Oxford University Hospitals
NHS Foundation Trust

Oxford University Hospitals NHS Foundation Trust

Quality Account 2023-24

Contents

Part 1: Introduction

Statement on quality from the Chief Executive Officer 2023-24

In our Quality Account we set out how Oxford University Hospitals (OUH) NHS Foundation Trust delivers high quality care through a relentless focus on our safety culture, and quality improvement routinely embedding best practice in the care provided to our patients so that avoidable harm is prevented.

Our strategic approach to improving the quality and safety of patient care

Our vision as an organisation is to be an exemplar in healthcare delivery that is compassionate and enabled by the highest levels of research and innovation.

Delivery of this vision remains centred around the OUH values of Learning, Respect, Delivery, Excellence, Compassion and Improvement, and will build on the Trust Strategy 2020-25 introducing four strategic pillars – People, Patient Care, Performance and Partnerships.

Our Quality Strategy aims to deliver high quality healthcare based on national and international comparisons, and to continuously improve our performance using Quality Improvement tools across the three key domains:

- Patient Safety
- Patient Experience
- Clinical Effectiveness

Patient Safety Incident Response Framework (PSIRF) and Patient Safety Culture

We have focused this year on planning for the introduction and then rolling out PSIRF which replaced the Serious Incident Framework in OUH in October 2023. PSIRF has the following four aims:

- Compassionate engagement and involvement of those affected by patient safety incidents.
- Use of a range of system-based approaches to learning from patient safety incidents.
- Considered and proportionate responses to patient safety incidents and safety issues.
- Supportive oversight focused on strengthening system functioning and improvement.

We have produced a Trust Board approved PSIRF Policy and Plan in which we describe our application of a Just Culture ensuring consistent, constructive and fair treatment of staff who have been involved in patient safety incidents. The PSIRF Policy goes on to describe our Patient Safety Culture which we have further developed with the introduction of our weekly Safety Learning and Improvement Conversation (SLIC). SLIC has a focus on learning and improvement and how this can be spread across OUH; our Quality Improvement team representatives form an integral part of these discussions. From SLIC a weekly learning summary is produced and shared widely in the Trust. We have two Patient Safety Partners who have helped to shape our PSIRF Policy and Plan and support our SLIC meetings, as well as providing input into other Clinical Governance meetings; in so doing they ensure the patient voice is heard as well as compassionate engagement delivered. We have also worked collaboratively with Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board's (BOB ICB) Patient Safety Manager and other Patient Safety teams across BOB.

Examples of other of initiatives which we have put in place to enhance our Patient Safety Culture at OUH include the following:

- QI Stand-Up: a bi-weekly forum to share and celebrate Quality Improvement (QI) projects.
- Reporting Excellence to identify and learn from examples of good practice in line with a Safety II approach.
- Patient Safety Response (PSR) team meetings are held every weekday to review all new moderate and above incidents so staff can be supported, and incident management started promptly.
- Safety Messages from the Chief Medical Officer and the Chief Nursing Officer are emailed to all staff once a week to raise awareness of important patient safety issues.
- Weekly learning from SLIC is shared across the Trust.
- All teams are encouraged to hold Safety Huddles either face-to-face or virtually every day to focus on what went well, what could have gone better, and what lessons can be learned.
- The Human Factors and Patient Safety Training offered through Oxford Simulation Training and Research (OxSTaR) informs our understanding of patient safety concerns in the clinical workplace across the Trust and the design of quality improvement projects to mitigate risk. We offer our Human Factors courses virtually, which has increased the accessibility and reach of this award-winning training across OUH.
- Our Oxford Scheme for Clinical Accreditation (OxSCA) programme, which evaluates clinical wards and departments against a set of standards to

measure quality and demonstrate improvement in the services they provide, is now embedded.

- Our DAISY Awards celebrate nurses and midwives working at OUH because patients, their families and our staff can nominate a nurse or midwife who has made a real difference through outstanding clinical care.

Response to the Lucy Letby case

We were all shocked and saddened by this case. The details were upsetting and difficult to hear for everyone, not least for staff who work in the NHS and strive to deliver compassionate and excellent care for all patients.

The Chair and I wrote to all staff on behalf of the Trust Board after the trial to acknowledge the distress this will have caused and to reiterate the systems, we have in place at OUH for our people to raise concerns as and when they arise.

We reminded all colleagues of the Board's absolute commitment to ensuring that every member of staff feels able to speak up safely if they have a concern or believe something is and knows how to do so.

In the first instance, staff who have a concern are invited to raise this with their line manager and follow the advice on our intranet about the support available.

In addition, our team of Freedom to Speak Up Guardians and Champions are also able to offer advice and support; and in March we launched a new 'Raising a concern' website making it easier to navigate the various routes and channels.

We also highlighted the process for raising patient safety concerns via the Trust's incident management system, Ulysses.

We stressed the importance of all staff feeling confident that they will be supported if they raise concern, without any risk of detriment or futility.

Martha's Rule

'Martha's Rule' will ensure that patients and their families have access to round-the-clock rapid review from an independent care team. It will be implemented across the NHS as part of a phased approach, beginning with at least 100 adult and paediatric acute provider sites that already offer a 24/7 critical care outreach capability. We have started strengthening and implementing systems to enable patients and carers to speak up if they have concerns about patient care; part of this is to develop an Outreach Team.

Our Quality Priorities

Staff, partners and stakeholders of OUH gathered at the John Radcliffe Hospital in Oxford in December 2023 for our Quality Conversation event to hear an update on the progress made by the Trust in achieving our Quality Priorities for 2023-24 and to contribute to the development of our Quality Priorities for 2024-25.

Following the Quality Conversation event and further input from members of the Trust's Clinical Governance Committee and Trust Board members, our Quality Priorities for 2024-25 were approved by the Trust Board in March 2024.

Our patients as partners

The cornerstone of healthcare is the partnership between patients and their clinical teams, enabling them to collaborate in maximising the patient's health and wellbeing, weighing up options and sharing in the decision-making in often complex situations.

This partnership extends to learning from the lived experience of patients and families, engaging with them to improve our services and collaborating to identify and resolve issues to ensure their healthcare journey remains on track. The unique perspective and experience as a patient alongside healthcare professionals' technical knowledge forges a valued partnership in delivering healthcare every day and shaping quality improvements to our services.

A patient or member of staff joins the Trust Board at our meeting in public to share their lived experience of receiving or delivering services. The election of patients and the public to our Council of Governors also ensures the patient voice is heard.

Prioritising patient safety during industrial action

In common with other NHS trusts, industrial action (IA) has impacted our work at OUH over the last year.

Patient safety and staff wellbeing have been our priorities during these periods of industrial action. This has included both extensive planning and preparation in advance of strikes, and patient harm reviews and Trust-wide debriefs after each period of industrial action.

Patients waiting for treatment

We remain committed to seeing more patients, more quickly and to reducing waiting lists. I am grateful to our staff who have worked on these improvements and to our partners with whom we are working to deliver better services to our patients.

We have reduced the number of patients waiting more than two years from four at the end of March 2023 to one in March 2024. Focused work has continued on recovering from a growing backlog of patients waiting more than 78 weeks following several periods of industrial action. At the end of March 2024, there were 80 patients waiting more than 78 weeks for elective treatment compared to 59 patients at the end of March 2023. We are committed to reducing further the number of patients waiting for elective treatment in 2024-25.

Harm reviews continue to be performed for patients waiting in excess of 52 weeks, to identify any psychosocial or clinical harm arising from delays. The methodology has evolved in line with the national e-prioritisation policy, which has meant that all patients can now be proactively prioritised electronically based on clinical need.

Harm reviews are then discussed in the monthly Harm Review Group (HRG). The harm reviews have allowed services to expedite treatment of patients as necessary. Where moderate or above impact has been confirmed at HRG, these cases are reviewed through the Serious Incident Requiring Investigation (SIRI) forum process to identify learning.

Following an agreed protocol, any cancer patient waiting for over 104 days for treatment also has a review conducted of potential for clinical harm from the delay. Details are reported to the Trust's HRG and then to the Patient Safety and Effectiveness Committee.

Maternity and Newborn Care Development Programmes

During 2023-24 work continued on the development programmes aligned to the 2022-23 independent culture and leadership reviews that were commissioned by the Trust into both Maternity and Neonatal (Newborn Care) services.

The Maternity Development Programme provided a vehicle to facilitate a transition into an enhanced responsive care culture for childbearing people and their families, students and their multi professional caregivers and to optimise opportunities to further promote safety and wellbeing of staff and service users.

In February 2024 the Integrated Assurance Committee received a paper outlining the final stage programme summary, which included the delivery of 61 (98%) of the 62 culture and leadership review recommendations, 177 (98%) of the emergent staff suggestions and sustained improvements, including a significant reduction in staff turnover from 20.3% in August 2022 to 12.9% in March 2024 and sickness absence from 6.6% to 4% in the same period. It was agreed that tangible progress had been sustained aligned to the terms of reference and the programme was formally closed.

Oxford Critical Care (OCC) Development Programme

The Oxford Critical Care Development Programme was co-produced with OCC staff to incorporate their views and ideas for positive change. It builds on the action plan which was developed following a Care Quality Commission (CQC) inspection of OCC in November 2022.

The programme comprises six inter-related Quality Improvement (QI) themes including Governance, Recruitment and Retention, Staff Wellbeing and Recognition, Communications, Professional Development and Education, and Standards and Culture.

Of these themes, we recognise that successful recruitment and retention of nursing staff is pivotal to making significant improvements and, in addition, another theme relates to proposed future service developments – a Critical Care Outreach Service, and a Step-down (enhanced care) Unit.

Positive progress since the Development Programme was launched include the introduction of 'Say on the day' devices, which collate instant feedback from staff

through a simple survey function; the first in a programme of all-staff Q&A sessions; a targeted recruitment campaign; a doubling of the number of critical care course places for nursing staff; and a new coaching and support programme for Band 7 nurses.

CQC Inspection of Horton General Midwifery-led Unit

The CQC reviewed the service and rated it as Requires Improvement under the Safe and Well-led domains. I share the disappointment in this result as I know the good work that has been done through our Maternity Development Programme to make consistent improvements in team culture and leadership, and to improve safety for birthing people. Unfortunately, this new rating has impacted the overall rating for the Horton General Hospital which has also moved to Requires Improvement.

The inspection highlighted some areas for improvement and, as an organisation that embraces feedback as an opportunity for reflection and continuous improvement, we will work on these elements, some of which have already been addressed.

The inspectors heard from women and people who used the service and who spoke very positively about our team at the Horton. They also found that staff training and numbers were good, that the environment was well-kept and clean, and women safeguarded and safe. In addition, they noted that leaders had the skills and abilities to run the service and support staff as well as having a vision for the future, and that they felt respected, supported and valued.

The Board’s commitment to the Horton General Hospital remains unwavering. We are proud of our role in provision of care to the people of Banbury and surrounding areas. We have increased capacity for diagnostics, ambulatory care and surgical capacity, as well as increasing specialist clinics at the Horton, and will continue to do so.

Quality Improvement (QI)

The recent Staff Survey shows that nearly three quarters of OUH staff state that they can confidently make suggestions for improvement and over 60% are now able to make improvements at work compared with 58% last year. This distributed leadership is a testament to a significant cultural shift towards continuous improvement. Over 1,200 of our staff have completed training in Quality Improvement in the last two years, pivotal for enhancing patient care through varied perspectives and expertise.

Our role in spearheading the region's first regional Improvement Festival has been instrumental in showcasing projects that bolster planetary health, reducing waste whilst drawing us nearer to our ambitious net-zero targets. As we look forward to presenting our Quality Improvement journey at the Institute for Healthcare Improvement (IHI) / British Medical Journal (BMJ) International Forum for Quality and Safety with colleagues from University Hospital Southampton, we celebrate the

continuous cultural evolution that champions compassionate excellence in patient care and sustainable leadership within the NHS.

New developments

Our staff have continued to innovate and develop new ways of working this year in order to improve patient safety, patient experience and clinical effectiveness:

- The UK's first womb transplant has been carried out at the Churchill Hospital in Oxford by a team from OUH and Imperial College Healthcare NHS Trust – the organ retrieval and subsequent transplant took place at the Oxford Transplant Centre as part of the YK living donor programme, sponsored and funded by the charity Womb Transplant UK with approval from the Human Tissue Authority.
- OUH is now a highly-specialised NHS centre offering chimeric antigen receptor T-cell (CAR-T) therapies to people with cancer, after NHS England expanded access to the potentially life-saving treatment – this development has been made possible by a partnership between OUH and NHS Blood and Transplant.
- Our OUH Radiotherapy Centre @ Swindon on the Great Western Hospital site, which enables our staff to provide high quality care closer to home for cancer patients, provided more than 6,000 radiotherapy treatments in its first year – a similar new facility, our new OUH Radiotherapy Centre @ Milton Keynes, is due to open later this year.
- A new app called 'Let's Talk Clots', which provides information on how to reduce the risk of developing a blood clot, has been launched by OUH Venous Thromboembolism Prevention Nurse Sarah Havord in collaboration with the national charity Thrombosis UK. It provides patients and their families with free access to medically approved information to save lives and restore lives affected by blood clots.
- The 16-bed Whitehouse Renal Dialysis Unit, which opened to patients in December 2023, is providing specialist care closer to home for people who require regular kidney dialysis treatment. The service is run by OUH staff and the development has been made possible through a partnership with Milton Keynes City Council and Milton Keynes University Hospital NHS Foundation Trust.

Excellent outcomes for patients captured in clinical audits

Examples include the following.

- The Cleft Registry and Audit Network (CRANE) results show the service continues to perform above average for all measures, with three positive outliers – dental outcomes, recording of speech outcomes and psychology screening.

- The National Neonatal Audit Programme (NNAP) demonstrates excellent performance when OUH is compared to other units at trust level. These include all optimal start measures such as antenatal steroids, delayed cord clamping, thermoregulation and mother's milk on day two. Other excellent trust level performance includes senior consultation with parents within 24 hours, mother's milk at day 14 and on discharge, and use of non-invasive ventilation only in the first week of life. For neonatal network measures, OUH were the best performing network for mortality and severe intraventricular haemorrhage; top three (out of 15 networks) for chronic lung disease, necrotising enterocolitis; and above average performance for cystic periventricular leukomalacia and born in the right place.
- The Sentinel Stroke National Audit Programme (SSNAP) shows that the John Radcliffe Hospital Stroke Service is performing well above the national average in nearly all domains including rates of early thrombolysis, percentage of patients treated by Early Supported Discharge team (ESD), and Occupational Therapy and Physiotherapy metrics.
- The National Oesophago-Gastric Cancer Audit (NOGCA) evaluates the quality of care received by patients diagnosed with oesophago-gastric (OG) cancer and High-Grade Dysplasia (HGD). Results show good case ascertainment for patients with OG cancer, and OUH performed well in most measures including use of staging investigations, planned active treatment and outcomes of surgery. For patients with HGD, OUH performed well in the key recommended process of care measures, such as multidisciplinary team discussion and planned active treatment.
- The National Congenital Heart Disease Audit showed that there were no procedural complications or requirements for a second operation during the reporting period. There was also no mortality amongst the patient group following surgical procedures. The weekly multidisciplinary meeting with Southampton, so clinical expertise can be shared, was highlighted as a success.

Innovations introduced and the positive impact of research on patient care

Oxford is one of the most vibrant places in the world for healthcare research because of the close working relationship with the University of Oxford and Oxford Brookes University.

OUH is also at the heart of a research ecosystem as the host organisation for the NIHR Oxford Biomedical Research Centre (BRC) and Health Innovation Oxford and Thames Valley; and as a member of Oxford Academic Health Partners (OAHP).

This has a positive impact on the quality and safety of patient care because new innovations and treatments are often introduced first in our hospitals and then rolled out to other NHS trusts – some examples of recent innovations include the following.

- Our Stroke Unit at the John Radcliffe Hospital in Oxford is now providing life-changing mechanical thrombectomy treatment 24 hours a day. This treatment, which can reduce disability and prevent or limit long-term care needs, has been made available to patients across our regional integrated stroke delivery network and the wider Thrombectomy Innovation and Transformation Network, which connects hospitals in Aylesbury, High Wycombe, Reading, Swindon, Northampton and Milton Keynes.
- OUH's capability to develop revolutionary new therapies has been enhanced by the opening of a new temporary Pharmacy Clinical Trials Unit on the Churchill Hospital site in Oxford. This facility can handle and prepare a new range of medicines known as advanced therapy medicinal products, which are based on gene, tissue or cell therapy products.
- An Artificial Intelligence (AI) tool that can predict the 10-year risk of heart attacks has been developed through NIHR Oxford Biomedical Research Centre-supported research carried out at the John Radcliffe Hospital in Oxford. This tool, which could transform treatment for patients who have CT scans to investigate chest pain, improved treatment for up to 45% of patients and was cost effective for NHS use. We are now part of an NHS England (NHSE) funded pilot study to roll out the tool in clinical practice.
- The first Oxfordshire patients have been treated in an mRNA cancer vaccine trial for head and neck cancer treatment at the Churchill Hospital in Oxford. The trial, which is led by OUH Consultant Clinical Oncologist Dr Ketan Shah, aims to assess if the vaccine can improve the effectiveness of immunotherapy treatments which help the immune system to fight cancer.

Our award-winning teams

Our staff are committed to delivering the highest quality care for our patients. This year we have celebrated their many successes including the following:

- Oxfordshire Rapid Intervention for Palliative and End-of-Life Care (RIPEL), an innovative partnership between OUH, Sobell House Hospice Charity, Macmillan Cancer Support and Social Finance which aims to enable more people to be cared for in their own home at the end of their life if that is their choice, was shortlisted for the Health Service Journal (HSJ) Patient Safety Awards 2023.
- The Integrated Severe Asthma Care project (ISAC) was shortlisted for the Health Service Journal (HSJ) Awards 2023. OUH staff in Pharmacy, and Respiratory and Intensive Care Medicine, co-led on this partnership project

which has reduced emergency hospital admissions for patients living with severe asthma.

- The Hip Fracture Team at the Horton General Hospital in Banbury was named as one of the best in the country in the annual National Hip Fracture Audit for the 11th year in a row. They met best practice criteria in their treatment of 92% of patients, compared with a national average of 54%, placing them in the top three nationally.
- The Oxford Muscle Service, which is based at the John Radcliffe Hospital in Oxford, has been named as a Centre of Excellence by national charity Muscular Dystrophy, in recognition of the outstanding care provided to people living with muscle wasting and weakening conditions.

Performance against some national standards is included in this Quality Account and is discussed in detail in the Annual Report.

I am responsible for the preparation of this report and its contents. To the best of my knowledge, the information contained in this Quality Account is accurate and a fair representation of the quality of healthcare services provided by Oxford University Hospitals NHS Foundation Trust.

Professor Meghana Pandit
Chief Executive Officer

27 June 2024

About us and the service we provide

Oxford University Hospitals NHS Trust was formally established on 1 November 2011 when the Nuffield Orthopaedic Centre NHS Trust merged with Oxford Radcliffe Hospitals NHS Trust. On the same date, a revised formal Joint Working Agreement between the Trust and the University of Oxford came into effect. The Trust became a Foundation Trust on 1 October 2015. OUH is an acute hospital Trust providing local, regional and some national hospital services to the population of Oxfordshire and beyond. It is registered with the Care Quality Commission and licensed to provide regulated activities by NHS England. The Trust provides a wide range of clinical services, specialist services and super specialist services, including emergency care, trauma and orthopaedics, maternity, obstetrics and gynaecology, paediatric services, newborn care, general and specialist surgery, cardiac services, critical care, cancer, renal and transplant, neurosurgery, maxillofacial surgery, infectious diseases and blood disorders. The Trust also draws patients from across the country for specialist services and leads networks in areas including trauma and vascular.

The Trust consists of four hospitals:

- John Radcliffe Hospital
- Churchill Hospital
- Nuffield Orthopaedic Centre
- Horton General Hospital

The John Radcliffe Hospital, Churchill Hospital and Nuffield Orthopaedic Centre are located in Oxford, and the Horton General Hospital in Banbury, North Oxfordshire. Most services are provided in our hospitals, others are delivered across more than 100 satellite locations across the region, which include outpatient peripheral clinics in community settings and satellite services in several surrounding hospitals, and some in patients' homes.

The Trust also delivers services from community hospitals in Oxfordshire, including Midwifery-led units; and is responsible for a number of screening programmes, including those for bowel cancer, breast cancer, diabetic retinopathy and chlamydia.

More information on OUH and its services is available on the Trust website at www.ouh.nhs.uk.

Part 2: Priorities for Improvement and Statements of Assurance from the Board

2.1. Priorities for Improvement

Results and achievements for the 2023-24 Quality Priorities

This section details the Trust's achievements against its quality objectives for 2023-24. While good progress has been made on many of the Quality Priorities for 2023-24, progress on others has been slower than planned due to operational pressures. The Trust continues to engage sensitively with clinical services to try to complete the outstanding objectives. In addition, the Surgical Morbidity Dashboard, Care of the Frail Elderly, Reducing Inpatient Falls and Reducing Health Inequalities Quality Priorities have been updated and rolled into 2024-25.

The next section is a summary of achievements against each Quality Priority objectives for 2023-24.

Patient Safety

Quality Priority 1(a): Medication Safety – Opiates

Why is this a priority?

National and international guidance now recognises the risk of excess prescribing of opioids in the postoperative period. While essential to maintain access to opioids in the management of acute pain where they are effective and necessary, opioid stewardship is needed across the Trust to ensure safe monitoring of patients and adequate, but not excessive, discharge prescribing.

Table 1: Summary of actions for Quality Priority 2023-24 1(a): Medication Safety – Opiates

What we will do	2023-24 Update on QP
Action 1 Introduce British Pain Society patient leaflet regarding pain and analgesic use into pre-operative assessment clinics to improve patient education and to manage patients' pain expectations. Q1: Collaborate with pre-operative assessment team to introduce and test patient leaflet as above, looking at patient feedback of understanding and ease of use. Q2: Revised and approved by the end of Q2. Q3: Introduction to routine practice. Q4: Introduction to routine practice.	**Partially Complete** • Content of the patient and staff feedback survey has been agreed in the OUH Opioid Stewardship Group meeting. This is to be piloted in pre-operative assessment areas at the JR and NOC.
Action 2 Develop leaflet on safe opioid use to be given in every discharge opioid pack. Q1: Identify current national leaflets and assess suitability or need for modification. Q2: Develop modified leaflet and collect patient feedback. Q3: Introduction into routine practice. Q4: Introduction into routine practice.	**Partially Complete** • Leaflet drafted – ongoing work with the Palliative Care Medicine team to refine final version in Q1 2024-25 prior to roll out in Q2 2024-25.
Action 3	**Complete**

What we will do	2023-24 Update on QP
• Collection of sample data of discharge opioid use from five different surgical procedures to help inform future procedure-specific opioid discharge prescribing and prescribing culture change. • Q1 and 2: Draft and pilot data collection tool. • Q3 and 4: Collect data and evaluate results.	• Plan exceeded with discharge opioid use data collected from 20 different surgical procedures and results analysis in progress. • Results to be presented at anaesthetic clinical governance meeting. Initial data shows only 33% of prescribed opioids (oral morphine equivalent) were used following discharge. • These results will inform discharge prescribing guidelines going forward.
Action 4 • Review and promote the use of the Oxford Pain Guide available via OUH MicroGuide to improve understanding of pain management and prescribing of pain treatment across the Trust. • Q1 and 2: Identify numbers of users of pain guidelines, feedback from clinical staff about their knowledge of the tool, how they use it and how its use could be promoted. • Q3: Develop the guidelines based on the feedback from clinical staff and use this to further promote the guidelines. • Q4: Repeat the scoping exercise gaining further feedback from clinical staff to determine whether knowledge of the resource and use has increased. Identify user numbers from website pages.	**Complete** • Direct link added to the new OUH SharePoint site and the Pain Service intranet page. • Contact made through the clinical tutor for Laboratory Medicine Course, to inform medical students of the Pain Guide on the MicroGuide app. • MicroGuide usage data are limited but download figures for the Pain Guide peak in August (130 junior doctors) coinciding with new foundation doctors starting.
Action 5 • To identify a selection of indicators around opioid prescribing and administration in collaboration with ePMA (electronic Prescribing and Medicines Administration) and Information Management and Training (IM&T) reporting teams and test for suitability and validity. • Q1 and 2: Identify the prescribing and administration data available in ePMA that could be used to measure aspects of opioid prescribing, administration and safety (e.g. obtain baseline data for the percentage of inpatients receiving naloxone).	**Complete** • Inpatient naloxone administration report has been set up in the Trust reporting tool (ORBIT) and the report discussed at every OUH Opioid Stewardship Group meeting. • Naloxone administration report analysed and discussed at OUH Opioid Stewardship Group every two months.

What we will do	2023-24 Update on QP
• Q3 and 4: Develop and refine reporting tools for ongoing monitoring.	
Action 6 • To develop a system for prescribers to document the intended duration (number of days), the weaning and cessation plan and the review and referral plan for opioids in the patient's healthcare record. • Q1and 2: Collaborate with ePMA and IM&T teams for opioid discharge quantity flags and the addition of mandated duration of opioid prescriptions on discharge in electronic medication system following evaluation Action 2. • Q3 and 4: Pilot plan and review.	**Partially Complete** • Action 6 will be initiated following analysis of result of Action 2. • Many patients are given excess weak opioids due to the UK minimum pack size of codeine (28 tablets): the Medicines and Healthcare products Regulatory Agency (MHRA) have been contacted to request a reduction in national pack size. • Highly variable discharge opioid prescribing after orthopaedic surgery presents a good opportunity for rationalisation and reduction that will be taken forward in 2024-25.
Action 7 • Establish Trust-wide baseline audit of patients being discharged from the emergency department with a supply of opioid prescription exceeding three days of treatment to inform need and plan for education and culture change. • Q1-2: Collect data on current Emergency Department (ED) opioid discharge prescriptions. • Q3-4: Based on data introduce education and guidance for limited opioid prescribing on ED discharge.	**Complete** • Data collected from both JR and Horton ED. Audit results to be presented at ED clinical governance meeting in Q2 for education and guidance.

Quality Priority 1(b): Medication Safety – Insulin (rolled over from 2022-23)

Why is this a priority?

Insulin is recognised as a high-risk medication. The Trust is required to identify and report rates of the most severe harms associated with insulin as part of the National Diabetes Inpatient Safety Audit (NDISA), a mandatory national audit. The rates of harms have slowly decreased nationally, driven primarily by a reduction in episodes of severe hypoglycaemia, but concerns have been raised about the accuracy of the data reported. Work has been undertaken in previous years within the Trust to ensure accurate reporting within OUH, but in order to improve accuracy nationally the definition of severe hypoglycaemia is soon to change. Trusts will be required to report all episodes of blood glucose below 2.2 mmol/l occurring in people with diabetes over the age of 18. Scoping has suggested over 600 such events occurred in the Trust Jan to Dec 2022. Hypoglycaemia is associated with increased morbidity and mortality as well as increased length of stay. The aim of the Quality Priority this year is to support clinical areas to identify and learn from episodes of severe hypoglycaemia, in order to use this learning to drive a reduction in the number of our patients experiencing severe hypoglycaemia.

Table 2: Summary of actions for Quality Priority 2023-24 1(b): Medication Safety – Insulin

What we will do	2023-24 Update on QP
Action 1 • Q1: Set up a monthly search within the point of care glucose software, which will be used to provide feedback on rates of severe hypoglycaemia to ward areas.	**Partially Complete** • A search has been set up in ORBIT which has provided baseline data for episodes of severe hypoglycaemia for January 22-Feb to February 23. • This has allowed us to compare frequency of episodes between different ward areas. • It has been identified that not all episodes can be attributed to a specific ward area, and this is being explored further. • In discussion with the data and analytics team to create a dashboard that will be visible so wards can review rates.
Action 2 • Q2: Trial a Severe Hypoglycaemia Analysis form (developed during the 2022-23 Insulin Quality Priority) to support ward areas	**Complete**

What we will do	2023-24 Update on QP
to identify underlying causes for episodes of severe hypoglycaemia. Use feedback to finalise a form to be used.	• The form was to be trialled against current incidents by members of the Insulin Safety Group to assess usability, but it was found to be too complicated. • It has been decided that an After-Action Review (AAR) as per PSIRF would be a better tool and will involve multiple members of the MDT where learning can be shared.
Action 3 • Q3 and 4: Support ward teams to develop and test improvement plans for reducing the rate of severe hypoglycaemia on their ward.	**Partially Complete** • Previous work on hypoglycaemia has demonstrated that people experiencing severe hypoglycaemia have experienced episodes of milder hypoglycaemia prior to this without treatment being adjusted. The development of a dashboard, based on the Trust's own data regarding hypoglycaemia, is intended to provide feedback to clinical areas regarding the frequency of both mild and severe hypoglycaemia, benchmarked across the Trust. By raising awareness, it is hoped that teams will be educated and empowered to act earlier to prevent hypoglycaemia. • AAR reviews of new hypoglycaemia episodes continue to be used to identify and improve learning and to support those involved. Themes identified in the AAR process will inform targeted learning for the MDT.
Action 4 • Q4: Co-develop interventions to reduce episodes of severe hypoglycaemia (glucose less than 2.2mmol/l) on three to five wards with the highest rates of hypoglycaemia.	**Not Complete** • This action will be taken forward in 2024-25.

Quality Priority 2: Care of the Frail Elderly

Why is this a priority?

Frail, elderly patients make up a substantial proportion of patients presenting to urgent and emergency care settings. Early, comprehensive assessment of these patients can improve outcomes by ensuring the acute care management pathway and future care plans are all tailored appropriately to the patient's needs. This quality priority focuses on strengthening the assessment of frail, elderly patients in the Emergency Department (ED) and Same Day Emergency Care (SDEC) settings. It aligns with Commissioning for Quality and Innovation (CQUIN)05 'Identification and response to frailty in emergency departments'.

Table 3: Summary of actions for Quality Priority 2023-24: Care of the Frail Elderly

What we will do	2023-24 Update on QP
Action 1 • Q1: Establish a Frailty multidisciplinary team to support early assessment of frail, elderly patients in the ED and Acute Ambulatory Unit (AAU). This will be supported in the first year by Commissioning for Quality and Innovation (CQUIN) funds.	**Complete** • Frailty team is fully recruited-to, including Clinical Lead, SpR and Specialist Nurse.
Action 2 • Q1-4: Strengthen documentation of Clinical Frailty Score (CFS) among patients aged 65 years and older attending ED or AAU.	**Complete** • CFS is fully embedded within ED admission workflow and is documented in >95% cases.
Action 3 • Q1-4: Strengthen documentation of cognitive assessment among patients aged 65 years and older admitted through ED or AAU.	**Partially Complete** • Revised tools (AMTS plus 4AT) and metrics for cognitive assessment agreed in line with national recommendations. • The digital team has developed the prototype for the assessment tool in EPR and the plan is to launch in May 2024.
Action 4 • Q1-4: Improve the assessment and further management of frail, elderly patients by creating and implementing a system for comprehensive geriatric assessment (CGA).	**Complete** • Completion of comprehensive geriatric assessment in each quarter as follows, against a CQUIN target of 30%: Q1 61.1%; Q2 53%; Q3 56%; Q4 56%.

What we will do	2023-24 Update on QP
Action 5 • Q1-4: Develop (Q1-2) and collect (Q3-4) metrics to measure the impact of the Frailty MDT on patient care and outcomes including care setting, ceilings of care and re-admissions. Use this data to develop a business case for continuation of the service as business as usual.	**Partially Complete** • Business case in progress.

Quality Priority 3: Reducing Inpatient Falls

Why is this a priority?

Inpatient falls are an important and potentially preventable cause of morbidity and mortality, especially as a cause of femoral fractures among the elderly. Key to reducing the risk of falls in hospital is a multifactorial falls risk assessment, followed by action to address each of the falls risk factors identified. Early assessment of patients with a suspected serious injury is also important following a fall to ensure timely and appropriate analgesia, investigations and management. This Quality Priority focuses on strengthening training and implementation of the multifactorial falls risk assessment; addressing key areas for improvement identified in the most recent National Audit of Inpatient Falls; and strengthening assessments and information sharing following a fall.

Table 4: Summary of actions for Quality Priority 2023-24: Reducing Inpatient Falls

What we will do	2023-24 Update on QP
Action 1 Update and roll out education and policies. • Q1: Roll out Hoverjack and Scoop training across OUH. • Q1: Develop Induction Training on Prevention of Falls for all new staff. • Q1-4: Expand and roll out 'Preventing Falls in Hospital' e-Learning to key staff groups. • Q2: Re-launch the Trust Falls Champion Group. • Q2: Update Falls and Bed Rail policies. • Q2 and 3: Update inpatient falls leaflet (Q2) and develop an EasyRead version (Q3). • Q4: Develop intranet page for Falls Prevention with key resources for staff.	**Complete** • Hoverjack and Scoop Training is available quarterly to all OUH staff, via the Moving and Handling Team and through My Learning Hub (MLH). • Induction training is conducted on the Trust Nursing and Midwifery and Health Care Support Worker programmes. • 'Preventing falls in Hospital' e-Learning package, remains an optional course through MLH. Staff are encouraged to complete at all teaching sessions. Ward managers have been sent the link and requested all staff to complete it. To date, the data shows 286 completions. • Bespoke ward/area training is available on request. • 13 wards have received this training, delivered through 36 one-hour sessions, covering 338 staff members during this quality priority year. • The Falls Champion Group was relaunched in May 2023. 119 Champions have been identified in the Trust. 77 of them have

	attended the four-hour training session. A further three sessions are available in 2024 for staff to attend. • The Falls Policy was updated and launched in September 2023 and the Bedrail Guidance was updated and relaunched in November 2023. • The falls and bedrails patient information leaflets have been reviewed, updated, and made available. • EasyRead versions of the falls and bedrails leaflets are in development. The Patient Information Team is scoping other trusts' leaflet content. • A Trust SharePoint intranet page for Falls Prevention was launched in September 2023.
Action 2 Increase Multifactorial Falls Risk Assessment (MFRA) compliance: Q1: • Identify two wards with the highest number of inpatient falls (one at Horton, one at JR). • Audit baseline MFRA compliance in these two wards; promote increased compliance. • Maximise uptake of falls prevention e-Learning among staff on each of these wards. • Routine sharing of falls / patients at risk of falls in Safety Huddles and handovers. Q2: Promote and support increased MFRA compliance using QI methodology. • Audit and feedback MFRA compliance monthly on focus wards. Q3-4: Expand to a further four wards with among the highest incidence of inpatient falls.	**Complete** • Eight wards were identified, from all four Trust sites, to take part in the improving Multifactorial Falls Risk Assessment (MFRA) project. These were devised by analysing audit data, falls data and willingness to participate. • The targeted ward areas have reviewed their local falls data and are sharing falls reports with their local teams. • The QI project to increase MFRA awareness was developed and Plan-Do-Study-Act (PDSA) cycle 1 has been completed in four out of eight and partially completed in the other four ward areas. For completion to be achieved 50% or more core staff were required to attend the training. Progress was delayed by staffing issues and industrial action. • The target ward areas' monthly audit compliance was reviewed. The audit shows all eight ward areas made improvements in either overall compliance or MFRA compliance. Four wards showed improvement in both audit areas. Falls rates on the targeted wards dropped on five of the eight wards. • Completion of the 'Preventing Falls in Hospital' e-Learning package improved in focus wards with room for further improvement;

• Continue to promote and support increased MFRA compliance on all six wards. • Audit and feedback MFRA compliance monthly on six focus wards.	marked improvement achieved in Neurosciences Purple Ward (91%). The review and potential build of an education programme for falls prevention has been carried over into the new Quality Priority.
Action 3 (Q1-2) • Improve front door walking aid access in all major admissions units in line with existing recommendations of the National Audit of Inpatient Falls.	**Complete** • Walking aids are replaced as they are allocated to patients. The areas contacted felt there was not an issue with the provision of this equipment.
Action 4 Strengthen early assessment following a fall: • Q1: Complete baseline audit of early medical assessment for all inpatient hip fractures. • Q2: Develop and implement tools (e.g., Safety Message) to improve early assessment. • Q3-4: Re-audit early medical assessment following inpatient hip fractures.	**Partially Complete** • Hip fractures sustained as a result of an inpatient fall, for one year have been reviewed in a baseline audit. • This showed limitations in the documentation of injury checks conducted at the scene. • A post-falls audit conducted in Q2 of all hip fractures sustained as a result of an inpatient fall, demonstrated little improvement in the documentation of post-falls management and care compared with Q1, suggesting the changes made after audit 1 (PDSA 1: Increasing awareness, PDSA 2: Information sharing, PDSA 3: Ulysses changes) appear to have made little impact. • Injury checks conducted on the floor remain stable in a high percentage of reports, however, the confirmation of a suspected injury is missing. Therefore, identifying if the correct retrieval methods have been used is still not possible nor was it clear if the medical examination took place in the correct timeframe according to NICE guidance. • Work to strengthen documentation of immediate post-fall management has been incorporated into an updated QP for 2024-25.
Action 5 (Q1-4) Improve falls benchmarking and performance.	**Complete** • The GAP analysis for the under-reporting of falls has been completed and found that 19% of post-fall care plans generated did

• Complete a gap analysis to determine magnitude of under-reporting of falls. • Use results of gap analysis to estimate number of falls per 1,000 occupied bed days. • Compare this metric to national benchmarks.	not have an associated incident report in the 2.5-year period reviewed. • These data were only available through the number of post-fall care plans generated and thus the number of unreported falls is suspected to be more. • The Trust tracks moderate or above injuries, monthly per 10,000 occupied bed days. • The NHS England Patient Safety and the National Reporting and Learning System (NRLS) have not produced data on national benchmarks and actively discourage this activity; they request hospitals benchmark themselves and review their data only. • Sharing and spreading communication is done monthly through Safety Learning Improvement Conversion (SLIC) and Harm Free Assurance Forum (HFAF), and Quarterly data are shared to Patient Safety Effectiveness Committee (PSEC). • A Falls Improvement Delivery Group has been established monthly to drive forward changes in falls prevention, and a Community of Practice, for Trust Champions, to learn and share ideas and stories, has also been established monthly.

Clinical Effectiveness

Quality Priority 4: Reducing Unwarranted Hospital Outpatient Cancellations

Why is this a priority?

