Oxford University Hospitals NHS Foundation Trust Annual Quality Report containing the Quality Account 2015/16

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Our quality priorities for 2016/17

The essence of the Trust and the NHS is a commitment to the delivery of compassionate and excellent patient care. OUHFT'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 programs.

How we chose our priorities

Throughout 2015/16 we have been updating our staff and our CCG and other stakeholders about our quality priorities for the year. We have agreed that work will continue on most of our previous quality priorities, particularly in five areas where we wish to avoid patient harm and deterioration wherever possible, and in our focus on partnership and patient experience. Our Divisions have been involved in identifying quality priorities through discussion in our Clinical Governance Committee and have developed Divisional quality plans as part of the business planning process for 2016/17. We have engaged with our governors and they have adopted priority TBC. A patient and public engagement event was held in April 2016.

This section of the report describes a suite of quality priorities for the coming year. These are part of a wider work plan to deliver high quality care to all of our patients. All quality improvement work is monitored closely by our Clinical Governance and Quality Committees and we regularly report our performance to our commissioners and regulators.

Over the year ahead, we aim to prioritise the delivery of quality improvements across a range of projects and services. There are six high level Trust wide quality priorities. There have been several different drivers in the development of these projects:

- Priorities set for the NHS nationally;
- Priorities arising through feedback that the Trust has received from service users and our local Healthwatch organisation;
- Priorities set from a review of incidents and internal audit reports and
- Priorities articulated in our Quality Strategy and Annual Business Plan.

Our quality priorities for 2016/17

Our quality priorities are as follows

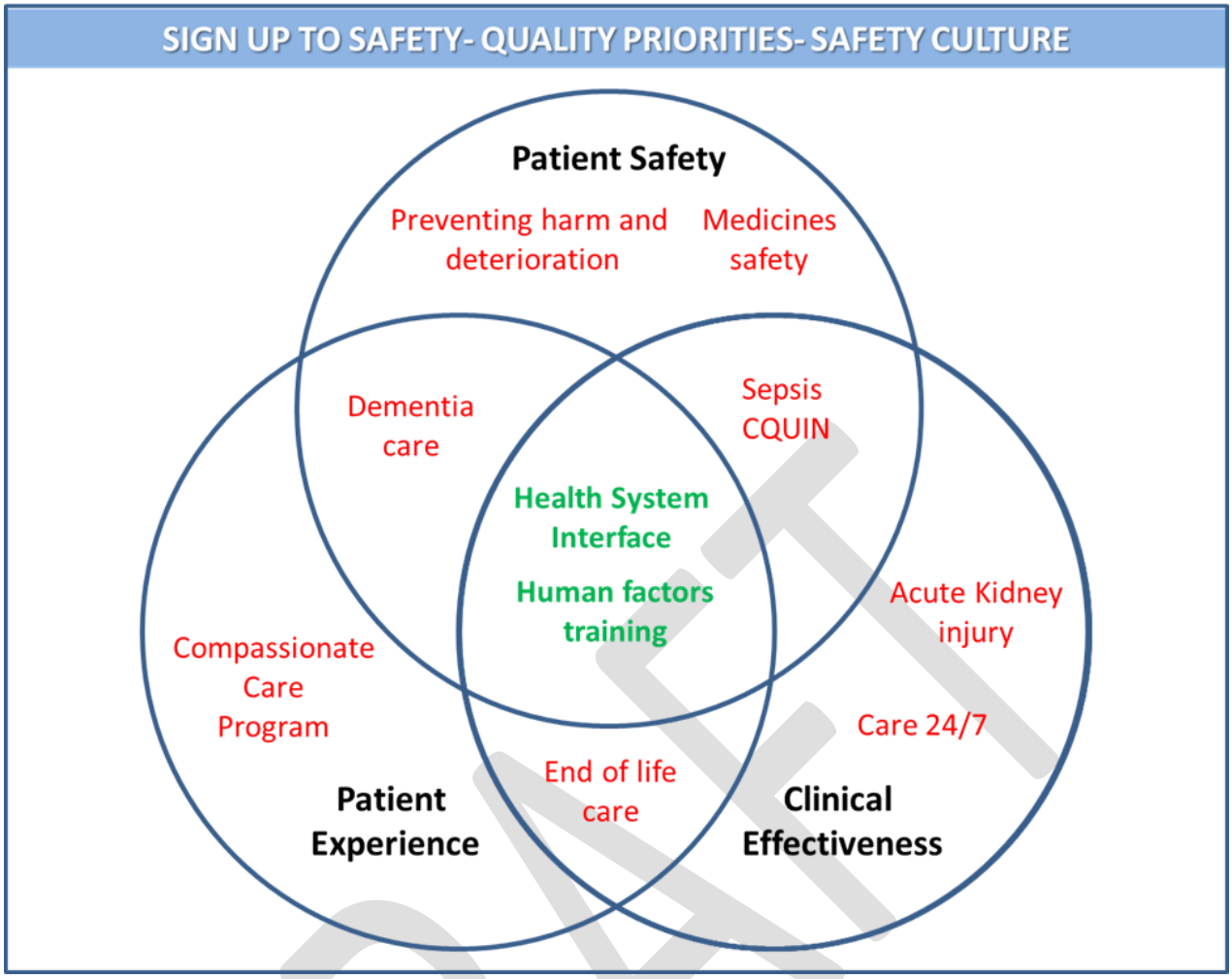
1. Preventing harm and deterioration including programmes for
    - Medication safety (in response to audits in 2014/15 and including antibiotic stewardship-a national CQUIN)
    - Acute kidney injury, AKI, (an alert affecting 30 patients per day)
    - Recognition and treatment of sepsis (National CQUIN)
    - Care 24/7 (NHS national priority)
    - Nationally recognised iPad based track and trigger SEND project

2. Following an expert external review of our investigations of Never Events that occurred in the Trust in 2014/15 we are committed to:
- Further Human factors training to enhance the lessons learned from adverse events.
- Improving our systems for sharing learning within and between teams across the Trust
- Improving our systems for ensuring knowledge of and compliance with essential policies

3. More effective care with better patient experience including programmes for
    - End of life care (proposed local CQUIN)
    - Dementia care
    - Our Compassionate Care programme to improve patient experience throughout the Trust

4. Stake holder engagement and partnership working

The place of our priorities in the domains of patient safety, clinical effectiveness and patient experience is shown on the following diagram.



Our quality priorities recognise the collaborative system leadership programmes instituted by the Chief Executive Officers (CEOs)) across our system.
We are committed to further improvement in our interface with stakeholders such as GPs, other Trusts such as Oxford Health and social care. We seek system solutions to the challenges which face our patients in navigating the healthcare system when they are ill and we want them to be cared for in the right place.

Priority 1: Preventing avoidable harm and patient deterioration in hospital

Why we chose this priority

This priority is the overarching theme underlying work streams in both patient safety and clinical effectiveness with a central theme of preventing avoidable deterioration of patients in hospital and avoidable healthcare related harm.

A million people use healthcare services every 36 hours, and the vast majority of them receive safe and high quality care. But things can be omitted or go wrong, and occasionally mistakes are made. Of the 17784 incidents and near misses reported at OUHFT in 2015/16 0.25% resulted in severe harm or death.

We are committed to a group of five priorities which all aim to detect patient deterioration at the earliest time and provide a rapid response to minimise both harm from health care errors and progression of the patients illness that could have be avoided by prompt delivery of the best standard of care. This priority seeks to build on last year's work to create digital systems and innovative data gathering to identify key opportunities to intervene and deliver safe care.

Our aims are to further progress programmes under the following domains

Priority 1A Medication safety

Priority 1B Improved recognition, prevention and management of patients with Acute Kidney Injury (AKI)

Priority 1C Identification and early treatment of Sepsis

Priority 1D Care 24/7

Priority 1E Detecting and acting on deterioration through the iPad based collection of patient observations with track and trigger analysis- The SEND project

Priority 1A: Medication safety

Why we chose this priority

Safe and secure medication audits across the Trust suggest there is more work we can do to ensure best practice in safe medication practice at all times. A deep dive into the 'omission or delay of administering an essential medicine' has confirmed the importance of this issue and a new work stream is being established to drive improvement. The Medicines Safety Team has been working with and supporting existing specialist multidisciplinary teams to improve medicines safety in their specialist area.

In 2015/16 the team has been supporting the Divisions with Trust investigations and learning from where more serious patient harm has been associated with medicines use. This has included reviewing all 'Serious Incidents' report investigations to identify themes, and enhance understanding of how and why things went wrong in order to share learning, develop and inform actions to reduce the potential and actual patient harm associated with prioritised work streams.

We are therefore dedicating this to medication safety in all its forms but with an emphasis on

- Safe anticoagulation
- Safe use of insulin
- Antimicrobial stewardship (National CQUIN)
- Prompt antimicrobial administration in severe sepsis (National CQUIN and supports priority 1C)

Our aims

To improve compliance against safe and secure medicines storage standards

To reduce the preventable harm associated with medication use

To improve the quantity and quality of medication incident reports in collaboration with the clinical areas

Monitoring and reporting

- Monthly updates to the Medicines Management and Therapeutics Committee (MMTC)
- Safe and secure medicines audits reported to Clinical Effectiveness Committee (CEC), monthly compliance on key aspects included in Divisional Quality report for the Clinical Governance Committee (CGC).
- Preventable harm; quantity and quality of incident reporting to be monitored by Medication Safety and project groups against progress of improvement plans
- Regular reports to the Clinical Governance Committee (CGC) and from there to the Quality Committees.

Goal	Target	Measure	Plan
To improve compliance with the safe and secure medicine standards	100% compliance and if required an action plan to address any non-compliance	Annual audits of all clinical areas	Divisions to monitor and report against actions plans. Clinical areas to incorporate standards into matron's rounds to be used as part of a Quality improvement program. Monitored by CGC
To increase the	15% increase	Number of reported	Awareness raising and training

Goal	Target	Measure	Plan
number of medication incidents reported (indicative of an open and learning culture)		medication incidents measured by data extracted from local incident reporting system	about the importance of incident reporting and sharing lesson learnt from actions taken as a result of reporting. Aligns with broader trust wide work on continually improving our safety culture
To reduce the proportion of medication incident reported and graded as moderate or above in severity.	10% reduction overall, 20% reduction with insulin, anticoagulation, antimicrobial and omitted or delayed administration of essential medicines.	Percentage of reported medication incidents that are harmful as measured by data extracted from local incident reporting system	Safety and projects groups' improvement plans will change practice where successful. This will be represented by a reduction inpatient harm which will be greatest in the prioritized areas.

<u>Priority 1B:</u> Improved recognition, prevention and management of patients with Acute Kidney Injury (AKI)

Why we chose this

AKI is a sudden deterioration in kidney function previously known as acute renal failure. It is not an actual physical injury and usually occurs without symptoms. Many patients are vulnerable to AKI: those with acute, severe illnesses; patients who have been admitted to hospital as an emergency; those who already have chronic kidney disease or other chronic conditions such as diabetes; and elderly patients. AKI also exacerbates the severity of other conditions, increasing the length of time spent in hospital and the risk of death. This priority has been chosen to improve care proactively, and save lives.

In late 2014, NHS England selected AKI as a national quality improvement project, and launched a national campaign ('THINK KIDNEYS') to raise awareness, develop educational materials and improve care. AKI is also a project within the Patient Safety Collaborative [(1)] launched by the Oxford Academic Health Science Network (OxAHSN) in October 2014.

In line with this, AKI was a quality priority in 2015-16. During this past year, we have undertaken a baseline Trust wide audit, developed an AKI care bundle, to improve the management of patients with AKI; developed online educational resources together with a programme of seminars in key clinical areas; and we are launching an automated electronic alerting system to proactively flag up AKI to practitioners.

Our aims

To continue the work undertaken in 2015-16 as follows:

- To develop a medication review tool to facilitate pharmacist review of medications for patients with AKI
- To undertake audit of the management of AKI
- To monitor patients who have alerted with AKI, ensuring that such patients consistently receive appropriate high quality clinical care, and facilitating specialist review if need
- To ensure efficient and clear communication with primary care for patients who have suffered AKI
- To continue to develop and provide Trust wide education about AKI
- To work with OxAHSN to share learning and improve quality in our region as well as to undertake benchmarking against other local Trusts
- To work with primary care colleagues to launch an electronic alerting system for AKI in primary care, together with a care bundle and educational materials for facilitating the primary care management of AKI, in the hope of avoiding unnecessary hospital admissions.

To successfully deliver this ambitious programme we will establish a multidisciplinary OUH AKI clinical team to oversee this work.

Goal	Target	Measure	Plan
Development of Trust wide education on AKI	Non-medical health professionals	Education program in place	Leadership of AKI group to develop education program in collaboration with Quality Improvement nurse educators
Improve communication with primary care for patients who have suffered AKI	To include AKI 2/3 flags in discharge summaries	Review of discharge summaries	ICT sub-work stream to evolve system to populate summaries with AKI flags
Pharmacy review of medication in patients with AKI	Increase early review of medication in AKI	Medication review tool in EPR	ICT sub-work stream
Work with primary care colleagues to improve management of AKI in primary care	Admission avoidance	Roll out of electronic alert and use of AKI care bundle in primary care	Shared group with primary care

Monitoring and reporting

- Audit reports to the Clinical Effectiveness Committee and onwards to Clinical Governance Committee and from there to the Quality Committee.
- Review of AKI processes within AKI multidisciplinary team, when it has been established.

Priority 1C: Identification and early treatment of Sepsis

Why we chose this priority

Sepsis is a common and potentially life-threatening condition whereby severe infection triggers widespread inflammation, swelling and organ failure. In the UK it is estimated that around 44,000 deaths are caused by sepsis each year. Some of these deaths may be prevented by early recognition and antibiotic treatment.

In September 2014 NHS England issued a National Patient Safety Alert to support the prompt recognition of sepsis and the rapid initiation of treatment. All Trusts are required to comply with this notice. NHS England has also selected sepsis for national quality improvement work.

Our aims

- Implement a sepsis care bundle to ensure prompt recognition and treatment of sepsis.
- Provide an oversight structure to provide senior leadership and supervision.

Goal	Target	Measure	Plan
Prompt recognition of sepsis	Standardized screening for sepsis across the Trust	We will audit the clinical records of patients eligible for screening.	We will strengthen systems and develop training for sepsis screening using standardized screening tools.
Prompt antibiotic treatment of sepsis	Antibiotics to be administered within 1 hour of presentation with severe sepsis	We will audit the clinical records of patients with sepsis.	We will strengthen patient pathways and develop electronic tools and training to ensure prompt delivery of care bundle including antibiotics.

Monitoring and reporting

- A Sepsis Quality Group has been set up which leads the work and provides regular reports to the Clinical Governance Committee and from there to the Quality Committee.
- Performance towards each goal will be monitored by auditing patient records.
- Electronic reporting tools will be developed to monitor performance in more detail in order to inform and drive further quality improvement.

Priority 1D: Care 24/7

Why we chose this

Care 24/7 is the Trust project to implement seven day services on all of our hospital sites. It is underpinned by ten clinical standards published by NHS England in 2013 following the Francis report[1]. We have made significant improvements to how our clinical teams handover patients out of hours and have a programme to complete this work on all of our hospital sites by the end of March 2017.

NHS England has been monitoring our progress and in the autumn 2015 identified the Trust as a 'beacon site', and invited us to become an 'early implementer' meaning that we were likely to have completed the crucial areas of this work by March 2017. This work relates to four of the ten standards considered to have the highest impact on patient outcomes. They include how quickly a consultant reviews a patient after admission, how quickly a patient receives diagnostic tests, how quickly patients get interventions requested by their consultant (such as MRI) and how often a consultant reviews patients on an ongoing basis, particularly those who have been critically ill.

Our aims

- Continue to make improvements to the way clinical staff hand over care between teams 'out of hours' and ensure that critically ill patients are seen by a consultant twice a day.
- Work with clinical teams to define areas in the hospital that are high dependency.
- Carry out six monthly audits of patient records against the four priority standards as part of the national work programme. The audit data will help us identify improvements we need to make to provide seven day services.

Goal	Target	Measure	Plan
All critically ill patients will be seen and reviewed by a consultant twice daily including all acutely ill patients directly transferred, or others who deteriorate	By Q4 100% of patients in intensive and areas defined as high dependency will be reviewed by consultants twice daily.	We will measure this by six monthly audits of patient records. This data will be submitted to NHS England.	We will work with our clinical teams to define areas within the Trust as high dependency areas. Relevant Directorates will prepare action plans
Complete our program of work to implement the four critical standards by March 2017.	By March 2017 the bi-annual audits will be complete with data and actions reported to NHS England	We will measure this by six monthly audits of patient records. This data will be submitted electronically to NHS England.	An audit team will be assembled, records audited in line with the NHSE reporting schedule. Data will be used for action planning by relevant Directorates.

Monitoring and reporting

- The Care 24/7 project is monitored by the Transformation Steering Group and provides regular reports to the Clinical Governance Committee, Trust Management Executive and Commissioners.

[1] Francis Report 2013 http://www.midstaffspublicinquiry.com/report

- The work to implement the four priority standards will be reported to NHS England following the six monthly audits.

<u>Priority 1E</u>: SEND System for recording and viewing patients' vital signs
(Note project lead to sign off/amend on return from leave)

Why we chose this

Paper-based early warning chart data are prone to recording error, and can be difficult to share or use for quality improvement. The electronic SEND system is an ergonomic, intuitive, efficient, early warning scoring system where real-time data is shared in the right way, with the right people whilst minimizing recording errors.

Our aims

Designed alongside patients and clinicians, the SEND project aims to improve the recognition of deteriorating patients within the Oxford University Hospitals NHS Foundation Trust and beyond.

SEND aims to improve patient care and safety by:

Making deteriorating patients immediately visible to appropriate clinicians (the right patient, to the right clinician, at the right time)

Making information available to patients and families in a way that supports their understanding, enabling them to be actively involved in their care

Incorporating the views of patients and families into the design of the displays they will use

Improving accuracy and speed of data recording

Eliminating errors in early warning score calculation

Prompting and supporting appropriate care for each set of vital signs

Supporting clinical governance and safety auditing

SEND aims to bring the full benefits of electronic data recording, processing and review to the patient bedside. The design has been developed to aid sharing of data with clinicians and patients; it is integrated with existing clinical workflows, and will maximize staff engagement, efficiency and effectiveness.

Goal	Target	Measure	Plan
Complete planned roll out across the OUH NHS Foundation Trust	Roll out to JR Cardiac Centre and West Wing, Horton ED, NOC Centre for Enablement and Outpatient areas	Monitor progress of rolling out the system across the Trust according to the project roll out plan	The implementation team will carry out the system deployment in-line with the project roll out plan
The wards and clinicians from any location can access	Clinical staff will use the system to capture patient	Track & Trigger data is gathered to audit usage of the system	Make SEND accessible from every computer in the Trust. The wards will be receive

Goal	Target	Measure	Plan
real-time vital sign observation charts and Track & Trigger scores	observations in real-time	and provide an overview in each clinical area	SEND support during roll out
Nursing time saved recording vital signs and calculating Track and Trigger scores	Nurses can provide better patient care due to saving time when using SEND to record patients' vital signs	A research study is measuring time saved between using paper charts and SEND	Deploy the SEND system onto a stand that incorporates the vital sign monitor and the computer tablet, making it ergonomic and efficient for the clinician to use

Monitoring and reporting

- The project will report to the Planning and Information Directorate and via the RAID committee to patient safety and clinical risk committee. As a quality priority it will provide quarterly updates to the Clinical Governance Committee.

Priority 2: Human factors training

Why we chose this priority

The evidence to support human factors and quality improvement as a key element in achieving excellence in healthcare is clear. Developing expertise and training healthcare professionals in these domains leads to improvements in patient outcomes. (Morgan et al 1-4 Weaver et al 5,)

The OxSTaR (Oxford Simulation Teaching and Research) centre has an established portfolio of training incorporating simulation across the OUHFT for all healthcare professionals. This includes a one-day human factors course (which incorporates fully immersive team training in the medical simulator) and a modular programme of training materials to train "OUH Human Factors Ambassadors" to use them in their clinical areas. So far we have 49 Ambassadors who are now training using these materials in the Horton, the Women's Centre, CTCC, AICU and theatres across the OUHFT.

We can now build on the expertise within our organization and have an opportunity to develop a robust and sustainable programme of human factors, quality improvement training, and project management for all staff in the OUHFT with the clear aim of improving quality and outcomes for our patients.

