Oxford University Hospitals
NHS Foundation Trust

Integrated Performance Report

M8 (November data)

TB2024.07

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1. Executive summary

Oxford University Hospitals NHS Foundation Trust

Overview

In month 8, we achieved our target in measures that support patient safety and experience of care, including MRSA, Clostridium difficile, E.Coli, MSSA and VTE assessments. Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) rates continued to demonstrate fewer patient deaths than expected and care was supported increases in our Care Hours Per Patient Day, overall, and the Midwife-to-birth ratio, both exhibiting improving Special Cause Variation (SCV).

The reporting period of October (NB. available in November) was the first month of reporting three Cancer standards. These are the Faster Diagnosis Standard: a diagnosis or ruling out of cancer within 28 days of referral, the 31-day treatment standard: commencing treatment within 31 days of a decision to treat for all cancer patients, and 62-day treatment standard: commencing treatment within 62 days of being referred or consultant upgrade. As the indicators do not yet have a time series, SPC reporting is not available.

Our staff supported patient care by meeting targets for the vacancy rate, turnover and non-clinical appraisals, the latter two standards exhibited improving SCV. Our staff were supported by our better-than-target time to hire, which also exhibited improving SCV. The Cancer Faster Diagnosis standard achieved the performance standard, and we remain amongst the highest-performing hospitals nationally for this indicator. We increased the percentage of patients discharged to their usual place of residence and the indicator exhibited improving SCV.

Successes are also recognised within the Divisional Performance Review meetings, and this incorporates contributions of our staff in improving the care and experience for our patients, to our workforce and to our population. These are documented in the summary of the Performance Review meetings and reported to the Integrated Assurance Committee.

Out of the 105 indicators currently measured in the IPR, 34 are reported on in further detail using the standardised assurance templates and are listed within the relevant domain below. 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.

Quality, Safety and Patient experience

We recorded hospital infections worse than our monthly threshold for Klebsiella cases and Pseudomonas, and the target was not met for our complaints response times (noting special cause variation improvement) and reactivated complaints. Safeguarding training for Children and Adults did not meet the performance standard but exhibited improving SCV and Adult and Children's Safeguarding activity continues to increase and exhibit improving SCV. Deteriorating SCV was exhibited for incidents with moderate harm per 10,000 beddays and Health and Safety incidents relating to Violence and Aggression. Performance targets were also not achieved for Non-Thematic Patient Safety Incidents, Category 2 and Category 3-4 Pressure Ulceration incidents, PFI cleaning at the John Radcliffe, and FFT percentage positive responses for ED, Outpatients and Maternity (the latter exhibiting improving SCV in the response rates).

Growing Stronger Together

Sickness absence rates continue to decrease and exhibit improving SCV but remain above the target. All other targets measured within the domain of Growing Stronger Together are meeting targets and exhibited improving SCV for Turnover, Appraisals (non-medical) and Time-to-hire.

Operational Performance

Patients attending our type-1 emergency departments and being seen within four hours did not meet the performance standard or the trajectory for November. The time patients spent over 12 hours in the department was below target. The number of patients waiting in the categories over 52 weeks increased and we continued to report patients waiting over 65, 78 and 104 weeks. We did not meet the diagnostic (DM01) standard but continue to report high volumes of activity relative to 2019/20 (Improving SCV). Assurance reports are also included in the two new Cancer standards for 62-days and 31-days. For both long waiting patients on RTT pathways and all cancer patients, specialty and tumour site plans are in place supported by the Elective Recovery Fund schemes and other targeted initiatives.

Finance

Finance summary for M8 to follow.

Digital

We have also included assurance templates on the one Priority one incident, DSPT / information governance training compliance, Externally Reported ICO incidents, Data Subject Access response (DSAR) times and response times for Freedom of Information (FOI) requests.

Data quality

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 • Klebsiella cases • PSAR cases • Reactivated complaints • Pressure Ulceration incidents per 10,000 bed days (Hospital acquired Cat 3 & 4) • FFT Outpatient % positive • FFT ED % positive • FFT Maternity % positive	Not achieving target • % of complaints responded to within agreed timescales • Safeguarding (Children) training compliance L1 - L3 • Safeguarding (Adults) training compliance L1 - L3 Not achieving target • Pressure Ulceration incidents per 10,000 bed days (Hospital acquired Cat 2)	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 • Adult safeguarding activity Not achieving threshold • Non-Thematic Patient Safety Incident Investigations
Growing Stronger Together		Not achieving target • Sickness absence (rolling 12-month)		
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	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.	Not achieving threshold • 62- day General Standard • 31-day General Standard
Corporate Support Services	Not achieving target • PFI cleaning score (JR) • Freedom of Information % responded to within target time • Data Subject Access Requests • Externally reported ICO Incidents	Not achieving target • Data Security and Protection Training compliance		Not achieving target • P1 Incidents

2. b) SPC indicator overview summary

Oxford University Hospitals NHS Foundation Trust

Quality, Safety and Patient Experience Summary

Latest Indicator Period: Nov-2023

Indicator Description	Period	Performance	Target / Threshold	Met?	Mean	LCL	UCL
MRSA bacteraemia infection rate COHA and HOHA (per 10,000 beddays)	Nov-23	0.0	-	-	0.2	-0.6	0.9
MRSA cases: HOHA+COHA	Nov-23	0	0		0	-2	3
Clostridium difficile infection rate COHA and HOHA (per 10,000 beddays)	Nov-23	2.0	-	-	3.6	0.1	7.0
C-diff cases: HOHA+COHA	Nov-23	6	9		10	0	20
E. coli infection rate COHA and HOHA (per 10,000 beddays)	Nov-23	3.7	-	-	5.4	0.9	10.0
E. Coli cases: HOHA+COHA	Nov-23	11	13		15	2	29
MSSA cases: HOHA+COHA	Nov-23	6	-	-	5	0	10
Klebsiella cases: HOHA+COHA	Nov-23	13	7	No	8	1	15
PSAR cases: HOHA+COHA	Nov-23	6	4	No	5	-4	13
Number of Never Events	Nov-23	0	0		0	-	-
Non-Thematic Patient Safety Incident Investigations	Nov-23	1	0	No	1	-	-
VTE Risk Assessment (% admitted patients receiving risk assessment)	Oct-23	98.1%	95.0%		98.1%	97.7%	98.5%
CAS alerts breaching deadlines at end of month and/or closed during month beyond deadline	Nov-23	0	0		0	-	-
Medication incidents causing moderate harm, major harm or death	Nov-23	5	-	-	2	-2	6
Mortality HSMR	Nov-23	88.8	100.0		92.8	-	-
Mortality SHMI	Nov-23	0.9	100.0		90.4	-	-
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	Nov-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	Nov-23	1367	-	-	1342	1309	1375
Number of active clinical research studies (commercial)	Nov-23	369	-	-	347	333	361
Number of active clinical research studies (non commercial)	Nov-23	998	-	-	995	974	1016
Number of incidents with moderate harm or above per 10,000 beddays	Nov-23	48.1	-	-	37.0	21.7	52.4
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 2)	Nov-23	27.5	26.0	No	28.0	16.0	40.0
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 3 and 4)	Nov-23	3.4	3.0	No	2.8	-0.2	5.8
Pressure Ulceration incidents per 10,000 beddays (Present on admission Cat 1+)	Nov-23	104.1	114.0		116.2	89.2	143.1
Harm from Falls (Moderate and above)	Nov-23	10	-	-	5	-2	11
Harm from Falls per 10,000 beddays (moderate and above)	Nov-23	3.4	-	-	1.6	-0.7	4.0

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	Nov-23	121	-	-	99	57	142
Number of complaints per 10,000 beddays	Nov-23	41.0	-	-	35.2	21.3	49.0
% of complaints responded to within agreed timescales	Nov-23	76.0%	95.0%	No	70.0%	51.9%	88.0%
Reactivated complaints	Nov-23	10	1	No	8	-1	17
Number of RIDDORs	Nov-23	3	5		3	-2	8
Health and Safety related incidents - Assault, Aggression and harassment	Nov-23	145	-	-	129	52	207
Incident rate of violence and aggression (rate per 10,000 beddays)	Nov-23	49.2	-	-	45.6	19.2	72.1
FFT inpatient % positive	Nov-23	95.5%	95.0%		95.1%	93.4%	96.9%
FFT outpatient % positive	Nov-23	93.9%	95.0%	No	93.7%	92.4%	95.1%
FFT ED % positive	Nov-23	74.4%	85.0%	No	78.2%	69.6%	86.7%
FFT maternity % positive	Nov-23	89.4%	90.0%	No	87.4%	65.0%	109.9%
Inpatient FFT (response rate)	Nov-23	24.8%	-	-	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)	Nov-23	22.5%	-	-	24.9%	21.7%	28.1%
Maternity FFT (response rate)	Nov-23	19.1%	-	-	8.7%	3.4%	13.9%
Adult safeguarding activity	Nov-23	899	-	-	687	499	876
Children's safeguarding activity	Nov-23	901	-	-	483	305	662
Number of safeguarding consultations initiated by provider (both to internal and external organisations)	Nov-23	1800	-	-	1172	898	1447
Safeguarding (Children) training compliance L1 - L3	Nov-23	89.0%	90.0%	No	83.6%	78.0%	89.2%
Safeguarding (Adults) training compliance L1 - L3	Nov-23	85.0%	90.0%	No	2.9%	-4.4%	10.2%
Trust level: CHPPD vs budget	Nov-23	-14.9	-	-	-40.1	-94.2	14.0
Trust level: CHPPD vs required	Nov-23	7.7	-	-	-15.5	-39.0	8.1
Mothers birthed	Nov-23	599	625	-	628	556	700
Babies born	Nov-23	611	-	-	639	566	712
Scheduled Bookings	Nov-23	704	750	-	711	575	848
Inductions of labour from iView	Nov-23	142	-	-	147	103	190
Midwife:birth ratio (1 to X)	Nov-23	21.9	28.0		27.3	23.4	31.2
PFI: % cleaning score by site (average) JR	Nov-23	91.8%	95.0%	No	93.0%	83.1%	102.8%
PFI: % cleaning score by site (average) CH	Nov-23	100.0%	95.0%		94.8%	87.7%	101.8%
PFI: % cleaning score by site (average) NOC	Nov-23	95.0%	95.0%		97.8%	93.8%	101.8%

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

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Growing Stronger Together Summary

Latest Indicator Period: Nov-2023

Indicator Description	Period	Performance	Target / Threshold	Met?	Mean	LCL	UCL
Vacancy rate %	Nov-23	6.7%	7.7%		6.8%	5.7%	7.8%
Turnover rate (rolling 12 months)	Nov-23	10.4%	12.0%		11.4%	10.8%	12.0%
Sickness absence (rolling 12 months)	Nov-23	3.9%	3.1%	No	4.1%	3.9%	4.3%
Appraisal compliance (non medical)	Nov-23	94.6%	85.0%		70.4%	47.5%	93.3%
Core skills training compliance	Nov-23	87.8%	85.0%		88.9%	86.5%	91.3%
Time to hire (average days)	Nov-23	43.5	53.0		50.9	41.2	60.6

Operational Performance Summary

Latest Indicator Period: Nov-2023

Indicator Description	Period	Performance	Target / Threshold	Met?	Mean	LCL	UCL
Proportion of ambulance arrivals delayed over 30 minutes	Oct-23	14.7%	-	-	9.2%	1.3%	17.1%
Ambulance turnaround time > 60 minutes	Oct-23	2.5%	-	-	1.4%	-0.5%	3.3%
ED 4hr performance - All	Nov-23	57.9%	76.0%	No	67.3%	59.4%	75.3%
ED 4hr performance - Type 1	Nov-23	50.8%	76.0%	No	61.9%	53.0%	70.8%
Proportion of patients spending more than 12 hours in an emergency department	Nov-23	7.0%	2.0%	No	5.3%	2.4%	8.1%
Proportion of patients discharged from hospital to their usual place of residence	Nov-23	92.7%	-	-	91.9%	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	Nov-23	95.4%	-	-	94.5%	91.8%	97.2%
Theatre utilisation (elective)	Nov-23	97.2%	85.0%		90.2%	86.5%	94.0%
% Diagnostic waits waiting under 6 weeks + (DM01)	Nov-23	79.7%	95.0%	No	89.6%	85.7%	93.5%
Total patients waiting more than 52 weeks to start consultant-led treatment	Nov-23	3353	-	-	2022	1531	2512
Total patients waiting more than 65 weeks to start consultant-led treatment	Nov-23	1048	-	-	867	575	1160
Total patients waiting more than 78 weeks to start consultant-led treatment	Nov-23	221	0	No	341	197	485
Total patients waiting more than 104 weeks to start consultant-led treatment	Nov-23	6	0	No	28	1	54
62-day General Standard	Oct-23	65.6%	85.0%	No	65.6%	-	-
28-day FDS General Standard	Oct-23	80.0%	75.0%		80.0%	-	-
31 Day General Treatment Standard	Oct-23	85.6%	96.0%	No	85.6%	-	-
Cancer: % patients diagnosed at stages 1 and 2	Apr-21	0.0%	-	-	0.0%	-	-
62 Day incomplete pathways >62 days	Nov-23	332	-	-	279	198	359
62 Day incomplete pathways >104 days	Nov-23	89	-	-	88	58	118
Total DC activity undertaken compared with 2019/20 baseline	Nov-23	96.4%	-	-	88.8%	71.0%	106.7%
Total IP elective activity undertaken compared with 2019/20 baseline	Nov-23	91.5%	-	-	82.6%	56.8%	108.4%
Total first outpatient activity undertaken compared with 2019/20 baseline	Nov-23	117.5%	-	-	104.5%	79.1%	129.9%
Total follow up outpatient activity undertaken compared with 2019/20 baseline	Nov-23	120.8%	-	-	110.0%	81.9%	138.1%
Total diagnostic activity undertaken compared with 2019/20 baseline	Nov-23	120.3%	-	-	115.0%	98.6%	131.3%
Total patients treated for cancer compared with the same point in 2019/20	Nov-23	96.0%	-	-	122.7%	82.7%	162.6%

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

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

Oxford University Hospitals NHS Foundation Trust

Finance Summary

Latest Indicator Period: Nov-2023

Indicator Description	Period	Performance	Target / Threshold	Met?	Mean	LCL	UCL
In-month financial performance Surplus/Deficit £'000	Nov-23	15373.9	-1113.1		-354.5	-7634.0	6925.0
Adjusted in-month financial performance Surplus/Deficit £'000	Nov-23	-7269.0	-	-	-2323.2	-7153.7	2507.3
Year-to-date financial performance Surplus/Deficit £'000	Nov-23	-14685.5	-9862.7	No	-7380.9	-14757.8	-4.0
Elective recovery funding (ERF) value-weighted activity % In month	Nov-23	102.3%	103.0%	No	93.6%	70.2%	117.0%
Cash £'000	Nov-23	24930	20491		44503	18806	70199
BPPC £ %	Nov-23	89.7%	95.0%	No	90.6%	82.9%	98.3%
BPPC Volume %	Nov-23	80.4%	95.0%	No	80.2%	73.1%	87.4%
In-month ICS CDEL capital expenditure	Nov-23	1256.5	2820.0	-	2277.5	-3376.4	7931.4
Efficiency delivery £'000	Nov-23	12863.0	4835.0		3054.0	-1073.2	7181.2