Cancellation and rearrangement of hospital outpatient appointments may delay patient treatment and follow-up, impacting on clinical effectiveness as well as administrative efficiency and patient experience. While some cancellations are appropriate, for example to expedite an appointment or because an appointment is no longer required, or the patient requests the appointment to be rescheduled, in other cases cancellations arise due to errors or inefficiencies. This quality priority focuses on reducing these unwarranted outpatient cancellations to improve clinical care, patient experience and outpatient and administration efficiency. It aligns with the Integrated Quality Improvement Outpatient Workstream.

Table 5: Summary of actions for Quality Priority 2023-24: Reducing Unwarranted Hospital Outpatient Cancellations

What we will do	2023-24 Update on QP
Action 1 Q1: Establish a dashboard for monitoring unwarranted hospital outpatient cancellations that includes the following metrics. • No. (%) unwarranted hospital cancellations* within 2, 4 and 6 weeks of appointment. • No. (%) patients subject to unwarranted hospital cancellations* >3 times in a year. • Average time to next booked appointment (days) following unwarranted cancellation. *Cancellations excluded include 'Added in error', 'Administrative Error', 'Appointment Expedited', 'Outpatient appointment not required', 'Patient Died (Auto-deceased)', 'Patient Medically Unfit', 'Request raised in error', 'Same day clinic amendment', 'Treatment no longer required', 'Industrial Action'	**Complete** • A dashboard is in operation reporting on the specified unwarranted hospital cancellation metrics. • The dashboard was also required to report the indicators at Trust, Division, Directorate and specialty level; and by factors associated with health inequalities including index of multiple deprivation (IMD), ethnicity, age and gender. • This report has been developed and is available within the Outpatient section of the ORBIT menu and meets the requirements specified.
Action 2	**Partially Complete** • We have introduced a new IPR that incorporates the NHSE SPC methodology. This has been developed in-house using Tableau

• Q2: Establish regular reporting of all metrics within the Divisional and Directorate Performance Reviews; and of one or more chosen metrics within the Integrated Performance Report (IPR).	software. We also incorporated the SPC methodology in Divisional Performance Review meetings for M11 reporting. This will be underpinned by targets to achieve a 50% reduction in the number of unwarranted outpatient cancellations (Action 3). A review of all indicators is planned for 2024-25 and this will incorporate unwarranted cancellations.
Action 3 • Q 2-4: Develop and implement interventions to reduce the number of unwarranted hospital cancellations.	**Complete** • Successful pilot for patient-led outpatient booking in Urology. This will now be rolled out to other specialties in 2024-25.

Quality Priority 5: Rolling out and embedding the Surgical Morbidity Dashboard (rolled over from 2022-23)

Why is this a priority?

Surgical morbidity refers to health problems arising as a result of surgical treatment, usually indicating that something has not gone as expected with a patient's recovery. It is common and affects at least one in 10 patients in hospital. It is a very good indicator of quality of care. Complications are also costly to manage and reducing morbidity is therefore a very cost-effective approach to healthcare.

This Quality Priority builds on our previous year's work by supporting rollout of the recently developed Morbidity Dashboard for more widespread use across the Trust. Monitoring the occurrence of complications, identifying areas of higher-than-expected rates, and assessing if they were avoidable will help teams to improve the quality of care that is delivered. We expect that by allowing clinical teams to monitor their outcomes better, the morbidity dashboard will facilitate efforts to improve the safety of patients and help us deliver high quality healthcare.

Table 6: Summary of actions for Quality Priority 2023-24: Rolling out and embedding the Surgical Morbidity Dashboard

What we will do	2023-24 Update on QP
Action 1 • Q1: Pilot use of the Surgical Morbidity Dashboard in selected surgical services with training and evaluation of the value it adds to Morbidity & Mortality (M&M) meetings.	**Complete** • Four services have been trained to use the dashboard and piloted it (Upper Gastrointestinal (GI), Hepatopancreatic and Biliary (HPB), Gynaecology, Surgical Emergency Unit (SEU). • On track with several services incorporating the Tracker to their M&Ms and monitoring for any trends.
Action 2 • Q2: Implement any identified minor improvements to the dashboard if/as required to improve functionality, on the basis of feedback from clinical services in Q1.	**Partially Complete** • Need for procedure-specific complications noted by UGI and HPB services. How this can be incorporated is being investigated with coders.
Action 3 • Q2-4: Expand rollout of the dashboard to other surgical services in OUH.	**Partially Complete** • All SuWOn surgical services except Urology have completed training – Urology planned to complete in Q1 2024-25. Expansion to other Divisions will progress over 2024.

Action 4 • Q2-4: Support introduction of selected, additional, procedure-specific complications for two services to increase dashboard utility for these services.	**Partially Complete** • Meeting with coders and IM&T has occurred. Further progress will need updates to EPR to facilitate accurate coding of these complications that can then be incorporated into the dashboard. This has been carried over into the QP for 2024-25.

Quality Priority 6: Helping more patients through Tissue Donation for Transplant

Why is this a priority?

As many as 50 lives can be helped by a single donor through the gift of tissues after death. Tissue donation, which is different from organ donation, includes corneas, heart valves, bone, tendons and skin. 70% patients express wishes to donate their organs or tissues after death but only a minority of these currently proceed to donation and knowledge among clinicians about the opportunities for tissue donation is limited. As a result, there is a potentially large, missed opportunity to help more patients through tissue donation. This Quality Priority focuses on increasing clinicians' awareness and knowledge of tissue donation, and the number of referrals for tissue donation that are made, in key clinical areas of the Trust: Emergency Department (ED), Acute General Medicine (AGM) and Palliative Medicine. It builds on a successful pilot project in the Emergency Department.

Table 7: Summary of actions for Quality Priority 2023-24: Helping more patients through Tissue Donation for Transplant

What we will do	2023-24 Update on QP
Action 1 Q1: Conduct a baseline audit, including: (a) Survey of doctors' and nurses' knowledge of tissue donation, including: • Knowledge of tissue donation uses, requirements and pathways. • Confidence and experience in discussing tissue donation with patients/next of kin. (b) Audit of the number (%) of deceased adult patients in OUH that had opted into the Organ Donation Register and/or who had 'deemed consent'.	**Complete** • Both Staff Survey and audit of Organ Donor Register complete. Presented to Organ Donation committee May 2023. • This has been presented at ED, palliative care and Adult General Medicine (AGM) governance meetings.

What we will do	2023-24 Update on QP
Action 2 Q1-2: Develop Trust-wide policy and process for tissue donation referral including: • Indications and contraindications for referral. • Approach to communication with patient and next of kin. • Standardised approach to documentation of patients' wishes regarding tissue donation. • Creation of EPR prompt embedded within the 'Referral to Bereavement Services' form. • Tissue donation referral pathway.	**Partially Complete** • The Trust-wide process for tissue donation referrals pathway has been developed, including indications/contraindications for referral and approach to communication with the patient and next of kin. • Policy agreed by AGM, ED and Palliative Medicine governance and Clinical Policy Group. • EPR changes have been agreed for standardised documentation of patient wishes and tissue donation prompt in the bereavement referral form. Awaiting implementation by EPR team.
Action 3 Q1-3: Identify Tissue Donation Champions and develop and deliver training for clinicians in ED, AGM and Palliative Medicine, including: • Departmental teaching and induction sessions. • Training day(s) for Tissue Donation Champions • Pre- and post-training survey to evaluate clinician knowledge and confidence.	**Complete** • At least 10 teaching sessions have been delivered over the year targeting a minimum of 150 staff members in total. • 16 staff members have been trained as Tissue Donation Champions, to act as a point-of-contact and facilitator in their daily practice for tissue donation. • Staff surveys demonstrated an 88% increase in self reported knowledge and confidence. • The Tissue Donation team is also completing regular ad-hoc teaching sessions in their respective departments, within embedded teaching infrastructure. Approx. 12-15 different teaching sessions given to a range of clinical audiences.
Action 4 Q1-3: Improve the information on tissue donation that is available to patients, relatives and clinicians by: • Developing a patient information leaflet and web resources. • Incorporating tissue donation information into bereavement documentation.	**Complete** • Existing NHS blood transfusion leaflets for tissue donation were identified and are being ordered for AGM, ED and Palliative Medicine for patients and staff.

What we will do	2023-24 Update on QP
• Editing and updating a Trust intranet page dedicated to tissue donation.	• Tissue donation intranet and internet pages have now been developed and updated to reflect current Trust activity, including signposting for service users to patient information resources.
Action 5 Q2-4: Focused effort to support and increase the number of tissue donation referrals in the Emergency Department and two or more medical wards.	**Complete** • The average annual number of referrals into OUH was six before this Quality Priority. • We exceeded our target of doubling referral activity, with a total of 32 referrals over 12 months. • Tissue donation activity increased in all three clinical areas (Palliative Medicine 21; ED 6; AGM 2; Other 3).

Patient Experience

Quality Priority 7: Health Inequalities – improving data capture including of ethnicity

Why is this a priority?

Reducing health inequalities is a key objective running through the Trust's Clinical Strategy. Key to understanding, improving and monitoring health inequalities are good quality data on the key determinants of inequality including ethnicity. This quality priority focusses on improving the ethnicity data to support a better understanding of, and interventions to improve, local health inequalities.

Table 8: Quality Priority 7: Health Inequalities – improving data capture including of ethnicity

What we will do	2023-24 Update on QP
Action 1 Q1: Undertake a baseline audit of the current availability and sources of ethnicity data on OUH patients, including: • Data directly captured in OUH clinical areas. • Data available through existing external data feeds. • Patterns in data completeness or quality that might inform data improvement work. • factors contributing to data quality (e.g. Summary Care Record data quality, policy and practice around data entry workflows, and staff education and training).	**Complete** • An information dashboard has been published which shows the current live state of the collection of ethnicity data through patient interactions via the inpatient, ED and outpatient pathways. This currently shows the proportion of unknown ethnicity to be around 21%, slightly down from the 24% in the original Trust-wide snapshot audit. This data will be available for ongoing audit and oversight.
Action 2 Q1-2: Informed by the baseline audit and in collaboration with the Operational Service Managers (OSMs) and local management teams, formulate a strategy and implementation plan to improve ethnicity data. This will include detailed plans to achieve actions 3 and 4 below.	**Partially Complete** • The manual process of collecting the data across a number of the NOTSSCaN specialties has had a small but measurable impact and the pilot will be rolled out across other specialties within the Division.

What we will do	2023-24 Update on QP
Action 3 Q2-4: Informed by the baseline audit, choose at least two clinical areas requiring improvement and implement changes (e.g. workflow changes, training) to improve to >95% the proportion of patients attending the hospital that have their ethnicity verified and documented at their visit.	**Partially Complete** • The Trust has provided an Ethnicity dashboard to allow for the selection of appropriate areas for audit.
Action 4 Q2-4: Work with the Digital team and system partners to optimise the quality and maximise sharing of ethnicity data across partner organisations by ensuring: • OUH data include all ethnicity data from primary care and the NHS Spine. • Changes made to ethnicity records on OUH or elsewhere are updated across the system.	**Complete** • Consolidation of shared records is evolving, locally with Graphnet in participating practices of the ICB and Health Information Exchange (HIE) with OneLondon, meaning that key patient data will be available to many more care partners, including key demographic and social care information.
Action 5 Q3-4: Identify any inequalities in cancer pathway metrics related to specific demographic groups (e.g. by age, ethnicity, postcode). Develop an action plan to address any opportunities to improve cancer pathways for any disadvantaged group identified.	**Complete** • Analysis completed and presented to Executive colleagues. No obvious new opportunities to target disadvantaged groups identified at secondary care level. Findings to be shared with Health Inequalities Steering Group in Q1 2024-25.
Action 6 Q1: Accurately define key population demographics among pregnant women/people (including language, ethnicity and postcode) that are associated with: a) Late booking for pregnancy care (as defined by NICE and OUH antenatal care guidance). b) Failure to attend two or more antenatal clinic appointments.	**Partially Complete** • This is an ongoing piece of work in collaboration with the Director of Data and Analytics. Data request has been submitted and will examine 5 years of routinely collected maternity information (pre-COVID and post-COVID). We aim to be able to report on retrospective data set by the end of Q1 2024-25.

What we will do	2023-24 Update on QP
Action 7 Q2-3: Identify any gaps in routinely captured data with respect to known social determinants of health within existing electronic maternity records and ensure gaps are addressed in BadgerNet maternity electronic patient record.	**Complete** • BadgerNet rollout completed late January 2024.
Action 8 Q2-3: Working with Maternity Service users including maternity advocate/community organisers and locality partners in health, use data from Action 6 to identify barriers to care and strategies to overcome these barriers.	**Partially Complete** • Addressing health inequalities is one of four strategic priorities in Maternity Clinical Strategy Plan. Key updates: • We have run a series of events to capture key stakeholder views/experiences to inform the Maternity Health Inequalities Strategy. • This is progressing to the next stage of the Theory of Change (ToC) to produce a dynamic strategy. • First (of three planned) ToC workshop was held in March 2024; the second and third will run over the next four months. • There will be external facilitation to ensure a robust approach that is as inclusive as possible. • 2024-25: Scoping other areas of need in Oxfordshire with view to extending ELES programme framework.
Action 9 Q3-4: Pilot at least one intervention from the strategic plan to address barriers to antenatal care.	**Complete** • Early Lives Equal Start Shared Learning Event was held in March; this included evaluation as well as community-driven initiatives (Equal Start Maternity Advocates film) and co-produced calls for action. This was attended by the Chief Medical Officer. • We will supply additional material to support the above-evaluation and link to the film.

Quality Priority 8: Empowering patients – building partnerships and inclusion

Why is this a priority?

This Quality Priority focuses on strengthening the Trust's partnerships with patients and their families, particularly those lived experience and voice is not heard, in order to improve patient experience (PE) and services.

Table 9: Summary of actions for Quality Priority 2023-24: Empowering patients – building partnerships and inclusion

What we will do	2023-24 Update on QP
Action 1 Further strengthen interpreting and translation services and uptake. • Q1: Develop easy to use booking guidelines. Rectify Information Technology (IT) challenges for video interpreting. • Q2: Make enhanced training available to staff 24/7. • Q3: Develop a Patient Story related to interpreting and present it to Trust Board. • Q4: Make available on the Trust website and social media an interpreting and translation film with communities' input. • Q1-4: Host Listening Events to learn from patients' lived experience of using interpreters.	**Partially Complete** • Simple booking guidance on SharePoint, Interpreting Policy undergoing review. • Contract review underway which will provide additional technology. • Interpreting story presented to Trust Board, following which a Deaf Awareness Task and Finish Group was established to make improvements. A film of the interpreting story to Board has been made to support staff learning.
Action 2 Q1-4: Patient and Public Engagement. • Re-launch Trust Patient Partnership Groups (PPGs), enabling groups to contribute to the work of their local clinical area and Trust development work. • Recruit a bank of 'experts by experience' (patients, families and carers) to contribute to service improvement and redesign. • Develop a Trust-wide Quality Improvement (QI) model to learn from lived experience including patients and families helping develop QI projects and being involved in training.	**Partially Complete** • The Patient Experience team has reached out to the organisation to determine who is already working with patients / experts by experience. • Experts by experience are now being factored into QI projects. • The Patient Experience team has attended community events and conducted some listening events within the hospitals to hear patient feedback directly.

What we will do	2023-24 Update on QP
• Host 2 'Listen Up' roadshows across Oxfordshire in partnership with local stakeholders including Healthwatch, governors and voluntary / advocacy / community groups.	
Action 3 Friends and Family Test (FFT). By Q1: • Promote FFT with both the community maternity teams and families. • Develop the Trust-wide 'You Said, We Did' approach and incorporate into ward reporting, Divisional Quality Reports and Performance Reviews, Trust Board reports, and external communications via the Trust website and social media. By Q2: • Implement FFT online / via SMS texting for people who do not speak or read English. • Develop interactive FFT dashboard for wards, departments, Directorates and Divisions. By Q4: • Identify patient groups that the Trust does not hear from via FFT and hold three focus days to collect FFT data from these groups. • Extend the Trust interactive FFT dashboard to be a publicly accessible dashboard.	**Partially Complete** • The FFT improvement project has taken longer than anticipated due to uncovering some historical systems which were no longer fit for purpose and didn't match the correct locations which compromised the data quality. This has been corrected and the new data set will be collected from 1 May 2024. Maternity data via SMS are currently not being collected following the move to BadgerNet notes, as the daily extract for FFT is not collected in the same way. • More work to promote FFT within the organisation needs to take place, which will be possible when the above workstream has concluded.

Quality Priority 9: Kindness into Action (KIA) - improving patient and staff experience

Why is this a priority?

Kindness into Action is a key deliverable we have committed to within our People Plan as part of Theme 1: Health, Wellbeing and Belonging for all our People and Theme 2: Making OUH a great place to work. Our staff survey continues to tell us that people are experiencing harassment, bullying or abuse from peers, managers and patients, and people do not feel equipped, confident or safe to speak up when they are negatively impacted by other people's behaviours. Leaders and managers have a disproportionate effect on culture, accounting for 70% in the variation in engagement levels between different teams. Our aim is to build a culture of kindness and provide guidance and support to have the conversations needed to resolve things together early.

Our purpose is to deliver a culture change programme in collaboration with Trusts and CCGs (ICB) that would instil a kinder culture within our workplace. Implementing a joined-up collaborative approach within the Trust with nominated resources, through integrated Care Systems (ICS) & Trust steering groups, and working with existing teams; Organisational Development (OD), Wellbeing, Human Resources (HR) etc. Kindness into Action brings to life the evidence showing how severe bullying harms people's health and wellbeing. Then introduces practical ways to reduce bullying and resolve it when it happens. It demonstrates how kindness also promotes trust - people in high trust organisations experience 50% higher productivity, 76% more engagement plus experience 40% less burnout and 13% less sick days. The programme is designed to support all to adopt new approaches, understand the value of kindness in teams and explore how to lead ourselves and others with kindness.

Table 10: Summary of actions for Quality Priority 2023-24: Kindness into Action - improving patient and staff experience

What we will do	2023-24 Update on QP
Action 1 Q1-4: Training and awareness building • Providing a blended learning approach to training; each leader attending two x 60-minute online sessions (two hours in total), taking Kindness into Action e-Learning modules between sessions to enhance learning. • 30 date options will be available (per workshop) to enable us to train up to 3,000 leaders and managers across the Trust,	**Partially Complete** • The Leading with Kindness (LwK) course has been revised to reduce overall time to complete and align more closely with OUH priorities. • LwK has been incorporated into the OUH Leadership Development Programme (LDP) to develop feedback skills and spread knowledge and resources. The LDP programme was launched in October 2023, and at end of March 2024 has four cohorts running.

<table>
<tr>
<td>providing 60 sessions over the next six months with the specific objectives to:
• Nurture a kinder culture across our healthcare system.
• Explore the evidence base for kindness in healthcare.
• Clarify what it means to be a kinder leader
• Create teams where people feel safe to speak up
• Launch and practise new approaches to building trust, wellbeing, belonging, equality and inclusion in our teams
• Respectfully resolve bullying and other poor behaviours
• Become a safer place to work and to be cared for.
• All staff will also be encouraged to complete the Kindness into Action e-Learning to help embed the tools and approaches in the way they work. To allow for more opportunities in having kinder conversations and for informal resolutions.</td>
<td>• Kindness into Action (KIA) training take-up continues to be part of monthly HR Governance meetings, where completion rates are monitored by the Divisional Heads of Workforce. The numbers are scrutinised in the monthly People Governance report that is presented at TME, and target trajectories for each Division are in place to meet our target of 1,800 managers completing LwK by December 2024.
• The numbers of staff who have completed LwK training in each Division at the end of March 2024 are as follows:
<table>
<tr><th>Division</th><th>Completed</th><th>Partially Completed</th></tr>
<tr><td>CSS</td><td>55</td><td>119</td></tr>
<tr><td>MRC</td><td>169</td><td>224</td></tr>
<tr><td>Corporate</td><td>147</td><td>129</td></tr>
<tr><td>SuWOn</td><td>61</td><td>223</td></tr>
<tr><td>NOTSSCaN</td><td>61</td><td>199</td></tr>
<tr><td>Other</td><td>26</td><td>75</td></tr>
<tr><td>Total</td><td>519</td><td>969</td></tr>
</table>
• The KIA e-Learning for all staff continues to be actively promoted. At the end of March, 1,060 members of staff have completed this course and 618 had started the training.</td>
</tr>
<tr>
<td>Action 2
Q1-2: Recruitment and Training of KIA Ambassadors
• Recruit (Q1) and train (Q2) a minimum of two KIA Ambassadors per Division, who will take opportunities in their role to talk about the value of kindness at an individual and team level:
• Using opportunities to share and promote KIA and Respectful Resolution (RR) tools.</td>
<td>Complete
Building on the success of August’s Ambassador engagement event the initial target for two Ambassadors per Division has been exceeded.
Current figures are below:
<table>
<tr><th>Division</th><th>No. of Ambassadors</th></tr>
<tr><td>CSS</td><td>8</td></tr>
<tr><td>MRC</td><td>17</td></tr>
</table>
</td>
</tr>
</table>

<table>
<tr>
<td>

Prompting discussions around acceptable behaviours in meetings or sharing experiences and success stories of applying tools.
Utilising opportunities to support others in using KIA and Respectful Resolution tools.

Train the Trainer sessions (two x three-hour workshops) will be developed and delivered to build capability within OUH (Q2-4). We will establish a forum to gather feedback from Ambassadors, to understand and monitor the help required to embed the new tools.

</td>
<td>
<table>
<tr><td>Corporate</td><td>10</td></tr>
<tr><td>SuWOn</td><td>7</td></tr>
<tr><td>NOTSSCaN</td><td>5</td></tr>
<tr><td>Total</td><td>47</td></tr>
</table>

New support has been put in place for Ambassadors including CPD sessions and a dedicated online site with resources for the community.

</td>
</tr>
<tr>
<td>
Action 3
Q1-2: Integration of tools in existing programmes

Building the Kindness into Action and Respectful Resolution (RR) modules into our ongoing Culture and Leadership training, supported by training materials, speaker notes, workbooks. This will include:

Face-to-face leadership training.
Onboarding.
Values Based Appraisal (VBA) and Values Based Conversation (VBC).
Developing 1:1 Feedback Skills Taster – introducing Action, Benefit, continue (ABC) and Behaviour, Understand, Impact, Listen, Do Differently (BUILD).

Q1: Identify programmes across the Culture and Leadership Service where KIA and RR tools can be integrated and develop a plan for integration by December 2023.
Q2: Review monthly the plan of all courses for integration of content within CLS Heads of Service meetings to ensure completion by Q2.
</td>
<td>
Complete

Over 400 people across the Trust have attended the one-to-one feedback skills workshop which supports the Kindness into Action approach and includes practical sessions using the feedback models.
Opportunities to further integrate Kindness into Action tools have been identified, with regular review to seek new opportunities. Recent examples include:

KIA feedback models added to updated 2024 Values Based Appraisal (VBA) resources and VBA comms
KIA feedback tools incorporated into the design of the staff recognition approach (monthly and quarterly)
integrated into leadership development programmes Trust-wide.
promoted across Staff and People Development Networks.

KIA content is included in the OUH Leadership Development Programme (LDP) reaching Directorate Managers, Matrons, new Clinical Directors, nominated Clinical Leads and nominated deputy roles.
We have worked closely with Practice Development and Education (PD&E) to maximise opportunities to integrate Leading

</td>
</tr>
</table>

	with Kindness and feedback skills in locally delivered workshops such as Band 6 and 7 nurse training days and Divisional leadership development workshops. • Sessions have also been delivered as part of several service-wide team and service development days. • The revised grievance procedure now renamed Resolution Procedure and Respect and Dignity Policy was signed off at Board in March 2024, supporting the early resolution of inter-personal issues and signposting to KIA feedback tools. • The Leading with Kindness course is part of a new managers' onboarding programme which is to be completed within six months of starting in a manager role. • KIA is also now part of the Trust-wide Eradicating Bullying and Harassment Programme and will be reinforced by other related activity under the eight workstreams in this programme.
Action 4 Q1-4: Identification and support for areas of concern • We will work with specific Divisions / Directorates / Clinical Service Units where there have been 'deep dives' into culture, e.g. through external reviews, to identify areas in need of additional support, and specific measures of 'behavioural' improvement, based on recommendations and Staff Survey data. Training will then be tailored to provide relevant additional support, e.g., kindness charters and targeted Leading with Kindness sessions.	**Complete** • Q3 and Q4 have seen an increase in face-to-face workshop delivery particularly in targeted areas where the need for further support has been identified. These areas and sessions have been informed by the triangulation of data from our 2023 Staff Survey and people metrics as part of discussions with Divisional Heads of Workforce and Divisional leadership teams.
Action 5 Q1-4: Monitoring impact through staff surveys • Within themes 1 and 2 (*Health, wellbeing and belonging for all our people* and *Making OUH a great place to work)* of our People Plan we have committed to delivering a cultural change programme to address poor behaviours in Year 2 and instil a more civil, respectful and kinder culture within our workplaces.	**Complete** • Review of the 2023 Annual Staff Survey results shows improvements in seven out of eight identified success measures for Kindness into Action (questions 7c, 7g, 8b, 8d, 9b, 9h and 21). Question 8c was the only question to see a decline but still scores above the national average.

- We will use the Staff Survey to gather feedback from all our colleagues about what is working well and to highlight what we could improve upon in the areas of bullying and harassment from managers, colleagues and patients. We will use feedback from both the quarterly Pulse and annual Staff Survey to inform improvement against specific questions, and our OUH People Plan Key Performance Indicators (KPIs).

- These questions cover the following areas: my line manager cares; respect and appreciation towards one another; disagreements dealt with effectively; people are kind and understanding.
- See table below for 2023 Staff Survey data.
- The biggest improvement was seen in question 9b 'My immediate manager gives me clear feedback on my work'. This is encouraging as the Leading with Kindness course for managers and leaders has a particular focus on feedback models introducing two practical models for people to use in feedback conversations.

Staff Survey Question	OUH 2022	OUH 2023	National Average 2023
7c – I receive the respect I deserve	70.73%	70.86%	70.96%
7g – In my team disagreements are dealt with constructively	57.46%	57.80%	56.71%
8b – People I work with are understanding and kind to one another	71.00%	71.25%	69.73%
8c – The people I work with are polite and treat each other with respect	72.49%	71.74%	70.95%
8d – People I work with show appreciation to one another	68.06%	68.58%	66.91%
9b – My immediate manager gives me clear feedback on my work	64.80%	67.11%	64.96%
9h – My manager cares about my concerns	71.51%	73.85%	69.73%
21 – I think that my organisation respects individual differences	71.29%	71.98%	70.33%

Choosing quality priorities for 2024-25

The ethos of the Trust and the NHS is a commitment to the delivery of compassionate and excellent patient care. Our quality of care has its foundation in the commitment of our staff to their patients and the focus on future excellence. Contained within this account are commitments to Quality Priorities within the domains of Patient Safety, Clinical Effectiveness and Patient Experience.

How we chose our priorities

We involve our patients, public, stakeholders and our staff in choosing our Quality Priorities through our annual public Quality Conversation event which was held in December 2023.

The Quality Conversation event provided an update on progress against the Quality Priorities for 2023-24 and focused on Quality Priorities for 2024-25 as part of the annual planning cycle and the Quality Account. Attendees chose priorities to be maintained and suggested new priorities both from those being developed by the Trust and their own suggestions, shaping our 2024-25 Quality Priorities.

Our Quality Priorities for 2024-25

The table below gives a description of our Quality Priorities for 2024-25. The full detail for each Quality Priority, why we chose them, and a description of how success will be evaluated over the course of the year can be found in Annex 1.

Table 11: Summary of Quality Priorities 20234-25

Quality Priority 2024-25	Summary
1) Medicines Safety Framework	A comprehensive Medicines Safety Framework is required to integrate a range of metrics and indicators to understand medicines safety over time. Examples of medication safety indicators that might be included in this framework include: • administration of naloxone and flumazenil as antidotes • time to dispense time critical medicines • delayed and omitted doses of time critical medicines • patients on insulin with severe episodes of hypoglycaemia • use of high-risk injectable ready-to-administer medicines • time taken to complete medicines reconciliation • proportion of patients with completed medicines reconciliation • safe and secure medicines management audit
2) Care of the frail elderly	Frail, elderly patients make up a substantial proportion of patients presenting to urgent and emergency care settings. Early, comprehensive assessment of these patients can improve outcomes by ensuring the acute care, management pathway and future care plans are all tailored appropriately to the patient's needs. This quality

Quality Priority 2024-25	Summary
	priority focuses on strengthening the assessment of frail, elderly patients in the Emergency Department (ED) and Same Day Emergency Care (SDEC) settings. It aligns with CQUIN 5 'Identification and response to frailty in emergency departments'.
3) Reducing inpatient falls	Inpatient falls are an important and potentially preventable cause of morbidity and mortality, especially as a cause of femoral fractures among the elderly. Key to reducing the risk of falls in hospital is a multifactorial falls risk assessment, followed by action to address each of the falls risk factors identified. Early assessment of patients with a suspected serious injury is also important following a fall to ensure timely and appropriate analgesia, investigations and management. This Quality Priority focuses on strengthening training and implementation of the multifactorial falls risk assessment; addressing key areas for improvement identified in the most recent National Audit of Inpatient Falls; and strengthening assessments and information sharing following a fall.
4) Outreach service from Oxford Critical Care	Develop and pilot an outreach service for the Trust, co-ordinated and overseen by Oxford Critical Care. This will improve the recognition of deteriorating patients, improve speed and quality of decision-making, improve bed length of stay, and provide a platform for improved nursing retention.
5) Surgical Morbidity Dashboard	This Quality Priority builds on our previous year's work by supporting roll out of the recently developed Morbidity Dashboard for more widespread use across the Trust. Monitoring the occurrence of complications, identifying areas of higher-than-expected rates, and assessing if they were avoidable will help teams to improve the quality of care that is delivered. We expect that by allowing clinical teams to monitor their outcomes better, the morbidity dashboard will facilitate efforts to improve the safety of patients and help us deliver high quality healthcare.
6) Reducing maternal and neonatal morbidity	The rate of induction of labour (IOL) is rising both nationally and locally and is associated with higher maternal and neonatal morbidity and poor patient experience when induction of labour is delayed due to high maternity unit activity and workload. This Quality Priority aims to improve the management of workload within Maternity Services by improving the induction of labour booking process, improving consistency of safe Delivery Suite staffing levels out of hours and providing focused training in the management of high acuity workload for senior midwifery and obstetric staff. The overall aim is improving patient experience and reducing the frequency of morbidity indicators associated with birth, specifically obstetric anal sphincter injury (OASI), severe postpartum haemorrhage (PPH) rates and term admission to SCBU for normal babies.
7) Embedding Health Inequalities	The NHS Long Term Plan articulated a need to take a more systematic approach to reducing health inequalities.

Quality Priority 2024-25	Summary
	The OUH Health Inequalities Programme was developed and agreed in 2022. It aims to address health inequalities across our own services, whilst at the same time building longer-term capability to promote the reduction of health inequalities and improved population health through working with partners in our local systems, developing population health management and recognising our role as an Anchor Institution. This Quality Priority builds on the progress made to date to embed the Trust's approach to health inequalities.
8) Patient Experience with Patient Safety Incident Response Framework (PSIRF)	We will understand and develop an improvement plan for compassionate engagement of patients, families and carers who have been involved in serious patient safety incidents. This will be based on the NHSE / HSIB / Learn Together document outlining the nine principles of engaging and involving patients, families and staff following a patient safety incident. We co-produce with Patient Safety Partners suitable tools to capture patient experience and improve our understanding of this part of the patient's journey.
9) Fragility Fracture Pathways, including fractured neck of femur pathway	The results of the National Hip Fracture Database (NHFD) demonstrate that at the John Radcliffe Hospital site there is a need to shorten the time taken for hip fragility patients to access surgery. The Horton General Hospital has delivered care that regularly meets the National Standards. This Quality Priority aims to combine a number of quality improvement (QI) workstreams to improve performance (time taken to get to theatre) and therefore reduce morbidity and mortality.

Monitoring and reporting

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

2.2 Statements of Assurance from the Board

During 2023-24 OUH provided and sub-contracted 233 relevant health services. OUH has reviewed all the data available to them on the quality of care of these relevant health services. The income generated by the relevant health services reviewed in 2023-24 represents 100% of the total income generated from the provision of relevant health services by OUH for 2023-24.

Clinical Audits and National Confidential Enquiries

Clinical audit is a process for reviewing clinical performance by measuring clinical practice against agreed standards, and as a result should lead to the refining of quality of clinical care.

During 2023-24, 71 national mandatory clinical audits and four national confidential enquiries covered relevant health services provided by OUH.

During that period OUH participated in 96% (68/71) of all the eligible national clinical audits as detailed within Table 12; and 100% (4) of national confidential enquiries in which we were eligible to participate as presented within Table 13 of the report.

The national clinical audits and confidential enquiries that OUH participated in, and for which data collection was completed during 2023-24, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Participation in National Clinical Audit

Data is still being collected for the national clinical audits

Table 12 below describes the national audit subject and whether the Trust participated in 2023-24.

Table 12: National audits and whether the Trust participated in 2023-24

National programme name	Trust Participation 2023-24	Cases Submitted
BAUS Nephrostomy Audit: British Association of Urological Surgeons (BAUS)	Yes	100%
Breast and Cosmetic Implant Registry (BCIR)	Yes	In Progress
British Hernia Society Registry Registry[1]	N/A; did not take place in 2023-24[1]	N/A
Case Mix Programme (CMP) Intensive Care National Audit and Research Centre (ICNARC)	Yes	100%
Cleft Registry and Audit Network (CRANE)	Yes	100%
Elective Surgery: Hip and Knee National Patient Reported Outcome Measures (PROMs) Programme	Yes	100%; patient response rate 55%
Emergency Medicine QIPs: Pain in Children (Care in Emergency Departments)	Yes	100%
Emergency Medicine Quality Improvement Projects (QIPs): Care of Older People	Yes	100%
Emergency Medicine QIPs: Mental Health Self-harm	Yes	100%
Falls and Fragility Fracture Audit Programme (FFFAP): National Audit of Inpatient Falls (NAIF)	Yes	9%[2]
Falls and Fragility Fracture Audit Programme (FFFAP): National Hip Fracture Database (NHFD)	Yes	100%
Falls and Fragility Fracture Audit Programme (FFFAP): Fracture Liaison Service Database (FLS-DB)	Yes	95.1%
IBD Registry: Improving Quality in Crohn's and Colitis (IQICC)	No[3]	N/A
Learning from lives and deaths of people with a learning disability and autistic people (LeDeR) - Learning Disabilities Mortality Review	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme (perinatal mortality surveillance)	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme (maternal mortality surveillance and confidential enquiry)	Yes	100%
National Adult Diabetes Audit (NDA): National Diabetes Foot Care Audit (NDFA)	Yes	4.7%[4]
National Adult Diabetes Audit (NDA): National Diabetes Inpatient Safety Audit (NDISA)	Yes	100%

National programme name	Trust Participation 2023-24	Cases Submitted
National Adult Diabetes Audit (NDA): National Pregnancy in Diabetes Audit (NPID)	Yes	100%
National Adult Diabetes Audit (NDA): National Core Diabetes Audit	Yes	100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): adult asthma secondary care	Yes	In Progress
National Asthma and COPD Audit Programme (NACAP): Paediatric - children and young people asthma secondary care	Yes	100%
National Asthma and COPD Audit Programme (NACAP): Chronic Obstructive Pulmonary Disease (COPD)	Yes	In Progress
National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	100%
National Audit of Cardiac Rehabilitation (NACR)	Yes	In Progress
National Audit of Care at the End-of-Life (NACEL)	Yes	100%
National Audit of Dementia (NAD): Royal College of Psychiatrists	No[5]	N/A
National Audit of Pulmonary Hypertension (NAPH)	No[6]	N/A
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Yes	100%
National Bariatric Surgery Registry	No[7]	N/A
National Cancer Audit Collaborating Centre: National Audit of Primary Breast Cancer	Yes	100%
National Cancer Audit Collaborating Centre: National Audit of Metastatic Breast Cancer	Yes	100%
National Cancer Audit Collaborating Centre: National Audit of Ovarian Cancer	Yes	100%
National Cancer Audit Collaborating Centre: National Audit of Pancreatic Cancer	Yes	100%
National Cancer Audit Collaborating Centre: National Audit of Non-Hodgkin lymphoma	Yes	100%
National Cancer Audit Collaborating Centre: National Audit of Kidney Cancer	Yes	100%
National Cardiac Arrest Audit (NCAA)	Yes	100%
National Cardiac Audit Programme (NCAP): National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Yes	100%
National Cardiac Audit Programme (NCAP): National Adult Cardiac Surgery Audit	Yes	100%
National Cardiac Audit Programme (NCAP): Myocardial Ischaemia National Audit Project (MINAP)	Yes	100%
National Cardiac Audit Programme (NCAP): National Audit of Cardiac Rhythm Management Devices and Ablation (CRM)	Yes	100%
National Cardiac Audit Programme (NCAP): National Congenital Heart Disease Audit (NCHDA)	Yes	100%
National Cardiac Audit Programme (NCAP): National Heart Failure Audit (NHFA)	Yes	100%

National programme name	Trust Participation 2023-24	Cases Submitted
National Cardiac Audit Programme (NCAP): National Audit of Mitral Valve Leaflet Repairs (MVLR)	Yes	100%
National Cardiac Audit Programme (NCAP): UK Transcatheter Aortic Valve Implantation (TAVI) Registry	Yes	100%
National Child Mortality Database (NCMD)	Yes	100%
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	99%
National Emergency Laparotomy Audit (NELA)	Yes	<50%
National Gastro-intestinal Cancer Audit Programme (GICAP): National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	100%
National Gastro-intestinal Cancer Audit Programme (GICAP): National Bowel Cancer Audit (NBOCA)	Yes	100%
National Comparative Audit of Blood Transfusion: Audit of NICE Quality Standard QS138	Yes	100%
National Comparative Audit of Blood Transfusion: Bedside Transfusion Audit	Yes	In Progress
National Joint Registry (NJR) - Royal College of Surgeons (with project management subcontracted to NHS Digital)	Yes	99%
National Lung Cancer Audit Programme: Royal College of Surgeons	Yes	100%
National Maternity and Perinatal Audit (NMPA)	Yes	In Progress
National Neonatal Audit Programme (NNAP)	Yes	100%
National Obesity Audit: NHS Digital	Yes	In Progress
National Ophthalmology Database Audit: Age-related Macular Degeneration Audit (AMD)	Yes	100%
National Ophthalmology Database Audit: Adult Cataract Surgery	Yes	100%
National Paediatric Diabetes Audit (NPDA): Royal College of Paediatrics and Child Health (RCPCH)	Yes	100%
National Perinatal Mortality Review Tool (PMRT)	Yes	In Progress
National Prostate Cancer Audit (NPCA): Royal College of Surgeons of England	Yes	In Progress
National Vascular Registry: Royal College of Surgeons of England	Yes	<5% - 90%[8]
Neurosurgical National Audit Programme	Yes	100%
Paediatric Intensive Care Audit Network (PICANet)	Yes	100%
Perioperative Quality Improvement Programme (PQIP)	Yes	92%
Renal Audits: National Acute Kidney Injury (AKI) Audit	Yes	100%
Renal Audits: UK Renal Registry Chronic Kidney Disease Audit	Yes	In Progress
Respiratory Audits: Adult Respiratory Support Audit	Yes	In Progress
Sentinel Stroke National Audit Programme (SSNAP) (2021-22)	Yes	In Progress

National programme name	Trust Participation 2023-24	Cases Submitted
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Yes	100%
Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	100%
Trauma Audit and Research Network (TARN)	No[9]	N/A
UK Cystic Fibrosis Registry	No[10]	N/A
UK Parkinson's Audit	Yes	100%

[1] British Hernia Society Registry has been in pilot phase in 2023-24 and has not been available for general use by OUH.

