Oxford University Hospitals
NHS Foundation Trust

Integrated Performance Report

M12 (March data)

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1. Executive summary

Oxford University Hospitals NHS Foundation Trust

Overview

In March, our staff supported patient care by meeting targets for the vacancy rate, turnover and non-clinical appraisals, the latter two continued to exhibit improving Special Cause Variation (SCV). The cleaning score used to measure our PFI sites was also compliant across the John Radcliffe, Churchill Hospital and Nuffield Orthopaedic Centre. The target time to hire continues to achieve the performance standard.

Measures related to patient safety and experience of care included the achievement of our targets or thresholds in Klebsiella cases and Pseudomonas, and VTE Risk Assessments. Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) rates demonstrate fewer patient deaths than expected and care was also supported by our Care Hours Per Patient Day overall, exhibiting improving SCV. No never events were reported and Pressure Ulcer incidents per 10,000 beddays (Category 2 and present on admission Category 1+) were better than the performance threshold. We also reported improving SCV for the proportion of patients discharged from hospital to their usual place of residence.

The Cancer Faster Diagnosis standard achieved the performance standard, and supporting this indicator, the level of diagnostic activity compared to 2019/20 remains significantly above the baseline and exhibited improving SCV. Successes raise in Divisional Performance Reviews continue to be recognised, incorporating contributions of our staff in improving the care and experience for our patients, workforce and 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, 35 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 SCV to be included in assurance reporting. Assurance reporting references updates to Tiering requirements for Elective, Cancer and Urgent and Emergency Care.

Quality, Safety and Patient experience

Performance targets were not achieved for Non-Thematic Patient Safety Incidents, and FFT percentage positive responses for Inpatients, ED and Outpatients. We recorded hospital infections worse than our monthly threshold for MRSA, Clostridium difficile and E.Coli, deteriorating SCV for MSSA cases, 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 (for Children). 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.

Growing Stronger Together

Rolling 12-month sickness absence rates exhibited improving SCV and favourable performance relative to the National, Shelford and ICS providers, but remain above the target, along with the monthly sickness absence rate (which exhibited CCV). All other targets measured within the domain of Growing Stronger Together are meeting targets for Turnover (improving SCV), Appraisals (non-medical) (improving SCV) and Time-to-hire (Common Cause Variation (CCV).

Operational Performance

The number of patients waiting in the categories over 52 weeks continued to exhibit deteriorating SCV. We reduced the number of patients waiting over 65 (CCV), 78 weeks (improving SCV) and 104 weeks (improving SCV). We did not meet the diagnostic (DM01) standard, and this indicator exhibited deteriorating SCV, noting high volumes of activity relative to 2019/20 (improving SCV). Assurance reports are also included for the 62-day and 31-day Cancer Standards. For both long waiting patients on RTT pathways and cancer patients, specialty and tumour site plans are supported by the Elective Recovery Fund schemes and other targeted initiatives. Patients attending our emergency departments and being seen within four hours did not meet the performance standard or the trajectory for March and exhibited CCV. The number of patients spending over 12 hours in the department was below target (CCV). Assurance templates are included for General and Acute (G&A) bed occupancy and the proportion of ambulances delayed over 30 minutes, both due to exhibiting deteriorating SCV.

Finance

The Income and Expenditure (I&E) reported performance in March was a £1.2m deficit. This included several non-recurrent income and expenditure items, which are set out in the IPR. The Trust delivered an outturn deficit position of £10.7m for the financial year (which was £0.1m better than forecast). The underlying in-month deficit increased in March to £8.8m, this deficit has more than doubled compared to the average underlying monthly deficit over the first half of the financial year. Cash was £46.8m at the end of March, £15.0m higher than the previous month and it is £30m higher than forecast. The improvement was due to additional income received (£12m), reduction in PDC dividend payable in March (£7.7m) and the timing benefit of payments (including capital) (£10m) that will catch up in April and May.

Digital

We have also included assurance templates on DSPT / information governance training compliance, Freedom of Information request performance, the externally reportable ICO incident and Data Subject Access Request (DSAR) response times.

Data quality

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

2. a) Indicators identified for assurance reporting

Oxford University Hospitals NHS Foundation Trust

	Common cause variation	Special cause variation - improving	Special cause variation - deterioration	Other *(where an increase or decrease has not been deemed improving or deteriorating, where SPC is not applicable, or the indicator has been identified for assurance reporting in the absence of performance vs target or special cause variation)*
Quality, Safety and Patient Experience	Not achieving target: • MRSA cases: HOHA+COHA • C-diff cases: HOHA+COHA • E.Coli cases • Pressure Ulcer incidents per 10,000 beddays (Cat 3&4) • FFT Inpatient % positive • FFT Outpatient % positive • FFT ED % positive • Safeguarding (Adults) training compliance L1 - L3	Not achieving target: • % of complaints responded to within agreed timescales • Safeguarding (Children) training compliance L1 - L3	Not achieving target: • Reactivated complaints • MSSSA cases No target: • Incidents with moderate harm or above per 10,000 beddays. • Assault, Aggression and Harassment.	No target: • Children's safeguarding activity • Adult safeguarding activity Not achieving threshold: • Non-Thematic Patient Safety Incident Investigations
Growing Stronger Together	Not achieving target: • Sickness absence (monthly)	Not achieving target: • Sickness absence (rolling 12-month)		
Operational performance	Not achieving target: • ED 4-hour performance (all types) • ED 4-hour performance (type-1) • Proportion of patients spending more than 12 hours in the Emergency Department • Ambulance • Patients waiting more than 65 weeks	Not achieving target: • Patients waiting more than 78 weeks • Patients waiting more than 104 weeks	Not achieving target: • % Diagnostic waits under 6 weeks (DM01) Not achieving target: • Patients waiting more than 52 weeks	No target: • Proportion of ambulances delayed over 30 minutes Not achieving threshold: • 62- day General Standard • 31-day General Standard
Corporate Support Services	Not achieving target: • Freedom of Information % responded to within target time • Data Subject Access Requests • Externally reportable ICO incidents	Not achieving target: • Data Security and Protection Training compliance		

2. b) SPC indicator overview summary

Oxford University Hospitals NHS Foundation Trust

Quality, Safety and Patient Experience Summary

Latest Indicator Period: Mar-2024

Indicator Description	Period	Performance	Target / Threshold	Met?	Mean	LCL	UCL
MRSA bacteraemia infection rate COHA and HOHA (per 10,000 beddays)	Mar-24	0.3	-	-	0.2	-0.5	0.8
MRSA cases: HOHA+COHA	Mar-24	1	0	No	0	-1	2
Clostridium difficile infection rate COHA and HOHA (per 10,000 beddays)	Mar-24	5.0	-	-	3.5	0.0	7.0
C-diff cases: HOHA+COHA	Mar-24	17	9	No	10	0	20
E. coli infection rate COHA and HOHA (per 10,000 beddays)	Mar-24	4.4	-	-	5.3	0.7	9.8
E. Coli cases: HOHA+COHA	Mar-24	15	13	No	15	2	29
MSSA cases: HOHA+COHA	Mar-24	10	-	-	5	0	11
Klebsiella cases: HOHA+COHA	Mar-24	6	7		8	1	15
PSAR cases: HOHA+COHA	Mar-24	2	4		5	-4	13
Number of Never Events	Mar-24	0	0		0	-	-
Non-Thematic Patient Safety Incident Investigations	Mar-24	2	0	No	2	-	-
Learning MDT Reviews (LMDTR)	Mar-24	5	-	-	5	-	-
After Action Reviews (AAR)	Mar-24	0	-	-	9	-	-
VTE Risk Assessment (% admitted patients receiving risk assessment)	Mar-24	97.6%	95.0%		98.1%	97.7%	98.4%
CAS alerts breaching deadlines at end of month and/or closed during month beyond deadline	Mar-24	0	0		0	-	-
Medication incidents causing moderate harm, major harm or death	Mar-24	2	-	-	2	-2	6
Mortality HSMR	Mar-24	90.3	100.0		92.5	-	-
Mortality SHMI	Mar-24	92.0	100.0		93.1	-	-
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	Mar-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	Mar-24	1401	-	-	1348	1317	1379
Number of active clinical research studies (commercial)	Mar-24	384	-	-	351	337	365
Number of active clinical research studies (non commercial)	Mar-24	1017	-	-	997	977	1016
Number of incidents with moderate harm or above per 10,000 beddays	Mar-24	49.8	-	-	38.3	22.0	54.7
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 2)	Mar-24	18.1	26.0		27.2	14.2	40.2
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 3 and 4)	Mar-24	3.3	3.0	No	2.8	0.1	5.6
Pressure Ulceration incidents per 10,000 beddays (Present on admission Cat 1+)	Mar-24	87.7	114.0		113.9	87.9	139.8
Harm from Falls (Moderate and above)	Mar-24	2	-	-	4	-3	11
Harm from Falls per 10,000 beddays (moderate and above)	Mar-24	0.6	-	-	1.5	-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

Number of complaints	Mar-24	123	-	-	100	55	145
Number of complaints per 10,000 beddays	Mar-24	36.4	-	-	34.8	19.7	49.9
% of complaints responded to within agreed timescales	Mar-24	85.9%	95.0%	No	71.4%	51.9%	90.8%
Reactivated complaints	Mar-24	22	1	No	9	0	18
Number of RIDDORs	Mar-24	3	5		3	-1	7
Health and Safety related incidents - Assault, Aggression and harassment	Mar-24	174	-	-	133	61	204
Incident rate of violence and aggression (rate per 10,000 beddays)	Mar-24	51.5	-	-	45.9	21.8	70.0
FFT inpatient % positive	Mar-24	94.6%	95.0%	No	95.1%	93.5%	96.7%
FFT outpatient % positive	Mar-24	94.3%	95.0%	No	93.8%	92.5%	95.0%
FFT ED % positive	Mar-24	81.2%	85.0%	No	78.4%	70.4%	86.5%
FFT maternity % positive	Mar-24	0.0%	90.0%	No	85.3%	57.2%	113.5%
Inpatient FFT (response rate)	Mar-24	24.6%	-	-	25.6%	22.5%	28.8%
Outpatient FFT (response rate)	Mar-24	9.3%	-	-	11.2%	5.5%	16.9%
A&E FFT (response rate)	Mar-24	26.0%	-	-	24.9%	21.6%	28.2%
Maternity FFT (response rate)	Mar-24	0.0%	-	-	8.9%	2.4%	15.3%
Adult safeguarding activity	Mar-24	939	-	-	708	513	904
Children's safeguarding activity	Mar-24	672	-	-	504	268	741
Number of safeguarding consultations initiated by provider (both to internal and external organisations)	Mar-24	1611	-	-	1214	864	1564
Safeguarding (Children) training compliance L1 - L3	Mar-24	89.0%	90.0%	No	83.8%	77.6%	90.1%
Safeguarding (Adults) training compliance L1 - L3	Mar-24	86.0%	90.0%	No	12.1%	4.7%	19.6%
Trust level: CHPPD vs budget	Mar-24	-3.9	-	-	-37.1	-87.0	12.9
Trust level: CHPPD vs required	Mar-24	4.1	-	-	-13.3	-34.8	8.2
Mothers birthed	Mar-24	613	625	-	625	554	696
Babies born	Mar-24	616	-	-	635	563	707
Scheduled Bookings	Mar-24	733	750	-	708	571	845
Inductions of labour from iView	Mar-24	195	-	-	147	102	193
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	Feb-24	91.9%	95.0%	No	92.9%	83.4%	102.5%
PFI: % cleaning score by site (average) CH	Feb-24	91.2%	95.0%	No	93.6%	82.6%	104.6%
PFI: % cleaning score by site (average) NOC	Feb-24	100.0%	95.0%		97.9%	93.9%	102.0%

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

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Growing Stronger Together Summary

Latest Indicator Period: Mar-2024

Indicator Description	Period	Performance	Target / Threshold	Met?	Mean	LCL	UCL
Vacancy rate %	Mar-24	5.5%	7.7%		6.7%	5.7%	7.7%
Turnover rate (rolling 12 months)	Mar-24	10.2%	12.0%		11.3%	10.7%	11.9%
Sickness absence (rolling 12 months)	Mar-24	3.8%	3.1%	No	4.1%	3.9%	4.3%
Sickness absence (monthly)	Mar-24	4.0%	3.1%	No	4.2%	3.2%	5.3%
Appraisal compliance (non medical)	Mar-24	94.1%	85.0%		73.1%	52.8%	93.4%
Core skills training compliance	Mar-24	88.7%	85.0%		89.0%	86.0%	92.0%
Time to hire (average days)	Mar-24	49.3	53.0		50.4	40.4	60.5

Operational Performance Summary

Latest Indicator Period: Mar-2024

Indicator Description	Period	Performance	Target / Threshold	Met?	Mean	LCL	UCL
Proportion of ambulance arrivals delayed over 30 minutes	Feb-24	10.9%	-	-	9.4%	2.1%	16.8%
Ambulance turnaround time > 60 minutes	Feb-24	1.3%	-	-	1.4%	-0.5%	3.2%
ED 4hr performance - All	Mar-24	72.2%	76.0%	No	67.1%	58.9%	75.3%
ED 4hr performance - Type 1	Mar-24	67.3%	76.0%	No	61.6%	52.4%	70.7%
Proportion of patients spending more than 12 hours in an emergency department	Mar-24	4.5%	2.0%	No	5.3%	2.6%	8.1%
Proportion of patients discharged from hospital to their usual place of residence	Mar-24	95.7%	-	-	92.2%	91.0%	93.5%
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	Mar-24	97.5%	-	-	94.6%	91.8%	97.5%
Theatre utilisation (elective)	Mar-24	99.0%	85.0%		91.0%	87.3%	94.8%
% Diagnostic waits waiting under 6 weeks + (DM01)	Mar-24	83.6%	95.0%	No	88.5%	84.3%	92.8%
Total patients waiting more than 52 weeks to start consultant-led treatment	Mar-24	3586	-	-	2179	1720	2639
Total patients waiting more than 65 weeks to start consultant-led treatment	Mar-24	685	-	-	875	571	1178
Total patients waiting more than 78 weeks to start consultant-led treatment	Mar-24	80	0	No	325	179	471
Total patients waiting more than 104 weeks to start consultant-led treatment	Mar-24	1	0	No	25	1	49
62-day General Standard	Feb-24	64.7%	85.0%	No	64.1%	-	-
28-day FDS General Standard	Feb-24	81.2%	75.0%		78.8%	-	-
31 Day General Treatment Standard	Feb-24	87.5%	96.0%	No	84.7%	-	-
Cancer: % patients diagnosed at stages 1 and 2	Apr-21	0.0%	-	-	0.0%	-	-
62 Day incomplete pathways >62 days	Mar-24	314	-	-	287	214	359
62 Day incomplete pathways >104 days	Mar-24	106	-	-	91	62	120
Total DC activity undertaken compared with 2019/20 baseline	Mar-24	86.9%	-	-	88.8%	72.1%	105.5%
Total IP elective activity undertaken compared with 2019/20 baseline	Mar-24	81.8%	-	-	83.1%	59.5%	106.7%
Total first outpatient activity undertaken compared with 2019/20 baseline	Mar-24	97.9%	-	-	104.4%	79.0%	129.7%
Total follow up outpatient activity undertaken compared with 2019/20 baseline	Mar-24	119.9%	-	-	110.8%	84.1%	137.4%
Total diagnostic activity undertaken compared with 2019/20 baseline	Mar-24	128.2%	-	-	116.1%	101.0%	131.1%
Total patients treated for cancer compared with the same point in 2019/20	Mar-24	120.2%	-	-	121.3%	80.9%	161.6%

