Oxford University Hospitals
NHS Foundation Trust

# Integrated Performance Report

## M4 (July data)

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# 1. Executive summary

Oxford University Hospitals NHS Foundation Trust

| | |
|---|---|
| Overview | In month 4, our Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) rates continued to demonstrate fewer patient deaths than expected and we provided high-quality care to our patients from the above target performance in VTE assessments, fewer pressure ulcer incidents per 10,000 beddays for category 2 and 3-4 incidents compared to our threshold, and fewer hospital infections than our monthly threshold (MRSA, MSSA, Klebsiella and PSAR). Our staff supported patient care by achieving the standards set for core skills training compliance, and our staff were supported by our better-than-target time to hire and achievement of the appraisal target for non-medical staff.<br><br>Our high performance in our Cancer Faster Diagnosis standard continued and we remain amongst the highest-performing hospitals nationally for this indicator. A long list of other successes are recognised within the Divisional Performance Review meetings relating to the contributions of our staff in improving the care and experience for our patients, workforce and population.<br><br>Out of the 96 indicators currently measured in the IPR, 33 are reported on in further detail using the standardised assurance templates. This includes indicators not meeting the performance standard or where there has been deteriorating special cause variation for where no target is identified. The review process at Trust Management Executive also enables other indicators without a target and not flagging special cause variation to be included in assurance reporting. |
| Quality, Safety and Patient experience | One Never Event was reported in July where a patient was dispensed and received the incorrect dose of Methotrexate. Immediate actions have been put in place, a duty of candour has been completed and recommendations from the investigation are scheduled to be reviewed at the Serious Incident Group. We recorded hospital infections above the monthly threshold for C-diff and E.Coli and assurance reports are provided for these and other indicators, including our complaints response rates, friends and family, safeguarding activity and training, PFI cleaning at the John Radcliffe, incidents with moderate harm or above, incidents of violence and aggression, and mothers birthed. |
| Growing Stronger Together | Sickness absence rates continue to decrease and exhibit improving special cause variation but remain above the target. Vacancy rates, although better than target, have exhibited deteriorating special cause variation. |
| Operational Performance | Patients attending our type-1 emergency departments and being seen within four hours did not meet the performance standard or trajectory for July. The time patients spent over 12 hours in the department was below standard but exhibited improving special cause variation. We recorded increases for some of our longest waiting patients and did not meet the diagnostic standard. Actions are included within the assurance reports referencing the Elective Recovery Fund schemes and other targeted initiatives. Tumour site actions are in place to improve cancer performance for patients on a 62-day GP pathway, and whilst the standard was not achieved there have been continued reductions in the number of patients waiting over 62 days. Improvement plans and actions are reviewed monthly at the Cancer Improvement Programme. |
| Finance | Reported financial performance in July was a £3.8m deficit. After adjusting for non-recurrent items, the average underlying deficit after four months is £6.6m per month. 1/3rd of this is due to inflationary costs hitting in full from April and a slow ramp-up of offsetting efficiency gains. The balance is over-spending. A financial recovery plan is being considered by the Board. |
| Digital | We recorded one Priority 1 incident in July. This is related to a temporary loss of network connectivity across multiple sites. We also reported two incidents to the Information Commissioner's Office (ICO) in July. Details of both incidents and actions are detailed within the assurance reports. Data Security and Protection Training and Subject Access Request response times also did not meet the performance standards in July. |
| Data quality | The assurance reports' data quality ratings have been completed and have outcomes ranging from 'satisfactory' to 'sufficient', as per the definitions referenced on page 8. |

# 2. a) Indicators identified for assurance reporting

Oxford University Hospitals NHS Foundation Trust

| | Common cause variation | Special cause variation - improving | Special cause variation - deterioration | Other *(where an increase or decrease has not been deemed improving or deteriorating, where SPC is not applicable, or the indicator has been identified for assurance reporting in the absence of performance vs target or special cause variation)* |
|---|---|---|---|---|
| **Quality, Safety and Patient Experience** | Not achieving target<br>• C-diff cases<br>• E.Coli<br>• Reactivated complaints<br>• Scheduled bookings<br>• Safeguarding (adults) training L3<br>• FFT outpatient % positive<br>• FFT ED % positive<br>• FFT Maternity % positive | Not achieving target<br>• Serious Incidents Requiring Investigation<br><br>Not achieving target<br>• % of complaints responded to within agreed timescales<br>• Safeguarding (children's) training L1-4<br>• CHPPD vs required | No target<br>• Assault, Aggression and Harassment.<br>• Incident rate of Violence and Aggression per 10,000 beddays.<br>• Number of incidents with moderate harm or above per 10,000 beddays.<br><br>Not achieving target<br>• PFI cleaning score (JR) | No target<br>• Mother's birthed<br>• Babies born<br><br>No target<br>• Children's safeguarding activity<br><br>No SPC<br>• Never Events<br>Not achieving target |
| **Growing Stronger Together** | | Not achieving target<br>• Sickness absence (rolling 12-month) | Achieving target<br>• Vacancy rate% | |
| **Operational performance** | Not achieving target<br>• ED 4-hour performance (all and type-1) | Not achieving target<br>• Proportion of patients spending more than 12 hours in the Emergency Department<br><br>Not achieving target<br>• Patients waiting more than 65 weeks to start consultant-led-treatment.<br>• Patients waiting more than 78 weeks<br>• Patients waiting more than 104 weeks | Not achieving target<br>• % Diagnostic waits under 6 weeks (DM01)<br>• Cancer 62-day waiting time from urgent referral<br><br>Not achieving target<br>• Patients waiting more than 52 weeks | |
| **Corporate Support Services** | | Not achieving target<br>• Data Security and Protection Training compliance | Not achieving target<br>• Data Subject Access Requests | No SPC<br>• Priority 1 incidents<br>• Externally reportable ICO incidents<br>Not achieving target |

# 2. b) SPC indicator overview summary

Oxford University Hospitals NHS Foundation Trust

## Quality, Safety and Patient Experience Summary

Latest Indicator Period: Jul-2023

| Indicator Description | Period | Performance | Target / Threshold | Met? | Mean | LCL | UCL |
|---|---|---|---|---|---|---|---|
| MRSA bacteraemia infection rate COHA and HOHA (per 10,000 beddays) | Jul-23 | 0.0 | - | - | 0.2 | -0.6 | 1.0 |
| MRSA cases: HOHA+COHA | Jul-23 | 0 | 0 | | 1 | -2 | 3 |
| Clostridium difficile infection rate COHA and HOHA (per 10,000 beddays) | Jul-23 | 6.4 | - | - | 3.6 | 0.1 | 7.2 |
| C-diff cases: HOHA+COHA | Jul-23 | 18 | 9 | No | 10 | 0 | 20 |
| E. coli infection rate COHA and HOHA (per 10,000 beddays) | Jul-23 | 7.1 | - | - | 5.5 | 0.8 | 10.1 |
| E. Coli cases: HOHA+COHA | Jul-23 | 20 | 13 | No | 15 | 2 | 29 |
| MSSA cases: HOHA+COHA | Jul-23 | 4 | - | - | 5 | 0 | 10 |
| Klebsiella cases: HOHA+COHA | Jul-23 | 6 | 7 | | 8 | 1 | 15 |
| PSAR cases: HOHA+COHA | Jul-23 | 4 | 4 | | 4 | -4 | 12 |
| Number of Never Events | Jul-23 | 1 | 0 | No | 0 | - | - |
| Serious Incidents Requiring Investigation (SIRI) | Jul-23 | 5 | 0 | No | 8 | -2 | 18 |
| VTE Risk Assessment (% admitted patients receiving risk assessment) | Jun-23 | 98.1% | 95.0% | | 98.1% | 97.8% | 98.5% |
| CAS alerts breaching deadlines at end of month and/or closed during month beyond deadline | Jul-23 | 0 | 0 | | 0 | - | - |
| Medication errors causing serious harm | Jul-23 | 3 | - | - | 2 | -1 | 5 |
| Mortality HSMR | Jul-23 | 92.7 | 100.0 | | 93.1 | - | - |
| Mortality SHMI | Jul-23 | 96.0 | 1.0 | No | 31.3 | - | - |
| Neonatal deaths per 1,000 total live births | Jun-23 | 3.8 | 3.2 | No | 3.7 | - | - |
| Stillbirths per 1,000 total births | Jun-23 | 4.3 | 4.0 | No | 3.5 | - | - |
| National Patient Safety Alerts not completed by deadline | Jul-23 | 0 | - | - | 0 | - | - |
| Potential under-reporting of patient safety incidents: Patient safety incident reporting rate per 10,000 beddays | Apr-21 | 0.0 | - | - | 0.0 | - | - |
| Inpatients with a learning disability and/or autism per million head of population | Apr-21 | 0.0 | - | - | 0.0 | - | - |
| Inappropriate adult acute mental health placement out -of -area placement bed days | Apr-21 | 0 | - | - | 0 | - | - |
| Number of active clinical research studies hosted | Jul-23 | 1386 | - | - | 1338 | 1305 | 1371 |
| Number of active clinical research studies (commercial) | Jul-23 | 361 | - | - | 344 | 328 | 359 |
| Number of active clinical research studies (non commercial) | Jul-23 | 1025 | - | - | 995 | 975 | 1014 |
| Number of incidents with moderate harm or above per 10,000 beddays | Jul-23 | 46.4 | - | - | 35.0 | 18.7 | 51.2 |
| Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 2) | Jul-23 | 24.6 | 26.0 | | 28.8 | 17.0 | 40.7 |
| Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 3 and 4) | Jul-23 | 1.8 | 3.0 | | 2.8 | -0.4 | 6.1 |
| Pressure Ulceration incidents per 10,000 beddays (Present on admission Cat 1+) | Jul-23 | 103.2 | 114.0 | | 117.8 | 88.8 | 146.7 |
| Harm from Falls (Moderate and above) | Jul-23 | 4 | - | - | 5 | -1 | 11 |
| Harm from Falls per 10,000 beddays (moderate and above) | Jul-23 | 1.4 | - | - | 1.7 | -0.5 | 3.9 |

*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

| Indicator | Period | Performance | Target | Mean | LCL | UCL |
|---|---|---|---|---|---|---|
| Number of complaints | Jul-23 | 133 | - | - | 98 | 55 | 141 |
| Number of complaints per 10,000 beddays | Jul-23 | 47.5 | - | - | 34.8 | 20.7 | 48.8 |
| % of complaints responded to within agreed timescales | Jul-23 | 81.0% | 95.0% | No | 68.1% | 49.5% | 86.8% |
| Reactivated complaints | Jul-23 | 11 | 1 | No | 8 | -2 | 17 |
| Number of RIDDORs | Jul-23 | 2 | - | - | 3 | -2 | 8 |
| Health and Safety related incidents - Assault, Aggression and harassment | Jul-23 | 190 | - | - | 124 | 56 | 191 |
| Incident rate of violence and aggression (rate per 10,000 beddays) | Jul-23 | 67.9 | - | - | 43.8 | 20.7 | 66.9 |
| FFT inpatient % positive | Jul-23 | 96.0% | 95.0% | | 95.1% | 93.3% | 96.8% |
| FFT outpatient % positive | Jul-23 | 93.9% | 95.0% | No | 93.7% | 92.2% | 95.2% |
| FFT ED % positive | Jul-23 | 82.3% | 85.0% | No | 78.1% | 69.4% | 86.7% |
| FFT maternity % positive | Jul-23 | 90.7% | 90.0% | | 87.5% | 63.2% | 111.8% |
| FFT children's % positive | Aug-22 | 93.9% | - | - | 93.6% | 87.2% | 100.1% |
| Inpatient FFT (response rate) | Jul-23 | 25.7% | - | - | 25.8% | 22.3% | 29.3% |
| Outpatient FFT (response rate) | Jun-23 | 24.4% | - | - | 11.5% | 6.7% | 16.2% |
| A&E FFT (response rate) | Jul-23 | 24.9% | - | - | 25.1% | 21.8% | 28.5% |
| Maternity FFT (response rate) | Jul-23 | 14.0% | - | - | 7.2% | 2.7% | 11.8% |
| Adult safeguarding activity | Jul-23 | 746 | - | - | 668 | 475 | 861 |
| Children's safeguarding activity | Jul-23 | 731 | - | - | 443 | 285 | 600 |
| Number of safeguarding consultations initiated by provider (both to internal and external organisations) | Jul-23 | 1477 | - | - | 1111 | 848 | 1373 |
| Safeguarding (children) training L1 - L4 compliance | Jul-23 | 90.8% | 90.0% | | 82.7% | 76.4% | 88.9% |
| Safeguarding (adults) training L3 | Jul-23 | 0.0% | 90.0% | No | 0.0% | 0.0% | 0.0% |
| Trust level: CHPPD vs budget | Jul-23 | 5.7 | - | - | -45.4 | -99.6 | 8.9 |
| Trust level: CHPPD vs required | Jul-23 | 5.2 | - | - | -19.8 | -43.0 | 3.5 |
| Mothers birthed | Jul-23 | 626 | 625 | - | 627 | 556 | 699 |
| Babies born | Jul-23 | 633 | - | - | 638 | 565 | 710 |
| Scheduled Bookings | Jul-23 | 726 | 750 | - | 710 | 566 | 853 |
| Inductions of labour from iView | Jul-23 | 149 | - | - | 147 | 106 | 188 |
| Midwife:birth ratio (1 to X) | Jul-23 | 29.0% | 28.0% | | 27.3% | 24.2% | 30.4% |
| PFI: % cleaning score by site (average) JR | Jul-23 | 89.0% | 95.0% | No | 93.7% | 84.9% | 102.5% |
| PFI: % cleaning score by site (average) CH | Jul-23 | 96.9% | 95.0% | | 94.4% | 88.4% | 100.4% |
| PFI: % cleaning score by site (average) NOC | Jul-23 | 97.6% | 95.0% | | 97.9% | 94.1% | 101.7% |

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

Oxford University Hospitals NHS Foundation Trust

## Growing Stronger Together Summary

Latest Indicator Period: Jul-2023

| Indicator Description | Period | Performance | Target / Threshold | Met? | Mean | LCL | UCL |
|---|---|---|---|---|---|---|---|
| Vacancy rate % | Jul-23 | 7.4% | 7.7% | | 6.8% | 5.7% | 7.8% |
| Turnover rate (rolling 12 months) | Jul-23 | 10.9% | 12.0% | | 11.6% | 10.9% | 12.2% |
| Sickness absence (rolling 12 months) | Jul-23 | 4.0% | 3.1% | No | 4.1% | 3.9% | 4.3% |
| Appraisal compliance (non medical) | Jul-23 | 93.7% | 85.0% | | 66.9% | 40.9% | 92.9% |
| Core skills training compliance | Jul-23 | 92.7% | 85.0% | | 88.9% | 87.6% | 90.3% |
| Time to hire (average days) | Jul-23 | 45.7 | 53.0 | | 51.9 | 42.0 | 61.7 |

