Oxford University Hospitals
NHS Foundation Trust

Progress against Quality Priorities 2021-22 and Priorities for 2022-23

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on behalf of
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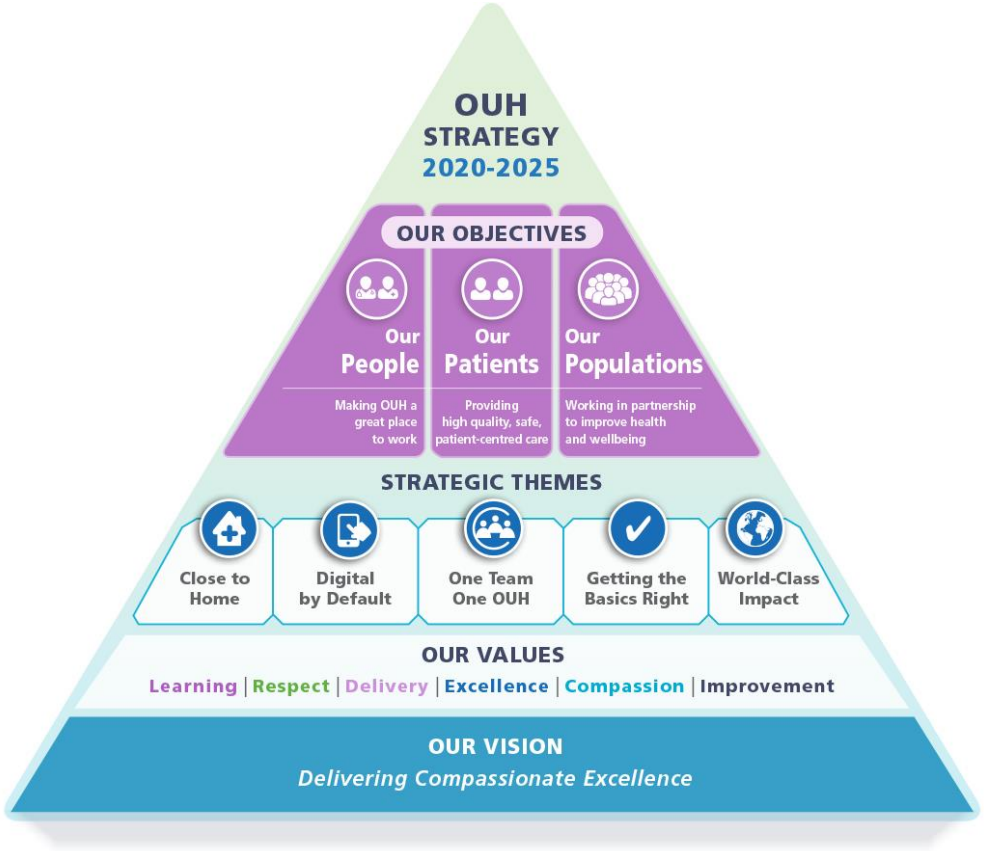
Chief Medical Officer

9 June 2022

The Joint Health Overview and Scrutiny Committee.
For Information June 2022

Our Strategic Framework 2020-2025

This is our strategic framework, developed by our staff and built on our vision and values



Quality Priorities 2021-22

Patient safety

- Triangulation of complaints, claims, incidents and inquests
- Safety huddles.
- Medication safety – Insulin and Anticoagulants.

Clinical effectiveness

- To minimise the occurrence of *C.difficile* and MRSA in OUH.
- Transition of children to adult services.
- Clinical Activity Recovery.

Patient experience

- Digital innovations .
- Staff health and wellbeing: Growing stronger.
- Quality Improvement (QI) Stand Up.

Did we achieve the 2021-22 Quality Priorities?

