Oxford University Hospitals
NHS Foundation Trust

Integrated Performance Report

M12 (March data)

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1. Executive summary

Oxford University Hospitals NHS Foundation Trust

Performance updates, challenges and risks – March 2023

Quality, Safety and Patient experience

Ensuring high-quality patient care and experience remains a top priority for the OUH. While our Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) rates demonstrate fewer patient deaths than expected, there are still areas for improvement in our safety and experience measures. In March, we recorded a number of incidents that require attention, including an increase in moderate harm incidents per 10,000 bed days, a decrease in outpatient Friends and Family Test ratings, two never events, and lower PFI cleaning scores at the John Radcliffe Hospital. These issues could lead to a decline in patient satisfaction and negatively impact our regulatory assurance regarding CQC inspections, which we closely monitor within Trust Governance Committees.

Operational Performance

The OUH recorded improvements in the number of patients waiting over 65 weeks on elective Referral to Treatment (RTT) pathways, supported by elective recovery activity in cancer services, diagnostics and first outpatient appointments, all recording higher activity volumes relative to 2019/20. Due to the continued emergency pressures elective inpatient and daycase activity remains below 2019/20 levels. We have identified specific actions for challenged RTT specialities with the support of Elective Recovery Fund schemes and are working to remodel and plan our theatre allocation according to clinical priority and specialty capacity requirements. These actions will support reductions in long waiting patients. Tumour site actions are in place to improve cancer performance for patients on a 62-day GP pathway and are reviewed monthly at the Cancer Improvement Programme. Whilst there are improvements required for the 62-day pathways, external benchmarking demonstrates that our performance for the 28-day Faster Diagnosis Standard (FDS) was better than target and 18th best out of 135 national providers.

We continue to face challenges in patients attending our emergency departments and being seen within four hours, time spent over 12 hours in the department, and demand for inpatient beds. This could lead to longer wait times for patients and impact their overall experience. Actions in place include evaluating the benefits of a Senior Medical Decision Maker in the John Radcliffe Emergency Department for evenings, implementing the '*Clinically Ready to Proceed*' functionality within the ED system and using this to focus on improving performance in waiting times. All initiatives will be overseen by the Urgent and Emergency Care Quality Improvement Programme in 2023/24, which was approved by the IAC. Project groups will be established and work programmes developed by June 2023. Additionally, we held a Multi Agency Discharge Event (MADE) on 26th April and plan a follow up event in early May. Initial results were positive with reductions in medically optimised for discharge patients. External support within Oxfordshire is also in place to design admission avoidance and discharge to assess models.

Growing Stronger Together

While people-related indicators demonstrate strong performance in appraisals and core skills training, our sickness absence remains marginally above other acute secondary care providers in the ICS. This could impact staff morale and potentially lead to decreased quality of care for patients and increased agency costs. To support reductions in our sickness absence we are promoting return to work interviews to be conducted and increasing the provision of absence reports to managers to enable timely supports and interventions. For complex cases, there are monthly meetings with Occupational Health.

Finance

Our Income and Expenditure (I&E) performance generated a reported £9.1m surplus in March, but we need to monitor and improve our performance in areas where targets have not yet been set.

Data quality

Finally, we need to address data quality for each indicator as it is currently listed as 'not yet assured.' Without accurate and reliable data, it is difficult to make informed decisions and improve patient care. Therefore, we will implement a rolling audit process to ensure that each indicator is valid, timely, and has sufficient granularity.

2. a) Indicators not achieving standard or exhibiting negative special cause variation

Oxford University Hospitals NHS Foundation Trust

	Indicators not achieving standard/target			Indicators with no target	
Domain	**Exhibiting special cause variation (deterioration)**	**Exhibiting common cause variation or SPC not applicable**	**Exhibiting special cause variation (improvement)**	**Exhibiting special cause variation (deterioration)**	**Exhibiting common cause variation or SPC not appliable**
Quality, Safety and Patient Experience		• Number of Never Events • Stillbirths per 1,000 births		• Number of incidents with moderate harm or above per 10,000 beddays. • FFT outpatient % positive • Safeguarding consultations • PFI % cleaning score (JR)	
Operational Performance	• ED performance (All types and type 1) • Proportion of patients spending more than 12 hours in an emergency department • % Diagnostic waits wating under 6 weeks (DM01) • Referral to treatment (RTT <%18 wks) • 62-days maximum waiting time from urgent referral to treatment for all cancers			• G&A bed occupancy • Total patients wating more than 52-weeks to start consultant-led treatment	
Growing Stronger together	• Sickness absence (monthly & rolling 12 months)			• Vacancy (WTE) Budgeted minus ESR staff in post	
Finance					
Corporate Support Services		• Externally reported ICO incidents	• Data Security and Protection Training Compliance		

2. b) SPC indicator overview summary

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Quality, Safety and Patient Experience Summary

Indicator	Period	Performance	Target	Mean	LCL	UCL
MRSA bacteraemia infection rate COHA and HOHA (per 10,000 beddays)	Mar-23	0.3	Not set	0.2	-0.5	0.8
MRSA cases: HOHA	Mar-23	1	Not set	0	-1	2
MRSA cases: COHA	Mar-23	0	Not set	0	-1	1
Clostridium difficile infection rate COHA and HOHA (per 10,000 beddays)	Mar-23	5.3	Not set	3.7	-0.1	7.5
C-diff cases: HOHA	Mar-23	14	Not set	7	-2	16
C-diff cases: COHA	Mar-23	2	Not set	3	-2	9
E. coli infection rate COHA and HOHA (per 10,000 beddays)	Mar-23	3.0	Not set	5.5	1.0	10.0
E. Coli cases: HOHA	Mar-23	3	Not set	8	1	15
E. Coli cases: COHA	Mar-23	6	Not set	8	0	15
MSSA cases: HOHA	Mar-23	2	Not set	4	-2	9
MSSA cases: COHA	Mar-23	1	Not set	2	-2	5
Klebsiella cases: HOHA	Mar-23	6	Not set	5	-2	12
Klebsiella cases: COHA	Mar-23	0	Not set	3	-1	6
PSAR cases: HOHA	Mar-23	3	Not set	3	-3	9
PSAR cases: COHA	Mar-23	0	Not set	1	-2	5
Number of Never Events	Mar-23	2	Not set	0	Not available	Not available
Serious Incidents Requiring Investigation (SIRI)	Mar-23	14	Not set	9	-1	18
Clinical Harm Reviews from extended waits	Feb-23	1950	Not set	1633	1089	2176
VTE Risk Assessment (% admitted patients receiving risk assessment)	Mar-23	98.1%	Not set	97.9%	96.1%	99.6%
Mechanical thrombectomy as a % of all stoke patients	Apr-21	0.0%	Not set	0.0%	Not available	Not available
CAS alerts breaching deadlines at end of month and/or closed during month beyond deadline	Mar-23	0	Not set	0	Not available	Not available
Medication errors causing serious harm	Mar-23	1	Not set	2	-2	6
Mortality HSMR	Mar-23	94.0	Not set	93.2	Not available	Not available
Mortality SHMI	Mar-23	96.0	Not set	20.6	Not available	Not available
Neonatal deaths per 1,000 total live births	Mar-23	0.0	4.0	3.0	Not available	Not available
Stillbirths per 1,000 total births	Mar-23	5.0	4.0	3.0	Not available	Not available
National Patient Safety Alerts not completed by deadline	Mar-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
Performance against relevant metrics for the target population cohort and five key clinical areas of health inequalities	Apr-21	0	Not set	0	Not available	Not available

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

Quality, Safety and Patient Experience Summary

Indicator	Period	Performance	Target	Mean	LCL	UCL
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	Mar-23	1349	Not set	1375	1311	1439
Number of active clinical research studies (commercial)	Mar-23	338	Not set	342	323	361
Number of active clinical research studies (non commercial)	Mar-23	1011	Not set	1033	985	1082
Number of incidents with moderate harm or above per 10,000 beddays	Mar-23	57.4	Not set	33.8	18.5	49.2
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 2)	Mar-23	23.0	26.0	29.8	18.2	41.3
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 3 and 4)	Mar-23	2.3	3.0	3.0	-0.7	6.8
Pressure Ulceration incidents per 10,000 beddays (Present on admission Cat 1+)	Mar-23	122.9	114.0	119.6	94.4	144.8
Harm from Falls (Moderate and above)	Mar-23	5	Not set	5	-1	11
Harm from Falls per 10,000 beddays (moderate and above)	Mar-23	1.7	Not set	1.7	-0.5	3.9
Number of complaints	Mar-23	123	Not set	95	52	138
Number of complaints per 10,000 beddays	Mar-23	40.8	Not set	33.9	19.6	48.2
% of complaints responded to within agreed timescales	Mar-23	80.0%	Not set	65.9%	45.5%	86.2%
Reactivated complaints	Mar-23	8	Not set	7	-3	17
Number of RIDDORs	Mar-23	6	Not set	3	-2	8
Health and Safety related incidents - Assault, Aggression and harassment	Mar-23	132	Not set	117	47	186
Incident rate of violence and aggression (rate per 10,000 beddays)	Mar-23	43.8	Not set	41.5	17.5	65.5
FFT inpatient % positive	Mar-23	95.2%	Not set	95.0%	93.0%	96.9%
FFT outpatient % positive	Mar-23	93.6%	Not set	93.7%	92.1%	95.3%
FFT ED % positive	Mar-23	82.1%	Not set	77.4%	68.6%	86.2%
FFT maternity % positive	Mar-23	86.5%	Not set	87.4%	59.8%	115.0%
FFT children's % positive	Aug-22	93.9%	Not set	93.6%	87.2%	100.1%
Inpatient FFT (response rate)	Mar-23	29.7%	Not set	25.8%	22.6%	29.0%
Outpatient FFT (response rate)	Feb-23	18.1%	Not set	10.3%	6.1%	14.4%
A&E FFT (response rate)	Mar-23	23.7%	Not set	25.1%	22.1%	28.1%
Maternity FFT (response rate)	Mar-23	16.8%	Not set	6.0%	1.7%	10.4%
Adult safeguarding activity	Mar-23	731	Not set	660	454	866
Number of safeguarding consultations initiated by provider (both to internal and external organisations)	Mar-23	961	Not set	696	537	854

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

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Quality, Safety and Patient Experience Summary

Indicator	Period	Performance	Target	Mean	LCL	UCL
Safeguarding (children) training L1 - L4 compliance	Mar-23	87.0%	Not set	81.6%	75.3%	87.9%
Safeguarding (adults) training L3	Mar-23	0.0%	Not set	0.0%	Not available	Not available
Trust level: CHPPD vs budget	Mar-23	-54.2	Not set	-51.7	-106.4	3.0
Trust level: CHPPD vs required	Mar-23	-5.4	Not set	-22.5	-45.0	0.0
Mothers birthed	Mar-23	605	625	631	552	710
Babies born	Mar-23	613	Not set	641	561	721
Scheduled Bookings	Mar-23	784	750	712	569	855
Inductions of labour from iView	Mar-23	160	Not set	145	101	188
Midwife:birth ratio (1 to X)	Mar-23	25.0%	28.0%	27.2%	24.1%	30.3%
PFI: % cleaning score by site (average) JR	Mar-23	88.0%	Not set	95.3%	90.9%	99.6%
PFI: % cleaning score by site (average) CH	Mar-23	100.0%	Not set	94.0%	88.5%	99.5%
PFI: % cleaning score by site (average) NOC	Mar-23	100.0%	Not set	97.8%	94.2%	101.5%

Growing Stronger Together Summary

Indicator	Period	Performance	Target	Mean	LCL	UCL
Vacancy rate %	Mar-23	7.7%	7.7%	5.7%	3.0%	8.5%
Turnover rate (rolling 12 months)	Mar-23	11.4%	12.0%	10.1%	6.6%	13.5%
Sickness absence (rolling 12 months)	Mar-23	4.3%	3.1%	4.1%	4.0%	4.3%
Sickness absence (monthly)	Mar-23	4.0%	3.1%	4.1%	3.9%	4.4%
Appraisal compliance (non medical)	Mar-23	94.2%	85.0%	70.9%	60.6%	81.1%
Core skills training compliance	Mar-23	90.2%	85.0%	88.5%	87.2%	89.8%
Bank spend vs target (variance) £m	Mar-23	-2.3	Not set	-1.1	-3.1	1.0
Agency spend vs target (variance) £m	Mar-23	-0.7	Not set	-0.3	-0.7	0.2
Budgeted establishment - staff in post (WTE)	Mar-23	12778	Not set	12622	12474	12770
ESR staff in post (WTE)	Mar-23	12965	Not set	12762	12641	12882
Vacancy (WTE) Budgeted minus ESR staff in post	Mar-23	1062	Not set	968	851	1085
Time to hire (average days)	Mar-23	41.4	53.0	53.5	44.0	63.1
Temporary spend on staff cover for absence relating to stress/anxiety	Apr-21	0	Not set	0	Not available	Not available
% staff participated in Wellbeing check-in	Mar-23	27.9%	Not set	27.8%	Not available	Not available

