Oxford University Hospitals
NHS Foundation Trust

# Cover Sheet

**Trust Board Meeting in Public: Wednesday 11 March 2026**

**TB2026.26**

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| **Title:** | **OUH Draft Quality Priorities 2026-27** |

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| **Status:** | **For Discussion** |
| **History:** | **New proposal for 2026-27 Quality Priorities** |

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| **Confidential:** | **No** |
| **Strategic Pillar:** | **Patients** |

# OUH Draft Quality Priorities 2026-27

## 1. Background

1.1. OUH aims to deliver and assure patients that they are receiving the very best quality of care. NHS England 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 2026-27

2.1. Based on earlier suggestions from the Clinical Governance Committee feedback and feedback from Executive Directors, the following Quality Priorities (QP) are proposed for 2026-27.

**Patient Safety**

- QP1. Improving escalation of the deteriorating patient
- QP2. Venous Thrombo-embolism (VTE)
- QP3. Martha's Rule

**Clinical Effectiveness**

- QP4. Excellence in the basics: reducing variation, improving care through Standard Work*
- QP5. Strengthening discharges*
- QP6. Ambient Voice Technology (AVT)

**Patient Experience**

- QP7. Advance Care Planning & End of Life Care
- QP8. Public and Patient Engagement Framework
- QP9. Maternity Patient Experience*

2.2. Detailed plans and how we will evaluate success for each of the proposed Quality Priorities for 2026-27 can be seen in Appendix 1.

*Carried over and updated from the 2025-26 Quality Priorities

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2.3. It is proposed that the following Quality Priorities from 2025-26 are absorbed into ‘business as usual’ in 2026-27:

- SEND (System for Electronic Notification and Documentation)
- Medicine Reconciliation
- Fragility Pathways including fractured neck of femur pathway
- Outreach Service from Oxford Critical Care
- ReSPECT (incorporated into the new End of Life Care Quality Priority)
- Reasonable adjustment flag

## 3. Delivery & Support for Trust Quality Priorities

3.1. Delivery of the Trust quality priorities is a key part of the core business of the Trust and of the teams which lead on each priority.

3.2. Support from other divisional and corporate teams is also required to appropriately prioritise delivery of these workstreams as identified Trust priorities.

## 4. Recommendations

4.1. Trust Board is asked to:

- Review and provide feedback on the proposed Quality Priorities for 2026-27 ahead of Trust Board on 26 March 2026.
- Confirm support for appropriate prioritisation of the proposed workstreams as identified Trust priorities.

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# Appendix 1 - Proposed Quality Priorities for 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.

| What we will do. | How will you know the objective is completed and that it is working? |
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| **Objective 1 (Q1-4)**<br>**Empower staff providing patient care with the tools to appropriately escalate a patient for whom they have concerns. This will be achieved by:**<br>• establishing a stakeholder group.<br>• supporting the education and development of staff in communicating information surrounding escalation. | **(Q1-4)**<br>• Reduction in the number of Ulysses incident reports pertaining to a delay in escalation of a deteriorating patient (target 25% reduction).<br>• 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. |
| **Objective 2 (Q1-4)**<br>**Understand the current enablers and barriers in escalating patient deterioration to develop a systems-based approach to escalation which is applicable across the Trust**<br>• Distribute a questionnaire to 100 nurses and resident doctors, collating a summary of enablers and barriers to escalation | **(Q1-4)**<br>• 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. |

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| What we will do. | How will you know the objective is completed and that it is working? |
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| from the responses received. Complete process mapping exercise using QI methodology and implement QI programme cycles.<br>• 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.<br>• Continue implementation of RAID Huddles. | • An observed decrease in Ulysses reporting relating to escalation (aiming for a 25% decrease).<br>• 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. |
| **Objective 3 (Q1-4)**<br>• Ensure the concerns raised by patients and those closest to them are heard and appropriately escalated, including incorporation of escalation through Martha's rule.<br>• Support education of staff in documenting concerns raised as per Martha's rule as part of routine documentation on EPR.<br>• Explore the use of EPR to capture patient concerns | **(Q1-4)**<br>• 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.<br>• This will be added to through a regular review of Martha's Rule calls and through a review of EPR documentation<br>• Data will be cross referenced with Ulyssess reporting (bi-monthly) to ensure compliance with the objective. |
| **Objective 4 (Q1-4)**<br>• Observations are recorded and documented in line with the Trust Recognising Acute Illness & 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. | **(Q1-4)**<br>• 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. |

