Quality Account 2017-18

Contents

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

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Part 1: Statement on quality from the Chief Executive 2017-18

In our Quality Account section 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 remain committed to delivering the highest quality care for our patients from Oxfordshire and beyond. Some of their exceptional achievements are included in this report, including the care of hip fracture patients at the Horton, care delivered to patients who are acutely unwell but can spend the night in their own bed rather than in hospital (with the support of the ambulatory units), and the community Cardiology service in partnership with GPs which offers reviews closer to home.

Along with many other NHS trusts, we did not achieve the constitutional standards for access (e.g. 4 hour A&E target and 18 week referral to treatment time targets) this year. Reviews were conducted by the Trust to be sure that the delay (beyond the time allowed for in the standard) did not affect patient outcome. Towards the end of the year this additionally attracted the attention of the regulator, NHS Improvement.

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. However, we maintained our progress against the cancer wait standards and a new "one stop shop" service to speed up cancer diagnosis is being piloted at the Churchill Hospital as part of NHS England's Accelerate, Co-ordinate, Evaluate (ACE) programme.

Oxford University Hospitals is leading the way in the use of technology in the NHS and has been named a 'global digital exemplar' which recognises that we are at the forefront of the use of digital technology to deliver exceptional treatment and care. We will use the resources linked to this status (£10 million) to champion the use of digital technology to drive radical improvements in the care of patients. One major project was for electronic core clinical documentation to enable nursing staff to record their care plans in real time into the electronic patient record (EPR). We were proud to be re-validated in October 2017 as a venous thrombo-embolism (VTE) exemplar centre. The Director of the VTE Exemplar Centres Network wrote: "We were particularly impressed with the electronic solutions used to improve risk assessment and prescription of thromboprophylaxis and the pharmacy-led audit".

Patent safety innovations in the past 12 months included the development of the Trust patient safety alert intranet page which has received over 16,900 hits in 11 months, with a steady increase in the number of views, and our Serious Incident (SIRI) Forum attendance which has doubled in every staff group, with the greatest increase among doctors. The Care Quality Commission well-led inspection also said that the SIRI Forum was seen as "an effective multidisciplinary meeting. The group operated in line with the Trust's value of respect and was a forum where learning took place".

However, during 2017-18 we reported that eight clinical incidents classified as Never Events took place. Immediate actions were introduced while these incidents were fully investigated. The Healthcare Safety Investigation Branch (HSIB) was invited into the Trust to review a set of similar incidents to see if some novel system changes could be suggested.

Positive clinical events have started to be reported in some parts of the Trust with good effect. This

process has been encouraged via the Clinical Governance Committee to be rolled out across other clinical areas.

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.

In March 2017 the National Quality Board published guidance based on the recommendations from the Care Quality Commission (CQC) report "Learning, candour and accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England". In accordance with the new national guidance the revised OUH Standardised Mortality Review Policy was published on 30 September 2017 and structured mortality review was introduced from 1 October 2017. Learning from deaths was reported to the Trust Board as required and specifications to improve patient care addressed. OUH is committed to continuously learning from all patient deaths to improve systems into the future.

As a provider of care the Trust is registered and regulated by the Care Quality Commission (CQC). The Trust is fully compliant with the registration requirements of the CQC and is currently registered with the CQC without restrictions and has an overall 'Good' rating, based on the CQC's rating process. During the second half of the year the Trust was reviewed by the CQC as follows: as part of the Oxfordshire system (Planned review); a well-led inspection (Planned inspection); a maternity services inspection (Responsive inspection); and an Oxford Centre for Enablement inspection (two Responsive inspections: one initial and one follow-up visit). The reports relating to the most recent CQC inspections were received by the Trust on 23 March 2018. The Trust is working to complete actions in relation to the recommendations raised in these reports.

We have continued to work hard to protect our patients from hospital-acquired infection. However, the number of patients acquiring *C difficile* during their hospital stay exceeded the level set for Oxford University Hospitals NHS Foundation Trust by three cases and the zero level of MRSA infections deemed 'avoidable' was not met, with one case apportioned to the Trust during 2017-18.

We believe that looking after our staff helps them to provide the high quality care that we all want to see being delivered. Activities have continued this year to support staff health and wellbeing, including the successful increase in the percentage of frontline staff who received the flu vaccination this year. The Health and Wellbeing Commissioning for Quality and Innovation (CQUIN) goal has influenced this by encouraging all food outlets to have healthier foods available around the counters and improving access to physiotherapy for members of staff.

This Quality Account, as well as looking back on how we performed against our standards and priorities in 2017-18, also looks ahead to priorities for 2018-19. 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 2018 we asked the 100 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 2018-19.

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 2018-19

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

Throughout 2017-18 we have reported to our Board, our staff and our commissioners on progress against our Quality Priorities. A well-received Quality Conversation public engagement event was held at the Trust on 16 January 2018. This event included short films outlining the 2017-18 Quality Priorities and why they might continue, as well as round table discussions in which participants could highlight their most important areas of work from the current priorities, other quality improvement work going on in the Trust and suggestions for new areas of focus. Feedback from the event showed that 98% of attendees felt they were able to contribute to decisions about the future Quality Priorities and 96% found the table discussions useful or extremely useful. The outputs from this event were reviewed by the Trust's Quality Committee.

Staff have also been involved in setting Quality Priorities via our business planning process and discussions in Clinical Governance Committees across the Trust.

Our Quality Priorities for 2018-19
Do no harm (patient safety)

a. Preventing patients deteriorating

Why we chose this Quality Priority	How we will evaluate success
Identifying deterioration early can allow prompt treatment to reduce the duration and severity of subsequent illness. This priority was the one of the 2017-18 priorities that stakeholders voted to continue into 2018-19 at our Quality Conversation public event in January 2018.	**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). **Antibiotics delivered within one hour of a 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.

b. Safe surgery and procedures

Why we chose this Quality Priority	How we will evaluate success
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 Local Safety Standards for Invasive Procedures (LocSSIPs) and thereby reduce the incidence of avoidable adverse events. The OUH had eight Never Events in 2017-18 and that is why focus on these standards has been chosen to be a Quality Priority.	Establish a new Safety Standards for Invasive Procedures group. Develop the remaining key overarching policies from which the specific LocSSIPs will develop. Develop/review LocSSIPs relevant to the eight Never Events that occurred in 2017-18. Scope other surgical and invasive procedural areas across the Divisions where LocSSIPs should be developed.

c. Right patient every time

Why we chose this Quality Priority	How we will evaluate success
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 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.	**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 2018-19. The app is being launched for Matron's assurance audits. Achieve a 50% reduction in PPID incidents in Radiology compared to 2017-18

War on waste (Clinical effectiveness)

a. Go Digital

Why we chose this Quality Priority	How we will evaluate success
Oxford University Hospitals NHS Foundation Trust 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.

b. Lean Processes

Why we chose this Quality Priority	How we will evaluate success
We chose this because we want to increase efficiency 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.	The Transformation Team will train a core team of Divisional staff in lean processes. Each directorate will then complete a lean pathway exercise for at least one patient pathway.

Respect for patients and partners (Patient experience)

a. Partnership working – we will work with system partners to implement a Systematic Stranded Patient Review process

Why we chose this Quality Priority	How we will evaluate success
This was the 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 2018-9 winter plan. Actively participate in the End Pyjama Paralysis campaign and report progress in the 2018-19 Quality report.
	Home Assessment 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.

b. End of life care

Why we chose this Quality Priority	How we will evaluate success
This was the 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.

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 2017-18 Oxford University Hospitals NHS Foundation Trust provided and sub-contracted 141 relevant health services.

Oxford University Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 141 of these relevant health services.

The income generated by the relevant health services reviewed in 2017-18 represents 100% of the total income generated from the provision of relevant health services by Oxford University Hospitals NHS Foundation Trust for 2017-18.

Participation in clinical audits and National Confidential Enquiries

Participation in national clinical audits

During 2017-18, 75 national clinical audits and five 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 93% of all the eligible national clinical audits as detailed in the table below and 100% of national confidential enquiries in which we were eligible to participate.

The reports of 58 national clinical audits were reviewed during 2017-18 and a summary of the actions the Trust intends to take to improve the quality of the healthcare we provide is described.

The reports of 430 local clinical audits were reviewed during 2017-18 and a summary of the actions taken by Oxford University Hospitals NHS Foundation Trust to improve the quality of healthcare are provided.

Participation in national clinical audits during 2017-18

Audit title	OUH Participation	% of cases submitted
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	100%
Adult Cardiac Surgery	Yes	100%
Cardiac Rhythm Management (CRM)	Yes	Ongoing
Congenital Heart Disease (CHD) - Adult	Yes	Ongoing
National Heart Failure Audit	Yes	Ongoing
National Cardiac Arrest Audit (NCAA)	Yes	98%
*National Chronic Obstructive Pulmonary Disease (COPD) Audit programme - Secondary Care	No	
Coronary Angioplasty National Audit of Percutaneous Coronary Interventions (PCI)	Yes	100%
Oesophago-gastric Cancer (NAOGC)	Yes	78%
National Prostate Cancer Audit	Yes	97%
Bowel Cancer (NBOCAP)	Yes	98%
National Audit of Breast Cancer in Older People (NABCOP)	Yes	100%
National Lung Cancer Audit (NLCA) - Lung Cancer Clinical Outcomes Publication	Yes	100%
**Head and Neck Cancer Audit	No	
National Audit of Dementia	Yes	100%
Elective Surgery (National PROMs Programme) - Hips and Knees	Yes	100%
Elective Surgery (National PROMs Programme) - Groin Hernia	Yes	61.3%
Elective Surgery (National PROMs Programme) - Varicose veins	Yes	65%
Sentinel Stroke National Audit programme (SSNAP)	Yes	100%
National Paediatric Diabetes Audit(NPDA)	Yes	Ongoing
British Association of Urological Surgeons (BAUS) Urology Audits - Female Stress Urinary Incontinence Audit	Yes	100%
Maternal, Newborn and Infant Clinical Outcome review Programme	Yes	100%
National Maternity and Perinatal Audit (NMPA)	Yes	90%
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes	100%
Paediatric Intensive Care (PICANet)	Yes	100%

Audit title	OUH Participation	% of cases submitted
Pain in Children (care in emergency departments)	Yes	100%
Serious Hazards of Transfusion (SHOT): UK national haemovigilance scheme	Yes	100%
***National Comparative Audit of Blood Transfusion programme - Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients	No	
2017 National Comparative Audit of Transfusion Associated Circulatory Overload (TACO)	Yes	100%
****Inflammatory Bowel Disease (IBD) programme/IBD Registry	No	
Learning Disability Mortality Review Programme (LeDeR)	Yes	100%
National Core Diabetes Audit	Yes	Ongoing
UK Parkinson's Audit: (incorporating Occupational Therapy Speech and Language Therapy, Physiotherapy Elderly Care and Neurology)	Yes	100%
Endocrine and Thyroid National Audit	Yes	93.75%
Fractured Neck of Femur (care in emergency departments)	Yes	Ongoing
Case Mix Programme (CMP) - Intensive Care Audit	Yes	100%
Major Trauma Audit	Yes	100%
National Joint Registry (NJR) - Knee replacement	Yes	Ongoing
National Joint Registry (NJR) - Hip replacement	Yes	86%
National Emergency Laparotomy Audit (NELA)	Yes	71.07%
National Audit of Intermediate Care (NAIC)	Yes	100%
National Ophthalmology Audit - Adult Cataract surgery	Yes	92%
National Bariatric Surgery Registry (NBSR)	Yes	98%
*****National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	No	
National Vascular Registry	Yes	65%
Neurosurgical National Audit Programme	Yes	100%
Fracture Liaison Service Database	Yes	100%
National Inpatient Falls	Yes	15%
National Hip Fracture Database	Yes	100%
Procedural Sedation in Adults (care in emergency departments)	Yes	Ongoing

Audit title	OUH Participation	% of cases submitted
BAUS Urology Audits - Radical Prostatectomy Audit	Yes	40%
BAUS Urology Audits - Cystectomy	Yes	68%
BAUS Urology Audits - Nephrectomy Audit	Yes	66%
BAUS Urology Audits - Percutaneous Nephrolithotomy (PCNL)	Yes	Ongoing

***** Resources are currently being identified to allow healthcare professionals to ensure collection of patient data in real time, development of Electronic Patient Record (EPR) systems to allow required automatic data field completion and 'push through' to national Royal College of Physicians website.

