Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 13 March 2024

TB2024.25

Title:	**OUH Draft Quality Priorities 2024-2025**

Status:	**For Discussion**
History:	**New proposal for 2024-25 Quality Priorities**

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Confidential:	**No**
Key Purpose:	**Assurance**

OUH Draft Quality Priorities 2024-2025

1. Background

1.1. OUH aims to deliver and assure patients that they are receiving the very best quality of care. NHS Improvement requires all NHS Foundation Trusts to produce reports on the quality of care as part of their annual reports.

1.2. It is a requirement of the annual Quality Account that Trusts include a rationale for the selection of the Quality Priorities and whether/how the views of patients, the wider public and staff were taken into account.

1.3. Quality Priorities need to be highly relevant and visible to staff across the Trust.

2. Proposed Quality Priorities for 2024-25

2.1. Based on earlier suggestions from the Clinical Governance Committee, feedback and suggestions from the Quality Conversation Event and feedback from Executive Directors, the following Quality Priorities (QP) are proposed for 2024-25.

Patient Safety

- QP1. Medication Safety Framework
- QP2. Care of the Frail Elderly – focussing on the urgent care pathway*
- QP3. Reducing Inpatient Falls*

Clinical Effectiveness

- QP4. Outreach Service from Oxford Critical Care
- QP5. Rolling out and embedding the Surgical Morbidity Dashboard*
- QP6. Reducing maternal and neonatal morbidity

Patient Experience

- QP7. Reducing Health Inequalities*
- QP8. Patient experience with PSIRF (patient safety incident response framework)
- QP9. Fragility Fracture pathways – including fractured neck of femur pathway

*Carried over and updated from the 2023-24 Quality Priorities.

2.2. It is proposed that the following Quality Priorities from 2023-24 are absorbed into ‘business as usual’ in 2024-25:

- Medication safety - Insulin and Opiates
- Reducing unwarranted hospital outpatient cancellations
- Helping more patients through tissue donation for transplant
- Empowering patients - building partnerships and inclusion
- Kindness into action - improving patient and staff experience

2.3. Detailed plans and how we will evaluate success for each of the proposed Quality Priorities for 2024-25 can be seen in Appendix 1.

3. Recommendations

3.1. Trust Board is asked to approve the proposed Quality Priorities for 2024-25.

Appendix 1 - Proposed Quality Priorities for 2024-25

Patient Safety

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

Why is this a priority?

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

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

What we will do	How we will evaluate success
Action 1 (Q1) Define a range of medicines safety metrics/indicators, using pharmacy inventory and supply data, in the context of medication related Never Events, NHS England's Enduring Standards and National Patient Safety Alerts.	Agreed plan detailing defined metric/indicator for five medicines where medicines supply controls apply.
Action 2 (Q1) For the five metrics/indictors, define the parameters and/or rules in the context of the organisation.	Summary document detailing the parameters of the five metrics/indicators.
Action 3 (Q2-Q4) Apply the five metrics/indicators to trust pharmacy inventory and supply data at regular time-points over 3-6 months. Analyse data to refine the measures as required using Quality Improvement (QI) methodology. Test feasibility of surveillance tool and capability to identify risks and errors in practice.	Application of metrics/indicators to real pharmacy inventory and supply data at regular time points over a 3-6 month period. Evidence of QI methodology to test and analyse the metrics/indicators to further refine definitions and parameters. Qualitatively analyse data and evaluate impact of the tool with trust stakeholders, to determine potential capability to identify risks and errors in practice.
Action 4 (Q4) Collaborate with The Hill digital innovation team to develop novel software to automate prospective surveillance of one of the safety metrics/indicators (subject to Cerner Pharmacy implementation in Q3).	Successful development of software in collaboration with The Hill's digital innovation team. Feasibility test of one indicator.

Patient Safety

Quality Priority 2: Care of the Frail Elderly

Why is this a priority?

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

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

Patient Safety

Quality Priority 3: Reducing Inpatient Falls

Why is this a priority?

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

What we will do	How we will evaluate success
Apply Improvement Framework throughout to structure and measure approach. Work in conjunction with the QI team on delivery of the QP objectives.	Using appropriate QI tools identified through each step of the improvement framework to enable a structured QI approach and monitoring of sustainability and impact of changes and sharing widely throughout OUH.
Action 1 (Q1-4): Education for staff and patients • Review and develop the falls prevention e-learning training for all staff (Q4). • Strengthen recording of local teaching by champions (Q2-4). • Easy Read version of falls and bedrails leaflets (Q2). • Creating patient stories for shared learning (Q2-4).	• Monitor compliance with the current “e-learning, preventing falls in hospital,” by Division. • Hold an e-learning focus group to evaluate and determine if the current package is to be maintained or a new version created. • Mapping this to related e-learning requirements within the harm reduction programme.

