Oxford University Hospitals
NHS Foundation Trust

Integrated Performance Report

M10 (January data)

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1. Executive summary

Overview	In month 10, we achieved our target in measures that support patient safety and experience of care, including MRSA, , E.Coli and VTE assessments. Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) rates demonstrate fewer patient deaths than expected and care was supported by increases our Care Hours Per Patient Day overall, and the Midwife-to-birth ratio, both exhibiting improving Special Cause Variation (SCV). Our staff supported patient care by meeting targets for the vacancy rate, turnover and non-clinical appraisals, the latter two of which continued to exhibit 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. Supporting this indicator, the level of diagnostic activity compared to 2019/20 remains significantly above the baseline and exhibited improving SCV. Successes within the Divisional Performance Review meetings continue to be recognised, and this incorporates contributions of our staff in improving the care and experience for our patients, to our workforce and to our population. Successes are documented in the summary of the Performance Review meetings and reported to the Integrated Assurance Committee. Out of the 107 indicators currently measured in the IPR, 39 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 SCV. 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. Our assurance reporting also references updates with respect to the Tiering requirements for Elective, Cancer and Urgent and Emergency Care.
Quality, Safety and Patient experience	We recorded hospital infections worse than our monthly threshold for Clostridium difficile, Klebsiella cases and Pseudomonas, and the target was not met for our complaints response times, noting improving SCV for compliance, but deteriorating SCV and below target performance for 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 exhibit increasing SCV in response to high demand. Incidents with moderate harm per 10,000 beddays and Health and Safety incidents relating to Violence and Aggression exhibited deteriorating SCV. 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 Churchill Hospital sites, and FFT percentage positive responses for ED and Outpatients. As supporting indicators to Non-Thematic Patient Safety Incidents, two new indicators include; Learning MDT Reviews (LMDTR) and After Action Reviews (AARs).
Growing Stronger Together	Rolling 12-month sickness absence rates exhibited improving SCV but remain above the target, along with the monthly sickness absence rate (which exhibited common cause variation). All other targets measured within the domain of Growing Stronger Together are meeting targets and recorded 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 January and exhibited deteriorating SCV. The number of patients spending over 12 hours in the department was below target. The number of patients waiting in the categories over 52 weeks decreased, but continued to exhibit deteriorating SCV. We reduced the number of patients waiting over 65 (common cause variation), 78 and 104 weeks. We did not meet the diagnostic (DM01) standard though are recording high volumes of activity relative to 2019/20 (improving SCV). Assurance reports are also included for the 62-days and 31-day Cancer Standards. 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	Income and Expenditure (I&E) performance in January was a £1.1m deficit. The average underlying deficit after ten months is £5.1m per month. However, the average underlying deficit has deteriorated since the start of Q3, and over the last four months has averaged £6.7m per month. The Trust Board has approved an I&E forecast outturn position of £15.3m deficit, £12.5m worse than the £2.8m full year plan. Cash was £19.8m at the end of January, £8.0m lower than the previous month.
Digital	We have also included assurance templates on the two Priority one incidents, DSPT / information governance training compliance, Data Subject Access response (DSAR) times and one externally reportable ICO incident.
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	• C-diff cases: HOHA+COHA • Klebsiella cases • PSAR cases • Pressure Ulceration incidents per 10,000 bed days (Hospital acquired Cat 3 & 4) • FFT Outpatient % positive • FFT ED % 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) *Not achieving target*	• Reactivated complaints *Not achieving target* • Incidents with moderate harm or above per 10,000 beddays. • Assault, Aggression and Harassment. • Incident rate of Violence and Aggression per 10,000 beddays. • MSSA cases *No target*	• Children's safeguarding activity • Adult safeguarding activity *No target* No SPC • Non-Thematic Patient Safety Incident Investigations • Learning MDT Reviews (LMDTR) • After Action Reviews (AARs) *Not achieving threshold*
Growing Stronger Together	• Sickness absence (monthly) *Not achieving target*	• Sickness absence (rolling 12-month) *Not achieving target*		
Operational performance	• Proportion of patients spending more than 12 hours in the Emergency Department • Patients waiting more than 65 weeks *Not achieving target*	• Patients waiting more than 78 weeks • Patients waiting more than 104 weeks *Not achieving target*	• ED 4-hour performance (all types) • ED 4-hour performance (type-1) • % Diagnostic waits under 6 weeks (DM01) *Not achieving target* • Patients waiting more than 52 weeks *Not achieving target*	No SPC • 62- day General Standard • 31-day General Standard *Not achieving threshold*
Corporate Support Services	• PFI cleaning score (JR and CH) • Freedom of Information % responded to within target time • Data Subject Access Requests • External IG incidents *Not achieving target*	• Data Security and Protection Training compliance *Not achieving target*		No SPC • P1 Incidents *Not achieving target*

2. b) SPC indicator overview summary

Oxford University Hospitals NHS Foundation Trust

Quality, Safety and Patient Experience Summary

Latest Indicator Period: Jan-2024

Indicator Description	Period	Performance	Target / Threshold	Met?	Mean	LCL	UCL
MRSA bacteraemia infection rate COHA and HOHA (per 10,000 beddays)	Jan-24	0.0	-	-	0.2	-0.5	0.9
MRSA cases: HOHA+COHA	Jan-24	0	0		0	-1	2
Clostridium difficile infection rate COHA and HOHA (per 10,000 beddays)	Jan-24	3.2	-	-	3.5	-0.1	7.0
C-diff cases: HOHA+COHA	Jan-24	11	9	No	10	0	20
E. coli infection rate COHA and HOHA (per 10,000 beddays)	Jan-24	2.9	-	-	5.3	0.9	9.6
E. Coli cases: HOHA+COHA	Jan-24	10	13		15	2	28
MSSA cases: HOHA+COHA	Jan-24	11	-	-	5	0	10
Klebsiella cases: HOHA+COHA	Jan-24	10	7	No	8	1	15
PSAR cases: HOHA+COHA	Jan-24	7	4	No	5	-4	13
Number of Never Events	Jan-24	0	0		0	-	-
Non-Thematic Patient Safety Incident Investigations	Jan-24	1	0	No	1	-	-
Learning MDT Reviews (LMDTR)	Jan-24	6	-	-	6	-	-
After Action Reviews (AAR)	Jan-24	4	-	-	14	-	-
VTE Risk Assessment (% admitted patients receiving risk assessment)	Dec-23	97.8%	95.0%		98.1%	97.7%	98.5%
CAS alerts breaching deadlines at end of month and/or closed during month beyond deadline	Jan-24	0	0		0	-	-
Medication incidents causing moderate harm, major harm or death	Jan-24	1	-	-	2	-2	6
Mortality HSMR	Jan-24	89.9	100.0		92.6	-	-
Mortality SHMI	Jan-24	92.0	100.0		93.2	-	-
Neonatal deaths per 1,000 total live births	Dec-23	1.6	3.2		3.5	-	-
Stillbirths per 1,000 total births	Dec-23	0.5	4.0		3.4	-	-
National Patient Safety Alerts not completed by deadline	Jan-24	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	Jan-24	1380	-	-	1344	1312	1376
Number of active clinical research studies (commercial)	Jan-24	376	-	-	349	335	362
Number of active clinical research studies (non commercial)	Jan-24	1004	-	-	996	976	1015
Number of incidents with moderate harm or above per 10,000 beddays	Jan-24	41.9	-	-	37.4	22.4	52.3
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 2)	Jan-24	26.6	26.0	No	27.6	14.5	40.7
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 3 and 4)	Jan-24	3.2	3.0	No	2.8	0.0	5.7
Pressure Ulceration incidents per 10,000 beddays (Present on admission Cat 1+)	Jan-24	94.6	114.0		115.3	88.4	142.3
Harm from Falls (Moderate and above)	Jan-24	1	-	-	4	-3	11
Harm from Falls per 10,000 beddays (moderate and above)	Jan-24	0.3	-	-	1.6	-0.9	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: Jan-2024

Indicator Description	Period	Performance	Target / Threshold	Met?	Mean	LCL	UCL
Number of complaints	Jan-24	105	-	-	99	52	145
Number of complaints per 10,000 beddays	Jan-24	31.0	-	-	34.6	19.3	50.0
% of complaints responded to within agreed timescales	Jan-24	76.1%	95.0%	No	70.8%	51.1%	90.5%
Reactivated complaints	Jan-24	16	1	No	9	0	18
Number of RIDDORs	Jan-24	4	5		3	-1	8
Health and Safety related incidents - Assault, Aggression and harassment	Jan-24	155	-	-	131	57	205
Incident rate of violence and aggression (rate per 10,000 beddays)	Jan-24	45.8	-	-	45.6	20.5	70.7
FFT inpatient % positive	Dec-23	95.5%	95.0%		95.1%	93.4%	96.8%
FFT outpatient % positive	Dec-23	94.0%	95.0%	No	93.8%	92.4%	95.1%
FFT ED % positive	Dec-23	80.0%	85.0%	No	78.2%	69.5%	86.9%
FFT maternity % positive	Dec-23	94.3%	90.0%		87.7%	65.5%	109.8%
Inpatient FFT (response rate)	Dec-23	23.6%	-	-	25.7%	22.4%	29.0%
Outpatient FFT (response rate)	Dec-23	8.7%	-	-	11.4%	5.1%	17.7%
A&E FFT (response rate)	Dec-23	22.9%	-	-	24.9%	21.7%	28.0%
Maternity FFT (response rate)	Dec-23	14.4%	-	-	8.8%	3.4%	14.3%
Adult safeguarding activity	Jan-24	918	-	-	698	507	889
Children's safeguarding activity	Jan-24	876	-	-	496	269	723
Number of safeguarding consultations initiated by provider (both to internal and external organisations)	Jan-24	1794	-	-	1195	864	1527
Safeguarding (Children) training compliance L1 - L3	Jan-24	81.0%	90.0%	No	83.7%	77.7%	89.6%
Safeguarding (Adults) training compliance L1 - L3	Jan-24	89.0%	90.0%	No	7.8%	0.1%	15.4%
Trust level: CHPPD vs budget	Jan-24	-22.5	-	-	-38.8	-90.3	12.7
Trust level: CHPPD vs required	Jan-24	3.4	-	-	-14.4	-36.9	8.2
Mothers birthed	Jan-24	569	625	-	626	554	698
Babies born	Jan-24	576	-	-	637	564	709
Scheduled Bookings	Jan-24	612	750	-	707	571	843
Inductions of labour from iView	Jan-24	139	-	-	146	105	188
Midwife:birth ratio (1 to X)	Dec-23	21.4	28.0		27.1	23.3	30.9
PFI: % cleaning score by site (average) JR	Jan-24	90.4%	95.0%	No	92.9%	83.2%	102.7%
PFI: % cleaning score by site (average) CH	Jan-24	90.6%	95.0%	No	93.7%	82.4%	105.1%
PFI: % cleaning score by site (average) NOC	Jan-24	100.0%	95.0%		97.9%	93.7%	102.1%

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

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Growing Stronger Together Summary

Latest Indicator Period: Jan-2024

Indicator Description	Period	Performance	Target / Threshold	Met?	Mean	LCL	UCL
Vacancy rate %	Jan-24	6.4%	7.7%		6.8%	5.7%	7.8%
Turnover rate (rolling 12 months)	Jan-24	10.4%	12.0%		11.4%	10.8%	11.9%
Sickness absence (rolling 12 months)	Jan-24	3.8%	3.1%	No	4.1%	3.9%	4.3%
Sickness absence (monthly)	Jan-24	4.5%	3.1%	No	4.2%	3.1%	5.3%
Appraisal compliance (non medical)	Jan-24	94.3%	85.0%		71.8%	50.3%	93.4%
Core skills training compliance	Jan-24	93.4%	85.0%		89.0%	86.3%	91.8%
Time to hire (average days)	Jan-24	42.9	53.0		50.5	40.7	60.3

Operational Performance Summary

Latest Indicator Period: Jan-2024

Indicator Description	Period	Performance	Target / Threshold	Met?	Mean	LCL	UCL
Proportion of ambulance arrivals delayed over 30 minutes	Dec-23	11.6%	-	-	9.3%	1.6%	17.1%
Ambulance turnaround time > 60 minutes	Dec-23	1.4%	-	-	1.4%	-0.5%	3.3%
ED 4hr performance - All	Jan-24	63.7%	76.0%	No	67.0%	59.0%	75.0%
ED 4hr performance - Type 1	Jan-24	57.1%	76.0%	No	61.5%	52.6%	70.3%
Proportion of patients spending more than 12 hours in an emergency department	Jan-24	6.0%	2.0%	No	5.3%	2.5%	8.1%
Proportion of patients discharged from hospital to their usual place of residence	Jan-24	95.0%	-	-	92.1%	90.8%	93.3%
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	Jan-24	95.8%	-	-	94.5%	91.6%	97.4%
Theatre utilisation (elective)	Jan-24	96.1%	85.0%		90.6%	86.8%	94.3%
% Diagnostic waits waiting under 6 weeks + (DM01)	Jan-24	77.8%	95.0%	No	88.9%	84.9%	92.9%
Total patients waiting more than 52 weeks to start consultant-led treatment	Dec-23	3381	-	-	2063	1585	2540
Total patients waiting more than 65 weeks to start consultant-led treatment	Dec-23	1158	-	-	876	583	1169
Total patients waiting more than 78 weeks to start consultant-led treatment	Dec-23	272	0	No	339	195	482
Total patients waiting more than 104 weeks to start consultant-led treatment	Dec-23	5	0	No	27	1	53
62-day General Standard	Dec-23	64.8%	85.0%	No	64.0%	-	-
28-day FDS General Standard	Dec-23	76.6%	75.0%		79.0%	-	-
31 Day General Treatment Standard	Dec-23	85.4%	96.0%	No	84.9%	-	-
Cancer: % patients diagnosed at stages 1 and 2	Apr-21	0.0%	-	-	0.0%	-	-
62 Day incomplete pathways >62 days	Jan-24	341	-	-	284	208	359
62 Day incomplete pathways >104 days	Jan-24	105	-	-	89	59	119
Total DC activity undertaken compared with 2019/20 baseline	Jan-24	89.2%	-	-	88.9%	71.4%	106.3%
Total IP elective activity undertaken compared with 2019/20 baseline	Jan-24	88.3%	-	-	83.0%	58.5%	107.5%
Total first outpatient activity undertaken compared with 2019/20 baseline	Jan-24	107.7%	-	-	104.4%	78.5%	130.4%
Total follow up outpatient activity undertaken compared with 2019/20 baseline	Jan-24	115.8%	-	-	110.2%	82.6%	137.8%
Total diagnostic activity undertaken compared with 2019/20 baseline	Jan-24	123.9%	-	-	115.4%	99.8%	131.1%
Total patients treated for cancer compared with the same point in 2019/20	Jan-24	114.6%	-	-	122.1%	83.1%	161.1%

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*

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Finance Summary

Latest Indicator Period: Jan-2024

Indicator Description	Period	Performance	Target / Threshold	Met?	Mean	LCL	UCL
In-month financial performance Surplus/Deficit £'000	Jan-24	-1087.3	-1464.1		-372.4	-8537.6	7792.8
Adjusted in-month financial performance Surplus/Deficit £'000	Jan-24	-6643.1	-	-	-2397.5	-7020.4	2225.4
Year-to-date financial performance Surplus/Deficit £'000	Jan-24	-16003.7	-12780.9	No	-7856.1	-14892.2	-820.1
Elective recovery funding (ERF) value-weighted activity % In month	Dec-23	103.2%	103.0%		94.1%	71.6%	116.5%
Cash £'000	Jan-24	19796	20329	No	43285	18267	68303
BPPC £ %	Jan-24	87.6%	95.0%	No	90.4%	83.0%	97.8%
BPPC Volume %	Jan-24	75.5%	95.0%	No	80.1%	73.0%	87.1%
In-month ICS CDEL capital expenditure	Jan-24	2109.5	2918.0	-	2237.9	-3167.1	7643.0
Efficiency delivery £'000	Jan-24	7924.2	4875.0		3321.1	-1060.3	7702.5

