Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 08 March 2023

TB2023.27

Title:	**Oxford University Hospitals NHS FT Proposed Quality Priorities 2023-24**
Status:	**For Decision**
History:	**New proposal for 2023-24 Quality Priorities**
Board Lead:	**Chief Medical Officer & Chief Nursing Officer**
Author:	**Dr Andrew Brent, Deputy CMO, Director of Improvement** **Rupali Alwe, Deputy Head of Clinical Governance**
Confidential:	**No**
Key Purpose:	**Assurance**

Executive Summary

1. The Quality Account contains commitments to areas of work referred to as Quality Priorities. Each Trust proposes a range for the forthcoming year and reports back achievements from the current year. Staff and public engagement is sought when devising quality priorities.
2. Most importantly the Quality Priorities need to be highly relevant and visible to staff across the Trust and something that they actively support and with which they can readily identify.
3. A Quality Conversation Event took place in January 2023. The event focussed on an update on progress made on Quality Priorities for 2022-23 and refresh of Quality Priorities for 2023-24 as part of the annual planning cycle and the Quality account.
4. Based on earlier suggestions from the Clinical Governance Committee and feedback and suggestions from the Quality Conversation Event, the Trust Management Executive and the Patient Experience, Membership & Quality (PEMQ) Committee, a new set of Quality Priorities is proposed for 2023-24.

Recommendations

5. The Board is asked to approve the proposed Quality Priorities for 2023-24.

Oxford University Hospitals NHS FT Proposed Quality Priorities 2023-24

1. Background

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

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

1.3. The Quality Account contains commitments to areas of work referred to as Quality Priorities. Each Trust proposes a range for the forthcoming year and reports back achievements from the current year. Staff and public engagement is sought when devising quality priorities.

1.4. Most importantly the Quality Priorities need to be highly relevant and visible to staff across the Trust and something that they actively support and with which they can readily identify.

1.5. Quality Priorities all have an Executive lead as well as an operational lead. Clear, measurable target objectives are included.

2. Development of the OUH Quality Priorities for 2023-2024

2.1. A Quality Conversation Event took place in August 2022 in lieu of the event that would normally have taken place in January 2022 but which was cancelled due to the COVID-19 pandemic. Feedback from this event included proposals for the 2023-24 Quality Priorities.

2.2. Further input on these and other proposed Quality Priorities was provided by the Clinical Governance Committee prior to the Quality Conversation Event in January 2023.

2.3. A Quality Conversation Event took place in January 2023, attended by members of the public, local stakeholder representatives, Governors, OUH executives and OUH staff including current Quality Priority leads. The event focussed on an update on progress made on Quality Priorities for 2022-23; and proposed Quality Priorities for 2023-24, as part of the annual planning cycle and the Quality account.

2.4. Based on feedback from the Quality Conversation Event, and further feedback from executive directors, a new set of Quality Priorities is proposed for 2023-24.

2.5. The list of proposed Quality Priorities for 2023-24 was approved by the Clinical Governance Committee on 15 February 2023.

2.6. Further feedback including minor proposed changes to the proposed Quality Priority plans and metrics was provided by the Trust Management Executive on 23 February 2023 and by the Patient Experience, Membership & Quality (PEMQ) Committee for their input on 22 February 2023. All the proposed changes have been incorporated in the updated Quality Priorities presented in this paper.

2.7. This paper provides a detailed summary of the proposed Quality Priorities and associated action plans and metrics.

3. Proposed Quality Priorities for 2023-24

3.1. It is proposed that the following 2022-23 Quality Priorities are refreshed and continue in 2023-24:

- Medication Safety – Opiates & Insulin
- Rollout and embed use of Surgical Morbidity Dashboard

3.2. The following Quality Priorities will be absorbed as 'business as usual' in 2023-24:

- Triangulation of learning from claims with incidents, inquests and complaints
- Reducing Pressure Ulcers
- Results endorsement
- Embed QI methodology more widely in the Trust
- Reduce incidents of violence, aggression
- Transition of children to adult services
- Staff health and wellbeing: Growing stronger.