What we will do	How we will evaluate success
• Sharing of learning through the Community of Practice and Improvement Stories (Q1-4).	• Create and test an e-learning package with relevant stakeholders. • Apply for role-specific status through the Education and Training Committee. • Measure compliance with the e-learning package. Target - 60% of Nursing and AHP to have completed e-learning training by March 2025, if mapped to the role. • Develop, test and evaluate a My Learning Hub (MLH) bespoke ward teaching course for Champions to record local teaching. • Develop in conjunction with the learning disabilities team and Patient Safety Partners, test and evaluate, an easy-to-read version of the falls and bedrail leaflet. • Hold patient focus groups with Careers Oxfordshire to review patient impact. • Develop and test mechanisms to capture patient and staff stories. • Continue to develop the Community of Practice for Falls and HAPU including other stakeholders as evolves.

What we will do	How we will evaluate success
Action 2 (Q1-4): Increase Multifactorial Falls Risk Assessment (MFRA) compliance • Monitoring audit Trust results for fallsafe audit completion (Q1-4). • Establishing assessments across day cases and maternity, using a QI approach (Q1-4). • Review falls assessment tool and care plans for adults (Q1-4).	• Establish within Ulysses a reporting system for audits, demonstrating trust-wide compliance. • Monitor monthly ward area compliance and create a reporting system to wider Trust Forums. • Ulysses audit reports will be reviewed monthly and wards that perform below 90% on two consecutive months will be contacted by the Falls Prevention Practitioner to review their action plan and supported to implement. • Use a QI approach to determine concerns and barriers around assessment, implement proposed assessment and audit outcomes, on compliance and staff response. • Determine elements of assessment required and develop and test appropriate assessment. • Discuss and seek support with digital and EPR teams for the implementation of new assessments. • Review current assessment tool and care plan. • Develop and test any proposed changes with stakeholders, evaluate, adopt, or adapt as appropriate.
Action 3 (Q1-4): Strengthen early assessment following a fall • Develop and implement tools (e.g., Safety Message) to improve early assessment (Q2-4).	• Write Safety Message and seek approval and distribution to all staff (Q1). • Re audit post falls data, 3 months after Safety Message communication.

What we will do	How we will evaluate success
	• Scope, develop, test and implement a nursing post falls assessment in IView, following the guidance provided by the National Audit team. • Scope, develop, test and implement, in conjunction with MRC and Gerontology, the digital implementation of a post falls medical proforma, following NICE guidance. • Re-audits of the early medical assessment for inpatient hip fractures, once the medical proforma has been implemented.
Action 4 (Q1-4): Optimising the use of falls related data • Strengthen Trust National audit of inpatient falls compliance. • Strengthen the use of falls data at local level.	• Review the National audit requirements with key stakeholders to maximise Trust compliance. • Develop a robust reporting system and monitor through Clinical Improvement Committee (CIC). • Use data from the National audit of inpatient falls to enhance Trust and local understanding and inform decision making. • Support the use of local-level data to inform and explore opportunities for improvement and track impact of change initiatives, through PDSA cycles and Ulysses Quality Improvement project registration.
Action 5 (Q1-3): Optimise the use of Assistive Technologies to support falls prevention	• Test and evaluate the QI Pressure Sensor with staff and patients in Ward 5E/F and Sobell House.

What we will do	How we will evaluate success
	• Map other related pressure sensor products insitu across the OUH, identifying the gaps and appropriate usage. • Identify and explore additional senor products for further expansion of the QI initiative. • Adapt and adopt assistive technologies as appropriate, defined through the Falls Prevention Improvement Delivery group.

Clinical Effectiveness

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

Why is this a priority?

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

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

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

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

What we will do	How we will evaluate success
Action 1: Understand metrics and benchmarking data to inform development Q1. Evaluation of OUH data including National Early Warning Scores (NEWS 2) recognition and treatment of the acutely ill and deteriorating patient (RAID), Intensive Care National Audit & Research Centre (ICNARC) and local audit data (NEWS2). Q2. Understand regional and Shelford Group Trusts escalation and outreach activity data. Q3. Seek broader OUH stakeholder engagement and feedback on prospective plans.	Q1-2. Data captured within project team plan, presented to and endorsed by Critical Care Outreach Working Group (CCO WG). Q3. Workshop/outreach summit held and responses captured.
Action 2: Define outreach team composition Q1. Identify preferred team composition, and training needs based on initial data analysis. Q2. Benchmark against regional and Shelford Group peers.	Q1. Composition of team by discipline and grade agreed by WG. Prospective rota templates generated to support. Training needs analysis completed. Q2. Benchmarking evaluation and gap analysis completed by project lead and endorsed by WG.

