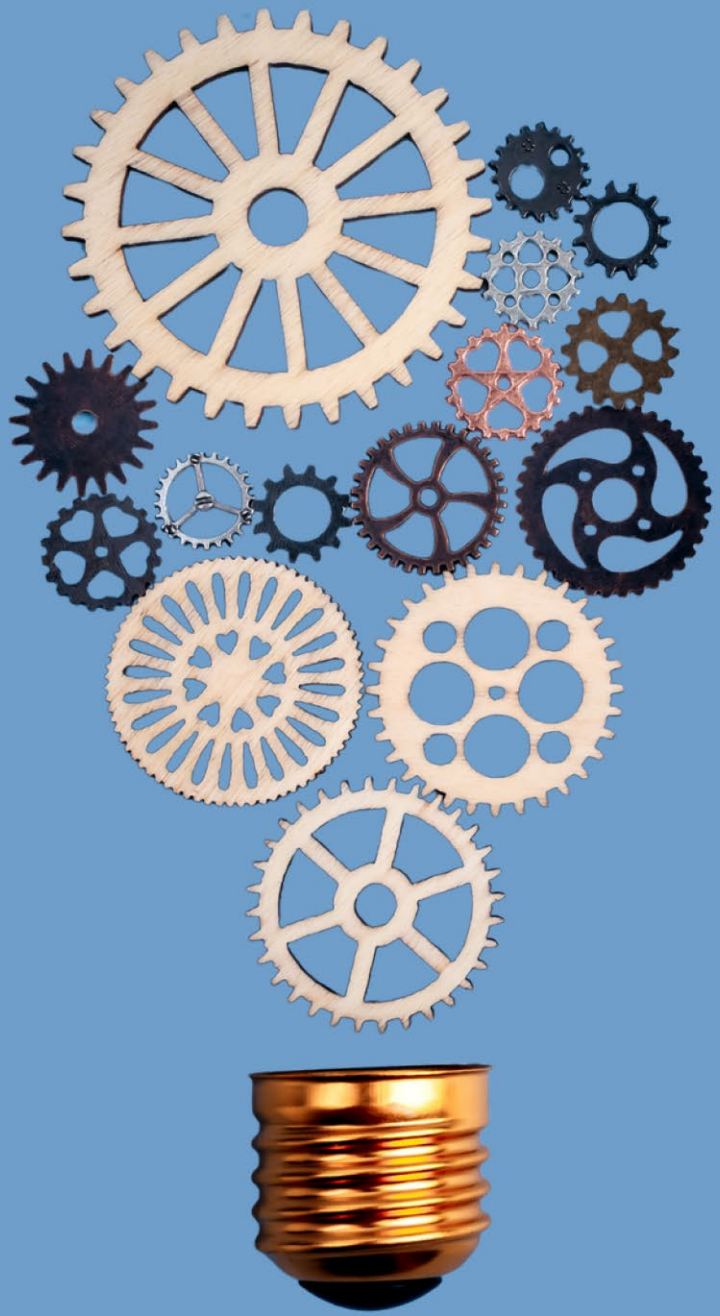
Health Innovation
Oxford & Thames Valley



Quarterly Report: Q1 2026/27

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Health Innovation Network
Local change, national impact

Office for Life Sciences

NHS

Contents

Overview by Professor Gary Ford, CEO

Our three case studies this quarter demonstrate our work across the innovation pathway. The first is the development and evaluation of an integrated community secondary care pathway for compression therapy for venous leg ulceration. Effective treatment of this common frequently neglected problem realises major patient and workforce benefits. The next phase of this programme is the scaling of the model across other sites in the Thames Valley.

The second is a feasibility study to understand the potential barriers to adoption of a new rapid diagnostic blood test to rule out infection in emergency settings. Such diagnostics will optimise the use of antibiotics, a critical element of preventing the development of antimicrobial resistance and facilitate the early identification and treatment of sepsis.

The third case study is an early health economic evaluation of a novel therapy to improve delivery of chemotherapy drugs for breast cancer brain metastases. Understanding the potential value and cost effectiveness of novel treatments in the NHS and other health systems is important in informing research and development investment decisions by research funders and companies.

