



# Oxford University Hospitals NHS Foundation Trust



## Quality Account 2025/26

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## Introduction

### Interim Chief Executive Officer Overview

Simon Crowther Interim Chief Executive Officer



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

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

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

Delivery of this vision remains centred around OUH values of Learning, Respect, Delivery, Excellence, Compassion and Improvement, and builds on the four strategic pillars – People, Patient Care, Performance and Partnerships which underpin our Trust Strategy.

In line with our OUH Trust Strategy, our 5 Year vision for Quality aims to improve the access, quality and experience of care of all our patients; and work with partners to improve the health and wellbeing of our populations, working collaboratively to deliver integrated and sustainable services. We will make OUH a great place to work by delivering the best staff experience and wellbeing for all our people, supported by a sustainable workforce model and a compassionate culture. The [Quality Strategy \(2025- 2030\)](#) encompasses three quality domains which apply to all staff and departments. These are: Patients safety, Patient experience and Clinical effectiveness and outcomes.

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

PSIRF processes have been established since October 2023 and replaced the Serious Incident Framework. The four aims of PSIRF (below) are being met by OUH:

- Compassionate engagement and involvement of those affected by patient safety incidents. OUH has strengthened compassionate engagement by embedding a consistent approach to involving patients, families and staff in investigations,

supported by an expanded group of Patient Safety Partners (PSPs) and Engagement Leads, as well as improved staff support mechanisms.

- Use of a range of system-based approaches to learn from patient safety incidents. OUH has advanced its use of system-based learning through widespread adoption of After Action Reviews (AARs), Learning Multidisciplinary Team Reviews (LMDTRs) and Patient Safety Incident Investigations (PSIIs), enhanced training, and new tools such as the refreshed PSII template and systems-analyst course.
- Considered and proportionate responses to patient safety incidents and safety issues. These have improved through clearer decision-making and streamlined PSII processes.
- Supportive oversight focused on strengthening system functioning and improvement. New quality-assurance mechanisms and the introduction of PSIRF metrics, collectively strengthening the Trust's ability to learn, improve and deliver safer care.

We held a second anniversary summit of PSIRF in November 2025. Representatives from Buckinghamshire, Oxfordshire, Berkshire West Integrated Care Board (BOB ICB), NHS England, our Patient Safety Partners, Patient Safety colleagues from surrounding Trusts together with our staff were invited. At the summit we launched several initiatives including:

- Our [updated PSIRF plan](#);
- A new PSII template which we and our Patient Safety Partners (PSP) believe provides a better format for patients and their families;
- The introduction of PSIRF metrics; a panel discussion introducing some of our [new PSPs](#);
- Presentation of our new thematic PSIIs by the leads (these are described in our updated PSIRF plan); and a presentation on measuring the quality of our PSIIs using the Healthcare Services Safety Investigations Body (HSSIB) learning response review and improvement tool.

## Martha's Rule

Following a successful pilot scheme, [Martha's Rule](#) was rolled out across all inpatient areas at the John Radcliffe Hospital, Churchill Hospital and Nuffield Orthopaedic Centre in Oxford, and the Horton General Hospital in Banbury from 2 March 2026.

Martha's Rule is a national patient safety initiative that enables patients, families, carers and staff to request an urgent clinical review if concerns about a patient's deteriorating condition remain unresolved.

It strengthens the culture of asking, listening and acting when patients or those close to them report worrying changes.

The programme was introduced nationally following the death of 13-year-old Martha Mills, who developed sepsis in hospital. Her case, and others like it, led to the national rollout of Martha's Rule to ensure serious concerns are always heard and acted upon.

## **Our Quality Priorities**

Each year we invite staff, patients and the public – as well as representatives of our key partners and stakeholders – to tell us what matters to them to help inform the development of Quality Priorities which are structured around the three key domains of quality.

Following this quality conversation event and further input from members of the Trust's Clinical Governance Committee and Trust Board members, our [Quality Priorities for 2026/27](#) were approved by the Trust Board in March 2026.

## **Our patients as partners**

At the bi-monthly public meetings of the Trust Board, a patient perspective is shared to enable Board members and others in attendance to hear directly from patients and to strengthen the patient voice.

To ensure wider dissemination and learning, patient perspectives are included in the Trust Board Blogs from the Chair which are published following each public Board meeting – they are emailed to all OUH staff and to all governors, including elected representatives of patients and members of the public.

Patient perspectives are also shared more widely through news stories published on the Trust website and through the Trust's social media channels.

For example, Waqar Taref shared his [story](#) at the Trust Board meeting in March 2026 praising the personalised support he had received from Daley Cross, a Renal and Transplant youth worker over the last six years.

## **Patients waiting for treatment**

We remain committed to seeing more patients, more quickly and to reducing waiting lists. I am grateful to our staff from across the Trust who have continued to focus on improvements to patient pathways, and to our system partners for the collaborative approach to delivering services to our patients.

For a second consecutive year, we successfully maintained a zero position for the number of patients waiting more than two years at the end of March 2026. Focused work has continued on reducing the number of patients waiting more than 65 weeks and 78 weeks; at the end of March 2026, there were 46 patients waiting over 65 weeks compared to 63 in March 2025, and 1 patient waiting over 78 weeks at the end of March 2026 compared to 15 in March 2025. We also increased the number of patients receiving a first outpatient appointment within 18 weeks (68%) against an increasing referral rate and remain committed to further reducing the waiting times for patients requiring elective care.

## Quality Improvement (QI)

The Trust continues to invest strongly in quality improvement capability, delivering training for staff, registering more than 1,000 QI projects, and significantly improving project approval times.

In 2025/26 the focus has been on practical, applied improvement through refreshed training offers (Introduction to QI, QI Fundamentals, masterclasses) and national leadership of the new Collaborative QI Practitioner (CQIP) programme.

The Quality Coach Development Programme has expanded Trust-wide coaching capacity, with 39 trained coaches now supporting teams, including early cross-organisation collaboration with Oxford Health.

Organisational learning has been strengthened through regular, accessible QI sharing events and improved dissemination via our QI Zone.

System-wide collaboration across the BOB ICS has deepened, supporting shared learning, co-production with patients and communities, and a growing regional QI network.

## New developments

Key developments to improve patient safety, experience and clinical effectiveness, include:

- The [national Cancer Plan](#), launched on World Cancer Day in February 2026, includes our Oxfordshire Rapid Intervention for Palliative and End of Life Care (RIPEL) project as a best practice case study. RIPEL enables more people to receive personalised palliative care, including being cared for in their own home at the end of their life if that is their preference.
- The OUH now has an enhanced service for patients with soft tissue and bone tumours at the Horton General Hospital in Banbury, providing faster access to specialist diagnosis and treatment closer to home. [Expanding the musculoskeletal interventional service under general anaesthesia to the Horton General](#) significantly enhances our ability to deliver timely, specialist care while strengthening the Trust's high quality imaging capacity.

- [A new state-of-the-art high intensity focused ultrasound \(HIFU\) machine has been installed at the Churchill Hospital](#) which provides OUH cancer patients access to the latest in this innovative technology. HIFU is a non-invasive treatment that uses ultrasound to heat and destroy targeted tumour cells. Studies in some conditions have found that outcomes for patients with HIFU are similar to surgery with faster recovery and fewer adverse effects.
- [The Kidney Transplant team at OUH marked a significant milestone of completing 5,000 adult kidney transplants since the first procedure in 1975.](#) This achievement reflects decades of dedication, innovation, and collaboration across multi-disciplinary teams, and an unwavering commitment to delivering outstanding patient care.
- Our [Surgical Elective Centre](#) is one of our most significant capital projects for many years. It will provide additional operating theatres to address waiting lists for complex routine procedures, meeting the demands of the growing population across the Thames Valley, when it opens in Autumn 2026.

### Excellent outcomes for patients captured in clinical audits

Examples include the following:

- National Ovarian Cancer Audit which showed that the ovarian cancer service performed above national averages on key treatment and survival indicators including lower rates of emergency admissions prior to diagnosis (36% OUH vs 41.1% nationally), higher treatment uptake within recommended timeframes (77% vs 72.7%), and stronger one-year survival (73% vs 69.4%). The audit provides substantial assurance of high-quality care and effective clinical pathways.
- Paediatric Intensive Care Audit Network (PICANet) - OUH Paediatric Intensive Care Unit continues to deliver strong outcomes, with a crude mortality rate of 2% and a standardised mortality ratio below 1, indicating better-than-expected survival rates. The timeframes for mobilisation of the retrieval ambulance and to reach the patient's bedside exceed national averages, along with accidental extubation rates that are significantly lower than national figures.
- Non-Hodkin Lymphoma - OUH demonstrated strong performance in lymphoma care, with one-year survival rates consistently exceeding national averages. Access to a Clinical Nurse Specialist was recorded for >95% of patients, well above national benchmarks.
- Nephrostomy - the British Association of Urological Surgeons Nephrostomy Audit demonstrates that the Trust achieved faster diagnosis and treatment than national averages. OUH achieved a 70% recovery rate, zero mortality, and continues to provide a 24/7 interventional radiology service supporting regional referrals, noting excellent collaboration between services, particularly radiology and urology.

- UK Cystic Fibrosis (CF) Registry – Paediatrics results demonstrated that the service were equal to or exceeding national averages across all of the audit criteria. These include the proportion of patients having an annual review, the recording of lung function and a reduction in treatment burden (i.e. interventions to treat CF such as IV antibiotics).
- Transcatheter Aortic Valve Implantation (TAVI) - the audit demonstrated OUH care was delivered in line with or surpassing all of the national averages across six audit criteria. This includes being in the top 5 Trusts nationally for length of stay (average 2 days vs 3 days); having lower incidence of stroke and major bleeding post-op; and lower rates of vascular complications.

### **Innovations introduced and the positive impact of research on patient care**

OUH is at the heart of a vibrant healthcare research and innovation ecosystem which has a positive impact on the quality and safety of patient care because new innovations and treatments are often introduced first in our hospitals.

We value our partnerships with the University of Oxford and Oxford Brookes University, our role as host organisation of both the Oxford Biomedical Research Centre (BRC) and Health Innovation Oxford and Thames Valley (HIOTV), and our membership of Oxford Academic Health Partners (OAHP).

Examples of recent innovations are:

- The first three patients have undergone revolutionary brain surgery at the John Radcliffe Hospital in Oxford in a bid to treat the chronic pain they have experienced since suffering a stroke. The EPIONE research study, involving Oxford neurosurgeons and engineers, is trialling whether [deep brain stimulation](#) – delivering an electrical pulse into affected areas of the brain – can help to relieve central post-stroke pain, which is experienced by 1 in 12 stroke survivors.
- Pioneering research taking place at the Churchill Hospital in Oxford that is shaping the future of cancer treatment was included in a Channel 4 documentary in November 2025. The first episode of [Cancer Detectives: Finding the Cures](#), produced in partnership with Cancer Research UK, featured the groundbreaking research of Sarah Blagden, Professor of Experimental Oncology at the University of Oxford and Honorary Oncology Consultant at OUH, including the development of cancer vaccines and new drug treatments.
- [Grace Bell became just the second person in the UK to give birth following a womb transplant – and the first following a transplant from a deceased donor.](#) Grace is the first person to have a baby as part of the approved deceased donor womb transplant research programme, initiated and funded by the charity Womb Transplant UK and includes OUH and Imperial College Healthcare NHS Trust as key partners. The womb

transplant programme is jointly led by Isabel Quiroga, a leading consultant transplant and endocrine surgeon at OUH.

- Brain tumour patients being treated at the Churchill Hospital in Oxford are the [first in the UK to benefit from a new way of carrying out MRI scans to plan specialist radiotherapy treatment](#). Thanks to £115,000 of new equipment funded by Oxford Hospitals Charity, this is faster, more precise, and targeted radiotherapy for patients, while also saving valuable time for staff. Initially, 250 patients per year will benefit from the new technology.

## Our award-winning teams

We are proud that the commitment of our staff to providing high quality and safe care for patients has been recognised this year:

- [Two senior surgeons from OUH have been recognised with prestigious national awards from the British Association of Oral and Maxillofacial Surgeons \(BAOMS\)](#). Daljit Dhariwal received the Down Surgical Prize, recognising a lifetime of exceptional service to surgery, while Montey Garg won the BAOMS Surgery Prize for surgeons in the first 10 years of consultant practice.
- An app developed by staff at OUH has been [celebrated as an 'outstanding patient resource'](#). Sarah Havord, a VTE Prevention Specialist Nurse Practitioner, and her colleagues won the 'Outstanding patient resource, sharing information about VTE prevention for patients' category at the Thrombosis UK VTE Awards 2025. The [Let's Talk Clots](#) app provides information to patients about blood clots and how to reduce the risk of developing one. Since its launch in November 2023, the app has been downloaded thousands of times.
- Sally Springett, a clinical nurse specialist working in bone marrow transplant research at OUH, won the Game Changer of the Year Award at the [Anthony Nolan Supporter Awards](#) in September 2025.
- The Thames Valley and Surrey Secure Data Environment (TVS SDE) project, a partnership between OUH, Telefónica Tech and Starlight Consulting, was Highly Commended in the 'Data Integration Project of the Year' category at the [Health Service Journal \(HSJ\) Partnership Awards](#) in March 2026.

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

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

**ADD SIGNATURE WHEN COMPLETED**

**Simon Crowther**  
**Interim Chief Executive Officer**

xx May 2026

## About us and the service we provide

Oxford University Hospitals (OUH) is a world renowned centre of clinical excellence and one of the largest NHS teaching trusts in the UK. We became a Foundation Trust on 1 October 2015.

The Trust is made up of four hospitals –

The [John Radcliffe Hospital](#) (which includes the Children's Hospital, West Wing, Eye Hospital, Heart Centre and Women's Centre), the [Churchill Hospital](#) and the [Nuffield Orthopaedic Centre](#), all located in Oxford, and the [Horton General Hospital](#) in Banbury, north Oxfordshire.

We provide a wide range of clinical services including specialised and highly specialised services, medical education, training and research.

Most services are provided in our hospitals, but some are delivered across more than 100 satellite locations across the region, and some in patients' homes.

Our collaboration with the [University of Oxford](#) underpins the quality of the care that is provided to patients, from the delivery of high-quality research, bringing innovation from the laboratory bench to the bedside, to the delivery of high-quality education and training of doctors.

Existing collaborations include the ambitious research programmes established through the [Oxford Biomedical Research Centre \(BRC\)](#) and [Oxford Clinical Research Facility](#), both funded by the [National Institute for Health Research \(NIHR\)](#), and at the [Biomedical Research Unit in musculoskeletal disease](#) at the Nuffield Orthopaedic Centre. These set the standard in translating science and research into new and better NHS clinical care.

More information on OUH and its services is available on the Trust website at [Oxford University Hospitals NHS Foundation Trust Website](#)

## Priorities for Improvement and Statements of Assurance from the Board

### Priorities for Improvement

#### Results and achievements for the 2025/26 Quality Priorities (QP)

This section details the Trust's achievements against its quality objectives for 2025/26. While good progress has been made on many of the Quality Priorities for 2025/26, progress on others has been slower than planned due to operational pressures. The Trust continues to support clinical services towards completion of the outstanding objectives. To support ongoing progress, three of the 2025/26 Quality Priorities have been extended into 2026/27, these are: *Excellence also in the basics - reducing variation, improving care through Standard Work, Strengthening Discharges* and *Advance care Planning - End of Life care*.

## Patient Safety

### Quality Priority 1 System for Electronic Notification and Documentation (SEND)

#### Why is this a priority?

#### Why is this a priority?

SEND (System for Electronic Notification and Documentation) was developed in Oxford with support from the National Institute for Health and Care Research (NIHR). It provides an electronic platform for inputting adult inpatient observations, and a clear graphical representation of the patient's observations and National Early Warning Score 2 (NEWS 2). This allows easy identification of trends, early identification of patient deterioration, and escalation recommendations in line with national and local guidance.

The system has faced some challenges leading to reduced use by clinical staff. Issues have included hardware failures, finite technical support, and limited awareness and therefore use among clinicians. The goal is to maximise the opportunity SEND presents to strengthen patient safety by addressing identified hardware issues; embedding equipment checks into standard work; streamlining systems for data entry; and piloting and rolling out the use of SEND for handovers.

Table 1 SEND and Documentation QP 2025/26

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
<p><b>Objective 1</b> <b>(Q1)</b></p> <p><b>Monitoring and governance</b></p> <ul style="list-style-type: none"> <li>Establish a formal SEND Task and Finish Group responsible for overseeing this</li> </ul>	<ul style="list-style-type: none"> <li>Agreement of Terms of Reference for the group</li> </ul>	<p><b>Complete</b></p> <ul style="list-style-type: none"> <li>As we have moved through the year, we have continued to engage with the group and with other key stakeholders to continue to work on issues</li> </ul>

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
<p>Quality Priority. This group will report to RAID committee and provide updates of these actions</p>		<p>surrounding documentation of observations.</p>
	<ul style="list-style-type: none"> <li>RAID <a href="#">[1]</a> minutes will highlight progress</li> </ul>	<p><b>Complete</b></p> <ul style="list-style-type: none"> <li>The SEND working group continues to report into the RAID committee.</li> <li>It is likely this group will merge with and continue to work on this project as part of the Escalation of deteriorating patient QP for the upcoming year.</li> </ul>
<p><b>Objective 2</b> <b>(Q1-3)</b> <b>Update and roll out education and policies</b></p> <ul style="list-style-type: none"> <li>Update the RAID policy (Q1)</li> </ul>	<ul style="list-style-type: none"> <li>RAID Policy finalised, and on the intranet</li> </ul>	<p><b>Complete</b></p> <ul style="list-style-type: none"> <li>The RAID policy has been finalised, published and shared on the RAID Share Point page.</li> </ul>

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
<ul style="list-style-type: none"> <li>Develop a Standard Operating Procedure (SOP) for the documentation of observations and escalation of concerns which links to the Recognising the Acutely Ill and Deteriorating Patient (RAID) Policy (Q1)</li> </ul>	<ul style="list-style-type: none"> <li>When the SOP is signed off, and on the intranet</li> </ul>	<p><b>In Progress</b></p> <ul style="list-style-type: none"> <li>SOP has been completed but approval is being sought. Sign off should occur in May/June 2026</li> </ul>
<ul style="list-style-type: none"> <li>Develop SEND online learning resources for (a) the documentation of observations using SEND; and (b) the use of SEND for monitoring observations</li> </ul>	<ul style="list-style-type: none"> <li>SEND learning resources available on My Learning Hub (MLH)</li> </ul>	<p><b>Complete</b></p> <ul style="list-style-type: none"> <li>SEND learning resources are now available on MLH for Midwifery, AHP and Nursing staff.</li> <li>Sharepoint page for medical staff and shared with incoming doctors at induction</li> <li>We continue to encourage staff to report equipment issues in a timely manner.</li> </ul>
<ul style="list-style-type: none"> <li>Update current training materials and roll these out across the organisation supported by education colleagues</li> <li>Update role-specific user guides</li> </ul>	<ul style="list-style-type: none"> <li>SEND learning resources included in core clinical induction</li> <li>Other training materials updated and available on intranet</li> </ul>	<p><b>Complete</b></p> <ul style="list-style-type: none"> <li>Sharepoint page for medical staff and shared with incoming doctors at induction</li> </ul>

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
		<ul style="list-style-type: none"> <li>• We have continued to train RAID Assessors                             <ul style="list-style-type: none"> <li>• 21 members completed RAID assessor training in 2025/26</li> <li>• 6 have completed the RAID training and are progressing towards completion.</li> <li>• There are 68 in date RAID assessors across the Trust</li> </ul> </li> <li>• We share data with ward managers emphasising the importance of documentation of observations on SEND.</li> <li>• Discussions are continuing with regard the platform for recording of observations. A new vital signs monitor is being trialled in the Trust at present which will support future direction in terms of documentation of observations.</li> </ul>

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
<ul style="list-style-type: none"> <li>• Include SEND in mandatory training for all clinical staff at induction and upload to My Learning Hub. The training undertaken will be appropriate to role and use of SEND (Q1-3)</li> </ul>	<ul style="list-style-type: none"> <li>• Increase in staff training compliance as reported by MLH</li> <li>• Improvement in reporting rates for equipment issues</li> <li>• Improved compliance with observation timeliness</li> </ul>	<p><b>Complete</b></p> <ul style="list-style-type: none"> <li>• SEND learning resources are now available on MLH for Midwifery, AHP and Nursing staff.</li> <li>• Sharepoint page for medical staff and shared with incoming doctors at induction</li> <li>• Overall compliance with documentation of observations in SEND for 2025/26 is 60%</li> <li>• This broken down as follows.             <ul style="list-style-type: none"> <li>• Low Risk: NEWS 2 Score of 0-4 Compliance 62%</li> <li>• Low-Medium Risk – NEWS 2 Score of 3 in one parameter- Compliance 47%</li> <li>• Medium Risk – NEWS 2 Score 5-6 – compliance 50%</li> </ul> </li> <li>• High Risk- NEWS 2 score of 7 or above or with any clinical concern captured – compliance 51%</li> </ul>

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
<p><b>Objective 3</b> <b>(Q1-3)</b></p> <p><b>Pilot and embed the use of SEND for clinical handovers</b></p> <ul style="list-style-type: none"> <li>Pilot for a period of 1-3 months; audit the use of SEND for handovers and as part of RAID Huddles</li> </ul>	<ul style="list-style-type: none"> <li>Successful use of SEND at the pilot locations, no issues have been identified, and staff are using and are engaged with its use</li> </ul>	<p><b>In Progress</b></p> <ul style="list-style-type: none"> <li>Plan, Do, Study, Act (PDSA) surrounding RAID Huddles is continuing and updates in electronic patient record (EPR) have occurred following initial PDSA cycles.</li> </ul>
<ul style="list-style-type: none"> <li>Following successful pilot, roll out to hospital at night team handovers Trustwide</li> </ul>	<ul style="list-style-type: none"> <li>Audits will show that clinical handovers and RAID Huddles with SEND are used 80% of the time</li> <li>Feedback from staff will be positive and any issues will be resolved</li> </ul>	<p><b>In Progress</b></p> <ul style="list-style-type: none"> <li>The use of SEND amongst medical staff remains low owing to the need to move between platforms when EPR is predominantly used. We have shared the correct desktop link to SEND with clinical areas to encourage use from computers which also contain EPR.</li> </ul>
<ul style="list-style-type: none"> <li>Q1: Task and Finish Group to agree at least one initial clinical area(s) for the pilot</li> </ul>	<ul style="list-style-type: none"> <li>The Task and Finish Group and RAID are satisfied that the pilot and rollout to hospital at night team handovers has been successful based on feedback and audits and sign off on the rollout</li> </ul>	<p><b>In Progress</b></p> <ul style="list-style-type: none"> <li>Uncertainties about the future of SEND and ongoing difficulties in use of the platform by medical staff have slowed progress for Objective 3</li> </ul>

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
<p><b>Objective 4</b> <b>(Q1-4)</b></p> <p><b>Access and troubleshooting</b></p> <ul style="list-style-type: none"> <li>• Provision and checking/maintenance of the required equipment (part of the Standard Work programme). This will be supported by the Clinical Engineering team</li> <li>• Embed clear processes to ensure ward staff can easily escalate to IM&amp;T and Clinical Engineering any maintenance issues</li> </ul>	<ul style="list-style-type: none"> <li>• Ticket turnaround time for SEND maintenance issues from ServiceNow</li> </ul>	<p><b>Complete</b></p> <ul style="list-style-type: none"> <li>• IM&amp;T colleagues continue to support areas in addressing issues with the SEND platform. The most common issues remain the need to reset tablets and WIFI connectivity. IM&amp;T colleagues are responsive however this remains a source of frustration for ward teams.</li> </ul>
<ul style="list-style-type: none"> <li>• Monitor the rollout of SEND devices to replace other models of machines</li> <li>• Ensure there is a clear and proactive process to issuing licences for staff</li> </ul>	<ul style="list-style-type: none"> <li>• Monitor the device registry rollout to ensure up-to-date SEND devices are rolled out across all clinical areas (where appropriate)</li> </ul>	<p><b>Complete</b></p> <ul style="list-style-type: none"> <li>• Evaluation of new vital signs monitors is complete; they will first be implemented in maternity to allow for further discussion on the future of the SEND platform.</li> </ul>

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
<p><b>Objective 5</b> <b>(Q1-4)</b></p> <p><b>Maintenance and sustainability</b></p> <ul style="list-style-type: none"> <li>• Work with Digital Services to resolve any existing issues with the SEND platform</li> </ul>	<ul style="list-style-type: none"> <li>• User feedback shows improved user satisfaction with the SEND platform</li> </ul>	<p><b>Complete</b></p> <ul style="list-style-type: none"> <li>• User feedback is complete and reflects that changes are required but there is lack of capacity in SEND to resolve this therefore other solutions are being reviewed to see what is available.</li> </ul>
<ul style="list-style-type: none"> <li>• Work with Digital Services to examine the optimal resource necessary to provide robust technical support for the SEND platform</li> </ul>	<ul style="list-style-type: none"> <li>• Maintenance items are resolved in a timely fashion</li> <li>• An examination has taken place to show the longer-term sustainability of SEND, or another bedside observation workflow</li> </ul>	<p><b>In progress</b></p> <ul style="list-style-type: none"> <li>• The continuing issues with the SEND platform have been escalated to the Chief Medical Officer and Chief Digital Information Officer for further review and ongoing discussion about future solutions.</li> <li>• The SEND options appraisal is on pause currently while the digital executive explores their wider EPR strategy</li> </ul>

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
<ul style="list-style-type: none"> <li>Work with Digital Services to review options for long-term bedside mobile solutions</li> </ul>	<ul style="list-style-type: none"> <li>Improvement in reporting rates for system issues</li> </ul>	<p><b>Complete</b></p> <ul style="list-style-type: none"> <li>Fewer WIFI issues are being reported due to the work undertaken by IM&amp;T colleagues to ensure improved connectivity.</li> </ul>
<ul style="list-style-type: none"> <li>Develop a digital quarterly report to monitor issues with SEND devices. The quarterly report will be presented at the SEND working group for monitoring</li> </ul>	<ul style="list-style-type: none"> <li>Improvement in the metrics in the quarterly report showing fewer maintenance issues with SEND devices</li> </ul>	<p><b>Complete</b></p> <ul style="list-style-type: none"> <li>It has been important to listen to staff frustrations with SEND and how this is impacting on documentation in the platform. It is important to look to future options to support clinical teams caring for acutely ill patients. – There is an options appraisals being developed to look at future options for recording adult in patient observations.</li> </ul>

[\[1\]](#) RAID - Recognising the acutely ill and deteriorating patient.

## Quality Priority 2: Medicines Reconciliation

### Why is this a priority?

A 2018 Cochrane review found that 56% of patients are at risk of medication discrepancies at transitions of care. Published data suggest inadequate reconciliation of medications is estimated to cause 40% of medication errors, 20% of which result in potentially avoidable harm. Avoidable Adverse Drug Events are associated with increased cost and length of stay.

This Quality Priority aims to strengthen medicines reconciliation during the inpatient stay and on discharge; and to link this to a Discharge Medicines Service through which referrals are made to community pharmacy teams. The benefits include improved patient safety and operational and financial efficiency.

Table 2 Medicines Reconciliation QP 2025/26

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
<p><b>Objective 1</b></p> <p><b>(Q1)</b></p> <p><b>Establish current baseline and ongoing monitoring</b></p> <ul style="list-style-type: none"> <li>Establish required dataset for measurement of improvement and cost avoidance by end of Month 1</li> </ul>	<ul style="list-style-type: none"> <li>Key Performance Indicator (KPI) defined</li> <li>Estimate financial savings from avoidable harm ± reduced length of stay</li> </ul>	<p><b>Complete</b></p> <ul style="list-style-type: none"> <li>Deep dive reported at Integrated Assurance Committee June 2025</li> <li>Dataset has been reviewed and revised.</li> <li>Able to report performance by ward/first location, and timing of completion at 24/48/72 hours.</li> <li>Reporting SOP written to confirm inclusions/exclusions in the reporting. Exclusions are minimal (services not using EPR; patients staying &lt;24 hours).</li> </ul>

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
<ul style="list-style-type: none"> <li>Establish regular KPIs, including monthly point prevalence audit on errors Identified at reconciliation as KPI and monthly point prevalence audit on patients who have not had admission reconciliation by point of reconciliation on discharge</li> </ul>	<ul style="list-style-type: none"> <li>Establish monthly point prevalence audit on errors identified at reconciliation</li> <li>Establish monthly point prevalence audit on patients who have not had admission reconciliation by point of reconciliation on discharge (to take out (TTO))</li> </ul>	<p><b>In Progress</b></p> <ul style="list-style-type: none"> <li>KPI aligned with Shelford organisations as 80% within 24 hours by time stamp.</li> <li>Point prevalence audit planned for June 2026, incorporating the financial impact of this KPI.</li> </ul>
<p><b>Objective 2</b></p> <p><b>(Q1)</b></p> <p><b>Discover and Diagnose</b></p> <ul style="list-style-type: none"> <li>Discover and diagnose current barriers to performance at both admission and discharge using QI tools by end of month 2</li> </ul>	<ul style="list-style-type: none"> <li>Sharing of output e.g. <ul style="list-style-type: none"> <li>Fishbone</li> <li>Driver Diagram</li> <li>Timed Observations</li> <li>Process Map of current state</li> <li>The wider teams understand the barriers to meeting KPI</li> </ul> </li> </ul>	<p><b>Complete</b></p> <ul style="list-style-type: none"> <li>The most challenging barrier to performance is workforce capacity. A 94% increase in demand since 2018/19 has not been matched by staffing growth.</li> <li>Alignment of current workforce to Monday to Friday services results in particularly poor performance for patients admitted Friday or Saturday.</li> <li>Development of novel pathways via triage, ambulatory and virtual services have not considered processes for</li> </ul>

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
		<p>medicines reconciliation, resulting in many patients not having medicines reconciled within the desired timeframe.</p>
<p><b>Objective 3</b> <b>(Q2-3)</b> <b>Test ideas for improvement</b></p> <ul style="list-style-type: none"> <li>A minimum of two Plan-Do-Study-Act (PDSA) cycles and one testing improvement to be completed by end of Q2. Options dependent on QI scoping, but could include redefining responsibilities, embedding 12 noon huddles, GIRFT approach with clerking clinician engagement and robotic processing. Utilise learning for further PDSA cycles in Q3</li> </ul>	<ul style="list-style-type: none"> <li>Summary of learning from PDSA cycle(s) produced</li> </ul>	<p><b>In Progress</b></p> <ul style="list-style-type: none"> <li>A standard work approach has been drafted for consultation by the pharmacy team.</li> <li>Ideas generated include: <ul style="list-style-type: none"> <li>Live oversight dashboard of work outstanding</li> <li>Acuity scoring to prioritise patients most likely to benefit from MR.</li> <li>Robotic process automation to pull information from the GP record to appropriate section of EPR.</li> </ul> </li> <li>Progress with digital solutions has been delayed due to competing Trust</li> </ul>

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
<ul style="list-style-type: none"> <li>Improvement idea tested within high frequency admission area(s)</li> </ul>	<ul style="list-style-type: none"> <li>There is a positive outcome from testing</li> <li>There are incremental improvements in performance with each PDSA cycle</li> </ul>	<p>priorities requiring digital team/ Inicio support.</p> <p><b>In Progress</b></p> <ul style="list-style-type: none"> <li>Workforce mapped to demand. Planning in place to transition Pharmacist late duty shifts to clinical areas following technician recruitment. Anticipated outcome is support to Emergency Assessment Units (EAUs) and SEU much later in the day i.e. to 8pm to align with admission patterns. The project will require approval of a business case for new technician posts and possible HR consultation; anticipated delivery by end of March 2027.</li> </ul>
<p><b>Objective 4</b> <b>(Q 1-3)</b> <b>Model capacity and demand with improvements in place</b></p>	<ul style="list-style-type: none"> <li>Clear mapping of demand and optimal work patterns to meet this</li> </ul>	<p><b>Complete</b></p> <ul style="list-style-type: none"> <li>Modelling complete.</li> </ul>

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
<ul style="list-style-type: none"> <li>Model capacity to meet demand (admissions and discharges), test impact of adjusted working patterns. Produce gap analysis and business case if needed to address shortfall via workforce and/or automation: by end of Q3</li> </ul>	<ul style="list-style-type: none"> <li>Productivity and efficiency gains of 7 days service modelled</li> <li>A business case has been produced (if required)</li> </ul>	<p><b>Unable to Complete</b></p> <ul style="list-style-type: none"> <li>Unable to fund additional hours to test this due to financial controls.</li> </ul>
<p><b>Objective 5</b> <b>(Q1-4)</b> <b>Facilitate community reconciliation on discharge</b></p> <ul style="list-style-type: none"> <li>Embed PharmOutcomes referral tool within EPR to efficiently refer patients to community pharmacy on discharge</li> </ul>	<ul style="list-style-type: none"> <li>1.5% of completed consultant episodes referred (from hospital episode statistics (HES) data)</li> <li>There should be a reduction in readmissions: assessment against modelling, predicting 100 pa</li> </ul>	<p><b>In Progress.</b></p> <ul style="list-style-type: none"> <li>Funding source identified. Business Case presented to CSS Divisional business planning group. Anticipating progression to TME and approval due to significant productivity gains identified. Currently with CSS Divisional leadership team, linked to transfer of other services to Pharmacy. Business case suggests significant potential productivity gain.</li> </ul>

## Quality Priority 3: Fragility Fracture pathways – including fractured neck of femur pathway

### Why is this a priority?

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

By contrast, the Horton General Hospital (HGH) continues to deliver care that regularly meets the National Standards.

This Quality Priority aims to combine several quality improvement (QI) workstreams to improve the pathway at the John Radcliffe Hospital and thereby reduce morbidity and mortality.

Table 3 Fragility Fracture pathways – including fractured neck of femur pathway QP 2025/26

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
<p><b>Objective 1 (Q1-4)</b></p> <p><b>Improving percentage of non-ambulatory fragility fracture (NAFF) patients operated on within 36 hours</b></p> <ul style="list-style-type: none"> <li>Q1: Development of a SOP to allow escalation of theatre capacity concerns, and creation of additional emergency trauma capacity in OUH Theatres</li> </ul>	<ul style="list-style-type: none"> <li>Surge capacity procedure in place</li> </ul>	<p><b>Partially Complete</b></p> <ul style="list-style-type: none"> <li>Surge capacity: Extra lists at HGH for ambulatory trauma and 3 x 3 session new trauma lists planned at JR as part of Surgical Elective Centre (SEC) planning.</li> </ul>

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
<ul style="list-style-type: none"> <li>Q2: Change in trauma consultant rota to allow more flexibility to deliver extra lists</li> <li>Q3: Review of demand and capacity following above changes and understanding opportunities from new theatre build if additional theatre capacity needed</li> </ul>	<ul style="list-style-type: none"> <li>New trauma consultant rota in place</li> <li>The additional lists are being used to help with capacity</li> <li>Demand and capacity modelling available</li> </ul>	<b>Complete</b> <ul style="list-style-type: none"> <li>New trauma consultant rota in place, rota consultation process continuing</li> <li>The Trauma capacity group have mapped the requirement for extra capacity and defined working with the JR/West wing Theatre Clinical Director. A strategy to increase capacity for fragility fracture patients at the JR has been developed.</li> </ul>
<ul style="list-style-type: none"> <li>Q4: Expand to a 7-day trauma coordinator service</li> </ul>	<ul style="list-style-type: none"> <li>Business case to deliver 7-day trauma coordinator service submitted to Business Planning Group (BPG)</li> </ul>	<b>In Progress</b> <ul style="list-style-type: none"> <li>Due to Trust's financial position, business case (BC) for 7-day trauma coordinator service has not progressed.</li> <li>The Trust financial position means that there has been a delay in the progression of a BC for another GO consultant, which would improve weekend cover.</li> </ul>
<ul style="list-style-type: none"> <li>Q4: Implement Geriatric Orthopaedics (GO) and</li> </ul>	<ul style="list-style-type: none"> <li>Data shows an increase in NAFF patients being operated on within 36 hours</li> </ul>	<b>In progress</b>

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
<p>anaesthetic review on day of admission</p>	<ul style="list-style-type: none"> <li>• Best Practice Tariff (BPT) criterion (a), time to theatre &lt;36 hours, &gt;85% performance</li> <li>• GO review on day of admission – target is 85% of patients seen on day of admission.</li> </ul>	<ul style="list-style-type: none"> <li>• At the JR, the percentages of medically fit enough patients having surgery within 36 hours was 91% in March 2026.</li> <li>• For the National Hip Fracture Database, there is an expectation that patients are reviewed by GO within 72 hours of admission. The JR currently stands at 97% and the Horton is 99%, which are both well above national average.</li> <li>• An 85% local target has been established for GO review on the day of admission, as early medical assessment is associated with improved surgical optimisation and outcomes.</li> </ul>
<p><b>Objective 2 (Q1-4)</b></p> <p><b>Improving therapy access to NAFF fracture patients</b></p> <ul style="list-style-type: none"> <li>• Q1-2: Develop a strong business case to allow 7-day access to therapy services</li> </ul>	<ul style="list-style-type: none"> <li>• Business case submitted to Business Planning Group</li> </ul>	<p><b>Complete</b></p> <ul style="list-style-type: none"> <li>• A Business case has been developed and submitted to OUH Business Planning Group</li> </ul>

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
<ul style="list-style-type: none"> <li>Q2-3: Appointment to expanded therapy posts following successful business case</li> </ul>	<ul style="list-style-type: none"> <li>Improved NHFD metrics (key performance indicator ((KPI) 4). Improved BPT criteria</li> <li>Reduced acute length of stay</li> <li>Q4: Improved NHFD KPI 4. Prompt mobilisation after surgery: therapists seeing patients on the day or the day after surgery</li> </ul>	<p><b>Partially Complete</b></p> <ul style="list-style-type: none"> <li>KPI 4: data for JR currently 93% patient mobilised the day after surgery (national average 82%).</li> <li>The Horton currently stands at 80%. There is a need to increase the % of patients mobilised the day after surgery. Work is ongoing to increase physiotherapy cover at the weekend.</li> </ul>
<ul style="list-style-type: none"> <li>Q4 Implementation of 7-day physiotherapy services to allow all fragility fracture patients to be mobilised on day or day after surgery</li> </ul>	<ul style="list-style-type: none"> <li>There are fewer complaints about accessing therapy services following NAFF surgery</li> <li>The acute length of stay has reduced, and patients are not being readmitted</li> </ul>	<p><b>Partially Complete</b></p> <ul style="list-style-type: none"> <li>The BC for this service has been developed but has been deprioritised given current good performance, including 93% mobility on day 1 post op at the JR (national average 82%). Work is ongoing to increase physiotherapy cover at the weekend at the Horton where performance against this KPI is 80%.</li> </ul>
<p><b>Objective 3 (Q1-3)</b></p> <p><b>Improving multi-specialty working to care for NAFF fracture patients</b></p>	<ul style="list-style-type: none"> <li>Daily MDT meeting in theatre</li> </ul>	<p><b>Complete</b></p> <ul style="list-style-type: none"> <li>The daily WHO briefing in theatre continues.</li> </ul>

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
<ul style="list-style-type: none"> <li>Q1-2: Workforce review to deliver a daily multidisciplinary meeting including theatre teams to facilitate preoperative care and shared decision-making</li> </ul>	<ul style="list-style-type: none"> <li>Data/questionnaires show that daily MDT meetings with theatre staff are occurring and that all staff groups feel that this teamwork has improved overall care for NAFF patients</li> </ul>	
<ul style="list-style-type: none"> <li>Q2-3: Workforce mapping and capacity modelling to deliver equitable orthogeriatric care across all OUH sites and provide 7-day cover</li> </ul>	<ul style="list-style-type: none"> <li>Workforce demand and capacity modelling completed</li> </ul>	<p><b>Partially Complete</b></p> <ul style="list-style-type: none"> <li>There has been more collaborative discussion between anaesthetics, GO and trauma regarding the care of complex NAFF patients.</li> <li>There has been increased input from anaesthetists including at the trauma screens meeting.</li> </ul>
<p><b>Objective 4 (Q1-4)</b></p> <p><b>Improving Cohorting of NAFF patients</b></p> <ul style="list-style-type: none"> <li>Q1: Develop pathways/SOPs for cohorting of NAFF patients to facilitate specialist medical/nursing/AHP care</li> </ul>	<ul style="list-style-type: none"> <li>Q2: Pathways agreed and supported by SOPs. Enacted where possible. Nominated NAFF ward/cohorted beds outside of Trauma Unit footprint in place</li> <li>The cohorting of NAFF patients is occurring and working well</li> </ul>	<p><b>Partially Complete</b></p> <ul style="list-style-type: none"> <li>NAFF patients are admitted to the trauma unit. This is largely due to the work undertaken by the trauma coordinators.</li> <li>The ED has led on improving the fragility fracture pathway to hasten the time</li> </ul>

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
<ul style="list-style-type: none"> <li>Prioritising initial perioperative care in the Trauma Unit (familiarity of staff, facilitation)</li> </ul>		<p>taken for patients to be admitted to the trauma unit.</p>
<ul style="list-style-type: none"> <li>Q2: Feasibility study on how to deliver pathways sustainably including a review of demand vs bed capacity to reduce outliers</li> <li>Admission of all operative NAFF fracture patients to specialist trauma ward from ED with cohorting of NAFF patients for care after the initial perioperative period</li> </ul>	<ul style="list-style-type: none"> <li>Q2-3: Feasibility study completed</li> <li>Q4: Number of unnecessary outlier NAFF patients to be minimised outside of Trauma Unit and/or dedicated NAFF ward</li> <li>Q4: NHFD KPI 0 – over 85% of patients are given a nerve block and admitted to an appropriate orthopaedic or orthogeriatric ward within four hours of presentation</li> </ul>	<p><b>Partially Complete</b></p> <ul style="list-style-type: none"> <li>KPI 0 – The JR is still at 3% (national average 10%) on the national hip fracture database. The Horton stands at <u>38% in February 2026</u>. Barriers to admission are being explored but building work adjacent to the trauma unit and works on air conditioning units have meant beds have been closed and some patients cannot be admitted to the trauma unit if they are immuno-compromised.</li> </ul>
	<ul style="list-style-type: none"> <li>That ‘ringfenced’ beds for NAFF patients are available and being used which aids with operating with 36 hours</li> </ul>	<p><b>Complete</b></p> <ul style="list-style-type: none"> <li>‘ring-fenced’ beds for NAFF patients are being used</li> </ul>
<p><b>Objective 5 (Q1-4)</b> <b>Nutrition and fasting process</b></p>	<ul style="list-style-type: none"> <li>Q3: Audit of ‘Sip until Send’ administration on EPR/Audit compliance with hip fracture</li> </ul>	<p><b>Complete</b></p> <ul style="list-style-type: none"> <li>Sip till send remains adopted by all areas.</li> </ul>

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
<ul style="list-style-type: none"> <li>Q1: Introduce 'Sip until Send' policy for non-ambulatory fragility fractures</li> </ul>	<p>power plan which includes Ensure juice administration</p> <ul style="list-style-type: none"> <li>Q4: Improve Malnutrition Universal Screening Tool (MUST) compliance on NHFD (BPT criteria)</li> <li>There is compliance with the MUST and there is no evidence of NAFF patients with nutritional issues (there may be unforeseen exceptions even with a completed MUST)</li> </ul>	<p><b>Partially Complete</b></p> <ul style="list-style-type: none"> <li>MUST compliance currently stands at 85% for the JR and 100% for HGH. This is for all trauma patients, (not exclusively NAFF patients)</li> </ul>
<ul style="list-style-type: none"> <li>Q2-3: Develop business case for nutritional assistant</li> </ul>	<ul style="list-style-type: none"> <li>Q4: Business case submission to BPG</li> </ul>	<p><b>Not Complete</b></p> <ul style="list-style-type: none"> <li>Due to the Trust's financial position, the BC has not progressed regarding nutritional assistance.</li> </ul>

## Clinical Effectiveness

### Quality Priority 4: Standard Work

#### Why is this a priority?

At OUH, we are committed to delivering the highest quality of care, therefore we are prioritising the implementation of the Standard Work (SW) concept across our services. Drawing from the learning and evidence base from wider industries, this approach is designed to ensure that every patient receives consistent, safe and effective care while supporting our teams in their daily work.

The initial focus for the Standard Work programme has been supporting clinical inpatient teams, working to align with existing structures and reduce duplication and enhance care, for example linking with and understanding the alignment with Care Assure. This provides a frequent opportunity to assess fundamentals of care.

Standard Work is a clear, step-by-step framework that outlines the best way to complete specific tasks based on evidence and expertise. It is about creating reliable processes that support excellence in care. Success will be evaluated through clear metrics, including audit results, staff engagement levels and outcome measures tied to organisational goals.

The overall aim of the Quality Priority is to enable the successful adoption of Standard Work in a structured, measurable and impactful manner on defined priority areas, building forward our culture of excellence and continuous improvement, benefiting patients, staff and the organisation.

