Oxford University Hospitals
NHS Foundation Trust

Integrated Performance Report

M2 (May data)

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Table of Contents

1 Executive summary — Page 3

2 Key performance indicators within the domains of:
- *Growing Stronger Together*
- *Operational Performance*
- *Quality, Safety and Patient Experience*
- *Finance*
- *Corporate support services, including Digital, Estates, and Assurance*

a) Indicators identified for assurance reporting
b) SPC indicator overview summary
c) SPC key to icons *(NHS England methodology)*

Pages 4 - 8

3 Assurance reports — Pages 9 - 30

4 Development indicators — Page 31

5 Assurance framework model — Page 32

1. Executive summary

Oxford University Hospitals NHS Foundation Trust

Overview

In month 2, OUH performance continued to demonstrate a reduction in staff turnover and the sickness rate. These indicators directly relate to our plans to reduce temporary staffing and associated expenditure. We sustained an improvement for type-1 ED performance, and our Cancer Faster Diagnosis performance remains better than the national standard and amongst the highest performing hospitals nationally. We continue to champion Quality Improvement methodologies to achieve improvements in all standards, and in particular, Cancer 62-day waiters and ED performance, where NHSE have adopted a tiering approach and are scrutinising performance closely via the ICB and the regional NHSE team. Out of the 93 indicators currently measured in the IPR, 23 are reported on in further detail using the standardised assurance templates. This includes indicators not meeting the performance standard or where there has been deteriorating special cause variation.

Quality, Safety and Patient experience

Our Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) rates continue to demonstrate fewer patient deaths than expected. There were zero Never Events declared, and we achieved the target set for VTE risk assessments and the percentage of our Friends and Family Test measuring the positive experience of our patients for inpatients and maternity. We recorded special cause variation improvement in Serious Incidents and Category 2 trust acquired, and Category 1 and above pressure ulcers per 10,000 beddays. We also recorded a significant increase in the number of research studies hosted (non-commercial). Our assurance reports include where we have exceeded the monthly threshold for hospital acquired infections. For C-difficile cases we are aware that from May there are a number of false positives following a change in our assay in February. As a result, all positive cases from this date are being reviewed. We also have assurance templates included for mother's birthed, scheduled bookings, safeguarding compliance, patient complaints, children's safeguarding consultations and our PFI cleaning score at the John Radcliffe.

Growing Stronger Together

Our people-related indicators continue to show strong performance in core skills training, vacancy, turnover, and average time to hire, all performing better than target. Our sickness absence remained above our internal target but improved compared to April. As expected, Appraisal compliance remained below target as the annual window is now open. We are focused on supporting all of our staff receiving their appraisal by the end of the appraisal window in July 2023. Further information is detailed in the assurance templates for these two indicators.

Operational Performance

Patients attending our type-1 emergency departments and being seen within four hours and time spent over 12 hours in the department improved and met the performance trajectory for May. However, we recognise that the long waiting times are an undesirable patient experience and that our improvement trajectory is at risk for June. Actions with progress updates are detailed within the assurance reports and are closely monitored within the Trust Wide Urgent Care Group.

The OUH cancer performance for the Faster Diagnosis standard was better than the national target and national benchmarking places us as the 11th highest performing Trust and the highest amongst Shelford Hospitals. We recorded an increase in some of our longest waiting patients and our actions are included within the assurance reports referencing the Elective Recovery Fund schemes and other targeted initiatives. Tumour site actions are in place to improve cancer performance for patients on a 62-day GP pathway and continue to be reviewed monthly at the Cancer Improvement Programme.

Finance

The M2 reported deficit was £6.7m (£6.5m adjusted run rate). This is due to the inflation linked increase in costs from April, with efficiency projects not yet delivering. Cash was £41.9m. The Trust is reprofiling its financial plan and developing a recovery plan which will need to have an impact from Q2 unlike 2022/23 when measures were implemented from Q3.

Data quality

Since M1 we have updated a number of indicator targets and are planning the criteria for a rolling assessment of data quality ratings for indicators currently listed as 'not yet assured'.

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	• C-diff cases • E-Coli cases • Klebsiella cases • PSAR cases • Reactivated complaints • Scheduled bookings • Safeguarding (adults) training L3 *Not achieving target*	• Serious Incidents Requiring Investigation *Not achieving target* • % of complaints responded to within agreed timescales • Safeguarding (children's) training L1-4 *Not achieving target*	• PFI cleaning score (JR) *Not achieving target*	• Mother's birthed *Not achieving target* • Children's safeguarding activity *No target*
Growing Stronger Together			• Sickness absence (rolling 12-month) *Not achieving target* • Appraisal compliance *Not achieving target*	
Operational performance	• ED 4-hour performance (all and type-1) *Not achieving target*	• Proportion of patients spending more than 12 hours in the Emergency Department *Not achieving target*	• % Diagnostic waits under 6 weeks (DM01) • Cancer 62-day waiting time from urgent referral *Not achieving target* • Patients wating more than 52 weeks *Not achieving target*	
Corporate Support Services		• Data Security and Protection Training compliance *Not achieving target*	• Data Subject Access Requests *Not achieving target*	No SPC • Priority 1 incidents *Not achieving target*

2. b) SPC indicator overview summary

Oxford University Hospitals NHS Foundation Trust

Quality, Safety and Patient Experience Summary

Indicator	Period	Performance	Target	Mean	LCL	UCL
MRSA bacteraemia infection rate COHA and HOHA (per 10,000 beddays)	May-23	0.0	Not set	0.2	-0.5	0.9
MRSA cases: HOHA+COHA	May-23	0	0	0	-1	2
Clostridium difficile infection rate COHA and HOHA (per 10,000 beddays)	May-23	6.4	Not set	3.8	0.2	7.5
C-diff cases: HOHA+COHA	May-23	19	9	11	0	21
E. coli infection rate COHA and HOHA (per 10,000 beddays)	May-23	5.0	Not set	5.3	0.6	10.1
E. Coli cases: HOHA+COHA	May-23	15	13	15	1	29
MSSA cases: HOHA+COHA	May-23	7	Not set	5	0	11
Klebsiella cases: HOHA+COHA	May-23	8	7	8	0	16
PSAR cases: HOHA+COHA	May-23	7	4	4	-4	12
Number of Never Events	May-23	0	Not set	0	Not available	Not available
Serious Incidents Requiring Investigation (SIRI)	May-23	1	Not set	8	-2	18
VTE Risk Assessment (% admitted patients receiving risk assessment)	Apr-23	98.2%	95.0%	97.9%	96.2%	99.6%
CAS alerts breaching deadlines at end of month and/or closed during month beyond deadline	May-23	0	0	0	Not available	Not available
Medication errors causing serious harm	May-23	3	Not set	2	-2	5
Mortality HSMR	May-23	92.4	100.0	93.2	Not available	Not available
Mortality SHMI	May-23	96.0	1.0	26.4	Not available	Not available
Neonatal deaths per 1,000 total live births	May-23	2.0	4.0	3.2	Not available	Not available
Stillbirths per 1,000 total births	May-23	0.0	4.0	2.5	Not available	Not available
National Patient Safety Alerts not completed by deadline	May-23	0	Not set	0	Not available	Not available
Potential under-reporting of patient safety incidents: Patient safety incident reporting rate per 10,000 beddays	Apr-21	0.0	Not set	0.0	Not available	Not available
Inpatients with a learning disability and/or autism per million head of population	Apr-21	0.0	Not set	0.0	Not available	Not available
Inappropriate adult acute mental health placement out -of -area placement bed days	Apr-21	0	Not set	0	Not available	Not available
Number of active clinical research studies hosted	May-23	1384	Not set	1334	1304	1365
Number of active clinical research studies (commercial)	May-23	356	Not set	342	327	357
Number of active clinical research studies (non commercial)	May-23	1028	Not set	992	974	1010
Number of incidents with moderate harm or above per 10,000 beddays	May-23	41.8	Not set	34.0	18.3	49.7
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 2)	May-23	22.8	26.0	29.5	17.9	41.0
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 3 and 4)	May-23	2.0	3.0	2.9	-0.6	6.4
Pressure Ulceration incidents per 10,000 beddays (Present on admission Cat 1+)	May-23	91.7	114.0	118.1	92.5	143.8
Harm from Falls (Moderate and above)	May-23	8	Not set	5	-1	11
Harm from Falls per 10,000 beddays (moderate and above)	May-23	2.7	Not set	1.7	-0.4	3.9

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

Quality, Safety and Patient Experience Summary

Indicator	Period	Performance	Target	Mean	LCL	UCL
Number of complaints	May-23	106	Not set	96	52	139
Number of complaints per 10,000 beddays	May-23	35.5	Not set	34.0	20.1	47.9
% of complaints responded to within agreed timescales	May-23	81.0%	95.0%	67.0%	47.9%	86.0%
Reactivated complaints	May-23	8	1	7	-2	17
Number of RIDDORs	May-23	3	Not set	3	-2	8
Health and Safety related incidents - Assault, Aggression and harassment	May-23	133	Not set	118	54	182
Incident rate of violence and aggression (rate per 10,000 beddays)	May-23	44.5	Not set	41.8	19.6	64.0
FFT inpatient % positive	May-23	95.8%	95.0%	95.0%	93.1%	96.9%
FFT outpatient % positive	May-23	93.8%	95.0%	93.7%	92.2%	95.2%
FFT ED % positive	May-23	82.6%	85.0%	77.9%	69.3%	86.5%
FFT maternity % positive	May-23	90.0%	90.0%	87.4%	61.9%	113.0%
FFT children's % positive	Aug-22	93.9%	Not set	93.6%	87.2%	100.1%
Inpatient FFT (response rate)	May-23	25.8%	Not set	25.9%	22.6%	29.2%
Outpatient FFT (response rate)	May-23	25.9%	Not set	10.9%	6.1%	15.7%
A&E FFT (response rate)	May-23	25.8%	Not set	25.2%	21.9%	28.5%
Maternity FFT (response rate)	May-23	11.1%	Not set	6.7%	2.1%	11.3%
Adult safeguarding activity	May-23	734	Not set	663	458	867
Children's safeguarding activity	May-23	687	Not set	418	269	567
Number of safeguarding consultations initiated by provider (both to internal and external organisations)	May-23	1421	Not set	1080	814	1346
Safeguarding (children) training L1 - L4 compliance	May-23	89.3%	90.0%	82.1%	76.1%	88.1%
Safeguarding (adults) training L3	May-23	0.0%	90.0%	0.0%	0.0%	0.0%
Trust level: CHPPD vs budget	May-23	4.8	Not set	-48.9	-105.6	7.7
Trust level: CHPPD vs required	May-23	-15.7	Not set	-21.9	-43.7	-0.1
Mothers birthed	May-23	600	625	628	553	703
Babies born	May-23	619	Not set	639	562	715
Scheduled Bookings	May-23	704	750	710	563	857
Inductions of labour from iView	May-23	173	Not set	146	105	188
Midwife:birth ratio (1 to X)	May-23	26.4%	28.0%	27.1%	24.1%	30.2%
PFI: % cleaning score by site (average) JR	May-23	77.6%	95.0%	94.3%	86.3%	102.4%
PFI: % cleaning score by site (average) CH	May-23	95.1%	95.0%	94.1%	88.1%	100.0%
PFI: % cleaning score by site (average) NOC	May-23	97.7%	95.0%	97.9%	94.3%	101.4%

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

Oxford University Hospitals NHS Foundation Trust

Growing Stronger Together Summary

Indicator	Period	Performance	Target	Mean	LCL	UCL
Vacancy rate %	May-23	7.0%	7.7%	5.8%	3.2%	8.5%
Turnover rate (rolling 12 months)	May-23	11.1%	12.0%	10.2%	7.0%	13.4%
Sickness absence (rolling 12 months)	May-23	4.2%	3.1%	4.1%	4.0%	4.3%
Appraisal compliance (non medical)	May-23	22.5%	85.0%	66.5%	46.0%	87.0%
Core skills training compliance	May-23	90.5%	85.0%	88.7%	87.5%	89.9%
Time to hire (average days)	May-23	42.4	53.0	52.6	42.0	63.1