This year we received an additional commission from NHS England to develop regional programmes of work with the Kent Surrey Sussex and Wessex health innovation networks. With Wessex we will increase use of Cognitive Behavioural Therapy for Insomnia (CBT-I) with NICE-recommended solutions such as Sleepio[1]. Insomnia disorder is among the top ten reasons for consulting a GP. Sleep loss costs the UK an estimated £34 billion annually. It is an example of an underserved and overlooked problem that if addressed would bring significant economic as well as health benefits. Despite this, the tools available in primary care have been limited to sleep hygiene advice and hypnotic drugs which only work short-term and have problems of dependence and addiction. CBT-I is more effective and should be the first line treatment but remains under-utilised.

We supported the successful development of Sleepio some years ago and it is pleasing to see that NHS England is now looking to nationally procure CBT-I solutions that will enable our plans for wider adoption of evidence-based digital therapies.

I was pleased to see the recently published Life Sciences Sector Plan one year update highlighting our team's leadership and brokerage in creating the Respiratory Transformation Partnership with AstraZeneca, Chiesi, GSK and Sanofi[2]. This unique national initiative and the role of health innovation networks was highlighted by Baroness Merron in response to a parliamentary question on respiratory disease and preventable deaths[3]. The report also notes the progress in reducing clinical trial set-up times is an important long overdue achievement necessary if we are to continue to attract life sciences companies' investment in the UK.

More controversial in the report is the commitment to double spending on innovative medicines as a proportion of UK GDP from 0.3% to 0.6%[4]. As part of that commitment the government instructed NICE to increase the Quality Adjusted Life Years (QALYs) threshold of £20,000-£30,000 used to decide whether new treatments should be provided by the NHS, to £25,000-£35,000. It is difficult to predict the impact of this change on uptake of new NICE-approved therapies which will depend on policies introduced in the NHS to support and drive adoption. Uptake by the NHS of NICE-approved therapies has improved but considerable postcode variation in uptake continues to exist, driven by the position local commissioners and providers take. The commitment to increased spending will require greater use of NICE-approved therapies which health innovation networks can support when national and local policies address adoption. The introduction later this year of a Single National Formulary (SNF)[5] is an important development that will support improving patient access to NICE-approved therapies. The initial focus is on four therapy areas; heart failure, type 2 diabetes, ophthalmology and asthma. The NHS Thames Valley Integrated Care Board is one of the early adopting sites. We will look for opportunities to achieve rapid and equitable adoption of cardiovascular and respiratory therapies that the SNF may provide.

Finally, I am delighted to announce the appointment of Ryan Kerstein as our Chief Medical Officer. Ryan, who joins us in September, is a Consultant Plastic and Reconstructive Surgeon and Associate Medical Director for Research at Buckinghamshire Healthcare NHS Trust. He is also the Lead for the Royal College of Surgeons Future of Surgery Innovation Hub. Ryan brings extensive clinical experience in innovation to the team.

1. https://www.nice.org.uk/guidance/htg624/resources/putting-nice-guidance-on-the-management-of-insomnia-disorders-into-practice-15662656333/chapter/Overview
2. https://www.gov.uk/government/publications/life-sciences-sector-plan-one-year-on
3. Respiratory Diseases: Health Services – Written Answer, 22 July 2026 (Hansard citation: HL Deb, 22 July 2026, cW)
4. Cross C, Claxton K, Hill A. Health costs of the UK-US trade deal on pharmaceuticals. Br Med J 2026;394:e340588
5. https://www.england.nhs.uk/blog/fairer-faster-access-to-medicines-for-nhs-patients-delivering-the-single-national-formulary/

Case studies

1 Developing safe and effective protocols for compression therapy in secondary care

Summary

Health Innovation Oxford and Thames Valley worked with Oxford University Hospitals to transform inpatient lower limb care in line with the National Wound Care Strategy Programme. A new pathway, led by advanced tissue viability nurse practitioners, was piloted on two medical wards at the Horton General Hospital. The pilot provides a strong foundation for wider adoption across integrated care systems and supports the development of a consistent, evidence-based model for inpatient lower limb care. It demonstrated a clear shift in clinical practice from routine removal of compression therapy to proactive assessment and delivery of evidence-based treatment. It enabled earlier identification of suitable patients, structured clinical decision-making and improved integration between acute and community services. Over 14 months, 130 patients received compression therapy, 100% of eligible patients were offered treatment and no adverse incidents were reported, demonstrating that compression therapy can be safely embedded into acute care pathways when supported by structured processes and workforce competency frameworks. The next phase of the programme will focus on scaling and embedding the pathway across additional wards and services.