3.3. The following Quality Priorities are proposed for 2023-24 (those marked with an asterix are to be carried over and updated from the 2022-23 Quality Priorities):

3.3.1. Patient Safety

- Medication Safety – Opiates & Insulin*
- Care of the Frail Elderly – focussing on the urgent care pathway
- Reducing Inpatient Falls

3.3.2. Clinical Effectiveness

- Reducing unwarranted hospital outpatient cancellations

- Rolling out and embedding the Surgical Morbidity Dashboard*
- Helping more patients through Tissue Donation for Transplant

3.3.3. Patient Experience

- Health Inequalities – Improving data capture including ethnicity
- Empowering Patients – building partnerships and inclusion
- Kindness into Action – improving patient and staff experience

3.4. Appendix 1 outlines in more detail the proposed 2023-24 Quality Priorities.

Recommendations

4. The Board is asked to approve the proposed Quality Priorities for 2023-24.

Patient Safety

Quality Priority 1(a): Medication Safety - Opiates Executive Lead: Anny Sykes, Chief Medical Officer; Sam Foster, Chief Nursing Officer Quality Priority Lead: Jane Quinlan *National and international guidance now recognises the risk of excess prescribing of opioids in the post-operative period. While essential to maintain access to opioids in the management of acute pain where they are effective and necessary, opioid stewardship is needed across the Trust to ensure safe monitoring of patients and adequate, but not excessive, discharge prescribing. Aim: By 31 March 2024, to rationalise opioid use in all adult patients at OUH.*	
What we will do	**How we will evaluate success**
Action 1: Introduce British Pain Society patient leaflet regarding pain and analgesic use into pre-operative assessment clinics to improve patient education and to manage patient's pain expectations. Q1: Collaborate with pre-operative assessment team to introduce and test patient leaflet as above, looking at patient feedback of understanding and ease of use Q2: Revised and approved by the end of Q2. Q3: Introduction to routine practice. Q4: Introduction to routine practice.	A test of the patient leaflet within suitable pathways by using patient feedback. Introduce into routine practice and measure the number of surgical specialities that have integrated the information into routine practice.
Action 2: Develop leaflet on safe opioid use to be given in every discharge opioid pack. Q1: Identify current national leaflets and assess suitability or need for modification Q2: Develop modified leaflet and collect patient feedback Q3: Introduction into routine practice Q4: Introduction into routine practice	Collect patient feedback on a proposed safety leaflet. Introduce into routine practice and measure number of areas using it.
Action 3:	Presentation of the data to relevant surgical departments.

Collection of sample data of discharge opioid use from 5 different surgical procedures to help inform future procedure-specific opioid discharge prescribing and prescribing culture change. Q1 and 2: Draft and pilot data collection tool. Q3 and 4: Collect data and evaluate results	The procedure specific normative opioid data will help guide the development of educational package for prescribers and support prescribing culture change in surgical areas identified.
Action 4: Review and promote the use of the Oxford Pain Guide available via OUH MicroGuide to improve understanding of pain management and prescribing of pain treatment across the Trust. Q1-2: Identify numbers of users of Pain Guidelines, feedback from clinical staff about their knowledge of the tool, how they use it and how its use could be promoted. Q3: Develop the guidelines based on the feedback from clinical staff and use this to further promote the guidelines. Q4: Repeat the scoping exercise gaining further feedback from clinical staff to determine whether knowledge of the resource and use has increased. Identify user numbers from website pages.	Improvement in the number of users of the Oxford Pain Guide between Q1 and Q4. Incorporation of user feedback into revised guidelines. Evaluate the changes in clinical practice and health outcomes by a re-audit of discharge opioid prescribing from inpatient areas.
Action 5: To identify a selection of indicators around opioid prescribing and administration in collaboration with ePMA (electronic Prescribing and Medicines Administration) and IM&T reporting teams and test for suitability and validity. Q1 and 2: Identify the prescribing and administration data available in ePMA that could be used to measure aspects of opioid prescribing, administration and safety (e.g. obtain baseline data for the percentage of inpatients receiving naloxone). Q3 and 4: Develop and refine reporting tools for ongoing monitoring	To identify and establish indicators and reporting tools for opioids prescribing and safety
Action 6: To develop a system for prescribers to document the intended duration (number of days), the weaning and cessation plan and the review and referral plan for opioids in the patient's healthcare record and discharge summary. Q1-2: Collaborate with ePMA and IM&T team for opioid discharge quantity flags and the addition of mandated duration of opioid prescriptions on discharge in electronic medication system following evaluation Action 2. Q3-4: Pilot plan and review.	Aim for reduction in opioid prescribing at discharge of at least 10% compared with 2022-23 baseline data, without evidence that pain management has been compromised.
Action 7:	

Establish Trust wide baseline audit of patients being discharged from the emergency department with a supply of opioid prescription exceeding three days of treatment to inform need and plan for education and culture change. Q1-2: Collect data on current ED opioid discharge prescriptions Q3-4: Based on data introduce education and guidance for limited opioid prescribing on ED discharge	Baseline opioid prescribing pattern in emergency department, and education to limit discharge opioid prescribing.