Operational Performance Summary

Indicator	Period	Performance	Target	Mean	LCL	UCL
Proportion of ambulance arrivals delayed over 30 minutes	May-23	8.8%	Not set	9.0%	0.8%	17.1%
Ambulance turnaround time > 60 minutes	May-23	0.6%	Not set	1.4%	-0.6%	3.5%
ED 4hr performance - All	May-23	70.3%	76.0%	68.0%	59.8%	76.1%
ED 4hr performance - Type 1	May-23	64.9%	76.0%	62.7%	53.6%	71.8%
Proportion of patients spending more than 12 hours in an emergency department	May-23	3.0%	2.0%	5.4%	2.4%	8.5%
Proportion of patients discharged from hospital to their usual place of residence	May-23	92.4%	Not set	91.8%	90.5%	93.0%
Available virtual ward capacity per 100k head of population	Apr-21	0.0	Not set	0.0	Not available	Not available
Number of virtual ward spaces available	Apr-21	0	Not set	0	Not available	Not available
G&A bed occupancy	May-23	94.8%	Not set	94.8%	92.3%	97.4%
Theatre utilisation (elective)	May-23	88.7%	85.0%	87.6%	83.8%	91.4%
% Diagnostic waits waiting under 6 weeks + (DM01)	May-23	88.9%	95.0%	91.4%	87.7%	95.2%
Total patients waiting more than 52 weeks to start consultant-led treatment	May-23	2717	Not set	1781	1240	2321
Total patients waiting more than 65 weeks to start consultant-led treatment	May-23	609	Not set	858	547	1170
Total patients waiting more than 78 weeks to start consultant-led treatment	May-23	70	0	386	224	549
Total patients waiting more than 104 weeks to start consultant-led treatment	May-23	4	0	33	2	64
62 days Maximum waiting time from urgent referral to treatment of all cancers	Apr-23	61.4%	85.0%	63.2%	52.3%	74.1%
Proportion of patients meeting the faster cancer diagnosis standard	Apr-23	80.9%	75.0%	79.2%	71.1%	87.3%
31-all (new standard)	Apr-21	0.0%	Not set	0.0%	Not available	Not available
Cancer: % patients diagnosed at stages 1 and 2	Apr-21	0.0%	Not set	0.0%	Not available	Not available
62 Day incomplete pathways >62 days	May-23	264	Not set	280	Not available	Not available
62 Day incomplete pathways >104 days	May-23	82	Not set	88	Not available	Not available
Total DC activity undertaken compared with 2019/20 baseline	May-23	92.2%	Not set	87.9%	70.3%	105.4%
Total IP elective activity undertaken compared with 2019/20 baseline	May-23	91.0%	Not set	82.8%	59.3%	106.4%
Total first outpatient activity undertaken compared with 2019/20 baseline	May-23	105.8%	Not set	102.6%	78.0%	127.2%
Total follow up outpatient activity undertaken compared with 2019/20 baseline	May-23	116.7%	Not set	108.2%	80.9%	135.4%
Total diagnostic activity undertaken compared with 2019/20 baseline	May-23	122.1%	Not set	113.0%	96.1%	129.8%
Total patients treated for cancer compared with the same point in 2019/20	May-23	110.8%	Not set	121.9%	86.5%	157.4%

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

Finance Summary

Indicator
Income vs plan Mth
Income vs plan YTD
Pay vs plan YTD
Pay vs plan Mth
Non pay vs plan Mth
Non pay vs plan YTD
ITDA Variance from plan Mth
ITDA Variance from plan YTD
EBITDA £ variance Mth
EBITDA £ variance
EBITDA % Mth
EBITDA % YTD
Financial YTD Surplus/Deficit £
Financial YTD Surplus/Deficit % of turnover
Underlying YTD Surplus/Deficit £
Forecast Surplus/Deficit £
Forecast Risks £
Forecast Opportunities £
Forecast Net of Risks & Opportunities £
Finanicial efficiency - Savings £ MTH
Finanicial efficiency - Savings £ YTD
Financial efficiency - variance from efficiency plan
Finanicial efficiency - Productivity Measures £ YTD
Bank spending (£m)
Agency spending (£m)
Cash (£m)
Cash vs plan
Capital vs plan
Capital expenditure charged to ICS CDEL
Overall level of capital expenditure - Other CDEL
Overall level of capital expenditure - IFRS
Financial stability - variance from break –even
Financial stability - variance from plan –even

NB. Financial performance is included separately to the IPR for M2.

Finance indicators appropriate for the IPR are being agreed and will be included when available.

Corporate support services – Digital Summary

Indicator	Period	Performance	Target	Mean	LCL	UCL
Priority 1 Incidents	May-23	1	0	1	Not available	Not available
Data Security and Protection Training compliance	May-23	93.0%	95.0%	87.3%	83.6%	91.0%
Data Security & Protection Breaches	May-23	26	Not set	25	11	38
Externally reportable ICO incidents	May-23	0	0	0	Not available	Not available
All IG reported incidents	May-23	33	Not set	26	12	40
Freedom of Information (FOI) % responded to within target time	May-23	80.0%	80.0%	65.6%	43.4%	87.7%
Data Subject Access Requests (DSAR)	May-23	59.0%	80.0%	76.6%	60.8%	92.5%

Corporate support services – Legal services Summary

Indicator	Period	Performance	Target	Mean	LCL	UCL
Legal Services: Number of claims	May-23	22	Not set	17	1	33

Corporate support services – Regulatory assurance

Indicator	Period	Performance	Target	Mean	LCL	UCL
CQC overdue actions ('must do')	May-23	0	0	0	Not available	Not available

NB. Indicators with a zero in the current month's performance and no SPC icons are not currently available. See page 23 for more information.

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

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.	

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.

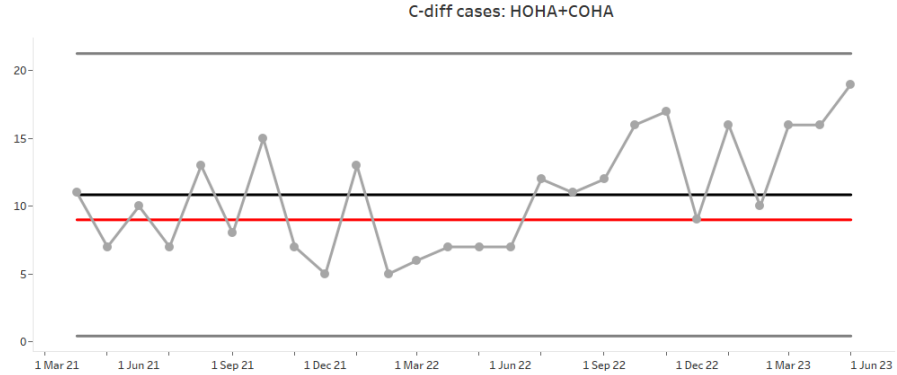
OUH Data Quality indicator

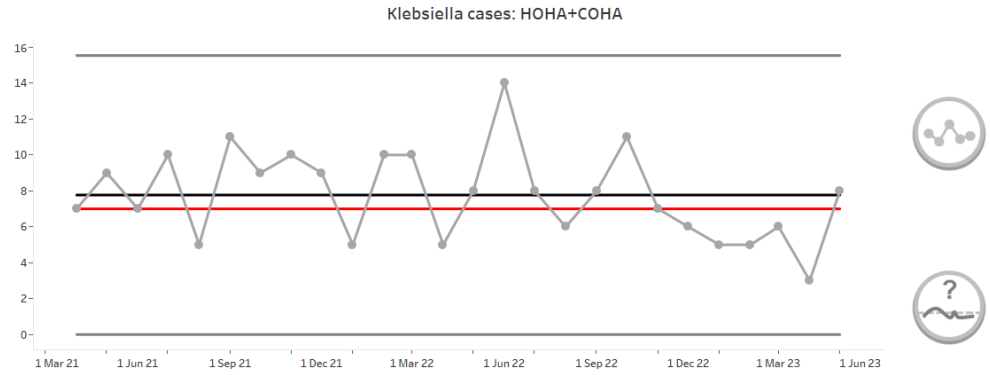
Valid: Information is accurate, complete and reliable	**Timely:** Information is reported up to the period of the IPR or up to the latest position reported externally	**Granular:** Information can be reviewed at the appropriate level to support further analysis and triangulation

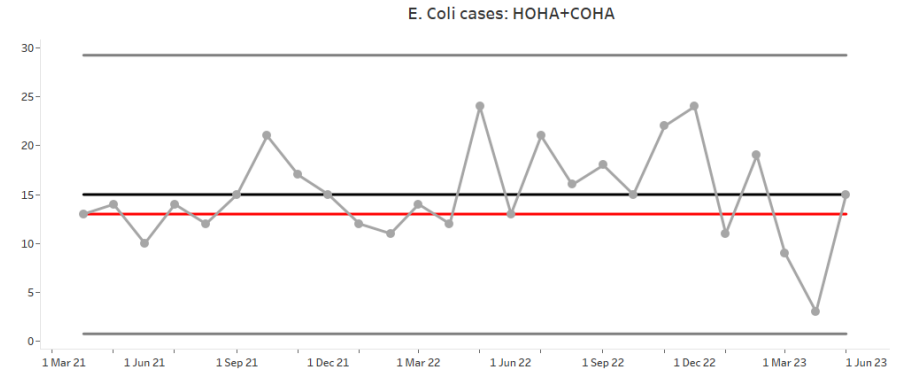
Sufficient	*Insufficient*	*Not yet assured*

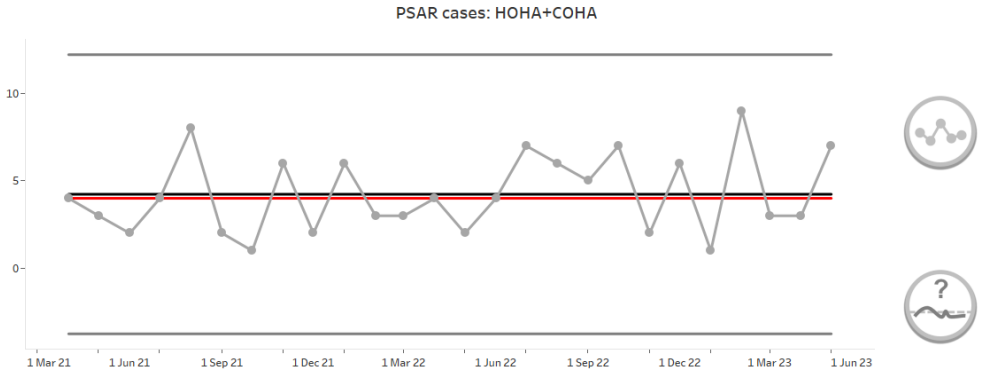
03. Assurance reports

3. Assurance report: Quality, Safety and Patient Experience



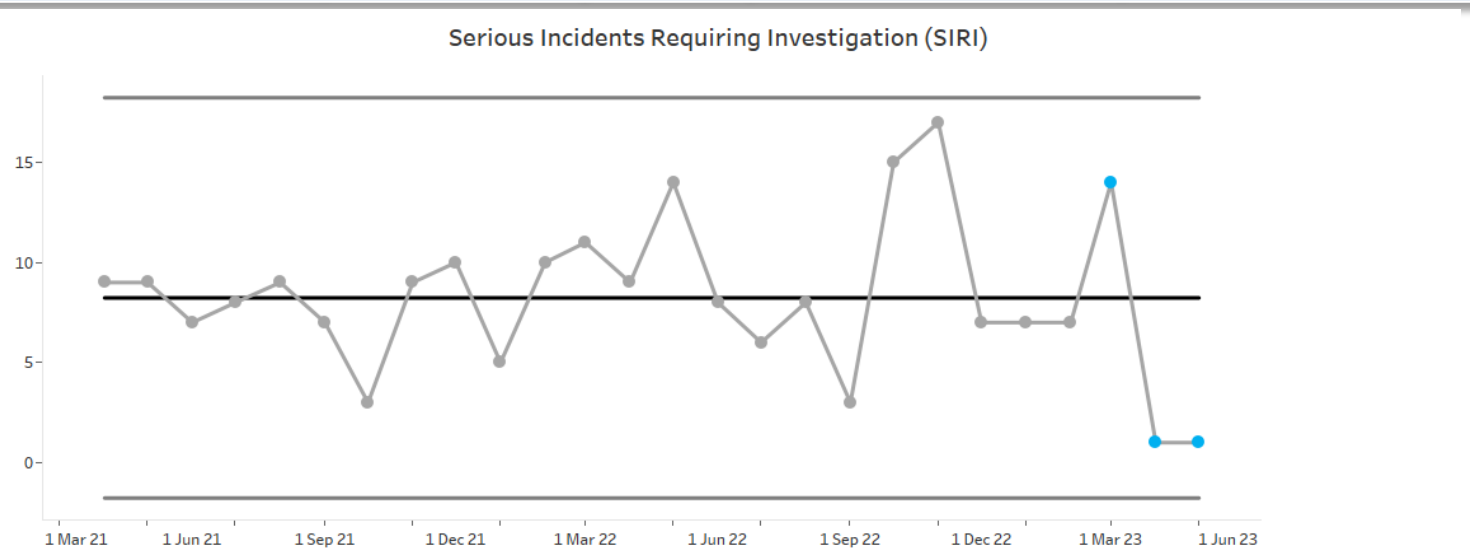






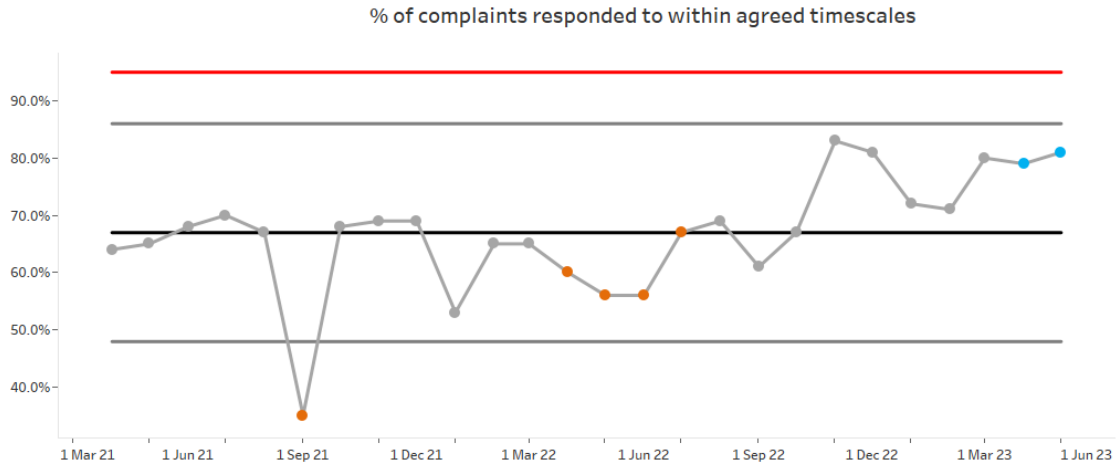
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The number of cases of C-diff, E.Coli, Klebsiella and Pseudomonas all exceeded the monthly threshold in May but exhibited common cause variation. The potential for increase in C-diff cases to be related to false positives has emerged and was under investigation.	An unexplained increase in the number of C.diff cases has been observed since March 2023. Further testing with alternative technologies has been undertaken, which has demonstrated a significant false positive rate in the subset of samples re-tested. This has been reported via the Ulysses system and reported to the MHRA. Trajectory for Klebsiella for the year is 86 cases, at 16 cases end of May, only 2 cases above this at present. Similarly, with E.coli, trajectory of 153 cases, currently 4 cases over cumulative monthly limit with total of 29 cases. No themes identified in RCAs.	Confirmatory testing of any new positive results is in place from 26th June.	BAF 4	*Not yet assured*

