Oxford University Hospitals
NHS Foundation Trust

# Integrated Performance Report

## M10 (January data)

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# Table of Contents

# 1. Executive summary: *Part 1 – Strategic priorities and performance*

Oxford University Hospitals NHS Foundation Trust

**1. Overview of strategic priorities and performance**

The January 2025, the Integrated Performance Report incorporates the key indicators associated with the OUH 3-year plan (2024-2027) and the four strategic pillars: People, Patient Care, Performance and Partnerships. Within our key priorities for our people and financial performance, we set a plan to reduce temporary staffing by 700 by the end of Q2. The plan was set in agreement with the Integrated Care Board (ICB) and NHSE. Up to the end of Month 10 (January) £17.8m has been saved on temporary staffing against a £27.6m target. The WTE reduction for this achieved at M10 was 287 WTE against a plan of 700 WTE and a forecast of 350 WTE. The potential effect on patient care is carefully evaluated by Pay Panels led by Chief Officers and incorporate Quality Impact Assessments (QIAs).

We achieved key measures related to patient safety and care experience, including the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI), which show fewer patient deaths than expected. We also met targets in VTE Risk Assessments which support high quality patient care, NICE guidelines for timely antibiotics in ED, and did not record any Never Events.

Our Patient Safety Incident Response Framework (PSIRF) guides our response to safety incidents for learning and improvement, while our Quality Improvement methodology supports our strategic goals. Safeguarding training compliance for both adults and children (L1-L3) was achieved.

Appraisals provide feedback, recognition, and identify development opportunities, aligning staff performance with our strategic pillars. In January, we met targets for non-medical appraisals and core skills training, demonstrating commitment to staff development and our time to hire standard was achieved. Core skills training exhibited improving SCV and process assurance for consistently meeting the target.

Lower staff sickness rates, vacancies, and turnover contribute to better patient care and reduced costs from temporary staffing. Our sickness absence rate, although higher than target, was lower than the National and Shelford averages. Turnover rates performed better than targets and exhibited improving SCV. The Vacancy rate was better than the performance threshold but exhibited deteriorating SCV. This was expected because of the recruitment pause. An exception process for essential posts is in place and is regularly reviewed.

The Cancer Faster Diagnosis standard measures the percentage of patients diagnosed or who have cancer ruled out within 28 days of being referred. It is an important indicator to show that patients receive a diagnosis as soon as possible, which can improve clinical outcomes, or provide peace of mind when cancer can be ruled out. Performance was better than the national target in December, and equal to our operational target of 77.0%.

Income and Expenditure (I&E) was a £28.7m deficit to Month 10, £16.7m worse than plan. The underlying deficit was £63.4m and the underlying deficit for the month was £0.6m worse than last month, at £8.0m. Within this, underlying pay expenditure worsened by £0.6m. Overall worked WTE (excluding R&D) increased by 95 WTE in January, however substantive worked WTE decreased by 15. Cash was £9.8m at the end of January, £4.9m lower than the previous month.

The forecast is indicating that since the delivery of the forecast I&E is at risk, the cash position is similarly under pressure to the end of the financial year. The teams are taking action to try and convert debtors to cash and prioritise staff and supplier payments as far as possible. The primary driver for the reductions in cash his year continues to be the operating cash deficit (driven by the underlying I&E deficit). Underlying performance in Month 10 (£8.0m underlying deficit) shows a worsening trend and will require further financial controls to address the position.

Of the 107 indicators currently measured in the IPR, 31 are detailed further using standardised assurance templates. These indicators, which include those failing to meet performance standards or showing deteriorating SCV, are listed in summary on the following page and elaborated within the relevant domain in section 3 (Assurance reports).

The Trust Management Executive review process also considers indicators without targets and those not flagging SCV in assurance reporting. Assurance reporting includes updates to Tiering requirements for Elective, Cancer, and Urgent and Emergency Care. The data quality ratings of the assurance templates range from 'satisfactory' to 'sufficient', as defined on page 11.

# 1. Executive summary: *Part 2 – performance challenges*

Oxford University Hospitals NHS Foundation Trust

**2. Performance challenges: integrated summary of assurance templates**

## Not achieving target

### Special cause variation - deterioration

- PFI: % of audits that achieve 4 out 5 stars NOC
- % Outpatient firsts and follow-up attendances (procedures)
- RTT standard: >52-week incomplete pathways
- % Diagnostic waits under 6 weeks
- 62-day Cancer standard: incomplete pathway >62 days
- Vacancy Rate
- Information Governance and Data Security training

### Common cause variation and missed target

- MRSA & C-Diff Cases: HOHA + COHA
- Pressure ulceration incidents per 10,000 bed days ( Cat 2, 3, and 4)
- Midwife ratios (birth rate/staffing level)
- Reactivated complaints
- FFT % positive IP and ED
- PFI: % cleaning score by site (average) JR and CH
- Sickness and absence rate (in month)
- Cancer 28-day combined Standard
- Cancer 31-day combined Standard
- Cancer 62-day combined Standard (2ww, Consultant upgrade and screening)
- Proportion of patients spending more than 12hrs in ED
- ED 4hr Performance – Type 1
- Data Subject Access Requests (DSAR)
- Freedom of Information (FOI) % responded within target

### Special cause variation - improving

- % of complaints responded to within 25 working days
- FFT % positive OP
- RTT standard: >65-week incomplete pathways
- Sickness absence (rolling 12-month)
- ED 4-hour performance All
- RTT patients > 78 weeks

### Other*

- Non-Thematic Patient Safety Incident Investigations

**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)*

**Healthcare-associated infection (HSC):** HCI results in poor outcomes for patients as well as increased length of stay. OUH reported 12 HOHA and 7 COHA C. difficile cases in January, Additionally, two healthcare-associated MRSA and 4 HOHA MSSA cases were recorded, with one MRSA case meeting HOHA criteria. Further analysis of C. difficile data, supported by the Oxford HPRU, suggests increased testing may be detecting asymptomatic carriers. A new national C. difficile testing SOP is under consultation. The antimicrobial stewardship programme reports a decline in antibiotic use likely predisposing to C. difficile infection. Recruitment for a new Lead Nurse/Manager starts in January 2025, and MRSA screening strategy review and compliance audit results will be presented in February.

**Patient safety incident investigation (PSIIs)**: PSIIs are detailed system-based investigations conducted to learn and improve from significant incidents. These reviews, completed within 3-6 months, involve the patient and/or family, and are discussed weekly at Safety Learning & Improvement Conversations (SLIC). Other learning responses include After Action Reviews (AARs) and Learning Multidisciplinary Team Reviews (LMDTR). In January, a new PSII was confirmed, involving a baby who died after being readmitted following a cardiac arrest. Since adopting the Patient Safety Incident Response Framework (PSIRF) in October 2023, 34 non-thematic PSIIs have been confirmed. Various actions, including after action reviews (AARs) and LMDTR, are underway to improve patient safety.

**Complaints and Response Times**: The percentage of complaints responded to within 25 for January 2025 was of 43%, below the target of 85%. Actions to address these issues include using the monthly interactive complaints dashboard, reviewing complaints by senior leaders, sharing weekly reports, and a process improvement work to identify bottlenecks.

**Friends and Family Test (FFT):** FFT performance was below target in IP, OP and ED areas. The patient experience team is promoting FFTs within departments using posters. A thematic analysis of patient feedback from complaints, Healthwatch, and FFT is being conducted to improve communication with patients waiting for appointments. Additionally, work has commenced on a dashboard for FFT.

**Pressure Ulcer Incidents**: Pressure Ulcers (PUs) per 10,000 bed-days, has had sustained increases in Category 2 HAPUs and there were 12 verified incidents in Category 3 HAPUs in January 2025. Actions include a quality improvement programme, reviewing clinical areas using the PSIRF approach, enhancing the Pressure Ulcer Dashboard, and ensuring audit compliance.

**Midwife Ratios**: In January, the ratio was 1:23.3. Staffing levels were maintained safely with no adverse events during labour. Actions to address staffing challenges include recruitment and retention plans, daily staffing meetings, and additional controls for NHSP.

**Adult Safeguarding Activity**: The main theme of concern is domestic abuse, substance misuse, neglect, and deprivation of liberty safeguards. Actions being taken to meet demand is a reduction on bespoke training to teams, and a reduction of information requests.

**PFI Score:** At the John Radcliffe (JR) site, the combined PFI cleaning score was 96.8%, with 94.5% of audits achieving 4 or 5 stars. The Churchill site had a score of 95.7%, with 94.2% of audits achieving 4 or 5 stars. The Nuffield Orthopaedic Centre (NOC) scored 97.3%, with 88.1% of audits achieving 4 or 5 stars. Actions taken to address failed audits include improving reporting and collaborating with Infection Prevention and Control (IPC) and ward/department leads. The Trust PFI management team oversees these plans, with progress monitored by domestic supervisors. Additionally, redefining KPIs are being reviewed to align with National Standards of Cleanliness.

**Sickness Rate:** In January, there was a small increase in sickness absence rates of 0.3%, primarily due to colds, coughs, and flu. The team has implemented several actions, including a wellbeing campaign, collaborative work with Occupational Health, targeted support for managers, and ongoing reviews of sickness absence management training content.

**Vacancy Rate:** In January, the vacancy rate remained at 7.6%, with a slight reduction in turnover from 9.7% to 9.6%. The Trust is taking various actions to address recruitment risks, such as investing in technology to streamline recruitment functions, offering training and development programs for line managers, and conducting comprehensive workforce analysis to identify current and future needs.

# 1. Executive summary: *Part 2 – performance challenges*

Oxford University Hospitals NHS Foundation Trust

**2. Performance challenges: integrated summary of assurance templates**

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### Common cause variation and missed target

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**ED 4-hour performance:** Prolonged wait times at the Emergency Department (ED) are associated with increased morbidity and mortality, and decreased patient satisfaction. The ED 4-hour performance for all types was 66.7%, with the Trust performing above the national average. The performance for Type 1 was 63.9%. Actions include ensuring senior medical decision maker coverage in the JR ED overnight, with recruitment underway and specific nights already covered. The Urgent and Emergency Care Quality Improvement Programme has been approved, focusing on five key national priorities, including Senior Decision Maker and Rapid Assessment & Treatment/Children's Urgent Care Pathway. Multidisciplinary teams are collaborating on these priorities, with regular updates provided. Additionally, Phase 4 of the ORU QI project will introduce a dedicated doctor for earlier assessment and treatment to enhance utilisation.

**Proportion of patients spending more than 12 hours in the emergency department:** In January, 4.8% of patients (778) had a length of stay over 12 hours in the Emergency Department, above the target. The Horton Hospital improved from 4.0% to 2.9% (114 patients), while the JR remained steady at 5.4% (664 patients). System improvements reduced the average delay by 0.6 days compared to January 2024. To mitigate this, the team has implemented the live bed state programme, with phase 2 due to launch in Q4 2024/25. The New Board Round Policy has been relaunched across all acute inpatient areas (41 wards), with a Trust-wide roll-out underway through the Quality Improvement (QI) Standard Work Programme.

**Diagnostic Waits:** The percentage of diagnostic waits over six weeks was 28.5% in January, below the target of 95.0%. The Trust faces significant delays in the elective recovery pathway, shortages in diagnostic radiology, and reduced capacity in endoscopy. To mitigate these issues, the team has implemented insourcing support, triaged referrals, and increased capacity through additional funding and training.

**Patient Waiting Times:** As of the end of January, 3,063 patients were waiting over 52 weeks for consultant-led treatment. Increased waiting times for orthopaedic and urology services have necessitated additional capacity and resources. To address these challenges, the Trust has taken several actions, including converting waiting lists to orthopaedic theatres, increasing daycase capacity, and conducting efficiency reviews. Orthopaedic services have engaged Independent Sector Providers and converted spinal theatre lists to orthopaedics. ENT services have increased Audiology and paediatric daycase capacities, while urology has implemented TULA and repurposed gynae lists. MEDCARE insourcing began in February for outpatients and diagnostics. The Trust has implemented Elective Recovery Fund schemes and conducted a Patient Engagement Validation exercise. All actions are reviewed via weekly meetings, the Elective Delivery Group, and Divisional Performance Reviews.

**Cancer Standards:** Cancer performance against the 62-day combined standard was 62.8% in December, below the performance target of 70%. Challenges in meeting the 62-day Cancer standard include complex patients, slow processes, and late interventions. The Trust has relaunched the Cancer Improvement Programme, increased capacity, and improved patient engagement to address these issues.

**Outpatient Activities:** The percentage of outpatient activities was 41.8% in January, below the target of 46.0%. The percentage of outpatient activities is below the target, with challenges such as delayed outcome forms and procedural errors. Actions taken include evaluating specialties to optimise outpatient procedure activity, digitising clinic outcomes, and conducting external audit analysis.

**Freedom of Information (FOI):** In January, FOI performance remained below the 80% target, with 35% achieved. Actions include a review of FOI processes, an improvement plan, an escalation process, closing non-responding requests, and staff education.

**Data Subject Access Requests (DSAR):** The DSAR performance has recovered to 79.9%, which was very close to the target of 80% and the highest performance since March 2023. The Trust received 844 DSAR requests in M10, an 18% drop from M9.

**Information Governance and Data Security Training**: Performance was 89%, further reducing from target of 95%. Actions being taken are being reviewed due to the lack in performance at the Digital Oversight Committee.

# 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>• MRSA and C-Diff Cases: HOHA + COHA<br>• Pressure ulceration incidents per 10,000 bed days ( Cat 2, and 3)<br>• Midwife ratios<br>• Reactivated Complaints<br>• FFT % positive IP and ED<br>• PFI: % cleaning score by site (average) JR and CH | Not achieving target<br>• FFT % positive OP<br>• % of complaints responded to within 25 days | Not achieving target<br>• FFT % positive IP<br>• PFI: % cleaning score by site (average) NOC<br><br>Not achieving target | No target<br>• Adult safeguarding activity<br><br>No SPC<br>Not achieving threshold<br>• Non-thematic Patient Safety Incident Investigations |
| **Growing Stronger Together** | Not achieving target<br>• Sickness and absence rate (in month)<br>• Sickness and absence rate (rolling 12 months) | | | |
| **Operational performance** | Not achieving target<br>• Cancer 31-day combined Standard (First and all Subsequent Treatments)<br>• Cancer 62-day combined Standard (2ww, Consultant upgrade and Screening)<br>• Cancer 28-day combined Standard (2ww, Consultant upgrade and Screening)<br>• ED 4-hour performance ( type-1)<br>• Proportion of patients spending more than 12 hrs in ED | Not achieving target<br>• ED 4-hour performance All<br><br>Not Achieving target<br>• RTT patients > 78 weeks<br>• RTT patients > 65 weeks | Not achieving target<br>• % Outpatient first (all) and follow-up attendances (procedures)<br><br>Not achieving target<br>• % Diagnostic waits under 6 weeks<br>• RTT standard: >52-week incomplete pathways<br>• 62-day Cancer Standard: >62 days | |
| **Corporate Support Services** | Not achieving target<br>• Data Subject Access Requests (DSAR)<br>• Freedom of Information % responded to within target time<br>• Elective Recovery Funding weighted activity<br>• Efficiency Delivery £'000<br>• In-month financial performance Surplus/Deficit £'000 | | Not achieving target<br>• Information Governance and Data Security Training compliance<br>• Adjusted in-month financial performance surplus/deficit £'000<br>BPPC £%<br>BPPC Volume %<br>Year-to-date financial performance surplus/Deficit £'000 | No SPC<br>Not achieving threshold<br>• Elective recovery funding (ERF) value-weighted activity % In month |

# 2. b) SPC indicator overview summary

Oxford University Hospitals NHS Foundation Trust

## Integrated Performance Report (SPC)

Quality, Safety and Patient Experience Summary: All

Latest Indicator Period: Jan-2025

| Indicator Description | Period | Performance | Target | Met? | Mean | LCL | UCL |
|---|---|---|---|---|---|---|---|
| MRSA cases: HOHA+COHA per 10,000 beddays | Jan-25 | 0.3 | - | - | 0.2 | -0.4 | 0.7 |
| MRSA cases: HOHA+COHA | Jan-25 | 1 | 0 | No | 1 | -1 | 2 |
| C-diff cases: HOHA+COHA per 10,000 beddays | Jan-25 | 3.6 | - | - | 3.6 | 0.3 | 6.9 |
| C-diff cases: HOHA+COHA | Jan-25 | 12 | 10 | No | 12 | 1 | 22 |
| MSSA cases: HOHA+COHA | Jan-25 | 6 | - | - | 6 | -1 | 12 |
| Number of Never Events | Jan-25 | 0 | 0 | | 0 | - | - |
| Non-Thematic Patient Safety Incident Investigations | Jan-25 | 1 | 0 | No | 2 | - | - |
| VTE- Submitted performance | Jan-25 | 98.1% | 95.0% | | 98.0% | 97.6% | 98.3% |
| % of emergency admissions 65yrs + receiving cognitive screen | Dec-24 | 64.7% | - | - | 57.3% | 49.9% | 64.8% |
| % patients with sepsis attending ED received timely antibiotics in accordance with NICE guidelines | Jan-25 | 100.0% | 90.0% | | 90.4% | - | - |
| CAS alerts breaching deadlines at end of month and/or closed during month beyond deadline | Jan-25 | 0 | 0 | | 0 | - | - |
| Medication incidents causing moderate harm, major harm or death as reported on Ulysses | Jan-25 | 4 | - | - | 2 | -1 | 6 |
| Hospital Standardised Mortality ratio | Jan-25 | 97.9 | 100.0 | | 93.1 | - | - |
| Summary Hospital-level Mortality Indicator | Jan-25 | 90.0 | 100.0 | | 92.1 | - | - |
| Neonatal deaths per 1,000 total live births | Dec-24 | 3.2 | 3.2 | No | 3.4 | -1.5 | 8.3 |
| Stillbirths per 1,000 total Live births | Dec-24 | 2.7 | 4.0 | | 3.9 | 0.7 | 7.0 |
| National Patient Safety Alerts not completed by deadline | Jan-25 | 0 | - | - | 0 | - | - |
| Potential under-reporting of patient safety incidents: Patient safety incident reporting rate per 10,000 beddays | Jan-25 | 0.0 | - | - | 0.0 | - | - |
| Number of active clinical research studies hosted | Jan-25 | 1420 | - | - | 1380 | 1345 | 1415 |
| Number of active clinical research studies (commercial) | Jan-25 | 404 | - | - | 369 | 355 | 383 |
| Number of active clinical research studies (non commercial) | Jan-25 | 1016 | - | - | 1011 | 988 | 1035 |
| Number of incidents with moderate harm or above per 10,000 beddays | Jan-25 | 45.9 | - | - | 42.3 | 26.6 | 58.1 |
| Number of patient incidents with moderate harm or above per 10,000 beddays | Jan-25 | 39.9 | - | - | 38.0 | 21.5 | 54.5 |
| Number of non-patient incidents with moderate harm or above per 10,000 beddays | Jan-25 | 6.0 | - | - | 4.4 | -2.3 | 11.1 |
| Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 2) | Jan-25 | 25.5 | 19.0 | No | 21.6 | 10.3 | 32.9 |
| Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 3) | Jan-25 | 3.0 | 2.0 | No | 2.2 | 0.4 | 4.1 |
| Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 4) | Jan-25 | 0.0 | 0.0 | | 0.1 | -0.2 | 0.4 |
| Pressure Ulceration incidents per 10,000 beddays (Present on admission Cat 1+) | Jan-25 | 110.3 | - | - | 98.8 | 72.2 | 125.3 |
| Patient falls (moderate and above) as reported on Ulysses | Jan-25 | 4 | - | - | 4 | -3 | 11 |
| Patient falls (moderate and above) as reported on Ulysses per 10,000 beddays | Jan-25 | 1.2 | - | - | 1.3 | -0.8 | 3.4 |