Quality Priority 1(b): Medication Safety - Insulin

Executive Lead: Anny Sykes, Chief Medical Officer; Sam Foster, Chief Nursing Officer

Quality Priority Lead: Dr Alistair Lumb

Insulin is recognised as a high-risk medication. The Trust is required to identify and report rates of the most severe harms associated with insulin as part of the National Diabetes Inpatient Safety Audit (NDISA), a mandatory national audit. The rates of harms have slowly decreased nationally, driven primarily by a reduction in episodes of severe hypoglycaemia, but concerns have been raised about the accuracy of the data reported. Work has been undertaken in previous years within the Trust to ensure accurate reporting within OUH, but in order to improve accuracy nationally the definition of severe hypoglycaemia is soon to change. Trusts will be required to report all episodes of blood glucose below 2.2 mmol/l occurring in people with diabetes over the age of 18. Scoping has suggested over 600 such events occurred in the Trust Jan to Dec 2022. Hypoglycaemia is associated with increased morbidity and mortality as well as increased length of stay. The aim of the quality priority this year is to support clinical areas to identify and learn from episodes of severe hypoglycaemia, in order to use this learning to drive a reduction in the number of our patients experiencing severe hypoglycaemia.

What we will do	How we will evaluate success
Action 1 (Q1): Set up a monthly search within the point of care glucose software, which will be used to provide feedback on rates of severe hypoglycaemia to ward areas.	Report available which will • Permit benchmarking in rates of severe hypoglycaemia between wards • Allow wards to track rates of severe hypoglycaemia over time
Action 2 (Q2): Trial a Severe Hypoglycaemia Analysis form (developed during the 2022-2023 Insulin Quality Priority) to support ward areas to identify underlying causes for episodes of severe hypoglycaemia. Use feedback to finalise a form to be used.	Severe Hypoglycaemia Analysis form to be trialled on 3 wards and feedback used to develop a final version.
Action 3 (Q3-4): Support ward teams to develop and test improvement plans for reducing the rate of severe hypoglycaemia on their ward.	Support 3 ward areas to develop and test an improvement plan for reducing severe hypoglycaemia
Action 4 (Q4): Co-develop interventions to reduce episodes of severe hypoglycaemia (glucose less than 2.2mmol/l) on 3-5 wards with the highest rates of hypoglycaemia.	Reduction in no. episodes of severe hypoglycaemia on intervention wards (target 10% reduction).

Quality Priority 2: Care of the Frail Elderly Executive Lead: Anny Sykes, Chief Medical Officer; Sam Foster, Chief Nursing Officer Quality Priority Lead: Sudhir Singh *Frail, elderly patients make up a substantial proportion of patients presenting to urgent and emergency care settings. Early, comprehensive assessment of these patients can improve outcomes by ensuring the acute care, management pathway and future care plans are all tailored appropriately to the patient's needs. This quality priority focusses on strengthening the assessment of frail, elderly patients in the Emergency Department (ED) and Same Day Emergency Care (SDEC) settings. It aligns with CQUIN05 'Identification and response to frailty in emergency departments'.*	
What we will do	**How we will evaluate success**
Action 1 (Q1): Establish a Frailty multi-disciplinary team to support early assessment of frail, elderly patients in the ED and Acute Ambulatory Unit (AAU). This will be supported in the first year by CQUIN funds.	Successful recruitment of Frailty multidisciplinary team.
Action 2 (Q1-4): Strengthen documentation of Clinical Frailty Score (CFS) among patients aged 65 years and older attending ED or AAU.	Increase to >70% the proportion patients aged 65 years and older attending ED or AAU that have a CFS documented.
Action 3 (Q1-4): Strengthen documentation of Cognitive Assessment among patients aged 65 years and older admitted through ED or AAU.	Increase to >80% the proportion patients aged 65 years and older attending ED or AAU that have a documented Cognitive Assessment.
Action 4 (Q1-4): Improve the assessment and further management of frail, elderly patients by creating and implementing a system for comprehensive geriatric assessment (CGA).	>30% patients aged 65 and over attending ED or AAU to have a CFS documented and, if CFS>5, initiation of a comprehensive geriatric assessment or referral to acute frailty service. [CQUIN metric]
Action 5 (Q1-4): Develop (Q1-2) and collect (Q3-4) metrics to measure the impact of the Frailty MDT on patient care and outcomes including care setting, ceilings of care and re-admissions. Use this data to develop a business case for continuation of the service as business as usual.	Development of a business case for continuation of the service to support early assessment and appropriate management of frail, elderly patients in ED and SDEC.

