Oxford University Hospitals
NHS Foundation Trust

Integrated Performance Report

M8 (November data)

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

Oxford University Hospitals NHS Foundation Trust

1. Overview of strategic priorities and performance

The month 8 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.

Within our key priorities for our people and financial performance, we have set a plan to reduce temporary staffing by 700 by the end of Q2. The plan has been set in agreement with the Integrated Care Board (ICB) and NHSE. Up to the end of Month 8 (November) £13.7m has been saved on temporary staffing against a £20.2m target. The WTE reduction for this achieved at M8 was 330 WTE against a plan of 700 WTE. The potential effect on patient care is carefully evaluated by Pay Panels led by Chief Officers and incorporate Quality Impact Assessments (QIAs). The Pay Panels have a circa 80% approval rate and there is ongoing work to reduce bank and agency to support our headcount reduction target.

We achieved key measures related to patient safety and care experience, including the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI), which show fewer patient deaths than expected. We also met targets in VTE Risk Assessments, pressure ulceration incidents for category 2 (hospital acquired) and C-diff cases, which support high quality patient care. Additionally, the midwife to birth ratio was better than target in November, exhibiting improving special cause variation (SCV) and the first month since March 2024 that the target has been achieved.

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 both adults and children (L1-L3) was achieved, and we recorded no "never events" in November.

Appraisals provide feedback, recognition, and identify development opportunities, aligning staff performance with our strategic pillars. In November, we met targets for non-medical appraisals 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 12-month rolling sickness absence rate showed improving SCV, with rates lower than the National and Shelford averages, and the second lowest within the Integrated Care System (ICS). Vacancy and turnover rates also performed better than targets, and the turnover rate exhibited improving SCV.

The Cancer Faster Diagnosis standard measures the percentage of patients diagnosed or who have cancer ruled out within 28 days of being referred. It is an important indicator to show that patients receive a diagnosis as soon as possible, which can improve clinical outcomes, or provide peace of mind when cancer can be ruled out. Performance was better than target in November and improvement in this area remains a key priority for 2024/25 to ensure delivery of our plan to achieve 80.1% by March 2025.

Income and Expenditure (I&E) was a £24.9m deficit to Month 8, £8.2m worse than plan. The underlying deficit was £48.6m and the underlying deficit for the month was consistent with last month at £6.2m. However, within this, underlying pay expenditure worsened by £0.8m (following last months increase in substantive staff WTE). Overall worked WTE (excluding R&D) increased by 3 WTE in November.

Cash was £9.4m at the end of November, £0.1m higher than the previous month. The forecast is indicating some recovery of the Trust's cash resources towards the end of the financial year although this is dependent on delivery of some key assumptions. The primary driver for the reductions in the cash balance this year continues to be the operating cash deficit (driven by the underlying I&E deficit) with a high proportion of efficiencies delivered being non-cash releasing.

The underlying position in November was a £6.2m deficit, this is consistent with the average for the YTD and last month's position. Tight control of headcount will need to be maintained.

Of the 107 indicators currently measured in the IPR, 32 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.

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

- PFI: % cleaning score by site (average) NOC
- Friends & Family Test: Maternity, Inpatient
- % Diagnostic waits under 6 weeks
- RTT standard: >52-week incomplete pathways
- Cancer 62-day combined Standard (2ww, Consultant upgrade and screening)
- % Outpatient firsts and follow-up attendances for procedures

Common cause variation and missed target

- Proportion of patients spending more than 12 hours in the Emergency Department
- MRSA Cases: HOHA+COHA
- Pressure ulceration incidents per 10,000 bed days (Cat 3)
- Non-Thematic Patient Safety Incidents investigations
- Reactivated complaints
- % of complaints responded to within 25 working days
- FFT % positive OP, and ED
- PFI: % cleaning score by site (average) JR and CH
- Sickness and absence rate (in month)
- ED 4-hour performance (type-1)
- Proportion of patients spending more than 12 hrs in ED
- RTT standard: >65-week incomplete pathways
- Cancer 28-day combined Standard
- Cancer 31-day combined Standard
- InData Subject Access Requests (DSAR)

Special cause variation - improving

- Sickness absence (rolling 12-month)
- ED 4-hour performance All
- RTT patients > 78 weeks

Other*

- Adult safeguarding activity
- Freedom of Information % responded to within target time
- Information Governance and Data Security Training compliance

**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)*

Healthcare-associated infection results in poor outcomes for patients as well as increased length of stay. There was one MRSA case in November.

PSIIs are detailed system-based investigations conducted to learn and improve from significant incidents. These reviews, completed within 3-6 months, involve the patient and/or family, and are discussed weekly at Safety Learning & Improvement Conversations (SLIC). Other learning responses include After Action Reviews (AARs) and Learning Multidisciplinary Team Reviews (LMDTR). In November 2024, two patient safety incident investigations (PSII) were initiated, one involving a cardiac arrest in the Emergency Department resulting in death, and another reviewing the management of unwell patients out of hours at the Churchill.

Pressure ulcer incidents per 10,000 bed-days (Hospital acquired Category 3) exceeded the threshold for November. Nine Category 3 Hospital-Acquired Pressure Ulcers (HAPUs) were reported across nine different clinical areas, with patients assessed as high risk for pressure damage before HAPUs were discovered. Two incidents were linked to medical devices, specifically casts and collars. Clinical areas review all incidents using the PSIRF approach to identify lessons learned and develop action plans. Recent reviews highlight the need for better early skin assessments, thorough wound documentation, and effective patient repositioning. These issues are being addressed through Safety Huddles, Board Rounds, and collaboration with clinical educators. Progress is monitored and reported at the Harm-Free Assurance Forum and Clinical Governance Committee, with a new HAPU dashboard in Power BI providing oversight and visibility for clinical areas.

In November, there were a total of 1,492 adult safeguarding activities, including 419 maternity-related cases and 587 children-related activities, primarily within the NOTSSCaN and MRC divisions. Domestic abuse continued to be the predominant theme in safeguarding. There were 147 Deprivation of Liberty Safeguards, marking an increase of 11, with two cases escalated to the Local Authority but not granted authorisations. Safeguarding liaison shared information for 1,285 cases with primary care, an increase of 217. The team is under significant pressure due to the high number and increased complexity of cases.

The combined PFI cleaning score for the JR, Churchill and NOC were below the performance standard of 95%, with compliance reported as 93.9%, 93.2% and 82.6%, respectively. The NOC's performance exhibited deteriorating SCV. 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 etc.

Mitie completed the planned audits at JR in November 2024, with 15 initially failing under domestic and clinical responsibility. All were rectified within the required timeframe, leading to improved scores. Challenges with new staff and training are being addressed. At the Churchill site, G4S completed audits, with five failing to meet Trust targets. These issues were promptly addressed, resulting in improved compliance, and ongoing collaboration with IPC and leaders continues to resolve concerns. At the NOC site, G4S completed the planned number of audits, with eight audits initially failing to meet the Trust target for domestic and clinical responsibilities, but subsequently rectified.

In November, the sickness absence performance (rolling 12 months) was 4.1%, showing special cause variation and running below the average since June 2023. This indicator has been tracking upwards since December 2023, with a slight increase of 0.1% this month. The in-month figure decreased to 4.7% from 5.0% in November. No single absence reason accounts for the change, but the top five reasons (cold/flu, mental health, headache/migraine, Covid, and gastro) have increased to varying degrees between months. The Trust continues to offer comprehensive well-being support across various aspects, including physical, financial, environmental, and psychological areas, with emphasis on stress management and training.

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

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2. Performance challenges: integrated summary of assurance templates

Not achieving target

Special cause variation - deterioration

- PFI: % cleaning score by site (average) NOC
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Common cause variation and missed target

- Proportion of patients spending more than 12 hours in the Emergency Department
- MRSA Cases: HOHA+COHA
- Pressure ulceration incidents per 10,000 bed days (Cat 3)
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Special cause variation - improving

- Sickness absence (rolling 12-month)
- ED 4-hour performance All
- RTT patients > 78 weeks

Other*

- Adult safeguarding activity
- Freedom of Information % responded to within target time
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**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)*

Reviewing feedback from patients can provide a direct insight into how the organisation delivers care and opportunities for improvement as well as celebrating success. In November, we fell short of the target for positive comments to be above 95% across IP, OP and ED areas. Patients' negative feedback mainly focused on long waiting times, car parking, discharge processes, and catering issues, consistent with concerns from previous months. Positive comments highlighted staff attitude, care implementation, admission procedures, and clinical treatment, reflecting ongoing appreciation for the professionalism and quality of care despite logistical challenges. Updated posters have been distributed to promote FFT and encourage patient participation and a thematic analysis of complaints in ED and OP is underway to identify actions to improve.

Our complaints response time performance and re-activated complaints did not achieve the performance standards. In November, 124 formal complaints were received, with 56% responded to within the 25-day target due to delayed contributions and sign-offs. Weekly reports and meetings with senior leaders and nursing directors address and escalate complaints to improve response times. A monthly complaints dashboard on Power BI aids Divisional Performance Reviews by providing scores and themes for open, closed, and reopened complaints.

Prolonged wait times at the Emergency Department (ED) are associated with increased morbidity and mortality, and decreased patient satisfaction. The Emergency Department's 4-hour performance for all types was 68.8% in November, with Type 1 performance at 59.6%. The JR had a 61.9% overall performance and 52.5% for Type 1, while the Horton had an 84.1% overall performance and 68.4% for Type 1. The most significant reason for breaches was the wait to be seen, accounting for 63% of all breaches. ED Consultant recruitment is underway to support 24/7 senior decision makers. The JR ED has implemented a new workforce model, increasing overnight senior medical coverage to one shift per week in October 2024, and two in November, along with three consultants on duty until midnight. An approved Quality Improvement Programme for 2024/25 focuses on five national priorities, emphasising Type 1 performance, with multidisciplinary teams working on these initiatives. Additional QI support is provided to other divisions to enhance improvement efforts.

At the end of November, 3,524 patients were waiting over 52 weeks for consultant-led treatment, showing a trend of deteriorating performance. There were no incomplete pathways reported for 104 weeks, and fifty-four patients wating 78 weeks, with the majority due to capacity issues. For 65 weeks, 536 incomplete pathways were reported, a decrease of 129 from the previous month. Efforts continue to eliminate pathways beyond 65 weeks, with less challenged services focusing on recovering the 52-week backlog. Contracts are in place with Independent Sector Providers and theatre lists have been repurposed to orthopaedics, ENT, and Urology services to increase capacity. Non-admitted pathways are being managed, and the Elective Recovery Fund schemes are active. A Recovery Action Plan is active, focusing on specialty level trajectories.

Cancer performance against the 62-day standard was 63.2%, falling short of the 85% target. The main challenges were capacity issues in surgery, diagnostics, and oncology (75%), complex tertiary patients (8%), late inter-provider transfers (15%), and patient-related reasons (2%). 31-day Cancer performance was 85.1%, below the 96% target. The main issue affecting performance was surgery capacity, causing over 70% of breaches. The Cancer Improvement Programme has relaunched, focusing on Quality Improvement and Strategy. Strategies include reviewing incomplete transfers, reallocating surgical capacity, engaging patients via personalised care, and benign patient communication.

In November, 42.1% of new and follow-up outpatient appointments with procedures were completed, below the target of 46.0%. The performance decline is partly due to delays in outcome form completion and some procedures shifting to theatres. Efforts to improve include optimising outpatient procedures, digitising clinic outcomes, and the Further Faster Programme's specialty evaluations.

There was one Priority one IT incident reported. On 28th November, users experienced temporary access loss to multiple systems. The issue was resolved and access restored at 16:45. The root cause remains undetermined, and a ticket has been raised with Microsoft for further investigation. Standards for Freedom of Information Request performance, Data Subject Access Requests (DSAR) and Information Governance and Data Security Training were not achieved in November.

1. Executive summary: *Part 4 – Tier 1 update*

Tier 1 update

- OUH was placed into Tier 1 for Elective Recovery in December 2024. The Trust had its first Tier 1 meeting on the 19th December 2024, Chaired by the Southeast Regional Director.
- We started with a cohort of 42,866 patients to treat in 2024/25 for 65-week clearance & have treated 38,216 patients.
- Of those treated, as at the 19th December we had 4,375 patients remaining to treat in the 65ww cohort before March 2025.
- We have been taking action to reduce waiting patients across the outpatient and diagnostic elements of pathways to complete treatment and diagnosis for these patients, the remaining cohort will progress for surgical intervention & we have worked to ensure that we can treat the remaining patients before the end of March 2024.
- Despite making progress as of the 19th December we had 878 patients who still require an outpatient appointment, 1,138 who require a 'middle' appointment and 2,359 who require surgical treatment.
- We are committed to delivery of zero patients waiting over 65weeks whilst retaining our cancer performance.
- Our progress to address the 65 week waiting patients has slowed across the year, we are working to address this with a recovery plan across the following areas:
    - Grip, control & validation
    - Accelerating mutual aid from acute and independent sector providers
    - Additional sessions on a cost per case basis for Orthopedics
    - Additional outsourcing with external providers for ENT and Urology
    - Review of pooling of lists within specialties
    - Review of Theatre allocations for those specialties that have a greater volume of long waiting patients
    - Review of booking order to ensure longest waiting patients are priortised.

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 • Pressure ulceration incidents per 10,000 bed days (Cat 3) • % of complaints responded to 25 days • Reactivated complaints • FFT % positive OP, IP and ED • PFI: % cleaning score by site (average) JR, CH		L: • PFI: % cleaning score by site (average) NOC — Not achieving target H: Not achieving target	No target: • Adult safeguarding activity • Trust Level: CHPPD vs Budget No SPC: • Non-Thematic Patient Safety Incident Investigations — Not achieving threshold
Growing Stronger Together	Not achieving target • Sickness and absence rate (in month)	L: • Sickness absence (rolling 12-month) — Not achieving target		
Operational performance	Not achieving target • RTT standard: >65-week incomplete pathways • Cancer 31-day combined Standard • Proportion of patients spending more than 12 hours in the Emergency Department • ED 4-hour performance (type-1)	H: • ED 4-hour performance All — Not achieving target L: • RTT patients > 78 weeks — Not Achieving target	L: • % Outpatient first (all) and follow-up attendances • Cancer 62-day combined Standard (2ww, Consultant upgrade and screening) — Not achieving target H: • RTT standard: >52-week incomplete pathways • % Diagnostic waits under 6 weeks — Not achieving target	
Corporate Support Services	Not achieving target • Data Subject Access Requests (DSAR) • Freedom of Information (FOI) % responded to within target • Elective Recovery Funding weighted activity • Adjusted in-month financial performance surplus/deficit £'000	H: • Elective recovery funding (ERF) value-weighted activity % In month — Not achieving target	L: • BPPC £% • BPPC Volume % • Cash £'000 • Year-to-date financial performance surplus/Deficit £'000 — Not achieving target	No SPC: • Information Governance and Data Security Training compliance — Not achieving threshold

NB: *Finance exceptions are given assurance via the separate financial reporting.