Corporate support services – Digital Summary

Latest Indicator Period: Jan-2024

Indicator Description	Period	Performance	Target / Threshold	Met?	Mean	LCL	UCL
Priority 1 Incidents	Jan-24	2	0	No	1	-	-
Data Security and Protection Training compliance	Jan-24	92.2%	95.0%	No	88.6%	85.6%	91.7%
Data Security & Protection Breaches	Jan-24	27	-	-	26	11	41
Externally reportable ICO incidents	Jan-24	1	0	No	0	-	-
All IG reported incidents	Jan-24	29	-	-	27	12	42
Freedom of Information (FOI) % responded to within target time	Jan-24	84.7%	80.0%		66.6%	41.0%	92.2%
Data Subject Access Requests (DSAR)	Jan-24	78.3%	80.0%	No	74.8%	56.9%	92.7%

Corporate support services – Legal services Summary

Latest Indicator Period: Jan-2024

Indicator Description	Period	Performance	Target / Threshold	Met?	Mean	LCL	UCL
Legal Services: Number of claims	Jan-24	21	-	-	17	3	31

Corporate support services – Regulatory assurance

Latest Indicator Period: Jan-2024

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

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

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

SPC Variation/Performance Icons

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

SPC Assurance Icons

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

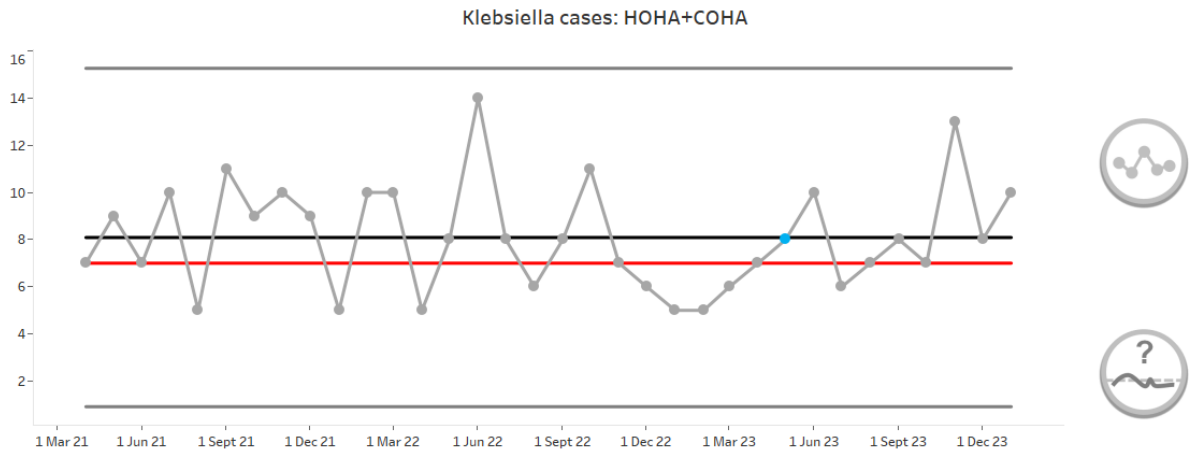
OUH Data Quality indicator

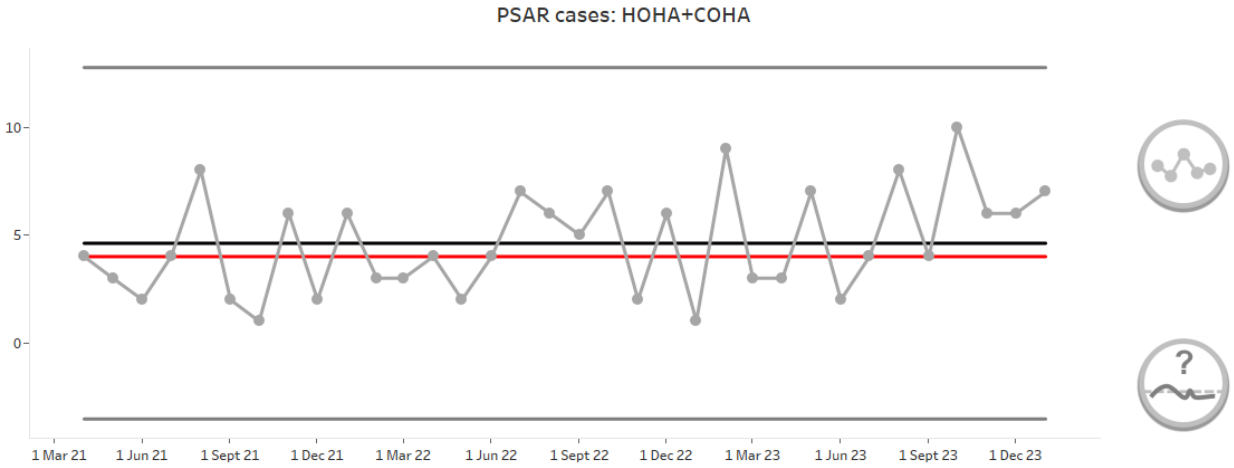
Valid: Information is accurate, complete and reliable. Standard operation procedures and training in place.	**Verified**: Process has been verified by audit and any actions identified have been implemented.	**Timely:** Information is reported up to the period of the IPR or up to the latest position reported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

Sufficient	Satisfactory	Inadequate

03. Assurance reports

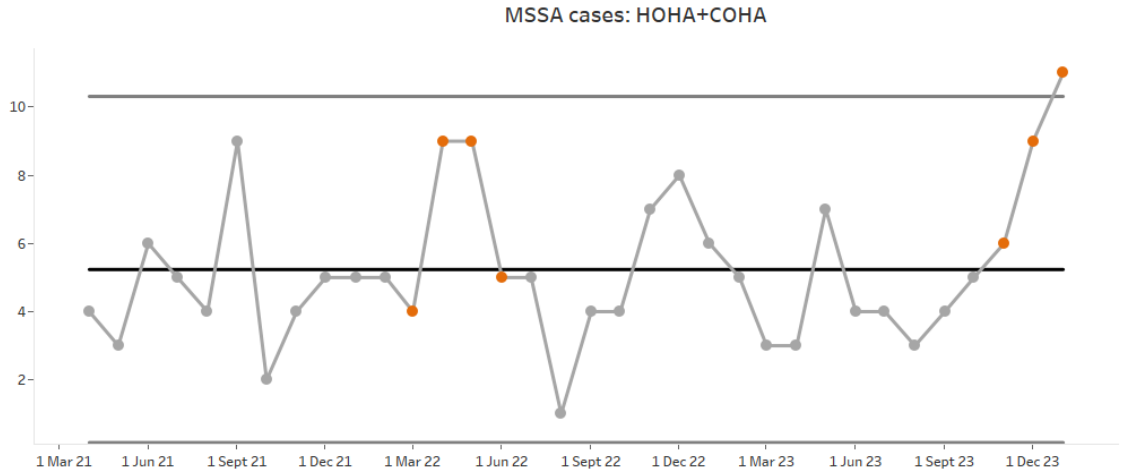
3. Assurance report: Quality, Safety and Patient Experience

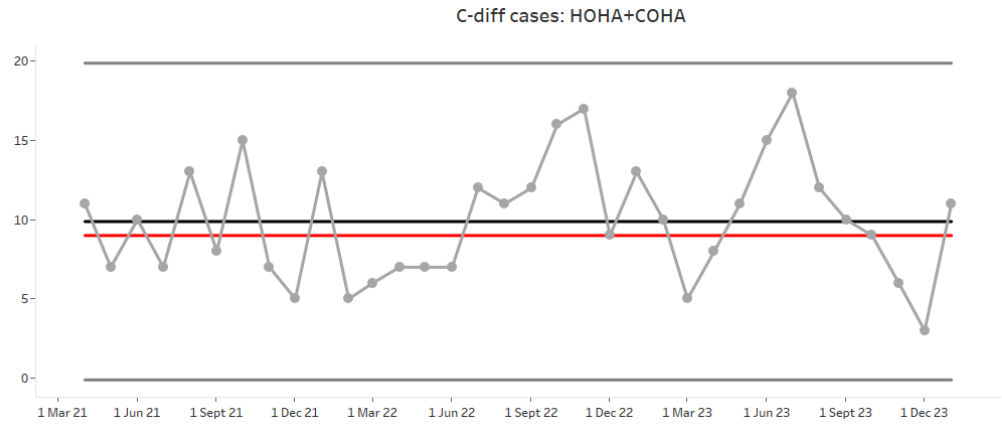




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The NHS England Long Term Plan is to halve healthcare-associated Gram-negative bloodstream infections (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 84 cases. Monthly threshold is 7.16 cases, this month there were 10 cases, only theme is that 6 of the 10 are cancer patients. The threshold for Pseudomonas is 47 cases. Currently at 57 cases, 3 of the patients have cancer as a risk factor. No new learning identified.	Continue to review all case to identify any learning.	BAF 4	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

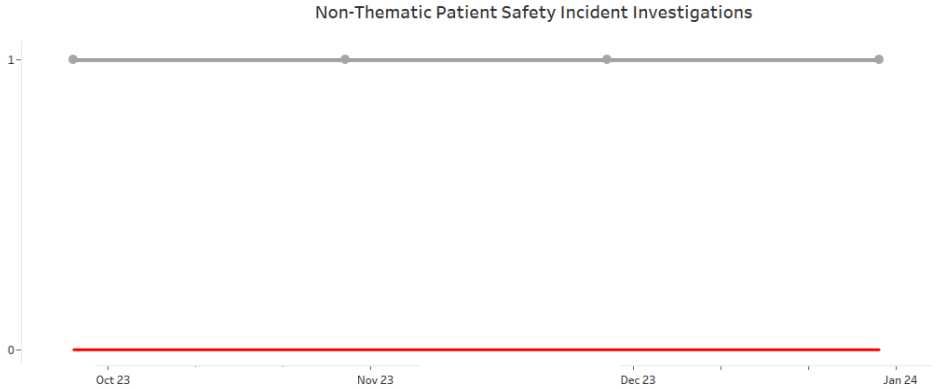
3. Assurance report: Quality, Safety and Patient Experience

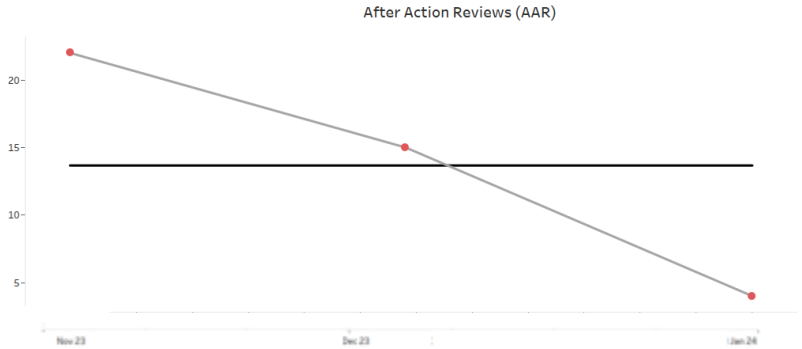


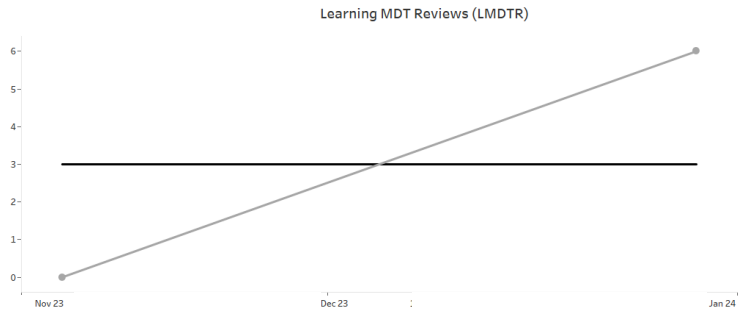


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
MSSA- thematic review undertaken of MSSA bacteraemia' s: upward trend and now special cause variation. 34 HOHA cases to date, of these, 16 have been reported as the source being attributable to invasive devices. **C.diff-** threshold for OUH for 2023/24 is 103 cases, to date is 106 cases.	MSSA- An initial analysis of cases suggests the actions will be around the following points: Survey of knowledge of staff who cannulate to understand where attention/training needs to focus, understanding of canulation training being given/who attends, observational audit of cannula siting/documentation/non-touch technique compliance. C.diff- no new learning identified from the Jan cases	Continue to review all case to identify any learning.	BAF 4	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

3. Assurance report: Quality, Safety and Patient Experience

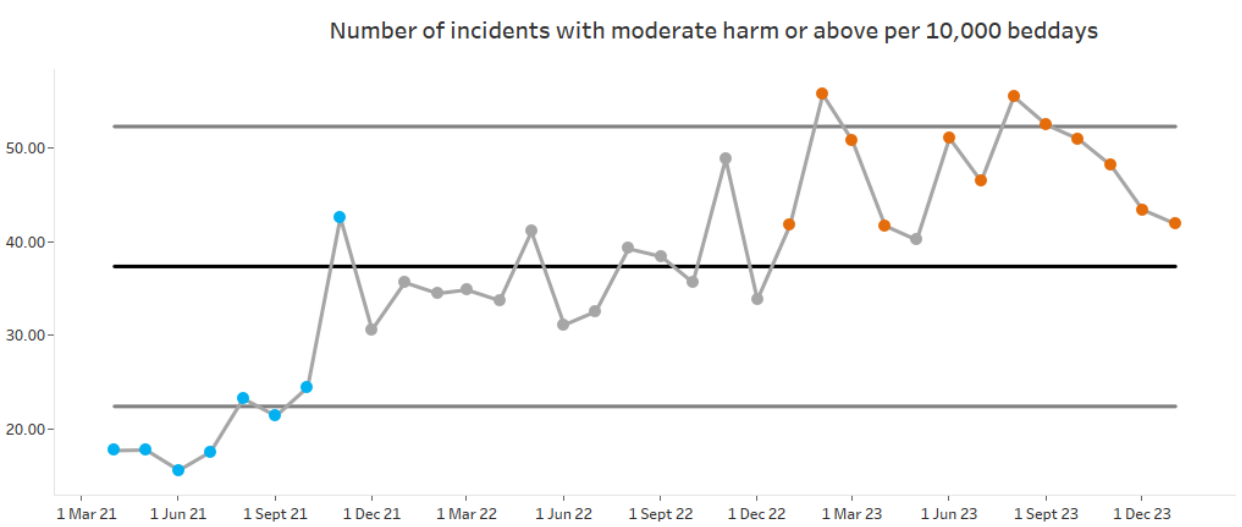


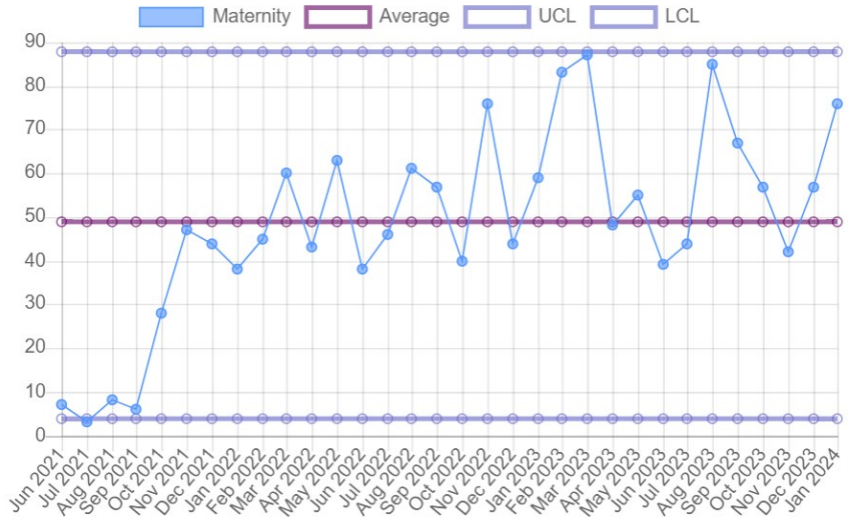




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
One Patient Safety Incident Investigation (PSII) was confirmed in January 2024 (excluding any incidents included in the 4 thematic PSIIs that form part of the PSIRF patient safety profile). The PSII confirmed is a multi-patient incident involving urology patients that have been lost to follow-up. Thematic PSIIs refer to the 4 key safety areas highlighted in our Patient Safety Profile which is part of our Patient Safety Incident Response Plan. Individual PSIIs are incidents that warrant an extensive system-based review (more than a Learning MDT Review response). The learning and improvement will be shared once the PSII has concluded, within 3-6 months. The specific timeline for PSIIs is set by the service in conjunction with the patient and family and confirmed at the weekly Safety Learning & Improvement Conversation (SLIC).	This is the fourth individual PSII (outside of our Patient Safety Profile) that has been confirmed since OUH started working under the new Patient Safety Incident Response Framework at the start of October 2023. Further data will be required to confirm any trend. The number of PSIIs called is low, but other learning approaches are used for other incidents. After action review (AAR) is a moderated discussion of incidents intended to identify learning, and 4 of these were completed in January; there is a similar long-established review process for significant falls and pressure ulcers. A learning MDT review is similar process, but it applies the Systems Engineering Initiative for Patient Safety (SEIPS) framework to the discussions. All of these are discussed in SLIC, to share learning and to hone actions, and this happened on 6 occasions in January. These figures can be seen on the second graph.	The sole action at this juncture is to complete the investigation. The PSII process is monitored by SLIC with responsibility for sign-off of final reports from Division, Head of Clinical Governance and DCMO.	BAF 4 CRR 112 2	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