Corporate support services – Digital Summary

Latest Indicator Period: Nov-2023

Indicator Description	Period	Performance	Target / Threshold	Met?	Mean	LCL	UCL
Priority 1 Incidents	Nov-23	1	0	No	1	-	-
Data Security and Protection Training compliance	Nov-23	92.2%	95.0%	No	88.4%	85.2%	91.6%
Data Security & Protection Breaches	Nov-23	32	-	-	26	10	41
Externally reportable ICO incidents	Nov-23	1	0	No	0	-	-
All IG reported incidents	Nov-23	33	-	-	27	12	42
Freedom of Information (FOI) % responded to within target time	Nov-23	51.4%	80.0%	No	66.3%	41.9%	90.7%
Data Subject Access Requests (DSAR)	Nov-23	75.4%	80.0%	No	74.7%	55.9%	93.5%

Corporate support services – Legal services Summary

Latest Indicator Period: Nov-2023

Indicator Description	Period	Performance	Target / Threshold	Met?	Mean	LCL	UCL
Legal Services: Number of claims	Nov-23	19	-	-	17	3	31

Corporate support services – Regulatory assurance

Latest Indicator Period: Nov-2023

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

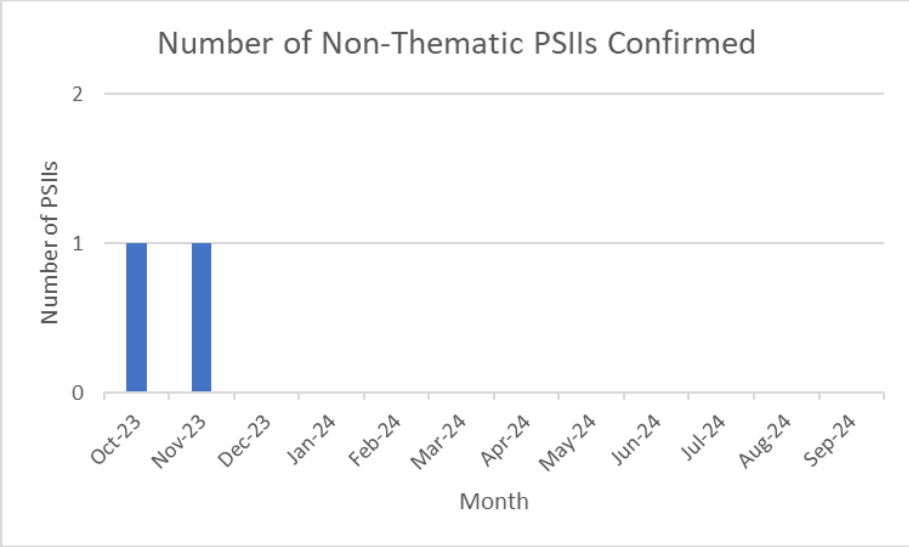
OUH Data Quality indicator

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***

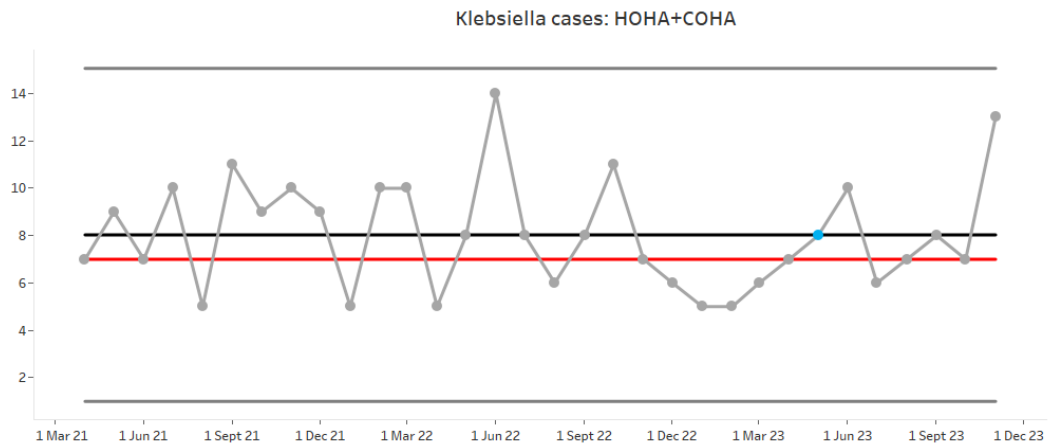
03. Assurance reports

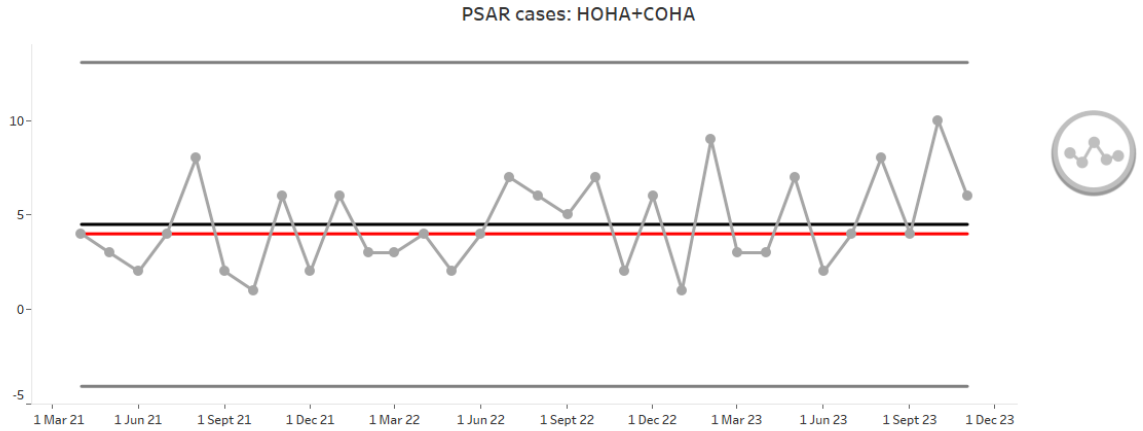
3. Assurance report: Quality, Safety and Patient Experience



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
One non-thematic PSII was confirmed in November. It concerned a patient who was found unresponsive in their home, 5 days after percutaneous endoscopic gastrostomy tube (PEG) insertion. Concerns have been raised regarding the post-operative care and discharge of the patient, which will be explored through this learning response.	As this is the second non-thematic PSII that has been confirmed since OUH started working under the new Patient Safety Incident Response Framework at the start of October, there is no trend to identify.	The sole action at this juncture is to complete the investigation. The need for immediate local actions were considered when a rapid review was completed by the service, and actions and findings from a previous investigation into a case relating to PEG management in FY 2019/20. The PSII process is overseen by the weekly Safety, Learning & Improvement Conversation.	BAF 4 CRR 112 2	Sufficient

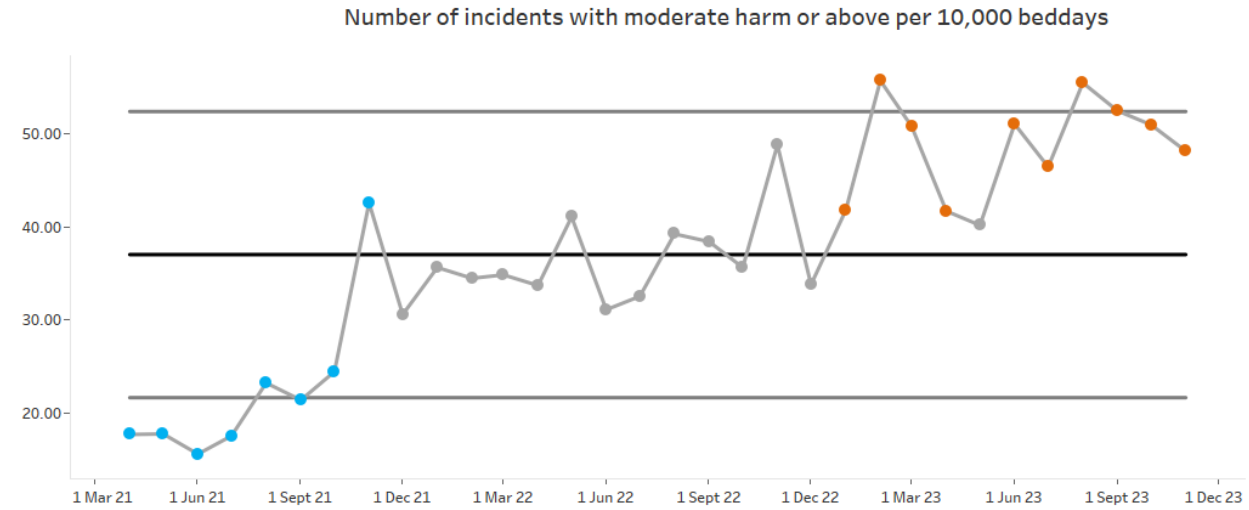
3. Assurance report: Quality, Safety and Patient Experience

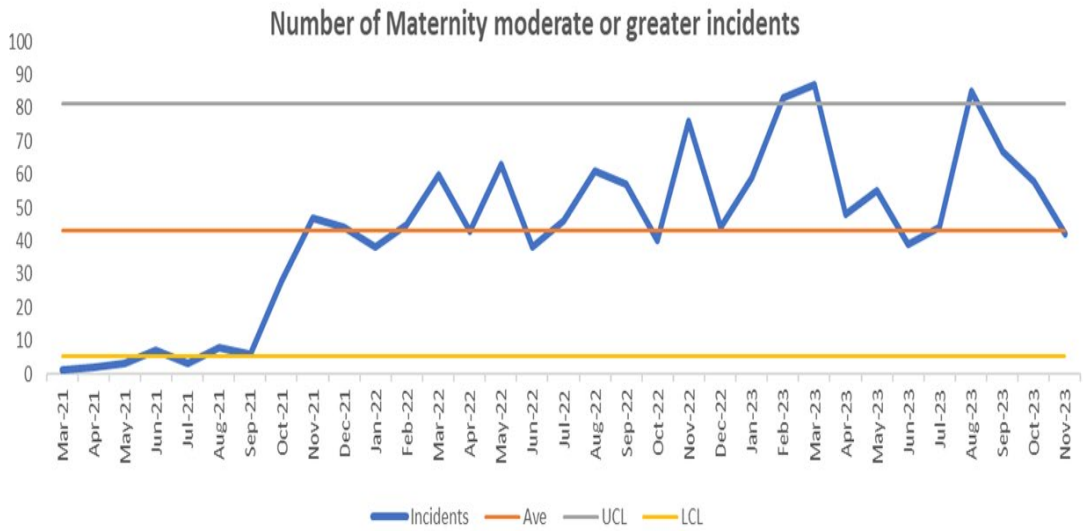




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The NHS England Long Term Plan is to halve healthcare-associated Gram-negative bloodstream infections (GNBSI) by March 2024/25. Nationally this ambition is not met, with cases continuing to increase.	Klebsiella cases: threshold for 2023/24 is 86 cases, currently on 66 cases. In November there were 13 cases, which is almost double the monthly limit, all in different areas. On review, over half the cases had an underlying risk factor of neutropoenia. The threshold for Pseudomonas is 47 cases. Currently at 44 cases, no themes identified for November cases,	Continue to review all case to identify any learning.	BAF 4	Sufficient

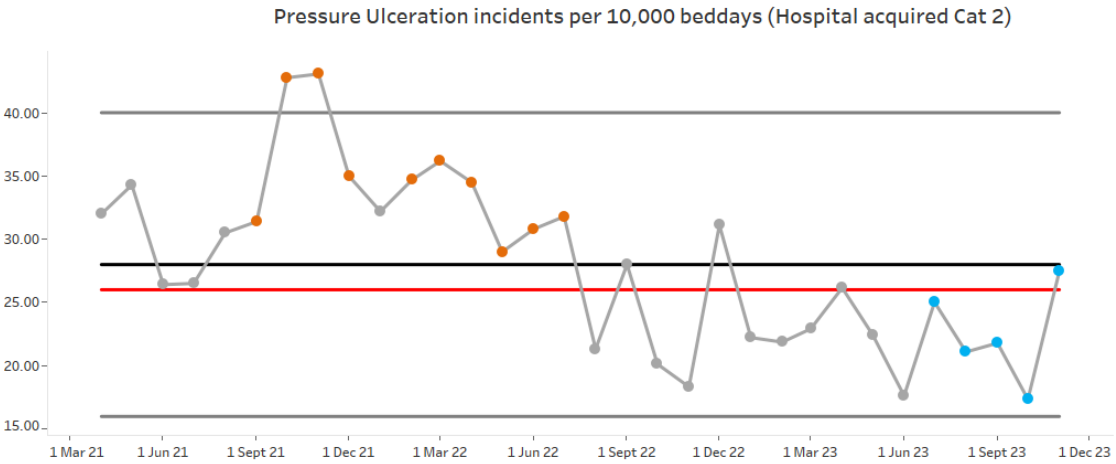
3. Assurance report: Quality, Safety and Patient Experience

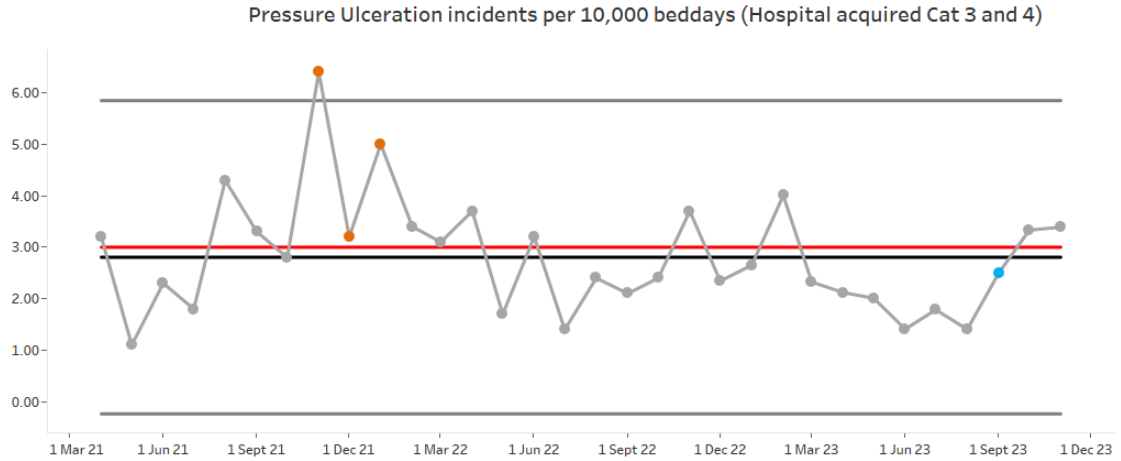




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
There were 48.1 incidents with moderate harm or above per 10,000 bed days in November. The indicator exhibited deteriorating special cause variation due to eleven consecutive periods recorded above the mean. 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; this approach embedded amongst the Maternity staff over the following 12 months, and is now well established. Maternity now calls a significant percentage of Moderate+ incidents (42 of the 140 incidents in November 2023, or 30%), and their reporting trend ca be seen in the second graph. That the graph against bed days includes 6 months prior to this change explains why so many later months show data near or above the mean.	Earlier in FY 2023/24, a large number of Moderate+ incidents were called under the Assault, Aggression & Harassment cause group, but only 1 was called in November 2023 (<1%). The most common cause group in November 2023 was Surgical/Return to Theatre (33 of 140 incidents, 24%). These were spread between 13 Directorates, so no significant trend has been identified. The Trust continues to report all returns to theatre as entailing Moderate harm, regardless of avoidability, in line with national guidance.	133 of the incidents reported were patient incidents, and at the time of writing, 67 of these have been through the Safety, Learning & Improvement Conversation (SLIC) review process (50%). Further information, or a formal learning response, are awaited for the remainder, and tracked by Patient Safety Team each week in discussion with Divisional governance staff and Deputy CMO. SLIC reports to the Patient Safety & Effectiveness Committee, which in turn reports to Clinical Governance Committee.	*N/A*	Sufficient