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

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

Oxford University Hospitals NHS Foundation Trust

Finance Summary

Latest Indicator Period: Mar-2024

Indicator Description	Period	Performance	Target / Threshold	Met?	Mean	LCL	UCL
In-month financial performance Surplus/Deficit £'000	Mar-24	-1189.0	10722.0	No	-205.8	-9056.8	8645.2
Adjusted in-month financial performance Surplus/Deficit £'000	Mar-24	-8819.0	-	-	-2679.2	-7180.9	1822.6
Year-to-date financial performance Surplus/Deficit £'000	Mar-24	-10748.2	-2854.0	No	-7983.8	-15197.9	-769.6
Elective recovery funding (ERF) value-weighted activity % In month	Mar-24	99.7%	103.0%	No	94.7%	74.0%	115.4%
Cash £'000	Mar-24	46813	12098		43063	17422	68705
BPPC £ %	Mar-24	84.8%	95.0%	No	90.2%	83.0%	97.4%
BPPC Volume %	Mar-24	71.2%	95.0%	No	79.6%	72.6%	86.6%
In-month ICS CDEL capital expenditure	Mar-24	21804.2	4762.0	-	2825.1	-3767.9	9418.1
Efficiency delivery £'000	Mar-24	14867.1	17151.0	No	3864.3	-794.5	8523.0

Corporate support services – Digital Summary

Latest Indicator Period: Mar-2024

Indicator Description	Period	Performance	Target / Threshold	Met?	Mean	LCL	UCL
Priority 1 Incidents	Mar-24	0	0		1	-	-
Data Security and Protection Training compliance	Mar-24	92.1%	95.0%	No	88.8%	85.9%	91.7%
Data Security & Protection Breaches	Mar-24	26	-	-	26	10	41
Externally reportable ICO incidents	Mar-24	1	0	No	0	-	-
All IG reported incidents	Mar-24	27	-	-	27	12	42
Freedom of Information (FOI) % responded to within target time	Mar-24	63.5%	80.0%	No	66.0%	37.8%	94.2%
Data Subject Access Requests (DSAR)	Mar-24	57.1%	80.0%	No	74.4%	55.9%	92.9%

Corporate support services – Legal services Summary

Latest Indicator Period: Mar-2024

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

Corporate support services – Regulatory assurance

Latest Indicator Period: Mar-2024

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

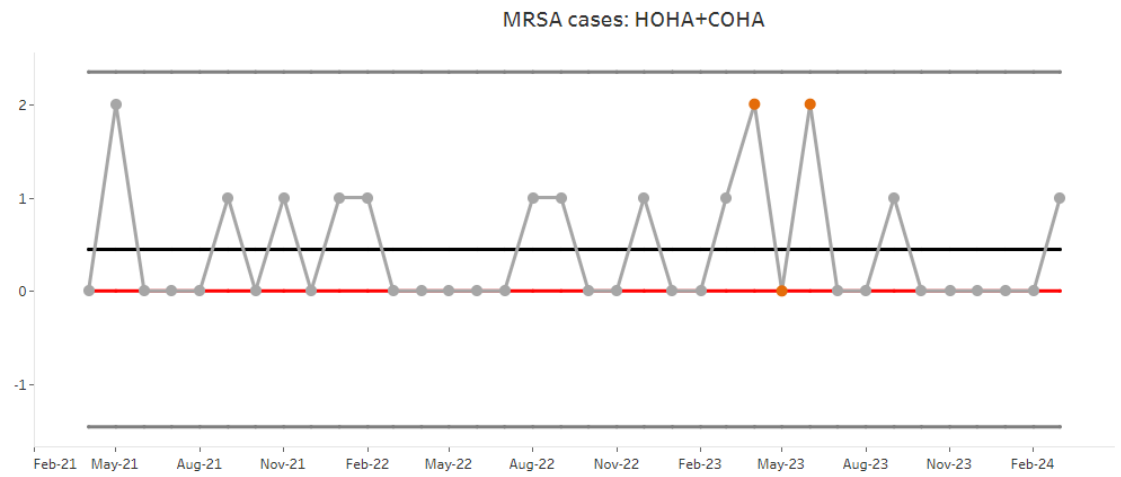
OUH Data Quality indicator

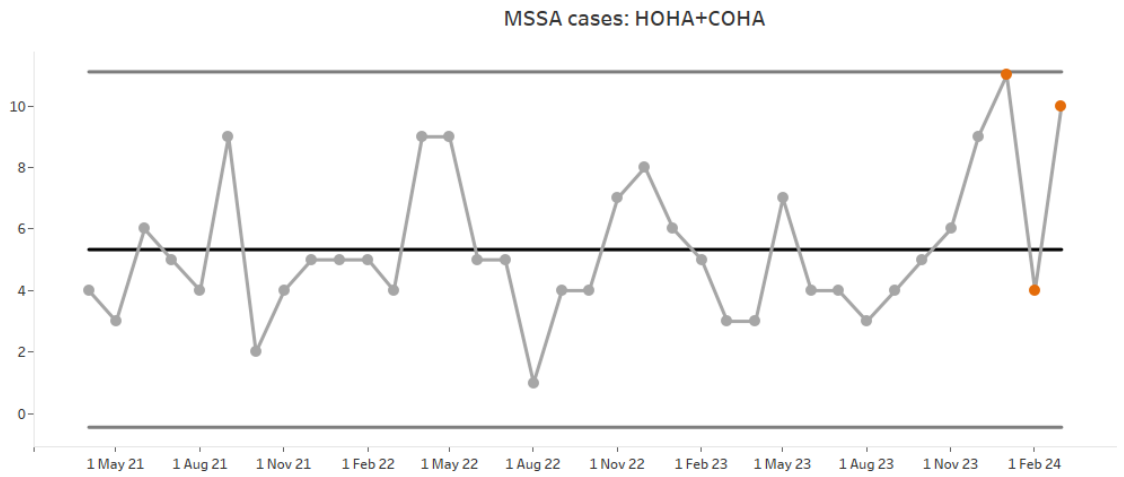
Valid: Information is accurate, complete and reliable. Standard operation procedures and training in place.	**Verified**: Process has been verified by audit and any actions identified have been implemented.	**Timely:** Information is reported up to the period of the IPR or up to the latest position reported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

Sufficient ***Satisfactory*** ***Inadequate***

03. Assurance reports

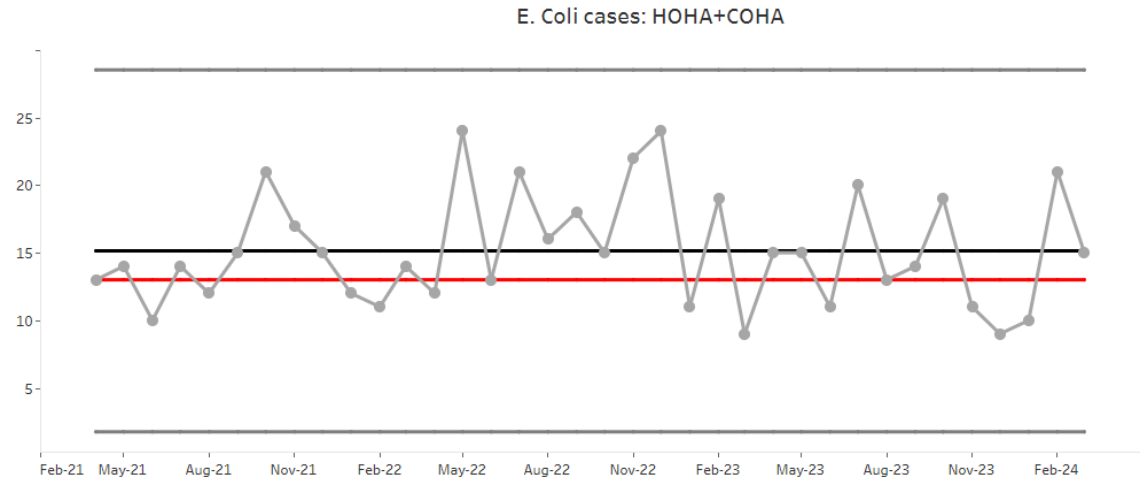
3. Assurance report: Quality, Safety and Patient Experience

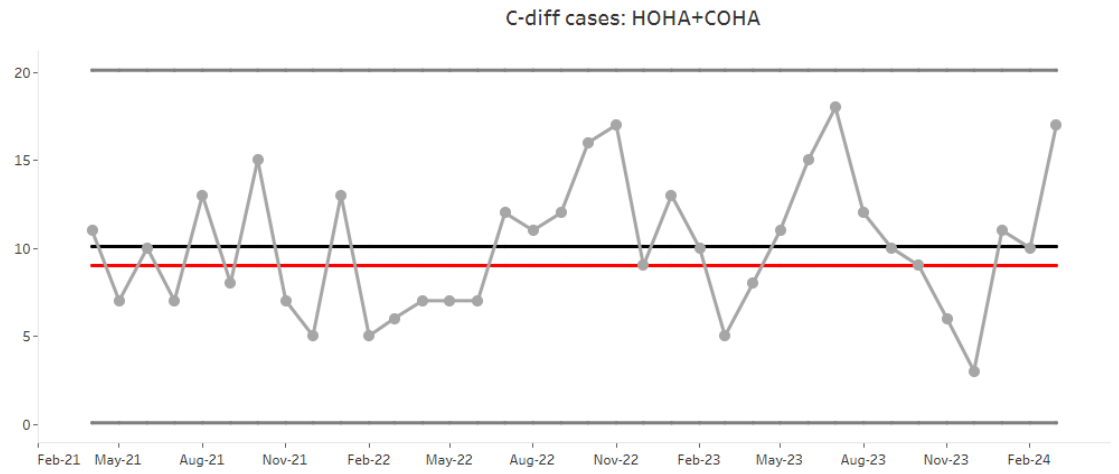




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
MSSA- thematic review undertaken of MSSA bacteraemia' s: upward trend and now special cause variation. **MRSA** – one case in March 2024	MSSA- previously raised at SLIC and HIPCC, plan for IPC team to audit cannulas in May to identify trends/issues. At the end of 2023-2024 we are at 43 HOHA cases (42 in 2022/23), therefore only more case than last year. Total COHA cases are 27 (24 in 2022/23). MRSA- no learning identified in this case, patient screened appropriately, spot check on screening compliance in the dept demonstrates 100% compliance	Continue to review all case to identify any learning. Results from audit in May will be shared.	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

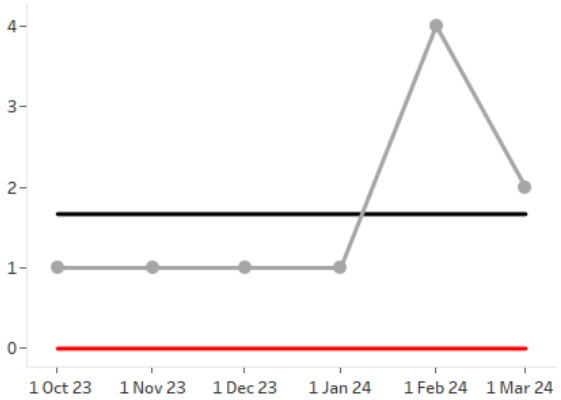




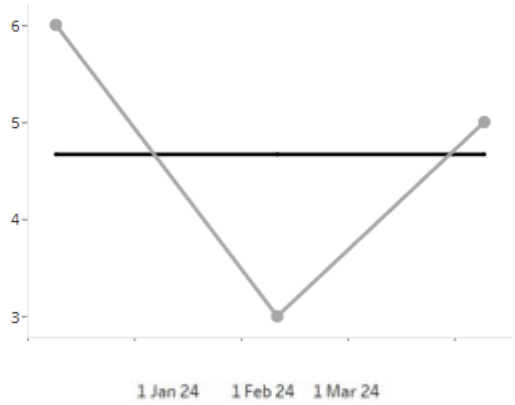
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
C.diff- threshold for OUH for 2023/24 is 103 cases The NHS England Long Term Plan is to halve healthcare-associated Gram-negative bloodstream infections (GNBSI) by March 2024/25. Nationally this ambition is not met, with cases continuing to increase.	C.diff- At the end of 2023/24 there have been 130 cases (124 in 2022/23) No new learning or themes identified from the March cases. Hot review of cases continues. E. Coli – 15 cases this month. 9 of which urinary thought to be the source- 3 pts had long term catheters	Continue to review all cases to identify any learning. Continue with Antimicrobial Stewardship ward rounds.	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

Non-Thematic Patient Safety Incident Investigations

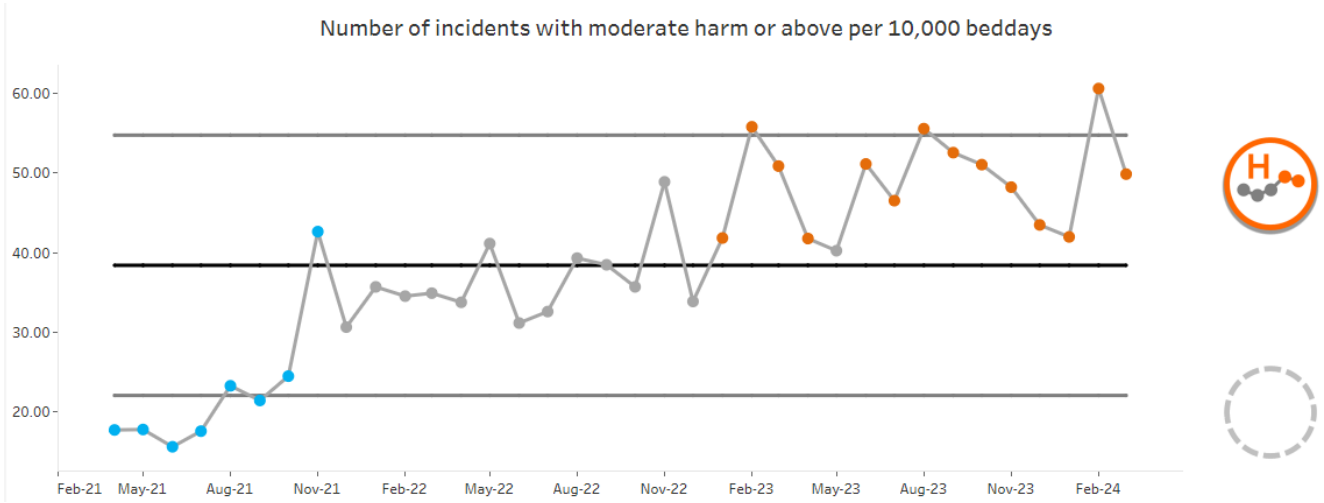


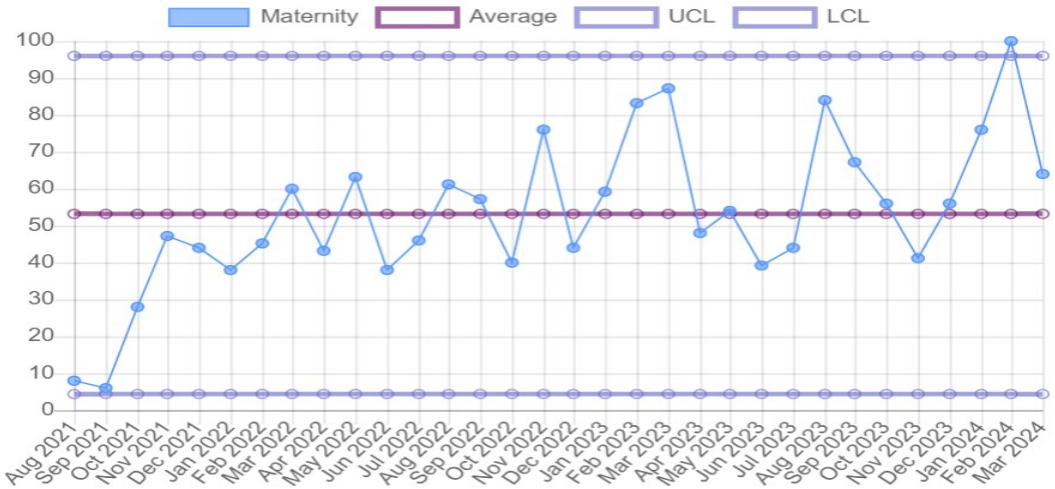
Learning MDT Reviews (LMDTR)