2. b) SPC indicator overview summary

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Integrated Performance Report (SPC)
Quality, Safety and Patient Experience Summary: All

Latest Indicator Period: Nov-2024

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
MRSA cases: HOHA+COHA per 10,000 beddays	Nov-24	0.3	-	-	0.1	-0.4	0.7
MRSA cases: HOHA+COHA	Nov-24	1	0	No	0	-1	2
C-diff cases: HOHA+COHA per 10,000 beddays	Nov-24	2.2	-	-	3.5	0.7	6.4
C-diff cases: HOHA+COHA	Nov-24	9	10		11	2	20
MSSA cases: HOHA+COHA	Nov-24	4	-	-	6	-1	12
Number of Never Events	Nov-24	0	0		0	-	-
Non-Thematic Patient Safety Incident Investigations	Nov-24	2	0	No	2	-	-
VTE- Submitted performance	Nov-24	97.9%	95.0%		98.0%	97.6%	98.3%
% of emergency admissions 65yrs + receiving cognitive screen	Nov-24	61.2%	-	-	57.1%	49.7%	64.5%
% patients with sepsis attending ED received timely antibiotics in accordance with NICE guidelines	Nov-24	92.3%	90.0%		90.0%	-	-
CAS alerts breaching deadlines at end of month and/or closed during month beyond deadline	Nov-24	0	0		0	-	-
Medication incidents causing moderate harm, major harm or death as reported on Ulysses	Nov-24	1	-	-	2	-1	6
Hospital Standardised Mortality ratio	Nov-24	97.9	100.0		92.8	-	-
Summary Hospital-level Mortality Indicator	Nov-24	88.0	100.0		92.3	-	-
Neonatal deaths per 1,000 total live births	Sept-24	2.2	3.2		3.4	-	-
Stillbirths per 1,000 total Live births	Sept-24	2.1	4.0		4.0	-	-
National Patient Safety Alerts not completed by deadline	Nov-24	0	-	-	0	-	-
Potential under-reporting of patient safety incidents: Patient safety incident reporting rate per 10,000 beddays	Nov-24	0.0	-	-	0.0	-	-
Number of active clinical research studies hosted	Nov-24	1407	-	-	1378	1342	1414
Number of active clinical research studies (commercial)	Nov-24	397	-	-	367	352	381
Number of active clinical research studies (non commercial)	Nov-24	1010	-	-	1011	987	1035
Number of incidents with moderate harm or above per 10,000 beddays	Nov-24	48.9	-	-	42.3	26.0	58.6
Number of patient incidents with moderate harm or above per 10,000 beddays	Nov-24	44.8	-	-	38.0	21.0	55.1
Number of non-patient incidents with moderate harm or above per 10,000 beddays	Nov-24	4.1	-	-	4.3	-2.7	11.2
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 2)	Nov-24	16.3	19.0		21.4	10.1	32.7
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 3)	Nov-24	2.5	2.0	No	2.2	0.3	4.1
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 4)	Nov-24	0.0	0.0		0.1	-0.2	0.4
Pressure Ulceration incidents per 10,000 beddays (Present on admission Cat 1+)	Nov-24	84.0	-	-	98.0	72.1	123.9
Patient falls (moderate and above) as reported on Ulysses	Nov-24	7	-	-	4	-2	11
Patient falls (moderate and above) as reported on Ulysses per 10,000 beddays	Nov-24	2.2	-	-	1.3	-0.8	3.4

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)
Corporate support services – Regulatory assurance Summary: All

Latest Indicator Period: Nov-2024

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Health and Safety related incidents - Assault, Aggression and harassment	Nov-24	164	-	-	155	79	230
Adult safeguarding activity	Nov-24	1492	-	-	871	591	1152
Children's safeguarding activity	Nov-24	587	-	-	619	317	922
Adult safeguarding activity and Children's safeguarding activity	Oct-24	2108	-	-	1471	1004	1939
Safeguarding (Children) training compliance L1 - L3	Nov-24	91.0%	90.0%		88.1%	82.6%	93.7%
Safeguarding (Adults) training compliance L1 - L3	Nov-24	91.0%	90.0%		34.8%	25.1%	44.4%
Total Deliveries in month	Nov-24	569	625	-	617	549	685
Babies born	Nov-24	575	-	-	626	558	694
Maternity Bookings (planned + unplanned)	Nov-24	678	750	-	708	553	864
Inductions of labour from iView	Nov-24	113	-	-	143	109	177
Midwife Ratios (birth rate / staffing level)	Nov-24	21.1	22.9		25.9	21.9	30.0
Learning MDT Reviews presented at SLIC	Nov-24	3	-	-	3	-	-
After Action Review (AAR)	Nov-24	15	-	-	15	-	-
Number of complaints	Nov-24	124	-	-	109	54	164
Number of complaints per 10,000 beddays	Nov-24	38.9	-	-	34.1	19.0	49.2
Reactivated complaints	Nov-24	13	1	No	10	2	18
% of complaints responded to within 25 working days	Nov-24	56.3%	85.0%	No	43.8%	23.6%	64.0%
Number of RIDDORs	Nov-24	4	5		4	-	-
Friends & Family test % likely to recommend - IP	Nov-24	94.1%	95.0%	No	95.1%	93.8%	96.3%
Friends & Family test % likely to recommend - OP	Nov-24	93.5%	95.0%	No	93.7%	93.0%	94.4%
Friends & Family test % likely to recommend - ED	Nov-24	78.0%	85.0%	No	78.9%	72.9%	84.9%
FFT maternity % positive (births)	Nov-24	0.0%	90.0%	No	74.3%	50.6%	97.9%
Inpatient FFT (Response Rate)	Nov-24	22.4%	-	-	25.1%	22.0%	28.3%
Outpatient FFT (response rate)	Nov-24	9.9%	-	-	7.8%	5.8%	9.9%
ED FFT (Response Rate)	Nov-24	19.7%	-	-	23.6%	18.5%	28.7%
Maternity FFT (response rate; births)	Nov-24	0.0%	-	-	9.7%	2.2%	17.2%
PFI: % of total audits completed that achieved 4 or 5 stars JR	Nov-24	93.9%	95.0%	No	93.0%	82.7%	103.4%
PFI: % of total audits completed that achieved 4 or 5 stars CH	Nov-24	93.2%	95.0%	No	94.1%	83.0%	105.3%
PFI: % of total audits completed that achieved 4 or 5 stars NOC	Nov-24	82.6%	95.0%	No	96.7%	91.6%	101.9%
Incident rate of violence and aggression (rate per 10,000 beddays)	Nov-24	51.4	-	-	48.4	26.3	70.5
Trust level: CHPPD vs budget	Nov-24	8.2	-	-	-20.9	-72.4	30.7
Trust level: CHPPD vs required	Nov-24	-9.6	-	-	-5.8	-25.4	13.8

2. b) SPC indicator overview summary

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

Latest Indicator Period: Nov-2024

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Vacancy rate	Nov-24	7.3%	7.7%		7.2%	6.2%	8.2%
Turnover rate	Nov-24	9.7%	12.0%		11.2%	10.8%	11.5%
Sickness absence rate (rolling 12 months)	Nov-24	4.1%	3.1%	No	4.2%	4.0%	4.3%
Non Medical Appraisals	Nov-24	93.1%	85.0%		78.6%	46.8%	110.5%
Sickness absence rate (in month)	Nov-24	4.7%	3.1%	No	4.2%	3.1%	5.3%
Core skills training compliance	Nov-24	92.3%	85.0%		90.2%	88.2%	92.3%
Time to hire (average days)	Nov-24	49.4	53.0		49.5	39.4	59.6

Integrated Performance Report (SPC)
Operational Performance Summary: All

Latest Indicator Period: Nov-2024

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Proportion of ambulance arrivals delayed over 30 minutes	Oct-24	10.7%	-	-	9.0%	4.6%	13.5%
Proportion of ambulance arrivals delayed over 60 minutes	Oct-24	1.1%	-	-	1.0%	-0.2%	2.2%
ED 4Hr perfromance - All	Nov-24	68.8%	78.0%	No	66.3%	58.1%	74.5%
ED 4Hr perfromance - Type 1	Nov-24	59.6%	73.6%	No	59.7%	50.8%	68.6%
Proportion of patients spending more than 12 hours in an emergency department	Nov-24	4.9%	2.0%	No	4.8%	2.5%	7.1%
Proportion of patients discharged from hospital to their usual place of residence	Nov-24	95.6%	-	-	95.1%	94.2%	96.0%
% Diagnostic waits waiting 6 weeks or more	Nov-24	22.1%	5.0%	No	15.2%	11.1%	19.4%
RTT standard: >52-week incomplete pathways	Nov-24	3524	-	-	2716	2380	3052
RTT standard: >65-week incomplete pathways	Nov-24	536	0	No	733	496	969
RTT standard: >78-week incomplete pathways	Nov-24	54	0	No	141	68	214
RTT standard: >104-week incomplete pathways	Nov-24	0	0		7	0	14
Cancer 62 Day Combined Standard (2WW, Consultant Upgrade and Screening)	Oct-24	63.2%	70.0%	No	63.2%	57.6%	68.9%
62-day Cancer standard: incomplete pathways >62-days	Nov-24	361	-	-	332	257	407
62-day Cancer standard: incomplete pathways >104-days	Nov-24	118	-	-	107	74	139
Inpatient Daycase activity vs 2019/20	Nov-24	97.5%	-	-	91.8%	77.0%	106.7%
Inpatient Elective activity vs 2019/20	Nov-24	88.3%	-	-	84.2%	62.6%	105.8%
Outpatient First Attendance activity vs 2019/20	Nov-24	105.6%	-	-	107.4%	85.4%	129.3%
Outpatient Follow Up Attendance activity vs 2019/20	Nov-24	124.3%	-	-	118.9%	96.2%	141.6%
Diagnostic activity vs 2019/20	Nov-24	124.0%	-	-	122.2%	109.6%	134.8%
Cancer First Treatments vs 2019/20	Nov-24	107.1%	-	-	125.8%	87.4%	164.1%
Bed Utilisation General & Acute	Nov-24	96.3%	-	-	95.2%	91.9%	98.5%
Cancer 28 Day combined Standard (2WW ,Breast Symptomatic and Screening Referrals)	Oct-24	77.4%	77.0%		78.7%	72.9%	84.5%
Cancer 31 Day combined Standard (First and All Subsequent Treatments)	Oct-24	85.1%	96.0%	No	84.7%	77.0%	92.5%
% outpatient activity: first (all) and follow-up (procedures)	Nov-24	42.1%	46.0%	No	43.0%	41.4%	44.6%

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: Nov-2024

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Adjusted in-month financial performance Surplus/Deficit £'000	Nov-24	-6153.0	-	-	-4415.0	-7187.3	-1642.6
BPPC £ %	Nov-24	68.5%	95.0%	No	85.1%	78.7%	91.6%
BPPC Volume %	Nov-24	45.4%	95.0%	No	71.8%	64.4%	79.3%
Cash £'000	Nov-24	9388	8381		32467	9694	55240
Efficiency delivery £'000	Nov-24	6183.1	7452.0	No	5601.9	-1074.9	12278.8
Elective recovery funding (ERF) value-weighted activity % In month	Nov-24	107.2%	107.0%		100.6%	90.0%	111.1%
In-month financial performance Surplus/Deficit £'000	Nov-24	585.8	-526.9		-1112.7	-11431.1	9205.7
In-month ICS CDEL capital expenditure	Nov-24	2522.9	9433.0	-	2488.0	-5371.1	10347.0
Year-to-date financial performance Surplus/Deficit £'000	Nov-24	-24943.1	-22016.6	No	-14469.3	-23832.7	-5105.8

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

Latest Indicator Period: Nov-2024

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Information Governance and Data Security Training	Nov-24	89.8%	95.0%	No	91.4%	-	-
Data Security & Protection Breaches	Nov-24	22	-	-	27	9	44
Externally reportable ICO incidents	Nov-24	0	0		0	-	-
All IG reported incidents	Nov-24	25	-	-	29	14	44
Freedom of Information (FOI) % responded to within target tim	Nov-24	57.8%	80.0%	No	59.3%	-	-
Data Subject Access Requests (DSAR)	Nov-24	71.0%	80.0%	No	68.8%	51.8%	85.8%
Priority 1 Incidents	Nov-24	1	0	No	1	-	-

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

Latest Indicator Period: Nov-2024

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Legal Services: Number of claims	Nov-24	18	-	-	19	5	34

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

Latest Indicator Period: Nov-2024

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
CQC overdue actions ('must do')	Nov-24	0	0		0	-	-

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.

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.

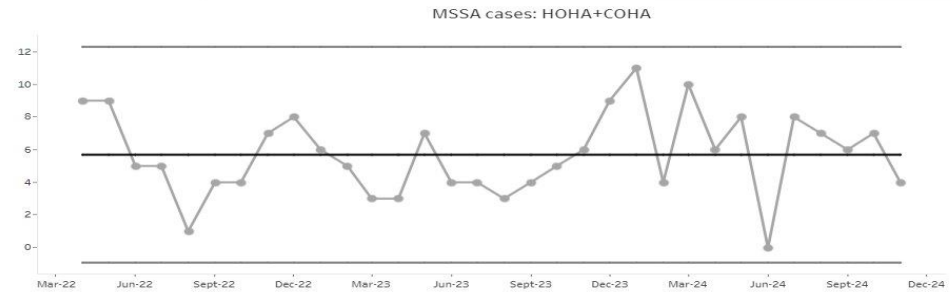
OUH Data Quality indicator

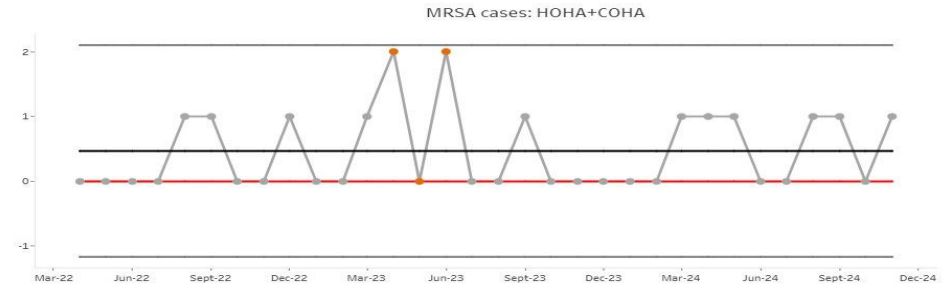
Valid: Information is accurate, complete and reliable. Standard operation procedures and training in place.	**Verified**: Process has been verified by audit and any actions identified have been implemented.	**Timely:** Information is reported up to the period of the IPR or up to the latest position reported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

