Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Public Trust Board Meeting: Wednesday 09 March 2022

TB2022.09

Title:	**Oxford University Hospitals NHS Foundation Trust Proposed Quality Priorities 2022-23**

Status:	**For Decision**
History:	**Clinical Governance Committee 26 January 2022**
	Trust Management Executive 27 January 2022
	Integrated Assurance Committee 9 February 2022

Board Lead:	**Chief Medical Officer**
Author:	**Dr Andrew Brent, Director of Clinical Improvement, Deputy CMO**
	Rupali Alwe, Deputy Head of Clinical Governance
Confidential:	**No**
Key Purpose:	**Assurance**

Executive Summary

1. The Quality Account contains commitments to areas of work referred to as Quality Priorities.
2. This paper presents the proposals for the 2022-23 Quality Priorities.
3. The Quality Conversation Event to select the 2022-23 Quality Priorities had been scheduled for January but was cancelled due to the COVID-19 pandemic. In lieu of the Quality Conversation Event a process of internal stakeholder engagement has taken place to propose Quality Priorities for 2022/23.
4. The proposed Quality Priorities for 2022/23 have been approved by the Clinical Governance Committee and Trust Management Executive for submission to Trust Board and are aligned with NHSE/I CQUINs and planning requirements for 2022/23.
5. The Patient Experience, Membership & Quality (PEMQ) Committee have also been engaged in this process, and PEMQ feedback on the proposed quality priorities incorporated into this paper.
6. The next public engagement event will be planned in the summer, in lieu of the cancelled Quality Conversation. At this event it is planned that key stakeholders such as patients, carers, staff, Governors, and commissioners will hear about progress with the 2022 23 Quality Priorities.

Recommendations

7. The Trust Board is asked to approve the 2022-23 Quality Priorities.

Oxford University Hospitals NHS Foundation Trust Proposed Quality Priorities 2022-23

1. Background

1.1. OUH aims to deliver and assure patients they are receiving the very best quality of care. NHS Improvement requires all NHS Foundation Trusts to produce reports on the quality of care as part of their annual reports. Quality reports allow trusts to be held accountable by the public and other stakeholders.

1.2. Foundation Trusts are required by the Health Act 2009, and in the terms set out in the National Health Service (Quality Accounts) Regulations 2010 ('the quality accounts regulations'), to publish quality accounts each year.

1.3. The Quality Conversation Event to select the 2022-23 Quality Priorities had been scheduled for January but was cancelled due to the COVID-19 pandemic.

1.4. In lieu of the Quality Conversation Event a process of internal stakeholder engagement has taken place to propose Quality Priorities for 2022/23, including agreeing which of the current Quality Priorities should be rolled into 2022-23, and considering other proposals and suggestions for new Quality Priorities.

1.5. The consolidated list of proposed Quality Priorities for 2022/23 have been approved by the Clinical Governance Committee & Trust Management Executive and are aligned with NHSE/I CQUINs and planning requirements for 2022/23.

1.6. The Patient Experience, Membership & Quality (PEMQ) Committee have been engaged in this process. The proposed quality priorities have been shared with PEMQ members, and their feedback collated and shared with the CMO through the PEMQ Chair and incorporated into this paper.

1.7. The next public engagement event will be planned in the summer, in lieu of the cancelled Quality Conversation. At this event it is planned that key stakeholders such as patients, carers, staff, Governors, and commissioners will hear about progress with the 2022 23 Quality Priorities.

2. 2022-23 Proposed Quality Priorities

2.1. The following proposed Quality Priorities for 2022/23 have been developed with OUH stakeholder input, taking account of NHSE/I planning requirements and CQUINs for 2022/23. They have been approved by the Clinical Governance Committee & The Management Executive.

2.2. As required, there are a total of 9 Quality Priorities, with 3 in each category:

Patient Safety

2.2.1. Triangulation of complaints, claims, incidents and inquests

2.2.2. Reducing Pressure Ulcers

2.2.3. Medication safety – Insulin and Opiates

Clinical Effectiveness

2.2.4. Results endorsement

2.2.5. Introduce and embed use of a surgical Morbidity Dashboard

2.2.6. Embed QI methodology more widely in the Trust

Patient Experience

2.2.7. Reduce incidents of violence, aggression

2.2.8. Transition of children to adult services

2.2.9. Staff health and wellbeing: Growing stronger

2.3. Appendix 2 provides further details on each of the Proposed Quality Priorities for 2022-23.

3. Previous Quality Priorities and update on progress

3.1. This paper contains an update on the progress to date against some of the previous year's (2019-20 and 2020-21) Quality Priority. The update provides summary of the effectiveness of some of the previous priorities including whether change has been sustained. The COVID-19 pandemic has had an impact on delivery in the last two years as focus has necessarily been on pandemic management.

3.2. The updates provide assurance on QP being embedded in the Trust as standard contract and remains a focus and priority for clinical teams across all divisions.

Quality Priority Patient Safety	Update on effectiveness and whether change has been sustained.
Patient Safety Response Teams	PSR is a success story and continues Mon – Fri and covers all moderate and above impact incidents including those from the weekend/Bank Holidays. Between April to December 2021 inclusive 777 incidents were reviewed at PSR, 26 visits to support staff/patients and 62 incidents were re-graded.
Reducing Never Events- particularly around safe surgery and procedures	Never Events reduced from 11 in 18/19 to 7 in 19/20, 2 in 20/21 and 4 so far in 21/22. Compliance with WHO checklist is always over 99 % and 100% in many months. To-date 32 LocSSIPs have been produced, reviewed, approved and published via the Safer Surgery & Procedures Implementation Group (SSPIG). Internal Assurance on the outputs from SSPIG produced a Significant Assurance with minor improvement opportunities outcome. The action plan is progressed and monitored in SSPIG
Implement NEWS2 across OUH during 2020-21.	NEWS2 was launched in the Trust on the SEND platform on the 27th April 2021. This is used in all adult in-patient areas. Paper versions of the NEWS 2 scoring and escalation criteria have been made available in the event of a downtime and for those areas who do not use the electronic SEND platform.
Safety Huddles	Safety Huddles have been now embedded in all clinical areas. These take place daily/several times/day across all areas of the Trust and there is now a MyAssure audit that Divisions undertake to check compliance.
Insulin safety	Systems that have been developed have worked well and have been able to highlight people who have experienced NaDIA harms. Work around this QP continues into 22/23
Reducing stillbirths	OUHT's stillbirth rate per 1000 births is currently meeting the target set out in 'Saving babies' Lives' care bundle Version 2. The data represents an overall reduction in the numbers of families who have not had to live through the devastation of stillbirth. The team