## Operational Performance Summary

Latest Indicator Period: Jul-2023

| Indicator Description | Period | Performance | Target / Threshold | Met? | Mean | LCL | UCL |
|---|---|---|---|---|---|---|---|
| Proportion of ambulance arrivals delayed over 30 minutes | Jul-23 | 6.5% | - | - | 8.7% | 0.8% | 16.7% |
| Ambulance turnaround time > 60 minutes | Jul-23 | 0.5% | - | - | 1.4% | -0.5% | 3.3% |
| ED 4hr performance - All | Jul-23 | 68.5% | 76.0% | No | 67.9% | 59.9% | 76.0% |
| ED 4hr performance - Type 1 | Jul-23 | 62.5% | 76.0% | No | 62.6% | 53.7% | 71.6% |
| Proportion of patients spending more than 12 hours in an emergency department | Jul-23 | 3.0% | 2.0% | No | 5.3% | 2.3% | 8.2% |
| Proportion of patients discharged from hospital to their usual place of residence | Jul-23 | 92.1% | - | - | 91.8% | 90.6% | 93.0% |
| Available virtual ward capacity per 100k head of population | Apr-21 | 0.0 | - | - | 0.0 | - | - |
| Number of virtual ward spaces available | Apr-21 | 0 | - | - | 0 | - | - |
| G&A bed occupancy | Jul-23 | 92.3% | - | - | 94.5% | 91.7% | 97.2% |
| Theatre utilisation (elective) | Jul-23 | 97.7% | 85.0% | | 89.2% | 85.1% | 93.3% |
| % Diagnostic waits waiting under 6 weeks + (DM01) | Jul-23 | 84.2% | 95.0% | No | 91.0% | 87.0% | 94.9% |
| Total patients waiting more than 52 weeks to start consultant-led treatment | Jul-23 | 2896 | - | - | 1858 | 1340 | 2376 |
| Total patients waiting more than 65 weeks to start consultant-led treatment | Jul-23 | 775 | - | - | 850 | 546 | 1155 |
| Total patients waiting more than 78 weeks to start consultant-led treatment | Jul-23 | 106 | 0 | No | 366 | 212 | 519 |
| Total patients waiting more than 104 weeks to start consultant-led treatment | Jul-23 | 4 | 0 | No | 31 | 2 | 60 |
| 62 days Maximum waiting time from urgent referral to treatment of all cancers | Jun-23 | 60.2% | 85.0% | No | 62.9% | 52.3% | 73.4% |
| Proportion of patients meeting the faster cancer diagnosis standard | Jun-23 | 82.1% | 75.0% | | 79.3% | 71.5% | 87.1% |
| 31-all (new standard) | Apr-21 | 0.0% | - | - | 0.0% | - | - |
| Cancer: % patients diagnosed at stages 1 and 2 | Apr-21 | 0.0% | - | - | 0.0% | - | - |
| 62 Day incomplete pathways >62 days | Jul-23 | 216 | - | - | 274 | 202 | 345 |
| 62 Day incomplete pathways >104 days | Jul-23 | 93 | - | - | 88 | 64 | 112 |
| Total DC activity undertaken compared with 2019/20 baseline | Jul-23 | 84.3% | - | - | 88.1% | 70.1% | 106.1% |
| Total IP elective activity undertaken compared with 2019/20 baseline | Jul-23 | 66.8% | - | - | 82.6% | 57.9% | 107.4% |
| Total first outpatient activity undertaken compared with 2019/20 baseline | Jul-23 | 98.2% | - | - | 103.2% | 77.1% | 129.4% |
| Total follow up outpatient activity undertaken compared with 2019/20 baseline | Jul-23 | 104.0% | - | - | 108.8% | 80.5% | 137.1% |
| Total diagnostic activity undertaken compared with 2019/20 baseline | Jul-23 | 118.0% | - | - | 114.0% | 96.6% | 131.3% |
| Total patients treated for cancer compared with the same point in 2019/20 | Jul-23 | 87.7% | - | - | 122.9% | 80.6% | 165.2% |

*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

Oxford University Hospitals NHS Foundation Trust

## Finance Summary

| Indicator |
|---|
| In-month financial performance Surplus/Deficit £ |
| In-month financial performance Surplus/Deficit % |
| Adjusted in-month financial performance Surplus/Deficit £ |
| In-month financial variance from breakeven duty £ |
| In-month financial variance from forecast outturn £ |
| Year-to-date financial performance Surplus/Deficit £ |
| Year-to-date financial performance Surplus/Deficit % |
| Year-to-date financial variance from breakeven duty £ |
| Year-to-date financial variance from forecast outturn £ |
| Forecast outturn financial performance Surplus/Deficit £ |
| Forecast outturn financial performance Surplus/Deficit % |
| Forecast outturn financial variance from breakeven duty £ |
| Forecast outturn financial variance from forecast outturn £ |
| Elective recovery funding (ERF) value-weighted activity % |
| iWAU (Weighted Activity Unit) |
| Total income £ |
| Commissioned and patient care income £ |
| Other income £ |
| Total pay £ |
| Substantive pay £ |
| Agency pay £ |
| Bank pay £ |
| Total non-pay £ |
| Drugs £ |
| Clinical supplies £ |
| Premises £ |
| Other non-pay £ |
| Cash £ |
| BPPC £ |
| BPPC Volume |
| Debtor days |
| Creditor days |
| In-month gross capital expenditure |
| In-month ICS CDEL capital expenditure |
| Year-to-date gross capital expenditure |
| Year-to-date ICS CDEL capital expenditure |
| Forecast outturn gross capital expenditure |
| Forecast outturn ICS CDEL capital expenditure |
| Efficiency delivery £ |
| Total pay WTE |
| Budgeted establishment - substantive staff in post (worked WTE) |

NB. Financial performance is included separately to the IPR for M4.

Finance indicators appropriate for the IPR have been agreed and shown on this summary page. A timetable is being prepared for dates for when all indicators will be available.

## Corporate support services – Digital Summary

Latest Indicator Period: Jul-2023

| Indicator Description | Period | Performance | Target / Threshold | Met? | Mean | LCL | UCL |
|---|---|---|---|---|---|---|---|
| Priority 1 Incidents | Jul-23 | 1 | 0 | No | 1 | - | - |
| Data Security and Protection Training compliance | Jul-23 | 94.0% | 95.0% | No | 87.8% | 84.2% | 91.3% |
| Data Security & Protection Breaches | Jul-23 | 32 | - | - | 25 | 12 | 38 |
| Externally reportable ICO incidents | Jul-23 | 2 | 0 | No | 0 | - | - |
| All IG reported incidents | Jul-23 | 32 | - | - | 26 | 12 | 41 |
| Freedom of Information (FOI) % responded to within target time | Jul-23 | 83.0% | 80.0% | | 66.4% | 43.6% | 89.1% |
| Data Subject Access Requests (DSAR) | Jul-23 | 62.4% | 80.0% | No | 75.2% | 58.7% | 91.8% |

## Corporate support services – Legal services Summary

Latest Indicator Period: Jul-2023

| Indicator Description | Period | Performance | Target / Threshold | Met? | Mean | LCL | UCL |
|---|---|---|---|---|---|---|---|
| Legal Services: Number of claims | Jul-23 | 19 | - | - | 17 | 2 | 32 |

## Corporate support services – Regulatory assurance

Latest Indicator Period: Jul-2023

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

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

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

## SPC Variation/Performance Icons

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

## SPC Assurance Icons

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

# OUH Data Quality indicator

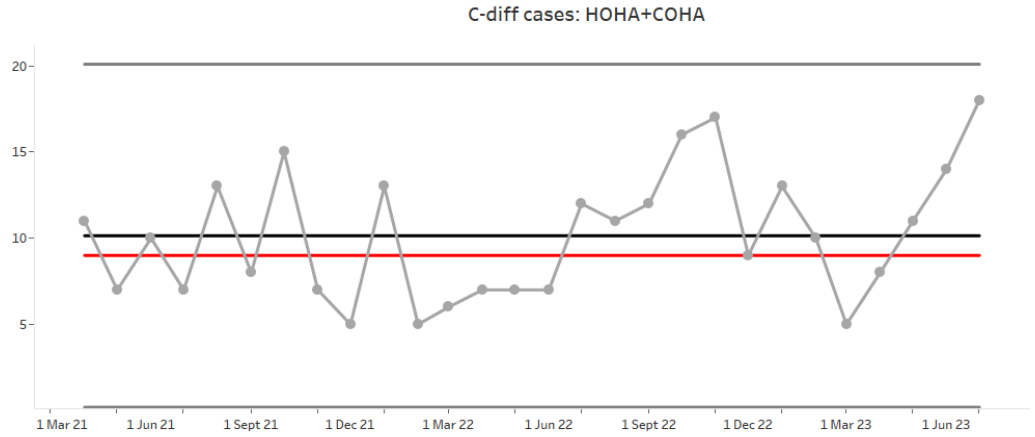
| | | | |
|---|---|---|---|
| **Valid**: Information is accurate, complete and reliable. Standard operation procedures and training in place. | **Verified**: Process has been verified by audit and any actions identified have been implemented. | **Timely:** Information is reported up to the period of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

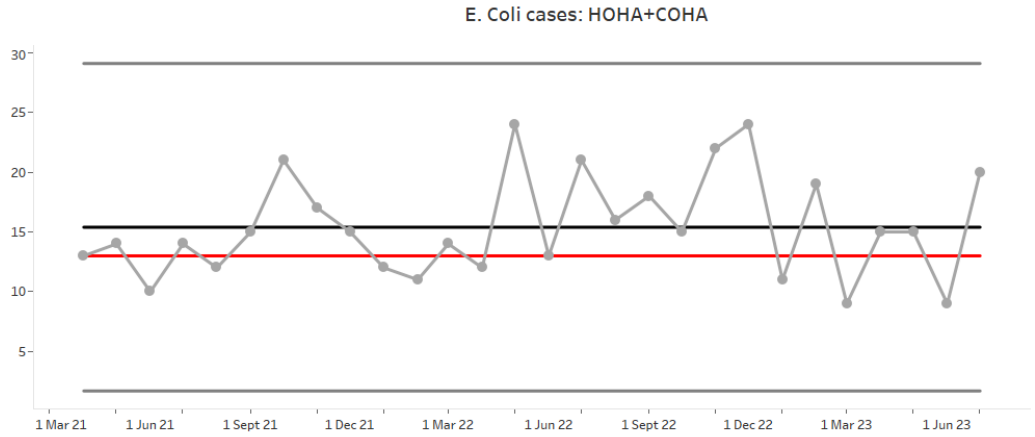
| Sufficient | Satisfactory | Inadequate |
|---|---|---|

# 03. Assurance reports

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

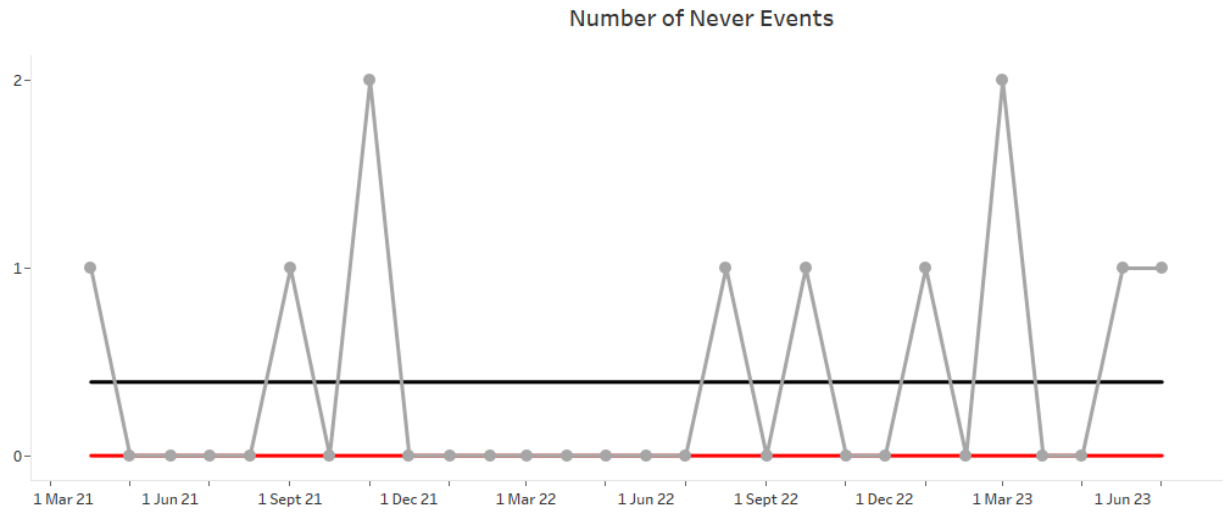




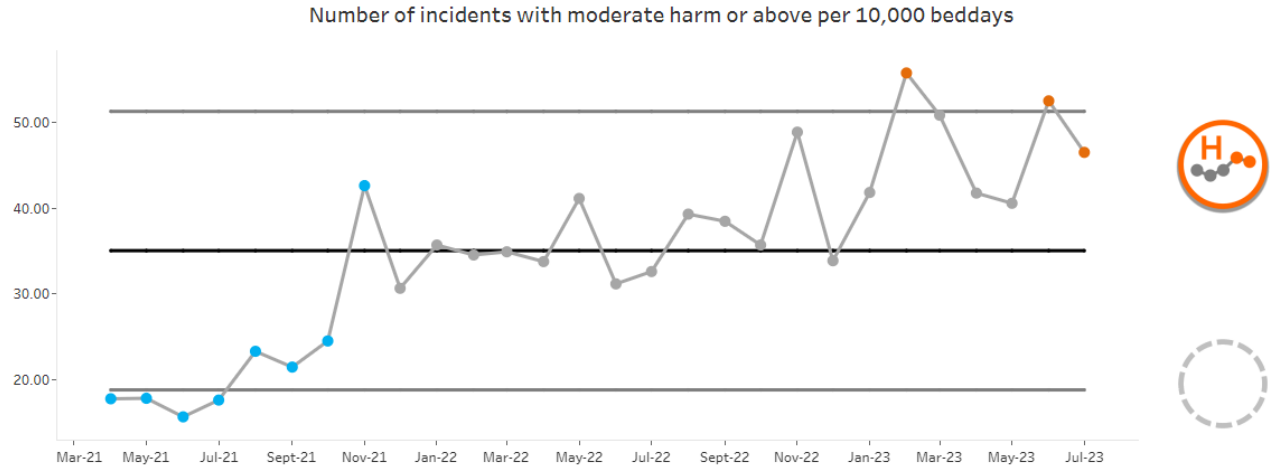




| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| The number of cases of C.diff and E.coli exceeded the monthly threshold in July but exhibited common cause variation. | E.coli, trajectory of 153 cases, currently 10 cases over cumulative monthly limit with total of 51 cases. 7 HOHA/COHA cases with urinary tract source. An increase in GNBSI is often observed nationally during summer, thought to be due to a lack of hydration.<br>A new assay is now in place for Cdiff, 18 cases were recorded in July, these were true positives.<br>Cluster of C.diff cases identified in CMUB, 3 cases in June and 4 in July. Ribotyping demonstrates a mix of person to person transmission and sporadic cases. Concerns regarding cleaning and appropriate use of sporicidal wipes identified. No antimicrobial concerns identified.<br>C.diff reduction interventions continue. | Action plan for increased incidence of cases on CMUB, update meeting planned for August. | BAF 4 | Sufficient |

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

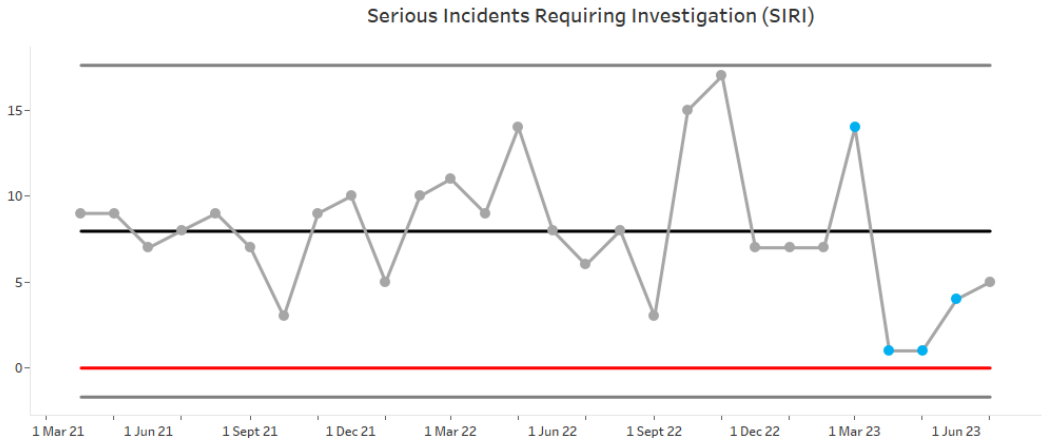



| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| July saw the confirmation of one Never Event, reference 2324-007. This concerned a patient who was dispensed and received the incorrect dose of methotrexate.<br><br>The Pharmacy system shows that 2.5mg tablets were requested for a 10mg weekly dose, however 16 x 10mg tablets were labelled with directions to take "Take FOUR tablets (10mg) ONCE A WEEK on the same day each week". | An investigation of this incident is being led by a DCMO, with discussions currently being arranged.<br><br>The 10mg methotrexate tablets have now been taken out of use at the Horton and removal in process in pharmacy on other sites.<br><br>The patient is no longer under OUH care, Duty of Candour has been completed. | A presentation of interim findings and proposed recommendations from this investigation is scheduled to take place at the SI Group meeting on 14 September 2023. | BAF 4 | Sufficient |




| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| There were 46.4 incidents with moderate harm or above per 10,000 beddays in July. The indicator exhibited negative special cause variation due to seven consecutive periods recorded above the mean of 35 incidents with moderate harm or above per 10,000 beddays.<br><br>The approach to some maternity incidents, such as post-partum haemorrhages, changed during October 2021, and the Trust began calling these as Moderate-impact incidents, in line with national practice. Maternity now calls a significant percentage of Moderate+ incidents (51 of the 133 incidents in July 2023, or 38%). That this graph includes 6 months prior to this change explains why so many later months show data near or above the mean. There is a standard pro-forma response to the majority of these incidents in Maternity, which allows the Trust to confirm whether there are any concerns around practice – in 2022 95% of these pro-formas confirmed that there were no significant concerns requiring follow-up. | June and July 2023 saw a large number of Moderate incidents called under the Assault, Aggression & Harassment cause group, primarily relating to incidents involving two inpatients. In July 2023, 26 of the 133 incidents (20%) were under this cause group and only one of these was a patient incident, the others all affected staff and visitors (the single patient incident here was raised by Safeguarding reflecting concerns raised about a patient's safety in their own home).<br><br>There is a possibility that not all of these non-patient incidents have been accurately graded, as they rarely receive further scrutiny through the SIRI Forum process. It is also noteworthy that the implementation of the Learn from Patient Safety Events system nationally in August means that there is no longer up-to-date national guidance on impact grading for non-patient incidents. | An approach to reviewing grading of non-patient Moderate+ incidents will be undertaken at the August meeting between Clinical Governance and Divisional governance staff. | *No* | Sufficient |