Operational Performance Summary

Indicator	Period	Performance	Target	Mean	LCL	UCL
Proportion of ambulance arrivals delayed over 30 minutes	Mar-23	10.5%	Not set	9.1%	1.0%	17.2%
Ambulance turnaround time > 60 minutes	Mar-23	1.8%	Not set	1.5%	-0.5%	3.6%
ED 4hr performance - All	Mar-23	64.7%	95.0%	67.8%	59.6%	75.9%
ED 4hr performance - Type 1	Mar-23	57.7%	95.0%	62.5%	53.5%	71.6%
Proportion of patients spending more than 12 hours in an emergency department	Mar-23	6.5%	2.0%	5.6%	2.7%	8.5%
Proportion of patients discharged from hospital to their usual place of residence	Mar-23	91.9%	Not set	91.7%	90.5%	92.9%
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	Mar-23	96.5%	Not set	94.9%	92.7%	97.1%
Theatre utilisation (elective)	Feb-23	89.4%	85.0%	87.7%	83.7%	91.7%
% Diagnostic waits waiting under 6 weeks + (DM01)	Mar-23	89.4%	99.0%	91.6%	87.7%	95.6%
Referral to treatment (RTT) - <%18 weeks	Mar-23	62.2%	92.0%	70.8%	67.8%	73.9%
Total patients waiting more than 52 weeks to start consultant-led treatment	Mar-23	2226	Not set	1716	1186	2247
Total patients waiting more than 65 weeks to start consultant-led treatment	Mar-23	473	Not set	882	559	1205
62 days Maximum waiting time from urgent referral to treatment of all cancers	Feb-23	61.5%	85.0%	63.5%	52.4%	74.5%
Proportion of patients meeting the faster cancer diagnosis standard	Mar-23	83.8%	75.0%	79.2%	71.0%	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	Mar-23	205	Not set	284	Not available	Not available
62 Day incomplete pathways >104 days	Mar-23	77	Not set	90	Not available	Not available
Total DC activity undertaken compared with 2019/20 baseline	Mar-23	92.6%	Not set	87.6%	69.6%	105.7%
Total IP elective activity undertaken compared with 2019/20 baseline	Mar-23	85.5%	Not set	83.0%	61.5%	104.5%
Total first outpatient activity undertaken compared with 2019/20 baseline	Mar-23	106.7%	Not set	102.0%	78.8%	125.2%
Total follow up outpatient activity undertaken compared with 2019/20 baseline	Mar-23	122.7%	Not set	107.6%	81.7%	133.5%
Total diagnostic activity undertaken compared with 2019/20 baseline	Mar-23	126.6%	Not set	112.5%	97.4%	127.7%
Total patients treated for cancer compared with the same point in 2019/20	Mar-23	122.5%	Not set	121.9%	90.4%	153.5%

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

2. b) SPC indicator overview summary

Oxford University Hospitals NHS Foundation Trust

Finance Summary

NB. Indicators provided to match new format, noting that for M12 narrative and slides will retain existing format and for M12 are reported separately.

Indicator	Period	Performance	Target	Mean	LCL	UCL
Income vs plan Mth						
Income vs plan YTD						
Pay vs plan YTD	Mar-23	-86.8	Not set	-10.7	-29.5	8.2
Pay vs plan Mth	Mar-23	-59.7	Not set	-5.1	-22.0	11.7
Non pay vs plan Mth	Mar-23	-4.3	Not set	-1.9	-13.8	10.1
Non pay vs plan YTD	Mar-23	-7.0	Not set	-7.4	-19.9	5.1
ITDA Variance from plan Mth	Apr-21	0.0	Not set	0.0	Not available	Not available
ITDA Variance from plan YTD	Apr-21	0.0	Not set	0.0	Not available	Not available
EBITDA £ variance Mth	Mar-23	-7.3	Not set	-0.3	-1.2	0.6
EBITDA £ variance	Mar-23	1.2	Not set	-3.5	-8.8	1.9
EBITDA % Mth	Mar-23	800.0%	Not set	37.8%	-57.9%	133.4%
EBITDA % YTD	Mar-23	510.0%	Not set	25.4%	-34.3%	85.0%
Financial YTD Surplus/Deficit £	Mar-23	-11.2	Not set	-5.1	-11.5	1.2
Financial YTD Surplus/Deficit % of turnover	Mar-23	-0.8%	Not set	-0.9%	-2.2%	0.5%
Underlying YTD Surplus/Deficit £	Mar-23	-10.4	Not set	-1.3	-5.5	2.9
Forecast Surplus/Deficit £	Apr-21	0.0	Not set	0.0	Not available	Not available
Forecast Risks £	Apr-21	0.0	Not set	0.0	Not available	Not available
Forecast Opportunities £	Apr-21	0.0	Not set	0.0	Not available	Not available
Forecast Net of Risks & Opportunities £	Apr-21	0.0	Not set	0.0	Not available	Not available
Finanicial efficiency - Savings £ MTH	Apr-21	0.0	Not set	0.0	Not available	Not available
Finanicial efficiency - Savings £ YTD	Apr-21	0.0	Not set	0.0	Not available	Not available
Financial efficiency - variance from efficiency plan	Apr-21	0.0	Not set	0.0	Not available	Not available
Finanicial efficiency - Productivity Measures £ YTD	Apr-21	0.0	Not set	0.0	Not available	Not available
Bank spending (£m)	Mar-23	6.8	Not set	5.2	4.2	6.2
Agency spending (£m)	Mar-23	1.5	Not set	1.0	0.7	1.3
Cash (£m)	Mar-23	0.0	Not set	45.9	16.2	75.5
Cash vs plan	Mar-23	42.7	Not set	-0.9	-28.3	26.5
Capital vs plan	Mar-23	-16.4	Not set	-0.7	-9.8	8.3
Capital expenditure charged to ICS CDEL	Apr-21	0.0	Not set	0.0	Not available	Not available
Overall level of capital expenditure - Other CDEL	Apr-21	0.0	Not set	0.0	Not available	Not available
Overall level of capital expenditure - IFRS	Apr-21	0.0	Not set	0.0	Not available	Not available
Financial stability - variance from break –even	Mar-23	9.1	Not set	0.1	-5.3	5.6
Financial stability - variance from plan –even	Mar-23	7.3	Not set	-0.6	-6.7	5.4

Corporate support services – Digital Summary

Indicator	Period	Performance	Target	Mean	LCL	UCL
Priority 1 Incidents	Mar-23	0	0	1	Not available	Not available
Data Security and Protection Training compliance	Mar-23	91.6%	95.0%	86.9%	83.0%	90.7%
Data Security & Protection Breaches	Mar-23	24	Not set	24	11	38
Externally reportable ICO incidents	Mar-23	1	0	0	Not available	Not available
All IG reported incidents	Mar-23	24	Not set	26	12	40
Freedom of Information (FOI) % responded to within target time	Mar-23	82.0%	80.0%	64.3%	40.5%	88.2%
Data Subject Access Requests (DSAR)	Mar-23	82.0%	80.0%	78.0%	63.5%	92.6%

Corporate support services – Legal services Summary

Indicator	Period	Performance	Target	Mean	LCL	UCL
Legal Services: Number of claims	Mar-23	21	Not set	16	1	32

Corporate support services – Regulatory assurance

Indicator	Period	Performance	Target	Mean	LCL	UCL
CQC well -led rating	Apr-21	0	Not set	0	Not available	Not available
Overall CQC rating	Apr-21	0	Not set	0	Not available	Not available
CQC overdue actions	Mar-23	2	0	2	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.

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.