******In April 2018, the ENT Head and Neck Team are participating in a national audit to collect follow-up data on head and neck cancer patients. The British Association of Head and Neck Oncology (BAHNO) Cancer Surveillance Audit 2018 assesses compliance with the national MDT guidance *Follow-up after treatment for head and neck cancer*, and therefore offers the team an opportunity to review current performance.

******* Due to low staffing levels of Transfusion Practitioners, OUH has been unable to participate in this re-audit. However OUH collects these data through the Trust's ORBIT reporting system and feeds back regularly to clinicians.

******** National ethical approval for the IBD database does not require patient consent, which conflicts with Oxford's generic ethical consent for the 2500 patient IBD database. OUH maintains a local registry.

********* 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.

Selected actions taken following review of the national clinical audits

Audit title	Summary
The Myocardial Ischaemia National Audit Project 2015 (MINAP) & QS68 Acute Coronary Syndromes (including myocardial infarction)	The primary angioplasty team are second best nationally with median door to balloon time at 26 minutes, meaning patients have the blood supply restored to their hearts very quickly by keyhole balloon treatment, which limits heart attack size and aids recovery and prognosis.
National Paediatric Diabetes Audit Report, including Verbal Update on the Publication of the 2015-16 National Paediatric Audit (NPDA) PREM reports	Compared to the national average, patient HbA1c levels for the Trust are better than the national average, and this should translate into long-term improvements in complications, reduced morbidity and mortality.
Sentinel Stroke (SSNAP) - Clinical Report (Aug-Nov 2016) - period 15 – JR	The John Radcliffe Hospital Stroke Service was rated B and as 'good and improving' by the Sentinel Stroke National Audit Programme
NHS Blood & Transplant - Annual Report on Pancreas & Islet Transplantation for 2015/16	Oxford Transplant Centre was noted to be one of the biggest centres in the country performing 60-90 transplants every year. The waiting time for a pancreas transplant in Oxford is in line with the national median and this has been decreasing due to changes in the national organ allocation policy. However, cancellation of transplants due to lack of intensive care unit beds remains a problem and has been identified as a risk by the Trust which is looking at increasing ITU / HDU capacity.
National Cardiac Arrest Audit (NCAA) 2016-17 - Quarter 4	The percentages of patients with return of spontaneous circulation for more than 20 minutes, and who survive to hospital discharge, are higher than nationally, with fewer cardiac arrests per 1000 admissions than the available national comparator

Audit title	Summary
	which coincides with the introduction of the Cardiac Arrest Reduction Strategy.
RCEM 2016-17 Asthma	The audit highlighted poor performance with recording initial observations, prescription of oxygen and vital medication. Monthly reports now indicate that the initial recording of observations has improved with the use of System for Electronic Notification and Documentation (SEND). A local champion has been appointed to promote the management of asthma.
National Neonatal Audit Programme – Neonatal Intensive and Special Care (NNAP)	The Newborn Care Unit at the JR was noted to be the best performing network in England for two year follow-up with significantly higher normal outcomes, the lowest incidence of bronchopulmonary dysplasia, and for use of magnesium sulphate. JR Newborn Care Unit was also the top performer for doctors giving information to parents and top quartile for magnesium sulphate administration and breast milk at discharge.
National Lung Cancer Outcomes Publication	The audit confirmed continuous increasing numbers of lung resections performed for lung cancer. Despite this increase in activity, survival rates at both 30 and 90 days have demonstrated consistent improvements over the last four years.
Falls and Fragility Fracture Audit Programme: NHFD Annual Report 2017	The Horton General Hospital (HGH) remains one of the best performing hospitals in the country for hip fracture care. In 2016 HGH was the first out of 177 sites for achieving best practice tariffs and for time to theatre.
Care 24/7 Trust-wide audit	The overall proportion of patients seen and assessed by a suitable consultant within 14 hours of admission was noted reduced from 100% in September 2016 to 97% in March 2017 and the patients requiring a daily consultant review and reviewed by a consultant had reduced from 100% in September 2016 to 91% in March, but the results for both the standards significantly exceeded the national mean.
National Emergency Laparotomy Audit	Case ascertainment increased significantly from 40% to 72.3% as a result of action taken during the reporting cycle to improve case tracking. There has been a significant increase in the proportion of CTs reported pre-operatively from 49% to 71.1% as a result of changes to, and clarification of, the forms of words used and timings in the CT report. The proportion of patients reaching theatre in a timely fashion has increased to 76.8% from 62% last year and is under monthly review, and has been significantly helped by the introduction of an electronic booking system.
National Joint Registry 2016-17 data (for NOC)	It was noted that the standard revision rates for hip and knee replacement and standardised mortality ratio lie within the accepted range.
Neuro ICU ICNARC CMP Annual Report	This report defines the high levels of critical care activity provided by the Neurosciences ICU when measured against all other national participating units. It also demonstrates improvement in the rate of unplanned readmission of patients within 48 hours of discharge. The Neurosciences ICU continues to demonstrate a strong and consistent performance against all remaining quality indicators. In particular, the risk-adjusted mortality remains below the national benchmark.

Actions taken following review of the local clinical audits

Paper name	Summary
Maternal and child nutrition (QS98)	The maternity unit reported 100% compliance with the three standards applicable to OUH. The maternity unit is working towards UNICEF Baby Friendly Level 2 accreditation.
QS87 Osteoarthritis (OA)	The audit has highlighted areas of excellence in the physiotherapy department's assessment of patients with OA. However, there were some areas where further improvements could be made to the recording of treatments and clinical discussions to better reflect compliance by highlighting them within teaching, increasing the supply of appropriate educational literature and encouraging physiotherapists to ask patients to sign their goal sheets once goals have been established.
QS119 Anaphylaxis	The audit shows that the ED is performing well against referral of patients with anaphylaxis to an allergy clinic and education in the use of an automatic injector.
QS105 Intrapartum Care Audit	Compliance was noted with the majority of the standards; however improved compliance was required with the documentation of women having skin-to-skin contact with their babies after the birth. A 'back to basics' presentation had been made available on the intranet to highlight the significance of skin-to-skin contact and options are explored for mandatory reporting of skin-to-skin contact within EPR.
Venous Thromboembolism (VTE) Prophylaxis Audit	The audit demonstrated maintained improvement in patients receiving appropriate Thromboprophylaxis (TP), with overall 98% of patients receiving appropriate TP and demonstrated overall improvement in levels of prescribing mechanical TP when appropriate. The Trust had revalidated its VTE exemplar centre status in October 2017 particularly being commended for the electronic solutions used to improve risk assessment and prescription of TP and the pharmacy-led audit.
Reducing duplication of point of care and laboratory U&Es in EMU	The audit was completed to avoid unnecessary and duplicate tests. Pre intervention there was 20% duplication of the test results. New posters were created and emails sent to the staff along with face-to-face reminders. Post intervention there was a noted decrease with only 5% duplication of the test results. There is now a formalised process agreed via local induction for the junior doctors and nurses by senior clinicians, posters displayed on wards and awareness raised periodically as a part of staff education especially at times of staff changeover.
Adult Pre-operative Fasting Audit - Elective Surgery	The audit highlighted that the pre-operative advice for patients should be changed to specifically advise patients to eat and drink in, but not after, the hour before the two hour cut-off for fluid and six hour cut-off for food. There should be continuing education for patients and staff (including anaesthetists, surgeons and nursing staff) regarding the importance of not only adequate starving of patients for safety, but also the issues related to starving patients for too long.
Improving Access to the Young Adult Hip Service Clinic	Analysis of the results suggested that clinical fellows/registrars most frequently booked follow-up appointments without instituting a treatment plan. As a consequence of this audit, a guide for the management of common young adult hip disorders was produced for fellows/registrars, including suggested management strategies specifically for the Nuffield Orthopedic Centre (NOC) Young Adult Hip Service.
Anaesthetic Review in Cardiothoracic Preassessment Clinic (CT PAC): Optimising Data Capture and Communication	This was a Quality Improvement (QI) project to explore the possibility of converting the paper consultant anaesthetic review data into an electronic format in the Pre-Assessment Clinic (PAC). More than 80% of thoracic patients seen in CT PAC by a consultant anaesthetist now have their review recorded electronically and securely communicated to the anaesthetic consultant responsible for their

Paper name	Summary
	perioperative care. As part of the project it is now in the Electronic Patient Record. Feedback confirmed that our digital system has improved time management and list planning for thoracic surgery.
QS114 Irritable Bowel Syndrome in Adults	Routine blood tests and dietary specialist advice were offered to the vast majority of patients. More expensive and invasive endoscopic procedures are frequently requested. Faecal calprotectin, which is relatively cheap, is a non-invasive tool for distinguishing between irritable bowel syndrome and bowel inflammation. This was only requested in a minority of cases, however, it could probably reduce the number of colonoscopies performed. The team is currently promoting faecal calprotectin testing in primary and secondary care through education and promotion of diagnostic algorithms.

The national clinical audits and confidential enquiries that Oxford University Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2017-18, 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 (NCEPOD) 2017-18

NCEPOD studies in 2017-18	Clinical questionnaire returned	Case notes returned
Cancer in Children, Teens and Young Adults Study (ongoing)	80%	80%
Chronic Neurodisability (CN) focusing on cerebral palsy study	69%	54%
Young People's Mental Health Study	56%	56%
Heart Failure Study	38%	31%
Peri-operative Management of Surgical Patients with Diabetes Study (ongoing)	52%	46%

In order to improve participation in future NCEPOD studies the Trust will be taking the following actions.

- Liaising with Divisional Directors and Divisional Medical Directors in sending out monthly email reminders to the responsible clinician reminding them of the deadline with each of the studies.
- The Clinical Audit Governance Manager will monitor monthly progress against NCEPOD studies together with the Clinical Governance Facilitator by producing a Trust NCEPOD Excel spreadsheet.
- Quarterly NCEPOD study reports from the Clinical Audit Manager to the Trust Clinical Effectiveness Committee for review and action.

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 Sciences 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 1,880 active clinical research studies hosted by OUH. During 2017-18 the Trust initiated 244 new studies and hosted 365 studies with commercial partners. There are 163 staff who are directly supported by the National Institute for Health Research Biomedical Research Centre (NIHR BRC) funding and 222 staff supported by the National Institute for Health Research Clinical Research Network (NIHR CRN). During 2017-18, OUH's performance against the NIHR's 70 day benchmark for the initiation of clinical trials was one of the best of any of the large research-active hospitals in England. In League 1, consisting of the 27 most research-active NHS trusts, OUH is the only trust to have continued to achieve more than 90% compliance with the 70 day target for the last two years.

The number of patients receiving relevant health services provided or sub-contracted by Oxford University Hospitals NHS Foundation Trust in 2017-18 that were recruited during that period to participate in research approved by a research ethics committee was 13,443 participants recruited to 416 studies which are CRN portfolio registered.

Our education and training

Over the last year the Trust has supported approximately 1000 pre-registration non-medical students across the organisation and there are 908 trainee doctors working at OUH.

Our achievements in 2017-18 included the following.

As part of a refresh of the induction process, nurses and midwives new to the Trust are given a bespoke programme to support their transition into the organisation and to enable them to work to their registration at the earliest opportunity.

Approximately 220 new non-medical professional registrants, including nurses, midwives and allied health professionals (AHPs) are currently undertaking the Trust's 12 month Foundation programme with a similar number having completed the programme. A Year 2 Foundation Year programme was launched in January this year to support the retention of Band 5 nurses and approximately 73 nurses have registered to undertake the programme.

Work continues to develop the Trust's in-house education faculty with an increased range of post-graduate certificate programmes now being offered in addition to our successful Leading Compassionate Excellence in Nursing and Midwifery programme.

In the 2017 General Medical Council (GMC) trainee survey, half of trainees at OUH reported concerns over the workload they experienced, however 78.89% (just below the national average of 79.30%) trainees expressed 'overall satisfaction' with their training programmes and over 90% expressed satisfaction with the level of clinical supervision they received. Concerns about post-graduate medical training in Neurosurgery, Medical Oncology and Clinical Radiology have also been reported via Health Education England, Thames Valley and there are action plans in place to remediate these problems which are being monitored via the Workforce Committee.

The Trust continues to focus on the development of clinical skills for its non-medical workforce with a projection that at the end of March 2018 in excess of 1,500 staff will have been trained in such clinical skills as venepuncture and cannulation, injectable medicines and tracheostomy care. Since April 2017 173 people have completed the Care Certificate programme.