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

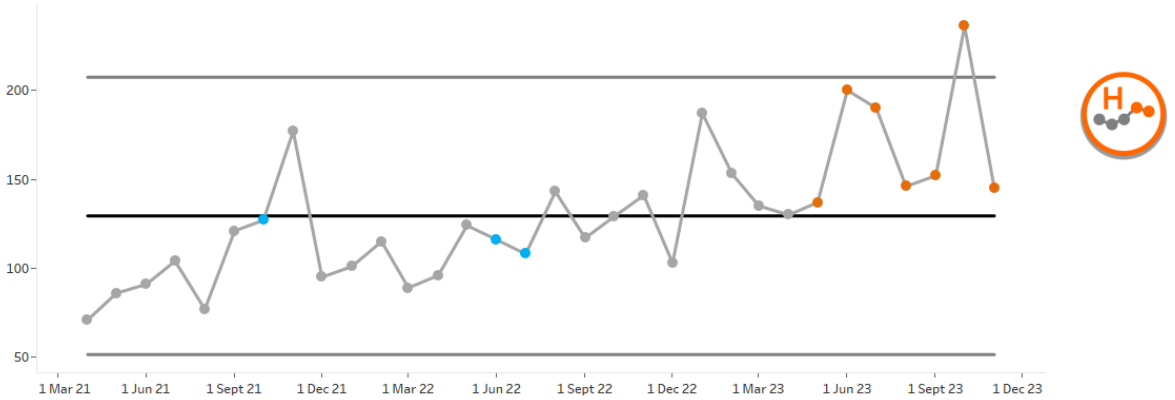




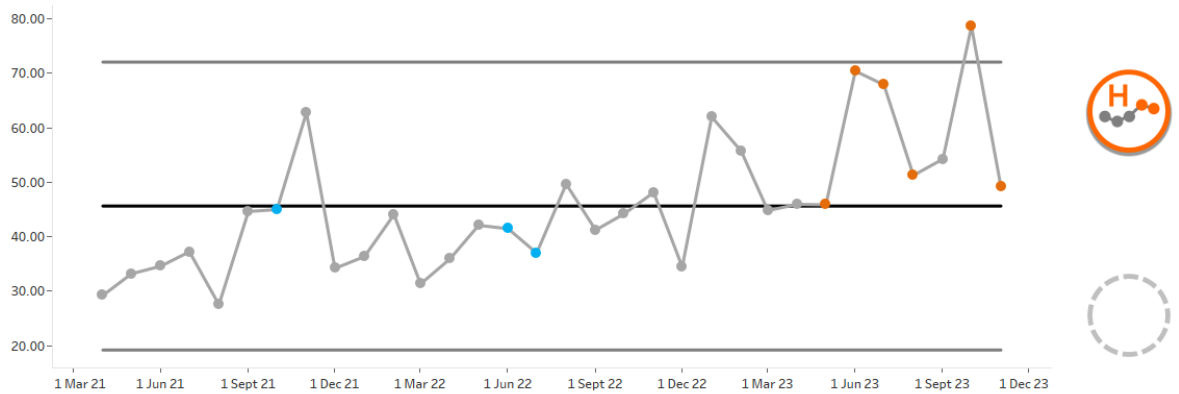
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
HAPU Category 2 103 incidents were initially reported as HAPU Category 2. Validation of the incidents was completed for approximately 60% of the incidents, not all incidents were validated due to the patient being discharged or passing away before validation could occur and capacity issues in the TV team. In these instances the reported level of skin damage remained unchanged. A review of the HAPU category 2 incidents will be undertaken and reported back to HFAF for discussion HAPU Category 3 and above There were 10 incidents reported in November 2023. Two occurred in one clinical area. All will be reviewed for thematic learning and discussed at HFAF in January	All incidents have been reviewed in line with the PSIRF approach, with the identification of learning and remedial action plans for the clinical divisions. The divisions have over-riding action plans to reduce the overall incidence of HAPU. • Delivery of education programme to support the revised Pressure Ulcer Prevention Policy by the Divisional education team. • Focus on increasing compliance with the Pressure ulcer prevention e-learning. • Quarterly peer review pressure ulcer audit.	Themes from these incidents will be identified in the Harm Free Assurance Forum scheduled for the January 2024 for shared learning.	N/A	Sufficient

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

Health and Safety related incidents - Assault, Aggression and harassment

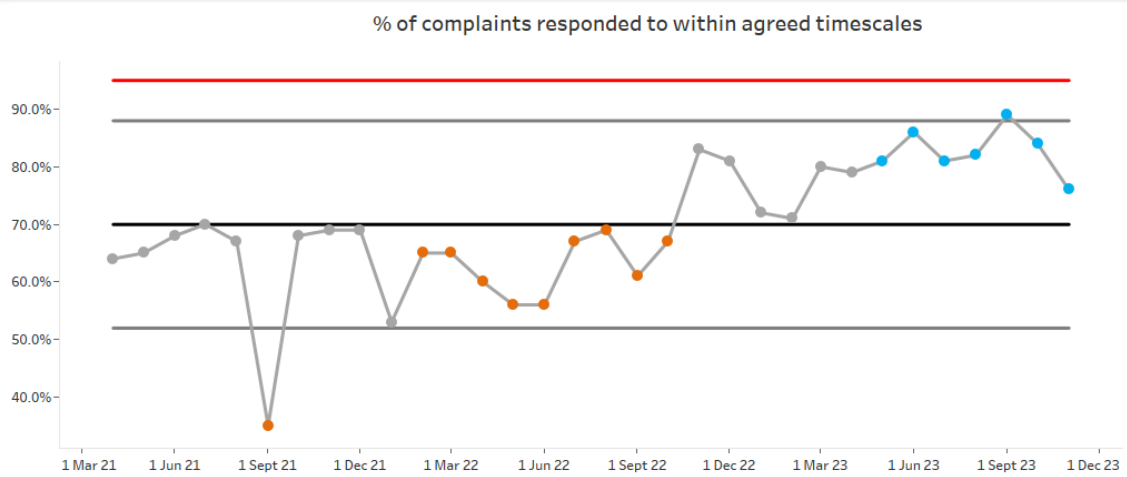


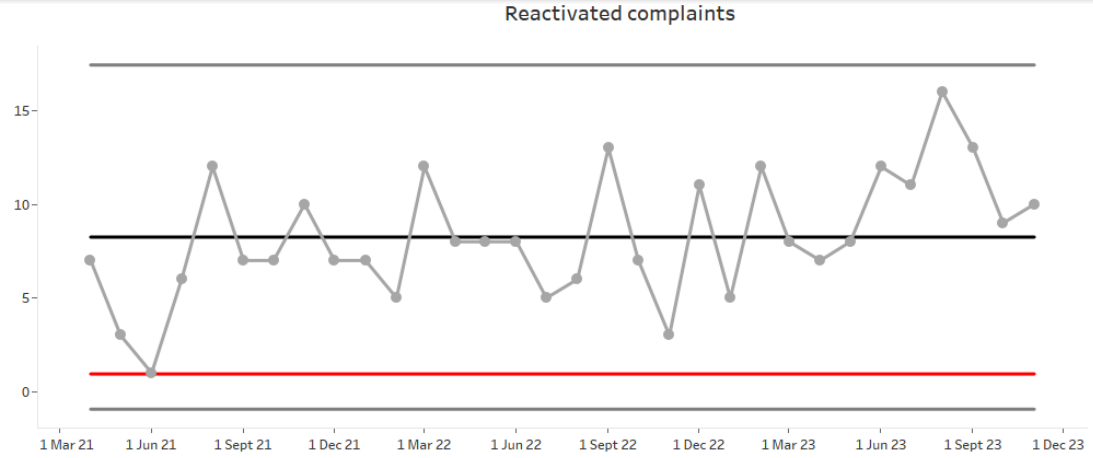
Incident rate of violence and aggression (rate per 10,000 beddays)



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 49.2 Health and Safety incidents relating to assault, aggression and violence per 10,000 bed days in November (145 incidents). The indicator exhibited special cause variation due to seven data points above the mean. 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

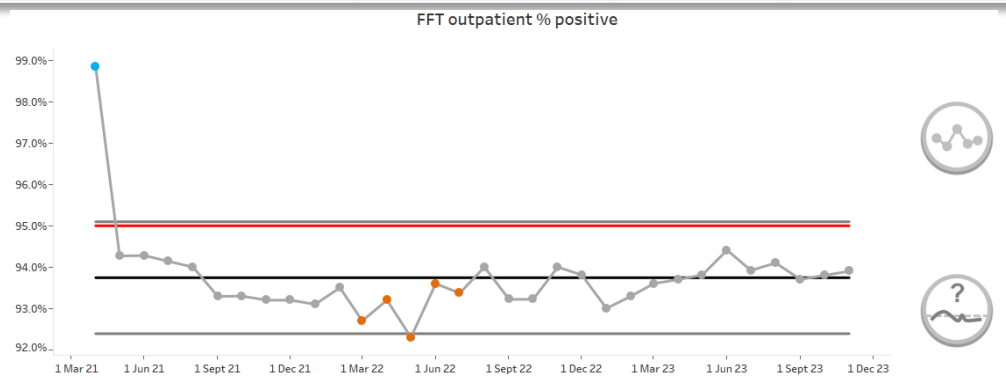
3. Assurance report: Quality, Safety and Patient Experience, *continued*

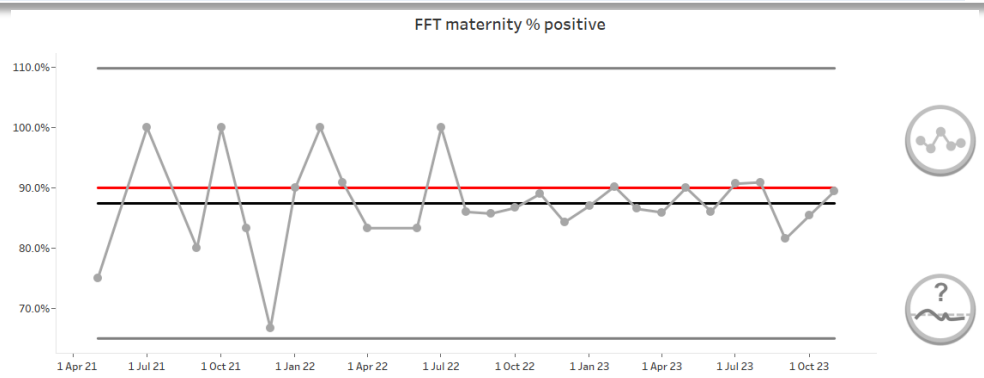


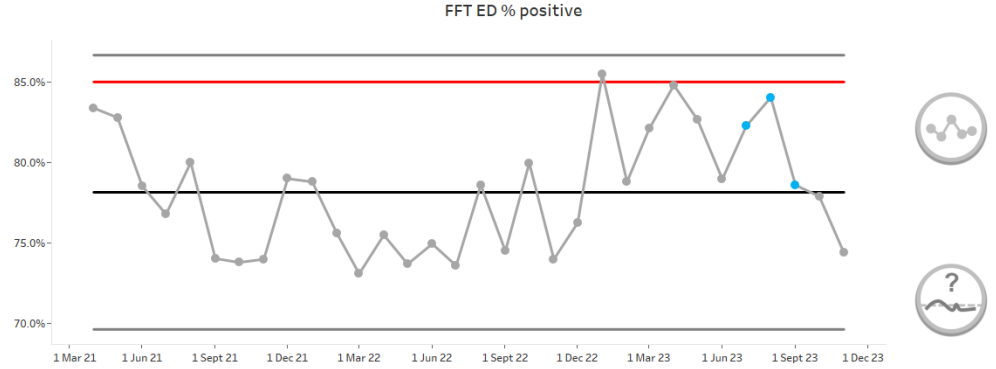


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
In November 2023, 76.0% of complaints were responded to within 40 days, below the target of 95%. The indicator has consistently not achieved the target. However, November's performance exhibited improving special cause variation with over seven data points performance above the mean of 70.0%. Reactivated complaints exhibited common cause variation but were above the threshold value of one reactivated complaint per month.	Work has begun with the Divisions and the Complaints team to commence the transition from a response time of 40 working days to 25 working days. The expectation is that complaints are responded to in full in 25 working days within the next 12 months. The weekly auto-generated breach sheet enables Divisions to track their overdue complaints, and those which will breach. These are discussed in weekly meetings held with the Complaints team. The staffing levels within the Complaints team remain under establishment due to ongoing sickness, leave and maternity leave, alongside an increase in the volume and complexity of complaints.	Ongoing, reviewed weekly.	BAF 4	Sufficient