*This Quality Priority is being rolled over to 2026/27*

Table 4 Standard Work QP 2025/26

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
<b>Objective 1 (Q1-4)</b>	<ul style="list-style-type: none"> <li>Develop standard protocols collaboratively with frontline staff, support adoption of continuous improvement approach and</li> </ul>	<b>In Progress</b>

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
<p><b>Embedding Practice</b></p> <ul style="list-style-type: none"> <li>• Embed Standard Work (SW) approach in defined Core Priority Areas of Practice – 25/26 focus on Board Rounds, Equipment Checking, Safe and <i>Secure Storage of Medicines and Safety Huddles</i></li> <li>• By the end of 2025/26, Standard Work approach will be established in phase one priority areas, demonstrating 80% increase in adherence to defined standards as measured through regular audits</li> </ul>	<p>digitisation of results at ward level across identified priorities (e.g. Board Rounds, Equipment Checking, Safe and Secure Storage of Medicines and Safety Huddles)</p> <ul style="list-style-type: none"> <li>• Capture lessons learnt and case study examples through ‘big room’ to share best practice, scale and spread.</li> <li>• There will be a reduction in variation in practice across selected areas.</li> <li>• Improvements in priority specific defined KPIs</li> </ul>	<ul style="list-style-type: none"> <li>• Blood Glucose Monitoring task and finish (T&amp;F) group overseeing actions, mitigating staffing levels in Biochemistry and maintaining momentum.</li> <li>• T&amp;F Groups established and meeting frequently for all key priority areas except Safety Huddles. Groups have adopted an approach underpinned by QI and continuous improvement. Initially diagnosing and understanding the problem and now working to define clear standards for wards to establish clear processes to achieve. Key standards have been developed or are under development and have been shared with key stakeholders.</li> <li>• Lessons learnt from all task and finish groups captured to support the reduction in variation across wards and are being shared to ensure inclusion in future work and wider Trust approach to standard work.</li> </ul>

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
	<p><b>Board Rounds:</b></p> <ul style="list-style-type: none"> <li>• % compliance to Board Round Policy, including core and enhanced elements</li> </ul>	<p><b>In Progress</b></p> <p><b>Board Rounds</b></p> <ul style="list-style-type: none"> <li>• Adult ward cohorts 1-6 completed with an overall average increase of 34% improvement (from a baseline average compliance of 54% to a final average compliance of 88%) in compliance to policy. There has also been a sustained reduction in the average length of stay for elective patients within OUH. The reduction in the average length of stay per ward was 12.5 hours.</li> <li>• There has also been an increase in the anticipated date of discharge (ADD) completion within 48 hours of admission from 10% to 50%.</li> <li>• There has been an average increase in the number of discharges before midday per week per ward of 1 and an average increase in discharges per weekend per ward of 1.</li> <li>• Cohort 7 (Paediatrics) – 14 PDSA’s have now been completed across Bellhouse Drayson, Horton Children’s and Toms wards which will support and inform spread to other Paediatric</li> </ul>

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
		<p>Wards. The wards have now moved into their 30-60-90 day reviews.</p> <ul style="list-style-type: none"> <li>• Whiteboard screens are being made operational. Training being planned for staff members where required. Good level of engagement and learning being shared within various forums prior to spread with other children's wards.</li> <li>• An end of Project report for the adult wards and the lessons learnt report have been completed and have been presented at the Standard Work Programme Group as part of governance.</li> <li>• A board round SharePoint page has now been created and live within the QI Zone for staff to refer to for ongoing support.</li> <li>• Sustainability – “holding the gains” - self assessment questions for Board Rounds for all wards now embedded into Ulysses which will have Divisional oversight. This is being completed monthly by all wards.</li> <li>• Board Rounds will now be observed as part of the OxSCA visits.</li> </ul>

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
		<ul style="list-style-type: none"> <li>• An NHS Impact case study has been completed to share learning from the project and currently planning to disseminate this both internally and externally.</li> </ul> <p><b>In Progress</b></p> <ul style="list-style-type: none"> <li>• The revised Board Round policy has been updated following feedback and was presented at the Clinical Policy Group at the beginning of November and was approved.</li> </ul> <p><b>In Progress</b></p> <p><b>Equipment Checking</b></p> <ul style="list-style-type: none"> <li>• Key priorities for equipment checking includes SEND, Resuscitation and Blood Glucose Monitoring</li> <li>• Task and Finish Groups underway with representation from key services and all Divisions</li> </ul> <p><b>In Progress</b></p> <p><b>Resuscitation Checks</b></p>

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
	<p><b>Equipment Checking:</b></p> <ul style="list-style-type: none"> <li>• % compliance of defined standards to check equipment</li> </ul>	<ul style="list-style-type: none"> <li>• First draft standard for resuscitation checks has been completed and will be published using the new OMI template. Rollout and monitoring plan to be agreed with Divisions.</li> <li>• Standard Work for resuscitators in progress and will be tested on the Newborn Care Unit in early 2026.</li> <li>• Key issue has been around consistency of checks and monitoring as resuscitation checks mainly take place over night.</li> <li>• The QI team are linking with the Care Assure team to check and integrate the appropriate questions into the visits linked to the Standard Work document.</li> <li>• Compliance is being measured within My Kit Check and My Assurance Hub.</li> </ul> <p><b>In Progress</b></p> <p><b>SEND</b></p> <ul style="list-style-type: none"> <li>• Ideas for tests of change for SEND have been developed within the task and finish group as well completion of high-level process maps.</li> </ul>

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
		<ul style="list-style-type: none"> <li>• The 'one best way' to perform an equipment check for SEND has been documented including photographs and key steps using the new standardised Standard Work Template</li> <li>• Testing is planned at the Horton at the Juniper and Laburnum wards due in early 2026 due to clinical pressures</li> </ul> <p><b>In Progress</b></p> <p><b>Blood Glucose Monitoring</b></p> <ul style="list-style-type: none"> <li>• Blood Glucose monitoring equipment priority has been progressing with the QI team visiting wards and identified areas to observe their current processes and speaking to staff to gain insights prior to process mapping.</li> <li>• Process map was completed and identified waste in unnecessary ketones checks being carried out within the Trust. The guidance states that ketone checks only need to be carried out once a week, however the meters were prompting staff to undertake a daily check.</li> </ul>

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
		<ul style="list-style-type: none"> <li>• The prompt could not be changed without changing the frequency of glucose checks.</li> <li>• The Point of Care team undertook an audit of over 10,000 data points and a literature review to determine whether the frequency of the quality checks could be changed. A decision was made to move to weekly checks from the beginning of October and was communicated to all key stakeholders.</li> <li>• The change from daily to weekly checks has projected to save per year:             <ul style="list-style-type: none"> <li>○ 16,337 clinical hours</li> <li>○ £30,318 from glucose strips not used.</li> <li>○ £84,640 from ketone strips not used.</li> </ul> </li> <li>• Weekly checks now form part of ‘one best way’ to perform a quality check.</li> <li>• Use of the Standard Work document for performing internal quality check to be drafted by end of January 2026.</li> </ul>

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
		<ul style="list-style-type: none"> <li>• The financial savings linked to the change from daily to weekly checks are being calculated at Divisional level and will be shared when ready.</li> </ul> <p><b>In Progress</b></p> <p><b>Safe and Secure Storage of Medicines (SSSM)</b></p> <ul style="list-style-type: none"> <li>• Task and finish group underway aligned to Medicines Quality Priority and other priorities</li> <li>• Focused observations and stakeholder engagement carried out in Endoscopy, SEU D, CMU A, WW Theatres, JR Theatres, ED and Neonates. Data had been gathered to understand challenges and opportunities in each area using QI methodology to inform work and share learning.</li> <li>• 5S (Lean methodology) in planning in conjunction with Standard work being progressed in pilot areas with alignment to planned pharmacy stock reviews. Endoscopy room undertaking tests of change and gathering staff feedback.</li> <li>• Standard work documents for key processes have been agreed within the task and finish</li> </ul>

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
		<p>group and now being tested. This mainly focuses on the stock handling of pharmacy items, breach escalations and temperature checks which were raised by Pharmacy as key processes that required a standard work approach.</p> <ul style="list-style-type: none"> <li>• There is clear alignment with the roll out of the digital fridge temperature monitoring solution.</li> <li>• SSSM audits have shown general level of improvement throughout the year in key areas where the QI team had been supporting alongside other priority initiatives in place.</li> <li>• Divisional teams have approached the QI team to review some other areas linked to SSSM following Care Assure visits and other audit results.</li> </ul> <p><b>In progress</b></p> <p><b>Safety Huddles</b></p> <ul style="list-style-type: none"> <li>• Trust wide clinical questionnaire has been distributed and baseline data available.</li> </ul>

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
	<p><b>Safe and Secure Storage of Medicines:</b></p> <ul style="list-style-type: none"> <li>• % increase in compliance measured through Safe and Secure Storage of Medicines audit</li> </ul> <p><b>Safety Huddles:</b></p> <ul style="list-style-type: none"> <li>• % clinical teams completing safety huddles in alignment with the policy</li> </ul>	<ul style="list-style-type: none"> <li>• Results had shown that discussions were patient centred, responsive and adaptable to departmental requirements.</li> <li>• Feedback from Standard Work Programme Group proposed a principle-based approach rather than a standard would work and will progress with Divisional Leads</li> <li>• QI teams are working with Ophthalmology, a service identified by the Chief Medical Officer, who could benefit from focus into the Standard Work concept, in particular for Safety Huddles.</li> </ul>
<p><b>Objective 2</b></p> <p><b>(Q1-4)</b></p> <p><b>Materials</b></p> <ul style="list-style-type: none"> <li>• Support Materials and Infrastructure for Wider Organisational Adoption of Standard Work</li> </ul>	<ul style="list-style-type: none"> <li>• Define and develop clear branding and approach to language to aid adoption and Trust wide engagement.</li> <li>• Develop Standard Work resources toolkits tailored to organisational need, facilitating the optimisation of current portal for Standard Work for sharing resources wider than defined priority areas.</li> </ul>	<p><b>In progress</b></p> <ul style="list-style-type: none"> <li>• Branding for Standard Work has been approved by Chief Officers</li> <li>• Continuation of ad-hoc engagement events with identified services (i.e. maternity, theatres, surgery, endoscopy) as to help staff understand more about standard work following requests within programme group.</li> <li>• Standard Work SharePoint page now available and linked for staff to easily access current</li> </ul>

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
	<ul style="list-style-type: none"> <li>• Integrate approach into core Trust business within Divisions with governance enabling scale and spread.</li> <li>• Toolkit and digital platform launched and actively used by staff.</li> <li>• Inclusion of Standard Work in 80% of induction and training programmes</li> <li>• Increased uptake of resources, measured by at least 70% of targeted staff engaging with the toolkit and platform.</li> <li>• Staff report increased confidence and ease in applying Standard Work practices</li> </ul>	<p>resources – additional pages under development linked to priority areas to provide specific resources for teams (i.e. Board Rounds and Resuscitation Checks)</p> <ul style="list-style-type: none"> <li>• Standard Work template for visual display to use in all OUH clinical and non-clinical areas designed by OMI and being shared for use with key teams / services the QI teams are working with at present – once tests of change are complete, the Standard Work documents for the priority processes will be rolled out across the organisation. The document will be instantly recognisable and provide a level of consistency.</li> <li>• Standard Work Masterclass (2 hrs) has been developed and has been tested with identified services. The masterclass was adapted for a one-hour session as part of the BOB ICS Quality Improvement Festival week back in September.</li> <li>• Staff providing feedback through tests of change which is increasing knowledge and confidence of using standard work concept.</li> <li>• Governance / Assurance</li> </ul>

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
		<ul style="list-style-type: none"> <li>• Bi-monthly programme meetings in place attended by Divisional leads, task and finish group leads and key stakeholders across the organisation.</li> <li>• Visibility from ward to board, ensuring that compliance is recorded centrally; to allow focus for services and any actions are acted on and changes linked into Care Assure or other groups where required.</li> <li>• Bi-weekly meeting with Accountable Officer in place to help with embedding programme at pace and opportunity to understand any risks and escalations.</li> </ul>
<p><b>Objective 3</b></p> <p><b>(Q2-4) Long-term strategy</b></p> <ul style="list-style-type: none"> <li>• Define long-term approach to Trust wide adoption of Standard Work</li> <li>• Engage staff and stakeholders to co-design</li> </ul>	<ul style="list-style-type: none"> <li>• Drafted and approved Trust wide roadmap with Divisional oversight framework</li> <li>• Evidence of measurable improvement in KPIs, e.g. safety, quality, efficiency and patient/staff experience metrics. Case studies sharing best practice to support further adoption</li> </ul>	<p><b>In Progress</b></p> <ul style="list-style-type: none"> <li>• Foundation and Engagement – focus has continued establishing standard work programme infrastructure to deliver within defined priorities.</li> <li>• Continued strong engagement across Divisions and wider support services - linked into Standard Work Programme Group.</li> </ul>

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
<p>a long-term strategy post 2025/26, defining ongoing approach to scale up and integrate into OUH's strategic planning / Quality Management System</p>		<ul style="list-style-type: none"> <li>• Standard Work Quality Priority agreed to continue into 2026/27 and has been presented to the Quality Conversation Event in December.</li> <li>• National and International Case Studies: Presentation of the Board Rounds project at the Institute for Healthcare Improvement (IHI) International Conference in Utrecht in May.</li> <li>• Submitted application to the Health Service Journal (HSJ) National Awards for the board round project, which was unfortunately not shortlisted, but opportunity to share and gather learning nationwide. It is expected that this will attract national interest as evident when shared in the improvement marketplace at the BOB Southeast Learning Improvement Network event back in May.</li> <li>• NHS Impact Case Study linked to Board Round project has been drafted and shared with key stakeholders internally within OUH. The QI Project Manager is progressing the publication of the case study with NHS Impact as well as the British Medical Journal (BMJ) Open Quality forum.</li> </ul>

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
		<p><b>Next Steps:</b></p> <ul style="list-style-type: none"> <li>• Year two proposal to focus on adopting Standard Work more widely across the organisation as part of a longer-term strategy.</li> <li>• The proposal will also include defining the approach with staff and key stakeholders, embedding it within OUH quality management system, working with selected services to test, adapt and implement changes before wider rollout with Divisional support.</li> <li>• The programme will also include continued work on Safety Huddles and Safe and Secure Storage of Medicines.</li> </ul>

## Quality Priority 5: Outreach Service from Oxford Critical Care

### Why is this a priority?

The aim of the Oxford Critical Care Outreach (CCO) Service is to ensure safe, equitable and quality care for all acutely unwell, critically ill and recovering patients. This service provides two main functions: post-ICU patient follow-up, and early recognition of deterioration and rapid response within main Trust sites.

In-hospital follow-up supports patients during the transition from unit to ward. The aim is that it will better support all patients discharged from critical care, and particularly those discharged out of hours. It has the potential to improve outcomes, including reduction in readmission to ICU, in-hospital mortality, and hospital length of stay. Early recognition of deterioration and intervention can improve patient outcomes and provide timely, expert advice to medical teams. The introduction of Martha's Rule is also likely to advocate a need for 24/7 access to a rapid review of patients and coordination where appropriate for additional input for critically unwell patients.

Implementation of a full 24/7 outreach service is recommended by key national guidance standards including Getting It Right First Time (GIRFT), and guidelines for the provision of intensive care surgery (GPICS) and is a recurrent theme in NCEPOD reports. It is also advocated in NICE guidance. Introduction of CCO was a recommendation in the 2022 Care Quality Commissions (CQC) inspection of OCC.

**Aim:** develop and pilot an outreach service for the Trust, coordinated and overseen by Oxford Critical Care / Critical Care, Anaesthetics, Preoperative Assessment and Resuscitation (CAPR). This will improve the follow-up of post-ICU patients, recognition of deteriorating patients, improve speed and quality of decision-making, improve bed length of stay, and provide a platform for improved nursing retention.

Table 5 Outreach Service from CCO QP 2025/26

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
<b>Objective 1 (Q1)</b>  <b>Project Board set-up</b>	<ul style="list-style-type: none"> <li>Project board initiated with agreed terms of reference</li> </ul>	<b>In progress</b>

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
<ul style="list-style-type: none"> <li>• Develop a CCO Project Board</li> <li>• To include Martha's Rule</li> </ul>	<ul style="list-style-type: none"> <li>• Minutes from meetings</li> <li>• Project plan progressing</li> <li>• Actions are occurring from the Project Board</li> </ul>	<ul style="list-style-type: none"> <li>• Project Board Terms of Reference (ToR) and Membership dependent on the option selected in the business case</li> <li>• Martha's Rule pilot progressed with support from Critical Care teams at JR and HGH.</li> <li>• Martha's Rule was rolled out to all areas of the Trust in March 2026.</li> </ul>
<p><b>Objective 2</b> (Q1)</p> <p><b>GAP analysis</b></p> <ul style="list-style-type: none"> <li>• GAP analysis for out of hours (OOH) medical and nursing escalation from wards</li> <li>• This will feed into the options appraisal / business case</li> </ul>	<ul style="list-style-type: none"> <li>• Completion of the GAP analysis</li> </ul>	<p><b>Completed</b> as part of business case</p>
<p><b>Objective 3</b> (Q2-3)</p> <p><b>Options appraisals</b></p>		<p><b>Completed</b></p> <ul style="list-style-type: none"> <li>• Submitted as part of business case</li> </ul>

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
<ul style="list-style-type: none"> <li>Four hospital site analysis for CCO needs to create options appraisal which will include options for 'do nothing', 'minimum investment / restructuring of available resources through to the most ambitious options – this will feed into the business case</li> </ul>	<ul style="list-style-type: none"> <li>Completion of options appraisal</li> </ul>	
<p><b>Objective 4</b> <b>(Q2-3)</b></p> <p><b>Communication</b></p> <ul style="list-style-type: none"> <li>Agreed communication escalation methods for CCO – Martha's Rule / GAP analysis feedback – interim step overlaid to CCO</li> <li>This may feed into the options and the business case</li> </ul>	<ul style="list-style-type: none"> <li>Implementation and communication of the escalation process</li> <li>Auditing will show if the escalation process is working effectively</li> <li>The escalation will be working well, and staff will understand how to use it</li> </ul>	<p><b>In progress</b></p> <ul style="list-style-type: none"> <li>Martha's Rule pilot (June – Dec 2025) provided additional route of escalation of concerns regarding rapidly deteriorating patient. Process for escalation has been agreed across JR and HGH adult wards. Rollout of patient and staff escalation of concerns has taken place in March 2026 across children and adults in all 4 sites.</li> <li>Also see objective 7</li> </ul>
<p><b>Objective 5</b> <b>(Q3)</b></p> <p><b>Business case</b></p>		<p><b>In Progress</b></p> <ul style="list-style-type: none"> <li>A draft outreach options appraisal and business case has been developed</li> </ul>

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
<ul style="list-style-type: none"> <li>Business case submission for CCO based on options appraisal</li> </ul>	<ul style="list-style-type: none"> <li>Successful submission of business case</li> </ul>	
<p><b>Objective 6</b> (Q3-4)</p> <p><b>Implementation</b></p> <ul style="list-style-type: none"> <li>CCO implementation based on outcome of options appraisal and business case</li> </ul>	<ul style="list-style-type: none"> <li>The OCC is in place as per the business case by end of Q4</li> </ul>	<ul style="list-style-type: none"> <li>Not yet commenced. Contingent on objective 5</li> </ul>
<p><b>Objective 7</b> (Q1-4)</p> <p><b>Martha's Law</b></p> <ul style="list-style-type: none"> <li>Agree alignment of Martha's Rule with CCO</li> </ul>	<ul style="list-style-type: none"> <li>Process map with GA analysis for Martha's Law escalation</li> <li>Communication strategy with resource allocation, potential alignment to the business case</li> </ul>	<p><b>In Progress</b></p> <ul style="list-style-type: none"> <li>Martha's Rule pilot was launched in June-December 2025 in adult areas at the John Radcliffe Hospital and Horton General Hospital.</li> <li>Roll out of escalation of patient and staff concerns across all areas of the Trust took place in March 2026</li> <li>Martha's Rule Implementation group working to reduce any impact on Critical Care teams by filtering out all non-critical calls from CCO.</li> </ul>

What will we do?	How will you know the objective is completed and that it is working?	Status to the end of Q4
		<ul style="list-style-type: none"> <li>A new QP on Martha's Rule has been approved for 2026/27 to implement all components of Martha's Rule across the Trust</li> </ul>

## Quality Priority 6: Discharges

### Why is this a priority?

There is increasing demand for our emergency and planned care services because of a growing and ageing population in Oxfordshire. Patients attending our hospitals are more complex, both medically and socially. Following a 'Home first' approach, we are striving to discharge as many patients as possible to their homes, where we know people recover and rehabilitate quicker than in a hospital. Discharges to care homes or to community hospitals should be limited to where it is not possible to deliver the level of care required in a person's home. Consequently, the volume and complexity of discharge planning has increased.

This Quality Priority will review discharge processes for all patients and seek to improve the quality and safety of discharge. This includes reducing delays and length of stay, as well as learning from incidents and feedback. There will also be an opportunity to explore the empowerment of nurses and other Allied Health Care Professionals to lead discharge-based decisions to improve quality and reduce length of stay.

*This Quality Priority is being rolled over to 2026/27*

Table 6 Discharges QP 2025/26

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
<b>Objective 1 (Q1-3)</b> <b>Improve experience of continuity and quality of care for patients</b> <ul style="list-style-type: none"> <li>Establish a process for reviewing quality, safety and risk of discharge from hospital</li> </ul>	<ul style="list-style-type: none"> <li>Availability and collation of internal and external information</li> <li>Thematic analysis of internal themes as well as from system partners</li> <li>Share internally to appropriate colleagues for awareness and action where needed</li> </ul>	<b>In Progress</b> and rolled over to 2026/27  <b>Complete (and ongoing)</b>  <b>Complete</b>

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
<ul style="list-style-type: none"> <li>Low threshold for picking up 'to take home' (TTO) related incidents, including those that are couriered via City Sprint</li> </ul> <p>Contact Medicines Information team for data from patient contacts</p>	<ul style="list-style-type: none"> <li>Close feedback loop to system partners.</li> <li>Increase patient satisfaction scores related to discharge communication by 15%</li> <li>Positive feedback from patients and families regarding discharge communication within six months (questionnaires and friends and family tests)</li> <li>There will be a 15% reduction in discharge-related complaints</li> <li>Reduction in incidents regarding discharges</li> </ul>	<p><b>Complete</b></p> <p><b>In Progress</b> and rolled over to 2026/27</p> <ul style="list-style-type: none"> <li>Dashboard not yet available to track progress and objectives linked to this outcome still in progress.</li> </ul> <p><b>In Progress</b> and rolled over to 2026/27</p> <p><b>In Progress</b> and rolled over to 2026/27</p> <ul style="list-style-type: none"> <li>Dashboard not yet available to track progress and objectives linked to this outcome still in progress.</li> </ul> <p><b>In Progress</b> and rolled over to 2026/27</p> <p><b>Workstream 1 Medication – detailed update</b></p> <p><i>Current activity and achievements</i></p> <ul style="list-style-type: none"> <li><i>Stopping routine over the counter medicines dispensed at discharge approved and implementation underway; aim is to</i></li> </ul>

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
		<p><i>reduce dispensary workload so pharmacy can focus on critical tasks.</i></p> <ul style="list-style-type: none"> <li>▪ <i>Limiting discharge supply to regular meds for &gt;5 day stays is in place with ICB negotiations progressing.</i></li> <li>▪ <i>Electronic FP10 (CLEO) funding secured for outpatient prescribing; platform implementation planning under way.</i></li> <li>▪ <i>Discharge Medicines Service (DMS) rolled out to improve GP/community pharmacy comms; expected productivity gains.</i></li> <li>▪ <i>Live pharmacy dashboard created; risk assessment for medication couriers (CitySprint) in progress.</i></li> <li>▪ <i>Recent workstream call captured the operational focus: timeliness of TTOs, patient information on medicines, and courier use; alignment with dispensary KPIs (objective of 2 hr turnaround).</i></li> <li>▪ <i>Existing procedure draft for discharging patients with medicines has been shared to</i></li> </ul>

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
		<p><i>unblock governance work; includes risk assessment flow considerations for leaving without meds and courier delivery.</i></p> <ul style="list-style-type: none"> <li><i>Data enablement: TTO monthly report exists analysis can identify the % prescribed ahead of day</i></li> <li><i>Monthly workstream meeting ongoing since programme commenced with Executive Oversight Meetings monthly to monitor progress of programme</i></li> </ul>
<p><b>Objective 2 (Q1-4)</b></p> <p><b>Improve and provide assurance of the safety of discharge from hospital</b></p> <ul style="list-style-type: none"> <li>Standardise discharge processes on departure from hospital</li> </ul> <p>Implement a mandatory Discharge Safety Checklist within the 'depart' process in the electronic patient record (EPR); one specifically for adult</p>	<ul style="list-style-type: none"> <li>The Discharge Safety Checklist is on EPR for both adults and children</li> <li>Completion rates of the Discharge Safety Checklist for both adult and paediatric inpatients</li> </ul>	<p><b>In Progress</b> and rolled over to 2026/27</p> <p><b>In Progress</b> and rolled over to 2026/27</p> <ul style="list-style-type: none"> <li>Due to discovery of greater than expected level of work required following the review of the checklist. Additionally the intention is to pre-empt safety issues at an earlier point than on discharge and to implement robust and sustainable changes in</li> </ul>

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
<p>inpatients and one for paediatric inpatients</p>	<ul style="list-style-type: none"> <li>• Achieve a 90% compliance rate with the new Discharge Safety Checklist within six months</li> <li>• Monthly audits showing increased compliance rates</li> <li>• Increase by 15% in positive feedback from patients and families regarding the discharge process</li> </ul> <p>15% reduction in discharge-related complaints and incidents</p>	<p>discharge safety planning at an earlier stage in the patient’s journey.</p> <p><b>In Progress</b> and rolled over to 2026/27</p> <p><b>In Progress</b> and rolled over to 2026/27</p> <p><b>In Progress</b> and rolled over to 2026/27</p> <ul style="list-style-type: none"> <li>• This has been amended on the QP 2026/27 to reflect the National Inpatient Survey question and response with appropriate target</li> </ul> <p><b>Workstream 2 Communication – detailed update</b></p> <p><i>Current activity and achievements</i></p>

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
		<ul style="list-style-type: none"> <li>▪ <i>Nurse-led discharge process being modelled in EPR, generic discharge summary template in development for all inpatients.</i></li> <li>▪ <i>Mandatory Discharge Safety Checklist under development for EPR; coordination across workstreams to remove duplication this has been added to the standard work programme and will be delivered by the QI team.</i></li> <li>▪ <i>Improved GP discharge letter format deployed into EPR following extensive work alongside documentation updates.</i></li> </ul> <p><b>Workstream 4 Documentation – detailed update</b></p> <ul style="list-style-type: none"> <li>▪ <i>Unified electronic discharge summary (“PowerNote”) rolled out in EPR for inpatients (Oct 2025).</i></li> <li>▪ <i>Revisions to GP discharge letter and distribution process are in progress and merged with Communication work stream</i></li> </ul>

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
		<ul style="list-style-type: none"> <li>▪ <i>Verification that summaries/letters are auto sent to community teams and specialty follow-ups is underway.</i></li> <li>▪ <i>Checklist build ownership transferred to Communication so Documentation can focus on content quality and AHP contribution. Oversight notes confirm AHP profile integration.</i></li> </ul>
<p><b>Objective 3 (Q1-2)</b></p> <p><b>Provide clear communication to patients and unpaid carers to on discharge processes and follow up support</b></p> <ul style="list-style-type: none"> <li>• Review and improve the clarity and comprehensiveness of discharge instructions for patients and their families</li> <li>• Discharge information leaflet</li> <li>a. Produce a discharge information leaflet for patients</li> </ul>	<ul style="list-style-type: none"> <li>• Completion and adherence rates of the discharge communication protocol</li> <li>• The leaflet has been produced, is in circulation and staff know about it and use it</li> <li>• Reduced misunderstandings from staff/patients on discharge pathways and expectations</li> </ul>	<p>Objective amended for year 2 following review of actions</p> <p><b>Complete and on track</b></p> <p><b>In Progress</b></p> <p><b><i>Workstream 3 Patient Experience – detailed update</i></b></p>

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
<p>b. Publish a discharge information leaflet for patients</p> <p>Brief ward staff on the contents and embed its use</p>	<p>Staff feel empowered and prepared to answer questions relating to complex discharge from patients/relatives</p>	<ul style="list-style-type: none"> <li>▪ <i>New patient discharge information leaflet created, and a plan for consultation with patients and Patient Safety Partners approved.</i></li> <li>▪ <i>Emphasis on early involvement of patients/carers and Home First approach.</i></li> <li>▪ <i>Regular FFT collection targeted specifically at discharge experience and analysis is ongoing conducted by the Patient Experience team and fed into the programme.</i></li> <li>▪ <i>Capacity constraints acknowledged; interviews and codesign sessions planned as staffing returns.</i></li> </ul>
<p><b>Objective 4 (Q1-4)</b></p> <p><b>Nurse, Midwife, Therapies and Allied Health Care Professionals (AHPs) led discharge opportunities</b></p>	<ul style="list-style-type: none"> <li>• Integration of the guidelines into the electronic patient record (EPR) system</li> <li>• Training completion for all staff participating in criterion-led discharge criteria</li> </ul>	<p><b>In Progress</b> and rolled over to 2026/27</p>

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
<ul style="list-style-type: none"> <li>• Q1-2: Set up a scoping session to identify what is required and who can discharge patients</li> <li>• Q3-4: Once established, produce a Standard Operating Procedure (SOP) for nurse-led discharges</li> <li>• Develop and implement a criterion-led discharge process for Nurses, Midwives and AHPs</li> </ul> <p>Q3-4: Train relevant nurses, midwives and AHP staff on the criterion-led discharge process</p>	<ul style="list-style-type: none"> <li>• Compliance reports showing adherence to the criterion-led discharge process</li> <li>• Achieve a 90% compliance rate with the criterion-led discharge process within 12 months</li> <li>• Reduction in length of stay once criterion-led discharges implemented</li> <li>• Positive feedback from patients and families regarding the discharge process</li> </ul> <p>Reduction in discharge-related complaints</p>	<p><b>Workstream 5 Safe Discharge (Criteria-/Nurse-led) Detailed update</b></p> <p><b>Current activity and achievements</b></p> <ul style="list-style-type: none"> <li>▪ Literature review completed to inform OUH approach; confirms safety/effectiveness of nurse/criteria led discharge.</li> <li>▪ Scoping meeting scheduled and stakeholders identified – defining criteria, scope, and pilot wards/patient groups.</li> <li>▪ Criteria led discharge workstream work continue into next year due to the size and complexity of the deliverables encompassing a systemic change in processes</li> </ul>

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
		<ul style="list-style-type: none"> <li>Supporting winter operations: early data shows 20–22% uplift in before midday discharges Dec 2025 over Dec 2024 linked to escalation flow meetings and process tweaks.</li> </ul>
<p><b>Objective 5 (Q2-4)</b></p> <p><b>25% of discharges are by midday on inpatient areas*</b></p> <ul style="list-style-type: none"> <li>Develop and implement a process to prioritise and facilitate discharges before midday</li> <li>Design, develop and implement a discharge prioritisation protocol/SOP</li> <li>Explore the requirement for an electronic dashboard</li> <li>Awareness of the new discharge prioritisation process through communications and</li> </ul>	<ul style="list-style-type: none"> <li>All communications and media about the new discharge protocol have been disseminated</li> <li>Data support adherence to 25% of ward discharge by midday</li> <li>Positive feedback from patients and families regarding the discharge process, through PALS and Friends and Family Test</li> </ul>	<p><b>In Progress</b> and rolled over to 2026/27</p> <p><b>On Track.</b> Most recent data indicates an increase in discharges before midday from 18% in December 2024 to 22% in December 2025</p> <p><b>In Progress</b> and rolled over to 2026/27</p> <p><b>In progress</b></p>

What we will do	How will you know the objective is completed and that it is working?	Status to the end of Q4
<p>media to advertise and disseminate</p> <p><i>* Note that this <u>excludes</u> Outpatients, Day Surgery Units, Short Stay areas (average &lt;24 hours, e.g. Maternity, Orthopaedic Short Stay Unit), Assessment areas</i></p>	<ul style="list-style-type: none"> <li>• Reduction in discharge-related complaints and incidents</li> </ul>	

## Patient Experience

### Quality Priority 7: Maternity Service User Experience

#### Why is this a priority?

The Trust is prioritising the improvement of ‘Maternity Service User Experience’ to enhance the quality of care and experience for expectant mothers and their families. This initiative aims to facilitate better communication and understanding between the healthcare professionals in our Maternity Service and service users, ensuring that the needs and preferences of women, birthing people and their families are effectively addressed.


By focusing on personalised care plans, we can support women, birthing people and their families throughout their maternity journey, from antenatal care to postnatal recovery. This Quality Priority emphasises the importance of a service user-centred approach, where healthcare professionals work closely with mothers and their families to understand their unique circumstances and expectations. The initiative will involve regular reviews and updates to care plans, ensuring they remain relevant and effective.

Improving the maternity experience will benefit patients by providing more tailored and compassionate care, reducing anxiety and enhancing overall satisfaction with Maternity Services. For the Trust, this focus on quality care will foster a positive reputation, increase patient trust, and promote a culture of continuous improvement in maternal and neonatal health.

*This Quality Priority is being rolled over to 2026/27*

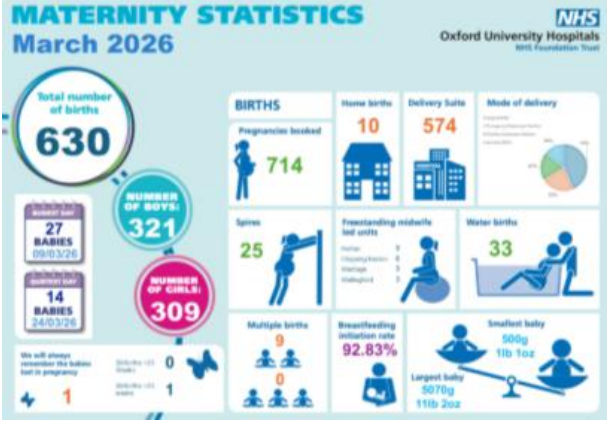
*Table 7 Maternity Service user experience QP 2025/26*

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
<b>Objective 1</b> <b>(Q1-2)</b> <b>Care planning</b>	<ul style="list-style-type: none"> <li>Evaluate and align the personalised care plans with the latest evidence-based practices and guidelines in maternity care</li> </ul>	<b>Complete</b> <ul style="list-style-type: none"> <li>Personalised care plans have been introduced- see objective 2 for more details</li> </ul>

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
<ul style="list-style-type: none"> <li>Undertake personalised care planning questionnaire for sample of expectant mothers and birthing people</li> <li>Undertake an audit for all feedback routes on satisfaction of care</li> </ul>	<ul style="list-style-type: none"> <li>Increase in service user satisfaction scores regarding maternity care via all feedback routes, reported monthly through the Triangulation and Learning Committee (TALC), Quality and Performance Dashboard Reports. Improved CQC Service User Feedback Survey</li> </ul>	<p><b>Complete and on going</b></p>  <p><b>Family and Friends Test</b> Our feedback scores Department: Maternity Month: March 2026</p> <p>518 Total number of responses</p> <p>92.5% Very Good</p> <p>4% Good</p> <p>3.5% Poor</p> <p><b>Your feedback matters</b></p> <p><b>We said:</b> Review indicators of labour pathway once ready for labour onset.</p> <p><b>We did:</b> We have reviewed and updated the induction pathway. This will ensure timely transfer once ready for the next stage of the labour process.</p> <p><b>Positive responses</b></p> <ul style="list-style-type: none"> <li>Staff have been supportive</li> <li>Very quick helpful responses from midwives</li> <li>Staff very friendly</li> <li>A positive experience overall</li> </ul> <p><b>YOUR FEEDBACK MATTERS</b></p>

- 163 Friends and Family Test (FFT) plus 355 Say On Day responses were received in March 2026. 96.5% rated the service as 'good' or 'very good' with an overall response rate of 82% when compared to the number of deliveries.
- Feedback across maternity services was overwhelmingly positive, particularly for the screening and vaccination clinics, for efficiency, kindness, and ability to put patients at ease. The Banbury and Witney Community Midwife Teams were commended for their compassionate, knowledgeable care. The Spires Midwifery Unit and Delivery Suite teams were highlighted for their

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
		<p>supportive, respectful, and professional approach. Postnatal care on Level 5 was generally well received. However, concerns were raised about long waits, discomfort, and communication issues at the Maternity Assessment Unit (MAU), indicating an area for improvement.</p> <p>Additional space has been identified to increase the physical capacity of MAU and work is ongoing to incorporate this space into the service. The expansion of 'Say on the Day' feedback devices into community and outpatient settings. This has included the 4 community birth centres and Florence park OX4. We have seen a consistent weekly response of 10-20. We are able to review these responses to ensure all voices including those from underrepresented or marginalised groups are heard and acted upon in real time. This is an example of the monthly published communications that are now consistently shared:</p>

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
	<ul style="list-style-type: none"> <li>Ensure that at least 50% of relevant healthcare professionals attend the training sessions within the first six months</li> </ul>	 <p><b>Complete</b></p> <ul style="list-style-type: none"> <li>Active Bystander training is now mandatory for all staff groups and measured as part of the PROMPT training. The training aims to empower staff to challenge poor behaviours that may have become normalised over time, and bring about change through the reinforcement of messages defining the boundaries of unacceptable behaviour.</li> <li>This is a rolling mandatory session with projected 100% compliance.</li> </ul>

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
	<ul style="list-style-type: none"> <li>• Positive feedback and evaluation from training modules and workshops</li> <li>• Reduce the number of red rated reported communication-related complaints by 50% with an improvement in communication ratings between healthcare professionals and service users</li> </ul>	<p>See objective 3</p> <p><b>Complete</b></p> <ul style="list-style-type: none"> <li>• Complaints are reviewed monthly. We have seen an increase this financial year (45 compared with 25 in the previous financial year). None of these are red rated complaints. We continue to promote real time feedback with introduction of a new patient responder role. Other actions include proactively identifying reported incidents of moderate harm and above following which the family may benefit from a one to one debrief while still in hospital.</li> <li>• Several specific actions have been taken in direct response to the feedback received. Recruitment is underway for a maternity-specific Pharmacy Technician to start in May 2026. Additionally, infographics are currently in development for the Maternity Assessment Unit, which will provide clear information on average wait times to improve transparency and patient experience. These initiatives are in addition to the ongoing training programmes, including communication skills and active bystander sessions, which continue to be monitored as part of the mandatory training</li> </ul>

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
	<ul style="list-style-type: none"> <li>Positive trajectory of personalised care plan compliance measured through regular audit</li> </ul>	<p>requirements. The focus remains on addressing the recurring concerns and ensuring that improvements are both meaningful and sustainable, with progress regularly reported to relevant governance committees.</p> <p><b>Complete</b></p> <p>See objective 2</p>
<p><b>Objective 2</b> <b>(Q2-4)</b></p> <p><b>Feedback from service users</b></p> <ul style="list-style-type: none"> <li>Incorporate feedback from service users into the regular review and update of care plans to ensure they meet the evolving needs and preferences of expectant mothers and birthing people</li> </ul>	<ul style="list-style-type: none"> <li>Complete the development and initial implementation of personalised care plans by end of Q4</li> <li>Monthly audit of personalised care plans to measure compliance – they should be &gt; 90% compliant</li> </ul>	<p><b>Complete</b></p> <ul style="list-style-type: none"> <li>The introduction of personalised care plans audit from BadgerNet shows a consistent high performing trajectory of &gt;90% compliance. This assures care is tailored to each individual’s background, preferences, and needs.</li> </ul> <p><b>Complete</b></p> <p>Oxfordshire Maternity and Neonatal Voices Partnership (OMNVP),</p> <ul style="list-style-type: none"> <li>The quarterly survey shows a positive trajectory towards our communication pathways over the last 6 months. This continues.</li> </ul>

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
		<ul style="list-style-type: none"> <li>The co-production of patient information leaflets including multilingual menu options and sensitive language training (e.g. around BMI discussions), demonstrates a commitment to inclusive communication and respect for diverse experiences:</li> </ul> <div data-bbox="1330 580 1957 600" style="text-align: center;"> <p><b>HOW MATERNITY EDI (EQUITY   DIVERSITY   INCLUSION) SUPPORTS YOU</b></p> </div> <div data-bbox="1330 624 1973 975"> <ul style="list-style-type: none"> <li><b>Translated Antenatal Classes and Unit tour</b> <ul style="list-style-type: none"> <li>Multi-lingual &amp; at Florence Park</li> <li>Refer via BadgerNet/EPR/Email</li> <li>Second evaluation ongoing</li> </ul> </li> <li><b>Ongoing Active Bystander Workshops:</b> <ul style="list-style-type: none"> <li>New mandatory for all OUH staff, both clinical and non-clinical</li> <li>Impact evaluation in progress with Health Innovation Oxford and Thames Valley – for maternity</li> </ul> </li> <li><b>Maternity Audits: Screening - focus on access:</b> <ul style="list-style-type: none"> <li>Look out for 'Book by 10' posters in GP waiting rooms, children centres, pharmacies, and churches near you.</li> <li>If you have not seen any, please collect a printed copy from the EDI office (Level 4, IR) or request one to be posted to your hub.</li> <li>Coming soon: 'SOP: Identification and Provision of Antenatal and Newborn Screening Information in Accessible Formats'</li> </ul> </li> <li><b>Neuro-inclusion, Disability &amp; Accessibility conversations:</b> <ul style="list-style-type: none"> <li>Continuing 1:1 and group support.</li> <li>Trust Reasonable adjustments policy now live</li> </ul> </li> <li><b>Engagement:</b> <ul style="list-style-type: none"> <li>For support or questions, email: <a href="mailto:EDIinclusion@ouh.oxh.nhs.uk">EDIinclusion@ouh.oxh.nhs.uk</a></li> <li>Outreach visits: Ro's, ARIUK, East Oxford Stay and Play</li> <li>Join your Maternity EDI working group</li> <li>Connect with Trust Staff Networks for additional support</li> </ul> </li> <li><b>Digital Inclusion funded by 'Good Things Foundation':</b> <ul style="list-style-type: none"> <li>Provision of free pre-installed SIMs and mobile phones for eligible women and birthing people (see SOP: Databank Sim Cards)</li> <li>Refer via BadgerNet, EPR, or Email</li> <li>In collaboration with Digital Nichives and Public Health Matron</li> </ul> </li> <li><b>Tackling bias &amp; discrimination:</b> <ul style="list-style-type: none"> <li>Continuing 1:1 and group support.</li> <li>Ongoing QI project: 'Tackling Bias to improve staff Inclusion and Cultural Safety in Maternity'</li> </ul> </li> <li><b>Patient Information 'Animations' (PIAs) - Burdett Grant Project:</b> <ul style="list-style-type: none"> <li>With Consultant Brenda Kelly, Maternity Clinical Governance, OMI and OUH communications</li> <li>Production of resources noted in Tatum with English Translation</li> </ul> </li> <li><b>Staff EDI resources:</b> <ul style="list-style-type: none"> <li>Find a wide range of EDI materials and useful links on the Maternity EDI Share/Join page.</li> </ul> </li> </ul> <div data-bbox="1547 1018 1749 1235" style="text-align: center;"> </div> <p style="text-align: center;"><a href="#">Friends and Family Test (FFT) - Oxford University Hospitals</a></p> </div>

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
<p><b>Objective 3</b> <b>(Q1-4)</b> <b>Training</b></p> <ul style="list-style-type: none"> <li>Conduct bi-monthly training sessions for healthcare professionals on effective communication and personalised care strategies. Pilot commencing April 25 (Q1) led by Maternity Psychologist</li> </ul>	<ul style="list-style-type: none"> <li>Monthly reports on training sessions</li> <li>Distribution records of educational materials</li> <li>Workshop attendance and feedback records</li> </ul>	<p><b>Complete</b></p> <ul style="list-style-type: none"> <li>The Practice Development team provide monthly maternity training sessions with educational materials</li> </ul> <p><b>Complete and on-going</b></p> <ul style="list-style-type: none"> <li>Successful Schwartz rounds with bimonthly advertised Microsoft teams sessions</li> </ul>

## Quality Priority 8: Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)

### Why is this a Priority?

ReSPECT is a national framework for discussing and documenting personalised recommendations for a person’s clinical care and treatment in a future emergency in which they may be unable to make or express choices. These recommendations are created through conversations between a person, their families and their health and care professionals to understand what matters to them and what is realistic in terms of their care and treatment. The process respects both patient preferences and clinical judgement. This includes discussion and decision-making about resuscitation. The ReSPECT document is held by the patient / legal proxy / significant other and also available electronically to all health and social care professionals.

The Trust is required to implement the national ReSPECT framework as part of the Berkshire, Oxfordshire and Buckinghamshire (BOB) Integrated Care System-wide approach to align Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) policies and procedures. Current guidelines require cardiopulmonary decision-making to be contained within advance care planning for patients of all ages that includes consideration of all realistic life-sustaining treatments.

We will launch, evaluate, embed, and educate staff, on ReSPECT throughout the Trust.

