Oxford University Hospitals
NHS Foundation Trust

Integrated Performance Report

M6 (September data)

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Table of Contents

1. Executive summary

Overview

Quality, Safety and Patient experience

Growing Stronger Together

Operational Performance

Finance

Digital

Data quality

The reporting period of September is the last month in which SIRIs will be called by the Trust, following the adoption of the new Patient Safety Incident Response Framework (PSIRF) in October. The metrics for PSIRF are in production and this will mean that SPC reporting is not available until the requisite number of data points are recorded, however we will continue to review performance closely regardless of SPC triggers. In month 6, our Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) rates continued to demonstrate fewer patient deaths than expected. We achieved our target in a number of measures that support patient safety and experience of care, including pressure ulcer incidents per 10,000 beddays for category 2 and 3-4 incidents, VTE assessments, medication errors causing serious harm and MSSA infections.

Our staff supported patient care by achieving the standards set for core skills training compliance, and the achievement of targets for the vacancy rate, turnover, non-clinical appraisals and core skills training. Our staff were supported by our better-than-target time to hire. The Cancer Faster Diagnosis standard achieved the performance standard and we remain amongst the highest-performing hospitals nationally. We report and celebrate other successes within the Divisional Performance Review meetings relating to the contributions of our staff in improving the care and experience for our patients, workforce and population. These are also documented in the summary of the Performance Review meetings and reported to the IAC.

Out of the 105 indicators currently measured in the IPR, 39 are reported on in further detail using the standardised assurance templates. This includes indicators not meeting the performance standard and/or where there has been deteriorating special cause variation. The review process at Trust Management Executive also enables indicators without a target and not flagging special cause variation to be included in assurance reporting.

We noted hospital infections as worse than our monthly threshold for MRSA, C.diff, E.Coli and Klebsiella cases and assurance reports are provided for these and other indicators identified for exception reporting, including our complaints response times (noting special cause variation improvement), reactivated complaints, FFT percentage positive responses (noting special cause variation improvement in outpatient and ED), serious incidents, neonatal deaths and stillbirths, safeguarding training (adults, level 3) and PFI cleaning at the John Radcliffe.

Sickness absence rates continue to decrease and exhibit improving special cause variation but remain above the target. As detailed above, all other targets measured within the domain of Growing Stronger Together are meeting targets.

The number of patients waiting in the categories over 52, 65, 78 and 104 weeks increased in September and we did not meet the diagnostic (DM01) standard. Within the assurance reports, actions for each of the challenged specialties are outlined with reference to 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. Improvement plans and actions are reviewed monthly at the Cancer Improvement Programme. Patients attending our type-1 emergency departments and being seen within four hours did not meet the performance standard or the trajectory for September. The time patients spent over 12 hours in the department was below standard but continued to exhibit improving special cause variation.

Income and Expenditure (I&E) performance in September was a £2.9m deficit. This is worse than plan, but has improved each month since May. The average underlying deficit after six months is £5.7m per month again improving each month. The year-to-date deficit is £27.3m. Cash is £20.9m.

We recorded one Priority 1 incident in September relating to the wireless network. A permanent fix was implemented and the system has remained stable. We have also included assurance templates on DSPT / information governance training compliance, Data Subject Access response (DSAR) times and response times for Freedom of Information (FOI) requests.

The assurance reports' data quality ratings have been completed and have outcomes ranging from 'satisfactory' to 'sufficient', as per the definitions referenced on page 8.

2. a) Indicators identified for assurance reporting

Oxford University Hospitals NHS Foundation Trust

	Common cause variation	Special cause variation - improving	Special cause variation - deterioration	Other (where an increase or decrease has not been deemed improving or deteriorating, where SPC is not applicable, or the indicator has been identified for assurance reporting in the absence of performance vs target or special cause variation)
Quality, Safety and Patient Experience	Not achieving target • MRSA cases • C-diff cases • E.Coli cases • Klebsiella cases • Serious Incidents Requiring Investigation • Reactivated complaints • Safeguarding (adults) training L3 • FFT Inpatient % positive • FFT Maternity % positive • Number of mother's birthed • Scheduled bookings	Not achieving target • % of complaints responded to within agreed timescales • Safeguarding (adults) training L3 • FFT ED % positive • FFT Outpatient % positive • Midwife:birth ratio	No target • Number of incidents with moderate harm or above per 10,000 beddays. • Assault, Aggression and Harassment. • Incident rate of Violence and Aggression per 10,000 beddays.	No target • Children's safeguarding activity • Number of safeguarding consultations initiated by provider Not achieving threshold (No SPC) • Neonatal deaths per 1,000 live births • Stillbirths per 1,000 live births
Growing Stronger Together		Not achieving target • Sickness absence (rolling 12-month)	Achieving target • Vacancy rate%	
Operational performance	Not achieving target • ED 4-hour performance (all types) • ED 4-hour performance (type-1) • Proportion of patients spending more than 12 hours in the Emergency Department • Cancer 62-day waiting time from urgent referral	Not achieving target • Patients waiting more than 78 weeks • Patients waiting more than 104 weeks	Not achieving target • % Diagnostic waits under 6 weeks (DM01) Not achieving target • Patients waiting more than 52 weeks • Patients waiting more than 65 weeks to start consultant-led-treatment.	
Corporate Support Services	Not achieving target • PFI cleaning score (JR) • Freedom of Information % responded to within target time • Data Subject Access Requests	Not achieving target • Data Security and Protection Training compliance		Not achieving target (No SPC) • Priority 1 incidents

2. b) SPC indicator overview summary

Oxford University Hospitals NHS Foundation Trust

Quality, Safety and Patient Experience Summary

Latest Indicator Period: Sept-2023

Indicator Description	Period	Performance	Target / Threshold	Met?	Mean	LCL	UCL
MRSA bacteraemia infection rate COHA and HOHA (per 10,000 beddays)	Sept-23	0.4	-	-	0.2	-0.5	0.9
MRSA cases: HOHA+COHA	Sept-23	1	0	No	1	-1	2
Clostridium difficile infection rate COHA and HOHA (per 10,000 beddays)	Sept-23	4.6	-	-	3.7	0.4	7.0
C-diff cases: HOHA+COHA	Sept-23	13	9	No	11	1	20
E. coli infection rate COHA and HOHA (per 10,000 beddays)	Sept-23	5.0	-	-	5.6	0.7	10.5
E. Coli cases: HOHA+COHA	Sept-23	14	13	No	16	2	30
MSSA cases: HOHA+COHA	Sept-23	4	-	-	5	0	9
Klebsiella cases: HOHA+COHA	Sept-23	8	7	No	8	1	14
PSAR cases: HOHA+COHA	Sept-23	4	4		4	-4	13
Number of Never Events	Sept-23	0	0		0	-	-
Serious Incidents Requiring Investigation (SIRI)	Sept-23	3	0	No	8	-3	18
VTE Risk Assessment (% admitted patients receiving risk assessment)	Aug-23	98.0%	95.0%		98.1%	97.7%	98.5%
CAS alerts breaching deadlines at end of month and/or closed during month beyond deadline	Sept-23	0	0		0	-	-
Medication errors causing serious harm	Sept-23	1	-	-	2	-1	5
Mortality HSMR	Sept-23	91.6	100.0		93.8	-	-
Mortality SHMI	Sept-23	96.0	100.0		93.7	-	-
Neonatal deaths per 1,000 total live births	Sept-23	3.6	3.2	No	3.7	-	-
Stillbirths per 1,000 total births	Sept-23	5.2	4.0	No	3.7	-	-
National Patient Safety Alerts not completed by deadline	Sept-23	0	-	-	0	-	-
Potential under-reporting of patient safety incidents: Patient safety incident reporting rate per 10,000 beddays	Apr-21	0.0	-	-	0.0	-	-
Inpatients with a learning disability and/or autism per million head of population	Apr-21	0.0	-	-	0.0	-	-
Inappropriate adult acute mental health placement out -of -area placement bed days	Apr-21	0	-	-	0	-	-
Number of active clinical research studies hosted	Sept-23	1351	-	-	1340	1306	1374
Number of active clinical research studies (commercial)	Sept-23	360	-	-	345	331	359
Number of active clinical research studies (non commercial)	Sept-23	991	-	-	995	973	1017
Number of incidents with moderate harm or above per 10,000 beddays	Sept-23	54.2	-	-	40.6	22.2	59.1
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 2)	Sept-23	18.6	26.0		27.8	16.1	39.4
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 3 and 4)	Sept-23	2.5	3.0		2.8	-0.3	5.9
Pressure Ulceration incidents per 10,000 beddays (Present on admission Cat 1+)	Sept-23	100.6	114.0		115.6	87.0	144.1
Harm from Falls (Moderate and above)	Sept-23	1	-	-	5	-1	10
Harm from Falls per 10,000 beddays (moderate and above)	Sept-23	0.4	-	-	1.6	-0.3	3.5

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

Latest Indicator Period: Sept-2023

Indicator Description	Period	Performance	Target / Threshold	Met?	Mean	LCL	UCL
Number of complaints	Sept-23	98	-	-	98	55	141
Number of complaints per 10,000 beddays	Sept-23	35.0	-	-	34.8	20.6	49.1
% of complaints responded to within agreed timescales	Sept-23	89.0%	95.0%	No	69.3%	51.2%	87.4%
Reactivated complaints	Sept-23	13	1	No	8	-1	18
Number of RIDDORs	Sept-23	3	-	-	3	-2	8
Health and Safety related incidents - Assault, Aggression and harassment	Sept-23	152	-	-	125	58	193
Incident rate of violence and aggression (rate per 10,000 beddays)	Sept-23	54.2	-	-	44.4	21.1	67.7
FFT inpatient % positive	Sept-23	94.8%	95.0%	No	95.1%	93.3%	96.9%
FFT outpatient % positive	Sept-23	93.7%	95.0%	No	93.7%	92.3%	95.2%
FFT ED % positive	Sept-23	78.6%	85.0%	No	78.3%	69.6%	87.0%
FFT maternity % positive	Sept-23	81.5%	90.0%	No	87.4%	64.0%	110.8%
FFT children's % positive	Aug-22	93.9%	-	-	93.6%	87.2%	100.1%
Inpatient FFT (response rate)	Sept-23	25.5%	-	-	25.8%	22.5%	29.1%
Outpatient FFT (response rate)	Jun-23	24.4%	-	-	11.5%	6.7%	16.2%
A&E FFT (response rate)	Sept-23	24.0%	-	-	25.1%	21.9%	28.3%
Maternity FFT (response rate)	Sept-23	18.5%	-	-	8.1%	3.1%	13.0%
Adult safeguarding activity	Sept-23	754	-	-	675	487	863
Children's safeguarding activity	Sept-23	735	-	-	457	281	632
Number of safeguarding consultations initiated by provider (both to internal and external organisations)	Sept-23	1534	-	-	1134	864	1403
Safeguarding (children) training L1 - L4 compliance	Sept-23	90.0%	90.0%		83.2%	77.3%	89.2%
Safeguarding (adults) training L3	Sept-23	0.0%	90.0%	No	0.0%	0.0%	0.0%
Trust level: CHPPD vs budget	Sept-23	-16.1	-	-	-42.5	-96.2	11.3
Trust level: CHPPD vs required	Sept-23	22.4	-	-	-16.9	-40.4	6.6
Mothers birthed	Sept-23	640	625	-	628	560	696
Babies born	Sept-23	652	-	-	639	569	708
Scheduled Bookings	Sept-23	703	750	-	711	572	849
Inductions of labour from iView	Sept-23	126	-	-	146	106	186
Midwife:birth ratio (1 to X)	Sept-23	32.0%	28.0%		27.5%	24.4%	30.7%
PFI: % cleaning score by site (average) JR	Sept-23	93.6%	95.0%	No	93.2%	82.9%	103.4%
PFI: % cleaning score by site (average) CH	Sept-23	98.3%	95.0%		94.5%	87.7%	101.3%
PFI: % cleaning score by site (average) NOC	Sept-23	97.9%	95.0%		98.0%	94.0%	102.0%

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

Oxford University Hospitals NHS Foundation Trust

Growing Stronger Together Summary

Latest Indicator Period: Sept-2023

Indicator Description	Period	Performance	Target / Threshold	Met?	Mean	LCL	UCL
Vacancy rate %	Sept-23	6.9%	7.7%		6.8%	5.7%	7.8%
Turnover rate (rolling 12 months)	Sept-23	10.6%	12.0%		11.5%	10.9%	12.1%
Sickness absence (rolling 12 months)	Sept-23	3.9%	3.1%	No	4.1%	3.9%	4.3%
Appraisal compliance (non medical)	Sept-23	95.6%	85.0%		68.8%	44.4%	93.2%
Core skills training compliance	Sept-23	91.6%	85.0%		89.2%	87.8%	90.5%
Time to hire (average days)	Sept-23	45.6	53.0		51.3	42.0	60.7

Operational Performance Summary

Latest Indicator Period: Sept-2023

Indicator Description	Period	Performance	Target / Threshold	Met?	Mean	LCL	UCL
Proportion of ambulance arrivals delayed over 30 minutes	Sept-23	14.3%	-	-	9.0%	0.9%	17.1%
Ambulance turnaround time > 60 minutes	Sept-23	1.3%	-	-	1.4%	-0.5%	3.2%
ED 4hr performance - All	Sept-23	63.7%	76.0%	No	67.8%	59.8%	75.8%
ED 4hr performance - Type 1	Sept-23	57.6%	76.0%	No	62.5%	53.6%	71.4%
Proportion of patients spending more than 12 hours in an emergency department	Sept-23	5.0%	2.0%	No	5.2%	2.3%	8.1%
Proportion of patients discharged from hospital to their usual place of residence	Sept-23	92.6%	-	-	91.8%	90.7%	93.0%
Available virtual ward capacity per 100k head of population	Apr-21	0.0	-	-	0.0	-	-
Number of virtual ward spaces available	Apr-21	0	-	-	0	-	-
G&A bed occupancy	Sept-23	94.3%	-	-	94.4%	91.7%	97.2%
Theatre utilisation (elective)	Sept-23	96.8%	85.0%		89.8%	85.9%	93.7%
% Diagnostic waits waiting under 6 weeks + (DM01)	Sept-23	79.4%	95.0%	No	90.3%	86.1%	94.4%
Total patients waiting more than 52 weeks to start consultant-led treatment	Sept-23	3081	-	-	1935	1435	2434
Total patients waiting more than 65 weeks to start consultant-led treatment	Sept-23	939	-	-	854	556	1153
Total patients waiting more than 78 weeks to start consultant-led treatment	Sept-23	137	0	No	350	204	496
Total patients waiting more than 104 weeks to start consultant-led treatment	Sept-23	6	0	No	29	1	58
62 days Maximum waiting time from urgent referral to treatment of all cancers	Aug-23	64.2%	85.0%	No	62.9%	52.7%	73.1%
Proportion of patients meeting the faster cancer diagnosis standard	Aug-23	80.1%	75.0%		79.4%	71.9%	86.8%
31-all (new standard)	Apr-21	0.0%	-	-	0.0%	-	-
Cancer: % patients diagnosed at stages 1 and 2	Apr-21	0.0%	-	-	0.0%	-	-
62 Day incomplete pathways >62 days	Sept-23	305	-	-	276	199	353
62 Day incomplete pathways >104 days	Sept-23	87	-	-	87	58	115
Total DC activity undertaken compared with 2019/20 baseline	Sept-23	92.5%	-	-	88.5%	70.3%	106.7%
Total IP elective activity undertaken compared with 2019/20 baseline	Sept-23	77.9%	-	-	82.6%	56.9%	108.3%
Total first outpatient activity undertaken compared with 2019/20 baseline	Sept-23	102.0%	-	-	103.6%	77.0%	130.3%
Total follow up outpatient activity undertaken compared with 2019/20 baseline	Sept-23	111.7%	-	-	109.5%	80.9%	138.1%
Total diagnostic activity undertaken compared with 2019/20 baseline	Sept-23	124.4%	-	-	114.7%	98.0%	131.3%
Total patients treated for cancer compared with the same point in 2019/20	Sept-23	80.6%	-	-	121.9%	79.9%	163.9%

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

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

Oxford University Hospitals NHS Foundation Trust

Finance Summary

Latest Indicator Period: Sept-2023

Indicator Description	Period	Performance	Target / Threshold	Met?	Mean	LCL	UCL
In-month financial performance Surplus/Deficit £'000	Aug-23	-3406.1	-1405.0	No	-725.2	-7000.6	5550.2
Adjusted in-month financial performance Surplus/Deficit £'000	Aug-23	-5144.0	-	-	-2084.3	-7046.8	2878.2
Year-to-date financial performance Surplus/Deficit £'000	Aug-23	-24371.4	-6224.0	No	-5661.6	-11828.0	504.7
Elective recovery funding (ERF) value-weighted activity % In month	Aug-23	99.1%	107.0%	No	91.7%	65.7%	117.7%
Cash £'000	Aug-23	43200	30417		46296	22384	70207
BPPC £ %	Aug-23	89.2%	95.0%	No	90.7%	82.5%	98.9%
BPPC Volume %	Aug-23	81.4%	95.0%	No	80.2%	72.8%	87.7%
In-month ICS CDEL capital expenditure	Aug-23	210.0	2485.0	-	2415.2	-	-
Efficiency delivery £'000	Aug-23	5566.6	-	-	2468.9	-	-

NB. At the time of reporting the Finance indicator values for M5 were used. We will report one month in arrears while we introduce Finance indicators into the IPR.