Our aims

Goal	Target	Measure	Plan
To deliver human factors training incorporating simulation to healthcare professionals from all Divisions	18 one day courses	Records of attendance Qualitative feedback forms Safety Attitudes Questionnaires	One day courses to be held in OxSTaR (or in –situ where appropriate) Data to be captured through OxSTaR database
To develop a Human Factors and Quality Improvement Advisory Group and an associated strategy for quality and safety led by the Deputy MD	To deliver a human factors and QI strategy for the OUHFT with the explicit aim of building capability across the Trust and delivering a sustainable programme of quality improvement	Activity in QI in year 1. Delivery on predefined process and patient outcome objectives in year 2	Develop expert group with monthly/bimonthly meetings and agenda for QI project development, coordinating and collaborating with the Transformation Team and other QI activity around the organisation
To deliver train the trainer courses to build capability and sustainability in human factors training across the OUHFT	4 one day ambassador courses to train an additional 50 trainers	Records of attendance Qualitative feedback forms Records of staff trained by HF Ambassadors	One day courses to be offered to all Divisions and held in OxSTaR Data to be captured through OxSTaR database

Goal	Target	Measure	Plan
To deliver training in quality improvement for healthcare professionals and managers from all Divisions	One day HF/QI training	Records of attendance Qualitative feedback forms Records of QI projects initiated after training	One day courses offered by the Patient Safety Academy Data to be captured through OxSTaR database

Goals

To deliver human factors training incorporating simulation to healthcare professionals from all Divisions.

To develop an advisory Human Factors-led Quality Improvement unit which can work with existing departments to develop HF-based solutions to patient safety and care quality problems.

To deliver train the trainer courses to build capability and sustainability in human factors training across OUHFT.

To deliver training in quality improvement for healthcare professionals and managers from all Divisions.

1: Morgan L, et al combined teamwork training and work standardisation intervention in operating theatres: controlled interrupted time series study. BMJ Qual Saf. 2015 Feb;24(2):111-9. doi: 10.1136/bmjqs-2014-003204. Epub 2014 Jul 22. PubMed PMID: 25053827.

2: Morgan L et al Effectiveness of facilitated introduction of a standard operating procedure into routine processes in the operating theatre: a controlled interrupted time series. BMJ Qual Saf. 2015 Feb;24(2):120-7. doi: 10.1136/bmjqs-2014-003158. Epub 2014 Nov 3. PubMed PMID: 25368320.

3: Morgan L, et al. The effect of teamwork training on team performance and clinical outcome in elective orthopaedic surgery: a controlled interrupted time series study. BMJ Open. 2015 Apr 20;5(4):e006216. doi: 10.1136/bmjopen-2014-006216. PubMed PMID: 25897025; PubMed Central PMCID: PMC4410121.

4: Robertson E, Morgan L et al Quality Improvement in Surgery Combining Lean Improvement Methods with Teamwork Training: A Controlled Before-After Study. PLoS One. 2015 Sep 18;10(9):e0138490. doi: 10.1371/journal.pone.0138490. eCollection 2015. PubMed PMID: 26381643; PubMed Central PMCID: PMC4575036.

5: Weaver Sj et al. Team-training in healthcare: a narrative synthesis of the literature. BMJ Qual Saf 2014;0:1–14. doi:10.1136/bmjqs-2013-001848

Priority 3: End of life: improving people's care in the last few days and hours of life

Why we chose this priority

The end of life and the time leading up to it are profound and often traumatic experiences, when patients and their families are at their most vulnerable. Our care of families at the start of their bereavement is an important extension of our care for our patients.

During 2015 we have developed our End of life Care strategy around the principles of the 'One Chance to get it Right'[2] report. This document describes the high-level outcomes that must be delivered for every dying person.

Although our end of life care was rated as good by the CQC, the National Care of the Dying Audit revealed that we could do better.

Our strategy as an organisation is based on five priorities: Recognise Communicate, Involve, Support and Plan and Do.

This will ensure that the possibility that a person may die within the coming days and hours is recognised and communicated clearly, decisions about care are made in accordance with the person's needs and wishes, and these are reviewed and revised regularly by doctors and nurses.
Sensitive communication should take place between staff and the person who is dying and those important to them. The dying person, and those identified as important to them, should be involved in decisions about treatment and care. The people important to the dying person should be listened to and their needs are respected.
Care should be tailored to the individual and delivered with compassion – with an individual care plan in place.

Our aims for 2016/17

- Improve the care we are delivering directly to patients and families. Using the resources funded by Sobell House Hospice Charity by September 2016 we will deliver enhanced care to dying patients

[2] *One Chance to Get it Right*. Produced by the Leadership Alliance for the Care of Dying People, June 2014 and published by the Department of Health.
www.gov.uk/government/uploads/system/uploads/attachment_data/file/323188/One_chance_to_get_it_right.pdf

- Seek feedback from every bereaved family to understand how and where we could improve quality of care for the patient and their family
- The Swan Scheme is a program of support for bereaved families. Small pragmatic elements such as ensuring personal items are respectfully handled, supporting families through the end stages of life are explicitly demonstrated. The Trust has commenced the program in Acute General Medicine and this will be rolled out Trust wide. Provide anticipatory drugs for all dying patients on their discharge
- Work with OCCG and Oxford Health to improve care when a dying patient is being discharged

Monitoring and reporting

The End of Life Care Group, chaired by the Medical Director, will oversee the work plan. This group includes representation from OCCG and Oxford Health.

Meeting notes are reviewed by the Clinical Governance Committee. Updates are reported to the Quality Committee and Trust Board.

Goal	Target	Measure	Plan
Additional palliative care provided in ED and EAUs	Palliative care staffed to provide daily rounds in ED and EAU	Staff in place Daily rounds 7/7	Commence implementation September 2016
Improved feedback from families	95% of families offered a feedback form	Bereavement service audit	Training and support to ensure feedback forms, distributed, collated and improvements follow
Swan scheme in place	Symbol Known to and understood by all staff	Swan boxes ordered and in use	Chief nurse leading implementation group
Improved staff confidence, skills and knowledge	75% of staff have undertaken e-learning training	Metrics on target	Group to design and make available e-learning through learning and development
Anticipatory medication	95% of patients have on discharge	Audit of notes and TTOs	Group to provide education, and audit of sample of notes
Joint work on discharge	Understanding blocks to discharges	Paper on understanding issues	

Priority 4: Dementia Care

Why we chose this priority

Oxford University Hospitals NHS Foundation Trust is committed to providing an excellent standard of care for all patients but particularly those that are vulnerable and frail.
The Trust will build upon its core values of delivering compassionate excellence in the care provided to patients with dementia and cognitive impairment. The goals detailed below link in with the Trust Dementia Strategy which details the Trust's objectives with respect to dementia care. This is aligned with national dementia guidance and Oxfordshire's Joint Health and Well Being Strategy 2012 – 2016.

Key elements of the Trust's strategy include: Early assessment using the modified FAIR model (Find, Assess, Investigate & Refer); Implementation of personalised care, through the promotion of appropriate and useful resources as well as 'expert' staff. Increased leadership, support and education through Dementia Leads and Dementia Champions; Education of staff within the Trust on Dementia Awareness; Information and support for Carers working with local agencies to provide information that will support people in and outside of hospital; and developing Dementia Friendly Environments.

Our aims

- To cognitively assess patients over 75 on admission and to support Carers. This will be achieved through the training of more staff in completing the appropriate cognitive screening tools and through the introduction of Carers information booklets and questionnaires. This would involve working with Oxfordshire Carers.
- To develop training that meets not only the set objectives of the National Framework but also the needs of staff. This would include packages of training that would focus of key topics, such as behaviour that challenges, Mental Capacity Act and Deprivation of Liberty.

Monitoring and reporting

Goal	Target	Measure	Plan
Dementia data reviews	90% of patients aged 75 years and over screened for dementia	Monthly reports	To provide support and education to staff.
To promote a positive experience for patients living with dementia and their Carers during any engagement with hospital services.	Improvement in qualitative feedback	Qualitative data from Oxfordshire Carers 1:1 sessions, F&F Test and the implementation of a new Carers questionnaire within patient information packs.	To provide support and information to people living with dementia and their Carers through the implementation of resources that are current, relevant and appropriate that include information about the hospital, it's current initiatives and feedback options.
To promote dementia awareness via training to	75%	Quarterly review of training records	To implement training for staff, about Dementia Awareness and

Goal	Target	Measure	Plan
relevant staff within the hospital			encouraging staff to become Dementia Friends.
To enhance the current knowledge and understanding of Dementia through appropriate training to all relevant staff.	Training of 50% of frontline staff	Training package in place and accessible to staff	To develop training and resources that will empower staff in managing complex and sometimes difficult cases, whilst implementing evidence based best practice

Priority 5: Patient experience and the compassionate care program

Why we chose this priority

The Compassionate Care programme

The purpose of this programme is to promote compassionate care as a core component of patient and carer experience and the delivery of compassionate excellence.

This programme will support the implementation of the Trust's Values into Action.

The compassionate care programme will have five elements

- Team based customer care training to
- E-Learning or film introduction to customer care
- Person centred care and dignity campaign
- Implementing the recommendations of the Trust's Complaints review to deliver a responsive, sensitive and humane complaints process based on early resolution of patients and relatives concerns and complaints. This will include
    - People contacting PALS and Complaints to be given the opportunity to tell their story to aid local and organisational learning as an option
    - Training and support for investigators to resolve concerns at an early stage. This training will be delivered by the Patient's Association and will involve patients.

Our aims

- To provide classroom training sessions for 1500 frontline staff on 'Delivering Compassionate Care'; increasing staff confidence and implementing compassionate excellence into interactions with patients, carers and colleagues.
- To evaluate the outcomes of learning leading to longer term behaviour and attitude change of frontline staff; measuring confidence in responding to concerns and implementing compassionate excellence into their interactions.
- To provide e-Learning training accessible to all staff on concepts underpinning 'Delivering Compassionate Care'; increasing staff awareness of compassionate excellence.

Monitoring and reporting

Goal	Target	Measure	Plan
To provide classroom training sessions for 1500 frontline staff on 'Delivering Compassionate Care'	1500 staff attend classroom sessions in 2016/2017 financial year.	95% of attendees provide a '*satisfied* to *very satisfied*' rating of their response to the classroom session.	Three training sessions per week provided for circa 30 staff.
To evaluate the outcomes of learning leading to longer term behaviour and attitude change of frontline staff.	50% of attendees complete evaluation 3-6 months post-training in 2016/2017 financial year.	90% of attendees note significant increases in the effect awareness of behaviour has on patient experience	Quarterly surveys to attendees measuring training outcomes.
To provide e-Learning training accessible to	1500 staff access and complete e-	95% of attendees provide a '*satisfied*	Launch of online modules by August 2016 with circulation

Goal	Target	Measure	Plan
all staff on concepts underpinning 'Delivering Compassionate Care'	Learning Package sessions in 2016/2017.	to *very satisfied*' rating of their response to the e-learning package.	through OUH.

Monitoring and reporting

- Quarterly reporting on progress against goal to Workforce Committee and Trust Board.

Priority 6: Stake holder engagement and partnership working

Why we chose this priority

In 2015/16, particularly since becoming a Foundation Trust OUHFT has prioritised working across the healthcare system with partners and stakeholders. Improving the interface between the hospital and general practice for each episode of patient care also continues to be an area that we wish to improve upon. Although we have undertaken considerable work to improve our responsiveness to a number of issues raised by GPs about the interface between GP and hospital, we recognise there are still substantial improvements that need to be made.

Aims

- To maximize the benefits to patients from taking a whole system approach to our strategy including Oxford University, our commissioners, other Trusts, Oxford Academic Health Science Network and stakeholders.
- To improve our interface with general practice by continuing to work on rapid electronic distribution of discharge summaries.

Goal	Target	Measure	Plan
To involve stake holders in future strategy	Work collaboratively as a healthcare system across Oxfordshire	Progress of strategic objectives in the Sustainability and Transformation Plan (STP)	To collaborate with the wider system stakeholders to design the Sustainability and Transformation Plan
To improve communication of patient information to primary care colleagues	To deliver 98% all e-discharge summaries to primary care colleagues within 24 hours of discharge	E-messaging of discharge summaries	To work with Divisions and Directorates via performance review meetings to monitor and share best practice in completing discharge summaries
To improve assurance that all test results have been acted upon	To endorse 95% of test results on EPR within 7 working days	Endorsement of results on EPR	To work with Divisions and Directorates via performance review meetings to monitor and share best practice in endorsing results
Progress system wide improvement in quality of care	Deliver aims of the delayed transfers of care (DToC) program	Patients cared for in the right place	•The continued use of beds in care homes for intermediate care •The implementation of a single system across health and social care for the management of post acute patients •Increased domiciliary care capacity to enable patients to return home when they are medically fit to be discharged.

Monitoring and reporting

These test results and discharge summaries results will be reported by Divisions to the Clinical Governance Committee and via the Quality report to the Board. Numbers of patients whose transfer of care has been delayed are reported to the board and the wider health system. Progress of the STP plan will be monitored at the STP board.

Statements of assurance from the Board of Directors

A review of our services

- During 2015/16 the Oxford University Hospitals NHS Foundation Trust provided and sub-contracted 141 NHS services.

- The OUHFT has reviewed all the available data on the quality of care in all of these relevant health services. Services review indicators of quality using dashboards, scorecards and reports so that their performance can be analysed on a monthly basis. This enables services to identify priorities and actions needed to deliver improvements.

- The income generated by the relevant health services reviewed in 2015/16 represents 100 per cent of the total income generated from the provision of relevant health services by the Oxford University Hospitals NHS Foundation Trust for 2015/16.

Participation in clinical audits and National Confidential Enquiries

During 2015/16, 45 national clinical audits and four confidential enquiries covered relevant health services provided by Oxford University Hospitals NHS Foundation Trust. In 2015/16, we took part in all of the national clinical audits and the four national confidential enquiries. By doing so we participated in 100% of national clinical audits and 100% of National Confidential Enquiries in which we were entitled to participate.

The national clinical audits and National Confidential Enquiries that we were eligible to participate in during 2015/16 are shown in the table on the following pages, together with those that we participated in and for which data collection was completed during 2015/16. The information provided also includes the percentage of registered cases submitted to each audit required by the terms of that audit or enquiry.

Participation in national clinical audits 2015/16

National Clinical Audit & Enquiry Project name	Work stream / Component (if more than one)	OUHFT Participation	Percentage of cases submitted
Child Health Clinical Outcome Review Programme	Chronic Neurodisability	Not collecting data in 2015-16	N/A New project
	Young People's Mental Health	Not collecting data in 2015-16	N/A New project
Maternal, New-born and Infant Clinical Outcome Review Programme	Perinatal Mortality Surveillance	Yes	100%
	Perinatal Mortality Surveillance	Yes	100%
	Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths)	Yes	100%
	Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths)	Yes	100%
	Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity) early pregnancy deaths and pre-eclampsia, plus psychiatric morbidity)	Yes	100%
	Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity) early pregnancy deaths and pre-eclampsia, plus psychiatric morbidity)	Not collecting data in 2015-16	NA
	Maternal mortality surveillance	Yes	100%
	Maternal mortality surveillance	Yes	100%
National Diabetes Audit - Adults	National Pregnancy in Diabetes Audit	Yes	100%
Diabetes (Paediatric) National Paediatric Diabetes Audit (NPDA)		Yes	Data collection in progress

Inflammatory Bowel Disease (IBD) programme (JR)	Inpatient care and experience - Children	Yes	JR 100%
Inflammatory Bowel Disease (IBD) programme	Biologics - Children	Yes	JR 100%
Neonatal Intensive and Special Care (NNAP)		Yes	JR -100%
Neonatal Intensive and Special Care (NNAP)		Yes	HG -100%
Paediatric Asthma		Yes	JR- 100%
Paediatric Asthma		Yes	HG- 100%
Paediatric Intensive Care (PICANet)		Yes	100%
UK Cystic Fibrosis Registry	Paediatric	Yes	98%
National Bowel Cancer Audit Project (NBOCAP)	Diagnostic/ Surgery/ Oncology	Yes	58.50%
Elective Surgery (National Patient Reported Outcome Measures (PROMs) Programme)		Yes	JR and HG 54%
Elective Surgery (National PROMs Programme)		Yes	
Inflammatory Bowel Disease (IBD) programme	Inpatient care and experience - Adult	Yes	JR- 0%
Inflammatory Bowel Disease (IBD) programme	Biologics - Adult	Yes	JR and HG 100%
Medical and Surgical Clinical Outcome Review Programme	Acute Pancreatitis (Organisational Questionnaire)	Yes	100%
Medical and Surgical Clinical Outcome Review Programme	Acute Pancreatitis (Clinical Questionnaires (Q) and Casenotes (C))	Yes	Clinical Q 45% Casenotes 18%
Medical and Surgical Clinical Outcome Review Programme	Physical and mental health care of mental health patients in acute hospitals	Yes	33%
National Complicated Diverticulitis Audit (CAD)	Acute surgical services	Yes	100%
National Emergency Laparotomy Audit (NELA)	Acute surgical services	Yes	JR- 41%
National Emergency Laparotomy Audit (NELA)	Acute surgical services	Not collecting data in 2015-16	CH- N/A
National Prostate Cancer Audit	Diagnostic/Urology/Oncology	Yes	93.84%
National Oesophago-gastric Cancer Audit (NAOGC)	Diagnostic / Surgical and Oncology	Yes	69%
Renal Replacement Therapy (Renal Registry)	Renal services (nephrology)	Yes	93%

Case Mix Programme (CMP)		Yes	100%
National Cardiac Arrest Audit (NCAA) JR		Yes	82%
National Cardiac Arrest Audit (NCAA) CHU		Yes	85%
National Cardiac Arrest Audit (NCAA) HGH		Yes	65%
Case Mix Programme (CMP)		Yes	100%
Child Health Clinical Outcome Review Programme	Chronic Neurodisability	Not collecting data in 2015-16	N/A New project
Elective Surgery (National PROMs Programme)		Yes	awaiting information
Elective Surgery (National PROMs Programme)		Yes	97.88%
Falls and Fragility Fractures Audit programme (FFFAP)	National Hip Fracture Database	Yes	100%
Major Trauma Audit		Yes	100%
Medical and Surgical Clinical Outcome Review Programme	Physical and mental health care of mental health patients in acute hospitals	Yes	0%
National Joint Registry (NJR)	Knee replacement	Yes	Data analysing in progress
National Joint Registry (NJR)	Hip replacement	Yes	Data analysing in progress
National Ophthalmology Audit	Adult Cataract surgery	Yes	Data collection in progress
National Vascular Registry		Yes	Data collection in progress
Rheumatoid and Early Inflammatory Arthritis	Clinician/Patient Follow-up	Yes	100%
Rheumatoid and Early Inflammatory Arthritis	Clinician/Patient Baseline	Yes	100%
Falls and Fragility Fractures Audit programme (FFFAP)	Fracture Liaison Service Database	Yes	Data collection in progress
Falls and Fragility Fractures Audit programme (FFFAP)	Inpatient Falls	Yes	100%
Falls and Fragility Fractures Audit programme (FFFAP)	National Hip Fracture Database	Yes	100%
Medical and Surgical Clinical Outcome Review Programme	Physical and mental health care of mental health patients in acute hospitals	Yes	40%
National Audit of Intermediate Care		Yes	100%
Procedural Sedation in Adults (care in emergency departments)		Yes	100%
Sentinel Stroke National Audit programme (SSNAP)		Yes	100%
Sentinel Stroke National Audit programme (SSNAP)		Yes	100%

UK Parkinson's Audit	Occupational Therapy	No - Service did not register	0%
UK Parkinson's Audit	Speech and Language Therapy	No- Service did not register	0%
UK Parkinson's Audit	Physiotherapy	Yes	0% Not enough eligible patients
UK Parkinson's Audit	Patient Management, elderly care and neurology	Yes	100%
Vital signs in children (care in emergency departments)		Yes	100%
Venous Thromboembolism, VTE risk in lower limb immobilisation (care in emergency departments)		Yes	100%
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)		Yes	Data collection in progress
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)		Yes	Data collection in progress
Adult Cardiac Surgery		Yes	100%
Cardiac Rhythm Management (CRM)		Yes	Data collection in progress
Case Mix Programme (CMP)		No	0 The Philips carevue system does not currently support Cardiothoracic data relating to this audit.
Congenital Heart Disease (CHD)	Adult	Yes	100%
Coronary Angioplasty / National Audit of Percutaneous Coronary Interventions (PCI)		Yes	100%
National Audit of Pulmonary Hypertension	National outcomes and tertiary care	Not eligible	OUHFT patients with PHT are referred to other centres. OUHFT data forms part of that centre's submission to the National Audit
National Heart Failure Audit		Yes	Data collection in progress
National Heart Failure Audit		Yes	Data collection in progress

Adult Asthma		Not collecting data in 2015-16	N/A
Emergency Use of Oxygen		Yes	100%
National Audit of Pulmonary Hypertension	National outcomes and tertiary care	Not eligible	N/A
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	Pulmonary rehabilitation	Not eligible	N/A
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	Secondary Care	Not collecting data in 2015-16	N/A
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	Primary Care (Data collection limited to Wales)	Not eligible	N/A
National Lung Cancer Audit (NLCA)	Lung Cancer Consultant Outcomes Publication	Yes	88%
Non-Invasive Ventilation - Adults		Not collecting data in 2015-16	N/A
UK Cystic Fibrosis Registry	Adult	Yes	100%
National Diabetes Audit - Adults	National Foot care Audit	Yes	awaiting information
National Diabetes Audit - Adults	National Inpatient Audit	Yes	100%
National Diabetes Audit - Adults	National Diabetes Transition	Not collecting data in 2015/2016	N/A New project
National Diabetes Audit - Adults	National Core	Yes	Data collection in progress
Use of blood in Haematology		Yes	94%
NHS Blood and Transplant (NHSBT) 2015 Audit of Lower GI Bleeding and the use of blood		Yes	100%
Audit of patient blood Management in scheduled surgery		Yes	78%

NCEPOD – Quality Accounts summary 2015/2016

NCEPOD is a study in which currently practising clinicians review the management of patients undergoing medical and surgical care by undertaking confidential surveys and reviewing care provision and resources in the units carrying out the care.
Method of collection –
A sample size of cases will be identified using a data collection spreadsheet meeting the study inclusion criteria. A clinical questionnaire will be sent to the consultant who was responsible for the patient's care at the time of discharge and the photocopies of the case notes of each included patient will be requested at the time of questionnaire dissemination. Following which an Organisational questionnaire collecting information regarding facilities, equipment, policies and guidelines relevant to the management of patients will be sent to the relevant Service leads to be completed accurately.

