Our peer review programme 2018-19

This year saw the conclusion of phase two of the internal peer review programme. One practice area was reviewed and the outcomes were explored during a quality summit. This year also saw the development, piloting and launch of a bespoke themed peer review programme, the focus of which is adult safeguarding, the Mental Capacity Act and Deprivation of Liberty Standards. Phase one involves the review of 16 practice areas across all four sites and this will conclude in June 2019. The aim of each peer review is to contribute to the continuous quality improvement of patient care. Peer reviews provide a way of further understanding how our services work, a tool to hear the voices of patients and staff, a method to identify what works well and what requires improving, a means of sharing good practice Trust-wide and a means of supporting the delivery of compassionate excellence.

External peer reviews 2018-19

Paediatric Intensive Care Peer Review 12/04/2018

On 12 April 2018 the Southampton and Oxford Retrieval Team (SORT), which is a collaboration between two paediatric intensive care units, underwent a peer view against the Paediatric Intensive Care Society Standards as part of the NHS England Quality Surveillance Programme. This identified seven significant achievements, including outstanding commitment and dedication of every team member and aspects of very robust governance; particularly the reports discussed at the Thames Valley and Wessex PCC Operational Delivery Network meetings. Reviewers noted that retrieval services operating within an intensive care unit allowed the flexibility to use staff where most needed. The leadership team was found to facilitate high quality outreach teaching at the District General Hospitals, which is well-established, and good relationships and mutual respect between the Oxford and Southampton teams were evident. One concern was noted involving processes relating to electronic recording of referrals and transfer communication, which is being managed through local governance processes. Feedback from parents has been sought and quality improvements made as a result of these are displayed visually with a 'tree of improvement'.

This peer review of the Southampton and Oxford retrieval team identified no immediate risks and one serious concern. The compliance self-declaration was scored as 100% whilst the peer review scored this as 63%. The concern was around the lack of electronic recording of referrals and transfer communication. The Trust has responded to this concern stating that it has the technology to support this type of recording, inbound calls are recorded by default but outbound calls were not recorded, all outbound calls are now recorded for this service. Seven significant achievements were noted; this included certain aspects of the governance being robust, outreach teaching being well-established and good relationships and mutual respect between the Oxford and Southampton teams.

Adult and Children's Major Trauma Centre Peer Review 01/11/2018

On Thursday 1 November 2018, the Oxford Major Trauma Centre (MTC) underwent a peer review visit to assess compliance against the national Major Trauma Service Quality Indicators. The Trust was commended for having a cohesive well-led team and a number of clinical services were highlighted as areas of good practice including the MTC psychological medicine services; the paediatric neurorehabilitation service; performance

against the British Orthopaedic Association Standards for Trauma and Orthopaedics (BOAST) for the multidisciplinary team management of patients with open fractures; emergency department nurse training; strong engagement with trauma research; and a high standard of patient discharge documentation. It was noted that the Oxford MTC does not currently meet all of the requirements of the national model for Major Trauma patient care and the Trust promptly produced a detailed action plan to respond to these immediate risks. Additionally there were a number of areas for development which have been included in the MTC business plan for the 2019-20 year. There has been ongoing close collaboration between Directorate, Divisional and Corporate services to progress the action plan resulting in development of numerous business cases for future investment in the MTC service. A paper on the outcomes of the peer review was presented to the Trust Board for assurance purposes in May 2019.

Hepatitis C for Adults Peer Review 03/05/2018

The Operational Delivery Network (ODN) for hepatitis C, led by OUH, underwent peer review which identified many achievements including: a detailed, bespoke service and strategy exists in a complex and varied prison network and a good response rate of patient feedback is in place which demonstrates positive evaluation. Concerns centred on the following: at partner hospitals in the ODN access to diagnosis and referral was unknown and there was limited or no access to local treatment. Actions to address findings at the partner hospitals include: a Clinical Nurse Specialist is to be appointed at one hospital who will prescribe, dispense and manage the hepatitis C drugs to ensure access via agreed systems. Staff at another hospital will prescribe, dispense and manage hepatitis C treatment to prevent patients having to come to Oxford to collect their hepatitis C drugs. Screening for treatment and follow-up treatment remains with the hepatology team at that hospital.

Paediatric Diabetes Peer Review 01/06/2018

A peer review submission was undertaken and assessment documentation submitted for consideration. The Trust is awaiting the outcome.

Haemoglobinopathy Peer Review 18/01/2019

A peer review submission was undertaken and assessment documentation submitted for consideration. The Trust is awaiting the outcome.

Our Human Factors training

In 2018-19 we ran 18 Human Factors courses for 196 staff from all Divisions in the Trust. This year we have responded to the emphasis on embedding LocSSIPs within the Trust and have adapted our teaching materials to focus on the Human Factors issues surrounding the use of Standard Operating Procedures (including checklists) for safe surgery and procedures. Our immersive simulated clinical scenarios incorporate tips on best practice in the use of checklists and our 50 trained Human Factors ambassadors are also delivering this training in their clinical areas. In addition we have provided training in ethnographic observation to allow more meaningful analysis of compliance with the use of LocSSIPs in relevant clinical areas.

We continue to deliver bespoke human factors training for teams after a serious incident has occurred to support and enhance learning and to co-design robust plans for improvement. Feedback from participants remains excellent and we have clear evidence of behavioural change (e.g. continued use of safety critical communication tools) in the workplace after training.

Our Transformation Team

The Transformation Team has worked with partner organisations in Oxfordshire, Buckinghamshire and West Berkshire to deliver the Quality, Service Improvement and Redesign (QSIR) five-day Practitioner level course as well as a condensed one-day Fundamentals course. These courses have been developed by NHS Improvement and focus on training frontline staff equipping them with the 'know how' to design and implement more efficient patient-centred services. Other projects included: rolling out a new voice recognition software initially in outpatients to allow letters to be dictated directly into the electronic patient record to reduce time spent transcribing, uniform use of electronic information boards, white boards, in wards to move patients through the hospital more efficiently, further improvement of the gynaecology service to reduce time waiting for treatment, improving patient experience and working with key services on a Trust-wide cancer improvement plan.

Our clinical teams: examples of best practice

OUH's out-of-hours MRI service has been cited as best practice in the national report by the NHS Getting It Right First Time (GIRFT) programme, published on 29 January 2019. The report, which recommends all hospitals provide 24-hour MRI scanning, found good practice at the John Radcliffe

Hospital has resulted in the ability to provide out-of-hours MRI scanning without any incremental cost to existing services.

The Oxford Sepsis Team Strategy was shortlisted for the British Medical Journal 2019 Award for Innovation in Quality Improvement.

The Hip Fracture Team at the Horton General has been ranked as the third best hospital in the 2018 National Hip Fracture Audit – they have now been in the top five hospitals nationally for treatment of hip fracture patients for six years in a row.

OUH was awarded Centre of Clinical Excellence status by Muscular Dystrophy UK for providing outstanding care for people with muscle-wasting conditions.

There was one OUH winner and one member of OUH staff shortlisted at the British Journal of Midwifery Practice Awards.

The Integrated Psychological Medicine Team won the Team of the Year at the Royal College of Psychiatrists Awards.

Patient information videos on anaesthetic procedures for elective caesarean sections and gastroscopy (a procedure in which a thin, flexible tube called an endoscope is used to look inside the oesophagus, stomach and first part of the small intestine) won BMA Patient Information Awards.

Maternity and Newborn Care Unit teams at the John Radcliffe Hospital were awarded the Stage 2 Baby Friendly Initiative (BFI) Accreditation by UNICEF.

Guardian of 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. 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.

Number of doctors in training	2018			2019
	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar
Total (approx.)	850	850	825	825
On 2016 TCS (approx.)	710	710	710	710

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

- All Doctors in Training (typically around 700) are provided with compliant 'Work Schedules' and an electronic process to report exceptions when there is variance to rostered hours. Data from exception reporting has been used to amend work schedules.
- 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 continued implementation of an electronic rostering tool for Doctors in Training.

Exception reporting		2018			2019	Total
		Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	
Number of exception reports		108	64	107	112	391
Number of doctors reporting		22	30	33	31	88
Specialties receiving reports		12	15	16	12	23
Nature of exception	Education	11	4	8	7	30
	Hours & Rest	100	60	101	109	370
Additional hours worked per exception report		1.4	1.1	1.5	1.9	1.5

Vacancies	2018			2019	Total
	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	
Unfilled training post	Organisational level data not reliably available as managed at a service level via departmentally commissioned data tools.				
Other					
Total					

Locum shifts		2018			2019	Total
		Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	
Total		3295	3547	3497	4186	14525
Agency		1560	1636	1694	2010	6900
Bank		1735	1912	1803	2176	7626
Reason for locum shift	Vacancy	2564	2682	2854	3367	11467
	Non-vacancy	731	865	643	819	3058

Oxford University Hospitals NHS Foundation Trust has recognised that the following actions are required to ensure improved rostering oversight of Doctors in Training.

- A standardised process for the collection, distribution and reporting of data relating to the rostering of Doctors in Training is required to

ensure that those with rostering responsibilities can better match the capacity and capability of Doctors in Training to both service activity and training opportunities.

- Whilst the 2016 TCS clearly describe a number of processes to protect safe working hours for individual Doctors in Training, these TCS are not responsible for assuring safe medical staffing levels. Safe medical staffing levels (e.g. as described by the Royal College of Physicians) not only contribute to a safe medical environment, but also mitigate against some of the risks that cause unsafe working hours.

Focus on nurse retention

Nurse vacancy data demonstrates that the focused UK and international nurse recruitment within OUH is enabling the vacancy position to stabilise with an overall vacancy rate having less than a 1% increase in January 2019 at 14.1% compared to that of January 2018 (13.7%). The nursing turnover position was a key indicator in NHSI's decision to invite OUH to join cohort three of their nurse retention support programme. At the time of the invitation Band 5 nurse turnover sat at 21.5% and this was chosen by the Nursing and Midwifery Recruitment Retention and Education Steering Group (NMRRE) to be the focus for improving nurse retention. An action plan was submitted to Trust Management Executive in June 2018 and approved at Trust Board in July 2018. NHSI wrote to the Associate Chief Nurse in September 2018, acknowledging the action plan and the aim to reduce Band 5 nurse turnover by 2% within 12 months.

Post implementation update on the Nurse Retention action plan

The Nursing and Midwifery Recruitment Retention and Education Steering Group (NMRRE) was set up in April 2018 to drive forward this key work.
The action plan focuses on six key thematic areas.

