



Quality Account

2010/11



Contents

	PAGE
Statement on quality from the Chief Executive	1
Statement from the Chairman	2
Priorities for improvement for 2011/12	3
Statements of assurance from the Trust Board	6
Review of quality performance for 2010/11	19
Statements from the Primary Care Trust (PCT)	27
Acknowledgements and Feedback	28

Statement on quality *from the Chief Executive*



The quality and safety of patient care is at the centre of all we do at the Oxford Radcliffe Hospitals NHS Trust (ORH) and remains a key focus for the Trust Board. I am impressed with the progress we have made since publishing our first Quality Account in June 2010.

This report outlines some of the activities which have been undertaken during 2010/11 to improve all aspects of quality and gives our priorities for quality improvements during 2011/12.

The commitment and dedication of all the staff to continually improve the experience of the people who use our services, both locally and from the wider health community, is truly impressive. This has been achieved within the context to deliver both our operational and financial performance requirements, as well as maintaining our commitment to patients and the overall quality of care.

For the financial year 2010/11, the Trust achieved a small surplus of 0.18% of turnover (c.£1.3 million). This is an important achievement, and means that we can remain on course with our financial commitments. In relation to performance, last year we also ensured that, over twelve months, more than 95% of emergency patients across the system were treated, discharged or admitted within four hours. However, we did not achieve all targets for 18 weeks admitted patients, and aspects of our cancer targets. Although performance is improving, we need more consistency to better serve our patients and set us up for Foundation Trust status.

During 2010/11 the ORH delivered an important pledge to introduce a new clinical management structure responsible for providing clinical and non-clinical services.

This has given clinical staff the authority to deliver services within a framework which ensures accountability for quality, and operational and financial standards.

Ensuring that we keep our patients safe is crucial to providing both high quality and consistent care, and we have continued to do all that we can to improve patient safety. Initiatives such as the 'RSVP communication tool' were introduced as a means of improving communications between all members of the clinical team. This was subsequently incorporated into a wider training scheme called Recognising the Acutely Ill and Deteriorating Patient (RAID).

We supported the National Patient Safety First campaign which has resulted in improvements including the reduction of falls by patients and the introduction of an electronic assessment tool to assess the risk of Venous Thromboembolism (VTE). A number of targeted activities are being undertaken to improve a reduction in the hospital mortality ratio which are reported to the Board on a monthly basis. We continue to have a programme of 'Executive walk rounds' which provide an opportunity for members of the Board to test the patient safety culture of the organisation. We also recognise that raising awareness amongst staff and in particular our clinical staff, will lead to improvements in the level of incident reporting which in turn will result in a safer culture.

“Ensuring that we keep our patients safe is crucial to providing both high quality and consistent care...”

Focusing on what matters to our patients and learning from the experience of people who come into contact with the ORH provides a valuable source of information. This helps to inform us not only about the things we do well but also ensures there is continual improvement to the services we provide. We have many different opportunities to receive feedback and ensure that departments put in place actions to make the necessary changes. An event which was held for the public to tell us what matters to individuals has helped to identify one of our key priorities for 2011/12. There are regular reviews on patient experiences and importantly on the lessons learned from these

Learning from others, benchmarking with other hospitals, participating in national audits and studies and implementing best practice are also important factors in quality improvement. We have participated in more than 40 national audits and other major studies including cancers, heart disease, diabetes and dementia. We contribute to data for the National Confidential Enquiries into Patient outcomes and deaths (NCEPOD) and Patient Related Outcome measures (PROMS). As a partner in the local health and social care economy we have been working on the Creating a Healthy Oxfordshire programme. This is now part of the wider Quality, Innovation, Productivity and Prevention (QIPP) programme being progressed at a local and regional level.

This Quality Account aims to improve public accountability for the quality of care and demonstrates the continued commitment of the Board and the staff of the ORH to deliver the highest quality of care, and to also develop better and safer systems of care. We greatly appreciate the contributions of our key partners in developing this document and their invaluable comments.



Sir Jonathan Michael, FRCP
Chief Executive



Statement *from the Chairman*

The Board of the Oxford Radcliffe Hospitals remains committed to the delivery of the highest possible quality of care to our patients within the available resources. I have reviewed the content of the Quality Account and confirm its accuracy.



Dame Fiona Caldicott, FRCP
Chairman

Priorities for improvement



Our quality priorities for the year ahead are divided into three areas:

- Patient safety
- Clinical effectiveness
- Patient experience

In addition to these, the priorities that were given in last year's Quality Account will continue to be measured, maintained and monitored via the quality and risk reporting process.

IN SUMMARY:

The quality improvement priorities for 2011/12 are:

Patient safety

- Venous thromboembolism (VTE) risk assessment
- Pressure ulcer reduction
- Improving medicines safety

Clinical effectiveness

- Mortality reduction

Patient experience

- Improving communication
- Caring for vulnerable patients:
 - end of life care
 - patients with dementia and delirium
 - patients with learning disabilities

Patient Safety

Venous thromboembolism or VTE risk assessment

VTE (or formation of blood clot) is a condition that can cause a significant number of deaths each year, many of which could be avoided. During 2009/10 national guidance on VTE was published by the National Institute for Health and Clinical Excellence (NICE) which stated that 90% of all inpatients should be assessed for their risk of suffering from a VTE on admission. An electronic assessment form has been developed.

The Trust will be working to achieve the 90% national target from a current position of less than 50%.

A monthly report will be generated outlining risk assessment performance by specialty. These data will be monitored and reported on by the Medical Director to the Board via the quality report.

This priority is part of the national Commissioning for Quality and Innovation payment framework.

Pressure ulcer (previously known as pressure sores or bed sores) reduction

Work began last year to report severe hospital acquired pressure ulcers (grades 3 and 4) as serious incidents. A root cause analysis (RCA) tool was developed to assist clinical teams to understand why pressure ulcers were occurring so that action could be taken to prevent avoidable occurrences.

Actions taken included; improved assessment of patients' skin when they arrive in hospital, better documentation so that the condition of the patients' skin is regularly reviewed, more training for staff to understand the risks to patients and preventive action, and the purchase of additional pressure-relieving mattresses.

However for 2010/11 56 hospital acquired grade 3 and 4 pressure ulcers were reported and so this must remain a priority, until all corrective action has been taken to prevent patients suffering this harm whilst in our care.

Monitoring of this will be reported to the Board by the Chief Nurse on a monthly basis via the quality report.

Improving medicines safety

Many patients with diabetes require treatment with an injection of insulin. Correct insulin prescribing is an important aspect of improving medicines safety by reducing avoidable errors. Internationally, nationally and at the ORH, a number of errors have been made. Some of these have been serious and hence the selection of this important priority for the year ahead.

There will be a focus on making sure insulin is prescribed correctly in accordance with hospital guidelines. Education is key to improving this aspect of care and will be targeted initially at all healthcare professionals who prescribe insulin.

Monthly audits of insulin prescriptions will be undertaken and results presented to clinical services and teams so compliance can be monitored.

Monthly reports on progress will be presented in the quality report to the Board by the Medical Director and Chief Nurse.

Clinical Effectiveness

Mortality reduction

Hospital Standardised Mortality Ratio (HSMR) is recognised as an important indicator of the quality of patient care being delivered and allows comparisons to be made with all hospitals. The system in place identifies expected deaths from a set of procedures, diagnoses and admission types.