Corporate support services – Digital Summary

Latest Indicator Period: Sept-2023

Indicator Description	Period	Performance	Target / Threshold	Met?	Mean	LCL	UCL
Priority 1 Incidents	Sept-23	1	0	No	1	-	-
Data Security and Protection Training compliance	Sept-23	93.0%	95.0%	No	88.1%	84.8%	91.5%
Data Security & Protection Breaches	Sept-23	19	-	-	25	11	39
Externally reportable ICO incidents	Sept-23	0	0		0	-	-
All IG reported incidents	Sept-23	21	-	-	26	12	41
Freedom of Information (FOI) % responded to within target time	Sept-23	64.0%	80.0%	No	66.5%	43.6%	89.4%
Data Subject Access Requests (DSAR)	Sept-23	73.0%	80.0%	No	75.2%	58.1%	92.3%

Corporate support services – Legal services Summary

Latest Indicator Period: Sept-2023

Indicator Description	Period	Performance	Target / Threshold	Met?	Mean	LCL	UCL
Legal Services: Number of claims	Sept-23	16	-	-	17	2	32

Corporate support services – Regulatory assurance

Latest Indicator Period: Sept-2023

Indicator Description	Period	Performance	Target / Threshold	Met?	Mean	LCL	UCL
CQC overdue actions ('must do')	Sept-23	0	0		0	-	-

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

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

SPC Variation/Performance Icons

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

SPC Assurance Icons

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

OUH Data Quality indicator

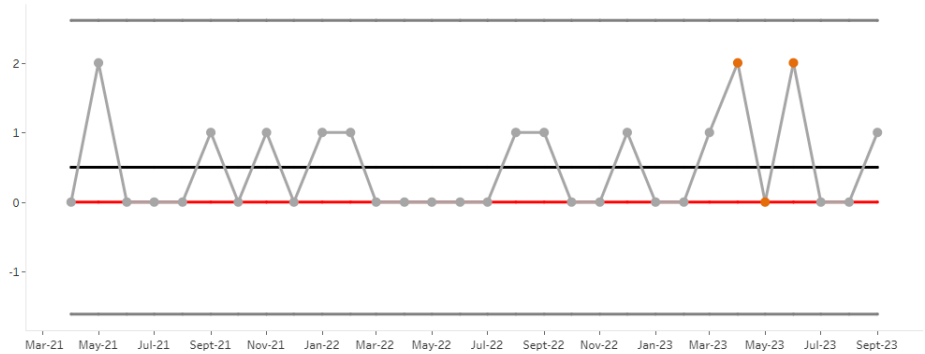
Valid: Information is accurate, complete and reliable. Standard operation procedures and training in place.	**Verified**: Process has been verified by audit and any actions identified have been implemented.	**Timely:** Information is reported up to the period of the IPR or up to the latest position reported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

Sufficient | Satisfactory | Inadequate

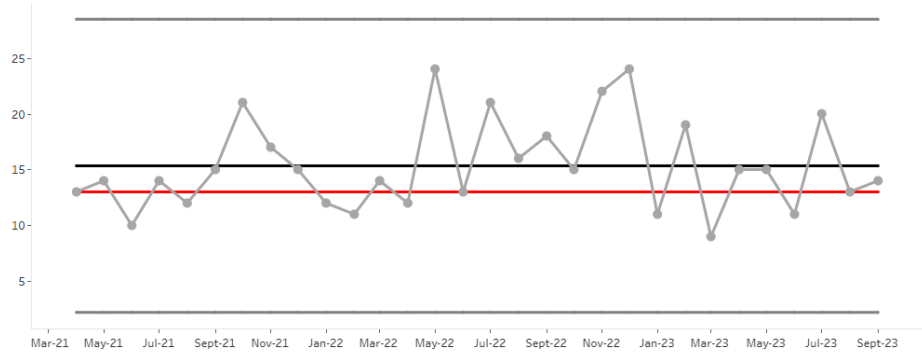
03. Assurance reports

3. Assurance report: Quality, Safety and Patient Experience

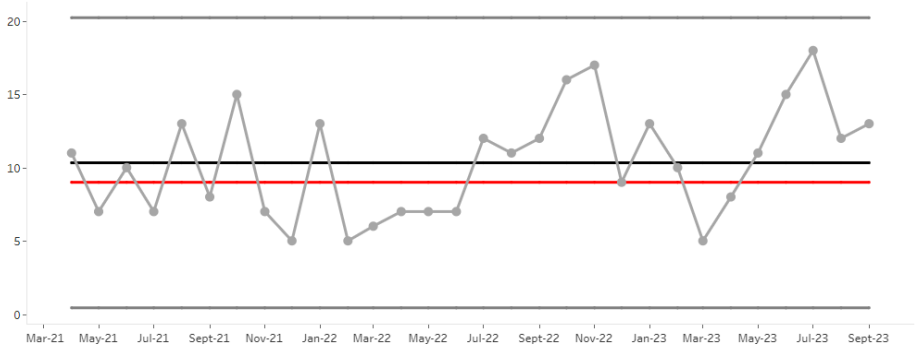
MRSA cases: HOHA+COHA



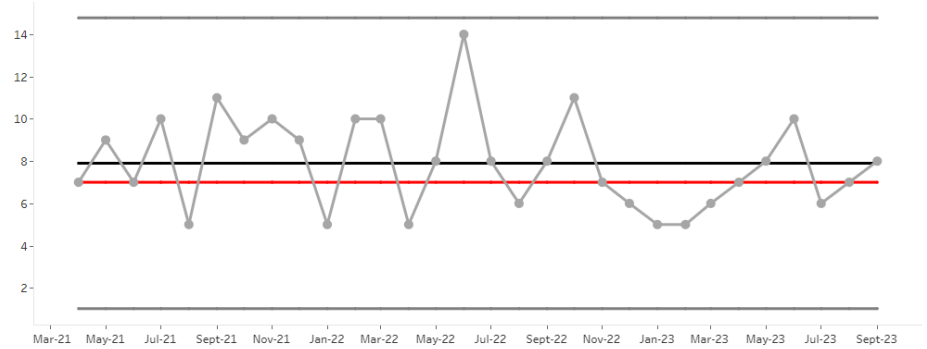
E. Coli cases: HOHA+COHA



C-diff cases: HOHA+COHA

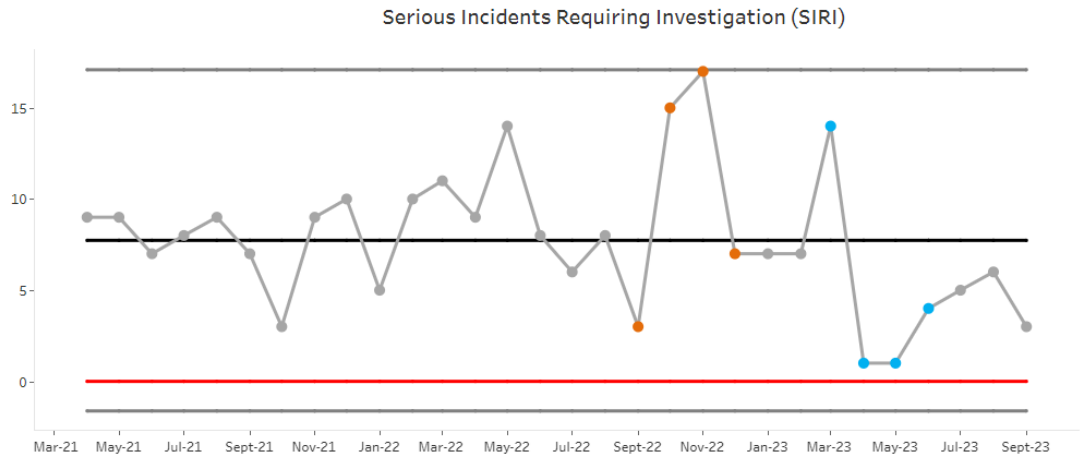


Klebsiella cases: HOHA+COHA

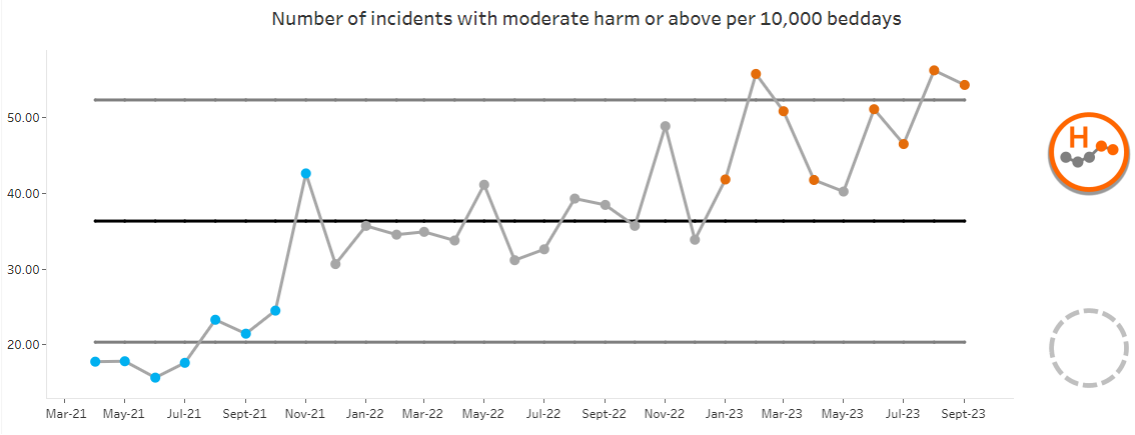


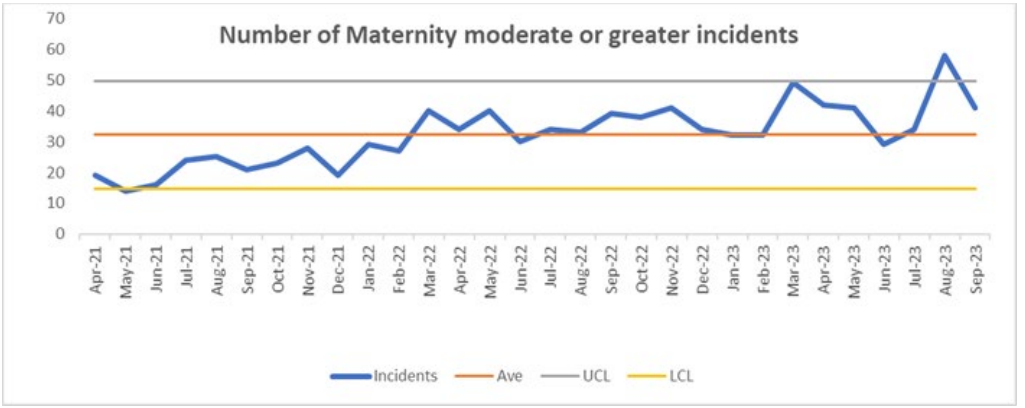
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The number of cases of MRSA, C-diff, E.coli and Klebsiella exceeded the monthly threshold in September but exhibited common cause variation.	1 MRSA bacteraemia, case review, no care quality issues observed. For September there were 9 HOHA and 4 COHA cases, cumulative total of 77 cases (cumulative limit 51). Klebsiella annual threshold is 86, currently 46 cases reported at month 6, therefore 4 cases over at present E.coli annual threshold 103 cases, currently at 87 cases reported at month 6, ten cases over at present	The NHS England Long Term Plan is to halve healthcare-associated Gram-negative bloodstream infections (GNBSI) by March 2024/25. Nationally this ambition is not met, with cases continuing to increase.	BAF 4	Sufficient

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

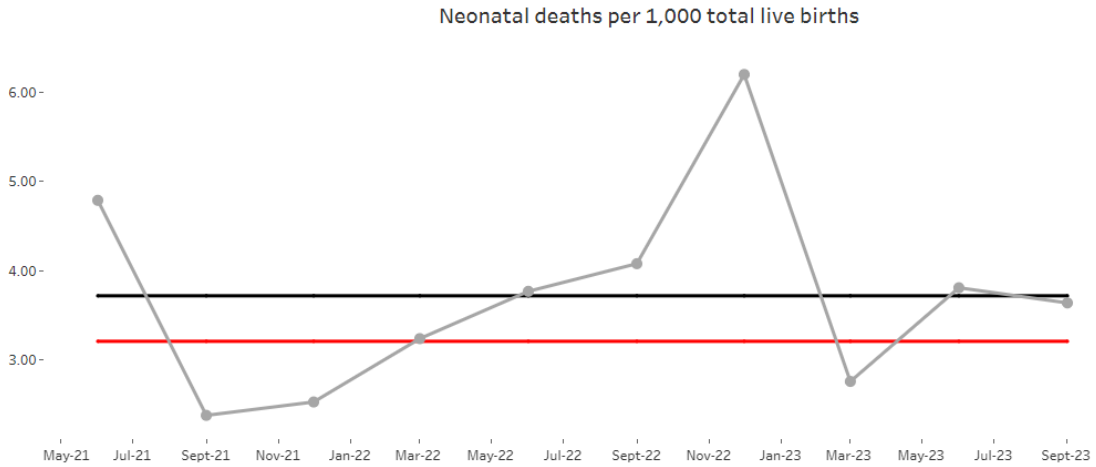


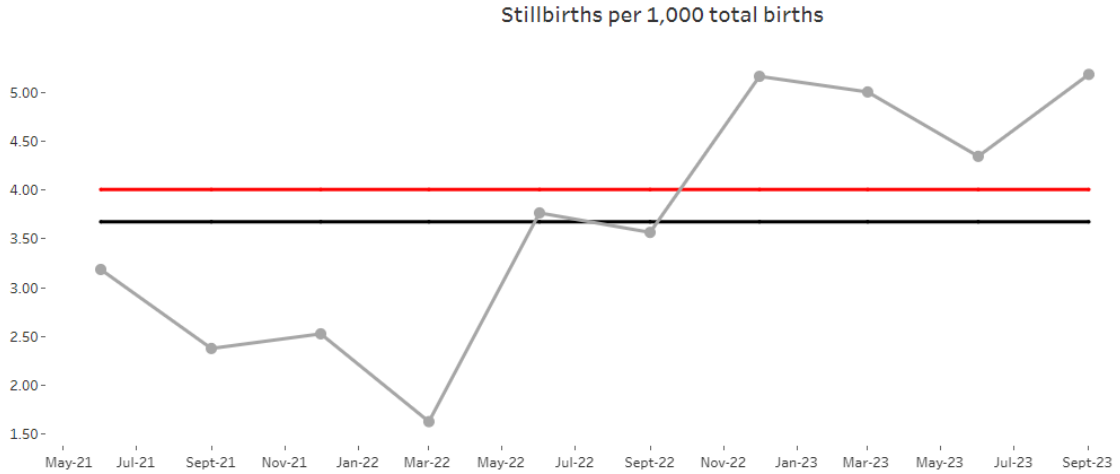
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
There were 3 Serious Incidents Requiring Investigation (SIRI) in September. The indicator common cause variation but has been identified for assurance reporting due to a threshold of zero SIRIs per month. The 3 SIRIs concerned: • A patient who was readmitted with a stroke having been discharged following a coronary artery bypass graft procedure • An intrauterine death being investigated by HSIB • A baby admitted to SCBU for cooling being investigated by HSIB	SIRIs are investigated according to the requirements of, and within the timeframe specified by, at the SI Framework. Interim findings will be discussed in the Serious Incident Group, where guidance on the final conclusions and action plan can be supplied; the exceptions are the HSIB investigations, which follow their own timetable and process. It should be noted that September is the last month in which SIRIs will be called by the Trust, following the adoption of the new Patient Safety Incident Response Framework (PSIRF) in October. Metrics for PSIRF are in production.	The SI Framework allows 60 working days for the investigation of SIRIs, although extensions may be agreed with our commissioners on a case-by-case basis. 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	Sufficient





