Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 12 March 2025

TB2025.18

Title:	**OUH Draft Quality Priorities 2025-2026**

Status:	**For Discussion**
History:	**New proposal for 2025-26 Quality Priorities**

Board Lead:	**Chief Medical Officer & Chief Nursing Officer**
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Confidential:	**No**
Key Purpose:	**Assurance**

OUH Draft Quality Priorities 2025-2026

1. Background

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

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

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

2. Proposed Quality Priorities for 2025-26

2.1. Based on earlier suggestions from the Clinical Governance Committee, feedback and suggestions from the Quality Conversation Event and feedback from Executive Directors, the following Quality Priorities (QP) are proposed for 2025-26.

Patient Safety

- QP1. System for Electronic Notification and Documentation (SEND)
- QP2. Medicines Reconciliation
- QP3. Fragility Fracture pathways – including fractured neck of femur pathway*

Clinical Effectiveness

- QP4. Standard Work
- QP5. Outreach Services from Oxford Critical Care*
- QP6. Discharges

Patient Experience

- QP7. Maternity Experiences
- QP8. ReSPECT (Recommended Summary Plan for Emergency Care and Treatment)
- QP9. Supporting vulnerable patients including those with learning difficulties

*Carried over and updated from the 2024-25 Quality Priorities.

2.2. It is proposed that the following Quality Priorities from 2024-25 are absorbed into ‘business as usual’ in 2025-26:

- Care of the Frail Elderly – focussing on the urgent care pathway
- Kindness into action – improving patient and staff experience
- Reducing Inpatient Falls
- Rolling out and embedding the Surgical Morbidity Dashboard
- Reducing Health Inequalities
- Patient experience with PSIRF (patient safety incident response framework)
- Medication Safety Framework

2.3. Detailed plans and how we will evaluate success for each of the proposed Quality Priorities for 2025-26 can be seen in Appendix 1.

3. Recommendations

3.1. Trust Board is asked to review the proposed Quality Priorities for 2025-26

Appendix 1 - Proposed Quality Priorities for 2025-26

Patient Safety

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

Why is this a priority?

SEND (System for Electronic Notification and Documentation) was developed in Oxford with support from 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 minutes will highlight progress
Objective 2	

(Q1-3) **Update and roll out education and policies by:** • 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 Policy (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 MyLearningHub (MLH) • SEND learning resources included in core clinical induction • Other training materials updated and available on intranet • The SOP is signed off and, on the intranet • The RAID policy is 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 • 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 Trust-wide	• 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 roll out to hospital at night team handovers has been successful based on feedback and audits and sign off on the roll out

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 roll out 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 roll out 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 • 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	• 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 • Improvement in the observation compliance rates • Improvement in cardiac arrest rates/2222 calls • Improvement in the metrics in the quarterly report showing less maintenance issues with SEND devices

Patient Safety

Quality Priority 2: Medicines Reconciliation

Why is this a priority?

A 2018 Cochrane review found that 56% patients are at risk of medication discrepancies at transitions of care. Published data suggest inadequate reconciliation of medications is estimated to cause 40% 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 data set 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 index (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 and

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 2 PDSA cycles1 testing improvement(s) to be completed by end of Q2. Options dependent on QI scoping, but could include redefining responsibilities, embedding 12noon huddles, GIRFT approach with clerking clinician engagement, 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 7days service modelled • A business case has been produced (if required)
Objective 5 **(Q1-4)** **Facilitate community reconciliation on discharge** • Embed PharmOutcomes referral tool within EPR to efficiently refer patients to community pharmacy on discharge	• 1.5% of completed consultant episodes referred (from hospital episode statistics (HES) data • 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 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) & 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 • BPT (Best Practice Tariff criterion (a), Time to theatre <36hours, >85% performance • GO review on day of admission- Target is 85% of patients seen on day of admission

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 reduced acute length of stay has reduced and patients are not being readmitted
Objective 3: **(Q1-3)** **Improving multi-speciality working to care for NAFF fracture patients** • Q1-2: Workforce review to deliver a daily multidisciplinary meeting including theatre teams to facilitate preoperative care and shared decision making. • Q2-3: Workforce mapping and capacity modelling to deliver equitable orthogeriatric care across all OUH sites and provide 7-day cover • Q2-3: Trauma anaesthetic workforce review and gap analysis to support a business case to increase number of trauma anaesthetists to support earlier pre-operative reviews	• Daily MDT meeting in theatre • Workforce demand and capacity modelling completed • Business cases Trauma anesthetist submitted to BPG • Data/questionnaires show that daily MDT meetings with theatre staff are occurring and that all staff groups feel that this has improved overall care for NAFF patients and the teamwork
Objective 4 **(Q1-4)** **Improving Cohorting of NAFF patients**	• 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