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## Patient Safety

### 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.

| What we will do. | How will you know the objective is completed and that it is working? |
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| **Objective 1 (Q1-4)**<br>**To reduce the number of missed doses of Thromboprophylaxis**<br>a) Thromboprophylaxis Column to be added to the electronic White Board in collaboration with the Digital Team – with a coloured | **(Q1-4)**<br>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). |

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| What we will do. | How will you know the objective is completed and that it is working? |
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| traffic light system, which will be mandated on every in-patient ward.<br>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.<br>c) We will add the 'missed LMWH figures' to clinical governance meetings for divisions and directorates – for their review.<br>d) We will work with the digital team to streamline the link between the VTE-RA and VTE prescribing.<br>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 & Mobility, VTE Prevention and Lower Limb Immobilisation. | • Our aim is to reduce missed doses by a challenging 50% (e.g. down to 10% in-patient days).<br><br>**Q4**<br>• 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%, ie down to 20 per year. |
| **Objective 2 (Q1-4)**<br>**Increase compliance of the VTE Risk Assessment (RA) for In-patients (e.g., specifically excluding VTE cohorts)**<br>In addition to the interventions above we will do the following to increase VTE-RA to >95% for all directly reviewed in-patients:<br>a) Visit other VTE Exemplar centres to learn directly from them, how to improve direct VTE-RA figures.<br>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. | **Q3-4**<br>• Achieve 95% of directly assessed VTE Risk Assessment completed within 14 hrs. |

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| What we will do. | How will you know the objective is completed and that it is working? |
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| c) Using data from the last 15 years, develop the evidence base to support earlier LMWH delivery. | |
| **Objective 3**<br>**Introduction of the electronic validated Risk Assessment tool for Lower Limb Immobilisation**.<br><br>a) Agreement with Key Stakeholders to implement the TriPCast Tool for Lower Limb Immobilisation (LLI).<br><br>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. | **Objective 3**<br><br>**Q1**<br>• Work with stakeholders to understand workflows and get agreement from all stakeholders to implement a digital risk assessment tool for LLI.<br><br>**Q2**<br>• Determine baseline assessment of LLI VTE risk assessment through roll out of the digital tool across the relevant teams.<br>• Aim to increase risk assessment by 50% from baseline<br><br>**Q3-4**<br>• Monitoring assessments-compliance/reporting system demonstrating sustained increase in compliance. |

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## Patient Safety

### 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.

| What we will do | How will you know the objective is completed and that it is working? |
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| **Objective 1 - Roll out of escalation pathways for patients, relatives, carers and staff of Martha's Rule (MR) in Q1-2**<br>• Full roll out of across all four OUH sites of the ability of patients, relatives, carers and staff to escalate concerns.<br>• Launch Martha's Rule in all patient groups ie adults, maternity and paediatrics.<br>• 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. | **(Q1-2)**<br>• Achieving roll out of to all 4 sites by the end of Q2.<br>• Completion of communications plan.<br>• Delivering consistent Trust-wide access to MR and access to an escalation pathway across all services. |
| **Objective 2 - Pilot Patient Wellness Questionnaire (PWQ), component of Martha's Rule (Q2-4)**<br>**Q2** | **(Q2)**<br>• Completion of 2 Plan, Do, Study, Act (PDSA) cycles in 2 adult wards of PWQ. |