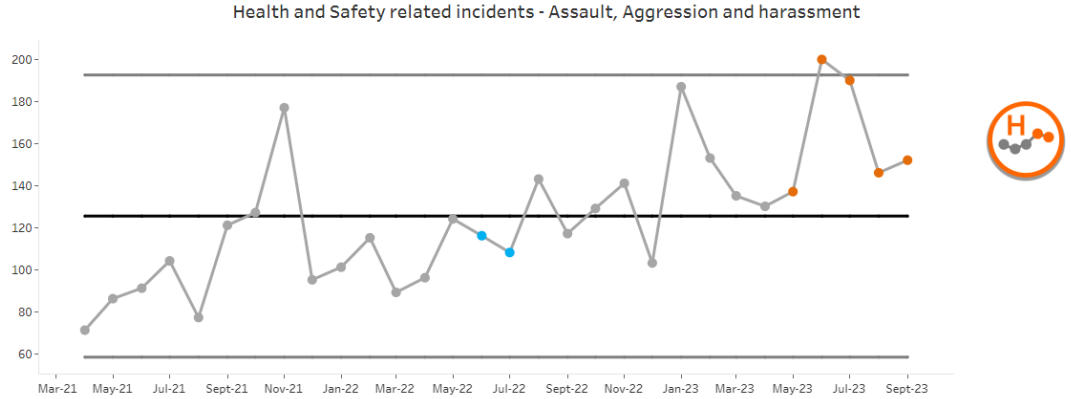
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
There were 54.2 incidents with moderate harm or above per 10,000 bed days in September. The indicator exhibited deteriorating special cause variation due to eight consecutive periods recorded above the mean of 36.3 incidents with moderate harm or above per 10,000 bed days, as well as exceeding the upper control limit. The approach to some maternity incidents, such as post-partum haemorrhages, changed during October 2021, and the Trust began calling these as Moderate-impact incidents, in line with national practice. Maternity now calls a significant percentage of Moderate+ incidents (68 of the 152 incidents in September 2023, or 45%), the second graph shows an increasing number of Moderate+ incidents in Maternity as this approach has embedded. That this graph includes 6 months prior to this change explains why so many later months show data near or above the mean. There is a standard proforma response to the majority of these incidents in Maternity, which allows the Trust to confirm whether there are any concerns around practice.	June and July 2023 saw a large number of Moderate incidents called under the Assault, Aggression & Harassment cause group, primarily relating to incidents involving two inpatients. In July 2023, 26 of the 133 incidents (20%) were under this cause group, but in August this rate had halved, and September's data is in line with this (16 of 152 incidents, 11%). 24 of the September incidents (16%) were not patient incidents, and there is a possibility that not all of these have been accurately graded, as they rarely receive further scrutiny through the SIRI Forum process, and there is less national advice on impact-grading for non-patient incidents. There was also a large amount of retrospective reporting in September, with 24 of the 152 incidents occurring at least a week before the start of the month (18%). Unlike previous months, these were split across 8 Divisions relatively equally.	The national Learn From Patient Safety Events system was adopted by the Trust on 21 August 2023, which encourages staff to consider psychological harm to a greater extent than previously. Trends relating to these incidents will be reviewed – Ulysses, the incident management software provider, is working on automatically accommodating Moderate+ psychological harm cases into the data (currently cases are added manually by PST).	*N/A*	Sufficient

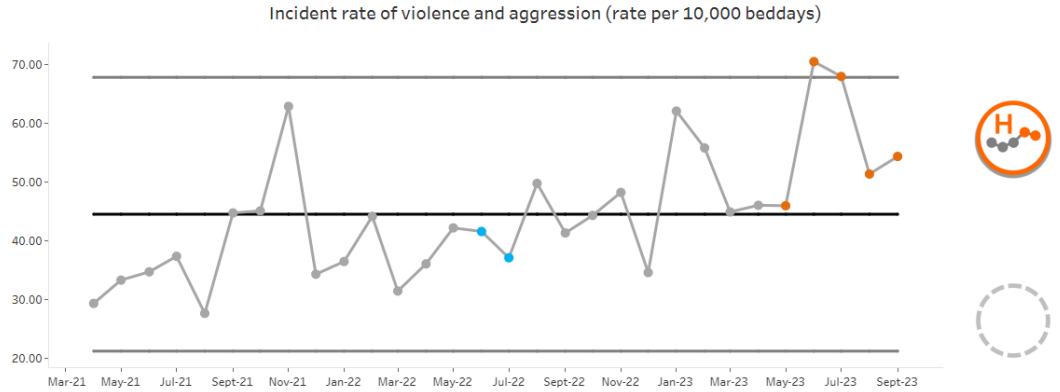




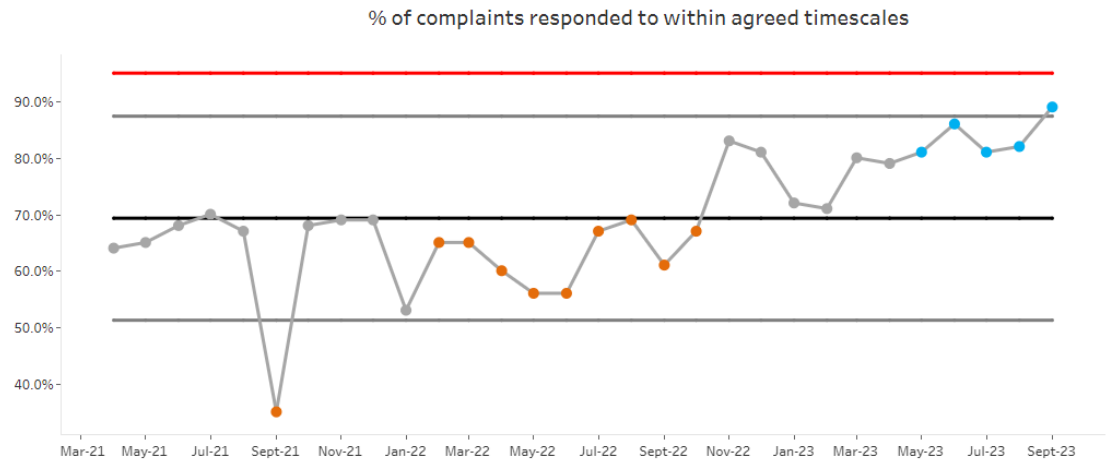
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Neonatal Deaths (NND's): In the quarter leading up to the end of September (Q2) there were 3.6 reported Neonatal deaths per 1,000 total live births, against a threshold of < 3.2. ***Stillbirths (IUD's):*** For the same period, 5.3 Stillbirths per 1,000 total births were reported against a threshold of <4.0. Given the small numbers per 1000 total live births, some variation can be expected. The indicators exceeded the threshold but exhibited common cause variation. *In month 6 there were seven cases reviewed through the perinatal mortality review tool (PMRT); Four IUD's and three NND's.*	All Neonatal deaths and stillbirths are reviewed weekly through the Perinatal Mortality Review (PMR) meetings using the Perinatal Mortality Review Tool (PMRT. The emerging themes from Quarter 2 were: 1. Routine Enquiry was not asked throughout the pregnancy in three cases reviewed in July 2023. The lead midwife for safeguarding has been undertaking supervision sessions with the community teams and routine enquiry (RE) forms part of this. RE is talked about when doing case reviews, training, supervision sessions and general safeguarding sessions. 2. In September 2023 it was found that Kleihauer results for one sample were not available despite being requested – this was also a theme in Quarter 1. Overall, there was an improvement to previous quarters.	1. There is ongoing work to improve Routine Enquiry during pregnancy and this had improved in the cases that were reviewed in August and September. 2. A Standard Operating Procedure (SOP) has been updated and shared with staff outlining the processing and reporting of Kleihauer requests in the investigation of IUD's for RhD positive women. This was ratified in July 2023.	*N/A*	Sufficient

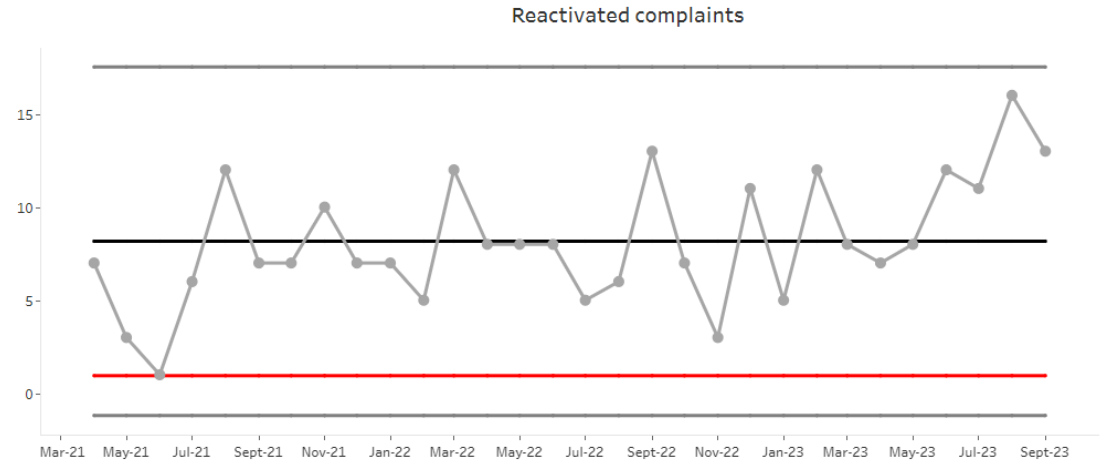
3. Assurance report: Quality, Safety and Patient Experience, *continued*





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 were 54.2 Health and Safety incidents relating to assault, aggression and violence per 10,000 beddays in September (152 incidents). The indicator exhibited common cause variation but has been included for assurance reporting given the effect on staff and importance of reducing incidents. The No Excuses campaign and raising awareness of the importance of reporting incidents of violence and aggression along with a focus on abuse 'not being part of the job' has led to a greater number of Ulysses being completed. The majority of violence and aggression incidents are attributed to the clinical condition of the patient and them lacking capacity. Increases in the numbers and complex nature of these patients along with them remaining in the acute setting for prolonged periods of time due to a lack of suitable locations to discharge them onto is a contributing factor in the rise in incidents. Multiple incidents are often a result of a few patients repeating their behaviour. The resources available within the Security Team are not sufficient to guarantee support due to the number of incidents (especially when there are multiple incidents in different locations) and the often-prolonged length of time incidents can take to de-escalate to a safe level.	Encouraging staff not to accept abusive behaviour and increased reporting is a positive outcome of the No excuses campaign but does lead to spikes in figures. Clinical Teams within Directorates manage clinically attributed aggression through individual care planning, 1:1 specialing and with Security support. The CNO chairs a Violence Reduction Group, and there are regular V&A Safety Groups within directorates. Clinically worn body cameras have been introduced into areas where they will have a de-escalation effect and continue to be rolled out. The Security Teams are undertaking enhanced physical intervention training to be compliant with the Restraint Reduction Network Standards. Conflict Resolution training as a whole is being discussed through the Violence Reduction Group.	VAR group meets monthly. ED V&A Staff Safety Group meets fortnightly, and this model is being rolled out throughout other directorates.	BAF 1	Sufficient

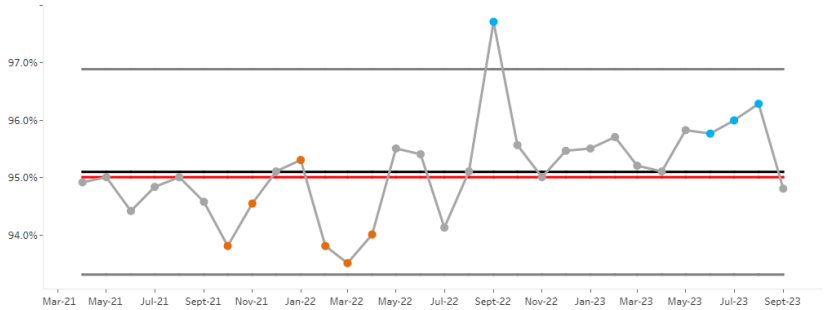




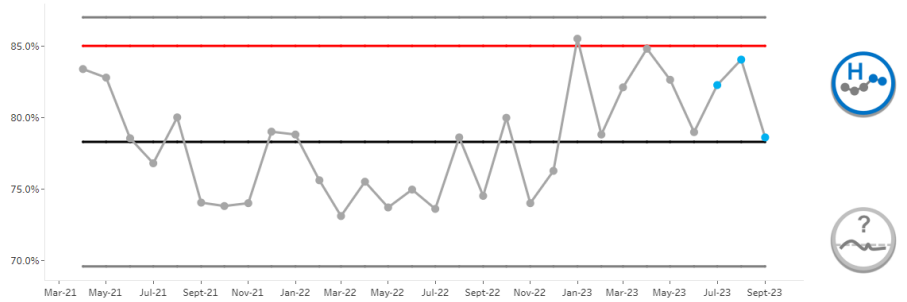
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
In September 2023, 89.0% of complaints were responded to within 40 days, below the target of 95%. The indicator has consistently not achieved the target. However, September's performance exhibited improving special cause variation with over six months' performance above the mean of 71.3%. Reactivated complaints exhibited common cause variation but were above the target value of one reactivated complaint per month.	Divisions continue to work with the Complaints Team to ensure overdue complaints are responded to as quickly as possible. Complaints that are approaching breach deadlines are escalated by the Complaints team to Service Leads and Divisional Management Teams in order to try and prevent a further breach. This is aided by the auto-generated breach sheet that is circulated to Divisions weekly, showing all open complaints (including reopened/reactivated) and the current stage the complaint is at. The recent increase in reactivated complaints is likely a reflection in the complexity of complaints the Trust is seeing in recent months, particularly associated with long waits for surgery/appointments/delays/cancellations.	Ongoing, reviewed weekly.	BAF 4	Sufficient