Table 8 ReSPECT QP 2025/26

What we will do	How will you know the objective is completed and that it is working?	Status to end Q4
<p><b>Objective 1</b> <b>(Q1)</b> <b>Launch ReSPECT</b></p> <ul style="list-style-type: none"> <li>Launch ReSPECT in OUH</li> </ul>	<p>Successful launch of ReSPECT in OUH following rollout and communication strategy</p>	<p><b>Complete</b></p> <p>Respect went live on the 11 March 2025</p> <ul style="list-style-type: none"> <li>ReSPECT document is working as designed.</li> <li>There is one unanticipated effect. The GP/Pt DNACPR form is not automatically marked and</li> </ul>

What we will do	How will you know the objective is completed and that it is working?	Status to end Q4
	<ul style="list-style-type: none"> <li>• ReSPECT is live and used in OUH</li>   <li>• EPR process is working as designed</li> </ul>	<p>this change has been requested through the EPR Clinical Advisory Group (CAG).</p> <ul style="list-style-type: none"> <li>• ReSPECT is now widely used in OUH. Examples include wards asking for order details for patient information leaflets as their original stock has run down.</li> </ul> <p><b>Numbers of ReSPECT plans each month approx. 900</b></p> <ul style="list-style-type: none"> <li>• The GP/Pt ReSPECT PDF is now available in the patient summary page.</li> </ul> <p><b>Complete</b></p> <ul style="list-style-type: none"> <li>• The previous Treatment Escalation Plan (TEP) form was reviewed and found to contain the same information as in ReSPECT so is no longer used, preventing duplication of information and saving clinicians' time.</li> </ul> <p><b>Complete</b></p>

What we will do	How will you know the objective is completed and that it is working?	Status to end Q4
		<ul style="list-style-type: none"> <li>BOB ICB have completed their ReSPECT digital form and ran a pilot with Headington GPs in Aug/September 2025. The BOB ReSPECT document is in the Thames valley <b>Shared Care Record</b> (GRAPHNET) which OUH clinicians can view but not edit. The BOB ReSPECT record does not interact with EPR nor open a related Mental Capacity Assessment (MCA). Options are being explored to fully integrate OUH and BOB ReSPECT forms.</li> </ul> <p><b>Complete</b></p> <ul style="list-style-type: none"> <li>Options are being explored to fully integrate OUH and BOB ReSPECT forms so that the ReSPECT digital record is editable by all organisations in BOB</li> </ul>
<p><b>Objective 2</b></p> <p><b>(Q 2-3)</b></p> <p><b>Evaluate</b></p> <ul style="list-style-type: none"> <li>Evaluate the ReSPECT process and its</li> </ul>		<p><b>Complete</b></p> <ul style="list-style-type: none"> <li>From March to June 2025 all ReSPECT plans were automatically delivered to Resuscitation inbox in EPR. These were read and acted upon during this time. This produced significant learning and has influenced the questions</li> </ul>

What we will do	How will you know the objective is completed and that it is working?	Status to end Q4
documentation in EPR across the organisation	<ul style="list-style-type: none"> <li>• Compliance with approved ReSPECT Policy</li> <li>• ReSPECT is used appropriately to document patients' wishes in the event of an emergency</li> <li>• Information from ReSPECT document is communicated via planned workflow to GPs and to South Central Ambulance Service (SCAS)</li> <li>• Review of documentation in line with patient admissions to the Trust and baseline data (numbers compared with current Resuscitation Status decisions)</li> <li>• ReSPECT plans increase and Do not Attempt CPR (DNACPR) forms go down (this can be seen as a summary on whiteboard)</li> </ul>	<p>within the audit plan currently being developed in Ulysess Assurance Hub.</p> <p><b>Complete</b></p> <p><b>Complete</b>- A safety message was also sent out.</p> <p><b>Complete</b>- Discern report created in EPR</p> <p><b>Complete</b></p> <ul style="list-style-type: none"> <li>• Turned off receiving all ReSPECT plans to resus message centre.</li> </ul> <p><b>Complete</b></p> <ul style="list-style-type: none"> <li>• No increase in ReSPECT complaints compared with DNACPR complaints since launch. Work with discharge lounge and discharge team ongoing.</li> </ul> <p><b>Complete</b></p>

What we will do	How will you know the objective is completed and that it is working?	Status to end Q4
	<ul style="list-style-type: none"> <li>• Monitor discharge information flow and review any issues highlighted by external partners</li> <li>• Audit of ReSPECT document completion – 90% of completed forms provide evidence of discussion with patients or those closest to them</li> <li>• The ReSPECT process is completed for 90% of patients with a pre-existing DNACPR as evident on EPR</li> </ul>	<ul style="list-style-type: none"> <li>• Monitoring practice through incident forms and PALS reports.</li> </ul> <p><b>In progress</b></p> <ul style="list-style-type: none"> <li>• 90% of new admissions have ReSPECT plans.</li> <li>• A way in which figures can be obtained from EPR is being reviewed</li> <li>• No increase in ReSPECT incidents as opposed to DNACPR incidents since launch.</li> </ul>
<p><b>Objective 3</b> <b>(Q1-4)</b></p> <p><b>Education and training</b></p> <ul style="list-style-type: none"> <li>• Provide education to clinical staff in the ReSPECT process, ensuring the process is used to enhance patient experience of</li> </ul>	<ul style="list-style-type: none"> <li>• By Q4 compliance with training appropriate to role is &gt;80%</li> </ul>	<p><b>Complete</b></p> <ul style="list-style-type: none"> <li>• ReSPECT is contained in all clinical mandatory resuscitation courses. Compliance is <b>84.3%</b></li> </ul> <p><b>Complete</b></p> <ul style="list-style-type: none"> <li>• There are two advanced RePSECT courses in MyLearning Hub (MLH), one for medical staff and one for senior health care professionals with job roles that require advance care planning with their patients.</li> </ul>

What we will do	How will you know the objective is completed and that it is working?	Status to end Q4
<p>emergency care planning</p> <ul style="list-style-type: none"> <li>• This will be achieved through the provision of education via various formats to various staff groups</li> <li>• Education content will be completed and launched on My Learning Hub (MLH) in Q1</li> <li>• We will monitor and report compliance on training in Q2 and provide an action plan to improve compliance if needed during Q3-4</li> <li>• We will run face to face training for staff undertaking the ReSPECT conversation piloting the first course</li> </ul>	<ul style="list-style-type: none"> <li>• ReSPECT education content available in My Learning Hub (MLH) to provide robust reporting and compliance structure</li> <li>• Positive staff feedback on experience of and confidence in the ReSPECT process</li> <li>• Positive patient feedback of their experience of the ReSPECT process</li> <li>• Positive patient feedback can be achieved through Friends and Family Test, via questionnaires or captured within the auditing of the ReSPECT process (this is not exhaustive)</li> </ul>	<p><b>Complete</b></p> <ul style="list-style-type: none"> <li>• The Resuscitation Council UK have released their new national e-Learning course hosted on e-LFH and we have now linked our Trust ReSPECT course to this updated national resource.</li> </ul> <p><b>Complete</b></p> <ul style="list-style-type: none"> <li>• ReSPECT courses have been well attended and will continue. There has been positive staff feedback.</li> </ul> <p><b>Complete</b></p> <ul style="list-style-type: none"> <li>• There has been a reduction in complaints and incidents and the Trust audit includes a patient evaluation.</li> </ul>

What we will do	How will you know the objective is completed and that it is working?	Status to end Q4
<p>in Q2, refining and evaluating this course in Q3-4</p> <ul style="list-style-type: none"> <li>• Design feedback form for face-to-face ReSPECT courses</li> <li>• Liaise with the Patient Advice and Liaison Service (PALS) to act on any feedback/complaints received in the organisation</li> </ul>	<ul style="list-style-type: none"> <li>• There will be a reduction in complaints and incidents regarding resuscitation and treatment decisions</li> </ul>	
<p><b>Objective 4 (Q1-4)</b></p> <p><b>Patient Information about ReSPECT</b></p> <ul style="list-style-type: none"> <li>• Make patient information available in a variety of formats-</li> </ul>	<p>Patients can access ReSPECT information with clinical staff also being able to demonstrate</p> <ul style="list-style-type: none"> <li>• Evidence of access to intranet site and use of ReSPECT patient information leaflets</li> <li>• Patients and those closest to them are aware of the ReSPECT process and how it is used within OUH</li> </ul>	<p><b>Complete</b></p> <ul style="list-style-type: none"> <li>• The Patient Safety Partner involved in audit and patient information leaflets has helped with this objective.</li> <li>• The information leaflets are on the Trusts internet</li> </ul>

What we will do	How will you know the objective is completed and that it is working?	Status to end Q4
<p>electronic/paper information leaflets</p> <ul style="list-style-type: none"> <li>• Liaise with Patient Safety Partners to review and refine messaging for patients</li> <li>• Review and action any complaints/feedback received associated with the ReSPECT process</li> <li>• Liaise with Patient Safety Partners for feedback</li> </ul>	<ul style="list-style-type: none"> <li>• Q4 audit within Discharge Lounge to establish that where a ReSPECT form exists patients and those closest to them are aware of the contents of the document and its purpose</li> <li>• A reduction in complaints received regarding resuscitation and treatment decisions when compared with previous years</li> <li>• Reduction in patient complaints associated with resuscitation decisions</li> <li>• Positive patient experiences with the ReSPECT process</li> </ul>	<p><b>In progress</b></p> <ul style="list-style-type: none"> <li>• The discharge lounge will be added to the ReSPECT audit.</li> </ul> <p><b>Complete</b> (see above)</p> <p><b>Complete</b></p> <ul style="list-style-type: none"> <li>• Liaised with PALS manager and we have set up a quarterly auto report on DNACPR and ReSPECT complaints which will be sent to the ReSPECT lead to inform annual reporting to CIC.</li> </ul>
<p><b>Objective 4</b> <b>(Q2-4)</b></p>		<p><b>Complete</b></p> <ul style="list-style-type: none"> <li>• A Specialist registrar from palliative medicine joined the ReSPECT lead in July 2025.</li> </ul>

What we will do	How will you know the objective is completed and that it is working?	Status to end Q4
<p><b>Audit</b></p> <ul style="list-style-type: none"> <li>• Build an audit tool to audit the ReSPECT documentation</li> <li>• Use the audit tool to audit completion/quality of the ReSPECT documentation</li> </ul>	<ul style="list-style-type: none"> <li>• Evidence of completion of the ReSPECT document in line with the Policy and ethos of ReSPECT</li> <li>• Evidence of quality conversations with the patient</li> </ul>	<ul style="list-style-type: none"> <li>• ReSPECT audit design and questions developed in Sept/Nov 2025.</li> <li>• Piloted questions Nov/Dec 2025</li> <li>• Linked with Assurance Hub team to develop audit design. Further pilot of questions. Linked with OxSCA team for advice formulating questions to be used for patients and staff.</li> <li>• Developed educational video to provide ward managers with ‘how to guide’ to completing the audit.</li> </ul> <p><b>Complete</b></p> <ul style="list-style-type: none"> <li>• Trust communications introducing new audit, including educational video, to the organisation and key stakeholders, who are the adult inpatient ward managers, was completed in February 2026</li> <li>• Liaised with Clinical Improvement Committee to ask for Divisional support to implement the new audit process which was agreed.</li> </ul>

<b>What we will do</b>	<b>How will you know the objective is completed and that it is working?</b>	<b>Status to end Q4</b>
		<ul style="list-style-type: none"><li>• The audit aims to interview patients and staff and examines the document to seek assurance against the ReSPECT policy.</li></ul>

## Quality Priority 9: Supporting vulnerable patients including those with learning disability

### Why is it a Priority?

Vulnerable patients including those with learning disabilities are at risk of poorer health outcomes and may require additional support through their healthcare journey. It is essential for staff to identify these patients and understand their needs.

This priority, supported by the Trust Learning Disability Liaison team, aims to improve staff confidence, enhance discharge processes, establish dedicated pathways, and implement the Reasonable Adjustment Flag (RADF) in the electronic patient record (EPR).

Table 9 Supporting vulnerable patients including those with learning disability QP 2025/26

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
<p><b>Objective 1:</b></p> <p><b>Deliver Oliver McGowan Training Trustwide</b></p>	<ul style="list-style-type: none"> <li>By the end of Q4 2025/26, achieve at least 85% compliance with mandatory Oliver McGowan training (Part 1) for all staff, with quarterly increases of at least 2.5%.</li> <li>Following delivery of Oliver McGowan training Part 2 use NHS Benchmarks staff questionnaire at the end of Q2 and Q4 to measure increased staff confidence in supporting people with learning disabilities.</li> </ul>	<p><b>Complete</b></p> <p>To end of March 2026:</p> <ul style="list-style-type: none"> <li>Part 1 (e-Learning) for tier 1 and 2 compliance at 85.6%</li> <li>(Part 2 delivery commenced 28/10/2025)</li> <li>Part 2 Tier 1&amp;2 Currently on track to achieve target of 30% of the work force trained by September 2027.</li> <li>Questionnaire developed and shared .</li> </ul>

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
<p><b>Objective 2:</b></p> <p><b>Improve Discharge Processes for Patients with Learning Disabilities (Integrate into the Discharge Assurance Group workstream Jan 2026)</b></p>	<ul style="list-style-type: none"> <li>• Benchmarking exercise (BOB)</li> <li>• Audit tool and completed audit</li>   <li>• Comparative data on discharge delays (Integrate into the Discharge Assurance Group workstream Jan 2026)</li>   <li>• Feedback reports from staff, patients, carers, and social care</li>   <li>• Discharge process documentation and pathway (Integrate into the Discharge Assurance Group workstream Jan 2026)</li>   <li>• Inclusion of discharge questions in Trust feedback process (Integrate into the Discharge Assurance Group workstream <b>Jan 2026</b>)</li> </ul>	<p><b>In Progress</b></p> <p>Audit tool developed and audit completed</p> <ul style="list-style-type: none"> <li>• Participation at the Trust QP Discharge working group.</li> <li>• Benchmarking within BOB ICB completed.</li>   <li>• Positive feedback: 88% carers and 89% patients satisfied with discharge discussions</li> </ul>

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
<p><b>Objective 3:</b></p> <p><b>Develop Pathway for Diagnostic Procedures under General Anaesthetic</b></p>	<ul style="list-style-type: none"> <li>• By Q1 2025/26, benchmark best practice for diagnostic procedures under general anaesthetic.</li> <li>• By Q4 2026, establish a Trust wide pathway and review its impact.</li> </ul>	<p><b>In Progress</b></p> <ul style="list-style-type: none"> <li>• Thematic review of cases with unmet needs for sedation completed</li> <li>• Pathway in development (SBAR); discussed with clinicians and LD steering group.</li> </ul>
<p><b>Objective 4:</b></p> <p><b>Enhance Coordination Across Specialties</b></p> <p><b>Revised timeline:</b> By the end of Q4 2027, review and update the Learning Disability policy to ensure effective care coordination for patients supported by multiple clinical</p>	<ul style="list-style-type: none"> <li>• Updated Learning Disability policy</li> <li>• Communication plan for policy changes</li> <li>• Benchmarking report on care coordination</li> <li>• Gap analysis report</li> <li>• Escalation plan for service/resource needs</li> <li>• Learning Disability Steering Group updates</li> </ul>	<p><b>Partially Complete</b></p> <p>Policy reviewed and updated.</p> <ul style="list-style-type: none"> <li>• This objective requires a detailed scoping project to confirm the range of needs for people with a LD. .</li> <li>• Monthly Learning Disability Steering Group monitoring coordination challenges / issues.</li> </ul>

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
<p>teams, benchmark against best practice, and identify gaps.</p>		
<p><b>Objective 5:</b></p> <p><b>Implement Reasonable Adjustment Flag (RADF) in EPR</b></p> <p>Complete EPR functionality for RADF, define and test the pathway in six areas, and scale up Trustwide with training and reporting mechanisms.</p> <p>By December 2025, establish an operational group in the Outpatient Delivery Group to</p>	<ul style="list-style-type: none"> <li>• EPR RADF functionality (ready for national deadline)</li> <li>• Defined pathway for requesting reasonable adjustments</li> <li>• Pilot test results from six areas</li> <li>• Training materials and completion records</li> <li>• Dashboard/reporting mechanism for RADF usage</li> <li>• Rollout plan for Trustwide implementation</li> <li>• Operational group terms of reference and meeting notes</li> </ul>	<p><b>Partially Complete</b></p> <ul style="list-style-type: none"> <li>• EPR project for RADF in place; rollout delayed pending Oracle Health system completion.</li> </ul> <p>Waiting for IT to build the defined pathway into EPR. There is currently a flagging process to indicate a healthcare passport is in place.</p>

What we will do	How will you know the objective is completed and that it is working?	Status to end of Q4
support the role out of the RADF.		
<p><b>Objective 6:</b></p> <p><b>Launch External Media Campaign on Reasonable Adjustments</b></p> <p>By Q2 2025/26, develop an easy-read leaflet on reasonable adjustments, and reasonable adjustment flag.</p> <p>By Q3/Q4, publish and distribute the leaflet and update the Trust website, once the process for requesting adjustments is finalised.</p>	<ul style="list-style-type: none"> <li>• Draft and final easy-read leaflet on reasonable adjustments and how to obtain information in a flag</li> <li>• Social media content plan and posts</li> <li>• Website updates for patients and families</li> <li>• Distribution plan for leaflets</li> </ul>	<p><b>Not complete</b></p> <ul style="list-style-type: none"> <li>• Campaign on hold until the process for requesting/providing reasonable adjustments is in place.</li> <li>• Objective 5 is required to be completed before Objective 6 commences.</li> </ul>

## Choosing Quality Priorities

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

### How we chose our Quality Priorities

We involve our patients, public, stakeholders and our staff in choosing our Quality Priorities through our annual public Quality Conversation event which was held in December 2025.

The Quality Conversation event provided an update on progress against the Quality Priorities for 2025/26 and focused on Quality Priorities for 2026/27 as part of the annual planning cycle and the Quality Account. Attendees discussed the proposed Quality Priorities for 2026/27 and made suggestions about how they could be shaped and what they should focus on.

### Our Quality Priorities for 2026/27

Table 10 below gives a brief description of our Quality Priorities for 2026/27. The full detail for each Quality Priority, why we chose them, and a description of how success will be evaluated over the course of the year can be found in Annexe 1.

*Table 10 Summary of Quality Priorities 2026/27*

Quality Priority 2026/27	Summary
<b>Patient Safety</b>	
<b>1. Improving escalation of the deteriorating patient</b>	The prompt response to patient deterioration through escalation to an appropriate clinician is essential to patient safety. It is important in preventing cardiopulmonary arrest or the need for transfer to an intensive care unit, both of which impact on a patient's length of stay in hospital but most importantly may influence the outcome for that patient and those closest to them. This Quality Priority will focus on adult in-patient areas, where patient deterioration may occur requiring a senior clinical response
<b>2. Venous Thrombo-embolism (VTE)</b>	Venous thromboembolism (VTE) is the leading cause of preventable hospital deaths. The early identification of patients at risk of VTE and prescription of

Quality Priority 2026/27	Summary
	<p>thromboprophylaxis are important measures in preventing the morbidity and mortality associated with hospital-associated thrombosis.</p> <p>In January 2025 NHS England stipulated that the VTE risk assessment must be completed on all patients age 16 and above within 14 hours of admission instead of 24 hours.</p> <p>The focus of this quality target will be to drive greater excellence in VTE prevention and to comply with, and exceed, the new NHS England target of 14 hours.</p>
<p><b>3. Martha’s Rule</b></p>	<p>Martha’s Rule is a patient safety initiative to support the early detection of deterioration by ensuring the concerns of patients, families, carers and staff are listened to and acted upon.</p> <p>It has been developed in response to the death of Martha Mills and other cases related to the management of deterioration. Central to Martha’s Rule is the right for patients, families and carers to request a rapid review if they are worried that a patient’s condition is getting worse and their concerns are not being responded to.</p> <p>Following a successful pilot in 2025, a full rollout of Martha’s Rule in adult and paediatric wards is planned in 2026</p>
<b>Clinical Effectiveness</b>	
<p><b>4. Excellence also in the basics: reducing variation, improving care through Standard Work</b></p> <p>(Rolled over from 2025/26)</p>	<p>We will build on the progress of our first year of Standard Work implementation as a successful vehicle for delivering high-quality care. Learning from year one has demonstrated measurable improvements in patient and staff safety, quality, and efficiency through the use of clear, evidence-based, step-by-step processes that create reliable and consistent care.</p> <p>The first year focused on key inpatient clinical teams, aligning Standard Work with existing structures to reduce duplication and improve areas such as equipment checks, board rounds, safe and secure storage of medicines, and safety huddles. In year two, the programme will shift towards wider organisational adoption as part of a longer-</p>

Quality Priority 2026/27	Summary
	<p>term strategy, supported by a clear, co-designed approach in partnership with key stakeholders, embedding Standard Work as a core element of our quality and operational management system</p>
<p><b>5. Strengthening Discharges</b></p> <p>(Rolled over from 2025/26)</p>	<p>We remain dedicated to progressing this Quality Priority into its second year and building on the objectives we have achieved so far. There is an increasing demand for our emergency and planned care services because of a growing and ageing population in Oxfordshire. Patients attending our hospitals are more complex, both medically and socially. Following a ‘Home first’ approach, we are striving to discharge as many patients as possible to their homes, where we know people recover and rehabilitate quicker than in a hospital. Discharges to care homes or to community hospitals should be limited to where it is not possible to deliver the level of care required in a person’s home. Consequently, the volume and complexity of discharge planning has increased.</p> <p>This Quality Priority will review discharge processes for all patients and seek to improve the quality and safety of discharge. This includes reducing delays and length of stay, as well as learning from incidents and feedback. There will also be an opportunity to explore the empowerment of nurses and other Allied Health Care Professionals to lead discharge-based decisions to improve quality and reduce length of stay.</p>
<p><b>6. Ambient Voice Technology (AVT)</b></p>	<p>AVT is a smart system that listens to the conversation between a patient and their clinician and turns it into accurate notes and letters automatically. Instead of writing everything down by hand, the technology does the hard work in the background, so the healthcare professional can give patients their full attention. This technology relies on Artificial Intelligence (AI) to capture consultation notes and turn them into letters, referrals and other documents for the clinician to check.</p> <p>To evaluate its impact on workflow efficiency and patient experience, we launched an AVT pilot in July 2025 across multiple departments. Clinicians reported saving time on</p>

Quality Priority 2026/27	Summary
	<p>writing notes and some additional benefits such as a faster turnaround of clinic letters, and patients reported a positive experience during the consultations. These positive results have led to a decision to purchase the technology.</p> <p>Local pilots have shown a positive impact on staff, including</p> <ul style="list-style-type: none"> <li>• Reduced burnout and improved work-life balance.</li> <li>• Patients report getting more eye contact and attention from their clinicians.</li> <li>• Better quality documentation,</li> <li>• Less out-of-hours working for staff,</li> <li>• Reduced admin burden</li> </ul>
<b>Patient Experience</b>	
<p><b>7. Advance Care Planning (ACP) and End of Life Care (EoLC)</b></p>	<p>End of Life care (EOLC) focuses on recognising when a patient is approaching the last year, months, or days of life and ensuring care aligns with their goals, values and best interests. The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) is a structured process and document that records personalised clinical recommendations. It summarises key information about a person’s health and uses this to guide decisions about treatment escalation, resuscitation and priorities for comfort or intervention</p> <p>This Quality Priority will focus on education for staff to better recognise patients who are at risk of dying, and to support them with high quality advance care plans using ReSPECT. Education strategies will support better End of Life care and communication.</p>
<p><b>8. Public and Patient Participation Framework</b></p>	<p>A robust Patient and Public Participation Framework is essential to ensure that OUH consistently listens to, involves and works in partnership with the people it serves. It will provide a clear Trustwide approach for embedding lived experience into decision-making, improving the quality, safety and responsiveness of care.</p>

Quality Priority 2026/27	Summary
	<p>By setting out agreed principles, expectations and practical tools, the Framework will help OUH meet national requirements for working with people and communities and support efforts to reduce health inequalities. It will help to ensure that all voices are heard, engagement is meaningful rather than tokenistic, and services are shaped in ways that reflect the diverse needs of patients, families, carers and communities.</p>
<p><b>9. Maternity Patient Experience</b></p> <p>(Rolled over from 2025/26)</p>	<p>Recent national interest and scrutiny has rightly put an even greater emphasis on the importance of improving maternity service user experience, underscoring the need for transparent, responsive and inclusive approaches that truly reflect the voices of those users by actively engaging with feedback and learning from both local and national findings.</p> <p>This Quality Priority highlights the value of a service user centred approach with healthcare professionals dedicating time to listen to and understand the perspectives of mothers and families. By actively incorporating feedback and respecting personal choices, we aim to support staff consistently to deliver care that is both respectful and empowering. The initiative encourages ongoing dialogue, shared decision making and partnership, fostering trust and confidence throughout the maternity journey. In turn, this ensures that care remains safe, compassionate and tailored to individual needs while helping staff feel valued and empowered to deliver the highest standards.</p>

### Monitoring and reporting

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

## Statements of Assurance from the Board

During 2026/27 OUH provided and sub-contracted 196 relevant health services. OUH has reviewed all the data available to it on the quality of care of these relevant health services. The income generated by the relevant health services reviewed in 2026/27 represents 100% of the total income generated from the provision of relevant health services by OUH for 2026/27.



## Clinical Audits and National Confidential Enquiries

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

During 2025/26, 76 national mandatory clinical audits and 4 national confidential enquiries covered relevant health services provided by OUH.

During that period OUH participated in 96% (73/76) of all the eligible national clinical audits and 100% (4) of national confidential enquiries in which we were eligible to participate.

The national clinical audits and confidential enquiries that OUH participated in, and for which data collection was completed during 2025/26, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

## Participation in National Clinical Audit

Data are still being collected for the national clinical audits so some are listed as 'in progress' as they have not yet published participation figures.

Explanation of ascertainment below 100% is after Table 11

Table 11 National audits and whether the Trust participated in 2025/26

National Programme Name	Trust Participation 2025/26	Cases Submitted to National Programme/Governing Body (%)
British Association of Urological Surgeons (BAUS) British audit Of the referral of women with rEcurrent uRinary tract infection using recent Guidance (BOOMERANG)	Yes	100
BAUS Evaluating Management Pathway for Suspected Testicular Cancer Referrals (EMPAST)	Yes	100
Breast and Cosmetic Implant Registry (BCIR)	Yes	In progress
British Spine Registry	No <sup>1</sup>	N/A
Case Mix Programme (CMP) Intensive Care National Audit and Research Centre (ICNARC)	Yes	100
Cleft Registry and Audit Network (CRANE)	Yes	100
Emergency Medicine Quality Improvement Projects (QIPs): Adolescent Mental Health	Yes	17 <sup>2</sup>
Emergency Medicine QIP: Care of Older People	Yes	80 <sup>3</sup>
Emergency Medicine QIP: Time Critical Medications	Yes	100
Emergency Medicine QIP: Mental Health Self Harm	Yes	0 <sup>4</sup>

National Programme Name	Trust Participation 2025/26	Cases Submitted to National Programme/Governing Body (%)
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Yes	100
Falls and Fragility Fracture Audit Programme (FFFAP): National Audit of Inpatient Falls (NAIF)	Yes	100
FFFAP: National Hip Fracture Database (NHFD)	Yes	100
FFFAP: Fracture Liaison Service Database (FLS-DB)	Yes	Non-spine 80 <sup>5</sup> Spine - 100
Learning from lives and deaths of people with a learning disability and autistic people (LeDeR) - Learning Disabilities Mortality Review	Yes	100
Maternal, Newborn and Infant Clinical Outcome Review Programme (perinatal mortality surveillance)	Yes	100
National Adult Diabetes Audit (NDA): National Diabetes Foot Care Audit (NDFA)	Yes	100
NDA: National Diabetes Inpatient Safety Audit (NDISA)	Yes	100
NDA: National Pregnancy in Diabetes Audit (NPID)	Yes	100
NDA: National Core Diabetes Audit	Yes	100
NDA Transition (Adolescents and Young Adults) and Young Type 2 Audit	Yes	100
National Audit of Cardiac Rehabilitation (NACR)	Yes	100
National Audit of Care at the End-of-Life (NACEL)	Yes	100
National Audit of Dementia (NAD)	No <sup>6</sup>	N/A

National Programme Name	Trust Participation 2025/26	Cases Submitted to National Programme/Governing Body (%)
National Cancer Audit Collaborating Centre (NATCAN): National Audit of Metastatic Breast Cancer (NaoMe)	Yes	100
NATCAN: National Audit of Primary Breast Cancer (NAoPri)	Yes	100
NATCAN: National Bowel Cancer Audit (NBOCA)	Yes	100
NATCAN: National Kidney Cancer Audit (NKCA)	Yes	100
NATCAN: National Lung Cancer Audit (NLCA)	Yes	100
NATCAN: National Non-Hodgkin Lymphoma Audit (NNHLA)	Yes	100
NATCAN: National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	100
NATCAN: National Ovarian Cancer Audit (NOCA)	Yes	100
NATCAN: National Pancreatic Cancer Audit (NPaCA)	Yes	100
NATCAN: National Prostate Cancer Audit (NPCA)	Yes	100
National Cardiac Arrest Audit (NCAA)	Yes	100
National Cardiac Audit Programme (NCAP): National Audit of Percutaneous Coronary Interventions (NAPCI) (Coronary Angioplasty)	Yes	100
NCAP: National Adult Cardiac Surgery Audit (NACSA)	Yes	100
NCAP: Myocardial Ischaemia National Audit Project (MINAP)	Yes	100

National Programme Name	Trust Participation 2025/26	Cases Submitted to National Programme/Governing Body (%)
NCAP: National Audit of Cardiac Rhythm Management Devices and Ablation (CRM)	Yes	100
NCAP: National Congenital Heart Disease Audit (NCHDA)	Yes	100
NCAP: National Heart Failure Audit (NHFA)	Yes	95% <sup>7</sup>
NCAP: UK Transcatheter Aortic Valve Implantation (TAVI) Registry	Yes	100
NCAP: Left Atrial Appendage Occlusion (LAAO) Registry	Yes	100
NCAP: Patent Foramen Ovale Closure (PFOC) Registry	Yes	100
NCAP: Transcatheter Mitral and Tricuspid Valve (TMTV) Registry	Yes	100
National Child Mortality Database (NCMD)	Yes	100
National Comparative Audit of Blood Transfusion: National Comparative Audit of NICE Quality Standard QS138	Yes	100
National Comparative Audit of Blood Transfusion: 2025 Major Haemorrhage Audit	Yes	100
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	100
National Emergency Laparotomy Audit (NELA)	Yes	83% <sup>8</sup>
National Emergency Laparotomy Audit: No Laparotomy	No <sup>9</sup>	N/A
National Joint Registry (NJR)	Yes	Horton – 45.1 <sup>10</sup> JR – 30.4 <sup>10</sup> NOC – 99.7 <sup>10</sup>

National Programme Name	Trust Participation 2025/26	Cases Submitted to National Programme/Governing Body (%)
National Major Trauma Registry (NMTR)	Yes	100
National Maternity and Perinatal Audit (NMPA)	Yes	100
National Neonatal Audit Programme (NNAP)	Yes	100
National Obesity Audit: NHSE <sup>1</sup> (NOA)	Yes	100
National Ophthalmology Database (NOD): Age-related Macular Degeneration Audit (AMD)	Yes	100
NOD: Cataract Surgery	Yes	100
National Paediatric Diabetes Audit (NPDA)	Yes	100
National Perinatal Mortality Review Tool (PMRT)	Yes	100
National Respiratory Audit Programme (NRAP): COPD Secondary Care	Yes	JR - 14.1 <sup>11</sup> HGH - 20 <sup>11</sup>
NRAP: Adult Asthma Secondary Care	Yes	29.3 <sup>12</sup>
NRAP: Children and Young People's Asthma Secondary Care	Yes	100
National Vascular Registry: Royal College of Surgeons of England (breakdown as follows)	Yes	
<ul style="list-style-type: none"> <li>Abdominal Aortic Aneurysm (AAA)</li> </ul>		54 <sup>13</sup>

<sup>1</sup> NHS England

National Programme Name	Trust Participation 2025/26	Cases Submitted to National Programme/Governing Body (%)
• Carotid Endarterectomy		88 <sup>13</sup>
• Amputation		43 <sup>13</sup>
• Infra-inguinal Bypasses		44 <sup>13</sup>
• Lower Limb Angioplasty/Stent		21 <sup>13</sup>
Paediatric Intensive Care Audit Network (PICANet)	Yes	100
Perioperative Quality Improvement Programme (PQIP)	Yes	14.3 <sup>14</sup>
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Yes	100
UK Cystic Fibrosis Registry: Adults	Yes	87 <sup>15</sup>
UK Cystic Fibrosis Registry: Children	Yes	97 <sup>15</sup>
UK Interstitial Lung Disease	Yes	100
UK Parkinsons Audit	Yes	100
UK Renal Registry Chronic Kidney Disease Audit	Yes	100
UK Renal Registry National Acute Kidney Injury Audit (AKI)	Yes	100

## **Explanation of National Audit where case ascertainment is below 100%**

### **<sup>1</sup> British Spine Registry:**

This was a new addition to the 2025/26 national audit list and the service did not have sufficient infrastructure to participate.

### **<sup>2,3,4</sup> Emergency Medicine Quality Improvement Projects (QIPs): Adolescent Mental Health/Care of Older People/Mental Health Self Harm:**

A change in audit lead occurred this financial year which led to an interruption in participation, however this is resolved for forthcoming years. This is with the exception of Mental Health Self Harm audit which ceased running in December 2025.

### **<sup>5</sup> Falls and Fragility Fracture Audit Programme: Fracture Liaison Service Database (FLS-DB):**

Participation has increased from 61% (non-spine) / 76% (spine) in 2024/25 as the service has embedded new staff into established roles.

### **<sup>6</sup> National Audit of Dementia:**

The Trust was not required to participate as the audit was in developmental stage following a tender to a new provider.

### **<sup>7</sup> NCAP: National Heart Failure Audit (NHFA):**

The team achieved a 95% submission rate against a background of staffing and capacity challenges; scoping has identified the potential for more audit work to be transferred to suitably trained non-clinical staff.

### **<sup>8</sup> National Emergency Laparotomy Audit (NELA):**

Overall case ascertainment rates were brought down by non-participation of the Churchill Hospital due to relatively few NELA-eligible cases being undertaken there, meaning identification processes were not as embedded compared to the John Radcliffe Hospital. Since September 2025, a new consultant has been appointed with dedicated time specifically allocated to NELA data collection and submission for the Churchill site. As a result, the team have successfully established an up-to-date dataset for Year 12. Retrospective updates to Year 11 are not possible, as the dataset is now locked.

### **<sup>9</sup> National Emergency Laparotomy Audit: No Laparotomy:**

The service does not contribute to NoLap NELA at present. They are in discussions with the national team regarding the clinical rationale for the audit, recognising the significant amount of clinical time it would take to identify patients and participate in the audit.

### **<sup>10</sup> National Joint Registry:**

NOC procedures are conducted for elective patients, allowing for a straightforward consent process. In contrast, HGH and JR focus primarily on emergency surgical cases, where obtaining consent to participate in the NJR may be more challenging due to patient pain or impaired cognitive function. As a result, the submission figures in these units tend to be lower.

#### **<sup>11</sup> National Respiratory Audit Programme (NRAP): COPD Secondary Care:**

Data collection is performed by the Oxford Health Foundation Trust respiratory nursing team and data is collected separately for the John Radcliffe and Horton General Hospital sites. Not all patients are captured as the nursing service operates only in office hours on weekdays.

During this period, some factors contributed to the lower submission.

- Nursing staff levels were 50% of expected. This has since improved.
- Communication between OUH teams and the respiratory nursing team required improvement
- Elective admissions were included in HES and not NRAP

#### **<sup>12</sup> National Respiratory Audit Programme: Adult Asthma Secondary Care:**

A staffing shortage of administration and specialist asthma nurses has been identified and is currently on the Divisional risk register. Clinical work has been prioritised, reducing the ability to participate in the audit process.

#### **<sup>13</sup> National Vascular Registry:**

In the previous year, case ascertainment varied from 2-81% of eligible cases, depending upon the intervention; current data show this has risen to 21-88% with work ongoing to improve this further. There is Divisional oversight of an action plan to support and to drive improvement.

#### **<sup>14</sup> Perioperative Quality Improvement Programme (PQIP):**

Participation in PQIP continues; however, the most recently reported case ascertainment was 14.3% (30 of 210 eligible cases). This reflects limitations in recruitment capacity and specialty coverage within a multi-site organisation and restricts the level of assurance that can be drawn from PQIP outcome data. The national PQIP Co-ordinator has liaised with OUH Audit lead and advised that the number of required cases can be reduced to 20 per year. (The study is close to achieving its overall project recruit number)

#### **<sup>15</sup> UK Cystic Fibrosis Registry Adult: UK Cystic Fibrosis Registry Children:**

Although the UK Cystic Fibrosis Registry demonstrates high population coverage, it does not routinely achieve 100% inclusion. This reflects the consent-based nature of the Registry and reliance on annual review data submission. A small proportion of patients under OUH care may not be captured in a specific reporting year due to patient choice, recent transfer into

or out of the service, death, or delayed annual review completion. This is recognised nationally and is not considered to undermine the overall robustness or representativeness of the data.

## Participation in National Confidential Enquiries into Patient Outcome and Death (NCEPOD) 2025/26

Table 12 shows the list of OUH eligible NCEPOD studies in 2025/26, in which hospital sites participated, and the percentage of clinical questionnaires, case notes and organisational questionnaires returned.

Table 12 NCEPOD studies 2025/26

NCEPOD Studies 2025/26	Participating Sites	Clinical Questionnaire Returned	Case Notes Returned	Organisational Questionnaire Returned
Stabilisation of the critically ill child: Receiving unit critical care questionnaire	John Radcliffe	2/11 Submission still open	Not required for this element of the study	Not required for this element of the study
Stabilisation of the critically ill child: Stabilisation questionnaire	John Radcliffe Horton	1/8 Submission still open	8/8	JR - submitted HG - submitted
Pleural Procedures	John Radcliffe Horton Churchill	8/15 Submission still open	15/15	Not yet due
Rib Fracture	John Radcliffe Horton	2/11 Submission still open	0/11	Not yet due
Managing acute illness in people with learning disability	John Radcliffe	1/4	4/4	Submitted

## Actions taken and improvements made from National audits

The reports of 49 national clinical audits were reviewed in 2025/26. Agreed actions and progress to improve the quality of healthcare provided are summarised in Table 13 below.

The majority of audits presented in 2025/26 are audits from prior years, e.g. 2023/24 etc; this is due to the timing of the publications from the governing bodies.

*Table 13 National audits with summary of actions and benefits for patient care following review (\*\*Fully achieved; \*Partially achieved)*

Audit	Summary of Agreed Actions
Adult Asthma Secondary Care Audit	<ul style="list-style-type: none"> <li>• Create and submit a business case for service comparison*</li> <li>• Audit of ambulatory management*</li> <li>• Statement of need for funding urgent nursing need*</li> <li>• Review of how this audit can run with no administrative support*</li> </ul>
Age-related Macular Degeneration (AMD) Audit	<ul style="list-style-type: none"> <li>• Develop a business plan for an off-site AMD north of the county hub and injection suite*</li> <li>• Recruit additional AMD co-ordinator**</li> <li>• Recruit a dedicated Specialty Doctor to the medical retina service*</li> <li>• Review and appraise administration team to support the service*</li> </ul>
BAUS Nephrostomy Audit for infected Obstructed Kidneys	<ul style="list-style-type: none"> <li>• To maintain the consultant led ward rounds to enable swift decision making**</li> </ul>
BAUS Transurethral REsection and Single instillation intra-vesical chemotherapy Evaluation in bladder Cancer Treatment (RESECT)	<ul style="list-style-type: none"> <li>• Standard proforma for all transurethral resection of bladder tumour surgery to go live on EPR once finalised*</li> </ul>
Chronic Obstructive Pulmonary Disease (COPD) Secondary Care Audit	<ul style="list-style-type: none"> <li>• Request to audit software platform to create a referral pool for patients in Ambulatory Assessment Unit (AAU), and EAU*</li> <li>• Work with coding to understand COPD coding and remove elective COPD admissions from the hospital episode statistics (HES) submission*</li> <li>• Review of current Oxford Health Respiratory Nurses service-level agreement**</li> <li>• Improve timely access to Non-Invasive Ventilation (NIV) treatment by reviewing the NIV pathway in the Emergency Assessment Unit and Emergency Department*</li> <li>• Increase in respiratory bed numbers where NIV treatment can be delivered at JR and HGH sites*</li> </ul>
	<ul style="list-style-type: none"> <li>• Review of current Oxford Health Respiratory Nurses service-level agreement**</li> </ul>

Audit	Summary of Agreed Actions
Emergency Medicines Quality Improvement Programme (QIP): Care of Older People (Year 2)	<ul style="list-style-type: none"> <li>No actions were identified; performance was above the national benchmark</li> </ul>
Emergency Medicines QIP: Mental Health Self Harm (Year 1 & 2)	<ul style="list-style-type: none"> <li>No actions were identified; performance was above the national benchmark</li> </ul>
Epilepsy 12	<ul style="list-style-type: none"> <li>A standardised pathway of mental health support resources should be developed for all children and young people with epilepsy*</li> <li>The completed resources leaflet will be shared at Paediatric Medicine and Paediatric Neurology governance meetings to ensure awareness and accessibility among clinicians*</li> <li>Ongoing re-audit work will continue to monitor epilepsy nurse involvement and demonstrate improvement in nurse input*</li> <li>Criteria for tertiary review will be promoted and discussed at Paediatric governance meetings to increase clinician awareness*</li> </ul>
Fracture Liaison Service Database (FLS-DB)	<ul style="list-style-type: none"> <li>Completion of digital uploading of patient and GP demographics to updated FLS platform*</li> <li>Complete homecare contracting*</li> <li>Trust approval of funding of FLS business case*</li> <li>NOTSSCaN to approve metabolic bone consultant statement of need*</li> </ul>
Intensive Care National Audit and Research Centre (ICNARC)	<ul style="list-style-type: none"> <li>No actions were required: <ul style="list-style-type: none"> <li>There was considered, appropriate and safe discharge and stepdown to ward based care</li> <li>Following a review, each readmission was deemed unavoidable as the patients had been assessed as being suitable to be stepped down to the ward.</li> </ul> </li> <li>Reasons for readmission included: cardiac arrest; cardiac arrhythmia and high oxygen requirement; hospital acquired pneumonia; relook laparotomy after ischaemic complications from recent surgery</li> </ul>
Kidney Cancer	<ul style="list-style-type: none"> <li>To improve the recording of ethnicity by 5% over the next audit period*</li> <li>To improve the recording of tumour size by 10% over the next audit period**</li> </ul>
MBRRACE: State of the Nation 2023 National Maternity and Perinatal Audit (NMPA)	<ul style="list-style-type: none"> <li>No OUH Trust level actions were required as a result of this national audit as the recommendations were aimed at national bodies rather than at Trusts</li> </ul>

Audit	Summary of Agreed Actions
MBRRACE: Maternity care – confidential enquiries 2021-23	<ul style="list-style-type: none"> <li>• No OUH actions were required as a result of this national audit as the recommendations were aimed at national bodies rather than at Trusts</li> </ul>
MBRRACE: The care of recent migrant women with language barriers who have experienced a stillbirth or neonatal death	<ul style="list-style-type: none"> <li>• No OUH actions were required as a result of this national audit as the recommendations were aimed at national bodies rather than at Trusts</li> </ul>
Myocardial Ischemia National Audit Programme (MINAP)	<ul style="list-style-type: none"> <li>• Collaborate with the ambulance service to review call-to-balloon (CTB) delays and implement pre-alert protocols*</li> <li>• Increase cardiac ward admissions for patients with Non-ST-segment Elevation Myocardial Infarction (NSTEMI)*</li> <li>• Improve CTB &lt;120 mins performance*</li> <li>• Increase staffing of outreach team through a business case for 1.0 whole time equivalent*</li> <li>• Ensure all eligible patients are referred to Cardiac Rehabilitation*</li> <li>• Review catheter lab scheduling and prioritise NSTEMI slots to increase timeliness of angiograms*</li> </ul>
National Audit of Cardiac Rehabilitation	<ul style="list-style-type: none"> <li>• Increase number of clinic spaces for assessments*</li> <li>• Increase capacity of gym space*</li> <li>• Implement the use of Digital Cardiac Rehab App*</li> <li>• Run an audit to see why patients decline rehab*</li> <li>• Comprehensive review of heart failure service, and possible business case*</li> <li>• Improve data compliance by working with Cardiac Information team and the audit provider to check data entry and uploaded data**</li> </ul>
National Audit of Cardiac Rhythm Management (RCM)	<ul style="list-style-type: none"> <li>• Prepare for national requirement to collect and report follow-up outcome data*</li> </ul>
National Audit of Cardiac Surgery (NCAS)	<ul style="list-style-type: none"> <li>• Implement a bed ring-fencing plan for elective cardiac surgery by: <ul style="list-style-type: none"> <li>Agreeing and documenting a minimum ring-fenced bed baseline for Cardiothoracic (CT) Ward and CT Critical Care Unit (including escalation/de-escalation triggers)*</li> </ul> </li> <li>• Introducing a weekly elective capacity review (beds, staffing, theatre slots) with agreed actions logged*</li> <li>• Reporting monthly elective cancellations due to bed unavailability and implementing corrective actions when thresholds are breached*</li> </ul>

Audit	Summary of Agreed Actions
	<ul style="list-style-type: none"> <li>• Establish consistent capture of MDT discussion for all non-emergency cases by: Agreeing on a single MDT documentation standard (what constitutes ‘discussed’, minimum dataset, and where recorded)*</li> <li>• Update referral/booking workflow so every elective/urgent case has an MDT status recorded before listing (local MDT or referring MDT)*</li> <li>• Produce a monthly speciality dashboard*</li> <li>• Increase same-day admissions (SDA) for elective cardiac surgery to ≥50% and sustain this level for 3 consecutive months by March 2027, reducing avoidable pre-op bed days*</li> <li>• Agree and implement a named cardiac surgery data manager function (either recruitment or protected time) with clear responsibilities for data entry, validation, and submission*</li> <li>• Publish a data dictionary (mandatory vs non-mandatory fields, definitions, data sources) and provide brief training to all contributors*</li> <li>• Agree procedure-specific eligibility criteria and a prospective ‘minimal access’ case list reviewed weekly*</li> <li>• Confirm equipment requirements and procurement/maintenance plan (including instrument sets and imaging where needed)*</li> <li>• Allocate protected theatre capacity (e.g., minimum 1 list per month per relevant sub-specialty) and identify named operators for each list*</li> <li>• Establish a quarterly emergency aorta review (case volumes per surgeon, outcomes, learning points) via the regional MDT/governance meeting*</li> </ul>
National Audit of Inpatient Falls (NAIF)	<ul style="list-style-type: none"> <li>• Improve falls informatics to aid internal benchmarking for falls per 1000 occupied bed days (OBD) as a measure*</li> <li>• Creation of a monthly dashboard for OBD*</li> <li>• Improve lying and standing blood pressure compliance                             <ul style="list-style-type: none"> <li>• Track monthly and present at Harm Free Assurance Forum and Falls delivery group**</li> <li>• Target teaching through the ward-based fall prevention training*</li> </ul> </li> <li>• Develop ward compliance tracking with the digital team**</li> <li>• Educate and strengthen documentation for post-fall injury checks**</li> </ul>