Quality Priority 3: Reducing Inpatient Falls Executive Lead: Anny Sykes, Chief Medical Officer; Sam Foster, Chief Nursing Officer Quality Priority Lead: Rebecca Pratt *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 falls risk assessment, followed by action to address each of the falls risk factors identified. Early assessment of patients with a suspected serious injury is also important following a fall to ensure timely and appropriate analgesia, investigations and management. This Quality Priority focusses on strengthening training and implementation of the multifactorial falls risk assessment; addressing key areas for improvement identified in the most recent National Audit of Inpatient Falls; and strengthening assessments and information sharing following a fall.*	
What we will do	**How we will evaluate success**
Action 1 (Q1-4): Update and roll out education and policies • Q1: Roll out Hoverjack and Scoop training across the OUH • Q1: Develop Induction Training on Prevention of Falls for all new staff • Q1-4: Review and roll out 'Preventing Falls in Hospital' e-Learning to key staff groups • Q2: Re-launch the Trust Falls Champion Group • Q2: Update Falls and Bed Rail policies • Q2-3: Update Inpatient Falls leaflet (Q2) and develop an Easy Read version (Q3) • Q4: Develop Trust homepage for Falls Prevention with key resources for staff	Documented delivery and uptake of Hoverjack, Scoop and Induction training Updated role-specific e-Learning module Recruitment and engagement of Falls Champions Updated Falls and Bed Rail Policies approved Update Inpatient Falls leaflets approved and available for use Updated Intranet/Sharepoint site with key resources for falls prevention 60% Nursing and AHP to have completed e-Learning training by March 2024.
Action 2 (Q1-4): Increase Multifactorial Falls Risk Assessment (MFRA) compliance: Quarter1: • Identify 2 wards with the highest number of inpatient falls (1 at Horton, 1 at JR) • Audit baseline MFRA compliance in these 2 wards; promote increased compliance • Maximize uptake of falls prevention e-Learning among staff on each of these wards • Routine sharing of falls / patients at risk of falls in Safety Huddles and handovers Quarter 2: • Promote and support increased MFRA compliance using QI methodology • Audit and feedback MFRA compliance monthly on focus wards Quarters 3-4: • Expand to a further 4 wards with among the highest incidence of inpatient falls • Continue to promote and support increased MFRA compliance on all 6 wards • Audit and feedback MFRA compliance monthly on 6 focus wards	Quarter 1: • 2 highest incidence wards identified. • Baseline audit of MFRA compliance completed for the 2 wards • >90% staff on 2 wards completed fall prevention e-Learning Quarter 2: • Increased MFRA compliance on monthly audit (target 90%) Quarters 3-4: • Baseline audit of MFRA compliance completed for the 4 wards • >90% staff on 4 wards completed fall prevention e-Learning • Increased MFRA compliance on monthly audits (target 90%)

Action 3 (Q1-2): Improve front door walking aid access in all major admissions units in line with existing recommendations of the National Audit of Inpatient Falls	Audit walking aid availability 7 days a week in JR and Horton ED and EAU (target >90%).
Action 4 (Q1-4): Strengthen early assessment following a fall: • Complete baseline audit of early medical assessment for all inpatient hip fractures (Q1) • Develop and implement tools (e.g. Safety Message) to improve early assessment (Q2) • Re-audit early medical assessment following inpatient hip fractures (Q3,4)	Target: >90% patients with hip fracture should have had a medical assessment within 30 minutes of a fall.
Action 5 (Q1-4): Improve falls benchmarking and performance • Complete a gap analysis to determine magnitude of under-reporting of falls • Use results of gap analysis to estimate no. falls per 1000 occupied bed days • Compare this metric to national benchmarks	Target: (a) 6 focus wards, and (b) OUH overall, to be in the best quartile nationally for the number of inpatient falls per 1000 occupied bed days

Clinical Effectiveness

Quality Priority 4: Reducing Unwarranted Hospital Outpatient Cancellations Executive Lead: David Walliker, Chief Digital & Partnerships Officer; Sara Randall, Chief Operating Officer Quality Priority Lead: David Walliker *Cancellation and rearrangement of hospital outpatient appointments may delay patient treatment and follow up, impacting on clinical effectiveness as well as administrative efficiency and patient experience, and potentially leading to patient harm. While some cancellations are appropriate, for example to expedite an appointment or because an appointment is no longer required or the patient requests the appointment to be rescheduled, in other cases cancellations arise due to errors or inefficiencies. This quality priority focusses on reducing these unwarranted outpatient cancellations to improve clinical care, patient experience, and outpatient and administration efficiency. It aligns with the Integrated Quality Improvement Outpatient workstream.*	
What we will do	**How we will evaluate success**
Action 1 (Q1): Establish a dashboard for monitoring unwarranted hospital outpatient cancellations that includes the following metrics: • No. (%) unwarranted hospital cancellations* within 2, 4 and 6 weeks of appointment • No. (%) patients subject to unwarranted hospital cancellations* >3 times in a year • Average time to next booked appointment (days) following unwarranted cancellation	Development of dashboard that reports the stated metrics at Trust, Division, Directorate and Specialty level; and by factors associated with health inequalities including index of multiple deprivation, ethnicity, age and gender.

