Oxford University Hospitals
NHS Foundation Trust

Integrated Performance Report

M2 (May data)

Accessible Information Standard notice: We are committed to ensuring that everyone can access this document as part of the Accessible Information Standard. If you have any difficulty accessing the information in this report, please contact us.

Table of Contents

1. Executive summary: *Part 1 – Strategic priorities and performance*

1. Overview of strategic priorities and performance

The month 2 Integrated Performance Report incorporates the key indicators associated with the OUH 3-year plan (2024-2027) and the four strategic pillars: People, Patient Care, Performance and Partnerships. We achieved key measures related to patient safety and care experience, including the Summary Hospital-level Mortality Indicator (SHMI), which show fewer patient deaths than expected. We also met targets in VTE Risk Assessments which support high quality patient care.

Our Patient Safety Incident Response Framework (PSIRF) guides our response to safety incidents for learning and improvement, while our Quality Improvement methodology supports our strategic goals. Safeguarding training compliance for adults (L1-L3) was achieved.

Appraisals provide feedback, recognition, and identify development opportunities, aligning staff performance with our strategic pillars. In May, we met targets for and core skills training, demonstrating commitment to staff development and our time to hire standard was achieved. Core skills training exhibited improving SCV and process assurance for consistently meeting the target.

Lower staff sickness rates, vacancies, and turnover contribute to better patient care and reduced costs from temporary staffing. Our sickness absence rate showed rates lower than the National and Shelford averages, and the third lowest within the Integrated Care System (ICS). Vacancy and turnover rates also performed better than targets and exhibited improving SCV.

Performance against the operating plan trajectories for RTT (% within 18 weeks (OP), % within 18 weeks (all pathways) and % over 52 weeks) and diagnostic waits were all compliant and improvements in the total waiting list size were also recorded and ahead of trajectory. Performance in May was also better than the operating plan trajectories for A&E performance within 4 hours, and patients spending more than 12 hours in the department.

Income and Expenditure (I&E) was a £3.2m deficit in Month 2, which was on plan. The plan included a £5.7m savings requirement in May, the majority of this has been achieved through non-recurrent underspends rather than through planned recurrent schemes. The underlying deficit was estimated to be £8.4m, which was £2.3m worse than planned. This was driven by underlying income and pay. Overall worked WTE (excluding R&D) decreased by 21 WTE in May (driven by a 15 WTE reduction in substantive staffing). Cash was £18.2m at the end of May, £2.0m higher than the previous month and £14.8m higher than planned. This variance was driven by the timing of a £9m PFI payment and the receipt of a £4m VAT reclaim. The year-end forecast for cash is unchanged. Any upsides in cash, for example, additional income received related to 2024/25 activity, are being used to offset the need for external cash support. The Trust is on plan in month and year to date with a £6.7m deficit, this has been partly achieved through non-recurrent underspends. Efficiency plans will need to be implemented rapidly to meet the £99.0m required to deliver the financial plan for the year. The plan to restore financial grip and control needs to be completed.

Of the 107 indicators currently measured in the IPR, 33 are detailed further using standardised assurance templates. These indicators, which include those failing to meet performance standards or showing deteriorating SCV, are listed in summary on the following page and elaborated within the relevant domain in section 3 (Assurance reports).

The Trust Management Executive review process also considers indicators without targets and those not flagging SCV in assurance reporting. Assurance reporting includes updates to Tiering requirements for Elective, Cancer, and Urgent and Emergency Care. The data quality ratings of the assurance templates range from 'satisfactory' to 'sufficient', as defined on page 11.

HSMR has been included in assurance reporting this month due to the increase in the relative risk in recent months. The indicator remains below 100 and is ‘lower than expected’ after excluding Hospices, as identified in last month’s IPR. Additionally, an assurance report is included for C. Difficile due to the national focus on increasing rates. For M2, the number of cases were lower than the threshold level for assurance reporting and the indicator exhibited common cause variation.

Performance for the timeliness of antibiotics in accordance with NICE guidelines for patients presenting to the ED with Sepsis was below the performance threshold in May (83.3% vs 90%). An assurance report is not included in the IPR due to the review and investigation process not concluding prior to the Trust Management Executive meeting. A verbal update will be provided to Trust Board.

1. Executive summary: *Part 2 – performance challenges*

Oxford University Hospitals NHS Foundation Trust

2. Performance challenges: integrated summary of assurance templates

Not achieving target

Special cause variation - deterioration

- Cancer 62-day combined Standard (2ww, Consultant upgrade and screening)
- % Diagnostic waits under 6 weeks
- Cancer 31-day combined Standard
- Non-medical Appraisals
- Information Governance and Data Security Training compliance

Common cause variation and missed target

- MRSA Cases: HOHA + COHA
- Pressure ulceration incidents per 10,000 bed days (Cat 2, and 3)
- Reactivated complaints
- Number of RIDDORS
- FFT % likely to recommend OP, and ED
- PFI: % cleaning score by site (average) JR
- Cancer 28 combined standard
- ED 4hr Performance – Type 1
- Sickness and absence rate (rolling and in month)
- Freedom of Information (FOI) % responded in target
- Data Subject Access Requests (DSAR)

Special cause variation - improving

- Safeguarding (children) training compliance L1-L3
- Midwife ratios (birth rate/staffing level)
- % of complaints responded to within 25 working day
- ED 4hr Performance – All
- Proportion of patients spending more than 12hrs in ED
- RTT patients > 65 weeks
- RTT patients > 78 weeks
- % Outpatient firsts and follow-up attendances (procedures)

Other*

- Non-Thematic Patient Safety Incident Investigations

**where an increase or decrease has not been deemed improving or deteriorating, where SPC is not applicable, or the indicator has been identified for assurance reporting in the absence of performance vs target or special cause variation)*

In May, there were 3 HOHA and 2 COHA cases of **MSSA bacteraemia**. There were 5 HOHA and 3 COHA cases of **C. Difficile** reported, with an increasing trend in incidence. Actions taken to address these are the antimicrobial stewardship programme, a new local sepsis treatment guideline, and a web-based information management system for IPC surveillance, which partially went live in May.

Two new **Patient Safety Incident Investigations (PSII)** were confirmed in May, involving a baby who required therapeutic cooling and a patient with ovarian cancer who had multiple delays to surgery and later died. Actions are underway to improve the timeliness of PSII completion and ensure learning is implemented. Other learning responses include after action reviews (AARs) and learning multi-disciplinary team response (LMDTR). The PSII process is monitored by SLIC, with CMO/CNO responsible for sign-off of final reports.

The **Hospital Standardised Mortality Ratio (HSMR)** reflects several changes in calculating the HSMR, including a new frailty index. This has been retrospectively applied to all data reported. Additionally, as referenced in the April report, the HSMR reporting in the IPR excludes Hospice services, which Telstra Health has advised for appropriate comparison to other trusts. HSMR remains rated 'lower than expected' and the individual monthly data points have improved over the past five months. Work is continuing with Telstra Health in understanding the increase in rolling 12-month data between June 2024 and February 2025.

In May 2025, 42% of **complaints** were responded to within 25 days, which remains below the target of 85% and down from April's performance of 63%. The Trust received 148 formal complaints in May 2025, with 14 of these being reopened cases. Weekly meetings continue to be held with the Complaints Team and Divisional Directors of Nursing to escalate complaints cases about to breach, ensuring engagement in resolving response times.

The overall Trust performance for the **Friends and Family Test (FFT)** in May was 93.8% positive, with a response rate of 10,749. Inpatient feedback highlighted staff attitude, care implementation, and admission as positive themes, while catering, waiting lists, and discharge were reported as negative themes. Outpatient responses were 93.8% positive with similar positive themes. Negative themes included catering, waiting lists, and discharge. The Emergency Department (ED) had a positive response rate of 81.4%. A thematic analysis of patient feedback is ongoing to improve communication with patients awaiting appointments or procedures.

Ongoing work is being done to increase the early identification and reporting of Category 1 Hospital Acquired Pressure Ulcers (HAPU). Thematic learning from all HAPU incidents continues to be presented and shared at the Clinical Governance Committee. The Trust saw a reduction in Category 2 pressure ulcers, which is encouraging given the increased patient activity and bed days.

In May, 629 mothers gave birth at OUH, 38 more than the previous month. The midwife-to-birth ratio was 1:25.51, above the Birthrate Plus recommendation of 1:22.9. The service continues with a robust recruitment and retention plan to align with the recommended Birthrate Plus uplift, address staff retention, optimise rostering KPIs, and reduce NHSP spend.

Training levels for children is just below the KPI of 90%. Adult level 3 is at 91.2%, and children level 3 is at 89.7%. Divisions are requested to encourage compliance as part of the appraisal window.

1. Executive summary: *Part 2 – performance challenges*

Oxford University Hospitals NHS Foundation Trust

2. Performance challenges: integrated summary of assurance templates

Not achieving target

Special cause variation - deterioration

- Cancer 62-day combined Standard (2ww, Consultant upgrade and screening)
- % Diagnostic waits under 6 weeks
- Cancer 31-day combined Standard
- Non-medical Appraisals
- Information Governance and Data Security Training compliance

Common cause variation and missed target

- MRSA Cases: HOHA + COHA
- Pressure ulceration incidents per 10,000 bed days (Cat 2, and 3)
- Reactivated complaints
- Number of RIDDORS
- FFT % likely to recommend OP, and ED
- PFI: % cleaning score by site (average) JR
- Cancer 28 combined standard
- ED 4hr Performance – Type 1
- Sickness and absence rate (rolling and in month)
- Freedom of Information (FOI) % responded in target
- Data Subject Access Requests (DSAR)

Special cause variation - improving

- Safeguarding (children) training compliance L1-L3
- Midwife ratios (birth rate/staffing level)
- % of complaints responded to within 25 working day
- ED 4hr Performance – All
- Proportion of patients spending more than 12hrs in ED
- RTT patients > 65 weeks
- RTT patients > 78 weeks
- % Outpatient firsts and follow-up attendances (procedures)

Other*

- Non-Thematic Patient Safety Incident Investigations

**where an increase or decrease has not been deemed improving or deteriorating, where SPC is not applicable, or the indicator has been identified for assurance reporting in the absence of performance vs target or special cause variation)*

In May 2025, the **PFI percentage of total audits** that achieved 4 or 5 stars was of 90.0%, lower than the 95% target. The audits that failed the 4-star requirement were promptly corrected. No specific trends or repetitive failures were noted, with issues spread across both clinical and domestic responsibilities.

The **sickness absence** performance in May(rolling 12 months) was 4.2%, steady from the previous month and exhibiting common cause variation. The in-month sickness decreased to 4.1%, partly due to fewer flu cases. Focus is on CSUs with consistent absenteeism. Collaboration with Occupational Health is ongoing to review top absenteeism reasons and managers are alerted about staff triggering.

Non-medical appraisal compliance was 7.3%, better than last year's 5.3% in the same month. Communication and support are provided Corporately and with Divisional Workforce teams to encourage appraisals. The Workforce team promotes appraisals at every meeting. Governance is managed through TME via the IPR, HR Governance Monthly meeting, and Divisional meetings.

The **Emergency Department (ED) performance** for all types was 75.8% in May, with Type 1 performance at 66.3%. There has been an 18% reduction in breaches due to quality improvement work. The Urgent and Emergency Care Quality Improvement Programme includes five key priorities, with the Senior Decision Maker and Rapid Assessment & Treatment / Children's Urgent Care Pathway priorities progressing well. The proportion of patients with a **length of stay** of more than 12 hours in the ED was 2.8% in May, showing improvement. Bed occupancy reduced to 92.5% in May, and the proportion of patients whose discharge was delayed rose slightly to 8.5%. The Discharge to Assess pathway has helped reduce delays, but housing-related discharge delays remain a concern.

In May **RTT performance** for 52 weeks had 2,818 patients waiting with special cause of improvement for >78-week waits. Efforts continue to eliminate pathways extending beyond 65 weeks, with services recovering the 52-week backlog. ENT, Urology, and Orthopaedic services are enhancing capacity through various measures, including insourcing and repurposing theatre sessions.

The percentage of **diagnostic waits over 6 weeks** was 21.1% in May. Audiology, Endoscopy, Neurophysiology, and Ultrasound services are working on recovery plans, with improvements expected in 2025/26.

Cancer performance against the 62-day combined standard was 56.4% in April and 76.2% for 28 days Faster Diagnosis standard, below the operational plan. Key challenges include capacity for surgery, diagnostics, and oncology, and late inter-provider transfers. The Cancer Improvement Programme will be relaunched, focusing on the 28-day Faster Diagnosis Standard and other key benchmarks

The percentage of first **new outpatient and follow-up outpatient** appointments with procedures was 44.6% in May, below the target of 46.0%. Efforts to improve this include optimising outpatient procedure activity by reviewing day-case procedures for conversion, releasing theatre capacity, reducing follow-up activity, and using the e-Outcome Form to improve the capture of procedure codes.

Data Security and Protection Training (DSPT) compliance was 91% in M2, recovering towards the 95% target. No divisions are currently achieving the target. Actions include contacting non-compliant staff individually and reminders in the staff newsletter.

Freedom of Information (FOI) performance was 54.5% in M2, below the 80% target. An Enforcement Notice from the ICO requires a response plan by 14th May and implementation by 31st October 2025.

Data Subject Access Requests (DSAR) performance dropped significantly to 68% in M2. Medical Records Subject Access closed 115 of 368 cases on time, PACS closed 83% of 247 cases on time, and Occupational Health closed 100% of 315 cases on time. Actions include procuring a new system to manage cases **3**.

Priority 1 Incident: On 23 May 2025, a system restoration process caused a temporary disruption to network access due to an OXNET domain-level rollback. The recovery was completed by 2:00 AM on 24 May, with services fully restored

2. a) Indicators identified for assurance reporting

Oxford University Hospitals NHS Foundation Trust

	Common cause variation	Special cause variation - improving	Special cause variation - deterioration	Other (where an increase or decrease has not been deemed improving or deteriorating, where SPC is not applicable, or the indicator has been identified for assurance reporting in the absence of performance vs target or special cause variation)
Quality, Safety and Patient Experience	Not achieving target • MRSA cases: HOHA+COHA • HSMR excluding hospice • Pressure ulceration incidents per 10,000 bed days (Cat 2, and Cat 3) • Reactivated complaints • PFI: % cleaning score by site (average) JR	Not achieving target • Safeguarding (children) training compliance • % of complaints responded to within 25 working days Not Achieving target • Midwife ratios (birth rate/staffing level)	Not achieving target • Inpatient FFT • ED FFT and maternity (response rate) Not achieving target • Health and safety related incidents • Number of complaints • Number of complaints per 10,000 bed days	No target Not achieving threshold • Non-thematic patient safety investigations
Growing Stronger Together	Not achieving target • Sickness and absence rate (in month) • Sickness and absence rate (rolling 12 months)		Not achieving target • Non-medical Appraisals	
Operational performance	Not achieving target • ED 4-hour performance (type-1) • Cancer 28-day combined Standard (First and all Subsequent Treatments)	Not achieving target • ED 4-hour performance All • % Outpatient first (all) and follow-up attendances (procedures) Not Achieving target • RTT patients > 65 weeks • RTT patients > 78 weeks • Proportion of patients spending more than 12 hrs in ED	Not achieving target • % of RTT patients waiting within 18 weeks • Cancer 31-day combined Standard (First and all Subsequent Treatments) Not achieving target • % Diagnostic waits under 6 weeks • Cancer 62-day Combined Standard • 62-day Cancer Standard: >62 days	
Corporate Support Services	Not achieving target • Freedom of Information % responded to within target time • Efficiency Delivery £'000 • In-month financial performance Surplus/Deficit £'000	Not achieving target • Year-to-date financial performance surplus/Deficit £'000	Not achieving target • Information Governance and Data Security Training compliance • Adjusted in-month financial performance surplus/deficit £'000 • BPPC £% • BPPC Volume % • Cash £'000	Not achieving threshold • Priority 1 Incidents

2. b) SPC indicator overview summary

Oxford University Hospitals NHS Foundation Trust

Integrated Performance Report (SPC)

Quality, Safety and Patient Experience Summary: All

Latest Indicator Period: Jun-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
MRSA cases: HOHA+COHA per 10,000 beddays	May-25	0.3	-	-	0.2	-0.4	0.8
MRSA cases: HOHA+COHA	May-25	1	0	No	1	-1	3
C-diff cases: HOHA+COHA per 10,000 beddays	May-25	2.5	-	-	3.6	0.3	6.9
C-diff cases: HOHA+COHA	May-25	8	10		12	1	22
MSSA cases: HOHA+COHA	May-25	5	-	-	6	-1	12
Number of Never Events	May-25	0	0		0	-	-
Non-Thematic Patient Safety Incident Investigations	May-25	4	0	No	2	-	-
VTE- Submitted performance	May-25	95.6%	95.0%		95.4%	94.8%	96.0%
% of emergency admissions 65yrs + receiving cognitive screen	May-25	63.8%	-	-	58.2%	50.6%	65.8%
% patients with sepsis attending ED received timely antibiotics in accordance with NICE guidelines	May-25	83.3%	90.0%	No	90.4%	-	-
CAS alerts breaching deadlines at end of month and/or closed during month beyond deadline	May-25	0	0		0	-	-
Medication incidents causing moderate harm, major harm or death as reported on Ulysses	May-25	5	-	-	2	-2	7
HSMR Excluding Hospices	Feb-25	92.8	100.0		85.3	-	-
Summary Hospital-level Mortality Indicator	May-25	91.0	100.0		91.9	-	-
Neonatal deaths per 1,000 total live births	Mar-25	2.3	3.2		3.3	-1.4	8.0
Stillbirths per 1,000 total Live births	Mar-25	5.1	4.0	No	4.0	0.5	7.4
National Patient Safety Alerts not completed by deadline	May-25	0	-	-	0	-	-
Potential under-reporting of patient safety incidents: Patient safety incident reporting rate per 10,000 beddays	May-25	0.0	-	-	0.0	0.0	0.0
Number of active clinical research studies hosted	May-25	1391	-	-	1420	1173	1667
Number of active clinical research studies (commercial)	May-25	384	-	-	381	308	454
Number of active clinical research studies (non commercial)	May-25	1007	-	-	1039	863	1215
Number of incidents with moderate harm or above per 10,000 beddays	May-25	44.2	-	-	40.3	23.9	56.8
Number of patient incidents with moderate harm or above per 10,000 beddays	May-25	38.0	-	-	35.9	18.8	53.0
Number of non-patient incidents with moderate harm or above per 10,000 beddays	May-25	6.2	-	-	4.4	-2.2	11.0
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 2)	May-25	20.1	19.0	No	20.0	7.4	32.6
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 3)	May-25	3.1	2.0	No	2.2	0.3	4.0
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 4)	May-25	0.0	0.0		0.1	-0.2	0.3
Pressure Ulceration incidents per 10,000 beddays (Present on admission Cat 1+)	May-25	88.7	-	-	93.7	59.3	128.1
Patient falls (moderate and above) as reported on Ulysses	May-25	6	-	-	4	-2	11
Patient falls (moderate and above) as reported on Ulysses per 10,000 beddays	May-25	1.9	-	-	1.2	-0.9	3.4
Health and Safety related incidents - Assault, Aggression and harassment	May-25	189	-	-	161	88	234

NB. Indicators with a zero in the current month's performance and no SPC icons are not currently available and will follow.