During 2015/16 hospitals were eligible to enter data into 4 NCEPOD studies. Please find below a summary for those studies in which Oxford University Hospitals NHS Foundation Trust participated.

NCEPOD studies in 2015/16	Sites participating	Clinical Questionnaire returned	Case notes returned	Organisational questionnaire returned
Physical and mental health care of mental health patients in acute hospitals (This study is still open and the figures have not been finalised)	John Radcliffe (JR), Nuffield Orthopaedic Center (NOC), Horton General Hospital (HG), Churchill Hospital (CH)	9 out of 21 questionnaires returned 43%	8 out of 21 case notes returned 38%	Expected 4 questionnaires to be returned in progress
Acute Pancreatitis	CH, HG, JR	5 out of 13 questionnaire returned 38%	2 out of 13 case notes returned 15%	3 out of 3 questionnaires returned 100%
Sepsis	JR, CH, HG	2 out of 11 questionnaires returned 18%	2 out of 11 case notes returned 18%	0 out of 3 questionnaires returned 0%
Gastrointestinal Haemorrhage	JR, CH, HG, NOC	6 out of 7 questionnaires returned 86%	5 out of 7 case notes returned 71%	2 out of 4 questionnaires returned 50%

The reports of 40 national clinical audits were reviewed during 2015/16 and Oxford University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of the healthcare we provide:

British Thoracic Society (BTS) Emergency Use of Oxygen	There is an EPR development underway to create a task for oxygen prescription. Work is underway to embed an online training tool from BTS into the mandatory training program.
UK Cystic Fibrosis Registry	The proportion of patients receiving DNase therapy has risen from ~ 45% in 2013 to 52% in 2014. The centre is actively working towards increasing rates of prescription of this drug amongst attending patients.
Inflammatory Bowel Disease (IBD) programme Adult	OUHFT is leading on a global initiative to develop internationally agreed PROMs for IBD.
Inflammatory Bowel Disease (IBD) programme Paediatrics	A designated specialist nurse practitioner is leading on the action to improve the completion of patient-reported outcome measures (PROMs).
National Joint Registry (NJR)	A Trauma Consultant has been proactively reminding surgeons to input their data to NJR and the need to obtain patient's consent for inclusion in NJR which requires improvement. The data entry process at the Horton needs to be reviewed to improve link-ability via the NHS number.
Paediatric Intensive Care Audit Network (PICANet)	There is an active recruitment and retention programme underway to achieve the designated 7.01 nurses per paediatric critical care bed.
Diabetes (Adult) - national pregnancy in diabetes	The use of pre-conceptual folic acid by women with pre-existing diabetes is being reviewed by the Audit Lead.
National Adult Cardiac Surgery Audit (including 2015-2016 consultant outcomes publication, pub 8/9/2015)	The audit findings were that OUHFT cardiac surgeons performed 2456 operations with an overall survival rate of 97.34%. The data shows very good/excellent surgeon-specific performance by all the surgeons. The report indicated that the OUHFT surgeons have performed significantly more operations during this 3 year period (range 452 - 506) than the national average of 334 per surgeon.
Neonatal Intensive and Special Care (NNAP)	The JR Unit was below average for Retinopathy of Prematurity (ROP) screening but demonstrated continued improvement over the last 4 years. The Unit are continuing with close monitoring of ROP screening. A marked improvement in the completion of 2 year follow up data entry was noted with the JR now having one of the highest rates in the country. The Unit are currently auditing practise to determine whether an improvement can be made in the number of babies admitted with a temperature <36.5ºC. The HGH Unit scored particularly well in ROP screening, babies receiving mother's milk at discharge, infection rate, information given to parents by medical staff and the completion of 2 year follow up data.
Cardiac Rhythm Management (CRM) Ablation Audit	The Unit advised that while data completeness was good it has been identified that all procedures had not been reported. This joint issue was advised to be common to many centres and the database is being replaced.

Major Trauma: The Trauma Audit & Research Network (TARN)	There has been an increase in plastic surgeon and theatre availability to ensure soft tissue cover for open fractures within 72hrs, improve consultant review of cases with an Injury Severity Score >15 and recruit a clinical lead for acute trauma rehabilitation.
Major Trauma: The Trauma Audit & Research Network (TARN)	The Service advised that there has been improved anaesthetic cover implemented since February 2015.
Royal College of Emergency Medicine (CEM) Moderate or severe asthma in children (care provided in emergency departments)	The low update of peak flow meter usage in children was identified as a weakness in the service. This has been addressed by the purchase of new meters thereby increasing availability and use.
CEM Paracetamol overdose	There is difficulty interpreting the results of the audit due to the need to analysis subgroups, however the services recognised the drop in overall compliance and have already put changes in place to improve care.
CEM Fitting child (care in emergency departments)	The resultant actions are for the Service to re-inforce the standards for management and documentation with junior staff and upload the Patient Information Leaflet to the Intranet for ease of access by staff.
CEM Mental health (care in emergency departments)	The audit identified a requirement for a mental health assessment room at HGH.
CEM Older people (care in emergency departments)	The audit recommended the need for the incorporation of cognitive screening into EPR which is underway.
Diabetes (Paediatric) (NPDA) 2013/14	The quality of the service is in line with national average; however the data reported by the centre is not in line with that reported internally. The Trust is in discussion with the audit centre to understand the discrepancies
Diabetes (Paediatric) (NPDA) 2013/15	This annual audit has highlighted that there continue to be delays in the outpatient services. It is anticipated that the appointment of a new consultant in April 2016 will improve the waiting times
Case Mix Programme (CMP) 2013/14 Annual Quality Report	A Trust-wide strategy for the development of adult critical care services was accepted in 2015. This is being implemented and will address the mismatch by opening more critical care beds, both in terms of staffed beds and physical bed spaces and then moving on to build a new adult intensive care and high dependency units. In the future, audit of outcomes and process will be integrated across the OUHFT's adult critical care services.
National Emergency Laparotomy Audit (NELA)	The National Emergency Laparotomy Audit (report published June 2015) has highlighted that there is a flaw in the method of analysing data. When re-analysed the arrival in theatre in timescale appropriate to urgency rose from 72% to 91%. The Trust action plan has been amended and the key actions from the audit are: • increasing the number of critical care beds and developing a new high dependency unit to address the lack of availability of post-operative critical care beds, • improve timely CT scan reporting by consultant radiologists by reviewing the consultant radiologist's availability • Ensuring availability of a consultant surgeon and a consultant anaesthetist (e.g. by freeing the consultant surgeon from ward round duties and establishment of a resident consultant anaesthetist during weekends) so that the patients are reviewed preoperatively by both the consultants.

National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - Secondary care work stream - national clinical audit report	Access to respiratory specialist expertise for COPD falls short of NICE Quality Standards recommendations. The service is part provided by Oxford Health OHFT and OUH and a business case to increase the establishment has been submitted, for recruitment in 2015/16. A quality strategy has been developed to resolve all outstanding issues
Elective surgery (National PROMs Programme) Groin Hernia	The Unit reported patient satisfaction rates of more than 90%. All patients reported that they returned to their previous level of physical activity. There were 53 patients identified to have been readmitted. The Unit are reviewing the records of these patients to determine if the readmission was related to the procedure.
BTS Pleural Procedure	The audit did not include activity at the Horton which has been agreed to be included in the next year.
Sentinel Stroke National Audit Programme (SSNAP)	The JR is due to conduct a stroke 'perfect week' to determine the barriers to flow through the pathway. There is on-going review of the Oxfordshire stroke pathway with the Oxfordshire CCG (OCCG), OHFT and other stakeholders. Horton General Hospital (HGH) advised that the key actions were to improve audit compliance by capturing relevant data on "stroke initial review form" and increasing consultant / registrar input to data entry process. HGH is awaiting the Horton Acute medicine review.
BTS Adult Community Acquired Pneumonia	The audit highlighted that improvement was required in compliance with local antibiotic prescribing guidelines. The resultant action is the implementation of the pneumonia care bundle. The care bundle is currently in use in the Emergency Department. The action is to extend use to Acute General Medicine and a recommendation for Trust wide implementation. The audit findings were to be further discussed at the John Radcliffe Acute General Medicine and Horton Medicine clinical governance meetings to increase awareness of early chest X-ray and antibiotic administration. It was recommended that patients with severe pneumonia admitted under non-Respiratory specialists should be discussed early (within 24 hours) with a member of the Respiratory team.
Bowel cancer NBOCAP (including 2015-2016 Consultant Outcome Publication)	The OUHFT adjusted 90 day mortality for elective colorectal cancer was 1.2% compared to 3.9% nationally. The Trust is a noted leading centre in laparoscopic surgery with rates of 84% compared to 57% nationally.
Congenital Heart Disease (Paediatric cardiac surgery) CHD - Adult service only	The Service is compliant with the required Data Quality Indicator for adult congenital heart disease.
National Head and Neck Oncology Audit (DAHNO)	The service have agreed actions to improve the data capture for biopsy reporting interval and for dietetic assessment pre-treatment and to improve the prioritisation and capacity for dental assessments.
National Oesophago-Gastric Cancer Audit Association of Upper Gastrointestinal Surgeons (AUGIS) - Consultant Outcome Publication	The 30-day and 90-day postoperative mortality were within the acceptable range and clinical activity was noted as satisfactory.

2014-2015	
National Vascular Registry	The multi-disciplinary team (MDT) co-ordinator has been designated to improve case ascertainment which is currently below the national average. The formation of a carotid MDT is under consideration by the Unit.
Falls and Fragility Fractures Audit Programme (FFFAP): National Audit of Falls	The audit results led the falls prevention Group to suggest the review of the Falls Prevention Policy, integration of risk assessments and falls prevention care plans in the electronic patient record (EPR) and continued roll-out of the Fall Safe Care Bundle will improve compliance with the standards. These actions are underway and monitored by the OUHFT Falls Prevention Group.
Falls and Fragility Fractures Audit Programme (FFFAP): National Hip Fracture Database	The audit found that the 30 day mortality post hip fracture has reduced significantly over the audit period compared to previous in accordance with the national average. The Horton Hospital (HGH) have reported that no patients developed pressure ulcers (reported if Grade 2 or above) during their stay. The HGH has maintained the Best Practice Tariff (BPT) standards and retained their position of 4th Nationally, highest achievement for meeting all of the BPT criteria. The length of stay has reduced at the Horton considered to be as a result of the care provided within the standards set out by the BPT and the KPIs that are reported monthly. The JR has improved on all metrics pertaining to Orthogeriatric medicine and the nursing staff should be commended on the care provided to reduce the rates of pressure ulcers sustained. The proportion of patients achieving BPT standards has improved. The JR has been identified as an outlier for reoperation within 30 days (2.7%). The service advises that actions have been implemented to reduce wound infection and the need for reoperation. A 'wound care protocol' after hip surgery is now in place and 'an oozy wound' protocol is to be added onto the Trauma intranet home page.
NCEPOD Severe gastrointestinal haemorrhage	The audit highlighted further work to ensure comparable equipment and nursing support across OUHFT sites and establish regular multi-disciplinary review process for all deaths within 30 days due to GI bleeding with regular audit of documentation of re-bleed plans and reviewing the local pathway.
NCEPOD Sepsis	The Trust has now appointed a Sepsis Lead who is has established a Sepsis Working Group (SWG). The OUHFT Sepsis Pathway has now been developed with further emphasis on Sepsis Training. The Trust is reviewing serious incidents related to sepsis management to identify care gaps and opportunities for improvement.
Interventional Cardiology, 2015 COP (1 Jan 2012 – 31 Dec 2014 Data), pub Dec 2015	The audit shows all operators undertaking percutaneous coronary interventions (PCI) procedures within the Trust are performing safely and with outcomes that are within those expected after adjustments made by the risk model.
National Lung Cancer Audit (LUCADA), 2014 data, pub Dec 2015	The change from National Lung Cancer audit (NLCA) to Cancer Outcomes and Services Dataset (COSD) caused significant challenges this year and it was clear that the data submitted this year was not as accurate as it had been in previous years. The data is now being pulled straight from COSD, rather than uploaded into Lung Cancer Audit Data Set (LUCADA), and requires these fields to be complete in COSD. Throughout the year the Trust has data completeness issues and delays in pulling together data meant that none of what was uploaded this year was clinically validated. This was a problem across the country and not just in Oxford university Hospitals NHS Foundation Trust. There was a noted reduction in patients being reviewed by Clinical Nurse Specialists due to incorrect data submission. The audit we will aim to increase the proportion of patients seen by a Lung Cancer Specialist Nurse (CNS) with health care support workers regularly checking multidisciplinary team (MDT) data and re-encouraging clinicians to use CNS and perform monthly clinical data validation meetings before final records submitted via COSD.

2015-2016 Consultant Outcomes Publication for Urological Surgery	OUHFT are in the upper quartile of UK Trusts for the number of cystectomies performed. OUHFT outcomes were found to be comparable or better than UK Trusts. The actions for the Unit are the development of the service as a tertiary regional referral centre, development of the minimal invasive cystectomy (robotic cystectomy) service and improving infrastructure for complete data submission. OUHFT performed a higher number of percutaneous nephrolithotomies (PCNL) than the national median. The median length of stay corresponded to the national average. The Unit reported that data submission for radical prostatectomy was incomplete. This was advised to be due to a lack of support specifically with the submission of follow up data. The Unit reported no concerns with nephrectomy outcomes. Transfusion rates were reported to be at the higher end of the range due to the complexity of the surgery undertaken at OUHFT. British Association of Urological Surgeons (BAUS) has included a statement on the OUHFT data page noting this. There was one death reported which was reviewed and attributed to another procedure.
Vermont Oxford Network Very Low Birth Weight Database Annual Report for Infants Born in 2014, pub Aug 2015 - Neonatology, John Radcliffe	OUHFT performed well when compared with the Network. The breastfeeding outcomes were reported as outstanding and continue to improve year after year. The areas the Unit identified for quality improvement were the use of non-invasive respiratory support and the prevention of hospital-acquired infection, intestinal and neurological complications.
Renal Registry	OUHFT graft and mortality are in line with UK averages and issues with data submission have been resolved.

Local clinical audit

The reports of 287 local clinical audits were reviewed by the provider in 2015/16 and the examples below demonstrate some of the actions taken Oxford University Hospitals NHS Foundation Trust to improve the quality of healthcare provided:

- Oxford Kidney Unit Peritoneal Dialysis Audit led to a programme to educate patients with leaflets and posters, web based and refresher training both group and individual training. The audit has also led to further participation in key research trials.
- Management of Acute Right Iliac Fossa Pain audit has led to the consideration of Diagnostic laparoscopy in place of computed tomography (CT) scans for young women and the decision to leave a normal appendix in situ during diagnostic laparoscopy
- Diagnostic testing for BRCA1/2 gene mutations in breast cancer patients through oncology clinic led to improved written communication with outcome letters for patients clearly indicating the individual pathway
- Audit of the Endoscopic mucosal resection of early oesophageal neoplasia in patients requiring anticoagulation confirmed safe practice when warfarin is discontinued 5 days before the endoscopic intervention and reinstituted on the evening of the procedure day.

- A pathway has been put into place following the completion of the Audit of stem cell collection and efficient use of therapeutic advisory service, for national The Joint Accreditation Committee of International society for cellular therapy-Europe and European society for blood and marrow transplantation standards (JACIE) so that the referring clinician can inform the unit as soon as possible if a patient requires a mobilising agent if not fit enough to proceed.

- An audit of pain prescriptions was conducted after electronic prescribing and medicines administration system (ePMA) was introduced in April 2015. There was an improvement in dosing of ibuprofen prescriptions as well as a 33% improvement in the correct frequency. Correct dosing of Morphine has improved significantly. A repeat audit is planned in 2017 following an upgrade in ePMA which will allow further improvements in patient safety.

- Microsatellite Mismatch Repair (MMR) immunohistochemistry is being performed for all cases of colorectal carcinoma and is being requested earlier to facilitate rapid turnaround and appropriate referral of patients to genetics following completion of the Audit Of Requests And Reporting Of MMR Protein Immunohistochemistry in Colorectal Carcinoma Patients who are less than 50 years of age

- Re-auditing of the Pre-Operative and Pre-Procedural Fasting for Elective and Urgent Medical and Surgical Procedures within the Adult Demographic enabled education through posters and discussions with our staff, as well as patients, to encourage patients to take in clear drinks until two hours prior to surgery.

- Use of melatonin in Community Paediatric Practice audit enabled departmental discussion and education through provision of sleep information leaflet around prescribed tablet formulation of Melatonin and the patients and the parents were given behavioural management advice regarding sleep.

- Gerotology wards have been regularly conducting audits every 6 months to improve compliance with the Visual Infusion Phlebitis (VIP) scores completed on the electronic patient record (EPR) and have been actively encouraging staff to use the online training module for effective completion of the VIP scores on the EPR.

- An Audit of Pulmonary Embolism (PE) on the medical take highlighted the significance of NICE guidance using Wells score in confirmation of the PE and indications for imaging. Posters summarising key guidance will now be displayed in the Emergency departments both inpatient and outpatient areas.

- Investigation into potential need for short term outpatient antibiotic therapy services in acute medicine audit led to a business case for the extension of the short term outpatient parenteral antibiotic therapy service.

- An audit was conducted to determine the number of discharge letters written during a fixed period for Emergency Assessment Unit (EAU) and helped determine the factors

which prevented the letters being written, or being released appropriately to the General Practitioner (GP).

- Delaying the ‘post-antibiotic era’: An audit of antimicrobial prescribing habits on the Neurosciences Intensive Care Unit highlighted the advantages of shortening antibiotic courses, even a small amount with increasing evidence regarding the emergence of resistance, to potentially benefit both the individual patient and the general population

- A local guideline on perineal care and repair management published in 2013 was suggested to be reviewed following completion of the Obstetric Anal Sphincter Injuries (OASIS) audit. The guideline will include specific guidance on perineal care during labour and delivery such as perineal protection at crowning being beneficial and warm compression during the second stage of labour reducing the risk of OASIS.

- A documentation proforma for the management of severe Pre-eclamptic Toxemia (PET) to reiterate all the criteria and encourage full documentation was completed following completion of the Management of Severe Pre-Eclampsia audit.

- Early Pregnancy - Record Keeping Audit enabled the design of a new proforma for early pregnancy patients to be used in the clinic and on the ward which will prompt the clinician to record the necessary information and facilitate safe handover between doctors and will be introduced in a teaching sessions for new staff to the department.

Our participation in clinical research

The OUHFT is one of the UK's leading University hospitals trusts, committed to achieving excellence and innovation through clinical research. The OUHFT 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.