The standardised benchmark is 100. Below this indicates a lower than expected death rate and a higher score means that the Trust has a higher than expected death rate. The Trust's annual HSMR for 2009/10 was 106.3.

Work to reduce the HSMR will have two components:

- (1) more thorough coding to enable a more accurate calculation of 'expected deaths' and
- (2) work within clinical directorates to reduce mortality through the redesign of care pathways and use of care bundles where appropriate.

Current performance is monitored on a monthly basis using the Dr Foster database. This is reported monthly to the Board by the Medical Director.

Patient Experience

Improving communication

The key priority identified at the public event held on 11th April 2011 was to improve communication along the patient journey and at key contact points with staff and services provided by the ORH. The current system will be strengthened to capture the patient experience to deliver meaningful and responsive improvements in how we communicate with our patients.

We will look particularly at communication as part of the process of consent for tests and operations. The impact of staff's behaviour on the patient experience will also be a key focus as a way of changing their approach, where required, to improve communication. Initiatives such as 'talk to me and talk to the team' will also be developed to improve direct communication with patients and the communication amongst teams of staff.

Actions taken and measurable outcomes will be reported monthly to the Board by the Chief Nurse.

Caring for vulnerable patients

End of life care

The percentage of the population over the age of 70 has been steadily increasing for some time. It is anticipated that patients will be less able to rely on family support to remain at home and more patients in the future will rely on the hospital setting for their end of life care. It is recognised nationally, regionally and locally that the quality of end of life care should be improved. The ORH receives a significant number of complaints about negative end of life experiences.

We need to ensure we provide excellent care for all those patients who have to or choose to die within our hospitals. We will need to be consistent in our approach with identified pathways to treat these patients effectively whilst always addressing the individual patient's needs. Work required will include: implementation of specific care pathways for patients who die in hospital; a discharge checklist for those with terminal disease who would like to go home and; an audit of practice to identify further areas for improvement.

Patients with dementia and delirium

The Department of Health baseline assessment against the National Dementia Strategy showed that patients with dementia at the ORH had an increased length of stay compared to the national average for this group of patients. The mental health needs of such patients are often not taken into account, as shown by the lack of mental health assessments even amongst those with known mental health problems. This contributes towards the increased length of stay and poor outcomes for this group of patients.

Every day the ORH cares for approximately 300 elderly patients with delirium, dementia or depression.

Work to improve care for these patients will include:

- Provision of education and training for ORH staff in mental health disorders in older people
- Early identification of older patients with dementia, who are hospitalised with an acute condition
- Provision of verbal and written information to patients and carers on their diagnosis and follow up plans.

Patients with learning disabilities

We are required to make reasonable adjustments to our service to ensure that all people who have a learning disability do not receive a service that is below the standard of any other patient. Feedback from this patient group and their carers, suggests that we could do this in a more consistent way.

We will continue our work to: identify people with a learning disability; listen to and involve relatives and carers; provide information that is accessible for patients with a learning disability and; ensure hospital passports are available.

The Medical Director and Chief Nurse will include monthly progress on this priority within the quality report to the Board.

Statements of assurance from the Board

The following quality statements demonstrate performance in relation to the following areas:

- Participation in national clinical audits and confidential enquires enables us to benchmark the quality of services that we provide against other NHS Trusts, and helps us develop and highlight best practice for providing high quality patient care
- Participation in clinical research demonstrates our commitment to enhancing the quality of care for current and future patients
- Commissioning for Quality and Innovation framework (CQUIN) – our commissioners identified and agreed with the Trust a number of schemes for 2010/11. The philosophy of this framework is to bring health gains for patients and reward the Trust for achieving specific quality improvements
- Registration with the Care Quality Commission was achieved in April 2010 in line with statutory requirements.
- Good quality data are an indicator that an organisation has robust systems and methods of capturing accurate information about their patients



Review of services

During 2010/11 the Oxford Radcliffe Hospitals NHS Trust provided and sub-contracted 102 NHS services.

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

The income generated by the NHS services reviewed in 2010/11 represents 100% of the total income generated from the provision of NHS services by the ORH for 2010/11.

Participation in clinical audits

During 2010/11, 44 national clinical audits and five national confidential enquiries covered NHS services that the ORH provides.

During that period the ORH participated in 98% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries in which it was eligible to participate.

The national clinical audits and national confidential enquiries that the ORH was eligible to and participated in, and for which data collection was completed during 2010/11, are listed 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 the audit or enquiry.

ELIGIBLE NATIONAL CLINICAL AUDIT	ORH PARTICIPATED IN	% CASES SUBMITTED
PERI AND NEONATAL		
1. Neonatal intensive and special care (NNAP)	✓	100%
CHILDREN		
2. Paediatric pneumonia (British Thoracic Society)	✓	100%
3. Paediatric asthma (British Thoracic Society)	✓	100%
4. Paediatric fever (College of Emergency Medicine)	✓	100%
5. Paediatric intensive care (PICANet)	✓	100%
6. Paediatric cardiac surgery (NICOR – Congenital Heart Diseases Audit)	✓	100%
7. Diabetes (RCPH National Diabetes Paediatric Audit)	✓	100%
ACUTE CARE		
8. Emergency use of oxygen (British Thoracic Society)	✓	100%
9. Adult community acquired pneumonia, (British Thoracic Society)	✓	<i>data entry still open</i>
10. Non-invasive ventilation (NIV) – adults, (British Thoracic Society)	✓	<i>data entry still open</i>
11. Pleural procedures (British Thoracic Society)	✓	100%
12. Cardiac arrest (National Cardiac Arrest Audit)	✓	<i>data entry still open</i>
13. Vital signs in majors (College of Emergency Medicine)	✓	100%
14. Adult critical care (Case Mix Programme)	✓	100%
15. Potential donor audit (NHS Blood and Transplant)	✓	100%
LONG-TERM CONDITIONS		
16. Diabetes (National Adult Diabetes Audit)	✓	100%
17. Heavy menstrual bleeding (RCOG National Audit of HMB)	✓	<i>data entry still open</i>
18. Ulcerative colitis and Crohn's disease (National IBD Audit)	✓	<i>data entry still open</i>
19. Parkinson's disease (National Parkinson's Audit)	✓	90%
20. COPD (British Thoracic Society)	✓	100%
21. Adult asthma (British Thoracic Society)	✓	100%
22. Bronchiectasis (British Thoracic Society)	✓	100%

KEY

Data entry still open: data collection continued after the end of the reporting period 31 March 2011

Awaiting data: data requested from specialty

Data not available: at time of reporting, unable to identify accurate information