	continue to work towards all elements of SBLCBv2 to further improve in this area.
Psychological Medicine	Tele-psychiatry provision has been established for the Horton and other OUH sites. On-going technical and practical challenges currently limit its use. Service expansion has continued but in some areas (e.g. haematology) this has been limited by available resources.
Staff health and wellbeing	In our 2020 staff survey we saw positive wellbeing improvements with a 6% increase from 27% to 33% in "my organisation definitely takes positive action on HWB" and above the 31.7% national average. The 2021 embargoed staff survey results show further positive improvements in this feedback and our Growing Stronger Together wellbeing quality priority continues into 2022/23.
Patients who have their procedure cancelled.	The delivery of this QP was halted due to the COVID-19. The patient experience strategy for the Trust for 2022 – 26 which is currently being drafted is envisaged to cover the work involved around this quality priority.
Reducing the number of patients with an extended length of stay (LOS)	Extended length of stay surveillance and reduction remains a focus and priority for clinical teams across all divisions to keep to our trajectory and below the National Target. As of 31st January 2022 12.7%, (113) of 886 adult inpatients had a length of stay over 21 days.
To minimize the occurrence of nosocomial COVID-19 in the OUH	7 Key Points to Prevent Hospital Community Acquired Infection (HCAI) during the COVID- 19 pandemic successfully launched. Trust internal auditors BDO findings report good knowledge across the MDT around 7 steps, identifies some actions around ventilator associated pneumonia (VAP). Task & Finish Group to review VAP bundles and delivery of them. This Quality priority was continued from the previous year (2020-21) and remains focussed on reducing opportunities for SARS- CoV2 transmission, considering both patients and staff (e.g., patient triage and pathways, diagnostics, patient placement, social distancing, cleaning, communications, education). A COVID-19 safety audit was introduced for areas to review compliance with safety factors such as personal protective equipment, social distancing, and ventilation. The Trust abides by the PHE guidelines for PPE; this is kept under regular review and discussed at COVID-19 Clinical Forum and Steering Group.

3.4. Appendix 2 details provides updates on the progress against previous years' (2019-20 and 2020-21) Quality Priorities.

4. Recommendations

4.1. The Trust Board is asked to approve the 2022-23 Quality Priorities.

Appendix 1: Proposed Quality Priorities 2022-23

Proposed Quality Priority 2022-23	How we will evaluate success	Executive Lead
Patient Safety		
Triangulation of learning from claims with incidents, inquests and complaints Potential safety issues are raised internally through the incident reporting system, and externally through complaints and patient liaison, safeguarding enquiries (under Section 42 of the Care Act 2014), deprivation of liberties safeguards (under the Mental Capacity Act 2005), legal claims, and Coronial inquests. Building on last year's quality priority, the aim is to strengthen the triangulation of learning from all these sources, with a particular focus on learning from claims.	**Action 1**: Review learning from all claims notified to NHS Resolution in the last 5 years in accordance with GIRFT litigation data pack dated May 2021 and "Learning from Litigation Claims" GIRFT/NHS Resolution best practice published February 2021 **Action 2**: Summarise and triangulate learning from claims with learning from incidents, inquests and complaints. Identify the core 8 GIRFT learning themes that might prevent future claims/complaints. • Review GIRFT 4th quartile specialty claims by 31 May 2022. • Review GIRFT 1st-3rd quartile specialty claims by 30 September 2022. • Claims are being reviewed in order of priority according to GIRFT Litigation Data Pack national benchmarking of the average cost of litigation per activity for each specialty starting with the specialties in Quartile 4 (red) **Action 3**: In depth analysis of four clinical specialties with development of training tools and documentation to reduce future claims, incidents and complaints. (Suggested	Professor Meghana Pandit, Chief Medical Officer; Sam Foster, Chief Nursing Officer; and Eileen Walsh, Chief Assurance Officer

	specialities are Neurosurgery, Trauma & Orthopaedics, Emergency Department and Obstetrics); one specialty each quarter in accordance with order of proiorty identified by GIRFT Litigation Data Pack and NHS Resolution's CNST scorecard.	
Reducing Pressure Ulcers Harms associated with pressure damage can have a lasting effect on patients and their carers and add a significant financial burden to the Health Economy as a whole. Pressure ulceration can be an indicator of the quality of care delivered. Reducing acquired Harms is a Trust priority	**PHASE 1 – IDENTIFY AND UNDERSTAND** By Q1&Q2 22/23 • Review and analyse all HAPU incidents with staffing, acuity, dependency, length of stay, complaints, and patient experience data from 2021/22, to identify and understand whether co-dependencies and/or commonalities exist. • Identify themes and issues related to environmental, clinical, educational, workforce and resourcing factors from the evidence established from the above action, to establish a baseline and identify learning opportunities. • Review National and Shelford data position for benchmarking and further learning opportunities. • Review the quality, availability, and reliability of the data sources currently available for gathering appropriate and specific intelligence and make recommendation to improve access and function. **PHASE 2 – DESIGN IMPROVEMENT, PLAN, AND IMPLEMENT** By Q2-Q3 22/23 • Establish clear themes and associated interventions for improvement with the clinical Divisional Teams (co-production).	Sam Foster, Chief Nursing Officer.

	• Plan and implement interventions identified from Phase 1, using a Quality Improvement (QI) approach. • Clinical Divisions to involve and engage staff in pilot areas with QI projects Evidence: Schedule Shared Showcase Events for presentation, dissemination of findings and building communities of practice within the Trust. • Develop systems to support effective multi-professional collaborative working practices, in association with pressure ulcer prevention and awareness. This will be achieved through highlighting the unique therapeutic contribution that each profession adds to the process of patient care. Evidence: Case Studies as exemplars • Undertake peer review of identified associated clinical audit for pressure ulcer prevention and wound management Evidence: MyAssure audit data • Review and re-launch Pressure Ulcer Prevention Policy with associated clinical resources through a targeted Awareness Campaign Evidence: Production of associated resources **Phase 3 – Review and Evaluation** By Q4 22/23 • Use data to measure effectiveness throughout the year and redesign and adjust interventions as necessary • Establish effective interventions and plan rapid spread • Monitor and evaluate further improvements.	