It is a strategic priority of the trust to continue to increase our research activity, further integrate it with clinical care and increase patient participation and involvement. Research and teaching is carried out in partnership with the University of Oxford Medical Sciences Division, Oxford Brookes University's Faculty of Health and Life Sciences, and Oxford Health NHS Foundation Trust, combining clinical expertise with academic excellence. Research and clinical facilities are co-located on our hospital sites to foster a culture of collaboration.

The OUHFT hosts the Oxford Academic Health Sciences Network (AHSN) and is a founder member of the Oxford Academic Health Sciences Centre (AHSC). In particular, the OUHFT works in close partnership with the University of Oxford (UoO) in clinical research, encompassing major programmes in all areas of medical sciences, including cardiovascular, stroke, dementia, cancer, infection, vaccines, surgery and imaging. In genetics, the OUHFT was designated a Genomics Medicine Centre in 2015, and the OUHFT-UoO partnership has made major contributions to the '100 000 genomes' project, with Genomics England.

Clinical research at OUHFT is supported by major competitive National Institute for Health Research (NIHR) funding programmes, including the NIHR Oxford Biomedical Research Centre (BRC; £21m/year), the NIHR Oxford Musculoskeletal Biomedical Research Unit BRU, £2.5m/year). The OUHFT hosts the NIHR Thames Valley and South Midlands Local Clinical Research Network (LCRN; £13.5m/year). NHS research income to OUH in 2015-16 was £48m, with the total research revenues across the OUH-OU partnership exceeding £350m.

The BRC supports public and patient involvement in research, including regular public lectures, a Patients Active in Research (PAIR) group and Research Priority Setting Partnerships, and the annual BRC Open Day when research themes highlight their work through interactive events, attended by hundreds of people and generating substantial media interest

In the last year, there have been more than 1,700 active clinical research studies hosted by OUHFT. During 2015-16 we initiated 351 new studies and hosted 285 studies with commercial partners. In NIHR clinical research network (CRN) studies, OUHFT is the top-recruiting NHS trust nationally, recruiting over 18,268 patients. There are 148 staff who are directly supported by NIHR BRC or NIHR BRU funding and 195 staff supported by the NIHR CRN. Overall, a total of 1087 staff are involved in the conduct of research at the OUHFT. During 2015-16, OUHFT's performance against the NIHR's 70 day benchmark for the initiation of clinical trials was the best of any of the large research-active hospitals in

England. OUHFT achieved a 100% track record in all 4 reporting quarters of 2015-16 in in recruiting the first patient within 70 days.

Our CQUIN performance

Oxford University Hospitals NHS Foundation Trust income in 2015/16 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because the Trust was not eligible to take part in this scheme during this period, due to NHS England's contracting rules.

Statements from the Care Quality Commission

Oxford University Hospitals NHS Foundation Trust is required to register with the Care Quality Commission (CQC). The current registration status is registered without conditions.

In February 2014, a planned inspection was undertaken by the CQC across the main hospitals of the Trust. The Trust was graded 'good' overall, except for A&E and surgery at the John Radcliffe site which were rated as 'requires improvement.' The ratings grid is provided below for the Trust overall and by site:

John Radcliffe Hospital

	Safe	Effective	Caring	Responsive	Well led	Overall
Urgent care centre	Good	Not rated	Requires improvement	Requires improvement	Good	Requires improvement
Medical care (including older people's care)	Good	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Intensive/critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	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	Requires improvement	Good	Good

Horton General Hospital

	Safe	Effective	Caring	Responsive	Well led	Overall
Urgent care centre	Not rated	Good	Good	Good	Good	Good
Medical care (including older people's care)	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Intensive/critical care	Requires improvement	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	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

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

Nuffield Orthopaedic Centre

	Safe	Effective	Caring	Responsive	Well led	Overall
Medical care (including older people's care)	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Outpatients	Good	Not rated	Good	Good	Good	Good

An action plan was agreed with the CQC and was actively managed in the Trust to ensure the actions were completed within defined timescales.

The Care Quality Commission has not taken enforcement action against Oxford University Hospitals NHS Foundation Trust during 2015/16.

Oxford University Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The Trust has participated in the Joint Targeted Inspections into Child Sexual Exploitation and Missing Children.

The Joint Targeted Inspections includes Care Quality Commission (CQC), Ofsted, Her Majesty's Inspectorate of Constabulary (HMIC) and Her Majesty's Inspectorate of Probation (HMIP). An overview report will be published once the review has concluded

Our data quality

Oxfordshire University Hospitals NHS Foundation Trust sees Data Quality as everybody's responsibility. Good quality information underpins the delivery of effective patient care and is essential to understanding where improvements need to be made.
This approach helps us to ensure that every staff member seeks to achieve high standards of data quality and aims to ensure that we continue with the ethos of data quality improvement throughout the organisation. The Trust has an established data quality infrastructure which is overseen by the Information Governance and Data Quality Group for monitoring and improvement. An update on the Trust data quality activities and performance is included in the six monthly information governance updates to the Trust Board

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. The date quality strategy aims to provide a robust yet flexible framework within which the Trust can maximise the completeness, accuracy and validity of patient information. It recognises the need to ensure that data is collected for justifiable purposes and used in accordance with sound principles of information management and governance. It endorses the use of mandatory, validated NHS Numbers on all patient records as the foundation on which all further information quality considerations must rest. Encompassing the information quality assurance requirements of information governance, it provides a fundamental statement of responsibilities which should underpin all data collection, management and monitoring activities within the Trust enabling efficient service delivery, performance management and the planning of future services

Oxford University Hospital NHS Foundation Trust will be taking the following actions to improve data quality:

- During 2016/17 the Trust will continue to reinforce a number of measures to strengthen data quality. The data quality activities are also underpinned by a programme of annual external and internal audits.

- Each of the clinical Divisions continues to strengthen its arrangements for securing good quality data making use of internal audit to identify areas for improvement and 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 specialities.
- The Trust has embedded the six 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.
- One of the most important elements of improving and maintaining service relies on the opportunity for continuing staff education and training. The training policy underpins the application of all relevant employment policies and ensures that for all staff including temporary staff, we apply access control, ensure data quality processes are adhered to and put procedures in place to support the consistent capture of quality data into our corporate systems.
- Continued development and review of e-learning programmes which include dedicated data quality workbooks and e-assessments takes into account any trends that may be assisted with reminders to staff via e-learning.

Oxford University Hospitals NHS Foundation Trust submitted records during 2015/16 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

Inpatients	OUHFT	National Average
Valid NHS number	98.6%	99.2%
General Medical Practice Code	100.0%	99.9%

Outpatients	OUHFT	National Average
Valid NHS number	99.7%	99.4%
General Medical Practice Code	100.0%	99.8%

A&E	OUHFT	National Average
Valid NHS number	96.5%	95.3%
General Medical Practice Code	100.0%	99.6%

Information Governance Toolkit

Information Governance Toolkit Attainment Levels

Information governance (IG) ensures necessary safeguards for, and appropriate use of, patient, staff and corporate information. The IG Toolkit is an on-line system that allows NHS organisations and partners to assess themselves against national IG policies and standards. Attainment levels are published on the 1st April each year for every organization submitting an IG Toolkit return. Our IG Toolkit score for 2015/16 was 97% with all requirements at either level 2 or 3 giving the Trust a satisfactory rating (Organizations are either rated satisfactory or unsatisfactory). This is colour coded green. To ensure our staff are kept up-to-date we provide training annually.

Clinical coding error rate

Oxford University Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2015/16 by the Audit Commission

National core set of quality indicators

Mortality

Preventing People from Dying Prematurely

Summary Hospital Mortality Indicator (SHMI)

The 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 preforming better than the national average. The SHMI is published quarterly by the Health and Social Care Information Centre (HSCIC) and each publication covers a 12 month rolling reporting period.

The latest SHMI, published on 23rd March 2016 (for the reporting period October 2014 to September 2015) was 1.00. This value is banded 'as expected' using the HSCIC 95% confidence intervals adjusted for over-dispersion.

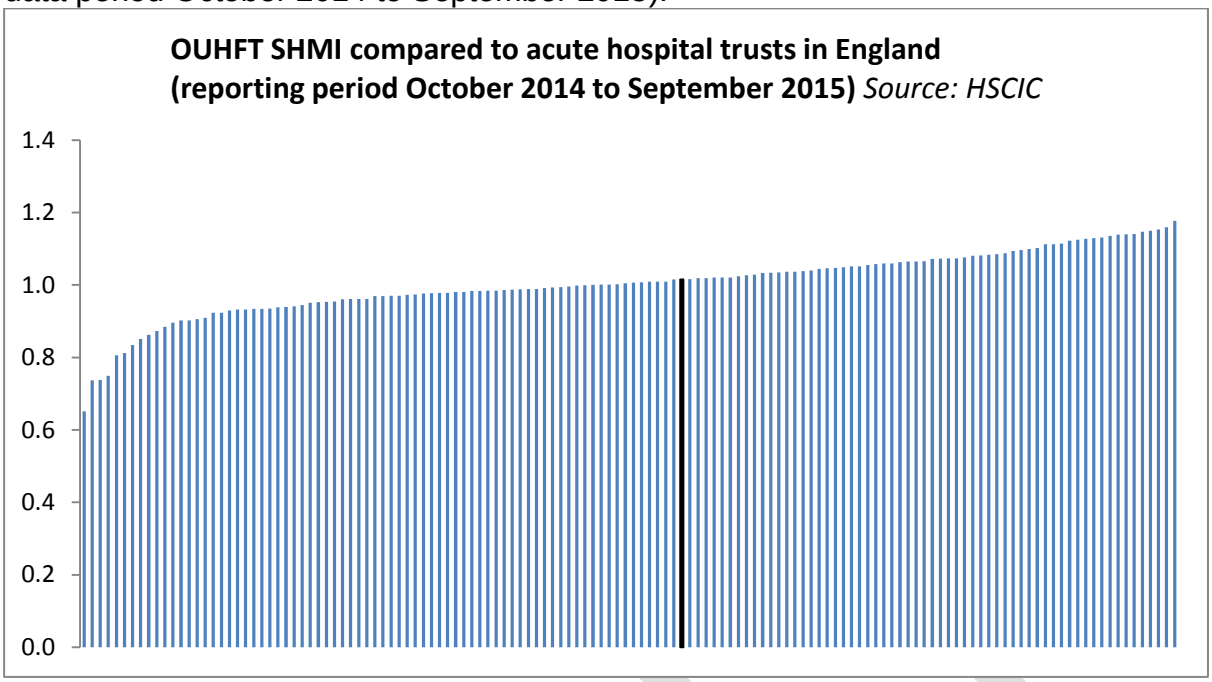
The Trust considers these data are as described for the following reasons:

- 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 the HSCIC via the Secondary Uses Service (SUS). The SHMI is then calculated by HSCIC.
- Data are compared to peers, highest and lowest performers, and our own previous performance, as set out in the table below.

The Trust reviews the SHMI in conjunction with other published mortality measures and the information from our internal review of deaths.

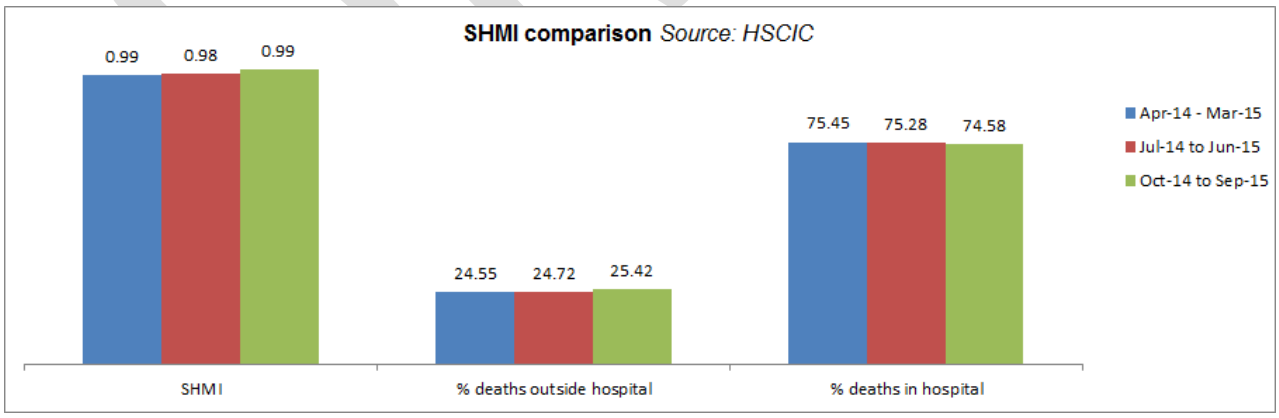
The graph below displays the OUH SHMI in comparison to other Trusts in England (for the

data period October 2014 to September 2015):



				October 2014 to September 2015		
Source: HSCIC	OUHFT (Apr-14 to Mar-15)	OUHFT (Jul-14 to Jun-15)	OUHFT (Oct-14 to Sept-15)	National Average	Highest (Worst Trust)	Lowest (Best Trust)
SHMI Value	0.98 (95% CI: 0.72 - 0.12)	0.98 (95% CI: 0.95 - 0.12)	1.00 (95% CI: 0.91 - 0.11)	1.00	1.17	0.65
SHMI Banding	2 - 'as expected'	2 - 'as expected'	2 -'as expected'			

The graph below provides a comparison of the SHMI for deaths that occur in hospital and within 30 days of discharge.



Review of patient deaths.

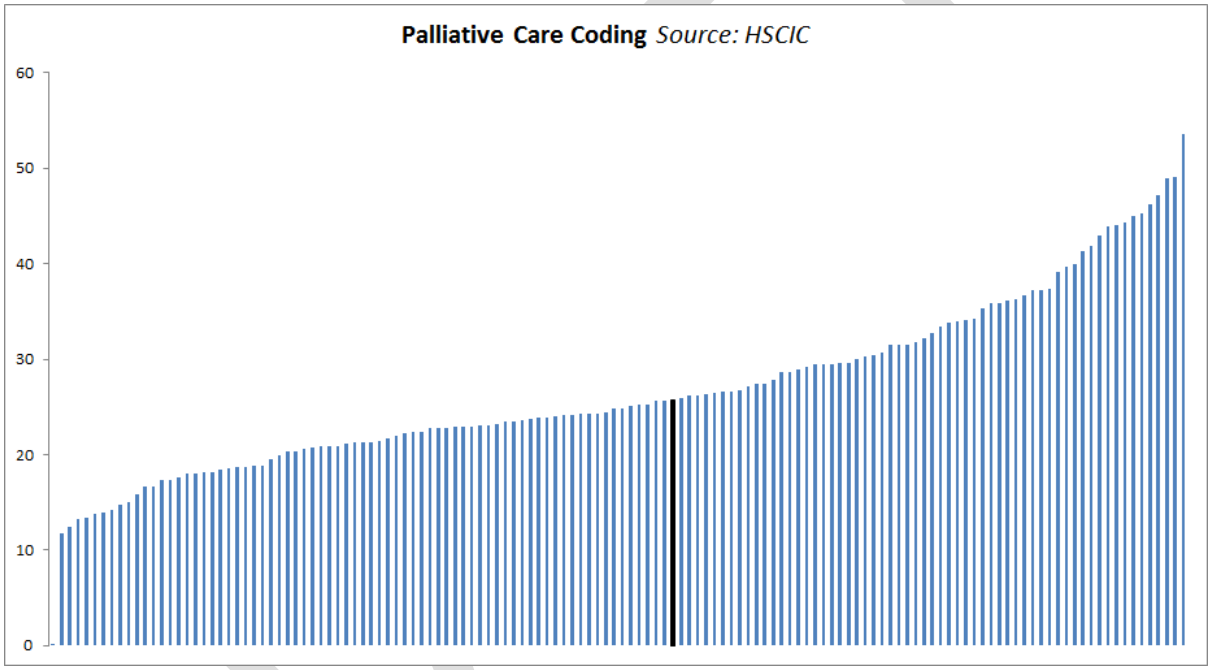
Our Trust target is for 100% of patient deaths to be reviewed to ensure that any omissions or actions taken are identified and learnt from to improve care. An analysis of the mortality reports for April 2015 to December 2015 indicate that 85% of deaths were reviewed.

The Trust has established a Mortality Review Group which meets monthly under the chairmanship of the Deputy Medical Director with multidisciplinary and multi-professional membership and the responsibility for mortality reporting to the Board.

Palliative Care Coding

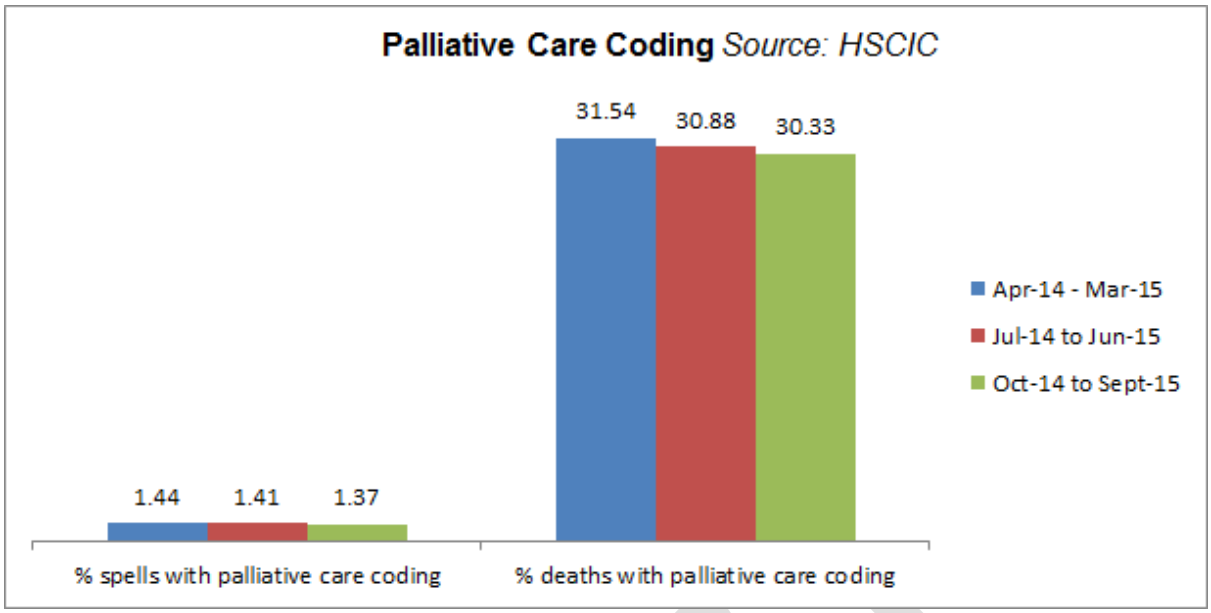
The HSCIC publishes information on palliative care coding as a contextual indicator to support the interpretation of the SHMI. The palliative care coding information collated nationally by the HSCIC relates to the numbers of patients assigned the with palliative (end of life) care coding at treatment specialty or diagnosis level while in hospital.

The graph below displays the rate of palliative care coding at OUHFT in comparison to other Trusts in England for the data period October 2014 to September 2015:



Source: HSCIC	OUHFT (Apr-14 to Mar-15)	OUHFT (Jul-14 to Jun-15)	OUHFT (Oct-14 to Sept-15)	National Average (Oct-14 to Sept-15)
Percentage of patient deaths with palliative care coded	31.54	30.88	30.30	26.60

The graph below provides a comparison of the palliative care coding:



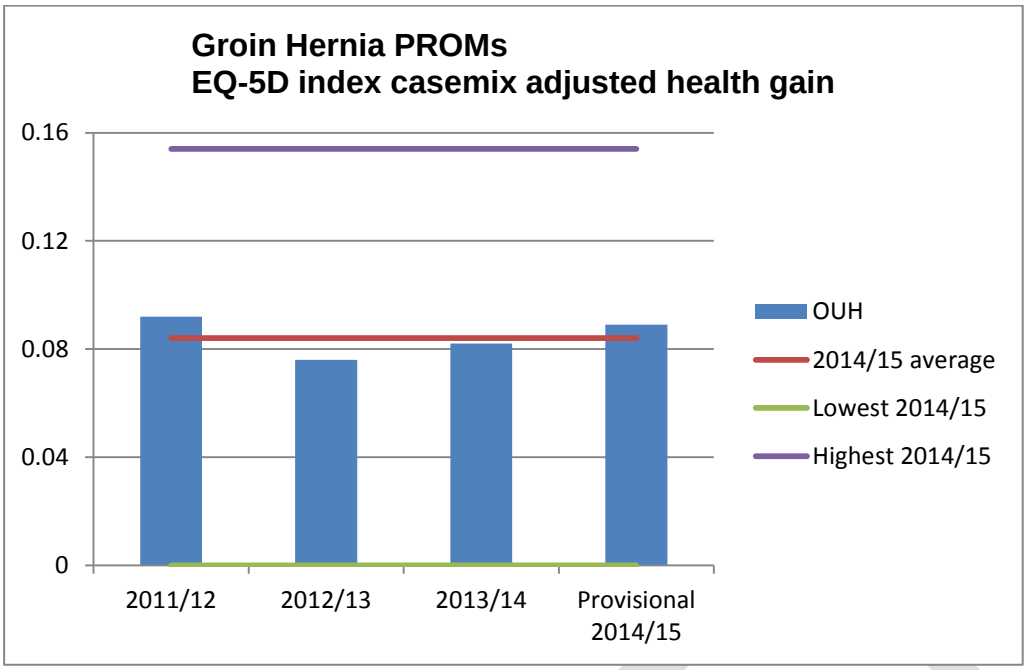
Patient reported outcome measures

Patient Reported Outcomes Measures (PROMs)
PROMs are used to ascertain the outcome following planned inpatient surgery for any of four common procedures (hip and knee replacement, varicose vein surgery and groin hernia 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 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 data available from the HSCIC are for the previous financial year 2014/15. Data for 2015/2016 will be available later in 2016 and will be published in our 2016/17 Quality Account.