Integrated Performance Report (SPC)

Quality, Safety and Patient Experience Summary: All

Latest Indicator Period: May-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Adult safeguarding activity	May-25	1737	-	-	985	663	1307
Children's safeguarding activity	May-25	505	-	-	620	304	936
Adult safeguarding activity and Children's safeguarding activity	May-25	2242	-	-	1605	1127	2083
Safeguarding (Children) training compliance L1 - L3	May-25	89.7%	90.0%	No	88.4%	83.7%	93.2%
Safeguarding (Adults) training compliance L1 - L3	May-25	91.2%	90.0%		43.8%	35.5%	52.1%
Total Deliveries in month	May-25	623	625	-	613	540	686
Babies born	May-25	641	-	-	623	549	696
Maternity Bookings (planned + unplanned)	May-25	674	750	-	704	549	858
Inductions of labour from iView	May-25	148	-	-	140	99	181
Midwife Ratios (birth rate / staffing level)	May-25	25.5	22.9	No	25.6	21.5	29.7
Learning MDT Reviews presented at SLIC	May-25	1	-	-	2	-	-
After Action Review (AAR)	May-25	16	-	-	14	-	-
Number of complaints	May-25	161	-	-	117	65	168
Number of complaints per 10,000 beddays	May-25	49.8	-	-	36.5	22.2	50.8
Reactivated complaints	May-25	14	1	No	11	2	19
% of complaints responded to within 25 working days	May-25	48.8%	85.0%	No	45.4%	24.9%	65.9%
Number of RIDDORs	May-25	5	5		5	1	9
Friends & Family test % likely to recommend - IP	May-25	95.4%	95.0%		95.0%	93.7%	96.3%
Friends & Family test % likely to recommend - OP	May-25	93.8%	95.0%	No	93.8%	92.9%	94.6%
Friends & Family test % likely to recommend - ED	May-25	81.4%	85.0%	No	79.0%	72.6%	85.4%
FFT maternity % positive (births)	May-25	95.7%	90.0%		71.1%	44.2%	98.0%
Inpatient FFT (Response Rate)	May-25	22.0%	-	-	24.6%	21.3%	27.9%
Outpatient FFT (response rate)	May-25	9.8%	-	-	8.2%	6.3%	10.0%
ED FFT (Response Rate)	May-25	16.2%	-	-	22.5%	17.6%	27.4%
Maternity FFT (response rate; births)	May-25	4.0%	-	-	8.7%	0.9%	16.5%
PFI: % of total audits completed that achieved 4 or 5 stars JR	May-25	90.0%	95.0%	No	93.1%	83.8%	102.5%
PFI: % of total audits completed that achieved 4 or 5 stars CH	May-25	97.5%	95.0%		94.5%	84.3%	104.7%
PFI: % of total audits completed that achieved 4 or 5 stars NOC	May-25	100.0%	95.0%		96.4%	89.1%	103.6%
Incident rate of violence and aggression (rate per 10,000 beddays)	May-25	58.4	-	-	48.4	25.4	71.4
Trust level: CHPPD vs budget	May-25	11.6	-	-	-17.0	-65.8	31.7
Trust level: CHPPD vs required	May-25	-2.8	-	-	-6.3	-25.5	12.8

2. b) SPC indicator overview summary

Oxford University Hospitals NHS Foundation Trust

Integrated Performance Report (SPC)
Growing Stronger Together Summary: All

Latest Indicator Period: May-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Vacancy rate	May-25	3.7%	7.7%		6.9%	4.9%	8.9%
Turnover rate	May-25	9.3%	12.0%		10.9%	10.5%	11.3%
Sickness absence rate (rolling 12 months)	May-25	4.2%	3.1%	No	4.2%	4.0%	4.3%
Non Medical Appraisals	May-25	20.4%	85.0%	No	76.4%	42.6%	110.2%
Sickness absence rate (in month)	May-25	4.1%	3.1%	No	4.2%	3.3%	5.2%
Core skills training compliance	May-25	91.5%	85.0%		90.4%	88.5%	92.3%
Time to hire (average days)	May-25	35.4	53.0		49.7	37.4	61.9

Integrated Performance Report (SPC)
Operational Performance Summary: All

Latest Indicator Period: May-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Patients whose operations cancelled for non-clinical reasons nc offered another binding date within 28 days	May-25	19.2%	-	-	12.9%	-12.2%	37.9%
Provider cancellation of Elective Care operation for non-clinical reasons either before or after Patient admission	May-25	0.3%	-	-	0.4%	0.2%	0.6%
Proportion of ambulance arrivals delayed over 30 minutes	Apr-25	5.6%	-	-	9.0%	4.7%	13.2%
Proportion of ambulance arrivals delayed over 60 minutes	Apr-25	0.2%	-	-	1.0%	-0.2%	2.1%
ED 4Hr perfromance - All	May-25	75.8%	78.0%	No	67.2%	59.2%	75.3%
ED 4Hr perfromance - Type 1	May-25	66.3%	73.6%	No	60.1%	51.2%	69.1%
Proportion of patients spending more than 12 hours in an emergency department	May-25	2.9%	2.0%	No	4.7%	2.5%	6.8%
Proportion of patients discharged from hospital to their usual place of residence	May-25	95.6%	-	-	95.2%	94.4%	96.0%
% of RTT patients waiting for a first appointment	May-25	64.8%	-	-	64.5%	62.6%	66.4%
% of RTT patients waiting within 18 weeks	May-25	58.2%	-	-	60.9%	58.8%	63.1%
% of RTT patients waiting over 52 weeks	May-25	3.3%	-	-	3.2%	3.2%	3.3%
RTT standard: >52-week incomplete pathways	May-25	2818	-	-	2750	2397	3103
RTT standard: >65-week incomplete pathways	May-25	152	0	No	664	419	910
RTT standard: >78-week incomplete pathways	May-25	7	0	No	125	56	193
RTT standard: >104-week incomplete pathways	May-25	0	0		6	0	13
% Diagnostic waits waiting 6 weeks or more	May-25	21.1%	5.0%	No	16.7%	12.2%	21.2%
Cancer 62 Day Combined Standard (2WW, Consultant Upgrade and Screening)	Apr-25	56.4%	70.0%	No	61.7%	54.3%	69.1%
62-day Cancer standard: incomplete pathways >62-days	May-25	443	-	-	342	263	420
62-day Cancer standard: incomplete pathways >104-days	May-25	121	-	-	107	77	138
Inpatient Daycase activity vs 2019/20	May-25	95.5%	-	-	92.2%	78.8%	105.7%
Inpatient Elective activity vs 2019/20	May-25	94.7%	-	-	87.4%	66.0%	108.7%
Outpatient First Attendance activity vs 2019/20	May-25	104.7%	-	-	107.3%	87.9%	126.8%
Outpatient Follow Up Attendance activity vs 2019/20	May-25	126.0%	-	-	120.5%	100.7%	140.3%
Diagnostic activity vs 2019/20	May-25	136.3%	-	-	124.1%	112.3%	136.0%
Cancer First Treatments vs 2019/20	May-25	111.2%	-	-	125.6%	91.0%	160.1%
Bed Utilisation General & Acute	May-25	92.5%	-	-	95.0%	91.8%	98.3%
Cancer 28 Day combined Standard (2WW ,Breast Symptomatic and Screening Referrals)	Apr-25	76.2%	77.0%	No	78.2%	73.0%	83.5%
Cancer 31 Day combined Standard (First and All Subsequent Treatments)	Apr-25	74.2%	96.0%	No	83.1%	74.5%	91.8%
% outpatient activity: first (all) and follow-up (procedures)	May-25	44.6%	46.0%	No	43.1%	41.4%	44.8%

NB. Indicators with a zero in the current month's performance and no SPC icons are not currently available and will follow.

2. b) SPC indicator overview summary, *continued*

Oxford University Hospitals NHS Foundation Trust

Integrated Performance Report (SPC)
Finance Summary: All

Latest Indicator Period: May-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Adjusted in-month financial performance Surplus/Deficit £'000	May-25	-7795.1	-	-	-4884.7	-7782.6	-1986.8
BPPC £ %	Apr-25	66.4%	95.0%	No	82.8%	77.0%	88.7%
BPPC Volume %	Apr-25	44.2%	95.0%	No	68.3%	61.7%	74.8%
Cash £'000	May-25	18169	26992	No	29346	8234	50457
Efficiency delivery £'000	May-25	2335.0	5126.0	No	5674.5	-802.8	12151.8
Elective recovery funding (ERF) value-weighted activity % In month	Mar-25	101.9%	-	-	102.1%	91.6%	112.5%
In-month financial performance Surplus/Deficit £'000	May-25	-3245.2	3440.0	No	-635.0	-13028.8	11758.9
In-month ICS CDEL capital expenditure	May-25	576.3	1321.5	-	3337.2	-7754.1	14428.4
Year-to-date financial performance Surplus/Deficit £'000	May-25	-6669.7	3440.0	No	-14838.6	-25003.1	-4674.1

Integrated Performance Report (SPC)
Corporate support services – Digital Summary: All

Latest Indicator Period: May-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Information Governance and Data Security Training	May-25	90.8%	95.0%	No	90.8%	89.1%	92.5%
Data Security & Protection Breaches	May-25	40	-	-	27	8	46
Externally reportable ICO incidents	May-25	0	0		0	-	-
All IG reported incidents	May-25	40	-	-	29	13	46
Freedom of Information (FOI) % responded to within target tim	May-25	54.5%	80.0%	No	56.3%	28.4%	84.2%
Data Subject Access Requests (DSAR)	May-25	68.2%	80.0%	No	69.7%	50.7%	88.7%
Priority 1 Incidents	May-25	1	0	No	1	-	-

Integrated Performance Report (SPC)
Corporate support services – Regulatory assurance Summary: All

Latest Indicator Period: May-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
CQC overdue actions ('must do')	May-25	0	0		0	-	-

Integrated Performance Report (SPC)
Corporate support services – Legal services Summary: All

Latest Indicator Period: May-2025

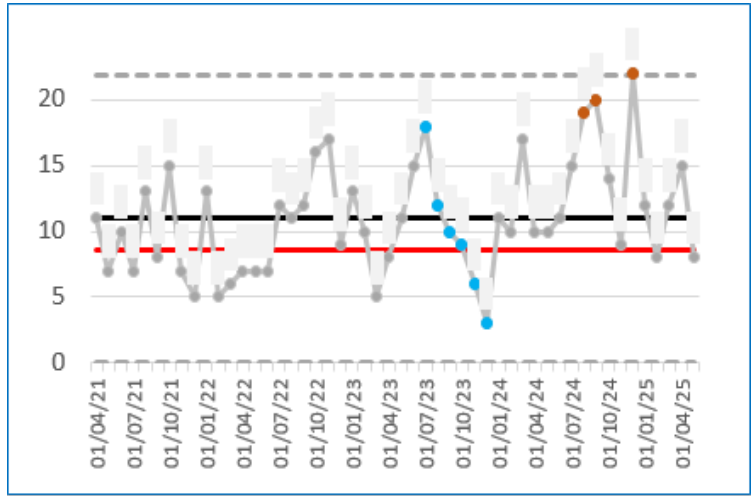
Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Legal Services: Number of claims	May-25	20	-	-	19	4	34

NB. Indicators with a zero in the current month's performance and no SPC icons are not currently available. See final page in report for more information.

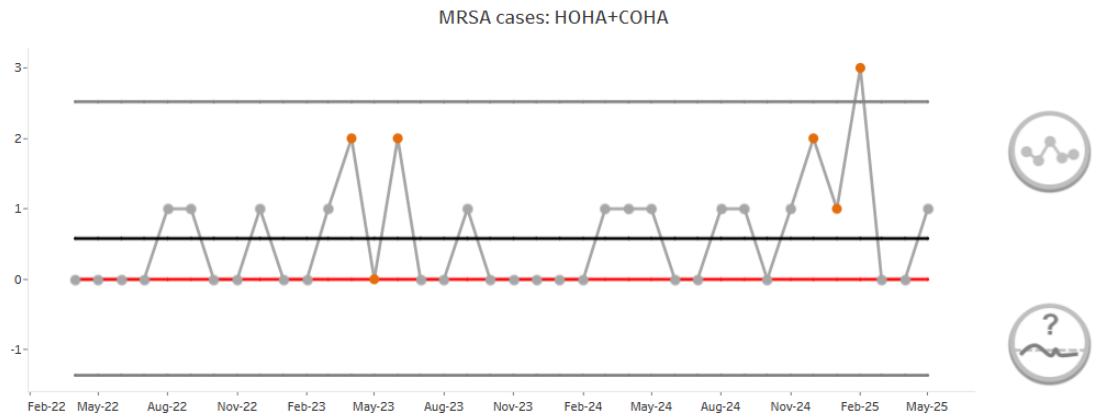
03. Assurance reports

3. Assurance report: Quality, Safety and Patient Experience

SPC chart of OUH apportioned *C. difficile* cases

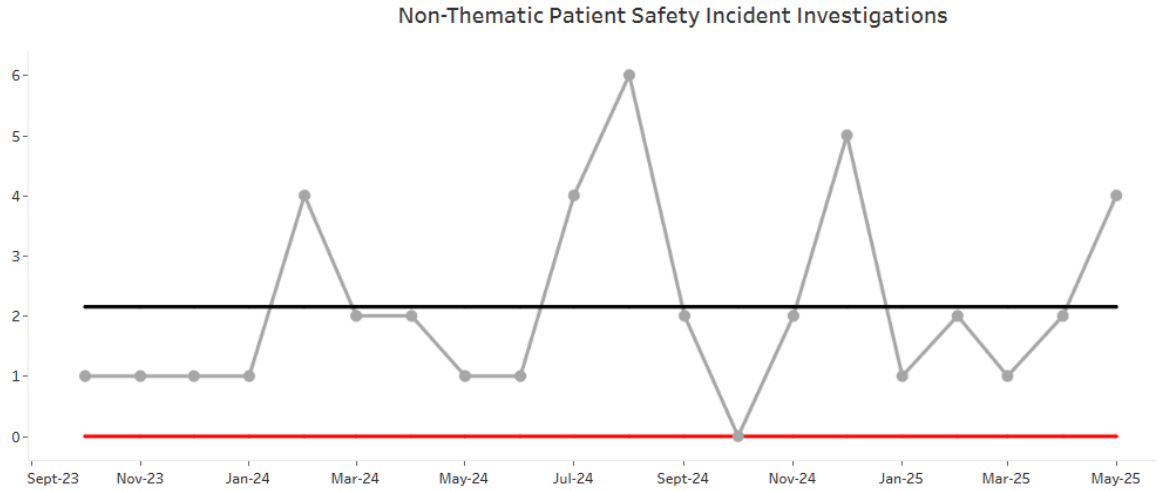


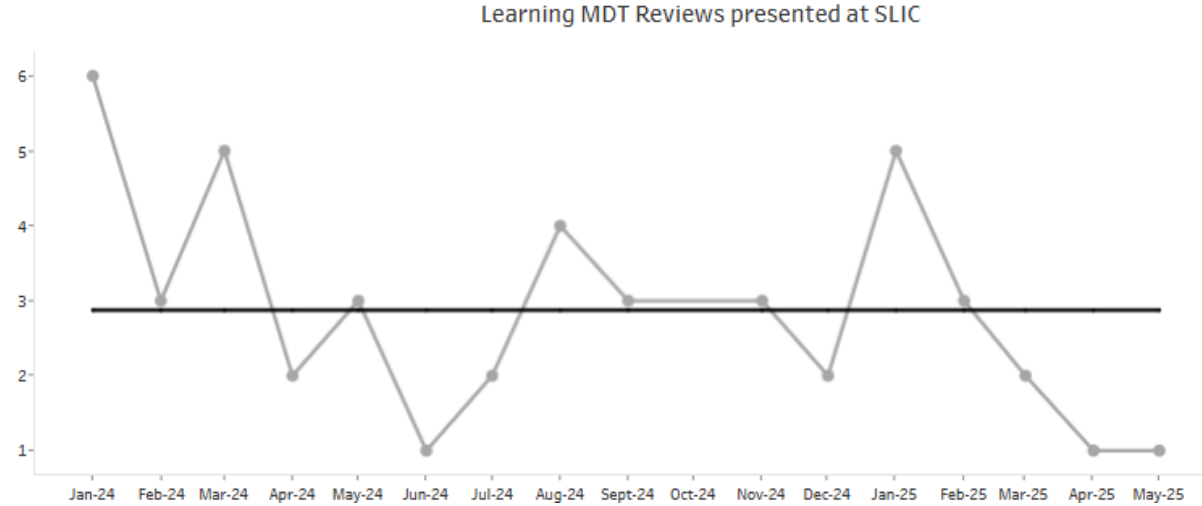
SPC chart of OUH apportioned MRSA cases



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality
MRSA Bacteraemia – there was 1 HOHA MRSA bacteraemia reported in May. This was from a patient known to be colonised with MRSA (long-standing), complex urological anatomy and short bowel syndrome on TPN with Hickmann line, admitted to Urology/Gastroenterology. The source is likely urological and not thought to be preventable. **MSSA Bacteraemia – t**here were 3 HOHA cases and 2 COHA cases of MSSA bacteraemia in May ***C. difficile* – t**here were 5 HOHA and 3 COHA cases in May. The OUH trend is in the context of a national increase of *C. difficile* incidence of 38% since 2019/2020 of hospital onset cases. There is currently no clear explanation for this national increase. **Staffing – a**pplications for the IPC Lead/Manager are now closed. Interviews are scheduled for the first week in July. A band 7 IPC nurse has been appointed which leaves a band 6 vacancy within the team. **IPC Surveillance –** following the implementation of the new LIMS and loss of the IPC surveillance system, partial mitigation is in place via laboratory reports and EPR messaging.	New local sepsis treatment guidelines were launched in May. Initial feedback has been positive and data is currently being collected via audit to assess the impact on empiric co-amoxiclav usage. ***C. difficile* –** OUH has been selected as sentinel site for whole genome sequencing as part of the C. diff ribotyping network (CDRN). Data from the CDRN will be used to support OUH C.difficile investigations. The first quarter's data will be available for review in July. **Staffing – r**ecruitment of a substantive lead nurse / manager is an urgent priority to support the IPC team. **IPC Surveillance** – the OUH Digital Engineering service have launched a web-based information management system which partially went live in May. The development of a business case for a IPC surveillance system (ICNET) is also underway.	Assurance group – IPC report to PSEC via HIPCC. The DIPC chairs HIPCC.	BAF 4	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

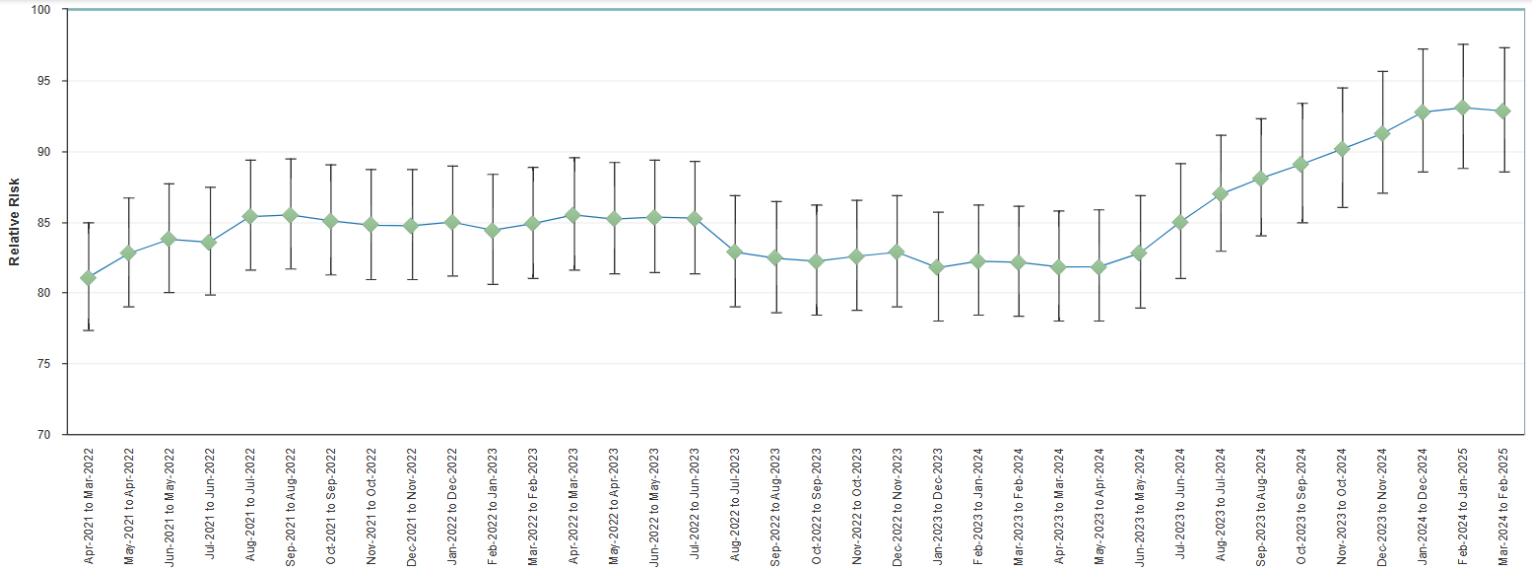
3. Assurance report: Quality, Safety and Patient Experience