Audit	Summary of Agreed Actions
	<ul style="list-style-type: none"> <li>• Create a hot debrief process**</li> <li>• Increase delirium screening for non-elective patients over the age of 65 years*</li> <li>• Create a cognition policy*</li> <li>• Develop the Power Bi dashboard to monitor delirium screening**</li> <li>• Reduce the length of time from injury to harm review meeting**</li> </ul>
National Audit of Metastatic Breast Cancer (NAOME)	<ul style="list-style-type: none"> <li>• A 2-year review (1 year retrospective and one year current) to be undertaken by the Breast MDT Chair into data collection*</li> </ul>
National Bowel Cancer Audit (NBOCA)	<ul style="list-style-type: none"> <li>• Improve recording of performance status from 2 week-wait referrals to Infoflex to allow capture in Rapid Cancer Dataset*</li> <li>• QI project to address timeliness of closure of ileostomy**</li> </ul>
National Comparative Audit of Blood Transfusion- Audit of NICE Quality Standard QS138	<ul style="list-style-type: none"> <li>• Complete OUH pre-op anaemia document guidance*</li> <li>• Refinement of transfusion PowerForm in EPR*</li> <li>• Develop business case for a patient blood management/peri-operative specialist nurse*</li> </ul>
National Early Inflammatory Arthritis Audit (NEIAA)	<ul style="list-style-type: none"> <li>• Locum consultant to be appointed**</li> <li>• Improve waiting times for new EIA appointments from ~3 months to 4-6 weeks**</li> </ul>
National Emergency Laparotomy Audit (NELA) (2 years data)	<ul style="list-style-type: none"> <li>• Improve poor case ascertainment**</li> <li>• Improve risk assessment documented before surgery*</li> <li>• Create a multidisciplinary pathway*</li> </ul>
National Heart Failure Audit (2 years data)	<ul style="list-style-type: none"> <li>• Run pilot intervention to improve rapid follow-up after hospital discharge**</li> <li>• Discussion at Oxfordshire Heart Failure Delivery Group to improve access to community heart-failure follow-up**</li> </ul>
National Hip Fracture Database (NHFD)	<ul style="list-style-type: none"> <li>• This audit topic is underpinned by the work of the Fragility Fractures Improvement Group, so no new actions were created as they are contained within Quality Priority 3: Fragility Fractures Pathway</li> </ul>
National Joint Registry (NJR)	<ul style="list-style-type: none"> <li>• Pathway improvements in theatres to ensure all patients undergoing eligible operations are consented to participate in the audit, improving data completeness and reliability**</li> </ul>
National Oesophago-Gastric Cancer Audit (NOGCA)	<ul style="list-style-type: none"> <li>• Work with Cancer Management team to explore data accuracy around the recording of disease stage and improve capture*</li> </ul>
National Ovarian Cancer Audit	<ul style="list-style-type: none"> <li>• Audit time frames for chemotherapy commencement after surgery in ovarian cancer*</li> </ul>

Audit	Summary of Agreed Actions
	<ul style="list-style-type: none"> <li>• Improve the recording of performance status using the MDT referral form*</li> </ul>
National Paediatric Diabetes Audit (NPDA)	<ul style="list-style-type: none"> <li>• Review NPDA quarterly reporting to identify missing and inconsistent data**</li> <li>• Aim for 90% of patients to have microalbuminuria recorded in next audit cycle, via doctors and nurses requesting a urine sample at every appointment*</li> <li>• Closed-loop group start sessions to commence*</li> <li>• Reduce missing ethnicity data in the next round of audit results by outpatient reception checking status and amending accordingly*</li> </ul>
National Pregnancy in Diabetes Audit (NPID)	<ul style="list-style-type: none"> <li>• Use of continuous glucose monitoring to increase by 20% in the next round of the audit by offering it at the first appointment*</li> </ul>
National Prostate Cancer Audit (NPCA)	<ul style="list-style-type: none"> <li>• Review of completeness of data entry to validate recording of MDT outcomes*</li> <li>• Accurate recording of true number of unplanned admissions within 90 days of robotic-assisted radical prostatectomy**</li> </ul>
National Primary Breast Audit (NAoPri) 2 years data	<ul style="list-style-type: none"> <li>• Year 1: Improve Performance Status- Data team to capture data from available information on EPR to flag improvement**</li> <li>• Recording of key-worker allocation*</li> <li>• Year 2: Create an audit of the reported recontraction rate*</li> <li>• Create an audit of the reoperation rate*</li> <li>• Do a root cause analysis of progesterone-receptor status*</li> </ul>
NCEPOD: Juvenile Idiopathic Arthritis	<ul style="list-style-type: none"> <li>• Business case development for replacement consultant*</li> <li>• Develop advice and guidance system for primary care, secondary care at OUH and secondary care outside of OUH*</li> </ul>
NCEPOD: Testicular Torsion	<ul style="list-style-type: none"> <li>• Re-audit the testicular pain pathway over a longer period to identify bottlenecks in pathway*</li> <li>• Analysis of 12-month audit data to quantify the extent of the delay in transfer to theatre and lack of post operative bed perceived problem*</li> <li>• Meeting with matrons and bed managers to find workable solutions that will not delay provision of NCEPOD 1 or 2 surgery*</li> <li>• Current paediatric testicular torsion patient information leaflet (PIL) to be updated and modified to include information on psychological support options*</li> <li>• Increase education on testicular torsion in primary and secondary care by running a training day for GPs and District General Hospitals*</li> </ul>

Audit	Summary of Agreed Actions
	<ul style="list-style-type: none"> <li>• Adult urology services to make use of the existing British Association of Urological Surgeons (BAUS) patient information leaflet*</li> </ul>
NCEPOD: Endometriosis	<ul style="list-style-type: none"> <li>• Update Trust website for both Endometriosis and Pelvic Pain services, including accurate information about the services and current contact details for administrative staff*</li> <li>• Organise and deliver a local training day focussed on endometriosis for any interested clinicians in primary or secondary care*</li> <li>• Replacement of pelvic pain consultant who retired*</li> <li>• Appoint to all pelvic pain physiotherapy posts that are currently not filled*</li> <li>• Business case for expanded pelvic pain service to have greater resources for patient support including nurse, doctor and psychology resource*</li> <li>• Deliver a training package to local NHS Talking Therapies clinicians on endometriosis*</li> <li>• Finalise standard operating procedure to include timing of medication reviews and ongoing shared care with primary care colleagues*</li> <li>• Finalise shared care protocol*</li> <li>• Develop further cooperation between clinical and pharmacological services to discuss possible drug interactions which might affect treatment efficacy and patient safety*</li> </ul>
Non-Hodgkin Lymphoma Audit	<ul style="list-style-type: none"> <li>• For radiology to remove 'refer to lymphoma MDT' from their reporting*</li> <li>• To replace with 'needs a biopsy' or other clinically appropriate comment*</li> <li>• Directorate/ Division to invest in day treatment unit infrastructure and space, nurses and pharmacists*</li> </ul>
Obesity Audit	<ul style="list-style-type: none"> <li>• Review body mass index data submission process to identify reason for invalid data**</li> </ul>
Paediatric Intensive Care Audit Network (PICAnet)	<ul style="list-style-type: none"> <li>• Reduce readmission rates by improving nursing recruitment, skill mix and decision making around discharging patients*</li> <li>• Continue to circulate lessons learnt and best practice about retrieval team mobilisation time*</li> <li>• Explore pathways that allow technology dependent patients to be looked after in non ICU settings*</li> </ul>
Perinatal Mortality Tool (PMRT)	<ul style="list-style-type: none"> <li>• Commence screening for early onset pre-eclampsia**</li> </ul>

Audit	Summary of Agreed Actions
	<ul style="list-style-type: none"> <li>• Update pre-booked scan pathways**</li> <li>• Additional high risk antenatal clinic**</li> </ul>
Perioperative Quality Improvement Programme (PQIP) (2 years data)	<ul style="list-style-type: none"> <li>• Discuss and agree new patient recruitment targets with national PQIP lead**</li> <li>• Ensure Direct Delivery team receives appropriate training and help with troubleshooting in the recruitment of patients**</li> <li>• DrEaMing (<b>D</b>rinking, <b>E</b>ating, and <b>M</b>obilising within 24 hours of surgery) audit scores displayed on local Safety Boards**</li> </ul>
Society of Acute Medicine Benchmarking Audit (SAMBA)	<ul style="list-style-type: none"> <li>• Education about post-take ward rounds based on clinical priority and geographical considerations to be delivered to the Medical Registrar Group**</li> </ul>
Sentinel Stroke National Audit Programme (SSNAP)	<ul style="list-style-type: none"> <li>• Increase speech and language therapy provision to meet national standards for bed therapy ratios*</li> <li>• Review of stroke pathway (led by ICB)*</li> </ul>
Serious Hazard of Transfusion (SHOT)	<ul style="list-style-type: none"> <li>• Annual review of current e-Learning package to incorporate human factor influences**</li> <li>• Work collaboratively with Haemonetics through active development of a transfusion-associated circulatory overload risk assessment process to be available at the bedside**</li> <li>• To complete the Human factors study commissioned by Hospital Transfusion Committee*</li> </ul>
Cleft Registry and Audit NETwork (CRANE)	<ul style="list-style-type: none"> <li>• Explore options to be able to supply a Paediatric Dentist provision at service level looking to dental hospitals for potential input*</li> <li>• Run an audit on consent collection and identifying patients that need following up**</li> <li>• Ensure that all data is being collected at Clinical Review Clinics to fulfil CRANE requirements to aid a GIRFT approach**</li> </ul>
Transcatheter Aortic Valve Implantation (TAVI)	<ul style="list-style-type: none"> <li>• Increase data completion through monitoring of national data*</li> <li>• Evaluate if same-day discharge would be appropriate for the service*</li> <li>• Develop selection criteria for low risk patients*</li> <li>• Implement a discussion of readmissions in M&amp;M Meetings**</li> <li>• Review of current data collection methods to identify areas for improvement in reducing readmissions rates*</li> </ul>
UK Cystic Fibrosis (CF) Registry-Adult	<ul style="list-style-type: none"> <li>• Review the significance of intravenous and inhaled antibiotics on CF patients while continuing to monitor and capture data*</li> </ul>
UK Cystic Fibrosis Registry-Children	<ul style="list-style-type: none"> <li>• Establish a regular core CF MDT half-day 'away day' to review latest evidence and local and national guidelines to ensure the</li> </ul>

Audit	Summary of Agreed Actions
	<p>service remains up-to-date and practicing in line with developments in CF management*</p> <ul style="list-style-type: none"> <li>• Develop a local patient information sheet on fertility issues in CF to help enable timely and open discussions with teenagers with CF*</li> </ul>
UK Interstitial Lung Disease (ILD)	<ul style="list-style-type: none"> <li>• Audit lead to meet with head of national registry and interrogate standards so they are fit for purpose**</li> <li>• Business case for additional radiology time at clinics*</li> <li>• Consider a proforma approach to ILD clinics**</li> </ul>

## Actions taken and improvements made from Trustwide audits

Trustwide audits are repeated annually and conducted across the organisation. The topics are derived from patient safety and quality standards and in 2025/26, there were ten Trustwide audits.

Six were reviewed by the Clinical Improvement Committee in 2025/26; the remaining four completed data collection in 2025/26 and will be presented in 2026/27.

Agreed actions and progress to improve the quality of healthcare provided are summarised in Table 14 below.

Table 14 Trustwide audits with actions taken and improvements made as a result (\*\*Fully achieved; \*Partially achieved)

Trustwide Audit	Summary of Actions
Safe and Secure Storage of Medicines	<ul style="list-style-type: none"> <li>• Business case for digital temperature monitoring to be approved**</li> </ul>
Pressure Ulcer Prevention Audit NICE Clinical Guideline (CG) 179/Quality Standard (QS) 89	<ul style="list-style-type: none"> <li>• Revision of a HAPU Reduction Quality Improvement Programme (QIP)**</li> </ul>
Nutrition Audit NICE Clinical Guideline (CG) 32	<ul style="list-style-type: none"> <li>• Modify or introduce a nutrition screening tool suitable for Maternity inpatients and adapt OUH-MUST audit accordingly*</li> <li>• Develop a nutrition training programme / modules and deliver this through a train-the-trainer model , consider using My Learning Hub. **</li> <li>• Update OUH Nutrition and Hydration Strategy*</li> <li>• Undertake MUST accuracy audits on sample group/wards**</li> </ul>
Deteriorating Patient Audit	<ul style="list-style-type: none"> <li>• Provision of information for consultant body by presentations at appropriate meetings. Ensuring SEND is easily accessible on computers in clinical areas*</li> <li>• Work with RAID Assessors in clinical areas to revise RAID education materials to meet current clinical needs*</li> <li>• Work with clinical colleagues and colleagues in IM&amp;T to develop a document which can easily be incorporated into current workflows*</li> </ul>
Health Records Audit	<ul style="list-style-type: none"> <li>• This audit was conducted from September-November 2025. The paper will be presented to CIC in the 2026/27 financial year.</li> </ul>
Consent Audit	<ul style="list-style-type: none"> <li>• This audit was conducted from September-November 2025. The paper will be presented to CIC in the 2026/27 financial year</li> </ul>

<p>VTE Prevention Audit</p>	<ul style="list-style-type: none"> <li>• Introduction of the Thrombosis Risk Prediction Following Cast Immobilisation (TRIPCast) risk assessment tool for Lower limb Immobilisation, an electronic and validated tool*</li> <li>• Explore the use of Thromboprophylaxis column to be added to ward White Boards, following a recommendation at Safety, Learning and Improvement Committee (SLIC) meeting*</li> </ul>
<p>AutoReporting</p>	<ul style="list-style-type: none"> <li>• Divisions should be emailed to collect this data with plenty of notice (e.g. 3 months)*</li> <li>• Alert radiographers regarding the new policy*</li> <li>• Reconsider if pre-op templating type X-rays with measurement overlays require documentation in notes, given they are self-explanatory*</li> </ul>
<p>Mental Health Act</p>	<ul style="list-style-type: none"> <li>• The audit provided strong assurance that the Trust had applied the requirements of the Act correctly, and so no action plan was required</li> <li>•</li> </ul>
<p>ReSPECT - Recommended Summary Plan for Emergency Care and Treatment</p>	<ul style="list-style-type: none"> <li>• ReSPECT was newly implemented at OUH in 2025/26 so this is the first year of auditing following initial teaching, training and roll-out. It is anticipated the audit will be presented to CIC in June 2026, covering 2025/26 data</li> </ul>



## GIRFT Implementation Plans

Getting It Right First Time (GIRFT) is a national programme designed to improve medical care within the NHS by reducing unwarranted

variations. A fundamental principle of this programme is to improve the quality of care and by doing so lead to a reduction in costs.

Peer review visits take place, resulting in observations and best practice recommendations which are then developed into an action plan for implementation and reported to the Clinical Improvement Committee.

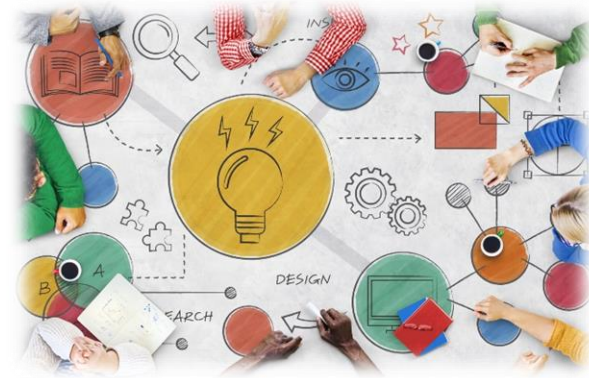
Table 15 below shows the specialties which have presented implementation plans to the clinical Improvement Committee in 2025/26.

Table 15 GIRFT implementation plans approved at Clinical Improvement Committee, observations and actions planned

Specialty and Date of Review	Observations and Actions Status
Diabetes in Children and Young People (CYP) (Dec 2024)	<ul style="list-style-type: none"> <li>• Oxford is a pilot site for the NHSE Transition and Young Adult diabetes project and benefited from additional staffing resource from 2023-25</li> <li>• The service has developed a standard operating procedure for managing CYP with high HbA1c levels</li> <li>• The use of hybrid closed-loop technology to monitor and manage bloods sugar levels was prioritised for the highest-risk patients and implementation is progressing well</li> <li>• Patient education is offered in the Young Adult Clinic, with follow-up provided by the Specialist Nurse and Dietician</li> <li>• Actions 4/8 delivered/total accepted</li> </ul>
Paediatric Rheumatology (January 2025)	<ul style="list-style-type: none"> <li>• There are examples of excellence including one-stop clinics with ophthalmology, highly respected chronic pain and skeletal dysplasia services, delivery of age-appropriate care from ages 0-25 years, and play specialist support</li> <li>• Challenges and opportunities include succession planning for the consultant workforce, expansion of the multi-disciplinary team to include a psychologist, and referral pathway review</li> <li>• There is a plan to deliver annual training across A&amp;E, paediatrics, orthopaedics, musculoskeletal hubs, and schools</li> <li>• Actions 5/31 delivered/total accepted</li> </ul>

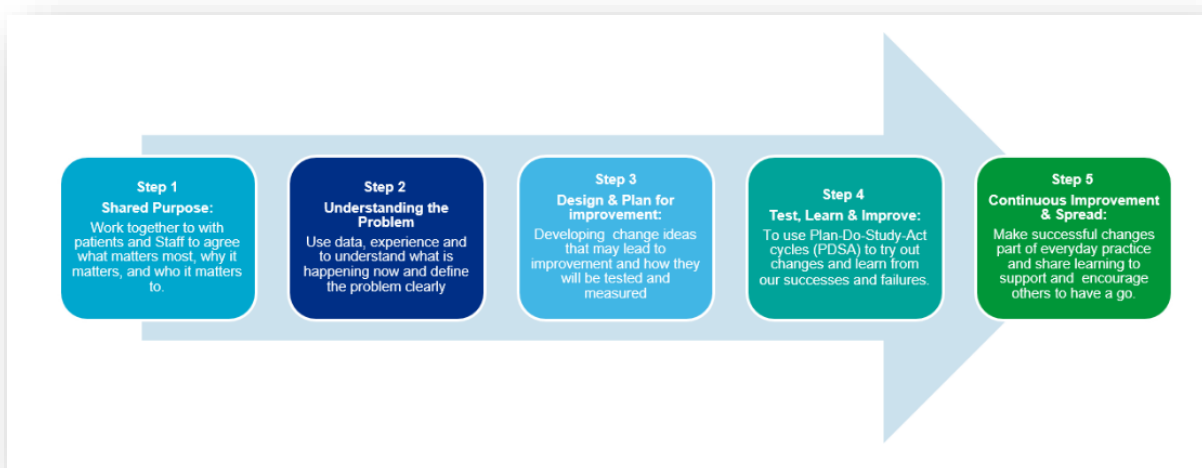
## Quality Improvement 2025/26 Report

Oxford University Hospitals (OUH) remains committed to advancing our culture of continuous improvement, underpinned by the Trustwide adoption of Quality Improvement (QI). Building on a strong foundation, 2025/26 has been a year of consolidation, increased engagement and a continued focus on enhancing both patient care and the working environment for our staff through the defined Integrated QI Programme. This commitment reflects the Trust’s resolve to align with the vision of NHS Impact and deliver healthcare that is continuously improving, patient-centred and efficient.



Building on the progress of the previous year, our Integrated Quality Improvement (IQI) Programme continues to drive meaningful change across these priority programmes, enabling improvements in both complex patient pathways and building our culture of continuous improvement and approach to meeting clinical and non-clinical standards. The OUH Improvement Framework, initiated in 2022 to guide teams and services through a five-step process of improvement was reviewed and updated in 2025/26 (see Figure 1 below). This update was informed by feedback of colleagues across the Trust.

Figure 1 OUH Improvement Framework (Version. Updated January 2026)



### Integrated Quality Improvement Programme Overview

The Integrated Quality Improvement (IQI) Programme has made significant contribution to embedding quality improvement (QI) within the Trust, drawing a QI approach to support key organisational priorities. Our structured approach is underpinned by OUH Improvement Framework (see above).

The IQI programme maximises the impact of improvements by supporting engagement and testing of new ways of working at service and team level building, leveraging both intrinsic and extrinsic motivators while recognising the unique characteristics of each project and programme. This remains both an ongoing opportunity and a challenge as we collectively work towards developing the wider maturity of our organisational culture of continuous improvement.

In the past 12 months the IQI Programme has comprised four core programmes: QI Learning Hub, Urgent and Emergency Care, Standard Work, Cancer Improvement; and the initiation of a new programme from January 2026, Improvement Sprints. The following sections provide an update on the achievements and programme across these programmes.

### **Cancer Improvement Programme**

The Cancer Improvement Programme supports multidisciplinary teams to address performance against the national cancer standards by using a QI approach. The Trust performs well for the 28-day faster diagnosis standard, so focus during 2025/26 has been on the 62-day standard (aim for 96% of patients receiving their first treatment within 62 days of diagnosis). The team have run a number of large collaborative multi-stakeholder workshops exploring constraints and identifying practical changes that can be put in place rapidly (e.g. within 100 days) to reduce waiting times for patients needing cancer treatment. Medium- and longer-term improvements have been discussed during the workshops which are helping to form a longer term Trust cancer strategy aligned to the National Cancer Plan (2026) published by NHS England <https://www.gov.uk/government/publications/national-cancer-plan-for-england>

Key improvements that have come out of the workshops in 2025/26

- Head and Neck (patients with thyroid cancers): waiting for treatment has improved by 30% and has exceeded the 96% aim of patients starting treatment within 31 days of a decision to treat. Also introducing remote clinics to give patients results where cancer has been excluded has helped the Head and Neck service exceed the 28-day faster diagnosis standard.
- Waiting times for patients with upper gastrointestinal and liver related cancers have improved by up to 30%, exceeding the national standards, by introducing a number of changes including earlier blood tests at appointments and identifying patients who need earlier multi-team reviews.
- A 'navigator role' was introduced to the renal service to closely scrutinise patients in the pathway and has contributed to nearly 30% reduction in waiting times for patients waiting treatment when a decision to treat is made by their doctor.
- The Breast cancer service has seen a 25% increase in performance for patients starting their cancer treatment within 62-days performance increased to 84.5% by

Dec 2026. This has been achieved by expediting patients for rapid review where breast cancer is likely, careful management of outpatient slots and other changes.

- The lower gastrointestinal service has set up a 'Pre-op Assessment Pool' by adding two clinic slots per week and enabling same day preop following surgical outpatient. This has reduced the time patients wait to for their fitness assessment before surgery. It is anticipated this will reduce delays for surgery associated with prehabilitation, the impact of this is being monitored by the service to inform ongoing adaptations and wider learning.

The QI team have used these workshops and follow up opportunities to support colleagues in cancer services develop and embed wider improvement knowledge expertise via coaching, mentoring and specific skill support.

The team has launched an Improvement Collaborative model within the lung cancer pathway as waiting times for patients to start their treatment have been challenging to meet. Lung cancer has particularly complex pathway involving multiple services that need to work seamlessly together including sharing important diagnostic information, communicating promptly with patients and experts from different services coming together in a coordinated way to propose the most effective and beneficial treatment options to patients. Robust administrative and communication systems and processes need to sit around this for all parts of the pathway to work efficiently. The Lung Improvement Collaborative is examining these processes referring to best practice in other Trusts and new technologies. We have started testing multimedia methods of running key multidisciplinary meetings where specialists come together to agree specific treatment options for patients, testing how this might expedite important follow up discussions with patients and arrangement of appointments so that treatment can be organised faster. In addition, we are testing new ways of tracking patients through their treatment pathway to ensure the most up to date and accurate information is visible for all members of the team providing care to both reduce unnecessary delays and support improved patient experience. Impact of testing will be tracked to adapt and adjust change ideas as the work continues, guided by the data and insights of staff.

## **Urgent and Emergency Care**

The Urgent and Emergency Care (UEC) Quality Improvement Programme supports the delivery of safe, effective and timely care by working with frontline teams to improve patient flow, reduce delays and enhance the quality and reliability of care.

During 2025/26, the programme focused on priority areas with the greatest impact on patient safety and experience, particularly children's urgent care, discharge processes and reducing extended lengths of stay. Quality improvement methods were used to support teams to understand problems, test changes safely and measure their impact.

Significant improvements have been made in children's urgent and emergency care. Work to redesign pathways at the front door of Paediatric Emergency Departments has improved the timeliness of assessment and decision-making. As a result, performance against the four-hour standard improved from 58% to 71%. While further improvement is needed to reach national standards, this represents meaningful progress for children and families accessing emergency care.

The programme has also improved patient flow from Emergency Departments to inpatient wards. Improvements to "bed readiness" processes reduced the average time from a decision to admit a child to transfer onto a paediatric ward from approximately 136 minutes to 100 minutes. This has reduced waiting times in emergency departments and supported safer, more timely admission to inpatient care.

Discharge quality and reliability have been a major focus. By analysing the causes of on-the-day cancelled discharges and testing targeted improvements, teams achieved a 50% reduction in cancelled discharges, from an average of 20 per week to 10. This has improved patient experience, reduced wasted capacity and supported better use of hospital beds.

Further work to reduce extended lengths of stay has led to fewer patients occupying beds longer than clinically necessary, with an average reduction of six extended-stay patients per week. In addition, improvements to discharge planning increased the number of children discharged before midday from an average of 26 to 29 per week, supporting smoother patient flow and safer transitions of care.

Across all workstreams, the Quality Improvement Programme has strengthened multidisciplinary working and supported staff to develop improvement skills. Coaching and structured improvement approaches have enabled teams to take ownership of change and embed learning into routine practice.

Overall, the Urgent and Emergency Care Quality Improvement Programme has delivered measurable improvements in quality, safety and performance. By focusing on patient flow, timely care and reliable discharge processes, the programme is supporting OUH to provide more consistent, high-quality urgent and emergency care for patients and families.

## **Standard Work**

At OUH, we are committed to delivering the highest quality of care, therefore we are prioritising the implementation of the Standard Work (SW) concept across our services. Drawing from the learning and evidence base from wider industries, this approach is designed to ensure that every patient receives consistent, safe and effective care while supporting our teams in their daily work.

The initial focus for the Standard Work programme has been supporting clinical inpatient teams, working to align with existing structures and reduce duplication and enhance care,

for example linking with and understanding the alignment with Care Assure. This provides a frequent opportunity to assess fundamentals of care.

Standard Work is a clear, step-by-step framework that outlines the best way to complete specific tasks based on evidence and expertise. It is about creating reliable processes that support excellence in care. Success will be evaluated through clear metrics, including audit results, staff engagement levels and outcome measures tied to organisational goals.

The overall aim of the Quality Priority is to enable the successful adoption of Standard Work in a structured, measurable and impactful manner on defined priority areas, building forward our culture of excellence and continuous improvement, benefiting patients, staff and the organisation.

The detail including key benefits from the first year of the programme is shown within the information within [Quality Priority 4, Standard Work](#)

## **QI Learning Hub (previously Building Quality Improvement Capability and Capacity)**

The Trust continues to invest in building capability and understanding of quality improvement (QI) and continuous improvement across the organisation. This is delivered through a combination of formal training programmes and informal development opportunities, enabling staff at all levels to develop the knowledge, skills and confidence needed to improve services and patient care.

### **Impact and Benefits Realisation (Education Framework, April 2022–2025):**

- At least 2,736 individuals have undertaken QI training, completing a total of 4,476 training courses.
- OUH staff have collectively dedicated over 568 hours to understanding the core concepts of QI, 6,126 hours to learning how to apply QI within their own services, and 7,908 hours to developing the skills needed to lead and support QI projects across the Trust.
- More than 1,000 new QI projects have been registered on Ulysses. The average time from project registration to approval has reduced significantly, from just under 40 days to just under 17 days.

## **QI Education Framework highlights from 2025/26**

Below are some specific highlights from the QI Education Framework delivery over 25/26, this includes development of new training options and a focus on continuing to ensure our training directly supports tangible improvement across OUH.

In addition to our established 'Introduction to QI' e-learning program, over the past twelve months we have launched an in-person introduction to QI session as part of the reinstated in-person Trust staff induction programme. This session introduces new colleagues with our Trust approach to improvement from their first day at OUH, highlighting the importance of

continuous improvement, and encouraging them get involved and share ideas to enhance patient care and workplace practices.

## QI Fundamentals

Our QI Fundamentals training is a 1-day introduction to focused improvement tools with a focus on application to a project or improvement initiative. Over 24/25 OUH partnered with NHS Elect to deliver these monthly one day QI Fundamentals session, testing a new redesigned format. The session aims to help staff move confidently from learning QI principles and tools to applying them in practice, supporting meaningful and measurable improvements within their teams and services.

## Collaborative QI Practitioner (CQIP)

OUH have played an active role in the national leadership of codesigning the new Collaborative QI Practitioner (CQIP) programme with NHS Elect. Focused on addressing the need for a more balanced QI curriculum that strengthens adaptive, relational, and system level improvement skills alongside traditional technical tools.

CQIP has been shaped through extensive national engagement, and OUH has been part of the national pilot from August 2025 in advance of wider adoption from spring 2026.

The programme replaces the previous 'Quality, Service Improvement and Redesign' (QSIR) Practitioner course and provides free, evidence based training to develop skilled improvement practitioners who can lead and sustain change across the organisation. OUH continues to contribute to the national development of this programme.

## Quality Coach Development Programme (QCDP)

The Quality Coach Development Programme continues to expand quality improvement (QI) expertise across OUH, focusing on establishing a core group of colleagues across the Trust who not only understand QI, but are also skilled and supported to help others embed this approach within projects and areas of practice. Since it's Trust launch in 2024/25 39 colleagues have been trained as a Quality Coaches, who are now actively supporting teams and individuals to deliver improvement work within Divisions and teams.

In early 2026 QCDP Cohort 3 started piloting a co-delivered approach in partnership with Oxford Health NHS Foundation Trust, aiming to strengthen collaboration and shared learning across organisations.

## Masterclasses

We have introduced targeted QI Masterclasses to rapidly build skills in priority areas. Two masterclasses are currently available: *Standard Work* and *Maximising Value and Reducing Waste*. These sessions help teams working on improvement projects to align their work with Trust priorities and have a positive impact more quickly.

## Further highlights from 2025/26

### QI Sharing and Learning Events

To foster organisational learning and improvement, various methods have been evaluated and refined to facilitate colleague connections. In 2025/26, we piloted both 'QI Lunch and Learn' sessions and quarterly Community Engagement Events. Recognising the difficulties associated with releasing staff for extended sessions, and responding to ongoing requests for enhanced networking opportunities, these initiatives were merged in late 2025 to test regular, one-hour online 'QI Sharing and Learning Events.' These concise and practical sessions are co-delivered by clinical and corporate teams, recorded, and distributed via the Trust QI Zone intranet to support wider accessibility and broaden the dissemination of learning. Between 10 – 25 colleagues have attended these sessions, with session topics having included sharing of locally delivered QI projects, value stream mapping and publishing QI case reports. On going testing of different approaches to networking and linking colleagues to support shared learning and improvement are in discussion for 2026 – 2027.

### BOB System Partnerships

Throughout 2025, OUH continued to collaborate with QI colleagues and share best practice and learning through the BOB QI Network. Following successful application for Q Community Grant from the Health Foundation the priorities over 2025/26 had been in four key areas that looked to enhance and mature the network support effective sharing and learning.

- **BOB QI Festival** – Building on the success of the past two years' virtual Improvement Festivals, we hosted an in-person conference attend by over 80 colleagues. Supported by all providers across BOB ICS this provided an opportunity to share best practice and link colleagues from different providers across the region to foster engagement and knowledge exchange.
- **Look, Go and See** – OUH Colleagues were supported to visit each of our organisations across the BOB ICS completing a QI 'show and tell' and discussion of key topics (PSIRF, RPIW, building QI Capability, QI Huddles).

In March 2026, we organised an industry visit to the Mini Factory in Oxford for 15 QI colleagues to explore Lean principles in manufacturing. Attendees reflected on applying these insights to the NHS with a virtual webinar is planned for 2026 to share learnings from the visits.

- **BOB QI and Co-Production Working Group** – OUH have been collaboratively working with Oxford Health to explore new opportunities for development of tools and

approaches to embed patient and community voices within all improvement. This work will continue into 2026/27.

- **BOB QI Practitioner Training** –OUH Took a leadership in running the pilot for the Collaborative QI Practitioner training, colleagues from across provider trust previously linking as faculty for QSIR practitioner delivery were invited to join the cohort.

Through these initiatives, the BOB QI Network will continue to grow as an inclusive and forward-thinking community, driving meaningful improvements in healthcare across the region.



## Oxford Simulation, Teaching and Research (OxSTaR)

### Human Factors and Patient Safety Education for OUH

OxSTaR has been providing award winning training using simulation and technology-enhanced learning for students and healthcare professionals in OUH for over 18

years. This collaboration has received national and international recognition for OxSTaR's teaching and research and benefits from an emphasis on robust educational governance (including accreditation by the UK's Association for Simulated Practice in Healthcare (ASPIH)). We have always focused on the importance of co-design in our educational interventions and have built strong relationships with educational teams across the Divisions in the Trust. This ensures we are responding to key quality and safety priorities in OUH and delivering learning outcomes that translate to safer, more effective care in the workplace.

Human Factors and safety training informs understanding of patient safety concerns in the workplace across the Trust and feeds directly into the design of quality improvement projects to mitigate risk and improve safety across the organisation. Feedback from participants is outstanding. We also collect data on safety culture using an internationally validated safety attitudes questionnaire designed for clinical staff.

There are three levels of training offered to OUH staff through OxSTaR.

**Level 1** – introductory Human Factors / Ergonomics (HFE) training for all staff in OUH. This includes freely available online half-day introductory HFE courses, this course is supported by online learning materials, including a handbook and podcasts covering relevant safety issues such as recognition of the deteriorating patient and medicines safety. 452 OUH staff members attended level 1 training

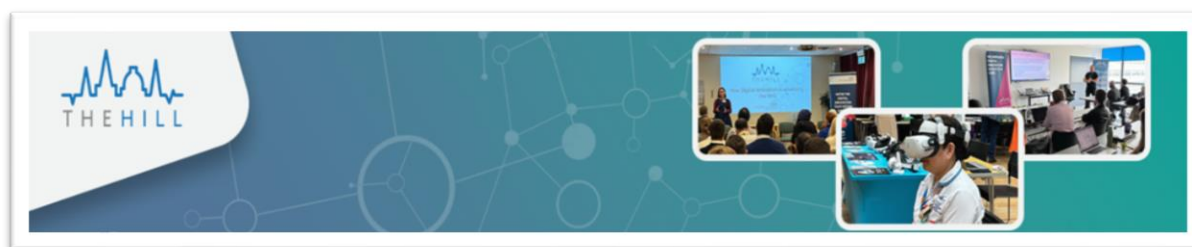
This year OxSTaR has created and delivered new courses on system-based incident analysis for Patient Safety Incident Investigations (PSII) using the London Protocol. This programme equips OUH incident analysts to deliver timely, system focused PSIIIs to maximise learning and improvement after safety incidents.

**Level 2** – Simulation-Based Education (SBE) and HFE training to support key quality and safety priorities in OUH (e.g. SBE faculty development, care of the critically ill newborn, Advanced Critical Care Practitioner (ACCP) training) 451 OUH staff members attended level 2 training.

**Level 3** – bespoke SBE and HFE training delivered according to need (e.g. in response to a specific safety incident or to support the development of a new patient pathway).

During 2025/26, OxSTaR collaborated with the psychological medicine team to deliver specialised training to OUH staff within their workplace environment. Certain hospital staff members require targeted instruction to manage behavioural disturbances in adults effectively, as such incidents may arise from various factors including mental illness, dementia, delirium, or substance use. Comprehensive training enables staff to identify early warning signs, de-escalate potentially aggressive situations, and respond in a manner that upholds patient safety, dignity, and minimally restrictive practices. Furthermore, it provides them with enhanced communication techniques, risk assessment capabilities, and a thorough understanding of legal and ethical obligations. Insufficient preparation can lead to diminished confidence among staff and reliance on reactive interventions, thereby increasing risks to both patients and personnel. This programme was attended by 31 OUH members, including security staff.

## Digital Innovation



### TheHill

TheHill plays an important role in supporting innovation across the Trust, enabling staff to engage with new technologies, build digital capabilities, and accelerate adoption of solutions that improve efficiency, effectiveness, and patient outcomes. Programmes supported by TheHill include:

#### Innovation Training

Innovation Training is delivered through a two-day, classroom-based programme featuring interactive sessions. It equips staff with the knowledge and skills to understand how innovation creates value, identify opportunities for improvement, and develop the practical capabilities required to lead and implement innovation projects successfully. The programme also promotes the adoption of new technologies and strengthens change leadership across departments.

Pre- and post-programme evaluation demonstrates a significant positive impact. The proportion of participants likely to explore innovative solutions increased from 0% to 100%, while those very likely to engage with new technologies or participate in trials rose from 60% to 100%. Confidence across key innovation competencies improved by an average of 60–80%.

#### Start-Up Labs

Start-Up Labs are designed for NHS staff with ideas for impactful innovations that can benefit colleagues and patients. It enables staff to turn their ideas into reality and provides opportunities to develop innovative technologies that address frontline challenges.

The 6 week programme offers a structured, fast-track pathway to support participants in developing their ideas into functioning prototypes. Participants have progressed their ideas in a variety of ways, including establishing companies, securing grant funding, submitting research proposals, and collaborating with SMEs and internal teams to co-develop and test solutions. Notable examples include a hand therapist at the Nuffield Orthopaedic Centre who secured grant funding for an AI-based solution developed during the programme and is now pursuing further research funding to support its development and validation. In a second example, a ward housekeeper is working with colleagues and voluntary services at the Churchill Hospital to develop a wayfinding solution to improve patient and visitor experience.

As well as offering a range of programmes for staff, TheHill enables collaboration between the Trust and the wider innovation ecosystem, bringing together NHS staff, SMEs, researchers, and industry partners to co-design and deliver digital solutions that address real-world healthcare challenges.

## **The Market Access Accelerator**

The Market Access Accelerator (MAA) is a twelve-month programme which focuses on supporting digital health start-ups in gaining an in-depth understanding of how the NHS works while helping to scale innovative technologies which can improve patient care and reduce the pressure and burdens on NHS staff.

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

In 2025, eight companies graduated from the programme, their details are below.

### **CEFREF**

CEFREF is an advanced electronic migraine and headache diary app, designed by founder and consultant neurologist to simplify accurate monitoring of headache frequency/severity and painkiller usage and was created to improve management of migraines. Patients can also analyse their own data and share this information with their healthcare provider which can help determine the most appropriate treatment.

### **eAltra**

eAltra is a conversational AI which aids cancer treatment delivery, reducing the time spent by clinicians in assessing patients by up to 50%. It allows patients to more freely exchange information with their clinical team, allowing for toxicity screening, holistic needs assessments, patient reported outcomes and patient concern logging, all while integrating with the patient's electronic health records (EHR).

### **Hatopy**

Hatopy provides a novel approach to managing eczema by utilising wearable technology and AI to objectively track the condition and transform the daily experience of living with it into meaningful insights. Unlike traditional tracking apps, Hatopy offers real-time feedback and personalised interventions to help users recognise potential triggers, prevent flare-ups, and take more control of their condition.

### **Matriwell**

Matriwell's innovation, MothersPA, is a healthcare companion for mothers which looks to tackle the systemic inequalities present in maternity care. The AI-powered software analyses the user's full medical history, symptoms, self-reported health data, and where possible, real-time electronic patient record (EPR) records to identify risks and provide a

summary. The summary empowers mothers to advocate for themselves and provides clinicians with data to enable them to make faster and more informed decisions, enabling mothers to receive the right care at the right time.

### **MedForce AI**

MedforceAI is transforming healthcare with a deep medical reasoning system designed to close the global clinical expertise gap. Deep medical reasoning is the use of advanced artificial intelligence that mimics how expert clinicians think. It acts as a vital safety net for clinicians, helping to catch potential medical errors before they can happen, while proactively identifying patients impacted by evolving medical guidelines, automatically re-running their diagnostic and treatment plans, notifying clinicians if an updated course of action is recommended.

### **Sens-Vue**

Sens-Vue have created an AI solution (GlauKomAI) to detect vision-threatening glaucoma for early prevention and precise treatment. Their artificial intelligence solutions operate on different devices, empowering care providers by enabling faster diagnosis, reducing referrals to ophthalmology clinics and wait times. GlauKomAI can diagnose glaucoma from eye images in seconds using an AI algorithm supported by bio-sensing technologies.

### **Skystrm (Senso24)**

Skystrm have developed Senso24 which is a 24/7 AI-driven monitoring solution, designed to ensure safety and independence for individuals at home or in care settings. It uses non-invasive computer vision and machine learning to detect falls and health abnormalities in real-time and provides instant alerts to healthcare staff, carers and, if needed, the emergency services.

### **Vocavibe**

VocaVibe's innovation is a conversational chatbot for people living with Parkinson's, which lets patients and clinicians catch the earliest signs of symptom progression. Through active interaction with patients throughout the day, the chatbot continuously monitors signs of motor symptom progression, cognitive decline, depression, swallowing difficulties and treatment effect. Real-time alerts are provided to the patient's clinicians, enabling earlier intervention and preventing common causes of hospitalisation, such as aspiration pneumonia and medication mismanagement.

## Innovation Pipeline

The Innovation Pipeline connects the Trust to the wider innovation ecosystem, enabling TheHill to match external digital solutions to identified needs and facilitate approved pilots, research collaborations, and early-stage testing. By providing a structured, step-by-step framework, the pipeline ensures each innovation is assessed against real-world needs and Trust priorities, with oversight from OUH Innovation Panel, a committee of key stakeholders providing independent review and recommendations. Piloting technologies on a smaller scale ensures that only solutions demonstrating tangible benefits and alignment with Trust processes progress to full adoption, reducing risk and avoiding ineffective procurements. This guarantees that projects are clinically relevant, evidence-based, and deliverable within the Trust's operational and regulatory context. Currently, the pipeline is progressing 28 companies through its six stages to adoption.

### Case study example: Ambient Voice Technology (AVT)

AVT is a tool that uses a microphone and secure artificial intelligence (AI) software to help clinicians document patient consultations in real time. It captures spoken words and converts them into clinical notes and letters, which clinicians then review to ensure accuracy and completeness before storing them in health records.

TheHill ran a 6-month AVT pilot which explored whether these tools could help ease the growing administrative pressures on clinicians and support more efficient, patient-centred care. The pilot ran across a variety of inpatient and outpatient settings, including Critical Care, Community Paediatrics and Outpatients, each with different levels of complexity and workflow needs, and tested four different AVT solutions.

Key outcomes from the AVT pilot included:

- **Time savings:** 88% of clinicians reported measurable reductions in documentation time, with nearly half saving 5–15 minutes per encounter and 22% saving an hour or more per day. Weekly time spent on documentation outside normal hours dropped from 3.02 to 1.55 hours.
- **Staff wellbeing:** Stress levels fell by 70.2%, fatigue at the end of shifts reduced from 82% to 57%, and staff reported improved work-life balance and reduced cognitive load.
- **Patient care:** Clinicians could focus more on consultations, producing more timely, thorough, and accurate documentation. Across the pilot, 199,651 minutes of transcription (138 days) produced 6,535 outputs.

Feedback from staff participating included:

- **Specialist Nurse:** “Not having the burden of extra paperwork has improved my wellbeing and job satisfaction. Losing AVT would feel like a step backwards”

- **Audiologist:** “After a back-to-back clinic, all admin would be done by the end of the day, which was previously unheard of. Reports went out on the day, families received them quicker, and referrals happen faster. It made a huge difference.”
- **Specialist Nurse:** “AVT let me focus on patients without taking notes, which enhanced the quality of interactions. Patients responded positively, appreciating the more open conversation.”

The AVT pilot demonstrated that AI-enabled voice tools can deliver significant benefits when implemented carefully, with strong engagement, training, and evaluation. Findings from the pilot have informed a Trustwide AVT procurement process and provide a practical model for the safe and effective adoption of AI technologies in healthcare.

### Case study example: The Health Research Centre (HRC)

The HRC is funded by the National Institute for Health and Care Research (NIHR) and aims to address health inequalities by supporting applied health research that is place-based, inclusive, and community-driven. The HRC focuses on co-designed research that reflects local and regional health needs, builds research capacity in underserved and high-need areas, and promotes equity in health outcomes through strong partnerships across the NHS, academia, local authorities, and the voluntary sector. TheHill co-leads the Digital theme for the Thames Valley and Oxfordshire HRC.

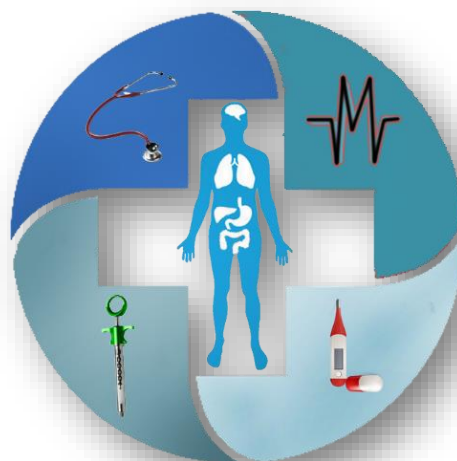
In collaboration with Adam Gordon, Professor of Care of Older People at the Academic Centre for Healthy Ageing, TheHill delivered a Falls Prevention workshop which:

- Identified key clinical challenges in falls prevention.
- Highlighted best practice approaches.
- Supported startups in refining their innovations with real-world clinical insights.
- Provided opportunities for collaboration between healthcare professionals, industry, and academia.

Over 100 participants registered, representing a wide range of health and care settings. The workshop facilitated cross-collaboration, sharing of best practice, and networking to improve falls prevention across the system.

## Our participation in clinical research

As one of the United Kingdom's leading university hospital Trusts, OUH is committed to integrating clinical care and research. Together with its research partners, OUH aims to discover better ways to diagnose and treat patients locally, and to contribute to healthcare advances nationally and internationally. This is underpinned by bringing together academic research expertise with clinical teams throughout the Trusts clinical sites.



OUH's close partnership with Oxford University (OU) encompasses major programmes in all areas of medical sciences, including cardiovascular, stroke, dementia, cancer, infection, vaccines, surgery and imaging, as well as interdisciplinary collaborations in digital health. Recent investment in the development of research led by nurses, midwives and allied health professionals (NMAHPs) at OUH, working closely with Oxford Brookes University (OBU's) Oxford Institute of Applied Health Research (OXInAHR), has helped to build a robust evidence base to drive improvements in broader aspects of patient care, as well as creating new career pathways for OUH staff.