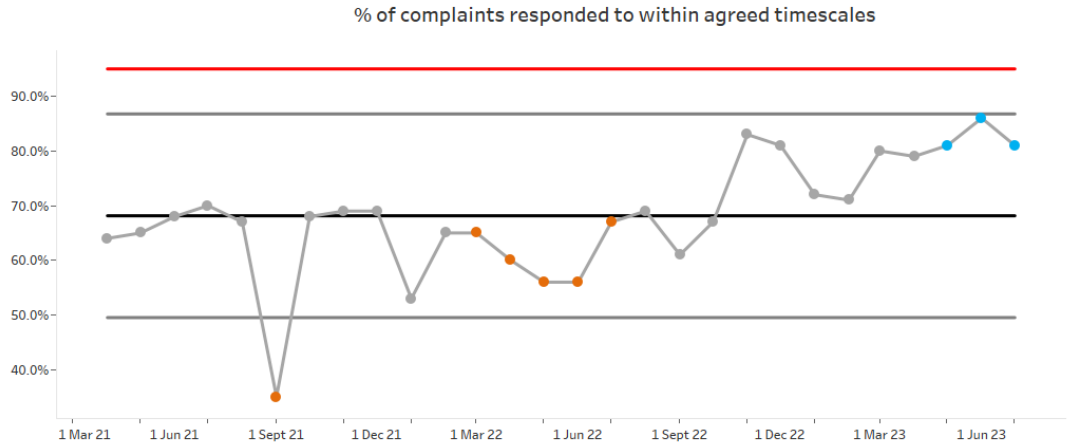
# 3. Assurance report: Quality, Safety and Patient Experience, *continued*



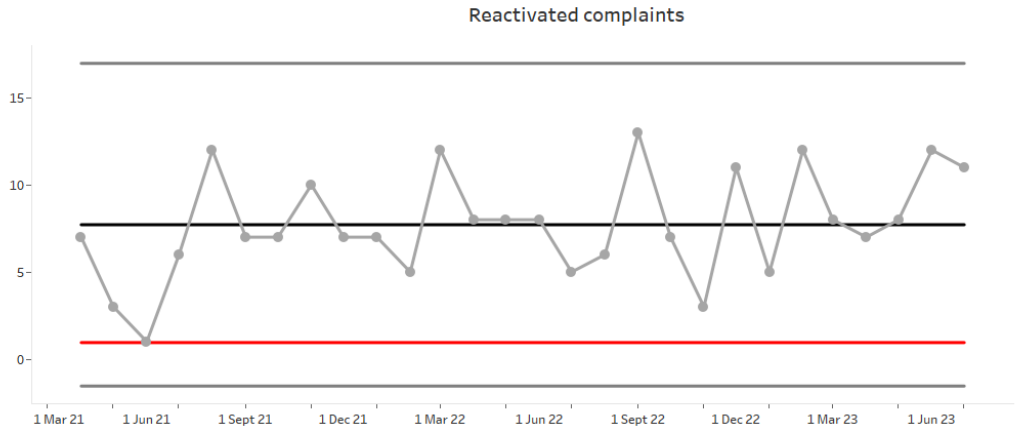

| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| There were 5 Serious Incidents Requiring Investigation (SIRI) in July. The indicator exhibited common cause variation, but has been identified for assurance reporting due to a threshold of zero SIRIs per month.<br><br>The five SIRIs concerned:<br>• HSIB investigations into a baby who required cooling, and a maternal death at 26 weeks of a woman with a cancer diagnosis<br>• Adelay in reporting a renal MRI scan for a patient with angiomyolipoma<br>• A patient with abnormal and unexpected anatomy underwent a ureteric re-implantation procedure<br>• A patient receiving the incorrect dose of methotrexate (this is a Never Event, and is detailed further on the previous slide) | SIRIs are investigated according to the requirements of, and within the timeframe specified by, at the SI Framework. Interim findings will be discussed in the Serious Incident Group, where guidance on the final conclusions and action plan can be supplied; the exceptions are the HSIB investigations, which follow their own timetable and process. | The SI Framework allows 60 working days for the investigation of SIRIs, although extensions may be agreed with our commissioners on a case-by-case basis.<br><br>SIRI Forum/Serious Incident Group (SIG) report to Patient Safety & Effectiveness (PSEC) a subcommittee of Clinical Governance Committee (CGC)<br>SIRI/Never Event Report presented bimonthly to CGC. | BAF 4<br><br>CRR 1122 | Sufficient |

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







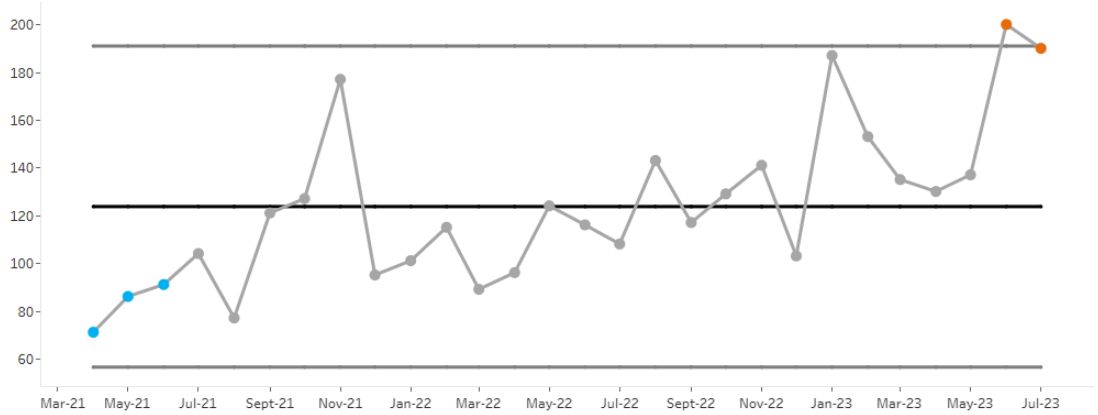




| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| In July 2023, 81.0% of complaints were responded to within 40 days, below the target of 95%. The indicator has consistently not achieved the target. However, July's performance exhibited improving special cause variation with over six months' performance above the mean of 68.1%.<br><br>Reactivated complaints exhibited common cause variation but were above the target value of one reactivated complaint per month.<br><br>The Trust saw a 13 percent increase in formal complaints in 2022/23, at a time of increased patient activity and national strike action. This has meant that complaints are not always responded to in the required timescale due to the pressures on the clinical and management teams. | Complaints about to breach response deadline given more focus by Divisional management teams, to try and prevent breach.<br><br>Weekly meetings held with Divisions to review complaints that have either breached or will breach 25 working days. Divisional Management teams, in conjunction with Complaints team, will chase where the complaint is in the system and support that member of staff/team to ensure it is addressed as soon as possible.<br><br>Themes and trends of complaints discussed weekly in ICCSIS meeting and raised in SIG / SIRI forum to raise awareness of issues being reported.<br><br>A review of the systems and processes for complaints is underway, the output from this will be presented to Trust Management Executive at the end of September 2023.<br><br>Additionally the Complaints and PALS team have now moved to a new version of Ulysses, which is web based. Divisions have read-only access to their complaints, to allow for greater collaboration between them and the Complaints team. | Ongoing, reviewed weekly | BAF 4 | Sufficient |

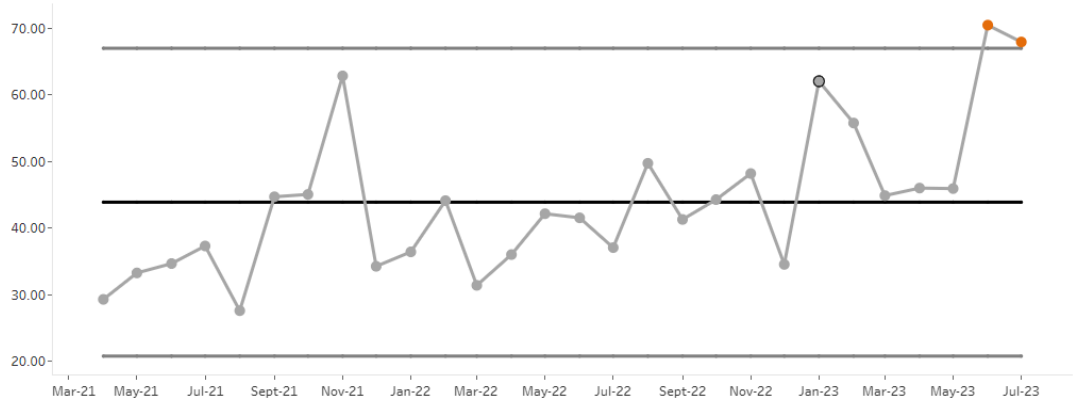
# 3. Assurance report: Quality, Safety and Patient Experience, *continued*



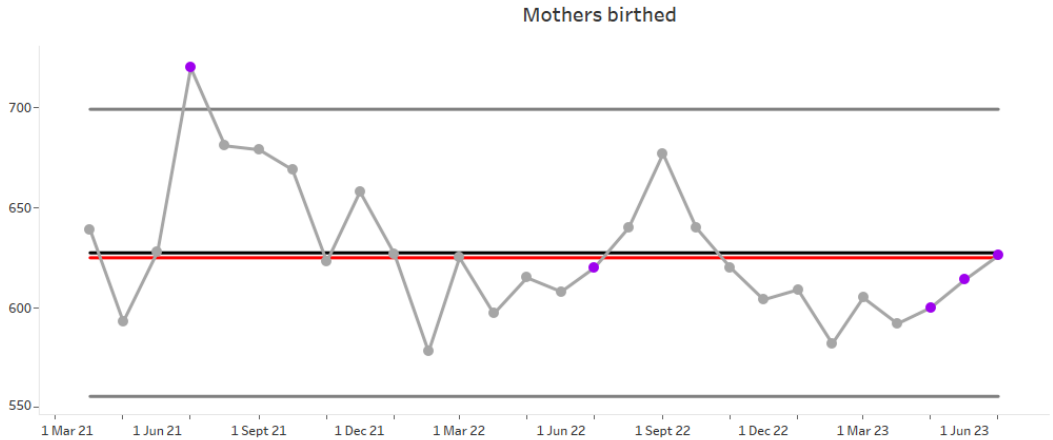
Health and Safety related incidents - Assault, Aggression and harassment

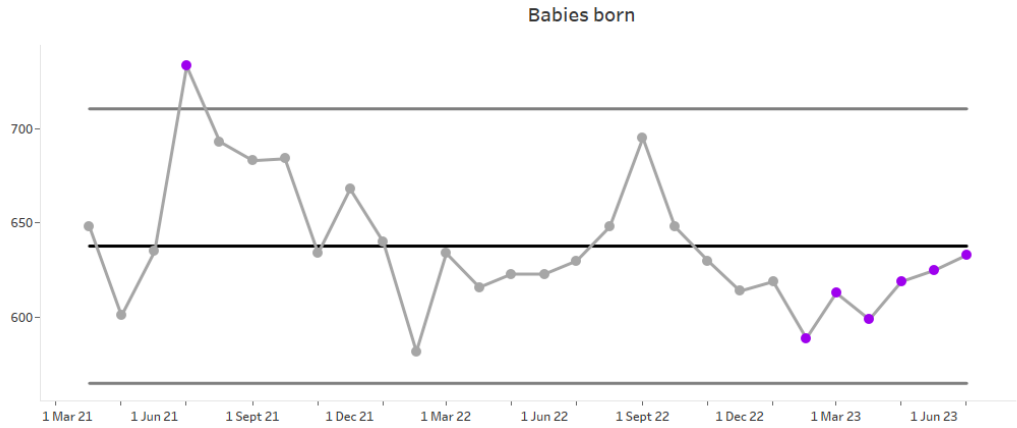



Incident rate of violence and aggression (rate per 10,000 beddays)

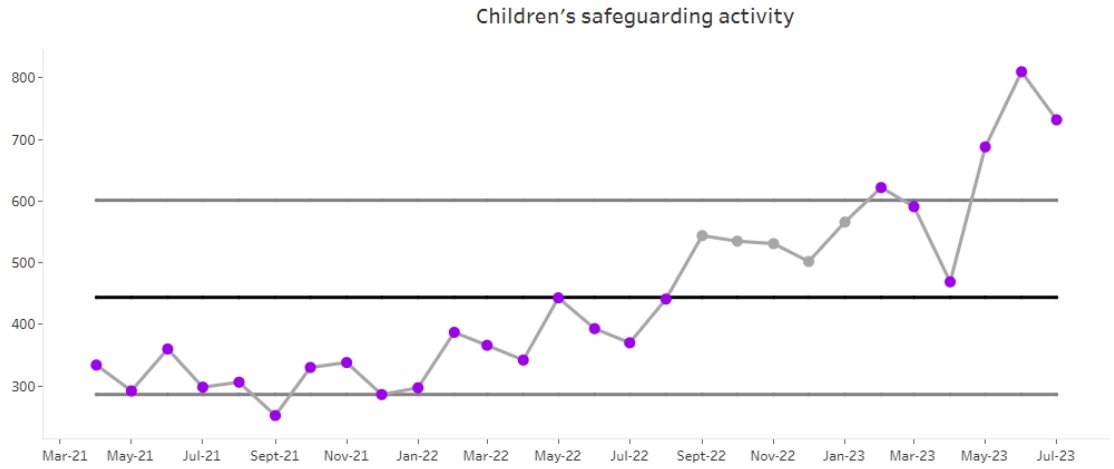



| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| There were 190 Health and Safety related incidents per 10,000 beddays in July. The indicator exhibited negative special cause variation due to seven consecutive periods recorded above the mean of 124 incidents with moderate harm or above per 10,000 beddays.<br><br>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.<br><br>The majority of violence and aggression incidents are attributed to the clinical condition of the patient and them lacking capacity. Increases in the numbers and complex nature of these patients along with them remaining in the acute setting for prolonged periods of time due to a lack of suitable locations to discharge them onto is a contributing factor in the rise in incidents. Multiple incidents are often a result of a few patients repeating their behaviour.<br><br>The resources available within the Security Team are not sufficient to guarantee support due to the number of incidents (especially when there are multiple incidents in different locations) and the often prolonged length of time incidents can take to de-escalate to a safe level. | Encouraging staff not to accept abusive behaviour and increased reporting is a positive outcome of the No excuses campaign but does lead to spikes in figures.<br><br>Clinical Teams within Directorates manage clinically attributed aggression through individual care planning, 1:1 specialing and with Security support.<br><br>The CNO chairs a Violence Reduction Group, and there are regular V&A Safety Groups within directorates.<br><br>Clinically worn body cameras have been introduced into areas where they will have a de-escalation effect and continue to be rolled out.<br><br>The Security Teams are undertaking enhanced physical intervention training to be compliant with the Restraint Reduction Network Standards. Conflict Resolution training as a whole is being discussed through the Violence Reduction Group. | VAR group meets monthly.<br><br>ED V&A Staff Safety Group meets fortnightly, and this model is being rolled out throughout other directorates. | BAF 1 | Sufficient |