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


## Integrated Performance Report (SPC)

Quality, Safety and Patient Experience Summary: All

Latest Indicator Period: Jan-2025


| Indicator Description | Period | Performan.. | Target | Met? | Mean | LCL | UCL |
|---|---|---|---|---|---|---|---|
| Health and Safety related incidents - Assault, Aggression and harassment | Jan-25 | 182 | - | - | 156 | 83 | 229 |
| Adult safeguarding activity | Jan-25 | 1768 | - | - | 916 | 630 | 1201 |
| Children's safeguarding activity | Jan-25 | 628 | - | - | 621 | 329 | 912 |
| Adult safeguarding activity and Children's safeguarding activity | Jan-25 | 2396 | - | - | 1536 | 1084 | 1989 |
| Safeguarding (Children) training compliance L1 - L3 | Jan-25 | 90.4% | 90.0% | | 88.3% | 82.9% | 93.6% |
| Safeguarding (Adults) training compliance L1 - L3 | Jan-25 | 90.2% | 90.0% | | 38.1% | 29.0% | 47.3% |
| Total Deliveries in month | Jan-25 | 572 | 625 | - | 616 | 545 | 687 |
| Babies born | Jan-25 | 583 | - | - | 625 | 554 | 696 |
| Maternity Bookings (planned + unplanned) | Jan-25 | 777 | 750 | - | 710 | 556 | 864 |
| Inductions of labour from iView | Jan-25 | 112 | - | - | 141 | 106 | 177 |
| Midwife Ratios (birth rate / staffing level) | Jan-25 | 23.2 | 22.9 | No | 25.8 | 21.6 | 30.0 |
| Learning MDT Reviews presented at SLIC | Jan-25 | 5 | - | - | 3 | - | - |
| After Action Review (AAR) | Jan-25 | 16 | - | - | 15 | - | - |
| Number of complaints | Jan-25 | 150 | - | - | 111 | 58 | 164 |
| Number of complaints per 10,000 beddays | Jan-25 | 45.0 | - | - | 34.6 | 20.1 | 49.2 |
| Reactivated complaints | Jan-25 | 12 | 1 | No | 10 | 2 | 18 |
| % of complaints responded to within 25 working days | Jan-25 | 44.2% | 85.0% | No | 43.9% | 24.1% | 63.7% |
| Number of RIDDORs | Jan-25 | 5 | 5 | | 4 | - | - |
| Friends & Family test % likely to recommend - IP | Jan-25 | 94.7% | 95.0% | No | 95.0% | 93.8% | 96.3% |
| Friends & Family test % likely to recommend - OP | Jan-25 | 94.7% | 95.0% | No | 93.8% | 93.0% | 94.5% |
| Friends & Family test % likely to recommend - ED | Jan-25 | 82.6% | 85.0% | No | 79.0% | 73.0% | 85.1% |
| FFT maternity % positive (births) | Jan-25 | 0.0% | 90.0% | No | 69.6% | 47.5% | 91.8% |
| Inpatient FFT (Response Rate) | Jan-25 | 21.7% | - | - | 24.9% | 21.4% | 28.3% |
| Outpatient FFT (response rate) | Jan-25 | 10.4% | - | - | 8.0% | 5.9% | 10.0% |
| ED FFT (Response Rate) | Jan-25 | 17.1% | - | - | 23.2% | 18.0% | 28.4% |
| Maternity FFT (response rate; births) | Jan-25 | 0.0% | - | - | 9.1% | 2.1% | 16.1% |
| PFI: % of total audits completed that achieved 4 or 5 stars JR | Jan-25 | 94.5% | 95.0% | No | 93.1% | 83.3% | 102.9% |
| PFI: % of total audits completed that achieved 4 or 5 stars CH | Jan-25 | 94.2% | 95.0% | No | 94.2% | 83.2% | 105.2% |
| PFI: % of total audits completed that achieved 4 or 5 stars NOC | Jan-25 | 88.1% | 95.0% | No | 96.4% | 90.2% | 102.6% |
| Incident rate of violence and aggression (rate per 10,000 beddays) | Jan-25 | 54.5 | - | - | 48.8 | 27.6 | 69.9 |
| Trust level: CHPPD vs budget | Jan-25 | 10.5 | - | - | -18.8 | -68.2 | 30.7 |
| Trust level: CHPPD vs required | Jan-25 | -12.3 | - | - | -6.0 | -25.1 | 13.1 |

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

Oxford University Hospitals NHS Foundation Trust

## Integrated Performance Report (SPC)
Growing Stronger Together Summary: All

Latest Indicator Period: Jan-2025

| Indicator Description | Period | Performance | Target | Met? | Mean | LCL | UCL |
|---|---|---|---|---|---|---|---|
| Vacancy rate | Jan-25 | 7.5% | 7.7% | | 7.2% | 6.3% | 8.2% |
| Turnover rate | Jan-25 | 9.6% | 12.0% | | 11.1% | 10.7% | 11.4% |
| Sickness absence rate (rolling 12 months) | Jan-25 | 4.1% | 3.1% | No | 4.1% | 4.0% | 4.3% |
| Non Medical Appraisals | Jan-25 | 90.9% | 85.0% | | 79.4% | 49.3% | 109.5% |
| Sickness absence rate (in month) | Jan-25 | 4.9% | 3.1% | No | 4.2% | 3.2% | 5.2% |
| Core skills training compliance | Jan-25 | 91.7% | 85.0% | | 90.3% | 88.3% | 92.3% |
| Time to hire (average days) | Jan-25 | 50.0 | 53.0 | | 49.4 | 39.1 | 59.7 |

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

## Integrated Performance Report (SPC)
Operational Performance Summary: All

Latest Indicator Period: Jan-2025

| Indicator Description | Period | Performance | Target | Met? | Mean | LCL | UCL |
|---|---|---|---|---|---|---|---|
| Patients whose operations cancelled for non-clinical reasons nc offered another binding date within 28 days | Jan-25 | 32.3% | - | - | 12.4% | -13.8% | 38.6% |
| Provider cancellation of Elective Care operation for non-clinical reasons either before or after Patient admission | Jan-25 | 0.4% | - | - | 0.4% | 0.2% | 0.6% |
| Proportion of ambulance arrivals delayed over 30 minutes | Dec-24 | 10.5% | - | - | 9.2% | 4.8% | 13.5% |
| Proportion of ambulance arrivals delayed over 60 minutes | Dec-24 | 0.8% | - | - | 1.0% | -0.1% | 2.2% |
| ED 4Hr perfromance - All | Jan-25 | 72.7% | 78.0% | No | 66.5% | 58.2% | 74.8% |
| ED 4Hr perfromance - Type 1 | Jan-25 | 63.9% | 73.6% | No | 59.7% | 50.6% | 68.9% |
| Proportion of patients spending more than 12 hours in an emergency department | Jan-25 | 4.9% | 2.0% | No | 4.8% | 2.6% | 7.0% |
| Proportion of patients discharged from hospital to their usual place of residence | Jan-25 | 95.4% | - | - | 95.1% | 94.3% | 96.0% |
| % Diagnostic waits waiting 6 weeks or more | Jan-25 | 28.5% | 5.0% | No | 16.0% | 11.6% | 20.4% |
| RTT standard: >52-week incomplete pathways | Jan-25 | 3063 | - | - | 2738 | 2385 | 3091 |
| RTT standard: >65-week incomplete pathways | Jan-25 | 509 | 0 | No | 722 | 490 | 954 |
| RTT standard: >78-week incomplete pathways | Jan-25 | 60 | 0 | No | 137 | 64 | 210 |
| RTT standard: >104-week incomplete pathways | Nov-24 | 0 | 0 | | 7 | 0 | 14 |
| Cancer 62 Day Combined Standard (2WW, Consultant Upgrade and Screening) | Dec-24 | 62.8% | 70.0% | No | 63.0% | 56.8% | 69.1% |
| 62-day Cancer standard: incomplete pathways >62-days | Jan-25 | 407 | - | - | 336 | 261 | 410 |
| 62-day Cancer standard: incomplete pathways >104-days | Jan-25 | 102 | - | - | 107 | 75 | 140 |
| Inpatient Daycase activity vs 2019/20 | Jan-25 | 94.7% | - | - | 92.0% | 77.8% | 106.2% |
| Inpatient Elective activity vs 2019/20 | Jan-25 | 92.3% | - | - | 84.9% | 62.9% | 106.9% |
| Outpatient First Attendance activity vs 2019/20 | Jan-25 | 102.2% | - | - | 107.5% | 86.2% | 128.7% |
| Outpatient Follow Up Attendance activity vs 2019/20 | Jan-25 | 125.1% | - | - | 119.4% | 98.0% | 140.9% |
| Diagnostic activity vs 2019/20 | Jan-25 | 129.5% | - | - | 122.7% | 110.7% | 134.8% |
| Cancer First Treatments vs 2019/20 | Jan-25 | 101.9% | - | - | 125.8% | 88.5% | 163.2% |
| Bed Utilisation General & Acute | Jan-25 | 95.2% | - | - | 95.2% | 91.8% | 98.5% |
| Cancer 28 Day combined Standard (2WW ,Breast Symptomatic and Screening Referrals) | Dec-24 | 77.0% | 77.0% | No | 78.5% | 73.3% | 83.6% |
| Cancer 31 Day combined Standard ( First and All Subsequent Treatments) | Dec-24 | 83.1% | 96.0% | No | 84.7% | 77.5% | 91.8% |
| % outpatient activity: first (all) and follow-up (procedures) | Jan-25 | 41.8% | 46.0% | No | 43.0% | 41.4% | 44.5% |

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

Oxford University Hospitals NHS Foundation Trust

## Integrated Performance Report (SPC)
**Finance Summary: All**

Latest Indicator Period: Jan-2025

| Indicator Description | Period | Performance | Target | Met? | Mean | LCL | UCL |
|---|---|---|---|---|---|---|---|
| Adjusted in-month financial performance Surplus/Deficit £'000 | Jan-25 | -7972.0 | - | - | -4589.4 | -7361.3 | -1817.5 |
| BPPC £ % | Jan-25 | 69.4% | 95.0% | No | 84.2% | 78.1% | 90.3% |
| BPPC Volume % | Jan-25 | 45.9% | 95.0% | No | 70.3% | 63.2% | 77.3% |
| Cash £'000 | Jan-25 | 9797 | 4037 | | 31277 | 9065 | 53489 |
| Efficiency delivery £'000 | Jan-25 | 7701.1 | 13624.0 | No | 5692.3 | -702.2 | 12086.8 |
| Elective recovery funding (ERF) value-weighted activity % In month | Jan-25 | 105.6% | 107.0% | No | 101.2% | 91.2% | 111.2% |
| In-month financial performance Surplus/Deficit £'000 | Jan-25 | -2080.2 | 4436.5 | No | -1157.0 | -11064.9 | 8751.0 |
| In-month ICS CDEL capital expenditure | Jan-25 | 8624.3 | 3985.0 | - | 2698.8 | -5175.8 | 10573.3 |
| Year-to-date financial performance Surplus/Deficit £'000 | Jan-25 | -28673.5 | -18452.0 | No | -15243.6 | -24340.3 | -6146.9 |

## Integrated Performance Report (SPC)
**Corporate support services – Digital Summary: All**

Latest Indicator Period: Jan-2025

| Indicator Description | Period | Performance | Target | Met? | Mean | LCL | UCL |
|---|---|---|---|---|---|---|---|
| Information Governance and Data Security Training | Jan-25 | 88.7% | 95.0% | No | 91.1% | 90.0% | 92.2% |
| Data Security & Protection Breaches | Jan-25 | 24 | - | - | 27 | 9 | 45 |
| Externally reportable ICO incidents | Jan-25 | 0 | 0 | | 0 | - | - |
| All IG reported incidents | Jan-25 | 26 | - | - | 29 | 13 | 45 |
| Freedom of Information (FOI) % responded to within target tim | Dec-24 | 50.0% | 80.0% | No | 58.7% | 31.2% | 86.2% |
| Data Subject Access Requests (DSAR) | Jan-25 | 79.9% | 80.0% | No | 69.2% | 52.3% | 86.0% |
| Priority 1 Incidents | Jan-25 | 0 | 0 | | 1 | - | - |

## Integrated Performance Report (SPC)
**Corporate support services – Legal services Summary: All**

Latest Indicator Period: Jan-2025

| Indicator Description | Period | Performance | Target | Met? | Mean | LCL | UCL |
|---|---|---|---|---|---|---|---|
| Legal Services: Number of claims | Jan-25 | 9 | - | - | 19 | 4 | 33 |

## Integrated Performance Report (SPC)
**Corporate support services – Regulatory assurance Summary: All**

Latest Indicator Period: Jan-2025

| Indicator Description | Period | Performance | Target | Met? | Mean | LCL | UCL |
|---|---|---|---|---|---|---|---|
| CQC overdue actions ('must do') | Jan-25 | 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

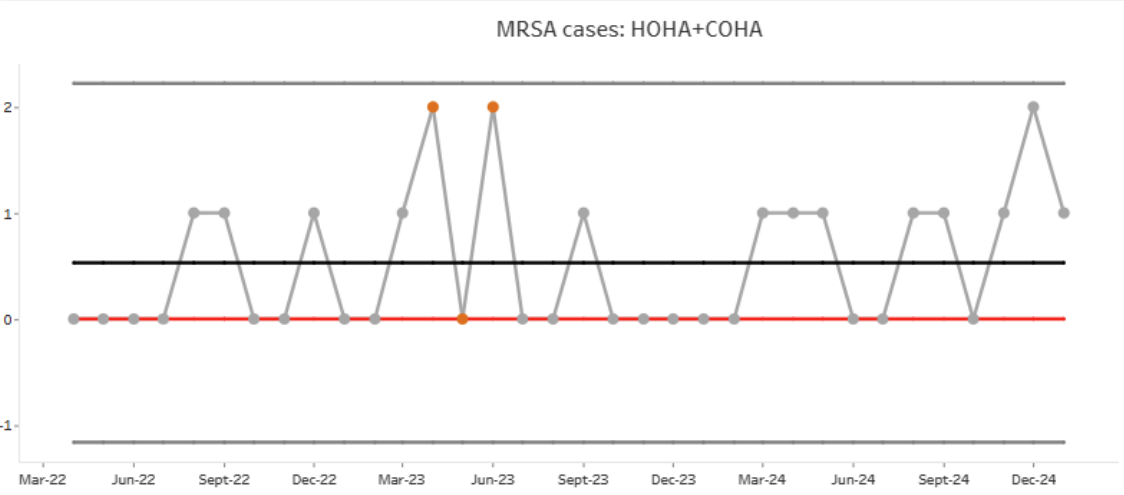
| | | | |
|---|---|---|---|
| **Valid**: Information is accurate, complete and reliable. Standard operation procedures and training in place. | **Verified**: Process has been verified by audit and any actions identified have been implemented. | **Timely:** Information is reported up to the period of 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. |

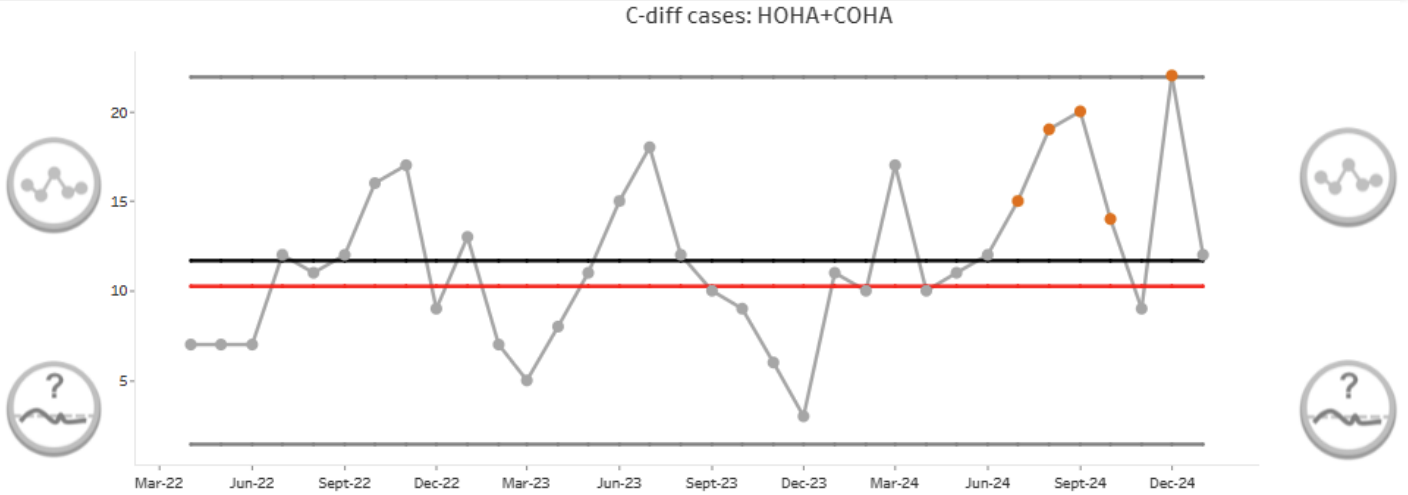
| Sufficient | Satisfactory | Inadequate |
|---|---|---|

# 03. Assurance reports

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





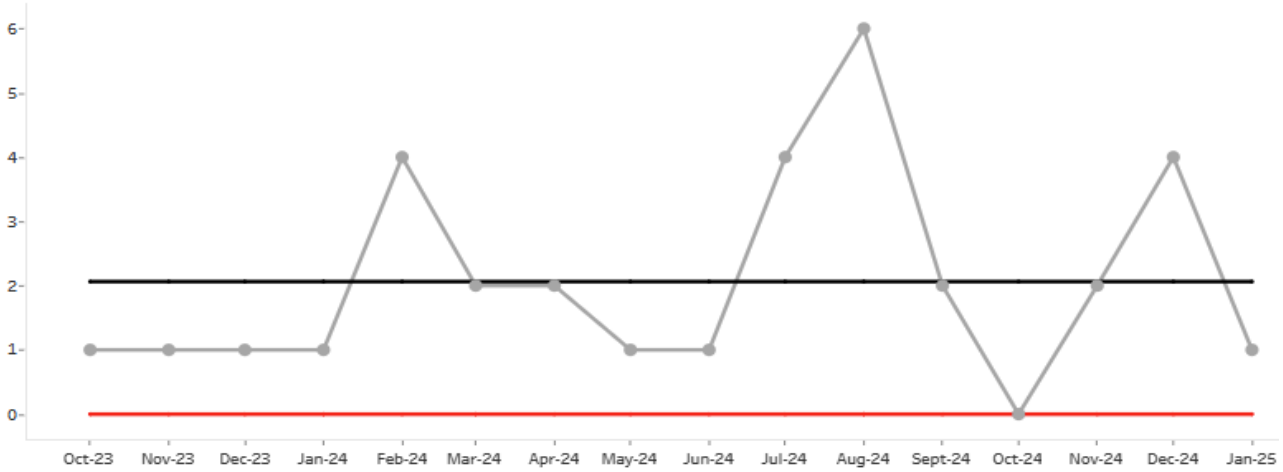




| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| C. difficile - OUH has reported 15 HOHA and 7 COHA C. difficile cases for December to the UK Health Security Agency (UKHSA). There are no clear themes to explain the high number of cases following a reduction in case numbers from September. The number of cases remains above the contract threshold for this time of year. The number of stool samples submitted to the laboratory continues to be high. The proportion of toxin positive samples is static.<br><br>The OUH trend is in the context of a national increase in C. difficile incidence of 54% since 2018/19, from 12.2 to 18.8 infections per 100,000 bed-days. There is currently no clear explanation for this national increase.<br><br>MRSA - 2 cases of healthcare associated MRSA bacteraemia were reported in December; both cases were admitted from the community. One case meets the definition for HOHA as the blood culture was not taken until day 2 of the admission; a safety message is planned.<br><br>MSSA - 4 cases of HOHA and 0 cases of COHA MSSA have been reported in December.<br><br>Staffing – An interim IPC Lead /Manager is in place, and recruitment to the definitive role is underway (job planning stage). | Further analysis of C. difficile data is underway supported by the Oxford HPRU. One hypothesis is that the increase in testing is driving detection of asymptomatic C. difficile carriers. The national team are also analysing data but have so far not been able to draw any conclusions. A revised national C. difficile testing SOP is out for consultation.<br><br>As reported in September, the antimicrobial stewardship programme continues to report a decline in use of antibiotics most likely to predispose to C. difficile infection.<br><br>Recruitment of a new substantive Lead Nurse/Manager will begin in January 2025.<br><br>A plan to review our MRSA screening strategy is being drawn up. MRSA screening compliance audit results will be presented in February. | The threshold C. difficile for 2024/25 is 123 cases. This is 20 more cases than 2023/24. The baseline has been changed because of an updated definition - where a patient has been admitted directly after attendance to A&E, the decision to admit is the admission date rather than the inpatient admission date. As a result of this definition change, case classifications will change from community-onset to hospital onset.<br><br>Assurance group – IPC report to PSEC via HIPCC. The DIPC chairs HIPCC. | BAF 4 | Sufficient<br><br>Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months |

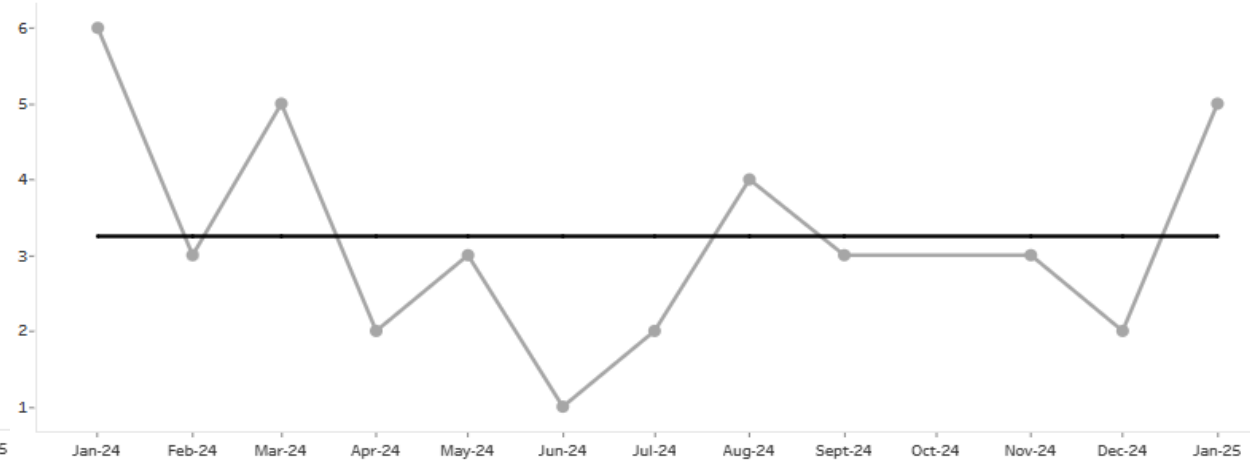
# 3. Assurance report: Quality, Safety and Patient Experience, *continued*