ELIGIBLE NATIONAL CLINICAL AUDIT	ORH PARTICIPATED IN	% CASES SUBMITTED
ELECTIVE PROCEDURES		
23. Hip, knee and ankle replacements (National Joint Registry)	✓	<i>data not available</i>
24. Elective surgery (National PROMs Programme)		
– Hernia	✓	55%
– Varicose veins	✓	23%
25. Coronary angioplasty (NICOR Adult cardiac interventions audit)	✓	100%
26. Peripheral vascular surgery (VSGBI Vascular Surgery Database)		
– Abdominal Aortic Aneurysm	✓	51%
– Infrainguinal Bypass	✗	
– Amputations	✗	
27. Carotid interventions (Carotid Intervention Audit)	✓	80%
28. Coronary Artery Bypass Graft and valvular surgery (Adult Cardiac Surgery Audit)	✓	100%
CARDIOVASCULAR DISEASE		
29. Familial hypercholesterolaemia (National Clinical Audit of Management of FH)	✓	100%
30. Acute Myocardial Infarction and other ACS (MINAP)	✓	100%
31. Heart failure (Heart Failure Audit)	✓	71%
32. Acute stroke (SINAP)	✗	
33. Stroke care (National Sentinel Stroke Audit)	✓	100%
RENAL DISEASE		
34. Renal replacement therapy (Renal Registry)	✓	<i>awaiting data</i>
35. Renal transplantation (NHSBT UK Transplant Registry)	✓	<i>awaiting data</i>
36. Patient transport (National Kidney Care Audit)	✓	121 questionnaires completed
37. Renal colic (College of Emergency Medicine)	✓	89%
CANCER		
38. Lung Cancer (National Lung Cancer Audit)	✓	100%
39. Bowel Cancer (National Bowel Cancer Audit Programme)	✓	68%
40. Head and neck cancer (DAHNO)	✓	<i>data not available</i>
TRAUMA		
41. Hip fracture (National Hip Fracture Database)	✓	92%
42. Severe trauma (Trauma Audit & Research Network)	✓	<i>data not available</i>
43. Falls and non-hip fractures (National Falls and Bone Health Audit)	✓	100%
BLOOD TRANSFUSION		
44. O negative blood use (National Comparative Audit of Blood Transfusion)	✓	100%
45. Platelet use (National Comparative Audit of Blood Transfusion)	✓	95%

Audits the ORH did not participate in:

- Peripheral vascular surgery; Infrainguinal Bypass and Amputations. We as a Trust, like most others, concentrated on participation with the audit for Abdominal Aortic Aneurysm but have now started to participate in these other categories.
- SINAP was not participated in due to uncertainty of the SINAP process: exacting data requirements of the PCT and Stroke Network and concerns about burden of data collection on clinicians. It is now clear that there will be a continuous real-time audit for every patient from April 2012 and therefore we are gradually increasing SINAP participation in preparation.

NATIONAL CONFIDENTIAL ENQUIRIES	ORH PARTICIPATED IN	% CASES SUBMITTED
NATIONAL CONFIDENTIAL ENQUIRY INTO PATIENT OUTCOME AND DEATH (NCEPOD)		
1. Surgery in Children	✓	100%
2. Peri-Operative care	✓	71%
3. Cardiac Arrest Procedures	✓	100%
CONFIDENTIAL ENQUIRY INTO MATERNAL AND CHILD HEALTH (CEMACH)		
4. Perinatal Mortality	✓	100%
5. Maternal Death Enquiry	✓	100%

The reports of 20 national clinical audits were reviewed by the Oxford Radcliffe Hospitals NHS Trust in 2010/11 and the Trust intends to take the following actions to improve the quality of healthcare provided:

AUDIT TITLE	ACTIONS
National Neonatal Audit Programme	The actions are to improve documentation of observations and to improve the rate and recording of two-year follow ups.
Paediatric asthma (British Thoracic Society)	This re-audit demonstrated a 15% improvement in antibiotic over-prescription compared to the results in 2009. Also actions undertaken improved the number of unnecessary chest x-rays performed from 44% of patients to 0% in 2010.
Potential donor audit NHS Blood & Transplant	6 monthly and end of year reports are reviewed at the Trust Organ Donation Committee. Actions for 2010/11 were to: <ul style="list-style-type: none"> • continue promoting organ donation throughout the Trust • explore strategies to increase tissue donation • further develop the process for helping families to understand the donation process more fully
Parenteral Nutrition (NCEPOD)	The results were reviewed by the lead consultant and pharmacist. An improved prescription chart has been implemented and guidelines are being reviewed. Staff will be educated as to the out of hours availability of parenteral nutrition.
Confidential Enquiry into Obesity in Pregnancy	There will be a review of the assessment of women with a BMI >40 in pregnancy with regards to preserving healthy skin condition and safe mobility. Work is ongoing with the diabetes group to ensure all pregnant women with a BMI >30 are screened for gestational diabetes.
Coronary angioplasty (NICOR adult cardiac interventions audit)	The cardiac department has reviewed proportions of radial procedures (those undertaken via an artery in the forearm), rates of use of abciximab (drug that reduces complications) and the amount of time between a heart attack patient's arrival at the hospital to the time he/she receives the appropriate procedure. Also the time it takes to diagnose a NSTEMI which is a heart condition and occurs when a coronary artery is partially blocked by a blood clot. The figures are used as a benchmark for local performance with comparisons made at each quarterly review meeting.

AUDIT TITLE	ACTIONS
Hip Fracture (National Hip Fracture Database)	Oxfordshire redesigned its fragility fracture, falls and bone health pathway. The benefits have included early discharge into rehabilitation and an average length of stay in hospital for patients of ten days.
Carotid interventions (Carotid Intervention Audit)	<ul style="list-style-type: none"> ● Expedite appointment of nurse co-ordinator to provide surgeons with any necessary support to allow them to participate in the National Carotid Endarterectomy Audit as this is a core part of supporting professional activity ● Work with physicians in district general hospitals to highlight the importance of rapid referral and to promote GP education in this area so that they continue to educate the public and healthcare professionals of the importance of early diagnosis and treatment of patients with transient ischaemic attack (TIA) and stroke ● Access to vascular surgical operating time remains a cause for delay in some cases and vascular surgical services need to be configured in order to allow a Carotid Endarterectomy (CEA) to be undertaken more expeditiously. This is a surgical procedure to prevent stroke by correcting narrowing in the carotid artery. When the operating list capacity is expanded to take in regional vascular inpatient workload this should allow extra flexibility to put patients on a list within 48-72 hrs ● All patients undergoing CEA should have an independent assessment at follow-up by a physician with an interest in stroke ● Explore additional neurology input
Acute Myocardial Infarction and other ACS (MINAP)	People suffering from a heart attack should receive appropriate treatment within 60 minutes of calling for professional help. Current data are very positive as in the last twelve months this has been 23 minutes for this Trust. However, for a few patients that are transferred from some hospitals there are prolonged times of which process issues have been identified and discussed at multi-disciplinary meetings on a monthly basis.
Heart failure (Heart Failure Audit)	A business case is being developed to increase staffing resource to ensure more patients are seen by the heart failure team.
Diabetes (National Audit Diabetes Audit)	<ul style="list-style-type: none"> ● To continue to work towards an electronic upload of retinal screening data onto a clinical management system. Diabetic Retinopathy Screening Service (DRSS) is in agreement with this goal and there is ongoing collaboration to achieve this within the next financial year. Diabetic retinopathy is damage to the retina caused by diabetes ● The possibility of sharing foot examination data with the community database will be explored ● The discrepancies between the National Diabetes Audit and in-house diabetes ketoacidosis (DKA) data need further investigation. DKA is a complication of diabetes which can lead to severe harm or even death if untreated ● Continue collaboration with primary care to facilitate management of diabetes in the community, where appropriate