What we will do	How we will evaluate success
Q3. Refine team composition (if required) following stakeholder engagement (see action 1, Q3) and benchmarking.	Q3. Revised composition of team by discipline and grade, agreed by WG. Prospective rota templates generated.
Action 3: Defined milestones (in parallel with business case (BC) Q1. Define recommended incremental development plan and project milestones for years 1-4. Q3. Refine development plan based on BC progression (action 5) and stakeholder engagement (action 2, Q3).	Plan endorsed by working group (WG). Risks identified.
Action 4: Business case progression Q1. Complete and submit Business Case Initiation Proposal (BCIP) to Division. Q2. Submit BCIP to TME. Q3. Submit full BC to TME.	Endorsed BCIP/BC by Q1-3.
Action 5 Commence follow-up provision (first stage of outreach provision), subject to funding and BC approval. Q3. Recruit initial staff. Q4. Deploy limited service (dependant on HR process and availability of applicants).	Service activity evident and effectively communicated throughout the Trust.

Clinical Effectiveness

Quality Priority 5: Surgical Morbidity Dashboard

Why is this a priority?

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

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

Clinical Effectiveness

Quality Priority 6: Reducing maternal and neonatal morbidity

Why is this a priority?

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

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

What we will do	How we will evaluate success
Action 2 (Q3): 'HARM – High Acuity Risk Management' Training Programme Pilot of novel formal training on management of high acuity workload for doctors and senior midwives with real time simulation of multiple obstetric emergencies and focused training on primary prevention of PPH and OASI.	**Metric:** Participant assessment score **Method:** Participant assessment before and after formal 'HARM' training **Objective:** Improvement in participant assessment score pre and post 'HARM' training
Action 3 (Q1-2): Establish prospective monitoring of maternal and neonatal morbidity indicators in women having induction of labour Women having induction of labour may experience delay in the process which is associated with higher levels of maternal and neonatal morbidity indicators. We will introduce prospective audit in women having IOL to monitor the impact of reduction in delayed IOL on morbidity. If there is no evidence of improvement in these morbidity indicators, we will undertake a thematic analysis to understand trends and patterns and introduce alternative interventions based on this analysis.	**Metric:** • Major Haemorrhage >1500 ml • Frequency of major transfusion (>2 units packed cells or use of FFP (fresh frozen plasma) for coagulopathy) • ITU admission following major haemorrhage • Obstetric anal sphincter injury • Unexpected SCBU admission in term babies without congenital abnormalities ((avoiding term admissions into neonatal units) ATAIN)) **Method:** Audit **Timeframe**: Quarterly **Objective:** Reduction in maternal and neonatal morbidity indicators in women having induction of labour

Patient Experience

Quality Priority 7: Reducing Health Inequalities

Why is this a priority?

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

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

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

Patient Experience

Quality Priority 8: Patient Experience with PSIRF

Why is this a Priority?

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

What we will do	How we will evaluate success
Action 1: Q1 Develop an improvement plan for Compassionate Engagement of patients, families and carers who have been involved in serious patient safety incidents.	Improvement plan drafted with contribution of current Patient Safety Partners. It will include: • Training provision for Engagement Leads. • Trust-wide communication about the role of engaging and involving patients following a patient safety incident. • Plan for recruitment of Quality Safety & Engagement Partners. • Review of the available tools to gather feedback from patients and families following involvement in a patient safety incident. • Development of a standard operating procedure (SOP) highlighting how to request feedback on the involvement experience.

Action 2: Q2-4 Recruit a Patient Safety Partner (PSP) to contribute to into the work to address this Quality Priority through the development of the improvement plan and tools to capture patient experience.	A PSP with relevant interest and skills will be recruited in line with the Level 4 Patient Safety Partner framework with a specific remit to contribute to the work related to this Quality Priority.
Action 3: Q1 Co-develop with the PSP tools to capture feedback on the experience of being involved following a patient safety incident.	Development of a survey to request feedback from patients and families following involvement in a learning response. Development of a procedure for having a face-to-face conversation to feedback on the experience of being involved in a learning response.
Action 4: Q1 Review and update tools following testing with different patient and family groups, community groups and other key stakeholders.	Update survey tool and procedure using QI methodology following testing with relevant stakeholder groups. Tools will be refined following user testing to ensure they meet EDI criteria.
Action 5: Q2-4 Scope other sources of information that can provide insight into patient and family experiences following investigations, for example through online forums or legal claims following an investigation.	Scoping exercise undertaken to explore what forums are available and how data can be obtained.
Action 6: Q2-4 Use feedback from tools developed and other sources of information to improve how patients and families are involved.	Review data and update policies, procedures, and explore additional training requirements as required.

Patient Experience

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

Why is it a Priority?

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

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

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

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

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

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