Issue being addressed

Compression therapy is an effective treatment for venous leg ulceration. It is routinely removed on admission leading to missed opportunities for early intervention leading to deterioration, delayed healing and increased risk of infection and complications. Workforce pressures, unclear clinical pathways and limited access to training further compound unwarranted variation in care, creating inequity in access to this first-line treatment. Embedding a more consistent, evidence-based approach to compression therapy delivery within inpatient care offers the potential to improve outcomes.

What we did

A pilot inpatient lower limb pathway was implemented across two medical wards, designed to align acute care delivery with national best practice.

Key interventions tested included:

- Development and implementation of a clinical proficiency framework to support safe application of compression therapy
- Upskilling of the Tissue Viability Service (TVS) in advanced assessment, diagnostics and decision-making
- Delivery of competency-based education and training for ward nursing staff
- Introduction of a revised clinical pathway incorporating early assessment, red flag identification and initiation or continuation of compression therapy
- Implementation of a structured data collection framework to monitor activity, eligibility, uptake and variation
- The pathway enabled earlier identification of suitable patients, structured clinical decision-making and improved integration between acute and community services.

Impacts

The pilot demonstrated strong clinical, operational and workforce outcomes, providing robust evidence to support the safe and effective implementation of compression therapy within inpatient settings. There was a clear shift in clinical practice from routine removal of compression therapy to proactive assessment and delivery of evidence-based treatment. A total of 130 patients received compression therapy during admission, with 100% of clinically eligible patients offered treatment, reflecting high pathway reliability and adherence. No adverse incidents were reported. The introduction of routine data metrics strengthened governance and oversight, enabling better visibility of activity, identification of variation and supporting continuous service improvement. Key outcomes are listed below.

Pre-pathway implementation >>>>>>>	Opportunity realised
Compression removed on admission	**Compression continued/initiated**
Inconsistent assessment	**Structured pathway of assessment and diagnosis**
Low confidence in staff	**Competency-based training in compression therapy application**
Reactive care	**Proactive, evidence-based care**
Risk of deterioration	**Safe and effective lower limb care**

Next steps

The next phase of the programme will focus on scaling and embedding the pathway across additional wards and services. Key priorities include:

- Scaling the pathway across OUH inpatient services
- Strengthening workforce training and maintaining competency frameworks
- Embedding digital data capture to support real-time monitoring and decision-making
- Strengthening integration with community services to ensure continuity of care
- Undertaking further evaluation of patient outcomes including healing rates, readmissions and system impact
- Exploring economic and environmental sustainability benefits including reduced resource utilisation and improved efficiency

Contact

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2 Supporting early rule-out of infection in urgent and emergency care: A feasibility study or a rapid molecular diagnostic device

Summary

Health Innovation Oxford and Thames Valley (HIOTV) performed a feasibility study of InfectiClear Rapid, a molecular diagnostic designed to support early rule out of infection in emergency and acute care settings, developed by Presymptom Health. Semi-structured interviews were conducted with clinicians across nine NHS trusts to explore unmet needs, perceived usefulness, barriers to adoption and practical pathway fit.

Problem being addressed

Suspected infection is a frequent reason for emergency attendance, yet existing diagnostics often leave clinicians uncertain. Blood cultures can take days, while biomarkers such as C-reactive protein (CRP) and procalcitonin (PCT) lack specificity, contributing to non-targeted or unnecessary antibiotic use, which increases antimicrobial resistance and exposes patients to avoidable treatment risks, as well as potentially unnecessary hospital admissions. These patterns drive considerable cost through longer hospital stays, repeated assessments and unnecessary testing and treatment.

What we did

HIOTV carried out a feasibility study using its Lean Assessment Process (LAP) methodology to understand the unmet needs and barriers to adoption in acute and emergency care settings. This included designing interview materials, engaging stakeholders across nine NHS organisations and analysing feedback from clinicians working in urgent infection pathways. The outputs shaped an evidence-informed view of pathway fit, clinical priorities and areas where the test may add most value.

What has been achieved?