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



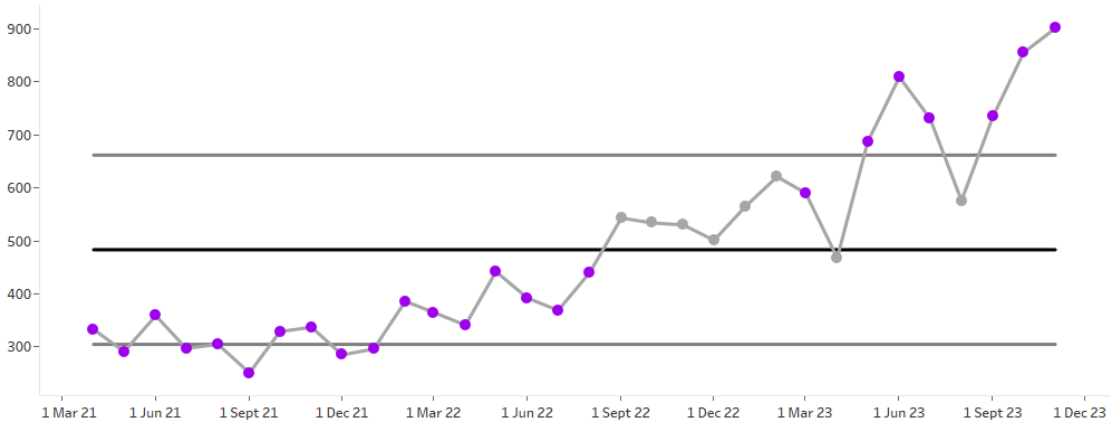




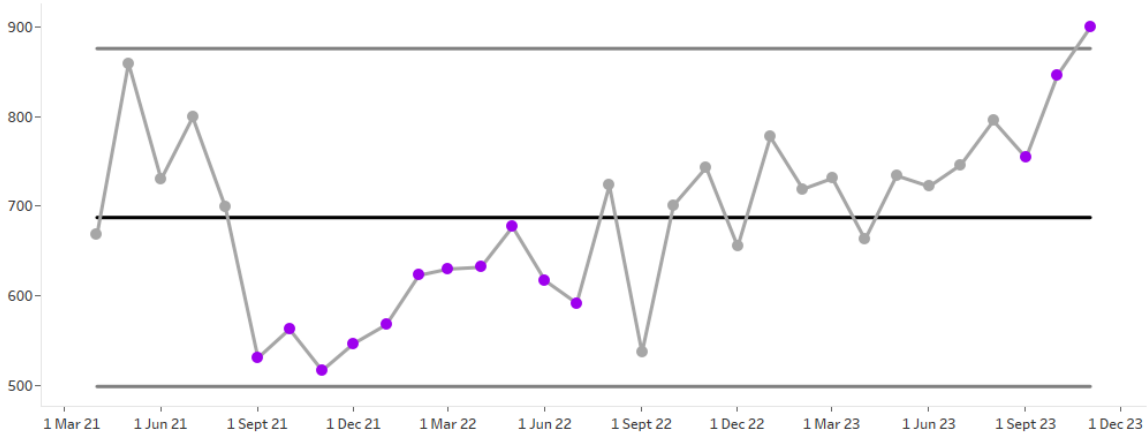
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Friends and Family Test (FFT) percentage positive rates were below the performance standard for outpatient, ED and Maternity. There was an increase in positivity in maternity for the second consecutive month, it remains relatively stable for inpatient and outpatient services. ED's results fluctuate more than the other services and is in response to the operational pressures within the service. The positive rate has reduced for the third consecutive month following good feedback in July and august 2023. All indicators, however, exhibited common cause variation. During November 2023, the top positive themes reported by patients relate to the Staff Attitude, implementation of care, and clinical treatment. The most commented negative themes were the time waiting on a waiting list, discharge process and car parking. This is reported to the weekly 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 2024.	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



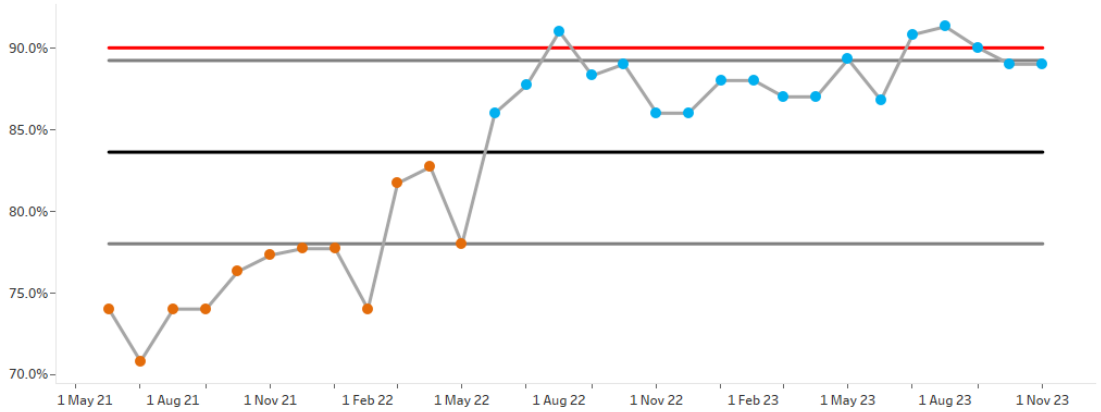
Adult safeguarding activity



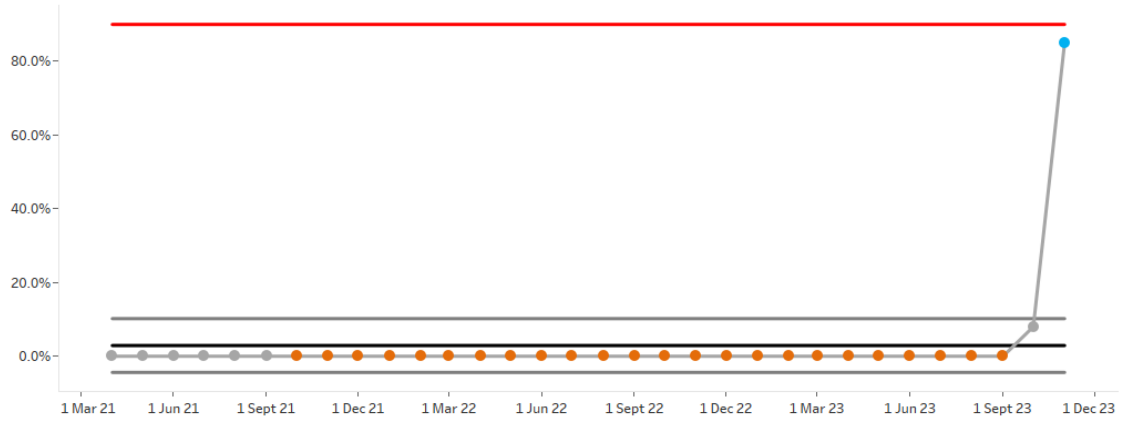
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The indicator continues to exhibit special cause variation due to more than seven periods above the mean and exceeding the upper process control limit. Safeguarding children and maternity activity increased in by 44 (n=901). Issues of DA and mental health and substance abuse in maternity continue. Childrens relates to adolescent mental health presentations dropped by 15 (n72) with 14% requiring admission for treatment. Maternity safeguarding assessed at pregnancy booking dropped slightly to 29.3% (202 cases) with a social or safeguarding element. Adult activity increased by 53 (n=899) across referrals, Ulysses and EPR referrals. Themes continue to relate to domestic abuse neglect and self-neglect. The DoLS activity dropped by 29 (n=86) audits of areas and requests for mental capacity assessments undertaken to improve reporting.	Self-harm data shared across the partnership continues to ensure support in place across education, Children Social Care (CSC) and OH school health team to support children in school. Attendance at multi agency meetings to share information for self-harm, domestic abuse conferences (MARAC and MATAC). Liaison information is shared with primary care and CSC increased by 159 for 1368 children attending ED in November. This information ensures professionals working with children and families in the community are aware of risks to provide support. Information for initial child protection case conferences and increase of 4 related to 67 children and 5 unborn babies. Divisional resource to the safeguarding team as staff vacancies and increased activity to manage support with DOLS applications and liaison function for all the information shares required to be compliant with the Care Act and s11 of the Children Act.	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*

Safeguarding (Children) training compliance L1 - L3



Safeguarding (Adults) training compliance L1 - L3



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Safeguarding children training L1-L3 compliance remained at 89.0%, just below the 90% KPI. The indicator exhibited special cause improving variation due to over seven periods above the mean. Level 3 adult training MLH is live. Mapping errors were noted and have been corrected so some groups of staff have moved from level 1 to level 2 safeguarding adults. Reporting is now correct and compliance with level 3 is at 85% (KPI 90%). Prevent training is below the 85% KPI due to the changes in mapping. Staff are encouraged to undertake training.	Mapping errors corrected and compliance improved to 85%. Shared at meetings (Div. governance, matrons and PSEC) to raise awareness of need to complete level 3 adult training. It has been agreed that safeguarding training will report in future level 1-3 adult and 1-3 children compliance. PSEC and each divisional governance report template provides details of gaps for training. Staff bulletin announcement that level 3 adult training is live in MLH went out in the staff bulletin.	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: Safe Staffing - Quality, Safety and Patient Experience, *continued*

Oxford University Hospitals NHS Foundation Trust

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 November 2023.

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

Increased bed capacity has remained open across several areas in November 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 December 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's month on month. 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.

NOTSSCaN Division –
All areas outside of rostering KPI's are being addressed by DDN. Neonatal Units staffed worked additional hours to support high acuity, will be redressed in next roster period. Trauma 3A had to give emergency annual leave, taking the ward above KPI.
Trauma 3A – 7 incidents reported, 2 of which are category 3. These are going through the harm free process, and learning identified from this process will be actioned.
Neuro ICU – medication incidents did not lead to patient harm. Incidents shared with staff involved for individual learning
Major Trauma 2A – 5 incidents reported, no common theme, one led to minor patient harm. Discussion taken place with staff involved for learning
Paediatric ICU- of 8 incidents reported all were without harm, except one. Analgesia prescribed incorrectly, leading to undue pain for the patient. This has been discussed with staff involved and with the parents of the patient. A deep dive continues in the department with pharmacy to review themes and trends.
Neonatal Unit – 5 incidents reported, no common theme. One incident led to minor harm. Discussed with staff and reiterated importance of following the drug monograph.
Robin's ward- - 5 incidents reported, 2 with minor harm. Incorrect prescription led to administration of high dose of drug. Incident discussed with Junior Doctor; parents made aware of incident

SuWOn Division -
Staffing in SUWON has remained at safe levels throughout November. Skill mix has remained a challenge on SEU due to high levels of temporary staffing to support the increased bed capacity which remains open, however, there are several new staff in a supernumerary period, that will flow into the numbers in the coming weeks.
Rostering KPI's were met for all rosters, along with the 8-week lead time. 3 rosters, SEU-F (under), Hematology Ward (under) and Transplant Ward (over) were outside of the Annual Leave KPI. The two areas under KPI, have given assurance that annual leave is on track to be used appropriately by the end of the year. Transplant ward was over due to annual leave being taken before and after the commencement of maternity leave

Hematology Ward - The 7 medication incidents were for a variety of reasons. No individual harm to patients, 4 related to late administration of medications, 1 related to systemic anti-cancer treatment (SACT) given too early. As stated last month, the Division has acted with further training and support with SACT.

Oncology ward – 5 medication incidents, 3 of which related to systemic anti-cancer treatment (SACT) delivery or prescription errors. 2 further incidents related to supportive care as part of the SACT regimen. There was no patient harm related to these, and ongoing work within the Division as above.
5 pressure ulcer incidents were recorded, however, 3 of these were documented on admission, and therefore not hospital acquired. A further one may have been present on admission, however, documentation did not support this. Staff reminded of the importance of documenting skin inspection on admission. The remaining incident, upon investigation, confirmed all risk assessments and pressure relieving equipment were in place, however, the patients at times, was declining to be moved.

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 - Only one area show roster not approved by manager for payroll. However, this roster was approved, but a change was then made on the roster before submission to payroll, which was not approved. Ward Manager advised that any changes need to be re-approved. Several departments did not achieve the 8-week lead time for roster publication. Lead time for Oak (HCU) and Laburnum has been addressed by the DDN with the ward managers. Both Complex Medicine Units B & C were also under the KPI for lead time. The Matron for these wards is working with the Ward Managers, providing support following Manager absence. Horton EAU and ED are behind in this period, but assurance has been given that this has improved in the next roster period
JR EAU – 7 falls were reported. No harm was sustained because of the fall. None were reported to be related to staffing level. No common theme, all patients had been risk assessed. Some did not follow instruction despite having full capacity.
JR ED – 6 falls reported. One fall resulted in minor harm, but no prolonged stay. One fall was unwitnessed, the others had staff or relative present. There were no common themes, and none reported to staffing levels.
8 Medication errors reported, none resulting in harm to the patient. None were reported to relate to staffing levels. 4 related to accurate recording of controlled drugs, 3 related to a lack of stock medication for TTO's, which caused a delay in discharging the patient.
5B Short Stay Ward – 8 reported falls. All patients had assessments completed. 4 falls were witnessed, 4 were not, none of the patients were cognitively impaired. 4 of the falls resulted in minor harm, the remaining 4, had no harm. The ward had been short of staff at times, due to high levels of sickness, however, upon investigation, it was noted that a common time for falls, was at break time. The timing of breaks has now been reviewed to always ensure more staff around.
Horton EAU & ED – total of 20 falls reported (15 in EAU, 5 in ED). Common theme of unwitnessed falls, related to extreme pressures across both departments and high numbers of patients presenting at the Emergency Department.
CTW – 5 medication incidents. 2 related to recording of controlled drugs, 2 related to incorrect administration of medication, patients came to no harm. Staff involved have reflected on errors.
CMU B- Significant enhanced observations with 3 daily wondering patients, increasing the acuity & dependency on the ward.
Of the six reported falls, only one was unwitnessed but the rest were during using a commode or during the therapy session. Risk assessments had been completed for all patients. No fall resulted in more than minor harm.
The pressure ulcer incidents reported, relate to pressure ulcers developed before admission. Assessments and appropriate equipment were put in place.
Osler RU – 8 hospital acquired pressure ulcer incidents. November saw an increase in acuity and dependency with several patients requiring continuous NIV, which then resulted in some patients sustaining harm to the bridge of their nose. All measures had been put in place and different interfaces trialed. Positioning of respiratory patients can be difficult, with some not tolerating relieving pressure by being on their side. The ward has acted, a board is being created by the Clinical educator to improve awareness and handover, particularly to the Clinical Support Workers.
Juniper – 5 reported falls, 3 of which were unwitnessed. The nursing team have reviewed the way of working to cover the high number of patients requiring enhanced observations.

CSS - of the 5 reported medication incidents, a common theme of prescriptions has been identified. Oxford Critical care Unit use two IT systems, which has led to incorrect transcription of medications. There is ongoing work within the unit to improve prescription templates. . 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 Quality Improvement Project for medication safety, led by the Governance Lead Nurse. No incidents related to a shortfall of staffing. 6 pressure ulcer incidents, 2 of which caused patient harm. Both incidents related to medical equipment (cervical collars). An MDT meeting identified an action plan with owners of actions identified.

Maternity – There were 9 reported medication incidents, however, this is across all Inpatients units. 3 occurred on level 5, the other 6 across all other maternity areas. No theme has been identified. There was no patient harm sustained. There is no evidence that any incident was related to staffing.
Roster publication time has significantly improved, now being met in 3 or the 4 areas. One roster not approved for payroll; however, this relates to only a small number of shifts on the roster. Therefore, it is likely the roster was approved, then a change needed to be made before being sent to payroll. This is being investigated further by the e-roster team.

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. An update on the results may be available for the next report.
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.