Much of this activity benefits substantially from the NIHR Oxford Biomedical Research Centre (Oxford BRC), which has been based at OUH and run in partnership with OU since 2007. The Oxford BRC funds innovation across 15 research themes and a core team that supports researchers in areas such as patient and public involvement and engagement, business development, training and education and ethics. Plans are being made for a further bid in late 2026 for a further 5 years funding.

The NIHR Oxford Clinical Research Facility (CRF) is another partnership with OU, which is already delivering a wider range of early phase studies (many with Oxford BRC funding) for the benefit of patients, as well as to train and develop a new generation of doctors, nurses and allied health professionals in early phase experimental medicine trials.

During 2025/26, OUH hosted 1645 active clinical research studies. These include 314 new studies that have opened to recruitment at OUH during 2025/26.

The Joint research office (JRO) is a shared resource with OU, Oxford Brookes and Oxford Health. It continues to evolve and in 2026 plans have been developed to facilitate and accelerate the integration between the four partner organisations. This will reduce study set up times and reduce some of the bureaucratic processes that can be associated with research.

The number of patients receiving relevant health services provided or sub-contracted by OUH in 2025/26 who were recruited during that period to participate in research approved

by a Research Ethics Committee, was 9885, recruited to 488 studies registered on the NIHR portfolio.

In 2025/26, 103 OUH staff were directly supported by NIHR Oxford BRC funding. An additional 55 staff with honorary OUH contracts are also supported by PAs funded by the NIHR Oxford BRC. 148 staff were funded by the NIHR Regional Research Delivery Network (RRDN).

The following examples illustrate some of the diverse high-impact clinical research studies and facilities which OUH has been involved in during 2025/26, in many cases working in close partnership with OU.

- OUH is sponsoring the UK's first multicentre randomised controlled trial of **AI-assisted fracture detection in Emergency Departments**, working with Danish MedTech company Radiobotics. The [SAMURAI-Fracture study](#) will evaluate the real-world impact of the RBfracture™ AI tool across four NHS Trusts in the Thames Valley, under OUH [OxCAIR](#) programme. It aims to generate robust prospective evidence on accuracy, workflow impact, patient outcomes and system-level effects, addressing key gaps highlighted by NICE's Early Value Assessment for fracture-detection AI. The study also seeks to determine whether AI can reduce clinical errors, missed fractures and delays in care.
- The **outcomes for patients with multiple myeloma** could be significantly improved as a result of new studies opened to recruitment at OUH. The OUH-sponsored [MAGNETO trial](#) is testing a novel radiotracer developed with GSK to improve PET-CT imaging, which has the potential for earlier and more precise disease detection.
- OUH is recruiting patients to a clinical study testing whether deep brain stimulation (DBS) can **relieve severe chronic pain following stroke**. The [EPIONE study](#), led by Oxford neurosurgeons and engineers, is trialling an implanted DBS device in 30 patients whose pain has not responded to existing treatments. By comparing periods when the device is switched “on” and “off” in a randomised design, the research aims to produce robust evidence on whether DBS can provide meaningful pain relief. The findings of this study, which is sponsored by OU and supported by the NIHR Oxford BRC, will help determine whether this approach could be adopted more widely within the NHS.
- OUH also supports several OU vaccine studies recruiting healthy volunteers including in screening for eligibility and analysing safety bloods. This includes eligibility screening for a Phase 1 study of a new vaccine against Lassa fever in adults, which is also supported by the NIHR Oxford BRC.
- An OUH patient is the first person in Europe to be recruited to a heart inflammation treatment study. FORTIFY is an international clinical trial, sponsored by US biopharmaceutical company Abcentra, which is testing orticumab, a monoclonal antibody aimed at reducing coronary inflammation after a heart attack. It uses the

Fat Attenuation Index (FAI) biomarker, which was developed at the University of Oxford and commercialised by the OU spin-out Caristo Diagnostics, to identify patients with high coronary inflammation.

- OUH has recruited its first patient into a [clinical trial of CAR-T cell therapy for multiple myeloma](#), marking a significant milestone in advanced cancer research in Oxford. The study tests an innovative form of immunotherapy in which a patient's own T cells are genetically modified to target cancer cells and is one of the first trials of its kind at OUH. This international, randomised commercial trial, sponsored by Bristol Myers Squibb, is enrolling patients whose myeloma has returned despite previous treatment and compares CAR-T therapy with standard care. The results will help determine whether this approach could expand treatment options for myeloma patients in the future
- OUH has been awarded over £1 million in a national competition to **fund state-of-the-art research facilities and equipment**. This will help the Trust to meet the growing demand for commercially sponsored studies, in line with the expectations of the government. This capital funding will support and enhance studies across numerous disciplines, including respiratory and vaccine trials, ground-breaking imaging research using hyperpolarised xenon gas, and the vital work being done in pharmacy and pathology that underpins experimental medicine studies.

## Reporting Excellence



The OUH Reporting Excellence (RE) Programme, established a decade ago, remains a key element of the Trust’s Recognition framework, supported by a suite of instant recognition tools to express thanks and acknowledge effort. The focus continues on reporting excellence in practice, expressing gratitude and learning from Excellence. Actions and innovations undertaken by staff are celebrated with the nominee and also, when summarised, are shared directly with groups whose focus is on quality, efficiency and improvement. These rich data enable clinical and non-clinical areas to benefit from what goes well in daily work and to identify innovative or highly adaptive practice. This, in turn, contributes positively to learning, future quality improvement and constructive appraisal of existing practice.

In 2025/26 there were 2876 reports at the time of writing the report, with an average of 240 nominations per month (Graph 1).

Graph 1 Excellence reporting by Month October 2024 to March 2026

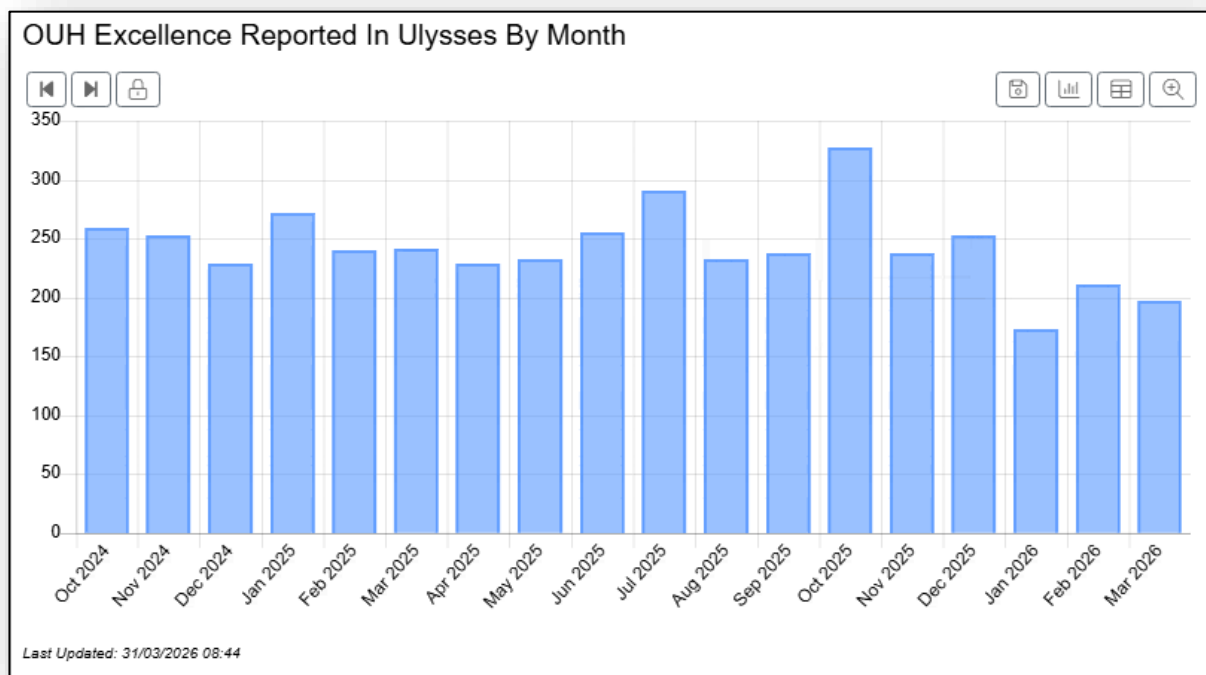


Table 16 OUH Excellence Reports in Ulysses by Theme August 2025 to February 2026

	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Total
Compassionate Care	47	27	69	55	47	24	31	300
Going Above And Beyond	104	109	141	99	114	81	115	763
Innovation	4	2	9	2	5	3	6	31
Teamworking	77	100	108	82	87	65	59	578
<b>Total</b>	<b>232</b>	<b>238</b>	<b>327</b>	<b>238</b>	<b>253</b>	<b>173</b>	<b>211</b>	<b>1672</b>

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Table 16 shows the breakdown of reports by theme. Alignment with Trust values remains a consistent strength of Reporting Excellence, providing assurance that these values underpin daily practice. ‘Going Above and Beyond’ is listed most commonly, followed by ‘Teamworking’. Innovation reports increased this year to 27 for the past six months, the highest since the scheme’s launch.

The Reporting Excellence Programme is far more than a simple way to thank individuals. While it preserves the essential cycle of recognition—from nominator to recipient—it goes further by reaching across professional groups to drive meaningful improvements in quality and safety. It uniquely supports the Trust in meeting national expectations for sharing innovation and positive healthcare outcomes. In doing so, RE fosters adaptability, strengthens professionalism and promotes healthy team dynamics. Ultimately Reporting Excellence doesn’t just recognise good work—it actively builds a safer, stronger organisation by investing in its greatest asset: it’s people.

## Statements from the Care Quality Commission (CQC)



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

The Trust is fully compliant with the registration requirements of the CQC. As of 31 March 2025, the Trust had an overall rating of 'Requires Improvement' (RI) from the CQC. This was consistent

with the rating disclosed in the previous Quality Account and reflected the activities undertaken by the CQC during the year 2025/26. The Trust continued engagement with the CQC; this is reported to the Clinical Governance Committee.

Activities involved, but were not limited to, the following.

- The management of 59 new enquiries from, or notifications to, the CQC.
- The notification of changes to the Executive team in accordance with regulatory requirements.
- Regular notifications covering: Deprivation of Liberty Standards (DoLS) applications, section 42 activities, allegations of abuse and IR(ME)R<sup>2</sup> related incidents in accordance with regulatory requirements.
- There was continued maintenance of quarterly engagement meetings with four held during the year. There were three new CQC inspections during 2025/26. These comprised maternity services at the Horton General Hospital, maternity services at the John Radcliffe Hospital and the neonatal services at the John Radcliffe Hospital.
- Commissioned a Trustwide Well-Led gap analysis against the CQC well led key questions by an external provider to support the development of a related action plan .
- Launch of phase 2 Perinatal Improvement Programme Continuing focus on staff wellbeing aligned to OUH People Plan 2025/28, with forums and initiatives to enable staff to discuss concerns and make recommendations for future focus.
- Engagement with national CQC surveys for Children and Young People (published May 25) Adult Inpatients (results published September 25), Maternity Services (results published December 25 ). Findings from surveys have resulted in action plans being produced by the services and will be monitored by the Evidence Review Group, Clinical Governance Committee and Maternity Safety Champions.

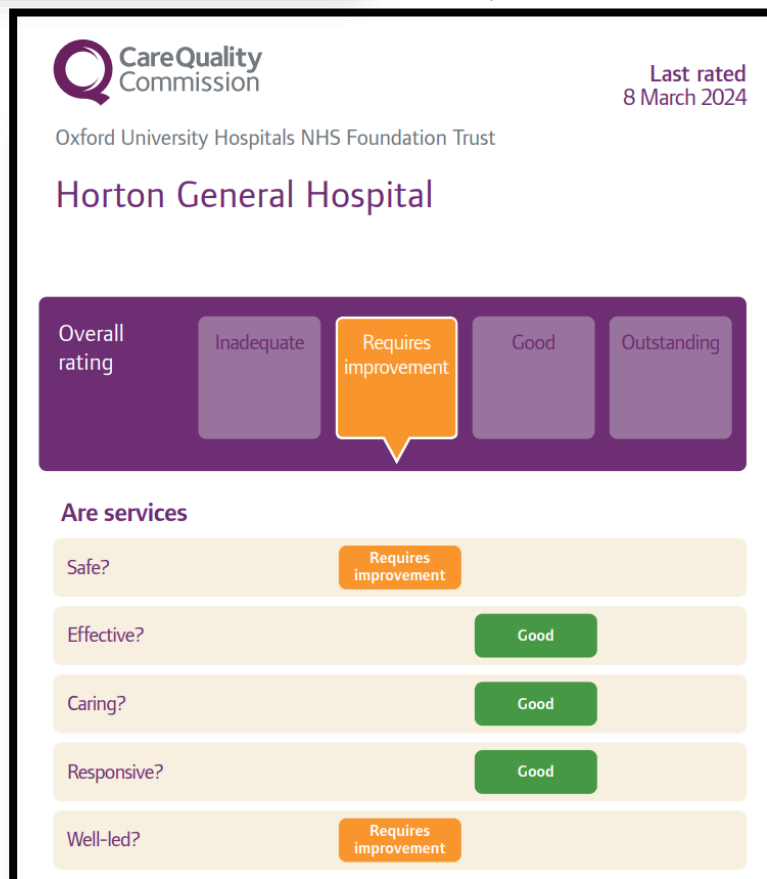
CQC ratings grids as published in the reports of April 2023 and March 2024 can be seen below, these did not change during 2025/26

<sup>2</sup> IR(ME)R - Ionising Radiation (Medical Exposure) Regulations

Figure 2 CQC ratings for John Radcliffe Hospital: last rated April 2023



Figure 3 CQC ratings for Horton General Hospital: last rated March 2024 part 1



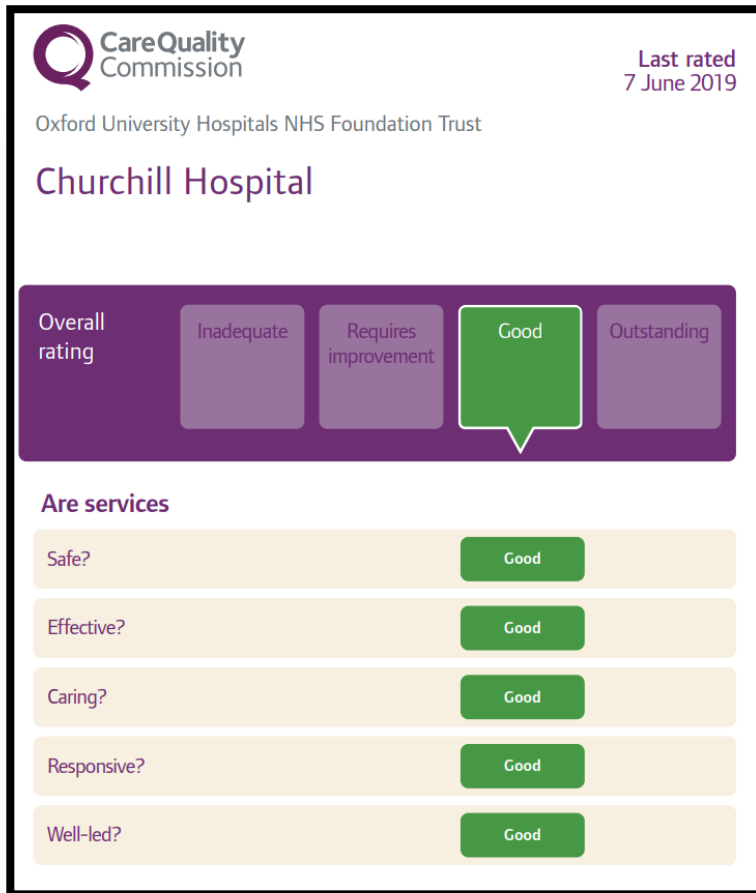
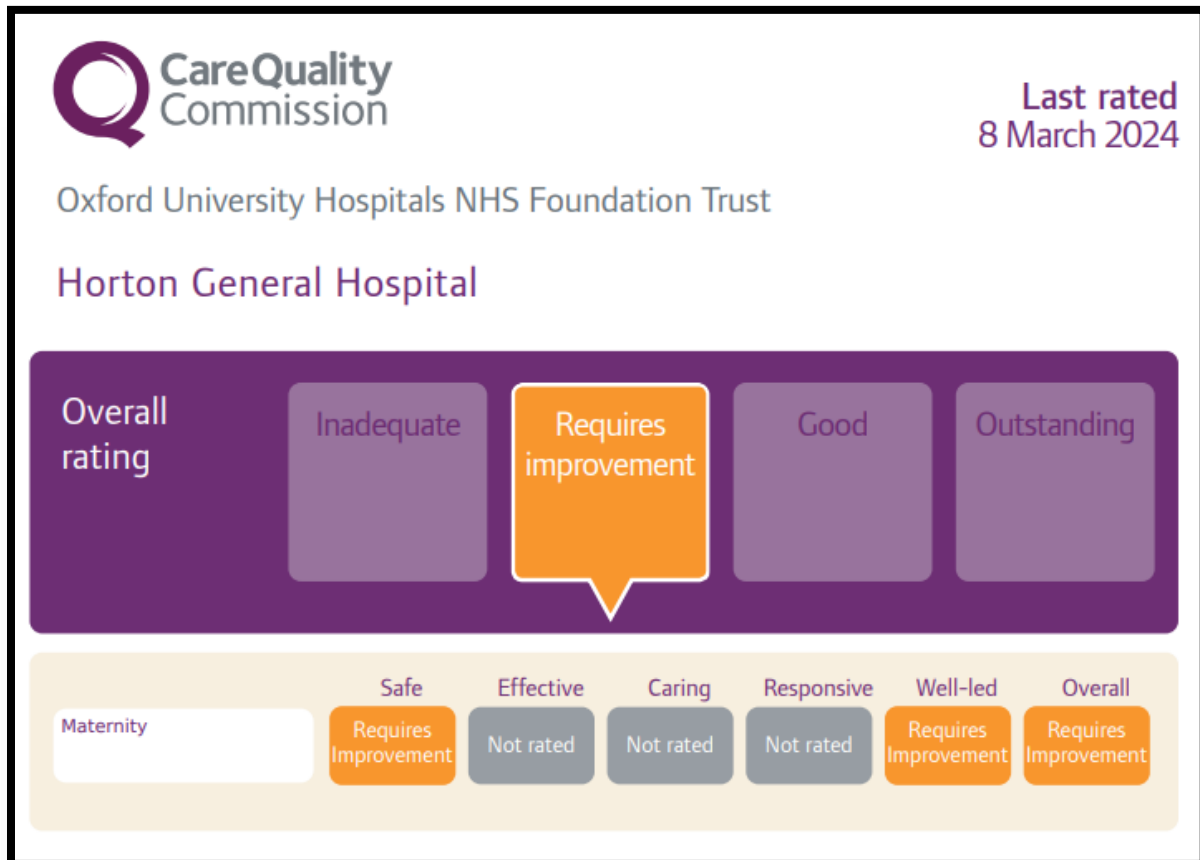


Figure 4 CQC ratings for the Churchill Hospital last rated June 2019



Figure 5 CQC ratings for Nuffield Orthopaedic Centre: last rated June 2019

Figure 6 CQC ratings for Horton General Hospital: last rated March 2024



## Regulation and Reviews (External Reviews)

The accreditation, regulation, quality reviews and national peer review programme provide the Trust and the CQC with a measurable level of assurance regarding the delivery and quality of our services.

### Perfusion Accreditation: College of Clinical Perfusion Scientists

An external accreditation visit of the Perfusion Service was undertaken by the College of Clinical Perfusion Scientists at the John Radcliffe Hospital in April 2025.

Following submission of the factual accuracy response, the final report was received in December 2025 and confirmed accreditation for one year. The report recognised strengths in training, procedural volume and team culture, and identified actions relating to workforce resilience, medicines management and development of a quality management framework.

Progress against actions will be monitored through service and Divisional governance, with a further progress report due to the College in May 2026.

### GIRFT Surgical Hub Accreditation: Orthopaedics

An outpatient hub accreditation review of the Orthopaedic service was undertaken by NHS England through the Getting It Right First Time (GIRFT) programme in April 2025.

Positive feedback was received following the review, including improvements in day case performance and reductions in outpatient follow-up activity, although ongoing theatre staffing challenges were noted. Actions are being progressed through service and Divisional governance to support continued optimisation of the hub model.

### Maternity Insight Visit and Rapid Quality Review

A rapid quality review and an insight visit both focussed on both the maternity and neonatal services was undertaken by NHS England and other key stakeholders in April 2025 as part of routine oversight and assurance arrangements. The visit reviewed service performance, safety and governance, with any feedback and actions progressed through service and Divisional governance processes.

### ISO 45001: Health and Safety Management System

An external re-accreditation audit of the Occupational Health and Safety Management System at the Churchill Hospital, covering non-clinical activities, was undertaken in June 2025 by the Trust's UKAS-accredited certification body.

The service successfully achieved re-accreditation, with certification confirmed through to 2028.

## **Joint Advisory Group on GI Endoscopy (JAG)**

An accreditation visit of the GI Endoscopy service was undertaken by the Joint Advisory Group on GI Endoscopy (JAG) in June 2025.

Positive feedback was received following the visit, and subsequent annual review submissions were completed in line with JAG requirements. Accreditation was renewed, subject to ongoing annual review, with progress and any required improvements monitored through service governance arrangements.

A further annual review took place in January 2026, with actions identified to be completed ahead of the next accreditation milestone. Progress is monitored through service governance arrangements in line with JAG standards.

## **Joint Area Inspection – Special Educational Needs and Disabilities (SEND)**

A joint area inspection of Special Educational Needs and Disabilities (SEND) services was undertaken during June 2025 by Ofsted and the Care Quality Commission (CQC) to assess how local authority and health partners work together to deliver SEND provision.

The inspection focused on partnership working, governance and outcomes for children and young people, with Trust engagement coordinated through Children's Services and safeguarding governance arrangements.

## **Environment Agency, Anti-terrorism Inspection**

An inspection was undertaken by the Environment Agency anti-terrorism team at the Churchill Hospital and the John Radcliffe Hospital in August 2025, to assess compliance with environmental protection, security and control requirements for regulated and hazardous substances. Both sites were found to be well managed, with no non-compliances identified.

A small number of observations and recommendations were noted, none of which required formal follow-up action.

## **National Maternity and Neonatal Investigation**

Oxford University Hospitals was identified as one of 14 NHS Trusts included in the National Maternity and Neonatal Investigation, a nationally commissioned independent review announced by the Secretary of State for Health and Social Care in June 2025.

Baroness Valerie Amos was appointed to chair the investigation in August 2025, with the participating trusts, including OUH, publicly confirmed in September 2025. During 2025 the Trust supported site visits, staff focus groups, interviews and evidence submissions as part of the local review activity.

An overarching national 'Reflections and Initial Impressions' report was published in December 2025. Baroness Amos further published an interim report on 26th February 2026. The report highlighted critical issues of racism, inconsistent care, and lack of transparency

when baby loss occurred. The full report is expected in June 2026. No individual Trust findings have been published at this stage.

### **ISO 9001: Medical Physics and Clinical Engineering (MPCE)**

A surveillance audit of the MPCE Quality Management System against the ISO 9001 standard was undertaken in September 2025 by SGS, the Trust's UKAS-accredited certification body.

The audit reported zero non-conformities and recommended continued certification, confirming that the quality management system remains effective.

### **ISO 13485: Surveillance Audit**

A surveillance audit against the ISO 13485 Quality Management System standard was undertaken in October 2025 by the Trust's UKAS-accredited certification body. The audit confirmed that the quality management system remains effective and recommended continued certification. One minor observation was noted, with no corrective actions required.

### **ISO 15189:2022: UKAS Inspection of Microbiology**

An external inspection of the Microbiology service against the ISO 15189:2022 Medical Laboratory standard was undertaken by the United Kingdom Accreditation Service (UKAS) in October 2025 as part of the routine annual accreditation cycle.

The inspection reviewed compliance with quality management, governance and technical laboratory standards. The outcome of the inspection is awaited from the Division and will be progressed through service and Divisional governance as required.

### **Maternity Services Unannounced CQC Inspection**

An unannounced inspection of the Trust's maternity services was undertaken by the Care Quality Commission (CQC) commencing 7 October 2025, covering the John Radcliffe, Horton and community units. The inspection included site visits, staff interviews and detailed evidence submissions. The draft report has been received by the Trust and the final report is being prepared by the CQC following factual accuracy checks.

### **Microbiology Containment Level 3 HSE Inspection**

A statutory regulatory inspection of the Containment Level 3 (CL3) Microbiology laboratories was undertaken by the Health and Safety Executive (HSE) in October 2025 to assess compliance with legal requirements for work involving hazardous biological agents.

A formal letter dated 30 October 2025 identified areas where minimum legal standards were not fully met and set out advisory, recommended and formal enforcement actions, including an improvement notice.

A formal response with supporting evidence was submitted within the required timeframe, and progress is being monitored through service and Divisional governance pending confirmation from the regulator.

### **OFSTED Regulatory Inspection: Apprenticeships (Education and Training)**

A statutory inspection of the Trust's apprenticeship provision was undertaken by Ofsted in November 2025 under the current education inspection framework.

The review assessed the quality of training, supervision and compliance across apprenticeship programmes delivered across hospital sites. The final report, published on 22 January 2026, confirmed that the Trust met the Expected Standard.

### **Sarcoma National Data Review for NHSE Commissioning**

A national compliance review of the Sarcoma service was undertaken by NHS England Specialised Commissioning during 2025 against the Sarcoma Service Specification.

The Trust submitted the required data returns and supporting evidence across two tranches, including documentation relating to pathways, standard operating procedures and audit activity.

Further information has been requested by NHS England, and additional evidence is being provided to address identified gaps.

Progress continues to be managed through service and Divisional governance pending feedback from the commissioner. The next meeting with NHSE is planned for March 2026.

### **Neonatal Unannounced CQC Inspection**

An unannounced inspection of the Neonatal Service was undertaken by the Care Quality Commission (CQC) as part of its regulatory oversight of maternity and neonatal services. The inspection included on-site review activity and requests for further documentary evidence.

The Trust submitted the requested data and supporting documentation in February 2026 and remains within the inspection process pending receipt of the draft report, which will be subject to factual accuracy review prior to publication.

### **Environmental Agency (EA)**

A planned visit by the Environmental Agency (EA) took place on 3<sup>rd</sup> March 2026 at the Specialist Service In-Patient (SSIP), Fracture Clinic and A&E Majors to review Gypsum disposal and Stoke Unit. Feedback was positive. The team await the final report.

### **Abdominal Aortic Aneurysm (AAA) Quality Review**

A Thames Valley quality assurance visit took place on 5 March 2026. Feedback was positive and constructive, with no immediate concerns or enforcement action identified. Reviewers recognised improvements within the service and the engagement of staff. A small number

of development themes were identified, including documentation, audit arrangements and health inequalities. A draft report is awaited and an action plan will be progressed through service and Divisional governance.

### **Joint Targeted Area OFSTED Inspection (JTAI)**

Led by OFSTED, the JTAI inspection took place in January 2026. JTAI is part of the multi-agency response to children who are victims of child sexual abuse in the family environment (CSAFE). The draft JTAI report has been received. Factual accuracy checks from an OUH Health perspective have been completed and returned via the ICB. The Trust now awaits publication of the final report.

## Data Quality and Information Governance

### Information Governance

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



OUH have taken the following actions to improve data quality and information governance:

- Improved tools to assist in managing Freedom of Information (FOI) and Subject Access Requests are now embedded, giving the Trust the ability to manage requests on a Divisional and department basis. The Trust continues to receive more of both types of requests than in previous years.
- Digitisation of paper records has commenced; which enables access to historical records immediately in a searchable electronic format will significantly improve the availability of records previously stored off site.
- A new Digital Consent platform has been rolled out and provides the Trust with a much improved and easily accessible record of the consent patients have given for treatments and consent for potential use of their data for secondary purposes.
- A review of Trustwide working practices and policies around the adoption of systems that involve AI and Machine Learning has occurred and an AI policy has been adopted. Strong Information Governance and transparency around how the Trust uses these new technologies is vital to giving assurance to staff and patients that their use is appropriate and beneficial to all. Information Governance team work closely with TheHill and digital team to ensure that there is good governance around AI within the Trust.

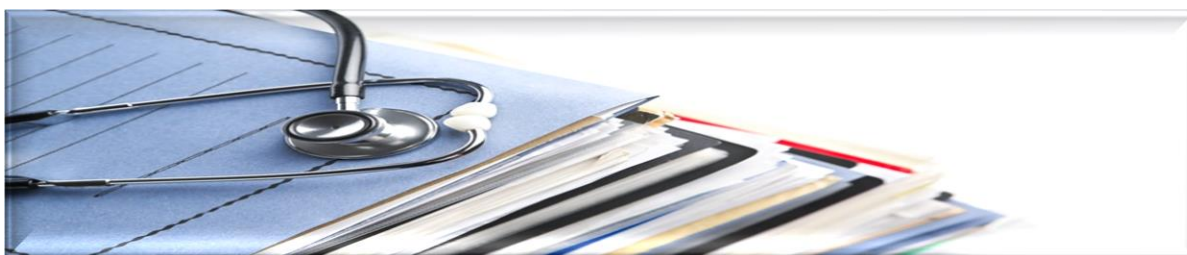
### Data Security and Protection Toolkit (DSPT)

OUH's submission of the Data Security and Protection Toolkit for the most recent reporting period of 2024/25 reported an overall assessment of 'Standards Met', which was agreed by NHSE. This provides significant assurance to other parties who may wish to share data with us.

As part of the annual DSPT cycle the Trust undergoes an external audit; this was completed in February and March 2026. The Trust was given 'High assurance' for the quality of its

responses and was given an overall 'low' risk score. This is the best result that can be achieved under the assessment framework.

The final submission for the current toolkit will be on 30 June 2026 and the Trust is expecting to achieve 'standards met'.



## Records submission

OUH submitted records during 2025/26 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

### SUS dashboards month 11 2025/26

Table 17 shows the information by inpatients, outpatients and ED demonstrating OUH compliance compared to the national average.

*Table 17 [YTD as at month 11 (February 2026) results.]*

<b>Inpatients</b>	<b>OUH</b>	<b>National Average</b>
Valid NHS number	99.5%	99.7%
General Medical Practice Code	100%	99.8%
<b>Outpatients</b>	<b>OUH</b>	<b>National Average</b>
Valid NHS number	99.9%	99.8%
General Medical Practice Code	100%	99.6%
<b>ED (type 01 only)</b>	<b>OUH</b>	<b>National Average</b>
Valid NHS number	98.8%	99.0%
General Medical Practice Code	100%	99.7%

## Clinical Coding Data Quality

Clinical engagement is an important part of this process. Coding and Clinical staff are involved in but not limited to the following workstreams.

- Clinical Coding Audit Programme.
- Analysis of Coded data to support improvement and clinical collaboration.
- Data validation with clinical colleagues to improve data quality and patient care.
- Assurance of coded data affecting the NHS Payment Scheme (formerly Payment by Results).
- Participation in all aspects of clinical coding within the national GIRFT project.
- Improvements in clinical coding training.

- Participation in the Mortality Reporting process.

These workstreams demonstrate the Trust's commitment to the collection, analysis and reporting of high quality clinically coded data.

## Learning from Deaths

During 2025/26, 2,661 people died in OUH. . Table 18 shows the number of case record reviews by quarter and the number of deaths judged more likely than not to have been due to problems in care.

The National Quality Board (2017) state that ‘Acute Trusts should use an evidence-based methodology for reviewing the quality of care provided to those patients who die’.

All deaths are subject to a case record review to identify any care quality concerns or other learning. Approximately half of deaths are also subject to an even more detailed case record review, including Level 2 comprehensive mortality reviews (an OUH initiative) or structured judgement reviews (SJRs, a national requirement). Cases for more detailed review include those where a concern has been identified, deaths in certain clinical areas, and cases chosen at random to quality assure the process.

*Table 18 Number of case record reviews by quarter and no. of deaths judged more likely than not to have been due to problems in care*

	Quarter 4 2024/25	Quarter 1 2025/26	Quarter 2 2025/26	Quarter 3 2025/26	Quarter 4 2025/26
Inpatient deaths	724	634	618	701	708
Number of case records reviewed (No./%)	287 (100%)	266 (100%)	278 (100%)	333 (100%)	<i>This Will be published in the 2026/27 Quality Account</i>
Number of deaths judged more likely than not to have been due to problems in care	0	1	1	0	

A total of 877 detailed case record reviews were carried out in relation to 1,953 deaths that occurred to the end of Q3 2025/26. Two avoidable deaths were identified in this period. (Further explanation of these are found in the summary of learning and impact of actions from mortality reviews section below)

In Quarter 4 2024/25, 287 case records were reviewed in relation to 724 inpatient deaths. No avoidable deaths were identified. These numbers have been compiled using the quarterly Divisional mortality reports submitted to the Trust Mortality Review Group.

The reviews of deaths which occurred during the fourth quarter of 2025/2026 are underway and the summary will be included in the Quality Account for 2026/27.

## **Summary of the learning and impact of actions from mortality reviews (from Q4 2024/25 and Q1-3 2025/26)**

### **Avoidable death -venous thromboembolism (VTE)**

A death in August 2025 was confirmed as avoidable by the Mortality Review Group (MRG), highlighting critical learning around the need to complete timely VTE risk assessment and administer VTE prophylaxis. The patient experienced missed opportunities for assessment and timely administration of preventative treatment during admission, ultimately resulting in a fatal pulmonary embolism following discharge.

The Coroner issued a narrative verdict noting that the delay in the risk assessment increased the risk of the development of the DVT and subsequent pulmonary embolus. While it was not possible to definitively determine whether earlier intervention would have prevented death, available evidence shows that appropriate VTE prevention significantly reduces risk. In response, actions have been implemented to strengthen the reliability of VTE assessment and prescribing processes, with a clear focus on ensuring consistent, timely risk assessment and delivery of prophylaxis as a core patient safety requirement across clinical teams. VTE risk assessment is also a Quality Priority for 2026/27. [Further information can be found in the VTE section below](#)

### **Avoidable death – suction rectal biopsy**

An avoidable neonatal death was identified following review by MRG. The neonate underwent a suction rectal biopsy and was discharged home on the same day but deteriorated and died the following day from sepsis due to *E. coli* bacteraemia. Key learning highlighted the importance of robust governance for invasive procedures, including ensuring clear and documented parental consent, having established clinical guidelines, administration of appropriate pre-procedure antibiotic prophylaxis, and providing structured post-procedure monitoring and safety-netting. The case also identified the need for improved multidisciplinary communication and review of discharge decisions following procedures.

Actions have focused on standardising clinical pathways and consent processes, strengthening post-procedure care and communication across teams, and improving parental information and safety-netting to support earlier recognition of deterioration. This case was subject to a Coroner's inquest and a Patient Safety Incident Investigation.

### **Electrocardiograms (ECGs)**

A small number of cases that were reviewed by the Mortality Review Group (MRG) highlighted critical learning relating to the recognition and escalation of abnormal ECG findings. Several factors contributed to a reduced awareness of an abnormal ECG. These included pathway design limitations (lack of real-time ECG review), atypical symptom presentation, and absence of timely escalation processes. In response, the Trust has

implemented a standardised ECG escalation algorithm, ensuring immediate review of abnormal results and prompt senior clinical input. This learning emphasises the need for robust diagnostic review systems and reliable escalation processes within elective and urgent care pathways to reduce the risk of similar events recurring.

There have been no reported incidents relating to ECGs since implementation of these standards.

### **Telemetry**

At the Horton General Hospital telemetry failures meant that staff could not reliably detect/document arrhythmias; consequently, these episodes were not escalated. New telemetry devices have been procured, and this issue has been resolved.

### **Venous Thromboembolism (VTE)**

Multiple mortality reviews in Neurosciences have highlighted the need for improved clarity and consistency in documentation of VTE risk assessment and prescribing practices for low molecular weight heparin. To address this, a mandatory field has been added to ward round proformas, which is completed daily. Regular audits are conducted to monitor compliance with an end of year compliance of 95.14 %. Outcomes are reported as part of Divisional quality reports to CGC meetings. VTE risk assessment is also a Quality Priority for 2026/27.

[Further information can be found in the VTE section below](#)

### **End of Life Care**

Families may be unaware of the reasons behind repositioning of family members during End of Life care. To improve the understanding of this aspect of care and alleviate concerns, a patient information leaflet has been developed to address this topic.

### **Controlled Drugs (CD)**

It was found that there were delays in administering pain relief medications on the Trauma Ward because some medications were not available on the ward. A ward pharmacist will work with staff to review controlled drug stock lists and ensure that these drugs are part of Ward CD stock which will reduce time to administration and improve availability of medicines. To further improve safety, a Medicines Safety representative will attend monthly Mortality Review Group meetings (starting in April 2026), to review cases where medication has affected patient care and ensure that the learning is translated into improvement on the ward.

### **Surgical Emergencies**

MRG discussions identified learning across both oncology and surgical pathways. MRG reviews identified variation in escalation to senior clinical oversight, particularly in patients with multiple comorbidities and complex presentations.

Learning from these cases has focused on strengthening multidisciplinary decision-making, improving reliability of treatment pathways, and ensuring timely senior review and escalation, alongside reinforcing adherence to clinical protocols and documentation

standards. Overall, the discussions emphasise the need for robust, consistent processes across both oncology and surgical services to manage risk effectively in complex patient groups and support safe, high-quality care delivery. [A Quality Priority for 2026/27](#) will also address the deteriorating patient.

Further incidents of this nature have not been highlighted in MRG to date.

### **Coding of palliative care admissions**

MRG discussions identified coding accuracy as a governance issue. Specific concerns were raised regarding the coding of palliative care admissions, including alignment of critical care data and classification standards, which had implications for mortality reporting and benchmarking. Work has been undertaken with clinical coding teams to clarify definitions and improve consistency in how palliative care activity is recorded, including in critical care settings. More broadly, MRG emphasised the importance of accurate clinical coding to ensure reliability of mortality indicators, appropriate case-mix adjustment, and meaningful interpretation of outcomes, alongside improving documentation quality to support coding accuracy.

This learning highlights the need for continued collaboration between clinical teams and coders, robust documentation, and strengthened governance oversight to ensure data accuracy and support effective mortality surveillance and improvement.

The quarterly and annual Learning from Deaths reports are presented to the Trust Board and are available online at [ouh.nhs.uk/about/trust-board/meetings-and-papers](https://ouh.nhs.uk/about/trust-board/meetings-and-papers)

## Summary Hospital-level Mortality Indicator (SHMI)

The Summary Hospital-level Mortality Indicator (SHMI) is the preferred hospital mortality indicator adopted by NHS England. The SHMI is the ratio between the reported number of patient deaths during admission or within 30 days of their discharge, against the expected number of deaths based upon the characteristics of the patients treated.

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

- The Trust has a process in place for collating data on hospital admissions, from which the SHMI is derived.
- Data are collected internally and then submitted monthly to NHSE via the Secondary Uses Service (SUS). The SHMI is then calculated by NHSE.
- Data are compared to the national benchmark, and the Trust's own previous performance, as set out in Table 19.
- The Trust reviews the SHMI in conjunction with other published mortality measures and the information from its internal review of deaths.

The SHMI, published on 12 March 2026, for the data period October 2024 to September 2025, is 0.89 (CL 0.85-1.17). This value is banded 'as expected'. The SHMI continues to compare favourably with national mortality benchmarks.

## Care at the End of Life (EOL)

- During 2025/26 2405 adults over 18 years of age died in OUH. Providing care at the end of a person's life is an important part of the provision of healthcare. Work this year to improve care at the End of Life has included the following.
- An End of-Life Lead funded by Sobell House Hospice Charity leads the Trust's EOL improvement work. Sobell House Hospice Charity has also funded a Band 8 nurse for the EOL team, and an administrator post yet to be filled.
- The EOL group reports to the Mortality Review Group.
- The National Audit of Care at the End of Life (NACEL) 2025 identified that training is needed for OUH staff who provide care at the End of Life, with a particular focus on recognising dying and discussing the management of hydration and nutrition for dying patients.
- End of Life care e-Learning courses are now available for staff via My Learning Hub but await agreement for mandatory status.
- Tissue donations from OUH patients are now uniformly managed by the National Referral Centre (NHSBT) pathway. The hospice eye donation project in collaboration

with NHSBT is underway with the support of Sobell House and Katherine House charities.

The EOL team have supported implementation, training and audit of ReSPECT since March 2025. Benchmarking of palliative and End of Life care in the Trust against the recommendations of the NCEPOD report Planning for the End has identified the following areas for further improvement:

- Recording and sharing advanced care planning (ACP) discussions
- Opportunities to increase timely ACP conversations
- Opportunities to improve understanding of palliative and end-of-life care

## Reporting against core indicators

Table 19 Reporting against core indicators

Indicator	Measure/Target	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source
Summary Hospital-level Mortality Indicator (SHMI)									
Ratio of observed mortality as a proportion of expected mortality	<1	Oct 2024-Sept 2025	0.89 (CL 0.85-1.17 as expected )	Jan 2024 - Dec 2024	0.91 CL <sup>3</sup> 0.88-1.14 (as expected, ) <sup>4</sup>	1.32	0.72	1.00	NHSE
Percentage of deaths which were coded as palliative deaths	NA	Oct 2024-Sept 2025	52.02%	Jan 2024 - Dec 2024	51.95%	-	-	42%	NHSE
Patient data of incidents, VTE and readmissions									
The number and percentage of patient safety incidents that resulted in severe harm or death	No. (% of all patient incidents)	FY 2025/26	86 (0.3%)	FY 2024/25	104 (0.34%)	-	-	-	OUH Ulysses
The percentage of patients who were admitted to hospital and who were risk	95%	FY 2025/26	95.14%	FY 2024/25	Q1-3 (24 hrs) 98% Q4 (14 hrs) 95%	-	-	-	ORBIT

<sup>3</sup> CL - Confidence limit

<sup>4</sup> SHMI data categorised as 'lower than expected', 'as expected', or 'higher than expected'

Indicator	Measure/ Target	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source
assessed for Venous Thromboembolism during the reporting period									
Percentage of patients readmitted within 28 days of discharge Age 0-15 yrs	Readmissions data (%)	Oct 2024- Nov 2025	11.3%	Nov 2023- Oct 2024	11.8%	21.1%	4.1%	-	Dr Foster
Percentage of patients readmitted within 28 days of discharge Over 16 yrs	Readmissions data (%)	Oct 2024- Nov 2025	10.7%	Nov 2023- October 2024	10.7%	13.6%	3.8%	-	Dr Foster
CQC inpatient Survey Results									
<i>To what extent did staff looking after you involve you in decisions about your care and treatment?</i>	Score out of 10 Trustwide	2024	7.4	2023	7.2	8.5	6.3		CQC Inpatient Survey 2024
<i>Did you find someone on the hospital staff to talk to about your worries and fears?</i>	Score out of 10 Trustwide	2024	7.9	2023	7.9	9.2	6.6	7.7	CQC Inpatient Survey 20243
<i>Thinking about any medication you</i>	Score out of 10 Trustwide	2024	5.1	2023	5.0	6.0	3.5	4.5	CQC Inpatient

Indicator	Measure/ Target	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source
<i>were to take home, were you given any of the following?</i>									Survey 20243
<i>Did hospital tell you whom to contact if you were worried about your condition or treatment after you left hospital?</i>	Score out of 10 Trustwide	2024	8.0	2023	8.4	9.6	5.	7.65	CQC Inpatient Survey 20243
<i>Staff employed by, or under contract to the Trust who would recommend the Trust as a provider of care to their family or friends</i>	% of staff	2024	74.35%	2023	74.84%	-	-	61.74%	NHS National Staff Survey 2024



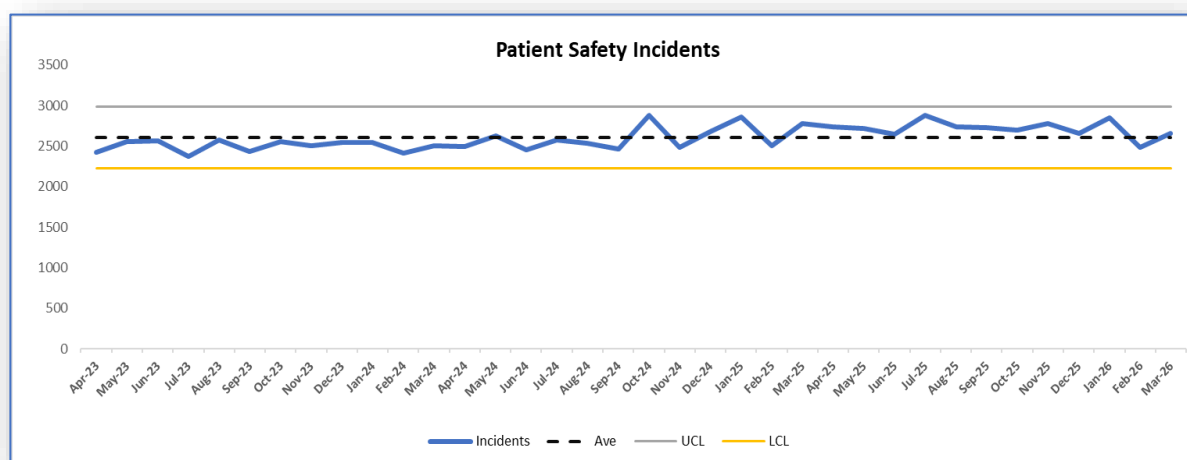
## Safety Incidents and Learning Responses

OUH is now in its second complete year since the implementation of the Patient Safety Incident Framework (PSIRF).