The findings showed strong clinical interest in the innovation. Clinicians felt that an accurate, rapid local laboratory infection rule-out test could help reduce diagnostic uncertainty, guide decisions around antibiotics and admission and improve patient flow. They also described potential operational benefits, noting that earlier clarity could reduce repeated reviews, support appropriate and targeted use of antibiotics and help staff prioritise higher-risk cases. This work enabled InfectiClear to refine its positioning and focus on priority pathway applications for future research.

If accuracy and performance are confirmed, InfectiClear Rapid could help improve the infection and sepsis pathway by enabling earlier and more consistent decision-making. Clinicians suggested that this could reduce unnecessary admissions, shorten stays and support safer discharge, helping to relieve pressure on emergency services and enhance patient experience.

While this phase did not include economic modelling, clinicians recognised the potential for system efficiencies through fewer avoidable hospital admissions, more appropriate antibiotic use and more efficient use of clinician time. Future economic analysis may help quantify these gains and support commissioning decisions.

PPIE conducted

Patient and public involvement activity has been included as part of the wider InfectiClear programme. Discussions with individuals who have lived experience of infection and sepsis were used to understand patient perspectives and ensure that user needs inform ongoing development.

Lessons learned

The feasibility work highlighted several conditions important for NHS adoption. Turnaround time was seen as critical, with most clinicians expecting results within 30–60 minutes to influence real-time decisions. Integration with existing workflows and digital systems will be essential to avoid increasing the burden on clinical teams. Clinicians also emphasised the need for strong diagnostic accuracy to build confidence and support widespread uptake.

In addition, several stakeholders noted that demonstrating cost-effectiveness will be an important factor for future commissioning decisions, particularly in showing value relative to existing diagnostic processes and hospital resource use. These lessons will guide future research, accuracy testing and commercial planning.

Feedback

"Working with the HIOTV team on this feasibility study has been an extremely positive experience. Their responsiveness, clarity and willingness to engage deeply with the technical and clinical questions we faced made the collaboration both efficient and genuinely constructive. The study has provided us with valuable insights that directly support our decision-making around assay optimisation, platform transfer and early clinical deployment.

"The feasibility work has already helped shape our development roadmap and strengthened our strategic planning for point-of-care integration. The expertise and partnership approach from HIOTV ensured we were able to interrogate key assumptions early, identify technical risks and build confidence in the direction of travel for InfectiClear." - Nadia Whittley, CEO, Presymptom Health

Next steps

The feasibility evaluation provides a strong foundation for InfectiClear's next phase of evidence generation. Stakeholders recommended progressing to multi-centre diagnostic accuracy trials to determine real-world performance, followed by a full economic evaluation to support future business cases. As development continues, the company will also need to explore workflow integration, usability and the potential for point-of-care deployment. The insights gathered through the feasibility study position InfectiClear well for these next steps and strengthen its readiness for further clinical validation.

Contact

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3 Health economic evaluation of novel drug discovery agent in breast cancer brain metastases

Summary

Breast cancer brain metastases (BCBM) occur when cancer cells spread from the breast to the brain and represent a substantial clinical and economic challenge for the NHS. mutTNF (mutant tumour necrosis factor) is a novel therapy designed to temporarily open the blood–brain barrier at sites of brain metastases, improving the delivery of treatments to tumours in the brain. Health Innovation Oxford and Thames Valley (HIOTV) conducted an early health economic evaluation of mutTNF, mapping the clinical care pathway and developing a cost-effectiveness model to explore its potential value for the NHS.

Problem being addressed

Breast cancer brain metastases are associated with poor prognosis and high healthcare costs within the NHS. In early disease, the blood–brain barrier blocks most chemotherapy drugs from entering the brain and later it lets some through, which limits how well treatments work. At the same time, new treatments that work by helping medicines cross the brain's protective barrier, like mutTNF, are still unproven and their future cost is unclear, so early economic analysis is needed to guide development and support future NHS decisions.

What did we do?

HIOTV carried out an early health economic evaluation of mutTNF in breast cancer brain metastases. We mapped the current care pathway and built a cost-effectiveness model to understand how improving delivery of treatment to tumours in the brain could affect patient outcomes and NHS costs. We also explored different scenarios and estimated the potential price range at which mutTNF could still represent good value for the NHS.

What has been achieved?