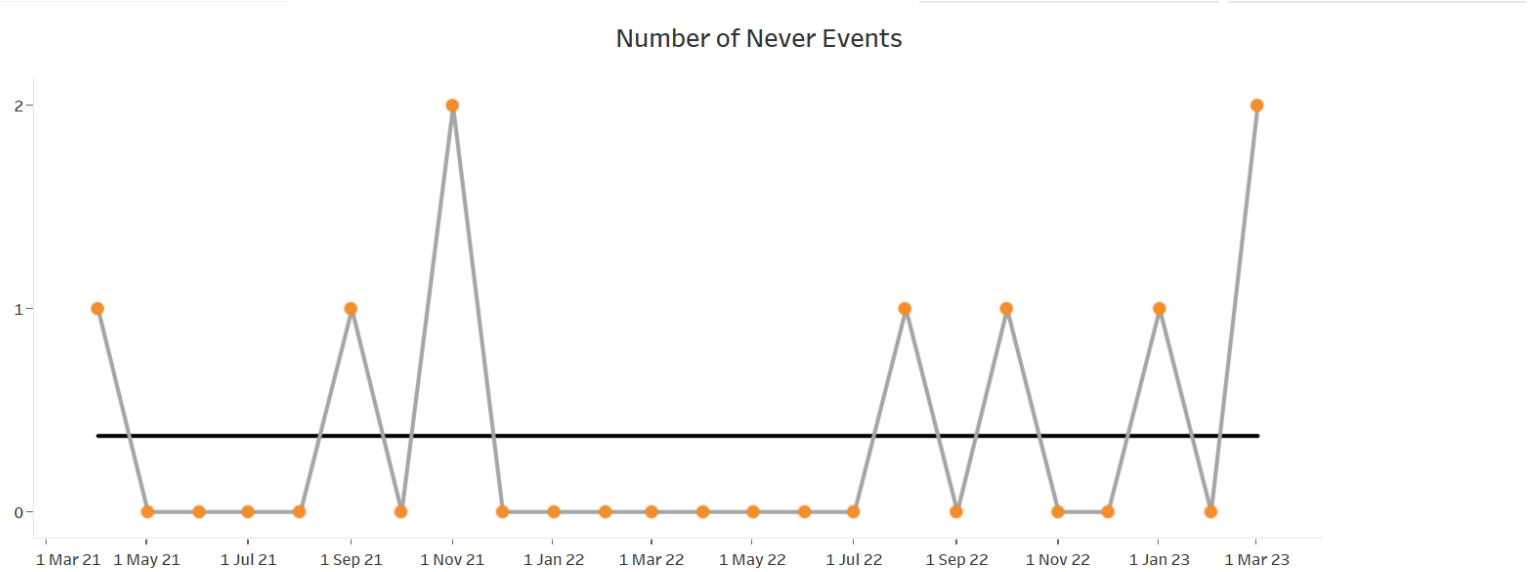
OUH Data Quality indicator

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*

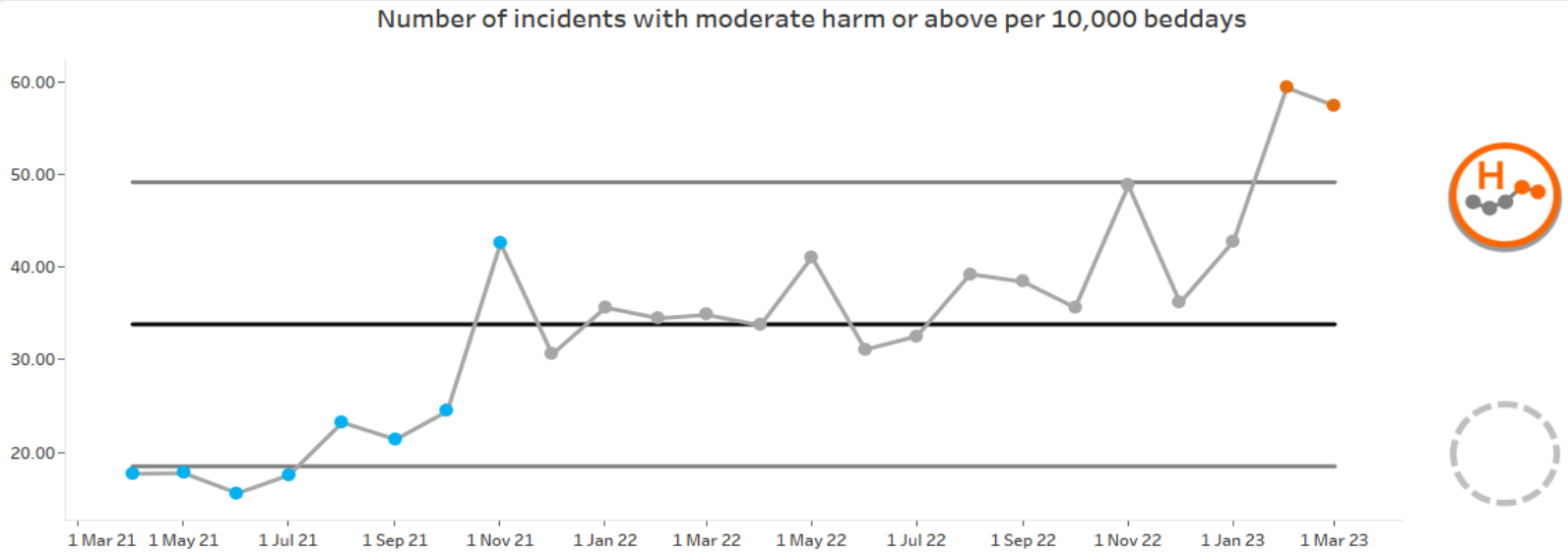
03. Assurance reports

3. Assurance report: Quality, Safety and Patient Experience



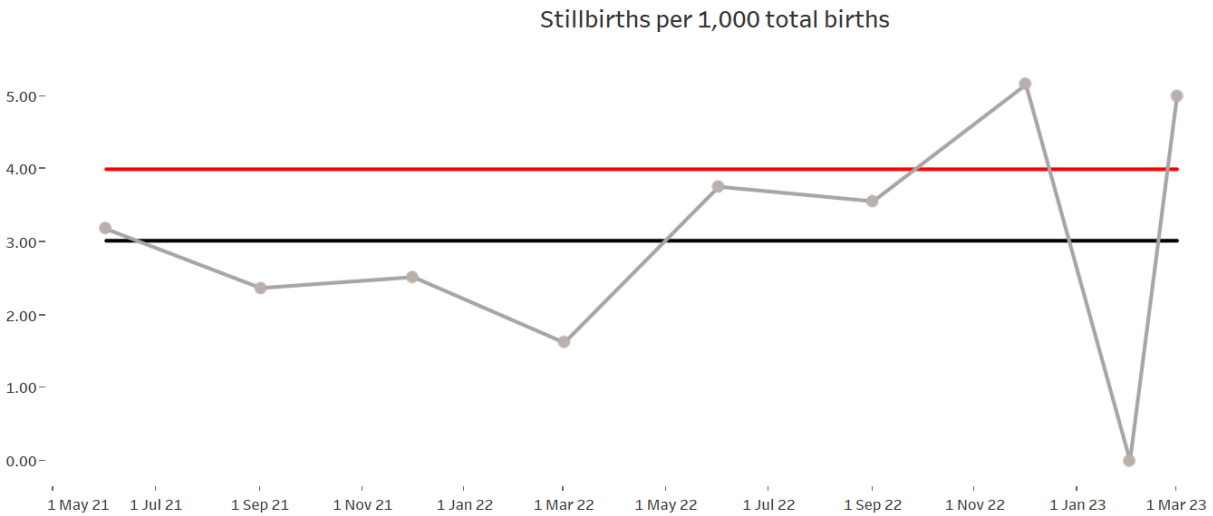
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register (Y/N)	Data quality rating
There were two Never Events recorded in March. SPC has not been applied to this indicator due to the low volumes and high variability due to periods where there are zero Never Events. 2223-105 concerned a patient who had a coronary artery bypass graft (CABG) operation. A post operative chest x-ray day 5 post operative identified a possible swab. A CT thorax scan confirmed this finding. It was removed the following day. An incident of this type has not occurred within the last 12 months. 2223-110 concerned the implantation of a prosthesis labelled left during revision surgery to the right knee. A previous Never Event of this type occurred in August 2022 (2223-045) NB. Different circumstances occurred in that case.	• 2223-105 immediate actions included - A hot debrief with all staff, no immediate safety actions identified. • It was confirmed that the swab count was documented as complete. • Verbal and written duty of candour was completed. The patient was informed of the suspected and then confirmed finding of the swab. This was successfully removed, and the patient is well. • 2223-110 immediate actions included- A debrief once the surgical list was completed to identify any immediate issues, and to agree that it was not necessary to bring the patient back to theatre to revise the implant. • The Divisional Medical Director visited the area to support the staff. • A supplier representative was present when this incident took place, and they have been contacted asking for their assistance with the investigation. • As this incident entailed Minor impact the formal Duty of Candour is not required, but the patient was fully informed of the incident.	These investigations are still on going and SMART action plans will be produced following the recommendations found from the investigations. These should occur at the beginning of June 2023.	*Y*	***Not yet assured***

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



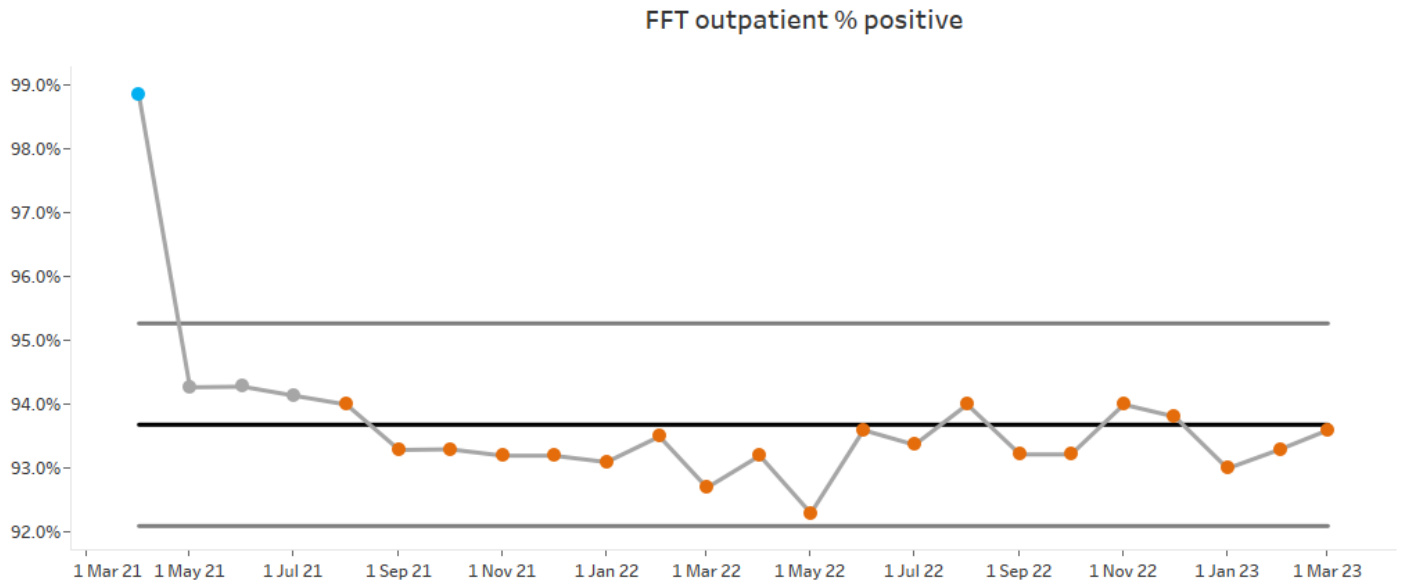
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register (Y/N)	Data quality rating
The number of incidents with moderate harm or above per 10,000 bed days was 57.4 in March. Performance exhibited special cause variation since the indicator exceeded the upper process control limit of 49.2. 93 out of 162 Moderate+ incidents reported in March were from Maternity Directorate, and 25 of these were retrospective reports dating back to 2022. The employment of a second perinatal risk coordinator at the start of February allowed for an acceleration of this retrospective reporting activity, hence the overall rise in Moderate+ incidents in February and March. Further analysis will take place and be presented in the next SIRI/NE report to IAC.	Thematic analysis of incident type, number and grading will be performed in the coming months. Of the 93 maternity moderate+ incidents the main numbers are made up as follows: 38 related to unplanned term admission to SCBU, 20 related to 3rd/4th degree tear, 19 related to post partum haemorrhage (PPH) above 1L for vaginal birth 4 related to PPH above 1.5L for Caesarean section. All of these have a proforma process for review and are graded according to potential learning and concerns from 'A' (no care quality concerns, no learning points) to 'D' (care quality concern and learning actions to be taken) These proformas are still under review for March but of the 49 reviewed to-date: 23 were rated as A and 26 as B (no care quality concerns, some learning). To provide context for 2022 out of a total of 166 incidents: 79 were graded A, 54 graded B, 6 graded C and 27 are outstanding.	Confirm whether the number of incidents has stabilised once data for June is available. More detailed analysis to be presented in the SUWON Divisional Quality Report to Clinical Governance Committee	N	***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 (Y/N)	Data quality rating
There were five stillbirths per 1,000 total births in March 2023, above the threshold of four. SPC has not been applied to this indicator due to the low volumes and high variability due to periods where there are zero deaths per 1,000 births. This is related to the data for quarter 4 (January, February, March). In quarter 4 there were four stillbirths reviewed through the Perinatal Mortality Review Tool (PMRT). These were graded as either an A – no care concerns identified or a B – care issues identified that had no impact on the outcome. The stillbirths that occurred in March will be reviewed through the PMR process. The themes identified from the reviews undertaken in this quarter were: fundal height (SFH) measurements not being plotted on a chart, the mothers progress in labour not being monitored on a partogram and a mother not having a Kleihauer test despite it being requested.	Kleihauer test not being undertaken despite it being requested. The actions (1-3) for this related to the laboratory were: 1. Remind staff that Kleihauer requests received from EPR on the laboratory system should be processed on a Group and Save sample even if no additional sample is sent for the Kleihauer 2. Remind staff that Kleihauer requests received from EPR on the laboratory system should be processed on a Group and Save sample even if no additional sample is sent for the Kleihauer. 3. To review their standing operating procedure for Kleihauers and have agreed that they need to update the information with regards to the processing and reporting of Kleihauer requests in the investigation of IUDs for RhD positive women. 4. PMR co-ordinator to ensure a Kleihauer result is available at the time of initial review, and contact the Laboratory if this is not the case. This is ongoing and is undertaken by the PMR coordinator. 5. SFH – this was raised at the community leads meeting on the 27/03/2023. This will be automated on the new maternity specific patient record (Badgernet).This was audited as part of the Antenatal Care audit. 6. Partogram – new "maternal wellbeing" partogram and bereavement guideline has been developed and is in practice – audit is currently being undertaken to review practice.	Point 1 and 2 to be completed by the 25/04/2023 Point 3 Due to be completed by the 31/07/2023 Point 4 – ongoing Point 5 – Due November 2023 Point 6 – in progress	*N*	***Not yet assured***

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

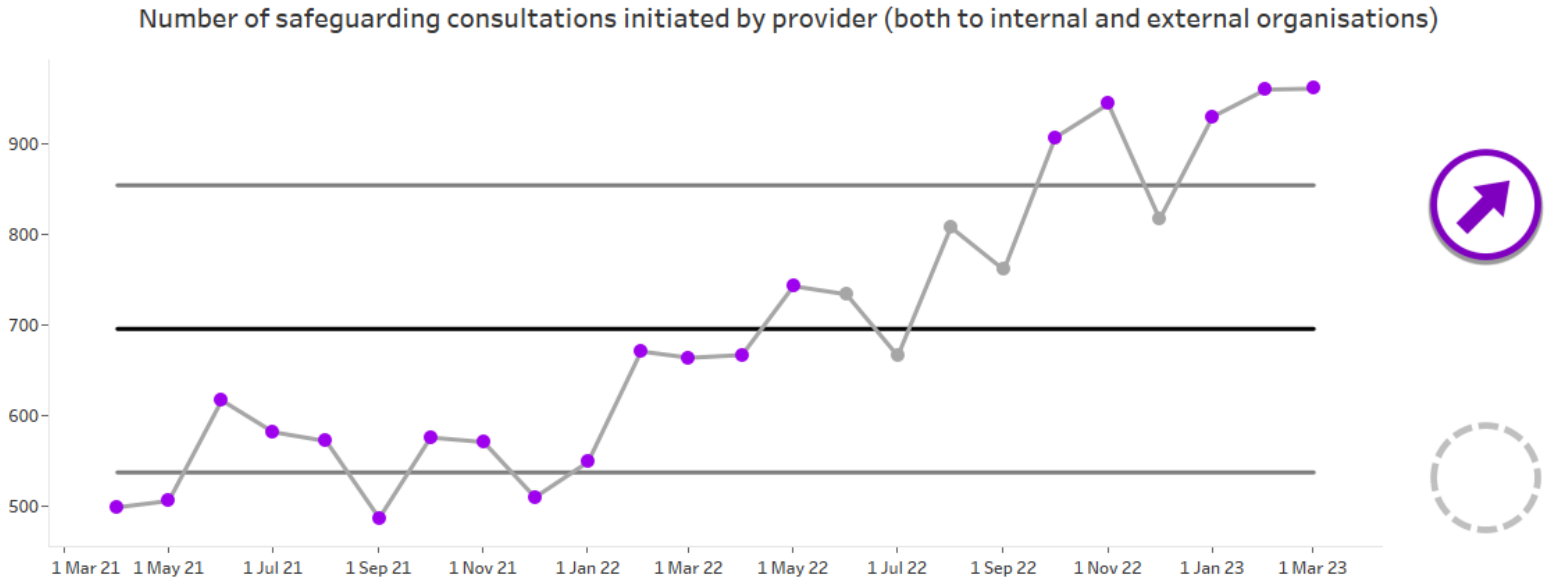


Benchmarking: Feb 23 FFT OP	
OUH	93%
National	94%
Shelford	95%
ICS	BHT: 93% RBH: 95%