[2] National Inpatient Falls Audit: case ascertainment was low when there was no Falls Practitioner in post; they are now leading on data submission and accuracy.

[3] Inflammatory Bowel Disease (IBD) National Audit: OUH did not submit data to the Inflammatory Bowel Disease (IBD) National Audit. National ethical approval for the IBD database does not provide a mechanism for patient consent which conflicts with Oxford's generic ethical consent policy. OUH will be unable to submit external data until the national audit produces e-consent.

[4] Data submission to the National Diabetic Foot Care Audit has been addressed by the team and is now part of routine practice.

[5] Dementia: The audit went to yearly frequency and the team had not received the results and report from the previous year, therefore participation was withheld to have time to implement changes. Participation will resume in the next audit round, August 2024.

[6] National Audit of Pulmonary Hypertension (NAPH) relates to the eight nationally commissioned centres - OUH is not one of those; OUH is a shared care partner of one of the eight centres, the Royal Brompton Hospital. Therefore, OUH's patients can access specialist treatments as part of the shared care arrangements (they fall within the Royal Brompton's service from an audit and compliance perspective).

[7] National Bariatric Surgery Registry: service is closed to new patients.

[8] National Vascular Registry: case ascertainment varied from <5% of eligible cases to 90% depending upon the intervention.

[9] TARN: there was a national data interruption during 2023-24 which prevented any Trust participation. This programme will relaunch as the National Major Trauma Registry in 2024 (date to be confirmed).

[10] UK Cystic Fibrosis Registry: the team was unable to participate in 2023-24 due to medical and nursing staffing challenges. The Clinical Lead anticipates that a return will be completed for 2024-25.

Participation in National Confidential Enquiries into Patient Outcome and Death (NCEPOD) 2023-24

Table 13 below shows the list of OUH eligible NCEPOD studies in 2023-24, in which hospital sites participated, and the percentage of clinical questionnaires, case notes and organisational questionnaires returned.

Table 13: NCEPOD studies 2023-24

NCEPOD Studies 2023-24	Sites Participating	Clinical Questionnaire Returned	Case Notes Returned	Organisational Questionnaire Returned
Rehabilitation following critical illness	John Radcliffe Horton General Hospital	Organisational and clinical questionnaires have been issued to the Trust. The ICU team is currently assisting with collection of patient notes and data collection		
End-of-Life Care	John Radcliffe Horton General Hospital	9/17 (submission still open)	100%	Not requested (data taken from national source)
Juvenile Idiopathic Arthritis	John Radcliffe Horton General Hospital	9/9	100%	Yes
Endometriosis	John Radcliffe Horton General Hospital	15/15	100%	Yes

Actions taken and improvements made from national audits

The reports of 52 national clinical audits were reviewed in 2023-24. Agreed actions and progress to improve the quality of healthcare provided are summarised in table below.

Table 14: National audits with summary of actions and benefits for patient care following review (**Fully achieved; *Partially achieved)

Audit	Summary of Agreed actions
Case Mix Programme: Intensive Care National Audit and Research Centre (ICNARC)	• Business case for dedicated Churchill HDU** • Oxford Critical Care has established a dedicated referrals service. Risk-adjusted hospital mortality is significantly lower when compared to similar units**
Child Health Clinical Outcome Review Programme (NCEPOD): Transition of Children and Young People in Healthcare	• Hold a Transition Conference** • Develop Transition / Moving to Adult Services Trust-wide programme chaired by Deputy Chief Nursing Officer* • Mentor support from Patient Experience team to the two Chief Nursing Officer Fellows working on six-month transition

Audit	Summary of Agreed actions
	projects funded by Oxford Hospitals Charity* • Ensure Transition / Moving to Adult Services is incorporated within the Shared Decision Making (SDM)*
Elective Surgery National PROMs Programme – Hip and Knee	• The results achieve the Best Practice Tariff for hip and knee replacement, with patients reporting adequate healthcare gains from surgery**
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	• To increase contact from epilepsy nurse for all children with epilepsy** • Epilepsy nurse to be involved in the completion of comprehensive care plans and school individual healthcare plans** • Plan how to train epilepsy nurse as nurse prescriber* • Increase involvement of epilepsy nurse in transition clinics*
Falls and Fragility Fracture Audit Programme (FFFAP): Fracture Liaison Service Database (FLSDB)	• Business case approved for the workforce required to use romosozumab** • Agreed funding with BOB ICB to fund romosozumab**
Falls and Fragility Fracture Audit Programme: National Audit of Inpatient Falls (NAIF)	• Undertake a gap analysis to determine whether there is any under-reporting of falls** • Undertake a bedrails audit, resulting in a new assessment flow chart and policy** • Re-audit walking aid accessibility** • Implement essential to role training for falls prevention** • Explore reporting of falls as a rate per 1,000 bed days*
Falls and Fragility Fracture Audit Programme: National Hip Fracture Database (NHFD)	• Increase the number of trauma surgeons working at the John Radcliffe by two** • Improve flow of patients and access to theatre by transferring some complex wrist, shoulder and hip surgery patients to the Nuffield Orthopaedic Centre from the JR**

Audit	Summary of Agreed actions
Maternal, Newborn and Infant Clinical Outcome Review Programme: MBRRACE[1]: Stillbirths and neonatal deaths in twin pregnancies	• All dichorionic (DC) twins should have serial growth scans at 24, 28, 32 and 36 weeks as a minimum** • Create a standard operating procedure (SOP) across the network for the correct labelling of twins referred to OUH for second opinion** • Review and update the OUH Multiple Birth Guideline in accordance with OUH response recommendation 3.4.3**
Medical and Surgical Clinical Outcome Review Programme (NCEPOD): Epilepsy	• Business case for additional epilepsy specialist nurses* • Availability of emergency out of hours EEGs* • Appointment of new consultant to achieve the first seizure Two Week Wait clinic* • Liaise with ED lead to discuss formalising investigation and documentation in ED*
Medical and Surgical Clinical Outcome Review Programme (NCEPOD): Alcohol Related Liver Disease	• Business case for additional alcohol specialist nurses* • Liaise with coding team to overcome barriers to correct coding*
National Adult Diabetes Audit (NDA): National Diabetes Foot Care Audit (NDFA)	• Set up administrative processes to collate and submit data. Podiatry staff to complete submission forms** • Liaise with Oxford Health (OH) team to ensure timely discharge of appropriate patients* • Agree notice on provision of OH podiatry staffing to OUH** • Recruitment of two new podiatrists and podiatry assistants; current 1.5 whole time equivalent (wte) vacancies (was 2.5 wte)* • Processes and services have been streamlined and external review to take place imminently*
National Adult Diabetes Audit (NDA): National Diabetes Inpatient Safety Audit (NDISA)	• Old e-learning slides have been reviewed and should be updated by May 2024* • QI project done with regards to perioperative diabetes. Project showed reduction in length of stay, reduced harms and improved glucose control which reduced complications**

[1] MBRRACE- Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries.

Audit	Summary of Agreed actions
	• Business case is being written to continue this and expand to all surgical service. In discussion with ORBIT to produce dashboard* • Development of a diabetes self-management policy for inpatients with diabetes to be discussed with Pharmacy*
National Adult Diabetes Audit (NDA): National Pregnancy in Diabetes Audit (NPID)	• Reinstate the pre-pregnancy clinic led by the Diabetes Specialist Nurse, particularly in relation to increasing folic acid consumption pre-conception*
National Asthma and COPD Audit Programme (NACAP): COPD Secondary Care	• To collect automated data entry via EPR with automatic 'push through' to national audit website* • Work with coding to understand COPD coding* • Improve timely access to NIV treatment by reviewing NIV pathway in EAU and ED* • Increase in respiratory bed numbers where NIV treatment can be delivered at JR and HGH sites* • Increased presence of respiratory medical staff at HGH site*. Increase respiratory nursing team working hours to include weekend cover* • Increase senior clinician input to COPD patient care* • Improving identification of patients out of hours and weekends* • Development of Smoke Free Strategy** • To develop an integrated respiratory team to support the development of community-based COPD / respiratory services* • To make lung function lab and ward spirometry results available on EPR** • To make GP spirometry results available to hospital teams** • To establish process for identifying patients who have opted out from data collection*
National Asthma and COPD Audit Programme (NACAP): Children and Young People's Asthma Secondary Care	• Promote early delivery of systemic steroid** • Communicate to ED, ward and paediatric respiratory team to record peak flow** • Communicate use of asthma clerking proforma**

Audit	Summary of Agreed actions
National Audit of Cardiac Rehabilitation	• Increased number of clinic spaces for assessments: plan of action to be agreed with OSM** • We have been working with BOB ICS cardiac rehab teams to develop our own App - Beat Better, which is just about to go live** • Funding given by BOB ICS for trial of PCI service for one year. This service commenced in October 2023** • All Oxfordshire elective PCI patients and patients diagnosed as inpatients with angina for PCI are seen in hospital and offered cardiac rehab** • Further funding for another year 2024-25 has been secured**
National Audit of Care at the End-of-Life (NACEL)	• Time limited working group to review qualitative feedback from families**
National Audit of Dementia (NAD)	• Needs a data scientist to assist with data collection from several different sources* • Add the *single question in delirium* (SQID) into the care support worker rounding proforma* • Improve access to training data so clinical staff can review completion rates*
National Cancer Audit Collaborating Centre - National Breast Cancer Audit (Breast Cancer in Older People)	• Technical issue is preventing data pulling to the Cancer Outcomes and Services Dataset (COSD) - national team is working with OUH to make it pull through* • Required data point to be added to MDT proforma** • Form to be added to patients' notes in appropriate age group. CNSs aware of need to fill in** • Audit recurrence rates to identify causes*
National Cardiac Arrest Audit (NCAA)	• The National Cardiac Arrest Audit shows improved outcomes and reduced incidence of cardiac arrest, which can be attributed to QI projects within the service**
National Cardiac Audit Programme (NCAP): National Adult Cardiac Surgery Audit (NACSA)	• Create a working group to improve same-day admission rates** • Adjust database to enable clinicians to record and transmit blood transfusion and MDT data, to increase submission to this audit*

Audit	Summary of Agreed actions
National Cardiac Audit Programme (NCAP): National Congenital Heart Disease Audit (NCHDA)	• No actions required; continue to provide data for national audit and monitor this internally
National Cardiac Audit Programme (NCAP): National Heart Failure Audit (NHFA)	• Increased staffing** • Increased OUH nursing staffing, increased clinic capacity* • Increased Oxford Health community heart failure nursing capacity* • Staff awareness, capacity for increased referrals within the Cardiac Rehabilitation team*
National Cardiac Audit Programme (NCAP): National Audit of Cardiac Rhythm Management (CRM)	• No actions required; continue to provide data for national audit and monitor this internally
National Cardiac Audit Programme (NCAP): Myocardial Ischaemia National Audit Project (MINAP)	• There should be discussion within the Division about priorities for admission to cardiac wards, and priority should be given to patients having MI** • Increase in staffing to support echocardiogram provision**
National Cardiac Audit Programme (NCAP): National Audit of Percutaneous Coronary Intervention (NAPCI)	• Procurement process under review for new reporting database*
National Early Inflammatory Arthritis Audit (NEIAA)	• Review service design to identify any improvements to patient flow* • Increase appointments for new patients in clinic*
National Emergency Laparotomy Audit (NELA)	• Work with Cerner and digital leads within the Trust to develop a multidisciplinary pathway* • Improve case ascertainment to >85% by improving access to NELA for surgical and anaesthetic trainees, and include in induction** • Liaise with surgical team about how to improve data entry** • Audit of electronic consent documentation* • Improvement of risk assessment documentation*
National Gastrointestinal Cancer Audit Programme (GICAP): National Oesophago-Gastric Cancer Audit (NOGCA)	• Audit of gastrectomy outcomes undertaken which excluded any concerns over positive margin rate** • Audit of palliative chemotherapy to explore reasons for non-curative chemotherapy rates being below average*

Audit	Summary of Agreed actions
National Joint Registry	• Introduction of infection bundle and change of antibiotic prophylaxis protocol** • New pathway in JR theatres in place to ensure all patients undergoing NJR eligible operations have forms completed and submitted**
National Lung Cancer Audit (NLCA)	• Business case to increase medical oncology provision and access to Day Treatment Unit* • Ensure data quality and increase Thoracic surgery capacity* • Review smoking cessation provision with Smoke Free Project Lead and Smoke Free Working Group*
National Maternity and Perinatal Audit (NMPA)	• Improve the availability and quality of information about possible interventions during labour and birth, by offering individualised evidence-based information** • Continue to monitor the rate of third and fourth degree tears** • QI project on postnatal care* • Ensure accurate data reporting in line with national guidance** • Quality of Postnatal Care Services*
National Neonatal Audit Programme (NNAP)	• Ongoing recruitment against approved business case* • Improve numbers of nursing staff Qualified in Specialty (QIS)* • Ongoing review of patterns of microbial resistance to determine antibiotic policies** • Continue with ongoing multifaceted QI bundle*
National Obesity Audit (NOA)	• Ongoing series of meetings with NOA team about data submission** • Establishment of regular ORBIT report of NOA data* • Complete the pathways of OUH patients under the bariatric service*
National Ophthalmology Database (NOD) Audit: National Cataract Audit	• Continued and correct data entry to ensure correct recording of complications and correct risk adjustment**
National Paediatric Diabetes Audit (NPDA)	• Continue twice-yearly recall of NPDA outcomes rather than annually**

Audit	Summary of Agreed actions
	• Continue additional screening during annual review** • Continue offering standard of care and education** • Named doctors and nurses to take responsibility for annual review collection of their patients** • Continue psychological assessment at annual review visits** • Accurate recording of education provided at all annual review clinics**
National Prostate Cancer Audit (NPCA)	• Aim for 85% of newly referred 2WW patients to have their MDT outcomes with tumour, node, metastasis (TNM) staging recorded* • 80% of MDT outcomes of newly referred 2WW patients to have their Performance Status recorded* • Accurate recording of true number of unplanned admissions within 90 days of Robotic Assisted Radical Prostatectomy (RARP)*
National Vascular Registry (NVR)	• Improve case ascertainment on the NVR to meet minimal national requirements* • Work towards GIRFT eight- week target for AAA repairs* • Work towards the seven-day GIRFT target time-to-treatment for symptomatic carotid patients* • Develop emergency protocol and training for endovascular anaurysm repair*
Paediatric Intensive Care Audit Network (PICANet)	• Business case for additional nurse staffing awaiting approval at Trust level** • Nursing establishment has progressed well and on target to achieve national standards*
Perioperative Quality Improvement Programme	• Improve early detection and treatment for anaemia* • Implement DrEaMing (drinking, eating mobilising) within 24 hours postoperatively* • Document individual risk assessments*
Sentinel Stroke National Audit Programme (SSNAP)	• Two additional Hyper-Acute Stroke Unit (HASU) beds**

Audit	Summary of Agreed actions
	• Protect two emergency beds on Hyper Acute Stroke Unit, operational team to support this** • Increase SLT provision to the budgeted resource* • Improve MUST screening and add to ward view to better identify those needing dietitian review** • Regular reviews of data accuracy / provide support to Rehabilitation Assistants
Serious Hazards of Transfusion (SHOT) UK National Haemovigilance Scheme	• Annual review of e-Learning package to incorporate Human Factors influences** • Implement a Transfusion Associated Circulatory Overload (TACO) checklist* • Review and update current policies, guidelines and training programmes in accordance with the safety alert actions** • Review and identify any possible gaps in local clinical and laboratory practices and systems to help implement recommendations from the 2022 Annual Report*
UK Renal Registry Chronic Kidney Disease Audit	• To assess performance real time for low clearance clinic and dialysis patients to help initiate and adjust Erythropoietin (EPO) dose* • To identify patients approaching End-stage Renal Disease (ESRD) and those currently on tesio line and promote early referral for definitive access* • Discussion with surgical colleagues to increase access clinic capacity and theatre capacity* • Review of current Peritoneal Dialysis (PD) staff / service capacity and introduction of refresher training for patients** • Review of infection rates monthly** • Move to EPR data extraction for registry returns**

Actions taken and improvements made from local audits

Local audits are monitored via clinical governance arrangements in Directorates and Divisions and are presented at local clinical governance meetings.

The reports of nine local clinical audits were prioritised for Trust-wide review by the Clinical Improvement Committee in 2023-24. Agreed actions and progress to improve the quality of healthcare provided are summarised in the table below.

Table 15: Local audits with actions taken and improvements made as a result

(**Fully achieved; *Partially achieved)

Local Audit	Summary of Actions
Atrial Fibrillation: Diagnosis and Management (NG196) NICE Audit	• Continue to maintain the service provided as the audit showed new diagnoses of atrial fibrillation were managed appropriately by the Arrhythmia Clinic**
Auto-reporting Policy Trust-wide Audit	• Recommend the requirement to record a written evaluation is included in the induction of all junior doctors; physician associates and ANPs in 'high use' areas (cardiothoracic surgery; critical care)* • Discussion within the radiology clinical governance group and during updates to the auto-reporting policy*
Deteriorating Patient Trust-wide Clinical Audit (2021-22 and 2022-23 data)	• Continue audit using SEND software* • Use data from this and continuing audit to identify non-compliant areas* • Recognising the Acutely Ill and Deteriorating Patient (RAID) committee to continue work with leads in areas involved to investigate issues behind poor compliance and agree action plans* • Monthly Report monitoring via OUHAssuranceHub in order to highlight areas which may need further support. * • Continue to audit RAID Huddle data* • Audit 2222 data in corelation with the RAID Huddle documentation and implement action plans as required*
Obstructive Sleep Apnoea / Hypopnoea Syndrome and Obesity Hypoventilation Syndrome in Over 16s (NG202) NICE Audit	• Use of the single inpatient sleep lab with Neuro-Sleep when not required by Neurology* • Increase capacity to report sleep studies through collaboration with the Oxford Community Diagnostic Centre (CDC)** • Increase capacity for follow-up appointments within one month for Continuous Positive Airway Pressure (CPAP) setup patients* • Increase capacity for annual follow-up appointments for patients established on CPAP* • Deliver mandibular advancement splints as a second line therapy for Symptomatic Obstructive Sleep Apnoea Hypopnea Syndrome (OSAHS) in appropriate patients*

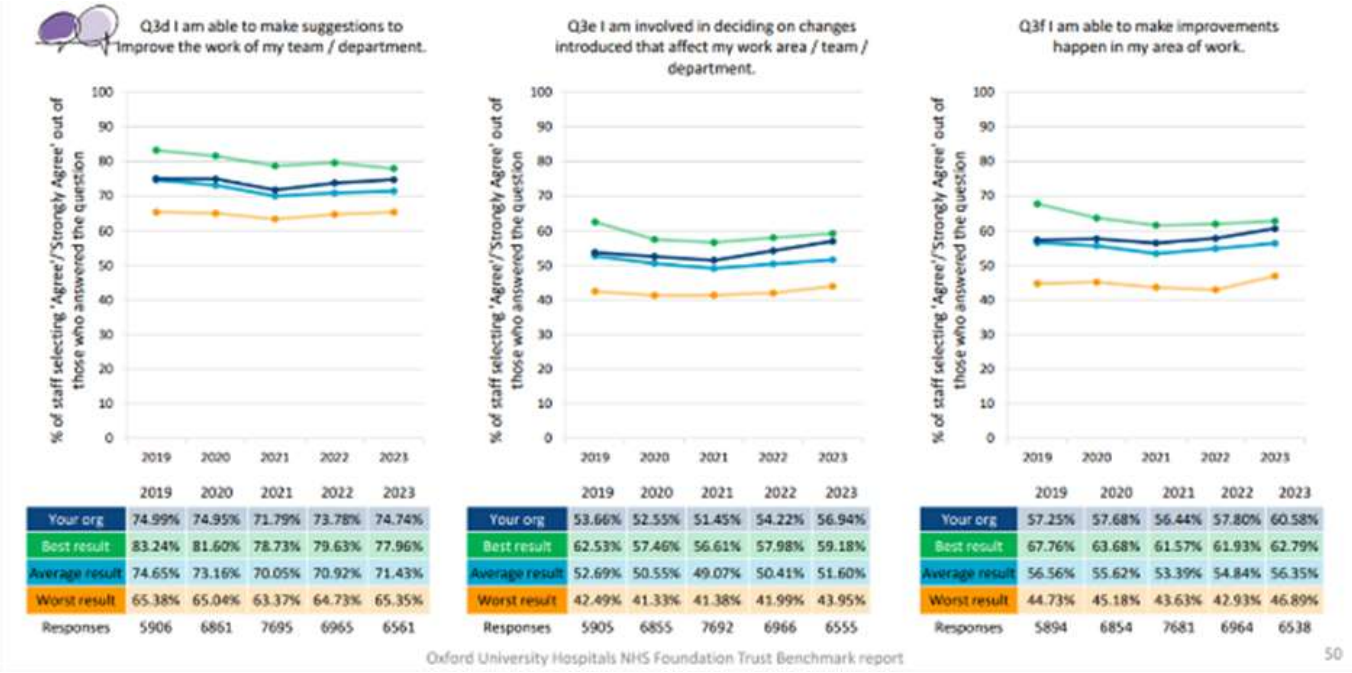
Local Audit	Summary of Actions
	• Access to nursing capillary blood gas testing at the John Radcliffe and Horton General hospitals*
Postnatal Care Audit (NICE NG194/QS37)	• Patient information leaflets (PILs) to be translated into the top 5 most commonly requested language line requests for interpreters* • Update the Birth Reflections advert to clarify what the service offers** • Translate the Birth Reflections Service leaflet into other languages* • The transition to BadgerNet maternity patient record system means relevant PILs will be automatically triggered depending on the patient's stage of pregnancy**
Renal Replacement New Starter Audit (NICE NG107)	• Promote and create uniformity in Low Clearance Clinic (LCC) MDT clinic referral process and practices** • Review LCC referral clinic referral criteria to incorporate risk assessment strategies** • Introduce Kidney Failure Risk Equation (KFRE) referral threshold to promote earlier referral of higher risk patients to LCC MDT clinic** • Introduce Kidney Failure Risk Equation (KFRE) score into low eGFR ops meeting list* • Automate calculation and reporting of KFRE on the electronic Laboratory Information Management System (LIMS)** • Establish QI project to establish dashboard for tesio line rate and improve the timely referral for vascular access** • Continue ongoing work of improving documentation on EPR if LCC referral not warranted at clinician discretion / patient choice* • Review of all renal replacement therapy starters on weekly basis to identify unplanned starters and offer LCC MDT clinic referral* • Meet with surgical teams to increase Vascular Access Clinic and theatre capacity*
Returns to Theatre in Cardiac Surgery	• Ensure a system of routine review for return-to-theatre bleeding tamponade cases at Cardiac Morbidity and Mortality meetings**
Safe and Secure Storage of Medicines Trust-wide Audit	• Redesign and implement new auditing software to host the audit questions** • Embed Divisional use of the audit on OUH Assurance Hub**

Local Audit	Summary of Actions
	• Business case for moving to a central digital monitoring system for refrigeration and room temperatures* • Make a financial case for installing air conditioning in required areas* • Review options to improve security* • Teams to review stock lists as appropriate. Pharmacy to review method of monitoring when stock lists have been reviewed* • Update and circulate promotional poster relating to this audit** • Reinstate core working group to discuss results from this audit**
VTE Prevention Trust wide Audit	• Development of 'safety nets' including EPR solutions following review of incidents or information from audits** • Involvement with Emerging Leaders Programme - VTE chosen for Quality Improvement project. Awaiting feedback and recommendations which the VTE Prevention team will review and take forward as appropriate** • Collaborative working with Quality Improvement team to review five years of Potentially Preventable HAT data. *Plan: Quality Improvement Project: Have our Interventions helped to reduce Potentially Preventable HATs?** • OUH successfully revalidated as VTE Exemplar Centre in May 2023, in addition awarded with a special commendation in recognition of the exceptional work achieved around VTE prevention. This has been awarded to organisations who have demonstrated outstanding quality, innovation and leadership in the field** • Renewal of all VTE prevention and safe anticoagulation training packages**

Quality Improvement 2024 Report

In the past year, Oxford University Hospitals (OUH) has continued to make substantial strides in the realm of Quality Improvement (QI), demonstrating our unwavering commitment to enhancing the quality of our services and the environment for both our staff and patients. Reflecting this is our positive feedback from the NHS Staff Survey, which highlights a significant cultural shift within our organisation towards greater staff autonomy and involvement in decision-making processes related to their work areas. These survey results reflect the increasing ability of our staff to contribute to improvements and compare favourably with many other NHS Trusts, as shown below.

Diagram 1: Survey results



	2019	2020	2021	2022	2023
Your org	74.99%	74.95%	71.79%	73.78%	74.74%
Best result	83.24%	81.60%	78.73%	79.63%	77.96%
Average result	74.65%	73.16%	70.05%	70.92%	71.43%
Worst result	65.38%	65.04%	63.37%	64.73%	65.35%
Responses	5906	6861	7695	6965	6561

	2019	2020	2021	2022	2023
Your org	53.66%	52.55%	51.45%	54.22%	56.94%
Best result	62.53%	57.46%	56.61%	57.98%	59.18%
Average result	52.69%	50.55%	49.07%	50.41%	51.60%
Worst result	42.49%	41.33%	41.38%	41.99%	43.95%
Responses	5905	6855	7692	6966	6555

	2019	2020	2021	2022	2023
Your org	57.25%	57.68%	56.44%	57.80%	60.58%
Best result	67.76%	63.68%	61.57%	61.93%	62.79%
Average result	56.56%	55.62%	53.39%	54.84%	56.35%
Worst result	44.73%	45.18%	43.63%	42.93%	46.89%
Responses	5894	6854	7681	6964	6538

Building on the foundation laid in the previous year, our Integrated Quality Improvement Team has actively advanced our QI agenda across four key areas: education and community building; infrastructure integration; supporting focused QI initiatives; and prioritised programme support. Each of these areas has seen noteworthy progress, from the expansion of QI knowledge and skills across the organisation to the successful application of the OUH Improvement Framework, guiding our approach from discovery through to the dissemination of improvements.

Our priority programmes, such as the Cancer, Urgent and Emergency Care and Harm Reduction Programmes, have utilised the structured approach provided by the OUH Improvement Framework to achieve important improvements. These include digitising processes, optimising recruitment, enhancing urgent care delivery, increasing clinic productivity, and improving cancer care access, alongside our focused efforts on reducing harm due to inpatient falls and pressure ulcers.

Looking ahead to 2024-25, we are setting clear priorities to further embed and expand QI in line with our commitment to continuous learning and improvement.

OUH Improvement Framework and its Impact

The OUH Improvement Framework provides a structured, five-step pathway guiding teams from problem identification through to the dissemination of learning and achievements.

Diagram 2: Improvement Framework

Priority Programmes Overview

Cancer Care Programme

The Cancer Care Programme at OUH has made good progress over the past year, enhancing operational efficiency and consistently achieving the 28-day Faster Diagnosis Standard (FDS) across multiple cancer groups.

In Gynaecology, a revised referral triage process has reduced the time to triage, optimising patient pathways and significantly decreasing waiting times. This success has allowed for the reallocation of clinic resources and a reduction in the waiting list, enhancing the overall patient experience.

In Urology, the adoption of enhanced MRI access has expedited diagnostics for prostate cancer patients, contributing to more timely and accurate treatment interventions. Through these improvements and the support of Advanced Nurse Practitioners, patients are receiving critical results an average of seven days sooner than was previously possible.

Collectively, these achievements, along with ongoing initiatives in other areas such as skin, lower gastrointestinal and oncology services, reflect the organisation's integrated approach to cancer care. This approach has not only improved diagnosis

times but has also been instrumental in treating our long waiters more effectively, reducing the number of patients waiting over both 104 and 62 days.

The progress of the Cancer Care Programme exemplifies the fruitful application of QI principles to improve patient care.

Urgent and Emergency Care

The Urgent Care Programme at OUH has made steady improvements in streamlining patient flow and enhancing care delivery. Automation of the Clinically Ready to Proceed (CRTP) Timestamp for non-admitted patients, which aligns with national guidance, contributed to a step improvement in reported service performance.

Increased utilisation of the Hospital at Home service has also supported the Emergency Department by facilitating supported discharge and admission avoidance, effectively streamlining the referral process with input from primary care stakeholders.

Digital enhancements, including the patient-facing dashboard, are improving communication and transparency with patients. Other improvements include refinement of the Transfer of Care Hub processes; strengthening of ward board rounds to support efficient patient flow; regular Multi Agency Discharge Event (MADE) meetings; improved processes for repatriation of patients to their local hospital when indicated; and increased utilisation of the Transfer Lounge resulting in an increase in discharges before midday.

The Live Bed State project has also been accelerated, where digital changes have facilitated a more dynamic and responsive approach to bed availability and patient movement.

Patient Safety – Reducing Inpatient Falls

This programme has focused on reducing the number of avoidable unwitnessed falls; alongside supporting the Reducing Inpatient Falls Quality Priority. Establishment of a monthly Falls Improvement Delivery Group and Community of Practice has led to broader engagement and shared learning. PDSA cycles have been conducted to improve multifactorial falls risk assessments, particularly in inpatient settings. Falls prevention sensors are being piloted in two inpatient wards, alongside focused QI and falls prevention training.

Patient Safety – Medication Safety

This programme has focused on improving perioperative diabetes through a pre-optimisation clinic, improving blood glucose measurement on day of surgery, and staff education resulting in improved glycaemic control prior to surgery and reduction in intra and postoperative complications and length of stay. The programme has also supported testing and adoption of a pharmacy inventory tracker tool for high-risk intravenous medicines to determine appropriate usage.

Patient Safety - Delirium and Dementia Assessments: This programme has supported the Cognitive Working Group to improve screening delirium and dementia rates, including implementation of updates to the Electronic Patient Record (EPR) to trigger screening tasks; and a new cognitive screening report to inform focused improvement work.

Quality Improvement Education and Community Building

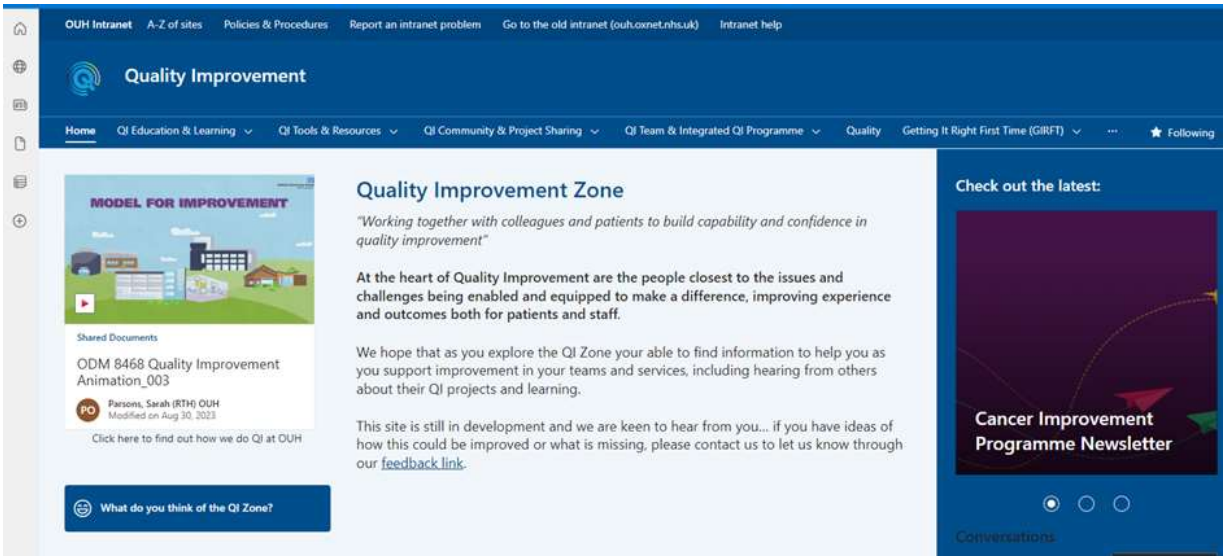
The Quality Improvement Education and Community Building Programme at OUH continues to flourish, with significant achievements in expanding the QI training in line with our QI Education Strategy. Despite a delay in the rollout of the 'Introduction to QI' e-Learning module, mitigating measures have ensured continued progress in QI skill development across the Trust. Group-based and open sessions of QI Essentials training sessions are now fully integrated into our QI Education programme, supporting the shared planning of PDSA cycles and the uptake of QI methodologies Trust-wide.

The QI in Action and QI Champions training levels, including quality, service improvement and redesign (QSIR) Practitioner courses, have remained highly subscribed, reflecting the growing interest and engagement in QI practices among OUH staff. In addition, the 'QI Managers and Leaders' programme is successfully running its third cycle of PDSA testing, with active participation from the staff.

The QI Education initiative has also seen the development of a strong community of practice, as demonstrated by the tenfold increase in activity on the QI Zone intranet page and the successful completion of training cohorts. These efforts are bolstered by the QI Coach and Faculty training programmes, which are expanding the internal capacity for QI coaching and leadership.

The QI Zone on the OUH intranet has been developed to host key QI resources, providing a comprehensive hub for staff seeking information and support, and facilitating collaboration and shared learning.

Diagram 3: QI Zone intranet page



These educational and community initiatives are building a robust foundation for continuous improvement across OUH, fostering a culture where quality improvement is not just an initiative but a fundamental aspect of daily work. The success of these programmes contributes significantly to the Trust's overarching goal of delivering outstanding healthcare services.

Successful Case Study

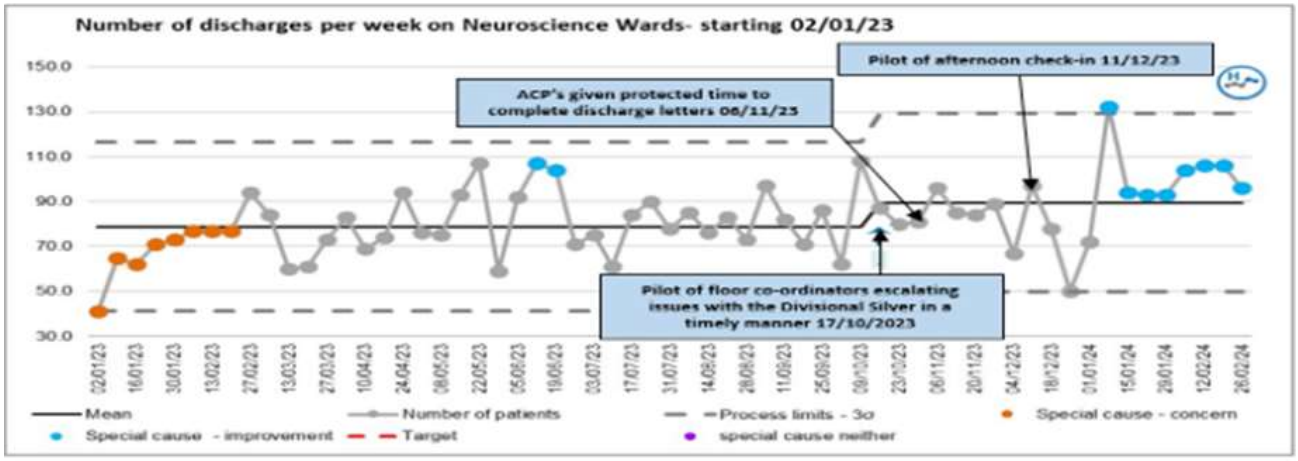
The Quality Improvement team has supported the Neuroscience Ward to make a marked improvement in discharge processes, starting from February 2023. This improvement journey has occurred through a series of Plan-Do-Study-Act (PDSA) cycles, each aiming to tackle different aspects of the discharge process.

Key interventions include the following.

- October 2023: implementing a pilot for floor co-ordinators to escalate issues with the Divisional team in a timely manner.
- November 2023: assigning Advanced Care Practitioners (ACPs) dedicated time to complete discharge letters.
- January 2024: piloting an afternoon check-in to address and prevent discharge delays.

These targeted actions contributed to a consistent increase in the number of discharges per week, achieving numbers well above the established target by March 2024. Notable special cause improvements were identified as shown below, indicating successful interventions that significantly enhanced the discharge process beyond expected variability.

Diagram 4: Number of discharges per week on Neuroscience Ward



The PDSA ramp illustrates a structured and escalating approach to QI, from initial small-scale tests to wider implementation across the wards. Each step of the ramp built on the learnings of the previous, demonstrating an iterative and responsive approach to QI.