- Positive engagement
- Improving our intelligence
- Creating a better vision
- A flexible and happy nursing and midwifery workforce
- Internal recruitment
- Employment at the first point of registration

Freedom to speak up

OUH has an up-to-date 'Freedom to Speak Up - Raising Concerns (Whistleblowing) Policy' which is based on the national template recommended by the National Guardian Office. The policy clearly states that staff can raise a concern with their Line Manager, the Freedom to Speak up Guardian, an OUH Executive or Non-Executive Director, a Trade Union Representative or relevant outside body i.e. Care Quality Commission. Concerns can be raised during a meeting, over the phone or in writing. The majority of staff contacting the Freedom to Speak Up (FtSU) team choose a one-to-one meeting to discuss their concerns. The majority of concerns discussed with the FtSU Guardians relate to poor working relationships / dignity and respect issues. A separate Freedom to Speak Up Annual Report is presented to TME and the Trust Board.

Feedback to staff who raise concerns is dependent upon the concern raised and the action the individual wishes to take. Many staff do not wish to take the concern further and are happy with the support and advice given by the FtSU Guardian. However, if the concern is formally raised with the Line Manager, HR or an Executive then feedback is provided, usually by email.

Ensuring staff do not suffer detriment.

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

A proportion of Oxford University Hospitals NHS Foundation Trust income in 2018-19 was conditional on achieving quality improvement and innovation goals agreed between Oxford University Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the *Commissioning for Quality and Innovation* (CQUIN) payment framework.

Further details of the agreed goals for 2018-19 and for the following 12 month period are available electronically at:
www.ouh.nhs.uk/about/publications/documents/cquins-2018-19.pdf

The monetary total for Oxford University Hospitals NHS Foundation Trust income in 2018-19 is conditional on achieving quality improvement and innovation goals will be known after 31 May 2019.

The monetary total for the associated payment in 2017-18 is as follows: Actual £14,406,000.

Statement regarding how OUH is implementing the priority clinical standards for seven day hospital services

Seven Day Hospital Services Board Assurance Framework

The new Seven Day Hospital Services Board Assurance Framework2 (7DSBAF) has been designed to allow a broader assessment of performance, capturing changes and improvements that the notes' audits may not have included, whilst reducing the administrative burden of reviewing large numbers of patient case notes.

The new measurement system uses a standard template with self-assessments of performance against the seven day services (7DS) clinical standards. The process requires bi-annual assessment and submission of the sign-off board assurance template to the Seven Day Services Regional Team.

At OUH, the 7DSBAF will be implemented gradually with a dry run (November 2018 – February 2019) using data from the April 2018 audit submission followed by full implementation in June 2019.

Data from the trial run will not be made public, but results from the subsequent full implementation will be published on the NHS Improvement (NHSI) and NHS England (NHSE) websites.

NHSI and NHSE have invited feedback on the 7DSBAF template design and process in general.

The bi-annual assurance process will be a requirement of the NHS Standard Contract and a metric based upon this will be included in the next CCG improvement and assessment framework. Furthermore the CQC will use providers' self-assessments of 7DS delivery as supporting evidence in its inspection processes covering 7DS.

Since February 2016 we have been one of number of early adopter Trusts aiming to be fully compliant with four priority standards for seven day services by March 2017. These four standards have been identified as priority on the basis of their potential to positively affect outcomes for patients.

- Time to first consultant review (e.g. by a senior level doctor)
- Access to diagnostic tests (e.g. X-rays and heart scans)
- Access to consultant-directed interventions (e.g. interventional radiology and emergency surgeon)
- Ongoing review by consultant twice daily if high dependency patients, daily for others

We have audited patient records every six months to check compliance against these standards and are pleased that our results have consistently put us in the top quartile of trusts across the UK.

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. The Care Quality Commission has taken enforcement action against Oxford University Hospitals NHS Foundation Trust during 2018-19; this was a Section 31 enforcement notice in relation to theatres in the JR 2 Theatre Complex.

Oxford University Hospitals NHS Foundation Trust has participated in a special review by the Care Quality Commission relating to the following areas during 2018-19: the follow-up review of the commissioning of services across the interface of health and social care and an assessment of the governance in place for the management of resources. The review looked specifically at how people move between health and social care, including delayed transfers of care, with a particular focus on people over 65 years old. Oxford University Hospitals NHS Foundation Trust intends to take the following action to address the conclusions or requirements reported by the

CQC: OUH has worked with other partner organisations in the Oxfordshire care system and a joint action plan has been developed to address the conclusions reported by the CQC in its report published in January 2019.

The Trust has been subject to a number of recent visits from the CQC they have covered the following.

- Core service reviews: this was an unannounced series of inspections conducted over November and December 2018 and mainly focused on the Maternity, Gynaecology, Urgent Care and Surgery core services. The formal publication of the outcome from this review is still awaited.
- Use of resources (conducted by NHSI using CQC methodology and resources) in December 2018; the outcome from this inspection is still awaited.
- Well-Led Review: the formal publication of the outcome from this review is still awaited.

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. During the core service reviews the Trust received a Section 31 notice in relation to the JR2 Theatres Complex, the action plan is owned by the Director of Clinical Services and is subject to weekly monitoring internally and reported to the CQC on a weekly basis. The issues found within JR2 theatres have been considered more widely by the Trust and any further learning in particular in relation to current practice for storage, cleaning, privacy and dignity and access into all theatre suites are being proactively considered across all theatre suites in all Trust locations. This specific action plan is due to conclude in August 2019.

Our Trust's overall rating to date of 'Good' remains unchanged at present.

- CQC ratings grid is provided below for the Trust overall and by site. There were three separate action plans from the reports addressing multiple actions across the areas previously identified as 'Requiring improvement'. These are overseen by a lead executive and updates are reported to the Clinical Governance Committee. It is likely that these will be reviewed and updated to reflect the results of the most recent inspections with completion dates to be revised accordingly.

CareQuality Commission

Last rated 27 March 2018

Oxford University Hospitals NHS Foundation Trust

John Radcliffe Hospital

Are services

Safe?	Requires improvement
Effective?	Good
Caring?	Good
Responsive?	Requires improvement
Well led?	Good

Last rated
27 March 2018

Oxford University Hospitals NHS Foundation Trust

Nuffield Orthopaedic Centre

Overall rating	Inadequate	Requires improvement	Good	Outstanding
			✓	

	Safe	Effective	Caring	Responsive	Well led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Outpatients	Good	Not rated	Good	Good	Good	Good

Last rated
14 May 2014

Oxford University Hospitals NHS Foundation Trust

Churchill Hospital

Overall rating	Inadequate	Requires improvement	Good	Outstanding
			✓	

	Safe	Effective	Caring	Responsive	Well led	Overall
Medical care (including older people's care)	Requires improvement	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Intensive/critical care	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients	Good	Not rated	Good	Good	Good	Good

CareQuality Commission

Last rated
14 May 2014

Oxford University Hospitals NHS Foundation Trust

Horton General Hospital

	Safe	Effective	Caring	Responsive	Well led	Overall
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Medical care (including older people's care)	Good	Good	Good	Good	Good	Good
Urgent and emergency services (A&E)	Not rated	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Intensive/critical care	Requires improvement	Good	Good	Good	Good	Good
Services for children & young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients	Good	Not rated	Good	Good	Good	Good

Our data quality

A vital pre-requisite to robust governance and effective service delivery is the availability of high quality data across all areas of the organisation. This underpins the effective delivery of patient care and is essential to both improvements in the quality of care and for patient safety. 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. 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.

A data quality assurance framework requires the data underpinning all the Trust's key performance indicators to be rated according to the data quality and the level of assurance. An update on the Trust data quality activities and performance is included in the six monthly information governance updates to the Trust Board. We have an established data quality infrastructure which

is overseen by the Information Governance and Data Quality Group for monitoring and improvement. This group is chaired jointly by the Trust's Strategic Data Quality Lead and the Caldicott Guardian.

Oxford University Hospitals NHS Foundation Trust will be taking the following actions to improve data quality.

- Enhance the internal audit programme to include audits to support the use of new functionality within the Electronic Patient Record.
- 'Deep dive' audits on specific Data Quality Performance Indicators to validate existing process and data capture.
- Establishing the embedded elements of the data quality diamond into its internal audits to ensure it is covering each aspect within each audit; the elements cover accuracy, validity, reliability, timeliness, relevance and completeness.
- Each of the clinical Divisions will continue to strengthen arrangements for securing good quality data making use of internal audit to identify areas for improvement: the quarterly compulsory audit programme for each Division is monitored by the Information Governance and Data Quality Group.
- In addition to this programme of audits, the Divisions also undertake a monthly programme of validation of key performance data underpinning the referral to treatment 18 week waiting time standard and the cancer waiting time standards. A programme of coding audits is undertaken by the Trust's Coding Department in collaboration with individual specialties.
- Upgrading the Electronic Patient Record system with a Right First Time approach which in turn will ensure more robust data quality at source.
- Continuing to enhance our data quality monitoring by adding additional reports via the Trust's business intelligence tool for both clinical and administrative tasks to promote the active management of performance on locally agreed requirements.

Oxford University Hospitals NHS Foundation Trust submitted records during 2018-19 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data shows:

SUS dashboards at month 10, 2018-19

Inpatients	OUH	National average
Valid NHS number	99%	99%
General Medical Practice Code	100%	100%

Outpatients	OUH	National average
Valid NHS number	100%	100%
General Medical Practice Code	100.0%	100%

A&E	OUH	National average
Valid NHS number	97%	98%
General Medical Practice Code	100%	99%

Information Governance Toolkit

The Trust submitted its annual Data Security and Protection Toolkit return to NHS Digital on 29 March 2019. The Data Security and Protection Toolkit replaces the Information Governance Toolkit and has been revised following the National Data Guardian's Review, 'Data Security, Consent and Opt Outs - 2016'. The Trust declared compliance against 23 mandatory assertions in its 2018-19 return. Nine assertions have not been met. These have been included as part of an action plan which has been agreed between NHS Digital and the Trust. The action plan is due for completion by the end of October 2019.

Clinical coding error rate

Oxford University Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2018-19.

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. A SHMI value of less than 1.00 indicates that a Trust is performing better than the national average.