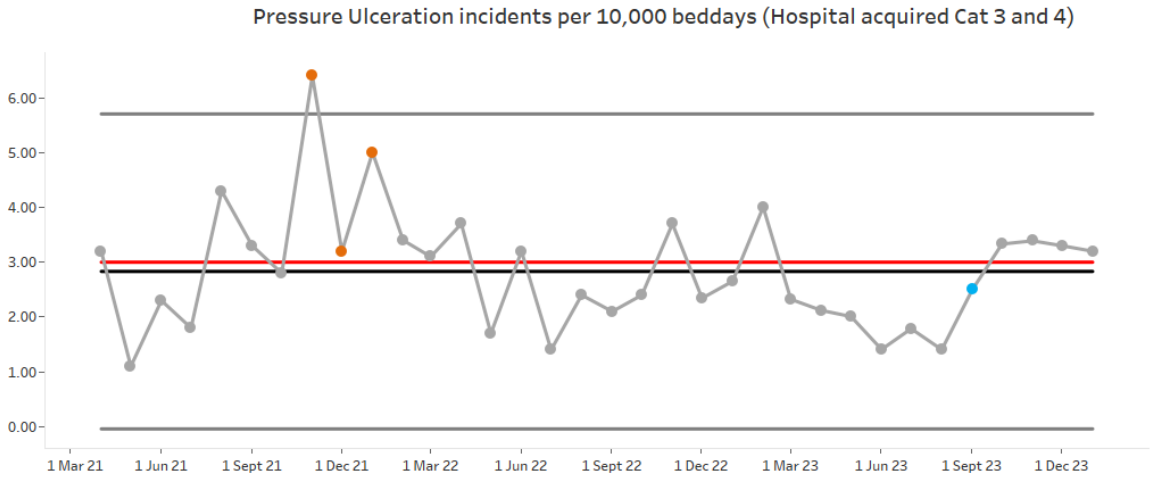
3. Assurance report: Quality, Safety and Patient Experience

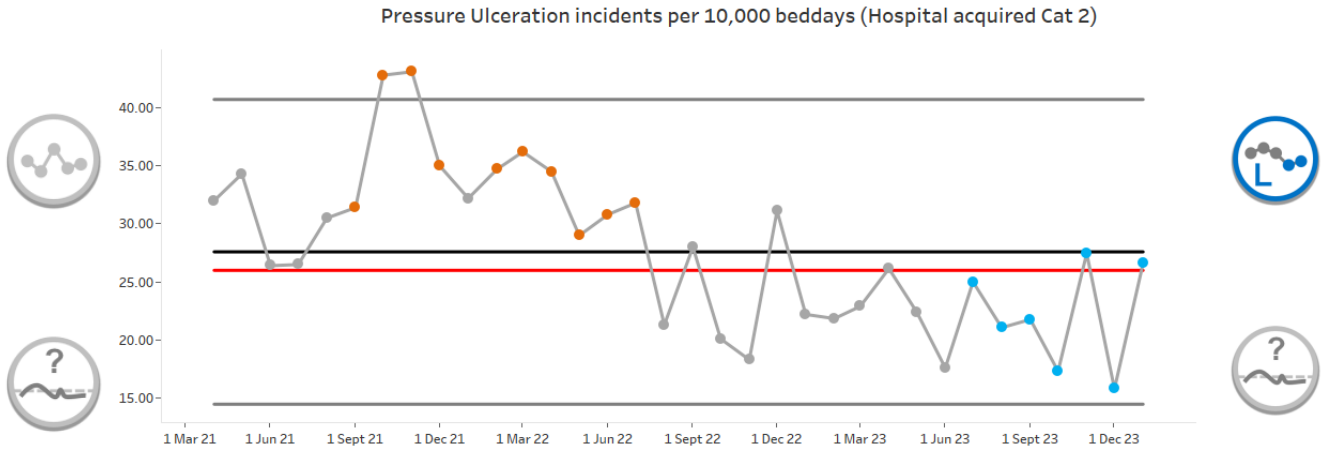




Summary of challenges and risks		Action timescales & assurance committee	Risk Register	Data quality rating
There were 41.9 incidents with moderate harm or above per 10,000 bed days in January 2024. The indicator exhibited deteriorating special cause variation due to thirteen consecutive periods recorded above the mean. The approach to several maternity incidents, such as post-partum haemorrhage, changed during October 2021 The Trust began calling these as Moderate-impact incidents, in line with national practice. This approach was embedded in Maternity over the following 12 months and is now well established. As a result, Maternity now calls a significant percentage of Moderate+ incidents (54 of the 105 incidents in January 2024, or 51%). The mean in the above Moderate+ graph includes 6 months prior to this change which explains why later months show data above the mean. The second graph shows the history of Maternity Moderate+ incidents. Note that the scales of the two graphs are different: total incidents are presented per 10,000 bed days in the first graph, c.f. absolute number of maternity incidents in the second graph.	Aside from the 54 Maternity incidents, the most common Cause Group in January 2024 was Surgical/Return to Theatre (38 of 105, 36%). All of these have been agreed as Local investigations, except 4, for which further information is being sourced. Apart from Maternity, the Directorate with the most Moderate+ incidents in January 2024 was Acute Medicine & Rehabilitation (16 of 105 incidents, 15%). Five of these covered violence and aggression against staff, and another 5 covered pressure damage that developed in hospital, which will all be reviewed with Tissue Viability via the harm-free assurance process. The remaining 6 incidents are split across 5 Cause Groups.	97 of the 105 incidents reported were patient incidents, and at the time of writing, 26 of these have been covered by the Safety, Learning & Improvement Conversation (SLIC) review process (27%). This is the same rate seen at this point for the December 2023 incidents. Further information, or a formal learning response, will be provided for the remainder. This is actively tracked by the 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.		*Sufficient* *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

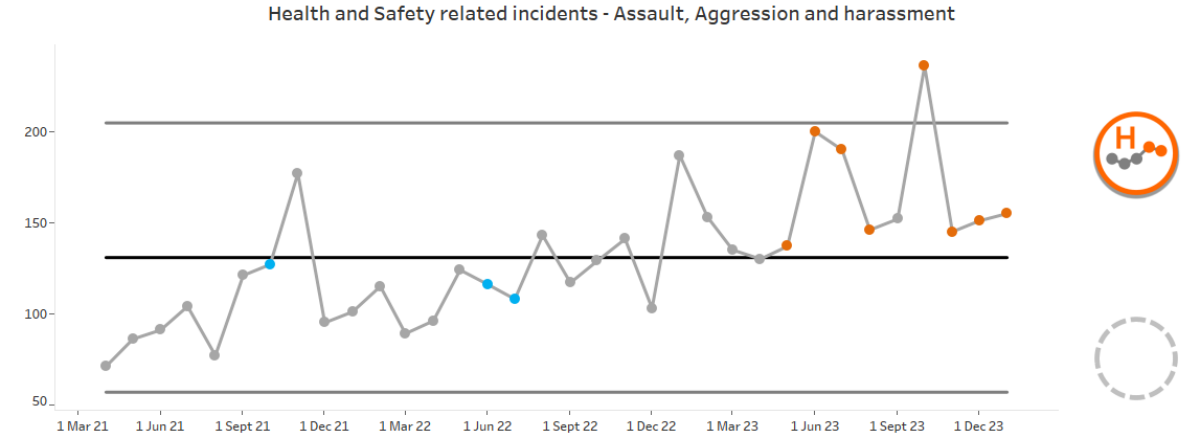
3. Assurance report: Quality, Safety and Patient Experience,

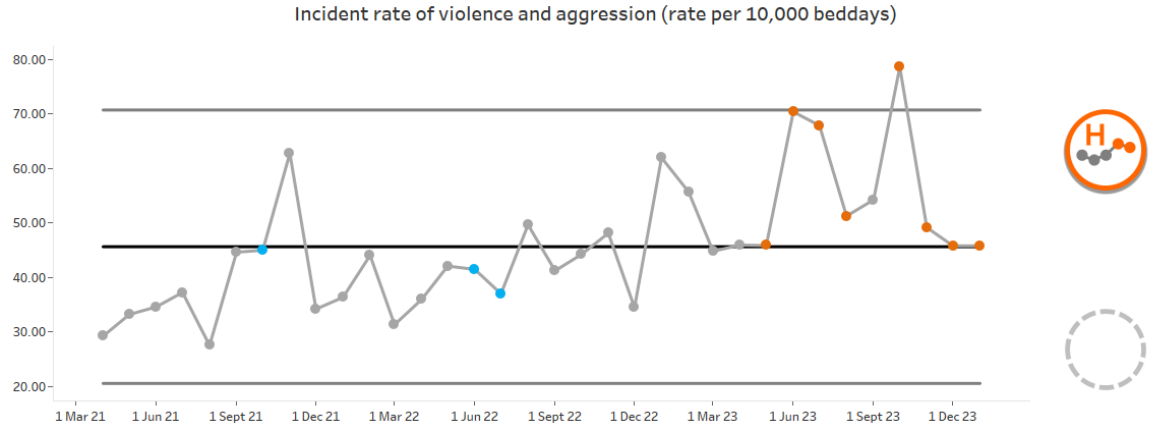




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
HAPU Category 3 and above: There were 12 incidents reported in January 2024. All will be reviewed for thematic learning and discussed at HFAF in March. HAPU Category 2: Incidents will be reviewed by the clinical divisions to identify themes for discussion and overarching improvement plans. Not all HAPU Category 2 incidents were reviewed by the Tissue Viability Team due to operational pressures.	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 March 2024 for shared learning.	N/A	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

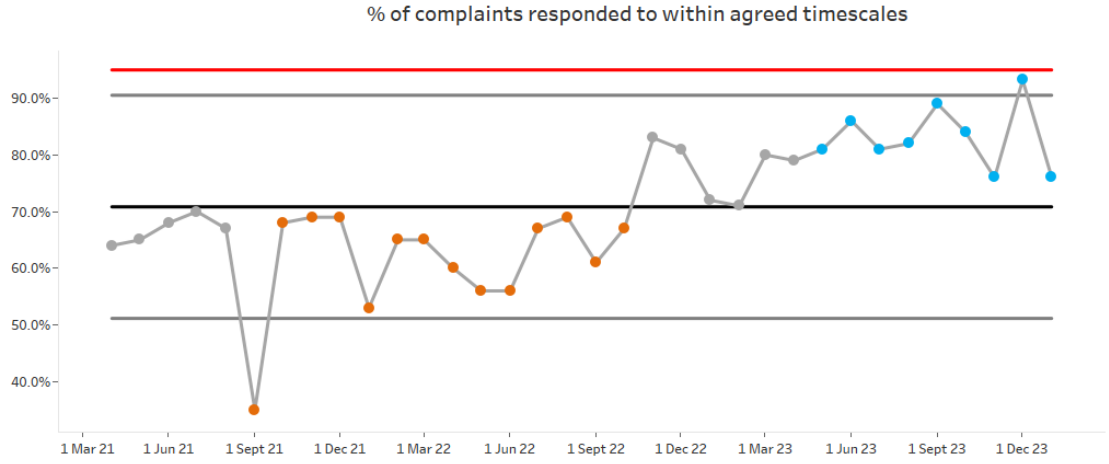
3. Assurance report: Quality, Safety and Patient Experience, *continued*

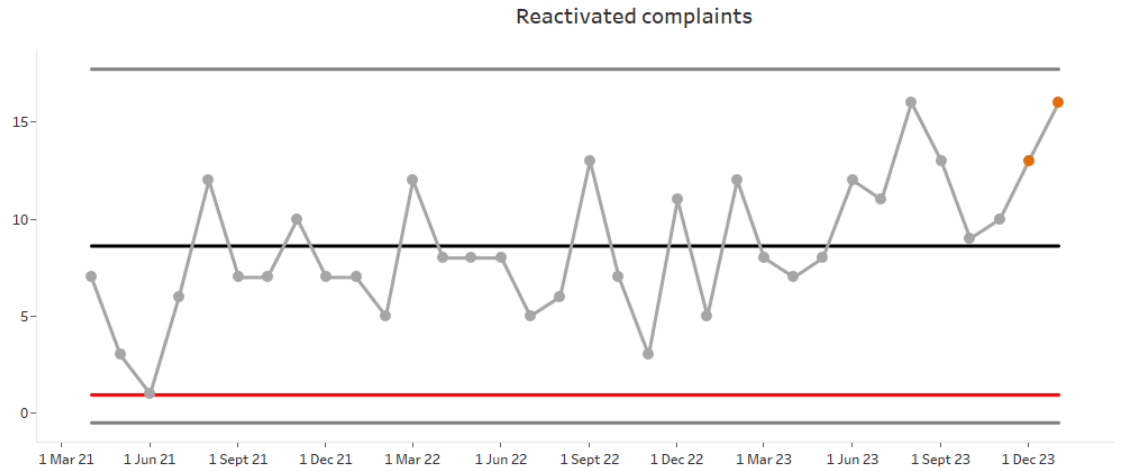




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
There were 45.8 Health and Safety incidents relating to assault, aggression and violence per 10,000 bed days in January. The indicator exhibited special cause variation due to over 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 next phase is concentrating on sexual violence and racial abuse. The majority of violence and aggression incidents can continue to be 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 enable a timely discharge continues to be 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. Clinical Teams within Directorates manage clinically attributed aggression through individual care planning, undertaking level of enhanced observation and utilising security support. The CNO chairs a Violence Reduction Group, and there continue to be regular V&A Safety Groups within directorates. Clinically worn body cameras have been introduced and have been received positively in the areas and the aim is that the use of the cameras will have a de-escalation effect. The Security Teams have undertaken enhanced physical intervention training which is compliant with the Restraint Reduction Network Standards. Conflict Resolution Training has been trialled in a number of areas, and trainer-trainer training in clinical holding is being undertaken in April. A paper with recommendations to increase Security Officer Numbers has been agreed, and funding options are being considered	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 *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months, and independent audit undertaken in last 18 months*