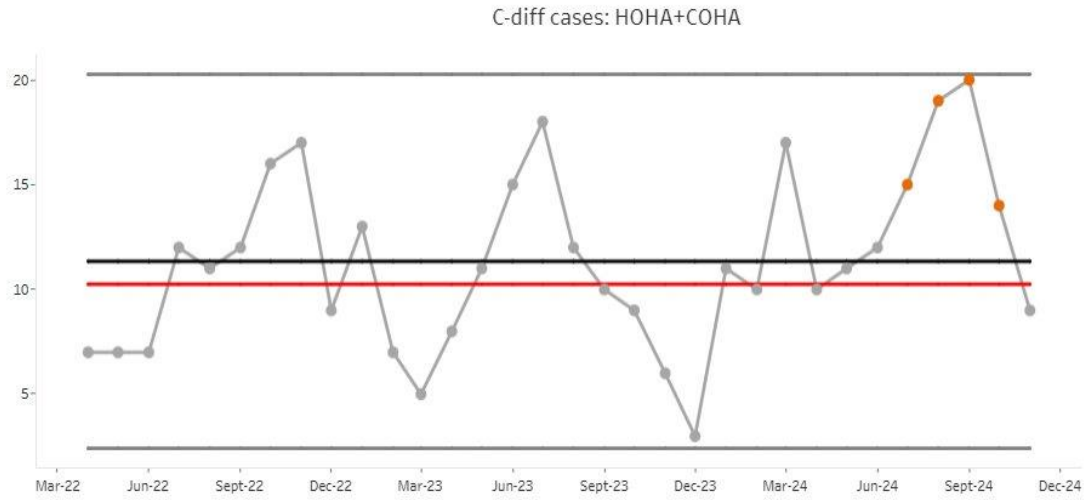
Sufficient	Satisfactory	Inadequate

03. Assurance reports

3. Assurance report: Quality, Safety and Patient Experience

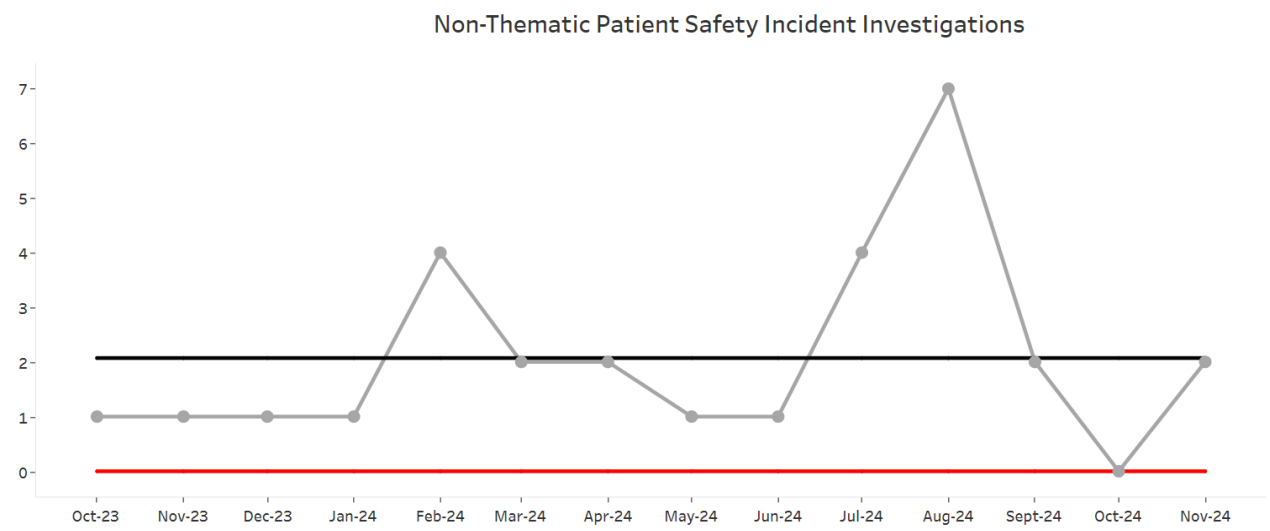


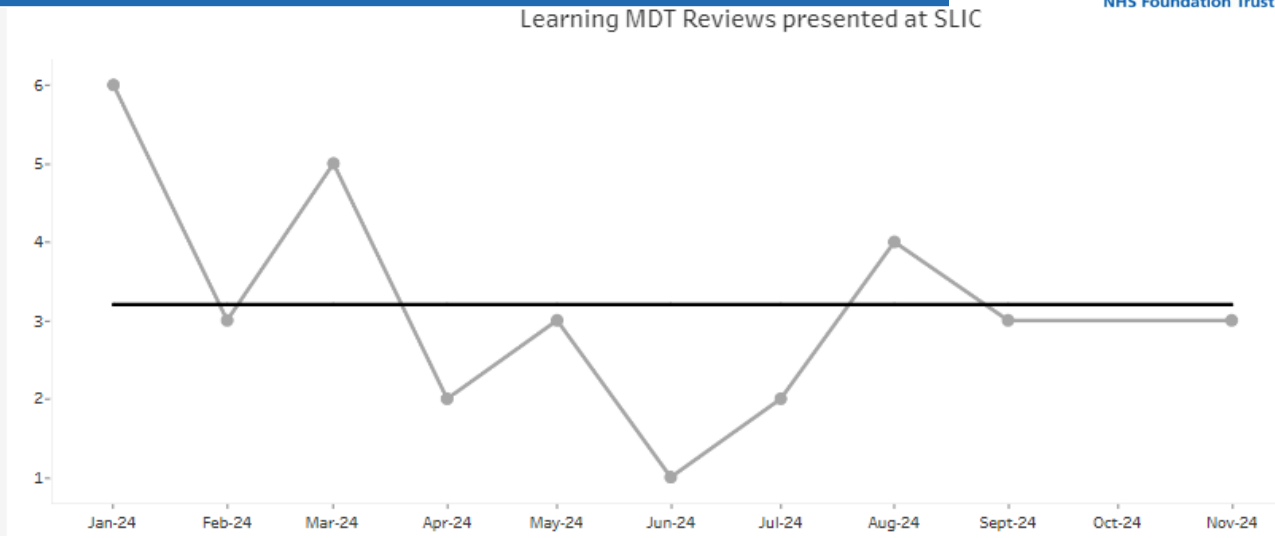




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
OUH has reported 6 HOHA and 3 COHA C. difficile cases for November to the UK Health Security Agency (UKHSA). This is a continued reduction in case numbers from September, but the number of cases remains above the contract threshold for this time of year. The number of stool samples submitted to the laboratory continues to increase. The proportion of toxin positive samples is static. The OUH trend is in the context of a national increase in C. difficile incidence of 54% since 2018/19, from 12.2 to 18.8 infections per 100,000 bed-days. There is currently no clear explanation for this national increase. **MRSA** - One case of healthcare associated MRSA bacteraemia was reported in November. **MSSA** - 4 cases of HOHA and 0 cases of COHA MSSA have been reported in November. **Staffing** – From the end of November the IPC team has an interim Lead Manager following 2 months with no-one in post, due to the secondment (and recent substantive appointment) of the previous Lead Nurse/Manager.	A detailed analysis of C. difficile data by the IPC team is underway supported by the Oxford HPRU. One hypothesis is that the increase in testing is driving detection of asymptomatic C. difficile carriers. The national team are also analysing data but have so far not been able to draw any conclusions. As reported in September, the antimicrobial stewardship programme continues to report a decline in use of antibiotics most likely to predispose to C. difficile infection. Recruitment of a new substantive Lead Nurse/Manager will begin in January 2025.	The threshold C. difficile for 2024/25 is 123 cases. This is 20 more cases than 2023/24. The baseline has been changed because of an updated definition - where a patient has been admitted directly after attendance to A&E, the decision to admit is the admission date rather than the inpatient admission date. As a result of this definition change, case classifications will change from community-onset to hospital onset. 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*

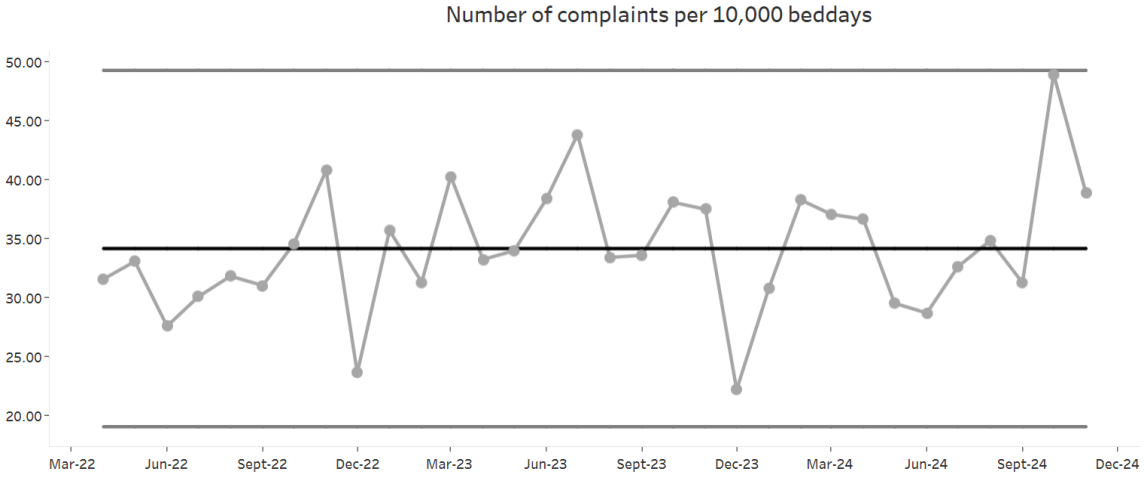
3. Assurance report: Quality, Safety and Patient Experience, *continued*

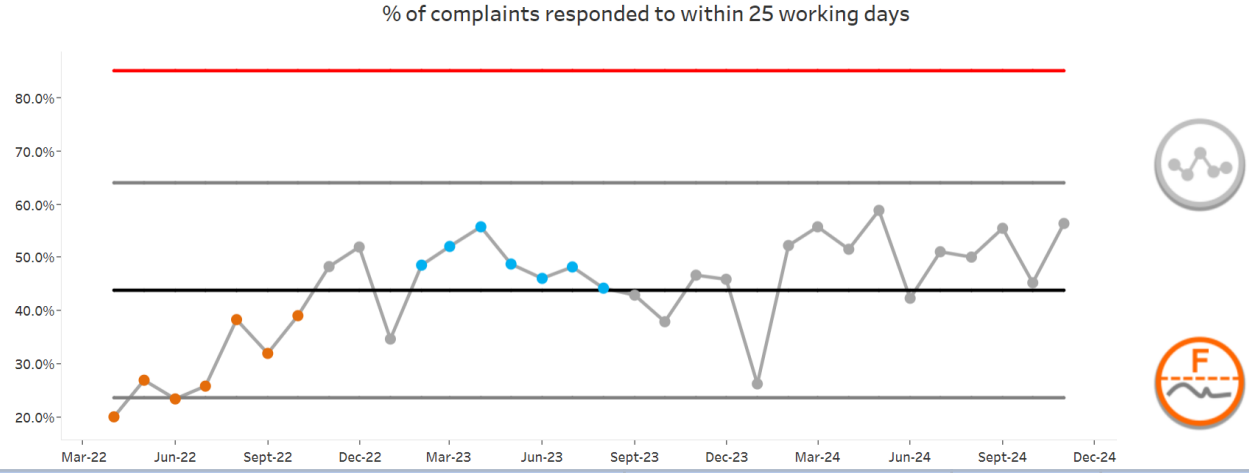




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Two new patient safety incident investigations (PSII) were confirmed in November 2024 (excluding any incidents included in the 4 thematic PSIIs that form part of the Patient Safety Incident Response Framework (PSIRF) patient safety profile). One of these concerned a patient who had a cardiac arrest in Emergency Department and died, and the other is a cluster PSII to review the escalation and oversight of unwell patients out of hours at the Churchill. Individual PSIIs are incidents that warrant an extensive system-based review (more than a learning multidisciplinary team review (LMDTR)). The learning and improvement will be shared once the PSII has concluded, within 3-6 months. The specific timeline for PSIIs is set by the service in conjunction with the patient and/or family and confirmed at the weekly Safety Learning & Improvement Conversation (SLIC).	A total of 28 non-thematic PSIIs have been confirmed since OUH moved to the PSIRF framework in October 2023. In response to the concern regarding the escalation and oversight of unwell patients out of hours at the Churchill Hospital, an additional general surgical registrar has been introduced in the evenings. This ensures that all post operative patients are reviewed and provides support for junior resident doctors. PSIIs are one of a range of learning responses. They are a detailed investigation using a systems analysis approach which can be applied to individual incidents or a cluster of similar incidents. Other learning responses include After Action Reviews (AARs) and LMDTR. AARs have a target of 2 weeks from the reporting of the incident to be completed, and LMDTRs 6 weeks. AARs were initially underreported in Ulysses. The Patient Safety Team now tracks all completed AARs, and AARs will be included once 6 monthly data points have been collected. In November 17 AARs (including harm-free assurance reviews for pressure ulcers and falls) were completed and submitted to PST.	The action is to complete the PSII investigations within the agreed timescale and share the learning across Divisions. 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.	BAF 4 CRR 1122	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, *continued*

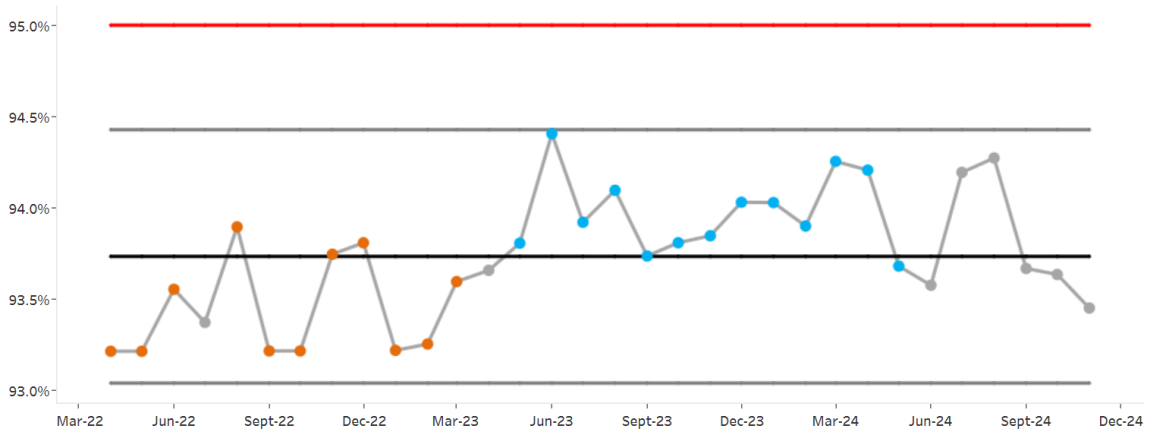




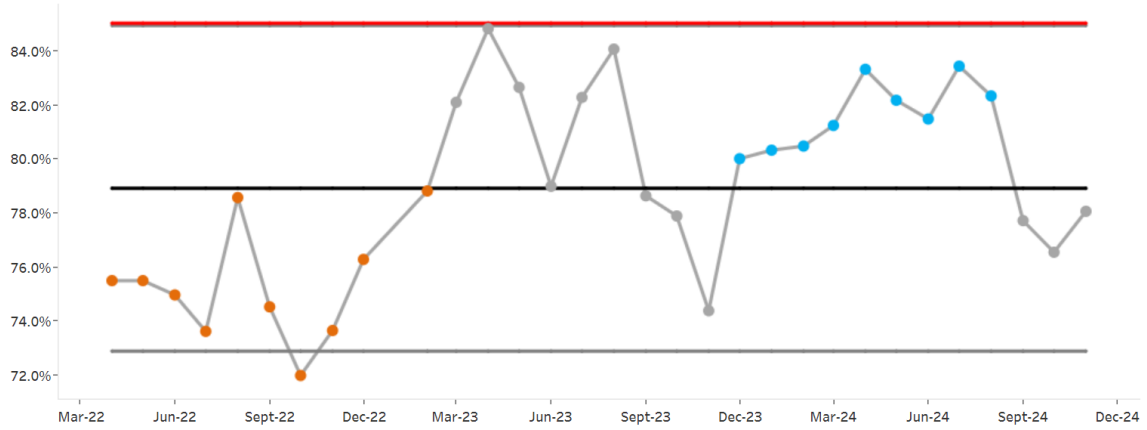
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
In November 2024, 56% of complaints were responded to within 25 days, below the target of 85%.	The Trust received 124 formal complaints in November. November is the first month to report the data on the progress for complaints responded to in 25 working days with 56% of complaints responded to in this timeframe, below the target of 85%. There are barriers to reaching the target. Provisional discussions have already taken place with the information team to establish the feasibility of extending the scope of the Complaints Dashboard to identify and track precise reason at all complaints stages for the delay. A weekly report showing the number of open complaints over 25 days is shared and discussed with senior leaders across Divisions and ensures they are engaged in resolving response times and provided with the necessary resources and support. Weekly meetings are held with the Complaints Team and Divisional Directors of Nursing, to escalate complaints cases about to breach, with each case given an identified way forward to bring the case to closure as quickly and appropriately as possible. This report also highlights the cases that are currently below 25 working days in the process, to ensure Divisions are aware and work to ensuring these cases do not breach. A monthly interactive complaints dashboard has been developed, which provides the divisions with a score for open, closed, reopened, and complaint themes. This is circulated to all Divisions for use in their Divisional Performance Reviews on Power BI.	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*

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

Friends & Family test % likely to recommend - OP

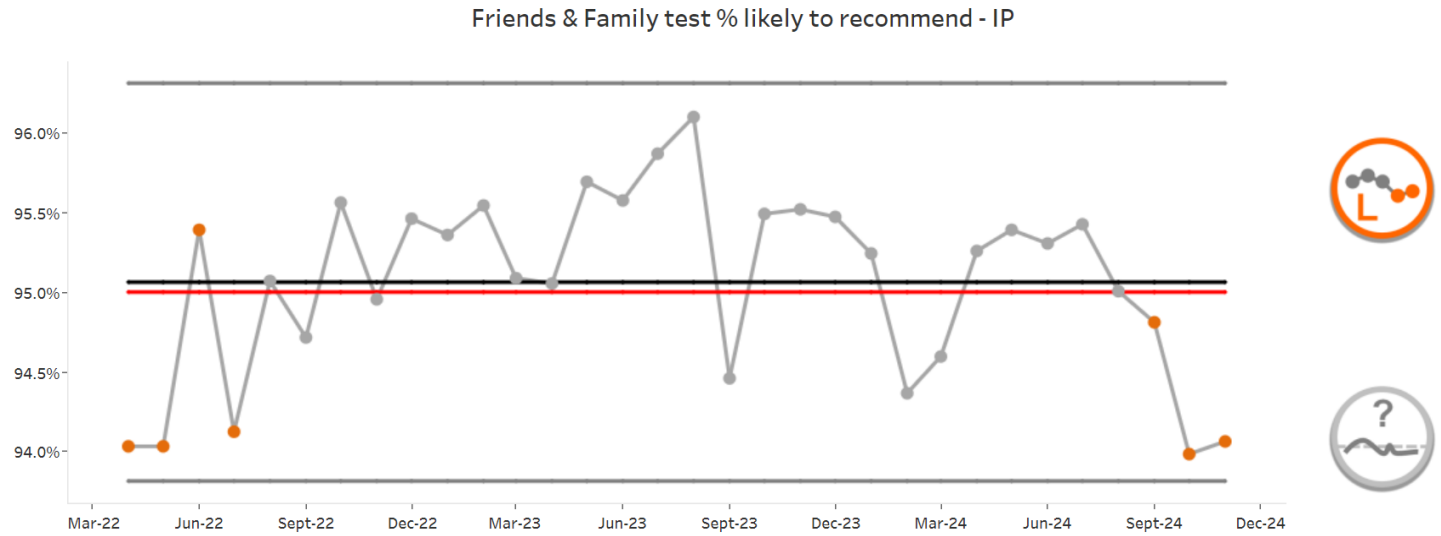


Friends & Family test % likely to recommend - ED



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. The negative themed comments during November were length of time on waiting list, car parking, discharge home and Catering. Over the over the previous 3 months, comments consistently centre on discharge home, cancelled admission and procedures, car parking and the length of time on waiting lists. 2. The positive themes during November were staff attitude, implementation of care, admission procedures and clinical treatment. consistent positive themed comments over the previous months centre on patients' appreciation of staff attitude, implementation of care and clinical treatment. 3. This continues to indicate that whilst patients are concerned about delays in their treatment, going home and parking, they experience good clinical care supported by professional staff who display a positive attitude. 4. The overall Trust performance for FFT for November is 92.22% positive when analysing 15,760 responses.	1. Updated posters have been shared with teams to ensure that FFT is being promoted and patients are being encouraged to complete. 2. A thematic analysis of complaints in both ED and OP is being conducted to look at what SMART actions can be taken to increase 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 and the Trust Governors Patient Experience and Membership Committee (PEMQ) every month.	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*