Following the annual senior leader visit (March 2017) the Health Education England (HEE) team noted that "there was evidence of innovation in educational practice, and strong leadership from the educational team in the Trust."

Our Peer Review programme

During 2017-18 we have completed our Directorate review of the Peer Review programme which has now seen trained teams of our staff, stakeholders and patients review all of the clinical facing directorates in the Trust. The programme aims to improve quality of care for patients by informing and empowering staff. We continue to see the benefits that a deeper understanding at clinical directorate level of the Care Quality Commission (CQC) fundamental standards, 'closing the loop' on learning and improvement, and staff empowered to take local action in timely way, brings. The emphasis is on a developmental approach and culture which has been very well-received by staff and recognised as good practice by NHS Improvement. We have spent some time reviewing the effectiveness of the programme and are developing further plans to ensure it progresses in 2018-19.

Our Human Factors training

- Oxford Simulation, Teaching and Research (OxSTaR) has continued to run one day Human Factors courses. Over 180 staff members attended 18 very highly rated sessions in 2017-18 with teams from all the clinical Divisions in OUH. Most importantly, these courses are

multidisciplinary and allow teams to come together in a safe training environment to explore and develop ways to work more effectively together for the benefit of our patients.

- The course combines classroom-based lectures and small group exercises with experiential learning in immersive hi-fidelity scenarios in the simulation suite and attract external continuing professional development (CPD) points. Attendance of the course is captured on the Trust electronic Learning Management System (eLMS).

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) course. This course has been developed by NHS Improvement and focuses on training front-line staff equipping them with the 'know how' to design and implement more efficient patient-centred services. Other projects included: establishing a community-based nurse-led early pregnancy service for women, setting up a satellite radiotherapy unit to provide treatment closer to home, maximising the efficiency of the gynaecology service to improve patient experience and reduce delays and improving the flow of patients from the Emergency Department through to the most appropriate clinical area.

Our clinical teams: examples of outstanding practice

Our Trust is proud to announce that we were re-validated in October 2017 as a venous thrombo-embolism (VTE) exemplar centre. The Director of the VTE Exemplar Centres Network wrote that "We were particularly impressed with the electronic solutions used to improve risk assessment and prescription of thromboprophylaxis and the pharmacy led audit".

Five Trust teams were shortlisted for the Health Service Journal prestigious national awards which recognise and reward outstanding efficiency and improvement.

- A partnership between the Trust, Oxford University's Institute of Biomedical Engineering and Drayson Health has been shortlisted in two categories.
    - System for Electronic Notification and Documentation (SEND); this system has standardised the recognition of deteriorating patients so that staff are alerted earlier and patients can receive the treatment they need as quickly as possible.
    - GDm-Health: this smartphone app enables pregnant women with diabetes to manage their condition during their pregnancy by connecting to their glucose monitors and automatically collecting blood glucose readings so that clinical staff can review the readings and provide feedback. Previously women would have had to keep a written diary and attend regular hospital clinics. The app has been tried and tested by more than 1,000 pregnant women and has reduced hospital visits by a quarter.
- Our Procurement and Supply Chain team's work in partnership with clinical teams to improve efficiency through innovative financial management.
- The Future Leaders Programme; a year-long programme to develop the leadership and quality improvement skills of newly-appointed consultants.

- The Hospital Energy Project to remove old boilers from the Churchill and John Radcliffe hospitals and replace them with a new energy and heating infrastructure to cut the Trust's CO^2 output by 10,000 tonnes per year.

The winners will be announced at an awards ceremony in Manchester in June 2018.

The Horton hip fracture team were finalists in the 'patient safety' category for a British Medical Journal (BMJ) award for their pioneering work in transforming hip fracture treatment and reducing the rehabilitation time from theatre to patient discharge.

The Oxford Reproductive Tissue Cryopreservation Service at Oxford Children's hospital is the country's only comprehensive fertility service. The programme is a collaboration between OUH and the University of Oxford; the team behind this service were announced as highly commended and runners-up in the Cancer Care Team category at the BMJ Awards ceremony on 10 May 2018.

Guardian of Safe Working Hours consolidated Annual Report

Doctors in Training: safe working hours

Nationally, 'Doctors in Training' represent 40% of the medical workforce. New terms and conditions of service (TCS) were introduced for this group in 2016. 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	2017			2018
	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar
Total (including Trust Grade doctors)	850	850	850	850
On 2016 TCS	250	674	674	710

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

- All Doctors in Training (typically around 700) are provided with 'Work Schedules' that are compliant with both the 2016 TCS and European Working Time Directive.

- Through the process of 'Exception Reporting' all Doctors in Training are able to document in real-time, any instance when their actual working hours vary from those in their agreed work schedule.

- The Exception Reporting process has also been used to raise immediate safety concerns related to staffing levels and, in parallel with the Datix system of incident reporting, concerns can be investigated through established governance processes.

- A 'Guardian of Safe Working Hours' has been appointed, a senior and managerially neutral appointment to ensure that issues of compliance with safe working hours regulations are addressed.

- Through quarterly and annual reports, the Guardian provides assurance to the Board that doctors' working hours are safe. (The Board is responsible for providing annual reports to

external bodies, including Health Education England (Local office), Care Quality Commission, General Medical Council and General Dental Council).

- The Guardian has convened a 'Junior Doctor Forum', which includes junior doctor colleagues from across OUH, the Joint Local Negotiating Committee and the Director of Medical Education.

- The Director of Medical Education and the Guardian have provided monthly education sessions for GMC-recognised Educational Supervisors who have key responsibilities with work schedule design and exception reporting.

Exception reporting		**2017**			**2018**	**Total**
		Apr-Jun	**Jul-Sep**	**Oct-Dec**	**Jan-Mar**	
Number of exception reports		142	209	121	53	525
Number of doctors reporting		23	47	41	26	99
Specialties receiving reports		10	14	18	11	25
Nature of exception	Education	9	2	9	16	36
	Hours & rest	136	207	116	44	503
Additional hours worked per exception report		1.6	1.4	1.7	1.8	1.5

Locum shifts		2017 Oct-Dec	2018 Jan-Mar	Total
Total		2978	2761	5739
Agency		1353	1179	2532
Bank		1625	1582	3207
Reason for locum shift	Vacancy	74.4%	74.8%	74.6%
	Non-vacancy	25.6%	25.2%	25.4%

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

- Central collation of data describing the number and causes of rostering gaps. An electronic rostering tool ('HealthRoster') facilitates collection of this data and has been fully implemented across nursing groups. HealthRoster is being rolled out for Doctors in Training, with the agreement that reporting on Doctors in Training staffing levels will be reported using the principles already established for their colleagues in nursing.

Our CQUIN performance

A proportion of Oxford University Hospitals NHS Foundation Trust income in 2017-18 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 2017-18 and for the following 12 month period are available electronically at:

www.ouh.nhs.uk/about/publications/documents/cquins-2017-18.pdf

NHS foundation trusts must include a statement that includes a monetary total for income in 2017-18 conditional on achieving quality improvement and innovation goals, and a monetary total for the associated payment in 2016-17.

The monetary total for Oxford University Hospitals NHS Foundation Trust income in 2017-18 is conditional on achieving quality improvement and innovation goals will be known after 31 May 2018.
The monetary total for the associated payment in 2016/17 is as follows:
Plan £17,192K
Actual £17,390K

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

Since February 2016 OUH has been one of a 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 priorities on the basis of their potential to positively affect outcomes for patients.

- Standard 2 – Time to first consultant review (e.g. by a senior level doctor)
- Standard 5 – Access to diagnostic tests (e.g. X-rays and heart scans)

- Standard 6 – Access to consultant-directed interventions (e.g. interventional radiology and emergency surgeon)
- Standard 8 – 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 not taken enforcement action against Oxford University Hospitals NHS Foundation Trust during 2017-18.

Oxford University Hospitals NHS Foundation Trust has participated in a special reviews by the Care Quality Commission relating to the following areas during 2017 18: 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 February 2018.

The majority of actions are due for completion during 2018/19. OUH will ensure progress to address the need for better co-ordination in order to improve our patients' experience of their care. This is monitored by the Health and Wellbeing Board.

The CQC conducted a focused inspection in November 2017 looking at the Trust level leadership (well-led inspection). The results from this inspection were not rated on this occasion. The inspection found the following.

- The Trust had an experienced and credible leadership team. They were approachable, visible and supportive to their staff and to people who used or supported the work of the Trust.
- The Trust Board presented as a cohesive and supportive leadership team and we saw evidence of sufficient challenge.
- The Trust had a clear vision and set of values informed by quality and sustainability. Candour, openness, honesty, transparency in general were the norm and the Trust applied duty of candour appropriately.
- The leadership team actively promoted staff empowerment to drive improvement.

A number of improvements were identified in relation to the risk management process, the performance review process and aspects of equality and diversity. These are being addressed through a series of actions to be undertaken in 2018-19.

In addition to the above review the Care Quality Commission conducted a review of the health and social care system in Oxfordshire. The CQC report made a point of praising the dedication of front-line staff

across the system. The report found that significant progress has been made in tackling delayed transfers of care as well as highlighting areas for improvement which senior managers in the NHS, social care and other organisations need to act upon to make the whole health and care system work better. A joint action has been developed with partners across the system to address the issues raised.

- CQC ratings grid is provided below for the Trust overall and by site.

The CQC conducted an inspection at the John Radcliffe Hospital site in November 2017 in relation to maternity services. The CQC rated the service as 'Requires improvement'.

The CQC inspectors noted areas of good practice, including the completion of mandatory training by all staff, and the completion and updating of risk assessments for each patient, which informed individual plans of care. It was noted that staff were positive about the support they received from their managers. It was recognised that the maternity service had links with local academic organisations and collaborated to provide accredited courses which provided development opportunities for staff at many levels. The CQC also reported that there were appropriate governance committees and meetings were in place, which provided a structure to the processes for providing assurance to the Board. A number of recommendations were made in the CQC report that was published in March 2018, in relation to infection prevention, medicine management, wider learning from incidents and the consistent monitoring of risk and quality across the maternity service; these are being formally managed by the related action plan.

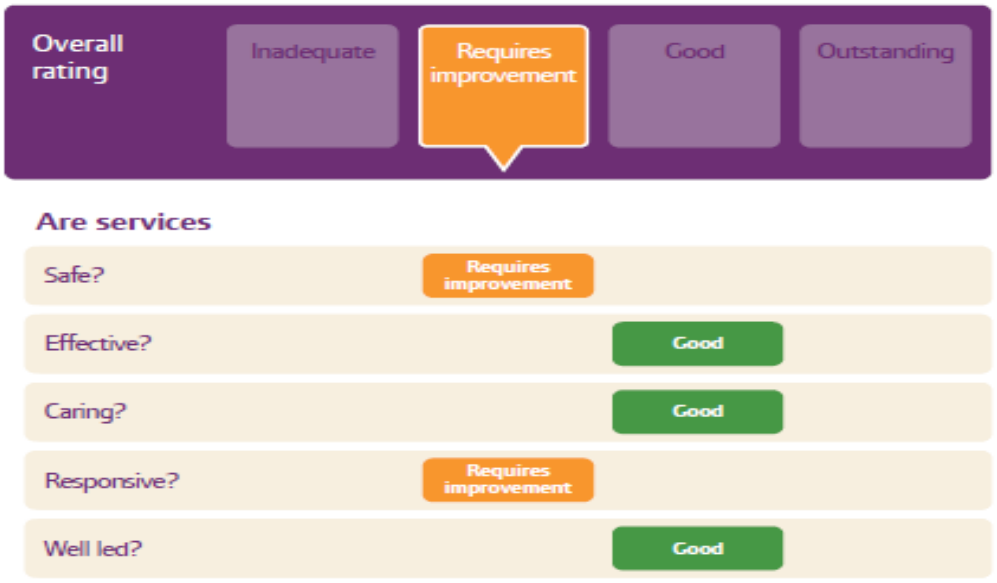
The rating for the John Radcliffe site is included below but remains as 'Requires improvement'.

Care Quality Commission

Last rated
27 March 2018

Oxford University Hospitals NHS Foundation Trust

John Radcliffe Hospital



The CQC has conducted two unannounced focused inspections at the Oxford Centre for Enablement (OCE) on the Nuffield Orthopaedic Centre site on 9 August 2017 and a follow-up visit on 8 November 2017. These inspections followed a Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) notification concerning a safety incident that occurred on 8 July 2017. The first inspection looked into the incident and the Trust response to the incident and made a number of recommendations, which the Trust was managing via an action plan. The follow-up visit concluded that good progress had been made in developing a more effective method of tracking and managing the patient's pathway via the use of daily quality board reviews. It also noted the following.