Non-Thematic Patient Safety Incident Investigations



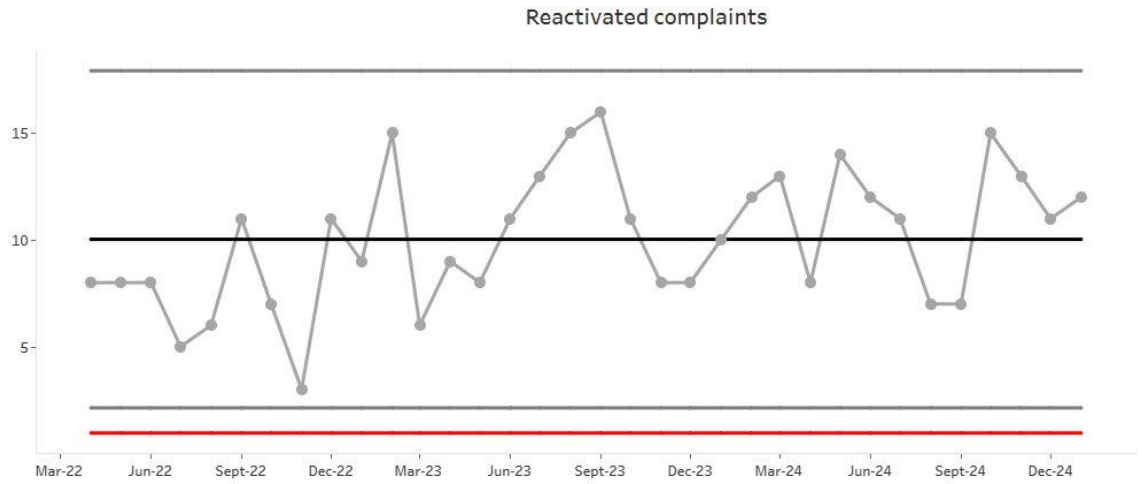

Learning MDT Reviews presented at SLIC

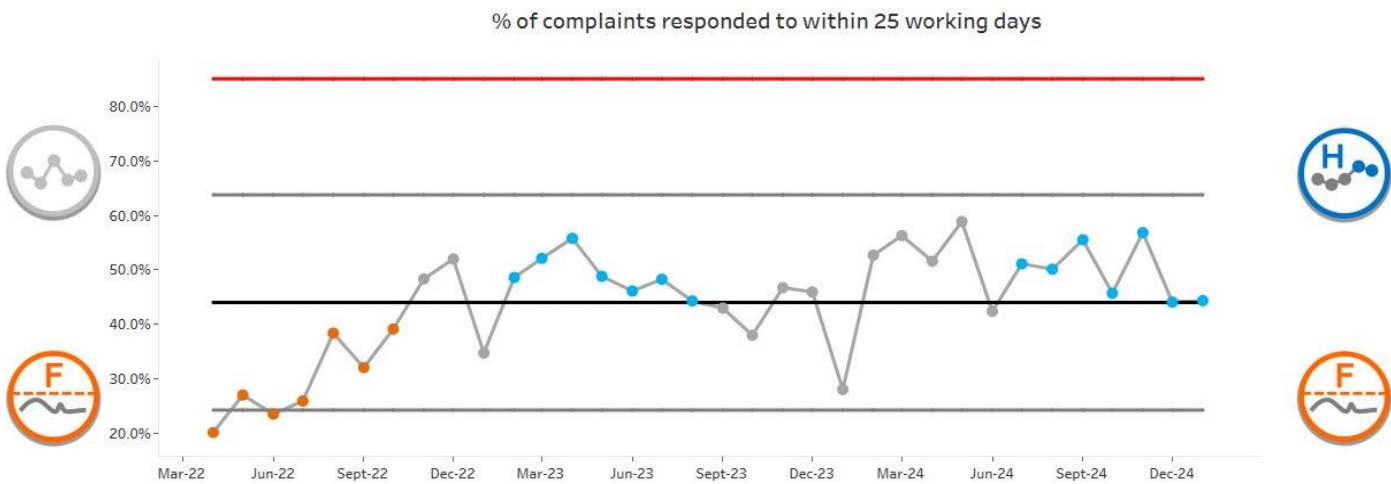



| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| One new patient safety incident investigation (PSII) was confirmed in January 2025 (excluding any incidents included in the 4 thematic PSIIs that form part of the Patient Safety Incident Response Framework (PSIRF) patient safety profile). This concerned a baby readmitted a day following discharge who had a cardiac arrest and died.<br><br>Individual PSIIs are incidents that warrant an extensive system-based review (more than a learning multidisciplinary team review (LMDTR)). The learning and improvement will be shared once the PSII has concluded. The specific timeline for PSIIs is set by the service in conjunction with the patient and/or family and confirmed at the weekly Safety Learning & Improvement Conversation (SLIC). | A total of 34 non-thematic PSIIs have been confirmed since OUH moved to the PSIRF framework in October 2023. The graph above shows 33 cases, one having been omitted from December 2024, but this will be rectified for future IPRs. Actions are underway to improve patient safety based on learning from these investigations.<br>PSIIs are one of a range of learning responses which can be applied to individual incidents or a cluster of similar incidents. Other learning responses include after action reviews (AARs) and LMDTR.<br><br>LMDTRs have a target of 6 weeks from the reporting of the incident to hold the meeting. The monthly median time to complete LMDTR meetings has been within this target 4 times in the 12 months where data is available (cases are selected by the month they were presented at SLIC); the median time was 71 days in January 2025. More staff are being trained in conducting learning responses with the aim of reducing the time to LMDTR meeting. Targets and adherence will be monitored at the PSIRF Improvement group.<br><br>Patient Safety has tracked all known completed AARs since May 2024. In January 2025 16 AARs (including harm-free assurance reviews for pressure ulcers and falls) were completed and submitted to PST. | The action is to complete the PSII investigations within the agreed timescale and share the learning across Divisions.<br><br>The PSII process is monitored by SLIC with CMO/CNO having responsibility for sign-off of final reports, following reviews by Divisional management, Patient Safety, Head of Clinical Governance, and DCMO. | BAF 4<br><br>CRR 1122 | Sufficient<br><br>*Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months* |

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

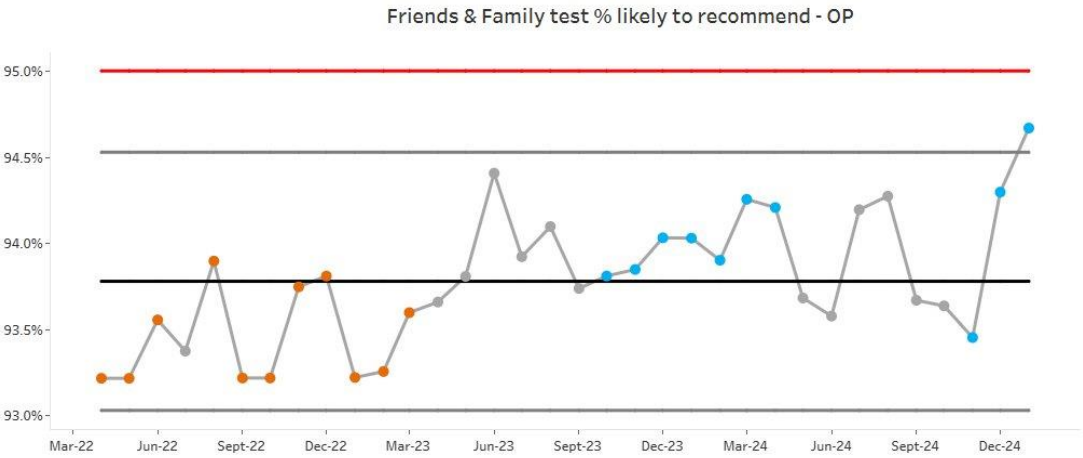


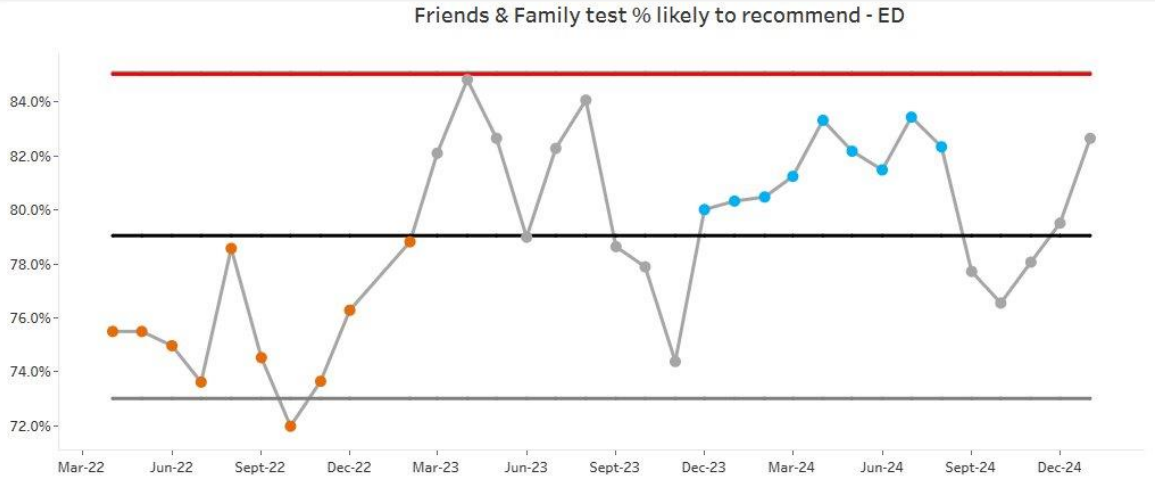


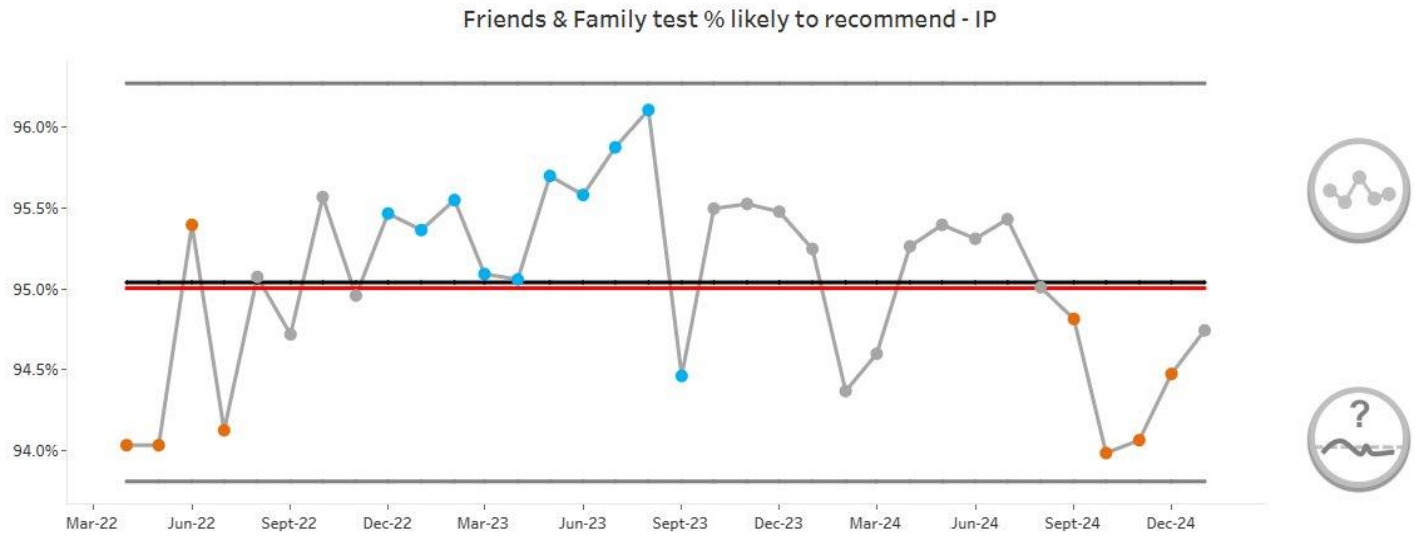

| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| In January 2025, 43% of complaints were responded to within 25 days, below the target of 85%. | The Trust received 147 formal complaints in January 2025, an increase from the number received in December 2024 (n=124).<br><br>43% of complaints were investigated, responded to and closed in 25 working days in January 2025. Barriers previously noted in last month's report continue to remain an issue, including operational pressures faced by the clinical teams and staff absence. Work is underway with the Information Team to scope out the practicalities of demonstrating how long a complaint has spent at each given stage of the process. It is expected these developments will be completed in the next four weeks so that a greater exposure will be possible in terms of the bottlenecks currently being experienced.<br><br>The monthly interactive complaints dashboard is in use for performance and compliance tracking (open, closed, reopened, and complaint themes) in Power BI. This is circulated to all Divisions for use in their Divisional Performance Reviews on Power BI.<br><br>All complaints continue to be reviewed by the Deputy Chief Nursing Officer or Head of Patient Experience prior to final sign off by the Chief Nursing Officer. This does not delay the closure date, as this review is completed within 24 hours.<br><br>A weekly report showing the number of open complaints over 25 days continues to be shared and discussed with senior leaders across Divisions and ensures they are engaged in resolving response times and provided with the necessary resources and support. Weekly meetings are held with the Complaints Team and Divisional Directors of Nursing, to escalate complaints cases about to breach, with each case given an identified way forward to bring the case to closure as quickly and appropriately as possible. This report also highlights the cases that are currently below 25 working days in the process, to ensure Divisions are aware and work to ensuring these cases do not breach. | Ongoing, reviewed weekly.<br><br>Oversight by Delivery Committee | BAF 4 | Sufficient<br><br>*Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months* |

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



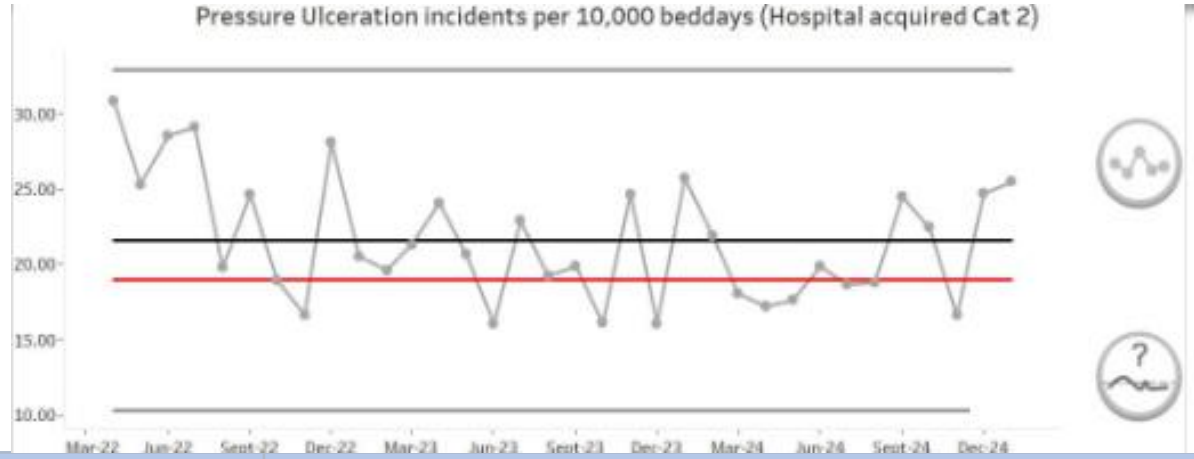

| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| 1. Inpatient Friends and Family Test (FFT) recommend rate = 94.7%. Outpatients = 94.7%. Emergency Departments = 82.6%. With a more positive trend reported in all areas over the previous three months.<br>2. The overall Trust performance for FFT for January '25 is 93.66% positive when analysing 16,619 responses. This is a total response rate for the Trust of 19.7%.<br>3. The top negative themed comments during January were - discharge home, cancelled admissions/procedures, and length of time on waiting list. These are consistent themes when we look at responses over a 12 month period. | 1. Updated posters have been shared with teams to better promote FFT within departments. A range of options are being considered, including the possibility of adding a QR code to patient letters which will direct to the online FFT survey.<br>2. A thematic analysis of patient feedback from complaints, Healthwatch and FFT is being undertaken relating to waiting times to understand how the Trust can more effectively keep in touch with patients whilst they are waiting for an appointment or procedure.<br>3. Discussions around development of a dashboard for FFT have been held with the information team to be able to provide a monthly analysis for service areas to access at any point in time rather than data being auto reported monthly.<br>4. A review into the comments around Discharge over the previous 12 months is being undertaken to better understand where improvements could be made. | 1. FFT data continues to be monitored on an ongoing basis. Ward / Clinical areas receive their reports automatically on a monthly basis.<br>2. The PE team report FFT data weekly to Incidents, Claims, Complaints, Safeguarding, Inquests [ICCSIS] which reports to the Patient Safety and Effectiveness Committee [PSEC].<br>3. The data is also reported to the Safety Learning and Improvement conversation (SLIC), Nursing Midwifery and Allied Health Professional Group and the Trust Governors Patient Experience and Membership Committee (PEMQ) every month. | BAF 4 | Satisfactory<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* |

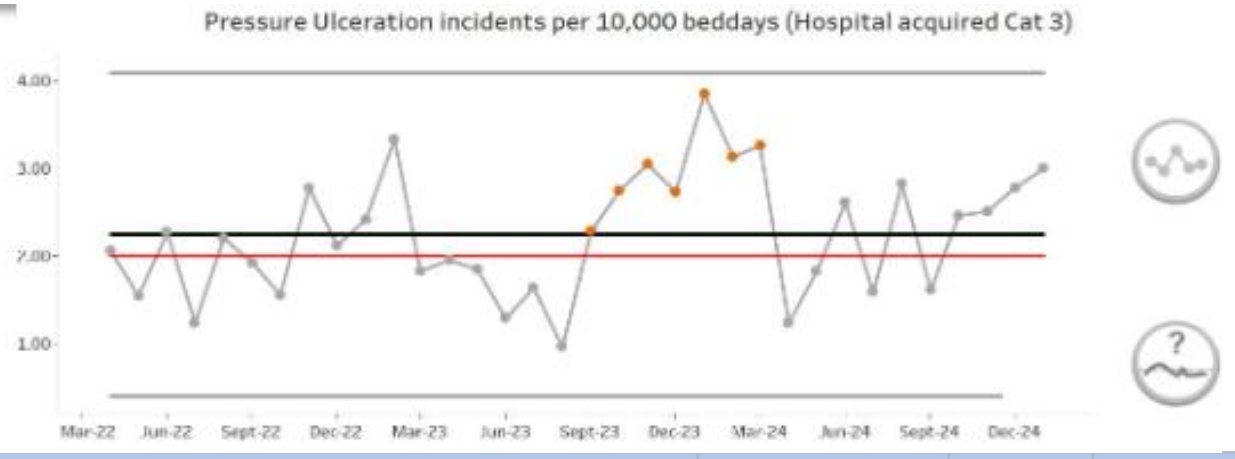



| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| 1. The top positive themes during January were staff attitude implementation of care, admission and clinical treatment . These are consistent top positive themed comments over the previous 12 months.<br>2. This continues to indicate that whilst patients are concerned about delays in their treatment, going home and parking, they experience good clinical care supported by professional staff who display a positive attitude. These themes are comparable with FFT data for January 2024. | 1. An area of focus as part of the CQC inpatient survey [IP] is to improve ratings for the question 'During your hospital stay, were you given the opportunity to give your views on the quality of your care?' This is to be discussed at the IP survey Improvement and Action meeting to determine what action can be taken and will be followed up in the Patient Experience and Family Carer forum.<br>2. A thematic analysis of previous data will be undertaken to provide a year-on-year comparison of response rates and likely to recommend rates. Data for the Buckinghamshire, Oxfordshire and Berkshire [BOB] system to the latest reporting period [Nov 24] indicates a positive response rate of 76% for inpatient services. | 1. Thematic analysis with action plan to be presented to the Integrated Assurance Committee in April '25. | BAF 4 | Satisfactory<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* |

