Oxford University Hospitals

NHS Foundation Trust

Quality Account 2024/25

Excellence, Compassion, Respect, Delivery, Learning & Improvement

30 June 2025

Contents

Introduction

Statement on quality from the Interim Chief Executive Officer 2024/25

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

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

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

Delivery of this vision remains centred around the OUH values of Learning, Respect, Delivery, Excellence, Compassion and Improvement, and will build on the 'Trust Strategy 2020-2025' introducing four strategic pillars – People, Patient Care, Performance and Partnerships.

Our Quality Strategy aims to deliver high quality healthcare based on national and international comparisons, and to continuously improve our performance using Quality Improvement tools across the three key domains:

- Patient Safety
- Patient Experience
- Clinical Effectiveness

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

We focused this year on embedding and refining PSIRF processes which replaced the Serious Incident Framework in OUH in October 2023. PSIRF has the following four aims.

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

We produced a Trust Board approved PSIRF Policy and Plan in which we describe our application of a Just Culture ensuring consistent, constructive and fair treatment of staff who have been involved in patient safety incidents. The PSIRF Policy goes on to describe our Patient Safety Culture which we have further developed with the introduction of our weekly

Safety Learning and Improvement Conversation (SLIC). SLIC has a focus on learning and improvement and how this can be spread across OUH; our Quality Improvement team representatives form an integral part of these discussions. From SLIC a weekly learning slide is produced and shared widely in the Trust.

Since March 2023, Patient Safety Partners (PSPs) have been involved in the patient safety agenda at OUH. PSPs are promoted nationally by NHS England to foster openness, understand patient perspectives, identify risks, support risk prioritisation, assist in action plans, and create patient information.

They helped to shape our PSIRF Policy and Plan and support our SLIC meetings, as well as providing input into other Clinical Governance meetings; in so doing they ensure the patient voice is heard as well as compassionate engagement delivered.

PSPs are registered Trust volunteers with significant experience in healthcare and volunteering, enabling them to act as trusted 'critical friends' to the Trust. They undergo DBS[1] checks and sign a code of conduct. As further recruitment takes place, the PSP role will develop further.

Martha's Rule

'Martha's Rule' will ensure that patients and their families have access to round-the-clock rapid review from an independent care team. It will be implemented across the NHS as part of a phased approach, beginning with at least 100 adult and paediatric acute provider sites that already offer a 24/7 critical care outreach capability. We have started strengthening and implementing systems to enable patients and carers to speak up if they have concerns about patient care; part of this is to develop an Outreach Team.

Our Quality Priorities

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

Following the Quality Conversation event and further input from members of the Trust's Clinical Governance Committee and Trust Board members, our Quality Priorities for 2025-26 were approved by the Trust Board in March 2025.

Our patients as partners

At each public meeting of the Trust Board, a Patient Perspective is shared which enables patients and the staff who care for them to share their experiences.

These valuable insights are then shared more widely through the Trust Board Blog which is published following each public meeting of the Board – the Blog is emailed to all Trust staff

[1] DBS – Disclosure and Barring Service. Employers can check the criminal record of someone applying for a role.

and to our Council of Governors which includes elected representatives of patients and members of the public.

Patient Perspectives are also disseminated through news stories published on the Trust website and through the Trust's social media channels.

For example, Nell Frizzell shared her experience of the Early Pregnancy Assessment Unit (EPAU) at Rose Hill at the Trust Board meeting in July 2024 – you can read her story on the Trust website: Patient experience: Early Pregnancy Assessment Unit - Oxford University Hospitals (ouh.nhs.uk/news/articles/2120).

Patients waiting for treatment

We remain committed to seeing more patients more quickly, and to reducing waiting lists. I am grateful to our staff who have worked on these improvements and to our partners with whom we are working to deliver better services to our patients.

In March 2024 we reported one two-year breach, and at the end of March 2025 no two-year breaches were reported. Focused work has continued on recovering from a growing backlog of patients waiting more than 78 weeks following the COVID-19 pandemic and several periods of industrial action. At the end of March 2025, there were 15 patients waiting more than 78 weeks for elective treatment compared to 80 patients at the end of March 2024. We are committed to reducing further the number of patients waiting for elective treatment in 2025/26.

Following an agreed protocol, any cancer patient waiting for over 104 days for treatment also has a review conducted of potential for clinical harm from the delay. Where harm is identified this is investigated as a clinical incident to identify and implement any learning to further strengthen our processes. Details are reported to the Trust's Harm Review Group and then to the Patient Safety and Effectiveness Committee.

Quality Improvement (QI)

The recent Staff Survey shows that nearly three quarters of OUH staff state that they can confidently make suggestions for improvement and over 60% are now able to make improvements at work compared with 58% last year. This distributed leadership is a testament to a significant cultural shift towards continuous improvement. Over 2,000 of our staff have completed training in Quality Improvement in the last two years, pivotal for enhancing patient care through varied perspectives and expertise.

We continued to serve as a key partner in the second regional Improvement Festival, contributing learning from across the system with a focus on enhancing services that support 'starting well, living well, and ageing well'. In April 2024, OUH co-led an international workshop at the Institute for Healthcare Improvement (IHI) / British Medical Journal (BMJ) International Forum for Quality and Safety, in collaboration with University Hospital Southampton (UHS). The session highlighted our collective improvement journey

and critically examined the proposition that 'culture eats strategy for breakfast'. This collaboration significantly strengthened the partnership between OUH and UHS, with improvement teams maintaining active engagement following the Forum. As a result, UHS has adopted the OUH Quality Improvement (QI) Stand Up model to support the dissemination of learning across their organisation, while OUH has drawn on UHS's experience with Patient Safety Partners to enhance the development of our local adoption strategy.

New developments

Our staff have continued to innovate and develop new ways of working this year in order to improve patient safety, patient experience and clinical effectiveness.

- A dedicated Bereavement Room for families following the sad loss of a baby is now available on the Delivery Suite in the Women's Centre at the John Radcliffe Hospital in Oxford. The room is fully soundproofed and offers a private and quiet space for grieving families to stay. It also has a separate pull-down double bed for comfort and features a medical bed to support any ongoing care requirements if needed.
- In January 2025 the first patients were treated at the new OUH Radiotherapy Centre at Milton Keynes University Hospital. OUH Radiotherapy @ Milton Keynes enables patients living in Milton Keynes and the surrounding areas to receive life-saving radiotherapy treatment closer to home rather than having to travel to the Churchill Hospital in Oxford for their treatment. The new centre builds on the success of OUH Radiotherapy @ Swindon – at Great Western Hospital in Swindon – which opened to patients in October 2022.
- The first NHS patients in a generation have started to receive life-saving plasma from the blood of UK donors thanks to a partnership between NHS Blood and Transplant (NHSBT) and NHS England. Jill Jones was the first patient to receive UK-sourced plasma medicine at the John Radcliffe Hospital in Oxford in March 2025.
- Adults in Oxfordshire and the surrounding areas who have been treated for cancer with radiotherapy can now benefit from a new specialist service that supports them with any long-term side effects. The OUH Macmillan Radiotherapy Late Effects Service accepts both GP referrals and self-referrals from patients. The service helps people improve their quality of life, cope with chronic symptoms, and access appropriate follow-up services. New service for long-term radiotherapy side effects - Oxford University Hospitals (ouh.nhs.uk/news/articles/2187).
- Our new breathlessness pathway is a one-stop diagnostic service for patients who need investigations, diagnosis, and management advice for breathlessness – all in one appointment at the Oxford Community Diagnostic Centre (CDC) in Cowley in order to reduce waiting times and multiple hospital visits.

Excellent outcomes for patients captured in clinical audits

Examples include the following.

- Cleft Registry and Audit Network (CRANE) results show the Spires Cleft Centre achieved performance levels exceeding the national average across all but one outcome measure, with six metrics designated as positive outliers leading to be deemed the second-best performing centre in the UK. The one measure that was below the national average – 5-year-olds with height and weight data submitted – has now been successfully addressed, which will be reflected in subsequent reports.
- National Comparative Audit of Blood Transfusion – Audit of NICE Quality Standard QS138. Results show that OUH has been rated above the national average for all four indicators relating to the management of safe patient blood transfusion processes. This offers substantial assurance that patients are receiving high quality, evidence-based care.
- National Neonatal Audit Programme (NNAP) results show that, once again, OUH exceeds many national standards in the delivery of neonatal care. At a Trust level, these include administration of antenatal magnesium sulphate to mothers at risk of very preterm birth; delayed cord clamping; parental discussion with a senior clinician on admission; mothers milk by day 2; screening for retinopathy of prematurity; and use of non-invasive ventilation in the first week of life. At a neonatal network-level, OUH was excellent in its performance for necrotising enterocolitis, mortality and intraventricular haemorrhage.
- Trustwide Venous Thromboembolism Prevention Audit: OUH has maintained high standards in the prevention of venous thromboembolism (VTE), with the latest Trustwide audit showing 97.9% of patients received appropriate blood clot prevention (thromboprophylaxis).
- As reflected in the National Audit of Inpatient Falls results, OUH continues to place patient safety at the forefront of activity by addressing falls prevention through a dual strategy of environmental optimisation and strategic leadership. Despite not being mandated by national guidelines, OUH voluntarily undertook a comprehensive re-audit of its infrastructure, demonstrating a culture of continuous improvement and high accountability.

Innovations introduced and the positive impact of research on patient care

Oxford is one of the most vibrant places in the world for healthcare research because of our close working relationship with the University of Oxford and Oxford Brookes University.

OUH is also at the heart of a research ecosystem as the host organisation for the National Institute for Health and Care Research (NIHR) Oxford Biomedical Research Centre (BRC) and Health Innovation Oxford and Thames Valley; and as a member of Oxford Academic Health Partners (OAHP).

This has a positive impact on the quality and safety of patient care because new innovations and treatments are often introduced first in our hospitals and then rolled out to other NHS Trusts – some examples of recent innovations include the following.

- Newborn babies in Oxford are being tested for more than 200 rare genetic conditions as part of a national study. OUH is one of around 30 NHS Trusts taking part in the Generation Study, a research programme being delivered by Genomics England and the NHS. Overall, the study aims to recruit 100,000 newborn babies, whose genomes will be sequenced after birth, with their parents' consent.
- For the first time in the UK, a woman has given birth following a womb transplant. New mother Grace and father Angus named their baby Amy Isabel after Grace's sister Amy, who donated her womb, and OUH surgeon Miss Isabel Quiroga, who co-led the transplant operation. This milestone followed more than 25 years of pioneering research and innovation by a collaborative team of UK experts led by Professor Richard Smith, a consultant gynaecological surgeon at Imperial College Healthcare NHS Trust, and also for over a decade by Miss Quiroga, a consultant transplant and endocrine surgeon at OUH.
- OUH has received £1 million to fund state-of-the-art research facilities and equipment, much of it to allow its Pharmacy team to meet growing demand. The funding was awarded after a competitive process by the NIHR as part of its capital funding to NHS organisations that are part of its wider infrastructure, such as Biomedical Research Centres (BRCs) and Clinical Research Facilities (CRFs). The funding will not only support NIHR-related research but also increase the Trust's ability to leverage additional funding for cutting-edge research, including from commercial companies.
- A new study by researchers at OUH and Imperial College Healthcare NHS Trust has found that an artificial intelligence (AI) conversational agent enhances patient care after cataract surgery. The AI automated voice system, Dora, is able to call patients to ask them questions, understand their answers, and accurately identify which patients require further medical assessment. It prioritises those patients who need additional clinical input and frees up the time of clinical staff to focus on more complex or serious cases. An updated version of Dora is now OUH's default system for post-cataract surgery assessment and is also used for preoperative assessments.

Our award-winning teams

Our staff are committed to delivering the highest quality care for our patients. This year we have celebrated their many successes including the following.

- A life-saving OUH initiative to manage postoperative bleeding was shortlisted in two categories of the *Health Service Journal* (*HSJ*) Patient Safety Awards 2024.The SCOOP (Skin exposure; Cut sutures; Open skin; Open muscles; Pack wound) Protocol for emergency management of neck haematoma following thyroid surgery was developed to manage and mitigate the risks associated with postoperative bleeding. This protocol, now internationally recognised, has become a cornerstone in national guidelines.
- Our partners Social Finance were shortlisted in the Best Not for Profit Working in Partnership with the NHS category of the *Health Service Journal (HSJ)* Partnership Awards 2025. This recognised their work with OUH on the Oxfordshire Rapid Intervention for Palliative and End of Life Care (RIPEL) project which enables more people to be cared for in their own home at the end of their life, if that is their choice.
- Steph Taylor, a Clinical Specialist Physiotherapist in Haemophilia and Allied Bleeding Disorders at OUH, won the Physiotherapist of the Year Award at the Haemophilia Society's Recognition Awards in November 2024.
- The Hip Fracture Team at the Horton General Hospital in Banbury was named as one of the best in the country in the annual National Hip Fracture Audit for the 12th year in a row. They met best practice criteria in their treatment of 85% of patients, compared with a national average of 50%, placing them in the top five units nationally.

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

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

Simon Crowther

Acting Chief Executive Officer

12 May 2025

About us and the service we provide

Oxford University Hospitals (OUH) NHS Trust was formally established on 1 November 2011 when the Nuffield Orthopaedic Centre NHS Trust merged with Oxford Radcliffe Hospitals NHS Trust. On the same date, a revised formal Joint Working Agreement between the Trust and the University of Oxford came into effect. The Trust became a Foundation Trust on 1 October 2015. OUH is an acute hospital Trust providing local, regional and some national hospital services to the population of Oxfordshire and beyond. It is registered with the Care Quality Commission and licensed to provide regulated activities by NHS England. The Trust provides a wide range of clinical services, specialist services and super specialist services, including emergency care, trauma and orthopaedics, maternity, obstetrics and gynaecology, paediatric services, newborn care, general and specialist surgery, cardiac services, critical care, cancer, renal and transplant, neurosurgery, maxillofacial surgery, infectious diseases and blood disorders. The Trust also draws patients from across the country for specialist services and leads networks in areas including trauma and vascular.

The Trust consists of four hospitals:

- John Radcliffe Hospital (JR)
- Churchill Hospital (CH)
- Nuffield Orthopaedic Centre (NOC)
- Horton General Hospital (HGH)

The John Radcliffe Hospital, Churchill Hospital and Nuffield Orthopaedic Centre are located in Oxford, and the Horton General Hospital in Banbury, North Oxfordshire. Most services are provided in our hospitals, others are delivered across more than 100 satellite locations across the region, which include outpatient peripheral clinics in community settings and satellite services in several surrounding hospitals, and some in patients' homes.

The Trust also delivers services from community hospitals in Oxfordshire, including Midwifery-led units, and is responsible for a number of screening programmes, including those for bowel cancer, breast cancer, diabetic retinopathy and chlamydia.

More information on OUH and its services is available on the Trust website at www.ouh.nhs.uk.

Priorities for Improvement and Statements of Assurance from the Board

Priorities for Improvement

Results and achievements for the 2024/25 Quality Priorities

This section details the Trust's achievements against its quality objectives for 2024/25. While good progress has been made on many of the Quality Priorities for 2024/25, progress on others has been slower than planned due to operational pressures. The Trust continues to engage sensitively with clinical services to try to complete the outstanding objectives. To support ongoing progress, Fragility Fractures and Oxford Critical Care Outreach Team Quality Priorities have been extended into 2025/26.

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Patient Safety

Quality Priority 1 Medicines Safety Framework

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.

Figure 1: Summary of actions for Quality Priority 2024/25. 1 Medicines Safety Framework

What we will do	2024/25 update
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.	**Complete** • A working group has been established with representation from relevant stakeholders. The types of indicators and method for determining the priority indicators have been agreed.

What we will do	2024/25 update

	• Potential metrics and indicators associated with known Never Events, NHS England's Enduring Standards and National Patient Safety Alerts were collated and reviewed. The five priority measures were agreed as, the restricted supply of the following.
	  • Concentrated potassium injectable products (≥10% potassium w/v (e.g. ≥0.1g/mL potassium chloride, 1.3mmol/mL potassium chloride).
	  • Insulin pre-filled pens and cartridges.
	  • Midazolam 1mg/ml for conscious sedation.
	  • Sodium chloride 0.18% with glucose 4% intravenous infusion.
	  • Potassium permanganate tablet for skin soak.

Action 2 (Q1) • For the five metrics/indictors, define the parameters and/or rules in the context of the organisation.	**Complete** • A detailed review of the supply and restrictions in place for the five priority areas was Complete. Parameters were set based on previous supply issues. As a result of this process, it was identified that further improvement work is required to standardise insulin stock, use of potassium permanganate soaks and to identify if there are more areas performing conscious sedation. A summary of agreed parameters is as follows.

What we will do	2024/25 update
	• Concentrated potassium injectable products restricted to neonatal/paediatric critical care and maternal medicine. • No insulin pre-filled pens or cartridges as stock in adult clinical areas. • Midazolam 1mg/ml in areas known to perform conscious sedation. • No sodium chloride 0.18% with glucose 4% intravenous infusion in children's areas. • Potassium permanganate soaks restricted to dermatology outpatients.
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.	**Complete** • Supply issue data over 6 months was derived manually. Analysis found feasibility to monitor safety restrictions associated with potassium, the infusion fluid and Midazolam in areas known to perform conscious sedation and adherence to standards. Some inadvertent supplies of medicines were identified demonstrating the value of this type of surveillance. It was also identified that restrictions of insulin stock and potassium permanganate soaks were not standardised as expected across the Trust. These unexpected findings have resulted in further work to address these disparities which is underway.

What we will do	2024/25 update
	• The next step is to consider how to automate the data analysis and develop a tool to identify potential risks or issues outside of agreed parameters.
Action 4 (Q4) • Collaborate with TheHill 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).	**Not Complete** • Progressing the development of an automated monitoring tool has not been possible due to the delayed implementation of the Cerner Pharmacy project.

Quality Priority 2: Care of the Frail Elderly (rolled over from 2023/24)

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 focuses on strengthening the assessment of frail, elderly patients in the Emergency Department (ED) and Same Day Emergency Care (SDEC) settings.

Figure 2: Summary of actions for Quality Priority 2024/24. 2 Care of the Frail Elderly

What we will do	2024/25 update
Action 1	**Complete** • Business case presented to Business Planning Group (BPG) in January 2025.

What we will do	2024/25 update
• Continuation of the Frailty multidisciplinary team to support early assessment of frail, elderly patients in the ED and Acute Ambulatory Unit (AAU).	• Business case approved by Trust Management Executive (TME) February 2025. **Not Complete** • Need to secure funding for business case.
Action 2 • Strengthen documentation of Clinical Frailty Score (CFS) among patients aged 65 years and older attending ED, AAU or EAU.	**Complete** • CFS is fully embedded within ED admission workflow and is achieving >95%. • Audit of CGA initiation (as per the CQUIN 23/24) continues to show high performance at 50-60% each month. **Not Complete** • CFS within the Rowan Ambulatory Unit (RAU) and AAU is 30-40% per month. • CFS completion within EAU 20%. • Ongoing QI work in RAU, AAU and EAU around CFS completion.
Action 3 • Strengthen documentation of Cognitive Assessment among patients aged 65 years and older admitted through ED or AAU.	**Complete** • Electronic Patient Record (EPR) cognitive screening task has been changed to reflect the recommendations presented to the Patient Safety and Effectiveness Committee (PSEC). • Screening rates have improved beyond previous highest rates.

What we will do	2024/25 update
	• Screening rates for all unplanned admissions aged 65 or older was 69.4% in Q4. • Screening rates using the old metric (aged 75 and over with LOS over 72 hours) were at 82.6% in Q4. • Live orbit reports available allowing clinical areas to track performance. **Not Complete** • QI work in ED to improve recognition of delirium and cognitive impairment.
Action 4 • Improve the assessment and further management of frail, elderly patients by creating and implementing a system for comprehensive geriatric assessment (CGA).	**Complete** • Performance remains at 50-60%. • Mostly initiated through seeing a geriatrician while on AGM or the Frailty Intervention Team (FIT). **Not Complete** • To fully achieve a meaningful intervention we require the progression of the business case and development of the Front Door Frailty team. We know this will reduce admissions and re-admissions.

Quality Priority 3: Reducing Inpatient Falls (rolled over from 2023/24)

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 factor 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 focuses 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.

It also focuses on using appropriate QI tools identified through each step of the improvement framework, to enable a structured QI approach and monitoring of sustainability and the impact of changes, and sharing this widely throughout OUH.

Figure 3: Summary of actions for Quality Priority 2024/25. Reducing Inpatient Falls

What we will do	2024/25 Update
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).	**Complete** • The proposed action was to review the current e-learning package 'Preventing Falls in Hospital' and create a new e-learning education package if required. • Feedback on the current package determined it was not meeting the requirements for staff in the acute setting. • After a discussion with the Chief Nursing Officers, it was decided that a new e-learning package would not be a viable option, and

What we will do	2024/25 Update
	the direction was changed to a ward-based education programme. • The ward-based education programme was tested in seven ward areas in October 2024 and launched in November 2024. The package covers the reasons why people fall, focusing on cognition, sensory impairment, postural hypotension and medications. It also includes the importance of assessment, care planning, mitigation and post-fall care. • The key content is delivered via slides and is adaptable to classroom and online teaching. A section has been created within this for educators to provide local data and information to drive key messages relevant to the patient population for the individual ward areas. • Education teams provide this ward-level training. Ward educators attend a train-the-trainer session to review key content, lesson plans and the recording system. • To date, 49 PDNs have attended the train-the-trainer session. 256 staff members have completed the training. • This training is logged on My Learning Hub and awaits Governance approval to become a core role requirement with a three-year certification cycle.

What we will do	2024/25 Update
• Easy Read version of falls and bedrails leaflets (Q2).	**Complete** • New Easy Read versions of the falls and bedrail patient information leaflets have been created in conjunction with the Patient Safety Partners. These are available through Oxford Medical Illustration (OMI).
• Creating patient stories for shared learning (Q2-4).	**Not Complete**. • A focus group with Carers Oxfordshire was held to support a patient story but unfortunately a participant was not found. A QI voice story, created by the Falls Prevention Practitioner, is available on the QI Trust intranet site, highlighting the QI journey in falls prevention and providing tips for staff. • A patient story will be shared at Board level, with managers asked to identify possible patients or carers. We are also collaborating with the Friends and Family Test team to find a suitable case. Identification is ongoing.
• Sharing of learning through the Community of Practice and Improvement Stories (Q1-4).	**Complete** • The Falls and Hospital Acquired Pressure Ulcer Community of Practice meets monthly to share best practices, collaborate, support each other and resolve problems. Approximately 10 people attend each month, and it is open to all Champions and ward leaders.

What we will do	2024/25 Update
Action 2 (Q1-4): Increase Multifactorial Falls Risk Assessment (MFRA) compliance • Monitoring audit Trust results for Fallsafe Audit completion.	**Complete** • Audit data is shared monthly within the Harm Free Assurance Forum and Clinical Governance Committee. Wards with results below 90% compliance for two consecutive months must submit action plans. • Suggested actions are available on the Ulysses audit platform to support ward leaders in improving audits. • Focus will remain on incomplete assessment elements, with targeted actions requested at Divisional level. • A maternity-based falls audit was launched in January 2025, to meet the needs for this patient population.
• Establishing assessments across Day Case and maternity, using a QI approach (Q1-4).	**Partially Complete** • Day Case: A set of questions to assess falls has been created and reviewed by leaders. A care plan accompanies it. The questions are currently being reviewed for user feasibility and acceptability. • After user review, a digital build will be requested for EPR. • Maternity: A set of questions to assess falls has been created and reviewed by leaders. A care plan accompanies it. The next step is to review with the digital Maternity lead the application of a new assessment into Badgernet.

What we will do	2024/25 Update
• Review falls assessment tool and care plans for adults (Q1-4).	**Partially Complete** • A new falls assessment is being developed and is currently under construction within EPR. The test version will be demonstrated to stakeholders for review. • The new assessment will help staff record clear and accurate information, as well as implement measures for safe mobility and fall prevention.
Action 3 (Q1-4): Strengthen early assessment following a fall • Develop and implement tools (e.g. Safety Message) to improve early assessment (Q2-4).	**Complete** • A safety message was sent in April 2024. Changes were made to the Ulysses incident report to capture accurate post-fall data. A new injury check assessment is being developed for EPR to improve the precise recording of injuries that occur on the floor post-fall, with a proposed readiness for user testing by the end of February 2025. • A medical proforma has been developed in MRC and is now available in EPR for Trustwide use, aiding comprehensive and systematic assessments after a fall. Shared through Safety Learning and Improvement Conversation (SLIC) in January 2025, it is accessible via the SLIC slide and share through Governance forums. • Following the monitoring of post-fall care for patients with hip fractures, an initial review was conducted between August 2022

What we will do	2024/25 Update
	and August 2023. This review revealed an unclear understanding of whether injury checks were conducted, if injuries were suspected, and whether appropriate retrieval methods were used. Due to the ambiguous assessment process, accurate data calculation was not possible. • In response, modifications were made to Ulysses to capture this crucial information, and training sessions were initiated. The subsequent review, spanning from August 2023 to January 2024, indicated an increase in injury checks on the floor. However, it still did not confirm whether injuries were suspected, and the correct retrieval method remained unclear. • Further adjustments were implemented in Ulysses. The final comprehensive review of hip injuries, covering the period from January 2024 to December 2024, demonstrated that injury checks are now being conducted on the floor. Additionally, the identification of whether an injury is suspected is clear, and retrieval methods are appropriately matched to the level of suspected injury. • While injury checks are being performed on the floor, there remains a need for staff to consistently recognise injuries. Continued efforts are necessary in this area. Training is ongoing

What we will do	2024/25 Update
	through ward-based sessions, Care Certificate programmes and Preceptorship simulation. • All teaching at ward levels, within CARE Certificate programmes and during Preceptorship, includes post-fall care, adhering to guidance provided by NICE and the National Audit of Inpatient Falls. This instruction is delivered either as taught sessions or through simulations.
Action 4 (Q1-4): Optimising the use of falls related data • Strengthen Trust National Audit of Inpatient Falls (NAIF) compliance.	**Complete** • In January 2025, the National Audit expanded its criteria to include all fractures and head injuries. Data for this audit is compiled by the Falls Prevention Practitioner. Audits are presented through the Clinical Improvements Committee, and the Trust is up to date with the reporting cycle. The Trust is currently awaiting its 2024 report.
• Strengthen the use of falls data at local level.	• **Complete** • Falls data is provided to wards on a monthly basis. Ward leaders have access to falls dashboards and Power BI charts to review falls details. • The Harm Free Assurance Forum, Clinical Governance Committee and Falls Delivery Improvement Group receive monthly falls data.

What we will do	2024/25 Update
	The Patient Safety Executive Committee reviews this data quarterly. • Data are used in the Community of Practice to support ward leaders. • Data are tracked for each fall in alignment with the Patient Safety Incident Response Framework (PSIRF).
Action 5 (Q1-3): Optimise the use of assistive technologies to support falls prevention	**Partially Complete** • Sensor technology was tested in wards 5E/F and Sobell House, using basic pressure sensors, bathroom alarms and an advanced sensor pad system. The Quality Improvement team and a Research Registrar supported the trials, employing pre- and post-questionnaires and analysing equipment use. Due to cognitive issues, minimal patient feedback was collected. The trials did not reduce falls but increased staff awareness. • An option paper was presented at the Harm Free Assurance Forum to consider purchasing basic pressure and bathroom sensors Trustwide or testing them in the top ten wards with higher fall rates. A decision is pending.

Clinical Effectiveness

Quality Priority 4: Oxford Critical Care Outreach Team

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 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 Getting It Right First Time (GIRFT), GPICS and is a recurrent theme in NCEPOD reports. It is advocated in NICE guidance.

Figure 4: Summary of actions for Quality Priority 2024/25. Oxford Critical Care Outreach Team

What we will do	2024/25 update
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	**Complete** • The following OUH data have been collated and reviewed by the WG: Complete.

What we will do	2024/25 update

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.
	• Reviewed datasets include:
	  • NEWS2 data (limited to number of triggers rather than patients)
	  • OCC referrals consultant data (including number of referrals and patients declined admission)
	  • Resus and 2222 data
	  • ICNARC data[1]
	• Team size of peer groups has been evaluated.
	• A stakeholder summit was held on 4 June 2024. Appetite for developing this service within OUH is high.
	• An additional stakeholder survey has been sent out to the Trust to elicit broader opinion, especially from junior nursing and medical staff. Further stakeholder engagement is recommended as potential scope and remit of outreach becomes more defined.

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.	**Complete** • The WG has agreed initial team construct and numbers, which has been used in initial draft BC. Draft rotas have been generated. All will be subject to revision subject to identifying immediate and sustainable funding. Given current Trust financial pressures these may be significant.

What we will do	2024/25 update
• Q3. Refine team composition (if required) following stakeholder engagement (see Action 1: Q3) and benchmarking.	**Complete** • Benchmarking review against Shelford/Model hospital peers' mean team size indicates that an Outreach team should consist of 18 to 20 staff. **Partially Complete** • Prospective team composition and rotas drafted but subject to change, particularly as dependent on finance and service development.
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).	**Partially Complete** • An incremental development plan has been agreed by the WG based on restarting a follow-up service and then Outreach, followed by progressing increasing site and hours covered. Without identified funding this remains aspirational. Initial service development to meet year 1 and 2 milestones is possible from within current OCC budget; however, this would be placed at risk were current funding to be reduced. A full service (year 3 and 4 milestones) remains unachievable without a commitment of additional Trust funding.
Action 4: Business case progression	**Partially Complete**

What we will do	2024/25 update
• Q1. Complete and submit Business Case Initiation Proposal (BCIP) to Division. • Q2. Submit BCIP to TME. • Q3. Submit full BC to TME.	• A draft BCIP was submitted to CSS Division but stalled due to lack of funding for a full service. It is recommended that an interim BC be re-submitted to cover initial phase of development (years 1 and 2). A paper was submitted to COF outlining service development, this did not include detailed costings but outlined potential areas of realising efficiencies to part-fund the service.
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 (dependent on HR process and availability of applicants)**.**	**Partially Complete** • Waiting for BC approval. **Complete** • Recruitment has occurred. **Complete** • OCC is five days per week for the JR site. • Paediatrics OCC is seven days a week, 24-hour service • Telephone advice for all other sites.

Quality Priority 5: Embedding the Surgical Morbidity Dashboard (rolled over from 2023/24)

Why is this a priority?

This Quality Priority builds on our previous year's work by supporting the rollout 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.

Figure 5: Summary of actions for Quality Priority 2024/25. Embedding the Surgical Morbidity Dashboard

What we will do	2024/25 update
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	**Complete** • Development of the Dashboard is complete; dissemination is an ongoing process. All SuWOn surgical teams have been trained; Meetings with the Cardiac Directorate and NOTSSCaN have familiarised them with both the Dashboard and databases using similar HES methodology (NCIP Model Hospital data).
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	**Not Complete and Ongoing** • Feedback from the initial trial was taken on board and used to add procedure-specific outcomes to the Dashboard to improve functionality. This was a major development and allowed users to analyse the data by clinical team or by procedure (Completed).

What we will do	2024/25 update
	• Further improvements can be made by individual services as per their needs. These include at least one procedure-specific complication outcome to service-based outcomes (in progress – long-term). • Divisions are to work with coders to improve the quality of coding data for their specialty (in progress – long-term). • Considering using return to theatres as a metric that becomes mandatory for surgical services on SuWOn to review through the Dashboard at each of their monthly Morbidity & Mortality (M&M) meetings (in progress).

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.

This is 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 special care baby unit (SCBU) for babies.

Figure 6: Summary of actions for Quality Priority 2024/25. Reducing Maternal and Neonatal Morbidity

<table>
<tr><th>What we will do</th><th>Update 2024/25</th></tr>
<tr><td>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.</td><td>Complete
We have audited the metrics described and the results are as follows:<table><tr><th>%</th><th>Delay >24hrs</th><th>Delay >48hrs</th><th>Delay >72hrs</th></tr><tr><td>Baseline (Pre-QP)</td><td>53.8</td><td>33.6</td><td>19.6</td></tr><tr><td>Q1 – April to June 2024</td><td>28.3</td><td>12.1</td><td>6.3</td></tr><tr><td>Q2 – July to September 2024</td><td>19.2</td><td>8.5</td><td>3.5</td></tr><tr><td>Q3 – October to December 2024</td><td>23.1</td><td>7.4</td><td>3.5</td></tr></table></td></tr>
</table>

What we will do	Update 2024/25

- On average, 40-50 inductions of labour bookings are requested by midwives 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 midwives to prioritise clinical care, rather than administrative process.
- Objective: Reduction in % of women having IOL delayed >24 hours (74% delayed >24 hours in baseline audit; stretch target <20%).

Q4 – January to March 2025	22.4	8.1	3.8

%		Day midwife staffing	Night midwife staffing	Overall midwife staffing	Overall midwife staffing by Quarter
Q1	Apr-24	89.6	88.9	89.4	
	May-24	88.7	86.5	87.9	87.2
	Jun-24	85.5	82.2	84.4	
Q2	Jul-24	86.5	79.9	84.3	
	Aug-24	86.5	80.9	84.6	85.3
	Sep-24	87.8	85.5	87.1	
Q3	Oct-24	86.5	83.6	85.5	
	Nov-24	86.3	83.7	85.4	87.1
	Dec-24	91.8	87.3	90.3	
Q4	Jan-25	87.6	86.1	86.9	
	Feb-25	86.0	84.1	85.0	86.3
	Mar-25	87.7	85.9	86.8	

Narrative: There was a marked reduction in delay in the IOL process over Q1 and Q2, with a plateau in Q3 and Q4. This is attributed to efforts to manage workflow by reducing overbooking of IOLs and evenly distributing service demand throughout the week to align with available staffing, in addition to efforts to improve the existing staffing model. Work has begun to explore

What we will do	Update 2024/25
	alternative staffing models for intrapartum care, specifically focusing on midwifery staffing dedicated exclusively to IOL. It is anticipated that further reductions in delay are achievable with alternative staffing arrangements.
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. • Objective: Improvement in participant assessment score pre and post 'HARM' training.	**Complete** We ran the first pilot HARM training on 11 December 2024 for junior obstetric medical staff – the session was 3 hours in length and delivered by consultant obstetricians and senior obstetric registrars. Participant feedback was universally positive. Following HARM training, anonymised individual operator data for participants relating to PPH and OASI was audited and demonstrated a reduction in the incidence of these complications over three months.

What we will do	Update 2024/25
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. • Objective: Reduction in maternal and neonatal morbidity indicators in women having induction of labour. Metrics are: • Major Haemorrhage >1500 ml • Obstetric anal sphincter injury • ITU admission following major haemorrhage • Frequency of major transfusion (>2 units packed cells or use of FFP (fresh frozen plasma) for coagulopathy	**Complete** We prospectively audited the metrics described.

%	ATAIN	OASI	PPH >1500ml	Blood Transfusion
Baseline (Pre-QP)	10.5	3.0	6.3	3.8
Q1 – April to June 2024	2.6	2.8	3.9	3.5
Q2 – July to September 2024	4.5	3.1	4.5	3.3
Q3 – October to December 2024	2.2	1.5	5.0	3.7
Q4 – January to March 2025	3.6	2.7	4.9	3.1

Narrative: We saw a significant reduction in ATAIN cases (term admissions to neonatal units) in women having IOL over the course of the year which mirrors the reduction in delay. There was no statistically significant change in the rate of OASI or blood transfusion over the course of the year, and while there was an overall reduction in rates of PPH, this has plateaued in Q3 and Q4 which is reflective of the corresponding plateau in delay. There was only one ITU admission in women having IOL therefore we have not included these data as the numbers are too small to be interpreted.

What we will do	Update 2024/25
• Unexpected SCBU admission in term babies without congenital abnormalities (Avoiding Term Admissions Into Neonatal units (ATAIN))	

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.

Figure 7: Quality Priority 7. 2024/25 Reducing Health Inequalities

What we will do	2024/25 update
Action 1: Embedding consideration of Health Inequalities (HI) across the Trust • Raise awareness and engagement of services across the Trust in our Health Inequalities dashboards. • Incorporate health inequalities considerations into the planning and delivery of services across the Trust. • Integrate reporting on Health Inequalities in the business and reporting of the Trust's Delivery Committee.	**Complete** • The HI Dashboard was used throughout 2023/24 to understand unwarranted variation in a number of OUH services, including Palliative Care and the Oxford Haemophilia and Thrombosis Centre (OHTC). • Neurosciences, Pharmacy & Renal, Transplant & Urology reviewed the HI data as part of the Equality Delivery System 2025. Oxford Kidney Unit added a specific question: "Do you have any religious or cultural needs that your Dialysis team needs to know about?" as part of Patient Passport. Neurosciences had a recent education session with the multi-faith Chaplin for the Neurophysiology team to better support patients. • Respiratory consultants have used the Dashboard to consider, which patients are not attending appointments (Did Not Attend (DNA)), if this relates to health inequalities and how they might make improvement.

What we will do	2024/25 update

	They are keen to engage further but are currently limited by staff resources.
	• Maternity continues to have a focus on HI through different initiatives.
	  • Working in partnership with communities: Equal Start Oxford.
	  • Place-based outreach clinics for asylum seekers in dispersal accommodation.
	  • Working with the Patient Experience team to improve language support for rare languages (including Tetum).
	  • Improving resource equity – community midwifery resource.
	• HI Dashboard drop-in clinics now in place with data analysts providing guidance to service users to tap into the data and explore inequalities in patient care, access and outcomes based on socio-economic backgrounds. Material to support colleagues to get the best out of the Dashboard is also provided on the Trust intranet.
	• Cancer inequalities: Two projects undertaken by breast screening services to improve uptake in Index Multiple Deprivation (IMDs) 1-3.
	• Project 1 - co-production with the Asian Muslim community in OX4 with Asian community advocate + elders, series of events planned and ongoing community building.
	• Project 2 - screening with GP practice in OX3 (walking distance from screening department) with update rate of 50% vs. 70% in practices covering IMDs 7-10.

What we will do	2024/25 update
	• Deep dive with GP practice to understand data (ethnic + deprivation profiles) with aims for plan to be devised with relevant communities to increase uptake. The Delivery and Clinical Quality Governance Committees receive regular reports on the progress of the OUH Health Inequalities Programme Plan.
Action 2: Work with system partners to promote the reduction of health inequalities • Work with system partners to identify marginalised health inclusion groups within our local population. • Work with system partners to scale up the use of Making Every Contact Count (MECC). • Share insights identified from integrated reporting on Health Inequalities to support system-based actions and interventions.	**Complete** Work was undertaken through a sub-group of the Oxfordshire Prevention and Health Inequalities Forum to identify and triangulate data on inclusion groups. • Work has focused on prisoners and those in contact with the criminal justice system. Community Safety Practitioners met with His Majesty's Prison (HMP) Bullingdon team to work in partnership to improve communication, handover, patient safety and discharge arrangements, including medication management considerations. • The OUH Here for Health team has worked with system partners to deliver MECC training across Buckinghamshire, Oxfordshire and Berkshire (BOB) (Better Housing Better Health and Connection Support). Connection Support works with refugee resettlement programmes to include Afghan Relocations and Assistance Programme (ARAP), Afghan Civilians Resettlement Service (ACRS) or United Kingdom Resettlement Programme (UKRS) and the Homes for Ukraine scheme.