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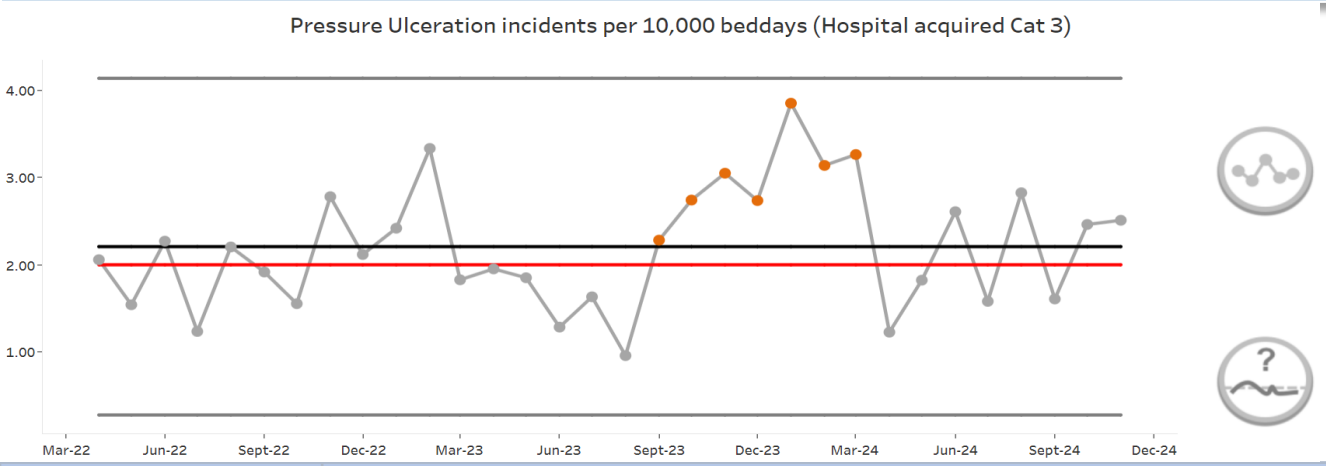
3. Assurance report: Quality, Safety and Patient Experience, *continued*

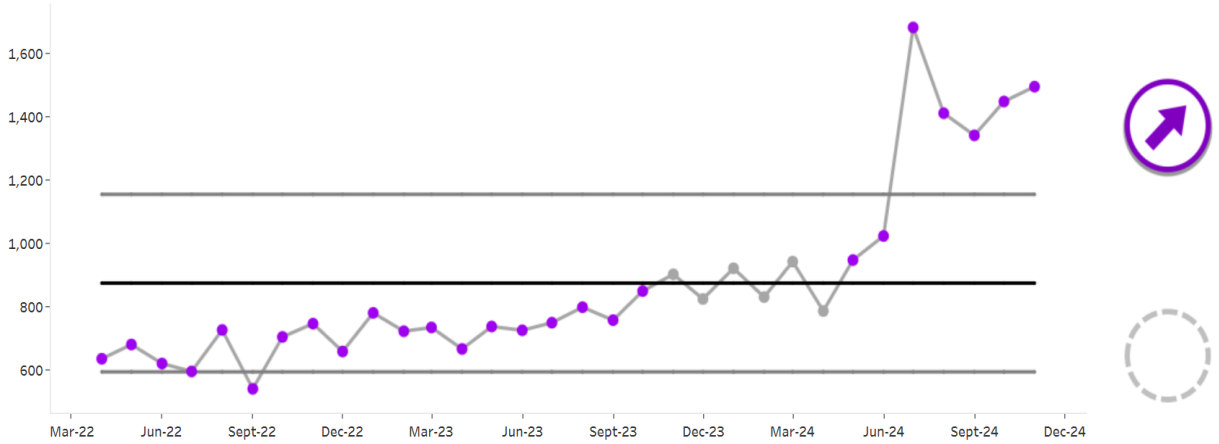


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance	Risk Register	Data quality rating
In November, a total of 9 Category 3 Hospital-Acquired Pressure Ulcers (HAPUs) were reported from 9 different clinical areas. These incidents have been reviewed, and lessons learned have been identified. All patients involved were assessed as being at high risk for pressure damage before the HAPUs were discovered. Notably, two of the 9 incidents were associated with medical devices, specifically casts and collars.	The clinical areas review all incidents using the PSIRF approach to identify lessons learned and develop remedial action plans. Recent reviews indicate that ongoing improvements are necessary in early skin assessments to ensure that effective interventions are applied promptly. This issue is being addressed through Safety Huddles and Board Rounds. Additionally, there is a need for improvements in thorough wound assessment documentation and effective patient repositioning. Clinical educators and tissue viability link nurses are working with clinical teams to enhance and improve practice. **HAPU QI Programme:** Progress on the actions outlined in the HAPU QI programme is monitored and reported at the Harm-Free Assurance Forum and Clinical Governance Committee, including: **Data Dashboard:** A Hospital-Acquired Pressure Ulcer dashboard has been launched in Power BI to provide oversight of reported incidents. This tool aims to give visibility for all clinical areas of the number of HAPUs and areas that require improvement. **Audit:** Monthly Pressure Ulcer Prevention Audits are now scheduled, with revised standards for completion beginning in November 2024. Monthly audit reports will be available in January 2025 and ensure that action plans based on the audit findings will be implemented for all clinical areas to ensure that improvements are targeted and effective. **Tissue Viability Link Nurse Academy:** A Tissue Viability Link Nurse Academy has been established and is facilitated by the Tissue Viability Team. This initiative provides a structured and supportive approach to enhance resources at ward level, focusing on improving wound care and preventing pressure ulcers. **Medical Devices:** A specialist group to focus on the themes related to the use of Medical Devices and pressure ulcer formation. has been established and will focus on improvement activity related to HAPUs associated with medical devices. **Skin Assessment and Repositioning:** Focused work has begun to identify current practices, gaps, and areas for improvement in skin assessment and patient positioning. This initiative aims to ensure that comprehensive skin assessment protocols are implemented, which include regular checks upon admission, daily assessments, and evaluations during patient transfers. Additionally, the guidelines will cover proper patient positioning techniques.	Themes from all HAPU incidents will be presented at Clinical Governance Committee to ensure appropriate actions are taken in a timely manner	BAF 1	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months, .*

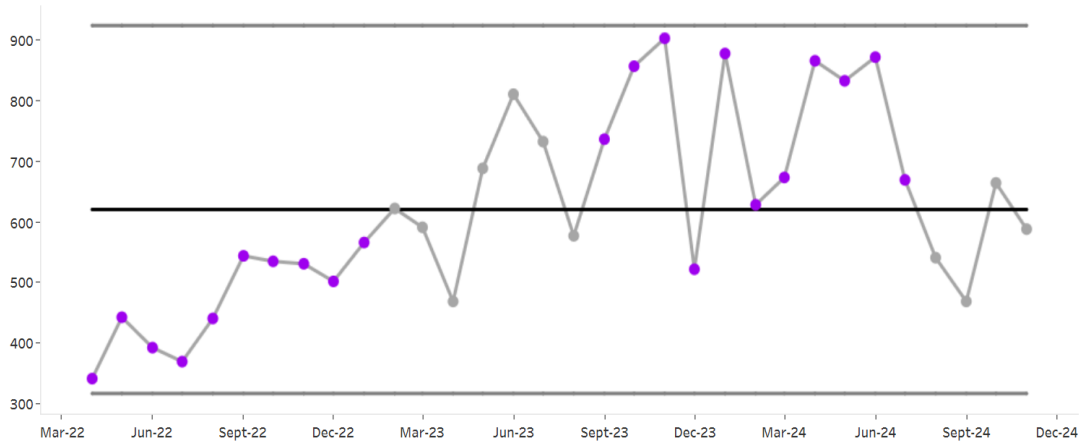
3. Assurance report: Quality, Safety and Patient Experience, *continued*

Oxford University Hospitals NHS Foundation Trust

Adult safeguarding activity



Children's safeguarding activity



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
Adult safeguarding activity total for November was 1492. This data includes maternity safeguarding activity of 419. Children activity for November was 587, mainly within NOTSSCaN and MRC division. Domestic abuse remains the main theme across safeguarding. There were 147 Deprivation of Liberty Safeguards; an increase of 11 in November. Two cases escalated to the Local Authority for authorisations due to escalating behaviours, neither were granted. Safeguarding liaison shared information for 1,285 cases with primary care, an increase of 217.	Activity continues to be complex in many cases and teams are supported by safeguarding. Complex cases that are multifaceted continue, as well as cases of self-neglect, neglect, and concerns around discharge. Domestic abuse is the main theme across adults and maternity and mental health/ self-harm and neglect for children. Information is shared with primary care, mental health and social care to support. Maternity are supported by the hospital Independent Domestic Violence Advisor project, funded by Public Health has proven to be such a success that the funding is being continued a further year. Honour based violence and illicit drug use has been a recuring theme in maternity. ED remains an area of high safeguarding activity with the need for management plans to be in place and shared with multi agency partners to aim to avoid attendances or ensure clear pathways followed to reduce time in ED when there is no clinical need for treatment. Close working with police, Oxford Health Adult MH and CAMHS services continue for complex and frequent attenders to ED.	ICCSIS updated on a weekly themes. PSEC monthly assurance report, safeguarding is embedded in the monthly divisional governance reports and presented to the Trust clinical governance committee. Safeguarding Steering group quarterly. SLIC presentation quarterly to share learning from safeguarding reviews and specific cases.	BAF 4	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: Safe Staffing - Quality, Safety and Patient Experience, *continued*

Oxford University Hospitals NHS Foundation Trust

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 coloured sections on the dashboard assist with the review, and any indicator not meeting the target is indicated in red. 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 three times a day and was maintained at Level 2 (Amber) throughout November 2024. The Trust-wide planned versus actual fill rates were 89.05% during the day and 99.7% 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.

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

Nurse and midwifery staffing levels and the nurse-sensitive indicators below were thoroughly reviewed and validated with the Lead Nurse for Nursing & Midwifery Staffing Regulation and the DDN's. The review aimed to triangulate all data in line with National Quality Board standards and determine whether these harm indicators were linked to staffing. Following the review, all divisions have confirmed that there were no instances of harm related to nurse or midwifery staffing levels in November.

SUWON – Transplant ward CHPPD higher than required during this period. During this period the ward had some empty beds with staffed moved to support other wards, however, not always reflected on the roster. Roster efficiencies have been reviewed in the newly introduced check and confirm meetings. The net hours difference for Upper GI, Gynaecology ward and SEU-F relate to students. Staff retention KPIs have been flagged to the DDN and will be monitored with increased oversight. All areas were safely staffed in November, using temporary workforce when appropriate.

Maternity – The service is aligning with the Birthrate+ numbers, and efforts are ongoing to ensure these are reflected in the budgets. Since the revised staffing numbers have not yet been incorporated into the budget at the time of reporting, the vacancy data does not fully represent the current situation, and the budgeted CHPPD is less than required, therefore the actual CHPPD will appear higher than budget at times to accommodate safe staffing in the clinical areas. Staff are in pipeline, with registered vacancies set to be filled by February 2025.The delays in induction of labour (IOL) due to midwifery staffing levels were no harm events and were managed and reviewed on a case-by-case basis. Two women had intended place of birth in the community changed to hospital births, as community midwives were called in to maintain safety in the hospital setting. Since the Implementation of the Quality Improvement Project for the enhanced induction of labour process, there continues to be a significant reduction in the number of delays in November. All areas were safely staffed in November.

MRC –Actual CHPPD for CMU wards appears lower than required for November. Following validation with the DDN, this appears to be due to clinical educators and ward managers, who were reallocated to support safety, not being moved electronically on the system and therefore the actual CHPPD appears lower than it was. There was no escalation of unsafe shifts and senior nurse visibility and oversight of all areas during November was in place. MRC continued to experience increased levels of sickness absence across both the JR and Horton sites. Roster efficiencies and performance is very good. All areas were safely staffed in November. The delay in publishing the roster for CTW has been addressed by the DDN. John Warin Ward has low uptake of Annual Leave, all staff have been written to advising to use annual leave.

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

NOTSSCAN – Roster efficiencies and KPI adherence is closely monitored by the DDN, four areas were not approved for payroll this month. This is exceptional for this division, they relate to one Matron, who was off unwell at the time approval was due. Blenheim Head & Neck, have one staff member who is reported to have underworked hours., Trauma Ward 3A reports overworked hours. This has been reviewed and relates to student hours not rostered correctly. There were 30 medication incidents recorded for PCCU, 19 were no harm and 11 with minor harm, none of which relate to staffing. The DDN has reviewed all incidents and implemented appropriate actions along with individual support and education.

CSS – JR ICU – New senior leadership are engaged to review the CHPPD budget and roster. There is a twice daily review of staffing to ensure appropriate senior cover is available across the two sites. All areas were safely staffed in November.

Nurse Sensitive Indicators
Of the 141 Medication incidents reported, 56 pressure ulcer incidents and 134 falls reported, the DDN's have confirmed that none of these incidents related to unsafe staffing concerns. Incidents have been reviewed in other forums which are reported within the IPR.

Critical Care Recruitment
Work has commenced under the Deputy Chief Nurse for Workforce to develop a joint recruitment campaign for critical care nurses across all OUH Critical Care settings. This multi-faceted work involves understanding the current critical care nurse landscape and defining and employing creative strategies to attract and retain skilled professionals. There are 8 new starters in the pipeline due to commence between September and December.

Vacancies above 15%
All areas with a vacancy rate above 15% are under review to develop a recruitment strategy. The review will take a local and trust-wide approach and implement a comprehensive plan that addresses immediate and long-term staffing needs in these areas. The review examines and assesses each area's specific requirements, care complexity, and the reasons behind the high vacancy rate to address underlying issues.

Unavailability
All areas with a high unavailability of workforce (HR data – vacancy, maternity leave, long term sickness) were mitigated to maintain a safe level of staffing with the use of Ward Managers and Clinical educators supporting, and temporary workforce where required (NHSP, Agency, Flexible Pool shifts for RMN's and Maternity). All metrics including rostering efficiencies and professional judgement, patient acuity, along with enhanced care observation requirements, skill mix, bed availability, RN:patient ratios are reviewed each shift to maintain safe and efficient staffing levels.