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
Two Patient Safety Incident Investigations (PSII) were confirmed in March 2024 (excluding any incidents included in the 4 thematic PSIIs that form part of the Patient Safety Incident Response Framework (PSIRF) patient safety profile). One concerned a patient who died following an unexpected cardiac arrest, and the other concerned a number of patients requiring Holter monitoring (portable ECG) who were discharged from an outsourced service without arrangements for cardiac physiology follow-up. 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).	A total of 10 non-thematic PSIIs have been confirmed over the last 6 months since OUH moved to the PSIRF framework in October 2023. PSIIs are one of a range of learning responses. They are a detailed investigation using a systems analysis approach which can be applied to individual incidents or a cluster of similar incidents. Other learning responses include After Action Reviews (AAR) and Learning Multidisciplinary Team reviews (LMDT). AARs have a target of 2 weeks from the reporting of the incident to complete, and LMDTs 6 weeks. PSIIs should ideally be completed within 3 months but extensions can be requested if necessary. The AAR graph has been removed as these are currently underreported in Ulysses. Work with Divisions is ongoing to ensure that all learning responses are consistently recorded on Ulysses The AAR graph will return as soon as the data is accurate and verified; the LMDT graph has been confirmed as accurate, and has been reinstated.	The action is to complete the PSII investigations within the agreed timescale and share the learning across Divisions. 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*

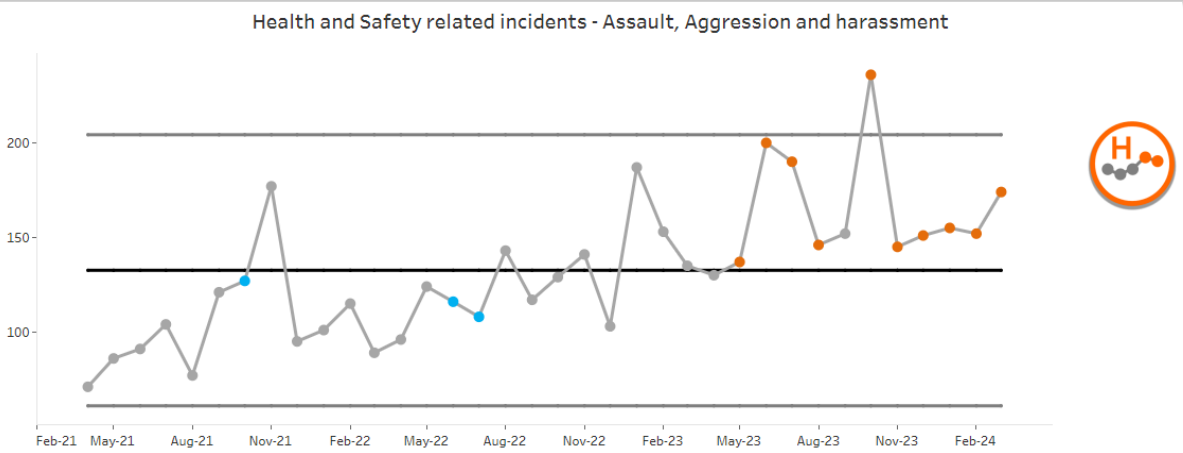
3. Assurance report: Quality, Safety and Patient Experience

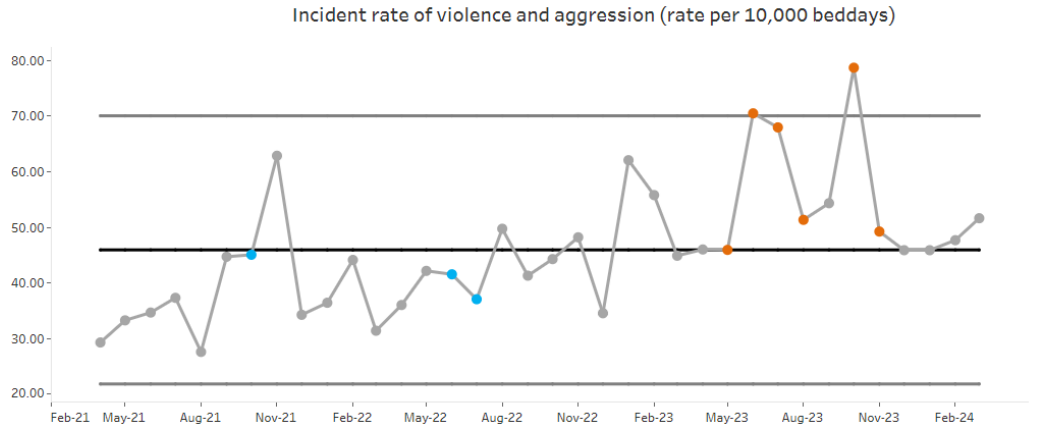




Summary of challenges and risks		Action timescales & assurance committee	Risk Register	Data quality rating
There were 49.8 incidents with moderate harm or above per 10,000 bed days in March 2024. The indicator exhibited deteriorating special cause variation due to thirteen consecutive periods recorded 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 Directorate now calls a significant percentage of Moderate+ incidents (71 of the 207 incidents in March 2024, or 34%). The mean in the above Moderate+ graph includes data from 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, compared with absolute number of maternity incidents in the second graph.	After Maternity, the most common Cause Group in March 2024 was Surgical/Return to Theatre (42 of 207, 20%); this is an increase on February's figures (20, 13% of all incidents). All of these are currently local investigations, with information awaited relating to 4 of them to allow the learning response to be confirmed. The Surgical Mortality & Morbidity dashboards include return to theatre data; these are being adopted across surgical services. Apart from Maternity, the Directorate with the most Moderate+ incidents in March 2024 was Surgery (21, of 207, 10%). 16 of these incidents come under the Surgical/Return To Theatre cause group, mentioned above.	189 of the 207 incidents reported this month were patient incidents, and at the time of writing, 88 (47%) of these have been covered by the Safety, Learning & Improvement Conversation (SLIC) review process; the mean monthly percentage is 35% (data from November 2023 onwards). Further information, or a formal learning response, will be provided for the incidents still awaiting completion of this process. 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*

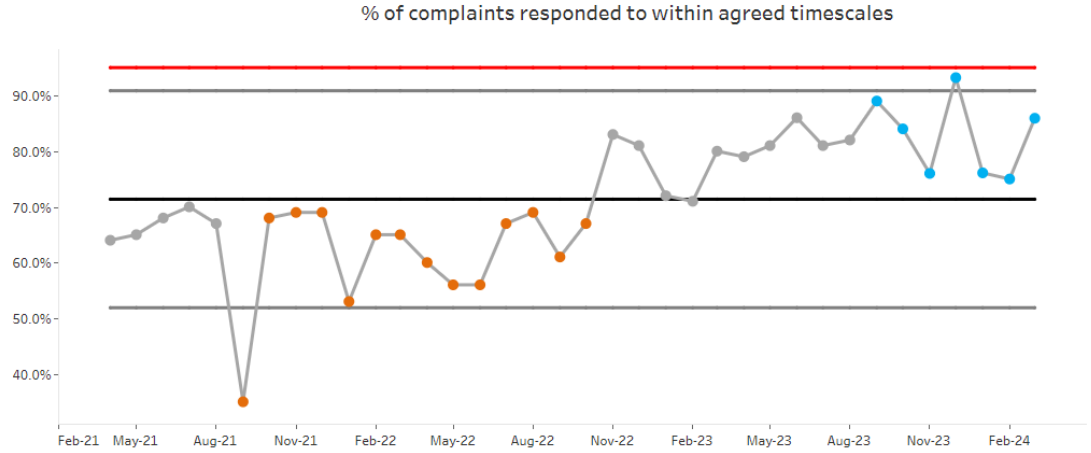
3. Assurance report: Quality, Safety and Patient Experience, *continued*

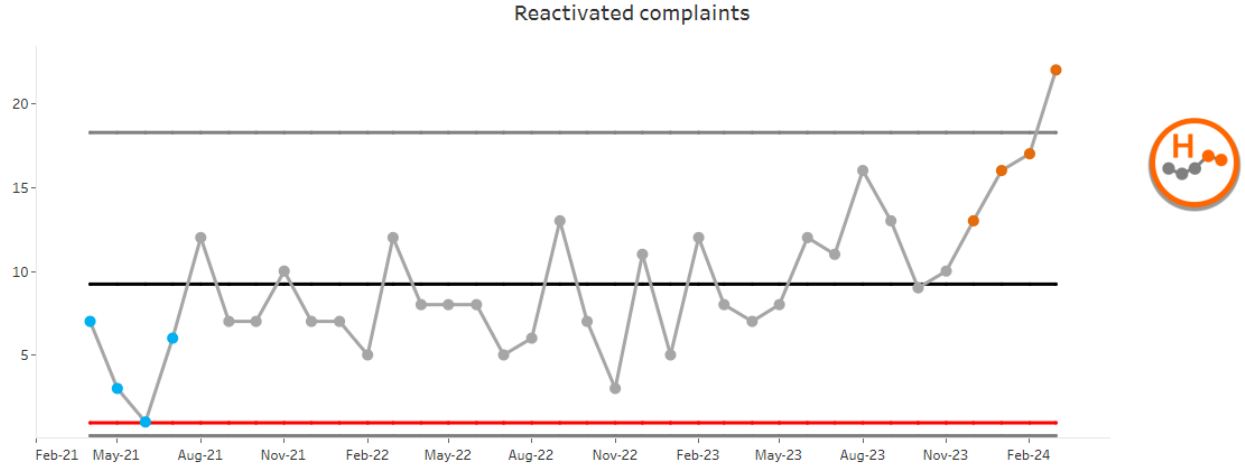




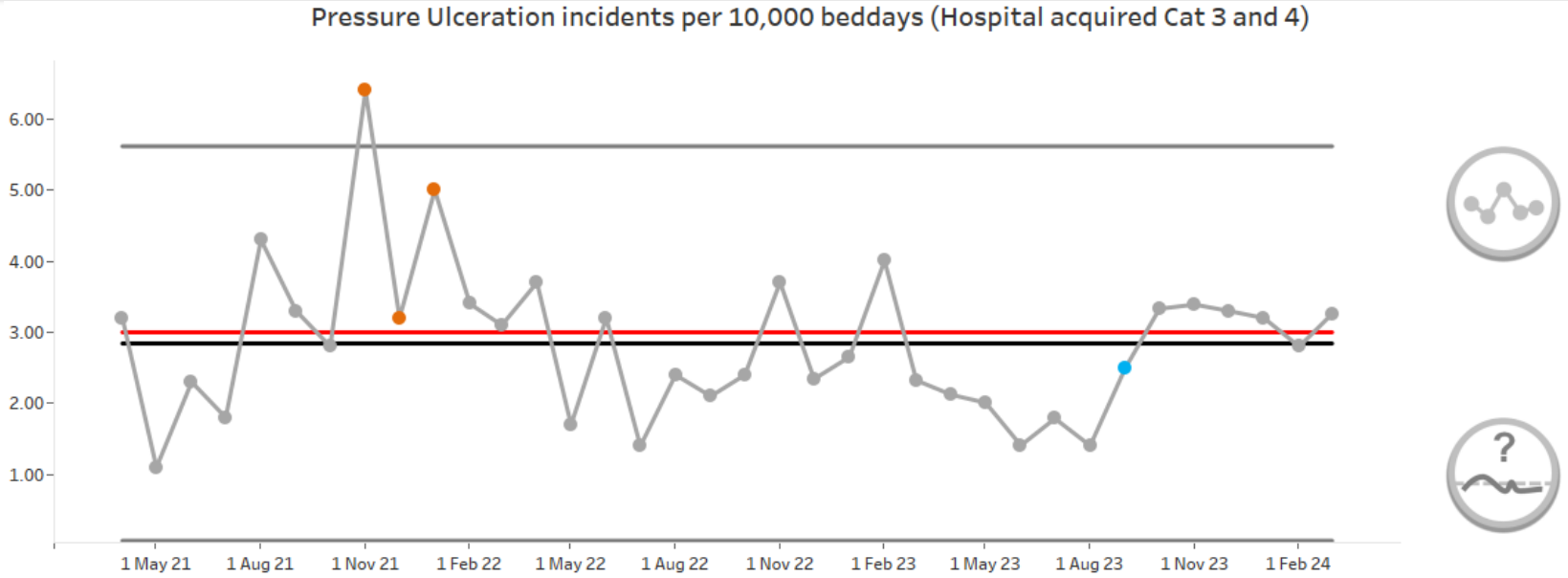
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
There were 49.8 Health and Safety incidents relating to assault, aggression and violence per 10,000 bed days in March. 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 trialed 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*