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| What we will do | How will you know the objective is completed and that it is working? |
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| • Pilot the Patient Wellness Questionnaire (PWQ) in adult wards, starting with 2 adult wards in Q2 and a further 2 wards in Q3.<br>**Q3-4**<br>• Roll out of PWQ for Paediatrics. | • Clear plan for digital capture of PWQ.<br>• Clear plan for how to incorporate PWQ into usual escalation triggers.<br>**(Q3-4)**<br>• Completion of 2 Plan, Do, Study, Act (PDSA) cycles in another 2 adult wards of PWQ.<br>• Paediatrics PWQ will be embedded into introduction of National Paediatric Early Warning Score (PEWS).<br>• Data from Paediatrics PWQ regularly captured and used to improve care. |
| **Objective 3 - Evaluation of Martha's Rule**<br>**Q2-4**<br>• Collect feedback from callers regarding the service.<br>• Measure awareness of Martha's Rule in staff and patients.<br>• Ensure robust escalation pathway.<br>• Implement monitoring questions surrounding Martha's rule into Care Assure framework. | **(Q2-4)**<br>• Consent to gather feedback will be incorporated into the Martha's Rule call proforma.<br>• Project manager will work in partnership with the Patient Experience Team to gather feedback from every patient and family that gives consent.<br>• Feedback will be analysed and reported appropriately.<br>• Service will be improved according to feedback.<br>• Embed staff and patient awareness in regular audits carried out of staff and patients across all 4 sites.<br>• Review escalation pathway at 6m of rollout and adjust as necessary. |

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| What we will do | How will you know the objective is completed and that it is working? |
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| | Review and amend question bank embedded within Care Assure framework and audit responses to assess effectiveness during evaluation stage. |

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## 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

| What we will do | How will you know the objective is completed and that it is working? |
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| **Objective 1a (Q1-4)**<br>• 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. | **(Q1-4)**<br>• 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.<br>o 100% of prioritised clinical areas with safe and secure storage and stock management using standard work documentation.<br>o By March 2027, achieve incremental improvement from baseline in Care Assure audit scores for the safe and |

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| What we will do | How will you know the objective is completed and that it is working? |
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| | 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).<br>• Staff report increased confidence and ease in applying Standard Work practices, as represented through:<br>  ○ Improvement in Care Assure audit compliance against Standard Work criteria.<br>  ○ Attendance and completion rates for divisional level Standard Work training across key defined staff groups<br>  ○ Qualitative feedback from key staff groups evidencing improved understanding and usability (i.e. pharmacy and ward-based nursing staff) |
| **Objective 1b (Q1-4)**<br>• 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. | **(Q1-4)**<br>• Agreed Trust Safety Huddle Principles and core standard incorporated into Trust policy by October 2026<br>• embedded within Divisional assurance as part of Care Assure.<br>• 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. |

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| | • Staff report increased confidence and ease in applying Standard Work practices, as represented through:<br>  ○ Improvement in Care Assure audit compliance against Standard Work criteria.<br>  ○ Attendance and completion rates for divisional level Standard Work training across key defined staff groups<br>  ○ Qualitative feedback from key staff groups evidencing improved understanding and usability (i.e. Inpatient ward Matrons) |
| **Objective 2 (Q1-4)**<br>• 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 standard work, refining proposed changes that could facilitate ongoing broader divisional led implementation.<br>• Services will be determined in consultation with the CMO and CNO, ensuring alignment with Trust priorities. This approach will include:<br>• 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. | **(Q1-4)**<br>• 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.<br>• 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.<br>• 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. |

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| What we will do | How will you know the objective is completed and that it is working? |
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| • Capture lessons learnt to share best practice, scale and spread | • 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.<br>• Services to share learning through QI Stand Up sessions where Standard work has been embedded. |