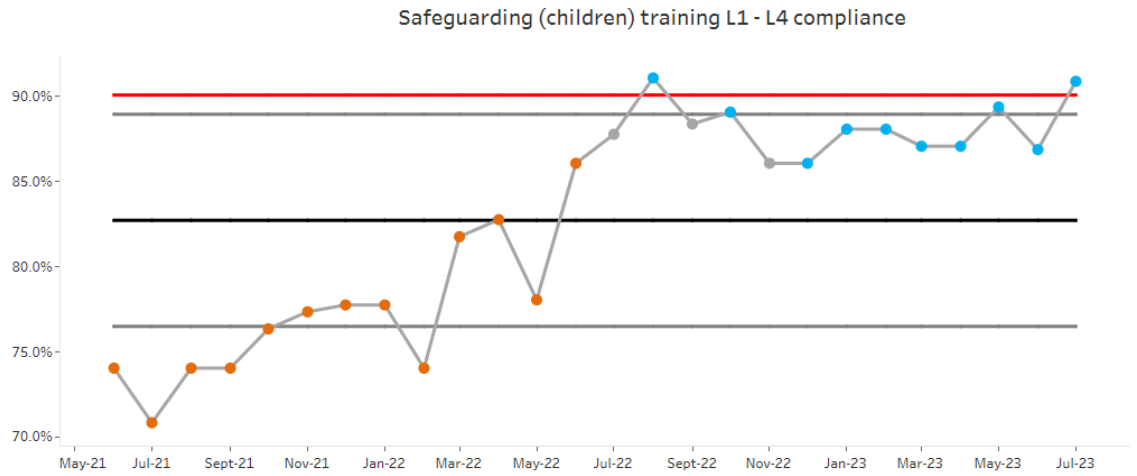

| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| There were 626 mothers birthed in July. The indicator exhibited special cause variation due to nine consecutive points below the mean. However, the number of Mothers birthed has seen a rise for three consecutive months and was above the threshold of 625.<br><br>The related indicator of babies born also exhibited special cause variation with over six months' performance on an upward trend but remains below the mean of 638. | OUHT have seen a reduction in birthrate overall which is aligned to the national trend. However, for the last three consecutive months the service has seen an upward trend in the number of births. As previously noted, it is nationally recognised that factors such as the Covid pandemic and the current economic crisis have impacted whether people have brought forward or delayed increasing their families.<br><br>Acuity remains high. The SVD rate is down, however, the induction of labour rate and caesarean section rate continues to rise. This upward trend in acuity continues to support the business case for the recommended uplift in Midwifery staffing. | A Maternity Safe Staffing paper which includes the birthrate plus recommendations is currently being taken through the appropriate governance process. This is following the latest analysis of the Birth Rate plus benchmarking tool in February 2023 which demonstrated that there is a need for an uplift in midwifery staffing of 22.38 wte. | BAF 4 | Satisfactory<br><br>*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* |

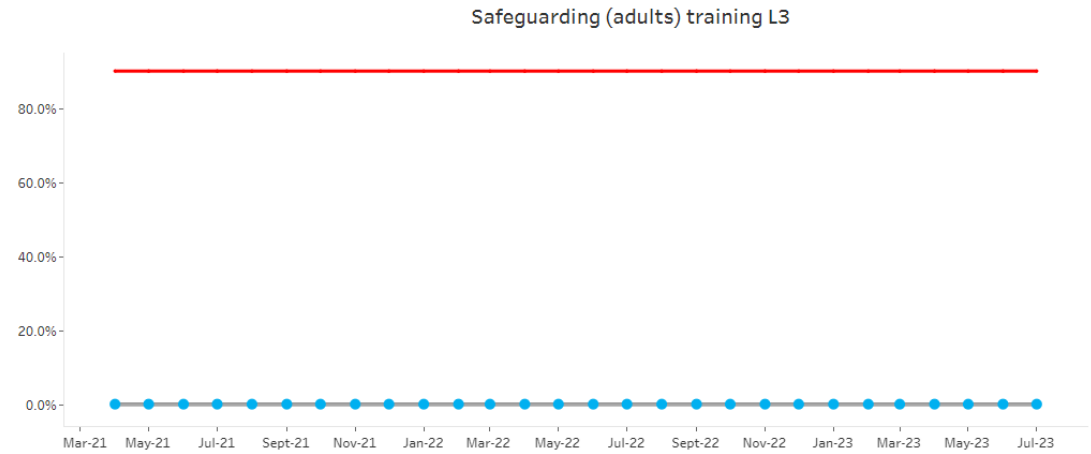



| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| Safeguarding children and maternity activity reduced in July by 78 (n=731). Childrens continue to see themes of adolescent mental health, complex attendances and issues for children in care presenting in crisis. | Escalation to primary care and children social care of complex cases. Attendance at multi agency meetings to share information for 67 cases in July – an increase of 20 from June.<br><br>Fortnightly meetings with social care senior managers and maternity safeguarding due to unprecedented numbers of high risk unborn safeguarding cases.<br><br>Information shares for initial child protection case conferences increased by 7 (n=32) related to 66 children and 3 unborn babies. | ICCSIS updated on weekly themes.<br><br>PSEC monthly assurance report, safeguarding is embedded in divisional governance reports and presented to the Trust clinical governance committee.<br><br>Safeguarding Steering group quarterly. | BAF 4 | Satisfactory<br><br>*Standard operating procedures in place, training for staff completed and service weekly validation of data entry, but no Corporate or independent audit yet undertaken for fuller assurance* |

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

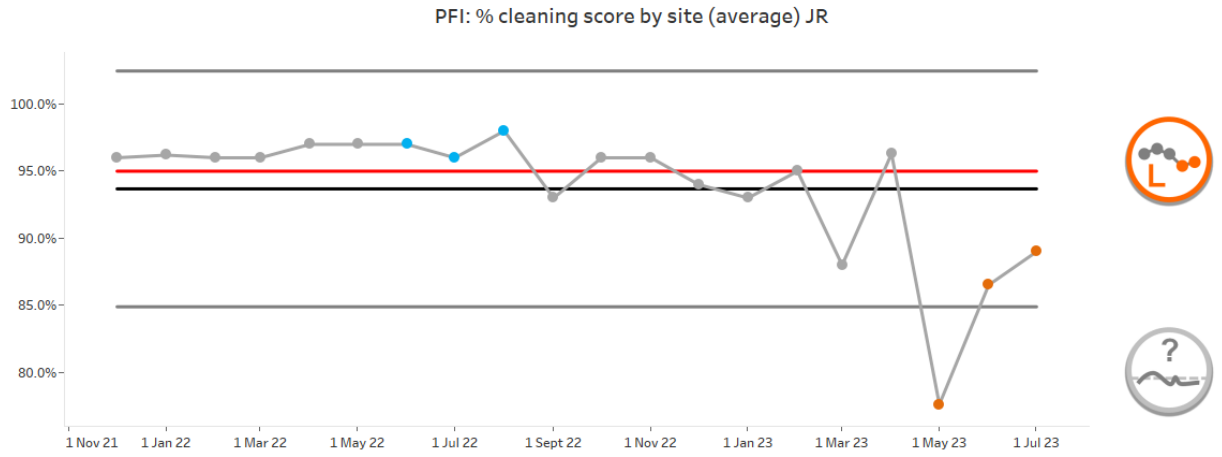





| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| Safeguarding (children) training L1-L4 compliance was 91% in July (KPI = 90%).<br><br>No challenges with children safeguarding as Trust wide training above the KPI of 90% for all levels in July. Children directorate level 2 compliance improved by 2% to 85% and level 3 by 1% to 88%. Maternity directorate compliance for level 3 improved 2% to 89% and above 90% KPI for levels 1 and 2.<br><br>Level 3 adult training awaiting MLH to move staff from level 2 to level 3. | Targeted focus for maternity and children training.<br><br>Divisional governance report template provides details of gaps for training.<br><br>Training is ready to be rolled out by MLH. | Sept 2023<br><br>PSEC monthly assurance report divisional governance reports and presented to the Trust clinical governance committee.<br><br>Safeguarding steering group quarterly. | BAF 4<br><br>CRR 1145 | Satisfactory<br><br>*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* |

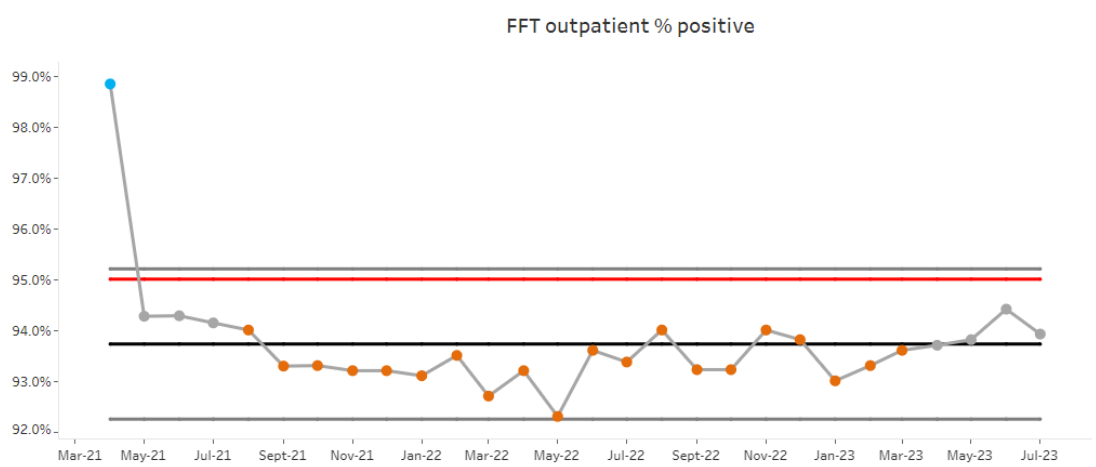
# 3. Assurance report: Quality, Safety and Patient Experience, *continued*

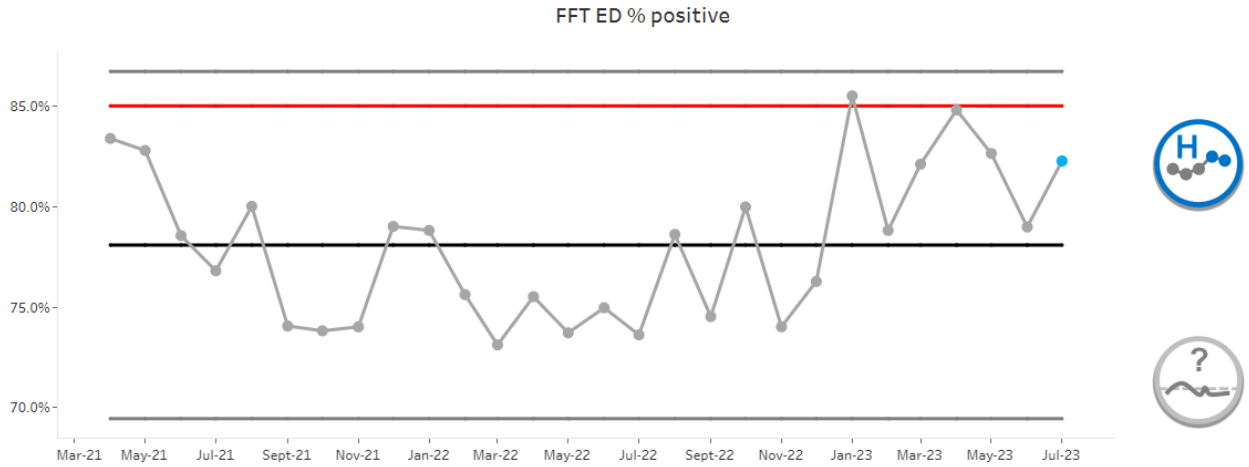



| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| In July 2023, the combined PFI % cleaning score by site (average) for the JR is 96%. However, the above graph demonstrates the percentage of total audits undertaken that achieved 4 or 5 stars, which has improved by 2.4% to 89.0%.<br><br>In total, 191 audits were conducted, but 21 of them did not meet the 4-star requirement during the first round. As a Trust, we strive to achieve a completion rate of 95% for audits that meet or exceed 4-stars every month. However, this is not a nationwide target outlined in the National Standards of Cleanliness 2021. These standards require all areas of healthcare facilities to be audited and meet specific combined cleaning percentage thresholds based on risk levels, including FR1 (98%), FR2 (95%), FR4 (85%), and FR6 (75%), to receive a 5-star rating.<br><br>It is important to note that a lower star rating does not necessarily indicate uncleanliness. The purpose of audits is to identify and address any issues promptly, with a follow-up audit conducted after rectification to ensure improvements have been made and to re-evaluate the star rating. | When managing cleaning risks, the top priority is always patient safety. At our Trust, we believe in working together to maintain cleanliness in our facilities. When an area receives a rating of three stars or below, Mitie creates action plans with actions for all responsibilities; domestic, estates and clinical, to improve those areas, which are overseen by the Trust PFI management team. Domestic supervisors and the Trust PFI team monitor the implementation of these plans with the support of IP&C.<br><br>We collaborate with the Domestic Service Teams, Clinical teams, and IP&C to improve the overall cleanliness of our facilities. In July, there has been progress in improving cleaning standards, and we continue to work towards achieving a sustainable service. At present, we do not require additional support as our current actions are achievable. | 1) Improvement to > 90 % for JR cleaning audits for the month of September 2023.<br><br>2) Information cascade - Monitoring carried out utilising the Synbiotix auditing platform, which reports each audit to the PFI management team, area Matron, ward manager and senior housekeeper at the time of completion.<br><br>3) Actions reviewed weekly at the Mitie/Trust PFI domestic services meeting, Monthly reporting to HIPCC | BAF 4<br><br>CRR 1123 | Sufficient |

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






| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| The FFT Outpatient and FFT Inpatient % positive rates are both similar to the previous month with improvements seen in both FFT Maternity and FFT ED. The response rates for ED and maternity are similar to previous months, and the inpatient response rates have increased.<br><br>There is no clear theme which determines whether this is connected to the national picture of NHS service delivery, although in June, patients did refer to the length of waiting times within ED and waiting lists across Trust services. This has been previously reported to the ICCSIS (Incidents, Complaints, Claims, Serious Incidents, Safeguarding) Triangulation Group. | 1. The Trust is implementing the fully managed service which is aiming to increase the FFT response rates overall. Specifically, 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.<br><br>2. This will reduce the resources required to administer and analyse the FFT results and enable the focus on feedback led QI initiatives. | 31st October 2023. | BAF 4 | Satisfactory<br><br>*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: Safe Staffing - Quality, Safety and Patient Experience, *continued*

Oxford University Hospitals NHS Foundation Trust

## Summary of challenges and risks

The dashboard presented on the following 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:

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

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

Increased bed capacity has remained open across SEU in July 2023, along with the additional challenges of increased patient acuity and dependency; particularly mental health patients requiring enhanced level, one to one observation. This has been mitigated by increased high- cost temporary staffing and use of the flexible pool of Registered Nurses and Care Support Workers on the bank. The flexible has also been increased to include Registered Mental Health Nurses on a trial basis which is due for review at the end of August 2023.
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 – DDN continues to work with Matron's around rostering KPI's and use of temporary staffing workforce. SuWOn Division - DDN is working with Matron's across all KPI's and NSI, performing a deep dive into some areas. MRC have a new Divisional Director of Nursing covering and the roster KPIs are being scrutinized alongside temporary staffing spend. Maternity declared Level 3 staffing on one occasion in July and the risk was reduced as much as possible by senior teams being based in the areas and re-prioritising care. CSS medication errors refer to CDs and PCAs. Training in relation to PCA use is ongoing and the professional development lead addresses medication safety and checking procedures on the foundation programme.
PICU has education in place to address the medication errors reported as there are a high number of new nurses and temporary staff
The Matron for Oncology and Haematology has reviewed falls and medication errors and is addressing with ongoing education, including TPN SACT and ensuring enhanced observation is in place.
A review of falls is being undertaken by the Matron for 5E/F which has indicated an increase of falls at weekends. The review when completed will be shared with the CNO and DCNO
9 of the falls across CMU A and B refer to 2 patients one agitated and one patient with delirium.

| Action timescales and assurance group or committee | Risk Register (Y/N) | Data quality rating |
|---|---|---|
| Assurance of ongoing oversight and assurance that nursing and midwifery staffing remains safe.<br><br>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.<br><br>Nurse sensitive indicators continue to be scrutinised within the divisions and actions to minimise risk continue to be a priority. | | Sufficient |