- *Staff followed the Trust Policy and assessed their patient's capacity using the Mental Capacity Act. There was documentary evidence to support this.*
- *Some work on the environment had been completed to help protect the patients from harm.*
- *There had been changes and development in the way unit managed and considered patients' safety.*
- *Staff were complimentary about the unit's local leadership and the general team.*
- *Staff were clear about their responsibilities to report incidents and how to do this. There was a process for feedback on incidents, actions and learning.*
- *Staff managed and administered medicines safely.*
- *The leadership team was involved in various research projects for improving patient outcomes.*

A number of recommendations were made in the CQC report that was published in March 2018, in relation to the continued completion of the action plan from the previous report, the need to review cleaning processes and the consistent monitoring of risk in the unit: these are being formally managed by the related action plan.

The rating for the Nuffield Orthopaedic Centre site is included below but remains as 'Good'.

CareQuality Commission

Last rated
27 March 2018

Oxford University Hospitals NHS Foundation Trust

Nuffield Orthopaedic Centre

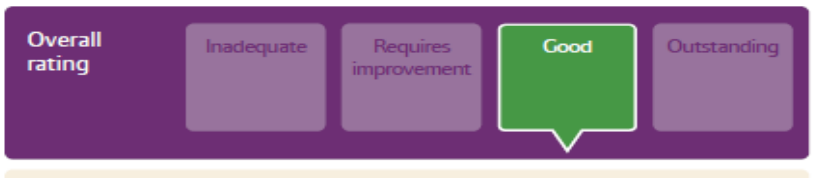
	Safe	Effective	Caring	Responsive	Well led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Outpatients	Good	Not rated	Good	Good	Good	Good

CareQuality Commission

Last rated
14 May 2014

Oxford University Hospitals NHS Foundation Trust

Churchill Hospital



	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

Good quality information 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. It 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.

The Trust has 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, the Chief Information and Digital Officer and the Caldicott Guardian. 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.

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

- '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 2017-18 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

SUS dashboards at month 11 17-18

Inpatients	OUH	National average
Valid NHS number	98.5%	99.4%
General Medical Practice Code	100.0%	99.9%

Outpatients	OUH	National average
Valid NHS number	99.7%	99.6%
General Medical Practice Code	100.0%	99.8%

A&E	OUH	National average
Valid NHS number	96.9%	97.4%
General Medical Practice Code	100.0%	99.3%

Information Governance Toolkit

Oxford University Hospitals NHS Foundation Trust Information Governance Assessment Report overall score for 2017-18 is 100% and graded green (satisfactory).

Clinical coding error rate

Oxford University Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2017-18.

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 22 March 2018, for the data period October 2016 to September 2017, 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.

Source: NHS Digital	Jan-16 to Dec-16	Apr-16 to Mar-17	Jul-16 to Jun-17	Oct-16 to Sept-17
SHMI Value	0.94	0.94	0.93	0.92
SHMI Banding	2 - as expected	2 - as expected	2 - as expected	2 - as expected
% deaths with palliative care coding	37.29	38.93	41.98	44.08

The Trust SHMI has improved from 0.94 to 0.92. There has been a decrease in the number of observed cases for frequent mortality diagnoses of pneumonia, acute cerebrovascular disease and congestive heart failure which has contributed to the improved SHMI.

The Trust Mortality Review Group meets monthly under the chairmanship of the Deputy Medical Director with responsibility for clear mortality reporting to the Board. The Mortality Review Group has multidisciplinary and multi-professional membership with clinical representation from all five clinical Divisions.

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 2017 to December 2017 indicate that 83% 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 three 2017-18.

During 2017-18 2,433 of OUH patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 539 in the first quarter; 552 in the second quarter; 647 in the third quarter; 695 in the fourth quarter.

By 31 March 2018, 964 (55%) case record reviews and four investigations have been carried out in relation to 1738 of the deaths included above. The reviews of deaths which occurred during the fourth quarter are underway and the summary will be included in the next Quality Account.

In four 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: 341 (63%) in the first quarter; 280 (51%) in the second quarter; 343 (53%) in the third quarter.

None of the patient deaths (0%) reviewed 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.

Key learning points, actions and assessment of the impact of the actions following structured reviews

Clinical Support Services

- A Nitric Oxide machine failure was reported to the Medicines and Healthcare products Regulatory Agency (MHRA).

- The vulnerability of the Nitric Oxide machine was reported to the manufacturer.
- All critical care areas in the Trust were advised of the vulnerability of the Nitric Oxide machine and the need for care when introducing the machine into a cramped space. All critical care areas are to ensure that their staff are familiar with the auxiliary Nitric Oxide port.
- When deciding to use a side room on the Adult Intensive Care Unit the team is to consider if the patient safety risk due to the limited space outweighs the increased infection control risk of placing the patient within the open ward.
- The Division highlighted issues with handover between clinical teams and the Intensive Care Unit. This led to the formalising and standardising of theatre handovers and the development of a new electronic handover document.
- The Division highlighted the importance of using a Picture Archiving and Communication System (PACS) standard screen when viewing radiological images as using a regular computer screen may lead to subtle signs being missed.

Medical Rehabilitation and Cardiac

- The Acute General Medicine Unit identified the following areas for improvement in the cases reviewed.
    - The requirement for improved communication regarding the patient's discharge.
    - The need for improved documentation for patient transfers.
    - The requirement for more detail in Post Take Ward Round notes.
    - The Post Take Ward Round notes for younger patients with pneumonia should include the appropriate tool to assess the severity of pneumonia.

  The mental capacity assessment and environmental risk assessment form used in the Emergency Department (ED) was updated to include a question regarding 1:1 assessment or frequency of observations and clarity for call bells or other potential ligature points. The system for escalation of the need for additional staff, when demand and acuity change, was being reinforced within the ED team. Emergency Department Psychiatric Service (EDPS) staff are to be co-located in ED where there is a greater opportunity for them to carry out face-to-face review and assess high-risk patients earlier in their admission.

- There were observational audits in ED of the CARE process (CARE is an acronym for Consider, Assess, Resuscitate, and Escalate). The CARE process, developed by the Thames Valley Trauma Network, aims for the early identification of elderly trauma patients to expedite early senior assessment of these patients. ED implemented the use of laminated cards in patients' notes to provide a readily visible indication that the patient required senior review. The induction training of all new medical and nursing staff in ED includes highlighting the importance of clear written discharge plans for each patient on the Electronic Patient Record (EPR) and the importance of clear discharge care planning to include discharge analgesia, written and ideally verbal communication with care home staff and/or family in the case of an elderly patient with cognitive impairment. The importance of the discharge summaries has also been included in the 'Hold the Front Door' ED newsletter which is widely read by ED staff.

- The OUH MIL (Medicines Information Leaflet) on Warfarin reversal is to be updated to include isolated haemoglobin drop (< 20g/L) in the definition of a major bleed.

- A drug interaction between the choice of antibiotic and the anticonvulsant a patient is taking will be included in Micro Guide, the mobile app used by the Trust for the publication of antibiotic guidelines to clinicians.

- The Cardiac Surgery Unit identified actions to review the outcomes of acute dissection surgery and the guidelines for the management of malperfusion in relation to type A dissection.

Children's and Women's

- A Standard Operative Procedure for Gynaecology Theatre rules and standards is being developed to ensure that patients in the Recovery area are overseen by the immediate operating team until they are transferred to the wards.
- Practical Obstetric Multi-Professional Training (PROMPT), an evidence-based training package for obstetric emergencies, is being introduced for all OUH obstetric and midwifery staff.
- The Maternity Unit is completing a review of the patient information leaflet 'After your waters break' together with representatives of service users.
- The Maternity Unit has completed a review of the processes for communication of potential urgent deliveries and for midwifery requests for an obstetric review of a cardiotocogram (CTG).
- Maternity guidelines related to referral and care during labour were reviewed and updated to be consistent in relation to referral criteria to transfer or seek medical opinion.

Surgery and Oncology

- The OUH Renal Service now documents permanent Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions for long-term dialysis patients from any location within the Renal Service, including the satellite units, on the OUH Electronic Patient Record banner. This enables the unit to maintain continuity and consistency of care.

- The Division highlighted the need for raised awareness and skills in managing difficult discussions regarding end of life issues. This has been particularly pertinent to patients who are transferred across specialties for specific interventions. The Intensive Care and Palliative Care teams were invited to the Surgery Directorate governance meeting to join the mortality review discussions. The OUH Chaplain was involved in discussions regarding the challenges of breaking bad news and end of life discussions including the mechanisms for supporting staff. The Oncology Unit held reflective lunches for challenging cases in order for staff to discuss and learn from their experiences.

- Sobell House Hospice identified issues with the completion of forms for the identification of pacemakers and raised concerns that families were paying undertakers for the removal of pacemakers. This service is provided free of charge by the John Radcliffe Hospital Mortuary. The Bereavement Officer will review the process for pacemakers with the Palliative Medicine Clinical Lead.

- A case that had a structured mortality review and was also investigated as a Serious Incident Requiring Investigation (SIRI) prompted an action for the development of a Local Safety Standards for Invasive Procedures (LocSSIP) for the management of patients requiring a colonic stent.

- The reviews of deaths within 30 days of chemotherapy identified the requirement for DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) discussions to occur with outpatients. It was underlined to all doctors to consider increasing primary antiepileptic prior to initiating additional agents. The importance of the patient's relatives feeling heard by the clinical team when expressing concerns about changes in the patient's condition was highlighted in one case.

Neurosciences, Orthopaedics, Trauma and Specialist Surgery

- The Neurosciences Intensive Care Unit highlighted to their team the need to define the level of care and frequency of observations required for a patient following discharge from critical care to the ward.

- The Division identified a requirement to review and improve the pathway for complex non-elective haemorrhagic stroke patients admitted to OUH. In order to facilitate this, a cross divisional multidisciplinary team (MDT) is being set up to review and improve this pathway.

- The Division recognised the need for timely and appropriate referral of patients to the Palliative Care Team. Those cases where palliation could have been improved have been discussed with the respective teams.

- The prolonged stay of a patient in the John Radcliffe Hospital Emergency Department (ED) had been highlighted in a structured review. A secondary review concluded that the length of stay of the patient in ED was not optimal. The management and monitoring of the patient overnight in ED was appropriate.

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 national mandatory varicose vein surgery and groin hernia surgery national PROMs collections ended on 1 October 2017. The final annual data publication for the half year 2017-18 data will take place in May 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 2016-17. The final annual data publication for 2017-18 will be available later in 2018 and will be published in our 2018-19 Quality Account.

Repair of a groin hernia – average health gain	2014-15	2015-16	2016-17	Provisional 2017-18 (Apr-Sept 2017)
OUH	**0.09**	**0.12**	**0.09**	*
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	0.00

*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.

Primary hip replacement – average health gain	2013-14	2014-15	2015-16	Provisional 2016-17
OUH	**0.47**	**0.44**	**0.42**	**0.43**
National average	0.44	0.44	0.44	0.44
Highest	0.54	0.52	0.51	0.54
Lowest	0.31	0.33	0.32	0.31

Primary knee replacement – average health gain	2013-14	2014-15	2015-16	Provisional 2016-17
OUH	**0.34**	**0.29**	**0.26**	**0.31**
National average	0.32	0.31	0.32	0.32
Highest	0.42	0.42	0.40	0.40
Lowest	0.21	0.20	0.20	0.24

OUH knee replacement PROMs is in the expected range.

The future actions by the Knee Service are to review the 2017-18 data to analyse trends, focus on the internal audit of PROMs data and establish the internal collection of PROMs data as a routine part of practice.

Varicose Veins – average health gain	2014-15	2015-16	2016-17	Provisional 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	0.00

*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.

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 Intelligence 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.

Readmissions	**2016-17**			**2017-18 (*April 2017- August 2017 only)**		
	Under 16	16 and over	Total	Under 16	16 and over	Total
Discharges	29975	164750	194725	11885	67040	78925
28 day readmissions	2398	14234	16632	905	6061	6966
28 day readmission rate	8.00%	8.60%	8.50%	7.6%	9.0%	8.3%

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.

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.