What we will do	2024/25 update
	• MECC intranet page live. Posters distributed across all 4 sites promoting MECC and the OUH resource. Launch promotion event being planned. MECC training delivered as part of the Healthcare Support Worker (HSW) induction. MECC awareness training part of Health Care Support Workers induction. • MECC awareness training for OUH pharmacists (two sessions delivered). • MECC training delivered for OUH volunteers October 2024 (18 volunteers). • Mental Health (MH) Nurse and Oxfordshire Physical Activity Clinical Champion (Active Oxfordshire). • MECC posters put up across the 4 main OUH hospital sites (August 2024). • MECC Awareness Week took place in January 2025. To highlight what MECC is, and the resources and training opportunities available to staff at OUH (including the SharePoint page). This will be a prelude to the Oxfordshire-wide MECC month of May (2025). • OUH is participating in a system-wide group (which identified the inclusion groups) to examine how the system should best respond to such groups. • A working group has been established and linked with the Oxfordshire Health & Homelessness Inclusion team to identify meaningful steps the Trust can take to reduce the health inequalities experienced by those without a home or in temporary accommodation. One important step

What we will do	2024/25 update
	in this work is to understand what different services are already doing, and where improvements could be made; a Trustwide survey has been sent.
Action 3: Further develop our Anchor Institution approach • Convene Anchor Institutions across Oxfordshire to identify common areas for action where collaboration offers greatest value and benefit. • 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. • Convene an internal Anchor Working Group to steer the process of creating an Anchor roadmap.	**Complete** • An Oxfordshire Anchor Network event was held in April 2024 where system-wide priorities were agreed which can be incorporated into the OUH roadmap. • OUH is working with Oxfordshire County Council towards becoming a Marmot Place. By adopting evidence-based principles and using methodology developed by Professor Michael Marmot and his team, we can improve key building blocks of health and reduce related inequalities in our county. • The approach represents a commitment towards the strengthening of the whole system approach to reducing health inequalities in Oxfordshire. • OUH is an active member of the Oxfordshire Inclusive Economic Partnership (OIEP). We are signed up to and meet the OIEP Anchor Pledges. • An internal Anchor Steering Group chaired by the Deputy Chief Executive Officer has been set up to steer the process of creating an Anchor roadmap. It has considered OUH's role in routes to employment, apprenticeships, sustainability and social impact in procurement. • The Anchor Steering Group uses the Leeds Anchor Framework to compare delivery nationally.

Quality Priority 8: Patient Experience with the Patient Safety Incident Response Framework (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 NHS England (NHSE) / HSSIB[2] / 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.

The improvement plan was drafted with the contributions of current Patient Safety Partners.

Figure 8: Summary of actions for Quality Priority 2024/25. Patient Experience with PSIRF

What we will do	2024/25 update
Action 1: Q1 • Develop an improvement plan for compassionate engagement of patients, families and carers who have been involved in serious patient safety incidents. • There will be training provision for Engagement Leads. • There will be a plan for Patient Safety Partners recruitment. • Trustwide communication about the role of engaging and involving patients following a patient safety incident.	**Complete** • Training has been provided by an external company, Being Human in Healthcare, who trained 26 members of staff. Other staff members have attended the HSSIB Engagement lead training course. **Partially Complete** • 4 Patient Safety Partners (PSPs) established in post and a further 5 recruited. Safer Recruitment checks currently being undertaken by the Voluntary Services team **Complete** • Duty of Candour letters reviewed in partnership with PSPs.

[2] Health Services Safety Investigations Body (HSSIB)

What we will do	2024/25 update
	• All Patient Safety Incident Investigation (PSII) reports include a pen portrait of the patient involved (where consent has been provided) to ensure a person-centred approach to the investigation. • PSPs are involved as part of the PSII review team.
• Development of a Standard Operating Procedure (SOP) highlighting how to request feedback on the involvement experience.	**Complete** • The wording, format and approach to Duty of Candour letters has been reviewed by a PSP to make sure our processes and letters are patient-centred and compassionate. **Complete** • Benchmarking and review of previous SOP undertaken as no data had been collected by this method and one family's feedback was received through the complaints process. This experience helped to develop an alternative approach which was agreed by the PSIRF Improvement Group.
• Review of the available tools to gather feedback from patients and families following involvement in a patient safety incident.	**Complete** • No available national tools identified. Locally developed tools from other Trusts are under review.
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.	**Complete** • PSP joined Clinical Governance Committee from 22 January 2025. • Phase 3 PSP recruitment in progress and on track. • All current PSPs have reviewed this plan.

What we will do	2024/25 update
Action 3: Q1 • Co-develop with the PSP tools to capture feedback on the experience of being involved following a patient safety incident.	**Complete** • A survey has been developed collaboratively with the Patient Safety Partners and the PSIRF Improvement Group. • Based on feedback, an SOP has been produced called the *PSII Patient Engagement. SOP* has been reviewed and ratified by the PSIRF Improvement Group. It is a guide for engagement leads which sets out how the Trust expects patients to be engaged at key stages throughout the investigation.
Action 4: Q1 • Review and update tools following testing with different patient and family groups, community groups and other key stakeholders.	**Complete** • This has been incorporated into the *PSII Patient Engagement SOP*. Patients and families are informed at the beginning of the process of our intention to ask for feedback once the final report has been approved. This embeds the process for obtaining feedback form the start of the investigation.
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.	**Complete** • PSP joined the Trust Patient Experience and Family Carer Forum. • PSP attendance at SLIC for the Patient Experience, Complaints and Legal Services presentations. • Model of PSP – professional curiosity at SLIC and Patient Safety and Effectiveness Committee (PSEC) – seeking assurance for the

What we will do	2024/25 update
	patient and family view and ensuring the person-centred approach. • The Inquest, Claims, Complaints, Safety, Incidents and Safeguarding (ICCSIS) meeting triangulates data to highlight shared issues and learning. Improving this mechanism for identifying concerns was on the agenda for the PSIRF Improvement Group 12 March 2025.
Action 6: Q2-4 • Use feedback from tools developed and other sources of information to improve how patients and families are involved.	**Complete and ongoing** • The PSPs have been fundamental in reviewing and providing input into policies and their implementation to ensure they are patient-centred and compassionate. • Education, training and mentoring plan and approach in development co-produced with the PSP, Quality Improvement and Strategy teams. • Experiences from the one of the Divisional Engagement Leads have been shared and led to the implementation of additional Engagement Lead roles in other Divisions. • Feedback from the Divisions and from Complaints has been used to improve processes.

Quality Priority 9: Fragility Fractures (rolled over to 2025/26)

Why is this a priority?

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

The Horton General Hospital 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.

Figure 9: Summary of actions for Quality Priority 2024/25. Fragility Fractures

What we will do	2024/25 Update
Action 1: Improving percentage of non-ambulatory fragility fracture (NAFF) patients operated on within 36 hours, Q1-4 • Q1: Development of an SOP to allow escalation of theatre capacity concerns, and creation of additional emergency trauma capacity in OUH Theatres. • Q2: Change in trauma consultant rota to allow more flexibility to deliver extra lists. • Q3: Review of demand and capacity following above changes and understanding opportunities from new theatre build if additional theatre capacity needed.	**Complete** • Surge capacity in place – additional lists as required – some limitations of surgical workforce. **Partially Complete** • Second consultation for new consultant rota in progress but delayed at Divisional level. Rota gaps remain but continue to be actively addressed. Substantive cross-site JR/HGH consultant with interest in fragility fracture started November 2024 (performs Total Hip Replacements (THR)). • Hip and Pelvis Joint NOC/JR consultant post nearly ready to be signed off at the Business planning group (BPG).

What we will do	2024/25 Update
• Q4: Implement Geriatric Orthopaedics (GO) and Anaesthetic review on day of admission. • Q4: Expand to a 7-day trauma coordinator service.	**Not Complete** • Demand and capacity modelling not yet started. **Not Complete** • 5-day trauma coordinators in post (2) – plan to evaluate delivery and enhanced benefits of 7-day cover to inform business case. **Not Complete** • Geriatric Orthopaedic business case to allow expansion of cover currently under review. **Metrics** • Best Practice Tariff (BPT) metrics improved: in November 2024 BPT criteria were met at OUH in 79.3% of cases (71% JR, 88.9 HGH). 89% of medically-fit patients reached the target of <36 hours time to theatre.
Action 2: Improving therapy access to NAFF fracture patients • Q1-2: Develop a business case to allow 7-day daily access to therapy services to BPG. • Q2-3: Appointment to expand therapy posts.	**Complete** • Key performance Index (KPI) 4 – 'promptly out of bed' – stands at 92% (up to end November 2024); national average is 82%.

What we will do	2024/25 Update
• Q2-3: Implementation of 7-day physiotherapy services to allow all fragility fracture patients to be mobilised on day or day after surgery. • Q4: Improved NHFD metrics (key performance index 4: Prompt mobilisation after surgery). • Q4: Reduced acute length of stay.	**Complete** • Length of stay (LOS) for all trauma inpatients continues to improve, mean LOS was 14 days Jan 2023, reducing to below 10 mean for Nov 2024 (data up to 18/11/24). Likely due to trauma coordinators and discharge coordinators who started in 2023. **Not Complete** • Second post for Discharge Coordinator approved, so there will be one for each of the trauma wards.
Action 3: Improving multi-specialty 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 preoperative reviews.	**Not Complete** • MDT for Trauma, Geriatric Orthopaedic (GO) and Anaesthetics not routinely possible at the JR, but GO consultants are liaising more closely with anaesthetics on individual cases. **Not Complete** • Geriatric Orthopaedic business case to allow expansion of cover currently under review.

What we will do	2024/25 Update
Action 4: Improving Cohorting of NAFF patients • Q1: Develop pathways/SOPs for cohorting of NAFF patients to facilitate specialist medical/nursing/Allied Health Professional (AHP) care. • Prioritising initial perioperative care in the Trauma Unit (familiarity of staff, facilitation). • 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 perioperative period. • Q4: Develop business case if needed.	**Complete** • Ring-fenced bed at HGH in place and working well. This allows NAFF patients from the JR to transfer to Ward F if safe. • 2 ring-fenced beds for NAFF patients at the JR. **Partially Complete** • Fast-track pathway from ED presented and commencing Q4 2024. • Project started to scope cohorting of NAFF patients in/within trauma wards. • June to December 2024 – 99% of all NAFF trauma patients admitted to trauma wards (likely due to trauma coordinators starting); this is trending to 100%.
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.	**Complete** • 'Sip until Send' in place – first 'Plan Do Study Act' (PDSA) cycle Complete – presented October 2024. This has been adopted as policy. **Not Complete**

What we will do	2024/25 Update
	• Business case for permanent Nutritional Assistant developed but not progressed. **Metrics** • June to December 2024 – Malnutrition Universal Screening Tool (MUST) compliance is 97%.

Choosing Quality Priorities for 2024/25

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

How we chose our Quality Priorities

We involve our patients, public, stakeholders and our staff in choosing our Quality Priorities through our annual public Quality Conversation event which was held in December 2024.

The Quality Conversation event provided an update on progress against the Quality Priorities for 2024/25 and focused on Quality Priorities for 2025/26 as part of the annual planning cycle and the Quality Account. Attendees discussed the proposed Quality Priorities for 2025/26 and made suggestions about how they could be shaped and what they should focus on.

Our Quality Priorities for 2025/26

Figure 10 below gives a brief description of our Quality Priorities for 2025/26. The full detail for each Quality Priority, why we chose them, and a description of how success will be evaluated over the course of the year can be found in Annexe 1.

Figure 10: Summary of Quality Priorities 2025/26

Quality Priority 2025/26	Summary
Patient Safety	
1. System for Electronic Notification and Documentation (SEND)	All adult inpatient observations must be recorded using SEND. This platform provides a clear graphical representation of the patient's observations and National Early Warning Score 2 (NEWS2), allowing easy identification of trends, early identification of patient deterioration, and escalation recommendations in line with the NEWS2 score. Despite this, the system has faced several challenges in recent years, leading to reduced compliance among clinical staff. Issues such as hardware failures, lack of technical support and the necessity for dual input platforms have hindered its consistent use.
2. Medicines Reconciliation	56% of patients are at risk of having one or more medication discrepancies at transitions of care. Inadequate reconciliation of medications is considered to be the causative factor in 40% of medication errors, 20% of which result in patient harm.
3. Fragility Fracture pathways- including fractured neck of	The results of the National Hip Fracture Database (NHFD) demonstrate that at the John Radcliffe site there is a need to

Quality Priority 2025/26	Summary
femur *(rolled over from 2024/25)*	shorten the time taken for hip fragility patients to access surgery. The Horton site has delivered care that regularly meets the National Standards.
Clinical Effectiveness	
4. Standard Work	The initial focus for the Standard Work programme has been supporting clinical inpatient teams, working to align with existing structures and reduce duplication and enhance care. Standard Work is a clear, step-by-step framework that outlines the best way to complete specific tasks based on evidence and expertise. It is about creating reliable processes that support excellence in care.
5. Oxford Critical Care Outreach Service *(rolled over from 2024/25)*	Develop and pilot an outreach service for the Trust, coordinated and overseen by Oxford Critical Care. This will improve the recognition of deteriorating patients, improve speed and quality of decision-making, improve bed length of stay, and provide a platform for improved nursing retention.
6. Discharges	There is increasing demand for our emergency and planned care services because of a growing and ageing population in Oxfordshire. Patients attending our hospitals are more complex, both medically and socially. Following a 'Home First' approach, we are striving to discharge as many patients as possible to their homes, where we know people recover and rehabilitate quicker than in a hospital. Discharges to care homes or to community hospitals should be limited to where it is not possible to deliver the level of care required in a person's home. Consequently, the volume and complexity of discharge planning has increased.
Patient Experience	
7. Maternity Experiences	The Trust is prioritising the improvement of 'Maternity Service User Experience' to enhance the quality of care and experience for expectant mothers and their families. This initiative aims to facilitate better communication and understanding between the healthcare professionals in our maternity service and service users, ensuring that the needs and preferences of women, birthing people, and their families are effectively addressed.

Quality Priority 2025/26	Summary
	By focusing on personalised care plans, we can support women, birthing people and their families throughout their maternity journey, from antenatal care to postnatal recovery.
8. Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)	The Trust is required to implement ReSPECT as part of a BOB-wide approach to align to the Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) policies and procedures. Current guidelines require cardiopulmonary decision-making to be contained within advance care planning for patients of all ages that includes consideration of all realistic life sustaining treatments. The ReSPECT national approach provides a model and document for all healthcare organisations to follow, which is held by the patient / legal proxy / significant other and available to all health and social care professionals.
9. Supporting vulnerable patients including those with learning difficulties	This Quality Priority will work to improve staff confidence in supporting people with a learning disability and their families; improve the discharge process for this group of patients; establish a pathway for diagnostic procedures under general anaesthetic and explore the feasibility of establishing a dedicated learning disability pathway. This is a national scheme which puts a flag into everyone's Electronic Patient Record (EPR) identifying the reasonable adjustments they require to access healthcare. The reasonable adjustments can be shared across health services.

Monitoring and reporting

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

Statements of Assurance from the Board

During 2024/25 OUH provided and sub-contracted 196 relevant health services. OUH has reviewed all the data available to it on the quality of care of these relevant health services. The income generated by the relevant health services reviewed in 2024/25 represents 100% of the total income generated from the provision of relevant health services by OUH for 2024/25.

Clinical Audits and National Confidential Enquiries

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

During 2024/25, 78 national mandatory clinical audits and 5 national confidential enquiries covered relevant health services provided by OUH.

During that period OUH participated in 94% (73/78) of all the eligible national clinical audits and 100% (5) of national confidential enquiries in which we were eligible to participate.

The national clinical audits and confidential enquiries that OUH participated in, and for which data collection was completed during 2024/25, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Participation in National Clinical Audit

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

Explanation of ascertainment below 100% is after Figure 11

Figure 11: National audits and whether the Trust participated in 2024/25

National Programme Name	Trust Participation 2024/25	Cases Submitted
British Association of Urological Surgeons (BAUS) Penile Fracture Audit	Yes	100%
BAUS Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices (I-DUNC)	Yes	100%
BAUS Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	Yes	100%
Breast and Cosmetic Implant Registry (BCIR)	Yes	In progress
British Hernia Society Registry	Yes	In progress
Case Mix Programme (CMP) Intensive Care National Audit and Research Centre (ICNARC)	Yes	100%
Child Health Clinical Outcome Review Programme: NCEPOD Juvenile Idiopathic Arthritis	Yes	100%
Cleft Registry and Audit Network (CRANE)	Yes	100%
Emergency Medicine Quality Improvement Projects (QIPs): Adolescent Mental Health	Yes	100%
Emergency Medicine QIP: Care of Older People	Yes	100%
Emergency Medicine QIP: Time Critical Medications	Yes	100%

National Programme Name	Trust Participation 2024/25	Cases Submitted
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Yes	100%
Falls and Fragility Fracture Audit Programme: National Audit of Inpatient Falls (NAIF)	Yes	100%
Falls and Fragility Fracture Audit Programme: National Hip Fracture Database (NHFD)	Yes	100%
Falls and Fragility Fracture Audit Programme: Fracture Liaison Service Database (FLS-DB)	Yes	61% non-spine & 76% spine[1]
Learning from lives and deaths of people with a learning disability and autistic people (LeDeR) - Learning Disabilities Mortality Review	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme (perinatal mortality surveillance)	Yes	100%
National Adult Diabetes Audit: National Diabetes Foot Care Audit (NDFA)	Yes	100%
National Adult Diabetes Audit: National Diabetes Inpatient Safety Audit (NDISA)	Yes	100%
National Adult Diabetes Audit: National Pregnancy in Diabetes Audit (NPID)	Yes	100%
National Adult Diabetes Audit: National Core Diabetes Audit	Yes	100%
National Diabetes Audit: Transition (Adolescents and Young Adults) and Young Type 2 Audit	Yes	100%
National Audit Diabetes Audit: Gestational Diabetes Audit	Yes	In progress
National Audit of Cardiac Rehabilitation (NACR)	Yes	100%
National Audit of Care at the End-of-Life (NACEL)	Yes	100%
National Audit of Dementia (NAD)	Audit did not run	N/A[2]

National Programme Name	Trust Participation 2024/25	Cases Submitted
National Cancer Audit Collaborating Centre (NATCAN): National Audit of Metastatic Breast Cancer (NaoM	Yes	100%
National Cancer Audit Collaborating Centre (NATCAN): National Audit of Primary Breast Cancer (NAoPri)	Yes	100%
National Cancer Audit Collaborating Centre (NATCAN): National Bowel Cancer Audit (NBOCA)	Yes	100%
National Cancer Audit Collaborating Centre (NATCAN): National Kidney Cancer Audit (NKCA)	Yes	100%
National Cancer Audit Collaborating Centre (NATCAN): National Lung Cancer Audit (NLCA)	Yes	100%
National Cancer Audit Collaborating Centre (NATCAN): National Non-Hodgkin Lymphoma Audit (NNHLA)	Yes	100%
National Cancer Audit Collaborating Centre (NATCAN): National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	100%
National Cancer Audit Collaborating Centre (NATCAN): National Ovarian Cancer Audit (NOCA)	Yes	100%
National Cancer Audit Collaborating Centre (NATCAN): National Pancreatic Cancer Audit (NPaCA)	Yes	100%
National Cancer Audit Collaborating Centre (NATCAN): National Prostate Cancer Audit (NPCA)	Yes	100%
National Cardiac Arrest Audit (NCAA)	Yes	100%
National Cardiac Audit Programme (NCAP): National Audit of Percutaneous Coronary Interventions (NAPCI) (Coronary Angioplasty)	Yes	100%
National Cardiac Audit Programme (NCAP): National Adult Cardiac Surgery Audit (NACSA)	Yes	100%

National Programme Name	Trust Participation 2024/25	Cases Submitted
National Cardiac Audit Programme (NCAP): Myocardial Ischaemia National Audit Project (MINAP)	Yes	100%
National Cardiac Audit Programme (NCAP): National Audit of Cardiac Rhythm Management Devices and Ablation (CRM)	Yes	100%
National Cardiac Audit Programme (NCAP): National Congenital Heart Disease Audit (NCHDA)	Yes	100%
National Cardiac Audit Programme (NCAP): National Heart Failure Audit (NHFA)	Yes	100%
National Cardiac Audit Programme (NCAP): UK Transcatheter Aortic Valve Implantation (TAVI) Registry	Yes	100%
National Cardiac Audit Programme (NCAP): Left Atrial Appendage Occlusion (LAAO) Registry	Yes	100%
National Cardiac Audit Programme (NCAP): Patent Foramen Ovale Closure (PFOC) Registry	Yes	100%
National Cardiac Audit Programme (NCAP): Transcatheter Mitral and Tricuspid Valve (TMTV) Registry	Yes	100%
National Child Mortality Database (NCMD)	Yes	100%
National Comparative Audit of Blood Transfusion: National Comparative Audit of NICE Quality Standard QS138	Yes	100%
National Comparative Audit of Blood Transfusion: National Comparative Audit of Bedside Transfusion Practice	Yes	100%
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	95%
National Joint Registry (NJR) – Royal College of Surgeons	Yes	99%

National Programme Name	Trust Participation 2024/25	Cases Submitted
National Major Trauma Registry (NMTR) (Previously TARN)	Yes	28%[3]
National Maternity and Perinatal Audit (NMPA)	Yes	In progress
National Neonatal Audit Programme (NNAP)	Yes	100%
National Obesity Audit: NHS Digital (NOA)	Yes	100%
National Ophthalmology Database Audit: Age-related Macular Degeneration Audit (AMD)	Yes	100%
National Ophthalmology Database Audit: Adult Cataract Surgery	Yes	100%
National Paediatric Diabetes Audit (NPDA)	Yes	100%
National Perinatal Mortality Review Tool (PMRT)	Yes	100%
National Respiratory Audit Programme (NRAP): COPD Secondary Care	Yes	JR 27%[4] HGH 37%
National Respiratory Audit Programme (NRAP): Adult Asthma Secondary Care	Yes	41%[5]
National Respiratory Audit Programme (NRAP): Children and Young People's Asthma Secondary Care	Yes	JR 51%[6] HGH 10%
National Vascular Registry: Royal College of Surgeons of England (breakdown as follows)	Yes	2%-81%[7]
• Abdominal Aortic Aneurysm (AAA)		74%
• Carotid Endarterectomy		81%
• Amputation		38%

National Programme Name	Trust Participation 2024/25	Cases Submitted
• Infra-inguinal Bypasses		80%
• Lower Limb Angioplasty/Stent		2%
Neurosurgical National Audit Programme	Yes	100%
Paediatric Intensive Care Audit Network (PICANet)	Yes	100%
Perioperative Quality Improvement Programme (PQIP)	Yes	56%[8]
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Oncology & Reconstruction	No[9]	N/A
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Trauma	No[10]	N/A
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Orthognathic Surgery	No[11]	N/A
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Non-melanoma skin cancers	No[12]	N/A
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Oral and Dentoalveolar Surgery	No[13]	N/A
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Yes	100%
Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	100%
UK Cystic Fibrosis Registry	Yes	100%
UK Renal Registry Chronic Kidney Disease Audit	Yes	100%

National Programme Name	Trust Participation 2024/25	Cases Submitted
UK Renal Registry National Acute Kidney Injury Audit (AKI)	Yes	100%

Explanation of National Audit where case ascertainment is below 100%

[1] **Falls and Fragility Fracture Audit Programme: Fracture Liaison Service Database (FLS-DB)**: Case ascertainment reduced during 2024 due to reallocation of experienced staff to delivering a new clinical pathway as well as natural staff turnover and therefore staff skill set. New staff are now establishing themselves so case ascertainment should improve for 2025.

[2] **National Audit of Dementia**: The Trust was not required to participate this year as the audit had gone out to tender for a provider and were not collecting data.

[3] **National Major Trauma Registry (Previously TARN)**: The service's 28% case ascertainment rate for NMTR is primarily due to the system relaunching in April 2024 and challenges with implementation due to the platform and resource pressures. Performance is improving with better results anticipated for 25/26.

[4 & 5] **National Respiratory Audit Programme (NRAP) COPD Secondary Care** & **Adult Asthma Secondary Care**: The latest available data published by the provider shows participation figures below the anticipated level when compared to HES data. During this period, there were some staffing and data management factors that contributed to the lower submission: NRAP request that services achieve a minimum 50% case ascertainment in audits by May 2026 and the service will work towards this aim.

[6] **National Respiratory Audit Programme (NRAP): Children and Young People's Asthma Secondary Care**: The latest available data published by the provider shows participation figures below the anticipated level when compared to Hospital Episode Statistics (HES) data. During this period, there were some factors that contributed to the lower submission: staffing and difficulty identifying eligible patients from the Electronic Patient Record, which is now anticipated to have been overcome by the use of regular ORBIT +[3] reporting. NRAP request that services achieve a minimum 50% case ascertainment in audits by May 2026 and the service will work towards this aim. Data added retrospectively were not accepted.

[7] **National Vascular Registry**: Case ascertainment varied from 2% of eligible cases to 81% depending upon the intervention AAA = 74%; Carotid Endarterectomy = 81%; Amputation = 38%; Infra-inguinal Bypasses = 80%; Lower Limb Angioplasty/Stent = 2%); current data show this has risen to 21-88% but is still a work in progress, with Divisional oversight of an action plan to support and to drive improvement.

[8] **Perioperative Quality Improvement Programme (PQIP)**: A substantial number of cases were submitted in 2023/24 (118 patients). PQIP recommends 5 patients per week are submitted over 42 weeks, making the total submission request 210 in a year. There are

[3] ORBIT + is a healthcare database

challenges to achieving the desired level of case ascertainment due to research nurse availability. The audit lead is addressing this.

9 -13 **Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS)**: This host of new audits were included on the Quality Account for the first time in 2024/25 without a communication plan to Trusts to prepare to participate. OUH did meet with the organising body to establish the parameters of the audits and explore provision for data collection, however this was not possible in the allocated timeframes.

Participation in National Confidential Enquiries into Patient Outcome and Death (NCEPOD) 2024/25

Figure 12 shows the list of OUH eligible NCEPOD studies in 2024/25, in which hospital sites participated, and the percentage of clinical questionnaires, case notes and organisational questionnaires returned.

Figure 12: NCEPOD studies 2024/25

NCEPOD Studies 2024/25	Participating Sites	Clinical Questionnaire Returned	Case Notes Returned	Organisational Questionnaire Returned
Rehabilitation following critical illness	John Radcliffe Horton	4/4	100%	Submitted
Emergency Procedures in Children and Young People	John Radcliffe Churchill Horton	26/28 Submission still open	100%	Submitted
Blood Sodium	John Radcliffe Churchill Horton NOC	9/16 Submission still open	100%	Submitted
Acute Limb Ischemia	John Radcliffe	9/10 Submission still open	100%	Submitted
Managing acute illness in people with learning disability	To be confirmed after case selection	This study is at the case ascertainment phase		

Actions taken and improvements made from national audits

The reports of 43 national clinical audits were reviewed in 2024/25. Agreed actions and progress to improve the quality of healthcare provided are summarised in Figure 13 below.

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

Audit	Summary of Agreed Actions
Breast and Cosmetic Implant Registry	• All implants to be entered in the registry* • Audit Lead and Clinical Coding Manager to discuss coding issues identified*
British Association of Urological Surgeons (BAUS) National Audit of Patient Satisfaction with Cystectomy Pathway for Bladder Cancer (CPAT PROMs)	• Conduct an audit specifically related to patients receiving ongoing care with the OUH Urology Service** • Business case submission to appoint a further bladder cancer surgeon*
Cleft Registry and Audit Network (CRANE)	• Explore options to employ a paediatric dentist*

Audit	Summary of Agreed Actions
Fracture Liaison Service Database (FLS-DB)	• Consolidate implementation of romosozumab for high fracture risk patients** • Work with Medicines Optimisation and Local Medical Committee to develop options for primary care delivery of denosumab for non-initiating GP practices* • Develop new platform options for FLS* • Resolve romosozumab staffing issue so FLS staff is released from managing romosozumab to seeing more non-spine fractures* • Improve time from fracture to assessment**
Lung Cancer Audit	• Increase Medical Oncology provision and access to Day Therapy Unit * • Ensure data quality and increase Thoracic Surgery capacity* • Appoint Trust Lead for Smoking Cessation**
MBRRACE - A comparison of the care of Black and White women who have experienced a stillbirth or neonatal death	• Ensure provision of maternal and fetal medicine services at the Horton General Hospital site to reduce barriers to specialist services*
MBRRACE Perinatal Mortality Surveillance Report - State of the Nation Report	• Contingency plan for perinatal pathology services*
National Core Diabetes Audit	• Greater provision of structured education for people with Type I diabetes, both face to face and virtually* • Improve eight key care processes for people with Type II diabetes*

National Audit of Cardiac Rehabilitation (NACR)	• Undertake a detailed analysis of the impact of the increased funding from NHS England to develop a Percutaneous Coronary Intervention (PCI) service on:
	  ○ the referral and uptake of patient undergoing elective PCI*
	  ○ clinic and gym capacity and wait times for the whole coronary heart disease service*
	• Start to use BOB integrated care system (ICS) Digital Cardiac Rehab app and monitor impact**
	• Run a small audit to see which patients decline cardiac rehabilitation and the reasons, to inform improvement of the service*
	• Work with NACR to improve the way data are collected to reflect the service that is being delivered*
	• Increase number of clinic spaces for assessments*
	• Routine follow-up for PCI Patients*

National Audit of Care at the End of Life (NACEL)	• Further education on recognising dying* • Further education on recognising dehydration and how to have a conversation with the patient* • A trial of ‘interpreters on wheels” with the Patient Experience team to support better discussions with patients, and those important to patients at the bedside*
National Audit of Inpatient Falls (NAIF)	• Improve falls informatics to aid internal benchmarking**

Audit	Summary of Agreed Actions
	• Build and test a ward-based falls training package education programme on My Learning Hub** • Track monthly lying-and-standing blood pressure data and present through Harm-free Assurance Forum and Safety Learning and Improvement Conversation** • Create a digital injury check assessment tool* • Medical post-falls proforma to be built and made Trustwide on EPR**
National Bowel Cancer Audit (NBOCA)	• Transpose Performance Status (PS) from 2WW referral to Infoflex to allow capture in Rapid Cancer Dataset* • Assess real rate of adjuvant chemotherapy for stage 3 colon cancer patients and investigate any variation from national levels* • Look at current performance in time to ileostomy closure and produce QI plan for improvement if necessary**
National Cardiac Arrest Audit (NCAA)	• NCAA Subcommittee to review quarterly reports, identify areas of concern requiring further investigation, and report findings to the Resuscitation Committee** • NCAA Subcommittee to review all cases of non-survivors with a predicted survival of >50%, identifying those requiring further investigation or support** • NCAA Subcommittee to investigate avoidable outcome variations where appropriate* • NCAA Subcommittee to examine the rise in events at the Nuffield Orthopaedic Centre (NOC) and provide feedback as needed* • Resuscitation Committee to review NCAA Subcommittee reports and make further recommendations to Divisions and clinical services across the Trust** • Use NCAA data proactively to identify quality indicators, areas for investigation, and actions for improvement** • Share key findings and learning from reports widely across clinical services** • Use continued data reporting to monitor quality indicators related to the Cardiac Arrest Reduction Strategy** • Review and investigate cases for recurring themes and learning opportunities**
National Clinical Audit of Seizures and Epilepsies for Children and Young People (Epilepsy 12)	• Increase contact from epilepsy nurse for all children with epilepsy* • Increase involvement of epilepsy nurse in school individual care plans* • Ensure all children with epilepsy have an electrocardiogram (ECG)* • Ensure all children with epilepsy are asked about their mental health and that it is documented*
National Comparative Audit of Blood Transfusion - Bedside Transfusion Audit	• Increase recognition and compliance of visual checks of blood components prior to the transfusion by updating face to face and e-learning* • Conduct a study on Human Factors with regards to sample labelling*

Audit	Summary of Agreed Actions
National Comparative Audit of Blood Transfusion - Audit of NICE Quality Standard QS138	• Improve diagnosis and management of preop iron deficiency anaemia (IDA)* • Move electronic consent management to EPR Smartzone** • Improve electronic prescription of Tranexamic Acid (TXA)** • Improve TXA adoption in patients undergoing operations with expected moderate blood loss (>500 ml)** • Promote patient blood management across OUH** • Development of 'Patient Blood Management (PBM) dashboard' with ORBIT+ team* • Business case to establish a new role for a patient blood management specialist nurse*
National Diabetes Audit, 2017-21: Adolescent and Young Adult Type 1 Diabetes	• Adult services, both specialist and primary care, should develop systems to ensure that all adolescents and young adults continue to receive NICE recommended health checks after discharge from paediatric care** • Specialist paediatric and adult services should collaborate to develop systems of care that are aligned with the multiple life changes which accompany late adolescence/early adulthood in order to minimise age associated deteriorations in level of glucose control (15-20 years old) and frequency of diabetic ketoacidosis (15-18 years old)** • Young adults with Type 1 diabetes transferring from paediatric services and using insulin pump therapy should be supported by adult specialist services to continue, and those who are eligible by NICE criteria should be offered insulin pump treatment**
National Early Inflammatory Arthritis (NEIA)	**Short-term Actions** • Use advice and guidance to reduce inappropriate referrals, with triage responsibilities shared among rheumatology consultants** • Allocate general clinic appointments for Early Inflammatory Arthritis (EIA) referrals one week per month* • Current consultant to restart the EIA clinic at Horton from October 2024 (three clinics per month) ** • Ensure all patients are discharged from the EIA clinic after 12 months following a multidisciplinary (MDT) review* • Contact patients in the EIA service for over 12 months post-diagnosis to transition them to general rheumatology clinics* • Research fellows (grant-funded) providing additional EIA clinics to support service capacity** **Long-term Solutions** • Review service design to improve patient flow, including remote and patient initiated follow-up (PIFU) plans** • Rationalise face to face appointments and report findings to the Rheumatology Governance meeting** • Increase nurse-led follow-up appointments to free up consultants for new patients – vacant nursing posts advertised, with training planned*

Audit	Summary of Agreed Actions
	• Expand capacity for new and follow-up patients – job plan created, and a new consultant post advertised using unoccupied PAs* • Ensure appropriate imaging support for EIA clinic expansion – discussions ongoing for additional sonographers at NOC and Banbury* • Apply for a new ultrasound machine to support EIA services in Banbury* • Strengthen Rheumatology Department staffing – new posts created for doctors, AHPs, administrative support and additional nursing staff*
National Hip Fracture Database (NHFD) Annual Summary	• Develop and identify capacity for 'Trauma Recon' lists at NOC** • Identify capacity at HGH to increase Trauma to three half day lists a week* • Develop increased regular and surge capacity for fragility fracture** • Develop SOP for priority first patient** • Development of Trauma Coordinator role and appoint Trauma Coordinators** • Ringfence beds in Trauma Unit once Trauma Coordinator role is established** • Develop SOP for cohorting of fragility fracture patients, scope delivery once MDT Coordinator role established and Feasibility Study** • Develop business case for 7-day Physiotherapy* • Business case for increased orthogeriatric support to cover all fragility fractures five days a week and increased cover seven days a week both sites* • Continuous MDT training for nutrition scoring** • Appointment to fragility fracture nurse role five days a week** • Nutrition HipQIP project** • 'Sip til Send' project team to be identified and Quality Improvement Programme (QIP) to be completed**
National Neonatal Audit Programme	• Rollout of new ventilators, once imported into the UK, to improve adherence to use of volume guarantee ventilation in the smallest infants* • New ventilation guideline development* • Infant feeding team, senior nursing and medical staff to review actions needed following the recent United Nations International Children's Emergency Fund (UNICEF) Baby Friendly Initiative (BFI) re-accreditation assessment* • Develop case of need for replacement of suitable chairs, allowing parents to stay in the unit* • Review and improve the brain injury care bundle through an audit* • Present and agree to new brain injury care bundle*
National Neurosurgical Audit Programme (NNAP)	• Create protected space for emergency cases in a daily neurosurgery emergency list (dependant on theatres new build)* • Review allocation of extra lists for long waiters with cranial pathologies*

Audit	Summary of Agreed Actions
National Ophthalmology Audit age-related macular degeneration (AMD)	• Increase capacity at Wantage Community Hospital and possibly north of county hub (no plans for this as yet). Plans would be to increase from a two day service to a five day service* • Increase consultant staffing levels (Wantage post to be appointed to)* • Review of admin workload distribution amongst the secretariat – no specific Injection Coordinator appointed – need more than one and robust plans for covering this work when staff are absent*
National Ophthalmology Database Cataract Report	• Continued and correct data entry to ensure correct recording of complications and correct risk adjustment*
National Paediatric Diabetes Audit (NPDA)	• Improve recording of foot examination and request urine sample at every appointment if not already done, children and young people (CYP) >12y** • Maintain or improve median HbA1c** • Aim for 90% of eligible patients to have microalbuminuria recorded within two years* • Improve accurate recording of education provided at all annual review clinics** • Increasing percentage of CYP with very high HbA1c, review case by case meetings**
National Pancreatic Cancer Audit	• MDT Chair and Coordinator to liaise with the referrers to confirm the Performance Status going forward** • Radiological stage of the disease to be provided by the Radiologist at the MDT** • A business case is in progress based on nursing constraints. Further detail in PC04 of the Pancreatic Getting It Right First Time (GIRFT) Implementation Plan*
National Prostate Cancer Audit (NPCA)	• Aim for 85% of newly referred 2WW patients to have their MDT outcomes with TNM[4] staging recorded* • Aim for 80% of MDT outcomes of newly referred 2WW patients to have their Performance Status recorded* • Accurate recording of true number of unplanned admissions within 90 days of Reverse Address Resolution Protocol (RARP) Surgery*
National Respiratory Audit: Children and Young People's Asthma	• Meet with Children's Hospital digital lead to explore way to improve data collection* • Identify staff responsible for data input and ensure they have understanding of the NRAP process* • Update EPR discharge summary template* • Include steroid administration within one hour of presentation in guideline* • Improve resources for inhaler technique check e.g. additional specialist asthma nurse*

[4] The TNM staging system is a method used to stage cancer, describing the size and extent of the primary tumour (T), whether it has spread to nearby lymph nodes (N), and whether it has metastasised to distant parts of the body (M).

Audit	Summary of Agreed Actions

National Vascular Registry (NVR)	• Improve case ascertainment on NVR to meet national standards:
	  • Upgrade banding of Vascular MDT Coordinator*
	  • Appoint Data Coordinator*
	• Work towards GIRFT/Provision of Vascular Services target of eight weeks:
	  • AAA pathway introduced*
	  • Increased theatre capacity and flexibility with hybrid opening*
	• Work towards 14 days NICE target for intervention and ultimately seven days GIRFT target via increased theatre capacity*

NCEPOD Community Acquired Pneumonia	• Create a Patient Information Leaflet (PIL) on pneumonia** • Setting up of a working group with key stakeholders from each Division – General Medicine, Infectious Diseases and Respiratory*
Paediatric Intensive Care Audit Network (PICANET) Report	• Relocation of PICU to an appropriate area within the Trust, pending the new build** • Continue to recruit to nursing business case over the five-year recruitment plan*
Royal College of Paediatrics and Child Health (RCPCH) Child Protection Service Delivery Standards Audit	• Revise written service arrangements to take into account RCPCH guidance regarding service provision** • Proforma for child protection assessments requires updating** • Develop written information explaining the child protection medical assessment process in languages other than English* • Discuss requirements for training of chaperones with Children's Matron and Directorate Manager with view to creating a business case* • Obtain feedback from service users, through a QI project, as to whether current reporting arrangements are sufficient/effective** • Create a feedback process, from local legal services and senior social work managers, regarding the clarity of child protection medical assessment medical reports*
UK Renal Registry Chronic Kidney Disease Audit	• Internal audit of anaemia management with development of monthly anaemia dashboard from EPR data and prospective real time data collection** • Review of current peritoneal dialysis infection rate, including service capacity to provide increased home care visits and refresher training. Business case submission to increase staffing levels* • Ongoing QIP and use of Tesio line dashboard to identify patients on a line and progress them through the access pathway* • Options appraisal for the Home Haemodialysis (HHD) to be submitted. Ongoing QIP around shared care to improve patient empowerment and activation and options appraisal submission to explore leasing alternative machines*
UK Renal Registry National Acute Kidney Injury (AKI) Audit	• Audit against NICE NG148 Acute Kidney Injury* • Explore health inequalities in AKI** This has been explored and there was no increased rate of AKI in those with higher deprivation.

Actions taken and improvements made from local audits

Local audits are monitored via clinical governance arrangements in Directorates and Divisions and are presented at local clinical governance meetings.

The reports of eleven local clinical audits were prioritised for Trustwide review by the Clinical Improvement Committee in 2024/25. Agreed actions and progress to improve the quality of healthcare provided are summarised in Figure 14 below.