Medication safety – Insulin and Opiates Insulin errors remain widespread around the country despite many local and national initiatives to improve insulin safety. They can be potentially life-threatening and on many occasions the harm suffered is ameliorable or avoidable. **Reducing opioid use:** National and international guidance now recognise 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	**Insulin Safety:** **Action 1**: Where the NaDIA Harm criteria have been met, irrespective of the actual impact to the patient, there will continue to be an investigation of what happened to learn and improve care. All 'Harms' will be reviewed in a multi-disciplinary diabetes meeting. The insulin safety group will continue to share learning from these investigations with the Medicines Safety Group. Insulin Safety Group wants to focus on identifying current themes for learning and will start with a quarterly review of incidents. **Action 2**: Review of hypoglycaemia events in inpatients using blood glucose results available via point of care testing and comparing with inpatient Ulysses reports to gauge awareness of hypoglycaemia management across the Trust and target training appropriately. A one-month sample of results will be selected for a baseline audit for review by the end of Q2 22/23. **Action 3**: People with diabetes will be represented on the diabetes safety group. Involvement of patients in identifying ways on improving safety while inpatients and creation of useful material to support inpatients during their stay. Review attendance to the monthly diabetes safety group meetings by the end of Q4 22/23. **Reducing opioid use:** **By 31 March 2023, to reduce opioids use in all adult patients:** **Action 1:** Development and review of Trust guidelines for pre-operative assessment to guide post-operative pain management with a particular focus on complex patients who are on oral daily morphine equivalent doses of greater	Professor Meghana Pandit, Chief Medical Officer and Sam Foster, Chief Nursing Officer.

are effective and necessary, opioid stewardship is needed across the Trust to ensure safe monitoring of patients and adequate, but not excessive, discharge prescribing.	than 120mg pre-operatively (guidelines to include patient defined comfort and functional goals to manage patient's pain expectations). Q1: Draft guideline, developed and tested during Q1. Q2: Revised and approved by the end of Q2. Q3: Introduction to routine practice Q4: Introduction to routine practice **Action 2:** Establish Trust wide baseline data of codeine, tramadol, dihydrocodeine, morphine and oxycodone discharge quantities from surgical areas for further education and culture change. Monitor the quantity of opioids supplied on discharge. Where clinically appropriate, aim to reduce the routine supply of opioids on discharge to an acceptable minimum and to increase the number of patients discharged with multi-modal analgesics. Q1 and 2: Identify and monitor baseline data for the quantities of opioids supplied on discharge from surgical areas. Q3 and 4: Introduce changes in practice to reduce routine supply of opioids and evaluate for effectiveness. **Action 3:** Review and promote the use of the Pain Guidelines available via OUH MicroGuide to improve understanding of pain management and prescribing of pain treatment across the Trust. Q1-2: 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 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 **Action 4:** Establish an opioid stewardship group to monitor and oversee the 'Reducing Opioid Use' quality priority and continue collaborative opioid stewardship work with the Academic Health Science Networks. Q1: Scope key stakeholders and develop terms of reference Q2: Launch meeting **Action 5:** To identify a selection of indicators around opioid prescribing and administration in collaboration with ePMA and 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 who have received naloxone) Q3 and 4: Refine and develop reporting tools	

Results Endorsement Ensuring that the results of requested tests/investigations are seen and acted upon is important to avoid serious findings being missed and patients coming to harm. Assurance that a test result has been acted upon is achieved by the requestor endorsing the result on EPR (Electronic Patient Record). This is termed 'Results Endorsement'. This priority aims to increase the number of total results endorsed, streamline the processes involved, reduce variability across the Trust and raise awareness of the importance of results endorsement.	**Action 1**: Identify 5 clinical areas with lower endorsement rates and focus education and awareness to increase results endorsement by at least 10% compared to Nov 2021 levels. • Q1 – identify areas and baseline data. Meeting with clinical leads and encourage clinical team attendance at virtual digital surgery and arrange presentations at clinical and governance meetings. Individuals clinician's to be given access to their personal endorsement rates. • Q3: Audit of results endorsement in 5 key areas **Action 2:** Raise awareness with safety messages and grand round presentations and monthly 'Virtual Digital Surgery' with a focus on results endorsement (pools, proxy and encounter) • Q1 - Results endorsement safety message to go out quarterly. Monthly digital surgeries to be established • Q2-4 – grand round presentations if reinstated post covid. **Action 3**: Ensure tests requested by non-medical requestors are endorsed. Identify non-medical requestors and if not able to endorse ensure processes for result being actioned by the Clinical Lead • Q1 **-**Identify all non-medical requestors and baseline endorsement rates • Q2 – Ensure non-medical requestors competent to endorse or alternative process in place • Q3 – Audit results endorsement rates of non-medical prescribers	Professor Meghana Pandit, Chief Medical Officer David Walliker, Chief Digital Officer

	Action 4: Implement auto endorsement of negative results i.e. normal MSU and MC&S results. • Auto endorsement to be considered by Q1 and in place by Q3. **Action 5**: Ensure all patients in ICU have results endorsed on EPR. • Consider ICU patients remaining under referring clinician who remains responsible for endorsing results. **Action 6**: Remove EPR access for all clinicians who have left the trust and implement a new digital leavers process to remove in future • Review EPR access for those already left by Q2 • Implementation digital leavers process by Q4 **Action 7**: Ensure all lead Clinicians have EPR pools set up to help manage results and are aware of the processes for managing these • Access to EPR pools by Q3.	
Introduce and embed use of a Morbidity Dashboard in surgical specialties To share learning and promote widespread adoption of morbidity dashboard to identify and understand any areas with higher rates of readmissions and returns to theatre across the Trust.	**Action 1**: Develop and implement Morbidity Dashboard for surgical specialties by end of Q2. **Action 2**: Embed routine review of the Morbidity Dashboard into surgical morbidity and mortality meetings by end of Q2 **Action 3:** By Q4, develop procedure-specific dashboard for five procedures that can be used by services and M+Ms to audit procedure-based outcomes **Action 4**: By Q4 Use the morbidity dashboard to identify and understand any areas with higher rates of readmissions and returns to theatre compared with regional and national benchmarks.	Professor Meghana Pandit, Chief Medical Officer Professor Chris Cunningham

Embed QI methodology more widely in the Trust Building on the success of the QI Hub, which won the *Health Service Journal Changing Culture Safety Award 2021*, this Quality Priority aims to embed the same culture of improvement more widely across the Trust. We will do this by expanding the QI Hub and QI methodology to a wider community of colleagues from all disciplines across the organization; sharing learning and good practice through this network and through our QI Stand Up forum; and thereby providing a platform for further training, support, mentorship, and system change.	Action 1 (Q1): Establish current Trust-wide QI capacity and activity, including: (a) Register of QI Hub members (faculty & participants) (b) Register of staff who have completed QI training (including OUH QSIR training) (c) Inclusivity of QI Hub & QSIR training (departments, professional groups, bands/grades, ethnicity) (d) Register of departmental QI and Audit leads (e) No. QI projects registered on Ulysses by month Action 2 (Q2-Q3): Strengthen QI Leadership & Support: (a) Engage existing QI and Audit leads with QI Hub to increase QI Hub reach, inclusivity and support (b) Encourage and support development of QI Leads in all departments (c) Develop and implement standardised SOP for registration and presentation of QI projects. Action 3 (Q3-Q4): Strengthen QI visibility and monitoring (a) Establish monitoring of QI activity across the Trust (b) Audit key metrics to assess impact of interventions: • No. and inclusivity of QI Hub members • No. (%) Staff trained in QI • No. registered QI projects (by quarter) • No. (%) QI projects using standard QI methodology • No. (%) QI projects presented at departmental / Trust level • No. (%) QI projects that achieved project aims (c) Use data to inform ongoing QI strategy development	Professor Meghana Pandit, Chief Medical Officer Sara Randall, Chief Operating Officer