Patient experience

Patient views count and help drive learning and improvement. Patients' thoughts, opinions and observations about all aspects of our hospitals are very important to us. 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

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	2014-15	2015-16	2016-17
OUH	**71**	**71.7**	**71.0**
National average	68.9	69.6	68.1
Highest scoring trust	86.1	86.2	85.2
Lowest scoring trust	59.1	58.9	60.0

Source: Health and Social Care Information Centre website - indicators.hscic.gov.uk/webview - 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 results for 2016-17 were published on 24 August 2017. The results for 2017-18 will be published on 23 August 2018.

Patient recommendation of our hospitals to family and friends

Results from the OUH Friends and Family Test (FFT) survey. *Note: results are from beginning of April 2017 to end of March 2018*	
FFT: inpatients and day cases	96% of patients were extremely likely or likely to recommend their ward, based on 32,966 responses.
FFT: emergency departments	86% of patients were extremely likely or likely to recommend the care they received in the Emergency Department, based on 14,573 responses.
FFT: outpatients	94% of outpatients were extremely likely or likely to recommend the care they received, based on 70,764 responses.
FFT: maternity	96% of women were extremely likely or likely to recommend the Trust's maternity services (labour and birth only), based on 3398 responses.

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

April 2017 to March 2018	Extremely likely	Likely	Neither likely nor unlikely	Unlikely	Extremely unlikely	Don't know
Number of responses	100343	13860	2694	1692	2330	782

overall						
Percentage	82.5%	11.4%	2.2%	1.4%	1.9%	0.6%

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 Chief Nurse or Deputy 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. Successful trials of texting for inpatients have taken place and an improvement in response rates has been seen. The introduction of texting to all adult inpatient areas (excluding palliative care and women's and maternity services) is planned for 2018.
- 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.
- Starting in May 2017, the Patient Experience Manager focused on each clinical Division's response rate in the monthly Board Quality Report. The Surgery and Oncology Division achieved a significantly higher response rate following the support provided.
- In March 2017, the Patient Experience Team introduced a process of reporting and learning from FFT feedback, following advice from the Non-Executive Directors. The process focuses on one area with excellent feedback and one area with feedback for improvement each month. The feedback is analysed to identify themes. The area with excellent feedback is asked what processes they have in place to enable them to get such good feedback. The area with feedback for improvement is asked what they are doing or will do to improve. A review of this process has been undertaken in November 2017, by revisiting all areas that had feedback for improvement, who were contacted more than six months ago. The Patient Experience Team asked the team leaders what changes they had made, and what further changes were planned.
- Teams across the Trust are consistently encouraged to raise patient awareness about feedback via automated methods, encourage patients to respond, opt out patients who do not wish to receive a text message, and offer paper questionnaires to those patients.
- 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.

- Further training sessions have been organised for staff to learn how to use the site and automated reports are easily set up for those who wish to display results and examine comments in detail. A list of staff who attended the training will be publicised so that colleagues in their directorate and Division can go to them with questions about accessing feedback.

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	2013-14	2014-15	2015-16	2016-17	2017-18
OUH	**76%**	**70%**	**75%**	**79%**	**71%**
National average	65%	65%	69%	70%	71%
Highest scoring trust	89%	89%	85%	85%	86%
Lowest scoring trust	40%	38%	46%	49%	47%

Recommendation of the organisation as a place to work:

OUH scores	2013-14	2014-15	2015-16	2016-17	2017-18
OUH	**67%**	**57%**	**60%**	**61%**	**57%**
National average	59%	58%	61%	61%	61%
Highest scoring trust	79%	78%	78%	76%	77%
Lowest scoring trust	34%	32%	42%	41%	43%

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.

- Completing a comprehensive review of the Appraisal process in order to roll out a values- based approach in 2018.
- Designing and developing more health and wellbeing interventions, launching a wellbeing newsletter, further promoting the Employee Assistance Programme and providing staff with fast track access to physiotherapy.
- Organising seven Trust-wide Staff Listening Events called 'Changing Things for the Better' regarding the NHS staff survey results, supported by the CEO and Executive Team to produce a Trust-wide action plan. A follow up Trust-wide Listening Event will take place to track progress in September 2018.
- A specific inbox is available and being used by staff to give further feedback and suggestions for improvements, plus showcase good patient care which will be shared.

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, Oxfordshire CCG 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**	**2014-15**	**2015-16**	**2016-17**	**2017-18**
Trust attributed (number)	**61**	**57**	**53**	**72**
Total bed days	**414,213**	**394,104**	**408,361**	Awaiting PHE figure publication date June 2018
Rate per 100,000 bed days (Trust attributed cases)	**13.9**	**14.1**	**13.0**	Awaiting PHE figure publication date June 2018
National average	15.0	14.9	13.3	Awaiting PHE figure publication date June 2018
Best performing trust	0.0	0.0	0.0	Awaiting PHE figure publication date June 2018
Worst performing trust	40.2	41.1	82.7	Awaiting PHE figure publication date June 2018

Throughout 2017-18 the Infection Prevention and Control Team has continued to work with the multidisciplinary team to minimise avoidable infections.

The number of cases of *C difficile* this financial year is three over the agreed trajectory of 69 set by the Oxfordshire Clinical Commissioning Group (OCCG).

In February we had 12 cases apportioned to OUH, having been under trajectory for the rest of the year. The number of frail elderly on antibiotics being cared for in the Trust at that time was unusually high, due to the high number of influenza-associated admissions. Whole genome sequencing of geographically associated isolates has shown evidence of nosocomial transmission in only one case.

Through case review with feedback, typing and/or sequencing of isolates, the continued promotion of antimicrobial stewardship, and good infection prevention practices, we continue to educate and promote a reduction in cases.

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 believes this reflects a positive culture of reporting incidents. 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 NRLS.
- Data are compared to peers, highest and lowest performers, and our own previous performance, as below.

	Oxford University Hospitals NHS Foundation Trust			
	Apr 14 to Mar 15	**Apr 15 to Mar 16**	**Apr 16 to Mar 17**	**Apr 17 to Sept 17**
Number of patient safety incidents	**17,784**	**17,788**	**17,121**	**8,545**
National average (acute non-specialist trust)	8,735	9,465	7,661	5,226
Highest reporting rate	24,804	24,078	27,991	13,425
Lowest reporting rate	478	3,058	2,880	697
Number of patient safety incidents that resulted in severe harm or death	**44**	**44**	**11***	**10**
National average (acute non-specialist trust)	43	39	38	18
Highest reporting rate	225	183	190	121
Lowest reporting rate	2	2	3	0
Percentage of patient safety incidents that resulted in severe harm or death	**0.20%**	**0.20%**	**0.06%**	**0.12%**
National average (acute non-specialist trust)	0.60%	0.40%	0.40%	0.37%
Highest reporting rate	10.70%	2.00%	1.38%	1.98%
Lowest reporting rate	0.10%	0.00%	0.02%	0.00%

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

*There is a reduction in severe harm or death incidents during April 2016 to March 2017. This may reflect closer monitoring of levels of harm in the Trust's weekly SIRI forum and validation of the level of harm every month by the Clinical Risk Management Team.

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 front-line staff, executives and leads for specialist areas such as tissue viability, pharmacy, venous thromboembolism (VTE) and information governance attend as required. The Care Quality Commission

well-led inspection in 2017 said that the SIRI Forum was seen as "an effective multidisciplinary meeting. The group operated in line with the Trust's value of respect and was a forum where learning took place".

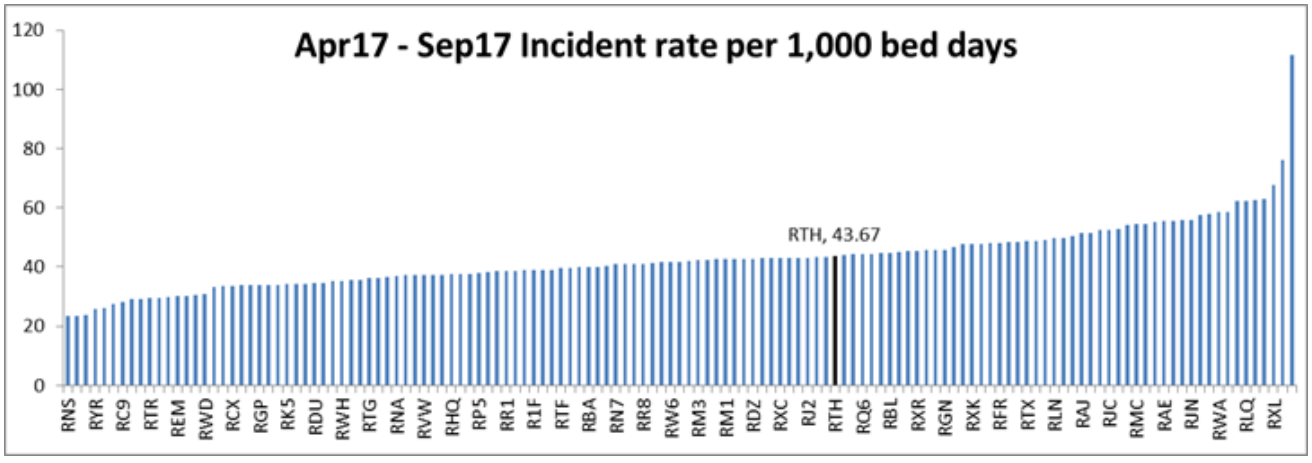
The purpose of the forum is:

- to provide an open, honest and transparent process in the decision-making of calling SIRIs
- to provide assurance to the Trust Management Executive (TME)
- to disseminate Trust-wide learning from SIRIs as close to the time of the incident as possible.

The attendance at this SIRI Forum continues to increase. During financial year (FY) 2017-18 there were 1,537 documented attendees compared to FY 2016-17 where there were 1,346 documented attendees. This equates to an increase of 14%.

During 2017-18 94 SIRIs were declared on the Strategic Executive Information System (STEIS) with three being downgraded. This follows a concerted effort to improve timeliness and extent of escalation of incidents.

Incident Rates					
	Apr 15 to Sep 15	Oct 15 to Mar 16	Apr 16 to Sep 16	Oct 16 to Mar 17	Apr 17 to Sept 17
Incident rate (per 1,000 bed days)	**41.9**	**41.4**	**44.1**	**40.4**	**43.67**
National average (acute non-specialist trust)	39.3	39.6	40.8	41.1	42.84
Highest reporting rate	74.67	75.91	71.8	69.0	111.69
Lowest reporting rate	18.07	14.77	21.2	23.1	23.47



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.

In 2017-18 Oxford University Hospitals NHS Foundation Trust reported eight incidents that met these criteria, compared to two Never Events in 2016-17 and seven Never Events in 2015-16. The Never Events

in 2017-18 were as follows:

1. Overdose of insulin due to abbreviations or incorrect device
2. Wrong site surgery: wrong patient received a cystoscopy
3. Retained foreign object post procedure: retained swab
4. Wrong site surgery: wrong site nerve block
5. Wrong site surgery: wrong site nerve block
6. Wrong site surgery: wrong site nerve block
7. Wrong site surgery: wrong side ureteric stent (recognised and rectified during the procedure)
8. Wrong site surgery: wrong patient received laser eye therapy

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

Overdose of insulin due to abbreviations or incorrect device.

Recommended system changes include:

- all point of care blood gas machines will be programmed to include 'up' and 'down' arrows for glucose outside critical limits
- all blood gas values out of range should be highlighted in EPR
- all World Health Organisation (WHO) safety checklists should be modified to include 'what medications has the patient received in the last 12 hours prior to surgery?' And 'does the patient require glucose monitoring?'
- the hyperkalaemia medicines information leaflet (MIL) algorithm will include a warning saying 'always draw up insulin in an insulin syringe'.

Wrong site surgery: Wrong patient.

Recommended system changes include:

- all outpatient departments and day case units in the Trust should review their practice regarding wristbands for patients undergoing invasive procedures, as specified in the Trust Patient Identification Policy
- staff carrying out procedures should receive specific training and information about consent procedures as part of their induction, including positive patient identification

Retained foreign object post procedure: retained swab.

System changes include the following.

- A sticker on the back of the hand with the initial 'VP' for patients with a vaginal pack in situ is to be introduced, and should only be removed once the pack is removed or a plan for its removal after discharge has been made with the patient.

- A bespoke WHO safety checklist for Gynaecology will be designed and will include the questions: Are there any packs, tampons or drains?' and 'If yes, describe these in detail and document the plan for their removal'.
- The current Maternity Swabs, Needles and Instruments Appendix 2016 within the Trust's Swabs, Sharps, Instruments and Accountable Items Policy 2016 should include a section for Gynaecology. It should highlight that a 'VP' sticker should be used whenever a pack is inserted; this is to be added to both the Trust Policy and the Maternity Appendix clarifying the need to check the wound before the 'VP' sticker is removed. If the pack is to remain in situ on discharge, then the person removing the 'VP' sticker must ensure there is a robust plan for its subsequent removal.