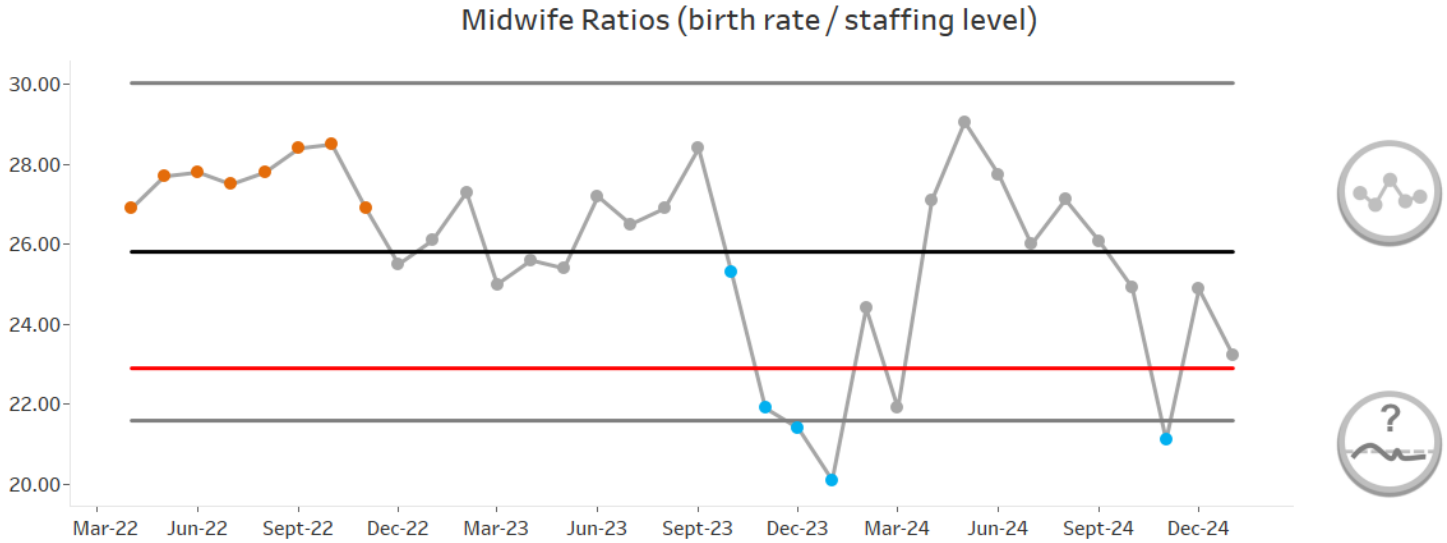
# 3. Assurance report: Quality, Safety and Patient Experience, *continued*





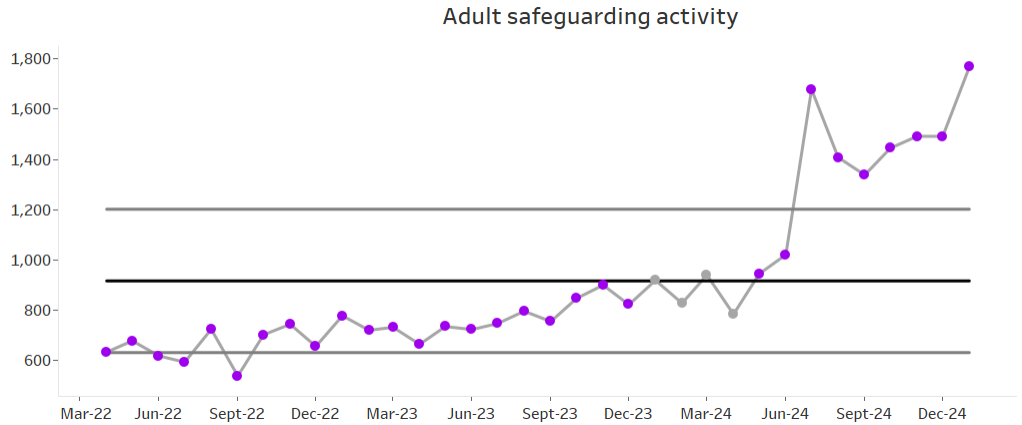

| Summary of challenges & risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance | Risk Register | Data quality |
|---|---|---|---|---|
| **HAPU Category 2:** January saw a sustained increase in the reporting of Category 2 HAPUs (Hospital-Acquired Pressure Ulcer)<br><br>**HAPU Category 3:** There were 12 verified incidents of Category 3 pressure ulcers in January 2025.<br><br>The Trust has continued to experience seasonal variation in the number of Category 2 and 3 HAPUs during the winter months. | Clinical areas review all incidents using the PSIRF approach to identify lessons learned and develop remedial action plans. Recent reviews indicate that ongoing improvements are necessary in appropriate care planning and delivery. This issue is being addressed through a review of care delivery models and standards of practice.<br>**HAPU QI Programme:**<br>Progress on the actions outlined in the HAPU QI programme is monitored and reported at the Harm-Free Assurance Forum and Clinical Governance Committee, including:<br>• **Data Dashboard:** A Hospital-Acquired Pressure Ulcer dashboard has been **enhanced** in Power BI to provide oversight of reported incidents in the form of SPC. This tool aims to give visibility for all clinical areas of the number of HAPUs and areas that require improvement.<br>• **Audit:** The Annual Clinical Pressure Ulcer Prevention Report was presented at HFAF and the Divisional Nurse meetings. Remedial actions have been taken to ensure the audit reflects the full completion requirements. The percentage of **patients identified as "at Risk "of pressure damage was 83%,** an increase from 81% in 2023 and a significant increase from **45% in 2018**, suggesting a significant shift in the patient cohort over the years. Overall compliance with the assessment criteria shows a small improvement from the previous year by 2%. Appropriate equipment scored highest at 99% compliance with care planning (70%) and evidence of repositioning (70%) the weakest indicators and will need to be the focus of improvement work going forward.<br>• **Pressure Ulcer Risk Assessment** work is underway to migrate the current assessment (Braden) to a national, evidence-based tool, Purpose-T. The Braden risk assessment tool has been consistently in use across the organisation for over 10 years, more contemporary evidence has suggested the Purpose-T tool is more sensitive and specific in identifying those at risk.<br>• **Hot Debriefs** to be undertaken at ward level within 24 hours of the reported incident to Safety Net patients and identify any trends in missed care delivery. Compliance with this will be monitored by the Clinical Divisions.<br>• **Medical Device Related Pressure Ulceration** a working group has been established, led by the Tissue Viability Team to identify the issues and trends associated with medical devices and pressure damage. This will include a review of all related care protocols.<br>• **Skin Assessment and Repositioning: ** Focused work continues to identify current practices, gaps, and areas for improvement in skin assessment and patient positioning. This has included observational assessments, which will continue to be undertaken by the Senior Teams. | Themes from all HAPU incidents will be presented at Clinical Governance Committee to ensure appropriate actions are taken in a timely manner | BAF 1 | Sufficient<br><br>*Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months, .* |




| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| In January the Midwife-to-birth ratio was 1:23.23, and staffing levels were maintained safely. 9.67% of shifts for the in-patient areas had the correct number of staff available with 76% of shifts being at 85% staffing or above which is consistent with the previous month. There was a significant decrease in the number of on call hours used, including community midwives, which were 158 compared to 212.8 in December.<br><br>There were no occasions when 1:1 care was not provided for women in established labour and no occasions during a shift when the delivery suite coordinator was not working in a supernumerary capacity. | The service continues with a robust recruitment and retention plan to align with the recommended Birthrate Plus uplift, address staff retention; optimise rostering KPIs and reduce NHSP spend.<br><br>Daily staffing meetings continue to ensure safe staffing across the service and enable tactical mitigations and trigger escalation as needed.<br><br>Further controls for NHSP authorisation now implemented for agreement at Matron level and above only.<br><br>Additional community night on-calls are now consistently rostered.<br><br>Cross service review commissioned of all short and long term sickness management and return to work processes to assure alignment to new absence policy. | Ongoing workforce plan to monitor:<br>➢ Recruitment to birthrate plus uplift,<br>➢ Staff retention strategies<br>➢ Reduction of NHSP spend.<br>Positive trajectory towards full recruitment by May 2025.<br><br>Weekly monitoring of:<br>➢ Community on-call hours required<br>➢ Community based births | 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 | Risk Register | Data quality rating |
|---|---|---|---|---|
| Adult safeguarding activity total for January was 1768 which included increased activity from maternity (n=390). Children activity for January was 628 a reduction of 24.<br><br>Domestic abuse, substance misuse, neglect are the main theme of concern.<br><br>There has been a new section 42 requested by the LA, related to discharge and medication.<br><br>There were 158 Deprivation of Liberty Safeguards; an increase of 15 in January.<br><br>Requests for information for multi-agency reviews continues.<br>- Four Safeguarding Adult Review (SAR)<br>- Two new Domestic Homicide reviews<br>- Mock partnership JTAI around child exploitation to review 10 children in preparation for a potential national review of child exploitation | Due to capacity pressures and increased partnership requests for significant amounts of information the team bespoke safeguarding training and supervision for teams has reduced.<br><br>All requests for information have been shared to partners for reviews and investigations. | ICCSIS updated on a weekly themes.<br><br>PSEC monthly assurance report, safeguarding is embedded in the monthly divisional governance reports and presented to the Trust clinical governance committee.<br><br>Safeguarding Steering group quarterly.<br><br>SLIC presentation quarterly to share learning from safeguarding reviews and specific cases. | 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: Safe Staffing - Quality, Safety and Patient Experience, *continued*

Oxford University Hospitals NHS

## Summary of challenges and risks

The Safe Staffing Dashboard in the three slides below triangulates nursing and midwifery quality metrics with CHPPD (Care Hours Per Patient Day) at the inpatient ward level. It is an NHSE requirement for this to be reviewed by Trust Boards each month. The coloured sections on the dashboard assist with the review, and any indicator not meeting the target is indicated in red. The NICE Safe Staffing guidelines inform the nurse-sensitive, paediatric, and maternity-sensitivity indicators summarised below.

Nursing and midwifery staffing is reviewed at a Trust level three times a day and was maintained at Level 2 (Amber) throughout January 2025. Paediatric Critical Care Unit (PCCU) declared level 3 on 11 occasions. With support from the other Critical Care Units, PCCU was able to implement team nursing as mitigation to make the unit safe. The Trust-wide planned versus actual fill rates were 83.45% during the day and 90.9% at night. Where fill rates were less than 90%, all shifts were reviewed, reported, and mitigated by a Matron or above at the safe staffing meeting, and shifts were not left at risk.

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

The staffing levels for nurses and midwives, as well as the nurse-sensitive indicators, are consistently reviewed and validated with divisional directors of nursing and deputy divisional directors of nursing. Each monthly review triangulates all relevant data in accordance with National Quality Board standards and assesses whether these nurse-sensitive harm indicators are directly related to staffing levels. The January review confirmed across all divisions that there were no instances of nurse-sensitive harm indicators directly linked to nursing or midwifery staffing levels.

**SUWON** – During this period, Upper GI ward CHPPD was higher than required due to some shifts having empty beds. Although staff were redeployed to other wards, this was not consistently reflected on the roster. Katharine House Hospice CHPPD were also higher than required, but due to the location of the hospice, a minimum number of staff are required to maintain safety, even on the shifts that may have empty beds. Roster efficiencies are reviewed in the monthly check and confirm meetings. The net hours difference for the Upper GI ward pertains to a RAF nurse, and for SEU-F, it relates to a student. Staff retention KPIs have been flagged to the DDN and will be monitored with increased oversight. All areas were safely staffed in January, utilising temporary workforce when appropriate

**Maternity** – The service is aligning with the Birthrate+ numbers, and ongoing efforts are being made to ensure these figures are accurately reflected in the budgets. As the revised staffing numbers have not yet been incorporated into the budget and signed off by finance, the vacancy data does not fully represent the current situation. Consequently, the budgeted Care Hours Per Patient Day (CHPPD) is lower than required, which may cause the actual CHPPD to appear higher than the budget at times to ensure safe staffing levels in clinical areas. Staff recruitment is in progress. Registered vacancies had been expected to be filled by February 2025, however, with the recruitment pause, this is now likely to be May 2025. Delays in the induction of labour (IOL) due to midwifery staffing levels and capacity issues were categorized as no harm events and managed on a case-by-case basis. The overall number of delays decreased by 50 from December. All areas were safely staffed in January using temporary workforce where appropriate. The roster for delivery suite was published late, as the Matron had commenced parenting leave. An interim matron is now in post this will be back on track next month.

**MRC** – The actual CHPPD for CMU, CTW, Juniper and Stroke wards appears lower than required for January. Following validation with the DDN, it was identified that clinical educators, ward managers, and when appropriate, supernumerary staff were reallocated to support safety but were not moved electronically on the system. No unsafe shifts were escalated, and senior nurse visibility and oversight were maintained in all areas during January. MRC experienced increased levels of sickness absence across both the JR site in January. Check and Confirm reviews indicate that roster efficiencies and performance are being tightly managed. The net hours difference for JR ED, relates to a senior nurse who has a split post. All areas were safely staffed in January.

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

**NOTSSCAN** – Roster efficiencies and KPI adherence are being closely monitored by the DDN, supported well with the check and confirm meetings. One area was not approved for payroll this month. A process is now in place to cover for the Matron's unexpected absences. The underworked hours across some wards have been reviewed and do not relate to substantive staff, but to student hours that were not rostered correctly. The Deputy DDN will challenge the HR vacancy data with the Workforce metrics team, as data suggests some wards are over recruited.

**CSS** – JR ICU – CHPPD, budget and roster were all reviewed. All areas were safely staffed in January, utilising temporary workforce when appropriate. The roster was not fully approved for payroll as the Clinical Lead Nurse had unplanned absence. This has been addressed with the Matron who will ensure this is complete in future should the situation arise again.

**Nurse Sensitive Indicators Directly Impacted by Staffing Levels**
The divisional directors of nursing have reviewed and approved the staffing levels for January. They confirmed that insufficient or unsafe staffing did not directly impact nurse-sensitive indicators, and thus, no exception reporting is required for this month

**Critical Care Recruitment**
During M10, critical care recruitment remained strong across the Trust, with nine candidates starting new roles across all five units. Additionally, ten offers were made, five of which were internal promotions.
In January, the Trust held dedicated critical care recruitment tours. The response was positive, with 30 candidates registering and 10 attending the tours. Among those who attended, there was a mix of experience levels, including individuals with critical care experience (both adult and paediatric), newly qualified staff nurses, and a couple of Internationally Educated Nurses (IENs) who had just received their NMC PIN. The feedback was positive, and we will continue to monitor the candidates who attended and any future applications.

**Vacancies above 15%**
All areas with a vacancy rate above 15% continue to be reviewed to ensure that there continues to be effective approaches to recruitment in place for those areas.

**Unavailability**
All areas experiencing a high unavailability of workforce, such as due to vacancies, maternity leave, or long-term sickness (according to HR data), were addressed to maintain safe staffing levels. This was achieved through the support of Ward Managers and Clinical Educators, as well as the use of temporary workforce solutions, including NHSP, Agency staff, and Flexible Pool shifts for Registered Mental Nurses (RMNs) and Maternity. All relevant metrics, such as rostering efficiencies, professional judgement, patient acuity, enhanced care observation requirements, skill mix, bed availability, and RN-to-patient ratios, are reviewed each shift to ensure safe and efficient staffing levels are maintained.

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

Oxford University Hospitals NHS Foundation Trust

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

**Key:**
Grey squares on the dashboard indicate where an indicator is either not relevant or not collected for the ward area.

**For HR Data:**
**Turnover:** This reflects the number of leavers divided by the average staff in post for both registered and unregistered Nursing staff. Leavers are based on a rolling 12 months, and do not include fixed term assignments or redundancies.

**Sickness:** This is a rolling twelve-month figure and is reported in the same manner as Trust Board sickness data. The figures presented reflect both registered and unregistered staff.

**Maternity:** This is taken on the last day of a particular month (aligned to all Trust reporting) and reflects those on maternity/adoption leave on that day. The FTE absent on this day is then divided by the total FTE for this cohort. The figures presented reflect both registered and unregistered staff.

**HR Vacancy:** For the designated areas this figure is the establishment (Budget FTE) minus the contracted FTE in post as at the last day of the month. The vacancy figure is then divided by the establishment. The figures presented reflect both registered and unregistered staff.

**HR Vacancy adjusted:** As per **"**HR Vacancy" ; with additional adjustment for staff on long term sick, career break, maternity leave, suspend no pay/with pay, external secondment. Data taken on last day of the month and reflects both registered and unregistered staff.

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

| Action timescales and assurance group or committee | Risk Register (Y/N) | Data quality rating |
|---|---|---|
| The Trust has commenced developing actions tailored to improving roster efficiency and effectiveness in nursing and midwifery. This work will ensure a balanced skill mix during each shift. Assurance of ongoing oversight and assurance that nursing and midwifery staffing remains safe. Although CHPPD should not be reviewed in isolation as a staffing metric, and always at ward level. Reviewing it at Trust level triangulated with other Trust level financial metrics allows the Board to see where there are increased, capacity and acuity, (required) versus budget. | N | ***Sufficient***<br>Information reported at required level. SOP in progress. Staff appropriately trained and quality assurance process in place each month for audit. Corporate validation/audit undertaken with DDNs and Deputy Chief Nurse workforce team monthly. External audit not undertaken in last 18-months. |

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

Oxford University Hospitals NHS Foundation Trust

| January | Care Hours Per Patient Day | | | Census | Nurse Sensitive Indicators | | | | HR | | | | | Rostering KPIs | | | | FFT |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward Name | Budgeted Overall | Required Overall | Actual Overall | Census Compliance (%) | Medication Administration Error or Concerns | Extravasation Incidents | Pressure Ulcers Category 2,3&4 | All reported falls | Vacancy (%) | Turnover (%) | Sickness (%) | Maternity (%) | Revised Vacancy HR Vacs plus LT Sick & Mat Leave (%) | Roster manager approved for Payroll | Net Hours 2/-2% | 8 week lead time | Annual Leave 12-16% | % Extremely likely or likely |
| Bellhouse / Drayson Ward | 8.95 | 10.35 | 11.4 | 92.47% | 3 | 1 | 1 | 0 | 13.8% | 22.1% | 4.3% | 1.8% | 15.4% | Yes | 2.0% | 8.9 | 15.1% | 93.5% |
| HH Childrens Ward | 8.66 | 9.08 | 12.2 | 93.55% | 2 | 1 | 0 | 0 | 14.8% | 7.1% | 4.0% | 13.6% | 30.9% | Yes | -1.1% | 9.4 | 12.9% | 91.1% |
| Kamrans Ward | 10.23 | 11.24 | 9.6 | 97.85% | 0 | 0 | 0 | 0 | -9.8% | 0.0% | 1.0% | 2.2% | -7.3% | Yes | 1.4% | 9.4 | 12.5% | 71.4% |
| Melanies Ward | 9.69 | 14.61 | 13.6 | 100.00% | 1 | 1 | 0 | 0 | -12.4% | 12.8% | 4.0% | 3.8% | -8.9% | Yes | -2.8% | 14.7 | 13.3% | 90.9% |
| Robins Ward | 10.68 | 10.21 | 8.8 | 98.92% | 1 | 0 | 0 | 0 | 11.4% | 17.3% | 3.8% | 3.4% | 20.5% | Yes | 0.7% | 14.7 | 12.1% | 94.1% |
| Tom's Ward | 8.05 | 9.47 | 8.9 | 100.00% | 7 | 1 | 0 | 1 | -13.1% | 5.8% | 2.1% | 6.7% | -5.6% | Yes | 0.0% | 9.7 | 13.9% | 89.7% |
| Neonatal Unit | 19.37 | | 22.5 | | 6 | 1 | 0 | 0 | 13.4% | 10.7% | 6.6% | 3.3% | 17.5% | Yes | -3.5% | 8.3 | 12.3% | |
| Paediatric Critical Care | 25.84 | | 28.7 | | 11 | 5 | 1 | 0 | -4.4% | 8.1% | 4.7% | 8.4% | 4.8% | Yes | -0.4% | 8.9 | 14.1% | |
| BIU | 6.05 | 6.09 | 7.2 | 80.65% | 1 | | 0 | 1 | 9.5% | 6.4% | 3.7% | 2.8% | 12.0% | Yes | 1.4% | 9.7 | 13.6% | |
| HDU/Recovery (NOC) | 9.04 | | 20.7 | | 0 | | 0 | 0 | 12.0% | 8.6% | 6.1% | 4.4% | 19.7% | No | 0.7% | 7.9 | 17.4% | |
| Head and Neck Blenheim Ward | 7.29 | 7.81 | 8.2 | 100.00% | 0 | | 0 | 1 | 12.4% | 0.0% | 4.8% | 0.0% | 14.2% | Yes | 5.5% | 9.4 | 15.4% | 100.0% |
| HH F Ward | 7.6 | 8.11 | 7.7 | 100.00% | 2 | | 2 | 1 | 5.7% | 8.0% | 6.0% | 2.2% | 8.2% | Yes | 0.2% | 9.7 | 13.5% | 100.0% |
| Major Trauma Ward 2A | 9.12 | 9.71 | 9.3 | 100.00% | 3 | | 4 | 3 | 5.2% | 8.9% | 4.4% | 0.0% | 5.2% | Yes | 5.7% | 9.4 | 13.0% | 93.3% |
| Neurology - Purple Ward | 8.94 | 9.65 | 8 | 100.00% | 1 | | 5 | 3 | -4.5% | 6.0% | 4.6% | 2.8% | -1.5% | Yes | 5.7% | 9.7 | 14.1% | 100.0% |
| Neurosurgery Blue Ward | 8.96 | 11.71 | 10.2 | 100.00% | 1 | | 0 | 4 | 13.1% | 7.9% | 4.1% | 2.2% | 15.1% | Yes | 2.5% | 8.9 | 14.2% | 80.8% |
| Neurosurgery Green/IU Ward | 11.78 | 9.93 | 9.7 | 100.00% | 1 | | 1 | 2 | 3.3% | 0.0% | 3.7% | 0.0% | 3.3% | Yes | 1.9% | 9.7 | 18.3% | |
| Neurosurgery Red/HC Ward | 12.81 | 12.52 | 12.2 | 100.00% | 3 | | 3 | 1 | -2.3% | 10.8% | 4.5% | 2.6% | 1.9% | Yes | -0.5% | 9.9 | 13.2% | 96.0% |
| Specialist Surgery I/P Ward | 7.28 | 6.55 | 8.4 | 100.00% | 8 | | 1 | 7 | 9.5% | 7.7% | 3.5% | 7.5% | 16.3% | Yes | 1.6% | 9.3 | 15.4% | 33.3% |
| Trauma Ward 3A | 9.11 | 9.35 | 8.8 | 100.00% | 3 | | 1 | 3 | 3.9% | 8.2% | 6.1% | 1.9% | 8.7% | Yes | 1.7% | 9.4 | 12.2% | 100.0% |
| Ward 6A - JR | 7.57 | 6.7 | 6.9 | 97.85% | 3 | | 3 | 6 | 11.8% | 11.1% | 3.0% | 6.7% | 17.7% | Yes | -2.2% | 9.3 | 16.5% | 100.0% |
| Ward E (NOC) | 6.3 | 7.53 | 7.9 | 95.70% | 0 | | 1 | 4 | 11.1% | 8.3% | 7.4% | 2.7% | 18.2% | Yes | 5.3% | 9.9 | 13.8% | 100.0% |
| Ward F (NOC) | 6.65 | 7.5 | 7 | 96.77% | 0 | | 3 | 5 | 10.0% | 5.9% | 4.2% | 2.8% | 15.0% | Yes | 1.5% | 8.7 | 14.2% | 100.0% |
| WW Neuro ICU | 27.94 | | 26.7 | | 5 | | 0 | 0 | 7.5% | 8.0% | 4.7% | 1.0% | 10.1% | Yes | -2.5% | 9.0 | 11.3% | |