The latest SHMI, published on 14 February 2019, for the data period October 2017 to September 2018, 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 below.
- 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. The Trust Mortality Review Group meets monthly under the chairmanship of the Deputy Chief Medical Officer with responsibility for learning from deaths. The Mortality Review Group has multidisciplinary and multi-professional membership with clinical representation from all four clinical Divisions.
- If there is an increase in the SHMI, the Mortality Review Group 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 Mortality Review Group.

Source: NHS Digital	Jan 17 to Dec 17	Apr 17 to Mar 18	Jul 17 to Jun 18	Oct 17 to Sept 18
OUH SHMI value	0.93	0.92	0.92	0.92
OUH SHMI banding	2 -as expected	2 -as expected	2 -as expected	2 -as expected
SHMI best performing trust	0.72	0.70	0.70	0.69
SHMI worst performing trust	1.22	1.23	1.26	1.27
OUH % deaths with palliative care coding	45.28	44.80	45.40	46.41

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 2018 to December 2018 indicate that 88% of deaths were reviewed within eight weeks.

Implementation of Learning from Deaths guidance

The Trust Mortality Review Policy was revised in accordance with the national guidance and published on 30 September 2017. Structured mortality reviews, derived from the Royal College of Physicians' Structured Judgement Review methodology, have been in place since Quarter 3 2017-18.

During 2018-19, 2,556 OUH patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 624 in the first quarter; 618 in the second quarter; 691 in the third quarter; 623 in the fourth quarter.

Total number of deaths 2018-19	Quarter 1 2018-19	Quarter 2 2018-19	Quarter 3 2018-19	Quarter 4 2018-19
2556	624	618	691	623

By 31 March 2019, 1,037 case record reviews and eight investigations had been carried out in relation to 1,933 of the deaths included above.

In six cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 325 in the first quarter; 339 in the second quarter; 373 in the third quarter.

	Quarter 4 2017-18	Quarter 1 2018-19	Quarter 2 2018-19	Quarter 3 2018-19
Number of case record reviews (Level 2 comprehensive mortality review or structured review)	367	325	339	373
Number of deaths judged more likely than not to have been due to problems in care	2	0	0	0

0 representing 0% of 1933 of the patient deaths during the reporting period is judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of: 0 representing 0% of 624 for the first quarter; 0 representing 0% of 618 for the second quarter; 0 representing 0% of 691 for the third quarter. The reviews of deaths which occurred during the fourth quarter are underway and the summary will be included in the next Quality Account.

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

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

New protocols and pathways

- The Emergency Department (ED) has improved therapist multidisciplinary team (MDT) working. In particular, physiotherapist rotas will be available to the ED coordinator, physiotherapists will be trained to review X-rays to the same level as the Emergency Nurse Practitioners (ENPs) and the physiotherapist case mix will be reviewed.
- A standard operating procedure for time critical implementation of renal replacement therapy has been developed and implemented.
- An airway proforma has been implemented to support communication from theatres to the Intensive Care Unit (ICU) about difficult airway patients.
- A pathway for patients requiring a colonic stent has been developed with all services (Acute Surgery, Colorectal and Endoscopy) involved in scheduling the procedure.
- EPR discharge summaries have been re-configured to include a section to record incidental findings from investigations and plans for follow-up.
- The review of VTE (venous thromboembolism) risk assessments is included on board rounds which are attended by the ward MDT (multidisciplinary team). The ward pharmacist is allowed time on the board round to raise any medication concerns with the ward MDT.
- To prevent staff of all grades missing Electronic Patient Record (EPR) alerts for venous thromboembolism (VTE) risk assessments the 'soft' pop up alerts, which can be clicked through, have been changed to 'hard' pop up alerts which cannot be bypassed without completing the required action. A preliminary review of this revised system has shown this functionality to be working well.
- The Critical Care and Interventional Radiology teams are developing a specific pathway for the management of massive and sub-massive pulmonary emboli.

Updates to guidance and checklists

- The OUH MIL (Medicines Information Leaflet) on warfarin reversal has been updated to include an isolated Haemoglobin drop < 20g/L in the definition of a major bleed.
- The 'Electronic Foetal Monitoring Antenatal Guideline' has been updated with improved clarity on the interpretation of cardiotocograms (CTG) and the actions for the team to take. This includes the urgency with which midwives should request obstetric reviews and obstetricians should advise delivery.

Clinical audits and service evaluations

- The Trauma Service completed an audit of the care of outlying patients in August 2018 to ensure that the same standard of care is delivered to patients regardless of their ward location. The results from this audit have led to the Clinical Nurse Specialist (CNS) reviewing outlying patients on a daily basis to check that appropriate VTE prophylaxis is being prescribed to all relevant patients who are not based on the trauma wards. The CNS runs a report from EPR each morning and reviews the outliers. During weekends the bleep holder assumes this responsibility.

Training and education

- Staff members in the Upper Gastrointestinal Team have completed Human Factors training focusing on the Track and Trigger Escalation Pathway.
- The 'Standard Operating Procedure (SOP) for Peri-operative Management of Pacemakers and Implantable Cardio-defibrillators' will be provided to the Anaesthetics and Surgery teams. The SOP will be enabled under the search function in the guidelines section of the OUH intranet.
- The Neonatal Unit has disseminated information to the Thames Valley Neonatal Network to raise awareness of patients with duct-dependent congenital anomalies and the need for referral to the Newborn Care Unit with communication between Local, Cardiology and Neonatal teams.

Support for staff

The Critical Care Team has appointed a nurse lead for wellbeing to provide staff with support. The Critical Care Team will be holding its first reflective round in May 2019 as part of a suite of interventions to enhance the wellbeing of staff.

Case record reviews and investigations from Quarter 4 of 2017-18

367 case record reviews and two investigations were completed after 31 March 2018 which related to deaths which took place in the fourth quarter of 2017-18, before the start of the reporting period. Two of the patient deaths representing 0.2% of 793 of the patient deaths reviewed from the fourth quarter of 2017-18 are judged to be more likely than not to have been due to problems in the care provided to the patient. These numbers have been estimated using the quarterly Divisional mortality reports submitted to the Trust Mortality Review Group

Endocrine Surgery structured mortality review

The level of preparation for a rare but well recognised and potentially life-threatening complication of thyroid surgery was inadequate, both in relation to the location where the patient was cared for after the operation and to the emergency equipment which should have been available.

Following this incident any patient requiring thyroid surgery must be admitted to the Head and Neck Ward. The 'S.C.O.O.P: Acute Management of Post Op Haemorrhage in Thyroid and Parathyroid Surgery' teaching video has been produced and made available to all teams. The protocol has been presented at national forums and disseminated at other hospitals.

The Coroner delivered a narrative conclusion following the Inquest.

Infected heart valve structured mortality review

The structured review found that the death was more likely than not to have been due to problems in the care provided to the patient. If identification of the need for urgent surgery had occurred soon after the patient was reviewed by the Infectious Diseases Team, it is likely that surgery would have been feasible and have taken place in the week prior to the patient's death.

Subsequent to this case, stronger links between the Cardiology and Infectious Diseases teams have been instigated, so that all patients with potential infective endocarditis are discussed, and weekly joint multidisciplinary team meetings are held where difficult or borderline cases are reviewed.

Two representing 0.07% of 2686 of patient deaths during 2017-18 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Patient Reported Outcome Measures (PROMs)

PROMs are used to ascertain the outcome following planned inpatient surgery for any of four common procedures (groin hernia surgery, hip and knee replacement and varicose vein surgery). Patients are asked to complete a questionnaire before and after their surgery to self-assess improvements in health from the treatment, rather than using scoring systems or judgements made by the treating clinicians.

The 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 previous performance, as set out in the tables.
- The Trust takes the following actions to improve the PROMs, and so the quality of its services, by the Orthopaedic Unit continuing to review the PROMs responses and presenting this to the Trust Clinical Effectiveness Committee.

The national mandatory varicose vein surgery and groin hernia surgery PROMs collections ended on 1 October 2017. The final annual data publication for the half year 2017-18 data was in June 2018.

The tables in this section show the improvement in health (adjusted health gain) perceived by patients following these four procedures. Comparisons are shown with all health providers who carry out the same procedure in England. The latest final data publications available from NHS Digital are for the previous financial year 2017-18. The final annual data publication for 2018-19 will be available later in 2019 and will be published in our 2019-20 Quality Account.

Repair of a groin hernia – average health gain	**2014-15**	**2015-16**	**2016-17**	**2017-18 (Apr to Sept 2017)**
OUH	**0.09**	**0.12**	**0.09**	**0.08**
National average	0.08	0.09	0.09	0.09
Highest	0.15	0.16	0.13	0.14
Lowest	0.00	0.02	0.01	0.03

Primary hip replacement – average health gain	2014-15	2015-16	2016-17	2017-18
OUH	**0.44**	**0.42**	**0.43**	**0.45**
National average	0.44	0.44	0.44	0.47
Highest	0.52	0.51	0.54	0.57
Lowest	0.33	0.32	0.31	0.38

Primary knee replacement – average health gain	2014-15	2015-16	2016-17	2017-18
OUH	**0.29**	**0.26**	**0.31**	**0.36**
National average	0.31	0.32	0.32	0.34
Highest	0.42	0.40	0.40	0.42
Lowest	0.20	0.20	0.24	0.23

Varicose veins – average health gain	2014-15	2015-16	2016-17	2017-18 (Apr-Sept 2017)
OUH	**0.09**	**0.06**	**0.08**	*
National average	0.09	0.10	0.09	0.10
Highest	0.15	0.15	0.15	0.13
Lowest	-0.01	0.02	0.01	0.03

*Where necessary for the protection of patient confidentiality, figures between 1 and 5 have been suppressed by NHS Digital and derived figures have also been suppressed.

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

- If there are negative responses identified in the PROMs returns, these are reviewed by the Orthopaedics Unit to determine if actions are required.
- The actions will be monitored by the Directorate Clinical Governance Team.

Emergency readmissions within 28 days of discharge from hospital

The Trust routinely monitors emergency readmissions as one of the indicators of the efficacy of the provision of care and treatment. In some cases, readmissions may be inevitable and appropriate. The complete circumvention of emergency readmissions would likely be reflected by a prolonged length of stay and lead to an inappropriate degree of risk aversion. As part of the Trust's discharge support, patients are encouraged to seek support directly if they are experiencing symptoms of ill health

following a treatment or procedure. The method of contact by patients would usually be by telephone but patients may also attend at hospital. Emergency departments are situated at the John Radcliffe and Horton General hospitals but patients known to the Trust's services may also be admitted directly to the Churchill Hospital.