Our work provided early evidence on the potential value of treatments that help therapies reach tumours in the brain in breast cancer brain metastases. The analysis also produced a flexible economic modelling framework that can be adapted for other cancers that metastasise to the brain, supporting future research and evaluation. The early findings were used to support a grant application for real-world evaluation. We also presented the work as a poster at an international conference (ISPOR), where the abstract was selected among the top 5% of submissions. In addition, we are preparing a health economic manuscript to further share the results.

Lessons learned

The project highlighted the importance of early health economic evaluation in guiding the development of emerging therapies. When clinical effectiveness and pricing remain uncertain, threshold analysis can be particularly valuable for exploring potential value and informing development decisions. The work also showed how methodology-led analysis can generate useful insights even when clinical evidence is still evolving.

Spread and adoption methodology used

- Clinical pathway mapping
- Decision-analytic cost-effectiveness modelling
- Deterministic and probabilistic sensitivity analyses
- Stakeholder-focused evidence synthesis to support translational decision-making

Feedback

"Working with Health Innovation Oxford and Thames Valley on this project has been extremely positive. They took time to fully understand mutTNF and its potential clinical application and, subsequently, produced a comprehensive independent analysis of the health economics benefits of mutTNF in clinical care for breast cancer patients. The results of this analysis are pivotal in supporting our case for onward clinical translation and demonstrating the potential clinical benefits of mutTNF." – Nicola Sibson, Professor of Imaging Neuroscience, University of Oxford

Next steps

This work provides a strong foundation for further development. Following the breast cancer brain metastases evaluation, Health Innovation Oxford and Thames Valley, in collaboration with the University of Oxford, has undertaken additional economic evaluations of mutTNF in other cancers that metastasise to the brain, including lung cancer and melanoma. Each evaluation was designed specifically to reflect the distinct clinical context, care pathways, and treatment patterns within each indication, while assessing the potential value of mutTNF within an NHS setting.

Collectively, this programme of work strengthens the early evidence base for mutTNF across multiple tumour types and demonstrates the applicability of economic evaluation in supporting development decisions in areas of high unmet need.

Further work will focus on generating real-world evidence to validate and refine these early findings, alongside developing return-on-investment (ROI) assessments to support future decision-making. This work will also inform trial design, patient and public involvement activities, and longer-term considerations around pricing, reimbursement, and potential NHS commissioning.

Contact

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Programme summaries

1 Clinical Innovation Adoption (CIA)

The Clinical Innovation Adoption team focused on mobilisation, stakeholder engagement and moving several programmes into active delivery during Q1. All projects remained green at quarter end, with progress across respiratory, diabetes, kidney disease, epilepsy, stroke and urology.

The Respiratory Transformation Partnership (RTP) continued to develop as HIOTV's flagship national programme. Formal governance was established with partners, the Steering Group met in April, and the national launch webinar attracted 712 registrations and 519 attendees. All 15 health innovation networks committed to delivery with roles, grant funding and monthly delivery arrangements confirmed. The 2025/26 Pathway Transformation Fund sites completed their final reports and took part in a national celebration of learning, while the six ex-mining community sites began local engagement, community delivery and diagnostic activity. Ten industry-aligned projects, covering 31 sites nationally and involving AstraZeneca, Chiesi, Sanofi and GSK, progressed through site selection and initial implementation. Regional readiness activity also began following NICE approval of the first COPD biologic.

In chronic kidney disease (CKD), the national LUCID programme formally launched on 22 June. A national implementation toolkit and stakeholder engagement resources were made available, and programme measures are being finalised, including indicators relating to primary care network implementation, workforce training and medicines outcomes. Q2 activity will concentrate on local planning, engagement and readiness.

The Type 1 Diabetes Outpatient Transformation programme mapped and engaged all nine services in scope, with baseline maturity assessments beginning at several sites. The team secured a regular position on the Hybrid Closed Loop Implementation Group and contributed to national communities of practice, aligning delivery with the National Diabetes Audit and national demand-and-capacity modelling. Early engagement identified workforce constraints and uncertainty around funding and reimbursement as common barriers to implementation.

Work on costed pathways for complex epilepsies commenced across four participating sites. Clinical teams are engaged and pathway mapping is under way to describe current service models, variation and associated costs, providing the foundation for future recommendations.

The Intracerebral Haemorrhage (ICH) pathway Quality Improvement programme moved its agreed stroke management prompt card into deployment across participating sites, supported by training in the Brainomix ICH module where required. Delivery continued despite the loss of protected time for Integrated Stroke Delivery Network clinical leads following the cessation of NHS England funding. The Sentinel Stroke National Audit Programme data request entered processing, with the first data transfer expected in July 2026.