The remaining Never Events are in the process of being investigated, however immediate actions have been put in place.

- A new check is being used during ureteric stenting between the radiographer and surgeon prior to stent deployment.
- A meeting between the Medical Director and Divisional, directorate and clinical leads has occurred following the incidents.
- Additional training sessions for medical and theatre staff with respect to 'stop before you block'.
- An audit of 'stop before you block' practice carried out within two weeks of the first wrong site block was presented to the anaesthetic governance day.
- Advice has been sought from the Healthcare Safety Investigation Branch (HSIB) and other trusts. HSIB came on site to walk through the areas where the wrong site block Never Events occurred and to contribute their knowledge and suggested immediate actions to the Never Event investigation finalisation meeting in relation to the first two wrong site block incidents.
- The meeting with the HSIB, Divisional team, the investigators of two of the blocks and the Medical Director's Team discussed means to standardise the environment in which blocks are done; the importance of consensus and buy-in in the success of any intervention; the absence of an accepted national approach which contrasted with the WHO checklist approach-the HSIB was asked to assist with raising this at national level.
- A 'stop before you zap' protocol is being trialled on the laser eye lists.

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.

Externally

- The OCCG and NHS England have read the completed reports and will undertake assurance visits to the departments once the action plans are complete

- 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.

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 and monitoring via the SIRI Forum as described above.

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

	Verbal	Letter
Q1	100% (50)	98% (49)
Q2	100% (20)	100% (20)
Q3	100% (19)	100% (19)
Q4	100% (16)	100% (16)

Q1 written compliance is lower (49 completed out of a total of 50) as the patient requested not to receive a letter.

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 2017-18

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	2015-16	2016-17	2017-18	Comment
OUH VTE assessment rate	**97%**	**96%**	**98%**	
National average	96%	96%	95%	2017-18 based on Q1-3
Best performing trust	100%	100%	100%	
Worst performing trust	81%	79%	76%	

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

- Education
    - The e-Learning VTE prevention and safe anticoagulation modules have been updated for doctors, nurses and nursing assistants. The Safe anticoagulation module is now mandatory. A bespoke Maternity VTE learning package for midwives was due for completion at the end of December 2017.
- Guidelines
    - New specific VTE Prevention Guideline for lower limb immobilisation in adult outpatients.
- Sustained robust Trust-wide audit of critical patient safety measure
    - Pharmacy support enabled a robust independent audit of 'appropriate thromboprophylaxis (TP)' in July 2016 and this has continued quarterly. The feedback of good quality data has helped drive improvement in patient safety.
- Reporting of all hospital associated thrombosis (HAT) incidents
    - Discussion of potentially preventable HATs in the Serious Incident Requiring Investigation (SIRI) Forum and dissemination of learning outcomes.
- Prescription of anti-embolism stocking (AES)
    - This has been improved by linking the electronic VTE risk assessment to e-prescribing (December 2016).
- Improving patient information with regard to hospital associated VTE on discharge
    - 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.
- OUH was re-validated as a VTE exemplar centre in October 2017. The Director of the VTE Exemplar Centres Network wrote that "We were particularly impressed with the electronic solutions used to improve risk assessment and prescription of thromboprophylaxis and the pharmacy led audit".

Part 3: Other information

Progress against priorities for 2017-18

Patient Safety		
Priority One: Partnership working		
Why we chose this priority	**How we will evaluate success**	**Evaluation March 2018**
This was the top choice from our Quality Conversation public event in January. It is also a major strategic aim for the Trust to work with system partners across Oxfordshire in areas such as the Sustainability and Transformation Programme (STP) across Buckinghamshire, Oxfordshire and Berkshire. We also recognise the value of our services that provide national and international expertise and will work to enhance care in this area particularly for rare diseases. Our Commissioning for Quality and Innovation (CQUIN) programme this year includes partnership networks with other local / regional hospitals to deliver best quality care together for spinal surgery, infection of the liver from a virus (hepatitis C), specific blood disorders and chemotherapy etc.	We will evidence the benefit to patients from taking a whole system approach to our strategy including the University of Oxford, our commissioners, other trusts, our STP area, Oxford Academic Health Science Network (AHSN) and stakeholders. Home Assessment and Reablement Team (HART) service development: we will ensure that the 50% of time is specifically for patient contact. This figure is derived by taking into consideration staff annual leave, sickness, maternity leave and travel time between each patient in the community as well as non-patient-facing organisational activities. By ensuring the Operational Delivery Networks (ODNs)-collaborations of doctors, nurses, managers and allied professionals we will offer opportunities to share learning and develop solutions within and across networks at regional and national levels, to build collaboration and accelerate change for patients. This will be evaluated via achievement of the CQUIN requirements. By fully embedding the OUH Public Health / Health and Wellbeing Strategy we will continue to improve the organisational infrastructure that underpins staff health and wellbeing. We will implement a management development programme to equip line managers with the skills and capabilities to manage teams and services. This will provide managers with the tools to help create a healthy workplace for staff.	STP: We Achieved this. Home Assessment and Reablement Team (HART) service development: We achieved this. Operational delivery networks (ODN): ODNs- We partially achieved this. The regional Spinal network holds regular MDT meetings and the network has produced regional policies to manage spinal emergencies including emergency imaging and transfer. The hepatitis C ODN has a greater than 98% cure rate. Haemoglobinopathies: By the end of Q3, 70% of patients had received an MDT review. Auto immune rheumatic disease: By the end of Q3, more than 90% of patients had received a MDT review. OUH Public Health / Health and Wellbeing Strategy. We achieved this. We implemented a management development programme.
Priority Two: Safe discharge		
Why we chose this priority	**How we will evaluate success**	**Evaluation March 2018**
Patients have told us that delays caused by their medicines not being ready when they expect to leave the hospital are a source of frustration. We have also had feedback from GPs that this is an area we can improve upon. This	Our aims are to improve the experience of discharge and the accuracy of discharge communication for future medication. • We will bring forward the time medicines to take home are reconciled / written, significantly	We partially achieved this. Analysis of January and February 2018 discharges before noon show an increase to 22.5% (mean average). It is anticipated that end of year data will show improvement on the 22.5% recorded to date. The percentages of patients on the wards in which the pilot is live,

<table>
<tr><td>was the favourite new priority identified at our Quality Conversation public event and will build upon work we did last year to improve medicines safety.</td><td>increasing the number of patients discharged before 12 noon, and reduce the number of changes needed on medicines to take home so they are ready at the time of discharge.
• Furthermore we aim to reduce the overall time it takes to turn around discharge medicines and ensure availability to the patient when they are ready to go home.
• We will aim to increase the percentage of patients discharged before noon from 8% to 30%. We will examine information from our electronic system (Cerner) and carry out audits to check our results.</td><td>who were discharged before 12 noon is as follows:
Complex Medical Unit (CMU) A – 23%
Complex Medical Unit (CMU) B – 37%
Complex Medical Unit (CMU) C – 28%
Complex Medical Unit (CMU) D – 42%
Trauma Adams – 17%
Trauma 7F – 26%
SEU D, E, F – 14%
Stroke – 17%.</td></tr>
<tr><td colspan="3">Priority Three: Preventing patients from deteriorating – delivering time critical care [heart attack, stroke, blood clots in the lungs, sepsis including the use of the System for Electronic Notification and Documentation (SEND)]</td></tr>
<tr><td>Why we chose this priority</td><td>How we will evaluate success</td><td>Evaluation March 2018</td></tr>
<tr><td>This was the third most popular priority to continue at our Quality Conversation public event and is a theme from our analysis of incidents or near misses in 2016-17.</td><td>• Through a programme of changes supported by the monitoring system SEND and as part of the cardiac arrest reduction strategy we expect to achieve a 10% reduction in cardiac arrests in 2017-18 from 2016-17.
• We will establish an education and communication programme to fully inform our staff about rapid response treatment for time critical diagnoses which may cause deterioration in hospital.
• We will work to achieve national priorities to improve care for patients with sepsis as described in the 2017-18 CQUIN.</td><td>Reduction in cardiac arrests: We achieved this. There is a 20% decrease in the instance of cardiac arrest in general ward areas between April 2017 and February 2018 when compared with the same period the previous year.

Education and communication programme: We partially achieved this. The number of midwives completing the recognition and treatment of the acutely ill and deteriorating patient (RAID) assessor training has increased and RAID assessments are now underway in maternity. This subject has also been included in all medical induction sessions since August 2017 (646 doctors). The groundwork is now complete for the e-learning package for time critical illnesses and the anticipated go live date for the training is by 31 May 2018.

Sepsis CQUIN: We fully achieved the screening element and partially achieved the intravenous antibiotics within an hour element.
% of eligible patient encounters screened against a target of >90%:
<table><tr><td>Mar-17</td><td>Apr-17</td><td>May-17</td><td>Jun-17</td><td>Jul-17</td><td>Aug-17</td><td>Sep-17</td><td>Oct-17</td><td>Nov-17</td><td>Dec-17</td><td>Jan-18</td><td>Feb-18</td></tr><tr><td>99.2%</td><td>99.3%</td><td>99.4%</td><td>99.3%</td><td>99.4%</td><td>99.3%</td><td>98.2%</td><td>98.7%</td><td>97.4%</td><td>95.4%</td><td>97.2%</td><td>96.0%</td></tr></table>% of IV antibiotics given less than 60 minutes from Alert against a target of 50-90%, ideally >90%:
<table><tr><td>Mar-17</td><td>Apr-17</td><td>May-17</td><td>Jun-17</td><td>Jul-17</td><td>Aug-17</td><td>Sep-17</td><td>Oct-17</td><td>Nov-17</td><td>Dec-17</td><td>Jan-18</td><td>Feb-18</td></tr><tr><td>59.6%</td><td>56.6%</td><td>68.8%</td><td>59.3%</td><td>58.6%</td><td>70.7%</td><td>71.2%</td><td>63.0%</td><td>54.4%</td><td>67.6%</td><td>66.7%</td><td>70.7%</td></tr></table></td></tr>
<tr><td colspan="3">Clinical Effectiveness</td></tr>
<tr><td colspan="3">Priority Four: Mental health in patients coming to our hospitals</td></tr>
<tr><td>Why we chose this priority</td><td>How we will evaluate success</td><td>Evaluation March 2018</td></tr>
<tr><td>We know that the Emergency Department (ED) is not the best place to care for patients with mental illness and we will be working with Oxford Health NHS</td><td>• For patients attending ED we will collaborate with Oxford Health to achieve the CQUIN target for 2017-18. We aim to reduce by 20% the ED</td><td>Mental health in ED CQUIN: We have achieved this with a 46% reduction in attendances since April for this patient cohort.</td></tr>
</table>