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

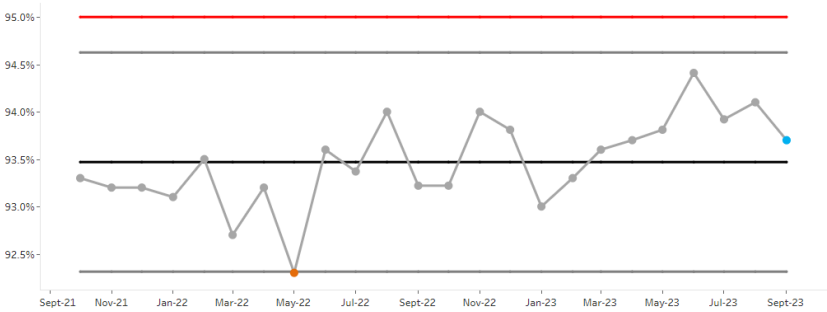
FFT inpatient % positive



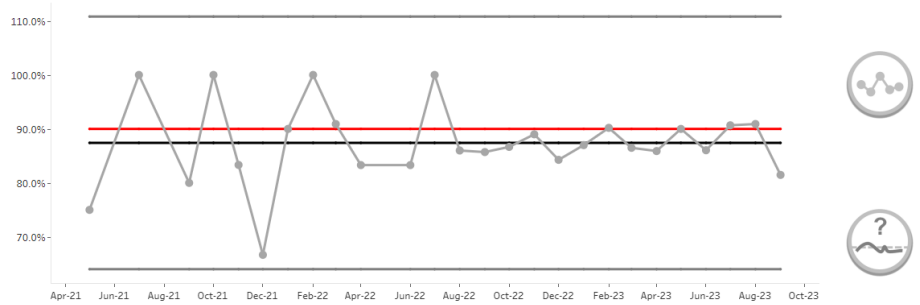
FFT ED % positive



FFT outpatient % positive



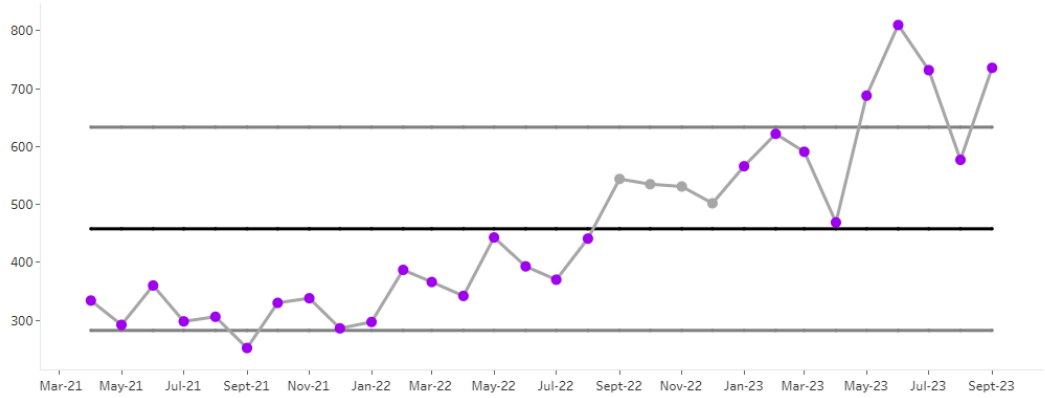
FFT maternity % positive



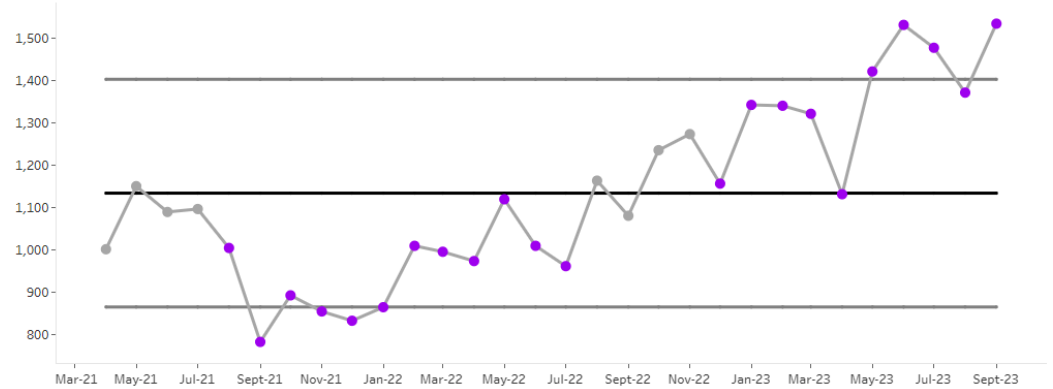
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Friends and Family Test (FFT) percentage positive rates were below the performance standard for inpatient, outpatient, ED and Maternity. FFT responses, despite being below target, exhibited improving special cause variation for ED and outpatients. FFT percentage positive rates exhibited common cause variation for inpatient and maternity. The response rates for ED and maternity are similar to previous months, and the inpatient response rates have increased. There is no clear theme which determines whether this is connected to the national picture of NHS service delivery, although in June, patients did refer to the length of waiting times within ED and waiting lists across Trust services. This has been previously reported to the ICCSIS (Incidents, Complaints, Claims, Serious Incidents, Safeguarding) Triangulation Group.	1. The Trust is implementing the fully managed service which is aiming to increase the FFT response rates and offer more inclusive methods of collection, such as translation options. Additionally, this includes implementing IVM (Instant Voice Message – patients can leave a two -minute voice message as their feedback) and increasing the number of services using SMS for feedback to reduce the use of paper, although this will not be eliminated. 2. The reduction in resources required to administer and analyse the FFT results will enable the focus on feedback led QI initiatives, which supports the revised guidance issued by NHS England.	The project is underway to implement the fully managed service however there have been some challenges identified with location mapping internally. This will have an impact on conclusion of the project. It is hoped that the project will be fully implemented and concluded by 31st March 2023.	BAF 4	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

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

Children's safeguarding activity

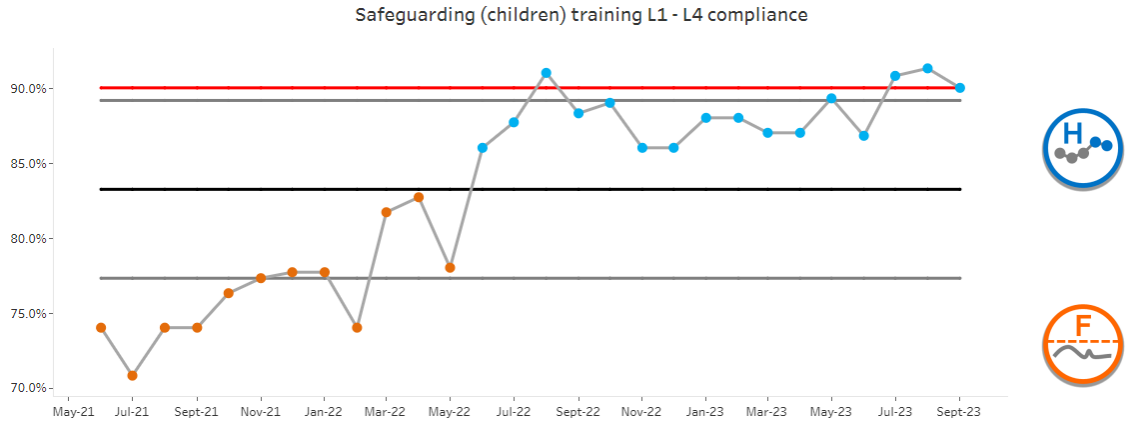


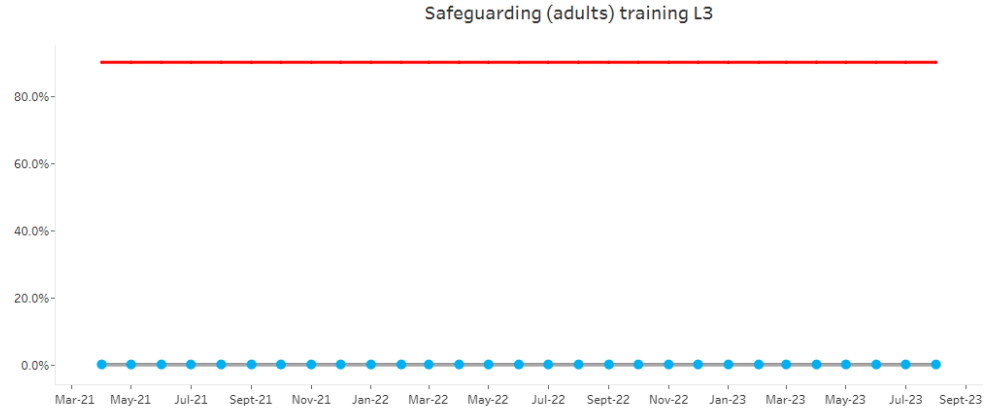
Number of safeguarding consultations initiated by provider (both to internal and external organisations)



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 children and maternity activity increased in September by 163 (n=735). Themes of neglect and emotional abuse. An increase in adolescent mental health presentations related to the return to school. Self-harm increased by 48% from August. The indicator continues to exhibit special cause variation due to more than seven periods above the mean. Maternity safeguarding reduced to 25.2% (n=180) of pregnancy bookings with a social factor. Maternal mental health, substance misuse and homelessness are the themes. Adult activity increased by 163 (n=754) that includes Ulysses and EPR referrals.	Self-harm data shared with education safeguarding team and OH school health team to support children in school. Attendance at multi agency meetings to share information for 66 cases in September, an increase of 22. Information is shared with primary care for 1019 children attending ED and increase of 136. The number of initial child protection case conferences information shared reduced by 13 (n=22) related to 35 children and 5 unborn babies. Maternity cases of homelessness has been a focus at the Preventing Homelessness Directors group. A pathway to prevent women presenting as homeless at birth is being developed with housing both antenatally and when issues arise at birth to avoid delays in discharge. Adult safeguarding team support staff with complex cases, DOLS and MCA. Escalating to the LA to ensure support is provided and police contacted to support victims of domestic abuse.	ICCSIS updated on weekly themes. PSEC monthly assurance report, safeguarding is embedded in divisional governance reports and presented to the Trust clinical governance committee. Safeguarding Steering group quarterly.	BAF 4	Satisfactory *Standard operating procedures in place, training for staff completed and service weekly validation of data entry, but no Corporate or independent audit yet undertaken for fuller assurance*

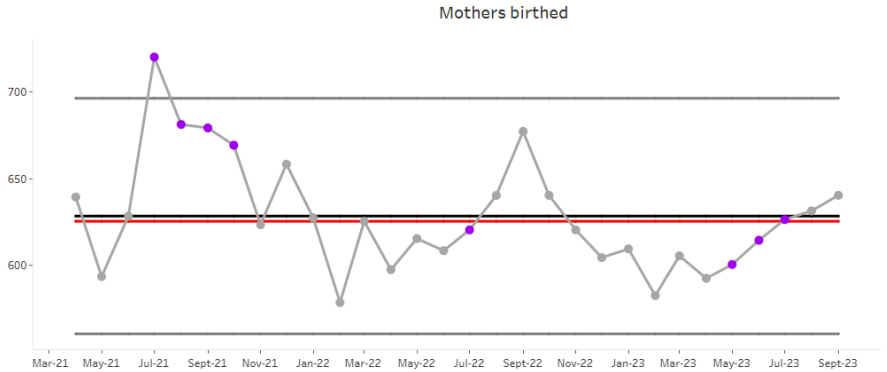
3. Assurance report: Quality, Safety and Patient Experience, *continued*

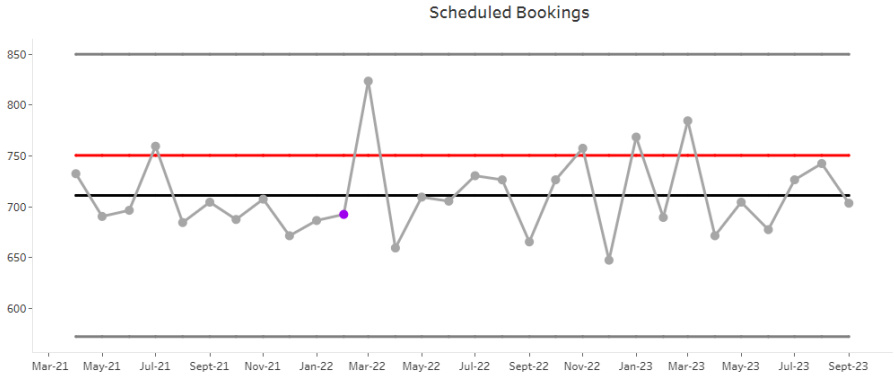


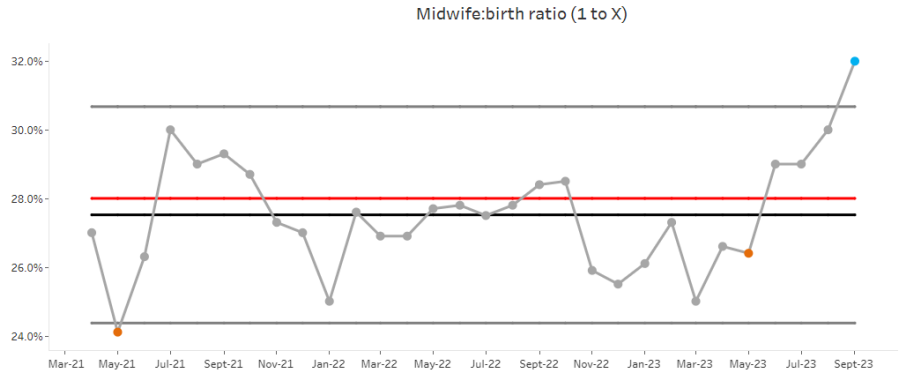


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Safeguarding children training L1-L4 compliance was 90% in September, achieving the 90% target. The indicator exhibited special cause improving variation due to seven consecutive periods above the mean and exceeding the upper control limit. The Children's directorate level 2 compliance dropped by 1 percentage point to 85% (18 staff requiring training) and level 3 dropped to 87% (103 staff requiring training). The Maternity directorate's compliance for level 3 is at 88.2% (53 staff requiring training) and just below the KPI of 90%. Level 3 adult training has been agreed and go live is imminent, moving relevant staff from level 2 to level 3. MLH are rewriting the rules and expected to be live by the end of October.	Targeted focus for maternity and children training requesting staff attend training or undertake online training. Divisional governance report template provides details of gaps for training. The compliance level is below the KPI of 90% in children's directorate and the staff not compliant staff are being contacted to request attendance at training. Names of staff being provided to directorate to encourage compliance. Meetings with Director of Nursing, Midwifery and AHP & Education and staff moving to level 3 adult safeguarding. Comms being prepared. Names of staff to directorate to encourage compliance.	Sept 2023 PSEC monthly assurance report divisional governance reports and presented to the Trust clinical governance committee. Safeguarding steering group quarterly.	BAF 4 CRR 1145	Satisfactory *Standard operating procedures in place, training for staff completed and service weekly validation of data entry, but no Corporate or independent audit yet undertaken for fuller assurance*

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







Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The number of Mothers birthed was 640 in September, above the threshold of 625. The indicator exhibited common cause variation. Scheduled bookings were 703 in September, below the threshold of 750. The Midwife to Birth Ratio exhibited increasing special cause variation in September. The indicator has increased in recent months following the seasonal variation in the number of mothers birthed.	OUHT have seen an increase in birthrate in September which is aligned to the national trend. This is a recognised seasonal increase. Prior to August 2023 the birth rate was lower than the target. There will be natural variation each month. There has been an update on the algorithm used to calculate the midwife to birth ratio. Following this exception, the data has been re-worked and the midwife to birth ratio in real terms for September 2023 is 1:28.39 with a yearly average of 1:26.67. From October 2023 the new calculation will show on the Maternity Dashboard.	To improve the midwife to birth ratio, a Maternity Safe Staffing paper which includes the birthrate plus recommendations has been passed at TME and Investment Committee in October 2023. The paper will be presented at Trust Board in November. This follows the latest analysis of the Birth Rate plus benchmarking tool in December 2022 which recommended a midwifery staffing uplift by 22.38 wte.	BAF 4	Satisfactory Progressing through process

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

Summary of challenges and risks

The dashboard presented over 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. The Nurse Sensitive Indicators, Paediatric Sensitive Indicators ad Maternity Sensitive Indicators are guided by the NICE Safe Staffing guidelines.