Triangulation of complaints, claims, incidents and inquests

Why we chose this Quality Priority	How we evaluated success	Evaluation March 2021
To promote optimal efficiency and learning from potential issues by embedding a combined approach to patient and relative responses, investigations and systemic improvements.	Action 1. A weekly Incidents, Complaints, Claims, Safeguarding & Inquests Scrutiny Group will take place a minimum of three times every four weeks in FY 21/22, with involvement of the Trust's corporate patient safety, legal, safeguarding and complaints teams. Action 2: Data around the following issues will be shared with attendees at or in advance of each meeting to allow the relevant team to follow up (e.g. is there already, or ought there to be, an incident raised on the OUH system correlating with a Coronial inquest into a patient death?)	Action 1: ***Fully achieved.*** The data collated for FY 2021-22 show that the nominated actions associate with this QP have been completed. Action 2: ***Fully achieved.*** A deep dive into a random selection of completed (partially) upheld complaints from Quarter 4 FY 2020-21 was completed, to see whether recorded incidents for the relevant patients show any potential gaps that might have stopped the complaint being raised had they been addressed through the incidents. The audit did not identify a sufficient number of cases from which to draw any conclusion.

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Safety Huddles

Why we chose this Quality Priority	How we evaluated success	Evaluation March 2021
Effective safety huddles involve agreed actions, are informed by visual feedback of data and provide the opportunity to celebrate success in reducing harm.	A standardised method to run and record safety huddles has been developed and implemented across the Trust. Action 1: We will audit huddle documentation. Success will be determined by 75% or greater documentation of huddles on 75% or more of intervention wards. Action 2: We will audit emergency calls and cardiac arrest rates in intervention areas. Success will be defined as a lower event rate in the year following the implementation and wash-in period.	Action 1: ***Fully achieved.*** An SOP has been developed for the use of the Clinical Worklist and illness severity, patient information, action list, situational awareness and contingency plans, and synthesis by receiver (IPASS) for the documentation of Safety Huddles. Action 2: ***Partially achieved.*** Based on the data from clinical areas (period 2019-2021) and feedback from staff, RAID committee members team have established the format in 10 ward areas (Ward 6A (Vascular), Neurosciences Wards, Short Stay Medical Wards, Gastro and Cardiology ward areas). The instance of 2222 calls in these areas are being monitored and evaluation in progress for the use of the whiteboards in terms of documentation for the purposes of audit.

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Insulin safety

Why we chose this Quality Priority	How we evaluated success	Evaluation March 2021
One in six people in hospital have diabetes and this is increasing. 35% of people with diabetes in OUH are treated with insulin and will be treated in all areas of the Trust.	Action 1: We will contribute to the development and testing of automated processes for identification of NaDIA Harms. Action 2: We will develop a formal mortality and morbidity process for the investigation of these Harms. Action 3: Where the NaDIA Harm criteria have been met, irrespective of the actual impact to the patient, there will be an investigation of what happened in order to learn and improve care. Action 4: Initially all 'Harms' will be reviewed in a Diabetes Safety meeting. Action 5: A multidisciplinary diabetes safety group will be set up to review the NaDIA Harm reports, identify learning and actions to improve care. Action 6: People with diabetes will be represented on the Diabetes Safety Group.	Action 1: ***Fully achieved*** Oxford University Hospitals NHS FT is one of 3 sites developing an automated approach to identification of harms for the new National Diabetes Inpatient Safety Audit (NDISA) Actions 2, 3 and 4: ***Fully achieved*** A monthly insulin safety group has been convened since July 2021, at which incidents are reviewed prospectively. Action 5***: Fully achieved*** An insulin safety group has been convened which consists of members of the diabetes specialist team and medicines safety pharmacists. This reports to the recently convened Medicines Safety Group. Action 6: ***Partially achieved*** A person with diabetes has been identified and agreed to attend the insulin safety group. Work in progress to find a solution about how best to obtain their input while maintaining patient identifiable information confidentiality.