Overall, this case study exemplifies how focused QI initiatives, driven by real-time data and staff engagement, can lead to substantial improvements in hospital operations and patient flow, contributing to the overall efficiency and quality of patient care.

Future Directions and Priorities for 2024-25

For 2024-25, OUH plans to advance its strategic framework for Quality Improvement within the broader context of the NHS Impact Framework. Strategic priorities include streamlining QI education through strengthening the delivery mechanisms to ensure sustainable QI learning; and fostering professional community engagement by expanding the OUH Improvers Hub and enhancing system-wide improvement partnerships.

Specific areas of clinical focus will continue to include Cancer and Urgent and Emergency Care pathways.

The organisation is committed to building upon its achievements in QI, with an eye towards sustainability and culture enhancement. The collective effort will be towards shaping an environment where QI principles are not only adopted but are also intrinsic to the fabric of OUH's healthcare delivery and operational excellence. This commitment reflects the Trust's resolve to align with the NHS Impact's vision and deliver healthcare that is continuously improving, patient-centred and efficient.

OxSTaR QI work for OUH

Oxford Simulation, Teaching and Research (OxSTaR) is based at the John Radcliffe Hospital. The centre provides a state-of-the-art environment where medical students and multidisciplinary healthcare professionals can use adult and paediatric high fidelity patient simulators to rehearse a wide variety of medical scenarios.

The Human Factor and safety training we offer at OUH via OxSTaR informs our understanding of patient safety concerns in the workplace and the design of quality improvement projects to mitigate risk.

There are three levels of training through OxSTaR:

- Level 1 – introductory human factors / ergonomics (HFE) training for all staff in OUH (incorporates online learning materials, links to HF resources, and freely available online half-day introductory HF courses): 537 people attended in 2023-24.
- Level 2 – simulation-based education (SBE) and HFE training to support key quality and safety priorities in OUH (e.g. SBE faculty development, SCOOP training, critical care team training, systems-based analysis of safety incidents to align with PSIRF): 504 people attended in 2023-24.
- Level 3 – bespoke SBE and HFE training delivered according to need (e.g. in response to a specific safety incident or to support the development of a new patient pathway): 94 people attended in 2023-24.

TheHill Digital Innovation Hub, Market Access Accelerator and Innovation Pipeline

TheHill

The Hill is an innovation catalyst. We empower innovation in health and care by supporting new approaches which seek to make the NHS more efficient and effective and to empower staff and benefit patients.

Our work centres around a needs-led approach, and we work closely with colleagues in QI, strategy, and clinical teams to understand needs on the front line and strategic imperatives. For prioritised needs and areas of interest, we support the Trust to interact with a variety of small and medium enterprises, researchers and start-ups to identify, co-develop and test appropriate technologies.

Key programmes include the Market Access Accelerator and our Innovation Pipeline.

The Market Access Accelerator

The Market Access Accelerator (MAA) is a six-month intensive programme which focuses on helping, supporting and helping to scale innovative technologies which can improve patient care and reduce the pressure and burdens on frontline staff.

The Accelerator model allows us to work with companies that are at an earlier stage than a procurement would, and whose technologies require co-development and testing within an NHS environment. This approach creates products that are better aligned to NHS frontline needs and allows us to safely interact with technologies on the cutting edge of development.

In 2022, six companies graduated from the programme. Their achievements are summarised below.

MindHealth AI

Personalised, preventative healthcare for your employees and patients.

- Winners of the Innovate UK, Women in Innovation Awards.
- FELIX partner.
- Accepted onto Digital Health Launchpad Programme.
- Won a grant from Innovate UK to support our research and development into first-of-its-kind predictive technology to support healthy behaviour change.

Goggleminds

Delivering virtual reality (VR) simulation training to healthcare professionals and students worldwide.

- Interviewed by BBC Newsnight, on the importance of collaboration and support to drive innovation in healthcare.

- Pilot within OUH.
- Winner of Start Up Wales, Medtech Start Up Company.

EnrichMyCare

A personalised healthcare platform for children and young people with disabilities.

- Finalists for this year's Medilink Midlands Business Awards.
- Awarded with CPI's Health Technology Regulatory and Innovation Project Award for our regulatory compliance.
- Commenced pilot study.
- Received ethics approval for a focus group study.
- Attended Digital Healthcare Show.
- Awarded with CPI's Health Technology Regulatory and Innovation Project grant funding award.
- Accepted South East Health Technologies Alliance accelerator programme.

Diagnostics

Oral glucose tolerance home-testing services for the detection of diabetes.

- Pilot of point of care testing kit at University Hospital of Southampton.
- Won an Innovate grant to investigate the feasibility of adding a c-peptide digital home test.
- Granted a CE Mark.
- Accepted to join the Johnson & Johnson Innovation JLABS incubator in New York city.
- Invited to showcase at MediWales' BioWales.
- Showcasing at Arab Health 2023.
- Exhibited in Lisbon for World Diabetes Congress.

Virtual Health Labs

Providing digital health solutions designed to help people make one or more behaviour changes likely to be associated with improved health, wellbeing, independence and quality of life.

Lister App

Helping clinicians capture, manage and prioritise their jobs list to complete tasks more efficiently and successfully:

- Accepted onto innovation fellowship at Mid and South Essex NHS Foundation Trust (previously applied in 2019 but not shortlisted).

- Accepted onto Digital Health Launchpad Programme.

The Trust is still engaging with all six companies for potential future work and/or use of their products and took equity in each of the start-ups which forms part of the Trust's capital investment portfolio. This portfolio has the potential to produce significant capital for re-investment into clinical services at a future point in time when companies mature.

Pipeline

TheHill's innovation pipeline process ensures the most promising digital ideas are championed to grow and scale and directed to the right support within the Trust.

This programme contributes to the overarching objectives of facilitating the adoption of digital innovation into OUH and ensuring our processes are optimal to lead new approaches into the Trust's innovation decision-making. Our connections to the broader ecosystem developed through our other programmes mean we are aware of digital innovations available in the broader ecosystem and are able to match these to identified needs.

The pipeline is currently progressing 25 companies through the six stages to adoption; successful outcomes in the last 12 months include:

Cardiolyse

Cardiolyse is a Medical CE-certified (class 2a) company that has designed a digital prognostic tool for the management of heart related disease. The OUH Cardiology team was keen to facilitate a feasibility pilot which would address the challenge of patient follow-up after catheter ablation for atrial fibrillation (AF) by obtaining electrocardiography (ECG) in a safe, timely and less costly manner using Cardiolyse's technology.

To enable successful delivery of the pilot, TheHill was successful in securing over £250k from the Digital Health Partnership Award (DHPA) which is designed to help NHS organisations in England to accelerate the adoption of digital health technologies supporting patients with long-term conditions. This funding enabled a six-month pilot, which has been overwhelmingly positive, with 100% of patients feeling safe at home being monitored by Cardiolyse, and 100% feeling that being monitored at home by Cardiolyse has improved their quality of life.

CPIP Cerebral Palsy Integrated Pathway

The Cerebral Palsy Integrated Pathway was established in 2013 in Scotland after it was identified across Europe that the chance of getting a dislocated hip or requiring major orthopaedic surgery reduces dramatically through the effective implementation of a patient management system. OUH clinicians devised a tool which is currently being incorporated into CPIP database. This additional tool will support clinicians across the UK to explore alternative interventions and/or referral routes for their patients. It is anticipated that this

will reduce inequality of access to care due to geography of available secondary, tertiary and quaternary services, reduce time to referral/treatment with consequent avoided disease/deformities progression and need for more surgery and reduce pain/spasms and therefore need for medications.

Concentric

Concentric Health is a digital consent and shared decision-making web application revolutionising how consent for a procedure or treatment is gained and recorded. Usage of Concentric's product in the NHS has grown, with the BOB ICS adopting the system through the NHSX Adoption Fund in October 2021. We have also supported them to secure integrations with hospital systems through the Fast Health Interoperability Resources (FHIR) API, Getting It Right First Time (GIRFT) and single sign-on, further removing barriers to care. Following a successful procurement exercise Concentric is currently being rolled out for use in OUH's Ophthalmology department and is gearing up for a Trust-wide deployment, part-funded by HTAF.

These examples illustrate how the innovation pipeline can help us to test new technology and prove its worth before deploying for the benefit of patients and staff.

Our participation in clinical research

As one of the United Kingdom's leading university hospital trusts, OUH is committed to achieving excellence through clinical research. Along with the related areas of education and innovation, research is central to World-Class Impact, one of OUH's five strategic themes for 2020-25, and is key to achieving all three of its Strategic Objectives: for Patients, People and Populations. Together with its research partners, OUH aims to discover better 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.

OUH hosts Health Innovation Oxford and Thames Valley (formally the Oxford Academic Health Science Network (AHSN)), as well as the NIHR Thames Valley and South Midlands Local Clinical Research Network (LCRN). Along with Oxford Health NHS Foundation Trust (OH), Oxford Brookes University (OBU) and the University of Oxford (OU), OUH is also a partner in the Oxford Academic Health Partners (OAHP) – one of the eight NIHR/NHSE/I designated Academic Health Science Centres in England - and in the Oxford Joint Research Office (JRO), which aims to facilitate the delivery of research by promoting and facilitating greater collaborative working across and between the partner organisations, for the benefit of the people they serve.

OUH's close partnership with OU encompasses major programmes in all areas of medical sciences, including cardiovascular, stroke, dementia, cancer, infection, vaccines, surgery and imaging, as well as interdisciplinary collaborations in digital health. Recent investment in the development of research led by Nurses, Midwives

and Allied Health Professionals (NMAHPs) at OUH, working closely with OBU's Oxford Institute of Applied Health Research (OXInAHR) has helped to build a robust evidence base to drive improvements in broader aspects of patient care, as well as creating new career pathways for OUH staff.

Much of this activity benefits substantially from the NIHR Oxford Biomedical Research Centre (Oxford BRC), which has been based at OUH and run in partnership with OU since 2007. In the most recent national competition, the Oxford BRC was awarded further funding of £86.7m for five years from 1 December 2022. The Oxford BRC funds innovation across 15 research themes and a core team that supports researchers in areas such as patient and public involvement and engagement, business development, training and education and ethics. A complementary and synergistic bid submitted by OH, in partnership with OU, secured an award of £35.4m for the NIHR Oxford Health BRC in the same competition, and supports 11 research themes focused on brain health. OUH provides a variety of services to support OH's research, ranging from specialist advice on contracts to imaging and laboratory analyses.

The new NIHR Oxford Clinical Research Facility (CRF) is another partnership with OU, which is already delivering a wider range of early phase studies – many with Oxford BRC funding – for the benefit of patients, as well as to train and develop a new generation of doctors, nurses and allied health professionals in early phase experimental medicine trials. Designated for five years from September 2022, with seed funding of £1m, the CRF attracted additional capital funding from the NIHR in June 2023 for a specialist endoscopy suite to support early-phase clinical studies of novel therapeutics across multiple disease states. The Oxford CRF works closely alongside the NIHR Oxford Health CRF, a partnership between OH and OU, to maximise opportunities for local patients and researchers.

During 2023-24, OUH hosted 1,606 active clinical research studies. These include 280 new studies that have opened to recruitment at OUH during 2023-24.

The number of patients, receiving relevant health services provided or sub-contracted by OUH in 2023-24, who were recruited during that period to participate in research approved by a Research Ethics Committee, was 21,067 participants recruited to 518 studies which were CRN portfolio registered.

In 2023-24, 91 OUH staff were directly supported by NIHR Oxford BRC funding. An additional 29 staff with honorary OUH contracts are also supported by PAs funded by the NIHR Oxford BRC. 252 staff were funded by the NIHR Clinical Research Network.

The following examples illustrate some of the diverse high-impact clinical research studies and facilities which OUH has been involved in during 2023-24, in many cases working in close partnership with OUH:

- In the largest trial of its kind, a team led by OUH cardiologists found that taking daily blood pressure readings at home and personalising medication

doses in the weeks after giving birth improves blood pressure control for the first year after a hypertensive pregnancy.

- A study led by an OUH Specialty Registrar and Fellow in Clinical Artificial Intelligence has developed a new, easy-to-use technique using federated learning for hospitals to contribute to the development of artificial intelligence (AI) models, without patient data leaving the hospital's premises. The researchers hope this could help address some of the privacy concerns around training AI models using patient data, and lead to models that are more representative and perform more fairly.
- The Symplify trial of a new blood test for more than 50 types of cancer, correctly revealed two out of every three cancers in more than 5,000 people who had visited their GP with suspected symptoms. The test also correctly identified the original site of cancer in 85% of those cases.
- The C-MORE study found that nearly a third of patients admitted to hospital with COVID-19 displayed abnormalities in multiple organs five months after being discharged.
- OUH patients were also being recruited to many landmark studies led by OU researchers in 2022-23, including the Stravinsky study, which aims to help identify individuals and patient groups most clinically vulnerable to COVID-19 infection, and inform future guidance.
- A successful OUH bid in a national competition secured £3.4m of capital funding for state-of-the-art research equipment that will enable scientific discoveries and new technologies to improve the prevention, management and treatment of disease. This included support for OU's Clinical Biomanufacturing Facility (CBF) which produces vaccines and other therapeutics for human use, and equipment for a specialist endoscopy suite at the NIHR Oxford CRF and to ensure a dedicated pathway for research procedures at Oxford Eye Hospital, including for ground-breaking retinal gene therapy studies.£3.4m of capital funding for state-of-the-art research equipment that will enable scientific discoveries and new technologies to improve the prevention, management and treatment of disease. This included support for OU's Clinical Biomanufacturing Facility (CBF) which produces vaccines and other therapeutics for human use, and equipment for a specialist endoscopy suite at the NIHR Oxford CRF and to ensure a dedicated pathway for research procedures at Oxford Eye Hospital, including for ground-breaking retinal gene therapy studies.
- A new temporary Pharmacy Clinical Trials Unit (CTU) was opened in August 2023 to handle and prepare a new class of medicines known as advanced therapy medicinal products (ATMPs), which are based on gene, tissue or cell therapy products. This enhanced capacity puts OUH in an excellent position to win tenders to provide patient care with these new medicines. It is also

crucial to enable us to support the research and development of other new ATMP therapies for the first time, which is an important objective of the Oxford BRC.to support the research and development of other new ATMP therapies for the first time, which is an important objective of the Oxford BRC.

- Since May 2023 the Acute Multidisciplinary Imaging and Interventional Centre (AMIIC) has contributed additional capacity for stroke thrombectomy at OUH. AMIIC is a purpose-designed research facility opened in January 2023, specifically adjacent to the Emergency Department and Oxford Heart Centre at the John Radcliffe Hospital. This procedure is a milestone for the centre as it opens up to more clinical as well as research service.

Reporting Excellence

The OUH Reporting Excellence (RE) Programme, was founded eight years ago by a small group of paediatric and anaesthetic specialists who recognised the value of positive feedback as the opportunity not only to thank a colleague but, perhaps more importantly, to recognise alignment with our Trust Values and learn from innovative practice. This latter aspect of the reporting system has been a fundamental element of applying local appreciative inquiry into local actions or processes that have improved patient care and staff working lives.

The system enables any member of staff to log on via a highly recognisable and visible intranet-based link to and Reporting Excellence home page that guides the user through the simple process. There have been many thousands of nominations submitted and many staff whose work has been recognised and celebrated. These have been matched in every case by the instant sense of pride and gratitude provided to the nominator, who in submitting heartfelt missives knows they will have contributed to a colleague's pride in their work and achievements.

The scheme is hosted within the Ulysses governance system as a key mechanism bridging learning from incidents, to learning from positive actions, processes and innovations. This aligns with and supports the national Learning from Patient Safety Events (LFPSE) initiative's requirement for OUH to submit reports of excellent and innovative care to NHSE.

In the past year, there have been more than 3,000 reports, with an average of 247 a month and no fewer than 200 in any given month. While reports themselves remain anonymous, the system provides real time summary and granular data by theme, Division, Directorate and department to inform learning and improvement.

CQUIN programme

The key aim of the Commissioning for Quality and Innovation (CQUIN) framework is to secure improvements in quality of services and better outcomes for patients, whilst also maintaining strong financial management.

Under the published NHS Payment System for 2023-24, a proportion of OUH income in 2023-24 was intended to be conditional on achieving quality improvement and

innovation goals agreed between OUH and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the CQUIN payment framework. For contracts worth less than £10m per annum, the CQUIN payment was fixed/blocked; for those contracts valued at more than £10m per annum, CQUIN funding for under-delivery of the targets could be clawed back.

Statements from the Care Quality Commission (CQC)

OUH is required to register with the Care Quality Commission (CQC) and its current registration status is without conditions.

The Trust is fully compliant with the registration requirements of the CQC. As of 31 March 2024, the Trust had an overall rating of ‘Requires Improvement’ (RI) from the CQC This was consistent with the rating disclosed in the previous Annual Report and reflected the activities undertaken by the CQC during the year 2023-24.

In April 2023 the Trust received the report from the November 2022 unannounced inspection of Oxford Critical Care services at the John Radcliffe Hospital. Services were inspected, but not rated under the domains of Safe and Well-led. The state-of-the-art facilities, which are spacious and designed using proven modern practices for improving infection prevention and control standards and reducing patient risk of contamination, were commended as examples of outstanding practice. The actions that the Trust was advised should be undertaken were integrated into the work of the Oxford Critical Care Development Programme, the outputs of which continue to be reported by the service and Division through their Divisional governance meeting, and other key committees via existing governance processes.

During 2023-24 there was one short notice CQC inspection of the Midwifery-led Unit at the Horton General Hospital. This inspection was part of the national maternity inspection programme, solely reviewing the Safe and Well-led key lines of enquiry. The inspection took place in October 2023 and the report was published in March 2024. The service was rated as 'Requires Improvement’ for both Safe and Well-led. This outcome resulted in a change to the CQC rating of the Horton General Hospital, to ‘Requires Improvement’. The Trust uses every opportunity for feedback in a proactive and positive way and whenever a report is received an action plan is developed with the service and executive leadership to address opportunities for improvement and celebrate successes. The Trust is developing actions in response to this report, which are due to be submitted to the CQC in the week commencing 15 April 2024 and which will be reported through the governance structures of the Trust.

The Trust has continued engagement with the CQC, which recommended engagement meetings following the launch of their new approach to regulation. The Trust has maintained routine engagement activity with the CQC and has responded to specific enquiries and information requests for the purpose of assurance. The Trust reports to the Clinical Governance Committee any CQC regulatory activity undertaken with the Trust.

During 2023-24, the Trust continued to report on progress with the two remaining actions from the CQC maternity inspection published in September 2021, alongside progress with the 'should do actions' identified in the November 2022 inspection of Oxford Critical Care Unit at the John Radcliffe Hospital. In addition, the Trust has continued to report on progress with any actions aligned to the immediate and essential actions outlined in the Ockenden Report, NHS England three-year plan for maternity and neonatal services and evidence requirements to support Maternity Incentive Scheme standards.

The Trust has engaged with a range of CQC stakeholder surveys during 2023-24, results of which have been published on the CQC internet pages. Findings from CQC inspections, ongoing monitoring activity and surveys have resulted in action plans being produced by the services and monitored by the Trust's Clinical Governance Committee and Maternity Safety Champions.

Actions taken during 2023-24 included, but were not limited to, the following:

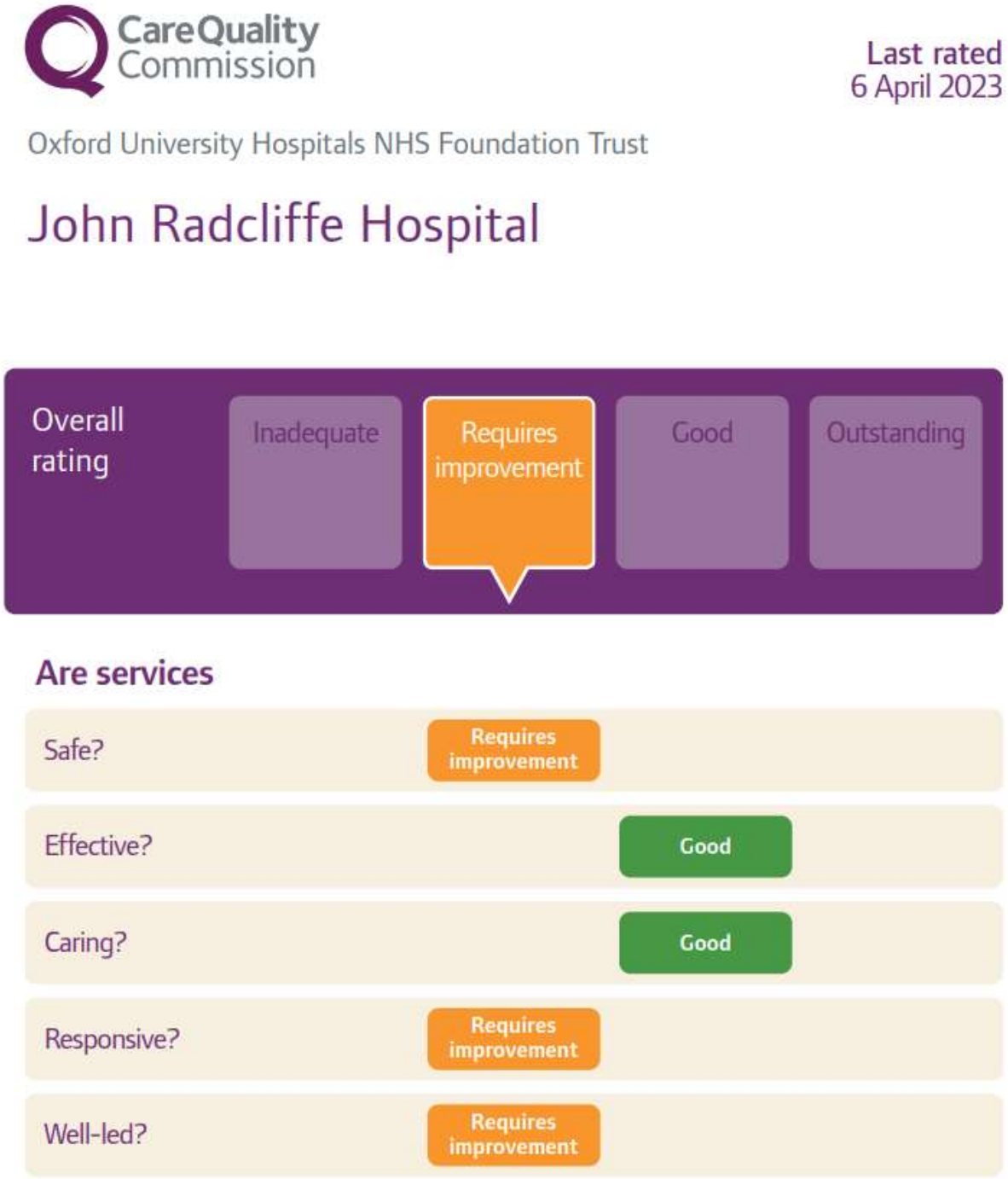
- Ongoing work with the commissioning and delivery of phase two of the culture and leadership review for Newborn Care.
- Ongoing work with the Oxford Critical Care Development Programme, into which the CQC inspection actions are subsumed.
- Conclusion of the Maternity Development Programme with implementation of local solutions aligned to the terms of reference.
- Continuing focus on embedding staff wellbeing aligned to the People Plan 2022-25, with forums and initiatives to enable staff to discuss concerns.
- Engagement meetings recommenced with Executive Directors in November 2023.
- Managed 61 new CQC enquiries or notifications between 1April 2023 to 31 March 2024.
- Engagement with CQC administered surveys for Urgent and Emergency Care (results published in July 2023), Adult Inpatients (results published Sept 2023) and Maternity Services (results published February 2024).
- Notification of changes to the Executive Team in accordance with regulatory requirements.
- Undertook regular notifications covering: Deprivation of Liberty Standards (DoLS) applications, section 42 activities, allegations of abuse and IR(ME)R-related incidents in accordance with regulatory requirements.

There are a range of areas that remain the subject of continuous review and focus for the Trust. These include statutory and mandatory training, appraisal rates, medicines management and infection control (for example, that relate to the current 'Requires Improvement' (RI) rating in the 'Safe' category). In addition, the Trust has continued to work on actions in relation to the national waiting time standards that

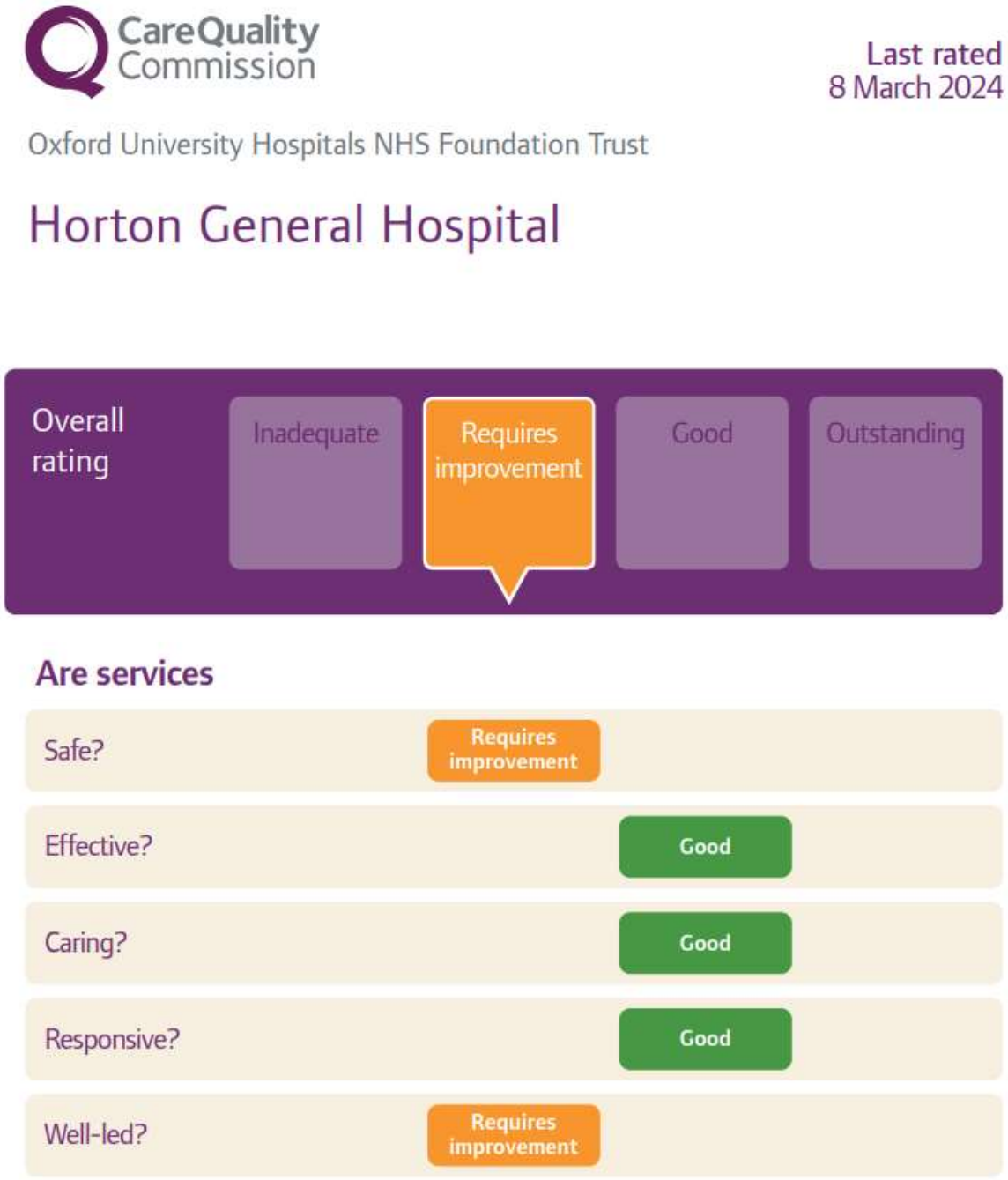
relate to the current RI rating in the ‘Responsive’ category.

CQC ratings grids as published in the reports of April 2023 and March 2024 may be seen below / overleaf.

Picture 1: CQC Ratings for John Radcliffe Hospital: last rated April 2023



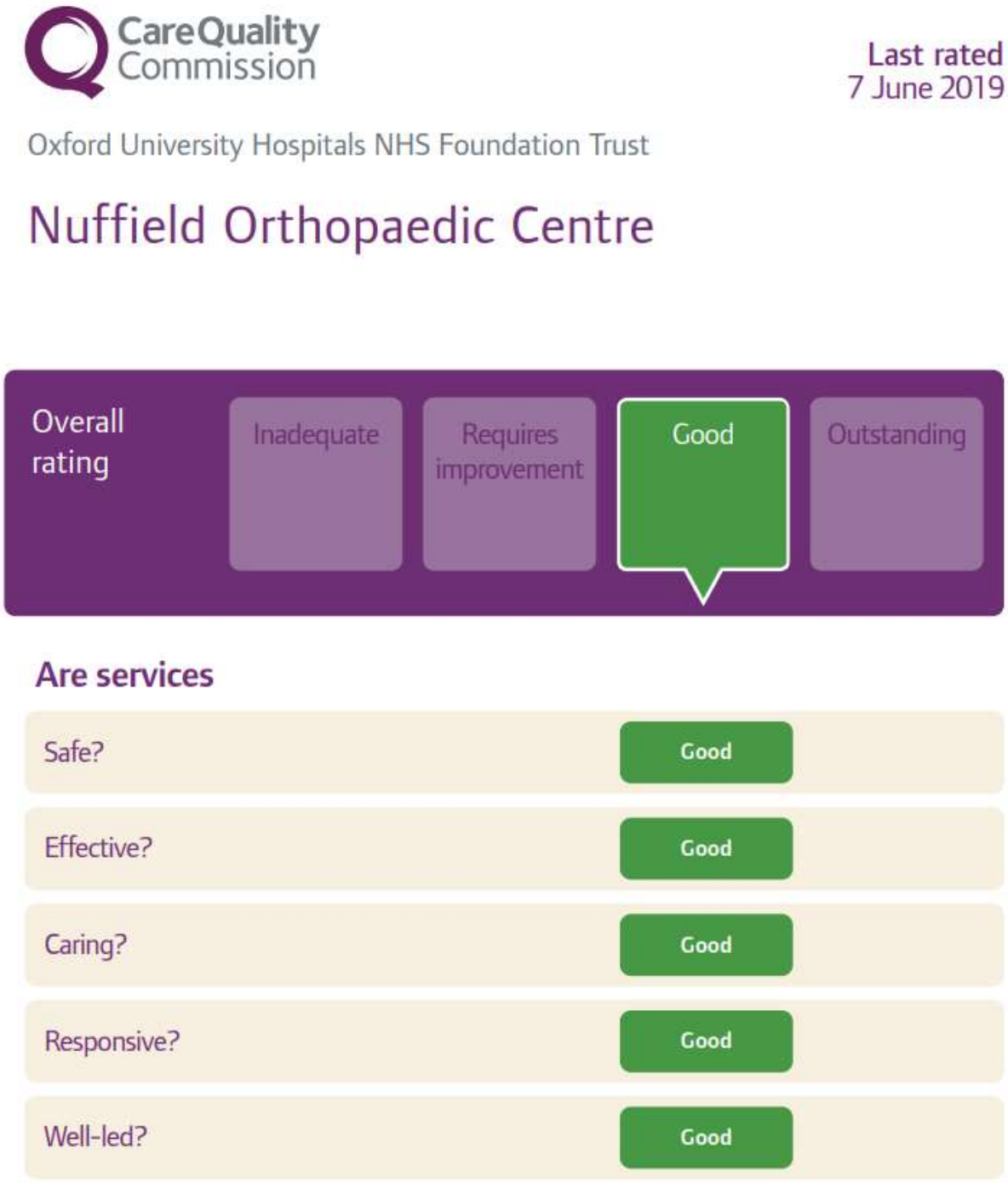
Picture 2: CQC Ratings for Horton General Hospital: last rated March 2024 part 1



Picture 3: CQC Activity Ratings poster for Horton General Hospital: last rated 8 March 2024 part 2

Picture 4: CQC Ratings for Churchill Hospital: last rated June 2019

Picture 5: CQC Ratings for Nuffield Orthopaedic Centre: last rated June 2019



Our Peer Review Programme 2023-24

Internal Peer Reviews

The Internal Peer Review Programme has been running successfully at the Trust since 2014. To support the ongoing development of Peer Reviews, the Assurance Team carried out consultation work from the information and data collected by the Theatres Steering Group, which was formed at the end of 2023 and met during 2023-24. The Theatres Steering Group invited subject matter experts and theatre

specialists to inform the design of a theatres-specific, peer review tool. The tool was further developed with intelligence from the Care Quality Commissions new way of inspecting utilising the 'I' and 'we' statements within the tools. A pilot peer review was carried out in November of the Cardiac and Thoracic Theatres Service. Learning from the review will be used to inform the delivery of further reviews of Theatre services across the Trust.

Alongside the work of the Theatres Peer Review Programme, two themed peer reviews took place to look at Equality, Diversity and Inclusion in two services, Workforce and Digital. The findings of the review have been used to inform the Equality Delivery System (EDS) 2022 work that is carried out in the Workforce Directorate.

Accreditation, Regulation and Reviews (External Reviews)

The accreditation, regulation and national peer review programme provides the Trust and the CQC with a measurable level of assurance regarding the delivery and quality of our services. Whilst the pandemic had an impact on the frequency of some external reviews, this programme of work has now fully resumed in 2023-24, with on-site visits included in most reviews. The *Thames Valley and Wessex Operation Delivery Network - Southeast Paediatric Spinal Review* took place on 16 January 2023. The resultant action plan is being managed by the service and Division, with oversight from the Chief Medical Officer. It is being monitored by the Operational Delivery Networks (ODNs), with quarterly returns.

NHS Cervical Screening Quality Review. A quality assurance review of the NHS Cervical Screening Quality Assurance Review was expected between March and April 2023. However, it was reported at CGC in April 2023 that the screening Quality Assurance Service would not be carrying out an inspection during 2023-24.

UKAS - Quality Standards for Imaging (QSI). The service advises that they currently update and save standard operating procedures and associated key documents with QSI in mind but are not currently actively working towards accreditation until they can have a dedicated QSI lead in post.

NHSE Quality Assurance Visit – Antenatal and Newborn Screening service. In January 2023 the Acting Director of Midwifery received notification that the NHSE Quality Assurance visit to OUH Antenatal and Newborn Screening Service planned for 16 May 2023 was postponed. The re-profiled date is 23 April 2024, and the service is actively engaged in preparations for this onsite visit to the John Radcliffe Hospital. The Maternity team is leading on preparation for this. Stakeholder meetings and submission of initial evidence requests were completed by 13 February 2024.

Human Tissue Authority (HTA) Mortuary. The submission to the HTA went ahead on 27 January 2023 followed by the submission for the minor findings on 21 March 2023. The actions were signed off by the HTA in April 2023. The final action regarding the building project refurbishment of the Churchill has been completed and

evidence is in review with the HTA. is ongoing and updates will be provided to the HTA as required.

The Trust has participated in Phase 1 of the Fuller enquiry. No immediate actions were required as the regulatory requirements were being met. Phase 2 is underway. This is being monitored via the Trust Board. By exception a paper went to Public Trust Board on 8 May 2024.

Ofsted: Apprenticeship Programme. The Ofsted action plan associated with the review of the Apprenticeship Programme in 2022 is managed by the Corporate Education Team. Progress is reported to and monitored bi-monthly by the Education Quality and Standards Committee.

Diabetic Eye Screening. The screening quality assurance visit to the Oxfordshire Diabetic Eye Screening Service took place on 1 February 2023. On 6 April 2023, the Trust received the final report, which highlighted recommendations raised following the visit and actions added to the Ulysses action module for the purpose of reporting and oversight.

UKAS: Microbiology ISO 15189:2012. An inspection will be carried out in Neuropathology and Ocular Pathology against UKAS - ISO 15189:2012 standards. The site visit to the John Radcliffe Hospital took place on 4 and 10 May 2023. Over the next three years, there will be a transition from ISO15189:2012 standards to ISO 15189:2022.

The Intensive Care National Audit and Research Centre (ICNARC) Case Mix Programme. The ICNARC manages the Case Mix Programme (CMP) National Audit. This report had previously been on hold due to COVID-19.
A report for 2023-24 was presented at Improvement Committee (CIC) on 19 March 2024. The report highlights that the OUH adult critical care units meet expected standards overall, but high-risk admissions signal strain in the system: recommendations for quality improvement were highlighted. This audit provides moderate assurance.

UKAS: Immunology UKAS 15189 (2012). The Immunology Laboratory Accreditation visit took place on 7and 8 June 2023.The outcome was successful regarding maintenance of our accreditation to UKAS 15189 (2012) subject to the clearing of the non-conformities.

Royal College of Physicians: Immunodeficiency. Quality in Immunodeficiency Accreditation from the Royal College of Physicians visit took place in May 2022. Over the following four years the service has to complete an annual review. The outcome letter was received by the Trust on 30 May 2023. This outcome was reported to the Directorate Board meetings and discussed at MRC Divisional Board meetings. The assessment team particularly congratulated the service on the following: “The patient survey about the changeover from Gammanorm to Cutaquig is thorough and identifies useful themes. Both assessors noted a clear priority for safety and a process for seeking out areas of improvement and finding solutions.” It

was noted that accreditation is awarded for 5 years, subject to successful completion of an annual review. In the fifth year a full reaccreditation assessment is undertaken to renew accreditation.

Lloyd's Register Quality Assurance (LQRA): ISO9001:2015 Radiotherapy Accreditation. The surveillance visit, to assess the compliance of the management system, took place in June 2023. The visit was highly successful, and the assessor shared positive feedback with the team, stating that they were impressed with how patient-focused and engaged staff were throughout all areas. The report was made available in August and the Trust was compliant, with one non-conformity that remained an open action.

Human Fertilisation and Embryology Authority (HFEA). The Trust has previously been accredited to the Human Fertilisation and Embryology Authority (HFEA), which was due for re-accreditation in June 2023. However, following discussions with the Chief Medical Officer and heads of service, it has been decided that Oxford Cell and Tissue Bank (OUH) no longer requires to hold this licence as we are not currently undertaking HFEA licensable activities. The service is in the process of revoking the licence with the HFEA and consequently was not inspected by the HFEA in June 2023.