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| **Objective 3 Q1-4**<br>Develop the Standard Work Toolkit – bringing together tools available to support wider adoption and implement within services taking an approach aligned with the OUH Improvement Framework.<br>• Review and align all trust adopted Standard Work documents to present clear materials for wider scale and spread, utilising the Standard Work branding.<br>• Roll out of Standard Work masterclasses to key divisional teams to help adoption, engagement and further spread of concept.<br>• Collation of videos sharing impact and learning from adoption of Standard Work principles from QP year 1 achievements<br>• Support videos to support team and service level leaders / managers engaging local staff to understand purpose and value of adoption of standard work principles | **(Q1-4)**<br>• Suite of Standard work documents as examples on QI Zone SharePoint for staff to download, use and understand the concept further.<br>• Inclusion of videos on QI Zone.<br>• 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.<br>• 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:<br>  ○ Increased numbers of Ward Managers or equivalent completed Standard work Masterclass across all divisional inpatient wards<br>  ○ Increased numbers of Inpatient Matrons completed Standard work Masterclass across all divisional inpatient wards<br>  ○ Increased numbers of Care Assure assessor colleagues completed masterclass, including corporate support staff.<br>• (Above numbers to be agreed with divisional representatives within programme board to ensure sustainable approach with clear divisional ownership and oversight). |

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| What we will do | How will you know the objective is completed and that it is working? |
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| **Objective 4 Q2-4**<br>• 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.<br>This will be delivered through:<br>• Embedding these principles at the centre of divisional development and delivery of the SW programme, supported by the QI Team, incorporating key enables such as:<br>  ○ "Go See" Leadership Walkabouts: Leaders observe work directly to identify opportunities for improvement.<br>  ○ Coaching: encourage developing staff through ongoing coaching, building team capability. Leaders being problem Framers not always problem solvers.<br>  ○ Visual Management: Performance is made visible with boards and charts to track key indicators, model through SW priority metrics.<br>  ○ Strategic Alignment: Align routine tasks direct link to the organisation's long-term goals throughout the programme.<br>• By the end of Q1, we will have integrated Leader Standard Work principles into the OUH QI Managers and Leaders offer, building on learning to date to better equip leaders for their role in setting both the context and culture for others to driver forward local continuous improvement. | **(Q2-4)**<br>• 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<br>• 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.<br>• 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<br>• Within the Standard Work Programme we will have:<br>  ○ 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.<br>  ○ 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.<br>  • 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 |

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| • 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 | discussions with at least one Task and Finish priority review meeting per month.<br>• 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. |

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## Clinical Effectiveness

### 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.

| What we will do. | How will you know the objective is completed and that it is working? |
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| **Foundation (overall) objective**<br>**Improve experience of continuity and quality of care for patients being discharged from hospital.**<br>• Write a Trust Discharge Policy.<br>• Establish a process for reviewing quality, safety and risk of discharge from hospital. | **(Q1-4)**<br>• There will be Trust wide engagement and awareness in agreed discharge processes.<br>• There will be standardisation in discharge safety checks across the Trust.<br>• There will be an approved Trust Policy on Hospital Discharge.<br>• Sustain a discharge assurance group. |

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| What we will do. | How will you know the objective is completed and that it is working? |
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| | • There will be a dashboard to collate and display internal and external information.<br>• Thematic analysis of internal themes as well as from system partners.<br>• Share internally to appropriate colleagues for awareness and action where needed.<br>• Close feedback loop to system partners. |
| **Objective 1 Medication (Q1-3)**<br>**Improve timeliness of TTO prescription and readiness**<br>• Improve TTO ('to take out') medication turnaround times<br>• Increase visibility and reporting of TTO medication related issues, including instances when TTOs couriered to the patient because not ready at time of discharge. | **(Q1-3)**<br>• Target reduction of 20% reduction in the use of courier to deliver TTO's.<br>• Risk assessment in place for the safe use of courier when it is required for TTO's.<br>• 10% improvement in percentage of TTO's turnaround within 120 minutes. 15% reduction in reported incidents related to TTO's timeliness. |
| **Objective 2 Communication (Q1-4)**<br>**Improve and provide assurance of the safety of discharge from hospital**<br>• Standardise the discharge processes on departure from hospital.<br>• Implement a mandatory Discharge Safety Checklist within the 'depart' process in the electronic patient record (EPR) with | **(Q1-2)**<br>• The Discharge Safety Checklist has been reviewed and validated for each patient group and includes key discharge safety concerns as identified in Overarching objective thematic review of incidents, complaints and feedback.<br>**(Q2-3)**<br>• The Discharge Safety Checklist is on EPR and is mandatory for all patient groups. |