* Cancellations excluded include 'Added in error', 'Administrative Error', 'Appointment Expedited', 'Outpatient appointment not required', 'Patient booked outside Choose and Book', 'Patient Died (Auto-deceased)', 'Patient Medically Unfit', 'Request raised in error', 'Same day clinic amendment', 'Treatment no longer required'.	
Action 2 (Q2): Establish regular reporting of all metrics within the Divisional and Directorate Performance Reviews; and of one or more chosen metrics within the Integrated Performance Report (IPR).	Inclusion of metrics in Divisional and Directorate Performance Reviews and IPR. In addition to headline metrics, Directorates to provide assurance that the health inequalities dashboard has been systematically reviewed for each specialty and any unwarranted variation documented and, where appropriate, organisational or system levels actions set and delivered.
Action 3 (Q2-4): Develop and implement interventions to reduce the number of unwarranted hospital cancellations.	Reduction by >50% in the number of unwarranted hospital outpatient cancellations

Quality Priority 5: Rolling out and embedding the Surgical Morbidity Dashboard

Executive Lead: Anny Sykes, Chief Medical Officer

Quality Priority Leads: Zahir Soonawalla, Lucy Cogswell, Andrew Brent

Morbidity, which refers to medical problems caused during or by a patient's hospital treatment, indicates that something has gone wrong with a patient's recovery. It is common and affects at least 1 in 10 of patients in hospital. It is a very good indicator of quality of care. Complications are also costly to manage and reducing morbidity is therefore a very cost-effective approach to healthcare.

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

What we will do	How we will evaluate success
Action 1 (Q1): Pilot use of the Surgical Morbidity Dashboard in selected surgical services with training and evaluation of the value it adds to Morbidity & Mortality (M&M) meetings.	At least 3 surgical services will have been trained and used the Dashboard in their M&M meetings by end of Q1.
Action 2 (Q2): Implement any identified minor improvements to the dashboard if/as required to improve functionality, on the basis of feedback from clinical services in quarter 1.	Feedback collected, evaluated and incorporated as required.
Action 3 (Q2-4): Expand rollout of the dashboard to other surgical services in OUH	All major surgical services at OUH are offered training and use the Dashboard for their M&M meetings by end of Q4

Action 4 (Q2-4): Support introduction of selected, additional, procedure-specific complications for 2 services to increase dashboard utility for these services.	Dashboard updated to include additional procedure-specific complications for 2 surgical specialties.

Quality Priority 6: Helping more patients through Tissue Donation for Transplant Executive Lead: Anny Sykes, Chief Medical Officer Quality Priority Leads: James Dearman (ED), Matthew Giles (AGM), Victoria Hedges (Palliative Medicine) *As many as 50 lives can be helped by a single donor through the gift of tissues after death. Tissue donation, which is different from organ donation, includes corneas, heart valves, bone, tendons and skin. 70% patients express wishes to donate their organs or tissues after death but only a minority of these currently proceed to donation and knowledge among clinicians about the opportunities for tissue donation is limited. As a result, there is a potentially large missed opportunity to help more patients through tissue donation. This quality priority focusses on increasing clinicians' awareness and knowledge of tissue donation, and the number of referrals for tissue donation that are made, in key clinical areas of the Trust: Emergency Department (ED), Acute General Medicine (AGM) and Palliative Medicine. It builds on a successful pilot project in the Emergency Department.*	
What we will do	**How we will evaluate success**
Action 1 (Q1): Conduct a baseline audit, including: (a) Survey of doctors' and nurses' knowledge of tissue donation, including: • knowledge of tissue donation uses, requirements and pathways • confidence and experience in discussing tissue donation with patients/next of kin (b) Audit of the number (%) of deceased adult patients in OUH that had opted into the Organ Donation Register and/or who had "deemed consent".	Completed survey presented in ED, AGM & Palliative Medicine clinical governance meetings.
Action 2 (Q1-2): Develop Trust-wide policy & process for tissue donation referral incl.: • indications and contraindications for referral • approach to communication with patient and next of kin • standardised approach to documentation of patients' wishes regarding tissue donation • creation of EPR prompt embedded within the "Referral to Bereavement Services" form. • tissue donation referral pathway	Ratification of policy by Clinical Policy Group Agreement and implementation of required EPR changes including: • Standardised documentation of patients' wishes re tissue donation • creation of tissue donation prompt in bereavement referral form
Action 3 (Q1-3): Identify Tissue Donation Champions and develop and deliver training for clinicians in ED, AGM and Palliative Medicine, including: • departmental teaching and induction sessions • training day(s) for tissue donation champions • pre- and post-training survey to evaluate clinician knowledge and confidence	Record of training sessions delivered including dates and no. staff in attendance. Documented increase in knowledge and confidence.