ISO45001 Health and Safety Management System. The Churchill Hospital recertification visit took place on 17July 2023. The initial results and feedback were very positive, and the site received its new accreditation with three major and four minor findings. The ISO45001 Steering Group reviewed the audit tools and actions following the review in order to improve. The aspiration involves preparing each site for accreditation over the next two years.

Environment Agency: Radioactive Materials. The Environment Agency inspection visit took place on 1 and 2 August 2023: This is an annual inspection to test compliance with the issued permits under which the Trust is allowed to operate. The inspectors found both sites compliant and made a few minor recommendations and observations mainly regarding the wear and tear of facilities. A full report was provided to the team 28 days after the inspection.

The Government Digital Service (GDS) Web Content Accessibility Guidelines (WCAG2.1 AA standards). It is a requirement of the Public Sector Bodies (Websites and Mobile Applications) (No. 2) Accessibility Regulations 2018 that public sector websites are accessible to everyone. The regulations came into force on 23 September 2018 and require organisations to publish an accessibility statement, including the website's level of conformance to the Web Content Accessibility Guidelines (WCAG 2.1) AA standard. The Government Digital Service (GDS), which is part of the Cabinet Office, check public sector websites for compliance with the accessibility regulations. The GDS tested the OUH internet pages for compliance. Whilst the results overall were positive, some accessibility issues were found. There was an issue with a patient leaflet, which has been amended on the leaflet in question but was likely to recur on leaflets and other documents throughout the

website. The Trust is also aware of other accessibility issues relating to documents that were not identified in the GDS check. It is expected that the Trust will put forward a disproportionate burden statement to the GDS rather than attempting to fix the accessibility of all its website documents in one go. The Trust received notification on 21 February 2024 that the Government Digital Service have re-checked a sample of information on the OUH website, and the Accessibility Officer will be recommending to the Equality and Human Rights Commission (EHRC) that the statement submitted to them is compliant and no action is to be taken.

Thames Valley and Wessex Operational Delivery Network - Southeast Paediatric Surgery Review. The Trust received notification of a planned Thames Valley and Wessex Operational Delivery Network service review into children's surgery, at both the Horton and the John Radcliffe sites. The team visited the Horton General Hospital on 16 October 2023 and the John Radcliffe Hospital on 17 October 2023. Following receipt of the service review report in January 2024, key staff within the Division and associated services communicated the areas of excellence reported and devised an action plan for recommended areas of focus.

Royal College of Surgeons and GIRFT. A meeting took place on 13 September in collaboration with the Royal College of Surgeons and Getting it Right First Time (GIRFT) team to assess trusts against a framework of standards designed to help to deliver faster access to surgical procedures. The initial results of the review were positive. The service was commended for openness and frankness of people they interviewed, patient focus, one-stop-shop embracing digital solutions infrastructure, pathways and dedicated wards. The reviewers were impressed with the 'one team' approach, which resonated with our hashtag #OneteamOneOUH. The reviewers were also interested to discuss OUH as a centre of innovation from which other trusts can learn; however, the main concerns were regarding 'ring-fencing' hub activity at the NOC; availability and recruitment of anaesthetists; availability of data from Model Hospital, and estate delineation. A meeting took place on 11 October 2023 to review the current position at the NOC regarding the work towards Surgical Hub Accreditation, with ongoing plans considered to achieve accreditation as an innovation hub.

Psychiatric Liaison Accreditation Network (PLAN). PLAN is a Royal College of Psychiatrists accreditation programme for mental health services in acute trusts. OUH has an outsourced mental health service to emergency departments (from Oxford Health) and provides its own in-house psychiatry and psychology service for inpatients and outpatients. Whilst the CQC does not formally require PLAN accreditation it regards it as desirable. A review of psychological services for accreditation to PLAN began in September 2023. The Trust completed a gap analysis against the 158 PLAN standards to explore the possibility of accreditation to this body. This process presents some challenges as many of the standards are designed for mental health trust delivered liaison services. Following gaps in documentation, the OUH leads for PLAN have postponed the submission until May

2024. This will allow time to ratify policies and processes. Updates to the programme and final decisions are reported through CSS Governance processes.

British Standards Institution (BSI) audit of Sterile Services: ISO 13485. The authorised body, BSI, carried out an audit against ISO 13485 in August 2023. Following the audit, five corrective actions were raised, and action plans have been provided by OUH to address these shortfalls.

Lloyds Register Audit: ISO9001.Medical Physics and Clinical Engineering (MPCE) was audited by Lloyd's Register on 12 and13 October 2023. The purpose of the audit was to assess compliance of the MPCE management system against ISO 9001:2015 standards. This was a highly successful HOSC visit and the team retained certification with zero non-conformities.

Joint Advisory Group on Endoscopy (JAG), JAG review of the Horton General Hospital Endoscopy Service was undertaken on 1 December 2023 and the outcome letter received on 18 December 2023. This resulted in the reaccreditation of the service demonstrating that OUH meets best practice quality standards. An action plan addressing the four points of correction was developed and returned to the assessment team.

UKAS re-assessment against ISO 15189:2012 for Cellular Pathology at the John Radcliffe (JR) and Histology at the Nuffield Orthopaedic Centre (NOC). This took place in November 2023. Accreditation has been achieved at both sites, with certificates for the NOC issued on 28 February 2024 and on 26 March 2024 for the John Radcliffe Hospital.

Data Quality and Information Governance

A vital prerequisite to robust governance and effective service delivery is the availability of high quality data across all areas of the organisation. This underpins the effective delivery of patient care and is essential to both improvements in the quality of care and for patient safety. We are committed to pursuing a high standard of accuracy, timeliness, reliability and validity within all aspects of data collection in accordance with NHS data standards and expect that every staff member seeks to achieve these standards of data quality.

OUH will be taking the following actions to improve data quality and information governance.

Improved tooling to audit access to our EPR is being acquired.

Improved tooling to assist in managing Freedom of Information (FOI) and Subject Access Requests is being rolled out – the Trust continues to receive more of both types of requests than in previous years.

Digitisation of paper records will begin shortly, being able to access historical records immediately in a searchable electronic format will significantly improve the availability of records previously stored off site.

Moving to the Digital Consent platform will provide the Trust with a much improved and easily accessible record of the consent patients have given for treatments and consent for potential use of their data for secondary purposes.

A review of Trust-wide working practices and policies around the adoption of systems that involve AI and Machine Learning is under way. Strong Information Governance and transparency around how the Trust uses these new technologies will be vital to giving assurance to staff and patients that their use is appropriate and beneficial to all.

Data Security and Protection Toolkit

OUH's submission of the Data Security and Protection Toolkit for the most recent reporting period of 2022-23 reported an overall assessment of 'Standards Met', which was agreed by NHS Digital. This provides significant assurance to other parties who may wish to share data with us. Baseline submission for 2023-24 does not result in a formal rating of the Trust's data security performance against Data Protection Toolkit (DPT) standards but is undertaken to demonstrate that work is ongoing in completing the Toolkit.

The final submission will be on 30 June 2024, and we are again working towards achieving 'Standards Met'.

Records submission

OUH submitted records during 2023-24 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

SUS dashboards month 12 2023-24

The table shows the information by inpatients, outpatients and ED demonstrating OUH compliance compared to the national average.

Table 16: The information by inpatients, outpatients and ED demonstrating OUH compliance compared to the national average

Inpatients	OUH	National Average
Valid NHS number	99.5%	99.7%
General Medical Practice Code	100%	99.7%
Outpatients	**OUH**	**National Average**
Valid NHS number	99.9%	99.7%
General Medical Practice Code	100%	99.5%
ED (type 01 only)	**OUH**	**National Average**
Valid NHS number	98.7%	98.9%
General Medical Practice Code	100%	99.6%

Payments by Results (PbR)

OUH was not subject to the Payment by Results (PbR) clinical coding audit during 2022-23 by the Audit Commission.

Learning from Deaths

During 2023-24, 3,039 OUH patients died. Table 17 shows the number of case record reviews by quarter and the number of deaths judged more likely than not to have been due to problems in care.

Table 17: Number of case record reviews by quarter and no. of deaths judged more likely than not to have been due to problems in care

	Quarter 1 2023-24	Quarter 2 2023-24	Quarter 3 2023-24	Quarter 4 2023-24
Number of case record reviews (Level 2 comprehensive mortality review of structured judgement review (SJR))	295	305	327	Will be reported in Quality Account 2024-25
Number of deaths judged more likely than not to have been due to problems in care	0	0	0	Will be reported in Quality Account 2024-25

A total of 927 case record reviews had been carried out in relation to 2,029 deaths that occurred to the end of Q3 2024. No unavoidable deaths have been identified in this period.

The reviews of deaths which occurred during the fourth quarter are underway and the summary will be included in the next Quality Account 2024-25. These numbers have been compiled using the quarterly Divisional mortality reports submitted to the Trust Mortality Review Group.

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

Work continues to improve oxygen prescribing compliance. Safety messages in relation to this have been shared across the organisation.

Death notification: work continues across the Trust to further improve timely completion of death notification summaries and level 1 mortality reviews. An issue was raised that when an electronic level 1 review was completed, and further review (level 2 or SJR) was required, the system did not automatically flag these cases. Systems are now in place to ensure that deaths requiring further review are

identified. This is monitored at the monthly Mortality Review Group meetings.

Patient transfers: a theme has been identified where transfer to OUH was delayed or not appropriate, most notably in the Vascular and Neurosurgery services. Informative feedback has been provided to referring hospitals.

Managing bereavement in Children's and Neonates: due to challenges conducting 'hot debriefs' of fatal cases during a busy shift and a need for more opportunities for discussion and reflection later, a working group is developing a formal half day of training for Paediatric, Paediatric Critical Care and ED staff.

The Mortality Review Policy was updated in line with the three-year review. Updates based on learning from previous deaths include addition of the process OUH must follow when a patient dies externally to the Trust with OUH involvement during the treatment pathway; and clearer guidance on Mortality and Morbidity (M&M) meetings.

The importance of accurate DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) endorsement on EPR has also been highlighted, particularly when a patient is readmitted.

Work continues to ensure Venous Thromboembolism (VTE) assessments are completed and reviewed according to Trust guidelines. Compliance is monitored monthly via the Clinical Governance Committee. Each clinical area is responsible for reviewing compliance with issues raised at local governance meetings and the implementation of an action plan if required.

Reminders have been disseminated via Divisional governance meetings and Safety Huddles to clinical teams regarding the importance of communication and updating of families when a patient's clinical status changes. This is particularly important when a patient has deteriorated and is likely to die.

The vital role of Hospital Passports for patients with Learning Disabilities has been highlighted as a source of guidance regarding support structures important to the individual. These documents provide a snapshot of the patient to underpin assessment of normal behaviours and coping mechanisms as well as guidance regarding appropriate interventions. This important resource for personalised patient care has been highlighted and shared across the Trust.

The quarterly and annual Learning from Deaths reports are presented to the Trust Board and are available online - Board meetings and papers - Oxford University Hospitals (ouh.nhs.uk).

Case record reviews and investigations from Quarter 4 2022-23

During Quarter 4 2022-23 there were 619 inpatient deaths reported at OUH. 96% (597) cases were reviewed within eight weeks. Of these reviews, there were 322 (52%) comprehensive level 2 reviews and structured mortality reviews completed. One death reviewed from the fourth quarter of 2022-23 was judged to be more likely than not to have been due to problems in the care provided to the patient.

Care at the end-of-life

During 2023-24, 2,837 adults over 18 years of age died in OUH. Providing care at the end of a person's life is an important part of the provision of healthcare. Work this year to improve care at the end of live has included the following:

a. An End-of-Life Care (EOLC) Lead continues in post funded by Sobell House Hospice Charity.

b. Quarterly meetings of the EOLC group restarted. The EOLC group reports to the Mortality Review Group.

c. An audit of the use of naloxone in OUH was conducted and learning identified. The proposed revision of the Medicines Information Leaflet is progressing through governance review. Teaching opportunities will be used to inform practice.

2.3 Reporting against core indicators

*There is no national comparison data available on incident reporting since NRLS has been taken over by LFPSE

**The previous financial year's data are given

Table 18: Reporting against core indicators

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source
Summary Hospital level Mortality Indicator (SHMI)	Ratio of observed mortality as a proportion of expected mortality	Jan 2023-Dec 2023	0.86 *(CL[1] 0.89-1.12)*	Oct 2021-Sept 2022	0.96 *(CL[1] 0.90-1.1)*	1.19	0.70	1.00	NHS Digital
These are the latest available data	Percentage of patient deaths with palliative care coded at diagnosis	Oct 2022-Sept 2023	56.87%	Oct 2021-Sept 2022	54.74%	N/A	N/A	N/A	NHS Digital
*The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period	No. (rate per 1,000 bed days)	Financial year 2021-222 (Data for 2022-23 not yet available from the national body)	18,123	Financial year 2020-21	14,259	49,603	3,441	14,368	NRLS

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source
*The number and percentage of such safety incidents that resulted in severe harm or death	No. (rate per 1,000 bed days)	Financial year 2021-22 (Data for 2022-23 not yet available from the national body)	120	Financial year 2020-2021	123	216	3	55	NRLS
The percentage of patients who were admitted to hospital and who were risk assessed for Venous Thromboembolism during the reporting period *(provisional data)*		Financial year 2023-24	97.9 %	Financial year 2022-23	98.1%	N/A	N/A	N/A	ORBIT
Clostridioides difficile cases	Target 103	Financial year 2023-24	130	financial year 2022-23 (target 104)	124	N/A	N/A	N/A	ORBIT
Percentage of patients readmitted within 28 days being discharged	Readmissions data	Sept 2022 to August 2023	10.4%	Oct 2021 to Sept 2022	10.6%	16%	3.1%	10.7%	Dr Foster

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source
(Latest available data)									
**Trust's responsiveness to the personal needs of its patients • To what extent did staff looking after you involve you in decisions about your care and treatment?	Score out of 10 Trust-wide	2022	7.4	2021	7.1	8.2	6.3	7.0	CQC Inpatient Survey 2022
**Did you find someone on the hospital staff to talk to about your worries and fears?	Score out of 10 Trust-wide	2022	8.0	2021	7.9	9.6	6.6	7.6	CQC Inpatient Survey 2022
**Were you able to discuss your condition and treatment without being overheard?	Score out of 10 Trust-wide	2022	This question was not asked in 2022	2021	6.8				CQC Inpatient Survey 2022
**Thinking about any medication you were to take home, were you	Score out of 10 Trust-wide	2022	5.0	2021	5.2	6.1	3.3	4.4	CQC Inpatient Survey 2022

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source
given any of the following?									
**Did hospital tell you whom to contact if you were worried about your condition or treatment after you left hospital?	Score out of 10 Trust-wide	2022	8.4	2020	8.5	9.7	5.7	7.5	CQC Inpatient Survey 2022
Staff employed by, or under contract to the Trust who would recommend the Trust as a provider of care to their family or friends	% (If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation)	2023	74.84%	2022	74.59%	88.82%	44.31%	63.32%	NHS National Staff Survey 2023

[1] CL = Confidence Limit

Summary Hospital-level Mortality Indicator (SHMI)

The Summary Hospital-level Mortality Indicator (SHMI) is the preferred hospital mortalityindicator 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.

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 monthly toNHS Digital via the Secondary Uses Service (SUS). The SHMI is then calculated by NHS Digital.
- Data are compared to the national benchmark, and our own previous performance, as set out in the table overleaf.
- The Trust reviews the SHMI in conjunction with other publishedmortality measures and the information from our internal review of deaths.

The SHMI, published on 9 May 2024, for the data period January 2023 to December 2023, is 0.86. This value is banded ‘lower than expected’ using NHS Digital 95% confidence intervals adjusted for over-dispersion. SHMI and Hospital Standardised Mortality Ratio (HSMR) confirmed that the Trust continued to compare favourably with national mortality benchmarks. This means that there were fewer deaths than expected using the rate predicted for the hospital.

OUH is unusual as an acute trust in incorporating two hospices (Sobell House Hospice and Katharine House Hospice). Since benchmarked acute hospital Trusts do not have embedded hospices, this impacts on the reported SHMI. NHS Digital has found a solution to report OUH SHMI without hospice data.

The HSMR for OUH is 90.3 for January 2023 to December 2023. HSMR has decreased and remains banded as ‘lower than expected’ (CL 85.3–92.9). The HSMR for the same time period, without hospice data is 80.4 (CL 76.7-84.2) lower than expected. Once available, we aim routinely to report the OUH SHMI both with and excluding hospice data.

Our Trust target is for 100% of patient deaths to be reviewed to ensure that any omissionsor actions taken are identified and learnt from to improve care. An analysis of the mortality reports for April 2023 to December 2023 indicate that 99% of deaths were reviewed within eight weeks. All the outstanding reviews have since been completed.

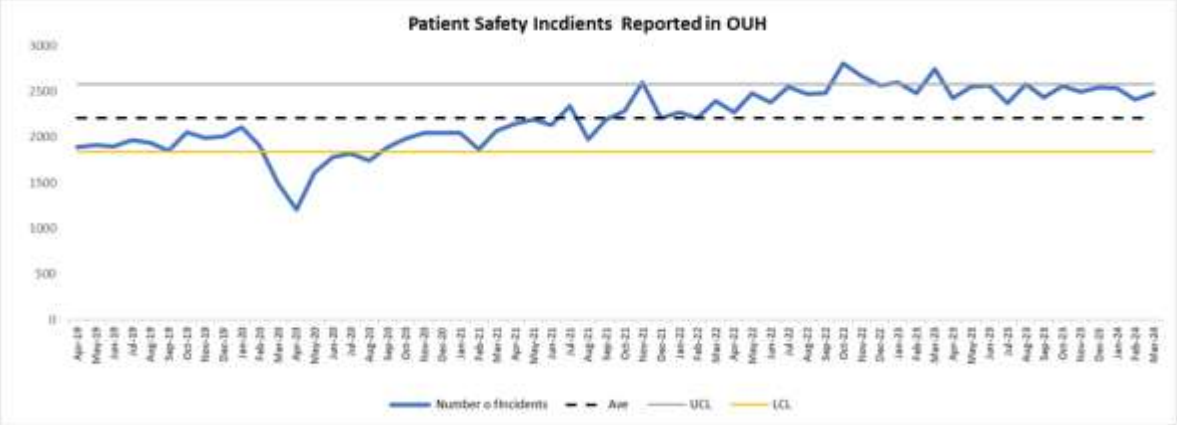
Safety Incidents and Serious Incidents Requiring Investigation

All incidents

It is crucial that we learn from every incident and near miss that happens, to address concerns and continually learn. OUH actively encourages staff to report clinical incidents and near misses so that lessons can be learned in order to improve care. Measures used by NHS England and others to indicate a positive 'safety culture' within an organisation include the rate of incident reporting (the higher the better) and the proportion with significant patient harm (the lower the better). Diagram 5 below shows the number of patient incidents reported per month by OUH since April 2017, which has been above the mean of 2,072 for the past 18 months. The number of incidents reported has seen a rising trend.

There was a reduction in the expected rate of incident reporting in April to June 2020, reflecting the cancellation of elective surgery and some outpatient activity as the Trust changed its clinical focus to concentrate on the COVID-19 pandemic.

Diagram 5: Number of patient incidents reported per month by OUH since April 2019



Trusts across England upload data relating to patient incidents reported locally to the Learn From Patient Safety Events system (LFPSE; formerly National Reporting and Learning System) to allow NHS England to view incidents and to identify trends at a national level. This also allows trusts to benchmark the data with similar trusts.

Because organisations have moved to LFPSE at different times, and the national system is still embedding, there are no national comparison data available on incident reporting. It is expected that such data will be available for 2024-25.

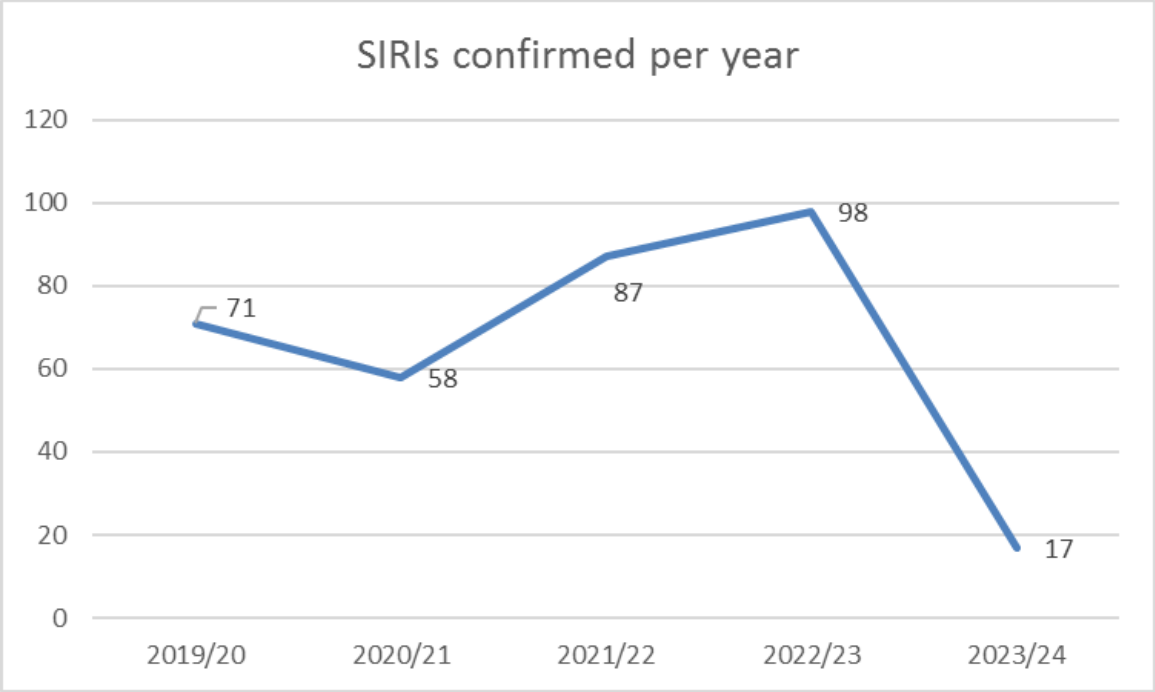
In addition to the review of all incidents by senior staff in each department, all incidents reported with moderate or above impact are reviewed each working day in a Patient Safety Response meeting, to confirm what immediate steps need to be taken or what information is required to be collected, as well as identifying whether any extra support is required for the staff involved. In 2023-24 our staff reported 29,968 patient safety incidents, 94.9% resulting in no impact or minor impact, 4.7%

resulting in moderate impact, 0.1% resulting in major impact, and 0.3% with an impact of death (the management of deaths in the Trust is discussed above). All impact gradings are confirmed through the Trust's incident management process and follow the LFPSE guidance.

Serious Incidents Requiring Investigation (SIRIs)

Diagram 6 below shows the number of SIRIs called over the past five financial years, excluding subsequent reclassifications agreed with the ICB. In line with national guidance SIRIs are reported to a national database and an in-depth investigation is completed to identify learning and any actions. The number for 2023-24 is low because no more SIRIs were called once the Trust moved from the Serious Incident Framework to the Patient Safety Incident Response Framework (PSIRF) on 2 October 2023.

Diagram 6: SIRIs confirmed per year



PSIRF encourages organisations to learn more from incidents and event trends through local learning responses, and less through formal investigations, but Patient Safety Incident Investigations (PSII) may be undertaken when significant patient safety risks and/or the potential for new learning are identified. These PSIIs may be instigated on an ad-hoc basis, in response to recent incidents, or may be larger thematic PSIIs, identified at the start of the financial year in response to common themes identified in incident reporting, complaints and other external feedback, and legal cases.

In 2023-24, 10 non-thematic PSIIs were confirmed. Wherever possible, patients or their representatives are involved in these investigations, offering guidance on areas to address and insight from their experiences.

The four thematic PSII topics for 2023-24 were as follows:

- Patients at risk (learning disabilities)
- Handover, communication
- Referrals and cancer multidisciplinary team processes
- Result reporting and endorsement

Because the Trust adopted PSIRF in the middle of the financial year, these four thematic PSIIs will continue into 2024-25. The leads for these four workstreams have given regular updates to the Safety Learning and Improvement Conversation (SLIC) meetings since October 2023, detailing the scopes for their investigations, sharing immediate learning, and detailing improvements planned or undertaken.

Diagram 7 below shows that the Trust reported two Never Events in 2023-24, compared to a five year mean of five. Never Events are defined by criteria published by NHS England, and the requirement to identify and investigate Never Events has not changed in the move to PSIRF.

Diagram 7: Never Events confirmed per year

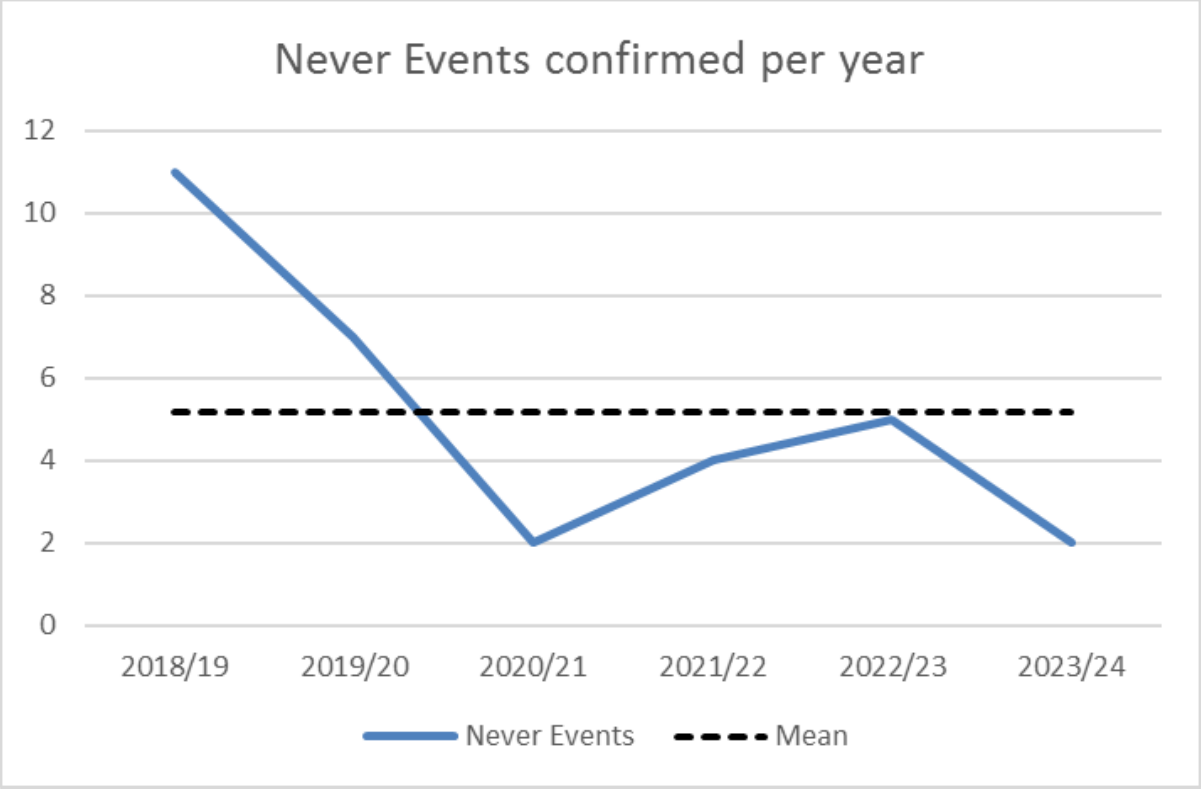
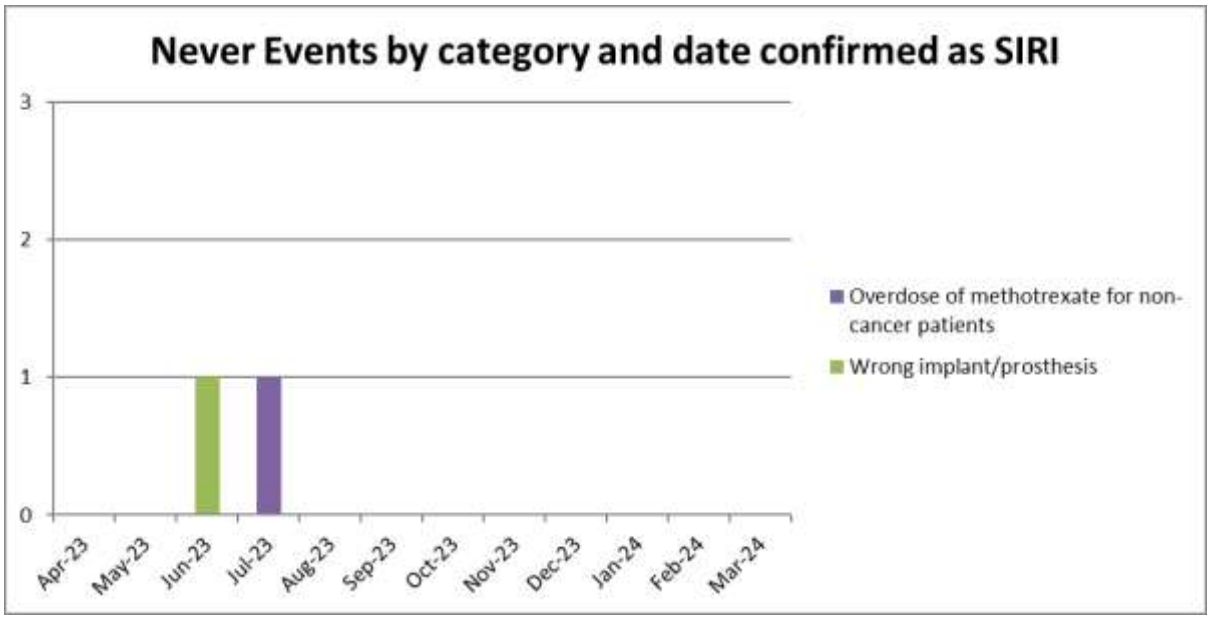


Diagram 8: Categories of the Never Events identified as SIRI



Learning from the investigations into these events includes:

- Ensuring that the WHO pause and check is repeated in full when it is not possible to implant the intended lens, for example when damage to the lens is identified.
- Creation of a standard operating procedure (SOP) for cataract surgery, which will include the step above, as well as a requirement for the surgeon to document details of all lenses used or discarded in the operation note, and guidance on how to confirm that the correct lens was inserted if patients complain of impaired vision post-operatively.
- Removal of any remaining stock of 10 mg methotrexate tablets from Horton and Churchill dispensaries and removal of the option to prescribe said tablets including for cancer use across the Trust.
- Removal of the paper methotrexate screening form, and integration of the screening process into electronic prescribing and medicines administration.

Venous thromboembolism (VTE) Prevention and Anticoagulation Safety

The Trust has met and exceeded the 95% target for VTE risk assessment (RA) of patients for 2023-24.

Highlights of the new work the VTE Prevention and Anticoagulation Teams have conducted in 2023-24 include the following:

- **Feedback to staff:** Compliance figures for the VTE Prevention and Anticoagulation ‘My Learning Hub’ packages continue to be sent by the SME

quarterly to clinical risk practitioners and Divisional leads. A target of 85% compliance has been agreed and since the introduction of Role Specific Skills in My Learning Hub there has been a gradual improvement within all Divisions with their overall compliance. Please see the following charts showing the increase in training compliance by staff groups and by each Division.

Hospital Associated Thrombosis (HAT) data are now incorporated into the accreditation in the Oxford Scheme for Clinical Accreditation (OxSCA).

Diagram 9: Percentage VTE training compliance across staff groups

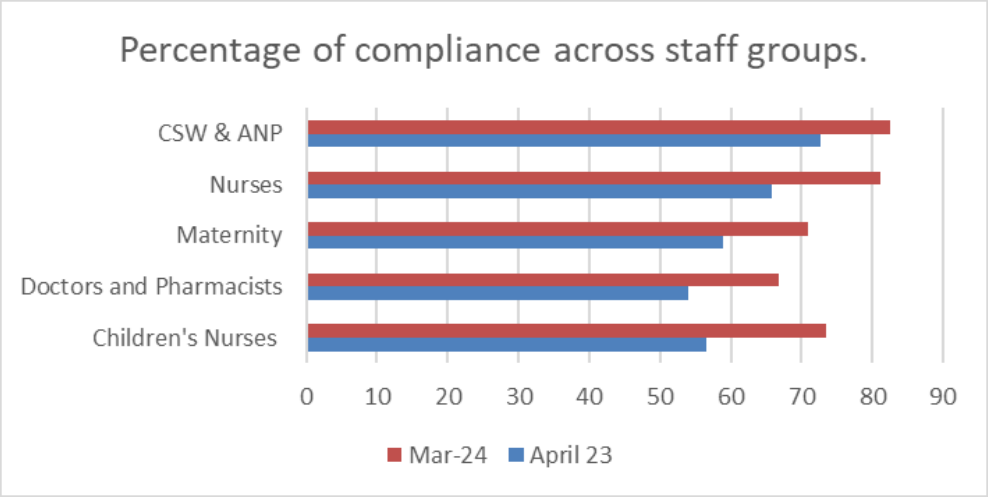
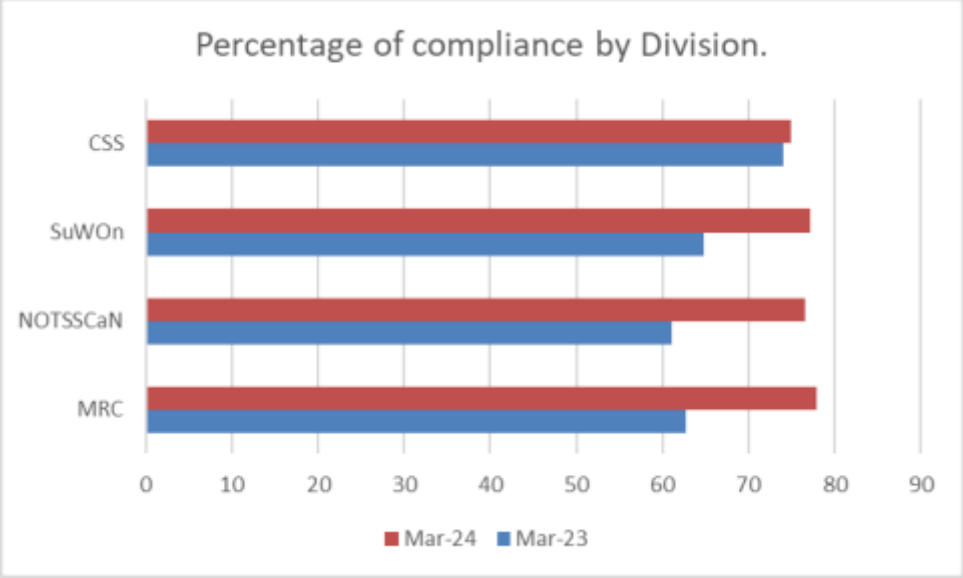


Diagram 10: Percentage VTE training compliance by Clinical Division



- **Palliative care work package:** Following collaborative work with the Palliative Care team regarding VTE prevention and Anticoagulation in the end-of-life patient, modification to the existing electronic VTE risk assessment to support decision-making in the palliative care pathway has been completed.

  Palliative care patients were included within the Trust-wide Audit of Appropriate Thromboprophylaxis in March 2023 for the first time.

- **Lower limb immobilisation work package:** The VTE Prevention Team in collaboration with key stakeholders has agreed to move forward with the TRiP (cast) score[2] VTE Risk Assessment tool for patients with Lower limb immobilisation. An electronic version has been completed with a plan to pilot in the Emergency Department, and to develop a patient friendly version that patients can complete. We will introduce a robust audit process for compliance with the NICE Quality Standard (QS201) statement 2: People aged 16 and over who are discharged with lower limb immobilisation are assessed to identify their risk of VTE.
- **Patient education:** The team worked in collaboration with Thrombosis UK to develop and launch a national UK patient information VTE App offering information to those at risk of VTE and those diagnosed with a VTE event. The App was launched in the Houses of Parliament at the VTE Awards in November 2023.
- **Virtual Wards:** With the expansion of virtual wards, the team will be reviewing the implications for NICE Guideline (NG89): if VTE risk should be assessed for patients on a virtual ward and the use of thromboprophylaxis in this setting.
- **VTE Exemplar Centres Revalidation**: In May 2023 OUH was revalidated as a VTE Exemplar Centre. Feedback stated “We would like to award your organisation with a special commendation in recognition of the exceptional work achieved around VTE prevention. This has been awarded to organisations who have demonstrated outstanding quality, innovation and leadership in the field, many congratulations.”
- **Cardiology Quality Improvement Project work package:** We are now nearing the end of the second phase in this project-which involves investigating inappropriate International Normalised Ratio (INR) ranges and ensuring these data are available on EPR to clinicians. This has expanded out to those patients with other clinical indications for warfarin. A second part of the project reviewed patients newly discharged on warfarin following cardiac surgery. This has led to the Anticoagulation service working alongside the Cardiothoracic pre-op teams to provide pre-op counselling to patients who will require warfarin on discharge. This ensures patients have the correct information to be involved in shared clinical decision making around their surgery and future management with the aim to improve adherence to medication treatment and to help in the transition on discharge back into primary care.
- **Anticoagulation Optimisation Support Service (AOSS):** This is a Pharmacist-led service in which patients with a low time in therapeutic range on warfarin are reviewed with the aim of identifying reasons for poor control and supporting them to improve this. Where eligible, patients are offered a switch to

[2] The TRiP(cast) score is the sum of the points scored for trauma, immobilisation and patient characteristic components

a Direct Oral Anticoagulant. Other work as part of the AOSS includes delivering education and training on anticoagulation to primary care teams.