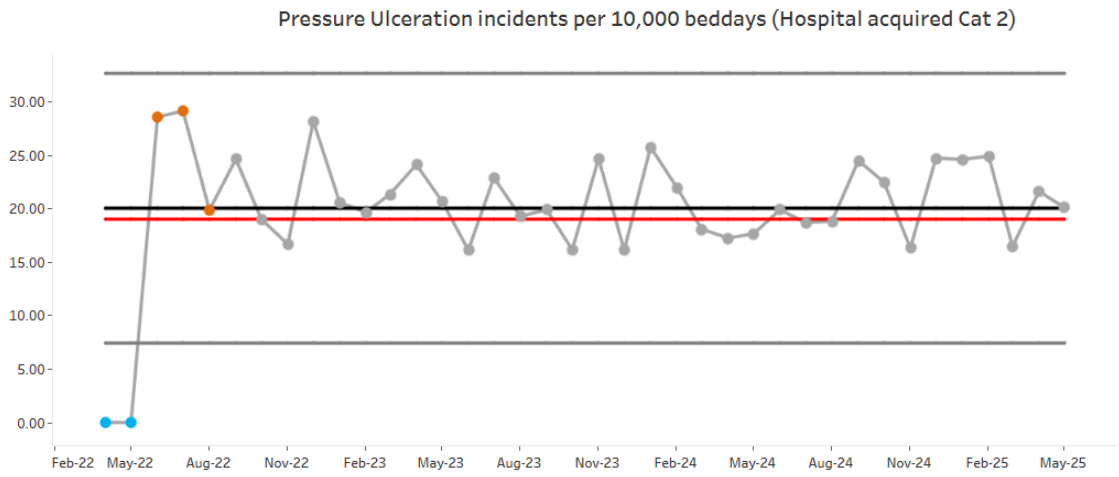
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
They concerned a baby who required therapeutic cooling; a patient with ovarian cancer who had multiple delays to surgery and later died; a patient referred for a suprascapular nerve block who received a steroid injection; and a patient that underwent arteriovenous malformation surgery was later returned to theatre due to a retained needle tip in the operative site. The first of these investigations is being undertaken by the Maternity & Newborn Safety Investigations national team (MNSI), and the others will be investigated by an OUH team. The learning and improvement will be shared once the PSIIs have concluded.	A total of 42 non-thematic PSIIs have been confirmed since OUH moved to the PSIRF framework in October 2023 (excluding one from February 2025 that was reclassified within a week), 20 (48%) of which have been fully completed and a final report circulated. Actions are underway to improve the timeliness of PSII completion and to ensure learning is implemented and improvements in safety can be demonstrated. LMDTRs have a target of 42 calendar days from the reporting of the incident to holding the meeting. The median time to complete the one LMDTR meeting which was tabled at SLIC in May 2025 was 112 calendar days. It took 69 days from reporting the incident to declaring a LMDTR due to further information coming to light and a MDT discussion taking place. The incident was upgraded to Moderate impact following this discussion, which triggered a review at Patient Safety Response Meeting at which a LMDTR was advised; therefore, it only took 33 days from agreeing that a LMDTR was required to the meeting taking place. AARs have a target of 14 calendar days from the reporting of the incident to holding the meeting. The median time to complete AAR meetings was 21 days in May. More staff are being trained in conducting learning responses with the aim of reducing the time to arrange and conduct LMDTR and AAR meetings. Targets and adherence are monitored at the PSIRF Improvement Group.	The action is to complete the PSII investigations within the agreed timescale and share the learning across Divisions. A quality improvement project has been created to address this. The PSII process is monitored by SLIC with CMO/CNO having responsibility for sign-off of final reports, following reviews by Divisional management, Patient Safety, Head of Clinical Governance, and DCMO. Challenges relating to actions arising from PSIIs are reported to Clinical Governance Committee, and in May 2025 a total of 46 actions were overdue.	BAF 4 CRR 11 22	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

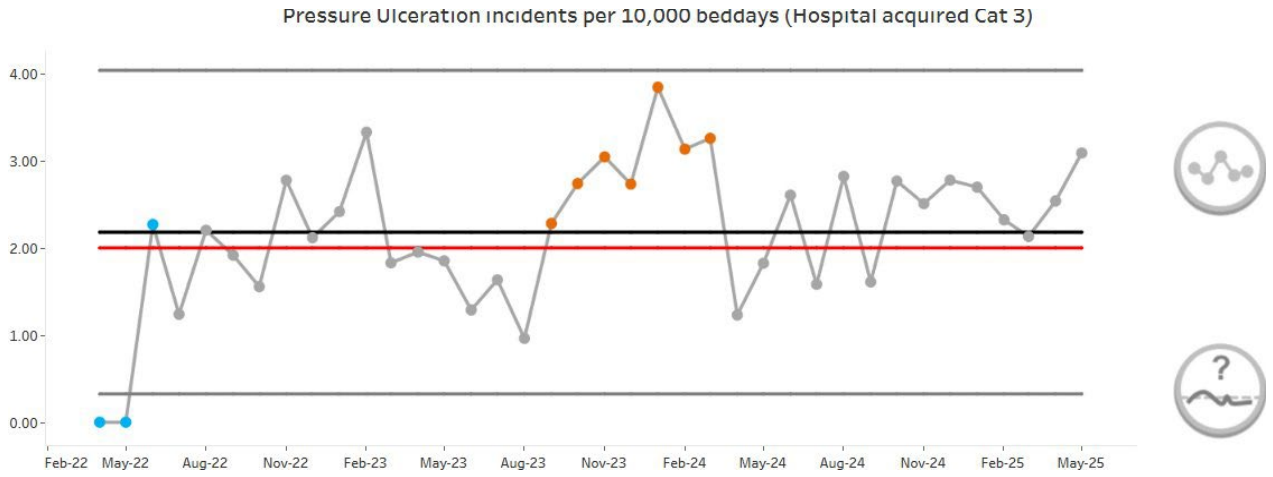
3. Assurance report: Quality, Safety and Patient Experience



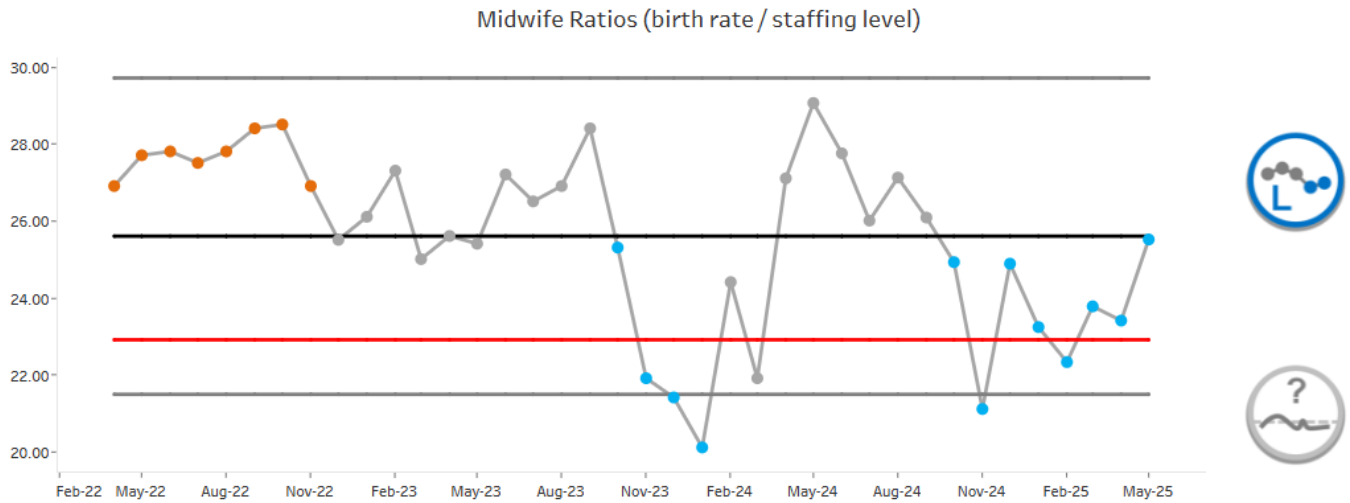
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality
The 12-month rolling HSMR data presented excludes the 2 hospices and uses Telstra's new ('HSMR+') methodology for all data points presented allowing analysis of trends. The HSMR for March 2024 to February 2025 is 92.8 and banded 'lower than expected'. A rise in HSMR is noted over the last year. The causes for this have been explored with Telstra and are driven by a reduction in the number of expected deaths at the JR site related to: • reduced coding of frailty and comorbidity • increasing proportion of spells and deaths with no recorded comorbidity or comorbidity score of 0 or <0 and reducing proportion of activity with the highest scores These 'depth of coding' indicators suggest a decline in the capture of acuity at the JR, reducing the expected mortality rate and driving the increasing HSMR+ trend at a Trust level.	• Discussions are ongoing with Telstra and our coding team to understand and address the issues raised, and thereby ensure that the HSMR+ reported accurately reflects the comorbidities, frailty and acuity of patients admitted to the JR.	The HSMR is monitored at the Mortality Review Group (MRG) and escalated where appropriate. The clinical governance and coding teams will work together to address the issues raised in the report to ensure the HSMR on the JR site is accurately reflected.		Sufficient Monthly reporting from Dr Foster (Telstra) Which is presented to MRG

3. Assurance report: Quality, Safety and Patient Experience



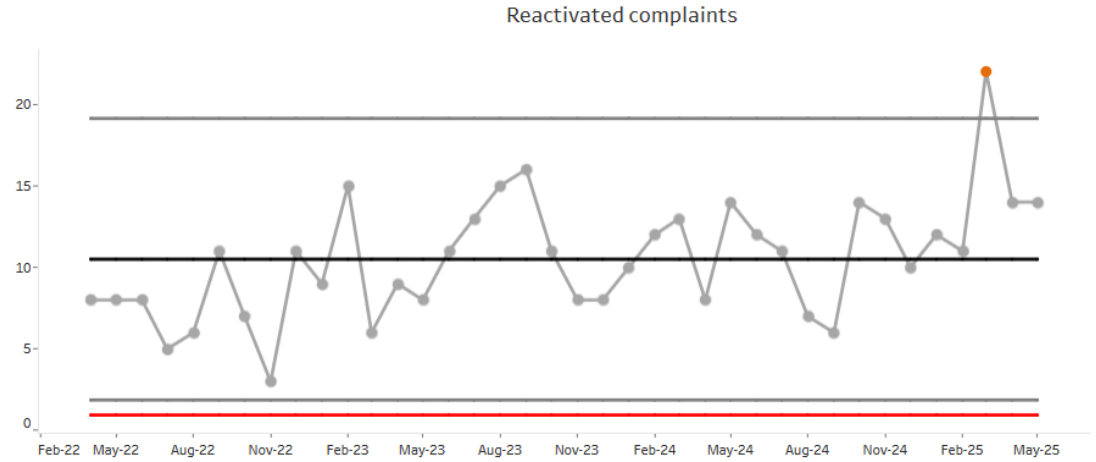


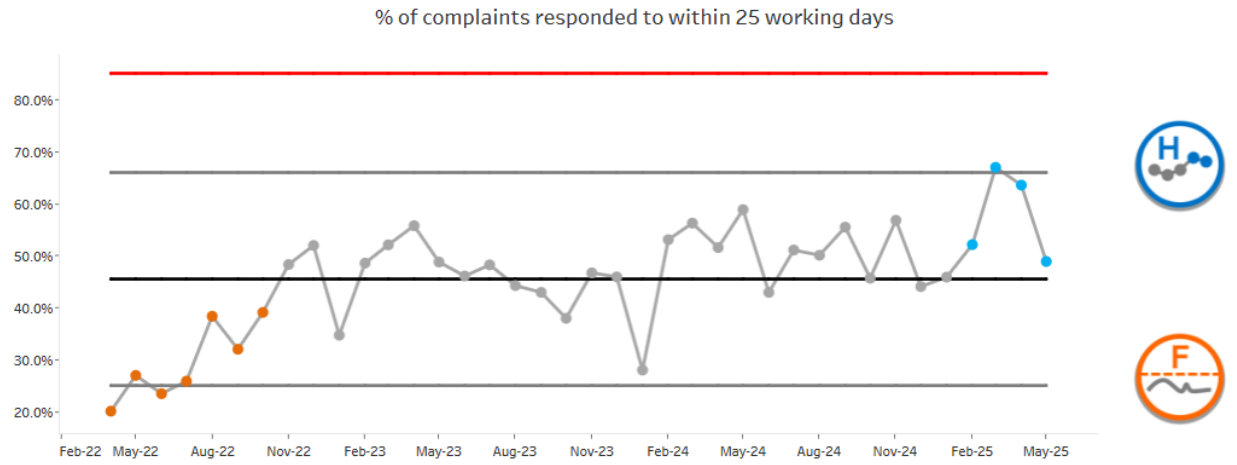
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group	Risk Register	Data quality
The Trust continues to demonstrate a proactive and data-informed approach to the prevention and management of pressure ulcers. In May 2025, a total of 64 pressure ulcers were reported, a slight decrease from 68 in April, despite an increase in bed days from 31,503 to 32,360. This suggests a positive trend in pressure ulcer prevention relative to the number of patient bed days.	• The data indicates a reduction in Category 2 pressure ulcers, which is encouraging given the increased patient activity and bed days. • The implementation of Purpose-T in is progressing smoothly and is expected to further enhance early detection and intervention. • Oversight is maintained through the Harm Free Assurance Forum, with escalation to the Clinical Governance Committee. • In depth harm reviews will be undertaken in areas with consistent challenges in delivering a sustained reduction. • A comprehensive Harm Free Quality Improvement Plan (QIP) has been developed, integrating learning from pressure ulcers, falls, nutrition and hydration. This cross-cutting approach is designed to foster shared learning and systemic improvement and will be ratified and implemented in July.	Ongoing, reviewed weekly. Oversight by Delivery Committee	BAF 4	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*



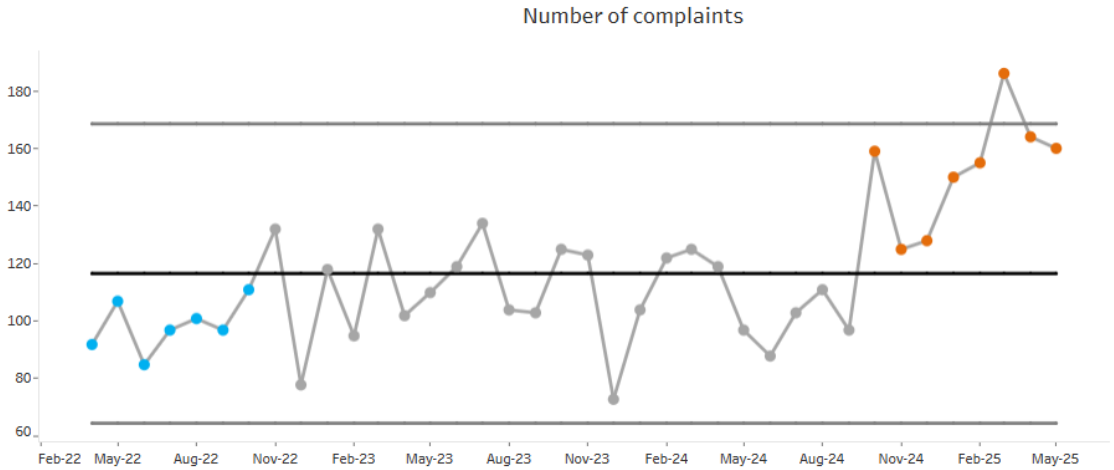
Summary of challenges & risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance	Risk Register	Data quality
In May 629 mothers birthed at OUH, 38 more than the previous month. The midwife to birth ratio was 1:25.51 which is above the Birthrate Plus recommendation of 1:22.9 and inclusive of all NHSP vacancy/unavailability backfill spend and clinical hours allocated by specialist roles. Unavailability remains a challenge for the service with a current 23.48wte (7.07%) on Maternity leave.	The service continues with a robust recruitment and retention plan to align with the recommended Birthrate Plus uplift, address staff retention; optimise rostering KPIs and reduce NHSP spend. The service have offered 21 Band 5 midwives jobs and interviews continue to backfill into the 23.48wte Maternity leave. Daily staffing meetings continue to ensure safe staffing across the service and enable tactical mitigations and trigger escalation as needed. Maternity safe staffing % fill rates improvement plan underway with weekly review of accuracy of planned V's actual fill rates – in collaboration with Trust Safe Staffing team. Further controls for NHSP authorisation now implemented for agreement at Matron level and above only. Additional community night on-calls are now consistently rostered. Cross service review commissioned of all short and long term sickness management and return to work processes to assure alignment to new absence policy.	Ongoing workforce plan to monitor: ➢ Recruitment to birthrate plus uplift, ➢ Staff retention strategies ➢ Reduction of NHSP spend. Positive trajectory towards full recruitment by June 2025. Weekly monitoring of: ➢ Accuracy of Safe Staffing fill rates ➢ Community on-call hours required ➢ Community based births	BAF 4 CRR 1145	Satisfactory *Standard operating procedures in place, training for staff completed and service weekly validation of data entry, but no Corporate or independent audit yet undertaken for fuller assurance*

3. Assurance report: Quality, Safety and Patient Experience, *continued*





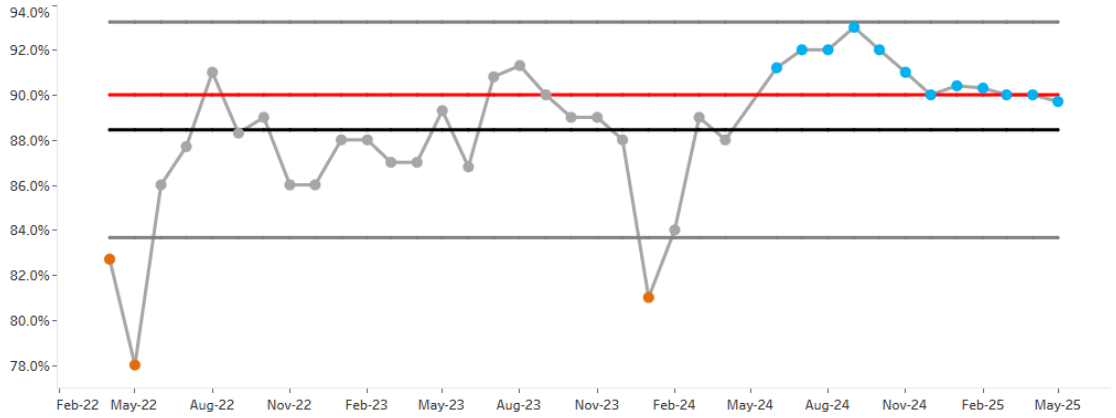
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group	Risk Register	Data quality
In May 2025, 42% of complaints were responded to within 25 days.	The closure rate of complaints within 25 days dropped from 63% in April to 42% in May 2025. Although the number of new complaints remains high, there was a slight reduction in May, with 148 complaints compared to 163 in April. The high volume of new complaints has hindered the Division's ability to close cases within the 25-day timeframe. Additionally, cross-divisional and multi-agency investigations, which involve longer timescales from other organizations, have further affected the closure rate. In May 2025, the Trust received a total of 148 formal complaints. The five primary categories of these complaints were as follows: Clinical Treatment (42 complaints), Values and Behaviours (23 complaints), Communications (22 complaints), Appointments (17 complaints), and Admission & Discharge (14 complaints). Additionally, 14 cases were reopened. The reasons for reopening included requests for further questions following the initial response and acceptance of a resolution meeting with senior clinical staff to discuss the findings of the investigation. A weekly report detailing all open cases at the investigation stage, along with the 14-day target date set by the Complaints team for Divisions to submit the first draft of the response, is circulated. This report assists Divisions in identifying which cases are on track for completion and which may require additional support. Divisions are expected to use this information to manage their open complaints and work towards improving the closure rate of all complaints. Weekly meetings are held with the Complaints Team and Divisional Directors of Nursing to escalate complaint cases that are in breach, with a plan identified to close the case as quickly and appropriately as possible. Engagement of clinical staff in adhering to the timescales required for the investigation of a complaint can be a challenge. The Divisional Directors of Nursing work with Clinical Leads and Divisional Medical Directors to support clinicians in responding to complaints promptly.	Ongoing, reviewed weekly. Oversight by Delivery Committee	BAF 4	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*