The reports of 45 local clinical audits were reviewed at Trust level by the Oxford Radcliffe Hospitals NHS Trust in 2010/11 and the Trust intends to take the following actions to improve the quality of healthcare provided:

SERVICE	AUDIT	ACTIONS
Children's Services	Rectal biopsy gun audit and subsequent re-audit	The re-audit shows that there has been a significant improvement in the success of rectal suction biopsies (a procedure to diagnose disease of intestines) from 70% to 95%. This has been forecast to save an estimated £10,000 per annum. This reduces the need to repeat biopsies in children and keeps their length of stay in hospital to a minimum.
	A survey of the staff and patients on Kamran's Ward (paediatric haematology/oncology)	Actions taken to address the areas for improvement include purchasing more DVDs, working on improving the ward menu and extra emphasis on how and when parents can get in contact with the team.
	Hip ultrasound and aspiration in children re-audit	The re-audit demonstrated how the introduction of a hip aspiration (surgical procedure) guideline resulted in the centralisation of care; meaning a safer, well structured service is being provided to these children. Just 19% of children were sedated for this procedure before the guideline existed; after the guideline was embedded in practice 90% were sedated, reducing discomfort and distress.
Women's Services	Documentation of the social and vulnerable score	This ongoing audit has shown largely appropriate use of the social and vulnerable scoring matrix. However education work with midwives will continue in this area.
Critical Care, Theatres and Anaesthetics	Suction equipment re-audit, Horton General Hospital	Education and dissemination of audit results to each clinical area has resulted in suction equipment being at the required standard for immediate use in 81% of areas. Ongoing work continues to ensure all areas are compliant with the standard.
Pathology and Laboratories	Performance of CHROM-agar (a medium used in microbial testing) E.coli isolated from blood tests	Findings from this audit demonstrate that altering the for identification of protocol for E.coli testing will remain reliable and safe for patients but would result in a saving of approximately £1,000 per annum.
	Electronic displays of laboratory results in the ORH and GP practices	The Laboratory Medicine IT Planning Group may make minor improvements to the electronic displays.

SERVICE	AUDIT	ACTIONS
Oxford Centre for Diabetes, Endocrinology and Metabolism (OCDEM)	Generic medical record keeping in Diabetes and Endocrinology	This audit monitors compliance with guidelines on record keeping. It highlighted the need for all entries in medical notes, from inpatient admissions and outpatient clinics, to include the date and time and details of most senior healthcare professional present. The admission/transfer entry in medical notes also needs to include details of the consultant responsible for the care of the patient during the admission. All entries in medical notes need to be signed with name, signature and designation of medical professional. The clinical team will implement recommendations and re-audit in 2012.
	Improving communication in clinical care. A re-audit of endocrinology and diabetes email advisory service following commissioning	<ul style="list-style-type: none"> • The department now aims to answer 90% of queries within two working days • GP feedback and nature of queries will be used to develop targeted teaching modules for GPs and trainees • Building on the success of the email advice line, the department intends to make more use of E-health Technologies in the future
Radiology	Suspected lung cancer: follow up imaging, Horton General Hospital	Audit results showed that some patients were waiting longer than expected for follow-up imaging. In response, all patients for whom imaging (x-rays) has indicated a possible lung cancer a check is made on a monthly basis to ensure they have been booked in for further investigatory imaging. If they have not, then the relevant clinician is written to by a radiologist to inform them to take action.
	Early treatment of aneurysmal subarachnoid (brain) haemorrhage	Neurointerventional service cover at weekends is being considered with back-up cover when no on-call interventional neuroradiology service can be provided. (Neurointerventional service is a specialty dedicated to the treatment of vascular disease.)

SERVICE	AUDIT	ACTIONS
Dermatology	Patient experience survey for skin cancer (Oct 09 - Jan 10 data)	<ul style="list-style-type: none"> • Permanent record of consultation poster displayed in all clinical areas. Patients asked if they would like a record of their consultation (discussion with doctor). This is a Cancer Centre instruction from May for all patients to receive copy of letters unless they opt out. This information will be displayed on the plasma screens in dermatology. • Improve written information for follow up / surveillance. • To alert GPs that results should be given with the specialist team involved, at a minimum to ensure the skin cancer team are aware of the diagnosis. The clinical nurse specialist can then provide adequate information and support. These recommendations have been incorporated into the local Skin Cancer Multidisciplinary Team Annual Report and work programme.
	The use of biological agents in psoriasis (skin condition)	NICE guidance adhered to. The recommendation is to ensure appropriate assessment tools (PASI/ DQLI) are used on all patients.
	Re-audit: Patch test information (skin test undertaken to detect allergies)	The percentage of patients that received patch test information has increased from 84% to 97% (the only patient without a leaflet was booked in on the day). This was due to the inclusion of a sentence in the patient's letter asking them to contact the letter production department if they did not receive the information leaflet. Similar change to the tumour (cancer) clinic letter is being considered.
	Acitretin (medication used in the treatment of severe psoriasis) monitoring and compliance with British Association of Dermatologists guidelines	The only action is to ensure three monthly tests are ordered. There will be a re-audit in December 2011.

SERVICE	AUDIT	ACTIONS
Dermatology	Audit of outpatient letters sent to GPs	In 85% of letters there was a clear diagnosis and in 53% a clear management plan. Investigations were listed in 55%. Results discussed with all members of department to make necessary improvements.
	Squamous cell carcinoma excision margins (removal of skin cancer and small amount of normal skin around the area)	Recommendation for surgeons to focus on deep margins. Re-audit planned 2012.
	Timing of photodynamic therapy (light therapy treatment for cancer) medication	Nurse and patient education needed as well as an improvement in medication stocks.
Geratology	Management of iron depletion in the Lionel Cosin Day Hospital (LCDH)	Protocol to be developed for patients requiring an iron infusion on LCDH.
	Level 4 (Geratology Department) discharge summary review	Guidance for doctors to be updated to reflect the improvements required.
	Hyperglycaemia (abnormally high blood sugar) on Level 4	Improved understanding of the treatment needed for patients with hyperglycaemia. Discussion with Clinical Lead and diabetic support team.
Acute General Medicine	Does current practice at the Horton General Hospital meet the Resuscitation Council's guidance on Do Not Attempt Resuscitation (DNAR) orders?	There has been improved documentation since the introduction of the new DNAR form but further education of health care professionals will ensure full compliance with the required documentation.
Cancer Care	Line team audit presentation (a line is a tube to administer treatment)	<ul style="list-style-type: none"> • Line service to facilitate registrar training in line removal • Ward team managers to ensure line issues and removal are documented clearly in notes. • Line team to use maximum barrier precautions (to prevent infection) for insertion as planned • All teams to use Aseptic Non Touch Technique (ANTT) for all line use • Line team to explore the use of chlorhexidine (antiseptic) baths/scrubs in insertion in neutropenic patients (patients who are susceptible to infection) • Re-audit prospectively 2012