- **Anticoagulation Safety Group:** This has been established and has attendance from key stakeholders from across the Trust with the aim of improving anticoagulation safety. Key challenges have been identified with input from the group and these will be used to inform a work plan going forward. This group feeds into the Medicines Safety Committee.
- **Thrombosis Working Group:** This is a multidisciplinary group consisting of members of the Anticoagulation and Thrombosis team and has representation from stakeholders across the Trust as needed. This group reviews hospital acquired thrombosis (HAT) data and trends with current action plans following on from any investigations. In recognition of new research in relation to specialist areas and newer oral anticoagulants it also reviews applications for unlicensed and off-label anticoagulation use. If approved these applications are taken forward by clinical teams to the Medicines Management Therapeutic Committee (MMTC), enabling specialist clinicians in the Trust to provide excellent care based upon the most up-to-date research and learning.
- **Expansion of the Point of Care Service for patients on Vitamin K Antagonists:** The Oxfordshire Anticoagulation Service has been successful in a bid to secure charitable funding to purchase a small stock of INR point of care testing devices which can be allocated to patients on vitamin K antagonist medication for whom venous INR tests are difficult, those who are unable to take an anticoagulant which doesn't require blood tests, and who are unable to fund their own point of care testing machine. This will allow the expansion of the existing point of care service to include patients who have found the cost of point of care testing devices prohibitive.

  The Anticoagulation service is also working closely with the Oxfordshire District Nursing team, which has secured primary care funding for a larger stock of point of care testing devices to provide to patients who would otherwise require DN visits for INR blood tests, thus also expanding point of care testing to housebound patients who might otherwise not have access.

  The expansion of the point of care service to include housebound patients and patients without the financial means to purchase their own testing devices will not only allow a wider group of patients to take ownership of their anticoagulation treatment and management, but also help to improve anticoagulant control and safety. It will also ensure that care can be provided closer to home for a wider cohort of patients, reducing hospital and primary care visits, and encouraging independence and improved quality of life for patients previously unable to make use of the point of care testing scheme.

Infection Prevention and Control

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

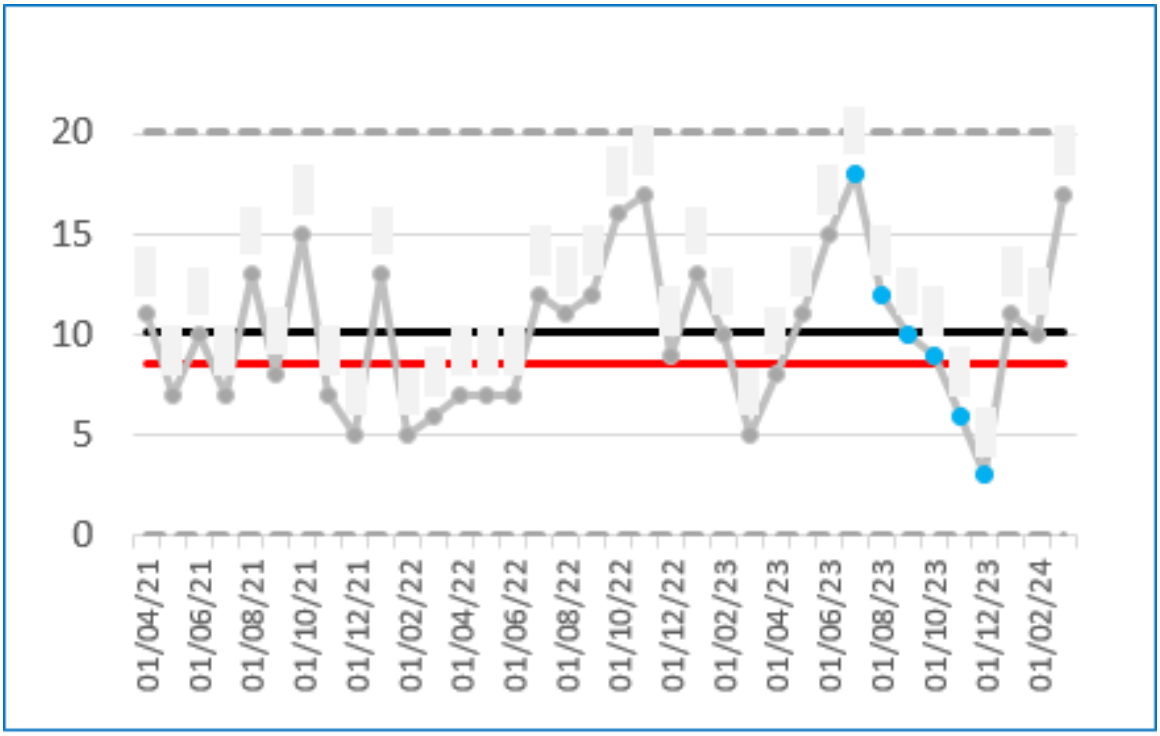
- OUH has a process in place for collating data on C.*difficile and MRSA cases.*
- Data is collated internally and submitted daily to the UK Health Security Agency (UKHSA).

Each year NHSE assigns the Trust a threshold for *C. difficile* cases, E. coli, Klebsiella and Pseudomonas bloodstream infections. Numbers of MRSA and MSSA are also submitted to UKHSA. There is no threshold for MSSA, and there remains zero tolerance for MRSA. These figures are not corrected for OUH activity. The trajectories set for healthcare associated *C. difficile* infection (CDI) and E. coli blood stream infection, Pseudomonas and Klebsiella (BSI) have all been exceeded this year.

Clostridioides difficile *(C.difficile)*

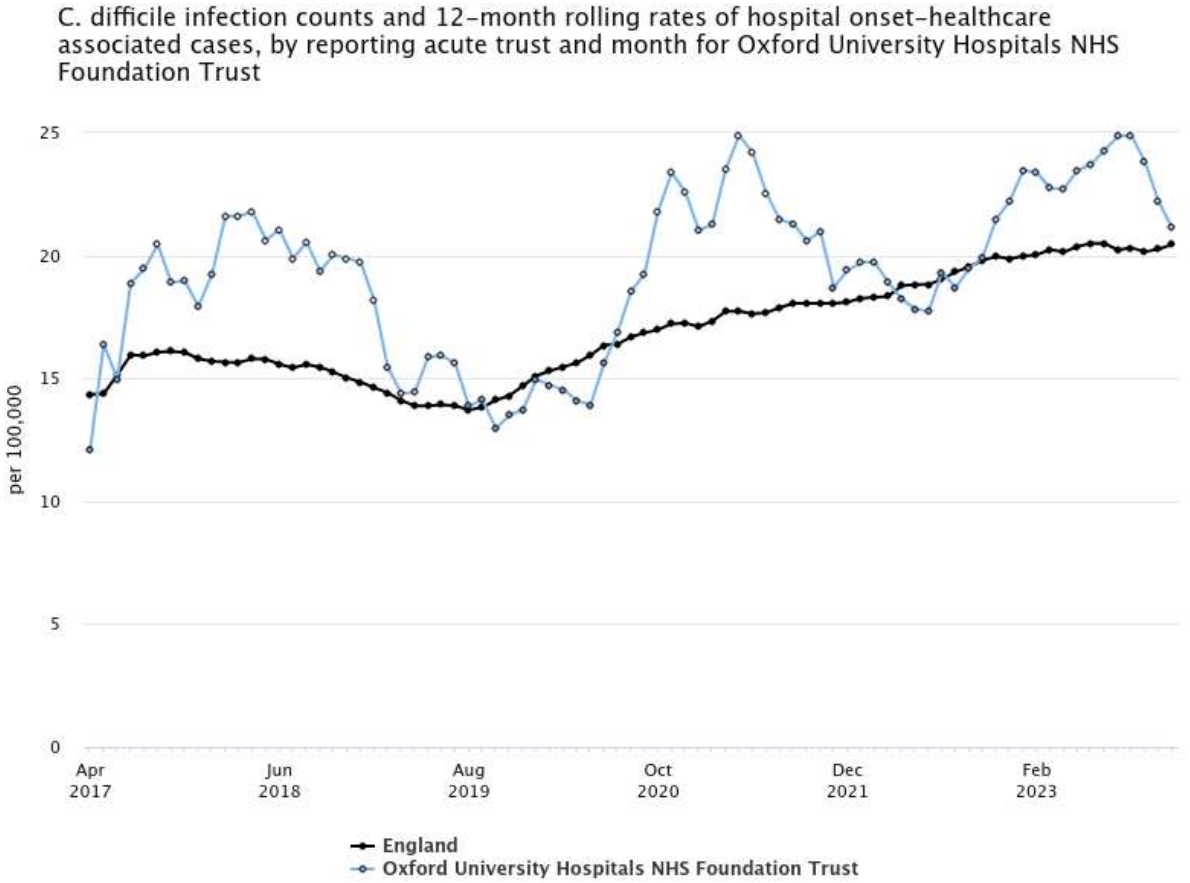
The threshold for OUH apportioned cases of *C. difficile* for 2023-24 was set by NHSES at 103 cases (one case fewer than the previous year's target). The threshold does not consider any changes in case mix or Trust activity. At the end March 2024, the Trust is reporting a total of 130 healthcare associated cases (hospital onset, healthcare associated (HOHA), and community onset healthcare associated (COHA)).

Diagram 11: Statistical Process Control (SPC) chart of OUH apportioned *C.difficile* infection counts



(Black line is the rolling average, red line is the UKHSA trajectory)

Diagram 12: HOHA *C-Difficile* infection counts in OUH against national rates

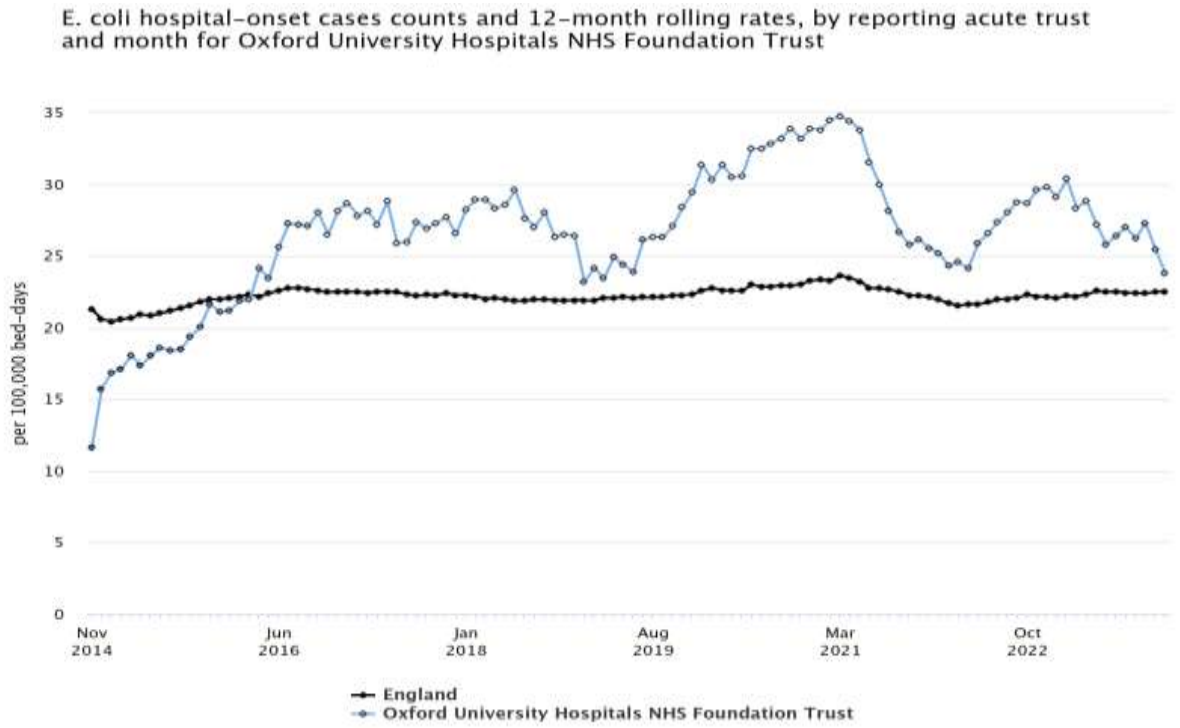


Gram negative bloodstream infections

There are no clear themes or interventions to reduce the rate of gram-negative bloodstream infections in secondary care. The changes in patient demographics with an ageing population (18.6% of the total population was aged 65 years or older in the 2021 census compared with 16.4% at the time of the previous census in 2011), and more people at risk because of comorbidity or treatment such as immunosuppression, are likely to contribute to the increase. An example of our data for E. coli against national rates is shown below.

An example of our data for E. coli against national rates is shown below.

Diagram 13: E-coli OUH cases against national rates

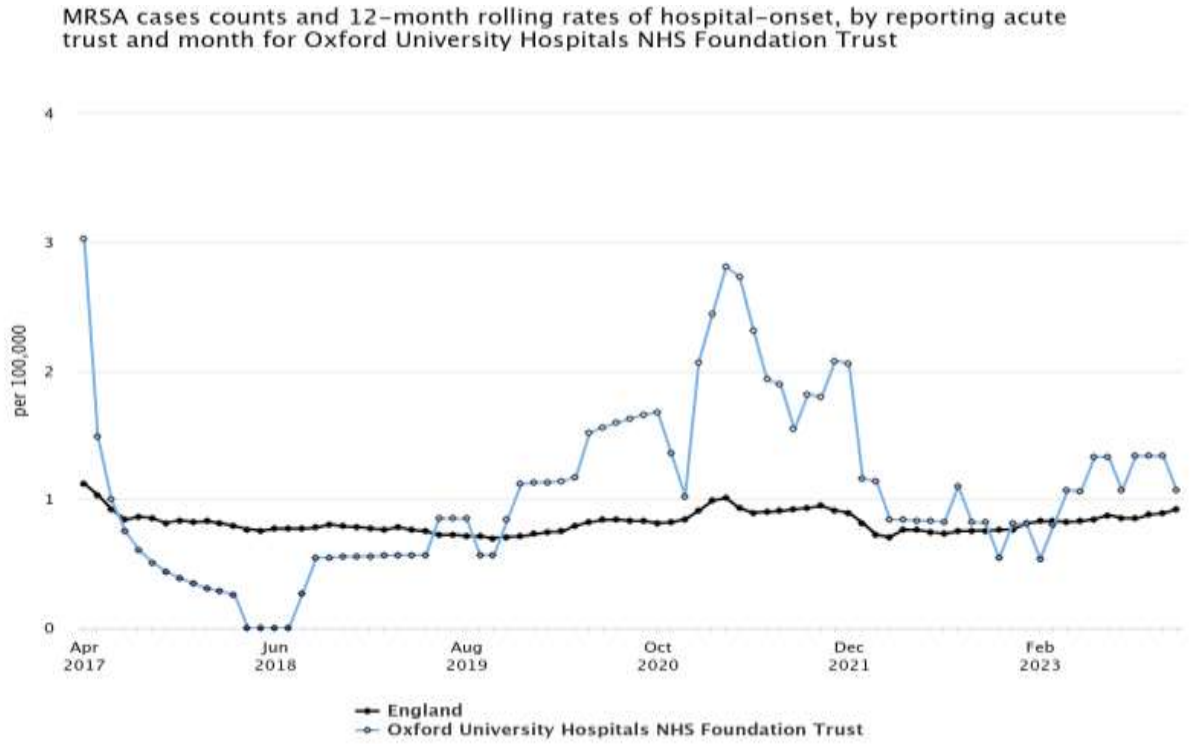


Methicillin-resistant Staphylococcus Aureus (MRSA) Bacteraemia

For the financial year 2023-24, at the end of March there were four HOHA and two COHA cases in OUH (for 2022-23 there were three HOHA and one COHA). Numbers have stabilised back to rates comparable with other Trusts across England post-pandemic.

All cases undergo a root cause analysis where learning and preventable actions, if any, are identified.

Diagram 14: MRSA cases in OUH compared to national rates



Patient Reported Outcome Measures (PROMs)

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

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

- The Trust has a process in place for collating data on patient reported outcomes.
- Data are then sent to the approved external company monthly which collates the PROMs responses and sends these to NHS Digital.
- Data are compared to peers, highest and lowest performers, and our own previousperformance, as set out in the tables.

Total hip replacement

Healthcare gain for primary hip replacement performed at OUH is within the acceptable range.

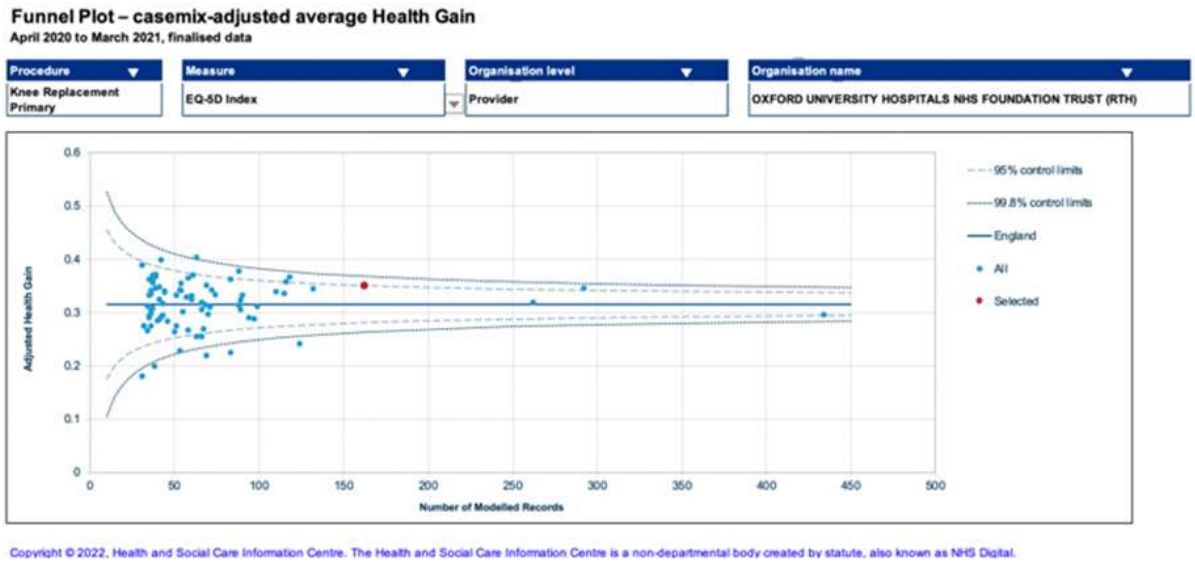
Diagram 15: Oxford Hip score

Patients are asked to complete a questionnaire before their hip replacement procedure, and again six months afterwards (to allow patients enough time to recover from the procedure). The difference between pre- and postoperative scores is the patient's self reported health gain or improvement in health.

Total knee replacement

Healthcare gain for primary knee replacement performed at the OUH is within the acceptable range.

Diagram 16: Oxford Knee score



- 97% of respondents reported improvement for hip replacements.
- 94% of respondents reported an improvement for knee replacements.

- At least 90% of respondents felt better after their operation.
- The majority of patients thought the results of their operation were excellent, very good or good (93% of hip replacement patients and 87% of knee replacement patients).
- Participation rates for February 2023 were as follows:
    - 89% for hip.
    - 103% for knee.

In some cases the participation rate figure can be over 100%. If this is the case, it may reflect an increase in clinical activity over and above that recorded by Hospital Episode Statistics (HES). There could be a variety of reasons for this, e.g. an increase in referrals; or bringing in-house activity that was formerly attributed to Independent hospitals.

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

- The Orthopaedic Unit reviews the PROMs responses and presents its review to the Trust's Clinical Improvement Committee (CIC).
- If there are negative responses identified in the PROMs returns, these are reviewed by the Orthopaedics unit to determine if actions are required. The actions are monitored by the Directorate Clinical Governance team.

Emergency readmissions within 28 days of discharge from hospital

The Trust routinely monitors emergency readmissions as one of the indicators of the efficacy of the provision of care and treatment. In some cases, readmissions may be inevitable and appropriate. The complete circumvention of emergency readmissions would likely be reflected by a prolonged length of stay and lead to an inappropriate degree of risk aversion. As part of the Trust's discharge support, advice is provided to patients regarding how to seek support if they are experiencing symptoms of ill health following a treatment or procedure (contacting the patient's GP, 111, 999 or contacting the treatment unit). Emergency Departments are situated at the John Radcliffe Hospital and Horton General Hospital, but patients known to the Trust's services may also be admitted directly to the Churchill Hospital.

The most up-to-date data on readmissions within 30 days of discharge is provided by Dr Foster (Telstra) for September 2022 to August 2023, during which period the OUH 28-day readmission rate was 10.4%. 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 monthly to NHS Digital via the

SUS. The data are then used to calculate readmission rates.

- NHS Digital develops the SUS data into Hospital Episode Statistics (HES).
- Dr Foster takes an extract from HES data to provide benchmarked clinical outcome data.
- Data are compared to peers, highest and lowest performers, and our own previous performance.

The Trust takes the following actions to improve this indicator and so the quality of its services.

Negative (higher than expected) readmission rates are investigated by the respective Division.

If the investigation identifies any care quality concerns, actions are implemented and monitored by the Divisional Clinical Governance team and reported to the Trust's Clinical Governance Committee.

Patient experience

The Trust is fully committed to putting patients, carers and families at the heart of everything that we do. We aim to provide timely, compassionate and inclusive access to services, care and treatment. We also want to ensure that our patients' thoughts and observations about their care and treatment are heard. The Trust collects information about patient experience through several formal and informal mechanisms, including: the Friends and Family Test, the National NHS Patient Survey Programme, Patient Stories, Patient Participation Groups (PPGs), ad hoc surveys and a dedicated patient feedback email. All feedback is sent to the relevant clinical service area and helps to drive quality improvement.

The drive for continuous improvement in our services to our patients, their friends and family is underpinned by the Trust Values of Learning, Respect, Delivery, Excellence, Compassion, and Improvement.

The Trust takes part in the CQC National Survey programme. The Inpatient, Emergency Department, Maternity and Under 16s Cancer surveys have been undertaken this year. The clinical hospitality team has used feedback from the surveys and Friends and Family Test (FFT) to monitor the quality and patient experience of food in the soft facilities management contract.

The Trust undertook the national Patient Led Assessment of the Care Environment (PLACE) between October 2023 and December 2023. 77 assessments took place across the Trust sites, and included communal and external areas, meal services, wards and outpatient departments. Overall, the assessors found the Trust to be clean and well cared for, and they were confident in the environment providing a good experience of patient care.

The national Shared Decision Making CQUIN Year 2 is running in collaboration with five clinical teams across the Trust. The available patient survey data to date

suggest that patients feel involved in weighing up options and decisions about their care.

Patient Involvement

The OUH is dedicated to strengthening the involvement and inclusion of patients in evaluating and developing services. Examples of this include:

The D/deaf awareness task and finish group started on 14 December 2023 following a D/deaf service user telling his healthcare story at Trust Board on 8 November 2023. The Group has been chaired by the Deputy Chief Nursing Officer and co-chaired by a D/deaf service user supported by British Sign Language (BSL) interpreters. We delivered:

- A deaf awareness film and teaching at six safety learning and improvement conversations.
- Funding for 100 members of staff to undertake BSL Level 1 course.
- Review of undergraduate nursing training to ensure the needs of D/deaf service users was included.
- BSL signs available and simplified instructions for booking an interpreter for staff on the Staff intranet site.
- The Patient Experience Team attendance at four D/deaf community coffee mornings during the year to listen to feedback about services and help to resolve issues of concern raised by the D/deaf Community.

The Moving to Adult Services conference on 26 October 2023 was jointly led by members of the Trust Youth Forum (YIPPEE). and the Patient Experience Team. 80 people attended the conference including families, young people and service partners. This conference has led to the formation of the Moving to Adult Services programme which will formally start next year and the development of the Moving to Adult Services Young People and families Group which will be led by a young person and Patient Safety Partners (PSPs).

We trialled filming 27 patients and staff asking ‘what matters to you’[3] to find a practical way to strengthen the patient’s voice at a local level with a view to including What Matters to patients in local QI projects and the introduction to all Patient Experience policies.

10 Mental Health Service users in ED have been helping with a mental health triage Quality Improvement service review, led by the ED junior doctors.

Three patient stories were presented at a Trust Board meeting in public in July, November and March to share lived experience of receiving or delivering services. Two patients presented in person and one story was presented on the family’s behalf by a nurse specialist and a music therapist. The emphasis is on the learning and

[3] What Matters To You? - wmty

how improvements can be made. These include experience of maternity care, experience of services for a profoundly deaf patient, support for a person and their family for end-of-life care and diabetes specialist support.

The Trust's PSP were recruited to support the implementation of PSIRF. They are volunteers and work at all levels across the organisation. They have helped to change the Trust's cannulation policy; support the Trust Frailty and Falls prevention programme and remind and help staff to work in a patient centred culture when investigations are carried out. They have helped with recruitment of a Patient Safety Engagement Lead and represent the patient voice in Safety Learning and Improvement Conversation (SLIC) weekly meetings, monthly Patient Safety and Effectiveness Committee and PSIRF implementation meetings.

Going into 2024-25 there will be a recruitment drive for more PSPs and we planning to recruit 14 PSPs in total.

The Patient Experience team continues to contribute to the weekly inquests, complaints, claims, safeguarding and serious incidents (ICCSIS) group giving a roundup of the weekly FFT feedback.

The FFT has been adopted nationally across all aspects of NHS healthcare. All trusts use the national NHS England recommended target to gauge patient satisfaction with their services, data for all NHS Trusts is published monthly. The Trust is delighted that overall, across the year, 92% of patients (144,079) told us that they rated their experience as good or very good (table 19). The FFT also asks patients to comment on their care. This feedback is shared with the respective wards and departments. The comments are also themed which helps the Trust to understand a balanced view of patient experience alongside complaints, claims and compliments.

Table 19: Results from the OUH Friends and Family Test (FFT) survey April 2023 to March 2024

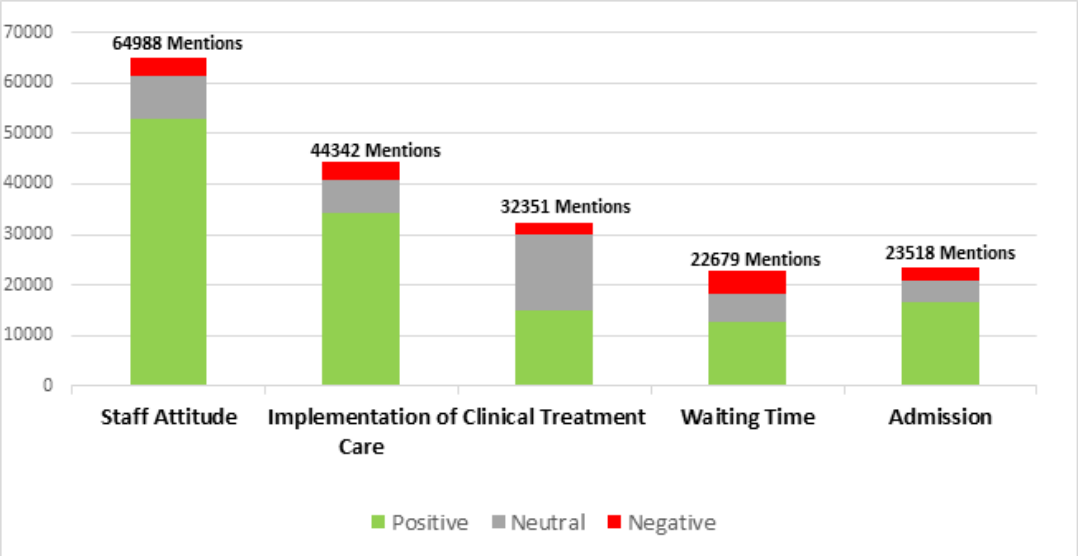
Service	Results
Inpatients and Day Cases	Based on 37,128 responses, 95.4% of patients rated their experience on their ward as very good or good.
Emergency Departments	Based on 19,817 responses, 80.5% of patients rated their experience within the emergency department as very good or good.
Outpatients	Based on 87,144 responses, 94% of outpatients rated their experience as very good or good.
Maternity	Based on 915 responses, 90% of women rated their experience of the Trust's maternity services as very good or good.

Table 20: Trust's overall results from the FFT survey for 2023-24

April 2023 to February 2024	Very good	Good	Neither good nor bad	Poor	Very poor	Don't know
No. of responses overall	115,203	17,767	4,446	2,863	3,020	780
Percentage	80%	12%	3%	2%	2%	1%

There have been 262,196 comments via the FFT throughout the year. Diagram 17 below shows the mix of positive and negative sentiment among comments relating to the five most mentioned themes: Staff Attitude, Implementation of Care, Clinical Treatment, Waiting Time and Admission.

Diagram 17: Mix of positive and negative sentiment among comments relating to the five most mentioned themes



The FFT data and information generated are submitted to NHS Digital as part of the national submissions programme. The Patient Experience team has been working on an improvement project to enable the test to run more smoothly and to enable wards and departments to access their feedback in a timely manner to help them learn and improve their services. The Children's FFT and the Maternity FFT survey (Question 3) is now distributed via by SMS text, and once the project concludes it is hoped that all areas will have SMS capability. Instant Voice Messaging (IVM) is also being introduced.

The Patient Experience team is working on a project to develop an interactive dashboard which can be added to the new and improved Patient Experience Team SharePoint site. This will enable wards, Directorates and Divisions to analyse their feedback to inform quality improvement projects to improve patient experience.

NHS England Learning Disability Improvement Standards

The Learning Disability Improvement Standards have been developed to help NHS trusts measure the quality of care provided to people with learning disabilities, autism or both. The outcomes have been developed by individuals and their families, keeping their experiences the focus for the standards. There are 4 standards (the first three apply to all NHS trusts and the fourth to specialist NHS trusts):

- Respecting and protecting rights.
- Inclusion and engagement.
- Workforce.
- Learning disability services standard (aimed solely at specialist mental health trusts providing care to people with learning disabilities, autism or both).

Further information about the standards can be found on the NHS England website. OUH submits an annual self-assessment alongside accessible patient questionnaires and staff questionnaires.

The Trust supports people with learning disabilities through the Learning Disability Liaison Nurse team and availability of reasonable adjustments. The number of patients with a learning disability flag continues to increase, and monitoring of the percentage of people with learning disabilities who are quickly readmitted has indicated that this is less than among the general population.

The Trust is focusing on identifying and tracking people with a learning disability on waiting lists; further improving the way we identify them and add a flag to ensure clinicians are aware. One of the Trust's Patient Safety workstreams is Care of Vulnerable People, starting with a focus on people with learning disability.

Staff recommendation of our hospitals to friends and family

Our Annual Staff Survey data for 2023 has shown very pleasing results relating to staff recommending our hospital to friends and family.

- 74.84% of staff would be happy with the standard of care provided at OUH if a friend or relative needed treatment – the national average is 63.32%.
- 79.35% of staff agree that care of patients is OUH's top priority – the national average is 74.83%.
- 63.55% of staff would recommend OUH as a place to work – the national average is 60.52%.

In 2023-24 the People and Communications Directorate has continued to deliver on the key elements of our People Plan 2022–25 and Year 2 Priorities. The highlights from Year 2 include the following:

- Our focus on psychological wellbeing and meeting our staff's basic needs has led to the permanent creation of our Staff Support Service, a group of clinical psychologists and one psychiatrist who support staff with work-related psychological requirements. We have continued to address the physical wellbeing of our people by setting up the 'Creating a Suitable Estates and Environment' Enabling Group. This group oversees capital wellbeing projects across the Trust. Outside gym equipment has been installed at three of our hospital sites, work has commenced on creating a new set of showers and changing rooms in the John Radcliffe Hospital, and we are finally installing improved secure cycle storage across our main sites.
- We have established an Eradicating Bullying and Harassment Programme, the purpose of which is to tackle all forms of negative behaviours ranging from incivility to violence and aggression. This programme has several key workstreams:
    - Kindness into Action programme for leaders and managers – at the end of March 2024, 519 managers had fully completed the Leading with Kindness Course since its launch with a further 969 currently completing it.
    - Improvements to support bullying and harassment cases for protected characteristics which has included new Respect and Dignity at Work (including Sexual Safety) Procedure and the Conduct and Expected Behaviour Procedure which received approval in March 2024.
    - During the same month we launched our 'Raising a Concern' platform on the OUH website to let staff know how to raise both an informal and formal concern, which includes signposting to further support and resources.
- Our Staff Networks have organised a variety of events to raise awareness around inclusion. There have been day conference events for our Women's, BAME and Disability and Accessibility Networks and our Young Apprentice Network. Our LGBT+ Network organised events for both LGBT+ History Month and Pride Month.
- Our Leadership and Talent Development team has continued delivering leadership development programmes. October 2023 saw the launch of the Leadership Development Programme (LDP) for Matrons, Directorate Managers, nominated Clinical Leads and new Clinical Directors. Four cohorts of this eight-month programme will have been completed it by the end of December 2024.
- As part of improving our onboarding experience, we have launched two new online onboarding programmes; All Staff Onboarding and New Managers Onboarding, which provide online training and resources for new starters and new managers respectively during their first six months in the Trust.

- We launched a new Staff Recognition Strategy starting in January 2024 with an instant note of appreciation, enabling staff to recognise a colleague who has gone above and beyond by sending a short personalised instant message aligned to the Trust values. So far, we have had 1,670 staff access this popular method of showing thanks. Our Annual Staff Recognition Awards nomination window closed on 3 March with 2,870 nominations, over 1,000 more than last year. Finally, we are building a new platform for monthly recognition which will launch later in the year.

The introduction of a Values Based Appraisal (VBA) window at OUH for the last two years has had a positive effect. 93.42% of those who took part in the Staff Survey in 2023 reported that they had had an appraisal in the previous 12 months, compared with 71.87% in 2021. The national average this year is 83.12%. We have continued to develop additional resources and training to support our people to hold quality appraisal conversations within the window, including a 'How to Guide' that directs people to the process and relevant resources.

Part 3: Other information

Our performance with NHS Oversight Framework indicators

OUH Performance Management and Accountability Framework governs the oversight and the delivery of the Trust's strategic and performance goals. The Framework provides a focus from Board to ward on Corporate Governance, Risk Management, Accountability and Performance Management, which is integrated across Trust Divisions (Clinical and Corporate).

OUH has been segmented into category 2; this is the default for all organisations (the segments indicate the scale and general nature of support needs, 1 being no support needs to 4 which is mandated intensive support).

The OUH is not in breach of licence and no formal action is needed, but with the potential for support in one or more of the five themes. There are no enforcement actions from NHS England currently in place.

Table 21: Performance against relevant indicators and national average

Indicator	Target	Trust Performance 2023-24	Trust Performance 2022-23
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	≥92%	57%	67%
Patients waiting for consultant-led treatment (RTT[1])	N/A	82,990	72,744
Patients waiting over 52 weeks (RTT[1])	<950	3,586	2,226
Patients waiting over 78 weeks (RTT[1])	0	80	59
Patients waiting over 104 weeks (RTT[1])	0	1	4
ED performance within 4 hours (all types) (ED[2])	≥95%	65.1%	62.1%

Indicator	Target	Trust Performance 2023-24	Trust Performance 2022-23
All cancers: 62-day GP Referral to Treatment standard	≥85%	62.5%	57.8%
All cancers: 62-day Screening to First Treatment standard	≥90%	56.4%	57.7%
Diagnostic activity levels (elective)	N/A	240,545	227,990
Maximum 6-week wait for diagnostic procedures	≥95%	83.6%	91.6%
C. difficile infection cases	103	130	124
Methicillin-resistant Staphylococcus aureus (MRSA) Bacteraemia cases	0	6	4
Local Priorities			
Venous thromboembolism risk assessment	>95%	97.9%	98.1%
Hospital Acquired Thrombosis (HAT)	0	16	13
Hospital Acquired Pressure Ulcers (HAPUs) Category 3 and 4 per 10,000 bed days	<3.0	2.5	2.2
Reported incidents of violence and aggression against staff[3]	0	1,708	1,366
Incidence of violence and aggression (rate per 10,000 bed days)	N/A	51.5	40.7
Results endorsed within 7 days	>85%	82.5%	82.2%

[1] Referral to Treatment (RTT) pathway

[2] Emergency Department (ED)

[3] Reported rate on Trust's incident management system

Elective care

We have reduced the number of patients waiting more than two years from 4 at the end of March 2023 to 1 in March 2024. Focused work has continued on recovering from a growing backlog of patients waiting more than 78 weeks following several periods of Industrial Action. At the end of March 2024, there were 80 patients waiting more than 78 weeks for elective treatment compared to 59 patients at the end of March 2023. We are committed to reducing further, the number of patients waiting for elective treatment in 2024-25.

Patients on a Referral to Treatment (RTT) waiting list at OUH increased by 12% from March 2022 to February 2024 (March position to be reported mid-April). In January 2024, OUH held the 25th largest incomplete waiting list nationally. Compared to March 2023, OUH held the 31st largest incomplete waiting list nationally.

A contributing factor to the challenge of fully recovering the long waiting patients in 2023-24, was reoccurring industrial action, resulting in the rescheduling of elective or day case admissions and outpatient appointments.

The Trust worked closely with staff to ensure that patient safety was always paramount, whilst supporting the right of colleagues to take industrial action if they

chose to. We worked to ensure that staffing was maintained at safe levels and to minimise the rescheduling of planned appointments, procedures and operations.

Harm reviews continue to be performed for patients waiting in excess of 52 weeks, to identify any psychosocial or clinical harm arising from delays. The methodology has evolved in line with the national e-prioritisation policy, which has meant that all patients can now be proactively prioritised electronically based on clinical need. Harm reviews are then discussed in the monthly Harm Review Group (HRG). The harm reviews have allowed services to expedite treatment of patients as necessary. Where moderate or above impact has been confirmed at the HRG, these cases are reviewed under the Patient Safety Incident Response Framework (PSIRF) to determine the best learning response.

Following an agreed protocol, any cancer patient waiting more than 104-days for treatment also has a review conducted of potential for clinical harm from the delay. Details are reported to the Trust's HRG and then to the Patient Safety and Effectiveness Committee.

Emergency care

The percentage of patients seen within four hours in our Emergency Departments for 'all types' increased from 62.1% in 2022-23 to 65.1% in 2023-24. By the end of March 2024, the proportion of patients seen within four hours had improved to 72.2%. We recorded a lower proportion of patients spending more than 12 hours in an Emergency Department, which decreased from 6.8% in 2022-23 to 4.4% in 2023-24. ED performance was below the national average for 'all types', which was 72.1% nationally in 2023-24.

In 2023-24, attendances at Emergency Departments and emergency admissions from ED increased by 4.4% and 11.9% respectively at OUH, compared to 2022-23. The increase in ED attendances was higher than the growth seen nationally, which increased by 3.6% for attendances and 7.1% for emergency admissions from ED.