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| specific check lists for adults, maternity, neonates and children's. | **(Q3-4)**<br>• Phased implementation will show increasing compliance rates to 100% of discharges for areas included.<br>• Increase positive feedback from patients and families regarding the discharge process (target 20% increase in positive feedback).<br>• 20% reduction in discharge-related complaints and incidents. |
| **Objective 3 Patient Experience (Q1-2)**<br>**Provide clear communication to patients and unpaid carers on discharge processes and follow up support**<br><br>• Increase awareness of the new Discharge Information Leaflet<br>• Brief ward staff on the contents and embed its use. | **(Q1-2)**<br>• The leaflet has been produced, is in circulation and staff know about it and use it.<br>• Reduced misunderstandings from staff/patients on discharge pathways and expectations.<br>• Staff feel empowered and prepared to answer questions relating to complex discharge from patients/relatives.<br>• Increase patient satisfaction scores related to discharge communication by 20%.<br>• Positive feedback from patients and families regarding discharge communication by end of Q4 (measured through questionnaires and friends and family tests – 6m to implement changes and 6m to see improvement in feedback).<br>• 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 *"Before you left hospital, were you given any information about what you should or should not do after leaving* |

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| What we will do. | How will you know the objective is completed and that it is working? |
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| | *hospital? This includes any verbal, written, or online information*" in the National inpatient survey.<br>• There will be a 20% reduction in discharge-related complaints. |
| **Objective 4 Documentation(Q1-4)**<br>**Improve the quality of discharge documentation**<br>• Revisions made to the GP discharge letter template that encompass community partner feedback on content.<br>• Enable a system and approach that allows for regular review and update of the template based on feedback and incident trends.<br>• Enable Allied Health Professionals (AHP) colleagues and other clinical colleagues to contribute to the discharge summary as required. | **(Q1-2)**<br>• The new discharge summary template will include feedback and requests from key community partners.<br>• OUH discharge summaries will be from the Multi-disciplinary Team, not just the medical team.<br>**(Q3-4)**<br>• There will be a decrease by 25% in negative feedback from community partners regarding discharge information.<br>• 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 *"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*" in the National Inpatient survey. |
| **Objective 5 Timeliness of Discharge (Q2-4)**<br>**Nurse, Midwife, Therapies and Allied Health Care Professionals (AHPs) led discharge opportunities**<br>• **Q1-2**: Set up a scoping session to identify what is required and who can discharge patients.<br>• **Q3-4**: Once established, produce a Standard Operating Procedure (SOP) for nurse-led discharges. | **(Q3-4)**<br>• Training completion for all staff participating in criterion-led discharge criteria.<br>• Compliance reports showing adherence to the criterion-led discharge process. |

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| What we will do. | How will you know the objective is completed and that it is working? |
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| • Develop and implement a criterion-led discharge process for Nurses, Midwives and AHPs.<br>• Train relevant nurses, midwives and AHP staff on the criterion-led discharge process.<br><br>**Reduce average length of stay and improve patient flow in the morning*.**<br><br>• Develop and implement a process to prioritise and facilitate discharges before midday.<br>• Embed discharge prioritisation guidance.<br>• Explore the requirement for an electronic dashboard.<br><br>** Note that this excludes Outpatients, Day Surgery Units, Short Stay areas (average <24 hours, e.g. Maternity, Orthopaedic Short Stay Unit), Assessment areas* | • Reduction in average length of stay by at least 6 hours once criterion-led discharges implemented for areas where this is embedded.<br>• 25% of discharges are by midday on inpatient areas on the JR site.<br>• Positive feedback from patients and families regarding the discharge process.<br>• 20% Reduction in discharge-related complaints.<br>• All communications and media about the new discharge protocol have been disseminated.<br>• Data support adherence to 25% of ward discharge by midday.<br>• Positive feedback from patients and families regarding the discharge process, through PALS and Friends and Family Test.<br>• Adapt discharge documentation process in EPR to support criteria led discharge. Integration of the guidelines into the electronic patient record (EPR) system. |