The national lower urinary tract symptoms pathway review continued to progress. Site visits were completed in Newcastle and at the Royal Liverpool and Aintree hospital sites, bringing the total visited to six of the ten participating trusts. Two trusts completed the four-week clinic audit and patient survey, and information governance approval was secured in a further six trusts, enabling additional audit activity to begin. NHS England also allocated £400,000 and requested a proposal for a second phase to support pathway transformation and referral-to-treatment improvement in a small number of trusts.

During Q2, the team will focus on converting mobilisation activity into measurable implementation, pathway change and outcomes. Priorities include confirming CKD metrics; receiving baseline data for stroke, diabetes and urology; and managing cross-cutting dependencies relating to clinical workforce capacity, protected leadership time, information governance and funding or reimbursement. Continued oversight will also be required to ensure that the scale and complexity of RTP delivery are matched by proportionate programme management, evaluation and governance capacity.

Programme summaries

2 Patient Safety and Clinical Improvement (PSCI)

The Patient Safety and Clinical Improvement team continued to deliver a broad portfolio of regional and national programmes during Q1. One significant highlight included the shortlisting of our cervical length ultrasound innovation and training programme for an HSJ Patient Safety Award, recognising its potential contribution to reducing preterm birth and improving outcomes for women and babies.

The team successfully re-established delivery of the PSIRF Insight to Improvement programme, establishing governance arrangements, stakeholder networks and delivery plans to support system-wide learning from patient safety incidents across Thames Valley organisations. Initial engagement has been completed with provider and system partners, creating a strong foundation for improvement activity during 2026/27.

In medicines safety, the team supported delivery of a Thames Valley-wide improvement package to reduce harm from psychotropic medicines in people with a learning disability. This included development of prescribing guidance, deprescribing resources, workforce development initiatives and a primary care prescribing incentive scheme, alongside continued system-wide stakeholder engagement.

As part of the national Avoiding Brain Injury in Childbirth programme, the team continued to support improvements in fetal monitoring and obstetric emergencies. Uptake of the new impacted fetal head training programme has been strong across the region, demonstrating significant clinical engagement and commitment to reducing avoidable harm associated with this obstetric emergency.

Martha's Rule implementation continued across acute, maternity, neonatal, emergency department and mental health settings. Components 2 and 3 are now implemented across all acute trusts in the region, supported through a well-established community of practice. The national Martha's Rule Mental Health pilot also continued to progress, with HIOTV providing coaching, improvement support and shared learning to participating organisations across England.

Wound care remained a significant area of activity. The team continued to support development of the Lower Limb Hub model across Thames Valley, providing expertise from the Transforming Wound Care programme to inform service design, pathway development and implementation planning. This was complemented by ongoing system-wide stakeholder engagement to support delivery of consistent, evidence-based lower limb care (see case study above).

The Women's Health portfolio expanded during the quarter through the development of new regional collaborations focused on identifying and accelerating innovations that address priority system needs. In partnership with Health Innovation Wessex, Health Innovation Kent Surrey Sussex and NHS England, the team facilitated a regional stakeholder workshop to explore opportunities within Women's Health Hubs and neighbourhood-based models of care. Insights from this work are now informing programme development. Alongside this, we are supporting an innovative approach to women's mental health relating to menstruation and menopause, women's risk in cardiovascular health and adaptations to insomnia services.

New work this quarter also included the support of a National Institute for Health and Care Research (NIHR)-funded study exploring suicide prevention and safety planning in general practice. Working with the University of Oxford Nuffield Department of Primary Care Health Sciences, HIOTV is helping establish the Oxford General Practice Mental Health and Suicide Prevention Partnership, bringing together people with lived experience to inform the development of practical approaches to supporting patients presenting with suicidal ideation or following self-harm in primary care settings.

Programme summaries

3 Strategic and Industry Partnerships (SIP)

In Q1 the Strategic and Industry Partnerships (SIP) team combined national programme delivery, independent evidence generation and regional partnership building - connecting NHS priorities with industry, academic and innovation partners across the Thames Valley and nationally.