CHPPD – **Green** – census complete 100%. **Amber** 80-99.9% complete (missing up to 18/90 census, will have a minor impact on CHPPD) **Red** below 79.9% complete (will have an impact on overall CHPPD)

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

Action timescales and assurance group or committee	Risk Register (Y/N)	Data quality rating
Overall, no actions for this month. Assurance of ongoing oversight and assurance that nursing and midwifery staffing remains safe. Although CHPPD should not be reviewed in isolation as a staffing metric, and always at ward level. Reviewing it at Trust level triangulated with other Trust level financial metrics allows the Board to see where there are increased, capacity and acuity, (required) versus budget.	N	***Sufficient***

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

Oxford University Hospitals NHS Foundation Trust

November 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 reported falls	Delay in induction (PROM or booked IOL)	Medication errors (administration, delay or omission)	Pressure Ulcers	Women readmitted postnatally within 28 days of delivery	Proportion of mothers who initiated breastfeeding	Births where the intended place of birth was changed due to staffing	Revised Vacancy HR Vacs plus LT Sick & Mat Leave (%)	Turnover (%)	Sickness (%)	Maternity (%)	Roster manager approved for Payroll	Net Hours 2/-2%	8 week lead time	Annual Leave 12-16%	% Extremely likely or likely
NOTSSCaN																							
Bellhouse / Drayson Ward	9.1	0.8	0.2	88.9%	3	0	0	2							13.7%	6.1%	3.3%	9.3%	Yes	4.2%	-1.1	13.1%	90.2%
HH Childrens Ward	13.4	1.3	3.9	94.4%	1	0	0	1							24.1%	10.7%	6.0%	0.0%	Yes	-1.3%	7.6	14.5%	94.6%
Kamrans Ward	9.0	-1.2	-2.0	100.0%	1	0	0	0							8.9%	14.8%	2.3%	2.6%	Yes	-5.4%	8.6	14.3%	66.7%
Melanies Ward	12.7	1.1	1.0	100.0%	0	0	0	0							-79.0%	6.1%	1.5%	3.3%	Yes	-0.4%	10.9	16.3%	100.0%
Robins Ward	9.6	-1.1	-2.1	98.9%	5	0	0	0							21.8%	4.3%	2.9%	3.8%	Yes	-1.6%	10.9	12.7%	96.4%
Tom's Ward	8.7	0.7	-0.6	97.8%	3	0	0	1							19.9%	6.7%	2.2%	5.1%	Yes	0.0%	10.7	14.6%	100.0%
Neonatal Unit	17.0	-1.1	-		6	2	0	0							14.0%	5.8%	6.8%	5.3%	No	-5.8%	7.9	13.0%	
Paediatric Critical Care	27.5	-5.3	-		8	3	3	0							0.4%	7.2%	4.3%	6.3%	Yes	-0.9%	10.1	12.5%	
BIU	7.3	1.2	1.6	100.0%	2		1	2							20.4%	19.3%	2.7%	0.0%	Yes	-1.2%	8.0	11.0%	100.0%
HDU/Recovery (NOC)	38.7	16.5	-		0		0	0							12.5%	9.8%	4.5%	0.0%	Yes	0.0%	8.9	14.8%	
Head and Neck Blenheim Ward	8.2	1.0	-0.3	100.0%	1		0	2							22.3%	10.2%	6.2%	4.4%	Yes	0.2%	8.6	14.1%	83.3%
HH F Ward	8.0	-3.9	0.1	98.9%	4		3	2							0.8%	6.6%	4.5%	0.0%	Yes	-0.5%	9.3	14.0%	100.0%
Major Trauma Ward 2A	9.2	-2.1	1.2	95.6%	5		3	3							7.4%	9.0%	4.1%	2.0%	Yes	0.8%	8.3	11.5%	100.0%
Neurology - Purple Ward	8.9	-0.0	-2.2	100.0%	4		1	4							4.2%	19.9%	5.4%	3.1%	Yes	1.2%	8.7	13.7%	100.0%
Neurosurgery Blue Ward	10.3	1.3	-0.2	100.0%	0		1	0							9.8%	10.1%	3.9%	0.0%	Yes	1.9%	8.4	11.7%	75.0%
Neurosurgery Green/IU Ward	9.9	0.2	0.4	100.0%	1		1	2							10.4%	1.7%	4.7%	3.3%	Yes	3.2%	8.3	16.0%	100.0%
Neurosurgery Red/HC Ward	13.4	1.7	-0.0	100.0%	1		1	3							-4.3%	2.6%	4.8%	3.1%	Yes	0.3%	8.4	14.1%	100.0%
Specialist Surgery I/P Ward	8.4	-0.1	-0.2	100.0%	3		2	3							20.7%	9.9%	3.7%	0.0%	Yes	-1.1%	8.6	13.6%	78.6%
Trauma Ward 3A	8.6	-3.6	-0.1	98.9%	3		7	2							18.0%	10.9%	5.4%	4.4%	Yes	1.6%	8.3	17.5%	80.0%
Ward 6A - JR	7.2	-0.0	-0.7	97.8%	2		2	0							13.0%	12.5%	4.1%	2.4%	Yes	-2.9%	8.1	13.2%	100.0%
Ward E (NOC)	8.2	1.9	0.1	96.7%	0		0	4							20.2%	24.9%	9.2%	0.0%	Yes	1.0%	8.3	14.1%	88.2%
Ward F (NOC)	6.8	0.2	-0.1	94.4%	0		0	0							11.3%	9.5%	7.2%	5.3%	No	-1.3%	8.3	14.8%	100.0%
WW Neuro ICU	30.2	4.9	-		5		2	0							16.3%	10.7%	4.2%	2.9%	Yes	-3.6%	8.0	15.4%	

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

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

Oxford University Hospitals NHS Foundation Trust

November 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 reported falls	Delay in induction (PROM or booked IOL)	Medication errors (administration, delay or omission)	Pressure Ulcers	Women readmitted postnatally within 28 days of delivery	Proportion of mothers who initiated breastfeeding	Births where the intended place of birth was changed due to staffing	Revised Vacancy HR Vacs plus LT Sick & Mat Leave (%)	Turnover (%)	Sickness (%)	Maternity (%)	Roster manager approved for Payroll	Net Hours 2/-2%	8 week lead time	Annual Leave 12-16%	% Extremely likely or likely
MRC																							
Ward 5A SSW	8.8	0.4	1.0	98.9%	2		2	4							7.7%	7.9%	3.0%	8.6%	Yes	-1.0%	7.7	14.0%	
Ward 5B SSW	8.9	0.6	0.3	98.9%	2		1	8							5.5%	14.8%	5.3%	5.7%	Yes	-1.0%	8.9	13.4%	100.0%
Cardiology Ward	7.5	1.3	0.3	96.7%	0		2	1							2.1%	11.6%	3.2%	4.4%	Yes	0.8%	8.6	14.7%	95.0%
Cardiothoracic Ward (CTW)	6.6	-0.8	1.4	100.0%	5		0	4							14.7%	13.0%	4.2%	2.6%	Yes	-6.3%	8.6	12.5%	100.0%
Complex Medicine Unit A	9.2	0.3	0.4	100.0%	0		1	2							8.6%	7.1%	4.9%	2.7%	Yes	1.2%	7.0	12.8%	
Complex Medicine Unit B	9.3	-2.0	1.4	98.9%	1		5	6							-1.5%	5.4%	5.2%	3.9%	Yes	-1.0%	5.1	13.3%	
Complex Medicine Unit C	8.8	0.0	1.9	98.9%	1		2	3							9.9%	13.4%	2.7%	0.0%	Yes	-0.7%	6.6	12.8%	94.7%
Complex Medicine Unit D	8.6	-2.0	0.6	94.4%	1		3	3							11.0%	14.1%	5.2%	0.0%	Yes	4.6%	8.1	12.4%	
CTCCU	22.3	0.4	-		3		2	0							8.4%	8.0%	4.2%	8.2%	Yes	-0.1%	9.3	12.1%	
Emergency Assessment Unit (EAU)		-	-	63.3%	1		1	7							20.4%	6.7%	3.7%	6.3%	Yes	-2.8%	8.4	11.2%	
HH EAU		-	-	71.1%	1		0	15							2.3%	6.9%	5.6%	7.8%	Yes	0.5%	6.3	13.5%	
HH Emergency Department		-	-		2		0	5							11.6%	11.3%	3.9%	6.6%	Yes	-1.9%	6.3	15.0%	79.5%
JR Emergency Department		-	-		8		0	6							15.0%	9.3%	5.6%	5.5%	No	5.1%	8.1	14.7%	71.6%
HH CCU	12.4	-9.2	-	94.6%	2		0	2							17.7%	11.1%	3.9%	3.0%	Yes	2.4%	4.3	14.1%	
John Warin Ward	9.7	0.8	0.6	100.0%	0		0	0							3.1%	5.6%	3.9%	0.0%	Yes	-1.9%	5.6	12.3%	100.0%
Juniper Ward	7.7	-0.3	1.6	100.0%	2		3	5							10.2%	5.7%	7.1%	1.9%	Yes	1.4%	9.9	16.4%	47.4%
Laburnum	7.7	-1.1	0.7	100.0%	0		3	2							17.4%	3.3%	5.1%	10.4%	Yes	-2.0%	6.4	13.1%	58.3%
OCE Rehabilitation Nursing (NOC)	10.3	-0.4	1.3	98.9%	3		3	0							9.0%	8.6%	6.5%	6.0%	Yes	-1.5%	6.9	11.0%	62.5%
Osler Respiratory Unit	12.9	-1.6	2.8	100.0%	2		8	2							14.1%	8.6%	3.8%	0.0%	Yes	0.3%	5.9	14.9%	53.8%
Ward 5E/F	10.5	-0.6	0.3	87.8%	2		1	4							20.2%	9.9%	4.9%	5.9%	Yes	0.4%	8.0	12.3%	53.8%
Ward 7E Stroke Unit	9.6	-1.3	0.2	100.0%	2		1	0							-9.3%	14.7%	4.7%	10.5%	Yes	1.1%	7.4	13.7%	100.0%

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

Oxford University Hospitals NHS Foundation Trust

November 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 reported falls	Delay in induction (PROM or booked IOL)	Medication errors (administration, delay or omission)	Pressure Ulcers	Women readmitted postnatally within 28 days of delivery	Proportion of mothers who initiated breastfeeding	Births where the intended place of birth was changed due to staffing	Revised Vacancy HR Vacs plus LT Sick & Mat Leave (%)	Turnover (%)	Sickness (%)	Maternity (%)	Roster manager approved for Payroll	Net Hours 2/-2%	8 week lead time	Annual Leave 12-16%	% Extremely likely or likely
SUWON																							
Gastroenterology (7F)	7.7	0.7	0.2	100.0%	2		1	1							10.00%	6.34%	3.71%	2.90%	Yes	-2.6%	8.0	10.5%	100.0%
Gynaecology Ward - JR	8.3	3.2	2.3	97.8%	1		0	1							27.48%	9.51%	5.80%	0.00%	Yes	3.8%	9.4	11.7%	98.0%
Haematology Ward	7.5	0.6	-0.1	100.0%	7		1	3							4.82%	10.90%	6.00%	9.06%	Yes	14.8%	7.9	7.0%	91.7%
Katharine House Ward	9.9	0.7	2.3	100.0%	0		3	4							6.16%	15.35%	6.23%	2.84%	Yes	1.2%	8.0	13.9%	
Oncology Ward	7.9	-0.8	-0.9	98.9%	6		5	2							22.80%	13.02%	5.27%	8.13%	Yes	8.3%	7.1	13.4%	50.0%
Renal Ward	8.8	-0.4	-1.2	98.9%	0		1	1							4.30%	6.98%	3.18%	0.00%	Yes	0.0%	8.0	14.1%	100.0%
SEU D Side	8.3	-0.4	0.0	100.0%	0		0	4							42.68%	7.57%	5.93%	6.22%	Yes	-0.8%	8.3	13.9%	93.1%
SEU E Side	8.3	-0.0	-0.0	100.0%	2		2	0							-2.29%	6.70%	3.87%	2.88%	Yes	0.0%	8.3	11.7%	97.3%
SEU F Side	7.4	-1.3	-0.9	100.0%	1		1	2							21.75%	21.61%	3.99%	2.51%	Yes	2.7%	8.3	9.8%	90.0%
Sobell House - Inpatients	8.1	-0.6	-0.1	96.7%	0		1	4							35.16%	18.06%	3.47%	8.36%	Yes	-1.8%	8.4	11.3%	
Transplant Ward	7.5	-1.9	-1.2	98.9%	2		1	4							29.85%	9.82%	5.41%	5.18%	Yes	2.1%	8.7	18.5%	96.2%
Upper GI Ward	7.9	-1.8	-0.2	98.9%	4		1	0							16.93%	0.00%	4.59%	7.80%	Yes	-3.5%	8.4	13.7%	100.0%
Urology Inpatients	8.8	0.1	-1.3	100.0%	1		0	2							25.45%	7.27%	1.81%	1.43%	Yes	0.0%	8.9	15.6%	100.0%
Wytham Ward	6.8	-0.8	-0.2	100.0%	2		0	0							22.35%	8.95%	5.28%	0.00%	Yes	-0.4%	8.3	16.9%	82.8%
MW The Spires	28.4	0.9	-		0		0	0	116	9	0	8	84.0%	0	-8.40%	12.90%	3.71%	4.49%	Yes	-2.1%	8.0	9.5%	
MW Delivery Suite	15.8	0.6	-		0		0	0											No	-2.9%	7.3	9.6%	
MW Level 5	5.1	-1.6	-		1		0	0											Yes	-2.8%	8.0	15.2%	
MW Level 6	7.8	3.4	-		2		0	0											Yes	-2.5%	8.0	12.6%	
CSS																							
JR ICU	20.4	-14.1	-		5		6	0							28.2%	9.9%	4.9%	6.6%	Yes	0.7%	6.6	13.7%	