It is crucial that we learn from every incident and near miss that happens, to

address concerns and continually learn. OUH actively encourages staff to report clinical incidents and near misses so that lessons can be learned in order to improve care. Measures used by NHS England and others to indicate a positive ‘safety culture’ within an organisation include the rate of incident reporting (the higher the better) and the proportion with significant patient harm (the lower the better). Graph 2 below shows the number of patient incidents reported per month by OUH since April 2023, demonstrating a sustained increase over that time. This has been driven by an increase in reporting of incidents of mild harm or no harm. Importantly, the number of incidents of moderate harm or above has not increased, suggesting the overall increase is driven by improved reporting rather than a true increase in incidents.

Graph 2 Number of patient safety incidents reported per month by OUH since April 2023 to March 2026



Trusts across England upload data relating to patient incidents reported locally to LFPSE (formerly NRLS) to allow NHS England to view incidents and to identify trends at a national level.

In addition to the review of all incidents by senior staff in each department, all incidents reported with moderate or above impact are reviewed each working day in a Patient Safety Response meeting, to confirm what immediate steps need to be taken or what information is required to be collected, as well as identifying whether any extra support is required for the staff involved.

In 2025/26 our staff reported

- 32,560 patient safety incidents,
- 31,063 (95.4%) resulting in no harm or minor harm,
- 1,411 (4.3%) resulting in moderate harm,
- 41 (0.1%) resulting in major harm,
- 45 (0.1%) with an impact of death (the management of deaths in the Trust is discussed above).

All impact gradings are confirmed through the Trust's incident management process and follow the LFPSE guidance.

The number of patient safety incidents has increased by 1437 since 2024/25. This demonstrates a positive reporting culture within the Trust. The percentage of incidents that were categorised as moderate harm, severe harm and death reduced from 5% to 4.5% indicating that fewer patient safety incidents resulted in higher levels of harm. All incidents are reviewed by the local manager to identify any potential learning. All moderate and above harm incidents are reviewed every working day by a team that includes senior Medical, Nursing and governance staff to identify immediate areas for investigation and support for staff.

The PSIRF framework provides for different learning responses to be undertaken including focused After Action Reviews, learning MDT meetings and Patient Safety Incident Investigations (PSII). Learning from these responses is shared by Divisions and subject matter experts at the Trust wide weekly Safety Learning and Improvement Conversation meeting. Key thematic patient safety initiatives are also presented, and the learning is shared in a summary slide across the Trust.

### **Patient Safety Incident Investigations (PSIIs)**

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

During 2025/26 a set of 26 quantitative metrics were agreed to assess the effectiveness of PSIRF within the Trust. These metrics cover the 4 pillars of PSIRF:

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

These metrics will be reported, monitored and refined as necessary in 2026/27, overseen by the PSIRF Improvement Group.

In-house training continues for staff who wish to conduct an After Action Review (AAR). In addition, in 2025/26 Q4, training for Learning Multidisciplinary Review (LMDTR) conductors and those delivering the systems analyst role in PSIs was delivered through OxSTaR to 19 staff across all 5 Divisions.

All learning responses are reviewed to ensure high quality investigations and improvement plans:

- AARs and Rapid Reviews are reviewed by the Deputy CMO and Head of Clinical Governance, with discussion at the Trust Safety Learning and Improvement Conversation (SLIC) if required
- LMDTRs are reviewed at SLIC. Comments are incorporated into the review which is subsequently signed off by Deputy CMO
- PSIs are reviewed by a panel of experts and stakeholders, and ultimately signed off by CNO and/or CMO

On completion, selected actions from LMDTRs and PSIs are discussed at SLIC which demonstrate a closing-the-loop assessment of the actions' impact on safety, efficiency, or culture.

In 2025/26, 22 non-thematic PSIs were confirmed.

The three thematic PSI topics for 2025/26 were as follows.

1. Safety and timely discharges with medications.
2. Escalation of deteriorating patients.
3. Positive Patient Identification (PPID).

Each Thematic PSII working group has a lead and regular updates and shared learning are presented at the Safety Learning and Improvement Conversation (SLIC) meeting. These 3 workstreams continue into 2026/27.

## Never Events

Graph 3 below shows that the Trust reported seven Never Events in 2025/26, compared to two last year. Details of these Never Events is summarised in Table 20. Never Events are defined by [criteria published by NHS England](#) and all Never Events were investigated as PSII. These PSII reports were presented to the CEO following sign off to summarise the investigation findings and recommendations and to update the progress against the improvement plan.

Graph 3 Never Events confirmed per year

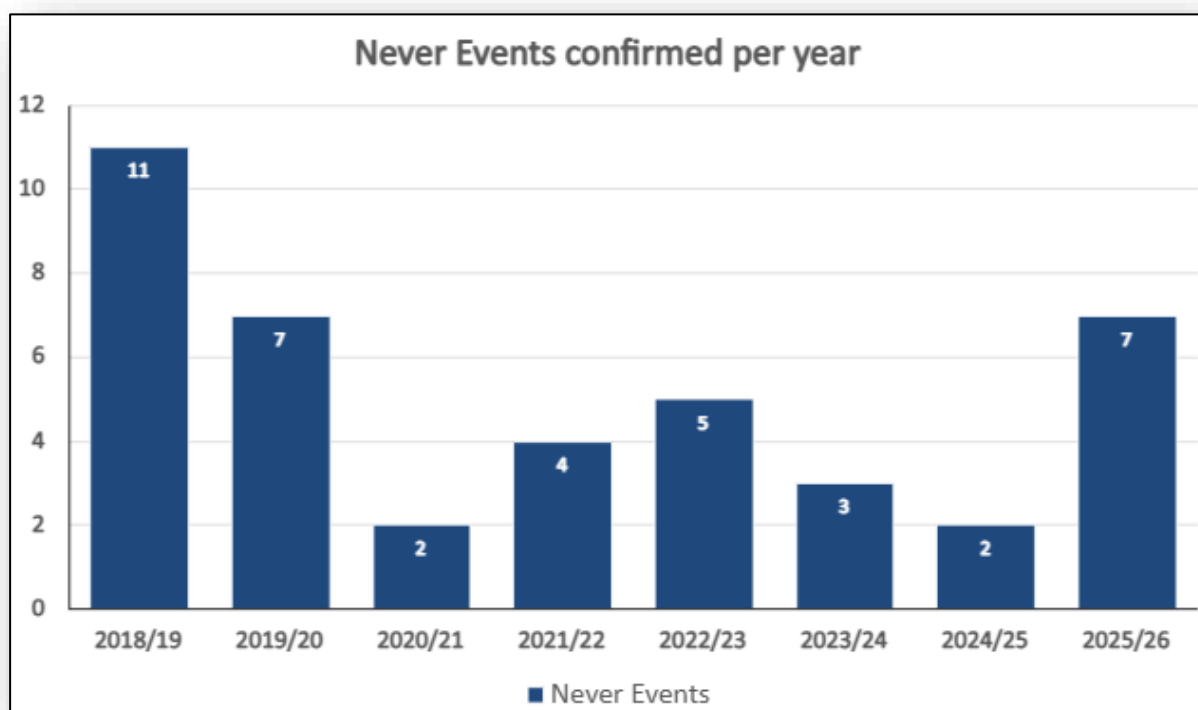


Table 20 Summary of Never Events 2025/26

STEIS number	Service	Type of event	Level of Harm	Response
2526-015	Ophthalmology	Wrong site injection	No harm	Ophthalmology Quality Group has been formed to address safety concerns. Actions include strengthening of departmental processes regarding WHO checklist and marking of sites.
2526-017	Ophthalmology	Wrong site laser	No harm	
2526-019	Ophthalmology	Retained corneal guard	No harm	
2526-021	Colposcopy	Retained swab	Moderate	Local Safety Standards for Invasive Procedures have been updated with clarity of roles and mirroring of processes used in theatres
2526-010	Maternity	Retained swab	Moderate	
2526-013	Anaesthetics	Wrong site anaesthetic block	Minor	The move to digital processes inadvertently impacted the 'Stop before you block process'. This has now been updated to better incorporate the digital processes. A standardised block tray has been developed with an embedded 'Stop before you block' process.
2526-009	Anaesthetics	Wrong site anaesthetic block	Minor	

# Venous thromboembolism (VTE) Prevention and Anticoagulation Safety

## VTE Prevention

Highlights of the new work the VTE Prevention and Anticoagulation teams have conducted in 2025/26 include the following.

### VTE Risk Assessment (VTE-RA) and the new Performance Indicator

The venous thromboembolism risk assessment (VTE-RA) figures for OUH have been excellent and consistently above the national target of 95% for many years.

In January 2025, NHS England changed the parameters for the national target for VTE-RA, from completion of a VTE RA within 24 hours to 14 hours of hospital admission.

The VTE prevention team has been supporting clinical teams to ensure compliance with the new indicator. Performance against the new metric has been above the national target of 95% since November 2025. Ongoing improvement work is overseen by the Medicines Safety Group and supported by the Trust's VTE Quality Priority for 2026/27.

### Lower Limb Immobilisation VTE Risk Assessment (VTE-RA)

Work is ongoing to introduce the TRiP<sup>5</sup> (cast) Tool for patients with Lower Limb Immobilisation. The TRiP (cast) Tool is a validated tool for lower limb immobilisation and trauma.

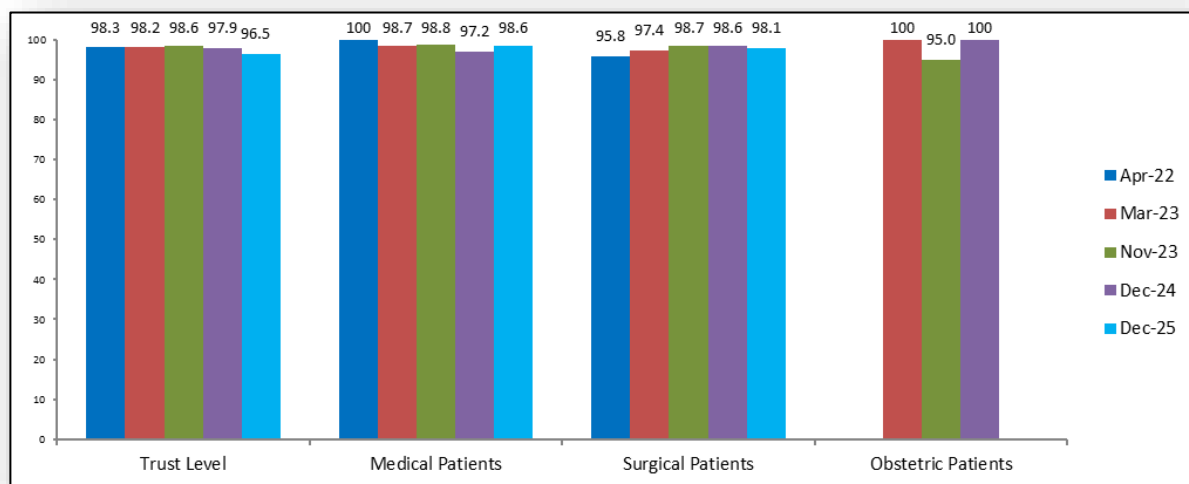
The research team for urgent and emergency care are currently using the TRiP (cast) Tool as part of the TILLi Trial evaluating the effectiveness and cost effectiveness of different methods of prophylaxis for patients with temporary lower limb immobilisation.

### Trustwide Audit of Appropriate Thromboprophylaxis (TP)

The audit was performed across all Divisions and evaluated whether a patient was prescribed and receiving appropriate TP. The audit demonstrated sustained high performance with 98.4% of patients receiving appropriate TP.

<sup>5</sup> [TRiP \(cast\)](#) stands for 'Thrombosis Risk Prediction for Patients with Cast Immobilisation' and is a score used to predict the risk of venous thromboembolism (VTE) in patients with lower limb trauma requiring immobilisation.

Graph 4 Comparison between, April 2022, March 2023, November 2023, December 2024 and December 2025 (No Obstetric patients included in Apr-22 and Dec-25) Trust wide audit of appropriate thromboprophylaxis



## Trustwide transition from dalteparin (Fragmin) to enoxaparin (Inhixa)

The VTE team successfully led the Trustwide transition from dalteparin (Fragmin) to enoxaparin (Inhixa) for VTE prevention in January 2026. This change brings the Trust in line with national practice, enhancing supply resilience and generating a significant cost saving to the Trust, allowing the savings to be reinvested to support high-quality patient care.

## Training and Education

Staff training modules have been updated to support the Trustwide switch from dalteparin to inhixa and training compliance continues to be monitored.

The VTE prevention team continue to provide education and training for the preceptorship training programme, health care support workers course, post graduate advanced perioperative care course, drs induction training, specific clinical areas as requested and training on mechanical TP. The VTE prevention and anticoagulation teams have also worked in collaboration with Thrombosis UK to develop and launch a national UK patient information VTE application(app) offering information to those at risk of VTE and those diagnosed with a VTE event. The app was launched in the Houses of Parliament at the VTE Awards in November 2023. The OUH VTE team was “Winner” of the Outstanding Patient Resource category at the 2025 VTE Awards for their work in sharing information about VTE prevention for patients.

## Research

The thrombosis research team has been collaborating with the NIHR trial examining the benefit of graduated compression stockings in the prevention of VTE in low-risk surgical patients. The Trust was the second highest recruiter to the large multicentre national PETS Trial.

## Deep Vein Thrombosis (DVT) Clinic and Outpatient Anticoagulation Service

### New DVT diagnostic pathway:

In April 2025, Oxfordshire DVT service introduced a new DVT diagnostic pathway based on recent published research from Canada. The new pathway has helped ensure timelier DVT investigations and improved compliance with national guidelines.

### Oxfordshire Warfarin POC service:

The Oxfordshire Warfarin Point Of Care (POC) service has three elements:

- i. **Home visit service:** The anticoagulation service continues to provide a point-of-care (POC) home visit service for patients who are housebound, difficult to bleed, or unsuitable for anticoagulants other than vitamin K antagonists. This service, which began during the COVID pandemic, has been highly successful in supporting a growing number of complex patients and has therefore been maintained.  
As a recent development, we have now trained the community phlebotomy team based in central Oxford. This enables them to see and support patients as part of the home visit service, further expanding our capacity to deliver safe and effective anticoagulation care to patients in the community.
- ii. **District nurse liaison project:** The District Nurse Liaison Project remains ongoing and continues to make progress in supporting patients to self-test their INR at home. To date, 17 patients have been successfully signed off and are now self-testing their INR. In addition, another 17 patients are currently in the process of being set up for self-testing. However, progress with this group has been slower than anticipated due to capacity constraints within the district nursing team.  
We will continue to monitor progress and explore opportunities to improve onboarding of patients.
- iii. **Charitable funds project:** The anticoagulation service was successful in obtaining funding from the charitable funds team for 50 coaguchek POC devices which can be given to patients who are otherwise unable to fund their own machines. The service is allocating these machines based on need and eligibility, are providing training and ongoing device support and calibration, and are following up the patients to measure and collect impact data.

### Time in therapeutic range

#### Improving Time in therapeutic range (TTR) for patients on dialysis project:

The anticoagulation team manages warfarin dosing for patients across Oxfordshire, with most testing done in the community. A small group of patients, however, have their INR tests performed during dialysis at three county units. This process required daily manual checks for results and frequent communication with dialysis staff about testing schedules, often leading to missed or delayed testing. Additionally, it was difficult to obtain timely updates on patient health or medication changes, impacting INR control for this complex group.

To address these challenges, we began a project at the Horton unit at the Horton General Hospital in collaboration with the lead nurse. We introduced a system where patients brought their therapy records for each blood test and dose instructions, which they complete and the dialysis team to submit with their blood sample. Dialysis staff now also been supplied with blank therapy record forms available if needed. This change streamlines communication supports safe and efficient dosing, and helps improve patient's compliance thus improving their TTR.

#### **Improving Time in therapeutic range (TTR) for dialysis patients:**

The anticoagulation team faced challenges managing warfarin dosing for patients having their INR tested during dialysis, due to manual result checks and communication issues. To resolve this, a new process at Horton General Hospital was introduced, requiring patients to bring therapy records for each test, which are completed and submitted with their blood sample. This has streamlined communication, improved safety and dosing efficiency, and enhanced patient compliance and TTR.

## Infection Prevention and Control

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

- OUH has a process in place for collating data on organisms subject to mandatory reporting (*Clostridioides difficile* (C. difficile) infections and *Methicillin resistant Staphylococcus aureus* (MRSA), *Methicillin sensitive Staphylococcus aureus* (MSSA), *Escherichia coli* (E. coli), *Klebsiella* species and *Pseudomonas aeruginosa* bacteraemia cases).
- Data is collated internally and submitted daily to the UK Health Security Agency (UKHSA).

Each year NHS England assigns the Trust a threshold for healthcare-associated C. difficile infection cases, and for E. coli, *Klebsiella* species and *Pseudomonas aeruginosa* bacteraemia cases. There is no threshold for MSSA, and there remains zero tolerance for MRSA.

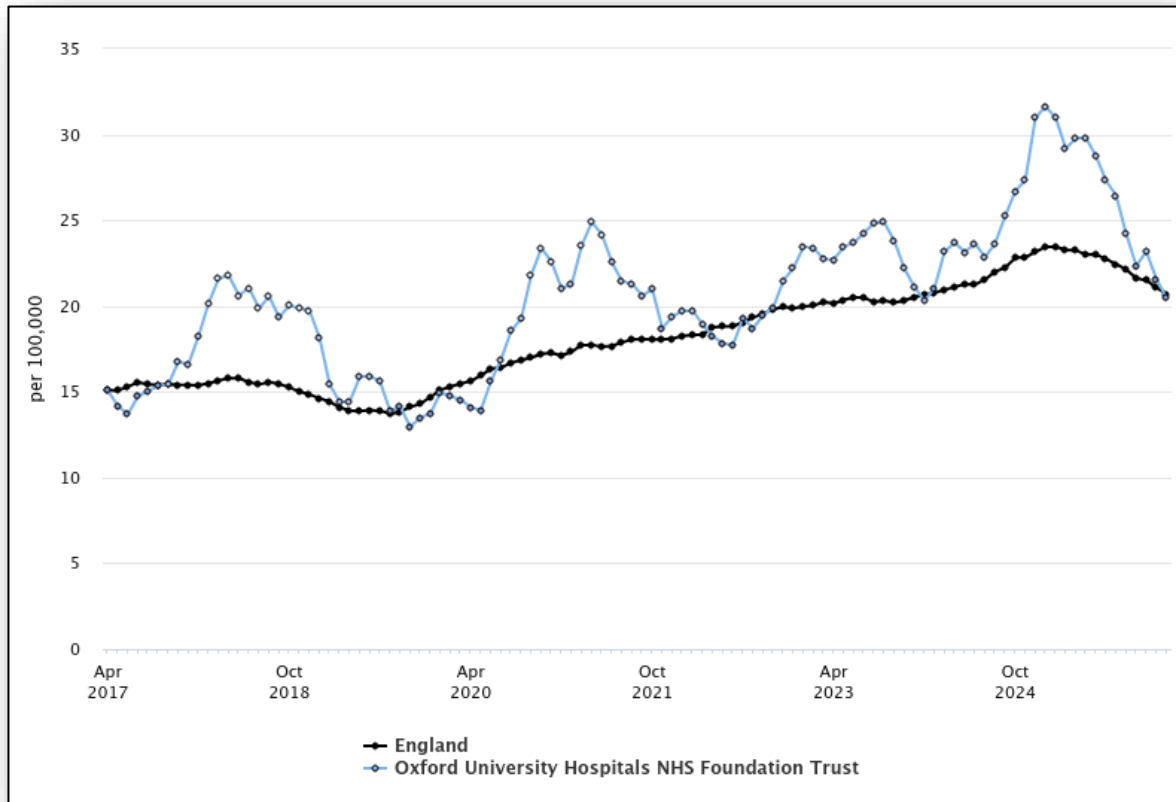
Table 21 Number of IPC cases in 2025/26 compared with 2024/25

Indicator	Target	2025/26	2024/25	2025/26 compared to 2024/25
<i>Methicillin-resistant Staphylococcus Aureus</i> (MRSA) bacteraemia cases	0	6	9	Decrease of 3 cases (improvement)
<i>Clostridioides difficile</i> infection (C. difficile) cases	123	109	164	Decrease of 55 cases (improvement) Target met
<i>Escherichia coli</i> (E. coli) bacteraemia cases	165	220	220	No change
<i>Pseudomonas aeruginosa</i> bacteraemia cases	59	46	63	Decrease of 17 cases (improvement) Target met
<i>Klebsiella</i> species bacteraemia cases	89	86	102	Decrease of 16 cases (improvement) Target met
<i>Methicillin-sensitive Staphylococcus Aureus</i> (MSSA) bacteraemia cases	n/a	75	66	Increase of 9 cases (deterioration)

## Clostridioides difficile (*C. difficile*)

The threshold for OUH-apportioned cases of *C. difficile* for 2025/26 was set by NHSE at 123 cases. At the end of March 2025/26 the Trust is reporting 109 cases, an improvement of 55 cases, and 14 cases below NHS trajectory

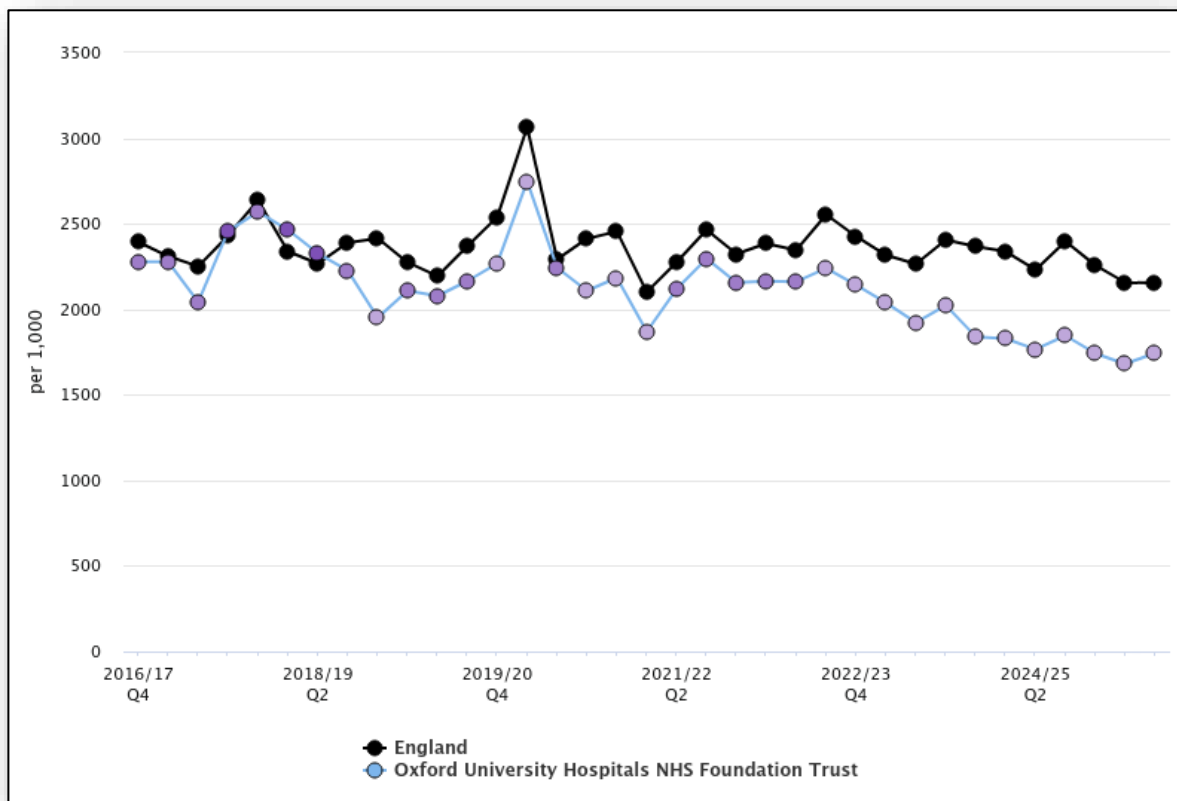
Graph 5 *C. difficile* infection 12-month rolling case counts and rates of hospital onset April 2017 to December 2024



The reduction in *C. difficile* follows the successful work of the antimicrobial stewardship team and the Trust in reducing antibiotic use in general, and certain antibiotics in particular as one of the major modifiable risk factors for *C. difficile*, in line with the National Standard Contract.

OUH 2025/26 prescribing data shows a continued reduction in overall antibiotic use, and in the use of particular antibiotics predisposing to *C. difficile*, including a reduction in 'watch and reserve' antibiotics as per the National Standard Contract and in comparison, with other English Trusts.

Graph 6 Antibiotic prescribing from the 'Watch' and 'Reserve' categories of the nationally adapted WHO AWaRe index; DDDs per 1000 \*



## Gram negative bloodstream infections

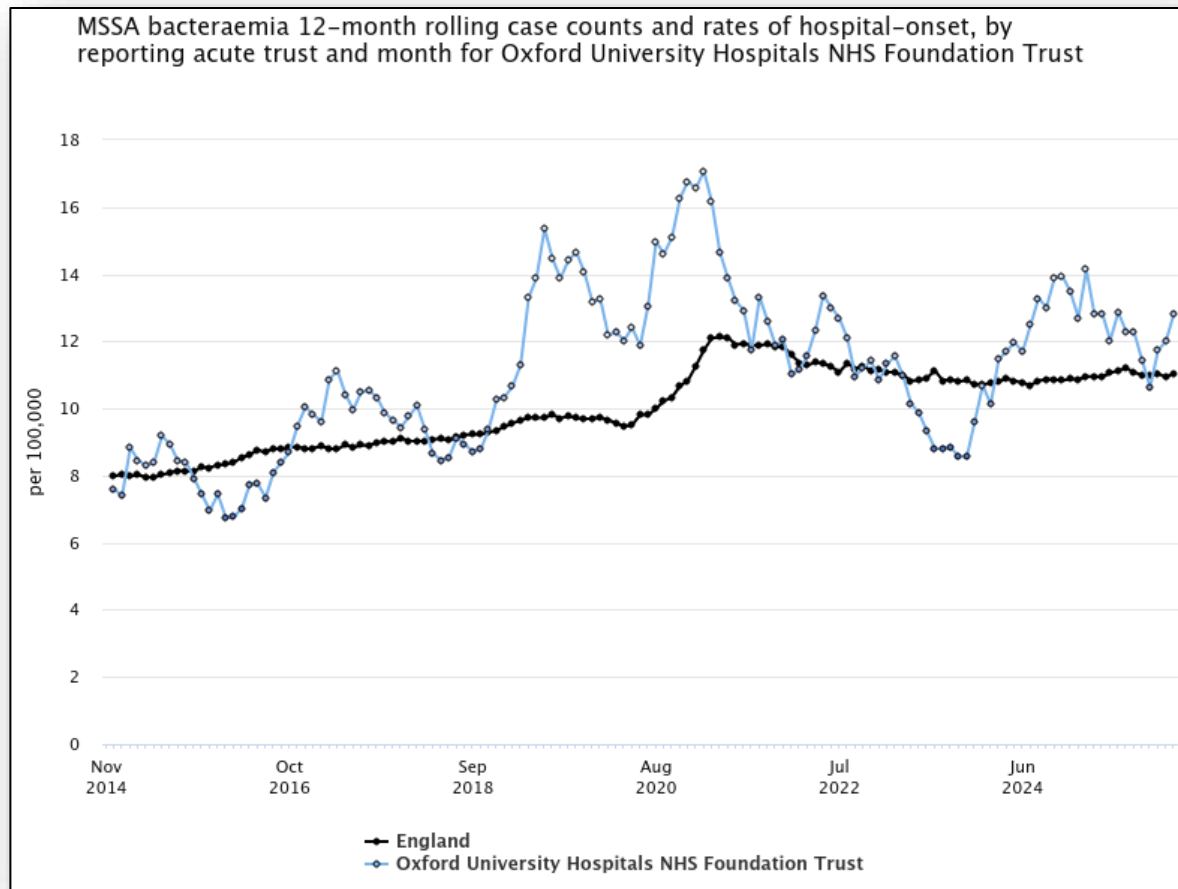
There has been a reduction in healthcare-associated *Klebsiella sp.*, and *Pseudomonas aeruginosa* cases this year with all numbers below the NHSE target value. The number of *E. coli* cases has remained static against the national trend.

There are no clear themes or interventions to reduce the rate of Gram-negative bloodstream infections in secondary care. The changes in patient demographics with an ageing population (18.6% of the total population was aged 65 years or older in the 2021 census compared with 16.4% at the time of the previous census in 2011), and more people at risk because of comorbidity or treatment such as immunosuppression make these targets especially challenging.

## Methicillin-sensitive Staphylococcus Aureus (MSSA) Bacteraemia

For 2025/26, at the end of March there were 75 healthcare associated MSSA cases in OUH, an increase of 9 cases from 2024/25. All cases undergo a root cause analysis. Peripheral cannula associated cases have been a theme this year, and work has been completed through the PSIRF and patient safety forum to highlight appropriate management of peripheral lines.

Graph 7 MSSA bacteraemia 12-month rolling case counts and rates of hospital-onset\* November 2014 to December 2025

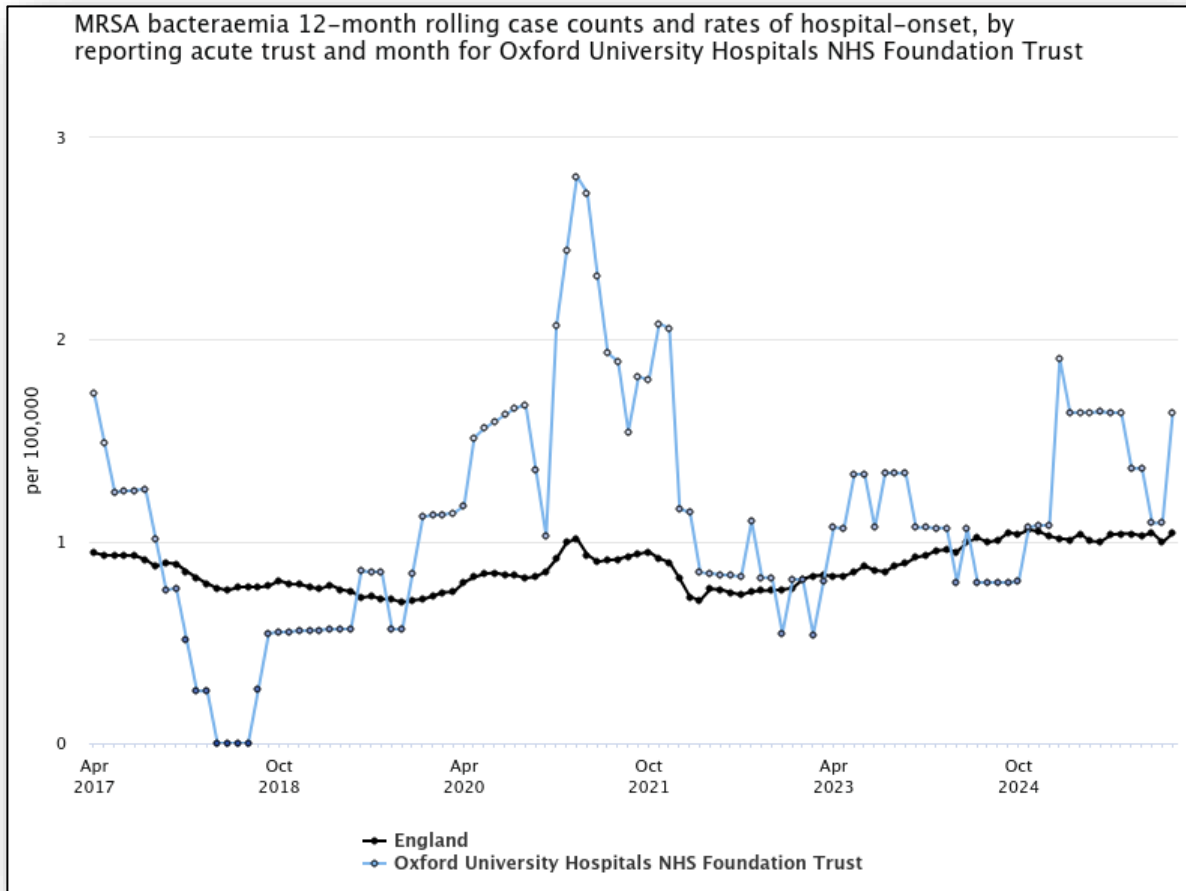


## Methicillin-resistant Staphylococcus Aureus (MRSA) Bacteraemia

For the financial year 2025/26, at the end of March there were three Hospital-Onset, Healthcare-Associated (HOHA) and three Community-Onset, Healthcare-Associated (COHA) cases in OUH making a total of six health care associated infections; in 2024/25 there were nine cases.

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

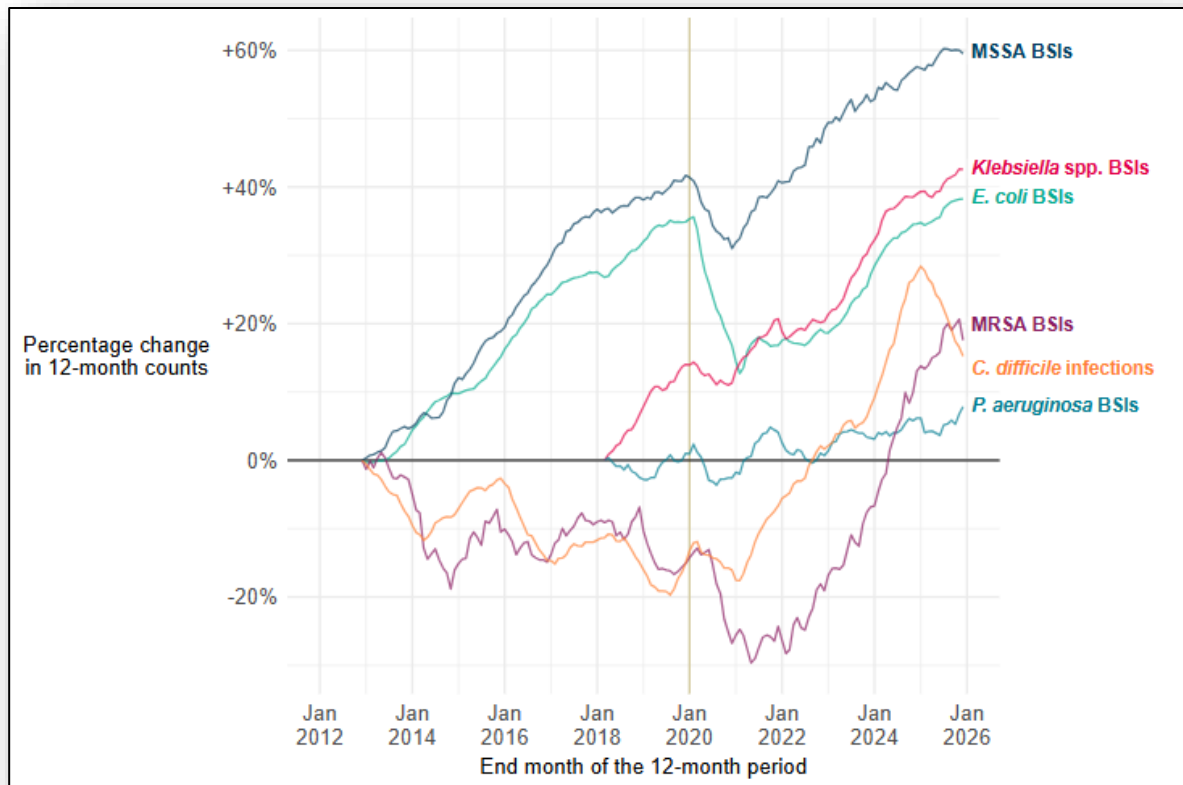
Graph 8: MRSA bacteraemia 12-month rolling case counts and rates of hospital onset\* April 2017 to December 2025



### National incidence of organisms subject to mandatory surveillance

These figures are in the context of a national increase in *E. coli*, *Pseudomonas aeruginosa* and *Klebsiella sp.* bacteraemia. The national data show a recent small decrease in hospital onset cases of both *C. difficile* infection and MRSA bacteraemia in the last year.

Graph 9: 12-month rolling percentage change since calendar year 2012 for MRSA, MSSA and E. coli bacteraemia and CDI, and from calendar year 2017 for Klebsiella spp. and P. aeruginosa bacteraemia, December 2012 to December 2025\*



Data source [Quarterly epidemiological commentary: mandatory Gram-negative bacteraemia, MRSA, MSSA and C. difficile infections \(data up to October to December 2025\) - GOV.UK](#)

\*Data up to date to January 2026

## Antimicrobial Stewardship

Antimicrobial resistance is a global public health threat, and the UK has responded to this global campaign with a series of National Action Plans (NAP) and national surveillance of antimicrobial resistance patterns with key aims around reduction of inappropriate antibiotic use, specifically broad-spectrum antibiotics.

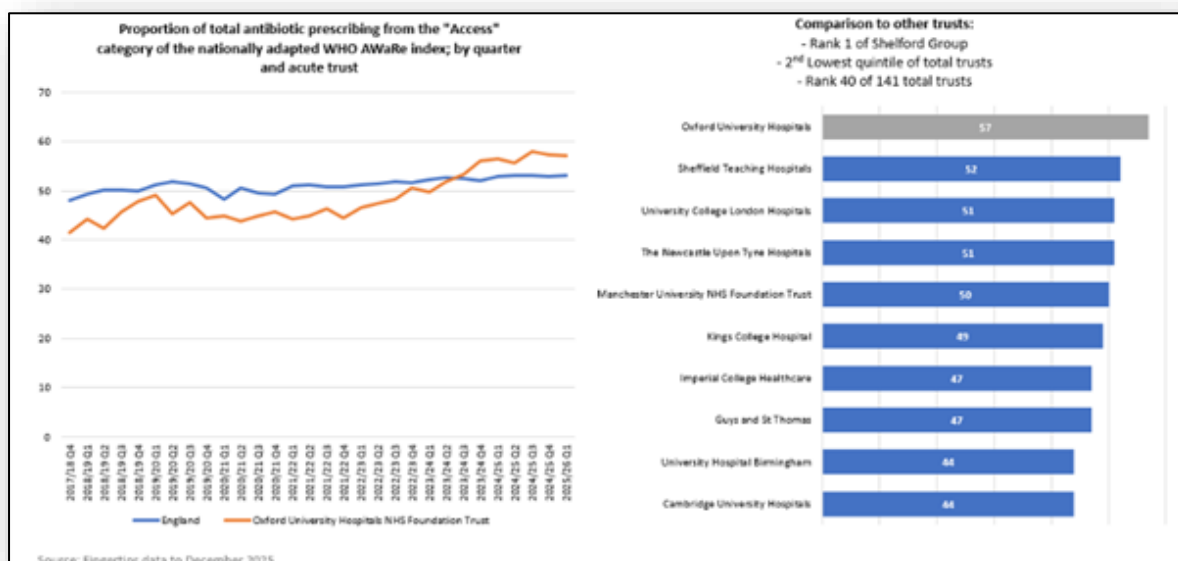
The World Health Organisation (WHO) categorised antibiotics into three broad groups ('AWaRe') based on their spectrum, anticipated risk of resistance development, risk of toxicity, and risk of causing healthcare-associated infection such as *Clostridioides difficile* Infection (CDI). The UK uses a modified version of the WHO list.

One of the targets within the UK NAP, 'Confronting antimicrobial resistance 2024 to 2029' is to achieve 70% of total use of antibiotics from the 'Access' category across the human healthcare system by 2029. To support this, as well as the broader stewardship agenda, the Antimicrobial Stewardship (AMS) team identifies and implements initiatives to increase the use of 'Access' antibiotics and reduce 'non-access' antibiotic use (i.e. 'Watch' and 'Reserve' antibiotics).

The AMS team monitor consumption of all antibiotics and consumption in the individual antibiotic categories using both local and national data. Graphs 10 and 11 below show data presented on a national platform (extracted from the Fingertips platform).

The AMS team have undertaken many activities to increase the proportion of 'Access' antibiotics. This has been successful with the proportion of 'Access' antibiotics gradually improving in OUH, and the consumption of this category is now better than the national average. Additionally, when comparing our results with peer-group (Shelford) UK Trusts, OUH is ranked first within the Shelford group as shown in Graph 10

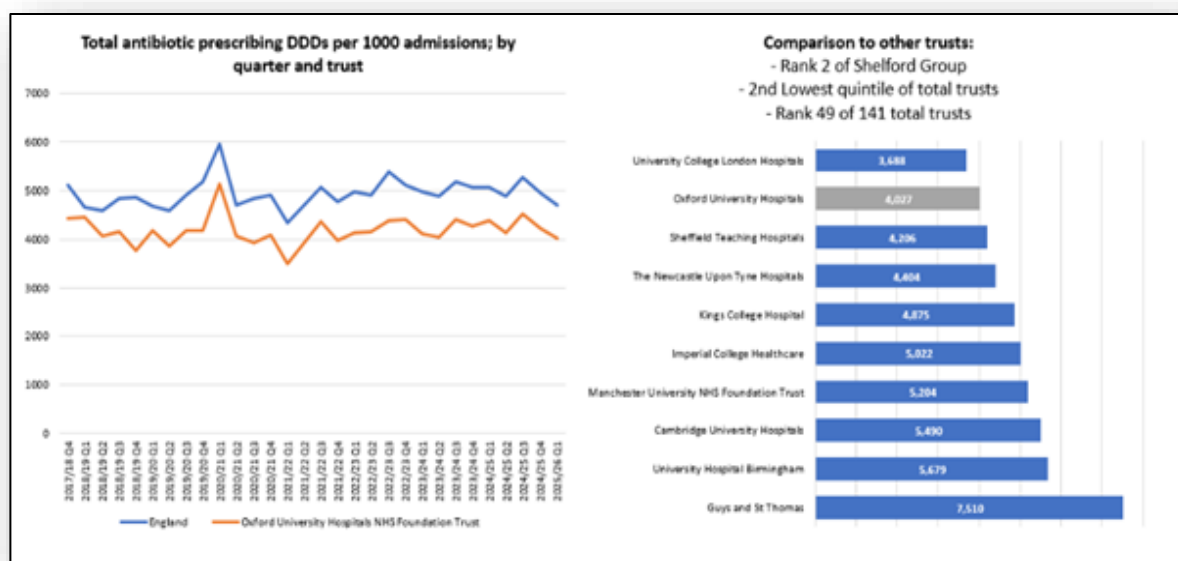
Graph 10 Proportion of total antibiotic consumption from the 'Access' category



To support reduction in total antibiotic consumption as well as increasing the proportion of antibiotic use in the 'Access' group, a coordinated multidisciplinary programme is required that promotes the appropriate use of antimicrobials. The AMS programme involves many activities which aim to achieve optimal antimicrobial use.

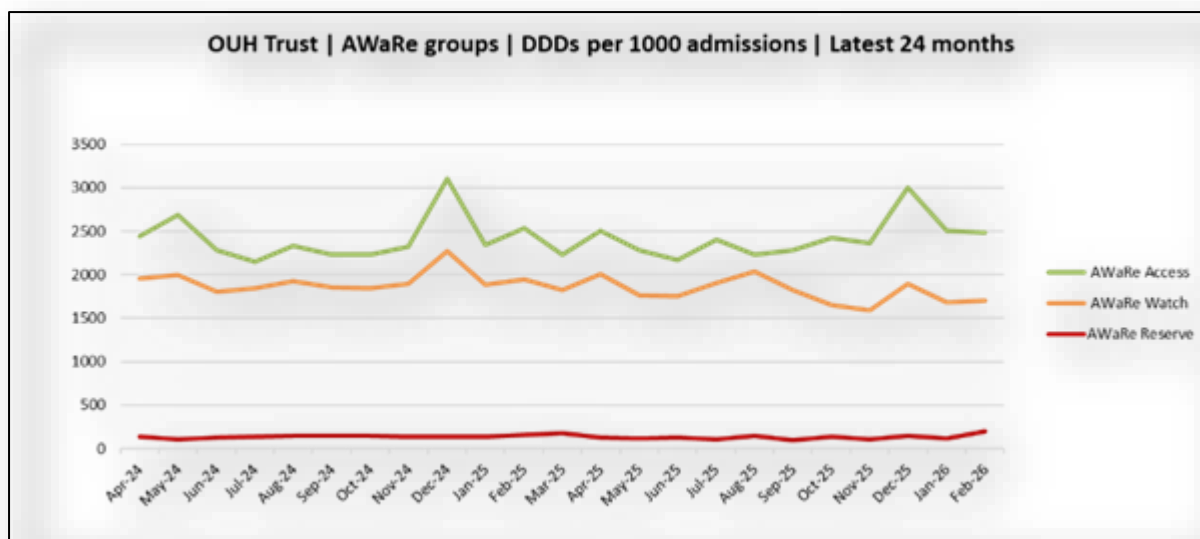
Another target in the NAP is to reduce total antibiotic use in human populations by 5% from a 2019 baseline. Graph 11 shows that OUH consumption of antibiotics is consistently less than the average for England. The Trust is second lowest user in the Shelford Group and 49<sup>th</sup> in all the Trusts on Fingertips platform. There are areas for improvement, and the AMS team continues to work with clinical teams to review antibiotic use.

Graph 11. Antibiotic consumption expressed as Defined Daily Doses (DDD) per 1,000 admissions



The AMS team monitor consumption internally as well as reviewing national data and Graph 12 shows the change in antibiotic groups over time.

Graph 12: Antibiotic consumption for each AWARe category expressed as Defined Daily Doses (DDDs) per 1,000 admissions



A key initiative in the AMS program is AMS multidisciplinary team (MDT) ward rounds. These are conducted on all sites for adults, paediatrics and neonates on a weekly basis and consist of AMS pharmacists, an AMS Advanced Clinical Practitioner (ACP) and infectious diseases clinicians to review patients on broad spectrum antibiotics. During each AMS MDT ward round interventions are made. The nature of the intervention is recorded, and the AMS ACP follows up to assess if the recommended intervention has been actioned.