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

Oxford University Hospitals NHS Foundation Trust

| July 2023 | Care Hours Per Patient Day | | | Census | Nurse Sensitive Indicators | | | | Maternity Sensitive Indicators | | | | | | HR | | | | Rostering KPIs | | | | FFT |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward Name | Actual Overall | Actual vs budget | Actual vs required | Census Compliance (%) | Medication Administration Error or Concerns | Extravasation Incidents | Pressure Ulcers Category 2,3&4 | Falls | Delay in induction (PROM or booked IOL) | Medication errors (administration, delay or omission) | Pressure Ulcers | Women readmitted postnatally within 28 days of delivery | Proportion of mothers who initiated breastfeeding | Births where the intended place of birth was changed due to staffing | Revised Vacancy HR Vacs plus LT Sick & Mat Leave (%) | Turnover (%) | Sickness (%) | Maternity (%) | Roster manager approved for Payroll | Net Hours 2/-2% | 8 week lead time | Annual Leave 12-16% | % Extremely likely or likely |
| **NOTSSCaN** | | | | | | | | | | | | | | | | | | | | | | | |
| Bellhouse / Drayson Ward | 10.5 | 2.9 | 0.5 | 100.0% | 2 | 0 | 0 | 0 | | | | | | | 19.0% | 12.7% | 1.8% | 13.0% | Yes | 2.1% | 6.6 | 11.3% | 100.0% |
| BIU | 7.8 | 1.7 | 1.3 | 100.0% | 0 | 0 | 1 | 1 | | | | | | | 25.0% | 5.3% | 1.8% | 0.0% | Yes | -0.3% | 8.9 | 14.1% | 100.0% |
| HDU/Recovery (NOC) | 22.3 | 0.1 | - | | 0 | 0 | 0 | 0 | | | | | | | 12.0% | 16.9% | 3.5% | 0.0% | Yes | 0.9% | 9.4 | 10.4% | |
| Head and Neck Blenheim Ward | 9.3 | 2.0 | 1.2 | 100.0% | 0 | 0 | 0 | 0 | | | | | | | 25.0% | 5.5% | 9.4% | 0.0% | Yes | -5.6% | 8.3 | 10.9% | 100.0% |
| HH Childrens Ward | 5.5 | -6.4 | -3.7 | 79.6% | 0 | 0 | 0 | 0 | | | | | | | 34.0% | 26.4% | 12.8% | 0.0% | Yes | 0.7% | 9.3 | 9.6% | 97.8% |
| HH F Ward | 7.5 | -2.4 | -0.7 | 98.9% | 2 | 0 | 2 | 2 | | | | | | | 26.0% | 2.8% | 4.5% | 2.9% | Yes | 0.1% | 8.0 | 10.7% | 90.9% |
| Kamrans Ward | 8.0 | -2.2 | -2.6 | 100.0% | 0 | 0 | 0 | 0 | | | | | | | 19.0% | 12.7% | 2.0% | 7.1% | Yes | -3.1% | 7.9 | 13.2% | 100.0% |
| Major Trauma Ward 2A | 10.1 | -0.8 | 1.7 | 100.0% | 2 | 0 | 2 | 1 | | | | | | | 22.0% | 10.9% | 1.4% | 4.5% | Yes | -6.6% | 8.1 | 12.4% | 100.0% |
| Melanies Ward | 16.3 | 4.8 | 2.6 | 93.6% | 0 | 0 | 0 | 1 | | | | | | | 3.0% | 2.7% | 1.2% | 7.4% | Yes | -1.8% | 11.4 | 12.9% | 95.5% |
| Neonatal Unit | 17.6 | -1.9 | - | | 3 | 1 | 0 | 0 | | | | | | | 20.0% | 7.2% | 7.6% | 5.8% | Yes | -3.6% | 8.3 | 11.9% | |
| Neurology - Purple Ward | 9.5 | 0.6 | -0.6 | 100.0% | 3 | 0 | 3 | 5 | | | | | | | 19.0% | 19.7% | 6.3% | 3.4% | Yes | 1.4% | 9.3 | 14.2% | 100.0% |
| Neurosurgery Blue Ward | 9.9 | 0.9 | -0.5 | 100.0% | 0 | 0 | 1 | 4 | | | | | | | 9.0% | 12.2% | 4.3% | 0.0% | Yes | 7.9% | 8.3 | 12.1% | 100.0% |
| Neurosurgery Green/IU Ward | 10.5 | 0.8 | 1.0 | 100.0% | 0 | 0 | 0 | 2 | | | | | | | 17.0% | 6.8% | 10.5% | 0.0% | No | 4.3% | 8.7 | 9.7% | 100.0% |
| Neurosurgery Red/HC Ward | 13.0 | 1.8 | 0.2 | 100.0% | 1 | 0 | 3 | 6 | | | | | | | 5.0% | 1.0% | 3.7% | 1.7% | Yes | -1.3% | 8.3 | 13.3% | 95.0% |
| Paediatric Critical Care | 30.1 | -3.6 | - | | 12 | 4 | 3 | 0 | | | | | | | 16.0% | 8.3% | 7.9% | 10.2% | No | -3.2% | 8.3 | 11.5% | |
| Robins Ward | 9.4 | -0.4 | -1.1 | 100.0% | 0 | 0 | 3 | 1 | | | | | | | 28.0% | 4.7% | 0.5% | 3.9% | Yes | 1.3% | 9.3 | 13.1% | 100.0% |
| Specialist Surgery I/P Ward | 8.8 | 0.4 | 1.0 | 100.0% | 3 | 0 | 1 | 1 | | | | | | | 12.0% | 14.1% | 3.1% | 1.5% | Yes | 2.8% | 8.3 | 12.6% | 100.0% |
| Tom's Ward | 9.0 | 2.4 | -0.5 | 96.8% | 2 | 0 | 0 | 0 | | | | | | | 19.0% | 15.8% | 2.0% | 3.6% | Yes | 1.0% | 7.9 | 14.7% | 97.1% |
| Trauma Ward 3A | 9.8 | -2.5 | 1.3 | 100.0% | 1 | 0 | 4 | 6 | | | | | | | 32.0% | 4.2% | 4.3% | 5.1% | Yes | -1.1% | 8.1 | 12.6% | 75.0% |
| Ward 6A - JR | 8.0 | 0.8 | 0.2 | 98.9% | 4 | 0 | 0 | 3 | | | | | | | 21.0% | 5.9% | 2.2% | 0.0% | Yes | 1.5% | 8.3 | 18.7% | 96.3% |
| Ward E (NOC) | 7.8 | 1.5 | -0.6 | 100.0% | 1 | 0 | 0 | 4 | | | | | | | 15.0% | 5.1% | 8.0% | 0.0% | Yes | 2.0% | 8.0 | 13.5% | 100.0% |
| Ward F (NOC) | 8.3 | 1.7 | 0.6 | 58.1% | 0 | 0 | 1 | 4 | | | | | | | 21.0% | 11.5% | 4.6% | 5.6% | Yes | 0.5% | 8.7 | 18.6% | 100.0% |
| WW Neuro ICU | 32.8 | 6.3 | - | | 1 | 0 | 1 | 1 | | | | | | | 26.0% | 8.6% | 3.3% | 6.8% | Yes | -1.3% | 8.4 | 13.8% | |

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

Oxford University Hospitals NHS Foundation Trust

| July 2023 | Care Hours Per Patient Day | | | Census | Nurse Sensitive Indicators | | | | Maternity Sensitive Indicators | | | | | | HR | | | | Rostering KPIs | | | | FFT |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward Name | Actual Overall | Actual vs budget | Actual vs required | Census Compliance (%) | Medication Administration Error or Concerns | Extravasation Incidents | Pressure Ulcers Category 2,3&4 | Falls | Delay in induction (PROM or booked IOL) | Medication errors (administration, delay or omission) | Pressure Ulcers | Women readmitted postnatally within 28 days of delivery | Proportion of mothers who initiated breastfeeding | Births where the intended place of birth was changed due to staffing | Revised Vacancy HR Vacs plus LT Sick & Mat Leave (%) | Turnover (%) | Sickness (%) | Maternity (%) | Roster manager approved for Payroll | Net Hours 2/-2% | 8 week lead time | Annual Leave 12-16% | % Extremely likely or likely |
| **MRC** | | | | | | | | | | | | | | | | | | | | | | | |
| Ward 5A SSW | 8.6 | | 0.2 | - 0.2 | 100.0% | 0 | 0 | 2 | 2 | | | | | | | 28.0% | 6.1% | 2.0% | 12.5% | Yes | -0.9% | 8.4 | 13.4% | |
| Ward 5B SSW | 8.9 | | 0.6 | - 0.1 | 100.0% | 1 | 1 | 4 | 3 | | | | | | | 14.0% | 0.0% | 2.5% | 6.8% | Yes | 13.6% | 8.3 | 11.4% | 92.3% |
| Cardiology Ward | 7.0 | | 0.8 | 0.5 | 92.5% | 3 | 1 | 0 | 2 | | | | | | | 6.9% | 8.8% | 4.6% | 3.8% | Yes | 1.2% | 7.7 | 13.1% | 100.0% |
| Cardiothoracic Ward (CTW) | 6.6 | - | 0.8 | - 1.2 | 96.8% | 3 | 0 | 1 | 2 | | | | | | | 18.5% | 14.9% | 4.9% | 2.5% | Yes | -0.6% | 6.4 | 12.9% | 96.3% |
| Complex Medicine Unit A | 8.6 | - | 0.3 | - 0.5 | 86.0% | 1 | 0 | 0 | 9 | | | | | | | 24.4% | 8.6% | 7.9% | 3.0% | No | 2.3% | 8.0 | 13.4% | |
| Complex Medicine Unit B | 9.7 | - | 0.5 | - 0.9 | 100.0% | 1 | 0 | 2 | 7 | | | | | | | 14.1% | 8.5% | 6.4% | 2.7% | No | 3.7% | 6.6 | 10.0% | 100.0% |
| Complex Medicine Unit C | 8.5 | | 0.3 | - 2.5 | 100.0% | 1 | 0 | 0 | 5 | | | | | | | 3.7% | 0.0% | 2.8% | 0.0% | No | 1.4% | 8.0 | 12.4% | 100.0% |
| Complex Medicine Unit D | 9.3 | | 1.2 | - 1.0 | 95.7% | 3 | 0 | 6 | 4 | | | | | | | 19.2% | 0.0% | 7.0% | 0.0% | No | 0.0% | 8.0 | 11.5% | 100.0% |
| CTCCU | 22.6 | | 0.6 | - | | 3 | 0 | 2 | 0 | | | | | | | 22.2% | 6.8% | 2.6% | 4.9% | Yes | -0.5% | 7.6 | 12.2% | |
| Emergency Assessment Unit (EAU) | | | - | - | 47.3% | 0 | 0 | 2 | 2 | | | | | | | 28.1% | 7.1% | 3.3% | 4.2% | Yes | 5.0% | 9.4 | 14.5% | |
| HH CCU | 16.2 | | 3.3 | - | 95.7% | 1 | 0 | 1 | 2 | | | | | | | 0.0% | 10.0% | 6.0% | 0.0% | No | 9.4% | 6.3 | 12.9% | |
| HH EAU | | | - | - | 89.3% | 1 | 0 | 2 | 2 | | | | | | | 10.0% | 0.0% | 5.4% | 6.3% | Yes | -2.9% | 4.9 | 11.1% | |
| HH Emergency Department | | | - | - | | 0 | 0 | 1 | 2 | | | | | | | 16.1% | 16.1% | 2.4% | 8.9% | Yes | -1.0% | 4.9 | 13.5% | 86.5% |
| John Warin Ward | 10.5 | | 1.6 | 0.3 | 97.9% | 0 | 0 | 1 | 4 | | | | | | | 1.5% | 0.0% | 3.0% | 0.0% | Yes | 1.8% | 8.0 | 11.9% | 90.0% |
| JR Emergency Department | | | - | - | | 6 | 0 | 0 | 4 | | | | | | | 26.3% | 12.7% | 6.1% | 5.3% | Yes | 8.3% | 8.0 | 15.7% | 79.1% |
| Juniper Ward | 7.2 | - | 0.1 | - 1.0 | 100.0% | 1 | 0 | 5 | 5 | | | | | | | 11.9% | 7.1% | 9.2% | 0.0% | Yes | -1.0% | 5.9 | 13.4% | |
| Laburnum | 7.7 | - | 0.3 | - 1.2 | 87.1% | 0 | 0 | 1 | 1 | | | | | | | 16.6% | 7.8% | 4.5% | 10.3% | Yes | -2.5% | 6.7 | 15.3% | 52.6% |
| OCE Rehabilitation Nursing (NOC) | 10.1 | | 0.5 | - 1.1 | 85.0% | 0 | 0 | 0 | 2 | | | | | | | 30.7% | 15.0% | 4.7% | 10.0% | Yes | 4.9% | 2.4 | 12.7% | |
| Osler Respiratory Unit | 13.4 | - | 1.1 | 4.1 | 100.0% | 0 | 0 | 1 | 0 | | | | | | | 20.0% | 15.0% | 1.5% | 2.9% | Yes | -0.7% | 8.0 | 11.7% | 50.0% |
| Ward 5E/F | 10.1 | - | 0.5 | 1.3 | 100.0% | 0 | 0 | 1 | 15 | | | | | | | 22.0% | 0.0% | 6.9% | 4.4% | Yes | -3.9% | 8.4 | 12.3% | 50.0% |
| Ward 7E Stroke Unit | 9.4 | - | 0.4 | 0.8 | 100.0% | 2 | 0 | 1 | 6 | | | | | | | 4.8% | 4.8% | 4.4% | 9.6% | Yes | 9.3% | 8.4 | 15.0% | 100.0% |

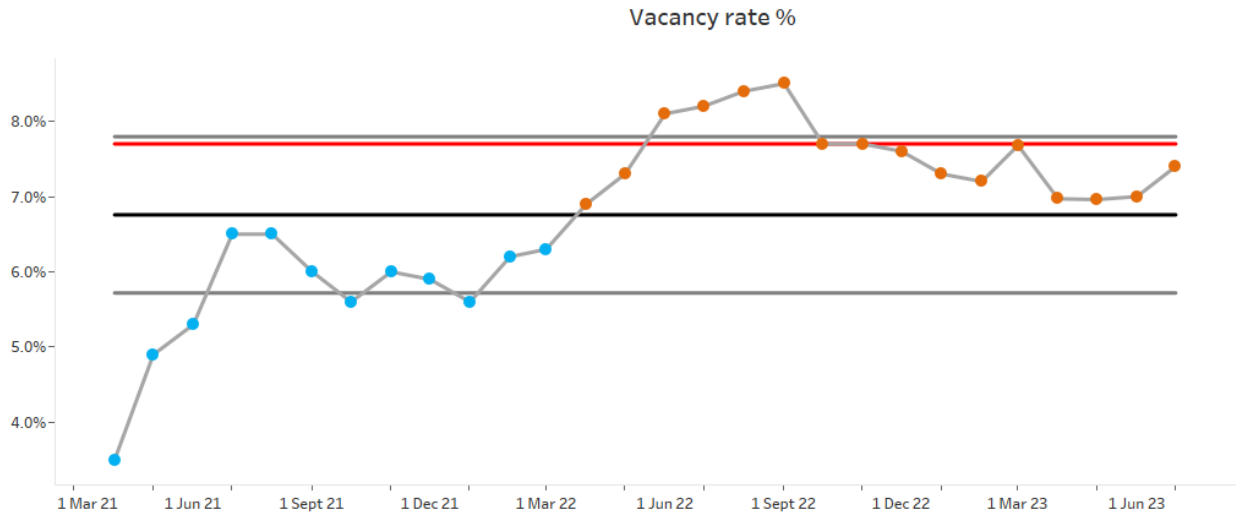
# 3. Assurance report: Safe Staffing - Dashboard: Part 3 (SuWOn and CSS)