Reduce incidents of violence, aggression and/or abuse initiated by members of the public directed towards patients or Trust Staff. These incidents may cause significant distress for both patients and Staff, either directly, or indirectly as witnesses of such incidents. This Quality Priority aims to understand the scale of the problem and the factors that contribute to violence and aggression; and implement interventions to reduce the frequency of these incidents and the impact they have on both patients and staff.	**Phase 1 - Diagnostics for completion by end of April 2022** Review via H&S committee a deep dive into the divisional positions and identify priority areas Review staff survey data to triangulate with incident reporting Review provision of handling Violence and aggression training and training needs analysis. Review current well-being offers/take up Review Trust wide security provision Review BOB position for sharing and learning opportunities. **Phase 2 - Intervention/Policy review for completion by end of September 2022** Pilot and evaluate interventions to deter individuals from these events and improve patient and staff wellbeing and safety in priority areas – e.g. Emergency Department (ED) body cameras, lone working devices, training, and line manager wellbeing meetings with team members. Undertake pulse surveys to evaluate interventions a/a. Review the Trust Violence & Aggression policy and develop implementation and communication plan **Phase 3 – Evaluation /Implementation completion by March 2023** Scale up of interventions that have shown to have impact. Policy re-launch Progression of areas identified in diagnostic Monitor and evaluate improvements.	Sam Foster, Chief Nursing Officer

Transition of children to adult services To deliver a consistent Trust wide service for every child/ young person making the move from receiving child-centred services to adult services. Scope: Children/young people with • long term condition • ongoing health needs receiving health services over the 15-18 age range **Why we chose this Quality Priority:** To ensure that all young people we treat receive a quality service to achieve optimum health and psychological wellbeing.	**Action 1:** Audit and feedback: How are we doing now? 1. Audit EPR Compliance with Ready Steady Go – Hello transition child centred plan (by 31 May 2022) 2. Identify children/ young people with long term conditions Trust wide on the moving to adulthood pathway (by 31 May 2022) 3. Further Gap Analysis and benchmarking exercise: ·By 1st April 2022, establish Trust wide status on Transition/ moving to adult hood pathway · By 16th April 2022, complete Moving to Adult hood Benchmarking (using the Burdett Foundation Trust Benchmarking tool, BOB ICS, and Shelford Group) 4. By 30th April 2022, Scope and Benchmark Partner working - BOB ICS, NHS Southeast and Shelford Group, Key Children's Hospitals, Oxfordshire Health, Education and social care system. 5. By 30th June 2022, collate audit and feedback into 'How well do we currently support children and young people's move to Adult services?' 20 from Children, 20 from families. One per transition clinic. 6. By 30th September 2022, Benchmark, scope and develop business case for overall Trust transition lead/ coordinator. **Action 2**: Improving the services to support moving to adulthood/ transition. Aim for end of Q3. 1. Plan Inclusive summit 2. Inclusive summit: Families, staff, and health, education, and social care partners. 3. Co-produce and develop the Trust's Moving to Adulthood/ transition standards of practice or Charter. Include a lead for children receiving multiple services. 4. Review and amend Moving to Adult /Transition policy 5. Implement reviewed Trust wide and Divisional practice.	Sam Foster, Chief Nursing Officer Sara Randall, Chief Operating Officer

	Action 3: How will we ensure/ assure the Trust, families, and partners that the moving to adult hood service works? It is envisaged that following the delivery of 1-4 in Action 2, that Trust wide practice would be implemented within 6 months 1. Monitor compliance with the Trust Moving to Adulthood/ transition standards of practice or Charter. 2. Regular (need to define and scope this) pulse check with staff, children and families to check and amend services if necessary	
Staff health and wellbeing: Growing Stronger The aim of this Growing Stronger Together priority is to look after the wellbeing of our people and teams and enable their recovery following the Covid-19 pandemic and transition into a 'new normal'. Focusing on the recovery of our people is essential to keep them safe and healthy at work, help reduce stress, anxiety and presenteeism and retain an engaged workforce.	**Action 1**: By end March 2023, 85% of our people to have participated in a Wellbeing Check-In. **Action 2**: By end June 2022, to have designed and commenced delivery of a menu of bespoke Post-Traumatic Growth support offering for our teams led by the Psychological Medicine Support for Staff Service. Deliver 80 team sessions by the end of March 2023. **Action 3**: Complete the Timewise flexible working assessment and action plan by the end of March 2023. **Action 4**: By end June 2022, launch a suite of 'leading self' resources and support for all our leaders to manage their own wellbeing as part of our Leading with Care series. **Action 5**: By March 2023 - reduce temporary staff cover for absence relating to stress/anxiety by £27,585 on the previous year. **Action 6**: By end of March 2023 develop an SLA between OH and the organisation, agree KPIs for the service and embed management reporting of these KPIs by the end of the year.	Terry Roberts, Chief People Officer.

Appendix 2: Previous year's (2019-20 and 2020-21) Quality Priority Updates

	How we will evaluate success	Evaluation March 2021	Update March 2022
Patient Safety Response Teams	A Patient Safety Response (PSR) Team will be piloted for 8-12 weeks in the JR and West Wing and evaluated before being considered for Trust-wide roll out.	The pilot of the PSR began 12 March 2019 and an evaluation took place at the end of July 2019, following which the process formally launched on 17 September 2019, World Patient Safety Day. • Between 1/4/19 and 31/3/20 950 incidents were discussed, of which 160 incidents had their impact downgraded (17%) and 43 inspired department visits from a PSR delegation (5%). **Fully achieved**	• PSR is a success story and continues Mon – Fri and covers all moderate and above impact incidents including those from the weekend/Bank Holidays. • Between April to December 2021 inclusive 777 incidents were reviewed at PSR, 26 visits to support staff/patients and 62 incidents were re-graded.
Reducing Never Events- particularly around safe surgery and procedures	1. A minimum of ten LocSSIPs will be developed over the course of the year. 2. Finalise the remaining overarching procedures and policies relating to Never Events in the next six months, to include: WHO Surgical Safety Checklist Policy. Prosthesis Verification Policy. 3. Aim for 100% compliance with WHO	1. Achieved: 16 LocSSIPs had been produced by 31 March 2020. 2. Achieved: The remaining policies have been approved, uploaded and communicated to staff. These were the WHO Surgical Safety Checklist Policy and the Prosthesis Verification Policy. 3. 3 Partially achieved: WHO compliance for March 2020: documentation audits 99% (262/265) 100% (268/269) for observational WHO audits. 4. Achieved: An action planning workshop took place on 30/04/19 facilitated by NHS Improvement (NHSI) and the Patient Safety Academy.	• Never Events reduced from 11 in 18/19 to 7 in 19/20, 2 in 20/21 and 4 so far in 21/22. Compliance with WHO checklist is always over 99 % and 100% in many months. • To-date 32 LocSSIPs have been produced, reviewed, approved and published via the Safer Surgery & Procedures Implementation Group (SSPIG); this includes an Elective Surgery LocSSIP covering the vast majority of surgical procedures covered by