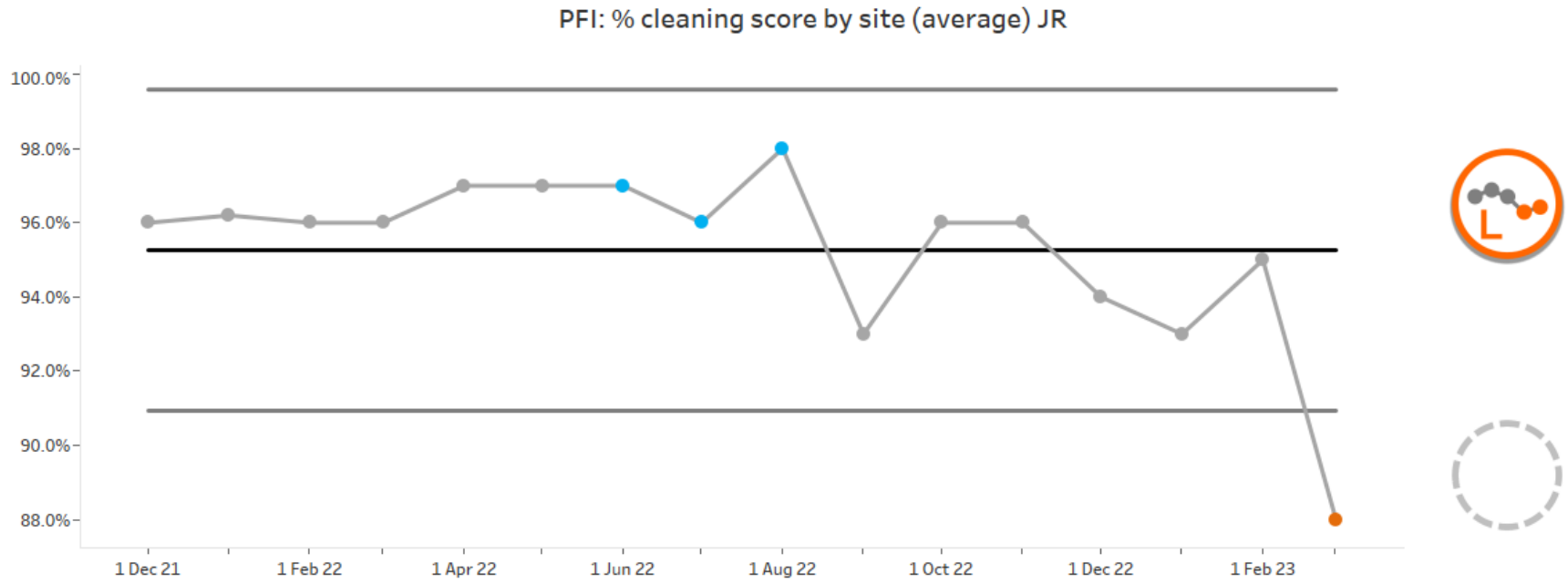
ICS key	
BHT	Buckinghamshire Healthcare NHS Trust
RBH	Royal Berkshire NHS Foundation Trust

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 (Y/N)	Data quality rating
The Outpatient Friends and Family Test % positive score was 93.6% in March. Performance exhibited special cause variation due to two out of the last three periods falling within one sigma of the lower process control limit.	1. Top themes across FFT are triangulated at ICCSIS (Incidents, Complaints, Claims, Serious Incidents Safeguarding triangulation and reported to SIG (Serious Incident Group) every week. +ve: Staff attitude. Implementation of care. Inpatient admission. -ve: Discharge. Waiting lists. Cancelled procedures. 2. Patient Experience plan presentation at Trust Board on 10/05/23. 3. Raise profile of FFT to inform QI to improve patient experience • Development of interactive FFT dashboard & FFT intranet • You said We did' on Quality Boards • Consistent FFT posters across the Trust advertising FFT • Paper forms available from Print Store	1. Themes: Current. On Track. SIG 2. PE plan: Current. On Track. TB 3. Profile: Sept 2023. On Track. NMAHP. CGC	N	***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 (Y/N)	Data quality rating
The number for safeguarding consultations initiated by provider (both to internal and external organisations) was 961 in March. Performance exhibited special cause variation due exceeding the upper process control limit of 854 consultations. Increases in cases of domestic abuse, mental health, and substance abuse. Maternity had high levels of cases with 31 babies born with social care plans and 187 (24%) of pregnancy bookings have a social or public health risk. DoLS dropped from 72 to 40 in March, documented. Safeguarding liaison contract to share information of ED attendances is delayed due to gaps in administrators. Training data for this report is being reviewed for future reports. Level 3 adults not mapped by MyLearningHub (MLH).	Recruitment of additional staff in adult and maternity team to full establishment will be in place in April to manage increased activity. Monitoring of activity to move resource across areas to manage . Administrator resourcing remains a challenge to manage activity, NHSP being used when available. Creative recruitment supported by HR. Clinical teams supported by safeguarding to with capacity assessments and audit of areas to improve documentation. Level 3 adult training is awaiting move of staff mapped to level 2 to be moved and implement training package.	Full recruitment plan in place to be at full establishment 1) Ongoing support for clinical teams with MC assessment and DoLS applications 2) ICSIS updated weekly on themes, PSEC and divisional / directorate governance committees monthly, Safe-guarding Strat. meeting quarterly reports. 3) MLH supporting changes needed to correctly map training levels for staff being undertaken, to be in place in April	N	***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 (Y/N)	Data quality rating
The Public Finance Initiative (PFI) % cleaning score by site (average) JR was 88.0% in March. Performance exhibited special cause variation due to performance falling below the lower process control limit of 90.9%. The decrease is in the main a consequence of a fall in the clinical cleaning component of the audit (drip stands/COWS/PPE dispensers) with ED achieving inconsistent scores relating to service pressures within the department, due to the need to turn around a bedspace rapidly.	Mitie have provided additional WTE domestic support for discharge and terminal cleans within ED/EAU. Mitie provide action plans for all areas achieving three stars or below for the domestic component with Trust PFI management team monitoring delivery of actions. Additional auditing/monitoring by domestic supervisors and Trust PFI team to assess success of initiatives and where required add further interventions.. IP&C working closely with ward managers to improve nurse cleaning element of combined cleaning scores. No additional support currently required as considered actions deliverable.	1) Improvement to > 90 % for JR cleaning scores for the month of April 2023. 2) Information cascade - Monitoring will be carried out utilising 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	*N*	***Not yet assured***