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

November	Care Hours Per Patient Day			Census	Nurse Sensitive Indicators				HR					Rostering KPIs				FFT
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%	% Extremely likely or likely
NOTSSCaN																		
Bellhouse / Drayson Ward	9.0	11.6	10.9	95.6%	1	0	0	0	6.7%	15.9%	4.2%	1.7%	8.3%	Yes	2.9%	9.4	11.9%	92.7%
HH Childrens Ward	8.7	9.1	10.4	100.0%	1	0	0	0	16.4%	3.3%	3.7%	9.8%	24.6%	Yes	-1.0%	10.9	12.5%	100.0%
Kamrans Ward	10.2	11.2	9.9	92.2%	3	0	0	0	-3.0%	0.0%	1.0%	0.0%	-3.0%	Yes	-5.5%	9.4	12.0%	77.8%
Melanies Ward	11.6	15.4	13.6	100.0%	1	0	0	0	-23.9%	7.5%	3.4%	3.4%	-19.7%	Yes	-1.9%	11.4	11.4%	90.9%
Robins Ward	10.7	10.2	9.0	98.9%	5	2	0	0	19.2%	18.6%	4.0%	3.6%	25.0%	Yes	0.4%	11.4	9.4%	90.5%
Tom's Ward	8.1	9.5	9.1	100.0%	3	2	0	0	-13.1%	6.0%	2.3%	5.8%	-6.6%	Yes	0.4%	10.9	10.9%	88.9%
Neonatal Unit	19.4		30.5		2	0	0	0	12.7%	8.6%	6.6%	4.5%	18.3%	Yes	-4.1%	8.4	12.7%	
Paediatric Critical Care	25.8		25.4		30	6	2	0	-3.3%	9.3%	5.0%	7.4%	7.7%	Yes	-1.1%	5.7	11.5%	
BIU	6.1	6.3	7.1	98.9%	0		1	5	14.6%	6.7%	3.2%	3.0%	17.1%	No	1.2%	8.9	14.4%	100.0%
HDU/Recovery (NOC)	9.0		22.0		1		0	0	8.7%	8.6%	5.3%	8.5%	16.4%	No	-0.2%	6.6	14.1%	
Head and Neck Blenheim Ward	7.3	7.6	8.2	100.0%	0		0	2	13.9%	0.0%	4.8%	0.0%	15.7%	Yes	8.2%	7.7	15.9%	94.1%
HH F Ward	7.5	9.4	9.4	100.0%	0		2	1	3.6%	5.8%	6.0%	2.2%	5.7%	Yes	-0.8%	9.9	14.0%	100.0%
Major Trauma Ward 2A	9.1	9.5	9.5	98.9%	3		1	3	8.8%	9.1%	4.1%	0.0%	8.8%	Yes	2.3%	8.0	13.7%	88.9%
Neurology - Purple Ward	9.0	9.3	8.0	100.0%	3		0	6	-1.5%	3.0%	4.7%	0.0%	-1.5%	Yes	3.2%	9.4	14.0%	100.0%
Neurosurgery Blue Ward	9.0	10.1	9.7	100.0%	1		0	8	15.1%	5.8%	3.9%	2.3%	17.0%	Yes	1.6%	7.4	11.3%	89.7%
Neurosurgery Green/IU Ward	11.8	9.5	9.8	100.0%	1		1	1	3.3%	0.0%	3.7%	0.0%	6.2%	Yes	0.9%	7.4	9.8%	92.3%
Neurosurgery Red/HC Ward	12.8	12.4	12.6	100.0%	0		0	1	-0.8%	11.5%	4.9%	2.6%	14.4%	Yes	-0.7%	8.6	10.0%	100.0%
Specialist Surgery I/P Ward	7.7	5.9	8.4	100.0%	1		2	4	8.1%	7.7%	3.3%	4.4%	12.2%	Yes	1.8%	8.3	11.5%	80.0%
Trauma Ward 3A	9.1	9.3	8.8	98.9%	1		1	1	2.1%	8.4%	4.6%	0.0%	9.3%	Yes	-10.9%	7.9	11.2%	92.3%
Ward 6A - JR	7.4	6.5	6.9	100.0%	3		1	3	7.6%	8.5%	3.0%	4.1%	11.4%	Yes	-1.1%	8.4	14.2%	25.0%
Ward E (NOC)	6.3	7.3	8.4	95.6%	1		0	1	12.4%	6.9%	7.9%	0.0%	12.4%	No	4.6%	8.9	14.3%	100.0%
Ward F (NOC)	6.7	7.0	7.4	98.9%	1		1	1	9.7%	7.7%	4.2%	5.6%	14.8%	No	0.5%	8.7	11.2%	83.3%
WW Neuro ICU	26.1		26.2		2		0	0	13.2%	9.8%	4.1%	1.1%	16.4%	Yes	-2.5%	8.0	13.2%	

Key to colour formatting: Any indicator meeting or not meeting the target is clearly indicated (Red or green). For indicators without targets, the performance indicator is formatted to help focus readers' attention on the range of variation between indicators and to easily identify outliers.

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

Oxford University Hospitals NHS Foundation Trust

November	Care Hours Per Patient Day			Census	Nurse Sensitive Indicators				HR					Rostering KPIs				FFT
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%	% Extremely likely or likely
MRC																		
Ward 5A SSW	8.8	8.5	8.1	100.0%	1		3	0	2.4%	4.1%	3.8%	4.0%	5.7%	Yes	0.0%	8.4	11.7%	100.0%
Ward 5B SSW	8.9	8.8	8.5	96.7%	0		0	2	7.4%	6.6%	3.7%	4.2%	11.3%	Yes	1.4%	8.3	12.9%	
Cardiology Ward	7.9	6.8	7.0	94.4%	4		1	4	14.6%	14.3%	4.5%	0.0%	17.0%	Yes	0.7%	8.3	11.2%	92.3%
Cardiothoracic Ward (CTW)	7.8	8.1	6.3	92.2%	2		0	5	11.9%	6.4%	2.4%	4.7%	16.0%	Yes	1.3%	4.6	14.9%	
Complex Medicine Unit A	8.9	11.0	8.4	97.8%	0		0	1	4.5%	7.4%	6.0%	6.9%	4.2%	Yes	1.5%	7.7	13.8%	100.0%
Complex Medicine Unit B	9.5	10.3	8.4	98.9%	1		2	2	2.4%	11.9%	2.9%	6.3%	8.6%	Yes	1.6%	10.6	13.4%	100.0%
Complex Medicine Unit C	8.8	10.5	8.4	98.9%	1		5	0	7.4%	8.2%	2.6%	0.0%	9.5%	Yes	0.1%	8.4	10.3%	100.0%
Complex Medicine Unit D	9.5	9.2	8.4	97.8%	0		0	3	6.3%	7.8%	7.6%	0.0%	12.5%	No	1.1%	7.4	11.9%	100.0%
CTCCU	21.9		21.2		3		0	0	8.5%	10.1%	3.9%	2.2%	15.2%	Yes	-1.5%	8.6	12.4%	
Emergency Assessment Unit (EAU)	8.5	9.0		96.7%	1		0	6	10.0%	10.7%	4.7%	1.9%	12.8%	Yes	1.6%	8.4	12.7%	
HH EAU	9.9	7.3		86.7%	3		1	7	4.7%	6.3%	5.3%	3.6%	9.9%	Yes	0.6%	8.7	12.4%	
HH Emergency Department	22.8				1		0	2	6.4%	10.1%	4.0%	3.8%	11.2%	Yes	-1.9%	8.7	14.0%	81.7%
JR Emergency Department	17.7				9		0	1	22.5%	14.5%	4.3%	5.5%	27.1%	Yes	0.7%	8.4	11.7%	76.3%
HH Juniper Ward	8.1	9.7	8.1	100.0%	1		1	3	1.6%	4.5%	4.0%	1.0%	4.3%	Yes	-2.8%	9.6	14.7%	63.3%
HH Laburnum	9.6	8.6	8.2	100.0%	0		1	8	1.5%	5.4%	7.5%	5.8%	12.4%	Yes	-0.1%	8.9	12.1%	54.5%
HH Oak (High Care Unit)	10.1		10.8	94.6%	1		0	1	2.6%	4.0%	6.4%	7.6%	9.3%	Yes	3.3%	9.0	12.5%	100.0%
John Warin Ward	10.7	10.4	9.2	97.8%	2		0	4	3.2%	6.4%	3.4%	7.0%	6.4%	Yes	-2.6%	8.0	9.6%	90.0%
OCE Rehabilitation Nursing (NOC)	10.4	10.7	10.5	100.0%	2		0	2	1.3%	4.0%	5.1%	3.9%	5.8%	Yes	-0.8%	8.3	12.1%	
Osler Respiratory Unit	14.5	11.5	12.2	98.9%	1		4	2	9.1%	4.3%	4.9%	1.4%	10.3%	Yes	-0.9%	8.3	12.1%	50.0%
Ward 5E/F	12.0	7.9	9.7	97.8%	4		0	3	17.0%	13.3%	4.2%	3.8%	21.7%	Yes	0.2%	8.4	11.3%	50.0%
Ward 7E Stroke Unit	10.9	9.4	8.8	100.0%	4		2	4	9.3%	16.2%	4.8%	3.7%	5.3%	Yes	2.5%	8.0	11.4%	100.0%

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

Oxford University Hospitals NHS Foundation Trust

November	Care Hours Per Patient Day			Census	Nurse Sensitive Indicators				HR					Rostering KPIs				FFT
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%	% Extremely likely or likely
SUWON																		
Gastroenterology (7F)	7.50	7.43	7.3	100.0%	4		3	5	6.7%	7.6%	4.5%	7.6%	18.8%	Yes	-5.0%	10.7	13.1%	100.0%
Gynaecology Ward - JR	6.00	5.52	7.8	96.7%	1		1	0	13.5%	2.3%	5.8%	2.8%	15.8%	Yes	23.9%	8.4	13.0%	96.1%
Haematology Ward	7.42	8.1	7.7	94.4%	5		1	5	26.4%	19.3%	5.1%	0.0%	30.5%	Yes	1.2%	8.4	10.7%	90.9%
Katharine House Ward	9.24	11.45	11.5	98.9%	1		0	0	10.8%	3.9%	4.6%	11.8%	21.4%	Yes	3.1%	8.6	12.0%	
Oncology Ward	8.67	8.49	7.8	88.9%	1		3	2	14.7%	2.7%	3.1%	2.6%	17.0%	Yes	0.0%	9.4	12.7%	87.5%
Renal Ward	9.28	9.79	9.0	100.0%	1		2	3	3.8%	7.8%	4.9%	12.5%	18.9%	Yes	0.2%	6.9	11.7%	100.0%
SEU D Side	8.69	8.57	8.7	91.1%	2		1	2	18.1%	0.0%	5.6%	6.5%	25.2%	Yes	-0.5%	8.3	12.1%	93.9%
SEU E Side	8.36	8.61	8.8	88.9%	0		3	5	16.5%	7.1%	3.7%	0.0%	16.5%	Yes	0.6%	8.3	12.9%	91.7%
SEU F Side	7.54	8.54	8.1	88.9%	3		0	0	36.7%	19.3%	2.4%	0.0%	36.7%	Yes	-12.0%	8.3	10.7%	80.0%
Sobell House - Inpatients	8.65	7.55	7.8	100.0%	1		8	5	25.4%	9.5%	5.6%	5.6%	29.5%	Yes	-1.0%	8.6	13.8%	
Transplant Ward	9.43	7.91	8.7	96.7%	2		1	4	22.0%	6.5%	5.0%	3.3%	27.1%	Yes	-0.6%	8.7	11.6%	92.9%
Upper GI Ward	9.74	7.63	8.0	100.0%	3		0	2	20.9%	2.8%	5.2%	15.4%	33.1%	Yes	-10.3%	8.4	6.5%	100.0%
Urology Inpatients	8.79	8.54	8.8	100.0%	1		1	0	23.5%	3.5%	2.4%	3.4%	30.3%	Yes	1.3%	8.6	15.6%	96.3%
Wytham Ward	7.72	7.01	6.5	100.0%	0		0	4	7.8%	6.5%	4.8%	8.9%	20.5%	Yes	3.6%	8.3	13.0%	88.9%
MW Delivery Suite	15.17		20.4						40.9%	20.0%	5.2%	3.7%	44.2%	Yes	-0.2%	7.3	10.9%	
MW Level 5	6.64		5.1											Yes	-0.5%	7.3	10.2%	
MW Level 6	4.48		6.9											Yes	-1.8%	7.3	10.0%	
CSS																		
JR ICU	31.13		29.7		11		0	0	9.2%	6.6%	5.2%	6.1%	16.0%	Yes	0.1%	8.7	13.7%	

NB. MW The Spires data excluded as currently under review

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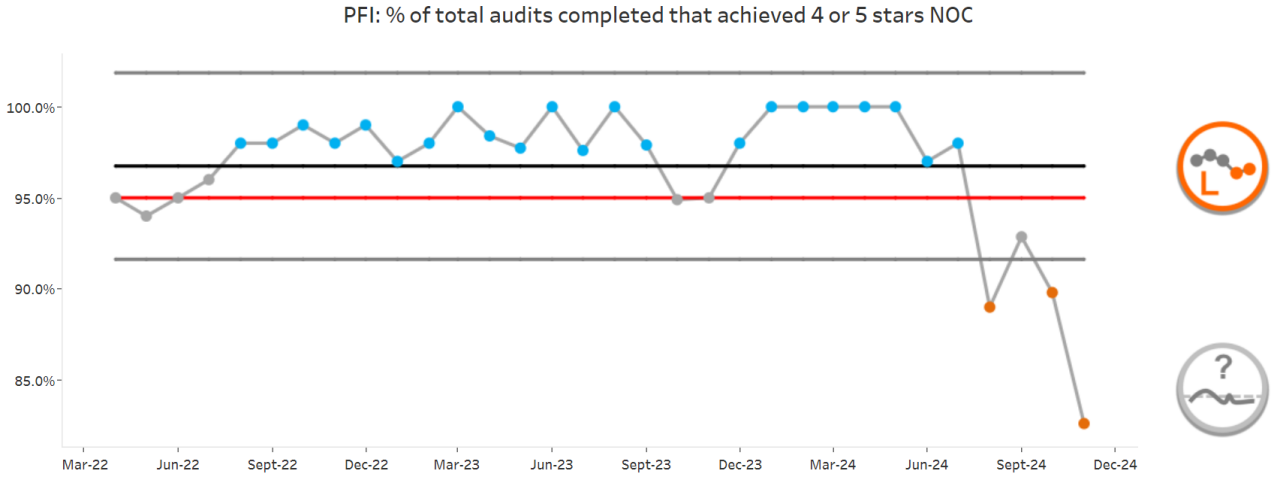
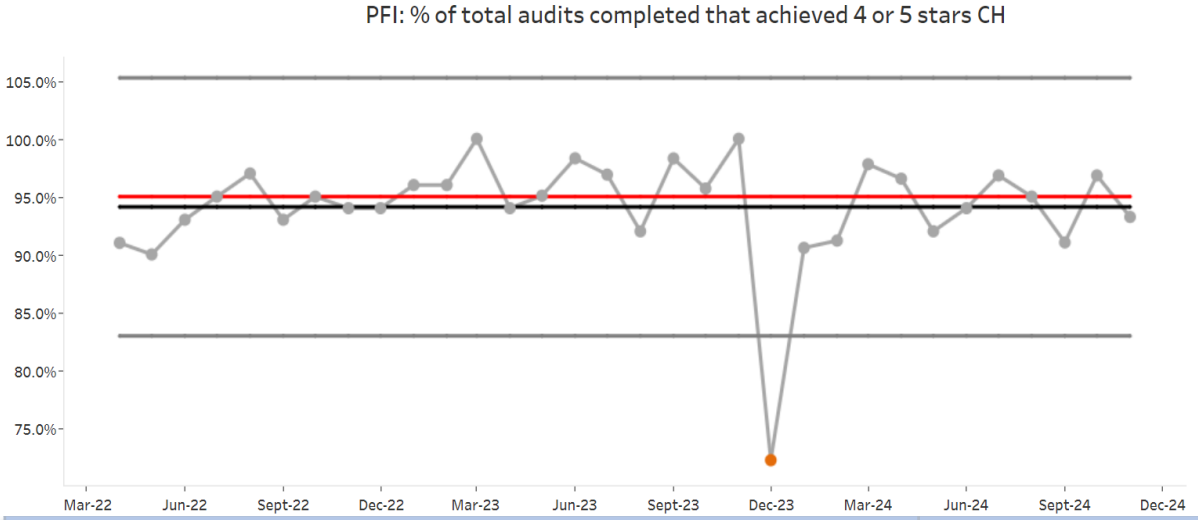
3. Assurance report: Estates, Facilities and PFI



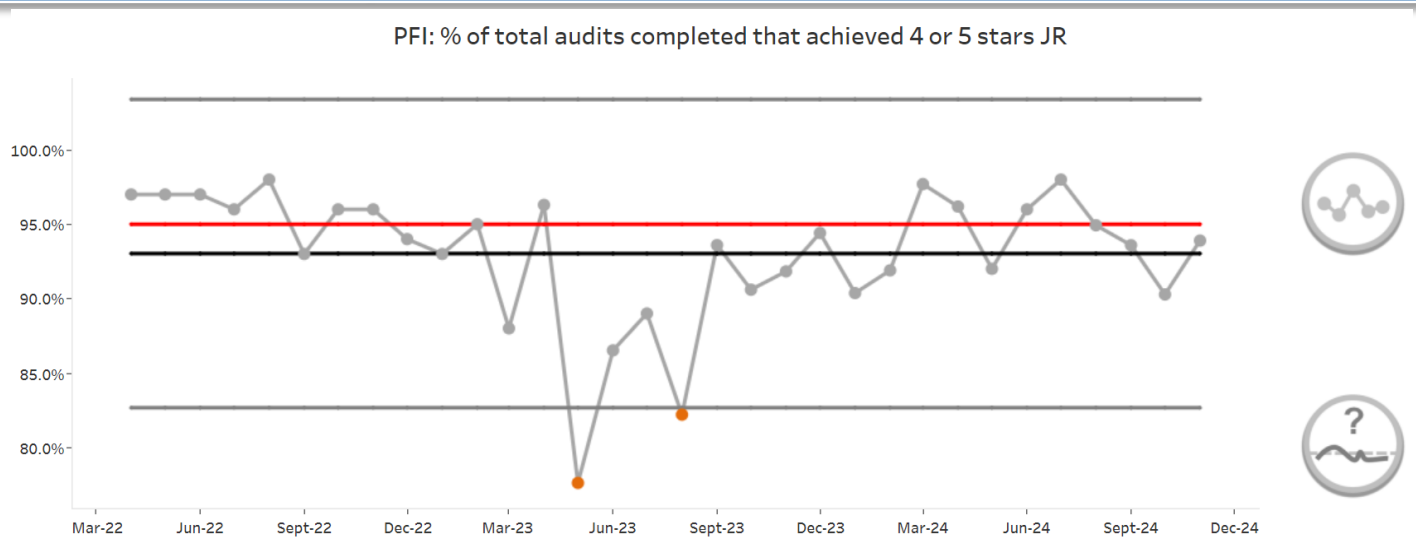
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
In November 2024, the combined PFI % cleaning score by site (average) for the NOC was 95.00%. However, the above graph demonstrates the percentage of total audits undertaken that achieved 4 or 5 stars, which sits at 82.61% which is below the 95% Trust target and unfortunately a decrease on last month. In total, at the NOC, 46 audits were conducted, 8 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 2021. 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 etc.	G4S completed the planned number of audits at the NOC in November 2024. Eight of these audits did not meet the established Trust target related to domestic and clinical responsibilities. However, all failed audits were addressed and rectified within the required timeframe, leading to an improvement in the reported percentage. We have observed an increase in clinical, Estates and domestic failures in the theatres for the past two consecutive months. As a result, we are working closely with IPC, G4S, and the ward and department leaders to address these issues. However, on a positive note, this has enabled lifecycle plans and maintenance of the area to be addressed to improve the environment. 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 2024 at NOC. 2) Information cascade - Monitoring carried out utilising the My Audits 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: 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 or committee	Risk Register	Data quality rating
In November 2024, the combined PFI % cleaning score by site (average) for the CH was 93.99%. However, the above graph demonstrates the percentage of total audits undertaken that achieved 4 or 5 stars, which sits at 93.24% which is below the 95% Trust target and unfortunately a decrease on last month. In total, at the CH, 74 audits were conducted, 5 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 2021. 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 etc.	G4S completed the planned number of audits at CH in November 2024. Five of those audits failed to achieve the set Trust target under domestic and clinical responsibility. However, all failed audits were addressed and rectified within the required timeframe, leading to an improvement in the reported percentage. As a result, we are working closely with IPC, G4S, and the ward and department leaders to address these issues.. 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 2024 at CH. 2) Information cascade - Monitoring carried out utilising the My Audits 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: Estates, Facilities and PFI