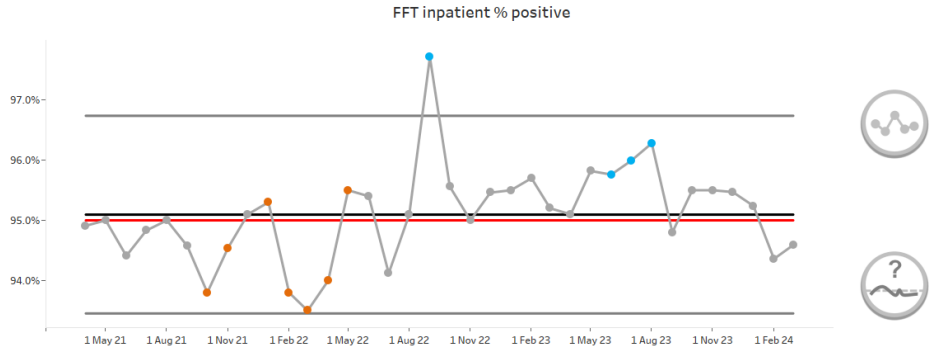


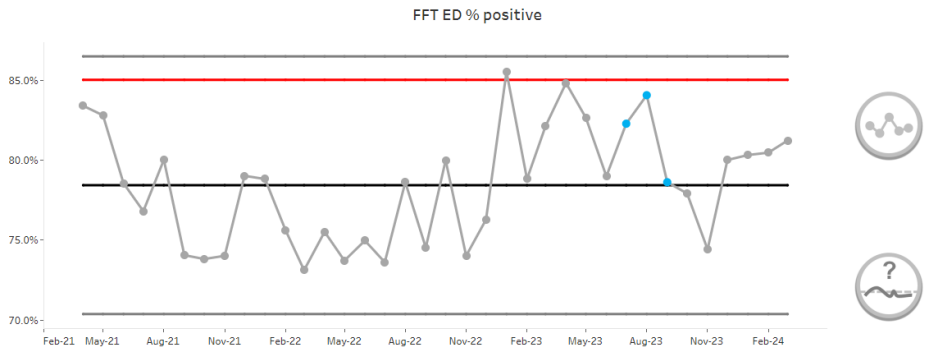
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
In March 2024, 85.9% of complaints were responded to within 40 days, below the target of 95%. The indicator has consistently not achieved the target. March's performance exhibited improving special cause variation with over seven data points performance above the mean of 71.4%. There were 22 reactivated complaints and the indicator exhibited deteriorating special cause variation due seven periods above the mean of 9 reactivated complaints.	The Trust received 125 formal complaints in March. Reactivated (reopened) complaints increased in March. However, as in previous months, the theme of reactivated complaints is predominantly in relation to the length of wait for appointments/treatment, with complainants expecting their appointment can be expedited through the complaints process. Work to reduce the complaints response timeframe from 40 working days to 25 working days continues, with a successful QI workshop recently held with all Divisions and members of the Complaints team to begin mapping out the process and understand the bottlenecks in the system. The weekly auto-generated breach sheet enables Divisions to track their overdue complaints, and those which have not yet breached to allow their focus to manage these, to try to prevent them breaching. 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*

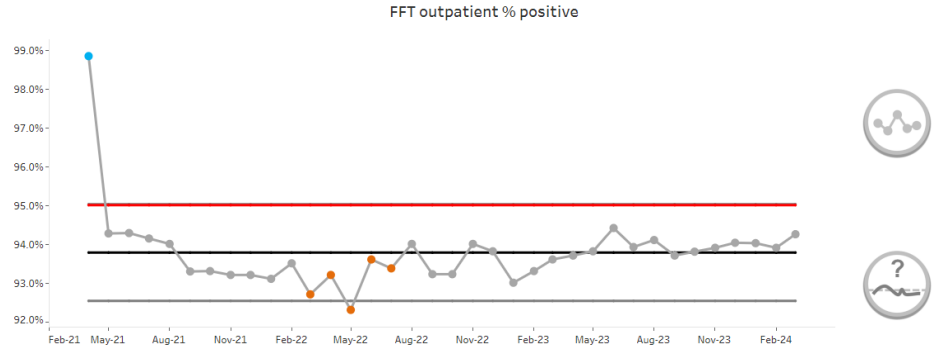


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The number of pressure ulcer incidents per 10,000 beddays (Hospital acquired cat. 3 and 4) was above the threshold for March, but exhibited Common Cause Variation. HAPU Category 3 and above There were 10 incidents reported in December 2023. All will be reviewed for thematic learning and discussed at HFAF in February.	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 February 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*



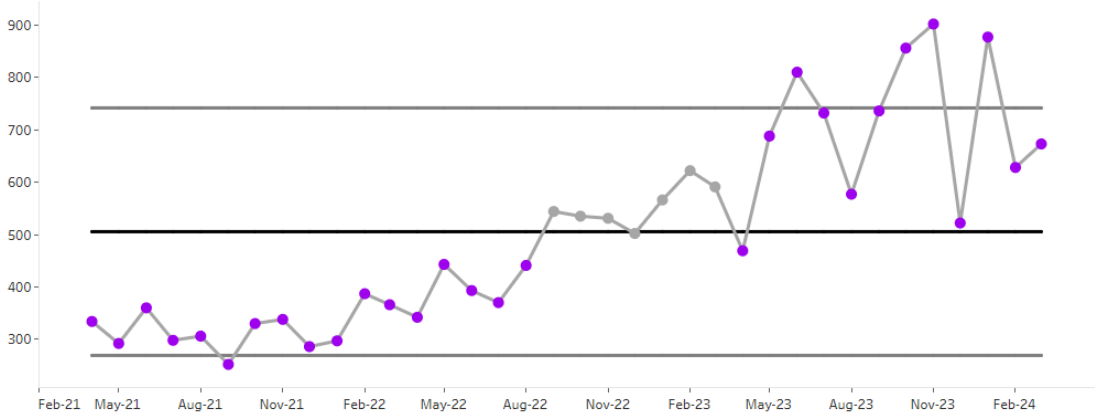




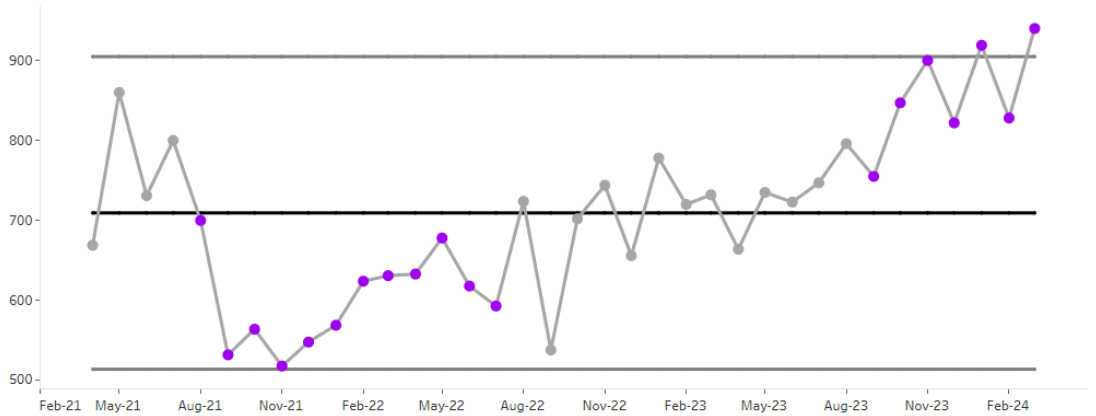
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Friends and Family Test (FFT): The percentage positive rates were below the 95% target for outpatient and ED although there has been an increase in positivity in both. ED's results fluctuate more than the other services and is in response to the operational pressures within the service. During March 2024, 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. Due to the switch to badger notes, the Trust is not currently collecting FFT data for Maternity Services. This will be addressed in the next phase of the project.	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 1st June 2024	BAF 4	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

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

Children's safeguarding activity

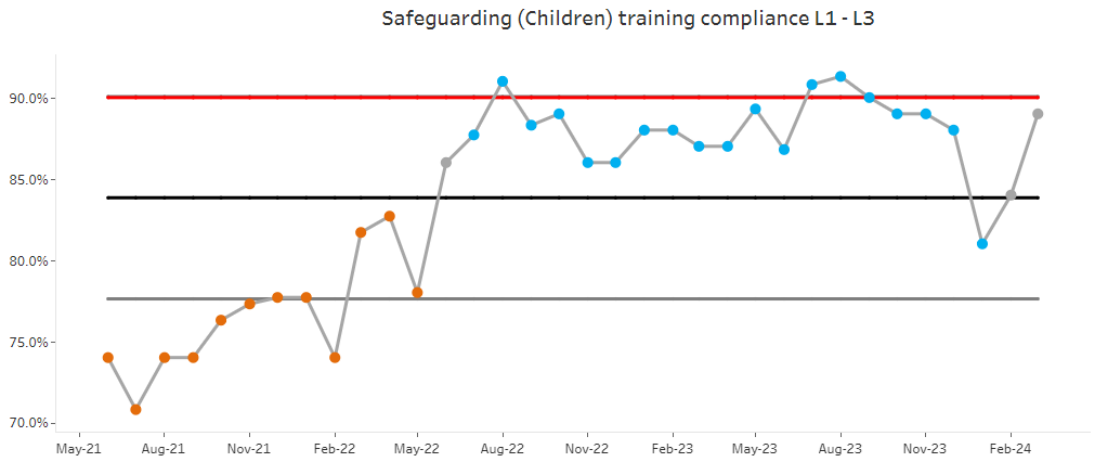


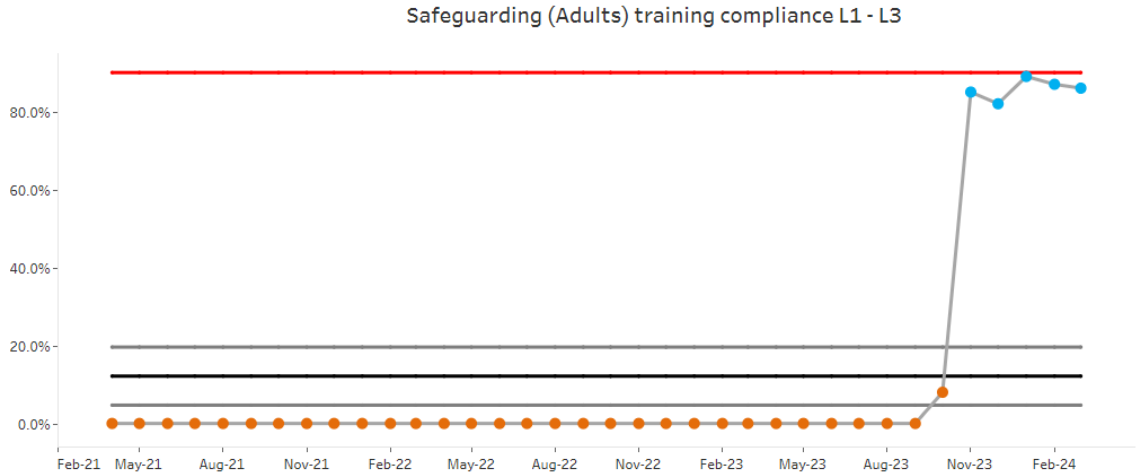
Adult safeguarding activity



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Safeguarding children and maternity case activity increased by 45 (n=672). Themes related to complex attendances that require significant multi agency working. Drugs and alcohol, assaults and mental health have been a theme, especially in a part of Oxon. Maternity risk data is not available due to moving to Badgernet patient record system. Domestic abuse, illicit substance abuse and housing issues remain the main themes. The activity and complexity remain high. Adult activity increased by 21 (n=939) in March. Themes relate to domestic abuse, neglect, and self-neglect. The DoLS activity dropped by 7 (n=114) with no authorisations undertaken by the LA in March. Staff vacancies due to 2 maternity leave posts is putting the team under pressure.	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. The team escalated related to concerns to have a multi-agency approach to support young people and put in a Community Around the School Offer (CASO). Children liaison shared information with primary care and CSC, this dropped by 28 (n=1094). The new Independent Domestic Abuse Advisor (IDVA) has been appointed by A2Dominion and awaiting honorary contract to commence role in Trust. Post is funded by Public Health following Home Office funding for a year to support the Trust. Recruitment to nurse and admin maternity leave has been halted. NHSP is in place for admin to manage the legal DoLS requirements.	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 2% to 89%. Level 3 children safeguarding compliance remained at 83%. The KPI is 90%. Level 1-3 adult training improved 2% to 86%. MLH is managing the mapping process which is expected to be in place for next months report. Compliance is below the 90% KPI. Q4 Prevent submission to national data system was compliant, training Prevent awareness training improved by 2.3% to 83% and Basic improved by 1% to 90% for March, the KPI is 85%.	Training options available online and face to face. Additional training is offered to teams. Data shared at meetings (Div. governance, matrons and PSEC) to request staff encouraged to undertake training. PSEC and each divisional governance report template provides details of gaps for training. MLH meetings to ensure review of mapping for groups of staff is corrected.	PSEC monthly assurance report divisional governance reports and presented to the Trust clinical governance committee. Safeguarding steering group quarterly.	BAF 4 CRR 1145	Satisfactory *Standard operating procedures in place, training for staff completed and service weekly validation of data entry, but no Corporate or independent audit yet undertaken for fuller assurance*

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

Oxford University Hospitals NHS Foundation Trust

Summary of challenges and risks

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

Nursing and midwifery staffing is reviewed at a Trust level three times daily and staffing has been maintained at Level 2 throughout March 2024.

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

Increased bed capacity, opened in December 2023, closed in March 2024. .
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. This related to annual leave given post maternity leave and staff new in post (NOTSSCaN had highest number of new starters across the trust).
The incidents below, did not relate to staffing levels:
Neonatal Unit – 8 medication incidents – no harm to patients
Paediatric ICU- 12 medication incidents reported all were without harm. A paper has been presented at the Integrated Assurance Board in April confirmed no harm, better vigilance and reporting of errors.
Major Trauma 2A – 5 pressure ulcer, all category 2 incidents. Assessments and measures in place to prevent deterioration.
Trauma 3A –6 pressure ulcers, DDN has no concerns, and encouraging good reporting
SSIP – 6 medication errors – 3 minor harm, one where patient missed medication due to difficulty with access. Other incidents with no harm. No themes identified.
Difference in CHPPD for NOC HDU – Actual higher than budget – 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 higher than actual. Actual higher than required. Safe staffing team will be working with the ward managers to support with improved rostering and recording of patients.
BIU now fully established to 24 beds, however, is consistently only full to 17 patients. Excess staff have been moved whenever possible or utilised in place of temporary workforce.
Neuro Blue – actual less than required. High number of enhanced level patients, extra staff have been utilised to support. Although data showing shortfall of CHPPD, the ward was throughout the month declared safe, using additional staff not included within the calculation.
Neurology (Purple) ward had short fall of CHPPD. This ward too has had high level of enhanced observation patients. One shift overnight was felt unsafe by staff. An incident form was completed, and additional staff provided on all following shifts. The Matron is reviewing with the Ward Managers to prevent a similar situation in the future

SuWOn Division -
Staffing in SUWON has remained at safe levels throughout March.
Rostering KPI's - several rosters were over on the Annual leave KPI, and some under the KPI. Matron's have given assurance that this did not impact on patient safety. High leave was largely to new starters having pre-approved leave.
Upper GI has high unused hours; however, this is an anomaly relating to RAF staff assigned to the ward and not accurate for the substantive staff.