• 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 peri-operative period • Q4: Develop business case if needed	• Q4: Number of unnecessary outlier NAFF patients to be minimised outside of Trauma Unit and/or dedicated NAFF ward • Q4: NHFD KPI 0 – Greater than 85% of patients are given a nerve block and admitted to an appropriate orthopaedic or orthogeriatric ward within 4 hours of presentation. • The cohorting of NAFF patients is occurring and working well • That 'ring fenced' 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 MUST (Malnutrition Universal Screening Tool) 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 the 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* • By the end of 25/26, Standard Work approach will be established in phase one priority areas, demonstrating 80%	• Develop standard protocols collaboratively with front-line staff, support adoption of continuous improvement approach and digitisation of results at ward level across identified priorities (e.g. Board Rounds, Equipment Checks, 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

increase in adherence increase to defined standards as measured through regular audits	• There will be a reduction in variation in practice across selected areas • 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 Trust wide 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
Objective 3: **(Q1-4)** **Long term strategy** • Define Long-Term approach to Trust wide Adoption of Standard Work • Engage staff and stakeholders to co-design a long-term strategy post 25/26, defining ongoing approach to scale up and integrating into OUH's strategic planning / Quality Management System	• Drafted and approved Trust-wide roadmap with divisional oversight framework • Evidence of measurable improvement in KPIs, i.e. 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 GIRFT (Getting it right first time), 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, co-ordinated and overseen by Oxford Critical Care / 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	• Project board initiated with agreed terms of reference • Minutes from meetings • Project plan progressing

• To include Marthas Rule	• Actions are occurring from the project board
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** • 4-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
Objective 6 **(Q3-4)**	• The OCC is in place as per the business case by end of Q4

Implementation • CCO implementation based on outcome of options appraisal and business case	
Objective 7 **(Q1-4)** **Marthas Law** • Agree alignment of Martha's Law with CCO	• Process map with GAP 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 TTO (to take home) 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 6 months (questionnaires and friends and family tests) • There will be a 15% reduction in discharge-related complaints

	• Reduction in incidents regarding discharges
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 6 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

• 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 has been disseminated • Data supports adherence to 25% of ward discharge by Midday • Positive feedback from patients and families regarding the discharge process, through PALS, Friends and family tests • 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 the 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 will we 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 (Feb 25 data collection) • Reduce the number of red rated reported communication-related complaints by 50% with an improvement in

	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 % compliance
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: ReSPECT (Recommended Summary Plan for Emergency Care and Treatment)

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 our the BOB Integrated Care System-wide approach to align DNACPR (Do not attempt CPR) 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 will we do?	How will you know the objective is completed and that it is working?
Objective 1 **(Q1)** **Launch ReSPECT** • Launch ReSPECT in the OUH	• Successful launch of ReSPECT in the OUH following rollout and communication strategy • EPR process is working as designed • ReSPECT is live and used in the OUH
Objective 2 **(Q 2-3)** **Evaluate**	• Compliance with approved ReSPECT policy • ReSPECT is used appropriately to document patient's wishes in the event of an emergency

• Evaluate the ReSPECT process and its documentation in EPR across the organisation	• Information from ReSPECT document is communicated via planned workflow to GPs and to South Central Ambulance Service (SCAS) • 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 cardio-pulmonary resuscitation (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 MyLearningHub (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	• 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 tests, 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.

• 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 • 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 in the 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 difficulties

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 including in consultations, diagnostic procedures or 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. 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 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 McGowen 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 McGowen 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
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 Trusts 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** • Some patients with learning disability or who are Autistic can find a diagnostic procedure impossible to undertake without a general anaesthetic. To develop a Trust wide pathway to facilitate diagnostic procedures under general anaesthetic	• 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

Objective 4 **(Q1-4)** **Working across specialities** • Some patients with learning disability have multiple health conditions which require active coordination across specialities. 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 Trust wide 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, 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 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 the 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 standards (AIS) when booking an outpatient appointment and when admitted to hospital
  • Test in 6 areas
  • Scale up to 5 areas per Division
• Roll out the RADF across Trust
• Complete training with teams
• Establish process of data capture and reporting mechanism by end of Q4 . Record number of reasonable adjustments 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 6 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 campaign, patient information leaflets and updates on the trust website for patients and their families who have a right to ask for reasonable adjustments. Draft by the end of Q2 and roll out from and including Q3 and Q4	• Completed patient information leaflets • Updates are on the Trusts website