Figure 14: Local audits with actions taken and improvements made as a result (**Fully achieved; *Partially achieved)

Local Audit	Summary of Actions
Tobacco Dependency Service NICE Guideline 209/Quality Standard 207	• Improve the recording of patient smoking status on the patient record** • The Trust should strive to provide as many patients as possible with nicotine replacement therapy, without prescription*
Safe and Secure Storage of Medicines	• Finalise the audit window, resource allocation, and communication plan with Divisional nurses, Divisional pharmacists and Pharmacy team. Ensure ward managers address previous audit actions and add unresolved issues to the Risk Register** • Implement a clear escalation process for temperature compliance through Divisional Nursing, aiming for 100% compliance** • Achieve 90-100% swipe access for drug rooms, phase out digipad locks, and update audit questions for accuracy* • Ensure all areas with digipads change lock codes every three months to meet 90-100% compliance* • Identify and risk-assess unlockable cupboards within lockable rooms* • Medicines Assurance Lead to share completed audit data with Divisional pharmacists, nurses and matrons and coordinate follow-up actions with ward managers* • Conduct regular staff and stock list reviews to ensure accuracy, evidenced by audits or alternative verification methods* • Achieve 100% compliance for Safe and Secure Storage of Medicines (SSSM) audit, temperature control and keypad code changes*
Pressure Ulcer Prevention Trustwide Audit NICE Clinical Guideline 179/Quality Standard 89	• Development of a Hospital-Acquired Pressure Ulcer Reduction Programme as part of wider Fundamentals of Care Improvement Programme under the Chief Nursing Officer* • Divisional teams to review Divisional results and develop remedial actions to address the issues identified*
Nutrition Trustwide Audit NICE Clinical Guideline 32	• Ensure all appropriate wards are completing the OUH-MUST (Malnutrition Universal Screening Tool) Adults audits by mapping locations* • Undertake MUST accuracy audits on sample group/wards* • Develop a non-compulsory nutrition training suite on My Learning Hub* • Update OUH Nutrition and Hydration Strategy*
Deteriorating Patient Trustwide Audit	• Small scale audit in a select number of clinical areas to review practice to inform learning and identify themes*

Local Audit	Summary of Actions
	• Review the education materials available for staff in relation to Early Warning Score (EWS)/support in the development of skills in escalation* • Continue work on most appropriate platform to support the documentation of observations* • Review medical decision-making in terms of use of NEWS scale 2* • Communication with clinical areas and support in the development of action planning in response to low compliance of monthly audit*
Sepsis and Serious Infection Audit	• Develop blood culture training video** • Reaudit of blood culture volume** • Updating sepsis teaching materials to focus on collection of blood cultures, blood volume, timeliness** • Reaudit of time to laboratory**
Health Records Trustwide Audit	• Clinical Support Services (CSS) Division to participate in next round of audit* • Provide more options (i.e. not applicable) on some questions* • Improve recording of whether the patient's first language has been captured; recording of next of kin; mental capacity assessment and post-anaesthetic instructions*
Diabetic Foot Baseline Assessment Tool Review NICE Guideline NG19	• Trustwide audit of completion of Touch the Toes on admission** • Evaluation of lower limb amputation and length of stay to nationally defined technical reporting document from Hospital Episode Statistics data* • Ongoing data entry for National Diabetes Footcare Audit (NDFA)* • Formulate action plan based on external review paper and local data/priorities*
Consent Trustwide Audit	• Communicate audit findings widely within Divisions, bespoke to their results** • Change the audit methodology to account for e-consent* • Communicate the Patient Information Leaflet (PIL) information in Specialist Medicine and Cardiac governance meetings for awareness in Medicine, Rehabilitation and Cardiac Division (MRC)* • Spread awareness for the confirmation of consent being signed by a member of the healthcare team by creating a safety message tailored for MRC* • Improve overall quality of information on consent with a focus on procedures written in full (no abbreviations) and printed name below signature on consent forms in Neurosciences, Orthopaedics. Trauma, Specialist Surgery, Children and Neonates Division (NOTSSCaN)*
VTE Prevention Trustwide Audit	• Discussion with key stakeholders to implement TRiPCast risk assessment tool* • EPR request for change form submitted to Digital team to create tool in EPR for TRiPCast* • EPR request for change form submitted to Digital team to explore the use of thromboprophylaxis column being added to the white board* • Both digital requests to be discussed at EPR Clinical Advisory Group*
AutoReporting	• Reiteration to all participating specialties of requirement for a written evaluation of any auto-reported examination. This is particularly relevant to high users of chest X-rays (CXR)*

Local Audit	Summary of Actions
	• Regular teachings on good interpretation of images by clinical teams, musculoskeletal (MSK) radiographs slightly below expected standard of 100%*

GIRFT Implementation Plans

Getting It Right First Time (GIRFT) is a national programme designed to improve medical care within the NHS by reducing unwarranted variations. A fundamental principle of this programme is to improve the quality of care and by doing so lead to a reduction in costs.

Peer review visits take place between OUH and GIRFT clinicians, resulting in observations and best practice recommendations which are then developed into an action plan for implementation and reported to the Clinical Improvement Committee. Figure 15 below shows the specialties which have presented implementation plans to the committee in 2024/25.

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

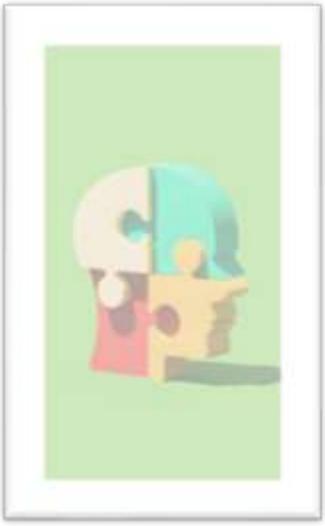
Specialty	Observations and Actions Status
Breast Surgery	• A full range of modern oncoplastic services are provided by the Trust • Implant loss at 1-year post-surgery was very low indicating medical management was effective • Low outpatient attendance rates post-surgery were exemplary showing low rate of complications and a lean follow-up policy • Actions 13/26 delivered/total accepted
Cranial Neurosurgery	• The service has good repatriation pathways • OUH is the second busiest elective unit in England • On the day medical cancellations are low suggesting good preadmission preparation • Actions 6/16 delivered/total accepted
Gynaecology	• Patient initiated follow-up (PIFU) has been adopted • Hysterectomies can now be offered on a day case basis • Actions 6/16 delivered/total accepted
Lung	• The referral pathway has been streamlined with a specialist nurse triaging referrals • Good anti-cancer treatment rates for patients with advanced disease • There is a robust peer review process in all steps of the radiotherapy pathway • Pathology Department to address local vacancies • MRC actions – 21/31 complete • CSS actions – 9/12 complete
Maternity and Obstetrics	• Address care inequalities, such as racial and geographical inequalities, and complex social factors. Early Lives Equal Start project works towards ensuring that every mother in OX4 feels well supported and can thrive • Improve recording of data about key aspects of maternity care, including outcome data for mothers and babies. For example, spontaneous birth, caesarean section, assisted birth • Increase focus on reducing the rate of obstetric anal sphincter injury (OASI) • All actions (15/15) complete

Specialty	Observations and Actions Status
Neurology	• There is a wide range of specialist clinics offered • The department has a strong research base • The service is working on establishing a consultant-led rapid access clinic • Actions 0/13 delivered/total accepted The Division is monitoring, to include review of the medical workforce.

Ophthalmology	• Capacity to see new patient referrals was raised as an issue and has been a focus for improvements, resulting in the following successes:
	  • The percentage of new wet age-related macular degeneration referrals receiving their treatment within two weeks increased to 76.6% (14 point increase since previous quarter)
	  • The percentage of urgent active proliferative diabetic retinopathy referrals from screening seen within six weeks in the Hospital Eye Service increased to 87.5% (18 point increase since previous quarter)
	• Actions 44/54 delivered/total accepted

Trauma Surgery	• Orthopaedic Trauma Consultant of week provides continuity of decision-making • Orthoplastics collaboration is exemplary • There is a well-established fracture liaison service • Trauma Coordinator roles have been introduced • All actions (6/6) complete
Tuberculosis (TB)	• Patients with active TB start treatment quickly, supported by flexible diagnostic services • There is high quality screening for contagious TB cases • The service manages complex and drug-resistant TB cases for a diverse population, including a significant East Timorese community • There are proactive efforts to prevent TB through screening and therapy for high-risk groups • Actions 0/8 delivered/total accepted (not yet due until later in 2025)
Pancreatic Cancer	• Patients have access to cardiopulmonary exercise testing and a prehabilitation programme • There is an embedded enhanced recovery programme for Whipple procedures • Wellbeing events are provided for patients and carers • A Hepatobiliary Dietitian and Clinical Support Worker are providing support for patients • Actions 0/10 delivered/total accepted (not due until later in 2025)
Plastic Surgery and Burns	• The team has a Major Trauma Strategy where six plastic surgeons have undertaken both microsurgery and hand fellowships which enables them to cover both upper and lower limb activity as part of their on-call duties • All actions (1/1) complete
Paediatric Trauma and Orthopaedics	• Pathway for children to be admitted to JR or Horton sites for day case is already in place • Protocols and standards of treatment in JR ED are established. There is some work to be done to replicate these at the Horton • Actions 57/67 delivered/total accepted

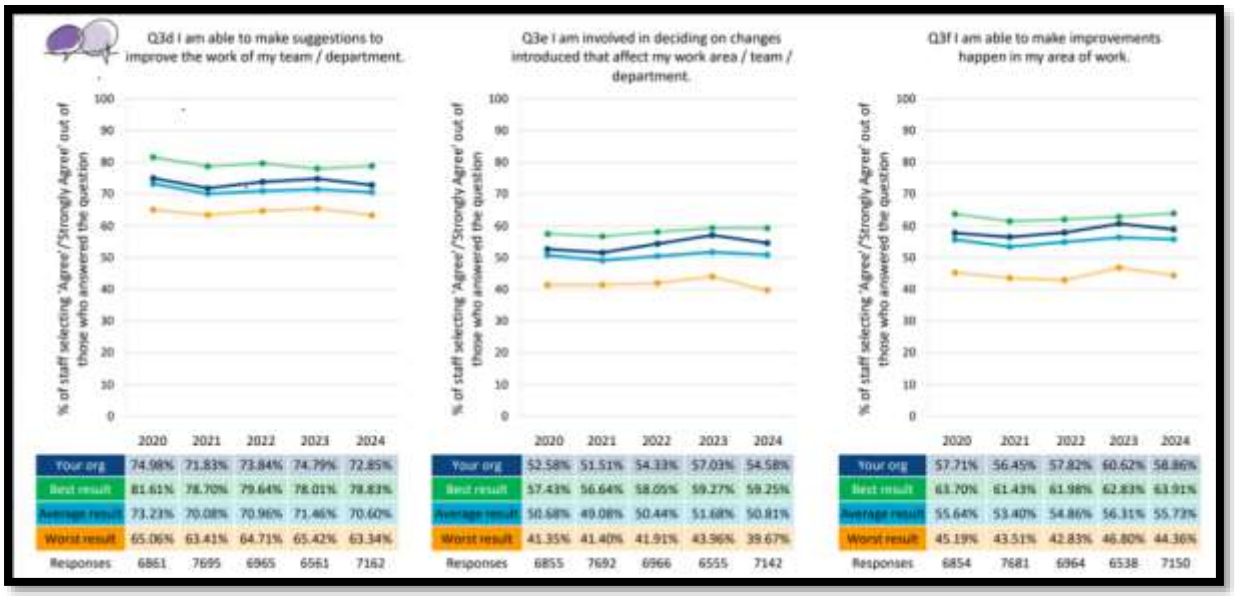
Quality Improvement 2024 Report



Oxford University Hospitals (OUH) remains committed to advancing our culture of continuous improvement, underpinned by the Trustwide adoption of Quality Improvement (QI). Building on a strong foundation, 2024 has been a year of consolidation, increased engagement and a continued focus on enhancing both patient care and the working environment for our staff through the defined Integrated QI Programme. This commitment reflects the Trust's resolve to align with the vision of NHS Impact and deliver healthcare that is continuously improving, patient-centred and efficient.

This commitment is reflected in our consistently above-national-average feedback from the NHS Staff Survey, which highlights staff experiences of making suggestions, implementing changes and driving improvements within their teams and the wider organisation (see below).

Figure 16: Survey results



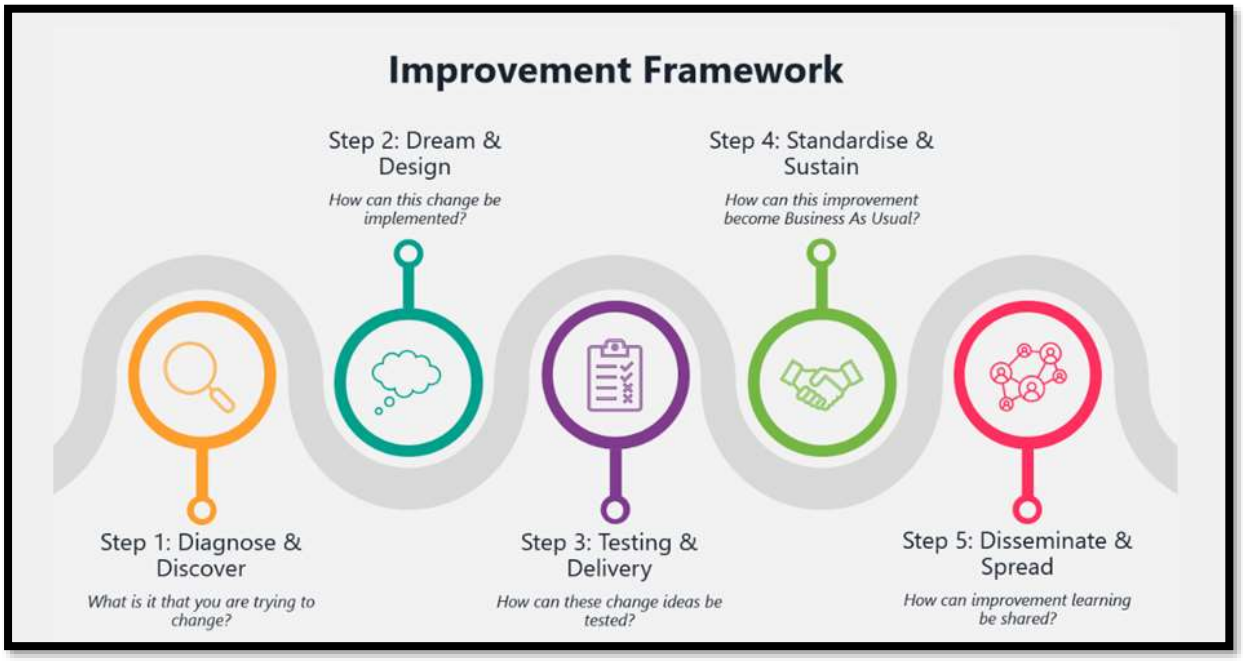
While the 2024 results show a marginal reduction in our overall percentage response for each question from previous years, the steady performance and gradual improvement over the years, particularly in decision-making involvement (Q3e), demonstrates progress. The slight decline is mirrored within the national average across all NHS Trusts and is during a period of significant financial and operational pressures.

Building on the progress of the previous year, our Integrated Quality Improvement (IQI) Programme continues to drive meaningful change across these priority programmes, enabling improvements in both complex patient pathways and building forward our culture of continuous improvement and approach to meeting clinical and non-clinical standards. The IQI programme over 2024 continued to support Cancer Urgent and Emergency Care and

Building Capability and Capacity, with the addition of a new programme focused on Standard Work. Each programme has leveraged a structured approach utilising the OUH Improvement Framework to work with colleagues closest to the challenges to drive forward and deliver impactful changes and learning.

The OUH Improvement Framework guides teams and services through a five-step process (see image below) of first understanding the challenge and opportunities, through to testing our assumptions and new ways of working that leads to establishing new evidence-based ways of working, culminating with spreading this learning and improvements with others.

Figure 17: Improvement Framework



Further highlights from 2024

BOB System Partnerships

Throughout 2024, OUH continued to collaborate with QI colleagues and share best practice and learning through the BOB QI Network. In November, the Network hosted the second BOB QI Festival, featuring three themed webinars—*Starting Well, Living Well, and Ageing Well*. Partners from primary, secondary and tertiary services shared their improvement stories, spanning from paediatrics to frailty, in a format inspired by the OUH QI Stand Up.

OUH has played a pivotal role in leading the QI Faculty's delivery of Quality, Service, Improvement and Redesign (QSIR) Practitioner training. In preparation for a sustainable system-wide QI Practitioner training model, OUH has contributed as an editor to the National Co-Design process for developing an open-source, evidence-based, free-access training replacement. This initiative is funded and supported by the Health Foundation's Q Community.

OUH has also led the testing of the nationally developed Quality Coach Programme organisationally, offering places to system partners to upskill colleagues across BOB while also laying the groundwork for co-delivery opportunities in 2025/26.

Institute for Healthcare Improvement (IHI) Conference Workshop

In April 2024, OUH and University Hospital Southampton (UHS) NHS Foundation Trust co-led a workshop at the Institute for Healthcare Improvement's European Quality and Safety Forum in London. The session explored the statement *'Culture eats strategy for breakfast'* through the lens of fostering a culture of continuous improvement within large acute Trusts. The full-day workshop, attended by 40 colleagues from the NHS and international healthcare systems, received positive feedback and led to ongoing collaboration for future learning. UHS and OUH have continued to strengthen links across improvement teams, sharing learning and challenges as both organisations work towards greater improvement maturity.

QI Forum Review

The Trustwide QI Forum was paused at the end of 2024 following a period of testing a new approach, which focused on shared improvement priorities during the summer and autumn. This trial supported greater diversity of attendees and increased group engagement. Following a review, 2025 will see the launch of a newly formatted QI Forum designed to better align with Trust priorities, strengthen membership and engagement, and enhance Divisional involvement in sharing and learning.

QI Voice

As an integral platform for sharing improvement stories across the organisation, *QI Voice* has enabled colleagues to document and promote the spread of improvement initiatives. By building a growing library of improvement lessons and staff experiences, *QI Voice* is supplementing training, reinforcing the credibility of QI tools and approaches, and amplifying diverse voices that highlight the value of continuous improvement.

Integrated Quality Improvement Programme Overview

The Integrated QI Programme has made significant contribution to embedding QI within the Trust, drawing on QI to support key organisational priorities. The programme maximises the impact of improvements by supporting testing at a local team level building toward scale and spread, leveraging both intrinsic and extrinsic motivators while recognising the unique characteristics of each project and programme. This remains both an ongoing opportunity and a challenge as we collectively work towards developing a more mature organisational culture of continuous improvement.

In the past 12 months the QI Team has supported services and team to apply the OUH QI Framework in alignment with programme priorities. This has led to teams completing defined diagnostics building towards Plan-Do-Study-Act (PDSA) cycles tailored to the specific needs of each programme.

Cancer Care Programme

During 2024/25 the Cancer Improvement Programme at OUH has carried out a deep dive to understand why some patients have experienced longer waits for treatment. The standards these specifically relate to are the '31-day standard' that aims to ensure that cancer patients start treatment within 31 days of the decision to treat, and the '62-day standard', by which, when cancer is first suspected, patients should have a diagnosis confirmed and treatment started within 62 days. The analysis showed that continuing to focus on the beginning of the pathway and incremental improvements throughout has the potential to reduce the overall time waiting for treatment. For example, in Gynaecology, the wait for an important diagnostic test has been reduced by more effectively managing other patients who have also been referred for the same test but compete for resource. The Gynaecology team, with QI support, managed to reduce the backlog of patients waiting from 300 waiting for nine months to 45 patients waiting for six weeks.

Bowel Cancer Screening has changed how they manage outpatient slots for patients who need a test after their sample test. This has reduced the number of people not turning up for appointments, avoiding wasted clinic slots with the result that there has been a step change improvement in relation to the 28-day 'faster diagnosis standard', from 30% in June 2024 to circa 70% in November 2024. The team is working hard to reach the 75% standard and sustain performance.

The Lung Cancer Service has examined how referrals are triaged when received to ensure actions are expedited. The Respiratory Early Diagnostic Service (REDS) is a well evaluated one-stop service offered off-site and arranges tests to help the diagnostic process run smoothly and quickly. The team is better managing specially ringfenced lung cancer slots within the larger outpatient clinic to ensure patients are seen as early as possible. Processes were changed in Q4 to allow a more effective oversight of how the clinics are run to ensure this process runs smoothly. This change is being measured to assess the impact on waiting times.

The Breast Screening team has been collaborating with members of our community who have lower rates of screening to understand the reasons behind this and to jointly plan ways to address concerns raised, thereby improving the uptake of these important health screening tests. The team has met with women, elders and leaders from the Asian and African communities over the past year and continues to plan locally-based health promotion opportunities and drop-in events. We hope that building stronger relationships, sharing the health benefits and dispelling myths will help to increase screening rates from ≤50% in these communities to 70%.

Urgent and Emergency Care

The QI team facilitated a workshop in May 2024 providing a forum to collaboratively coproduce the new Trustwide Urgent Care Improvement Programme for 2024 - 2026. Following the mapping and prioritisation a phased plan for QI support for the five shared priorities (see below) was agreed, within an initial focus from Quarter 3 2024 on priorities 2 and 4. These priorities were aligned with the published Winter Guidance. All Divisions are represented within the working groups.

Urgent Care Improvement Programme Priorities 2024 - 2026

1. Streaming & Direction and Initial Assessment
2. Senior Decision Maker & Rapid Assessment and Treatment (RAT)
3. Maximising the Use of Urgent Treatment Centres (UTCs)
4. Children's Urgent Care Pathway
5. Reducing Time in Departments

Since Quarter 3 steady progress has been made in identifying and testing new ways of working to support the Senior Decision Maker at the front door and its impact on clinical decision-making and flow.

Between December 2024 and February 2025, the Emergency Department Ambulatory team has completed 2 PDSA cycles focused on Senior Decision Maker being closer to the start of patient front door. Following these cycles of testing the team has regrouped holding a workshop to consolidate and support their learning from the QI approach. Initial impact has been seen within the testing period of reduced diagnostic testing and appreciative value of the multidisciplinary collaboration. Future cycles of testing are in planning, working to accommodate recent environment changes in the department. Work is ongoing with the Information team to develop the metrics to support the current qualitative feedback where it has been felt that more patients have been seen and discharged within a shorter time period.

Work on the Children's Urgent Care Pathway commenced in November and December 2024 with local engagement meetings building towards agreed Terms of Reference and shared understanding of key priorities to determine the next steps. In February 2025 a shared agreement was reached to focus on Paediatric ED Front Door, Prevention and Pharmacy.

Standard Work

In 2024, OUH reaffirmed its commitment to delivering the highest quality of care through the introduction of the Standard Work Programme. Drawing on learning and evidence from wider industries, this approach ensures that every patient receives consistent, safe and effective care while supporting our teams in their daily work.

The programme initially focuses on supporting clinical inpatient teams, aligning with existing structures to reduce duplication and enhance care. For example, this includes linking with and understanding the alignment with Care Assure, providing frequent opportunities to assess the fundamentals of care.

Standard Work is a structured, step-by-step framework that defines the best way to complete essential daily tasks, based on evidence and expertise. It aims to create reliable processes that support excellence in care, improving patient outcomes, enhancing safety, clarifying roles and responsibilities, and reducing duplication. By fostering collaboration, building engagement and trust, and enabling continuous improvement, this approach benefits both staff and patients alike.

A strong example of the programme's impact is highlighted later in this report as a case study, detailing the Trust's adoption of Board Rounds within inpatient settings.

Within the Board Round priority project, to date the delivery against current metrics within each cohort of wards are as follows.

- Cohort 1 and 2 (Completed) – Average 28% increase in compliance with the Board Round Policy and average reduction in ward length of stay of 0.85 days
- Cohort 3 (Still in progress) – Average 47% increase in compliance with the Board Round Policy and average reduction in ward length of stay of 0.23 days
- Cohort 4 (Still in progress) - Average reduction in ward length of stay of 0.10 days

Building Quality Improvement Capability and Capacity

Within 2024, OUH has continued to strengthen its QI education offer with the following.

- Delivering QI education plans, strengthening improvement partnerships, and integrating improvement into management systems to maximise impact, scale and spread.
- Embedding QI training into programme delivery, improving team engagement and immediate application of the QI approach.
- Guided by the QI Education Framework, the Trust now has training that supports colleagues from the concept of 'What is QI?' to developing expertise and skills to coach others looking to make improvements.

QI Education Framework development highlights from 2024

Introduction to QI

Introduction to QI onboarding onto the Trust learning platform, has supported open access for all staff to a 20-minute basic introduction to principles and concepts of QI. As well as enabling improved tracking of training completion at this level, supporting line manager oversight of who on their team has started their QI.

Quality Coach Development Programme (QCDP)

In July 2024, OUH launched its first Quality Coach Development Programme (QCDP) cohort.

This programme builds on the success of the nationally co-designed QCDP initiated by the Q Community in 2023.

The QCDP cohort was co-led and delivered by the Trust's Head of Quality Improvement (QI), who serves on the National Faculty, along with QI Project Managers, who previously completed the QCDP through national cohorts led by NHS Elect.

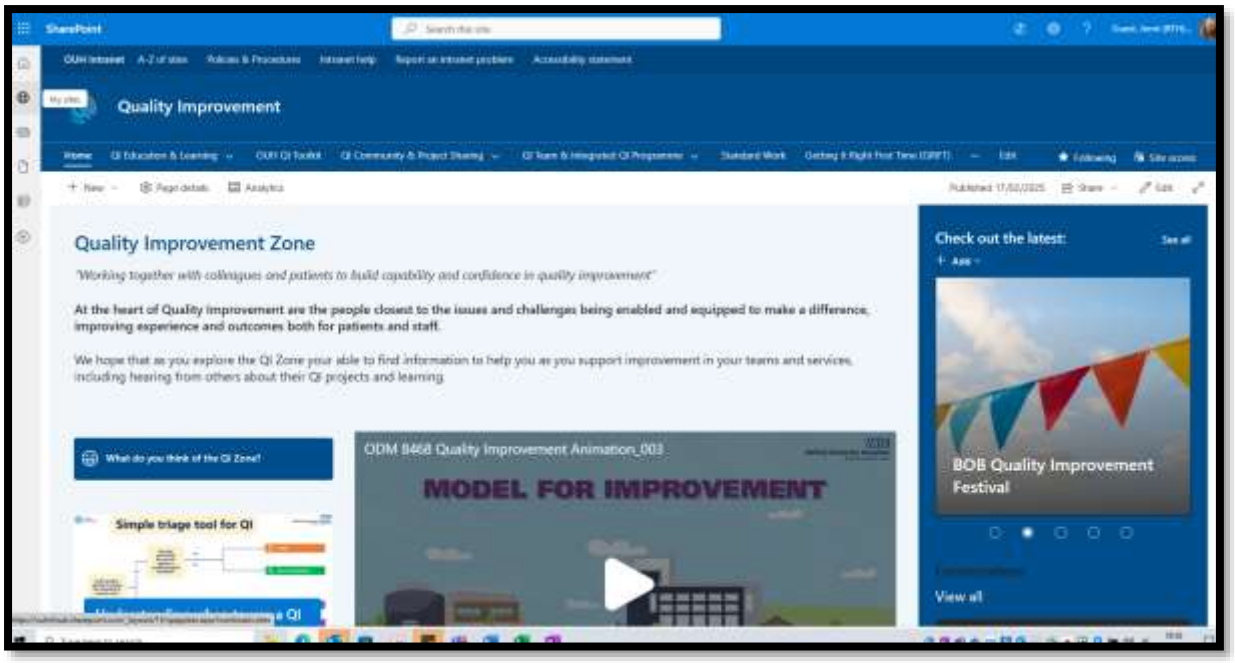
The programme received 35 applications via an open application process, resulting in selection of 20 OUH colleagues for the cohort. An additional five places were allocated to colleagues from the Buckinghamshire, Oxfordshire and Berkshire (BOB) Integrated Care System (ICS) and other partners, including Acute Provider Collaborative, Milton Keynes and University Hospital Southampton (UHS).

The QCDP provides a structured pathway to develop QI expertise within OUH, expanding the pool of QI faculty and certified Quality Coaches across the organisation, with 19 OUH colleagues graduating in early 2025, and all committed to supporting the organisational aspiration of embedding QI at the heart of how we support improvement. The QCDP cohort was scheduled to commence in May 2025, with coaches from cohort 1 supporting the direct training and mentoring of the new cohort. Future opportunities over 2025/26 are currently in development for a joint cohort between OUH with Oxford Health NHS Foundation Trust (Oxford Health), with OUH invited to explore the opportunities to build communities that support improvement across collaborative pathways and priorities.

OUH QI Toolkit

In 2023 we launched our new QI Zone on the Trust intranet, a central space to host key QI resources, providing a comprehensive hub for staff seeking information and support, and facilitating collaboration and shared learning.

Over 2024 we have continued to develop and review accessibility and resources within the site, to provide colleagues with easy access to tools and support materials to make meaningful improvements in their areas. One key development has been a newly updated and adapted OUH QI Toolkit, with embedded guides on how to use it, aimed at supporting local self-driven improvement.



OUH Improvers Community

A core priority within the Building Quality Improvement Capability and Capacity programme has been establishing a community of improvers at OUH. With the focus on building momentum and supporting a robust foundation for continuous improvement across OUH, the community has a key role in fostering a culture where quality improvement is not just an initiative but a fundamental aspect of daily work.

This year we launched our Coffee Conversation Trials, an OUH QI networking initiative aimed at facilitating cross-departmental connections and conversations providing opportunity for informal networking and sharing across OUH. Initially the approach was tested with a defined small group of colleagues who have completed QI training in the past two years, to refine the approach and mechanisms for pairing up colleagues. To date this initiative has had engagement from a range of staff across the Trust who are then linked up with a peer that month to meet for a coffee and improvement conversation. By the end of 2024/25 around a third of those invited were registering to take up the networking opportunity, with a total of 245 colleagues taking part. Future focus during 2025/26 is on the wider socialisation of the initiative as the process is automated to support wider spread of invites and building to Trustwide open invitation in Autumn 2025.

We were also able to build on the success of Trust QI Stand Up sessions by establishing another opportunity for colleagues to share their improvement ideas and learn through QI 'Lunch & Learn'. Co-designed with staff following a session in June, these monthly 1-hour sessions provided more informal and longer sessions for colleagues to share and connect with one another. To date, topics have ranged from utilising Microsoft Teams to support improvement, to codesigning a Paediatric and Young Person Oncology After Care Service.

The space has already connected some teams to share their improvements outside of the sessions and will continue to be built upon in 2025/26.

Successful Case Study Trust Board Round Improvement

The Trust previously rolled-out Board Rounds in 2017 with a focus on driving flow and care delivery, but there were variations in adherence and adoption of the Policy post-COVID-19.

As part of a wider focus on supporting improvement in flow and discharge, the QI team supported the adoption of Board Rounds as core practice within inpatient wards. With input from all Divisions the Board Round Policy was refreshed and an improvement project launched with the multidisciplinary teams on the 42 adult inpatient wards to both review their Board Rounds and work to increase compliance with the Policy, ensuring that changes made are sustained.

The Board Round Project commenced in September 2023 with seven wards piloting the revised policy and testing the robustness of the document, with a focus on improving compliance.

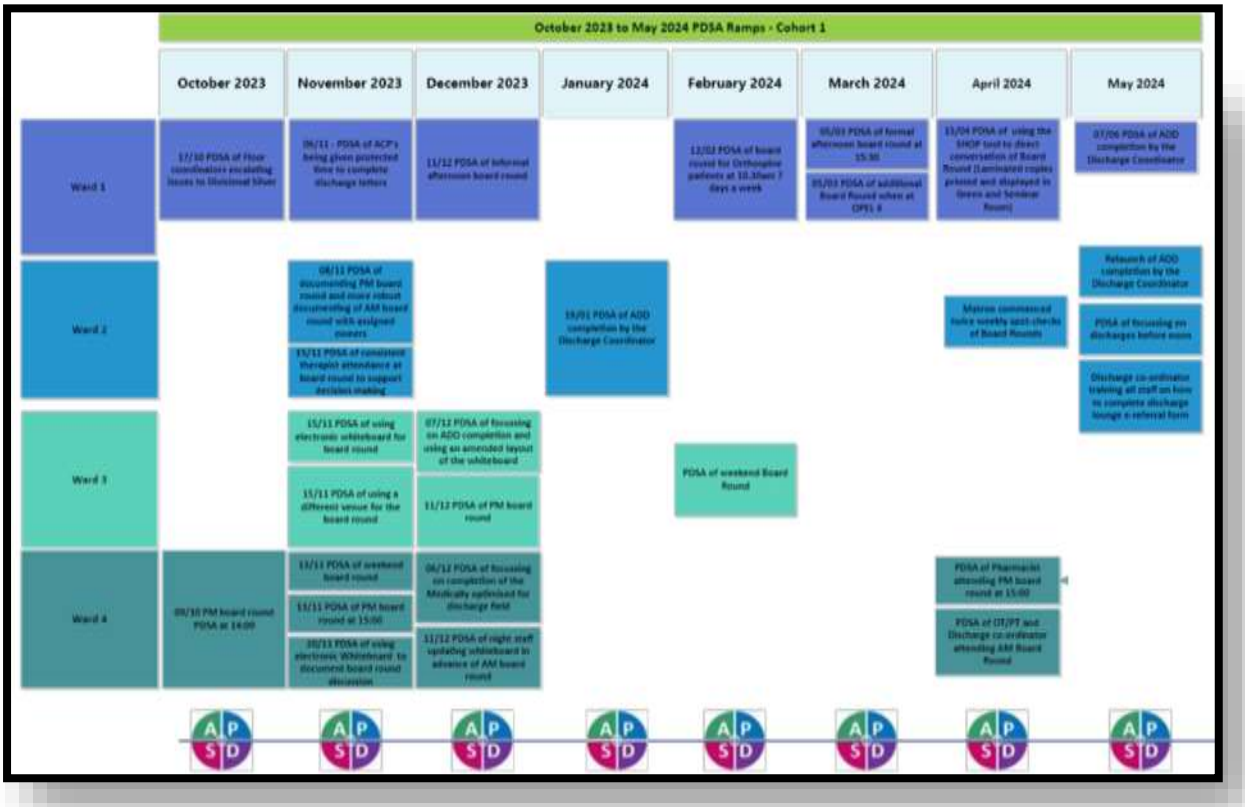
The initial pilot was underpinned by QI methodology with the learning from this first phase informing directly the ongoing phased rollout and spread approach, building to all adult wards across the organisation, over 2024/25 (phased approach outlined in Figure 18 below).

Figure 18: The phased approach for Board Round Projects

Phase	Start	End	% of Adult inpatient Wards onboarded
Phase 1 - 7 wards	01/10/2023	01/05/2024	17%
Phase 2 - 7 wards	01/04/2024	18/10/2024	33%
Phase 3 - 9 wards	02/10/2024	27/02/2025	55%
Phase 4 - 9 wards	07/11/2024	31/03/2025	76%
Phase 5 - 10 wards	Dec-24	31/05/2025	100%

Typical changes introduced and tested is demonstrated in the PDSA ramps below in Figure 19

Figure 19: Board Round PDSA cycles across Cohort 1



Adopting a QI approach (example of cause and effect below) has allowed staff to break down changes they need to introduce into manageable stages. The QI team has coached ward sisters to lead the project and engage with the diverse MDT to test new ways of working and embed best practice.

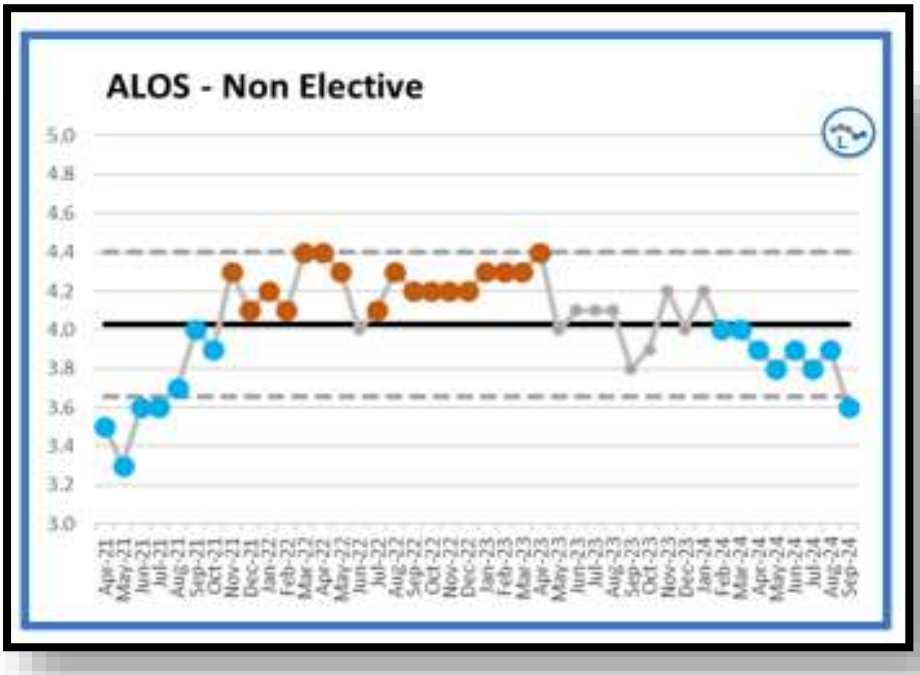
To aid effective rollout, previous cohorts offer peer to peer support for new wards to overcome challenges and share their learning. Phases 4 and 5 (November and December 2024 launch) have been coached by colleagues currently undergoing our Trust QI Coach Programme, supporting ward sisters to expedite the rollout timeline whilst also providing a support context for our Quality Coaches to develop and learn. A focus on Anticipated Date of Discharge (ADD) completion provided an opportunity for patient/carer involvement and discussion around discharge; this is an area of further focus going forward to work collaboratively with patients/carer to achieve the ADD.

Across the wards involved, measurable improvements were achieved, including the following.

- Reduction in average ward LOS of 8.89 hours
- Average increase in number of discharges per week per ward: 3
- Average increase in number of discharges before midday per week per ward: 1
- Average increase in compliance with the Board Round Policy: 32%

The below Statistical Process Control (SPC) demonstrates the reduction in average LOS (ALOS) of non-elective patients across the Trust.

Figure 20: ALOS Non Elective



This project meaningfully impacted on patient flow within wards, accumulatively contributing to a non-cash releasing saving 2024/25 Year to date (YTD) of £0.9m. As we continue to scale and spread the learning from this work is recognised as a key enabler for continuous improvement in flow across the organisation.

Key lessons learned

- Ward level SPCs instrumental in engagement of all staff capturing the impact and purpose of the Board Round.
- Onboard support from the Data and Analytics team at the start of the process, availability of data via a dashboard produced by central Information team to be prioritised within programme of work via Digital Oversight Committee.
- Aligning the approach, to both the personal development of the ward sister, the NHS Staff Survey and our ward accreditation process, helped engagement.
- Using the knowledge of previous cohorts to onboard the next cohort has been fundamental to our success. This approach has helped build relationships across wards and Divisions so that practices and knowledge can be shared to the betterment of the services we deliver.
- The approach we have adopted has helped to inform our Trust QI Strategy, and the wider development of both our Standard Work programme and our response to the productivity challenge.

OxSTaR Human Factors and Patient Safety Education for OUH

Oxford Simulation, Teaching and Research (OxSTaR) is based at the John Radcliffe Hospital. The centre provides a state-of-the-art environment where all OUH staff, medical students and multidisciplinary healthcare professionals can practise a wide variety of medical scenarios using adult and paediatric high fidelity patient simulators. We are able to adapt our teaching to underpin key safety priorities in OUH including the recognition and management of deterioration.

The Human Factors and safety training we offer at OUH via OxSTaR informs our understanding of patient safety concerns in the workplace across the Trust and the design of quality improvement projects to mitigate risk. Feedback from participants on our courses is outstanding, but we also collect data on safety issues across the Trust during our courses which feed directly into QI projects.