The last available readmissions data from NHS Digital is for 2011-12. Dr Foster has provided more recent data.

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 Secondary Uses Service (SUS). The data is then used to calculate readmission rates.
- NHS Digital develops the SUS data into Hospital Episode Statistics (HES).
- Dr Foster takes an extract from HES data to provide benchmarked clinical outcome data.
- Data are compared to peers, highest and lowest performers, and our own previous performance.
- The Trust takes the following actions to improve the readmissions rates, and so the quality of its services, by the individual clinical units continuing to review the readmissions rates and including the findings in the monthly quality reports to the Trust Clinical Governance Committee.

Readmissions	2016-17			2017-18			2018-19 (April 2018-September 2018 only)		
	Under 16	16 and over	Total	Under 16	16 and over	Total	Under 16	16 and over	Total
OUH Discharges	**29972**	**164638**	**194610**	**28670**	**160944**	**189614**	**13905**	**80329**	**94234**
OUH 28 day readmissions	**2397**	**14223**	**16620**	**2470**	**14823**	**17293**	**1270**	**7928**	**9198**
OUH 28 day readmission rate	**8.0%**	**8.6%**	**8.5%**	**8.6%**	**9.2%**	**9.1%**	**9.1%**	**9.9%**	**9.8%**
National 28 Day readmission rate average	9.0%	8.0%	8.5%	9.2%	8.3%	9.1%	9.1%	8.7%	8.7%
Highest NHS Trust value	14.5%	10.8%	10.5%	16.5%	11.5%	11.4%	16.3%	11.5%	11.5%
Lowest NHS Trust value	3.7%	5.8%	5.8%	3.3%	5.9%	5.8%	2.5%	6.0%	5.9%

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

Patient views count and help drive learning and improvement. We listen to patients' views, opinions, feedback and observations about all aspects of our hospitals as they are very important in helping us to continually improve the experience of patients their family and friends that we serve, and of those who use Trust services. Our aim is that every patient's experience is an excellent one. Understanding what matters most for our patients and their families is a key factor in achieving this.

Compassionate Care

Our Trust Values underpin our drive for continuous improvement in delivering high quality services that exceed our patients' expectations.

The Trust Values are Learning; Respect; Delivery; Excellence; Compassion; Improvement

The Trust's responsiveness to the personal needs of its patients during the reporting period.

Responsiveness to inpatients' personal needs	2015-16	2016-17	2017-18
OUH	**72**	**71**	**73**
National average	70	68	69
Highest scoring trust	86	85	85
Lowest scoring trust	59	60	60

Source: Health and Social Care Information Centre website - indicators.hscic.gov.uk/web view - indicator 4.2.

Note: This data set is part of NHS Outcomes Framework Indicators – the data are published once a year and patient experience is measured by scoring the results of a selection of questions from the National Inpatient Survey focusing on the responsiveness to personal needs. This creates a compound metric where a perfect score would be 100 - comparison is made above with National results. The Trust will receive embargoed reports of the 2018 Inpatient survey results on February 2019 and the results will be published by CQC in June 2019.

Patient recommendation of our hospitals to family and friends

Results from the OUH Friends and Family Test (FFT) survey	
FFT: inpatients and day cases	96% of patients were extremely likely or likely to recommend their ward, based on 31,522 responses.
FFT: emergency departments	88% of patients were extremely likely or likely to recommend the care they received in the Emergency Department, based on 23,582 responses.
FFT: outpatients	95% of outpatients were extremely likely or likely to recommend the care they received, based on 74,492 responses.
FFT: maternity	95% of women were extremely likely or likely to recommend the Trust's maternity services (labour and birth only), based on 3,096 responses.

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

April 2018 to March 2019	Extremely likely	Likely	Neither likely nor unlikely	Unlikely	Extremely unlikely	Don't know
Number of responses overall	95,945	11,965	2,493	1,544	2,167	639
Percentage	84%	10%	2%	1%	2%	1%

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 checking and processing the data. For example, the data are checked for anomalies against previous data sets.

- These data are checked and signed off by the Head of Adult Safeguarding or the Chief Nurse before submission.

- Data are collated internally and then submitted on a monthly basis to NHS England.

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

- Automated surveys (via text message) are in place across all services except some inpatient wards and maternity services.

- A member of the Patient Experience Team attends the volunteers' induction sessions to promote the Friends and Family Test and explain to the new volunteers about how they can support patients to complete the FFT questionnaires and also support staff to gather feedback consistently.

- All team leaders of outpatient and day case areas have been encouraged to use the website where the automated feedback is uploaded – Envoy Messenger. There are facilities on the site to create 'You said, we did' posters and to create action plans around any feedback that requires follow-up and the training has shown staff how to use this tool.

Staff recommendation of our hospitals to family and friends

NHS Staff Survey results

Recommendation of the organisation as a place to be treated:

OUH scores	2015-16	2016-17	2017-18	2018-19
OUH	**75%**	**79%**	**71%**	**74%**
National average	69%	70%	71%	71%
Highest scoring trust	85%	85%	86%	87%
Lowest scoring trust	46%	49%	47%	40%

Recommendation of the organisation as a place to work:

OUH scores	2015-16	2016-17	2017-18	2018-19
OUH	**60%**	**61%**	**57%**	**57%**
National average	61%	61%	61%	63%
Highest scoring trust	78%	76%	77%	81%
Lowest scoring trust	42%	41%	43%	39%

Oxford University Hospitals NHS Foundation Trust is taking the following actions to improve the outcomes associated with these indicators, and therefore the quality of its services.

The action plans from 2017-18 are to be continued along the six key themes.

- Recognising and valuing each other
- Supporting and developing managers
- Empowering teams
- Dignity, respect and fairness
- Meaningful appraisals
- Health and wellbeing at work.

Trust-wide Listening Events are in the process of running to encourage sharing of ideas around what is working well, what could be better and how the Trust can support that to happen. These will be followed by a full set of 25 Directorate-specific and site-specific events which will result in local focused action plans that will feed into the Trust-wide action plan and priorities. Together, this will have a positive impact on these two measures going forward.

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* cases.
- Data is collated internally and submitted on a daily basis to Public Health England.

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

- A root cause analysis of each *C difficile* case is presented at the monthly Health Economy meeting which includes representation from OUH, Oxford Health NHS Foundation Trust, Oxfordshire Clinical Commissioning Group (OCCG) and Public Health England.
- The purpose of this meeting is to review all reported cases of *C difficile* to apportion responsibility, identify causality and trends, identify lapses in care and develop agreed action plans for quality improvement.
- Data is compared to peers, highest and lowest performers, and our own previous performance, as set out below.

***C Difficile* rates per 100,000 bed days**	**2015-16**	**2016-17**	**2017-18**	**2018-19**
OUH attributed (number)	57	53	72	51
Total bed days	394,104	408,361	391,765	Awaiting PHE figure publication date June 2019
Rate per 100,000 bed days (OUH attributed cases)	14.1	13.0	18.1	Awaiting PHE figure publication date June 2019
National average	14.9	13.3	13.7	Awaiting PHE figure publication date June 2019
Best performing trust	0.0	0.0	0.0	Awaiting PHE figure publication date June 2019

C Difficile rates per 100,000 bed days	2015-16	2016-17	2017-18	2018-19
Worst performing trust	41.1	82.7	91.0	Awaiting PHE figure publication date June 2019

End of life care

There have been significant strides in end of life care in OUH over the last two years and the following highlights some of the achievements.

Direct

- There has been a significant increase in overall referrals to the service which equated to over 1,900 patients and over 5,100 patient consultations by the specialist team across all our sites.

Indirect

- There are in excess of 40 projects across OUH to improve care of the dying, many initiated by teams recognising that this is an important area of care for their patients, those important to them and staff. Trust-wide projects include a survey of OUH care offered to all bereaved families, development of EOLC criteria for Structured Judgement Review, grant-sourced for staff education, development of 'what to expect when someone is dying in hospital and at home; rollout of the sunflower logo highlighting that a patient is dying to alert all staff entering the clinical area, and the completion of the National End of Life Care Audit.
- There has been a significant amount and variety of education for all staff groups including masterclasses for specific staff groups, the annual End of Life Care Symposium and Grand Rounds.
- The Palliative Care Service has also gained ethics approval and commenced a prospective cohort research study to look at outcome metrics and cost effectiveness of pro-active palliative care for over 75 year old patients, a unique national NHS study.

Culture

- There has been a definite increase in engagement of all staff groups with regard to end of life care across the organisation, evidenced by the number and breadth of projects and being undertaken and requests for education.
- Greater collaboration and assurance is evident across the Trust, including understanding of all the services involved in and providing

end of life and palliative care to our patients, as well as bereavement support, from neonates to the elderly, expected and sudden deaths.

- There has also been significant investment from charities who support the people of Oxfordshire, including Sobell House Hospice Charity and Ronald McDonald House Charity building new facilities for our patients and their families, and our local hospice charities, Sobell House, Katharine House and Helen and Douglas House supporting clinical posts and providing expertise and resources to enable us to provide excellent palliative and bereavement care to children and adults dying in the Trust.

Patient safety incidents

Trusts across England upload data relating to incidents reported locally to the National Reporting and Learning System (NRLS). The number of patient safety incidents and near misses reported at OUH via our electronic Datix system is similar to the previous financial year. The Trust actively encourages staff to report clinical incidents so lessons can be learned from incidents and near misses 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).

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 patient safety incidents (Datix).
- Incident reporting has increased following the implementation of Datix in 2012.
- Data are collated internally and then submitted on a monthly basis to the National Reporting and Learning System (NRLS).
- Data are compared to peers, highest and lowest performers, and our own previous performance, as below.