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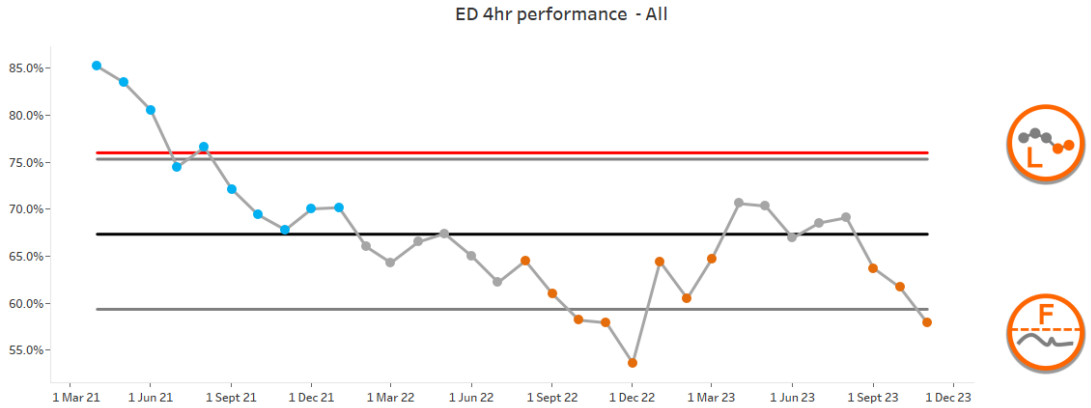
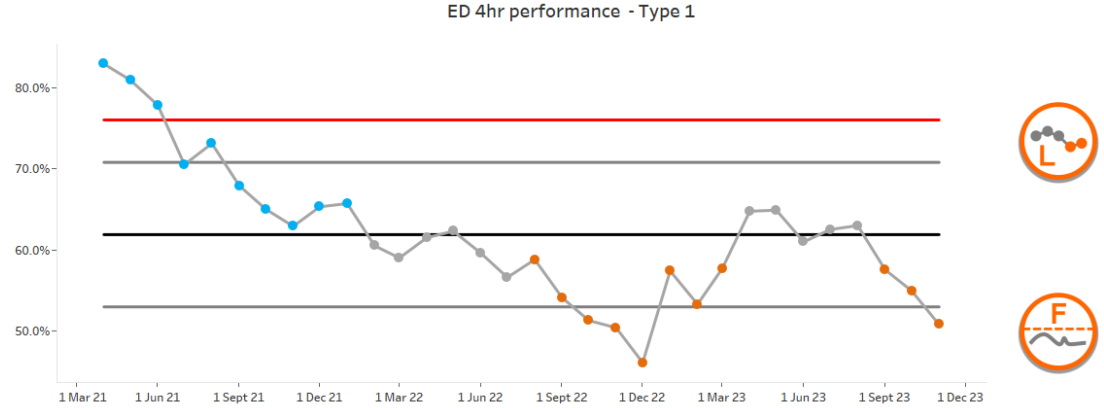
3. Assurance report: Operational Performance

Oxford University Hospitals NHS Foundation Trust



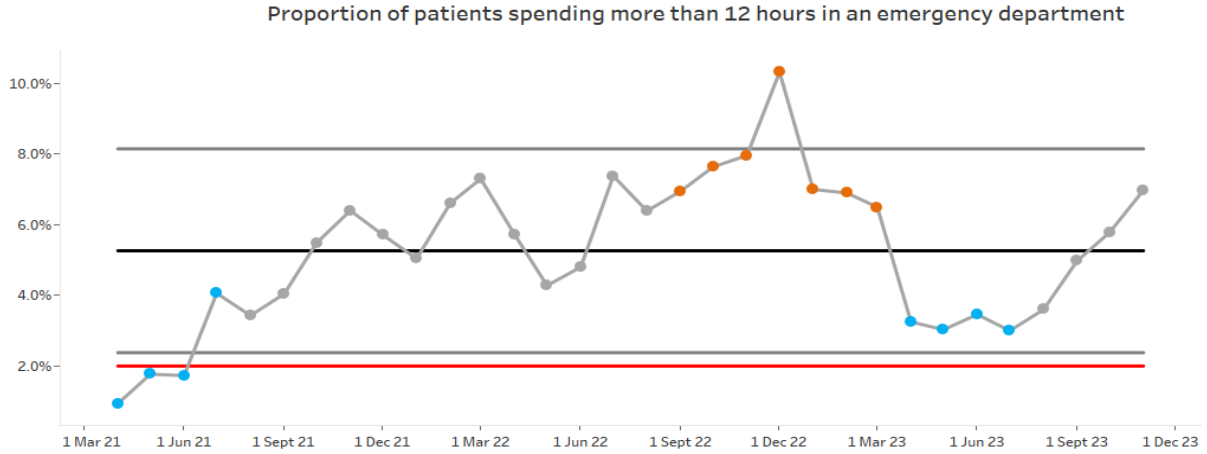


Benchmarking: ED (All types): November 23				
OUH: 57.9%	**National: 68.6%**	**Shelford: 66.8%**	BHT: 69.2%	RBH: 66.8%

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

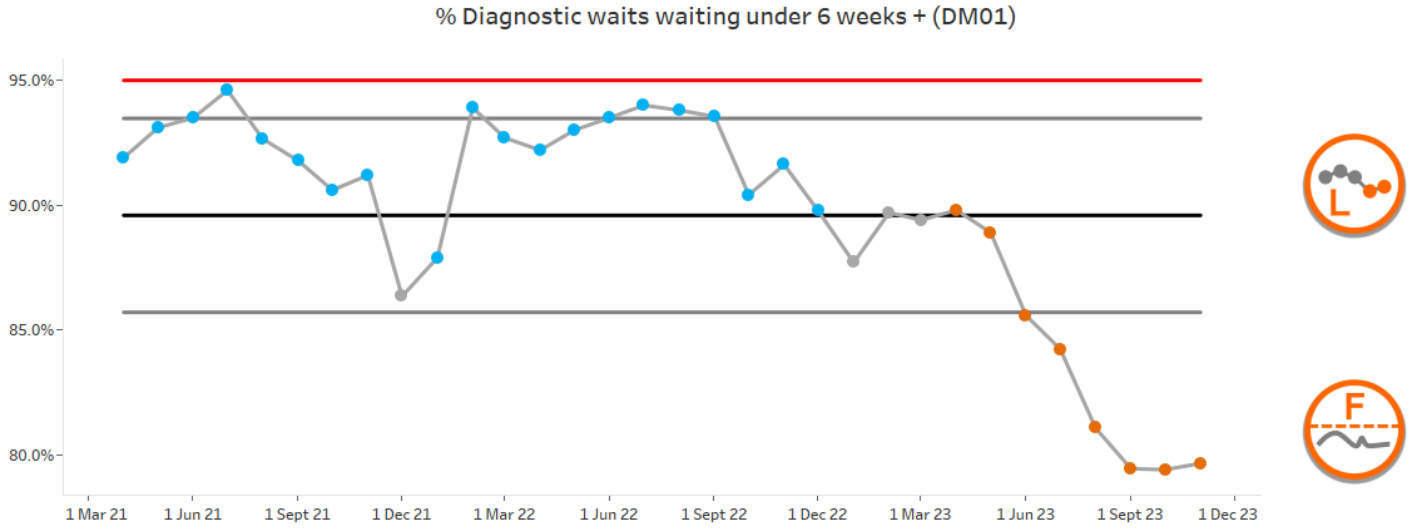
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
ED 4-hour performance (All types) was 57.90% in November and for Type 1 activity, performance was 50.80%. For 4 hour performance (all types) and Type-1 performance exhibited common cause variation. The indicators have consistently not achieved the target. Breach performance by site was 57.60% for all types and 47.60% for Type 1 at the JR and 58.84% for all types and 58.83% for type 1 at the Horton Hospital in November. This significant deterioration in performance is in part attributed to a continuation in high attendances. November saw the highest number of attendances for the year to date, with a very challenged half term week and on OPEL 4 for a period at the beginning of the month. The increase in attendances was seen at the John Radcliffe and mainly in paediatric attendances, with the Horton Hospital on a par with previous months. Wait to be seen continues to be the most significant breach reason on both sites for admitted and non-admitted patients attributing to 66% of all 4-hour breaches. 77% of non-admitted patients breached 4 hours in November in comparison to 47% of admitted patients breaching 4 hours. 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. A revised trajectory for ED 4 hour performance has been submitted with a number of these areas offered as interventions to improve performance. Occupancy has remained high at 95.37% (97.7% at JR) despite the additional funded capacity open on the JR and Horton sites.	**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. Consideration being given on routes for interim solutions. • 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. • Improvement ideas generated within ED with a focus on pharmacy and transfer lounge usage in the first instance. Triage models being reviewed in line with feedback from visit to exemplar Trust. **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 7.0% in November, a deterioration from the improvements seen over the summer months. Performance remained above the target of 2% and is now also above the mean of 5.6%. The indicator has consistently not achieved the target and has exhibited common cause variation. Both sites have struggled to sustain the improvement seen in earlier in the year with 6% of patients at the Horton residing in ED for more than 12 hours and 8% at the John Radcliffe in November. The wait to be seen in ED continues to be a challenge with an increasing percentage of breaches attributed to this (66% of 4-hour breaches for November). Average length of stay in both the ED's has remained on a par with the previous month at 5 hours at Horton and 5hours 20mins at the JR. However, average length of stay has reduced for non-admitted patients by 65mins to approximately 4 ½ hours. Average length of stay for admitted patients has risen by 22 mins to almost 7 hours. Bed occupancy across all sites has remained high at 95.37% and AAU at the JR has been required to remain open. In addition, a non-inpatient area at the Horton has been converted for short spells to accommodate patients overnight due to the high number of medical patients for admission and lack of inpatient ward capacity. 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. Associated with the increase in attendances and complexity of admissions, there has been an increase in the number of patients becoming medically optimised for discharge with the Transfer of Care Hub seeing a very large number of referrals per day. Despite this, the continued work to reduce length of stay across all pathways continues to go well and for three consecutive months, OUHFT has been the best performing Shelford Trust for patients with a length of stay over 21 days.	**Departures within 60mins of the Decision to Admit** • Two pathways – Mental Health and Frailty – have been confirmed for the initial phase of the Clinical Pathways QI work. Initial meetings held in September. • Identify improvement percentages per speciality • Project teams in place • Launch of live bed state project across the Trust held in October. Phase 1 pilot wards identified. Project plan in development with implementation starting from January. • Opening of additional space to support admission avoidance on the JR site from early January 2024 • Capacity plan developed to support peaks of admissions for January	Quarter 1: On track Quarter 2: On track Quarter 3: On track Trust Wide Urgent Care Group	BAF 4 Link to 1133 (Red)	Sufficient

3. Assurance report: Operational Performance, *continued*



Benchmarking: October 23 DM01	
OUH	77.8%
National	79.7%
Shelford	78.0%
ICS	BHT: 59.0% RBH: 74.3%

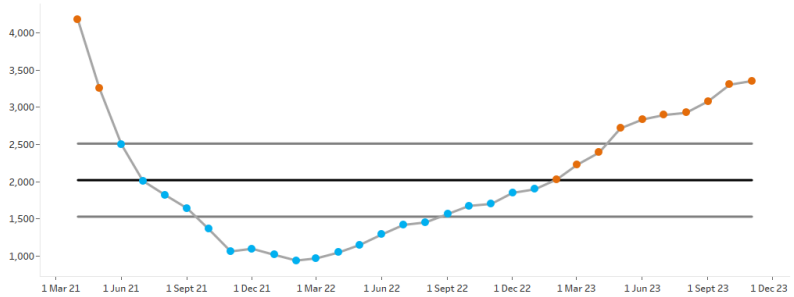
ICS key	
BHT	Buckinghamshire Healthcare NHS Trust
RBH	Royal Berkshire NHS Foundation Trust

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The % of Diagnostic waits waiting under 6 weeks+ (DM01) was 79.4% in November. The indicator exhibited special cause deteriorating variation due to performance being below the mean of 89.9% 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 due to ENT pathway change. **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. **Non-US**: increase in referrals have resulted in a capacity demand mismatch	**Audiology:** Options appraisal completed with a recommendation to transfer a cohort of clinically appropriate patients to Another Qualified Provider (AQP). Engagement with private provider to assess what support is available delayed agreement between ICB's. Notice period of 6 months is being discussed with BOB ICB. **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. Technicians to be fully trained to conduct EMGs. Business case to convert insourced capacity to recurrent capacity written and presented at Business Planning Group (BPG), feedback received and revised version resubmitted in November. **Non-US**: The Trust is working with Health share to provide additional imaging capacity; this is now starting to show a decrease in DM01 breaches. In addition, agency staff and alternative US support is being sought to provide increased resilience.	Weekly Assurance meeting will monitor all actions on a bi-weekly basis **Audiology:** improvement expected once transfer to AQP agreed via ICS – January 2024 **Clinical Neurophysiology:** Improvement from July 2023 Outcome from BPG – January 2024 **Non-US**: March 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*

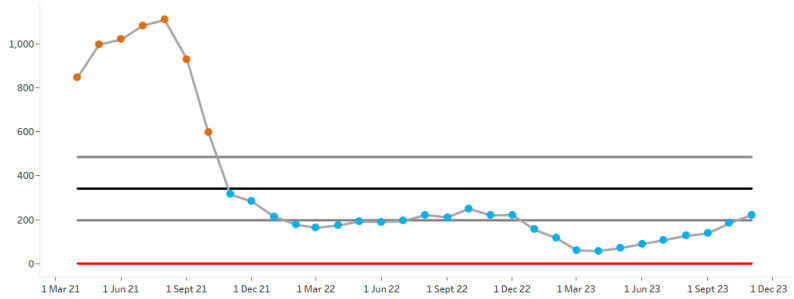
3. Assurance report: Operational Performance, *continued*

Oxford University Hospitals NHS Foundation Trust

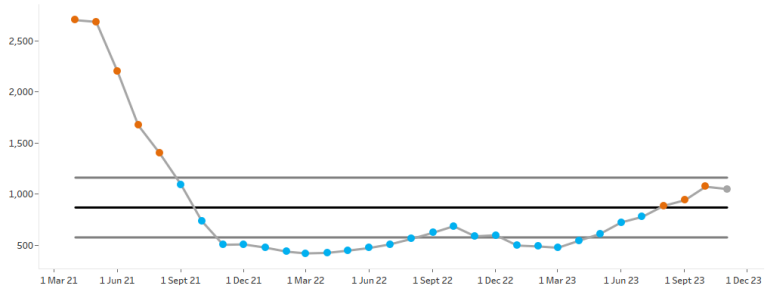
Total patients waiting more than 52 weeks to start consultant-led treatment



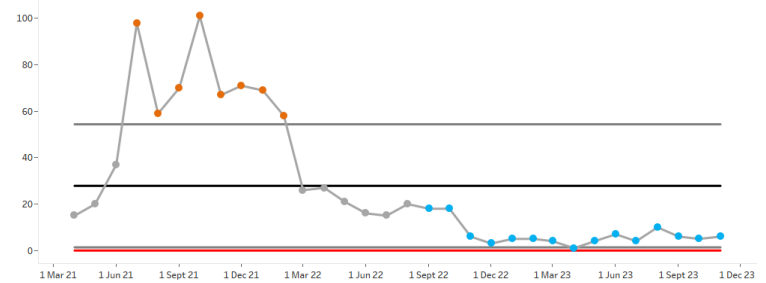
Total patients waiting more than 78 weeks to start consultant-led treatment



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



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

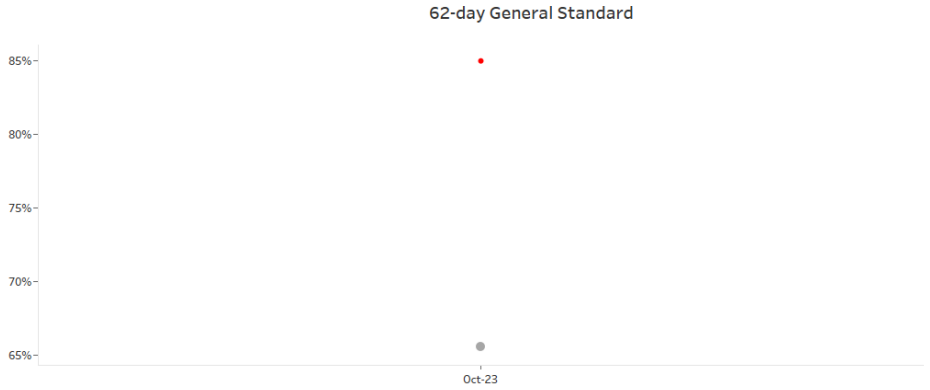


Benchmarking >52-weeks: October 23	
OUH	3,301
National	1,871 (avg.)
Shelford	3,598 (avg.)
ICS	BHT: 3,213 RBH: 13