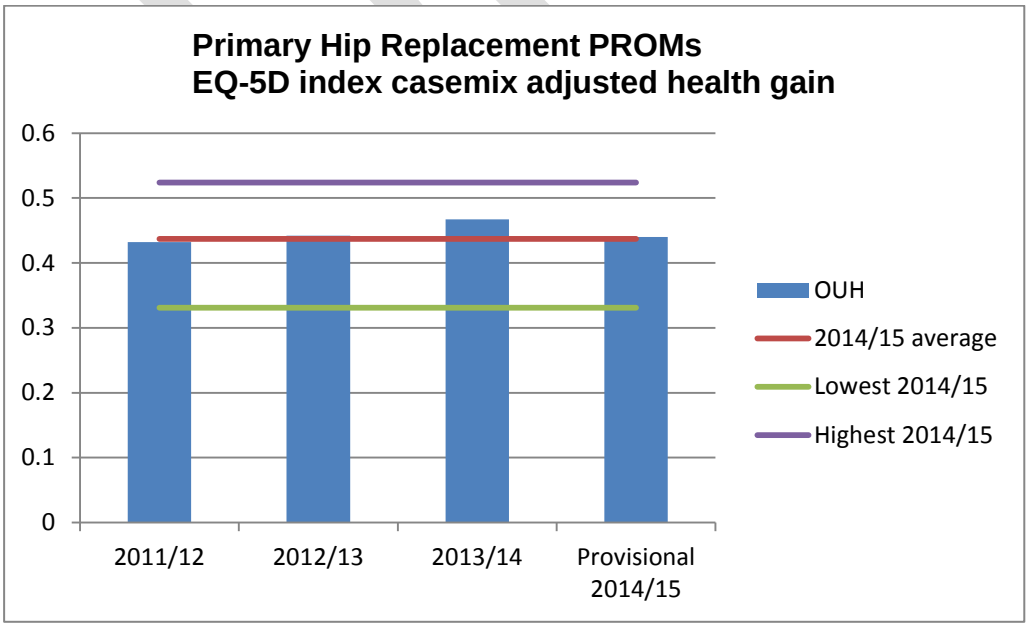
Repair of a groin hernia

	EQ-5D index casemix adjusted health gain				
Groin Hernia	**Adjusted average health gain**				
	2010/11	2011/12	2012/13	2013/14	Provisional 2014/15
OUHFT	0.115	0.092	0.076	0.082	0.089
2014/15 average	0.084	0.084	0.084	0.084	0.084
Lowest 2014/15	0.000	0.000	0.000	0.000	0.000
Highest 2014/15	0.154	0.154	0.154	0.154	0.154



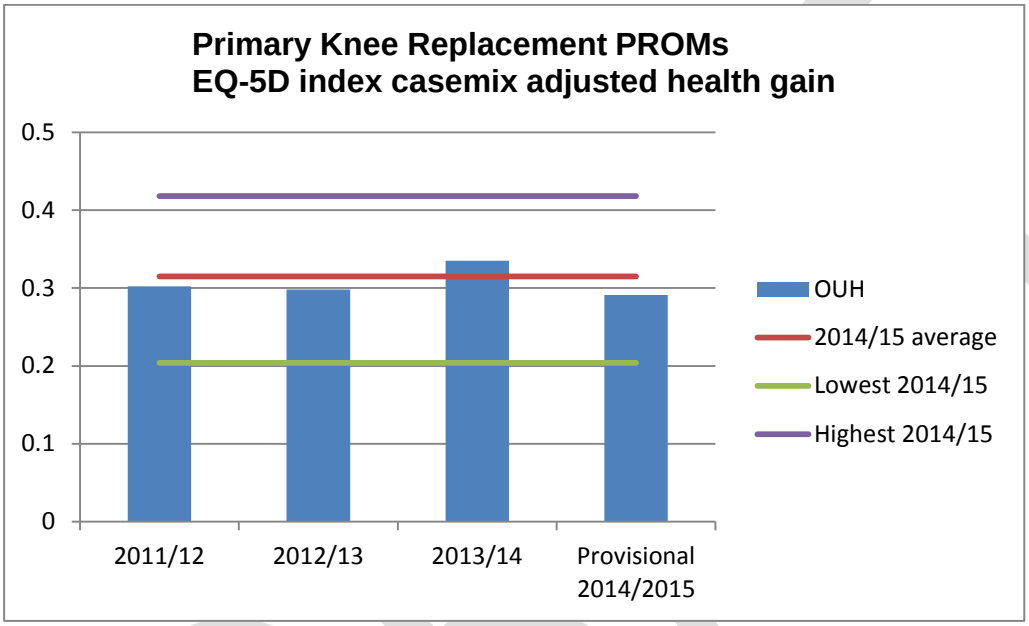
Primary (first) hip replacement

	EQ-5D index casemix adjusted health gain				
Hip Replacement primary	**Adjusted average health gain**				
	2010/11	2011/12	2012/13	2013/14	Provisional 2014/15
OUHFT	0.407	0.432	0.442	0.467	0.440
2014/15 average	0.437	0.437	0.437	0.437	0.437
Lowest 2014/15	0.331	0.331	0.331	0.331	0.331
Highest 2014/15	0.524	0.524	0.524	0.524	0.524



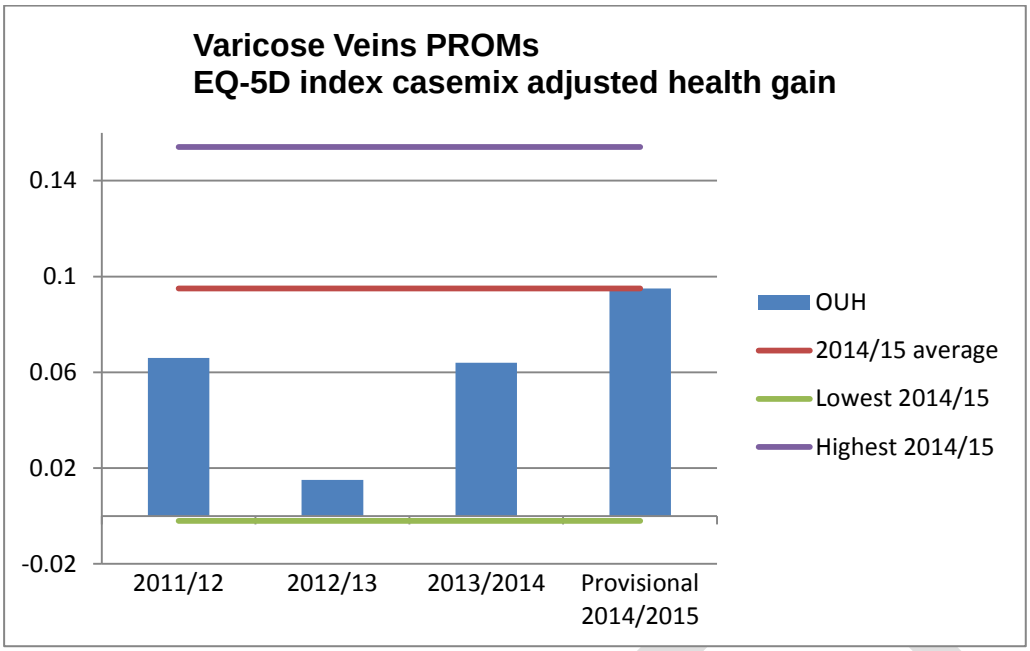
Primary (first) knee replacement

	EQ-5D index casemix adjusted health gain				
Knee Replacement primary	**Adjusted average health gain**				
	2010/11	2011/12	2012/13	2013/14	Provisional 2014/2015
OUHFT	0.307	0.302	0.298	0.335	0.291
2014/15 average	0.315	0.315	0.315	0.315	0.315
Lowest 2014/15	0.204	0.204	0.204	0.204	0.204
Highest 2014/15	0.418	0.418	0.418	0.418	0.418



Varicose Veins

	EQ-5D index casemix adjusted health gain				
Varicose Vein	**Adjusted average health gain**				
	2010/11	2011/12	2012/13	2013/2014	Provisional 2014/2015
OUHFT	0	0.066	0.015	0.064	0.095
2014/15 average	0.095	0.095	0.095	0.095	0.095
Lowest 2014/15	-0.002	-0.002	-0.002	-0.002	-0.002
Highest 2014/15	0.154	0.154	0.154	0.154	0.154



The Trust considers that the PROMs data are correct 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 the HSCIC.
- Data are compared to peers, highest and lowest performers, and our own previous performance, as set out in the tables.

The HSCIC advice is that these results are provisional and subject to change until the publication of finalised data later in 2016.

Readmission within 28 days of discharge

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 on the John Radcliffe and Horton General Hospitals but patients known to the Trust services may also be admitted directly to the Churchill.

The information on emergency readmissions provided by the HSCIC relates to the percentage of patients readmitted to any hospital in England occurring within 28 days of discharge from a hospital which forms part of the Trust; aged: (i) 0 to 15; and (ii) 16 or over.

The last versions of the emergency readmissions information was released by HSCIC in April 2014 for 0 to 15 year old patients and in March 2014 for patients aged 16 years or older. The publications related to the reporting period up to 2011/2012 and values are displayed in the table below. A section of the reporting period relates to the time before the Nuffield Orthopaedic Centre (NOC) and Oxford Radcliffe Hospitals (ORH) merged hence the figures are depicted separately on the table.

The emergency readmissions rate at ORH NHS Trust for the reporting period up to 2011/2012, was 9.52% for patients up to 15 years of age and 11.41% for patients over 16 years of age; both values were banded by HSCIC as the 'national average lies within expected variation (95% confidence interval)'.

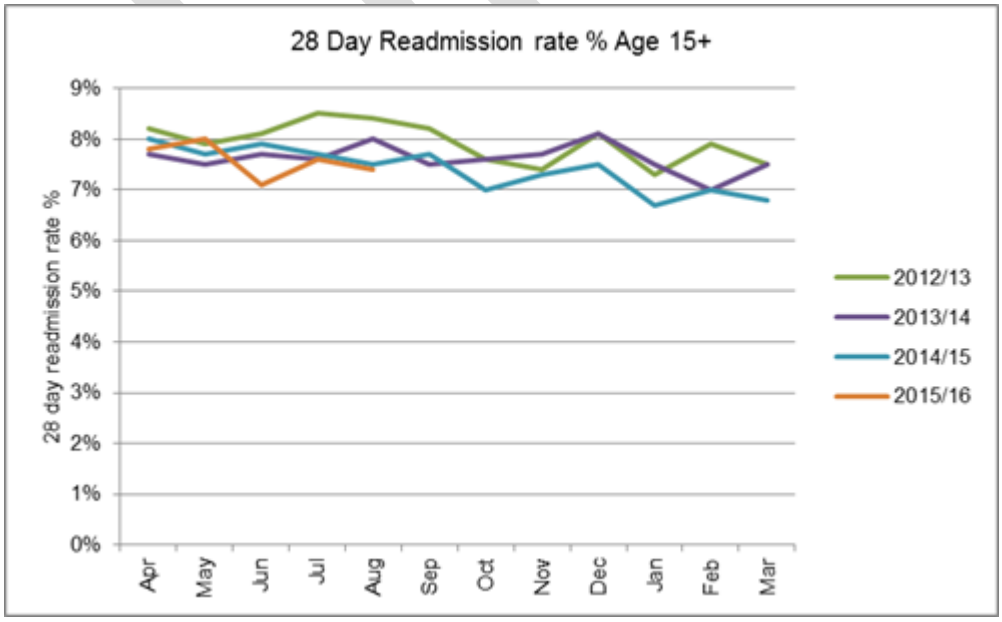
Emergency readmissions within 28 days of discharge from hospital up to 2011/2012 *(Source: HSCIC)*

Age Groups	2009/2010	2010/2011	2011/2012
(i) 0 to 15 (NOC)	0.00	0.00	
(i) 0 to 15 (ORH)	8.51%	9.25%	9.52%
(ii) 16 or over (NOC)	10.32%	10.86%	
(ii) 16 or over (ORH)	11.97%	11.73%	11.41%

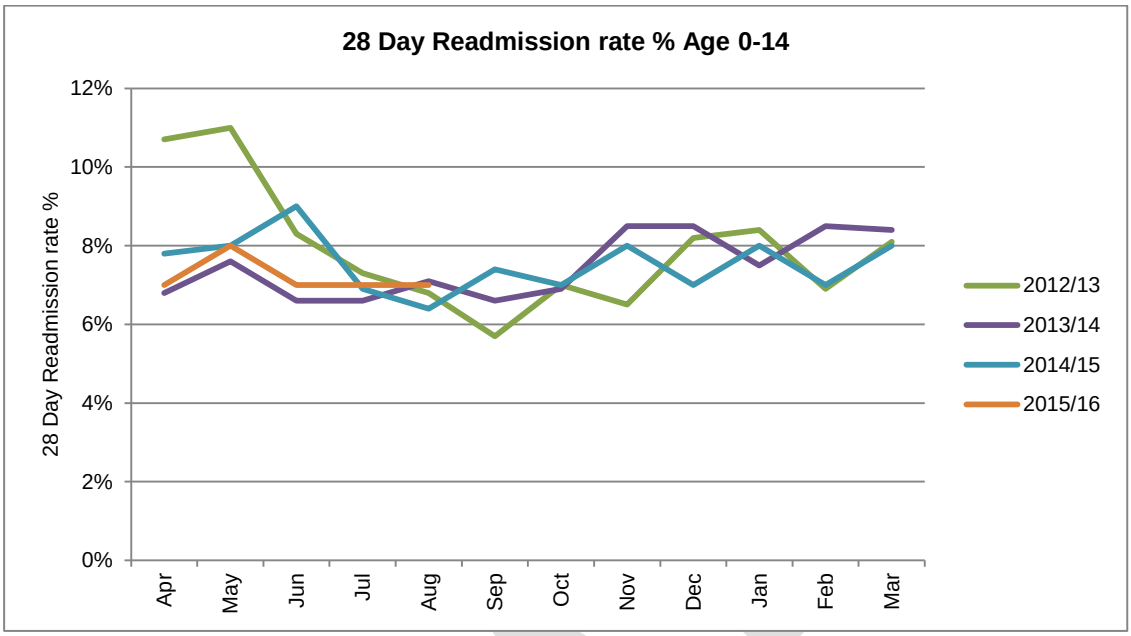
Data from the HSCIC are not currently available beyond 2012 hence we have also provided comparable data from Dr. Foster.

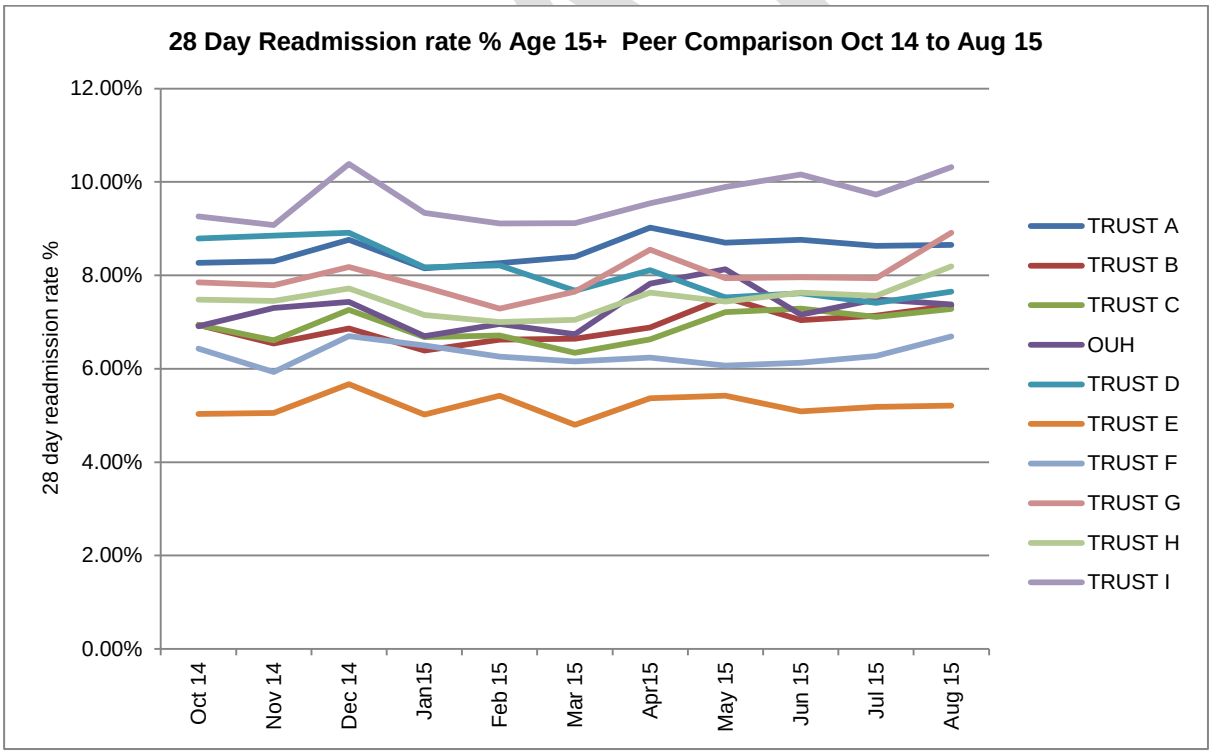
Dr. Foster readmissions data

Readmission rates published by Dr. Foster are available until August 2015 and indicate that readmission rates are 7-8% substantially lower than the HSCIC data period of 2011/12. Readmission rates as a percentage of total admissions for patients 15 years and over were slightly higher in May and July 2015 (0.3%) and lower in June (0.9%) and August 2015 (0.5%) than the same period in the previous year.



Readmission rates as a percentage of total admissions for patients 0-14 years are 7-8%, substantially lower than the HSCIC data period of 2011/12. The rate has decreased in April (0.8%) and June 2015 (2%) and increased slightly in July (0.1%) and August 2015 (0.6%) compared to the same period the previous year.





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. For example; a fracture to the leg following an accident within 28 days of removal of the appendix is categorised as a readmission. In general OUHFT is in the mid-range for readmissions compared to peers.

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 the HSCIC via the Secondary Uses Service (SUS). The data is then used to calculate readmission rates.
- HSCIC 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.

Cancer assessment unit - Triage service

The Triage service is a nurse-led service on the Churchill site with facilities to review patients in a dedicated Triage area, based in an outpatient clinical setting. There are 5 beds used to assess patients, and undertake acute interventions as indicated. The service is open 7 days a week (Monday – Sunday 8am -8pm). Patients may be admitted, discharged or referred, from this service.

Through access to this service patients can receive expert advice and guidance to support their care needs and reduce the requirement for admission. Currently 75% of calls results in no admission. The remainder of patients are seen within the assessment area and of these 32% of patients will go home.
Prior to the introduction of the triage service the majority of these patients would have been admitted to hospital.

Patient experience

Patient's 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

The 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

Learning from you

The Trust is committed to seeking and acting upon feedback from patients and their friends and family. This is because we want every patient to have the best experience possible. Feedback helps our staff to know what we are doing well (and we should keep on doing) and what we need to change. We also use this information to ensure that our Quality Account reflects the wishes and experiences of people who use our services.