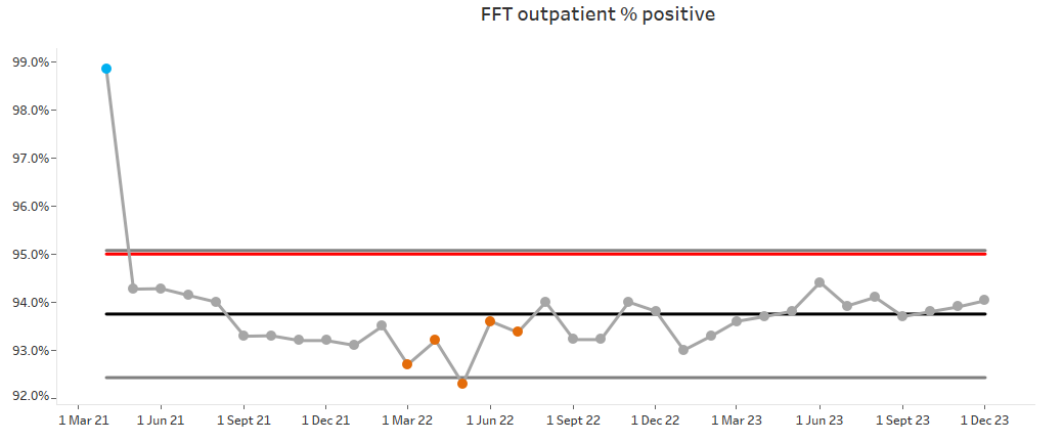
3. Assurance report: Quality, Safety and Patient Experience, *continued*

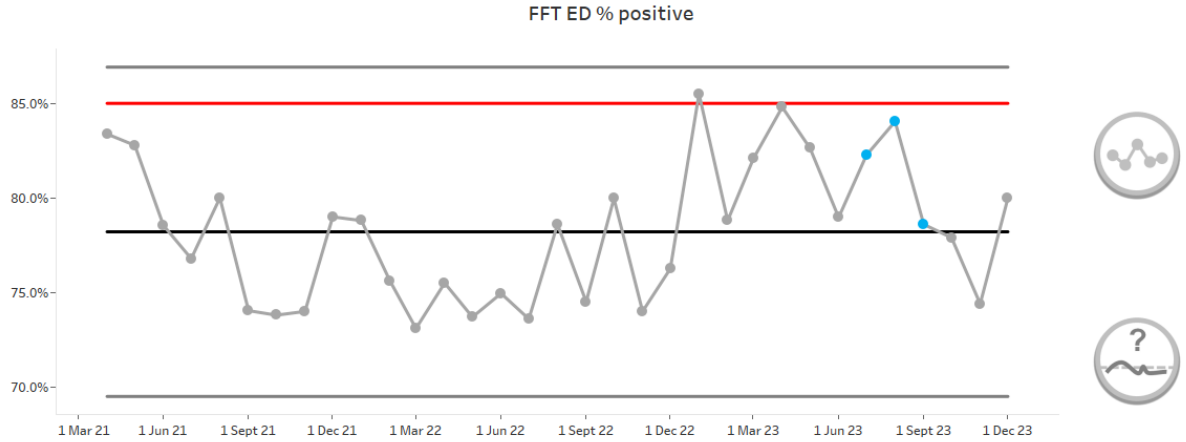




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
In January 2023, 76.1% of complaints were responded to within 40 days, below the target of 95%. The indicator has consistently not achieved the target. January's performance exhibited improving special cause variation with over seven data points performance above the mean of 70.8%. Reactivated complaints exhibited deteriorating special cause variation due to seven points above the mean of 9 and was above the threshold value of one reactivated complaint per month (16 reactivated complaints).	The Trust received 102 formal complaints in January. Reactivated (reopened) complaints continue to also increase, with reasons for complainants requesting a further response being predominantly related to the length of wait for appointments/procedures, which cannot be expedited through the complaints process. The Complaints team continue to actively work with Divisions to support them in addressing overdue complaints and will support with the drafting of responses where possible. The weekly auto-generated breach sheet enables Divisions to track their overdue complaints, and those which will breach. These continue to be discussed in weekly meetings held with the Complaints team.	Ongoing, reviewed weekly.	BAF 4	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

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

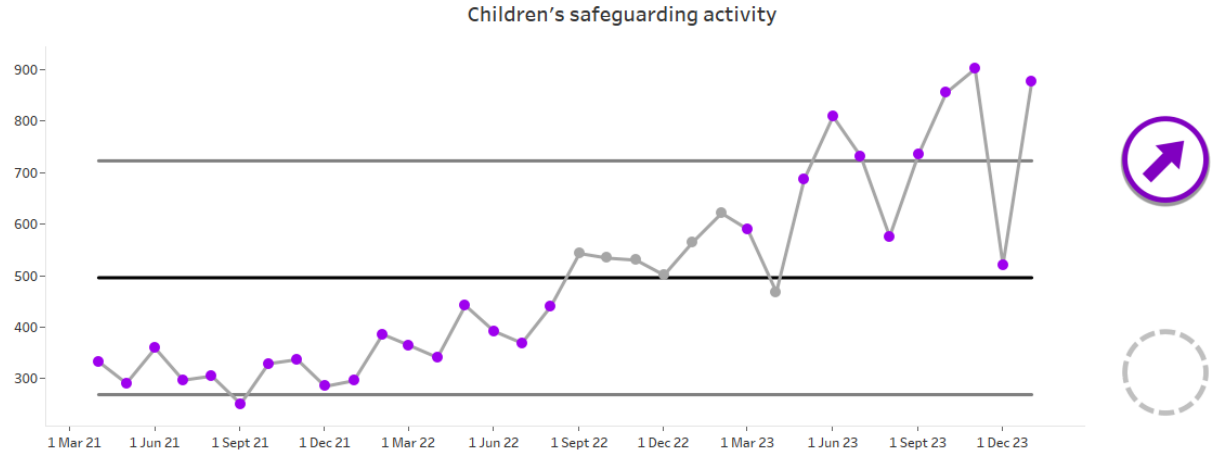


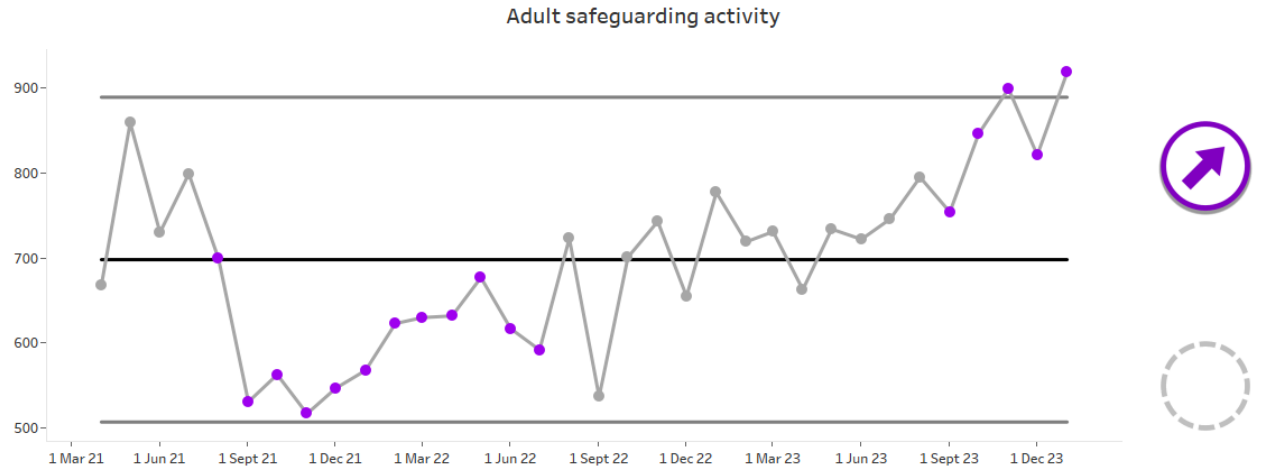


January FFT data is not available.

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): Although the percentage positive rates were below the performance standard for outpatient and ED and there was an increase in positivity in both services. ED's results fluctuate more than the other services and is in response to the operational pressures within the service. During December 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, cancelled appointments/ procedures, discharge process and car parking. This is reported to the weekly ICCSIS (Incidents, Complaints, Claims, Serious Incidents, Safeguarding) Triangulation Group.	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. 1.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*

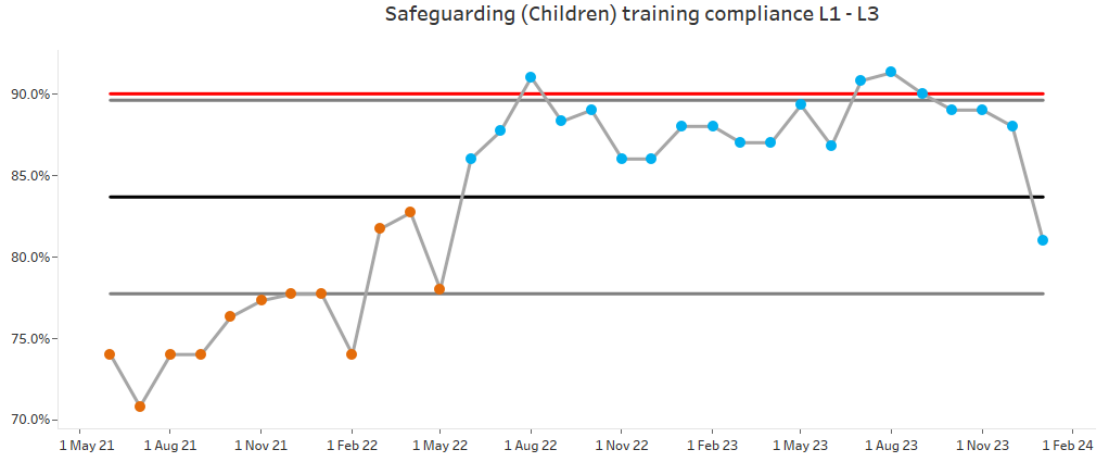
3. Assurance report: Quality, Safety and Patient Experience, *continued*

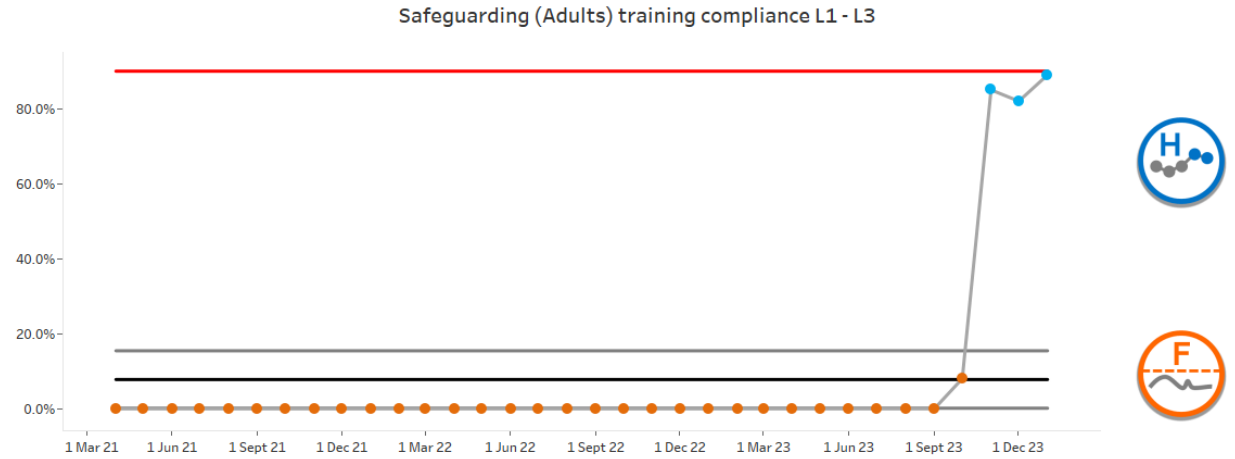




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The indicator continues to exhibit special cause variation due to more than eight periods above the mean and exceeding the upper process control limit. Safeguarding children and maternity activity increased by 355 (n=876). The increase returns to levels of activity previously seen. Ongoing issues of complex cases. Maternity pregnancy bookings cannot be reported due to changes from EPR to Badgernet and data not available. Themes of domestic abuse, mental health and substance misuse. There are currently 297 pregnant women with a safeguarding concern. Adult activity increased by 17 (n=918) in January. Themes continue to relate to domestic abuse neglect and self-neglect. The DoLS activity increased by 38 (n=124) and no authorisations by the LA undertaken in January.	The teams are attending multi agency meetings to share information and identify risk to ensure plans are in place to keep children safe across the system. Children liaison shared information with primary care and CSC, this dropped by 225 (n=1122). Activity continues to pressure on the team due to increase activity and complexity of cases. Additional resources being sought.	ICCSIS updated on weekly themes. PSEC monthly assurance report, safeguarding is embedded in divisional governance reports and presented to the Trust clinical governance committee. Safeguarding Steering group quarterly.	BAF 4	Satisfactory *Standard operating procedures in place, training for staff completed and service weekly validation of data entry, but no Corporate or independent audit yet undertaken for fuller assurance*

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





Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Safeguarding children training L1-L3 compliance increased by 1% to 89.0%, the KPI id 90%. The indicator exhibited special cause improving variation due to over seven periods above the mean. Level 3 is the only level below the 90% KPI at 82%. Level 1-3 adult training dropped 1% to 81%. Mapping issues are being resolved. Level 2 and 3 are below the 90% KPI at 72% and 86%. Prevent training awareness improved by 5% and is at 77% for January, this remains below the 85% KPI and related to mapping changes.	There are teams, face to face and online training options available. Shared at meetings (Div. governance, matrons and PSEC) to raise awareness of need to complete level 3 adult training. PSEC and each divisional governance report template provides details of gaps for training. Review of mapping ongoing for groups of staff.	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*

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 January 2024.

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

Increased bed capacity, opened in December 2023, has remained open in January 2024. High use of temporary workforce has been needed to staff the additional capacity.
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. DDN provided assurance that the additional Annual leave granted did not have a detrimental impact on patient care.
The incidents below, did not relate to staffing levels:
Neonatal Unit – 7 medication incidents – no harm to patients
Paediatric ICU- 15 medication incidents reported all were without harm. Skill mix is believed to be a large factor, with many junior nurses in post, often checking medications with each other, rather than with a senior nurse. This is due to low number of senior staff and conflicting priorities on time. There is also a common theme relating to pumps, incorrectly programmed. Actions have already been identified and commenced to reduce incidents.
CHOX wards – review of incidents taken place, no themes or areas of concern identified. Ward Managers raising awareness within newsletters.
SSIP – 6 medication incidents, 4 with no harm, 2 with minor harm. Common theme has been missed dose of medication; individual nurses spoken to.
Neurology ward – 5 medication incidents – no harm to patients, no specific trends, however, number relating to Controlled drugs are higher. 6 falls – 3 with no harm, 3 with minor harm. High number of patients requiring enhanced observation care. Both Medications and falls incidents being addressed within top 3 safety priorities this year.

Difference in CHPPD for NOC HDU – Actual higher than budget – throughout January, there were reduced patient numbers in HDU, especially overnight. However, due to the location, there is a minimum level of staffing required, regardless of the number of patients.
PCCU – Budget higher than actual – funding has been approved to increase the establishment . Recruitment has commenced, but several posts currently remain unfilled. Staffed to required levels for number of patients throughout January.
Horton Children's ward – Budgeted less than actual. Actual higher than required. There have been several days where the lift to the Children's ward has been out of action, requiring post operative children to be recovered by a ward nurse moving to the Adult Day Surgery Unit. More staff were needed to facilitate this safely. A complex child was on the ward for several days needing support of 1:1 care.

SuWOn Division -
Staffing in SUWON has remained at safe levels throughout January, despite the challenges of continuing to have additional beds open on the Churchill site.
Most Rostering KPI's were met. One ward fell short of 8-week lead time (Transplant) due to Manager illness. The Matron has given assurance this will be addressed with the next roster. 5 rosters were over on the Annual leave KPI. Matron's have given assurance that this did not impact on patient safety. 1 ward has high unused net hours; however, this relates to student staff not being updated correctly on the roster, which is being resolved.

Difference in CHPPD for Katharine House Hospice – On occasions there are empty beds and currently the Hospice has 2 beds closed for refurbishment. However, due to the remote location, staffing cannot be reduced to maintain safety.

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

SuWOn – (continued) - The incidents below, did not relate to staffing levels:
Hematology Ward - The 8 medication incidents were for a variety of reasons, without harm, however, several relating to storage which is being addressed in safety huddles. No reported falls resulted in harm to patients, action plans in place around reduction in falls
Oncology Ward – 6 incidents – none with patient harm
SEU-E – 5 reported medication errors – none with harm. No common themes.