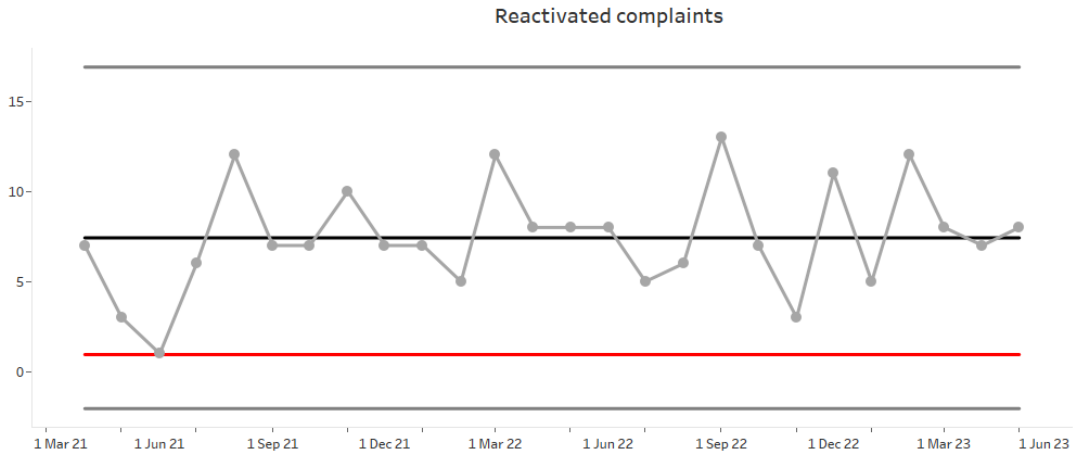
3. Assurance report: Quality, Safety and Patient Experience, *continued*



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
There was one Serious Incident Requiring Investigation (SIRI) reported against a target of zero. Due to the low volume of incidents SPC has not been applied to this indicator. The most significant landmark to note is that the default declaring all major impact incidents as a SIRIs ceased in April 2023 following a review of previous incidents. A comparison of incident numbers for March – June is demonstrated in the table below: **Month / Total incidents reported / Incidents covered by SIRI forum / SIRI declared / Divisional investigation / Local investigation** June: 3391 / 134 / 4 / 3 / 134 May: 3185 / 123 / 1 / 4 / 118 April: 2958 / 76 / 1 / 4 / 71 March: 3465 / 154 / 11 / 1 / 141 To compare this to November 2022 where there was a spike of 17 SIRIs, 8 of these were major impact all of which were default SIRIs, and 4 have been reclassified since which is not reflected on the graph as the graph does not consider reclassifications from SIRI.	No specific reason can be found for the decrease in SIRIs being declared in April and May but 4 have been declared in June which is closer to the mean. The mean will also fall because of the change in default declaring of major impact incidents as SIRIs. It should be noted that as part of preparation for the introduction of PSIRF in Autumn 2023 different types of investigations such as After Action Reviews (AARs) are currently being trialled and assessed. 32 AARs have so far been completed (parts 1 and 2) with completed AARs being taken through the Serious Incident Group. Several iterations of the AAR form has taken place with feedback from stakeholders. Assurance can be given that the same robust governance processes and external scrutiny are occurring.	SIRI Forum/Serious Incident Group (SIG) report to Patient Safety & Effectiveness (PSEC) a subcommittee of Clinical Governance Committee (CGC) SIRI/Never Event Report presented bimonthly to CGC.	BAF 4 CRR 1122	*Not yet assured*

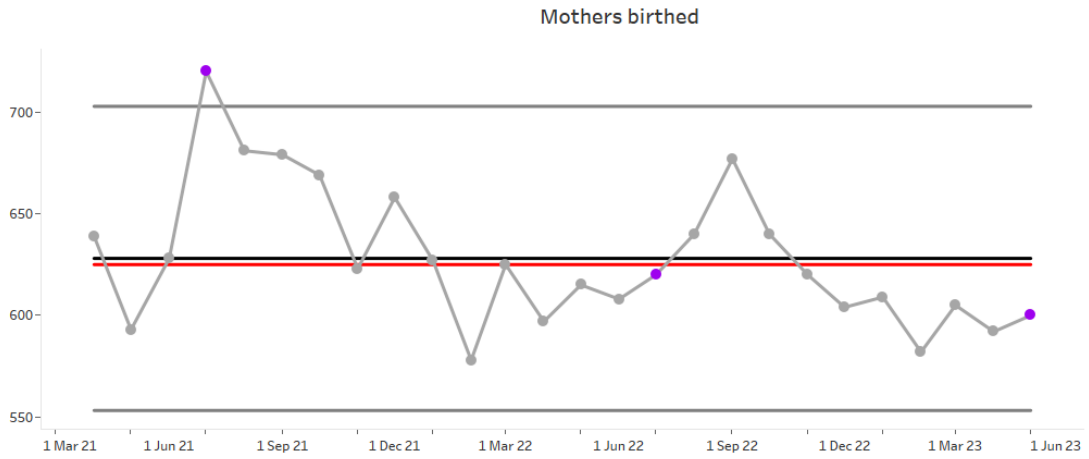
3. Assurance report: Quality, Safety and Patient Experience, *continued*

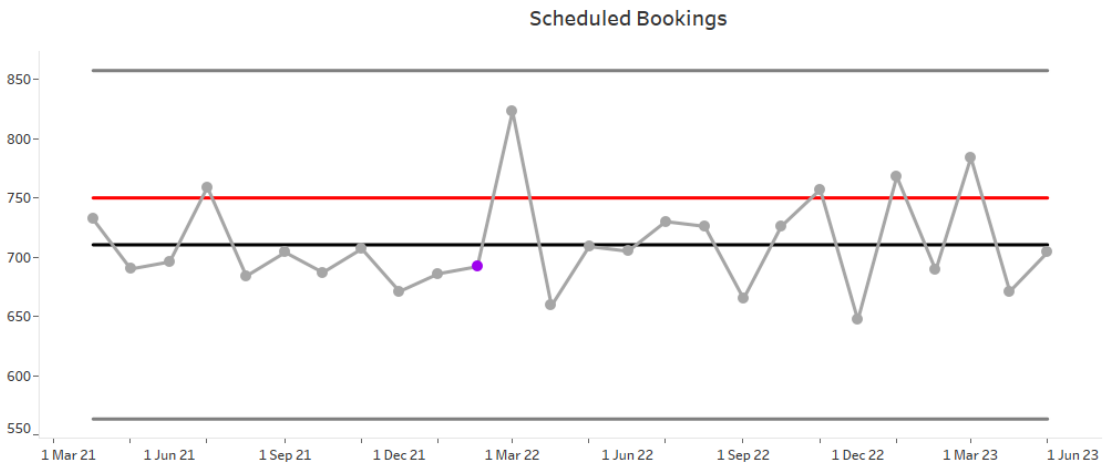




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
In May 2023, 81.0% of complaints were responded to within 40 days, below the target of 95%. The indicator has consistently not achieved the target. However, May's performance exhibited improving special cause variation with over six months' performance above the mean of 67.0%. Reactivated complaints exhibited common cause variation but was above the target value of one reactivated complaint per month. The Trust saw a 13 percent increase in formal complaints in 2022/23, at a time of increased patient activity and national strike action. This has meant that complaints are not always responded to in the required timescale due to the pressures on the clinical and management teams.	Complaints about to breach response deadline given more focus by Divisional management teams, to try and prevent breach. Weekly meetings held with Divisions to review complaints that have either breached or will breach 25 working days. Divisional Management teams, in conjunction with Complaints team, will chase where the complaint is in the system and support that member of staff/team to ensure it is addressed as soon as possible. Themes and trends of complaints discussed weekly in ICCSIS meeting and raised in SIG / SIRI forum to raise awareness of issues being reported. A review of the systems and processes for complaints is in the initial planning stages, the output from this will be presented to Trust Management Executive at the end of September 2023.	Ongoing, reviewed weekly	BAF 4	*Not yet assured*

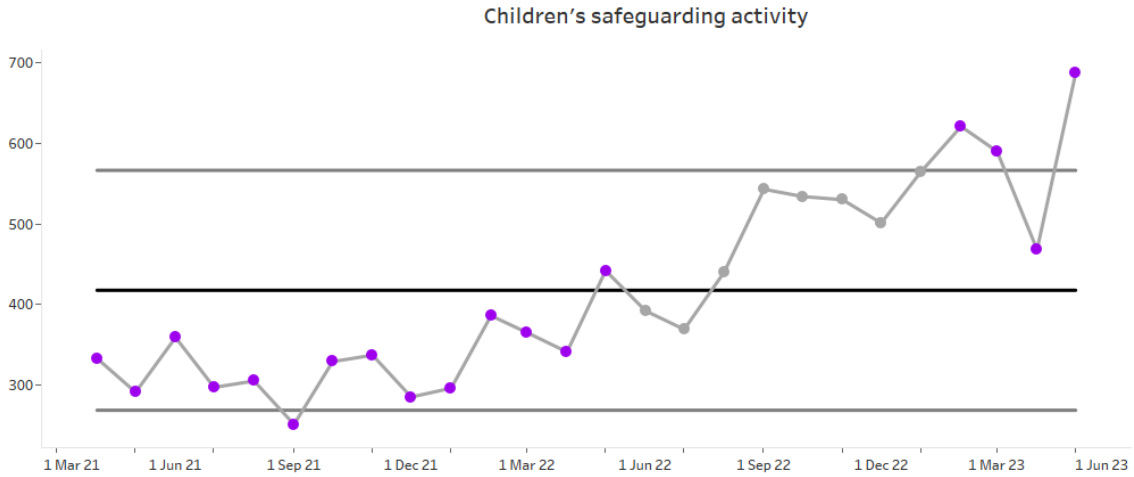
3. Assurance report: Quality, Safety and Patient Experience, *continued*

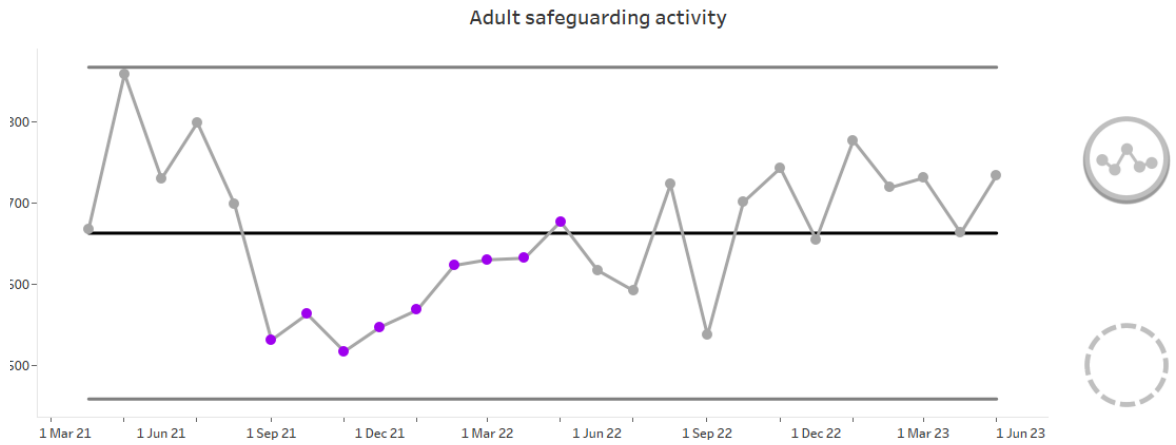




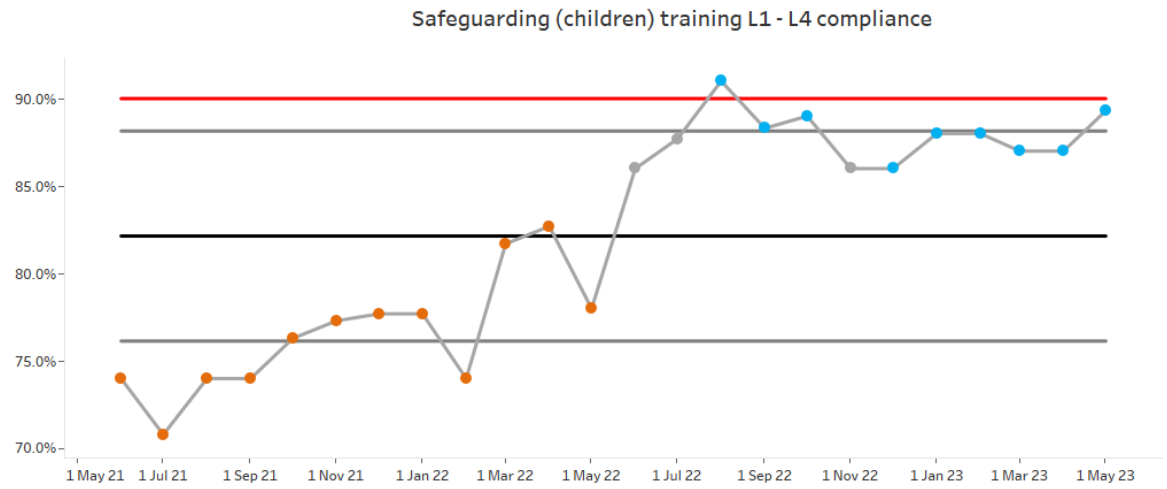
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The number of Mothers birthed exhibited special cause variation due to seven consecutive points below the average. Additionally, the number of Mothers birthed was below the target of 625. The related indicator of babies born also exhibited special cause variation (chart not shown). The number of scheduled bookings exhibited common cause variation and was similar to the average (704 vs 710) but lower than the target of 750. This is seasonal variation which is not reflected in the target.	We have seen a reduction in our birthrate which is aligned to the national trend. However, our birthrate plus data and our latest analysis undertaken in February 2023 continues to indicate that the acuity of our mothers and babies is higher than the national average. The upward trend in acuity supports our safe midwifery staffing review and the business case for the recommended uplift.	Business case to support recommendations in progress.	BAF 4	*Not yet assured*