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

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

Increased bed capacity has remained open across several areas in September 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 use of the flexible pool of Registered Nurses and Care Support Workers on the bank. The flexible pool has also been increased to include Registered Mental Health Nurses, (RMN), on a trial basis which has been reviewed and will continue until end of October 2023 at a newly negotiated, lower pay rate. If the service is still required, it will be reviewed again at this point. There has been an increase in requirement for agency RMN in September. This has been across the Trust due to the number of vulnerable patients at risk of self- harm or absconding, to keep them safe.
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 retrospectively each month by the Divisional Directors of Nursing.

Maternity – Breast feeding figure is low at 67%, the KPI is over 80%. The data is being validated, as it is not uncommon for some data to be picked up and completed retrospectively. The Senior team believe that some data has not been included, therefore the percentage is likely to be higher. Work will be ongoing to ensure this is included in the following months.

NOTSSCaN Division – Neonatal Intensive Care unit, Horton F ward and Trauma 2A and 3A have recently had an approved increase in budgeted staffing, this accounts for a sudden appearance of deficit between budgeted CHPPD and actual. Although these areas have an increase in budget this does not mean that all beds were required to be staffed to that budget in September, and acuity, skill mix and bed numbers are reviewed each shift with other safe staffing metrics to ensure safe staffing. These areas were at level 2 staffing throughout September. BIU has decreased acuity census compliance and skewed CHPPD due to being closed for the first part of September as staff were moved physically but not always electronically meaning this CHPPD may not be accurate for September, matrons have been reminded to ensure all staff are moved electronically to support accurate data. There were increased beds open on Neuro intensive care which required increased staffing above budget. There is an unusual increase in the number of rosters not being approved for payroll, and this is being urgently reviewed by the DDN. There were 20 medication errors in neonatal intensive care and PICU, this is believed to be due to improved reporting and the sheer number of complex IV medications required to be given. There were no themes identified and no harm came to patients. Staffing was not deemed to be a contributor. OUHFT is however benchmarking relatively high and therefore a deep dive into these with pharmacy support is underway. There is also support to look at the complex drug calculations and training needs by the Divisional Education Lead. 6A had 6 falls in September 4 with no harm and 2 with minor harm, 4 were also unwitnessed. 6A are trialing a "hot debrief" within 2 hours of a fall attempting to capture live learning. These falls had no identified themes and were not deemed as related to staffing. There have been several covid outbreaks in NOTSSCAN division in September which caused increased staff sickness, and this may have contributed to decreased skill mix in the division. DDN and Deputy continues to work with Matron's around rostering KPI's and use of temporary staffing workforce. Carrying out spot checks and challenging teams on annual leave and net contracted hours. This is being followed up in divisional meetings.

SuWOn Division - Staffing in SUWON has remained at safe levels throughout September, however skill mix is challenged on SEU due to high levels of temporary staffing to support the increased bed capacity which remains open. This is currently not in budget, but recruitment is underway as budget approval for these extra beds is anticipated. SEU D had 8 medication errors in September, and DDN currently reviewing location of drug room, which is not large enough to accommodate the increased number of staff required to prepare and check medications within this space following increase, (double) in bed capacity. There were no themes to these errors and no harm came to patients. UGI had 7 falls in September, 6 unwitnessed, no harm came to patients and no themes identified, staffing was not deemed as a contributor. UGI ward clinical educator is focusing on falls teaching and learning in the coming weeks. Oncology ward had 8 pressure ulcers in September, believed to be due to improved reporting following work done by the directorate senior nursing team with individual staff to improve direct observation of pressure ulcers by registered staff. Learning actions include ongoing educational and senior support required to consolidate learning and improve intervention when a patient is deemed at risk of HAPU or a HAPU is identified. No incidents were associated with staffing. Sobell had 7 falls in September relative to high acuity and high levels of palliative care patients in side rooms, matron and team are reviewing closely. No harm came to patients.

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

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

MRC Compliance with acuity data census should be 100% in all areas and the DDN is addressing this with their teams. Both EAUs have not long been completing acuity data and this should compliance should improve with support going forward. Only one area show roster not approved by manager for payroll, an improvement from last month, this area is being addressed. OCE had 5 falls involving 3 patients. Two fell twice, 4 falls were unwitnessed with no harm, and one was supported by nursing staff which resulted in minor harm. Staffing on OCE has been challenging due to vacancy, turnover, parenting leave, sickness, and a new ward manager is only just in post following long vacancy. This is complicated by the nature of the patients with challenging needs. OCE have also had a high number of temporary staffing making skill mix a challenge. The matron is monitoring closely, and recruitment is underway. EAU and ED have significantly high numbers of patients and have had a relative numbers of falls in September. Two falls were due to young patients mobilising and having syncope episodes due to their presenting conditions, one fall was an elderly patient who was assisted by family to the toilet and fell trying to come back alone. One patient was intoxicated and refusing to remain sitting down, and one fall was unwitnessed of a septic confused patient who was cohort enhanced care observed, increased to one-to-one enhanced care following fall. No harm to patients. Five medication incidents for JR ED, are being reviewed by the matron, 2 were incidents of unavailability due to no pharmacy delivery so delay in receiving, and two were where EPR was not signed and therefore the medication was given twice. One was where an IV was stopped when it should not have been due to miscommunication. No harm came to patients and staff substantive and temporary are being reminded of the importance of ensuring EPR is signed and of clear communication. Computer access within the department for this purpose is also being reviewed. CMU A had 7 falls in September, 6 with no harm and 1 with minor harm, it is possible that the sheer number of patients requiring one to one and minimal staffing may have contributed. Most falls happened at a similar times to multiple staff being urgently required to support another patient and complex, worsening delirium patients in saferooms trying to independently mobilise without calling for assistance. No harm came to patients. 5A had 6 pressure ulcers in September, one was initially category 3 improving to category 2, and the others were category 2. One was present on admission. All were unavoidable as all appropriate care and pressure relieving devices were in place. All patients were frail elderly, and one palliative. Although staffing does not appear to have contributed to this, the acuity was very high in September due to the nature of the frail patients and one to one enhanced care patient numbers high too. An MRC matron is leading a piece of work on enhanced care observation patients assessment and escalation, this is in line with the publication of the new policy on enhanced care observation. Low levels of booked AL throughout September is being addressed by the DDN, to ensure there is not an increased beyond KPI going forward resulting in high use of temporary staffing requirement. Sickness may not be accurate due to staff members not being moved area on GoodShape, this is also being addressed by the DDN. Oak ward High Care beds, (nee HH CCU) have had a recently improved increase in budget to support the increased bed capacity, not all beds have been open or staffed in September, which accounts for lower actual CHPPD to budgeted, but where they have been open temporary workforce has been utilised to provide level 2 staffing whilst recruitment is underway.

CSS - there were no common themes highlighted. No incident led to patient harm. Each staff member involved in an incident has taken part in a reflective discussion. The department are working on a Quality Improvement Project for medication safety. No incidents related to staffing.

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

General

All areas with a high unavailability of workforce (HR data – vacancy, maternity leave, long term sickness) were mitigated to maintain a safe level of staffing with the use of Temporary Workforce (NHSP, Agency, Flexible Pool shifts) along with Ward Managers and Clinical educators supporting.

Falls narrative from Trust Falls Lead Nurse: Unwitnessed falls are a predominant theme and falls which reoccur for the same patients.
MRC is taking a proactive approach to falls management and prevention. The division held a falls summit in September and all wards have been asked to review their data and reflect on quality improvement plans, these findings, and plans are to be presented back to the division in October. Suwon held a five-week harm-free training programme for nursing assistants which involved falls prevention.
The Prevention and Management of Adult Falls policy, New Fall Prevention SharePoint page, and three "At a Glance" documents covering falls prevention, bedrails and post-fall care were released for clinical areas in September 2023.
The review of incidence related to falls has altered in line with PSIRF to review lower harm falls at a local level as well as a continued focus on moderate or above harm levels through multidisciplinary investigations.
The assisted technologies quality improvement project in falls prevention is pending through the OUH approval system, and Sobell House is part of this trial. Falls champion and bespoke training continue across the Trust.

Key:
Grey squares on the dashboard indicate where an indicator is either not relevant or not collected for the ward area.
Green squares indicate where indicator performance is meeting or better than the target, and red squares indicate where performance is not meeting the target for the indicator.

For HR Data:
Turnover: This reflects the number of leavers divided by the average staff in post for both registered and unregistered Nursing staff. Leavers are based on a rolling 12 months, and do not include fixed term assignments or redundancies.
Sickness: This is a rolling twelve-month figure and is reported in the same manner as Trust Board sickness data. The figures presented reflect both registered and unregistered staff.
Maternity: This is taken on the last day of a particular month (aligned to all Trust reporting) and reflects those on maternity/adoption leave on that day. The FTE absent on this day is then divided by the total FTE for this cohort. The figures presented reflect both registered and unregistered staff.
HR Vacancy: For the designated areas this figure is the establishment (Budget FTE) minus the contracted FTE in post as at the last day of the month. The vacancy figure is then divided by the establishment. The figures presented reflect both registered and unregistered staff.
HR Vacancy adjusted: As per "HR Vacancy" ; with additional adjustment for staff on long term sick, career break, maternity leave, suspend no pay/with pay, external secondment. Data taken on last day of the month and reflects both registered and unregistered staff.

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

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

Oxford University Hospitals NHS Foundation Trust

September 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	All 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	Number of 'dropped babies'	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	9.6	1.95	0.71	78.9%	3	0	0	0								14.4%	11.1%	3.7%	12.3%	No	2.5%	9.3	14.5%	92.6%
HH Childrens Ward	17.2	5.08	8.24	97.8%	0	0	0	0								33.2%	15.8%	7.4%	0.0%	No	-5.4%	9.9	10.8%	96.2%
Kamrans Ward	8.0	-2.22	-2.80	100.0%	2	0	0	0								11.2%	14.7%	2.4%	2.6%	No	-5.7%	8.3	16.3%	75.0%
Melanies Ward	13.7	2.12	1.77	95.6%	2	0	0	0								-64.7%	6.4%	1.3%	4.5%	Yes	0.6%	11.4	15.3%	92.9%
Robins Ward	10.1	-0.60	-0.49	97.8%	2	0	0	0								31.2%	3.1%	3.1%	3.9%	Yes	-0.2%	9.9	10.4%	95.7%
Tom's Ward	9.0	2.42	-0.57	100.0%	0	1	0	0								7.6%	12.2%	2.3%	3.1%	No	-0.1%	9.6	12.8%	84.0%
Neonatal Unit	16.0	-5.20	-		5	1	0	0								20.1%	7.0%	7.3%	5.5%	No	-4.3%	9.4	11.5%	
Paediatric Critical Care	31.8	-0.86	-		15	1	3	0								11.7%	6.7%	3.9%	8.8%	No	1.8%	7.4	12.0%	
BIU	9.0	3.00	2.81	63.3%	0		1	0								25.4%	13.3%	2.6%	0.0%	Yes	-1.0%	8.7	16.1%	100.0%
HDU/Recovery (NOC)	21.0	-1.19	-		0		0	0								12.5%	13.9%	4.2%	0.0%	No	0.5%	9.0	16.6%	
Head and Neck Blenheim Ward	8.5	1.16	0.19	95.6%	1		1	0								30.9%	14.0%	5.3%	0.0%	Yes	1.6%	8.9	12.9%	100.0%
HH F Ward	7.8	-4.19	-0.22	98.9%	1		2	3								16.2%	7.1%	4.6%	2.6%	Yes	0.5%	8.0	12.6%	100.0%
Major Trauma Ward 2A	9.8	-1.03	0.62	100.0%	4		1	3								16.2%	8.3%	4.6%	4.2%	Yes	0.7%	8.1	11.1%	88.9%
Neurology - Purple Ward	9.2	0.30	-2.10	100.0%	0		0	1								16.0%	21.2%	4.9%	3.4%	Yes	2.2%	9.4	14.6%	100.0%
Neurosurgery Blue Ward	9.7	0.71	-0.78	95.6%	3		0	3								19.0%	10.3%	3.6%	0.0%	Yes	3.4%	8.3	11.5%	95.5%
Neurosurgery Green/IU Ward	11.2	1.36	-0.37	100.0%	0		2	2								11.5%	1.7%	4.5%	0.0%	Yes	5.3%	8.3	9.5%	84.6%
Neurosurgery Red/HC Ward	12.4	0.71	-0.28	100.0%	3		0	1								-0.3%	2.6%	4.8%	1.6%	Yes	-2.3%	9.0	16.0%	95.0%
Specialist Surgery I/P Ward	9.5	1.00	1.19	82.2%	4		1	0								20.4%	10.8%	4.2%	1.6%	Yes	-0.4%	8.3	13.2%	97.1%
Trauma Ward 3A	8.8	-3.45	-0.77	100.0%	1		2	2								26.1%	9.7%	5.7%	4.6%	Yes	2.6%	8.1	12.0%	84.2%
Ward 6A - JR	8.0	0.80	-0.21	100.0%	1		2	6								19.3%	13.0%	5.1%	2.5%	Yes	0.4%	8.4	14.1%	100.0%
Ward E (NOC)		-	-	0.0%	0		0	0								26.0%	23.0%	9.7%	0.0%	Yes	2.3%	8.7	14.9%	
Ward F (NOC)	7.3	0.64	0.43	100.0%	1		0	3								23.8%	11.6%	7.0%	5.6%	Yes	-0.4%	8.9	16.5%	100.0%
WW Neuro ICU	31.3	5.81	-		3		3	0								21.6%	10.7%	4.6%	3.3%	No	-3.8%	8.4	13.5%	

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

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

Oxford University Hospitals NHS Foundation Trust

September 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	All 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	Number of 'dropped babies'	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	8.8	0.39	-0.43	97.8%	2		6	3								28.4%	6.3%	2.9%	10.0%	Yes	-1.0%	9.9	14.6%	83.3%
Ward 5B SSW	9.3	0.91	0.57	97.8%	2		1	4								19.5%	10.4%	5.9%	6.3%	Yes	0.8%	8.3	11.9%	100.0%
Cardiology Ward	7.0	0.86	0.48	82.2%	2		1	3								6.2%	11.7%	3.6%	3.7%	Yes	0.3%	8.4	13.0%	92.0%
Cardiothoracic Ward (CTW)	6.5	-0.88	-1.29	100.0%	1		0	0								20.6%	16.1%	4.6%	2.6%	Yes	-3.2%	7.9	12.7%	88.0%
Complex Medicine Unit A	9.0	0.02	-1.13	98.9%	1		1	7								8.8%	4.3%	4.3%	0.0%	Yes	3.2%	8.7	13.7%	
Complex Medicine Unit B	9.4	-1.90	-0.44	97.8%	0		4	4								4.1%	5.6%	5.1%	2.5%	Yes	1.1%	7.7	14.1%	100.0%
Complex Medicine Unit C	8.3	0.08	-2.38	98.9%	0		1	2								-2.3%	8.6%	2.9%	0.0%	Yes	0.4%	6.4	14.3%	91.7%
Complex Medicine Unit D	8.5	0.42	-1.23	92.2%	0		1	5								14.9%	11.6%	5.9%	0.0%	Yes	4.9%	8.7	6.9%	
CTCCU	24.0	2.10	-		1		1	0								17.8%	8.5%	4.2%	4.6%	Yes	1.0%	9.1	11.8%	
Emergency Assessment Unit (EAU)		-	-	57.8%	2		1	2								26.0%	6.4%	4.0%	5.4%	Yes	1.7%	8.4	9.9%	
HH EAU		-	-	77.8%	0		0	5								4.8%	6.1%	6.0%	5.7%	Yes	1.0%	6.0	13.9%	
HH Emergency Department		-	-		3		0	5								12.7%	16.2%	3.8%	6.9%	Yes	-1.9%	6.3	14.9%	80.0%
JR Emergency Department		-	-		5		0	6								27.1%	11.9%	5.6%	4.8%	Yes	7.1%	9.3	14.4%	77.7%
HH CCU	14.3	-7.24	8.14	92.2%	0		1	2								33.6%	8.3%	4.5%	0.0%	Yes	16.8%	5.3	14.1%	
John Warin Ward	10.7	1.84	1.31	95.6%	0		0	0								-3.3%	3.8%	3.9%	0.0%	Yes	-0.9%	7.4	14.2%	80.0%
Juniper Ward	7.4	-0.25	-1.04	100.0%	0		1	3								4.6%	12.2%	6.6%	0.0%	No	0.1%	8.6	13.7%	64.7%
Laburnum	7.8	-0.25	-0.32	93.3%	0		3	3								15.8%	1.3%	4.9%	10.0%	Yes	-3.5%	4.3	13.2%	60.0%
OCE Rehabilitation Nursing (NOC)	10.3	0.58	-1.33	76.7%	0		0	5								25.3%	12.2%	6.4%	7.5%	Yes	-0.8%	6.3	12.6%	50.0%
Osler Respiratory Unit	12.9	-1.53	3.80	100.0%	0		1	1								19.6%	8.7%	4.1%	1.5%	Yes	0.6%	6.7	11.3%	58.3%
Ward 5E/F	10.4	-0.19	2.10	95.6%	2		3	0								19.0%	8.6%	5.0%	4.2%	Yes	2.9%	7.7	7.8%	46.7%
Ward 7E Stroke Unit	9.9	0.09	1.09	96.7%	1		0	3								5.7%	14.5%	4.5%	11.0%	Yes	2.4%	7.3	11.0%	100.0%