	Oxford University Hospitals NHS Foundation Trust			
	2015-16	**2016-17**	**2017-18**	**April-September 2018**
Number of patient safety incidents	**17,788**	**17,121**	**17,002**	**8,577**
National average (acute non-specialist trust)	9,465	7,661	10,714	5,583
Highest reporting trust	24,078	27,991	31,007	23,692
Lowest reporting trust	3,058	2,880	2,444	566
Number of patient safety incidents that resulted in severe harm or death	**44**	**11**	**16**	**10**
National average (acute non-specialist trust)	39	38	37	19
Highest reporting trust	183	190	220	87
Lowest reporting trust	2	3	0	0
Percentage of patient safety incidents that resulted in severe harm or death	**0.20%**	**0.06%**	**0.09%**	**0.12%**
National average (acute non-specialist trust)	0.40%	0.40%	0.37%	0.37%
Highest reporting trust	2.00%	1.38%	1.76%	1.22%
Lowest reporting trust	0.00%	0.02%	0.00%	0.00%

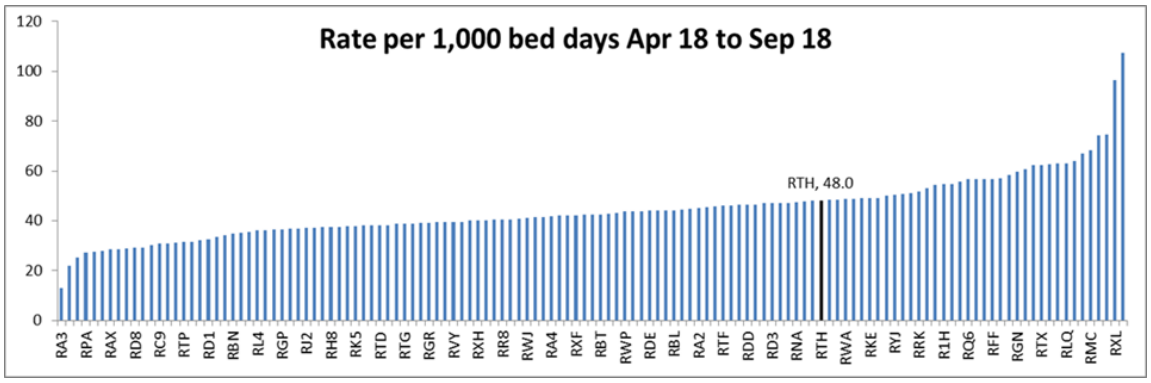
Source: NRLS, Organisation Patient Safety Incident reports which are published six months in arrears.

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

Facilitating the Serious Incident Requiring Investigation (SIRI) Forum which is a weekly meeting where frontline staff, executives and leads for specialist areas such as tissue viability, pharmacy, venous thromboembolism (VTE) and information governance attend as required. During financial year (FY) 18-19 there were 1,486 documented attendees compared to FY 2017-18 where there were 1,537 documented attendees.

During 2018-19 116 SIRIs were declared on the Strategic Executive Information System (STEIS) with five being subsequently downgraded. This is a 23% increase in reported SIRIs on 2017-18, in which 94 SIRIs were identified, with three downgrades. This follows a concerted effort to improve timeliness and extent of escalation of incidents.

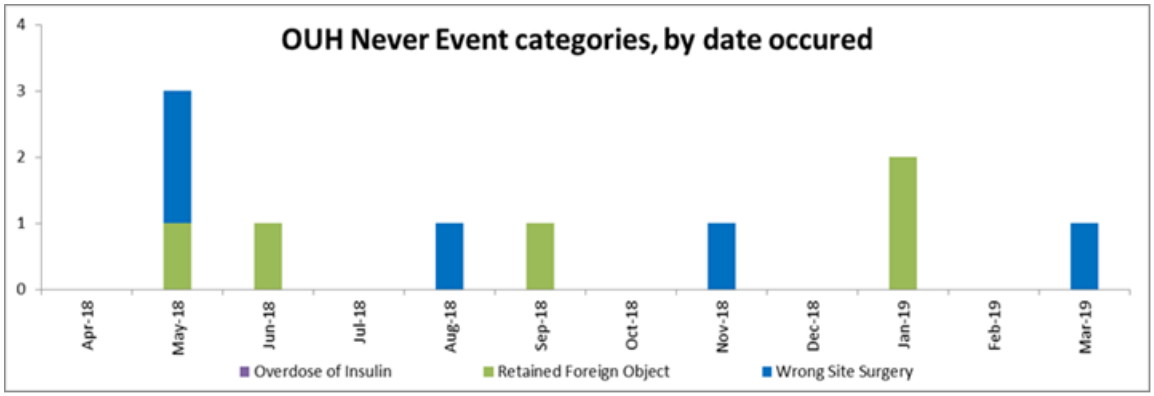
Incident rates - acute non-specialist Trust						
	Oct 15 Mar 16	**Apr 16 Sep 16**	**Oct 16 Mar 17**	**Apr 17 Sept 17**	**Oct 17 Mar 18**	**Apr 18 Sep 18**
Incident rate (per 1,000 bed days)	**41**	**44**	**40**	**44**	**44**	**48**
National average	40	41	41	43	43	45
Highest reporting rate	76	72	69	112	124	107
Lowest reporting rate	15	21	23	23	24	13



Source: NRLS, Organisation Patient Safety Incident reports

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).



In 2018-19 OUH reported 11 Never Events compared to eight in 2017-18 and four Never Events in 2016-17. The Never Events in 2018-19 were as follows:

- six wrong site surgery cases*
- five retained foreign object post-procedure cases.

*One incident occurred in 2017-18, but came to light during an investigation, it was reported on STEIS and investigated retrospectively.

The learning stemming from the incidents, with a particular focus on the system changes made to reduce the probability of recurrence is as follows.

- System changes enacted based on learning from these Never Event investigations.
- Creation of a video detailing use of the World Health Organization (WHO) Surgical Safety Checklist, with emphasis on positive patient identification (PPID) elements, for use in Endoscopy induction training.
- Addition of the question "Were any items retained post-procedure that require removal at a later date, and has a plan been documented for their removal?" to the generic WHO Surgical Safety Checklist.
- Campaign to promote PPID and inform patients that staff will ask their name and date of birth at each contact - made a quality priority for the Trust for 2018-19. Including instigation of 'Wristband Wednesdays;, in which senior staff visit clinical areas to confirm whether PPID is being enacted.
- Development of a revised, robust stock checking and ordering process for Nuffield Orthopaedic Centre (NOC) theatres.
- Creation of a system for prescribing Botox via the electronic patient record (EPR) on an individual patient basis once the clinical decision for its use has been made.
- Change of appointment letters to refer to the Neurological Injection Clinic rather than the Botox Clinic, to reflect the fact that various procedures are completed in this clinic, and to increase patient understanding of their required treatment.
- Implementation of the relevant appendix to the Trust Swabs, Sharps, Instruments and Accountable Items Policy in Gynaecology and Maternity theatres.
- Review of all radiological procedures currently offered, and implementation of the WHO surgical safety checklist where required. Pre-list team briefings being completed before interventional radiology procedure lists.
- The Interventional & Fluoroscopy Modality Manager visited all clinical areas Trust-wide in which interventional radiology procedures are performed to confirm that all equipment requisite to maximise patient safety was available.

- Roll-out of an adapted WHO surgical safety checklist for central venous catheters.
- Development of a formal appendix to the Trust Swabs, Sharps, Instruments & Accountable Items Policy specific to the Orthopaedics service.
- Creation of a standard operating procedure (SOP) to cover all invasive procedures carried out in Neurology Outpatients, involving a standardised checklist and reflecting the 'Stop Before You Block' procedure for local anaesthetic blocks.
- Alteration of the computerised radiology information system to clearly include the site and side of procedures.

How learning of 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 Clinical Risk Committees, Clinical Governance Committee and Quality Committee.
- The Never Events reports have been discussed within departments, for example for Gynaecology morbidity and mortality meeting, Directorate and Divisional Governance meetings and departmental staff meetings.
- 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 immediate consideration regarding sharing learning.
- All SIRI root cause analysis reports are now uploaded to the Trust intranet on completion.
- The Trust has held two Never Event Risk Summits (see below).

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 consider all completed root cause analysis reports, and complete assurance visits once action plans are complete to ensure that learning has been sufficiently embedded, before closing the incident on STEIS.
- Representatives from commissioning and regulatory bodies attended the two Never Event Risk Summits (see below).

In response to the high number of Never Events reported, the Trust created a Never Event Improvement Plan during 2018-19. This identified activity to deliver improvements in areas such as Never Event action monitoring, policy content, the National Safety Standards in Invasive Procedures (NatSSIPs) and Local Safety Standards in Invasive Procedures (LocSSIPs), and positive patient identification (PPID). The plan also included engagement with NHS Improvement and the National Patient Safety Team.

The Trust held a Never Event Risk Summit in August 2018. 84 members of Divisional and corporate staff, executive and non-executive directors, patients and external stakeholders attended. Posters were displayed and presentations given concerning the nature of Never Events identified since April 2018, the WHO checklist, NatSSIPs, the Stop Before You Block procedure for local anaesthetic blocks, PPID, and the role of human factors in Never Events.

A second summit was held in January 2019. This was attended by 82 staff members and representatives from our commissioners. Presentations and discussions centred around (NatSSIPs) and the development of LocSSIPs via the Safe Surgery & Procedures Implementation group, positive patient identification (PPID) – including an impactful patient perspective and examples of best practice including a video developed in Endoscopy.

New patient safety strategies introduced by the incoming Medical Director.

- In January 2019 a new weekly Safety Message email, sent to all staff from the Medical Director and Chief Nurse, was launched to raise awareness of important patient safety issues. These continue weekly and cover a variety of areas partly informed by recent incidents, national patient safety alerts and internal quality improvement schemes e.g. the falls prevention initiative ‘low before you go’

where relevant patient beds are lowered after a patient has been seen to reduce the impact of a fall should the patient attempt to get out of bed without assistance.

- In March 2019 a Patient Safety Response Team pilot was started on the John Radcliffe Hospital site to review all moderate and above clinical harm incidents daily – this multidisciplinary staff team discusses any incidents in the previous 24 hours and, if required, senior doctors and nurses will visit clinical areas to meet the staff and patient involved to offer support and ensure the safety of all those involved. This process will be evaluated and reviewed prior to potential Trust-wide roll-out.

Duty of Candour

Continuing significant work has gone on to embed the legal, professional and regulatory Duty of Candour in the Trust. This has involved extensive work in the Divisions. All incidents with outstanding Duty of Candour are tabled for discussion at the weekly SIRI Forum and, once completion is confirmed by Divisional management representatives, this is recorded in the Forum's minutes. Completion of Duty of Candour and wherever possible a copy of the relevant correspondence is recorded both in the Trust incident management system against the reported incident and in the patient's notes.

Compliance with Duty of Candour in the last calendar year is as follows.

	Verbal	Letter
Q1 2018-19	100% (36/36)	100% (36/36)
Q2 2018-19	100% (49/49)	100% (49/49)
Q3 2018-19	100% (52/52)	100% (52/52)
Q4 2018-19	98% (64/65)	98% (64/65)

The single outstanding case from Quarter 4 is being managed: a meeting has been booked for the consultant to meet the deceased patient's family in May, as part of which the Duty of Candour discussion will take place. A letter will be sent thereafter.