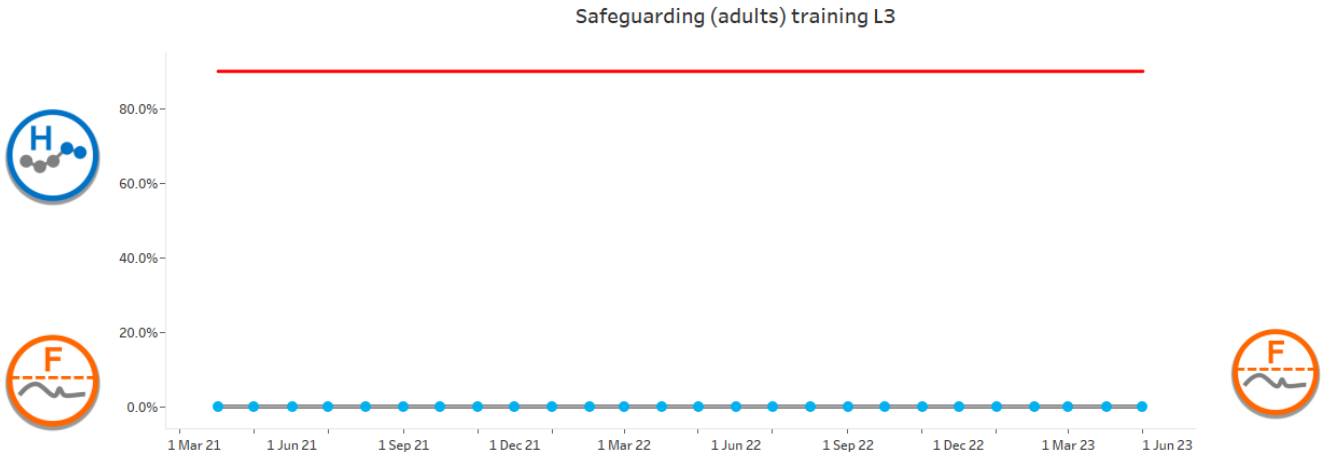
3. Assurance report: Quality, Safety and Patient Experience, *continued*





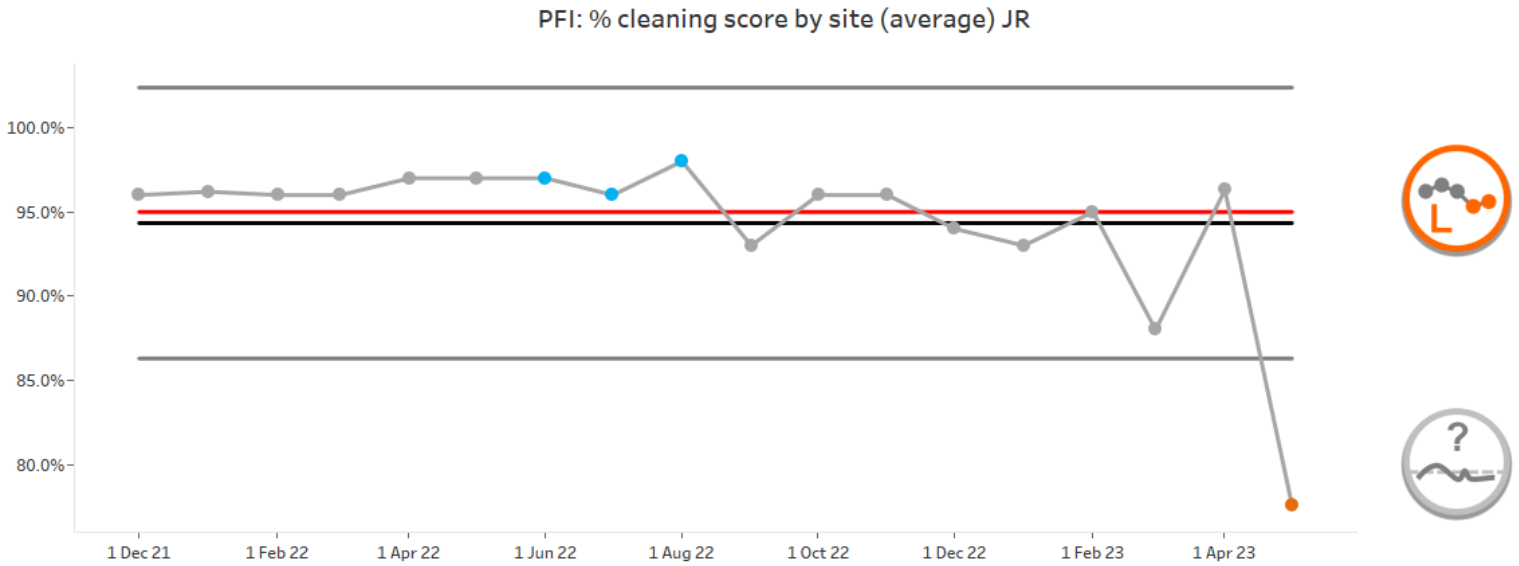
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Safeguarding activity continues to exhibit special cause variation due to consecutive periods recorded above the mean of 418 consultations, and in May the number breached the upper control limit of 567 consultations. Adult safeguarding exhibited common cause variation. Admin recruitment to manage the level of information request due to long term sickness, vacancies and unable to recruit. DoLS request in May dropped by 15 (n=47). Mental Capacity Act (MCA) training remains at 76% below the 85% KPI.	In May children safeguarding activity increased by 219 contact (n=468) and adult safeguarding activity increased by 71 (n=7345). Complexity continues across adults, children and maternity and themes are domestic abuse, mental health, discharge issues and delays in discharge. NHSP admin continues support team processing information shares adding pressure on the safeguarding budget. Information shares for the safeguarding liaison service increased by 186 (n=1062). Information request for initial child protection case conferences for 26 children and 3 unborn babies. Capacity for safeguarding walk arounds has dropped due to increase in case requests for advice and support. Staff being encouraged to undertake MCA training as part of adult safeguarding compliance.	ICCSIS updated on weekly themes. PSEC monthly assurance report, safeguarding is embedded in divisional governance reports and presented to the Trust clinical governance committee. Safeguarding steering group quarterly. Recruitment and review of admin structure being undertaken to attract a senior administrator to manage service. Awaiting approval. .	BAF 4	*Not yet assured*





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
Level 3 safeguarding children training was below the target of 90% and is currently at 85%. The indicator exhibited special cause improving variation due to exceeding the upper process control limit. Level 3 adult training is not available currently to all staff and mapping is required to move staff from level 2 to level 3.	Training for level 3 children safeguarding is being targeted at maternity and children. Maternity improved to 85% for with a gap of 69 staff. Children is at 85% requiring 122 staff to undertake training. Bespoke days are in place to improve compliance. Training is ready to be rolled out by MLH. The current level 2 included additional modules therefore the current level 2 is comprehensive, and compliance is at 92% (gap of 761) Divisional governance report template being undertaken to ensure all division are aware of safeguarding training gaps.	3 months PSEC monthly assurance report divisional governance reports and presented to the Trust clinical governance committee. Safeguarding steering group quarterly.	BAF 4 CRR 1145	*Not yet assured*

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 May 2023, the PFI % cleaning score by site (average) for the JR was 77.6% and below the 95% target. The indicator exhibited deteriorating special cause variation due to breaching the lower control limit of 86.3% Among 201 audits conducted across 11 locations, 45 failed to obtain a rating of three stars or higher. The decrease in ratings can be attributed mainly to a decline in the clinical cleaning component of the audit, which involves cleaning drip stands, COWS, and PPE dispensers. Furthermore, public areas' scores continued to decline in May, with an average score of 83.35% for Domestic Services. Although isolated incidents caused temporary dips in scores for other identified areas in May, IPC and PFI management have been involved in rectifying the situation and improving overall cleaning standards in June.	In May, the Trust PFI management spent a day observing the ED, Children's ED, and EAU. As a result, Mitie reviewed the resourcing levels to meet the high demand of the areas and the limited time available to clean between patients. Mitie has provided action plans to improve the domestic component of areas with low scores. The Trust PFI management team oversees the implementation of these plans, and domestic supervisors and the Trust PFI team monitor and audit them. The identified concerns with public and circulation spaces have been discussed, and additional joint audits have been undertaken. This has resulted in staff being more vigilant and beginning to improve the standards. IP&C is working closely with ward managers to improve the clinical cleaning element of combined cleaning scores. Currently, no additional support is required as the considered actions are deliverable.	1) Improvement to > 90 % for JR cleaning scores for the month of June 2023. 2) Information cascade - Monitoring will be carried out utilising the Synbiotix 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 Mitie/Trust PFI domestic services meeting, Monthly reporting to HIPCC	BAF 4 CRR 1123	***Not yet assured***

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

Oxford University Hospitals NHS Foundation Trust

Summary of challenges and risks

The dashboard presented on the following three slides triangulates nursing and midwifery quality metrics with CHPPD, (Care Hours Per Patient Day), at inpatient ward level. It is a NHSE mandated requirement for this to be reviewed by Trust Boards each month at a ward level. The coloured sections on the dashboard are to assist review and the following measures in each section below provide assurances of the safety and governance processes around this dashboard of metrics and safe nursing and midwifery staffing at OUHFT:

Nursing and midwifery staffing is reviewed at a Trust level three times daily and staffing has been maintained at Level 2 throughout May 2023.

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

Increased bed capacity has remained open across the divisions in May 2023, along with the additional challenges of increased patient acuity and dependency; particularly mental health patients requiring enhanced level, one to one observation. This has been mitigated by increased high- cost temporary staffing and use of the flexible pool of Registered Nurses and Care Support Workers on the bank. The flexible has also been increased to include Registered Mental Health Nurses on a trial basis for 3 months.

CHPPD, at ward level can be used to address any indicators of ongoing risk to staffing, triangulated with the roster Key Performance Indicators and quality and Human Resource, (HR) metrics, and these are reviewed and addressed each month by the Divisional Directors of Nursing. NOTSSCaN Division are conducting a deep dive into rostering focusing on Annual Leave and net hours that are outside of the rostering KPI (+/- 2%). SuWOn Division have 3 areas outside of the rostering KPI for annual leave, which has now been addressed, along with one ward not achieving the timely publication of the roster.

Action timescales and assurance group or committee	Risk Register (Y/N)	Data quality rating
Overall, no actions for this month. 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	***Not yet assured***