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## Clinical Effectiveness

### 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

| What we will do | How will you know the objective is completed and that it is working? |
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| **Objective 1 (Q1-3): Complete procurement, governance, and mobilisation**<br>• Finalise AVT procurement and award contract. | **(Q1-3)**<br>• Procurement completed and contract signed.<br>• DPIA, safety case and DTAC documentation approved.<br>• Divisional POCs in place; Implementation Group active. |

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| What we will do | How will you know the objective is completed and that it is working? |
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| • Complete Data Protection Impact Assessments (DPIA), Clinical Safety Case, Digital Technology Assessment Criteria (DTAC) and cybersecurity assurance.<br>• Confirm divisional Points of Contact and establish Implementation Group.<br>• Develop standardised templates, workflows, and training materials. | • Training materials and templates ratified by governance. |
| **Objective 2 (Q1-2)**<br>**Phased rollout**<br>**Onboarding of priority areas**<br>• Identify, train and onboard priority areas.<br>• Implement AVT in standardised “stand-alone” mode.<br>• Activate Trust-wide comms and engagement plan.<br>• Monitor early safety, user experience and accuracy metrics. | **(Q1-2)**<br>• ≥5 priority services onboarded.<br>• ≥80% of trained clinicians routinely using AVT within one month.<br>• Monthly early phase benefits reports produced.<br>• No unresolved high severity safety/IG issues. |
| **Objective 3 (Q 1-4)**<br>**Evaluate benefits and embed AVT into business as usual (BAU)**<br>• Produce Trust-wide evaluation across clinical, operational and staff experience domains.<br>• Confirm long-term ownership and BAU support model.<br>• Agree ongoing training and optimisation plan.<br>• Develop recommendations for integration and licence scaling. | **(Q 1-4)**<br>• Evaluation completed and submitted to CGC.<br>• Demonstrated improvements in documentation, turnaround time, administrative time, staff wellbeing and patient experience.<br>• AVT embedded as BAU with clear governance and reporting structure. |

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## Patient Experience

### Quality Priority 7: Advance Care Planning (ACP) & 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.

| What we will do | How will you know the objective is completed and that it is working? |
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| **Objective 1 e.g. (Q1-4)**<br>**Improve recognition of inpatients who are at risk of deterioration and dying.**<br>• Enlist end of life care link nurses in all inpatient areas.<br>**Q1-4**:<br>• Introduce tiered and role-specific EoLC training.<br>• Offer educational resources and teaching sessions (that focus on recognition of dying, conversations about hydration, | **(Q1-4)**<br>• Recruitment and engagement of EoLC link nurses.<br>• There are mandated role-specific e-Learning modules.<br>• At least 50% of patient-facing staff working in inpatient areas will have completed training by the end of Q4. |

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| What we will do | How will you know the objective is completed and that it is working? |
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| recording ethnicity, using translating services and discharging a dying patient from hospital) to all inpatient areas.<br>• 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.<br><br>**Q1-2**:<br>• Encourage and increase use of the *Care of the Dying Patient Prompt* 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. | • Aim for all inpatient areas to be offered palliative and end of life care education, aiming for 50% uptake by end of Q4.<br><br>• Reduce the number of complaints related to discharges and translation services at the end of life (by 10%).<br><br>• 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. |
| **Objective 2 (Q1-4):**<br>**All patients should have personalised care and support planning (PCSP) conversations that are documented in ReSPECT and advance care planning (ACP) PowerNotes.**<br><br>• Undertake audit to assess how well all sections of ReSPECT document are completed. | **(Q1 - 4)**<br><br>• 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 |