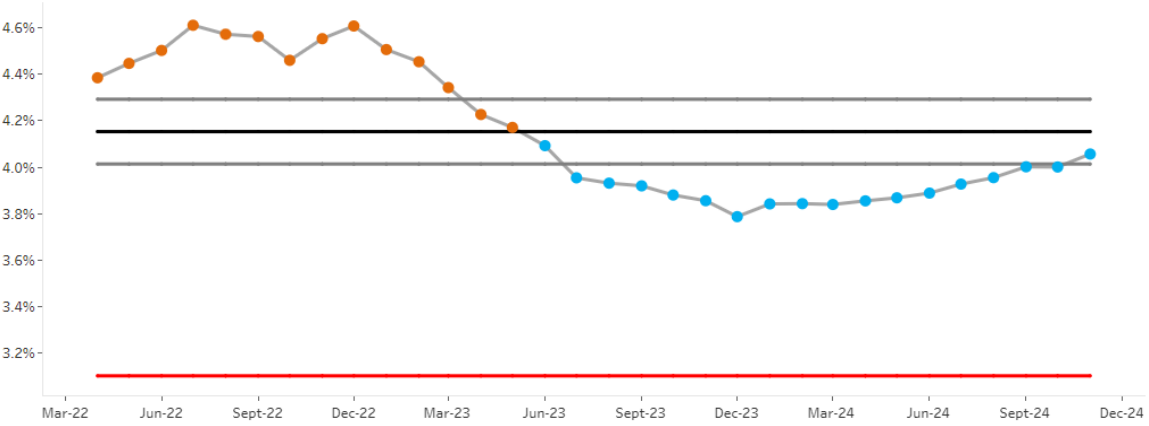


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
In November 2024, the combined PFI % cleaning score by site (average) for the JR was 96.30% which is a positive increase on last month. However, the above graph demonstrates the percentage of total audits undertaken that achieved 4 or 5 stars, which sits at 93.90% which is below the 95% Trust target, however a £5 increase on last month. In total, at the JR, 246 audits were conducted, 15 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 2021. 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 etc.	Mitie completed the planned number of audits at JR in November 2024, and 15 of those audits failed to achieve the set Trust target under domestic and clinical responsibility. However, all the failed audits were rectified within the required timeframe, resulting in an improvement in the reported percentage. Whilst PICU has moved to level 3 OCCU, we are still seeing an increase in clinical responsibility failures resulting in a drop in audit score therefore working closely with IPC and the ward/department leads. We have also seen a drop in a few wards due to new staff and training which we are addressing with Mitie. 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 2024 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*

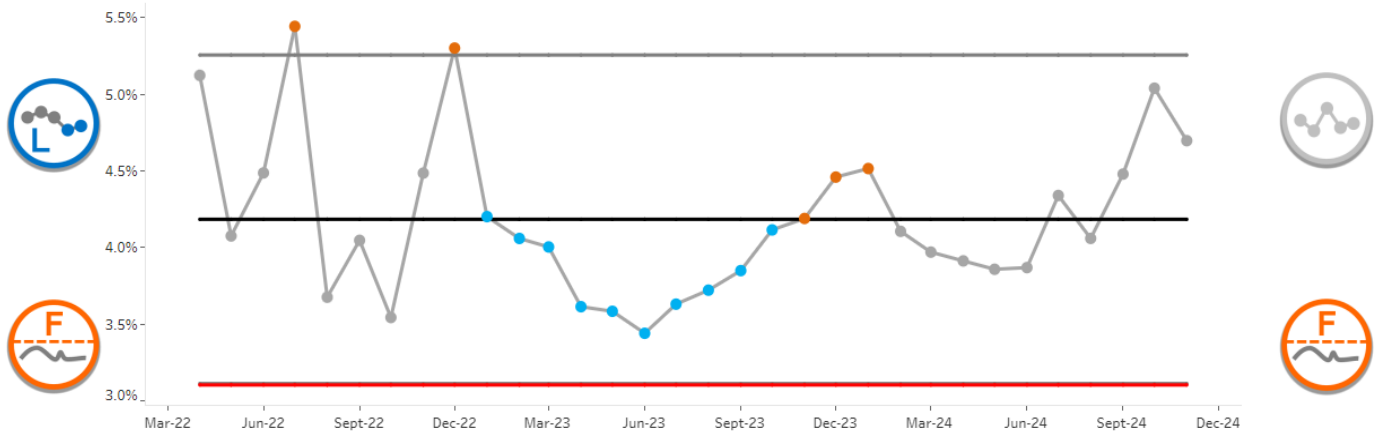
3. Assurance report: Growing Stronger Together

Oxford University Hospitals NHS Foundation Trust

Sickness absence rate (rolling 12 months)



Sickness absence rate (in month)



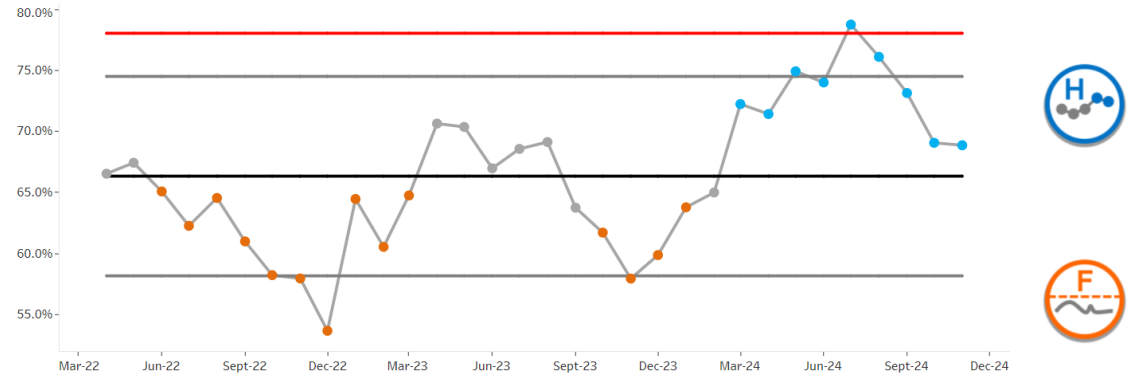
Benchmarking: June 24 (monthly performance – *lag due to availability of published data from National Sickness Absence Rate report*).

OUH: 3.8% **National: 4.9%** **Shelford: 4.5%** Buckinghamshire Healthcare NHS Trust: 3.7% Royal Berkshire NHS Foundation Trust: 3.7% Oxford Health: 4.4% South Central Ambulance Service: 6.1%

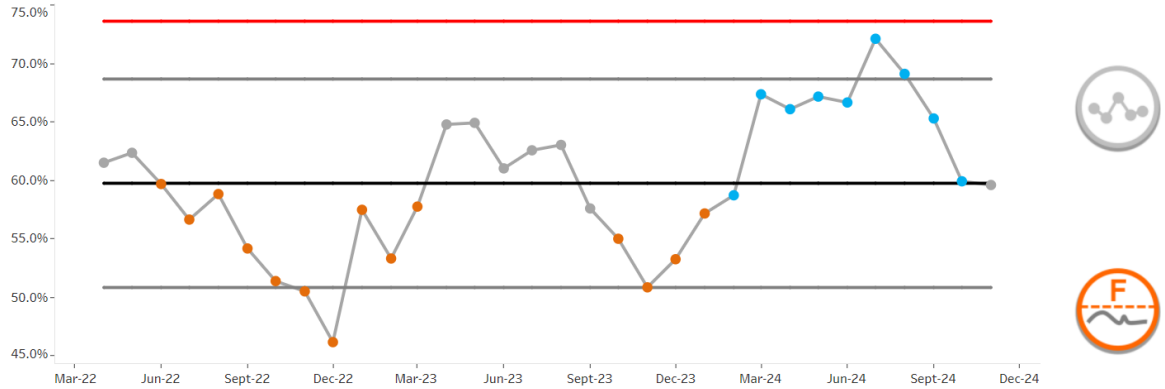
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Sickness absence performance (rolling 12 months) was 4.1% in November. Performance exhibited special cause variation, running below the mean since June 2023. This indicator has continued to track upwards since December 2023, with this month showing a small increase of 0.1%. In month figure was 4.7% in November with an in month decrease from 5.0%. No one absence reason accounts for the change, although the top 5 absence reasons have increased to varying degrees between months (Cold/ flu, Mental Health, Headache/ Migraine, Covid and Gastro).	• We are continuing to offer a full range of well-being support including physical, financial, environmental and psychological wellbeing. This includes stress management and wellbeing training. • There is a focus on the top CSUs who have a consistent absence. • Collaborative work with Occupational Health to support managers and staff with a review on the top three absence reasons. • A call to action on long term sickness making sure that staff are supported to successfully return to work. • Alerting managers on staff who have triggered, signposting them to support and coaching them through the sickness absence process • HR pro-actively reviewing sickness absence management training content to reflect changes in new policy, to be launched shortly. • HR to work closely with managers to ensure RTW's are completed. • Sickness absence workshops continuing to support managers • Continuation of support from OH colleagues at monthly meetings to unblock issues and support with proactive actions • Monthly meetings with Wellbeing lead in place to identify areas where additional support may be needed.	Governance - TME via IPR, HR Governance Monthly meeting & Divisional meetings All actions are ongoing	BAF 1 BAF 2 CRR 1144 (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

ED 4Hr perfromance - All



ED 4Hr perfromance - Type 1

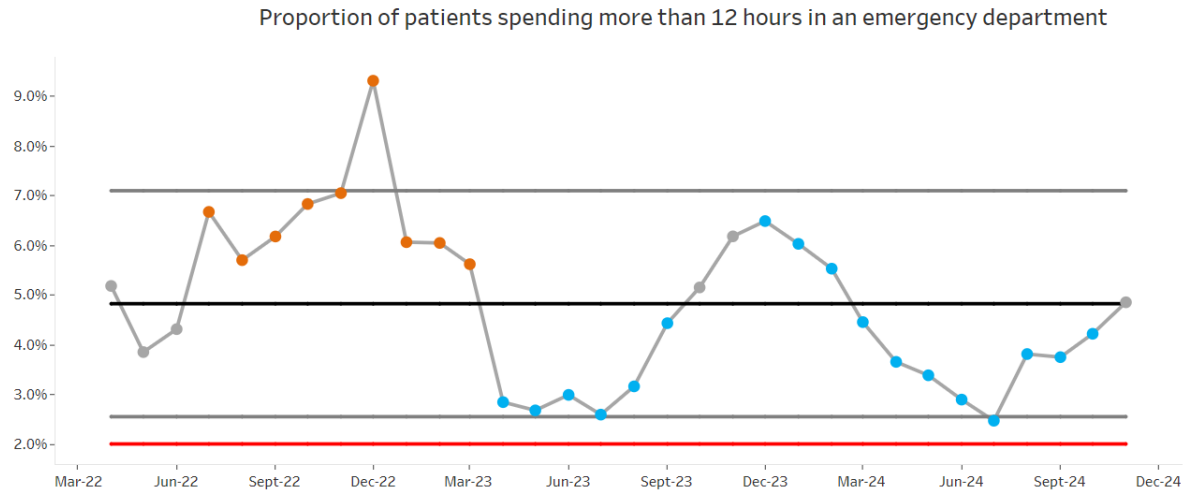


Benchmarking: ED (All types): November 24				
OUH: 68.8%	**National: 70.5%**	**Shelford: 69.7%**	BHT: 68.1%	RBH: 69.9%

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

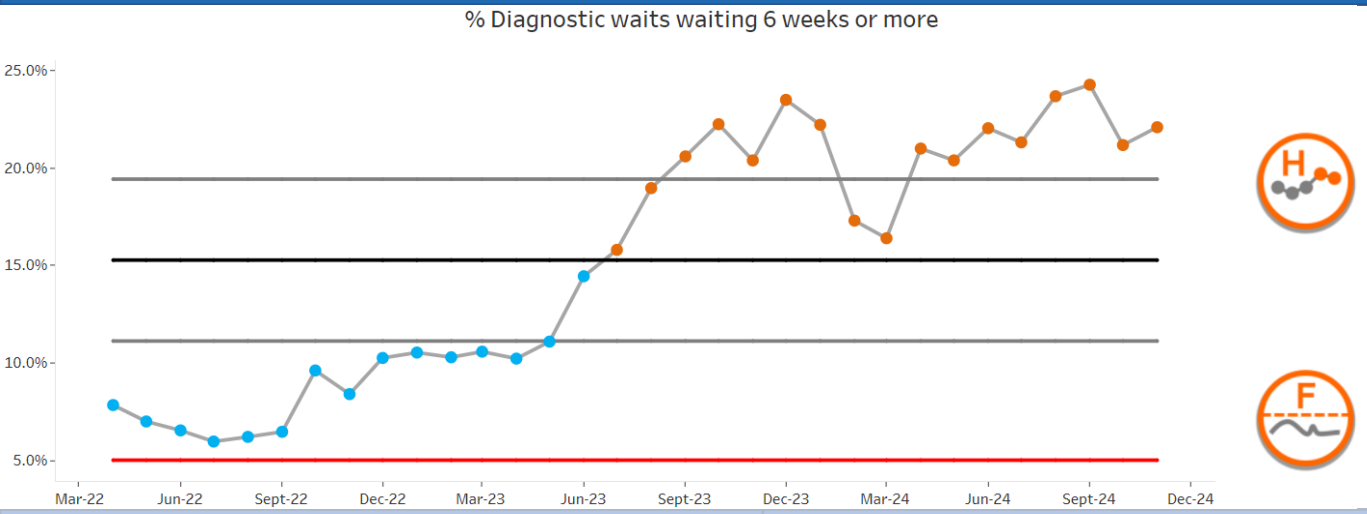
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The Emergency Department 4hr performance for all types was 68.82% in November for the Trust overall. Whilst a deterioration from the previous month, performance remains above trajectory. Type 1 performance was 59.6% for the Trust overall. Breach performance by site was 61.86% for all types and 52.50% for Type 1 at the John Radcliffe Hospital (JR), and 84.08% for all types and 68.37% for Type 1 at the Horton Hospital in November. Monthly attendances to ED remained very high and for November was the second highest monthly attendances for the last three years and only slightly reduced from the previous month. The increase in attendances remains predominantly in adults, to the John Radcliffe site. 'Wait to be seen' continues to be the most significant breach reason on both sites for admitted and non-admitted patients attributing to 63% of all 4-hour breaches in November 2024. 75% of non-admitted breaches were due to wait to be seen which has been slowly increasing. ED Consultant recruitment is underway to support provision of 24/7 senior decision makers within the JR Emergency Department. As a result of challenges with nurse staffing, and the rota gaps for senior decision makers 24/7 the use of ORU has declined in October. Utilisation has dropped from 75% in the summer months to 57% in October. This has therefore been an area of focus through November and December. Updated utilization figures are currently awaited.	**Senior Medical Decision Maker (Consultant) in the JR ED in the overnight period.** • ED workforce models – supported by Trust Management Executive. Consultation complete with existing recruitment underway. • One overnight shift per week covered in October 2024 and increased to 2 nights in November 2024. In addition, there are now 3 Consultants on duty until midnight. The Urgent and Emergency Care Quality Improvement Programme 2024/25 has been approved by Trust Wide Urgent Care Group and TME. Five key national priorities have been agreed, with the Senior Decision Maker and Rapid Assessment & Treatment / Childrens Urgent Care Pathway priorities having commenced in October. This will have a specific focus on Type 1 performance. The two working groups will launch first with key stakeholders from multidisciplinary teams collaboratively working together to agree aims, performance / productivity metrics and change ideas using QI methodology. The ideas for change will form part of the overall workplan and updates will be provided to the Trust Wide Urgent Care Group every three weeks. The other three working groups will commence in early 2025 with the ability to adapt them to emerging guidance and ensure review of current priorities. Ad-hoc QI support is being provided to other QI initiatives within the Divisions. This will allow scale and spread of improvement at pace with trained QI staff within Divisions being involved and leading improvement initiatives. ORU Working group – QI actions in place and Senior Decision Maker 24/7 cover	Completed - Recruitment approach underway through 2024/25 Quarter 3 & 4 2024/25 TWUCG Quarter 3 & 4	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 relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The proportion of patients with a length of stay of more than 12 hours in the Emergency Department was 4.81% (815 patients) in November. Whilst this is above the target, it is a sustained improvement in performance. The Horton has achieved good performance with this metric with only 1.33% of patients (52 patients) residing in the ED for greater than 12 hours. The JR position was on a par with the previous month at 5.85% in November, 763 patients. The average total length of stay in both ED's increased in November for the fourth consecutive month, in contrast to the steady decline seen this year. Average daily admissions continues to steadily increase month on month. Trust occupancy of General and Acute beds in November increased to similar figures seen in the same period last year to 96.27%. However, SDEC capacity has remained protected and remains a focus of the Trust's Winter Plan. Patients whose discharge was delayed remains a challenge with 7.9% of patients delayed, or 2,592 bed days lost in November. The average number of patients delayed per day was 86 in November. This continues a downward trajectory, along with the average number of days delayed, which was 5.44 days in November. The patients with the longest delays were Oxfordshire patients waiting for pathway 3 or out of county delays. Whilst Discharge To Assess (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 the 5-day average wait for these beds. In contrast generic patients are transferred in under 24hrs. Average length of stay for non-elective patients who are not delayed has steadily reduced each month from 4.2 days in December 2023 to 3.5 days in September. Additionally, 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 is due to launch by January 2025. • Board Round policy relaunched successfully in pilot wards; Trust wide roll-out will be undertaken over the coming months through the Quality Improvement (QI) Standard Work Programme.	Trust Wide Urgent Care Group January 2025 Q3/Q4 2024/25 – 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*