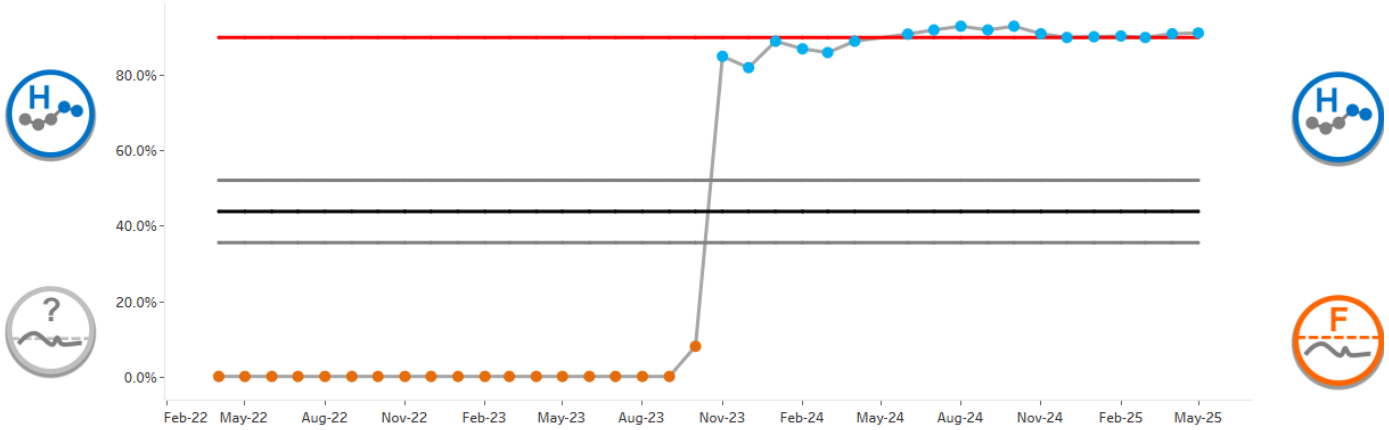
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Ensuring consistent progress towards achieving an 85% closure rate, which may be affected by the increased number of complaints received.	In May, the primary areas of concern highlighted by complainants within the Trust were Clinical Treatment (n=42), Values and Behaviours (n=23), Communications (n=22), Appointments (n=17), and Admission & Discharge (n=14). The comprehensive thematic data provided by the Power BI Complaints dashboard allows divisions to analyse the causes of their complaints and assess their performance in achieving the 25-day resolution target.	Ongoing, reviewed weekly. Oversight by Delivery Committee	BAF 4	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

3. Assurance report: Quality, Safety and Patient Experience, *continued*

Safeguarding (Children) training compliance L1 - L3



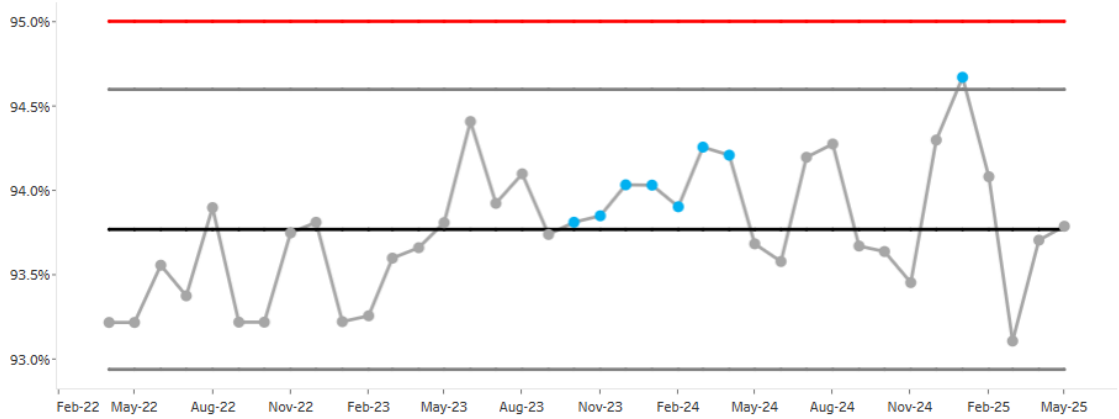
Safeguarding (Adults) training compliance L1 - L3



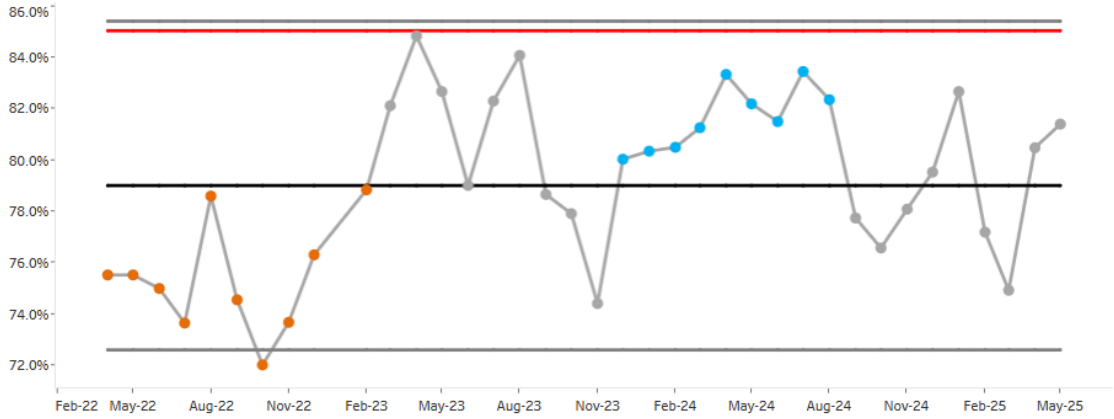
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Training level are just below the KPI of 90%. Adult level 3 is at 87.8% requiring 832 staff to complete this training and children level 3 is at 86.4% that required 246 staff to complete. Level 1 & 2 are above the 90% KPI.	Divisions are requested to encourage compliance as part of the appraisal window. Names of staff for children's directorate provided to division. Children level 3 training moved to teams from face to face to allow addition capacity to access training. Reviewed available training sessions and spaces available and online options are available.	• ICCSIS updated on weekly themes. • PSEC monthly assurance report, safeguarding is embedded in divisional governance reports and presented to the Trust clinical governance committee. • Safeguarding Steering group quarterly.	BAF 4	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

3. Assurance report: Quality, Safety and Patient Experience, *continued*

Friends & Family test % likely to recommend - OP



Friends & Family test % likely to recommend - ED



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
1. Outpatient responses accounted for 10,749 of the total responses received, and the recommend rate has increased to 93.8% in May, compared to 93.7% in April. 2. The top positive themes during May for outpatients was staff attitude, implementation of care, and admission. The top negative themes were catering, waiting list and discharge. 3. ED response numbers were 1561, with a positive recommend rate of 81.4% which has increased in comparison to 80.54% in April. 4. The top positive themes during May for ED was staff attitude, admission, and implementation of care. The top negative themes were car parking, waiting list and communication.	1. A thematic analysis of patient feedback from complaints, Healthwatch and FFT is underway relating to waiting times, to understand how the Trust can more effectively keep in touch with patients whilst they are waiting for an appointment or procedure. 2. A dashboard for FFT is being developed by the performance team. 3. Each division presents an update on patient experience, including FFT data and themes at the PE forum monthly. 4. A deep dive into FFT over an 18-month period is being undertaken to look at specific areas that need support with increasing response number and recommend rates.	1. FFT data continues to be monitored on an ongoing basis. Ward / Clinical areas receive their reports automatically on a monthly basis. 2. The PE team report FFT data weekly to Incidents, Claims, Complaints, Safeguarding, Inquests [ICCSIS] which reports to the Patient Safety and Effectiveness Committee [PSEC]. 3. The data is also reported to the Safety Learning and Improvement conversation (SLIC), Nursing Midwifery and Allied Health Professional Group, Patient and Family Carer Forum, and the Trust Governors Patient Experience and Membership Committee (PEMQ).	BAF 4	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

3. Assurance report: Safe Staffing - Quality, Safety and Patient Experience, *continued*

Summary of challenges and risks

The Safe Staffing Dashboard in the three slides below triangulates nursing and midwifery quality metrics with CHPPD (Care Hours Per Patient Day) at the inpatient ward level. It is an NHSE requirement for this to be reviewed by Trust Boards each month. The NICE Safe Staffing guidelines inform the nurse-sensitive, paediatric, and maternity-sensitivity indicators summarised below.

Nursing and midwifery staffing is reviewed at a Trust level twice daily and was maintained at Level 2 (Amber) throughout May 2025. Neonatal Unit, declared level 3 on one night shift, along with Paediatric Critical Care Unit (PCCU) who declared level 3 on three day shifts. With support from the other Critical Care Units, PCCU was able to implement team nursing as mitigation to make the unit safe. The Trust-wide planned versus actual fill rates were 88.05% during the day and 93.55% at night. Where fill rates were less than 90%, all shifts were reviewed, reported, and mitigated by a Matron or above at the safe staffing meeting, and shifts were not left at risk. The figures reflect that many wards across the trust are working with minimum, rather than, optimum staffing levels.

Actions to address risks, issues and emerging concerns relating to performance and forecast

The staffing levels for nurses and midwives, as well as the nurse-sensitive indicators, are consistently reviewed and validated with divisional directors of nursing and deputy divisional directors of nursing. Each monthly review triangulates all relevant data in accordance with National Quality Board standards and assesses whether these nurse-sensitive harm indicators are directly related to staffing levels. The May review confirmed across all divisions that there were no instances of nurse-sensitive harm indicators directly linked to nursing or midwifery staffing levels.

SUWON – Rostering KPI's- some areas with low annual leave, is being monitored carefully, with emails sent to staff reminding to use leave as per the policy. SEU-F net hours relate to a student, not substantive hours. Upper GI ward also has a net hours difference outside of the KPI, which relates to RAF staff and students. The fill rates were very good for the division (94.7% overall), reflected in the required and actual CHPPD aligned for most wards. Three wards had fill rate less than 90%, however, this related to unrequired shifts not being cancelled for two wards, with the third having been mitigated by the ward manager and educator but not moved into clinical duties on the roster. Ward managers reminded to update correctly and cancel unrequired shifts. The HR data is being reviewed, as following the amendment to budgets, based on M11, the data is inaccurate. The division will work with HR and finance teams to ensure budgets are aligned with safe staffing requirement

MRC – The rostering KPI's for the division are good. JR-ED net hours are skewed by an RN doing some project work that has not been recorded accurately. This will be resolved with the Matron and roster team. The review of red flags is much improved. Two wards had several open flags, which has been addressed by the DDN, with flags now reviewed and closed where possible. Wards continue to work mainly on minimum levels rather than fully staffed, accounting for the difference between required and actual CHPPD, but assurance given that shifts were safe and nurse sensitive indicator reporting was not directly related to staffing concerns. Overall fill rate improved slightly to 90.7%. Areas with fill rate below 90% has been addressed with each ward manager. The main theme revealed unrequired shifts had not been cancelled, and for one ward agreed reduction of support worker shifts has not yet been updated on the roster. The HR data is being reviewed, as following the amendment to budgets, based on M11, the data is inaccurate. The division will work with HR and finance teams to ensure budgets are aligned with safe staffing requirement

NOTSSCAN – Roster efficiencies and KPI adherence are being closely monitored by the DDN, as most areas are below the KPI for booked annual leave. The net hours for Blenheim Head & Neck relate to a student. The hours for Neuro Green relate to an employee who is being supported by the Matron, HR and Occupational Health. Review of Red flags has improved across the division.. For most wards the actual CHPPD are lower than required, but more aligned to budgeted staffing. Although most wards have not been fully staffed, assurance given by DDN that they have been at a minimum safe level. The areas with higher than required CHPPD, relate mostly to the time around bank holidays where there were some empty beds. Medication incidents in Paediatric Critical Care (15), Neonatal Unit (7) and Bellhouse Drayson (7) are attributed to nurse administration errors. Each incident has been reviewed by the DDoN, who confirmed at formal sign-off that appropriate actions and interventions have been implemented. All wards with low fill rate related to unrequired shifts not beign cancelled. This is actively being addressed across the division. The division will work with finance teams to ensure budgets are aligned with safe staffing requirements.

Actions to address risks, issues and emerging concerns relating to performance and forecast (continued)

CSS – JR ICU – CHPPD, budget and roster were all reviewed. Budgeted CHPPD were higher than actual, as not all beds were required to be staffed. Throughout May, most patients were cared for on one level. All areas were safely staffed in May, utilising temporary workforce when appropriate, with overall fill rates over 96%. The division will work with finance teams to ensure budgets are aligned with safe staffing requirements.

Maternity – Labour induction delays over 24 hours increased from 13 in April to 23 in May, there were periods of high acuity that contributed to this, the Induction of Labour (IOL) improvement group will review all delays and look to implement timely interventions to respond to this. There were 16 medication errors, not related to staffing concerns. Learning has been shared around timely administration and documentation. Positively choice of place of birth was protected this month with no intended place of birth changes occurring.
Shift fill rates dropped slightly below 90% due to unrequired shifts not being cancelled. Collaborative efforts to improve this with the Corporate team are ongoing, including tactical staff education and retrospective spot check audits, linking to the completion of the alignment exercise. On-call shifts were not being redeployed 'live'. This is now being addressed, which will further improve the fill rates.
Vacancies and overall vacancy has been removed from reporting as the finance ledger is inaccurate against ESR data since Birth rate Plus was approved. As the ledger has not yet been updated, it appears the directorate are over recruited. This will be reported again when the alignment exercise is completed

Nurse Sensitive Indicators Directly Impacted by Staffing Levels
The divisional directors of nursing have reviewed and approved the staffing levels for May. They confirmed that insufficient or unsafe staffing did not directly impact nurse-sensitive indicators, and thus, no exception reporting is required for this month

Critical Care Recruitment
During M1, the Trust welcomed 22 new starters to our Critical Care teams across the Trust. This included both external hires and internal promotions. Additionally, we have a robust pipeline with 24 candidates currently progressing through pre-employment checks for both band 5 and band 6 roles. This strong pipeline is a testament to ongoing recruitment efforts.
Moreover, a dedicated microsite aimed at attracting candidates to Critical Care in Oxford continues to be developed alongside the Trust's updated website. This initiative is expected to significantly bolster our future recruitment efforts, with the microsite set to go live in M3. The focus will be particularly on band 6 vacancies, complementing the ongoing recruitment activities.
However, following the recent budget allocations, there have been some concerns raised. Specifically, band 6 vacancies that were in place in the previous financial year have now been cut from the budgets. In light of the recent establishment reviews, the divisions are working closely with their finance teams to ensure that staffing numbers are aligned with safe staffing requirements. The goal is to continue recruiting to fill these previous band 6 vacancies despite the budget cuts.

Vacancies above 15%
All areas with a vacancy rate above 15% continue to be reviewed to ensure that there continues to be effective approaches to recruitment in place for those areas.

Unavailability
All areas experiencing a high unavailability of workforce, due to vacancies, maternity leave, or long-term sickness (according to HR data), were addressed to maintain safe staffing levels. This was achieved through the support of Ward Managers and Clinical Educators, as well as the use of temporary workforce solutions, including NHSP, Agency staff, and Flexible Pool shifts for Maternity. All relevant metrics, such as rostering efficiencies, professional judgement, patient acuity, enhanced care observation requirements, skill mix, bed availability, and RN-to-patient ratios, are reviewed each shift to ensure safe and efficient staffing levels are maintained.

3. Assurance report: Safe Staffing - Quality, Safety and Patient Experience, *continued*

Actions to address risks, issues and emerging concerns relating to performance and forecast (continued)

Key:
Grey squares on the dashboard indicate where an indicator is either not relevant or not collected for the ward area.

For HR Data:
Turnover: This reflects the number of leavers divided by the average staff in post for both registered and unregistered Nursing staff. Leavers are based on a rolling 12 months, and do not include fixed term assignments or redundancies.

Sickness: This is a rolling twelve-month figure and is reported in the same manner as Trust Board sickness data. The figures presented reflect both registered and unregistered staff.

Maternity: This is taken on the last day of a particular month (aligned to all Trust reporting) and reflects those on maternity/adoption leave on that day. The FTE absent on this day is then divided by the total FTE for this cohort. The figures presented reflect both registered and unregistered staff.

HR Vacancy: For the designated areas this figure is the establishment (Budget FTE) minus the contracted FTE in post as at the last day of the month. The vacancy figure is then divided by the establishment. The figures presented reflect both registered and unregistered staff.

HR Vacancy adjusted: As per "HR Vacancy" ; with additional adjustment for staff on long term sick, career break, maternity leave, suspend no pay/with pay, external secondment. Data taken on last day of the month and reflects both registered and unregistered staff.

Please note that all data is taken at the last day of the month. This is how data is reported internally to Board and externally to national submissions. This ensures consistent reporting and assurance that the data is being taken at the same point each month for accurate comparisons to be made.

Action timescales and assurance group or committee	Risk Register (Y/N)	Data quality rating
The Trust has commenced developing actions tailored to improving roster efficiency and effectiveness in nursing and midwifery. This work will ensure a balanced skill mix during each shift. Assurance of ongoing oversight and assurance that nursing and midwifery staffing remains safe. Although CHPPD should not be reviewed in isolation as a staffing metric, and always at ward level. Reviewing it at Trust level triangulated with other Trust level financial metrics allows the Board to see where there are increased, capacity and acuity, (required) versus budget.	N	***Sufficient*** Information reported at required level. SOP in progress. Staff appropriately trained and quality assurance process in place each month for audit. Corporate validation/audit undertaken with DDNs and Deputy Chief Nurse workforce team monthly. External audit not undertaken in last 18-months.