<table>
<tr><td>Foundation Trust to find ways to prevent the need to come to ED for some of these patients. We will also work on further improving care for those with mental illness complicating physical illness who are admitted to our hospitals. This was the second most popular suggested new priority at our Quality Conversation public event.</td><td>attendances of those within a selected cohort of frequent attenders in 2016-17 who would benefit from psychiatric and psychological interventions.
• For inpatients, our Psychological Medicine Team will identify, train and support medical and nursing champions for psychological and psychiatric care of our patients in all key Trust services.</td><td>Education / training quality initiative: We achieved this.</td></tr>
<tr><td colspan="3">Priority Five: Cancer pathways</td></tr>
<tr><td>Why we chose this priority</td><td>How we will evaluate success</td><td>Evaluation March 2018</td></tr>
<tr><td>We plan to review cancer pathways with a focus on reducing the number of, and time between, patient encounters (coming to hospital as an in- or outpatient or for tests) in order to consistently improve patient experience, meet cancer targets and provide diagnosis and treatment in a timely manner.</td><td>We aim to improve patient experience by increasing the numbers of individuals who are diagnosed and treated for cancer within target. We also aim to avoid unnecessary delays and we have a programme for quality in each cancer pathway. We will:
• increase the timeliness of first contact or visit for individuals with a suspected cancer so that >93% of referrals are seen within 14 days
• increase the number of individuals confirmed with cancer who are treated within 62 days from 2 Week Wait referral to treatment start (Aim: >85% in 2017-18)
• increase the number of patients who are treated within 31 days of decision to treat (Aim: 96% or greater in 2017-18)</td><td>We partially achieved this.
The table provides the trend data:
<table><tr><th>Target (%)</th><th>Apr 17</th><th>May 17</th><th>Jun 17</th><th>Jul 17</th><th>Aug 17</th><th>Sep 17</th><th>Oct 17</th><th>Nov 17</th><th>Dec 17</th><th>Jan 18</th><th>Feb 18</th></tr><tr><td>2ww(93)</td><td>92.4</td><td>92.0</td><td>96.8</td><td>96.1</td><td>97.0</td><td>97.7</td><td>97.6</td><td>96.9</td><td>95.3</td><td>95.7</td><td>97.0</td></tr><tr><td>62(85)</td><td>86.3</td><td>82.7</td><td>83</td><td>84.9</td><td>85</td><td>85.4</td><td>81.6</td><td>81.7</td><td>87.0</td><td>81.9</td><td>81.4</td></tr><tr><td>31 day first (96)</td><td>98.4</td><td>96.6</td><td>97.5</td><td>97.7</td><td>96.4</td><td>96.8</td><td>96.1</td><td>96.1</td><td>96.7</td><td>93.6</td><td>97.5</td></tr></table></td></tr>
<tr><td colspan="3">Priority Six: Go Digital</td></tr>
<tr><td>Why we chose this priority</td><td>How we will evaluate success</td><td>Evaluation March 2018</td></tr>
<tr><td>We have been named a ‘global digital exemplar’ which recognises that we are at the forefront of the use of digital technology to deliver exceptional treatment and care. As a digital exemplar, we have ambitious plans to accelerate the opportunities that digital technology offers, in line with the ambition of the NHS to be ‘paper-free’ and for patient records to</td><td>• We will establish a patient portal to be used for appointment booking, receipt of letters and review of parts of the clinical record (for limited numbers of patients).
• We will deliver a major project for Core Clinical Documentation: this major project will be accelerated to deliver the capability providing the outstanding online</td><td>Patient portal: We did not achieve this. Preparatory work to facilitate this has been undertaken by the OUH, in partnership with Cerner, to upgrade Cerner Millennium Code from 2015 to 2018.

Core Clinical Documentation: We partially achieved this. The latest documentation standards for Nursing Care Plans, Assessments and Clinical Referrals went live as planned across the NOC site on 19 February 2018. A decision on the rollout approach to remaining OUH sites will be based on learning from live use at the NOC.</td></tr>
</table>

be held electronically and accessible across different systems. We will leverage electronic health records, data and technology to innovate and join up how we provide patient care across organisational boundaries and support self-care and research. We are committed to ensuring these processes improve our safety, effectiveness and patient experience.	documentation required by clinical staff to document electronically in real-time into the patient record. It includes Care Plans, Assessments, Decision Support Rules, extended catalogues of orderables (clinical referrals), and 'best practice' clinical pathway guidance.	

Patient Experience

Priority Seven: End of life care: improving people's care in the last few days and hours of life		
Why we chose this priority	**How we will evaluate success**	**Evaluation March 2018**
This was the second most popular priority to continue when we asked our patients and the public at our event in January 2017. We agree that while we achieved a lot last year we can still do more to develop our end of life care in 2017-18.	• We will implement further improvements in end of life care as described in our work plan for 2017-18. The work plan is based on our End of Life Care (EoLC) Strategy and builds on last year's work plan. • We will deliver and learn from the daily palliative care input to the Emergency Department (ED) and Emergency Admissions Unit (EAU) as part of the End of Life Care Project funded by Sobell House Hospice Charity. • We will increase the number of wards with enhanced skills in supporting end of life care. • We will continue to gather feedback from bereaved families to understand their experience of care in the Trust and incorporate learning in the work plan.	We completed the EOLC work plan. Palliative care input to ED and EAU: We achieved this. Increasing ward accreditation: We partially achieved this. Juniper, Laburnum and the Critical Care Unit at the Horton are currently preparing to accredit as is the Emergency Admissions Unit (EAU) at the JR. This should be complete early in 2018-19. Bereavement survey: We achieved this.
Priority Eight: Dementia care		
Why we chose this priority	**How we will evaluate success**	**Evaluation March 2018**
We are committed to providing an excellent standard of care for all patients but we know that we particularly need to ensure that those who are vulnerable and frail are getting the best possible care. Dementia is an increasingly common condition and we want to continue to build on last year's progress in this area.	• We will implement a paperless process for cognitive screening. A uniform core electronic clerking pro forma should help improve screening because junior doctors will then become familiar with using the same core form regardless of specialty. • We will modify our consent forms to prompt consideration of the need for a capacity assessment prior to consent. • We will design electronic systems to trigger individualised nursing care plans / bundles once the cognitive screen has been	Paperless screening; We achieved this. Consent forms: We achieved this modification. The modifications to the consent forms have been approved by the Clinical Governance Committee (CGC) and will launch shortly. Individual care plans: We partially achieved this. A new form to record the assessment of the patient's mental capacity has been agreed for use once the cognitive screen is positive however the rollout of

	completed and it is positive.	the triggered individualised nursing care plans / bundles will not take place before 31 March 2018.
Priority Nine: Learning from complaints		
Why we chose this priority	**How we will evaluate success**	**Evaluation March 2018**
It is fundamental that we listen to our patients and learn from their experiences therefore we want to make this an explicit priority this year. Communication is one of the top three themes from complaints and this will be an area of focus.	• We will carry out an in-depth review of 2016-17 complaints related to communication to better develop actions and stories which will have the greatest impact for staff. • We will also review complaints about access to treatment to ensure the Trust is listening to the patient's views on what aspects of access really matter for their experience. • This will be used to understand where improvements can be made.	Completed a review of complaints about communication. Access to treatment: We partially achieved this. A programme of work led by the Director of Nursing is underway and will complete after 31 March 2018.

Our 2017-18 performance against the relevant indicators and performance thresholds set out in the oversight documents issued by NHS Improvement

Indicators		Performance			Quarterly Trend				
		Target	Actual		Q1	Q2	Q3	Q4	Last update
Cdiff	Rates of Clostridium difficile	< 69	72	🔴	15	21	10	26	17/04/2018
18Incomp	RTT - incomplete % within 18 weeks	> 92%	85.1%	🔴	89.8%	86.9%	86.2%	85.1%	19/04/2018
AESITREP4	4 Hour Target Sitrep Months	> 95%	82.8%	🔴	85.9%	82.7%	81.6%	81.0%	17/04/2018
CancerUrgTreat	Maximum waiting time of 62 days from urgent referral to treatment for all cancers	> 85%	83.5%	🔴	83.7%	85.0%	83.3%	81.4%	10/03/2018
CancerNatScr	Extended 62-Day Cancer Treatment Targets (following detection via national screening programme of hospital specialist)	> 90%	95.0%	🟢	91.9%	99.1%	95.4%	91.7%	10/03/2018
VTES	% of all adult inpatients who have had a VTE risk assessment	> 95%	97.5%	🟢	97.6%	97.6%	97.8%	97.0%	17/04/2018
DIV01	Maximum 6-week wait for diagnostic procedures	> 99%	99.0%	🟢	99.0%	98.9%	99.4%	98.6%	17/04/2018

Emergency Department (ED) access: 95% ED patients wait less 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
No of four hour Breaches	8,994	14,017	15,893	21,046	26,673
No of attendances	132,838	137,883	145,473	151,073	155,352
Performance	93.23%	89.83%	89.07%	86.07%	82.83%
Nat average	95.69%	93.64%	91.91%	89.13%	88.36%
Best performing trust	100%	100%	100.00%	100.00%	100.00%
Worst performing trust	88.48%	82.03%	78.49%	72.37%	70.95%

The patients presenting to ED and to the other assessment areas are requiring more investigations and treatments followed by admission. In Quarter 1 and 2 2016-17 (April to September) ED managed to achieve approximately 85% (ranged from 82% to 89%). In Quarter 3 and 4 2017-18 (October to March), compliance with the four hour standard reduced to approximately 81%.

Oxfordshire has had a particularly difficult time this winter with the levels of Flu-like illness being particularly high and prolonged. This has led to high numbers of medical admissions.

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

- Over the past year, a number of interventions have been put in place to help improve the performance – increased capacity in ambulatory care (JR and HGH), consultant phone holding in acute general medicine (AGM), direct referral to medicine from paramedic ambulance crews, recruitment to the Home Assessment Reablement Team (HART), development of Acute Hospital at Home (AHaH) and systematic reviews of patients in hospital over seven days.
- There has been a focus to ensure that patients in the Minor Injuries section of ED do not remain in the department for more than four hours. In addition to the above, ED has added a junior and senior medical staff member over night.
- We have expanded the medical workforce with increased numbers of senior doctors to support early decision-making. This has been coupled with nurse-led streaming to ensure patients get seen by the most appropriate team directly.

Cancer waits

Oxford University Hospitals NHS Foundation Trust is responsible for meeting eight national cancer wait standards. In February 2018 (the latest month reported), all were met except the 62 day wait from GP urgent referral to first cancer treatment. The number of people waiting for over 62 days continues to reduce and Oxford University Hospitals NHS Foundation Trust aims to meet this standard in and from

April 2018.

It is recognised nationally that a small proportion of patients may remain on a 62 day cancer pathway and wait for more than 104 days for first treatment, i.e. for six weeks beyond the 62 day standard. We developed an agreed protocol that any patient reaching a 104 day wait should have a clinical review conducted to establish whether any potential clinical harm resulted from the delay. The findings from such reviews are received in quarterly reports by the Trust's Clinical Governance Committee. Patient-level detail from these reviews is shared with the clinical teams involved and with lead commissioners on a weekly basis to ensure that any emerging trend is identified quickly.

Post-diagnostic and slow decision-making, particularly for patients on complex clinical pathways, and late referrals from other trusts have been identified as the two key causal factors in cancer waits at Oxford University Hospitals NHS Foundation Trust during the year 2017-18.

A cancer performance improvement plan was implemented, together with individual tumour site-specific actions for improving performance, with particular focus given to the Urology, Lower Gastrointestinal (LGI), Gynaecological Oncology, Lung and Head and Neck tumour site groups which together accounted for over half of the people waiting for over 62 days from referral for first treatment.

During the year Urology achieved the 62 day standard in six months, LGI and Gynaecological Oncology saw some improvement, whilst in February 2018 waits worsened in the Head and Neck and Lung tumour site groups.

Additional support that was introduced during 2017-18 included:

- twice weekly 'cancer huddle' teleconference involving service managers, senior clinicians and the Trust-wide cancer management team, focusing on checking progress and resolving issues involving patients waiting for over 42 days on pathways from GP urgent referral to first treatment (85% of which should be completed within 62 days)
- pathway coordinator employed on behalf of the Thames Valley Cancer Network to assist with tertiary referrals from other hospitals
- collaborative working with NHS Improvement and individual tumour site clinical teams to improve systems and processes.

Waits for planned care

The national standard of 92% of people waiting no more than 18 weeks from referral to treatment for elective care (on what are termed 'incomplete pathways') has not been met since June 2015 for patients waiting for treatment by Oxford University Hospitals NHS Foundation Trust (OUH).

Performance

At the end of February 2018, 6,802 of 48,585 patients on incomplete pathways in our Trust were waiting for over 18 weeks. This was the first month of growth in the total waiting list size since July 2017 with an increase of 440 patients compared to January 2018.

Performance from April 2017 to February 2018 was better than the agreed trajectory, which reflected the fact that the numbers of treatments that OUH was being funded to carry out was not sufficient to meet the national standard. Performance against the 92% standard continues to worsen and was 86% at the end of February 2018.

Speciality waits

The number of people waiting for over 52 weeks for treatment grew from 90 in December 2017 to 157 in January 2018 and again to 176 in February. The number of women waiting for over 52 weeks for gynaecological surgery rose to 150 in February, when a further 26 patients were waiting for over 52 weeks in 18 other specialties.

Activity

Following guidance to all NHS trusts from the National Emergency Pressures Panel, Oxford University Hospitals NHS Foundation Trust postponed some elective inpatient procedures for adults in January and restarted in February 2018.

Elective activity was also lost due to staffing shortages causing the closure of inpatient beds and some operating theatre sessions, and adverse weather also had an impact. OUH provided 793 fewer elective inpatient admissions than planned in January. Although this was offset by 453 more day case admissions than planned, it took the Trust to 189 elective admissions below its plan for the year to date.

The total size of the waiting list reduced by 0.75%, with most of the reduction in waits for first outpatient attendance offset by growth in the number of people waiting in the 'diagnosis' stage of their pathway (between having a first outpatient attendance and a decision being taken on surgery).