Benchmarking: October 24 DM01	
OUH	21.2%
National	14.5%
Shelford	25.2%
ICS	BHT: 15.7% RBH: 19.1%

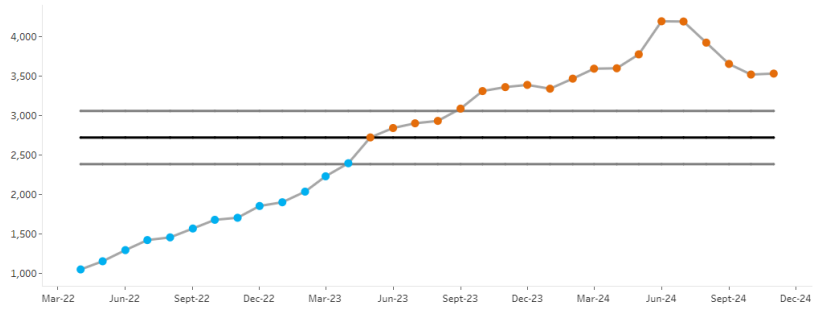
ICS key	
BHT	Buckinghamshire Healthcare NHS Trust
RBH	Royal Berkshire NHS Foundation Trust

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
The percentage of diagnostic waits waiting over 6 weeks+ (DM01) was 22.05% in November. The indicator exhibited special cause variation due to performance being below 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:** • Significant increase in demand and vacancies has driven a deficit (backlog 2,300) with capacity due to ENT pathway change • Clinical vacancy of 1 WTE, will become 2.5 WTE in Jan-25 • Paediatric Audiology now seeing Community Paediatric Audiology **Endoscopy:** • 1 Consultant fixed term contract ends 06/08/24 with expected 6-month gap • 1 Nurse Endoscopist undergoing training • Demand and capacity modelling identified deficit **Ultrasound:** • Demand and capacity challenges for ultrasound examinations due to Sonographer vacancies and increases in demand across a number of areas	**Audiology:** • ERF scheme to procure additional resource started mid-October to address backlog by March 2025, alongside supporting elective recovery (additional 400 patients per month) to address the backlog • AQP in place since September by Northamptonshire ICB • Seeking mutual aid via DMAS to no avail. • Alternative options to be explored following feedback from Business Planning Group. • Community Diagnostic Centre looking into staffing resources. **Endoscopy:** • Surveillance patients included within the DM01 cohort completed • Triaging all referrals for efficient referral management • Training list reviewed and acknowledged • Training for efficient booking processes are in place • ERF for additional activity approved and underway • Weekend lists ongoing although limited uptake over summer holidays • 2 Nurse Endoscopists doing 12-months of training to undertake lists independently • Agreed all consultants to do 12-point lists unless a training list • Insourcing and Mutual Aid options are being considered as part of ERF allocation; mutual aid offered – BOB ICB reviewing the proposal **Ultrasound:** • Additional scanning room secured at Brackley Health Centre providing additional 5 days (100 appointments) a week • Insourcing capacity secured starting in January	Weekly Assurance meeting will monitor all actions on a bi-weekly basis **Audiology:** Expected to recover standard by March 2025 **Endoscopy:** Expected to recover standard by March 2025 **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*

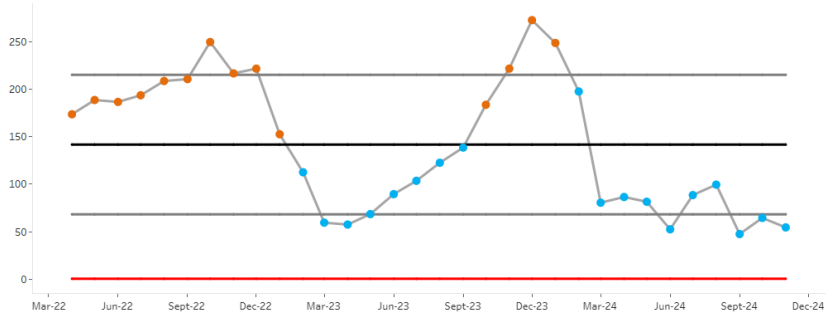
3. Assurance report: Operational Performance, *continued*

Oxford University Hospitals NHS Foundation Trust

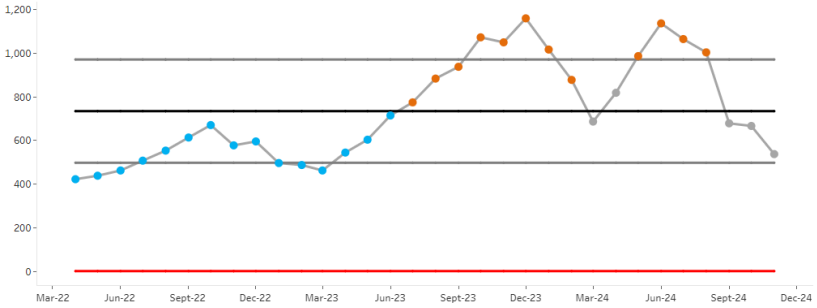
RTT standard: >52-week incomplete pathways



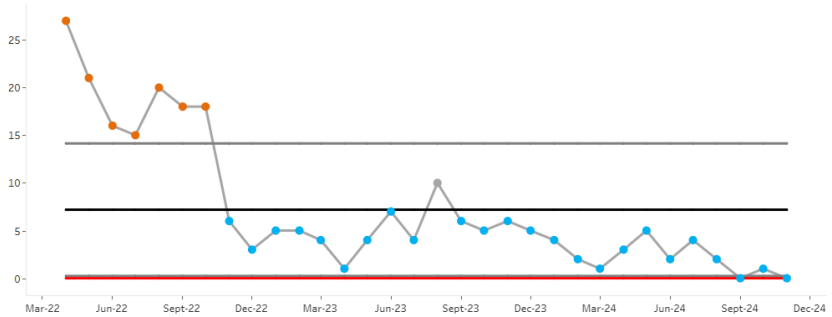
RTT standard: >78-week incomplete pathways



RTT standard: >65-week incomplete pathways



RTT standard: >104-week incomplete pathways

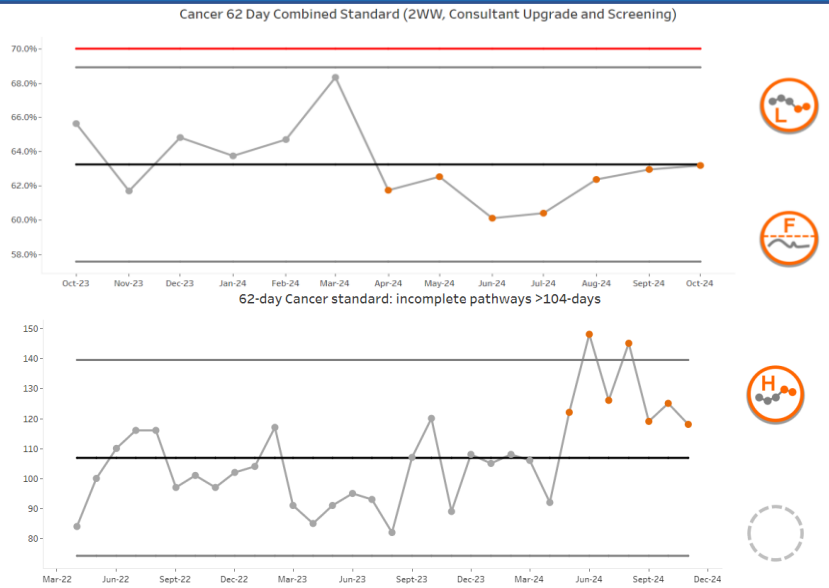


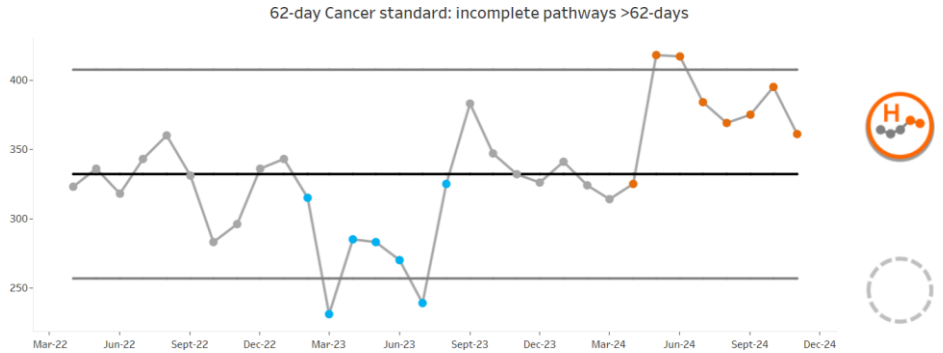
Benchmarking >52-weeks: October 24	
OUH	3,510
National	1,312 (avg.)
Shelford	3,417 (avg.)
ICS	BHT: 1,937 RBH: 12

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
The number of patients waiting more than 52 weeks to start consultant-led treatment was 3,524 at the end of November. Performance exhibited special cause variation due to >six consecutive periods of deteriorating performance above the mean and exceeding the upper process control limit. **104 weeks** - **Nil** incomplete pathway reported **78 weeks** - **54** incomplete pathways of which 35 were due to capacity, 1 due to Patient Choice reportable (C1), 3 Corneal and 15 due to Complex pathways **65 weeks – 536** incomplete pathways reported which is a decrease from the previous month by 129 pathways. Focus remains in place to deliver nil pathways beyond 65-weeks. Services not as challenged are undertaking recovery of **52-week backlog.**	• **Orthopaedic services** contracts/agreements are in place with several Independent Sector Providers and 5x spinal theatre lists converted to orthopaedics in Q4. Hip & Knee Super-Week in Feb. Clinical review of BMI 35+ on waiting list. • **ENT services** now have insourcing in place for Audiology capacity, increased paediatric daycase capacity, contract in place for insourcing clinics and theatres and due to transfer a large cohort of willing patients to BOB partners. • **Urology services** repurpose theatre sessions (TULA) in place and additional gynae lists identified for repurposing to urology. Scoping additional theatre lists to accelerate recovery. • **Non-admitted pathways** increasingly scheduled and either clock stopped or converted to admitted in advance of entering the monthly cohort at risk • **Elective Recovery Fund** schemes live and tracked at Elective Care Recovery Group. • **Patient Engagement Validation** exercise for H2 65-weeks concluded. Commenced contacting 1,646 of undated admitted pathways 1,001 responded (61%), 62 wish to be removed (6.2% of responses). Trialling other cohorts lower down for services such as Dermatology and plan to commence the contact of all 2025/26 1st outpatients undated in Q4 2024/25. and All responses from challenged services will be prioritised for mutual aid with BOB Provider or ISP. • Recovery Action Plan is now live and being populated against specialty level trajectories for delivery of forecast	Delivery of 65-week plan by December 2024 (indicative) All actions are being reviewed and addressed via weekly Assurance meetings and Elective Recovery 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*



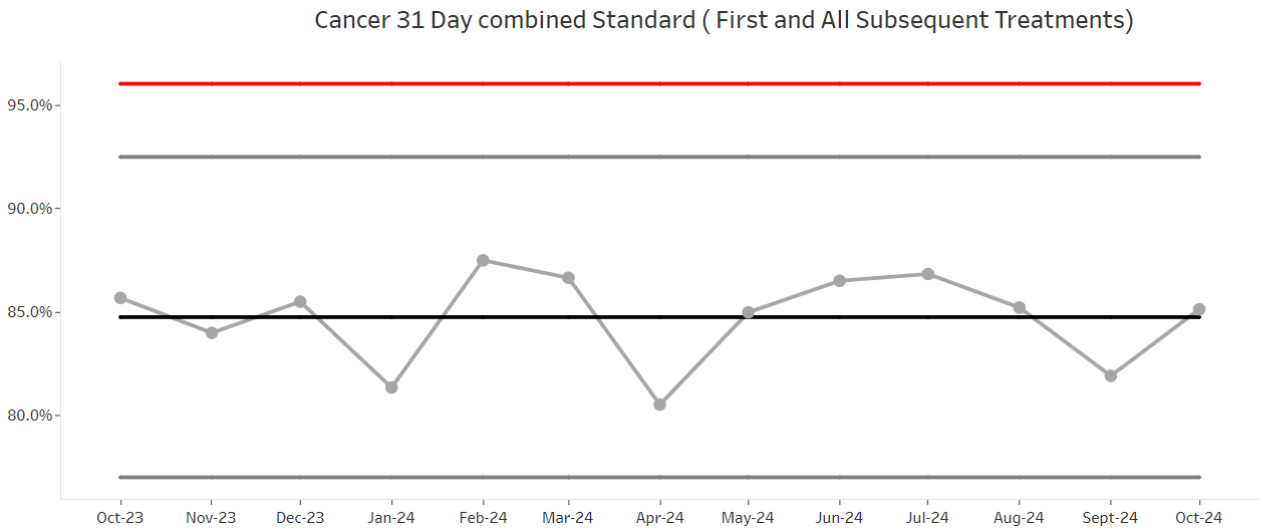


Benchmarking: October 24 62-day General Standard	
OUH	63.2%
National	70.8%
Shelford	63.3%
ICS	BHT: 49.2% RBH: 76.3%