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

Oxford University Hospitals NHS Foundation Trust

March 2023	Care Hours Per Patient Day					Nurse Sensitive Indicators				Maternity Sensitive Indicators						HR				Rostering KPIs				FFT	
Ward Name	Actual vs budget	Actual vs required	Budgeted Overall	Required Overall	Actual Overall	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	Number of women readmitted postnatally within 28 days of delivery	Proportion of mothers who initiated breastfeeding	Number of 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	% Extremely unlikely or unlikely
NOTSSCaN																									
Bellhouse / Drayson Ward	- 0.1	- 0.4	9.86	10.18	9.8	1	1	0	0							15.3%	14.1%	5.0%	7.4%	Yes	0.5%	8.3	19.4%	91%	3%
BIU	1.7	1.2	6.05	6.61	7.8	0	0	0	0							31.2%	13.8%	0.8%	6.8%	Yes	0.6%	9.4	17.3%		
HDU/Recovery (NOC)	- 2.1	-	21.16		19.0	0	0	0	0							18.9%	12.3%	7.8%	8.5%	Yes	3.4%	8.7	12.9%		
Head and Neck Blenheim Ward	1.4	0.7	7.29	7.97	8.7	0	1	0	2							23.1%	11.1%	6.3%	0.0%	Yes	-3.7%	8.4	18.9%	91%	0%
HH Childrens Ward	0.6	3.4	11.85	9.12	12.5	1	1	0	0							29.9%	30.5%	6.9%	0.0%	Yes	10.6%	7.3	17.3%	92%	4%
HH F Ward	- 0.9	- 1.1	8.14	8.32	7.2	0	0	4	4							-5.2%	0.0%	5.0%	2.9%	Yes	-0.7%	7.7	18.8%	100%	0%
Kamrans Ward	- 2.4	- 2.7	10.23	10.48	7.8	1	0	0	0							11.3%	12.7%	2.4%	4.1%	Yes	-4.9%	7.3	17.5%	100%	0%
Major Trauma Ward 2A	0.5	0.9	8.11	7.80	8.7	7	0	1	3							6.0%	9.1%	3.4%	4.6%	Yes	1.4%	8.1	21.1%	94%	6%
Melanies Ward	5.7	1.0	6.71	13.42	12.4	0	0	1	0							5.5%	15.5%	0.6%	5.8%	Yes	-2.3%	10.6	22.7%	94%	6%
Neonatal Unit	- 0.8	-	18.76		18.0	3	1	0	0							18.3%	5.5%	6.0%	5.7%	Yes	2.2%	7.4	19.5%		
Neurology - Purple Ward	- 0.1	- 1.3	9.04	10.23	8.9	1	0	1	6							12.2%	6.1%	5.3%	3.2%	Yes	1.7%	9.9	13.6%	97%	3%
Neurosurgery Blue Ward	0.4	- 1.3	8.94	10.73	9.4	0	0	3	7							14.9%	8.2%	4.9%	0.0%	Yes	1.0%	8.4	20.7%	80%	5%
Neurosurgery Green/IU Ward	- 0.4	- 0.6	10.78	11.01	10.4	0	0	0	9							10.0%	3.5%	4.1%	0.0%	Yes	1.6%	8.4	23.2%	100%	0%
Neurosurgery Red/HC Ward	1.5	- 0.5	11.64	13.60	13.1	0	0	1	10							9.1%	1.0%	2.6%	1.7%	Yes	1.8%	8.4	19.9%	100%	0%
Paediatric Critical Care	- 3.4	-	33.05		29.7	6	3	1	0							-0.4%	7.1%	1.2%	8.9%	No	0.7%	9.3	19.2%		
Robins Ward	- 2.7	- 2.2	12.24	11.71	9.5	2	0	2	0							4.8%	4.7%	7.6%	5.3%	Yes	-0.8%	9.9	17.4%	88%	8%
Specialist Surgery I/P Ward	0.1	0.6	8.48	7.97	8.6	0	0	0	2							23.7%	12.4%	4.4%	5.1%	Yes	-0.6%	8.4	20.1%	92%	3%
Tom's Ward	- 0.2	- 1.8	8.05	9.60	7.8	4	1	0	0							9.6%	21.6%	1.8%	0.0%	Yes	3.3%	7.3	19.3%	100%	0%
Trauma Ward 3A	3.7	0.0	11.64	7.91	7.9	1	0	3	5							18.6%	0.0%	2.5%	8.1%	Yes	3.6%	8.1	21.9%	50%	50%
Ward 6A - JR	0.1	- 0.8	7.21	8.09	7.3	3	0	3	2							13.3%	4.1%	4.6%	2.5%	Yes	-0.6%	8.3	19.5%	100%	0%
Ward E (NOC)	0.5	- 0.9	6.30	7.66	6.8	0	0	1	5							18.4%	16.7%	7.7%	2.9%	Yes	1.7%	9.3	17.3%	100%	0%
Ward F (NOC)	1.1	0.3	6.65	7.46	7.8	1	0	1	1							26.9%	0.0%	9.9%	3.2%	Yes	9.2%	9.3	19.0%	96%	0%
WW Neuro ICU	0.1	-	28.03		28.1	3	0	0	0							21.7%	6.9%	6.8%	6.4%	Yes	-16.9%	8.4	17.6%		
MRC																									
Ward 5A SSW	- 0.9	- 1.0	8.88	9.05	8.0	0	0	3	3							31.2%	6.8%	5.1%	12.2%	Yes	-0.4%	8.4	14.4%	100%	0%
Ward 5B SSW	- 0.0	- 0.1	8.63	8.47	8.6	1	0	5	7							21.1%	4.7%	7.6%	6.7%	Yes	-0.6%	8.4	17.0%	100%	0%
Cardiology Ward	- 0.4	- 1.0	7.38	8.00	7.0	2	0	1	3							18.2%	14.3%	2.0%	4.3%	Yes	1.7%	7.0	16.7%	100%	0%
Cardiothoracic Ward (CTW)	- 2.7	- 1.7	8.74	7.71	6.0	1	0	1	2							24.2%	7.0%	4.9%	2.6%	Yes	4.2%	3.9	20.0%	96%	0%
Complex Medicine Unit A	- 0.3	- 0.1	8.94	8.75	8.6	0	0	2	7							23.5%	16.7%	3.1%	2.9%	Yes	0.7%	8.3	20.8%	100%	0%
Complex Medicine Unit B	- 1.4	- 1.6	10.15	10.33	8.7	0	0	3	4							16.4%	0.0%	6.2%	8.0%	Yes	-0.1%	6.9	17.6%	100%	0%
Complex Medicine Unit C	- 0.4	- 2.6	8.88	11.04	8.4	0	0	1	2							21.5%	0.0%	4.0%	8.2%	Yes	-3.1%	7.6	15.6%	90%	10%
Complex Medicine Unit D	0.6	- 1.0	8.06	9.67	8.6	0	0	1	0							9.3%	4.9%	5.6%	1.4%	Yes	-0.7%	6.6	22.8%		
CTCCU	6.8	23.7	16.92	0.00	23.7	4	0	1	0							17.7%	7.5%	2.5%	5.9%	Yes	-0.1%	9.3	17.4%		
Emergency Assessment Unit (EAU)	-	- 8.6	8.53	8.56		2	0	2	10							29.5%	3.2%	3.1%	7.4%	Yes	4.5%	9.4	20.9%		
HH CCU	- 12.1	-	25.88		13.8	0	0	0	0							13.7%	10.0%	6.0%	0.0%	Yes	4.6%	3.6	15.0%		
HH EAU	-	- 7.4	11.16	7.36		0	0	2	9							19.3%	6.7%	5.1%	7.0%	Yes	1.0%	4.9	18.0%		
HH Emergency Department	-	-	23.00			2	0	0	0							21.2%	16.5%	3.9%	6.3%	Yes	-1.3%	4.7	14.9%	85%	6%
John Warin Ward	- 1.4	0.5	11.49	9.60	10.1	0	0	1	0							26.2%	5.0%	1.2%	3.2%	Yes	0.0%	7.3	15.9%	100%	0%
JR Emergency Department	-	-	16.00			6	0	0	10							24.5%	14.6%	6.5%	3.9%	Yes	2.3%	7.6	17.7%	80%	8%
Juniper Ward	0.1	0.7	7.35	8.18	7.5	0	0	5	7							20.2%	15.4%	4.1%	0.0%	No	-1.2%	5.7	18.9%		
Laburnum	- 0.6	- 1.3	8.00	8.74	7.4	1	1	3	4							19.1%	10.9%	2.6%	6.6%	Yes	-5.2%	5.7	18.0%	53%	0%
OCE Rehabilitation Nursing (NOC)	- 2.0	- 1.3	10.64	9.94	8.6	0	0	1	0							28.5%	8.3%	6.0%	5.9%	Yes	-3.4%	2.6	19.5%		
Osler Respiratory Unit	- 0.9	- 3.6	13.50	8.95	12.6	1	0	2	0							24.5%	8.3%	2.2%	3.1%	Yes	0.9%	7.7	17.5%	50%	0%
Ward 5E/F	- 0.7	- 1.0	10.56	8.84	9.9	1	0	2	12							22.5%	0.0%	6.6%	0.0%	Yes	-0.4%	7.0	15.6%	50%	0%
Ward 7E Stroke Unit	- 2.1	- 0.3	10.86	9.02	8.7	1	0	0	6							14.2%	5.0%	3.7%	5.5%	Yes	9.7%	9.7	15.8%	100%	0%
SUWON																									
Gastroenterology (7F)	0.4	- 0.5	7.06	8.03	7.5	0	0	0	4							11.7%	7.8%	2.0%	5.9%	No	0.3%	7.7	15.0%	100%	0%
Gynaecology Ward - JR	- 0.4	- 2.3	8.75	6.02	8.4	1	0	0	0							37.3%	9.3%	7.9%	0.0%	No	3.4%	9.7	17.9%	100%	0%
Haematology Ward	- 1.6	- 0.2	9.26	7.85	7.6	3	0	0	11							12.1%	5.5%	6.5%	6.7%	Yes	1.4%	6.6	24.2%	100%	0%
Katharine House Ward	0.7	2.3	9.20	7.55	9.9	0	0	1	1							4.1%	10.4%	1.3%	4.4%	Yes	5.5%	8.3	25.0%		
Oncology Ward	- 2.5	- 0.2	10.40	8.09	7.9	7	0	4	3							39.2%	12.2%	8.3%	8.1%	Yes	-1.4%	7.4	17.7%	86%	0%
Renal Ward	- 0.5	- 0.1	9.49	9.07	9.0	1	0	1	5							6.2%	0.0%	3.6%	3.2%	Yes	0.0%	7.7	17.4%	100%	0%
SEU D Side	- 0.2	- 0.3	8.67	8.21	8.5	0	0	1	2							22.8%	12.6%	2.7%	0.0%	Yes	-0.5%	8.4	19.5%	78%	11%
SEU E Side	- 0.1	- 0.3	8.39	8.58	8.2	4	0	0	2							21.6%	26.4%	1.7%	3.5%	Yes	-1.1%	8.4	15.8%	96%	0%
SEU F Side	0.3	- 1.2	6.99	8.52	7.3	0	0	1	2							22.3%	16.4%	4.8%	5.9%	Yes	2.3%	8.4	15.7%	83%	9%
Sobell House - Inpatients	- 0.9	- 0.2	8.66	7.96	7.7	1	0	2	0							24.9%	8.6%	4.8%	3.4%	Yes	1.5%	9.4	18.9%		
Transplant Ward	0.2	0.8	9.17	8.58	9.4	2	0	1	1							29.0%	10.8%	5.6%	6.0%	Yes	4.5%	6.4	18.8%	95%	0%
Upper GI Ward	- 1.6	0.1	10.23	8.61	8.7	0	0	0	5							25.1%	1.2%	1.8%	2.9%	Yes	-0.4%	8.3	12.6%	100%	0%
Urology Inpatients	- 1.0	- 1.2	9.10	9.26	8.1	0	0	2	3							37.6%	4.6%	0.5%	8.9%	Yes	0.9%	9.4	23.5%	99%	1%
Wytham Ward	- 1.7	0.0	8.81	7.06	7.1	1	0	0	1							23.1%	17.2%	5.0%	0.0%	Yes	-5.2%	8.1	19.0%	100%	0%
MW The Spires	- 12.9	-	27.50		14.6	0	0	0	0											Yes	0.0%	8.0	14.7%		
MW Delivery Suite	- 5.4	-	25.48		20.1	1	0	0	0	40	14	0	5	76.0%	5	-18.6%	10.3%	4.2%	5.5%	Yes	-0.6%	6.7	11.3%		
MW Level 5	- 2.6	-	7.38		4.8	2	0	0	0											Yes	5.8%	7.6	18.6%		
MW Level 6	2.3	-	4.96		7.3	0	0	0	0											Yes	1.2%	5.6	13.8%		
CSS																									
JR ICU	- 5.1	-	29.05		23.9	7	1	2	1							28.6%	11.4%	7.3%	6.5%	Yes	0.1%	7.7	16.9%		
Trust total	- 54.2	- 5.4																							

Summary of challenges and risks

The above dashboard triangulates nursing and midwifery quality metrics with CHPPD, (Care Hours Per Patient Day), at inpatient ward level. It is a NHSE/I mandated requirement for this to be reviewed by Trust Boards each month.

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

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

Increased bed capacity has remained open across the divisions in March 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.

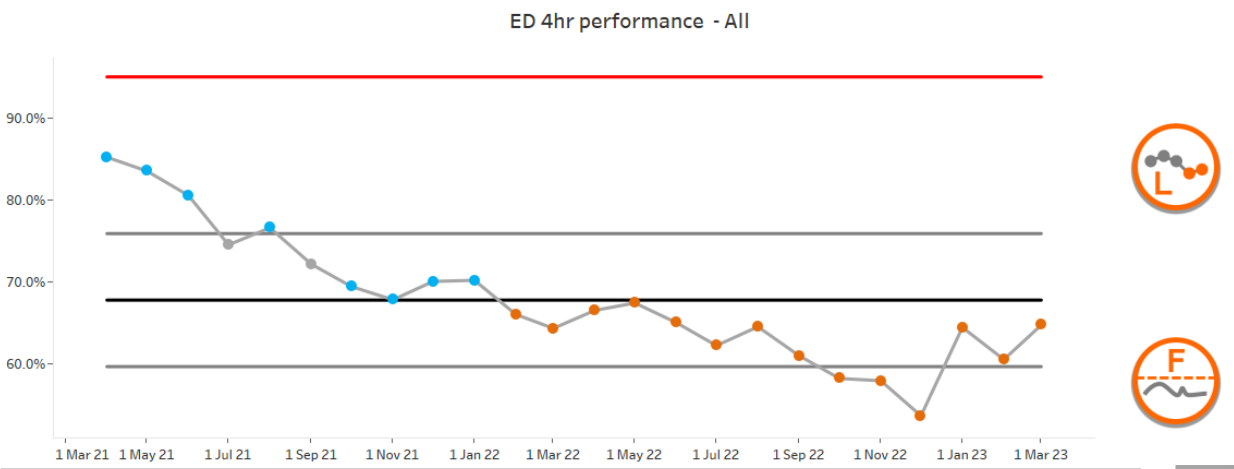
CHPPD, at ward level can be used to address any indicators of ongoing risk to staffing, triangulated with the roster Key Performance Indicators and quality and Human Resource, (HR) metrics, and these are reviewed and addressed each month by the Divisional Directors of Nursing.

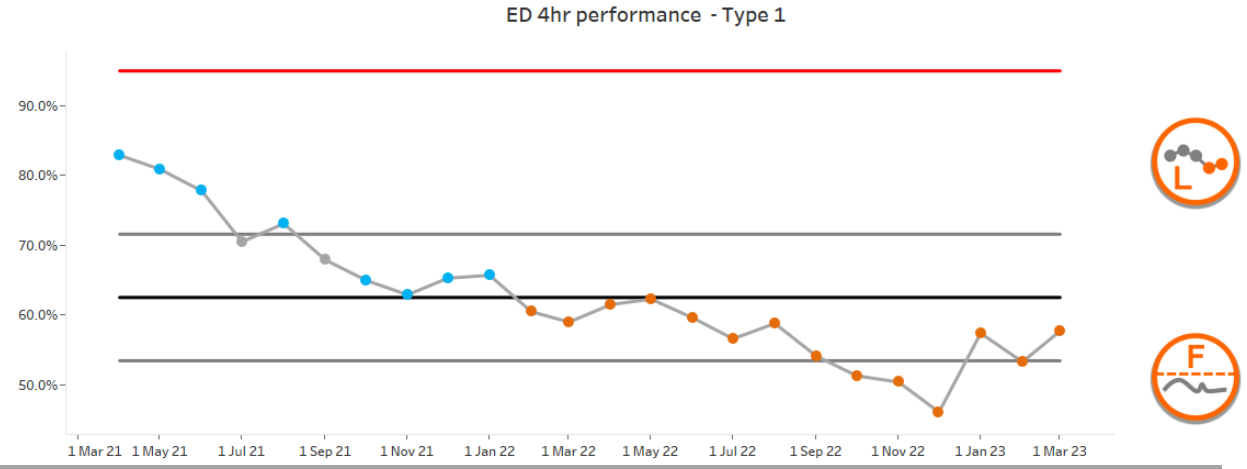
Annual leave has been slightly over target for the month of March as end of financial year, this is being addressed within the divisions to ensure more even spread throughout next financial year to remain on target.