MRC - Four departments did not achieve the 8-week lead time for roster publication, however, following conversations by the DDN, these are improving, except for John Warin Ward. This has been addressed with the relevant Matron and ward manager with clear trajectory to bring back in line. Areas with high AL related to a combination of emergency leave approved, and a change in designation of some staff since roster approval (e.g. pre-pin had gained PIN).

The incidents below, did not relate to staffing levels.
CTCCU – 5 medication incidents – no harm to patients. 2 identified relating to high number of Agency staff used, not familiar with Trust Diabetes protocols. Increased activity on unit due to Impact of escalation beds open.
JR EAU – 5 medications, no harm to patient. All reviewed, no common theme, individuals supported following incident. 5 falls with no or minor harm. Large number of patients requiring enhanced observation care, team to ensure staff on duty are prioritised to this care
JR ED – 8 medication incidents, no harm to patients. Staff involved are being supported with relevant performance plans
Cardiology ward 6 falls - no harm
CMU-A 6 falls no or minor harm, no themes
CMU-C – 6 falls no or minor harm, no themes
CMU-D 7 falls 1 with harm, which is under Divisional investigation
HH EAU 12 falls. No or minor harm. A high number of patients requiring enhanced observations this month. Large vacancy in support staff, therefore relying heavily on temporary workforce.
Juniper – 5 falls - no fall with harm. Challenging patients with high risk of falls

Difference in CHPPD – All CMU wards show actual hours less than required. Upon investigation, the DDN advises that all wards were mitigated and safe, but support staff such as ward manager, clinical educators, were not moved into the numbers on the roster to accurately reflect the position. The DDN is working with Matron teams to rectify this moving forward. Ward 5E/F had higher number of hours than required which related to the use of RMN's to safely manage mental health patients beyond planned or budgeted staffing.

CSS - The incidents below did not relate to staffing levels
6 reported medication incidents. No incident led to patient harm.
5 pressure ulcer incidents, 1 with patient harm. Tissue Viability team now engaged with Critical Care, delivering education sessions. Team raising awareness of the importance of clear documentation of skin, especially when medical devices are being used.

Difference in CHPPD: The budgeted hours are higher than the actual, due to a high vacancy with ongoing recruitment, not all beds open, therefore requirement less than budget for January.

Maternity – the incidents below did not relate to staffing levels.
There were 9 reported medication incidents, however, this is across all Inpatients units. No individual area had higher than 4 incidents. No patient harm or common themes noted.
13 women were readmitted postnatally. These all related to conditions with babies, rather than unwell woman.
2 areas fell short of 8-week lead time. Roster writer absent unexpectedly so Matrons taken over the writing, but due to clinical demands, there was a delay in publication.

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

Oxford University Hospitals NHS Foundation Trust

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: The number of falls across the Trust was lower in January than previous month, with a total of 171 falls recorded. 75% of patients had assessments completed, with care plans generated in line with the assessment, however, this is an overall reduction from those completed in December. A large number (115/171) were unwitnessed falls. MRC are holding a second falls summit in February 2024 to review falls data which will inform actions moving forward. ECCO policy will be included in falls and BNA teaching. "At a glance" guides have been completed and now available along with patient leaflets on falls.

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*** Information timely, and reported at required level. SOP in progress. Staff appropriately trained and two stage quality assurance process in place each month for audit. Corporate validation/audit undertaken with DDNs and Deputy Chief Nurse monthly. External audit not undertaken in last 18-months.

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

Oxford University Hospitals NHS Foundation Trust

January 2024	Care Hours Per Patient Day			Census	Nurse Sensitive Indicators				Maternity Sensitive Indicators							HR					Rostering KPIs			
Ward Name	Budgeted Overall	Required Overall	Actual Overall	Census Compliance (%)	Medication Administration Error or Concerns	Extravasation Incidents	Pressure Ulcers Category 2,3&4	All reported falls	Delay in induction (PROM or booked IOL)	Medication errors (administration, delay or omission)	Pressure Ulcers	Women readmitted postnatally within 28 days of delivery	Proportion of mothers who initiated breastfeeding	Births where the intended place of birth was changed due to staffing	Number of 'dropped babies'	Vacancy (%)	Turnover (%)	Sickness (%)	Maternity (%)	Revised Vacancy HR Vacs plus LT Sick & Mat Leave (%)	Roster manager approved for Payroll	Net Hours 2/-2%	8 week lead time	Annual Leave 12-16%
NOTSSCaN																								
Bellhouse / Drayson Ward	8.3	9.1	10.8	100.0%	7	2	0	0								16.6%	3.5%	3.2%	9.7%	26.8%	Yes	3.1%	9.57	14.4%
HH Childrens Ward	10.2	9.2	17.6	98.9%	0	0	0	0								17.0%	8.1%	5.3%	0.0%	19.4%	Yes	0.9%	8.57	18.1%
Kamrans Ward	10.2	10.6	9.4	100.0%	2	1	0	0								5.1%	10.1%	2.0%	6.5%	11.2%	Yes	-4.5%	7.43	14.3%
Melanies Ward	11.5	11.1	12.0	96.8%	2	0	0	1								-32.1%	7.3%	1.7%	1.2%	-27.9%	Yes	-3.0%	15.29	18.6%
Robins Ward	11.4	12.2	11.8	95.7%	2	2	0	0								12.9%	4.5%	2.9%	0.0%	12.9%	Yes	0.1%	9.57	15.3%
Tom's Ward	8.1	9.6	9.6	98.9%	5	3	0	2								14.6%	6.7%	2.2%	4.8%	18.7%	Yes	1.9%	9.57	14.5%
Neonatal Unit	18.1		16.7		7	2	0	0								11.1%	6.5%	6.5%	3.8%	18.5%	Yes	-8.7%	8.43	15.2%
Paediatric Critical Care	32.8		25.5		15	4	1	0								-1.6%	9.5%	4.8%	7.3%	10.2%	Yes	0.2%	10.29	15.8%
BIU	6.1	5.6	7.1	100.0%	1		0	0								20.4%	19.3%	3.0%	0.0%	20.4%	Yes	-0.4%	8.43	17.6%
HDU/Recovery (NOC)	22.2		31.0		0		0	0								8.6%	14.3%	4.6%	4.2%	12.5%	No	0.7%	8.43	12.4%
Head and Neck Blenheim Ward	7.3	8.2	8.9	100.0%	2		0	1								16.0%	9.4%	6.0%	4.1%	19.5%	Yes	-3.2%	8.57	15.0%
HH F Ward	12.4	8.7	8.4	100.0%	0		5	1								4.9%	6.6%	4.9%	0.0%	8.6%	Yes	0.7%	7.86	14.9%
Major Trauma Ward 2A	10.9	8.6	9.6	100.0%	4		4	2								10.8%	11.3%	3.3%	2.1%	15.7%	Yes	1.7%	8.14	14.7%
Neurology - Purple Ward	8.9	10.2	7.7	100.0%	5		1	6								5.3%	15.0%	5.6%	0.0%	5.3%	Yes	2.0%	8.57	15.3%
Neurosurgery Blue Ward	8.9	10.7	10.2	100.0%	0		0	2								8.0%	7.5%	3.7%	0.0%	11.9%	Yes	0.5%	8.29	13.8%
Neurosurgery Green/IU Ward	9.7	9.3	10.2	100.0%	0		1	1								6.2%	1.7%	4.4%	3.2%	9.2%	Yes	3.7%	8.29	17.2%
Neurosurgery Red/HC Ward	11.7	12.3	12.3	100.0%	2		2	2								1.7%	3.8%	4.8%	5.0%	10.9%	Yes	0.6%	8.57	13.6%
Specialist Surgery I/P Ward	8.5	8.7	8.5	100.0%	6		1	3								18.2%	5.3%	3.1%	0.0%	18.2%	No	0.4%	8.43	14.9%
Trauma Ward 3A	12.2	8.7	9.0	97.9%	2		5	2								12.8%	10.1%	4.1%	2.1%	16.5%	Yes	1.6%	8.14	15.1%
Ward 6A - JR	7.2	7.9	7.2	100.0%	1		1	3								11.7%	10.2%	3.3%	2.4%	13.8%	Yes	-0.8%	8.57	15.5%
Ward E (NOC)	6.3	7.5	6.6	100.0%	2		1	2								24.7%	26.0%	8.4%	0.0%	24.7%	Yes	0.6%	8.29	16.2%
Ward F (NOC)	6.7	6.9	8.2	71.0%	0		0	1								13.9%	11.5%	6.1%	8.4%	21.2%	Yes	1.4%	8.29	16.0%
WW Neuro ICU	25.4		28.5		4		2	0								18.9%	14.7%	3.9%	4.1%	22.8%	Yes	-3.5%	8.00	14.9%

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

January 2024	Care Hours Per Patient Day			Census	Nurse Sensitive Indicators				Maternity Sensitive Indicators							HR					Rostering KPIs			
Ward Name	Budgeted Overall	Required Overall	Actual Overall	Census Compliance (%)	Medication Administration Error or Concerns	Extravasation Incidents	Pressure Ulcers Category 2,3&4	All reported falls	Delay in induction (PROM or booked IOL)	Medication errors (administration, delay or omission)	Pressure Ulcers	Women readmitted postnatally within 28 days of delivery	Proportion of mothers who initiated breastfeeding	Births where the intended place of birth was changed due to staffing	Number of 'dropped babies'	Vacancy (%)	Turnover (%)	Sickness (%)	Maternity (%)	Revised Vacancy HR Vacs plus LT Sick & Mat Leave (%)	Roster manager approved for Payroll	Net Hours 2/-2%	8 week lead time	Annual Leave 12-16%
MRC																								
Ward 5A SSW	8.9	9.2	8.6	100.0%	0		4	2								1.4%	8.0%	3.2%	8.0%	11.4%	Yes	-1.9%	8.57	16.6%
Ward 5B SSW	8.4	9.2	9.2	100.0%	2		0	4								9.7%	10.3%	4.3%	2.3%	11.8%	Yes	-2.1%	8.57	13.6%
Cardiology Ward	6.2	7.4	7.2	98.9%	3		0	6								4.0%	9.9%	3.5%	4.5%	11.2%	Yes	1.8%	8.43	15.4%
Cardiothoracic Ward (CTW)	7.4	7.5	6.5	100.0%	1		1	2								18.7%	15.1%	4.2%	2.7%	20.9%	Yes	-3.8%	6.00	16.3%
Complex Medicine Unit A	8.9	10.4	9.7	100.0%	1		3	6								8.6%	5.6%	5.2%	2.7%	11.1%	Yes	1.1%	8.71	16.9%
Complex Medicine Unit B	11.3	10.0	9.6	97.9%	0		0	3								-3.0%	4.1%	5.0%	3.8%	0.9%	Yes	-0.7%	7.71	15.2%
Complex Medicine Unit C	8.8	11.4	8.9	100.0%	0		2	6								9.6%	11.6%	2.4%	0.0%	9.6%	Yes	0.7%	8.00	16.4%
Complex Medicine Unit D	10.6	10.6	9.0	95.7%	0		2	7								12.1%	15.6%	4.7%	0.0%	16.2%	Yes	2.7%	7.57	21.2%
CTCCU	21.9		18.6		5		2	3								6.1%	8.4%	3.6%	8.0%	19.1%	Yes	0.1%	13.43	13.8%
Emergency Assessment Unit (EAU)	8.5	8.8		63.4%	5		4	5								18.6%	4.9%	3.5%	7.5%	24.7%	Yes	-0.2%	9.43	14.5%
HH EAU	9.2	7.5		86.7%	0		3	12								1.7%	7.3%	6.0%	5.4%	7.7%	Yes	1.8%	7.86	16.7%
HH Emergency Department	20.8				2		0	4								14.6%	9.7%	4.0%	5.5%	20.5%	Yes	-0.4%	10.29	14.9%
JR Emergency Department	15.5				8		0	2								16.7%	8.9%	5.9%	4.3%	22.8%	Yes	6.7%	8.00	13.2%
HH CCU	8.1	9.8	8.6	100.0%	0		5	5								12.5%	5.7%	6.8%	3.1%	15.9%	Yes	1.2%	8.29	16.0%
John Warin Ward	8.8	9.6	8.6	100.0%	0		1	3								14.8%	4.1%	5.4%	6.1%	23.9%	Yes	0.2%	8.29	14.0%
Juniper Ward	21.6		10.8	94.6%	2		4	3								9.3%	10.2%	4.6%	2.9%	11.9%	Yes	2.6%	5.86	17.1%
Laburnum	8.8	9.3	9.8	98.9%	1		4	3								0.5%	5.7%	3.4%	0.0%	5.3%	Yes	0.1%	3.86	14.1%
OCE Rehabilitation Nursing (NOC)	10.6	10.4	10.3	98.9%	0		1	3								8.9%	7.3%	5.1%	4.6%	16.3%	Yes	-5.3%	8.00	16.2%
Osler Respiratory Unit	14.5	10.5	12.7	98.9%	0		4	2								14.0%	8.8%	3.6%	0.0%	14.0%	Yes	-0.1%	6.71	16.3%
Ward 5E/F	11.1	9.0	10.8	100.0%	1		4	2								17.8%	8.0%	4.7%	5.7%	22.5%	Yes	0.3%	8.43	16.6%
Ward 7E Stroke Unit	10.9	8.8	9.4	97.9%	0		4	2								-10.4%	14.7%	4.4%	6.0%	-2.1%	Yes	0.8%	8.00	16.6%

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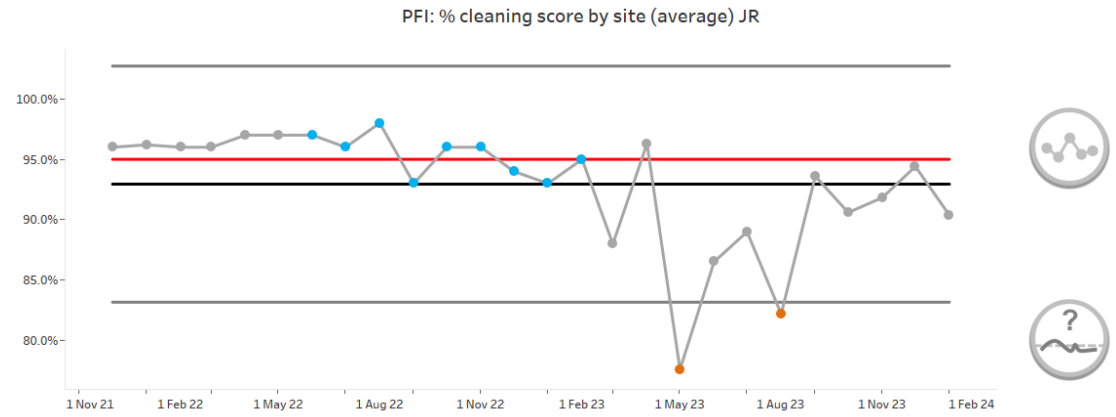
3. Assurance report: Safe Staffing - Dashboard: Part 3 (SuWOn and CSS)

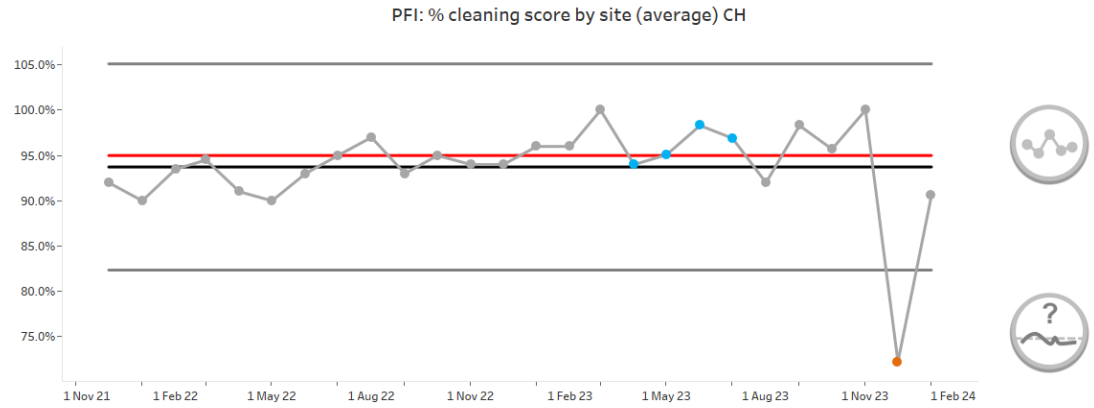
Oxford University Hospitals NHS Foundation Trust