SERVICE	AUDIT	ACTIONS
	Deaths within 30 days of chemotherapy	<ul style="list-style-type: none"> ● Ongoing audit of deaths of patients on chemotherapy will be carried out ● Improved documentation of performance status and toxicity ● Management of complications of chemotherapy, e.g. neutropenic sepsis to be reaudited ● Improve access to specialist services; the triage service recommenced in 2010 and work has been carried out to provide patients with a single point of contact card ● Improve end of life care and advanced directives – The Liverpool Care Pathway has been implemented on the Oncology ward. The Trust is participating in the National Care of the Dying Audit and carries out local audits of the Liverpool Care Pathway ● All clinicians to know to report deaths within 30 days of chemotherapy to the Coroner ● Improved documentation by multi-disciplinary team ● Adequate availability of written information for patients
	Herceptin (medication) use for the adjuvant treatment of early breast cancer	This audit showed that the uniformity of patient consent needed to be improved. This action has been completed. It has been agreed that, as a minimum, the following should be stated: Benefit: reduction of recurrence; Risk: heart failure.
	Chemotherapy Toxicity Documentation Audit	The action required is to document blood results in notes at time of chemotherapy administration and to state whether the results are satisfactory or not.
Cardiothoracic and vascular	Cardiothoracic Surgery Echocardiogram	The audit resulted in a plan to improve the pathway of the pre-operative care of cardiac surgical patients so that better imaging is available

Information on research



Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by the Oxford Radcliffe Hospitals NHS Trust in 2010/11 that were recruited during that period to participate in research approved by a research ethics committee was 22,139.

Participation in clinical research demonstrates the Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvements. Our clinical staff stay abreast of the most recent treatment developments, and active participation in research leads to more successful patient outcomes.

There were 1,100 clinical staff participating in research approved by a research ethics committee at the ORH during 2010/11. These staff participated in research covering 17 medical specialties.

Goals agreed with commissioners

Use of the CQUIN payment framework

A proportion of the Trust's income (1.5%) in 2010/11 was conditional on achieving quality improvement and innovation goals agreed between the Trust and Oxfordshire PCT, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for 2010/11 and for the following 12 month period are available electronically at: http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html

Quality improvement initiatives associated with CQUINs for 2010/11 include:

- Improved responsiveness to personal needs of patients
- Improved outcomes and experiences of patients admitted for a coronary artery bypass graft
- Improved outcomes and experiences of patients admitted who have an acute myocardial infarction
- Improved outcomes and experiences of patients in hospital with heart failure
- Improved outcomes and experiences of patients in hospital with pneumonia

Statements from the Care Quality Commission (CQC)

The ORH is required to register with the CQC and its current status is registered without conditions. The CQC undertook a planned review of compliance during 2010/11. This involved reviewing a range of information about the hospital and making unannounced visits to all three hospital sites. During these visits, the inspectors observed how people were cared for, they talked to patients and staff and checked patient records.

Following this the CQC made a judgement that the ORH was compliant with 12 of the 16 essential standards of quality and safety. Progress is being made with the following actions to ensure the ORH returns to full-compliance across all of the essential standards in all of our hospitals.

OUTCOME	ACTION REQUIRED
OUTCOME 4: Care and welfare of people who use services	<ul style="list-style-type: none"> • Compliance with patient waiting times for treatments following referral and for waiting times for cancer • Clear evidence of the actions taken by the Trust in relation to the high numbers of patients waiting to be transferred from hospital to care placements • Consistent achievement of radiology reporting target times. • Improvement in bed management at the Horton • Best practice consistently implemented for stroke care at the Horton • Audit of implemented NICE guidance
OUTCOME 13: Staffing	<ul style="list-style-type: none"> • The Trust must ensure that there are sufficient numbers and types of staff working across the organisation at all times to meet the needs of the people who use the service
OUTCOME 14: Supporting workers	<ul style="list-style-type: none"> • All staff to receive an annual appraisal and complete all required statutory and mandatory training so that they are competent to deliver the required care and treatment to people who use our services • The Trust should ensure staff have access to appropriate supervision
OUTCOME 16: Assessing and monitoring the quality of service provision	<ul style="list-style-type: none"> • Ensure there is a systematic process in place to show how actions from key meetings are identified, implemented, followed up and their impact monitored • Continue to embed the new clinical governance system and ensure appropriate assurance systems are in place

In addition, minor concerns were highlighted and improvement actions identified for the following outcomes. **Outcome 1:** *Respecting and involving people who use services* and **Outcome 7:** *Safeguarding people who use services from abuse.*

The ORH has participated in one special review by the CQC relating to the *Support for families with disabled children* during 2010/11. The report from this is due to be published imminently and recommendations will be taken forward as required.

Statement on relevance of Data Quality and our actions to improve the Data Quality

Good quality data underpin the effective delivery of patient care and are essential if improvements in quality of care are to be made. Improving data quality, which includes the quality of ethnicity and other equality data will thus improve patient care and value for money.

The National Data Quality Dashboard is available to help monitor and drive improvements in the quality and completeness of data. The ORH benchmarks well against other trusts as the average results of the overall Commissioning Dataset (CDS) data validity is 93.6% for all CDS submitters and the results of the ORH was 94.8%.

The Audit Commission undertook a review of data quality management arrangements during 2010/11 at the ORH. As a result the ORH is taking the following actions to improve data quality:

- Corporate objectives for data quality to be:
 - clearly defined and agreed at top management level
 - linked to the Trust's business objectives, cover all activities and have an associated delivery plan. Completion by end of May 2011.
- Implementation of a programme for regular assessment of the risks associated with unreliable or inaccurate data at a clinical level so that quality and risk is fully integrated. Completion by end of June 2011.
- Data quality to be included in the annual objectives and appraisals of all staff, including front line employees who are involved in data collection, recording, analysis and reporting. Completion by end of March 2012.
- Clear roles and responsibilities to be specified in relation to data quality for all staff involved in data collection, recording, analysis and reporting. Clear links to job descriptions to be provided. Completion by end of March 2012.
- Strengthen arrangements for ensuring adherence to data quality standards by temporary staff using a targeted training module and framework. Completion by end of June 2011.

NHS Number Code Validity

The patient NHS number is the key identifier for patient records and the quality of NHS number data has a direct impact on improving clinical safety.

The ORH submitted records during 2010/11 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

- 99.2% for admitted patient care**
- 99.4% for outpatient care**
- 95.4% for accident and emergency care**

Information Governance Toolkit attainment levels

The ORH Information Governance Assessment Report overall score for 2010/11 was 72% and was graded as green (satisfactory).

Clinical coding

Clinical coding translates the medical terminology written by clinicians to describe a patient's diagnosis and treatment into standard, recognised codes. This is important because it affects the accuracy of income the Trust receives and provides a high level indicator of the accuracy and ability to interpret patient records.

The ORH was subject to the Payment by Results clinical coding audit during 2010/11 by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

Primary Diagnoses Incorrect	5.0 %
Secondary Diagnoses Incorrect	4.3%
Primary Procedures Incorrect	5.3 %
Secondary Procedures Incorrect	2.9%

The results of the coding audit carried out in the autumn of 2010 showed a major improvement from the previous year. Our results are good and fall into the lower quartile of errors for diagnosis, procedures and Healthcare Resource Groups. Further improvement could be made by regular audit to improve coder accuracy and understanding, as well as liaison with clinicians to improve the quality and clarity of information in the hospital notes.

Review of quality performance for 2010/11

Our priorities last year were:

PATIENT SAFETY

- Implement Surgical Working Group findings
- Serious about standards – raise awareness of standards of nursing care at ward level
- Reductions in pressure ulcers and falls
- Action on venous thromboembolism (VTE)
- Respond to the staff safety survey
- Improvements in the recognition and treatment of the acutely ill patient
- Reductions in hospital standardised mortality ratios, working through the Dr Foster Group

CLINICAL EFFECTIVENESS

- To take action on lessons learned from audits
- To contribute to the Creating a Healthy Oxfordshire programme.