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

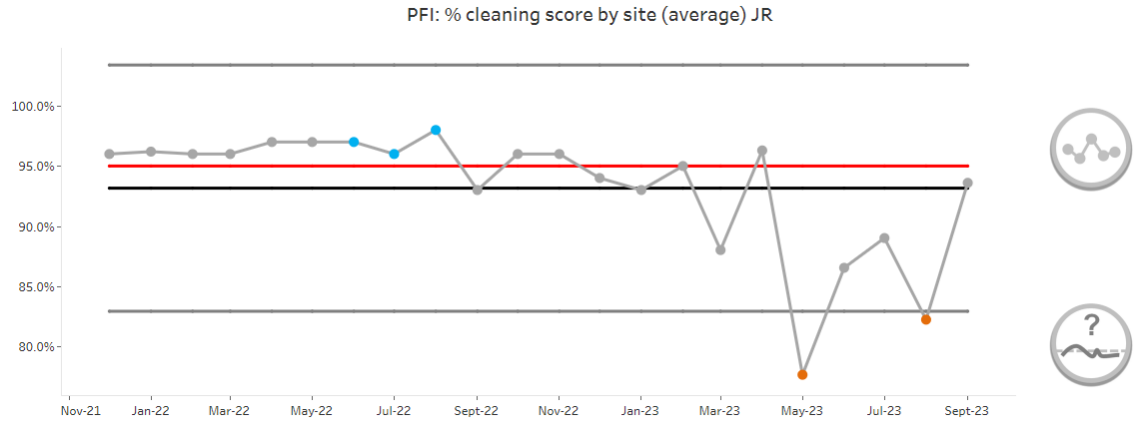
3. Assurance report: Safe Staffing - Dashboard: Part 3 (SuWOn and CSS)

Oxford University Hospitals NHS Foundation Trust

September 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	All 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	Number of 'dropped babies'	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)	7.8	0.75	0.13	97.8%	2		0	3								14.1%	14.6%	3.4%	3.0%	Yes	-3.0%	7.4	17.2%	100.0%
Gynaecology Ward - JR	8.7	3.63	2.92	100.0%	0		0	2								21.1%	8.9%	4.5%	0.0%	Yes	4.4%	8.9	13.0%	98.3%
Haematology Ward	7.7	-0.92	-0.29	90.0%	2		1	3								26.2%	13.8%	6.9%	10.2%	Yes	0.4%	8.4	15.1%	100.0%
Katharine House Ward	9.8	0.44	2.29	97.8%	0		3	1								13.8%	13.3%	5.9%	2.8%	Yes	5.3%	8.3	15.0%	
Oncology Ward	7.9	-2.45	-0.46	97.8%	2		8	3								34.8%	15.3%	5.3%	10.2%	Yes	3.4%	9.0	7.8%	85.7%
Renal Ward	10.5	1.30	1.35	98.9%	0		1	3								4.3%	6.9%	3.2%	0.0%	Yes	-1.3%	8.3	14.3%	95.8%
SEU D Side	8.0	-0.68	0.28	100.0%	6		0	1								-0.1%	11.3%	5.9%	6.5%	Yes	-1.3%	8.4	12.2%	81.0%
SEU E Side	8.4	0.00	-0.20	100.0%	2		1	0								3.6%	10.0%	4.7%	3.0%	Yes	0.1%	8.4	14.6%	100.0%
SEU F Side	7.2	-1.51	-0.61	100.0%	4		1	0								28.7%	21.8%	4.2%	2.7%	Yes	2.7%	8.4	14.9%	84.2%
Sobell House - Inpatients	8.2	-0.49	0.08	98.9%	1		2	7								40.3%	17.7%	3.4%	8.0%	Yes	-5.7%	7.6	9.5%	
Transplant Ward	9.1	-0.30	0.90	100.0%	1		0	3								29.0%	13.1%	5.4%	0.0%	Yes	0.5%	8.0	14.3%	100.0%
Upper GI Ward	8.4	-1.33	0.30	100.0%	3		0	7								25.7%	0.0%	4.6%	8.0%	Yes	-1.7%	8.6	12.3%	100.0%
Urology Inpatients	8.9	0.17	0.19	100.0%	0		2	1								30.9%	7.0%	1.7%	1.5%	Yes	0.2%	8.9	12.2%	100.0%
Wytham Ward	7.7	0.12	0.21	100.0%	0		1	4								25.3%	14.9%	4.7%	0.0%	Yes	2.2%	8.0	10.9%	95.7%
MW The Spires	20.3	-7.20	-		0		0	0												Yes	-2.3%	6.9	8.5%	
MW Delivery Suite	18.1	2.90	-		1		0	0												Yes	-4.1%	7.3	8.5%	
MW Level 5	5.3	-1.33	-		1		0	1	184	12	0	12	67.0%	3	0	-25.0%	15.3%	3.9%	4.2%	Yes	1.4%	6.7	12.1%	
MW Level 6	5.2	0.75	-		1		0	0												Yes	0.6%	7.3	14.5%	
CSS																								
JR ICU	26.1	-13.32	-		4		2	0								32.8%	9.9%	4.6%	6.5%	Yes	-2.5%	7.4	14.0%	

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

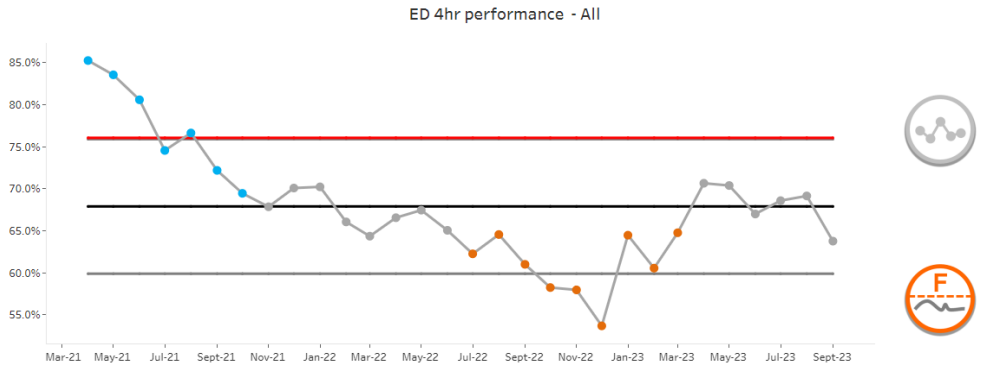
3. Assurance report: Estates, Facilities and PFI

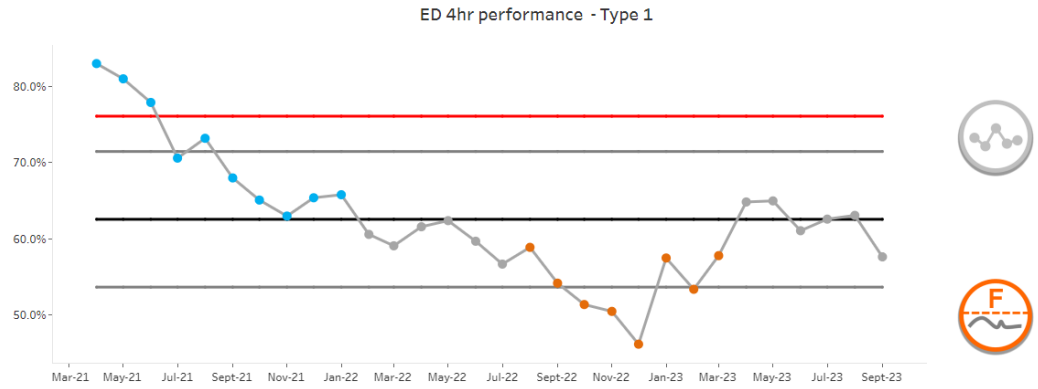


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
In September 2023, the combined PFI % cleaning score by site (average) for the JR was 95.4%. However, the above graph demonstrates the percentage of total audits undertaken that achieved 4 or 5 stars, which has positively increased by 11.46% to 93.62%, just shy of the 95% target. In total, 298 audits were conducted, but 19 of them did not meet the 4-star requirement during the first round. As a Trust, we strive to achieve a completion rate of 95% for audits that meet or exceed 4-stars every month. However, this is not a nationwide target outlined in the National Standards of Cleanliness 2021. These standards require all areas of healthcare facilities to be audited and meet specific combined cleaning percentage thresholds based on risk levels, including FR1 (98%), FR2 (95%), FR4 (85%), and FR6 (75%), to receive a 5-star rating. It is important to note that a lower star rating does not necessarily indicate uncleanliness. The purpose of audits is to identify and address any issues promptly, with a follow-up audit conducted after rectification to ensure improvements have been made and to re-evaluate the star rating.	When managing cleaning risks, the top priority is always patient safety. At our Trust, we believe in working together to maintain cleanliness in our facilities. When an area receives a rating of three stars or below, Mitie creates action plans with actions for all responsibilities, domestic, estates and clinical, to improve those areas, which are overseen by the Trust PFI management team. Domestic supervisors and the Trust PFI team monitor the implementation of these plans with the support of IP&C. Our teamwork in partnership with the Domestic Service Teams, Clinical teams, and IP&C to improve the cleanliness of our facilities. In September, we achieved a significant increase in the number of 4 & 5-star audits compared to the previous 6 months. This highlights the benefits of working together towards a common goal. We will continue to focus on improving our cleaning standards throughout October and beyond, with a commitment to providing a sustainable service. At present, we do not require additional support as our current actions are achievable.	1) Improvement to work towards the 95% target for 4 & 5-star cleaning audits for the month of October 2023 and ongoing. 1) Information cascade - Monitoring 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. 2) Actions reviewed weekly at the service providers/Trust PFI domestic services meeting, Monthly reporting to HIPCC	BAF 4 CRR 1123	Sufficient

3. Assurance report: Operational Performance

Oxford University Hospitals NHS Foundation Trust



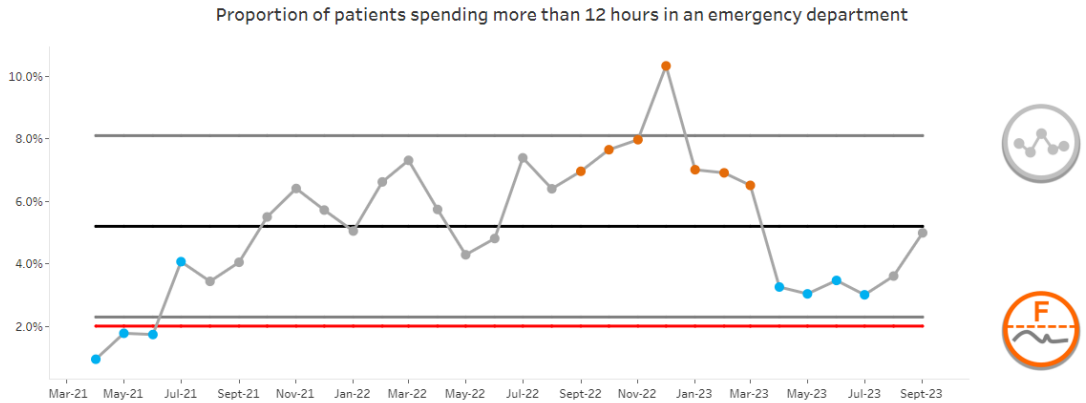


Benchmarking: ED (All types): September 23				
OUH: 63.7%	**National: 69.9%**	**Shelford:** 73.0%	BHT: 69.8%	RBH: 69.7%

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

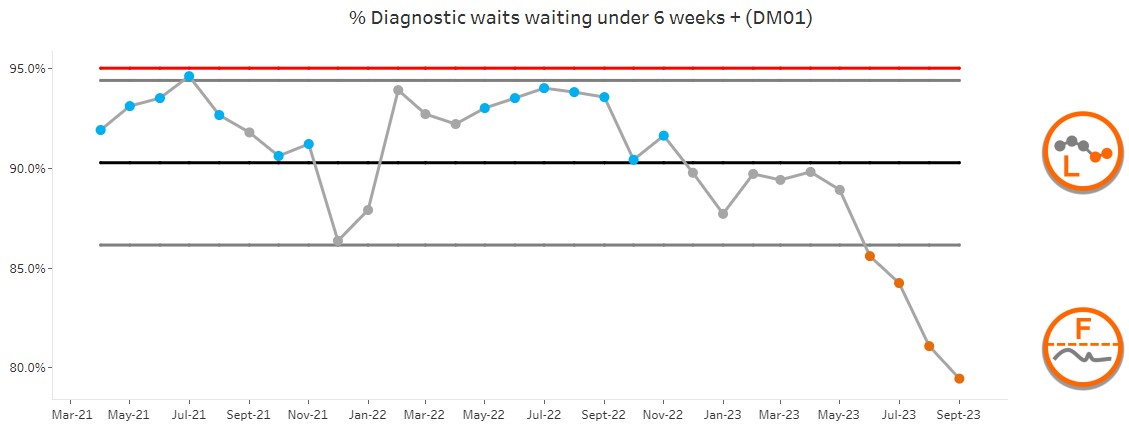
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
ED 4-hour performance (All types) was 63.71% in September and for Type 1 activity, performance was 57.5%. For 4-hr performance (all types) and Type-1 performance exhibited common cause variation. The indicators have consistently not achieved the target. Type 1 breach performance by site was 66.75% at the Horton Hospital and 53.49% at the John Radcliffe Hospital in September. This significant deterioration in performance is in part attributed to unusually high attendances in the first two weeks of September, with the second week seeing the second highest weekly attendances (second to 'pollen bomb' week) and moving into Opel level 4. At the beginning of the month, the Trust came out of a period of Industrial Action for medical colleagues which was challenging given the time of year and ensuring a safe level of medical cover. Attendances overall were higher in September compared to July and August, in both Adults and Children on both sites. Wait to be seen continues to be the most significant breach reason on both sites for admitted and non-admitted patients attributing 67% of all 4-hour breaches. A recent visit to another NHS Acute Trust has illustrated how an organisational alignment on patient flow can improve many performance indicators. Areas for consideration within OUHFT include Triage model's, management of flow, real time live bed state and integration with support services. Occupancy has remained high despite the additional capacity open and funded on the JR and Horton sites. Occupancy has risen from 93.03% to 94.29%.	**Senior Medical Decision Maker (Consultant) in the JR ED in the evenings.** • Pilot conducted during the Consolidated Improvement Cycle with early indication of improvement and SPCs being aligned to the shifts to correlate with any improvement. • Options paper developed for sustainable ED workforce models – supported by Trust Management Executive. • Metrics: - 4hr breach performance (Type 1) - 12hr Length of Stay (LOS) performance **Implement 'Clinically Ready to Proceed' (CRtP) functionality on FirstNet.** • Approval at Trustwide Urgent Care Group to automate the process for non-admitted patients to increase engagement by using the discharge time as a surrogate marker – completed. Reporting to commence from November 2023. • Non admitted target compliance 70% by the end of Q3 – currently an average of 48% (plan above in place to increase engagement and compliance) **Departure from ED within 60mins of CRtP** • Focus on Non-admitted performance – using discharge time. Process mapping has highlighted the main constraints – target 50% of non-admitted patients by Q2 • Improvement ideas generated within ED with a focus on pharmacy and transfer lounge usage in the first instance **Urgent and Emergency Care Quality Improvement Programme 2023/24** approved by IAC. Project groups in place covering 3 QI projects – ED Flow; Clinical Pathways and Discharge.	Quarter 1: Not on track. Quarter 2 – TME support received – completed. Quarter 1: On Track. Quarter 2: Completed Quarter 3: Reporting to commence Trust Wide Urgent Care Group Quarter 2: On Track Quarter 3: New reports to be available from November Trust Wide Urgent Care Group	BAF 4 CRR 1133 (Red)	Sufficient