Ways we get your feedback	How we use this feedback
The Friends and Family Test Asks if you would recommend the ward or department to your friends and family	Comments are used to show excellent practice or areas for improvement across the Trust. We feed back our FFT results so teams can tackle issues raised. Results are frequently displayed in ward and outpatient areas.
Annual National Inpatient Survey	Gives us examples of what patients say about our wards and helps us plan improvement work for the coming year.
Listening to what you say in person (Face to face discussions)	We try to resolve any issues as quickly as possible. This direct feedback helps us to quickly see where we need to make improvements to specific aspects of our service.
Feedback to Patient Advice and Liaison Service (PALS)	Concerns, issues, and compliments are fed back to relevant departments in the Trust so improvements can be made. These are collated as it helps to see the feedback broken down into themes so we can see if there are one-off or recurrent problems to fix. Positive feedback from NHS Choices is recorded weekly and feedback is sent out to Divisional leads on a monthly basis.
Letters and emails	
Feedback on the NHS Choices website	
Patient stories	Gives us an in-depth account of a patient's experience to help us to understand the issues better. Our Chief Nurse presents, with the patient's permission, a case study and associated learning to Trust bi-monthly public Board meetings.
Engagement with partner, voluntary and community organisations	We engage with voluntary and community groups, covering a wide range of communities and issues. For examples: carers, older people, black and minority ethnic groups, mental health, young carers. We also work closely with health and social care partners in Oxfordshire.
Workshops	We hold workshops to hear the views of individuals, patients, carers, the public and representatives from community and voluntary groups, such as Public Participation Group (PPG) workshops, Seldom heard Groups, and Quality Priorities events.
PPI involvement in BRC research studies	To define new areas for research and to comment on research priorities and quality of lay summaries

Children's Patient Experience	• In September 2015, a Project Lead for Children's patient experience came into a 2 year post, funded by Health Education Thames Valley • The young persons' public partnership group successfully relaunched as part of Oxford University Hospitals Foundation Trust participating in National Takeover Day. • Two members are now Governors

	• Feedback so far received from young people and changes made: ○ Improved general appearance of Children's hospital and waiting areas. ○ Improved signage based on feedback, for example improving lift signage in the West Wing

The table below shows Oxford University Hospitals NHS Foundation Trust results, in a national context, regarding the five questions in the National Inpatient Survey that relate to responsiveness to patients' personal needs. We consistently score above the national average due to our commitment to delivering compassionate excellence and our ongoing dedication to person centered care.

Responsiveness to Inpatients' Personal Needs	2011/12	2012/13	2013/14	2014/15
OUH	**69.3**	**69.9**	**69.2**	**71**
National Average	67.4	68.1	68.7	68.9
Highest Scoring Trust	85	84.4	84.2	86.1
Lowest Scoring Trust	56.5	57.4	54.4	59.1

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

Staff recommendation of our hospitals to family and friends

The degree to which staff are willing to recommend their organisation both as a place for their friends and families to be treated, and as a place to work, are strong indicators of staff engagement and motivation. These areas are included within the annual NHS Staff Survey and also tested as part of the quarterly Staff Friends and Family Test (Staff FFT), which was first introduced in June 2014. The results, including free text comments provided by individuals, are reported at the Workforce Committee and disseminated through Divisional management structures.

With respect to the two key advocacy questions associated with the annual NHS Staff Survey, compared with the national scores the Trust's performance is as follows:

Recommendation of the organisation as a place to be treated:

OUHFT Scores				**National Scores 2015/16 Acute Trusts**		
2012/13	**2013/14**	**2014/15**	**2015/16**	**Average**	**Highest**	**Lowest**
67%	77%	70%	75%	69%	85%	46%

Recommendation of the organisation as a place to work:

OUHFT Scores				**National Scores 2015/16 Acute Trusts**		
2012/13	**2013/14**	**2014/15**	**2015/16**	**Average**	**Highest**	**Lowest**

54%	67%	58%	60%	61%	78%	42%

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

- the Trust has a process in place for collating data on the Friends and Family Test
- data is collated internally and then submitted on a monthly basis to Department of Health

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

- using both the national Staff Survey and Staff FFT data to inform the internal peer review process;
- more widely publicising the data through local communication channels at ward level, to ensure it is more visible to staff;
- Inviting staff to contribute to the development and implementation of local Divisional and corporate improvement plans.

Staff Survey focus groups held in early 2015 provided a good engagement opportunity for individuals and teams to review the results and determine local priorities for action.

Patient recommendation of our hospitals to family and friends

RESULTS from the Friends and Family Test Survey	NOTE: Results are from beginning of April 2015 to September 15
FFT: inpatients and day cases	97% of patients were extremely likely or likely to recommend their ward, based on 7,709 responses.
FFT: A&E	85% of patients were extremely likely or likely to recommend the care they received in the Emergency Department, based on 5,596 responses.
FFT: Outpatients	95% of outpatients were extremely likely or likely to recommend the care they received, based on 16,254 responses.
FFT: Maternity	95% of women were extremely likely or likely to recommend the Trust's maternity services, based on 1685 responses.

The table below shows the Oxford University Hospitals NHS Foundation Trust's overall results from the FFT test:

April 15 – September 15	Extremely Likely	Likely	Neither Likely nor Unlikely	Unlikely	Extremely Unlikely	Don't know
Number of responses	23410	5486	1027	502	465	354

overall						
Percentage	75%	18%	3%	2%	1%	1%

The Oxford University Hospitals NHS Foundation Trust considers that these data is as described for the following reasons:

- The Trust has a robust process in place for collating data on the Friends and Family Test

- Data is collated internally and then submitted on a monthly basis to Department of Health

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

- Full implementation of text messaging and agent calls across outpatients and day cases. This was implemented in August 2015 after a successful trial in the A&E services. Some patients have been excluded from this automated method due to sensitivity issues and following NHS England guidelines; Palliative care patients, Sexual Health and those who may have had a pregnancy loss

- Staff and volunteers across the Trust have been 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 offering paper questionnaires to those patients

- All team leaders of outpatient and day case areas have been encouraged to use the website where all of the automated feedback is uploaded – Envoy Messenger

- Training sessions have been held 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

- 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.

National patient surveys

We undertook one National survey for 2015-16 – the National Inpatient Survey. Results are currently embargoed as they will not be published until May 2016. To be added: Date of embargo release, request sent

The nationally mandated sample increased from 850 to 1250. However, the Trust commissioned an additional sample of 3492, meaning that a total of 4742 surveys were sent out. This additional sample has allowed for ward level data to become available without compromising the anonymity of the responses. The Trust's extended sample results will not be part of nationally published results.

The Oxford University Hospitals NHS Foundation Trust has taken the following actions to

improve this indicator, and the quality of its services, by:

- Ensuring a continued focus on 'responsiveness to patient needs, as measured via call bells'
- The Patient Experience Team will work with the sister and matron of three selected wards to improve responsiveness to patient needs, measured via patient feedback about call bell response times
- The wards will be resurveyed with a mini version of the national inpatient survey
- Successful methods for improving responsiveness will be replicated across the Trust
- The plan to improve call bell response times will be incorporated into the professional practice model for the Trust as part of the 'Magnet' accreditation process. This is being led by the Chief Nurse.

Infection control

We believe this data is 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
- All the C.Difficile cases are presented at the monthly health economy meeting which includes representation from OUHFT, Oxford Health, Oxfordshire CCG and Public Health England
- The purpose of this meeting is to review all reported cases of C.Difficile to ascertain availability, 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	**2013/14**	**2014/15**	**2015/16**
Trust attributed(number)	64	61	57
Total bed days	454489	414213	394104
Rate per 100,000 bed-days for specimens taken from patients aged 2 years and over **(Trust attributed cases)**	**13.9**	**13.8**	14.5
National Average	14.7	12.02	-
Best performing Trust	Awaited from PHE	Awaited from PHE	-
Worst performing Trust	Awaited from PHE	Awaited from PHE	-

Throughout 2015/16 the Infection Prevention and Control team in partnership with staff has driven forward safer practices in order to minimise preventable infections. Team work and a constant focus by staff on antimicrobial stewardship, cleaning, disinfection of surfaces and equipment and hand hygiene audits and training have all contributed to minimising infection rates. The most recent audit of compliance with antibiotic guidance showed a high compliance rate of 92% across the Trust.

Patient safety incidents

Trusts across England upload data relating to incidents reported locally to the 'National Reporting and Learning System (NRLS)'. The main purpose of the NRLS is to facilitate learning from patient safety incidents that occur in the NHS. The NRLS allows Trusts to benchmark incident reporting rates and the levels of harm associated with incidents. The NRLS publishes information every six months, covering six-month periods as official statistics for incident reporting across the NHS for England and Wales. The number of patient safety incidents and near misses reported at Oxford University Hospitals NHS Foundation Trust continues to increase and we believe this reflects a positive culture of reporting incidents. We actively encourage our staff to report clinical incidents so we can learn from mistakes to improve our 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).

The Oxford University Hospitals NHS Foundation Trust considers that this data is 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
- All reported incidents are reviewed each working day by Clinical Risk Management. Incidents which have been graded as "no harm" or "minor" but which give rise to concern are discussed with the Divisions and added to the Serious Incident Requiring Investigation (SIRI) forum agenda. Any incidents that are graded as moderate or above are added to the SIRI forum agenda and an initial summary report is requested. As part of this initial review the harm grading is assessed to ensure that the grading is considered correct. Some incidents that have initially been graded as moderate or greater will be downgraded at this stage as it will be apparent from the initial review that the reporter has overstated the patient harm.

  At the SIRI forum the harm level of all incidents presented is discussed and agreed following the standards outlined in the Serious Incident Framework (NHS England).

- After the SIRI forum the harm level is updated in Datix. At the point of the uplift of information to the NRLS the harm grading for the exported incident should be accurate.

- There are occasions when the harm level of an incident is amended after the NRLS uplift. For example, when further results or clinical interventions have occurred some weeks after the initial report which reveals more information about the Trust impact on an incident. If this means a no harm or minor incident is upgraded to a moderate (or greater) or a moderate (or greater) incident is downgraded to minor or no harm, the NRLS is updated by the nominated staff member in the Datix team

- Data are compared to peers, highest and lowest performers, and our own previous performance, as below:

	Oxford University Hospitals NHS Foundation Trust			**National comparison for 'Acute (non-specialist) organisations' Apr-14 to Mar-15**		
	Apr-12 to Mar-13	**Apr-13 to Mar-14**	**Apr-14 to Mar-15**	***Average***	***Highest***	***Lowest***
Number of patient safety incidents	8495	14,875	17784	8764	24804	2116
Number of patient safety incidents that resulted in severe harm or death	63	46	44	42.7	193	4
Percentage of patient safety incidents that resulted in severe harm or death	0.7%	0.3%	0.25%	0.54%	3.65%	0.05%

In June 2015 the Trust introduced a weekly Serious Incident Forum, where all incidents graded as moderate and above, or any 'no harm' incidents of concern are taken to discuss. Divisions, frontline staff, executives and leads for specialist areas such as tissue viability, pharmacy, VTE, and information governance attend as required. 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 Board (TME)
- To disseminate Trust wide learning from SIRIs called through this process

During 2015/16 176 SIRI have been declared onto the strategic executive information system [STEIS]. This follows a concerted effort to improve timeliness and extent of escalation of incidents. Reporting has increased this year, compared to 2014/15 when 82 SIRIs were declared.

The three most common types of serious incident reported in the Trust are as follows, in descending order of frequency:

Nature of Incident

Hospital Acquired Pressure Ulcers
Falls resulting in injury
Delays in treatment

From April 2015 the NRLS changed the rates used to compare reporting between Trusts from incidents per 100 admissions to rate of incidents per 1000 bed days – the table below presents the last three 6 month periods for which these data are available alongside the average, highest and lowest for the most recent (Oct-14 to Mar-15) NRLS release.

	Oxford University Hospitals NHS Foundation Trust			**National comparison for 'Acute (non-specialist) organisations' Apr-14 to Mar-15**		
	Oct-13 to Mar-14	**Apr-14 to Sep-14**	**Oct-14 to Mar-15**	***Average***	***Highest***	***Lowest***[3]
Incident Rate (per 1,000 bed days)	36.4	39.4	41.9	37.2	82.2	20.0

Source: NRLS, Organisation Patient Safety Incident reports from April 2014 and September 2015.

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

- Staff continuing to attend the monthly Risk Management and Incident Investigation training, and during 2015/16 75 members of staff have been trained
- Working closely with Oxford Simulation, Teaching and Research) OxSTaR to align incident investigation and Human Factors and to target incident investigators

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 14 types of incidents categorised as such by the NHS England.

In 2015/16 Oxford University NHS Foundation Trust reported 7 incidents that met these criteria during this financial year, as follows:

- Wrong Site surgery: Wrong spinal disc removal
- Retained foreign object: swab from surgery
- Wrong Site Surgery: Emergency craniotomy
- Wrong Site Surgery: Wrong side Portacath removal (event occurred during 2014-15 but reporting was delayed by clinical team)
- Wrong Site Surgery: Wrong site incision for an Oesophagectomy
- Wrong Site Surgery: Wrong Site nerve block

[3] The lowest rate for a single provider within the 'Acute (non-specialist)' was 3.6 for the six months October 2014 to March 2015; this was for a Trust which reported a total of 443 incidents for the period – the next lowest is reported in the table as a more representative comparison.

- Wrong Site Surgery: Wrong Site nerve block

In response to these events and Never Events in prior years the Trust has developed a wide ranging Never event action plan which is regularly monitored both within the Trust and with commissioners. Other actions included the external review described below which is available on the Trust's website.

Toft review into Oxford University Hospital NHS FT Never Events (2014/15)
Professor Toft was commissioned in 2015/16 by the Chief Executive Officer to carry out an external review of the Investigation reports into seven Never Events reported by Oxford University Hospitals in financial year 2014/15 (one of which related to an error in the previous financial year).

An overall set of conclusions and recommendations was provided at the end of the review. The review concluded that no evidence had been found to suggest that a patient safety problem exists within the Trust and the evidence strongly suggests that the Trust has a proactive safety culture. Additionally, the review found that the Trust's commitment to openness with respect to SIRIs and 'Never Events' is exemplary.

Venous thrombo-embolism

The Trust has met and exceeded the 95% target for VTE risk assessment of patients for 2015/2016.The 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 thrombo-embolism assessments
- data is collated internally and then submitted on a monthly basis to Department of Health
- Data is compared to peers, highest and lowest performers, and our own previous performance, as set out in the table below.

OUHFT VTE Assessment rate

		2013-14	2014-15	2015-16	
VTE	Assessed	207862	200181	231997	Month 12(2015-16) is an average of the previous 11
	Admitted	217965	214142	239326	Month 12(2015-16) is an average of the previous 11
	Assessment rate	95.36%	93.48%	96.94%	
	Nat Average	95.76%	96.09%	95.80%	2015-16 based on Q1-Q3
	Best Performing Trust	100.00%	100.00%	100.00%	2015-16 based on Q1-Q3
	Worst Performing	82.05%	88.45%	80.55%	2015-16 based on Q1-Q3

Trust				

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

- The investigation of all hospital acquired thromboses (HATs). Discussion of all potentially preventable HATs in the Serious Incident Requiring Investigation (SIRI) forum and dissemination of learning outcomes..
- Improving patient information on admission and discharge (VTE information to be included in generic admission 'safety leaflet', exploring the use of bedside TV's, VTE business cards are now included in medications for discharge bags, and VTE information is being added to generic 'plan well' discharge leaflet).
- Improving compliance with prescribing and safety checks for anti-embolism stockings.
- Improving electronic VTE risk assessment: alerts for repeat VTE risk assessment being implemented.

A&E access: 95% A&E patients wait less than four hours

The 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 ED attendances and 4 hour breaches
- Data is collated internally and then submitted on a monthly basis to Department of Health
- Data is compared to peers, highest and lowest performers, and our own previous performance, as set out in the table below.

		2013-14	2014-15	2015-16	
ED	No of 4 hour Breaches	8994	14017	13115	2015-16 (includes up to February)
	No of attendances	132838	137883	132298	2015-16 (includes up to February)
	performance	93.23%	89.83%	90.09%	2015-16 (includes up to February)
	Nat Average	95.69%	93.61%	93.30%	2015-16 based on Q1-Q3
	Best Performing	100%	100%	100.00%	2015-16 based on Q1-Q3

Trust				
Worst Performing Trust	88.48%	82.03%	81.20%	2015-16 based on Q1-Q3

Reflecting national trends, Emergency Department (ED; 'A&E') attendances rose at both the Horton and John Radcliffe sites. Increases were seen across all age groups and across all pathways (Minor, Major, Paediatric and Critical Care). Increased complexity of medical presentation and of additional social and/or psychological need was a further feature of the attending patient group.

The months of January, February and March were particularly challenging: ED attendances were 12% higher than the equivalent period in 2015, an unprecedented rate of growth that may in part reflect intensifying pressures in primary care and developing care-seeking behaviours as well as the patient and population vulnerability that comes with increased numbers of people living with complex, chronic illness.

The 4 hour access standard was not achieved. Factors include exceptionally high activity, acuity and complexity levels, outflow block (a failure to transfer care promptly to a clinical setting in the hospital beyond ED), and internal factors as the urgent care pathway reconfigures to a more capable, sustainable model of care. Outflow block from ED reflected very high bed occupancy levels, itself a product of exceptional acute clinical need and the levels of delayed transfers of care (DToC) that remained high despite the successful and ongoing DToC 'Care Home beds' initiative.

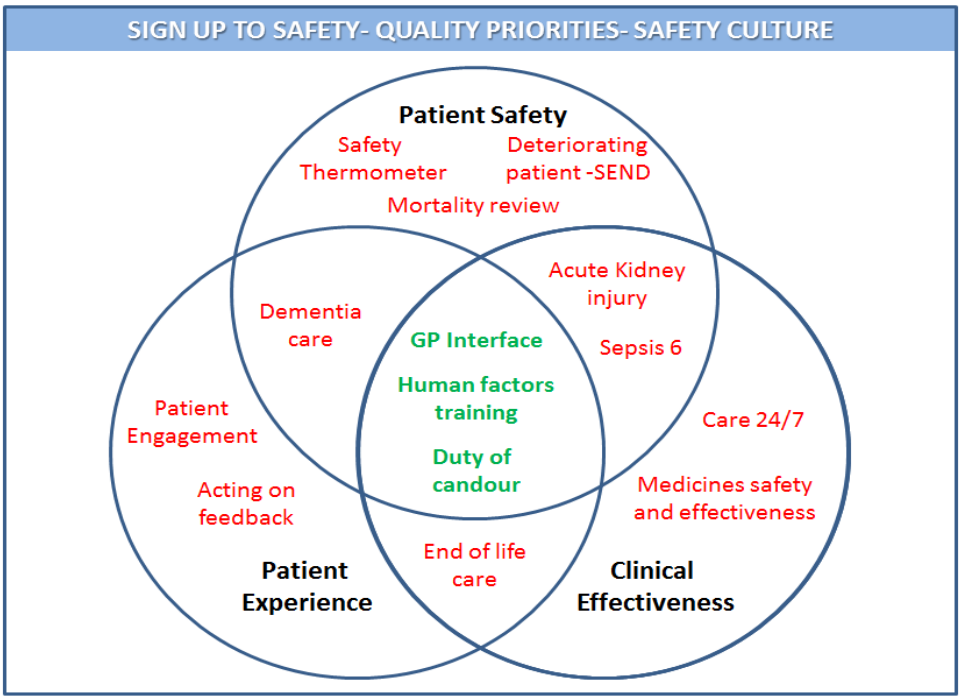
The Oxford University Hospitals NHS Foundation Trust has taken the following actions to improve this indicator and so the quality of its services by:

- Strengthening the clinical team with additional experienced nursing and medical staff, support services such as portering and Radiology have been strengthened, advanced 'point-of-care' diagnostic approaches are in routine use, pathways are 'ambulatory (non-admitting) by default', and physical works and reconfiguration in ED and the Emergency Assessment Units (EAUs) has improved patient experience and supported earlier more effective clinical care.

Looking forwards, the service must continue to adapt to better meet growing and different patient needs. Key patient groups include the very young, the very elderly and frail, patients with psychological needs, and patients with severe critical illness. Delivering individualised, patient-centered care across boundaries is key to delivering best care and best value-for-money; we are working intensively with teams within and beyond OUHFT - including Primary Care, Community Health and Social Care providers and commissioners - to identify innovative solutions to support delivery of best clinical care 24-7.

Progress against priorities for 2015-16

How did we do against last year's priorities?



This venn diagram shows the relationship between the different quality priorities in the Trust in 2015/16 and the three domains of quality.

Our interactions with GPs; providing human factors training; and our responsibilities regarding duty of candour (being open), are priorities that impacted on all three quality domains.