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 2018-19.

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

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

VTE	2016-17	2017-18	2018-19
OUH VTE assessment rate	**96%**	**98%**	**97% (Q1-Q4)**
ational average	**96%**	**95%**	**96% (Q1–Q3)**
Best performing Trust (All Acute Trusts)	**100%**	**100%**	**100% (Q1–Q3)**
Worst performing Trust (All Acute Trusts)	**79%**	**74%**	**78% (Q1-Q3)**

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

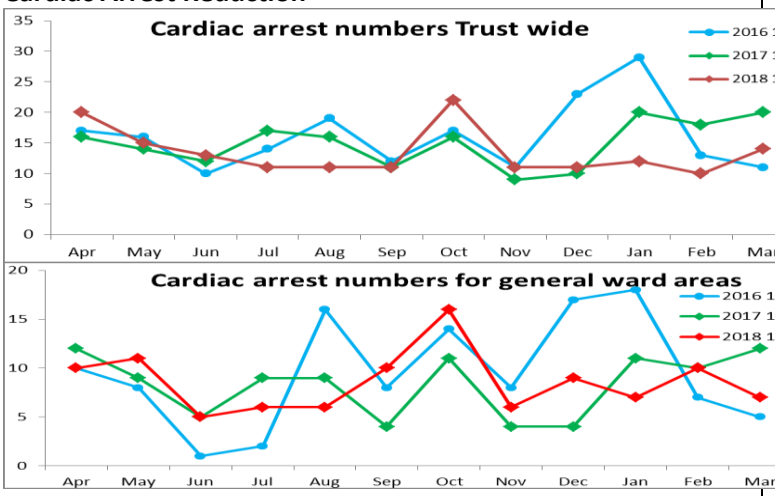
- The VTE Prevention Team and obstetrics have worked closely with the Electronic Patient Record (EPR) team to improve safety with a direct link of the obstetric e-VTE risk assessment 'recommended outcome' to e-prescribing. This was implemented in April 2018. This built on previous work linking medical and surgical e-VTE risk assessments to e-prescribing.

- E-Learning VTE prevention and safe anticoagulation modules are regularly reviewed and are up to date. A bespoke Maternity VTE learning package for midwives went live in January 2019.

- Pharmacy support has enabled a robust independent Trust-wide audit of 'appropriate thromboprophylaxis' since July 2016 and this has continued quarterly. The feedback of good quality data has helped drive improvements in patient safety.

- All hospital associated thrombosis (HAT) incidents are reported. Potentially preventable HATs are discussed in the Serious Incident Requiring Investigation (SIRI) forum and learning outcomes are disseminated.
- Improvements have been made in patient information about hospital acquired venous thromboembolism that is provided on discharge from hospital. In order to provide all patients with information on discharge, a statement on VTE risk on discharge has been included in electronic discharge summary since July 2017.
- Implementation of new guidelines from the National Institute for Health and Care Excellence on 'Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism' is in progress.

Part 3: Other information
Progress against priorities for 2018-19

<table>
<tr><th colspan="3">a. Preventing patients deteriorating</th></tr>
<tr><th>Why we chose this priority</th><th>How we will evaluate success</th><th>Evaluation March 2019</th></tr>
<tr><td rowspan="2">Identifying deterioration early can allow prompt treatment to reduce the duration and severity of subsequent illness. This priority was one of the 2017-18 priorities that stakeholders voted to continue into 2018-19 at our Quality Conversation public event in January 2018.</td><td>Cardiac Arrest Reduction
Our goal is a 25% reduction in general ward areas and a 15% overall reduction (which would include areas within the Heart Centre).</td><td>Cardiac Arrest Reduction
• The overall progress against the target set out in the Quality Priority is a 10% decrease overall with a 3% increase in general ward areas when the period 2017-18 is compared with the same period in 2018-19.
• The Resuscitation Team continues to observe a number of patients who are subject to a 2222 call and for whom a decision regarding resuscitation status would have been appropriate prior to the point of cardiac arrest. These cases are reviewed and highlighted to the patients' consultants who share the learning with their respective teams.
Cardiac Arrest Reduction
 

*Cardiac arrests which occur in the emergency department are excluded from both graphs.
Not achieved.

Sepsis
• Overall, since April 2018, 504/727 (69%) acute admissions and 976/1,503 (65%) inpatients with sepsis have received antibiotics within one hour.
We have improved to 65% but have not fully achieved this.
<table>
<tr><th></th><th colspan="10">Proportion of patients that received antibiotics within 1 hour</th></tr>
<tr><th></th><th>Apr-18</th><th>May-18</th><th>Jun-18</th><th>Jul-18</th><th>Aug-18</th><th>Sep-18</th><th>Oct-18</th><th>Nov-18</th><th>Dec-18</th><th>Jan-19</th><th>Feb-</th></tr>
<tr><td>Adm</td><td>42/65
65%</td><td>38/52
73%</td><td>39/56
70%</td><td>50/70
71%</td><td>41/54
76%</td><td>41/59
69%</td><td>36/56
64%</td><td>38/49
78%</td><td>49/70
70%</td><td>45/60
75%</td><td>43/6
66</td></tr>
<tr><td>Inp</td><td>71/105
68%</td><td>79/124
64%</td><td>74/113
66%</td><td>110/155
71%</td><td>100/156
64%</td><td>61/105
58%</td><td>87/138
63%</td><td>79/121
65%</td><td>124/172
72%</td><td>136/196
68%</td><td>106/1
64</td></tr>
</table>
• Outcomes of patients with sepsis at OUH: Dr Foster data demonstrates a sustained fall in Summary</td></tr>
<tr><td>Antibiotics delivered within one hour of a</td><td></td></tr>
</table>

	sepsis flag We will improve upon our 2017-18 achievement of 65% patients receiving antibiotics within one hour of alerting for sepsis, and set the target of >90%. We will develop and deliver a sepsis training package to >50% of regular clinical staff working in the emergency departments by 31 March 2019.	Hospital-level Mortality Indicator (SHMI) for sepsis since Trust sepsis work began in July 2015. • The Oxford Sepsis Team strategy has been shortlisted for the British Medical Journal 2019 Award for Innovation in Quality Improvement. Training has been delivered to 197/319 (62%) of regular clinical staff in the Emergency Department (target 50%). ***We have fully achieved this.***
b. Safe surgery and procedures		
Why we chose this priority	**How we will evaluate success**	**Evaluation**
National Safety Standards for Invasive Procedures (NatSSIPs) have been produced to address many of the underlying causes of Never Events (events that should be wholly avoidable due to the consistent application	Establish a new Safety Standards for Invasive Procedures Group (SSIPG). Develop the remaining key overarching policies from which the specific LocSSIPs will develop. Develop/review LocSSIPs relevant to	• The SSPIG has been established and meets regularly. • The remaining key overarching policies from which the specific LocSSIPs will develop are all either complete or nearing completion. • An implementation plan for LocSSIPs has been developed and reviewed at SSPIG. A small number of LocSSIPs have been completed with work on the others currently underway. • The scoping work for LocSSIPs has been completed before the end of March 2019. F2s (junior doctors)

of specific safety checks e.g. WHO surgical safety checklist). The aim is to produce Local Safety Standards for Invasive Procedures (LocSSIPs) and thereby reduce the incidence of avoidable adverse events. OUH had eight Never Events in 2017-18 and that is why focus on these standards has been chosen to be a Quality Priority.	the eight Never Events that occurred in 2017-18. Scope other surgical and invasive procedural areas across the Divisions where LocSSIPs should be developed.	are supporting clinical areas with the creation of LocSSIPs as part of their Quality Improvement Projects (QIPs). ***We have partially achieved this.***
c. Right patient every time		
Why we chose this priority	**How we will evaluate success**	**Evaluation**
This Quality Priority is key to ensuring safe diagnostic tests, procedures and treatments are identified with the correct patient every time. We chose this priority following a number of	**Positive patient identification (PPID)** Delivery of a campaign to promote PPID across the Trust. Questions on PPID will be rotated through the new Matron's Assurance App during 2018-	• Final sign-off for the revised PPID policy happened at Clinical Policies Group on 5 March 2019. New 'at a glance' documents will be circulated following this sign-off. • 'Wristband Wednesday' continues however the audit tool is being updated for March 2019 and an associated document "What good looks like" is being produced for the audit. • There has been 1 PPID incident in radiology (in February 2019). This was presented at the serious incident requiring investigation (SIRI) forum and a local investigation is now underway. Learning will be shared once this investigation is complete.

incidents, particularly in Radiology where the wrong patient received a test or procedure in the previous year. We are committed to learning from these events.	19. The app is being launched for Matron's assurance audits. Achieve a 50% reduction in PPID incidents in Radiology compared to 2017-18	***We have fully achieved this.***
d. War on waste (Clinical effectiveness) - Go Digital		
Why we chose this priority	**How we will evaluate success**	**Evaluation**
OUH is one of the UK Global Digital Exemplar trusts and Go Digital is one of our strategic priorities. This was also one of the 2016-17 priorities that stakeholders voted to continue into 2018-19 at our Quality Conversation public event.	**Global Digital Exemplar programme - patient portal** The patient portal will be live in Q4 2018-19 (January-March) for use by OUH staff. During Q4 (January-March) 2018-19 a phased release across different departments will allow patients to view appointments, results and contribute information to their health records via the portal.	• The patient portal went live for use on 30 January 2019 as planned. • An eight-week pilot with the Diabetes service will help understand how best to engage with users and provide a baseline prior to roll-out to the rest of the organisation throughout 2019. ***We have partially achieved this.***
e. War on waste (Clinical effectiveness) – Lean Processes		
Why we chose this priority	**How we will evaluate success**	**Evaluation**
We chose this because we want to increase efficiency	The Transformation Team will train a core team of Divisional staff in Lean Processes.	• From September 2018-February 2019 we will have had 172 staff participate in Quality Service Improvement and Redesign (QSIR) fundamental courses run by the Transformation Team. • Feedback has been outstanding with the most

within the directorates in order to eliminate waste (including respecting patients' time) and improve patient experience. This will include consideration of streamlining administration processes that meet the needs of patients.	Each Directorate will then complete a Lean pathway exercise for at least one patient pathway.	describing the course as 'Inspiring'. • Directorates the Transformation Team is supporting, incorporating 'Lean' as one of the improvement tools, include: Gynaecology, Trauma and Orthopaedics, Specialist Surgery, Children's, Renal Transplant and Urology and Oncology and Haematology. ***We have fully achieved this.***
f. Respect for patients and partners (Patient experience) - Partnership working		
Why we chose this priority	**How we will evaluate success**	**Evaluation**
This was one of the 2017-18 priorities that stakeholders voted to continue into 2018-19 at our Quality Conversation public event.	A Systematic Stranded Patient Review Process will be embedded to ensure critical clinical decision-making prevents harm from deconditioning and patients leave hospital for their next destination in a timely way. Use outcomes of Systematic Stranded Patient Review Process to advise joint funding priorities and to advise 2018-19 Winter Plan. Actively participate in the End Pyjama Paralysis campaign and report progress in the 2018-19 Quality report.	• Patients who are ready for discharge are discussed at 12:00hrs Monday to Friday to identify actions that will further support their discharge. This is to reduce their overall length of stay in hospital. • In addition we are working with the community locality teams to provide further support for 'discharge to assess'. • Partners we are working with include the North locality teams, The Order of St John and the continuing healthcare team (CHC). ***We have fully achieved this.*** • All inpatient areas actively participated in the campaign to end pyjama paralysis. This work continues through the wards particularly within the general medical wards. ***We have fully achieved this.***
	Home Assessment	• HART's February 2019 contact time percentage was