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 5.0% in September, a deterioration from the improvements seen over the summer months. Performance remained above the target of 2% but below the mean of 5.6%. The indicator has consistently not achieved the target and in September exhibited common cause variation. Both sites have struggled to sustain the improvement seen in earlier in the year with the Horton at 3% and JR at 6% of patients residing in ED for more than 12 hours in September. The wait to be seen in ED continues to be a challenge with an increasing percentage of breaches attributed to this (67% of 4-hour breaches for September). However, the average total length of stay in both ED's has been maintained at approx. 100 minutes lower in both ED's when compared to December 2022. Bed occupancy across all sites has risen from 93.03 to 94.29%. Mental Health presentations remain high, and this group of patients has a higher total length of stay. The pathway for patients presenting with mental health conditions is an area of QI focus across the Trust and Oxford Health. We continue to see a sustained improvement in the number and length of stay of medically optimised for discharge patients. In addition, we have also seen improvement in the number of patients with a length of stay of 21 days.	**Departures within 60mins of the Decision to Admit** • Two pathways – Menth Health and Frailty – have been confirmed for the initial phase of the Clinical Pathways QI work. Initial meetings held in September. • Identify improvement percentage per speciality	Quarter 1: On track Quarter 2: On track Trust Wide Urgent Care Group	BAF 4 Link to 1133 (Red)	Sufficient

3. Assurance report: Operational Performance, *continued*



Benchmarking: August 23 DM01	
OUH	81.1%
National	77.0%
Shelford	78.0%
ICS	BHT: 55.2% RBH: 64.7%

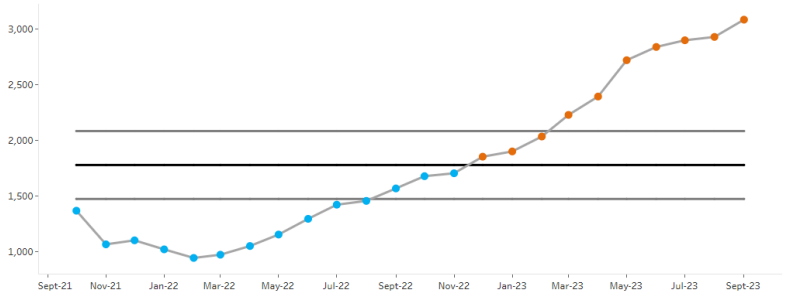
ICS key	
BHT	Buckinghamshire Healthcare NHS Trust
RBH	Royal Berkshire NHS Foundation Trust

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	Data quality rating
The % of Diagnostic waits waiting under 6 weeks+ (DM01) was 79.4% in September. The indicator exhibited special cause deteriorating variation due to performance being below the mean of 89.6% for more than six successive periods as well as below the lower process control limit. The indicator has consistently not achieved the target of 95.0%. **Complex Audiology**: Significant increase in demand and vacancies has driven a deficit with capacity **Cardiology**: Awarded community echo service; TUPE staff left before transfer to OUH and backlog has accumulated. **Clinical 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:** Options appraisal completed with a recommendation to transfer a cohort of clinically appropriate patients to Another Qualified Provider (AQP). Discussions are being held with commissioners, awaiting feedback from ICS. **Cardiology:** Continues to improve. All vacancies now filled. Services provided via Community Diagnostic Centre (CDC) in place. **Clinical Neurophysiology:** patients waiting continues to reduce, however performance has plateaued. Significant impact by the recurrent Industrial Action, and clinically urgent patients have taken priority. Staffing improved due to the return of 2 staff members from maternity leave. Technicians to be fully trained to conduct EMGs. Business case to convert insourced capacity to recurrent capacity written and presented at BPG, feedback received and revised version being worked on for resubmission in November. **Respiratory Sleep studies:** Continues to improve. CDC optimally used and is being considered for further expansion to accelerate recovery.	Weekly Assurance meeting will monitor all actions on a bi-weekly basis **Audiology:** improvement expected once transfer to AQP agreed via ICS – October 2023 **Cardiology:** compliance by March 2024. **Clinical Neurophysiology:** Improvement expected from July 2023 **Respiratory Sleep studies:** compliance by January 2024	BAF 4 Link to CRR 1136 (Red)	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

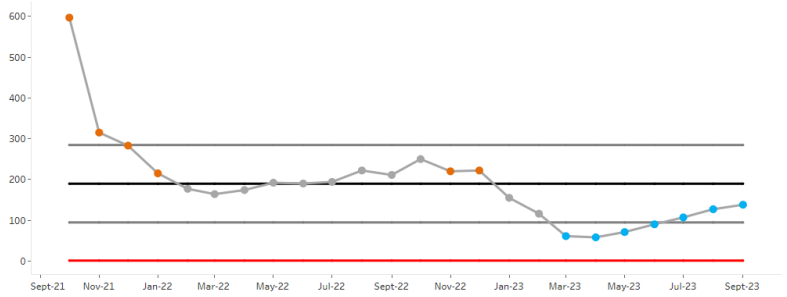
3. Assurance report: Operational Performance, *continued*

Oxford University Hospitals NHS Foundation Trust

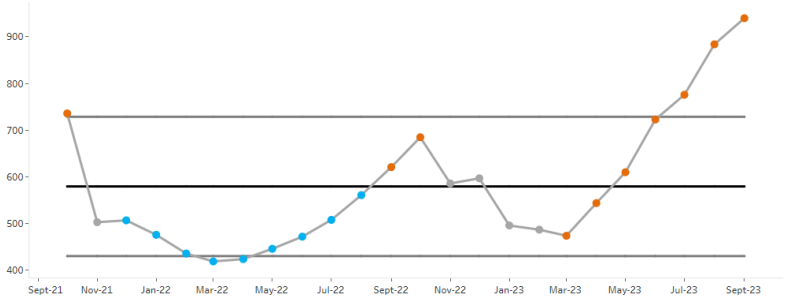
Total patients waiting more than 52 weeks to start consultant-led treatment



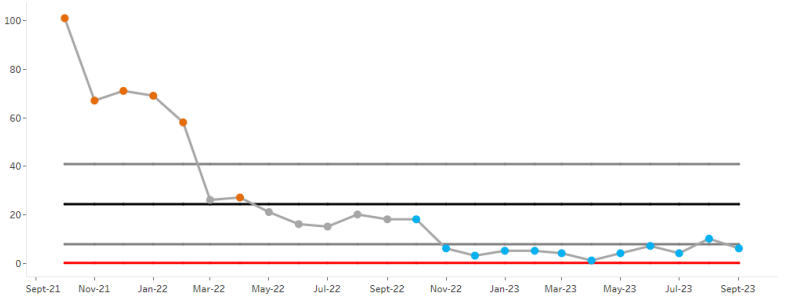
Total patients waiting more than 78 weeks to start consultant-led treatment



Total patients waiting more than 65 weeks to start consultant-led treatment



Total patients waiting more than 104 weeks to start consultant-led treatment

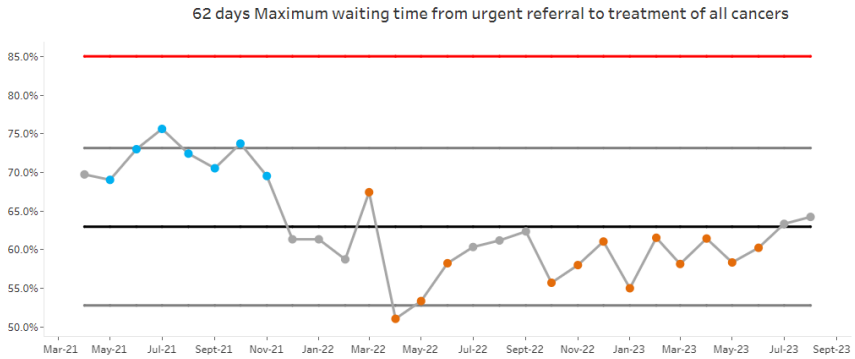


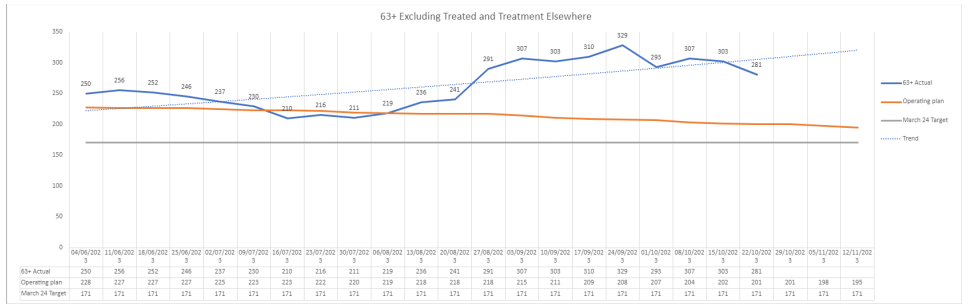
Benchmarking: August 23	
OUH	2,925
National	1,871 (avg.)
Shelford	3,499 (avg.)
ICS	BHT: 4,525 RBH: 7

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	Data quality rating
The number of patients waiting more than 52 weeks to start consultant-led treatment was 3,081 in September. Performance exhibited special cause variation due to >six consecutive periods of deteriorating performance above the mean and exceeding the upper process control limit. **104 weeks** reported 6 patients waiting due to the two late ENT transfers from another Trust who have also triggered Patient Choice upon scheduling treatment dates, a Paediatric Spinal patient who has also triggered Patient Choice, a complex Plastic Surgery patient requiring a custom product. **78 weeks** - as well as Paediatric Spinal and Plastic Surgery stated above, challenges are found within Urology due to a capacity deficit against demand levels, Adult Spinal due to complexity, Ophthalmology due to national shortages of corneal graft requiring centralised distribution, as well as Orthopaedics due to theatre 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 week waiting times**.	• **Corneal graft supplies** are being managed centrally by NHSE via NHSB&T as this is a recognised national issue. NHSE gave instructions to begin the procurement for 65-week patients. Recovering without uptake of mutual aid. • **Spinal services** contracts to Independent Sector Providers at The Portland and Royal National Orthopaedic Hospital are in place. • **Theatre re-modelling and planning** further evaluation of all services proportionately allocated capacity to manage the longest waiting patients, in conjunction with emergency and cancer requirements. • **Key milestone deadlines set for pathway stages at specialty level** to mitigate risk of not delivering the Operating Plan. Tracking via Elective Care Recovery Group (ECRG) • **Elective Recovery Fund** schemes live and tracked at ECRG	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)	Sufficient

3. Assurance report: Operational Performance, *continued*



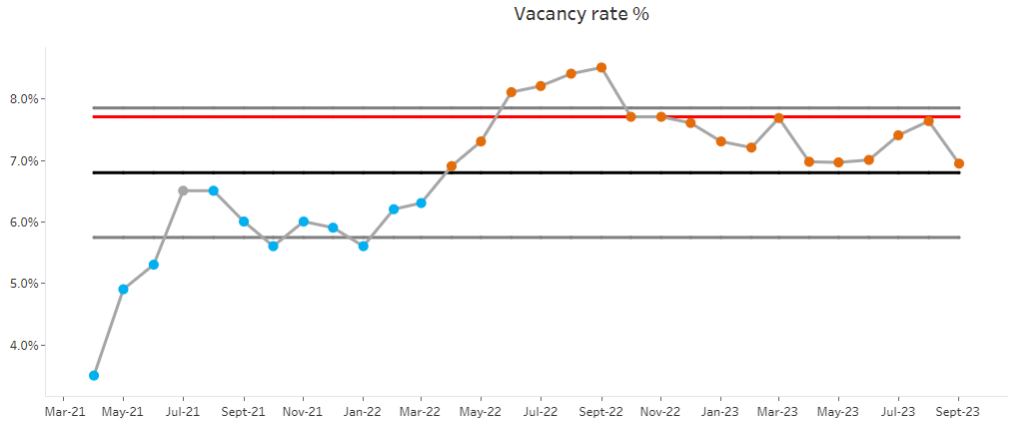


Benchmarking: August 23 62-day Standard	
OUH	64.2%
National	65.2%
Shelford	54.7%
ICS	BHT: 56.0% RBH: 70.7%

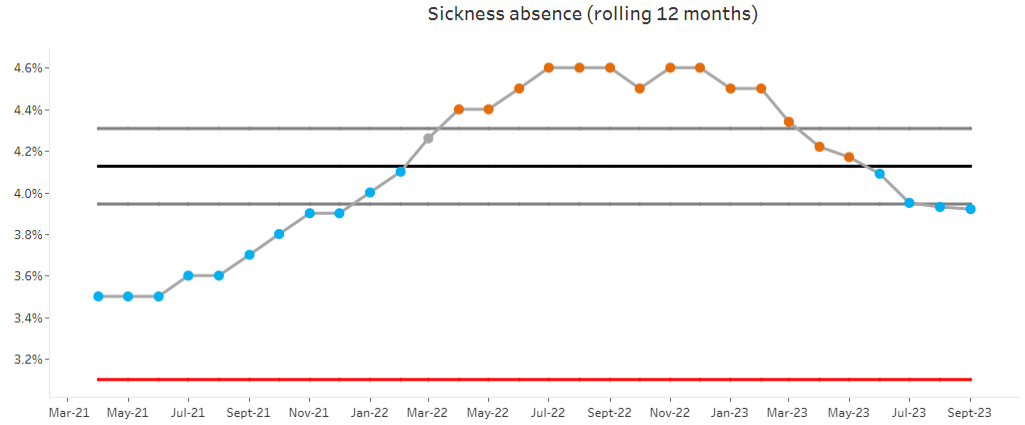
ICS key	
BHT	Buckinghamshire Healthcare NHS Trust
RBH	Royal Berkshire NHS Foundation Trust