The AMS ward rounds were started in 2021, and the number of rounds has increased over time. In a previous Quality Account, the AMS team shared that a paper was published in the Journal of Infection showing that OUH multidisciplinary AMS ward rounds (between September 2021 to December 2022) reduced antibiotic use and likely reduced length of hospital stay. Senior clinician input and more AMS experience increased advice uptake. Following advice to de-escalate / stop antimicrobials was associated with a 0.58 day [95% CI 0.22-0.94] reduction in hospital stay. In 2025 the AMS team won the research category at the national Antibiotic Guardian Awards for the AMS ward round work within OUH.

During January to December 2025 there were 347 AMS ward rounds, adults and paediatrics, reviewing 4,543 patients with 3,257 interventions. Ward rounds have provided opportunities for education of colleagues about AMS and have supported guideline reviews, local audits related to antimicrobials, and engagement from clinical teams with the AMS vision for OUH.

Antibiotic prescribing feedback is available at Division, speciality and consultant level via a dashboard. The data allows departments and consultants to evaluate their performance with their peer group for reflection and learning.

## Emergency readmissions within 28 days of discharge from hospital

The Trust routinely monitors emergency readmissions as one of the indicators of the efficacy of its provision of care and treatment. In some cases, readmissions may be inevitable and appropriate. A complete avoidance of unrelated emergency readmissions is therefore not realistic, and too low a readmission rate might reflect excessive lengths of stay due to an inappropriate degree of risk aversion and the associated harm of prolonged hospitalisation.

As part of the Trust's discharge support, advice is provided to patients regarding how to seek support if they are experiencing symptoms of ill health following a treatment or procedure (contacting the patient's GP, 111, 999 or contacting the treatment unit directly). Emergency Departments are situated at the John Radcliffe Hospital and Horton General Hospital, but patients known to the Trust's services may also be admitted directly to the Churchill Hospital or Nuffield Orthopaedic Centre, or unit that they were discharged from.

The most up-to-date data on readmissions within 28 days of discharge are provided by Dr Foster. For November 2024 to October 2025, the rate was 10.8% for children and adults. The Trust considers these data are as described for the following reasons.

The Trust has a process in place for collating data on hospital admissions, from which the readmissions indicator is derived.

Data are collected internally and then submitted monthly to NHSE via the SUS. The data are then used to calculate readmission rates.

NHSE develops the SUS data into Hospital Episode Statistics (HES).

Dr Foster takes an extract from HES data to provide benchmarked clinical outcome data.

Data are compared to peers, highest and lowest performers, and our own previous performance.

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

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

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

## Patient Experience

The Trust is dedicated to prioritising patients, carers, and families in everything we do. Our goal is to ensure timely, compassionate, and inclusive access to services, care, and treatment. We strive to listen to our patients' feedback about their care and treatment. To capture this, we gather patient experience data through various formal and informal channels, including the Friends and Family Test, Healthwatch Oxfordshire,



the National CQC Patient Survey Programme, Patient Stories, Patient Participation Groups (PPGs), ad-hoc surveys, and a dedicated patient feedback email. All feedback is shared with the relevant clinical service areas and plays a vital role in driving continuous quality improvement as well as sharing positive experiences of care.

Our commitment to ongoing service enhancement for patients and their families is grounded in the Trust's core values of Learning, Respect, Delivery, Excellence, Compassion, and Improvement.

Our Divisions and corporate teams utilise the feedback from the national patient surveys and the Friends and Family Test (FFT) to assess and enhance the quality of care and services provided, including monitoring aspects like patient satisfaction with food, as well as overall experience.

The Trust undertook Patient Led Assessment of the Care Environment (PLACE) visits in October 2025. Over 70 assessments took place across the Trust sites over the course of a week, and included communal and external areas, meal services, wards and outpatient departments. Overall, the patient assessors found the Trust to be clean and tidy, the environment well cared for, and they were confident in the environment providing a good experience.

The Trust has established a Patient Experience and Engagement Committee (PEEC). PEEC is responsible for the development and oversight of the Trust's strategic objectives relating to patient experience and engagement and reflects the Trust's recognition of the value of listening to the voice of lived experience to enhance continuous learning and improvement. The committee meets monthly with an alternating strategic and assurance focus to facilitate implementation of the new Patient Experience and Engagement Strategy, and to provide oversight of patient experience data and improvement initiatives.

## Patient Involvement

The Trust continues to present patient stories to the Trust Board meetings in public to share lived experience of receiving or delivering services. These stories have included a patient who overcame substance misuse and encouraged others to get tested for Hepatitis C, a long-term paediatric patient and family discussing multidisciplinary communication and financial challenges, and a family's experience with the RIPEL team as they supported them during a terminal diagnosis while ensuring their priorities were respected. A patient safety partner also shared an insightful account of their experience in the role. These unscripted stories, shared by patients, relatives, or healthcare professionals, allow the Trust Board to hear healthcare experiences directly from our patients and families.

Patient Safety Partners (PSPs) are being recruited in alignment with the NHS Patient Safety Strategy, and the Trust has recruited and onboarded nine PSPs to date. These volunteers contribute at all levels of the organisation and are invited to participate in Trust committee meetings including the Patient Safety and Effectiveness Committee, Clinical Governance Committee, Safety Learning and Improvement Conversation (SLIC) meeting, Clinical Improvement Committee, as well as the recently established Patient Experience and Engagement Committee. PSPs also engage in short-term project workstreams, such as the Martha's Rule implementation project. Their insights play a crucial role in ensuring that the patient perspective remains integral to organisational decision-making.

## Friends and Family Test (FFT)

The Trust is delighted that, overall, across the year, 172,483 responses were received.

93% patients told us that they rated their experience as good or very good. The FFT also asks patients to provide any further comment on their care, and this feedback is shared with the respective wards and departments. The comments are themed which helps the Trust to understand a balanced view of patient experience alongside complaints, claims and compliments.

Table 22 Results from OUH Friends and Family Test (FFT) survey April 2025 to Feb 2026

Service	Results
Inpatients and Day Cases	Based on 35,862 responses, 94% of patients rated their experience on their ward as very good or good (*national average: 95%).
Emergency Departments	Based on 15,121 responses, 83% of patients rated their experience within the Emergency Department as very good or good (*national average 79%).

Outpatients	Based on 119,456 responses, 94% of outpatients rated their outpatient experience as very good or good (*national average: 94%).
Maternity	Based on 2044 FFT responses, 88.8% of women rated their experience of the Trust’s Maternity Services as very good or good (*national average 92%). This is a significant improvement compared to 2024/25 data where there were 106 responses and 63% rated the Maternity Services as very good or good **

\* National average sourced from NHS England, February 2026 data.

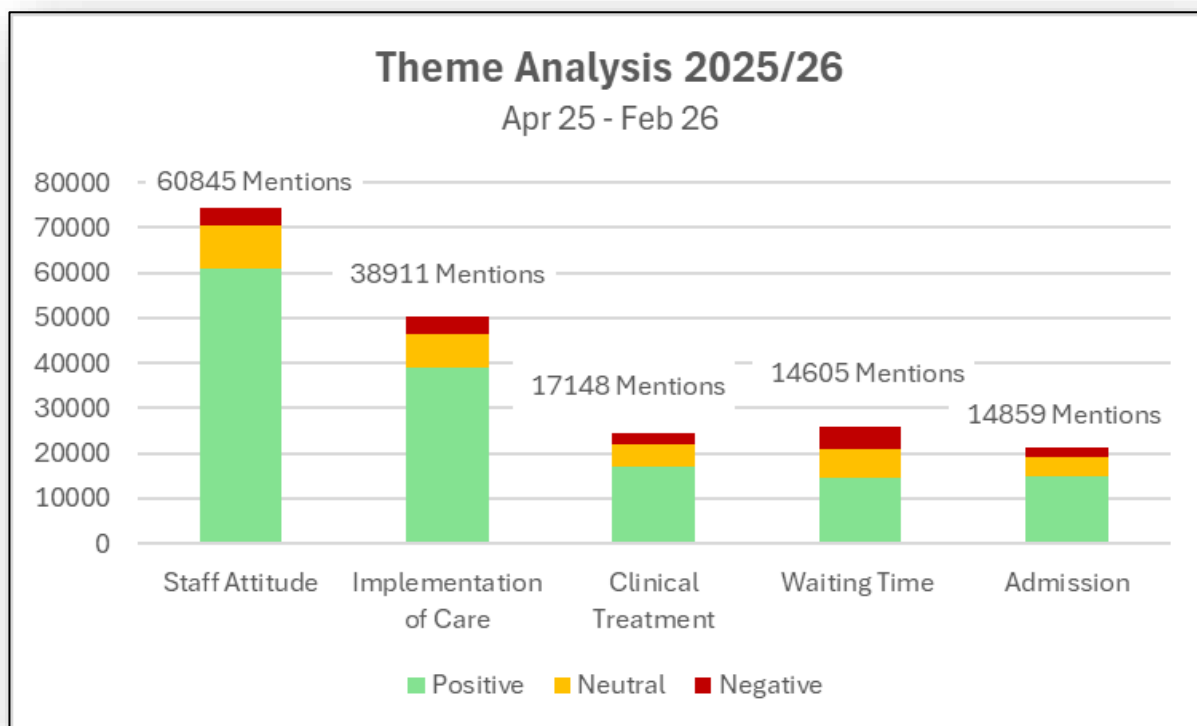
\*\* This data is for FFT only. Additional feedback is also received via ‘Say on the Day’, with >95% service users now rating the service as ‘good’ or ‘very good’.

*Table 23 Trust’s overall results from the FFT survey for 2025/26, April 2025 to Feb 2026*

April 2025 to February 2026	Very good	Good	Neither good nor bad	Poor	Very poor	Don’t know
No. of responses overall	139,325	21,045	5,108	2993	3215	797
Percentage	81%	12%	3%	2%	2%	0%

There have been 318,078 comments via the FFT throughout the year. Graph 13 below shows the mix of positive and negative sentiment among comments relating to the five most mentioned themes: Staff Attitude, Implementation of Care, Clinical Treatment, Waiting Time and Admission.

Graph 13 Mix of positive and negative sentiment among comments relating to the five most mentioned themes



## NHS England Learning Disability Improvement Standards

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

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

Further information about the standards can be found on the [NHS England website](#). OUH submits an annual self-assessment alongside accessible patient questionnaires and staff questionnaires. The Trust's systems and process's support compliance across the majority of the standards, with a focus for further improvement on staff confidence in their ability to provide person centred care. Significant developments have taken place in identifying people with learning disabilities on waiting lists and involving people with learning disabilities and carers in service development.

Improvement work is co-ordinated by the learning disability steering group through the delivery of OUH Learning Disability Plan.



## Staff Experience

### Staff recommendation of our hospitals to friends and family

Our 2025 Annual Staff Survey results relating to staff recommending our hospital to friends and family are as follows.

- 70.6% staff would be happy with the standard of care provided at OUH if a friend or relative needed treatment – the national average is 60.8%.
- 72.8% staff agree that care of patients is OUH's top priority – the national average is 71.6%.
- 58.2% staff would recommend OUH as a place to work – the national average is 57.7%.

## Our People Plan

The [People Plan 2025-2028](#) sets out a vision that *'together we make OUH a great place to work where we feel we belong'*. In 2025/26 the People and Communications Directorate has continued to deliver on the key elements of the People Plan including the following:

- The launch of a new Wellbeing and Occupational Health Programme of Support intranet site at the beginning of February 2026. This provides a 'one stop shop' where all our staff can find the health and wellbeing support that they require, quickly and easily. Since the launch, there have been more than 3400 staff visit the site.
- A series of six lunchtime financial wellbeing webinars showcasing all the financial organisations we have partnered with to support our staff. Approximately 150 staff attended these. Over 130 staff attended wellbeing check-in training and self-care strategies workshops online with a further 150 doing sessions in person.
- The creation of new changing rooms on our Horton site which will also encourage staff to use more sustainable forms of transport to work such as cycling.
- Creation of bespoke support programmes for our Emergency Department and Maternity and Neonatal Departments.
- Our Wellbeing Service Leads (Occupational Health, Staff Support Service, Here for Health, Wellbeing team, Oxford Hospitals Charity and Freedom to Speak Up) met quarterly to ensure a connected, holistic wellbeing offer is available to our people.

- Our team of 350+ Wellbeing Champions at OUH continued to promote and identify ways to support our colleagues. They share wellbeing information at local level and organise team meetings to share all the support available and monthly forums to share excellent practices. Wellbeing Champions are connected to Divisional Programme Leads of our Eradication of Bullying and Harassment Programme to help support their work.
- Approximately 4,200 staff had a Wellbeing Check-in with their manager to discuss their wellbeing and explore practical ways to support it in the workplace
- Our 'Creating a Suitable Estates and Environments Enabling Group' met quarterly to provide a forum for staff feedback on our estates and to escalate any issues directly impacting staff wellbeing to the Trust's senior management.

### **Active Bystander Training**

In November 2025 we launched the Active Bystander Training, which was offered across the Trust. This includes e-Learning for all staff and an optional workshop for staff to further explore the skills required to become an active bystander. At the end of 2025/26, 1553 people have completed the Active Bystander Training e-Learning and 151 have attended a workshop. This work has been integrated into the Leadership Development Programme and is a workstream in the eradication of bullying and harassment programme as a key part of our strategy to develop skills in calling out behaviours and helping people develop the confidence to become an active bystander. The workshops were initially delivered by a supplier as we developed our internal training team to take on the delivery from June 2026 onwards. This work will ensure a sustainable model to deliver the workshops ongoing.

### **OUH Leadership Development Programme**

In October 2025, OUH Leadership Development Programme for Matrons, Clinical Directors, Clinical Leads, Directorate Managers and Corporate Directors commenced. This content has been adapted from the LDP delivered in 2023/24 to include content from the Better People Leaders Programme and links to the updated people plan objectives. This programme has also been updated to align with the soon to be launched NHS Managers and Leaders framework to ensure that we are modelling best practice and aligning our leadership development to the demands of the future. The first cohort started in March 2026 with two further cohorts planned for the summer offering a total of 75 places.

### **Onboarding programme for new managers**

We continue to develop our onboarding programme for new managers. Revised and updated resources include new pages around career conversations, additional resources and 'how to' guides, training opportunities for managers and links to opportunities for personal development including skills development pathways.

## Equity Diversity and Inclusion

There have been conference vents for Black History Month, International Day for Persons with Disabilities, and International Women's Day.

We have worked with our Staff Networks to implement initiatives that advance equality, such as launching site accessibility maps with AccessAble, and increasing provision of breastfeeding and expressing spaces.

We launched our new Reasonable Adjustments Policy that will facilitate managers to better support their disabled staff in the workplace. The launch included various materials to support implementation such as training and a reasonable adjustments passport tool.

We implemented an accountability intervention for recruitment of consultants to mitigate against bias and enable equality of opportunity for candidates. This involves panels having to provide clear justifications for their recruitment decisions, with those justifications being regularly reviewed by the Chief People Officer (CPO).

## Staff Recognition

During the reporting period, 5788 colleagues sent Instant notes of appreciation, enabling staff to recognise a colleague who has gone above and beyond by sending a short personalised instant message aligned to the Trust Values.

Our Annual Staff Recognition Awards this year received 1,928 nominations, and we saw 157 colleagues being recognised in our monthly recognition programme in the last year. From these monthly recognitions, 52 colleagues have been recognised in the last year Quarterly Recognition Events, as well other colleagues who have celebrated long-service awards and reporting excellence. These initiatives. All of these programmes support the Trust's continuous commitment to recognising staff for their outstanding contributions.

To help people have more focused training and development, a new section within the Values Based Appraisal (VBA) was created in the *My Personal Development Plan (PDP)* section focussing on staff development and career aspirations. To support this a new career development site was also launched in May 2025; this offers resources, training and guidance to help staff with career planning and development.

The national appraisal compliance rate for 2025 was 85.1% and our Trust compliance rate was 91.7%.. This was the highest score nationally.

## Bullying, Harassment and Discrimination-

From the 2024 and 2025 Staff Survey results, there are several areas showing improvement in staff experience relating to bullying, harassment and discrimination. At organisation level, the proportion of staff saying they never experienced harassment, bullying or abuse improved across all three sources: from patients/service users/public, increasing from 77.8% in 2024 to 79.2% in 2025 (+1.4 percentage points); from managers, increasing from 90.3% to 90.7% (+0.4 percentage points); and from other colleagues, increasing from 81.7% to 82.6%

(+0.9 percentage points). There were also improvements in discrimination-related measures, with staff reporting no discrimination from patients/service users/public increasing from 91.0% to 91.9% (+0.9 percentage points) and staff reporting no discrimination from managers/team leaders/colleagues increasing from 89.8% to 91.1% (+1.3 percentage points). Reporting of the last incident of harassment, bullying or abuse remained unchanged at 50.1% in both years.

We have continued to deliver the Trustwide Eradication of Bullying and Harassment Programme, the purpose of which is to tackle all forms of negative behaviours ranging from incivility to violence and aggression.

We have delivered two parts of a 'No Excuses' campaign, that promotes behaviours in line with our Trust Values and advises staff how to raise complaints of discrimination and harassment.

We have rolled out a WorkinConfidence platform that enables all staff to raise Freedom to Speak Up concerns anonymously.

## OUH performance with NHS Oversight Framework indicators

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

Table 24 Performance against relevant indicators and national average

Indicator	Target	Trust Performance 2025/26	Trust Performance 2024/25	Trust Performance 2023/24
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	≥92%	63.0%	57.1%	57%
Patients waiting for consultant-led treatment (RTT <sup>1</sup> )	N/A	88,213	89,833	82,990
Patients waiting over 52 weeks (RTT <sup>1</sup> )	<950	1,590	2,711	3,586
Patients waiting over 78 weeks (RTT <sup>1</sup> )	0	1	15	80
Patients waiting over 104 weeks (RTT <sup>1</sup> )	0	0	0	1
ED performance within 4 hours (all types)	≥78%	78.5%	72.2%	65.1%
62-day general standard	≥85%	56.5%	60.6%	63%
Diagnostic activity levels (elective) *New system introduced in 2025/26	N/A	321,849*	254,800	240,545
Percentage of people waiting within 6 weeks for a diagnostic procedure or test	95.1%	79.1%	76.3%	83.6%
<b>Local priorities</b>				
Hospital Acquired Pressure Ulcers (HAPUs) Category 3 per 10,000 bed days	<2.0	2.7	2.2	2.8

Indicator	Target	Trust Performance 2025/26	Trust Performance 2024/25	Trust Performance 2023/24
Hospital Acquired Pressure Ulcers (HAPUs) Category 4 per 10,000 bed days	0	0	0.1	2
Reported incidents of violence and aggression against staff <sup>3</sup>	0	2,210	2,192	1,708
Incidence of violence and aggression (rate per 10,000 bed days)	N/A	62.6	56.8	51.5
Results endorsed within 7 days	>85%	80.9%	81.2%	82.5%

<sup>1</sup> Referral to Treatment (RTT) pathway; <sup>2</sup> Emergency Department (ED); <sup>3</sup> Reported rate on Trust's incident management system.

## Elective care

We are committed to seeing more patients more quickly, and to reducing the time patients are waiting. We are grateful to our staff from across the Trust who have continued to focus on improvements to patient pathways, and to our system partners for the collaborative approach to delivering services to our patients.

For a second consecutive year, we successfully maintained a zero position for the number of patients waiting more than two years at the end of March 2026. Focused work has continued on reducing the number of patients waiting more than 65 weeks and 78 weeks; at the end of March 2026, there were 46 patients waiting over 65 weeks compared to 63 in March 2025, and 1 patient waiting over 78 weeks at the end of March 2026 compared to 15 in March 2025. We remain committed to further reducing the waiting times for patients requiring elective care.

Patients on a Referral to Treatment (RTT) incomplete (i.e. still waiting) waiting list at OUH decreased by 2% from March 2025 to March 2026. In February 2026, OUH held the 13th largest incomplete waiting list nationally.

Contributing to the challenge of fully recovering the long waiting patients in 2025/26, was a group of specialty capacity constraints either due to recovering from a pathway redesign, staff vacancies, inability to secure mutual aid at another qualified provider across region or a greater volume of patients in the cohort, resulting in the reliance of delivery fund schemes.

Harm reviews continue to be performed digitally for patients waiting in excess of 52 weeks, to identify any psychological clinical harm arising from delays in line with the national e-prioritisation policy. The harm reviews have allowed services to expedite treatment of patients as necessary.

In line with an agreed protocol, any cancer patient waiting more than 104 days for treatment also has a review conducted of potential for clinical harm from the delay.

## Emergency care

Performance within the ED, measured across the full year using the national standard for the percentage of patients attending the ED for less than four hours from arrival to admission, transfer or discharge, was 78.5% for 'all types', and 70.7% for 'type 1' attendances. 'Type 1' activity accounts for approximately 72% of patients at OUH and covers the Emergency Departments at the John Radcliffe and Horton General hospitals. 'All types' includes activity outside these settings that incorporate 'type 2' single speciality departments and 'type 3' Minor Injury Units.

ED performance improved compared to the previous year by 6.3% for 'all types' and by 6.8% for 'type 1'. ED performance was better than the national average for 'all types', which was 74.9% nationally, and also better than the national average for 'type 1' attendances, which was 60.9% in 2025/26.

## Cancer treatment within 62 days

OUH cancer demand continues to grow year-on-year, with an increase in demand of 6.7% compared to 2024/25. OUH delivered 82.9% for 28-day Faster Diagnosis Standard (FDS) at the end 2025/26 compared to 77.9% in 2024/25. This is above the national target of 75%.

The proportion of patients waiting more than 62-days on 31st March 2026 was 7.3% of the total waiting list size which is 2% improvement compared to 2024/25.

OUH achieved one out of the three national standards at the end of March 2026 (28-day FDS). The 62-day and 31-day combined standards were not achieved and are the focus of specific initiatives within the Trust's Cancer Improvement Programme. The achievement of the 28-day FDS has been supported by the Trust's investment in increasing diagnostic capacity as well as capacity from the Community Diagnostic Centre.

## Diagnostic test within six weeks

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

The March 2026 diagnostic performance, against the standard measuring patients waiting within six weeks, was 79.1% (an improvement on last year's 76.3%). OUH was ranked below the national average. The Trust holds one of the largest waiting list volumes in the region and the Shelford Group. The main reason for not achieving a higher performance was a 2024/25 change in the national referral process to allow direct audiology referrals and for audiology to refer directly to ENT rather than via the GP. A recovery plan was developed and implemented, with steadily continued improving waiting times for patients into 2026/27. Additionally, challenges related to demand and capacity for endoscopy modalities contributed to the outcome.

## Freedom to Speak Up (FtSU)

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



Most issues raised are addressed quickly and effectively through our established procedures, as set out in the Trust's *Freedom to Speak Up – Raising Concerns (Whistleblowing) Policy*, which was refreshed in 2025/26 to strengthen guidance, protections and accessibility for staff. Under this Policy, the Freedom to Speak Up (FtSU) Lead Guardian and the wider Guardian team provide support and guidance to anyone wishing to raise a concern. Speaking up is something that everyone is encouraged to do, and our current Policy aligns with the National Model Policy and the recommendations of the National Guardian's Office to ensure it fully supports this aim. The FtSU Lead Guardian presents an Annual Report to both the Trust Management Executive (TME) and the Trust Board. We also have a nominated Non-Executive Director and a nominated Executive Director with responsibility for FtSU, ensuring independent representation and leadership at Board level.

The Trust launched a new anonymous reporting platform as an extension of our existing Freedom to Speak Up service in November 2024. This provides a confidential, two-way anonymous speaking up platform operated independently by Work in Confidence, offering an additional route for staff to raise concerns in writing or anonymously. Overseen by the Freedom to Speak Up Guardian team, the platform helps reduce barriers to speaking up, particularly for those concerned about confidentiality or potential detriment, supports earlier reporting of issues, and enables ongoing dialogue while protecting staff identity, contributing to a culture of psychological safety and continuous improvement

The purpose of the FtSU function is to support all staff and help foster an open, transparent and supportive culture where speaking up is normalised and staff feel safe to raise issues without fear.

## Ensuring staff do not suffer detriment

Speaking up about concerns at work is essential to helping the Trust continuously improve services for patients and the working environment for staff. We recognise that some staff may feel anxious about raising a concern, but this should never deter them. In line with our duty of candour, our senior leaders and the Trust Board remain committed to maintaining an open and honest culture.

Staff who raise concerns will always be treated with respect and supported throughout the process. The Trust will apply the new guidance on detriment issued by the National Guardian's Office in February 2025, ensuring that no-one who raises a concern under the Policy is at risk of losing their job or experiencing any form of reprisal. Harassment or victimisation of anyone raising a concern will not be tolerated and, if upheld following investigation, may lead to disciplinary action as it represents a breach of Trust Values.

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<https://www.workinconfidence.com/about-workinconfidence/https://www.workinconfidence.com/measuring-the-success-of-employee-engagement/>

## Rota Gaps and the Plan for Improvement

### Resident Doctors: Safe working hours

#### Background and contractual framework

Resident doctors represent approximately 40% of the medical workforce nationally. The Terms and Conditions of Service (TCS) for NHS Doctors and Dentists in Training (2016) include governance arrangements requiring partnership working between resident doctors and their employing Trusts to ensure safe working hours and appropriate executive oversight.

Oxford University Hospitals NHS Foundation Trust (OUH) employs approximately 1,500 resident doctors, including around 1000 on national training programmes, alongside locally employed, university-employed, and military doctors. Although contractual arrangements differ across these groups, OUH applies the principles of the 2016 TCS to all resident doctors in order to support consistent oversight of safe working hours and promote safe and sustainable service delivery.

#### Governance and oversight arrangements

To support compliance with the 2016 TCS during 2025–2026, OUH ensured that all resident doctors were provided with compliant work schedules and access to an electronic exception reporting process to report variance from rostered hours. The Trust Board continued to receive quarterly and annual reports from the Guardian of Safe Working Hours, informed by workforce data, exception reporting intelligence, and feedback from the Resident Doctors' Forum.

#### National and local context

The reporting year took place against a challenging national context, including ongoing industrial action involving resident doctors and continued financial pressures across the NHS. During this period, national contractual reforms were introduced, including the NHS England 10-Point Plan to Improve Resident Doctors' Working Lives and a revised national Framework Agreement for exception reporting. These developments required Trusts to review and strengthen local arrangements for working hours oversight, rota transparency, rest facilities, and resident doctor engagement.

## Exception reporting

In previous years, limitations within the legacy exception reporting system reduced the reliability of aggregate exception reporting data for assurance purposes. These limitations included inaccurate attribution of supervisors and specialties and were formally recorded on the Trust risk register. As a result, exception reporting data were excluded from the 2024/25 annual report.

During 2025/26, OUH transitioned from the legacy system to DRS5, a supported and reform-compliant exception reporting platform aligned with national requirements. While exception reporting continues to support individual contractual outcomes, including payment or time off in lieu, aggregate assurance remains limited for part of the year due to the timing of the system transition. The implementation of DRS5 establishes stronger foundations for exception reporting governance in future reporting periods.

## Improving working lives

Implementation of the NHS England 10-Point Plan to improve Doctor's working lives progressed during the year through the Improving Working Lives Group, supported by multidisciplinary engagement and executive oversight. Our performance against the 10 point plan showed 95% compliance.

Activity during 2025/26 included improvements in resident doctor engagement, strengthened governance arrangements, continued operation of the Resident Doctors' Forum, and the appointment of a resident doctor peer lead. OUH also progressed the appropriate use of fatigue and facilities funding and funding accrued from Guardian-levied fines, in line with national guidance and local agreement.

## Rota gaps and locum usage

Trust-wide vacancy data for resident doctor posts were not available in a single consolidated dataset due to variation in local data collection arrangements across services. This continues to limit Trust-level assurance and remains an area for further development. Locum shift activity is therefore presented as an indirect indicator of rota pressure. During 2025/26, locum shifts continued to be used primarily to mitigate vacancies and maintain service delivery, with the majority of shifts filled through OUH bank and a smaller proportion through agency cover.

Table 25 Number of locum shifts undertaken by bank and agency staff, broken down by quarter, and the reason for the locum shift

Locum Shifts	2025			2026	Total
	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	
Total	2660	3043	2775	2845	11323
Agency	330	211	84	133	758
OUH Bank	2330	2832	2691	2712	10565

## Summary

In summary, OUH remains committed to supporting safe working hours for resident doctors. This year's report reflects progress in system reform, governance arrangements, and implementation of national initiatives, while acknowledging ongoing data limitations. Further improvement and assurance will be reflected in future reporting as these developments continue to embed.

## Annexes

**Annexe 1:** [Quality Priorities 2026/27](#)

**Annexe 2:** [Statements from the Integrated Care Board, Local Health watch organisations, NHSE, Council of Governors Health, Overview and Scrutiny Committee \(HOSC\)](#)

**Annexe 3:** [Statement of Directors' responsibilities in respect of the Quality Account](#)

**Annexe 4:** [Glossary Medical, Clinical and Technical Terms](#)

## Annexe 1: Quality Priorities 2026/27

### Patient Safety

#### Quality Priority 1: Improving escalation of the deteriorating patient

##### Why is this a priority?

The prompt response to patient deterioration through escalation to an appropriate clinician is essential to patient safety. It is important in preventing cardiopulmonary arrest or the need for transfer to an intensive care unit, both of which impact on a patient's length of stay in hospital but most importantly may influence the outcome for that patient and those closest to them. This Quality Priority will focus on adult in-patient areas, where patient deterioration may occur requiring a senior clinical response.

Table 26 Improving escalation of the deteriorating patient QP 2026/27

What we will do.	How will you know the objective is completed and that it is working?
<p><b>Objective 1 (Q1-4)</b>  <b>Empower staff providing patient care with the tools to appropriately escalate a patient for whom they have concerns. This will be achieved by:</b></p> <ul style="list-style-type: none"> <li>• establishing a stakeholder group.</li> <li>• supporting the education and development of staff in communicating information surrounding escalation.</li> </ul>	<p><b>(Q1-4)</b></p> <ul style="list-style-type: none"> <li>• Reduction in the number of Ulysses incident reports pertaining to a delay in escalation of a deteriorating patient (target 25% reduction).</li> <li>• Pre and post implementation questionnaire to clinical staff who may be required to escalate deterioration to determine whether communication and confidence in escalation has improved.</li> </ul>
<p><b>Objective 2 (Q1-4)</b></p>	<p><b>(Q1-4)</b></p>

What we will do.	How will you know the objective is completed and that it is working?
<p><b>Understand the current enablers and barriers in escalating patient deterioration to develop a systems-based approach to escalation which is applicable across the Trust</b></p> <ul style="list-style-type: none"> <li>• Distribute a questionnaire to 100 nurses and resident doctors, collating a summary of enablers and barriers to escalation from the responses received. Complete process mapping exercise using QI methodology and implement QI programme cycles.</li> <li>• Identify key clinical areas for intervention following QI exercises. Conduct a focus group in the pilot areas to assess the effectiveness of measures and guide future planning.</li> <li>• Continue implementation of RAID Huddles.</li> </ul>	<ul style="list-style-type: none"> <li>• To have defined and commenced 2 focused PDSAs cycles informed by robust, frontline-informed evidence on escalation barriers and enablers, shaping clear quality improvement interventions next steps.</li> <li>• An observed decrease in Ulysses reporting relating to escalation (aiming for a 25% decrease).</li> <li>• RAID Huddles will be embedded in 25% of adult in-patient ward areas as part of daily ward routine. This measure will support a 10% reduction in the instance of 2222 calls to these areas.</li> </ul>
<p><b>Objective 3 (Q1-4)</b></p> <ul style="list-style-type: none"> <li>• Ensure the concerns raised by patients and those closest to them are heard and appropriately escalated, including incorporation of escalation through Martha's rule.</li> <li>• Support education of staff in documenting concerns raised as per Martha's rule as part of routine documentation on EPR.</li> <li>• Explore the use of EPR to capture patient concerns</li> </ul>	<p><b>(Q1-4)</b></p> <ul style="list-style-type: none"> <li>• PDSA cycles on 4 different wards will take place to understand how best to capture the concerns raised by patients and relatives. The workflow will be subsequently defined and embedded.</li> <li>• This will be added to through a regular review of Martha's Rule calls and through a review of EPR documentation</li> <li>• Data will be cross referenced with Ulysses reporting (bi-monthly) to ensure compliance with the objective.</li> </ul>

What we will do.	How will you know the objective is completed and that it is working?
<p><b>Objective 4 (Q1-4)</b></p> <ul style="list-style-type: none"> <li>• Observations are recorded and documented in line with the Trust Recognising Acute Illness and Deterioration (RAID) Policy and the Early Warning Score with supporting documentation provided if the observation interval deviates from that laid out by the National body.</li> </ul>	<p><b>(Q1-4)</b></p> <ul style="list-style-type: none"> <li>• Monitor compliance with the documentation of patient observations monthly and work with areas where compliance is not at the expected standard, aiming for a 20% increase in baseline recorded compliance. Share learning across clinical areas.</li> </ul>

## Quality Priority 2: Venous Thrombo-embolism (VTE)

### Why is this a priority?

Venous thromboembolism (VTE) is the leading cause of preventable hospital deaths. One in every four preventable hospital deaths across the UK is related to a blood clot. The early identification of patients at risk of VTE and prescription of thromboprophylaxis are important measures in preventing the morbidity and mortality associated with hospital-associated thrombosis. Evidence from clinical trials has shown that thromboprophylaxis can reduce rates of VTE by 60% in the highest risk patients.

At OUH, we use a VTE risk assessment tool that is available electronically in the patient record which is based on the national tool and complies with NICE guidance. A key feature of our VTE risk assessment is the automatic generation of an appropriate prescription for thromboprophylaxis, on completion of the form. Since 2012, OUH has met and exceeded the 95% national target for VTE risk assessment within 24 hrs of admission.

In January 2025 NHS England stipulated that the VTE risk assessment must be completed on all patients age 16 and above within *14 hours* of admission, this is supported by NICE guideline NG-89. This is an appropriately challenging target, and one that will improve the safety of all adult (16 years +) in-patients, both during their hospital stay and will protect them from hospital-associated morbidity (and mortality) during their immediate discharge period.

The focus of this quality target will be to drive greater excellence in VTE prevention and to comply with, and exceed, the new NHS England target of 14 hours.

Table 27 VTE QP 2026/27

What we will do.	How will you know the objective is completed and that it is working?
<b>Objective 1 (Q1-4)</b> <b>To reduce the number of missed doses of Thromboprophylaxis</b>	<b>(Q1-4)</b>

What we will do.	How will you know the objective is completed and that it is working?
<p>a) Thromboprophylaxis Column to be added to the electronic White Board in collaboration with the Digital team – with a coloured traffic light system, which will be mandated on every in-patient ward.</p> <p>b) After the traffic light system has been introduced – we will audit the number of missed doses of low molecular weight heparin (LMWH) across all wards, using digital support.</p> <p>c) We will add the ‘missed LMWH figures’ to clinical governance meetings for Divisions and Directorates – for their review.</p> <p>d) We will work with the digital team to streamline the link between the VTE-RA and VTE prescribing.</p> <p>e) We will, with the support of the medical photography/video team develop five 60 second teaching videos aimed at different front line staff groups, to increase their awareness, knowledge and confidence around VTE e.g. VTE Prevention and Mobility, VTE Prevention and Lower Limb Immobilisation.</p>	<p>Our preliminary data show that there are 20% in-patient days where LMWH is not given. We will collect data on missed doses and continue to collect data on Hospital Acquired Thrombosis (HATs).</p> <ul style="list-style-type: none"> <li>• Our aim is to reduce missed doses by a challenging 50% (e.g. down to 10% in-patient days).</li> </ul> <p><b>Q4</b></p> <ul style="list-style-type: none"> <li>• We expect, over time to see a meaningful reduction in the number of Potentially Preventable HATs. At present we have 30 - 35 potentially preventable HATs per year. We will aim to reduce this by 30%, i.e. down to 20 per year.</li> </ul>
<p><b>Objective 2 (Q1-4)</b></p> <p><b>Increase compliance of the VTE Risk Assessment (RA) for In-patients (e.g., specifically excluding VTE cohorts)</b></p> <p>In addition to the interventions above we will do the following to increase VTE-RA to &gt;95% for all directly reviewed in-patients:</p>	<p><b>Q3-4</b></p> <ul style="list-style-type: none"> <li>• Achieve 95% of <u>directly assessed</u> VTE Risk Assessment completed within 14 hrs.</li> </ul>

What we will do.	How will you know the objective is completed and that it is working?
<p>a) Visit other VTE Exemplar centres to learn directly from them, how to improve direct VTE-RA figures.</p> <p>b) Focus our work with junior clinical staff to understand barriers to timely VTE-RA, and how to develop innovative measures to overcome these barriers.</p> <p>c) Using data from the last 15 years, develop the evidence base to support earlier LMWH delivery.</p>	
<p><b>Objective 3</b></p> <p><b>Introduction of the electronic validated Risk Assessment tool for Lower Limb Immobilisation.</b></p> <p>a) Agreement with Key Stakeholders to implement the TriPCast Tool for Lower Limb Immobilisation (LLI).</p> <p>b) Development and roll out of the LLI tool on EPR and assistance with development of the tool to be suitable for patients to start to complete prior to their – mostly fracture clinic – appointments, to assist with the limited time available for clinicians to complete these risk assessments in their clinics which commonly see 50+ patients.</p>	<p><b>Objective 3</b></p> <p><b>Q1</b></p> <ul style="list-style-type: none"> <li>• Work with stakeholders to understand workflows and get agreement from all stakeholders to implement a digital risk assessment tool for LLI.</li> </ul> <p><b>Q2</b></p> <ul style="list-style-type: none"> <li>• Determine baseline assessment of LLI VTE risk assessment through roll out of the digital tool across the relevant teams.</li> <li>• Aim to increase risk assessment by 50% from baseline</li> </ul> <p><b>Q3-4</b></p>

What we will do.	How will you know the objective is completed and that it is working?
	<ul style="list-style-type: none"><li>• Monitoring assessments-compliance/reporting system demonstrating sustained increase in compliance.</li></ul>

## Quality Priority 3: Martha's Rule

### Why is this a priority?

Martha's Rule is a patient safety initiative to support the early detection of deterioration by ensuring the concerns of patients, families, carers and staff are listened to and acted upon.

It has been developed in response to the death of Martha Mills and other cases related to the management of deterioration.

Central to Martha's Rule is the right for patients, families and carers to request a rapid review if they are worried that a patient's condition is getting worse and their concerns are not being responded to.

Following a successful pilot in 2025, a full rollout of Martha's Rule in adult and paediatric wards is planned in 2026.

Table 28 Martha's Rule QP 2026/27

What we will do	How will you know the objective is completed and that it is working?
<p><b>Objective 1 - Roll out of escalation pathways for patients, relatives, carers and staff of Martha's Rule (MR) in Q1-2</b></p> <ul style="list-style-type: none"> <li>• Full roll out of across all four OUH sites of the ability of patients, relatives, carers and staff to escalate concerns.</li> <li>• Launch Martha's Rule in all patient groups i.e. adults, maternity and paediatrics.</li> <li>• Deliver a communications plan to raise awareness internally and externally to our local population that MR will be available for everyone to use across all sites.</li> </ul>	<p><b>(Q1-2)</b></p> <ul style="list-style-type: none"> <li>• Achieving roll out of to all 4 sites by the end of Q2.</li> <li>• Completion of communications plan.</li> <li>• Delivering consistent Trustwide access to MR and access to an escalation pathway across all services.</li> </ul>

What we will do	How will you know the objective is completed and that it is working?
<p><b>Objective 2 - Pilot Patient Wellness Questionnaire (PWQ), component of Martha's Rule (Q2-4)</b></p> <p><b>Q2</b></p> <ul style="list-style-type: none"> <li>• Pilot the Patient Wellness Questionnaire (PWQ) in adult wards, starting with 2 adult wards in Q2 and a further 2 wards in Q3.</li> </ul> <p><b>Q3-4</b></p> <ul style="list-style-type: none"> <li>• Roll out of PWQ for Paediatrics.</li> </ul>	<p><b>(Q2)</b></p> <ul style="list-style-type: none"> <li>• Completion of 2 Plan, Do, Study, Act (PDSA) cycles in 2 adult wards of PWQ.</li> <li>• Clear plan for digital capture of PWQ.</li> <li>• Clear plan for how to incorporate PWQ into usual escalation triggers.</li> </ul> <p><b>(Q3-4)</b></p> <ul style="list-style-type: none"> <li>• Completion of 2 Plan, Do, Study, Act (PDSA) cycles in another 2 adult wards of PWQ.</li> <li>• Paediatrics PWQ will be embedded into introduction of National Paediatric Early Warning Score (PEWS).</li> <li>• Data from Paediatrics PWQ regularly captured and used to improve care.</li> </ul>
<p><b>Objective 3 - Evaluation of Martha's Rule</b></p> <p><b>Q2-4</b></p> <ul style="list-style-type: none"> <li>• Collect feedback from callers regarding the service.</li> <li>• Measure awareness of Martha's Rule in staff and patients.</li> <li>• Ensure robust escalation pathway.</li> <li>• Implement monitoring questions surrounding Martha's rule into Care Assure framework.</li> </ul>	<p><b>(Q2-4)</b></p> <ul style="list-style-type: none"> <li>• Consent to gather feedback will be incorporated into the Martha's Rule call proforma.</li> <li>• Project manager will work in partnership with the Patient Experience team to gather feedback from every patient and family that gives consent.</li> <li>• Feedback will be analysed and reported appropriately.</li> </ul>

What we will do	How will you know the objective is completed and that it is working?
	<ul style="list-style-type: none"> <li>• Service will be improved according to feedback.</li> <li>• Embed staff and patient awareness in regular audits carried out of staff and patients across all 4 sites.</li> <li>• Review escalation pathway at 6 months of rollout and adjust as necessary.</li> </ul> <p>Review and amend question bank embedded within Care Assure framework and audit responses to assess effectiveness during evaluation stage.</p>

## Clinical Effectiveness

### Quality Priority 4: Excellence in the basics: reducing variation, improving care through Standard Work

#### Why is this a priority?

We will build on the progress of our first year of Standard Work implementation as a successful vehicle for delivering high-quality care. Learning from year one has demonstrated measurable improvements in patient and staff safety, quality, and efficiency through the use of clear, evidence-based, step-by-step processes that create reliable and consistent care.