Action 4 (Q1-3): Improve the information on tissue donation that is available to patients, relatives and clinicians by: • developing a patient information leaflet and web resources • incorporating tissue donation information into bereavement documentation • Editing and updating a trust intranet page dedicated to tissue donation	Approved patient information leaflet and system for sharing information with next of kin after death.
Action 5 (Q2-4): Focussed effort to support and increase the number of tissue donation referrals in the Emergency Department and two or more medical wards.	Aim to increase the number of tissue donation referrals in each clinical area, and to at least double the annual number of referrals overall in OUH.

Patient Experience

Quality Priority 7: Health Inequalities Executive Lead: Anny Sykes, Chief Medical Officer; David Walliker, Chief Digital & Partnerships Officer Quality Priority Lead: Simon Noel, Cheryl Muldoon, Brenda Kelly *Reducing health inequalities is a key objective running through the Trust's Clinical Strategy. Key to understanding, improving and monitoring health inequalities are good quality data on the key determinants of inequality including ethnicity. This quality priority includes work to improve ethnicity data to support a better understanding of, and interventions to improve, local health inequalities. It also focusses on understanding better how health inequalities impact on cancer and antenatal care. Poor engagement with antenatal care is a major risk indicator for adverse maternal and perinatal outcomes. As part of this quality priority we will explore local demographics and barriers associated with low engagement with antenatal care, and co-develop strategies to overcome these barriers with maternity service users including maternity advocate/community organisers and locality partners in health.*	
What we will do	**How we will evaluate success**
Action 1 (Q1): Undertake a baseline audit of the current availability and sources of ethnicity data on OUH patients, including: • data directly captured in OUH clinical areas • data available through existing external data feeds • patterns in data completeness or quality that might inform data improvement work • factors contributing to data quality (e.g. Summary Care Record data quality, policy and practice around data entry workflows, and staff education and training).	Completion of baseline audit.
Action 2 (Q1-2): Informed by the baseline audit and in collaboration with the OSMs and local management teams, formulate a strategy and implementation plan to improve ethnicity data. This will include detailed plans to achieve actions 3 and 4 below.	Agreement of action plan by stakeholders including action owners.

Action 3 (Q2-4): Informed by the baseline audit, choose at least 2 clinical areas requiring improvement and implement changes (e.g. workflow changes, training) to improve to >95% the proportion of patients attending the hospital that have their ethnicity verified and documented at their visit.	Quarterly audit of ethnicity data capture among patients attending hospital in the chosen clinical areas (target >90%).
Action 4 (Q2-4): Work with the digital team and system partners to optimise the quality and maximize sharing of ethnicity data across partner organisations by ensuring: • OUH data includes all ethnicity data from Primary Care and the NHS Spine • changes made to ethnicity records on OUH or elsewhere are updated across the system	Systems in place to ensure OUH and system partners have access to the same high quality ethnicity data.
Action 5 (Q3-4): Identify any inequalities in cancer pathway metrics related to specific demographic groups (e.g. by age, ethnicity, postcode). Develop an action plan to address any opportunities to improve cancer pathways for any disadvantaged group identified.	Summary of any inequalities identified. Action plan to address any improvement opportunities identified.
Action 6 (Q1): Accurately define key population demographics among pregnant women/people (including language, ethnicity and postcode) that are associated with: a) late booking for pregnancy care (as defined by NICE & OUH Antenatal Care guidance) b) failure to attend 2 or more antenatal clinic appointments.	Summary of key demographic factors and barriers associated with poorer engagement with antenatal services. Mapping analysis to determine any overlap with known health inequalities e.g. locality specific/place-based.
Action 7 (Q2-3): Identify any gaps in routinely captured data with respect to known social determinants of health within existing electronic maternity records and ensure gaps are addressed in BadgerNet maternity electronic patient record (rollout planned Autumn 2023).	Inclusion in BadgerNet of key social determinants of maternal health
Action 8 (Q2-3): Working with maternity service users including maternity advocate/community organisers and locality partners in health, use data from Action 6 to identify barriers to care and strategies to overcome these barriers.	Development of a strategic plan to address barriers to antenatal care among underserved groups identified.
Action 9 (Q3-4): Pilot at least one intervention from the strategic plan to address barriers to antenatal care.	Pilot data including evidence of the impact of the intervention on engagement with antenatal care among the group(s) targeted.