	Surgical Safety Checklist. 4. Run an action planning workshop with input from NHSI, Patient Safety Academy and Clinical Governance to ensure robust actions are put in place to prevent recurrence of serious incidents / Never Events. 5. Complete all actions from RCAs following NEs in 2018-19. Demonstrate learning across all Divisions at Governance meetings.	5. Achieved: To the end of March 2020: 100% of Never Event actions for 2018/19 for which the target date has passed have been completed 6. Five OCCG/NHSE assurance visits have taken place since April 2019 closing 20 Never Events and providing assurance that learning and actions have been demonstrated. 7. A Safety Symposium focusing on WHO surgical safety checklist took place 8th October 2019. **Fully achieved**	the generic WHO surgical safety checklist. • The National Safety Standards for Invasive Procedures policy and other clinical policies (including the WHO checklist policy) under this framework have been produced and reviewed within their 3 year time-frames. • Internal Assurance on the outputs from SSPIG produced a Significant Assurance with minor improvement opportunities outcome. The action plan is progressed and monitored in SSPIG • WHO checklist compliance is monitored monthly via Divisional Quality reports to Clinical Governance Committee (CGC) and reported via the Integrated Performance Report to Trust Board/IAC. December 2021 data provided 100% compliance across observational and documentation audits. • SSPIG was asked to provide support for the implementation of the electronic WHO checklist and has worked closely with the EPR team responsible to

			ensure completion of the project in time for going live • Action plans from Serious Incidents pertaining to safe surgery and procedures are followed through by the Divisions and outstanding actions/actions completed reported via Divisional Quality Reports to CGC and then to IAC via the SIRI/NE report bimonthly. These are also taken monthly to the Serious Incident Group which meets weekly and actions that have proved more challenging to follow through are discussed and amended or extended where required.
NEWS2 In April 2018 NHS Englandmandated the implementation of NEWS2across all acute hospital trusts and ambulance services. (Patient Safety Alert NHS/PSA/RE/2018/ 003).	We will implement NEWS2 across OUH during 2020-21. **Action 1:** Deliver Trust-wide communication for the launch of NEWS2 during 2020-21. **Action 2:** Test and deliver the technical requirements for the deployment of NEWS2	**Action 1**: Trust-wide communication about the launch of NEWS2 and the subsequent changes to this have taken place in a timely fashion. As this is an ongoingprocess due to the delay in introducing the system caused by the pandemic, theaction is ***partially achieved.*** **Action 2:** The technical solution, including the fix of the problem experienced at the September 2020 launch, has been tested and was ready to be launched on 12 January 2021. Some potential risks remain as the testing process is similar to that used in September but the team is more	• NEWS2 was launched in the Trust on the SEND platform on the 27th April 2021. This is used in all adult in-patient areas. Paper versions of the NEWS 2 scoring and escalation criteria have been made available in the event of a downtime and for those areas who do not use the electronic SEND platform. • Work with the SEND provider Sensyne Health is ongoing to ensure that the ward reporting functionality as was available in the previous version is updated

	within the System for Electronic Notification and Documentation (SEND) platform and the electronic patient record (EPR) during 2020-21.	confident insuccess. However, it was considered that the launch of NEWS2 atthis time would place an unacceptable stress on clinical teams tackling rising COVID-19 patient numbers and so, following an options appraisal, a decision to delay the launch was approved by the COVID-19 Steering Group until, at least, April 2021. ***Partially achieved.***	for NEWS 2. This will allow for local monitoring of compliance with observations and also to compare performance with similar ward areas. This reporting in the interim is being provided by colleagues in the Information team. • Funding has been approved to replace all the existing SEND tablets in the organisations with an updated model. Over 100 of these have already been distributed in clinical areas, the remainder to replace all older models have been ordered. This will improve efficiency in terms of observation entry for staff in ward areas.
Safety Huddles A safety huddle is a short multidisciplinary briefing, held at a predictable time and place, and focused onthe patients most at risk.	A standardised method to run and record safety huddles has been developed and implemented acrossthe Trust. **Action 1:** Assess effectiveness (we would expect to see an increase in the number of incidents reported with a lower	**Action 1:** Although it is not possible to undertake a meaningful comparison with the same time in the previousyear due to the COVID-19 pandemic, the data show thatthe number of incidents reported has remained aboutthe same over the last two years with the proportion of high harm incidents appearing to increase very slightly over that time. It is impossible to draw any meaningful conclusion from this as the numbers are so small and the variables are many and complex although analysis is ongoing. No commonalities or trends havebeen	• Safety Huddles have been now embedded in all clinical areas. These take place daily/several times/day across all areas of the Trust and there is now a MyAssure audit that Divisions undertake to check compliance.

	proportion of high harm incidents). **Action 2:** Assess the safety culture across the organisation using a validated tool.	identified. ***Partially achieved.*** **Action 2:** The University of Texas Safety Attitudes Questionnaire (UTSAQ), used by the OxSTaR for ourhuman factors programme, has been distributed to multidisciplinary teams who have undergone training collectively as a result of Never Events including Interventional Radiology, Plastics and Dermatology. Analysis of data from the UTSAQ will inform ongoing safety interventions and we will revisit these teams in the coming year using the UTSAQ to understand any change in culture as a result of these interventions. Future plans include broadening the use of this questionnaire across OUH to support more teams in the delivery of effective safety interventions. The initial draft of the data analysis from the UTSAQ shows that feedback was limited, but when combined with course, effective. **Partially achieved.**	
Insulin Safety Insulin errors remain widespread around the country despite many local and national initiatives to improve insulin safety. They canbe	By 31 March 2021 there will be a 20%reduction in two of the National Inpatient Diabetes Audit (NaDIA) Harms: severe hypoglycaemia and hospital acquired diabetic ketoacidosis.	**Action 1:** Previously identified incidents reviewed against nationally defined criteria to clarify baseline. Information query built to ensure all DKA incidents areidentified using current systems. Query built for Ulysses to identify reporting of previousincidents.	• Systems that have been developed have worked well and have been able to highlight people who have experienced NaDIA harms. This has enabled the diabetes team to intervene and improve patient safety, particularly for those people experiencing severe