Cancer treatment within 62 days

OUH cancer demand is significantly above pre-pandemic levels and continues to grow year-on-year (2023 vs 2022) by more than 12% cumulative. OUH delivered end of March national target of 75% for 28-day Faster Diagnosis Standard (FDS) as well as the 62-day backlog target set at 171 pathways within the Trust's Operating Plan. Both metrics make up the fair share triggers for national (tier 1) or regional (tier 2) tiering, which OUH, as well as many other providers, was notified that it had triggered during Q4, following the industrial action over the festive period and in January 2024. OUH was therefore placed in the regional (tier 2) level from January to April 2024.

NHSE published updated cancer waiting times guidance in October 2023, which saw the Two-Week-Wait (2WW) standard replaced by the 28-day Faster Diagnosis Standard (FDS), the 31-day standards combined, 62-day standards also combined

as well as the inclusion of non-site-specific and lower grade Brain pathways that have previously been excluded. The new standards are not currently reflected in the prescribed format of the Quality Account. Against the new standards, OUH achieved one out of the three national standards at the end of March i.e. 28-day FDS. The 62-day and 31-day combined standards were not achieved and are the focus of specific initiatives within the Trust's Cancer Improvement Programme. The achievement of the 28-day FDS has been supported by the Trust's investment in increasing diagnostic capacity as well as capacity from the Community Diagnostic Centre.

Diagnostic test within six weeks

A fundamental aspect of delivering elective treatment for patients within timeframes set in the Trust's Operating Plan, as well as the national standards, includes diagnostic waiting time performance.

The February 2024 diagnostic performance, against the standard measuring patients waiting within six weeks, was 83%. OUH was ranked 86th out of 157 nationally. The Trust holds one of the largest volumes in the region and the Shelford Group. The main causal factor for not achieving a higher performance was a change in the Ear, Nose and Throat (ENT) pathway, and consequently the reporting for Audiology referrals. A recovery plan has been developed and tracked for all challenged modalities, providing executive assurance with improving waiting times for patients in 2024-25.

3.1 Freedom to Speak Up (FtSU)

The Trust takes very seriously its responsibility for ensuring all members of staff feel confident and supported in being able to speak up when they believe the highest standards of care and service are being compromised or could be compromised. Processes are in place to ensure that our staff feel able and safe to raise concerns and have confidence they will be listened to, and their concerns acted upon.

Where such issues are raised, they are generally addressed quickly and efficiently through our established processes as outlined in the Trust's Freedom to Speak Up – Raising Concerns (Whistleblowing) Policy. Under the terms of the Policy our Freedom to Speak Up (FtSU) Lead Guardian has a guardianship role in support of any employee who wishes to raise an issue of concern. Speaking up should be something that everyone does and is encouraged to do. Well in advance of the nationally set deadline of 31 January 2024, our Trust Policy was updated in line with the National Model Policy and National Guardian's Office recommendations, to ensure it fully supports this aim. The FtSU Lead Guardian presents an Annual Report to the Trust Management Executive (TME) and the Trust Board. We have a nominated Non-Executive Director responsible for Freedom to Speak Up so that speaking up is represented independently at Trust Board level. In addition, we have a nominated Executive Director lead for Freedom to Speak Up.

The purpose of the FtSU role is to work with all staff to support the organisation in becoming a more open and transparent place to work and where staff are encouraged and enabled to speak up safely. In 2022, the work of the OUH FtSU Team was Highly Commended at the Health Service Journal (HSJ) National Awards.

Ensuring staff do not suffer detriment

Speaking up about any concern an employee has at work is really important. In fact, it is vital because it will help the Trust to keep improving our services for all patients and the working environment for our staff. Staff may feel worried about raising a concern, and the Trust understands this, but this should not deter individuals from raising their concerns. In accordance with our duty of candour, our senior leaders and entire Board are committed to an open and honest culture. We will always ensure that concerns are appropriately considered, and staff will always have access to the support they need. If a member of staff raises a concern under our Policy, they will not be at risk of losing their job or suffering any form of reprisal as a result. The Trust does not tolerate the harassment or victimisation of anyone raising a concern. Any such behaviour is a breach of the Trust Values and if upheld following investigation could result in disciplinary action.

3.2 Rota Gaps and the Plan for Improvement

Nationally, ‘Doctors in Training’ represent 40% of the medical workforce. New Terms and Conditions of Service (TCS) were introduced for this group in 2016. The 2016 TCS include governance processes that require partnership working between Doctors in Training and their employing trusts to ensure safe hours’ working practices and to enable enhanced executive supervision of this group.

The transition of all Doctors in Training to the 2016 TCS was completed in February 2020. At any one time there are about 900 Doctors in Training at Oxford University Hospitals NHS Foundation Trust (OUH). Additionally, there are locally employed doctors sharing the same rosters, roles and responsibilities, with the local contract now mirroring safe hours’ working practices of the national 2016 TCS.

OUH has taken the following actions to ensure compliance with the 2016 TCS, and so the quality of its services, by:

- All Doctors in Training are provided with compliant ‘Work Schedules’ and an electronic process to report exceptions when there is variance to rostered hours.
- The Board receives quarterly and annual reports from the Guardian of Safe Working Hours. The Guardian’s reports are informed by workforce data relating to the Doctors in Training as well as feedback from the Junior Doctors Forum.

Table 22: The number of exception reports, the number of doctors reporting, the number of specialties receiving reports, the nature of the exception and the additional hours worked per exception, broken down by quarter and then showing the total

Exception Reporting	Apr-Jun 23	Jul-Sep 23	Oct-Dec 23	Jan-Mar 24	Total
Number of exception reports	152	336	343	300	1,131
Number of doctors reporting	54	91	88	62	181
Specialties receiving reports	20	21	24	19	31
Nature of exception – Education	19	22	41	38	120
Nature of Exception – Hours and rest	148	323	321	275	1,067
Additional hours worked per exception report	2.8	1.5	1.5	1.3	1.6

Table 23 below does not contain information because the local level data are not reliably available

Vacancies	2023			2024	Total
	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	
Unfilled training post	Organisational level data not reliably available as managed at a service level via departmentally commissioned data tools.				
Other					
Total					

Table 24: Number of locum shifts undertaken by bank and agency staff, broken down by quarter, and the reason for the locum shift

Locum Shifts	Apr-Jun 23	Jul-Sep 23	Oct-Dec 23	Jan-Mar 24	Total
Total	4,144	4,907	3,972	4,992	18,015
Agency	723	1,321	504	1,211	3,759
OUH Bank	3,421	3,586	3,468	3,781	14,256
Reason for locum shift – Vacancy	2,945	3,456	2,948	4,069	13,418
Reason for locum shift – Non-vacancy	1,199	1,451	1,024	923	4,597

OUH has recognised that the following actions are required to promote safe hours' working.

OUH complies with the safe working hours framework for NHS doctors and dentists in training but has acknowledged the need to improve its Assurance Framework. OUH is implementing a standardised process for data relating to safe working hours, with each Division expected to review their data quarterly and produce reports on their performance in promoting safe hours' working. The Guardian of Safe Working Hours will assess how the Divisions support safe working hours to provide better oversight for the deployment of the junior doctor workforce and meet contractual requirements.

Annex 1: Quality Priorities 2024-25

Patient Safety

Quality Priority 1: Medicines Safety Framework – Monitoring use of high-risk medicines

Why is this a priority?

In recent years, improving medicines safety has been an international and national focus, with the launch of the World Health Organization's third Global Patient Safety Challenge: Medication Without Harm, and NHS England's National Medicines Safety Improvement Programme. To evaluate medicines safety across the organisation, it is essential that a range of diverse metrics and indicators derived from a range of data sources are utilised as part of a broad framework. The development of the Medicines Safety Framework is part of an ongoing workstream by the medicines safety team and committee; this Quality Priority will focus on one aspect of the framework- the use of high-risk medicines.

Monitoring high-risk medicines across the organisation is essential to ensure they are used safely and that processes align with local and national recommendations. Currently retrospective audit of pharmacy inventory data is the main method used to understand adherence to safety controls. However, this process requires manual review, is time-consuming, and focuses on identifying past errors rather than prevention of errors. Therefore, this work aims to develop an automated tool to monitor use of high-risk medicines using pharmacy inventory and supply data. Implementation will provide prospective medicines use surveillance with the potential to provide opportunity for intervention to prevent harm and unsafe practice.

What we will do	2023-24 Update on QP
Action 1 (Q1) • Define a range of medicines safety metrics/indicators, using pharmacy inventory and supply data, in the context of medication related Never Events, NHS England's Enduring Standards and National Patient Safety Alerts.	• Agreed plan detailing defined metric/indicator for five medicines where medicines supply controls apply.

What we will do	2023-24 Update on QP
Action 2 (Q1) • For the five metrics/indictors, define the parameters and/or rules in the context of the organisation.	• Summary document detailing the parameters of the five metrics/indicators.
Action 3 (Q2-Q4) • Apply the five metrics/indicators to trust pharmacy inventory and supply data at regular time-points over 3-6 months. • Analyse data to refine the measures as required using Quality Improvement (QI) methodology. • Test feasibility of surveillance tool and capability to identify risks and errors in practice.	• Application of metrics/indicators to real pharmacy inventory and supply data at regular time points over a 3–6-month period. • Evidence of QI methodology to test and analyse the metrics/indicators to further refine definitions and parameters. • Qualitatively analyse data and evaluate impact of the tool with trust stakeholders, to determine potential capability to identify risks and errors in practice.
Action 4 (Q4) • Collaborate with The Hill digital innovation team to develop novel software to automate prospective surveillance of one of the safety metrics/indicators (subject to Cerner Pharmacy implementation in Q3).	• Successful development of software in collaboration with The Hill's digital innovation team. Feasibility test of one indicator.

Quality Priority 2: Care of the Frail Elderly

Why is this a priority?

Frail, elderly patients make up a substantial proportion of patients presenting to urgent and emergency care settings. Early, comprehensive assessment of these patients can improve outcomes by ensuring the acute care, management pathway and future care plans are all tailored appropriately to the patient's needs. This quality priority focusses on strengthening the assessment of frail, elderly patients in the ED and SDEC settings. It aligns with CQUIN 5 'Identification and response to frailty in emergency departments'.

What we will do	2023-24 Update on QP
Action 1 (Q1) • Continuation of the Frailty multi-disciplinary team to support early assessment of frail, elderly patients in the ED and Acute Ambulatory Unit (AAU).	• Successful continuation of the Frailty Multidisciplinary Team established in year one.
• **Action 2 (Q1-4)** Strengthen documentation of Clinical Frailty Score (CFS) among patients aged 65 years and older attending ED or AAU.	• Increase and sustain to >70% the proportion patients aged 65 years and older attending ED or AAU that have a CFS documented.
Action 3 (Q1-4) • Strengthen documentation of Cognitive Assessment among patients aged 65 years and older admitted through ED or AAU.	• Increase to >80% the proportion patients aged 65 years and older attending ED or AAU that have a documented Cognitive Assessment.
Action 4 (Q1-4) • Improve the assessment and further management of frail, elderly patients by creating and implementing a system for comprehensive geriatric assessment (CGA).	• >50% patients aged 65 and over attending ED or AAU to have a CFS documented and, if CFS>5, initiation of a comprehensive geriatric assessment or referral to acute frailty service.

Quality Priority 3: Reducing Inpatient Falls

Why is this a priority?

Inpatient falls are an important and potentially preventable cause of morbidity and mortality, especially as a cause of femoral fractures among the elderly. Key to reducing the risk of falls in hospital is a multifactorial risk assessment, followed by action to address each falls risk factors identified. Early assessment with a suspected serious injury is also important following a fall to ensure timely and appropriate analgesia, investigations and management. This quality priority focusses on strengthening training and implementation of the multifactorial falls risk assessment, addressing key areas for improvement identified in the most recent National Audit of Inpatient Falls and strengthening assessments and information sharing following a fall.

What we will do	2023-24 Update on QP
• Apply Improvement Framework throughout to structure and measure approach. Work in conjunction with the QI team on delivery of the QP objectives.	• Using appropriate QI tools identified through each step of the improvement framework to enable a structured QI approach and monitoring of sustainability and impact of changes and sharing widely throughout OUH.
Action 1 (Q1-4): Education for staff and patients • Review and develop the falls prevention e-learning training for all staff (Q4). • Strengthen recording of local teaching by champions (Q2-4). • Easy Read version of falls and bedrails leaflets (Q2). • Creating patient stories for shared learning (Q2-4). • Sharing of learning through the Community of Practice and Improvement Stories (Q1-4).	• Monitor compliance with the current “e-learning, preventing falls in hospital,” by Division. • Hold an e-learning focus group to evaluate and determine if the current package is to be maintained or a new version created. • Mapping this to related e-learning requirements within the harm reduction programme. • Create and test an e-learning package with relevant stakeholders. • Apply for role-specific status through the Education and Training Committee. • Measure compliance with the e-learning package. Target - 60% of Nursing and AHP to have completed e-learning training by March 2025, if mapped to the role.

What we will do	2023-24 Update on QP
	• Develop, test and evaluate a My Learning Hub (MLH) bespoke ward teaching course for Champions to record local teaching. • Develop in conjunction with the learning disabilities team and Patient Safety Partners, test and evaluate, an easy-to-read version of the falls and bedrail leaflet. • Hold patient focus groups with Careers Oxfordshire to review patient impact. • Develop and test mechanisms to capture patient and staff stories. • Continue to develop the Community of Practice for Falls and HAPU including other stakeholders as evolves.
Action 2 (Q1-4): Increase Multifactorial Falls Risk Assessment (MFRA) compliance • Monitoring audit Trust results for fallsafe audit completion (Q1-4). • Establishing assessments across day cases and maternity, using a QI approach (Q1-4). • Review falls assessment tool and care plans for adults (Q1-4).	• Establish within Ulysses a reporting system for audits, demonstrating trust-wide compliance. • Monitor monthly ward area compliance and create a reporting system to wider Trust Forums. • Ulysses audit reports will be reviewed monthly and wards that perform below 90% on two consecutive months will be contacted by the Falls Prevention Practitioner to review their action plan and supported to implement. • Use a QI approach to determine concerns and barriers around assessment, implement proposed assessment and audit outcomes, on compliance and staff response. • Determine elements of assessment required and develop and test appropriate assessment. • Discuss and seek support with digital and EPR teams for the implementation of new assessments. • Review current assessment tool and care plan.

What we will do	2023-24 Update on QP
	• Develop and test any proposed changes with stakeholders, evaluate, adopt, or adapt as appropriate.
Action 3 (Q1-4): Strengthen early assessment following a fall • Develop and implement tools (e.g., Safety Message) to improve early assessment (Q2-4).	• Write Safety Message and seek approval and distribution to all staff (Q1). • Re audit post falls data, 3 months after Safety Message communication. • Scope, develop, test and implement a nursing post falls assessment in iView, following the guidance provided by the National Audit team. • Scope, develop, test and implement, in conjunction with MRC and Gerontology, the digital implementation of a post falls medical proforma, following NICE guidance. • Re-audits of the early medical assessment for inpatient hip fractures, once the medical proforma has been implemented.
Action 4 (Q1-4): Optimising the use of falls related data • Strengthen Trust National audit of inpatient falls compliance. • Strengthen the use of falls data at local level.	• Review the National audit requirements with key stakeholders to maximise Trust compliance. • Develop a robust reporting system and monitor through Clinical Improvement Committee (CIC). • Use data from the National audit of inpatient falls to enhance Trust and local understanding and inform decision making. • Support the use of local-level data to inform and explore opportunities for improvement and track impact of change initiatives, through PDSA cycles and Ulysses Quality Improvement project registration.

What we will do	2023-24 Update on QP
Action 5 (Q1-3): Optimise the use of Assistive Technologies to support falls prevention	• Test and evaluate the QI Pressure Sensor with staff and patients in Ward 5E/F and Sobell House. • Map other related pressure sensor products insitu across the OUH, identifying the gaps and appropriate usage. • Identify and explore additional senor products for further expansion of the QI initiative. • Adapt and adopt assistive technologies as appropriate, defined through the Falls Prevention Improvement Delivery group.

Clinical Effectiveness

Quality Priority 4: Development of Critical Care Outreach (CCO) Service

Why is this a priority?

OUH is a national outlier, being one in only 14% of Trusts nationally with no CCO service. The aim of CCO is to ensure safe, equitable and high quality care for all acutely unwell, critically ill and recovering patients. This service provides two main functions: patient follow-up post-ICU, and early recognition of deteriorating patients to enable a rapid response within main Trust sites.

In-hospital follow-up supports patients during the transition from unit to ward. It will better support all patients discharged from critical care, and particularly those discharged out of hours. It has the potential to improve outcomes, including reduction in readmission to ICU, in-hospital mortality, and hospital length of stay. Early recognition of deterioration and intervention can improve patient outcomes and provide timely, expert advice to wards. Early intervention has the potential to reduce the demands on critical care units by facilitating prompt admission to (and discharge from) critical care. The potential introduction of Martha's Rule is also likely to advocate a need for 24/7 access to a rapid review from a CCO team.

Implementation of a full 24/7 outreach service is recommended by key national guidance standards including GIRFT, GPICS and is a recurrent theme in NCEPOD reports. It is advocated in NICE guidance (CG50, CG83 and QS158).

Aim: Develop and pilot an Outreach Service for the Trust, co-ordinated and overseen by Oxford Critical Care. This will improve the recognition of deteriorating patients, improve speed and quality of decision making, reduce length of stay, and provide a platform for improved nursing retention. Objective is that by 31 March 2025 to have commenced stage 1 of a 4-year development plan for of an OUH Outreach Service.

What we will do	2023-24 Update on QP
Action 1: Understand metrics and benchmarking data to inform development • Q1. Evaluation of OUH data including National Early Warning Scores (NEWS 2) recognition and treatment of the acutely ill and	• Q1-2. Data captured within project team plan, presented to and endorsed by Critical Care Outreach Working Group (CCO WG). • Q3. Workshop/outreach summit held and responses captured.

What we will do	2023-24 Update on QP
deteriorating patient (RAID), Intensive Care National Audit & Research Centre (ICNARC) and local audit data (NEWS2). • Q2. Understand regional and Shelford Group Trusts escalation and outreach activity data. • Q3. Seek broader OUH stakeholder engagement and feedback on prospective plans.	
Action 2: Define outreach team composition • Q1. Identify preferred team composition, and training needs based on initial data analysis. • Q2. Benchmark against regional and Shelford Group peers. • Q3. Refine team composition (if required) following stakeholder engagement (see action 1, Q3) and benchmarking. •	• Q1. Composition of team by discipline and grade agreed by WG. Prospective rota templates generated to support. Training needs analysis completed. • Q2. Benchmarking evaluation and gap analysis completed by project lead and endorsed by WG. • Q3. Revised composition of team by discipline and grade, agreed by WG. Prospective rota templates generated.
Action 3: Defined milestones (in parallel with business case (BC) • Q1. Define recommended incremental development plan and project milestones for years 1-4. • Q3. Refine development plan based on BC progression (action 5) and stakeholder engagement (action 2, Q3).	• Plan endorsed by working group (WG). Risks identified.
Action 4: Business case progression • Q1. Complete and submit Business Case Initiation Proposal (BCIP) to Division. • Q2. Submit BCIP to TME. • Q3. Submit full BC to TME.	• Endorsed BCIP/BC by Q1-3.

What we will do	2023-24 Update on QP
Action 5 • Commence follow-up provision (first stage of outreach provision), subject to funding and BC approval. • Q3. Recruit initial staff. • Q4. Deploy limited service (dependant on HR process and availability of applicants).	Service activity evident and effectively communicated throughout the Trust.

Quality Priority 5: Surgical Morbidity Dashboard

Why is this a priority?

This Quality Priority builds on our previous year's work by supporting roll out of the recently developed Morbidity Dashboard for more widespread use across the Trust. Monitoring the occurrence of complications, identifying areas of higher-than-expected rates, and assessing if they were avoidable will help teams to improve the quality of care that is delivered. We expect that by allowing clinical teams to monitor their outcomes better, the morbidity dashboard will facilitate efforts to improve the safety of patients and help us deliver high quality healthcare.

What we will do	2023-24 Update on QP
Action 1 (Q1-4): • Train and encourage all surgical services at OUH on use of the Surgical Morbidity Dashboard for Morbidity & Mortality (M&M) meetings and by their Clinical Governance teams.	• At least 10 surgical services will have been trained and use the dashboard in their M&M meetings by end of Q4.
Action 2 (Q1-4): • Implement any identified service-specific improvements to the dashboard if required to improve functionality, on the basis of feedback from clinical services.	• Feedback collected, evaluated and incorporated as required. Dashboard improved to include at least one new procedure and one procedure-specific complication by the end of Q4.

Quality Priority 6: Reducing maternal and neonatal morbidity

Why is this a priority?

The rate of induction of labour (IOL) is rising both nationally and locally and is associated with higher maternal and neonatal morbidity and poor patient experience when induction of labour is delayed due to high maternity unit activity and workload. This Quality Priority aims to improve the management of workload within Maternity by improving the induction of labour booking process, improving consistency of safe Delivery Suite staffing levels out of hours and providing focused training in the management of high acuity workload for senior midwifery and obstetric staff with the overall aim of improving patient experience and reducing the frequency of morbidity indicators associated with birth, specifically obstetric anal sphincter injury (OASI), severe postpartum haemorrhage (PPH) rates and term admission to SCBU for babies.

What we will do	2023-24 Update on QP
Action 1 (Q4): Reduce delay in induction of labour process by reviewing Delivery Suite midwifery rostering and establishing a nominated IOL booking coordinator • A Maternity Working Group will review the midwifery staff rostering patterns with the aim of improving out of hours cover to allow adequate staffing to provide one to one labour care for women and thereby reduce the number of women delayed more than 24 hours during the process of induction of labour. • On average, 40-50 inductions of labour bookings are requested by midwifes and obstetricians per day which are processed, actioned and booked by midwives who are also providing induction of labour care on the antenatal ward. Provision of a nominated booking coordinator will allow midwifes to prioritise clinical care, rather than administrative process.	**Metrics:** • Expected and actual midwifery staff numbers over each 24 hour period • Number of women having IOL delayed >24 hours **Method:** Audit **Timeframe**: Quarterly **Objective:** Reduction in % of women having IOL delayed >24 hours (74% delayed >24 hours in baseline audit; stretch target <20%).
Action 2 (Q3): 'HARM – High Acuity Risk Management' Training Programme	**Metric:** Participant assessment score **Method:** Formal 'HARM' training

What we will do	2023-24 Update on QP
• Pilot of novel formal training on management of high acuity workload for doctors and senior midwives with real time simulation of multiple obstetric emergencies and focused training on primary prevention of PPH and OASI.	**Objective:** Improvement in participant assessment score pre and post 'HARM' training
Action 3 (Q1-2): Establish prospective monitoring of maternal and neonatal morbidity indicators in women having induction of labour • Women having induction of labour may experience delay in the process which is associated with higher levels of maternal and neonatal morbidity indicators. We will introduce prospective audit in women having IOL to monitor the impact of reduction in delayed IOL on morbidity. If there is no evidence of improvement in these morbidity indicators, we will undertake a thematic analysis to understand trends and patterns and introduce alternative interventions based on this analysis.	**Metric:** • Major Haemorrhage >1500 ml • Frequency of major transfusion (>2 units packed cells or use of FFP (fresh frozen plasma) for coagulopathy) • ITU admission following major haemorrhage • Obstetric anal sphincter injury • Unexpected SCBU admission in term babies without congenital abnormalities ((avoiding term admissions into neonatal units) ATAIN)) **Method:** Audit **Timeframe**: Quarterly **Objective:** Reduction in maternal and neonatal morbidity indicators in women having induction of labour

Patient Experience

Quality Priority 7: Reducing Health Inequalities

Why is this a priority?

The NHS Long Term Plan articulated a need to take a more systematic approach to reducing health inequalities. The OUH Health Inequalities programme was developed and agreed in 2022. It aims to address health inequalities across our own services whilst at the same time, building longer-term capability to promote the reduction of health inequalities and improved population health through working with partners in our local systems, developing population health management and recognising our role as an anchor institution. This Quality Priority builds on the progress made to date to embed the Trust's approach to health inequalities.

What we will do	2023-24 Update on QP
Action 1: Embedding consideration of Health Inequalities across the Trust • Raise awareness and engagement of services across the Trust in the Health Inequalities dashboards. • Incorporate health inequalities considerations into the planning and delivery of services across the Trust. • Integrate reporting on Health Inequalities in the business and reporting of the Trust's Delivery Committee.	• Services across the Trust access the health inequalities dashboards to explore if/where inequity exists. • Services across the Trust identify actions they can take which help tackle health inequalities. • Delivery Committee receives: i. A regular report on the progress of the OUH Health Inequalities Programme Plan. ii. Theme-base reports from clinical divisions with a focus on health inequalities aligned with the forward plan for areas of focus within the agenda of each meeting (e.g. cancer/diagnostics).
Action 2: Work with system partners promote the reduction of health inequalities • Work with system partners to identify marginalised health inclusion groups within our local population.	• Health inclusion groups identified for Oxfordshire. • Increased awareness and availability of resources to support staff to use MECC.

What we will do	2023-24 Update on QP
• Work with system partners to scale up the use of Making Every Contact Count (MECC). • Share insights identified from integrated reporting on Health Inequalities to support system-based actions and interventions.	• Share information on health inequalities with Health inclusion groups where there are system opportunities to reduce health inequalities and improve population health.
Action 3: Further develop our Anchor institution approach • Convene Anchor institutions across Oxfordshire to identify common areas for action where collaboration offers greatest value and benefit. • Work with system partners and community stakeholders to develop an Anchor 'roadmap' to steer activity to maximise the OUH potential to improve health through our influence on local social and economic and environmental conditions. • Convene an internal Anchor Working Group to steer the process of creating an Anchor Roadmap.	• Anchor institutions across Oxfordshire are convened and identify the potential areas for collaborative action. • An Anchor 'roadmap' is developed in collaboration with stakeholders and agreed by the Trust. • An internal Anchor Working Group is convened to steer the process of developing a roadmap.

Quality Priority 8: Patient Experience with PSIRF

Why is this a Priority?

We will develop an improvement plan for compassionate engagement of patients, families and carers who have been involved in high level patient safety learning response. This will be based on the NHSE / HSIB / Learn Together document outlining the 9 principles of Engaging and involving patients, families and staff following a patient safety incident. We will co-produce with Patient Safety Partners suitable tools to capture patient experience and improve our understanding of this part of the patient's journey.

What we will do	2023-24 Update on QP
Action 1: Q1 • Develop an improvement plan for Compassionate Engagement of patients, families and carers who have been involved in serious patient safety incidents.	Improvement plan drafted with contribution of current Patient Safety Partners. It will include: • Training provision for Engagement Leads. • Trust-wide communication about the role of engaging and involving patients following a patient safety incident. • Plan for recruitment of Quality Safety & Engagement Partners. • Review of the available tools to gather feedback from patients and families following involvement in a patient safety incident. • Development of a standard operating procedure (SOP) highlighting how to request feedback on the involvement experience.
Action 2: Q2-4 • Recruit a Patient Safety Partner (PSP) to contribute to into the work to address this Quality Priority through the development of the improvement plan and tools to capture patient experience.	• A PSP with relevant interest and skills will be recruited in line with the Level 4 Patient Safety Partner framework with a

	specific remit to contribute to the work related to this Quality Priority.
Action 3: Q1 • Co-develop with the PSP tools to capture feedback on the experience of being involved following a patient safety incident.	• Development of a survey to request feedback from patients and families following involvement in a learning response. • Development of a procedure for having a face-to-face conversation to feedback on the experience of being involved in a learning response.
Action 4: Q1 • Review and update tools following testing with different patient and family groups, community groups and other key stakeholders.	• Update survey tool and procedure using QI methodology following testing with relevant stakeholder groups. Tools will be refined following user testing to ensure they meet EDI criteria.
Action 5: Q2-4 • Scope other sources of information that can provide insight into patient and family experiences following investigations, for example through online forums or legal claims following an investigation.	• Scoping exercise undertaken to explore what forums are available and how data can be obtained.
Action 6: Q2-4 • Use feedback from tools developed and other sources of information to improve how patients and families are involved.	• Review data and update policies, procedures, and explore additional training requirements as required.

Quality Priority 9: Improving quality of care for fragility fracture patients at OUH

Why is it a Priority?

The results of the National Hip Fracture Database (NHFD) demonstrate that at the John Radcliffe site there is a need to shorten the time taken for hip fragility patients to access surgery.

The Horton site has delivered care that regularly meets the National Standards.

This Quality Priority aims to combine a number of quality improvement (QI) workstreams to improve performance (time taken to get to theatre) and therefore reduce morbidity and mortality.

What we will do	2023-24 Update on QP
Action 1: Improving percentage of non-ambulatory fragility fracture (NAFF) patients operated on within 36 hours • Q1: Development of a SOP to allow escalation of theatre capacity concerns, and creation of additional emergency trauma capacity in OUH Theatres. • Q2: Change in trauma consultant rota to allow more flexibility to deliver extra lists. • Q3: Review of demand and capacity following above changes and understanding opportunities from new theatre build if additional theatre capacity needed. • Q4: Implement Geriatric Orthopaedics (GO) & Anaesthetic review on day of admission. • Q4: Expand to a 7-day trauma coordinator service.	• Q1: Surge capacity Trust Procedure in place. • Q2: New trauma consultant rota in place. • Q3: Demand and capacity modelling available. • Q4: Business case to deliver 7 day trauma coordinator service submitted to BPG. • Q4: BPT (Best Practice Tariff) (Time to theatre <36hours) >85% performance.
Action 2: Improving therapy access to NAFF fracture patients	• Q3: Business case submitted to BPG.

• Q2-3: Submission of a business case to allow 7-day daily access to therapy services. • Q4: Appointment to expanded therapy posts. • Q4: Implementation of 7-day physiotherapy services to allow all fragility fracture patients to be mobilised on day or day after surgery.	• Q4: New therapists in post. • Q4: Improved NHFD metrics (key performance index (KPI) 4: Prompt mobilisation after surgery). • Q4: Reduced acute length of stay.
Action 3: Improving multi-speciality working to care for NAFF fracture patients • Q1-2: Workforce review to deliver a daily multidisciplinary meeting including theatre teams to facilitate preoperative care and shared decision making. • Q2-3: Workforce mapping and capacity modelling to deliver equitable orthogeriatric care across all OUH sites and provide 7 day cover. • Q2-3: Trauma anaesthetic workforce review and gap analysis to support a business case to increase number of trauma anaesthetists to support earlier pre-operative reviews.	• Q1: Daily MDT meeting in theatre. • Q3: Workforce demand and capacity modelling completed. • Q4: Business cases as required – orthogeriatric service and trauma anaesthetist submitted to BPG.
Action 4: Improving Cohorting of NAFF patients • Q1: Develop pathways/SOPs for cohorting of NAFF patients to facilitate specialist Medical/Nursing/AHP care. • Prioritising initial perioperative care in the trauma unit (familiarity of staff, facilitation). • Q2: Feasibility study on how to deliver pathways sustainably including a review of demand vs bed capacity to reduce outliers.	• Q2: Pathways agreed and supported by SOPs. Enacted where possible. Nominated NAFF Ward/cohorted beds, outside of Trauma Unit footprint in place. • Q2-3: Feasibility study completed.

• Admission of all operative NAFF fracture patients to specialist trauma ward from ED with cohorting of NAFF patients for care after the initial peri-operative period. • Q4: Develop business case if needed.	• Q4: Number of unnecessary outlier NAFF patients to be minimised outside of Trauma Unit and/or dedicated NAFF ward. • Q4: NHFD KPI 0 – Greater than >85%.
Action 5: Nutrition and fasting process • Q1: Introduce 'Sip until Send' policy for non-ambulatory fragility fractures. • Q2-3: Develop business case for nutritional assistant.	• Q3: Audit of 'Sip until Send' administration on EPR / Audit compliance with hip fracture power plan which includes Ensure juice administration. • Q4: Business case submission to BPG. • Q4: Improve MUST (Malnutrition Universal Screening Tool) compliance on NHFD.

Annex 2: Statements from commissioners, Governors, local Healthwatch Oxfordshire organisation and Overview and Scrutiny Committees

Council of Governors Statement

Governor Response to the 2023/24 Quality Account

The Council of Governors has reviewed the 2023/24 Quality Account, which provides a comprehensive summary of the Trust's achievements and challenges in delivering high-quality care to patients. We appreciate the opportunity to comment on the document and to prepare a statement of response, which reflects our role as a critical friend of the Trust.

Governors have had the opportunity to comment on the report, with a detailed discussion at the Patient Experience, Membership and Quality Committee, which was joined by the Director of Clinical Improvement, who summarised the report and invited the Committee to comment on the draft document. Feedback from the Committee was incorporated into the final version where relevant.

This account is very detailed and comprehensive, with additional information in comparison with the Quality Account from 2022/23. Given that many people will not have the opportunity to read it in full we would welcome the production of a summary version based on the presentation provided to the PEMQ Committee.

We welcome the Trust's approach to quality improvement, which is embedded in the culture and practice of the organisation. We are pleased to see the progress made against the quality priorities for 2023/24, and those that have been agreed for 2024/25. These were informed by the Quality Conversation event with a wide range of stakeholders including governors. We are also encouraged by the Trust's use of the Patient Safety Incident Response Framework (PSIRF), which aims to foster a culture of learning and improvement from incidents. We appreciate the Trust's openness and transparency in reporting and investigating Never Events and other serious incidents, and the actions taken to prevent recurrence and to share learning.

Governors are impressed by the Trust’s aspirations for changing behaviour and practice but encourage it to consider how best to measure and quantify the impact of changes across different services so as to ensure rigour in defining and evaluating objectives so that these are realistic and meaningful.

The use of safety huddles within the organisation was welcomed but governors are interested in understanding how the Trust learns from them and makes changes based on them, and how that learning is disseminated across the Trust. Governors also suggested that it would be useful to incorporate information from the Patient Advice and Liaison Service (PALS) on the main themes that patients raise with them regarding their care.

We note the areas where the Trust has identified the need for further improvement, such as in response to the CQC inspection of the Horton General Hospital midwifery-led unit and in the patient

experience of administration for appointments. We welcome the plans and initiatives that the Trust has put in place to address these issues, and we will continue to monitor their implementation and impact through our committees and meetings. We also recognise the ongoing challenges that the Trust faces in reducing waiting times, managing demand and capacity, and ensuring staff wellbeing and retention. We urge the Trust to maintain its focus on these priorities.

We commend the Trust for its resilience in the face of the challenges posed by industrial action, which have tested the capacity and capability of the NHS. Governors are impressed by the dedication and commitment of all staff, who have continued to support the provision of compassionate, safe, and effective care to patients in these difficult circumstances. We are proud of the many examples of excellence and improvement that are showcased in the Quality Account, such as the womb transplantation programme, the use of CAR-T therapies, and the development of radiotherapy centres to provide care closer to home for cancer patients. We also congratulate the teams who have received awards in recognition of their work.

Overall, we are confident that the Quality Account reflects the Trust's commitment to delivering high standards of care and improving outcomes for patients and the public. We thank the Trust for its hard work and achievements in 2023/24, and we look forward to supporting its quality improvement journey in 2024/25.

Graham Shelton

Lead Governor

Gemma Davison

Chair of the Patient Experience, Membership and Quality Committee

Statement from NHS England Specialised Commissioning

To: Professor Meghana Pandit
Chief Executive Officer

Oxford University Hospitals NHS Foundation Trust
John Radcliffe Hospital
Headley Way
Headington
Oxford
Oxfordshire OX3 9DU

NHS England
Premier House
Reading
RG1 7EB

6th June 2024

Dear Professor Pandit

Re: Quality Account 2023-2024

Thank you for sharing the Oxford University Hospitals NHS Foundation Trust (The Trust) 2023/2024 Quality Account with NHS England as the commissioner of Specialised services. I would like to express my thanks to the team in recognition of the continued hard work and dedication to the delivery of specialised services.

The Quality Account demonstrates the Trust's commitment to providing high quality care to patients accessing its services and it is pleasing to see an aim to continuously improve performance through Quality improvement tools across the key domains of Patient Safety, Patient Experience and Clinical Effectiveness.

The focus on the implementation of the Patient Safety Incident Response Framework (PSIRF) with Trust Board approval of the PSIRF policy and plan supporting the application of a Just Culture encourages Quality Improvement whilst ensuring a fair and consistent approach towards staff involved in patient safety incidents. Several initiatives have been developed that support the patient safety culture that include opportunities for collaboration and shared learning.

In response to the Thirlwall Inquiry the Trust have highlighted to staff the importance of feeling able to speak up safely and raise patient safety issues without detriment. The promotion of the role of Freedom to Speak-Up Guardians and implementation of the Raising a Concern website in addition to the Trust's incident reporting system provide guidance to staff and reinforces the Trust commitment to ensuring staff feel safe to speak up.

It is acknowledged that Patients on a Referral to Treatment (RTT) waiting list at OUH increased by 12% from March 2022 to February 2024 and that a contributing factor was industrial action. The continued commitment to reduce waiting times for patients is acknowledged and it is encouraging that clinical harm reviews for patients with treatment delays to identify both psychosocial and clinical harm are integral while waiting list challenges remain.

It is noted that the Trust's cultural shift towards continuous improvement has yielded some positive results, with 60% of staff now able to make improvements at work and over 1000 staff completing Quality Improvement training over the last 2 years.

Outcome data for patients obtained through participation in clinical audit, including the Cleft Registry and Audit Network (CRANE) and the National Neonatal Audit Programme (NNAP) is favourable with areas of achievement also noted in the Sentinel Stroke National Audit Programme (SSNAP), National Oesophago-Gastric Cancer Audit (NOGCA) and National Congenital Heart Disease Audit.

It is pleasing to see the OUH Reporting Excellence (RE) Programme, enabling staff to provide positive feedback and gratitude to colleagues has continued to flourish, with over 3000 reports completed in the last year.

Following the CQC inspection of the Midwifery-led Unit at the Horton General Hospital it is disappointing to find that the unit 'Requires Improvement' for both Safe and Well-led but it is noted that the Trust is developing an action plan in response to the report and that this will be monitored until completion.