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Anticoagulation Safety

Why we chose this Quality Priority	How we evaluated success	Evaluation March 2021
Errors related to use of anticoagulants are widespread despite local and national guidance and initiatives to improve patient safety. Anticoagulants are an ever increasingly complex area where suboptimal use can cause serious patient harm	Action 1: VTE prevention We aim to reduce the number of missed doses of dalteparin thromboprophylaxis by 10% compared to amalgamated data from the last 5 years. Action 2: Anticoagulation We aim to optimise the perioperative management of patients on oral anticoagulants. •We will introduce an updated MIL (Periop management of oral anticoagulants) •We will introduce a patient information sheet (PIL for patients on warfarin. •We will increase multidisciplinary educational resources and training •We aim to perform a baseline audit of Ulysses incidents related to perioperative anticoagulation prior to introduction of these measures to compare with a follow up audit. •We aim to improve the perioperative pathway for patients requiring new/repair of mechanical heart valves. Improve database recording of valve type Investigate improved inpatient support with dosing post operatively Optimise anticoagulation support on hospital discharge	Action 1: ***Partially achieved.*** Multidisciplinary education resources are now in place with monthly teaching session for Nurses and Midwives on their induction programme and Ad hoc teaching sessions for clinical areas on request. Action 2: ***Partially achieved*** MIL (Perioperative management of oral anticoagulants) Fully approved Jan 2022 PIL draft form for review with working party From August 2021 Anticoagulation Inpatient Safety Nurse returned to ward-based reviews of patients with high INR to provide more ‘at the elbow’ teaching and guidance. Baseline audit of Ulysses incidents related to anticoagulation over 4 months (Jan-April 2021) performed and re-audit now planned Jan-Apr 2023- 1 year post revised MIL and staff training increase. Ongoing - Monthly review of incidents by anticoagulation team with feedback into medicines safety group quarterly.

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To minimise the occurrence of C.difficile and MRSA in OUH

Why we chose this Quality Priority	How we evaluated success	Evaluation March 2021
People who are already weak or frail can sometimes become seriously ill as a result of contracting these serious infections in hospital.	Action 1: Record numbers and present these through the hospital infection prevention and control committee (HIPCC) and CGC. Action 2. All cases to have an incident report form submitted with root cause analysis completed by the clinical area. This will be reported in Clinical Governance papers and completion of the action log evidenced. Action 3. Review ventilator associated pneumonia (VAP) bundles and delivery of them. Review standard and delivery of mouth care to all patients in the Trust. Action 4: Launch of the seven Key Points to prevent Healthcare Associated Infections (HCAI). Action 5: Intensive Therapy Unit (ITU) capacity to return to normal in terms of bed spacing and staffing following the operational pressures of the COVID-19 pandemic. Action 6: IPC business plan to bring team establishment in line with Shelford Group incl. an anti-microbial stewardship (AMS) team. Action 7: Improvement in antimicrobial stewardship (AMS) Action 8: Review of insertion and ongoing care of intravascular devices.	Action 1: ***Fully achieved.*** Numbers continue to be reported monthly. Action 2: ***Partially achieved.*** Incident reports are now being submitted with root cause analyses being completed by the clinical area. Action 3: ***Fully achieved.*** Task and Finish group convened. VAP audit presented to HIPCC, bundle updated and shared. Action 4**:** ***Fully achieved*** 7 Key Points to Prevent HCAI during the COVID- 19 pandemic now launched. Trust internal auditors BDO findings report good knowledge across the MDT around 7 steps. Action 5: ***Partially achieved*** Surveillance in ICU settings continues a quarterly basis. Impact of COVID-19 has been limiting ability of ICUs to return to normal capacity. Action 6: ***Fully achieved*** Action 7: ***Partially achieved*** Action 8: ***Partially achieved*** Ongoing CLABSI surveillance in ICUs and haem and oncology

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Transition of children to adult services

Why we chose this Quality Priority	How we evaluated success	Evaluation March 2021
To ensure that all young people we treat receive a quality service in order to achieve optimum health and psychological wellbeing.	Action 1: Compliance with Transition From Children to Adult Services Policy. Include identification of lead service for patients that are under multiple services. Action 2: Develop a Trust wide multidisciplinary group to develop good practice on Transition From Children to Adult Services led by a Transition Co-ordinator. Action 3: Data Audit – EPR Ready Steady Go – Hello compliance. Action 4: Patient feedback from children and adults - inclusive of all backgrounds. Children will be asked about their experience of transitioning to adult services. The Trust's well established children's patient group, YiPpEe, will assist with this. Action 5: Staff feedback. Action 6: Partner feedback – include general practitioners (GPs) as some patients will be transitioned to GP services.	Action 1: ***Partially achieved.*** Early work has been undertaken with the services and the information team to identify robust and sustainable processes to capture data of lead service for patients that. Action 2: ***Fully Achieved*** Trust wide MDT Children Young Person (CYP) to Adult transition Group has been established. ToR have been developed. Action 3: ***Partially achieved***. The functionality is available on EPR to identify patients on the Ready Steady Go – Hello programme. Further work in progress to capture accurate data. Action 4: ***Partially achieved.*** Patient story presented to Board and summit planned for March – May 2022. Action 5: ***Fully achieved***. All staff feedback in our action log from the Transiton of children to adult services being captured Action 6: ***Fully achieved*** There have not been any emails or letters of correspondences, complaints or Ulysses reports received from system partners.