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

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

Oxford University Hospitals NHS Foundation Trust

| January | Care Hours Per Patient Day | | | Census | Nurse Sensitive Indicators | | | | HR | | | | | Rostering KPIs | | | | FFT |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward Name | Budgeted Overall | Required Overall | Actual Overall | Census Compliance (%) | Medication Administration Error or Concerns | Extravasation Incidents | Pressure Ulcers Category 2,3&4 | All reported falls | Vacancy (%) | Turnover (%) | Sickness (%) | Maternity (%) | Revised Vacancy HR Vacs plus LT Sick & Mat Leave (%) | Roster manager approved for Payroll | Net Hours 2/-2% | 8 week lead time | Annual Leave 12-16% | % Extremely likely or likely |
| **MRC** | | | | | | | | | | | | | | | | | | |
| Ward 5A SSW | 8.8 | 9.5 | 9.4 | 100.0% | 1 | | 1 | 2 | -2.4% | 3.9% | 4.2% | 5.9% | 7.7% | Yes | 0.1% | 9.4 | 13.2% | 100.0% |
| Ward 5B SSW | 8.9 | 9.5 | 8.6 | 98.9% | 0 | | 1 | 5 | 3.5% | 8.7% | 4.1% | 4.0% | 7.4% | Yes | 2.5% | 9.3 | 11.4% | 87.5% |
| Cardiology Ward | 7.9 | 7.0 | 6.7 | 96.8% | 4 | | 2 | 6 | 12.3% | 16.2% | 4.8% | 0.0% | 15.8% | Yes | -1.9% | 9.7 | 13.3% | 100.0% |
| Cardiothoracic Ward (CTW) | 7.8 | 8.3 | 6.5 | 100.0% | 1 | | 1 | 1 | 11.9% | 4.5% | 2.7% | 4.7% | 18.1% | Yes | 0.8% | 7.9 | 16.3% | |
| Complex Medicine Unit A | 8.9 | 10.7 | 8.2 | 97.9% | 0 | | 1 | 6 | -9.1% | 7.3% | 6.6% | 6.6% | 2.0% | Yes | 0.0% | 9.6 | 14.8% | |
| Complex Medicine Unit B | 10.2 | 10.2 | 8.5 | 98.9% | 3 | | 1 | 3 | 0.1% | 11.7% | 3.3% | 8.5% | 8.6% | Yes | 0.6% | 9.6 | 16.2% | 100.0% |
| Complex Medicine Unit C | 8.8 | 10.6 | 8.5 | 97.9% | 1 | | 0 | 7 | 3.2% | 6.8% | 3.3% | 0.0% | 7.4% | Yes | 0.5% | 9.6 | 14.0% | 100.0% |
| Complex Medicine Unit D | 9.5 | 8.7 | 8.3 | 96.8% | 0 | | 2 | 4 | 2.1% | 8.7% | 8.2% | 0.0% | 8.3% | Yes | 3.2% | 9.4 | 16.3% | |
| CTCCU | 21.9 | | 21.6 | | 7 | | 2 | 0 | 8.8% | 10.4% | 4.2% | 3.2% | 16.3% | Yes | -0.4% | 12.6 | 11.6% | |
| Emergency Assessment Unit (EAU) | 9.2 | 8.7 | | 86.0% | 7 | | 0 | 6 | 9.9% | 11.4% | 5.8% | 1.9% | 15.3% | Yes | 2.5% | 8.4 | 15.9% | |
| HH EAU | 9.7 | 7.3 | | 86.7% | 3 | | 5 | 6 | 4.7% | 5.0% | 5.3% | 3.6% | 11.1% | Yes | 0.8% | 12.7 | 12.3% | |
| HH Emergency Department | 22.8 | | | | 2 | | 0 | 0 | 5.6% | 8.0% | 4.0% | 3.2% | 8.7% | Yes | -2.4% | 12.9 | 13.6% | 86.0% |
| JR Emergency Department | 18.0 | | | | 6 | | 0 | 4 | 17.0% | 14.9% | 4.3% | 5.1% | 22.9% | Yes | 9.5% | 9.3 | 11.9% | 80.9% |
| HH Juniper Ward | 8.1 | 10.9 | 7.6 | 100.0% | 0 | | 3 | 4 | -0.7% | 4.4% | 4.2% | 0.0% | 0.9% | Yes | -3.9% | 8.9 | 13.9% | 63.6% |
| HH Laburnum | 9.6 | 8.8 | 8.3 | 100.0% | 0 | | 5 | 10 | -2.0% | 3.4% | 7.9% | 3.3% | 8.2% | Yes | 2.0% | 8.9 | 12.3% | 52.6% |
| HH Oak (High Care Unit) | 10.1 | | 11.0 | 94.6% | 1 | | 3 | 3 | 1.0% | 6.1% | 6.7% | 7.8% | 10.4% | Yes | 1.4% | 8.9 | 12.3% | 100.0% |
| John Warin Ward | 10.2 | 9.6 | 8.9 | 98.9% | 2 | | 0 | 2 | -0.8% | 6.4% | 3.5% | 7.1% | 6.4% | Yes | -1.3% | 8.0 | 14.7% | 87.5% |
| OCE Rehabilitation Nursing (NOC) | 10.3 | 11.1 | 10.3 | 97.9% | 0 | | 0 | 1 | -3.3% | 5.0% | 5.3% | 3.8% | 4.2% | Yes | -1.7% | 8.4 | 15.4% | |
| Osler Respiratory Unit | 14.5 | 12.4 | 12.2 | 100.0% | 0 | | 2 | 0 | 11.8% | 8.7% | 4.8% | 2.9% | 15.6% | Yes | -0.9% | 8.0 | 13.5% | 50.0% |
| Ward 5E/F | 11.1 | 8.7 | 9.5 | 100.0% | 1 | | 3 | 4 | 15.5% | 18.7% | 5.0% | 1.9% | 20.2% | Yes | -0.3% | 9.3 | 11.7% | |
| Ward 7E Stroke Unit | 10.9 | 10.6 | 8.8 | 100.0% | 2 | | 0 | 10 | -7.8% | 14.7% | 4.6% | 5.1% | -0.7% | Yes | -0.2% | 8.4 | 14.1% | 95.7% |

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

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

Oxford University Hospitals NHS Foundation Trust

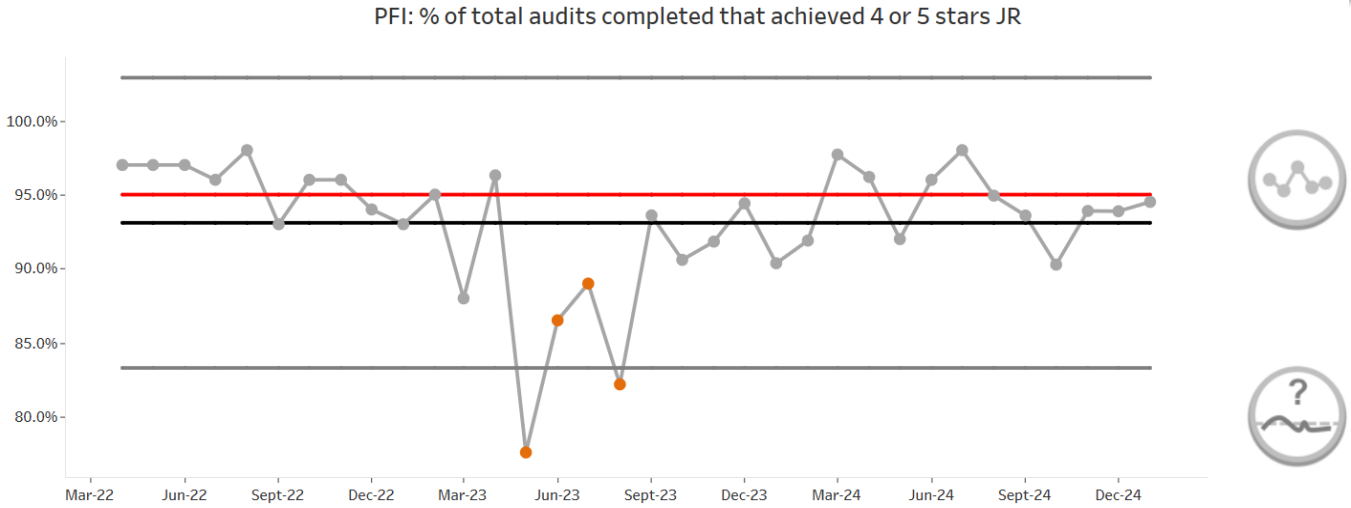
| January | Care Hours Per Patient Day | | | Census | Nurse Sensitive Indicators | | | | HR | | | | | Rostering KPIs | | | | FFT |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward Name | Budgeted Overall | Required Overall | Actual Overall | Census Compliance (%) | Medication Administration Error or Concerns | Extravasation Incidents | Pressure Ulcers Category 2,3&4 | All reported falls | Vacancy (%) | Turnover (%) | Sickness (%) | Maternity (%) | Revised Vacancy HR Vacs plus LT Sick & Mat Leave (%) | Roster manager approved for Payroll | Net Hours 2/-2% | 8 week lead time | Annual Leave 12-16% | % Extremely likely or likely |
| **SUWON** | | | | | | | | | | | | | | | | | | |
| Gastroenterology (7F) | 7.5 | 8.75 | 8.6 | 100.0% | 7 | | 1 | 4 | 9.2% | 7.9% | 5.0% | 5.6% | 16.8% | Yes | -2.4% | 10.4 | 15.1% | 75.0% |
| Gynaecology Ward - JR | 5.48 | 5.74 | 7.3 | 100.0% | 0 | | 0 | 2 | 14.1% | 5.2% | 5.6% | 5.6% | 23.7% | Yes | -1.3% | 8.3 | 12.3% | 85.0% |
| Haematology Ward | 7.42 | 7.84 | 7.8 | 93.6% | 7 | | 2 | 5 | 25.9% | 19.1% | 6.3% | 0.0% | 28.0% | Yes | -2.6% | 9.0 | 13.2% | 100.0% |
| Katharine House Ward | 9.23 | 7.41 | 9.6 | 100.0% | 1 | | 5 | 3 | 13.2% | 2.9% | 4.2% | 12.1% | 27.0% | Yes | 3.0% | 9.4 | 12.9% | |
| Oncology Ward | 8.67 | 8.76 | 8 | 97.9% | 4 | | 6 | 2 | 16.3% | 5.7% | 3.3% | 3.5% | 19.3% | Yes | -0.5% | 9.7 | 14.7% | 66.7% |
| Renal Ward | 9.3 | 9.19 | 10 | 100.0% | 1 | | 2 | 3 | 3.8% | 7.5% | 4.9% | 12.5% | 21.9% | Yes | 3.1% | 9.7 | 12.4% | 100.0% |
| SEU D Side | 8.69 | 8.41 | 8.3 | 98.9% | 4 | | 6 | 6 | 18.7% | 0.0% | 4.5% | 4.4% | 25.8% | Yes | -1.3% | 9.3 | 15.9% | 97.2% |
| SEU E Side | 8.34 | 9.13 | 9.4 | 98.9% | 4 | | 0 | 2 | 16.5% | 7.3% | 4.0% | 0.0% | 16.5% | Yes | 0.4% | 9.3 | 14.1% | 98.3% |
| SEU F Side | 7.53 | 7.91 | 7.7 | 97.9% | 2 | | 0 | 5 | 36.5% | 15.8% | 2.9% | 0.0% | 39.1% | Yes | -9.5% | 9.3 | 13.4% | 96.0% |
| Sobell House - Inpatients | 8.65 | 8.77 | 8.5 | 98.9% | 4 | | 5 | 4 | 30.0% | 8.1% | 5.1% | 8.1% | 35.7% | Yes | -0.1% | 9.7 | 12.7% | |
| Transplant Ward | 9.43 | 8.18 | 9 | 100.0% | 2 | | 1 | 0 | 20.0% | 8.4% | 5.3% | 0.0% | 22.6% | Yes | 0.1% | 8.9 | 18.4% | 97.0% |
| Upper GI Ward | 9.51 | 7.29 | 8.9 | 100.0% | 1 | | 1 | 3 | 18.8% | 2.7% | 5.4% | 15.0% | 32.5% | Yes | -6.8% | 8.9 | 17.1% | 96.7% |
| Urology Inpatients | 8.76 | 9 | 9.2 | 100.0% | 0 | | 1 | 1 | 26.1% | 3.6% | 2.8% | 7.0% | 35.5% | Yes | 1.7% | 8.7 | 12.4% | 98.6% |
| Wytham Ward | 7.7 | 7.01 | 7.4 | 100.0% | 1 | | 1 | 1 | 11.9% | 6.6% | 4.7% | 12.4% | 27.3% | Yes | 3.4% | 8.6 | 13.4% | 91.4% |
| MW Delivery Suite | 15.13 | | 23.2 | | | | | | 39.1% | 0.0% | 0.0% | 11.2% | 47.5% | Yes | -2.0% | 6.9 | 9.3% | |
| MW Level 5 | 6.65 | | 5.1 | | | | | | -38.5% | 16.0% | 5.2% | 3.8% | -30.2% | Yes | -1.5% | 7.4 | 12.3% | |
| MW Level 6 | 4.47 | | 8.7 | | | | | | | | | | | Yes | -0.3% | 7.4 | 13.9% | |
| **CSS** | | | | | | | | | | | | | | | | | | |
| JR ICU | 31.13 | | 27 | 93.6% | 8 | | 2 | 1 | 9.7% | 5.2% | 5.1% | 4.5% | 15.7% | No | -0.8% | 8.7 | 12.3% | |

*NB: HW The Spires data excluded as currently under review*

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

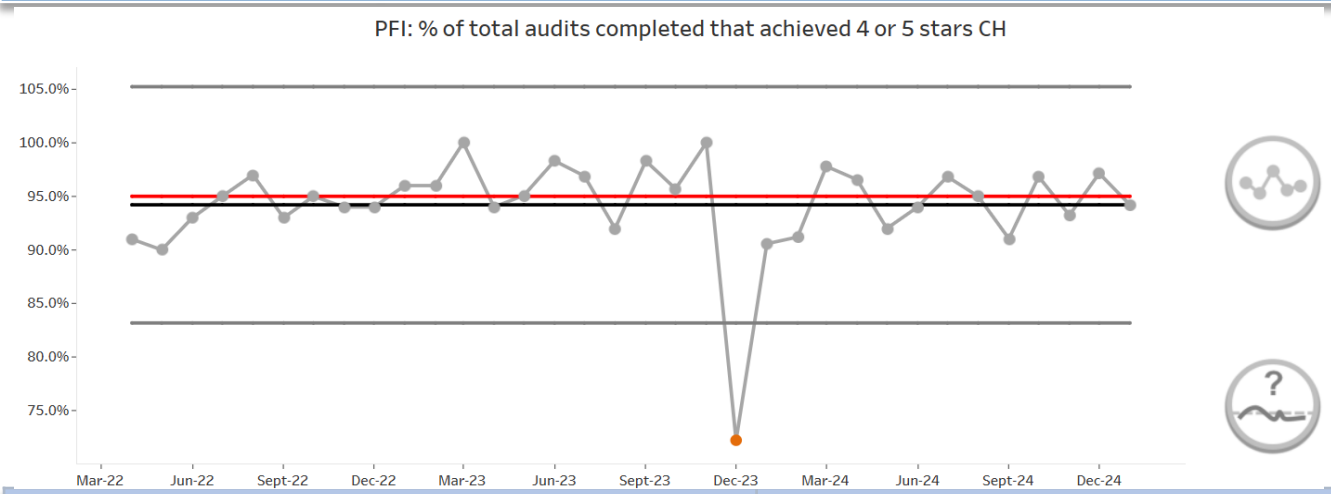
# 3. Assurance report: Estates, Facilities and PFI





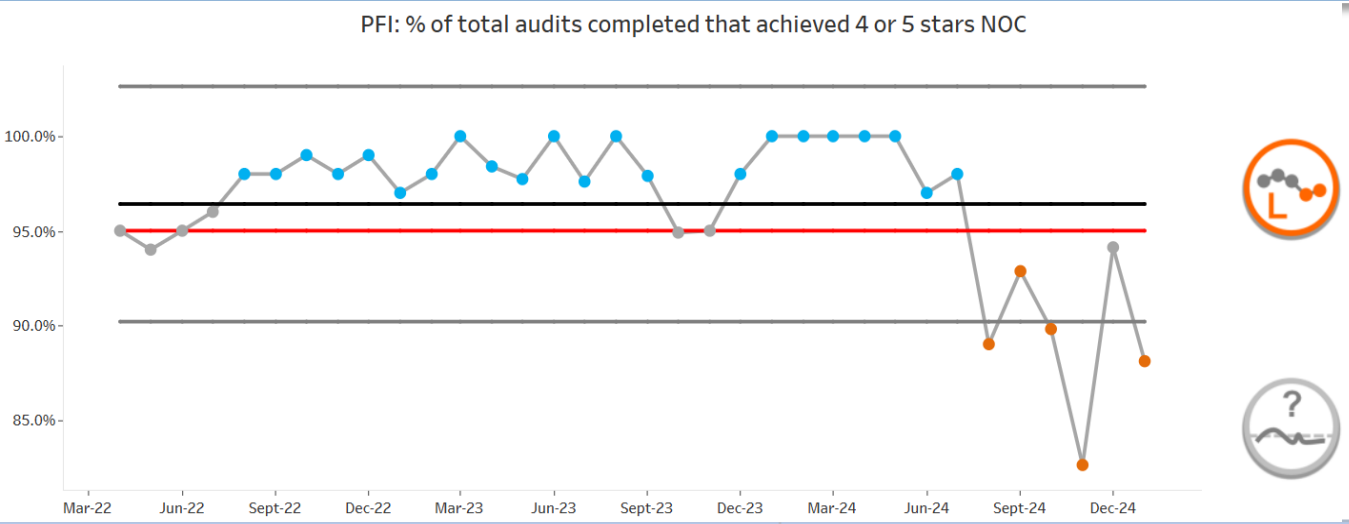

| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| In January 2025, the combined PFI % cleaning score by site (average) for the JR was 96.83% which has been a positive gradual increase over the past 4 months. However, the above graph demonstrates the percentage of total audits undertaken that achieved 4 or 5 stars, which sits at 94.51% which is below the 95% Trust target however an increase on last month.<br><br>In total, at the JR, 225 audits were conducted, 14 of which did not meet the 4* 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 2025. 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 along with re training if required, review of cleaning equipment etc. | Mitie completed the planned number of audits at JR in January 2025, and 14 of those audits failed to achieve the set Trust target under domestic and clinical responsibility. However, all the failed audits were rectified within the required timeframe, resulting in an improvement in the reported percentage with each area meeting the 4*/5*. There are no trends or repetitive departments and wards failing however failures came from both clinical and domestic responsibilities. OCCU Level 2 saw a significant drop in standards from both responsibilities. We are working closely with IPC and the ward/department leads to highlight the issues and address.<br><br>When it comes to managing cleaning risks, patient safety is our top priority. At our Trust, we believe in working together to maintain cleanliness in all our facilities. Whenever an area scores three stars or below, Service Providers create action plans that include responsibilities for domestic, estates, and clinical staff to improve those areas. The Trust PFI management team oversees the implementation of those plans, while domestic supervisors and the Trust PFI team monitor the progress with the support of IP&C. We work collaboratively with the Domestic Service Teams, Clinical teams, and IP&C to enhance the cleanliness of our facilities.<br><br>The PFI team is discussing with the CEFO to redefine the KPIs for cleaning scores to align them more closely to the NSC. The objective is to determine the appropriate measures and provide a better understanding of what is being measured, by whom, and how | 1) Improvement to work towards the 95% target for 4 & 5-star cleaning audits for 2025 at JR.<br>2) Information cascade - Monitoring carried out utilising the My Audit auditing platform, which reports each audit to the PFI management team, area Matron, ward manager and senior housekeeper at the time of completion.<br>3) Actions reviewed weekly at the service providers/Trust PFI domestic services meeting, Monthly reporting to HIPCC<br>4) Review current KPI metrics and align with NSC with redefined metrics clearly set out for ongoing IPR Reports | BAF 4<br><br>CRR 1123 | Sufficient<br><br>*Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months* |