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

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

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

SuWOn – (continued) -
The incidents below did not relate to staffing levels:
Oncology Ward – 11 medication incidents – no common theme, however, has been noted some errors relating to discharge medications. Senior nurses now buddying up to support inexperienced nurses to further their learning.
6 pressure ulcers – all category 2 except one category 3. Cat 3 reviewed with a local investigation to follow. 8 falls - 5 unwitnessed, no harm sustained. 3 witnessed, no harm. One patient had a lying/standing blood pressure measurement missing, another had a post falls care plan missing. These have been addressed with the team involved.
SEU-D 7 falls all with no, or minor harm (slight abrasion). Assessments and care plans in place, no new learning
SEU-F – 6 medication incidents - no or minor harm. No themes identifed. – 9 falls, 6 of the falls related to the same patient. His journey is beign reviewed in depth to establish future learning.

The Division are introducing a weekly harm free huddle to discuss Hospital Acquired Pressure Ulcers to identify possible contributory factors and actions in a timely manner.

MRC - Most areas achieved the 8-week lead time for roster publication, this is being closely monitored by the DDN. 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) and honoring pre booked annual leave for some new staff. The DDN has given assurance this was not detrimental to patient care. CMU-D above the KPI for net hours. This relates to an OU student and should be resolved next month.

The incidents below, did not relate to staffing levels.
JR EAU – 5 medication incidents - no harm/ minor harm. Includes delays in TTO's being sent by City Sprint, delays with medication being supplied by Pharmacy, wrong dose medication given, lack of communication from the medical teams and extravasation of a cannula
5B – 8 falls no or minor harm. No themes identified
Cardiology – 8 falls 3 with no harm, 5 with minor harm. No theme identified. Assessments had been completed
CMU-C 7 falls , no or minor harm, mainly within patient group who had challenging an agitated behaviours. All assessments had been complete.
HH EAU 10 falls. 5 of the falls related to 3 patients. No or minor harm. no themes identified. Assessments complete and updated following falls.
Laburnum – 5 falls , 2 linked to same patient. No harm to any patient.
Ward 5E/F - 7 falls, no or minor harm. No themes identified. Assessments had been complete. Commencing a trial of sensor products.

Difference in CHPPD – All wards and departments are now closely aligned between budgeted and actual CHPPD. Where required is higher than actual, the DDN has given assurance that all areas were safe, utilising supernumerary and support staff. Ongoing work within the division to ensure these staff are reflected within the CHPPD.

CSS - Roster KPI's – 8-week lead just missed. Senior staff getting back on track after falling behind in February due to illness and clinical commitments.
The incidents below did not relate to staffing levels
10 medication incidents. no themes were identified, and no patient came to harm. Continue to run medicines safety group and commencing work with the Adult Pain Service especially around the use of Nurse Controlled Analgesia pumps.
Difference in CHPPD: The budgeted hours are higher than the actual, due to a high vacancy with ongoing recruitment,, however, the unit was safe with the lowest occupancy of patients since September 2023, with a higher number of patients being level 1, rather than level 2 and level 3.

Maternity – All rosters fell short of the 8 week lead time. This was due to sickness in the Matron team, combined with a Band 7 vacancy. This figure should improve for next month. The Spires roster has many overworked hours. This relates to one member of staff with the issue being addressed.
the incidents below did not relate to staffing levels.
10 women were readmitted postnatally. This figure is within the 'expected' number of readmissions, including infection, sepsis and hypertension. There were a total of 8 medication errors across the 4 maternity areas, with 3 incidents being the highest in any one area.
Difference in CHPPD – A review to take place of roster templates to ensure the budgeted staff are reflected correctly within the templates across maternity.

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: Again, the number of falls across the Trust in March was equal to February with 170 reported falls. 83% of patients had assessments completed, with care plans generated in line with the assessment, an improvement on February. The second MRC Falls Summit took place in February, with ward 5E/F commencing a trial of sensor products. SuWOn had one patient fall multiple times. The patient journey is being analysed to discover if there is learning from this that can be taken forward. Horton EAU and Oncology ward are taking part in the CNO research project for enhanced observations.

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

March 2024	Care Hours Per Patient Day			Census	Nurse Sensitive Indicators				HR					Rostering KPIs				FFT
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	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%	% Extremely likely or likely
NOTSSCaN																		
Bellhouse / Drayson Ward	7.7	10.3	9.5	87.1%	4	3	0	0	5.2%	2.8%	3.4%	4.8%	12.2%	Yes	2.7%	6.4	22.0%	81.6%
HH Childrens Ward	10.2	9.5	12.1	78.5%	0	0	0	0	15.4%	3.2%	4.7%	4.4%	21.6%	Yes	-1.1%	9.6	17.0%	92.5%
Kamrans Ward	10.2	10.5	9.0	97.9%	2	0	0	0	5.1%	9.9%	1.7%	4.0%	8.9%	Yes	-7.5%	7.7	19.4%	100.0%
Melanies Ward	11.6	9.7	9.1	100.0%	1	1	0	0	-37.4%	3.9%	2.0%	1.2%	-34.7%	Yes	-1.4%	11.4	15.4%	94.7%
Robins Ward	11.4	12.9	11.7	97.9%	2	0	0	0	7.7%	4.6%	2.0%	0.0%	7.7%	Yes	1.7%	9.9	17.0%	79.4%
Tom's Ward	8.1	9.5	8.5	100.0%	2	1	0	0	-2.2%	13.2%	2.0%	8.1%	6.1%	Yes	-1.2%	9.7	15.6%	88.4%
Neonatal Unit	18.3		23.8		8	1	0	0	9.6%	8.3%	6.5%	2.8%	15.7%	No	-3.5%	8.7	18.4%	
Paediatric Critical Care	32.7		24.3		12	2	0	0	-1.2%	10.0%	5.3%	6.4%	6.4%	Yes	-1.1%	9.0	18.6%	
BIU	6.1	6.5	8.2	98.9%	2		1	3	23.6%	17.4%	3.4%	0.0%	23.6%	Yes	0.5%	8.3	15.1%	95.7%
HDU/Recovery (NOC)	22.2		33.4		0		0	0	8.2%	10.8%	4.2%	4.2%	12.1%	Yes	-1.0%	6.6	14.5%	
Head and Neck Blenheim Ward	7.3	8.2	8.3	100.0%	1		1	2	13.7%	5.5%	6.0%	4.0%	21.0%	Yes	-4.4%	8.6	15.4%	100.0%
HH F Ward	12.4	8.5	8.4	100.0%	0		1	4	3.0%	6.4%	5.0%	4.3%	9.3%	Yes	-0.5%	8.3	16.0%	100.0%
Major Trauma Ward 2A	9.1	8.9	9.8	92.5%	2		5	2	8.7%	12.9%	2.7%	0.0%	11.8%	Yes	-5.0%	8.3	18.6%	100.0%
Neurology - Purple Ward	8.9	9.9	7.5	100.0%	1		1	2	7.4%	12.5%	5.4%	0.0%	7.4%	Yes	2.0%	10.4	13.3%	100.0%
Neurosurgery Blue Ward	8.9	10.4	9.5	100.0%	0		0	3	8.0%	9.9%	3.6%	0.0%	11.9%	Yes	0.4%	8.3	15.0%	83.3%
Neurosurgery Green/IU Ward	9.6	10.2	10.0	100.0%	0		0	4	3.3%	1.7%	4.1%	3.1%	6.2%	Yes	1.7%	8.3	16.7%	93.8%
Neurosurgery Red/HC Ward	11.7	12.1	12.3	100.0%	1		1	2	-4.3%	5.4%	5.2%	3.2%	3.2%	Yes	-0.4%	9.6	14.9%	100.0%
Specialist Surgery I/P Ward	8.5	8.3	8.1	92.5%	6		1	2	7.9%	5.6%	3.4%	0.0%	9.3%	Yes	0.0%	8.6	17.5%	80.0%
Trauma Ward 3A	9.2	8.4	9.1	100.0%	1		6	1	14.7%	15.5%	4.2%	4.3%	18.4%	Yes	-0.5%	8.3	15.5%	100.0%
Ward 6A - JR	7.2	7.9	7.0	91.4%	2		3	4	13.8%	10.7%	3.0%	2.5%	15.9%	Yes	0.6%	8.6	15.8%	
Ward E (NOC)	6.3	7.1	6.7	100.0%	2		1	0	22.5%	24.2%	8.2%	0.0%	22.5%	Yes	-0.3%	9.3	14.0%	95.5%
Ward F (NOC)	6.7	6.8	6.7	90.3%	1		0	2	13.0%	14.3%	4.9%	8.4%	20.3%	Yes	-1.7%	9.3	19.0%	
WW Neuro ICU	25.4		30.1		0		1	0	19.4%	14.8%	3.6%	4.1%	25.1%	Yes	-3.1%	5.6	14.3%	

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

March 2024	Care Hours Per Patient Day			Census	Nurse Sensitive Indicators				HR					Rostering KPIs				FFT
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	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%	% Extremely likely or likely
MRC																		
Ward 5A SSW	8.7	9.1	9.2	100.0%	1		4	4	-0.9%	6.8%	2.8%	5.8%	5.0%	Yes	-2.1%	7.6	16.1%	50.0%
Ward 5B SSW	8.9	9.1	9.3	100.0%	2		0	8	5.5%	7.3%	3.8%	2.2%	9.7%	Yes	4.4%	8.4	16.7%	100.0%
Cardiology Ward	6.2	7.4	7.2	89.3%	1		2	8	3.4%	9.8%	3.8%	4.5%	7.7%	Yes	0.8%	8.4	15.0%	100.0%
Cardiothoracic Ward (CTW)	7.8	7.6	6.5	97.9%	0		0	2	16.5%	17.1%	4.2%	2.6%	18.7%	Yes	-9.4%	6.4	12.1%	100.0%
Complex Medicine Unit A	8.9	9.9	9.1	98.9%	0		2	4	3.7%	5.5%	5.7%	2.6%	7.7%	Yes	-0.1%	6.7	17.6%	100.0%
Complex Medicine Unit B	11.3	10.3	9.7	90.3%	0		3	3	-5.6%	6.5%	4.4%	3.7%	-1.7%	Yes	0.1%	7.6	15.9%	87.5%
Complex Medicine Unit C	8.7	10.3	8.6	97.9%	1		3	7	2.3%	10.1%	2.2%	0.0%	2.3%	Yes	-3.5%	8.6	16.2%	100.0%
Complex Medicine Unit D	9.5	9.0	8.9	89.3%	2		1	3	5.8%	13.9%	4.9%	0.0%	12.0%	Yes	6.3%	8.6	16.9%	
CTCCU	21.9		22.0		3		3	0	8.5%	9.9%	3.5%	4.7%	15.9%	Yes	-0.4%	9.6	18.2%	
Emergency Assessment Unit (EAU)	8.5	8.1		57.0%	5		0	1	16.7%	7.1%	3.6%	6.2%	22.8%	Yes	0.3%	9.4	18.7%	
HH EAU	9.5	7.5		86.7%	2		0	10	0.5%	7.1%	5.8%	4.2%	6.9%	Yes	0.6%	12.7	16.5%	
HH Emergency Department	20.8				0		0	0	16.0%	4.9%	4.2%	7.0%	24.3%	Yes	-1.5%	9.3	18.8%	83.8%
JR Emergency Department	17.5				6		1	4	15.0%	12.0%	5.6%	5.5%	22.9%	Yes	1.8%	8.6	14.7%	79.6%
HH Juniper Ward	8.1	9.6	8.2	100.0%	0		1	4	8.7%	6.2%	6.3%	3.0%	12.0%	Yes	-3.1%	8.6	14.6%	55.6%
HH Laburnum	9.6	8.3	8.6	100.0%	2		1	5	5.0%	5.1%	6.1%	5.5%	14.1%	Yes	-0.9%	9.3	12.6%	53.3%
HH Oak (High Care Unit)	20.1		11.1	94.6%	1		4	0	5.0%	12.1%	4.1%	2.7%	7.6%	Yes	-1.1%	6.6	16.6%	
John Warin Ward	10.1	8.7	9.6	90.3%	0		0	0	3.1%	5.8%	3.5%	0.0%	12.7%	Yes	-3.2%	8.3	15.8%	100.0%
OCE Rehabilitation Nursing (NOC)	10.5	10.1	10.2	100.0%	0		1	0	10.4%	9.5%	4.0%	9.0%	21.4%	Yes	-2.4%	8.4	14.4%	54.5%
Osler Respiratory Unit	14.5	9.7	13.2	97.9%	2		1	1	11.8%	6.0%	3.8%	0.0%	11.8%	Yes	-1.0%	8.3	16.4%	56.7%
Ward 5E/F	11.1	9.1	11.0	90.3%	3		0	7	22.6%	8.6%	4.2%	4.1%	25.7%	Yes	0.9%	8.7	17.1%	
Ward 7E Stroke Unit	10.9	9.0	9.4	98.9%	1		1	3	-12.1%	11.9%	4.2%	3.0%	-7.6%	Yes	-0.2%	8.6	17.4%	