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

- Level 1 – introductory Human Factors / Ergonomics (HFE) training for all staff in OUH (incorporates online learning materials, links to innovative HFE resources including a new handbook and podcasts covering relevant safety issues such as retained foreign objects and prosthesis verification, and freely available online half-day introductory HF courses): over 600 staff from all Divisions attended in 2024/25.
- Level 2 – Simulation-Based Education (SBE) and HFE training to support key quality and safety priorities in OUH (e.g. SBE faculty development, care of the critically ill newborn, Advanced Critical Care Practitioner (ACCP) training, and systems-based analysis of safety incidents to align with PSIRF. Over 500 staff from all Divisions attended in 2024/25.
- Level 3 – bespoke SBE and HFE training delivered according to need (e.g. in response to a specific safety incident or to support the development of a new patient pathway). Over 90 staff attended in 2024/25.

Digital Innovation

TheHill

Key programmes include the Market Access Accelerator and our Innovation Pipeline.

The Market Access Accelerator

The Market Access Accelerator (MAA) is a six-month intensive programme which focuses on helping, supporting and helping to scale innovative technologies which can improve patient care and reduce the pressure and burdens on frontline staff.

The Accelerator model allows us to work with companies that are at an earlier stage than a procurement would, and whose technologies require co-development and testing within an NHS environment.

This approach creates products that are better aligned to NHS frontline needs and allows us to safely interact with technologies on the cutting edge of development.

We are currently in the process of onboarding the 2025 cohort of companies, with two contracts signed so far.

In 2024, ten companies graduated from the programme. Their achievements are summarised below.

Careful Systems

Careful is a clinical coordination app that improves the efficiency of patient flow, enables faster decisions and saves hours of clinician time with digital communication, accountability and task management. It raised £200k in October 2024 at an £8 million valuation selected by City Cancer Challenge as part of their digital solution library winner of MedFit 2024 Pitch Session. Careful has been piloted in Maidstone and Tunbridge Wells NHS Trust, Hywel Dda University Health Board NHS Wales and Hughesdale Family Medical Centre in Australia.

Cogni DX

Unbiased, early access to dementia diagnosis and care. They conducted a feasibility study at Pacific University, Oregon, USA. Cogni DX has been piloted at King Faisal Specialist Hospital and Research Centre in Riyadh, Saudi Arabia.

GoodYouAsked

GoodYouAsked aims to be the largest repository of patient recovery journeys, using insightful analysis of patient journeys and cutting-edge data analytics, to transform healthcare into a more personalised and effective experience for all. They are currently exploring a pilot with the OUH Diabetes team.

Healthnix

Healthnix provides personalised diets and lifestyle support for osteoarthritis to help users feel less tired and stronger, and to reduce arthritis flare-ups. It was recently accepted to the Entrepreneurs Roundtable Accelerator (ERA) programme in New York, USA, receiving $150k in investment, amongst other benefits. Healthnix was a finalist in AgeTech Collaborative's Making Aging Easier Pitch Competition. The company has a research collaboration in place with the Self-care Academic Research Unit at Imperial College London and is a winner of University College London's Tech for Good Competition.

On The Mend

On The Mend enables the delivery of tailored care, encouraging shared decision-making between patients and healthcare professionals at a system-wide level. On The Mend was invited to form part of a UK trade delegation to China.

PadicAI

PadicAI's mission is to enhance the efficiency and effectiveness of medical professionals, allowing them to focus on what matters most – patient care.

SurgeryAI

AI-enabled, smart theatre scheduling – simplifying the administrative and operational complexities that lead to scheduling errors, delays and inefficiencies.

Part of the NHS Clinical Entrepreneur Programme's 2024 cohort, SurgeryAI was a finalist in the Venture Catalyst Challenge 2024 at Imperial College London, won an InnovateUK Smart Grant of £300k to improve operating room efficiency, and is currently setting up a pilot at OUH.

TDR Aero

TDR Aero Ltd is a pioneering drone-based company at the forefront of unlocking complex drone operations and recognises the need to improve efficiency through drone utilisation around hospital environments and across hospital networks.

Torbay Charts

Torbay Charts have developed a practical patient-centred decision aid that can be used during consultation. This has been piloted in the Physiotherapy Department at Torbay and South Devon NHS Trust.

TychoMedLink

By combining Augmented Reality (AR) and real-world evidence in our easy-to-learn app, TychoMedLink delivers clinically proven, personalised brain exercises that help people regain healthy brain function TychoMedLink has been part of the Judge Business School, Cambridge University's Accelerate programme, winner of an InnovateUK Young Innovators grant and part of Digital Health London's Launchpad programme, as well as OUH's Accelerator.

OUH is still actively engaging with five of the companies for piloting and/or use of their products and took equity in all ten of the start-ups which forms part of the Trust's capital investment portfolio. This portfolio has the potential to produce significant capital for re-investment into clinical services at a future point in time when companies mature.

Innovation Pipeline

TheHill's innovation pipeline process ensures the most promising digital ideas are championed to grow and scale and directed to the right support within the Trust.

This programme contributes to the overarching objectives of facilitating the adoption of digital innovation into OUH and ensuring our processes are optimal to lead new approaches into the Trust's innovation decision-making. Our connections to the broader ecosystem developed through our other programmes mean we are aware of digital innovations available in the broader ecosystem and are able to match these to identified needs. Piloting of technologies also helps us to avoid procurements which may not deliver the value that we expect, by testing whether the technology fits with our processes and delivers benefits on a smaller scale before committing.

The pipeline is currently progressing 38 companies through the six stages to adoption.

Case study example: Concentric

Concentric Health is a digital consent and shared decision-making web application revolutionising how consent for a procedure or treatment is gained and recorded. Concentric graduated from TheHill's MAA programme in 2021 and since then they have been on a constant upward trend, having gone from an eight-week feasibility trial at OUH to becoming the most widely used digital consent system in the NHS. The technology was piloted through our Innovation Pipeline process over the last two years, and following a successful procurement process, the tool is now in the process of being rolled out across OUH, with a projected £750,000 in efficiency savings.

Recent survey results from one department who have adopted Concentric shows that staff have reported 100% satisfaction with the experience of using digital consent, with everyone reporting how easy the system is to use with 88% reporting it is better than paper consent and a further 91% reporting improved efficiency and effectiveness with time in motion study, demonstrating 30-44% time savings compared to paper consent.

The patient feedback on digital consent was largely positive, with 72% finding the information easy to understand and 95% experiencing no technical difficulties. Overall satisfaction was high, with 62% of patients reporting they were satisfied or very satisfied, while 21% remained neutral. Feedback from patients included:

- 'Much prefer digital. I end up throwing the paper copy away but with the digital it's stored away in case I need it again'
- 'Process excellent… felt very person-centred'
- 'I loved using it, it was so easy'
- 'Signing using the signature pad was better than most pads and my signature actually resembled mine!'

Notably, 64% of respondents were aged 65+.

Case study example: MyMynd

MyMynd is a wellbeing platform for individuals and organisations which gives users the tools to support their wellbeing and offers 1 to 1 support from a trained professional when required. They first joined us at TheHill in late 2021, being part of our men's mental health workshops that year and later joined us at other events like our social mixers before joining our flagship NHS Market Access Accelerator (MAA) programme in 2023. From mid-2024 and into 2025 we have been working with them on a pilot of the solution in Digital and Maternity, with promising early results including an impact on staff sickness, mental health and retention.

Our participation in clinical research

As one of the United Kingdom's leading university hospital Trusts, OUH is committed to improving patient outcomes through clinical research. Along with the related areas of education and innovation, research is central to World-Class Impact, one of OUH's five strategic themes for 2020-25, and is key to achieving all three of its Strategic Objectives: Our People, Our Patients, Our Populations. Together with its research partners, OUH aims to discover better ways to diagnose and treat patients locally, and to contribute to healthcare advances nationally and internationally. This is underpinned by bringing together academic research expertise with clinical teams.

OUH hosts Health Innovation Oxford and Thames Valley (formerly the Oxford Academic Health Science Network (AHSN)). Along with Oxford Health, Oxford Brookes University (OBU) and the University of Oxford (OU), OUH is also a partner in the Oxford Academic Health Partners (OAHP) – one of the eight National Institute for Health and Care research (NIHR) /NHSE designated Academic Health Science Centres in England – and in the Oxford Joint Research Office (JRO), which aims to facilitate the delivery of research by promoting and facilitating greater collaborative working across and between the partner organisations, for the benefit of the people they serve.

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

Much of this activity benefits substantially from the NIHR Oxford Biomedical Research Centre (Oxford BRC), which has been based at OUH and run in partnership with OU since 2007. In the most recent national competition, the Oxford BRC was awarded further funding of £86.7m for five years from 1 December 2022. The Oxford BRC funds innovation across 15

research themes and a core team that supports researchers in areas such as patient and public involvement and engagement, business development, training and education and ethics. A complementary and synergistic bid submitted by Oxford Health, in partnership with OU, secured an award of £35.4m for the NIHR, Oxford Health and BRC in the same competition, and supports 11 research themes focused on brain health. OUH provides a variety of services to support Oxford Health's research, ranging from specialist advice on contracts to imaging and laboratory analyses.

The NIHR Oxford Clinical Research Facility (CRF) is another partnership with OU, which is already delivering a wider range of early phase studies (many with Oxford BRC funding) for the benefit of patients, as well as to train and develop a new generation of doctors, nurses and allied health professionals in early phase experimental medicine trials. Designated for five years from September 2022, with seed funding of £1m, the CRF attracted additional capital funding from the NIHR in June 2023 for a specialist endoscopy suite to support early-phase clinical studies of novel therapeutics across multiple disease states. The Oxford CRF works closely alongside the NIHR Oxford Health CRF, a partnership between OH and OU, to maximise opportunities for local patients and researchers.

During 2024/25, OUH hosted 1,649 active clinical research studies. These include 334 new studies that have opened to recruitment at OUH during 2024/25.

The number of patients, receiving relevant health services provided or sub-contracted by OUH in 2024/25, who were recruited during that period to participate in research approved by a Research Ethics Committee, was 15,053 participants recruited to 474 studies which were registered on the NIHR portfolio.

In 2024/25, 104 OUH staff were directly supported by NIHR Oxford BRC funding. An additional 51 staff with honorary OUH contracts are also supported by PAs funded by the NIHR Oxford BRC. 148 staff were funded by the NIHR Regional Research Delivery Network (RRDN).

The following examples illustrate some of the diverse high-impact clinical research studies and facilities which OUH has been involved in during 2024/25, in many cases working in close partnership with OUH.

- **New Maternity Early Warning Score to be implemented across the NHS**.
  Researchers in Oxford have developed a new Maternity Early Warning Score that is derived from patient data. The new system, which is being rolled out across the English NHS, will help healthcare providers identify and respond to signs of deterioration in pregnant women.

- **Potential new treatment for chronic kidney disease (CKD) trialled**
  The first participants in a new Oxford-led multinational clinical trial investigating a novel treatment that can help slow the progression of CKD have been recruited at OUH.

- **First new treatment for asthma attacks in 50 years**
  An injection given during some asthma and chronic obstructive pulmonary disease (COPD) attacks is more effective than the current treatment of steroid tablets, reducing the need for further treatment by 30%.

- **Research at OUH gets £1m funding boost**
  OUH has received £1 million to fund state-of-the-art research facilities and equipment, much of it to allow its Pharmacy team to meet growing demand.

- **Blood test developed to allow early detection of multiple cancers**
  Researchers at the University of Oxford have unveiled TriOX, a new blood test – powered by machine learning – which shows real promise in detecting multiple types of cancer in their earliest stages, when the disease is hardest to detect.

- **Study charts course for next generation of drug targets in autoimmune diseases**
  In a world first, researchers in Oxford have mapped the cellular dynamics following treatment with the most commonly used advanced therapy in autoimmune diseases. They have discovered why some patients benefit from this therapy while others do not, potentially paving the way for new therapies.

- **Funding awarded for world's first ovarian cancer prevention vaccine**
  Oxford researchers have been awarded up to £600,000 from Cancer Research UK (CRUK) to create the world's first vaccine to prevent ovarian cancer.

Reporting Excellence

The OUH Reporting Excellence (RE) Programme holds a unique position within the OUH framework. The scheme was launched nearly a decade ago by Trust clinicians and has grown whilst adhering to a simple but highly effective concept: it serves not only as a portal for staff to thank colleagues but equally to report excellence in practice at Departmental and Divisional level.

The RE scheme is built into the existing confidential Ulysses incident reporting infrastructure; it offers a direct but complementary alternative to reporting and learning from adverse incidents. In this way, actions and innovations undertaken by staff are celebrated with the nominee but also, when summarised, are shared directly with groups whose focus is on quality, efficiency and improvement. These rich data enable clinical and non-clinical areas to benefit from what goes well in daily work and to identify innovative or highly adaptive practice. This, in turn, contributes positively to learning, future quality improvement and constructive appraisal of existing practice.

Excellence reports are not only expressions of gratitude to the individual or teams named. They also provide detailed narratives about high quality healthcare that are collated and sent back to Departments and Divisions across the organisation. In 2024/2025 there were approximately 3,000 reports submitted, averaging 250 a month (Figure 21 overleaf). There is a national requirement for innovative practice across healthcare to be reported centrally to NHS England. Excellence Reports that specifically highlight innovative change contribute to this.

Figure 22 overleaf displays a breakdown of Excellence Reports by Theme. The ‘Going Above and Beyond’ and ‘Teamworking’ themes feature strongly.

Alignment with Trust values has always been a strength of the Excellence Reporting process, enabling continuous, clear confirmation that these values underpin all the work done every single day.

Figure 21: OUH Excellence Reported in Ulysses by Month November 2023 to April 2025

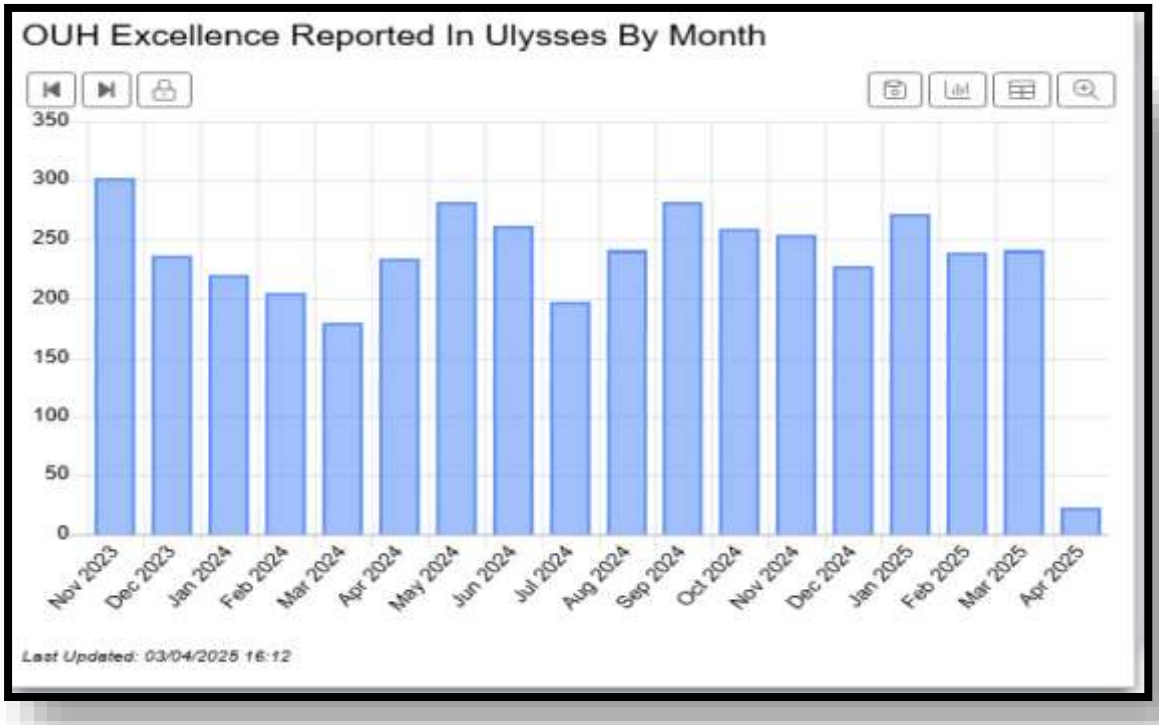
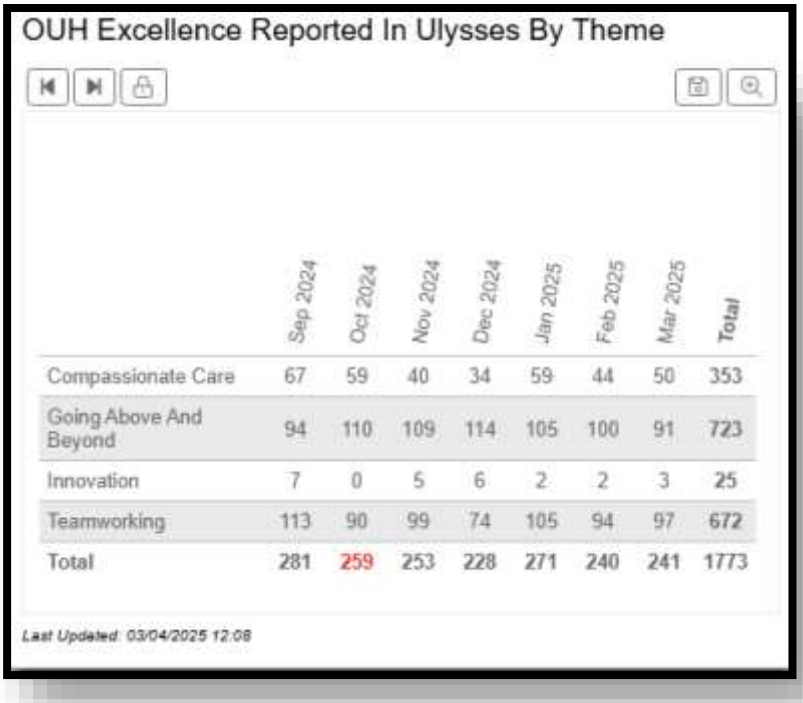


Figure 22: OUH Excellence Themes Reported by Ulysses September 2024 to March 2025



	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Total
Compassionate Care	67	59	40	34	59	44	50	353
Going Above And Beyond	94	110	109	114	105	100	91	723
Innovation	7	0	5	6	2	2	3	25
Teamworking	113	90	99	74	105	94	97	672
Total	281	259	253	228	271	240	241	1773

Statements from the Care Quality Commission (CQC)

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

The Trust is fully compliant with the registration requirements of the CQC. As of 31 March 2024, the Trust had an overall rating of 'Requires Improvement' (RI) from the CQC. This was consistent with the rating disclosed in the previous Quality Account and reflected the activities undertaken by the CQC during the year 2024/25. The Trust continued engagement with the CQC; this is reported to the Clinical Governance Committee.

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

- The management of 37 new enquiries from, or notifications to, the CQC.
- With the support of Oxford Hospitals Charity, enhancements to the bereavement facilities available to women, birthing people and their families at the John Radcliffe Hospital were concluded. The environments were designed to optimise privacy and dignity for all using them in keeping with Trust aspiration and CQC recommendations.
- The notification of changes to the Executive Team in accordance with regulatory requirements.
- Regular notifications covering: Deprivation of Liberty Standards (DoLS) applications, section 42 activities, allegations of abuse and IR(ME)R[5] related incidents in accordance with regulatory requirements.
- The maintenance of engagement meetings with two held virtually in April and October 2024 and a third held at the John Radcliffe Hospital in January 2025. This onsite visit involved presentations from the Complex Medicine Unit and Patient Experience teams and a tour of the Complex Medicine Unit; enabling contextualisation and opportunities to meet staff and service users.
- There were no new CQC inspections during 2024/25. However, on 8 March 2024, the Trust received the report into the October 2023 CQC maternity services inspection of the Horton Midwifery-led Unit location. The findings and associated actions have been reported to Trust Board and Integrated Assurance Committee, and assurance evidence to support completion and embedding of actions has been considered by the Evidence Review Group.

[5] IR(ME)R - Ionising Radiation (Medical Exposure) Regulations

- Developed and launched the OUH Assurance Plan, the deliverables against which are tracked via Delivery Committee. Activities included Divisional team engagement with aspects of assurance mapping against the key questions and quality statement within the CQC Single Assessment Framework, and a range of Trustwide well-led activities in partnership with BDO, (internal auditors) and Arden and Greater East Midlands Commissioning Unit (AGEM).
- Conclusion of phase 2 of the culture and leadership review for Newborn Care.
- Continuing focus on staff wellbeing aligned to the OUH People Plan 2022/25, with forums and initiatives to enable staff to discuss concerns and make recommendations for future focus.
- Engagement with national CQC surveys for Urgent and Emergency Care (results published in November 2024), Adult Inpatients (results published August 2024) and Maternity Services (results published November 2024). Findings from surveys have resulted in action plans being produced by the services and will be monitored by the Evidence Review Group, Clinical Governance Committee and Maternity Safety Champions.

There are a range of areas that remain the subject of continuous review and focus for the Trust. These include statutory and mandatory training, appraisal rates, medicines management and infection control (for example, that relate to the current 'Requires Improvement' (RI) rating in the 'Safe' category).

In addition, the Trust has continued to work on actions in relation to the national waiting time standards that relate to the current RI rating in the 'Responsive' category.

CQC ratings grids as published in the reports of April 2023 and March 2024 can be seen below.

Figure 23: CQC ratings for John Radcliffe Hospital: last rated April 2023

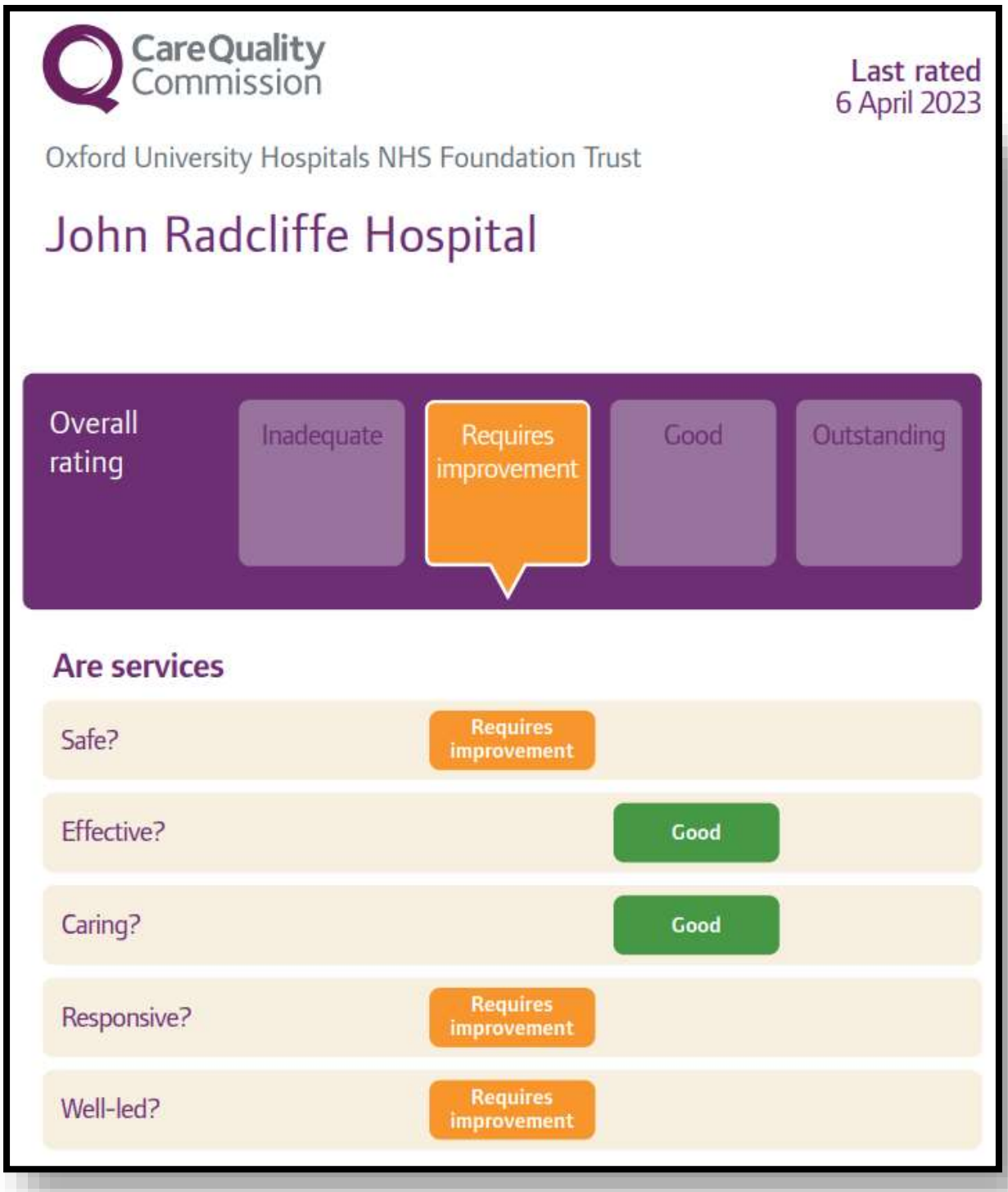


Figure 24: CQC ratings for Horton General Hospital: last rated March 2024 part 1

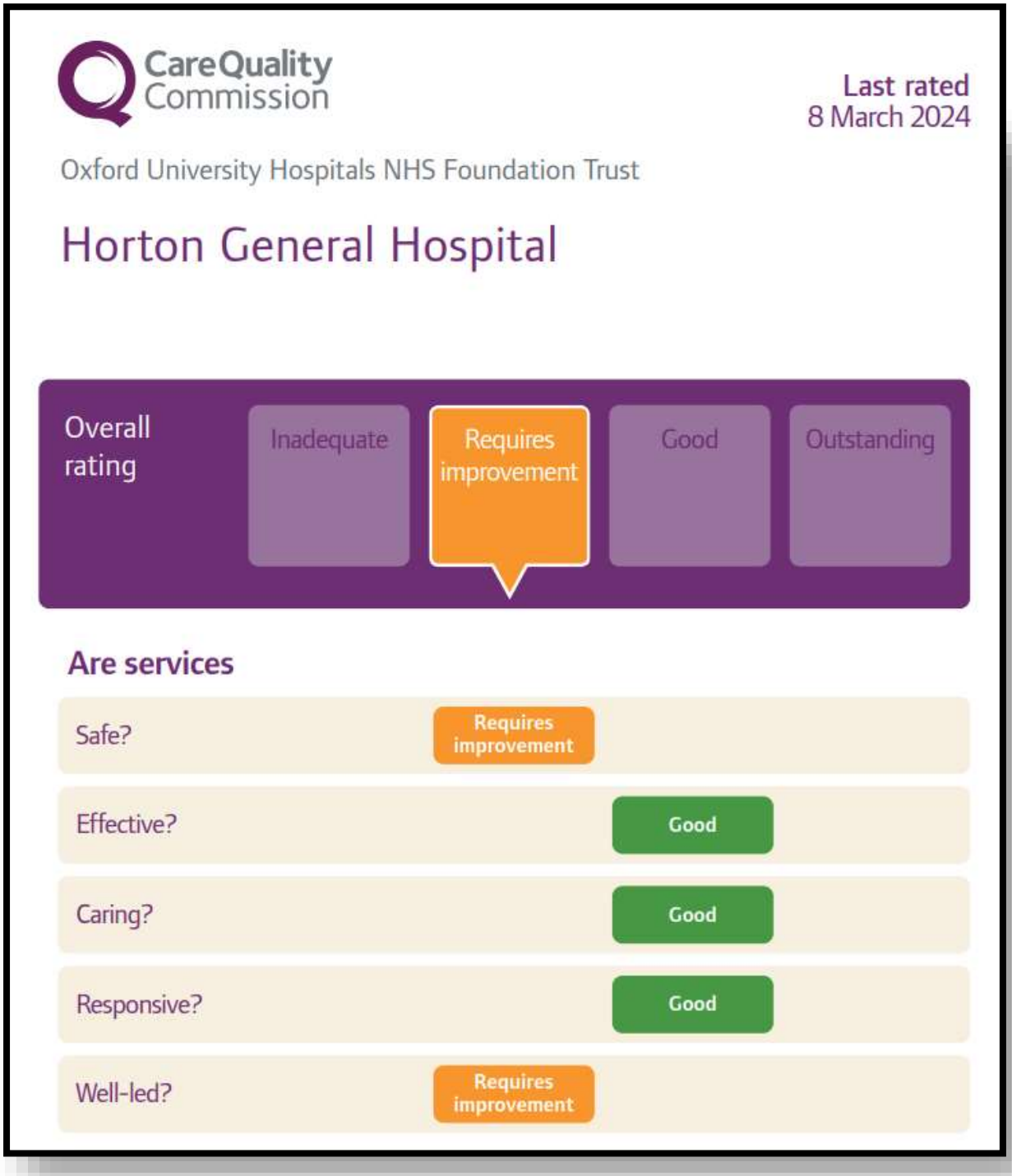


Figure 25: CQC Activity ratings poster for Horton General Hospital: last rated 8 March 2024 part 2

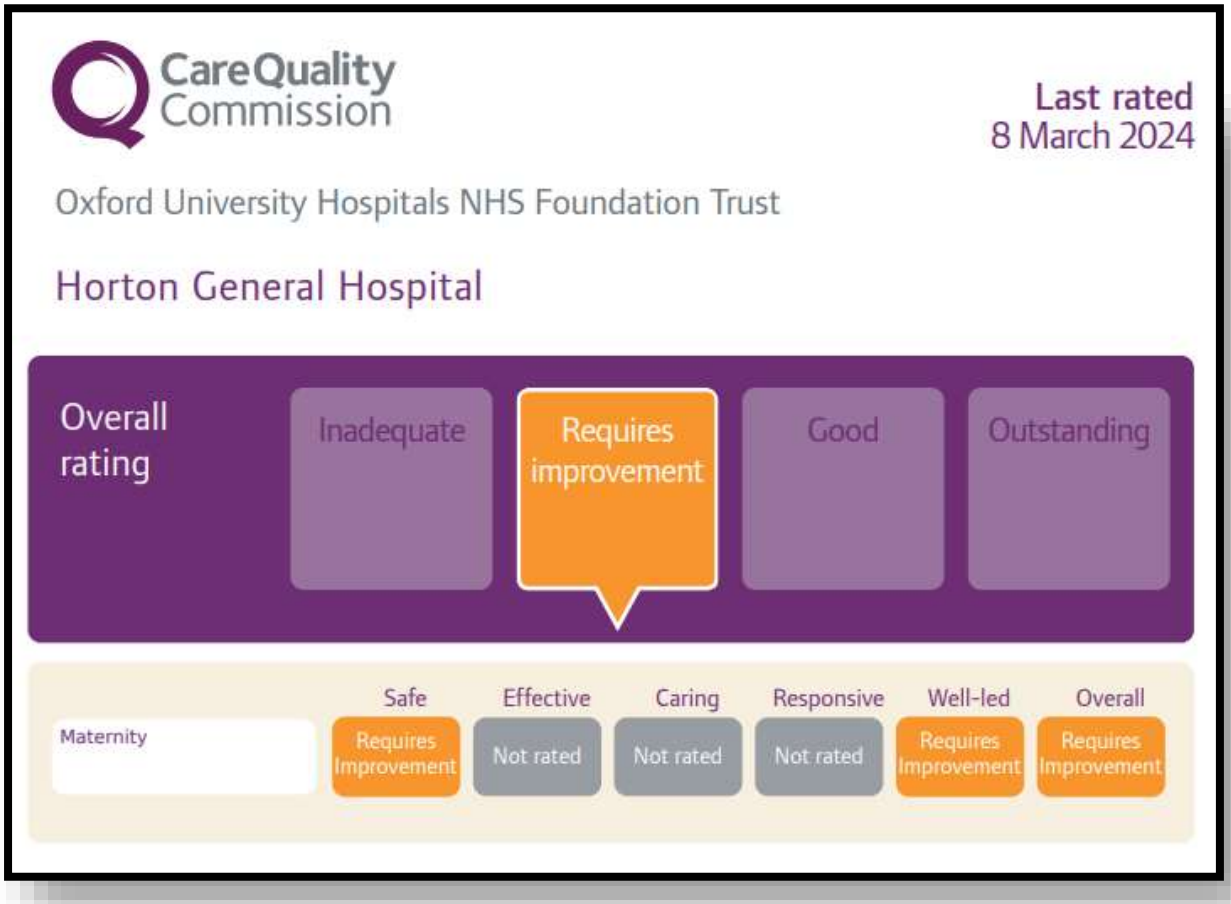


Figure 26: CQC ratings for Churchill Hospital: last rated June 2019

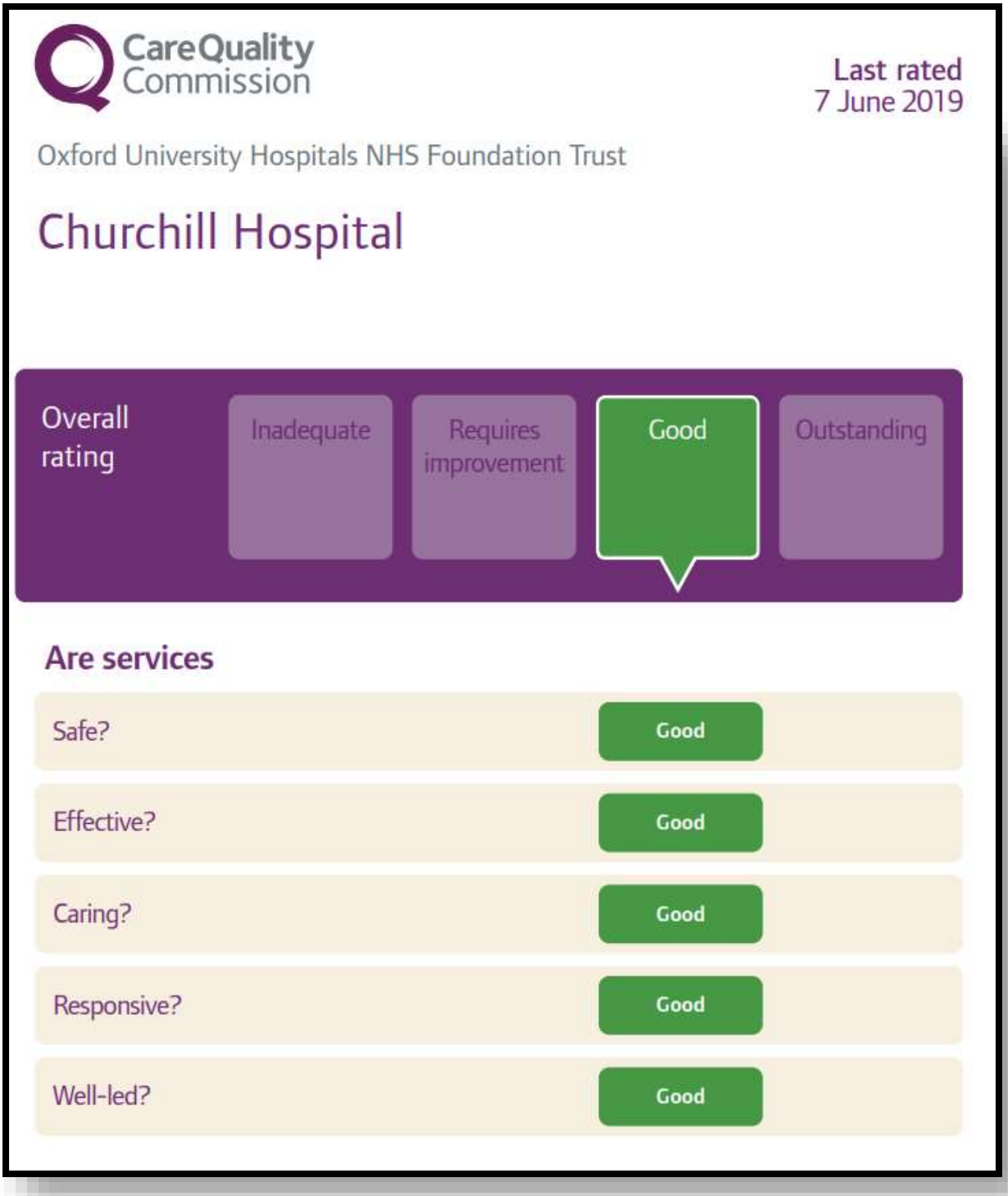
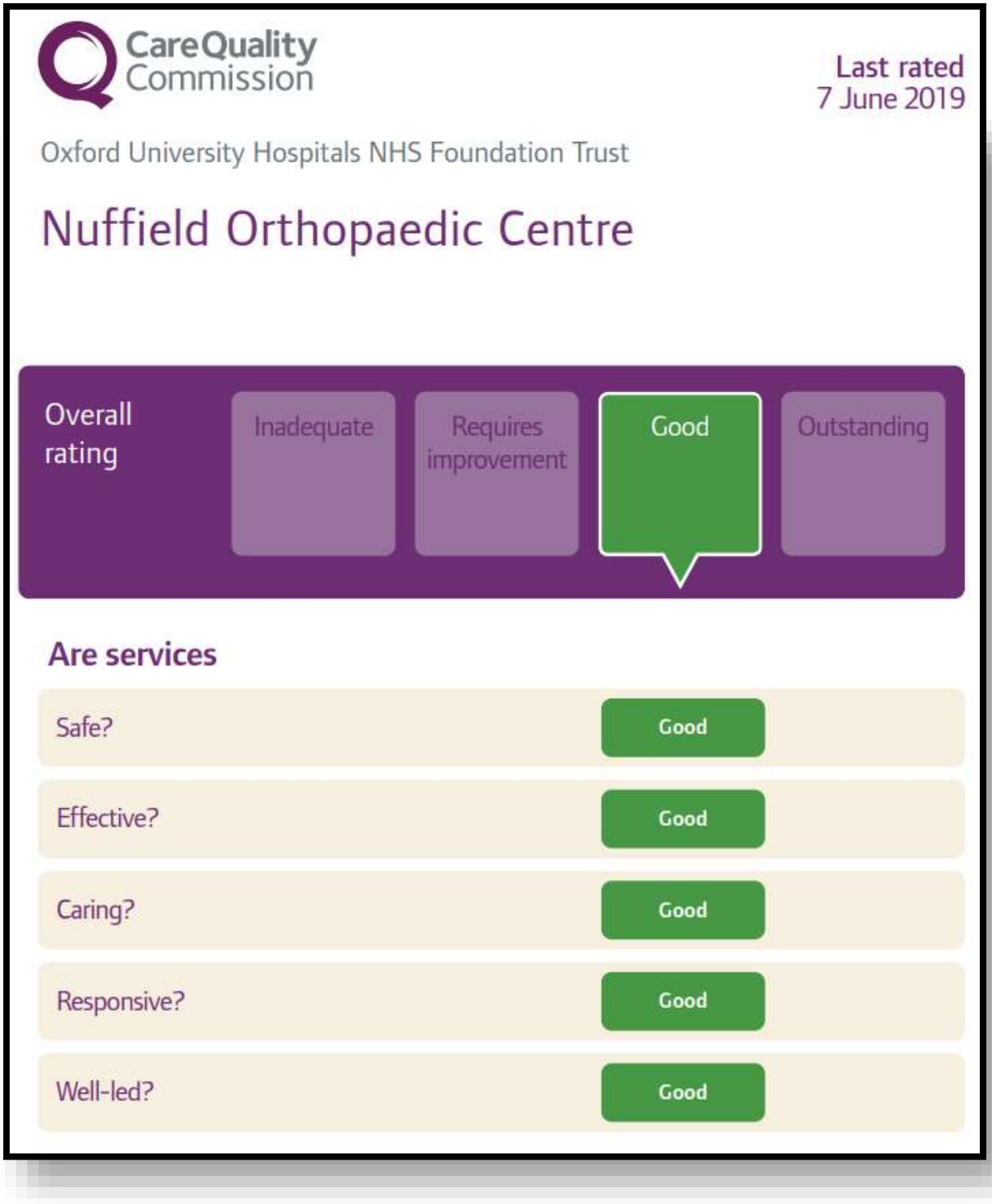


Figure 27: CQC ratings for Nuffield Orthopaedic Centre: last rated June 2019



Our Peer Review Programme 2024/25

Internal Peer Reviews

The focus of internal peer review activities for 2024/25 has involved the launch of the Care Assure Programme in October 2024.