January 2024	Care Hours Per Patient Day			Census	Nurse Sensitive Indicators				Maternity Sensitive Indicators							HR					Rostering KPIs			
Ward Name	Budgeted Overall	Required Overall	Actual Overall	Census Compliance (%)	Medication Administration Error or Concerns	Extravasation Incidents	Pressure Ulcers Category 2,3&4	All reported falls	Delay in induction (PROM or booked IOL)	Medication errors (administration, delay or omission)	Pressure Ulcers	Women readmitted postnatally within 28 days of delivery	Proportion of mothers who initiated breastfeeding	Births where the intended place of birth was changed due to staffing	Number of 'dropped babies'	Vacancy (%)	Turnover (%)	Sickness (%)	Maternity (%)	Revised Vacancy HR Vacs plus LT Sick & Mat Leave (%)	Roster manager approved for Payroll	Net Hours 2/-2%	8 week lead time	Annual Leave 12-16%
SUWON																								
Gastroenterology (7F)	7.0	7.8	7.8	100.0%	0		4	3								13.6%	9.7%	3.8%	5.4%	18.3%	Yes	-0.4%	8.57	15.0%
Gynaecology Ward - JR	5.1	6.1	7.7	97.9%	0		0	1								29.8%	6.9%	6.4%	0.0%	29.8%	Yes	3.8%	8.43	14.9%
Haematology Ward	6.9	8.1	7.6	98.9%	8		1	6								3.8%	10.9%	5.6%	9.0%	14.4%	Yes	0.5%	9.57	16.9%
Katharine House Ward	9.2	7.9	10.2	100.0%	0		3	4								2.6%	16.9%	6.1%	2.7%	5.3%	Yes	3.0%	8.29	15.4%
Oncology Ward	8.7	8.6	8.0	96.8%	6		2	3								30.4%	8.9%	4.8%	9.0%	36.7%	Yes	13.5%	8.43	16.4%
Renal Ward	9.2	9.9	8.9	100.0%	3		1	4								2.5%	6.5%	3.3%	3.0%	3.7%	Yes	0.3%	5.43	11.1%
SEU D Side	8.7	10.0	8.5	100.0%	4		2	1								32.0%	3.4%	5.9%	5.2%	35.6%	Yes	-1.5%	8.00	16.6%
SEU E Side	8.4	8.8	8.8	100.0%	7		0	2								5.4%	6.5%	3.1%	0.0%	5.4%	Yes	3.6%	8.00	16.6%
SEU F Side	7.6	8.1	7.4	100.0%	0		2	1								24.8%	19.8%	3.6%	0.0%	24.8%	Yes	1.3%	8.00	15.0%
Sobell House - Inpatients	8.7	7.7	8.0	98.9%	2		2	2								35.2%	20.7%	3.6%	8.4%	40.6%	Yes	-0.3%	8.29	14.8%
Transplant Ward	9.4	8.6	6.9	100.0%	3		0	1								27.6%	9.3%	5.3%	8.1%	35.3%	Yes	-0.3%	8.86	16.2%
Upper GI Ward	9.8	8.2	7.9	100.0%	2		2	1								12.3%	0.0%	3.9%	7.4%	21.1%	Yes	-2.9%	8.00	15.9%
Urology Inpatients	8.8	9.3	8.8	98.9%	1		2	0								28.1%	7.5%	2.1%	3.7%	32.5%	Yes	-1.2%	8.57	20.3%
Wytham Ward	7.6	7.1	7.1	100.0%	1		1	2								17.0%	8.8%	4.9%	0.0%	21.8%	Yes	0.2%	7.86	16.7%
MW The Spires	27.5		21.4		0		0	0	29	9	2	13	86.0%	0	0	8.4%	14.1%	4.0%	4.3%	2.7%	Yes	-6.9%	7.29	11.0%
MW Delivery Suite	15.2		18.6		1		0	1													Yes	-2.2%	6.86	8.9%
MW Level 5	6.7		4.8		2		0	0													Yes	-1.9%	6.86	14.0%
MW Level 6	4.5		8.4		1		0	0													Yes	2.0%	7.29	11.7%
CSS																								
JR ICU	34.5		20.7		6		5	1								26.2%	11.3%	4.9%	5.9%	32.4%	Yes	0.6%	7.43	12.6%

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

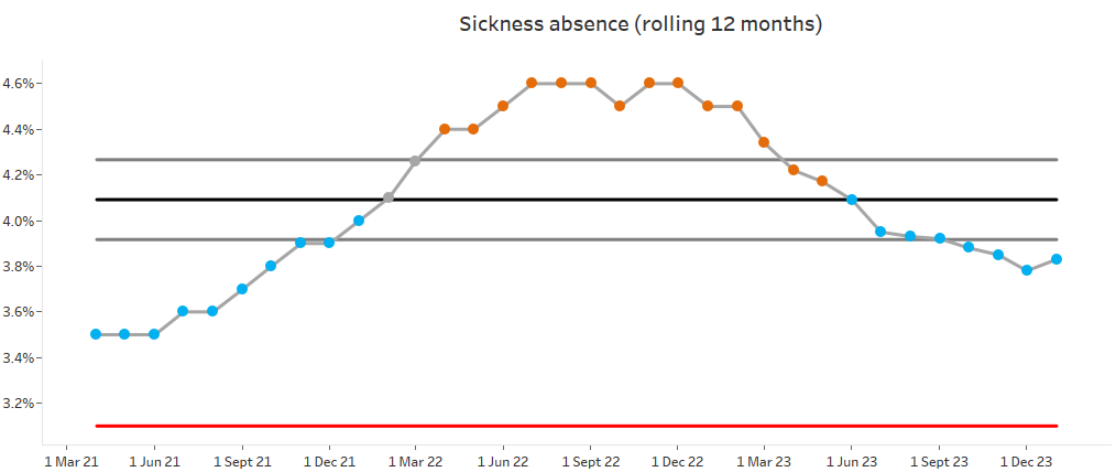
3. Assurance report: Estates, Facilities and PFI

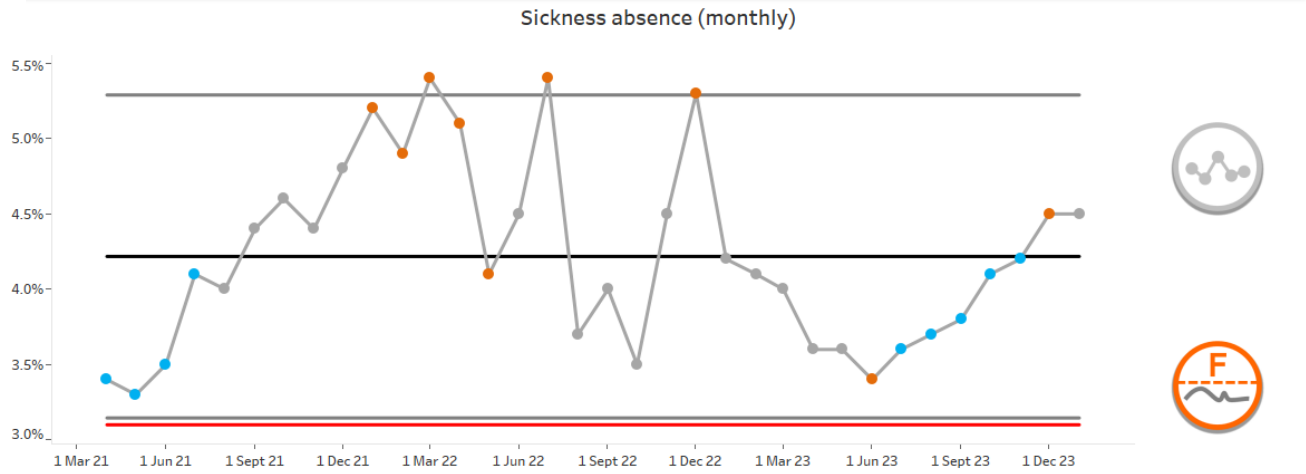




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
In January 2024, the combined PFI % cleaning score by site (average) for the JR was 96.58%. However, the above graph demonstrates the percentage of total audits undertaken that achieved 4 or 5 stars, which has decreased by 4.04% to 90.37%; below the 95% target. Additionally, the combined PFI % cleaning score by site (average) for the Churchill was 94.84%. However, the above graph demonstrates the percentage of total audits undertaken that achieved 4 or 5 stars, which has increased this month to closer to the target by 18.35%, to 90.57%. In total, 271 audits were conducted, 26 of which 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.	G4S completed the planned number of audits at Churchill in January, and 9% of those audits failed to achieve the set target. However, all the failed audits were rectified within the required timeframe, resulting in an improvement in the reported percentage. In terms of the OJR status, 10% of the total audits undertaken failed, which is in line with the six-month average. Nevertheless, all the elements that failed were rectified. When it comes to managing cleaning risks, patient safety is our top priority. At our Trust, we believe in working together to maintain cleanliness in all our facilities. Whenever an area scores three stars or below, Service Providers create action plans that include responsibilities for domestic, estates, and clinical staff to improve those areas. The Trust PFI management team oversees the implementation of those plans, while domestic supervisors and the Trust PFI team monitor the progress with the support of IP&C. We work collaboratively with the Domestic Service Teams, Clinical teams, and IP&C to enhance the cleanliness of our facilities. The PFI team is discussing with the CEFO to redefine the KPIs for cleaning scores to align them more closely to the NSC. The objective is to determine the appropriate measures and provide a better understanding of what is being measured, by whom, and how.	1) Improvement to work towards the 95% target for 4 & 5-star cleaning audits for 2024 at CHU & 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 *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

3. Assurance report: Growing Stronger Together





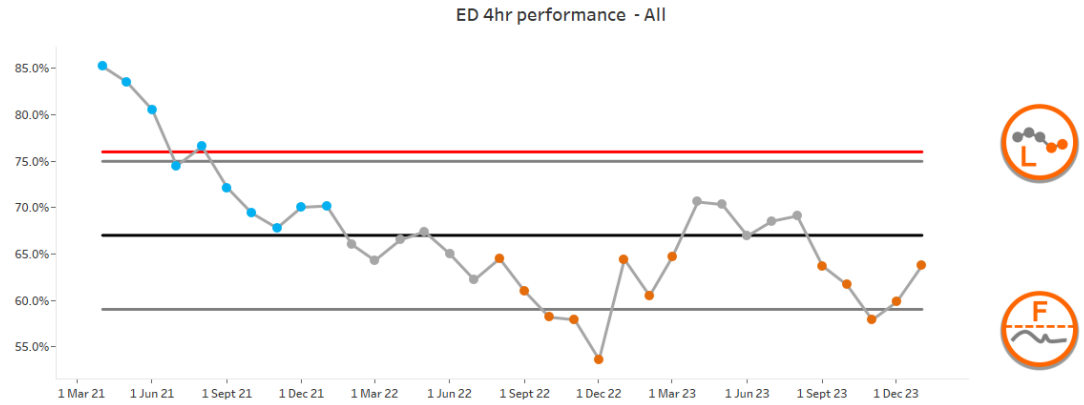
Benchmarking: September 23 (monthly performance – *lag due to availability of published data from National Sickness Absence Rate report*).

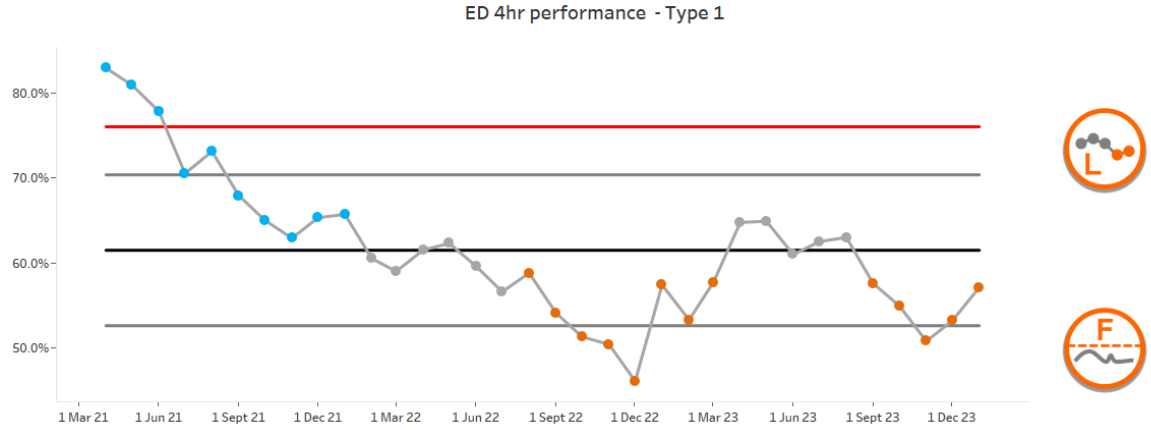
OUH: 3.7% **National: 5.0%** **Shelford: 4.6%** Buckinghamshire Healthcare NHS Trust: 3.7% Royal Berkshire NHS Foundation Trust: 3.6% Oxford Health: 4.5% South Central Ambulance Service: 6.5%

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Sickness absence performance (rolling 12 months) was 3.8% in December and has remained at 3.8% in January. 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 monthly figure for M10 is 4.5% which is an increase from 4.4 % in M9. The absence reasons Colds/Cough/Flu have steadily increased since Autumn and are currently at 15.2%. Mental Health reasons account for 17.8% of all absences. Of those currently absent from work, 26.5% are long term.	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. HR sickness meetings and training sessions are taking place to ensure consistency in managing and supporting managers. 4. Drop-in sessions and sickness workshops are being arranged to provide extra support to managers to deal with absence cases. 5. Monthly meetings with Occupational Health are helping to move along long-term sickness cases. 6. Reports containing absence management information are being disseminated to areas with frequent absences being highlighted. 7. 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: Operational Performance

Oxford University Hospitals NHS Foundation Trust



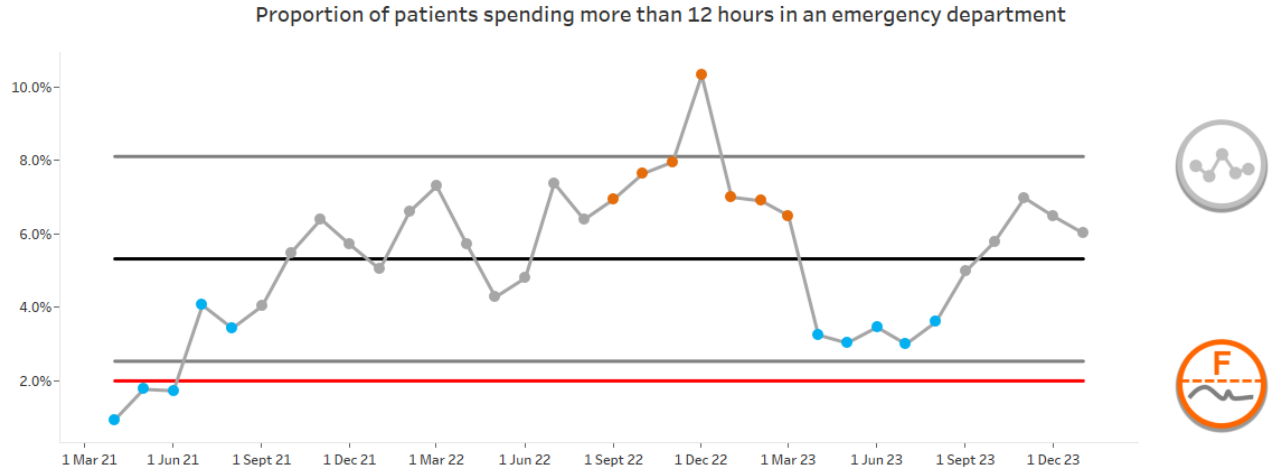


Benchmarking: ED (All types): January 24				
OUH: 63.7%	**National: 68.1%**	**Shelford: 68.5%**	BHT: 69.5%	RBH: 69.1%