potentially life-threatening however, onmany occasions the harm suffered is ameliorable or avoidable.	**Action 1:** We are going to cleanse our data to ensurethey provide an accurate representation of our case mix. Action 2: Where the NaDIA Harm criteria have been met there will be an investigation of what happened in order to learn and improve care. Action 3: Investigation templates for each of the harms will be produced and adapted as required to fit the needs of the investigations. Action 4: A multidisciplinary Insulin Safety Group will be set up to review the NaDIA Harm reports, identify learning and actions to improve care.	System implemented foridentification of new incidents from EPR- generated alerts and diabetes team consults. ***Action achieved.*** **Action 2:** Members of the Diabetes Team are reviewing incidents while awaiting the formation of aninsulin safety group. ***Partially achieved.*** **Action 3:** No existing templates identified for NaDIA Harms from local /national sources (peer experts, charities and national societies with aninterest in inpatient care approached). Local templates for otherharms identified and reviewed. Literature search undertaken. The work to complete this action is in thevery early stages. ***Partially achieved.*** **Action 4:** There is a Trust imperative to set up a Medicine Safety Group first (inaugural meeting December 2020). Insulin safety is being considered in the round as part of this group. The Insulin Safety Sub Group will report to the main Medicine Safety Group.A planning meeting for the Insulin Safety Group has	hypoglycaemia. The rates of NaDIA harms have increased, but this is due to systems being able to more accurate identification as many of them were not being recorded on Ulysses. The Insulin Safety Group has been established and a patient representative has been identified and included. The insulin e-learning package is to be re-introduced for clinical staff involved with prescribing, administration or supply of insulin. The medicine safety group has been established and the insulin safety group reports to this group. • Work remains over the coming year to build on the current successes.

<table>
<tr>
<td>Reducing stillbirths</td>
<td>Reduction in stillbirth rate by 20% by 31 March 2020. Reducing stillbirth rate from 5.2 per 1000 births to 4.0 per 1000 births by the introduction of the five elements recommended in the ‘Saving Babies’ Lives’ Care Bundle:
Element 1 – Reducing smoking in pregnancy.
Element 2 – Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction.
Element 3 – Raising awareness of reduced fetal movement.
Element 4 – Effective fetal monitoring during labour.
Element 5 – Reducing the number of preterm births.</td>
<td>Element 1 – Carbon monoxide testing being offered together with referral to Stop Smoking service where appropriate.
Element 2: OUH were one of the first Trusts in the country to introduce routine 36 week growth ultrasound scanning plus identification of women whose baby might struggle to grow properly, with an offer of an extra ultrasound scan at 28 weeks.
Element 3: All women are asked about how their baby is moving at every appointment. Language appropriate literature with information on self-referral should the baby not move is shared.
Element 4: Standardisation across the region for monitoring during labour has taken place, together with competency based training for all doctors and midwives.
Element 5: Our stillbirth rate per 1000 births continues to fluctuate (2019-20 quarters so far: Q1 4.18, Q2 5.57, Q3 3.14). This represents an overall reduction in the numbers of families who have not had to live through the devastation of stillbirth. To ensure sustained improvement in this project, we need to continue this work and become compliant with SBL v2.
Fully achieved</td>
<td>OUHT’s stillbirth rate per 1000 births is currently meeting the target set out in SBLCBv2. 2021/2022 data is recorded up to Quarter 3 ending 31/12/2021.This data represents an overall reduction in the numbers of families who have not had to live through the devastation of stillbirth. We continue to work towards all
<table>
<tr><th>Year</th><th>Mean</th></tr>
<tr><td>2019/2020</td><td>3.83</td></tr>
<tr><td>2020/2021</td><td>3.83</td></tr>
<tr><td>2021/2022</td><td>2.69</td></tr>
</table>
elements of SBLCBv2 to further improve in this area.

Carbon Monoxide (CO) testing was temporarily suspended during the Covid pandemic but was replaced with verbal advice. Since June 2021 CO face to face testing has now been resumed. The compliance rate is currently 82% at booking, and 84.75% at 36/40 weeks (measured over a rolling six week period). OUHT have introduced a new physiological approach to CTG monitoring/fresh eyes. Data is currently showing low compliance with the timely</td>
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			administration of steroids and work is being undertaken with the lead consultant and the Digital Midwife to determine whether this is a data error or whether this is an area for improvement.
Sepsis care – antibiotics within 1 hour	Increase from 74% to more than 90% the proportion of sepsis patients receiving antibiotics within an hour by 31 March 2020. Undertake an audit of sepsis in which the first dose of antibiotics was delayed > 1h in order to identify and share learning by 31 March 2020. Include 'Sepsis' as a subject for learning on a 'Grand Round' by 31 March 2020.	1. Proportion of patients who received antibiotics within 1hr of a sepsis alert • May 19 – 41/60 (68%) • Jun 19 – 44/56 (78%) • July 19 – 47/59 (78%) • Aug 19 – 40/50 (80%) • Sep 19 – 62/75 (83%) • Oct 19 – 57/70 (81%) • Nov 19 – 40/52 (77%) • Dec 19 – 60/81 (74%) • Jan 20 – 36/45 (80%) • Feb 20 – 32/44 (73%) • Mar 20 – 30/46 (65%) 2. Audit Audit completed and report shared with the Sepsis Team. Formal presentation to the Sepsis working group deferred to next meeting due to Covid-19. Key findings included: • The OUH Sepsis Agent is an effective tool for identifying patients with sepsis.	Sepsis care Team is now part of the standard contract continuing to work hard on addressing this goal (teaching / time to antibiotics audit / new dashboard etc.). The OUH performance on time to antibiotics from a sepsis alert between April 2020 and December 2021 has seen a steady upward trend in performance since 2020, with 90% at December demonstrating that we met the standard in both ED and MRC.