Oxford University Hospitals NHS Foundation Trust

| July 2023 | Care Hours Per Patient Day | | | Census | Nurse Sensitive Indicators | | | | Maternity Sensitive Indicators | | | | | | HR | | | | Rostering KPIs | | | | FFT |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward Name | Actual Overall | Actual vs budget | Actual vs required | Census Compliance (%) | Medication Administration Error or Concerns | Extravasation Incidents | Pressure Ulcers Category 2,3&4 | Falls | Delay in induction (PROM or booked IOL) | Medication errors (administration, delay or omission) | Pressure Ulcers | Women readmitted postnatally within 28 days of delivery | Proportion of mothers who initiated breastfeeding | Births where the intended place of birth was changed due to staffing | Revised Vacancy HR Vacs plus LT Sick & Mat Leave (%) | Turnover (%) | Sickness (%) | Maternity (%) | Roster manager approved for Payroll | Net Hours 2/-2% | 8 week lead time | Annual Leave 12-16% | % Extremely likely or likely |
| **SUWON** | | | | | | | | | | | | | | | | | | | | | | | |
| Gastroenterology (7F) | 8.2 | 1.2 | 1.4 | 100.0% | 1 | 0 | 0 | 1 | | | | | | | 18.0% | 7.9% | 7.9% | 5.7% | Yes | -1.1% | 8.3 | 16.3% | 93.3% |
| Gynaecology Ward - JR | 10.2 | 5.2 | 4.1 | 98.9% | 0 | 0 | 0 | 1 | | | | | | | 20.0% | 8.8% | 1.8% | 0.0% | Yes | 6.5% | 9.6 | 14.5% | 91.4% |
| Haematology Ward | 8.1 | -0.6 | -0.6 | 100.0% | 7 | 0 | 1 | 10 | | | | | | | 28.0% | 0.0% | 5.2% | 12.7% | No | 19.7% | 4.9 | 13.8% | |
| Katharine House Ward | 9.6 | 0.4 | 2.0 | 100.0% | 5 | 0 | 3 | 2 | | | | | | | 11.0% | 12.5% | 8.0% | 4.7% | Yes | 6.1% | 8.6 | 11.5% | |
| Oncology Ward | 8.3 | -2.1 | -0.3 | 100.0% | 7 | 0 | 0 | 4 | | | | | | | 33.0% | 14.7% | 1.5% | 10.2% | Yes | -0.1% | 6.4 | 10.7% | 100.0% |
| Renal Ward | 10.5 | 1.2 | -0.2 | 98.9% | 1 | 0 | 1 | 5 | | | | | | | 5.0% | 11.3% | 3.4% | 3.2% | Yes | 0.3% | 8.3 | 16.3% | 100.0% |
| SEU D Side | 8.3 | -0.4 | 0.2 | 100.0% | 2 | 0 | 0 | 4 | | | | | | | 14.0% | 12.3% | 4.8% | 3.9% | Yes | -1.0% | 8.4 | 14.4% | 85.7% |
| SEU E Side | 9.1 | 0.7 | -0.6 | 100.0% | 0 | 0 | 0 | 2 | | | | | | | 16.0% | 20.2% | 4.9% | 3.3% | Yes | -1.9% | 8.3 | 15.5% | 90.9% |
| SEU F Side | 7.6 | -1.1 | -1.2 | 100.0% | 2 | 0 | 1 | 1 | | | | | | | 31.0% | 19.4% | 0.4% | 6.8% | Yes | -1.5% | 8.3 | 13.7% | 90.9% |
| Sobell House - Inpatients | 7.9 | -0.7 | 0.3 | 100.0% | 2 | 0 | 3 | 4 | | | | | | | 35.0% | 8.4% | 1.5% | 3.9% | Yes | -0.8% | 8.0 | 14.7% | |
| Transplant Ward | 10.6 | 1.2 | 1.9 | 95.7% | 1 | 0 | 0 | 4 | | | | | | | 30.0% | 17.8% | 6.7% | 3.1% | No | 2.7% | 8.0 | 16.3% | 92.6% |
| Upper GI Ward | 9.0 | -0.7 | 0.0 | 94.6% | 2 | 0 | 1 | 1 | | | | | | | 21.0% | 0.0% | 1.5% | 2.5% | Yes | 1.1% | 8.6 | 16.7% | 100.0% |
| Urology Inpatients | 8.1 | -0.6 | -0.5 | 100.0% | 0 | 0 | 0 | 3 | | | | | | | 38.0% | 9.0% | 6.4% | 1.5% | No | -0.3% | 9.0 | 7.5% | 98.1% |
| Wytham Ward | 7.6 | 0.1 | 0.2 | 100.0% | 3 | 0 | 1 | 0 | | | | | | | 28.0% | 20.2% | 6.4% | 0.0% | Yes | -3.8% | 8.4 | 14.6% | 91.3% |
| MW The Spires | 20.7 | -6.8 | - | | 0 | 0 | 0 | 0 | | | | | | | | | | | Yes | -1.4% | 5.6 | 13.1% | |
| MW Delivery Suite | 18.7 | 3.5 | - | | 2 | 0 | 0 | 0 | 96 | 7 | 1 | 13 | 69.0% | 3 | 7.0% | 11.9% | 3.2% | 6.5% | Yes | -0.7% | 6.7 | 11.2% | |
| MW Level 5 | 5.1 | -0.6 | - | | 3 | 0 | 0 | 0 | | | | | | | | | | | Yes | 6.4% | 5.6 | 12.5% | |
| MW Level 6 | 6.5 | 2.0 | - | | 0 | 0 | 0 | 0 | | | | | | | | | | | Yes | -8.0% | 5.6 | 12.4% | |
| **CSS** | | | | | | | | | | | | | | | | | | | | | | | |
| JR ICU | 25.1 | -9.74 | - | | 11 | 0 | 2 | 0 | | | | | | | 32.0% | 11.5% | 2.5% | 6.5% | Yes | -0.5% | 8.3 | 14.8% | |

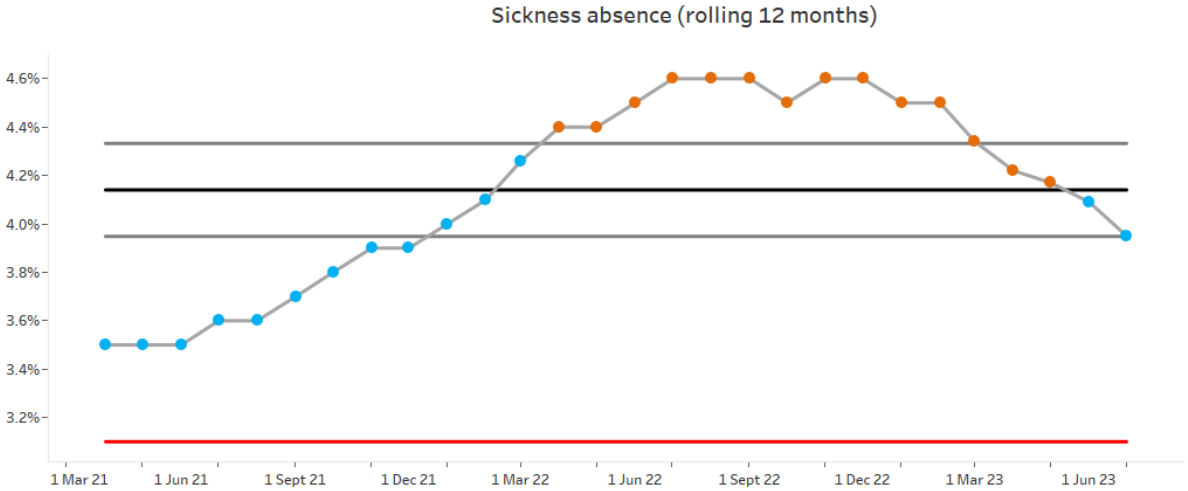
# 3. Assurance report: Growing Stronger Together






| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| The vacancy rate was 7.4% in July, better than the Trust target of 7.7%.<br><br>Performance exhibited special cause variation due to successive periods of performance (>6 months) above the mean of 6.8%. | • There have been budget increases which have resulted in higher vacancy levels this month. As the budgets evolve, this will reduce the vacancies<br>• Recruitment SLA in place and medical staffing SLA to be implemented to assist with timely recruitment<br>• HCSW have high vacancy levels and there is a working group prioritising interventions in this area<br>• The delay in the implementation of one person, One post means that vacancy data is not as accurate as it could be. The additional focus on implementation would facilitate appropriate identification of vacancies that need to be recruited to. | • Governance - TME via IPR, HR Governance Monthly meeting & Divisional meetings<br>• All actions are ongoing | No | Satisfactory<br><br>*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: Growing Stronger Together





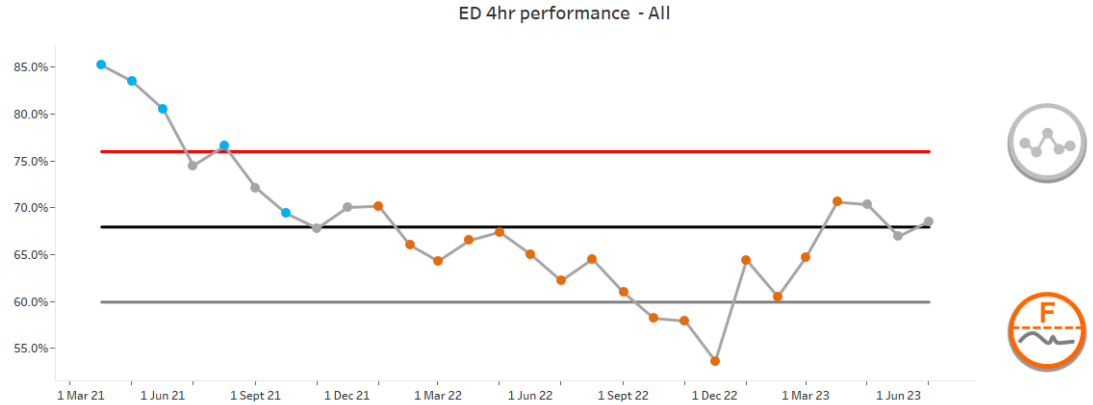

**Benchmarking: March 23 (monthly performance)**

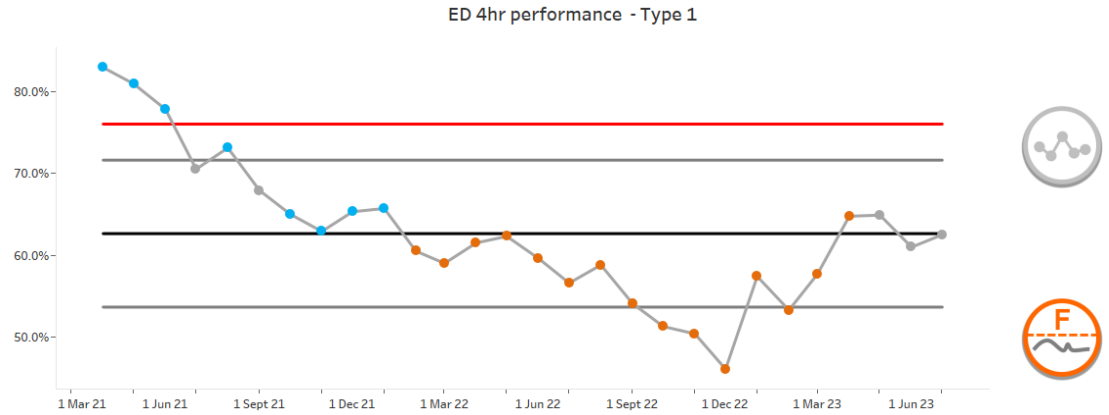
**OUH: 3.9%** **National:** 5.1% **Shelford:** 4.4% Buckinghamshire Healthcare NHS Trust: 3.7% Royal Berkshire NHS Foundation Trust: 3.3% Oxford Health: 4.5% South Central Ambulance Service: 6.7%

| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| Sickness absence performance (rolling 12 months) was 4.0% in July. Performance exhibited special cause improving variation due to two out of the last three periods being within one sigma of the lower control limit. This indicator is on a downward trend and has reduced every month since the last quarter of 2022/23.<br><br>The most recent figure for M4 shows a slight decrease of 0.1% in sickness absence. Therefore, it is reducing as the lower COVID sickness rates take effect within the rolling 12-month data | 1. We are continuing to offer a full range of well-being support including Wellbeing, financial, environmental and psychological<br>2. RTW (Return to work) compliance and reasons for late RTW interviews are raised at monthly manager meetings.<br>3. Weekly HR sickness meetings are taking place in areas to ensure consistency in managing and supporting managers.<br>4. Monthly meetings with Occupational Health are helping to move along long-term sickness cases.<br>5. We have refreshed our approach to ensure a greater focus and support areas with their case management and RTW *Return to work), as well as improved utilisation of all the absence management information we have relating to sickness.<br>6. Sickness 'hotspot areas' are being identified in the divisions with 'deep dives' taking place into the data to understand the issues and provide targeted support, particularly focusing on the short-term prevalence, as well as mental health related absence. | • Governance - TME via IPR, HR Governance Monthly meeting & Divisional meetings<br>• All actions are ongoing | BAF 1<br>BAF 2<br><br>CRR 1144 (Amber) | Satisfactory<br><br>*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



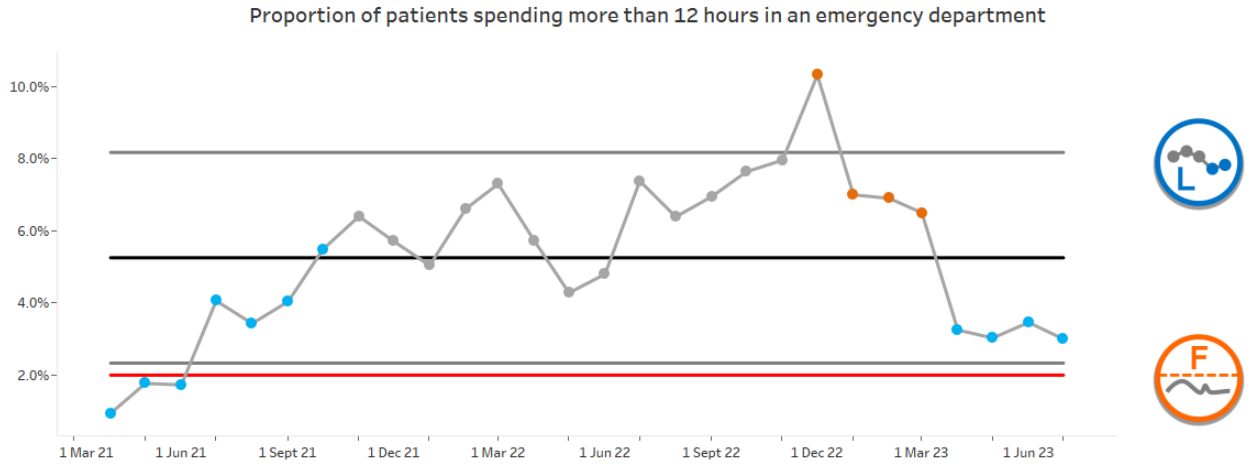




| Benchmarking: ED (All types): July 23 | | | | |
|---|---|---|---|---|
| **OUH: 68.5%** | **National:** 72.6% | **Shelford:** 73.0% | BHT: 72.8% | RBH: 75.8% |

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

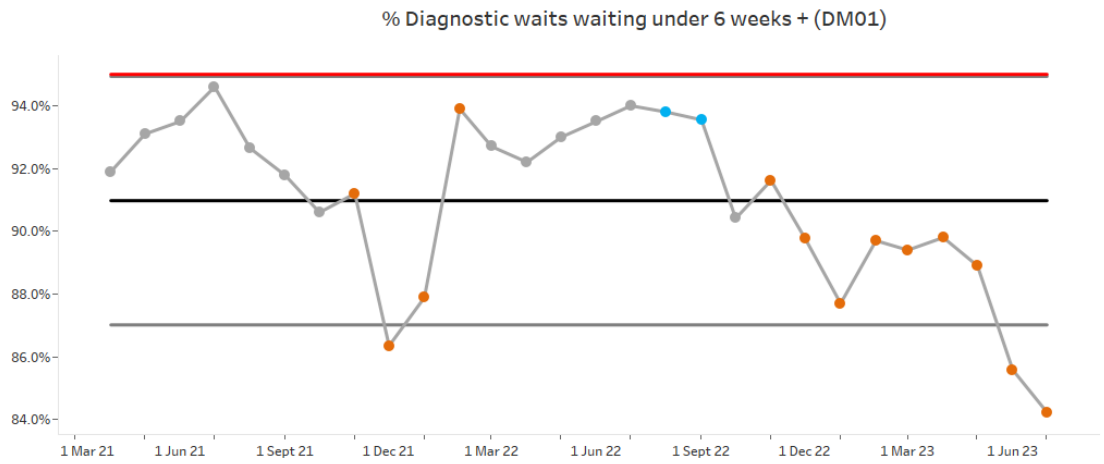
| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| ED 4-hour performance (All types) was 68.5% in July and for Type 1 activity, performance was 62.5%. For both indicators, performance exhibited common cause variation. The indicators have consistently not achieved the target. Type 1 breach performance by site was 74.9% at the Horton Hospital and 57% at the John Radcliffe Hospital in July.<br>Attendances in adults and children remained high in July compared to the first four months of the calendar year but was down 4% from June. The small reduction was seen equally on both sites and across children and adults.<br>Wait to be seen continues to be the most significant breach reason on both sites for admitted and non-admitted patients attributing 66% of all 4 hour breaches. Recent Industrial Action from the British Medical Association (BMA) has highlighted how a different medical staffing model can impact on 4hr performance. Occupancy has remained high and additional capacity remains open and fully utilised on F Ward at the Horton and 6D escalation 'urgent care' beds, 5B, and Trauma on the JR site. This has allowed occupancy to reduce in recent months, now sitting at 92.32% overall. Divisions are now working to substantively recruit to staff the additional capacity, whilst also reviewing opportunities to reduce the profile of beds across the year. Trauma has succeeded in doing this in July and August. At times, there has been capacity in EAU from improvement work within Discharge processes thereby supporting improvements in patient flow. | **Senior Medical Decision Maker (Consultant) in the JR ED in the evenings.**<br>• Pilot conducted during the Consolidated Improvement Cycle with early indication of improvement and SPCs being aligned to the shifts to correlate with any improvement.<br>• Options paper developed for sustainable ED workforce models<br>• Metrics:<br>- 4hr breach performance (Type 1)<br>- 12hr Length of Stay (LOS) performance<br>**Implement 'Clinically Ready to Proceed' (CRtP) functionality on FirstNet.**<br>• 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<br>• Target compliance 70% by the end of Q1 – currently an average of 48% (plan above in place to increase engagement and compliance)<br><br>**Departure from ED within 60mins of CRtP**<br>• Focus on Non-admitted performance – using discharge time. Process mapping has highlighted the main constraints – target 50% of non-admitted patients by Q2<br>• Improvement ideas generated within ED with a focus on pharmacy and transfer lounge usage in the first instance<br>**Role review of Nurse and Consultant in Charge, OSM/Deputy and Ops Manager for ED.**<br><br>**Urgent and Emergency Care Quality Improvement Programme 2023/24** approved by IAC. Project groups now being established with detailed work programmes developed by July 2023. Clinically Ready to Proceed action is one of three elements of this programme of work. | Quarter 1: Not on track. Aiming for decision by mth 5.<br>Trust Wide Urgent Care Group<br><br>Quarter 1: On Track. Completion due by end of Q2.<br>Trust Wide Urgent Care Group<br><br>Quarter 2: On Track<br>Trust Wide Urgent Care Group<br><br>Quarter 1: Not on track. Due to complete during Q2.<br>2023/34:On Track<br>Trust wide Urgent Care Group | BAF 4<br><br>CRR 1133 (Red) | Sufficient |