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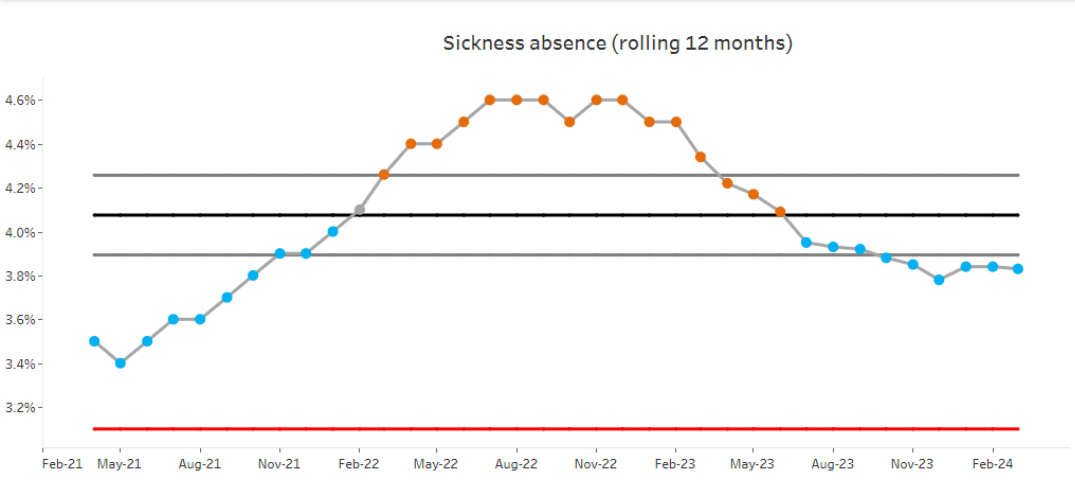
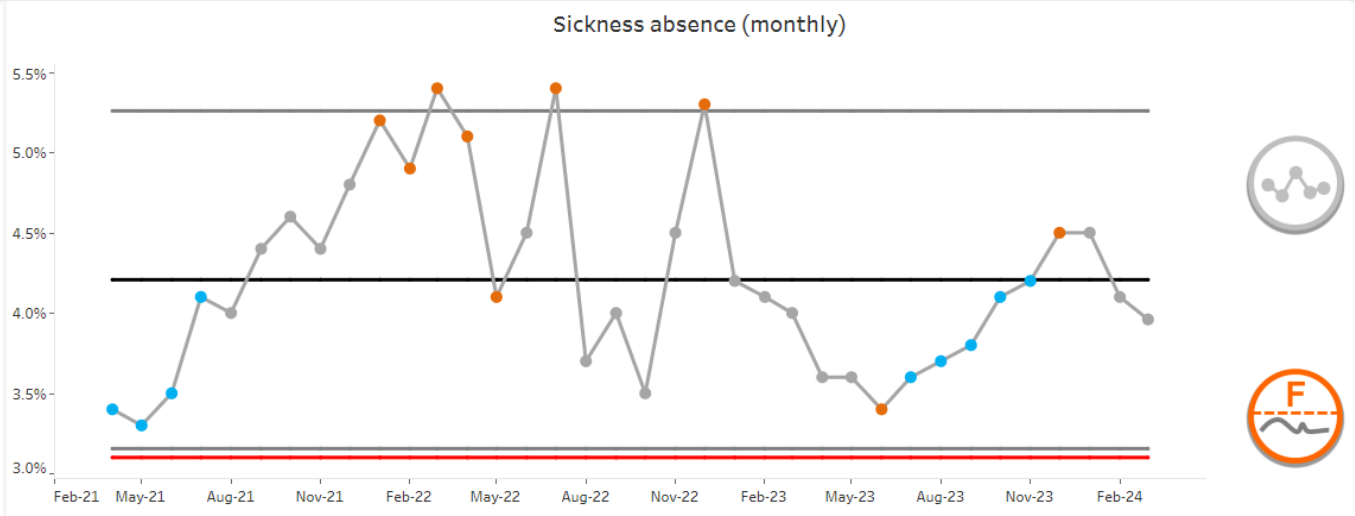
3. Assurance report: Safe Staffing - Dashboard: Part 3 (SuWOn and CSS)

March 2024	Care Hours Per Patient Day			Census	Nurse Sensitive Indicators				HR					Rostering KPIs				FFT
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	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%	% Extremely likely or likely
SUWON																		
Gastroenterology (7F)	7.0	7.2	7.6	93.6%	3		3	1	11.7%	9.2%	3.8%	5.4%	16.5%	Yes	-3.0%	6.4	8.7%	100.0%
Gynaecology Ward - JR	6.0	6.1	8.3	100.0%	1		0	0	26.1%	1.0%	5.8%	0.0%	28.2%	Yes	3.5%	8.3	14.4%	95.0%
Haematology Ward	6.9	8.2	7.8	97.9%	3		1	3	7.8%	15.4%	5.6%	9.3%	20.4%	Yes	-3.3%	4.7	17.4%	100.0%
Katharine House Ward	9.2	7.7	12.4	100.0%	0		0	1	2.6%	17.7%	5.9%	2.7%	5.3%	Yes	6.3%	7.9	14.8%	
Oncology Ward	8.7	8.4	7.9	97.9%	11		6	8	21.9%	5.8%	4.1%	8.0%	28.2%	Yes	9.6%	6.7	18.7%	94.7%
Renal Ward	9.3	8.6	8.6	98.9%	1		1	3	-4.5%	6.2%	3.5%	6.0%	4.9%	Yes	0.5%	7.6	13.8%	100.0%
SEU D Side	8.7	8.1	8.5	100.0%	4		1	7	22.1%	3.1%	5.4%	9.3%	31.1%	Yes	-1.0%	8.1	16.3%	80.8%
SEU E Side	8.4	8.1	8.8	100.0%	3		1	0	9.5%	8.0%	3.2%	0.0%	11.3%	Yes	-2.0%	8.1	15.8%	95.8%
SEU F Side	7.6	8.2	7.7	100.0%	6		1	9	20.2%	23.2%	3.3%	0.0%	23.0%	Yes	-0.5%	8.1	19.8%	94.4%
Sobell House - Inpatients	8.7	8.0	8.7	95.7%	2		2	3	36.3%	14.7%	3.6%	8.5%	46.1%	Yes	-0.6%	7.7	16.4%	
Transplant Ward	9.4	7.7	8.1	100.0%	0		0	0	26.2%	6.0%	4.8%	8.0%	32.1%	Yes	1.0%	8.1	23.6%	100.0%
Upper GI Ward	9.7	8.4	8.1	98.9%	1		1	4	12.3%	0.0%	4.0%	4.8%	18.8%	Yes	-10.4%	8.4	14.8%	100.0%
Urology Inpatients	8.8	9.5	9.3	97.9%	0		0	3	30.8%	7.5%	2.2%	3.8%	35.1%	Yes	-1.0%	8.6	21.0%	97.7%
Wytham Ward	7.6	7.5	6.9	100.0%	1		0	3	19.7%	12.2%	4.7%	0.0%	19.7%	Yes	-1.2%	8.3	20.0%	100.0%
MW The Spires	27.5		32.5		0		0	0	-8.3%	13.7%	4.5%	4.2%	2.9%	Yes	-8.5%	5.4	14.5%	
MW Delivery Suite	15.2		19.6		2		0	0						Yes	-2.9%	6.1	10.2%	
MW Level 5	6.7		4.6		1		0	0						Yes	-0.1%	6.9	14.2%	
MW Level 6	4.5		5.5		2		0	0						Yes	1.0%	5.4	12.3%	
CSS																		
JR ICU	34.5		20.7		10		4	1	25.4%	10.6%	4.9%	4.6%	31.1%	Yes	-0.4%	7.7	15.9%	

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: Growing Stronger Together





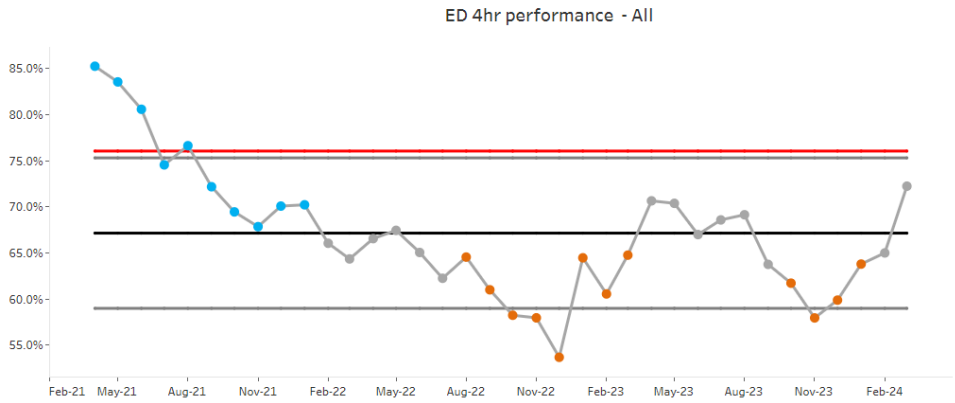
Benchmarking: November 23 (monthly performance – *lag due to availability of published data from National Sickness Absence Rate report*).

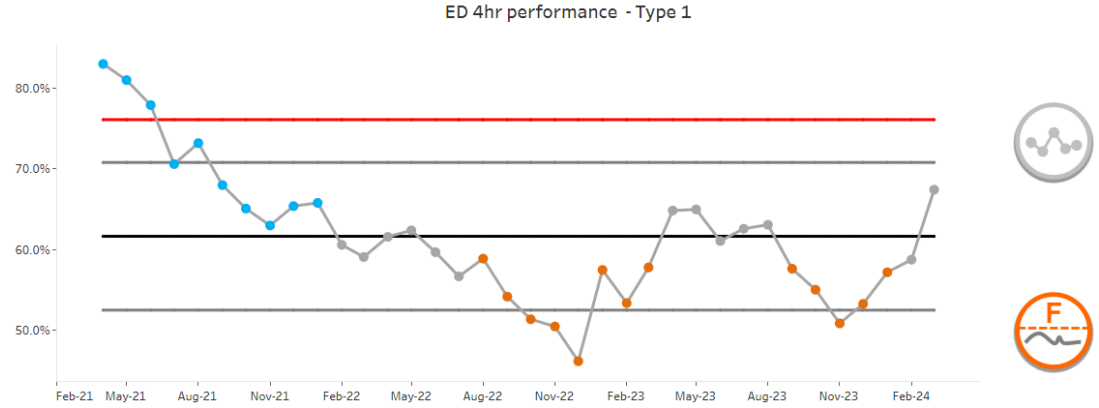
OUH: 4.1% **National: 5.3%** **Shelford: 4.8%** Buckinghamshire Healthcare NHS Trust: 4.3% Royal Berkshire NHS Foundation Trust: 3.8% Oxford Health: 5.0% South Central Ambulance Service: 6.6%

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Sickness absence performance (rolling 12 months) was 3.8% in February and has remained at 3.8% in March. 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 M12 is 4.0% which is a slight decrease from 4.1% in M11. Absences relating to mental health issues account for 34.4% of long-term sickness reasons and are also the highest reason overall at 18.2%. Long term sickness accounts for 40.5% of all Trust sickness.	We are continuing to offer a full range of well-being support including Wellbeing, financial, environmental and psychological. This includes stress management training. 1.HR sickness meetings and training sessions are taking place to ensure consistency in managing and supporting managers. 2.Drop-in sessions and sickness workshops are being arranged to provide extra support to managers to deal with absence cases. 3.Monthly meetings with Occupational Health are helping to move along long-term sickness cases. 4.Reports containing absence management information are being disseminated to areas with frequent absences being highlighted, continued communication about the benefits of return-to-work interviews is also taking place. 5.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



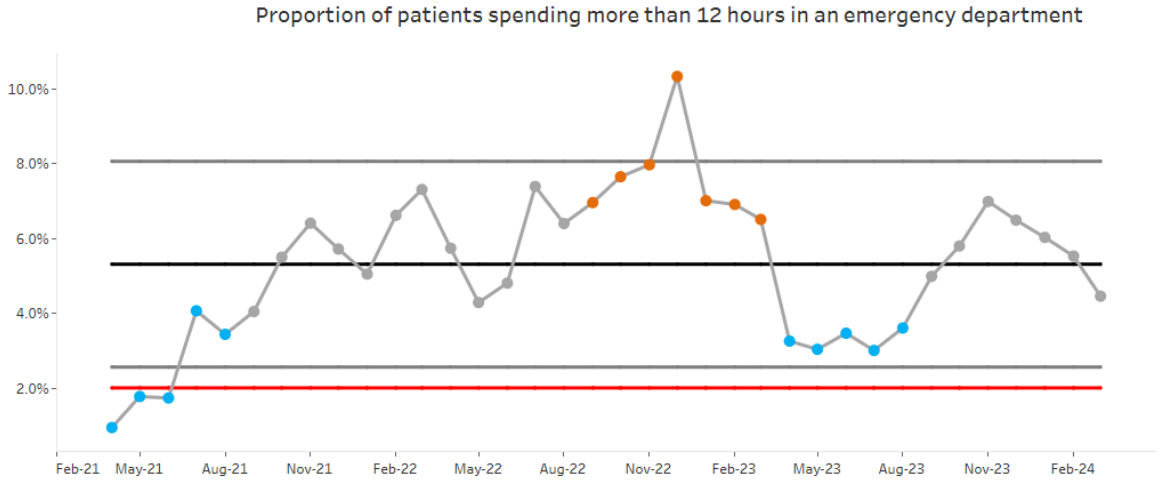


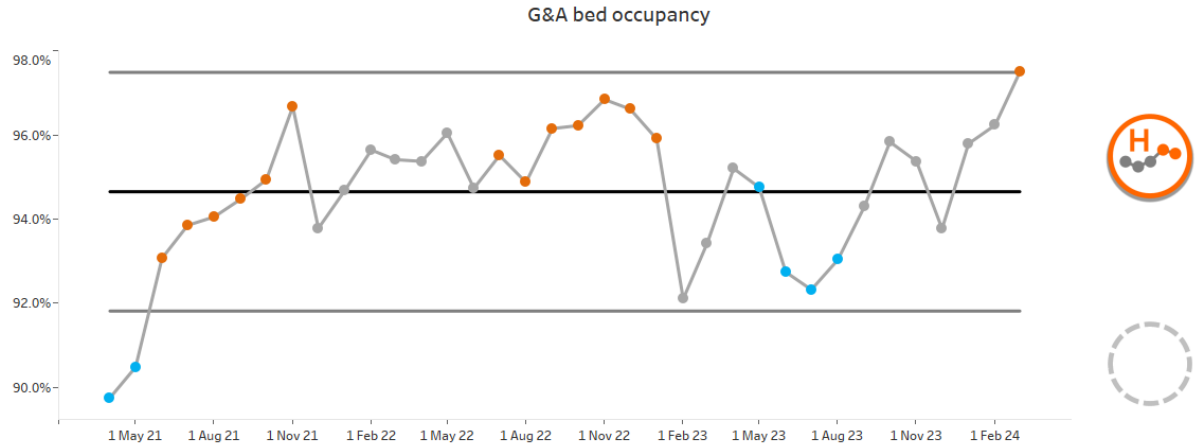
Benchmarking: ED (All types): February 24				
OUH: 65.0%	**National: 69.8%**	**Shelford: 65.8%**	BHT: 69.8%	RBH: 67.8%

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

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The Emergency Department (ED) 4-hour performance (All types) was 72.2% in March and for Type 1 activity, performance was 67.3%. 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 70.14% for all types and 62.62% for Type 1 at the John Radcliffe Hospital (JR) and 78.57% for all types and 78.52% for type 1 at the Horton Hospital in March. March saw the highest monthly attendance figures for the year. This is despite the 'Call before you Convery' pilot which commenced in March to try and reduce conveyances for category 3 and 4 calls with SCAS. Wait to be seen continues to be the most significant breach reason on both sites for admitted and non-admitted patients attributing to 56% of all 4-hour breaches in March 2024. Most significantly 70% of not admitted patients breached 4 hours in March. Waiting time to be seen extends far beyond 4 hours overnight therefore 4-hour performance deteriorates with most breaches occurring between 4pm and 6am. Skill mix of medical staffing is a key area of focus and whilst recruitment takes place, as an interim solution, shifts have been offered on an additional session basis but with limited fill rate. 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. Most notably the ED Observation and Review Unit concept has been tested with positive feedback and impact on helping to reduce overcrowding in the department, as well as contributing to the improved 4-hour performance. A focus on breaches through the day is becoming sustainably embedded in the Operational site meetings.	**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*