3. Assurance report: Safe Staffing - Dashboard: Part 1 (NOTSSCaN)

Oxford University Hospitals NHS Foundation Trust

May 2025	Care Hours Per Patient Day			Census	Nurse Sensitive Indicators				HR					Rostering KPIs (21.4.25-18.5.25)			
Ward Name	Budgeted Overall	Required Overall	Actual Overall	Census Compliance (%)	Medication Administration Error or Concerns	Extravasation Incidents	Pressure Ulcers Category 2,3&4	All reported Falls	Vacancy (%)	Turnover (%)	Sickness (%)	Maternity (%)	Revised Vacancy HR Vacs plus LT Sick & Mat Leave (%)	Roster manager approved for Payroll	Net Hours 2/-2%	8 week lead time	Annual Leave 12-16%
NOTSSCaN																	
Bellhouse / Drayson Ward	8.95	11.08	10.1	83.87%	7	1	0	0	22.20%	20.90%	2.80%	1.90%	23.70%	Yes	2.58%	9.43	5.89%
HH Childrens Ward	9.54	9.14	13.9	97.85%	1	0	0	0	10.20%	4.00%	5.20%	14.30%	23.00%	Yes	-3.60%	9.43	14.04%
Kamrans Ward	7.67	11.12	10.5	94.62%	0	0	0	0	10.90%	3.90%	1.30%	2.40%	13.00%	Yes	2.98%	9.43	10.76%
Melanies Ward	9.68	10.24	9.5	100.00%	1	0	0	0	14.10%	14.00%	4.30%	0.00%	19.50%	Yes	-0.93%	9.57	11.87%
Robins Ward	10.68	12.05	12.1	100.00%	3	0	0	0	8.60%	17.90%	6.70%	3.90%	15.70%	Yes	2.63%	9.43	8.71%
Tom's Ward	8.05	9.31	7.8	96.77%	4	2	0	1	7.40%	0.00%	2.90%	3.90%	11.00%	Yes	2.58%	9.57	8.53%
Neonatal Unit	19.92		16.2		7	2	0	0	6.30%	8.90%	6.30%	3.00%	11.50%	Yes	-3.53%	9.43	13.43%
Paediatric Critical Care	27.60		29.4		15	3	0	0	9.30%	8.50%	4.60%	8.80%	18.10%	Yes	-0.79%	7.71	11.43%
BIU	6.05	5.75	6.9	97.85%	3		0	3	-2.40%	3.40%	3.70%	5.60%	3.40%	Yes	1.45%	10.00	17.50%
HDU/Recovery (NOC)	9.04		27.7		0		0	0	10.00%	7.00%	7.90%	4.10%	13.70%	Yes	1.49%	8.71	6.58%
Head and Neck Blenheim Ward	7.29	8.06	8.4	100.00%	3		0	0	13.80%	0.00%	3.70%	0.00%	13.80%	Yes	-7.21%	9.71	10.31%
HH F Ward	7.42	8.62	7.7	100.00%	1		4	0	1.80%	7.90%	4.80%	2.20%	3.90%	Yes	0.69%	9.57	14.84%
Major Trauma Ward 2A	9.12	9.58	9.2	100.00%	2		1	1	12.90%	12.00%	5.20%	1.20%	15.70%	Yes	3.52%	8.00	15.85%
Neurology - Purple Ward	8.96	9.95	8.2	100.00%	1		2	6	14.50%	6.10%	5.90%	2.90%	17.00%	Yes	3.59%	9.43	9.55%
Neurosurgery Blue Ward	8.93	10.80	9.6	93.55%	1		0	3	4.30%	6.90%	3.20%	2.10%	6.30%	Yes	0.35%	8.86	11.35%
Neurosurgery Green/IU Ward	12.49	10.51	9.8	100.00%	1		0	2	7.30%	3.00%	4.50%	0.00%	10.00%	Yes	7.39%	9.43	9.32%
Neurosurgery Red/HC Ward	12.80	12.64	12.6	96.77%	2		1	1	2.10%	10.10%	4.20%	3.30%	8.50%	Yes	0.60%	8.86	11.38%
Specialist Surgery I/P Ward	7.28	7.05	8.5	100.00%	1		2	6	8.70%	4.70%	3.30%	6.10%	14.30%	Yes	2.62%	9.71	15.54%
Trauma Ward 3A	9.13	9.02	9.5	96.77%	2		2	1	5.20%	8.20%	8.10%	4.00%	12.70%	Yes	2.95%	6.14	12.41%
Ward 6A - JR	7.53	7.63	7.6	96.77%	1		7	3	-3.40%	10.70%	2.80%	6.10%	3.00%	Yes	-0.13%	9.14	9.05%
Ward E (NOC)	6.30	6.80	8.4	96.77%	0		0	4	-4.80%	6.30%	7.50%	2.80%	-1.80%	Yes	2.79%	7.71	14.76%
Ward F (NOC)	6.65	9.15	8.8	96.77%	0		0	1	-4.10%	2.90%	4.70%	0.00%	-1.10%	Yes	-1.80%	9.57	14.97%
WW Neuro ICU	27.90		30.5		4		0	0	-2.00%	9.00%	4.90%	3.10%	1.10%	Yes	-0.90%	8.00	16.97%

3. Assurance report: Safe Staffing - Dashboard: Part 2 (MRC)

Oxford University Hospitals NHS Foundation Trust

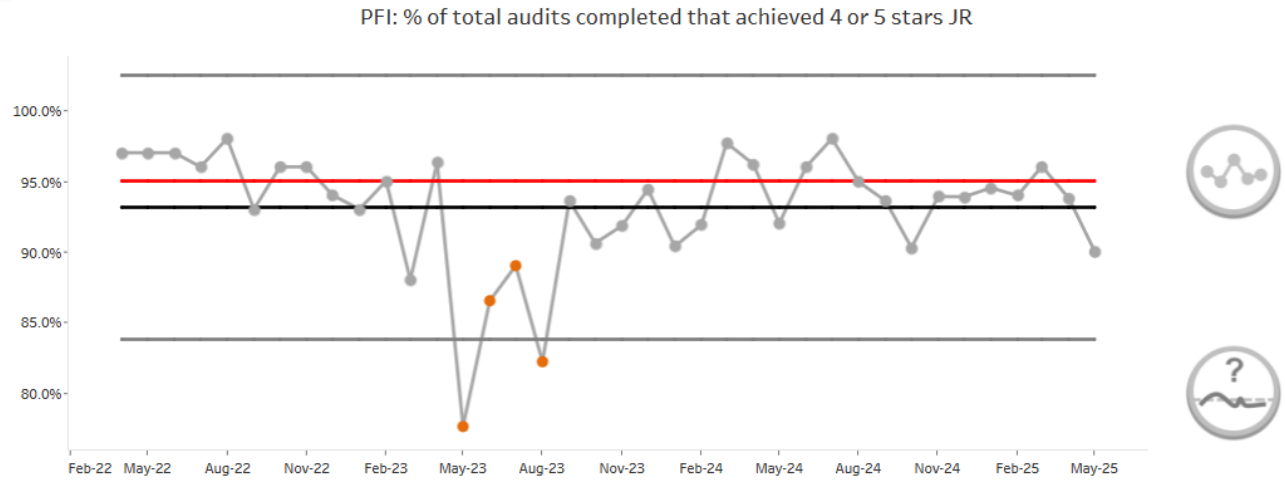
May 2025	Care Hours Per Patient Day			Census	Nurse Sensitive Indicators				HR					Rostering KPIs (21.4.25-18.5.25)			
Ward Name	Budgeted Overall	Required Overall	Actual Overall	Census Compliance (%)	Medication Administration Error or Concerns	Extravasation Incidents	Pressure Ulcers Category 2,3&4	All reported Falls	Vacancy (%)	Turnover (%)	Sickness (%)	Maternity (%)	Revised Vacancy HR Vacs plus LT Sick & Mat Leave (%)	Roster manager approved for Payroll	Net Hours 2/-2%	8 week lead time	Annual Leave 12-16%
MRC																	
Ward 5A SSW	8.81	9.17	8.1	100.00%	0		3	1	2.30%	4.10%	4.40%	10.00%	12.10%	Yes	0.38%	9.57	10.06%
Ward 5B SSW	8.88	9.01	8.6	100.00%	2		2	4	1.00%	8.50%	3.30%	0.00%	1.00%	Yes	-0.53%	9.57	14.47%
Cardiology Ward	7.85	6.82	8.2	100.00%	4		2	5	10.20%	13.90%	6.30%	0.00%	11.40%	Yes	0.08%	9.29	11.21%
Cardiothoracic Ward (CTW)	7.82	6.89	6.4	96.77%	0		0	0	4.70%	0.70%	3.50%	2.30%	6.90%	Yes	0.12%	8.43	10.09%
Complex Medicine Unit A	8.94	10.97	8.1	100.00%	0		2	3	3.10%	9.60%	6.10%	2.10%	8.80%	Yes	1.40%	9.86	12.35%
Complex Medicine Unit B	10.15	11.02	8.8	100.00%	0		1	5	-4.00%	9.70%	4.20%	4.60%	0.80%	Yes	2.02%	9.86	15.13%
Complex Medicine Unit C	8.75	10.18	8.4	100.00%	4		0	1	8.90%	8.80%	3.30%	1.60%	10.30%	Yes	0.18%	9.86	12.56%
Complex Medicine Unit D	9.21	8.43	8.4	100.00%	4		1	2	7.00%	20.10%	7.40%	0.00%	7.00%	Yes	-0.70%	9.86	10.13%
CTCCU	21.10		21.6		2		2	0	7.80%	8.20%	4.40%	4.50%	13.20%	Yes	-0.11%	9.71	11.36%
Emergency Assessment Unit (EAU)	9.23	8.52		95.16%	4		1	2	-9.60%	10.20%	6.50%	1.10%	-6.50%	Yes	0.42%	9.29	10.46%
HH EAU	9.77	7.57		96.77%	0		2	4	2.80%	4.80%	5.50%	2.30%	5.60%	Yes	-0.41%	9.57	13.04%
HH Emergency Department	22.83				1		0	1	2.50%	7.70%	3.50%	4.80%	7.20%	Yes	-2.03%	9.71	12.92%
JR Emergency Department	18.23				6		0	6	14.50%	14.70%	4.80%	3.80%	19.80%	Yes	-6.76%	9.43	9.84%
HH Juniper Ward	8.07	10.15	8.1	100.00%	0		2	4	6.90%	6.90%	4.90%	1.50%	9.80%	Yes	-1.51%	9.71	12.39%
HH Laburnum	9.66	10.27	8.5	100.00%	0		0	2	-3.10%	5.60%	7.50%	2.80%	3.30%	Yes	1.54%	9.71	15.45%
HH Oak (High Care Unit)	10.58		12.8	94.62%	1		2	1	-4.40%	2.10%	6.50%	12.10%	8.30%	Yes	-1.04%	9.71	12.78%
John Warin Ward	10.18	11.69	10.2	98.92%	0		2	1	-8.00%	3.90%	4.10%	8.90%	1.60%	Yes	-0.76%	9.57	13.20%
OCE Rehabilitation Nursing (NOC)	10.55	10.13	11.0	100.00%	0		1	1	-0.90%	9.00%	5.40%	3.50%	3.40%	Yes	-0.40%	8.57	14.15%
Osler Respiratory Unit	14.43	10.3	11.9	97.85%	2		4	0	1.00%	9.50%	4.90%	1.40%	3.10%	Yes	-0.48%	9.57	10.01%
Ward 5E/F	11.05	9.24	10.3	98.92%	1		2	3	-1.80%	17.80%	5.20%	5.10%	3.40%	Yes	-1.15%	9.57	11.52%
Ward 7E Stroke Unit	10.93	9.28	9.0	98.92%	2		2	5	-1.40%	14.70%	4.90%	3.50%	3.60%	Yes	-2.00%	8.57	11.37%

3. Assurance report: Safe Staffing - Dashboard: Part 3 (SuWOn and CSS)

Oxford University Hospitals NHS Foundation Trust

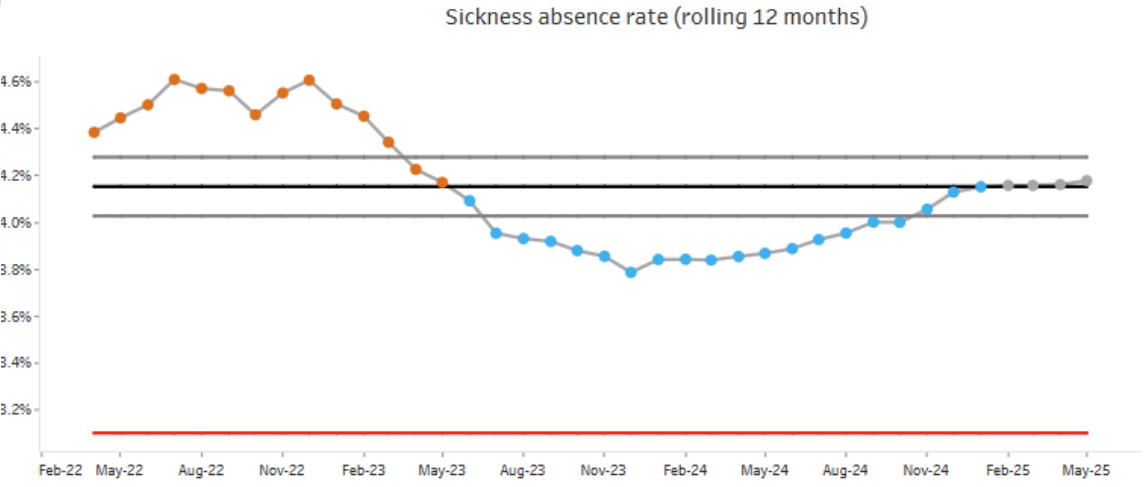
May 2025	Care Hours Per Patient Day			Census	Nurse Sensitive Indicators				HR					Rostering KPIs (21.4.25-18.5.25)			
Ward Name	Budgeted Overall	Required Overall	Actual Overall	Census Compliance (%)	Medication Administration Error or Concerns	Extravasation Incidents	Pressure Ulcers Category 2,3&4	All reported Falls	Vacancy (%)	Turnover (%)	Sickness (%)	Maternity (%)	Revised Vacancy HR Vacs plus LT Sick & Mat Leave (%)	Roster manager approved for Payroll	Net Hours 2/-2%	8 week lead time	Annual Leave 12-16%
SUWON																	
Gastroenterology (7F)	7.50	7.99	7.3	97.85%	2		2	3	9.00%	7.70%	6.10%	7.30%	18.10%	Yes	-2.38%	8.57	11.95%
Gynaecology Ward - JR	5.14	5.59	7.9	100.00%	1		0	0	0.80%	9.80%	5.70%	5.60%	8.60%	Yes	-3.12%	9.00	12.96%
Haematology Ward	7.63	7.18	8.5	94.62%	10		0	6	25.30%	17.90%	6.60%	4.70%	28.80%	Yes	-1.28%	6.86	12.65%
Katharine House Ward	9.25	8.06	10.1	100.00%	1		0	2	10.40%	7.00%	5.20%	7.80%	17.40%	Yes	-0.49%	9.71	13.40%
Oncology Ward	7.71	8.67	8.2	96.77%	4		2	5	8.40%	8.40%	3.60%	3.00%	11.10%	Yes	0.52%	5.86	11.86%
Renal Ward	9.28	8.64	9.2	100.00%	0		1	6	10.30%	14.10%	4.10%	10.40%	19.60%	Yes	0.41%	9.57	8.76%
SEU D Side	8.69	8.44	8.5	93.55%	3		2	1	18.60%	4.80%	4.80%	4.70%	22.40%	Yes	-1.67%	9.43	12.95%
SEU E Side	8.36	8.27	8.6	93.55%	0		1	2	21.60%	3.30%	5.20%	0.00%	26.40%	Yes	-0.62%	9.43	15.53%
SEU F Side	7.53	8.41	7.8	93.55%	2		0	1	20.60%	6.70%	3.00%	0.00%	20.60%	Yes	-6.34%	9.43	10.24%
Sobell House - Inpatients	8.65	8.49	8.1	96.77%	0		5	7	14.70%	6.40%	4.70%	10.50%	23.60%	Yes	-1.52%	7.71	9.68%
Transplant Ward	9.43	8.12	8.7	97.85%	0		0	2	13.00%	8.50%	6.20%	0.00%	15.90%	Yes	-2.90%	9.43	8.22%
Upper GI Ward	9.63	7.23	8.3	96.77%	2		2	2	-0.80%	0.00%	5.20%	12.90%	14.80%	Yes	-7.40%	9.29	7.66%
Urology Inpatients	8.81	9.15	8.8	100.00%	2		1	1	18.40%	0.00%	4.40%	3.60%	24.20%	Yes	-1.35%	9.43	10.15%
Wytham Ward	7.65	7.10	7.6	98.92%	1		2	1	-8.10%	6.50%	4.70%	14.90%	10.10%	Yes	-2.99%	8.57	9.87%
MW Delivery Suite	15.15		20.2											Yes	-4.04%	7.57	8.10%
MW Level 5	6.64		5.7											No	0.45%	7.57	12.06%
MW Level 6	4.48		7.9											Yes	-1.50%	7.57	13.73%
MW The Spires	15.46		17.5											Yes	-0.02%	7.57	9.23%
CSS																	
JR ICU	31.13		26.2	96.77%	8		3	0	10.30%	7.10%	4.70%	6.80%	16.90%	Yes	0.99%	8.57	8.70%

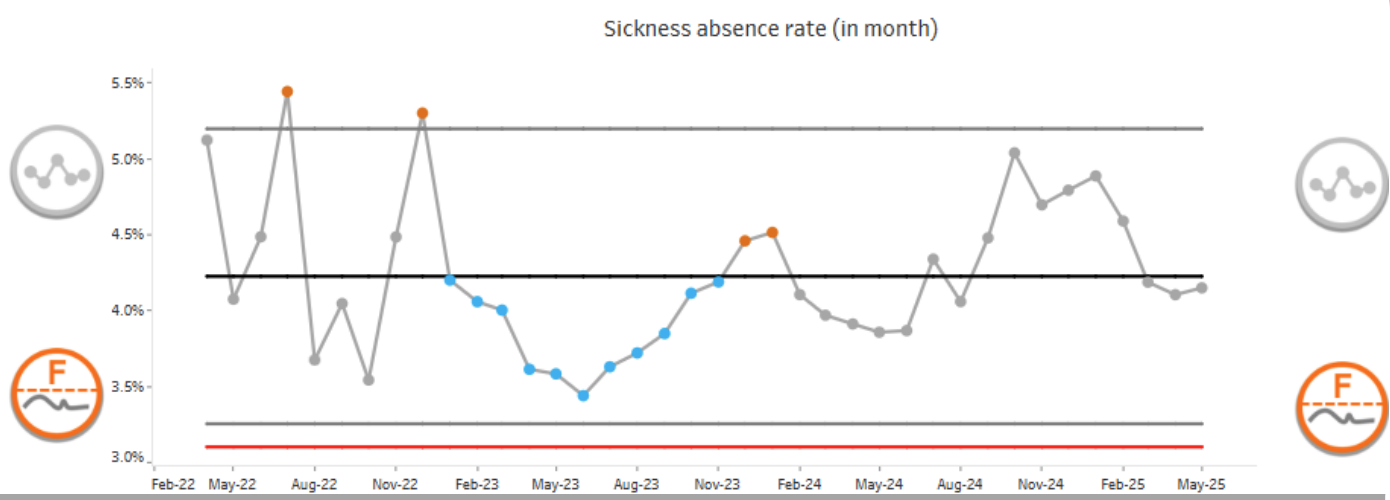
3. Assurance report: Estates, Facilities and PFI