Care Assure is a weekly, unannounced peer review assurance process that is undertaken by all Band 7 and above nurses, midwives, AHPs, healthcare scientists and pharmacists. Each week ten inpatient areas are reviewed and scored on a validated tool which examines fundamentals of care and identifies good practice and areas for improvement. Reviews are recorded on Ulysses information management system which enables visibility of outcomes, action tracking and reporting. All inpatient areas across all the sites and Divisions are reviewed on a six to eight weekly cycle, and to date areas have undergone three visits.

Summary reports outlining outcome data are created for the Divisions outlining an overall compliance and any red flag triggers for each clinical area reviewed ensuring accountability to required action plans. To date revisit data are showing an increase in performance across all Divisions.

Phase 2 of Care Assure involves the expansion of Care Assure into outpatient departments. This tool has been developed in line with relevant areas of the NHS England (2025) 'Reforming elective care for patients' and was piloted in March/April ready for implementation.

Care Assure works in synergy with OxSCA in supporting practice areas knowledge of what good and outstanding practice looks like and completements CQC preparedness work. Care Assure will form the observational element of OxSCA, which is due to be relaunched in 2025.

Regulation and Reviews (External Reviews)

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

Theatre Sterilisation Services Unit (TSSU) ISO13485:2016 – Quality Management System

An unannounced audit by the British Standards Institute (BSI) was carried out in April 2024 to review the service against ISO13485 standards. The Trust was found compliant with the standards following the review.

NHSE Quality Assurance Visit – Antenatal and Newborn Screening (ANNB) service

The NHSE Quality Assurance visit to OUH Antenatal and Newborn Screening Service planned for May 2023 was postponed and carried out in April 2024. The review resulted in five safety actions. An action plan was developed and presented to the Integrated Assurance Committee (IAC) in June 2024. The Evidence Review Group has been set up to oversee the

action plan delivery. This is led by the Chief Nursing Officer and Director of Regulatory Compliance and Assurance. There are quarterly monitoring meetings in place with NHSE.

Haemophilia Peer Review

A peer review of haemophilia services was conducted in May 2024. The purpose of the latest visit was to review compliance with the Quality Standards for Inherited and Acquired Haemophilia and other Bleeding Disorders (V1 July 2018), which were developed by the UK Haemophilia Centres. The Trust submitted data which included Self Declarations, Annual Assessments, Peer Reviews and Specialist Services Quality Dashboards. The review found that three standards were not met, which included environment, facilities and space for the paediatric team in the John Radcliffe Hospital West Wing. An action plan was developed and presented to the Clinical Governance Committee in December 2024.

Elective Care Review (ECR) British Orthopaedic Association (BOA)

The Trust invited the BOA to undertake an ECR of its hip and knee joint replacement service on the recommendation of the National Joint Registry (NJR). The review took place in June 2024 and the final report has been received and was presented at the Clinical Improvement Committee in December 2024.

Haemoglobinopathy Disorders Peer Review

A peer Review of haemoglobinopathy services was carried out in June 2024. The final report was received on 25 September 2024, which identified eight areas of good practice and no immediate risks, with some concerns regarding the support available to Milton Keynes University Hospital NHS Trust. The business case to recruit more staff was accepted in October 2024 and the recruitment process is ongoing.

Human Tissue Authority (HTA) – Licence for Postmortem

A site visit inspection to review compliance with HTA licensing standards for pathology and postmortem took place at the John Radcliffe and Churchill hospitals in June 2024. Positive high-level feedback was provided by the lead HTA inspector at the time of inspection.

The review identified five findings, all of which were addressed by the Corrective Action and Preventative Action (CAPA) plan. The Trust was reported as an exemplar by the HTA. Information regarding the review was presented to the Clinical Improvement Committee in January 2025.

Primary Malignant Bone Tumour Service Review (Sarcoma)

A peer review by NHS England was carried out of sarcoma services for primary malignant bone tumour. The reviewers were highly positive about the service and reported no immediate risks, however, they did raise one serious concern regarding physiotherapy support and in total five recommendations were made. An action plan has been developed and shared with NHSE.

Review of Children's Epilepsy Surgery Services (CESS)

A review of services took place in July 2024 and reported three immediate concerns. The service is working with the Bristol team to address an action plan with ongoing monitoring by the Operational Development Network.

Quality and Safety for Human Application – HTA Regulations 2007 (Licence)

A Human Tissue Authority (HTA) Human Tissue Application License for the regulation for procurement, processing, testing, storage, distribution and export of human tissues and cells for human application took place in July 2024**.** The review raised four shortfalls, which were fully addressed by the CAPA plan, and completed in December 2024.

Public Sector Decarbonisation Scheme

The Public Sector Decarbonisation Scheme (phase 3b) evaluates the controls in place for ensuring the grant recipient complied with the grant terms and conditions, including the mitigation of fraud risk; safeguarding the use of the grant funds; and achieving project outcomes. An audit against the scheme was carried out in July 2024 and found the grant has been used in accordance with the terms and conditions and that the project has been delivered in line with the objectives approved by and reported to Salix. Minor issues raised were identified as low risk.

Teenage and Young Adult Cancer Benchmarking Review

The Thames Valley and Wessex Operational Delivery Network (ODN) carried out a benchmarking review against the Teenage and Young Adults Cancer Principal Treatment Centre Service Specifications. The benchmarking data and actions were submitted to ODN in August 2024. Feedback was received from the Children and Young Persons ODN on 7 October 2024 which outlined the legacy issues in relation to the commissioned service. The actions to address the findings were signed off by Assurance and the CMO Office and sent to Thames Valley and Wessex (TVW) Children's Cancer ODN in December 2024.

Radiation: Environment Permitting Regulations and Management System (JR & CH). (Office of Nuclear Regulation (ONR) Environment Agency)

The ONR Environment Agency and Thames Valley Policy carried out an on-site review of the Trust's Environment Permitting Regulations and Management System at the John Radcliffe and Churchill hospitals. The review looked at compliance with the regulations, including systems and storage of radioactive materials. The Trust was found compliant.

Genetics Service Quality Review

The NHSE conducted a quality review of the Clinical Genetics service following a serious incident. The review considered clinical outcomes, patient experience and access to services. The final report was received in December 2024 and highly commended the service. There were minor suggestions for improvement.

Congenital Heart Disease (CHD) Quality Review of the Adult and Paediatric Services

A quality review was carried out by NHS England (South-East) in September 2024. The review covered all services in the South East. The final report was received in December 2024. As the CHD services across the two Trusts are interdependent, NHSE and the ODN have proposed a joint action plan and oversight meetings, the first of which will take place in June 2025.

Elective Surgical Hub Accreditation: Royal College of Surgeons and GIRFT

Following an initial visit in September 2023, a second visit by the Royal College of Surgeons and Getting It Right First Time (GIRFT) team took place at the Nuffield Orthopaedic Centre in October 2024, leading to accreditation as an Elective Surgical Hub in November 2024. Progress against an agreed action plan will be monitored through quarterly reviews.

Cervical Screening Quality Assurance Review (SQAS) (Colposcopy)

A quality assurance pathway review of the Cervical Screening Programme took place in November 2024. The review included colposcopy, nursing and administration. Evidence was submitted and the final report received in December 2024 outlined 10 findings. There is a staggered timescale to address the findings of between three, six and 12 months. The Chief Medical Officer, NHSE and the Colposcopy team met with SQAS in February 2025 and a finalised action plan was submitted in March 2025. Assurance evidence against the recommendations will be submitted to and monitored by SQAS. The next meeting is planned for May 2025.

Psychiatric Liaison Accreditation Network (PLAN)

PLAN is a Royal College of Psychiatrists accreditation programme for mental health services in acute Trusts. A review of psychological services for accreditation to PLAN began in September 2023. The Trust completed a gap analysis against the 158 PLAN standards to explore the possibility of accreditation to this body.

The peer review of psychological medicine services took place in November 2024. The peer review was to provide a preliminary overview of the service, ahead of applying for full accreditation, for which we await results. The report was shared with the service in March 2025. The findings were largely positive, noting hard working, caring and compassionate staff involved in a number of quality improvements. There is a recommendation around the process for medication reviews, a rolling training programme and inclusion of service users in recruitment.

Healthcare Information and Management Systems Society (HIMSS)

The Healthcare Information and Management Systems Society is a global advisor and thought leader supporting the transformation of health through information and technology. HIMSS stages, such as Stage 6, are part of the Electronic Medical Record Adoption Model (EMRAM), which assesses the progress and impact of electronic medical

record systems within hospitals. Achieving Stage 6 indicates that a hospital has robust digital processes embedded into clinical workflows, has established clear goals for improving safety, minimising errors, and prioritises IT implementations.

The Digital team has been working towards the accreditation for the past eight months for pharmacy at the NOC. It was confirmed in March 2025 that they were successful in being awarded HIMSS Stage 6 accreditation following a presentation in January 2025.

European Neuroendocrine Tumour Society (ENETs) Centre of Excellence Re-certification Audit

The re-certification audit for ENETs Centre of Excellence was last reviewed in 2018. This audit is part of a five-year programme; however, the previous audit was postponed during the COVID-19 pandemic. The audit was conducted on site in January 2025 and achieved re-accreditation for five years, with no recommendations or actions. This is highly commendable and a credit to the service.

Burns Specialist Service Review

NHS England South East Regional Specialised Commissioning Team carried out a review of the commissioned burns service provision across the South East, which included OUH. The review took place on 20 November 2024 at Stoke Mandeville Hospital Burns Unit. Evidence has been submitted for consideration. The final report is awaited.

Paediatric Audiology Service Quality Assurance Tool (PASQAT) (Community and Acute)

A quality review of paediatric auditory services was carried out by NHS England in June 2024. The reports for both acute and community were provided in September 2024. There was a follow-up review of community paediatric auditory services in March 2025. The final report is awaited.

Surgery in Children's Service Review

In February 2025, Thames Valley and Wessex ODN undertook an annual review of progress with the actions associated with their previous visit. This review took place virtually in February 2025. The final report is awaited.

Data Quality and Information Governance

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

OUH will be taking the following actions to improve data quality and information governance.

Improved tooling to assist in managing Freedom of Information (FOI) and Subject Access Requests has been adopted, giving the Trust the ability to manage requests on a Divisional and department basis. The Trust continues to receive more of both types of requests than in previous years.

Digitisation of paper records will begin shortly; being able to access historical records immediately in a searchable electronic format will significantly improve the availability of records previously stored off site.

A new Digital Consent platform is being rolled out and will provide the Trust with a much improved and easily accessible record of the consent patients have given for treatments and consent for potential use of their data for secondary purposes.

A review of Trustwide working practices and policies around the adoption of systems that involve AI and Machine Learning is underway. Strong Information Governance and transparency around how the Trust uses these new technologies will be vital to giving assurance to staff and patients that their use is appropriate and beneficial to all.

Data Security and Protection Toolkit (DSPT)

OUH's submission of the Data Security and Protection Toolkit for the most recent reporting period of 2023/24 reported an overall assessment of 'Standards Met', which was agreed by NHS Digital. This provides significant assurance to other parties who may wish to share data with us. For 2024/5 the underlying framework of DSPT changed to align with the National Cyber Security Centre Cyber Assurance Framework, so reporting methods and standards have changed. This includes the guidance on the Interim Submission, which is now required to be a snapshot of the Trust's situation at the time of Submission, whereas previously it was a prediction of the Trust's final assessment result. Consequently, OUH's baseline submission for 2024/54 made on 31 December 2024 was 'Standards Not Met'. At the time

of submission the Trust has achieved the expected standard in 11 of the 18 areas where this is required and has partially achieved the expected standard in seven of the 23 areas where this level is required. There are 29 areas where the Trust is not currently achieving the required standard.

The final submission will be on 30 June 2025, 26 of the current ‘Standards Not Met’ areas must be improved to ‘Achieved’ or ‘Partially Achieved’ and we are again working towards achieving ‘Standards Met’.

Records submission

OUH submitted records during 2024/25 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

SUS dashboards month 12 2024/25

Figure 28 shows the information by inpatients, outpatients and ED demonstrating OUH compliance compared to the national average.

Figure 28:

Inpatients	OUH	National Average
Valid NHS number	98.9%	99.7%
General Medical Practice Code	100%	99.4%
Outpatients	**OUH**	**National Average**
Valid NHS number	99.5%	99.7%
General Medical Practice Code	100%	99.3%
ED (type 1 only[6])	**OUH**	**National Average**
Valid NHS number	98.5%	99.9%
General Medical Practice Code	100%	99.7%

Clinical Coding Data Quality

OUH recognises and is committed to the timely and accurate recording of clinically coded data.

Clinical engagement is part of this important process. Coding and Clinical staff are involved in the following workstreams.

- Clinical Coding Audit Programme.
- Clinical coding data analysis to support improvement and clinical collaboration.
- Validation of coded data with clinical colleagues to improve data quality and improve patient care.

[6] Type 1 covers the Emergency Departments at the John Radcliffe and Horton General hospitals.

- Assurance of coded data affecting the NHS Payment Scheme (formerly Payment by Results).
- Assessing the impact of coded data on the national GIRFT project.
- Improvements in clinical coding training.
- Participation in the Mortality Reporting process.

This work demonstrates the Trust's commitment to the collection, analysis and reporting of high quality clinically coded data.

Learning from Deaths

During 2024/25, 2,743 OUH inpatients died. Figure 29 shows the number of case record reviews by quarter and the number of deaths judged more likely than not to have been due to problems in care.

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

Case record reviews include a Level 2 comprehensive mortality review (which is an OUH initiative) or a structured judgement review (SJR) (which is a national requirement).

Figure 29: Number of case record reviews by quarter and no. of deaths judged more likely than not to have been due to problems in care

	Quarter 4 2023/24	Quarter 1 2024/25	Quarter 2 2024/25	Quarter 3 2024/25	Quarter 4 2024/25
Number of case records reviewed (No./%)	351 (100%)	295 (100%)	305 (100%)	327 (100%)	*Will be published in the 2025/26 Quality Account*
Number of deaths judged more likely than not to have been due to problems in care	0	0	0	0	

A total of 927 case record reviews were carried out in relation to 2,037 deaths that occurred to the end of Q3 2025. No avoidable deaths were identified in this period.

In Quarter 4 2024, 351 case records were reviewed in relation to 725 inpatient deaths. No avoidable deaths were identified.

The reviews of deaths which occurred during the fourth quarter are underway and the summary will be included in the next Quality Account 2025/26. These numbers have been compiled using the quarterly Divisional mortality reports submitted to the Trust Mortality Review Group.

Summary of some of the learning and impact of actions from case record reviews and investigations

Work continues to improve oxygen prescribing compliance. Safety messages in relation to this have been shared across the organisation.

Death notification: work continues across the Trust to further improve timely completion of death notification summaries and level 1 mortality reviews. An issue was raised that when

an electronic level 1 review was completed, and further review (level 2 or SJR) was required, the system did not automatically flag these cases. Systems are now in place to ensure that deaths requiring further review are identified. This is monitored at the monthly Mortality Review Group meetings.

Patient transfers: a theme has been identified where transfer to OUH was delayed or not appropriate, most notably in the Vascular and Neurosurgery services. Informative feedback has been provided to referring hospitals.

Managing bereavement in Children's and Neonates: due to challenges conducting 'hot debriefs' of mortality during a busy shift and a need for more opportunities for discussion and reflection later, a working group is developing a formal half day of training for Paediatric, Paediatric Critical Care and ED staff.

The Mortality Review Policy was updated in line with the three-year review. Updates based on learning from previous deaths include addition of the process OUH must follow when a patient dies externally to the Trust with OUH involvement during the treatment pathway; and clearer guidance on Mortality and Morbidity (M&M) meetings.

The importance of accurate DNACPR endorsement on EPR has also been highlighted, particularly when a patient is readmitted.

Work continues to ensure Venous Thromboembolism (VTE) assessments are completed and reviewed according to Trust guidelines. Compliance is monitored via Divisional performance reviews and via summary papers to Clinical Improvement Committee (CIC). Each clinical area is responsible for reviewing compliance with issues raised at local governance meetings and the implementation of an action plan if required.

Reminders have been disseminated via Divisional governance meetings and Safety Huddles to clinical teams regarding the importance of communication and updating of families when a patient's clinical status changes. This is particularly important when a patient has deteriorated and is likely to die.

The vital role of Hospital Passports for patients with Learning Disabilities has been highlighted as a source of guidance regarding support structures important to the individual. These documents provide a snapshot of the patient to underpin assessment of normal behaviours and coping mechanisms as well as guidance regarding appropriate interventions. This important resource for personalised patient care has been highlighted and shared across the Trust.

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

Summary Hospital-level Mortality Indicator (SHMI)

The Summary Hospital-level Mortality Indicator (SHMI) is the preferred hospital mortality indicator adopted by NHS England. The SHMI is the ratio between the reported number of

patient deaths during admission or within 30 days of their discharge, against the expected number of deaths based upon the characteristics of the patients treated.

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

- The Trust has a process in place for collating data on hospital admissions, from which the SHMI is derived.
- Data are collected internally and then submitted monthly to NHS Digital via the Secondary Uses Service (SUS). The SHMI is then calculated by NHS Digital.
- Data are compared to the national benchmark, and the Trust's own previous performance, as set out in Figure 30.
- The Trust reviews the SHMI in conjunction with other published mortality measures and the information from its internal review of deaths.

The SHMI, published on 24 April 2025, for the data period January 2024 to December 2024, is 0.91. This value is banded 'as expected'. The SHMI continues to compare favourably with national mortality benchmarks.

Care at the end of life (EOL)

During 2024/25, 2,837 adults over 18 years of age died in OUH. Providing care at the end of a person's life is an important part of the provision of healthcare. Work this year to improve care at the end of life has included the following.

- An End of-Life Lead continues in post funded by Sobell House Hospice Charity; in addition, the charity has funded an administrator and Band 7 Clinical Nurse Educator for the EOL team These posts are filled.
- Quarterly meetings of the EOL group restarted. The EOL group reports to the Mortality Review Group.
- An audit of the use of Naloxone in OUH was conducted and learning identified. The revised Medicines Information Leaflet on Naloxone has been approved for use. The National Audit of Care at the End of Life (NACEL) 2024 identified that training is needed for OUH staff who provide care at the end of life, with a particular focus on recognising dying and discussing the management of hydration and nutrition in dying patients. End of life care e-learning courses are now available for staff via My Learning Hub.
- Tissue donations from OUH patients are now uniformly managed by the National Referral Centre (NHSBT) pathway. OUH tissue donation is co-led by the EOL Lead. In 2024, a Band 7 Clinical Nurse Educator for Tissue Donation was appointed, funded by the Organ Donation Committee. Since their commencement in post, in July 2024, tissue donation numbers have increased (45 donations until February 2025, from 31

and then 1 referral(s) in the two preceding years). The hospice eye donation project in collaboration with NHSBT is also underway.

- The EOL team supported planning and training ahead of ReSPECT implementation in March 2025.

Reporting against core indicators

*There is no national comparison data available on incident reporting since the National Reporting and Learning System (NRLS) was replaced by Learn From Patient Safety Events (LFPSE). The figures given are taken from the Trust's incident management system, Ulysses. Data per 1,000 bed days are not used as a metric any longer as there are no comparable Trust data.

Figure 30: Reporting against core indicators

Indicator	Measure/Target	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source
Summary Hospital-level Mortality Indicator (SHMI)									
Ratio of observed mortality as a proportion of expected mortality	<1	Jan 2024 - Dec 2024	0.91 *CL[7] 0.88-1.14* (as expected)[8]	Jan 2023 - Dec 2023	0.86 *CL 0.89-1.12* (as expected)	1.19	0.70	1.00	NHS Digital
Percentage which were palliative deaths (coded)	NA	Jan 2024 - Dec 2024	51.95%	Jan 2023 - Dec 2023	48.67%	-	-	-	NHS Digital
*The number and percentage of patient safety incidents that resulted in severe harm or death	No. (% of all patient incidents)	FY 2024/25	104 (0.3%)	FY 2023/24	107 (0.4%)	-	-	-	OUH Ulysses

[7] CL - Confidence limit
[8] SHMI data categorised as 'lower than expected', 'as expected', or 'higher than expected'

Indicator	Measure/Target	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source
The percentage of patients who were admitted to hospital and who were risk assessed for Venous Thromboembolism during the reporting period	95% In Q4 the criteria changed from a VTE assessment completed by 24 hrs to 14 hrs	FY 2024/25	Q1-3 (24 hrs) 98% Q4 (14hrs) 95%	FY 2023/24	97.9 %	-	-	-	ORBIT
Clostridioides difficile cases (figures up to Jan 25)	123	FY 2024/25	164	FY 2023/24	130	-	-	-	ORBIT
Percentage of patients readmitted within 28 days being discharged **Age 0-15yrs**	Readmissions data (%)	Nov 2023-October 2024	1.8%	Sept 2022 - August 2023	10.4% (0-15 and over 16 yrs data)	20.1% (0-15 and over 16 yrs data)	4% (0-15 and over 16 yrs data)	-	Dr Foster
Percentage of patients readmitted within 28 days being discharged **Over 16 yrs**	Readmissions data (%)	Nov 2023-October 2024	9.1%	Sept 2022 - August 2023				-	Dr Foster

Indicator	Measure/Target	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source
Trust's responsiveness to the personal needs of its patients									
To what extent did staff looking after you involve you in decisions about your care and treatment?	Score out of 10 Trustwide	2023	7.2	2022	7.4	9.2	7.0	7.7	CQC Inpatient Survey 2022
Did you find someone on the hospital staff to talk to about your worries and fears?	Score out of 10 Trustwide	2023	7.9	2022	8.0	9.2	6.8	7.7	CQC Inpatient Survey 2023
Thinking about any medication you were to take home, were you given any of the following?	Score out of 10 Trustwide	2023	5.0	2022	5.0	6.5	3.4	4.3	CQC Inpatient Survey 2023
Did hospital tell you whom to contact if you were worried about your condition or	Score out of 10 Trustwide	2023	8.4	2022	8.4	9.7	6.1	7.5	CQC Inpatient Survey 2023

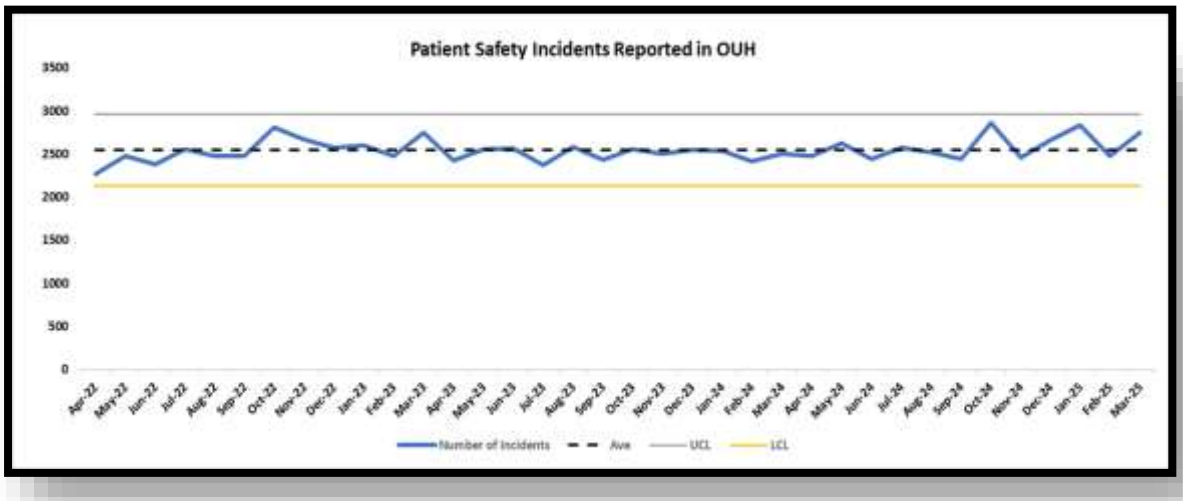
Indicator	Measure/Target	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source
treatment after you left hospital?									
Staff employed by, or under contract to the Trust who would recommend the Trust as a provider of care to their family or friends	% of staff	2024	74.35%	2023	74.84%	-	-	61.74%	NHS National Staff Survey 2024

Safety Incidents and Learning Responses

All incidents

It is crucial that we learn from every incident and near miss that happens, to address concerns and continually learn. OUH actively encourages staff to report clinical incidents and near misses so that lessons can be learned in order to improve care. Measures used by NHS England and others to indicate a positive 'safety culture' within an organisation include the rate of incident reporting (the higher the better) and the proportion with significant patient harm (the lower the better). Figure 31 below shows the number of patient incidents reported per month by OUH since April 2022, which has been above the mean of 2,545 for the past 36 months. The number of incidents reported has seen a rising trend in recent months but are still within the control limits.

Figure 31: Number of patient safety incidents reported per month by OUH since April 2022



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

In addition to the review of all incidents by senior staff in each department, all incidents reported with moderate or above impact are reviewed each working day in a Patient Safety Response meeting, to confirm what immediate steps need to be taken or what information is required to be collected, as well as identifying whether any extra support is required for the staff involved. In 2024/25 our staff reported 31,123 patient safety incidents, 29,591 (95.0%) resulting in no harm or minor harm, 1,431 (4.6%) resulting in moderate harm, 52 (0.2%) resulting in major harm, and 49 (0.2%) with an impact of death (the management of

deaths in the Trust is discussed above). All impact gradings are confirmed through the Trust's incident management process and follow the LFPSE guidance.

Patient Safety Incident Investigations (PSIIs)

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

In 2024/25, 27 non-thematic PSIIs were confirmed (although one was subsequently reclassified because it transpired that an investigation by the national Maternity and Newborn Safety Investigations body had already been recorded on the national database by another Trust who shared the patient's care). In 2023/24, 10 non-thematic PSIIs were confirmed; this number is low because the Trust transitioned to PSIRF in the middle of the financial year. Wherever possible, patients or their representatives are involved in these investigations, offering guidance on areas to address, and insight from their experiences.

The four thematic PSII topics for 2024/25 were as follows.

- Patients at risk (learning disabilities).
- Handover, communication.
- Referrals and cancer multidisciplinary team processes.
- Result reporting and endorsement.

The leads for these four workstreams have given regular updates to the SLIC meetings since October 2023, detailing the scopes for their investigations, sharing immediate learning, and detailing improvements planned or undertaken, and the incoming PSIRF Learning Lead will work with the four investigation teams to finalise reports on this work.

New thematic PSIIs have been completed and presented at the Clinical Governance Committee in Quarter 1 of 2025/26.

- Safety and timely discharges with medications.
- Escalation of deteriorating patients.
- Positive Patient Identification (PPID).
- Patients at risk (learning disabilities) (rolled over from 2023/24).

Never Events

Figure 32 below shows that the Trust reported two Never Events in 2024/25, compared to a five year mean of five. Never Events are defined by criteria published by NHS England and all Never Events are investigated as PSIIs.

Figure 32: Never Events confirmed per year

Figure 33: Categories of the Never Events identified as a PSII

Both investigations are ongoing. Interim discussions take place at the SLIC meeting for all PSIIs, and at the time of writing this has happened for one of the two Never Events, involving the implantation of the incorrect valve of a ventriculoperitoneal shunt. The following potential improvement opportunities have been identified, although it must be noted that the final investigation report is awaited.

- Different shunt devices from two manufacturers are available in theatres. There is no standardisation in use, and operator preference is often the deciding factor. Operators are to check previous surgical records to confirm the type of device implanted and establish whether these are held prior to the procedure; where an equivalent is not available the consultant will be contacted.
- There will be training on available shunt devices for all neurosurgical trainees on induction.
- A shunt registry records what devices have been implanted, and the data quality of this will be improved.
- The small print on some device packaging is difficult to discern, this will be passed to the manufacturer.

Venous thromboembolism (VTE) Prevention and Anticoagulation Safety

VTE Prevention

The Trust has met and exceeded the 95% target for VTE risk assessment (RA) of patients for 2024/25.

Highlights of the new work the VTE Prevention and Anticoagulation Teams have conducted in 2024 include the following.

VTE Risk Assessment and the new Performance Indicator

NHS England has stipulated that the VTE risk assessment must be completed on all patients aged 16 and above within 14 hours of admission (previously within 24 hours of admission). NICE Guideline (NG-89) states that "where required, pharmacological thromboprophylaxis should be started within 14 hours of admission, therefore risk assessments should be completed prior to this".

The VTE Prevention team has been collaborating with clinical teams to ensure that we are compliant with the new indicator. Actions have included:

- a safety message
- introduction of several enhancements to the VTE Dashboard in ORBIT to incorporate the new performance indicator e.g. user is now able to alternate between 'within 14 hours' and 'within all' performance.

Lower Limb Immobilisation VTE Risk Assessment

Ongoing collaboration with key stakeholders to introduce the TRiP[9] (cast) Tool for patients with Lower Limb Immobilisation. The TRiP (cast) Tool is a validated tool for lower limb immobilisation and trauma and the Digital team has created an electronic version in EPR. We will introduce a robust audit process for compliance with the NICE Quality Standard (QS201) statement 2: People aged 16 and over who are discharged with lower limb immobilisation are assessed to identify their risk of VTE.

Hospital Associated Venous Thromboembolism (HATs)

The two most common themes of why patients have not received appropriate thromboprophylaxis and have gone on to develop potentially preventable HATs are:

a. Low Molecular Weight Heparin (LMWH) not prescribed

b. LMWH suspended and not reviewed following surgery or radiological interventions.

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

Following discussion at SLIC the VTE Prevention team, in collaboration with the Digital Team, are exploring how to increase awareness of these situations by adding a Thromboprophylaxis column to the Electronic White Board (e.g. anyone with LMWH suspended or not given requires a review – traffic light colour coded on white board). The Anticoagulation Safety team will work alongside VTE Prevention in this project to ensure patients on long-term anticoagulation are appropriately risk assessed and managed during their admission.

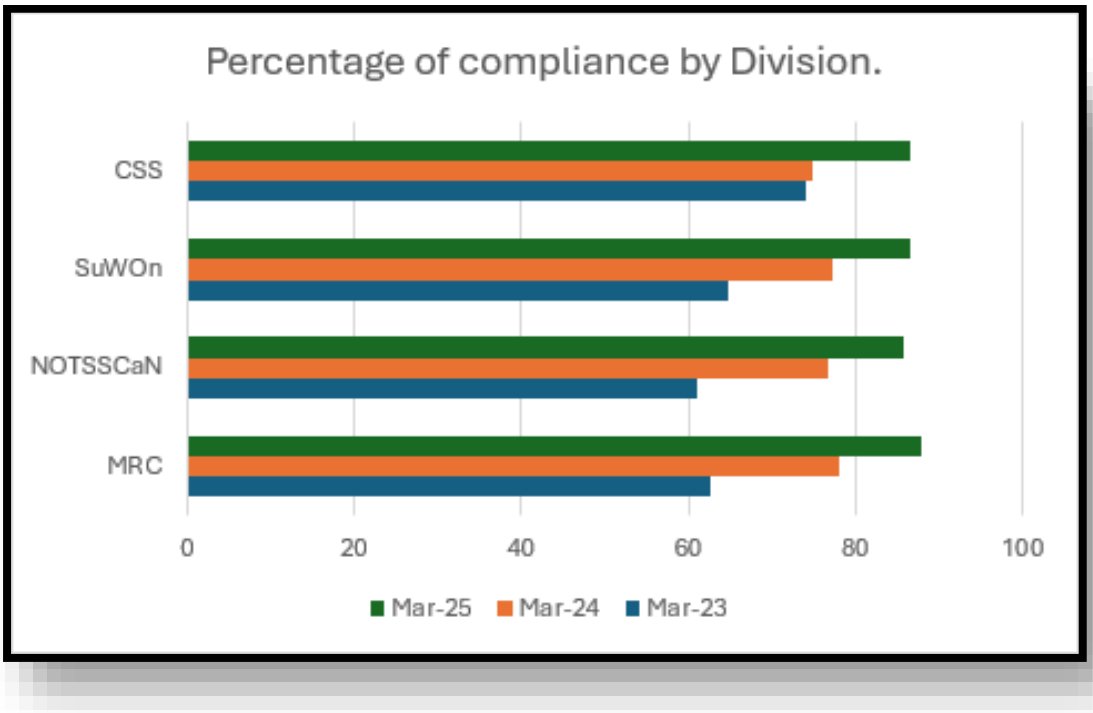
Feedback to staff

Compliance figures for the VTE Prevention and Anticoagulation 'My Learning Hub' packages continue to be sent by the subject matter expert (SME) quarterly to clinical risk practitioners and Divisional leads. A target of 85% compliance has been agreed and since the introduction of role specific skills in My Learning Hub (which are mandatory) there has been a gradual improvement within all Divisions. See Figure 34 showing the increase in training compliance by Division.

The VTE prevention team continue to provide VTE education and training for the preceptorship training programme, health care support workers, post graduate advanced perioperative care course, mechanical thromboprophylaxis and teaching in clinical areas as requested.

We have recently been invited to teach on the International Bridging Programme in collaboration with the Anticoagulation team; we provide education and training for the Resident Doctor's induction and hold thrombosis education days.

Figure 34: Percentage of staff by clinical Division who have completed the VTE e-learning by the end of each financial year



Patient Education

The VTE Prevention and Anticoagulation teams worked in collaboration with Thrombosis UK to develop and launch a national UK patient information VTE App offering information to those at risk of VTE and those diagnosed with a VTE event. The App was launched in the Houses of Parliament at the VTE Awards in November 2023. OUH has submitted an application to the VTE Awards 2025 which celebrate outstanding practice across healthcare services to prevent, and embed effective management of, VTE.

Research

The Thrombosis Research team has been collaborating with the NIHR trial examining the benefit of graduated compression stockings in the prevention of venous thromboembolism in low-risk surgical patients. The Trust was the second highest recruiters to the large national study with a multicentre randomised controlled trail (PETS Trial) of 913 patients.

Anticoagulation Inpatient Safety

With a new Consultant lead supporting the anticoagulation pharmacists and the Anticoagulation Inpatient Safety Nurse we have worked on the following safety projects in 2024.

Andexanet Roll Out

After gaining Trust Board approval for the use of this high-cost medicine in line with NICE Guidelines, the team worked to ensure a safe and cost-effective rollout. This included providing education to various multidisciplinary teams in high use areas such as the Emergency Department, Gastroenterology, Endoscopy and Acute General Medicine. Pharmacy teams were also provided with training to ensure a safe and efficient supply to ward areas for this time critical medication.

EPR and Carevue

Working with the EPR and Carevue[10] teams to provide a powerplan for safe prescribing along with an appropriate use sign-off form and a notification of prescribing to the team EPR pool, allowing for audit of safe and effective use of this high-cost medication. The team can review the patients in real time and offer support to ward teams if required.

Medicines Safety Group

The team continues with its involvement in the Medicines Safety Group with the sub-group of Anticoagulation Safety, which works with specific ward areas to address local issues in relation to anticoagulation. These include:

- Gastroenterology for the safe use of Direct Oral Anticoagulants (DOACs) in bowel resection patients
- Surgical Emergency Unit for the safe management of anticoagulation during admission.

[10] A digital system used for clinical workflow.

- Cardiothoracic Team for the safe use of anticoagulation post valve surgery- the third phase of our Cardiac QIP to review current evidence and management to create a Standard Operating Procedure (SOP) for ward areas, pharmacists and outpatient anticoagulation services to follow.

This project work will continue into 2025.

Trustwide Projects:

Audit of bleeding on anticoagulation

This included an audit of patients requiring reversal of anticoagulation, looking for common themes that may have contributed to a bleeding risk. These themes were then used to create a dynamic worklist to enable our Pharmacy team to review the most high-risk patients on anticoagulation to ensure medication was prescribed appropriately and that measures were in place to reduce bleeding risk. This work continues into 2025 with an audit of patients with bleeding on DOACs which focuses on appropriate reintroduction of anticoagulation following a bleeding event.

Quality Improvement Project to improve the documentation of an accurate measured weight in EPR

Following incidents of patients experiencing a HAT or bleeding event related to inaccurate estimated weight documentation; the team proposed a project to the emerging leader's group in 2025 to improve documentation of a measured weight and review of any weight dependent medication prescriptions in EPR.

Thrombosis Clinic Referral Audit

Following incidents where patients inappropriately stopped or continued their anticoagulation medication, the team audited referrals and follow-ups to the 3-month review Thrombosis Clinic. This showed that declined referrals were not being appropriately followed up by the referring team, leading to miscommunication with patients and primary care services. This led to a review of the referral pro-forma and a Trustwide safety message. Following these interventions this will be re-audited in 2025.

DVT Clinic and Outpatient Anticoagulation Service

DVT diagnostic pathway

The Oxfordshire DVT Service introduced a new diagnostic pathway on 31 March 2025 aimed at streamlining the service and improving the time from referral to investigation. Recent published evidence from Canada supports an amended diagnostic pathway which allows for a 47% relative reduction in ultrasound scans, while maintaining an >99% negative predictive value. A large validation study using retrospective Oxford data replicated the results of the Canadian study and suggested that one DVT would be missed for every 167 scans saved. The new pathway represents a derogation from NICE Guidance so was presented to Trust Board in March for approval and was approved for use on the basis of rigorous audit after six months' use, and strict patient safety netting. This new pathway will reduce the number of

first and repeat ultrasound scans required in patients with clinically suspected DVT, while maintaining a very similar level of diagnostic accuracy (>99% negative predictive value) and reducing waiting time for patients given that demand for the service consistently outnumbers availability.

Oxfordshire Point of Care (POC) service

The Oxfordshire POC service has three elements.

Home visit service

The Anticoagulation Service provides a POC home visit service for patients who are housebound, difficult to bleed, and/or are unsuitable for anticoagulants other than vitamin K antagonists. This service began during the COVID-19 pandemic and was successful in supporting the growing number of very complex patients on anticoagulation, and as such has been continued with great success.

District Nurse liaison project

The Anticoagulation Service has been working closely with the Oxfordshire District Nursing team to apply for funding from the Integrated Care Board (ICB) for a stock of POC machines which can be provided to patients who receive District Nurse visits for INRs[11], in order to give patients control and ownership of their anticoagulation management, and to enhance District Nurse capacity for their growing workload. The application was successful, and the Anticoagulation team is working with the District Nursing team to roll the project out, allocating machines to patients post triage and review (as to suitability for self-testing and suitability for a change to a DOAC) and coordinating training to use the machines, as well as ongoing support with machine calibration.

Oxford Hospitals Charity project

The Anticoagulation Service was successful in obtaining funding from Oxford Hospitals Charity for 50 POC devices called ‘coaguchecks’ which can be given to patients who are otherwise unable to fund their own machines. The service is allocating these machines based on need and eligibility. The team is providing training and ongoing device support and calibration and following up the patients to measure and collect impact data.

[11] INR, or International Normalized Ratio, is a blood test that measures how quickly your blood clots, particularly important for people taking the anticoagulant medication Warfarin.

Infection Prevention and Control

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

- OUH has a process in place for collating data on *C. difficile* and *Methicillin resistant Staphylococcus aureus* (*MRSA*) cases.
- Data are collated internally and submitted daily to the UK Health Security Agency (UKHSA).

Each year NHS England assigns the Trust a threshold for healthcare-associated *Clostridioides difficile* (*C. difficile*) infection cases, and *Escherichia coli* (*E. coli*), *Klebsiella* species and *Pseudomonas aeruginosa* bacteraemia cases.

The national contract threshold for OUH-apportioned cases of *C. difficile* for 2024/25 has been uplifted by 20 cases following a change in the definition of healthcare-associated cases to include cases from 'decision to admit' – an increase in healthcare-associated cases is therefore anticipated.

There is no threshold for *Methicillin sensitive Staphylococcus aureus* (*MSSA*), and there remains zero tolerance for *MRSA*. These data are reported to the UK Health Security Agency (UKHSA) as part of mandatory surveillance.

The trajectories set for healthcare-associated *C. difficile* cases and *MRSA*, *E. coli*, *Pseudomonas aeruginosa* and *Klebsiella* species bacteraemia have all been exceeded this year. There has been a reduction in healthcare-associated *MSSA* bacteraemia cases.