		• 81% (177/218) of the patients with a sepsis alert had sepsis. • Among patients for whom there was a delay to antibiotics, median time from Sepsis Alert to antibiotics was 90 mins. • Much of this delay is between antibiotic prescription and administration: among patients for whom there was a delay to antibiotics, median time from Prescription to antibiotics was 58 mins. • There was limited documentation on other reasons for delays, but from the data we did have the main reason was difficulty in gaining IV access. 3. Grand Round - Completed Sepsis Surgical & Medical Grand Rounds took place 31/01/2020 & 20/02/2020. Regular sepsis slots are scheduled for student nurse grand round. **Partially achieved**	

Psychological Medicine Improving the provisionof psychological medicine to all OUH patients (formerly referred to as 'mental health care')*	We aim to build onthe already good level of 'mental healthcare' OUH offers its patients by enhancing it in several areas as follows. **Action 1:** We will improve access to psychiatry for inpatients at the Horton General Hospital by implementing tele-psychiatry for medical inpatients. **Action 2:** We will expand the provision of integrated psychiatry and psychology to cover more of theTrust's high needareas such as haematology and gastroenterology. **Action 3**: We will work with our partners Oxford Health to ensure that we deliver thenationally requiredCore 24 standard by ensuring that there is	**Action 1:** We have enhanced tele-psychiatry provision for all medical inpatients (on all sites including the Horton) in part as a response to COVID-19.Further work is needed to address practical and technical issues (suitable space in the psychiatry office, availability of suitabledevices, staff training and reliable connections to Wi-Finetworks). ***Partially achieved.*** **Action 2:** We have expanded Psychological Medicine to some, but not yet all, high need areas. New posts for haematologyhave been approved. Psychological Medicine continues to work with medical and surgical specialties including gastroenterology, respiratory medicine, stroke, specialist surgery and cardiology to improve provision. COVID-19 has emphasised the need but also slowed progress in contracting and approvals. ***Partially achieved.*** **Action 3:** OUH Psychological Medicine has extended provision to include weekend and bank Holidays. Oxford Health continues to cover night-time emergencies (and ED).As a result, OUH now meetsthe NHSE Core 24 standardof delivering a rapid response to all emergency (1 hour) and urgent (24 hours) referrals every day inboth ED and OUH wards. Although the action has been achieved, at this	**Action 1:** Tele-psychiatry provision has been established for the Horton and other OUH sites. On-going technical and practical challenges limiting its use are (a) quality of Wi-Fi and (b) availability of appropriate space in the psychiatry office which to conduct remote consultations (space used during the pandemic has been removed from the team. It would help for this to be reinstated. **Action 2:** Service expansion has continued but in some areas (e.g. haematology) this has been limited by funding for agreed business cases not being released / transferred. Other areas of high need (e.g. gastroenterology) have indicated that developing integrated psychological medicine is not a priority. There has, however, been some success in developing services in the Heart Centre, Long COVID, and Stroke. There are so far unfunded pilot projects in Infectious Diseases and Respiratory Medicine. As part of the OUH recovery plan Trust

	a rapid response to all emergency and urgent psychiatric referrals at nights and weekends as well as during weekdays.	point in time, ongoing input will berequired to ensure this performance is maintained. ***Fully achieved***	support for progressing these plans is needed.
Staff health and wellbeing Related to feedback from the Staff Survey.	The aim is to provide an effective, safe and healthy working environment which will be reflected by an improvement in the staff health and wellbeing scores in the 2020 OUH StaffSurvey. **Action 1:** Using Staff Survey data, engage with staff to identify and prioritiseinitiatives for implementation by end March 2021 to improve people's health and wellbeing	**Action 1:** Health and wellbeing (HWB) has beena core priority throughout 2020-21. Our 2020 Staff Survey results showed a significant improvement in our wellbeing scores, including a 6% increase inpeople feeling that OUH definitely takes positive action on health and wellbeing. Key components that have driven this improvement include: HWB Lead commenced 11/01/21 to work with ourBlack, Asian and MinorityEthnic (BAME) staff members to co-design culturally relevant initiatives. • 'Your Wellness Matters'winter wellbeing campaign launched 11/01/21 through to the end of March 2021. • Weekly workshops for wellbeing leads facilitated by Psychological Medicineand Culture and Leadership. • Fortnightly PsychologicalMedicine and Here for Health 'self-care' webinars for our people. • Respite rooms beingidentified.	• Following on from 2019/20 the Wellbeing Quality Priority continued into 2020/21 with a particular focus on the wellbeing support for our people during Covid, including our OH risk assessment, Guide to Health and Wellbeing, Psychological Medicine support for teams and the introduction of team Wellbeing Leads. We also developed our people business case receiving Board investment in additional Occupational Health and Culture and Leadership resource (including a new Head of Wellbeing and Wellbeing Practitioner). The wellbeing theme continued into 2021/22 with a further Quality Priority being focused on our people recovery programme: Growing

	Action 2: A newly revised policy and procedure for managing stress in the workplace will bedrafted ready for consultation by 31 March 2021. **Action 3:** Ensure the use of a recognised Health and Wellbeing Framework to support our work is in place by 31 March 2021.	• Risk assessments completed for all ourpeople. • Greater flexible workingarrangements positively received. • Specific HWB questionsincluded in 2020 Staff Survey. • Rollout of flu and COVID-19 vaccinations.Over 11,000 OUH staff have now had a COVID-19 vaccine and over 3500 staff have now hadboth doses. • Winter incentives package offered over Christmas. • 'Recognition' annual leave day – 2021-22. • Regional funding for a rest pod for Neuro ICU. • Participation in the national arts programme – one of 20 trusts. • Leadership Behaviours Framework in development – based onleading with care. • DMTs and three CSUsrolling out Affina. • Non-Executive Director(NED) Wellbeing Guardian identified***. Action achieved.*** **Action 2:** The Managing Stress in the Workplace policy has been drafted and is ready for consultation in April 2021.***Action achieved.*** **Action 3:** The OUH Guide to Health and Wellness was launched in June 2020and this was	Stronger Together – Rest, Reflect, Recover led by our newly appointed Head of Wellbeing (June 2021) and Psychological Medicine support for staff service; working in collaboration with a number of different wellbeing services across the Trust, ICS and regional/national teams. Outcomes in 2021/22 included R3P workshops to support our teams with post-traumatic growth, the introduction of wellbeing check-ins for our people, Mental Health First Aiders and the consolidation of our wellbeing offers including an updated Guide to Health and Wellbeing and wellbeing website with regional/national offers. Our new Wellbeing Practitioner will be joining in April 2022. • The NHS Annual Staff Survey continues to be regarded as an important part of our engagement approach to obtain feedback from our people regarding what is working well and what could be even better. We have continued to build on 2020 activities, by learning from what has