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

Oxford University Hospitals NHS Foundation Trust

May 2023	Care Hours Per Patient Day			Census	Nurse Sensitive Indicators				Maternity Sensitive Indicators						HR				Rostering KPIs				FFT
Ward Name	Actual Overall	Actual vs budget	Actual vs required	Census Compliance (%)	Medication Administration Error or Concerns	Extravasation Incidents	Pressure Ulcers Category 2,3&4	Falls	Delay in induction (PROM or booked IOL)	Medication errors (administration, delay or omission)	Pressure Ulcers	Women readmitted postnatally within 28 days of delivery	Proportion of mothers who initiated breastfeeding	Births where the intended place of birth was changed due to staffing	Revised Vacancy HR Vacs plus LT Sick & Mat Leave (%)	Turnover (%)	Sickness (%)	Maternity (%)	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	11.0	1.1	0.1	100.00%	5	2	1	1							21.6%	13.1%	4.7%	12.5%	Yes	1.3%	7.6	6.8%	96.0%
BIU	7.4	1.3	0.9	100.00%	0	0	0	2							22.4%	8.4%	2.1%	3.2%	Yes	-0.9%	9.6	11.7%	100.0%
HDU/Recovery (NOC)	19.4	1.8	-		1	0	0	0							18.9%	11.7%	3.9%	8.1%	Yes	2.2%	8.1	12.5%	
Head and Neck Blenheim Ward	9.9	2.6	0.2	100.00%	0	0	2	5							19.1%	5.9%	5.0%	0.0%	Yes	-2.9%	8.3	11.6%	100.0%
HH Childrens Ward	15.5	3.6	6.2	100.00%	1	0	0	0							29.9%	29.7%	0.1%	0.0%	Yes	-2.0%	7.6	10.2%	96.1%
HH F Ward	7.9	1.9	0.4	100.00%	1	0	1	3							-2.5%	2.9%	2.7%	3.0%	Yes	4.8%	8.1	15.1%	100.0%
Kamrans Ward	10.0	0.3	0.6	100.00%	2	0	0	0							13.6%	8.6%	4.0%	4.2%	Yes	-1.7%	7.6	9.3%	90.9%
Major Trauma Ward 2A	8.5	2.3	0.6	98.92%	2	0	2	3							4.3%	12.5%	3.0%	2.3%	Yes	-1.4%	8.4	12.4%	100.0%
Melanies Ward	13.1	6.0	1.2	94.62%	4	0	0	2							1.6%	7.2%	0.9%	9.5%	Yes	-1.6%	9.0	5.6%	94.4%
Neonatal Unit	21.6	2.8	-		4	1	0	0							14.9%	5.8%	6.1%	8.0%	Yes	-4.3%	8.3	10.1%	
Neurology - Purple Ward	9.4	0.5	0.5	100.00%	3	0	2	5							6.5%	12.6%	2.1%	3.1%	Yes	3.2%	8.9	15.5%	100.0%
Neurosurgery Blue Ward	11.0	2.1	0.8	100.00%	1	0	2	9							18.8%	8.0%	1.1%	0.0%	Yes	0.6%	7.7	9.1%	84.6%
Neurosurgery Green/IU Ward	10.4	0.7	0.6	100.00%	0	0	0	5							12.0%	3.3%	2.5%	0.0%	Yes	3.5%	8.7	10.0%	87.5%
Neurosurgery Red/HC Ward	12.1	0.9	0.5	100.00%	1	0	3	6							7.4%	1.0%	5.1%	0.0%	Yes	1.2%	8.4	11.6%	100.0%
Paediatric Critical Care	27.4	6.3	-		7	2	1	0							-0.8%	4.8%	3.5%	11.0%	Yes	-1.8%	9.0	7.1%	
Robins Ward	9.8	0.1	2.0	100.00%	4	1	0	0							4.8%	4.7%	1.4%	5.5%	Yes	-2.5%	9.0	10.5%	100.0%
Specialist Surgery I/P Ward	8.4	0.1	0.4	100.00%	4	0	0	5							17.4%	15.2%	2.5%	4.8%	Yes	0.9%	8.6	7.6%	91.2%
Tom's Ward	8.0	1.5	1.5	100.00%	1	1	0	0							12.6%	18.2%	0.4%	3.3%	Yes	2.5%	7.6	9.8%	89.3%
Trauma Ward 3A	8.5	3.8	0.6	98.92%	1	0	2	3							19.3%	0.0%	1.3%	8.1%	Yes	-4.3%	8.3	8.8%	88.2%
Ward 6A - JR	7.4	0.2	0.6	100.00%	4	0	3	4							11.3%	3.9%	5.3%	0.0%	Yes	1.3%	8.3	12.7%	100.0%
Ward E (NOC)	6.5	0.2	1.4	100.00%	1	0	0	1							10.6%	12.6%	9.2%	0.0%	Yes	3.0%	8.3	9.2%	96.2%
Ward F (NOC)	7.2	0.6	0.4	98.92%	2	0	0	2							21.7%	6.1%	4.1%	6.2%	Yes	7.7%	9.0	9.5%	100.0%
WW Neuro ICU	29.6	3.1	-		6	0	3	1							21.0%	9.5%	5.6%	4.5%	Yes	-0.7%	8.4	11.6%	

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

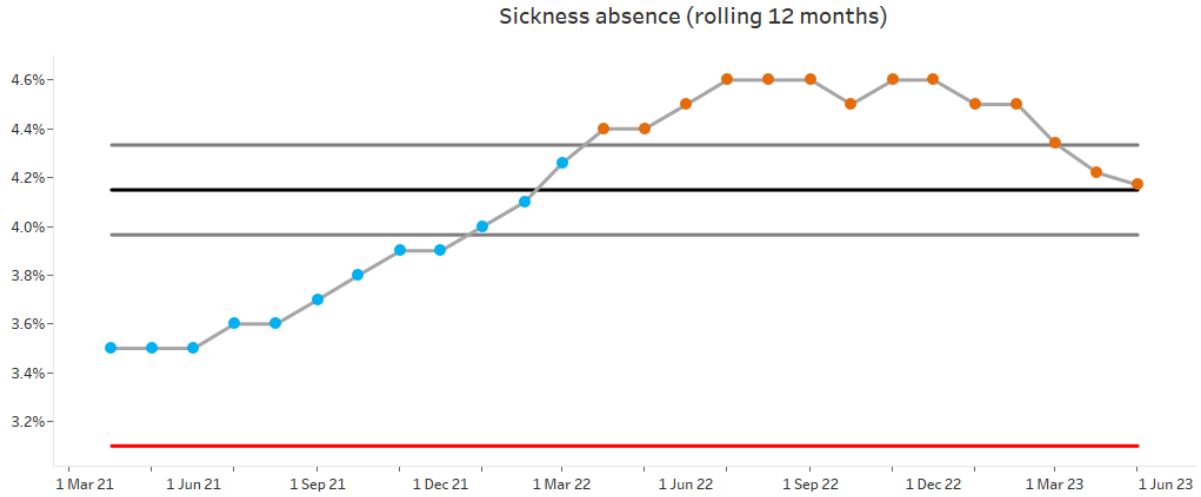
Oxford University Hospitals NHS Foundation Trust

May 2023	Care Hours Per Patient Day			Census	Nurse Sensitive Indicators				Maternity Sensitive Indicators						HR				Rostering KPIs				FFT
Ward Name	Actual Overall	Actual vs budget	Actual vs required	Census Compliance (%)	Medication Administration Error or Concerns	Extravasation Incidents	Pressure Ulcers Category 2,3&4	Falls	Delay in induction (PROM or booked IOL)	Medication errors (administration, delay or omission)	Pressure Ulcers	Women readmitted postnatally within 28 days of delivery	Proportion of mothers who initiated breastfeeding	Births where the intended place of birth was changed due to staffing	Revised Vacancy HR Vacs plus LT Sick & Mat Leave (%)	Turnover (%)	Sickness (%)	Maternity (%)	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	8.6	0.1	-0.4	100.00%	0	0	1	4							21.9%	6.1%	3.8%	9.3%	Yes	-0.6%	8.6	14.3%	100.0%
Ward 5B SSW	8.9	-0.9	0.3	100.00%	0	0	1	4							13.5%	4.9%	2.5%	6.7%	Yes	5.3%	8.6	12.1%	100.0%
Cardiology Ward	7.0	0.7	0.1	97.85%	2	0	1	6							6.9%	10.8%	1.9%	3.8%	Yes	1.7%	7.9	13.2%	86.7%
Cardiothoracic Ward (CTW)	6.2	-1.1	-1.3	100.00%	0	0	1	2							22.0%	10.8%	5.7%	2.6%	Yes	2.5%	7.6	11.3%	96.7%
Complex Medicine Unit A	9.2	1.5	0.4	94.62%	0	0	0	7							23.5%	15.1%	3.7%	3.0%	Yes	1.8%	8.7	13.0%	62.5%
Complex Medicine Unit B	9.6	-0.5	-0.6	98.92%	1	0	1	4							10.1%	0.0%	8.4%	2.7%	Yes	2.0%	8.1	16.5%	100.0%
Complex Medicine Unit C	8.1	-0.8	-2.6	100.00%	0	0	1	2							19.2%	0.0%	2.1%	5.5%	Yes	-0.8%	7.9	12.5%	100.0%
Complex Medicine Unit D	9.5	1.4	0.1	90.32%	0	0	2	1							12.6%	0.0%	4.5%	1.5%	Yes	0.9%	8.1	9.8%	100.0%
CTCCU	30.4	6.9	-		2	0	0	0							17.5%	6.6%	2.1%	3.5%	Yes	0.3%	10.3	12.2%	
Emergency Assessment Unit (EAU)		-	-8.5	50.54%	0	0	0	4							25.9%	3.9%	3.4%	4.1%	Yes	5.1%	7.9	9.3%	
HH CCU	15.9	2.9	-	73.12%	2	0	2	1							4.7%	10.0%	6.0%	0.0%	No	5.6%	5.9	12.7%	
HH EAU		-	-7.5	84.95%	1	0	1	9							10.6%	6.5%	4.2%	5.2%	Yes	0.3%	4.7	14.6%	
HH Emergency Department		-	-		1	0	0	1							20.7%	14.7%	3.1%	6.3%	Yes	0.3%	5.0	9.1%	87.2%
John Warin Ward	10.5	-0.6	1.1	100.00%	1	0	1	5							5.6%	4.8%	2.2%	0.0%	No	2.0%	7.1	13.6%	100.0%
JR Emergency Department		-	-		5	1	0	6							21.6%	12.7%	4.6%	4.6%	Yes	7.4%	10.6	9.4%	79.8%
Juniper Ward	8.3	1.0	-1.5	100.00%	1	0	3	7							15.1%	11.6%	7.0%	0.0%	Yes	-2.2%	5.9	12.0%	50.0%
Laburnum	8.0	0.0	-1.1	100.00%	0	0	3	5							10.1%	8.2%	4.0%	6.0%	Yes	-3.5%	7.9	15.5%	45.5%
OCE Rehabilitation Nursing (NOC)	9.1	-1.6	-1.3	100.00%	1	0	0	0							26.1%	9.0%	5.2%	7.6%	No	1.6%	3.0	11.3%	
Osler Respiratory Unit	12.8	-0.7	2.8	100.00%	0	0	3	0							22.0%	9.0%	6.6%	3.0%	Yes	-0.2%	8.4	12.4%	60.0%
Ward 5E/F	10.6	-0.0	1.9	98.92%	0	0	2	6							26.0%	0.0%	7.1%	4.5%	No	-2.7%	7.6	12.8%	55.6%
Ward 7E Stroke Unit	10.0	-0.8	-0.5	100.00%	1	0	1	4							6.3%	5.0%	3.2%	5.1%	Yes	6.7%	8.7	10.9%	100.0%

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

May 2023	Care Hours Per Patient Day			Census	Nurse Sensitive Indicators				Maternity Sensitive Indicators						HR				Rostering KPIs				FFT
Ward Name	Actual Overall	Actual vs budget	Actual vs required	Census Compliance (%)	Medication Administration Error or Concerns	Extravasation Incidents	Pressure Ulcers Category 2,3&4	Falls	Delay in induction (PROM or booked IOL)	Medication errors (administration, delay or omission)	Pressure Ulcers	Women readmitted postnatally within 28 days of delivery	Proportion of mothers who initiated breastfeeding	Births where the intended place of birth was changed due to staffing	Revised Vacancy HR Vacs plus LT Sick & Mat Leave (%)	Turnover (%)	Sickness (%)	Maternity (%)	Roster manager approved for Payroll	Net Hours 2/-2%	8 week lead time	Annual Leave 12-16%	% Extremely likely or likely
SUWON																							
Gastroenterology (7F)	7.3	0.27	0.28	100.00%	0	0	3	5							9.4%	12.0%	3.4%	3.0%	Yes	-0.3%	7.7	13.6%	90.9%
Gynaecology Ward - JR	8.3	1.25	2.03	100.00%	1	0	0	3							38.4%	8.7%	2.4%	0.0%	Yes	5.5%	9.6	15.8%	75.0%
Haematology Ward	7.9	-1.36	-0.47	96.77%	4	0	1	5							25.2%	5.6%	7.7%	4.8%	Yes	27.3%	4.7	14.0%	100.0%
Katharine House Ward	9.2	0.05	1.69	100.00%	0	0	2	2							6.5%	9.9%	2.9%	4.5%	Yes	6.8%	9.6	16.3%	
Oncology Ward	7.9	-2.52	-0.11	97.85%	1	0	3	7							33.5%	11.3%	2.7%	7.6%	Yes	0.7%	9.0	10.3%	100.0%
Renal Ward	10.5	1.27	0.64	100.00%	1	0	0	6							-10.3%	0.0%	0.7%	3.1%	Yes	-0.7%	7.9	11.3%	100.0%
SEU D Side	8.3	-0.37	0.46	100.00%	5	1	0	2							13.7%	5.9%	5.0%	0.0%	Yes	0.4%	8.4	11.7%	95.0%
SEU E Side	8.9	0.51	-0.68	100.00%	0	0	1	0							16.2%	21.2%	1.7%	3.4%	Yes	-0.9%	8.3	12.4%	90.0%
SEU F Side	7.5	0.50	-0.37	100.00%	2	0	0	2							22.3%	13.4%	5.0%	5.9%	Yes	2.2%	8.3	6.6%	93.8%
Sobell House - Inpatients	8.2	-0.45	0.40	98.92%	1	0	6	3							28.6%	8.1%	5.0%	3.2%	Yes	1.2%	8.6	10.6%	
Transplant Ward	10.6	1.18	2.05	100.00%	1	0	1	0							34.1%	13.0%	4.5%	9.2%	Yes	4.6%	9.0	9.8%	100.0%
Upper GI Ward	8.5	-1.74	-0.09	95.70%	2	0	1	6							19.9%	1.2%	4.2%	2.9%	Yes	1.6%	8.6	12.2%	100.0%
Urology Inpatients	8.4	-0.37	-0.68	100.00%	0	0	2	2							42.5%	8.8%	0.5%	9.2%	Yes	1.8%	8.4	10.5%	97.3%
Wytham Ward	7.3	-1.09	-0.21	97.85%	2	0	0	2							10.3%	22.3%	1.7%	0.0%	Yes	-2.9%	8.6	9.0%	100.0%
MW The Spires	20.3	-7.21	-		0	0	0	0											Yes	-0.2%	5.7	12.2%	
MW Delivery Suite	19.4	4.24	-		1	0	0	0											Yes	-1.2%	5.9	10.4%	
MW Level 5	5.2	-0.44	-		4	0	0	0	93	15	1	12	82.0%	2	3.9%	13.3%	4.2%	5.3%	Yes	2.5%	5.4	11.6%	
MW Level 6	7.4	2.96	-		1	0	0	0											Yes	-2.2%	5.3	11.91%	
CSS																							
JR ICU	24.9	-9.9	-		4	0	6	0							31.2%	12.5%	6.7%	6.5%	Yes	-0.8%	771.4%	11.8%	