The Elective Care Respiratory Programme tackles the waiting times, diagnostic variation and capacity pressures facing high-volume respiratory services, combining national clinical leadership, pathway mapping and hands-on implementation support. In its first year, the Optimal Sleep Pathway workstream engaged 11 NHS trusts and delivered nine action learning sets spanning referral, diagnostics, community diagnostic centres, management, follow-up, business cases, workforce and procurement. It also produced a practical implementation toolkit with case studies, a PCRS-backed primary care referral form and a dedicated programme webpage. Work now continues across the breathlessness and cough workstreams, with shared learning through communities of practice and the five-part Better Elective Respiratory Pathways webinar series.

SIP helped Oxford-based innovator Ultromics generate the independent evidence needed for NHS adoption, investor confidence and global market access. The team's peer-reviewed health economic evaluation of EchoGo Pro, an AI tool for stress echocardiography in coronary artery disease, was published in Value in Health Regional Issues on 18 June, strengthening the case for both domestic adoption and international commercial growth.

Following a ministerial steer, SIP established the Respiratory Transformation Partnership (RTP) HealthTech Support Working Group, which met several times in Q1. Acting as a national front door for respiratory innovation, it convenes NHSE, OLS, NICE, ABHI, Asthma + Lung UK, CARRii, NIHR HealthTech Research Centres and the health innovation networks to identify, triage and assess the adoption readiness of promising technologies. It is embedded within RTP governance, with a Clinical Chair now being recruited.

Evidence continued to translate into system impact. The myAsthma+ real-world evaluation was completed and extended into the Hull and Birmingham severe asthma centres, supporting improvement of biologics pathways.

The Tympa community pharmacy pathway, piloted across eight pharmacies in the Frimley area, has now reached 230 patients and is one of the most advanced national pilots informing NHS England's evaluation of community-based ear and hearing care.

Regionally, SIP strengthened connections between NHS partners, industry, academia and innovators across the Thames Valley, creating clearer routes to engagement, adoption and partnership, and anchoring collaboration in system need rather than technology push.

A new HIOTV Strategic Industry Advisory Group moved towards launch, with its Expression of Interest in preparation. Once live, this Board-commissioned group will bring strategic challenge, market insight and regional growth perspective into HIOTV's partnership pipeline.

The AI and digital portfolio also grew spanning ambient voice technology (AVT), AI-enabled radiology and wider digital pathway opportunities reinforcing HIOTV's role in evidence generation, adoption support and the responsible deployment of emerging technologies.

New Q1 projects included the CAT&MAUS health economic analysis (NIHR, University of Oxford) on ultrasound-based motion analysis in musculoskeletal and orthopaedic care; the Transforming Wound Care evaluation of lower limb pathway redesign and digital wound management; the Noetic app feasibility study for digital self-management in fibromyalgia; and the RBfracture usability study of AI-enabled fracture detection in urgent care and radiology.

Programme summaries

4 Community Involvement and Workforce Innovation (CIWI)

The CIWI Team continues to support a wide range of projects to ensure that the perspective of patients and the public are included in the work we do with our NHS and our industry partners. Projects range from innovative approaches to involvement and coproduction with seldom heard communities to focus groups about the use of AI.

During Q1 our new pieces of work have focused on supporting industry projects and national work supporting transparent and trustworthy use of health and care data.

Supporting industry

- We have been working closely with the company Ufonia which produces an autonomous telephone triage assistant. We have run five community conversations to support translations of the product. In Q1 we ran a community conversation with the Bengali-speaking community in London, discussing their views on barriers to healthcare, AI and the appropriateness of the language used by the triage assistant. We also published a report of findings from a similar discussion group with Urdu-speaking women at Banbury Mosque.
- We continue to work with Medical iSight, a company that produces virtual reality technology for use in thrombectomy. The current work assessing patients' views has been extended to October 2026.
- Working with the company Precision Life we have been awarded European Union funding for a PPIE package with a focus on pelvic pain in women. The company's AI product is assessing new ways to diagnose and treat endometriosis. We have carried out initial work to find clinicians, charities and patients to take part in interviews about experience of pelvic pain pathways and views on the utility of new technology.

Supporting transparent and trustworthy use of health and care data

Funding was awarded by the Secure Data Environment (SDE) Network for a project to develop resources to support cross-SDE projects. A planning and phase kick-off meeting took place with the central NHS England team.