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| What we will do | How will you know the objective is completed and that it is working? |
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| • Undertake audit to assess the patient's and/or their significant other's experience of a ReSPECT conversation<br><br>• Undertake audit to evaluate the clinician's perspective in undertaking ReSPECT conversations and recommendations. | • The second element, wards will provide evidence of the patient's experience.<br><br>• 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. |
| Review incidents in Ulyssess relating to identified search terms and identify trends and produce safety messages to summarise key learning from clinical events.<br>• Produce learning materials based on learning from practice and locate on Resuscitation/ACP-ReSPECT Sharepoint page. | • Incidents and complaints regarding conversations will be collated to establish a baseline of numbers of incidents and patient complaints associated with ReSPECT.<br>• Safety messages sent periodically to OUH clinicians<br>• Education materials located on Resuscitation/ACP-ReSPECT Sharepoint page. |
| **Objective 3: (Q1-4)**<br>**Make ReSPECT and related ACP documents easier to understand and access, for clinicians, patients and those close to them.**<br>• 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. | **(Q1-4)**<br><br>• Results of patient and family feedback on ReSPECT and related conversations.<br>• A OUH patient information leaflet. |

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| What we will do | How will you know the objective is completed and that it is working? |
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| • Work with informatics to rationalise place of documenting **ACP** on EPR, aiming to collate all related documentation in one place on EPR.<br><br>• Work with informatics to rationalise place of documenting **LPA** on EPR, aiming to collate all related documentation in one place on EPR. | • Develop a 'help' guide to locate ACP documents on EPR.<br>• Evidence that the EPR have created a shared folder on EPR.<br><br>• Develop a 'help' guide to locate LPA documents on EPR. Evidence that the EPR have created a shared folder on EPR. |
| **Objective 4 Q1-4**<br>**Work in partnership with Integrated Care Board and other local providers to improve sharing of ReSPECT across organisations and with patients.**<br>• Develop an options appraisal for integration of the OUH and ICB digital ReSPECT forms.<br>• 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). | • OUH options appraisal developed and presented to Clinical Governance Committee and Digital Clinical Advisory Group.<br>• Formation of OUH ReSPECT Graphnet scoping group.<br>• Regular engagement with ICB ReSPECT stakeholder group to move the project forward. |

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## Patient Experience

### 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 Trust-wide 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.

| What we will do | How will you know the objective is completed and that it is working? |
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| **Objective 1 (Q1-4)**<br>**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.**<br>• **Q1:** 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, induction, mentorship, supervision, remuneration and impact evaluation.<br>• **Q1-3:** Develop a policy and toolkit.<br>• **Q3-4**: Implement the policy and toolkit. | **(Q1-4)**<br>• Policy, tools and resources are developed and published.<br>• Increased evidence of governance, quality improvement, policy development and service redesign involving PSPs and PPGs:<br>  ○ At least one PSP member on key governance committees, including CGC, CIC, PSEC, Policy Committee, Patient Experience & Engagement Committee (PEEC) and divisional CGCs.<br>  ○ A pathway for PPGs to escalate issues to governance committees.<br>• Stakeholder evaluation (PSP, PPG, staff) demonstrates positive experience and impact on outcomes. |

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| What we will do | How will you know the objective is completed and that it is working? |
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| **Objective 2 (Q1-2)**<br>**Develop and deliver an annual Patient Census to capture demographic, cultural, linguistic, accessibility, social and spiritual characteristics of OUH patients and service users**.<br><br>• **Q1:** Develop and pilot the Census instrument.<br>• **Q2:** Administer the Census and present findings to PEEC and consider engagement of community partners to optimise reach. | **(Q1-2)**<br><br>• Instrument developed and piloted.<br>• Demographic, cultural, linguistic, accessibility, social and spiritual characteristics of OUH patients and service users captured and presented.<br>• Community partners reflect diversity of patient population. |
| **Objective 3 (Q1-3)**<br>**Establish a comprehensive and regularly updated network of community groups, charities and Voluntary Community & Social Enterprise organisations (Trusted Partners) that reflect the diversity of OUH's patient populations**.<br>• **Q1-3:** Establish database and accessible, culturally safe methods of sharing information with at least **10 priority organisations**.<br>• **Q3:** Capture learnings and insights in central repository to inform equality, diversion and inclusion improvement initiatives. | **(Q1-3)**<br><br>• Database and communication methods available<br>• Evidence of improvements using lived experience voices from diverse populations available. |
| **Objective 4 (Q3-4)**<br>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.<br>• **Q3**: Develop and implement an evaluation tool for measuring the impact of patient and public participation. | **(Q3-4)**<br><br>• Evaluation tool available.<br>• Reporting implemented and continuous learning evident. |