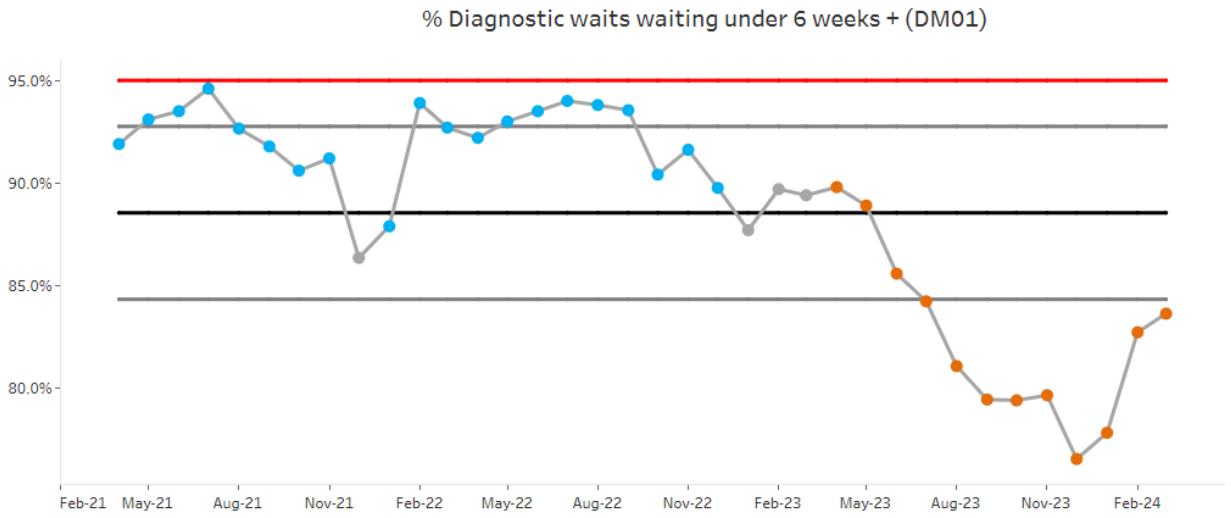
3. Assurance report: Operational Performance, *continued*





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 with a length of stay of more than 12 hours in an emergency department was 4% in March. For the first time since September last year performance was below the mean average of 5.6%, however above the target of 2%. The indicator has consistently not achieved the target. By site, the Horton met the target with only 2% of patients residing in the ED for more than 12 hours in March. The John Radcliffe was 5%. Occupancy has remained high and increased in March at 97.5% (98.9% at JR) triggering Special Cause Variation. Factors contributing this are • Attendances for the month were 14,427, the highest since before April 2021 and 9% above the three yearly average. • The ED Conversion rate to admission was high for the month at 34.75% at the JR and 21.45% at the Horton. This is above the 2-year average by 2.65% on both sites. • The additional beds opened for winter, and additional surge capacity both de-escalated in February (the additional beds remain open on the Churchill site for Urology elective recovery). • SDEC capacity has been protected and there was no overnight opening of AAU. • The average number of patients medically optimised for discharge decreased in March but remained above the mean . 17.36% of patients who did not meet the criteria to reside in March had been medically optimised for more than 14 days. This is 1.87% of the G&A bed stock and were Oxfordshire patients waiting for pathway 3 or out of county delays. Associated with the increase in attendances, is the medical and social complexity of patients and there has been an increase in the number of patients becoming medically optimised for discharge with the Transfer of Care Hub reviewing a very large number of referrals per day. The impact of the new Discharge to Assess pathway is beginning to embed and is reflected in the continued reduction in average length of stay for medically optimised Oxfordshire residents waiting for pathway 1. OUHFT is holding its position as the best performing Shelford Trust for patients with a length of stay over 21 days.	**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*



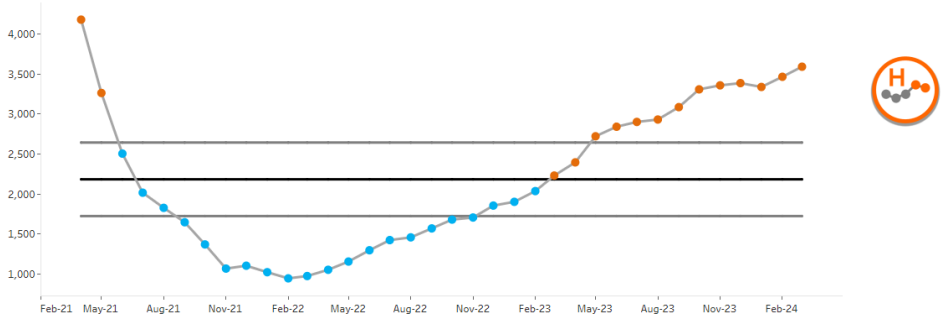
Benchmarking: February 24 DM01	
OUH	82.7%
National	83.6%
Shelford	71.2%
ICS	BHT: 77.0% RBH: 80.0%

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

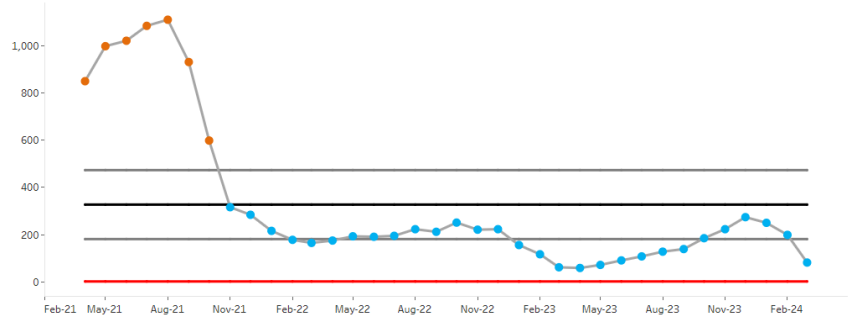
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The percentage of Diagnostic waits waiting under 6 weeks+ (DM01) was 84% in March. The indicator 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. **Endoscopy:**. • 1 Consultant is currently not practising • Vacancy for 1 Nurse Endoscopist • Vacancy for 1 Consultant • Sessions lost due to Industrial Action	**Audiology:** • Agreement to transfer a cohort of clinically appropriate patients to Another Qualified Provider (AQP). A 6-months' notification has been given in February dated back to January 2024, to take effect from July 2024. **Endoscopy:** • Seeking to continue HGH weekend lists from April 2024 • Review of points allocated to endoscopists with increases where applicable • Increase in capacity by reviewing patients and assessing clinical suitability • Review of training list requirement. • New Starter WC 11.03.24 and job planned for HGH Endoscopy • More efficient booking processes to actively avoid breaches • Request for ERF Funding to employ more Consultants	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) **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*

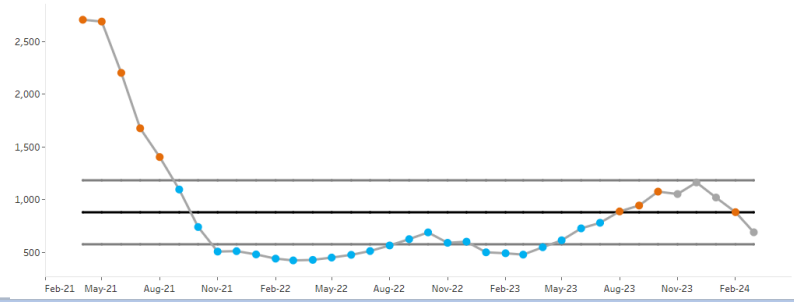
Total patients waiting more than 52 weeks to start consultant-led treatment



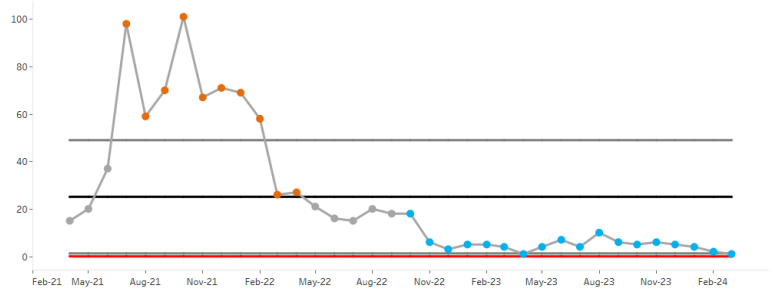
Total patients waiting more than 78 weeks to start consultant-led treatment



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



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

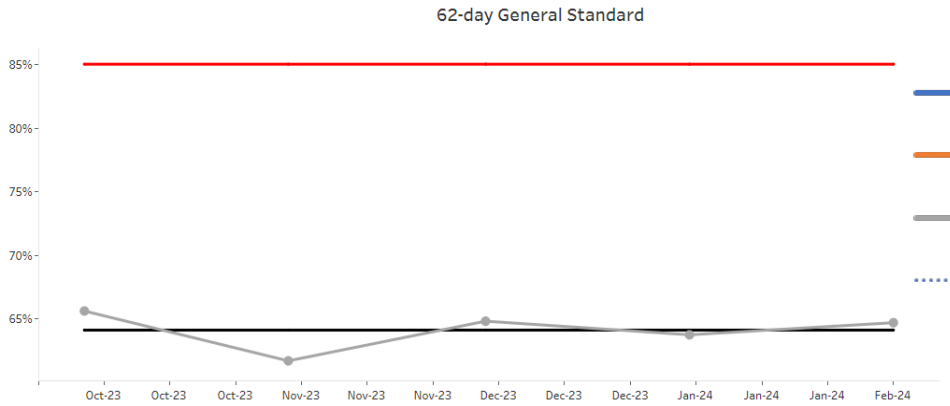


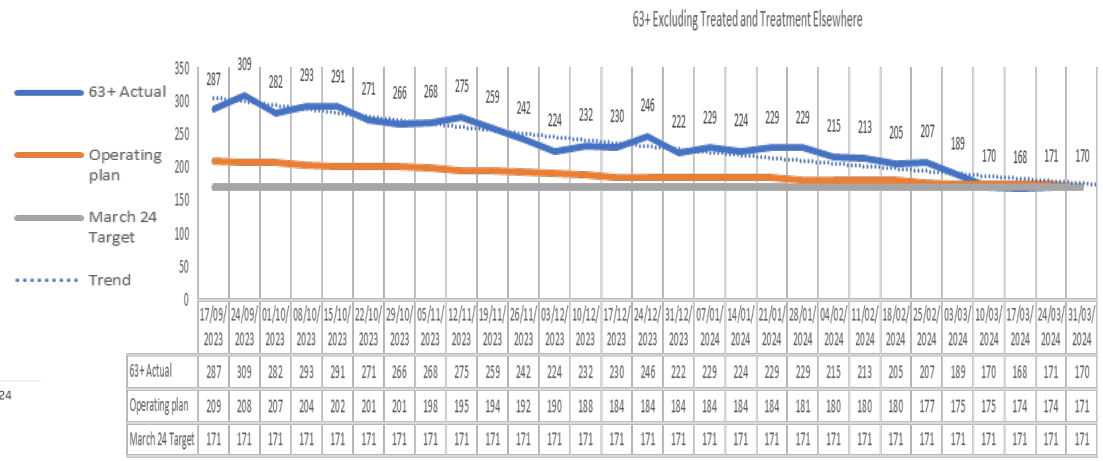
Benchmarking >52-weeks: February 24	
OUH	3,458
National	1,597 (avg.)
Shelford	3,660 (avg.)
ICS	BHT: 2,290 RBH: 9

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

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The number of patients waiting more than 52 weeks to start consultant-led treatment was 3,588 end of March. 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** - One Orthopaedic patient on a complex pathway breached. **78 weeks** - 80 incomplete pathways of which, 31 are due to capacity, 13 are due to Patient Choice, 24 are due to Complex pathways, 7 are Corneas and 5 Paediatric Spinal. **65 weeks –** 685 incomplete pathways reported. Focus remains in place to deliver nil pathways beyond 65-weeks by September in line with the Trust's Operating Plan 2024/25. Services not challenged in the longer wait cohorts are undertaking recovery of **52 week backlog.** Backlog recovery for end of year was exacerbated due to the impact of Industrial Action in February and competing theatre capacity needs with regards to clinical prioritisation.	• **Orthopaedic services** contract in place with an Independent Sector Provider and Mutual Aid has been requested via System and DMAS. • **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. • **Plastic services** are in discussions at System level for complex procedure mutual aid. • **Adoption of the national Interim Choice Guidance** has reduced the number of reported incomplete RTT Pathways. Tracking of these patients continue via Elective Assurance meeting led by the COO. • **Elective Recovery Fund** schemes live and tracked at ECRG • **Anaesthetic services** have appointed Locums to bridge capacity gap and increase baseline activity. • Patient Engagement Validation to be redone across entire 65-week cohort with support from ERF to administer and a forecast of over 10% reduction in the cohort.	Delivery of 65-week plan by September 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*





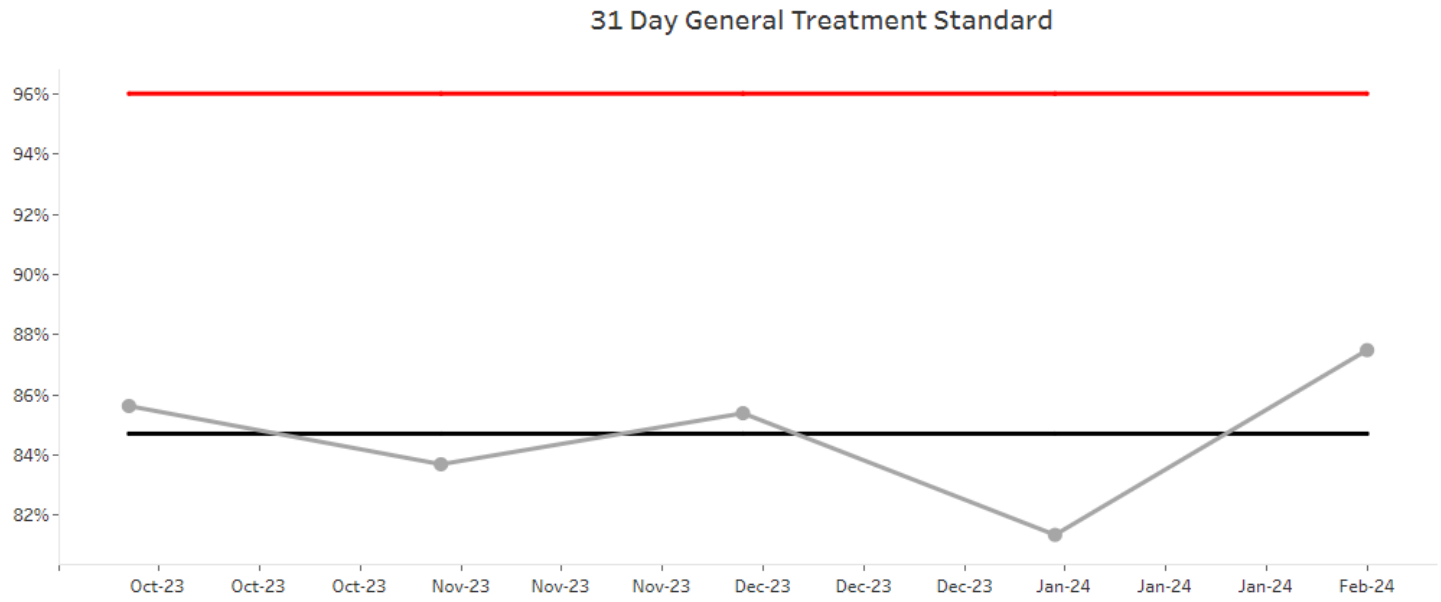
	17/09/2023	24/09/2023	01/10/2023	08/10/2023	15/10/2023	22/10/2023	29/10/2023	05/11/2023	12/11/2023	19/11/2023	26/11/2023	03/12/2023	10/12/2023	17/12/2023	24/12/2023	31/12/2023	07/01/2024	14/01/2024	21/01/2024	28/01/2024	04/02/2024	11/02/2024	18/02/2024	25/02/2024	03/03/2024	10/03/2024	17/03/2024	24/03/2024	31/03/2024
63+ Actual	287	309	282	293	291	271	266	268	275	259	242	224	232	230	246	222	229	224	229	229	215	213	205	207	189	170	168	171	170
Operating plan	209	208	207	204	202	201	201	198	195	194	192	190	188	184	184	184	184	184	184	181	180	180	180	177	175	175	174	174	171
March 24 Target	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171