PATIENT EXPERIENCE

- To rationalise and focus the feedback of patient experience, drawing on patient surveys, feedback through comments and complaints and NHS Choices

Patient Safety

Surgical Working Group findings

The Surgical Working Group, consisting of external professionals, a patient representative and ORH staff, made a number of recommendations to the Board aimed at developing all aspects of patient safety. Progress has been made in the following areas:

- Human Factors training has continued using the clinical simulation (OxSim) facility in the Trust. This enables learning and training of individuals and teams through the recreation of the real clinical situation. Members of the Board attended a presentation at this facility in November 2010. Courses on patient safety continue for medical students which are facilitated by clinicians. In addition, the human factors approach was used with teams in paediatric cardiac intensive care and paediatric cardiac surgery following the pause of surgery in March 2010. It provided a useful mechanism for staff to review events and consider whether any changes were required. The identification of resources to support the continuation of the simulation programme, 'train the trainer' in OxSim, is actively being pursued from the Divisions.

- Two safety verbal confirmation initiatives were introduced and audited. Firstly, the World Health Organisation (WHO) surgical safety checklist was introduced into all ORH theatres in late 2009 and has been audited. Further spot checks to ensure ongoing compliance have been completed. Secondly, the *Reason Story Vitals Plan* (RSVP) communication tool was piloted in acute general medicine. This is a framework to improve communications between all members of the clinical teams, particularly when reviewing a deteriorating patient. Since September 2010 it has been included in all RAID training and is being implemented trust-wide.

Serious about standards

Ward sisters / charge nurses across the Trust took part in the 'Serious about Safety and Standards Programme' between May and August 2010. This followed the Board's review of the Healthcare Commission Report into the failures of care at the Mid Staffordshire Hospitals and the publication of the Francis Enquiry Report in February 2010. This programme confirmed the standards expected and provided a self-assessment against each standard in each clinical area.

Reduction in pressure ulcers and falls

Pressure ulcers

Board Quality Reports have included regular updates on the assessment, identification and management of pressure ulcers. This has shown a reduction in sacral ulcers with further work needed to prevent tissue breakdown on heels. A large number of overlay mattresses have recently been purchased. These mattresses have been used primarily in high risk areas such as the Medical Assessment Unit, Surgical Emergency Unit and the Emergency Department as a number of Serious Untoward Incidents have identified extended trolley waits as a contributory factor in pressure ulcer formation.

An analysis of the Trust's profile of reported incidents of pressure ulcers compared with the national profile highlights the benefits of developing a tissue viability service within the Trust to enhance the current approach to education and training to reduce the incidence of pressure ulcer formation.

Falls

In November 2010 the Trust supported the National Patient Safety First campaign and participated in a week of 'one stop' activities to improve the safety of patient care. This included an audit on patient anxiety about having a fall. Specific work continues in acute general medicine, neurosciences and trauma. Data confirm there has been a small reduction in the number of falls compared to last year. The ORH and Nuffield Orthopaedic Centre jointly chair the Falls Safety Action Group and will continue to oversee an improvement in this area of patient care. This will include implementation of a falls prevention checklist and a care plan for when a patient has had a fall.

Action on venous thromboembolism (VTE)

An electronic risk assessment tool has now been implemented to support the risk assessment of patients developing VTE. Compliance with this priority requires improvement so continues to be an area of focus for 2011/12.

Staff Safety Survey

Early in 2010 all ORH staff were invited to participate in a survey co-ordinated by the National Patient Safety Association (NPSA) on the patient safety culture within the Trust. This has led to a focus on strengthening the culture by emphasising that every member of staff has a part to play in patient safety.

Incident reporting training has been reviewed at different levels within the organisation and staff from the risk team provide individualised programmes of education directly to departments. Work continues to ensure there is a local feedback mechanism for any incident reported so that staff know that necessary actions are taken as a result. Strengthening incident reporting by clinicians was a specific recommendation within the paediatric cardiac action plan, which has now been signed off by the Strategic Health Authority and the Independent Review Panel. The latest data available from the National Reporting and Learning System (NRLS) indicates that the Trust rate of incident reporting to the NRLS is now within the top 25% of acute teaching hospitals.

The aim of Executive walkrounds is to embed and test the safety and quality culture. These are completed by Executive and Non-executives Directors throughout the Trust visiting wards or departments. 98 quality walkrounds were completed in 2010/11. The 'walkround' provides staff with the opportunity to discuss quality and safety issues and any other areas of concern. Patients and relatives may also be asked for their views.

Executive walkrounds identify both local issues requiring resolution and also bring to the attention of Board members those areas which require Board support. One such area of concern was the physical environment of the Transplant Ward which has now been relocated within the Churchill Hospital site.

Recognising the Acutely Ill and Deteriorating Patient (RAID)

Figures confirm that the majority of nursing and medical staff have received the appropriate training in care of the deteriorating patient. One of the measures is the number of cardiac arrest calls which continues to reduce. Research confirms that the track and trigger scoring system currently in use is the most evidence-based early warning system available. The escalation pathway for clinical review has been revised following audits within clinical teams. Distribution of the revised generic trustwide chart is imminent and will require all clinical wards and departments to use the track and trigger framework. Progress with the implementation of the framework will be reported on by the Divisions to the Clinical Governance Committee.

Reduction in hospital standardised mortality ratio

The Board Quality reports include regular updates on the work of the Dr Foster Steering Group. A particular area of focus for this group has been on improving the accuracy of coding of the primary diagnosis and co-morbidities, particularly those which are contained within the Charlson Index, through improved documentation in the health records. The Trust document outlining 'Top tips for coding' and the Charlson Index of co-morbidities have been distributed to clinicians. In addition clinical coding is now part of the junior doctor induction programme. Work also continues to improve on specific patient pathways, readmission rates, length of stay and day case rates.

A project has commenced to reduce the HSMR at the ORH through the review of up to 600 sets of health records so that accurate data on the clinical condition and care of patients at the ORH can be precisely published. Health records are also being scrutinised for quality of care concerns which will be examined in depth using an audit tool developed by the Patient Safety Federation (South Central SHA).

A new Clinical Coding Task and Finish Group has been set up to strengthen current performance in clinical coding. The work includes improving the accuracy, depth and identification of co-morbidities to ensure data are of good quality and exploring how clinicians and coders can work together to enhance accurate clinical coding.

The ORH patient safety framework strategy is being revised and includes a workstream to improve mortality rates and hence the HSMR. The patient safety road map as devised by the Patient Safety Federation (South Central SHA) is being used within the strategy to ensure all activities are coordinated. Guidance has been developed and implemented on conducting Morbidity & Mortality meetings for all clinical specialties. These standards will be audited on an annual basis as required by the paediatric cardiac action plan which is reviewed by the Board each month.

Providing safe care

A variety of tools are being used in the Trust to monitor the safe care provided for our patients. These include Global Trigger Tool (GTT) and Mortality Reviews. The information gained from such tools is analysed and the findings are used in the development of future strategies.