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: Operational Performance

Oxford University Hospitals NHS Foundation Trust





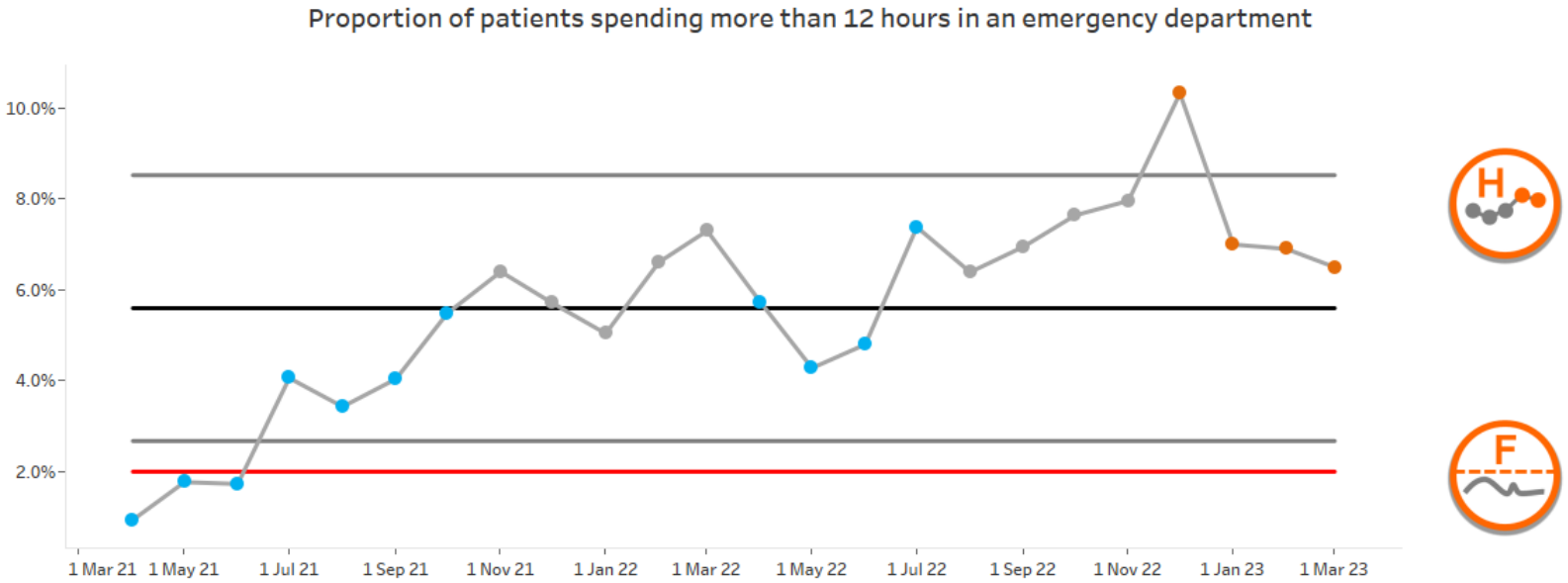
Benchmarking: ED (All types): March 23

OUH: 64.7% **National:** 70.7% **Shelford:** 65.2% BHT: 70.0% RBH: 71.9%

ICS key

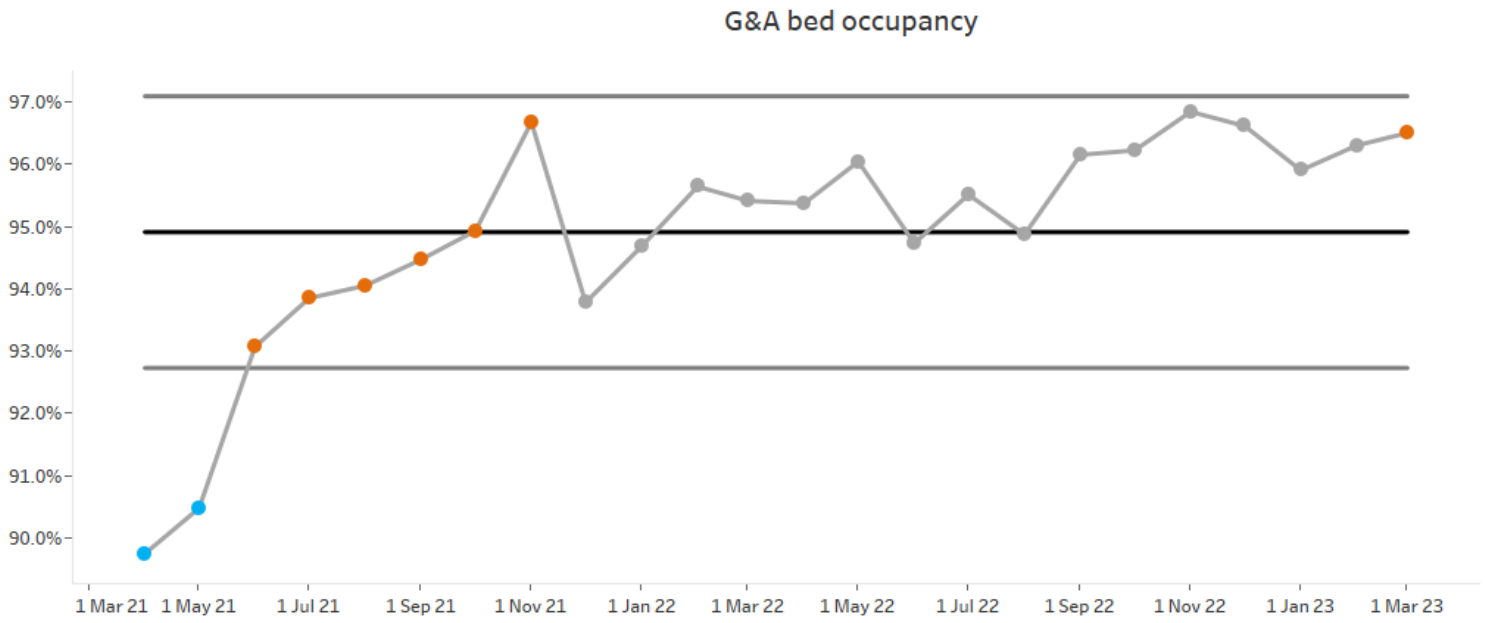
BHT	Buckinghamshire Healthcare NHS Trust	**RBH**	Royal Berkshire NHS Foundation Trust

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 (Y/N)	Data quality rating
ED 4-hour performance (All types) was 64.7% in March and for Type 1 activity, performance was 57.7% in March 2023. For both indicators, performance exhibited special cause variation due to more than seven consecutive periods of performance below the mean and two of the last three periods recording performance within one sigma of the lower process control limit. The indicator has consistently not achieved the target. Attendances had increased by 10.36% when compared to the previous month. Most notably, when taking into consideration variance in the number of days in the month, paediatric presentations had increased significantly resulting in further challenge for an under-pressure Children's Hospital. Wait to be seen continues to be the most significant breach reason for admitted and non-admitted patients. Recent Industrial Action from the BMA has highlighted how a different medical staffing model can impact on 4hr performance. Both sites were challenged from a capacity perspective with additional escalation beds remaining open on both sites. In addition, the Discharge Lounge space on CCU at the Horton was required to be converted to inpatient capacity for short periods and AAU at the JR remained open on a small number of occasions.	**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. ○ 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.	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	*Yes*	***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 (Y/N)	Data quality rating
The proportion of patients spending more than 12 hours in an emergency department was 6.5% in March. Performance exhibited special cause variation due to over seven consecutive performance periods above the mean of 5.6%. The indicator has consistently not achieved the target. Whilst March saw an improvement on the previous month, there were still challenges around wait to be seen and urgent care capacity on the wards at the JR and Horton sites. IPC considerations compound the issue, particularly in the Children's Hospital. In addition, patients presenting with mental health related illness have a longer length of stay in the Emergency Department.	**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	Yes	***Not yet assured***

3. Assurance report: Operational Performance, *continued*

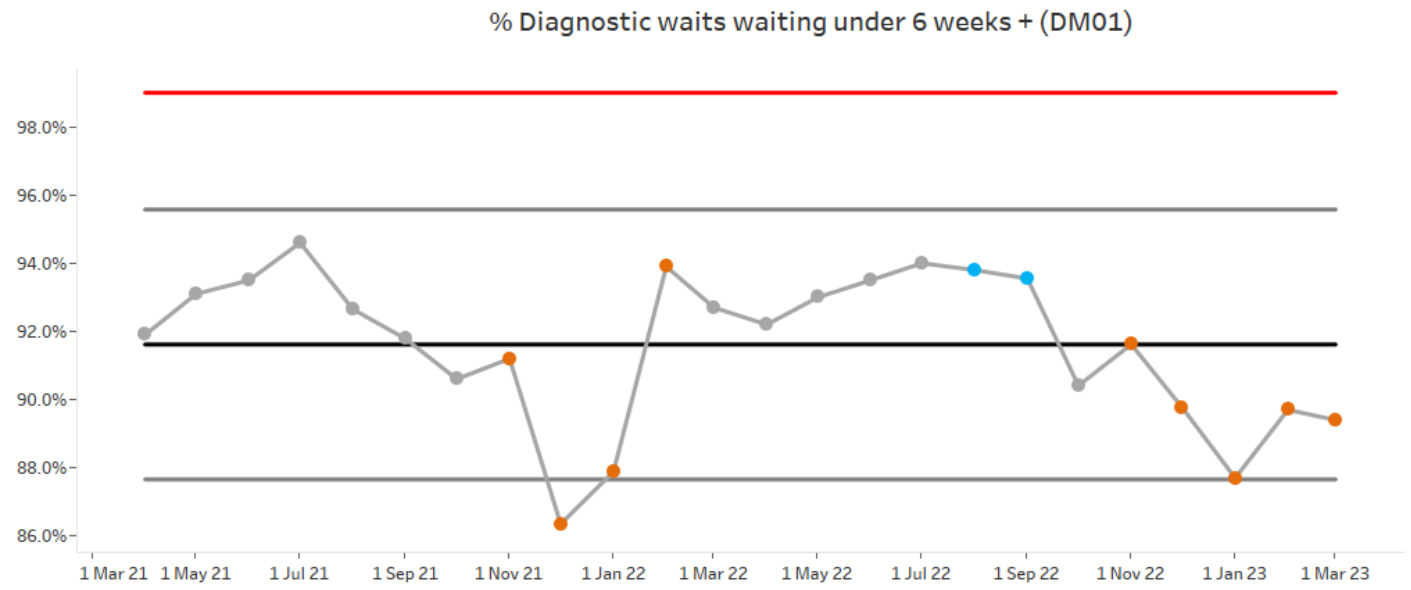


Benchmarking: Q3 22/23 G&A bed occupancy	
OUH	96.6%
National	91.9%
Shelford	92.7%
ICS	BHT: 99.8% RBH: 93.7%

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 (Y/N)	Data quality rating
G&A bed occupancy was 96.5% in March. Performance exhibited special cause variation due to over seven consecutive performance periods above the mean of 94.9%.Patients medically optimised for discharge and length of stay continue to be a challenge, alongside elective recovery and urgent care capacity.	**MADE Event** 26/04/23 yielded an 18% reduction in MOFD total numbers. Follow-on event planned for the beginning of May. Overall **reduction in bed days lost** for patients medically optimised for discharge but whose discharge was delayed by 50% from August 2022. Target reduction of a further 25% by Quarter 2 Head of the Oxfordshire **Transfer of Care Hub** appointment made with the backfill into the Discharge Team Manager proceeding through recruitment process. PWC supporting Oxfordshire with designing **Admission Avoidance** and **Discharge to Assess** models with a Business Case to be submitted for the end of Quarter 1.	May 2023: On Track Oxfordshire System UEC DG End of Quarter 2: On Track Oxfordshire System UEC DG July 2023: On Track Oxfordshire System UEC DG End of Quarter 1: On Track Oxfordshire System UEC DG /A&E Delivery Board	No	***Not yet assured***