Domain	CQC Questions	Priorities for the Trust 2015/16
PATIENT SAFETY	Safe Caring Responsive Well led	• Preventing avoidable patient deterioration and harm in hospital • Partnership working to improve urgent and emergency care • Improving recognition, prevention and management of acute kidney injury
CLINCIAL EFFECTIVENESS	Effective Safe Caring	• Learning from deaths and harm to improve patient care • Management of patients presenting with sepsis
PATIENT EXPERIENCE	Caring Responsive Well led	• End of life care: improving people's care in the last few days and hours of life • Improving communication, feedback,

		engagement and complaints management

Patient Safety

<u>Priority 1:</u> Preventing avoidable patient deterioration and harm in hospital:
Sign Up to Safety

Our aims

- Reduce the number of unexpected cardiac arrests and unplanned admissions to our critical care units by quickly recognising when a patient's condition deteriorates.
- Continue to make improvements to the way clinical staff hand over care between teams 'out of hours' and ensure that critically ill patients are seen by a consultant twice a day. These will be part of the 'Care 24/7' project. (Care 24/7 is a Trust-wide project to meet the NHS England and NHS Improving Quality priorities for 7 day working in the Trust)
- Increase our understanding of the safety culture in the Trust and identify ways of improving.
- Continuously evaluate our compliance with policies and procedures. Improving the way our clinical guidelines are developed, approved and stored centrally.
- Improve our processes for maintaining an accurate record of the medication a patient is taking and communicated this appropriately (medicines reconciliation).
- Improve the efficiency at which patients receive their TTOs (medicines to take out) on discharge.
- Increase the number of patients receiving 'harm free care' as measured by the NHS Safety Thermometer to 95% by the end of 2016. This includes:
  - working towards our target of having no avoidable pressure ulcers by 2016
  - 10% reduction in inpatient falls causing severe harm
  - Reducing the rate of urinary catheter associated infection (CAUTI), including training staff to use bladder ultrasound scanners as part of the Oxford Academic Health Science Network[4] (AHSN) collaborative.
  - Reducing the incidence of new venous thromboembolism.

Goal	Target	Measure	Plan
All critically ill patients will be seen and reviewed by a consultant twice daily, including all acutely ill patients directly transferred, or others who deteriorate.	By Q4 100% of patients on intensive and high dependency area will be reviewed by consultants twice daily.	We will measure by Direcorate audits of patient records. Directorates will report their figures to the Care 24/7 project team.	Each of our Directorates will prepare an action plan to implement twice daily reviews.
How did we do?			

[4] The AHSN brings together the NHS, universities, business, patients and the public to promote best health for our population and prosperity for our region. For information see: www.oxfordahsn.org

Goal	Target	Measure	Plan
• We are pleased to confirm that patients in all of our intensive care departments receive twice daily clinical reviews by consultants as a minimum • There are no designated high dependency units at the Trust however a number of our ward areas also care for very sick patients; during the year ahead we will be carrying out work to define a number of these areas as high dependency. This will be part of the Trust programme of work to implement standard 8 of the national clinical standards for seven day working. Standard 8 is one of the 4 'critical standards' considered to have the biggest impact on mortality rates			
Improve the way we recognise when a patient's condition deteriorates, so we can take prompt action to treat them.	Roll out electronic track and trigger system in all acute areas of the Trust. Produce a cardiac arrest reduction strategy by March 2016.	Number of acute areas in the Trust with electronic track and trigger Ratified cardiac arrest reduction strategy by 31 March 2016.	Our intensive care team will lead this work. The first phase of our roll out programme will prioritise areas with higher levels of cardiac arrest, based on data from the resuscitation department. Resources for the project (including bedside scanner and tablet) will be helped by external funding from the NHS technology fund. Our RAID* committee will develop the cardiac arrest reduction strategy and will meet bi-monthly to monitor this work. (* recognising acutely ill and deteriorating patients)
How did we do? • Deteriorating patient –SEND. The roll out of SEND electronic track and trigger project is on time and on target. It is fully implemented in all acute areas across the Trust and in all areas at the NOC and Churchill. • The cardiac arrest reduction strategy was updated and ratified at the RAID Committee in January 2016 – clinical areas with high levels of cardiac arrest call outs, are being piloted with facilitated recognition training and proactive monitoring of System for Electronic Notification and Documentation (SEND). • The RAID committee is reviewing and updating the RAID policy with input from the Quality Improvement (QI) team. This incorporates the track and trigger system • A strategy meeting with the Practice Development Nurses (PDNs) within the Trust was held in order to review all education provision across the Divisions and sites in relation to RAID training and assessment • One of the quality improvement (QI) Nurse Educators has scoped where all the RAID training is being provided within the Divisions. An education strategy was presented and signed off at the RAID Committee (January 2016) • An educational roll out programme has been developed which includes the train the trainer model and uses the Plan Do Study Act(PDSA) quality improvement methodology to gather the data			

Goal	Target	Measure	Plan
• The use of Situation Background Assessment Recommendation(SBAR) as a model for handover/escalation has been agreed, with a view to wider consultation and roll out. The QI team will be scoping training and education requirements			
Reduce all harms measured by the Safety Thermometer	Deliver 95% harm-free care by 31 March 2016	We will measure this by the monthly Safety Thermometer	• Focused staff training and link nurse support to reduce pressure ulcers • Standardise all specialist equipment • Implement the FallSafe care bundle • Develop and implement the CAUTI care bundle • Intense focus to increase venous thrombo-embolism(VTE) assessment rate including prompts in the Electronic Patient Record(EPR) to carry out VTE assessment within 6 hours of admission

How did we do?

- The Trust achieved 95.2% harm free care for new harm (which aligns to hospital acquired harm in most instances) by March 2016.
- When 'old harm' as define in safety thermometer is included the rate of harm free care has varied from 94.7 at its highest to 90.1% at the end of 2015/16 which is disappointing.
- The OUHFT harm reduction Quality Priority includes aiming towards zero avoidable hospital acquired pressure ulcers, a 10% reduction in inpatient falls resulting in severe harm, reducing the rate of catheter associated UTIs and reducing the incidence of new venous thromboembolism.

- However, progress has been made with specific actions identified to reach the goal and improvement is evidenced in other outcome measures

Pressure Ulcers

- The Trust has continued to focus on Hospital Acquired Pressure Ulcers in 2015/16 in order to reduce harms. A thorough process of reporting and investigation has been developed to ensure learning from incidents occurs at all levels

- Safety Thermometer data demonstrate improved reporting of superficial Hospital Associated Pressure Ulcers (HAPU), showing improved recognition and ward level responsibility for the ongoing management of patients at risk.

- An Electronic (E)-Learning module was released to support clinical staff in caring for patients at risk of pressure damage. Levels of uptake will be monitored and reported at Trust level.

- Tissue Viability link nurses have now been established and are supported with an

Goal	Target	Measure	Plan
educational programme and a forum which meets regularly **Falls Prevention** • The lead Quality Improvement QI Falls Prevention trainer has benchmarked, scoped and gathered information via ward visits and data review to inform a gap analysis across the Trust with respect to Fall safe roll out and the level of high impact falls. • The Falls Safe Nurse Educator has completed two Falls Champion training days at the Churchill and NOC, with a view to wider roll out to the Horton and JR • A Fallsafe educational roll out programme has been developed, examining data to identify where the key issues and high levels of high impact falls that cause harm, as a priority in terms of the roll out programme • The electronic Falls Assessment is now on the Electronic Patient Record(EPR) task list, which provides easier accessibility for clinical staff, with the capability of audit to understand compliance **Venous thrombo-embolism(VTE)** • See prior section • **Catheter Acquired Urinary Tract Infection (CAUTI)** • CAUTI meetings are held two monthly to progress the project, work is in collaboration with Oxford Health NHS FT and a lead at the Academic Health Science Network(AHSN) • The OUH FT Chief Nurse is regional lead for CAUTI • Definitions of a CAUTI have been established • 3 pilot wards are in place with ward sisters or Professional Development Nurses(PDNs) as leads, using the electronic patient record (EPR) to record catheterisation events. This forms the baseline audit for quality improvement • Initial surveys of staff practice and education levels as well as patient's care has identified key issues related to variable practice and a large educational component requirement.			
Increase the provision of human factors training to staff to improve awareness of the various factors associated with decision making. Phase one will focus on staff who have been involved in Never Events and other serious incidents.	100% of staff involved in Never Events to receive human factors training	We will check staff training records and ask staff to feedback following training.	Staff will be identified by Risk Management through incident investigations, and training requirements will be included in incident action plans which the Divisions will take responsibility for. The training will be provided by OxSTaR (Oxford Simulation Training and Research).

Goal	Target	Measure	Plan
How did we do? • 207 members of staff attended Human Factors training in 2015/16. A review of the training records shows that there has been multi-disciplinary attendance to the training, not only from those areas involved in Never Events, but the wider Trust • 46 human factors ambassadors have been trained to deliver human factors training at the clinical front line.			
Improve discharge planning and discharge process (related to providing TTOs – medicines to take out)	30% of TTOs written for non-emergency areas and released to pharmacy for dispensing the day prior to patient discharge	We will measure this using our ORBIT information tool	We will use a discharge review tool to help clinical teams to write and send the TTOs the day before patients are discharged
How did we do? • 28% of TTOs across the Trust were written and released to pharmacy for dispensing the day prior to patient discharge- narrowly missing this goal. • For the period 2015/16 the Trust produced in excess of 47000 TTOs of which just over 13300 were written and released to pharmacy for dispensing the day prior to patient discharge. • Medicine, Rehabilitation and Cardiac Division released just under 32% of their TTOs to pharmacy the day prior to discharge meeting the aim.			
To ensure acute emergency and elective inpatients (excluding day case, ward attenders and OPD) have had stage one medicines reconciliation completed within 24 hours.	By 31 March 2016 we will achieve 80% medicines reconciliation in clinical areas visited by pharmacists.	We will measure this using our ORBIT information tool.	We will complete the medicines reconciliation reporting tool (ORBIT). We will establish baselines levels to assess the impact of the ePMA implementation to enable a target to be set in Q2. We will review current practice and establish a workflow plan for attaining the target set.
How did we do? • By 31st March 2016 we had achieved 80% medicines reconciliation in clinical areas visited by pharmacists. • Pharmacy currently provides, in the main, a five out of seven day ward based clinical service • During 2016/17 the medicines reconciliation reporting tool was developed, reviewed and implemented. This tool now provides the monthly report for this metric • The tool now reports on ALL medicines reconciliation tasks fired for admitted patients which is a significant change in audit completion from 14/15 which required manual once monthly spot audit checks • Recent investment in weekend working service for most medical wards at the JR, all			

Goal	Target	Measure	Plan
wards at the Horton and a small number at the CH has improved ward based pharmacy services for the seven day service. Medicines reconciliation is higher in these areas.			

<u>Priority 2:</u> Partnership working to improve urgent and emergency care, including sustained achievement of the 4 hour Emergency Department(ED) standard[5].

Our aims

- To work with partners in health and social care to reduce avoidable A&E attendances and emergency admissions. This will work will examine and refine the urgent care pathway, producing solutions that will impact the entire system, not just our hospitals. It will also build on the Emergency Care Intensive Support Team (ECIST) action plan.
- To improve how we diagnose and support patients with mental health conditions and alcohol related reasons for attending A&E. Enhance staff training to care for these patients including signposting to liaison mental health teams, aiming for 100% of staff in A&E to be trained.
- To enhance the timeliness and quality of assessment of complex, frail and/or confused patients and to ensure that their ongoing care is in an appropriate setting.
- Achieve a sustainable electronic method of sharing key discharge information such as care plans by continuing to develop our electronic discharge system.
- To further develop our ambulatory pathways and our ability to 'signpost' clinicians and patients along those pathways.

Goal	Target	Measure	Plan
Improve the way we diagnose and support patients with mental health and alcohol related conditions.	100% of A&E clinical staff to receive guidance during induction and to know how to access relevant resources	We will measure this by collecting induction and meeting minutes, email communiques, review meeting with A&E psychiatric service and by collecting patient experience feedback.	We will achieve this by: • Presentations to meetings, both regular and at induction • Email communication • Providing our staff with web-based information • Review of current process with A&E psychiatric service • Development of patient experience feedback system for these patients
How did we do? • 100% of ED clinical staff completed a local induction which gives them information on the ED Community Safety Practitioner role and how to refer when patients present from alcohol intoxication or dependency • 100% of ED clinical staff complete a local induction which covers the mental health			

[5] ED is the emergency department, commonly known as A&E. The standard is that 95% of patients attending ED will be seen, treated, admitted or discharged in under four hours.

Goal	Target	Measure	Plan
pathway • Monthly clinical meetings are held with the Emergency Department Psychiatric Service (EDPS – Oxford Health NHS Foundation Trust) to improve the way we diagnose and support patients. Attendees include the ED Matron, EDPS Psychiatrist, ED Specialist Doctor and ED Community Safety Practitioner. • Multi agency shared management plans are held on the patient record system in OUHFT. The multi-agency management plans are support by the GP, Turning Point (drug and alcohol services in Oxfordshire), mental health services and EDPS. The patient is aware of the Management Plan and is asked to agree to the plan.			

<u>Priority 3:</u> Improved recognition, prevention and management of patients with Acute Kidney Injury (AKI)

Our aims

- Measure the percentage of emergency patients with a major risk factor for AKI who have:
  - a medication review
  - kidney blood tests re-checked within 24 hours of admission.
- OUH care bundle implemented; key to this are physiological scoring on admission and senior clinical review within 12 hours of admission.
- Embed the AKI algorithm within the Trust.
- Have an internal alert system from laboratories linked to EPR so that kidney blood test results are immediately visible to the treating doctor.
- Have an electronic system to alert community care providers that a diagnosis of AKI is suspected by kidney blood test results.
- Include key information on discharge correspondence to help the GP with onward management
- Have an AKI team comprising a dedicated nurse and medical backup. This structure would provide leadership and deliver training.
- Develop a pharmacy role to carry out medication reviews, helping with AKI prevention.

Goal	Target	Measure	Plan
Ensure emergency admissions are screened for AKI	All emergency admissions are given: • Medication review • Kidney blood	We will measure this by auditing notes of patients admitted in an emergency.	• Establish an AKI team • Implement the AKI care bundle and algorithm. • Development of a pharmacy role to carry our medication reviews

Goal	Target	Measure	Plan
	tests re-checked within 24 hours of admission		• Roll out the EPR alert system

How did we do?

- A Task and Finish group was established to plan and implement the necessary changes in Trust wide working related to AKI.

- A Trust wide audit required by Clinical Governance Committee has been completed:
  - Although AKI was correctly identified in 97% of Trust wide patient notes, the cause of AKI and assessment of severity of AKI was poorly recorded. It is anticipated that this will improve with the e-alert system

- An electronic alert system for automatically identifying AKI and AKI severity was launched in April 2016.

- The AKI care bundle has been updated and is available on the intranet. This covers the initial management steps and when to seek specialist advice. In order to aid its use, the care bundle has been embedded into EPR and will be triggered automatically in patients with an AKI e-alert.

- The electronic alert system will update the patient records with AKI stage, to aid coding and quality of information provided on discharge summaries.

- Educational resources to inform staff have been distributed together with a programme of seminars in key clinical areas.

- AKI group members have actively participated in OxAHSN stakeholder events, which aim to share learning and improve quality in our region.

- Beyond the Thames Valley, benchmarking against other NHS England Trusts is being conducted, with visits to Salford, Sheffield and the national THINK KIDNEYS campaign quality improvement meeting.

- Quality Improvement Projects are being undertaken around the roll-out of the Trust wide electronic alert for AKI in various different clinical areas. The AKI group are also examining larger scale outcomes, such as progression to higher AKI stage and AKI related mortality.

- Resources have been agreed for an additional medicines review by pharmacists after an AKI alert, with a planned start for this work in the summer 2016. AKI pharmacist review to be documented in a bespoke EPR note. Quality improvement work to be undertaken around this implementation.

Clinical Effectiveness

Priority 4: Learning from deaths and harms to improve patient care

Our aims

- Achieve a year-on-year reduction in mortality by:
    - raising the profile of the mortality review process across the Trust
    - maximising learning from deaths by ensuring a standard approach is taken
    - improving the way we share lessons learnt from mortality reviews and mortality and morbidity meetings across the Trust
    - Improve how we collate internally generated information on our mortality rates, mortality review and learning points by creating a core Trust mortality database.

Division

Goal	Target	Measure	Plan
Systematic process of reviewing deaths in place across the Trust so we can improve care and achieve a year on year reduction in avoidable deaths.	100% deaths reviewed in line with our mortality review process.	We will carry out compliance audits of our mortality review process in each Division.	We are raising the profile of mortality reviews by implementing a new mortality reduction strategy and by carrying out a review of our mortality review process. Lessons learned from our mortality reviews will be fed back into our proactive strategies to save lives such as our work on AKI and sepsis

How did we do?

- An analysis of the Divisional mortality reports for April to December 2015 indicate that 85% of deaths were formally reviewed.
- The quarterly Divisional mortality reports were reviewed at the Clinical Effectiveness Committee which is attended by clinicians representing the different medical specialties. The learning points highlighted in the mortality reports are disseminated by the clinical membership within their respective clinical areas. The Clinical Effectiveness Committee has commissioned working groups to review specific areas of concern identified in the mortality reports

- The Trust has established a Mortality Review Group which meets monthly with multidisciplinary and multi-professional membership and the responsibility for clear mortality reporting to the Board

- The Group is reviewing the mortality process and proposals for a revised Mortality Reduction Strategy.

Priority 5: Management of patients presenting with sepsis

Our aims

- Implement a sepsis care bundle to ensure prompt recognition and treatment of sepsis.
- Provide an oversight structure to provide senior leadership and supervision.

Goal	Target	Measure	Plan
Ensure prompt recognition and treatment of sepsis	Standardised sepsis care screening tool to be used in emergency admission areas	We will audit the notes of patients with sepsis	We will agree a standardised screening tool and care bundle based on sepsis six. We will provide training for staff in emergency admission areas.
Rapid administration of IV antibiotics to patients with sepsis.	Patients presenting to emergency admission areas with severe sepsis or septic shock to receive IV antibiotics within 1 hour of presenting	We will audit the notes of patients with sepsis	We will agree a standardised screening tool and care bundle based on sepsis six. We will provide training for staff in emergency admission areas.

How did we do?

- The Sepsis Group is now established; this is an inter-disciplinary group with representatives from pharmacy, nursing, Quality Improvement(QI), different medical specialties, & patient involvement
- The group has signed up to the UK Sepsis Trust for information and is involved in the UK Sepsis Nurses Forum, which is national forum
- A paper ‘sepsis screening tool’ has been agreed and has been rolled out from January 2016. Initially this will be used in Emergency Department(ED), Emergency Admission Unit(EAU) /Medical Admissions Unit(MAU), and Surgical Emergency Unit(SEU)
- Separate versions of the sepsis screening tool have been developed for paediatrics and maternity
- Electronic tools for sepsis identification using the electronic patient record are currently being explored
- Work is underway to develop a Sepsis PowerPlan to facilitate delivery of the sepsis care bundle
- A baseline audit of sepsis management has been undertaken
- An educational strategy and roll out programme is in progress and will be presented at the next Sepsis working group meeting.
- Educational material which includes presentations, and the use of an educational quiz game, has been developed ready for roll out
- Sepsis training for doctors has been incorporated into induction, foundation doctor (

Goal	Target	Measure	Plan
first year after graduation) and medical student teaching. Excellent feedback has been received from the monthly induction talk • OUHFT is an active participant in the newly formed OxAHSN sepsis group and one of the team is its chair. The QI Nurse Educator has benchmarked with other hospitals and has visited Great Western Hospital (Swindon) with some information sharing and network opportunities • The filming of a patient story related to this subject has taken place with the aim of using the film for educational purposes, and include e-learning as part of the education programme • The Plan Do Study Act(PDSA) improvement cycles for Sepsis have been commenced with the data being presented at various forums • The ED Sepsis 'grab bags' were implemented in November 2015.			

Patient Experience

<u>Priority 6:</u> End of life: improving people's care in the last few days and hours of life

Our aims

- Provide compassionate, consistent and reliable care to patients coming to the end of their lives, and to families after the death of their relative, in all areas of the Trust and on all shifts.
- Develop a new End of Life (EOL) Care Strategy aligned with the latest guidance 'One Chance to Get it Right'. Phase one of the strategy will focus on end of life care at the John Radcliffe Hospital in 2015.
- Continue to examine our practice by repeating the National Care of the Dying Audit in 2015.
- Help our staff deliver care by focusing on staff education.
- Enhance how we work with our community colleagues by providing expert palliative care advice and by receiving feedback to allow us to adjust our service where possible.
- Learn from good practice around the country by hosting an EOL care symposium in 2015/16.