	Reablement Team (HART) We will maintain our 2017-18 achievement of 50% direct face-to-face contact time with patients. In addition we will aim for the stretch target of up to 55% by 30 September 2018 which we will thereafter aim to maintain.	47%, a slight decrease on previous performance. • However the drive to achieve the 55% will continue as HART have recently entered into a subcontract agreement with Oxford Health who are supporting patients in four agreed postcodes across a wide geographical location. ***We have not achieved this.***

g. Respect for patients and partners (Patient experience) – End of life care		
Why we chose this priority	**How we will evaluate success**	**Evaluation**
This was one of the 2017-18 priorities that stakeholders voted to continue into 2018-19 at our Quality Conversation public event.	An electronic care plan will be in place to document end of life care to ensure clear communication and continuity of end of life care across the Trust.	• There has been learning from the two areas of OUH that have trialled the care plans. • Following review, the care plan will be rewritten into the electronic patient record (EPR) in the next three months. • An advice sheet for staff has been written. • The EOLC care plan is likely to be rolled out initially at sites that are confident with care at the end of life and where there is a strong level of daily support from the Hospital Palliative Care Team. • Continuation of the work has been incorporated into the EOL work plan for 2019-20. ***We have partially achieved this.***

Our 2018-19 performance against the relevant indicators and performance thresholds set out in the oversight documents issued by NHS Improvement February 2019.

	Target		2018-19 Annual	Q1	Q2	Q3	Q4
Rates of Clostridium difficile	<68		51	11	26	40	51
18 Week Incomplete -	>92%		83.73%	85.48%	83.99%	82.38%	82.95%
4 hour Target	>95%		87.19%	88.74%	87.75%	87.82%	84.50%
Maximum wait of 62 days from urgent referral to treatment for all cancers	>85%		72.29%	77.24%	70.06%	73.03%	68.26%
Extended 62-Day Cancer Treatment Targets (following detection via national screening programme of hospital specialist)	>90%		79.42%	84.80%	87.67%	84.00%	60.18%
Supporting measures: number of diagnostic waits <6 weeks - DiagWaits	>99%		97.93%	97.56%	97.67%	98.51%	97.95%

Emergency Department (ED) access: 95% ED 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 is collated internally and then submitted on a monthly basis to the Department of Health.
- Data is compared to peers, highest and lowest performers, and our own previous performance, as set out in the table below.
- The Trust is regularly and independently audited to ensure accuracy of the figures.

Emergency Department	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
No. of four hour Breaches	8,994	14,017	15,893	21,046	26,673	20,588
No. of attendances	132,838	137,883	145,473	151,073	155,352	160,714
Performance	93%	90%	89%	86%	83%	87%
Nat. average	96%	94%	92%	89%	89%	88%
Best performing trust	100%	100%	100%	100%	100%	100%
Worst performing trust	88%	82%	78%	72%	73%	62%

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

- The Emergency Department has remained very busy in 2018-19 but there have been a number of developments which have helped to support high quality patient care. These include the following.
- The introduction and further development of direct to specialty referrals (streaming) where appropriate.
- The introduction of a GP-led Urgent Care Centre on the JR site to support patients with minor illness.
- We have increased consultant staffing into the late evening seven days a week and added an extra registrar (junior doctor) shift overnight.
- We have developed a cardiac chest pain pathway to improve flow and make early decisions within the ED (especially supporting safe

discharge).

- We have introduced rapid flu testing (bedside result within five minutes) to allow appropriate decision-making and isolation where needed.
- Building works have been undertaken within the JR ED to provide an 'ambulance receiving area' to support early assessment and intervention. This will be further supported with ED resuscitation area build which is currently underway.

Cancer waits

We consistently achieved the two week from GP referral cancer national standard every month through 2018-19. Another four of the standards were achieved for the majority of months across 2018-19. However, the 62 day standard for cancer treatment has provided our biggest challenge throughout the year.

Nationally there has been a decline in achievement of the 62 day standard. This 62 day standard has not been met by the NHS in England in any month since December 2015.

The most significantly challenged tumour sites remained in the urological, head and neck, gynaecological oncology, lung and lower gastrointestinal tumour site groups.

We have developed an action plan for each of the tumour sites and these will form a large part of our improvement plan for 2019-20. We aim to achieve the standard on 62 day cancer treatment by December 2019. The improvement plan will be overseen by a new Cancer Strategy Board which will be chaired by the Chief Executive.

Following an agreed protocol, any cancer patient waiting for over 104 days for treatment has a review conducted of potential for clinical harm from the delay and details are reported to the Trust's Clinical Governance Committee.

Waits for planned care

Referral to Treatment (RTT) Performance

OUH agreed as part of its plan for 2018-19 two key metrics with regards to the 18 week Referral to Treatment Time (RTT) national metrics. These were as follows:

- reduce the number of people waiting on incomplete elective care pathways for care at OUH to a waiting list size of 50,147 by March 2019;
- halve the number of patients waiting over 52 weeks by the end of March 2019.

On 31 March 2019, 49,706 people were waiting on incomplete elective pathways for care at OUH. This was a decrease of 441 pathways when compared to March 2019, meaning that the agreed target waiting list size of 50,147 was achieved.

The number of patients waiting over 52 weeks reduced from a peak of 203 during 2018-19 to eight by 31 March 2019.

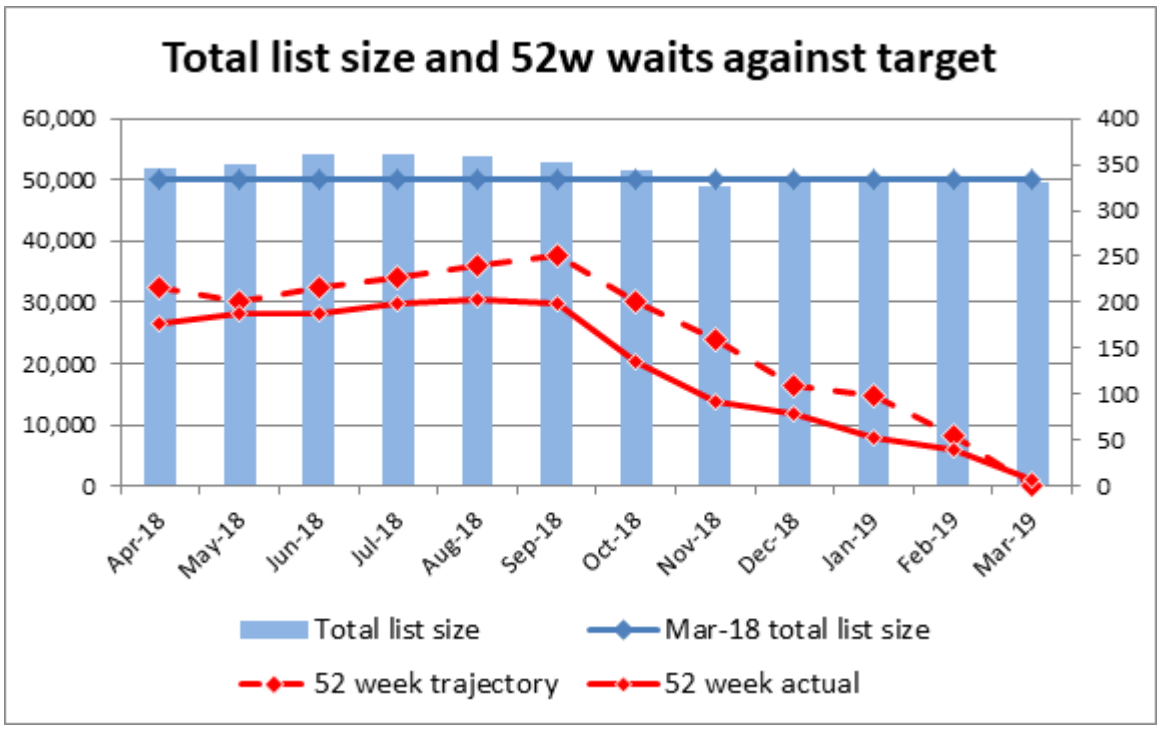


*Figure **5**: RTT incomplete waiting list size and over 52 week waits, OUH, from April 2018*

Statements

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

Statement from Oxfordshire Clinical Commissioning Group (OCCG)

NHS
Oxfordshire
Clinical Commissioning Group

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

Telephone: 01865 336795
Email: oxon.gpc@nhs.net

14th May 2019
Dear Colleague,

NHS Oxfordshire Clinical Commissioning Group response to the Oxford University Hospitals NHS Foundation Trust's 2018/19 Quality Account

Oxfordshire Clinical Commissioning Group has reviewed the Oxford University Hospitals NHS Foundation Trust (OUHFT) Quality Account and believed that it provides accurate information. OUHFT is a large NHS organisation that provides many services. OCCG recognises that, as a result, this Account cannot fully provide the public with assurance about the Quality of NHS services provided by the OUHFT. This Quality Account highlights some of the challenges faced by the Trust in 2018/19 and describes areas of quality improvement work which have been undertaken.