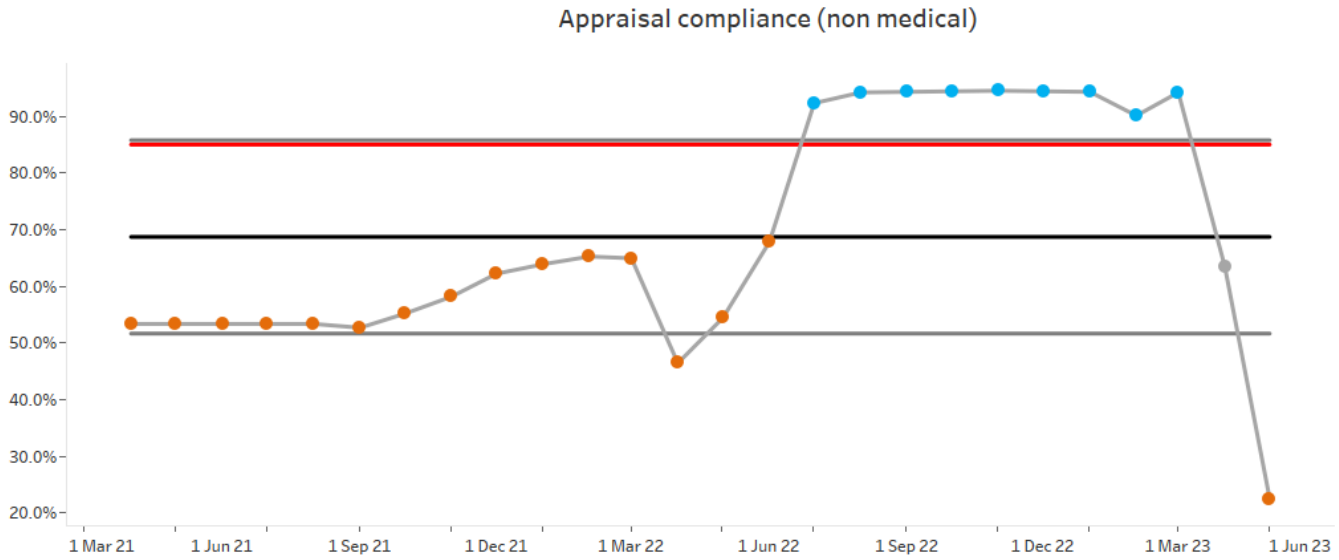
3. Assurance report: Growing Stronger Together



Benchmarking: January 23

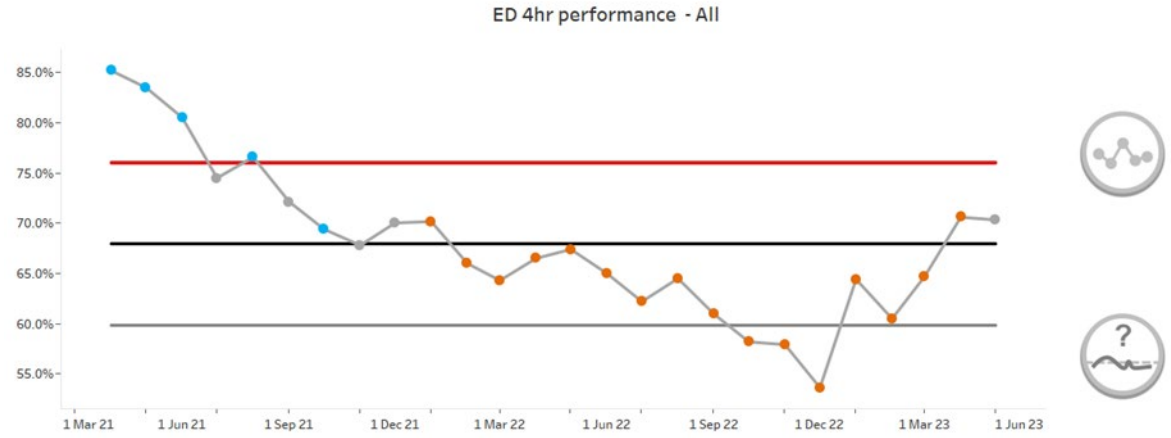
OUH: 4.1% **National:** 5.4% **Shelford:**4.5% Buckinghamshire Healthcare NHS Trust: 4.3% Royal Berkshire NHS Foundation Trust: 3.8% Oxford Health: 4.7% South Central Ambulance Service: 7.6%

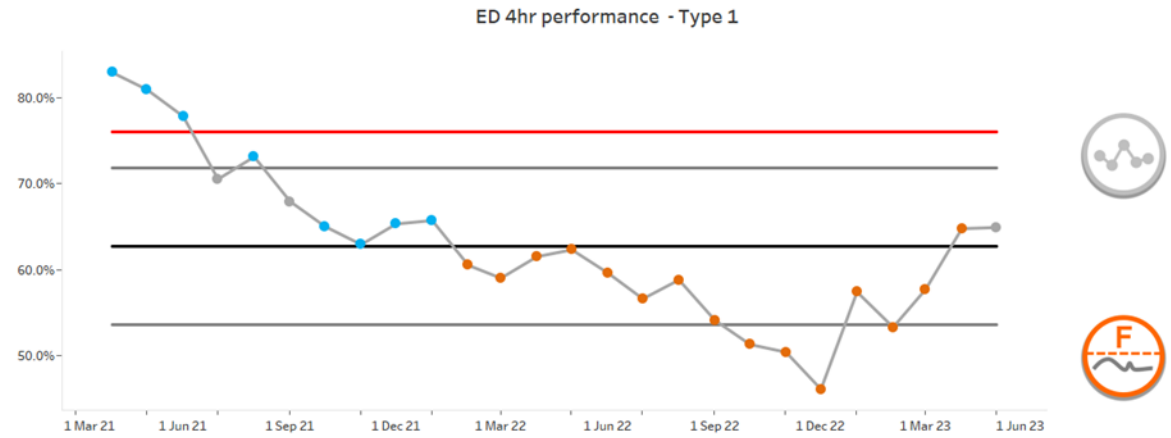
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Sickness absence performance (rolling 12 months) was 4.2% in May. Performance exhibited special cause variation due to successive periods of performance (>6 months) above the mean of 4.1%. The indicator has consistently not achieved the target; however, it is on a downward trend and has reduced every month since the last quarter of 2022/23. Covid sickness has reduced in M2 from 0.8% to 0.7%	1. We are continuing to offer a full range of well-being support including Wellbeing, financial, environmental and psychological 2. RTW (Return to work) compliance and reasons for late RTW interviews are raised at monthly manager meetings. 3. Weekly HR sickness meetings are taking place in areas to ensure consistency in managing and supporting managers. 4. Monthly meetings with Occupational Health are helping to move along long-term sickness cases. 5. We have refreshed our approach to ensure a greater focus and support areas with their case management and RTW *Return to work), as well as improved utilisation of all the absence management information we have relating to sickness 6. Sickness 'hotspot areas' are being identified in the divisions with 'deep dives' taking place into the data to understand the issues and provide targeted support	• Governance - TME via IPR, HR Governance Monthly meeting & Divisional meetings • All actions are ongoing	BAF 1 BAF 2 CRR 1144 (Amber)	*Not yet assured*



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
Appraisal compliance has dropped as expected, as the annual window is now open. The decrease exhibited special cause variation due to falling below the lower process control imit. The data demonstrates non-compliance since the opening of the window on 1st April 2023. Compliance has increased from 6.33% in M1 to 22.53% in M2. There needs to be continued focus on appraisal completion across all areas to ensure compliance by the end of the window.	1. Daily data is being provided to allow areas to identify where they need to focus on in terms of compliance 2. A weekly e-mail is being sent from the CPO containing a leader board which highlights compliance progress by Division 3. Areas are leading on the Appraisal Trajectory to ensure that the necessary compliance is reached 4. Divisions are being advised to record their booked appraisal dates on the system so that the trajectory can accurately demonstrate the expected compliance levels from the current point until the end of the window, and when 85% compliance will be reached 5. Support material and advice is being provided on completing a quality VBA, VBA training dates and examples of EDI objectives to include 6. Work is currently taking place to include compliance for appraisals completed January – March 2023.	• Governance - TME via IPR, HR Governance Monthly meeting & Divisional meetings • All actions are ongoing	BAF 3 Link to CRR 1148 (Amber)	*Not yet assured*

3. Assurance report: Operational Performance



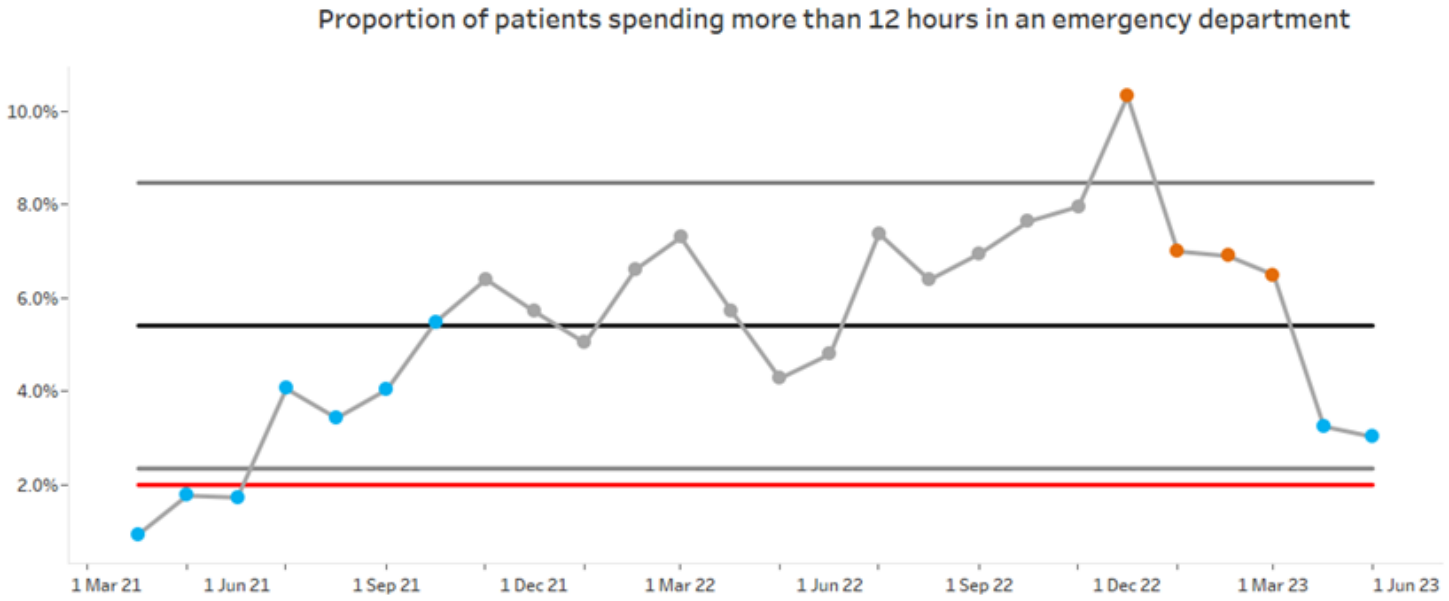


Benchmarking: ED (All types): May 23				
OUH: 70.3%	**National:** 73.3%	**Shelford: 72.4%**	BHT: 68.5%	RBH: 75.6%