Division

Goal	Target	Measure	Plan
Education and training programme in place for all staff caring for dying patients. This will include communication skills	At least 75% of clinical staff to completed core modules by 31 March 2016.	Review of training records.	An educational programme comprising eLearning modules will be available on the Trust learning and development site.

Goal	Target	Measure	Plan
training, and skills for supporting families and those close to dying patients. Recommendation from National Care of Dying Audit for Hospitals Report[6]			The educational programme will be supported by the EOL strategy containing guidelines, and EOL champions to drive forward improvements in attitudes and care.

How did we do?

- The lead for this work stream is a Palliative Care consultant from Sobell house working with the Clinical Lead from a Palliative Care consultant, according to the 5 key national End of Life Care Priorities

- The End of life care group is chaired by the Medical Director, adding conspicuous executive commitment to this area of work, and is attended by stakeholders including the CCG.

  An EOLC symposium took place in November 2015. Over 200 staff attended to learn from national speakers. The symposium was open to health and social care partners across Oxfordshire and was well attended with 200 attendees and a lot of positive feedback. One of the Trust's consultants, Dr. Bee Wee, who was a speaker at the symposium, has been reappointed as National Clinical Director for End of life care.

- Training packages have been developed but not yet rolled out. Training is to be arranged for staff in two modules for clinical and non-clinical staff and will adopt a tiered approach

- A National Care of the Dying audit has been undertaken to look at deaths in the Trust. A report on the findings of this audit will be presented at the Trust Clinical Effectiveness Committee in May 2016

- A survey had been sent out to relatives of those who had died at the OUH. Feedback had been positive

- The Sobell House Charity and the Trust's CEO have approved £650k for the next 2-3 years to employ staff to drive forward face to face care. A team will be put together to provide seven days a week cover. This will comprise of medical, nursing and pharmacy staff

- The Trust received feedback from four regional Islamic funeral directors that the Trust's bereavement service provides an exemplary service.

<u>Priority 7:</u> Improving communication, feedback, engagement and complaints management: with patients, carers, healthcare staff and social care providers

[6] See Royal College of Physicians www.rcplondon.ac.uk/sites/default/files/ncdah_national_report.pdf

Our aims

- Improve the experience for carers when they come to our hospitals. We will improve how we collect their feedback and use this information to improve our care.
- Ensure our Trust-wide privacy and dignity policy fully respects the needs of vulnerable patients.
- Improve how we communicate with patients whose first language is not English or people who have visual or hearing impairments, or learning disabilities. This will include ensuring the letters we send are in easy to understand plain English, developing a new IT communication system for hearing impaired people and redeveloping our internet and intranet sites to publicise our interpreting services.
- Improve how we manage complaints and act on feedback particularly how we change our services in response to this and how we train our staff.
- To meet the national targets of assessing 90% of patients over 75 who have been in hospital for 72 hours or more for dementia.
- All our staff and clinical environments will be dementia-friendly and all our staff will receive dementia awareness training.
- Strong nursing leadership to drive improvements in our dementia care.
- Manage the emergency care pathway effectively to safeguard and improve the experience for patients with dementia.
- Participate in the AHSN Dementia Clinical Network[7] dementia strategy.
- Support staff to be candid with patients and their families if something goes wrong, and help our staff to understand why things go wrong and how to put them right.
- High reliability in the generation and sending of discharge summaries and letters, and the signoff of results.
- Streamlined and reliable arrangements in each specialty for contact with GPs to discuss patient issues.

Goal	Target	Measure	Plan
We will have a method of collecting feedback from carers for people with dementia that is easy to use and developed by carers themselves.	Feedback from carers will be reported to the Board and Quality Committee each month from July 2015	We will measure this by linking feedback received against the content in Board reports.	The survey form will be co-produced by carers (Carers Oxfordshire), Carers Voice[8] and will incorporates the national 'John's campaign. Carer volunteers will test and refine it. We will monitor how effective this process is at our dementia steering group.
How did we do? • A questionnaire designed by the Carers Project group in 2015 is used on wards to collect feedback from carers. However, after hearing from carers that they would prefer face to face advice rather than filling out a questionnaire, a new project stream was developed; an Outreach Worker from Carers Oxfordshire is available 3 days per week to speak 1:1 with carers, providing advice and emotional support			
We will produce a privacy and dignity policy that respects the needs of vulnerable people.	First draft by September 2015. Final draft within 2015/16.	Ratified policy by 31 March 2016.	We will develop this policy will be developed in association with patient advocacy groups*, Healthwatch Oxfordshire and Foundation Trust members. Our

[7] See www.oxfordahsn.org/our-work/clinical-networks/dementia

[8] Carers Voice Oxfordshire helps people to speak up about services and support provided for carers. For more information see: www.carersvoiceoxfordshire.org

Goal	Target	Measure	Plan
			P&D steering group will monitor this process. *Carers Oxfordshire, Carers Voice, Oxfordshire MIND, Patients Voice, My Life My Choice,[9] Healthwatch Oxfordshire '*Dignity in Care'* campaign.
How did we do? • The Trust's Privacy and Dignity Policy has been revised using a model of co-production with a wide range of stakeholders • It was ratified by the Trust in November 2015 • The groups that contributed were: Age UK, Carers Oxfordshire, Unlimited (Physical disability organisation), Healthwatch, Guideposts Trust, Alzheimer's Society, Oxfordshire County Council, My Life My Choice (Learning Disability self-advocacy organisation), Patient Voice and Public Partnership Groups, Oxfordshire Mind • A new Patient and Public Involvement Strategy has been developed and approved by the Quality Committee. The Strategy outlines the Trust's objectives over the next 3 years and aims to increase the involvement in all areas of the Trust's work and expand the diversity of those involved			
We improve the way we manage complaints by having well trained staff.	100% staff trained who investigate complaints by 31 March.	We will measure this by checking training records.	New complaints management training will be provided to all staff investigating complaints including PALS and Complaints Department, Matrons and Clinical Leads. This includes mediation and facilitation training for complaint resolution.
How did we do? • 100% of the Complaints and PALS teams were trained in complaints mediation in 2015/16. • The training sessions in 2015 were attended by 5 matrons, 2 deputy matrons, 16 consultants, the Head of Patient Experience and the Head of Midwifery. Numbers trained are be monitored by the Complaints team after each session. • Since April 2015, all complaints are now coded using the national complaints coding categories. A detailed analysis of the complaints is then written each month and presented to the Trust Board/Quality Committee. This helps to identify particular themes and trends			
Our staff will be open with patients and families if something goes wrong in line with the Being	Roll out DATIX monitoring of all aspects of Duty of Candour	DATIX system in place with compliance monitored via performance reviews	We will amend DATIX system to guide staff to carry out and document being open and offering an apology to patients or relatives

[9] My Life My Choice is a self-advocacy charity run for and by people with learning disabilities. See http://mylifemychoice.org.uk

Goal	Target	Measure	Plan
Open policy			after any health care acquired moderate or severe harm in line with the legal and professional Duty of Candour Our policy will be updated to reflect this.

How did we do?

- Since the introduction of the Duty of Candour, this area has attracted significant attention with changes incorporated in the monitoring of incidents resulting in moderate or greater harm.

- The Trust's incident reporting and risk management system (Datix) was modified in August 2015 to capture the required information, to provide supportive information about the Duty of Candour, and assist with the monitoring of the Duty of Candour.

- Incidents continue to be reviewed on a daily basis by Clinical Risk Management with all incidents reported with suspected moderate or greater actual harm followed up specifically to: 1) ascertain the correct level of harm and if so, 2) to advise the area of the requirements regarding the Duty of Candour.

- This is further monitored at the weekly SIRI forum as a standing agenda item. Each incident that potentially meets the requirement for Duty of Candour is discussed to ascertain whether the patient or their representative has received: an apology in person, information regarding what has happened and what further enquires will take place from an appropriate member of staff. In addition, details regarding whether a letter has been sent to the patient or their representative is also recorded.

- Clinical Governance also report on compliance regarding the Duty of Candour on a monthly basis (Schedule 4) with each incident potentially meeting the requirement for Duty of Candour checked for evidence that this has taken place from a range of sources, including: SIRI forum minutes, SIRI log and Datix. The final return is signed-off by the Head of Clinical Governance prior to submission to the Trust's reporting systems (ORBIT).

We will improve how we communicate the signing off of test results with our GP colleagues	95% of test results to be signed off within a week of the result being available	We will measure this with data extracted from EPR	The Medical Director and Divisional Directors have communicated this priority to all medical staff. It will be monitored via performance reviews and managed in the Divisions.

How did we do?

- In March 2016 the Trust wide endorsement of test results was 63% by the end of the financial with ongoing work to enhance monitoring of performance at Direcorate and Divisional level. The highest achieving Division achieved 90% sign off within 7 days.

- Achieving the 95% target has been challenging, with a concerted effort to achieve improvements in this measure. It is possible to see and act on test results without endorsing the result. OUHFT sees endorsement as best practice showing that the person who reviews them has signed them off.

Goal	Target	Measure	Plan
• Significant improvements in reporting on this data from the electronic patient record(EPR) and ORBIT have been developed; including early development work to incorporate results endorsement data onto the new information system (Tableau); this will hopefully improve reporting on this indicator locally and make it easier to identify areas of good performance or those requiring improvement.			

Other areas of ongoing work (2015/16) included:

- Diabetes – continued implementation of our diabetes action plan, addressing issues raised in national audits, internal peer review and a risk summit held in 2014/15

  How did we do?

  - The NaDIA audit took place on the 29th of September 2015. There was a 15% prevalence of in-patients with diabetes (170 patients) within the Trust which is in line with the national average. There were consistent improvements in the quality of diabetes care across nearly all metrics. Overall patient satisfaction of the inpatient diabetes care continued to rise from 85.7% to 86.2%, remaining above the national average of 84.1%
  - The significant improvement in the quality of care for in patients with diabetes has come about through investment in workforce, re-writing and implementing the diabetes statutory mandatory training and using IT to improve communication between clinicians and visibility of diabetes data.
  - Diabetic Foot Audit
    - 181 in-patients with diabetes were identified on the day of audit, of which 175 had their feet assessed. 43 were found to have an active diabetic foot problem. This gives a prevalence of 24%. All the metrics had improved substantially from the audit of the previous year with some further work to do. It is felt that the changes achieved from last year to this year have been reached by the increased presence of the Podiatry Team on the wards. The Tissue Viability Team has also played a key part in highlighting issues of Pressure Damage on the wards.

- Dementia – implementation of the our Dementia Strategy, agreed by the Trust Board in November 2014, with a particular focus during 2015/16 on improving both the assessment of patients and the environment in which they are treated, as well as training for staff.

  How did we do?

  - An educational strategy has been drafted and approved through the Dementia Steering Group (March 2016)
  - The tier 2 dementia simulation training that is currently in place continues until May 2016 with 5 events in total, this includes peer discussion and facilitation. These are being evaluated with a view to further development to incorporate Mental Capacity Assessment, and DOLS training to form part of a whole days training with aims and outcomes well defined

- Podcasts and Apps, and other simulation aids are being developed and procured to enhance other training materials
- The Dementia Information Café has proved successful with carers' attendance, but this is being benchmarked with a highly effective Dementia Café in Bristol, in order to maximise its user friendliness before roll out to other hospital sites in the Trust
- The Trust now has eight dementia-friendly computers and two tablets supporting reminiscence in hospital
- The Dementia Leads who were trained through Worcester University are ensuring parity of education provision across the Trust and are supporting well defined Leads and Champions in areas
- A new post was created for a Quality Improvement Nurse Educator in Dementia and End of Life care. The post holder started in February 2016 and will help to lead on education and Dementia awareness throughout the Trust.

- Seven day working - Care 24/7 is one of the projects in our Transformation programme. A baseline self-assessment on preparedness to meet the NHS England and NHS Improving Quality priorities for seven day working, supported by an in depth audit of 150 case notes has demonstrated the progress that has been made.

  How did we do?

  - The out of hours handover process is fully embedded on one of our four sites (Horton hospital) and is being implemented across our three remaining hospitals starting with the Churchill hospital and Nuffield Orthopaedic Centre during 2015/16. A phased implementation process has enabled us to iron out any teething issues as we go along
  - Positive feedback has been reported by the out of hours team and compliance visits have noted improved communication at handover meetings underpinned by the Situation, Background, Assessment and Recommendation(SBAR) tool and adherence to the new handover guidance
  - The SBAR tool and video showing best practice is now part of the junior doctor's induction programme and all resources are available on our intranet
  - Extended skills training revisions for managing a deteriorating patient and advance life support have been provided to fully equip the out of hours team across the Churchill site

- Medicines management, including antibiotic prescribing.

  How did we do?

  - This work stream has reviewed the most common medication safety incidents reported in England and within the Trust with regard to numbers and harm caused. The main themes were similar in both settings. Four areas have been prioritised for action:

1. Anticoagulants
2. Insulin
3. Antimicrobials

4. Omission or delay of administering an essential medicine.

- The medicines safety team has been working with and supporting existing specialist multidisciplinary teams to improve medicines safety in the first three areas. A 'deep dive' into the final area has confirmed the important of this issue and a new work stream is being established to drive improvement. The overlap between these first three and the omission or delay of essential medicines has not been lost and is essential in managing sepsis.

- The team has been supporting the Divisions with Trust investigations and learning from where more serious patient harm has been associated with medicines use. This has included reviewing all 'Serious Incidents' reports to identify themes, share learning, develop and inform action plans to reduce the potential and actual patient harm associated with these prioritised work streams

- Continued development of **psychological medicine services** – the focus for 2015/6 will be cancer, women's and children's services.

How did we do?

- Cancer: 0.5 whole time equivalent (WTE) psychiatrist appointed into post. We are appointing 3 Macmillan funded specialist nurses and starting to develop comprehensive depression care for cancer outpatients
- Women's: 0.5 WTE psychiatrist appointed into post. Implementing systematic mental health care through specialist midwives
- Children's: additional WTE psychiatrist appointed to supplement existing psychological support, developing comprehensive psychosocial care for children's services

Continuing development of these services remains a focus for the Trust

Our performance against Monitor Risk Assessment Framework indicators

A number of national measures are used by Monitor to make an assessment of governance at NHS foundation Trusts. Performance against these indicators is used by Monitor as a trigger to detect potential governance issues. As a Foundation Trust, we are required to report on these indicators either monthly or quarterly.
Our performance against these indicators can be seen in the table below:

Key performance indicators

Performance Indicators

	Performance			Quarterly Trend			
	Target	2015-16 Annual		Q1	Q2	Q3	Q4
28 day breaches as a % of last minute cancellations	= 0%	3.0%	🔴	1.8%	1.4%	6.5%	-
Incidence of MRSA bacteraemia	= 0	3	🔴	2	0	1	0
Rates of Clostridium difficile	< 64	54	🟢	15	15	16	8
18 week Admitted	> 90%	86.3%	🔴	87.1%	87.3%	85.2%	82.3%
18 week Non admitted including Audiology	> 95%	94.2%	🔴	95.1%	95.1%	93.2%	91.9%
RTT - incomplete % within 18 weeks	> 92%	92.5%	🟢	93.2%	92.2%	92.2%	92.1%
Supporting measures: number of diagnostic waits <6 weeks	> 99%	99.6%	🟢	99.8%	99.8%	99.5%	99.2%
4 Hour Target Sitrep Months	> 95%	90.1%	🔴	94.3%	93.7%	88.3%	81.0%
2 week maximum wait for urgent suspected cancer referrals from GP to first outpatient appointment	> 93%	94.2%	🟢	94.9%	94.6%	94.0%	91.5%
Proportion of patients with breast symptoms referred to a specialist who are seen within two weeks of referral	> 93%	95.3%	🟢	98.2%	93.6%	94.5%	95.5%
31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers	> 96%	97.5%	🟢	97.7%	97.5%	97.8%	95.6%
31-Day Wait For Second Or Subsequent Treatment: Surgery	> 94%	95.4%	🟢	96.0%	96.0%	95.6%	92.2%
31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments	> 98%	99.4%	🟢	100.0%	99.5%	99.6%	96.9%
31-Day Standard for Subsequent Cancer Treatments (Radiotherapy)	> 94%	97.7%	🟢	98.8%	97.9%	98.0%	93.0%
Maximum waiting time of 62 days from urgent referral to treatment for all cancers	> 85%	84.1%	🔴	81.4%	85.2%	85.6%	84.8%
Extended 62-Day Cancer Treatment Targets (following detection via national screening programme of hospital specialist)	> 90%	95.1%	🟢	91.1%	96.9%	95.5%	100.0%
% of eligible patients receiving primary angioplasty within 90 minutes of arrival at interventional centre door	> 90%	94.8%	🟢	97.2%	89.3%	98.7%	95.7%
2 week maximum wait for rapid access chest pain clinic	TBC	100.0%	-	100.0%	-	-	-
Percentage of stroke patients who spend at least 90% of their time on a stroke unit	> 85%	90.7%	🟢	84.1%	93.4%	93.4%	93.3%
% of all adult inpatients who have had a VTE risk assessment	> 95%	97.2%	🟢	97.2%	-	-	-

Statements

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.

Monitor 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 2015/16 and supporting guidance

 the content of the Quality Report is not inconsistent with internal and external sources of information including:

o board minutes and papers for the period April 2015 to(the date of this statement)

o papers relating to Quality reported to the board over the period April 2015 to(the date of this statement)

o feedback from commissioners dated XX/XX/20XX

o feedback from governors dated XX/XX/20XX

o feedback from local Healthwatch organisations dated XX/XX/20XX

o feedback from Overview and Scrutiny Committee dated XX/XX/20XX

o the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated XX/XX/20XX

o the (latest) national patient survey XX/XX/20XX

o the (latest) national staff survey XX/XX/20XX

o the Head of Internal Audit's annual opinion over the Trust's control environment dated XX/XX/20XX

o CQC Intelligent Monitoring Report dated XX/XX/20XX

 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 Monitor'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

.....Date.....Chairman

.....Date.....Chief Executive

2015/16 limited assurance report on the content of the quality reports and mandated performance indicators

Independent auditor's report to the council of Governors of Oxford University Hospitals NHS Foundation Trust on the quality report

To be carried out 18/4/16

Oxfordshire CCG statement on Oxford University Hospitals NHS Foundation Trust
2015/16 Quality Accounts

To be added once CCG have had Quality account for review and responded

Response from Healthwatch Oxfordshire to Oxfordshire University Hospitals NHS Foundation Trust Quality Accounts

To be added once Healthwatch have had Quality account for review and responded

Additional NHS England requirements 2015/16:

In your report on your local improvement plans, we would be grateful if you would consider including the following information:

 How you are implementing the Duty of Candour

- Duty of Candour is now recorded on DATIX with a new module which provides decision support for all instances of moderate and severe harm
- Duty of Candour is also discussed and minuted in the Trust SIRI forum following review of all incidents of moderate and greater harm by Clinical Risk Management

 (where applicable) your patient safety improvement plan as part of the Sign Up To Safety campaign;

The Oxford University Hospitals NHS Foundation Trust Sign up to Safety pledges and corresponding patient safety improvement plan were interwoven with the 2014/15 Quality Improvement priorities and work plans. It is anticipated that the same is continued in 2016/17 to allow the pledges and plans to come to fruition

 your most recent NHS Staff Survey results for indicators KF19 (percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months) and KF27 (percentage believing that Trust provides equal opportunities for career progression or promotion) for the Workforce Race Equality Standard*;

Please note: There is a discrepancy between the descriptors and the numbers provided as requests for the report. The information for KF26 and KF21 have been summarised as per the description.

Key Finding	Description	OUH 2015 score	National average 2015	Best 2015 score for Acute Trusts	Workforce Race Equality Standard	WRES Average median for Acute Trusts
Key Finding 26	% of staff experiencing harassment, bullying or	23%	26%	16%	White - 23% BME - 20%	White - 25% BME - 28%

	abuse from staff in the last 12 months					
Key Finding 21	% believing that Trust provides equal opportunities for career progression or promotion	89%	87%	96%	White – 92% BME – 76%	White - 89% BME – 75%

 your CQC ratings grid, alongside how you plan to address any areas that require improvement or are inadequate, and by when you expect it to improve. Where no rating exists yet, please set out your own view on the five key questions used by the Care Quality Commission in their inspections of services:

1. Are they safe?
2. Are they effective?
3. Are they caring?
4. Are they responsive to people's needs?
5. Are they well-led?

* https://www.england.nhs.uk/ourwork/gov/equality-hub/equality-standard/

Please see ‘statements from CQC’ section in body of the report