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

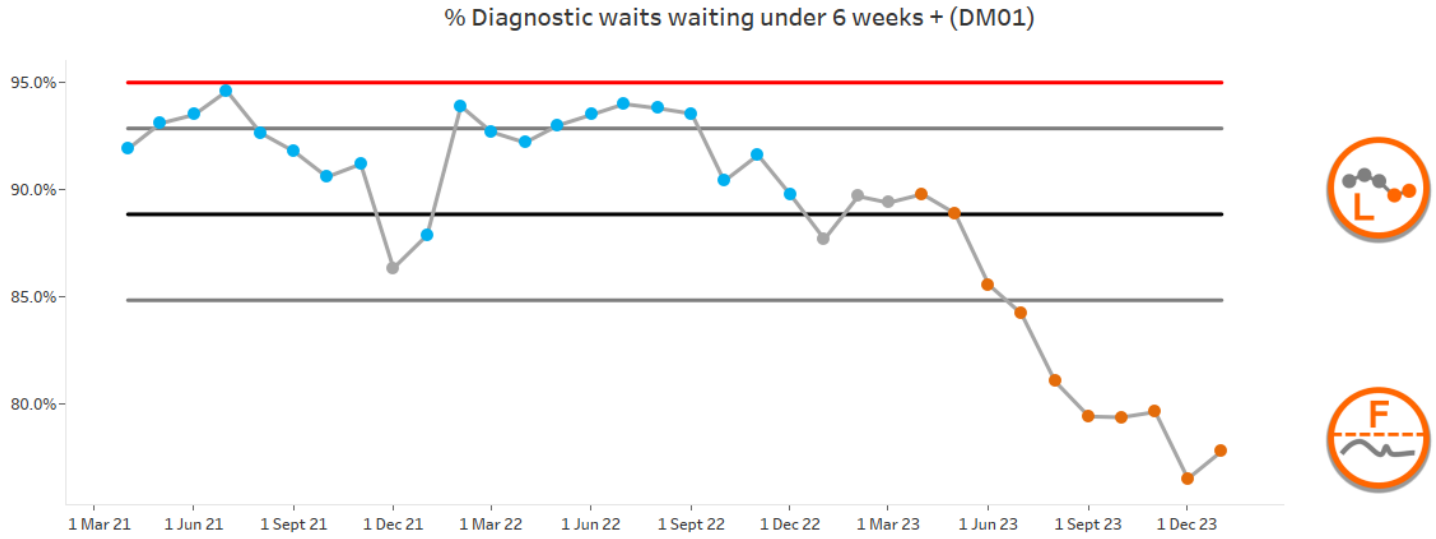
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The Emergency Department (ED) 4-hour performance (All types) was 63.74% in January and for Type 1 activity, performance was 57.1%. 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 61.94% for all types and 52.16% for Type 1 at the John Radcliffe Hospital (JR) and 69.26% for all types and 69.24% for type 1 at the Horton Hospital in December. Whilst there has been two consecutive months of improvement, performance has been very challenged since the autumn with winter pressures impacting patient flow and acuity. Attendances were significantly higher in January 2024 compared to the January 2023, predominantly at the JR. The number of patient's medically optimised for discharge was also higher than the same period last year. This position resulted in three separate occasions of reaching Operational Pressure Escalation Level 4 (OPEL 4) and the associated impact on performance as a result. Wait to be seen continues to be the most significant breach reason on both sites for admitted and non-admitted patients attributing to 60% of all 4-hour breaches. This occurs predominantly out of hours impacting waiting times at the start of each day. Overnight senior decision making is a key area of focus; interviews for ED consultants are due to take place early in March. The Quality Improvement initiatives that commenced in January are progressing well and are beginning to have some impact for those that have come to fruition. Occupancy has remained high in January at 95.80% (97.7% at JR) despite the additional funded capacity open on the JR and Horton sites. Work is underway with the de-escalation of the Surge Plan that was enacted in early January.	**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. During Q4, overnight consultant cover will be available periodically, supported by non-recurrent funding. • 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 – performance in December was 82%. **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 3 Quarter 4 – Partially on track (risk to fill rate) Quarter 1: On Track. Quarter 2: Completed Quarter 3: Reporting to commence – Completed. Trust Wide Urgent Care Group Quarter 2: On Track Quarter 3: New reports to be available from November – Completed Quarter 4: Improvement cycles to be undertaken. Trust Wide Urgent Care Group	BAF 4 CRR 1133 (Red)	Sufficient *Standard operating procedures in place, staff training in place, local audit undertaken in last 12 months, and independent audit completed in last 18 months*

3. Assurance report: Operational Performance, *continued*



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The proportion of patients spending more than 12 hours in an emergency department was 6% in January. Performance has remained slightly above the mean average since April '21 of 5.6% for the last four months and significantly above the target of 2%. The indicator has consistently not achieved the target. Both sites have struggled to sustain the improvement seen earlier in the year. The wait to be seen in ED continues to be a challenge with an increasing percentage of breaches attributed to this (60% of 4-hour breaches for January). Average length of stay in both the ED's has remained on a par with the previous months at 4hours 22minutes at Horton and 5 hours 6 minutes at the JR. However, average length of stay has continued to reduce for non-admitted patients and was 4hrs 10mins for January and average length of stay for admitted patients has reduced to 6hours and 43 minutes following a prolonged period of deteriorating performance. Bed occupancy across all sites has remained high at 95.8% and AAU at the JR has been required to remain open at times. Capacity has improved at the Horton and there has been no requirement to increase capacity. The Discharge Lounge co-located on Oak High Care was embedded well and is supporting a good number of discharges per day. The surge plan that was designed and deployed at pace in January has been reviewed and a de-escalation programme designed which will be worked through February. 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 five consecutive months, OUHFT has been the best performing Shelford Trust for patients with a length of stay over 21 days. 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 NHS FT.	**Departures within 60mins of the Decision to Admit** • Three pathways – Mental Health, Frailty and Heart Failure have all commenced their Clinical Pathways QI work. Each pathway have a number of initiatives that are currently progressing through the PDSA cycles of improvement. • Launch of the live bed state project across the Trust was held in October. Project plan in development with implementation starting from March. • 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 and de-escalation through February.	Quarter 4: On track Trust Wide Urgent Care Group	BAF 4 Link to 1133 (Red)	Sufficient *Standard operating procedures in place, staff training in place, local audit undertaken in last 12 months, and independent audit completed in last 18 months*

3. Assurance report: Operational Performance, *continued*



Benchmarking: December 23 DM01	
OUH	76.5%
National	79.1%
Shelford	68.1%
ICS	BHT: 61.5% RBH: 74.5%

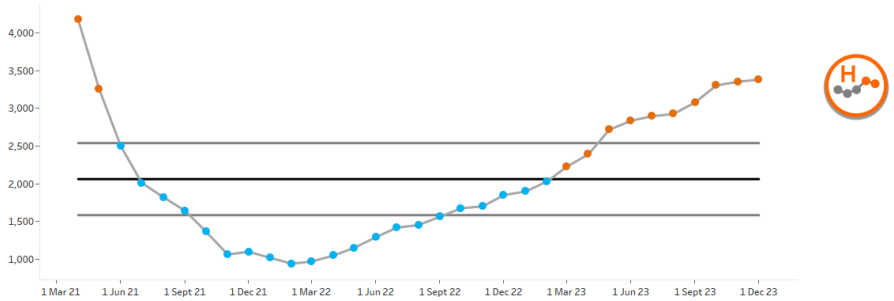
ICS key	
BHT	Buckinghamshire Healthcare NHS Trust
RBH	Royal Berkshire NHS Foundation Trust

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 percentage of Diagnostic waits waiting under 6 weeks+ (DM01) was 77.8% in January. 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 above capacity. Ongoing insource supplier unable to offer same levels of additional capacity due to a competitive market and complexity of cases. **Non-Obs Ultrasound (US)**: Demand and capacity mismatch for US examinations. This is due to Sonographers being a hard to recruit group and increased demand, particularly in gynaecology work **Endoscopy:** Demand and capacity mismatch for procedures (Gastroscopy, Colonscopy, Flexi sigmoidsocopy). Outpatient backlog clearance has required re-allocation of workforce and generated significant additional requests for these diagnostics.	**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 has delayed agreement between ICB's. Notice period has been given in February. **Clinical Neurophysiology:** improving position however plateauing. Technicians to be fully trained to conduct EMGs. Business case to convert insourced capacity to recurrent capacity approved in December and this will come into effect from April 2024. **Non-obs US**: Health-share providing additional imaging capacity. Agency staff and alternative US support is also being sought. **Endoscopy:** In-house weekend sessions scheduled until end of March to maintain performance. Northumbria triage model started in January and capacity from Outpatient Network also due to commence in January. Both initiatives are aimed at supporting the reduction in patients needing investigations. Exploring CDC capacity from 2024/25 to support endoscopy/2WW diagnostics. Long line agency cover for endoscopy nursing team.	Weekly Assurance meeting will monitor all actions on a bi-weekly basis **Audiology:** Improvement expected once transfer to AQP agreed via ICS – December 2023 (notice given in February therefore impact from May/June 2024) **Clinical Neurophysiology:** Improvement from May 2024 **Non-obs US**: March 2024 **Endoscopy:** Expected demand to level off and start to recover in Q4. Seek temporary ERF funding to aid recovery and explore conversion of additional session activity into substantive appointments.	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*

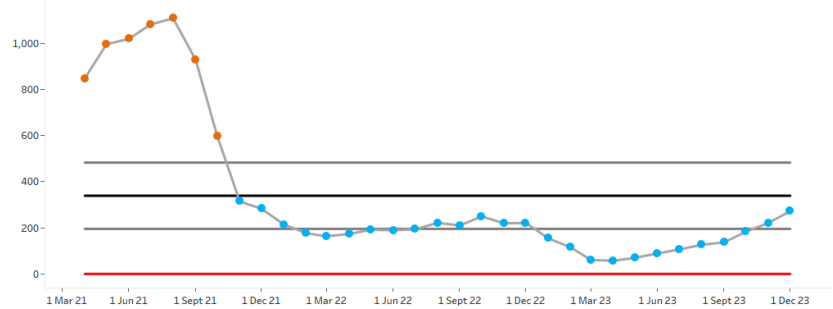
3. Assurance report: Operational Performance, *continued*

Oxford University Hospitals NHS Foundation Trust

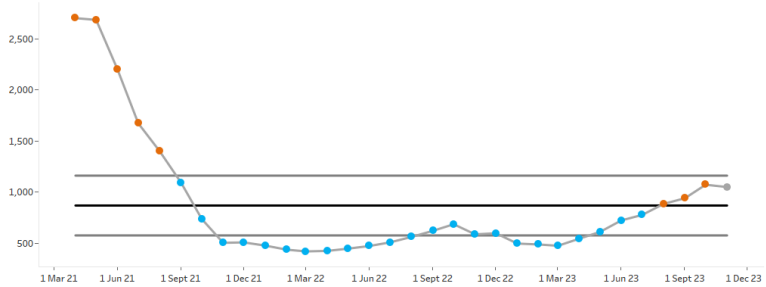
Total patients waiting more than 52 weeks to start consultant-led treatment



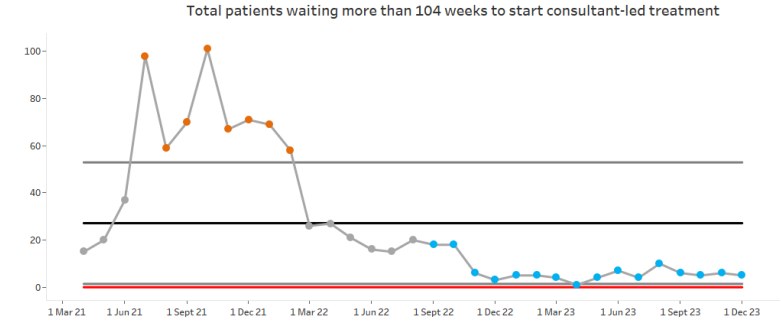
Total patients waiting more than 78 weeks to start consultant-led treatment



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



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

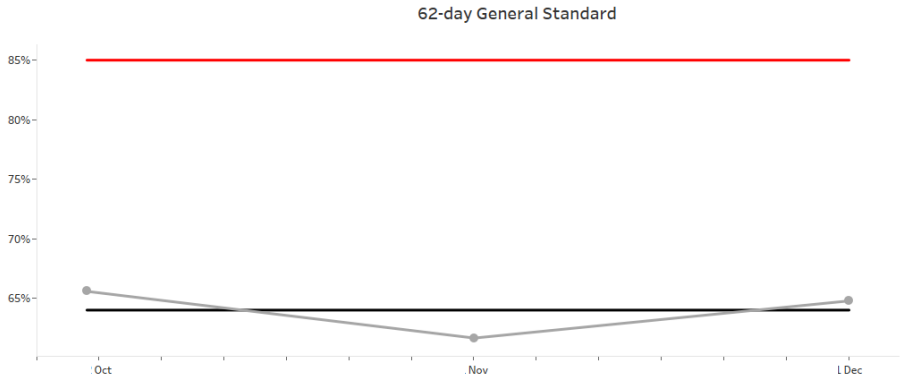


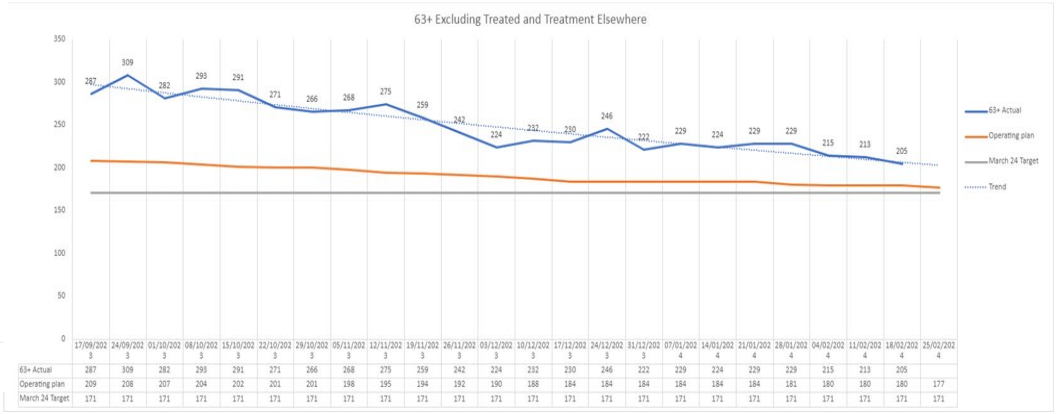
Benchmarking >52-weeks: December 23	
OUH	3,379
National	1,698 (avg.)
Shelford	3,755 (avg.)
ICS	BHT: 2,207 RBH: 11

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 3,333 in January. 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** - 4 patients breached >104 weeks. Three Orthopaedic patients (two due to patient choice and one complex case) and a Urology patient (due to capacity). **78 weeks** - specialties that are experiencing challenges mainly include Orthopaedics, Urology, Ophthalmology (Cornea's) 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 Action and 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**. Recovery will be challenged with additional Industrial Action (February 2024)	• **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. • **Ophthalmology services** are in discussions at System level for Corneal procedure mutual aid • **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 *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