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group	Risk Register	Data quality
In May 2025, the combined PFI % cleaning score by site (average) for the JR was 95.85% which is a slight increase on last month and has maintained a consistent and high standard for the past six months. However, the above graph demonstrates the percentage of total audits undertaken that achieved 4 or 5 stars, which sits at 90.04% which is below the 95% Trust target. In total, at the JR, 251 audits were conducted, 25 of which did not meet the 4* requirement during the first round. As a Trust, we strive to achieve a completion rate of 95% for audits that meet or exceed 4 stars every month. However, this is not a nationwide target outlined in the National Standards of Cleanliness 2025. These standards require all areas of healthcare facilities to be audited and meet specific combined cleaning percentage thresholds based on risk levels, including FR1 (98%), FR2 (95%), FR4 (85%), and FR6 (75%), to receive a 5-star rating. It is important to note that a lower star rating does not necessarily indicate uncleanliness. The purpose of audits is to identify and address any issues promptly, with a follow-up audit conducted after rectification to ensure improvements have been made and to re-evaluate the star rating along with re training if required, review of cleaning equipment, understanding the responsibilities of each party involved etc.	Mitie completed more than planned number of audits at JR in May 2025. Out of these audits, 25 failed to meet the established Trust targets for both domestic and clinical responsibilities. However, all identified issues were rectified within the required timeframe, leading to an improvement in the reported percentages, with each area ultimately achieving ratings of 4 out of 5 stars or higher. There were no recurring trends or departments/wards that consistently failed the audits; the failures were spread across both clinical and domestic responsibilities. The Mitie Training Manager is conducting additional training and retraining on specific elements for the domestic teams as we saw many new recruits in May. We are collaborating closely with the Infection Prevention and Control team and the leads of the relevant wards and departments to address these issues effectively. When it comes to managing cleaning risks, patient safety is our top priority. At our Trust, we believe in working together to maintain cleanliness in all our facilities. Whenever an area scores three stars or below, Service Providers create action plans that include responsibilities for domestic, estates, and clinical staff to improve those areas. The Trust PFI management team oversees the implementation of those plans, while domestic supervisors and the Trust PFI team monitor the progress with the support of IP&C. We work collaboratively with the Domestic Service Teams, Clinical teams, and IP&C to enhance the cleanliness of our facilities. The PFI team is discussing with the CEFO to redefine the KPIs for cleaning scores to align them more closely to the NSC. The objective is to determine the appropriate measures and provide a better understanding of what is being measured, by whom, and how.	1. Improvement to work towards the 95% target for 4 & 5-star cleaning audits for 2025 at JR. 2. Information cascade - Monitoring carried out utilising the My Audit auditing platform, which reports each audit to the PFI management team, area Matron, ward manager and senior housekeeper at the time of completion. 3. Actions reviewed weekly at the service providers/Trust PFI domestic services meeting, Monthly reporting to HIPCC 4. Review current KPI metrics and align with NSC with redefined metrics clearly set out for ongoing IPR Reports	BAF 4 CRR 1123	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

3. Assurance report: Growing Stronger Together



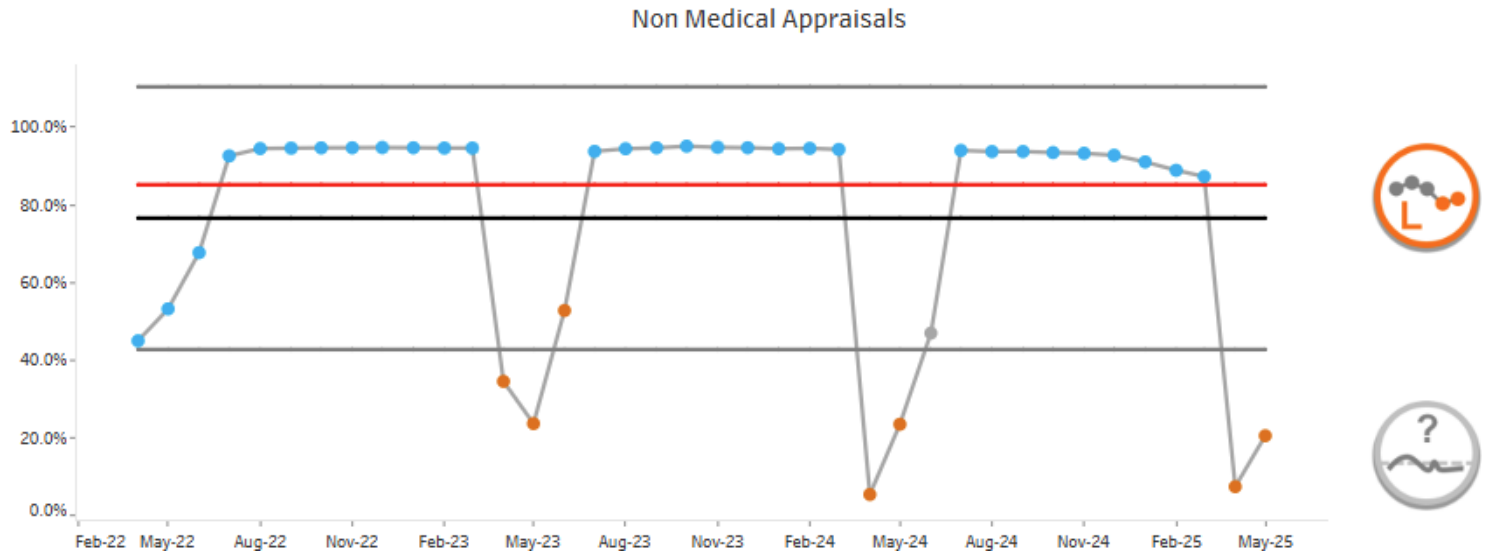


Benchmarking: April 25 (monthly performance – *lag due to availability of published data from National Sickness Absence Rate report*).

OUH: 4.61% **National: 5.81%** **Shelford: 4.87%** Buckinghamshire Healthcare NHS Trust: 4.42% Royal Berkshire NHS Foundation Trust: 4.11% Oxford Health: 5.27% South Central Ambulance Service: 7.78%

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Sickness absence performance (rolling 12 months) was 4.2% on May 25 and remained steady at 4.2% for months 1 and 2. We expect this to decrease further as we are out of winter period. The monthly figure has remained steady at 4.1% for months 1 and 2. In the month, the key reasons for sickness top 5:- • Mental Health - Anxiety/Stress • Flu-like Symptoms • Gastrointestinal problems • Surgery – Other • Pregnancy-related disorders Long-term sickness top 5 reasons:- • Mental Health - Anxiety/Stress • Mental Health - Depression • Benign and malignant tumours, cancers • Surgery – Other • Mental Health - Other	• Divisions to review the top 20 absences and work on action plans to reduce the numbers. • We are focusing on the top Cost Service Units (CSUs) that have consistent absenteeism. • We are collaborating with Occupational Health to assist managers and staff in reviewing the top three reasons for absenteeism. • There is a call to action regarding long-term sickness, ensuring that staff receive the support needed to return to work successfully. • Managers will be alerted about staff who have triggered absenteeism, with guidance provided to support them through the sickness absence process • .HR is proactively promoting sickness absence management training to help managers implement the new procedures effectively • HR is closely working with managers to ensure Return to Work (RTW) meetings are completed. • Sickness absence workshops are ongoing to provide continued support for managers. • Occupational Health colleagues will continue to offer support during monthly meetings to address issues and implement proactive measures. • Monthly meetings with the Wellbeing lead are held to identify additional areas where support may be required. • Work is ongoing on naming conventions for sickness reasons	Governance - TME via IPR, HR Governance, Monthly meeting & Divisional meetings All actions are ongoing	BAF 1 BAF 2 CRR 1616 (Amber)	Satisfactory Standard operating procedures in place, training for staff completed and service evaluation in the previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance

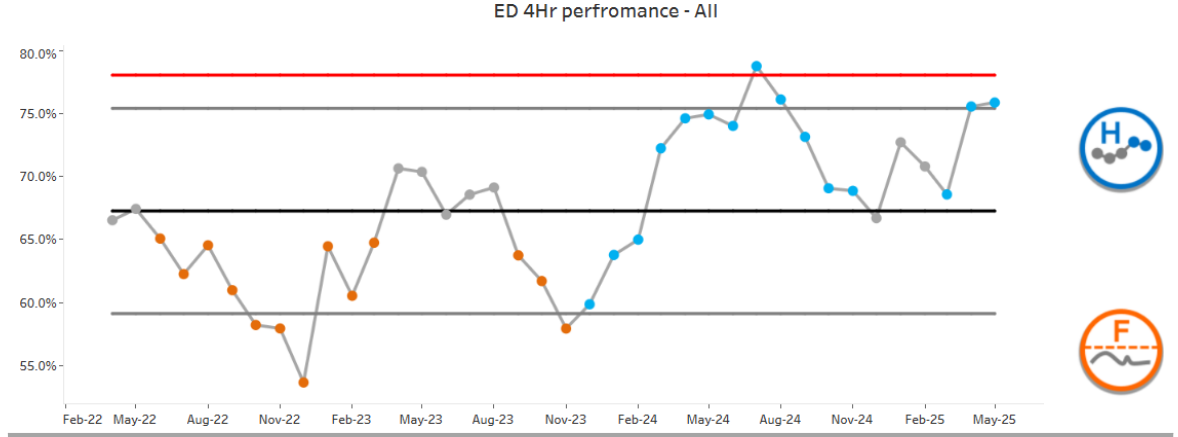
3. Assurance report: Growing Stronger Together

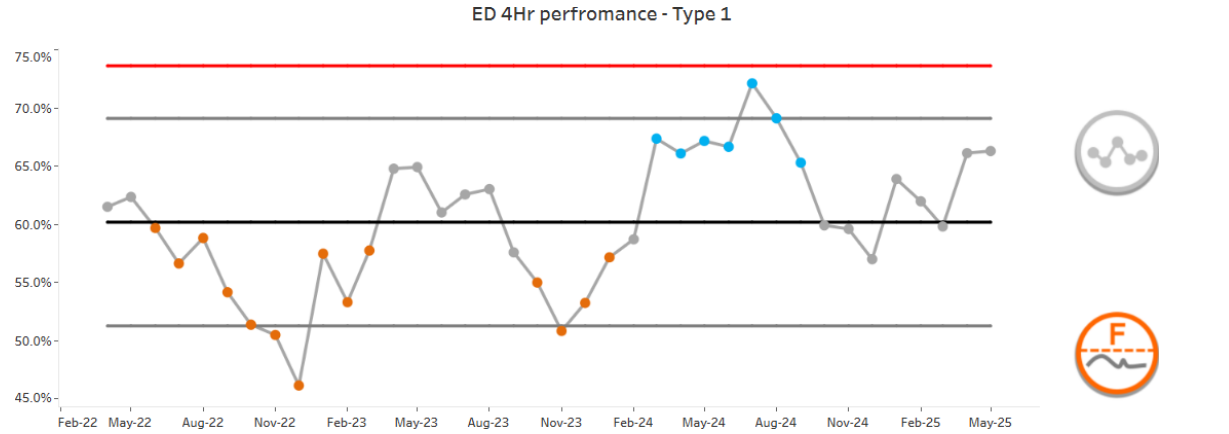


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
M2 compliance is currently at 20.3%, previous month was 7.3 % for M1 2025. Colleagues in the Divisional Workforce receive weekly reports detailing progress and the names of compliant and non-compliant staff.	• We offer a full range of communication, resource, and leadership support both corporately and with our Divisional Workforce teams. • Divisional communications encouraging all managers and staff to book and prepare for their appraisals. • Bespoke team brief emphasis on 'quality' appraisals – using the toolkit and guidance available on MLH. • Service Leads are drafting an email to all managers to share their approach regarding longer-serving staff members and those who are not interested in career progression or do not recognise the value of VBA. The goal is to focus the discussion on Values when delivering services and outcomes. • The Divisional Workforce Team is promoting appraisals at every meeting. • Signposting staff and managers to the appraisal resources.	Governance - TME via IPR, HR Governance Monthly meeting & Divisional meetings All actions are ongoing	BAF 1 BAF 2 CRR 2331 (Amber)	Satisfactory Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance

3. Assurance report: Operational Performance

Oxford University Hospitals NHS Foundation Trust



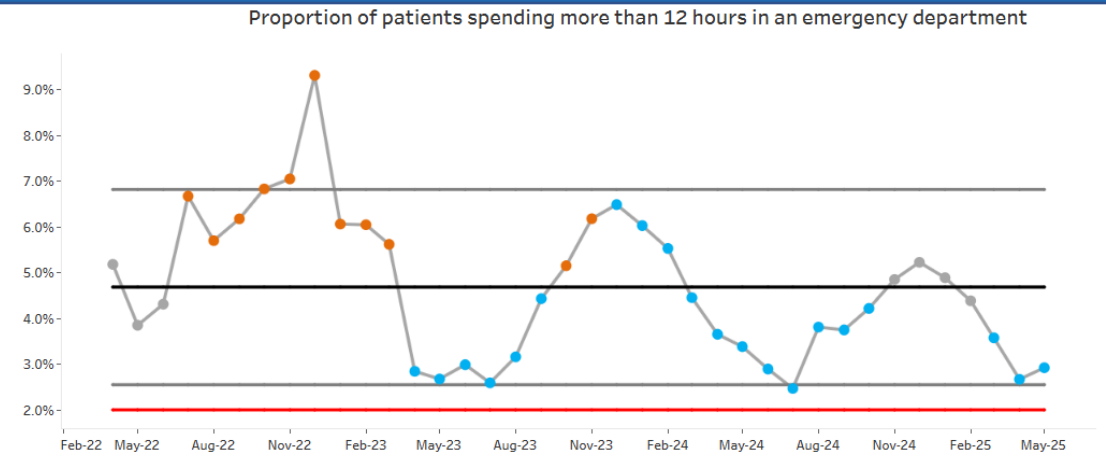


Benchmarking: ED (All types): May 25				
OUH: 75.82%	**National: 74.20%**	**Shelford: 73.87%**	BHT: 77.56%	RBH: 71.16%

ICS key			
BHT	Buckinghamshire Healthcare NHS Trust	**RBH**	Royal Berkshire NHS Foundation Trust

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The Emergency Department 4hr performance for all types was 75.82% in May for the Trust overall. Type 1 performance in May was 66.3% for the Trust overall. Breach performance by site was 70.28% for all types and 59.22% for Type 1 at the John Radcliffe Hospital (JR), and 89.32% for all types and 84.43% for Type 1 at the Horton Hospital in May. ED attendances were very high in May, the second highest month in the last three years and 5% increase on May 2024. Ambulance conveyance rates steadily increased over winter but have now plateaued with an improving Hear & Treat rate. Admission avoidance and the utilisation of alternative pathways via SPA is still emerging and requires further focus and targeted work with system partners to maximise this opportunity. May's conveyances to ED were higher than April but not to the extent seen in March. Despite the increased activity, the average handover time remained the same. OUH continues to raise work with system colleagues on improving the data quality of ambulance handover data. 'Wait to be seen' continues to be the most significant breach reason on both sites for admitted and non-admitted patients. However, there has been an 18% percentage point reduction in breaches due to this reason in May. This is attributed to the quality improvement work in ED ambulatory pathway and rota completion for overnight senior decision makers. ORU continues to have a positive impact on patient experience, with a sustained improvement in the number of patients seen per day and improvements to the pathway. During May, ORU saw 1218 patients supporting 4.4% less Type 1 4hr breaches. Phase 4 of the ORU QI project has been achieved – Nurse streaming and dedicated doctor to provide earlier assessment and treatment, enhancing efficiency and utilisation.	**Senior Medical Decision Maker (Consultant) in the JR ED in the overnight period.** The team continue to recruit to the full complement; (with attrition) this is expected to be complete by June 2025. Quantified benefit realisation is being visualised in dashboard format to enable greater productivities where possible. Through Vacancy Control Process, posts have been approved and out to advert to support agile further recruitment. 4 nights continued to be covered in Q1, with continued phased approach to 7/7 implementation. The **Urgent and Emergency Care Quality Improvement Programme 2024/26** has been in place during the year. Five key priorities were agreed, with the Senior Decision Maker and Rapid Assessment & Treatment / Childrens Urgent Care Pathway priorities having commenced in October. Both of these workstreams are progressing well, with a number of PDSA cycles having been undertaken in the Decision Maker and Rapid Assessment workstream. During Q1 25/26, roll-out of this model is becoming embedded. Alignment with the UCC for reporting purposes has been completed. Phase 4 of the ORU QI project has been completed which provides a dedicated doctor for earlier assessment and treatment, enhancing efficiency and utilisation.	Recruitment approach underway through 2025/26, completed in June 2025. TWUCG Quarter 1 25/26 Complete	BAF 4 CRR 1133 (Red)	Sufficient *Standard operating procedures in place, staff training in place, local audit undertaken in last 12 months, and independent audit completed in last 18 months*

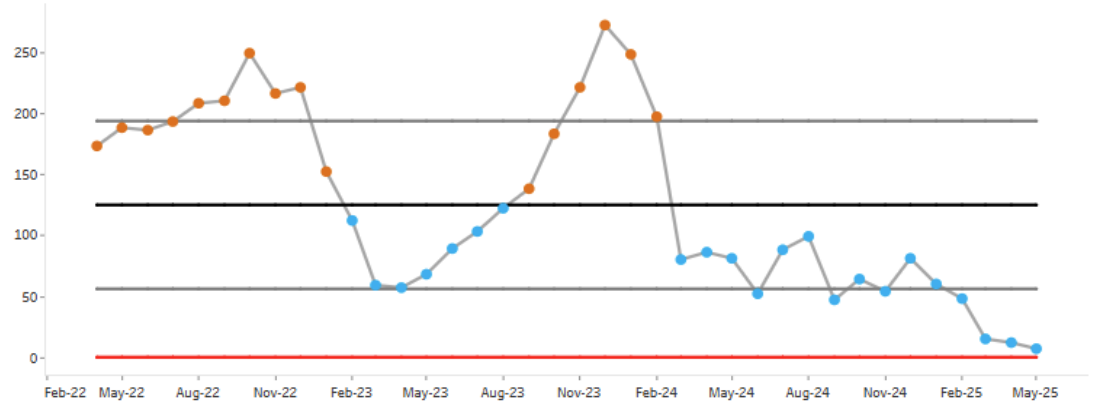
3. Assurance report: Operational Performance, *continued*



Summary of challenges and risks	Actions to address risks, issues and emerging concerns	Action timescales and assurance group	Risk Register	Data quality rating
The proportion of patients with a length of stay of more than 12 hours in the Emergency Department was 2.8% (499 patients) in May. Whilst there has been an improvement month on month since December, this remains just above the target and sustaining previous positive performance has been more challenging. The Horton Hospital has made consistent improvements since the winter with 0.4% in May, just 18 patients. The JR position was on a par with the previous month at 3.6% (481 patients) following a period of month-on-month improvement. Bed occupancy has dramatically reduced since the winter and was 92.53% in May for the Trust. This position is driven mainly by the Horton which has seen ample medical ward capacity in May and occupancy of 89.81% for the month. The JR occupancy has also reduced to 96.66% for May in line with a reduction in medical outliers and overall reduction in length of stay. The proportion of patients whose discharge was delayed rose slightly in May to 8.5% and average daily number of delayed patients was 104. This is above the target and trajectory for OUH. Average days delayed also rose slightly to 5.5 days but remains on trajectory The average days delayed in May 2024 was 6.3 days. OUH continues to work with system partners to make further improvements to the patient pathways both pre hospital and discharge. The patients with the longest delays were Oxfordshire patients waiting for pathway 3 or specialist rehabilitation bed or out of county delays. Through improvement with data quality and validation processes we are more accurately recording Pathway 3 discharges. As a result, the average days delayed for Pathway 3 had reduced to 7.7 days in April, with an increase again in May due to some particularly complex cases. Whilst D2A is now embedded and there are minimal delays for Oxfordshire residents on this pathway, delays for Pathway 3 and housing related discharge delays continue to be an area of concern for patients in all Oxfordshire bed bases. Associated with the increase in ED attendances, is the medical and social complexity of patients and the impact of D2A where there is a significant increase in care package size and support required for a person to return home. Delays for non-generic pathway 2 beds are becoming an increasing concern and driving an increasing length of delay on this pathway at 5.1 days in May. In contrast, generic patients are transferred in under 24hrs. OUH is holding its position as the best performing Shelford Trust for patients with a stay over 21 days.	• The **live bed state** programme launched in Q3 23/24 with phase 1 successfully implemented across the Trust during Q4. Work continues to finalise plans for phase 2 which was due to launch in Q4 2024/25. • Plans for 12hr total length of stay improvement work commencing at the end of June. • New **Board Round Policy** relaunched successfully across all adult inpatient areas (44 wards), including Hospices. Trust wide roll-out is underway through the Quality Improvement (QI) Standard Work Programme.	<u>Trust Wide Urgent Care Group</u> January 2025 – not on track due to delays with Cerner. Now resolved. Timescales to be amended once confirmation of Digital work plan confirmed for 2025/26. Q1/2 2025/26 On Track	BAF 4 Link to 1133 (Red)	Sufficient *SOP's are in place, staff training in place, local audit undertaken in last 12 months, and independent audit completed in last 18 months*