Digital Innovations

Why we chose this Quality Priority	How we evaluated success	Evaluation March 2021
Due to the pressure on outpatients waiting lists and space a digital channel shift is required. This will build upon progress made in 2020/21, with the implementation of self service for vaccinations and video consultations.	Action 1:Reduce the number of patient outpatient letters sent, and shift to digital solutions. Action 2:Implement self-service solutions so that patients can re-schedule or cancel their appointments on-line. Action 3;Ensure the electronic patient record (EPR) is configured to enable accurate appointment types and clinics and increase the number of outpatient appointments to video or telephone. Action 4:Automate processes in scheduling to support services to reduce administration and clerical staff time and prioritise patients correctly. Action 5:Increase use of the Patient Portal by establishing an automated process where patients can register for the solution.	Action 1 ***Fully achieved*** Digital solution is Live. 100% of appointment letters directed to Letter Production were made available to patients digitally. Action 2: ***Partially achieved*** The delivery of cancel and reschedule is being worked on. Staff utilised self-service booking for over 45,000 vaccinations. Action 3: ***Fully achieved*** There were 160,000 non F2F appointments to end Mar21. YTD 2021-22 – 745,218 virtual consultations to end Dec 2021 Action 4: ***Partially achieved*** Endoscopy have seen an increase up to 75% of patients contacted booked for procedures by using the DrDr messaging booking platform. Action 5: ***Partially achieved*** Services are assisting patients to register for the Patient Portal. 2021-22 registrations are over 125% increase on 2020-21 registrations. The semi-automated registration process is under review to enable wider adoption in 2022-23.

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Clinical Activity Recovery

Why we chose this Quality Priority	How we evaluated success	Evaluation March 2021
Due to the effects of the COVID-19 pandemic, more patients are waiting longer for surgery. This priority will help minimise harm to these patients from delayed treatment.	During 2021-22 patients on inpatient surgical waiting list will be clinically reviewed and allocated a timeframe for treatment as set out in the national priority scoring system with treatment scheduled within these agreed time frames. An investigation will be carried out for any patient who comes to harm due to delayed treatment. Our electronic patient record will be used to record and collate this information. Action 1: 90% of patients in identified cohorts to have RCS codes. Action 2: 85% P2 patients have had their treatment within their 4 week time allocation. Action 3: We will investigate any incident when harm has occurred due to a patient waiting for longer than the time frame documented in the P category. Action 4: Clinical prioritisation to be fully integrated with our electronic patient record through improvements to electronic workflows and interface with commissioning systems to record procedures.	Action 1: ***Partially achieved*** Clinical prioritisation is well established at OUH, and data is being submitted in line with national expectations. 70% of patients are identified as having RCS codes as of 2.1.22. Action 2: ***Partially achieved*** The percentage of patients categorised at P2 and admitted within 4 weeks is 65-79% (Oct-Dec 2021). Lapsed P codes are scrutinised at weekly PTL and Assurance meetings including plans to address shortfall in capacity. Action 3: ***Partially Achieved*** To date 3 divisional level investigations are in progress for harm associated with lapsed P categories. These relate to spinal cases and the investigations have not yet concluded. There are no current SIRI's specifying lapsed P- categories. Action 4: ***Not yet achieved*** The optimal workflow agreed in March 2021 has been beset with technical issues and as of 19.1.22 is not yet live. The introduction of D-codes for diagnostic investigations added an extra layer of complexity to the technical process.