# 3. Assurance report: Estates, Facilities and PFI




| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| In January 2025, the combined PFI % cleaning score by site (average) for the Churchill was 95.65% which is an excellent standard. However, the above graph demonstrates the percentage of total audits undertaken that achieved 4 or 5 stars, which sits at 94.20% which is below the 95% Trust target, and unfortunately a decrease from last month.<br><br>In total, at the Churchill, 69 audits were conducted, 4 of which did not meet the 4* 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 2025. 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 along with re training if required, review of cleaning equipment etc. | G4S completed the planned number of audits at the Churchill in January 2025, and 4 of those audits failed to achieve the set Trust target under domestic and clinical responsibility. However, all the failed audits were rectified within the required timeframe, resulting in an improvement in the reported percentage with each area meeting the 4*/5*. There are no trends or repetitive departments and wards failing however failures came from both clinical and domestic responsibilities. Haematology saw a slight drop in standards from both responsibilities on 2 of the 4 audits completed in January. We are working closely with IPC and the ward/department leads to highlight the issues and address.<br><br>When it comes to managing cleaning risks, patient safety is our top priority. At our Trust, we believe in working together to maintain cleanliness in all our facilities. Whenever an area scores three stars or below, Service Providers create action plans that include responsibilities for domestic, estates, and clinical staff to improve those areas. The Trust PFI management team oversees the implementation of those plans, while domestic supervisors and the Trust PFI team monitor the progress with the support of IP&C. We work collaboratively with the Domestic Service Teams, Clinical teams, and IP&C to enhance the cleanliness of our facilities.<br><br>The PFI team is discussing with the CEFO to redefine the KPIs for cleaning scores to align them more closely to the NSC. The objective is to determine the appropriate measures and provide a better understanding of what is being measured, by whom, and how | 1) Improvement to work towards the 95% target for 4 & 5-star cleaning audits for 2025 at Churchill.<br>2) Information cascade - Monitoring carried out utilising the My Audit auditing platform, which reports each audit to the PFI management team, area Matron, ward manager and senior housekeeper at the time of completion.<br>3) Actions reviewed weekly at the service providers/Trust PFI domestic services meeting, Monthly reporting to HIPCC<br>4) Review current KPI metrics and align with NSC with redefined metrics clearly set out for ongoing IPR Reports | BAF 4<br><br>CRR 1123 | Sufficient<br><br>*Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months* |

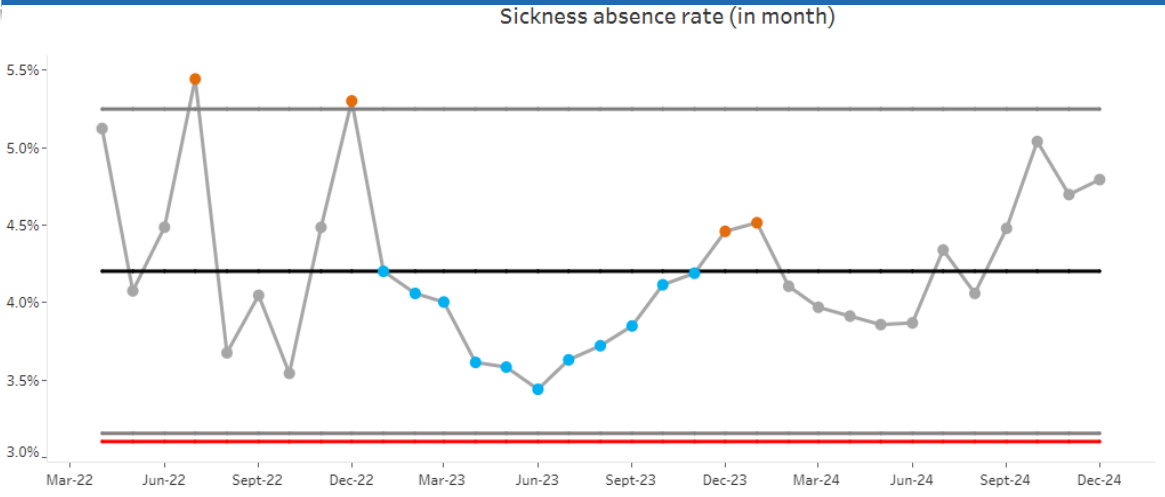
# 3. Assurance report: Estates, Facilities and PFI

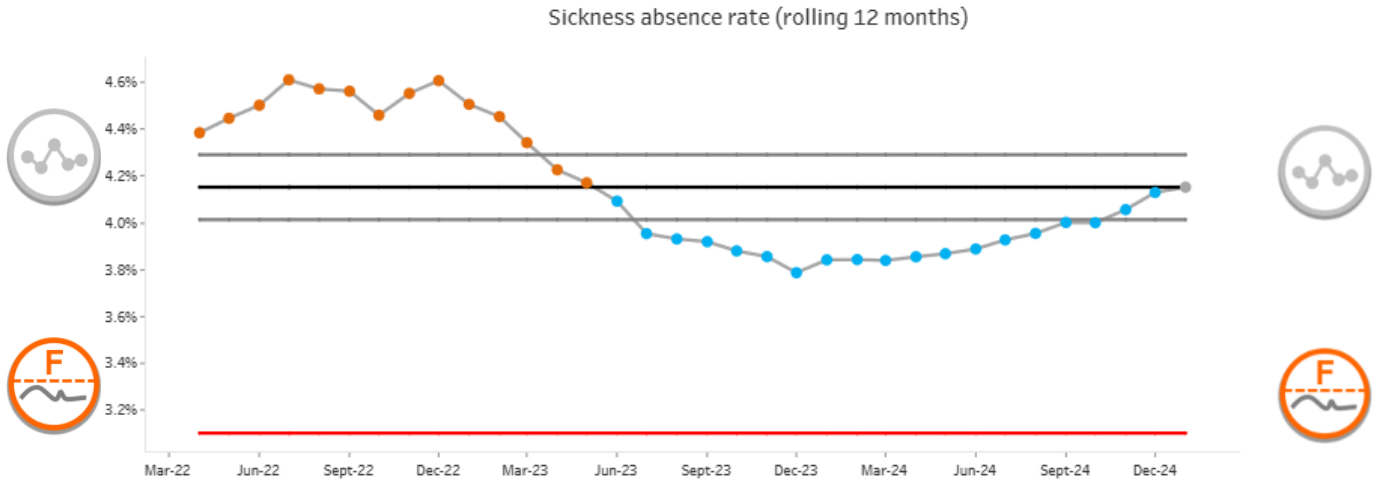



| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| In January 2025, the combined PFI % cleaning score by site (average) for the NOC was 97.26% which is an excellent standard. However, the above graph demonstrates the percentage of total audits undertaken that achieved 4 or 5 stars, which sits at 88.10% which is below the 95% Trust target.<br><br>In total, at the NOC, 42 audits were conducted, 5 of which did not meet the 4* 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 2025. 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 along with re training if required, review of cleaning equipment etc. | G4S completed the planned number of audits at the NOC in January 2025, and 5 of those audits failed to achieve the set Trust target under domestic and clinical responsibility. However, all the failed audits were rectified within the required timeframe, resulting in an improvement in the reported percentage. We are seeing a continued clinical and domestic failures in theatres 1-6, 7&8 and recovery from the previous 2 months. We continue to work closely with IPC, G4S and the ward/department leads and are completing additional audits with the management.<br><br>When it comes to managing cleaning risks, patient safety is our top priority. At our Trust, we believe in working together to maintain cleanliness in all our facilities. Whenever an area scores three stars or below, Service Providers create action plans that include responsibilities for domestic, estates, and clinical staff to improve those areas. The Trust PFI management team oversees the implementation of those plans, while domestic supervisors and the Trust PFI team monitor the progress with the support of IP&C. We work collaboratively with the Domestic Service Teams, Clinical teams, and IP&C to enhance the cleanliness of our facilities.<br><br>The PFI team is discussing with the CEFO to redefine the KPIs for cleaning scores to align them more closely to the NSC. The objective is to determine the appropriate measures and provide a better understanding of what is being measured, by whom, and how | 1) Improvement to work towards the 95% target for 4 & 5-star cleaning audits for 2025 at NOC.<br>2) Information cascade - Monitoring carried out utilising the My Audit auditing platform, which reports each audit to the PFI management team, area Matron, ward manager and senior housekeeper at the time of completion.<br>3) Actions reviewed weekly at the service providers/Trust PFI domestic services meeting, Monthly reporting to HIPCC<br>4) Review current KPI metrics and align with NSC with redefined metrics clearly set out for ongoing IPR Reports | BAF 4<br><br>CRR 1123 | Sufficient<br><br>*Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months* |

# 3. Assurance report: Growing Stronger Together

Oxford University Hospitals NHS Foundation Trust



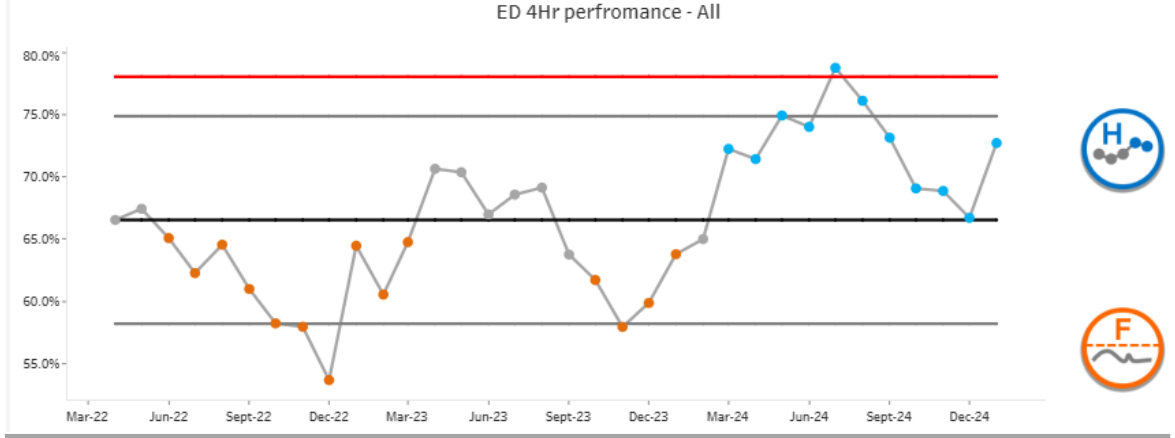



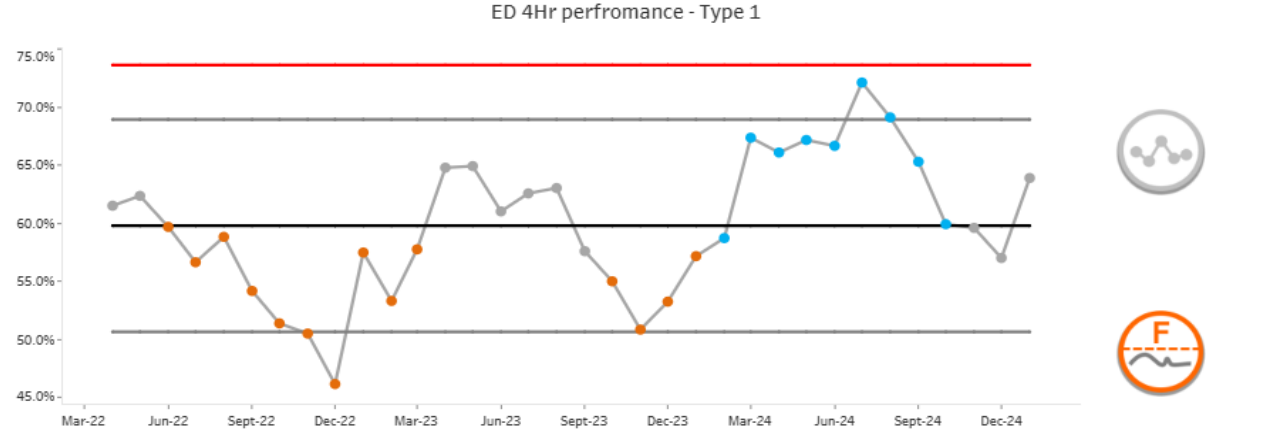

**Benchmarking: October 24 (monthly performance – *lag due to availability of published data from National Sickness Absence Rate report*).**

**OUH: 4.99%** **National: 4.8%** **Shelford: 5.5%** Buckinghamshire Healthcare NHS Trust: 4.5% Royal Berkshire NHS Foundation Trust: 4.3% Oxford Health: 4.9% 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 4.1% in January. Performance exhibited special cause variation, running below the mean since June 2023. This indicator has continued to track upwards since December 2023, with this month showing a small increase of 0.3%.<br><br>In month figure was 4.9% in January with an in-month increase from 4.8%. There has been a noticeable rise in sickness absence reported for colds, coughs and flu. | • A wellbeing campaign ran throughout January 2025 to support staff. This highlighted the full range of wellbeing support including physical, financial, environmental and psychological wellbeing, as well as stress management and wellbeing training.<br>• There is a focus on the top CSUs who have a consistent absence.<br>• Collaborative work with Occupational Health to support managers and staff with a review on the top three absence reasons.<br>• A call to action on long term sickness making sure that staff are supported to successfully return to work.<br>• Alerting managers on staff who have triggered, signposting them to support and coaching them through the sickness absence process<br>• HR pro-actively reviewing sickness absence management training content to reflect changes in new policy, to be launched shortly.<br>• HR to work closely with managers to ensure RTW's are completed.<br>• Sickness absence workshops continuing to support managers<br>• Continuation of support from OH colleagues at monthly meetings to unblock issues and support with proactive actions<br>• Monthly meetings with Wellbeing lead in place to identify areas where additional support may be needed. | 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




**Benchmarking: ED (All types): January 25**

**OUH: 72.7%** **National: 71.3%** **Shelford: 71.6%** BHT: 76.6% RBH: 70.6%

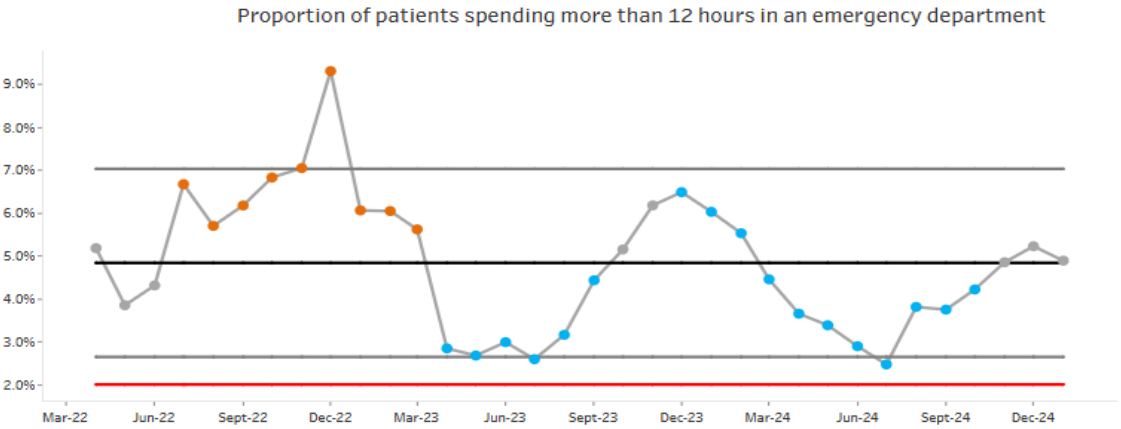
**ICS key**

| | | | |
|---|---|---|---|
| **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 | Risk Register | Data quality |
|---|---|---|---|---|
| The Emergency Department 4hr performance for all types was 72.67% in January for the Trust overall. This is marked improvement in performance, and above trajectory, following a number of consecutive months where performance was more challenged. Type 1 performance was 63.9% for the Trust overall making OUH the second-best performing Shelford Trust for Type 1 performance in January. Breach performance by site was 67.65% for all types and 59.89% for Type 1 at the John Radcliffe Hospital (JR), and 82.79% for all types and 73.67% for Type 1 at the Horton Hospital in January. Monthly attendances to ED remained high during January with a 4.5% increase compared to the monthly average for the last three years. The increase in attendances remains predominantly in adults to the John Radcliffe site where there has been a 6% increase in total attendances.<br><br>Admission avoidance and the utilisation of alternative pathways via SPA is still emerging and requires further focus and targeted work with system partners.<br><br>'Wait to be seen' continues to be the most significant breach reason on both sites for admitted and non-admitted patients. However, this attributes to a reduced percentage of breaches when compared to previous months at 56%.<br><br>The Observation and Review Unit continues to have a positive impact on patient experience, currently accommodating approximately 35 patients per day, with peaks of up to 50. Phase 4 of the ORU QI project will introduce a dedicated doctor to provide earlier assessment and treatment, enhancing efficiency and utilisation. Full utilisation will be realised once posts fully recruited to for the Senior Decision Maker and nursing staff. | **Senior Medical Decision Maker (Consultant) in the JR ED in the overnight period.**<br>ED workforce models supported by Trust Management Executive. Consultation complete with existing recruitment underway.<br>7th January through to 20th February Tuesday, Wednesday and Thursday nights covered. 24th February until the end of the rota block on 28th March Monday night also covered providing senior decision maker cover four nights per week.<br><br>The **Urgent and Emergency Care Quality Improvement Programme 2024/25** has been approved by the Trust Wide Urgent Care Group and TME. Five key national priorities have been agreed, with the Senior Decision Maker and Rapid Assessment & Treatment / Childrens Urgent Care Pathway priorities having commenced in October. This will have a specific focus on Type 1 performance. The two working groups have launched with key stakeholders from multidisciplinary teams collaboratively working together to agree aims, performance / productivity metrics and change ideas using QI methodology. The ideas for change will form part of the overall workplan and updates will be provided to the Trust Wide Urgent Care Group every three weeks. There has been a great level of engagement from all levels of the multidisciplinary team with tests of change underway within the Senior Decision Maker priority and the outputs are being reviewed prior to learning being applied to future PDSA cycles. Meetings are planned to understand the Children's priorities in more depth to identify where QI support can be aligned and plan any tests of change that would be required.<br><br>Phase 4 of the ORU QI project will introduce a dedicated doctor to provide earlier assessment and treatment, enhancing efficiency and utilisation. | Completed - Recruitment approach underway through 2024/25<br><br>Quarter 3 & 4 2024/25<br><br>TWUCG Quarter 3 & 4 | BAF 4<br><br>CRR 1133 (Red) | Sufficient<br><br>*Standard operating procedures in place, staff training in place, local audit undertaken in last 12 months, and independent audit completed in last 18 months* |