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	Data quality rating
Cancer performance against the 62 days standard for urgent referral to treatment was 64.2% in August, and below the performance target of 85%. Performance is reported one month in arrears due to the extended reporting period for this indicator. Performance exhibited common cause variation. The indicator has consistently not achieved the target. The number of patients waiting over 62 days has deteriorated in September and is a high priority of focus within the Trust. All tumour sites apart from Breast, Skin and Testicular are non-compliant for this standard in July. **Challenges identified:** • Complex tertiary level patients (8%) • Some slow pathways and processes (26%) • Capacity for some surgery, diagnostics and oncology (46%) • Late inter provider transfers (14%) • Patient reasons (6%)	**The Cancer Improvement Programme** launched in 2022/23 with a focus on 28-day Faster Diagnosis Standard (FDS). For July, **the Trust was 24th 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. **Performance of >62-day PTL vs plan –** recovery includes: • Incomplete and late Inter-Provider Transfer analysis and escalation • Surgical capacity through theatre reallocation, • Patient engagement through the Personalised Care agenda • SOP and escalation of benign patients awaiting communication **Urology** holds the highest proportion of long waiting patients but is recovering well since developing a one-stop clinic and MRI pathway with radiology services. **Gynae** holds the second highest volume of long waits. A joint BOB Integrated Care Board (ICB) draft Standard Operating Procedure (SOP) for the management of 2ww referrals is undergoing formal evaluation and process for approval.	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 clinic: adopted Gynae referral management: on track	BAF 4 Link to CRR 1135 (Amber)	Sufficient

3. Assurance report: Growing Stronger Together



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The vacancy rate was 7.6% in August and 6.9% in September, better than the Trust target of 7.7%. Performance exhibited special cause variation due to successive periods of performance (>6 months) above the mean of 6.8%.	• There have been budget increases in M5 and M6, however, an increase in staff in post has still resulted in a decrease in vacancy levels. • A proportion of the additional staff in post in M6 will be due to graduate recruitment. • Recruitment SLA in place and medical staffing SLA to be implemented to assist with timely recruitment • HCSW have high vacancy levels and there is a working group prioritising interventions in this area • The delay in the implementation of one person, one post means that vacancy data is not as accurate as it could be. The additional focus on implementation would facilitate appropriate identification of vacancies that need to be recruited to.	• Governance - TME via IPR, HR Governance Monthly meeting & Divisional meetings • All actions are ongoing	No	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

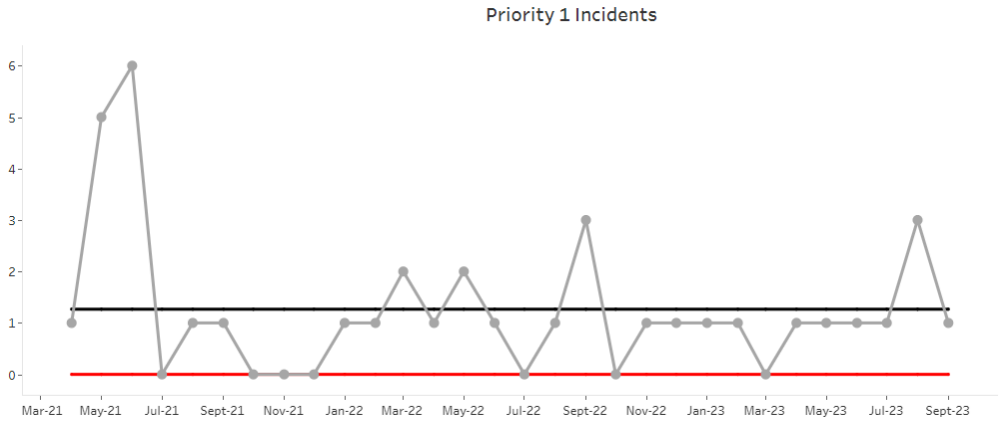


Benchmarking: May 23 (monthly performance)

OUH: 3.5% **National: 4.6%** **Shelford: 4.0%** Buckinghamshire Healthcare NHS Trust: 3.3% Royal Berkshire NHS Foundation Trust: 3.1% Oxford Health: 4.5% South Central Ambulance Service: 6.5%

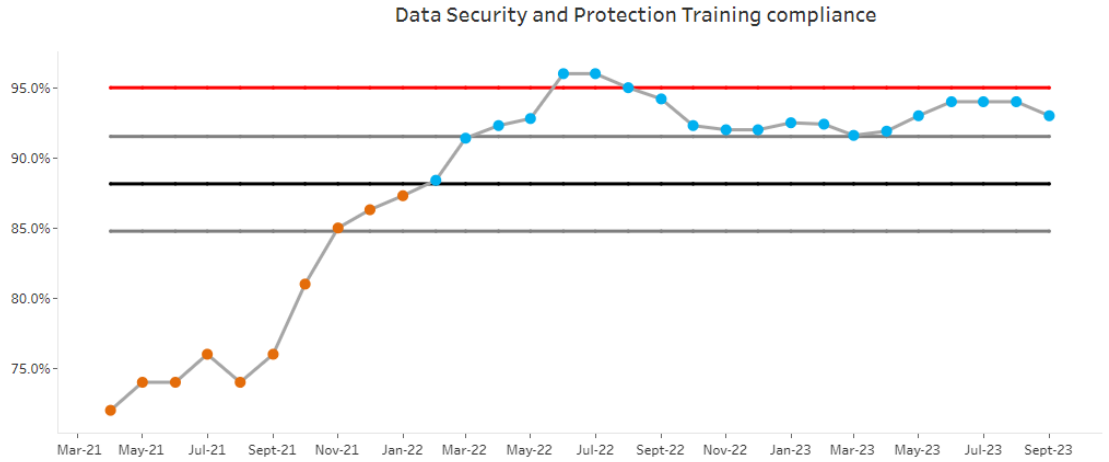
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Sickness absence performance (rolling 12 months) was 3.9% in August and has remained at 3.9% in September. Performance exhibited special cause improving variation due seven consecutive improving months and performing below the lower control limit. This indicator is on a downward trend and has reduced every month since the last quarter of 2022/23. The most recent figure for M6 has not changed compared to M5 sickness absence. It should be noted that COVID absence has continued to rise since M5, and this will be starting to have an impact on the overall sickness levels.	1. We are continuing to offer a full range of well-being support including Wellbeing, financial, environmental and psychological 2. The vaccination programme is being actively communicated to support the reduction of flu and COVID absence. 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, particularly focusing on the short-term prevalence, as well as mental health related absence.	• Governance - TME via IPR, HR Governance Monthly meeting & Divisional meetings • All actions are ongoing	BAF 1 BAF 2 CRR 1144 (Amber)	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

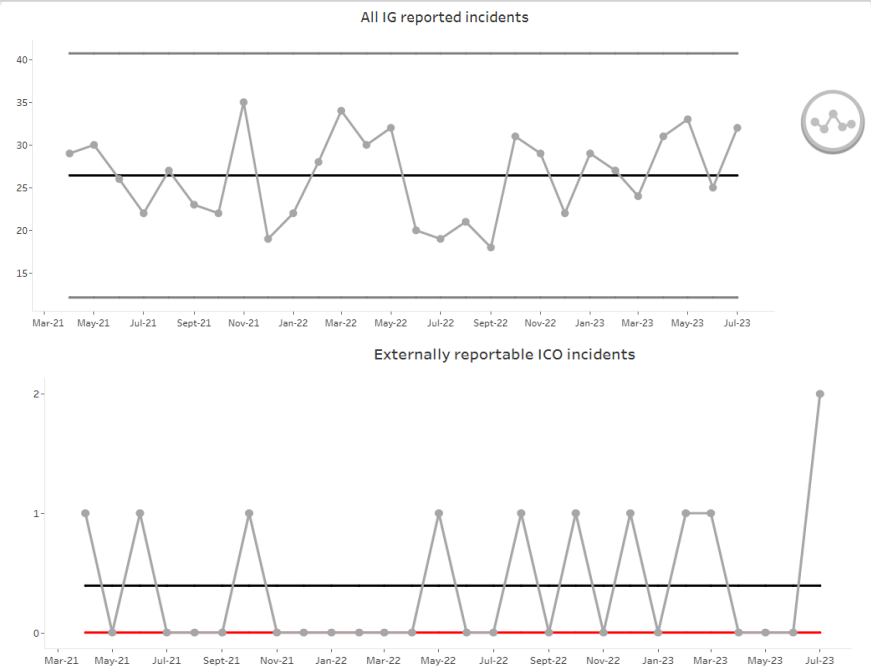
3. Assurance report: Corporate support services – Digital



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 September 2023 against a target of zero. Incident 1: On 18/09/23 at 08:19 the OUH wireless network became unavailable due to a bug in the version of software the Trust was running.	A permanent fix was implemented on 18/09/23 and the system has been stable since then.	Digital Oversight Group	BAF 4 Link to CRR 1116 (Amber), 1113 (Amber)	Sufficient

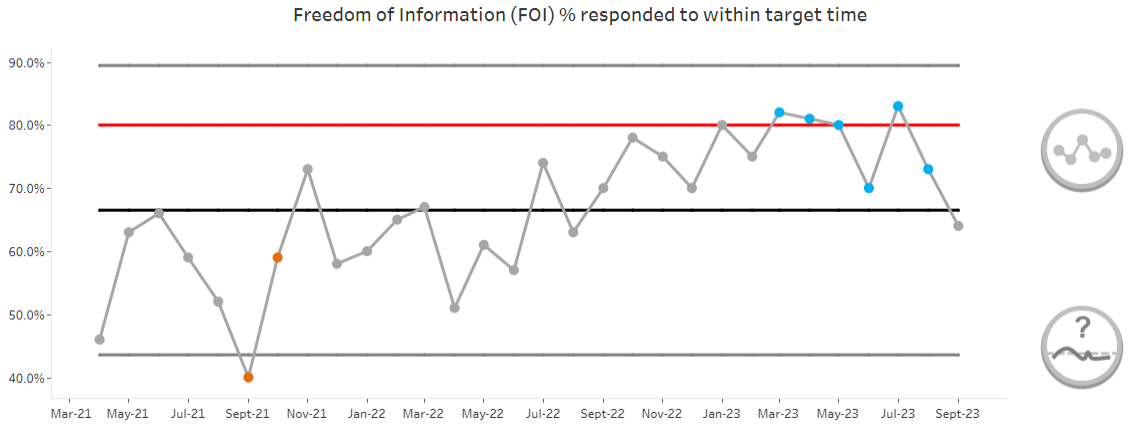
3. Assurance report: Corporate support services – Digital, *continued*



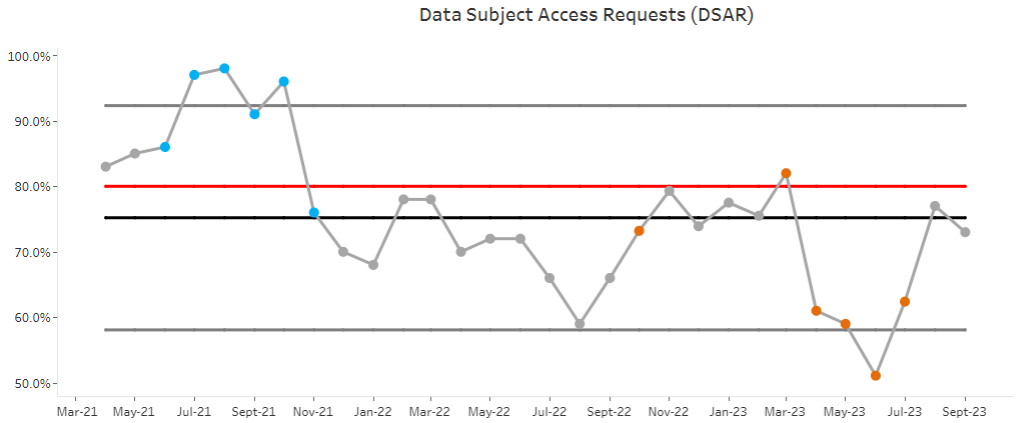


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Data security and Protection Training (DSPT) compliance was 93.0% in September, below the target of 95%. Performance exhibited improving special cause variation due to successive periods of performance improvement (>6 months) above the mean of 91.6% as well as exceeding the upper process control limit of 94.4% The aim of achieving 95% by 30/06/2023 was missed. This did not affect the OUH DSPT submission as the Trust had already been 95% compliant within the July 2022 - June 2023 reporting period. As a result, the Trust was able to submit a "Standards Met" 2022-23 DSPT return. To pass the 2023-24 submission we are not required to achieve 95% but will be retaining this target internally. The 2023-24 DSPT submission requires a new, and more detailed, training and communications needs analysis to be completed, delivered and reported on. This will require more specialist training for some user groups to be designed or acquired, and we are now expected to be running multi-channel communications campaigns to complement the training.	A new training needs analysis will be completed to meet the new requirements for the DSPT for IG and Cyber Security training. The full NHS Guidance on the Training Needs Analysis (TNA) and how to meet the other new standards has now been issued and is being reviewed by Digital senior management – it requires training to delivered and reported on in a more granular fashion than previously, and for complimentary awareness activities to be delivered and reported on. These requirements are being discussed at the relevant existing working groups, and in the DSPT working group which has now been formed.	Development of Training Needs Analysis for DSPT requirements and any revision of measurement indicator(s) by December 2023. TNA to be submitted to the Board Actions will be overseen by the Digital Oversight Committee	BAF 6	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

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



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Freedom of Information (FOI) requests responded to within target time performance was 64.0% in September and below the target of 80.0%. The indicator exhibited common cause variation. The number of cases received in M6 was almost double the number received in M5 and although the FOI team has closed more cases in M6 than M5, the overall effect has been a reduction in performance. A review of the reasons for the longer response times by the FOI team noted that the increase in average times was relatively low. However, as the average was close to the target time the small increase resulted in relatively more breaches. The reasons for the extended response times have been identified as relating to staff finding it difficult to respond alongside clinical and operational requirements, and as teams seek to manage FOIs within their existing busy workloads there has been an increase in checking and challenging whether the FOI needs to be responded to. In these instances, querying the validity can add to the workload for the FOI team, and elongate the amount of time it takes to generate a response.	1) Local guidance on the circumstances in which FOI requests can and cannot be refused or challenged is being written and will be published on the Information Governance Intranet site – a link to which will be included in all emails sent by the FOI team. This should better equip teams wishing to make a refusal or seek clarification. 2) The significant update to the software used to manage FOIs is scheduled for 31/10/2023. The original targets of 31/08/2023 and 21/09/2023 were missed as setup of the new system was more complex than was indicated by the vendor.	1) In draft – will be published by 13/11/2023 2) New software up and running by 31/10/2023 Report on progress to be made to Digital Oversight Committee	BAF 6	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*



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 73.0% in September, below the target of 80%. Performance exhibited common cause variation. As reported in the M4 and M5 IPRs, the Medical Records SAR team have a significant backlog of cases to work through as well as now regularly receiving high volumes of requests per month. This team is in the process of recruiting and training new staff. Performance in M6 was 57% closed on time a similar figure to M5 (61%) The PACS team performance was 83% closed on time in M6, having been 95% in M5, which whilst meeting the target but does not contribute to the overall Trust performance as it did in M5, which explains the reduction in overall performance from 77% to 73%	1) A new software package to better manage subject access requests across all teams is being brought in. This is an extension of the existing FOI management package, and update to which is noted elsewhere and has similar automation and management features. 2) A wider review of the issues around handling Subject Access Requests, particularly in Medical Records/Legal Services and PACS/Radiology by the Data Protection Officer and Head of IG is underway and recommendations will be passed to DOC. 3) Additional temporary staff will be employed to address the current backlog of SARs within the Medical Records Team. This is forecast to improve performance sustainably from December onwards. 4) Targeted and short-term temporary staffing has been identified to support the Medical Records SAR backlog and recruitment is now under way.	1) New software is in setup but not yet rolled out – now targeting October 2023 (previously this was reported as August 2023) 2) End of October 2023 3) December 2023 4) End of October 2023 Oversight from Digital Oversight Committee	BAF 6	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

4. Development indicators

Chief Officer	Domain	Reporting section	Indicator type	Indicator	Comments
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 M6 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