Quality Priority 8: Empowering patients – building partnerships and inclusion Executive Lead: Sam Foster, Chief Nursing Officer Quality Priority Lead: Caroline Heason *This Quality Priority focusses on strengthening the Trust's partnerships with patients and their families, particularly those lived experience and voice is not heard, in order to improve patient experience and services.*	
What we will do	**How we will evaluate success**
Action 1 (Q1-4): Further strengthen interpreting and translation services and uptake	Easy to use booking guidelines available to all staff.

Q1: Develop easy to use booking guidelines. Rectify IT challenges for video interpreting. Q2: Make enhanced training available to staff 24/7 Q3: Develop a Patient Story related to interpreting and present it to Trust Board Q4: Make available on the Trust website and social media an interpreting and translation film with communities' input Q1-4: Host Listening Events to learn from patients' lived experience of using interpreters.	IT challenges overcome to facilitate video interpreting. Enhanced training available to staff 24/7 on MyLearning Hub. Patient Story related to interpreting presented to Trust Board Interpreting and Translation film available on Trust website Listening events held with patient groups on lived experience using Interpretation & Translation services
Action 2 (Q1-4): Patient and Public Engagement • Re-launch Trust Patient Partnership Groups (PPGs), enabling groups to contribute to the work of their local clinical area and Trust development work • Recruit a bank of 'experts by experience' (patients, families, and carers) to contribute to service improvement and redesign • Develop a trust wide Quality Improvement (QI) model to learn from lived experience including patients and families helping develop QI projects and being involved in training • Host 2 'Listen Up' roadshows across Oxfordshire in partnership with local stakeholders including Healthwatch, governors and voluntary/advocacy/ community groups.	By end of Q4: • Experts by Experience plan and QI model developed • 20 experts by experience volunteers recruited • 10 Experts by Experience completed the Quality, Service Improvement and Redesign (QSIR) fundamentals training • 2 'Listen Up' events hosted with local stakeholders
Action 3 (Q1-3): Friends and Family Test (FFT) By Q1: • Promote FFT with both the community maternity teams and families. • Develop the Trust wide 'You said and we did' approach and incorporate into ward reporting, Divisional Quality Reports and Performance Reviews, Trust Board reports; and external communications via the Trust website and social media. By Q2: • Implement FFT online / via SMS texting for people who do not speak or read English • Develop interactive FFT dashboard for wards, departments, directorates and divisions. By Q4: • Identify patient groups that the Trust does not hear from via FFT and hold 3 focus days to collect FFT data from these groups • Extend the Trust interactive FFT dashboard to be a publicly accessible dashboard.	• FFT promoted to community maternity teams, families, Maternity Voices Partnership, 5X More and community groups. • 'You said and we did' incorporate into internal reporting and external communications as planned. • FFT developed and made available online / via SMS texting for people who do not speak or read English. • Interactive FFT dashboard for wards, departments, directorates, and divisions developed. • FFT underrepresented groups identified. Report following focus days presented to Trust Board/Integrated Assurance Committee. • Trust interactive FFT dashboard available on the Trust website as a publicly accessible dashboard.

Quality Priority 9: Kindness into Action - improving patient and staff experience

Executive Lead: Terry Roberts & Rachel Stanfield, Joint Chief People Officers

Quality Priority Lead: Jane Smith

Kindness into Action is a key deliverable we have committed to within our People Plan as part of Theme 1: Health, Wellbeing and Belonging for all our People and Theme 2: Making OUH a great place to work. Our staff survey continues to tell us that people are experiencing harassment, bullying or abuse from peers, managers and patients, and people do not feel equipped, confident or safe to speak up when they are negatively impacted by other people's behaviours. Leaders and managers have a disproportionate effect on culture, accounting for 70% in the variation in engagement levels between different teams. Our aim is to build a culture of kindness and provide guidance and support to have the conversations needed to resolve things together early.

Our purpose is to deliver a culture change programme in collaboration with Trusts and CCGs (ICB) that would instil a kinder culture within our workplace. Implementing a joined-up collaborative approach within the Trust with nominated resources, through ICS & Trust steering groups, and working with existing teams; OD, Wellbeing, HR etc. Kindness into Action brings to life the evidence showing how severe bullying harms people's health and wellbeing. Then introduces practical ways to reduce bullying and resolve it when it happens. It demonstrates how kindness also promotes trust - people in high trust organisations experience 50% higher productivity, 76% more engagement plus experience 40% less burnout and 13% less sick days. The programme is designed to support all to adopt new approaches, understand the value of kindness in teams and explore how to lead ourselves and others with kindness.