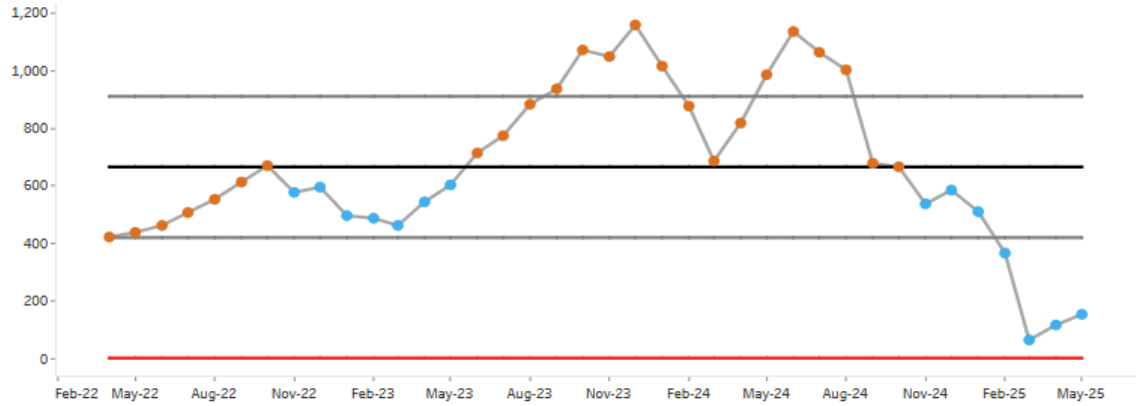
3. Assurance report: Operational Performance, *continued*

RTT standard: >78-week incomplete pathways



Benchmarking >78-week: April 2025				
OUH: 12	National: 12	Shelford: 5	BHT: 0	RBH: 0

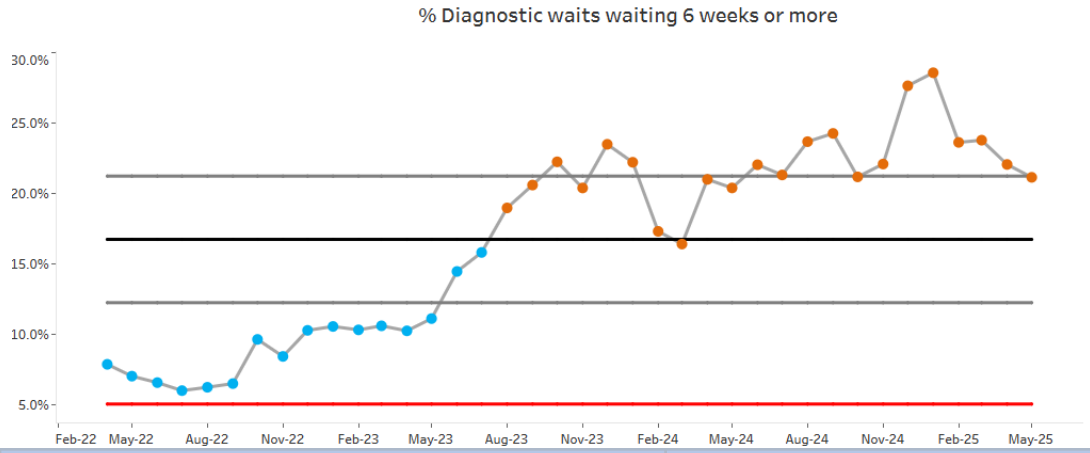
RTT standard: >65-week incomplete pathways



Benchmarking >65-week: April 2025				
OUH: 115	National: 57	Shelford: 87	BHT: 0	RBH: 0

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The number of patients waiting more than 52 weeks to start consultant-led treatment was 2,818 at the end of May. Performance exhibited special cause of improvement due to >six consecutive periods of performance below the mean and exceeding the lower process control limit. **104 weeks - 0** incomplete pathways reported. **78 weeks - 7** incomplete pathways reported. 1 complex, 3 capacity, 1 corneal, and 2 patient choice **65 weeks – 152** incomplete pathways reported which is an increase from the previous month by 37 pathways however achieved our trajectory plan. Focus remains in place to deliver nil pathways beyond 65-weeks. Services have moved to recovering **52-week backlog in 2025/26.**	**ENT services**: Audiology insourcing is helping with backlog recovery. Insourced ENT clinics continues. All new appointments in the 52-week cohort are being scheduled in H1. Patient Engagement waiting list validation commenced in May has supported the removal of patients requesting to come off the list. **Urology services**: Insourcing continues, focusing on outpatients and diagnostics. Patients waiting for HOLEP procedure offered mutual aid have been transferred. Patient Engagement waiting list validation commenced in June will support the removal of patients requesting to come off the list. **Orthopaedic services:** Weekend lists continue and show good recovery. Patient Engagement waiting list validation commenced in June for Spinals and Orthopaedics in May has supported the removal of patients requesting to come off the list. **Patient Engagement Validation:** Relaunched 2025/26 52-week cohort with 1st appointments (about 10k referrals), following LMC protocol to discharge non-responsive patients after 3 communication attempts within 40 days. Circa 4.5% removed so far and c.50% willing to travel to another Provider in BOB – list submitted via APC for capacity within BOB. **Recovery Action Plan**: Live and populated against specialty level trajectories for delivery of the forecast.	All actions are being reviewed and addressed via weekly Assurance meetings, Elective Delivery Group & Divisional Performance Reviews	BAF 4 Link to CRR 1135 (Amber)	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

3. Assurance report: Operational Performance, *continued*



H

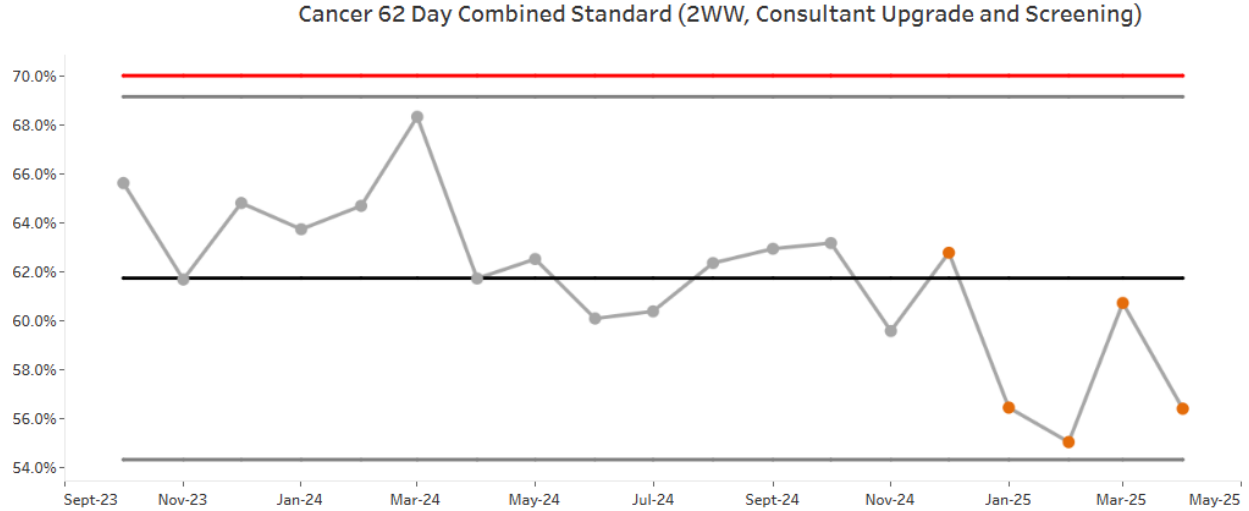
F

Benchmarking: April 25 DM01	
OUH	22.02%
National	17.05%
Shelford	19.34%
ICS	BHT: 24.31% RBH: 6.23%

ICS key	
BHT	Buckinghamshire Healthcare NHS Trust
RBH	Royal Berkshire NHS Foundation Trust

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group	Risk Register	Data quality
The percentage of diagnostic waits over 6 weeks+ (DM01) was 21% in May. The indicator exhibited special cause variation due to performance being above the mean for more than six successive periods, as well as below the lower process control limit. The indicator has consistently not achieved the target of 95.0%. **Audiology:** • Demand above capacity since ENT pathway changes • Clinical staffing gaps • Capacity shortfall for children's audiology tests **Endoscopy:** • Capacity shortages to meet demand • Lapsed Planned patients retriggering as a reportable **Neurophysiology**: • Capacity mismatch with demand. **Ultrasound**: • Difficulty recruiting to sonographer vacancies • Increased demand • Reduced sessions due to NHSP changes	**Audiology:** • Meeting scheduled with ICB and AQPs in June to pick back up commissioning discussions for conclusion • Working with procurement to work on extending Insourced capacity that commenced in November • Filled several vacancies with start dates in May/June. 1WTE vacancy remains on hold until budget confirmed. • Audiology was on trajectory of recovery into 2025/26; however, Children's Audiology continues to experience demand / capacity shortfall. Location to install funded Booth's are underway and MA requested via APC **Endoscopy:** • Nurse endoscopist is now independently working since April. • Delivery fund utilised and scheme fully allocated. • Job plans reviewed introducing additional endoscopy list in place of outpatient clinic • Clinical triage continued into 2025/26 **Neurophysiology**: • Replacement of Insourcing supplier occurred 9th May • Additional sessions considered where possible • 4PA clinician returning from a sabbatical in June has resigned. PA's on hold as no longer in budget. **Ultrasound: Most accelerated recovery of all modalities with 557 less breaches than last month** • Additional capacity through insourcing agreed for Q1 2025/26 • Sessional tracker in place monitoring substantive gaps as well as NHSP uptake. • Workforce plan developed in conjunction with TME approved case for converting the ERF scheme to substantive posts.	Weekly Assurance meeting will monitor all actions on a bi-weekly basis **Audiology:** Expected to start recovering from Feb 2025. **Endoscopy:** Expected to start recovering from March 2025 **Neurophysiology:** Expected to recovering from March 2025 – to be reviewed due to resignation **Ultrasound:** Improvement trajectory in development	BAF 4 Link to CRR 1136 (Red)	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

3. Assurance report: Operational Performance, *continued*

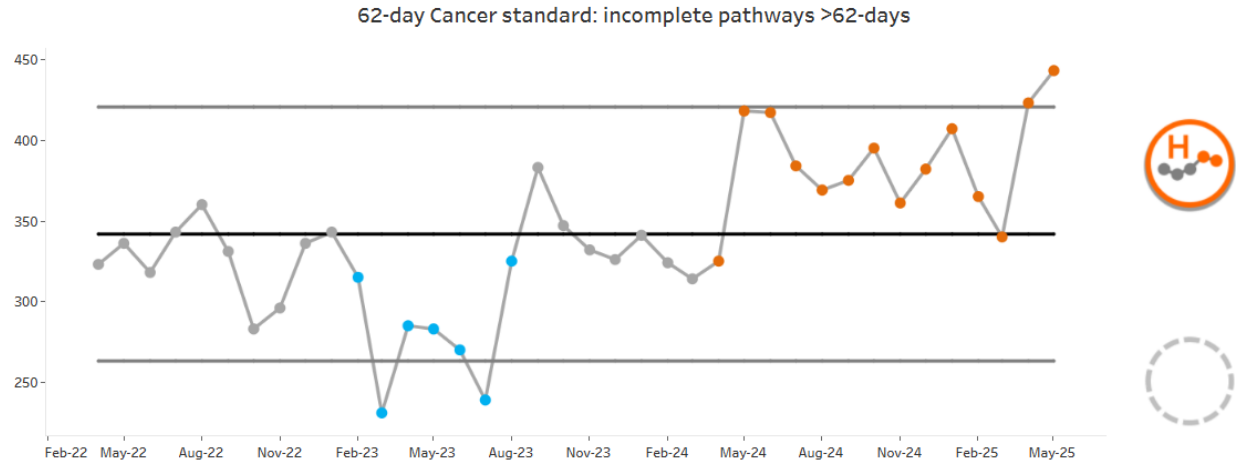


Benchmarking: January 25				
OUH: 56.41%	**National: 72.49%**	**Shelford:68.54%**	BHT: 64.66%	RBH: 75.49%

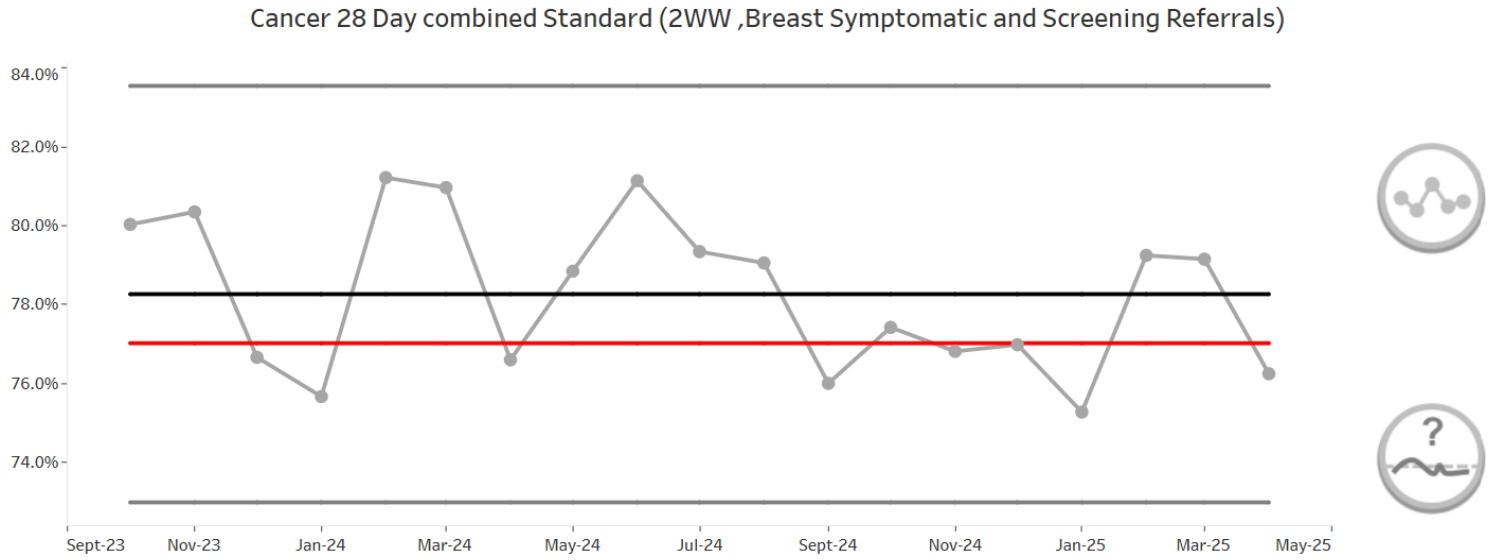
ICS key			
BHT	Buckinghamshire Healthcare NHS Trust	**RBH**	Royal Berkshire NHS Foundation Trust

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group	Risk Register	Data quality rating
Cancer performance against the 62 days combined standard was 56.4% in April 2025, and below the operational plan of 60.2%. Performance is reported one month in arrears due to the extended reporting period for this indicator. All tumour sites apart from Children's, Haematology Acute Leukaemia and Skin are non-compliant for this standard in April. **Challenges identified:** • Complex tertiary level patients (9%) • Capacity for surgery, diagnostics and oncology (71%) • Late inter provider transfers (18%) • Patient reasons (2%) **>62-day incomplete PTL** census 18th June 2025 is 443 patients and 11.7% as a proportion of the PTL.	**3 Tumour Site Workshop held 16th May** for Lung, Gynaecology and H&N with a range of senior leaders, clinical leads and subject matter experts to implement actions over 100-days. **Day 25 updates** due for presentation by each owner at the Cancer Improvement Programme Group meeting on **Friday 27th June** with Day 50 and beyond escalations to be raised accordingly to mitigate non-delivery of agreed plans. **Performance of >62-day PTL vs plan –** recovery includes cross-cutting elements: • Incomplete and late Inter-Provider Transfer review and escalation to referring Providers • Surgical capacity through theatre reallocation • Patient engagement through the Personalised Care agenda • SOP and escalation of benign patients awaiting communication • Pathway mapping of tumour sites against Best Practice Timed Pathways **Waiting List Census 18/06/2025:** **Urology** remains the highest deficit to plan for >62-days (169) predominantly due to the increase in referrals linked to public figure awareness. Demand on diagnostics such as MRI being further explored, process issues with CTU and flexi procedures are being streamlined. System wide meeting with clinical and operational leaders scheduled for 23rd June 2025 **Gynaecology** – several change ideas undergoing mobilisation including new referral proforma, ambient voice technology pilot in pre-hysteroscopy clinics, become pilot for WID-easy test, ring-fenced theatre lists **Lung -** – several change ideas undergoing mobilisation including patient engagement to mitigate missed appointments and cancellations, clinical representation at PTL meetings to rapidly troubleshoot bottle-necks at pathway level, additional theatre lists to increase from fortnightly to weekly.	Faster Diagnostic Standards (FDS) to be achieved by all tumour sites outlined within the FDS Framework 2023/2024 186 patients over 62 days on the Combined Patient Tracking List to deliver 6% ask. Above trajectory (186) with 443 patients (11.7% vs 6% target) Full baseline review by tumour site against best practice standards to be undertaken in May this will be used to identify key areas to address which may require further actions following deep dives.	BAF 4 Link to CRR 1135 (Amber)	Sufficient *Standard operating procedures in place, staff training in place, local audit undertaken in last 12 months and independent audit undertaken in previous 18 months*

3. Assurance report: Operational Performance, *continued*

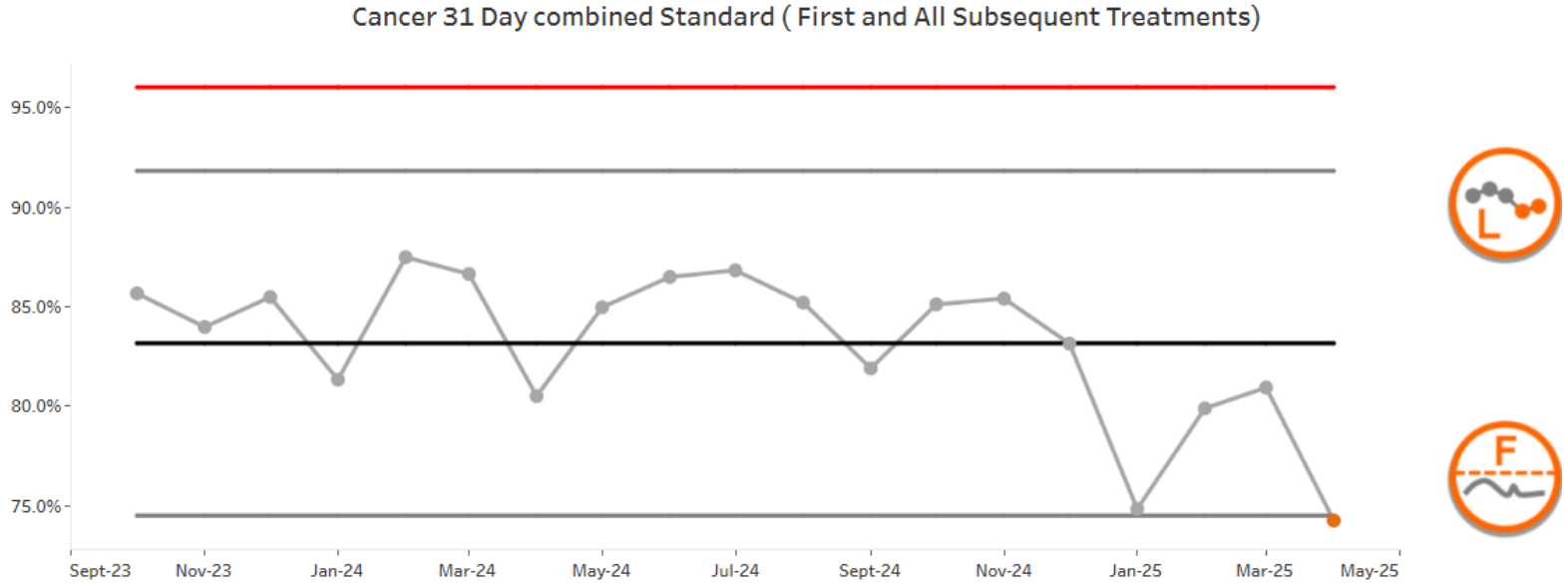


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
As per previous slide	As per previous slide	As per previous slide	As per previous slide	As per previous slide