The Trust's willingness to understanding and respond to patient experience using a variety of tools is appreciated. Results from the Friends and Family test 2023-2024 are excellent with 92% of patients rating their experience as good or very good. A project being undertaken by the Patient Experience Team to develop an interactive dashboard to analyse feedback and inform quality improvement projects may further improve patient experience.

It is encouraging to see that the Trust has made good progress against its quality priorities for 2023-2024 but also noted that several priorities have not yet reached a satisfactory conclusion. South East Specialised Commissioning encourage input to continue into these areas and looks forward to celebrating the achievement of completion in due course.

South East Specialised Commissioning give recognition to the leadership of the clinical team in the effort and focus on improved patient safety enabling the reintroduction of gynaecological cancer surgery. Proactive participation in the clinical genetics quality review is appreciated and input into the paediatric spinal review with the commitment to improve waiting times and Infection Prevention Control with the introduction of the infection bundle is acknowledged.

It is reassuring that understanding, improving and monitoring health inequalities remains a focus and priority for 2024-2025 thereby supporting the OUH Health Inequalities Programme.

South East Specialised Commissioning is in support of the quality priorities in place for 2024-2025 and the evaluation criteria set against them. We look forward to continuing to work collaboratively with the Trust on their priorities during the coming year to support the quality improvements identified.

Yours sincerely

Rosie Baur

Interim Director of Nursing, Direct and Specialised Commissioning NHS England South East

Statement from Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB)

NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Professor Meghana Pandit
Chief Executive Officer
Chief Executive's Office
Level 3, John Radcliff Hospital
Headley Way
Headington
Oxford OX3 9DU

BOB ICB
First Floor
Unipart House
Garsington Road
Cowley, Oxford
OX4 2PG

rachael.corser@nhs.net

14 June 2024

Sent by email to meghana.pandit@ouh.nhs.uk

Dear Meghana

RE: Quality Account 2023/24

NHS Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) has reviewed the Oxford University Hospitals NHS Foundation Trust (OUHFT) Quality Account 2023/24, and we believe that it is accurate and meets the requirements of a Quality Account. The account provides a clear picture of the quality of care provided by OUHFT as well as of the ways in which the Trust seeks to understand the quality of care it provides and the huge range of quality improvement, research and innovation undertaken by the Trust.

Of the 50 actions which make up the 2023/24 Trust Quality Priorities, 28 have been fully completed, 21 partially completed and only one not completed. The work on reducing falls is to be commended and we welcome the extension of this focus to further improve the level of harm free care. Reducing health inequalities is a national priority and a key focus for the BOB system. It is essential that we have high quality data to support this ambition. Early work on improving data collection needs to be built on to support this vital system goal. We welcome the continuation and further development of this priority in 2024/25. The ICB would also like to see a clear alignment between the Trust's Quality Priorities and the overall Integrated Care System goals as set out in the Buckinghamshire, Oxfordshire and Berkshire West Joint Forward Plan.

The National Quality Board now includes the dimensions of sustainability and leadership to its definition of quality in addition to the established areas of safety, effectiveness, and experience. We would encourage the consideration of these additional dimensions in the Trust's Quality Priorities.

Kindness into Action is an important and timely quality priority. We commend the Trust's work in this area and note the measurable results of this initiative. The link between culture, civility, psychological safety, staff wellbeing and patient safety is well established. We know that when things go wrong within organisations it is frequently the culture which

prevents early detection and rectification. We welcome the Trust's efforts in this complex area.

We note some of the priorities have been continued into 2024/25, ensuring that the focus continues in these important areas. Medicines safety, care of the frail elderly and the further development of the surgical morbidity data all continue into next year. The ICB welcomes the Critical Care Outreach Priority. The achievement of this priority is crucial to meeting the requirements of Martha's law.

The ICB welcomes the fragility fracture pathway being made a quality priority for the coming year. Urgent access to theatres is a significant patient safety issue and we welcome the work to ensure that the pathway is improved. The Horton Hospital has a hip fracture pathway which is a national exemplar. The achievement of similar timescales on the John Radcliffe Hospital site would lead to a significant reduction in morbidity and a greatly improved patient experience.

The Patient Safety Incident Response Framework (PSIRF) is a new approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. The OUHFT has embraced this change and has been a leader in Buckinghamshire, Oxfordshire and Berkshire West in making the changes. The new framework shifts the focus from looking at harm to understanding where there is potential for learning. The new approach puts patients at the centre and allows the Trust to focus on the areas where improvement is needed. OUHFT has worked with partners across BOB to introduce PSIRF and we look forward to continuing to work together on system-wide safety priorities.

OUHFT has a process in place to identify harm in patients who are waiting longer than expected by national standards. The ICB notes the work done to reduce those patients waiting a very long time.

The mortality rates at OUHFT remain stable and continue to compare well, with both Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) well below the expected level. The embedding of the medical examiner system and the development of community medical examiners further increases the potential to learn from deaths. The ICB will continue to work with system partners to ensure the whole patient pathway is considered and mortality in a wider context. We look forward to continued work with the Trust in this area.

The quality account provides infection prevention and control (IP&C) data of reportable healthcare associated infections. This data indicates that OUHFT have higher than national counts per bed day although clarifies that the figures are not corrected for OUHFT activity. The account does not include any measures of performance, specifically IP&C compliance monitoring. It would be helpful to provide greater clarification to include reference to action plans that have been put in place to mitigate these rates.

The Learning Disability Improvement Standards described in the quality account are an important tool for improving the experience and outcomes of people with learning disabilities and/or autism in NHS services. These improvements are crucial to address the differences in access and outcomes for this disadvantaged group. The quality account would benefit from some detail on how experts by experience have been involved in co-design and service improvement.

The Thirlwall Inquiry has been set up to investigate the events at the Countess of Chester hospital following the conviction of Lucy Letby. The OUHFT is to be commended for the

Response to the BOB ICB

Suggestions from ICB	Commentary
'The National Quality Board now includes the dimensions of sustainability and leadership to its definition of quality in addition to the established areas of safety, effectiveness, and experience. We would encourage the consideration of these additional dimensions in the Trust's Quality Priorities'	**Leadership** These will be considered in our Quality Priorities next year. Background: In October 2023 OUH launched its new Leadership Development Programme (LDP) for Directorate Managers, Clinical Leads, Matrons, new Clinical Directors and nominated deputy roles from the 18 Directorate Management teams. The goal was to deliver 4 cohorts of this programme by the end of 2024 and we are on track to deliver this. **OUH LDP Programme Goal** To develop and empower this leadership group to take accountability and to develop the leadership skills to enact change within OUH and the broader system. **Programme Objectives** • To develop self-awareness, leadership skills and capability • To empower our leaders to enact change. • To create space to develop networks and partnership working. • To embed the Trust's commitment to EDI so that leaders are acting on new awareness, developing new behaviours and embedding these in their leadership practice. • To support our leaders to build a culture of trust and psychological safety to enable their teams to thrive.
	Sustainability These will be considered in our Quality Priorities next year. In 2023-24, the Trust calculated its carbon emissions for those activities over which it has direct responsibility, such as energy, water, waste and business miles. We have improved our data collection, so it is both more granular and of a higher quality. We have now compared this to last year which is our base year and look at *relative* emission as well as *absolute* emissions to take account of areas of expansion but where we emit less carbon pre mile/dose or m^2. We also look at fugitive emissions from our fluorinated gases such as refrigerants, over and above the NHS methodology. The Trust has participated in a new carbon accounting methodology trial called E-liability. We are the first healthcare setting to have joined the trial and completed the calculations

Suggestions from ICB	Commentary
	for a procedure. This work will inform global carbon accounting improvements.
Infection, prevention, and control *'The account does not include any measures of performance, specifically IP&C compliance monitoring. It would be helpful to provide greater clarification to include reference to action plans that have been put in place to mitigate these rates.'*	C. difficile rates are rising nationally, and the rate reported in England in March 2024 is the highest for 7 years (21 cases/100,000 bed days, AMR local indicators - produced by the UKHSA - Data - OHID (phe.org.uk)). Current C. difficile rates in the OUH are in line with other Shelford group teaching hospital Trusts and are stable when compared with 2022-23. A C. difficile questionnaire is linked with Ulysses incident reporting. No major themes have been identified. Potential outbreaks (2 or more cases connected by location within a short time frame) are investigated by Ribotyping. Some evidence of nosocomial transmission has been demonstrated on a medical ward, but other outbreaks have shown only unlinked cases. Proactive work is in place in the OUH to minimise the occurrence of C. difficile infection. We have recently introduced: • Additional testing to identify those patients who are carriers of toxigenic strains but do not have C. difficile infection. • Isolation of patients who are carriers of toxigenic strains as these patients can still transmit C. difficile. • Pre-emptive treatment of patients who are carriers of toxigenic strains to reduce development of C. difficile infection and environmental contamination. • 6 day a week on-site infection prevention and control and antimicrobial stewardship (AMS) service • A trial of regular cleaning with a different disinfectant across level 7 of the JR hospital. • Block booking of enhanced cleans to avoid missing enhanced cleans due to requesting. • A cleaning improvement project between infection prevention and control team and medical wards at JR resulting in sustained improvement in cleaning scores. • Questionnaire for C. difficile cases reviewed and updated to reduce time spent investigating and more on proactive work. A quarterly report from Ulysses is being developed to be able to more easily identify themes from completed questionnaires.

Suggestions from ICB	Commentary
	• Modification of Microguide to further reduce the empirical use of 'C. diffogenic' antibiotics such as Ciprofloxacin and Co-amoxiclav • AMS ward rounds – 340 ward rounds took place in 2023-24, compared with 147 in 2022-23, including both adult and paediatric patients. 4,244 patients received a formal AMS team review, and 2,468 interventions were made (58%). This is in addition to the regular antibiotic reviews performed by the Infection Team across all 6 intensive units in the OUH, and the infection team consult work. • Use of data to monitor antibiotic consumption at divisional, directorate and speciality level to identify areas to target for improvement by the AMS team. • Introduction of metrics for the monthly divisional reports to HIPCC which show the divisions consumption of antibiotic in the "Reserve, "Watch" and "Access". • Monitoring the use of antibiotics most likely to be associated with the development of *C. difficile* infection to support learning from C. *difficile* cases, and to guide which antibiotics to target on AMS rounds. • Education for clinical teams and divisions about their prescribing practice and consumption, including audit and individual feedback. The OUH has made good progress against the NHS National Contract in England for 2023-24 with target of a 10% reduction in consumption of antibiotics in the "Reserve" and "Watch" categories from World Health Organisation (WHO) AWaRE classification (adapted) against a 2017 (calendar year) baseline value. At the end of Quarter 3 23/24 the data shows that OUH has a 6.6% reduction against the baseline value. Quarter 4 data is not yet available.
HGH CQC report *'More specific detail about the positive aspects of the Horton CQC maternity report would be welcomed, as well as clear demonstration of the achievements of the maternity incentive scheme, the maternity*	The Maternity Services Update Paper is a monthly public paper and provides a detailed overview of the current status and future plans for maternity services. It includes updates on the **CQC inspection action plan**, highlighting the progress made and the actions still pending. The paper also discusses the **Maternity Incentive Scheme (MIS)** where the service has successfully completed all ten safety actions and the **Maternity Safety Support Programme (MSSP)**, outlining the objectives and achievements of these initiatives. The **Ockenden Assurance** is another key focus, with the paper detailing the steps taken to comply with the Ockenden

Suggestions from ICB	Commentary
safety support programme, progress with the deliverables of year one of the single delivery plan for maternity and neonates, and the essential actions of the Ockenden report.'	recommendations. Lastly, the paper presents the **three-year delivery plan** for maternity and neonatal services, which sets out the strategic direction and goals for the upcoming years. The paper serves as an essential document for the Trust Board to ensure that maternity services are aligned with the required standards and are moving towards the set objectives. Maternity Services Update Report (ouh.nhs.uk)

Statement from Health and Wellbeing Board

OXFORDSHIRE COUNTY COUNCIL

Professor Meghana Pandit
CEO
Oxford University Hospitals NHS Foundation Trust
Manor House
John Radcliffe Hospital
Oxford
OX3 9DU

By email

The Leader's Office
Oxfordshire County Council
County Hall
New Road
Oxford
Oxfordshire
OX1 1ND

Councillor Liz Leffman
Leader of the Council

30 May 2024

Dear Professor Meghana Pandit

Thank you for the opportunity to comment on the OUH's Draft Quality Account for 2023-24.

It has clearly been a busy year at the OUH and there is much to celebrate within the report. I noted with interest the implementation of the new Patient Safety Incident Response Framework in October 2023 which appears to have provided a new and positive overarching approach to patient safety in the trust. I was reassured to see how you have prioritised patient safety during times of industrial action which I am sure has been very challenging at times. I agree with your comment on the Lucy Letby case as we were all deeply saddened by this incident. The actions you have put put in place to ensure your staff are able to speak up and raise concerns when they need to are of great importance.

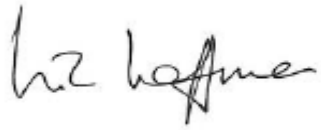
I was pleased to see the progress made against the 2023-24 quality priorities and look forward to seeing more progress against those rolled over into the 24-25 year. I welcome the OUH having health inequalities within both the 23-24 and 24-25 quality priorities. As you know, this remains a fundamental principle of our new Oxfordshire Joint Health and Wellbeing Strategy published in January this year and we will only make progress in addressing the avoidable and unfair differences in health we see between different groups of residents locally if we all work together on this. I would therefore encourage you to continue to reach out and work across the system on areas of your quality work like this. I know the innovations with our ICS such as the Provider Collaborative mean provider trusts are working more closely together and would be interested to see what shared quality priorities across our system might look like in future years. There are many opportunities for NHS organisations to take action to address the climate crisis we are facing, and this could be an area to consider for a future system-wide quality priority. I was pleased to see that local residents have been involved in the setting of 24-25 quality priorities through your quality conversation event in December as we must not

underestimate the importance of putting patients themselves front and centre of all that we do.

I share your disappointment in the outcome of the CQC inspection of maternity services at the Horton Hospital and the overall rating of Requires Improvement for the hospital as a consequence. I am reassured to read of the action taken to address the challenges and the Board's commitment to delivery of crucial services from the Horton site. I am very aware of the important role the Horton Hospital plays in the Banbury area and how highly valued it is by local residents. This of course includes the clinical service provision from this site but also the role it plays as an Anchor Institution in the local area.

Thank you again for the chance to comment on your Quality Account. As the Chair of the Oxfordshire Health and Wellbeing Board, I welcome the input the OUH provide to this partnership and look forward to our continued partnership working in the coming years.

Yours sincerely,



Cllr Liz Leffman
Leader, Oxfordshire County Council
liz.leffman@oxfordshire.gov.uk

Statement from Healthwatch Oxfordshire

healthwatch Oxfordshire
Your voice on health and care services

Sent by email to Professor Meghana Pandit, Chief Executive Officer, Oxford University Hospitals NHS Foundation Trust
meghana.pandit@ouh.nhs.uk

May 28th 2023

Dear Professor Pandit,

Oxford University Hospitals NHS Trust Quality Account 2023-4

Thank you for letting Healthwatch Oxfordshire have sight of the Trust's Quality Account 2023-24 prior to publication.

The account gives a clear insight into the breadth of work being undertaken towards improving quality of services across the Trust, and indicates, in spite of a challenging year with increased demand that you remain committed to improving quality. It is clear as an organisation that you demonstrate openness to ongoing learning and review from both to the positive and the insights of challenges you face.

Again, we welcome the Trust's continuing commitment to *'putting patients, carers, families at the heart'* of everything you do.

We note reference to the work of the Patient Experience Team, and commend the efforts made to bring patient, carers and those with lived experience into service development, listening events, and design of patient facing information. Healthwatch Oxfordshire has developed strong links with this team, and welcome efforts to ensure the Trust embeds more proactive responses to our reports and insights shared – however, we would like to understand more clearly how our reports and feedback are used and embedded within the reviews of patient experience and quality improvement discussions as a whole.

We note the focused work with members of the D/deaf community to bring improvements to the interpreting and translation support given to people with language and communication needs, something that we have given feedback on following meetings with the D/deaf community this year.

Progress has been made, again, bearing in mind operational constraints- towards for example, aspirations to re-lunch of Patient Participation Groups.

The value of bringing qualitative data, patient stories and lived experience into building improvements to services is clear. It can also be brought into the clinical research work that the hospital is involved in. This should also include hearing from carers in some of the discussions. OUH as noted works with a range of academic and other research partners. Links to the emerging Oxfordshire Community Research network could also be noted – as a way of ensuring that communities are also at the heart of research. The Anchor event held in autumn 2023, also showed OUH reaching out to hear from communities.

It is positive to see the continued clear focus on tracking and understanding health inequalities- and impact on access, uptake and treatment. Some progress has been made on data collection around ethnicity, although you have identified where progress needs to continue.

We welcome the application of this especially in the area of maternity care. Healthwatch Oxfordshire has attended some OUH maternity inclusion events, and welcomed the work being done to reach into wider communities in order to hear their experiences, in order to develop care and identify barriers. Translation of information leaflets is welcomed.

You note in passing some aspects of your work aligned to BOB ICB and partnerships. Increasingly work is being undertaken across the health and care system, and OUH contribution to Oxfordshire Place Based Partnership has supported this focus on ways to improve 'joined up' care around patients. The work around Discharge from Hospital pathways and streamlining patient flow is an example of this and could be noted in the context of improving not only discharge rates, and it is hoped patient recovery.

Clear and transparent communication with the public remains key – in the context of the challenges to the health service, including waiting times and cancelled appointments.

We would also urge you to continue to ensure the final Quality Document (and all documentation) is accessible, clear, jargon and acronym free and in plain English to

healthwatch Oxfordshire
Your voice on health and care services

ensure that members of the public can easily understand it – including clearly explaining data tables, scoring and comparative sources. For example the tables pages 97 onwards, and table 21 (p.119) - perhaps could be more easily interpreted for a lay reader with e.g. a Red/Amber/ Green to show improvement/other, and the indicator on p.98 of patient feedback – the numerical scales could be explained – 1-10 is 10 good or 1?

On a final note, I draw attention to the reports Healthwatch Oxfordshire has produced over the last year with focus on OUH services, based on what we have heard from patients, families and staff. Some of these reports give further qualitative insights into the areas addressed in the OUH Quality Report.
All reports from 2023-4 can be seen here https://healthwatchoxfordshire.co.uk/reports including:

- **Enter and View** visit reports https://healthwatchoxfordshire.co.uk/our-work/enter-and-view/ : reports published: A&E John Radcliffe (April 2023) Oxford Children's Hospital (April 2023), Oxford Haemophilia and Thrombosis Centre (July 2023), Day Case Unit- Horton Hospital (Aug 2023).
- **Research Reports of relevance to OUH**: Long Covid (May 2023), Podiatry and Footcare (Aug 2023), How People Experience Joined Up Care in Oxfordshire (Oct 2023), Community Research in Oxfordshire (Nov 2023), Maternal Mental Health in Oxfordshire (Dec 2023).
- **Our ongoing feedback** to OUH Patient Experience Team on what we heard e.g. in November 2023, from Oxford D/deaf meeting and Action for Deafness on interpreting services and accessibility challenges at the hospital

Finally, we thank all staff at the Trust for their continuing commitment to provide a quality, caring and safe service for the community of Oxfordshire. Feedback from the public about their care to Healthwatch Oxfordshire show how much the public value all that the staff do – including good communication, patient centred and compassionate care.

Yours sincerely,

Veronica Barry

Dr. Veronica Barry,
Executive Director- Healthwatch Oxfordshire.

Healthwatch Oxfordshire
Registered office: Healthwatch Oxfordshire, Office 1, Cypher House, Bampton Business Centre South, Weald, Oxon, OX18 2AN
T: 01865 520520 W: www.healthwatchoxfordshire.co.uk
Registered in England and Wales as a Company Limited by Guarantee, No: 8758793
Registered Charity number 1172554

Statement from Health, Overview and Scrutiny Committee (HOSC)

FEEDBACK REPORT OF: THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (HOSC): Oxford University Hospitals NHS Foundation Trust Quality Account 2023/2024.

REPORT BY: HEALTH SCRUTINY OFFICER, OXFORDSHIRE COUNTY COUNCIL,

The Oxfordshire Joint Health Overview Scrutiny Committee (JHOSC) welcomes the Oxford University Hospitals NHS Foundation Trust (OUH) quality account for the year 2023-2024 and is pleased to see the extensive effort and level of detail that has been invested into producing this year's quality account. The account provides a good and comprehensive overview of key activities and developments within the Trust over the past year, and the JHOSC would like to congratulate the Trust on the improvements it has made in the realm of safety as well as around the effectiveness of treatments for patients.

This quality account has provided useful insights into the following:

- What the Trust has been doing well over the past year.
- The potential areas where improvements in the quantity and quality of services are needed.
- The Trust's priorities for improvement in the following year.
- The degree to which the Trust has been involving patients/residents who utilise its services, as well as staff, in determining these priorities for improvement.

Below are some key feedback points and reflections that the JHOSC has on specific themes. These themes have also been drawn from the quality account. The themes below are generally directly related to the content of the quality account, although they may contain broader reflections on the Trust's services as a whole.

Staff engagement and culture: The Committee is pleased to see that there is evidence of improvement in staff engagement and staff culture. However, it is crucial that the Trust routinely monitors and measures the impact of the staff wellbeing initiatives, such as the kindness interaction training, the 'time to talk' sessions and the 'freedom to speak up' platform. The Trust should indeed utilise both quantitative and qualitative data, such as staff turnover, sickness absence, feedback, complaints and incidents, to assess the effectiveness of the initiatives and identify areas for further improvement. It is therefore important for staff to feel that their voices are being sufficiently heard, and this can be achieved through providing both avenues for them to be heard as well as concrete actions which the Trust can commit itself toward in demonstrating that they are taking the voices and concerns of staff into account.

Martha's rule: The Committee welcomes the Trust's commitment to adopt Martha's rule. Nonetheless, there could be some further clarity around the process of applying Martha's rule in the day-to-day treatments and activities undertaken by the Trust. The quality account makes reference to round-the-clock rapid reviews, which is a positive development. Although, further details on how these rapid reviews will occur, as well as around the extent to which there is adequate resourcing for such frequent reviews, would be required so as to provide reassurance to patients and their families. The Committee is pleased to hear that the Trust has embarked on strengthening and implementing systems to enable patients and carers to speak up if they have concerns about patient care. Patients (including their families/carers) should have a voice and avenue through which they can express concerns relating to their care. This could also help to instil further confidence in the Trust and its services by patients and their loved ones.

Patient safety during industrial action: The commitment to patient safety demonstrated during industrial action is welcomed by the Committee, and it is good to see that this has involved the use of extensive planning and preparation in advance of strikes, patient harm reviews, and Trust-wide debriefs subsequent to each period of industrial action. Nonetheless, it is also key to share the Trust's evaluation of how it has performed in periods of industrial action. This should ideally include elaborations on the degree to which the three aforementioned measures produced positive outcomes.

Medicines safety: Medication safety is an area highlighted by the quality account, and this is also a topic of significant interest for the JHOSC. It is crucial that there is more clarity around the remit of the Trust's initiatives on medication safety, particularly in the context of current significant medicine shortages affecting various medical areas, including epilepsy. However, the Committee was pleased to hear that the Trust is aware of this and that it is actively managing medication safety within its medicine safety framework. Additionally, in light of reports of nationwide medicines shortages, the Committee urges for there to be continuous efforts to mitigate the impact of medicine shortages on patient safety.

Learning from deaths: A key focus of the quality account is on learning from deaths. The JHOSC notes that work continues across the Trust to further improve timely completion of death notification summaries level 1 mortality reviews, and urges that every effort and possible resource is dedicated toward the timely completion of these. Furthermore, although the reviews of deaths indicate that there have been no unavoidable deaths, perhaps more reassurances could be provided as to how these conclusions are reached. Considerations could also be given as to whether certain deaths would be indirectly unavoidable, as opposed to only being directly unavoidable. Additionally, it is crucial that the families and carers of patients are also involved with the process of learning from deaths.

Patient involvement in safety incidents: The Committee would like to emphasise the importance of involving patients who have experienced safety incidents in the feedback and improvement process. It is crucial that patients are informed about the follow-up actions and improvements made after such incidents. The Committee is pleased to hear of the existence of patient engagement leads in each division who are responsible for maintaining communication with patients affected by safety incidents, and that the Trust is recruiting patient safety partners to enhance this engagement. In essence, all efforts should be made to ensure that patients are aware of, as well as involved in, the learning and improvement processes following safety incidents.

Reliance on agency staff: The Committee remains concerned in regard to the continued reliance on agency staff, but notes and appreciates that this issue spans across various NHS organisations nationally. There are indeed potential risks associated with using a different workforce, and the Committee has received reports/feedback from residents regarding incidents involving agency staff. It is important that agency staff are integrated and that they interact with the Trust in the same manner as substantive staff as much as possible. This should constitute a key part of the Trust's efforts to maintain high standards and continuous improvement, regardless of whether the staff are permanent or agency workers.

Staff safety: The Committee feels that whilst the quality account makes reference to staff wellbeing, there could have been further elaboration on the measures taken by the Trust to improve staff safety. The JHOSC understands that staff safety remains a national issue. NHS staff can often be subjected to verbal and physical aggression or abuse. It is vital that staff are confident, as well as able, to report incidents of verbal and physical aggression against them whilst at work. These reports feed into patient safety responses and the health and safety team. Consideration could be given to the use of behavioural contracts with patients in extreme cases, as this could help to address such issues. If staff feel safe and secure in the environment that they work in, this would help to improve the ways in which the Trust delivers its services overall for patients. Whilst the wellbeing of patients is crucial, so too should be the wellbeing of those staff helping to treat these patients.

Metrics for quality priorities: The Committee feels that there should be ease (for the Trust as well as the wider public) in identifying appropriate metrics for various priorities, such as waiting times and patient safety, and the baseline for these metrics. Collaboration with local clinical teams to identify quality priorities and metrics is key. This should include determining the baseline, defining success, and deciding how to measure and report progress. The JHOSC appreciates the challenges with setting and achieving goals within a year that are both realistic yet stretching for the Trust. Nonetheless, this is still a necessary undertaking. The Trust's quality priorities should be as measurable and as impactful as possible.

Waiting times: The Committee is aware of the challenges experienced by the Trust around waiting times for patients. Patient waiting times are indeed a national issue and long wait times are not unique to Oxford University Hospitals NHS Foundation Trust. Nonetheless, the Trust could potentially expand on how as well as why long wait times continue to be a

challenge. It is crucial that the Trust outlines with clarity the measures it plans to embark on to reduce wait times. Additionally, there is also a point about providing regular communication and support to patients who are experiencing long waits for diagnosis or treatments.

Maternity services at the Horton: The Committee is aware of the CQC inspection of the Midwifery-led unit at the Horton General, and that the service was rated as Requires Improvement under the domains of 'Safe' and 'Well-led'. The Committee has also separately received reports of mothers having poor experiences with maternity services. The Committee therefore urges that the Trust make every effort to hear and understand the concerns of those who have had poor experiences with the service, and an improvement journey is embarked upon. This improvement journey should have clear goals and key performance indicators so as to measure its effectiveness. It is also crucial that any improvement journey for maternity services at the Trust are co-produced with patients and key stakeholders.

Response to the HOSC

Feedback from HOSC	Commentary
Staff engagement and culture *There should be concrete actions which the Trust can commit itself toward in demonstrating that they are taking the voices and concerns of staff into account.*	We run at an organisational level a series of quarterly listening events to update all staff on progress against our people priorities and to gain their feedback on what is working and what would be better. This insightful feedback is used, alongside the staff survey, to form our annual people priorities. For example, staff have told us that despite the improvements we made to onboarding in year two of our people plan more needs to be considered, so we have committed to making further enhancements to onboarding as a priority for the year 3 people plan. Divisional and Corporate local staff listening events have been held between April and June using our Time to Talk methodology and resulting in the co - creation of local action plans. Divisional Leaders have also identified areas needing additional support based on people metrics and staff survey data. These areas will be supported in forming people improvement plans to address the local areas of concern and monitored via our monthly performance committee. Examples of “You said and we did” can be evidenced in regard to the quality of appraisals, which staff told us needed to be improved. We focussed 2023-24 on refreshing the resources and holding workshops to support people in having great conversations, our 2023 staff survey questions on the quality of the appraisal has seen on average of 3% improvement in these questions, which we will continue to strengthen during our appraisal window in 2024. Staff also told us they wanted more methods of recognition; we launched our instant recognition initiative which has received over 2,600 instances of appreciation since the launch in January 2024. In 2023-24 in response to staff telling us about negative experiences and feeling safe to speak up, we formed the Eradication of Bullying and Harassment Programme whose progress is monitored through our internal governance committee. The programme involves multiple streams of work to embed a culture aligned to our values, including the launch of our Sexual Safety Charter and our Respect and Dignity at Work procedure, with new internet page for staff explaining how to raise a concern and the delivery of a series of workshops educating staff on how they address sexual harassment and the support available. For our leaders and managers, we continue to deliver and evaluate our Kindness into Action programme, and new for 2024 is the launch this Autunm of our Inclusion Programme for our Exec, Board, Governors and Directors to enable them to lead and deliver on our EDI objectives. This year will also see the launch in FTSU week in October our Work in Confidence platform to provide staff with greater confidence to raise concerns

Feedback from HOSC	Commentary
	anonymously and that these concerns will be investigated.
Martha's rule *The Committee welcomes the Trust's commitment to adopt Martha's rule. Nonetheless, there could be some further clarity around the process of applying Martha's rule in the day-to-day treatments and activities undertaken by the Trust. The quality account makes reference to round-the-clock rapid reviews, which is a positive development. Although, further details on how these rapid reviews will occur, as well as around the extent to which there is adequate resourcing for such frequent reviews, would be required so as to provide reassurance to patients and their families.*	We are strengthening and standardising escalation pathways for staff, patients and relatives whenever they are concerned about the clinical care that they are receiving. This will include a clear process for each clinical area as to who to contact if there are any concerns. There will also be a communications campaign across the Trust for both staff and patients / relatives. In addition to escalating their concerns to the clinical team, patients, relatives and carers who have any concerns with their care can at present also contact the PALS team who will be able to assist them with resolving their concerns. One of the Quality Priorities 'development of critical care outreach service' will further support the roll out of Martha's rule.
Patient safety during industrial action *…..It is key to share the Trust's evaluation of how it has performed in periods of industrial action. This should ideally include elaborations on the degree to which the three aforementioned measures produced positive outcomes.*	Patient Safety is our primary concern and this is no exception during industrial action. Throughout each period of industrial action we have worked collaboratively as a multidisciplinary team to keep patients safe, prioritising the most urgent elective work (e.g. cancer). Nevertheless, there has been an impact on other elective care due to the need to cancel many operating lists during the periods of industrial action over the year. We continue to work hard to reduce our backlog.

Feedback from HOSC	Commentary
Medicines safety *…..in light of reports of nationwide medicines shortages, the Committee urges for there to be continuous efforts to mitigate the impact of medicine shortages on patient safety.*	These are some of the ways that we are addressing this issue: • Dedicated member of staff looking at shortages (Pharmacy Technician). • Live internal database of stock. • Meetings with pharmacy procurement, medication safety and medicines information weekly to review status and manage stock. • NPSA alerts area also managed via Trusts incident management system. • Monthly reports into Pharmacy Governance. • There are internal alerts with any shortage of medication and then guidance on alternatives and supply updates. • Where required, escalations to the Chief pharmacist for additional prioritisation, planning and monitoring to be put in place to manage clinical safety. E.g. Bupivacaine and fentanyl epidural bags.
Learning from deaths *…although the reviews of deaths indicate that there have been no unavoidable deaths, perhaps more reassurances could be provided as to how these conclusions are reached. ……Additionally, it is crucial that the families and carers of patients are also involved with the process of learning from deaths.*	All level 2 reviews are independent of the person who looked after the patient. Most departments review 100% of their deaths at level 2 with only a minority (8) departments reviewing a minimum of 25% of their deaths at level 2 due to a higher caseload. These 25% are chosen at random, with the addition of those cases in which concerns were identified in the level 1 review, thereby ensuring that there is scrutiny of deaths across the department. All deaths of people with learning disabilities, and selected cases where concerns are raised through incident reporting (as per national guidance), are scrutinised with Structured Judgement Reviews (SJRs). Any SJRs that raise concerns about the quality of care provided to patients are discussed by an independent group of clinicians at the Trust's monthly Mortality Review Group and avoidability is decided at this meeting. The Medical Examiners scrutinise 100% of all hospital deaths including those of children and Hospice patients. They are independent of the Trust, but the service is hosted within the Trust, and they have access to the medical notes of patients. All families of patients who have died are spoken to either by Medical Examiner Officers or Medical Examiners and asked if they have any concerns about the care of their relative. Any concerns are passed back to the team looking after the patient and escalated further if required, and the response co-ordinated through the Divisional Clinical Governance and Risk Practitioners. A summary of concerns is presented at the Trust's Mortality Review Group every quarter.

Feedback from HOSC	Commentary
Reliance on agency staff *It is important that agency staff are integrated and that they interact with the Trust in the same manner as substantive staff as much as possible. This should constitute a key part of the Trust's efforts to maintain high standards and continuous improvement, regardless of whether the staff are permanent or agency workers.*	Since December 2023, the Trust has considerably reduced its use of agency staff by 88 WTE, there is biweekly scrutiny of temporary staffing use at Trust Management Executive and there are weekly Temporary Staffing Task and Finish Groups focussing on temporary staffing reduction. The Trust has not engaged off framework agency workers for a considerable period of time and it does not have any A&C agency, but if there is an urgent need, where framework agency staff are required, there is full scrutiny by the division before an agency worker commences at the Trust. There is also a requirement for the worker to complete an online induction and, where possible, we use agency workers who have worked in the department before so they are used to the team, our patients and our culture. There will always be a small requirement for agency staff due to national shortage specialities such as ICU, biomedical scientists and radiographers, however the Trust is working hard to attract staff to these roles to continue to reduce our need for temporary staffing.
Staff safety *The Committee feels that whilst the quality account makes reference to staff wellbeing, there could have been further elaboration on the measures taken by the Trust to improve staff safety……. Consideration could be given to the use of behavioural contracts with patients in extreme cases, as this could help to address such issues.*	Behavioural contracts are used within OUH and Incidents of violence and aggression towards staff are reported via the incident management system.
Metrics for quality priorities ***…..*** *The Trust's quality priorities should be as measurable and as impactful as possible*	Thank you, we agree with this. Waiting times and other operational metrics are routinely reported and monitored by NHSE. Measurement is a key element of our Quality Improvement framework. All quality priority actions are decided at a local level and then Divisionally, before Trust Board sign off.
Waiting times ***….*** *the Trust could potentially expand on how as well as why long wait times continue to be a challenge. It is crucial that the Trust outlines with*	We acknowledge and agree with the importance of good communication with patients. The backlog waiting list increased dramatically during the COVID-19 pandemic, as many non-urgent services were postponed or cancelled to free up resources and staff for the emergency response. This has been exacerbated by several periods of industrial action during which services have had to

Feedback from HOSC	Commentary
clarity the measures it plans to embark on to reduce wait times. Additionally, there is also a point about providing regular communication and support to patients who are experiencing long waits for diagnosis or treatments.	postpone less urgent elective care to focus on providing care for urgent, emergency and the highest priority patients (e.g. those with cancer). Both the pandemic and industrial action have occurred against a background of an ageing population with increasing prevalence of chronic diseases. As a Trust we are addressing the backlog through a combination of maximizing efficiency and productivity; and prioritising and triaging the patients based on their clinical urgency, complexity, and vulnerability, to ensure that the most in need receive the timely and appropriate care. Progress against our plan is reported regularly and monitored continually to ensure maximal impact.
Maternity services at the Horton *The Committee has also separately received reports of mothers having poor experiences with maternity services. The Committee therefore urges that the Trust make every effort to hear and understand the concerns of those who have had poor experiences with the service, and an improvement journey is embarked upon. This improvement journey should have clear goals and key performance indicators so as to measure its effectiveness. It is also crucial that any improvement journey for maternity services at the Trust are co-produced with patients and key stakeholders.*	We are very grateful for all feedback on our services – positive and critical – as it helps us to focus on what is working well and areas that we need to improve. Our maternity services have been working on a Maternity Development Programme across all our maternity services over the last year, with a focus on leadership, standards and culture, governance, staff support and wellbeing, practice development and education, the working environment and equipment, communications and digital. We have been working with the Maternity Voices Partnership (MVP), the official body that represents the voices of women who have used or are using our maternity services, to ensure that women's real experiences are always at the heart of what we do. Co-production with service users is very important to us and has been an integral part of the Maternity Development Programme.

Annex 3: Statement of Directors' responsibilities in respect of the Quality Account

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Account.

In preparing the Quality Account, Directors are required to take steps to satisfy themselvesof the following.

The content of the Quality Account meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance provided on.

https://www.england.nhs.uk/financial-accounting-and-reporting/quality-accounts-requirements/

The content of the Quality Report is consistent with internal and external sources of information including the following:

- Board minutes and papers for the period April 2023 to May 2024.
- Papers relating to Quality reported to the Board over the period April 2023 to May 2024.
- The Trust's Complaints Report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated June 2021.
- The National Maternity CQC survey for 2023 published on 9 February 2024.
- The National CQC Adult inpatient survey for 2022 published on 12 September 2023
- The National CQC Urgent and Emergency Care survey 2022 published on 8 August 2023
- The (latest) national and local Staff Survey conducted in 2023.
- CQC inspection reports Horton General Hospital Maternity Led-Unit dated 8 March 2024 and John Radcliffe Hospital, Oxford Critical Care dated 6 April 2023.

The Quality Account presents a balanced picture of the NHS Foundation Trust's performance over the period covered.

The performance information reported in the Quality Account is reliable and accurate.

There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, 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 Account are robust and reliable, conforms to specified data quality standards and prescribed definitions, and are subject to appropriate scrutiny and review.

The Quality Account has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Account.

The Directors confirm to the best of their knowledge and belief they have complied withthe above requirements in preparing the Quality Report.

By order of the Board

NB: sign and date in any colour ink except black

Professor Meghana Pandit
Chief Executive Officer

Professor Sir Jonathan Montgomery
Chair