Benchmarking: February 24 62-day General Standard	
OUH	64.9%
National	67.1%
Shelford	61.2%
ICS	BHT: 63.6% RBH: 70.8%

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

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
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 64.9% in February 2024, 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 has delivered the Operating Plan of below 171 pathways. All tumour sites apart from Children, Haematology – Acute & non-Acute Leukaemia, Head & Neck – Thyroid, Skin and Urology - Testicular are non-compliant for this standard in February. **Challenges identified:** • Complex tertiary level patients (6%) • Some slow pathways and processes (0%) • Capacity for some surgery, diagnostics and oncology (64%) • Late inter provider transfers (25%) • Patient reasons (5%) **>62-day PTL** impacted by the above with a backlog of **170** (census 31/03/24) against a year-end target of 171 (delivered operating plan).	**The Cancer Improvement Programme** launched in 2022/23 with a focus on 28-day Faster Diagnosis Standard (FDS). For January, **the Trust was 50th best out of 134 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 19/03/2024:** **Urology** still holds the highest proportion of long waiting patients and is already delivering its individual year-end target (59) since developing a one-stop clinic and MRI pathway with radiology services. **Gynae** holds the second highest volume and 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 an in-tear revision of the cancer waiting times guidance, low grade Brain pathways are reportable.	Faster Diagnostic Standards (FDS) to be achieved by all tumour sites outlined within the FDS Framework 2023/2024 170 patients over 62 days on the Patient Tracking List by March 2024 - delivered 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*

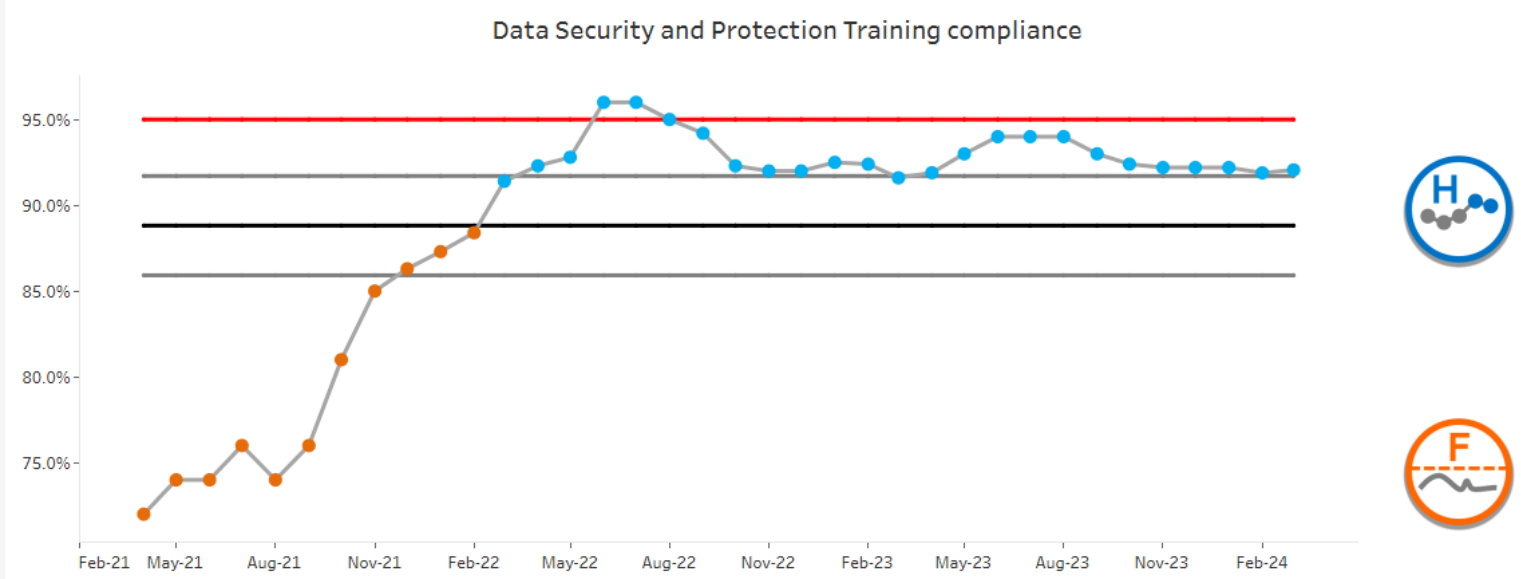


Benchmarking: February 24 31-day General Standard	
OUH	87.5%
National	93.5%
Shelford	88.3%
ICS	BHT: 83.9% RBH: 91.2%

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

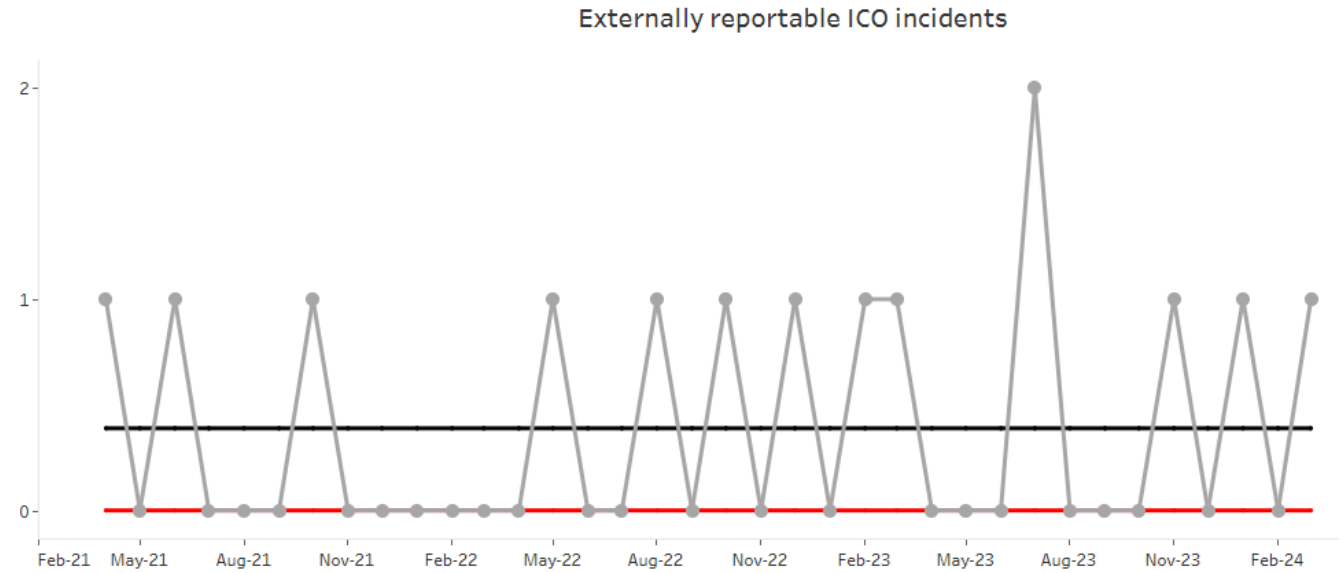
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Reporting of Cancer Standards have changed from October 2023 in line with the National Cancer Waiting Times guidance. Cancer performance against the 31-day combined standard was 87.5% in February, 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 January was 81.3% 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, *continued*



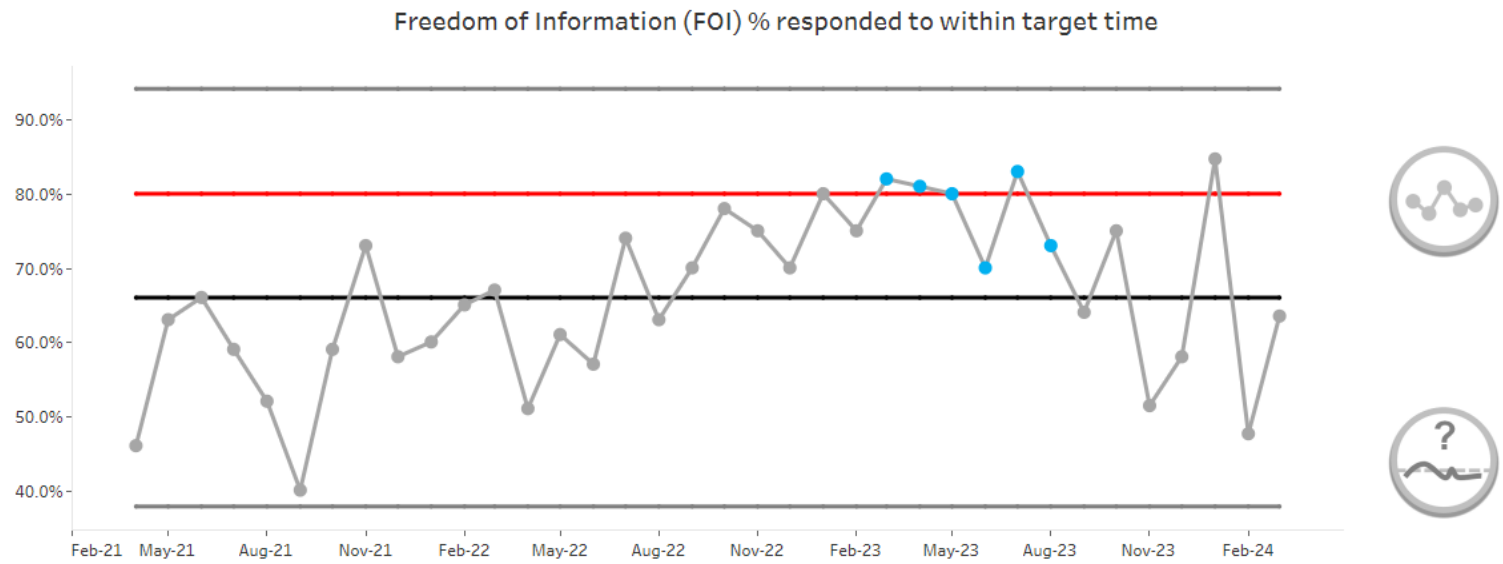
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Data security and Protection Training (DSPT) compliance was 92% in M12, below the target of 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%	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 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.	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*



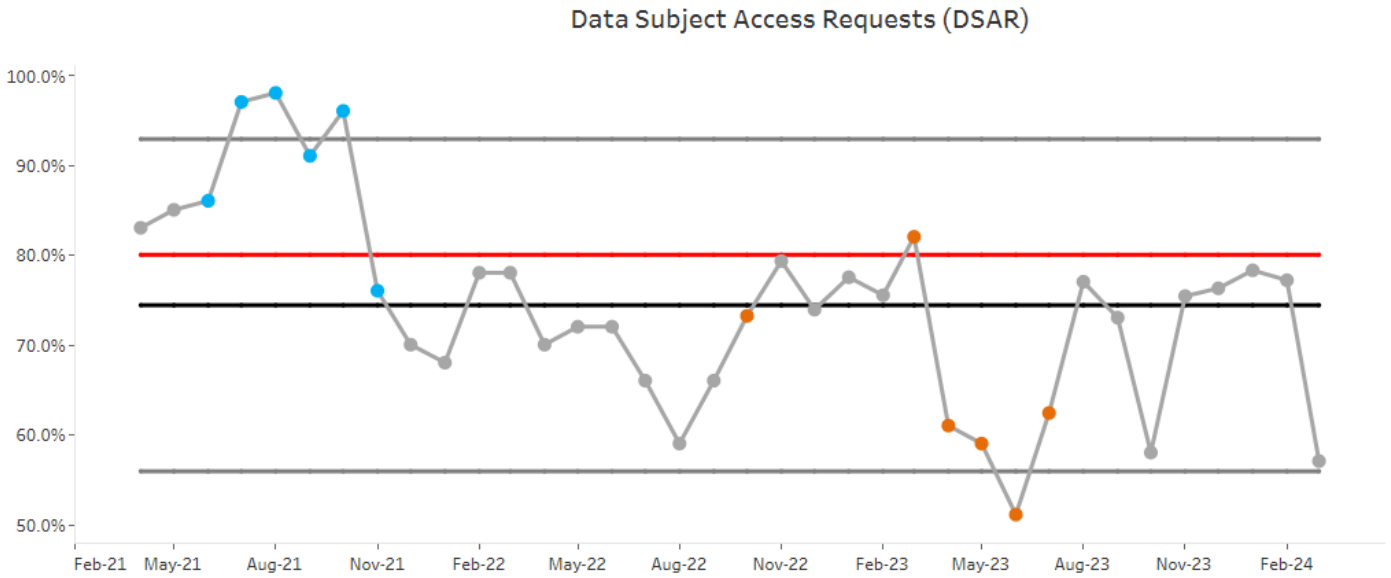
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Over the Easter weekend a break-in took place and photography equipment was stolen from the Clinical Photography office. Included within the stolen equipment was a memory card that contained 5 sets of patient images with patient identifying information.	Clinical Photography to review their security arrangements and procedures that at present require clinical images to be left on the memory card in the camera until it has been confirmed that the images are backed up on the central server. IG team and DPO are liaising with the ICO to answer queries they have sent us.	The final outcome of ICO investigation will be shared with DOC	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
M12 FOI performance against the 80% target was poor as 63 requests were received though 40 individual cases were closed which is above the recent average of 35.	New team member has started and has started work on live FOI cases as of 09/04/2024	Effect of increased capacity should be visible in M1 2025/6 IPR – further changes to FOI process to be discussed in DOC	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
In M12 DSAR performance has dipped again as the PACS team were only able to return 9 of the 193 DSAR requests received – 5% - on time.. The Medical Records team returned 319 of their 472 requests on time (68%) and Occupational Health 138 of 152 (91%). PACS were understaffed in M12 (one vacancy + holidays) and chose to prioritise clinical requests – they do not have staff dedicated to SAR requests.	PACS performance issue has been discussed with manager who is going to put more resource to clearing backlog	Performance improvement visible in M1 2024 IPR – SAR. Wider SAR performance challenges to be discussed in DOC	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