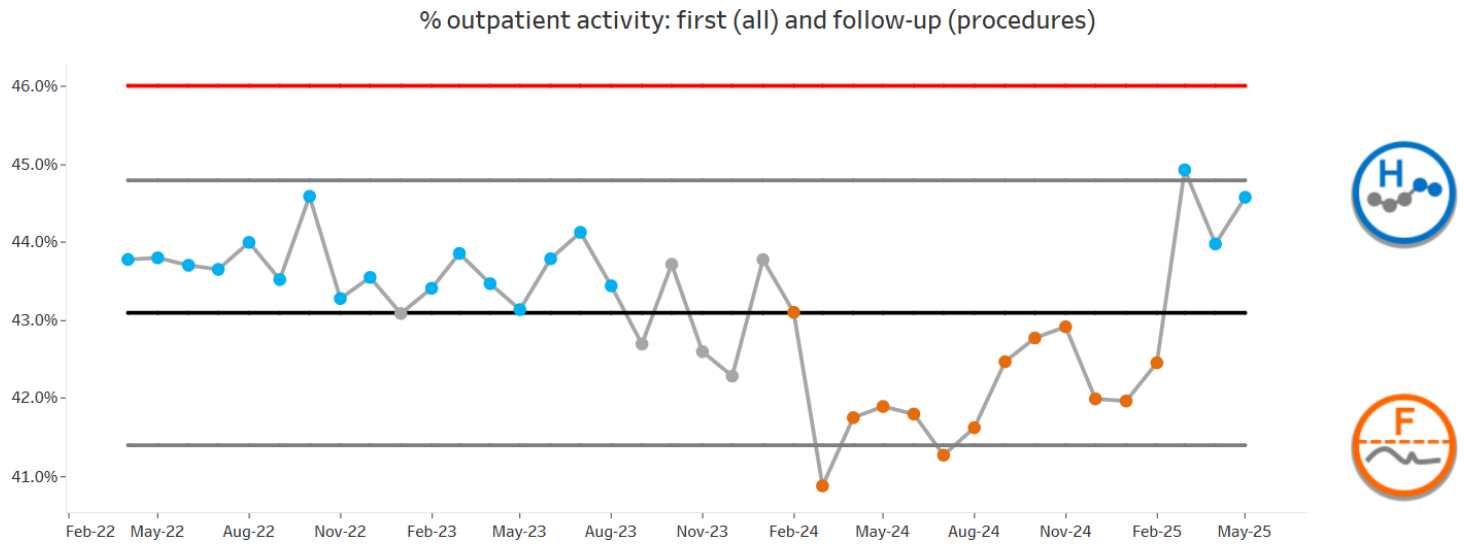
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Cancer performance against the 28 days Faster Diagnosis Standard was 76.2% in April 2025, and below the operational plan of 77.1% and the national standard of 77.0%. Performance is reported one month in arrears due to the extended reporting period for this indicator. All tumour sites apart from Breast, NSS, Skin and Upper GI are non-compliant for this standard in April. OUH ranked 86th out of 132 Providers in April and 8th out of the 10 Shelford Group. Urology nationally ranked 114th out of 116 Providers and Gynaecology nationally ranked 111th out of 119.	As mentioned under 62-day performance: Gynaecology has recently participated in a QI workshop involving Trust wide key stakeholders and is undergoing a 100-day plan for delivering change. Urology is scheduled to undergo the same model or workshop in August but in the interim is collaborating with RBH/BHT colleagues to evaluate and propose system wide change ideas to support the wider BOB performance.	To commence May 2025 and conclude September 2025 To commence June 2025 and conclude December 2025	BAF 4 Link to CRR 1135 (Amber)	Sufficient *Standard operating procedures in place, staff training in place, local audit undertaken in last 12 months and independent audit undertaken in previous 18 months*

3. Assurance report: Operational Performance, *continued*



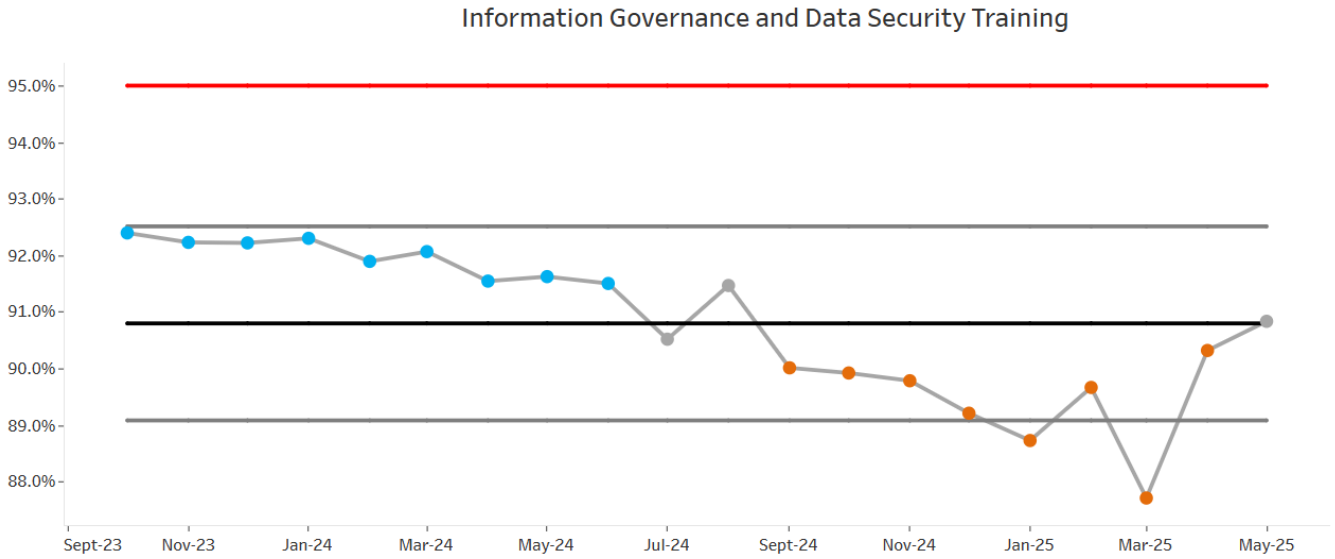
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Cancer performance against the 31 days Decision to Treat was 74.2% in April 2025, and below the operational plan of 80.0% and below the national standard of 96.0%. Performance is reported one month in arrears due to the extended reporting period for this indicator. All tumour sites apart from Children's, Haematology Acute Leukaemia and Other (Endocrine) are non-compliant for this standard in April. OUH ranked 134th out of 135 Providers in April and 10th out of the 10 Shelford Group. Lower GI and Lung are both nationally ranked 122nd out of 123 Providers, Breast nationally ranked 118th out of 120 and Gynaecology nationally ranked 117th out of 119. Urology is ranked 114th out of 119 Providers.	As per previous slides.	As per previous slide	As per previous slide	As per previous slide

3. Assurance report: Operational Performance, *continued*



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The percentage of first new outpatient and follow-up outpatient appointments with procedures was 44.6% in May. The indicator exhibited no special cause for improvement. The indicator has consistently not achieved the target of 46.0%. Delayed completion of outcome forms to identify procedures in recent months under-reports performance Possibility of some procedures being carried out in theatres instead of an outpatient setting. *the most recent month's position may increase due to the completion of processing outpatient procedure coding.	Evaluation of individual specialties to optimise outpatient procedure activity by reviewing daycase procedures for conversion to an outpatient setting, releasing theatre capacity as well as modelling a one-stop services in outpatients, thus reducing follow-up activity. Using Model hospital GIRFT procedure specific analysis. The Further Faster Programme cohort 3 in association with GIRFT to support this performance metric. Several specialty level working groups in place undertaking evaluation and improvement work under this Programme. Clinic e-Outcome Form piloted in Orthopaedics to improve capture of procedure codes as well as several other benefits. Roll-out plan for Early Adopter presented at Outpatient Improvement Group on 16th June with services required to complete pre-requisition process ahead of adopting followed by trust-wide rollout throughout the fin-year External audit supplier, IQVIA analysed missed opportunity for procedure coding by benchmarking specialty level activity. This programme of work is overseen by the Productivity Committee.	March 2025	BAF 4 Link to CRR 1135 (Amber)	

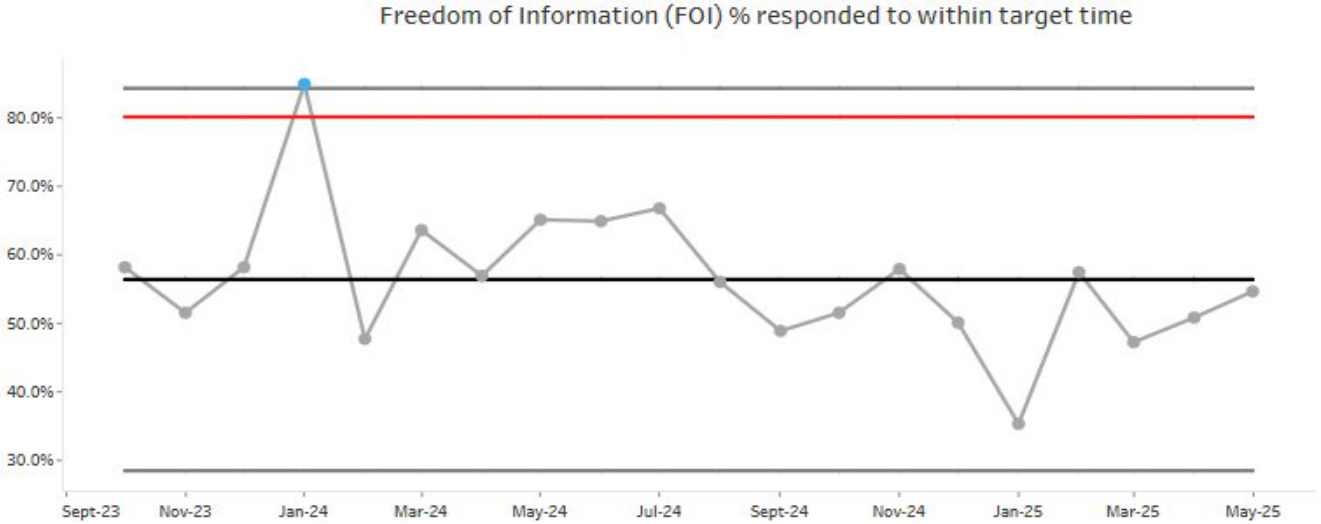
3. Assurance report: Corporate support services – Digital, *continued*



Division	Employees Total Number	Heads Outstanding	% Completed
NOTSSCAN	3646	478	86.9%
Medicine Rehabilitation and Cardiac	3348	376	88.8%
Surgery Women and Oncology	3317	353	89.4%
Clinical Support Services	2406	228	90.5%
Corporate	1013	99	90.2%
Operational Services	220	16	92.7%
Estates	194	26	86.6%
Research and Development	160	22	86.2%

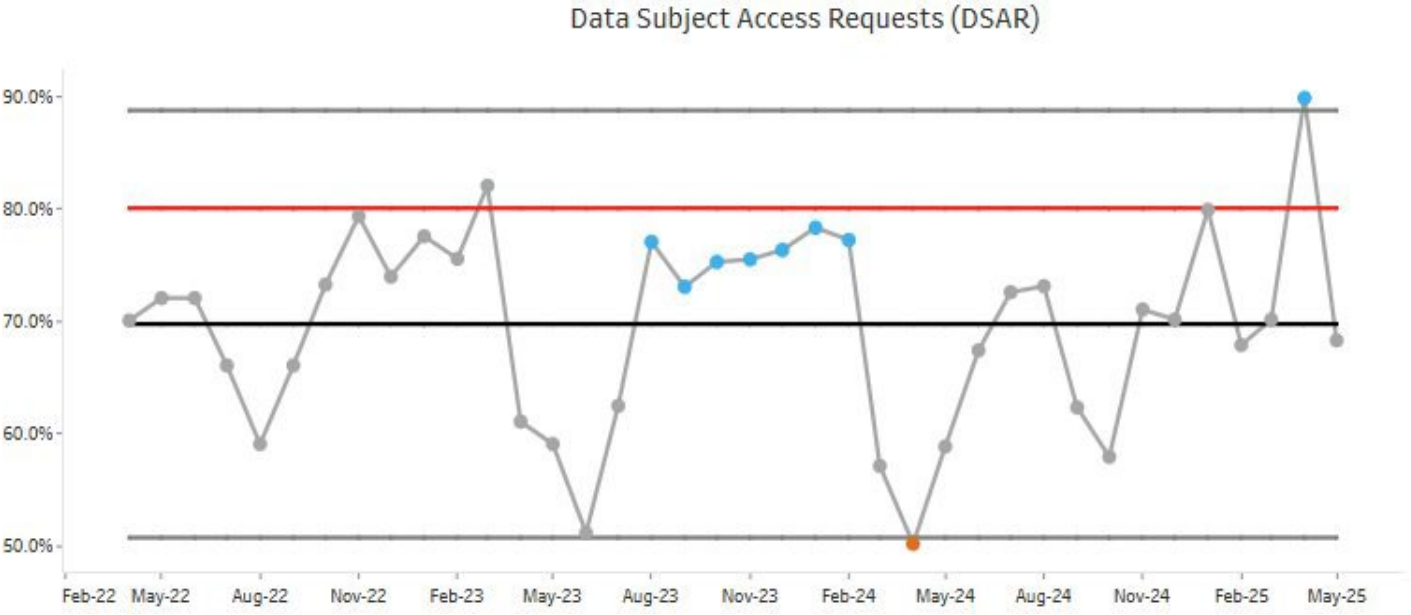
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Data security and Protection Training (DSPT) compliance was 91% in M2 – this is a recovery towards the target of 95%. With the change in calculation method, a breakdown per Division is now available and included at the top of this slide. No Divisions are currently achieving the 95% target. Satisfactory IG training completions rates are a requirement to pass DSPT – the current situation would not put us in a position to pass the training and awareness section.	1588 staff are currently non-compliant – they (and their managers) are being further contacted individually outside of the MyLearningHub platform to encourage them to complete it. All staff comms to be sent out, and reminders in the staff newsletter Current training levels were noted as a low risk in the recent DSPT audit	Actions and performance are overseen by the Digital Oversight Committee DSPT Audit has been completed and report submitted to Audit Committee	BAF 6	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

3. Assurance report: Corporate support services - Digital, *continued*



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality
M2 Freedom of Information (FOI) performance against the 80% target remained below the performance standard at 58% and exhibited common cause variation. 73 valid cases were received in M2, of which 69 have been closed, 35 of which were closed on time. The Trust is facing significant challenges in managing FOI requests, prompting the Information Commissioner's Office (ICO) to issue an Enforcement Notice requiring OUH to respond with a plan by 14th May and implement that action plan by 31st October 2025. There are approximately 900 FOIs open and beyond the target response time. These cases must be assessed and have either been answered or refused by 31st October.	The action plan will incorporate learnings from a review of FOI processes being undertaken in partnership with the Trust's Data Protection Officer, and the ICO. This has been expanded to include colleagues from the Quality Improvement team and stakeholders from across the Trust. Responsibility for compliance will also be managed across all areas of organisation. The IG team are actively engaged in procuring an appropriately designed system to manage FOI cases as it is clear that the current one is not fit for purpose. This is being done in conjunction with Legal Services A change in the way FOIs are distributed across the Trust is being implemented – each Division will have two nominated contacts who receive all FOIs for them to then pass on to the relevant people within their area. This will ensure more rapid identification of data holders and allow divisions to monitor and manage their own cases. Work to identify and recruit temporary resources to assist with the backlog is ongoing	Completion of all actions: 31st October 2025 Updates provided to Digital Oversight Committee and TME	BAF 6	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

3. Assurance report: Corporate support services - Digital, *continued*



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
M2 DSAR performance dropped significantly, to 68%. Medical Records Subject Access were only able to close 115 of the 368 cases they received on time PACS closed 83% of their 247 cases on time Occupational Health closed 100% of their 315 cases on time	The Medical Records SAR team have been encountering difficulties with the platform used to manage cases – this is the same platform used by the IG team to manage FOIs. As a result of the ongoing issues, both teams are working together to procure a new system better sized to OUH. A demonstration of one such system has already happened, and a second is scheduled for w/c 23/06, with the intention being to move to the new system as soon as possible.	Actions and performance are overseen by the Digital Oversight Committee	BAF 6	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

3. Assurance report: Corporate support services - Digital, *continued*

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
On 23 May 2025, at 15:30, a system restoration process unintentionally affected how computers connected to the Trust's network, causing a temporary disruption to access. This was the result of a OXNET domain-level rollback that affected authentication services.	A coordinated response was immediately initiated, involving detailed investigation, risk assessment, and the implementation of a carefully managed recovery plan. The team opted for a targeted restoration approach to minimise risk and ensure stability, which proceeded through the evening/night. Regular communication with the Ops Team continued throughout. The recovery was completed by 2:00 AM on 24 May, with services fully restored and normal operations resumed.	Problem Management Board	BAF 6	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

4. Development indicators

2. c) SPC key to icons (NHS England methodology and summary)

SPC Variation/Performance Icons

Icon	Technical Description	What does this mean?	What should we do?
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of an CONCERNING nature where the measure is significantly HIGHER.	**Something's going on!** Your aim is to have low numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an CONCERNING nature where the measure is significantly LOWER.	**Something's going on!** Your aim is to have high numbers but you have some low numbers - something one-off, or a continued trend or shift of low numbers.	
	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.	**Something good is happening!** Your aim is high numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	Find out what is happening/ happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Special cause variation of an IMPROVING nature where the measure is significantly LOWER.	**Something good is happening!** Your aim is low numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	
	Special cause variation of an increasing nature where UP is not necessarily improving nor concerning.	**Something's going on!** This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Do you need to change something? Or can you celebrate a success or improvement?
	Special cause variation of an increasing nature where DOWN is not necessarily improving nor concerning.	**Something's going on!** This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of low numbers.	

SPC Assurance Icons

Icon	Technical Description	What does this mean?	What should we do?
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

OUH Data Quality indicator

Valid: Information is accurate, complete and reliable. Standard operation procedures and training in place.	**Verified**: Process has been verified by audit and any actions identified have been implemented.	**Timely:** Information is reported up to the period of the IPR or up to the latest position reported externally.	**Granular:** Information can be reviewed at the appropriate level to support further analysis and triangulation.

Sufficient	Satisfactory	Inadequate

Oxford University Hospitals NHS Foundation Trust

1. Assurance reports: format to support Board and IAC assurance process

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales	Risk Register (Y/N)	Data quality rating
This section should describe the reason why the indicator has been identified for an assurance report and interpret the performance with respect to the Statistical Process Control chart, if appropriate. Additionally, the section should provide a succinct description of the challenges / reasons for the performance and any future risks identified.	This section should document the SMART actions in place to address the challenges / reasons documented in the previous column and provide an estimate, based on these actions, when performance will achieve the target. If the performance target cannot be achieved, or risks mitigated, by these actions any additional support required should be documented.	This section should list: 1) the timescales associated with action(s) 2) whether these are on track or not 3) The group or committee where the actions are reviewed	This section notes if performance is linked to a risk on the risk register	This section describes the current status of the data quality of the performance indicator

2. Framework for levels of assurance:

Levels of assurance: model
1. Actions documented with clear link to issues affecting performance, responsible owners and timescales for achievement and key milestones
2. Actions completed or are on track to be completed
3. Quantified and credible trajectory set that forecasts performance resulting from actions
4. Trajectory meets organisational requirements or tolerances for levels of performance within agreed timescales, and the group or committee where progress is reviewed
5. Performance achieving trajectory