Use of the GTT from January 2010 meant that forty sets of notes were reviewed each month to identify whether actual or potential harm had occurred during the patients' hospital stay. The main findings were that there were a number of medications that had been stopped abruptly, mainly attributed to insufficient medicines reconciliation, and incomplete or inaccurate scoring on track and trigger (observation) charts. Specific actions to address these findings will be monitored by Pharmacy and the RAID Committee respectively.

Overall, the rate of avoidable harm for the Trust was 4% over twelve months which is comparable with other Trusts in the South Central region.

The Trust is participating in the Department of Health Safety Express Initiative. This is an ambitious patient safety national programme focusing on decreasing harm events from the following four areas: pressure ulcers, patient falls, catheter related infections and VTE episodes. Patients are currently randomly selected across four wards and their notes reviewed to ascertain whether any of the above harm has occurred. Once the data have been collected, a series of interventions will be devised and their effectiveness monitored by further monthly audits.

Clinical Effectiveness

Audits

The Trust has contributed to more than 40 national audits and major studies including cancers, heart disease, diabetes and dementia. In addition, many services carry out their own local and regional audits. Reports from national audits are presented to the Clinical Governance Committee and the aim is to ensure that the recommendations are reviewed and implemented as far as is possible.

The Trust contributed to the measurement of patient-related outcome measures for hernia and varicose vein patients. The numbers of these procedures were relatively small because both these procedures are subject to agreed protocols governing effectiveness. The data for the ORH were more positive than the national position.

The data showed that 61% of hernia patients saw an improvement in their condition post-operatively (compared to 50% nationally), 27% remained the same (32% nationally) and 12% deteriorated. In terms of their overall measure of health state, 43% showed improvement (38% nationally), 19.5% remain the same (19% nationally) and 38.5% deteriorated (43% nationally).

For varicose vein, 69% of patients saw an improvement in their condition post-operatively (52% nationally). The remaining numerators were too small to calculate the difference between static (33% nationally) and deteriorating (14% nationally).

Creating a Healthy Oxfordshire

All partners in the local health and social care economy have been working together on the Creating a Healthy Oxfordshire programme. The aim is to improve patient services and is intended to support the ORH's internal cost improvement efforts. This is now part of the wider Quality, Innovation, Productivity and Prevention (QIPP) programme being progressed locally and across the region. The acute workstream prioritised three areas of work for 2010/11. These include the 'whole systems' pilot in Abingdon to help define Oxfordshire adult services, the development of community paediatric services across Oxfordshire, and a workstream on community development of diagnostic imaging and pathology services.

In January 2011 the CQC identified Oxfordshire as one of the best performing areas in the country for people who have had a stroke or transient ischaemic attack (TIA). The review looked at care provided along the whole care pathway; in hospital through to discharge and out into the community for ongoing health and social care. These improvements can be attributed to the partnership between NHS Oxfordshire, the ORH, the University of Oxford, Health Oxfordshire and Oxfordshire County Council.

Patient Experience

The Chief Executive emphasised the importance of the entire patient experience and customer care in his Briefing held in November 2010. The existing customer care standards are:

- being friendly, helpful and welcoming
- taking time to listen and find out what people really want or need
- actively seeking feedback, responding promptly and doing what we promise
- finding someone else to help if you're not able to
- treating everyone with respect, and apologising if appropriate, and looking for ways of improving and enhancing our services

There are many different opportunities for patients and relatives to provide feedback on their experiences and this is encouraged, to ensure continual improvement of services. Work to embed these standards into the recruitment and appraisal of staff is continuing to bring about greater consistency in the reported patient experience. The Trust 'Let us know your views' questionnaire is in place both paper-based and electronically and results are regularly reviewed.

Feedback is sent to the relevant department so that it can be discussed and actions put in place to make the necessary changes. The Care Quality Board which was succeeded by the Clinical Governance Committee in February 2011, regularly reviews reports on patient experiences and lessons learned.

Patient experience surveys of specific services have been conducted in 22 areas across the Trust and around 1,000 patients gave their views about the services, care and treatment they received. Details of a few of them are provided below.

PATIENTS SAID	CHANGES MADE / ONGOING
Some patients in a specialty outpatient department said they had to wait more than 15 minutes and were not informed of the reasons for the delay.	Delays of 30 minutes or more are now reported to the health care assistant, who informs the patients of the situation. The senior department manager is contacted if there are delays of more than 60 minutes so they can assist with resolving the delay.
A previous lung cancer survey in 2009 showed that 30% of patients did not receive a written letter confirming the type of cancer they had and their treatment plan.	The survey in 2010 shows that practice had dramatically improved. 90% of lung cancer patients now receive a letter explaining their type of cancer and their treatment plan.
Very few patients are making use of Heads2gether, the national head and neck cancer support group.	Clinical nurse specialists have met with the committee of Heads2gether to explore ways of making the group more useful to patients. Actions will include improving printed literature, re-instating information coffee meetings and a survey to find out what patients would most value from the support group.
31% of patients expressed a wish to join a prostate support group.	A new prostate cancer support group was launched in October 2010. Sessions are supported by past patients, the specialist nurses and a consultant.
Some patients were not aware that 'Lung Nurses' are lung cancer nurses and can be called with any questions following their oncology consultation.	A new patient information leaflet has been produced clarifying the role of the lung cancer nurse and the support and information they can provide.



Face to face feedback from patients and other people who use our hospital services has provided a valuable source of information to tell us about the positive experiences and where there is further scope for improvement. The organisation and its staff always appreciate receiving compliments from patients and families about their care. The feedback has been used to help monitor progress and inform our priorities. Complaints form a rich source of patient feedback so that trends and patterns of concern can be identified and acted upon. Though we strive to deliver both excellence and compassion in everything we do, at times we have fallen short of this.

The Trust was identified in the Ombudsman's Report 'Care and Compassion' in February 2011. The case of a patient treated at the John Radcliffe Hospital in 2007, was one of ten examples used by the Ombudsman to illustrate her concern that the NHS sometimes forgets the compassionate and human aspects of the work that we do. The family of the patient covered in the report were let down both in communication and behaviour.

The Chief Executive asked staff to read the report and reflect on the way that the NHS sometimes fails patients and their families. He considered it to be a timely reminder that however technologically advanced our treatments and procedures may be, that our patients and their families are inevitably anxious and often vulnerable and dependent on us for support. He emphasised that patients should 'always be treated with compassion and understanding' as we hope that others would treat each of us and those that we love, were we to be patients.

Specific actions that have been undertaken since this report to prevent reoccurrence of the failings have included:

- Full acknowledgement and apology to the family
- Sharing the learning across the organisation
- Staff training
- Recognition of need to do more work on end of life pathways. This is included in one of our priorities for 2011/12

There have been many local initiatives which have been implemented to improve the patient experience as a result of feedback. Daily ward rounds by matrons, sisters/charge nurses have been enforced in the latter months of the year, to deal specifically with any concerns that patients or relatives have during their stay. Work has started on a Trust Patient Experience Framework, building on the key points above and will provide a comprehensive approach to take forward work that arises from the feedback provided by patients and their families.