3. Assurance report: Operational Performance, *continued*



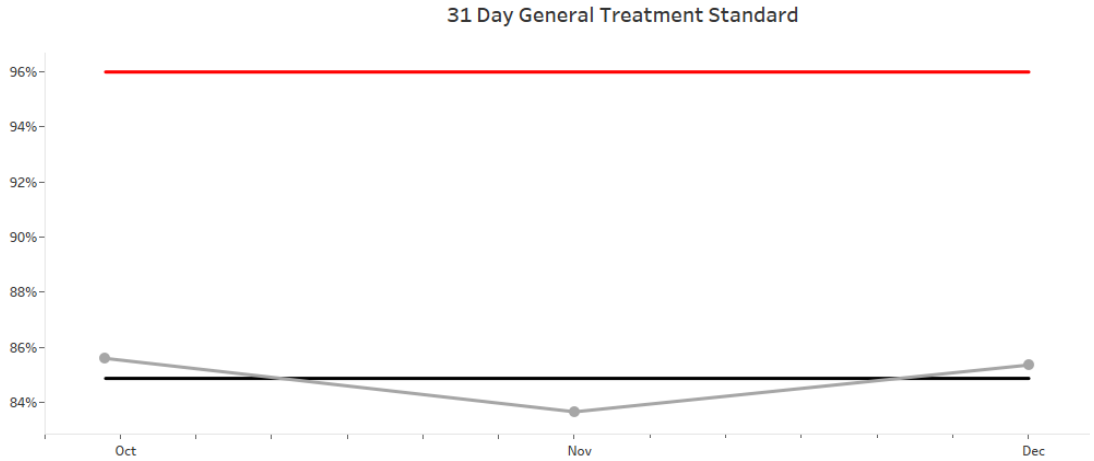


Benchmarking: October 23 62-day General Standard	
OUH	
National	Not yet available
Shelford	Not yet available
ICS	BHT: N/A RBH: N/A

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 64.8% in December, 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 continues to reduce from its peak in September 2023 and is a high priority of focus within the Trust. All tumour sites apart from Haematology (Acute & non-Acute Leukaemia, Myeloma), Head & Neck-Thyroid, Skin, Upper-GI (Liver & Bile ducts, Stomach) and Urological (Testicular) and Other are non-compliant for this standard in November. **Challenges identified:** • Complex tertiary level patients (5%) • Some slow pathways and processes (1%) • Capacity for some surgery, diagnostics and oncology (70%) • Late inter provider transfers (16%) • Patient reasons (8%) **>62-day PTL** impacted by the above with a backlog of **205** (census 19/02/24) against a year-end target of 171 (19.8% above at present) and above trajectory set within the operating plan of 180 (13.8% above at present)	**The Cancer Improvement Programme** launched in 2022/23 with a focus on 28-day Faster Diagnosis Standard (FDS). For December, **the Trust was 57th best out of 138 national providers and has delivered this standard consecutively since June 2022**. FDS remains a key priority for 2023/24 as well as addressing the challenges faced with delivering treatment for our patients by day 62. **Performance of >62-day PTL vs plan –** recovery includes: • Incomplete and late Inter-Provider Transfer analysis and escalation • Surgical capacity through theatre reallocation, • Patient engagement through the Personalised Care agenda • SOP and escalation of benign patients awaiting communication **Waiting List Census 19/02/2024:** **Urology** still holds the highest proportion of long waiting patients but is already delivering its individual year-end target (64) since developing a one-stop clinic and MRI pathway with radiology services. **Gynae** holds the second highest volume but again are below their individual trajectory. A referral management SOP is being evaluated for endorsement and adoption, which will expect to have an improving impact. **Brain:** due to the revised cancer waiting times guidance, low grade Brain pathways are reportable therefore an in-year review has been carried out on the 171 target. The target is now expected to achieve 190 for end of March.	Faster Diagnostic Standards (FDS) to be achieved by all tumour sites outlined within the FDS Framework 2023/2024 190 patients over 62 days on the Patient Tracking List by March 2024 (in-year revision) Urology one-stop MRI clinic: adopted. Reviewing biopsy next step to further improve Prostate pathway. Gynae referral management: On track SOP for referral management: On track	BAF 4 Link to CRR 1135 (Amber)	Sufficient *Standard operating procedures in place, staff training in place, local audit undertaken in last 12 months and independent audit undertaken in previous 18 months*

3. Assurance report: Operational Performance, *continued*

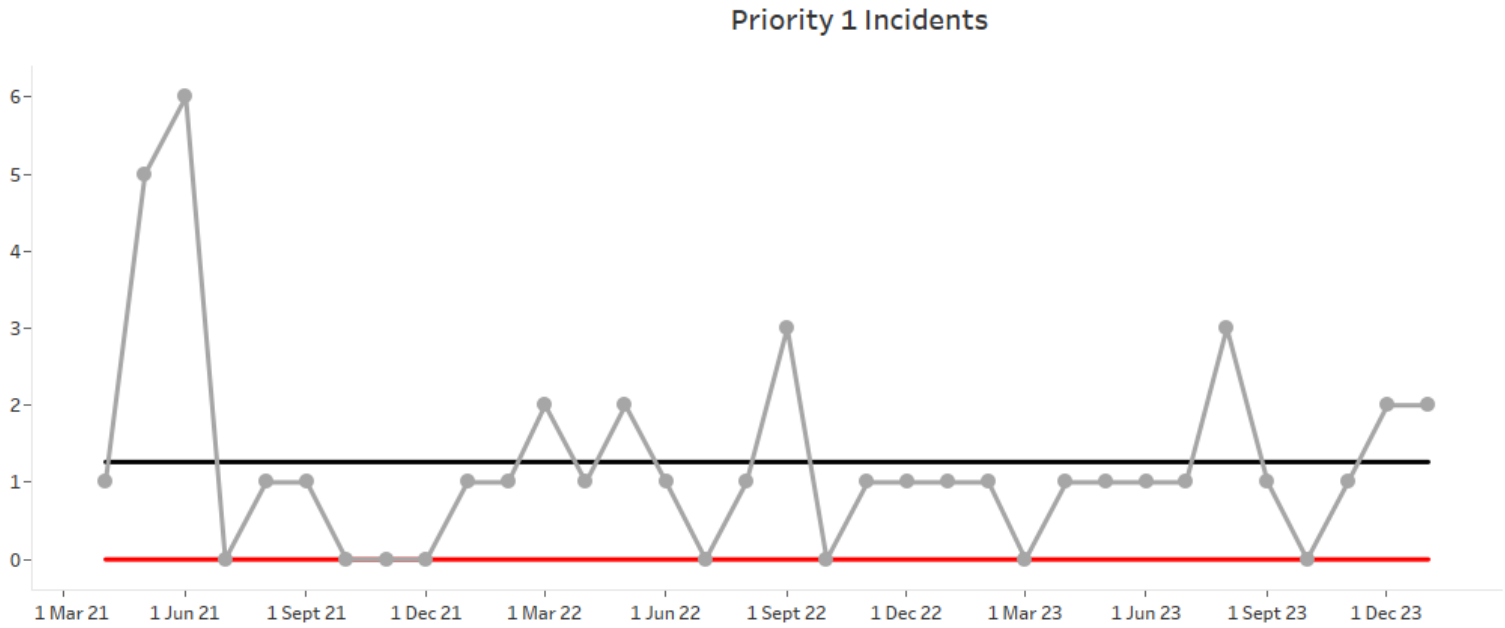


Benchmarking: October 23 31-day General Standard	
OUH	
National	Not yet available
Shelford	Not yet available
ICS	BHT: N/A RBH: N/A

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

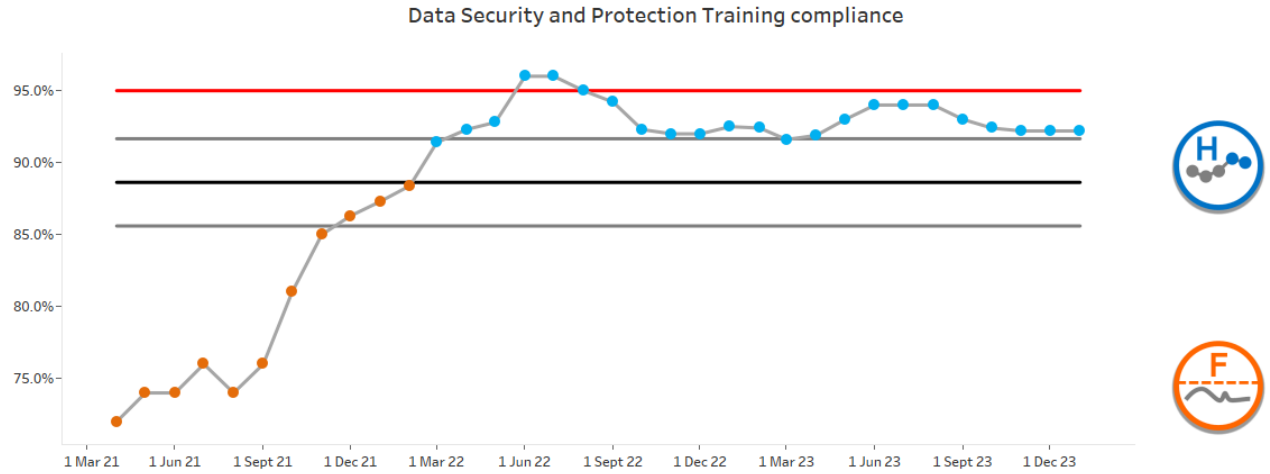
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Reporting of Cancer Standards have changed from October 2023 in line with the National Cancer Waiting Times guidance. Cancer performance against the 31-day combined standard was 85.4% in December, 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 November was 83.7% therefore an improving position. Surgery is the key driver in poor performance with over 70% of breaches due to surgery capacity (impact exacerbated by a sequence of Industrial Actions).	Transfer benign capacity to cancer where available until the end of the financial year to reduce the time waiting for surgery. Local consideration given to the impact this may have to 65-week recovery at specialty level. Work underway with prehab services to ensure patients are fully optimised for clinical intervention and recovery. Focussed areas are Upper GI and Colorectal procedures with a plan to extend into Head & Neck services and other specialties. Work with primary care to specifically educate patients on smoking cessation initiatives to reduce delays from decision to treat to procedure date.	Q4 2023/24 Q4 2023/24 staggering into 2024/25 for other specialties not named. March 2024	BAF 4 Link to CRR 1135 (Amber)	Sufficient *Standard operating procedures in place, staff training in place, local audit undertaken in last 12 months and independent audit undertaken in previous 18 months*

3. Assurance report: Corporate support services – Digital



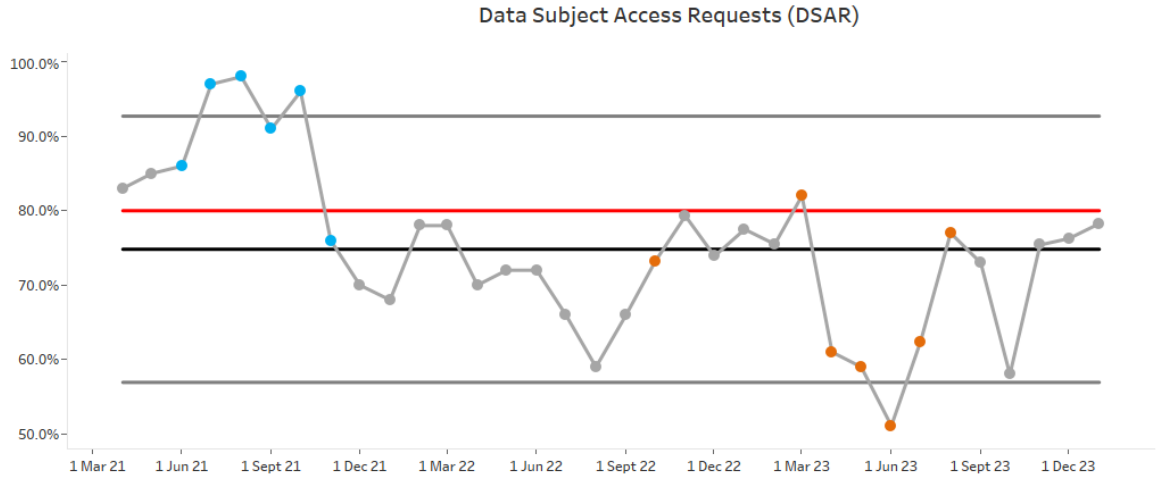
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
There were two Priority 1 incidents in January 2024 against a target of zero. On 10/01/2024 at 10:04 Configuration change error led to delays to ADT messages between EPR and other systems. (approx 1 hour interruption to affected services) On 31/01/2024 at 16:01 SEND system unavailable due to system offline. (approx 8 hour interruption to affected services)	Configuration updated to have correct settings, change record updated to reflect failed change. Memory configuration software bug identified and workaround put in place.	Further checks and peer review in place for future changes. Configuration change made according to knowledge base		***Sufficient*** *Standard operating procedures in place, staff training in place, local audit undertaken in last 12 months, and independent audit completed in last 18 months.*

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



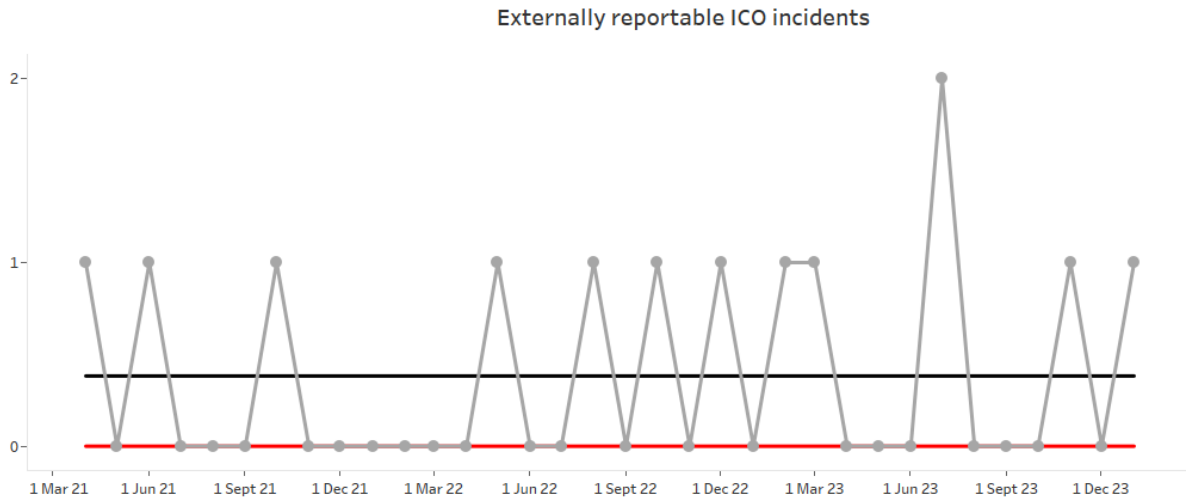
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Data security and Protection Training (DSPT) compliance was 92.2% in January, below the target 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 As part of DSPT compliance an education campaign for IG and cyber security issues has started – reminders and tips to complete IG training are included within this package. Completion of IG training forms part of the mandatory training associated with VBAs, so the completion rate will improve as we enter the appraisal window Design work on the new training/communications package is underway – the first session on Phishing is complete is on MyLearningHub.	Guidance for TNA was updated by NHSE on 15th January 2024 – changes are being included before TNA is submitted to DOC and then Trust Board. Actions will be overseen by the Digital Oversight Committee	BAF 6	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

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



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Data Subject Access Request compliance was 76.3% in M10, below the target of 80%. Performance exhibited common cause variation. Performance of the Medical Records team who handle the bulk of SARs for the Trust has stabilised – though they are still understaffed and recruiting. PACS do not have dedicated SAR handling staff so completion of these requests competes with clinical needs.	1) A new software package to better manage subject access requests across all teams is being brought in and deployed in the Medical Records SAR team. 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.	1) New software package rollout has started within Medical Records SAR 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 March 2024 DOC. 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*

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



Summary of incident	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Appointment form for one Deanery applicant sent to another Deanery applicant via the TRAC recruitment system. This included details of the wrong individual's - name, DOB, address, passport number, bank details etc. being disclosed to another applicant.	Incident reported to ICO via DSPT reporting tool. OUH Data Protection Officer working with Director of Workforce to investigate incident. Final report from Workforce has not been received at time of writing.	OUH yet to receive outcome or further questions from ICO - will update in next IPR	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	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	

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