The Trust reports a mixed picture in the delivery of 2017/18 quality priorities. The CCG acknowledges the hard work which has gone into the full achievement of half of the priorities. The CCG would like the Trust to consider how areas not fully achieved in 2018/19 could be taken forwards to build on the progress made. The CCG hopes that the adoption of NEWS2 early warning system will assist the Trust in detecting clinical deterioration and acting early, to improve care of patients.

The priorities for 2019/20 have been developed by the Trust in partnership with stakeholders, including patients, the public and the CCG.

This has been a challenging year for the system. The account acknowledges that challenge and that, as a result, NHS Constitution access targets have been missed. Long waits result in a poor experience for patients and OCCG would welcome a clearer statement from the Trust on how it is planning to address access issues in order to minimise the impact on patients.

The Trust is to be commended on its work to reduce the number of patients waiting over 52 weeks. The Trust has put in place a harm review process to understand whether patients are coming to harm as a result of waiting. While the need for the harm review process was unfortunate the process itself has been a positive one, with good collaborative working between the Trust, the CCG and NHSI. The process has led to improvements in patient pathways and has provided a level of assurance.

One area which has been a particular challenge this year is Gynaecology. The Trust has ensured that patients who have been waiting for over a year have now been treated. The temporary suspension of some Gynae-oncology surgery means that some patients have had to travel to other hospitals to be treated.

The number of Never Events at the Trust has continued to present a challenge in 2018/19.
The Trust has given these avoidable patient safety incidents a high priority. It is challenging to learn from and prevent these incidents and to ensure that changes are made across the Trust, not just in the areas where the Never Events have occurred. The Trust's very positive campaign on positive patient identification demonstrates how learning from these incidents can be spread out across a large organisation. Many of the contributory factors in these incidents relate to culture and individual behaviours. The Trust has a programme of work ensuring Local and National Safety Standards for Invasive procedures (LocSSIPs and NatSSIPs) are in place. It is important to recognise that even when the correct policies and procedures are in place human beings do not always follow them. For this reason, OCCG welcomes the Trust's plan to make this a focus of the Human Factors training in the coming year.

The CCG is pleased that the Trust continues to perform very well in SHMI and HSMR measures of mortality.

The impact for patients of the Trust's global digital exemplar status has yet to be demonstrated. This year we have seen a small improvement in the Trust's electronic communication with primary care and with patients. The electronic endorsement of test results continues to present a patient safety challenge. The solution to this issue will be a combination of the right technology with a culture which supports and promotes its consistent use for the benefit of patients.

Recruitment and retention of a highly skilled and motivated workforce is perhaps the greatest challenge facing health care. In Oxfordshire this is particularly challenging. OCCG welcomes the Trust's focus on this area.

The Oxford University Hospitals Foundation Trust Quality Account is presented in a clear format. OCCG believes that this Quality Account gives readers confidence that the Trust is being open and honest about the quality of services across the organisation and is committed to driving continuous quality improvement. The Oxfordshire system continues to face significant challenges. It is essential that partners work together to deliver integrated health and social care and that quality and safety remains central. This year there have been some improvements in partnership working – an achievement recognised by the CQC. We believe there is still much to be gained from further integration and we look forward to working closely with the Trust in 2019/20.

Yours sincerely

Louise Patten
Chief Executive

NHS England Specialised Commissioning statement on Oxford University Hospitals NHS Foundation Trust 2018-19 Quality Accounts

NHS England (South)
Specialised Commissioning
60 Caversham Road
Reading
Berkshire
RG1 7EB

Email address: england.speccomm-south@nhs.net

10 May 2019

Dear Clare

Thank you for sharing the Oxford University Hospitals NHS Foundation Trust (OUH) Quality Account with NHS England as the Specialised Commissioner for the Trust. This quality account provides a clear picture of the quality challenges the Trust is addressing and the improvements that have been made during the year.

The initiation of a robust clinical harm review process, which commendably has also attempted to capture psychosocial harm, has been welcomed alongside the considerable achievement in reducing the number of patients waiting over 52 weeks for treatment.

The number, themes and frequency of never events encountered remain a top safety concern. The fact that reducing never events is seen as a top priority for the coming year will give further impetus to the on-going programmes and training focussing on applying the learning from these cases. Correspondingly the continuing work to identify, investigate and respond appropriately to serious incidents is noted.

While 62 day waiting times is seen as the "biggest (cancer) challenge" and there is a key focus on gynaecology services elsewhere perhaps a specific mention could have been made to gynaecology oncology services which has seen some specific challenges and the formation of a taskforce group.

The focus on partnership working under the clinical effectiveness banner is welcomed, however, this could also have explored initiatives around effective team working. As a Tertiary referral centre for many specialities the effectiveness of communication within teams and across teams in other hospitals and for patients with complex care needs across more than one specialty is key to patient outcomes both in timely and appropriate referral and in follow-up. Maybe some of this important work could also have been highlighted.

Participation, follow-up and actions resulting from Peer Reviews, in particular Adult and Children's Major Trauma Centre, Paediatric Intensive Care and Hepatitis C are noted. Collaboration around understanding and responding to services appearing on Specialised Services Quality Dashboards and in the Quality Surveillance Information System annual declaration will be developed further in 2019/20 and may merit mention in future Quality Accounts.

NHS England Specialised Commissioning endorses this Quality Account and looks forward to building upon the collaborative working arrangements already established in the coming year in order that improvements to the quality of care will continue for patients using OUH specialised services.

Yours sincerely

Wendy Cotterell
Director of Nursing – Specialised Commissioning: NHS England South East and South West Regions

Response from the Health Overview and Scrutiny Committee to Oxford University Hospitals NHS Foundation Trust Quality Accounts

OXFORDSHIRE COUNTY COUNCIL

Oxfordshire Joint Health Overview and Scrutiny Committee
County Hall
New Road
Oxford
OX1 1ND

Re: OUHT Quality Account 2018/19

Thank you for sharing the Oxford University Hospitals Foundation Trust (OUHFT) draft Quality Account with the Oxfordshire Joint Health Overview and Scrutiny Committee (HOSC) for comment. The committee were pleased to receive a presentation of an early view of progress against OUHFT's 2018-19 quality priorities and the emerging priorities for 2019-20 at its meeting on 4th April 2018.

The committee is particularly pleased to note the number of awards that OUHFT have achieved over the 2018-19 period and this is testament to the Trust's eminence. Patient experience is one of the issues in which HOSC takes a keen interest and we are therefore pleased to see that 95% of patients report that they are likely or very likely to recommend OUHFT to others.

HOSC takes a keen interest also in the view and experience of staff; who are the critical interface between the Trust and its patients. Workforce sustainability is the issue which HOSC hears most about for delivering good health and care services in Oxfordshire and are therefore pleased to see that staff satisfaction at OUHFT is good. Despite this, there appears to be a disparity between the proportion of staff recommending the Trust as a place 'to be treated' at 74%, compared to those recommending it as 'a place to work' at 57%. We therefore urge the Trust's curiosity and action around this. It would be helpful for the Trust to understand why staff levels of recommendations with the Trust 'as a place to work' has dropped from 61% since 2016/17, has remained static at 57% for the last two years and is lower than the national average (63%).

With regards to the achievement of priorities for 2018-19, the committee is reassured to understand that where a priority was partially or not achieved, that work will continue to fully achieve the priorities that were set. We note the achievement of actions to improve the early identification of sepsis and encourage you to continue striving to improve the administering of antibiotics within an hour from 74% to meet the identified 90% target.

Similarly, the committee is pleased to note achievement of a priority of 'right first time' patient identification and it encourages continued vigilance in this area to ensure patient safety and identity are protected at all times.

The committee were concerned to learn of the high number of 'never events' which have occurred at OUHFT during 2018/19 and are encouraged to see there is a strong focus on this proposed for 2019/20. The responsibility of the Trust in this area is crucial and we are pleased to note how seriously never events are being managed and would welcome closer HOSC scrutiny of the 'Never Event Improvement Plan' to understand the issues and plans to tackle the issues moving forward.

HOSC is very supportive of the quality priorities identified for 2019/20; particularly the work to prevent deterioration of patients, to improve the care of those with mental health issues and vitally; to reduce still births. We hope that on this last point, the work to address the Secretary of State and Independent Reconfiguration Panel (IRP) on the closure of obstetric services at the Horton General Hospital features heavily in the plans to ensure women and their babies get the right monitoring and care at the Horton to reduce still births.

During the 2018/19 year, the issue of suspension of gynaecology outpatient appointments at the JR came to HOSC's attention. The workforce issues around Oxfordshire are well rehearsed as previously mentioned so HOSC is familiar with the issues and some of the work done to ensure staffing levels are maintained appropriately. However, we would urge the Trust to take a more proactive approach with the management of such situations in future to avoid the need for a complete suspension of services in Oxfordshire. We encourage you to work with Trusts over the Oxfordshire boarder to manage patient flow more effectively to improve patient pathways across the county and avoid unnecessary delays in both diagnosis and treatment.

In addition to these points discussed at the HOSC meeting on the 4th of April, I would like to urge the Trust to prioritise quality improvements in the areas of Emergency Department (ED). The committee recognises there have been improvements in A&E performance, but we encourage a greater and more integrated focus to reduce both patient demand and flow through A&E.

This Quality Account is a valuable tool in helping the public to understand the Trust's performance and priorities for improving the quality of local services. The committee looks forward to seeing how the priorities identified through this process develop through the 2019/20 financial year and would welcome further discussion at a future HOSC meeting about the progress being made.

Yours Sincerely

Cllr Arash Fatemian
Chairman Oxfordshire Joint Health Overview & Scrutiny Committee

Annexe 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 that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018-19 and supporting guidance detailed requirements for quality reports 2018-19.
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2018 to May 2019
  - papers relating to Quality reported to the Board over the period April 2018 to May 2019
  - feedback from commissioners dated 14 May 2019 (Oxfordshire Clinical Commissioning Group), 10 May 2019 (NHS England Specialised Commissioning)
  - feedback from Overview and Scrutiny Committee dated 14 May 2019
  - the Trust's Complaints Report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated September 2018
  - the (latest) national and local patient survey dated June 2018 and March 2019 respectively
  - the (latest) national and local staff survey September to November 2018
  - the Head of Internal Audit's annual opinion over the Trust's control environment dated 17 April 2019

- CQC inspection report dated January 2019 (System-wide review).

- the Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered.
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review, and
- 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

Sir Jonathan Montgomery
Chair
22 May 2019

Dr Bruno Holthof
Chief Executive
22 May 2019