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 63.2% in October 2024, and below the performance target of 85%. Performance is reported one month in arrears due to the extended reporting period for this indicator. All tumour sites apart from Brain, Haematology –Acute Leukaemia, Skin, UGI – Pancreas, and Urology – Testicular are non-compliant for this standard in October. **Challenges identified:** • Complex tertiary level patients (8%) • Some slow pathways and processes (0%) • Capacity for some surgery, diagnostics and oncology (75%) • Late inter provider transfers (15%) • Patient reasons (2%) **>62-day combined PTL as at 15th December 2024*** remains above trajectory of delivering 6% proportion of long waits.	**The Cancer Improvement Programme has been relaunched and now comprises of part Quality Improvement (QI) and the other, Strategy.** Both focus on 28-day Faster Diagnosis Standard (FDS) and other key standards. For October, performance was **77.4%, above the national target of 75% and above year end operational target of 77%.** **Performance of >62-day PTL vs plan –** recovery includes: • 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 **Waiting List Census 21/11/24:** **Urology** remains the highest deficit to plan for >62-days (*110) although seeing a recovery trend – yet remains above trajectory (65). One-stop MRI clinics and additional biopsy clinics in place. Process redesign for Flex without CT report in place. TVCA funding is in use supporting backlog recovery. **Gynae** – holds the second highest volume (44) and are significantly above trajectory (26). New consultant starting 18/01/25 with hysteroscopy in job plan as well as theatres (2 key challenged areas in pathway). Pre-hyster clinic pilot resulted in a 30% diversion rate, decompressing demand on service. Clinical lead oversight of all GA hysteroscopy requests. Clinic slot reallocation of benign to cancer and scheduling from December. **Lung & LGI** – jointly hold the third highest volume (41) which are above their trajectories (30 Lung & 17 LGI). - Lung have additional bronchoscopy capacity identified and mitigating risk of limited scopes. Locum consultant approved until March – Business case in development for sustainable solution. - LGI have been allocated TVCA funds for 100 additional lists/clinics – being worked through to commence in January.	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 (254) with 371 patients (10.5% vs 6% target)	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*

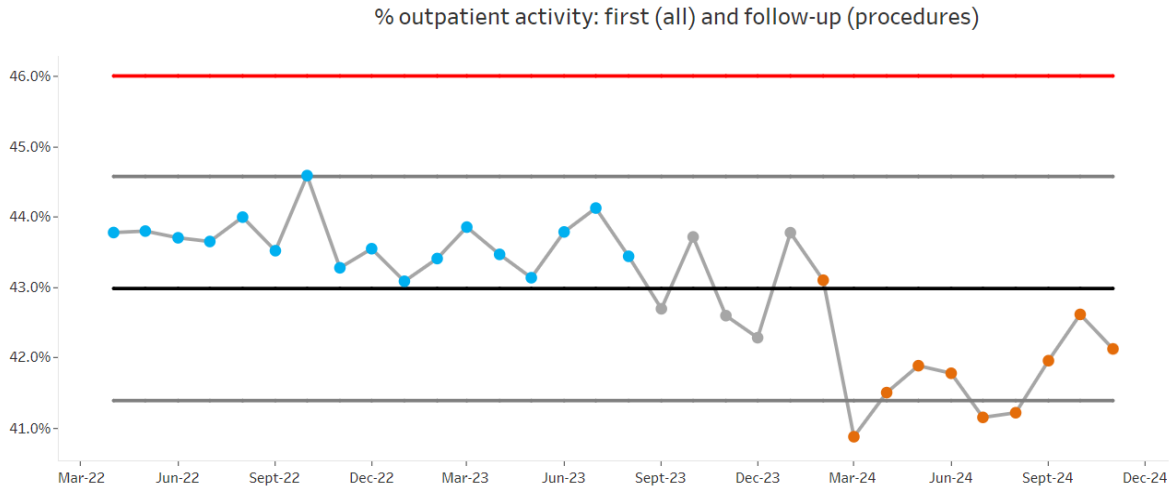


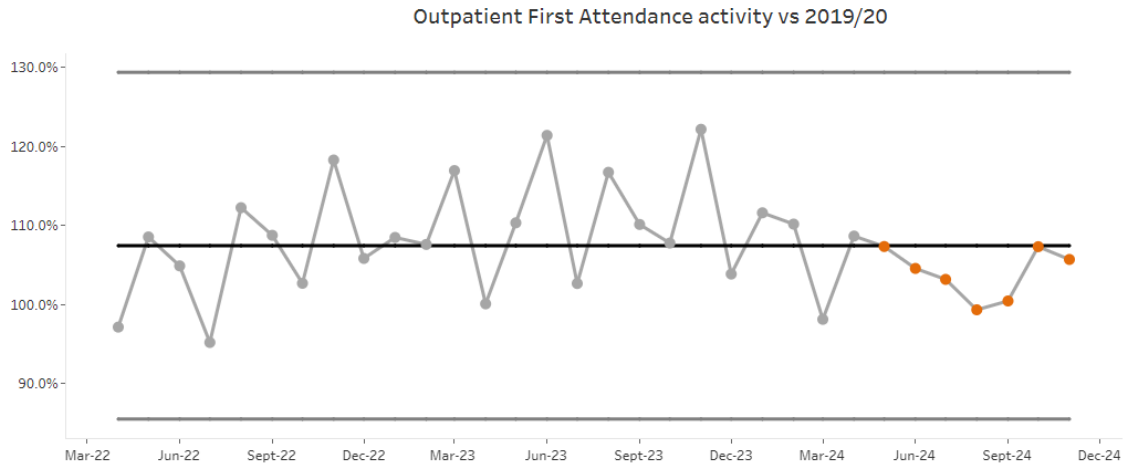
Benchmarking: October 24 31-day General Standard	
OUH	85.1%
National	94.5%
Shelford	86.5%
ICS	BHT: 85.7% RBH: 93.9%

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
Reporting of Cancer Standards changed from October 2023 in line with the National Cancer Waiting Times guidance. Cancer performance against the 31-day combined standard was 85.1% in October, and below the performance target of 96%. Performance is reported one month in arrears due to the extended reporting period for this indicator. Performance in September was 81.9% therefore an improved position. Audits and analysis shows surgery capacity is the key issue affecting performance with over 70% of breaches due to surgery capacity.	Mutual aid for benign general capacity across BOB Partner Providers to support repurposing of OUH capacity. Agreement to run a minimum 96% theatre lists during term time and a minimum of 89% during peak holiday periods throughout the year. Mitigating cancellation reasons and utilisation lists from 6-4-2 process. Prehab service redesign to be taken through Peri-Operative working group for formal steer and support.	Q4 2023/24 Q4 2023/24 staggering into 2024/25 for other specialties not named. Q3 2024/25	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*

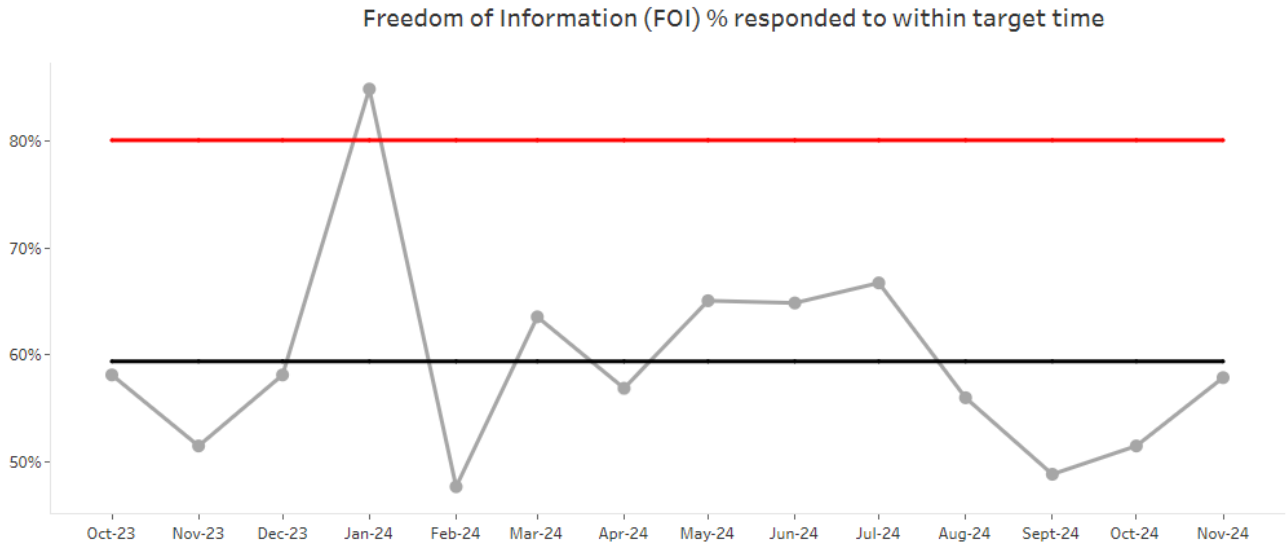
3. Assurance report: Operational Performance, *continued*





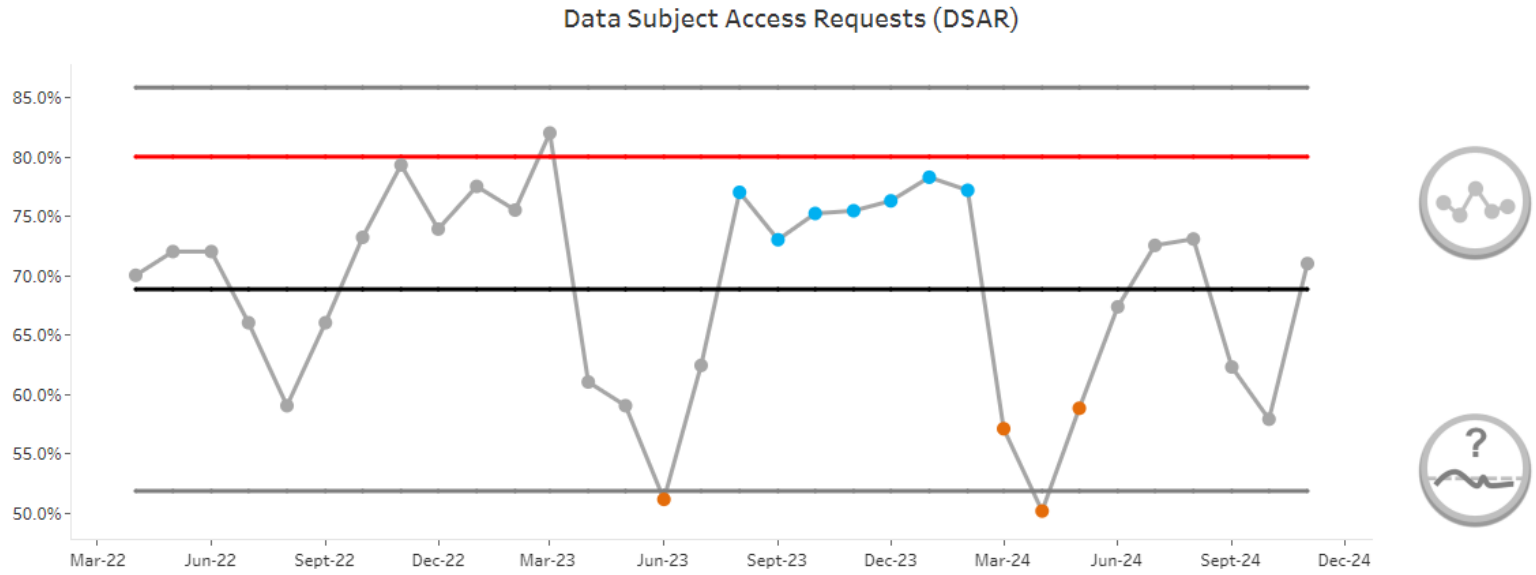
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The percentage of first new outpatient and follow-up outpatient appointments with procedures was 42.1% in November. The indicator exhibited special cause deteriorating variation due to performance being below the lower process control limit. 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 Outcome Form Project Board commenced in December, to digitise clinic outcomes and improve capture of procedure codes as well as several other benefits. Project Board reporting to newly relaunched Outpatient Steering Group and Digital Oversight Committee.	OPSG – December 2024	BAF 4 Link to CRR 1135 (Amber)	

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



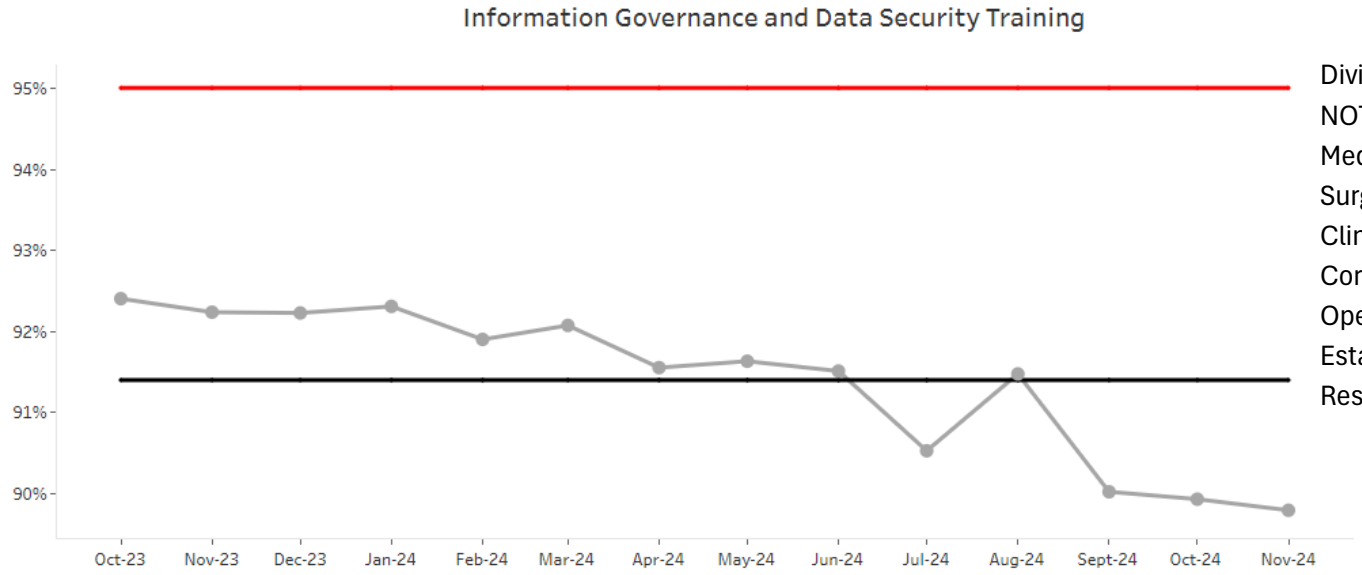
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
M8 FOI performance against the 80% target remained below the performance standard at 5% and exhibited common cause variation. 64 cases were closed in M8 of which 37 were on time – an average number of closures against an elevated number of received cases.	Review of FOI processes is being undertaken in partnership with the Trust's Data Protection Officer, and the Information Commissioner's Office – this has been expanded to include colleagues from the Quality Improvement team and stakeholders from across the Trust.	A QI project to examine the FOI process and awareness amongst staff and stakeholders is under way – a stakeholder engagement meeting to kick this off is being held on 15/01/2025 Assurance reviewed at 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 incident	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
In M8 DSAR performance has recovered to 71% though this is still below the target of 80% Within the main areas responsible for DSAR performance, Occupational Health returned 92% of their 239 requests on time, and Information Governance 50% of their 4 requests. PACS returned 97% of their 219 requests on time, a significant improvement on M7 Subject Access received 541 cases – another record high– closing 278 on time (consistent with performance in recent months) resulting in a 51% on time closure rate. The Trust received 1003 DSAR requests in M8, the second highest figure on record.	PACS' performance varies depending on clinical pressures. They have one staff member on secondment and one vacancy on hold due to recruitment pause. Performance improved this month due to reduced clinical demand. The Subject Access Request team continue to receive a very high number of cases and close a very high number of cases – unfortunately, demand continues to exceed capacity despite an additional staff member being recruited.	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*



Division	Employees Total Number	Heads Outstanding	% Completed
NOTSSCAN	3665	490	86.60%
Medicine Rehabilitation and Cardiac	3329	393	88.20%
Surgery Women and Oncology	3279	374	88.60%
Clinical Support Services	2407	209	91.30%
Corporate	1003	98	90.20%
Operational Services	210	15	92.90%
Estates	194	30	84.50%
Research and Development	158	27	82.90%

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 89.8% in M8 – this is a further fall away from 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.	As part of DSPT compliance an education campaign for IG and cyber security issues has started – reminders and tips to complete IG training are included in a communications plan.	Actions and performance are overseen by the Digital Oversight Committee DSPT Audit has been moved to February 2025 (now confirmed) as NHSE published their guidance late (6th November)	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 incident	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 28/11/2024 users temporarily lost access to multiple systems, including Aria, MedOnc, ScanIT and network shares.	At 14:00 one of the file clusters (which provides access to network shares) became unresponsive. The file cluster was restarted resolving the issue, with access being restored at 16:45. The root cause has yet to be fully established. A ticket has been raised with Microsoft for further investigation.	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*

4. Development indicators

Chief Officer	Domain	Reporting section	Indicator type	Indicator	Comments
COO	Operational Performance	Elective access	National	Cancer: % patients diagnosed at stages 1 and 2	Further information due on the calculation method of this indicator within the National Planning Guidance

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