3. Assurance report: Operational Performance, *continued*

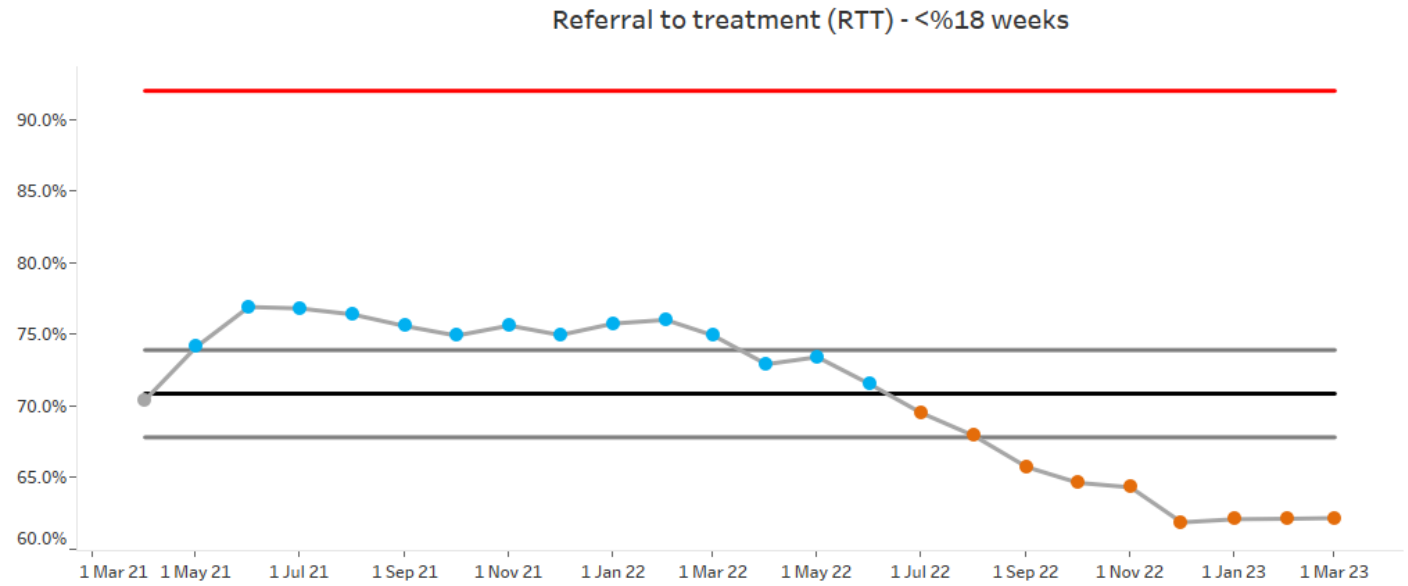


Benchmarking: Feb 23 DM01	
OUH	89.4%
National	80.6%
Shelford	86.1%
ICS	BHT: 58.4% RBH: 75.7%

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 (Y/N)	Data quality rating
The % of Diagnostic waits waiting under 6 weeks+ (the DM01) was 89.4% in March. Performance exhibited special cause variation due to two of the last three periods recording performance within one sigma of the lower process control limit. The indicator has consistently not achieved the target of 99%. **Audiology**: 3.7 vacancies (retention has been an issue) and ENT referral re-alignment has changed performance **Cardiology**: Awarded community echo service with 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:** Appointed 3wte staff and seeking locum cover for additional gaps. Procuring 2 further booths to increase capacity at JR site. Options appraisal for reducing waiting times for first hearing appointments. **Cardiology:** Insourcing due to commence to address backlog clearance. **Clinical Neurophysiology:** Return of 2 staff members from maternity leave and technicians to be fully trained to conduct EMGs - reduced insourced capacity or support increased demand. **Respiratory Sleep studies:** CDC now in use and is being considered for expansion.	Weekly Assurance meeting will monitor all actions on a bi-weekly basis **Audiology:** improvement expected from May 2023 **Cardiology:** compliance by December 2023 **Clinical Neurophysiology:** improvement expected from July 2023 **Respiratory Sleep studies:** compliance by January 2024	*Y*	***Not yet assured***

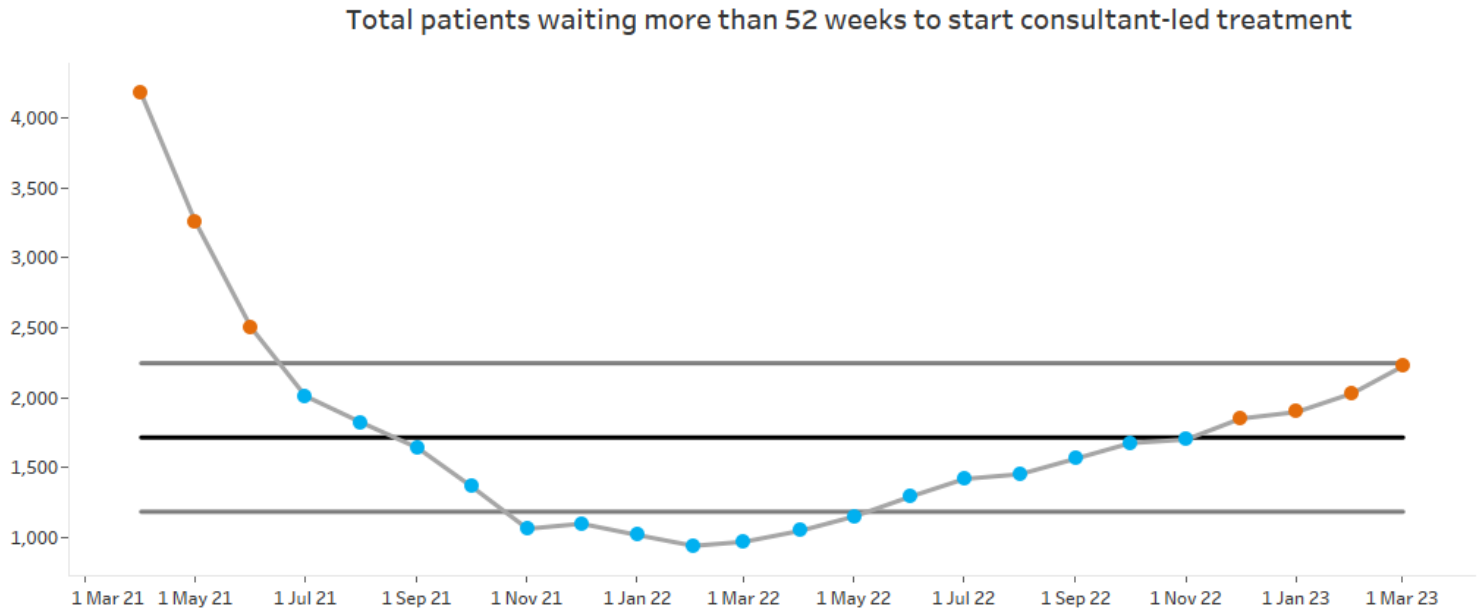
3. Assurance report: Operational Performance, *continued*



Benchmarking: Feb 23	
OUH	62.3%
National	61.7%
Shelford	61.5%
ICS	BHT: 47.7% RBH: 83.7%

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 (Y/N)	Data quality rating
Referral to treatment (RTT) performance within 18 weeks was 62.2% in March, and below the performance standard of 92%. Performance exhibited special cause variation due to more than seven consecutive performance periods below the mean of 70.8% and below the lower process control limit of 67.8%. The indicator has consistently not achieved the target. Significant challenges remain in the longer waiting pathways as described below: <u>PTL Profile and Growth: March 23 vs March 22</u> ○ **1st appt** – 62.8% of Total PTL and 24% increase in patients waiting for their 1st appointment ○ **FUP/Diagnostic** – 18.5% of PTL and 8% increase in patients waiting for the next appointment ○ **Admission** – 18.5% of PTL and 35% increase in patients waiting for their elective procedure	Focus remains on longest waiting patient cohorts with the Trust working towards delivery of 65 weeks in line with our operating plan 2023/24 With 63% of patients on the PTL waiting for 1st outpatient appointments and likelihood of their pathway progressing to follow-up/diagnostic, and potentially elective admission, the approach to booking all outpatients early this year is being considered. This could provide clearer plans to organise complex pathways prior to any challenges encountered near the end of year. Known challenged specialty pathways are being factored in with theatre re-modelling that supports our operating plans for cancer, P2 and long wait elective admissions A new referral management solution is being considered for implementation that would reduce admin inefficiencies and if used directly by primary care as a frontend portal instead of eRS, would have benefits such as increased proforma compliance and improved access to Advice and Guidance	All actions are being reviewed and addressed via weekly Assurance meetings and Elective Recovery Group	*Y*	***Not yet assured***

3. Assurance report: Operational Performance, *continued*

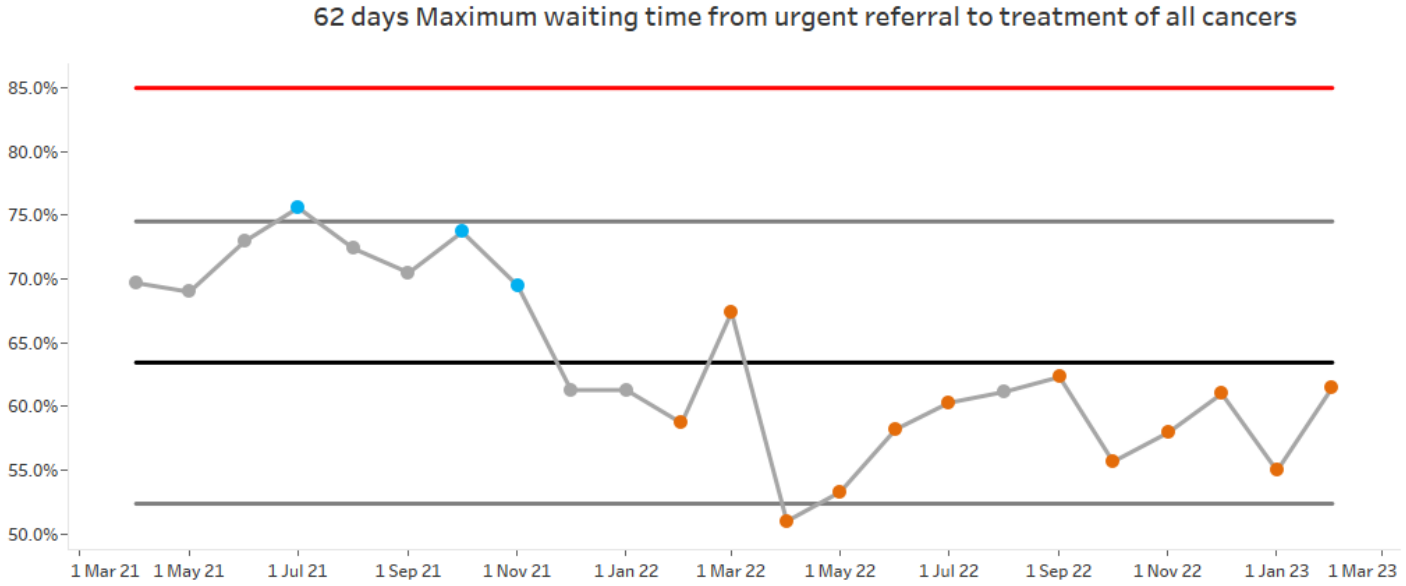


Benchmarking: Feb 23	
OUH	2,031
National	1,288 (avg.)
Shelford	3,082 (avg.)
ICS	BHT: 2,953 RBH: 27

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 (Y/N)	Data quality rating
The number of patients waiting more than 52 weeks to start consultant-led treatment was 2,226 in March. Performance exhibited special cause variation due to over seven consecutive periods of deteriorating performance. **104 weeks** were challenged for March mainly due to the complexity and PICU capacity for paediatric spinal cases and a national shortage of corneal grafts supplies for Ophthalmology patients. **78 weeks** along with the above specialties, have also been challenged within Urology due to a capacity deficit against demand levels, Adult Spinal due to complexity and adequate capacity, and Plastic surgery due to capacity in the main.	○ **Corneal graft supplies** are being managed centrally by NHSE via NHSB&T as this is a recognised national issue. We are seeing supplies being provided for our longest wait patients ○ **Paediatric Spinal services** remain a challenge due to PICU bed availability. A short/medium term solution to address PICU capacity is being considered. ○ **Theatre re-modelling and planning** has commenced and continues to evolve to ensure all services have a fair proportion of capacity to manage our longest waiting patients. ○ **Enabling all outpatient activity** to be undertaken early as well as the above will reduce the risk of not delivering the Operating Plan. ○ **Elective Recovery Fund** schemes proposed for 2023/24 are to be finalised early May 2023	Delivery of 65 weeks is planned by March 2024 All actions are being reviewed and addressed via weekly Assurance meetings and Elective Recovery Group	*Y*	***Not yet assured***