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Staff health and wellbeing: Growing Stronger Together

Why we chose this Quality Priority	How we evaluated success	Evaluation March 2021
Focusing on the recovery of our people is essential to keep them safe and healthy at work, help reduce stress, anxiety and presenteeism and retain an engaged workforce.	This priority will build on the success of our Wellbeing Strategy and Quality Priority from 2020-21 as well as allow for new and innovative interventions to support the wellbeing of our people. Action 1: By end March 2022, 85% of our people to have participated in a wellbeing conversation with their line manager. Action 2: Recovery, Readjustment and Reintegration (R3P) Programme to be developed to enable post traumatic growth for teams; with 20 sessions offered by end December 2021. Action 3: Review and agree home working and flexible working policies by end March 2022. Action 4: Test out the fit of our new leadership behaviours framework as we transition into a 'new normal' as part of our leading with care pathway by September 2021. Action 5: All Divisions to have workforce plans in place to address sustainable staffing issues by October 2021. Action 6: Recognition, celebration and commemoration event(s) by end December 2021.	Action 1: ***Partially achieved*** Manager Wellbeing Check-in briefings were delivered between Sept – Nov 2021 with c560 managers attending. As of 3rd Dec, 1,327 check-ins have been recorded, approximately 9% of our people. These Wellbeing check-ins are being welcomed although are impacted by winter/service pressures. Action 2: ***Partially achieved*** From Apr - end Nov 2021 we have delivered 32 sessions. Action 3: ***Partially achieved*** The Trust launched its new Remote Working Policy on 13th Oct 2021. Action 4: ***Partially Achieved*** Head of Leadership is currently creating a suite of leadership programmes as part of our leading self – teams – organisation and system approach. Action 5: ***Partially Achieved*** Workforce plans were developed for all areas and submitted to the BOB ICS as part of the annual operational planning round in May 2021. Action 6: ***Fully achieved*** Images of teams published in a book: COVID-19 pandemic - #OneTeamOneOUH

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Quality Improvement (QI) Stand Up

Why we chose this Quality Priority	How we evaluated success	Evaluation March 2021
To share learning and promote widespread adoption of quality improvement across the Trust.	Four speakers will present their QI projects each month. They will discuss their initiative, QI journey and share learning from their successes and failures. The audience is invited to share insights, feedback, and discuss ways to scale and spread QI in other areas of the Trust. Action 1: Set up fortnightly and then weekly QI presentations and monitor attendance and number of projects presented. Action 2: Seek evaluation from attendees and presenters to measure the benefit of attending QI Stand Up April 2021 to July 2021 Action 3: Monitor the number of QI projects being registered on Ulysses to explore if the number of projects registered increases over the year. Action 4: Enable scale and spread of at least three QI projects out of every 30 undertaken, across at least two Directorates.	Action 1: ***Fully achieved*** QI Stand up has been established and running successfully at OUH. 4 projects have been presented each month since April. The speakers from a range of multi-professional backgrounds including medical, nursing, and allied health professionals presented their QI at the stand-up. The average attendance has been between 60-70 staff. Attendees came from all professional backgrounds. Following a gradual increase in QI project registration between July and November 2021, the number of project registrations fell in December and January, coinciding with the latest COVID-19 peak. Action 2, 3 & 4: ***Partially Achieved*** A small number of QI projects have been scaled and spread to new clinical areas. Formal evaluation has been delayed by the COVID-19 pandemic. Planned next steps are to undertake a formal evaluation of the program and further enable scale and spread of QI projects.

Quality Priorities 2022/23

- The Quality Conversation Event scheduled for January this year had to be cancelled due to the COVID-19 pandemic.

- Discussion with internal stakeholders considered
  - new proposals with a focus on patient and staff wellbeing and recovery
  - which of the 2021/22 Quality Priorities should be continued into 2022-23.

- The 2022/23 Quality Priorities have been agreed by the Trust Management Executive (TME), Integrated Assurance Committee (IAC), Governors and the Board.

Quality Priorities 2022-23

Patient safety

- Triangulation of learning from claims with incidents, inquests and complaints
- Reducing Pressure Ulcers
- Medication safety – Insulin and Opiates

Clinical effectiveness

- Results endorsement
- Introduce and embed use of a Morbidity Dashboard in surgical specialties
- Embed QI methodology more widely in the Trust

Patient experience

- Reduce incidents of violence, aggression
- Transition of children to adult services
- Staff health and wellbeing: Growing stronger.

OneTeamOneOUH