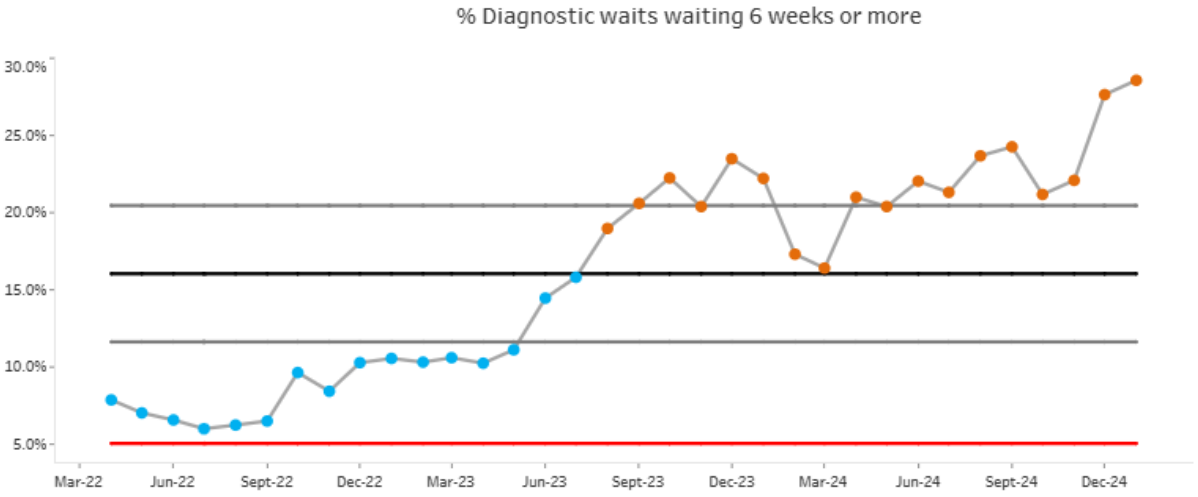
# 3. Assurance report: Operational Performance, *continued*






| Summary of challenges and risks | Actions to address risks, issues and emerging concerns | Action timescales and assurance group | Risk Register | Data quality rating |
|---|---|---|---|---|
| The proportion of patients with a length of stay of more than 12 hours in the Emergency Department was 4.84% (778 patients, 78 less than previous month) in January. This is above the target and sustaining previous positive improvement in performance has been more challenging. The Horton Hospital has made some improvements in comparison to the previous month where challenges were most apparent, decreasing from 4% to 2.9% of patients residing in ED for more than 12 hours (114 patients, 50 less than previous month). The JR position was on a par with the previous month with 5.4% of patients residing in ED for more than 12 hours (664 patients). This is 27 less patients compared to December.<br>Conversion rate at the Horton was on a par to December where rates were similar to those previously seen in the summer months indicating that the higher-than-average number of patients with a total length of stay over 12 hours and increase in ED average length of stay at the Horton, is primarily due to flow out of ED to EAU and the wards. This is further supported by a dramatic increase in occupancy at the Horton from 86.11% in November to 96.16% in December and 95.14% in January. Bed occupancy at the JR was marginally higher than the previous month at 97.94%. The planned additional funded winter beds were open in December and work was undertaken to prepare a Winter Super Surge Ward should it be needed. To date this has not been required on the JR site and no additional beds were required at the Horton. SDEC capacity has remained protected and remains a focus of the Trust's Winter Plan. There has been minimal impact to planned care owing to increasing urgent and emergency care pressures with plans in place to mitigate these over the remaining weeks of 'winter'.<br>The number of patients whose discharge was delayed became increasingly challenged through December and January, increasing from 7.9% in November to 9.7% in December and 9.9% in January. This equates to 3,837 bed days lost in January. The average number of patients delayed per day increased from 86 in November to 113 in December and 121 in January. This is on a par with the January 2024. However, through system improvement work the average number of days delayed has reduced by 0.6 of day comparing January 2024 to January 2025 where the average was 6.5 days. The patients with the longest delays were Oxfordshire patients waiting for pathway 3 or out of county delays. Whilst Discharge To Assess (D2A) is now embedded and there are minimal delays for Oxfordshire residents on this pathway, delays for Pathway 3 and housing related discharge delays continue to be an area of concern for patients in all Oxfordshire bed bases. Associated with the increase in ED attendances, is the medical and social complexity of patients and the impact of D2A where there is a significant increase in care package size and support required for a person to return home. Delays for non-generic pathway 2 beds are becoming an increasing concern and driving an increasing length of delay, now at 7.2 days in January. In contrast, generic patients are transferred in under 24hrs. OUH is holding its position as the best performing Shelford Trust for patients with a stay over 21 days. | • The live bed state programme launched in Q3 23/24 with phase 1 successfully implemented across the Trust during Q4. Work continues to finalise plans for phase 2 which was due to launch in Q4 2024/25.<br><br>• New Board Round Policy relaunched successfully across all acute inpatient areas (41 wards). Trust wide roll-out is underway through the Quality Improvement (QI) Standard Work Programme. | Trust Wide Urgent Care Group<br><br>January 2025 – not on track due to delays with Cerner. Now resolved. Timescales to be amended once confirmation of Digital work plan confirmed for 2025/26.<br><br>Q3/Q4 2024/25 – on track | BAF 4<br><br>Link to 1133 (Red) | Sufficient<br><br>SOP's are in place, staff training in place, local audit undertaken in last 12 months, and independent audit completed in last 18 months |

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




| Benchmarking: December 24 DM01 | |
|---|---|
| OUH | 27.6% |
| National | 16.7% |
| Shelford | 24.9% |
| ICS | BHT: 23.2%<br>RBH: 12.6 |

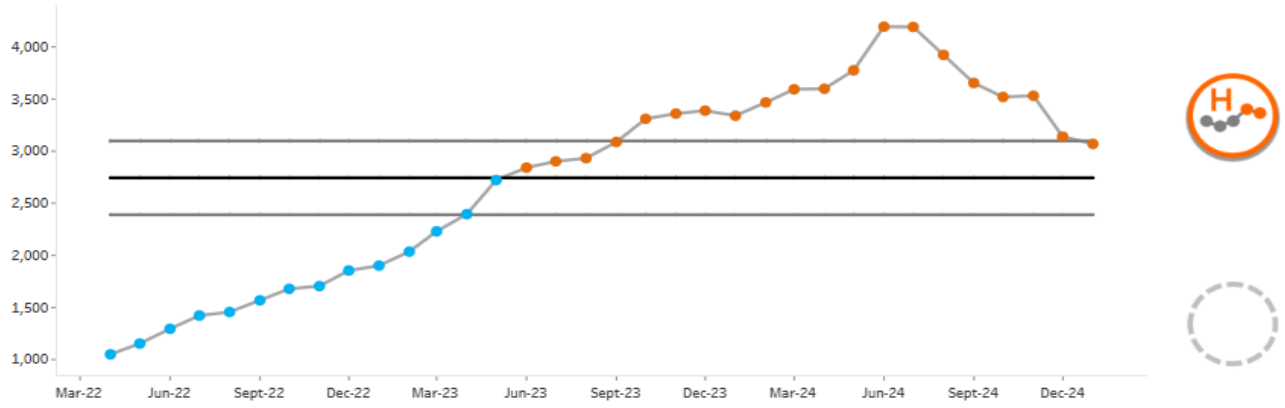
| ICS key | |
|---|---|
| BHT | Buckinghamshire Healthcare NHS Trust |
| RBH | Royal Berkshire NHS Foundation Trust |

| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group | Risk Register | Data quality |
|---|---|---|---|---|
| The percentage of diagnostic waits over 6 weeks+ (DM01) was 28.54% in January. The indicator exhibited special cause variation due to performance being below the mean for more than six successive periods, as well as below the lower process control limit. The indicator has consistently not achieved the target of 95.0%.<br><br>Audiology:<br>• Significant deficit in demand and capacity to meet the standard alongside a change in the ENT pathway<br>• Clinical vacancy of 1 WTE which may increase to 2.5 WTE<br>• Paediatric Audiology now seeing Community Paediatric Audiology<br><br>Endoscopy:<br>• Capacity shortages to meet demand<br>• Reduction in sessions being volunteered for due to changes in NHSP rates<br>• Lapsed Surveillance/Planned pathways now retriggering as a DM01 reportable | Audiology:<br>• Insourcing in place supporting DM01 and ENT elective recovery (adults)<br>• AQP in place since September by Northamptonshire ICB, reducing demand<br>• Community Diagnostic Centre unable to resource staff however continue to monitor for any opportunities<br>• Recruiting into 1.5WTE (January 2025)<br><br>Endoscopy:<br>• Paper to BPG in January 2025 for additional capacity to sustain Surveillance capacity and TVCA funding to support diagnostic funding commenced. Additional TVCA funding to increase capacity approved.<br>• Triaging all referrals for efficient referral management commenced 7th February<br>• Training list reviewed and acknowledged<br>• ERF allocated for additional activity has been utilised<br>• 2 Nurse Endoscopists will complete training to run independent lists from April – BPG paper to support 2025/26<br>• Agreed all consultants to do 12-point lists unless a training list<br>• Mutual Aid options are being considered with Frimley however very low patient uptake<br><br>Ultrasound:<br>• Additional scanning room continues at Brackley Health Centre providing additional 300 appointments a week<br>• TVCA funding supporting 3,000 slots in Q4 via insourced supplier<br>• Workforce plan developed to ensure resilience going forward, initial paper for ERF conversation to substantive approved by TME September 2024, full workforce plan being developed.<br><br>MRI:<br>• Additional TVCA funded scanner on site through to end of March to support increase in demand seen over recent months | Weekly Assurance meeting will monitor all actions on a bi-weekly basis<br><br>Audiology: Expected to recover standard by March 2025<br><br>Endoscopy: Expected to recover standard by March 2025, subject to mutual aid*.<br><br>Ultrasound: Improvement trajectory in development | 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 |

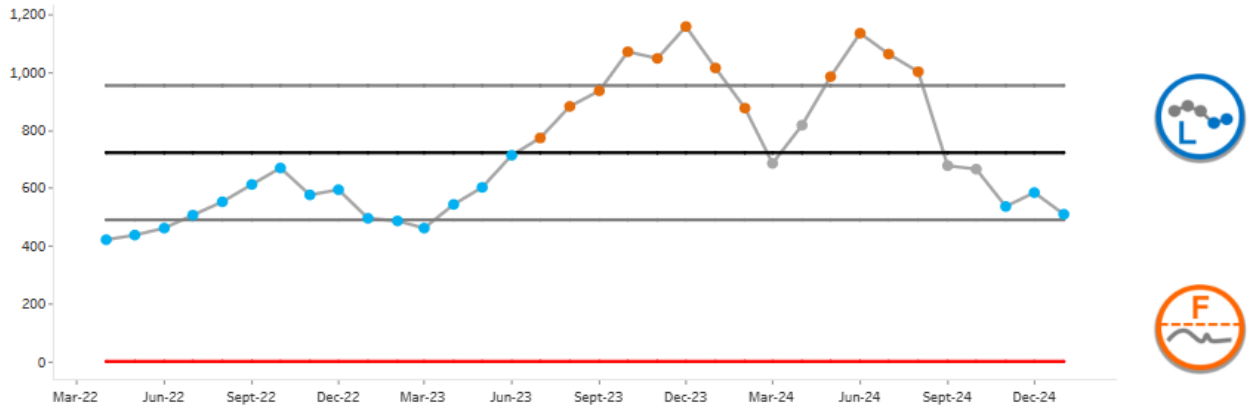
# 3. Assurance report: Operational Performance, *continued*

Oxford University Hospitals NHS Foundation Trust

RTT standard: >52-week incomplete pathways




RTT standard: >65-week incomplete pathways

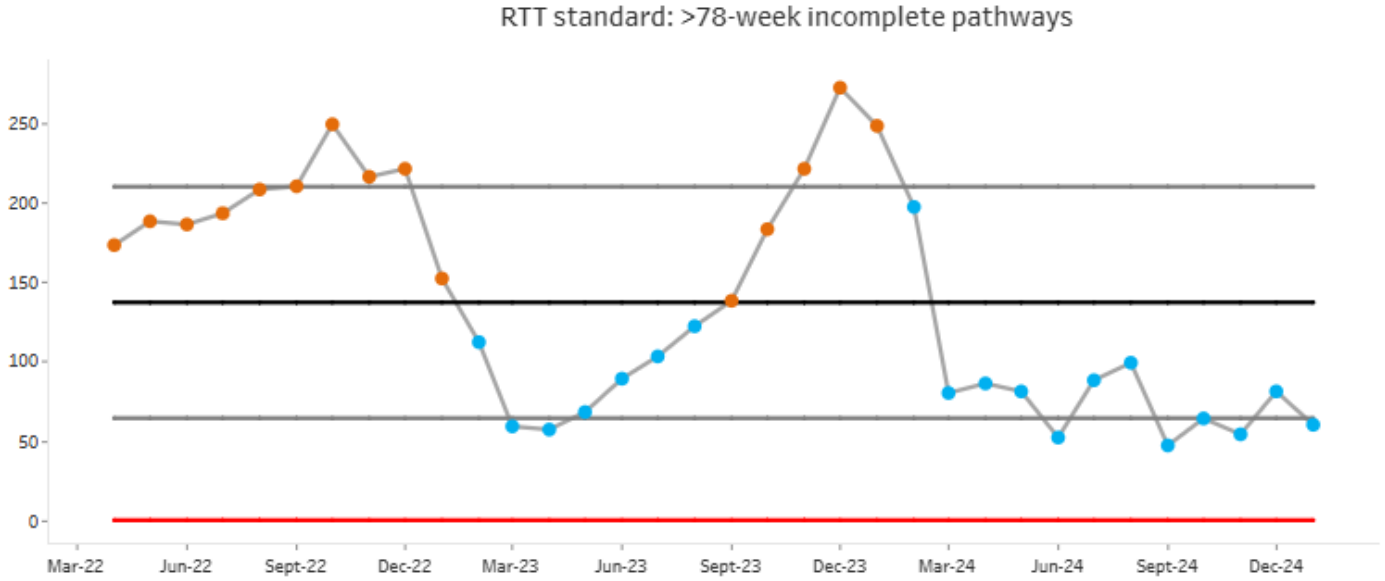



| Benchmarking (>52 weeks): December 24 | | | | |
|---|---|---|---|---|
| **OUH: 3,132** | **National: 1,142** *(avg.)* | **Shelford: 2,499** *(avg.)* | BHT: 1,213 | RBH: 23 |

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

| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| The number of patients waiting more than 52 weeks to start consultant-led treatment was 3,063 at the end of January. Performance exhibited special cause variation due to >six consecutive periods of performance above the mean and exceeding the upper process control limit.<br><br>**104 weeks** - **Nil** incomplete pathway reported<br><br>**78 weeks** - **60** incomplete pathways of which 38 were due to capacity, 7 due to Patient Choice reportable (C1), 2 Corneal and 13 due to Complex pathways<br><br>**65 weeks – 509** incomplete pathways reported which is a decrease from the previous month by 75 pathways and was in line with our forecast trajectory. Focus remains in place to deliver nil pathways beyond 65-weeks. Services not as challenged are undertaking recovery of **52-week backlog.** | • **Orthopaedic services** contracts/agreements are in place with several Independent Sector Providers and 5x spinal theatre lists converted to orthopaedics in Q4. Weekend trial lists commenced in January. Extend x3 Locum posts beyond March 25 dependant on EPR funding 25/26.<br>• **ENT services** now have insourcing in place for Audiology capacity, increased paediatric daycase capacity, 4x additional insourcing clinics set up in January. Nose conditions offered within BOB for Mutual Aid however backlog is patients waiting for ear procedures. Evaluation of an efficiency review undertaken in existing clinic during January underway.<br>• **Urology services** (TULA) in place and additional gynae lists identified for repurposing to urology. Insourcing of MEDCARE commenced in February focusing on outpatients and diagnostics.<br>• **Non-admitted pathways** increasingly scheduled and either clock stopped or converted to admitted in advance of entering the monthly cohort at risk<br>• **Elective Recovery Fund** schemes live and tracked at Elective Care Delivery Group.<br>• **Patient Engagement Validation** exercise for H2 65-weeks concluded; launch of H1 2025/26 undated 1st appointments for challenged services commenced - most other specialties have also partaken with a few exclusions (clinical genetics, palliative care, oncology etc.). All responses will be prioritised for mutual aid with Partner Providers or Independent Sector Providers. Also contacting cohorts lower down for services such as Dermatology to improve DNAs and Endoscopy patients to create a standby list of short notice cancellations (utilisation).<br>• **Recovery Action Plan** is now live and populated against specialty level trajectories for delivery of the forecast, mutual aid is required to deliver on zero patients waiting over 65 weeks at the end of March 2025. | All actions are being reviewed and addressed via weekly Assurance meetings, Elective Delivery Group & Divisional Performance Reviews | BAF 4<br><br>Link to CRR 1135 (Amber) | Sufficient<br><br>*Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months* |

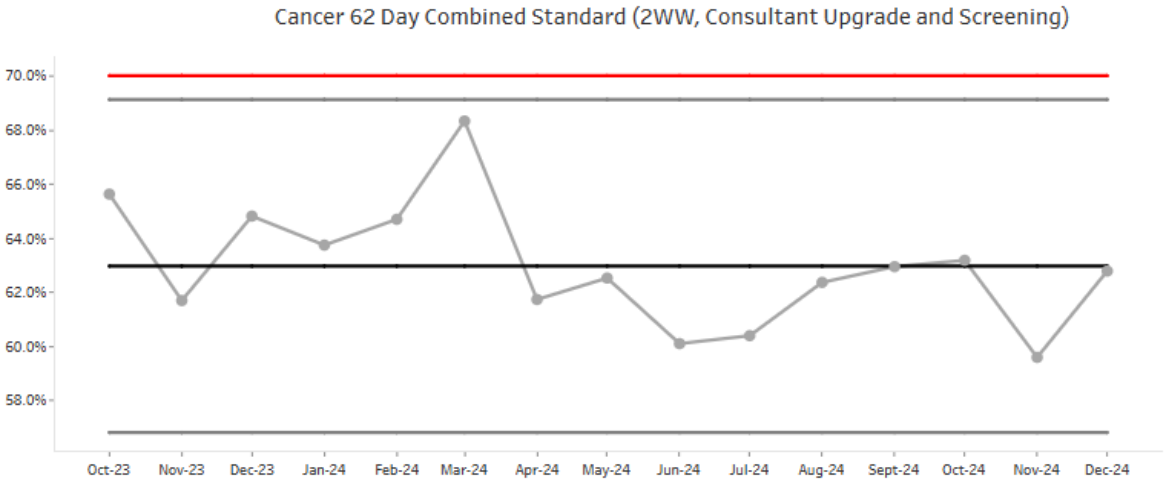
# 3. Assurance report: Operational Performance, *continued*

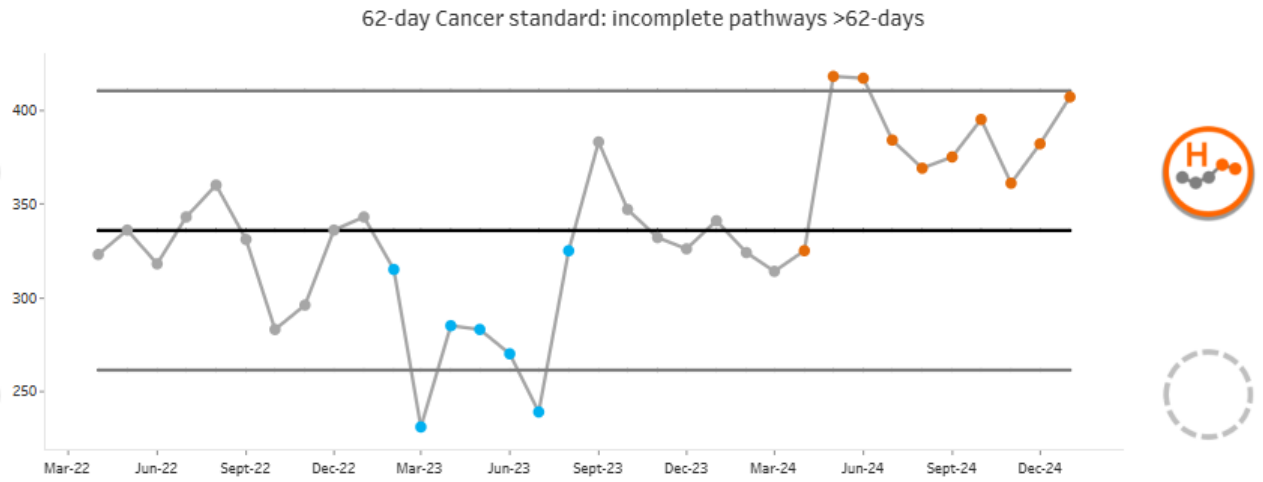



| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| As stated on previous slide | • As stated on previous slide | As stated on previous slide | As stated on previous slide | As stated on previous slide |

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





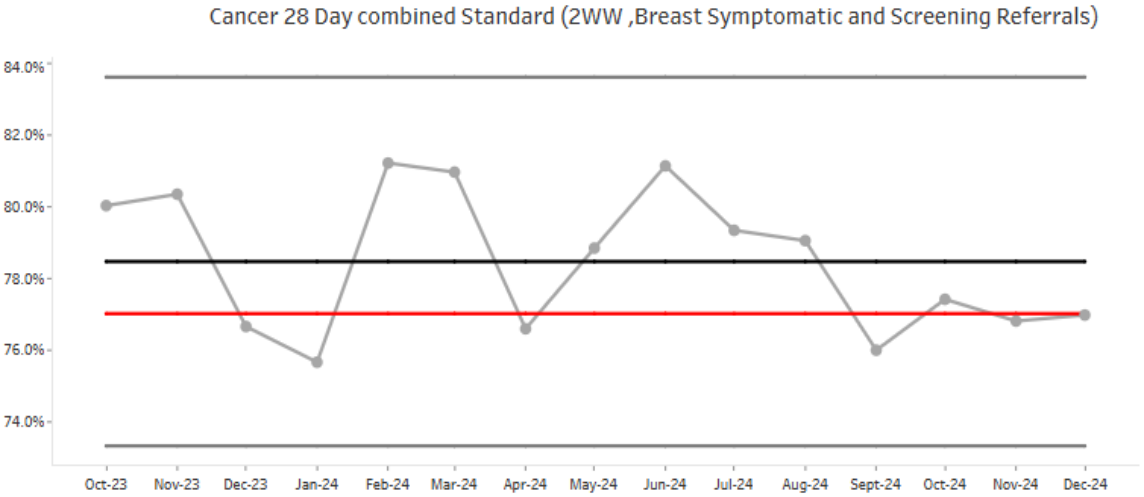

| Benchmarking: December 24 | | | | |
|---|---|---|---|---|
| **OUH: 62.8%** | **National: 73.6%** | **Shelford: 63.2%** | BHT: 61.2% | RBH: 77.1% |