3. Assurance report: Operational Performance, *continued*

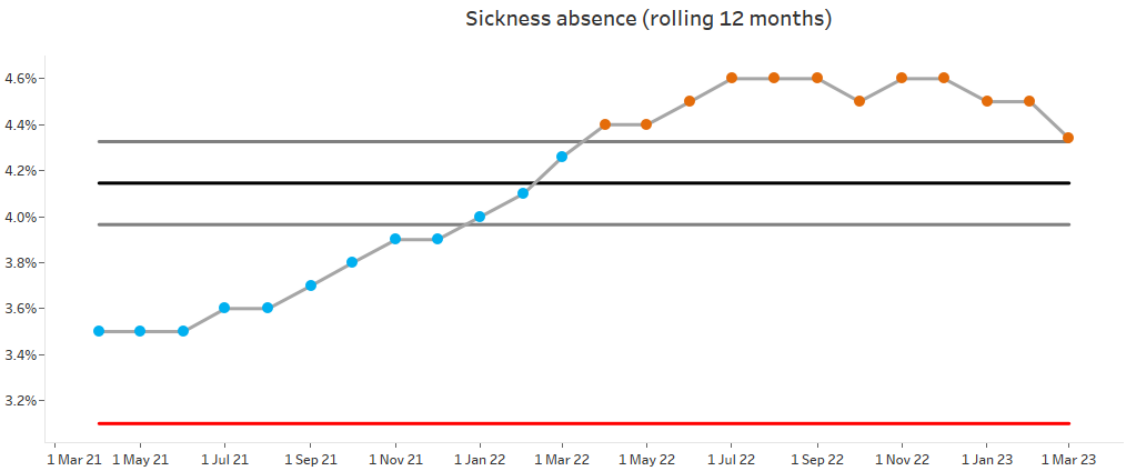


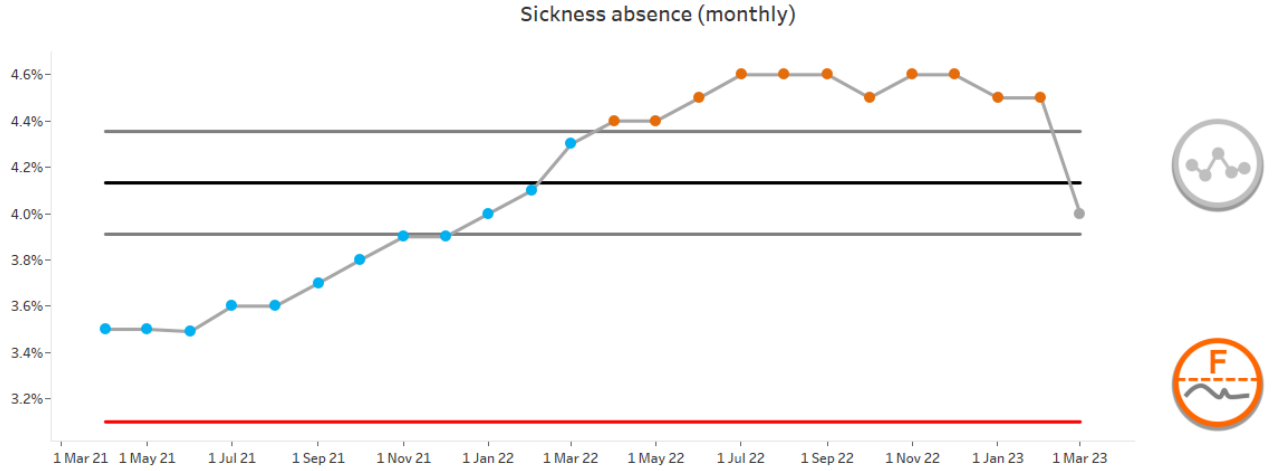
Benchmarking: Feb 23 62 day Standard	
OUH	59.5%
National	58.8%
Shelford	58.8%
ICS	BHT: 67.1% RBH: 67.4%

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 (Y/N)	Data quality rating
Cancer performance against the 62 days standard for urgent referral to treatment was 61.5% in March, 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 63.5%. The indicator has consistently not achieved the target. All tumour sites apart from Skin are non-compliant for this standard in February. **Challenges identified:** • Complex tertiary level patients • Some slow pathways and processes • Capacity for some surgery, diagnostics and oncology • Late inter provider transfers • Patient choice	**The Cancer Improvement Programme** launched in 2022/23 with a focus on 28-day Faster Diagnosis Standard (FDS). For February, **the Trust was 18th 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 change ideas 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	Y	***Not yet assured***

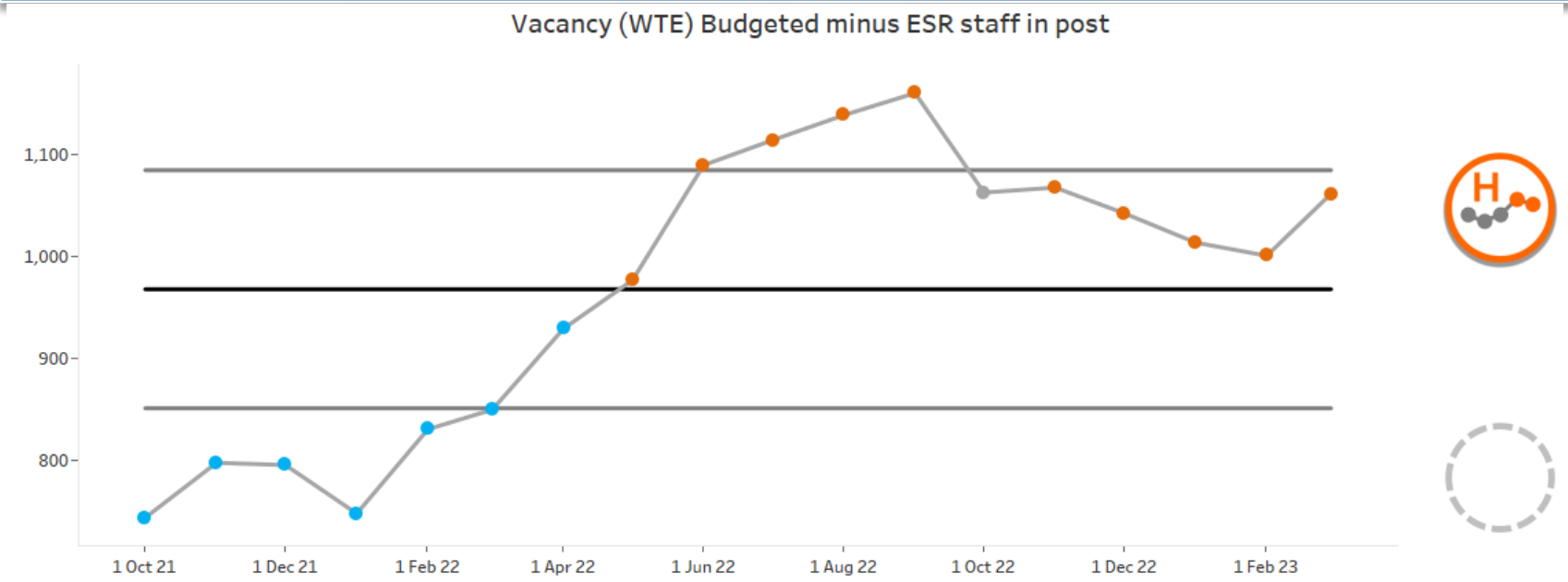
3. Assurance report: Growing Stronger Together





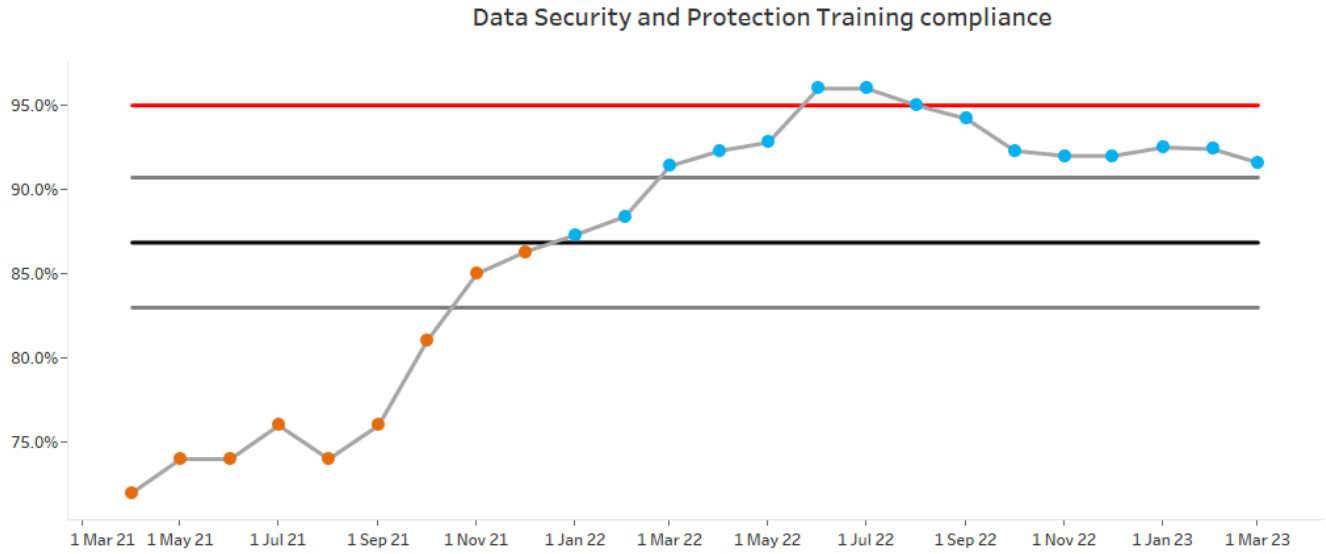
Benchmarking: Nov 22						
OUH: 4.5%	**National:** 5.5%	**Shelford:**4.7%	Buckinghamshire Healthcare NHS Trust: 4.2%	Royal Berkshire NHS Foundation Trust: 4.1%	Oxford Health: 4.9%	South Central Ambulance Service: 7.6%

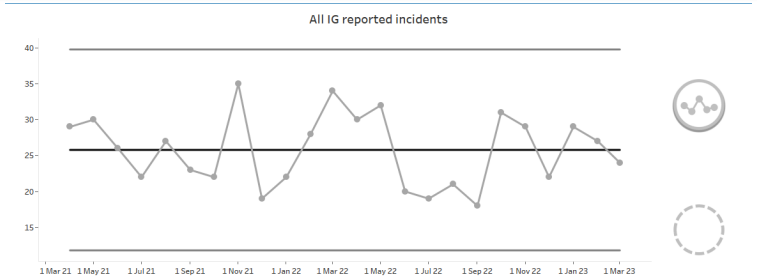
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register (Y/N)	Data quality rating
Sickness absence performance (rolling 12 months) was 4.3% in March. Performance exhibited 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. Sickness absence performance (monthly) was 4.0% in March. Performance exhibited common cause variation. The indicator has consistently not achieved the target. Sickness absence has reduced in March. Key to this is the reduction in the COVID19 absence rate. This is now at 0.9%.	1. Wellbeing Equipment from Capital Funds: All Energy Pods, Sleep Tubes and Wellbeing Nooks were installed before the end of March. 2. The divisions are encouraging managers to conduct RTW within 30 days and providing reports to assist with this. 3. HR Team focussing on weekly provision of frequent absence reports to managers to initiate formal processes where required. 4. Sickness dashboard being produced to provide further information on sickness absence for Divisions. 5. Monthly meetings with Occupational Health with Divisional HR Teams to discuss complex cases.	1. March 2023 – Completed – TME via IPR 2. June 2023 – On track – HR Governance Monthly meeting & Divisional meetings /TME via IPR 3. June 2023 – On track – HR Governance & Divisional meetings / TME via IPR 4. May 2023 – On track – TME via IPR 5. March 2023 – Completed – HR Governance / TME via IPR	*N/A*	***Not yet assured***

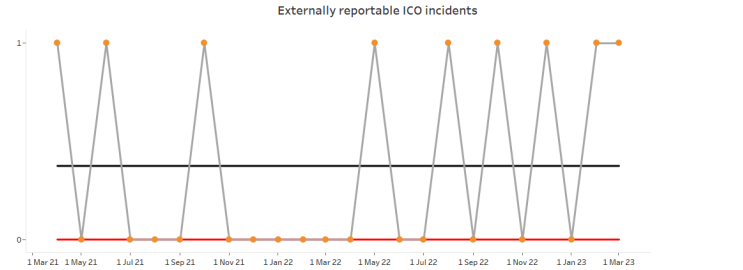


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register (Y/N)	Data quality rating
Vacancy (WTE) Budgeted minus ESR staff in post totalled 1,062 in March, Performance exhibited special cause variation due to successive periods of performance (>6 months) above the mean of 968 WTE. Health Care Assistants having the highest vacancy factor at 16.2%. "Other" staff, primarily Administrative in nature are at 9.8%. At 9.5% NOTSSCaN has the highest vacancy rate of the clinical Divisions.	1. Targeted approaches where required e.g. MRC HCSW Task & Finish Group. Report will be presented at next CWRRE Steering Group.	1. June 2023 – On track – CWRRE	N/A	***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 (Y/N)	Data quality rating
Data security and Protection Training compliance was 91.6% in March, below the target of 95%. Performance exhibited special cause variation due to successive periods of performance improvement (>6 months) above the mean of 86.9% as well as exceeding the upper process control limit of 90.7%. 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 during the reporting period	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. All staff emails to be send fortnightly in May and June explaining the importance of completing IG training	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	Y	***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 M1 2023/2024

5. Assurance framework model

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