Clostridioides difficile *(C. difficile)*

The threshold for OUH-apportioned cases of *C. difficile* for 2024/25 was set by NHSE at 123 cases. At the end of March 2025, the Trust is reporting a total of 164 healthcare-associated cases (hospital onset, healthcare associated (HOHA), and community onset healthcare associated (COHA)).

Figure 35: Statistical Process Control (SPC) chart of OUH apportioned *C.difficile* infection counts (black line is rolling average, red line is UKHSA trajectory)

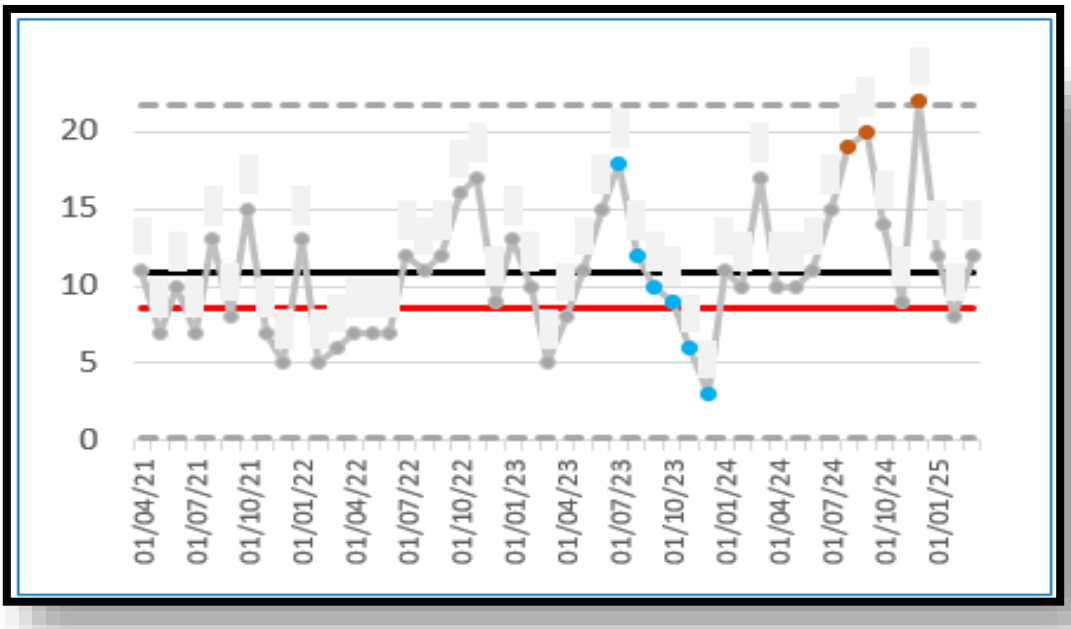
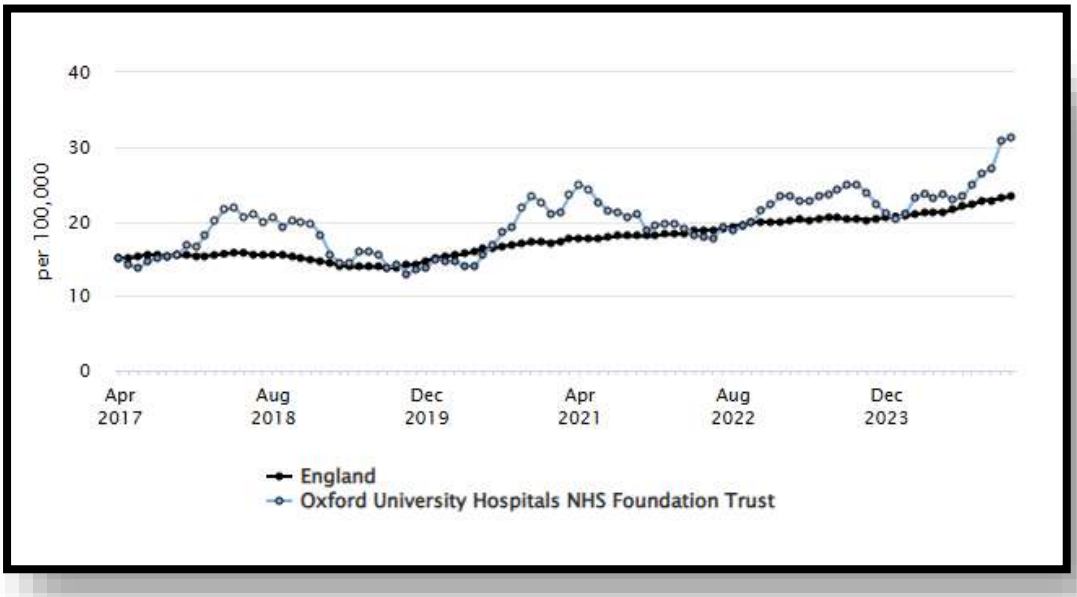


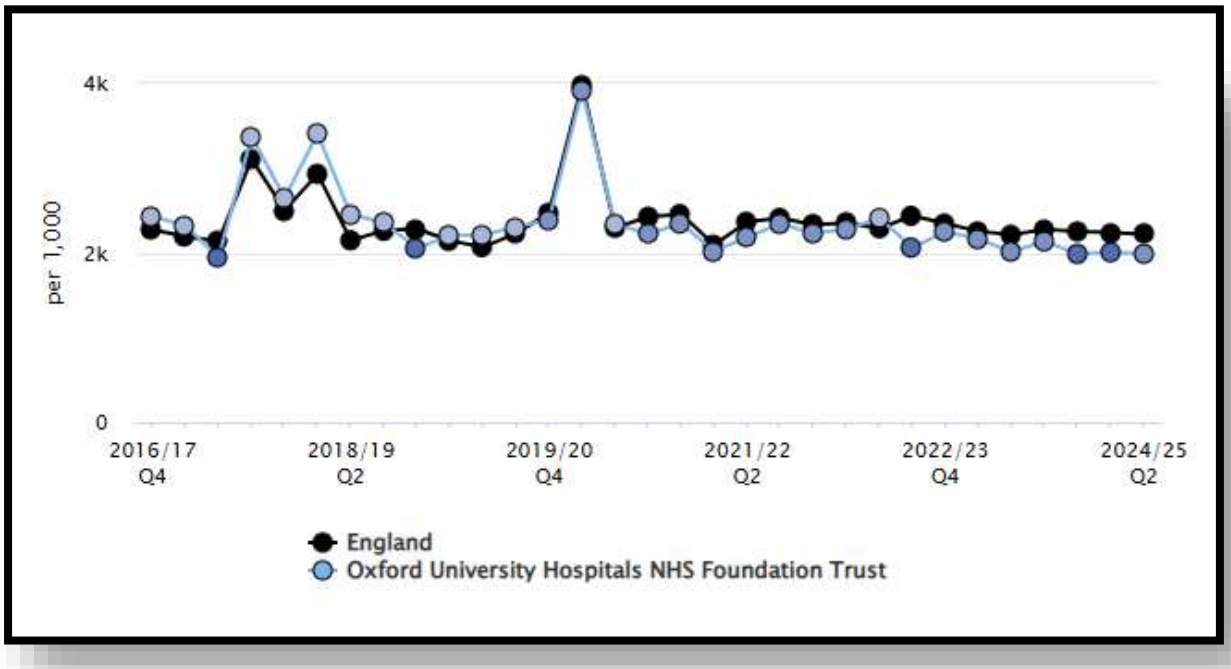
Figure 36: *C. difficile* infection 12-month rolling case counts and rates of hospital onset[12]



[12]Data source for Figures 10-15 AMR local indicators - produced by the UKHSA | Fingertips | Department of Health and Social Care

One of the major modifiable risk factors to reduce *C. difficile* infection is antibiotic use in general, and certain antibiotics in particular. OUH 2024/25 prescribing data shows a reduction in overall antibiotic use, and in the use of particular antibiotics predisposing to *C. difficile*, including a reduction in 'Watch' and 'Reserve' antibiotics as per the National Standard Contract and in comparison, with other English Trusts.

Figure 37: Antibiotic prescribing from the 'Watch' and 'Reserve' categories of the nationally adapted World Health Organization (WHO) AWaRe[13] index; DDDs per1,000



Gram negative bloodstream infections

There are no clear themes or interventions to reduce the rate of Gram-negative bloodstream infections in secondary care.

The changes in patient demographics with an aging population (18.6% of the total population was aged 65 years or older in the 2021 census compared with 16.4% at the time of the previous census in 2011), and more people at risk because of comorbidity or treatment such as immunosuppression, are likely to contribute to the increase.

An example of our data for *E. coli* and *Klebsiella spp*. against national rates is shown below.

[13] AWaRe - Access Watch and Reserve.

Figure 38: *E. coli* bacteraemia 12-month rolling case counts and rates of hospital onset

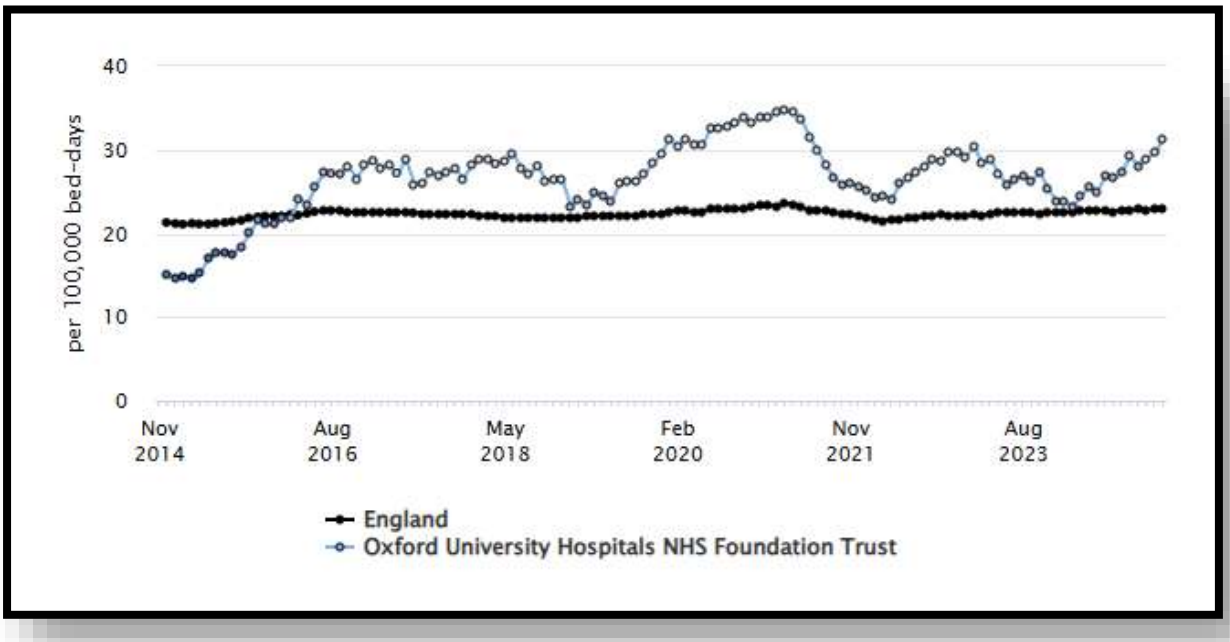
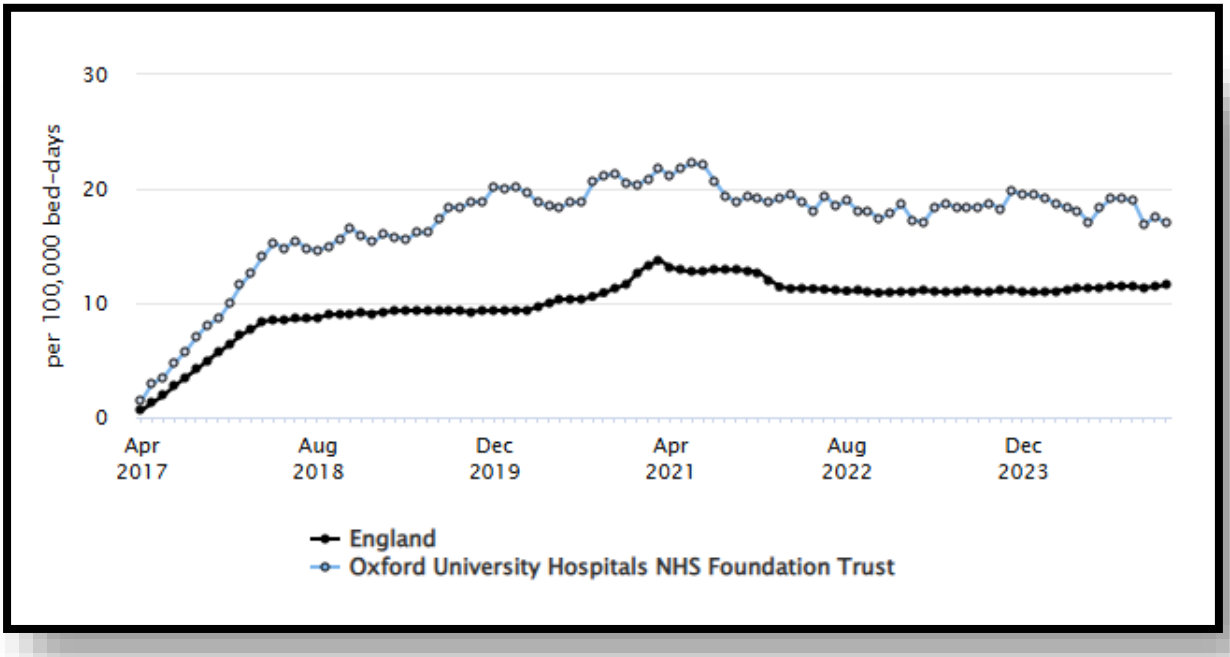
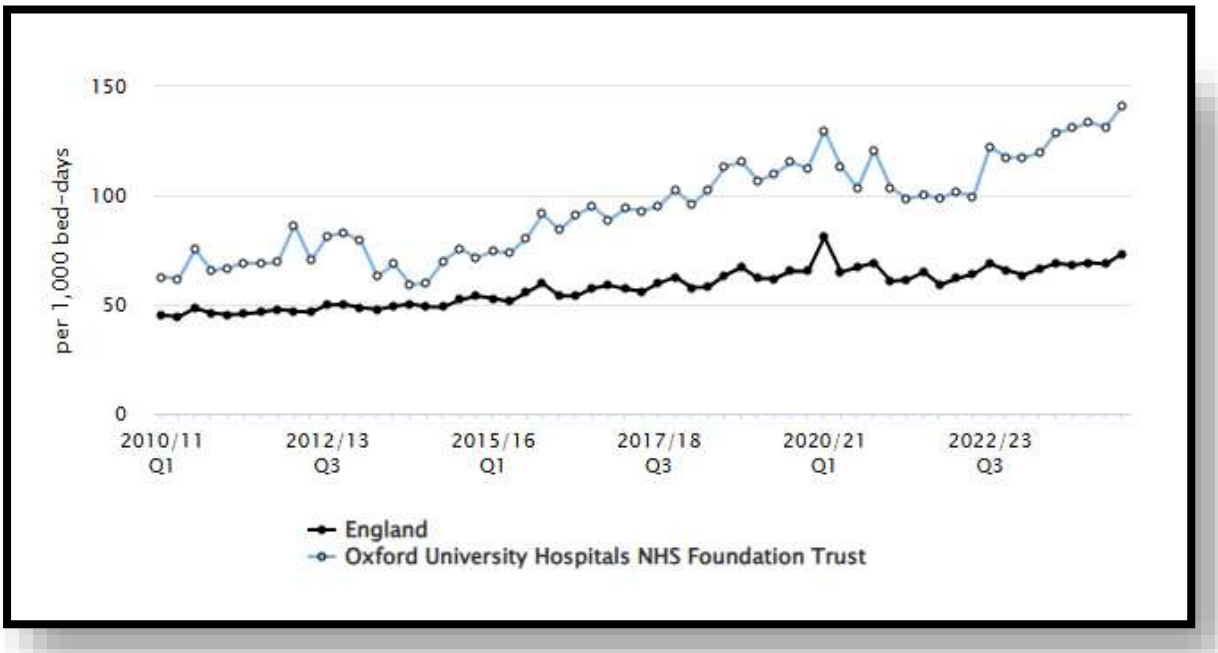


Figure 39: *Klebsiella spp*. bacteraemia 12-month rolling case counts and rates of hospital onset



The OUH is a positive outlier for the number of blood cultures taken per 1,000 bed days. This may contribute to our higher-than-average rates of Gram negative bacteraemia as we have good ascertainment.

Figure 40: Blood culture sets per 1,000 bed-days performed

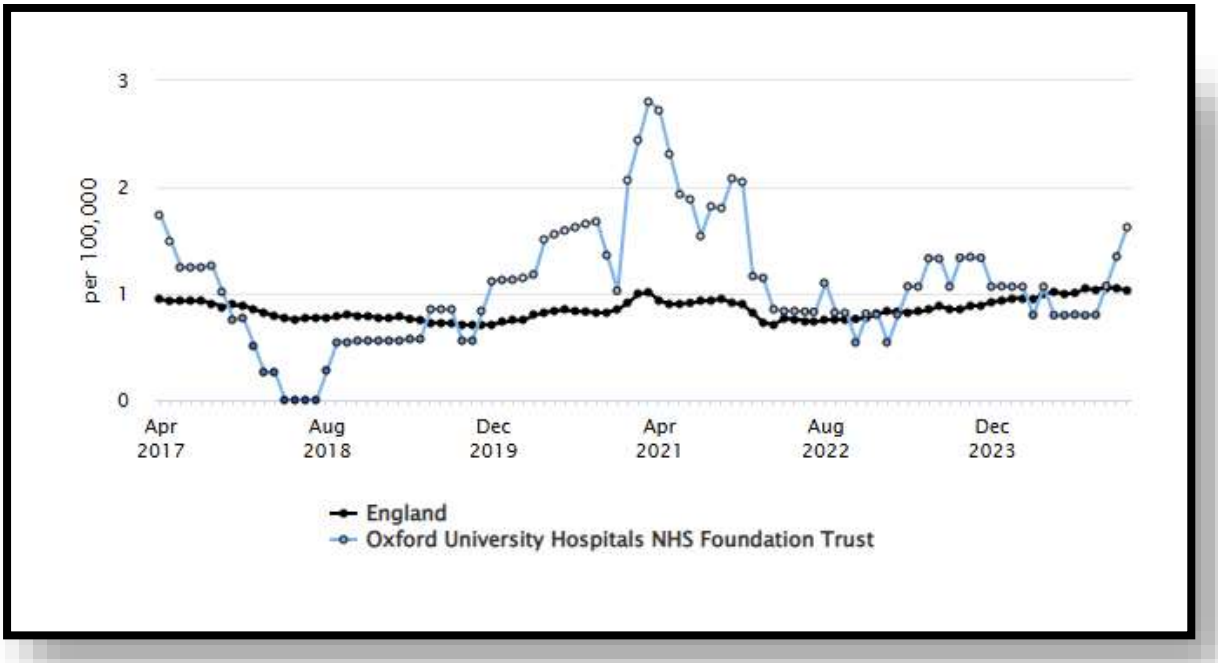


Methicillin-resistant Staphylococcus Aureus (*MRSA*) bacteraemia

For the financial year 2024/25, at the end of March there were eight HOHA and three COHA cases in OUH (for 2022/23 there were four HOHA and two COHA cases).

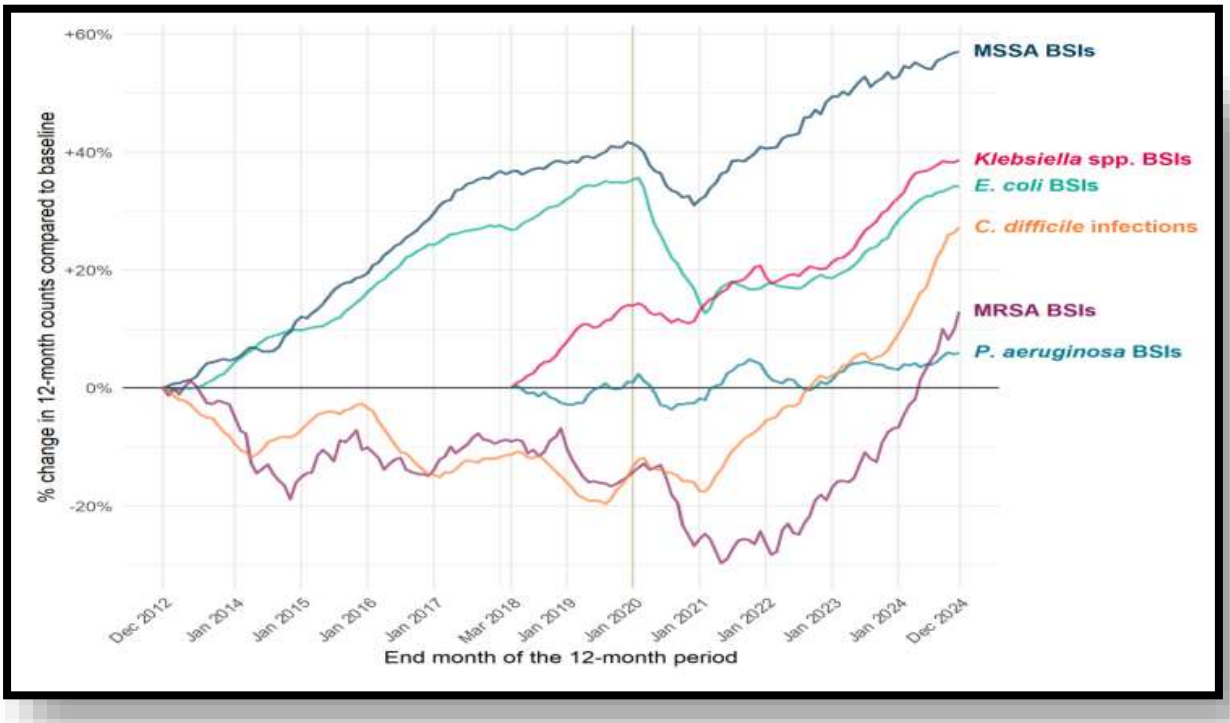
All cases undergo a root cause analysis where learning and preventable actions, if any, are identified.

Figure 41: *MRSA* bacteraemia 12-month rolling case counts and rates of hospital onset



All these figures need to be viewed in the context of a national increase in all organisms subject to mandatory surveillance. The national data show an increase in hospital onset cases of both *C. difficile* infection and *MRSA* bacteraemia approaching 40% since 2019/20. The reason for these increases is not fully understood locally or nationally.

Figure 42: Percentage change in national rates of organisms subject to mandatory surveillance (data up to date to January 2025)

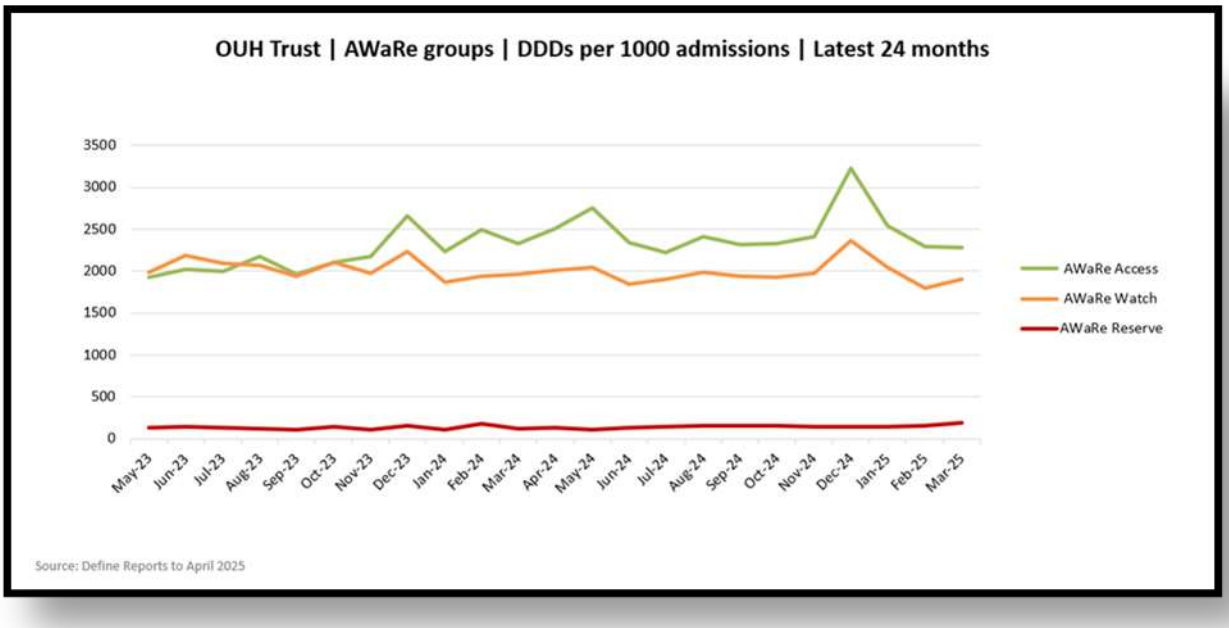


Antimicrobial Stewardship

- Antimicrobial resistance is a global public health threat, and the UK has responded to this global campaign with a series of National Action Plans (NAP) and national surveillance of antimicrobial resistance patterns with key aims around reduction of inappropriate antibiotic use, specifically broad-spectrum antibiotics.
- The WHO categorised antibiotics into three broad groups ('AWaRe') based on their spectrum, anticipated risk of resistance development, risk of toxicity, and risk of causing healthcare-associated infection such as *Clostridioides difficile Infection* (CDI). The UK uses a modified version of the WHO list.
- The target specified within the UK NAP, 'Confronting antimicrobial resistance 2024 to 2029' includes achieving 70% of total use of antibiotics from the 'Access' category across the human healthcare system. To support this, as well as the broader stewardship agenda, the Antimicrobial Stewardship (AMS) team identifies and implements initiatives to increase the use of 'Access' antibiotics and reduce 'non-access' antibiotic use (i.e. 'Watch' and 'Reserve' antibiotics).

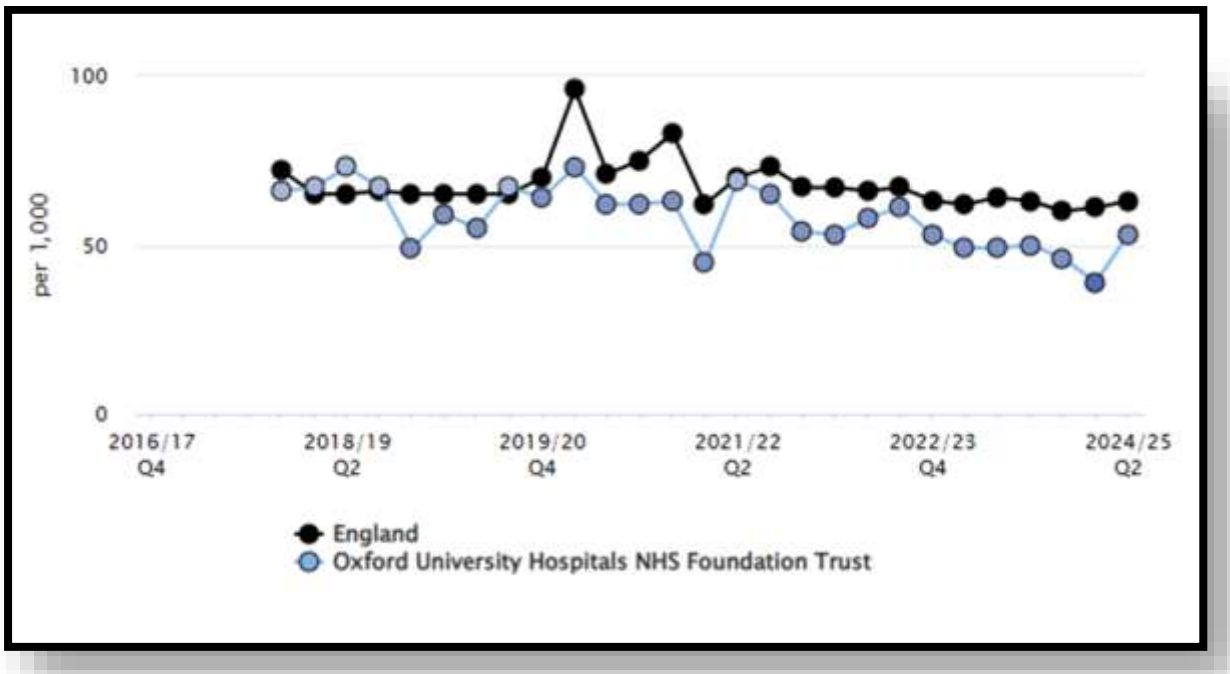
- Internal monitoring of the consumption of antibiotics in the AWaRe classification (adapted) is shown in Figure 43. This is presented as antibiotic consumption for each AWaRe category expressed as Defined Daily Doses (DDDs) per 1,000 admissions. The plot shows variation in consumption of 'Watch' and 'Access' but similar usage of 'Reserve' antibiotics over time. The plot shows an increase in use of 'Access' antibiotics over time.

Figure 43: Antibiotic consumption for each AWaRe category expressed as Defined Daily Doses (DDDs) per 1,000 admissions



- Considering the 'Watch' and 'Reserve' categories, the usage within OUH is less than the England average value and follows a similar trajectory to the England trend.
- Carbapenems are 'Reserve' broad spectrum antibiotics. Infections caused by organisms resistant to carbapenems have high mortality hence there is a global priority to reduce inappropriate exposure to carbapenems. Carbapenem usage continues to be a key indicator monitored by UK Health Security Agency (UKHSA). The AMS team undertake activities to optimise the use of carbapenems and Department of Health data (Figure 44 below) shows that OUH use remains below the England average.

Figure 44: Carbapenem consumption per 1,000 admissions



- Another target in the NAP is to reduce total antibiotic use in human populations by 5% from a 2019 baseline. To support reduction in total antibiotic consumption as well as increasing the proportion of those used to be 'Access' antibiotics, a coordinated multidisciplinary programme is required that promotes the appropriate use of antimicrobials. The AMS programme involves many activities which aim to achieve optimal antimicrobial use.
- A key initiative is AMS multidisciplinary team (MDT) ward rounds. These are conducted on all sites for adults and paediatrics on a weekly basis and consist of AMS pharmacists, an AMS Advanced Clinical Practitioner (ACP) and infectious diseases clinicians to review patients on broad spectrum antibiotics. During each AMS MDT ward round interventions are made. The nature of the intervention is recorded and the AMS ACP follows up to assess if the recommended intervention has been actioned.
- The AMS ward rounds were started in 2021 and the number of rounds has increased over time. In 2024 a paper was published in the Journal of Infection showing that OUH multidisciplinary AMS ward rounds (between September 2021 to December 2022) reduced antibiotic use and likely reduced length of hospital stay. Senior clinician input and more AMS experience increased advice uptake. Following advice to de-escalate / stop antimicrobials was associated with a 0.58 day [95%CI 0.22-0.94] reduction in hospital stay.[14]

[14] Eyre D W *et al*. The impact of antimicrobial stewardship ward rounds on antimicrobial use and predictors of advice, uptake, and outcomes. Journal of Infection. 2025. Volume 90. Issue 2. doi.org/10.1016/j.jinf.2025.106419

- During 2024/25 there were 344 AMS ward rounds, adults and paediatrics, reviewing 4,726 patients, 5,183 prescriptions and 3,216 interventions. Ward rounds have provided opportunities for education of colleagues about AMS and have supported guideline reviews, local audits related to antimicrobials, and engagement from clinical teams with the AMS vision for OUH.
- Fluoroquinolones are associated with many MHRA[15] Drug Safety alerts related to serious and potentially irreversible adverse effects, including a high risk of *C. difficile* infection. To support the Trust priority of patient safety in July 2023 an AMS pharmacist-led review of patients prescribed fluoroquinolones was implemented. This approach has led to 561 fluoroquinolone prescriptions being reviewed, with 121 interventions being suggested e.g. antibiotic allergy clarification, switching to another antibiotic or stopping the fluroquinolone. The AMS team presented two posters related to this work at the European Society of Clinical Microbiology and Infectious Diseases (ESCMID) conference in April 2025 with positive feedback.
- The AMS team continues to strive to optimise antimicrobial prescribing and look for innovative ways to use data to support targeted interventions and inform behaviour changes to improve patient outcomes.

[15] MHRA - Medicines and Healthcare products Regulatory Agency regulates medicines, medical devices and blood components for transfusion in the UK.

Patient Reported Outcome Measures (PROMs)

Patient Reported Outcome Measures (PROMs) are used to ascertain the outcome following planned inpatient surgery for the procedures of hip and knee replacement. Patients are asked to complete a questionnaire before and after their surgery to self-assess improvements in health from the treatment, rather than using scoring systems or judgements made by the treating clinicians.

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

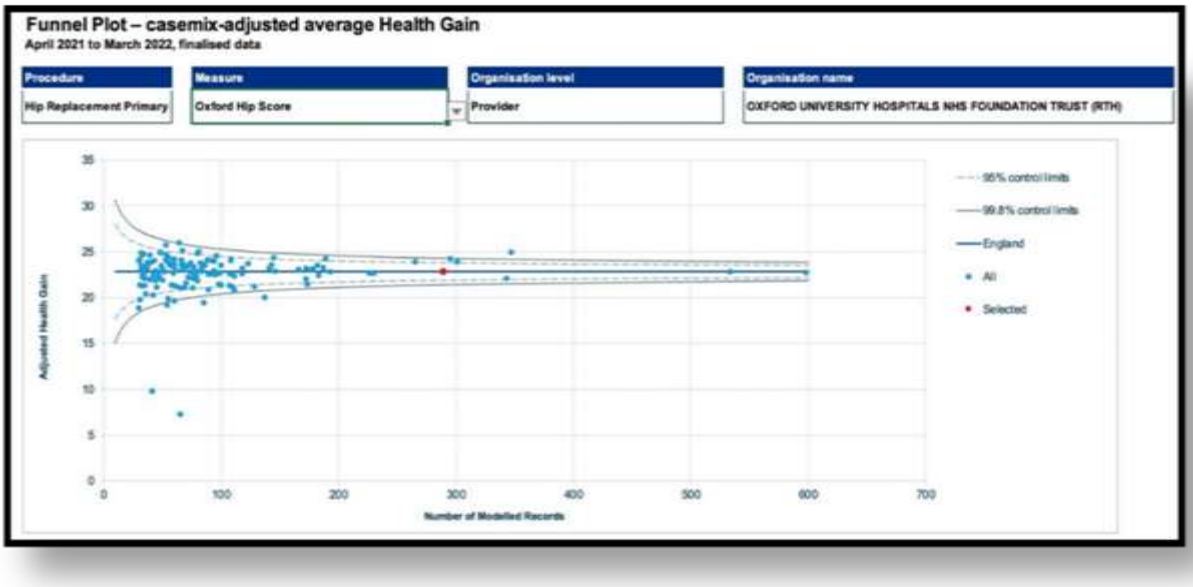
- The Trust has a process in place for collating data on patient reported outcomes.
- Data are then sent to the approved external company monthly which collates the PROMs responses and sends these to NHS Digital.
- Data are compared to peers, highest and lowest performers, and our own previous performance, as set out in the Figures 45 and 46.

The data supplied have a delay of approximately three years, consequently the Figures shown are from April 2021 to March 2022.

Total hip replacement

Healthcare gain for primary hip replacement performed at OUH is within the acceptable range.

Figure 45: Oxford Hip Score



Patients are asked to complete a questionnaire before their hip replacement procedure, and again six months afterwards (to allow patients enough time to recover from the procedure). The difference between pre- and postoperative scores is the patient's self-reported health gain or improvement in health.

Total knee replacement

Healthcare gain for primary knee replacement performed at OUH is within the acceptable range.

Figure 46: Oxford Knee Score

- 97% of respondents reported improvement for hip replacements.
- 94% of respondents reported an improvement for knee replacements.
- At least 90% of respondents felt better after their operation.
- Most patients thought the results of their operation were excellent, very good or good (93% of hip replacement patients and 87% of knee replacement patients).
- The latest participation rates were as follows:
    - 147% for hip.
    - 205% for knee.

In some cases, the participation rate figure can be over 100%. If this is the case, it may reflect an increase in clinical activity over and above that recorded by Hospital Episode Statistics (HES). There could be a variety of reasons for this, e.g. an increase in referrals; or bringing in house activity that was formerly attributed to independent hospitals.

The Trust takes the following actions to improve the PROMs, and so the quality of its services.

- The Orthopaedics Directorate reviews the PROMs responses and presents its review to the Trust's Clinical Improvement Committee (CIC).
- If there are negative responses identified in the PROMs returns, these are reviewed by the Orthopaedic s Directorate to determine if actions are required. The actions are monitored by the Directorate Clinical Governance team.

Emergency readmissions within 28 days of discharge from hospital

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

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

The most up-to-date data on readmissions within 28 days of discharge are provided by Dr Foster. For November 2023 to October 2024, the rate was 10.9% for children and adults. The Trust considers these data are as described for the following reasons.

- The Trust has a process in place for collating data on hospital admissions, from which the readmissions indicator is derived.
- Data are collected internally and then submitted monthly to NHS Digital via the SUS. The data are then used to calculate readmission rates.
- NHS Digital develops the SUS data into Hospital Episode Statistics (HES).
- Dr Foster takes an extract from HES data to provide benchmarked clinical outcome data.
- Data are compared to peers, highest and lowest performers, and our own previous performance.

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

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

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

Patient Experience

The Trust is fully committed to putting patients, carers and families at the heart of everything that we do. We aim to provide timely, compassionate and inclusive access to services, care and treatment. We want to ensure that our patients' thoughts and observations about their care and treatment are heard. The Trust collects information about patient experience through several formal and informal mechanisms, including: the Friends and Family Test, Healthwatch Oxfordshire, the National NHS Patient Survey Programme, Patient Stories, Patient Participation Groups (PPGs), ad hoc surveys and a dedicated patient feedback email. All feedback is sent to the relevant clinical service area and helps to drive quality improvement.

The drive for continuous improvement in our services to our patients, their friends and family is underpinned by the Trust Values of Learning, Respect, Delivery, Excellence, Compassion and Improvement.

The Trust takes part in the CQC National Survey programme. The Inpatient, Emergency Department, Maternity and Children and Young People's Survey surveys have been undertaken this year. The Divisions and corporate teams have used feedback from the surveys and Friends and Family Test (FFT) to monitor the quality and patient experience of food in the soft facilities management contract.

The Trust undertook the national Patient Led Assessment of the Care Environment (PLACE) in October 2024. 71 assessments took place across the Trust sites, and included communal and external areas, meal services, wards and outpatient departments. Overall, the assessors found the Trust to be clean and the environment well cared for, and they were confident in the environment providing a good experience of patient care. The 2024 results were a considerable improvement compared to the results in 2023, supported by a Trustwide PLACE Delivery Group to drive improvements.

The Shared Decision-Making project following the national CQUIN project focused on the Medialisation Clinic (run by the Ear, Nose and Throat [ENT] department and associated with voice and swallowing) and reviewed the extent to which patients supported by this clinic felt included in key decisions about their treatment and care. This was undertaken using the Shared Decision-Making Questionnaire 9 (SDMQ-9) and showed that patients felt involved and included in decision-making. We added the qualitative question 'What Matters To You?' at the end of the SDMQ-9, which gave rich and valuable feedback including the importance of partnership, family involvement, person-centred healthcare and the compassion of the team's healthcare professionals. This approach also introduced the team to a patient and family who, based on giving their narrative feedback in the What Matters To You? question, shared their healthcare story at Trust Board on 11 September 2024 and the Allied Health Professional Conference on 14 October 2024.

Patient Involvement

The Trust is dedicated to strengthening the involvement and inclusion of patients in evaluating and developing services. Examples of this include the following.

A model for recruiting Experts by Experience into Trust projects has been trialled and confirmed. This approach has then been used to successfully recruit PLACE assessors, Equality Delivery System (EDS) Graders, the Patient Information Reading and Review Group and the Learning Disability Steering Group.