The first year focused on key inpatient clinical teams, aligning Standard Work with existing structures to reduce duplication and improve areas such as equipment checks, board rounds, safe and secure storage of medicines, and safety huddles. In year two, the programme will shift towards wider organisational adoption as part of a longer-term strategy, supported by a clear, co-designed approach in partnership with key stakeholders, embedding Standard Work as a core element of our quality and operational management system

Table 29 Excellence in the basics: reducing variation, improving care through Standard Work QP 2026/27

What we will do	How will you know the objective is completed and that it is working?
<p><b>Objective 1a (Q1-4)</b></p> <ul style="list-style-type: none"> <li>Continue to build on the work initiated during QP year 1 – applying standard work principles of practice in defined core clinical domain of Safe and Secure Storage of Medicines to complete adoption - ensuring metrics agreed within task and finish groups.</li> </ul>	<p><b>(Q1-4)</b></p> <ul style="list-style-type: none"> <li>Standard Work documents to be completed and rolled out across defined clinical areas as prioritised by Trust wide Safe and Secure Storage Medicines Audit and Care Assure Audit. Improvement in agreed metrics will be linked to the Safe and Secure Storage of Medicines – e.g.</li> </ul>

What we will do	How will you know the objective is completed and that it is working?
	<ul style="list-style-type: none"> <li>○ 100% of prioritised clinical areas with safe and secure storage and stock management using standard work documentation.</li> <li>○ By March 2027, achieve incremental improvement from baseline in Care Assure audit scores for the safe and secure storage of medicines, through Divisional implementation of 5S using the SW template, with ongoing monitoring via Care Assure audits to ensure sustained compliance. The scale of improvement will be defined in alignment with local baseline/root cause to support sustainable and meaningful improvement).</li> <li>● Staff report increased confidence and ease in applying Standard Work practices, as represented through: <ul style="list-style-type: none"> <li>○ Improvement in Care Assure audit compliance against Standard Work criteria.</li> <li>○ Attendance and completion rates for Divisional level Standard Work training across key defined staff groups</li> <li>○ Qualitative feedback from key staff groups evidencing improved understanding and usability (i.e. pharmacy and ward-based nursing staff)</li> </ul> </li> </ul>
<b>Objective 1b (Q1-4)</b>	<b>(Q1-4)</b>

What we will do	How will you know the objective is completed and that it is working?
<ul style="list-style-type: none"> <li>Continue to build on the work for initiated during QP year 1 – applying standard work principles of practice in defined core clinical domain of Safety Huddles to complete adoption - ensuring metrics agreed within task and finish groups and including review of safety huddles principles.</li> </ul>	<ul style="list-style-type: none"> <li>Agreed Trust Safety Huddle Principles and core standard incorporated into Trust policy by October 2026</li> <li>embedded within Divisional assurance as part of Care Assure.</li> <li>By March 2027, Divisions will have embedded agreed Safety Huddle Principles across 50% of inpatient clinical teams will achieve increased compliance, as measured through Care Assure. The increase in compliance will be defined in alignment with local baseline/root cause to support sustainable and meaningful improvement.</li> <li>Staff report increased confidence and ease in applying Standard Work practices, as represented through: <ul style="list-style-type: none"> <li>Improvement in Care Assure audit compliance against Standard Work criteria.</li> <li>Attendance and completion rates for Divisional level Standard Work training across key defined staff groups</li> <li>Qualitative feedback from key staff groups evidencing improved understanding and usability (i.e. Inpatient ward Matrons)</li> </ul> </li> </ul>
<p><b>Objective 2 (Q1-4)</b></p> <ul style="list-style-type: none"> <li>Building forward on the work already in progress with Ophthalmology, the team will collaborate with two or three chosen Directorates/services to trial, adapt, and introduce</li> </ul>	<p><b>(Q1-4)</b></p> <ul style="list-style-type: none"> <li>By May 2026, have identified 2–3 Directorates/services with the CMO and CNO to trial and implement Standard Work, building on the Ophthalmology pilot and aligned to Trust priorities.</li> </ul>

What we will do	How will you know the objective is completed and that it is working?
<p>standard work, refining proposed changes that could facilitate ongoing broader Divisional led implementation.</p> <ul style="list-style-type: none"> <li>• Services will be determined in consultation with the CMO and CNO, ensuring alignment with Trust priorities. This approach will include:</li> <li>• Development of Standard Work documentation collaboratively with frontline staff, support adoption of continuous improvement approach and digitisation of results from ward/department to board level.</li> <li>• Capture lessons learnt to share best practice, scale and spread</li> </ul>	<ul style="list-style-type: none"> <li>• Co-develop and approve Standard Work documentation with frontline staff in each participating service, with 100% of agreed processes documented and made accessible at ward/department level by the end of working with each service. All final versions for the services will be complete by March 2027.</li> <li>• Improvement in agreed priority metrics agreed with CMO and CNO aligned to identified priorities services, including consideration of safety, quality, efficiency and patient/staff experience metrics. The size of improvement will be defined in alignment with local baseline/root cause to support sustainable and meaningful improvement.</li> <li>• By March 2027, complete a lesson learnt review for each participating service, with identified best practice and improvement themes shared Divisional-wide to support scale and spread. Including, internal and external shareable case studies.</li> <li>• Services to share learning through QI Stand Up sessions where Standard work has been embedded.</li> </ul>

What we will do	How will you know the objective is completed and that it is working?
<p><b>Objective 3 Q1-4</b></p> <p>Develop the Standard Work Toolkit – bringing together tools available to support wider adoption and implement within services taking an approach aligned with OUH Improvement Framework.</p> <ul style="list-style-type: none"> <li>• Review and align all Trust adopted Standard Work documents to present clear materials for wider scale and spread, utilising the Standard Work branding.</li> <li>• Roll out of Standard Work masterclasses to key Divisional teams to help adoption, engagement and further spread of concept.</li> <li>• Collation of videos sharing impact and learning from adoption of Standard Work principles from QP year 1 achievements</li> <li>• Support videos to support team and service level leaders / managers engaging local staff to understand purpose and value of adoption of standard work principles</li> </ul>	<p><b>(Q1-4)</b></p> <ul style="list-style-type: none"> <li>• Suite of Standard work documents as examples on QI Zone SharePoint for staff to download, use and understand the concept further.</li> <li>• Inclusion of videos on QI Zone.</li> <li>• Pages on the Standard Work section within QI Zone on SharePoint for any key priorities – e.g. in Year 1 the Board Rounds page was developed and assisted all staff involved and provided a level of sustainability.</li> <li>• Increased uptake of Standard Work masterclasses across all Divisional teams, with initial focus on colleagues linked to priority areas and ongoing assurance processes. Captured through: <ul style="list-style-type: none"> <li>○ Increased numbers of Ward Managers or equivalent completed Standard work Masterclass across all Divisional inpatient wards</li> <li>○ Increased numbers of Inpatient Matrons completed Standard work Masterclass across all Divisional inpatient wards</li> <li>○ Increased numbers of Care Assure assessor colleagues completed masterclass, including corporate support staff.</li> </ul> </li> </ul>

What we will do	How will you know the objective is completed and that it is working?
	<ul style="list-style-type: none"> <li>(Above numbers to be agreed with Divisional representatives within programme board to ensure sustainable approach with clear Divisional ownership and oversight).</li> </ul>
Objective 4 Q2-4	(Q2-4)

What we will do	How will you know the objective is completed and that it is working?
<ul style="list-style-type: none"> <li>• Supporting adoption of OUH approach to the concept and principles of “Leader Standard Work” (SWL), underpinning our ongoing Trust approach to developing our culture of excellence and continuous improvement.</li> </ul> <p>This will be delivered through:</p> <ul style="list-style-type: none"> <li>• Embedding these principles at the centre of Divisional development and delivery of the SW programme, supported by the QI team, incorporating key enablers such as: <ul style="list-style-type: none"> <li>○ “Go See” Leadership Walkabouts: Leaders observe work directly to identify opportunities for improvement.</li> <li>○ Coaching: encourage developing staff through ongoing coaching, building team capability. Leaders being problem Framers not always problem solvers.</li> <li>○ Visual Management: Performance is made visible with boards and charts to track key indicators, model through SW priority metrics.</li> <li>○ Strategic Alignment: Align routine tasks direct link to the organisation’s long-term goals throughout the programme.</li> </ul> </li> <li>• By the end of Q1, we will have integrated Leader Standard Work principles into OUH QI Managers and Leaders offer, building on learning to date to better equip leaders for their role in setting</li> </ul>	<ul style="list-style-type: none"> <li>• By the end of Q4, to achieve a 25% increase in the uptake of Band 7+ leaders/managers attending QI for Leaders and Managers training at the Trust</li> <li>• By the end of Q4, we will deliver a Standard Work Symposium to showcase Standard Work implementation and impact, share learning, and celebrate achievements, with participation from identified Divisional teams and key stakeholders.</li> <li>• By the end of Q3, work in collaboration with the Culture and Leadership team to identify 2 PDSA cycles focused on priority areas supporting ongoing integration of Leader Standard Work principles at OUH</li> <li>• Within the Standard Work Programme we will have: <ul style="list-style-type: none"> <li>○ By the end of Q2, each defined SW priority will have had leaders conduct at least two structured workplace observations, documenting a minimum of one improvement opportunity per visit, with actions reviewed in monthly team meetings.</li> <li>○ Over duration of the programme 100% of OUH QI Coaches will access Standard Work Masterclass and be supported to consider impact and learning within their Divisions.</li> </ul> </li> </ul>

What we will do	How will you know the objective is completed and that it is working?
<p>both the context and culture for others to driver forward local continuous improvement.</p> <ul style="list-style-type: none"> <li>Working in collaboration with the Culture and Leadership team, identify areas of organisational strength and map opportunities for joint approach to incorporating principles into leader and management training and development at OUH</li> </ul>	<ul style="list-style-type: none"> <li>By the end of Q3, all priorities in the programme will have a visual performance board displaying agreed SW priority metrics, for local adoption aligned to support performance discussions with at least one Task and Finish priority review meeting per month.</li> <li>Divisional Leadership will be supported to review and draft clear well led CQC preparation question or briefing for clinical staff aligned to sharing standard work impact through priority areas at OUH.</li> </ul>

## Quality Priority 5: Strengthening Discharges

### Why is this a priority?

We remain dedicated to progressing this Quality Priority into its second year and building on the objectives we have achieved so far. There is an increasing demand for our emergency and planned care services because of a growing and ageing population in Oxfordshire. Patients attending our hospitals are more complex, both medically and socially. Following a 'Home first' approach, we are striving to discharge as many patients as possible to their homes, where we know people recover and rehabilitate quicker than in a hospital. Discharges to care homes or to community hospitals should be limited to where it is not possible to deliver the level of care required in a person's home. Consequently, the volume and complexity of discharge planning has increased.

This Quality Priority will review discharge processes for all patients and seek to improve the quality and safety of discharge. This includes reducing delays and length of stay, as well as learning from incidents and feedback. There will also be an opportunity to explore the empowerment of nurses and other Allied Health Care Professionals to lead discharge-based decisions to improve quality and reduce length of stay.

Table 30 Strengthening Discharges QP 2026/27

What we will do.	How will you know the objective is completed and that it is working?
<p><b>Foundation (overall) objective</b></p> <p><b>Improve experience of continuity and quality of care for patients being discharged from hospital.</b></p> <ul style="list-style-type: none"> <li>• Write a Trust Discharge Policy.</li> <li>• Establish a process for reviewing quality, safety and risk of discharge from hospital.</li> </ul>	<p><b>(Q1-4)</b></p> <ul style="list-style-type: none"> <li>• There will be Trust wide engagement and awareness in agreed discharge processes.</li> <li>• There will be standardisation in discharge safety checks across the Trust.</li> <li>• There will be an approved Trust Policy on Hospital Discharge.</li> </ul>

What we will do.	How will you know the objective is completed and that it is working?
	<ul style="list-style-type: none"> <li>• Sustain a discharge assurance group.</li> <li>• There will be a dashboard to collate and display internal and external information.</li> <li>• Thematic analysis of internal themes as well as from system partners.</li> <li>• Share internally to appropriate colleagues for awareness and action where needed.</li> <li>• Close feedback loop to system partners.</li> </ul>
<p><b>Objective 1 Medication (Q1-3)</b></p> <p><b>Improve timeliness of TTO prescription and readiness</b></p> <ul style="list-style-type: none"> <li>• Improve TTO ('to take out') medication turnaround times</li> <li>• Increase visibility and reporting of TTO medication related issues, including instances when TTOs couriered to the patient because not ready at time of discharge.</li> </ul>	<p><b>(Q1-3)</b></p> <ul style="list-style-type: none"> <li>• Target reduction of 20% reduction in the use of courier to deliver TTO's.</li> <li>• Risk assessment in place for the safe use of courier when it is required for TTO's.</li> <li>• 10% improvement in percentage of TTO's turnaround within 120 minutes. 15% reduction in reported incidents related to TTO's timeliness.</li> </ul>
<p><b>Objective 2 Communication (Q1-4)</b></p> <p><b>Improve and provide assurance of the safety of discharge from hospital</b></p>	<p><b>(Q1-2)</b></p> <ul style="list-style-type: none"> <li>• The Discharge Safety Checklist has been reviewed and validated for each patient group and includes key discharge safety</li> </ul>

What we will do.	How will you know the objective is completed and that it is working?
<ul style="list-style-type: none"> <li>Standardise the discharge processes on departure from hospital.</li> <li>Implement a mandatory Discharge Safety Checklist within the 'depart' process in the electronic patient record (EPR) with specific check lists for adults, maternity, neonates and children's.</li> </ul>	<p>concerns as identified in Overarching objective thematic review of incidents, complaints and feedback.</p> <p><b>(Q2-3)</b></p> <ul style="list-style-type: none"> <li>The Discharge Safety Checklist is on EPR and is mandatory for all patient groups.</li> </ul> <p><b>(Q3-4)</b></p> <ul style="list-style-type: none"> <li>Phased implementation will show increasing compliance rates to 100% of discharges for areas included.</li> <li>Increase positive feedback from patients and families regarding the discharge process (target 20% increase in positive feedback).</li> <li>20% reduction in discharge-related complaints and incidents.</li> </ul>
<p><b>Objective 3 Patient Experience (Q1-2)</b></p> <p><b>Provide clear communication to patients and unpaid carers on discharge processes and follow up support</b></p> <ul style="list-style-type: none"> <li>Increase awareness of the new Discharge Information Leaflet</li> <li>Brief ward staff on the contents and embed its use.</li> </ul>	<p><b>(Q1-2)</b></p> <ul style="list-style-type: none"> <li>The leaflet has been produced, is in circulation and staff know about it and use it.</li> <li>Reduced misunderstandings from staff/patients on discharge pathways and expectations.</li> <li>Staff feel empowered and prepared to answer questions relating to complex discharge from patients/relatives.</li> <li>Increase patient satisfaction scores related to discharge communication by 20%.</li> </ul>

What we will do.	How will you know the objective is completed and that it is working?
	<ul style="list-style-type: none"> <li>• Positive feedback from patients and families regarding discharge communication by end of Q4 (measured through questionnaires and friends and family tests – 6 months to implement changes and 6 months to see improvement in feedback).</li> <li>• All Inpatient Directorates will achieve the national average score of 7.9 with 75% exceeding the Trust average for the previous year (8.6) for <i>“Before you left hospital, were you given any information about what you should or should not do after leaving hospital? This includes any verbal, written, or online information”</i> in the National inpatient survey.</li> <li>• There will be a 20% reduction in discharge-related complaints.</li> </ul>
<p><b>Objective 4 Documentation(Q1-4)</b></p> <p><b>Improve the quality of discharge documentation</b></p> <ul style="list-style-type: none"> <li>• Revisions made to the GP discharge letter template that encompass community partner feedback on content.</li> <li>• Enable a system and approach that allows for regular review and update of the template based on feedback and incident trends.</li> <li>• Enable Allied Health Professionals (AHP) colleagues and other clinical colleagues to contribute to the discharge summary as required.</li> </ul>	<p><b>(Q1-2)</b></p> <ul style="list-style-type: none"> <li>• The new discharge summary template will include feedback and requests from key community partners.</li> <li>• OUH discharge summaries will be from the Multi-disciplinary Team, not just the medical team.</li> </ul> <p><b>(Q3-4)</b></p> <ul style="list-style-type: none"> <li>• There will be a decrease by 25% in negative feedback from community partners regarding discharge information.</li> <li>• All Inpatient Directorates will achieve the national average score of 7.9 with 75% exceeding the Trust average for the previous</li> </ul>

What we will do.	How will you know the objective is completed and that it is working?
	<p>year (8.6) for <i>“Before you left hospital, were you given any information about what you should or should not do after leaving hospital? This includes any verbal, written, or online information”</i> in the National Inpatient survey.</p>
<p><b>Objective 5 Timeliness of Discharge (Q2-4)</b></p> <p><b>Nurse, Midwife, Therapies and Allied Health Care Professionals (AHPs) led discharge opportunities</b></p> <ul style="list-style-type: none"> <li>• <b>Q1-2:</b> Set up a scoping session to identify what is required and who can discharge patients.</li> <li>• <b>Q3-4:</b> Once established, produce a Standard Operating Procedure (SOP) for nurse-led discharges.</li> <li>• Develop and implement a criterion-led discharge process for Nurses, Midwives and AHPs.</li> <li>• Train relevant nurses, midwives and AHP staff on the criterion-led discharge process.</li> </ul> <p><b>Reduce average length of stay and improve patient flow in the morning*.</b></p> <ul style="list-style-type: none"> <li>• Develop and implement a process to prioritise and facilitate discharges before midday.</li> <li>• Embed discharge prioritisation guidance.</li> <li>• Explore the requirement for an electronic dashboard.</li> </ul>	<p><b>(Q3-4)</b></p> <ul style="list-style-type: none"> <li>• Training completion for all staff participating in criterion-led discharge criteria.</li> <li>• Compliance reports showing adherence to the criterion-led discharge process.</li> <li>• Reduction in average length of stay by at least 6 hours once criterion-led discharges implemented for areas where this is embedded.</li> <li>• 25% of discharges are by midday on inpatient areas on the JR site.</li> <li>• Positive feedback from patients and families regarding the discharge process.</li> <li>• 20% Reduction in discharge-related complaints.</li> <li>• All communications and media about the new discharge protocol have been disseminated.</li> </ul>

What we will do.	How will you know the objective is completed and that it is working?
<p><i>* Note that this <u>excludes</u> Outpatients, Day Surgery Units, Short Stay areas (average &lt;24 hours, e.g. Maternity, Orthopaedic Short Stay Unit), Assessment areas</i></p>	<ul style="list-style-type: none"> <li>• Data support adherence to 25% of ward discharge by midday.</li> <li>• Positive feedback from patients and families regarding the discharge process, through PALS and Friends and Family Test.</li> <li>• Adapt discharge documentation process in EPR to support criteria led discharge. Integration of the guidelines into the electronic patient record (EPR) system.</li> </ul>

## Quality Priority 6: Ambient Voice Technology (AVT)

### Why is this a priority?

AVT is a smart system that listens to the conversation between a patient and their clinician and turns it into accurate notes and letters automatically. Instead of writing everything down by hand, the technology does the hard work in the background, so the healthcare professional can give patients their full attention. This technology relies on Artificial Intelligence (AI) to capture consultation notes and turn them into letters, referrals and other documents for the clinician to check.

To evaluate its impact on workflow efficiency and patient experience, we launched an AVT pilot in July 2025 across multiple departments. Clinicians reported saving time on writing notes and some additional benefits such as a faster turnaround of clinic letters, and patients reported a positive experience during the consultations. These positive results have led to a decision to purchase the technology.

Local pilots have shown a positive impact on staff, including

- Reduced burnout and improved work-life balance.
- Patients report getting more eye contact and attention from their clinicians.
- Better quality documentation,
- Less out-of-hours working for staff,
- Reduced admin burden

Table 31 AVT QP 2026/27

What we will do	How will you know the objective is completed and that it is working?
<p><b>Objective 1 (Q1-3): Complete procurement, governance, and mobilisation</b></p>	<p><b>(Q1-3)</b></p> <ul style="list-style-type: none"> <li>• Procurement completed and contract signed.</li> <li>• DPIA, safety case and DTAC documentation approved.</li> </ul>

What we will do	How will you know the objective is completed and that it is working?
<ul style="list-style-type: none"> <li>• Finalise AVT procurement and award contract.</li> <li>• Complete Data Protection Impact Assessments (DPIA), Clinical Safety Case, Digital Technology Assessment Criteria (DTAC) and cybersecurity assurance.</li> <li>• Confirm Divisional Points of Contact and establish Implementation Group.</li> <li>• Develop standardised templates, workflows, and training materials.</li> </ul>	<ul style="list-style-type: none"> <li>• Divisional POCs in place; Implementation Group active.</li> <li>• Training materials and templates ratified by governance.</li> </ul>
<p><b>Objective 2 (Q1-2)</b></p> <p><b>Phased rollout</b></p> <p><b>Onboarding of priority areas</b></p> <ul style="list-style-type: none"> <li>• Identify, train and onboard priority areas.</li> <li>• Implement AVT in standardised “stand-alone” mode.</li> <li>• Activate Trustwide comms and engagement plan.</li> <li>• Monitor early safety, user experience and accuracy metrics.</li> </ul>	<p><b>(Q1-2)</b></p> <ul style="list-style-type: none"> <li>• ≥5 priority services onboarded.</li> <li>• ≥80% of trained clinicians routinely using AVT within one month.</li> <li>• Monthly early phase benefits reports produced.</li> <li>• No unresolved high severity safety/IG issues.</li> </ul>
<p><b>Objective 3 (Q 1-4)</b></p> <p><b>Evaluate benefits and embed AVT into business as usual (BAU)</b></p> <ul style="list-style-type: none"> <li>• Produce Trustwide evaluation across clinical, operational and staff experience domains.</li> <li>• Confirm long-term ownership and BAU support model.</li> <li>• Agree ongoing training and optimisation plan.</li> </ul>	<p><b>(Q 1-4)</b></p> <ul style="list-style-type: none"> <li>• Evaluation completed and submitted to CGC.</li> <li>• Demonstrated improvements in documentation, turnaround time, administrative time, staff wellbeing and patient experience.</li> <li>• AVT embedded as BAU with clear governance and reporting structure.</li> </ul>

What we will do	How will you know the objective is completed and that it is working?
<ul style="list-style-type: none"><li>• Develop recommendations for integration and licence scaling.</li></ul>	

## Patient Experience

### Quality Priority 7: Advance Care Planning (ACP) and End of Life Care (EoLC)

#### Why is this a priority?

End of Life care (EOLC) focuses on recognising when a patient is approaching the last year, months, or days of life and ensuring care aligns with their goals, values and best interests. The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) is a structured process and document that records personalised clinical recommendations. It summarises key information about a person's health and uses this to guide decisions about treatment escalation, resuscitation and priorities for comfort or intervention

This Quality Priority will focus on education for staff to better recognise patients who are at risk of dying, and to support them with high quality advance care plans using ReSPECT. Education strategies will support better End of Life care and communication.

Table 32 Advance Care Planning (ACP) and End of Life Care (EoLC) QP 2026/27

What we will do	How will you know the objective is completed and that it is working?
<p><b>Objective 1 e.g. (Q1-4)</b>  <b>Improve recognition of inpatients who are at risk of deterioration and dying.</b></p> <ul style="list-style-type: none"> <li>Enlist End of Life care link nurses in all inpatient areas.</li> </ul> <p><b>Q1-4:</b></p> <ul style="list-style-type: none"> <li>Introduce tiered and role-specific EoLC training.</li> </ul>	<p><b>(Q1-4)</b></p> <ul style="list-style-type: none"> <li>Recruitment and engagement of EoLC link nurses.</li> <li>There are mandated role-specific e-Learning modules.</li> </ul>

What we will do	How will you know the objective is completed and that it is working?
<ul style="list-style-type: none"> <li>• Offer educational resources and teaching sessions (that focus on recognition of dying, conversations about hydration, recording ethnicity, using translating services and discharging a dying patient from hospital) to all inpatient areas.</li> <li>• Use complaints and feedback on discharges and translation services to identify and address further opportunities for improvement. Present quarterly data at Mortality Review Group meeting.</li> </ul> <p><b>Q1-2:</b></p> <ul style="list-style-type: none"> <li>• Encourage and increase use of the <i>Care of the Dying Patient Prompt</i> in EPR, which highlights the key parameters: recognise dying, communicate about dying, manage discussions about hydration, chaplaincy and use a translator; manage symptoms at EoLC and stop all unnecessary tests, treatment and medications.</li> </ul>	<ul style="list-style-type: none"> <li>• At least 50% of patient-facing staff working in inpatient areas will have completed training by the end of Q4.</li> <li>• Aim for all inpatient areas to be offered palliative and End of Life care education, aiming for 50% uptake by end of Q4.</li> <li>• Reduce the number of complaints related to discharges and translation services at the End of Life (by 10%).</li> <li>• Audit recognition of dying before and after establishing use of the prompt in specialities where number of deaths are high – i.e. Adult General Medicine (AGM). Target: 50% of AGM ward doctors are confident in recognising and managing dying patients following training on this and using the prompt.</li> </ul>
<p><b>Objective 2 (Q1-4):</b></p>	

What we will do	How will you know the objective is completed and that it is working?
<p><b>All patients should have personalised care and support planning (PCSP) conversations that are documented in ReSPECT and advance care planning (ACP) PowerNotes.</b></p> <ul style="list-style-type: none"> <li>• Undertake audit to assess how well all sections of ReSPECT document are completed.</li> <li>• Undertake audit to assess the patient's and/or their significant other's experience of a ReSPECT conversation</li> <li>• Undertake audit to evaluate the clinician's perspective in undertaking ReSPECT conversations and recommendations.</li> </ul> <p>Review incidents in Ulysess relating to identified search terms and identify trends and produce safety messages to summarise key learning from clinical events.</p>	<p><b>(Q1 - 4)</b></p> <ul style="list-style-type: none"> <li>• ReSPECT mandatory audit is created in Assurance Hub, adult inpatient ward managers or appointed deputy will complete 2 ReSPECT audits monthly. Each audit has three elements. In the first element of the audit, wards will provide evidence on how well the ReSPECT form is completed</li> <li>• The second element, wards will provide evidence of the patient's experience.</li> <li>• The third element, wards will provide evidence of the clinician's experience of the ReSPECT process. All three elements will be collated and presented as an annual report presented at clinical improvement committee.</li> <li>• Incidents and complaints regarding conversations will be collated to establish a baseline of numbers of incidents and patient complaints associated with ReSPECT.</li> <li>• Safety messages sent periodically to OUH clinicians</li> </ul>

What we will do	How will you know the objective is completed and that it is working?
<ul style="list-style-type: none"> <li>Produce learning materials based on learning from practice and locate on Resuscitation/ACP-ReSPECT Sharepoint page.</li> </ul>	<ul style="list-style-type: none"> <li>Education materials located on Resuscitation/ACP-ReSPECT Sharepoint page.</li> </ul>
<p><b>Objective 3: (Q1-4)</b></p> <p><b>Make ReSPECT and related ACP documents easier to understand and access, for clinicians, patients and those close to them.</b></p> <ul style="list-style-type: none"> <li>Develop resources for patients and families explaining the importance of these conversations. Work with the patient experience group to develop an OUH information leaflet on ReSPECT and ACP.</li> <li>Work with informatics to rationalise place of documenting <b>ACP</b> on EPR, aiming to collate all related documentation in one place on EPR.</li> <li>Work with informatics to rationalise place of documenting <b>LPA</b> on EPR, aiming to collate all related documentation in one place on EPR.</li> </ul>	<p><b>(Q1-4)</b></p> <ul style="list-style-type: none"> <li>Results of patient and family feedback on ReSPECT and related conversations.</li> <li>A OUH patient information leaflet.</li> <li>Develop a ‘help’ guide to locate ACP documents on EPR.</li> <li>Evidence that the EPR have created a shared folder on EPR.</li> <li>Develop a ‘help’ guide to locate LPA documents on EPR.</li> <li>Evidence that the EPR have created a shared folder on EPR.</li> </ul>
<p><b>Objective 4 Q1-4</b></p>	

What we will do	How will you know the objective is completed and that it is working?
<p><b>Work in partnership with Integrated Care Board and other local providers to improve sharing of ReSPECT across organisations and with patients.</b></p> <ul style="list-style-type: none"> <li>• Develop an options appraisal for integration of OUH and ICB digital ReSPECT forms.</li> <li>• Work with partners towards implementation of a single shared digital ReSPECT document (that is readable and editable and can be accessed across partner organisations including out of hours and emergency services).</li> </ul>	<ul style="list-style-type: none"> <li>• OUH options appraisal developed and presented to Clinical Governance Committee and Digital Clinical Advisory Group.</li> <li>• Formation of OUH ReSPECT Graphnet scoping group.</li> <li>• Regular engagement with ICB ReSPECT stakeholder group to move the project forward.</li> </ul>

## Quality Priority 8: Public and Patient Participation Framework

### Why is this a Priority?

A robust Patient and Public Participation Framework is essential to ensure that OUH consistently listens to, involves and works in partnership with the people it serves. It will provide a clear Trustwide approach for embedding lived experience into decision-making, improving the quality, safety and responsiveness of care. By setting out agreed principles, expectations and practical tools, the Framework will help OUH meet national requirements for working with people and communities and support efforts to reduce health inequalities. It will help to ensure that all voices are heard, engagement is meaningful rather than tokenistic, and services are shaped in ways that reflect the diverse needs of patients, families, carers and communities.

Table 33 Public and Patient Participation Framework QP 2026/27

What we will do	How will you know the objective is completed and that it is working?
<p><b>Objective 1 (Q1-4)</b></p> <p><b>Collaboratively develop and publish a set of clearly defined roles, responsibilities and expectations for Patient Safety Partners (PSPs) and Patient Participation Groups (PPGs), including their contribution to governance, quality improvement, policy development and service redesign.</b></p> <ul style="list-style-type: none"> <li>• <b>Q1:</b> Establish a small group of PSPs, PPG members and staff to determine principles and collaborate on development of policy and toolkit. These should cover recruitment, onboarding,</li> </ul>	<p><b>(Q1-4)</b></p> <ul style="list-style-type: none"> <li>• Policy, tools and resources are developed and published.</li> <li>• Increased evidence of governance, quality improvement, policy development and service redesign involving PSPs and PPGs: <ul style="list-style-type: none"> <li>○ At least one PSP member on key governance committees, including CGC, CIC, PSEC, Policy Committee, Patient Experience and Engagement Committee (PEEC) and Divisional CGCs.</li> <li>○ A pathway for PPGs to escalate issues to governance committees.</li> </ul> </li> </ul>

What we will do	How will you know the objective is completed and that it is working?
<p>induction, mentorship, supervision, remuneration and impact evaluation.</p> <ul style="list-style-type: none"> <li>• <b>Q1-3:</b> Develop a policy and toolkit.</li> <li>• <b>Q3-4:</b> Implement the policy and toolkit.</li> </ul>	<ul style="list-style-type: none"> <li>• Stakeholder evaluation (PSP, PPG, staff) demonstrates positive experience and impact on outcomes.</li> </ul>
<p><b>Objective 2 (Q1-2)</b>  <b>Develop and deliver an annual Patient Census to capture demographic, cultural, linguistic, accessibility, social and spiritual characteristics of OUH patients and service users.</b></p> <ul style="list-style-type: none"> <li>• <b>Q1:</b> Develop and pilot the Census instrument.</li> <li>• <b>Q2:</b> Administer the Census and present findings to PEEC and consider engagement of community partners to optimise reach.</li> </ul>	<p><b>(Q1-2)</b></p> <ul style="list-style-type: none"> <li>• Instrument developed and piloted.</li> <li>• Demographic, cultural, linguistic, accessibility, social and spiritual characteristics of OUH patients and service users captured and presented.</li> <li>• Community partners reflect diversity of patient population.</li> </ul>
<p><b>Objective 3 (Q1-3)</b>  <b>Establish a comprehensive and regularly updated network of community groups, charities and Voluntary Community and Social Enterprise organisations (Trusted Partners) that reflect the diversity of OUH's patient populations.</b></p> <ul style="list-style-type: none"> <li>• <b>Q1-3:</b> Establish database and accessible, culturally safe methods of sharing information with at least <b>10 priority organisations.</b></li> <li>• <b>Q3:</b> Capture learnings and insights in central repository to inform equality, diversion and inclusion improvement initiatives.</li> </ul>	<p><b>(Q1-3)</b></p> <ul style="list-style-type: none"> <li>• Database and communication methods available</li> <li>• Evidence of improvements using lived experience voices from diverse populations available.</li> </ul>

What we will do	How will you know the objective is completed and that it is working?
<p><b>Objective 4 (Q3-4)</b></p> <p>Introduce a structured approach for evaluating the impact of PSP, PPG and Trusted Partner involvement on quality improvement, governance, policy development and service redesign to improve patient experience.</p> <ul style="list-style-type: none"> <li>• <b>Q3:</b> Develop and implement an evaluation tool for measuring the impact of patient and public participation.</li> <li>• <b>Q4:</b> Implement reporting of patient and public participation including impact evaluation through the PEEC.</li> </ul>	<p><b>(Q3-4)</b></p> <ul style="list-style-type: none"> <li>• Evaluation tool available.</li> <li>• Reporting implemented and continuous learning evident.</li> </ul>

## Quality Priority 9: Maternity Patient Experience

### Why is it a Priority?

Recent national interest and scrutiny has rightly put an even greater emphasis on the importance of improving maternity service user experience, underscoring the need for transparent, responsive and inclusive approaches that truly reflect the voices of those users by actively engaging with feedback and learning from both local and national findings.

This Quality Priority highlights the value of a service user centred approach with healthcare professionals dedicating time to listen to and understand the perspectives of mothers and families. By actively incorporating feedback and respecting personal choices, we aim to support staff consistently to deliver care that is both respectful and empowering. The initiative encourages ongoing dialogue, shared decision making and partnership, fostering trust and confidence throughout the maternity journey. In turn, this ensures that care remains safe, compassionate and tailored to individual needs while helping staff feel valued and empowered to deliver the highest standards.

Table 34 Maternity Patient Experience QP 2026/27

What we will do	How will you know the objective is completed and that it is working?
<p><b>Objective 1 (Q1-4)</b> <b>Strengthen mechanisms for listening to service users</b></p> <ul style="list-style-type: none"> <li>• Increase promotion and accessibility of feedback routes (FFT, surveys, digital platforms, focus groups).</li> <li>• Introduce targeted postnatal listening events and listening clinics, particularly for women with complex or adverse experiences.</li> </ul>	<p><b>(Q1-4)</b></p> <ul style="list-style-type: none"> <li>• Increase volume and diversity of feedback received across all maternity pathways by 10%.</li> <li>• Evidence of an increase of feedback (by at least 5%) from underrepresented groups</li> <li>• Increase service user satisfaction scores (e.g. FFT, CQC survey) by 10% including among service users with protected characteristics.</li> </ul>

What we will do	How will you know the objective is completed and that it is working?
<ul style="list-style-type: none"> <li>• Work closely with the community partners including the Oxfordshire Maternity Neonatal Voices Partnership (OMNVP) to co-design engagement activity.</li> <li>• Reinforce personalised care planning and shared decision-making across antenatal, intrapartum and postnatal care.</li> </ul>	<ul style="list-style-type: none"> <li>• Increase by 10% the proportion of service users (compared to the number of deliveries/month) reporting feeling involved in decision-making, with increases among all demographic groups.</li> <li>• Reduce number and themes of complaints related to communication, discrimination, or cultural insensitivity by 10%.</li> <li>• We should see an increase in the proportion of appointments with interpreter support provided when requested. This will be monitored through existing systems.</li> </ul>
<p><b>Objective 2 (Q1-4)</b>  <b>Ensure feedback leads to visible action (“You said, we did”)</b></p> <ul style="list-style-type: none"> <li>• Implement a clear feedback-to-action process with defined timescales.</li> <li>• Share learning and improvements with service users via newsletters, posters, social media and the Trust website.</li> <li>• Align local learning with national findings from CQC survey.</li> </ul>	<p>(Q1-4)</p> <ul style="list-style-type: none"> <li>• “You said, we did” communications published monthly.</li> <li>• Audit of the rapid responder role-service demonstrates that users report increased confidence that their feedback is heard and acted upon.</li> <li>• Evidence of changes made directly in response to feedback.</li> <li>• Comments from social media and Trust web sites are reviewed and appropriately responded to.</li> <li>• OMNVP will highlight any feedback from other media sources.</li> <li>• Completed CQC survey action plan.</li> </ul>

What we will do	How will you know the objective is completed and that it is working?
<p><b>Objective 3(Q1-4)</b></p> <p><b>Support and develop staff to deliver excellent patient experience</b></p> <ul style="list-style-type: none"> <li>• Provide training and reflective learning sessions focused on communication, compassion, cultural humility and trauma-informed care.</li> <li>• Use learning from complaints, incidents and national reviews to support improvement rather than blame.</li> <li>• Celebrate good practice and staff contributions to positive experiences.</li> </ul>	<p><b>(Q1-4)</b></p> <ul style="list-style-type: none"> <li>• &gt;95% of all staff completing Active Bystander and Equality Diversity Inclusion (EDI) training.</li> <li>• Staff Survey results demonstrate improvement in inclusion, respect, and confidence in addressing bias.</li> <li>• Improved diversity of maternity workforce compared to local population demographics.</li> <li>• Reduced number of staff-reported incidents related to discrimination or bias, and resolution rates.</li> <li>• Increased examples of positive feedback naming staff and teams (through FFT).</li> <li>• Increase in Daisy awards- staff recognition rewards including nominations.</li> </ul>
<p><b>Objective 4 (Q1-4)</b></p> <p><b>Strengthen openness, transparency and learning culture</b></p> <ul style="list-style-type: none"> <li>• Share outcomes of CQC inspection findings and national investigations openly with staff and service users.</li> <li>• Regularly review patient experience data at local and Directorate governance meetings.</li> </ul>	<p><b>(Q1-4)</b></p> <ul style="list-style-type: none"> <li>• Clear evidence of patient experience discussed at maternity governance forums and Triangulation and learning committee (TALC).</li> <li>• Completed CQC inspection action plans.</li> </ul>

What we will do	How will you know the objective is completed and that it is working?
<ul style="list-style-type: none"> <li>• Ensure learning is embedded into practice and monitored.</li> </ul>	<ul style="list-style-type: none"> <li>• Number of improvement actions arising from TALC including specific themes around triage and induction of labour.</li> <li>• Dashboard demonstrates sustained improvement trends over the year.</li> <li>• Feedback forms from staff to confirm they have been made aware of learning and improvements.</li> </ul>

**Annexe 2: Statements** from the Integrated Care Board, Local Health watch organisations, NHSE, Council of Governors Health, Overview and Scrutiny Committee (HOSC)

**Council of Governors Statement**

**Statement from NHS England Specialised Commissioning**

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

**Statement from Health and Wellbeing Board**

**Statement from Healthwatch Oxfordshire**

**Response to Healthwatch Oxfordshire**

**Statement from Health, Overview and Scrutiny Committee (HOSC)**

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

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

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

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

- The content of the Quality Account meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance provided on [www.england.nhs.uk/financial-accounting-and-reporting/quality-accounts-requirements](http://www.england.nhs.uk/financial-accounting-and-reporting/quality-accounts-requirements)
- The content of the Quality Account is consistent with internal and external sources of information.
- The Quality Account presents a balanced picture of the NHS Foundation Trust's performance over the period covered.
- The performance information reported in the Quality Account is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Account are robust and reliable, conform to specified data quality standards and prescribed definitions, and are subject to appropriate scrutiny and review.

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

By order of the Board

**NB: sign and date in any colour ink except black**



**Simon Crowther**  
**Acting Chief Executive Officer**



**Sarah Hordern,**  
**Acting Chair**

## Annexe 4: Glossary Medical, Clinical and Technical Terms

This glossary provides explanations of medical, clinical, and technical terms used within this Quality Account. It is intended to support accessibility for all readers, including governors, patients, and members of the public.

Table 35 Glossary of medical, clinical and technical terms

Term	Definition
<b>A</b>	
<b>Advance Care Planning (ACP)</b>	A structured process in which patients, often together with healthcare professionals and family members, discuss and record their wishes, values, and preferences for future care and treatment. This is particularly important for patients with long-term conditions or those approaching the End of Life
<b>Adverse Drug Event (ADE)</b>	An injury or harm resulting from the use of medication.
<b>After Action Review (AAR)</b>	A structured reflective process undertaken after an incident or event. It helps teams understand what happened, why it happened, and what can be learned to improve future care and safety
<b>Allied Health Professional (AHP)</b>	A healthcare professional who is not a doctor, nurse, or dentist but plays a key role in patient care. Examples include physiotherapists, occupational therapists, radiographers, and speech and language therapists
<b>Ambulatory Care</b>	Medical care provided on a same-day basis without hospital admission
<b>Antimicrobial Resistance</b>	The ability of microorganisms to resist treatment with antibiotics, making infections harder to treat.
<b>Antimicrobial Stewardship (AMS)</b>	A coordinated approach to promoting the appropriate use of antibiotics and other antimicrobial medicines. Its aim is to improve patient outcomes while reducing the risk of antimicrobial resistance.

<b>Artificial Intelligence (AI)</b>	Technology that enables systems to perform tasks that typically require human intelligence, such as analysing data or generating clinical documentation.
<b>B</b>	
<b>Bacteraemia</b>	The presence of bacteria in the bloodstream. This can lead to serious infections such as sepsis and requires prompt treatment.
<b>Best Practice Tariff (BPT)</b>	A national NHS financial incentive used to encourage high-quality care by rewarding healthcare providers for meeting evidence-based clinical standards.
<b>C</b>	
<b>Care Quality Commission (CQC)</b>	The independent regulator of health and social care services in England. The CQC assesses and rates organisations to ensure services are safe, effective, caring, responsive, and well-led
<b>Case Ascertainment</b>	The proportion of eligible patients included in an audit or dataset.
<b>Clinical Informatics</b>	The use of data, information systems, and digital tools to improve patient care, safety, and service delivery.
<b>Clinical Pathway</b>	A structured, multidisciplinary plan of care designed to support the diagnosis and treatment of specific conditions.
<b>Clinical Trial</b>	A research study involving patients to evaluate new treatments or interventions.
<b>Cohorting (Patients)</b>	Grouping patients with similar conditions together in a specific clinical area to improve care and efficiency.
<b>Critical Care Outreach (CCO)</b>	A specialist clinical service that supports patients who are deteriorating on wards and provides follow-up care for patients discharged from intensive care units
<b>D</b>	
<b>Dashboard (Clinical/Operational Dashboard)</b>	A visual display of key metrics and performance indicators used to support decision-making.

<b>Deep Brain Stimulation (DBS)</b>	A neurosurgical treatment that involves implanting a device to deliver electrical signals to specific areas of the brain to treat certain neurological conditions.
<b>Deep Vein Thrombosis (DVT)</b>	A condition where a blood clot forms in a deep vein, usually in the leg. It can be serious if the clot travels to the lungs (pulmonary embolism).
<b>Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)</b>	A clinical decision indicating that cardiopulmonary resuscitation (CPR) should not be attempted if a patient's heart or breathing stops.
<b>E</b>	
<b>Electronic Patient Record (EPR)</b>	A digital record containing a patient's medical history, treatment, and care information. It enables healthcare professionals to access and share information more efficiently.
<b>Electrocardiogram (ECG)</b>	A diagnostic test that records the electrical activity of the heart to help detect abnormalities.
<b>End of Life Care (EoLC)</b>	Care provided to patients in the final phase of life, focusing on comfort, dignity, and quality of life, rather than cure.
<b>F</b>	
<b>Friends and Family Test (FFT)</b>	A national feedback tool used across the NHS, asking patients whether they would recommend the services they received to others.
<b>G</b>	
<b>Getting It Right First Time (GIRFT)</b>	A national NHS improvement programme focused on reducing variation in care, improving outcomes, and sharing best practice across organisations.
<b>H</b>	
<b>High Intensity Focused Ultrasound (HIFU)</b>	A non-invasive treatment that uses focused ultrasound waves to heat and destroy targeted tissue, such as tumours, without surgery.

<b>Hospital-Acquired Infection (HAI)</b>	An infection developed as a result of care in a hospital or healthcare setting
<b>Hospital Episode Statistics (HES).</b>	Hospital Episode Statistics (HES): NHS data on hospital activity (admissions, outpatient and A&E), used to monitor services and support improvement
<b>I</b>	
<b>Integrated Care Board (ICB)</b>	An NHS organisation responsible for planning, funding, and overseeing healthcare services within a defined geographical area.
<b>Intensive Care Unit (ICU)</b>	A highly specialised hospital unit that provides intensive monitoring and treatment for critically ill patients.
<b>K</b>	
<b>Key Performance Indicator (KPI)</b>	A measurable value used to assess how effectively a service, team, or organisation is achieving its objectives.
<b>L</b>	
<b>Learn from Patient Safety Events (LFPSE)</b>	A national NHS system used to record, analyse, and learn from patient safety incidents.
<b>Learning Multidisciplinary Team Review (LMDTR)</b>	A structured review process involving multiple clinical disciplines to assess patient safety incidents and identify system-wide learning.
<b>Length of Stay (LOS)</b>	The duration of a patient's hospital admission.
<b>M</b>	
<b>Magnetic Resonance Imaging (MRI)</b>	A scanning technique that uses magnetic fields and radio waves to produce detailed images of the body.
<b>Medication Discrepancy</b>	A difference between a patient's prescribed medications and what they are actually taking or should be taking
<b>Mental Capacity Assessment (MCA)</b>	An assessment used to determine whether a patient has the ability to make a specific decision about their care or treatment.

<b>Multidisciplinary Team (MDT)</b>	A group of healthcare professionals from different disciplines who work together to plan and deliver patient care.
<b>Malnutrition Universal Screening Tool (MUST)</b>	A validated screening tool used to identify patients who are malnourished or at risk of malnutrition.
<b>N</b>	
<b>National Early Warning Score 2 (NEWS2)</b>	A standardised scoring system used across the NHS to identify early signs of a patient deteriorating, based on observations such as heart rate, oxygen levels, and blood pressure.
<b>National Confidential Enquiry into Patient Outcome and Death (NCEPOD)</b>	A national programme that reviews patient care to identify areas for improvement and enhance clinical outcomes.
<b>O</b>	
<b>Options Appraisal</b>	A structured process used to evaluate different solutions or approaches before making a decision, often for digital or service changes
<b>P</b>	
<b>Palliative Care</b>	Specialist care focused on relieving symptoms and improving quality of life for patients with serious illness.
<b>Patient Safety Incident Investigation (PSII)</b>	A structured investigation carried out under the Patient Safety Incident Response Framework to understand incidents and identify improvements.
<b>Patient Safety Incident Response Framework (PSIRF)</b>	A national NHS framework guiding how organisations respond to and learn from patient safety incidents. It focuses on systems-based learning rather than individual blame.
<b>Patient Safety Partner (PSP)</b>	A patient, carer, or member of the public who works with healthcare organisations to improve patient safety by contributing to governance and learning processes
<b>Plan–Do–Study–Act (PDSA)</b>	A quality improvement method used to test changes in practice, evaluate their impact, and refine improvements.

<b>Q</b>	
<b>Quality Improvement (QI)</b>	A systematic and continuous approach to improving healthcare services, patient outcomes, and experiences.
<b>R</b>	
<b>Radiotherapy</b>	A treatment that uses high-energy radiation to kill cancer cells.
<b>Rapid Review</b>	A short, initial review of a patient safety incident to determine whether further investigation is required.
<b>Readmission</b>	When a patient is admitted to hospital again within a defined period after discharge.
<b>Recognising the Acutely Ill and Deteriorating Patient (RAID)</b>	A clinical approach and policy framework focused on identifying and responding promptly to patients whose condition is worsening.
<b>Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)</b>	A personalised care plan that records a patient's wishes and clinical recommendations for emergency care when they may not be able to communicate their preferences.
<b>Rota (Clinical Rota)</b>	A schedule showing staff shifts and working patterns.
<b>S</b>	
<b>Safety Learning and Improvement Committee (SLIC)</b>	The Trust's governance forum where patient safety issues, investigations, and learning are reviewed at organisational level which included patient safety partners and Trust staff.
<b>Serious Incident Framework (Superseded)</b>	The previous national NHS framework for investigating serious patient safety incidents, now replaced by the Patient Safety Incident Response Framework (PSIRF).
<b>Standard Operating Procedure (SOP)</b>	A formal written document providing step-by-step instructions on how to carry out a specific clinical or operational task.
<b>Summary Hospital-level Mortality Indicator (SHMI)</b>	A national measure that compares the number of deaths in a hospital with the number expected, based on patient characteristics.

<b>System for Electronic Notification and Documentation (SEND)</b>	An electronic system used to record patient observations and support early identification of deterioration.
<b>T</b>	
<b>Thematic Patient Safety Incident Investigation (Thematic PSII)</b>	A type of investigation that examines patterns or recurring themes across multiple incidents to identify system-wide improvements.
<b>Thromboprophylaxis</b>	Medication or treatment used to prevent blood clots.
<b>To Take Out (TTO) Medicines</b>	Medications provided to patients when they are discharged from hospital to take home.
<b>Transcatheter Aortic Valve Implantation (TAVI)</b>	A minimally invasive procedure used to replace a narrowed or damaged heart valve.
<b>Treatment Escalation Plan (TEP)</b>	A clinical plan outlining the level of treatment appropriate for a patient if their condition deteriorates.
<b>V</b>	
<b>Venous Thromboembolism (VTE)</b>	A condition involving blood clots, including deep vein thrombosis (DVT) and pulmonary embolism.
<b>W</b>	
<b>Whole Time Equivalent (WTE)</b>	A measure of staffing levels that represents the number of full-time staff required.
<b>Work in Confidence (WiC)</b>	A secure, anonymous platform that allows staff to raise concerns safely as part of the Trust's Freedom to Speak Up arrangements

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