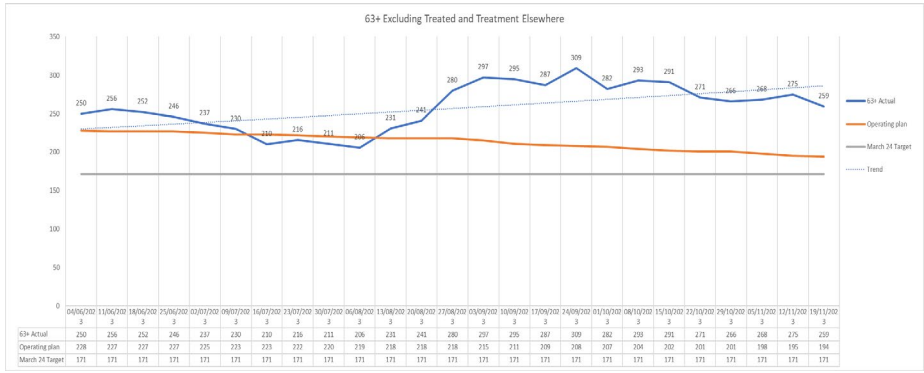
ICS key	
BHT	Buckinghamshire Healthcare NHS Trust
RBH	Royal Berkshire NHS Foundation Trust

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 3,353 in November. Performance exhibited special cause variation due to >six consecutive periods of deteriorating performance above the mean and exceeding the upper process control limit. **104 weeks** - 6 patients breached >104 weeks. Five Orthopaedic patients (two due to patient choice, one complex case and three due to insufficient capacity) and a Paediatric Plastic Surgery patient (due to capacity). **78 weeks** - specialties that are experiencing challenges mainly include Orthopaedics, Urology and Plastic services due to a capacity deficit against demand levels, Adult and Paediatric Spinal due to complexity. Orthopaedics hold the highest proportion and is due to the impact of Industrial Actions and the lack of 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**.	• **Orthopaedic services** have procured additional support from an Independent Sector Provider with the intention to recover the long wait cohort by the end of the year • **Spinal services** contracts to Independent Sector Providers at The Portland and Royal National Orthopaedic Hospital are in place. • **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 • **65-week planning** further evaluation has taken place of all services to manage the longest waiting patients based on no further Industrial Action, in conjunction with emergency and cancer requirements.	Delivery of 65-week plan 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*



62-day General Standard is a new indicator therefore no time series is available as this is the first month reported.

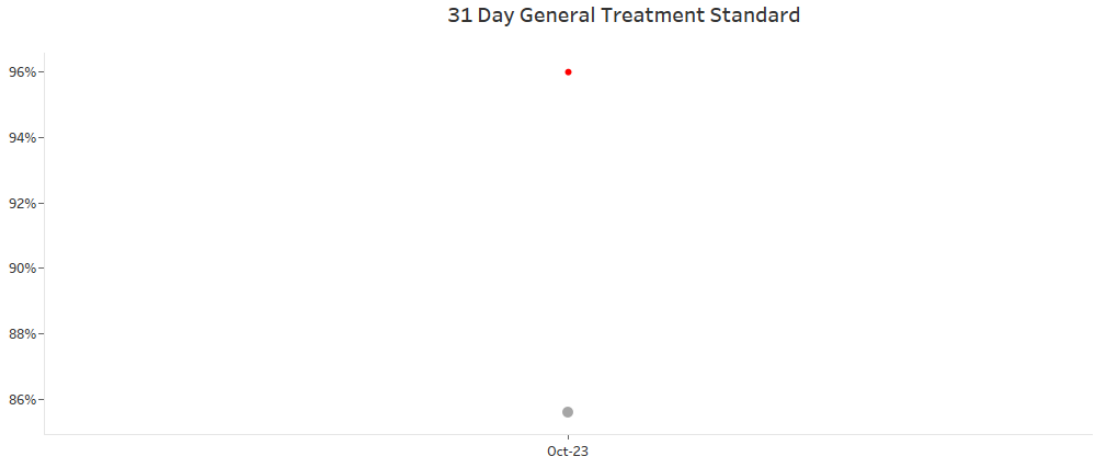


Benchmarking: October 23 62-day General Standard	
OUH	
National	Not yet available
Shelford	Not yet available
ICS	BHT: N/A RBH: N/A

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

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Reporting of Cancer Standards have changed from October 2023 in line with the National Cancer Waiting Times guidance. Cancer performance against the 62 days combined standard was 65.6% in October, and below the performance target of 85%. Performance is reported one month in arrears due to the extended reporting period for this indicator. The number of patients waiting over 62 days has reduced from its peak in September and is a high priority of focus within the Trust. All tumour sites apart from Children, Haematology-Acute Leukaemia & Myeloma, Head & Neck-Thyroid, Skin and Testicular are non-compliant for this standard in October. **Challenges identified:** • Complex tertiary level patients (8%) • Some slow pathways and processes (1%) • Capacity for some surgery, diagnostics and oncology (62%) • Late inter provider transfers (27%) • Patient reasons (2%)	**The Cancer Improvement Programme** launched in 2022/23 with a focus on 28-day Faster Diagnosis Standard (FDS). For October, **the Trust was 7th best out of 21 regional 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** still holds the highest proportion of long waiting patients but has been recovering well since developing a one-stop clinic and MRI pathway with radiology services. **Gynae** holds the second highest volume and is recovering well against plan. An enhanced triage process for earlier management plans has helped. A joint BOB Integrated Care Board Standard Operating Procedure for the management of urgent suspected cancer referrals is undergoing formal endorsement with external bodies.	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. Revised trajectory of 193 to be approved. Urology one-stop MRI clinic: adopted. Reviewing biopsy next step to further improve Prostate pathway Gynae referral management: on track	BAF 4 Link to CRR 1135 (Amber)	Sufficient

3. Assurance report: Operational Performance, *continued*



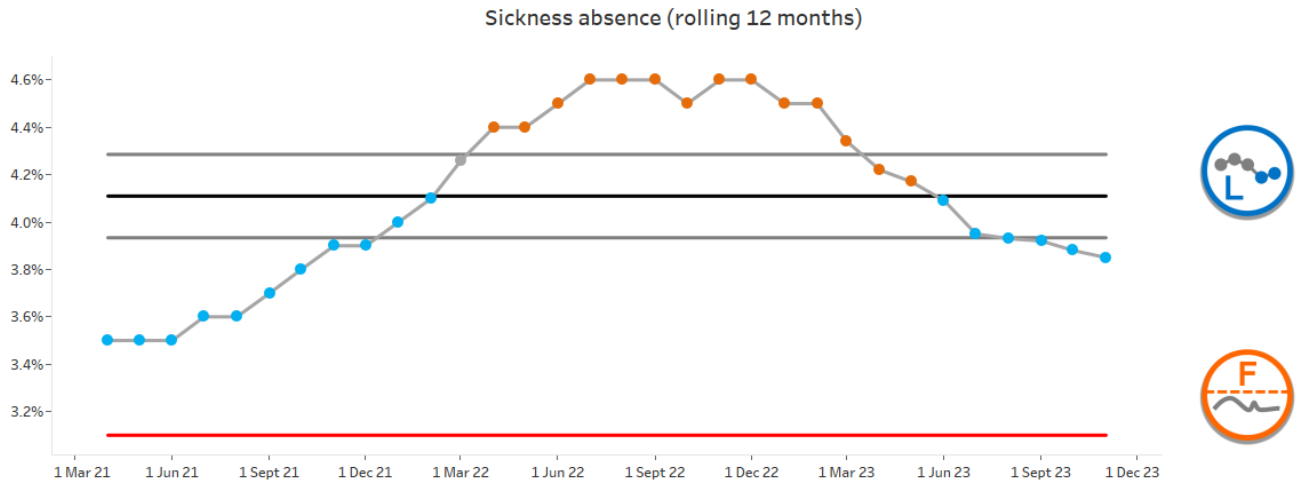
31-day General Standard is a new indicator therefore no time series is available as this is the first month reported.

Benchmarking: October 23 31-day General Standard	
OUH	
National	Not yet available
Shelford	Not yet available
ICS	BHT: N/A RBH: N/A

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

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Reporting of Cancer Standards have changed from October 2023 in line with the National Cancer Waiting Times guidance. Cancer performance against the 31-day combined standard was 85.6% in October, and below the performance target of 96%. Performance is reported one month in arrears due to the extended reporting period for this indicator. Performance in September was 83.2% therefore an improved position. Surgery is the key driver in poor performance with 85% of breaches being surgery treatments (significant impact of Industrial Action).	Transfer benign capacity to cancer where available until the end of the financial year to reduce the time waiting for surgery. Consideration given to the impact this may have to 65-week recovery. Ensure Decision To Treat (DTT) is correctly documented at point of DTT in line with national guidance; increase validation of 31-day pathways as well as campaign the importance of DTT on a cancer pathway to be accurately processed.	Q4 2023/24 Q4 2023/24	BAF 4 Link to CRR 1135 (Amber)	Sufficient

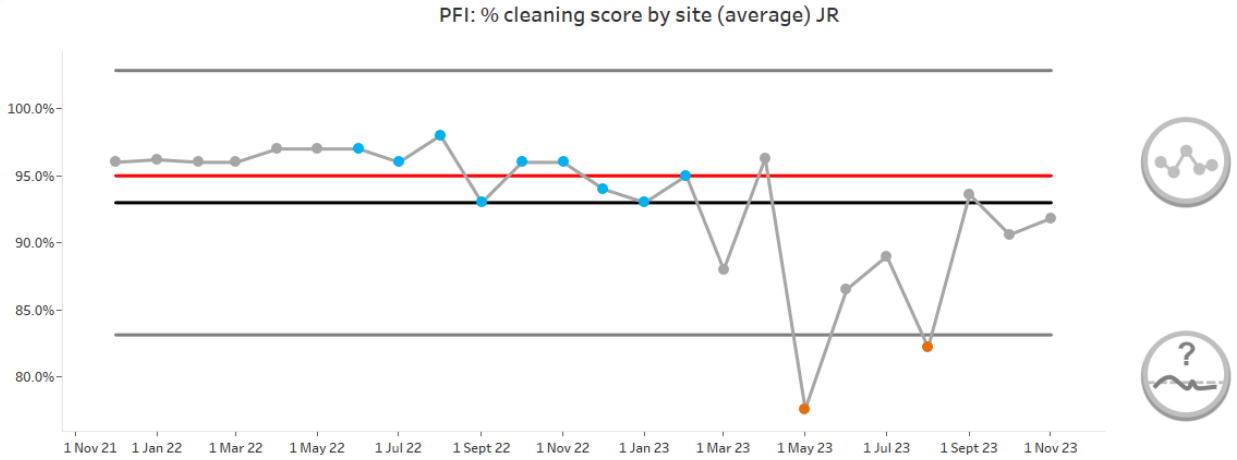
3. Assurance report: Growing Stronger Together



Benchmarking: July 23 (monthly performance)						
OUH: 3.6%	**National: 4.8%**	**Shelford: 4.0%**	Buckinghamshire Healthcare NHS Trust: 3.6%	Royal Berkshire NHS Foundation Trust: 3.1%	Oxford Health: 4.2%	South Central Ambulance Service: 6.9%

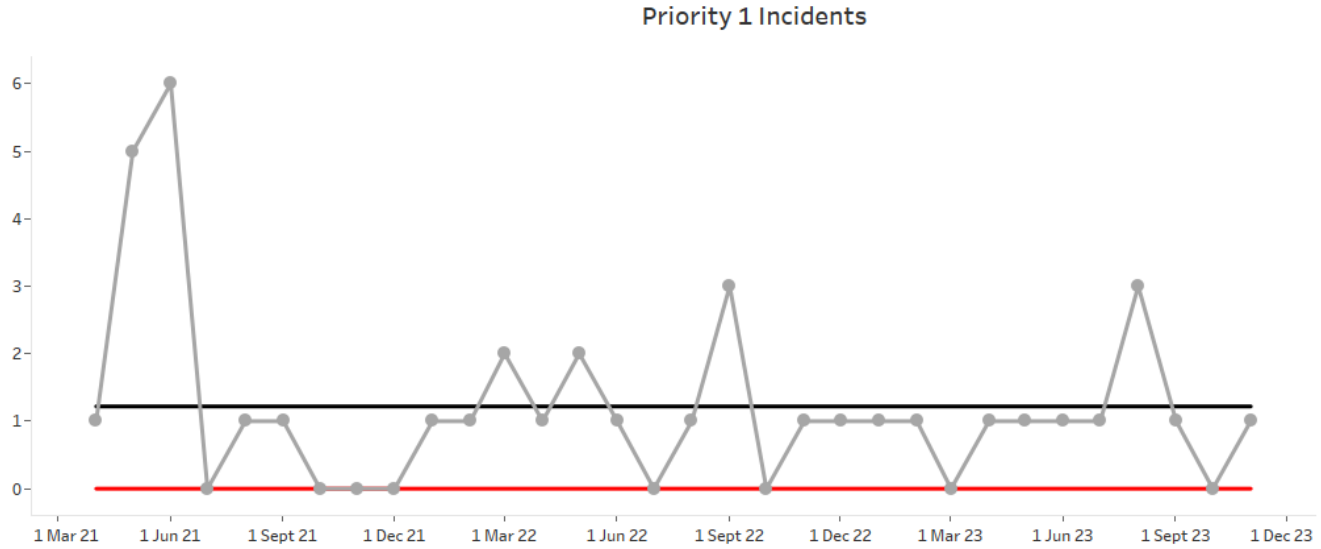
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Sickness absence performance (rolling 12 months) was 3.9% in October and has remained at 3.9% in November. Performance exhibited special cause improving variation 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 M8 has not changed compared to M7 sickness absence. Cough/Colds/Flu have noticeably increased in October/November 23 compared to September 23 in working days lost. Of open absences 74% are long term and 26% are short term at the end of November 23.	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: Estates, Facilities and PFI