Following the previous year's successful trial of 'What matters to you?'[16] to find a practical way to strengthen the patient's voice at a local level, the team included the approach in the Visiting Policy, the Medialisation Clinic Shared Decision-Making Project, Postnatal Ward Improvement Project and the MRC patient Engagement Project.

Six patient stories were presented at the Trust Board meetings in public in May, July, September, November, January and March to share lived experience of receiving or delivering services. These stories included experience of the High Intensity Users service in the ED, collaboration between Diabetes services and a home support team to implement technology in Diabetes care, shared decision-making in the Medialisation Clinic, person-centred support to improve health and reduce the need for secondary healthcare, kindness in the Early Pregnancy Assessment Unit following a miscarriage and specialist trauma and Diabetes team intervention to avoid amputation of a patient's foot. These unscripted stories, presented by the patient, their relative or healthcare professional alongside the clinical team that looked after them, provide an opportunity for Trust Board to hear about healthcare from the patients' and families' perspectives and learn about joint problem-solving to improve individuals' healthcare.

Several Patient Safety Partners (PSPs) have been recruited to support the implementation of PSIRF. They are volunteers and work at all levels across the organisation. Their model of practice has developed into three areas of practice.

- Trust Committee Membership
- Project Team Membership
- Professional Curiosity

PSPs are members of key Trust committees including the Patient Safety and Effectiveness Committee, Clinical Governance Committee, Safety Learning and Improvement Conversation, Patient Experience and Family Carer Forum and Clinical Improvement Committee. The PSPs are also involved in the Falls Prevention Improvement Group, Healthcare Transition and Moving into Adult Services, Medication Delivery, PLACE Lite and the MRC Patient Engagement Project. The PSPs' professional curiosity involves following up and speaking with healthcare teams who have presented their work at the above

[16] What Matters To You? - wmty

committees. This approach enables the PSPs to influence change at a local level, for example, person-centred duty of candour letters, improving wayfinding signs across the hospitals, and person- and family-centred safety investigations.

The Patient Experience team continues to contribute to the weekly Inquests, Complaints, Claims, Safeguarding and Serious Incidents (ICCSSI) group giving a roundup of the weekly FFT feedback and has joined the Maternity Triangulation and Learning Conversation (TALC) forum.

The Friends and Family Test (FFT) has been adopted nationally across all aspects of NHS healthcare. All Trusts use the national NHS England recommended target to gauge patient satisfaction with their services; data for all NHS Trusts are published monthly. The Trust is delighted that, overall across the year, 184,764 responses were received.

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

Figure 47: Results from the OUH Friends and Family Test (FFT) survey April 2024 to March 2025

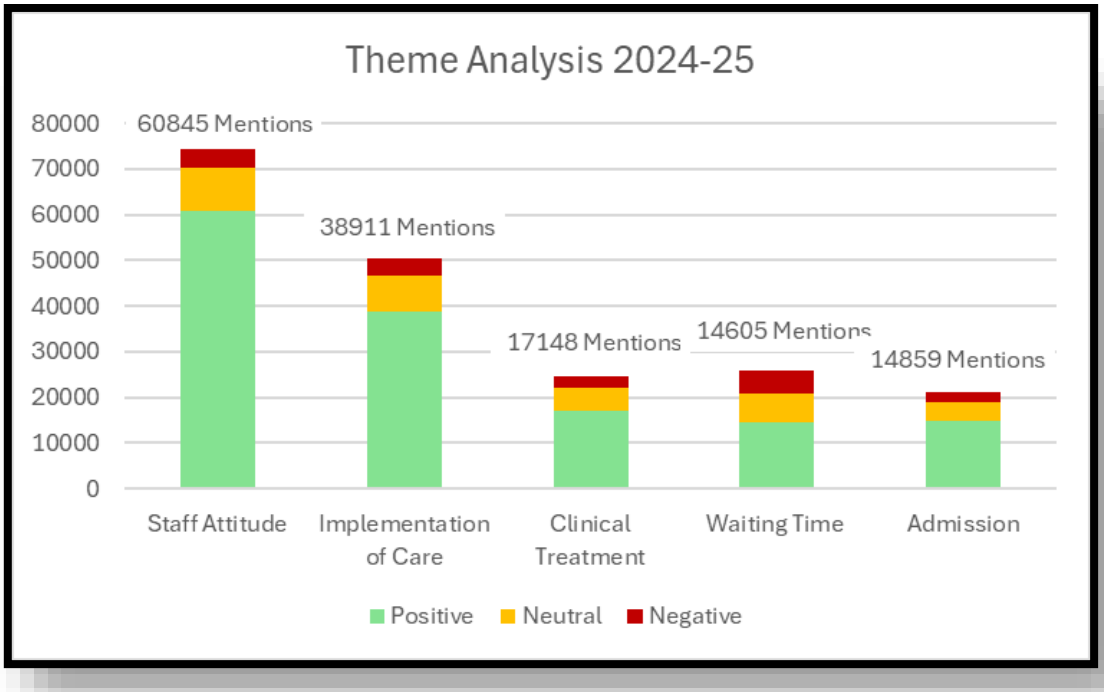
Service	Results
Inpatients and Day Cases	Based on 43,694 responses, 95% of patients rated their experience on their ward as very good or good.
Emergency Departments	Based on 18,137 responses, 80% of patients rated their experience within the Emergency Department as very good or good.
Outpatients	Based on 122,827 responses, 94% of outpatients rated their outpatient experience as very good or good.
Maternity	Based on 106 responses, 63% of women rated their experience of the Trust's Maternity Services as very good or good.

Figure 48: Trust's overall results from the FFT survey for 2024/25

April 2024 to February 2025	Very good	Good	Neither good nor bad	Poor	Very poor	Don't know
No. of responses overall	148,109	23,226	5553	3260	3711	905
Percentage	80%	13%	3%	2%	2%	0%

There have been 318,078 comments via the FFT throughout the year. Figure 49 below shows the mix of positive and negative sentiment among comments relating to the five most mentioned themes: Staff Attitude, Implementation of Care, Clinical Treatment, Waiting Time and Admission.

Figure 49: Mix of positive and negative sentiment among comments relating to the five most mentioned themes



The FFT data and information generated are submitted to NHS Digital as part of the national submissions programme.

The Patient Experience team is working on a project to develop an interactive dashboard which can be added to the new and improved Patient Experience SharePoint site. This will enable wards, Directorates and Divisions to analyse their own feedback in more detail to inform quality improvement projects to further improve patient experience.

NHS England Learning Disability Improvement Standards

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

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

Further information about the standards can be found on the NHS England website. OUH submits an annual self-assessment alongside accessible patient questionnaires and staff questionnaires.

The Trust supports people with learning disabilities through the Learning Disability Liaison Nurse team and availability of reasonable adjustments. The number of patients with a learning disability flag continues to increase.

The Trust formed a Trustwide Learning Disability Steering Group in recognition of the multidisciplinary collaboration required to improve care and services for people with learning disabilities. This group will be supported by 14 Experts by Experience all of whom have a learning disability or a relative with learning disability or autism.

Staff Experience

Staff recommendation of our hospitals to friends and family

Our 2024 Annual Staff Survey results relating to staff recommending our hospital to friends and family are as follows.

- 74.35% staff would be happy with the standard of care provided at OUH if a friend or relative needed treatment – the national average is 61.54%.
- 77.48% staff agree that care of patients is OUH's top priority – the national average is 74.42%.
- 61.74% staff would recommend OUH as a place to work – the national average is 60.90%.

Our People Plan

The People Plan 2022–25 sets out a vision that '*together we make OUH a great place to work where we feel we belong*' In 2024/25 the People and Communications Directorate has continued to deliver on the key elements of the People Plan including the following.

- The opening of changing rooms at the John Radcliffe Hospital providing new showers, toilets and changing facilities for our people. These facilities were co-funded by the Trust and the Oxford Hospitals Charity.
- The completion of the installation of outdoor gym equipment at the Churchill site which was the last of three outdoor gyms to be installed to provide staff exercise equipment close to our people's work environment.
- The Trust Wellbeing Service Leads (Occupational Health, Staff Support Service, Here for Health, Wellbeing Team, Oxford Hospitals Charity and Freedom to Speak Up) meet quarterly to ensure a connected holistic and wellbeing approach, where offers and resources are communicated out through a range of channels to our people.
- The Creating a Suitable Estates and Environments Enabling (CSEEE) Group continues to meet quarterly to provide a forum for our people to feedback on our Estates and escalate any issues that may have an impact on wellbeing.
- At the end of March 2025, 1,267 managers had fully completed the Leading with Kindness course for managers, with a further 1,515 part-way through the training. In addition, 1,844 members of staff have completed the Kindness into Action e-Learning for all staff.
- The Leadership and Talent Development team has continued delivering leadership development programmes. October 2023 saw the launch of the new Leadership Development Programme (LDP) for Matrons, Directorate Managers, nominated Clinical

Leads and new Clinical Directors. Four cohorts had completed this programme by December 2024, offering 100 places to our senior leaders. A programme evaluation and review with proposed next steps has been shared with the Trust management Executive (TME).

- We continue to develop our onboarding programme for new managers. Revised and updated resources include new pages around career conversations, additional resources and 'how to' guides, and training opportunities for managers.
- In September 2024 we launched the Better People Leaders Programme for developing inclusive leaders. This programme was designed for Governors, Non-Executive Directors (NEDs), Executive and Senior leaders. By the end of March 2025, 97 people had participated in the programme.
- We have established an Eradicating Bullying and Harassment Programme, the purpose of which is to tackle all forms of negative behaviours ranging from incivility to violence and aggression.
- We have delivered two parts of a 'No Excuses' campaign, that promotes behaviours in line with our Trust Values and advises staff how to raise complaints of discrimination and harassment.
- We have rolled out a Work in Confidence platform that enables all staff to raise Freedom to Speak Up concerns completely anonymously.
- There have been conference events for Black History Month, LGBT+ History Month, International Day for Persons with Disabilities, and International Women's Day.
- We have implemented initiatives that advance equality, such as increasing provision of breastfeeding and expressing spaces, mapping accessibility of Trust sites with AccessAble, and providing interview skills sessions for Black and Minority Ethnic (BME) staff.
- We launched a new Staff Recognition Strategy starting in 2024 with a new instant note of appreciation, enabling staff to recognise a colleague who has gone above and beyond by sending a short personalised instant message aligned to the Trust values. So far, we have had 6,852 staff send their note of appreciation to their colleagues. Our Annual Staff Recognition Awards this year received over 1,500 nominations. In April 2024 we launched a new platform for monthly recognition and over 351 nominations have been sent. From these monthly recognitions, staff have been invited to our new Quarterly recognition events, the first event being held in November 2024. Through these, an additional 41 staff members have been recognised.
- To help people have more focused training and development, a new section within the Values Based Appraisal (VBA) was created in the *My Personal Development Plan (PDP)* section. To support this a new career development site was also launched in May 2025;

this offers resources, training and guidance to help staff with career planning and development.

- The appraisal compliance rate for 2024 was 87.1%. Self-reported figures by staff as part of the Staff Survey 2024 gives a higher figure (94.41%) which will include any appraisals completed but for which completion was not formally recorded. This was the highest score nationally.

OUH performance with NHS Oversight Framework indicators

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

Figure 50: Performance against relevant indicators and national average

Indicator	Target	Target Performance 2024/25	Trust Performance 2023/24	Trust Performance 2022/23
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	≥92%	57.1%	57%	67%
Patients waiting for consultant-led treatment (RTT[1])	N/A	89,833	82,990	72,744
Patients waiting over 52 weeks (RTT[1])	<950	2,711	3,586	2,226
Patients waiting over 78 weeks (RTT[1])	0	15	80	59
Patients waiting over 104 weeks (RTT[1])	0	0	1	4
ED performance within 4 hours (all types)	≥78%	72%	65.1%	62.1%
62-day general standard	≥85%	60.6	63%	-
Diagnostic activity levels (elective)	N/A	254,800	240,545	227,990
Maximum 6-week wait for diagnostic procedures	≥95%	76.3%	83.6%	91.6%
C. difficile infection cases	123	164	130	124
Methicillin-resistant Staphylococcus aureus (*MRSA*) bacteraemia cases	0	11	6	4
Local priorities				
Venous thromboembolism risk assessment	>95%	Q1-3 (24 hrs) 98% Q4 (14hrs) 95%	97.9%	98.1%

Indicator	Target	Target Performance 2024/25	Trust Performance 2023/24	Trust Performance 2022/23
Hospital Acquired Pressure Ulcers (HAPUs) Category 3 per 10,000 bed days	<2.0	2.2	2.8	-
Hospital Acquired Pressure Ulcers (HAPUs) Category 4 per 10,000 bed days	0	3	2	-
Reported incidents of violence and aggression against staff[3]	0	2,192	1,708	1,366
Incidence of violence and aggression (rate per 10,000 bed days)	N/A	56.8	51.5	40.7
Results endorsed within 7 days	>85%	81.2%	82.5%	82.2%

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

Elective care

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

We successfully reduced the number of patients waiting more than two years to zero at the end of March 2025. Focused work has continued on reducing the number of patients waiting more than 65 weeks and 78 weeks; at the end of March 2025, there were 63 patients waiting over 65 weeks compared to 685 in March 2024, and 15 patients waiting over 78 weeks at the end of March 2025 compared to 80 in March 2024. We remain committed to further reducing the waiting times for patients requiring elective care.

Patients on a Referral to Treatment (RTT) waiting list at OUH increased by 9% from March 2024 to March 2025. In February 2025, OUH held the 14th largest incomplete waiting list nationally.

Contributing to the challenge of fully recovering the long waiting patients in 2024/25, was a group of specialty capacity constraints either due to pathway redesign, staff vacancies, national supply shortages or a greater volume of patients in the cohort, resulting in the reliance of elective recovery schemes and mutual aid on another qualified Provider.

Harm reviews continue to be performed digitally for patients waiting in excess of 52 weeks, to identify any psychological clinical harm arising from delays in line with the national e-prioritisation policy. Harm reviews are discussed in the monthly Harm Review Group (HRG). The harm reviews have allowed services to expedite treatment of patients as necessary. Where moderate or above impact has been confirmed at the HRG, these cases are reviewed

under the Patient Safety Incident Response Framework (PSIRF) to determine the best learning response.

In line with an agreed protocol, any cancer patient waiting more than 104 days for treatment also has a review conducted of potential for clinical harm from the delay. Details are reported to the Trust's HRG and then to the Patient Safety and Effectiveness Committee.

Emergency care

Performance within the ED, measured across the full year using the national standard for the percentage of patients attending the ED for less than four hours from arrival to admission, transfer or discharge, was 72.0% for 'all types', and 63.9% for 'type 1' attendances. 'Type 1' activity accounts for approximately 78% of patients at OUH and covers the Emergency Departments at the John Radcliffe and Horton General hospitals. 'All types' includes activity outside these settings that incorporate 'type 2' single specialty departments and 'type 3' Minor Injury Units.

ED performance improved compared to the previous year by 6.9 percentage points for 'all types' and by 5.1 percentage points for 'type 1'. ED performance was slightly below the national average for 'all types', which was 72.5% nationally in 2024/25 but better than the national average for 'type 1' attendances, which was 58.7% nationally in 2024/25.

Cancer treatment within 62 days

OUH cancer demand is significantly above pre-pandemic levels and continues to grow year-on-year (2024 vs 2025) by more than 10% cumulative. OUH delivered 77.9% for 28-day Faster Diagnosis Standard (FDS) at the end 2024/25, which is above the national target of 75% (in March 2025 the national target changed). The proportion of patients waiting more than 62 days at the end of March 2025 was 9.3%.

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

Diagnostic test within six weeks

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

The March 2025 diagnostic performance, against the standard measuring patients waiting within six weeks, was 76.3%. OUH was ranked below the national average. The Trust holds one of the largest waiting list volumes in the region and the Shelford Group. The main reason for not achieving a higher performance was a change in the national referral process to allow direct audiology referrals and for audiology to refer directly to ENT rather than via the GP. A recovery plan has been developed and implemented, with improving waiting times for patients in 2025/26.

Freedom to Speak Up (FtSU)

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

Where such issues are raised, they are generally addressed quickly and efficiently through our established processes as outlined in the Trust's Freedom to Speak Up – Raising Concerns (Whistleblowing) Policy. Under the terms of the Policy our Freedom to Speak Up (FtSU) Lead Guardian and other Freedom to Speak Up Guardians have a guardianship role in support of any employee who wishes to raise an issue of concern. Speaking up should be something that everyone does and is encouraged to do. Our Trust Policy is in date and currently aligns with the National Model Policy and National Guardian's Office recommendations, to ensure it fully supports this aim. The FtSU Lead Guardian presents an Annual Report to the Trust Management Executive (TME) and the Trust Board. We have a nominated Non-Executive Director responsible for Freedom to Speak Up so that speaking up is represented independently at Trust Board level. In addition, we have a nominated Executive Director lead for Freedom to Speak Up.

The purpose of the FtSU role is to work with all staff to support the organisation in becoming a more open and transparent place to work and where staff are encouraged and enabled to speak up safely.

Ensuring staff do not suffer detriment

Speaking up about any concern an employee has at work is important. In fact, it is vital because it will help the Trust to keep improving our services for all patients and the working environment for our staff. Staff may feel worried about raising a concern, and the Trust understands this, but this should not deter individuals from raising their concerns. In accordance with our duty of candour, our senior leaders and entire Board are committed to an open and honest culture. We will always ensure that concerns are appropriately considered, and staff will always have access to the support they need. The Trust will follow new guidance on detriment issued by the National Guardian Office in February 2025 to protect our staff, ensuring that members of staff who raise a concern under our Policy will not be at risk of losing their job or suffering any form of reprisal as a result. The Trust does not tolerate the harassment or victimisation of anyone raising a concern. Any such behaviour is a breach of the Trust Values and if upheld following investigation could result in disciplinary action.

Rota Gaps and the Plan for Improvement

Nationally, Resident Doctors represent 40% of the medical workforce. New Terms and Conditions of Service (TCS) were introduced for this group in 2016. The 2016 TCS include governance processes that require partnership working between Doctors in Training and their employing Trusts to ensure safe hours' working practices and to enable enhanced executive supervision of this group.

OUH has taken the following actions to ensure compliance with the 2016 TCS, and so the quality of its services.

- All Doctors in Training are provided with compliant 'Work Schedules' and an electronic process to report exceptions when there is variance to rostered hours.
- The Board receives quarterly and annual reports from the Guardian of Safe Working Hours. The Guardian's reports are informed by workforce data relating to the Doctors in Training as well as feedback from the Resident Doctors' Forum.

In September 2024, as part of the resolution of a long-running pay dispute, the term 'Junior Doctor' was officially replaced by 'Resident Doctor'. At OUH, there are approximately 1,400 Resident Doctors, including around 900 on national training programmes, alongside locally employed, university-employed, and military doctors. Although contract types differ, OUH has extended the safe working hour principles of the 2016 TCS to all Resident Doctors, to improve safe working oversight.

Nationally, exception reporting has not delivered its expected role in supporting safe working hour improvements. In response, a new national framework agreement was signed this year. While exception reporting remains a useful mechanism for individual compensation, the assurance is limited by limitations in the aggregate data. Due to concerns about the reliability of the data, exception data have been excluded from this year's report.

To address these challenges, we have done the following.

- Reconfigured the Medical Staffing team into two: a recruitment team and a team dedicated to supporting Resident Doctors.
- Established a multidisciplinary 'Improving Working Lives' group, which has improved management of fatigue and facilities funds and is responding to feedback on induction.
- Committed to reviewing and implementing recommendations from the new exception reporting framework.

Vacancy data were unavailable at a Trustwide level due to local variation in data collection. Locum shift data are presented below.

Figure 51: Number of locum shifts undertaken by bank and agency staff, broken down by quarter, and the reason for the locum shift

Locum shifts		2024			2025	Total
		Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	
Total		3,006	2,737	2,812	2,668	11,223
Agency		225	108	744	410	1,487
OUH Bank		2,781	2,629	2,068	2,258	9,736
Reason for locum shift	Vacancy	2,532	2,260	2,226	1,841	8,859
	Non-vacancy	474	477	586	827	2,364

OUH complies with the safe working hours framework for NHS doctors and dentists in training. However we acknowledge the need to improve the Assurance Framework. In line with this we are implementing a standardised process for collection and review of data relating to safe working hours at Divisional level. The Guardian of Safe Working Hours will assess how the Divisions support safe working hours to provide better oversight for the deployment of the resident doctor workforce and meet contractual requirements.

Annexe 1: Quality Priorities 2025/26

Patient Safety

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

Why is this a priority?

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

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

What we will do	How will you know the objective is completed and that it is working?
Objective 1 **(Q1)** **Monitoring and governance** • Establish a formal SEND Task and Finish Group responsible for overseeing this Quality Priority. This group will report to RAID committee and provide updates of these actions	• Agreement of Terms of Reference for the group • RAID[17] minutes will highlight progress

[17] RAID - Recognising the acutely ill and deteriorating patient.

What we will do	How will you know the objective is completed and that it is working?
Objective 2 **(Q1-3)** **Update and roll out education and policies** • Develop SEND online learning resources for (a) the documentation of observations using SEND; and (b) the use of SEND for monitoring observations (Q1-2) • Update current training materials and roll these out across the organisation supported by education colleagues • Update role-specific user guides • Include SEND in mandatory training for all clinical staff at induction and upload to My Learning Hub. The training undertaken will be appropriate to role and use of SEND (Q1-3) • Develop a Standard Operating Procedure (SOP) for the documentation of observations and escalation of concerns which links to the Recognising the Acutely Ill and Deteriorating Patient (RAID) Policy (Q1) • Update the RAID policy (Q1) • Adding the finalised SOP to the RAID Policy (Q1)	• SEND learning resources available on My Learning Hub (MLH) • SEND learning resources included in core clinical induction • Other training materials updated and available on intranet • SOP signed off, and on the intranet • RAID Policy finalised, and on the intranet • Increase in staff training compliance as reported by MLH • Improvement in reporting rates for equipment issues • Improved compliance with observation timeliness
Objective 3 **(Q1-3)** **Pilot and embed the use of SEND for clinical handovers** • Q1: Task and Finish Group to agree at least one initial clinical area(s) for the pilot	• Successful use of SEND at the pilot locations, no issues have been identified and staff are using and are engaged with its use • Audits will show that clinical handovers and RAID Huddles with SEND are used 80% of the time • Feedback from staff will be positive and any issues will be resolved • The Task and Finish Group and RAID are satisfied that the pilot and rollout to hospital at night team handovers has been

What we will do	How will you know the objective is completed and that it is working?
• Pilot for a period of 1-3 months; audit the use of SEND for handovers and as part of RAID Huddles • Following successful pilot, roll out to hospital at night team handovers Trustwide	successful based on feedback and audits and sign off on the rollout
Objective 4 **(Q1-4)** **Access and troubleshooting** • Provision and checking/maintenance of the required equipment (part of the Standard Work programme). This will be supported by the Clinical Engineering team • Embed clear processes to ensure ward staff can easily escalate to IM&T and Clinical Engineering any maintenance issues • Monitor the rollout of SEND devices to replace other models of machines • Ensure there is a clear and proactive process to issuing licences for staff	• Ticket turnaround time for SEND maintenance issues from ServiceNow • Monitor the device registry rollout to ensure up-to-date SEND devices are rolled out across all clinical areas (where appropriate)
Objective 5 **(Q1-4)** **Maintenance and sustainability** • Work with Digital Services to resolve any existing issues with the SEND platform • Work with Digital Services to examine the optimal resource necessary to provide robust technical support for the SEND platform	• User feedback shows improved user satisfaction with the SEND platform • Maintenance items are resolved in a timely fashion • An examination has taken place to show the longer-term sustainability of SEND, or another bedside observation workflow • Improvement in reporting rates for system issues

What we will do	How will you know the objective is completed and that it is working?
• Work with Digital Services to review options for long-term bedside mobile solutions • Develop a digital quarterly report to monitor issues with SEND devices. The quarterly report will be presented at the SEND working group for monitoring	• Improvement in the observation compliance rates • Improvement in cardiac arrest rates/2222 calls • Improvement in the metrics in the quarterly report showing fewer maintenance issues with SEND devices

Patient Safety

Quality Priority 2: Medicines Reconciliation

Why is this a priority?

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

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

What we will do	How will you know the objective is completed and that it is working?
Objective 1 **(Q1)** **Establish current baseline and ongoing monitoring** • Establish required dataset for measurement of improvement and cost avoidance by end of Month 1 • Establish regular KPIs, including monthly point prevalence audit on errors Identified at reconciliation as KPI and monthly point prevalence audit on patients who have not had admission reconciliation by point of reconciliation on discharge	• Key Performance Indicator (KPI) defined • Establish monthly point prevalence audit on errors identified at reconciliation • Establish monthly point prevalence audit on patients who have not had admission reconciliation by point of reconciliation on discharge (to take out (TTO)) • Estimate financial savings from avoidable harm ± reduced length of stay

Objective 2
(Q1)
Discover and Diagnose
	• Sharing of output e.g.
	  • Fishbone
	  • Driver Diagram
	  • Timed Observations

What we will do	How will you know the objective is completed and that it is working?
Discover and diagnose current barriers to performance at both admission and discharge using QI tools by end of month 2	• Process Map of current state • The wider teams understand the barriers to meeting KPI
Objective 3 **(Q2-3)** **Test ideas for improvement** • A minimum of two Plan-Do-Study-Act (PDSA) cycles and one testing improvement to be completed by end of Q2. Options dependent on QI scoping, but could include redefining responsibilities, embedding 12 noon huddles, GIRFT approach with clerking clinician engagement and robotic processing. Utilise learning for further PDSA cycles in Q3 • Improvement idea tested within high frequency admission area(s)	• Summary of learning from PDSA cycle(s) produced • There is a positive outcome from testing • There are incremental improvements in performance with each PDSA cycle
Objective 4 **(Q 1-3)** **Model capacity and demand with improvements in place** • Model capacity to meet demand (admissions and discharges), test impact of adjusted working patterns. Produce gap analysis and business case if needed to address shortfall via workforce and/or automation: by end of Q3	• Clear mapping of demand and optimal work patterns to meet this • Productivity and efficiency gains of 7 days service modelled • A business case has been produced (if required)
Objective 5 **(Q1-4)**	• 1.5% of completed consultant episodes referred (from hospital episode statistics (HES) data)

What we will do	How will you know the objective is completed and that it is working?
Facilitate community reconciliation on discharge • Embed PharmOutcomes referral tool within EPR to efficiently refer patients to community pharmacy on discharge	• There should be a reduction in readmissions: assessment against modelling, predicting 100 pa

Patient Safety

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

Why is this a priority?

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

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

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

What we will do	How will you know the objective is completed and that it is working?
Objective 1 **(Q1-4)** **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 • Q2: Change in trauma consultant rota to allow more flexibility to deliver extra lists • Q3: Review of demand and capacity following above changes and understanding opportunities from new theatre build if additional theatre capacity needed • Q4: Implement Geriatric Orthopaedics (GO) and anaesthetic review on day of admission • Q4: Expand to a 7-day trauma coordinator service	• Surge capacity procedure in place • New trauma consultant rota in place • Demand and capacity modelling available • Business case to deliver 7-day trauma coordinator service submitted to Business Planning Group (BPG) • The additional lists are being used to help with capacity • Data shows an increase in NAFF patients being operated on within 36 hours • Best Practice Tariff (BPT) criterion (a), time to theatre <36 hours, >85% performance • GO review on day of admission – target is 85% of patients seen on day of admission

What we will do	How will you know the objective is completed and that it is working?
Objective 2 **(Q1-4)** **Improving therapy access to NAFF fracture patients** • Q1-2: Develop a strong business case to allow 7-day access to therapy services • Q2-3: Appointment to expanded therapy posts following successful business case • Q4 Implementation of 7-day physiotherapy services to allow all fragility fracture patients to be mobilised on day or day after surgery	• Business case submitted to Business Planning Group • Improved NHFD metrics (KPI 4). Improved BPT criteria • Reduced acute length of stay • Q4: Improved NHFD key performance index 4. Prompt mobilisation after surgery: therapists seeing patients on the day or the day after surgery • There are fewer complaints about accessing therapy services following NAFF surgery • The acute length of stay has reduced, and patients are not being readmitted
Objective 3 **(Q1-3)** **Improving multi-specialty 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 preoperative reviews	• Daily MDT meeting in theatre • Workforce demand and capacity modelling completed • Business cases for trauma anaesthetist submitted to BPG • Data/questionnaires show that daily MDT meetings with theatre staff are occurring and that all staff groups feel that this teamwork has improved overall care for NAFF patients
Objective 4 **(Q1-4)**	• 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

What we will do	How will you know the objective is completed and that it is working?
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: 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 perioperative 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 – over 85% of patients are given a nerve block and admitted to an appropriate orthopaedic or orthogeriatric ward within four hours of presentation • The cohorting of NAFF patients is occurring and working well • That 'ringfenced' beds for NAFF patients are available and being used which aids with operating with 36 hours
Objective 5 **(Q1-4)** **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 Malnutrition Universal Screening Tool (MUST) compliance on NHFD (BPT criteria) • There is compliance with the MUST and there is no evidence of NAFF patients with nutritional issues (there may be unforeseen exceptions even with a completed MUST)

Clinical Effectiveness

Quality Priority 4: Standard Work

Why is this a priority?

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

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

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

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

What will we do?	How will you know the objective is completed and that it is working?
Objective 1 **(Q1-4)** **Embedding Practice** • Embed Standard Work (SW) approach in defined Core Priority Areas of Practice – 25/26 focus on *Board Rounds, Equipment Checking, Safe and Secure Storage of Medicines and Safety Huddles*	• Develop standard protocols collaboratively with frontline staff, support adoption of continuous improvement approach and digitisation of results at ward level across identified priorities (e.g. *Board Rounds, Equipment Checking, Safe and Secure Storage of Medicines and Safety Huddles*) • Capture lessons learnt and case study examples through 'big room' to share best practice, scale and spread • There will be a reduction in variation in practice across selected areas

What will we do?	How will you know the objective is completed and that it is working?
• By the end of 2025/26, Standard Work approach will be established in phase one priority areas, demonstrating 80% increase in adherence to defined standards as measured through regular audits	• Improvements in priority specific defined KPIs ***Board Rounds**:* • % compliance to Board Round Policy, including core and enhanced elements ***Equipment Checking**:* • % compliance of defined standards to check equipment ***Safe and Secure Storage of Medicines**:* • % increase in compliance measured through Safe and Secure Storage of Medicines audit ***Safety Huddles**:* • % clinical teams completing safety huddles in alignment with the policy
Objective 2 **(Q1-4)** **Materials** • Support Materials and Infrastructure for Wider Organisational Adoption of Standard Work	• Define and develop clear branding and approach to language to aid adoption and Trustwide engagement • Develop Standard Work resources toolkits tailored to organisational need, facilitating the optimisation of current portal for Standard Work for sharing resources wider than defined priority areas • Integrate approach into core Trust business within Divisions with governance enabling scale and spread • Toolkit and digital platform launched and actively used by staff • Inclusion of Standard Work in 80% of induction and training programmes • Increased uptake of resources, measured by at least 70% of targeted staff engaging with the toolkit and platform • Staff report increased confidence and ease in applying Standard Work practices

What will we do?	How will you know the objective is completed and that it is working?
Objective 3 **(Q1-4)** **Long-term strategy** • Define long-term approach to Trustwide adoption of Standard Work • Engage staff and stakeholders to co-design a long-term strategy post 2025/26, defining ongoing approach to scale up and integrate into OUH's strategic planning / Quality Management System	• Drafted and approved Trustwide roadmap with Divisional oversight framework • Evidence of measurable improvement in KPIs, e.g. safety, quality, efficiency and patient/staff experience metrics. Case studies sharing best practice to support further adoption

Clinical Effectiveness

Quality Priority 5: Outreach Service from Oxford Critical Care

Why is this a priority?

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

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

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

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

What will we do?	How will you know the objective is completed and that it is working?
Objective 1 **(Q1)** **Project Board set-up** • Develop a CCO Project Board • To include Martha's Rule	• Project board initiated with agreed terms of reference • Minutes from meetings • Project plan progressing • Actions are occurring from the Project Board

What will we do?	How will you know the objective is completed and that it is working?
Objective 2 **(Q1)** **GAP analysis** • GAP analysis for out of hours (OOH) medical and nursing escalation from wards • This will feed into the options appraisal / business case	• Completion of the GAP analysis
Objective 3 **(Q2-3)** **Options appraisals** • Four hospital site analysis for CCO needs to create options appraisal which will include options for 'do nothing', 'minimum investment / restructuring of available resources through to the most ambitious options – this will feed into the business case	• Completion of options appraisal
Objective 4 **(Q2-3)** **Communication** • Agreed communication escalation methods for CCO – Martha's Law / GAP analysis feedback – interim step overlaid to CCO • This may feed into the options and the business case	• Implementation and communication of the escalation process • Auditing will show if the escalation process is working effectively • The escalation will be working well, and staff will understand how to use it
Objective 5 **(Q3)** **Business case** • Business case submission for CCO based on options appraisal	• Successful submission of business case

What will we do?	How will you know the objective is completed and that it is working?
Objective 6 **(Q3-4)** **Implementation** • CCO implementation based on outcome of options appraisal and business case	• The OCC is in place as per the business case by end of Q4
Objective 7 **(Q1-4)** **Martha's Law** • Agree alignment of Martha's Law with CCO	• Process map with GA analysis for Martha's Law escalation • Communication strategy with resource allocation, potential alignment to the business case

Clinical Effectiveness

Quality Priority 6: Discharges

Why is this a priority?

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

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

What we will do	How will you know the objective is completed and that it is working?
Objective 1 **(Q1-3)** **Improve experience of continuity and quality of care for patients** • Establish a process for reviewing quality, safety and risk of discharge from hospital • Low threshold for picking up 'to take home' (TTO) related incidents, including those that are couriered via City Sprint • Contact Medicines Information team for data from patient contacts	• Availability and collation of internal and external information • Thematic analysis of internal themes as well as from system partners • Share internally to appropriate colleagues for awareness and action where needed • Close feedback loop to system partners. Increase patient satisfaction scores related to discharge communication by 15% • Positive feedback from patients and families regarding discharge communication within six months (questionnaires and friends and family tests) • There will be a 15% reduction in discharge-related complaints • Reduction in incidents regarding discharges

What we will do	How will you know the objective is completed and that it is working?
Objective 2 **(Q1-4)** **Improve and provide assurance of the safety of discharge from hospital** • Standardise discharge processes on departure from hospital • Implement a mandatory Discharge Safety Checklist within the 'depart' process in the electronic patient record (EPR); one specifically for adult inpatients and one for paediatric inpatients	• The Discharge Safety Checklist is on EPR for both adults and children • Completion rates of the Discharge Safety Checklist for both adult and paediatric inpatients • Achieve a 90% compliance rate with the new Discharge Safety Checklist within six months • Monthly audits showing increased compliance rates • Increase by 15% in positive feedback from patients and families regarding the discharge process • 15% reduction in discharge-related complaints and incidents
Objective 3 **(Q1-2)** **Provide clear communication to patients and unpaid carers to on discharge processes and follow up support** • Review and improve the clarity and comprehensiveness of discharge instructions for patients and their families • Discharge information leaflet a. Produce a discharge information leaflet for patients b. Publish a discharge information leaflet for patients c. Brief ward staff on the contents and embed its use	• Completion and adherence rates of the discharge communication protocol • The leaflet has been produced, is in circulation and staff know about it and use it • Reduced misunderstandings from staff/patients on discharge pathways and expectations • Staff feel empowered and prepared to answer questions relating to complex discharge from patients/relatives
Objective 4 **(Q1-4)** **Nurse, Midwife, Therapies and Allied Health Care Professionals (AHPs) led discharge opportunities**	• Integration of the guidelines into the electronic patient record (EPR) system • Training completion for all staff participating in criterion-led discharge criteria • Compliance reports showing adherence to the criterion-led discharge process

What we will do	How will you know the objective is completed and that it is working?
• Q1-2: Set up a scoping session to identify what is required and who can discharge patients • Q3-4: Once established, produce a Standard Operating Procedure (SOP) for nurse-led discharges • Develop and implement a criterion-led discharge process for Nurses, Midwives and AHPs • Q3-4: Train relevant nurses, midwives and AHP staff on the criterion-led discharge process	• Achieve a 90% compliance rate with the criterion-led discharge process within12 months • Reduction in length of stay once criterion-led discharges implemented • Positive feedback from patients and families regarding the discharge process • Reduction in discharge-related complaints
Objective 5 **(Q2-4)** **25% of discharges are by midday on inpatient areas*** • Develop and implement a process to prioritise and facilitate discharges before midday • Design, develop and implement a discharge prioritisation protocol/SOP • Explore the requirement for an electronic dashboard • Awareness of the new discharge prioritisation process through communications and media to advertise and disseminate ** Note that this excludes Outpatients, Day Surgery Units, Short Stay areas (average <24 hours, e.g. Maternity, Orthopaedic Short Stay Unit), Assessment areas*	• All communications and media about the new discharge protocol have been disseminated • Data support adherence to 25% of ward discharge by midday • Positive feedback from patients and families regarding the discharge process, through PALS and Friends and Family Test • Reduction in discharge-related complaints and incidents

Patient Experience

Quality Priority 7: Maternity Service User Experience

Why is this a priority?

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

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

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

What we will do	How will you know the objective is completed and that it is working?
Objective 1 **(Q1-2)** **Care planning** • Undertake personalised care planning questionnaire for sample of expectant mothers and birthing people • Undertake an audit for all feedback routes on satisfaction of care	• Evaluate and align the personalised care plans with the latest evidence-based practices and guidelines in maternity care • Increase in service user satisfaction scores regarding maternity care via all feedback routes, reported monthly through the Triangulation and Learning Committee (TALC), Quality and Performance Dashboard Reports. Improved CQC Service User Feedback Survey (February 25 data collection) • Reduce the number of red rated reported communication-related complaints by 50% with an improvement in

What we will do	How will you know the objective is completed and that it is working?
	communication ratings between healthcare professionals and service users • Positive trajectory of personalised care plan compliance measured through regular audit • Positive feedback and evaluation from training modules and workshops • Ensure that at least 50% of relevant healthcare professionals attend the training sessions within the first six months
Objective 2 **(Q2-4)** **Feedback from service users** • Incorporate feedback from service users into the regular review and update of care plans to ensure they meet the evolving needs and preferences of expectant mothers and birthing people	• Complete the development and initial implementation of personalised care plans by end of Q4 • Monthly audit of personalised care plans to measure compliance – they should be > 90% compliant
Objective 3 **(Q1-4)** **Training** • Conduct bi-monthly training sessions for healthcare professionals on effective communication and personalised care strategies. Pilot commencing April 25 (Q1) led by Maternity Psychologist	• Monthly reports on training sessions and proficiency assessments • Distribution records of educational materials • Workshop attendance and feedback records

Patient Experience

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

Why is this a Priority?