Staff

The Trust is committed to delivering the NHS Constitution and its four pledges to staff:

- To provide all staff with clear roles, responsibilities and rewarding jobs for teams.
- To provide all staff with personal development, access to appropriate training for their jobs and line management support to succeed.
- To provide support and opportunities for staff to maintain their health and well-being and safety.
- To engage staff in decisions that affect them and the services they provide and empower them to put forward ways to deliver better and safer services for patients and their families.

Results from the staff survey in 2010 provide similar themes to those of 2009. These include the need to increase the quantity and quality of personal development plans, and improve the contribution of staff to decision making and communication within the Trust. In addition staff feedback supports the need to prioritise improvement in employee engagement.

However, there have been improvements in: staff job satisfaction, quality of job design, support from immediate managers and perceptions of effective action from employer toward violence and harassment. Staff at the ORH scored the Trust most highly in the availability and use of flexible working options and provision of equal opportunities for career progression or promotion.



Performance indicators

The data presented provides an overview of performance on certain aspects of the care pathway achieved by the organisation, comparing 2010/11 with 2009/10. These are national standards and data are reported monthly as part of the contract with the PCT. Action plans are in place to ensure achievement of the targets for quarter 1 (April-June 2011).

PERFORMANCE INDICATOR	TARGET*	2010/11	2009/10
Four hour maximum wait in the Emergency Department from arrival to admission, transfer or discharge	95%	95.13% ●	97.16% ●
Cancelled operations	5%	7.09% ●	3.23% ●
MRSA (actual number of cases)	12	9 ●	32 ●
C. Difficile (actual number of cases)	205	146 ●	238 ●
Referral to Treatment Time (RTT)** admitted – median	<=11.1	10.16 ●	
RTT admitted – 95th percentile	<=27.7	27.85 ●	
RTT non-admitted including audiology	<= 6.6	3.19 ●	
RTT non-admitted including audiology – 95th	<=18.3	17.3 ●	
RTT incomplete – median	<= 7.2	6.57 ●	
RTT incomplete – 95th percentile	<=36.1	21.84 ●	
Cancer Access			
2 week GP referral to 1st outpatient	93%	87.4% ●	91.58% ●
2 week GP referral to 1st outpatient – breast symptoms	93%	74.8% ●	
31 day second or subsequent treatment – surgery	94%	95.45% ●	95.11% ●
31 day second or subsequent treatment – drug	98%	99.83% ●	99.61% ●
31 day diagnosis to treatment for all cancers	96%	97.5% ●	97.69% ●
Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (radiotherapy treatments)	94%	87.57% ●	
	<i>(only applies for Q4)</i>		
62 day referral to treatment from screening	90%	86.8% ●	97.76% ●
62 day referral to treatment from hospital specialist	85%	93.6% ●	●
62 day urgent GP referral to treatment of all cancers	85%	77% ●	79.69% ●
Cardiac Access			
Reperfusion: Primary Angioplasty (PPCI)^ (technique for treating coronary heart disease and angina)	75%	76.7% ●	
Patients with 2 week recent onset of chest pain seen in rapid access chest pain clinic	98%	100% ●	99.90% ●
Stoke Care			
Patients who have had a stroke that have spent more than 90% of their stay in hospital on a stroke unit	60%	81.33% ●	54.42% ●
Access to GUM clinic			
48 hour access to Genitourinary medicine (GUM) clinic	98%	99.76% ●	121.05% ●

● Achieved ● Not achieved

NOTES:

* Target figure provided is for 2010/11. Target threshold for 2009/10 may have differed
Data has not been presented if target not measured in 2009/10

** For Referral to Treatment Time (RTT) data, quarter 4 (Jan-March) performance has been presented.
RTT = the national standard is that from referral to hospital no patient should wait longer than 18 weeks to be treated.

Statement from the Primary Care Trust

NHS Oxfordshire have reviewed the Oxford Radcliffe Hospitals (ORH) NHS Trust Quality Account against the three domains of quality: patient experience, patient safety and clinical effectiveness. There is evidence that the Trust has relied on both internal and external assurance mechanisms and NHS Oxfordshire is satisfied as to the accuracy of the data contained in the Account.

During 2010/11, the ORH completed a process of restructuring the management of their clinical services. NHS Oxfordshire believes the increased clinical input into operational delivery will raise the profile of quality within the Trust. The appointment of a new Medical Director last year has also assured the PCT that quality will be managed more effectively which as stated within the Quality Account was an action that the CQC stated that the Trust needed to address to achieve full compliance with the essential standards.

NHS Oxfordshire have also reviewed the key priorities stated in last year's Quality Account. The Trust have progressed well in most of the priorities set out with brief descriptions set out in the areas where changes have been made. The two exceptions would be the priorities on VTE risk assessments and reducing hospital mortality ratio as little progress was made on these topics in 2010/11. The Trust had a high predicted HSMR of 108 and was one of the few trusts in the country that was unable to measure VTE risk assessments. However, the Trust have maintained these two priorities in their objectives for 2011/12. NHS Oxfordshire agrees with the key priorities stated by the Trust for 2011/12 as they highlight areas which require improvement and will have great impact on the quality of the services.

NHS Oxfordshire recognise that the Trust have taken on board the comments made by the PCT last year by improving the presentation of this document making it clearer for the public to read. There are sections within the Account, however, which may still require more simplicity and the use of less jargon. The PCT also recognise that there is also a greater level of detail around the actions taken for clinical audits and actions proposed for where improvements are needed.

The Trust should consider providing the public with a greater narrative around the performance indicators and stating the actions that the Trust has in place to address underperforming cancer wait, 18 week wait targets and inconsistent A&E performance. The Trust should also consider writing brief details of the quality improvement initiatives that have been implemented as a result of CQUIN as well as providing a link to a web page outlining CQUIN details.

The primary purpose of Quality Accounts is to encourage boards and leaders of healthcare organisations to assess quality across all of the services they offer. This document achieves this objective and provides a good overview of the quality of care within the Trust. The planned integration of the NOC (Nuffield Orthopaedic Centre) and the ORH may generate some risks for quality of services as integration of services can lead to a loss of managerial focus on quality. However, NHS Oxfordshire is encouraged by this Account and is looking forward to working closely with the ORH as we move towards GP Commissioning in Oxfordshire.

Acknowledgements and feedback

Acknowledgements

The Oxford Radcliffe Hospitals NHS Trust wishes to thank corporate and divisional teams for their contribution to the production of the Quality Account 2010/11. Equally, the Trust would like to acknowledge the invaluable contribution of those that supported the public engagement event on 11 April 2011 and the many individuals and groups that give their time to advise us on how to improve our services on an ongoing basis, throughout the year.

We would like to acknowledge the helpful feedback from the PCT which we have responded to by making the necessary adjustments to our final version of the Quality Account.

Feedback

Readers can provide feedback on the report and make suggestions for the content of future reports. Please contact our Media and Communications department:

Media and Communications Unit

Level 3 Academic Centre
John Radcliffe Hospital
Headley Way
Headington
Oxford OX3 9DU

Tel: 01865 231471

Email: feedback@orh.nhs.uk

Please note, there will be a public engagement event on 19 October where progress with the Quality Account priorities will be discussed as well as an opportunity to start to consider priorities for 2012/13. Please contact above for further details.



John Radcliffe Hospital



Churchill Hospital



Horton General Hospital

If you need an interpreter or need a document in another language, large print, Braille or audio version, please call 01865 221473 or email PALSJR@orh.nhs.uk