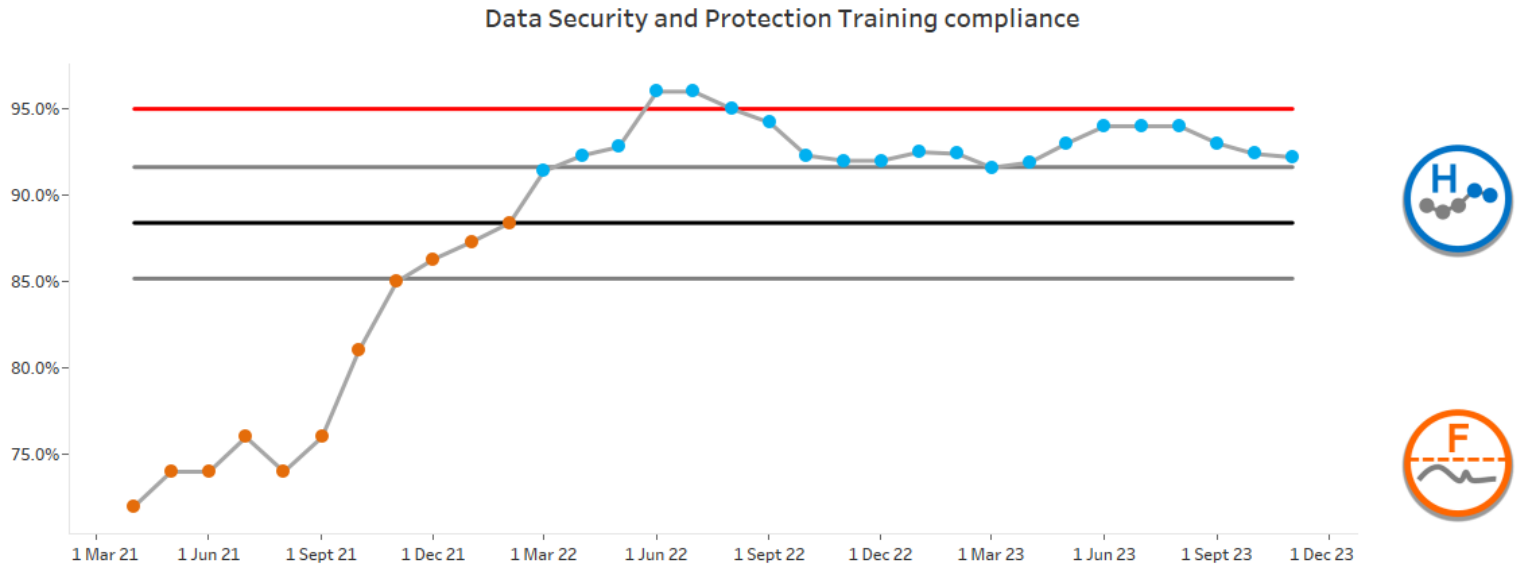
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
In November 2023, the combined PFI % cleaning score by site (average) for the JR was 96.28%. However, the above graph demonstrates the percentage of total audits undertaken that achieved 4 or 5 stars, which has slightly increased by 1.24% to 91.83%. In total, 208 audits were conducted, but 17 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, the Service Providers create 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 team works in partnership with the Domestic Service Teams, Clinical teams, and IP&C to improve the cleanliness of our facilities. We will continue to focus on improving our cleaning standards throughout December and into 2024, with a commitment to providing a sustainable service. At present, we do not require additional support as our current actions are achievable. The PFI team is discussing with the CEFO to redefine the KPIs for cleaning scores to align them more closely to the NSC. The objective is to determine the appropriate measures and provide a better understanding of what is being measured, by whom, and how.	1) Improvement to work towards the 95% target for 4 & 5-star cleaning audits for 2024 at OJR. 2) 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. 3) Actions reviewed weekly at the service providers/Trust PFI domestic services meeting, Monthly reporting to HIPCC 4) Review current KPI metrics and align with NSC with redefined metrics clearly set out for ongoing IPR Reports	BAF 4 CRR 1123	Sufficient

3. Assurance report: Corporate support services – Digital



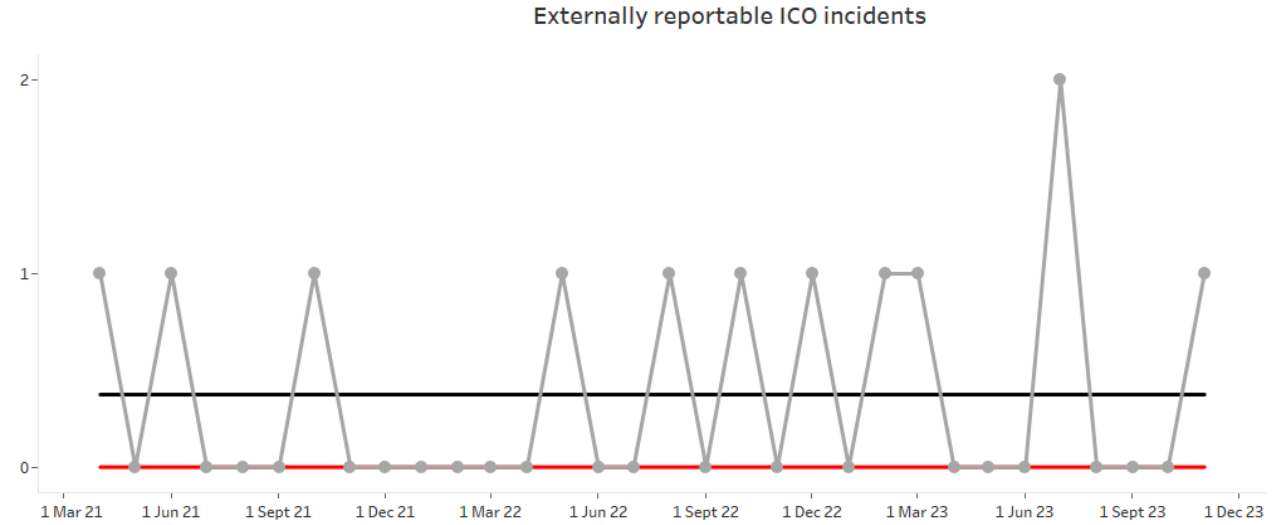
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
There was one Priority 1 incident in November 2023 against a target of zero. On 22/11/23 at 11:55 the OUH wireless network became unavailable, this was caused as a result of a software crash on the wireless controllers . This resulted in them both restarting (causing the outage), following a reboot of the wireless controllers full service was restored at 12:30pm.	The issue was escalated to the 3rd party supplier who advised the issue would occur whenever a failover event is triggered, to prevent this from reoccurring their advice was to upgrade the wireless controllers, the upgrade was carried out on the 11th December 2023.	Digital Oversight Group	BAF 4 Link to CRR 1116 (Amber), 1113 (Amber)	Sufficient

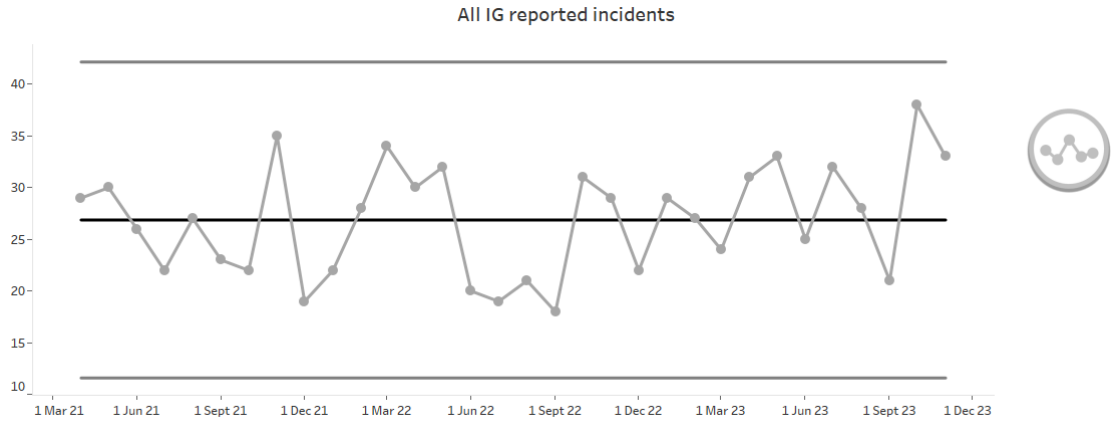
3. Assurance report: Corporate support services – Digital, *continued*



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 92.2% in November, below the target of 95%. Performance exhibited improving special cause variation due to successive periods of performance improvement (>6 months) above the mean of 88.4% as well as exceeding the upper control limit of 91.6% 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*

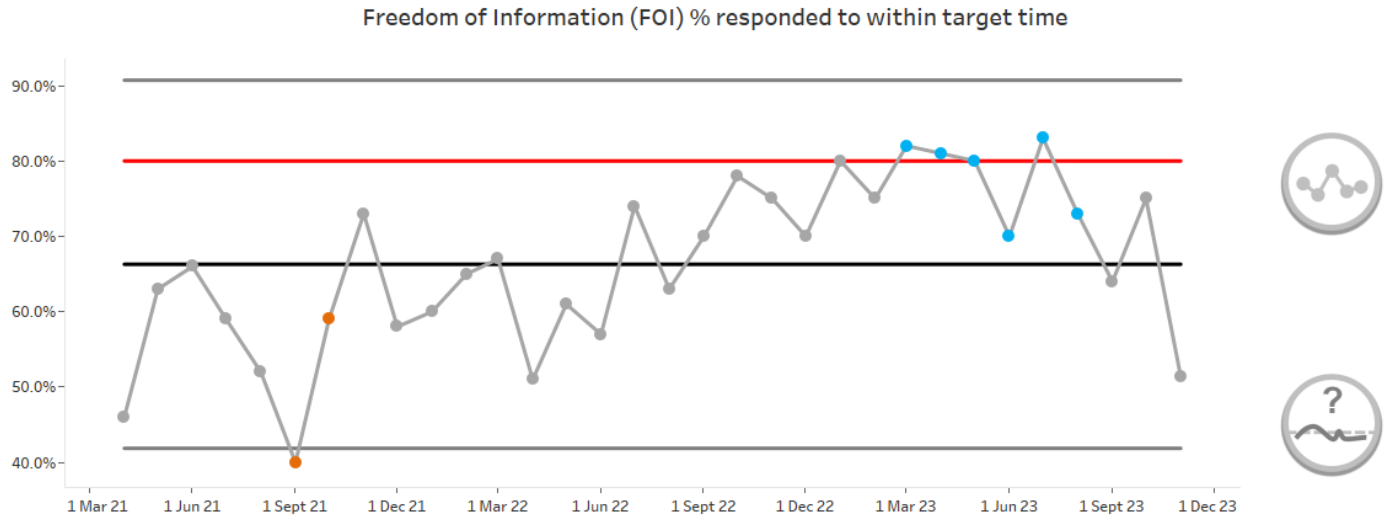
3. Assurance report: Corporate support services – Digital





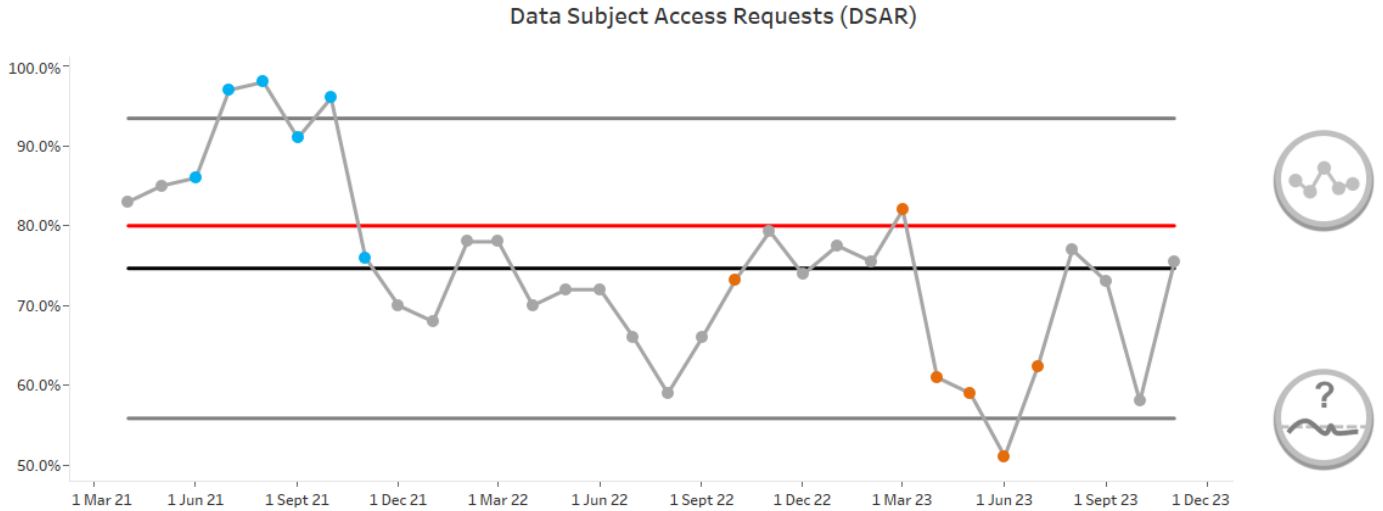
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
On 29/10/2023 an NHS.net account assigned to an OUH employee was compromised and used to send out spam emails. The system locked the account automatically upon detection of his behaviour, but the activity was not discovered until the user tried to access their account on 01/11/2023 and found it locked. This account's regular purpose was used to report details of patients whose pregnancies had been scored as being at high risk of trisomy defects to Public Health England. emails containing excel documents with details of approximately 1000 patients were in the "sent mail" box of this account. It would have been possible for the person who gained access to the account to have viewed or exported this PID.	NHS England's Cyber Security Operations Centre were informed and worked with OUH and NHSMail to investigate the unauthorised access. No evidence of data exfiltration was discovered. The member of staff who the account belonged to was interviewed and demonstrated good knowledge of IG and Cyber Security principles. Under NHSMail policy, MFA was not enabled for this account but since the incident it has been switched on. The user has also changed all of their other NHS system passwords.	Work to enforce MFA of all OUH NHSmail accounts has started	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 51.4% in November, below the target of 80.0%. The indicator exhibited common cause variation. The number of cases received in M8 was well above average, as was the number received in M7. As the large number of cases from M6 and M7 still need to be cleared the overall effect been a continuation of the reduced performance. Requests continue to increase in complexity, often straddling several departments/directorates and requiring significantly more co-ordination that a single topic request. Particular pressure falls on the Information Team who are relied upon to generate data sets for a significant percentage of requests.	Transition to the much delayed updated FOI software platform has now started – this will enable automated "follow up" of requests that have been sent out and not responded to yet. Currently this is a manual task. It has not been possible to transfer our older/current cases to the new system so they will have to operate in parallel for a period of time until all the cases in the old system have been closed. IG team now meet monthly with the Information Team to discuss cases and workload.	Transition to new software complete by 31/01/2024 Report on progress continue 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*

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



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Data Subject Access Request compliance was 75.4% in November, below the target of 80%. Performance exhibited common cause variation. Performance across the PACS and Medical Records teams who handle the bulk of SARs for the Trust continues to improve.	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.	1) New software package rollout has started – completion targeted for 31/01/2024 as per FOI tool 2) Previously targeted for end of October 2023 but was not complete in time for DOC on 20/11/2023 so will be presented at the January 2024 DOC. 3) December 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 M8 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