# 3. Assurance report: Operational Performance, *continued*




| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| The proportion of patients spending more than 12 hours in an emergency department was 3% in July, a sustained improvement over the last four months. Performance remained above the target of 2% but below the mean of 5.6%. The indicator has consistently not achieved the target but exhibited special cause variation (improvement) due to two out of the last three months recording a value within one sigma from the lower control limit.<br><br>Both sites have been able to sustain the improvement seen in earlier in the year and improve on the previous month with the Horton at 2% and JR at 3% of patients residing in ED for more than 12 hours in July. Keeping the additional escalation beds open has supported the reduction in bed occupancy, helped to reduce delays in waiting for beds and improved flow. The wait to be seen in ED continues to be a challenge attributing to 66% of 4-hour breaches. However average total length of stay in both ED's has reduced by approx. 100 minutes in both ED's compared to December 2022. Mental Health presentations remain high, and this group has a higher total length of stay.<br><br>The maturing of the Transfer of Care Hub has had positive impact in reducing length of stay once medically optimised for discharge and thus reducing beds days for that cohort of patients. The Hub has developed further and now determines the discharge pathway for Oxfordshire residents in out of county Hospitals. Royal Berkshire Hospital was the first pilot site in this expansion. In, addition, a far greater proportion of patients are now going straight home improving the patient experience and morale of staff. The percentage of patients leaving our hospitals on P0 is 92.35%, and for P1 is 3.38%. Further improvement work and PDSA cycles have been run within HomeFirst allocation and the Transfer Lounge. The Discharge to Assess pilot commenced in Oxford City has now been extended to the North of the County. | **Departures within 60mins of the Decision to Admit**<br>• Each Division to identify a speciality to undertake deep dive focused improvement work based on metrics from Consolidated Improvement Cycle – focus to be on two clinical pathways in the first instance.<br>• Identify improvement percentage per speciality | Quarter 1: On track<br>Quarter 2: Clinical Pathway Group established – on track for first 2 clinical pathways<br>Trust Wide Urgent Care Group | BAF 4<br><br>Link to 1133 (Red) | Sufficient |

# 3. Assurance report: Operational Performance, *continued*




| Benchmarking: June 23 DM01 | |
|---|---|
| OUH | 85.6% |
| National | 79.1% |
| Shelford | 82.7% |
| ICS | BHT: 55.5%<br>RBH: 70.0% |

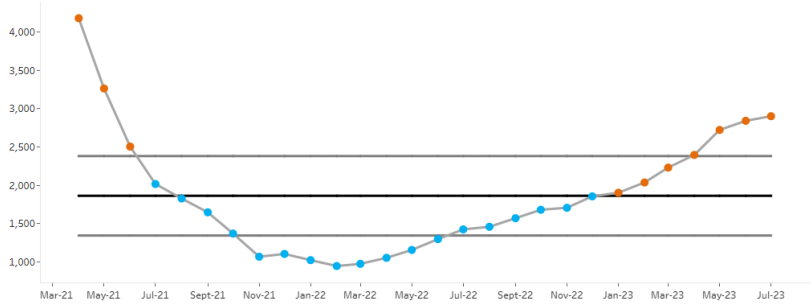
| ICS key | |
|---|---|
| BHT | Buckinghamshire Healthcare NHS Trust |
| RBH | Royal Berkshire NHS Foundation Trust |

| 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 % of Diagnostic waits waiting under 6 weeks+ (DM01) was 84.2% in July. The indicator exhibited special cause variation due to performance being below the mean of 91.0% for more than six successive periods as well as below the lower process control limit. The indicator has consistently not achieved the target of 99%.<br><br>**Audiology**: Significant increase in demand and vacancies has driven a deficit with capacity<br>**Cardiology**: Awarded community echo service; TUPE staff left before transfer to OUH and backlog has accumulated.<br>**Clinical Neurophysiology**: Demand remains above capacity after increased activity and rigorous triage. Ongoing insource supplier unable to offer same levels of additional capacity due to a competitive market. Complexity of cases requiring two technicians are required for a cohort of patients, mostly inpatients.<br>**Respiratory Sleep studies**: Demand and Capacity deficit | **Audiology:** Options appraisal completed with a recommendation to transfer a cohort of clinically appropriate patients to Another Qualified Provider (AQP). Discussions are being held with commissioners.<br><br>**Cardiology:** All vacancies now filled. Procurement process slowly underway and due to conclude end of July. Recruited one day per week of an echocardiographer via Community Diagnostic Centre (CDC) to support.<br><br>**Clinical Neurophysiology:** Return of 2 staff members from maternity leave due later this year and technicians to be fully trained to conduct EMGs. Business case under development to convert insourced capacity to recurrent capacity.<br><br>**Respiratory Sleep studies:** CDC optimally used and is being considered for expansion.<br><br>**Assurance:** reviewing the delivery of the operational plan for delivery of zero 65+ week by end of March 2024 recognising the impact of Industrial Action. | Weekly Assurance meeting will monitor all actions on a bi-weekly basis<br><br>**Audiology:** improvement expected once transfer to AQP agreed – September 2023<br><br>**Cardiology:** compliance by March 2024.<br><br>**Clinical Neurophysiology:** improvement expected from July 2023<br><br>**Respiratory Sleep studies:** compliance by January 2024 | BAF 4<br><br>Link to CRR 1136 (Red) | Satisfactory<br><br>*Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance* |

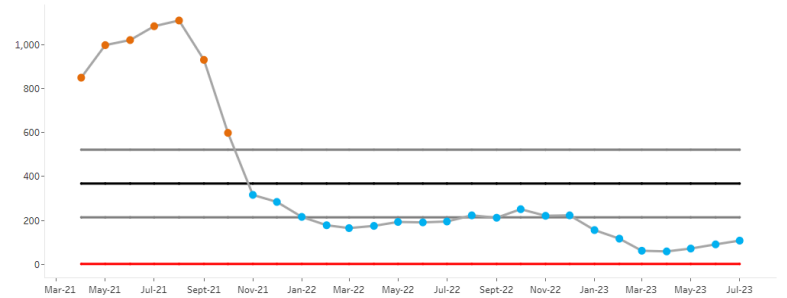
# 3. Assurance report: Operational Performance, *continued*

Oxford University Hospitals NHS Foundation Trust

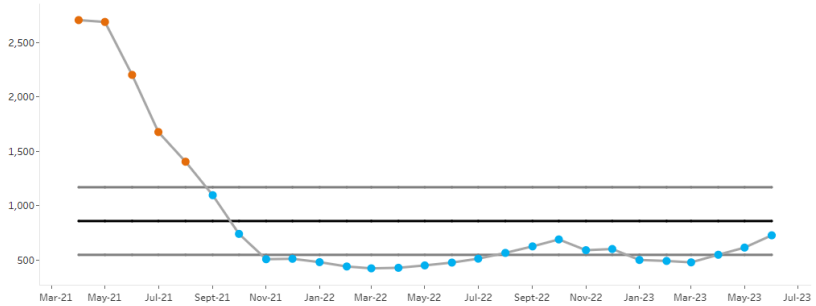
Total patients waiting more than 52 weeks to start consultant-led treatment



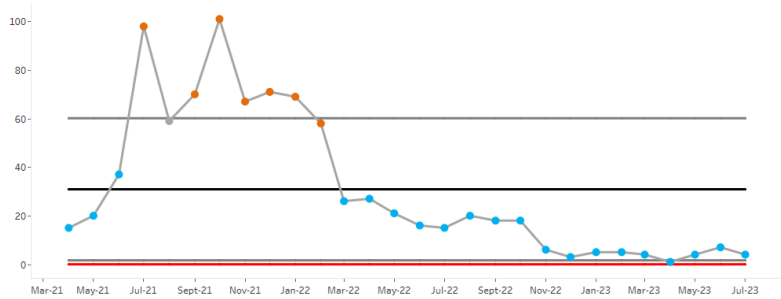

Total patients waiting more than 78 weeks to start consultant-led treatment




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




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

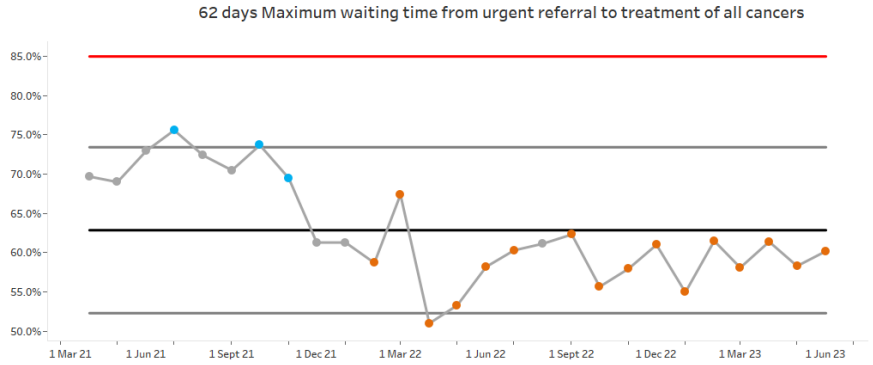


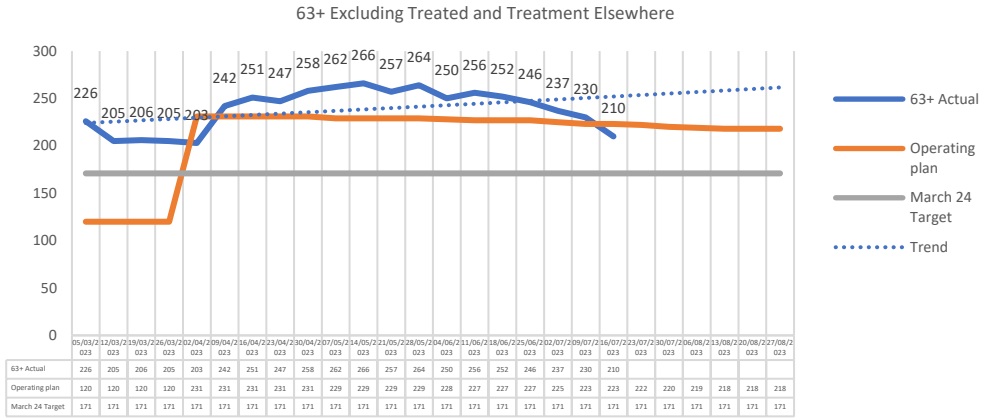

| Benchmarking: May 23 | |
|---|---|
| OUH | 2,714 |
| National | 1,689 (avg.) |
| Shelford | 3,137 (avg.) |
| ICS | BHT: 4,239<br>RBH: 12 |

| 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 2,896 in July. Performance exhibited special cause variation due to six consecutive periods of deteriorating performance above the mean of 1,858 and exceeding the upper process control limit.<br><br>**104 weeks** reported 7 patients waiting due to the two late ENT transfers from another Trust, complexity and PICU capacity for a Paediatric Spinal patient, supplier delay with a Plastic Surgery custom product, a corrected Vascular Referral to Treatment (RTT) pathway, and an Ophthalmology patient impacted by the national shortage of corneas.<br><br>**78 weeks** - as well as Paediatric Spinal and Ophthalmology stated above, challenges are found within Urology due to a capacity deficit against demand levels, Adult Spinal due to complexity, as well as Orthopaedics and Plastic surgery due to theatre capacity.<br><br>**65 weeks** remains the focus in line with the Trust's Operating Plan 2023/24. Services not challenged in the longer wait cohorts are undertaking recovery of **52 week waiting times**. | • **Corneal graft supplies** are being managed centrally by NHSE via NHSB&T as this is a recognised national issue. NHSE gave instructions to begin the procurement for 65-week patients. Risks with service capacity for long waits therefore mutual aid request is being considered if capacity cannot be identified for Aug/Sept.<br>• **Spinal services** contracts to outsource to Independent Sector Providers at The Portland and Royal National Orthopaedic Hospital have been finalised.<br>• **Theatre re-modelling and planning** further evaluation of all services proportionately allocated capacity to manage the longest waiting patients, in conjunction with emergency and cancer requirements.<br>• **Key milestone deadlines set for pathway stages at specialty level** to mitigate risk of not delivering the Operating Plan. Tracking via Elective Care Recovery Group (ECRG)<br>• **Elective Recovery Fund** schemes live and tracked at ECRG | Delivery of 65 weeks is planned by March 2024<br><br>All actions are being reviewed and addressed via weekly Assurance meetings and Elective Recovery Group | BAF 4<br><br>Link to CRR 1135 (Amber) | Sufficient |

# 3. Assurance report: Operational Performance, *continued*



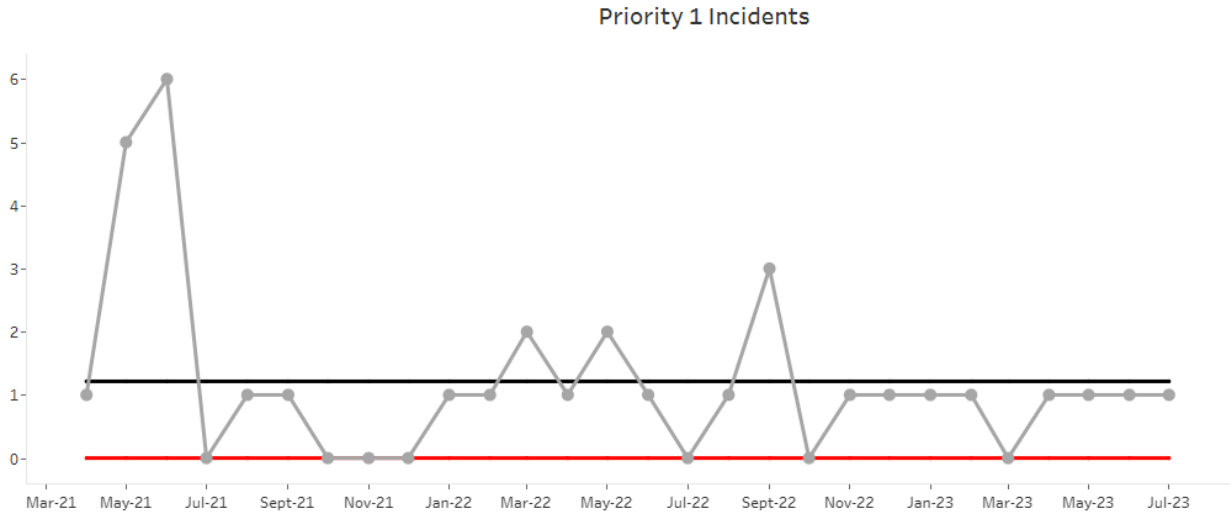




| Benchmarking: June 23<br>62-day Standard | |
|---|---|
| OUH | 60.2% |
| National | 62.2% |
| Shelford | 57.9% |
| ICS | BHT: 57.1%<br>RBH: 70.5% |