Finance

Table 1: Financial Year Ending 31 March 2027

	Opening Plan	Forecast 2026/27	Fcast Variance	YTD Plan Q1	YTD Actuals Q1	YTD Variance Q1
INCOME						
Commissioning Income - NHS England Master Licence	-2,835,140	-2,835,140	0	-708,786	-708,786	0
Commissioning Income - Office for Life Sciences	-1,273,013	-1,273,013	0	-318,254	-318,253	-1
Commissioning Income - NHSE PSC	-988,201	-988,201	0	-251,759	-251,759	0
Other Income	-3,405,270	-3,457,245	51,975	-2,247,640	-2,042,114	-205,526
Total income	**-8,501,624**	**-8,553,599**	**51,975**	**-3,526,439**	**-3,320,912**	**-205,527**
HIN FUNDING OF ACTIVITIES						
Patient Safety & Clinical Improvement	1,098,329	1,089,340	8,989	274,589	269,002	5,587
Clinical Innovation Adoption	1,201,570	1,114,714	86,856	287,628	263,997	23,631
Respiratory Transformation Partnership	2,472,458	2,544,902	-72,444	1,984,989	1,911,091	73,898
Strategic & Industry Partnerships	1,389,737	1,332,651	57,086	347,436	320,277	27,159
Community Involvement & Workforce Innovation	559,905	605,679	-45,774	139,980	107,828	32,152
Other Programme Costs	385,081	443,724	-58,643	149,535	128,743	20,792
Communications	164,890	164,985	-95	41,220	37,562	3,658
Programmes and themes	**7,271,970**	**7,295,996**	**-24,026**	**3,225,377**	**3,038,500**	**186,877**
Corporate Office	1,229,654	1,257,603	-27,949	301,062	282,413	18,649
Total expenditure	**8,501,624**	**8,553,599**	**-51,975**	**3,526,439**	**3,320,913**	**205,526**
Net Surplus or Deficit	**0**	**-0**	**0**	**0**	**1**	**-1**

Risk register

#	Programme	Risk	Description of Impact	Likelihood	Impact	Time	Mitigating Action	Owner	Actioner	Date	Date mitigated	RAG
2	Corporate	Failure to sustain HIOTV financially through income generation to mitigate against reduced central funding or policy changes	Improvement and innovation activities cease for the local systems HIOTV termination liabilities crystallise	Low	Medium	Ongoing	Additional 26/27 National Commission £0.9m. Sustaining OLS £0.3m confirmed for 2 years to 2028 with a small uplift of £0.1m. Sustaining Martha's Rule for Mental Health £0.1m and continuation of Avoiding Brain Injury in Childbirth £0.16m with small uplift of £0.1m. Reduced non-recurrent income target in 26/7 which is fully planned and achieved. New process introduced at Senior Management level to review opportunities. Forecast to breakeven 26/27 with small contingency. Keep liabilities and costs under review. Proportion of non-recurrent income means we have an ongoing task to deliver increased business development targets each year. Aim each year to achieve £0.2m to cover increase in potential termination liabilities	HIN Chief Operating Officer	Programme Directors, CEO, COO and Senior Finance Manager	31-Jul 14	Ongoing	GREEN
5	Corporate	Failure to align and support ICBs and providers with improvement and innovation	Lack of alignment would mean HIOTV is not supporting ICB and providers transformation priorities enabled	Low	Medium	Ongoing	Business plans developed with BOB and Frimley ICBs and approved. HIOTV will ensure alignment to merged ICBs Strategic Commissioning intentions and support local providers. Regular calls with	HIN Chief Operating Officer	HIN CEO and Programme Directors	Sept 2021	Ongoing	GREEN

		agenda and 3 shifts	by improvement and innovation.				BOB Primary Care Leads, LTC and clinical network leads. HIOTV convenes or takes part in more than 20 clinical groups in the region. Need to expand links with providers at corporate level to align priorities and opportunities					
6	Corporate	NHS funding for innovation Adoption not available	Patient, clinical and financial benefits not realised	Medium	Medium	Ongoing	Case for adoption must be strong with realisable gains in productivity and/or cash releasing savings. Issue flagged in submission to TV ICB design consultation. Adoption of innovation with longer term benefits requires central support.	HIN Chief Operating Officer	HIN CEO and Programme Directors	Jan 2025	Ongoing	AMBER