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

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

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

What we will do	How will you know the objective is completed and that it is working?
Objective 1 **(Q1)** **Launch ReSPECT** • Launch ReSPECT in OUH	• Successful launch of ReSPECT in OUH following rollout and communication strategy • EPR process is working as designed • ReSPECT is live and used in OUH
Objective 2 **(Q 2-3)** **Evaluate** • Evaluate the ReSPECT process and its documentation in EPR across the organisation	• Compliance with approved ReSPECT Policy • ReSPECT is used appropriately to document patients' wishes in the event of an emergency • Information from ReSPECT document is communicated via planned workflow to GPs and to South Central Ambulance Service (SCAS)

What we will do	How will you know the objective is completed and that it is working?
	• Review of documentation in line with patient admissions to the Trust and baseline data (numbers compared with current Resuscitation Status decisions) • ReSPECT plans increase and Do not Attempt CPR (DNACPR) forms go down (this can be seen as a summary on whiteboard) • Monitor discharge information flow and review any issues highlighted by external partners • Audit of ReSPECT document completion – 90% of completed forms provide evidence of discussion with patients or those closest to them • The ReSPECT process is completed for 90% of patients with a pre-existing DNACPR as evident on EPR
Objective 3 **(Q1-4)** **Education and training** • Provide education to clinical staff in the ReSPECT process, ensuring the process is used to enhance patient experience of emergency care planning • This will be achieved through the provision of education via various formats to various staff groups • Education content will be completed and launched on My Learning Hub (MLH) in Q1 • We will monitor and report compliance on training in Q2 and provide an action plan to improve compliance if needed during Q3-4 • We will run face to face training for staff undertaking the ReSPECT conversation piloting the first course in Q2, refining and evaluating this course in Q3-4	• ReSPECT education content available in My Learning Hub (MLH) to provide robust reporting and compliance structure • By Q4 compliance with training appropriate to role is >80% • Positive staff feedback on experience of and confidence in the ReSPECT process • Positive patient feedback of their experience of the ReSPECT process • Positive patient feedback can be achieved through Friends and Family Test, via questionnaires or captured within the auditing of the ReSPECT process (this is not exhaustive) • There will be a reduction in complaints and incidents regarding resuscitation and treatment decisions

What we will do	How will you know the objective is completed and that it is working?
• Design feedback form for face to face ReSPECT courses • Liaise with the Patient Advice and Liaison Service (PALS) to act on any feedback/complaints received in the organisation	
Objective 4 **(Q1-4)** **Patient Information about ReSPECT** • Make patient information available in a variety of formats- electronic/paper information leaflets • Liaise with Patient Safety Partners to review and refine messaging for patients • Review and action any complaints/feedback received associated with the ReSPECT process • Liaise with Patient Safety Partners for feedback	• Patients can access ReSPECT information with clinical staff also being able to demonstrate • Evidence of access to intranet site and use of ReSPECT patient information leaflets • Patients and those closest to them are aware of the ReSPECT process and how it is used within OUH • Q4 audit within Discharge Lounge to establish that where a ReSPECT form exists patients and those closest to them are aware of the contents of the document and its purpose • Positive patient experiences with the ReSPECT process • A reduction in complaints received regarding resuscitation and treatment decisions when compared with previous years • Reduction in patient complaints associated with resuscitation decisions
Objective 4 **(Q2-4)** **Audit** • Build an audit tool to audit the ReSPECT documentation • Use the audit tool to audit completion/quality of the ReSPECT documentation	• Evidence of completion of the ReSPECT document in line with the Policy and ethos of ReSPECT • Evidence of quality conversations with the patient

Patient Experience

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

Why is it a Priority?

Vulnerable patients including those with learning difficulties are at risk of inferior care and health outcomes and may require additional support for consultations, diagnostic procedures, surgery and discharge processes. It is important that vulnerable patients can be identified by healthcare professionals and that staff understand and are aware of their additional needs.

Supported by the Trust Learning Disability Liaison team, this Quality Priority will work to improve staff confidence in supporting people with learning disability and their families through further education; improve the discharge process for this group of patients; establish a pathway for diagnostic procedures under general anaesthetic when this is required; explore the feasibility of establishing a dedicated learning disability pathway; and roll out the Reasonable Adjustment Flag in the electronic patient record (EPR). The Reasonable Adjustment Flag (RADF) is a national scheme to flag in a patient's record the reasonable adjustments they require to access healthcare. These can be shared across health services and are designed to make it easier for health care teams to look after patients with additional needs. The Quality Priority will implement the RADF in conjunction with the integrated care system.

What we will do	How will you know the objective is completed and that it is working?
Objective 1: Oliver McGowan training (Q1-3) • Media and communications surrounding Oliver McGowan training will be advertised in the staff bulletin • Healthcare teams are confident supporting people with learning disability and their families because they have undergone the mandatory Oliver McGowan training	• The compliance data will be included in the Divisional quality reports for Clinical Governance Committee: by the end of Q1 Oliver McGowan training compliance is 75% and rising each quarter by 2.5% to 85% by the end of Q4 • By the end of Q2 and Q4 repeat the NHS Benchmarks staff questionnaire to establish if Oliver McGowan training has increased healthcare teams' confidence in supporting people with learning disability • First round of awareness training/education session completed in Staff bulletin: repeat at the end of Q1 and Q3

What we will do	How will you know the objective is completed and that it is working?
Objective 2 **(Q1-4)** **Going home from hospital** • Going home from hospital either to the family home, supported living or a care home can cause anxiety, and requires considerable detailed planning and practical support to develop a discharge process for people with learning disability to facilitate a smooth and stress-free transfer of care • By the end of Q1: going home from hospital benchmarking against Shelford Group and BOB (Berkshire, Oxfordshire and Buckinghamshire) to establish best practice for discharge of patients receiving tertiary care, and Oxfordshire residents living in social care and people with profound learning disability • A member of Trust's Learning Disability Liaison team will join the main Trust Discharge QP working group and ensure learning informs discharge policies and processes in development	• By the end of Q2 – test the discharge process for 10 people with a learning disability– establish lessons learned, feedback on experience (staff, patients, social care, community and families) • By the end of Q3 – scale up the discharge process across MRC and NOTSSCaN for referrals of patients with learning disabilities. Evaluate using methodology developed in Q2 • By the end of Q4 - roll out across MRC and NOTSSCaN . Evaluate using methodology developed in Q2
Objective 3 **(Q1-4)** **Diagnostic procedures under general anaesthetic** • To develop a Trustwide pathway to facilitate diagnostic procedures under general anaesthetic – some patients with learning disability or who are Autistic can find a diagnostic procedure impossible to undertake without a general anaesthetic.	

What we will do	How will you know the objective is completed and that it is working?
Objective 4 **(Q1-4)** **Working across specialties** • Some patients with learning disability have multiple health conditions which require active coordination across specialties. This causes considerable stress for people and their families because they don't understand who is coordinating their care when there are multiple teams involved. To develop a Trustwide pathway to facilitate coordination of people's healthcare who are supported by multiple clinical teams to maximise their health outcomes • By the end of Q1: benchmark against Shelford Group and BOB for best practice for a pathway for diagnostic procedure under GA. Form ICB wide group with ICB leads – Learning Disability, Autism and Primary Care. Establish complex needs pathway group with Oxford Health Community Learning Disability teams to identify people who require diagnostic procedures under GA and establish a plan for each person • Q2: System-wide summit to establish what the pathway should look like given experiences of families, primary care and secondary/tertiary care healthcare teams. Establish resources, policies and service level agreements required to develop this • By the end of Q3: Develop/draft policies and service level agreements required. Business case development for additional resources/changes in commissioning • By the end of Q4: Implement Learning Disability waiting list function on EPR. This will help the Learning Disability Liaison	• By the end of Q4: review impact to date by being able to identify all learning disability patients on the waiting list; and/or system in place to review and address needs of learning disability patients waiting for a diagnostic procedure

What we will do	How will you know the objective is completed and that it is working?
teams to understand who is waiting for a diagnostic procedure and enable them to intervene if required	

Objective 5
(Q1)
Readjustment flag
• Establish operational group workstream in Outpatient Delivery Group to deliver RADF
• Establish workstream in Outpatient Delivery Group by the end of Q1 (2024/25)
• Complete EPR function in readiness for implementation (nationally this must be completed by end of December 2025)
• Define pathway for asking for reasonable adjustments and Accessible Information Standard (AIS) when booking an outpatient appointment and when admitted to hospital
  • Test in six areas
  • Scale up to five areas per Division
• Roll out the RADF across the Trust
• Complete training with teams
• Establish process of data capture and reporting mechanism by end of Q4: record number of Reasonable Adjustment Flags and reasonable adjustments put in place
	• There will be a function in EPR
	
	• Define pathway for discussion and agreement by the end of Q1
	• Test in six areas (not yet identified) by the end of Q2
	
	• Training records show that training is complete

Objective 6 **(Q2-4)** **External media campaign** • Social media, leaflets and updates on the Trust website for patients and their families who have a right to ask for reasonable adjustments. Draft Q2 and roll out Q3 and Q4	• Completed patient information leaflets • Updates are on the Trust's website

Annexe 2: Statements from commissioners, Governors, local Healthwatch Oxfordshire organisation and Overview and Scrutiny Committees

Council of Governors Statement

Governor Response to the 2024/25 Quality Account

The Council of Governors has reviewed the 2024/25 Quality Account, which provides a thorough summary of the Trust's achievements and challenges in delivering high-quality care to patients. We appreciate the opportunity to comment on the document and to prepare a statement of response. It is our desire to contribute constructively to this process by helpful interrogation of the information and reflection of the problems that we see from our perspective as governors.

Governors have taken the opportunity to provide detailed comments on the report, reflecting opportunities to improve clarity and accuracy and to provide additional explanations. The Committee was pleased by the positive response to these comments and the commitment to follow up and respond to the issues raised.

Governors have also had the opportunity to provide feedback during a detailed discussion at the Patient Experience, Membership and Quality Committee, joined by the Director of Clinical Improvement, who summarised the report and invited comments. The Committee was also joined by non-executive directors who were able to clarify their role in assuring themselves regarding the matters reflected in the Quality Account.

We acknowledge the ongoing challenge of making progress in the context of persistent operational pressures, funding limitations, workforce challenges and data quality shortfalls. Governors also recognise the change and complexity at national, regional and local level that impact on the Trust’s ability to deliver its goals. It is important, however, for the Trust to be able to demonstrate how it is achieving its vision and embedding improvements despite these obstacles.

We appreciate the Trust's openness and transparency in acknowledging areas where improvement work remains incomplete and where the desired outcomes have not yet been achieved. However the dedication to change is evident, and it is apparent that staff are working hard to enhance standards further. Governors would particularly welcome assurance regarding improvements to the discharge process for patients in relation to which we are aware of instances where the experience of patients has not been as the Trust would wish.

We commend the Trust's approach to quality improvement, which is embedded in the organisation's culture and practice. We are pleased with the progress against the quality priorities for 2024/25 and those agreed for 2025/26, informed by the Quality Conversation event involving a wide range of stakeholders including governors.

Governors are impressed by the dedication and commitment of all staff, who have continued to support compassionate, safe, and effective patient care under difficult circumstances. We are proud of the many examples of excellence and improvement showcased in the Quality Account.

Highlights include pleasing improvements in the number of falls and pressure ulcers which are persistent challenges for acute trusts. Governors have also commended the Trust's impressive performance in treating hip fractures at the Horton Hospital.

The Trust should also be proud of how it encourages research internally and in collaboration with universities, demonstrating a strong commitment to driving research forward.

Governors are impressed by the Trust's aspirations for changing behaviour and practice. However, we encourage consideration of how best to measure and quantify the impact of changes across different services to ensure rigor in defining and evaluating objectives, making them realistic and meaningful. This should support reporting mechanisms that demonstrate the timely delivery of a trajectory towards a stated goal.

In improving patient experience we encourage the Trust to focus on the importance of measuring and presenting data effectively and to ensure that staff have the time and resources to engage meaningfully with it to improve health inequalities. It is important that data from the Friends and Family Test, PALS (Patient Advice and Liaison Service) contacts, PLACE (Patient-Led Assessments of the Care Environment) visits and other relevant information feeds into the process of improvement for patients.

We note the areas identified for further improvement and welcome the plans and initiatives in place to address these issues. We will continue to monitor their implementation and impact through our committees and meetings but are also enthusiastic to contribute more directly to the delivery process where appropriate opportunities arise.

Overall, we are confident that the Quality Account reflects the Trust's commitment to delivering high standards of care and improving outcomes for patients and the public. We thank the Trust for its hard work and achievements in 2024/25 and look forward to supporting it in making further improvements for patients during the current year.

Graham Shelton

Lead Governor

Robin Carr

Chair of the Patient Experience, Membership and Quality Committee

Statement from NHS England Specialised Commissioning

NHS England
South East

Simon Crowther
Acting Chief Executive Officer
Oxford University Hospitals NHS Foundation Trust
John Radcliffe Hospital
Headley Way
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OXFORD
OX3 9DU

NHS England
Premier House
Reading
RG1 7EB

16 June 2025

Dear Mr Crowther

Re: Quality Account 2024-2025

Thank you for sharing the Oxford University Hospitals NHS Foundation Trust (the trust) 2024/2025 Quality Account with NHS England, as the commissioner of Specialised services. I would like to express my thanks to the team in recognition of the continued hard work and dedication to the delivery of specialised services.

The Quality Account demonstrates the trust's commitment to providing high quality care to patients accessing its services and it is pleasing to see an aim to continuously improve performance through quality improvement tools across the key domains of Patient Safety, Patient Experience and Clinical Effectiveness.

The focus on continued implementation of the Patient Safety Incident Response Framework (PSIRF) including the application of a Just Culture ensures a fair and consistent approach towards staff involved in patient safety incidents. The introduction of a weekly Safety Learning and Improvement Conversation is used as a tool to share learning and improvement across the organisation. The recruitment and inclusion of Patient Safety Partners in aspects of patient safety including the design of the PSIRF plan and clinical governance ensures the patient voice is heard. It is encouraging that the trust is nearing completion of the actions relating to the

Patient Experience with the Patient Safety Incident Response Framework (PSIRF) Quality Priority for 2024-2025, with only one action outstanding.

It is noted that the trust's cultural shift towards continuous improvement continues to yield positive results, with 60% of staff able to make improvements at work and over 2000 staff completing quality improvement training over the last 2 years. The feedback received from staff who have participated in Oxford Simulation, Teaching and Research (OxSTaR) human factors and safety training programmes is commended, with over 1000 staff accessing courses. The integration of data obtained through OxSTaR into quality improvement projects is recognised.

In response to the introduction of 'Martha's Rule', and to ensure that patients and their families have access to round-the-clock rapid review from an independent care team, the trust have begun strengthening and implementing systems to enable patients and carers to speak up if they have concerns about patient care with plans to develop an outreach team to support this piece of work.

It is acknowledged that patients on a Referral to Treatment (RTT) waiting list at OUH increased by 9% from March 2024 to March 2025, with contributing factors relating to specialty capacity constraints either due to pathway redesign, staff vacancies, national supply shortages or a greater volume of patients in the cohort, resulting in the reliance of elective recovery schemes and mutual aid on another qualified provider. The continued commitment to reduce waiting times for patients is acknowledged, and it is encouraging that clinical harm reviews for patients with treatment delays to identify both psychosocial and clinical harm continue, while waiting list challenges remain. It is reassuring that harm reviews are discussed in the monthly Harm Review Group (HRG) and that treatment is expedited where necessary.

Outcome data for patients, obtained through participation in clinical audit, including the Cleft Registry and Audit Network (CRANE) and the National Neonatal Audit Programme (NNAP), continues to be favourable, with areas of achievement also noted in blood transfusion, venous thromboembolism prevention and inpatient falls. The trust has demonstrated its commitment to

participate in clinical research to facilitate improved patient outcomes through involvement by hosting 1649 clinical research trials relating to several specialties.

The trust's willingness to understanding and respond to patient experience using a variety of methods including 'Experts by Experience' and 'What matters to you' is encouraging. Results from the Friends and Family test 2024-2025 are excellent, with 93% of patients rating their experience as good or very good. It is pleasing to see the OUH Reporting Excellence (RE) programme continues, enabling staff to provide positive feedback and gratitude to colleagues, with 'Going Above and Beyond' and 'Teamworking' themes featuring strongly.

It is encouraging to see that the trust has continued to make progress against its Quality Priorities for 2024-2025 but also noted that some priorities have not progressed as hoped. South East Specialised Commissioning looks forward to celebrating the achievement of completion in due course. It is reassuring to see that the trust completed all actions relating to the Reducing Health Inequalities quality priority in 2024-2025, thereby supporting the OUH Health Inequalities Programme agreed in 2022.

It is acknowledged that the evidence supporting completion and embedding of the actions borne out of the CQC inspection of the midwifery-led unit at the Horton General Hospital in March 2024 has been considered by the Evidence Review Group. South East Specialised Commissioning encourage input to continue into this area, with assurance provided to the Integrated Care Board.

South East Specialised Commissioning give recognition for those involved in the NHS England-led clinical genetics quality review and the progress made against the recommendations. It is also encouraging to note progress being made against action plans relating to the Children's Epilepsy Surgery Services (CESS) service review and the Congenital Heart Disease (CHD) Quality Review of the Adult and Paediatric Services.

South East Specialised Commissioning is in support of the quality priorities in place for 2025-2026 and the evaluation criteria set against them. We look forward to continuing to work

collaboratively with the trust on their priorities during the coming year to support the quality improvements identified.

Yours sincerely

Rosie Baur

Interim Director of Nursing, Direct Commissioning

Direct and Specialised Commissioning Quality Team (DSCQT)

NHS England – South-East Region

cc:

Sadaf Dhalabhoy, Deputy Director Delegation, Contracts and Performance, Specialised Commissioning SE, NHS England

Janette Harper, Deputy Director of Transformation & Recovery, Specialised Commissioning SE, NHS England

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

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

Simon Crowther
Interim Chief Executive Officer

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10 June 2025

Dear Simon

NHS Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board (BOB ICB) is pleased to provide a response to the Quality Account 2024/25 submitted by Oxford University Hospitals NHS Foundation Trust (OUH).

From our review, we believe the Quality Account has clearly set out both the significant achievements of the Trust in respect of the quality of its services, and a realistic appraisal of the challenges met by OUH and the wider system. The Quality Account provides information on the services provided by OUH and progress on the priorities for improvement that were set for 2024/25, giving an overview of the quality of care provided during this period and progress against core quality indicators. It also gives clear evidence of achievements and how the Trust is aiming to maintain or improve the quality of care.

The clinical quality priorities for 2025/26 are also set out in the report. We acknowledge and support the aspiration to maintain high quality services, supported by these priorities. We are pleased to see the inclusion of patient experience in maternity, patient discharge and medicines reconciliation in the quality priorities as these are system wide priorities. We are also pleased to see the level of research leadership and participation, excellence reporting and conclusion of Phase 2 of the culture and leadership review for newborn care.

The National Quality Board definition of quality has six dimensions, including sustainability, equity and leadership, in addition to the established areas of safety, effectiveness, and experience. It is pleasing to see the commitment to further embedding the national patient safety incident response framework (PSIRF), implementing ReSPECT and supporting people with a learning disability.

Addressing the sustainability challenge through models of care and stable resilient workforce is a key priority nationally and across BOB. The ICB are keen to see this, and clear alignment between the organisations quality priorities and the overall

Integrated Care System goals as set out in our Joint Forward Plan. We are committed to working with the organisation to build upon and achieve further improvements in the areas identified.

We are satisfied that the Quality Account has been developed in line with the national requirements and gives an overall accurate account and analysis of the quality of services.

We would like to recognise in particular, improvements and achievements in the following areas:

- Breathlessness pathway – supporting the move to care being in the community
- The results in the clinical audits undertaken by the Trust and the breadth of work the audits have resulted in showing a culture of continuous improvement
- The sustained above national average scores in the National Neonatal Audit Program and level of care provided to our population
- The improvement in the bowel screening programme from 30% to 70% over 6 months is a notable improvement and supporting positive outcomes for patients
- The exceeding of the VTE national target and the focused work of the teams to significantly improve training compliance
- The focus on personalised care and patient involvement in evident throughout the account showing the Trusts commitment and understanding of the importance of this for quality improvement and patient safety
- The improvement in the UEC performance, which is significantly above the national average, which the national evidence shows has a direct impact on patient outcomes and quality of care
- The dedicated bereavement room at the John Radcliffe for families following the loss of a baby with support families at a sad and vulnerable time
- The reduction in delayed induction of labour and associated morbidities.

We note the work undertaken by the organisation in relation to Infection Prevention and Control challenges and would welcome the Trusts continued focus on ensuring this remains a focus for 25/26.

Maternity services at the Horton were visited in October 2024 with an overall rating of requires improvement. We welcome the information contained in the report and have been kept fully sighted on the actions taken by OUH to address the recommendations.

Conclusion

The ICB would like to take this opportunity to acknowledge and praise Oxford University Hospitals NHS Foundation Trust for their continued commitment to quality improvement and innovation, as well as ensuring that the ICB and partners are actively involved in conversations around the quality and safety of services. The ICB have attended the Trust's Quality Meetings throughout the year and are assured of the strength of the organisation's clinical governance framework. The Trust has also consistently contributed as a partner in the System Quality Groups, bringing expertise, learning, and escalations to these system-wide forums. Alongside the progress reported on the Trust's main quality priorities, we acknowledge the depth of improvement work reported across all its services.

2024/25 has been a challenging year for health and social care and we know that, as a system, we continue to face significant challenges with capacity and demand across a range of pathways and we value the commitment and expertise that Oxford

University Hospitals NHS Foundation Trust continues to provide in system-wide, regional, and national work to transform services in the face of these challenges.

BOB ICB is looking forward to collaborating with its system partners to develop the national direction of travel for healthcare to future proof the NHS for future generations by working on the following 3 key shifts at the core of the government's health mission:

- From hospital to community – providing better care close to or in people's own homes, helping them to maintain their independence for as long as possible, only using hospitals when it is clinically necessary for their care
- From treatment to prevention – promoting health literacy, supporting early intervention and reducing health deterioration or avoidable exacerbations of ill health
- From analogue to digital – greater use of digital infrastructure and solutions to improve care.

Yours sincerely

Rachael Corser
Chief Nursing Officer

CC: Caroline Armitage - Deputy Head of Clinical Governance

Statement from Health and Wellbeing Board

OXFORDSHIRE COUNTY COUNCIL

Simon Crowther
Acting Chief Executive
Oxford University Hospitals
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OX3 9DU

By email

The Leader's Office
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Councillor Liz Leffman
Leader of the Council

10 June 2025

Dear Simon

Thank you for sharing the comprehensive quality statement, highlighting progress against quality measures. We are committed to working in partnership with OUH, and noted the reference to the OUH Health Inequalities programme. As one of the anchor institutions, OUH is a core partner in the development of Oxfordshire as a Marmot place, and this report demonstrates engagement with interventions to address health inequalities, such as Making Every Contact Count (MECC). This is supported by positive feedback about patient experience through the Friends And Family Test, a staff opinion regarding the care provided.

We noted your concern with the increase in healthcare associated infection rates, which is monitored by UKHSA, and your note that this is in line with national trends.

Yours sincerely,

Liz Leffman

Cllr Liz Leffman
Leader, Oxfordshire County Council
liz.leffman@oxfordshire.gov.uk

Statement from Healthwatch Oxfordshire

healthwatch Oxfordshire
Your voice on health and care services

Sent by email to Simon Crowther, Interim Chief Executive Officer, Oxford University Hospitals NHS Foundation Trust

June 4th, 2025

Dear Simon,

Oxford University Hospitals NHS Trust Quality Account 2024-5

Thank you for letting Healthwatch Oxfordshire have sight of the Trust's Quality Account 2024-25 prior to publication.

The account gives a comprehensive view of the breadth of work being undertaken towards improving quality of services across the Trust, and indicates, your ongoing commitment to improving quality. It is clear as an organisation that you demonstrate openness to ongoing learning and review from both to the positive and the other insights of challenges you face.

Again, we welcome the Trust's continuing commitment to seeking ways to make sure patient experience is integral to improving what you do, and the examples that show you are keen to improve your reach to include those who may be seldom heard, or face inequalities of access and experience.

We would like to thank the Patient Experience Team, and commend the efforts made to bring patient, carers and those with lived experience into service development, listening events, and design of patient facing information. Healthwatch Oxfordshire has positive dialogue with this team, and make sure that we provide feedback on what we are hearing from the public about OUH services.

We have been pleased to see how our reports and feedback are used and embedded within improvement discussions as a whole. However, we see no reference in the Quality Accounts of Healthwatch Oxfordshire being a source

of insight for reflection on improving patient experience, and identification of Quality goals (for example Priority 7- Discharge) - and wonder if this might be acknowledged, along with your other sources?
It is positive to see developing focus on addressing health inequalities - including wider system engagement, links to Marmot Oxfordshire, and through some focused outreach with some of the communities who may face barriers to care.

We welcome focus on improving experience of maternity care being taken as a Quality Priority no.7 for 2025-6, and some of the steps outlined to improve patient experience. Healthwatch Oxfordshire has kept informed of progress on maternity care through the year.

We welcome Discharge being selected as Priority no.6 for 2025-6 Quality Improvement priorities, and are pleased to see that Objective 3 "*Provide clear communication to patients and unpaid carers on the discharge process and follow up support*" directly draws on the acceptance of the recommendation made in the Healthwatch Oxfordshire report published in November 2024. This included the need to involve carers more proactively in the discharge process. This report, "People's experience of leaving hospital in Oxfordshire" was carried out by Healthwatch Oxfordshire, working closely with the Oxford University Hospital (OUH) Discharge Team, and other system partners, and was a positive example of joined up working. We thank all staff for their positive cooperation in supporting us to gather feedback from patients and carers on this important issue, and to support discussion and identification of action from our recommendations.

We are pleased to see the work to involve patients across the trust. The support of experience champions in the development of the Patient Safety Incident Response Framework (PSIRF) is a positive example. I was able to attend the PSIRF event and hear directly about how this framework has been developed and co - produced with patient safety champions, and with patients and families. The embedding of patient stories into the process is clear.

Whilst there is some reference in the document to Accessible Information Standard, and to some improvements for example, in offer of interpreting, commitments to ongoing improvements, and monitoring experience could be highlighted more clearly. Interpreting continues to be an issue raised to Healthwatch Oxfordshire by members of the public and is essential to experience of access to care. In addition, provision of information in a range of formats could be highlighted more centrally.

We hope you continue to ensure the final Quality Document (and all documentation) is accessible, clear, jargon and acronym free and in plain English to ensure that members of the public can easily understand it – including clearly explaining data tables, scoring and comparative sources.

On a final note, I draw attention to the reports Healthwatch Oxfordshire has produced over the last year with focus on OUH services, based on what we have heard from patients, families and staff. Some of these reports give further qualitative insights into the areas addressed in the OUH Quality Report. We thank OUH for formal responses and commitments to action, following the recommendations of our reports. All OUH responses are published on our website. As noted above, we would be pleased to see impact of these reports cited in Quality improvements where relevant and acknowledged as a source of additional insight for the Trust.

All our reports from 2024-5 can be seen on our website at:
https://healthwatchoxfordshire.co.uk/reports
including:

- **Enter and View** visit reports https://healthwatchoxfordshire.co.uk/our-work/enter-and-view/ : reports published on visits to: Surgical Emergency Unit, John Radcliffe (Sept 2024), Oxford Eye Hospital (Sept 2024), Ambulatory Care Unit, Churchill Hospital (Sept 2024), Discharge Lounge, John Radcliffe (Nov 2024).
- **Research Reports of relevance to OUH**: Peoples' Experience of Leaving Hospital in Oxfordshire (Nov 2024), Supporting Oral Health in Children (July 2024), People's experience of eye care services in Oxfordshire (Sept 2024), What you told us about hospitals August 2023- July 2024 (Sept 2024).

- **Our ongoing feedback** to OUH Patient Experience Team on what we hear from the public, including published on line service reviews of all OUH services, here: https://healthwatchoxfordshire.co.uk/services enabling the public to comment, and providers to respond. We also feed back what we hear from the public at our regular outreach stands at OUH Hospitals.

Finally, we thank all staff at the Trust for their continuing commitment to provide a quality, caring and safe service for the community of Oxfordshire. Feedback from the public about their care to Healthwatch Oxfordshire shows how much the public value all that the staff do – including good communication, patient centred and compassionate care.

Yours sincerely

Veronica Barry

Dr Veronica Barry
Executive Director
Healthwatch Oxfordshire.

Response to Healthwatch Oxfordshire

Thank you for highlighting the work and involvement you have, and continue to have, with the Patient Experience team in providing insight and reflection from the public about OUH services; this helps to identify and embed quality goals. We apologise that this was not acknowledged. This has been rectified on page 142.

We also note the list of resources you have provided which focuses on OUH services; these have been included on page 196-7.

Statement from Health, Overview and Scrutiny Committee (HOSC)

FEEDBACK REPORT OF: THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (JHOSC): Oxford University Hospitals NHS Foundation Trust Quality Account 2024/2025.

REPORT BY: HEALTH SCRUTINY OFFICER, OXFORDSHIRE COUNTY COUNCIL, DR OMID NOURI

The Oxfordshire Joint Health Overview Scrutiny Committee (JHOSC) welcomes the Oxford University Hospitals NHS Foundation Trust (OUH) quality account for the year 2024-2025, and is pleased to see the extensive effort and detail that has been invested into producing this year's quality account. The account provides a comprehensive overview of key developments and activities within the Trust in the previous year, and the JHOSC congratulates the Trust on the advancements and innovations it has made to improve patient safety, patient experience and clinical effectiveness. The Committee notes the requirements on Provider Trusts and the challenging context for service delivery, and would like to thank all who work at the hospital for their dedication over the last year.

This quality account has provided useful insights into the following:

- What the Trust has been doing well over the past year.
- The service areas that are in need of improvements, both in terms of the quality as well as the quantity of services.
- The Trust's priorities for improvement for the ensuing year.
- The extent to which the Trust has continued to involve and engage with patients/residents who utilise the services, as well as staff, in shaping the Trust's priorities for improvement.

Below are some key feedback points and reflections that the JHOSC has on specific themes. These themes have also been drawn from the quality account. The themes below are generally directly related to the content of the quality account, although they may contain broader reflections on the Trust's services as a whole.

Staff engagement and culture: The Committee is pleased to see that there is evidence of improvement in staff engagement and staff culture. It is promising to see that the Trust's recent Staff Survey indicates that almost three quarters of OUH staff expressed that they can confidently make suggestions for improvement, and that over 60% are now able to make improvements at work compared with 58% in the previous year. It

is also positive to see that 74.35% of staff feel that they would be happy with the standard of care provided at OUH if a friend or relative needed treatment (this being above the national average of 61.54%).The Committee notes the staff evidence about working at the Trust, and encourages the Trust to continue listening and improving at all levels of the organisation. It is vital for the Trust to continuously monitor and measure the tangible impacts of any initiatives to improve staff wellbeing; including the Eradicating Bullying and Harassment Programme, the Work in Confidence platform that enables all staff to raise Freedom to Speak Up Concerns completely anonymously, and the onboarding programme for new managers. The Trust can make use of qualitative and quantitative data, such as staff turnover, sickness absence, feedback, complaints and incidents, to assess the effectiveness of the initiatives and identify areas for further improvement. It is crucial that Trust staff feel that they are being heard.

Collaboration with partners: The Committee welcomes OUH partnership working and congratulates the Trust on its innovations and awards. With NHS and local authority reforms creating much uncertainty, the Committee would urge the further building of relationships at a local level. The Committee commends the work to reduce travel time with the Milton Keynes centre, and looks forward to OUH and system partner delivery on the much awaited hospital to community plan coproduced with Wantage Town Council and the whole population (as an exemplar of working with local communities for services and to tackle rural inequalities in Oxfordshire).

Medicines reconciliation: The Committee is pleased to see that one of the key quality priorities for the Trust is medicines reconciliation, which is essentially a vital process in healthcare that ensures that medications are accurately and consistently managed during transitions of care. This is important so as to avert the prospect of adverse drug events, which can increase financial burdens as well as length of stay in hospital (in addition to having poor outcomes on the health and wellbeing of individual patients). The Trust needs to therefore continuously monitor any financial savings it makes or any reductions in prolonged length of stay that would be achieved through effective medicine reconciliation and the averting of adverse drug events.

Standard work processes: Broadly speaking, any commitment to deliver the highest quality of care or service would require the implementation of the standard work concept across the Trust's services. It is good to see that the Trust is adopting learning from wider industries, through adopting the standard work approach which exists to contribute to ensuring all individual patients can receive the highest quality of care that is safe and consistent. The standard work process would support staff in making them feel guided and empowered in every aspect of their work. A consistency in the quality of care that patients receive is pivotal, and the Trust should not only establish

clear and detailed standard work processes, but should engage in routine and effective monitoring of how these processes are actually being implemented and experienced by staff and wider teams. Lessons should also be learned from where specific Trust services have not been as effective as they could be, and for this to be utilised to shape the ongoing development of standard work processes to improve patient outcomes.

Oxfordshire Critical Care Outreach Service (CCO): It is crucial that patients who are being transitioned from an intensive care unit into a ward are effectively followed up and supported whilst they are in the hospital setting. The Committee is pleased to see that the Trust has made it a priority to ensure that the Oxford CCO is working to achieve safe, equitable and quality care for patients who may be acutely unwell, who may be critically ill, or who may be recovering patients. Continuous monitoring of patients and early-detection of signs of deterioration would help to avert the prospects of longer in-hospital stays, patient deaths, or even readmissions back into intensive care units. It is positive to see that the Care Quality Commission's (CQC) recommendation in 2022 to launch an Oxford CCO service was taken on board by the Trust.

Discharging: The Committee notes the role of discharging as being a key quality priority for the Trust, and is well aware of the increased demand for the Trust's emergency and planned care services, which is being elicited by a growth in both general and ageing population throughout Oxfordshire. The quality account refers to the Home First approach, which is to prioritise provision of care in people's homes. Through its previous and ongoing scrutiny of the support provided for patients who leave hospital, the Committee understands that this Home First approach is also in line with the Oxfordshire Way and national guidance. Nonetheless, and in line with previous recommendations issued by the JHOSC to OUH and its Oxfordshire partners, it is vital that there is a balance between efficient discharging on the one hand, whilst ensuring that patients receive care that is comprehensive, attentive, and personalised. It is important that the Trust continuously learns from both feedback from discharged patients (and their families/carers) as well as from incidents; consider integration of SEND and the Discharge Safety Checklist so there is an objective measure that can be communicated as well as communicating the availability and timely access to the discharge leaflet. Previous scrutiny has also identified particular patient groups such as those with poor mental health and learning disabilities who end up in patient beds for a long time because of delays in there being appropriate settings for ongoing care. The hospitalisation experience can be distressing. The Committee would encourage increasing collaboration with local partners with a view to improving the hospital

experience and outcomes for these patients and reducing unnecessary time in hospital.

Maternity Services: It is positive to see that the Trust has made improving the 'Maternity Service User Experience' a key priority in the realm of improving patient experience. Given the outcome of the most recent CQC inspection of maternity services provided by the Trust, it is important that the Trust continues to take steps to improve the quality of care and experience for expectant mothers and their families. This Maternity Service User Experience can act as a useful initiative for better communication and understanding between service users on the one hand, and maternity healthcare professionals on the other. The Trust should continue to measure the success of this initiative, and ensure that the voices, preferences, and needs of women, birthing people, and their families are taken on board. The Trust's endeavours to improve maternity services should continue to include the use of Key Performance Indicators that measure safety/quality of clinical care as well as patient experience/satisfaction. Coproduction should also remain at the heart of the improvement journey for maternity including stakeholders who can represent high risk patients.

Reducing Health Inequalities: Tackling Health Inequalities remains a key priority of all of Oxfordshire's system partners, and it is therefore no surprise that this constitutes a key priority for the Trust as indicated in the quality account. This ambition is also in line with the NHS long term plan. It is positive to see that the Trust recognises that its contribution to health inequalities reduction is not confined to its own internal functions but also in the collaborative work it undertakes with its fellow partners within the Oxfordshire system. The Trust should continue to make use of health inequalities dashboards that are as detailed and comprehensive as possible. It is also crucial that vulnerable population groups or patients with comorbidities are subjected to continuous monitoring in the spirit of averting the health inequalities that they be susceptible to. It is good to see OUH is working on Marmotisation at Oxfordshire Place. As a result of its scrutiny so far, the Committee recommended that Town and parish councils who work with community organisation stakeholders at neighbourhood level are included, and that work recognises and builds on existing networks tackling rural as well as urban inequalities.

Martha's rule: As was the case last year, the Committee is again supportive of the commitment of the Trust to adopt Martha's rule. However, whilst recognising that this rule will be implemented across the NHS through a phased approach, the quality account could provide more detail on how Martha's rule will be applied in the day-to-

day care undertaken by the Trust. The quality account pertains to the use of rapid reviews, which is certainly positive. Nonetheless, further clarity is required over the nature of these reviews and whether existing resources at the Trust's disposal allow for such rapid reviews and their monitoring, especially with regard to a health inequalities lens. This would again help reassure patients and their carers/loved ones. It is good to see the Trust's commitments to strengthen and implement systems that allow patients and their carers/loved ones to voice any concerns they have with the quality of the care being provided. This would further help to ensure trust and confidence in services delivered by the Trust.

Patients awaiting treatment: The Committee is pleased to see that the Trust is continuing to recover from a large backlog of waiting lists/times for patients as a result of industrial action and the Covid pandemic. It is a positive development that fewer patients are waiting for over 78 weeks for elective treatments this year, as opposed to the numbers from the previous year. It is vital that the Trust explores as many avenues as possible through which to further reduce the number of patients awaiting elective treatment in the ensuing year. The Trust has met its 28 day diagnostic target and has harm reviews for over 52 week waits. In the case of cancer patients, prolonged waits can have detrimental effects on the progression of their disease, and the Trust should exercise as much transparency as possible on the types of cancers that have the longest waits and harms. The OUH epilepsy service that was scrutinised during the last year caused particular concern because of the starkness of the evidence about patient safety in light of wait times (between 9-12 months and 3 years for children for the ketogenic diet) and impact of a two clinicians rule required by new MHRA regulations on the welfare of the clinical team. As generalised seizures are strongly associated with A&E and sudden fatality and OUH has accepted the recommendations of the Committee, the JHOSC looks forward to seeing inclusion of epilepsy across the quality priorities as well as continued escalation.

Digital innovation: It is interesting to see that the Trust has embarked on the use of a Market Access Accelerator programme and is using Artificial Intelligence (AI) in novel settings e.g. Dora. This would certainly help the Trust to explore and secure various technological tools that could enhance the quality of clinical care as well as assisting staff in executing their responsibilities. The other benefit of this programme is its ability to enable the Trust to codevelop technologies at an early phase prior to ensure that they can operate effectively in the context of a healthcare environment. In light of this, the Committee urges that the Trust explores innovations around technologies not only for clinical but also for administrative/managerial staff, taking into consideration themes from health scrutiny aimed at building confidence and public trust.

Genome project: This development is exciting and important, and may have impacts regarding waiting lists for care where genes are identified, especially in services with long waits. The Committee would encourage transparency on whether there is a whole care pathway and how this is being taken forward with the local voluntary sector who work on rare conditions.

Medicines safety: Medication safety is an area of significant interest for the Committee. The quality account could have expanded on the degree of medicine shortages and how these could have been impacting the Trust's services. Again, as was emphasised by the Committee in the previous year, there is an imperative for further clarification around the remit of the Trust's initiatives on medication safety, particularly in the context of current significant medicine shortages affecting various medical areas, including epilepsy. However, through its own scrutiny of this area, the JHOSC is pleased that the Trust is aware of the challenges around medicine safety/shortages and that it seeks to find ways to address this (as indicated in the responses to the Committee's previous recommendations on medicine safety). As part of its scrutiny of medicines shortages, the Committee recommended whole system collaboration with a focus on how best to support patients and clinicians caught up in finding solutions where there is a shortage of time-critical medicines. Additionally, the Committee would urge that where possible, a patient's weight is taken within the hospital setting prior to them being provided with strong painkilling medications such as morphine.

RESPECT: The Trust is embedding a new model of care developed by the ICB and will be monitoring this. The Committee would encourage local coproduction including Patient Safety Partners in the Trust and the importance of training staff on the diversity of death and dying. Of particular note is that advance directives will be shared with GPs and ambulance crews, and that in this regard the Committee would urge that there is clear communication with patients and their relatives about the process for changing their mind. As this model will be implemented across local Provider Trusts, the Committee would encourage collaboration.

Learning from deaths: The quality account sheds light on the how the Trust learns from deaths. The Committee is aware of the ongoing work undertaken by the Trust to maintain a robust process of learning from deaths; and urges that these reviews continue to be completed in a timely fashion so as to produce learnings and avert harm to future patients. Nonetheless, in line with the Committee's feedback on last year's quality account, whilst there have been no deaths that were avoidable, consideration should be given as to whether certain deaths would be potentially

avoidable or indirectly avoidable. In addition, it is vital for learning and care for the process of learning from deaths to offer early inclusion and transparency to the bereaved.

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

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

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

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

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

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

By order of the Board

NB: sign and date in any colour ink except black

Simon Crowther
Acting Chief Executive Officer

Professor Sir Jonathan Montgomery
Chair