		comprised of six dimensions of wellness: Emotional and psychological; environmental; physical; occupational and intellectual; financial; social. These are based onthe eight dimensions of wellness framework and they have driven the OUH work priorities during 2020-21. Furthermore, as part ofthe collaboration in the BOB ICS, OUH undertook an organisational assessment in November 2020 against the NHS Health and Wellbeing Framework to help to plan and implement system priorities to improve the wellbeing of our people. ***Action achieved.***	worked well to date within the national best in class trusts, as well as identifying areas of internal good practice to enable collective improvement. In our 2020 staff survey we saw positive wellbeing improvements with a 6% increase from 27% to 33% in "my organisation definitely takes positive action on HWB" and above the 31.7% national average. The 2021 embargoed staff survey results show further positive improvements in this feedback and our Growing Stronger Together wellbeing quality priority continues into 2022/23.
Patients who have their procedure cancelled Gathering information to understand the impact of cancelled admissions and procedures on patientsand their families. Thiswill provide valuable	The aim is to improvethe position of the Trust regarding cancelled proceduresin national surveys tothe middle quartile by31 March 2021. **Action 1:** We will ensure that all staff who are likely to be delivering this newsare trained to do so	**Action 1:** Discussions with Urology are ongoing regarding a potential pilot site for this action. Work hasbeen delayed due to the pandemic pressures. ***Partially achieved.*** **Action 2:** From August 2020to January 2021 there have been 69 patient cancellations (on average 11per month). This is for JR and WW theatres (no data for SUWON at present). The team have not had capacity to explore in depth with patients why they have declined their	There was some progress made to improve patient experience surrounding cancelled/ postponed procedures but was halted due to the COVID – 19 pandemic. The patient experience team is drafting a patient experience strategy for the Trust for 2022 - 26. It is envisaged this will be in two stages and this piece of work would fit into Stage two 2023-6.

insight for recommendations to enhance the patient experience.	appropriately. **Action 2:** We will explore the reasons for 'patients declining treatment on the day' and reduce the monthly average fromsix to three per month.	operation, however, COVID-19 is recorded as a detail for this on the dataset. Further workon this has been delayed due to the pandemic pressures. ***Not achieved.***	As the Trust moves forward with patient care following the pandemic this may be a useful project to reinstate. This would need to undertake in conjunction with the QI team.
Reducing the number of patientswith an extended length of stay (LOS) Ensuring patients reach the discharge destination that is rightfor them in a timely manner which will alsohelp to improve flow through the Trust.	We will achieve a reduction in the number of patients with an extended length of stay (LOS) of over 21 days, to fewer than 90 patientsby 31 March 2021. **Action 1:** The Deputy Divisional Nurse will lead on this for each Division. **Action 2:** A weekly discharge patient tracking list (DPTL) will be sent out every Thursday.	In February 2021 the numberof patients with an extended LOS was 114. This is above the target of 90. When compared with February 2020 there has been a 17% drop year on year in the average daily LOS numbers. In March 2021 the average daily LOS numbers decreased to 104. **Action 1:** ***Achieved.*** **Action 2:** ***Achieved.*** **Action 3:** ***Achieved.***	Extended length of stay surveillance and reduction remains a focus and priority for clinical teams across all divisions. As of 31st January 2022 12.7% (113) of 886 adult inpatients had a length of stay over 21 days. The 113 patients consisted of: • 2% (2) are waiting for repatriation • 37% (42) are out of county • 7% (8) are NEWs 5 and above • 39% (44) are Medically Fit for Discharge, of this 43% (19) are waiting for community hospital

	Action 3: Each Division will carry outa weekly review of this cohort of patientswhich will be documented on the patient's electronic record .**Action 4:** Monday to Friday all delays will be reviewed at the midday huddle to resolve issues and reduce LOS	**Action 4: Achieved.**	placement or any other bedded intermediate/ reablement care and 7% (3) are waiting for social care reablement or home-based intermediate care time limited The team continue with focused work in this area to keep to our trajectory and below the National Target
To minimise the occurrence of nosocomial COVID-19 in the OUH	**Action 1:** Set up a database to monitor the proportion of cases likely to be hospital acquired using the definitions* of HOIHA, HOPHA, HODHA, and to act swiftly to work with clinical areas where an increased number of cases is noted. To submit data on nosocomial infection rates nationally as required. **Action 2:** To complete a gap analysis against the NHSE&I Infection Prevention and Control Board Assurance Framework document **Action 3:**To work with all	**Action 1:** Database set up and admission screening compliance can be accessed via the Orbit dashboard. Data continues to be reported nationally. **Action 2:** The BAF was reviewed and updated following presentation to Integrated Assurance Committee (IAC) in February 2021 and will be provided to NHSE&I for assurance of IPC measures being undertaken in the Trust. No significant gaps identified. ***Fully achieved.*** **Action 3:** To work with all clinical areas to reduce opportunities for SARS- CoV2 transmission, considering both patients and staff (e.g. patient triage and pathways, diagnostics, patient placement, social distancing, cleaning, communications, education). The IPC Team has worked seven days a week since December 2020 with onsite services, the Health and Safety Team and Occupational Health to reduce the risk of	7 Key Points to Prevent HCAI during the COVID- 19 pandemic now launched. Trust internal auditors BDO findings report good knowledge across the MDT around 7 steps, identifies some actions around ventilator associated pneumonia (VAP) and that standardised reporting mechanism to hospital infection prevention and control committee (HIPCC) required. Task & Finish Group to review VAP bundles and delivery of them has been completed. This Quality priority has continued into 2021 22 and remains focussed on reducing opportunities for SARS- CoV2

	clinical areas to reduce opportunities for SARS-CoV2 transmission, considering both patients and staff (e.g. patient triage and pathways, diagnostics, patient placement, social distancing, cleaning, communications, education). **Action 4:** To support widespread testing of both patients (emergency, elective, regular weekly testing) and staff. To monitor the uptake of patient and staff regular testing **Action 5:** To ensure staff are supplied with and trained to use PPE appropriate for the clinical area for their own and patient protection**.**	transmission and outbreaks in clinical and non-clinical areas (two or more staff or patients linked in time and place) to review, investigate and recommend actions if required. Outbreaks are reported nationally and through the Trust's clinical governance process. **Action 4:** A dashboard has been developed that shows that the majority of patients are screened within 12 hours of admission. **Action 5: Action 5:** The educational resources for using PPE during COVID-19 were updated in November and are available on the Infection Prevention and Control intranet. Resources include videos, posters and visual guides. There is also a new e-Learning module available on My Learning Hub. The PPE Support Team continues to visit wards and is primarily staffed by the IPC Team. A COVID-19 safety audit was introduced for areas to review compliance with safety factors such as personal protective equipment, social distancing and ventilation. The Trust abides by the PHE guidelines for PPE; this is kept under regular review and discussed at COVID-19 Clinical Forum and Steering Group.	transmission, considering both patients and staff (e.g. patient triage and pathways, diagnostics, patient placement, social distancing, cleaning, communications, education).