Key risks we are mitigating

- Staffing continues to pose the greatest risk to Oxford University Hospitals NHS Foundation Trust delivering its planned and commissioned level of elective care. Shortages of ward staff led to unplanned bed closures and shortages in theatre staff led to loss of operating sessions, particularly affecting specialist surgery at the John Radcliffe in autumn 2017 and affecting surgical services at the Churchill from early 2018.
- Work has continued to secure theatre capacity and has focussed on the recruitment and training of anaesthetic and recovery nurses and theatre scrub nurses. There was an overall reduction in the cancellation of operating sessions since late 2017.
- The scale of elective activity growth continues to be greater than is funded by commissioners or than can be provided in the short term by Oxford University Hospitals NHS Foundation Trust. Discussions have therefore taken place with independent sector providers to identify alternative capacity to provide surgery for our patients, using our surgeons wherever possible. The focus is on treating patients experiencing the longest waits, such as within gynaecology.

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

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

11 May 2018

Statement from Oxfordshire Clinical Commissioning Group (OCCG)

OCCG has reviewed the Oxford University Hospitals Foundation Trust (OUHFT) Quality Account and believes that it provides accurate information. The OUHFT is a large NHS organisation that covers many services and, consequently, the CCG recognises that this document will never fully be able to provide the public with full assurance about the quality of NHS services. This Quality Account highlights many of the challenges faced by the Trust and describes areas of quality improvement work which have been undertaken.

The Account sets out the Trust's performance against the nine quality priorities for 2017/18. Of these, five were achieved in full and four were partially achieved. The CCG would like the Trust to consider how areas not fully completed from the 17/18 priorities could be taken forwards so as not to lose the good work already completed.
The priorities for 2018/19 have been developed by the Trust in partnership with stakeholders, including patients and the public. The CCG welcomes the priorities agreed. In particular the choice of 'safe surgery and procedures' and 'right patient every time' will provide a welcome focus on areas which have been identified through serious incidents and never events.

The CCG was disappointed that the Trust did not meet the agreed trajectories for timeliness of discharge summaries, outpatient clinical communication and the endorsement of test results. The CCG recognises the difficulties in achieving these targets and wishes to continue to work with the Trust to deliver the improvements in system working and patient safety.

A skilled and motivated workforce is essential to the delivery of high quality healthcare. It is important

that the Trust does everything it can attract, support and develop staff. The staff survey measure of the percentage of staff who would recommend the organisation as a place to work is therefore an important indicator. OCCG would encourage the Trust to look to other Trusts which score more highly in this domain to understand whether there is anything that could be applied to Oxfordshire to improve staff morale and boost recruitment and retention.

The work of the Trust on implementing the requirements of the CQC's report 'Learning, Candour and Accountability' is to be commended. The Trust has implemented a structured mortality review process. OCCG looks forward to seeing the improvements in patient care which will result from the better understanding of mortality.

There were eight never events declared by the Trust in 2017/18. This is a significant increase on previous years. The Trust has done some excellent work in providing human factors training, developing patient safety alerts, and raising the profile of learning from serious incidents. The number of these incidents is extremely concerning for the CCG. The prevention of further never events in this complex environment is extremely challenging. An understanding of the importance of cultural factors is essential. The CCG welcomes the approach the Trust has taken in inviting the external expertise of the Health Services Investigation Branch and other organisations which may be able to share insight and expertise

High levels of demand have resulted in quality issues such as long waiting times and 12 hour trolley waits in A&E. Managing quality in these circumstances is extremely challenging and requires the Trust to develop a systematic approach to maintaining quality when performance falls below expected levels. The CCG recognises the considerable efforts made by the Trust to ensure the quality of care provided to patients during the extremely busy winter period.

While a number of NHS Constitution targets were not met in 2017/18 the Trust has worked hard to deliver five out of six of the cancer targets.

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. We recognise that 2018/19 will be a challenging year for the NHS and look forward to working collaboratively with the Trust to ensure quality and safety remains central. The CCG believes that the system should work together in a culture of openness to face the current challenges. We encourage the Trust to be ambitious in its delivery of high quality compassionate care.

NHS England Specialised Commissioning statement on Oxford University Hospitals NHS Foundation Trust 2016-17 Quality Accounts

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

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

15 May 2018

Dear Colleague

Thank you for sharing the Oxford University Hospitals NHS Foundation Trust (OUH) Quality Account with NHS England. The quality account has been reviewed from the perspective of NHS England as the Specialist Commissioner for the Trust and it is our view this quality account provides an accurate picture of the challenges the Trust faces and improvements made during the year in relation to the quality agenda.

During this year the Trust has further developed its clinical governance and the processes established in place in previous years have helped to strengthen the Trust's safety culture. The Trust recognised eight Never Events during 2017/18 and NHS England acknowledges the depth of investigation and speed of remedial actions carried out by OUH for those incidents relating to Specialised Commissioned Services. The Trust has recognised this is an area requiring focus and included specific work as a priority for 2018/19, which is welcomed by NHS England as is the emphasis the trust is placing on ensuring patients leave hospital in a timely manner.

The 2018/19 quality priorities for OUH have been identified against well-defined and appropriate rationale and it is pleasing to see the involvement of the wider Trust community in establishing the priorities for the future. It would have been beneficial to have included greater detail in relation to project plans and goals with clarity provided on the outcomes that were anticipated.

We are pleased to see good participation in national clinical audits and evidence of changes made as a result of these audit findings. Local clinical audit activity and follow up provides evidence of the Trust's commitment to focus on clinical effectiveness. NHS England is assured that the actions the trust intends to adopt in relation to response to NCEPOD studies will improve response rates in this area.

The OUH Quality Account provides clarity in relation to the Trust's major challenges and demonstrates the openness and transparency of the Trust where standards have not been met. The extraordinary winter pressures experienced by OUH impacted on the Trust's ability to achieve all of the NHS Constitutional standards, notably the referral to treatment time (RTT) standard. NHS England is supporting OUH to rectify this position.

NHS England endorses this Quality Account and we look forward to enhancing our effective relationships in order that improvements to the quality of care will continue for the patients using OUH specialised services.

Yours sincerely

Wendy Cotterell
Director of Nursing – Specialised Commissioning

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 2017/18

Thank you for sharing the Oxford University Hospitals Trust (OUHT) draft Quality Account with the Joint Health Overview and Scrutiny Committee (HOSC) for comment. This document is a valuable tool in helping the public to understand the Trust's performance and priorities for improving the quality of local services.

The progress against OUHFT's 2017-18 quality priorities and the emerging priorities for 2018-19 were considered by HOSC at its meeting on 19th April 2018 and since then Committee members have reviewed the full draft document.

The Committee is pleased to note improvements made in a number of services. They are particularly pleased to see the progress made on services for patients with mental health illnesses. The Committee would however like to seek assurance from the Trust that there will be a continued focus on the quality targets that were not achieved within 2017-18. In particular:

- HOSC would be keen to see end of life care be considered more holistically in future so the care available to patients in a hospital setting can be provided for those who wish to die at home.

- HOSC would wish to see a continued effort to improve the cancer pathways to avoid unnecessary delays in diagnosis and treatment. The Committee recently received a presentation from OUHFT regarding the chemotherapy services it provides and therefore understands some of the challenges in ensuring quality and performance. The Committee is keen to understand more detail of the quality across each cancer pathway, which contributes to the overall performance in this area.

- The Committee would like to encourage the Trust to continue making improvements to the complaints process and management to ensure they are listening to patients.

In addition to these points discussed at the HOSC meeting on the 19th of April, I would like to urge the Trust to prioritise quality improvements in the areas of Emergency Department (ED) waiting times and on delayed transfers of care. HOSC are particularly keen to see OUHFT bring its ED wait times of 82.83% of patients seen within four hours

in line with the national average of 88.36%. Finally, whilst recognising the complexities and system-wide challenges in reducing delayed transfers of care, I would like to urge the Trust to consider giving this a priority in its quality improvements.

The Committee welcomes the Trust's approach to engaging with patients and stakeholders in their 'Quality Conversation' and look forward to seeing how the priorities identified through this process develop through the 2018/19 Quality Priorities. The Committee would welcome further discussion at a future HOSC meeting about the progress being made against the Trust's 2018-19 priorities.

Yours Sincerely

Cllr Arash Fatemian
Chairman Oxfordshire Joint Health Overview & Scrutiny Committee

healthwatch Oxfordshire

15th May 2018

Healthwatch Oxfordshire contribution to the Quality Account 2017/18 for Oxford University Hospitals NHS Trust

Healthwatch Oxfordshire welcomes the opportunity to contribute to Oxford University Hospitals NHS Trust's Quality Account. The Account sets out a significant level of achievements by the Trust in delivering a range of services to the people of Oxfordshire and further beyond.

During 2017/18 Healthwatch attended all four hospital sites as part of our listening to patients' experiences outreach programme. Together with the information gathered on our web site feedback centre the common themes that have appeared are:

1. Most people we have heard from report that they have had a very positive experience when asked about their treatment and care, and staff. "I was in the JR for a long period of time and they were wonderful." People felt listened to and thought the quality of care and treatment were good.
2. The two areas that patients are most dissatisfied about are access to services, and administration. These areas include parking, multiple letters about appointments, cancelled appointments, length of time waiting for an appointment and waiting times when attending for appointments. We believe that the good work that has been done at the eye hospital around improving communications and administration has resulted in improved patient experience. **Healthwatch asks that within the quality action plans for 2018/19 the Trust will once again focus on improving administration and communication with patients.**

As reported in the Quality Report the Trust was reviewed as part of the CQC Planned review of the Oxfordshire system. The key messages from this review were that there was no collective vision or joined

up leadership across the system. Healthwatch welcomes the joint response from the system leaders and believes that the Trust must continue to work collaboratively with other health and social care partners to improve patient experience; particularly around delayed transfer of care and A&E waiting times. As such we welcome the partnership working priority within the Trust's Respect for patients and partners (Patient Experience) quality priority for 2018/19.

Healthwatch Oxfordshire will continue to work with Trust to ensure that patient experiences are heard from as many people as possible.

Oxford University Hospitals
NHS Foundation Trust

Feedback from OUH Governors dated 17th May 2018

In March 2018, the Council of Governors' Patient Experience, Membership and Quality [PEMQ] Committee received an update from the Deputy Medical Director on the development of Quality Priorities for 2018/19 and was also asked to select the quality indicator for external audit. After due consideration, the Committee recommended that 'Patient recommendation of our hospitals to family and friends' should be selected as the quality indicator for external audit. This was subsequently approved by Governors.

At its meeting held on 30 April, the Council of Governors then reviewed the latest available draft of the OUH Quality Account 2017/18, presented by the Deputy Medical Director.

In discussion of the Quality Account, Governors took the opportunity to raise queries in relation to some specific points, including the work that was noted to be underway to reduce the number of 'stranded' patients, related to the Quality Priority for Partnership Working.

A final draft of the OUH Quality Account 2017/18 (as shared with external stakeholders, including the Oxfordshire Health Overview and Scrutiny Committee and Oxfordshire Clinical Commissioning Group) was then circulated to all Governors in May and this elicited some further helpfully detailed drafting comments which the Trust has taken into account.

Overall, Governors have welcomed the Quality Account as a comprehensive document, and have commented that it includes information on a lot of very good work that is being done to maintain high quality care for patients in Oxfordshire.

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 2017-18 and supporting guidance
- 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 2017 to May 2018
  - papers relating to Quality reported to the Board over the period April 2017 to May 2018
  - feedback from commissioners dated 11th May 2018 (Oxfordshire Clinical Commissioning Group), 15th May 2018 (NHS England Specialised Commissioning).
  - feedback sought from Governors May 2018
  - feedback from local Healthwatch organisations dated 15th May 2018
  - feedback from Overview and Scrutiny Committee dated 15th May 2018
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 13th September 2017
  - the (latest) national patient survey dated August 2017
  - the (latest) national staff survey September to November 2017
  - the Head of Internal Audit's annual opinion over the Trust's control environment dated 18th April 2018
  - CQC inspection reports dated 27/03/2017 (System-wide review, Well-Led inspection, Maternity inspection and the Oxford Centre for Enablement inspection)
  - 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

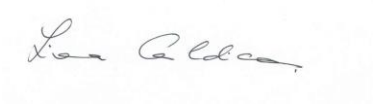
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review, and

- 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



Chairman
23 May 2018

Chief Executive
23 May 2018