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| What we will do | How will you know the objective is completed and that it is working? |
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| • **Q4:** Implement reporting of patient and public participation including impact evaluation through the PEEC. | |

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## Patient Experience

### 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.

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| What we will do | How will you know the objective is completed and that it is working? |
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| **Objective 1 (Q1-4)**<br>**Strengthen mechanisms for listening to service users**<br><br>• Increase promotion and accessibility of feedback routes (FFT, surveys, digital platforms, focus groups).<br><br>• Introduce targeted postnatal listening events and listening clinics, particularly for women with complex or adverse experiences.<br><br>• Work closely with the community partners including the Oxfordshire Maternity Neonatal Voices Partnership (OMNVP) to co-design engagement activity.<br>• Reinforce personalised care planning and shared decision-making across antenatal, intrapartum and postnatal care. | **(Q1-4)**<br>• Increase volume and diversity of feedback received across all maternity pathways by 10%.<br>• Evidence of an increase of feedback (by at least 5%) from underrepresented groups<br>• Increase service user satisfaction scores (e.g. FFT, CQC survey) by 10% including among service users with protected characteristics.<br>• 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.<br>• Reduce number and themes of complaints related to communication, discrimination, or cultural insensitivity by 10%.<br>• We should see an increase in the proportion of appointments with interpreter support provided when requested. This will be monitored through existing systems. |
| **Objective 2 (Q1-4)**<br>**Ensure feedback leads to visible action ("You said, we did")**<br>• Implement a clear feedback-to-action process with defined timescales.<br>• Share learning and improvements with service users via newsletters, posters, social media and the Trust website. | **(Q1-4)**<br>• "You said, we did" communications published monthly.<br>• Audit of the rapid responder role-service demonstrates that users report increased confidence that their feedback is heard and acted upon.<br>• Evidence of changes made directly in response to feedback. |

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| What we will do | How will you know the objective is completed and that it is working? |
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| • Align local learning with national findings from CQC survey. | • Comments from social media and Trust web sites are reviewed and appropriately responded to.<br>• OMNVP will highlight any feedback from other media sources.<br>• Completed CQC survey action plan. |
| **Objective 3(Q1-4)**<br>**Support and develop staff to deliver excellent patient experience**<br>• Provide training and reflective learning sessions focused on communication, compassion, cultural humility and trauma-informed care.<br>• Use learning from complaints, incidents and national reviews to support improvement rather than blame.<br>• Celebrate good practice and staff contributions to positive experiences. | **(Q1-4)**<br>>95% of all staff completing Active Bystander and Equality Diversity Inclusion (EDI) training.<br>• Staff survey results demonstrate improvement in inclusion, respect, and confidence in addressing bias.<br>• Improved diversity of maternity workforce compared to local population demographics.<br>• Reduced number of staff-reported incidents related to discrimination or bias, and resolution rates.<br>• Increased examples of positive feedback naming staff and teams (through FFT).<br>• Increase in Daisy awards- staff recognition rewards including nominations. |
| **Objective 4 (Q1-4)**<br>**Strengthen openness, transparency and learning culture** | **(Q1-4)** |

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| What we will do | How will you know the objective is completed and that it is working? |
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| • Share outcomes of CQC inspection findings and national investigations openly with staff and service users.<br>• Regularly review patient experience data at local and Directorate governance meetings.<br>• Ensure learning is embedded into practice and monitored. | • Clear evidence of patient experience discussed at maternity governance forums and Triangulation and learning committee (TALC).<br>• Completed CQC inspection action plans.<br>• Number of improvement actions arising from TALC including specific themes around triage and induction of labour.<br>• Dashboard demonstrates sustained improvement trends over the year.<br>• Feedback forms from staff to confirm they have been made aware of learning and improvements. |

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