What we will do	How we will evaluate success
Action 1 (Q1-4): Training and awareness building Providing a blended learning approach to training; each leader attending 2 x 60-minute online sessions (2 hours in total), taking Kindness into Action e-learning modules between sessions to enhance learning. 30 date options will be available (per workshop) to enable us to train up to 3,000 Leaders and Managers across the trust, providing 60 sessions over the next 6 months with the specific objectives to**:** • To nurture a kinder culture across our healthcare system • To explore the evidence-base for kindness in healthcare • To clarify what it means to be a kinder leader • To create teams where people feel safe to speak up • To launch and practice new approaches to building trust, wellbeing, belonging, equality and inclusion in our teams • To respectfully resolve bullying and other poor behaviours • To become a safer place to work and to be cared for	Training uptake among 1800 based on providers best estimate of uptake (approx. 30% of staff) leaders and managers across the Trust, and by division, directorate and CSU (1800) (attendance as of 16/2/23 450 Session A and 252 session B) Quarter 1: • Establish a framework for reporting the take up of training attendance across the Divisions. (IPR/Divisional Reviews) Quarter 2-4: • Include reporting of uptake in Divisional Reviews. • Embed monitoring of take up into Integrated Performance Report (IPR) on a monthly basis by Division, to identify 'hot spots' and discuss actions to increase attendance.

All staff will also be encouraged to complete the Kindness into Action e-learning to help embed the tools and approaches in the way they work. To allow for more opportunities in having kinder conversations and for informal resolutions.	
Action 2 (Q1-2): Recruitment & Training of KIA Ambassadors Recruit (Q1) and train (Q2) a minimum of 2 KIA Ambassadors per Division, who will take opportunities in their role to talk about the value of kindness at an individual and team level: • using opportunities to share and promote KIA and Respectful Resolution tools • prompting discussions around acceptable behaviours in meetings or sharing experiences and success stories of applying tools • utilising opportunities to support others in using KIA and RR tools. Train the Trainer sessions (2 x 3-hour workshops) will be developed and delivered to build capability within OUH (Q2-4). We will establish a forum to gather feedback from Ambassadors, to understand and monitor the help required to embed the new tools.	KIA Ambassador training attendance A minimum of 2 Ambassadors in each Division – including 1 in HR KIA Ambassador feedback: A minimum of 80% of attendees feel more confident promoting the use of the tools as a result of attending the train the trainer workshops
Action 3 (Q1-2) Integration of tools in existing programmes Building the Kindness into Action and Respectful Resolution modules into our ongoing Culture and Leadership training, supported by training materials, speaker notes, workbooks. This will include: 1. Face-to-face leadership training 2. Onboarding 3. VBA and VBC 4. Developing 1:1 Feedback Skills Taster – introducing ABC and BUILD Quarter 1: Identify programmes across the culture and Leadership Service where KIA and RR tools can be integrated and develop a plan for integration by December 2023. Quarter 2: Review monthly the plan of all courses for integration of content within CLS Heads of Service Meetings to ensure completion by Q2.	We will have integrated the tools within existing Culture and Leadership programmes, to ensure there is understanding of the tools and how they relate to other programme agendas by the end of Quarter 2.
Action 4 (Q1-4): Identification and support for areas of concern We will work with specific Divisions/Directorates/CSUs where there have been 'deep dives' into culture, e.g., through external reviews, to identify areas in need of additional support, and specific measures of 'behavioural' improvement, based on recommendations and staff survey data. Training will then be tailored to provide relevant additional support, e.g., kindness charters and targeted Leading with Kindness sessions.	Areas in need of additional support based identified and specific actions/training provided to address specific cultural and/or behavioural challenges.

Action 5 (Q1-4): Monitoring impact through staff surveys Within themes 1 and 2 (*Health, wellbeing and belonging for all our people* and *Making OUH a great place to work)* of our People Plan we have committed to delivering a cultural change programme to address poor behaviours in year 2 and instil a more civil, respectful and kinder culture within our workplaces. We will use the Staff Survey to gather feedback from all our colleagues about what is working well & to highlight what we could improve upon in the areas of bullying and harassment from managers, colleagues and patients. We will use feedback from both the quarterly Pulse and annual survey to inform improvement against specific Staff survey questions, and our OUH People Plan KPI's.	Staff survey metrics related to bullying and harassment from managers, colleagues and patients including: • improvements in all 3 questions on bullying and harassment (2023 Staff Survey) • improvement in Advocacy and *Making OUH a great place to work* (2023 Staff Survey) • improved performance in quarterly Pulse Surveys (results in Feb, May and Aug 2023) We also monitor and report workforce KPIs as part of our People Plan and monthly IPR reporting, including sickness, turnover, informal resolutions, disciplinary cases.