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

| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| Cancer performance against the 62 days standard for urgent referral to treatment was 60.2% in June, and below the performance target of 85%. Performance is reported one month in arrears due to the extended reporting period for this indicator. Performance exhibited special cause variation due to more than six consecutive periods of performance below the mean of 62.9%. The indicator has consistently not achieved the target.<br><br>All tumour sites apart from Haematological, Leukaemia, Other, Skin and Testicular are non-compliant for this standard in May.<br><br>**Challenges identified:**<br>• Complex tertiary level patients (19%)<br>• Some slow pathways and processes (17%)<br>• Capacity for some surgery, diagnostics and oncology (42%)<br>• Late inter provider transfers (10%)<br>• Patient reasons (13%) | **The Cancer Improvement Programme** launched in 2022/23 with a focus on 28-day Faster Diagnosis Standard (FDS). For May, **the Trust was 18th best out of 135 national providers and has delivered this standard consecutively since June 2022**. FDS remains a key priority for 2023/24 as well as addressing the challenges faced with delivering treatment for our patients by day 62.<br><br>**Tiering triggered by >62-day PTL vs plan –** recovery includes:<br>• Incomplete and late Inter-Provider Transfer analysis and escalation<br>• Surgical capacity through theatre reallocation, and<br>• Patient engagement through the Personalised Care agenda<br>• SOP and escalation of benign patients awaiting communication<br><br>**Urology** holds the highest proportion of long waiting patients and have worked with radiology to implement a one-stop clinic and MRI pathway. **Gynae** holds the second highest volume of long the BOB Integrated Care Board (ICB) to formally revise the referral management of 2ww referrals. | Faster Diagnostic Standards (FDS) to be achieved by all tumour sites outlined within the FDS Framework 2023/2024<br><br>171 patients over 62 days on the Patient Tracking List by March 2024<br><br>Urology one-stop MRI clinic: adopted<br><br>Gynae referral management: on track | BAF 4<br><br>Link to CRR 1135 (Amber) | Sufficient |

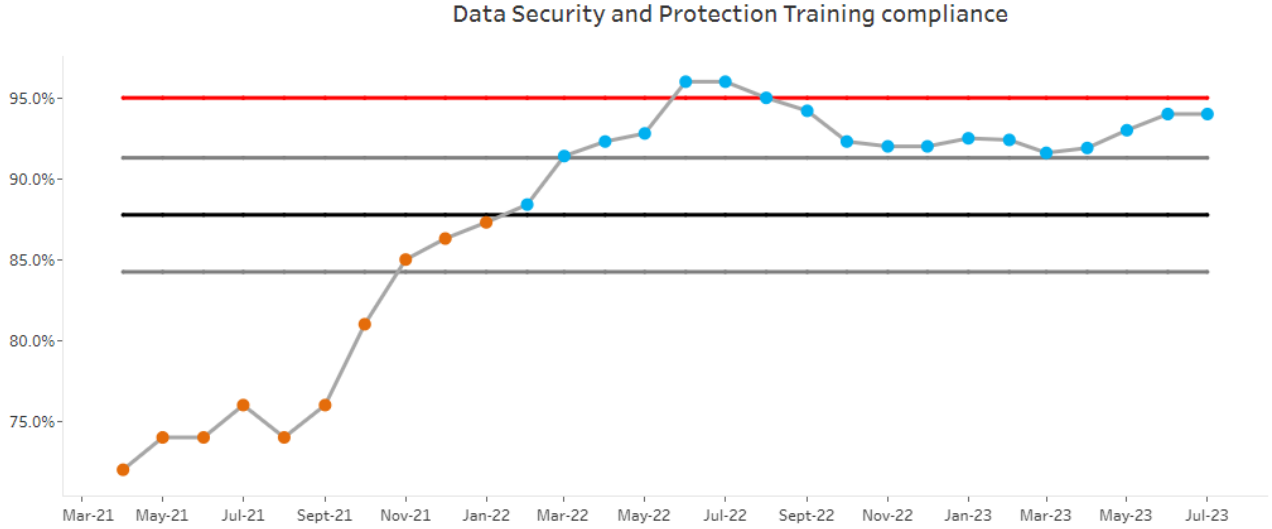
# 3. Assurance report: Corporate support services - Digital

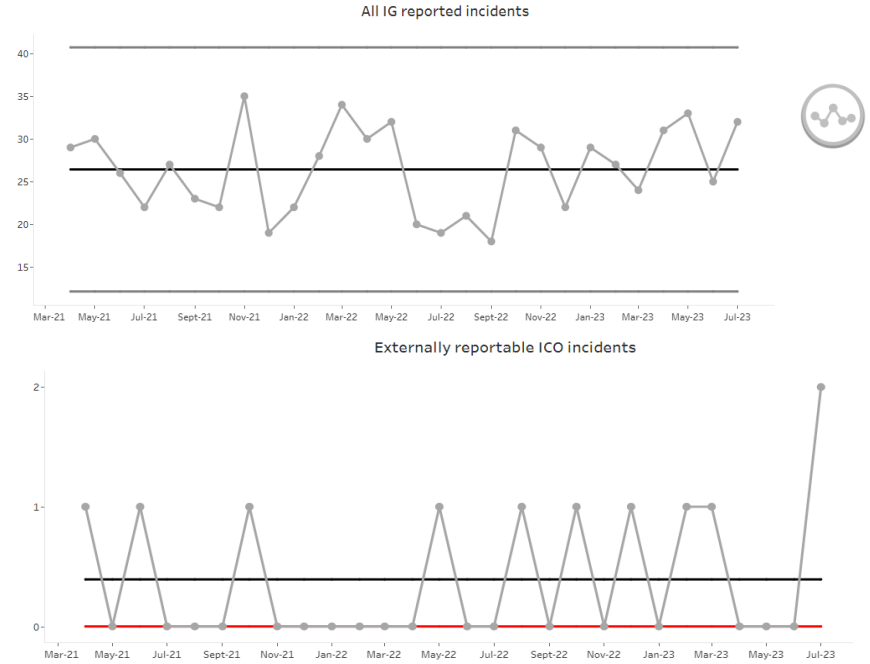



| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| There was one Priority 1 incident in July 2023 against a target of zero. Due to the low volume of incidents, SPC has not been applied to this indicator.<br><br>The incident occurred on Thursday 20th July 2023 at 15:20Hrs. There was a loss of connectivity to OXNET WLAN across multiple sites for unknown reason. The availability of the OxNET-WLAN SSID was restored at roughly 15:40. The Network Team continue to investigate and perform RCA. | The network team began investigation immediately. Connectivity was restored roughly 20 minutes later due to unknow factors.<br><br>Ongoing monitoring and investigation is being performed by the network team to diagnose and fix the issue. | August 2023, with oversight at the Digital Oversight Committee | BAF 4<br><br>Link to CRR 1116 (Amber), 1113 (Amber) | Sufficient |

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

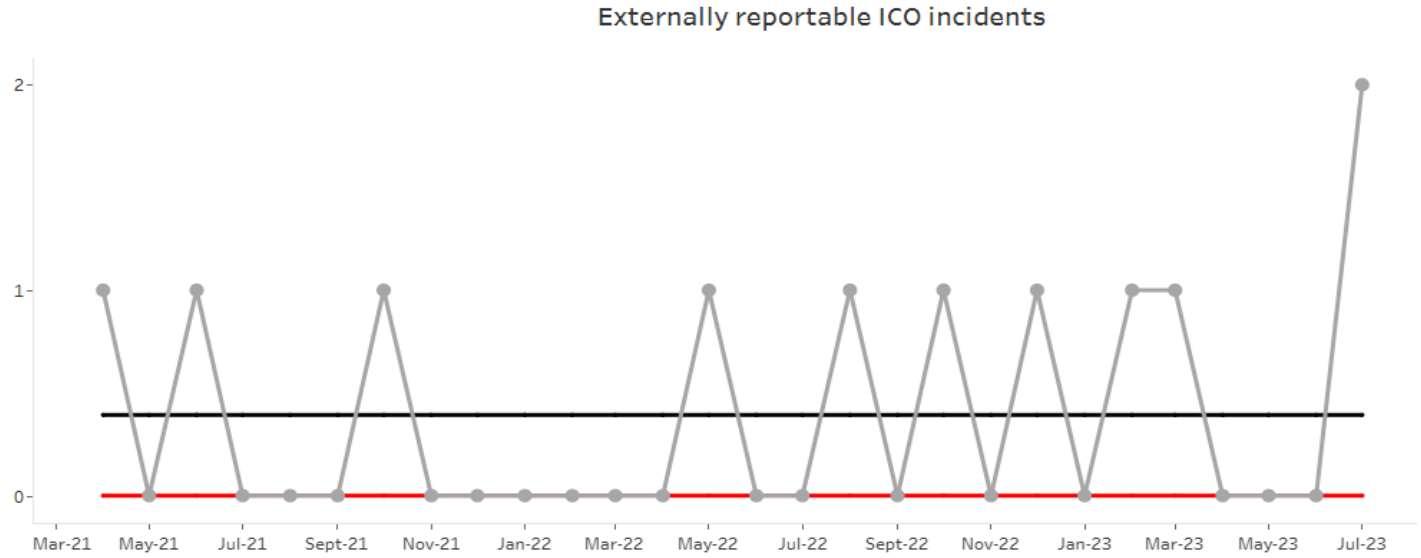


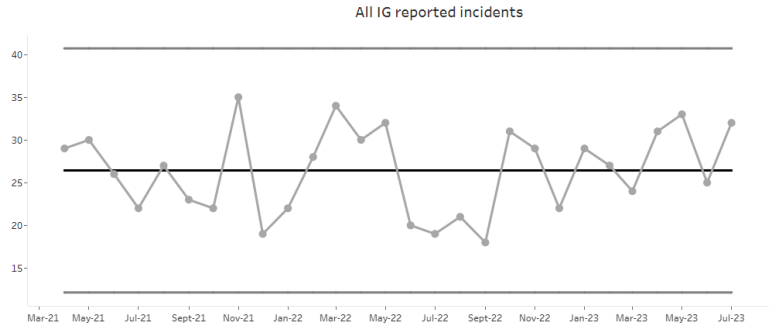



| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| Data security and Protection Training (DSPT) compliance was 94.0% in July, below the target of 95%. Performance exhibited improving special cause variation due to successive periods of performance improvement (>6 months) above the mean of 87.8% as well as exceeding the upper process control limit of 91.3%.<br><br>Non-compliance was highlighted in VBAs. Since IG training is part of the Trust's mandatory training, improvements were anticipated as rates of Appraisal compliance increased throughout the Appraisal window target month of July 2023. This underpinned the forecast for 95% to be achieved by end July.<br><br>The aim of achieving 95% by 30/06/2023 was missed. This did not affect the OUH DSPT submission as the Trust had already been 95% compliant within the July 2022 - June 2023 reporting period. As a result, the Trust was able to submit a "Standards Met" 2022-23 DSPT return. To pass the 2023-24 submission we are not required to achieve 95% but will be retaining this target internally. | Staff receiving their Appraisal will support improved IG training compliance since part of mandatory training.<br><br>Automated reminders continue to be sent out to non-compliant staff and their line managers through My learning hub and a targeted staff list, to be drawn up by the IG Manager, will be identified for follow up by Divisional and Corporate Teams. | Completed, however as this action was previously forecast to result in the achievement of the target by end July additional actions have been identified with a revised timescale of achieving 95% by end September 2023.<br><br>Actions will be overseen by the Digital Oversight Committee and Divisional Performance Reviews. | BAF 6 | Satisfactory<br><br>*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* |

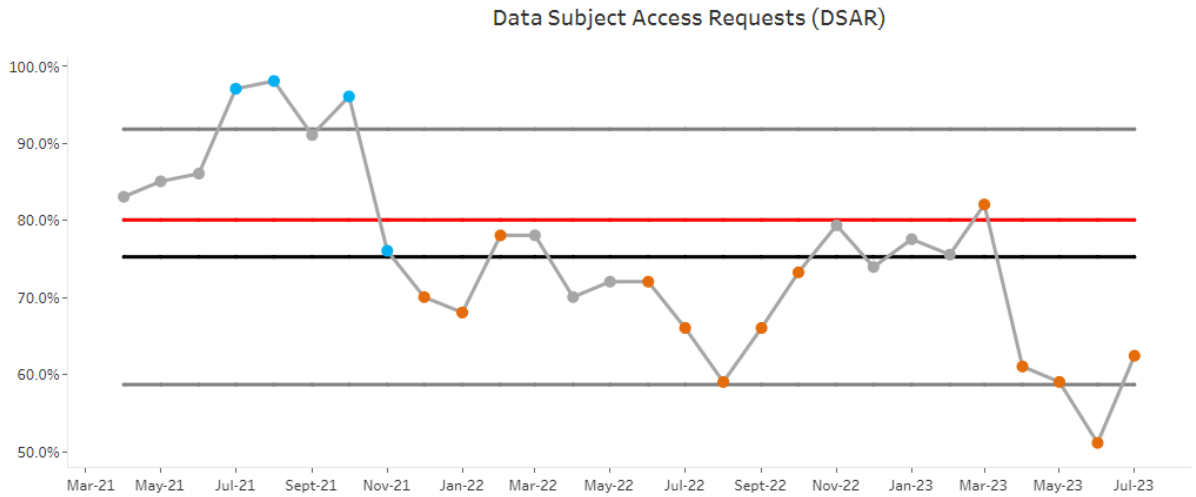
# 3. Assurance report: Corporate support services – Digital, *continued*




| 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 |
|---|---|---|---|---|
| There were two externally reported ICO incidents in July against a target of zero. Due to the low volume of incidents, SPC has not been applied to this indicator.<br><br>Incident 1: Our Occupational Health Records & Management System incorrectly and auto-populated the employee address field on management referral reports meaning that a patient was provided with a manager's personal address.<br><br>Incident 2: A baby, previously a neonatal patient, was due to attend for an outpatient appointment. (Patients are monitored until they are two years old.) Two volumes of their paper medical records have been and remain lost despite an extensive search of the unit/department. | Incident 1: Local investigation conducted by OH and the software provider was contacted to investigate and resolve. A review exercise was also conducted to see if incident had happened before, which it hadn't. In response, the ICO sent a questionnaire about incident and then closed the case upon receipt of answers. ICO recommendations will be implemented.<br><br>Incident 2: An e-mail was sent to all paediatric teams asking if they have the notes. Temporary notes file created for the appointment. The ICO has closed the case based on the information provided by OUH. ICO recommendations will be implemented. | Reports will be made available to DOC | BAF 6 | Satisfactory<br><br>*Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance* |

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




| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| Data Subject Access Request compliance was 62.4% in July, below the target of 80%. Performance exhibited deteriorating special cause variation due to two out of three data points falling within 1 sigma of the lower process limit.<br><br>As reported in the M3 IPR, the Medical Records SAR team have a significant backlog of cases to work through as well as now regularly receiving high volumes of requests per month.<br><br>Similarly, the PACS team who deal with requests for copies of radiological imaging have also experienced an increase in the number of DSARs and corresponding decline in performance. This has been exacerbated by competing demands on staff time due to other projects and work. | 1) A new software package to better manage subject access requests across all teams is being brought in. This is an extension of the existing FOI management package, and update to which is noted elsewhere and has similar automation and management features.<br><br>2) A wider review of the issues around handling Subject Access Requests, particularly in Medical Records/Legal Services and PACS/Radiology by the Data Protection Officer and Head of IG is underway and recommendations will be passed to DOC.<br><br>3) Targeted and short-term temporary staffing has been identified to support the Medical Records SAR backlog. | 1) New software up and running by 31/08/2023<br><br>2) October 2023<br><br>3) October 2023<br><br>Oversight from Digital Oversight Committee | BAF 6 | Satisfactory<br><br>*Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance* |

# 4. Development indicators

| Chief Officer | Domain | Reporting section | Indicator type | Indicator | Comments |
|---|---|---|---|---|---|
| CMO | Quality, Safety and Patient Experience | Clinical outcomes and effectiveness | SOF | Performance against relevant metrics for the target population cohort and five key clinical areas of health inequalities | Indicators TBA |
| COO | Operational Performance | Elective access | National | 31-all (new standard) | Further information due on the new standard: Not currently available |
| COO | Operational Performance | Elective access | National | Cancer: % patients diagnosed at stages 1 and 2 | Further information due on the calculation method of this indicator within the National Planning Guidance |
| COO | Operational Performance | Emergency care | SOF | Available virtual ward capacity per 100k head of population | Not currently recorded: TBA |
| COO | Operational Performance | Emergency care | National | Number of virtual ward spaces available | Performance is due to be reported from M6 2023/24 |

Oxford University Hospitals NHS Foundation Trust

## 1. Assurance reports: format to support Board and IAC assurance process

| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales | Risk Register (Y/N) | Data quality rating |
|---|---|---|---|---|
| This section should describe the reason why the indicator has been identified for an assurance report and interpret the performance with respect to the Statistical Process Control chart, if appropriate.<br><br>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.<br><br>If the performance target cannot be achieved, or risks mitigated, by these actions any additional support required should be documented. | This section should list:<br>1) the timescales associated with action(s)<br>2) whether these are on track or not<br>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 |