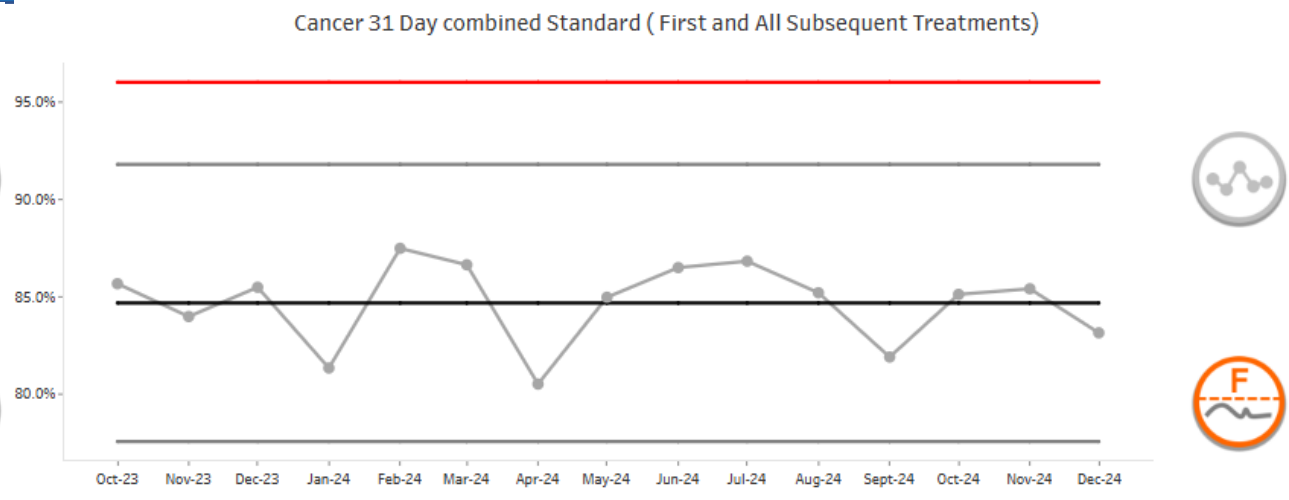
| ICS key | | | |
|---|---|---|---|
| **BHT** | Buckinghamshire Healthcare NHS Trust | **RBH** | Royal Berkshire NHS Foundation Trust |

| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| Cancer performance against the 62 days combined standard was 62.8% in December 2024, and below the performance target of 70%. Performance is reported one month in arrears due to the extended reporting period for this indicator.<br><br>All tumour sites apart from Brain, Children's, Gynae – Other, Haematology Leukaemia, Skin, Upper GI – Pancreas, and Urology – Testicular are non-compliant for this standard in December.<br><br>**Challenges identified:**<br>• Complex tertiary level patients (9%)<br>• Some slow pathways and processes (2%)<br>• Capacity for some surgery, diagnostics and oncology (77%)<br>• Late inter provider transfers (10%)<br>• Patient reasons (2%)<br><br>**>62-day combined PTL as at 19th Feb 2025** remains above trajectory of delivering 6% proportion of long waits. | **The Cancer Improvement Programme was relaunched and now comprises of part Quality Improvement (QI) and the other, Strategy.** Both focus on 28-day Faster Diagnosis Standard (FDS) and other key standards.<br>**Performance of >62-day PTL vs plan –** recovery includes:<br>• Incomplete and late Inter-Provider Transfer review and escalation to referring Providers<br>• Surgical capacity through theatre reallocation<br>• Patient engagement through the Personalised Care agenda<br>• SOP and escalation of benign patients awaiting communication<br><br>**Waiting List Census 19/02/2025:**<br>**Urology** remains the highest deficit to plan for >62-days (125 actual vs 74 plan) predominantly due to the increase in referrals linked to public figure awareness. One-stop MRI clinics and additional biopsy clinics in place. Process redesign for Flexi without CT report in place. TVCA funding is in use mitigating backlog increase.<br>**Gynae** – holds the second highest volume against plan (40 actual vs 26 plan). New consultant started in January providing additional hysteroscopy and operating sessions (2 key challenged areas in the pathway). Pre-hyster clinic pilot resulted in a 30% diversion rate, decompressing demand on service. Clinical lead oversight of all GA hysteroscopy requests. Clinic slot reallocation of benign to cancer and scheduling from December onwards.<br>**Lung -** has the third highest volume against plan (45 actual vs 34 plan). Additional bronchoscopy capacity identified and in place. Locum consultant approved until March – Business case in development for sustainable solution. | Faster Diagnostic Standards (FDS) to be achieved by all tumour sites outlined within the FDS Framework 2023/2024<br><br>186 patients over 62 days on the Combined Patient Tracking List to deliver 6% ask. Above trajectory (271) with 362 patients (10.5% vs 6% target) | BAF 4<br><br>Link to CRR 1135 (Amber) | Sufficient<br><br>*Standard operating procedures in place, staff training in place, local audit undertaken in last 12 months and independent audit undertaken in previous 18 months* |

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

Oxford University Hospitals NHS Foundation Trust



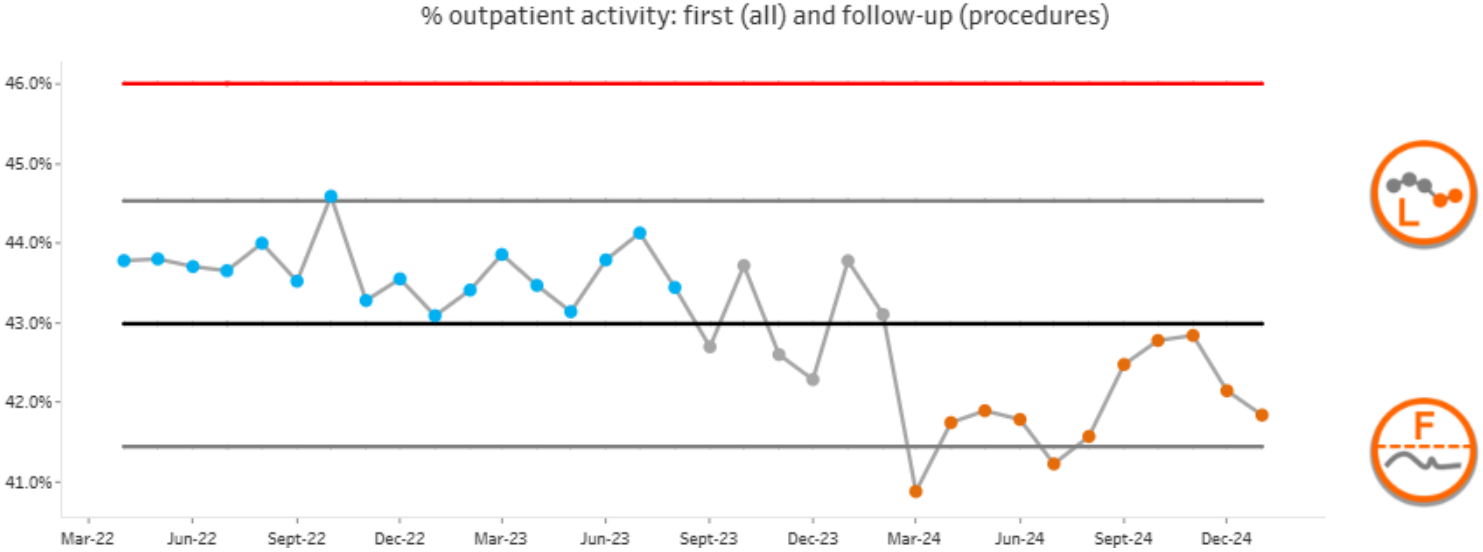




| Benchmarking (Cancer 31 day standard): December 24 | | | | |
|---|---|---|---|---|
| **OUH: 83.1%** | **National: 95.2%** | **Shelford: 86.4%** | BHT: 86.8% | RBH: 96.0% |

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

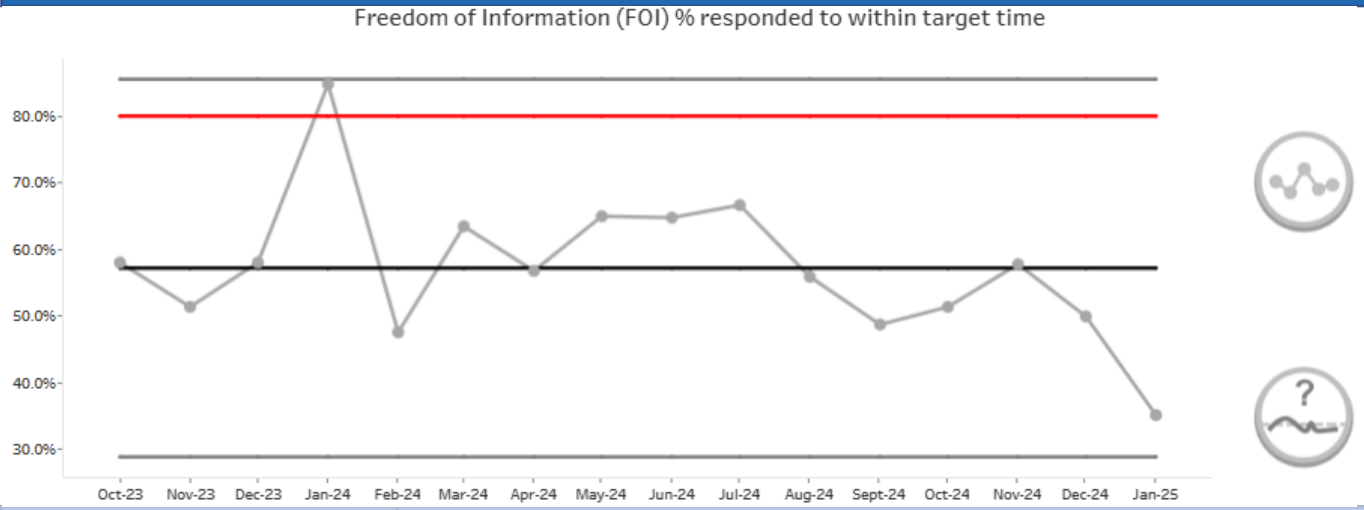
| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| Reporting of Cancer Standards changed from October 2023 in line with the National Cancer Waiting Times guidance. Cancer performance against the **31-day combined standard was 83.1% in December**, and below the performance target of 96%. Performance is reported one month in arrears due to the extended reporting period for this indicator. This is a deteriorating position against 85.4% in November and 85.1% in October.<br><br>In relation to the **Faster Diagnosis Standards (FDS)** , performance for **December was 76.9%**, above the national target of 75% and close to year end operational target of 77%.<br><br>Audits and analysis shows surgery capacity is the key issue affecting performance with over 70% of breaches due to surgery capacity. | Mutual aid for benign general capacity across BOB Partner Providers to support repurposing of OUH capacity.<br><br>Agreement to run a minimum 96% theatre lists during term time and a minimum of 89% during peak holiday periods throughout the year. Daily focus on mitigating patient cancellations and utilisation of lists via the 6-4-2 process. Shadow booking of patients to avoid loss of theatre time due to medical cancellation.<br><br>Prehab service redesign to be taken through Peri-Operative working group for formal steer and support.<br><br>More time given at weekly Check and Challenge to tackle backlog challenges and ensure patients are not only scheduled within 31-days but primarily by day 62. | Q4 2023/24<br><br>Q4 2023/24 staggering into 2024/25 for other specialties not named.<br><br>Q3 2024/25 | BAF 4<br><br>Link to CRR 1135 (Amber) | Sufficient<br><br>*Standard operating procedures in place, staff training in place, local audit undertaken in last 12 months and independent audit undertaken in previous 18 months* |

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



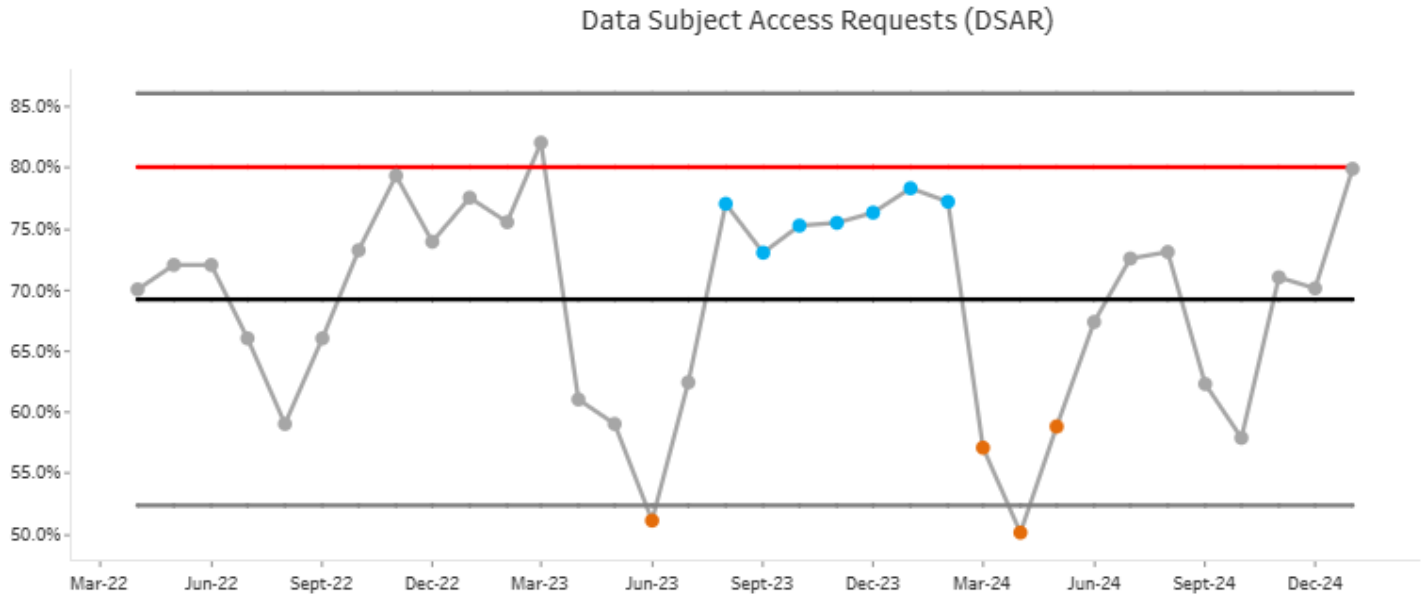

| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| The percentage of first new outpatient and follow-up outpatient appointments with procedures was 41.8% in January. The indicator exhibited special cause deteriorating variation due to performance being below the lower process control limit. The indicator has consistently not achieved the target of 46.0%.<br><br>Delayed completion of outcome forms to identify procedures in recent months under-reports performance<br><br>Possibility of some procedures being carried out in theatres instead of an outpatient setting.<br><br>*the most recent month's position may increase due to the completion of processing outpatient procedure coding. | Evaluation of individual specialties to optimise outpatient procedure activity by reviewing daycase procedures for conversion to an outpatient setting, releasing theatre capacity as well as modelling a one-stop services in outpatients, thus reducing follow-up activity. Using Model hospital GIRFT procedure specific analysis.<br><br>The Further Faster Programme cohort 3 in association with GIRFT to support this performance metric. Several specialty level working groups in place undertaking evaluation and improvement work under this Programme.<br><br>Clinic Outcome Form Project Board commenced in December, to digitise clinic outcomes and improve capture of procedure codes as well as several other benefits. Project Board reporting to newly relaunched Outpatient Steering Group and Digital Oversight Committee.<br><br>External audit supplier, IQVIA analysing missed opportunity for procedure coding by benchmarking specialty level activity. This programme of work is overseen by the Productivity Committee. | OPSG – April 2025 | BAF 4<br><br>Link to CRR 1135 (Amber) | |

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



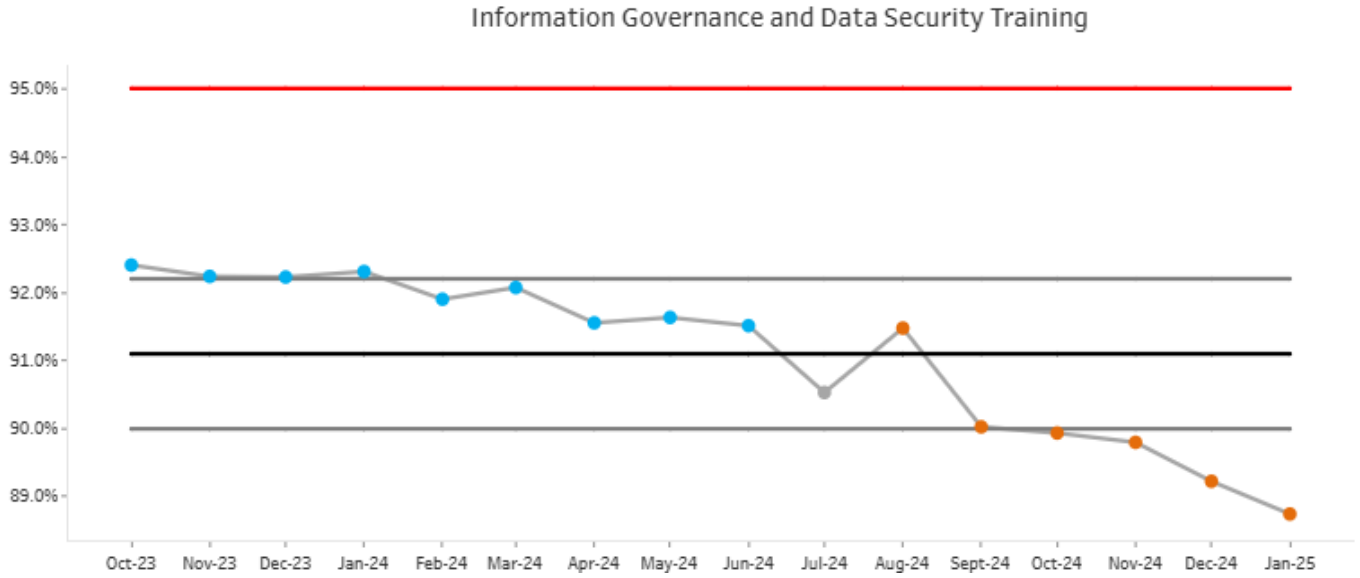

| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| M10 FOI performance against the 80% target remained below the performance standard at 35% and exhibited common cause variation.<br><br>88 cases were closed in M10 of which 31 were on time – an average number of closures against an elevated number of received cases.<br><br>The FOI team have been working on a QI project which has taken up time that would usually be dedicated to FOI casework – as such some performance potential has been lost this month. | Review of FOI processes is being undertaken in partnership with the Trust's Data Protection Officer, and the Information Commissioner's Office – this has been expanded to include colleagues from the Quality Improvement team and stakeholders from across the Trust.<br><br>An Improvement Plan has been presented to Board – some actions from this plan have already been completed. Thus far:<br><br>**Software:** FOI platform with significant improvements to reporting data functions was activated on 01/02/2025 – this will allow metrics on performance of individual departments and divisions that will be reported to senior managers giving improved oversight on where cases are going and opportunities to identify bottlenecks.<br><br>**Escalation Process:** The improved management data will enable an improved escalation process for "stuck" cases. Chief officers will be presented with a list of cases in their areas in this situation<br><br>**Backlog:** Old cases that had not been closed due to a lack of response to requests from clarification to the requestor have been closed<br><br>**Benchmarking:** Other Shelford Group Trusts are being contacted for information on their FOI processes, systems and resourcing<br><br>**Staff Education:** an email detailing FOI responsibilities has been sent to all staff – a follow up in more detail will be sent to FOI stakeholders | A QI project to examine the FOI process and awareness amongst staff and stakeholders is under way – third meeting is being held on 28/02/2025<br>Assurance reviewed at 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* |

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




| Summary of incident | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| In M10 DSAR performance has recovered to 79.9%. This was very close to the target of 80% and the highest performance since March 2023.<br><br>The Trust received 844 DSAR requests in M10, an 18% drop from M9 | PACS' performance varies depending on clinical pressures. They have one staff member on secondment and one vacancy on hold due to recruitment pause. Performance was good this month due to reduced clinical demand. | Actions and performance are overseen by the 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* |

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




| Division | Employees Total Number | Heads Outstanding | % Completed |
|---|---|---|---|
| NOTSSCAN | 3724 | 527 | 85.80% |
| Medicine Rehabilitation and Cardiac | 3357 | 433 | 87.10% |
| Surgery Women and Oncology | 3334 | 412 | 87.60% |
| Clinical Support Services | 2422 | 283 | 88.30% |
| Corporate | 1000 | 107 | 89.30% |
| Operational Services | 213 | 17 | 92.00% |
| Estates | 197 | 26 | 86.80% |
| Research and Development | 160 | 24 | 85.00% |

| 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 89% in M10 – this is a further fall away from the target of 95%.<br><br>With the change in calculation method, a breakdown per Division is now available and included at the top of this slide. No Divisions are currently achieving the 95% target.<br><br>The continual downward trend needs to be arrested – individual managers already receive reminder emails when their staff's training is out of date but this is no longer effective.<br><br>Satisfactory IG training completions rates are a requirement to pass DSPT – the current situation would not put us in a position to pass the training and awareness section. | Current situation to be presented at DOC on 03/03/2025 to agree actions with Divisional Directors and senior Digital staff. | Actions and performance are overseen by the Digital Oversight Committee<br><br>DSPT Audit has been moved to February 2025 (now confirmed) and is underway | 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 |
|---|---|---|---|---|---|
| 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 | Elective Access | National | SDEC: % of Same Day Activity | |

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 |