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

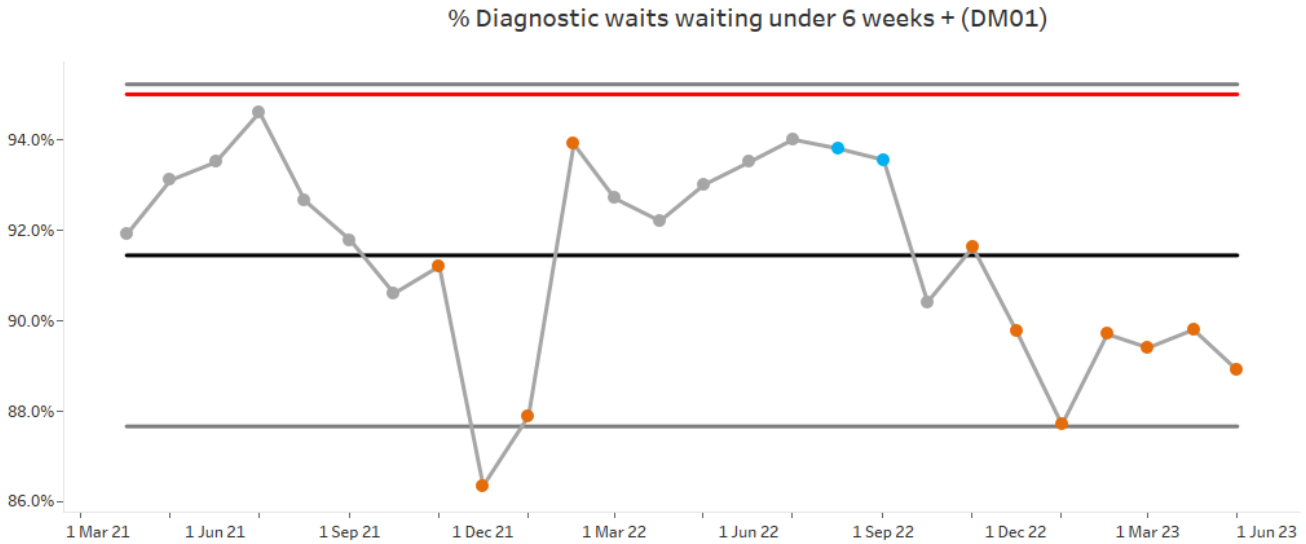
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
ED 4-hour performance (All types) was 70.3% in May and for Type 1 activity, performance was 64.9%. By site, the JR type 1 performance was 59.2% in May and the Horton was 77.7%. For both indicators, performance exhibited common cause variation. The indicators have consistently not achieved the target. Attendances in adults and children had significantly increased in May by 13.5% compared to the previous month and in addition saw the highest attendance rates of the year to date. By site there was a 15% increase at the Horton ED and 10% increase at the JR ED. Higher attendances, acuity and at times, congestion has resulted in challenging periods for both ED's. Wait to be seen continues to be the most significant breach reason for admitted and non-admitted patients (50% of breaches). Recent Industrial Action from the BMA has highlighted how a different medical staffing model can impact on 4hr performance. Occupancy has reduced on both sites from 96.65% at the Horton to 94.02% and 98.16% at the JR to 94.69%, however capacity remains a challenge. Additional capacity remains open and fully utilised on F Ward and CCU at the Horton and 6D escalation 'urgent care' beds, 5B, and Trauma on the JR site. Divisions are now working to substantively recruit to staff this capacity.	**Senior Medical Decision Maker (Consultant) in the JR ED in the evenings.** ○ Pilot conducted during the Consolidated Improvement Cycle with initial positive feedback and early indication of improvement. ○ Metrics: - 4hr breach performance (Type 1) - 12hr LOS performance **Implement 'Clinically Ready to Proceed' (CRtP) functionality on FirstNet.** ○ Initiated during Consolidated Improvement Cycle with learning identified. ○ Data available via UEC Recovery Dashboard ○ Target compliance 70% by the end of Q1 **Departure from ED within 60mins of CRtP** ○ Focus on Non-admitted performance ○ Target performance for non-admitted patients 50% by Q2 **Role review of Nurse in Charge, Consultant in Charge, OSM/Deputy and Ops Manager for ED.** **Urgent and Emergency Care Quality Improvement Programme 2023/24** approved by IAC. Project groups to be established with work programmes developed by June 2023. Clinically Ready to Proceed action is one of three elements of this programme of work.	Quarter 1: On Track Trust Wide Urgent Care Group Quarter 1: On Track Trust Wide Urgent Care Group Quarter 2: On Track Trust Wide Urgent Care Group Quarter 1: On Track 2023/34:On Track Trust wide Urgent Care Group	BAF 4 CRR 1133 (Red)	*Not yet assured*

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 spending more than 12 hours in an emergency department was 3% in May, a sustained improvement from the previous month and was the same on both sites. Performance remained above the target of 2% but below the mean of 5.6% for the first time in ten months. The indicator has consistently not achieved the target but exhibited special cause variation (improvement) due to two out of the last three months recording a value within one sigma from the lower control limit. The improvement was driven by performance on the Horton site where performance improved from 5.1% in March to 3% in April and 2% in May. The JR has consistently remained within 2.2% to 3% over the last three months. Keeping the additional escalation beds open at the Horton on F Ward and on CCU has helped to reduce delays in waiting for beds and improved flow. The wait to be seen in ED continues to be a challenge affecting the total length of stay in ED, particularly at the JR. In addition, patients presenting with mental health related illness have a longer length of stay in the Emergency Department. The maturing of the Transfer of Care Hub has had positive impact in reducing length of stay once medically optimised for discharge and thus reducing beds days for that cohort of patients. In addition, a far greater proportion of patients are now going straight home improving the patient experience and morale of staff. The percentage of patients leaving our hospitals on P0 is 92.35%, and for P1 is 3.385%. Further improvement work and PDSA cycles have been run within HomeFirst allocation and the Transfer Lounge Utilisation has supported greater flow and improved 12 hour performance.	**Departures within 60mins of Decision to Admit** ○ Each Division to identify a speciality to undertake deep dive focused improvement work based on metrics from Consolidated Improvement Cycle ○ Identify improvement percentage per speciality	Quarter 1: On track Trust Wide Urgent Care Group	BAF 4 Link to 1133 (Red)	*Not yet assured*

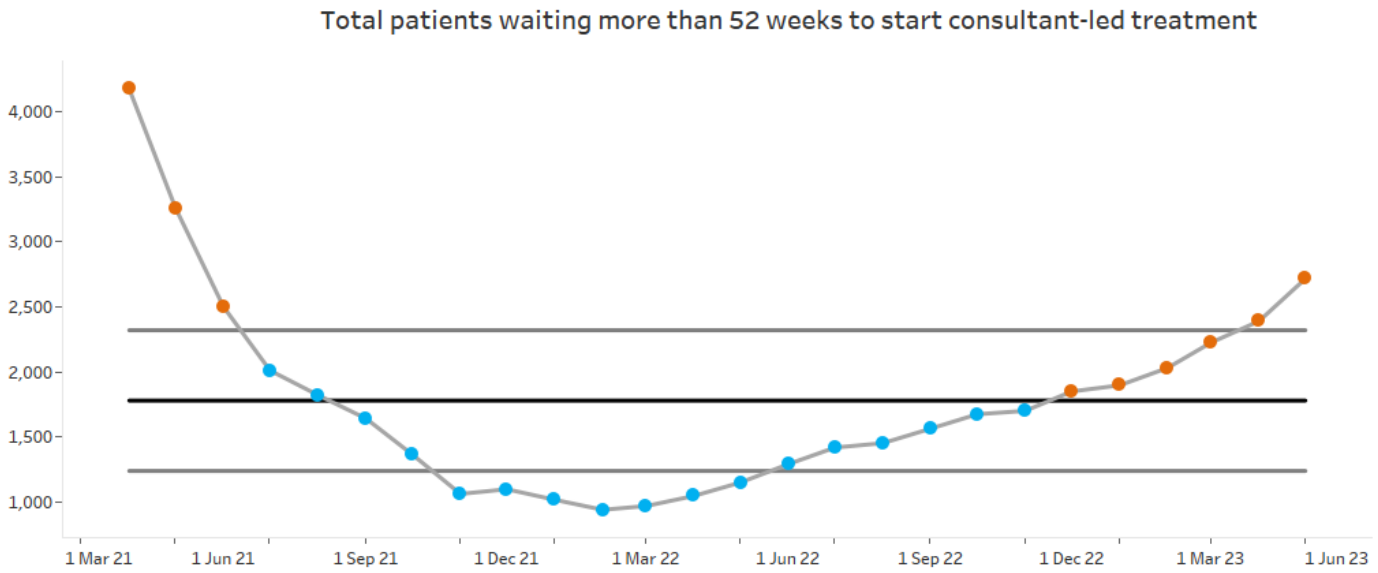
3. Assurance report: Operational Performance, *continued*



Benchmarking: April 23 DM01	
OUH	89.8%
National	77.5%
Shelford	82.7%
ICS	BHT: 49.8% RBH: 70.6%

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 % of Diagnostic waits waiting under 6 weeks+ (DM01) was 88.9% in May. Performance exhibited special cause variation due to the indicator being (> 6 months) below the mean of 91.4% but above the lower process control limit. The indicator has consistently not achieved the target of 99%. **Audiology**: 3wte vacancies and ENT referral re-alignment has impacted performance **Cardiology**: Awarded community echo service; TUPE staff left before transfer to OUH **Neurophysiology**: Demand remains above capacity after increased activity and rigorous triage. Ongoing insource supplier unable to offer same levels of additional capacity due to a competitive market. Complexity of cases requiring two technicians are required for a cohort of patients, mostly inpatients. **Respiratory Sleep studies**: Demand and Capacity deficit	**Audiology:** Considering skill-mix change. Although challenges with supplier, procuring 2 additional booths. Options appraisal completed with a recommendation to transfer a cohort of clinically appropriate patients to Another Qualified Provider (AQP). Discussions are to be held with commissioners. **Cardiology:** Insourcing trial commenced in May and due to fully start once official procurement process completed in July. **Clinical Neurophysiology:** Return of 2 staff members from maternity leave and technicians to be fully trained to conduct EMGs. Business case under development to convert insource to BAU. **Respiratory Sleep studies:** CDC now in use and is being considered for expansion. Technically under-reported performance due to relocation of service to CDC. This will be corrected for next month.	Weekly Assurance meeting will monitor all actions on a bi-weekly basis **Audiology:** improvement expected once transfer to AQP agreed, and recruitment/skill-mix concluded - TBC **Cardiology:** compliance by December 2023 **Clinical Neurophysiology:** improvement expected from July 2023 **Respiratory Sleep studies:** compliance by January 2024	BAF 4 Link to CRR 1136 (Red)	*Not yet assured*

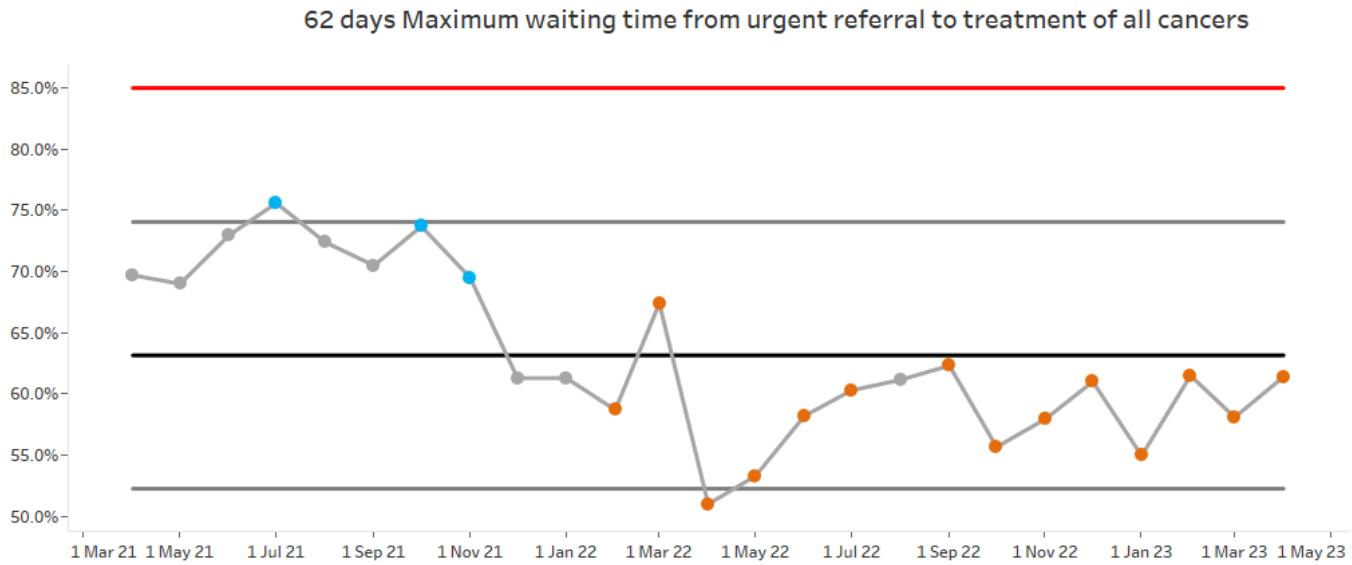


Benchmarking: April 23	
OUH	2,386
National	1,462 (avg.)
Shelford	2,994 (avg.)
ICS	BHT: 3,659 RBH: 21

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 number of patients waiting more than 52 weeks to start consultant-led treatment was 2,717 in May. Performance exhibited special cause variation due to six consecutive periods of deteriorating performance above the mean of 1,781 and exceeding the upper process control limit. **104 weeks** reported 4 waiting due to the complexity and PICU capacity for two Paediatric Spinal, compliance of one Neuroradiology, an Ophthalmology patient impacted by national shortage of corneas. **78 weeks** as well as Paediatric Spinal and Ophthalmology stated above, challenges are found within Urology due to a capacity deficit against demand levels, Adult Spinal due to complexity, critical care and theatre capacity, and Plastic surgery due to capacity. **65 weeks** remains the focus in line with the Trust's operating plan 2023/24. Services not challenged in the longer wait cohorts are undertaking recovery of **52 weeks**.	○ **Corneal graft supplies** are being managed centrally by NHSE via NHSB&T as this is a recognised national issue. NHSE has given instructions (20/06/23) to begin the process for 65 week patients. ○ **Paediatric Spinal services** remain a challenge – mutual aid arrangements are being finalised to support additional capacity. ○ **Theatre re-modelling and planning** commenced and further evaluation to ensure all services have a fair proportion of capacity to manage our longest waiting patients. ○ **Key milestone deadlines set for pathway stages at specialty level** to mitigate risk of not delivering the Operating Plan. ○ **Elective Recovery Fund** schemes are in place to support the recovery of 65 weeks.	Delivery of 65 weeks is planned by March 2024 All actions are being reviewed and addressed via weekly Assurance meetings and Elective Recovery Group	BAF 4 Link to CRR 1135 (Amber)	*Not yet assured*

3. Assurance report: Operational Performance, *continued*

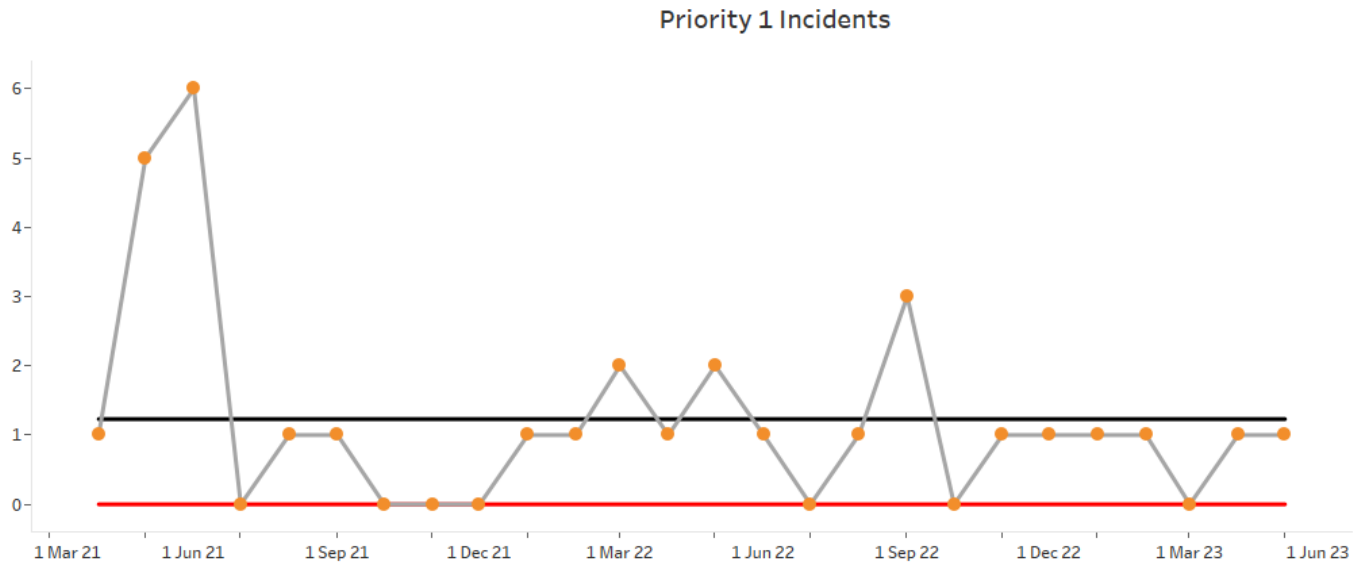


Benchmarking: April 23 62 day Standard	
OUH	61.4%
National	62.3%
Shelford	59.5%
ICS	BHT: 71.7% RBH: 64.4%

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

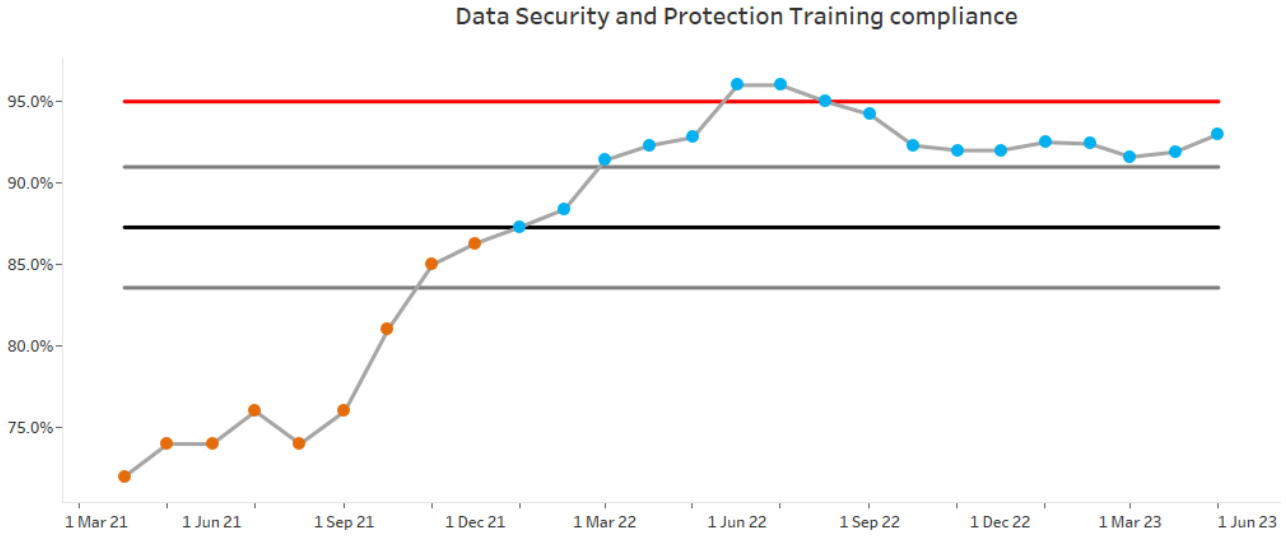
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Cancer performance against the 62 days standard for urgent referral to treatment was 61.4% in April, and below the performance target of 85%. Performance exhibited special cause variation due to more than seven consecutive periods of performance below the mean of 63.2%. The indicator has consistently not achieved the target. All tumour sites apart from Brain/Central Nervous System, Childrens, Skin and Testicular are non-compliant for this standard in April. **Challenges identified:** • Complex tertiary level patients (12.2%) • Some slow pathways and processes (15.6%) • Capacity for some surgery, diagnostics and oncology (52.2%) • Late inter provider transfers (12.2%) • Patient reasons (7.8%)	**The Cancer Improvement Programme** launched in 2022/23 with a focus on 28-day Faster Diagnosis Standard (FDS). For April, **the Trust was 11th best out of 135 national providers and has delivered this standard consecutively since June 2022**. FDS remains a key priority for 2023/24 as well as addressing the challenges faced with delivering treatment for our patients by day 62. **Tumour sites** are developing improvement plans to improve 62 day performance: • Incomplete and late Inter-Provider Transfers • Surgical capacity through theatre reallocation and • Patient choice delays by improving patient engagement through the Personalised Care agenda **Urology** holds the highest proportion of treatments beyond 62 days. Working with radiology to implement a one-stop clinic and MRI. **Gynae** is also a challenged service with development underway with ICB colleagues to support referral management change ideas to ease pressure on the 62 day pathway	Faster Diagnostic Standards (FDS) to be achieved by all tumour sites outlined within the FDS Framework 2023/2024 171 patients over 62 days on the Patient Tracking List by March 2024 Urology one-stop MRI pilot clinic: on track Gynae referral management: on track	BAF 4 Link to CRR 1135 (Amber)	*Not yet assured*

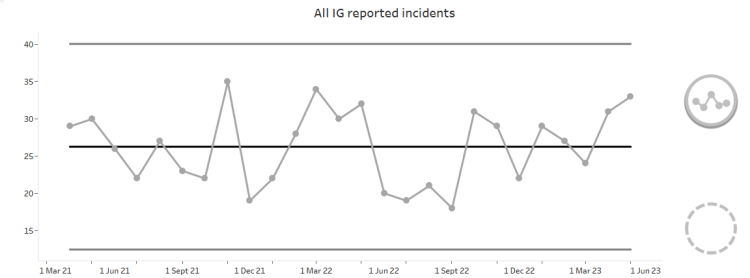
3. Assurance report: Corporate support services - Digital

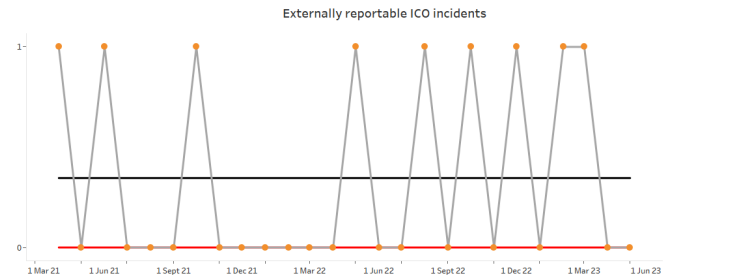


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
There was one Priority 1 incident in May 2023 against a target of zero. Due to the low volume of incidents SPC has not been applied to this indicator.	04:30 29/5/23 Reports of slow performance of CRIS and failed logins for new users in JR and HGH ED's.	Technical investigation to root cause is underway, and monitored via the Digital "Problem" process. Concerns around lack of RCA will be raised with Magentus management team. No recurrence since, at the time of writing.	BAF 4 Link to CRR 1116 (Amber), 1113 (Amber)	*Not yet assured*

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

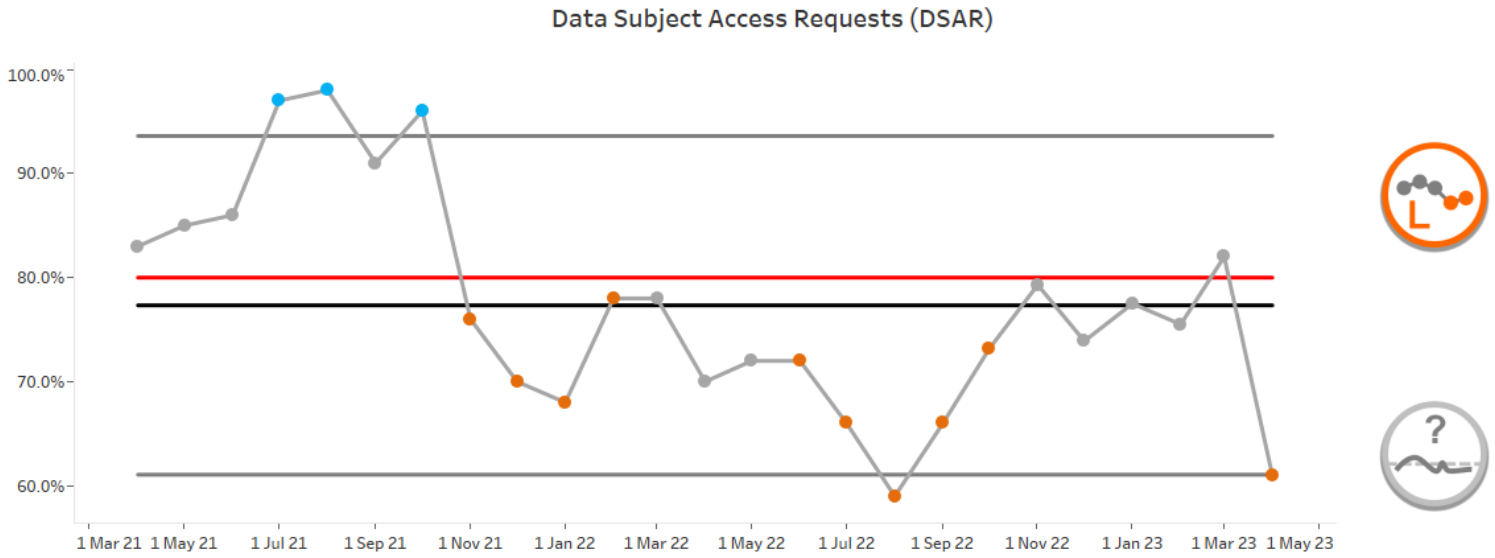






Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Data security and Protection Training compliance was 93.0% in May, below the target of 95%. Performance exhibited improving special cause variation due to successive periods of performance improvement (>6 months) above the mean of 87.3% as well as exceeding the upper process control limit of 91.0%. The compressed face to face staff induction process no longer includes IG training, and is instead done entirely electronically through the MyLearningHub platform with reminders sent through email, which not all staff who need to do the training check regularly. It is however part of the Trust's Statutory and Mandatory training package that all staff must complete as part of their appraisal process, so the completion rate should rise as we enter the appraisal time window. The Data Security and Protection Toolkit requires us to demonstrate that we have achieved a 95% training rate between July 2022 and June 2023	MyLearningHub system to be used fortnightly to send all staff who have not completed IG training in the last year, and their managers, messages highlighting the need to complete the training. One more email to be sent to every non-compliant staff member and their manager on 23/06/2023	1) Timescales associated with action: 95% rate achievable by 30/06/2023 2) Actions on track: Yes 3) Group or committee where the actions are reviewed: Digital Oversight Committee	BAF 6	*Not yet assured*

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
Data Subject Access Request compliance was 59.0% in May, below the target of 80%. Performance exhibited deteriorating special cause variation due to falling below the lower process control limit of 61.0%. As a result, the decrease in performance was a statistically significant change. Subject Access Requests come to the Trust through multiple channels depending on what part of the data the Trust holds on the subject is being requested. Most teams regularly achieve 90-100% compliance with the 1 calendar month deadline to comply with the request and send the data back to its subject, but since late 2021 the Medical Records Subject Access Team (part of Legal Services) who process requests for transcripts of paper records and notes held within Cerner Millennium have experienced a 30% increase in the number of requests being received each month from ~300 to ~400. This represents ~40% of all SARs received by the Trust so any impacts in the team have influence the Trust's overall performance. The SAR team have been affected by staff sickness and high turnover as well as the increase in workload. There is a lead time to ensure that training of new of SAR staff meets GDPR regulations, this month there has also been a significant dip in PACS performance this month.	IG team assisting SAR team with process improvements IG team to meet with PACS team to investigate dip in performance	Digital Oversight Committee	BAF 6	*Not yet assured*

4. Development indicators

Chief Officer	Domain	Reporting section	Indicator type	Indicator	Comments
CMO	Quality, Safety and Patient Experience	Clinical outcomes and effectiveness	SOF	Performance against relevant metrics for the target population cohort and five key clinical areas of health inequalities	Indicators TBA
COO	Operational Performance	Elective access	National	31-all (new standard)	Further information due on the new standard: Not currently available
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
COO	Operational Performance	Emergency care	SOF	Available virtual ward capacity per 100k head of population	Not currently recorded: TBA
COO	Operational Performance	Emergency care	National	Number of virtual ward spaces available	Performance is due to be reported from M3 2023/24

Oxford University Hospitals NHS Foundation Trust

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

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

2. Framework for levels of assurance:

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